Mississippi Division Of Medicaid

Provider Workshops

2018

(Revised 11.16.18)

MISSISSIPPI DIVISION OF
MEDICAID

Purpose of the 2018 Provider Workshop

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

Division of Medicaid in collaboration with Conduent and the managed care Coordinated Care Organization's (CCO) is 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.*

DAY 1 AGENDA

9:00 a.m.	9:30 a.m.	**Welcome & Introductions**
9:30 a.m.	10:30 a.m.	**Medicaid Overview**

Managed Care Overview
Provider Enrollment   Credentialing   Medicaid Changes

CCO Overview
Magnolia Health   Molina Healthcare   UnitedHealthcare

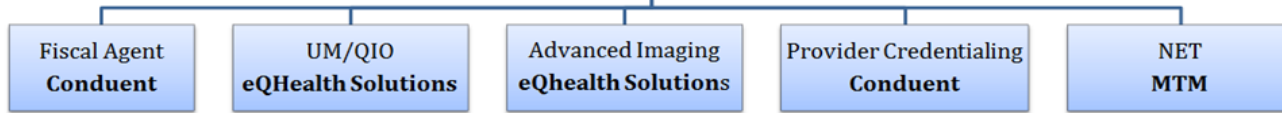|		
10:30 a.m.	12:30 p.m.	**Prior Authorizations** **Retro Reviews** **Claims Review**
12:30 p.m.	1:30 p.m.	****LUNCH BREAK - On Your Own****
1:30 p.m.	2:30 p.m.	**Dental** **Vision** **Non-Emergency Transportation**
2:30 p.m.	3:30 p.m.	**Home Health Services** **Waiver Services** **Durable Medical Equipment**

Medicaid Organizational Chart
Effective October 1, 2018

MISSISSIPPI DIVISION OF MEDICAID

- Fiscal Agent **Conduent**
- UM/QIO **eQHealth Solutions**
- Advanced Imaging **eQhealth Solutions**
- Provider Credentialing **Conduent**
- NET **MTM**

Managed Care

MississippiCAN

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*

MOLINA HEALTHCARE

Behavioral Health *Molina Healthcare*	Pharmacy *CVS Caremark*
Dental *Avesis*	Non-Emergency Transportation *Southeastrans*
DME *Molina Healthcare*	Vision *March Vision*
Nurse Advice Line *Behavioral Health Crisis*	Advanced Imaging *Molina Healthcare*
Care Management & Disease Management *Molina Healthcare*	

UnitedHealthcare Community Plan

Behavioral Health *UBH-Optum Healthcare*	Pharmacy *Optum RX*
Dental *Dental Benefits Provider*	Non-Emergency Transportation *National MedTrans*
DME *UnitedHealthcare*	Vision *March Vision*
Nurse Line	Advanced Imaging *EviCore*
Case Management *Optum Healthcare*	

CHIP

- **Magnolia Health CHIP Contractor**
- **UnitedHealthcare Community Plan CHIP Contractor**

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

Medicaid Overview

Top 5 Medicaid Issues

Adjusting and Voiding Claims

▪**Adjustment –** *Adjustment is two-fold. Recouping of funds and reprocessing claim (with corrections) on same RA.*

- With an adjustment, the money is recouped and reprocessed based on the provider's corrections.
- Denied claims cannot be adjusted.
- Crossover claims cannot be adjusted.

▪**Void –** *Completely recoups funds that were previously paid.*

- Crossovers can be voided
- Any previously paid claim can be voided. (Timely filing still applies)

Importance of Updating Your Banking Information

CONDUENT

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

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

Timely Filing

- Claims for covered services must be filed within 12 months from the through/ending date of service.

- Claims filed within 12 months from the initial date of service, but denied, can be resubmitted with the transaction control number (TCN) from the original denied claim.

- Claims over **12 months** can be processed if the beneficiary's Medicaid has been retroactively approved by DOM or Social Security Administration.

- Medicare crossover claims for co-insurance and/or deductible must be filed with the Division of Medicaid within **180 days** of the Medicare paid date. This is also applicable to Medicare Part C claims.

    - **NOTE:** *Claims filed after the 180 day limit will be denied.*

- Crossover claims over **180 days** old can be processed if the beneficiary's Medicaid eligibility is retroactive. Paper crossovers must be filed within 180 days of the Medicaid retroactive eligibility determination date.

Timely Filing TCN Location

Forms	Fields
CMS-1500	Field 22
UB-04	Field 64
ADA Dental	Field 35
Crossover Part A	None
Crossover Part B	None

Request for Information (RFI) Submittal

- You can submit a RFI or request for public records in writing by contacting the Mississippi Division of Medicaid (DOM) multiple ways as listed below, including postal mail, fax and email. It is advised that you do not email forms or submit online forms with protected health information or personally identifiable information, to protect your confidentiality in accordance with the Health Insurance Portability and Accountability Act of 1996.

  - Mailing address: Mississippi Division of Medicaid, Attn: Public Records Officer, 550 High Street, Suite 1000, Jackson, MS 39201-1399
  - Fax: 601-576-6342
  - Email: RFI@medicaid.ms.gov
  - If you have questions regarding RFI policy or procedure, contact the RFI Public Records Officer by phone at **601-359-6093**.

National Correct Coding Initiative

- The Centers for Medicare and Medicaid Services (CMS) developed the National Correct Coding Initiative (NCCI) to promote national correct coding methodologies and to eliminate improper coding. The Affordable Care Act of 2010 required state Medicaid programs to incorporate compatible NCCI methodologies in their systems for processing Medicaid claims.

- NCCI associated modifiers may be appended when and only when appropriate clinical circumstances are documented in accordance with the NCCI policies and the HCPCS/CPT Manual instructions/definitions for the modifier/procedure code combination.

- NCCI/MUE service limits supersedes system service limits.

- Claim coding should be reviewed for accuracy.

- Billing Handbook (Section 0.3)

- Link: https://medicaid.ms.gov/providers/national-correct-coding-initiative/

NCCI Resources

- Find more information about the CMS National Correct Coding Initiative in Medicaid on the Medicaid website. The Medicaid NCCI Policy Manual should be reviewed for more on the appropriate use of modifiers.

- Mississippi Medicaid Billing Handbook

- NCCI Billing Guidance

- A procedure or service code included in the attached documents is not an indication of coverage. Please verify coverage on the Medicaid Envision web portal.

- Global Surgical Days – effective Jan. 1, 2015

- Bilateral Code List – effective Jan. 1, 2018

- Multiple Surgery Code List – effective Jan. 1, 2018

- The Centers for Medicare and Medicaid Services establishes new procedure-to-procedure associated modifiers – effective Jan. 1, 2015

Medicaid Fee-for-Service Claims Review

Claim Reconsideration

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

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

Completing a Claim Reconsideration Form

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

- Specifics of the claim (Bene Name/ Medicaid ID#, TCN, date paid, date(s) of service, etc.)

- The specific provider contact(s) information: name, address, and phone number (which may be used for further contact if needed);

- The specific code(s) and related diagnosis to be reviewed;

- The Exception Code pended to the claim;

- A checklist of documentation submitted with the Claim Reconsideration Form; and

- Additional narrative detail the provider wants to be considered in the review of the claim.

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

Claim Reconsideration Process

- Only claims that have gone through the system and denied, need to be sent in to Medical Review to be reviewed. Please make sure all proper documentation is included. *(THE FULLY COMPLETED RECONSIDERATION FORM SHOULD BE ATTACHED TO THE CLAIM EACH TIME IT IS SENT TO CONDUENT MEDICAL REVIEW)*

- Once claims are in the review process, if there's any information missing or required, instead of resending all documentation back to provider, the provider will receive a letter requesting any and all information required to continue the process of the individual claim(s).

- All codes billed for the same date of service should be billed on the same claim form **(unless additional lines are needed)**

Medical Review Reminders

- Please make sure you have received a denial before submitting your claim/documentation to Medical Review.

- New claims (never processed) are not reviewed by Medical Review.

- If documentation has been requested by phone, fax or via letter from Medical Review, your claim will not be further processed until all needed documentation has been resubmitted to Conduent Medical Review. All requested forms and documentation should be received within 30 business days of the date of the RTP letter.

- Please remember to include a Reconsideration form with the appropriate contact information for all reconsiderations.

- When checking the status of a reconsideration and there has been no record on file for at least 60 days, please resubmit all documentation.

Common Edits Not Subject to Medical Review

CONDUENT

Edits

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

Edits

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

Global Edits

- 3456—Global Package Applies

- 3457--Global Claim Rendering Taxonomy does not match provider record.

- 3458--Global Claim Rendering Taxonomy Required

Exception Code 0610

- Explanation of Benefits (EOB) requires review or is missing or invalid.

- This exception code is received when a traditional Medicare cross-over claim/Advantage Plan claim is submitted via the Web Portal or hardcopy.

- This exception code is three-part:
  - Suspended – needs to be reviewed
  - Denied – EOMB is missing (EOMB did not electronically upload or file is not compatible)
  - Denied – EOMB is invalid (EOMB does not include payor name, beneficiary mismatch, date of service mismatch or Medicare amount mismatch

Exception Code 0610 Helpful Hints

- The sequestration amount should not be included in the coinsurance or deductible.

- Medicare payments should not be reported in Field 29 (CMS-1500) nor Field 54 (UB-04). *__Only applicable to traditional Medicare__*

- Entering prior payments from Medicare and/or Medicaid in these fields will result in a reduced or zero payment.

- When remittance advices are received electronically (835), the provider's version of the Medicare RA should include: payor name, beneficiary name/identifier, date of service, total charges, Medicare allowed amount or advantage plan allowed amount, paid amount, EOMB paid date, coinsurance and deductible amounts. (copay part C-Advantage plans)

Updated Provider Enrollment Application

- **On May 7, 2018**, the Division of Medicaid (DOM) rolled out its updated Mississippi Medicaid Provider Enrollment Application that has been revised to collect additional information required for enrollments.

- **Effective July 29, 2018**, Conduent will return any applications that are not completed on the revised Mississippi Medicaid Enrollment Application. The provider will be required to complete and resubmit the updated application packet located at https://www.ms-medicaid.com/msenvision/downloadenrollPackage.do.

- Providers with questions or needing additional information about the updated enrollment application should contact Provider Enrollment at (800) 884-3222.

Provider Enrollment Required Documentation

- A completed Mississippi Medicaid Enrollment Application
- A completed Mississippi Medicaid Provider Disclosure Form
- Electronic Funds Transfer (Direct Deposit Authorization Form) including verification of the bank account (preprinted voided check, deposit slip or letter from the bank verifying the account number and transit routing number)
- Medical Assistance Participation Agreement
- Completed W-9 for the enrolling provider
- Completed Civil Rights Compliance Information. Pages 4,5,13
- Medicaid approval letter (**waiver providers only**)

*Refer to the Credentialing Requirements Checklist for specific provider type documentation requirements.

Provider Enrollment

- **Viewing Provider Profile**
  - Via Web: (Envision Web Portal)
  - Inquiry Information → Provider Inquiry → Provider Profile
- **Updating Provider File**
  - Change of address form
  - Updating license information
  - Updated EFT form
  - Linking/Delinking providers to groups
  - Email addresses
  - Phone numbers
- **Provider Enrollment Submission Options**
  - Via Web: (Envision Web Portal)
  - Fax: **888-495-8169**
  - Hardcopy: **Conduent Provider Enrollment Department, P.O. Box 23078 Jackson MS 39225**
  - (providerenrollment@conduent.com)

Clarification

Attestation

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

Updating Licenses

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

Provider Revalidation

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

What is Provider Revalidation?

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

What if I Fail to Revalidate

- Providers that fail to revalidate by the deadline will be terminated and required to re-enroll.

- If your Mississippi Medicaid Provider Number is termed due to failure to complete revalidation, your participation with the CCOs (Magnolia and United Healthcare and Molina Healthcare) will be termed as well.

- If you are terminated, you will have the option to appeal the decision. The appeal must be in writing, and the reasons the provider believes the denial is incorrect should be clearly identified. The appeal letter must be submitted within thirty (30) calendar days of the date of the termination letter. Appeals should be mailed to:
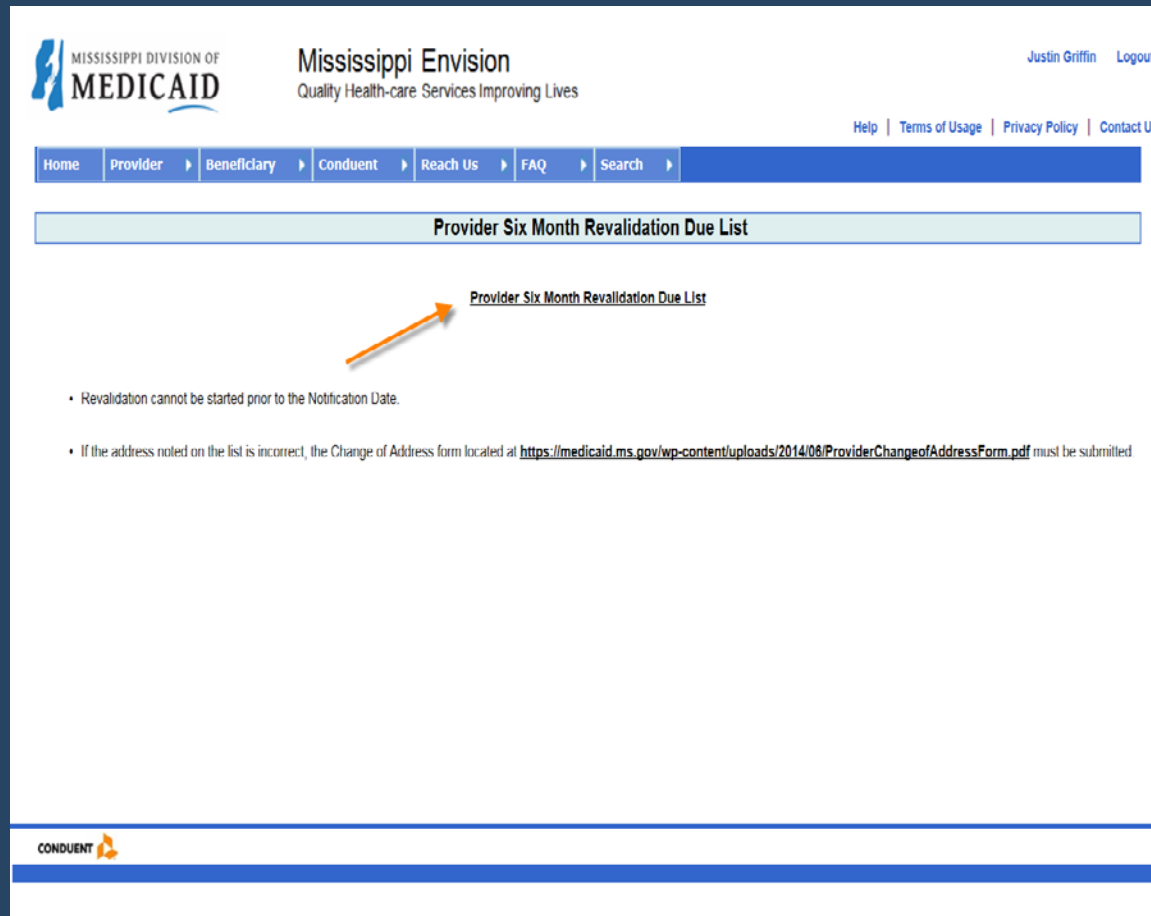
    Division of Medicaid
    Office of Appeals
    550 High Street, Suite 1000
    Jackson, MS 39201

Six Month Provider Revalidation Due List

Six Month Provider Revalidation Due List

Six Month Provider Revalidation Due List

Managed Care Overview

Goals of
MississippiCAN Program

Mississippi Coordinated Access Network (MississippiCAN) implemented on January 1, 2011 is a statewide care coordination program designed to:

- Improve beneficiary access to needed medical services;
- Improve the quality of care; and
- Improve program efficiencies as well as cost effectiveness

Evolution of Mississippi Managed Care

2009

- Mississippi Medicaid Managed Care approved by Legislature

January 1, 2011

- Mississippi Coordinated Access Network (**MississippiCAN)** Go Live Medicaid disabled members were enrolled, including SSI, Disabled Children Living at Home, Working Disabled, CWS Foster Care, and Breast and Cervical Cancer member.

December 1, 2012

- MississippiCAN Expansion, and carve-out of Hemophilia
- MississippiCAN population became mandatory, except disabled children MississippiCAN population expanded to include Pregnant Women and Infants, all Foster Care children, and Medical Assistance adults.
- MississippiCAN expanded services to include Behavioral Health.

Evolution of Mississippi Managed Care

July 1, 2014

- MississippiCAN expanded contract
- MississippiCAN expanded services to include non-emergency transportation

December 1, 2014

- MississippiCAN population expanded to include Quasi-CHIP children, who were formerly eligible for CHIP

January 1, 2015

- Mississippi CHIP program delivery system was changed from one vendor to a managed care delivery system with two vendors, CCOs.

July 1, 2015

- MississippiCAN population expanded services to include non-disabled Medical Assistance Children

Evolution of Mississippi Managed Care

December 1, 2015

- MississippiCAN expanded services to include Inpatient Hospital Services, and deemed Newborns enrolled from the month of birth.

- MississippiCAN expanded services to include, case management and ancillary services (e.g. physician, pharmacy) for PRTF residents.

July 1, 2017

- MississippiCAN new contracts awarded

July 1, 2018 to August 31, 2018

- Special Open Enrollment period allowing members to choose between the three CCOs. This replaces the Annual Open Enrollment period from October to December for MississippiCAN.

October 1, 2018

- Effective date on which MississippiCAN members will receive services from three CCOs – Magnolia Health, Molina Healthcare, and UnitedHealthcare.

- Annual Open Enrollment period for CHIP from October to December.

MississippiCAN and CHIP Enrollment Statistics

674,804

Medicaid & CHIP beneficiaries

Of the total Medicaid Beneficiaries

434,047

MississippiCAN

45,756

CHIP beneficiaries

As of November 1, 2018

Mississippi Managed Care Overview

Provider Enrollment

- **Updated Provider Enrollment Application**

- **May 7, 2018**   The Division of Medicaid (DOM) rolled out its Updated Mississippi Medicaid Provider Enrollment Application that has been revised to collect additional information required for enrollments.

- **July 29, 2018**   Conduent will return any applications that are not completed on the revised Mississippi Medicaid Enrollment Application. The provider will be required to complete and resubmit the updated application packet located at

- https://www.ms-medicaid.com/msenvision/downloadenrollPackage.do.

- Providers with questions or needing additional information about the updated enrollment application should contact Provider Enrollment at (800) 884-3222.

Mississippi Managed Care Overview

- **Provider Credentialing** – Legislative mandate Prohibits the CCOs from requiring its providers to be credentialed by the organization and requires that the CCOs recognize the credentialing of the providers by DOM

- Mississippi Medicaid has included this requirement in the MississippiCAN contract for each of the three (3) Coordinated Care Organizations (CCOs).

- Mississippi Medicaid has been working with the CCOs, provider groups, other states, and National Committee for Quality Assurance (NCQA) to ensure proper implementation of this requirement and to ensure that the CCOs maintain their required accreditation.

- At this time, providers are instructed to continue to follow the CCO credentialing process until Mississippi Medicaid announces that the state process has been finalized.

- Provider NPI numbers must be the same for DOM and CCOs per contract.

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Mississippi Managed Care Overview

Legislative Updates

Senate Bill 2836

http://billstatus.ls.state.ms.us/documents/2018/dt/cr/SB2836CR.pdf

- **5% Assessment** - Exempts outpatient services from the 5% rate reduction established in Miss. Code Ann. § 43-13-117 (B)

- **Physician –Administered Drugs** – Allowed to be billed as Medical or POS

- **Physician's Services** – Allowed DOM to determine physician visit limits (TBD)

- **Prescriptions** – Allowed DOM to determine prescription limits (TBD)

- **Vaccines** – Allowed through pharmacy venue for children ages 10-18

- **Innovative Payment Models** – To be developed and implemented by managed care plans

- **Medicaid Managed Care Commission** - Establishes a commission to study and make recommendations on the expansion of Medicaid managed care to include additional categories of Medicaid beneficiaries and the feasibility of developing an alternative managed care payment model for medically complex children

MississippiCAN Enrollment

Who is eligible for MississippiCAN?

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

Optional Population **may return** to regular Medicaid.
Mandatory Population **may switch** between CCOs.
Note: Always check eligibility on the Date of Service
to ensure submission to correct payer by methods below:

Telephone 1-800-884-3222
Envision Web Portal at new address
www.ms-medicaid.com

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MississippiCAN Enrollment

- Medicaid Beneficiaries that fall in the Mandatory or Optional categories of eligibility are automatically eligible for the MississippiCAN Program.

  Individuals must be in the mandatory or optional population to join the MississippiCAN program.

- After the member has been enrolled into regular Medicaid in one of these categories of eligibility, DOM will send a letter to the member to respond within **30 Days**:

Mandatory: You (Member) are in a Medicaid Program type that requires you to be enrolled in the program. Check with you doctor to see which plan they accept. Fill out the form and return in enclosed postage paid envelope. If you do not send this form back in 30 days to let us know your choice, a CCO will be picked for you. If you do not, you will be auto assigned to a plan. You will then have an additional 90 days to switch.

Optional: You (Member) do not have to join the MississippiCAN program. You can keep your Medicaid just like it is now. If you do not want to join, you must put a check mark by "Opt Out" on the form on the back of this letter and sign your name. If you do want to join, put a check mark by the CCO you want and sign your name. Mail the form back with your choice in the enclosed postage paid envelope within 30 days. If you do not send this form back in 30 days to let us know your choice, a CCO will be picked for you. You will have 90 days to pick a different CCO or to "opt out" of the program. After the 90 days you will be locked into the program. You will only be able to change your CCO or "opt out" once a year during October 1 through December 15, effective January 1.

Mississippi
Department Of Human Services (MDHS) Child Protection Services (CPS) Beneficiaries

- Currently Foster Care children under MDHS/CPS custody are primarily enrolled with MississippiCAN – Magnolia Health

- Adoption Assistance Parents may select their choice of MississippiCAN CCO, therefore, providers should always check eligibility

Beneficiaries Not Eligible for MississippiCAN

- **Hemophilia diagnosis and treatment**

- **Dual Eligible** (Medicare/Medicaid)

- **Waiver program enrollees** (ex. HCBS, TBI, IL, etc.)

- **Institutionalized Residents** (ex. Nursing Facility, ICF-MR, Correctional Facilities, etc.)

- **Beneficiaries currently with inpatient hospital stays**

- **American Indians** *(They may choose to opt into the program)*

Who is eligible for CHIP?

The **Children's Health Insurance Program (CHIP)** provides health coverage for uninsured children up to age 19, whose family income does not exceed 209 percent of the Federal Poverty Level.

To be eligible for CHIP, a child cannot be eligible for Medicaid or have other major medical health insurance at the time of application. CHIP members may have supplemental policies.

Category of Eligibility	Age
CHIP	**0** - **19** (19th year birth month)

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Eligibility Re-certifications and Updates

- For those MSCAN beneficiaries whose Medicaid eligibility has ended or is about to end, the 20th of each month is the deadline for RO approvals and reinstatements to ensure that beneficiaries remain with MSCAN.
  (**Ex.** Approval/Reinstatement 6.14.2018, then MSCAN CCO assignment 7.1.2018)

- For those MSCAN beneficiaries whose Medicaid eligibility has ended or is about to end, and RO approval and **reinstatement is after** the 20th of the month, then the beneficiaries will return to regular Medicaid for a month before reassignment to MSCAN CCO.
  (**Ex.** Approval/Reinstatement 6.26.2018, then MSCAN CCO assignment 8.1.2018)

Eligibility Re-Certifications and Updates

- For those MSCAN beneficiaries whose Medicaid eligibility has ended and they were reinstated after the 20th of the month, those beneficiaries will return to regular Medicaid for a month before reassignment to MSCAN CCO.

  > **Ex.** *If a beneficiary had 2 physician visits remaining on regular Medicaid on 10.25.18, then for the next month November 2018 prior to the MSCAN CCO assignment 12.1.2018, they will still be restricted to the 12 physician visits per fiscal year, which is 2 physician visits remaining.*

- If beneficiaries have a temporary loss of eligibility of less than 60 days, then DOM will automatically re-assign beneficiaries into the CCO in which beneficiaries were most recently assigned.

- If beneficiaries have a temporary loss of eligibility of more than 60 days, then DOM will not automatically re-assign beneficiaries into the CCO in which beneficiaries were most recently assigned.

Changes for the MississippiCAN and CHIP Program

Upcoming Changes for the MississippiCAN Program

The MSCAN program now has **3 CCOs** effective October 1, 2018.

- Magnolia Health
- Molina Health Care
- UnitedHealthcare Community Plan

Upcoming Changes for the MississippiCAN Program

- Effective **October 1, 2018**, additional services were included in the MississippiCAN Program.

    - Mississippi Youth Programs Around the Clock (**MYPAC**), and

    - Psychiatric Residential Treatment Facility (**PRTF**) facility services, will now be included in MississippiCAN covered services.

Upcoming Changes for the CHIP Program

Mississippi Division of Medicaid began **CHIP Procurement** in June 2018.

- June 8, 2018 - The Request for Qualifications (RFQ) was posted.

- July 1, 2019 - The date of the new contract operations begins.

https://medicaid.ms.gov/resources/procurement/

SPECIAL OPEN ENROLLMENT 2018

- The Division of Medicaid had a **Special Open Enrollment** to allow members to choose between the 3 CCOs.

  Magnolia Health Plan   Molina Health Care   UnitedHealthcare Community Plan

- Letters were mailed June 2018 to all Medicaid beneficiaries eligible for the MississippiCAN Program.

- There **will not** be a regular open enrollment this year in October **for MississippiCAN**. The special open enrollment will serve as the regular open enrollment.

  *Ex. Jane Doe was mailed a special open enrollment letter
  complete. Jane Doe is already on Magnolia Health Plan
  and has been since 2014. If Jane Doe chooses to keep the plan
  she is already with she does not have to complete the form.
  If Jane Doe does choose to switch from Magnolia to Molina or United
  She must complete the form.*

Open Enrollment

MississippiCAN and CHIP

- MississippiCAN Special Open enrollment was available to members from July 1, 2018 to August 31, 2018. Members could choose 1 of 3 CCOs.

- CHIP Open Enrollment is available to members from October 1, 2018 to December 15, 2018. Members may choose 1 of 2 CCOs.

- Beneficiaries can only switch once during the initial 90 days after CCO assignment.
- DOM will only acknowledge the first open enrollment form submitted.

- If the member calls stating they need an enrollment form direct them to the Office of Coordinated Care at:
  Toll Free: 1-800-421-2408 or
  Local: 601-359-3789

Special Open Enrollment
-VS-
Open Enrollment

Special Open Enrollment	Open Enrollment
"ONLY FOR MISSISSIPPICAN BENEFICIARES" **July 1st – August 31st** Letters were sent to beneficiaries receiving MississippiCAN services giving them a choice to choose between the 3 CCOs (Magnolia, Molina and United Healthcare). The mandatory population has a choice to choose between the 3 CCOs (Magnolia, Molina and United Healthcare). The optional population has a choice to choose between the keeping regular Medicaid or the 3 CCOs (Magnolia, Molina and United Healthcare).	**"ONLY FOR CHIP THIS YEAR"** **October 1st – December 15th** Letters were mailed in August giving beneficiaries a choice to choose between the 2 CHIP CCOs (Magnolia and UnitedHealthcare).

2018 Division of Medicaid Provider Workshops

Magnolia Health Plan

11/26/2018

Welcome to Magnolia Health!

We thank you for being part of Magnolia's network of providers, hospitals, and other healthcare professionals participating in the Mississippi Coordinated Access Network (MississippiCAN). Our number one priority is the promotion of healthy lifestyles through preventive healthcare. Magnolia works to accomplish this goal through close relationships with the providers who oversee the healthcare of Magnolia members.

Magnolia Health Overview

- Medicaid Coordinated Care Organization (CCO)

- Contracted with Mississippi Division of Medicaid (DOM)

- Serving Mississippi Members in the MississippiCAN (eff. 01/01/2011), Ambetter (eff. 01/01/2014), Mississippi CHIP (eff. 01/01/15), and Medicare Advantage (01/01/17) Programs

- Goals:

  - Ensure access to primary and preventive services

  - Ensure care is delivered in the best setting

  - Encourage quality, continuity, and appropriateness of medical care

What's Important in 2018?

- Reviewing Provider News at www.magnoliahealthplan.com
- Signing up for our weekly e-blast (come see us at our table!)
- Registering for our Secure Web Portal
- Signing up for EFT through PaySpan
- Updating your demographic information
- Ensuring that you meet appointment availability and after hours access standards

Molina Healthcare of Mississippi, Inc.

2018 Division of Medicaid Provider Workshops

MOLINA®
HEALTHCARE

About Molina Healthcare

Our Vision

We envision a future where everyone receives quality health care.

Our Mission

Our mission is to provide quality health services to people receiving government assistance.

About Molina Healthcare

We strive to be an exemplary organization. These are our values:

Caring
We care about those we serve and advocate on their behalf. We assume the best about people and listen so that we can learn.

Enthusiastic
We enthusiastically address problems and seek creative solutions.

Respectful
We respect each other and value ethical business practices.

Focused
We focus on our mission.

Thrifty
We are careful with scarce resources. Little things matter and the nickels add up.

Accountable
We are personally accountable for our actions and collaborate to get results.

Feedback
We strive to improve the organization and achieve meaningful change through feedback and coaching. Feedback is a gift.

One Molina
We are one organization. We are a team.

We sustain our mission and invest in our organization by being profitable.

MOLINA
HEALTHCARE

The Molina Story

In 1980, the late Dr. C. David Molina, founded Molina Healthcare with a single clinic and a commitment to provide quality healthcare to those most in need and least able to afford it. This commitment to providing access to quality care continues to be our mission today, just as it has been for the last 35 years.

The Molina Family of Health Plans

- Molina Healthcare of California
- Molina Healthcare of Utah
- Molina Healthcare of Michigan
- Molina Healthcare of Washington
- Molina Healthcare of New Mexico
- Molina Healthcare of Texas
- Molina Healthcare of Ohio
- Molina Healthcare of Florida
- Molina Healthcare of Wisconsin
- Molina Healthcare of Illinois
- Molina Healthcare of South Carolina
- Molina Healthcare of Puerto Rico
- Molina Healthcare of New York
- Molina Healthcare of Mississippi

Recognized for Quality, Innovation and Success

Molina Healthcare, Inc.

- **Molina Healthcare plans have been ranked among America's top Medicaid plans by U.S. News & World Report.**

- **FORTUNE 500 Company by Fortune Magazine**

- **Business Ethics magazine 100 Best Corporate Citizens.**

- **Alfred P. Sloan Award for Business Excellence in Workplace Flexibility in 2011.**

- **11 of our 13 plans have earned the Multicultural Health Care Distinction from Robert Wood Johnson Foundation, for organizations that meet or exceed its rigorous requirements for providing care in a culturally-sensitive manner.**

- **Molina Healthcare is a leader in quality with the majority of its health plans accredited and rated by the National Committee for Quality Assurance (NCQA).**

Strategic Priorities – Molina Healthcare of Mississippi

In all that we do, we will stay true to our mission, vision and values by delivering on four strategic priorities:

Maximizing value	Facilitating effective care management
strategic priorities	
Improving administrative efficiency, eliminating obstacles	Breaking down barriers to accessing care
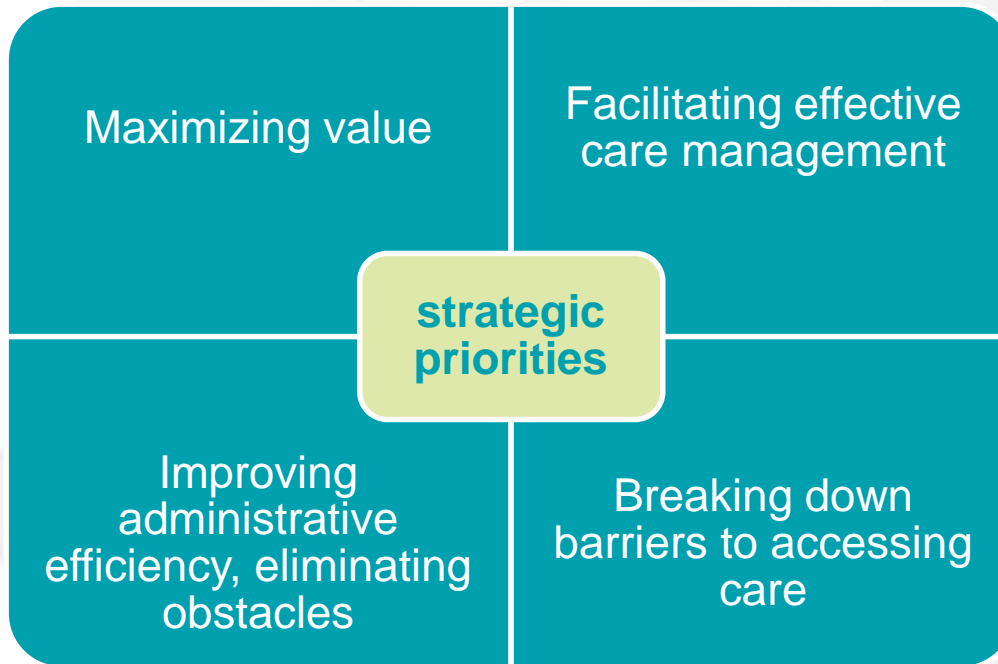
Achieving our Goals

Establish a Collaborative Approach

- Excellence begins with understanding

- Establish a relationship

  - Successful implementation
    - System load (benefits, contract terms, demographics)
    - FFS and DOM rules testing

  - Commitment to communication
    - Scheduled and ad hoc meetings
    - Growth through positive initiatives
    - Removal of unnecessary barriers

UnitedHealthcare of Mississippi, Inc.

Overview

UnitedHealthcare: Who We Are

UnitedHealthcare®
Community Plan

Our Mission

To help people live healthier lives and to help make the health system work better for everyone

Our Core Values

- **Integrity** – Honor commitments & Never compromise ethics

- **Compassion** – Walk in the shoes of people we serve and those with whom we work

- **Relationships** – Build trust through collaboration

- **Innovation** – Invent the future and learn from the past

- **Performance** – demonstrate excellence in everything we do

Our Vision

To be the premier health care delivery organization in the eyes of our state partners, providing health plans that meet the unique needs of our Medicaid members as well as our members in other government-sponsored health care programs. And to be effective partners with physicians, hospitals and other health care professionals in serving their patients.

UnitedHealthcare: Who We Are

UnitedHealth Group℠

OPTUM®

OptumHealth
OptumRx
OptumInsight

NCQA
ACCREDITED
HEALTH PLAN

NCQA
DISTINCTION
MULTICULTURAL
HEALTH CARE

UnitedHealthcare®

UnitedHealthcare Community & State
UnitedHealthcare Medicare & Retirement
UnitedHealthcare Employer & Individual
UnitedHealthcare Military & Veterans

FORTUNE
WORLD'S MOST
ADMIRED
COMPANIES 2017

5. UNITEDHEALTH GROUP

Number 5 on
Fortune 500

UnitedHealthcare®
Community Plan

- **We actively engage with our members throughout the state**
  - Health fairs
  - Thanksgiving turkey giveaways – Holiday Season
  - Farm to Fork – May-September.
  - 4-H Partnership – Eat4-Health to empower youth to help improve the health of their peers, their families and their communities
  - Heart Smart Sisters - Promotes Heart Disease Awareness with weekly classes.
  - Sesame Workshop Partnership – Food for Thought, a bilingual (English and Spanish) initiative that helps families make food choices that are affordable, nutritional and set the foundation for lifelong healthy habits.
  - Healthy First Steps & Baby Building Blocks – Maternal/Child initiatives
  - Local Schools – Supplies, backpacks, uniforms, shoes, etc.

Joining our Network as a Provider

Entering the Network

UnitedHealthcare®
Community Plan

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

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

3. **Contact UHC Credentialing to request participation in MSCAN and/or CHIP**
   - 877-842-3210
   - Enter Tax ID
   - Clinic Credentialing must be completed for FQHC & RHCs.
   - Contact your Network Account Manager (SWProviderServices@uhc.com)

4. **Disclosure of Ownership forms**
   - UHCProvider.com > Providers > Mississippi > Forms > Disclosure of Ownership (group/individual)
   - Online submission or mail/fax/email
   - State & Federal requirement delegated to CCOs

5. **Contract will be sent once credentialing and disclosures are completed/approved**
   - Questions can be directed to Network Management at 1-866-574-6088
   - Demographic forms/info can be sent to:
     - Fax: 855-773-3156
     - email HPDemo@uhc.com

6. **Sign and return contract**

Re-credentialing

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

- UHC begins outreach efforts several months in advance of re-credentialing date.
  - Needed action is specified in the letter/email.
  - If provider takes no action, additional contact will be attempted.
  - If re-credentialing date is reached and no provider action has taken plan, then the termination process will begin.

Question & Answers

MEDICAID PRIOR AUTHORIZATION AND RETROSPECTIVE REVIEW PROCESS

Prepared for:

Mississippi Medicaid Providers

eQ Health SOLUTIONS

AGENDA

- Introduction
- Getting Started
  - Eligibility
  - Required Information
  - eQSuite®
- Prior Authorization Process
- Retrospective Review Process
- Questions & Answers

GOALS

- Become familiar with the prior authorization and retrospective review process.

- Obtain necessary information to successfully complete the prior authorization and retrospective review process.

- Provide resources to further educate or assist with questions in the future.

eQHEALTH SOLUTIONS

- 21 year Utilization Management and Quality Improvement partnership with the MS Division of Medicaid (DOM).

- Multidisciplinary Review Team includes licensed registered nurses and physicians.

- Dr. Wesley Prater, Interim Medical Director, oversees the review team.

GETTING STARTED

- Providers are responsible for checking beneficiary eligibility **before** services are rendered.
- Verification of eligibility is performed through [ENVISION](#).
    - Automated Voice Response 1-800-884-3222
    - Personal computer software or point of service swipe card device
    - Website Verification
        - https://www.ms-medicaid.com/msenvision/

TIME TO SUBMIT A PRIOR AUTHORIZATION OR RETROSPECTIVE REVIEW

**Submitting a
Prior Authorization
or Retrospective Review**

- eQSuite® web portal - preferred.
- eQHealth prior authorization form **(if not submitted on the web).**
- eQHealth precertification line.

TYPES OF REVIEW REQUESTS

Now that you have all the information needed to submit a review ......WHEN TO SUBMIT?

- **PRIOR AUTHORIZATION REQUESTS**
  - Submit the authorization request at least 2 business days before services are rendered.
- **RETROSPECTIVE REQUESTS**
  - If service has already been rendered and claim denies due to office visit limits, submit your review as soon as possible, but within one (1) year from date of service.
- **RETROSPECTIVE –ELIGIBILITY REQUEST**
  - Applies to beneficiaries who are determined retroactively eligible and have already had hearing services performed.
  - Submit the review as soon as eligibility is confirmed and within one (1) year of the retroactive eligibility determination date.
  - For extenuating circumstances, contact eQHealth Solutions.

PRIOR AUTHORIZATIONS

eQHealth Solutions completes requests for services as quickly as possible, but within specific timeframes. The review completion timeframe is measured from the date eQHealth Solutions receives your request.

*A review that has been pended will cause the "clock" to stop. When requested information has been received the clock will start new.

PROCESSING TIMELINE –PRIOR AUTHORIZATION

Review Type	Review Determination
Inpatient - Admission and Continued Stay	Within 1 business day of receipt of requested and necessary information.
Outpatient Hospital Mental Health – Admission and Continued Stay	Within 2 business days of receipt of requested and necessary information.
Community Mental Health Center Services – Admission and Continued Stay (Acute Partial, Crisis Residential, ACT)	Within 2 business days of receipt of requested and necessary information.
Community Mental Health Center Services – Admission and Continued Stay (Day Treatment, Day Support, Psychosocial Rehabilitation)	Within 7 business days of receipt of requested and necessary information.
Psychiatric Residential Treatment Facility (PRTF) Preadmission and Continued Stay	Within 3 business days of receipt of requested and necessary information.
MYPAC – Preadmission and Continued Stay	Within 3 business days of receipt of requested and necessary information.
Therapeutic and Evaluative (T & E) – Admission	Within 2 business days of receipt of requested and necessary information.
Outpatient PT, OT and ST – Admission and Continued Stay Review	Within 2 business days of receipt of requested and necessary information.
Cardiac Rehab - Admission	Within 2 business days of receipt of requested and necessary information.
Hospice – Admission/Precertification and Continued Stay/Subsequent Enrollment Period	Within 3 business days of receipt of requested and necessary information.

PROCESSING TIMELINE – PRIOR AUTHORIZATION

Review Type	Review Determination
Home Health – Admission and Continued Stay	Within 2 business days of receipt of requested and necessary information.
Private Duty Nursing/PPEC – Admission and Continued Stay	Within 10 business days of receipt of requested and necessary information.
DME – Admission	Within 2 business days of receipt of requested and necessary information.
Expanded MD, Vision, Hearing - Admission	Within 3 business days of receipt of requested and necessary information.
General Dentistry, Oral Surgery and Orthodontics - Admission	Within 7 business days of receipt of requested and necessary information.
Genetic Testing - Admission	Within 2 business days of receipt of requested and necessary information.
Advanced Imaging - Admission	Within 2 business days of receipt of requested and necessary information.
Diabetes Self-Management Training/Continuous Glucose Monitoring - Admission	Within 2 business days of receipt of requested and necessary information.
Nutritional Counseling - Admission	Within 3 business days of receipt of requested and necessary information.
Autism Spectrum Disorder (ASD) - Admission	Within 2 business days of receipt of requested and necessary information.

PROCESSING TIMELINE – RETROSPECTIVE REQUESTS

➢Retrospective reviews – 20 business days from the date of receipt.

*A review that has been pended will cause the "clock" to stop. When requested information has been received the clock will start new.

REVIEW PROCESSING

First Level Reviewer

- Apply DOM guidelines.
- May request additional information – "Pend".
- Approve services based on DOM regulation and clinical based standards of care.
- Refer requests that cannot be approved to a second level reviewer.

Second Level Reviewer
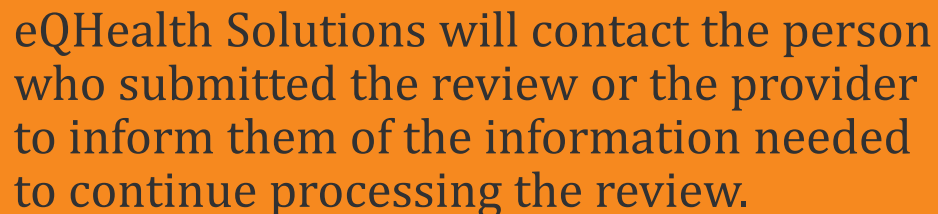
- May contact the requesting, ordering or treating provider to obtain additional information - "Pend".
- Approve Services.
- Partially Approve Services.
- Deny Services.

PENDED REVIEWS

- Reviews that require additional information or clarification before they can be completed.

- May be from a First Level Reviewer or Second Level Reviewer.

- May occur anytime there are:
  - Questions about the information submitted.
  - Required information is missing.

PENDED REVIEWS

eQHealth Solutions will contact the person who submitted the review or the provider to inform them of the information needed to continue processing the review.

Electronic notifications are sent via fax and are placed in eQSuite® for review.

eQSuite® is available 24 hours a day, 7 days a week to check for messages regarding pended reviews.

DENIALS AND RECONSIDERATION

Technical Denial

- Occurs when any portion of requested services are denied because it did not comply with DOM rules and regulations.

Clinical Denial

- Occurs when any portion of requested services is denied by a second level reviewer for a clinical reason.

Reconsiderations

- A review by a different eQHealth Solutions SLR (a different physician who was not involved in the original denial).
- Available when eQHealth Solutions issues a clinical denial.
- Denial notifications have specific instructions for requesting reconsiderations.

DOM ADMINISTRATIVE APPEAL RIGHTS

- If a reconsideration is upheld or modified (partially approved) **ONLY** the beneficiary, parent, or legal guardian/caregiver may request an administrative appeal of the eQHealth Solutions determination.

- Administrative appeals must be requested in writing within thirty (30) calendar days of the reconsideration notification date.

- DOM performs the Administrative Appeal (Hearing).

eQSUITE®
PROPRIETARY WEB-BASED SOFTWARE

- Secure HIPAA-compliant technology allowing providers to electronically record and transmit most information necessary for a review to be completed.
- Encrypted data transfer.
- System access control for changing and adding users.
- Rules-driven functionality and system edits to assist providers by alerting them to situation for which a review is not required.
- Reporting module that provides real time status of all review requests.
- HELPLINE module for providers to submit questions about specific review requests.

eQSUITE®

- eQSuite® requires a secure user name and password.

- Please contact the Provider Education department for assistance in obtaining a user name and password.
  - 866-740-2221

eQSUITE®

Create New Review | Respond to Add'l Info | Online Helpline | Utilities | Reports | Search | Attachments | Letters | Respond to Denial | Update My Profile

Home
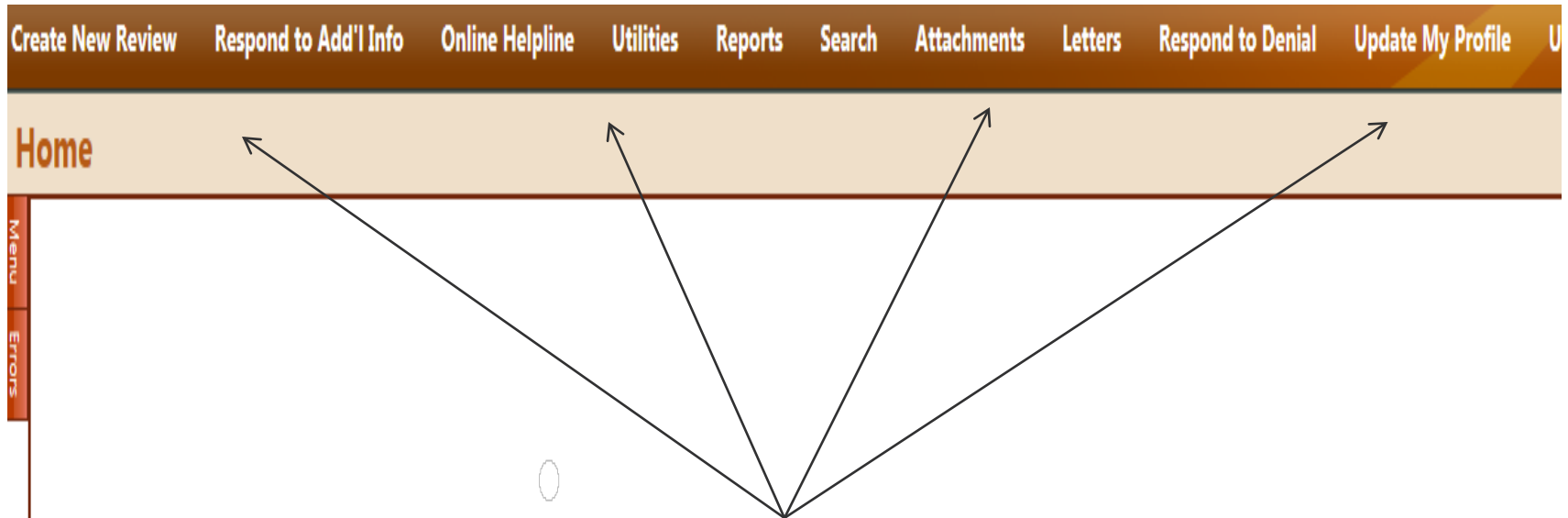
Menu

Errors

Tabs running across the top give you multiple options.

eQSUITE®

eQSUITE®

Providers may search for partially saved reviews, pended reviews or TANS by date, beneficiary number, or TAN number.

eQSUITE®

Under this tab, the provider can view all letters from eQHealth Solutions. However, if the review was not submitted online the letters will not be available for viewing.

eQSUITE®

Respond to Denial

Please select the type of ID number you have and click "Search"

Review ID ▼ [   ]

[Search]   [Clear Entry]

If a denial is received, you may use this option to respond and request reconsideration.

eQSUITE®

Providers need to make sure their profile is correct at all times.

PENDED REVIEWS

- Responding to "pends" as soon as possible keeps the review process moving.

- Information needed by eQHealth Solutions can be found under "Respond to Add'l Info".

Review Entry

Review Header Information

Provider #: [redacted]   Provider Name: [redacted]
Bene ID: [redacted]   Bene Name: [redacted]   Admit Age: [redacted]   Current Age: [redacted]   Admit DT: [redacted]   Review ID: [redacted]

Start	DX/PROCS	VITALS/LABS	FINDINGS	DC PLAN	MEDS	SUMMARY	ADDL INFO

QUESTION:

Please provide physician's MS Medicaid number.

ADDITIONAL INFO:

Web submitted additional information on 7/12/18.

CANCEL   SUBMIT INFO

- Questions or needed information will be listed in the "Question" box.
- Providers may respond to the pended request via the "ADDITIONAL INFO" box.
  - Exception includes required forms (MD order, clinic notes, etc). Forms will need to be faxed or uploaded.

HealthSOLUTIONS

PROVIDER EDUCATION

- Helpline: 866-740-2221
- For additional resources, forms, etc. visit our website:

  ms.eqhs.org

Authorization, Retrospective Review and Claims Review

Authorization

Authorization is a request to the Magnolia Utilization Management (UM) department for medical necessity determination of services.

- Prior to rendering services, check MS Envision for eligibility and benefits. Also, check the Magnolia Pre-Auth Tool at www.magnoliahealthplan.com to verify if authorization is required.

- Please initiate the authorization process at least at least 14 calendar days and no later than five (5) calendar days in advance for non-emergent outpatient services and pre-scheduled hospital inpatient services.

- 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 pre-scheduled. *(Please see specific requirements for Deliveries and Newborns which differ slightly for normal uncomplicated care.)*

- The Provider should contact the UM department via telephone, fax, mail, secure email or secure web portal with the appropriate clinical information to request an authorization.

- Expedited requests can be requested from the UM department as needed.

- Authorization is NOT required for emergent or urgent care 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 as stated above.)*

- Authorization is NOT required for post-stabilization services. Once the member's emergency medical condition is stabilized, authorization for hospital admission or follow-up care is required as stated above.

Failure to obtain authorization may result in an administrative claim denial!

Authorization Determinations

magnolia health™

Type of Service		Determination Timeframe
All Inpatient Admissions	→	Within 24 hours or one (1) workday of receipt of all necessary clinical information
Standard Outpatient Services	→	Within three (3) calendar and/or two (2) business days of receipt of all necessary clinical information
Urgent Outpatient Services	→	Within 24 hours of receipt of all necessary clinical information
Retrospective Review	→	Within 14 calendar days of receipt of all necessary clinical information

If sufficient clinical information is not received with the authorization request, additional information may be requested to determine medical necessity and the timeframe for decision making may be extended.

Pre-Auth Tool

Medicaid Pre-Auth

DISCLAIMER: All attempts are made to provide the most current information on the Pre-Auth Needed Tool. However, this does NOT guarantee payment. Payment of claims is dependent on eligibility, covered benefits, provider contracts, correct coding and billing practices. For specific details, please refer to the provider manual. If you are uncertain that prior authorization is needed, please submit a request for an accurate response.

Vision services, including all services rendered by an Optician, Ophthalmologist or Optometrist need to be verified by Envolve Vision
Dental services need to be verified by Envolve Dental
Behavioral Health/Substance Abuse need to be verified by Cenpatico
Complex imaging, MRA, MRI, PET, and CT Scans need to be verified by NIA

Non-participating providers must submit Prior Authorization for all services.
For non-participating providers, Join Our Network.

Basic laboratory chemistries and basic radiology do NOT require prior authorization for participating or non-participating providers.

Are Services being performed in the Emergency Department or Urgent Care Center, FQHC or RHC, or Family Planning services billed with a V25 to V25.9 diagnosis?

☐ Yes ☐ No

Types of Services	YES	NO
Is the member being admitted to an inpatient facility?	○	○
Are anesthesia services being rendered for pain management or dental surgeries?	○	○
Is the member receiving hospice services?	○	○
Are services other than DME, orthotics, prosthetics, and supplies, being rendered in the home?	○	○

To submit a prior authorization Login Here.

Submitting Authorization Requests

Prior Authorization Form(s) can be located on our website at:

http://www.magnoliahealthplan.com/for-providers/provider-resources/

FAX

Requests can be faxed to:
1-877-291-8059 (MSCAN Inpatient)
1-877-650-6943 (MSCAN Outpatient)
1-855-684-6747 (CHIP)

WEB

Requests can be made securely at:
magnoliahealthplan.com/login/

Mail

Requests can be mailed to:
Magnolia Health Plan
Attn: Utilization Management
111 E. Capitol Street, Suite 500
Jackson, MS 39201

EMAIL

Requests can be emailed securely to:
magnoliaauths@centene.com

PHONE

Requests can be phoned in to:
1-866-912-6285 (MSCAN/CHIP)

Retrospective Review

- Requests for retrospective review will only be considered when authorization and/or notification to the Plan was not obtained due to extenuating circumstances. For requests for retrospective review that do not meet the criteria described above, the requestor is advised that the Plan does not retrospectively authorize services that have already been rendered and educates the requestor of the proper authorization procedures. Medical necessity retrospective decisions and written member and provider notifications as applicable per decision type will occur no later than fourteen (14) calendar days from receipt of the request.

- In the event a member entering the Plan (either as a new member or transferring from another contractor) is receiving medically necessary services the day before enrollment, the Plan shall be responsible for the costs of continuation of such medically necessary services without authorization and without regard to network status. The Plan shall provide continuation of these services for up to 90 calendar days or until the member may be reasonably transferred without disruption to a network provider. Since most cases of eligibility are assigned retrospectively, the requests for services should be entered as retrospective and will not require a medical necessity review if services have been rendered.

- If eligibility is retrospectively assigned to Magnolia Health Plan and an authorization was obtained as required, the provider can submit a request for retrospective review prior to filing their claim. The provider should include a copy of the approval letter with their request and Magnolia will honor the approval. If no authorization was required by the previous CCO or Medicaid, Magnolia will retrospectively review the services for medical necessity. If a claim is submitted prior to requesting a retrospective review, the provider must complete the claims reconsideration process.

Claims Filing – MSCAN

- ALL Claims must be filed within six (6) months of date of service.

- ALL requests for correction, reconsideration, retroactive eligibility, or adjustment must be received within ninety (90) days from the date of notification of denial.

- Option to file electronically through the clearinghouse

- Option to file directly through the Magnolia website

- All member and provider information must be complete and accurate.

File online at
www.magnoliahealthplan.com

- Option to file on paper claim, please mail to:
  Magnolia Health Plan MSCAN
  Attn: CLAIMS DEPARTMENT
  P.O. Box 3090
  Farmington, MO 63640

- Paper claims are to be filed on approved UB-04 (CMS 1450) claim forms or CMS 1500 (No handwritten or black and white copies)

- To assist our mail center improve the speed and accuracy of complete scanning, please take the following steps when filing paper claims:

  - ✓ Remove all staples from pages
  - ✓ Do not fold the forms
  - ✓ Make sure claim information is dark and legible
  - ✓ Please use a 12pt font or larger
  - ✓ Red and White approved claim forms are required when filing paper claims as our Optical Character Recognition ORC scanner system will put the information directly into our system. This speeds up the process and eliminates potential sources for errors and helps get your claims processed faster.

Claims Filing – CHIP

- ALL Claims must be filed within six (6) months of date of service.

- ALL requests for correction, reconsideration, retroactive eligibility, or adjustment must be received within ninety (90) days from the date of notification of denial.

- Option to file electronically through the clearinghouse

- Option to file directly through the Magnolia website

- All member and provider information must be complete and accurate.

File online at
www.magnoliahealthplan.com

- Option to file on paper claim, please mail to:
  Magnolia Health Plan CHIP
  Attn: CLAIMS DEPARTMENT
  P.O. Box 5040
  Farmington, MO 63640

- Paper claims are to be filed on approved UB-04 (CMS 1450) claim forms or CMS 1500 (No handwritten or black and white copies)

- To assist our mail center improve the speed and accuracy of complete scanning, please take the following steps when filing paper claims:

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  ✓ Red and White approved claim forms are required when filing paper claims as our Optical Character Recognition ORC scanner system will put the information directly into our system. This speeds up the process and eliminates potential sources for errors and helps get your claims processed faster.

Corrected Claim, Reconsideration, Claim Dispute – MSCAN and CHIP

All requests for corrected claims, reconsiderations or claim disputes must be received within ninety (90) days of the last written notification of the denial or original submission date.

Corrected Claims	Reconsideration	Claim Dispute
•Submit via Secure Web Portal	•Written communication (i.e. letter) outlining disagreement of claim determination	•ONLY used when disputing determination of Reconsideration request
•Submit via an EDI Clearinghouse	•Indicate "Reconsideration of (original claim number)"	•Must complete Claim Dispute form located on www.magnoliahealthplan.com
•Submit via paper claim:	•Submit reconsideration to:	•Include original request for reconsideration letter and the Plan response
•Submit corrected claims to along with the original EOP to:	•**Magnolia Health Plan**	•Send Claim Dispute form and supporting documentation to:
•**Magnolia Health Plan**	•**Attn: Reconsideration**	
•**PO BOX 3090 (MSCAN)**	•**PO BOX 3090 (MSCAN)**	•**Magnolia Health Plan**
•**PO BOX 5040 (CHIP)**	•**PO BOX 5040 (CHIP)**	•**Attn: Claim Dispute**
•**Farmington, MO 63640**	•**Farmington, MO 63640**	•**PO BOX 3090 (MSCAN)**
	•**If your claim denied for no authorization on file, please include the reason why a PA was not obtained in your request for reconsideration.**	•**PO BOX 5040 (CHIP)**
		•**Farmington, MO 63640**

Common Billing Errors

Diagram showing "Common Billing Errors" in the center with arrows pointing to it from:
- Code Combinations not appropriate
- Timely Filing
- Diagnosis code not appropriate or missing digits
- Unbundling
- Illegible paper claims (handwritten claims)
- Duplicate Claims
- TIN or NPI missing or mismatch
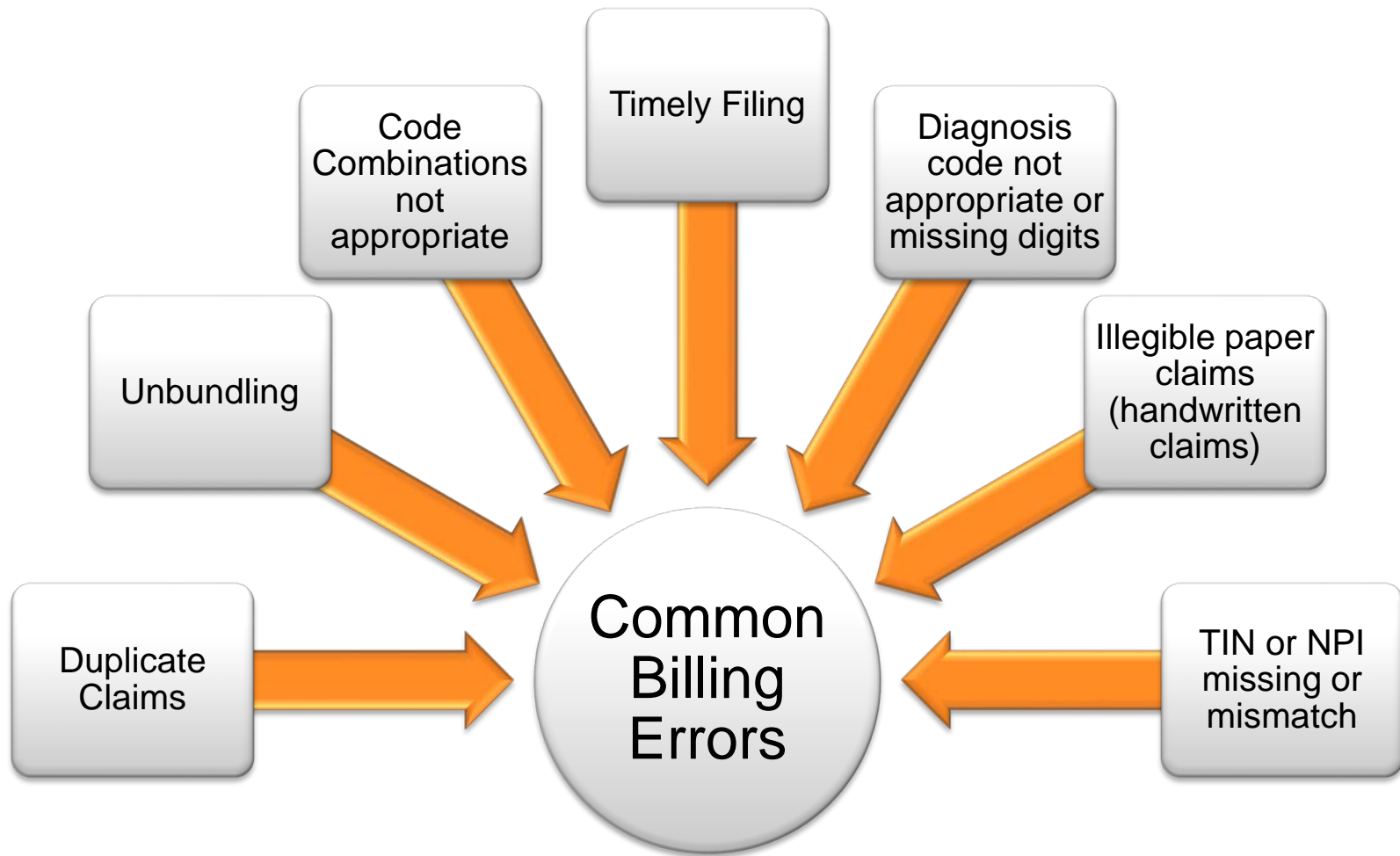
For a complete list of common billing errors refer to the Magnolia provider manual

Prior Authorization, Retrospective Review, and Claims Review Information

Referrals and Prior Authorization

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.

- Prior Authorization is a request for prospective review. It is designed to:
  - Assist in benefit determination
  - Prevent unanticipated denials of coverage
  - Create a collaborative approach to determining the appropriate level of care for Members receiving services
  - Identify Case Management and Disease Management opportunities
  - Improve coordination of care

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

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

MOLINA HEALTHCARE

Request Submissions

Providers may submit request for prior authorizations via the Molina WebPortal.
Web Portal: https://eportal.molinahealthcare.com/Provider/Login

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:	Behavioral Health Authorizations:
Phone: 1 (844) 826-4335	**Phone: 1 (844) 826-4335**
Inpatient Requests Fax: 1 (844) 207-1622	**Inpatient Requests Fax: 1 (844) 207-1622**
All Non-Inpatient Fax: 1 (844) 207-1620	**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.*

Requests may also be made via telephone
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

MOLINA
HEALTHCARE

Prior Authorization Review Guide

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

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

EMERGENCY SERVICES DO NOT REQUIRE PRIOR AUTHORIZATION.

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

- **Behavioral Health: Mental Health, Alcohol and Chemical Dependency Services:**
  - Inpatient, Crisis Residential Treatment, Partial hospitalization, Day Treatment; PACT, MYPAC, PRTF Electroconvulsive Therapy (ECT)
  - Applied Behavioral Analysis (ABA) – for treatment of Autism Spectrum Disorder (ASD). Behavior Identification Assessment (0359T) does NOT require prior authorization
  - Community Mental Health Center (CMHC)/Private Mental Health Center (PMCH) services: Evaluations or to exceed the service standard; Prior authorization is required for ALL services provided to individuals under the age of 3;
  - Therapeutic and Evaluative Mental Health services for Expanded EPSDT (T&E): For evaluations, or to exceed the service standard. Prior authorization is required for ALL services provided to individuals under the age of 3.

- **Cosmetic, Plastic and Reconstructive Procedures** (in any setting).

- **Dental services**: Prior authorization required for all services except for emergencies.

- **Durable Medical Equipment/ Medical Supplies:** Refer to Molina's Provider website or portal for specific codes that require authorization. All DME / Supplies must be ordered by a physician.

- **Imaging, Advanced and Specialty. Laboratory and X-Ray services:** For certain outpatient, non- emergency advanced imaging procedures (CT, MRI, PET and Nuclear cardiac studies).

- **Inpatient Admissions:** Elective, Acute hospital, Skilled Nursing Facilities (SNF), Rehabilitation, Long Term Acute Care (LTAC) Facility.

- **Long Term Services and Supports:** Refer to Molina's Provider website or portal for specific codes that require authorization. (Per State benefit).

- **Neuropsychological and Psychological Testing.**

- **Non-Par Providers/Facilities:** Office visits, procedures, labs, diagnostic studies, inpatient stays except for:
  - Emergency Department Services;
  - Professional fees associated with ER visit and approved Ambulatory Surgery Center (ASC) or inpatient stay;
  - Local Health Department (LHD) services;
  - Other services based on State Requirements.

- **Occupational & Physical Therapy**: After initial evaluation plus six (6) visits for office and outpatient settings.

- **Office-Based Procedures:** do not require authorization, unless specifically included in another category (i.e. advanced imaging) that requires authorization even when performed in a participating provider's office.

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HEALTHCARE

Prior Authorization Review Guide (cont'd)

- **Expanded EPSDT services.**

- **Experimental/Investigational Procedures**

- **Eyeglasses (Vision) services:** for children after 2nd pair per FY.

- **Genetic Counseling and Testing** except for prenatal diagnosis of congenital disorders of the unborn child through amniocentesis and genetic test screening of newborns mandated by state regulations.

- **Hearing services:** Hearing aids (for EPSDT eligible members

- **Home Healthcare Services after initial evaluation**

- **Hospice**

- **Hyperbaric Therapy**

- **Outpatient Hospital/Ambulatory Surgery Center (ASC):** Refer to Molina's Provider website or portal for specific codes that require authorization

- **Pain Management Procedures.** (Except trigger point injections).

- **Pediatric Skilled Nursing (Private Duty Nursing) Services.**

- **Physician Services:** Hospital inpatient visits

- **Prosthetics/Orthotics.** Refer to Molina's Provider website or portal for specific codes that require authorization

- **Radiation Therapy and Radiosurgery** (for selected services only).

- **Sleep Studies.** (Except Home sleep studies).

- **Specialty Pharmacy drugs.** (Oral or Injectable): Refer to Molina's Provider website or portal for specific codes that require authorization.

- **Speech Therapy:** After initial evaluation plus six (6) visits for office and outpatient settings.

- **Transplants including Solid Organ and Bone Marrow** (Cornea transplant does not require authorization).

- **Transportation:** Non-Emergent Air Transport. Emergency ambulance services (Prior authorization is required for Urgent Air Ambulance (Fixed Wing) only; Non-emergency transportation services.

- **Unlisted & Miscellaneous Codes:** Molina requires standard codes when requesting authorization. Should an unlisted or miscellaneous code be requested, medical necessity documentation and rationale must be submitted with the prior authorization request.

STERILIZATION NOTE: Federal guidelines require that at least 30 days have passed between the date of the individual's signature on the consent form and the date the sterilization was performed. The consent form must be submitted with claim.

MOLINA
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Pre-Service Review

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

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

Post Service Review

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

- Failure to obtain authorization for an elective service that requires authorization may result in an administrative denial. Emergent services do not require authorization.

- Post service reviews related to retroactive eligibility are reviewed for medical necessity and will not be denied for failure to obtain prior authorization.

- Coverage of emergent services up to stabilization of the patient will be approved for payment. If the patient is subsequently admitted following emergent care services, authorization is required within one (1) business day or post stabilization stay will be denied.

Post Service Review Cont'd

- Failure to obtain authorization when required will result in denial of payment for those services.

- The only potential exception for payment as a result of post-service review is if information is received indicating the provider did not know nor reasonably could have known that patient was a Molina member or in the case of an error by Molina, a medical necessity review will be performed.

- Decisions, in this circumstance, will be based on the following:
    - medical need; and
    - appropriateness of care guidelines defined by UM policies and criteria;
    - regulation and guidance; and
    - evidence based criteria sets.

MOLINA HEALTHCARE

Prior Authorization – Peer-to-Peer Review Process

- Peer-to-Peer review of an adverse determination may be requested if the Provider directing the Member's care wishes to provide additional information related to the authorization request.

- The requesting Provider has five (5) business days from the receipt of the denial notification to schedule the review.

- Requests can be made by contacting Molina at (844) 826-4335.

Prior Authorization Reconsideration

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

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

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

Prior Authorization – Appeals

- A Provider may file a formal Appeal orally or in writing, requesting Molina to review an Adverse Benefit Determination related to a Provider.

- Appeals must be filed within thirty (30) calendar days from the Adverse Benefit Determination or denial. A written acknowledgement letter must be sent within ten (10) calendar days of receipt of the Appeal. Appeals must be resolved as expeditiously as possible, and no later than thirty (30) calendar days from receipt.

- For decisions not resolved wholly in the Provider's favor, Providers have the right to request a State Administrative Hearing from the Division of Medicaid.

Claims

- **Claims Processing Standards**: On a monthly basis, over 90% of claims received by Molina from our health plan network providers are processed within 30 calendar days;100% of claims are processed within 45 working days

    – These standards have to be met in order for Molina to remain compliant with regulatory requirements and to ensure that our providers are paid in a timely manner

- **Claims Submission Options**

    – Molina prefers contracted providers to submit all claims electronically.
    – Electronic claims include claims submitted via a clearinghouse using the EDI process and claims submitted through the Molina Provider Web Portal
    – The Provider Portal (https://provider.molinahealthcare.com) is available free of charge and allows for attachments to be included.
    – Via a Clearinghouse.
        - Providers may use the Clearinghouse of their choosing. (Note that fees may apply).
        - Claimsnet is Molina Healthcare's chosen clearinghouse. When submitting EDI Claims (via a clearinghouse) to Molina Healthcare, providers must use the applicable payer ID # 77010

- **EDI Claim Submission Issues**

    – Providers can call the EDI customer service line at (866) 409-2935; and/or
    – Submit an email to EDI.Claims@molinahealthcare.com.

MOLINA HEALTHCARE

Claims Submission Options

EDI Claims Submission Information

Clearinghouse:

- Molina Healthcare of Mississippi uses ClaimsNet as its gateway clearinghouse. ClaimsNet has relationships with hundreds of other clearinghouses. Typically, Providers can continue to submit Claims to their usual clearinghouse.

- Molina accepts EDI transactions through our gateway clearinghouse for Claims via the 837P for Professional and 837I for institutional. In order to ensure that all data being submitted to our gateway is received properly your submitter must utilize the latest version of the 837 standard. It is important to track your electronic transmissions using your acknowledgement reports. The reports assure Claims are received for processing in a timely manner.

- ClaimsNet Payer ID# **77010**

EDI Claim Submission Issues

- Please call the EDI customer service line at (866) 409-2935; and/or
  - Submit an email to EDI.Claims@molinahealthcare.com; and/or
  - Contact your provider services representative

MOLINA
HEALTHCARE

Claims Submission Options

Molina's Provider Web Portal (Provider Portal)

- Free registration; contact a Molina Provider Services call center agent to obtain the "Molina ID #" required to register
- Allows for submission of UB and CMS 1500 claims, including claims with attachments and corrected claims

  - ***The web portal is the recommended method to submit claims with attachments***

  - The portal can be accessed at: https://provider.molinahealthcare.com

Claims Reconsiderations, Disputes, and Appeals - Important Definitions

- **Adverse Benefit Determination**: The denial or limited authorization of a requested service, including determinations on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit; the reduction, suspension, or termination of a previously authorized services; the denial, in whole or in part, of payment for a service; the failure to provide services in a timely manner, as defined by the Division of Medicaid.

- **Provider appeal**: request for Molina to review an Adverse Benefit Determination related to a Provider; which may include, but is not limited to, for cause termination by Molina, or delay or non-payment for Covered Services.

How to File a Claim Reconsideration, Dispute or Appeal

- **Preferred Method** – online via Molina's Provider Portal: https://provider.MolinaHealthcare.com/provider/login

- **Fax**: (844) 808-2409

- **Mail**:

    Molina Healthcare of Mississippi, Inc.

    Attention: Provider Grievance & Appeals

    188 E. Capitol St. 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, e.g. 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.

Important Timeframes to Remember

- Providers shall have one-hundred eighty (180) calendar days to submit claims from the date of service.

- Claims filed within the appropriate time frame but denied may be submitted for reconsideration within ninety (90) calendar days from the date of denial.

MOLINA HEALTHCARE

Important Timeframes to Remember

- Provider's are required to file an appeal within thirty (30) calendar days of receiving a notice of Adverse Benefit Determination.

- Molina will confirm receipt of the Appeal and provide an expected resolution date within ten (10) calendar days of receipt of the Appeal.

- Molina will resolve an appeal:
  – Within thirty (30) calendar days of the date Molina receives the Appeal or as expeditiously as the Member's health condition requires; or
  – Within three (3) calendar days after Molina receives the request for an Expedited Resolution of an Appeal.
    - Molina may extend time frames by up to fourteen (14) calendar days

Resources on Reconsiderations, Disputes, and Appeals

- Provider Manual found on the Molina website: www.molinahealthcare.com

- Provider Portal: https://provider.MolinaHealthcare.com/provider/login

- Explanation of payments (EOP)

- Adverse Benefit Determinations

- Contacting your Molina Provider Services Representative

Balance Billing and Claims Payment

Providers *may not* balance bill Molina Members for any reason for *covered* services. Detailed information regarding the billing requirements for non-covered services are available in the MHMS Provider Manual.

Your Provider Agreement with MHMS requires that your office verify eligibility prior to rendering any service and obtain approval for those services that require prior authorization.

In the event of a denial of payment, providers shall look solely to **MHMS** for compensation for services rendered, with the exception of any applicable cost sharing/co-payments.

- ✓ The date of claim receipt is the date as indicated by its data stamp on the claim.
- ✓ The date of claim payment is the date of the check or other form of payment.

MOLINA HEALTHCARE

Electronic Funds Transfer & Remittance Advice (EFT & ERA)

Contracted Providers are required to register for EFT within 30 days of entering the Molina Network. Providers enrolled in EFT payments will automatically receive ERAs as well. Molina partners with Change Healthcare ProviderNet for EFT and ERA services. Additional information regarding EFTs and ERAs will be available under the "EDI, ERA/EFT" tab on the Molina website.

Benefits of EFT/ERA:
- Faster payment (as little as 3 days from the day the claim was electronically submitted)
- Search historical ERAs by claim number, member name, etc.
- View, print, download and save PDF ERAs for easy reference
- Providers can have files routed to their ftp and/or their associated clearinghouse

How to Enroll:
- To register for EFT/ERAs with Change Healthcare go to: https://providernet.adminisource.com/Start.aspx
- Step-by-step registration instructions are available on Molina's website (www.molinahealthcare.com) under the "EDI, ERA/EFT" tab.

MOLINA HEALTHCARE

Prior Authorization, Retrospective Review and Claims Review

Authorization, Prior Authorization & Notification

UnitedHealthcare®
Community Plan

- An **Authorization** is defined as an UHC administrative or clinical review of an *inpatient* admission stay, as well as *outpatient* procedures or services. The basic elements of an authorization review include eligibility verification, benefit interpretation, medical necessity review, and appropriateness of care for making accurate utilization determinations.

- A **Prior Authorization (PA)** is defined as a UHC administrative or clinical review conducted *prior to* an elective or non-emergent inpatient admission stay, as well as outpatient procedures or services. The basic elements of a PA review include eligibility verification, benefit interpretation, medical necessity review, and appropriateness of care for making utilization determinations.

- A **Notification** is a process by which a hospital notifies United of all urgent/emergent hospital admissions and provides clinical information to United to support all inpatient days beyond the day of admission.

Prior Authorization/Notification

List of services requiring prior authorization, UHCProvider.com > Health Plans by State > Mississippi > Prior Authorization

Request prior authorization online, or by phone or fax:

- Online: Use the Prior Authorization and Notification app on Link
- Phone: 866-604-3267 (Mon-Fri, 8am-5pm; or 24/7 for emergencies)
- Fax: 888-310-6858; fax form is available at UHCProvider.com > Health Plans by State > Mississippi > Prior Authorization > PA Paper Fax Forms

Prior authorization is not required for emergency or urgent care

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

Prior Authorization

UnitedHealthcare®
Community Plan

Radiology/Cardiology/Chemo Prior Authorization

UHCProvider.com > Health Plans by State > Prior Authorization

Phone: 866-889-8054
Fax: 866-889-8061

Go to Prior Authorization and Notification Tool

Current Prior Authorization Plan Requirements

UnitedHealthcare Community Plan - Mississippi Children's Health Insurance Program (CHIP)
- UnitedHealthcare Community Plan Prior Authorization MS CHIP - 10/1/2018

UnitedHealthcare Community Plan - Mississippi Coordinated Access Network (MississippiCAN)
- UnitedHealthcare Community Plan Prior Authorization MS CAN - Effective 10/1/2018

UnitedHealthcare Medicare Solutions & UnitedHealthcare Community Plan (Dual Special Needs Plan) Prior Authorization Requirements
- View UnitedHealthcare Medicare Solutions & UnitedHealthcare Community Plan (Dual Special Needs Plan) Authorization Requirements.

Cardiology Prior Authorization and Notification Program +

Electronic Data Interchange (EDI) +

Oncology Prior Authorization and Notification Program +

Previous Prior Authorization Requirements +

Prior Authorization Paper Fax Forms +

Radiology Prior Authorization and Notification Program +

Retrospective Review Process

A retrospective review is conducted after services are provided to a member. We perform these reviews for retro-eligibility or for extenuating circumstances related to the member:

- The member is unconscious upon presentation, and the care provider has not previously submitted a claim for the member; or

- Acts of nature impairing the facility's ability to verify a member's coverage/eligibility status. The request for retrospective review must include a reason and be submitted within 60 days of the service date.

- Not providing a reason for the retrospective review request will result in a denial.

For a retrospective review request:

- Call: 866-604-3267, Monday-Friday, 8 a.m. – 5 p.m. Central Time.
    Emergency calls are accepted after hours.

- Fax: 888-310-6858

A retrospective review is <u>not</u> conducted for:

- <u>Elective</u> ambulatory or inpatient services on the UnitedHealthcare Community Plan advance notification list for which prior approval did not occur before providing the services.

- <u>Emergency inpatient</u> services on the advance notification list that did not meet notification requirements. Notification of inpatient admission is required within one <u>business</u> day of the admission date.

- Services not requiring prior approval

- Reconsideration and/or review of an adverse benefit determination

- Previously submitted claim

Claim Filing

Electronic vs. Paper
- Electronic claims help reduce errors and shorten payment cycles
  - Learn more about electronic claims submission at:
    UHCprovider.com > Claims & Payments
    Link

- If a claim must be submitted on paper, use the following address:
    UnitedHealthcare
    P.O. Box 5032
    Kingston, NY 12402-5032

Format
- Claims must be submitted using the standard CMS-1500 for professional claims and CMS-1450 (UB04) for facility or institutional claims,
  or respective electronic format
- Include all appropriate secondary diagnosis codes for each line item

Timely Filing
- 180 days timely filing is now allowed for both MississippiCAN and CHIP

Inpatient
- The payer (CCO or DOM) on record on the **date of admission** should be billed for the entire inpatient stay.

Disagree With a Decision?

UnitedHealthcare®
Community Plan

Claims

Provider Services

    1-877-743-8734

Website

    UHCProvider.com > Link

Reconsideration

    (when additional information is added)

    Within 90 days of determination

Corrected Claim

    (when the provider wants to "try again" & disregard original claim)

    UHCProvider.com > Claims & Payments > Claim Reconsideration

Appeal

    Within 30 days of determination

State Hearing (MSCAN)

    Within 30 days of UHC appeal determination

Prior Auth/UM

Peer-to-peer (pre-service)

    Outpatient: Within 21 days of determination

    Inpatient: Within 3 days of determination

Concurrent Review

   Within 14 days of determination or 3 days post-discharge

Appeal

    Within 30 days of determination

State Hearing (MSCAN)

    Within 30 days of UHC appeal determination

Appeals & Filing Timeframe

- Timeframe for Requesting an Appeal - Within thirty (30) calendar days from notice of adverse action

- Acknowledgement Letter - UHC will send an acknowledgment letter within ten (10) calendar days of receipt

- Resolution Letter - Once determination has been made, UHC will send an Appeal Resolution letter within thirty (30) calendar days

- Expedited appeals require resolution within three (3) calendar days

- A State Administrative Hearing through Division of Medicaid must be requested within thirty (30) calendar days of UHC final determination
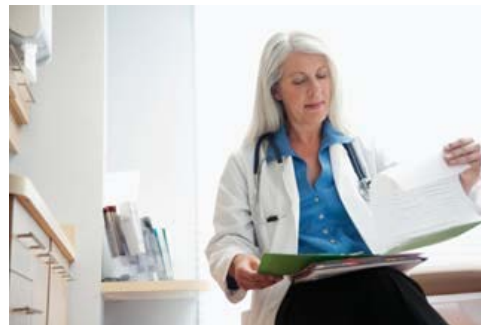
Case Management

We use retrospective and prospective methods to help ensure that potential high-risk members are identified as early as possible. These data sources include but are not limited to:

- Short health risk assessments conducted during new member welcome calls
- Member reported health needs in calls made to our Member Services Department
- Pharmacy and lab data indicating the incidence of a specific condition (e.g., insulin or inhalers)
- Emergency room utilization reports, authorization requests and transitional care coordination requests.
- Physician referrals
- Referrals from health departments, rural health clinics and FQHCs
- UnitedHealthcare Community Plan clinical staff referrals

UnitedHealthcare Community Plan's Case Management office
877-743-8731
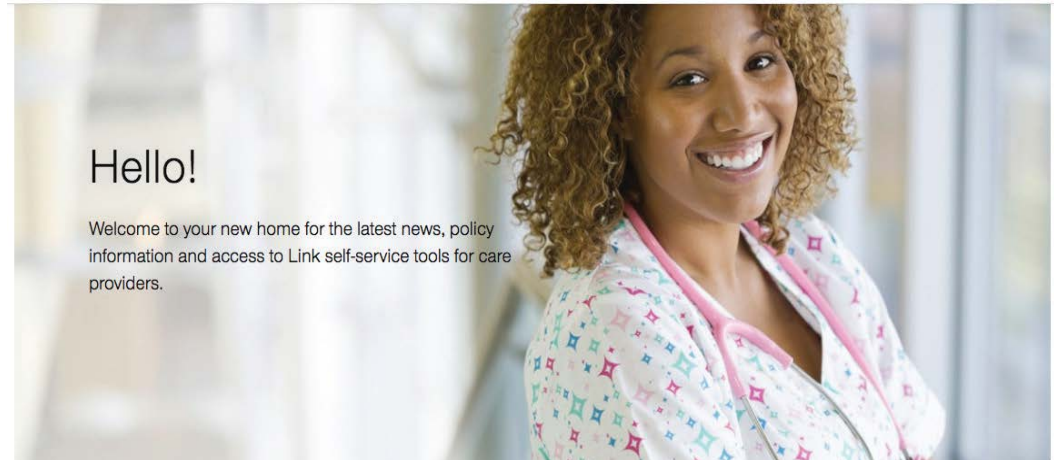
Network Resources

Link
UHC On Air
UHCprovider.com

Claims, PCP Panel, Demographics,
Check Eligibility, PA, Prescriptions,
Update Demographics, Care Plans,
EPSDT/HEDIS Care Gaps, CEUs,
Make a Referral,
Behavioral Health Tools,
Provider Directory, etc.

(website support 866-842-3278)

Provider Services
877-743-8734

Key Online Resources

Updated annually and as program changes occur
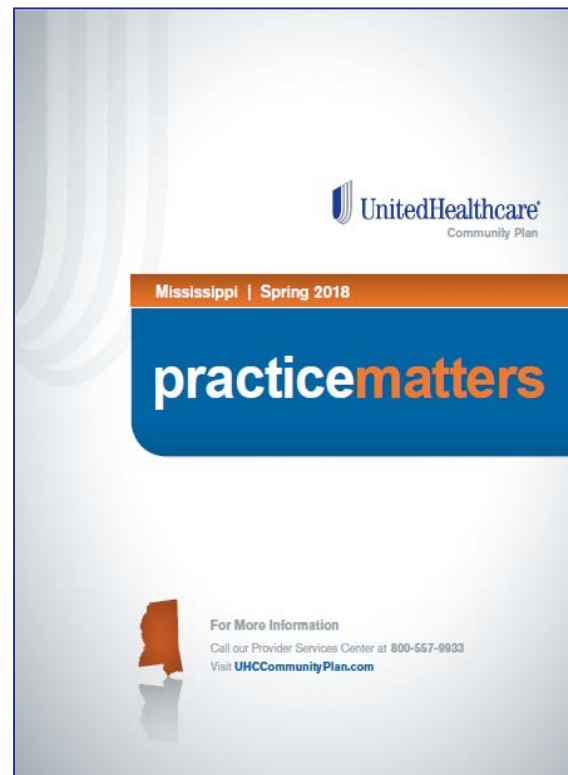
Newsletter for UnitedHealthcare Community Plan of Mississippi

Monthly online newsletters and real-time alerts to changes in policies or procedures

Key Resources

UHCProvider.com

Link, UHC On Air, claim submission, reconsiderations, electronic payments/EDI, provider directories, plan details, prior authorizations, disclosures, and more

Provider Services

MSCAN: 877-743-8734

MS-CHIP: 800-557-9933

Mississippi_PR_Team@uhc.com

Network Management Team

866-574-6088 ~ swproviderservices@uhc.com

Emails, Faxes, and Mailings

As needed for any significant changes or updates

Provider Advocates

Clinical Transformational Consultants

UHC On Air

Tune in to what's new.

UHC On Air

It's programming just for providers.

Our live broadcasts give you the opportunity to simply listen in or interact with speakers by asking questions or offering suggestions. And we're always creating more on-demand programs that you can choose to watch any time, from any smart device or computer. Our live and on demand programs include these topics and much more:

UHCProvider.com>Link

Provider Service Model

Your Provider Advocate is an important resource. They can help make your interactions with us easier and more efficient.

Please follow the Provider Relations Service Model before contacting a Provider Advocate about claim payment decisions:

1. Check the status of a claim by logging on to UHCProvider.com> LINK
2. If you disagree with a claim payment decision, please submit a claim reconsideration on LINK and be sure to save the PTPCR number or contact the UnitedHealthcare Community Plan Provider Service Team:
   - 877-743-8734

3. Be sure to obtain a call **tracking number** for future reference. This is a 4-digit number
1. If the issue remains unresolved after 30 days, supply all relevant details to your Provider Advocate (i.e. copy of the claim, member name, member ID number, date of service, call tracking number).

   If you do not know your Provider Advocate, email the team at Mississippi_PR_Team@uhc.com

5. Your Provider Advocate will work with our issue resolution teams and facilitate follow-up and communication

Question & Answers

Lunch Break
Own Your Own

EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT (EPSDT)

EPSDT

- Federally mandated service that provides preventive and comprehensive health services for Medicaid-eligible children (birth – 21)

- Provides a way for children to get medical exams, checkups, follow-up treatment, and special care they need to make sure they enjoy benefits of good health.

EPSDT PROVIDERS

- Medicaid providers with signed EPSDT specific provider agreement

- Must conduct periodic screenings and medically necessary interperiodic visits for all EPSDT-eligible beneficiaries in accordance with EPSDT Periodicity Schedule (American Academy of Pediatrics (AAP) Bright Futures Periodicity Schedule)

- Must provide or refer EPSDT-eligible beneficiaries with identified need for additional assessment, diagnosis, and/or treatment services to an appropriate provider

EPSDT Periodic Examination Schedule

Screening Code		Modifier	Age of Child	Unit
New Patient	**Established Patient**			
99381	99391	EP	3 – 5 Days	1
99381	99391	EP	0 – 1 Month	1
99381	99391	EP	2 Months	1
99381	99391	EP	4 Months	1
99381	99391	EP	6 Months	1
99381	99391	EP	9 Months	1
99382	99392	EP	12 Months	1
99382	99392	EP	15 Months	1
99382	99392	EP	18 Months	1
99382	99392	EP	24 Months	1
99382	99392	EP	30 Months	1
99382	99392	EP	3 – 4 Years*	1
99383	99393	EP	5 – 11 Years*	1
99384	99394	EP	12 – 17 Years*	1
99385	99395	EP	18 – 21 Years*	1

Beginning at 3 years of age, EPSDT Screenings must be done annually up to the age of 21. Yearly visits must be planned to occur once during the state fiscal year (July 1 – June 30).

Sensory Screenings and Developmental/Behavioral Assessments

Screening Code	EPSDT Service	Age of Child	Period	Unit
99173-EP	Vision Screen	3 – 21 Years	Annually	1
92551-EP	Hearing Screen	4 – 21 Years	Annually	1
96110-EP	Developmental Screen	9, 18, and 30 Months	9, 18, & 30 Months	1
96110-EP	Autism Screen	18 and 24 Months	18 & 24 Months	1
96160-EP	Depression Screen	12 – 21 Years	Annually Beginning at Age 12	1
96161-EP	Maternal Depression Screen	1-6 Months	1, 2, 4, & 6 Months	1

NON-EMERGENCY TRANSPORTATION (NET)

MISSISSIPPI DIVISION OF
MEDICAID

Non-Emergency Transportation

DOM contracts with a NET Broker to provide non-emergency transportation (NET) to Medicaid beneficiaries in appropriate vehicles, including wheelchair vans, taxis, minivans, and sedans depending on the beneficiary's mobility status and personal capabilities on date of service.

Administrative Code

Part 201: Transportation Services

https://medicaid.ms.gov/wp-content/uploads/2014/01/Admin-Code-Part-201.pdf

Non-Emergency Transportation Changes for Long Term Care Facilities

The removal of long-term care (LTC) residents from the Non-Emergency Transportation (NET) Broker program has been delayed until February 1, 2019. September 9, 2018, the removal of language allowing NET ambulance services provided to LTC residents to be billed directly to the Mississippi Division of Medicaid will be effective.

For more information read the question and answer document for non-emergency ambulance transportation.

https://medicaid.ms.gov/wp-content/uploads/2018/08/QA-for-NET-Ambulance-Services.pdf

Non-Emergency Transportation Changes for Long Term Care Facilities

Medicaid Fee-for-Service Net vendor is Medical Transportation Management (MTM)

- To schedule a ride, call 1-866-331-6004

- For late arrival and no shows, call 1-886-334-3794

- For complaints about transportation, call 1-866-436-0457

Dental, Vision, and Non-Emergency Transportation

Provider Orientation & Training for Magnolia Health

Envolve Dental, Inc.
2018

Envolve Dental Introduction
For Provider Network

Presenter:
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Reshemia.Ratcliff@Envolvehealth.com
601-559-2268

Who is Envolve Dental?

- Dental benefits administrator
- Sister company of Magnolia Health Plan
- Specializes in administration of government dental programs
- Mississippi plans: MSCAN & MSCHIP
- Works directly with states and managed care organizations

Envolve Dental Key Elements

- Administrating benefits since January 1, 2015

- Participation requires contracting and credentialing.

- After credentialing is confirmed, register for the Provider Web Portal by calling Provider Services at 844-464-5636

- Enroll in Electronic Funds Transfer (EFT) for quick payments.

Envolve Dental Key Elements

Continuation of Care Process

Dental Continuation of Care (COC) is a 90-day allowance.

> When Envolve Dental receives members from another Dental Plan, then Envolve Dental will honor the previously approved authorizations from the other Medicaid provider, i.e. Dentaquest etc.

> Process:

> If a member came from another plan and the service was approved, then Envolve Dental will request that the current provider sends in supporting documentation for the pre-approved service for consideration and Envolve Dental will review and approve the service in a timely manner.

Envolve Dental Contact Information

Provider Services	
Web Portal	https://pwp.envolvedental.com
Email	providerrelations@envolvehealth.com
Provider Services	844-464-5636 (Phone) 844-815-4448 (Fax)
Contracting and Credentialing	844-847-9807 (Fax)
EDI Payor ID	46278
Paper Claims Mailing Address (All Plans)	Envolve Dental Claims PO Box 25255 Tampa, FL 33622-5255
Authorization Mailing Address (All Plans)	Envolve Dental Authorizations PO Box 25255 Tampa, FL 33622-5255
Provider Appeals Address (Medicaid, CHIP, and Ambetter)	Envolve Dental Appeals: MS P O Box 25255 Tampa, FL 33622-5255

Envolve Dental Contact Information

Claims, image and prior authorization submission options	
Web Portal	https://pwp.envolvedental.com
Email	providerrelations@envolvehealth.com
Change Healthcare (formerly Emdeon) Clearinghouse	Payor ID : 46278 @ www.changehealthcare.com
DentalXChange Clearinghouse	Payor ID : 46278 @ www.dentalxchange.com
Trizetto Clearinghouse	Payer ID : 46278 @ www.trizetto.com
National Electronic Attachment	www.nea-fast.com Master ID 463011: Medicaid (MSCAN) Master ID 463013: CHIP Master ID 463012: Ambetter Master ID 463039: Medicare Advantage
Provider Appeals Address (Medicare Advantage)	Envolve Dental Attn: Appeals and Grievances PO Box 4000 Farmington, MO 63640

Envolve Vision

Is the eye care administrator for *Magnolia Health*

Important Contact Information

NETWORK MANAGEMENT

Provider Participation Inquiries:
800-531-2818, option 4

CUSTOMER SERVICE

Medicaid/Allwell………………..…..(888) 241-0663
CHIP………………….…………….(844) 293-7701
Ambetter………………................(866) 842-6177

CLAIMS SUBMISSION

Electronic Claims Submission:
Change Healthcare Pay ID # 56190
Eye Health Manager:
www.envolvevision.com/logon
Paper:
PO Box 7548, Rocky Mount, NC 27804

www.envolvevision.com

magnolia health

Member Benefit Highlights

MEDICAID
> Under 21: Two complete eye exams and two pairs of eyeglasses every calendar year.
> Members 21 & over: One complete eye exam and eyeglasses every calendar year.
> Under 21: Replacements for eyeglasses due to loss or theft.
> Medically necessary eyewear covered.
> Medically necessary eye care services covered for all members. Medical/Surgical services are subject to Envolve Vision Utilization Management polices and procedures.

CHIP
> One complete eye exam every calendar year.
> One pair of eyeglasses every calendar year.
> Replacements for glasses that are broken or damaged.
> Medically necessary eyewear covered.
> Medically necessary eye care services covered for all members. Medical/Surgical services are subject to Envolve Vision Utilization Management policies and procedures.

AMBETTER
> One complete eye exam every calendar year.
> Under 19: One pair of eyeglasses or contacts every calendar year.
> Members 19 & over: $130 allowance for eyeglasses **or** contacts every calendar year.
> Medically necessary eyewear covered.
> Medically necessary eye care services covered for all members. Medical/Surgical services are subject to Envolve Vision Utilization Management policies and procedures.

ALLWELL
> One complete eye exam every calendar year.
> $150 retail eyewear allowance every calendar year.
> Medically necessary eyewear covered.
> Medically necessary eye care services covered for all members. Medical/Surgical services are subject to Magnolia's Medicare Advantage policies and procedures.

INTRODUCING **MTM**

Medical Transportation Management (MTM) is a non-emergency transportation (NET) manager. We provide rides free of charge for eligible Division of Medicaid (Fee for Service(FFS)) and Magnolia beneficiaries throughout the entire state.

MTM HAS A PURPOSE

Provide a high quality Member experience → Introduce increased transparency → Build confidence in the NEMT program statewide

Modes of Transportation

- ✓ **Public transportation**
- ✓ **Ambulatory**
  - ❖ **Sedan**
  - ❖ **Van**
- ✓ **Wheelchair lift van**
- ✓ **Stretcher and Ambulance**
- ✓ **Gas Mileage Reimbursement (GMR)**

Important Telephone Numbers

Important Numbers for Beneficiaries

▶ Trip Reservations: 1-866-331-6004

▶ Where's My Ride: 1-866-334-3794

▶ Hours of Operation:

  M-F 7am-6pm

Important Numbers for Providers:
Nakeesha Luckett
769-572-6182
Community Outreach Trainer
CO-MS@mtm-inc.net
nluckett@mtm-inc.net

Support Team Fax: 1-877-361-9791
Support Team Email:
MSCSCOT@mtm-inc.net

Dental and Hearing Subcontractor Overview -Avesis

- Founded in 1978, Avēsis is one of the nation's leading administrators of managed dental, vision (routine and eye medical/surgical), and hearing care programs for the commercial, Medicaid, and Medicare Advantage markets.

- We cover more than nine million members:

    - 7.5 million Medicaid, CHIP, and Medicare Advantage
    - 1.5 million commercial

Local Presence, Provider-Centric Service

- Directors in each state (state-licensed)
- Local, accessible provider relations representatives
- Familiarity with state-level issues that can impact your practice
- Clinical claim review by state-licensed practitioners
- Dental advisory boards

Avesis Provider Resources

- **General Network information** – Available on www.avesis.com

- **How to become an Avēsis provider**
  - visit www.avesis.com provider contracting /credentialing information and all documentation is available along with the link to obtain assistance.

- **Claim filing information**
  1. Avēsis Provider Portal – to gain access contact your provider relations representative
  2. Clearinghouse Submission – Avēsis Payor ID -**86098**
  3. On a claim form to:

     Avēsis Dental Claims
     P.O. Box 38300
     Phoenix, AZ 85069-8300

- Online resources – Available at www.avesis.com

- <u>General Covered Benefits</u>:
  - **Dental Program:** Standard MississippiCAN dental benefits for members over/under 21, exams, cleaning, etc., orthodontics (prior authorization required)
  - **Hearing Program:** Hearing Tests and Hearing Aids are limited to members under 21

- Contact information for provider services -
  1. **833-282-2419** Monday through Friday, 7:00 a.m. to 8:00 p.m. EST
  2. Provider Relations - Dana Flood -410-413-9230 or dflood@avesis.com
  3. Provider Relations - Kwiinta Anderson -410-413-9344 or KwAnderson@avesis.com
  4. Provider Relations Internal – Jarhonda Brown – 410-413-9113 or jlbrown@avesis.com

Avesis – Claims Payment

Clean claims are processed and adjudicated within 15 business days. State guidelines are within 30 days.

- Checks are run weekly.

- Electronic Funds Transfer (EFT) payments are deposited weekly.

Avesis – Corrected Claims

If you are missing information (e.g., tooth number or area), or you have submitted incorrect information (wrong code, wrong tooth number, etc.), you may edit the ADA claim form and send it with the claim number, if one has been assigned, to the Phoenix office.

- Write "Corrected Claim" on the top of the ADA claim form in blue or black ink. The scanner does not read red ink.

- Please do not highlight notes on the claim in blue or green highlighter. The scanner reads these colors as black, so whatever is highlighted will be blacked out.

Corrected claims cannot be submitted on the web portal.

Avesis – Appeals Process

We have two (2) processes for appeals depending on the type. Both require submission within 60 days, and neither may be submitted on the web portal.

- Administrative appeals are those involving adverse determination for reasons other than medical necessity (e.g., filing timeliness, missing prior authorization, etc.).

- Medically Necessary appeals involve findings that there was no medical necessity for the claim.

  – Your written request within 30 days of denial must state that it is an appeal.

  – Send the appeal to the Avēsis Phoenix headquarters in an envelope marked "Attn: Appeals"

  – We will notify you if our initial decision is upheld or pay the claim if it is overturned.

Avesis – Prior Approval Requirements

Services requiring prior approval are listed in detail on the covered benefits schedule and describe the attachments required.

- Providers may submit pre-treatment estimates on an ADA claim form to our Phoenix address or by electronic attachment through either the Avēsis provider portal or NEA (National Electronic Attachment) .

- We recommend electronic submission for quicker turnaround, higher accuracy, and no chance of the request being lost in the mail.

- All codes that require *post review* and that are submitted on a prior authorization form will be denied on the PTE. The provider will get the PTE with the following message for services with PD28 or GH5:

  "The service has been denied because it does not require prior authorization. This service does, however, require post review. Please submit the required documents with the claim after services have been rendered."

The member will not receive a denial letter on these services.

Avesis – Continuation of Care Form

An orthodontic continuation of care case requires the following information:

- A completed ADA prior authorization form
- The Orthodontic continuation of care form (completely filled out)
- EOB/patient ledgers to verify previous payments noted on the COC form (patient ledger not required if the EOBs submitted from the previous carrier contain procedure codes, amounts paid, dates paid, etc.)
- Previous authorization from other carrier
- Models/panoramic x-ray/cephalometric x-ray/photographs, if previous insurer was private pay or commercial carrier

Vision Services Subcont **MARCH® Vision Care**

Who is MARCH® Vision Care?

- MARCH® specializes in the administration of vision care benefits for health care organizations, specifically for government sponsored programs such as Medicaid, Medicare, and Medicare-Medicaid plans.
- MARCH® partners with dedicated eye care professionals throughout the United States and currently supports over 6.9 million Medicaid and Medicare members nationwide.

Benefit Information

MARCH® administers the routine eye exam, eyewear, and eyewear after cataract surgery benefits for Molina Healthcare of Mississippi – MississippiCAN members.

Claim Information

Providers should submit their claims electronically via eyeSynergy®, MARCH®'s web-based provider portal. MARCH® has a direct agreement with Optum to accept electronic claims.

March Vision Care Provider Resources

MARCH® Vision Care

How to Become a MARCH® Vision Care Provider

To become a MARCH® Vision Care provider, visit
www.marchvisioncare.com/becomeaprovider.aspx   and complete the online MARCH®
Provider Contract Form.

Where to Find Participating Network Providers

MARCH® Vision Care offers a diverse panel of providers who can be found in the online
provider directory. To access the directory, visit the "Locate a Provider" page on
MARCH®'s website www.marchvisioncare.com.   You can search for providers by using
specific criteria (i.e. plan state, benefit plan, zip code, provider name, etc.).

Provider Resources

To access online provider resources, including the Provider Reference Guide, providers
can go to the "Provider Resources" page on MARCH®'s website. Information regarding
state-specific benefits, frame kit catalogs, and forms, just to name a few, can be found on
this page.

Provider Contact Information

Providers may contact MARCH®'s Provider Services Department by using our Mississippi-
specific phone number:

(844) 606-2724, extension 7576.

MOLINA HEALTHCARE

Non-Emergent Transportation Subcontractor

Molina Healthcare has contracted with Southeastrans to manage all non-emergent transportation (NET) services for their MississippiCAN Members. Southeastrans is responsible for the following components of the Molina MS NET program:

- Establishing a network of NET providers throughout the State
- Assurance of NET provider, driver, and vehicle compliance
- Call center services and web portal for Members to request transportation
- Authorizing and assigning trips to NET providers
- NET claims administration
- Quality assurance
- Data management and reporting of NET services

Southeastrans Provider Resources

SOUTHEAS**TRANS**

As a medical facility, you may set up trips for your patients several ways.

- Call us. We have a staff of Special Service Representatives (SSRs) ready to take calls and handle requests directly from facilities. You may reach them on the Facility line at 1-888-822-6102.
- If you have members who come twice or more weekly, at the same times each week, our SSRs can send you a Standing Order Request. This will create an automatically generating trip for them.
- Email our agents at: msssr@southeastrans.com
- Our facility portal is also a way to manage appointments and see who is coming and going from your facility.

MOLINA HEALTHCARE

Southeastrans Provider Resources (Cont.)

SOUTHEASTRANS

Local Contact Information:

- Tammie Sanford, State Director, may be reached by phone, email, or fax for any issues that may arise.
    - 404-977-8666 (cell) / 864-529-9880 (fax)
    - tsanford@southeastrans.com
- We have two (2) local Compliance Officers who spend their days in the field observing and inspecting. Their goal is to visit every medical facility and introduce themselves by the end of the year.
- Please let us know if you have a favorite transportation company who visits your facility, or a least favorite and why. Our goal is to make transportation for your patients safe, comfortable, reliable, and enjoyable.

Laboratory Services

Quest Laboratories is the preferred provider of laboratory services for Molina Healthcare. Molina members will benefit from Quest Diagnostics comprehensive access, convenience, and choice with a broad array of services available at locations throughout our service delivery areas.

Quest Laboratories offers:

- An extensive testing menu with access to more than 3,400 diagnostic tests so you have the right tool for even your most complicated clinical cases.
- Approximately 900 PhDs and MDs are available for consultation at any time.
- Results within 24 hours for more than 97% of the most commonly ordered tests.
- 24/7 access to electronic lab orders, results, ePrescribing and Electronic Health Records.
- Trained IT Specialists provide 24/7/365 support for all Quest Diagnostics IT solutions in your office, minimizing downtime and providing the answers you need quickly.
- Less wait time at Patient Service Center locations with Appointment Scheduling by phone or online.
- Email reminders either in English or Spanish about upcoming tests or exams.

If a provider does not currently use Quest Diagnostics for outpatient laboratory services or has questions about Quest Diagnostics services, test menus, and patient locations, they can call 866-MY-QUEST to request a consultation with a Quest Diagnostics Sales Representative.

Dental, Vision and Non-emergency Transportation

Pharmacy

Preferred Drug List (PDL) is defined by DOM and updated quarterly

– Access the PDL through Medicaid or at <u>UHCCommunityPlan.com > For Health Care Professionals > Mississippi > Pharmacy Program</u>.

– Definitions for prior authorization, quantity level limits, step therapy, and specialty medications can be found in the PDL.

Requesting Prior Authorization for non-preferred medications or for those requiring prior authorization (turnaround time is typically < 24 hours)

– Phone: 800-310-6826

– Fax: 866-940-7328 (Forms can be found at the website above)

An Emergency 3-Day Supply is available for immediate need of a new non-preferred medication or a medication requiring prior authorization

– Direct communication is provided to network pharmacies on how to process

Medical Injectable Drugs most commonly given in provider-based settings are processed as medical claims.

Nutritional Products (AKA "Caloric Agents" on DOM PDL) can be processed via OptumRX POS pharmacy claims and will NOT count against monthly limits

Pharmacy Network Finder UHCProvider.com > Find A Care Provider > OptumRX

Rx Provider Services: 877-842-3210

Dental

DENTAL BENEFIT PROVIDERS

Website & Portal: UHCProviders.com or dbp.com

Provider Relations: (800) 508-4862

Provider Portal:

UHC Providers.com > Log In

> File claims

> Eligibility

> Benefits

> Claims

> Lab Order Status

> Prior Authorizations

> Coordination of Care/Orthodontia

> Add Providers

> Member Service History

> Review Payments and PRAs

Business by Mail:

Prior Authorizations	Claims	Appeals*
United Healthcare Dental	UnitedHealthcare Dental	United Healthcare Dental
P.O. Box 1313	P.O. Box 781	Attn: Provider Appeals
Milwaukee, WI 53201	Milwaukee, WI 53201	P.O. Box 1391
		Milwaukee, WI 53201

* This process is for provider appeals. If a providers is filing an appeal on behalf of a consenting member, please follow the UHC processes outlined in the applicable UHC manual (previously referenced)

Dental *(cont'd)*

DENTAL BENEFIT PROVIDERS

All Prior Authorization Requests (portal or paper):

- Submit ADA dental claim:
  - Mark "Request for Predetermination/ Preauthorization"
  - Submit applicable documentation as outlined in provider manual

- Continuity of Care (COC) Orthodontia Authorization (same as above +)
  - Include D8999 and D8670 codes on ADA claim
  - Mark "Request for Predetermination/ Preauthorization"
  - Supplemental documents:
    - Copy of initial orthodontia case approval
    - Attestation that preventative and dental treatment services have been completed
    - Copy of orthodontic treatment notes from the provider that began treatment
    - Recent diagnostic photographs and/or panoramic radiographs
    - Date when active treatment began and the expected number of months for active treatment (max 24 months)
    - Payment history for all previous services

    - **Coordination of Care - Orthodontia**

UnitedHealthcare®
Community Plan

MARCH® Vision Care

Website & Portal: MarchVisionCare.com

Provider Relations: (844) 606-2724

Provider Portal:

MarchVisionCare.com > EyeSynergy > Log In >

- > File claims
- > Eligibility
- > Benefits
- > Claims
- > Lab Order Status
- > Become a Participating Provider*

Mail Claims:

Claims Processing Center
6701 Center Drive West, Suite 790
Los Angeles, CA 90045

Referrals are NOT needed

March Vision Care currently utilizes CAQH for credentialing processes.

Non-Emergency Transportation

National MedTrans supplies resources for both members and providers to schedule transportation.

National MedTrans Member Reservations: 844-525-3085 **or**

UHC Member Services: 877-370-4009

Facilities and Providers: 844-525-2331

Or request transportation online at:

https://nationalmedtrans.com/request-a-ride/

Things to Remember:

- Be sure to schedule 3 business days in advance
- Have your member's info on hand (Name, Phone#, Address, DOB, Member ID#.)
- Name and Address of Pick-up/Drop-off Locations

Members and Providers should not reach out to the drivers directly. All communication and dispatch is handled by National MedTrans representatives through their call centers and scheduling platform.

Question & Answers

2018 Provider Workshops
Home Health
Medicaid 1915(c)- *Home & Community-Based Services (HCBS) Waivers*
Medikey
Durable Medical Equipment (DME)

MISSISSIPPI DIVISION OF
MEDICAID

Home Health

42 C.F.R. Part 440

Effective September 1, 2018, DOM must comply with Home Health Final Rule, published by Centers for Medicare and Medicaid Services (CMS) on February 2, 2016

https://www.gpo.gov/fdsys/pkg/FR-2016-02-02/pdf/2016-01585.pdf

Home Health

- Home Health services require face-to-face visit with physician or authorized non-physician practitioner prior to initiation of home health visits or provision of durable medical equipment (DME) and appliances

- Requires provision of home health services in any setting in which normal life activities take place.

Home Health

- Proposed changes to Administrative Code, Title 23: Medicaid, Part 215: Home Health Services filed on June 22, 2018.

- Administrative Code can be found on DOM's website: **https://medicaid.ms.gov/providers/administrative-code/**

- For more information regarding changes to Home Health Services, please contact Office of Medical Services at (601) 359-6150.

What is a Medicaid Waiver ?

- 1915(c) waivers allow the provision of long term care services in home and community-based settings (HCBS) under the Medicaid Program. States can offer a variety of services under a HCBS Waiver program.

- HCBS waiver programs can provide a combination of standard medical services and non-medical services in order for persons to remain in a home or community-based setting as an alternative to nursing facility or other institutional care.

- Mississippi has five HCBS 1915(c) waivers:

  ❖ Elderly and Disabled (E&D) Waiver

  ❖ Independent Living (IL) Waiver

  ❖ Traumatic Brain Injury/Spinal Cord Injury (TBI/SCI) Waiver

  ❖ Assisted Living (AL) Waiver

  ❖ Intellectual Disabilities/Developmental Disabilities (ID/DD) Waiver

How to get more information

For more information about these waivers, contact:

Mississippi Access to Care Center (MAC Center)
    Toll-free: 844-822-4MAC (4622)
    Website: **http://mississippiaccesstocare.org**

Office of Long Term Care, Mississippi Division of Medicaid
    Toll-free: 800-421-2408
    Phone: 601-359-6141
    Website: **https://medicaid.ms.gov/programs/long-term-care-2/**

Elderly & Disabled Waiver Adult Day Care (ADC) Billing

Types	Codes
Procedure Code	S5100
Modifier	U1
Provider Type	W04
Place of Service	11 or 99

- For dates of service on or after November 1, 2017, the rate for Adult Day Care has been changed to $3.88 per 15 minute unit for the duration of time the services were provided. Services will be reimbursed by DOM the lessor of the total amount of the 15 minute increment units billed or the maximum daily rate of $62.08.

- The duration of the service time should begin upon the person's entry in the facility and ends upon their departure, and does not include transportation time.

- The requirement for a person to attend the ADC for a minimum of four hours per day has been removed. This change optimizes autonomy and flexibility in choices for ADC attendance.

- Services for the month cannot be billed until the first (1st) day of the month following the month in which services were rendered. (i.e. April services cannot be billed until May 1)

- All services for the month must be billed on a single claim with individual lines for each date of service to accurately capture units provided each day.

Top 10 Waiver Provider Compliance Findings

- Claims paid were not supported by the documentation maintained by the provider (i.e. incomplete timesheets, no participant signature, etc.).

- The Adult Day Care facility environment did not fully meet the standards of the waiver (i.e. exposed wiring, out of date food, toxic chemicals not secured, etc.).

- Personal Care and In-Home Respite providers are not operating from a non-residential physical address/office located in an area zoned for business.

- Providers did not ensure that initial and annual training requirements, for all persons with the responsibility of providing direct care to beneficiaries, which includes PCAs and those in supervisory positions, were met and that documentation of training completion was maintained by the provider agency.

- Adult Day Care providers failed to provide, or contract for, safe reliable transportation to enable persons, including persons with disabilities, to attend the center and to participate in center-sponsored outings.

- Providers failed to maintain required supervisor/staff or staff/participant ratios.

MISSISSIPPI DIVISION OF MEDICAID

Top 10 Waiver Provider Compliance Findings (Continued)

- Providers did not have compliance policies and procedures or designated staff tasked with ensuring that their agencies are in compliance with both internal policies/procedures, and all applicable state and federal regulatory requirements.

- Required national criminal background checks with fingerprints were not performed for all employees/volunteers prior to employment, and every two (2) years thereafter, or maintained in the employee personnel file.

- Required checks of the Office of Inspector General's (OIG) Exclusion List (https://exclusions.oig.hhs.gov) and the MS Nurse Aide Abuse Registry, to ensure no direct care staff member is on the list, were not performed prior to employment, and monthly thereafter, or maintained in the employee personnel file.

- The provider failed to maintain auditable records to substantiate claims submitted to Medicaid or failed to provide immediate access to the provider's physical service locations, facilities, or any records relating to licensure, medical care, and services rendered to beneficiaries, and billings/claims during regular business hours (8 a.m. to 5 p.m., Monday – Friday) and all other hours when employees of the provider are normally available and conducting the business of the provider.

Upcoming Changes

- Updates to Mississippi Administrative Code Title 23 Division of Medicaid (DOM), Part 208: Home and Community Based Services (HCBS), Long Term Care, Chapter 1: Elderly & Disabled Waiver and Chapter 2: Independent Living Waiver to include new/enhanced requirements.

- Updates to the Elderly & Disabled Waiver Provider Proposal Packet submitted by providers prior to initial enrollment to incorporate new/enhanced requirements.

- Elderly & Disabled Waiver Provider Proposal Packets will be posted to the Division of Medicaid website to ensure reference access for all potential and current providers.

- Implementation of mandatory orientation for provider applicants prior to enrollment to provide education on specific provider requirements to ensure that facilities and applications submitted meet designated requirements.

Notification of Updates on the State Plan, Administrative Code or Waivers

- If a provider or individual would like to be added to the distribution list for notification of updates to the State Plan, Administrative Code, or Waiver please notify the Division of Medicaid at **DOMPolicy@medicaid.ms.gov**.

What is Medikey?

Medikey is an electronic visit verification system designed to ensure the Division of Medicaid's mission of providing access to quality health care coverage for vulnerable Mississippians with accountability, consistency and respect.

The system automates the manual processes associated with provider agency submission of claims.

The system is currently utilized by providers of personal care and in-home respite services on the Elderly & Disabled (E&D) Waiver and the Intellectual Disabilities/Developmental Disabilities (ID/DD) Waiver.

Provider agency staff clock-in/clock-out by calling into an automated visit verification system via the beneficiary's telephone land line.

Beneficiaries without reliable land lines are assigned a one time password (OTP) device that workers will use to clock in and out. The visit verification line will recognize if a device has been assigned and prompt the caller with instructions.

Full FAQs and Medikey Training Manuals are available at: **https://evv-www-two.ltssmississippi.org/TrainingResource/TrainingResource/List/**.

MISSISSIPPI DIVISION OF
MEDICAID

Medikey FAQ's

- Why is the system not recognizing my voiceprint?
  Staff must use exact wording from first voiceprint setup. Static or background noise may also disrupt voiceprint recognition.

- What if my client does not have an OTP device?
  Clients with a reliable land line may not have an assigned OTP device. The voice response system will not ask for the password if OTP has not been assigned.

- What do I do if my staff forgot to clock-in/out?
  Staff have 24 hours to call in to the voice response system. Provider administrators also have the capability to manually enter clock in/out times for staff.

- What if my claim pends with a "Provider not on PSS" message?
  Contact the waiver case manager to verify that you are listed on the PSS with the correct provider number for the service.

- Who do I contact for help with Medikey claims, training, and reports?
  Contact the LTSS helpdesk at 1-844-366-5877 or email **LTSSMSHelpDesk@feisystems.com**.

CHANGES TO DURABLE MEDICAL EQUIPMENT

MISSISSIPPI DIVISION OF
MEDICAID

Durable Medical Equipment

- The Division of Medicaid shares the concerns of providers who believe the physician order requirement in 42 C.F.R. § 440.70 may pose an additional barrier to needed services and care. The agency is actively working with Centers for Medicare and Medicaid Services (CMS) and other stakeholders to address these concerns.

- According to written guidance, CMS will defer to Mississippi's collaborative practice agreement procedures regarding the ordering of medical supplies, equipment and appliances.

Durable Medical Equipment

- If the collaborative agreement allows the non-physician practitioner to order medical supplies, equipment and appliances, the non-physician practitioner's signature on the order is sufficient and the collaborating physician is not required to sign or co-sign that order for the medical supplies, equipment and appliances to be covered by the Division of Medicaid.

Durable Medical Equipment

- The durable medical equipment (DME) provider must include the collaborating physician's national provider identifier (NPI) number on (1) any required prior authorization requests submitted to Utilization Management/Quality Improvement Organization (UM/QIO) vendors, and (2) all claims submitted to the Division of Medicaid or Coordinated Care Organizations (CCOs) in accordance with 42 C.F.R. § 455.440.

Durable Medical Equipment

FAQ document https://medicaid.ms.gov/dme-provider-frequently-asked-questions/.

News and Notice update https://medicaid.ms.gov/additional-guidance-regarding-the-ordering-of-medical-equipment-supplies-and-appliances/

Letter to providers https://medicaid.ms.gov/wp-content/uploads/2018/06/Clarification-Regarding-DME-Letter-6.22.18.pdf

Durable Medical Equipment

Updated DOM Medical Supply CMN form

https://medicaid.ms.gov/wp-content/uploads/2018/09/Medical-Item-CMN-NP_PA-update-9_7_18-Form-Fillable.pdf

Update eQHealth Solutions Durable Medical Equipment CMN forms

http://ms.eqhs.org/Home.aspx

Durable Medical Equipment

For more information regarding ordering requirements of medical supplies, equipment and appliances, please contact **Office of Medical Services at (601) 359-6150**.

Home Health Services and Durable Medical Equipment

Home Health

- Home Health services are covered in accordance with Medicaid guidelines.

- Magnolia understands the nature of Home Health services and does not require authorization for Home Health evaluations for all providers.

- Magnolia allows up to two (2) business days after Home Health services have been initiated and/or rendered for providers to submit authorization requests.

- Home Health visits are limited to 25 visits per benefit year. Requests exceeding 25 visits per calendar year will be reviewed for medical necessity.

Durable Medical Equipment

- Durable Medical Equipment is covered in accordance with Medicaid guidelines.

- Prior to rendering services, providers should check MS Envision for benefit coverage and allowable fee schedule. Also, check the Magnolia Pre-Auth Tool at www.magnoliahealthplan.com to verify if authorization is required.

Purchase Reimbursement

The payment for purchase of new durable medical equipment is made from a statewide uniform fee schedule which is updated by July 1 of each year and is effective for services provided on or after that date based on one of the following instances:

- The lesser of the provider's usual and customary charge or:
- 80% of the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DEMPOS) fee schedule in effect by January 1.
- If no DEMPOS fee is available and a fee cannot be calculated the item will be manually priced at the Manufacturer's Suggested Retail Price (MSRP) minus 20% to provide the 80% price range that is offered by Medicare. (Items that do not have a fee or MSRP may be priced at the provider's cost plus 20 %.)

Rental Reimbursement

The payment for the rental of DME is made from a statewide uniform fee schedule which is based on 10% of the purchase allowance for new DME not to exceed 10 months.

- After the rental benefits are paid for 10 month, the equipment becomes property of the beneficiary/member unless, otherwise authorized by the Division of Medicaid through specific coverage criteria.

- The payment for purchase of used DME also follows the uniform fee schedule and cannot exceed more than 50% of the new DME purchase allowance.

- The payment of repair of DME equipment also cannot exceed 50% of the new DME purchase allowance.

- The payment for other individual consideration items must receive prior authorization from the Utilization Management Department.

Payment method for manually priced items:

Most manually priced items are priced at the MSRP minus 20%.

- You must submit clear, written, dated documentation from a manufacturer or distributor that specifically states the MSRP for the item. The documentation must be provided with an official manufacturer's or distributor's letterhead, price list, catalog, or other forms that clearly show MSRP.

- We will accept a quote from the manufacturer or distributor if the manufacturer does not make an MSRP available. The quote must be in writing and must be dated.

- The payment of repair of DME equipment also cannot exceed 50% of the new DME purchase allowance.

If the item does not have an MSRP or fee they may be priced at the provider's cost plus 20%.

- You must attach a copy of the current invoice indicating the cost to you for the item and a statement showing that there was no MSRP available for the item.

- If purchased from a manufacturer, a manufacturer's invoice is required.

- If purchased from a distributor, a distributors' invoice is required.

- Quotes, catalog pages, printouts, price lists, or any form of documentation other than an invoice are NOT acceptable.

- The invoice must not be older than one year prior to the date of request.

Home Health Services, Waiver Services, Durable Medical Equipment (DME)

MOLINA HEALTHCARE

Home Health Services

- Home Health services must be provided to a member in any setting in which "*normal life activities take place*," other than:
    - A hospital,
    - Nursing facility,
    - Intermediate care facility for individuals with intellectual disabilities except when the facility is not required to provider home health service; or
    - Any setting in which payment is or could be made under Medicaid for inpatient services that include room and board.

- Home Health services must be provided as part of a physician's written plan of care.
    - The plan of care must be reviewed every 60 days
    - The servicing physician must document face-to-face encounters no more than 90 days before or 30 days after the beginning of the provision of home health services.
    - Face-to-face encounter must be related to the primary reason home health services are required.

New "Carved-In" Services (*formerly Waiver)*

Collaborating with their support system

PRTF

2nd most restrictive LOC

Revenue Code 1001

Requires PA

MYPAC

Alternative to PRTF

H2022 HT

1 unit = 1 day

Requires PA

MOLINA
HEALTHCARE

Durable Medical Equipment

- Per CMS requirements, DME has to be ordered by a treating physician, not mid-level providers. For prior authorization purposes, we will monitor compliance with this requirement to ensure proper claims adjudication.

- Payment for DME is the lesser of the provider's usual and customary charge or a fee from a statewide uniform fee schedule update July 1 of each year. The fee schedule is calculated using eighty percent (80%) of the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Fee Schedule in effect on January 1 of each year.

  - If there is no DMEPOS fee the item will be priced at the Manufacturer's Suggested Retail Price (MSRP) minus twenty percent (20%).

  - If there is no MSRP the item will be priced at the provider's invoice plus twenty percent (20%).

  - When it is determined by DOM, based on documentation, that the DMEPOS fee is insufficient for the Mississippi Medicaid population or could result in a potential access issue, then a fee will be calculated using market research from the area.

Home Health and Durable Medical Equipment

Home Health Services

Sometimes continued care is needed after leaving the hospital or urgent care.

For example, after a serious illness, surgery or injury, a nurse will make home visits to:

- Provide medical care.
- Answer any questions and concerns.
- Adult members can get up to 25 home health care visits per year.
- For children, there is no limit on the number of visits; however, authorizations are required.

- **Prior Authorization:**

  Children - Prior Authorizations required for over 25 visits per calendar year.

  Adults -   No Prior Authorizations required.

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

- **Home Infusion:**

  Certain medications may require prior authorizations depending on the DOM preferred drug list, which can be accessed on the DOM Pharmacy website
  https://medicaid.ms.gov/providers/pharmacy/preferred-drug-list/

Durable Medical Equipment

UnitedHealthcare®
Community Plan

Prior Authorization Requirements:

Please note that all PAs will be reviewed for Medical Necessity.
Review the Mississippi Prior Authorization requirements for specific services or call

- UHCProvider.com > Health Plan by State > Current PA Requirements
- 1-866-604-3267

- **Medical Supplies**
  - When total claim is above $500
  - When items exceed maximum allowable quantity limit
    (example: 6 undergarments/underpads per day for age 3 and up)

- **Out of Network**
  - DME provider not contracted with UHC should secure an authorization before rendering non-emergent services

- **Exceed Service Limits**
  - Any item priced from the Medicaid Preferred Drug List (PDL) that results in > 5 claims per month to OptumRX
  - 1-800-310-6826

Durable Medical Equipment

UHC Mississippi CHIP follows standard billing procedures recognized by CMS and outlined in UHC CHIP payment policies.

UHC MississippiCAN follows coverage and billing guidelines as established by DOM (below):

Manual Pricing Process:

- Manual Pricing does NOT apply to any items on the fee schedule with valid reimbursement rates listed at: https://medicaid.ms.gov/providers/fee-schedules-and-rates/#

- Reimbursement rules currently established by MS-DOM:
  - MSRP minus 20%
  - Invoice plus 20%
      https://www.medicaid.ms.gov/wp-content/uploads/2014/01/Admin-Code-Part-209.pdf
  - Documentation must be within one year, clear to read, and strictly adhere to DOM guidelines

Enteral & Parenteral Products & Supplies
- Nutritional items listed on the Medicaid PDL as "Caloric Agents" are priced through pharmacy POS claims as the preferred method. Medical claims should be considered only if there is no OptumRX contract in place. These items can be found at:
      https://www.medicaid.ms.gov/providers/pharmacy/preferred-drug-list/ > Caloric Agents

- For manual-pricing, UHC currently recognizes two codes for non-specified products & supplies:
  - B9998 – for enteral supplies & products (not otherwise specified)
  - B9999 – for parenteral supplies and products (not otherwise specified)

Custom wheelchairs must meet DOM criteria for "custom" and reimbursement will only be for authorized and covered services as outlined in the DOM Administrative Code
  - Standard frames with added components may not meet definition of "custom" and should be billed as outlined by DOM Administrative Code
  - Invoice/MSRP should be submitted with the claim and must match what was approved in the PA process

Rental Equipment

- Rental equipment is provided for 10 months unless the rental price exceeds the purchase price.

- Time periods greater than 10 months should follow the purchase policy.

- Sales tax should not be applied to rentals.

- "Trial periods" are included in the rental period calculation.

- Additional costs (set-up, delivery, etc.) may be included as part of the estimated costs of the rental, and may be considered.

- Proper coding should be utilized to indicate "rental"

- Please refer to the DOM Administrative Code:
  - https://www.medicaid.ms.gov/wp-content/uploads/2014/01/Admin-Code-Part-209.pdf

Question & Answers

DAY 2

DAY 2 AGENDA

9:00 a.m.	9:30 a.m.	**Welcome & Introductions**
9:30 a.m.	10:30 a.m.	**Medicaid Overview**
		Managed Care Overview Provider Enrollment Credentialing Medicaid Changes
		CCO Overview Magnolia Health Molina Healthcare UnitedHealthcare
10:30 a.m.	12:30 p.m.	**Prior Authorizations** **Retro Reviews** **Claims Review**
12:30 p.m.	1:30 p.m.	****LUNCH BREAK – Own Your Own****
1:30 p.m.	2:30 p.m.	**Hospital Services** **Newborns**
2:30 p.m.	3:30 p.m.	**Third Party Liability** **Program Integrity / Special Investigation Unit** **HIPAA**

Division of Medicaid
Hospital Programs and Services

Hospital Policy Updates

Administrative Code

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

- **Provider Based Billing** – Part 202, Chapter 2, Rule 2.2
  - Proposed Effective Date 01/01/2019

- **Dental Services Provided in a Hospital** – Part 204, Chapter 1, Rule 1.1
  - Effective 12/01/2018

- **Inpatient Charge Cap Policy** – Part 202, Chapter 1, Rule 1.14
  - Effective 11/01/2018

- **Hospitals and 340B program** – Part 214, Chapter 1, Rule 1.5
  - Effective 11/01/2018

- **Emergency Department Visits** – Part 202, Chapter 2, Rule 2.3
  - Effective 09/01/2018

Hospital Policy Updates

State Plan Amendment (SPA)

https://medicaid.ms.gov/about/state-plan/

- Attachment 4.19-B   SPA 18-0007 OPPS Reimbursement

- Attachment 4.19-A   SPA 18-004 All Patient Refined Diagnosis Related Groups (APR/DRG)

- Attachment 4.19-B   SPA 18-011 Physician Administrated Drugs (PAD)

MISSISSIPPI DIVISION OF
MEDICAID

Hospital Policy Updates

- Professional Services Reimbursement for MSCAN/FFS Beneficiaries

- Beneficiary eligibility lock-in changed in the middle of Inpatient stay:
  From CCO to FFS
  From FFS to CCO

Stay Informed
Listserv – DOMPolicy@medicaid.ms.gov
Late Breaking New (LBN) https://www.ms-medicaid.com/msenvision/index.do

Questions regarding Hospital Programs and Services please contact Zeddie R. Parker at Zeddie.Parker@Medicaid.ms.gov

MississippiCAN
Newborn Enrollment

Division of Medicaid Administrative Code
Title 23: Division of Medicaid
Part 202: Hospital Services, Chapter 1: Inpatient Services

Newborns

    a. Well newborn services provided in the hospital must be billed separately from the mother's hospital claim.

        i. The hospital must notify the Division of Medicaid within five (5) calendar days of a newborn's birth via the <u>Newborn Enrollment Form</u> located on the Division of Medicaid's website.

        ii. The Division of Medicaid will notify the provider within five (5) business days of the newborn's permanent Medicaid identification (ID) number.

MississippiCAN
Newborn Enrollment

Newborn Enrollment Form Menu option display when Conduent user logs into Web Portal:

MississippiCAN
Newborn Enrollment

HPE Service Modifier

• A service modifier is in place in MMIS to restrict claims payments to the HPE period. **When a full Medicaid application that covers HPE months is approved, the service modifiers must be voided to allow full eligibility and payment of all allowable claims.** This is true when the full application is approved by HPE staff or the RO and when a reapplication that includes approved HPE months is subsequently filed with the regional office after a full Medicaid denial.

Division of Medicaid Administrative Code
Title 23: Division of Medicaid, Part 100: General Provisions
Chapter 8: Coverage of the Categorically Needy in Mississippi
Rule 8.11: Mandatory Presumptive Eligibility Determined by Qualified Hospitals

MississippiCAN
Newborn Enrollment

Title 23: Division of Medicaid
Part 200: General Provider Information, Chapter 3: Beneficiary Info
Rule 3.2: Newborn Child Eligibility

A. The Division of Medicaid covers an infant:

- 1. Whose mother was eligible for Medicaid in the child's birth month for the first year of life.

   a. Deemed newborn Medicaid eligibility begins with the birth month and continues   through the month of the child's first (1_{st}) birthday unless one (1) of the termination reasons in Miss Admin Code Part 101, Rule 11.2 is applicable.

   b. There is no requirement that the newborn live with the biological mother in order for the continuous eligibility to apply for the infant.

- 2. Born to immigrant mothers who qualify for Medicaid on the basis of emergency medical services for the first (1_{st}) year of the infant's life.

MississippiCAN
Newborn Enrollment

When are Newborns enrolled?

- Newborns born to a Medicaid mom who is currently enrolled in MississippiCAN will automatically be placed in the same plan as the mother.

- The mother has to be on Medicaid to allow the newborn to be deemed eligible for the birth month.

- DOM is aware that not all beneficiaries are being placed in the same CCO as the mom.
    - **Not submitting newborn forms timely or appropriately**
    - **Non-Medicaid mothers**
    - **Retroactive Medicaid mothers, and Hospital Presumptive Eligibility (HPE)**
    - **Newborn Name Changes**

- Should you receive a call regarding this issue please forward these calls to the Office of Coordinated Care 601-359-3789.

MississippiCAN
Newborn Enrollment

Frequently Asked Questions (FAQs)

Medicaid Provider Bulletin – Dec2017

1. What is the timeframe for receiving a Medicaid Beneficiary ID number for Newborns?
2. Please consider creating a tracking number for Newborn Enrollment Forms submitted in the Envision web portal.
3. Why are Newborn and Mother not linked to the same CCO?
4. What is the timeframe for retrospective review authorization for Newborns?
5. When a baby is in the NICU and authorization is required, what Medicaid number is used when the baby does not have its own number?
   - Immediate need for medication of the Newborn, please contact DOM Pharmacy or CCO Pharmacy departments. https://medicaid.ms.gov/wp-content/uploads/2015/12/Mississippi-Medicaid-pharmacy-contact-and-billing-information.pdf
6. Why are there so many medical record requests for NICUs?
7. How are the CCOs linking the Newborn Medicaid ID number to the Authorization number for the claim to adjudicate timely?

MISSISSIPPI DIVISION OF MEDICAID

OFFICE OF THE GOVERNOR | MISSISSIPPI DIVISION OF MEDICAID

Newborn Form Questions and Concerns Contact Information

MSCAN/CHIP Enrollment & Eligibility	**Charlotte McNair** Telephone Number: 601-359-3789 Fax Number: 601-359-5252 *MississippiCAN.Quality@medicaid.ms.gov*
Newborn Enrollment Form	**Lisa Willis Smith** *Office of Eligibility* Telephone number : 601-576-4122 ***Inquiries for no Medicaid ID***

For questions regarding MississippiCAN and CHIP Enrollment, call 601-359-3789 or email Charlotte McNair Charlotte.McNair@medicaid.ms.gov or view the website at https://medicaid.ms.gov/programs/managed-care/.

MISSISSIPPI DIVISION OF MEDICAID

Inpatient Admissions, Deliveries and Newborns

Inpatient Admissions

- Please initiate the authorization process at least at least 14 calendar days and no later than five (5) calendar days in advance for pre-scheduled inpatient admissions.

- 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 pre-scheduled. *(Please see specific requirements for Deliveries and Newborns which differ slightly for normal uncomplicated care.)*

- The Provider should contact the UM department via telephone, fax, mail, secure email or secure web portal with the appropriate clinical information to request an authorization.

- Authorization is NOT required for emergent or urgent care 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 as stated above.)*

- Authorization is NOT required for post-stabilization services. Once the member's emergency medical condition is stabilized, authorization for hospital admission or follow-up care is required as stated above.

Failure to obtain authorization may result in an administrative claim denial!

Deliveries and Newborns

- Facilities should complete and submit the Division of Medicaid's Newborn Enrollment Form within five (5) calendar days of delivery.

- Upon Magnolia's receipt of the Newborn Enrollment Form, Magnolia will create an authorization for claims payment for routine deliveries (3 day stay for vaginal deliveries, 5 day stay for C sections). No authorization is required for routine well-baby DRG care.

- If the Newborn Enrollment Form is completed and submitted timely, Magnolia Health Plan does not require any additional information for mother or newborn, unless complications develop during the stay.

- If complications develop with mother or baby that may necessitate additional hospital days or a non well-baby DRG or NICU admission, clinical information to support the stay should be submitted within two business days of the decision that the higher level of care was needed.

- If it is indicated on the Newborn Enrollment form that the newborn is not healthy, Magnolia will reach out to the provider to request clinical information and start the authorization process.

11/26/2018

Newborn Enrollment Form

Effective 12/01/2015

MISSISSIPPI DIVISION OF MEDICAID

This form is to be used by birth hospitals to enroll **all** deemed eligible newborns in Medicaid. All information must be completed by the birth hospital to obtain a Medicaid Identification Number for the newborn. Please type or print clearly. Return by email to newborn@medicaid.ms.gov or fax to the Office of Eligibilty at 601-576-4164.

MOTHER'S INFORMATION

MEDICAID ID NUMBER: _____-_____-_____

FIRST NAME: _____

LAST NAME: _____

MOTHER'S SOCIAL SECURITY NUMBER: _____-_____-_____

MOTHER'S DATE OF BIRTH (MM/DD/YY) _____-_____-_____

MOTHER'S ADDRESS: _____

_____

NEWBORN INFORMATION

FIRST NAME: _____ MIDDLE NAME: _____

LAST NAME: _____

DATE OF BIRTH (MM/DD/YY) _____-_____-_____ TIME OF BIRTH: _____

GENDER (M/F): _____ Birth order, if multiples: _____ Check if parental rights terminated: _____

FATHER'S NAME: _____

CONTINUE ENTERING MOTHER/CHILD INFORMATION BELOW

HOSPITAL NAME: _____ MEDICAID PROVIDER ID#_____

CONTACT NAME: _____ EMAIL:_____

TELEPHONE: _____ EXT: _____ FAX: _____ DATE: _____

TO BE COMPLETED BY DIVISION OF MEDICAID OFFICE OF ELIGIBILITY

Newborn Medicaid ID: _____-_____-_____

OTHER INFORMATION:_____

DOM CONTACT: _____ DATE: _____

MOTHER'S DATE OF LAST MENSTRUAL PERIOD: _____

DELIVERY TYPE: ___VAGINAL ___ V-BAC ___CESAREAN

SCHEDULED DELIVERY? ___YES ___NO

GESTATIONAL AGE: _____WEEKS _____DAYS

BIRTH WEIGHT: _____ LBS/OUNCES _____GRAMS

APGAR SCORES: _____ 1 MIN _____ 5 MIN

BIRTH STATUS: ____HEALTHY/DISCHARGED HOME WITH MOTHER

____HEALTHY/ADOPTED OR FOSTER CARE

____SICK HOSPITALIZED

____DETAINED BORDER BABY

____STILLBORN/EXPIRED

ADMISSION DATE, IF APPLICABLE: _____

DISCHARGE DATE, IF APPLICABLE: _____

IF TRANSPORTED TO ANOTHER FACILITY, FACILITY NAME: _____

DELIVERING PHYSICIAN'S NAME: _____

DELIVERING PHYSICIAN'S NPI/TIN: _____

PEDIATRICIAN NAME: _____

PEDIATRICIAN NPI/TIN: _____

Hospital Services and Newborn Enrollment

![Molina Healthcare logo]

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.

Inpatient 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.

- Hospital's 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 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.

Discharge Planning

IMPROVE discharge planning
REDUCE re-admissions & length of stay
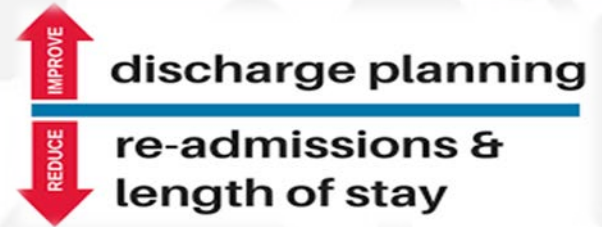
- Discharge planning begins at admission, and is designed for early identification of medical/psychosocial issues that will need post-hospital intervention. The goal is to initiate cost-effective, quality-driven treatment interventions for post-hospital care at the earliest point in the admission.

- 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.

MOLINA HEALTHCARE

Newborn Enrollment

- 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 determine if an authorization for the newborn will be created as indicated by the form. For all other deliveries Molina Healthcare must be notified within one (1) business day of admission.

- Authorization is required for all deliveries. Newborn notification is required within one (1) business day for all sick newborns requiring inpatient hospitalization.

- To initiate notification and authorization processes, please call Molina at (844) 826-4335 or fax Molina at (844) 207-1620.

Hospital Services and Newborns

Inpatient Management

Verify Eligibility:
- Online
  - Medicaid Envision website: www.ms-medicaid.com/msenvision
  - Link Provider Portal: www.UHCProvider.com
- Call UHC Provider Services: 877-743-8734

Notify UHC Care Management/Utilization Review:
- Call: 866-604-3267
- Fax: 888-310-6858

Notification Requirements:
- Urgent/emergent admissions and Post-stabilization care require notification within one (1) business day, even if occurring during the weekend or on a holiday.

Concurrent reviews:
- Performed until medical services are no longer needed

Inpatient Management (Newborn)

- Notification
  - NICU admissions: Notification is required within one (1) business day for
  - Maternal admission: Notification is required within one (1) business day

- The state newborn notification form is used by DOM to determine eligibility and issue a Medicaid ID
  - Newborn notification form should be sent directly to DOM (Fax: 601-576-4164)
  - UHC does <u>not</u> use the newborn notification form for inpatient admission authorizations

- Concurrent reviews will be performed if the newborn remains inpatient at time of notification

- Retrospective review requests must be submitted by the hospital if the newborn has been discharged prior to receipt of a Medicaid ID

Retrospective Review Process

Review conducted after services are provided in response to extenuating circumstances

- **Retroactive enrollment/eligibility determinations**
- The member is unconscious upon presentation, and the provider has not previously submitted a claim for the member
- Acts of nature impairing the ability to verify a member's coverage/eligibility status
- The request for retrospective review must provide a specific reason and be submitted within 60 days of the service date.
- Not providing a reason for the retrospective review request will result in a denial.

To initiate a retrospective review request:

- Call 866-604-3267, Monday-Friday, 8AM-5PM (24/7 for emergencies)
- Fax: 888-310-6858

A retrospective review is <u>not</u> conducted for:

- Elective services on the prior auth list for which prior approval was not requested
- Emergency inpatient services that did not meet notification requirements. (Notification of inpatient admission is required within one business day of the admission date)
- Reconsideration and/or review of an adverse determination

Question & Answers

Third Party Liability (TPL)

Overview

The Office of Recovery performs third party functions in two ways: by avoiding Medicaid payments when other commercial or public health insurance carriers should pay for a service; and by recovering Medicaid payments made prior to the identification of a legally-obligated third-party source. Third party liability (TPL) refers to the legal obligation of health care sources (third party sources) to pay for all, or part, of a medical claim of a Medicaid beneficiary. This may include health insurance, casualty coverage resulting from an accidental injury, or payments received directly from an individual who has either voluntarily accepted or been assigned legal responsibility for the healthcare of a Medicaid beneficiary. By law, Medicaid is the payer of last resort.

Health Management Systems (HMS)

What is Health Management Systems (HMS)?

- The Division of Medicaid has contracted with Health Management Systems (HMS) to identify third party liability resources or supplemental medical benefits including private and governmental insurance coverage for Medicaid beneficiaries.

- The TPL recovery process consists of contacting providers, advising them that Medicaid is payer of last resort and that they must file with other coverage plans prior to filing with Medicaid.

- HMS also conduct Credit Balance and LTC audits. Based on the audit findings, providers submit overpayments due back to Medicaid.

HMS Voids

What Providers Should Do?

1) Follow the instructions provided in the initial contact letter from HMS.
2) Be sure to contact HMS before the 60 day deadline.
3) For claims your are refuting, please provide acceptable documentation to HMS *before* the deadline.
4) If payments are recouped in error and to request a refund, please contact HMS at:

Health Management Systems, Inc.
Third Party Liability Recovery Unit
5615 High Point Drive, Suite 100
Irving, TX 75038
866-389-6345 (phone)
877-256-1226 (fax)
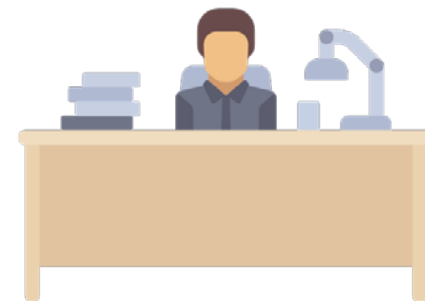
Submitting a Medicare Part C Claim Paper or Web portal

Billing Medicare Part C Claims

The Mississippi Medicaid Part A & B Crossover Claim form must be used when billing for **Medicare Part C Advantage Plans only**.

- Medicare Advantage Plans claims are for dually eligible beneficiaries enrolled in Medicare and eligible for Medicaid coverage.

- Instructions for completing the Medicare Part A & B crossover billing form when billing Medicare Part C Advantage Plan claims can be found in Section 2.3 (Part A) & Section 3.2 (Part B) of the Mississippi Medicaid Provider Billing Handbook.

- An additional requirement is that a copy of the Medicare EOMB for the billed services **must** be attached for all paper Crossovers.

- This claim form and instructions are available on DOM's website at http://www.medicaid.ms.gov . Select the Resources link then choose the Forms link.

Submitting a Medicare Part C Claim

Submitting a Medicare Part C Claim (Cont.)

Next, enter the Beneficiary ID.
- Once you have entered this information, click Submit.
- After you click Submit, the electronic *Medicare Part C Professional Claim Form* will display.

Submitting a Medicare Part C Claim (Cont.)

Medicare Part C Professional Claim form

Provider Information   If the appropriate NPI is not listed, please contact Provider Enrollment.

Billing Provider

*Medicaid Provider ID   `DDD2DD46`   *National Provider ID   `1649226952`

⊞ Additional Billing Provider Information*

Beneficiary Information

*Medicaid ID   `DDDDD85232D5D8`

*Beneficiary's Name   `MICHAEL`   `D`   `HARRIS`

⊞ Additional Beneficiary Information

Claim Information

Claim Data

Patient Account #/Medical Record # `[_____]`

Additional Claim data

Provider Signature on File ○ Yes ◉ No

*Provider Signature Date `[_____]` 🗔

*Diagnosis Codes

Primary `[_____]`   Secondary `[_____]`   3rd `[_____]`   4th `[_____]`

Does the Claim have Attachments?   ○ Yes ◉ No

Basic Line Item Information

Note: Please ensure you have entered any necessary claim information (found in the other sections of this or another page) before adding this service line.

Add Service Line Item

Ln #	Service Dates Begin	End	Procedure Code	Modifiers 1 2 3 4	Service Units	Medicare Billed Charges	Medicare Allowed Amount	Medicare Non- Covered Amount	Medicare Blood Deductible	Medicare Paid Amount	Medicare Deductible	Medicare Co- Insurance	Medicare Paid Date	Third Party Amount	CO Amount	NDC Code	Edit	Delete

---

Summary

Total Submitted Charges $ `0.00`

☐ I certify that the foregoing information is true, accurate, and complete and understand that falsifying essential information to receive payments from federal and state funds requested by this form may upon conviction be subject to fine and imprisonment under applicable federal and state laws. I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the state's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the state agency may request. I further agree to accept, as payment in full, the amount paid by the Medicaid program for claims submitted with the exception of authorized copayment.

Submit   Reset

CONDUENT

Other TPL Related Concerns

QMB Remittance Advice Issue
CMS Actions Affecting Medicare RAs for QMB October 2, 2017 thru December 8, 2017

- To help providers more readily identify the QMB status of their patients, CMS incorporated QMB notifications in the Medicare Remittance Advice (RA) for claims processed on or after October 2, 2017 under Change Request (CR) 9911.

- However, the RA changes caused unforeseen issues affecting the processing of QMB cost-sharing claims directly submitted by providers to states and other payers secondary to Medicare.

- CMS will reintroduce QMB information in the RA without disrupting claims processing by secondary payers under CR 10433. These changes will be effective for claims processed on or after **July 2, 2018**.

- To assist providers impacted by the CR 9911 RA changes, CMS has directed each MAC to initiate non-monetary mass adjustments for QMB claims that were last paid after October 2 and up to December 31, 2017, that have not been voided or replaced.

Take Backs/Recoupments & Other Issues
Beyond the Timely Filing Limit

Who to Contact for Resolution?

- **Fee For Service Claims**
  Health Management Systems (HMS) 1-866-389-6345

- **Managed Care Claims**

  United Healthcare 1-877-743-8731

  Magnolia Health Plan 1-866-912-6285

  Molina Healthcare (Coming Soon)

New Policy Updates

 On February 9, 2018, the Bipartisan Budget Act of 2018 (Pub. L. 115-123) was signed into law. This new law includes several provisions which modify third party liability (TPL) rules related to special treatment of certain types of care and payment.

- The Act requires State Medicaid Agencies (SMAs) to **cost avoid** for prenatal services before making payments; therefore, providers should bill the third party insurance prior to billing Medicaid. This change also applies to CHIP.

- In conclusion, prenatal claims **will no longer** be a part of the Pay & Chase process.

- DOM is currently working to incorporate this change.

QUESTIONS
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Office of Program Integrity

Objective

- To reduce and eliminate fraud, waste and abuse in the Medicaid Program
    - Ensure provider compliance with State and Federal regulations
    - Ensure services are medically necessary
    - Ensure providers meet participation requirements
    - Ensure payments are for correct amounts and covered services
    - Investigate cases of possible provider and recipient fraud, waste or abuse

Duties of Program Integrity

Prevention

Investigation

Education

Audit and recovery of overpayments

Cooperation with the Medicaid Fraud Control Unit (MFCU)

What is Fraud, Waste, and Abuse?

Fraud	Intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law. 42CFR §455.2
Abuse	Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to me meet professionally recognized standards for healthcare. It also includes beneficiary practices that result in unnecessary cost t to the Medicaid program. 42CFR §455.2
Waste	The overutilization, underutilization or misuse of resources.

Fraud and Abuse Laws

False Claims Act
- Prohibits knowingly presenting a false or fraudulent claim to Medicaid state agencies for payment or approval

Anti-Kickback Statute
- Prohibits knowingly and willfully offering, paying, soliciting and/or receiving remuneration to induce referrals for items or services covered by government

Exclusion Statute
- Excluded physicians may not bill directly for treating Medicare and Medicaid patients, nor may their services be billed indirectly through an employer or a group practice (including administrative and management services).

Medicaid Fraud Consequences

- Punishable by up to 5 years in state prison or mandatory fine of not more than $50,000 or both per Miss. Code Ann. § 43-13-215 (*per offense)

- Exclusion from the Medicaid/Medicare programs

- Suspension or loss of professional licenses

- Restitution/Recovery of overpayments

Examples of Provider Fraud & Abuse

- Billing for services not actually performed

- Billing for services not medically necessary

- Kickbacks – Hidden financial arrangements between providers involving some material benefit in return for another provider prescribing or using their product or services

- Upcoding – billing for more expensive services than what was provided

- Dispensing for generic drugs but billing for brand-name drugs to Medicaid

- Unbundling – Billing for services separately that should legitimately be a combination/packaged code

- Violating Medicaid policies, procedures, rules, regulations, and/or statutes

Examples of Beneficiary Fraud & Abuse

- Submitting a false application to Medicaid

- Providing false or misleading information about income, assets, family members, or resources

- Identity swapping – using another's Medicaid identification card

- Simultaneously receiving benefits in Mississippi and another state

- Prescription fraud - Resale, inappropriate use or diversion of prescription drugs

- Participated in doctor or pharmacy shopping

Program Integrity Contractors

- Recovery Audit Contractor – Healthmind LLC
- Unified Program Integrity Contractor – Qlarant
- Coordinated Care Organizations
  - Magnolia Health
  - Molina Healthcare of Mississippi
  - United Healthcare

Provider Responsibilities

- Make charts and records available to Medicaid staff, other State and Federal agencies, and its contractors thereof, upon request.

- Follow all timelines when it comes to records requests, response to demand letters, hearing requests, etc.

- Failure to participate or comply with the audit process is considered abandonment of the audit. If the DOM suspects a provider of fraud, abusive practice, audit abandonment, or present a risk of imminent danger to clients, the DOM may take one or more of the actions listed below:

  - Immediately issue a final report
  - Terminate the provider's agreement with Medicaid
  - Issue a subpoena for the provider's records
  - Refer the provider to the appropriate prosecuting authority

How to Report Fraud & Abuse

- **Toll-free: 800-880-5920**

- **Phone: 601-576-4162**

- **Fax: 601-576-4161**

- **Mailing address: 550 High Street, Suite 1000, Jackson, MS 39201**

- **Submit a fraud and abuse complaint form https://medicaid.ms.gov/wp-content/uploads/2017/04/Fraud-and-Abuse-Complaint-Form.pdf**

Third Party Liability, Program Integrity/Special Investigation Unit, and HIPAA

Third Party Liability (TPL)

Third party liability refers to any other health insurance plan or carrier (e.g., individual group, employer-related, self-insured, or self-funded, commercial carrier, automobile insurance, and worker's compensation) or program that may be liable to pay all or part of healthcare expenses of the member.

Magnolia providers shall make reasonable efforts to determine the legal liability of third parties to pay for services furnished to Magnolia members. If the provider is unsuccessful in obtaining necessary cooperation from a member to identify potential third party resources, the provider shall inform Magnolia that efforts have been unsuccessful. Magnolia will make every effort to work with the provider to determine liability coverage.

If third party liability coverage is determined after services are rendered, Magnolia will coordinate with DOM on eligibility requirements for members identified to have another carrier, which could impact member's eligibility for Magnolia.

Third Party Liability (TPL) Cont..

Magnolia will reimburse a practitioner for certain covered services even when a third party source exists. For these services, Magnolia is required to use the pay and chase method of payment. This means that Magnolia will reimburse the practitioner for specific covered services and pursue recovery from the third party. Some of the services that fall under the pay and chase method are:

- Pregnancy related services for women (prenatal, labor and delivery, and post-partum)

- Preventative pediatric services (including ESPDT services)

Special Investigations Unit (SIU) Mission:

To protect and serve Magnolia's commitment to fighting fraud, waste and abuse (FWA) through increased awareness, detection, investigation and education.

- SIU conducts random audits via prepay review or retrospective review
- SIU monitors providers, facilities, pharmacies and members
- SIU investigates internal and external referrals received for potential FWA
- SIU provides education to providers, facilities, pharmacies and members regarding issues found in reviews

Health Insurance Portability and Accountability Act (HIPAA)

Three parts of HIPAA regulations to establish guidelines for the protection and use of Protected Health Information (PHI):

- HIPAA Privacy Rule -45 C.F.R. § 164.530(C)
  - Release of PHI
- HIPAA Security Rule
  - Appropriate administrative, physical, and technical safeguards
- Breach Notification Rule
  - Notify members when PHI has been compromised

Safeguards

Why do we implement reasonable safeguards:

- Ensure confidentiality and integrity is maintain
- Limit incidental
- Avoid prohibited uses and disclosures of PHI, including in connection with the disposal of such information
- HIPAA Security Rule requires safeguards

How do we implement reasonable safeguards:

- Training employees
- Policies and procedures
- Properly disposal of PHI
- Limiting access
- Monitoring

HIPAA Hints

- Protected Health Information (PHI) must be kept private!

- Only discuss information for work purposes.

- Think about where you are and who can overhear you.

- The same HIPAA rules apply for PHI in conversations as in written or electronic formats.

- Use ONLY your work email for business purposes.

- ALWAYS 'Send Securely' when you have to include PHI in an email!

- Put the minimum amount of PHI necessary to get the job done in the message. That's a HIPAA requirement!

- **NEVER** put any PHI in the subject line – it can't be encrypted. Think of it as the *outside* of the envelope. All PHI should go <u>*inside*</u>!

- When you are finished with paper that contains patient information (PHI) or other sensitive information, it MUST be disposed of properly by shredding. Place it in a secure shred bin, use a cross-cut shredder, burning, pulping, or pulverizing.

Provider Services (Call Center)

Mississippi Based Provider Services Call Center:

- Provides phone support

- **First line of communication**

- Answer questions regarding eligibility, authorizations, claims, payment inquiries

- Available Monday through Friday, 8am to 5pm CST

    1-866-912-6285 (CAN/CHIP)

Provider Relations

Provider Education

- Provider Contract Clarification
- Schedule In-services/Training for New and Existing Staff
- Web Demonstration
- Education and Information on Electronic Solutions to Authorizations, Claims, etc.
- Initiate Credentialing of New Providers
- Policy and Procedure Clarification

Thank you!

Third Party Liability, Program Integrity/Special Investigation Unit, HIPAA

Program Integrity/ Special Investigation Unit

- Utilization and trend analyses to review Provider spend

- Peer comparisons identify Providers who represent good value versus those that are driving higher costs. Additionally, comparing instances of claims coding among similar Providers to identify billing and claims coding issues.

- Analysis of actual claims payments versus calculated claims payments in order to audit contract configurations on an *ad hoc* basis

- Outliers referred to Compliance/ Special Investigations Unit, if appropriate

- Annual review of prior authorization requirements

MOLINA HEALTHCARE

Program Integrity/ Special Investigation Unit

Strategies employed by the Molina Special Investigation Unit (SIU) when conducting retrospective fraud, waste, and abuse investigations:

Molina employs processes that retrospectively detect/identify issues and address instances of FWA that may have already occurred

The SIU conducts post-payment reviews using a fraud analytics system that employs multiple algorithms to identify billing outliers and aberrant service patterns, potential areas of overutilization or underutilization, changes in billing behavior, and possible improper schemes

The FWA analytics system brings enhanced solutions in identifying suspect behavior, which includes thorough risk assessments, provider scoring, and machine learning capabilities via the proprietary data platform

Providers exceeding a certain risk score will be considered leads and reviewed. Steps involved include performing a conflict check on the provider, initiating work on a lead, reviewing the provider scorecard to determine risk score, ranking in the peer group, reviewing risk factors

All cases, either proactive or via the Molina AlertLine, go through a two-tier process for investigation, which includes a preliminary and extensive investigation (as applicable)

Program Integrity/ Special Investigation Unit

SIU Audits
- Desk Audit
- On-site Audit
- May be randomized or focused

SIU Technical Professionals
- The SIU employs clinicians and certified medical coders capable of conducting highly detailed and intensive audits involving medical review and/or billing and coding schemes

Criteria Considered During Audits
- Audits include, but are not limited to: pertinent state Medicaid guidelines, national and local coverage determinations, medical journals, coding guidelines, specialty board publications, and other reputable references (WHEN NOT IN CONFLICT WITH DOM GUIDELINES AND PROCESSES)

Systems Utilized for Audits
- FWA Case Management and Analytics System
- AAPC Audit Manager
- Power BI
- SIU-developed audit tools specific to the investigation in question

Health Insurance Portability and Accountability Act (HIPAA)

- Molina requires that Providers respect the privacy of Molina Members (including Molina Members who are not patients of the Provider) and comply with all applicable Laws and regulations regarding the privacy of patient and Member PHI.

- Providers should develop and implement confidentiality procedures to guard Member protected health information, in accordance with HIPAA privacy standards and all other applicable Federal and State regulations. This should include, and is not limited to, the following:

  - Ensure that medical information is released only in accordance with applicable Federal or State Law in pursuant to court orders or subpoenas;
  - Maintain records and information in an accurate and timely manner;
  - Ensure timely access by Members to the records and information that pertain to them;
  - Abide by all Federal and State Laws regarding confidentiality and disclosure of medical records or other health an enrollment information;
  - Medical Records are protected from unauthorized access;
  - Access to computerized confidential information is restricted; and
  - Precautions are taken to prevent inadvertent or unnecessary disclosure of protected health information.

MOLINA HEALTHCARE

HIPAA

Our core claims engine houses our claims data, which serves as the main data source for encounter data extracts.

We comply with CMS and HIPAA standards for electronic submission, security and privacy, and we verify our subcontractors adhere to these standards as well.

Protected Health Information (PHI) for members is protected by UHC, and is only disclosed to members and authorized representatives in the communication format authorized.

Telephones, faxes, and secure portals or secure emails are authorized means of CCO/provider communications.

Program Integrity

UnitedHealthcare maintains both prospective and retrospective processes to assure that medically necessary services are appropriately reimbursed.

- These processes are managed by both UHC and Optum payment integrity teams.

Providers should respond to all record requests within the requested timeframe.

Reporting Fraud, Waste and Abuse:

- If you suspect another care provider or a member has committed fraud, waste or abuse, then you have a responsibility and a right to report it.
- Call the Anti-Fraud and Recovery Solutions (AFRS) unit at Optum to make anonymous reports and offer tips about suspected fraud, waste or abuse.
- **866-242-7727**
  - Hours of operation are Monday – Friday, 8 a.m. – 4:30 p.m. CST
  - This number is accessible to both providers and members.
  - After-hours calls have the option to leave a message and/or request a call back.

Third-Party Liability/ Coordination of Benefits (COB)

UnitedHealthcare® Community Plan

Please always check eligibility and potential COB.

You can view eligibility and any other insurance on file for the member through the UHC provider portal.

- UHCProvider.com>Link

UHC is the source of truth for identifying other insurance when billing UHC for all covered services.

How to file COB claims:

- When UHC is primary, submit directly to us.
- When UHC is secondary, submit to the primary carrier first, then, submit the EOB with the claim to UHC for consideration.
    - EOB's can be submitted to UHC electronically, in the Provider to Payer ANSI COB Model.
- Certain services will allow claim submission to UHC as primary even though there is another primary insurance available.

    These Pay and Chase services are limited to the following three type claims:

    1. Pregnancy related services for women (prenatal, delivery, post-partum, etc)

    2. Preventive pediatric services (including EPSDT services).

    3. Covered services furnished to an individual on whose behalf child support enforcement is being carried out by the state Title IV-D program.

Provider Services

(877) 743-8734

Thank you!

Question & Answers