

Office of the Governor | Mississippi Division of Medicaid

**Mississippi Division of Medicaid**

# **MississippiCAN Program**

**2014 Provider Workshop**



# Agenda

## 2014 Provider Workshops

### Welcome & Introduction of Teams

Division of Medicaid

Provider Beneficiary Relations

Magnolia Health Plan

UnitedHealthcare Community Plan

### *MississippiCAN Presentation*

### *MississippiCAN Questions & Answer Session*

**This will be your opportunity to ask the plans and/or the Division of Medicaid any questions.**

**Please complete your “Questions” form to submit prior to this session.**

***MississippiCAN***

# DOM Bureau of Coordinated Care

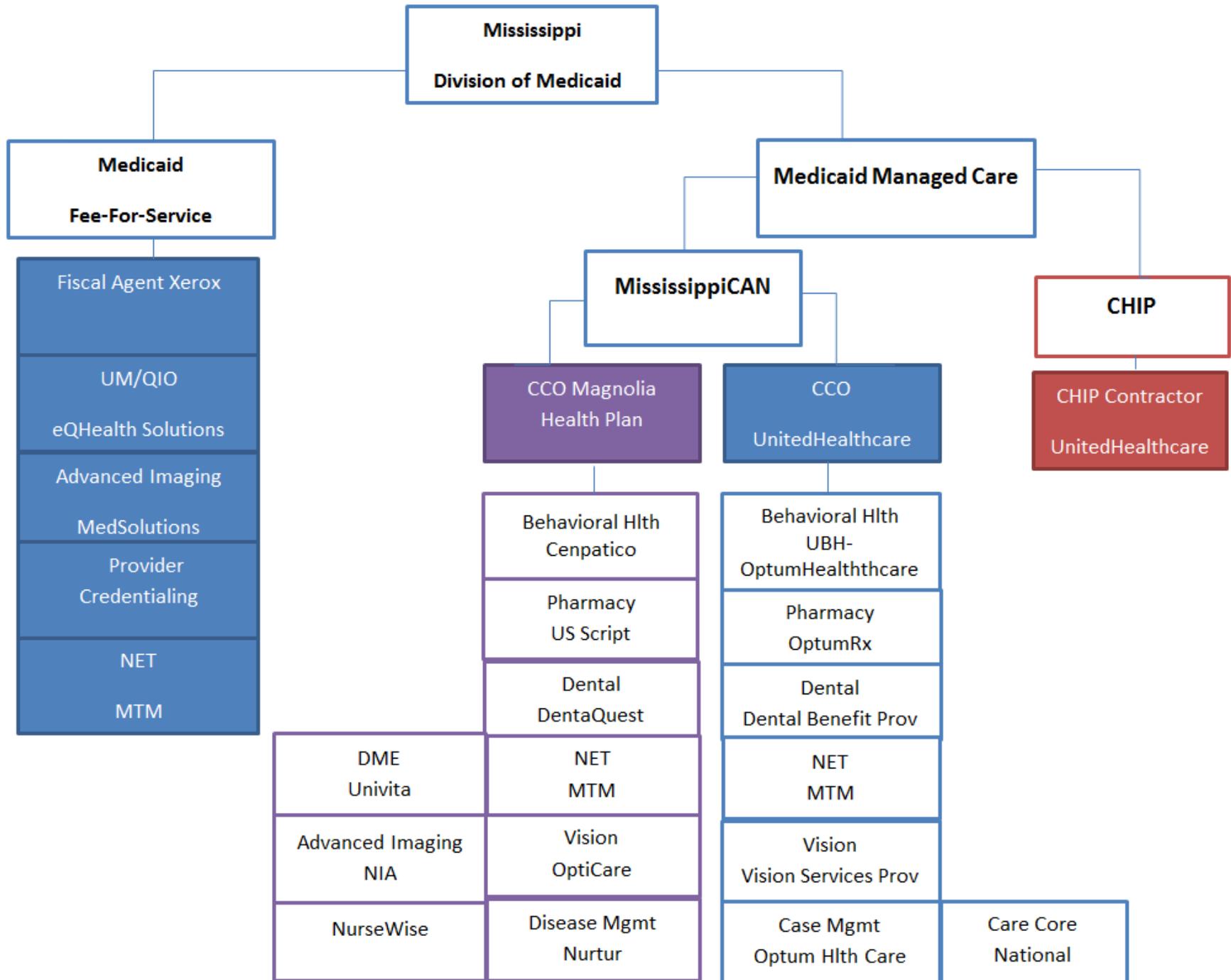
The DOM Bureau of Coordinated Care manages two statewide programs designed to improve beneficiary access to needed medical services, and to improve the quality of care.

- Mississippi Coordinated Access Network (**MississippiCAN**)
- Children’s Health Insurance Program (**CHIP**)

There are two coordinated care organizations (CCOs) which provide services to certain Medicaid eligible beneficiaries:

- **Magnolia Health Plan** and
- **UnitedHealthcare Community Plan**

For questions regarding MississippiCAN, call 601-359-3789 or email [MississippiCAN.Plan@medicaid.ms.gov](mailto:MississippiCAN.Plan@medicaid.ms.gov) or view the website at <http://www.medicaid.ms.gov/programs/mississippican/>



# Goals of MississippiCAN Program

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

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

# Evolution of the MississippiCAN Program

- Mississippi House Bill 71 – 2009 Second Extraordinary Session
- Mississippi House Bill 421 – 2012 Regular Session
- Mississippi House Bill 1275 – 2014 Regular Session
- The MississippiCAN program has evolved from January 2011 to present.
  - Increased limit to the greater of:
    - 45% of total enrollment of Medicaid beneficiaries, or
    - All categories of eligible beneficiaries as of January 1, 2014, plus the categories of beneficiaries composed primarily of persons younger than nineteen (19) years of age
  - Inclusion of services, except Inpatient Hospital Services (NET now included)

# MississippiCAN 2014 Contract Changes

The renewed MississippiCAN contract will be effective July 1, 2014, which may be viewed at [www.medicaid.ms.gov](http://www.medicaid.ms.gov) under request for bids/proposals. Below are some changes in new contract:

## PCP assignment

- The member has thirty (30) calendar days to select a Primary Care Provider (PCP). The Contractor must inform PCPs of Member assignments via web portal unless the PCP requests an alternate format (e.g., surface mail, secure fax) when completing the provider contract. If the Contractor elects to notify PCPs via web portal, the Contractor must confirm that the PCP received and has acknowledged receipt of the Member listing and **acknowledges** receipt of list of Members assigned to them.

## Pharmacy

- The Contractor **must** use the most current version of the Medicaid Program Preferred Drug List (PDL), which is subject to periodic changes. The Contractor must use the Medicaid PDL developed by the Division or its Agent and may not develop and use its own PDL.

# MississippiCAN 2014 Contract Changes

## Non-Emergency Transportation

- The Contractor **shall provide** Non-Emergency Transportation for its Members to access Medically Necessary Services, in compliance with minimum Federal requirements for the provision of transportation services and according to DOM policies, which are outlined in Mississippi Administrative Code, Title 23, Part 201 Non-Emergency Transportation, shall be provided to Members who require transportation to and from Medicaid covered non-emergency services.

## Prior Authorization

- The Contractor shall have the capability and established procedures to receive Prior Authorization requests via secure web-based submissions and facsimile from providers. The Contractor must make standard authorization decisions and provide notice within **three (3) calendar days or two (2) business days** following receipt of the request for services.

# MississippiCAN 2014 Contract Changes

## Provider Network Requirements-PCP providers

Urban-two within fifteen (15 ) minutes or thirty (30) miles

Rural-one within thirty (30) minutes or thirty (30) miles

## Credentialing

- The Contractor shall credential all completed application packets within ninety (90) calendar days of receipt. In cases of network inadequacy, the Contractor shall credential all completed application packets within forty-five (45) calendar days of receipt.

## Claims:

- The Contractor shall encourage providers to submit claims as soon as possible after the dates of service. Providers shall be provided a **minimum** of ninety (90) calendar days and a **maximum** of six (6) months to submit claims from the date of service. Claims filed within the appropriate timeframe but denied may be resubmitted to the Contractor within ninety (90) calendar days from the date of denial.

# MississippiCAN

## Optional Populations

Category of Eligibility	COE	New COE	Age
SSI - Supplemental Security Income	001	001	0 - 19
Disabled Child Living at Home	019	019	0 - 19
DHS – Foster Care Children- IV-E	003	003	0 - 19
DHS – Foster Care Children- CWS	026	026	0 - 19

Note: **Always check eligibility** for 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](http://www.ms-medicaid.com)

# MississippiCAN

## Mandatory Populations

Category of Eligibility	COE	New COE	Age
SSI -Supplemental Security Income	001	001	19 - 65
Working Disabled	025	025	19 - 65
Breast and Cervical Cancer	027	027	19 - 65
Parents and Caretakers (TANF)	085	075	19 - 65
Pregnant Women (below 185% FPL)	088	088	8 - 65
Newborns (below 185% FPL)	088	071	0 - 1
Children (TANF)	085	below	1 - 19
Children (< age 6) (< 133% FPL)	087, 085	072	1 - 5
Children (< age 19) (<100% FPL)	091, 085	073	6 - 19
Quasi-CHIP (100%-133% FPL) (previously qualified for CHIP)	099	074	6 - 19
<b>Children (Beginning SFY 2015)</b>	<b>085--091</b>	<b>072 – 074</b>	<b>1 - 19***</b>

## Beneficiaries Who Are Not Eligible for MississippiCAN

- Beneficiaries enrolled in any waiver program. (ex. HCBS, TBI, IDDD, IL, MYPAC, etc.)
- Beneficiaries who are dually eligible. (Medicare/Medicaid)
- Beneficiaries who at the time of application are institutionalized. (ex. Nursing Facility, ICF-MR, Correctional Facilities, etc.)

# MississippiCAN Enrollment

- Beneficiaries can enroll at any time.
- Every member will have a 90-day window to make changes after his/her initial enrollment.
- During the 90-day window, mandatory members may only switch between the plans one time.
- During the 90-day window, optional members may dis-enroll or switch between the plans one time.
- DOM will have an open enrollment period each year (October – December) to allow members to make changes.
- Enrollment is always effective at the beginning of the month and disenrollment, for those in the optional population, is effective the last day of the month.
- Newborns born to a Medicaid mom who is currently enrolled in MississippiCAN will automatically be placed in the same plan as the mother.

# **CHIP**

## **Children's Health Insurance Program**

# New Medicaid and CHIP Eligibility Income Calculation

Effective January 1, 2014, a new methodology based on Modified Adjusted Gross Income (**MAGI**) will be used for determining CHIP eligibility. As a result of a conversion to MAGI, children in households with income limits up to 133 percent of the federal poverty level will be transitioning from CHIP to traditional Medicaid.

This population will be moved to the MississippiCAN program effective December 1, 2014.

*Federal authority for the change in the Medicaid limit that affects CHIP is Section 2001 (a)(5)(B) of the Affordable Care Act implemented through federal regulations for the Medicaid program at 42 CFR § 435.118.*

# SFY2015 Program Changes

## **Quasi-CHIP Population Transitioning to Medicaid MississippiCAN**

- December 1, 2014
- Children in families with income at or below 133% of the federal poverty level are now eligible for Medicaid rather than CHIP and will be enrolled in the MississippiCAN program.

## **CHIP**

- January 1, 2015
- Children enrolled in the CHIP program beginning CY2015 will receive service from the two Coordinated Care Organizations (CCOs) rather than one contracted vendor. Their CHIP coverage and services will remain the same.

## **MississippiCAN Expansion - Children**

- February to June 2015
- Children ages 1 to 19 will be enrolled in the MississippiCAN program, except those excluded as members on Medicare, on waivers, or in institutions.

# What is the difference between programs?

	Medicaid Fee-for-Service	MississippiCAN	CHIP
<b>Beneficiary Eligibility</b>	Beneficiaries qualify based on income, resources, age and/or medical disability.  Coverage for children, families, pregnant women, elderly and disabled persons.	Beneficiaries in certain Medicaid categories of eligibility (SSI, Disabled Children at Home, Working Disabled, Breast/Cervical, Newborns and Children)	Children ages 0-19 whose income exceeds Medicaid maximum, up to 209% Federal Poverty Level.
<b>Beneficiary Enrollment Site</b>	Division of Medicaid, Regional Office	Division of Medicaid, Regional Office	Division of Medicaid, Regional Office
<b>Beneficiary Enrollment</b>	Members can only receive services from one program at a time, no overlap.	Members can only receive services from one program at a time, no overlap.	Members can only receive services from one program at a time, no overlap.
<b>Beneficiary Services</b>	Medicaid services MississippiCAN Inpatient Hospital	Medicaid services, plus additional services such as case management	CHIP services
<b>Provider Enrollment</b>	Enroll with Medicaid	Enroll with MSCAN vendor (Magnolia or UnitedHealthcare)	Enroll with CHIP vendor UnitedHealthcare (current vendor) Magnolia (after 1-1-15)
<b>File Claims</b>	Division of Medicaid Xerox	Vendors (Magnolia or UnitedHealthcare)	
<b>Website</b>	<a href="http://www.medicaid.ms.gov">www.medicaid.ms.gov</a> <a href="http://www.ms-medicaid.com">www.ms-medicaid.com</a>	<a href="http://www.medicaid.ms.gov/programs/mississippi-can/magnoliahealthplan.com">www.medicaid.ms.gov/programs/mississippi-can/magnoliahealthplan.com</a> <a href="http://uhcommunityplan.com">uhcommunityplan.com</a>	<a href="http://www.medicaid.ms.gov/programs/childrens-health-insurance-program-chip/">www.medicaid.ms.gov/programs/childrens-health-insurance-program-chip/</a> <a href="http://uhcommunityplan.com">uhcommunityplan.com</a> (current vendor)  <a href="http://magnoliahealthplan.com">magnoliahealthplan.com</a> (after 1-1-2015)

# Contact Information

Payer	Card Color	Type Service	Telephone	DOM
<b>Mississippi Medicaid</b>	Blue (new cards) Green (old cards)	Multiple	1-800-884-3222	1-800-421-2408
<b>Medicare</b>	Red/White/Blue		1-800-633-4227	
<b>MississippiCAN</b>			1-800-884-3222(*)	1-800-421-2408
<b>Magnolia Health Plan</b>	Purple	Medical	1-866-912-6285	
<b>Cenpatico</b>	(same card)	Behav Hlth	1-866-912-6285	
<b>Univita</b>	(same card)	DME	1-866-912-6285	
<b>US Script</b>	(same card)	Pharmacy	1-800-460-8988	
<b>MississippiCAN</b>			1-800-884-3222(*)	1-800-421-2408
<b>UnitedHealthcare</b>	White	Medical	1-877-743-8731	
<b>UBH-OptumHealth</b>	(same card)	Behav Hlth		
<b>OptumRx</b>	(same card)	Pharmacy	1-877-305-8952	
<b>CHIP</b>			1-800-884-3222	1-800-421-2408
<b>UnitedHealthcare</b>	White	Multiple	1-877-743-8731	

# Contact Information for the MississippiCAN program

Mississippi Division of Medicaid

Phone: 601-359-3789

Toll-free: 1-800-421-2408

<http://www.medicaid.ms.gov/programs/mississippican/>

Inquiry/Complaint Form available

Magnolia Health Plan

Toll-free: 866-912-6285

[www.magnoliahealthplan.com](http://www.magnoliahealthplan.com)

United Healthcare

Toll-free: 877-743-8731

[www.uhcommunityplan.com](http://www.uhcommunityplan.com)

Office of the Governor | Mississippi Division of Medicaid

# Provider Recruitment

**MSCAN Provider Workshop - July 2014**



# **Division of Medicaid (DOM)**

## **Mission Statement**

To responsibly provide access to quality health coverage for vulnerable Mississippians.

# Medicaid Enrollment Facts

- Appropriately 22,000 currently enrolled providers
- Appropriately 682,000 currently enrolled beneficiaries



# Key Benefits of being a MS Medicaid Provider

- Increase your Patients/Clients
- Receive uninterrupted reimbursement (payment) for services rendered
- Help improve health care of those most in need of quality health care services
- Provide recommended preventive health care services

# Key Benefits of being a MS Medicaid Provider

- Access to web-based claims submission and timely claims processing
- Access to a dedicated Provider Representative for claim questions and resolution of claim payment issues
- **FREE** online claims submission software
- **FREE** Medicaid provider Education and Trainings (Workshops, Webinars. Etc.)
- **FREE** telephonic access to a customer service call center to address questions or concerns

# Children Health Insurance Program (CHIP)



# Who is eligible for CHIP?

- Uninsured children up to age 19 years old
- Children not eligible for Medicaid
- Children with no other insurance coverage  
*(at the time of application)*
- Children of families that meet the income requirements

# Medicaid Enrollment

- Download an enrollment package
- Enroll online
- Request an enrollment package

**Please Visit:**

**<https://www.ms-medicaid.com>**

**Phone: 1-800-884-3222**

**Fax: 888-495-8169**

# Ordering, Referring, or Prescribing Providers (ORP)



# What is ORP?

- Affordable Care Act (ACA)
- January 1, 2014
- Ordering, Referring, or Prescribing Providers (ORP)

# ORP vs. Billing/Servicing Provider

## Enroll as ORP provider ONLY.

- Complete short application on Envision Website
- Allows Medicaid reimbursement for the covered services and supplies that are ordered, referred, or prescribed for Medicaid beneficiaries
- Does not obligate you to see Medicaid patients
- Provider will not be listed as a Medicaid provider for patient referral or assignment
- Ensures that your orders, referrals, and prescriptions for Medicaid patients are accepted and processed appropriately

## Enroll as a MS Medicaid

### “Billing/Servicing Provider”

- Can order
- Can refer
- Can prescribe
- Can receive payments for services rendered

\*\*Both ORP and the regular enrollment application are located at:

<https://www.ms-medicaid.com>

**Active MS Medicaid Providers are NOT REQUIRED to enroll as ORP providers.**

# ORP Implementation

- Claims submitted January 1, 2014 and thereafter suspended if the ordering or referring provider's NPI was not valid and the provider was not actively enrolled as a participating Medicaid provider.
- If the NPI number of the ordering/referring provider was not enrolled as an active provider, the claim suspended for a 90 day grace period, giving the ordering/referring provider time to enroll.
- When the claim suspends, the Medicaid system will look for the most current address for the ordering/referring provider and generate a letter to the provider with information regarding ORP requirements and enrollment instructions.
- If the provider is not enrolled during the 90 day grace period, the claim will deny on the 91<sup>st</sup> day and thereafter until the ordering/referring provider enrolls.
- Beginning November 1, 2014, Pharmacy claims for Medicaid beneficiaries will be denied if the prescription was from a provider who has not enrolled with the Division of Medicaid.

# Medicaid Enrollment

- Enroll as a Billing / Servicing Medicaid provider **OR**
- Enroll as an ORP Provider
- Individual NPI number
- Specialty Type

# CONTACT US

Office of Governor | Division of Medicaid  
550 High Street, Suite 1000  
Jackson, Mississippi 39201

Or

P.O. Box 23078  
Jackson, Mississippi 39225  
Phone: 1-800-884-3222  
Fax: 1-888-495-8169

## Websites:

<http://www.medicaid.ms.gov> (DOM)  
<http://www.ms-medicaid.com> (Xerox)



# DOM PROVIDER WORKSHOP *2014*

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7/11/2014

## Verify Eligibility



Change is inevitable, so we highly recommend that you verify member eligibility on the date service is rendered. Please use one of these convenient methods:

- Log on to Medicaid Envision website at [www.ms-medicaid.com](http://www.ms-medicaid.com).
- Log on to our secure Provider portal at [www.magnoliahealthplan.com](http://www.magnoliahealthplan.com).
- Call our automated Member Eligibility Interactive Voice Response (IVR) system at **1-866-912-6285**.
- Call Magnolia Provider Services at **1-866-912-6285**.

**Member ID Cards Are NOT a Guarantee of Eligibility**

## Prior Authorization (PA)

### Prior Authorization (PA) 101:

- PA is a request for a review of medical necessity for a non-emergent service.
- Requests are submitted to the Magnolia Health Utilization Management (UM) department.
- Emergency room and Urgent Care services do not require PA.
- PA must be approved before service is rendered.
- Out of Network providers (non-participating) must receive PAs for **all services except** basic lab chemistries and basic radiology.
- Find the current PA form, PA form tutorial, and PA list at [www.magnoliahealthplan.com](http://www.magnoliahealthplan.com).

### PA Processing:

- Magnolia Health does not receive incomplete requests. The requestor will automatically receive a fax-back form requesting the missing information.
- We will make two (2) attempts to obtain any necessary information, after which our Medical Director will make a review determination based on the information received.
- We will make a PA determination and notify the requestor within three (3) calendar days and/or two (2) business days of receipt of all necessary information, not to exceed 14 calendar days from receipt of request, **ONLY** if request is made for an extension or an extension is needed.

**We highly recommend that you initiate the PA process at least five (5) calendar days prior to service date.**

(Urgent request may be made if service is medically necessary to treat non-life threatening injury, illness or condition within 24 hours to avoid complications, unnecessary suffering or severe pain. Urgent request must be signed by requesting provider to receive priority.)

**PA Denial Questions? Call 1-866-912-6285, ext. 66771**  
**Claims Denial Questions? Call 1-866-912-6285, ext. 66402**

# Claims Filing



## You may file claims via

- 1) our secure site at [www.magnoliahealthplan.com](http://www.magnoliahealthplan.com)
- 2) an approved clearinghouse\*
- 3) paper claim

\*Please bill Magnolia via **paper claim** or via **our website**, *UNTIL you have established a relationship with an approved clearinghouse.*

Find a complete list at [www.magnoliahealthplan.com/providers/electronic-transactions/edi/](http://www.magnoliahealthplan.com/providers/electronic-transactions/edi/)

## PLEASE REMEMBER:

- To file all claims within **180** days of Date of Service (DOS).
- To complete claims in accordance with Division of Medicaid billing guidelines.
- To submit all member and provider information completely and accurately.
- To include a copy of Explanation of Payment (EOP)
  - 1) when other insurance is involved, and/or
  - 2) when you bill electronically.
- Magnolia must receive all requests for correction, reconsideration or adjustment within **90** days of date of notification or denial.

**File Online!**  
[www.magnoliahealthplan.com](http://www.magnoliahealthplan.com)

## PAPER CLAIMS:

Follow these easy steps to help our mail center improve paper claim scanning speed and accuracy:

- ✓ Remove all staples from pages
- ✓ Do not fold forms
- ✓ Make sure claim information is dark and legible
- ✓ Use a 12pt font or larger
- ✓ Use CMS 1500 printed in red (**Approved OMB-0938-1197 Form CMS-1500 (02-12)** for compatibility with our Optical Character Recognition (ORC) scanner system.
- ✓ **NO HANDWRITTEN OR BLACK AND WHITE COPIES.**

Mail 1<sup>ST</sup> time paper claims to:

**Magnolia Health Plan**  
**Attn: CLAIMS DEPARTMENT**  
**P.O. Box 3090**  
**Farmington, MO 63640-3825**

## Corrected Claims/Reconsiderations/Appeals



**Correct or Resubmit Claims Conveniently** through EDI or our secure web portal:

- Reference original claim number from EOP
- Submit within **90** days of notice of adjudication

### **Paper Submissions:**

- Clearly mark **“RE-SUBMISSION”** or **“CORRECTION”**
- Reference original claim number or original EOP
- Mail paper submissions to:

**Magnolia Health Plan**

**ATTN: (Select appropriate dept: RECONSIDERATION, CORRECTED CLAIM, APPEALS, or MEDICAL NECESSITY)**

**P.O. Box 3090**

**Farmington, MO 63640-3825**

**Claims Submitted Directly to Our Local Office Will be Returned UNPROCESSED**

## Top Ten Claim Denials

1. Duplicate claims
2. Not filed timely (within **180** days of date of service/**90** days of notice of adjudication)
3. No authorization obtained
4. Incorrect modifiers filed
5. NDC number missing or invalid
6. Rendering provider has no valid MS Medicaid ID
7. Invalid POS
8. Incorrect form type
9. EOB from primary carrier missing or incomplete
10. Diagnosis code missing 4<sup>th</sup> or 5<sup>th</sup> digit

**For a copy of our Claims Filing Manual, Provider Manual, and a complete list of common billing errors, please visit [www.magnoliahealthplan.com](http://www.magnoliahealthplan.com).**

## Behavioral Health



**Behavioral Health Services are managed on behalf of Magnolia Health by Cenpatico.**

### **Obtain authorization:**

- Complete an Outpatient Treatment Request (OTR) from the Form Section at [www.cenpatico.com](http://www.cenpatico.com), or
- Request an OTR form from Utilization Management at **1-866-912-6285**
- Find the Covered Services Grid online in the Cenpatico Mississippi Provider Manual at [www.cenpatico.com](http://www.cenpatico.com).

### **Prior Authorization required for:**

- Psychological Testing
  - Crisis Residential
  - Intensive Outpatient Program (IOP)
  - Partial Hospitalization Program (PHP)
  - Certain Injectable Medications
  - Electroconvulsive Therapy (ECT)
- Community Mental Health Centers (CMHC) **are required** to get authorization for community support services.
- Authorization is **no longer required** for *participating* providers to provide psychotherapy services (Individual, Family or Group Therapy), due to mental health parity effective Jan 1, 2014.

**Provider/Customer Service: 1-866-912-6285**

**Angela Stewart, Network Manager**  
**601-863-0738**  
**[anstewart@cenpatico.com](mailto:anstewart@cenpatico.com)**

**Jennifer Stevens, Provider Relations Specialist**  
**601-863-0709**  
**[jestevens@cenpatico.com](mailto:jestevens@cenpatico.com)**

# Dental



Dental Services are managed on behalf of Magnolia Health by DentaQuest.

**DentaQuest Provider Services**

1-800-235-6147  
12121 N. Corporate Parkway  
Mequon, WI 53092

**Provider Relations**

Stephanie Bullock  
Stephanie.Bullock@DentaQuest.com  
601-376-8089

Claims Questions: [denclaims@DentaQuest.com](mailto:denclaims@DentaQuest.com)

Eligibility or Benefit Questions: [denelig.benefits@DentaQuest.com](mailto:denelig.benefits@DentaQuest.com)

**Fax numbers:**

Claims to be Processed: **262-834-3589**

Claims/payment issues: **262-241-7379**

All other: **262-834-3450**

**Mail Claims to:**

**DentaQuest-Claims**  
**12121 N. Corporate Parkway**  
**Mequon, WI 53092**

**Submit Electronic Claims to:**

Direct entry on the web –  
**[www.dentaquest.com](http://www.dentaquest.com)**  
Or Via Clearinghouse –  
**Payer ID CX014**

**Prior authorization is required  
for the following codes:**

D8080, D8670, D8670, D8999, D9500, D0321, D0999, D2750-D2752, D2952, D2999, D3999, D4210, D4211, D4240, D4241, D4260, D4261, D4341, D4342, D5110, D5120, D5211, D5212, D5955, D7220, D7230, D7240, D7241, D7250, D7260, D7272, D7280, D7285, D7286, D7288, D7290, D7310, D7311, D7320, D7321, D7340, D7350, D7410, D7411, D7413, D7414, D7440, D7441, D7450, D7451, D7460, D7461, D7465, D7471, D7490, D7530, D7540, D7550, D7560, D7610, D7620, D7630, D7640, D7650, D7660, D7670, D7671, D7680, D7710, D7720, D7730, D7740, D7750, D7760, D7770, D7780, D7810, D7820, D7830, D7840, D7850, D7860, D7870, D7910, D7911, D7912, D7920, D7940, D7941, D7943, D7944, D7945, D7946, D7947, D7948, D7949, D7950, D7955, D7960, D7970, D7980, D7981, D7982, D7983, D7990, D7991, D9220, D9221, D9241, D9242, D9940, D9999, D9500,

## Non-Emergent Medical Transportation (NEMT)

**Magnolia has contracted with Medical Transportation Management (MTM) to provide NEMT to members, effective July 1, 2014.**

- MTM may use public bus, van, taxi, paralift, ambulance or gas reimbursement to transport members to health care appointments.
- Only eligible members are covered for NEMT, unless member requires assistance from a caregiver (in which case caregiver will also be eligible for services).
- Member must call to request transportation at least three (3) days before scheduled appointment. If the request is deemed urgent, the notice requirement is waived.

**Prior to calling, member must have the following information available:**

- Medicaid Identification Number
- Date transportation is needed
- Name, address and phone number for destination
- Reason for transportation request
- Type of appointment
- Any mobility aide(s) assistance required



**NEMT Call Center Hours of Operation:**  
**Monday through Friday, 7am to 6pm CST**  
**Call 1-866-331-6004**

## Durable Medical Equipment, Home Health & Home Infusion Services



- Univita Health will continue to manage Durable Medical Equipment, Home Health & Home Infusion Services and reimburse all claims for said services through **November 30, 2014**.
- Magnolia Health will assume management of all Durable Medical Equipment, Home Health & Home Infusion Services on **December 1, 2014**.
- Please contact Provider Services at **1-866-912-6285** with any questions you may have regarding this transition.

### The following services are covered and require Prior Authorization:

- ✓ DME/Medical Supplies greater than \$500
- ✓ Orthotics and Prosthetics greater than \$500 (**This is only a covered benefit for members 21 years and older**)
- ✓ Home Health care (**limited to 25 visits per year and Home-based OT/PT/ST is a non-covered benefit for members 21 years and older**)
- ✓ Hospice Care (**the requesting provider must submit all documentation listed in the MS Division of Medicaid's Administrative Code Title 23: Medicaid Part 205 Hospice Services**)

The guidelines will remain the same with the Univita transition. For Prior Authorization Requests, please contact Univita via fax at 1-888-914-2202

# HEDIS/EPSTD



## HEDIS (Healthcare Effectiveness Data and Information Set):

- One of the most widely-used set of health care performance measures in the United States
- Includes 81 measures, focusing on prevention, screening, and maintenance of chronic illnesses
- Information is collected via claims or through medical record review.
- HEDIS scores are used to compare health plans. They show us how well we educate our membership and provide access to quality care.
- Members and providers can see our yearly HEDIS scores on our website [www.magnoliahealthplan.com](http://www.magnoliahealthplan.com).
- Providers can get information on how well they (or their practice) are managing their member panels in comparison to their peers.

## EPSTD (Early Periodic Screening, Diagnosis, and Treatment):

- Comprehensive and Preventive Child Health Program for individuals under the age of 21 years
- EPSTD services must be documented in the member's medical record.
- Please bill vaccines with specific antigen codes, **even if** you participate in the Vaccines For Children (VFC) program. This will ensure we receive HEDIS information and the child is up-to-date on immunizations. It will also help improve Magnolia Health HEDIS rates. (Please note, payment will be made for the accompanying administration code **only**.)

**For information on proper documentation of EPSTD services, please contact  
Iris Killingsworth at 601-863-0814 or [ikillingsworth@centene.com](mailto:ikillingsworth@centene.com)  
Sai Kota at 601-863-0906 or [skota@centene.com](mailto:skota@centene.com)**

## Care Management



- Magnolia's Care Management Program uses a multidisciplinary team approach to provide individualized process for assessment, goal planning and coordination of services.
- The Care Management Program is available to **all** members, emphasizing prevention and continuity of care.
- Magnolia's Care Management team provides assistance with complex medical conditions, health coaching for chronic conditions, transportation assistance to appointments, interpreter services, location of community resources, and encouragement of self-management through disease education.
- The Care Management team will incorporate the provider's plan for the member into our Care Plan, so we can focus on the same problems and same care interventions.



# PCP Panel/PCP Assignment



## PCP Panel:

- PCPs can locate and download their panel list by accessing our secure web portal at [www.magnoliahealthplan.com](http://www.magnoliahealthplan.com).
- Log on using your username and password and select “Patients” at the top of the screen.
- Providers have the option to download their panel list to an Excel spreadsheet.
- Panel list includes information regarding Eligibility, Care Gaps, and Case Management/Disease Management Alerts.
- Providers are encouraged to use this tool, as it is the most up-to-date method for tracking their member panel.  
*(Providers may modify their panels, and are not required to accept all patients submitted to by the CCO.)*

**Members have the option to select a PCP.**

**If no selection is made within 30 days of enrollment, the member is auto-assigned to a PCP.**

**Magnolia Health will use an Auto-Assignment Algorithm to assign an initial PCP.**

## **The Auto-Assignment Algorithm assigns members to a PCP according to the following criteria:**

- Member history with a PCP: The algorithm will first look for a previous relationship with a network PCP.
- Family history with a PCP: If the member has no previous relationship with a PCP, the algorithm will look for a PCP to which someone in the member’s family, such as a sibling, is or has been assigned.
- Appropriate PCP type: The algorithm will use age, gender, and other criteria to ensure appropriate match, such as children assigned to pediatricians and pregnant women assigned to OB/GYNs.
- Geographic proximity of PCP to member residence: Auto-assignment logic will ensure members travel no more than 30 miles in rural regions and 15 miles in urban regions.

# Provider Web Portal



## SUBMIT:

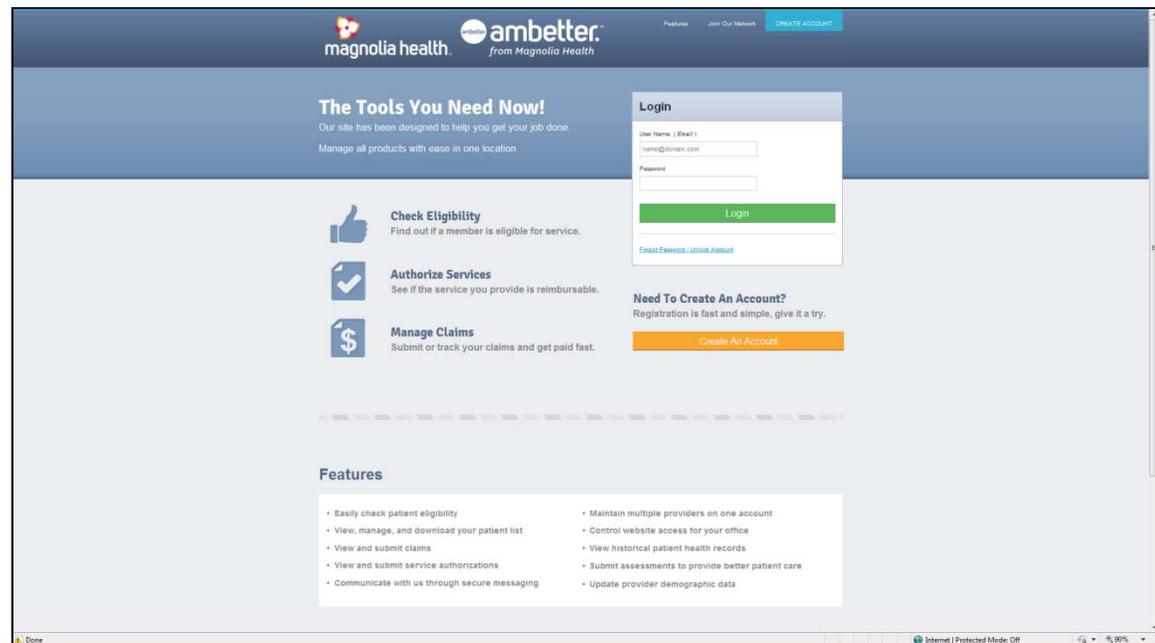
- Claims
- Provider Complaints
- Demographic Updates

## VERIFY:

- Eligibility
- Claim Status

## VIEW:

- Provider Directory
- Important Notifications
- Provider Training Schedule
- Provider Resources – PIRC
- Claim Editing Software
- Provider Newsletter
- Member Roster for PCPs



**For more information, or to schedule a demonstration of our Provider Web Portal, please contact your Provider Relations Specialist or Provider Services at 1-866-912-6285.**

## Innovative Payments

**Innovative Payment Agreements:** Our new innovative payment program encourages providers contractually to increase their quality and decrease costs. We want to share the savings of high quality service with our providers.

### Two Types:

#### ➤ Pay for Performance

- Based on HEDIS measures
- Provider will have up to 5 HEDIS measures to focus on (such as Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life, HbA1c Control, and LDL-C Screening).
- Provider will receive payout based on which range of NCQA percentiles the provider achieves. The higher the percentile, the higher the payout.

#### ➤ Shared Savings

- Based on utilization measures (such as ER diversion and inpatient admission reduction)
- Payout is based on provider utilization measure score, which is percentage reduction in utilization measure. For example, if a provider reduced the emergency room visits per assigned covered persons by 5%, provider would achieve a payout.

**For more information on Innovative Payments, contact Whitney Bondurant at  
601-863-0720 or [wbondurant@centene.com](mailto:wbondurant@centene.com)**

## Provider Services



### Provider Services Call Center:

- Provides Phone Support
- Available Monday through Friday, 8am to 5pm CST **1-866-912-6285**

### Provider Relations:

- Provides a local point of contact for Providers
- Assists Providers with any Magnolia operational issues they may have, including: prior authorizations, claims, policy and procedure clarifications, credentialing, web portal demonstrations, contract clarification, on-site training, etc.

Region	Contact Name	Phone	Email
North	Ashley Armstrong	662-372-0209	aarmstrong@centene.com
Statewide FQHC	Johnnie Allen	601-594-8182	johallen@centene.com
Central	Brandy Deck	601-397-1406	bdeck@centene.com
Central	Earl Robinson	601-978-0332	earobinson@centene.com
South	Tina Lawrence	228-239-3490	tlawrence@centene.com
North	Chinwe Nichols	601-850-0056	cnichols@centene.com
South	Jennifer Hobock	601-863-0699	jhobock@centene.com



*Division of Medicaid - MississippiCAN*  
**Provider Workshop 2014**



- ✓ **Community-focused**  
*Ranked #1 for health care industry in the Civic 50*
- ✓ **Provider-centric**  
*Empowering the physician/patient relationship with information and tools to support personal health choices and clinical decisions*
- ✓ **Quality-driven**  
*NCQA Health Plan Accredited*
- ✓ **Health care innovator**  
*Ranked #1 by Fortune magazine as insurance and managed care innovator*



# Communicating with UHC

- 1. [www.UHCCommunityPlan.com](http://www.UHCCommunityPlan.com)**
  - Primary source of information
  - Provider manual
  - Provider newsletter
  - Reimbursement policies
- 2. Provider Services Call Center**
  - MississippiCAN: (877) 743-8734
  - MS CHIP: (800) 557-9933
  - Record Reference # for issue escalation
- 3. Direct Mailings**
  - As needed for significant changes and updates
- 4. Monthly Townhall Webinar**
  - 3rd Wednesday of every month
  - 1 HR, in-depth presentation of the UHC Community Plan
  - Open Q&A session
- 5. Provider Advocate**
  - Health professional education and escalated issue resolution
- 6. Network Management**
  - Credentialing and contracting questions
- 7. Clinical Practice Consultant**
  - Clinical collaboration and quality improvement

# Provider Web Portal



[www.uhccommunityplan.com](http://www.uhccommunityplan.com)

- Maximize time and efficiency
- Online tools
- Website Support Team:  
Email: [ac\\_edi\\_ops@uhc.com](mailto:ac_edi_ops@uhc.com)  
Phone: 800-210-8315

The screenshot displays the UnitedHealthcare Community Plan Provider Web Portal. At the top, there is a search bar and a navigation bar with options for 'For Health Care' and 'For Community Partners'. Below this, a navigation menu on the left lists various services: 'Provider Information', 'Claims and Member Information', 'Pharmacy Program', 'Provider Administrative Manual', 'Reimbursement Policy', 'Newsletters', 'Bulletins', 'Medicare Part D Educational Materials', 'Provider Forms', 'Clinical Practice Guidelines', 'Electronic Data Interchange (EDI)', 'Radiology', and 'Cardiology'. The main content area is titled 'Provider Information' and contains a welcome message, a notice about MS-CHIP Payer ID changes effective May 17, 2014, and sections for 'Reimbursement Policies', 'Medical Injectables', 'Contact Us', and 'Disclaimer'.

# Provider Contacts



## Network Management Resource Team

Call (866) 574-6088  
 Email: [swproviderservices@uhc.com](mailto:swproviderservices@uhc.com)

### North MS

Veronica Eatman  
[veronica\\_eatman@uhc.com](mailto:veronica_eatman@uhc.com)  
 (205) 437-8652

### Central & South MS

Teresa Morris  
[teresa\\_morris@uhc.com](mailto:teresa_morris@uhc.com)  
 (601) 718-6594

### Coastal Region

Amber Serio  
[amber\\_serio@uhc.com](mailto:amber_serio@uhc.com)

### FQHCs & RHCs

Karen Suitt  
[karen\\_suitt@uhc.com](mailto:karen_suitt@uhc.com)  
 (205) 437-8508

**\*PLEASE NOTE THAT A CALL REFERENCE # IS NEEDED BEFORE ESCALATING UNRESOLVED ISSUES TO A PROVIDER ADVOCATE.**

## Provider Advocates

### North MS & All FQHCs

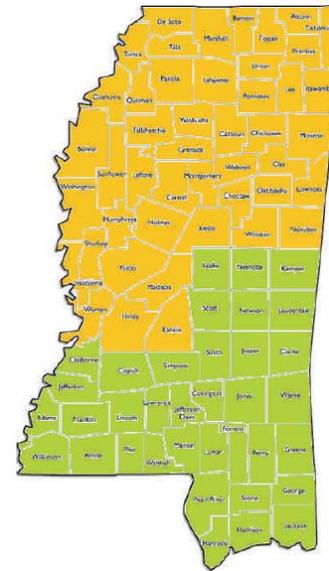
Morgan Jones  
[Morgan\\_w\\_jones@uhc.com](mailto:Morgan_w_jones@uhc.com)  
 (601) 718-6541

### South MS

Pam Hogan  
[Pamela\\_hogan@uhc.com](mailto:Pamela_hogan@uhc.com)  
 (601) 296-6733

### All Hospitals

Ann Downs  
[Saraha\\_downs@uhc.com](mailto:Saraha_downs@uhc.com)  
 (205) 437-8703



# Provider Incentives & Case Management

## *UHC's Enhanced Clinical Accelerator Model*

- **5 Accountable Care Community Practices** - Embedded Practice Care Managers perform a blended role of face to face case management and ACC agent; PCMs are active members of the PCP team, not "advisors" to the practice and perform traditional case manager responsibilities
- **5 Geographic Care Managers** – Traditional case management services delivered face to face and telephonically as needed based upon members' risk stratification
- **Medical Mall Care Transitions Program** –14 Community Health workers deployed statewide to outreach and follow-up with members identified as high risk and/or SuperUtilizer
- **Behavioral Health Care Advocates** – All members that receive BH service are assigned a Care Advocate, working in tandem with PCM and GCMs
- **MS Health Department Perinatal High Risk/Infant Services** – UHC's Healthy First Steps program is deployed for members who decline enrollment in MSDH's high risk case management program
- **Delta Health Home Project** – SuperUtilizers in specified zip codes have been enrolled into the CMS grant funded program for follow-up and case management
- **Provider Access to Timely Information** - Admissions and ER visits through the Population Registry and MS-HIN
- **Member Self-management Education** - member education, monitoring, health coaching, proper medication compliance, ADLs, transportation, overcoming isolation

# PCP Assignment & Panel Management

- As members select a preferred PCP, UHC checks participation status and panel specifications
- If the PCP is in Network, has an open panel, and the member meets panel restrictions, the member will be placed in that PCP's panel
- If a member does not select an available PCP at enrollment within 30 days, then the member will be auto-assigned based on decision logic
- PCPs communicate desired panel restrictions/limitations to Network Management (*initial setup or anytime thereafter*)
- Email notification is delivered every Monday to inform PCPs of any member panel change that occurred during the previous week
- PCP/Panel changes
  - Members may call member services to request a PCP change at any time and receive an updated ID card
  - Providers may initiate or change panel restrictions at any time by contacting Network Management
  - PCPs can also request changes to composition of their member panel

## Top 10 Denials – April 2014

1. Not a covered service
2. Submitted after timely filing limit
3. MS Medicaid ID needed
4. DOS after subscriber termination
5. Duplicate claim/service
6. Procedure/service done by another provider
7. Claim lacks needed info
8. DOS prior to subscriber effective date
9. Claim may be covered by third party/Coordination of Benefits (COB)
10. Absence of prior authorization

# Behavioral Healthcare

- **Authorization is NOT Required for Routine Outpatient Services**
  - Routine Initial Assessments
  - Outpatient Individual, Group, and Family Therapy
  - Medication Management
  - Targeted and Intensive Case Management
- **Intensive Outpatient Services DO Require Prior Authorization**
  - Acute Partial Hospitalization
  - Intensive Outpatient
  - ECT
  - Crisis Residential
  - Assertive Community Treatment
  - Psychosocial Rehabilitation
  - Day Treatment and Day Support
  - Psychological, Neuropsychological and Developmental Evaluation
- **To Obtain Authorization**
  - Call prior authorization (877) 743-8731
  - Submit via secure fax (855) 250-8159
  - Submit via secure e-mail [atlbehavmedreferral@uhc.com](mailto:atlbehavmedreferral@uhc.com)
- **MSCHIP:** *all codes require authorization unless performed by MD or RXN*

# UBH/Optum Contact Information



- **General Information**

- MississippiCAN (877) 743-8734
- Mississippi CHIP (800) 557-9933

- **[www.providerexpress.com](http://www.providerexpress.com) is first-line resource to:**

- Network Manual and MississippiCAN Network Manual Addendum
- Submit claims and prior authorization requests electronically
- Register for Clinical Learning programs
- Download Key Forms
- Review clinical guidelines
- Access Optum network newsletter (Network Notes)
- Obtain a secure user ID or get tech support, click first-time visitor “view information” link or call (866) 209-9320

- **UBH/Optum Provider Relations**

**Michael Strazi**

Network Manager MSCHIP  
(612)632-5727

[michael.strazi@optum.com](mailto:michael.strazi@optum.com)

Fax: (877) 331-5852

**Ricardo Fraga**

Network Manager MSCAN  
(601)718-6631

[ricardo.fraga@optum.com](mailto:ricardo.fraga@optum.com)

Fax:(888) 960-3835

- **Field Care Team**

- Meredith Clemmons, LCSW - MSCAN Field Care Advocate
- Ellen Santolucito, LCSW - MS CHIP Field Care Advocate

- **EDI Support : (800) 842-1109, 8AM-5PM**

- **UBH/Optum Claims Customer Service: 866-673-6315**

- **Paper Claims: PO Box 30757, Salt Lake City, UT 84130**

# Dental Benefits

- Children
  - Preventive
  - Diagnostic
  - Restorative
  - Orthodontia (\$4200 lifetime max)
  - \$2500 benefit max per calendar year (MSCAN)
  - \$1500 benefit max per calendar year (CHIP)
- Adults
  - Emergency pain relief
  - Palliative care
  - \$2500 benefit max per calendar year (MSCAN)
- *Certain dental procedures such as crowns, root canals, dentures and orthodontics require prior authorization.*
- Helpline: (800) 508-4862
- Online: [www.uhcproviders.com](http://www.uhcproviders.com)

## Dental Correspondence

UnitedHealthcare Dental  
Attn: **Claims**  
P.O. Box 781  
Milwaukee, WI 53201

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

UnitedHealthcare Dental  
Attn: **Prior Authorization**  
P.O. Box 1313  
Milwaukee, WI 53201

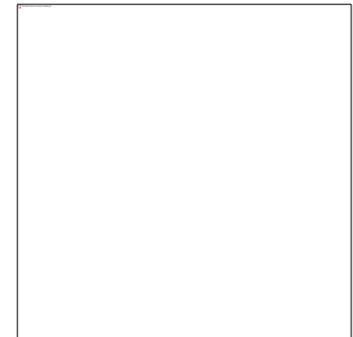
UnitedHealthcare Dental  
Attn: **Provider Relations**  
6220 Old Dobbin Lane  
Columbia, MD 21045

# Non-Emergent Transportation

- Non-Emergency Transportation (NET) is provided to Members who require transportation to and from Medicaid covered non-emergency services
- Members are required to request NET services 3 business days in advance
  - All NET requests are screened for necessity and appropriateness of the transportation service requested
  - Special processes are in place to handle urgent trips, last minute requests, scheduling changes, and NET Providers who do not arrive for scheduled pick-ups
  - Additional education is provided to Members who habitually request transportation less than 2 business days in advance of the appointment date
  - Denied requests are documented and further communicated in writing
- UHC has contracted with MTM to credential and manage the transportation network, as well as adjudicate all claims for NET services

# DME/Medical Supply & Home Health (MSCAN)

- All Medicaid benefits are administered
- All Medicaid restrictions apply
- DME/Medical Supply
  - Manually-priced/by-report services require documentation
  - DME/Supply items over \$500 require prior authorization
- Home Health
  - 25 home health visits allowed per Medicaid FY
    - Adult: prior auth required for all services (*skilled nurse or home health aide visits*)
    - Pediatric: prior auth required for visits beyond first 25 (*skilled nurse, home health aide, physical therapy, speech therapy visits*)
- Prior authorization
  - Phone: (866) 604-3267
  - Fax: (888) 310-6858
  - Online



[www.uhccommunityplan.com](http://www.uhccommunityplan.com) ▶ [Claims & Member Information](#) ▶ [Access Secure Provider Website](#)

# Timely Filing & Check Eligibility



- Timely Filing
  - Effective for dates of service 7/1/2014 and after, all MSCAN claims must be filed within 6 months from the date of service
  - CHIP timely filing definitions/requirements are defined in provider participation agreements and can vary
- Check Eligibility
  - Access Medicaid's Envision website ([msmedicaid.acs-inc.com](https://msmedicaid.acs-inc.com))
  - Log onto UHC Community Plan secure provider portal
  - Call Provider Services
    - MississippiCAN: (877) 743-8734
    - MS CHIP: (800) 557-9933

# HEDIS & Other Clinical Quality Initiatives

*Quality initiatives are developed by integrating non-compliant member level data into multi-faceted strategies designed to drive improved HEDIS scores and achieve better health outcomes.*

- **Performance Improvement Projects** target Asthma, CHF, Diabetes, & Obesity
- **Clinical Practice Consultants (CPCs)** field-based staff offering HEDIS education, review member reports, and discuss improvement opportunities
  - 2014 HEDIS in a box kit includes a coding reference for office staff to ensure quality metrics are captured via coding
  - [cheryl\\_h\\_jones@uhc.com](mailto:cheryl_h_jones@uhc.com) / (601) 853-0072
- **Member education** includes reminder calls, member incentives, participation in community outreach events, and educational brochures.
- **View360 online tool** helps physicians quickly identify UHC patients with clinical care opportunities (*based on evidence-based clinical quality criteria*)
  - Identifies when a test or procedure was last done and when it is next due
  - Uses claims data to monitor month-to-month changes in 49 preventive measures
  - Provides up to 3 years of UHC patient care history (i.e. labs, prescriptions, procedures billed)
  - Access can be delegated to authorized staff



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

- Preventive services for children up to age 21
  - Performed at regular intervals (Birth to 1 month, 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months, annually for ages 2 - 21 years)
- Services include
  - Complete physical, dental, hearing, and vision exams
  - Immunizations
  - Necessary blood and urine tests
  - Developmental assessment
  - Adolescent counseling services
  - Additional treatments and services as needed (i.e. prescriptions and therapy services)
- Missed Appointment Protocol (*effective 7/1/2014*)
  - Effort to reduce no-shows and increase EPSDT compliance
  - Providers are asked to complete a missed appointment form for any member who misses a scheduled EPSDT appointment (monthly fax submission to UHC)
  - UHC will engage in targeted outreach to close care gaps and increase compliance

## Contacts

- Online
  - [www.UHCCommunityPlan.com](http://www.UHCCommunityPlan.com) - medical
  - [www.ProviderExpress.com](http://www.ProviderExpress.com) - behavioral
  - [www.UHCproviders.com](http://www.UHCproviders.com) – dental
- Provider Services Call Center
  - MississippiCAN: (877) 743-8734
  - MS CHIP: (800) 557-9933
- Network Account Managers (*slide #4*)
- Provider Advocates (*slide #4*)
- Clinical Practice Consultants (*slide #14*)
- Subcontractors/Vendors
  - UBH/Optum Behavioral Health: (877) 743-8731
  - OptumRx/Pharmacy: (877) 305-8952
  - Dental Benefit Provider: (800) 508-4862
  - MTM/Non-Emergent Transportation: (866) 331-6004
  - Vision Services Provider: (800) 877-7195
  - Case Management : (877) 743-8731
  - CareCore National: (866) 889-8054



# Questions?



MISSISSIPPI DIVISION OF  
**MEDICAID**

