Mississippi Division Of Medicaid

Provider Workshops

2019

MISSISSIPPI DIVISION OF MEDICAID

Morning Agenda

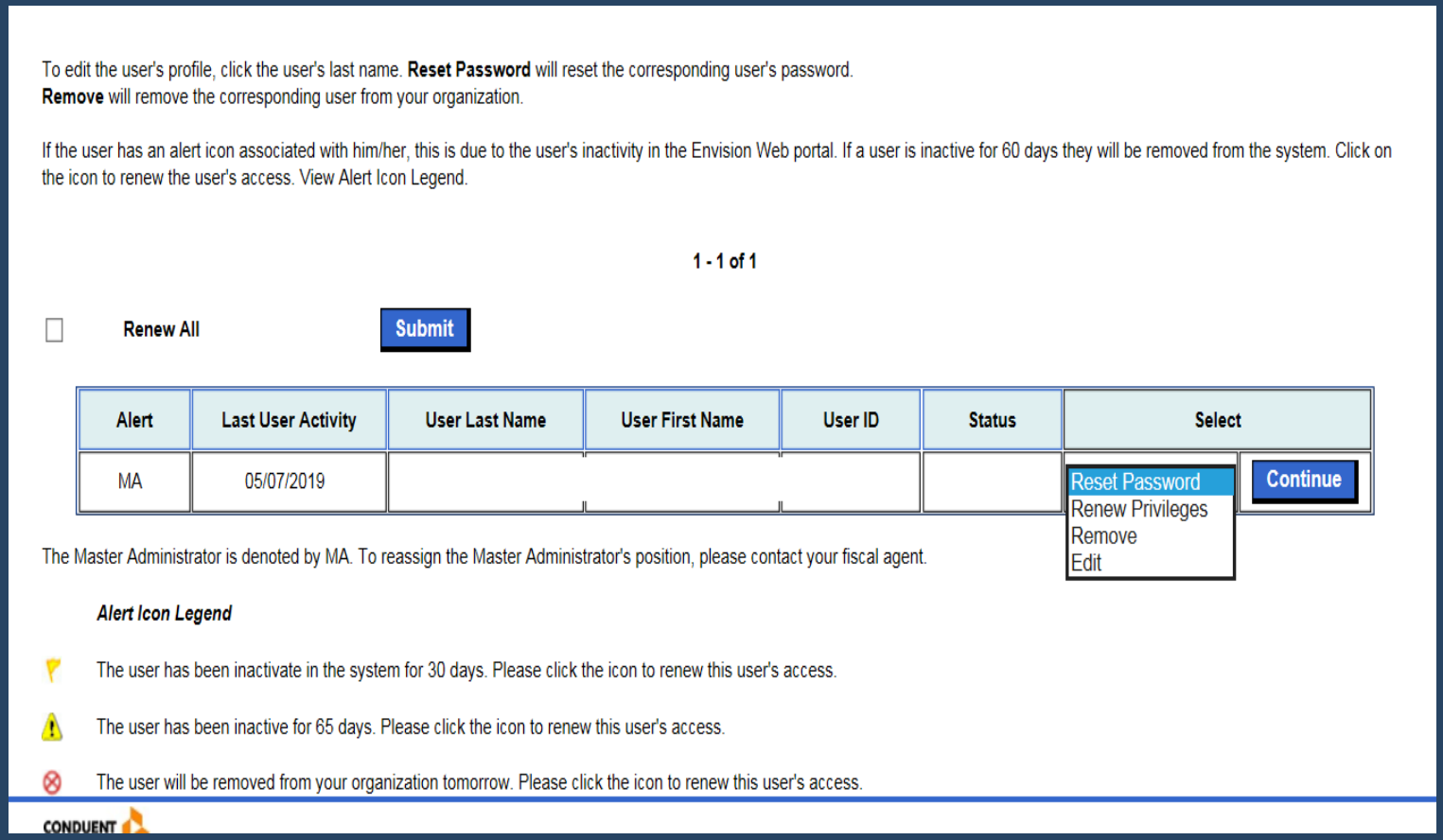
8:30 a.m.	9:00 a.m.	Registration
9:00 a.m.	9:15 a.m.	Welcome & Introductions
9:15 a.m.	11:00 a.m.	**General Medicaid Claims** **Timely Filing** **Managed Care Overview** **Home Health** **Waiver Services**
11:00 a.m.	11:30 a.m.	Question & Answer Session
11:30 a.m.	12:30 p.m.	Help Desk
12:30 p.m.	1:30 p.m.	LUNCH ON YOUR OWN

General Claims Billing, Reviews, and Processing

Table of Contents

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.

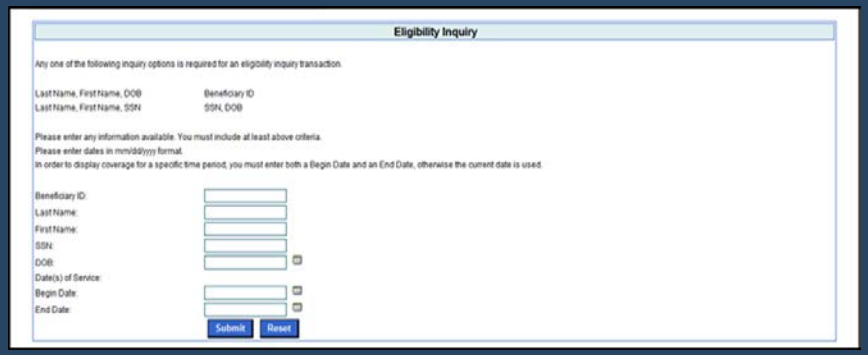
The user will be removed from your organization tomorrow. Please click the icon to renew this user's access.

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

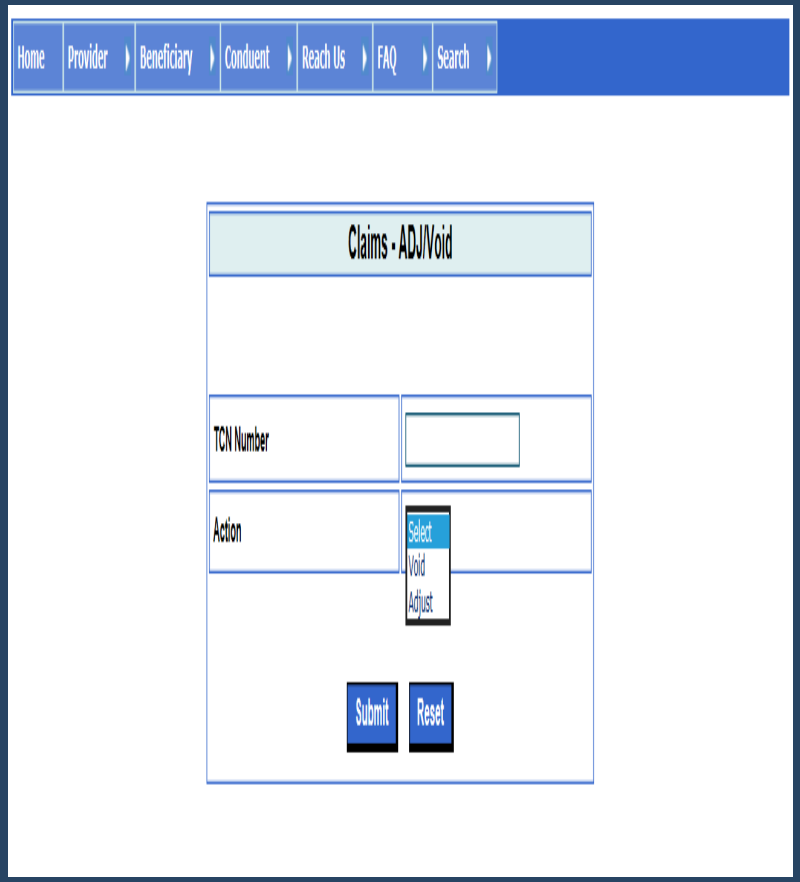


- You may check a Beneficiary's eligibility status by entering the following options:
  - Beneficiary ID or
  - SSN or
  - Beneficiary's name (*first name, last name*) and DOB

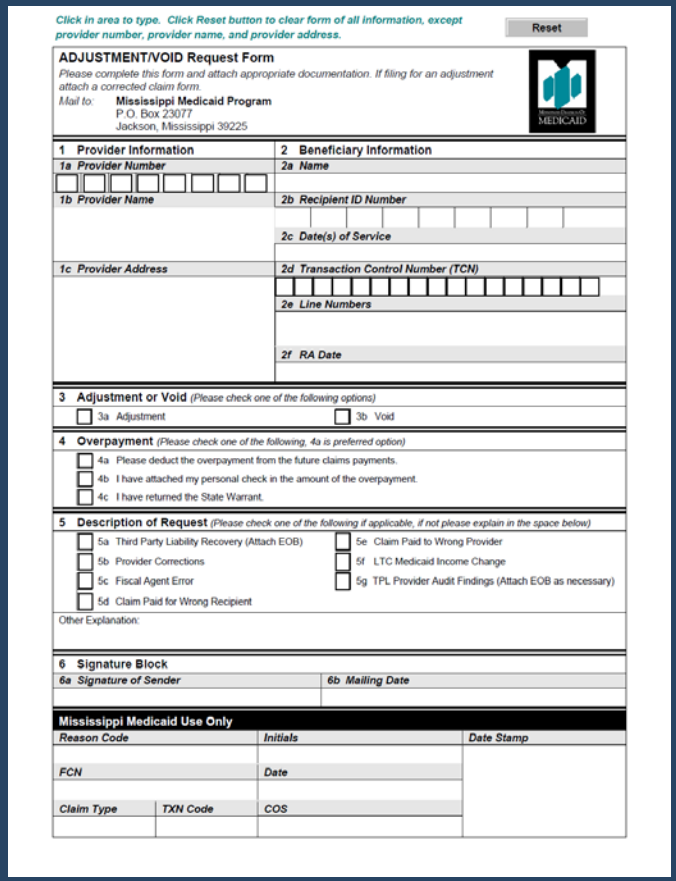
Adjusting and Voiding Claims

- **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

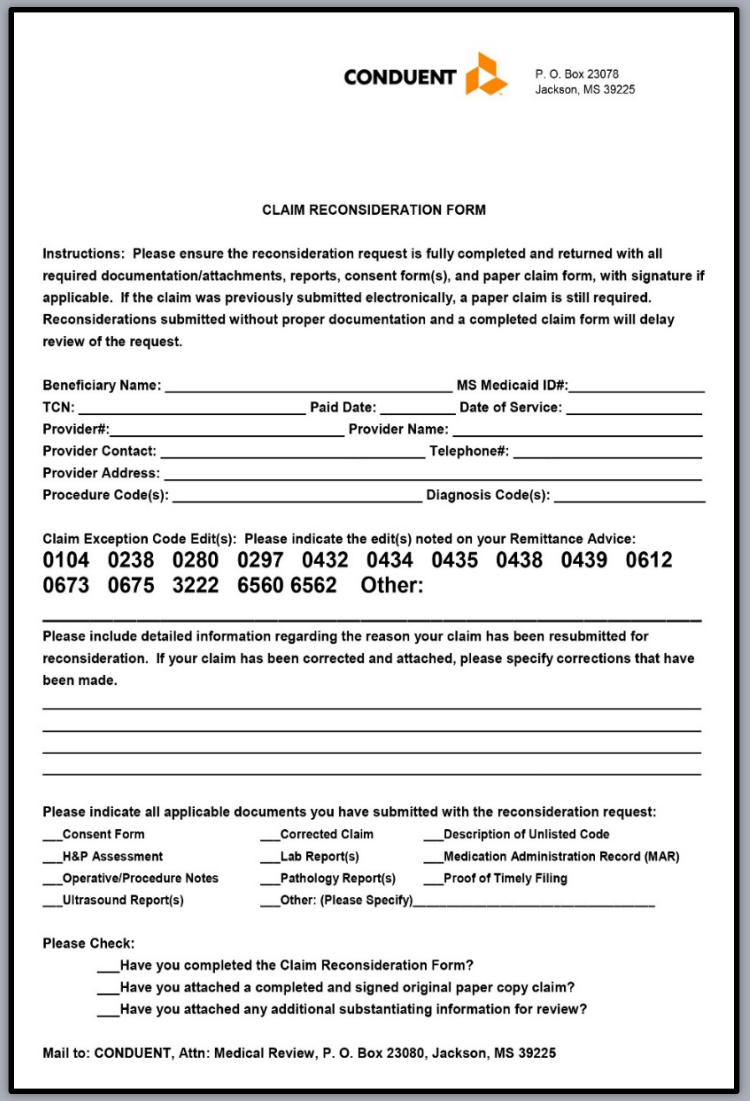
- Submit a RFI or request for public records in writing, by:
- You can submit a RFI or request for public records in writing by contact the Mississippi Division of Medicaid (DOM) multiple ways as listed below, including postal mail, fax and email. It is advised that you do not email forms or submit online 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 fully completed Reconsideration Form should be attached to the claim each time it is sent to Conduent Medical Review.)*

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

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

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

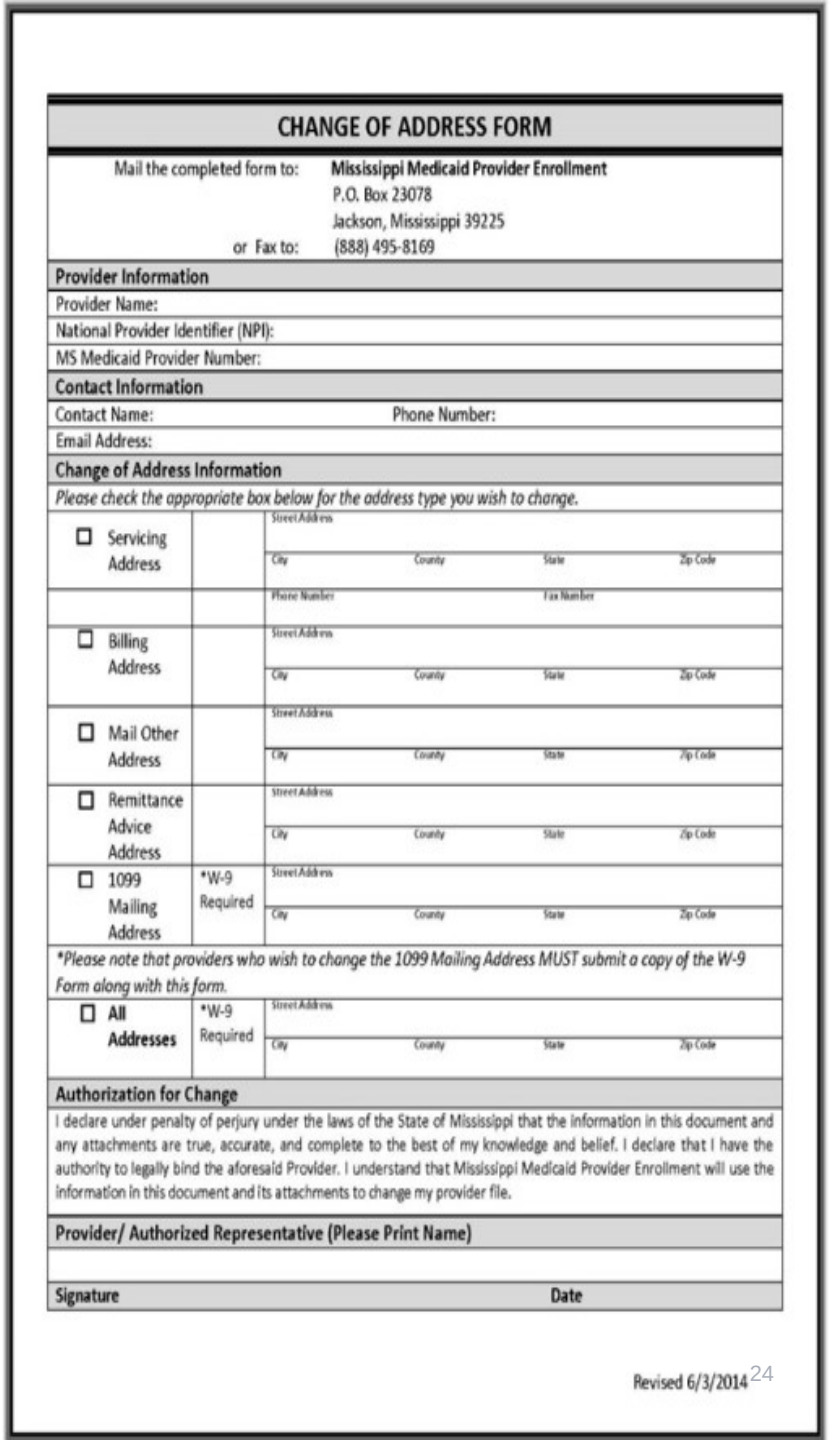
  Fax: 888-495-8169

- 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.

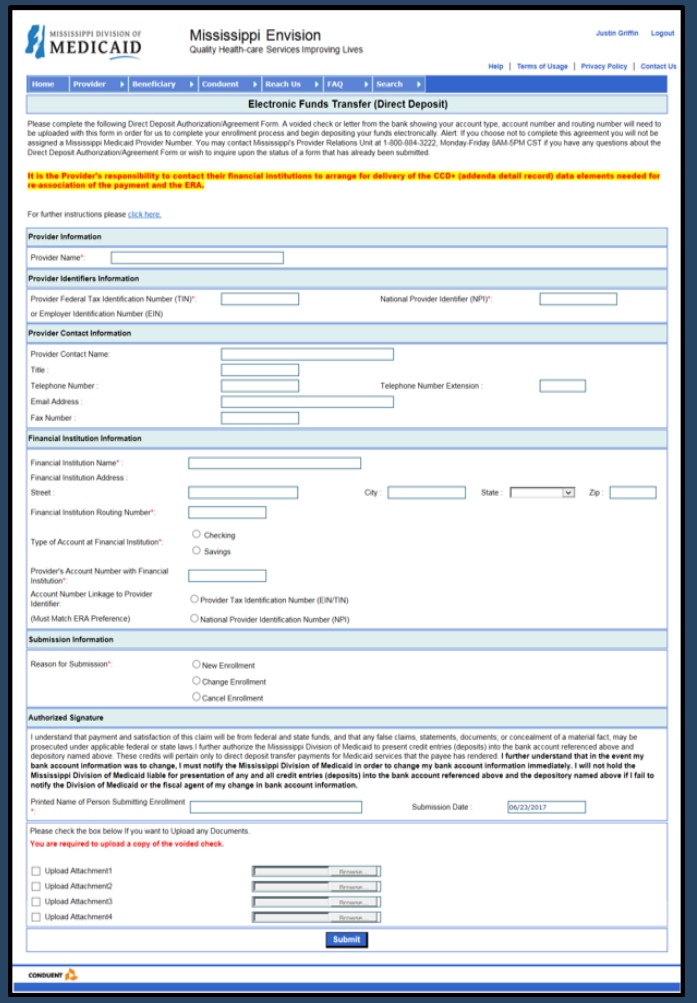
Banking (EFT) Form

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

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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?

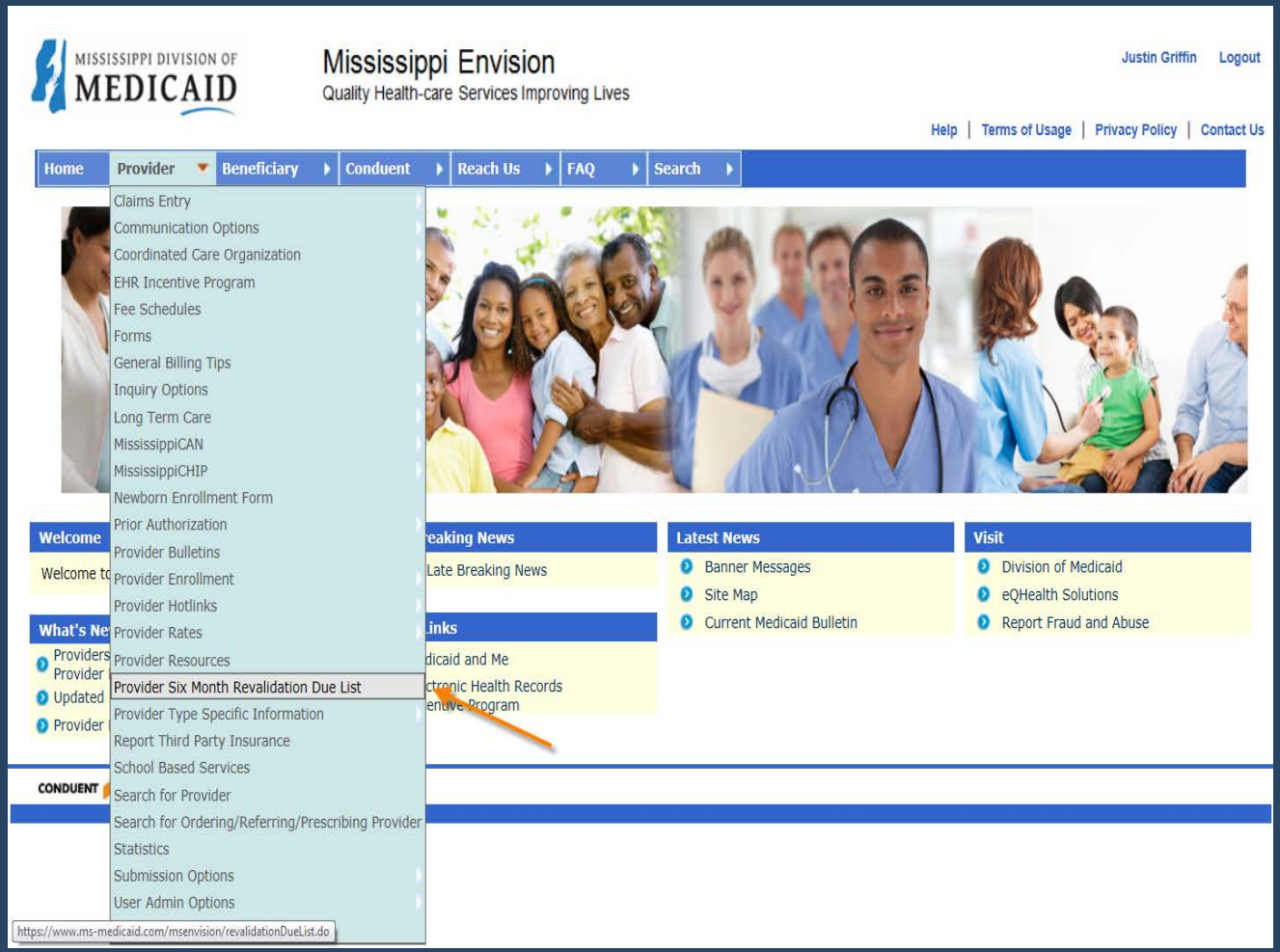
Provider Revalidation – a CMS requirement that mandates that providers who have been enrolled in Medicaid, regardless of provider type, must revalidate at least every five (5) years. Providers will need to verify that the information currently on his/her provider file is accurate and up-to-date in order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

What if I Fail to Revalidate

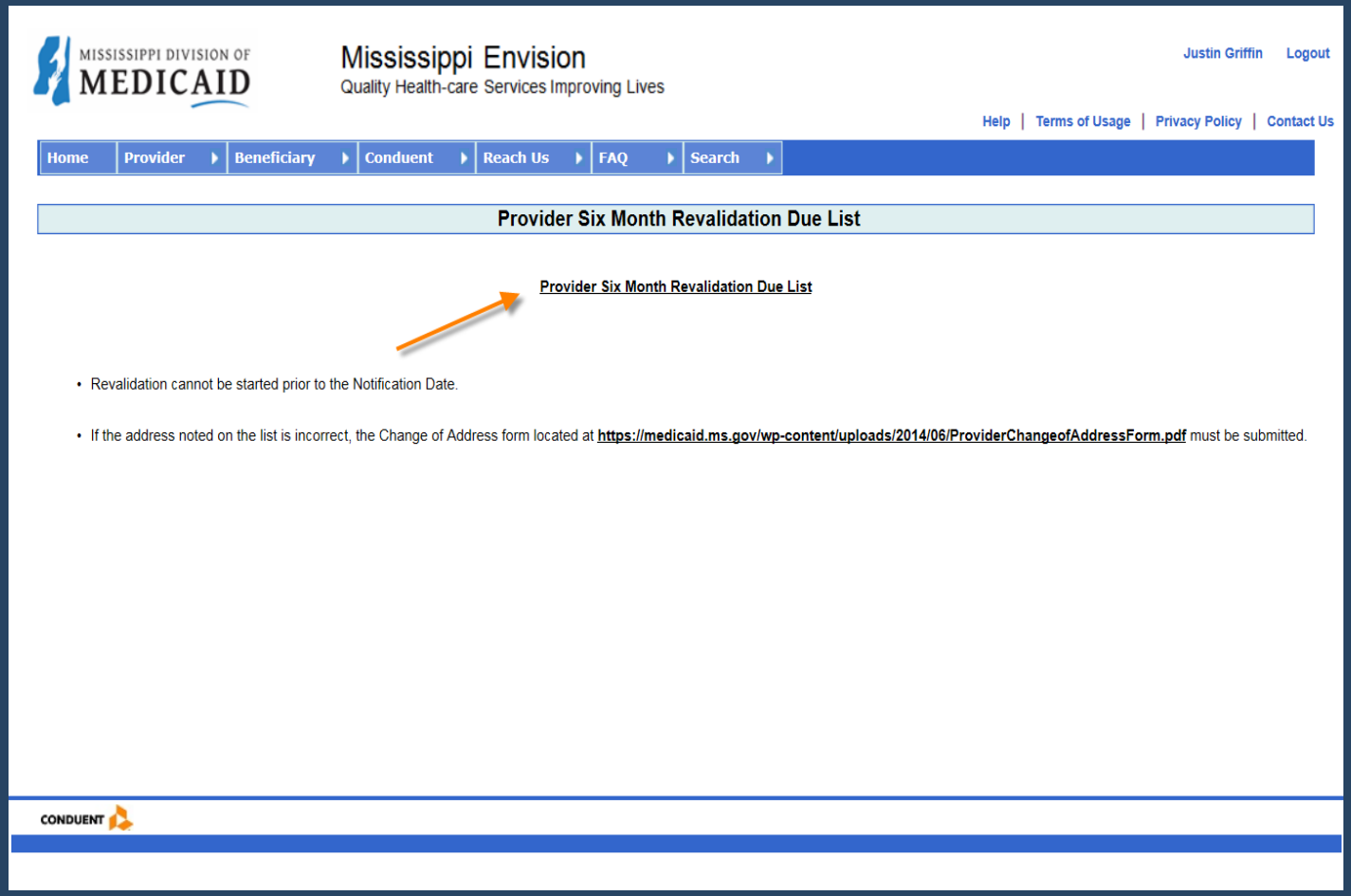
- Providers that fail to revalidate by the deadline will be terminated and required to re-enroll.
- If your Mississippi Medicaid Provider Number is termed due to failure to complete revalidation, your participation with the CCOs (Magnolia and United Healthcare and Molina Healthcare) will be termed as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

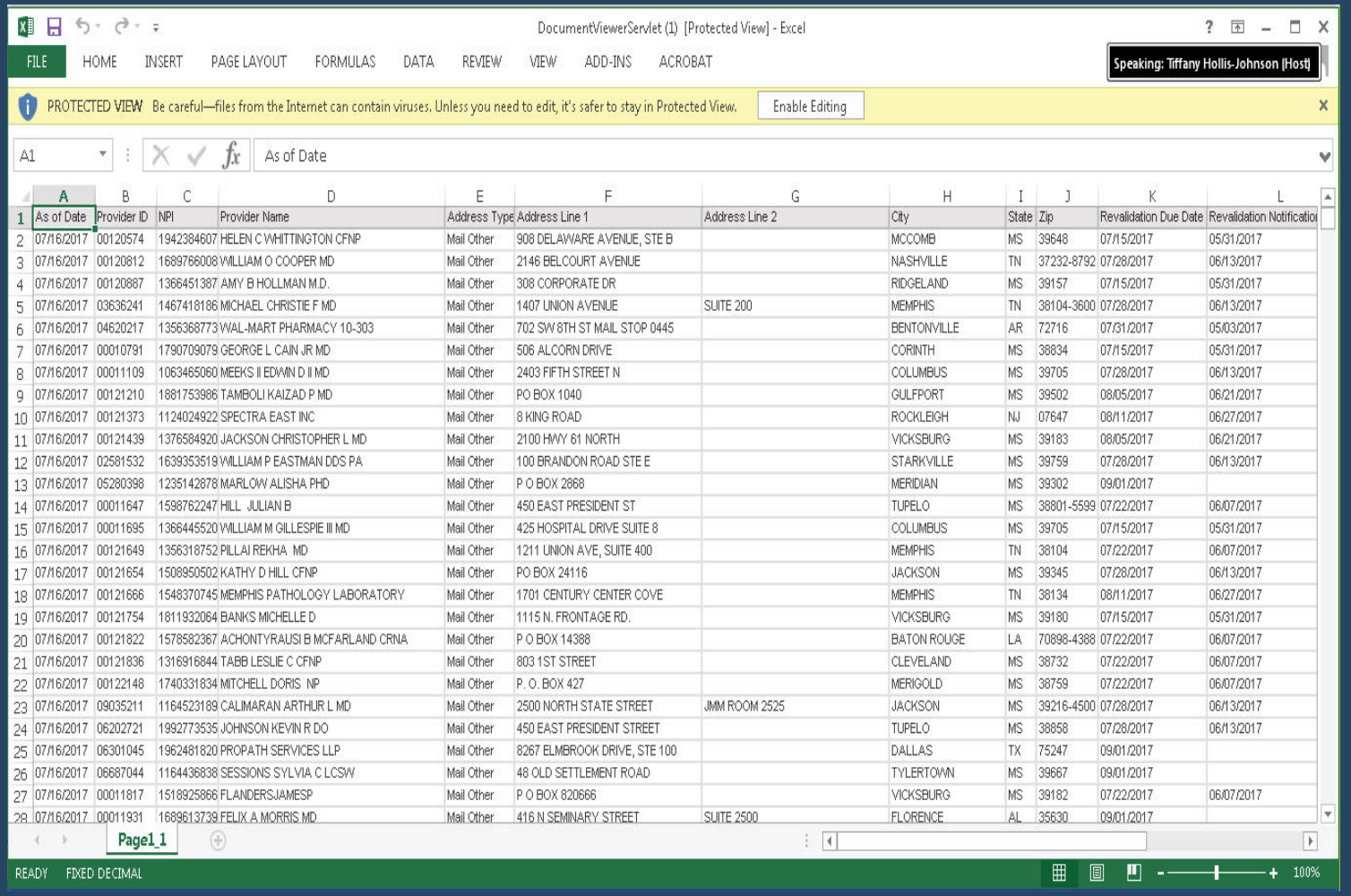
Six Month Provider Revalidation Due List



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
for All Claims Not Paid by June 30, 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:

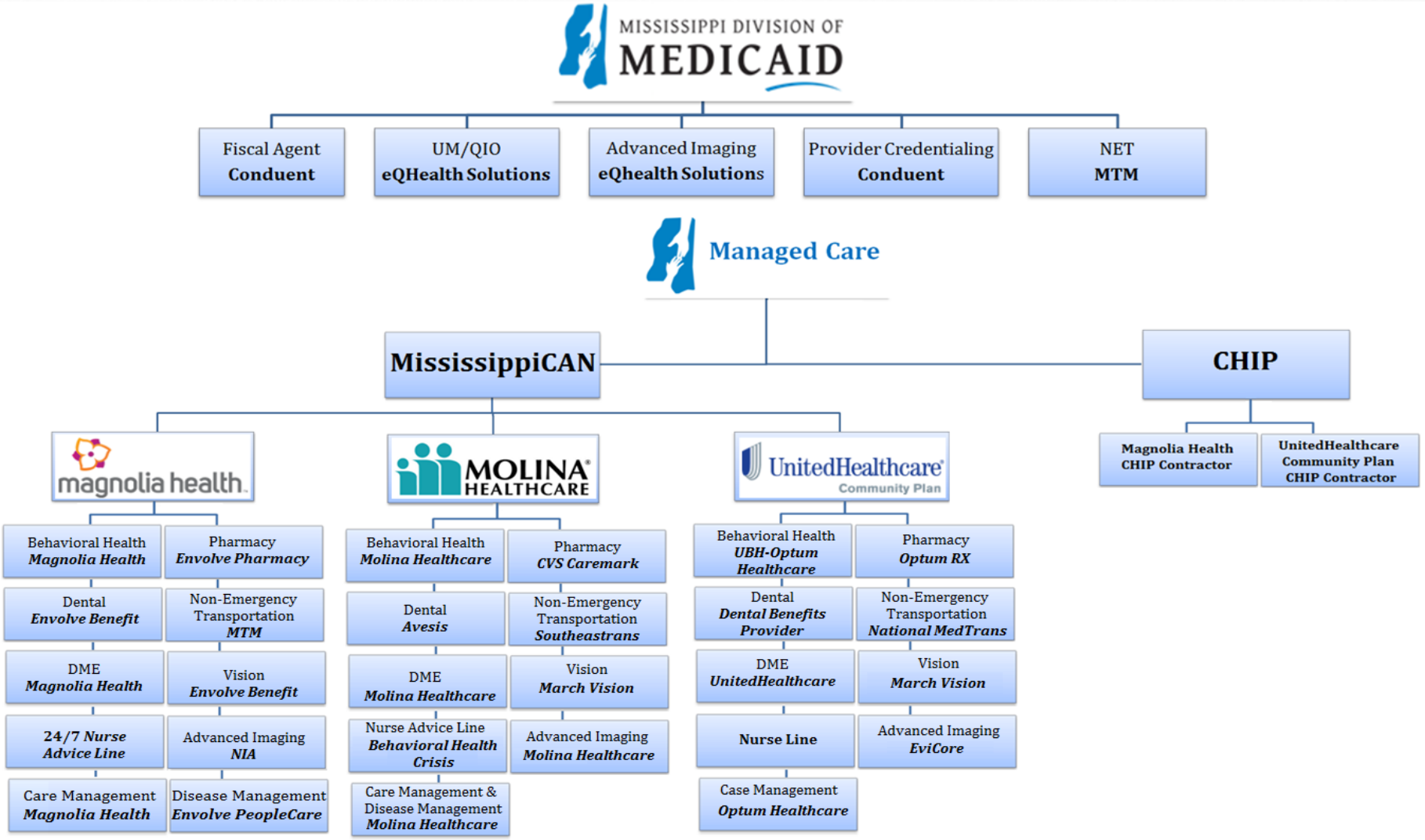
Division of Medicaid
Attention: Office of Appeals
550 High Street, Suite 1000
Jackson, MS 39201

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

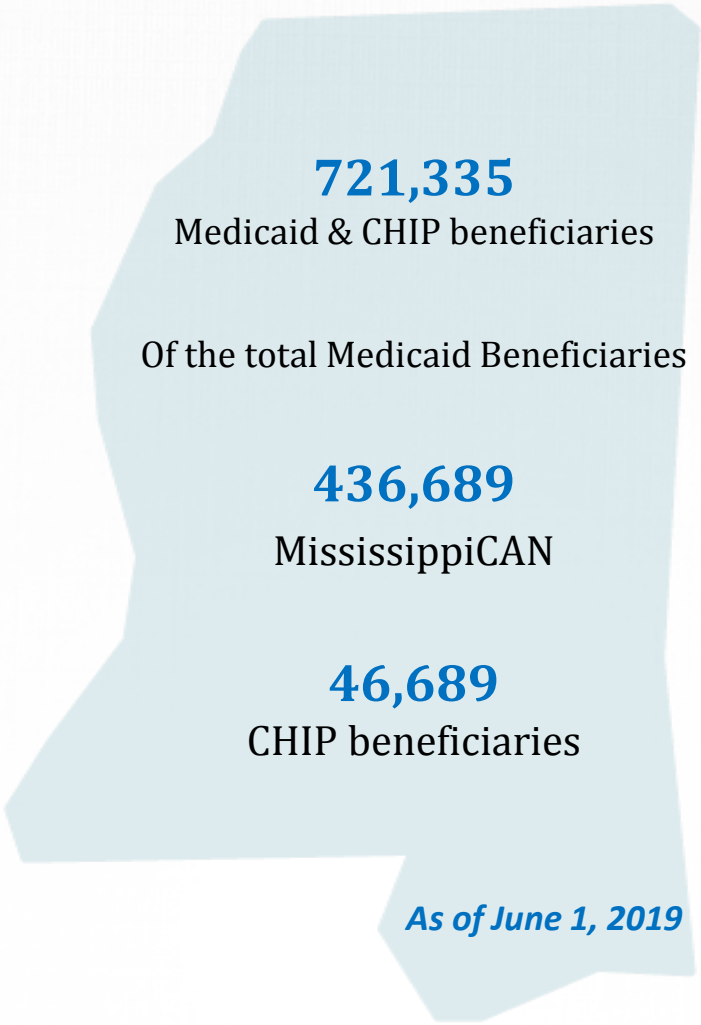
Managed Care Inquiries and Complaints	
Date	
Provider Name	
Provider ID Number	
Facility Name	
Contact Person	
Telephone Number	
Fax Number	
Beneficiary Name	
Beneficiary ID Number	
Telephone Number	
PLEASE PROVIDE DETAILED QUESTIONS AND/OR COMPLAINTS	

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

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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.

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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.

Mississippi Medicaid
Home and Community Based Waivers
(Administrative Code: Title 23: Part 208)

What is a Medicaid Waiver ?

- 1915(c) waivers allow the provision of long term care services in home and community-based settings (HCBS) under the Medicaid Program. States can offer a variety of services under an HCBS Waiver program.
- Programs can provide a combination of standard medical services and non-medical services in order for persons to remain in a home or community-based setting as an alternative to nursing facility or other institutional care.

Mississippi's HCBS 1915(c) Waivers

- Elderly and Disabled **(E&D)** Waiver
- Independent Living ***(IL)*** Waiver
- Traumatic Brain Injury/Spinal Cord Injury ***(TBI/SCI)*** Waiver
- Assisted Living ***(AL)*** Waiver
- Intellectual Disabilities/Developmental Disabilities ***(ID/DD)*** Waiver

Case Management Across Long Term Care Waivers

Case Management is a core service included in each of the waivers administered by the Office of Long Term Care. While Case Management is handled by different providers/entities for each waiver, the service definition reflects the following components uniformly in each waiver application. All Case Managers must:

- Assess an individual's need for services,
- Implement a person-centered planning process that coordinates services (both waivered and non-waivered) to meet those needs,
- Complete regularly scheduled monitoring to ensure that services are being provided in accordance with the approved Plan of Services and Supports and that the individual's needs are continually met, and
- Report all suspicion or allegation of abuse, neglect, or exploitation.

Elderly & Disabled (E&D) Waiver

- Eligibility for the Elderly & Disabled Waiver is limited to age 21 years old and older who, but for the provision of such services, would require the level of care provided in a nursing facility.
- It is a statewide program, administered and operated by the by the Division of Medicaid.
- Beneficiaries of this waiver must be Medicaid eligible either as a Supplemental Security Income (SSI) recipient or meet the income level up to 300% of the SSI federal benefit rate.

E&D Waiver Covered Services

- Case Management
- Adult Day Care
- Home-Delivered Meals
- Personal Care Services
- Institutional Respite Services
- In-Home Respite
- Expanded Home Health Visits
- Community Transition Services

Independent Living (IL)Waiver

- Eligibility for the Independent Living Waiver is limited to individuals age 16 years old or older, who have severe orthopedic and/or neurological impairments. Individuals must also be medically stable and be able to express ideas and wants either verbally or nonverbally with caregivers, personal care attendants, case managers, or others involved in their care.
- It is a statewide program, administered by the Division of Medicaid and operated by the Mississippi Department of Rehabilitation Services (MDRS).

IL Waiver Financial Eligibility

A person must qualify for full Medicaid benefits in one of the following categories of eligibility (COE):

- Supplemental Security Income (SSI)
- Parent/Caretaker group and low income families
- Disabled child living at home
- Working disabled
- Children under age 19 under 100 percent of poverty
- Disabled adult child
- Protected foster care adolescents
- Child Welfare Services Foster children and Adoption Assistance Children
- IV-E foster children and adoption assistance children
- An aged, blind or disabled person who meets all factors of eligibility if your income is under 300 percent of the SSI limit for an individual. If income exceeds the 300 percent limit, you must pay the amount that is over the limit each month to the Division of Medicaid under an income trust, provided you are otherwise eligible.

IL Waiver Covered Services

- Case Management
- Personal Care Attendant
- Environmental Accessibility Adaptations
- Specialized Medical Equipment and Supplies
- Transition Assistance

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

- Eligibility for the TBI/SCI Waiver is limited to individuals who have a traumatic brain injury or a spinal cord injury and are medically stable. The extent of the injury must be certified by the individual's physician. Brain or spinal cord injury that is due to a degenerative condition, congenital condition, or that resulted from medical intervention is excluded.

- It is a statewide program, administered by the Division of Medicaid and operated by the Mississippi Department of Rehabilitation Services (MDRS).

TBI/SCI Waiver Financial Eligibility

A person must qualify for full Medicaid benefits in one of the following categories of eligibility (COE):

- Supplemental Security Income (SSI)
- Parent/Caretaker group and low income families
- Disabled child living at home
- Working disabled
- Children under age 19 under 100 percent of poverty
- Disabled adult child
- Protected foster care adolescents
- Child Welfare Services Foster children and Adoption Assistance Children
- IV-E foster children and adoption assistance children
- An aged, blind or disabled person who meets all factors of eligibility if your income is under 300 percent of the SSI limit for an individual. If income exceeds the 300 percent limit, you must pay the amount that is over the limit each month to the Division of Medicaid under an income trust, provided you are otherwise eligible.

TBI/SCI Waiver Covered Services

- Case Management
- Personal Care Attendant
- Respite
- Environmental Accessibility Adaptations
- Specialized Medical Equipment and Supplies
- Transition Assistance

Assisted Living (AL) Waiver

- The Assisted Living Waiver is a home and community-based waiver that provides services to beneficiaries who, but for the provision of such services, would require the level of care provided in a nursing facility.
- Qualified beneficiaries are allowed to reside in a Personal Care Home-Assisted Living (PCH-AL) facility that is licensed as a PCH-AL Facility by the Mississippi State Department of Health, and is approved as a Medicaid provider for Assisted Living services. Medicaid reimburses for the services received in the facility.

AL Waiver Eligibility

Eligibility for the Assisted Living Waiver is limited to individuals age 21 years old and older, who meet clinical eligibility requirements determined through screening the following areas:

- activities of daily living
- instrumental activities of daily living
- sensory deficits
- cognitive deficits
- client behaviors
- medical conditions
- medical services

Beneficiaries of this waiver must be Medicaid eligible either as a Supplemental Security Income (SSI) recipient or meet the income level up to 300% of the SSI federal benefit rate.

AL Waiver Covered Services

- Case Management
- Personal Care
- Homemaker Services
- Attendant Care
- Medication Oversight/Administration
- Therapeutic Social Recreational Programming
- Intermittent Skilled Nursing Services
- Transportation
- Attendant Call System

Traumatic Brain Injury Slots on the Assisted Living Waiver

The Assisted Living Waiver has five (5) designated waiver slots for people with acquired traumatic brain injuries who are in a family/participant crisis or have behavioral issues that require 24-hour supervision and assistance to successfully thrive in a community or residential setting.

Services provided are to strengthen and support informal and formal services to meet the unique needs, cognitively and behaviorally, for people in a specialized residential setting.

Qualifications for the TBI Residential Facility Setting

The participant must:

- have a diagnosis of acquired traumatic brain injury which is non-degenerative structural brain damage (excludes brain injuries that are congenital or due to injuries induced by birth trauma).
- be in a family/participant crisis or have behavioral issues requiring 24-hour supervision.
- have completed acute rehabilitation treatment.
- be age 21 or older and meet nursing facility level of care.

Home and Community Based Waiver Services (HCBS)

All persons who are eligible to receive Home and Community-Based Waiver Services (HCBS) must first be approved through the Division of Medicaid.

Intellectual Disabilities/Developmental Disabilities Waiver (ID/DD)

- Contact Department of Mental Health at (877) 210-8513

Assisted Living Wavier (AL)

- Contact Division of Medicaid toll-free at (800) 421-2408

Elderly and Disabled Wavier (ED)

- Contact Division of Medicaid toll-free at (800) 421-2408
  (Planning & Development District/Area Agency on Aging list to be provided)

Independent Living Wavier (IL)

- Contact Department of Rehabilitation Services (800) 443-1000

Traumatic Brain Injury/Spinal Cord Injury Wavier (TBI/SCI)

- Contact Department of Rehabilitation Services (800) 443-1000

How to get more information

For more information about the Medicaid Waivers, contact:

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

Office of Long Term Care, Mississippi Division of Medicaid
Toll-free: 800-421-2408
Phone: 601-359-6141
Website: http://medicaid.ms.gov

Intellectually Disabilities/Developmental Disabilities (ID/DD) Waiver

The Intellectually Disabilities/Developmental Disabilities (ID/DD) Waiver provides services to individuals who, but for the provision of home and community-based services, would require placement in an Intermediate Care Facility for Individuals with Intellectual Disabilities.

The ID/DD waiver is administered by the Department of Mental Health, Bureau of Intellectual and Developmental Disabilities.

ID/DD Eligibility

Individuals in this program must qualify for one of the following eligibility categories:

- Supplemental Security Income (SSI)
- Protected foster care adolescent
- Foster children and adoption assistance children
- Disabled Child Living at Home
- Aged, blind, or disabled individuals whose income is under 300 percent of the SSI limit for an individual
- Women and children under age 19, up to 133 percent of the federal poverty level

ID/DD Covered Services

The Department of Mental Health, through its regional centers and assessment process, provides support coordination and makes referrals for the following services:

- Behavior Support
- Day Services-Adult
- Home and Community Supports
- Occupational Therapy
- Physical Therapy
- Speech Therapy
- Supervised Living
- In-Home Respite
- In-Home Nursing Respite
- Community Respite
- Host Homes
- Crisis Support
- Crisis Intervention
- Support Living
- Shared Supported Living
- Transition Assistance
- Support Coordination
- Supported Employment
- Prevocational Services
- Job Discovery
- Specialized Medical Supplies

ID/DD Covered Services

Support Coordination Services is provided by Department of Mental Health's four (4) regional centers and responsible for monitoring and coordinating all the persons services, to ensure the person's health and welfare needs are met.

Day Services-Adult is designed to assist the individual with obtaining, retaining, or improving self-help, socialization, and adaptive skills.

Home and Community Supports is for people who live in the family home and provides assistance with activities of daily living (ADLs), instrumental activities of daily living (IADLs), and inclusion in the community.

Prevocational services are intended to develop and teach an individual general skills that contribute to paid employment in an integrated community setting.

ID/DD Covered Services

Supported Employment provides intensive, ongoing supports which enable people, for whom competitive employment at or above the minimum wage is unlikely without the provision of these supports.

Job Discovery is a time limited service used to develop a person-centered career profile and employment goals or career plan.

Crisis Intervention provides immediate therapeutic intervention, available to person on a 24-hour basis, to address personal, social, and/or behavioral problems which otherwise are likely to threaten the health and safety of the person or others and/or may result in the person's removal from his/her current living arrangement.

Crisis Support is a time limited service that is provided in an ICF/IID when a person's behavior, or family/primary caregiver notification regarding behavior, warrants a need for immediate specialized services that exceeds the capacity of Crisis or Behavior Support Service

ID/DD Covered Services

Supervised Living is designed to assist the participant with acquisition, retention, or improvement in skills related to living in the community.

Supported Living is provided to individuals age 18 and above who reside in their own residences (either owned or leased) for the purposes of increasing and enhancing independent living in the community.

Shared Supported Living services are for persons 18 years of age and older and provided in compact geographical areas (e.g. an apartment complex) in residences either owned or leased by themselves or a provider. Staff supervision is provided at the program site and in the community but does not include direct staff supervision at all times.

Transitional Assistance is a one-time set up expense for persons who transition from an institution to a less restrictive community living arrangement.

ID/DD Covered Services

Host Homes are personal care and supportive services through a family living arrangement in which the principal caregiver in the Host Home assumes the direct responsibility for the participant's physical, social and emotional well-being and growth in a family environment.

In-Home Respite provides temporary, periodic relief to those persons normally providing care for the eligible person.

In Home Nursing Respite are services provided for temporary, periodic relief to the primary caregiver.

Community Respite are services provided in a Department of Mental Health certified community setting.

Specialized Medical Supplies covered under the ID/DD Waiver are specified types of catheters, disposable briefs, and under pads. These supplies are not covered under Medicaid State Plan benefits.

ID/DD Covered Services

Physical, Occupational and Speech Therapy which are in excess of therapy services covered in the Medicaid State Plan, either in amount, duration or scope. Therapy services provided through the ID/DD Waiver begin at the termination of State Plan therapy services.

Behavior Support Services provide assistance for persons whose behaviors are significantly disrupting their ability to remain in the least restrictive setting. This service also includes consultation and training provided to families and staff working with the person.

Home & Community-Based Services (HCBS) State Plan Services

(Administrative Code: Title 23: Part 208; Chapter 7)

Community Support Program (CSP)

- Community Support Program (CSP) provides 1915(i) state plan services to individuals with Intellectual Disabilities and/or Developmental Disabilities or Autism Spectrum Disorder.

- The individual must have significant limitations of functioning in two (2) or more areas of major live activity including self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, and economic self-sufficiency.

- The CSP is operated by the Mississippi Department of Mental Health, Bureau of Intellectual and Developmental Disabilities.

CSP Eligibility

- Individuals in this program must be 18 years or older.
- Cannot be enrolled in another waiver.
- Must receive full benefits Medicaid.

CSP Covered Services

The Department of Mental Health, through its regional centers and assessment process, provides targeted case management and makes referrals for the following services:

- Day Services –Adult
- Prevocational Services
- Supported Employment
- Supported Living

CSP Covered Services

Day Services-Adult is designed to assist the individual with obtaining, retaining, or improving self-help, socialization, and adaptive skills.

Prevocational services are intended to develop and teach an individual general skills that contribute to paid employment in an integrated community setting.

Supported Employment provides intensive, ongoing supports which enable people, for whom competitive employment at or above the minimum wage is unlikely without the provision of these supports.

Supported Living is provided to individuals age 18 and above who reside in their own residences (either owned or leased) for the purposes of increasing and enhancing independent living in the community.

How to get more information

For more information about the Intellectually Disabilities/Developmental Disabilities Waiver or the Community Support Program, contact:

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

- **Office of Mental Health, Mississippi Division of Medicaid**
  Toll-free: 800-421-2408
  Phone: 601-359-9545
  Website: **http://medicaid.ms.gov**

- **Mississippi Department of Mental Health**
  Toll-free: 877-210-8513
  Local: 601-359-1288
  Website: **http://dmh.ms.gov**

Home Health Services

(Administrative code: Title 23 Part 215; Chapter 1; Rule 1.1 – 1.7)

Home Health

In accordance with the Mississippi Medicaid State Plan, the Division of Medicaid covers the following home health services:

- Skilled Nursing Visits
- Home Health Aide Visits
- Durable medical equipment, medical supplies and appliances as described in Miss. Admin. Code Title 23, Part 209.

Home Health is limited to a combined total of twenty-five (25) visits per state fiscal year, through June 30, 2019.

Home Health Visit Limit

State Plan Amendment (SPA) 19-0005 Home Health Visit Increase has been approved by Centers for Medicare and Medicaid Services (CMS), effective July 1, 2019, to allow the Division of Medicaid to increase the number of home health visits from twenty five (25) visits to thirty-six (36) visits per state fiscal year (SFY).

Additionally, SPA 19-005 offers clarification regarding the provider appeals process to include reconsideration prior to an administrative hearing request, effective July 1, 2019.

Home Health Visit Limit (cont.)

Effective July 1, 2019, Home Health visits are limited to a combined total of thirty-six (36) visits per state fiscal year.

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.

Mississippi Medicaid Administrative Code Part 215:
Home Health Services
https://medicaid.ms.gov/wp-content/uploads/2014/01/Admin-Code-Part-215.pdf

Home Health (cont.)

Home Health services require:

- Face-to-face visit with physician or authorized non-physician practitioner prior to initiation of home health visits or provision of durable medical equipment (DME) and appliances
- Provision of home health services in any setting in which 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.

Skilled Nursing

Skilled Nursing Visits are defined as Intermittent or part-time nursing services provided by a

- Registered nurse Employed by a home health agency in accordance with Mississippi State Department of Health, Division of Health Facilities Licensure and Certification standards or
- Registered nurse when no home health agency exists in the area.

Home Health Aide

Home Health Aide Visits are defined as:

- Personal care services provided directly by an aide employed by a home health agency and in accordance with Mississippi State Department of Health, Division of Health Facilities Licensure and Certification standards.
- The home health aide must be an individual who has successfully completed a state-established or other home health aide training program approved by the State.
- Home Health aide services may be provided without a requirement for skilled nursing services and must be supervised by a registered nurse.

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Home Health

8/7/2019

Home Health

- Home health services are defined as skilled nursing visits provided at the member's place of residence.

- In accordance with the Mississippi Administrative Code, Magnolia provides Medicaid-covered services. Magnolia also covers all medically necessary services for EPSDT-eligible members, regardless of service limitations with prior authorization. (EPSDT is applicable to Medicaid and MississippiCAN)

Where do I send my PA request?

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)

Prior Authorizations

Due to the nature of Home Health services, Magnolia allows up to **two (2) business days** after services have been initiated and/or rendered for providers to submit authorization requests.

Home Infusion Services

- Services requested must be listed in the Plan of Care.

- Home Infusion services are not included in the Home Health skilled nursing visit benefit limits.

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Care Management

8/7/2019

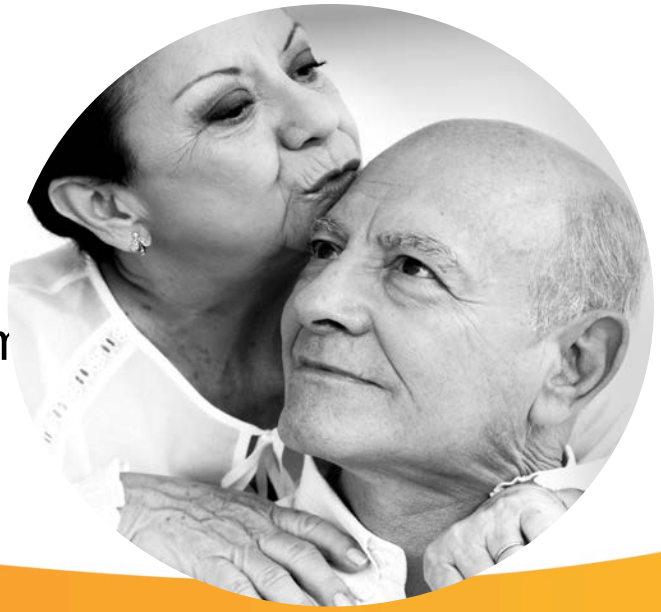
What is Care Management

Magnolia Care Management focuses on Prevention and Preventative Care by supporting and educating the member, closing their care gaps, and making healthy choices.

Key Focus

Integrated Care Management

- Proactive outreach to members with n
- Holistic Approach



Meet The Team

- Care Managers
  - Registered Nurses specially trained in Physical Health and/or Behavioral Health
- Social Service Specialists
  - Social workers and licensed clinical counselors
- Program Coordinators
  - Non-clinical team members
- Community Connection Coordinators
  - Member Locator Team and Community Support

Partnerships

Care Management is partnered with the following departments to ensure they meet members where they are with a 100% member approach

- Pharmacy
- Quality Assurance
- Medical Directors
- Utilization Management
- DME Suppliers

Prior Authorization Requests

- Some medical and behavioral health services require prior authorization. Standard prior authorization requests should be submitted for medical necessity as soon as needed service is identified.

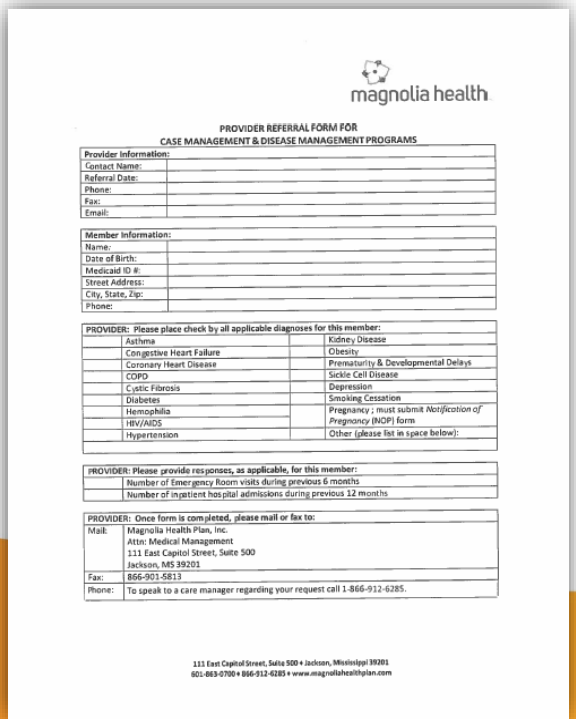
- Verify whether pre-authorization is necessary, use our online tool, https://www.magnoliahealthplan.com/providers/preauth-check.html

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

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

Care Management Referrals

To refer members to care management, providers may access our Secure Web Portal and complete the Provider Referral Form located on www.magnoliahealthplan.com



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PROVIDER REFERRAL FORM FOR
CASE MANAGEMENT & DISEASE MANAGEMENT PROGRAMS

Provider Information:	
Contact Name:	
Referral Date:	
Phone:	
Fax:	
Email:	

Member Information:	
Name:	
Date of Birth:	
Medicaid ID #:	
Street Address:	
City, State, Zip:	
Phone:	

PROVIDER: Please place check by all applicable diagnoses for this member:			
	Asthma		Kidney Disease
	Congestive Heart Failure		Obesity
	Coronary Heart Disease		Prematurity & Developmental Delays
	COPD		Sickle Cell Disease
	Cystic Fibrosis		Depression
	Diabetes		Smoking Cessation
	Hemophilia		Pregnancy ; must submit *Notification of Pregnancy* (NOP) form
	HIV/AIDS		Other (please list in space below):
	Hypertension		

PROVIDER: Please provide responses, as applicable, for this member:	
	Number of Emergency Room visits during previous 6 months
	Number of inpatient hospital admissions during previous 12 months

PROVIDER: Once form is completed, please mail or fax to:	
Mail:	Magnolia Health Plan, Inc. Attn: Medical Management 111 East Capitol Street, Suite 500 Jackson, MS 39201
Fax:	866-901-5813
Phone:	To speak to a care manager regarding your request call 1-866-912-6285.

111 East Capitol Street, Suite 500 • Jackson, Mississippi 39201
601-863-0700 • 866-912-6285 • www.magnoliahealthplan.com

Discharge Planning

Post Discharge Assessment

- A post discharge assessment is completed following the hospital stay for all members enrolled in care management, and members who score 50 or higher on the readmission risk score.
- This assessment includes questions to the member regarding the reason that they sought hospital treatment, whether the member has a primary care provider, details about their medications, discussions about follow up care.
- Outreach is initiated within 72 hours of member discharge from the hospital.
- Magnolia has various brochures, newsletters, and other mailing material for members, such as:
  - Disease-specific educational material,
  - Neonatal Intensive Care Unit (NICU) kits for babies,
  - Sickle Cell kits for our Sickle Cell members,
  - Scale program for our Congestive Heart Failure (CHF) members,
  - Inhalers/spacers for our Asthma members.

UnitedHealthcare®
Community Plan

Home Health Services

Home Health Services

UnitedHealthcare Community Plan

Sometimes continued care is needed after leaving the hospital or urgent care.
For example, after a serious illness, surgery or injury, a nurse will make home visits to:

- Provide medical care.
- Answer any questions and concerns.

- **Prior Authorization:**

  Children - Prior Authorizations required

  Adults - Prior Authorizations required. Limited to 25 visits per calendar year.
  (Effective July 1, 2019, Adult visits will increase to 36 per calendar year)

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

- **Home Infusion:**

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

Case Management
Behavioral and Medical

UnitedHealthcare Community Plan

Facilitating the coordination and continuity of care to ensure that our members' physical, behavioral, and social needs are met

Data Sources (include, but not limited to)

- Short health risk assessments conducted during new Member Welcome Calls
- Member-reported health needs during calls made to our Member Services Department
- Pharmacy and laboratory information indicating the incidence of a specific condition (e.g., insulin or inhalers)
- Emergency room utilization reports, authorization requests, and transitional care coordination requests.
- Physician referrals
- Referrals from health departments, Rural Health Clinics, and FQHCs
- UnitedHealthcare Community Plan clinical staff referrals

Multi-Disciplinary Team

- Registered Nurses
- Behavioral Health Advocates
- Community Health Workers
- Physician Advisor
  - Medical
  - Behavioral
- Pharmacy Advisor

MISSION Helping people live healthier lives.

VISION Be the most trusted name in healthcare.

UnitedHealthcare Community Plan's Case Management office

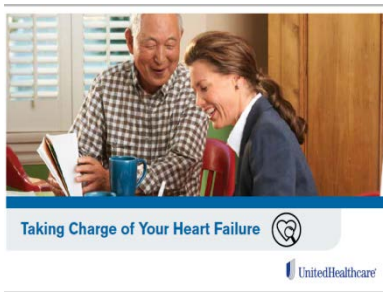
877-743-8731

Case Management
Behavioral and Medical

UnitedHealthcare Community Plan

Care Management helps members get the care needed, and is *available to all members*.
Our care managers provide:

- Telephone contact, home visits, facility visits
- Health education and educational materials
- Health Assessment
- Plan of Care
- Care Coordination
- Appointment Scheduling
- Referrals to community resources, as needed
- Assistance with medical transportation
- PRTF Discharge Planning
- MYPAC Management
- Transitional Care Management



Our **Disease Management** program includes management for conditions such as Asthma, Diabetes, Congestive Heart Failure, COPD, CAD.

The program includes:

- Disease specific education during care management enrollment.
- Member mailings.

For more information or to make a referral, call member services and request a referral at 877-743-8731.

Home Health Services

2019 Mississippi Medicaid Provider Workshops

MOLINA HEALTHCARE

Home Health Services

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

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

Pre-Service Review

Pre-service review is required for ANY HOME HEALTH VISIT following the initial evaluation visit.

Adult members are limited to 25 home health care visits a year.

Children are not limited; however, authorizations are required.

The pre-service review process ensures 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. tests/procedures, 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 apprised 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 prior 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.

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

- 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 criteria based sets.

Prior Authorization Reconsideration

- Requests for authorization not meeting criteria must be reviewed by a designated Molina Medical Director or other appropriate clinical professional. Only a licensed physician (or pharmacist, psychiatrist, doctoral level clinical psychologist or certified addiction medicine specialist as appropriate) may determine to delay, modify or deny services to a Member for reasons of Medical Necessity.
- Board certified licensed Providers from appropriate specialty areas must be utilized to assist in making determinations of Medical Necessity, as appropriate. All utilization decisions must be made in a timely manner to accommodate the clinical urgency of the situation, in accordance with regulatory requirements and NCQA standards.
- Providers may contact Molina's Healthcare Services **Utilization Management** team at **(844) 826-4335** to obtain Molina's UM Criteria.

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 – 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.

- Following Molina appeal resolutions, 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.

Top 5 Reasons for Delay in PA Request

Our #1Goal is to get your PA request correct and returned to the you as soon as possible

- Incorrect Fax number on the Submitted PA request
- Not enough clinical information to make a medical determination
- Call to UM department to change dates or service or add CPT codes
- Unreadable PA request or insufficient information(i.e. NPI #, CPT codes, TIN#)
- Incorrect use of URGENT/STANDARD PA request type

The lack of critical information can create multiple phone calls or outreach attempts that can cause delays in getting an Prior Authorization number back.

Specialty Pharmaceuticals and Infusion Services

- Many self-administered and office-administered injectable products require Prior Authorization (PA).

- In some cases they will be made available through a vendor.
  - Molina's pharmacy vendor will coordinate with Molina and ship the prescription directly to your office or the Member's home.
  - All packages are individually marked for each Member, and refrigerated drugs are shipped in insulated packages with frozen gel packs.
  - The service also offers the additional convenience of enclosing needed ancillary supplies (needles, syringes and alcohol swabs) with each prescription at no charge...

Specialty Pharmaceuticals and Infusion Services – Prior Authorizations

- All authorization requests will be reviewed based on
  - Medical Necessity
  - Prior Authorization Criteria
  - Provider network Status
  - PA Request Form
    - PA request mail, fax or sent via the provider portal
    - Attach additional documentation of other treatment failures with other drugs or treatments, if necessary.

Question & Answer Session

Afternoon Agenda

1:30 p.m.	3:00 p.m.	**Therapy Services** *-Physical* *-Occupational* *-Speech Therapy*
3:00 p.m.	3:30 p.m.	Question & Answer Session
3:30 p.m.	4:30 p.m.	Help Desk

Therapy Services

(Administrative Code: Title 23; Part 213; Chapters 1, 2, 3 and 4)

Physical Therapy (PT)

The Division of Medicaid defines Physical Therapy as:

- Medically prescribed services designed to develop, improve or restore neuro-muscular or sensory-motor function, relieve pain, or control postural deviations.
- Services are concerned with the prevention of disability, and rehabilitation for congenital or acquired disabilities, resulting from or secondary to injury or disease.
- Mississippi Administrative Code Part 213: Therapy Services
  Chapter 1: Physical Therapy
  https://medicaid.ms.gov/wp-content/uploads/2014/01/Admin-Code-Part-213.pdf

PT Covered Services

Physical therapy services require the knowledge, skill, and judgment of a state-licensed physical therapist.

The Certificate of Medical Necessity (CMN) for the initial referral/order is completed by the prescribing provider prior to the physical therapy evaluation.

The plan of care (POC) is developed by a state-licensed physical therapist.

The prescribing provider approves the initial/revised POC with a signature and date:

- Before the initiation of treatment or change in treatment, or
- Within thirty (30) calendar days of the verbal order for the initial treatment plan or change in treatment.

PT Covered Services (Cont.)

Physical therapy services are rendered as individualized therapy consistent with the symptoms and diagnosis, and do not exceed the beneficiary's needs.

The services do not duplicate another provider's services including those services provided in a school-based setting.

PT Reimbursement

The Division of Medicaid reimburses for covered physical therapy services provided by:

- A state-licensed physical therapist.
- A state-licensed physical therapist assisted by a state-licensed physical therapist assistant under direct, on-site supervision by a state-licensed physical therapist.

The Division of Medicaid covers physical therapy services in the outpatient setting when medically necessary, ordered by a physician, physician assistant or nurse practitioner, and prior authorized by the Division of Medicaid or a designated entity, and when certain requirements are met.

NOTE: *Refer to Administrative Code Part 213, Chapter 1, Rule 1.3 for a list of requirements.*

Occupational Therapy (OT)

The Division of Medicaid defines Occupational Therapy as:

- Medically prescribed services that address developmental and/or functional needs related to the performance of self-help skills, adaptive behavior, and/or sensory, motor and postural development.
- Services include therapeutic goal-directed activities and/or exercises used to improve mobility and Activities of Daily Living (ADL) functions when such functions have been impaired due to congenital and/or developmental abnormalities, illness or injury.

OT Covered Services

Occupational therapy services require the knowledge, skill and judgment of a state-licensed occupational therapist.

The Certificate of Medical Necessity (CMN) for the initial referral/order is completed by the prescribing provider prior to the occupational therapy evaluation.

The plan of care (POC) is developed by a state-licensed occupational therapist.

The prescribing provider approves the initial/revised POC with a signature and date:

- Before the initiation of treatment or change in treatment, or
- Within thirty (30) calendar days of the verbal order for the initial treatment plan or change in treatment.

OT Covered Services (cont.)

Occupational therapy services are rendered as individualized therapy consistent with the symptoms and diagnosis and do not exceed the beneficiary's needs.

The services do not duplicate another provider's services including those services provided in a school-based setting.

OT Reimbursement

The Division of Medicaid reimburses for covered occupational therapy services provided by:

- A state-licensed occupational therapist.
- A state-licensed occupational therapist assisted by a state-licensed occupational therapist assistant under direct, on-site supervision by a state-licensed occupational therapist.

The Division of Medicaid covers occupational therapy services in the outpatient setting when medically necessary, ordered by a physician, physician assistant or nurse practitioner, and prior authorized by the Division of Medicaid or a designated entity, and when certain requirements are met.

NOTE: *Refer to Administrative Code Part 213, Chapter 2, Rule 2.3 for a list of requirements.*

Speech Therapy (ST)

The Division of Medicaid defines Speech Therapy as:

- Medically prescribed services necessary for the diagnosis and treatment of communication impairment and/or swallowing disorder that has occurred due to disease, trauma or congenital anomaly.

The Children's Health Insurance Program (CHIP) coverage for Speech Therapy states:

- Medically necessary speech therapy services prescribed by the enrollee's practitioner and specified in a treatment plan. Speech therapy is not covered for maintenance speech, delayed language development, or articulation disorders.

ST Covered Services

Speech-language pathology (speech therapy) services require the knowledge, skill and judgment of a state-licensed speech-language pathologist or audiologist.

The Certificate of Medical Necessity (CMN) for the initial referral/order is completed by the prescribing provider prior to the speech-language pathology or audiology evaluation.

The plan of care (POC) is developed by a state-licensed speech-language pathologist or audiologist.

The prescribing provider approves the initial/revised POC with a signature and date:

- Before the initiation of treatment or change in treatment, or
- Within thirty (30) calendar days of the verbal order for the initial treatment plan or change in treatment.

ST Covered Services (cont.)

Speech-language pathology and audiology services are rendered as individualized therapy consistent with the symptoms and diagnosis and do not exceed the beneficiary's needs.

The services do not duplicate another provider's services including those services provided in a school-based setting.

ST Reimbursement

The Division of Medicaid reimburses for covered speech-language pathology and audiology services provided by:

- A state-licensed speech-language pathologist or audiologist.
- A state-licensed speech-language pathologist or audiologist assisted by a speech-language pathology or audiology student who is enrolled in an accredited speech-language pathology or audiology program while completing the clinical requirements necessary for graduation under direct, on-site supervision of a state-licensed speech-language pathologist or audiologist, referred to as student assisted speech-language pathology or audiology services.

The Division of Medicaid covers speech-language pathology and audiology services in the outpatient setting when medically necessary, ordered by a physician, physician assistant or nurse practitioner, and prior authorized by the Division of Medicaid or a designated entity, and when certain requirements are met.

NOTE: *Refer to Administrative Code Part 213, Chapter 3, Rule 3.3 for a list of requirements.*

Therapy Direct Supervision

The Division of Medicaid defines direct supervision as a state licensed therapist physically being on the premises where services are rendered and is available for immediate assistance during the entire time services are rendered.

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 213: Therapy Services
https://medicaid.ms.gov/wp-content/uploads/2014/01/Admin-Code-Part-213.pdf

magnolia health™

Therapy Services

8/7/2019

Recent Therapy Changes

Effective April 8, 2019

Magnolia no longer requires prior authorization for Physical Therapy, Occupational Therapy and Speech Therapy codes for MSCAN members age 12 and under.

Therapy Evaluations

Prior Authorization for Initial Evaluation for Physical Therapy, Occupational Therapy and Speech Therapy services is not required for MSCAN and CHIP.

Therapy Services-MSCAN

Prior Authorization is required for Physical Therapy, Occupational Therapy and Speech Therapy services for members age 13 and over after completion of the Initial Evaluation and for continuation of therapy.

Therapy Services-CHIP

Prior Authorization is required for Physical Therapy, Occupational Therapy and Speech Therapy services after completion of the Initial Evaluation and for continuation of therapy.

Where do I send my PA request?

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)

Coordination of PA's Between Other Payers

- In the event a member is transferring to Magnolia from another payer, Magnolia shall be responsible for the costs of continuation of medically necessary services.

- Magnolia will honor prior authorizations from Medicaid and MSCAN/CHIP CCO's.

Top Issues

- Requests for continuation of therapy services without providing supporting clinical documentation such as attendance during last authorization period, Home Exercise Program (HEP) compliance and objective documentation of progress toward goals set at Initial Evaluation.

- All services rendered to MSCAN recipients must be performed by a Mississippi Medicaid provider.

- Electronic signatures must have a date and time associated with it.

PA Denials and Recourse

- **Peer to Peer**

  Conducted by the Medical Director

  1-866-912-6285

- **Appeal**

  All appeal documents will be fully investigated.

- **State Hearing**

  If dissatisfied with appeal resolution, a member or authorized representative may request a hearing

Peer to Peer Review

- If the treating physician/practitioner does not agree with an adverse determination, the practitioner may discuss the decision with the Medical Director who rendered the decision.

- Contact information:

  1-866-912-6285

  Request the UM Department

Prior Auth. Appeals Address

If services have not been rendered, then

Prior authorization appeals should only be mailed to the address below:

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

Therapy Services

2019 Mississippi Medicaid Provider Workshops

MOLINA HEALTHCARE

Services Provided – (PT,OT,ST)

Therapy Services include

- Active POC (Plan of Care)
- Therapy within 30 days of the treatment plan
- Certificate of Medical necessity by prescribing provider
- Measurable goals

Therapy Services not included

- Services that do not meet medical necessity
- Services of duplicate therapy
- Services provided by Physical therapy aide
- Services in a group setting

Top 5 Issues – (PT,OT,ST)

- Failure to submit in a timely manner
- Failure to obtain PA in timely manner after Plan of Care expired.
- Insufficient clinical to support Plan of Care, lack or Face-to-Face
- Call to UM department to request change to existing PA request
- Unreadable PA request or Missing information (NPI#,TIN#)

Prior Authorizations Submissions

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

Notification is required for all emergent inpatient admissions within twenty-four (24) hours of admission or by the close of the next business day when emergent admissions occur on weekends or holidays.

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

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

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

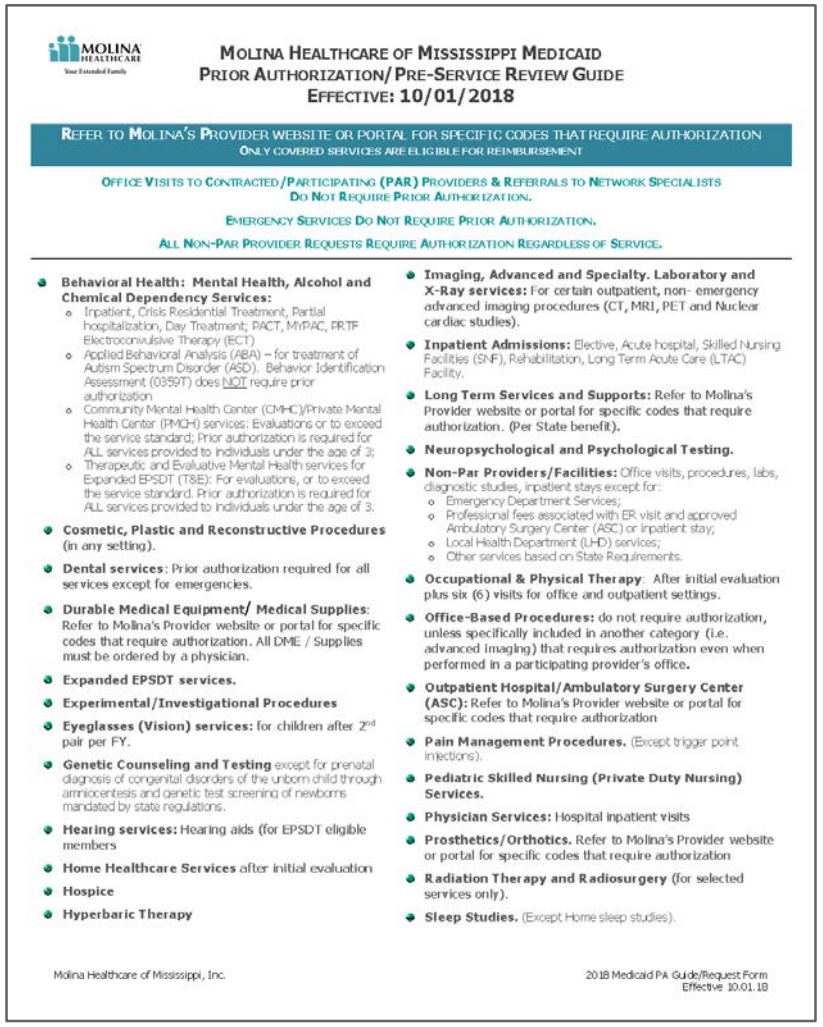
Behavioral Health Authorizations:
Phone: 1 (844) 826-4335
Inpatient Requests Fax: 1 (844) 207-1622
All Non-Inpatient Fax: 1 (844) 206-4006

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

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 prior 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.

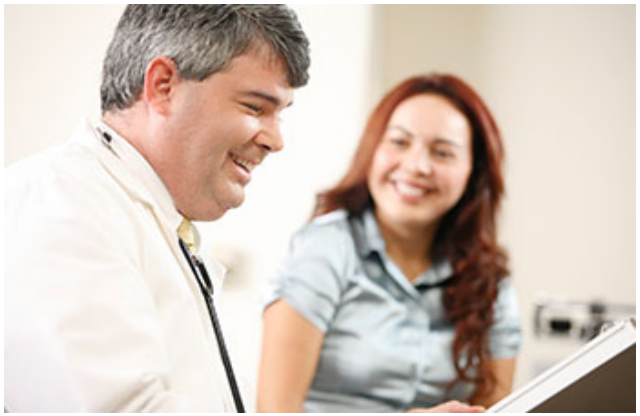
- Providers can contact Molina's Healthcare Services Utilization Management team at **(844) 826-4335** to obtain Molina's UM Criteria.

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.



Top 5 Reasons for Delay in PA Request

Our #1Goal is to get your PA request correct and returned to the you as soon as possible

- Incorrect Fax number on the Submitted PA request
- Not enough clinical information to make a medical determination
- Call to UM department to change dates or service or add CPT codes
- Unreadable PA request or insufficient information(i.e. NPI #, CPT codes, TIN#)
- Incorrect use of URGENT/STANDARD PA request type

The lack of critical information can create multiple phone calls or outreach attempts that can cause delays in getting an Prior Authorization number back.

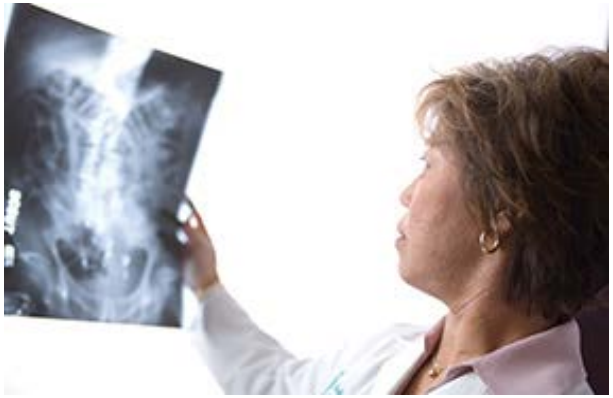
Coordination of Care and Services

There are two (2) main coordination of care processes for Molina Members.

1. The First occurs when new Members enroll in Molina, and need transitional medical from Molina contracted Providers.

    - Member and Provider Contact Center will provide assistance in obtaining authorizations, transferring to contracted DME Vendors, receiving approval for prescription medications, etc.

2. The second coordination of care process occurs when a Molina Member's benefits will be ending and they need assistance in transitioning to other care.



Coordination of Care and Services

It is Molina's Policy to provide Members with advance notice when a Provider will no longer be in Network.

The Provider leaving the Network shall provide all appropriate information related to the course of treatment.

Acute Conditions or Serious Conditions
Following termination the Terminated provider will continue to provide Covered Services to the member for 90 Days or longer, if necessary, for safe transfer of care.

High Risk of Second or Third Trimester Pregnancy
The Terminated provider will continue to provide services following termination until postpartum services related to delivery are completed.

Rejected vs Denied Claim

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

Rejected Claim
Claim does not meet basic claims processing requirements. A few examples of rejected claims include the use of an incorrect claim form, required fields are left blank or required information is printed outside the appropriate fields.

Denied Claim
The claim has been reviewed and was determined not to meet payment requirements. A few examples of reasons for denied claims include an invalid modifier, a missing: provider address, date of service or NPI and corrected claims indicator or original claim number.

Top Billing Errors

Error	Resolution
Duplicate claim/service submission	If a claim is in process, resubmitting duplicate claim will not speed up claim processing for payment
No prior authorization on file	For services that require authorization, provider should obtain authorization prior to submitting claim and/or rendering services
Procedure code inconsistent with modifier	To ensure that claims are as accurate as possible, cross-check with medical coding resources to ensure the correct code and modifier combination is being used
Missing/incomplete/invalid replacement claim information	Corrected Claim can be submitted via EDI or E-Portal
Procedure not covered when performed for reported diagnosis code	To ensure that claims are as accurate as possible, cross-check with medical coding resources to ensure the correct code and modifier combination is being used

ClaimsNet Top Denials & Rejections

Error	Resolution
Baby claim submitted with mother's ID number	Claims must be submitted with member's own unique ID number
Claim for inpatient hospital care with POS 21 missing Date of Admission	For services that require authorization, provider should obtain authorization prior to submitting claim and/or rendering services
Patient Relationship to Insured not checked off as Self	Provider should validate all required fields are checked off and filled out correctly prior to submitting claim
Invalid/missing member ID	Member ID can be submitted with or without leading zero's. When leading zero's are added, it must only contain 5 leading zeros

UnitedHealthcare
COMMUNITY & STATE

Physical Therapy
Occupational Therapy
Speech Language Pathology

UnitedHealthcare

Physical Health (PT & OT)

- The Optum utilization review process/clinical submission form is not required, at this time, for UnitedHealthcare Community Plan MississippiCAN members.

- There are currently no PA requirements for PT or OT services

Physical Therapy & Occupational Therapy

UnitedHealthcare COMMUNITY & STATE

Top Issues

Mississippi CAN	Mississippi CHIP
Claims	
Inactive Member	Inactive Member
Duplicate Claim	Duplicate Claim
Timely Filing	Send Primary Carriers EOB
Send Primary Carriers EOB	Timely Filing
Claim Submission Error	Service Not Covered

Speech Therapy

- Prior authorization is required for CPT 92507
- **Top Issues**
  - Incomplete information
  - Required documentation not submitted
    - Certificate of Medical Necessity
    - Member Evaluation
    - Plan of Care
  - Documentation does not support medical necessity
  - No prior authorization request submitted

Speech Therapy
Coordination/Denial/Appeal

UnitedHealthcare COMMUNITY & STATE

Documentation

- Provider/Facility Demographics
  - Requesting and Rendering
- Member Demographics
- Requested Date of Service
- Requested Procedure Codes
- Diagnoses
- Supporting Documentation as Needed

Coordination of PAs

- Continuity of Care for medically necessary services up to 90 calendar days.
- May require PA - medical necessity review for continuation after 30 days.
- Request PA following standard procedures
- Provide documentation of prior PA approval upon PA request submission; indicate continuity of care.

PA Denials

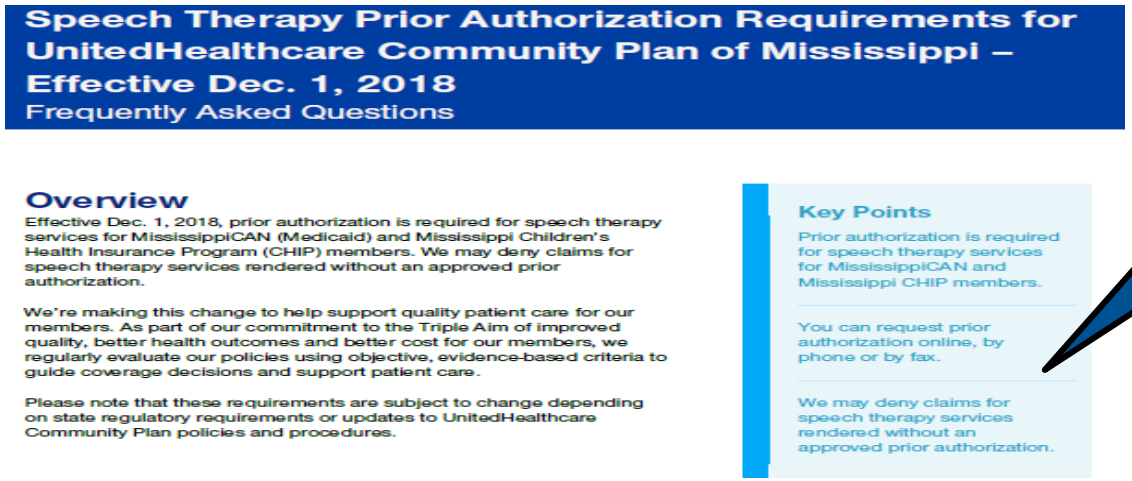
- Medical necessity
- Lack of information

Recourse

- Written notice, explaining actions to take, provided to member and a copy sent to requesting provider.
- Peer-to-Peer within 14 calendar days.
- Appeal within 30 calendar days from notice of adverse action.
- State Administrative Hearing through Division of Medicaid within 30 calendar days of UHC appeal final determination.

Speech Therapy
Resources

UHCProvider.com >Health Plans by State>Mississippi> Provider Training



UHCProvider.com >Health Plans by State>Mississippi

Speech Therapy
Frequently Asked Questions

UnitedHealthcare COMMUNITY & STATE

Prior Authorization Process and Requirements

Which speech therapy-related procedure codes require prior authorization?

Prior authorization is required for all services billed under CPT® code 92507.

How do I request prior authorization for speech therapy services?

You can submit your prior authorization request online, or by phone or fax. Here's how:

Online: Use the Prior Authorization and Notification tool on Link. Sign in to Link by going to **UHCprovider.com** and clicking on the Link button in the top right corner. Then, select the Prior Authorization and Notification tile on your Link dashboard. Learn more at **UHCprovider.com/paan.**

Phone: 866-604-3267

Fax: 888-310-6858. To download the fax form, go to **UHCprovider.com/MScommunityplan** > Prior Authorization and Notification Resources > Prior Authorization Paper Fax Forms.

- To comply with Health Insurance Portability and Accountability Act (HIPAA) requirements, please send one fax request per member with each fax having its own cover sheet. We're unable to process requests received with multiple members per fax.

Who can request prior authorization for speech therapy services?

The speech-language pathologist is responsible for requesting prior authorization for speech therapy.

Speech Therapy
Frequently Asked Questions

UnitedHealthcare COMMUNITY & STATE

How will I know if you received my prior authorization request?
You'll receive a reference number when you submit a request using the Prior Authorization and Notification tool on Link. If you submit your request by fax, we'll fax you back a confirmation with your reference number.

Who will review my prior authorization request?
Licensed medical professionals, including speech-language pathologists, will review your request using evidenced-based clinical criteria. This helps us ensure your request meets administrative and medical necessity guidelines. A Mississippi-licensed physician will review all requests considered for denial.

How far in advance can I submit my request?
You can request prior authorization up to 14 days in advance of the requested service date.

How quickly will you process my request?
We'll process a **complete** prior authorization request within two business days.

How will I be notified of the coverage determination?
We'll notify you of the coverage determination first by phone, and then by fax if we're unable to reach you. We'll also notify you and the member by mail if we deny your request.

Speech Therapy
Frequently Asked Questions

UnitedHealthcare COMMUNITY & STATE

What happens if I don't have a prior authorization on file?

When we process your claim, we'll validate that a prior authorization is on file. If your prior authorization is on file, we'll consider the claim for reimbursement. If the authorization is not on file, we'll deny the claim with an explanation that the service had not been prior authorized. Please note, prior authorization is not a guarantee of payment and services rendered are subject to benefit limitations.

Will you backdate requests for prior authorization?

No. We won't backdate requests for prior authorization because doing so bypasses case management and medical necessity reviews.

What happens if I submit my request with incomplete information?

If you submit a prior authorization request with incomplete information, we'll make two attempts to contact you to obtain the information we need within a designated timeframe. If we don't receive the information we need within that timeframe, we'll forward your request to the medical director for review. A request submitted with incomplete information may result in a denial of your request.

Speech Therapy
Frequently Asked Questions

UnitedHealthcare COMMUNITY & STATE

Clinical Coverage Criteria

What criteria do you use to review prior authorization requests for speech therapy?

We use different clinical coverage criteria for MississippiCAN and Mississippi CHIP members. These are the criteria we use to review prior authorization requests for each plan:

MississippiCAN Clinical Coverage Criteria

For MississippiCAN members, we conduct medical necessity reviews using state guidelines, nationally recognized standards – including the MCG care guidelines, 22nd edition – and Early and Periodic Screening, Diagnostic and Treatment (EPSDT) standards. Under EPSDT mandates, we're required to provide all **medically necessary** speech therapy services to children and adolescents ages 20 and younger. We don't approve or deny requests for speech therapy solely on the basis of disease, trauma or birth defect.

Mississippi CHIP Clinical Coverage Criteria

For Mississippi CHIP members, we do not cover speech therapy for maintenance speech, delayed language development or articulation disorders. We **do** cover speech therapy if the need arises from injury or illness if:

- There is a reasonable expectation that the therapy will improve a medical condition.
- Improvement is expected within a reasonable and predictable timeframe.
- The therapy is ordered by a doctor and performed by a licensed therapist.

Speech Therapy
Frequently Asked Questions

UnitedHealthcare COMMUNITY & STATE

What documents are required for prior authorization requests?

The Mississippi Division of Medicaid (DOM) Administrative Code Title 23 – "Medicaid Part 213 Therapy Services" – lists documentation requirements for evaluations, reevaluations and plans of care. We require care providers to meet minimum documentation standards in accordance with these requirements. To read the requirements, go to **medicaid.ms.gov** > Providers > Administrative Code.

You're required to include the following documents when requesting prior authorization for speech therapy:

1. **Certificate of Medical Necessity (CMN):** The prescribing care provider must complete a CMN with their original signature and send it to the speech-language pathologist to initiate an evaluation for the MississippiCAN or Mississippi CHIP member. Speech-language pathologists cannot independently perform evaluations at the request of parents or other caregivers; a written order signed by the ordering care provider must be present on the CMN. See *Mississippi DOM Administrative Code Rules 3.3(A)(2) and 3.7(A)* to learn more.
2. **Member Evaluation:** The speech-language pathologist must complete a member evaluation using current versions of standardized assessments to determine if the member has a communication and/or swallowing disorder. *See Mississippi DOM Administrative Code Rule 3.7(C)(9) and Jakubowitz, M. & Jo Schill, M. (2008)* to learn more.

Speech Therapy
Frequently Asked Questions

What documents are required for prior authorization requests?

3. **Plan of Care:** The recommended speech therapy plan of care must be signed and dated by the prescribing care provider. Services requested or provided without a current, signed and dated plan of care will be denied. The prescribing care provider's signature is considered current within 30 days of the original signing date. *See Mississippi DOM Administrative Code Rule 3.3(A)(4)* to learn more.

   - A speech therapy plan of care cannot be more than 180 days old. Services provided with an expired plan of care will be denied. *See Mississippi DOM Administrative Code Rule 3.6(E)* to learn more.
   -

If you don't include these documents with your prior authorization request, we'll issue a denial for missing documentation.

Speech Therapy
Frequently Asked Questions

UnitedHealthcare COMMUNITY & STATE

How often does the referring care provider need to complete the CMN?

The referring care provider must complete the CMN annually.

Will you accept a verbal order or referral in lieu of a CMN?

No. We will not accept a verbal order or referral in lieu of a CMN. We will, however, accept a written referral in lieu of a CMN if all of the following criteria are met:

- The **referral** is written on the ordering care provider's letterhead. MD, DO, NP or PA titles are acceptable.
- The **written referral** includes all of the following:
  - The ordering care provider's name and Medicaid ID number
  - The date of the member's last medical exam, which must be dated within the last six months
  - The member's name, date of birth and Medicaid ID number
- The written referral indicates whether the request is an **initial referral** for a speech therapy evaluation.
- If the **request is not for an initial referral**, the referring care provider has documented the member's length of time in treatment and the date of the last speech therapy visit.
- The written **referral includes all applicable ICD-10 codes** pertinent to the request for speech therapy.
- The written **referral includes the member's pertinent medical history**, with clinical justification related to specific ICD-10 codes for speech therapy.
- The written referral has the ordering care provider's signature and the signature date.

Speech Therapy
Frequently Asked Questions

UnitedHealthcare COMMUNITY & STATE

How often do I need to update a member's standardized assessments?
Standardized assessments must be updated at least annually.

What are the requirements for completing standardized assessments?
These are the requirements for completing standardized assessments:

- **Clinical documentation** must include the name of the standardized assessment, scores and/or results and the dates administered. When establishing member eligibility for services, articulation and language screeners will not be accepted in lieu of standardized assessments.
- The **standardized tests administered** must correspond to the delays identified and relate to the long- and short-term goals established.
- **Bilingual members** should receive culturally and linguistically adapted norm-referenced standardized testing in all languages the child is exposed to in order to compare potential deficits.
- If the **member has a medical condition** that prevents them from completing the standardized assessment(s), the speech-language pathologist may provide in-depth objective clinical information using task analysis to describe the member's deficit area(s) in lieu of standardized assessments. The speech-language pathologist should include checklists, caregiver reports or interviews and clinical analysis of articulatory and language samples. Errors with normative speech and language skills should also be noted.

Speech Therapy
Frequently Asked Questions

UnitedHealthcare COMMUNITY & STATE

How do I document medical necessity to support speech therapy services?

The member's diagnosis may not be the only factor required to determine that speech therapy is medically necessary. The member's need for services must be evident in the documentation you provide with your prior authorization request. The amount, frequency and duration of therapy must comply with accepted standards of care as indicated in the clinical coverage criteria. Your documentation should reflect the member's functional strengths and weaknesses using the following guidelines:

- **Reasonable:** Your request for services is determined to be reasonable based on the severity of disorder(s), comorbidities, prognosis and progress in treatment. The specified severity level should be supported by accepted standardized norms.
- **Necessary:** Necessity for services is based on the functional abilities of the member being significantly disordered. Treatment frequency and duration recommendations should be appropriate based on the member's medical and treatment diagnoses and prior level of function.
- **Specific:** When documenting medical necessity, goals should be specific to the functional skills targeted in treatment. Write short-term goals that can be met within the duration of the authorization period. You should report progress in terms of time, percentage, scales or independence, and track progress across the authorization periods and in a manner consistent with how the goals were written.
- **Effective:** Treatment is considered effective when functional improvement is noted within a reasonable timeframe.
- **Skilled:** Interventions with a level of complexity that a caregiver could not provide.

Speech Therapy
Frequently Asked Questions

UnitedHealthcare COMMUNITY & STATE

How do you define a skilled intervention?

We define a skilled intervention as one that's provided at a level of complexity and sophistication such that the intervention requires a speech-language pathologist to perform the intervention. The intervention must require the expertise, knowledge, clinical judgment and decision-making abilities of a speech-language pathologist.

Examples of services that **do not** require the skills of a speech-language pathologist include:

- Treatments that maintain function using routine, repetitive or reinforced procedures (e.g., practicing word drills for developmental articulation errors)
- Procedures that can be carried out effectively by the member or the member's caregivers
- When no further functional progress is supported by treatment notes or when therapy progress has plateaued

Speech Therapy
Frequently Asked Questions

UnitedHealthcare COMMUNITY & STATE

How do you define progress when determining medical necessity for continuation of care?

We define progress as a meaningful change that enables the member to function more independently and within a reasonable period of time. Progress noted during the prior approval period should reflect:

- A meaningful improvement in function
- Achievement of a majority of the long- and short-term goals established
- That the member has gained mastery of a skill that promotes increased independence

If the member has not achieved a majority of the long- and short-term goals established, the plan of care should include a description of the barriers to progress and/or an explanation of why the goal(s) needed to be modified or discontinued.

We will not accept a revised plan of care in instances where the speech-language pathologist has not made a meaningful update to the clinical documentation to support the need for continued services. Noting the percentage of accuracy towards the member's goals alone is not sufficient to establish a need for continued, medically necessary care.

Speech Therapy
Frequently Asked Questions

UnitedHealthcare COMMUNITY & STATE

What are some reasons you might deny my prior authorization request?

We might deny your request if:

- You haven't met the prior authorization administrative requirements.
- The services you're requesting don't meet medical necessity criteria.
- Your request does not indicate that the member has a communication and/or swallowing disorder.
- Requested services do not require the knowledge, skill and judgment of a state-licensed speech-language pathologist or audiologist.
- The documentation you include in your request indicates that the member has attained the speech- language pathology goals outlined in their plan of care, or has reached the point where no further significant improvement can be expected.
- The documentation indicates that the member has not reached the speech-language pathology goals and is unable to participate and/or benefit from skilled intervention, refuses to participate or is otherwise noncompliant with the speech language pathology or audiology regimen.
- The member can perform services independently or with the assistance of unskilled personnel or family members.
- Requested services duplicate other concurrent therapy.
- The services are for maintenance therapy.
- The member's medical condition could be reasonably expected to improve spontaneously without therapy.

Speech Therapy
Frequently Asked Questions

UnitedHealthcare COMMUNITY & STATE

What documentation is required when the member is receiving services in more than one setting?

Members younger than 21 may receive medically necessary outpatient therapy services in more than one setting if the services are coordinated and not duplicative in nature. Evaluation reports should include documentation of collaboration with early intervention, head start and public school programs as applicable. Members should not be discouraged from seeking services in these settings.

The following information must be included when submitting a prior authorization request for speech therapy services in more than one setting:

- A copy of the member's current Individualized Family Education Service Plan (IFSP) or Individualized Educational Plan (IEP)
- If the current IEP is not available, the requesting therapist must include a description of the goals and objectives from both therapists. This information is necessary to ensure that:
    - Duplicate services are not being provided by multiple providers.
    - The services are medically necessary.
    - The member's care is coordinated between providers.
    - The member is receiving quality care.

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What should I do if I disagree with your prior authorization determination?

If you disagree with our determination, the prescribing provider can request a peer-to-peer review with a member of the medical review team. The prescribing provider has up to **14 calendar days** from the denial date to request a peer-to-peer review**.**

If you still disagree with our determination following the peer-to-peer review, you can follow the appeal and grievance processes for providers. You can file an appeal or grievance within **30 days** of the determination. Upon exhausting these processes, you can request a hearing with Medicaid (for MississippiCAN), or an independent third party (for Mississippi CHIP). Additionally, the consenting member can authorize you or another individual to appeal on their behalf. This follows the appeal processes for members and requires the member to provide us with signed consent that indicates someone is legally authorized to act on their behalf.

Appeal, grievance and hearing rights are outlined in your Provider Agreement and the care provider manual. To view the care provider manual, go to **UHCprovider.com/manuals** > Mississippi. Then, select the link for the “UnitedHealthcare Community Plan of Mississippi Care Provider Manual for CHIP” or the “UnitedHealthcare Community Plan of Mississippi Care Provider Manual for MississippiCAN.”

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Where can I learn more about documentation for speech therapy services?

American Speech-Language-Hearing Association: Documentation in Health Care
Go to **asha.org** > Practice Management > Enter the Practice Portal > Documentation in Healthcare.

American Speech-Language-Hearing Association: ICD-10 FAQ for Audiologists and Speech-Language Pathologists
Go to **asha.org** > Practice Management > Coding for Reimbursement > ICD-10 Codes > ICD-10-CM FAQs for Audiologists and Speech-Language Pathologists.

AOTA, APTA, ASHA Consensus Statement on Clinical Judgment in Health Care Settings
Go to **asha.org** > Search "AOTA APTA ASHA Consensus Statement"

Importance of Using Current Versions of Standardized Assessments
Jakubowitz, Melissa & Jo Schill, Mary. (2008). Ethical Implications of Using Outdated Standardized Tests. *Perspectives on School-based Issues. 9*. 79-83. 10.1044/sbi9.2.79

Go to **asha.org** > Publications > ASHAWire > Search "Ethical Implications of Using Outdated Standardized Tests"

Who should I contact if I have questions? Provider Services at **877-743-8734.**

Question & Answer Session