Mississippi Division Of Medicaid

Provider Workshops

2019

MISSISSIPPI DIVISION OF MEDICAID

Morning Agenda

8:30 a.m.	9:00 a.m.	Registration
9:00 a.m.	9:15 a.m.	Welcome & Introductions
9:15 a.m.	11:00 a.m.	Vision & Durable Medical Equipment
11:00 a.m.	11:30 a.m.	Question & Answer Session
11:30 a.m.	12:30 p.m.	Help Desk
12:30 p.m.	1:30 p.m.	LUNCH ON YOUR OWN

General Claims Billing, Reviews, and Processing

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1. Top 10 Medicaid Issues

2. Medicaid Fee-for-Service Claims Review

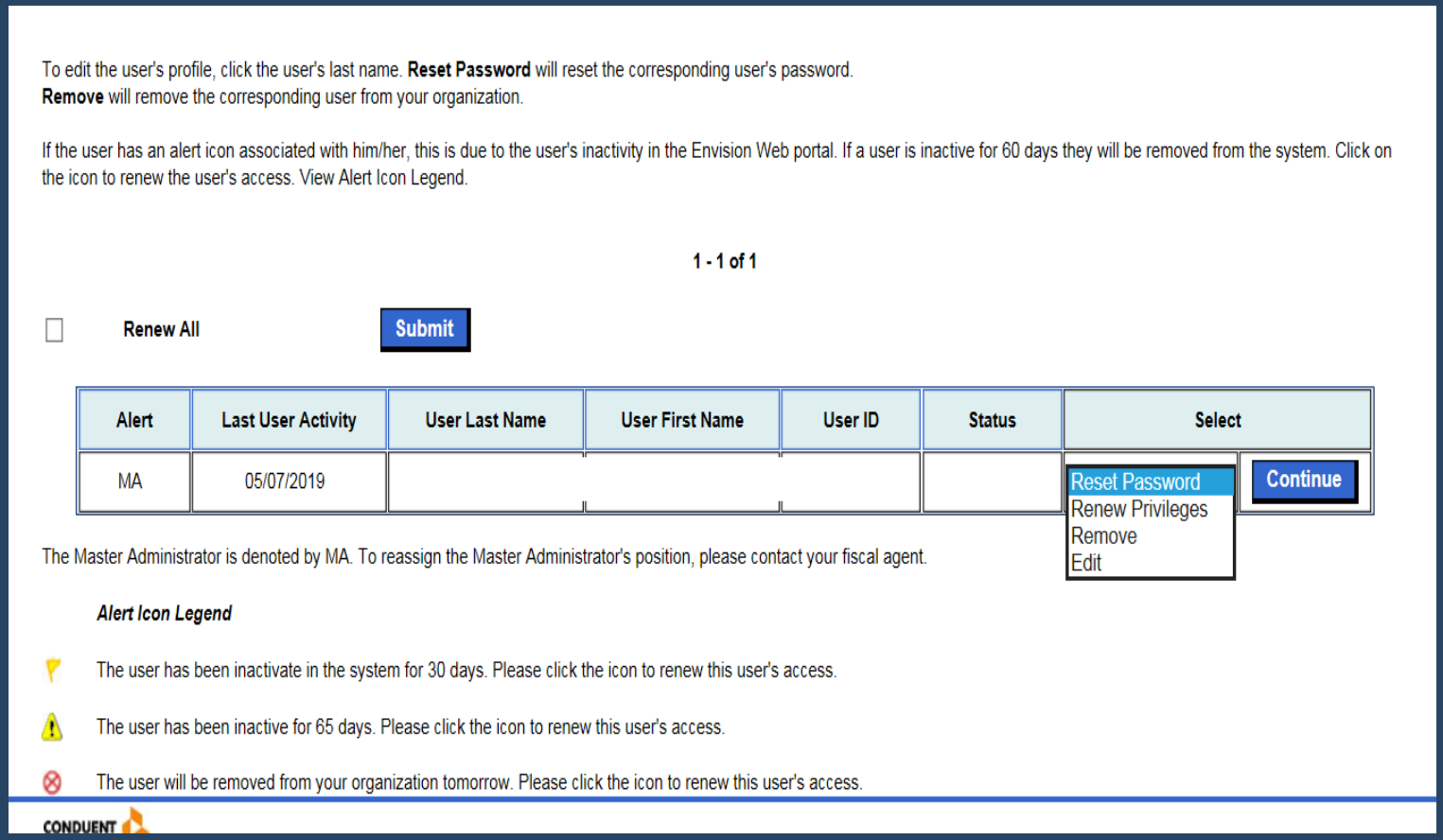
3. Provider File Maintenance and Updates

4. Common Edits not subject to Medical Review

5. Revalidation

Top 10 Medicaid Issues

Web Portal Password Resets



To edit the user's profile, click the user's last name. **Reset Password** will reset the corresponding user's password.
Remove will remove the corresponding user from your organization.

If the user has an alert icon associated with him/her, this is due to the user's inactivity in the Envision Web portal. If a user is inactive for 60 days they will be removed from the system. Click on the icon to renew the user's access. View Alert Icon Legend.

1 - 1 of 1

Renew All Submit

Alert	Last User Activity	User Last Name	User First Name	User ID	Status	Select
MA	05/07/2019					Reset Password / Renew Privileges / Remove / Edit — Continue

The Master Administrator is denoted by MA. To reassign the Master Administrator's position, please contact your fiscal agent.

Alert Icon Legend

The user has been inactivate in the system for 30 days. Please click the icon to renew this user's access.

The user has been inactive for 65 days. Please click the icon to renew this user's access.

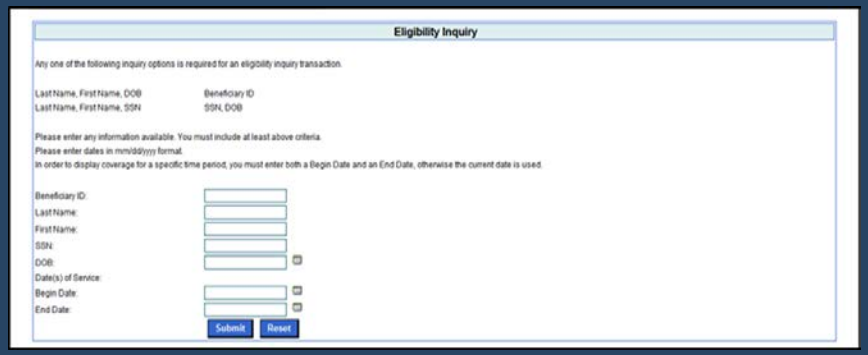
The user will be removed from your organization tomorrow. Please click the icon to renew this user's access.

CONDUENT

Verifying Eligibility

Providers may verify beneficiary eligibility using one of the following:

- Calling the fiscal agent at 1-800-884-3222,
- Calling the Automated Voice Response System (AVRS)
- Accessing the Point of Service eligibility verification system
- Accessing the Envision Web Portal at http://ms-medicaid.com

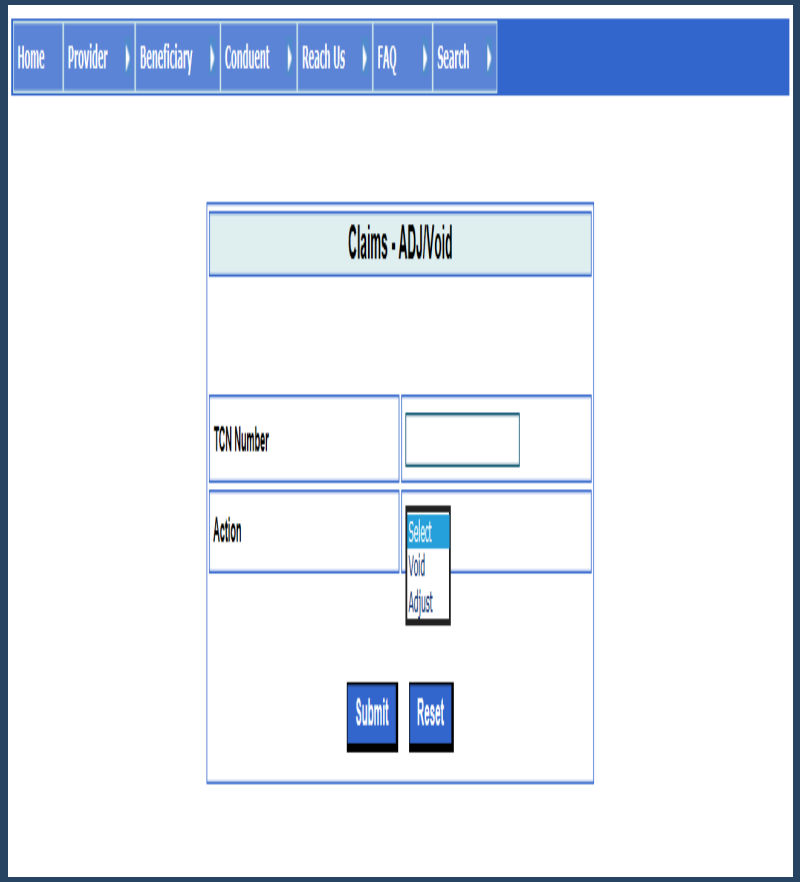


- You may check a Beneficiary's eligibility status by entering the following options:
  - Beneficiary ID or
  - SSN or
  - Beneficiary's name (*first name, last name*) and DOB

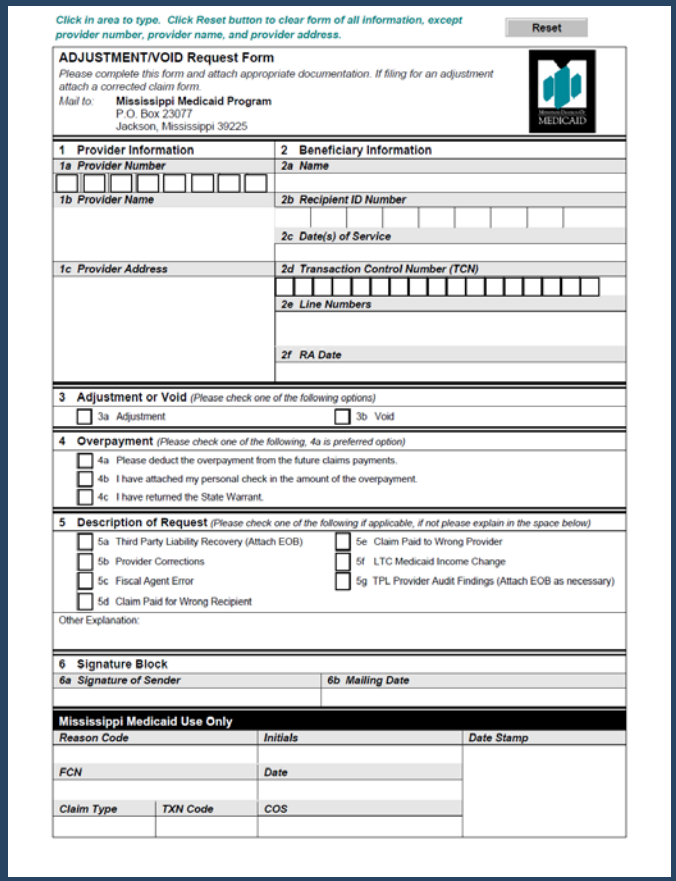
Adjusting and Voiding Claims

- **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)
- Claims with adjusting and voiding claims will be on the same remittance advice

Web Portal Option



Paper Form Option



Click in area to type. Click Reset button to clear form of all information, except provider number, provider name, and provider address.

Reset

ADJUSTMENT/VOID Request Form

Please complete this form and attach appropriate documentation. If filing for an adjustment attach a corrected claim form.

Mail to: Mississippi Medicaid Program
P.O. Box 23077
Jackson, Mississippi 39225

1 Provider Information

1a Provider Number

1b Provider Name

1c Provider Address

2 Beneficiary Information

2a Name

2b Recipient ID Number

2c Date(s) of Service

2d Transaction Control Number (TCN)

2e Line Numbers

2f RA Date

3 Adjustment or Void (Please check one of the following options)

☐ 3a Adjustment ☐ 3b Void

4 Overpayment (Please check one of the following, 4a is preferred option)

☐ 4a Please deduct the overpayment from the future claims payments.
☐ 4b I have attached my personal check in the amount of the overpayment.
☐ 4c I have returned the State Warrant.

5 Description of Request (Please check one of the following if applicable, if not please explain in the space below)

☐ 5a Third Party Liability Recovery (Attach EOB)
☐ 5b Provider Corrections
☐ 5c Fiscal Agent Error
☐ 5d Claim Paid for Wrong Recipient
☐ 5e Claim Paid to Wrong Provider
☐ 5f LTC Medicaid Income Change
☐ 5g TPL Provider Audit Findings (Attach EOB as necessary)

Other Explanation:

6 Signature Block

6a Signature of Sender

6b Mailing Date

Mississippi Medicaid Use Only

Reason Code | Initials | Date Stamp

FCN | Date

Claim Type | TXN Code | COS

Importance of Updating Your Banking Information

- **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

Beneficiary File Updates

- The fiscal agent for Medicaid does not create or update the data for beneficiary files.

- Various Medicaid Sources (Regional Offices, Social Security Offices etc.) are responsible for creating, and updating all beneficiary data.

All 9's National Provider Identifier

EDIT #	Edit Description	Reason
0426	**Billing provider NPI is missing/invalid**	Billing Provider Medicaid ID on claim; No Billing NPI billed on claim, **Billing NPI** will default to 9999999999.
0427	**Servicing provider NPI is missing/invalid**	Servicing Provider Medicaid ID on claim; No Servicing NPI billed, **Servicing NPI** will default to 9999999999.
0429	**NPI/Provider Number Mismatch**	Medicaid ID (Billing and/or Servicing) on claim; NPI billed on the claim does not match the Medicaid ID on claim.
0120	**Billing Provider Number is Missing**	No Medicaid ID submitted on claim; NPI submitted not found on Provider file, **Medicaid ID** will be defaulted to 99999998.
0300	**Billing Provider Not On File**	Medicaid ID submitted on claim is not on provider file; No NPI on claim; **Medicaid ID** defaulted to all 99999998.

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

Billing Vs. Coding

Your Provider Field Representative

can . . . .

assist with Billing includes helping providers with policies and procedures in relation to the Medicaid Administrative Code and the Billing Handbook.

Your Provider Field Representative

cannot . . .

assist with Coding as in providing procedure codes, diagnosis codes, modifiers.

It is the providers responsibility to educate themselves on the proper coding for the submission of their claims.

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

Request for Information (RFI) Submittal

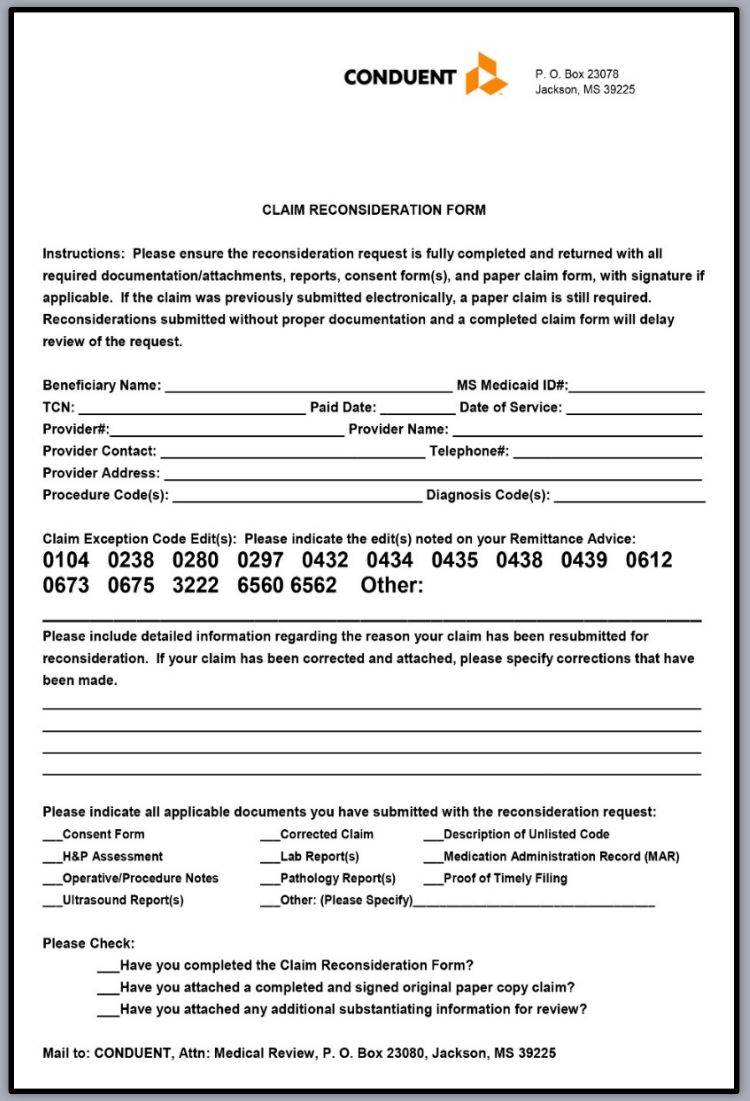
- Submit a RFI or request for public records in writing, by:
- You can submit a RFI or request for public records in writing by contact the Mississippi Division of Medicaid (DOM) multiple ways as listed below, including postal mail, fax and email. It is advised that you do not email forms or submit online 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**.

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



CONDUENT

P. O. Box 23078
Jackson, MS 39225

CLAIM RECONSIDERATION FORM

Instructions: Please ensure the reconsideration request is fully completed and returned with all required documentation/attachments, reports, consent form(s), and paper claim form, with signature if applicable. If the claim was previously submitted electronically, a paper claim is still required. Reconsiderations submitted without proper documentation and a completed claim form will delay review of the request.

Beneficiary Name: _____ **MS Medicaid ID#:**_____
TCN: _____ **Paid Date:** _____ **Date of Service:** _____
Provider#:_____ **Provider Name:** _____
Provider Contact: _____ **Telephone#:** _____
Provider Address: _____
Procedure Code(s): _____ **Diagnosis Code(s):** _____

Claim Exception Code Edit(s): Please indicate the edit(s) noted on your Remittance Advice:
0104 0238 0280 0297 0432 0434 0435 0438 0439 0612 0673 0675 3222 6560 6562 Other:
_____

Please include detailed information regarding the reason your claim has been resubmitted for reconsideration. If your claim has been corrected and attached, please specify corrections that have been made.
_____
_____
_____
_____

Please indicate all applicable documents you have submitted with the reconsideration request:

___Consent Form	___Corrected Claim	___Description of Unlisted Code
___H&P Assessment	___Lab Report(s)	___Medication Administration Record (MAR)
___Operative/Procedure Notes	___Pathology Report(s)	___Proof of Timely Filing
___Ultrasound Report(s)	___Other: (Please Specify)_____	

Please Check:
___Have you completed the Claim Reconsideration Form?
___Have you attached a completed and signed original paper copy claim?
___Have you attached any additional substantiating information for review?

Mail to: CONDUENT, Attn: Medical Review, P. O. Box 23080, Jackson, MS 39225

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 filly 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)**

Provider File Maintenance and Updates

Change of Address Form

- When updating a provider's file with a new address, the Change of Address form must be utilized. Requests on company letterhead is not acceptable.

- Change of address forms should be submitted, when an individual provider or group provider has changed servicing, billing, or mail other locations.

Change of Address Form

- Change of Address Forms submitted by an individual provider must be signed by that provider. Only the individual Provider may sign the Change of Address Form.

- Change of Address Forms submitted by a group provider can be signed by the authorized contact persons or personnel in the office.

- Forms can be mailed or faxed to Provider Enrollment:

- **Conduent Provider Enrollment Department**
  P. O. Box 23078
  Jackson, MS 39225

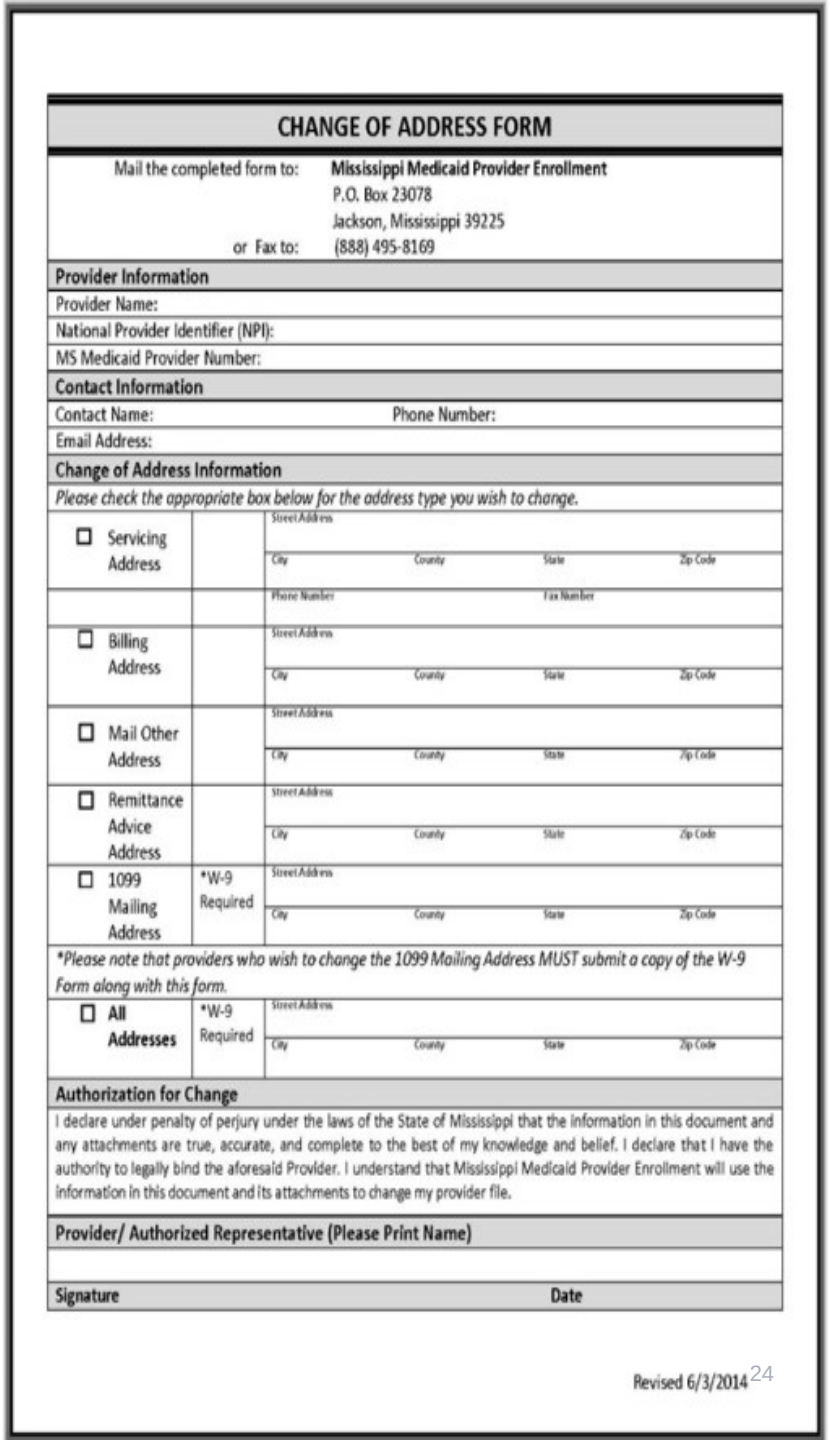
  Fax: 888-495-8169

- Incomplete forms will be returned to the provider.

Change of Address Form

The Change of Address form should be printed from the web portal at and must be completed and signed by the provider. The Change of Address form can be faxed to Conduent Provider Enrollment at (888) 495-8169 or can be mailed to the following address:

Conduent
Provider Enrollment Department
P.O. Box 23078
Jackson MS 39225



CHANGE OF ADDRESS FORM

Mail the completed form to: **Mississippi Medicaid Provider Enrollment**
P.O. Box 23078
Jackson, Mississippi 39225
or Fax to: (888) 495-8169

Provider Information

Provider Name:
National Provider Identifier (NPI):
MS Medicaid Provider Number:

Contact Information

Contact Name: Phone Number:
Email Address:

Change of Address Information

Please check the appropriate box below for the address type you wish to change.

☐ Servicing Address		Street Address City County State Zip Code Phone Number Fax Number
☐ Billing Address		Street Address City County State Zip Code
☐ Mail Other Address		Street Address City County State Zip Code
☐ Remittance Advice Address		Street Address City County State Zip Code
☐ 1099 Mailing Address	*W-9 Required	Street Address City County State Zip Code

**Please note that providers who wish to change the 1099 Mailing Address MUST submit a copy of the W-9 Form along with this form.*

☐ **All Addresses**	*W-9 Required	Street Address City County State Zip Code

Authorization for Change

I declare under penalty of perjury under the laws of the State of Mississippi that the information in this document and any attachments are true, accurate, and complete to the best of my knowledge and belief. I declare that I have the authority to legally bind the aforesaid Provider. I understand that Mississippi Medicaid Provider Enrollment will use the information in this document and its attachments to change my provider file.

Provider/ Authorized Representative (Please Print Name)

Signature **Date**

Revised 6/3/2014

Provider Linkage Letters

- Provider Link Letters must be submitted to link a individual to a particular group provider. The provider link letter entails:
  - Individual provider ID that's being linked to group number.
  - Group provider ID that the individual provider will be linked to.
  - Effective date of the individual provider being linked.
  - Must be mailed or faxed on company letterhead.
  - Linkage letter must be signed by authorized personnel.

Provider De-Linkage Letters

- Provider De-link Letters must be submitted to de-link a individual from a particular group provider. The provider de-link letter entails:
  - Individual provider ID that's being de-linked to group number.
  - Group provider ID that individual provider will be de-linked from.
  - Effective date of the individual provider being de-linked.
  - Must be mailed or faxed on company letterhead.
  - Linkage letter must be signed by authorized personnel.

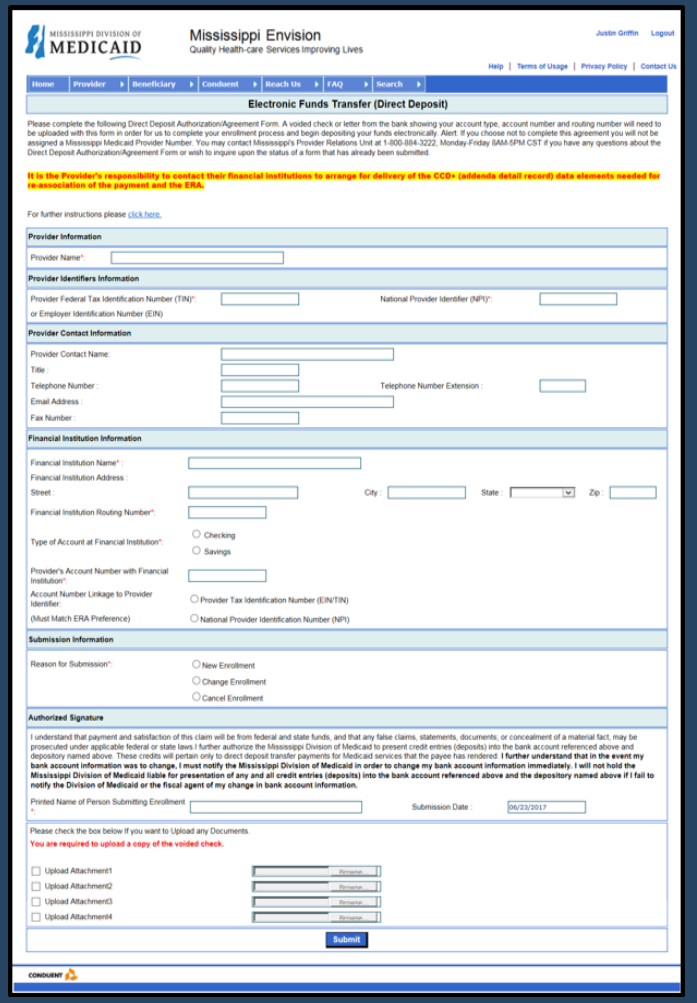
Banking (EFT) Form

The Banking (EFT) is used to update any banking information by a provider. (Group or individual)

Incorrect banking information by individual or group providers can cause payments to incorrect payees.

When an individual provider leaves a billing group, it is imperative to update banking information.

Form can be found online on the Envision website and submitted via fax or mailed in to Provider Enrollment or submitted through the web portal/Envision website



MISSISSIPPI DIVISION OF MEDICAID

Mississippi Envision
Quality Health-care Services Improving Lives

Justin Griffin | Logout

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Electronic Funds Transfer (Direct Deposit)

Please complete the following Direct Deposit Authorization/Agreement Form. A voided check or letter from the bank showing your account type, account number and routing number will need to be uploaded with this form in order for us to complete your enrollment process and begin depositing your funds electronically. Alert: If you choose not to complete this agreement you will not be assigned a Mississippi Medicaid Provider Number. You may contact Mississippi's Provider Relations Unit at 1-800-884-3222, Monday-Friday 8AM-5PM CST if you have any questions about the Direct Deposit Authorization/Agreement Form or wish to inquire upon the status of a form that has already been submitted.

It is the Provider's responsibility to contact their financial institutions to arrange for delivery of the CCD+ (addenda detail record) data elements needed for re-association of the payment and the ERA.

For further instructions please click here.

Provider Information

Provider Name*:

Provider Identifiers Information

Provider Federal Tax Identification Number (TIN)*:
or Employer Identification Number (EIN)

National Provider Identifier (NPI)*:

Provider Contact Information

Provider Contact Name:
Title :
Telephone Number :
Email Address :
Fax Number :

Telephone Number Extension :

Financial Institution Information

Financial Institution Name* :
Financial Institution Address :
Street :
City :
State :
Zip :
Financial Institution Routing Number*:
Type of Account at Financial Institution*: Checking / Savings
Provider's Account Number with Financial Institution*:
Account Number Linkage to Provider Identifier:
(Must Match ERA Preference)
Provider Tax Identification Number (EIN/TIN)
National Provider Identification Number (NPI)

Submission Information

Reason for Submission*: New Enrollment / Change Enrollment / Cancel Enrollment

Authorized Signature

I understand that payment and satisfaction of this claim will be from federal and state funds, and that any false claims, statements, documents, or concealment of a material fact, may be prosecuted under applicable federal or state laws.I further authorize the Mississippi Division of Medicaid to present credit entries (deposits) into the bank account referenced above and depository named above. These credits will pertain only to direct deposit transfer payments for Medicaid services that the payee has rendered. **I further understand that in the event my bank account information was to change, I must notify the Mississippi Division of Medicaid in order to change my bank account information immediately. I will not hold the Mississippi Division of Medicaid liable for presentation of any and all credit entries (deposits) into the bank account referenced above and the depository named above if I fail to notify the Division of Medicaid or the fiscal agent of my change in bank account information.**

Printed Name of Person Submitting Enrollment *:
Submission Date : 06/23/2017

Please check the box below if you want to Upload any Documents.
You are required to upload a copy of the voided check.

Upload Attachment1 Browse...
Upload Attachment2 Browse...
Upload Attachment3 Browse...
Upload Attachment4 Browse...

Submit

CONDUENT

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.

Common Edits not subject to Medical Review

Common Edits Not Subject to Medical Review

Edits

- **1109 - S**ervice 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

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.

Revalidation

What is Provider Revalidation?

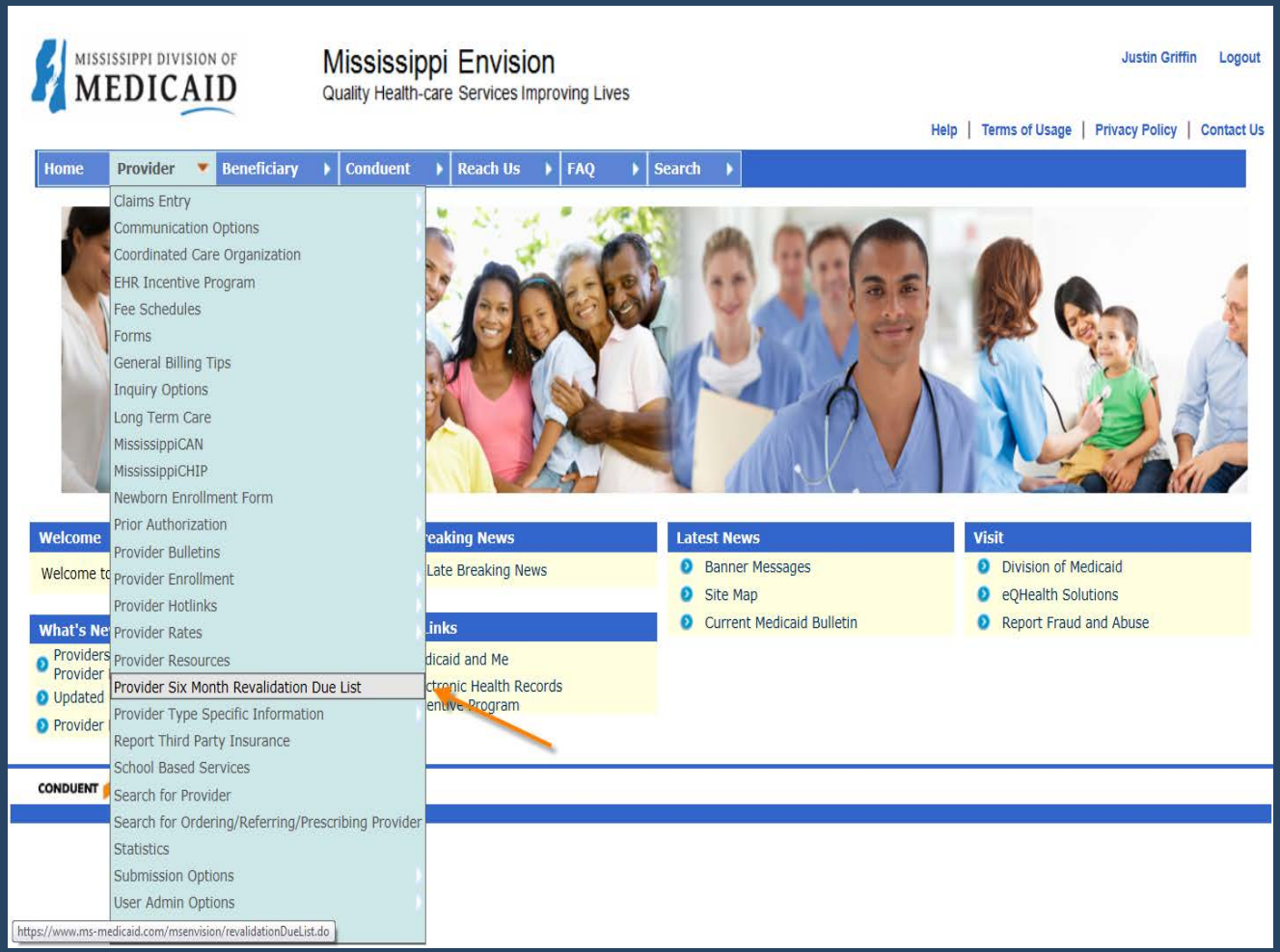
Provider Revalidation – a CMS requirement that mandates that providers who have been enrolled in Medicaid, regardless of provider type, must revalidate at least every five (5) years. Providers will need to verify that the information currently on his/her provider file is accurate and up-to-date in order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

What if I Fail to Revalidate

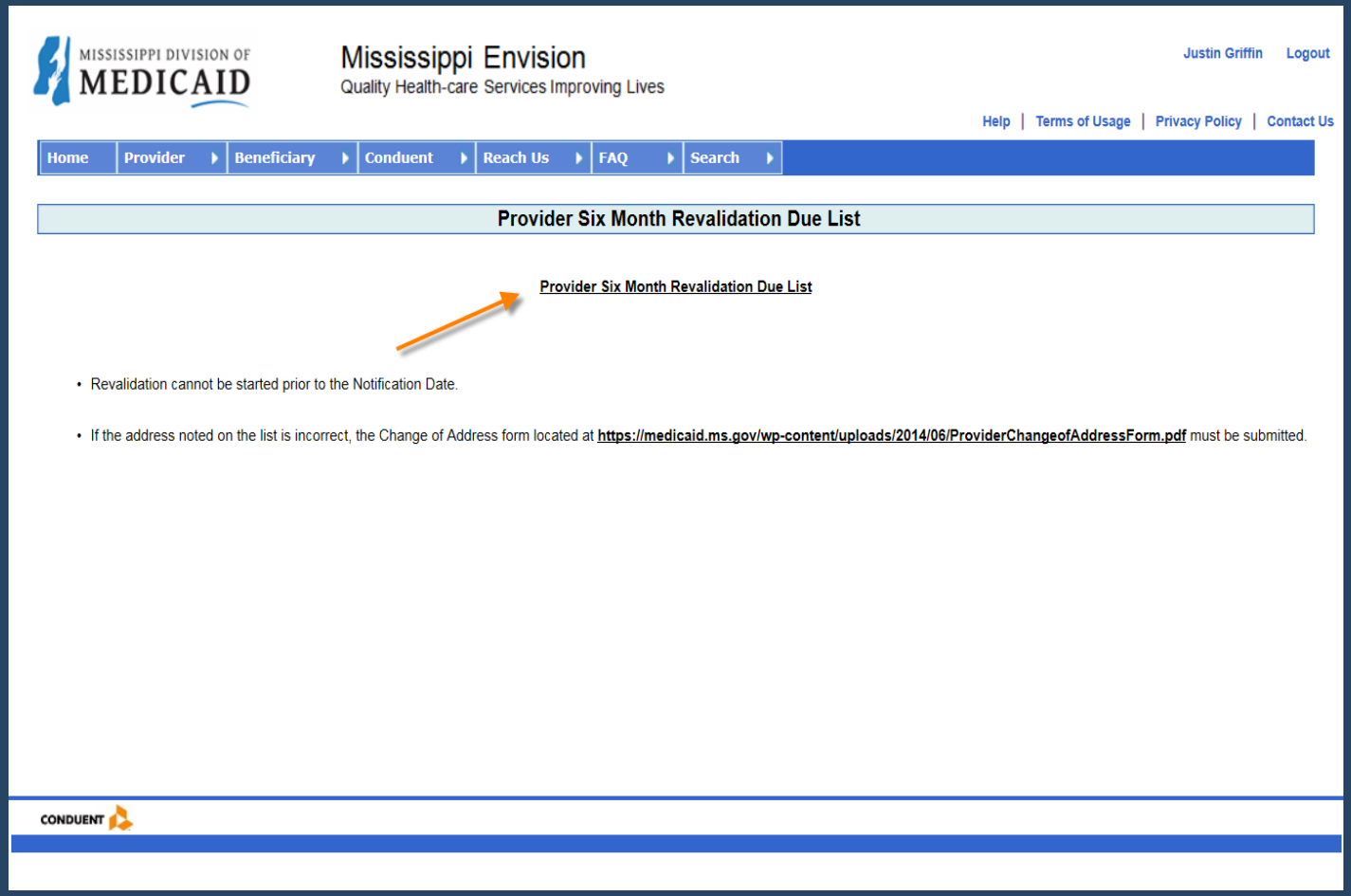
- Providers that fail to revalidate by the deadline will be terminated and required to re-enroll.
- If your Mississippi Medicaid Provider Number is termed due to failure to complete revalidation, your participation with the CCOs (Magnolia and United Healthcare and Molina Healthcare) will be termed as 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

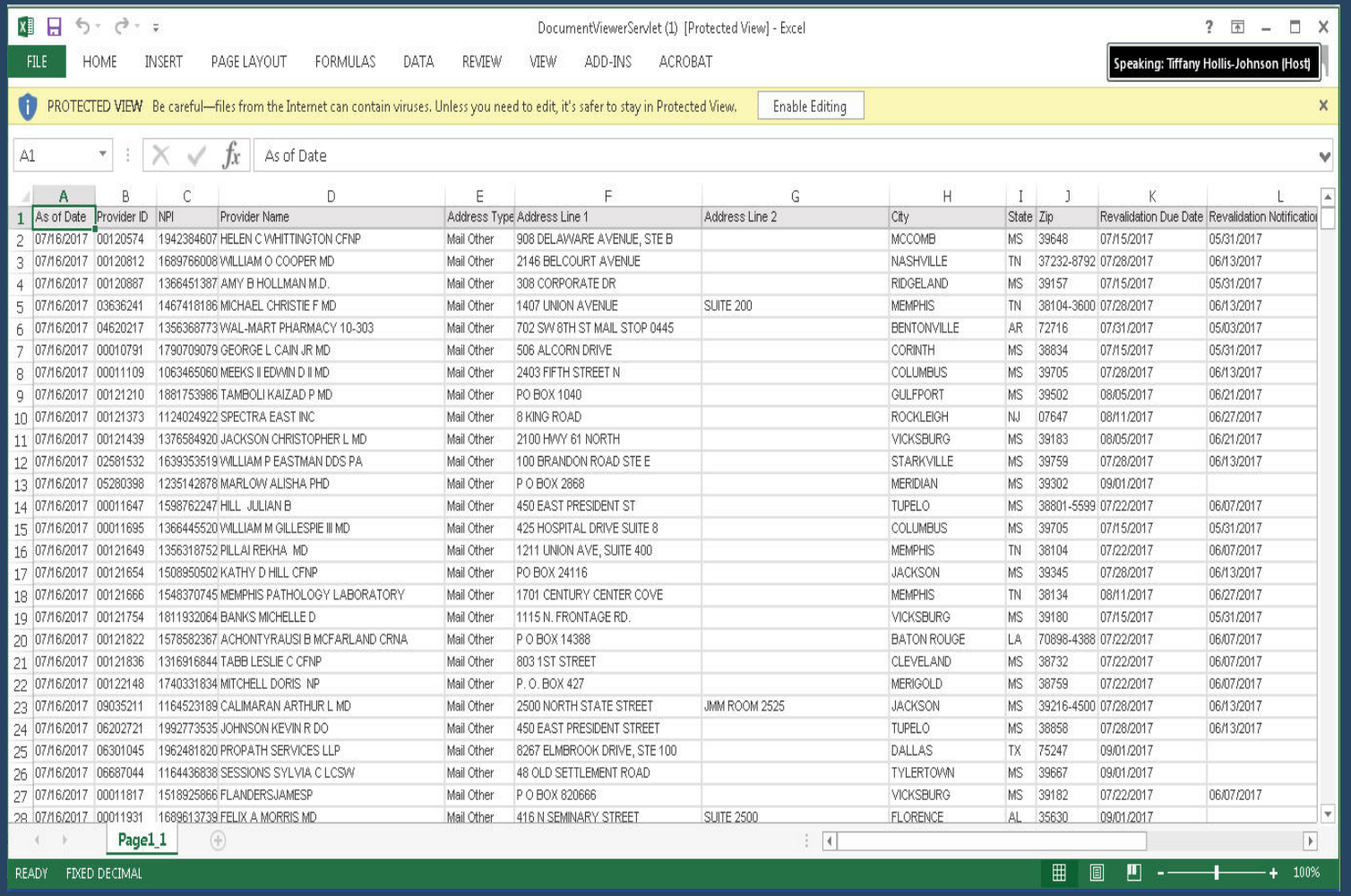
Six Month Provider Revalidation Due List



Six Month Provider Revalidation Due List



Six Month Provider Revalidation Due List



DocumentViewerServlet (1) [Protected View] - Excel

FILE HOME INSERT PAGE LAYOUT FORMULAS DATA REVIEW VIEW ADD-INS ACROBAT

Speaking: Tiffany Hollis-Johnson [Host]

PROTECTED VIEW Be careful—files from the Internet can contain viruses. Unless you need to edit, it's safer to stay in Protected View. Enable Editing

A1 | As of Date

As of Date	Provider ID	NPI	Provider Name	Address Type	Address Line 1	Address Line 2	City	State	Zip	Revalidation Due Date	Revalidation Notificatio
07/16/2017	00120574	1942384607	HELEN C WHITTINGTON CFNP	Mail Other	908 DELAWARE AVENUE, STE B		MCCOMB	MS	39648	07/15/2017	05/31/2017
07/16/2017	00120812	1689766008	WILLIAM O COOPER MD	Mail Other	2146 BELCOURT AVENUE		NASHVILLE	TN	37232-8792	07/28/2017	06/13/2017
07/16/2017	00120887	1366451387	AMY B HOLLMAN M.D.	Mail Other	308 CORPORATE DR		RIDGELAND	MS	39157	07/15/2017	05/31/2017
07/16/2017	03636241	1467418186	MICHAEL CHRISTIE F MD	Mail Other	1407 UNION AVENUE	SUITE 200	MEMPHIS	TN	38104-3600	07/28/2017	06/13/2017
07/16/2017	04620217	1356368773	WAL-MART PHARMACY 10-303	Mail Other	702 SW 8TH ST MAIL STOP 0445		BENTONVILLE	AR	72716	07/31/2017	05/03/2017
07/16/2017	00010791	1790709079	GEORGE L CAIN JR MD	Mail Other	506 ALCORN DRIVE		CORINTH	MS	38834	07/15/2017	05/31/2017
07/16/2017	00011109	1063465060	MEEKS II EDWIN D II MD	Mail Other	2403 FIFTH STREET N		COLUMBUS	MS	39705	07/28/2017	06/13/2017
07/16/2017	00121210	1881753986	TAMBOLI KAIZAD P MD	Mail Other	PO BOX 1040		GULFPORT	MS	39502	08/05/2017	06/21/2017
07/16/2017	00121373	1124024922	SPECTRA EAST INC	Mail Other	8 KING ROAD		ROCKLEIGH	NJ	07647	08/11/2017	06/27/2017
07/16/2017	00121439	1376584920	JACKSON CHRISTOPHER L MD	Mail Other	2100 HWY 61 NORTH		VICKSBURG	MS	39183	08/05/2017	06/21/2017
07/16/2017	02581532	1639353519	WILLIAM P EASTMAN DDS PA	Mail Other	100 BRANDON ROAD STE E		STARKVILLE	MS	39759	07/28/2017	06/13/2017
07/16/2017	05280398	1235142878	MARLOW ALISHA PHD	Mail Other	P O BOX 2868		MERIDIAN	MS	39302	09/01/2017	
07/16/2017	00011647	1598762247	HILL JULIAN B	Mail Other	450 EAST PRESIDENT ST		TUPELO	MS	38801-5599	07/22/2017	06/07/2017
07/16/2017	00011695	1366445520	WILLIAM M GILLESPIE III MD	Mail Other	425 HOSPITAL DRIVE SUITE 8		COLUMBUS	MS	39705	07/15/2017	05/31/2017
07/16/2017	00121649	1356318752	PILLAI REKHA MD	Mail Other	1211 UNION AVE, SUITE 400		MEMPHIS	TN	38104	07/22/2017	06/07/2017
07/16/2017	00121654	1508950502	KATHY D HILL CFNP	Mail Other	PO BOX 24116		JACKSON	MS	39345	07/28/2017	06/13/2017
07/16/2017	00121666	1548370745	MEMPHIS PATHOLOGY LABORATORY	Mail Other	1701 CENTURY CENTER COVE		MEMPHIS	TN	38134	08/11/2017	06/27/2017
07/16/2017	00121754	1811932064	BANKS MICHELLE D	Mail Other	1115 N. FRONTAGE RD.		VICKSBURG	MS	39180	07/15/2017	05/31/2017
07/16/2017	00121822	1578582367	ACHONTYRAUSI B MCFARLAND CRNA	Mail Other	P O BOX 14388		BATON ROUGE	LA	70898-4388	07/22/2017	06/07/2017
07/16/2017	00121836	1316916844	TABB LESLIE C CFNP	Mail Other	803 1ST STREET		CLEVELAND	MS	38732	07/22/2017	06/07/2017
07/16/2017	00122148	1740331834	MITCHELL DORIS NP	Mail Other	P. O. BOX 427		MERIGOLD	MS	38759	07/22/2017	06/07/2017
07/16/2017	09035211	1164523189	CALIMARAN ARTHUR L MD	Mail Other	2500 NORTH STATE STREET	JMM ROOM 2525	JACKSON	MS	39216-4500	07/28/2017	06/13/2017
07/16/2017	06202721	1992773535	JOHNSON KEVIN R DO	Mail Other	450 EAST PRESIDENT STREET		TUPELO	MS	38858	07/28/2017	06/13/2017
07/16/2017	06301045	1962481820	PROPATH SERVICES LLP	Mail Other	8267 ELMBROOK DRIVE, STE 100		DALLAS	TX	75247	09/01/2017	
07/16/2017	06687044	1164436838	SESSIONS SYLVIA C LCSW	Mail Other	48 OLD SETTLEMENT ROAD		TYLERTOWN	MS	39667	09/01/2017	
07/16/2017	00011817	1518925866	FLANDERSJAMESP	Mail Other	P O BOX 820666		VICKSBURG	MS	39182	07/22/2017	06/07/2017
07/16/2017	00011931	1689613739	FELIX A MORRIS MD	Mail Other	416 N SEMINARY STREET	SUITE 2500	FLORENCE	AL	35630	09/01/2017	

Page1_1

READY FIXED DECIMAL 100%

Claims Timely filing

(Administrative code Part 200; Chapter 1; Rules 1.6, 1.7 and 1.8)

Effective July 1, 2019

MISSISSIPPI DIVISION OF MEDICAID

Timely Filing
Fee-For-Service Claims

42 C.F.R. § 447.45 (d)(1) "*The Medicaid agency must require providers to submit all claims no later than 12 months from the date of service.*"

- Claims filed within three-hundred sixty-five (365) calendar days from the initial date of service, but denied, can be resubmitted with the transaction control number (TCN) from the original denied claim. The original TCN must be placed in the appropriate field on the resubmitted claim and be received by the Division of Medicaid within three-hundred and sixty-five (365) days from the date of the submittal of the original claim.
- If a provider is unable to submit a claim within three-hundred sixty-five (365) days from the date of service due to retroactive beneficiary eligibility, claims must be submitted within sixty (60) days of the eligibility determination.
- Claims by newly enrolled providers must be submitted within three hundred sixty-five (365) calendar days from the date of service and must be for services provided on or after the effective date of the provider's enrollment.

Timely Filing – Crossover Claims

Medicare crossover claims for coinsurance and/or deductible must be filed with DOM within 180 days of the Medicare Paid Date.

- Providers may resubmit a corrected claim within 180 days of the Medicare paid date.
- Providers may request an Administrative Review within thirty (30) calendar days of a denied Medicare crossover claim once the 180 day timely filing has been met.
- Providers are encouraged to submit a corrected claim within 180 days of the Medicare paid date if the claim can be corrected.

Administrative Claim Review

Providers may request an Administrative Review of a claim when:

- A beneficiary's retroactive eligibility prevents the provider from filing the claim timely and the provider submits the claim within sixty (60) days of the beneficiary's eligibility determination,
- The Division of Medicaid adjusts claims after timely filing and timely processing deadlines have expired, or
- The provider has submitted a Medicare crossover claim within one-hundred and eighty (180) days of the Medicare paid date and the provider is dissatisfied with the disposition of the claim.

Administrative Claims Review

Requests for Administrative Reviews must be submitted to the Office of Appeals at the Division of Medicaid and must include:

- Documentation of timely filing or documentation that the provider was unable to file the claim timely due to the beneficiary's retroactive eligibility,
- Documentation supporting the reason for the Administrative Review, and
- Other documentation as required or requested by the Division of Medicaid.
- Submit Administrative Reviews to:

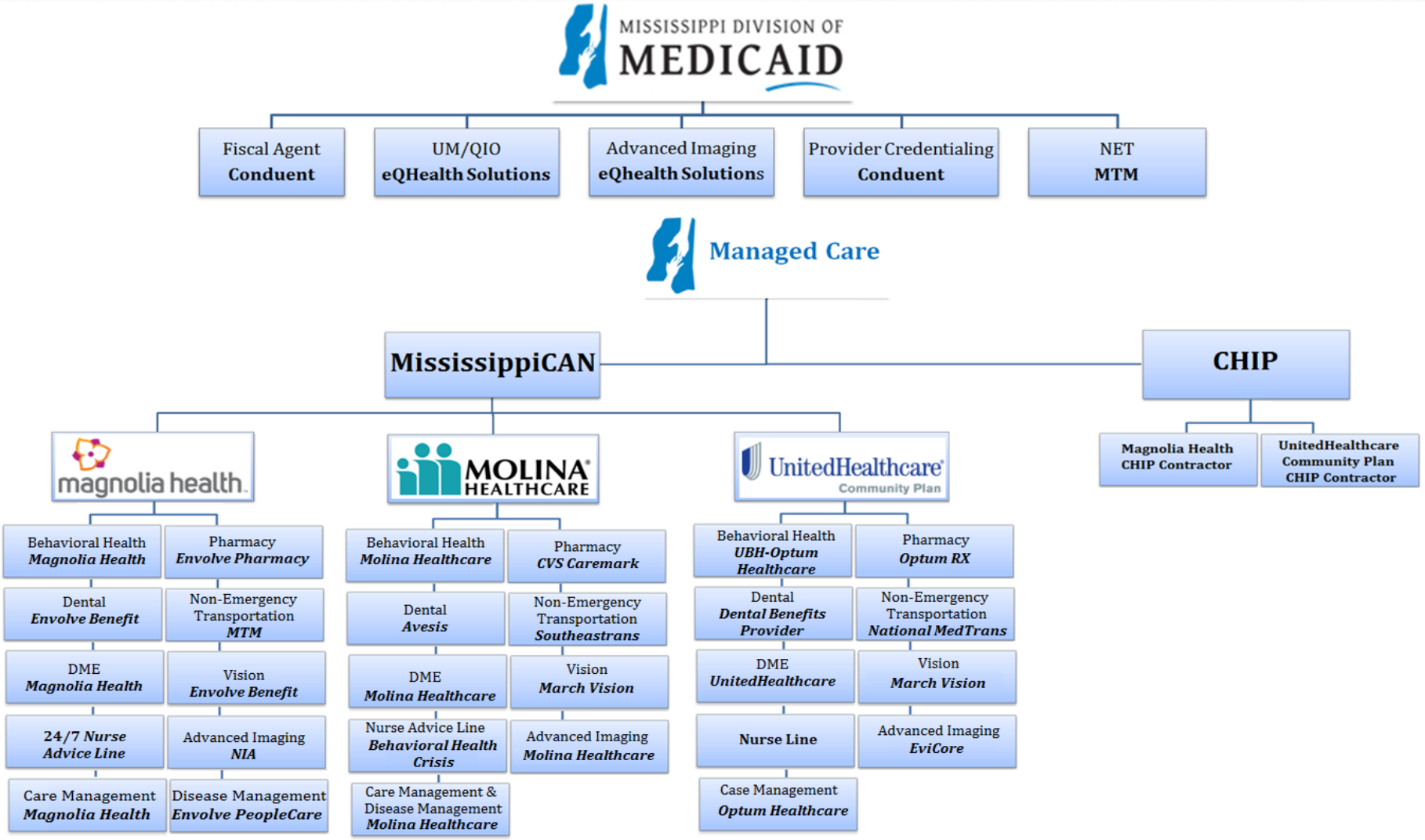
Division of Medicaid
Attention: Office of Appeals
550 High Street, Suite 1000
Jackson, MS 39201

Phone: **601-359-6050**

Fax: **601-359-9153**

Managed Care Overview

Medicaid Organizational Chart
Effective October 1, 2018



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

Managed Care Contact Information

Enrollment & Eligibility	**Charlotte McNair** Telephone Number: 601-359-5785 Fax Number: 601-359-5252 *Charlotte.McNair@medicaid.ms.gov*
Member Issues	**Michelle Robinson** Telephone Number: 601-359-9131 Fax Number: 601-359-5252 *Michelle.Robinson@medicaid.ms.gov*
Provider Issues	**Tanya Stevens** Telephone Number: 601-359-4143 Fax Number: 601-359-5252 *Tanya. Stevens@medicaid.ms.gov*

For questions regarding MississippiCAN or CHIP please view the website at https://medicaid.ms.gov/programs/managed-care/.

Managed Care
Inquires and Complaints

Please submit MississippiCAN/ CHIP inquires or complaints with the below detailed information:

Fax: 601-359-5252

Mail: Division of Medicaid
Office of Coordinated Care
550 High Street
Jackson, MS 39201

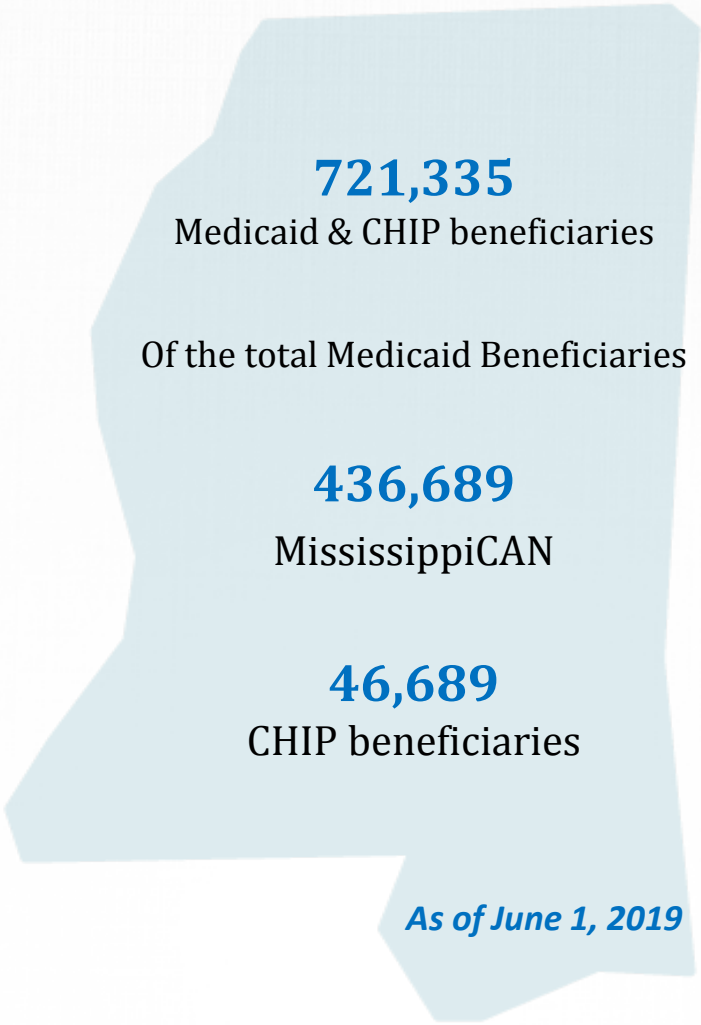
Managed Care Inquiries and Complaints	
Date	
Provider Name	
Provider ID Number	
Facility Name	
Contact Person	
Telephone Number	
Fax Number	
Beneficiary Name	
Beneficiary ID Number	
Telephone Number	
PLEASE PROVIDE DETAILED QUESTIONS AND/OR COMPLAINTS	

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

MississippiCAN and CHIP Enrollment Statistics



721,335
Medicaid & CHIP beneficiaries

Of the total Medicaid Beneficiaries

436,689
MississippiCAN

46,689
CHIP beneficiaries

As of June 1, 2019

Evolution of MississippiCAN Program

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.

July 1, 2014

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

Evolution of MississippiCAN Program

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

December 1, 2015

- MississippiCAN expanded services to include Inpatient Hospital Services/Long Term Accute Care (LTAC), and deemed Newborns enrolled the month of birth.
- Also, case management and ancillary services (e.g. physician, pharmacy) for PRTF residents.

Evolution of MississippiCAN Program

July 1, 2017

- MississippiCAN new contract

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.
- MYPAC and PRTF Facility services were added to MississippiCAN.

2019

- New CHIP Contract
- CHIP members will receive services from two CCOs – UnitedHealthcare and Molina Healthcare.

OFFICE OF THE GOVERNOR | MISSISSIPPI DIVISION OF MEDICAID 52

Mississippi Managed Care Overview

Legislative Updates

- **SB 2268 Mental Health Services**
- During the 2019 legislative session, lawmakers passed Senate bill (SB) 2268, which authorizes the Mississippi Division of Medicaid (DOM) to reimburse for psychiatric services provided to Medicaid beneficiaries in any free-standing acute care psychiatric hospital in the state.

Beneficiaries Not Eligible for MississippiCAN

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 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**

MississippiCAN Enrollment

CATEGORY OF ELIGIBILITY	AGE	POPULATION
SSI- Supplemental Security Income	19 - 65	Mandatory
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

Mandatory Population:

- These beneficiaries in above categories are required to be enrolled in the program.
- Beneficiaries are encouraged to check with their doctor to see which plan they accept. They mark the CCO of their choice on the back of this letter.
- If you DOM does not receive enrollment form in 30 days selecting a choice, a CCO will be picked for them. Beneficiaries will have 90 days to switch CCOs.
- After the 90 days they will be locked into the program and will not be eligible to change from CCOs or “opt out” except during annual open enrollment.

MississippiCAN Enrollment

CATEGORY OF ELIGIBILITY	AGE	POPULATION
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

Optional Population:

- These beneficiaries do not have to join the MississippiCAN program. They may choose to keep regular Medicaid.
- If beneficiaries do not want to join, they must put a check mark by “Opt Out” on the form on the back of this letter.
- If you DOM does not receive enrollment form in 30 days selecting a choice, a CCO will be picked for them.
- Beneficiaries will have 90 days to pick a different CCO or to “opt out” of the program.
- After the 90 days they will be locked into the program and will not be eligible to change from CCOs or “opt out” except during annual open enrollment.

Open Enrollment

MississippiCAN and CHIP

- MississippiCAN and CHIP Open Enrollment is available to members from October 1 through December 15 each year.
- 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

Eligibility Re-certifications and Updates

- MississippiCAN beneficiaries whose **Medicaid eligibility has ended or is about to end**, the 20th of each month is the deadline for the Medicaid Regional Offices to approve and/or reinstate to ensure that beneficiaries remain with MSCAN for the 1st day of the next effective month.

  *(**Example:** A beneficiary was approved/reinstated for Medicaid on 6.11.2019. The beneficiary is then auto assigned to the selected plan of choice on the initial enrollment form or auto assigned to a CCO assignment 7.1.2018.)*

- MississippiCAN beneficiaries whose Medicaid eligibility has ended or is about to end, and Regional Offices approve and/ or reinstate is **after the 20th of the month**, then the beneficiaries will return to regular Medicaid for a month before assignment to MSCAN CCO.

  *(**Example:** A beneficiary was approved/reinstated for Medicaid on 6.21.2019. The beneficiary will go back to fee for service Medicaid for a month and will be assigned to selected plan of choice on the initial enrollment form or auto assigned to a CCO assignment 8.1.2019.*

Eligibility Re-Certifications and Updates

- If beneficiaries have a temporary **loss of eligibility of <u>less than</u> 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 <u>more than</u> 60 days**, then DOM will not automatically re-assign beneficiaries into the CCO in which beneficiaries were most recently assigned.
- When beneficiaries go back to regular Medicaid due to loss of eligibility and reinstatements, they will have to pay the **Medicaid co-pay** for office visits and medication.

Beneficiaries Rights

- Please **do not select a CCO for beneficiaries.** It is the responsibility of the beneficiary to make a choice, sign enrollment form, and submit to DOM within the requested time frame.
- The **member cannot be balance billed for any denied charges** under circumstances including but not limited to failure to obtain a notification or prior authorization, either prospectively or retrospectively, clinical or administrative denial of the claim or service.
  - *Per the **Medicaid Provider Agreement** and the **Administrative Code**, the Medicaid Provider agrees to accept as payment in full the amount paid by the Medicaid program for Medicaid covered services with the exception of authorized deductibles, co-insurance, and co-payments.*
- **General Provider Information. Rule 3.8**

  Charges Not Beneficiary's Responsibility

https://medicaid.ms.gov/wp-content/uploads/2014/01/Admin-Code-Part-200.pdf

- Members may file grievances or appeals of any dissatisfaction to the CCOs.

Vision Services

(Administrative Code: Title 23; Part 217; Chapters 1, 2 and 3)

Vision Services

Vision service is an optional benefit under the state's Medicaid program and financial assistance is provided as follows:

- Eyeglasses for all Medicaid beneficiaries who have had surgery on the eyeball or ocular muscle that results in a vision change for which eyeglasses are medically indicated within six (6) months of the surgery and is in accordance with rules established by Medicaid, or
- One (1) pair of eyeglasses every five (5) years and in accordance with rules established by Medicaid. In either instance, the eyeglasses must be prescribed by a physician skilled in diseases of the eye or an optometrist, whichever the beneficiary selects.
- Eye exams for all eligible beneficiaries are covered.

Vision Services Reimbursement

Medicaid covers vision services under a statewide uniform fixed fee schedule.

Medicaid does not permit providers of optometric services to charge a beneficiary an additional amount for services or supplies, such as frames, above the fee established.

NOTE: *The provider cannot dispense a more expensive frame than is covered under the Medicaid program and collect the difference from the beneficiary.*

A beneficiary may purchase non-covered services, such as scratch resistant lens coating.

Non-Covered Vision Services

The Division of Medicaid (DOM) does not cover vision services including, but not limited to, eye exams, eyeglasses, frames, lenses and/or contact lenses for beneficiaries enrolled in the Family Planning Waiver.

The Division of Medicaid does not cover the following including, but not limited to:

- Eyeglasses solely for protective, fashion, cosmetic, sports, occupational or vocational purposes,
- More than one (1) pair of eyeglasses every five (5) years,
- Single vision eyeglasses in addition to multifocal eyeglasses,
- Progressive bifocals,
- Sunglasses,
- Upgraded frames,
- Eyeglass cases,
- Engraving,
- Contact lens supplies and/or solutions, except as specified in Part 217 of Administrative Code

Non-Covered Vision Services (Cont.)

- Eyeglass or contact lens insurance,
- Lens coating,
- Orthoptics,
- Dispensing fees,
- Contact lenses,
- Refractive surgery including, but not limited to, Lasik surgery, radial keratotomy, photorefractive keratectomy, and/or astigmatic keratotomy,
- Services and items requiring prior authorization for which authorization has been either denied or not requested, or
- Replacement of lenses or frames due to:
  - Provider error in prescribing, frame selection, or measurement, or
  - Poor workmanship and/or materials.

Contact Lenses

Medicaid covers contact lenses with prior authorization when prescribed by an ophthalmologist or an optometrist, and there is documentation that supports the following criteria:

- Conventional eyeglasses will not result in acceptable visual correction, and
- Contact lenses are medically necessary for the treatment of certain diseases or injury to the eye

Eyeglasses

Medicaid covers eyeglasses prescribed by an ophthalmologist or optometrist when documentation supports the following:

- Eyeglasses are medically necessary,
- Eyeglasses are prescribed to significantly improve vision or correct a medical condition, and
- Eyeglasses meet eyeglass program specifications for frames and lenses.

Eyeglasses (cont.)

Coverage benefits/limitations include:

- One (1) complete pair of eyeglasses every five (5) years.
- Repairs and replacements are not covered.
- Prescriptions for eyeglass lenses must include lens specifications such as lens type, power, axis, prism, absorptive power, and impact resistance.
- Prescriptions for lens coating must include the appropriate diagnosis codes and/or narrative diagnosis.
- Lenses may be glass or plastic.
- Only standard frames with the appropriate code are covered.
- Fitting is a separate service and is covered.

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

The Division of Medicaid pays for all medically necessary services for EPSDT-eligible beneficiaries in accordance with Part 223 of Title 23, without regard to service limitations and with prior authorization.

Mississippi Administrative Code Part 217: Vision Services
https://medicaid.ms.gov/wp-content/uploads/2014/01/Admin-Code-Part-217.pdf

magnolia health™

Envolve Benefit Options Vision

8/7/2019

envolve®
Benefit Options

Vision Member Benefits

magnolia health

MISSISSIPPICAN

> Under 21: Two complete eye exams and two pairs of eyeglasses every year.

> Members 21 & over: One complete eye exam and eyeglasses every 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 year.

> One pair of eyeglasses every 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.

Vision Member Benefits

magnolia health

envolve

Contrast Off Off

a a a

OUR SOLUTIONS | WHO WE SERVE | CONTACT | MEMBERS & PROVIDERS

- Our Solutions
- Who We Serve
- About Us
- News & Events
- Contact
- Careers
- Accreditation and Awards

Members & Providers

Please click below to enter your Member or Provider web portal or for more information. If you'd prefer, please use the toll-free numbe for more information or assistance.

Members

- Vision or 800-840-7032
- Dental or call the member services number on the back of your card
- Pharmacy or 800-460-8988
- EAP (Employee Assistance Program) or call the number on your EAP wallet card or 800-646-9923

Providers

- Vision or 800-531-2818
- Dental or 855-735-4395
- Pharmacy or 800-460-8988
- **Pharmacy Prior Authorization Department:** 866-399-092

Questions about the Vision Van

- seemore@envolvehealth.com

envolve
Benefit Options

https://www.envolvehealth.com/members-providers.html

Verifying Member's Eligibility

- Providers should verify the Member's eligibility prior to delivering service at each visit

- Presentation of a Member ID card does not guarantee eligibility

<u>Envolve Vision offers two (2) ways to verify eligibility</u>

- The Eye Health Manager www.envolvevision.com/logon
- And the Interactive Voice Response System

Becoming a Provider

- To request consideration to join Envolve Vision's network – complete the electronic form at https://visionbenefits.envolvehealth.com/joinus.aspx

Credentialing

- The optometrist or ophthalmologist must be currently licensed to practice within the service area of the plan

- Optometrists and ophthalmologists must hold a therapeutic pharmaceutical agent certification and DEA/DPS/BNDD Certification, if applicable in that state, to be considered for medical/surgical panels

- The Provider must agree to meet the standards of care and service as specified by the appropriate quality committees within Envolve Vision

- Ophthalmologists must be Board eligible with the American Board of Ophthalmology, at a minimum, for initial credentialing
- Providers must not have greater than six (6) months of unaccounted time gaps in work history.

Claims

- Claims timely filing –180 days
- Payments for clean claims made within 25 days of the claim receipt
- Members with dual insurance should submit claims to member's primary insurance first and then send copy of primary EOB with claim
- Electronic Claims submissions with Envolve Vision, use Change Healthcare Payor ID – 56190
- Submit also via Eye Health Manager: www.envolvevision.com/logon

Paper: PO Box 7548
Rocky Mount, NC 27804

Faxing Claims: Envolve Vision does not accept faxed claims

Provider Portal

- The Envolve Vision website is located at www.envolvevision.com/logon.
- Participating Providers have access to the secure online portal, Eye Health Manager
- User name and password information is included in the Provider Welcome Letter or upon request
- The Eye Health Manager is available at www.envolvevision.com/logon.

Provider Tools:

- Verify member eligibility and benefits
- File claims
- Review claim status
- Download, research, and reprint Explanation of Benefits/Explanation of Payments
- Request/submit secure, HIPAA-compliant Pre-Authorization

Provider Portal (cont'd)

Additional Resources available via Eye Health Manager:

Provider Resources:

- Provider Manual
- Plan Specifics
- Policies and Procedures
- Forms
- Educational Webinar Schedule
- Group Benefit Information
- Newsletters
- Announcements

Contact Us

- Providers may contact Envolve Vision by Phone or Online

- Customer Service Call-center is available from 8:00 a.m. to 8:00 p.m.

- MississippiCAN……..(888) 241-0663
- CHIP……..(844) 293-7701

- Envolve Vision website allows immediate access 24 hours/ 7 days a week at www.envolvevision.com/logon

Vision

2019 Mississippi Medicaid Provider Workshops

MOLINA HEALTHCARE

Vision Subcontractor

MARCH® Vision Care

Routine vision, which includes a comprehensive eye exam and eyewear, is provided through our third-party vendor, MARCH® Vision Care.

Who is MARCH® Vision Care?

- MARCH® specializes in the administration of vision care benefits for health care organizations, specifically for government sponsored programs such as Medicaid, Medicare, and Medicare-Medicaid plans.
- MARCH® partners with dedicated eye care professionals throughout the United States and currently supports over 6.2 million Medicaid and Medicare members nationwide.

Credentialing

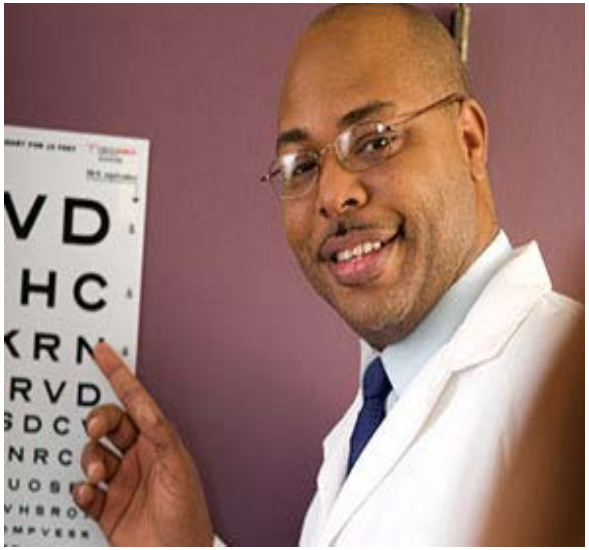
All providers are required to complete an electronic Provider Credentialing Application or submit their CAQH number for credentialing.

Contact Information

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.



Provider Contact Information

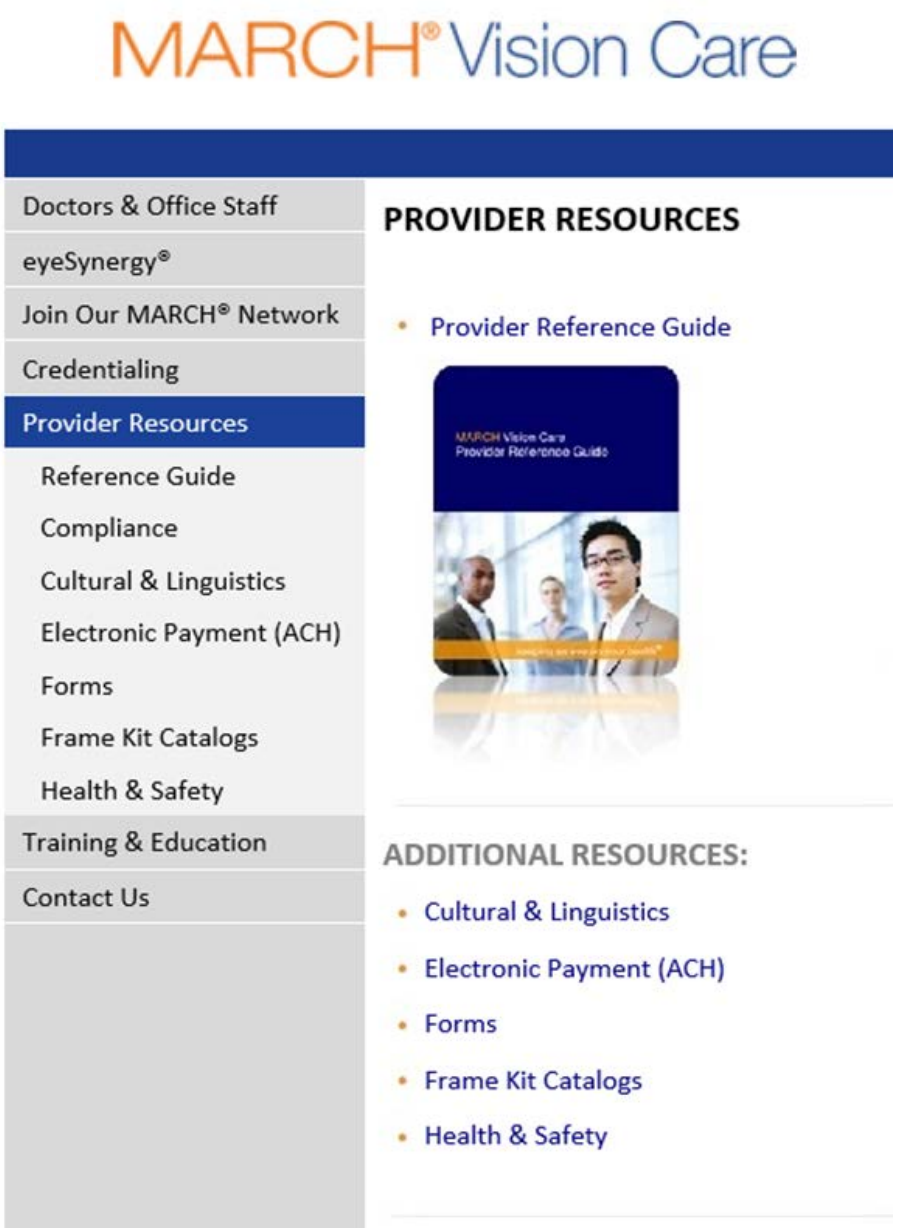
Providers may contact MARCH® Vision Care by:

- Phone: **(844) 606-2724, extension 7576** (for Provider Services)
- Website: **www.marchvisioncare.com**
- Email: **providers@marchvisioncare.com**
- Mail: **6701 Center Drive West, Suite 790**
  Los Angeles, CA 90045

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.

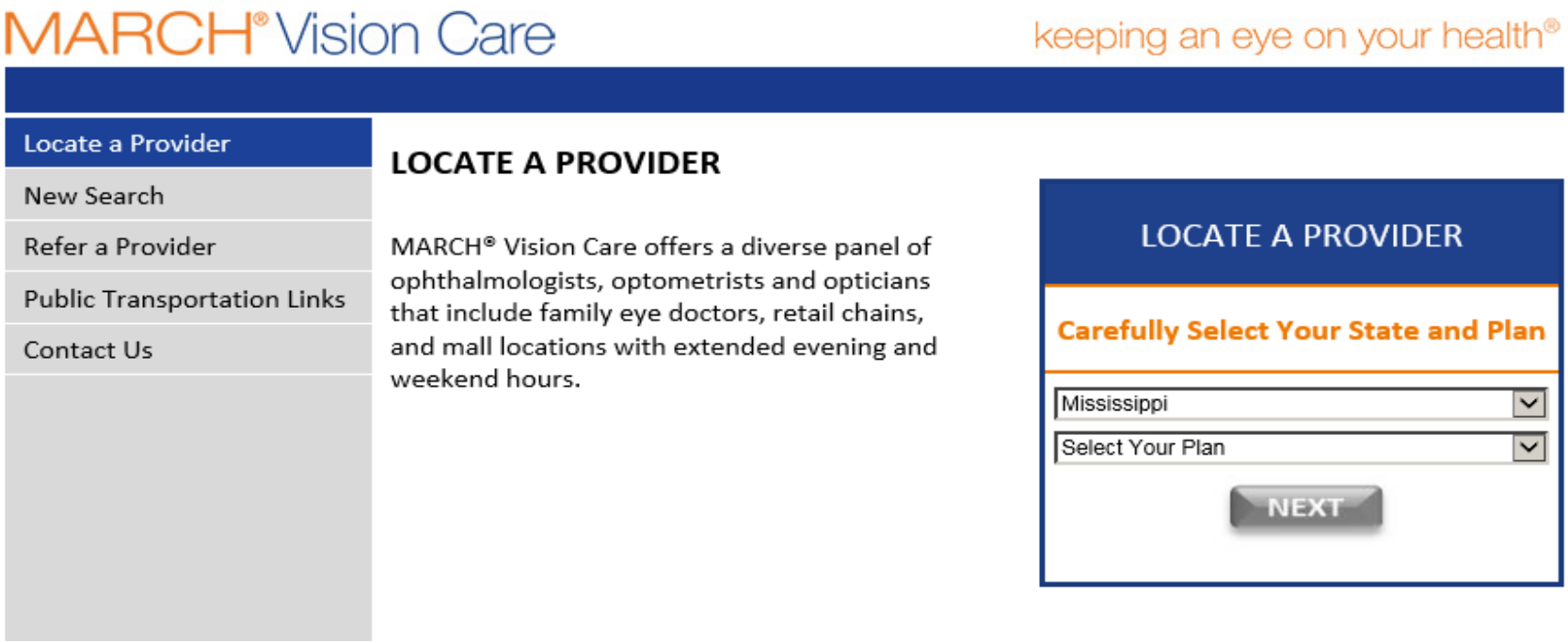


Provider Resources

MARCH® Vision Care

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

MARCH® Vision Care

Benefit Information

MARCH® administers the routine eye exam, eyewear (including polycarbonate and/or reflective coating at no charge to the member), frame and lens replacement, and eyewear after cataract surgery benefits for Molina Healthcare of Mississippi – MississippiCAN members.

A detailed summary of all covered benefits can be found on our website: **www.marchvisioncare.com**. To access these state-specific benefits, look under "Doctors and Office Staff", select "Provider Resources", click on "Provider Reference Guide", and then select "Mississippi" from the drop down menu.

Provider Portal – eyeSynergy®

eye Synergy® is MARCH® Vision Care's web portal that gives you 24/7 access to eligibility, benefit, claim and lab order information.

To register and access eyeSynergy®, visit providers.eyesynergy.com.

Claim Information

Providers should submit their claims electronically via eyeSynergy®. MARCH® has a direct agreement with Optum to accept electronic claims.

UnitedHealthcare®
Community Plan

Vision

Vision MARCH® Vision Care

UnitedHealthcare® Community Plan

Routine vision, which includes a comprehensive eye exam and glasses or contacts, is provided through our third-party vendor, MARCH® Vision Care. Referrals are **NOT** needed.

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 6.2 million Medicaid and Medicare members nationwide.

Credentialing

All providers are required to complete an electronic Provider Credentialing Application or submit their CAQH number for credentialing.

Vision – Contact Information

UnitedHealthcare Community Plan

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.

Provider Contact Information

Providers may contact MARCH® Vision Care by:

- Phone: **(844) 606-2724, extension 7576 (for Provider Services)**
- Website: **www.marchvisioncare.com**
- Email: **providers@marchvisioncare.com**
- Address: **6701 Center Drive West, Suite 790**
  Los Angeles, CA 90045

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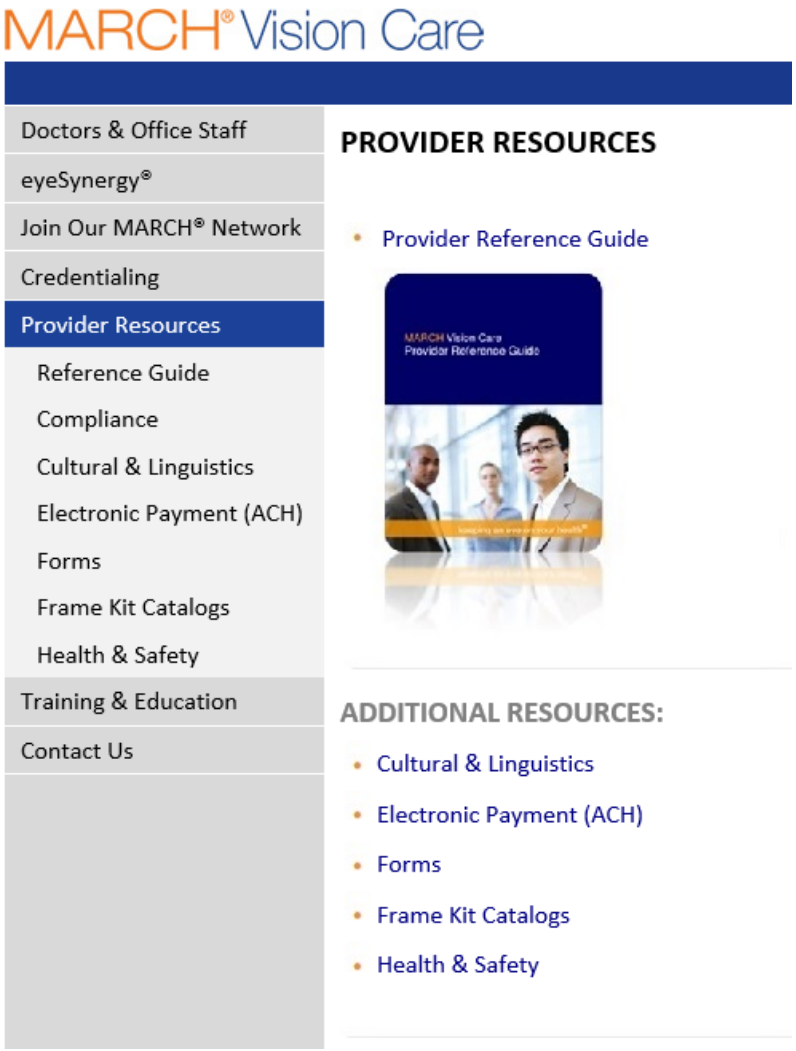
Vision – Provider Resources

UnitedHealthcare® Community Plan

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.



Vision – Provider Resources

UnitedHealthcare Community Plan

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.).

Vision – Provider Resources

UnitedHealthcare Community Plan

Benefit Information

MARCH® administers the routine eye exam, eyewear, eyewear after cataract surgery, necessary contact lenses, lens replacement (ages 20 and under), and repairs (ages 20 and under) benefits for UnitedHealthcare Community Plan – MississippiCAN members.

A detailed summary of all covered benefits can be found on our website: www.marchvisioncare.com. To access these state-specific benefits, look under "Doctors and Office Staff", select "Provider Resources", click on "Provider Reference Guide", and then select "Mississippi" from the drop down menu.

Vision – Provider Portal: eyeSynergy®

UnitedHealthcare Community Plan

eyeSynergy® is MARCH® Vision Care's web portal that gives you 24/7 access to eligibility, benefit, claim and lab order information.

To register and access eyeSynergy®, visit providers.eyesynergy.com.

Claim Information

Providers should submit their claims electronically via eyeSynergy®. MARCH® has a direct agreement with Optum to accept electronic claims.

Durable Medical Equipment (DME)

(Administrative Code: Title 23: Medicaid Part 209; Chapter 1 and 2)

Durable Medical Equipment and Medical Supplies

The Division of Medicaid defines Durable Medical Equipment (DME) and/or medical appliance as an item meeting all five (5) criteria below:

1. It can withstand repeated use,
2. Is reusable or removable,
3. Is primarily and customarily used to serve a medical purpose,
4. Is generally not useful to a person in the absence of a disability, illness, or injury, and
5. Is appropriate for use in any setting where the beneficiary's normal life activities take place other than a hospital, nursing facility, intermediate care facility for individuals with intellectual disabilities, or any setting in which payment is or could be made under Medicaid for inpatient services that include room and board.

DME Certificate of Medical Necessity (CMN)

Updated DOM Medical Supply CMN form:
https://medicaid.ms.gov/wp-content/uploads/2019/04/Medical-Supplies-Certificate-of-Medical-Necessity-CMN.pdf

eQHealth Solutions Durable Medical Equipment CMN forms:
http://ms.eqhs.org/Home.aspx

DME Contact Info

For more information regarding ordering requirements of medical supplies, equipment and appliances, please contact:

Division of Medicaid
Office of Medical Services
601-359-6150

Durable Medical Equipment (DME)

8/7/2019

New Group Contract Process

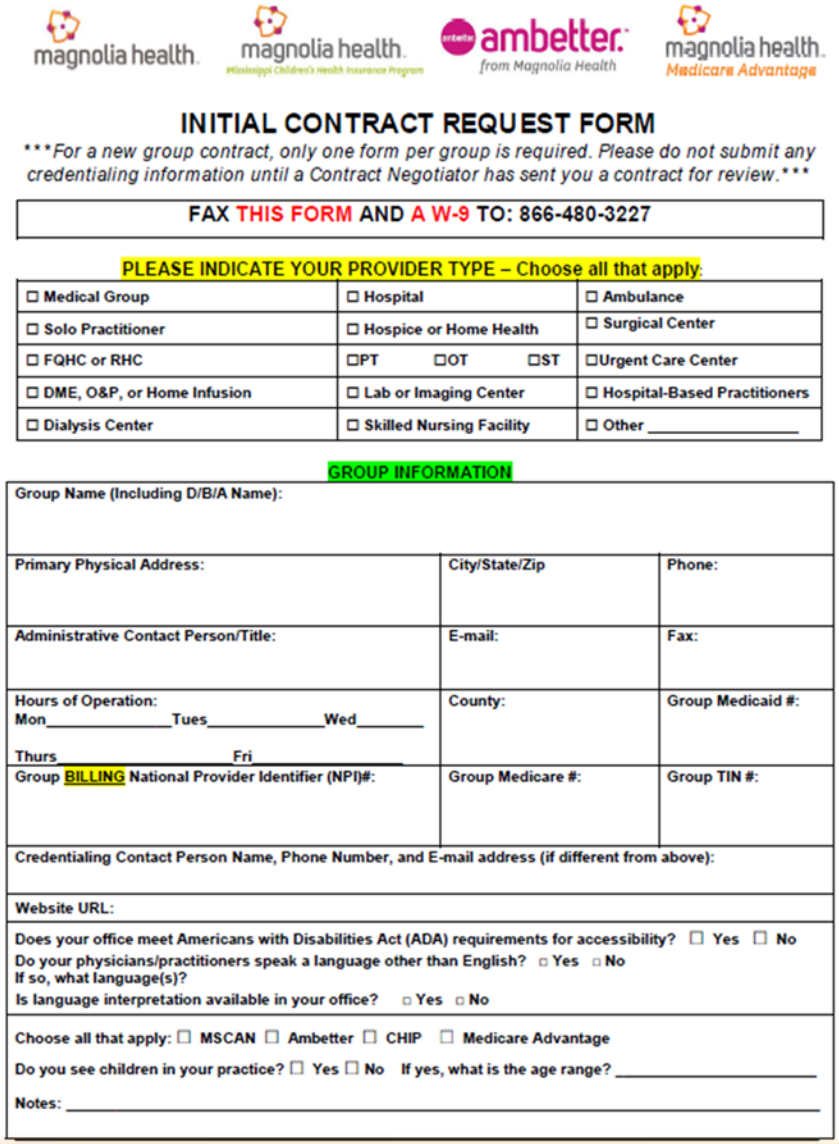
- To begin the contracting process, complete an **Initial Contract Request Form** in its entirety.

- Please send it back to the Contracting department along with a current W9 to fax number 1-866-480-3227.

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

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

**This form is not used by Behavioral Health Providers*



magnolia health | magnolia health | ambetter. from Magnolia Health | magnolia health Medicare Advantage

INITIAL CONTRACT REQUEST FORM

****For a new group contract, only one form per group is required. Please do not submit any credentialing information until a Contract Negotiator has sent you a contract for review.****

FAX THIS FORM AND A W-9 TO: 866-480-3227

PLEASE INDICATE YOUR PROVIDER TYPE – Choose all that apply:

☐ Medical Group	☐ Hospital	☐ Ambulance
☐ Solo Practitioner	☐ Hospice or Home Health	☐ Surgical Center
☐ FQHC or RHC	☐PT ☐OT ☐ST	☐Urgent Care Center
☐ DME, O&P, or Home Infusion	☐ Lab or Imaging Center	☐ Hospital-Based Practitioners
☐ Dialysis Center	☐ Skilled Nursing Facility	☐ Other _____

GROUP INFORMATION

Group Name (Including D/B/A Name):		
Primary Physical Address:	City/State/Zip	Phone:
Administrative Contact Person/Title:	E-mail:	Fax:
Hours of Operation: Mon_____Tues_____Wed_____ Thurs_____Fri_____	County:	Group Medicaid #:
Group BILLING National Provider Identifier (NPI)#:	Group Medicare #:	Group TIN #:
Credentialing Contact Person Name, Phone Number, and E-mail address (if different from above):		
Website URL:		
Does your office meet Americans with Disabilities Act (ADA) requirements for accessibility? ☐ Yes ☐ No Do your physicians/practitioners speak a language other than English? ☐ Yes ☐ No If so, what language(s)? Is language interpretation available in your office? ☐ Yes ☐ No		
Choose all that apply: ☐ MSCAN ☐ Ambetter ☐ CHIP ☐ Medicare Advantage Do you see children in your practice? ☐ Yes ☐ No If yes, what is the age range? _____ Notes: _____		

envolve Benefit Options

Adding a New Practitioner

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

- Provider Data Form
- Current licensure
- Collaborative practice agreement (Nurse Practitioners and Physician Assistants)
- W-9
- Locations page

Before starting this process, please email magnoliacredentailing@centene.com to find out if the practitioner is already in network and linked to another provider.

Durable Medical Equipment & Medical Supplies

- Durable Medical Equipment is covered in accordance with the Medicaid guidelines.
- Verify if services are covered by going to Mississippi Envision > Provider > Fee Schedules
- Verify the frequency and allowed amount by reviewing the Fee Schedules and Rates documentation on medicaid.ms.gov.
- Verify if authorization is required prior to rendering services at www.magnoliahealthplan.com > For Providers > Pre-Auth Check
- Out of network providers, will be reimbursed at 50%.

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 (MS CAN/CHIP)

envolve
Benefit Options

Manual Pricing:

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.

If the item does not have an MSRP, it will 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 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.

Custom Wheelchair

- Follow Administrative Code: Title 23; Part 209 Rule 1.47 located on the Division of Medicaid's website.
  https://medicaid.ms.gov/wp-content/uploads/2014/01/Admin-Code-Part-209.pdf

- Ensure that all components of the chair are medically necessary.

- Ensure the chair is submitted as an entire unit, i.e., if one part of the chair is not medically necessary; the chair is fully denied.

Purchase Reimbursement

The reimbursement for purchase of new Durable Medical Equipment is based on 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 (DMEPOS) fee schedule in effect by January 1.

- If there is no DMEPOS fee schedule available and a fee cannot be calculated, the item will be manually priced based on the following:
  - ❖ Manufacturer's Suggested Retail Price (MSRP) minus 20%.
  - ❖ If the there is no Manufacturer's Suggested Retail Price (MSRP) available, it will be priced at 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, or up to the purchase price, whichever is lesser.

- 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.

Claims Filing

- 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.

EFT/ERA

- We partner with PaySpan Health for Electronic Funds Transfers (EFTs) and Electronic Remittance Advices (ERAs) at no cost. This service is provided at no cost to providers and allows online enrollment.

- Visit PaySpan's website for more information: www.payspanhealth.com

- Benefits of EFT Payments:
  - Receive payments faster
  - No snail mail
  - Electronic remittance
  - Safe and secure

For more information, contact PaySpan at 1-877-331-7154 or by e-mail providerssupport@payspanhealth.com

Corrected Claim, Reconsideration, Claim Dispute

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

Claim Appeal

- **Claim Appeal** – A written request for review of an adverse benefit determination. Must be accompanied by a Claim Appeal Form. The Claim Appeal should be filed within thirty (30) calendar days of receiving Magnolia's notice of Adverse Benefit Determination.

Mailing Address:

Attn: Claim Appeal

P.O. BOX 3090

Farmington, MO 63640-3800

Durable Medical Equipment

2019 Mississippi Medicaid Provider Workshops

MOLINA HEALTHCARE

Out of Network

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

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

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

Exceed Service Limits

To determine max units, daily rates and service limits, review the Mississippi Division of Medicaid Fee Schedule at **https://medicaid.ms.gov/providers/fee-schedules-and-rates/#**

For additional questions, please contact your provider services representative or Molina's provider contact center at **(844) 826-4335**.

Purchase & Rental Reimbursement

Purchase
Payment for DME is the lesser of the provider's usual and customary charge or a fee from a statewide uniform fee schedule. The fee schedule is calculated using eighty percent (80%) of the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Fee Schedule.

Rental
Molina covers rental of DME and/or medical appliance up to ten (10) months, or up to the purchase price, whichever is the lesser. Rental items are set at ten percent (10%) of the Medicaid allowable fee.

After rental benefits are paid for ten (10) months, the DME becomes the property of the beneficiary, unless otherwise authorized by the Division of Medicaid through specific coverage criteria.

For Additional information, please refer to
Administrative Code Part 209, Chapter 1, Rule 1.4 Reimbursement *at*
https://medicaid.ms.gov/providers/administrative-code/.

Manual Pricing

Most manually priced items are priced at the Manufacturer's Suggested Retail Price (MSRP) minus twenty percent (20%).

Items that do not have a fee or MSRP may be priced at the provider's cost plus twenty percent (20%).

The provider must attach a copy of the MSRP or current invoice to the claim submission indicating the cost to the provider for the item dispensed. Failure to submit the required documentation may result in a claims denial.

Wheelchairs

Molina covers wheelchairs for all beneficiaries when ordered by the appropriate medical professional, is medically necessary and prior authorized.

Please refer to our Prior Authorization Codification Matrix at **MolinaHealthcare.com/provider**.

Prior Authorizations Submissions

We require that all PA submissions to Molina include:

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

Prior Authorization is required for some durable medical equipment

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.

Prior Authorizations and Referrals

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

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

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

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

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

Request Submissions

Web Portal: https://eportal.molinahealthcare.com/Provider/Login

Phone: (844) 826-4335. Please follow the prompts for prior authorization.

Note: *For telephonically submitted requests, it may be necessary to submit additional documentation before the authorization can be processed.*

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

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

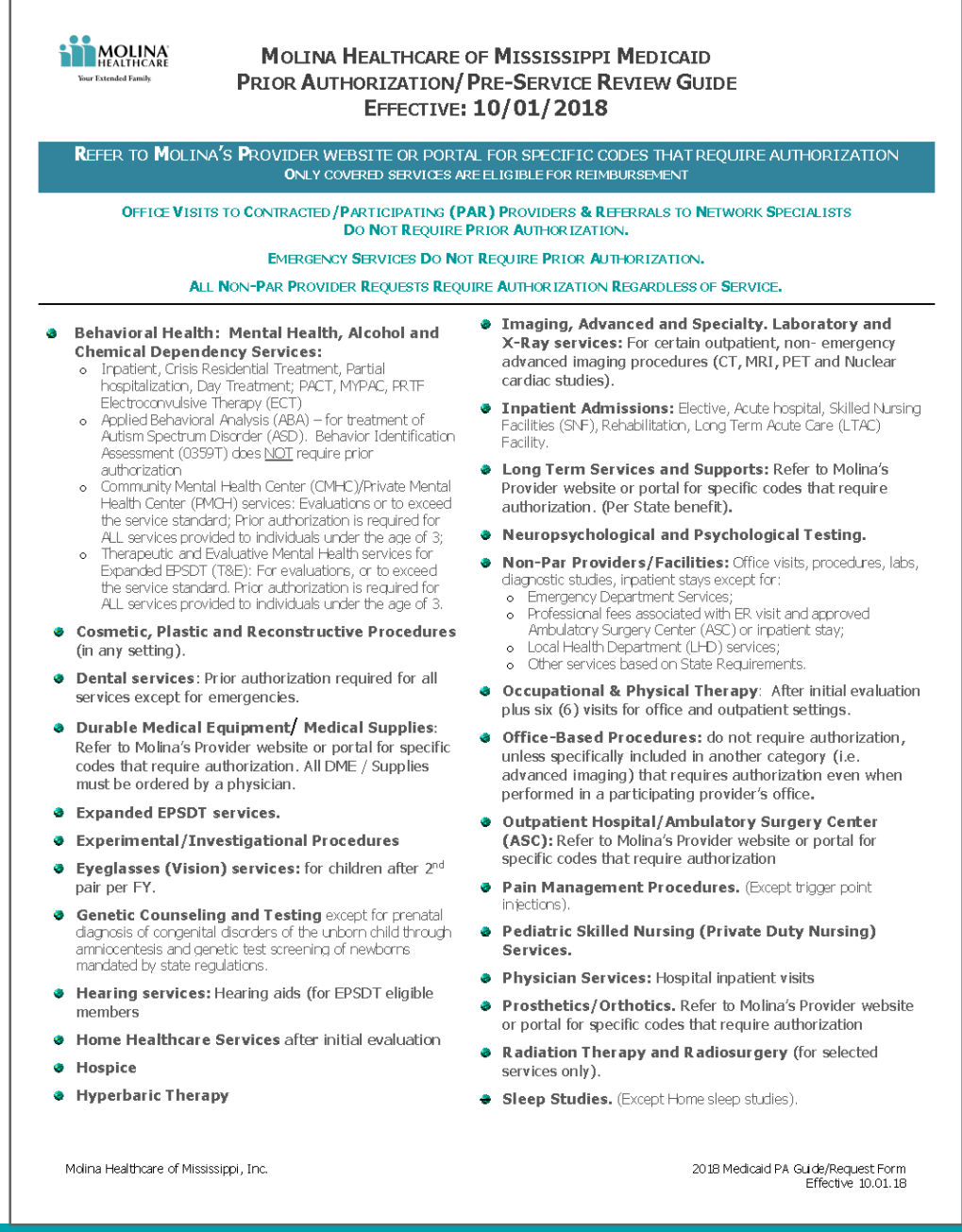
Behavioral Health Authorizations:
Phone: 1 (844) 826-4335
Inpatient Requests Fax: 1 (844) 207-1622
All Non-Inpatient Fax: 1 (844) 206-4006

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

Mail:
188 East Capital Street
Suite 700
Jackson, MS 39201

Prior Authorization Review Guide

https://www.molinahealthcare.com/providers/ms/PDF/Medicaid/PA-Guide-Request-Form.pdf



MOLINA HEALTHCARE
Your Extended Family

MOLINA HEALTHCARE OF MISSISSIPPI MEDICAID PRIOR AUTHORIZATION/ PRE-SERVICE REVIEW GUIDE EFFECTIVE: 10/01/2018

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.
- **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**
- **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.
- **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).

Molina Healthcare of Mississippi, Inc.

2018 Medicaid PA Guide/Request Form
Effective 10.01.18

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
- 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.

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**.

Concurrent Review

- Molina performs concurrent inpatient review in order to ensure patient safety, Medical Necessity of ongoing inpatient services, adequate progress of treatment and development of appropriate discharge plans.

- Molina will request updated original clinical records from inpatient facilities at regular intervals during a Member's inpatient admission.

This information is due from the inpatient facility within twenty-four (24) hours of the request.

Prior Authorization – Appeals

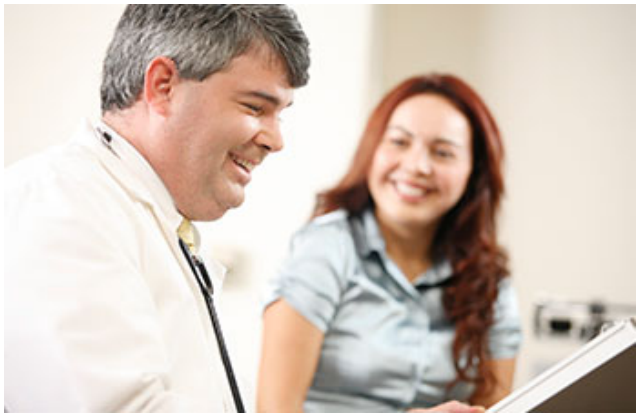
- Requests for authorization not meeting criteria must be reviewed by a designated Molina Medical Director or other appropriate clinical professional. Only a licensed physician (or pharmacist, psychiatrist, doctoral level clinical psychologist or certified addiction medicine specialist as appropriate) 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.



Contact Information

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

Phone Numbers

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

Fax Numbers

Main Fax	(844) 303-5188
Prior Auth – Inpatient	(844) 207-1622
Prior Auth – All Non-Inpatient	(844) 207-1620
Behavioral Health - Inpatient	(844) 207-1622
Behavioral Health /All Non-Inpatient	(844) 206-4006
Pharmacy Authorizations	(844) 312-6371
Radiology Authorizations	(877) 731-7218
Transplant Authorizations	(877) 813-1206
NICU Authorizations	(877) 731-7220

Vendors

Avesis
Toll Free: (833) 282-2419
Toll Free: (844) 826-4335
www.avesis.com

Southeastrans
Toll Free: (855) 391-2355
Toll Free: (844) 826-4335
www.southeastrans.com/members/mississippi

CVS Caremark
Toll Free: (844) 826-4335
PA submissions Fax: (844) 312-6371

March Vision
Toll Free: (844) 606-2724
Toll Free: (844) 826-4335
www.marchvisioncare.com

Durable Medical Equipment

UnitedHealthcare®

Durable Medical Equipment

Prior Authorization Requirements

- UnitedHealthcare MS CAN still requires Prior Authorization of DME services as outlined on PA lists:

https://www.uhcprovider.com/en/health-plans-by-state/mississippi-health-plans/ms-comm-plan-home/ms-cp-prior-auth.html

Preferred Drug List (PDL) Nutritional Items

- Nutritional products covered on the PDL will continue to be priced as Pharmacy POS. This requires a contract with OptumRX

https://www.medicaid.ms.gov/providers/pharmacy/preferred-drug-list/

Prior Authorization (PA) Required

- DME/Medical Supplies
  - When claim is above $500
  - When items exceed maximum allowable quantity limit

    (example: 6 undergarments/underpads per day for age 3 and up)
  - UHCprovider.com > Link >

    Prior Authorization & Notification
- Any DME provider not contracted with UHC should secure an authorization before rendering non-emergent services
- Any item priced from the Medicaid Preferred Drug List (PDL) that results in > 5 claims per month to OptumRX
  - 1-800-310-6826

    **** Please note that all prior authorizations will be reviewed for Medical Necessity***

Manual Pricing Process-1

- This does NOT apply to any items on the fee schedule with valid reimbursement rates listed

  https://medicaid.ms.gov/providers/fee-schedules-and-rates/#
- Manual pricing does NOT apply to Nutritional

  Products listed on the Medicaid PDL

  (under "Caloric Agents" these are priced through pharmacy, OptumRX)
- Search here for PDL items NOT manually priced, **but ARE** processed through pharmacy claims:

  https://www.medicaid.ms.gov/providers/pharmacy/preferred-drug-list/

- Secure PA before rendering services if claim meets criteria to require PA (>$500, exceeds allowable qty, on PA list, etc.).

Manual Pricing Process-2

After PA has been obtained and services have been rendered…

- Claim documentation* MUST include:
  - Customary Claim Form(s) from provider
  - Invoice from the distributor/manufacturer

    OR
  - A documented MSRP* that:
    - Matches the description on the claim
    - Is evidenced by one of the following:
      - Official invoice* (and labeled as such) from distributor

        OR
      - Official pricing from a current catalog*
      - Official price list* from distributor that includes letterhead
      - Other legitimate form* that reliably conveys an MSRP

** All documents used to substantiate pricing must be <1 year old*

Manual Pricing Process-3

If all documents are included:

- 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

- Note rules if there is no MSRP available! Must include statement as outlined

Tips:

- Claims/Invoices should only reflect items for which payment is sought
- Claims/Invoices should not reflect items disallowed in PA Process
- All documents used to substantiate pricing must be <1 year old
- Submitting the documented PA information is not required but is acceptable
- It is OK to submit invoice/MSRP info that includes unrelated items. Just mark what is applicable. Do not grossly alter or deface any documents.

Please note failure to submit these items may result in denial of claim payment.

Nutritional Agents
(parenteral & enteral-1)

UnitedHealthcare®

Refer to MS Medicaid's PDL:

https://medicaid.ms.gov/providers/pharmacy/preferred-drug-list/

CALORIC AGENTS (example only-may change):

Preferred:		Non-Preferred:	
BOOST (includes all Boost)	Breakfast Essentials	COMPLEAT	Tolerex
BRIGHT BEGINNINGS	Pediasure	EO28 SPLASH	Vital
CARNATION INSTANT BREAKFAST	Promod	FIBERSOURCE	Vivonex
DUOCAL	Resource	ISOSOURCE	
ENSURE	Scandishake	JEVITY	
JUVEN	Solcarb	KINDERCAL	
GLUCERNA	Twocal HN	PEPTAMEN	
NUTREN (includes all Nutren)		PROMOTE	
OSMOLITE		SIMPLY THICK	

These and only these are processed through pharmacy claims (OptumRX) as point-of-sale items. This requires your company to be contracted as a retail pharmacy with OptumRX. If you are currently established as another type of pharmacy, this may not be adequate.

Please contact OptumRX 1.800.788.4863 to verify your participation status.

Items NOT on this list are non-preferred. Pricing may be obtained through the manual-pricing methodology previously noted.

Nutritional Agents
(parenteral & enteral-2)

UnitedHealthcare

For manually-priced Nutritional Agents (non-caloric agents), UHC currently recognizes two codes:

- B9998 – for enteral nutrition (not otherwise specified)
- B9999 – for parenteral nutrition (not otherwise specified)

(unlike PDL items, these are filed as medical claims)

For supplies, UHC recognizes all Mississippi Medicaid Fee Schedule codes (note PA requirements still apply):

http://www.medicaid.ms.gov/wp-content/uploads/2015/07/DMEOrthoProsth.pdf

Note that B4102, B4103, B4105, etc. are NOT listed under Medicaid fee schedules. Work is underway to open these codes for providers.

Nutritional Agents
(baby formulas)

Baby formulas are provided by other resources across the state

- Enfamil
- Similac
- Gerber Good Start
- Etc.

Members should access WIC resources:
http://msdh.ms.gov/msdhsite/_static/41,0,128.html

Wheelchairs

- All wheelchair components must be listed on the DOM fee schedule *(either with a reimbursement amount or indication of "priced by PA.")*

https://www.ms-medicaid.com/msenvision/AMA_ADA_licenseAgreement.do?strUrl=feeScheduleInquiry

- All custom wheelchairs must conform to definition of "customized" according to Medicaid Administrative Code
  - Standard frames with added components may NOT meet this definition and are priced according to frame and covered attachments with each separately listed on CMS1500 claim form

https://medicaid.ms.gov/wp-content/uploads/2014/01/Admin-Code-Part-209.pdf

- PA required
- Medical Necessity Review WILL be done
- Adverse determinations (denials and partial denials) are communicated to member and ordering provider
- P2P available within 14 days of determination but NOT available during the appeal process

Custom Wheelchairs

- Custom wheelchairs use the E1220 code…not CMS/Medicare codes and K Codes

https://www.ms-medicaid.com/msenvision/AMA_ADA_licenseAgreement.do?strUrl=feeScheduleInquiry

- "Add-ons" are also manually priced along with the E1220 code
  - Manufacturer quote
  - Invoice charged to distributor
  - Recent catalog page, etc.
- Only request reimbursement for what was approved
- "Add-ons" should be listed and priced separately (not bundled under E1220)
- 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 could be taken into consideration

https://www.medicaid.ms.gov/wp-content/uploads/2014/01/Admin-Code-Part-209.pdf

Question & Answer Session

Afternoon Agenda

1:30 p.m.	3:00 p.m.	Dental
3:00 p.m.	3:30 p.m.	Question & Answer Session
3:30 p.m.	4:30 p.m.	Help Desk

Dental Services

(Administrative Code: Title 23: Part 204; Chapters 1 and 2)

Dental Services

The Division of Medicaid is authorized to furnish:

- Adults (age 21 and over): Dental care that is an adjunct to treatment of an acute medical or surgical condition; services of oral surgeons and dentists in connection with surgery related to the jaw or any structure contiguous to the jaw or the reduction of any fracture of the jaw or any facial bone; and emergency dental extractions and treatment related thereto are covered services.
- Children (under age 21): Dental services are a necessary component of overall health services provided to children who are eligible for services. Beneficiaries under age twenty-one (21) are eligible for medically necessary dental services, including diagnostic, preventive, therapeutic, emergency, and orthodontic services.

Covered Dental Services

Covered dental services include:

1. Limited oral evaluation, problem-focused,
2. Radiographs,
3. Gingivectomy and/or gingivoplasty for Dilantin therapy only,
4. Oral surgery,
5. Extractions, and
6. Alveoloplasty

Non-Covered Dental Services

Non-covered dental services include, but not limited to, the following:

1. Comprehensive oral evaluation,
2. Preventive services,
3. Amalgams, composites, and crowns,
4. Endodontics,
5. Dentures, and
6. Orthodontia.

The Division of Medicaid does not cover for scheduling or rescheduling for any dental or oral surgical procedure in any treatment setting.

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

The Division of Medicaid pays for all medically necessary services for EPSDT-eligible beneficiaries in accordance with Miss. Admin. Code Part 223, without regard to service limitations and with prior authorization.

Dental Benefit Limits

The Division of Medicaid covers dental expenditures, excluding orthodontia-related services, up to twenty five hundred dollars ($2,500.00) per beneficiary per state fiscal year.

All American Dental Association (ADA) dental procedure codes, except orthodontia-related services, are applied to the $2,500 annual limit.

Orthodontia Benefit Limits

Orthodontia services are covered with prior approval for beneficiaries under age twenty-one (21) only.

Orthodontia-related services are limited to $4,200 per beneficiary per lifetime.

Additional dental services in excess of the $4,200 lifetime limit may be provided with prior approval from the Division of Medicaid.

Prior Authorization

The Division of Medicaid requires prior authorization, except for emergencies, from the Utilization Management/Quality Improvement Organization (UM/QIO) of certain dental services.

- *Refer to Administrative Code Part 204, Chapter 1, Rule 1.6 for a list of dental services requiring prior authorization.*

Mississippi Administrative Code Part 204: Dental Services
https://medicaid.ms.gov/wp-content/uploads/2014/01/Admin-Code-Part-204.pdf

Outpatient Hospital Setting

Under some circumstances, it is necessary to perform dental procedures in an outpatient hospital setting. Effective March 2019, all dental services rendered in an outpatient hospital setting and billed on a UB-04 claim , the following will apply:

1. Requires prior authorization to be obtained by the dentist (*Failure to obtain prior authorization will result in denial of payment*),
2. Each unit must be billed on a separate line, and
3. Multiple discounting will apply.

Outpatient Hospital Setting Maximum Units

Effective, July 1, 2018, the maximum units for certain Current Dental Terminology codes (CDT) were updated.

The Dental Fees for Outpatient Hospital fee schedule is located at:

https://medicaid.ms.gov/providers/fee-schedules-and-rates/#.

National Correct Coding Initiative

In accordance with Section 6507 of the Patient Protection and Affordable Care Act, the Mississippi Division of Medicaid utilizes National Correct Coding Initiative (NCCI) methodologies in claims processing.

Providers must report services in accordance with Medicaid NCCI guidance.

Claims Timely filing

(Administrative code Part 200; Chapter 1; Rules 1.6, 1.7 and 1.8)

Effective July 1, 2019

MISSISSIPPI DIVISION OF MEDICAID

Timely Filing
Fee-For-Service Claims

42 C.F.R. § 447.45 (d)(1) "*The Medicaid agency must require providers to submit all claims no later than 12 months from the date of service.*"

- Claims filed within three-hundred sixty-five (365) calendar days from the initial date of service, but denied, can be resubmitted with the transaction control number (TCN) from the original denied claim. The original TCN must be placed in the appropriate field on the resubmitted claim and be received by the Division of Medicaid within three-hundred and sixty-five (365) days from the date of the submittal of the original claim.
- If a provider is unable to submit a claim within three-hundred sixty-five (365) days from the date of service due to retroactive beneficiary eligibility, claims must be submitted within sixty (60) days of the eligibility determination.
- Claims by newly enrolled providers must be submitted within three hundred sixty-five (365) calendar days from the date of service and must be for services provided on or after the effective date of the provider's enrollment.

Timely Filing – Crossover Claims

Medicare crossover claims for coinsurance and/or deductible must be filed with DOM within 180 days of the Medicare Paid Date.

- Providers may resubmit a corrected claim within 180 days of the Medicare paid date.
- Providers may request an Administrative Review within thirty (30) calendar days of a denied Medicare crossover claim once the 180 day timely filing has been met.
- Providers are encouraged to submit a corrected claim within 180 days of the Medicare paid date if the claim can be corrected.

Administrative Claim Review

Providers may request an Administrative Review of a claim when:

- A beneficiary's retroactive eligibility prevents the provider from filing the claim timely and the provider submits the claim within sixty (60) days of the beneficiary's eligibility determination,
- The Division of Medicaid adjusts claims after timely filing and timely processing deadlines have expired, or
- The provider has submitted a Medicare crossover claim within one-hundred and eighty (180) days of the Medicare paid date and the provider is dissatisfied with the disposition of the claim.

Administrative Claims Review

Requests for Administrative Reviews must be submitted to the Office of Appeals at the Division of Medicaid and must include:

- Documentation of timely filing or documentation that the provider was unable to file the claim timely due to the beneficiary's retroactive eligibility,
- Documentation supporting the reason for the Administrative Review, and
- Other documentation as required or requested by the Division of Medicaid.
- Submit Administrative Reviews to:

Division of Medicaid
Attention: Office of Appeals
550 High Street, Suite 1000
Jackson, MS 39201

Phone: **601-359-6050**

Fax: **601-359-9153**

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Envolve Benefit Options Dental

8/7/2019

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Benefit Options

Who Is Envolve Dental

- Dental benefits administrator, specializing in government insurance programs
- Administrating benefits since January 1, 2015
- Works directly with health plans and Coordinated Care Organizations (CCOs)
- Part of fully integrated, customizable healthcare benefit company, Envolve Benefit Options
- Sister company of Magnolia Health Plan and subsidiary of Centene Corporation, a national leader in healthcare services, operating in 31 states with 14 million members

Member Dental Benefits

- MEDICAID
  - All ages: $2,500 annual benefit limit
- CHIP
  - Under age 19: $2,000 annual benefit limit
  - Cost Sharing, $5.00, Codes D2935 & UP

Credentialing

- Credentialing takes up to 90 days
- CAQH application required or CAQH number
  - W-9
  - Roster
  - DOO
  - Attestation
- Please make sure DOO and attestation is current and within 90 days on signature/attestation date
- After credentialing is confirmed, register for the Provider Web Portal by calling Provider Services at 844-464-5636

Claims

- Claims timely filing –180 days
- Payments for clean claims made within 25 days of the claim receipt
- Members with dual insurance should submit claims to member's primary insurance first and then send copy of primary EOB with claim
- For clearinghouse submissions with Envolve Dental, use payor ID – 46278
- Web Portal Address: https://pwp.envolvedental.com
- Enroll in Electronic Funds Transfer for quick payments

See Provider Manual for details

Claims

Dental Claims Issues

- D0330 Panoramic X-ray
  - Denials for panoramic x-rays when member changes dentists, and new dentist does their own x-ray.
- Bill Primary Insurer 1st then Resubmit with EOB
  - Magnolia is required to use the pay and chase method of payment.
  - Preventive pediatric services (including Dental ESPDT services)
- Envolve Dental approves a request, issues a PA; however, claim is denied when submitted with PA

Authorizations

- Requests should be submitted to Envolve Dental at least 3 calendar days prior to scheduled services
- Envolve Dental will make determinations within 3 calendar days or 2 business days after receiving all information
- Expedited requests are determined within 24 hours
- Determination (approved or denied) is sent to providers via fax
- Notice of Adverse Benefit Determination is mailed to the member, with a copy sent to the provider
- Prior authorization expiration – 180 days
- Dental prior authorization is required for:
  - Orthodontic, BLEs, out-of-network providers, and selected codes (see manual)

Orthodontic Services

- Orthodontic procedures are covered only when medically necessary for Medicaid Children Ages 0-20
- Envolve Dental prefers electronic study models as documentation for authorization submissions. If an actual study model is received, Envolve Dental will use it for the assessment, retain for up to three months, and then discard it.

Prior authorization for orthodontia services

Submit the following required documentation as a prior authorization request:

- Cephalometric film with interpretation;
- Panoramic or full series of intra-oral radiographs;
- Intra-oral and facial photographs;
- Narrative describing member's medical condition and anticipated compliance;
- A completed Envolve Dental *Orthodontic Clinical Criteria Evaluation Form*;
- Treatment plan, including projected length and cost of treatment; and
- Study models (electronic, when possible).

Dental Services in a Hospital Setting

As of March 2019 DOM requires for all Outpatient Hospital services to be billed to Magnolia directly on a UB-04 claim form

* Please be sure to follow the Prior Authorization process with Magnolia.

Appeals

- Please note the following:
  - Authorization and claim appeals must be filed within 30 days of receiving the denial
  - To request reconsideration of a denied authorization or claim, email dentalappeals@envolvehealth.com or write to:

    Envolve Dental

    PO Box 25255

    Tampa, FL 33622-5255
- Providers who are not satisfied with the Envolve Dental decision have the option of Appealing decisions

See Provider Manual for details

Key Contacts

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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
Mailing Address (Claims, Authorizations, Appeals)	Envolve Dental - MS PO Box 25255 Tampa, FL 33622-5255
Change Healthcare 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

Key Contacts

magnolia health

REFERENCE	CONTACT
Provider Web Portal (Claims, authorizations, remittances)	https://pwp.envolvedental.com
EDI Payor ID	46278
Provider Services	844-464-5636 or providerrelations@envolvehealth.com
Magnolia Member Services (including translation assistance)	866-912-6285
Member Transportation Assistance (MississippiCAN only)	866-912-6285
Fraud, Waste and Abuse	800-345-1642
Provider Credentialing	Fax: 844-847-9807 Email: dentalcredentialing@envolvehealth.com Mail: Envolve Dental Credentialing P.O. Box 20606 Tampa, FL 33622-0606
Authorization Address	***Envolve Dental*** Authorizations PO Box 25255 Tampa, FL 33622-5255
Paper Claim and Corrected Claim Address	***Envolve Dental*** Claims and Corrected Claims PO Box 25255 Tampa, FL 33622-5255
Appeals Address	***Envolve Dental*** Appeals *PO Box 25255* Tampa, FL 33622-5255

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Quick Reference

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Quick Reference Guide	
Member Eligibility	Check eligibility through one of the following. You must provide your NPI number to access member details. • Log on to Provider Web Portal: https://pwp.envolvedental.com • Call the Interactive Voice Response (IVR) eligibility hotline: 844-464-5636 • Call Provider Services: 844-464-5636
Authorization Submission	Authorization request submissions must be received via one of the following: • Provider Web Portal at https://pwp.envolvedental.com • Electronic clearinghouses using payer ID 46278: o Change HealthCare (www.changehealthcare.com) o DentalXChange (www.dentalxchange.com) o Trizetto (www.trizetto.com) o Include attachments with NEA FastAttach® number • Alternate, pre-arranged HIPAA-compliant 837D file • Paper authorization via ADA 2012 claim form and mailed to: Envolve Dental MS CAN Authorizations PO Box 25255 Tampa, FL 33622-5255
Pre-payment Review Submission	Pre-payment reviews are post-treatment authorizations submitted with claims. Required documentation for each code—listed in the benefit grids—must be included and meet specified clinical criteria. Submit pre-payment review authorizations as claims, according to claim submission options.
Dental Services in a Hospital Setting	Providers must use a participating Magnolia Health Plan hospital. To obtain the current list of hospitals in your area: • Visit Magnolia Health's website under "Find a Provider": www.magnoliahealthplan.com • Call Magnolia Health Provider Services: 866-912-6285 Providers must request facility authorization from Envolve Dental at the same time that dental service authorization is requested.

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Quick Reference

magnolia health

Quick Reference Guide	
Claim Submission	All claims and encounters must be submitted within 180 calendar days of the date of service. This is a Magnolia Health timely filing requirement. Submit claims in one of the following formats: • Envolve Dental Provider Web Portal at https://pwp.envolvedental.com • Electronic clearinghouses using payer ID 46278: o Change Healthcare (formerly Change Healthcare, www.changehealthcare.com) o DentalXChange (www.dentalxchange.com) o Trizetto (www.trizetto.com) o Include attachments with NEA *Fast*Attach® number • Alternate pre-arranged HIPAA-compliant electronic submissions • Paper claims: Envolve Dental MSCAN Claims PO Box 25255 Tampa, FL 33622-5255 All claims submitted must include the member's Medicaid ID number. All claims should also include the provider NPI number.
Corrected Claim Submission	Providers who receive a claim denial and need to submit a corrected claim must send a paper claim including ALL codes originally submitted, plus the corrected code with supporting documentation, within 90 calendar days of the denial to: Envolve Dental MSCAN Appeals and Corrected Claims PO Box 25255 Tampa, FL 33622-5255
Provider Appeals - Claims	Claim payment appeals must be submitted within 90 calendar days from the date the denial was issued or the non-payment notification date (as indicated on the remittance advice). To request a reconsideration of a claims denial as an appeal, a provider may: • Call: 844-464-5636 • Write: Envolve Dental MS CAN Appeals PO Box 25255 Tampa, FL 33622-5255

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Quick Reference

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Quick Reference Guide	
Inquiries and Grievances	To make an inquiry or file a grievance: • Call: 844-464-5636 • Write to: Envolve Dental Envolve Dental MS CAN Grievances PO Box 25255 Tampa, FL 33622-5255
Provider Appeals - Authorizations	Authorization appeals must be filed within thirty (30) days following the date the denial letter was issued. To request reconsideration of a denied authorization, a provider may: • Call: 844-464-5636 • Write: Envolve Dental-MSCAN Appeals PO Box 25255 Tampa, FL 33622-5255 Providers must exhaust their appeal rights with Envolve Dental prior to requesting a Fair Hearing. Fair Hearing requests must be submitted in writing to the following address within thirty (30) calendar days of receiving the notice of action by Envolve Dental: Division of Medicaid Attention: Office of Appeals 550 High St., Suite 1000 Jackson, MS 39201

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Quick Reference

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Quick Reference Guide	
Member Appeals	Members must submit appeals within 30 days of receiving the adverse Notice of Action. Members submit written appeals to: Magnolia Health Plan Clinical Appeals Coordinator 111 East Capitol St Suite 500 Jackson, MS 39201 MississippiCAN members can request a State Fair Hearing after exhausting all health plan-level Grievance and Appeal procedures. State Fair Hearing requests must be received within thirty (30) days of the member receiving the final decision by the health plan, by writing to: Division of Medicaid, Office of the Governor Attention: Office of Appeals 550 High St., Suite 1000 Jackson, MS 39201 601-359-6050 For more information about filing an appeal for MississippiCAN members, see page 42 or contact the Magnolia clinical appeals coordinator at 866-912-6285. Members who file verbal appeals must follow up with a written, signed appeal unless an expedited resolution is requested.
Additional Provider Resources	For information about additional provider resources: • Call Provider Services: 844-464-5636 • Access the Provider Web Portal at https://pwp.envolvedental.com • Send an email to: providerrelations@envolvehealth.com

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Benefit Options

Benefit Limit Exception (BLE) process for EPSDT medically necessary services.

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Envolve Dental Benefit Limit Exception (BLE) Checklist

When submitting the BLE Request Form, please provide the following additional information:

- ☐ 2012 ADA Form
- ☐ Charting of Decayed/Missing/Restored Teeth
- ☐ Radiographs
- ☐ Medical History
- ☐ Additional Dental Needs/History
- ☐ Treatment Plan
- ☐ Periodontal Charting
- ☐ Photographs
- ☐ BLE Form
- ☐ Narrative of Medical Necessity

BLE Reminders:

- Submit **ALL** documentation to have BLE processed correctly.
- The turn-around time (TAT) is 30 days after BLE is received completed.
- If Envolve Dental has not reached out to you with a faxed request for additional information, and you have not received an Approval/ Denial fax within 30 days, please contact Customer Service to check the status of an existing BLE request.
- A BLE request approval is **NOT** a guarantee of payment.

Please send the requested information by email or mail to the following:

Email: BLE@EnvolveHealth.com

Mail: Envolve Dental, Mississippi Authorizations, Post Office Box 25255, Tampa, FL 33622-5255

Questions: Call Provider Services at 844-464-5636

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Benefit Options

Partner With Us

- Envolve Dental values your participation in our network!
- Provider Services staff are available to answer your calls and questions at 844-464-5636, Monday through Friday, 8:00 AM to 5:00 PM local time.
- Send emails to Envolve Dental at any time at providerrelations@envolvehealth.com or dentalpr@envolvehealth.com. Be sure to encrypt emails if personal health information is included.
- You may also contact me directly at 727-437-1827 or Elroy.Velasquez@EnvolveHealth.com.

Dental & Hearing

2019 Mississippi Medicaid Provider Workshops

MOLINA HEALTHCARE

Dental and Hearing Subcontractor Overview – Avēsis

- 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

Avēsis Provider Resources

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

- **General Covered Benefits:**
  - **Dental Program:** Standard MississippiCAN 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 - Kwiinta Anderson -410-413-9344 or KwAnderson@avesis.com
  3. Provider Relations Internal – Jarhonda Brown – 410-413-9113 or jlbrown@avesis.com
  4. Provider Relations Supervisor - Dana Flood -410-413-9230 or dflood@avesis.com

Claims Payments

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

- A clean claim must include correct member information, provider, rendering service location , and billing information along with services provided.
  - *Please note that the 5 leading zeros must be included as part of the member ID that is printed on the members card.
- Checks are run weekly.
- Electronic Funds Transfer (EFT) payments are deposited weekly.
- Claim filing information
  - Avēsis Provider Portal – to gain access contact your provider relations representative
  - Clearinghouse Submission – Avēsis Payor ID -**86098**
  - On a claim form to:

    Avēsis Dental Claims
    P.O. Box 38300
    Phoenix, AZ 85069-8300
- Online resources – Available at www.avesis.com

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.

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.

Prior Approval Requirements

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

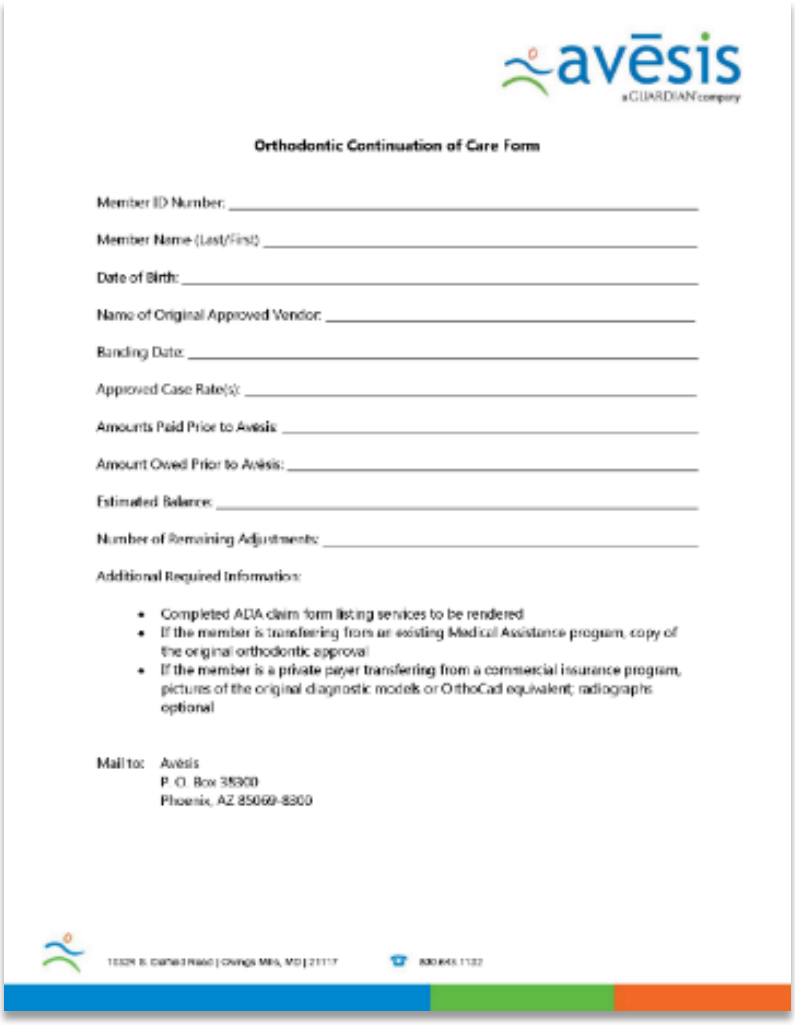
- Providers may submit pre-treatment estimates (PTE) on an ADA claim form to our Phoenix address or by electronic attachment through either the Avēsis provider portal www.avesis.com or NEA (National Electronic Attachment) .
- We recommend electronic submission for quicker turnaround, higher accuracy, 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 member will not receive a denial letter on these services.

Prior Authorization of Dental Treatment in an Outpatient department or Ambulatory Surgery Center setting must be submitted as follows:

- Providers should submit request using ADA code D9999 with the required Molina Mississippi Hospital Worksheet and all services that are requested to be performed on the ADA Claim form.
- If **approved**, the provider is to submit the request to Molina including the Avesis dental authorization to review and determine the approval of the Out- Patient department or ASC facility.
- The final determination with both Avesis Dental and Molina Out- Patient facility Prior Authorization numbers will be emailed or faxed to the provider. The member can then be scheduled for treatment requested.
- A copy of the determination will also be received via mail.
- If **denied**, the provider and member have options listed for the appeals process on the notification received.

Please note that all provider fax, and email information must be kept up to date

Continuation of Care Form



avēsis
a GUARDIAN company

Orthodontic Continuation of Care Form

Member ID Number: _____

Member Name (Last/First) _____

Date of Birth: _____

Name of Original Approved Vendor: _____

Banding Date: _____

Approved Case Rate(s): _____

Amounts Paid Prior to Avesis _____

Amount Owed Prior to Avesis: _____

Estimated Balance: _____

Number of Remaining Adjustments: _____

Additional Required Information:

- Completed ADA claim form listing services to be rendered
- If the member is transferring from an existing Medical Assistance program, copy of the original orthodontic approval
- If the member is a private payer transferring from a commercial insurance program, pictures of the original diagnostic models or OrthoCad equivalent; radiographs optional

Mail to: Avesis
P. O. Box 35300
Phoenix, AZ 85069-8300

avēsis
a GUARDIAN company

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

*To obtain a copy of the Orthodontic Continuation of Care form visit the Avesis provider portal at www.Avesis.com located under the knowledge center and forms.

Credentialing

Credentialing is responsible for ensuring that new providers meet appropriate guidelines and existing providers remain current and recredentialed.

Contact Information:

- **JaRhonda Brown** –Internal Provider Relations Representative, **410-424-9113**
- Monday through Friday, 9:00 a.m. to 4:00 p.m. EST

Key Processes: Initial and Re-Credentialing (every 36 months) for provider network acceptance

Need to Know:

- Submit to the appropriate credentialing mailboxes:
  - Initial credentialing: Credentialingdept@avesis.com
  - Re-credentialing: Re-credentialing@avesis.com
- The Avēsis credentialing Department adheres to NCQA guidelines.
- Provider participation in CAQH is highly preferred.
- Average length of time to credential is 30 to 45 days from receipt of complete application.
- Credentialing Department serves as an internal resource to Provider Relations.

Call When: You believe you have submitted a complete credentialing or recredentialing application, and it has been more than 45 days.

Recredentialing

In order to be compliant with Avēsis corporate policies and procedures *and* National Commission of Quality Assurance (NCQA) requirements, Avēsis is required to recredential contracted providers every (3) three years. Failure to complete the recredentialing process in a timely fashion does significantly challenge your network participation with Avēsis.

The following supporting documents and information must be legible and current:

- Certificate of Professional Malpractice Liability Insurance
- Professional State License
- Federal DEA or CDS Certificate, if applicable
- Board Certification, if applicable
- Work History for past 5 years, include an explanation for each gap of unemployment
- Updated Attestation, must be completed and signed within last 120-days
- Updated W-9 form, special attention to Question #4 must be answered (enclosed)
- Disclosure of Ownership form, applicable copy can be downloaded at https://www.avesis.com

If you have issues with this request, please contact your designated provider relations representative.

Dental

United Healthcare Dental

- Your MS Provider Advocate
- Community Engagement
- Contact Information
- How to Join Our Network
- Preauthorization and Claim Submission
- Provider Web Portal
- Provider Appeals
- Orthodontics
    - Continuity of Care (CoC)

Mississippi Provider Advocate

UnitedHealthcare

Your local Provider Advocate is available to support network providers, recruit new dentists, promote program compliance, and ensure members have access to high quality care.

Debbie Vogt

- Deborah_vogt@uhc.com
- Phone: 952-202-2072

Contact Information

UnitedHealthcare®

NEED:	Address:	Phone Number:	Submission Guidelines:
Claim Submission (initial)	**Claims:** UnitedHealthcare P.O. Box 781 Milwaukee, WI 53201	**1-800-508-4862**	Within 180 calendar days from the date of service
Corrected Claims	**Corrected Claims:** P.O. Box 481 Milwaukee, WI 53201	**1-800-508-4862**	Within 90 calender days of the date of denial
Prior Authorization Requests	**Authorizations/ Retro Authorizations:** UnitedHealthcare P.O. Box 1313 Milwaukee, WI 53201	**1-800-508-4862**	N/A
Provider Administrative/ Claims Appeals	**Claims Appeals:** UnitedHealthcare P.O. Box 1391 Milwaukee, WI 53201	**1-800-508-4862**	Within 30 days from the date of payment or claim determination
Change of Address, Phone Number, Email, Fax or Tax Identification Number (TIN)	UnitedHealthcare Dental P.O. Box 30567 Salt Lake City, UT 84130	**1-800-508-4862**	N/A
UnitedHealthcare Member Complaints & Appeals /Provider UM Appeals	**Grievance and Appeals:** UnitedHealthcare P.O. Box 5032 Kingston, NY 12402-5032	**1-877-743-8731, TTY 711**	Appeals must be submitted within 60 days of the date of authorization decision
State Fair Hearing Requests – Mississippi CAN only	Division of Medicaid Office of the Governor Attn: Office of Appeals 550 High Street, Suite 1000 Jackson, MS 39201	**601-359-6050 or 1-800-421-0488**	Within 120 days from the date of notice of resolution

Joining our Network as a Provider

UnitedHealthcare

UHC Dental Network Advancement

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

3. **Contact UHC to request participation in MSCAN and/or CHIP**
   - 952-202-2072
   - Deborah_vogt@uhc.com

4. **American with Disabilities Act Forms is now required for every participating provider and each location.**

5. **MS Participating physician application - required now by the State.**

6. **Fully executed UHC contract**

Pre-Authorization and Claims Submission

UnitedHealthcare

Providers participating in the MS CAN/MS CHIP program have 180 calendar days from the date of service to submit claims.

- Claims filed within the appropriate time frame but denied may be resubmitted to within ninety (90) calendar days from the date of denial.
- **Claims Payment**

  90% of all clean claims paid within 30 calendar days

  99% of all clean claims paid within 90 calendar days

Pre-Authorization is required for many services, including crowns, dentures, some oral surgery, orthodontia and services performed in the OR/ASC

- Review the latest copy of your dental provider manual for a full list of codes requiring pre-authorization or call the Provider Customer Service Center at 1-800-508-4862.
- Standard authorization decisions are made within 3 calendar days and/or 2 business days

UnitedHealthcare

Dental Claims Issues

- D0330 Panoramic X-ray

  Denials for panoramic x-rays when member changes dentists, and new dentist does their own x-ray.

- Bill Primary Insurer 1st then Resubmit with EOB

  MississippiCAN is required to use the pay and chase method of payment.

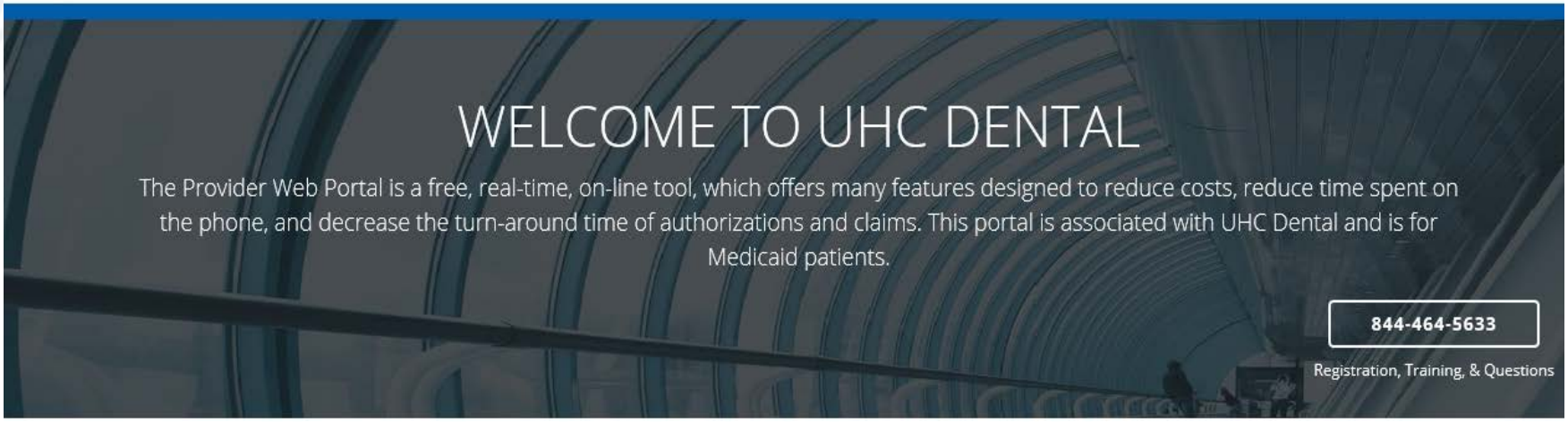
  Preventive pediatric services (including Dental ESPDT services)

Provider Web Portal Submission

- **Link:** www.UHCproviders.com
- **Phone Number:** 1-855-434-9239

You may contact the provider portal number to schedule a one-on-one training on the navigation of the provider portal, or you may request it through your Provider Advocate.

Provider Web Portal – Log In Screen



RETURNING USERS

Username *

Password *

LOGIN

About UnitedHealthcare Community and State Plans

At UnitedHealthcare Community Plan, we look forward to helping our members.

We're one of the largest providers of Medicare and Medicaid coverage on behalf of states across the nation. We offer a wide range of plans designed for:

- Pregnant mothers and their babies.
- Children up to age 19.

PROVIDER ALERTS

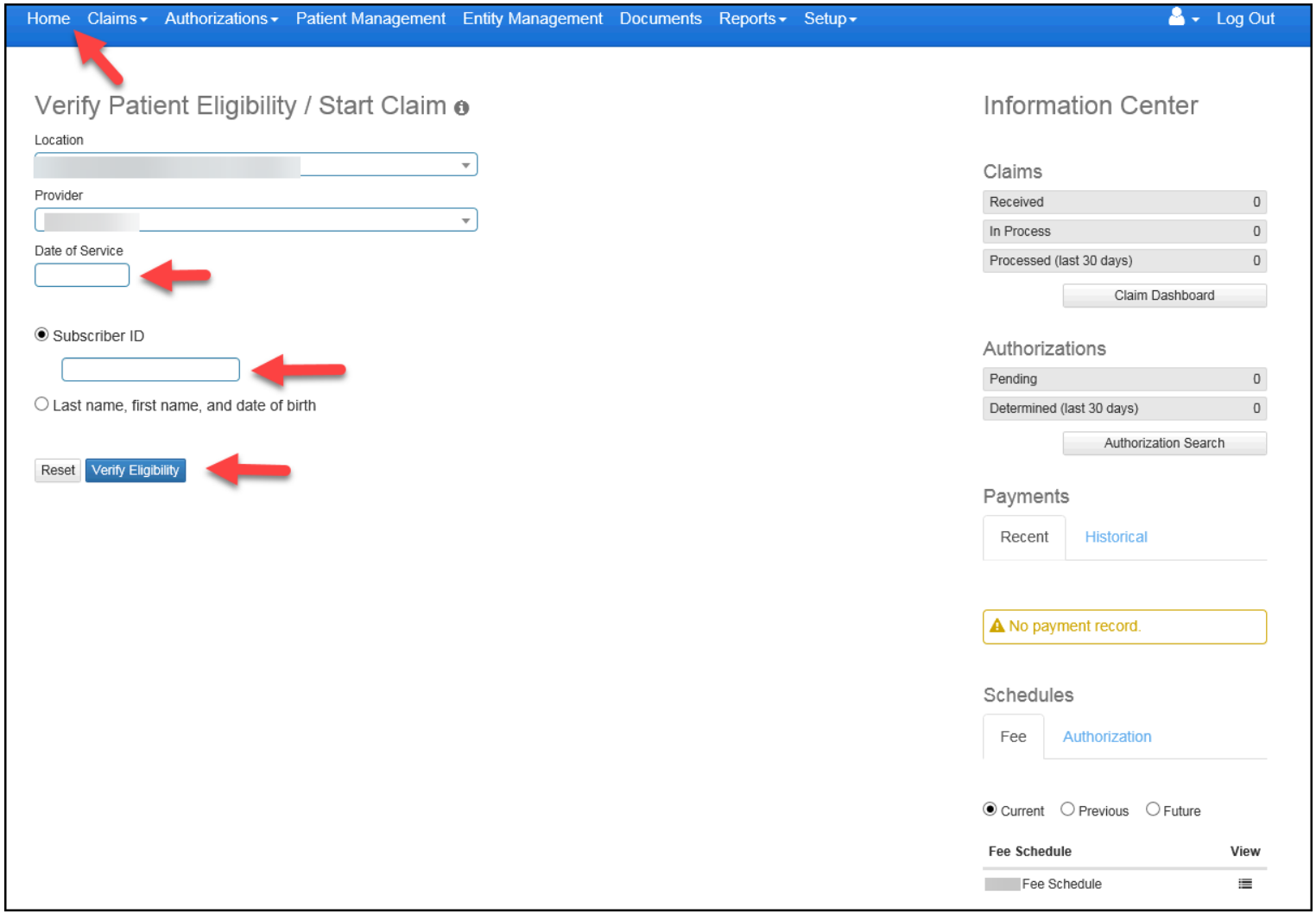
Click here for Forgotten Password Instructions

Click here for Multi-Factor Authentication Instructions

Q. How do I change my demographics with UnitedHealthcare Dental?

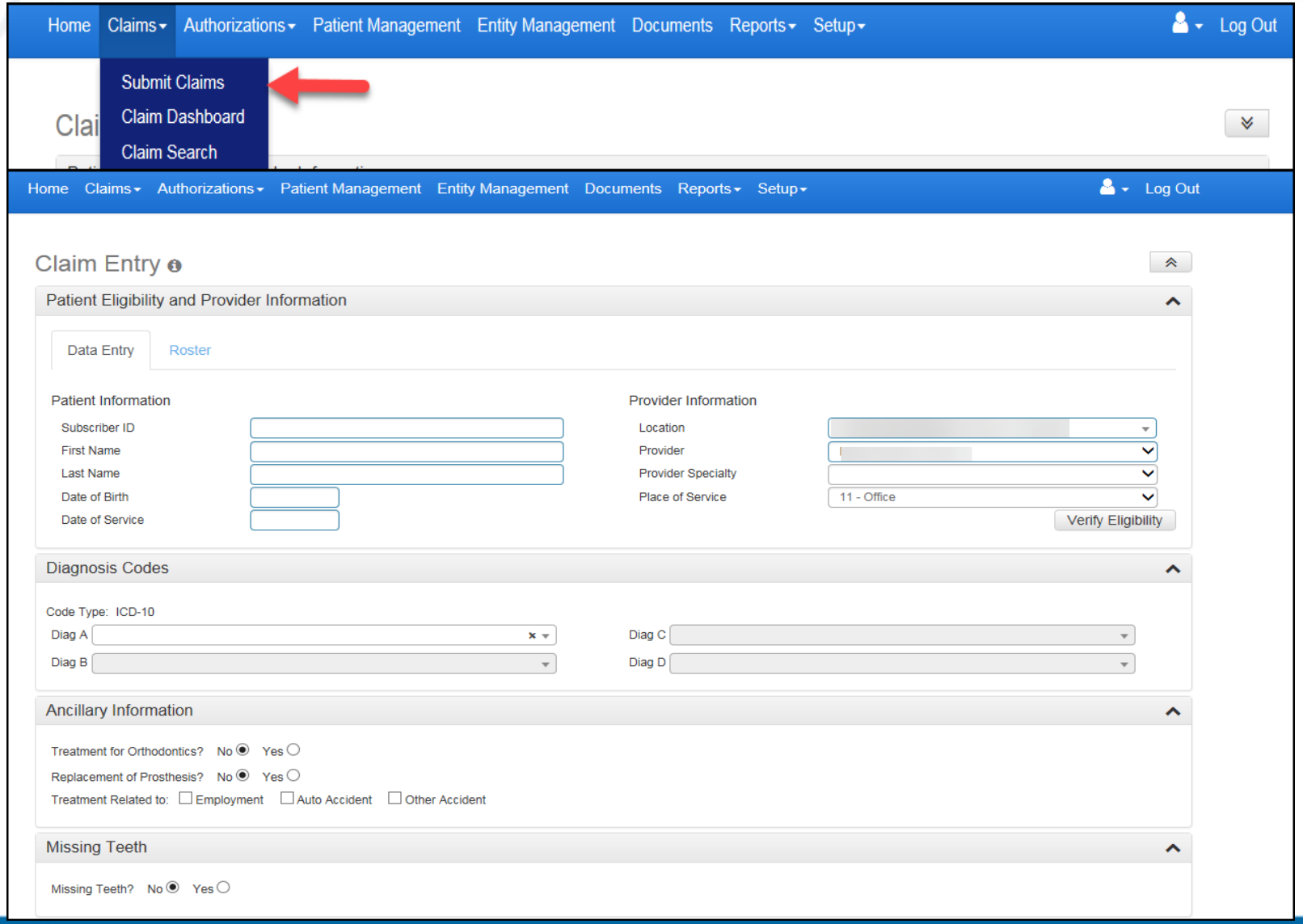
A: Contact UnitedHealthcare Dental Provider Services to make the necessary demographic changes. To

Provider Web Portal – Checking Eligibility

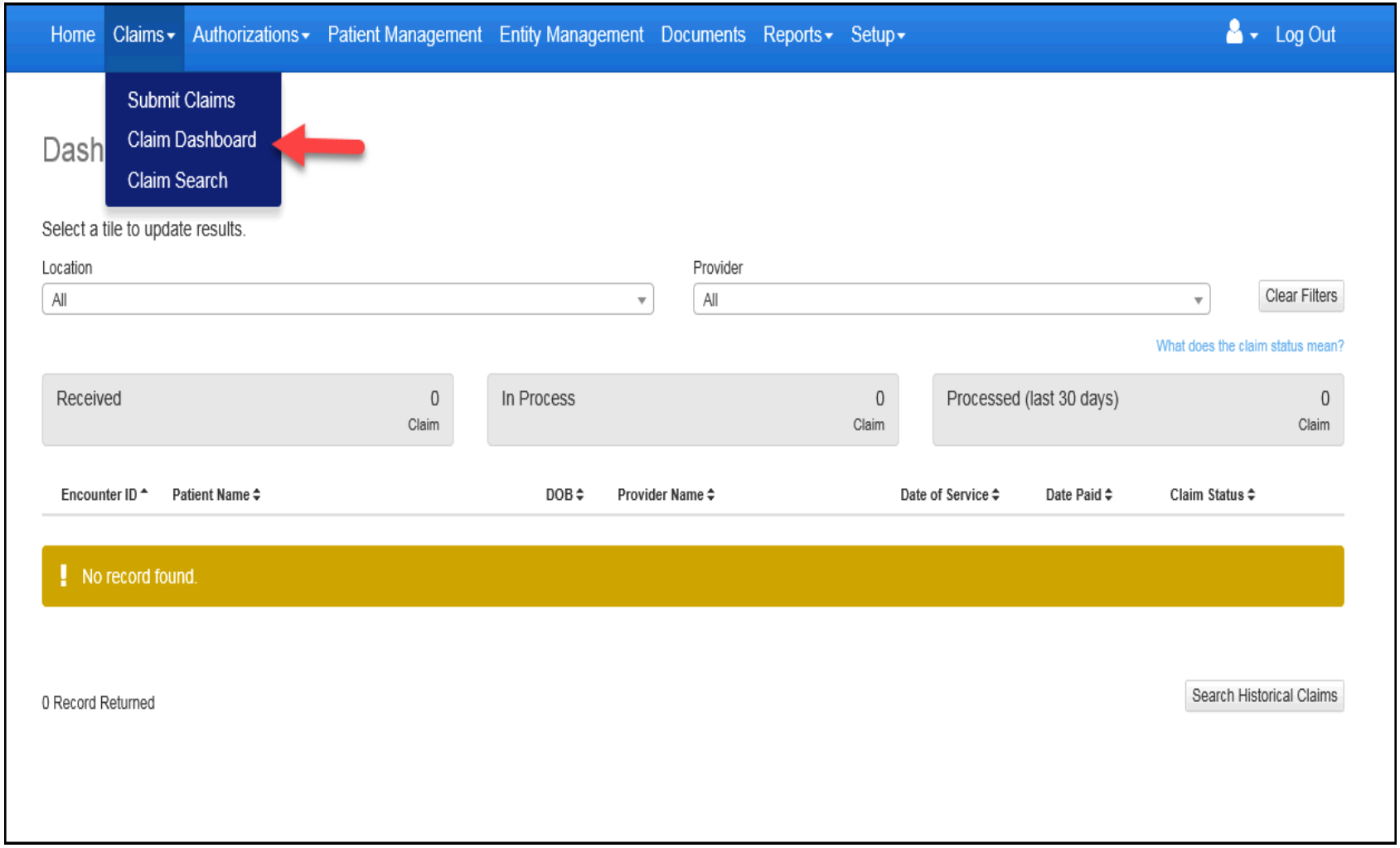


Provider Web Portal – Claim Submission

UnitedHealthcare



Provider Web Portal – Claim Status



Provider Appeals

Providers have 30 calendar days to appeal a claim denial.

UHC will resolve appeals within 30 calendar days of receipt.

By Mail:

United Healthcare Dental
Attn: Provider Appeals
UnitedHealthcare
P.O. Box 1391
Milwaukee, WI 53201

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

Orthodontic Benefits – MS CAN

UnitedHealthcare

Children < 21 years old $4,200 lifetime maximum

UHC will consider orthodontic authorization requests for beneficiaries under 21 who meet at least one of the following pre-qualifying criteria:

- Cleft lip, cleft palate and other craniofacial anomalies
- Overjet of 9 millimeters or more
- Reverse overjet of 2 millimeters or more
- Extensive hypodontia with restorative implications (more than one tooth per quadrant) requiring pre-prosthetic orthodontics
- Anterior open bites greater than 4 millimeters
- Upper anterior contact point displacement with greater than 4 millimeters
- Requiring pre-prosthetic orthodontics
- Individual anterior tooth crossbites with greater than a 2 millimeter discrepancy between retruded contact position and intercuspal position
- Impinging overbite with evidence of gingival or palatal trauma
- Impeded eruption of teeth (except third molars) due to crowding, displacement, presence of supernumerary teeth, retained primary teeth, and any pathologic cause; unless extraction of the displaced teeth or adjacent teeth, requiring no orthodontic treatment would be more expedient.

Orthodontic Benefits – MS CHIP

UnitedHealthcare

Prior authorization is required for all orthodontic benefits

- No benefits will be provided for orthodontics, dentures, occlusion reconstruction, or for inlays unless such services are provided pursuant to an accidental injury as described above or when such services are recommended by a physician or dentist for the treatment of severe craniofacial anomalies or full cusp Class III malocclusions.

Continuity of Care

UnitedHealthcare

CoC

Orthodontic services are restricted to EPSDT eligible beneficiaries who meet criteria as described in the Mississippi Medicaid Administrative Code. Benefits provided and coverage guidelines for MississippiCAN (MSCAN) covered orthodontic services are set forth in accordance with the Administrative Code Part 204.

Providers may submit Continuity of Care (CoC) requests using three (3) methods of submission:

- ✓ Online via the provider web portal at www.uhcproviders.com.
- ✓ Electronic submission via payer ID GP133
- ✓ By mail to:

UnitedHealthcare Community Plan of Mississippi
P.O. Box 1391
Milwaukee, WI 53201

Continuity of Care

UnitedHealthcare

Requirements for all methods of submission:

- All CoC requests must contain Code D8999 and Code D8670
  Code D8670 must include the number of adjustments requested.
- CoC requests received without the required code will result in incorrect processing.
- D8999 must be submitted for CoC requests only.
- Claims should be submitted with the actual services rendered.
- Select the applicable box when submitting a CoC request. Selecting the incorrect box will result in a claim denial.
  For Continuation of Care requests, select “Request for Pre- Determination/Pre Authorization”.
  For claim submissions, select "Actual Services" which indicates that the submission is specifically for a claim.

Continuity of Care

UnitedHealthcare

CoC Required Documentation

1. A copy of the initial orthodontic case approval if applicable;
2. Attestation from the referring or treating primary care dentist that preventive and dental treatment services have been completed;
3. A copy of the orthodontic treatment notes if available from provider that started the case;
4. Recent diagnostic photographs and/or panoramic radiographs and if available pre-treatment ones (comprehensive and exceptions only);
5. The date when active treatment was started and the expected number of months for active treatment and retention with a maximum of 24 visits to be expected to treat a case; and, (If applicable) a new treatment plan and documentation to support the treatment change if re-banding is planned.
6. Payment history for all previous services.

Question & Answer Session