DOM Office of Coordinated Care

The DOM Office 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 for MississippiCAN and CHIP are:

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

For questions regarding MississippiCAN, call 601-359-3789 or email MississippiCAN.Plan@medicaid.ms.gov or view the website at [www.medicaid.ms.gov](http://www.medicaid.ms.gov)
Medicaid Organizational Chart

Managed Care

MississippiCAN
- Magnolia Health
  - Behavioral Health Cenpatico
  - Dental Health Dental
  - DME Magnolia Health
  - NurseWise
- UnitedHealth Community Plan
  - Behavioral Health UBH OptumHealthcare
  - Dental Benefits Provider Dental
  - Care Core National
  - Vision OptiCare
  - Disease Management Nurtur

CHIP
- United Healthcare CHIP Contractor
- Magnolia Health CHIP Contractor

UM/QIO eQHealth Solutions
- Provider Credentialing
- NET MTM
## Contact Information

<table>
<thead>
<tr>
<th>Division of Medicaid</th>
<th>Magnolia Health Plan</th>
<th>UnitedHealthcare Community Plan</th>
<th>CHIP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fiscal Agent and Provider Credentialing&lt;br&gt;Xerox&lt;br&gt;Toll Free: 1-800-884-3222</td>
<td>Dental&lt;br&gt;Dental Health and Wellness&lt;br&gt;Toll Free: 1-866-912-6285</td>
<td>Dental&lt;br&gt;Dental Benefit Prov&lt;br&gt;Toll Free: 1-800-508-4862</td>
<td></td>
</tr>
<tr>
<td>Non-Emergency Transportation&lt;br&gt;MTM&lt;br&gt;Toll Free: 1-866-331-6004</td>
<td>Non-Emergency Transportation&lt;br&gt;MTM&lt;br&gt;Toll Free: 1-866-331-6004</td>
<td>Non-Emergency Transportation&lt;br&gt;MTM&lt;br&gt;Toll Free: 1-866-331-6004</td>
<td></td>
</tr>
<tr>
<td>DME&lt;br&gt;Magnolia&lt;br&gt;Toll Free: 1-866-912-6285</td>
<td>Care Core National&lt;br&gt;Toll Free: 1-866-889-8054</td>
<td>Care Core National&lt;br&gt;Toll Free: 1-866-889-8054</td>
<td></td>
</tr>
<tr>
<td>NurseWise&lt;br&gt;Toll Free: 1-866-912-6285</td>
<td>Provider Credentialing&lt;br&gt;Toll-free: 866-574-6088</td>
<td>Provider Credentialing&lt;br&gt;Toll-free: 866-574-6088</td>
<td></td>
</tr>
</tbody>
</table>
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 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
  - All Medicaid services included except Inpatient Hospital Services as of July 2014
MississippiCAN
Program Changes

Uniform Preferred Drug List (PDL)
Effective January 1, 2015, instead of a different PDL for DOM and each CCO, there will be one Uniform PDL for those specific drugs.

Non-Emergency Transportation (NET)
Effective July 1, 2014, each CCOs will contract with MTM for MississippiCAN beneficiaries.

Prior Authorizations (PA)
Prior authorization requests will be approved/disapproved within 3 calendar days or 2 business days, if all documentation provided.

Provider Credentialing
The CCO shall credential all completed application packets within ninety (90) calendar days of receipt.

Claims
Timely filing within 180 days of date of service. Reconsidered claims within 90 days of timely filing adjudication.
MississippiCAN and CHIP Enrollment Statistics

743,362
Medicaid beneficiaries
(Regular Medicaid)

Of the total Medicaid Beneficiaries
422,448
MississippiCAN

49,339
CHIP beneficiaries

As of May 31, 2015
MississippiCAN Enrollment 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 moved from CHIP and enrolled in the MississippiCAN program.

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

Their CHIP coverage and services will remain the same.

MississippiCAN Expansion - Children
- May through July 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.
Increased MississippiCAN Enrollment

- Between May 1 and July 31, 2015, Medicaid-eligible children up to the age of 19 are set to be transitioned from regular Medicaid to the managed care program, Mississippi Coordinated Access Network (MississippiCAN).

- One third of the 300,000 children are being enrolled in three monthly phases:
  - May 1, 2015
  - June 1, 2015
  - July 1, 2015

- Children not included in this expansion are those who are on Medicare, waivers or reside in institutions.

- For the children being transitioned, this does not change their coverage and there is no loss of benefits.
Why is the transition happening?

- Of the nearly 800,000 Mississippians enrolled in Medicaid or the Children’s Health Insurance Program (CHIP), children are the largest population we serve. Authorized by the Mississippi Legislature in 2011, MississippiCAN was established to create more efficiency and provide better access to health services, making Mississippi one of at least 26 other states to adopt a managed-care approach.

<table>
<thead>
<tr>
<th>Transition Children (Beginning SFY 2015)</th>
<th>085 - 091</th>
<th>072 – 073</th>
<th>1 - 19***</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children (TANF)</td>
<td>085</td>
<td>071 – 073</td>
<td>1 - 19</td>
</tr>
<tr>
<td>Children (&lt; age 6) (&lt; 143% FPL)</td>
<td>087, 085</td>
<td>072</td>
<td>1 - 5</td>
</tr>
<tr>
<td>Children (&lt; age 19) (&lt;100% FPL)</td>
<td>091, 085</td>
<td>073</td>
<td>6 - 19</td>
</tr>
</tbody>
</table>
How do providers know to which program beneficiaries have been assigned?

• Health-care providers should verify their patients’ eligibility and plan at each date of service, and make sure patients are in their provider network. This is essential to receive proper reimbursement for services.

  To check eligibility information, contact us by:
  Xerox AVRS toll-free: 800-884-3222 Xerox Web Portal: ms-medicaid.com

• Note: Mississippi Medicaid health benefits encompass multiple programs administered by DOM: Medicaid, MississippiCAN and CHIP.
• The MississippiCAN and CHIP programs are administered by two coordinated care organizations (CCOs).
• Providers voluntarily enroll with the programs and with these CCOs. However, DOM encourages all providers to enroll ensuring that your patients remain under your care, and you receive payment from the proper source.
How do providers obtain prior authorizations?

• For children being transitioned, there will be a 90-day grace period for all existing prior authorizations received from DOM and eQHealth.

• If beneficiary is enrolled May 1, then the existing prior authorization will expire in 90 days or July 30, then a separate 90 days for those with effective dates June 1 and July 1.

  Within the 90-day grace period, providers should contact CCOs for a new prior authorization or for a renewal beyond this period

• If PA ends during the 90 day grace period, then a new PA must be obtained by the provider. PAs will not automatically be extended during that 90 day period if they were to expire during the 90-day grace period.

  For example: PA period is January 1, 2015 to June 20, 2015, and beneficiary is enrolled May 1; then provider would need a new PA by June 20, 2015. However, if the PA was January 1, 2015 to October 1, 2015, then provider would need a new PA by August 1, 2015.
Is the primary care provider (PCP) on MississippiCAN card the only PCP that member can see?

- No, the PCP on the member card is simply to direct them to an enrolled PCP, rather than seeking emergency treatment.
- Many members have their own PCPs, but they are not reflected in our records. Members should continue to be treated by their own PCPs, and call the CCOs to update their record with their actual treating provider.
- The beneficiaries can contact the CCO and get an updated card with the PCP of their choice, as long as the PCP is in the CCOs network.
Medicaid Requirements for Provider Reimbursement

- In accordance with State law, CCOs are required to reimburse all providers in those organizations at rates no less than what Medicaid reimburses Fee-For-Service Providers, if in-network providers.

- All claims for services covered by the CCOs for MississippiCAN members must be submitted to the designated CCO in order to receive payment.

- Claims for services not covered by MississippiCAN must be submitted to Medicaid, specifically Inpatient Hospital stays, or any other non-covered services.
Medicaid Requirements for Provider Networks

- All CCO contracted MississippiCAN providers must be Mississippi Medicaid providers.

- CCO networks must include all types of Medicaid providers and the full range of medical specialties necessary to provide covered benefits.

- Access standards for the network require primary care services be available within 30 minutes or 30 miles in rural regions and 15 minutes or 15 miles in urban regions.
Beneficiaries Eligible for MississippiCAN
# MississippiCAN

Optional Populations

*These beneficiaries may return to regular Medicaid.*

<table>
<thead>
<tr>
<th>Category of Eligibility</th>
<th>COE</th>
<th>New COE</th>
<th>Age</th>
</tr>
</thead>
<tbody>
<tr>
<td>SSI - Supplemental Security Income</td>
<td>001</td>
<td>001</td>
<td>0 - 19</td>
</tr>
<tr>
<td>Disabled Child Living at Home</td>
<td>019</td>
<td>019</td>
<td>0 - 19</td>
</tr>
<tr>
<td>DHS – Foster Care Children- IV-E</td>
<td>003</td>
<td>003</td>
<td>0 - 19</td>
</tr>
<tr>
<td>DHS – Foster Care Children- CWS</td>
<td>026</td>
<td>026</td>
<td>0 - 19</td>
</tr>
</tbody>
</table>

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](http://www.ms-medicaid.com)
# MississippiCAN Mandatory Populations

<table>
<thead>
<tr>
<th>Category of Eligibility</th>
<th>COE</th>
<th>New COE</th>
<th>Age</th>
</tr>
</thead>
<tbody>
<tr>
<td>SSI - Supplemental Security Income</td>
<td>001</td>
<td>001</td>
<td>19 - 65</td>
</tr>
<tr>
<td>Working Disabled</td>
<td>025</td>
<td>025</td>
<td>19 - 65</td>
</tr>
<tr>
<td>Breast and Cervical Cancer</td>
<td>027</td>
<td>027</td>
<td>19 - 65</td>
</tr>
<tr>
<td>Parents and Caretakers (TANF)</td>
<td>085</td>
<td>075</td>
<td>19 - 65</td>
</tr>
<tr>
<td>Pregnant Women (below 194% FPL)</td>
<td>088</td>
<td>088</td>
<td>8 - 65</td>
</tr>
<tr>
<td>Newborns (below 194% FPL)</td>
<td>088</td>
<td>071</td>
<td>0 - 1</td>
</tr>
<tr>
<td>Transition Children (Beginning SFY 2015)</td>
<td>085 - 091</td>
<td>072 – 073</td>
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<tr>
<td>Children (&lt; age 19) (&lt;100% FPL)</td>
<td>091, 085</td>
<td>073</td>
<td>6 - 19</td>
</tr>
<tr>
<td>Quasi-CHIP (100%-133% FPL) (age 6- 19) (previously qualified for CHIP)</td>
<td>099</td>
<td>074</td>
<td>6 - 19</td>
</tr>
<tr>
<td>CHIP (age 0-19) (&lt;209% FPL)</td>
<td>099</td>
<td>099</td>
<td>1 - 19</td>
</tr>
</tbody>
</table>
Mississippi Department Of Human Services (MDHS) Beneficiaries

• Currently Foster Care children under MDHS custody are primarily enrolled with MississippiCAN – Magnolia Health

• Adoptive Assistance Parents may select their choice of MississippiCAN CCO, either Magnolia or UnitedHealthcare

  *(therefore, case workers should always check eligibility)*

• Now beginning May 1, 2015, children under age 19 will be mandatorily enrolled in MississippiCAN, except those not eligible for MississippiCAN.
Beneficiaries Not Eligible for MississippiCAN

Who is not eligible for MississippiCAN

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

- **Dually eligibles** (Medicare/Medicaid)

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

- **Hemophilia diagnosis**

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

- **Beneficiaries currently with inpatient hospital stays**
MississippiCAN Enrollment
MississippiCAN Enrollment

When can Beneficiaries enroll in MSCAN?
• Beneficiaries not already enrolled may enroll throughout the year.

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

When is Enrollment effective?
• Enrollment is always effective at the beginning of the month and disenrollment is effective the last day of the month.
  – The exception is when beneficiary is transferred to a nursing home or waiver program.

When can Members choose a CCO?
• After receiving initial notification letter, beneficiaries may choose a plan within 30 days, or they will be automatically assigned to a CCO. Members may be added each month to Medicaid and MississippiCAN.

When can Members change CCOs?
• After initial enrollment with a CCO, every member will have a 90-day window to make changes
• During the 90-day window, mandatory members may only switch once between CCOs.
• During the 90-day window, optional members may switch once between the CCOs or return to regular Medicaid.
• The open enrollment period each year (October – December) to allow members to make changes.
  Effective January 1.
Beneficiary Notification and Choice of Coordinated Care Organization (CCO) for MississippiCAN or MississippiCHIP

- **Initial Notification Letter (MSCAN-005 Mandatory or CHIP-002)**
  - The letter is mailed to beneficiaries advising them that they have 30 days to choose a CCO. Beneficiaries are recommended to ask their doctors with which CCO they are enrolled. Enrollment Form is on the back of the letter.

- **Auto-Assignment Letter (MSCAN-002 or CHIP-003)**
  - The letter is mailed to beneficiaries advising them that they did not choose a CCO, therefore, one has been assigned for them. However, beneficiaries may switch CCOs once within the initial 90 days. The next time that beneficiaries may switch CCOs is during Annual Open Enrollment from October 1 to December 15 (effective January 1 of following year)

- **Selection Forms**
  - Beneficiaries may complete the form mailed to their home, or they may go online to the Envision web portal and select CCO.
    - [https://www.ms-medicaid.com/msenvision/mschipInfo.do](https://www.ms-medicaid.com/msenvision/mschipInfo.do)
  - Go to the DOM website and select form.
Benefits for Members

- CCOs connect enrollees to a medical home through PCPs, and offer case management to all enrollees.

- CCOs implemented comprehensive care management programs which include coordinating services with mental health providers, social service agencies and out-of-state providers to improve care and quality outcomes.

- CCOs were required to develop disease management programs which include, but are not limited to:
  - Diabetes
  - Organ Transplants
  - Congestive Heart Disease
  - Obesity
  - Asthma
  - Hypertension
  - Hemophilia to 11-30-2012

Both CCOs have Nurses available 24 hours, seven days per week to address beneficiary or provider issues:

- **Magnolia Health** 1-866-912-6285 24/7 NurseWise
- **UnitedHealthcare** 1-877-743-8731 NurseLine 24/7
MississippiCAN CARDS
MississippiCHIP
Children’s Health Insurance Program
Evolution of Children’s Health Insurance Program (CHIP)

- Mississippi House Bill 1275 – 2014 Regular Session

- The CHIP program and contract for insurance services was transferred from School Employees Health Insurance Management Board (DFA) to the Division of Medicaid (DOM) as of January 1, 2013. 41-86-9

- The CHIP program is now authorized to operate under a managed care delivery system as of January 1, 2015. 43-13-117(H)
The CHIP Program is not changing. 
“There are now 2 vendors.”

What is changing?

– Effective January 1, 2015, the CHIP program is now operated by 2 vendors, instead of 1 vendor:
  - UnitedHealthcare and Magnolia Health

– Effective January 1, 2014, CHIP income level begins at 133% instead of 100% of the Federal Poverty Level per ACA.

What is the same?

– Same Benefits
– Same Co-Payments
– Providers must be enrolled as a CHIP provider to receive payment.

Providers with CHIP children enrolled with both CCOs, must be enrolled with both CCOs to receive payment.
Who is eligible for CHIP?

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

<table>
<thead>
<tr>
<th>Category of Eligibility</th>
<th>COE</th>
<th>New COE</th>
<th>Age</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHIP</td>
<td>099</td>
<td>099</td>
<td>0 - 19**</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>(19th year birth month)</td>
</tr>
</tbody>
</table>
Mississippi CHIP CARDS

Magnolia Health
Mississippi Children's Health Insurance Program

Member Name: Jane Doe
CHIP ID: XXXXXXXXXXXX
PCP Number: XXX-XXX-XXXX
Effective Date of Coverage: XX/XX/XXXX
Out of Pocket Maximum: $XXXX

If your child has an emergency, call 911 or go to the nearest emergency room (ER). You do not have to contact Magnolia for an okay before your child gets emergency services. If you are not sure whether your child needs to go to the ER, call your child’s PCP or Magnolia NurseWise® toll-free at 1-866-912-6285 (TDD/TTY 1-877-726-7763) or Mississippi Relay Services at 711. NurseWise is open 24 hours a day.

UnitedHealthcare
Community Plan

Member ID: 999999999
Member: SUBSCRIBER M BROWN
Payer ID: OPTUMRx

Copy of: Office / ER
CO/PAY: Office / ER

This card does not guarantee coverage. To verify benefits or find a provider, visit the website www.ahcommunityplan.com or call:

For Members: 800-903-9540
For Providers: 800-557-0033

For medical claim information, call:

800-992-9540
For Pharmacies: 888-366-3243

Payment Plan Available

Magnolia Address
111 East Capitol Street
Suite 500
Jackson, MS 39201

PROVIDERS:
IVR Eligibility inquiry - Prior Auth 1-866-912-6285
US Script Help Desk 1-800-460-8988
Behavioral Health 1-866-912-6285
Prior Authorization 1-866-912-6285

Medical claims:
Magnolia
Attn: CLAIMS
PO Box 5040
Farmington, MO 63640-3325

Provider/claims information via the web: MagnoliaHealthPlan.com.
<table>
<thead>
<tr>
<th>What is the difference between programs?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medicaid Fee-for-Service</strong></td>
</tr>
<tr>
<td>Beneficiary Eligibility: Beneficiaries qualify based on income, resources, age and/or medical disability. Coverage for children, families, pregnant women, elderly and disabled persons.</td>
</tr>
<tr>
<td><strong>MississippiCAN</strong></td>
</tr>
<tr>
<td>Beneficiaries in certain Medicaid categories of eligibility (SSI, Disabled Children at Home, Working Disabled, Breast/Cervical, Newborns and Children)</td>
</tr>
<tr>
<td><strong>CHIP</strong></td>
</tr>
<tr>
<td>Children ages 0-19 whose income exceeds Medicaid maximum, up to 209% Federal Poverty Level.</td>
</tr>
<tr>
<td><strong>Beneficiary Enrollment Site</strong></td>
</tr>
<tr>
<td>Division of Medicaid Regional Office</td>
</tr>
<tr>
<td>Division of Medicaid Regional Office</td>
</tr>
<tr>
<td>Division of Medicaid Regional Office</td>
</tr>
<tr>
<td><strong>Beneficiary Enrollment</strong></td>
</tr>
<tr>
<td>Members can only receive services from one program at a time, no overlap.</td>
</tr>
<tr>
<td>Members can only receive services from one program at a time, no overlap.</td>
</tr>
<tr>
<td>Members can only receive services from one program at a time, no overlap.</td>
</tr>
<tr>
<td><strong>Beneficiary Services</strong></td>
</tr>
<tr>
<td>Medicaid services</td>
</tr>
<tr>
<td>MississippiCAN services</td>
</tr>
<tr>
<td>Medicaid services, plus additional services such as case management</td>
</tr>
<tr>
<td>CHIP services</td>
</tr>
<tr>
<td><strong>Provider Enrollment</strong></td>
</tr>
<tr>
<td>Enroll with Medicaid</td>
</tr>
<tr>
<td>Enroll with Medicaid and MSCAN vendor (Magnolia or UnitedHealthcare)</td>
</tr>
<tr>
<td>Enroll with CHIP vendor (UnitedHealthcare and/or Magnolia)</td>
</tr>
<tr>
<td><strong>File Claims</strong></td>
</tr>
<tr>
<td>Division of Medicaid Xerox</td>
</tr>
<tr>
<td>Vendors (Magnolia or UnitedHealthcare)</td>
</tr>
<tr>
<td>Vendors (UnitedHealthcare or Magnolia –DOS after 1-1-15)</td>
</tr>
<tr>
<td><strong>Website</strong></td>
</tr>
<tr>
<td><a href="http://www.medicaid.ms.gov">www.medicaid.ms.gov</a></td>
</tr>
<tr>
<td><a href="http://www.ms-medicaid.com">www.ms-medicaid.com</a></td>
</tr>
<tr>
<td><a href="http://www.medicaid.ms.gov/programs/mississippiCAN">www.medicaid.ms.gov/programs/mississippiCAN</a></td>
</tr>
<tr>
<td><a href="http://magnoliahealthplan.com">magnoliahealthplan.com</a></td>
</tr>
<tr>
<td><a href="http://uhccommunityplan.com">uhccommunityplan.com</a></td>
</tr>
<tr>
<td><a href="http://uhccommunityplan.com">uhccommunityplan.com</a></td>
</tr>
<tr>
<td><a href="http://magnoliahealthplan.com">magnoliahealthplan.com</a></td>
</tr>
</tbody>
</table>
CONTENTS

1. Verifying Eligibility
2. Updates/Changes to Your Medicaid Provider File
3. Taxonomy Code Placement
4. Medicare Advantage Plans Part C
5. Prior Authorization
6. Timely Filing Limits
7. Envision Web Portal
It is the responsibility of the Medicaid Provider to verify a Medicaid beneficiary’s eligibility each time the beneficiary presents for a service.

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 or
- Accessing the Envision Web Portal at www.ms-medicaid.com
Taxonomy Code Placement

The Taxonomy Code is required when there exists a one-to-many link with the Medicaid Provider Numbers. The fields utilized for claims are as follows:

- **CMS 1500 Claim** – The taxonomy code should be entered in field 33b when required.

- **UB-04 Claim** – The taxonomy code should be entered in field 3b when required.

- **State Specific Part A Crossover Claim form for Medicare Advantage Plans** – The taxonomy code should be entered in field 3c when required.

- **State Specific Part B Crossover Claim form for Medicare Advantage Plans** – The taxonomy code should be entered in field 2c when required.

- **American Dental Association (ADA) Dental Claim Form** – The taxonomy code should be placed in field 56A and is indicated as a require field for this form only.
The Mississippi Medicaid Part A & B Crossover Claim forms are state specific forms and must be used when billing for Medicare Part C Advantage Plans only.

- A copy of the Medicare EOMB (Explanation of Medicare Benefits) must be attached to each Medicare Part C Advantage Plan claim.

- The claim forms and instructions are available on DOM’s website at www.medicaid.ms.gov. Select Resources link then the Forms link.
The Division of Medicaid has contracted with two Utilization Management/Quality Improvement Organizations (UM/QIO) for the purpose of evaluating medical necessity of medical services and services for certain advanced imaging procedures. Services per Contractor are:

**eQ Health Solutions**
- Inpatient Medical/Surgical
- Acute Psychiatric
- Swing Bed
- Psychiatric Residential Treatment Facilities
- Private Duty Nursing
- Home Health Visits beginning with visit 26 for beneficiaries under age 21
- Durable Medical Equipment, Prosthetics, Orthotics, and Diapers/Under pads (Other Medical Supplies excluded)
- Outpatient Hospital Mental Health Services
- Outpatient Physical, Occupational, and Speech Therapy
- Transplant Services
- Mississippi Youth Programs Around the Clock Waiver (MYPAC)
- Dental / Oral Surgery / Orthodontics
- Vision
- Hearing
Prior Authorization

**MedSolutions**
Provides medical necessity reviews for all out-patient, non-emergent imaging services:
- Magnetic Resonance Imaging (MRI/MRA)
- Computed Tomography (CT)
- Positron Emission Tomography (PET)
- Nuclear Cardiac Studies

A list of CPT codes which requires prior authorization located at www.medicaid.ms.gov (click on Resources then Helpful Links, and then the MedSolutions link). The link also includes a provider procedure manual to assist providers with policy and guidelines for the authorization process.
Timely Filing

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

Claims filed within the first 12 months and denied can be resubmitted with the original transaction control number (TCN). The appropriate field for placement of the TCN for each corresponding claim form is as follows:

<table>
<thead>
<tr>
<th>Forms</th>
<th>Fields</th>
</tr>
</thead>
<tbody>
<tr>
<td>CMS-1500</td>
<td>Field 22</td>
</tr>
<tr>
<td>UB-04</td>
<td>Field 64</td>
</tr>
<tr>
<td>ADA Dental</td>
<td>Field 35</td>
</tr>
<tr>
<td>Crossover Part A</td>
<td>None</td>
</tr>
<tr>
<td>Crossover Part B</td>
<td>None</td>
</tr>
</tbody>
</table>
Timely Filing

- Claims over 12 months can be processed if the beneficiary’s Medicaid has been retroactively approved by DOM or Social Security Administration.
- The 12 month filing limit for newly enrolled provider begins with the date of issuance of the provider’s Welcome Letter.

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

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

Important Web Addresses

- **DOM website**
  - [http://www.medicaid.ms.gov](http://www.medicaid.ms.gov)
- **eQ Health Solutions**
  - [www.ms.eqhs.org](http://www.ms.eqhs.org)
- **MedSolutions**
  - [www.medsolutionsonline.com](http://www.medsolutionsonline.com)
- **Mississippi Envision Web Portal**
  - [https://ms-medicaid.com](https://ms-medicaid.com)
- **Xerox EDI website**
  - [www.acs-gcro.com](http://www.acs-gcro.com)
## Web Portal Eligibility

### Mississippi Envision

Quality Health-care Services Improving Lives

<table>
<thead>
<tr>
<th>Home</th>
<th>Provider</th>
<th>Beneficiary</th>
<th>Xerox</th>
<th>Reach Us</th>
<th>FAQ</th>
<th>Search</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claims Entry</td>
<td>Communication Options</td>
<td>Coordinated Care Organization</td>
<td>EHR Incentive Program</td>
<td>Fee Schedules</td>
<td>Forms</td>
<td>General Billing Tips</td>
</tr>
</tbody>
</table>

### What's New

- **RUG-IV TIF**
- **RAC Website**
- **MSCAN BIDS**

### Welcome

- **Welcome**
- **Massage**

### News

- **Living News**

### Visit

- **Division of Medicaid**
- **eQHealth Solutions**
- **Report Fraud and Abuse**

### Latest News

- **Banner Messages**
- **Site Map**
- **Current Medicaid Bulletin**
# Web Portal Eligibility

## Eligibility Inquiry

Any one of the following inquiry options is required for an eligibility inquiry transaction.

- Last Name, First Name, DOB  
- Beneficiary ID  
- Last Name, First Name, SSN  
- SSN, DOB

Please enter any information available. You must include at least above criteria. Please enter dates in mm/dd/yyyy format.

In order to display coverage for a specific time period, you must enter both a Begin Date and an End Date.

<table>
<thead>
<tr>
<th>Field</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beneficiary ID:</td>
<td></td>
</tr>
<tr>
<td>Last Name:</td>
<td></td>
</tr>
<tr>
<td>First Name:</td>
<td></td>
</tr>
<tr>
<td>SSN:</td>
<td></td>
</tr>
<tr>
<td>DOB:</td>
<td></td>
</tr>
<tr>
<td>Date(s) of Service:</td>
<td></td>
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</table>

*The Begin date and End date entered must be within same calendar month.*

<table>
<thead>
<tr>
<th>Field</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Begin Date</td>
<td>05/13/2015</td>
</tr>
<tr>
<td>End Date</td>
<td>05/13/2015</td>
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[Submit]  [Reset]
# Web Portal Eligibility

<table>
<thead>
<tr>
<th><strong>Beneficiary Eligibility Response</strong></th>
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<tbody>
<tr>
<td><strong>Name:</strong></td>
</tr>
<tr>
<td><strong>Beneficiary ID:</strong></td>
</tr>
<tr>
<td><strong>Beneficiary Address:</strong></td>
</tr>
<tr>
<td><strong>Gender:</strong></td>
</tr>
<tr>
<td><strong>Date Of Birth:</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Eligibility Information</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Eligibility or Benefit information:</strong></td>
</tr>
<tr>
<td><strong>Begin date:</strong></td>
</tr>
<tr>
<td><strong>End date:</strong></td>
</tr>
<tr>
<td><strong>Plan Coverage:</strong></td>
</tr>
<tr>
<td><strong>This beneficiary has Full Medicaid Benefits Coverage.</strong></td>
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</table>

<table>
<thead>
<tr>
<th><strong>Lock-In Information</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Lock-In Type:</strong></td>
</tr>
<tr>
<td><strong>Begin Date:</strong></td>
</tr>
<tr>
<td><strong>End date:</strong></td>
</tr>
<tr>
<td><strong>Lock-In Provider ID:</strong></td>
</tr>
<tr>
<td><strong>Lock-In Status Description:</strong></td>
</tr>
<tr>
<td>This Beneficiary is enrolled in the Mississippi Coordinated Access Network (Mississippi/CAN). All services except inpatient hospital service should be coordinated through the plan sponsor listed above. While enrolled in Mississippi/CAN, only claims for inpatient hospital services should be submitted to Xerox for processing.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Plan Sponsor:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MAGNOLIA HEALTH PLAN INC</strong></td>
</tr>
<tr>
<td><strong>1-866-912-6285</strong></td>
</tr>
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</table>
## Web Portal Eligibility

### Beneficiary Eligibility Response

<table>
<thead>
<tr>
<th>Field</th>
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<tbody>
<tr>
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<td>Beneficiary Address:</td>
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### Eligibility Information

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<td>Eligibility or Benefit Information:</td>
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<tr>
<td>End date:</td>
<td>12/31/9999</td>
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<td>Plan Coverage:</td>
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### Lock-In Information

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<td>End date:</td>
<td>12/31/9999</td>
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<tr>
<td>Lock-In Provider ID:</td>
<td>09974046</td>
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<tr>
<td>Lock-In Status Description:</td>
<td>MississippiCHIP</td>
</tr>
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</table>

This Beneficiary is enrolled in the Mississippi Child Health Insurance Program (MississippiCHIP).

Plan Sponsor: UNITED HEALTHCARE OF MISSISSIPPI IN 1-800-992-9840
# Available Service Limits

For chiropractic service limits and orthodontia limits, please call the AVRS or the Xerox call center.

Screenings are available at age appropriate intervals ONLY.

<table>
<thead>
<tr>
<th>Service</th>
<th>Limit</th>
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<tbody>
<tr>
<td>Physician Office Visits</td>
<td>12</td>
</tr>
<tr>
<td>Hospital Inpatient Days</td>
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<tr>
<td>Physician Inpatient Days</td>
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<tr>
<td>Home Health Visits</td>
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<tr>
<td>Hospital Outpatient Visits</td>
<td>99999</td>
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<tr>
<td>Physician Long Term Care Visits</td>
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<tr>
<td>Blood Units</td>
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<td>LTC Home Leave Days</td>
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<td>Mental-Health Meds Check</td>
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<tr>
<td>Mental-Health Individual Therapy</td>
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<td>Mental-Health Family Therapy</td>
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<td>Mental-Health Case Management</td>
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<td>Dental Exams Limit</td>
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<tr>
<td>Waiver282 ProdCodeW3117</td>
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<td>Psych Office Visits 90XX</td>
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<td>Mental-Health ProcedureW3027</td>
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<tr>
<td>Phys Annual Assessment</td>
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</table>

### Other Eligibility Information

- **Dental Coverage**
- **Vision Coverage**

[New Inquiry] [Back]
Edit 1109

Edit 1109: Service not authorized for MississippiCAN Beneficiary

Ways to avoid this edit:

- Verify eligibility through AVRS (800-884-3222) Option 3
- Verify MSCAN information with beneficiary.
- Verify eligibility through Envision/Web Portal.
Helpful Hints

Make sure you periodically update provider information as needed:

• Addresses
• Contact information
• Phone numbers
• E-mail addresses
• Banking information
• Fax number

*Make sure to check “Late Breaking News” and review quarterly Medicaid bulletins
# Provider Field Reps Area by County

<table>
<thead>
<tr>
<th>AREA 1</th>
<th>AREA 2</th>
<th>AREA 3</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>County</strong></td>
<td><strong>County</strong></td>
<td><strong>County</strong></td>
</tr>
<tr>
<td>Desoto</td>
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<td>Bolivar</td>
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<tr>
<td>Lafayette</td>
<td>Benton</td>
<td>Coahoma</td>
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<td>Marshall</td>
<td>Itawamba</td>
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<td>Panola</td>
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<td>Quitman</td>
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<td>Tate</td>
<td>Pontotoc</td>
<td>Sunflower</td>
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<tr>
<td>Tunica</td>
<td>Prentiss</td>
<td>Tallahatchie</td>
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<td>Tippah</td>
<td>Tishomingo</td>
<td>Yalobusha</td>
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<tr>
<td>Tishomingo</td>
<td><em>Memphis</em></td>
<td>Union</td>
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<thead>
<tr>
<th>AREA 4</th>
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<tr>
<td><strong>County</strong></td>
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<td><strong>County</strong></td>
</tr>
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<td>Attala</td>
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<td>Kemper</td>
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<td>Calhoun</td>
<td>Humphreys</td>
<td>Lauderdale</td>
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<td>Carroll</td>
<td>Issaquena</td>
<td>Lowndes</td>
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<td>Chickasaw</td>
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<td>Neshoba</td>
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<td>Sharkey</td>
<td>Newton</td>
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<td>Clay</td>
<td>Washington</td>
<td>Noxubee</td>
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<tr>
<td>Grenada</td>
<td>Yazoo</td>
<td>Winston</td>
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<td>Monroe</td>
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<tr>
<td>Montgomery</td>
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<tr>
<td>Oktibbeha</td>
<td></td>
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<tr>
<td>Webster</td>
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*MISSISSIPPI DIVISION OF MEDICAID*

*xerox [logo]®*
<table>
<thead>
<tr>
<th>AREA 7</th>
<th>AREA 8</th>
<th>AREA 9</th>
</tr>
</thead>
</table>
| Candice Granderson (601.206.3019) candice.granderson@xerox.com | Justin Griffin (601.206.2922)  
Zip Codes (39041-39215)  
justin.griffin@xerox.com  
Randy Ponder (601.206.3026)  
Zip Codes (39216-39296)  
randy.ponder@xerox.com | Joyce Wilson (601.359.4293) joyce.wilson@medicaid.ms.gov |

<table>
<thead>
<tr>
<th>County</th>
<th>County</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Adams</td>
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<td>Amite</td>
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<tr>
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<td>Rankin</td>
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<td>Scott</td>
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<td>Jefferson</td>
<td>Simpson</td>
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<td>Warren</td>
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<td>Wilkinson</td>
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<table>
<thead>
<tr>
<th>AREA 10</th>
<th>AREA 11</th>
<th>AREA 12</th>
</tr>
</thead>
</table>
| Nadia Shelby (601.206.2961) nadia.shelby@xerox.com | Pamela Williams (601.359.9575)  
pamela.williams@medicaid.ms.gov | Connie Mooney (601.572.3253)  
connie.mooney@xerox.com |

<table>
<thead>
<tr>
<th>County</th>
<th>County</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Clarke</td>
<td>Covington</td>
<td>George</td>
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<tr>
<td>Forrest</td>
<td>Jefferson-Davis</td>
<td>Hancock</td>
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<tr>
<td>Greene</td>
<td>Lawrence</td>
<td>Harrison</td>
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<tr>
<td>Jasper</td>
<td>Lincoln</td>
<td>Jackson</td>
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<tr>
<td>Jones</td>
<td>Marion</td>
<td>Pearl River</td>
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<tr>
<td>Lamar</td>
<td>Pike</td>
<td>Stone</td>
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<tr>
<td>Perry</td>
<td>Walthall</td>
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<tr>
<td>Smith</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wayne</td>
<td></td>
<td>Mobile, AL</td>
</tr>
</tbody>
</table>

**OUT OF STATE PROVIDERS**

Lashundra Othello (601.206.2996) lashundra.othello@xerox.com  
Jonathan Dixon (601.206.3022) jonathan.dixon@xerox.com
Program Integrity
Mission

- To identify and stop fraud and abuse in the Medicaid Program and MSCAN;
- To identify weak areas in policy and the MES;
- To make recommendations for change and improvement; and
- To investigate cases of possible provider and beneficiary fraud or abuse by analyzing provider records, medical charts, eligibility records and payment histories as well as conducting interviews with provider staff and Medicaid beneficiaries.
Fraud

Fraud - an intentional material deception or misrepresentation made by a person with the knowledge that the deception could result in any unauthorized benefit to him or some other person. It also includes any act that constitutes fraud under applicable Federal or Mississippi law.

Examples may include:

• Knowingly billing for services that were not furnished and/or supplies not provided, including billing Medicaid for appointments that the patient failed to keep; and
• Knowingly altering claims forms and/or receipts to receive a higher payment amount.
Abuse - practices that are inconsistent with sound fiscal, business or medical practices and result in unnecessary costs to the Medicaid program. Abuse also includes claims for reimbursement for services that fail to meet professionally recognized standards for health care.

Examples may include:

- Misusing codes on a claim;
- Charging excessively for services or supplies; and
- Billing for services that were not medically necessary.
Investigations

Performs Provider and Beneficiary fraud/abuse investigations:

- Reviews provider records;
- Interviews beneficiaries;
- Conducts on-site investigations;
- Monitors provider utilization in the Medicaid Program and MSCAN;
- Provider oversight of the activities conducted by the MCO’s Special Investigative Units.
Divisions

- Investigations
- Medical Review
- Medicaid Eligibility Quality Control (MEQC)
- Data Analysis
Medical Reviews

Nurses analyze data histories and provider files for:

- Qualified Medical decisions
- Policy adherence
- Ensuring quality of care
- Medical necessity
- Appropriate coding
Medicaid Eligibility Quality Control (MEQC)

- Federally mandated program
- Determine the accuracy of Medicaid eligibility decisions
- Handles complaints alleging the improper receipt of Medicaid benefits
Data Analysis

- Creates algorithms that uncover areas of fraud and abuse in the Medicaid Program
- Develops analysis reports for use in investigations
- Works closely with multiple contracted agencies
- Collects data for internal and external program integrity analysis reports
- Documents the recovery and recoupment of funds from Program Integrity cases
Credible Allegation of Fraud

**Credible allegation of fraud** - an allegation of fraud, which has been verified by the State, from any source, including but not limited to the following:

- Fraud hotline complaints;
- Claims data mining; and
- Patterns identified through provider audits, civil false claim cases and law enforcement investigations.

Allegations are considered to be credible when they have indicia of reliability, and DOM has reviewed all allegations, facts and evidence carefully and acts judiciously on a case-by-case basis.
DIVISION OF MEDICAID
Provider Workshop
Magnolia Health Mississippi CAN Overview

Timeline

**30,000 MEMBERS**
- SSI
- Foster Care
- Women with breast/cervical cancer

**78,000 MEMBERS**
- Behavioral health
- SSI
- Foster Care
- Women w/breast/cervical cancer
- Pregnant women
- Infants 0-1 year old
- TANF Adults

**30,000 MEMBERS**
- Added Quasi-CHIP

**115,000 MEMBERS**
- Added CHIP

**Go Live**
*January 1, 2011*

**Expansion**
*December 2012*

**Expansion**
*December 2014*

**Expansion**
*January 2015*

**Upcoming Expansion**
*May-July 2015*

- 330,000 TANF kids will be in Managed Care
- Magnolia will provide care to at least 50% of this population
Magnolia Health Mississippi CHIP Overview

- Magnolia Health Mississippi Children’s Health Insurance Program (MS CHIP) became effective January 1, 2015.

- MS CHIP is designed to provide health care insurance for children in families without health insurance or with inadequate health insurance.

- MS CHIP covers children from birth to age 19.

- MS CHIP is administered by the Mississippi Division of Medicaid (DOM).

- Section 4901 of the Balanced Budget Act of 1997 (BBA) amended the Social Security Act by adding a new title XXI, the State Children’s Health Insurance Program (SCHIP).

- Title XXI provides funds to states to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children.

- The MS CHIP provider network is primarily delegated through a contractual agreement with Mississippi Physicians Care Network (MPCN).
Disease/Care Management

- Case Managers offer TANF kids with complex medical conditions such as sickle cell, kidney or renal disease, HIV/AIDS and organ transplant with education and assistance with services.
- Disease Management Health Coaches empower members to take control of conditions like asthma, diabetes, high blood pressure, heart disease and weight management.
- Health Coaches listen to concerns and offer expert advice.
- Our Social Services Specialists provide coordination with third party vendors and community agencies to supplement provider care as well as coordinate/assist with transportation to and from doctor visits.

NurseWise

Magnolia Health offers the following services to members after your clinic has closed and on weekends when they call NurseWise® at (866) 912-6285:

- Medical advice about a sick child
- Health information library
- Answers to questions about the child’s health
- Help scheduling doctor visits

Quality Improvement Coordinators

Magnolia Health assigns a Quality Improvement Coordinator to work with you to provide education on preventive measures and help with any quality initiatives within your clinic to include Patient panel management, care gaps, HEDIS guidance, and ER usage are some examples of assistance we can provide.
Provider Network Relations

We appoint a Provider Network Specialist to enhance communication between our company and your practice.

Our specialists provide the following:

• On-site or online education and in-services about new programs/procedures
• Timely webinars
• Answers to your questions
• Provider workshops and e-newsletters

Find My Representative – www.magnoliahealthplan.com

Provider Services (Call Center)

We understand that your time is dedicated to your patients, which is why we have devoted staff members to assist you with:

• Questions concerning Member eligibility status
• Prior Authorization and referral procedures
• Claims payment procedures and handling provider disputes and issues
• Navigating and troubleshooting issues on the Provider Secure Portal
• Provides Phone Support
• Available Monday through Friday, 8am to 5pm CST  1-866-912-6285
Magnolia Health Services

Vendor Services

- Cenpatico (Behavioral Health)
  - Full scope management for Behavioral Health services

- Dental Health & Wellness (Dental)
  - Effective 01/01/2015

- Opticare (Vision)
  - Routine and Medical

- MTM (Transportation)
  - Non-Emergent transportation benefits are excluded for MS CHIP

- National Imaging Associates (Radiology Management)
  - Radiology management for high tech imaging (MRI, CT Scan, PET Scan)
Verify Eligibility

It is highly recommended to verify member eligibility on the date services are rendered due to changes that occur throughout the month, using one of the following methods:

• Log on to the Medicaid Envision website at:
  – www.ms-medicaid.com/msenvision

• Log on to the secure provider portal at
  – 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):**

- 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.

**PA Processing:**

- Magnolia Health does not process 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.

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. 66814 (MSCAN), 66992 (MSCHIP)  
**Claims Denial Questions? Call** 1-866-912-6285, ext. 66402
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.
- Providers can get information on how well they (or their practice) are managing their member panels in comparison to their peers.

EPSDT (Early Periodic Screening, Diagnosis, and Treatment)/WELL CHILD CARE:
- Comprehensive and Preventive Child Health Program for individuals under the age of 21 years
- EPSDT/WELL CHILD CARE 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 EPSDT/WELL CHILD CARE services, please contact
Sai Kota at 601-863-0906 or skota@centene.com
ALL Claims must be filed within 180 days from the Date of Service (DOS)

All requests for correction, reconsideration or adjustment must be received within 90 days from the date of notification or denial

Providers should include a copy of the Explanation of Payment (EOP) when other insurance is involved or provide information when billing electronically

Option to file electronically through clearinghouse

Option to file directly through Magnolia website

Claims must be completed in accordance with Division of Medicaid billing guidelines

All member and provider information must be complete and accurate

FILE ONLINE AT WWW.MAGNOLIAHEALTHPLAN.COM!

Option to file on paper claim – 1ST time paper claims, mailed to:
Magnolia Health
Attn: CLAIMS DEPARTMENT
P.O. Box 3090 (MSCAN)
P.O. Box 5040 (MS CHIP)
Farmington, MO 63640-3825

Paper claims are to be filed on approved CMS 1500 (NO HANDWRITTEN OR BLACK AND WHITE COPIES)

To assist our mail center in improving the speed and accuracy to complete scanning please take the following steps when filing paper claims:
- Remove all staples from pages
- Do not fold the forms
- Make sure claim information is dark and legible
- Please use a 12pt font or larger
- Please use the CMS 1500 printed in red (Approved OMB-0938-1197 Form CMS-1500 (02-12))
- Red and White approved claim forms are required when filing paper claims as our Optical Character Recognition ORC scanner system will put the information directly into our system. This speeds up the process and eliminates potential sources for errors and helps get your claims processed faster.
Common General Issues

- Duplicate Claims
- Credentialing Documentation
- Claim Filing
- Prior Authorization Documentation
- Web Portal Usage
UnitedHealthcare Community Plan of Mississippi

Provider Education Session

“Helping People Live Healthier Lives”
UnitedHealthcare Community Plan of Mississippi in Action

• **Just Have A Ball**: We work with the Partnership for A Healthy Mississippi and SUBWAY® to promote physical activity to 6,000+ school-aged children across the state and help reduce childhood obesity.

• **Adopt-a-Floor**: We adopted a floor at Blair E. Batson Hospital for Children and provided healthy snacks to families of hospitalized children.

• **Farm to Fork**: We distribute free bags of produce to members and their families at events throughout the state. 500+ turkeys were also donated at Thanksgiving.

• **Community Activism**: We participate in health fairs and partner with community organizations to promote health awareness.
Important Updates

Effective March 1, 2015: Migration to new claims/IT platform

- UnitedhealthcareOnline.com is now the website to use for secure transactions. You may also continue to use UHCCommunityPlan.com.
- Provider remittance advice has been streamlined to include clearer explanation codes and help simplify administrative tasks.
- Electronic Payments & Statements is available.

Effective July 1, 2015: Primary care provider (PCP) designation for CHIP members

- A preferred PCP is identified for each member either through member self-selection or auto-assignment.
- PCPs are identified on member ID cards.
- Members can request a PCP change at any time and will then receive a new ID card.
- PCP designation is an existing requirement for MississippiCAN.

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

- To help reduce no-show and canceled appointments, we developed a form you can fax to us to report when members miss their ESPDT appointments.
- We will contact the members you report to educate them about scheduling responsibilities and help reschedule appointments.
- Please submit completed fax forms by the third business day of the next month. For example, March 2015 missed visits would be faxed to UnitedHealthcare on or before April 3.
- For more information, please contact Kenisha Potter, UnitedHealthcare ESPDT Coordinator, at 601-718-6609 or kenisha_potter@uhc.com
Reminder

Provider Medicaid ID number requirement for MississippiCAN

- Existing requirement
- Claim denial edit triggered if there is no Mississippi Medicaid ID number on file
- Please call provider services at 877-743-8734 if you need to update your contact information or adjust claims.
- If you do not have a current Mississippi Medicaid ID number, you can download the Provider Enrollment application at https://www.ms-medicaid.com/msenvision/downloadenrollPackage.do.
- Does not apply to Mississippi CHIP
Check Eligibility and Assigned PCP

To check member eligibility

- Go to UnitedHealthcareOnline.com > Patient Eligibility & Benefits
- Go to Medicaid’s Envision website at msmedicaid.acs-inc.com
- Call UnitedHealthcare Community Plan Provider Services:
  - MississippiCAN: 877-743-8734
  - Mississippi CHIP: 800-557-9933

To verify PCP affiliation, please call Provider Services

- A preferred PCP is identified for each member either through member self-selection or auto-assignment.
- PCPs are identified on member ID cards.
- PCP designation is an existing requirement for MississippiCAN.
- PCP designation is new for Mississippi CHIP, effective July 1, 2015.
- Members can request a PCP change at any time and receive a new member ID card.
Prior Authorization & Case Management

Prior Authorization
- Call 866-604-3267 (Mon-Fri, 8am-5pm; or 24/7 for emergencies)
- Fax prior authorizations to 888-310-6858
- Online: UnitedHealthcareOnline.com > Notifications/Prior Authorizations
- For a complete list of services requiring prior authorization, go to UHCCommunityPlan.com > For Health Care Professionals > Mississippi

Radiology/Cardiology Prior Authorization
- CareCore National manages our Rad/Card prior authorization process
- Tools and resources are available on:
  - UHCCommunityPlan.com > For Health Care Professionals > Mississippi > Radiology
  - UHCCommunityPlan.com > For Health Care Professionals > Mississippi > Cardiology
- Request and verify prior auth with CareCore the following ways:
  - Online: (URL web address above)
  - Phone: 866-889-8054
  - Fax: 866-889-8061

Utilization Management/Case Management
- Call 877-743-8731 (Mon-Fri, 8am-5pm; or 24/7 for emergencies)
- Staff can assist with routine prior authorizations, admissions, discharges and coordination of members’ care.
Pharmacy Benefits

Our Preferred Drug List (PDL) is defined by the Division of Medicaid and updated quarterly

- Access the PDL at UHCCommunityPlan.com > For Health Care Professionals > Mississippi > Pharmacy Program.
- Definitions for prior authorization, quantity level limits, step therapy, and specialty medications can be found in the PDL.

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

- Phone: 800-310-6826
- Fax: 866-940-7328 (Forms can be found at the website above)

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

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

Pharmacy Network Finder under Find a Pharmacy link on website

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

Rx Provider Services: 877-842-3210
How Do We Communicate?

**UHCCommunityPlan.com or UnitedHealthcareOnline.com**
- Key contact information, provider directory, benefit plan details, claims filing, prior authorization procedures and more

**Administrative Guide**
- Updated annually; available at UHCCommunityPlan.com > For Health Care Professionals > Mississippi > Provider Administrative Manual

**Practice Matters Newsletter**
- Provider newsletter for UnitedHealthcare Community Plan of Mississippi

**Network Bulletin Newsletter:**
- Monthly newsletter that alerts you to changes in policies or procedures and updates to the Administrative Guide
- UnitedHealthcareOnline.com > Tools & Resources > News & Network Bulletin, or sign up to receive the newsletter at www.uhc-networkbulletin.com/registration

**Emails, Faxes and Mailings**
- As needed for any significant changes or updates

**Network Management Resource Team**
- 866-574-6088 or swproviderservices@uhc.com

**Provider Services Service Model**
Provider Relations Service Model

Your Provider Advocate is an important resource. They can help make your interactions with us easier and more efficient across all lines of business and benefit plans.

Please follow the Provider Relations Service Model before contacting a Provider Advocate about claim payment decisions:
1. Check the status of a claim by logging on to UHCCommunityPlan.com.
2. If you disagree with a claim payment decision, please contact the UnitedHealthcare Community Plan Provider Service Team:
   • MississippiCAN: 877-743-8734
   • Mississippi CHIP: 800-557-9933
3. Be sure to obtain a tracking number for future reference. This is a 15-digit number beginning with a “C.”
4. If the issue remains unresolved after 30 days, please send your Provider Advocate the member name, member ID number, date of service and tracking number or a copy of the claim.
5. Your Provider Advocate will work with Market Service Agents and others to determine the cause and resolve your issue.
MS Provider Advocates

Provider Advocates

Celeste Love
North MS
901-921-0956
celestine_love@uhc.com

Teresa Morris
Central MS
601-718-6594
teresa_morris@uhc.com

Pam Hogan
South MS
601-296-6733
pamela_hogan@uhc.com
Behavioral Health Contact Information

• Behavioral Health
  – For information on benefits, prior auth, referrals, appeals and grievances:
    MississippiCAN Provider Services: 877-743-8734
    Mississippi CHIP Provider Services: 800-980-7393

• Behavioral Health Provider Relations
  – For information on contracting, credentialing and unresolved claims issues:
    Michael Strazi
    Mississippi Network Manager, Mississippi CHIP
    612-632-5727
    michael.strazi@optum.com
    Fax: 877-331-5852
    Ricardo Fraga
    Mississippi Network Manager, MississippiCAN
    601-718-6631
    ricardo.fraga@optum.com
    Fax: 888-960-3835

• Mississippi CHIP & MississippiCAN Behavioral Health Team
  – Lisa Seaton, LCSW: Mississippi CHIP Field Care Advocate
  – Meredith Clemmons, LCSW: MS CAN Field Care Advocate
Network Management Resource Team

The Network Management Resource Team can help with:
• Status of credentialing
• Your contract
• Demographic changes
• Basic network questions

For help with contracting information or credentialing status, please contact 866-574-6088 or swproviderservices@uhc.com.

If your issue cannot be resolved by the Network Management Resource Team, it will be forwarded to your Network Account Manager.
Questions?
MississippiCAN & CHIP
Provider Workshops
Afternoon Session
UnitedHealthcare Community Plan of Mississippi

Provider Education Session
Welcome/Agenda

- Mission/Vision
- Important Updates
- Benefits
- Check Eligibility and Assigned PCP
- Prior Authorizations
- Claims Submission
- Pharmacy Benefits
- Online Care Provider Resources
- Communicating with Us
- Provider Relations & Service Model
- Behavioral Health
- Network Management
- SFY2015 Program Changes
- Questions
Mission and Vision

Our Mission
Helping people live healthier lives

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

Effective March 1, 2015: Migration to new claims/IT platform
- UnitedhealthcareOnline.com is now the website to use for secure transactions. You may also continue to use UHCCommunityPlan.com.
- Provider remittance advice has been streamlined to include clearer explanation codes and help simplify administrative tasks.
- Electronic Payments & Statements is available.

Effective July 1, 2015: Primary care provider (PCP) designation for CHIP members
- A preferred PCP is identified for each member either through member self-selection or auto-assignment.
- PCPs are identified on member ID cards.
- Members can request a PCP change at any time and will then receive a new ID card.
- PCP designation is an existing requirement for MississippiCAN.

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Appointment Initiative
- To help reduce no-show and canceled appointments, we developed a form you can fax to us to report when members miss their ESPDT appointments.
- We will contact the members you report to educate them about scheduling responsibilities and help reschedule appointments.
- Please submit completed fax forms by the third business day of the next month. For example, March 2015 missed visits would be faxed to UnitedHealthcare on or before April 3.
- For more information, please contact Kenisha Potter, UnitedHealthcare ESPDT Coordinator, at 601-718-6609 or kenisha_potter@uhc.com.
Reminder

Provider Medicaid ID number requirement for Mississippi CAN

- Existing requirement
- Claim denial edit triggered if there is no Mississippi Medicaid ID number on file
- Please call provider services at 877-743-8734 if you need to update your contact information or adjust claims.
- If you do not have a current Mississippi Medicaid ID number, you can download the Provider Enrollment application at https://www.ms-medicaid.com/msenvision/downloadenrollPackage.do.
- Does not apply to Mississippi CHIP
Program Benefits

• MississippiCAN and administers the Medicaid benefit package, as defined by the state of Mississippi, to Medicaid beneficiaries. The Mississippi CHIP benefit package is also defined by the state of Mississippi.

• UnitedHealthcare Community Plan provides additional benefits to MississippiCAN and Mississippi CHIP plan members:
  • Unlimited visits
  • Case management
  • Member outreach
  • Health education
  • And more

• View benefit details at:
  – medicaid.ms.gov
  – UHCCommunityPlan.com > For Health Care Professionals > Mississippi
Check Eligibility and Assigned PCP

• To check member eligibility:
  • Go to UnitedHealthcareOnline.com > Patient Eligibility & Benefits
  • Go to Medicaid’s Envision website at msmedicaid.acs-inc.com
  • Call UnitedHealthcare Community Plan Provider Services:
    • MississippiCAN: 877-743-8734
    • Mississippi CHIP: 800-557-9933
  • To verify PCP affiliation, please call Provider Services at 877-743-8734 for MississippiCAN, or 800-557-9933 for Mississippi CHIP.
  • A preferred PCP is identified for each member either through member self-selection or auto-assignment.
  • PCPs are identified on member ID cards.
  • PCP designation is an existing requirement for MississippiCAN.
  • PCP designation is new for Mississippi CHIP, effective July 1, 2015.
  • Members can request a PCP change at any time and receive a new member ID card.
Prior Authorization

• Call 866-604-3267
  • Monday-Friday 8 a.m. – 5 p.m. CST
  • 24 hours a day for emergencies
• Fax prior authorizations to 888-310-6858
• Online: UnitedHealthcareOnline.com > Notifications/Prior Authorizations
• For a complete list of services requiring prior authorization, go to UHCCommunityPlan.com > For Health Care Professionals > Mississippi.

Utilization Management/Case Management

• Call 877-743-8731
  • Monday through Friday, 8 a.m. to 5 p.m. EST
  • On-call staff is available 24/7 for emergency prior authorization
• Staff can assist with routine prior authorizations, admissions, discharges and coordination of members’ care.
Radiology Prior Authorization

• Prior authorization is required for the following radiology services performed in an outpatient hospital location, freestanding imaging center or physician office:
  • MRI
  • MRA
  • CT
  • PET
  • Nuclear medicine
  • Select nuclear medicine studies, including nuclear cardiology.

• Prior authorization is not required for radiology services provided in an emergency room, urgent care center, observation unit or during an inpatient stay.

• CareCore National manages the UnitedHealthcare Community Plan prior authorization process. Physicians may request, and if approved, verify prior authorization with CareCore National the following ways:
  • Online: UHCCommunityPlan.com > For Health Care Professionals > Mississippi > Radiology
  • Phone: 866-889-8054
  • Fax: 866-889-8061
Radiology Prior Authorization tools are available on UHCCommunityPlan.com > For Health Care Professionals > Mississippi > Radiology:

- FAQ
- Quick Reference Guide
- Prior Authorization Fax Form
- CPT Code List
- Crosswalk Table
- Imaging Criteria
- Radiology Prior Authorization List

If you do not follow the Radiology Prior Authorization protocol, administrative claim denials will result. Claims denied for failure to request prior authorization may not be balanced billed to the patient.
Cardiology Prior Authorization

- All care providers, facilities and other health care professionals are required to obtain authorization before performing select inpatient, outpatient and office-based cardiac procedures.
- Cardiac procedures ordered through an emergency room treatment visit, while in an observation unit, when performed at an urgent care facility, or during an inpatient stay do not require prior authorization. **One exception is EP implants, which require prior authorization in an inpatient setting.**
- A complete list of services that require prior authorization is available at UnitedHealthcareOnline.com > Clinician Resources > Cardiology > UnitedHealthcare Community Plan Cardiology Prior Authorization Program.
- CareCore National manages the UnitedHealthcare Community Plan prior authorization process. Physicians may request, and if approved, verify prior authorization with CareCore National the following ways:
  - Online: UHCCommunityPlan.com > For Health Care Professionals > Mississippi > Cardiology
  - Phone: 866-889-8054
  - Fax: 866-889-8061
Cardiology Prior Authorization

If a cardiology procedure is required on an urgent basis, or if prior authorization cannot be obtained because it is outside of our normal business hours, the service can be performed and authorization requested retrospectively.

- Retrospective authorization requests for Electrophysiology Implants and Diagnostic Catheterizations must be made within 15 calendar days of service.
- Retrospective authorization requests for Echocardiograms and Stress Echocardiograms must be made within two business days of service.

If you do not follow the Cardiology Prior Authorization Program protocol, administrative claim denials will result. Claims denied for failure to request prior authorization may not be balanced billed to the patient.

Cardiology prior authorization tools are available on UHCCommunityPlan.com:
  - Cardiology Prior Authorization CPT Code Crosswalk
  - Cardiology Prior Authorization FAQs
  - Cardiology Prior Authorization Quick Reference Guide
  - Cardiology Evidence Based Guidelines
  - Live Recording Radiology & Cardiology Prior Authorization Provider Education
  - Radiology & Cardiology Provider Authorization Provider Education
Claims Filing

Electronic vs. Paper
• Electronic claims can help reduce errors and shorten payment cycles.
• Learn more about electronic claims submission at UnitedHealthcareOnline.com > Tools & Resources > EDI Education for Electronic Transactions or call 800-842-1109.
• If a claim must be submitted on paper, please use the following address:
  UnitedHealthcare
  P.O. Box 5032
  Kingston, NY 12402-5032

Format
• All claims must be submitted using the standard CMS-1500, CMS-1450/UB04 or respective electronic format.
• Please include all appropriate secondary diagnosis codes for line items.

Timely Filing
• MississippiCAN: Effective July 1, 2014, claims must be filed within six months from the date of service.
• Mississippi CHIP: Effective Jan. 1, 2015, claims must be filed within six months from the date of service.
Defining a Corrected Claim

What is a corrected claim?
We follow the industry definition of a corrected claim, which is a bill that has altered, removed or replaced the same data elements that were submitted on the original claim.

Claim Data Elements

- Place of service
- Date of service
- Charge
- Procedure code
- Diagnosis
- Addition/deletion of a modifier or units
- Primary carrier’s explanation of benefits indicating allowed or paid amounts different from original submission
Submitting a Corrected Claim Electronically

• When correcting or submitting late charges on a CMS-1500, CMS-1450, UB-04 or 837 institutional claim, resubmit all original lines and charges as well as the corrected or additional information.

• For CMS-1450/UB-04 or 837 institutional claims, use bill type Xx7.

• For CMS-1500 claims, use box 19 to indicate “Corrected Claim.”
Submitting a Corrected Claim by Paper

1. Make any necessary corrections to the claim in the practice management system.

2. Print the entire claim, including corrections and previously paid line items.

3. Stamp the CMS-1500 form with “Corrected Claim.”
Submitting a Corrected Paper Claim

• The Claim Reconsideration Request Form is available at UnitedHealthcareOnline.com > Claims & Payments > Claim Reconsideration.
• Check box #4, Resubmission of a corrected claim.
• Complete the Comments section, clearly stating what data elements have been corrected and why.

• Send the claim and Claim Reconsideration Request Form to the address on the explanation of benefits or back of the member ID card.
Pharmacy Benefits

• **Our Preferred Drug List (PDL)** is defined by the Division of Medicaid and updated quarterly
  – Access the PDL at UHCCommunityPlan.com > For Health Care Professionals > Mississippi > Pharmacy Program.
  – Definitions for prior authorization, quantity level limits, step therapy, and specialty medications can be found in the PDL.

• **Requesting Prior Authorization** for non-preferred medications or for those requiring prior authorization (turnaround time is typically < 24 hours)
  – Phone: 800-310-6826
  – Fax: 866-940-7328 (Forms can be found at the website above)

• **An Emergency Five-Day Supply** is available for immediate need of a new non-preferred medication or a medication requiring prior authorization
  – Direct communication is provided to network pharmacies on how to process

• **Pharmacy Network Finder** under Find a Pharmacy link on website

• **Medical Injectables** most commonly given in provider-based settings are processed as medical claims.

• **Rx Provider Services**: 877-842-3210
Register at UnitedHealthcareOnline.com for secure access to use the following tools:

- Claims inquiry/status/remittances
- Request claims adjustments
- Review and request demographic changes
- Verify member eligibility
- Submit prior notifications/authorizations
- Check prior authorization status
- View PCP panel roster
- View member care plans and health risk assessment data
- Review EPSDT and preventive health screening reports
- Review claim trend reports
- Link to Continuing Education website
- View online help topics
- Manage group access
Use UHCCommunityPlan.com to access the following information:

- Physician directory
- Pharmacy program information
- Provider administrative guides
- Reimbursement policies
- Newsletters
- Bulletins
- Medicare Part D educational materials
- Provider forms
- Clinical practice guidelines
- EDI information
- Radiology/cardiology prior authorization information
How Do We Communicate?

UHCCommunityPlan.com or UnitedHealthcareOnline.com
  • Key contact information, provider directory, benefit plan details, claims filing, prior authorization procedures and more

Administrative Guide
  • Updated annually; available at UHCCommunityPlan.com > For Health Care Professionals > Mississippi > Provider Administrative Manual

Practice Matters Newsletter:
  • Provider newsletter for UnitedHealthcare Community Plan of Mississippi

Network Bulletin Newsletter:
  • Monthly newsletter that alerts you to changes in policies or procedures and updates to the Administrative Guide
  • UnitedHealthcareOnline.com > Tools & Resources > News & Network Bulletin, or sign up to receive the newsletter at www.uhc-networkbulletin.com/registration

Emails, Faxes and Mailings
  • As needed for any significant changes or updates

Network Management Resource Team
  • 866-574-6088 or swproviderservices@uhc.com

Provider Advocates
Provider Relations Service Model

Your Provider Advocate is an important resource. They can help make your interactions with us easier and more efficient across all lines of business and benefit plans.

Please follow the Provider Relations Service Model before contacting a Provider Advocate about claim payment decisions:
1. Check the status of a claim by logging on to UHCCommunityPlan.com.
2. If you disagree with a claim payment decision, please contact the UnitedHealthcare Community Plan Provider Service Team:
   • MississippiCAN: 877-743-8734
   • Mississippi CHIP: 800-557-9933
3. Be sure to obtain a tracking number for future reference. This is a 15-digit number beginning with a “C.”
4. If the issue remains unresolved after 30 days, please send your Provider Advocate the member name, member ID number, date of service and tracking number or a copy of the claim.
5. Your Provider Advocate will work with Market Service Agents and others to determine the cause and resolve your issue.
MS Provider Advocates

Provider Advocates

Celeste Love
North MS
901-921-0956
celestine_love@uhc.com

Teresa Morris
Central MS
601-718-6594
teresa_morris@uhc.com

Pam Hogan
South MS
601-296-6733
pamela_hogan@uhc.com
Behavioral Health Contact Information

• Behavioral Health
  – For information on benefits, prior authorization, referrals, and appeals and grievances:
    MississippiCAN Provider Services: 877-743-8734
    Mississippi CHIP Provider Services: 800-980-7393

• Behavioral Health Provider Relations
  – For information on contracting, credentialing and unresolved claims issues:
    **Michael Strazi**
    Mississippi Network Manager, Mississippi CHIP
    612-632-5727
    michael.strazi@optum.com
    Fax: 877-331-5852
    **Ricardo Fraga**
    Mississippi Network Manager, MSCAN
    601-718-6631
    ricardo.fraga@optum.com
    Fax: 888-960-3835

• Mississippi CHIP & MississippiCAN Behavioral Health Team
  – Lisa Seaton, LCSW: Mississippi CHIP Field Care Advocate
  – Meredith Clemmons, LCSW: MS CAN Field Care Advocate
Network Management Resource Team

The Network Management Resource Team can help with questions about:

- Status of credentialing
- Your contract
- Demographic changes
- Basic network questions

For help with contracting information or credentialing status, please contact 866-574-6088 or swproviderservices@uhc.com.

If your issue cannot be resolved by the Network Management Resource Team, it will be forwarded to your Network Account Manager.
Quasi-CHIP Population Transitioning to Medicaid MississippiCAN
• As of Dec. 1, 2014, children in families with income at or below 133 percent of the federal poverty level are eligible for Medicaid instead of CHIP and are enrolled in the MississippiCAN program.

Mississippi CHIP
• As of Jan. 1, 2015, children enrolled in CHIP may choose to receive services from one of the two Coordinated Care Organizations instead of one contracted vendor.
• CHIP coverage and services remain the same.

MississippiCAN Expansion – Children
• May through July 2015: Approximately 300,000 children ages 1 to 19 will be enrolled in the MississippiCAN program (except those excluded as members on Medicare, on waivers or in institutions).
• Beneficiaries started receiving notification in March 2015.
The Credentialing Process

The Credentialing process exists to ensure that participating providers meet the criteria established by Magnolia Health, as well as government regulations and standards of accrediting bodies. All providers who participate in the MississippiCAN program and choose to participate with Magnolia Health must also be a Medicaid provider in good standing with a VALID MISSISSIPPI MEDICAID NUMBER.

Magnolia Health Mississippi CHIP does NOT require a MISSISSIPPI MEDICAID NUMBER to initiate credentialing.

• Magnolia has a contractual agreement with Mississippi Physicians Care Network (MPCN) to utilize their network of physicians and facilities statewide for the Magnolia Health Mississippi CHIP
• For additional information regarding contracting for MS CHIP through MPCN, please contact MPCN's Customer Service at 1-800-931-8533
• To contract directly with Magnolia Health for MS CHIP, please call 866-912-6285

EXCEPTION:
Federally Qualified Health Clinics (FQHC) and Rural Health Centers (RHC) that are currently contracted with Magnolia Health are automatically amended to participate in the Magnolia MS CHIP product. FQHC’s or RHC’s that are NOT contracted with Magnolia Health can contact a representative in our Network Development and Contracting Department at 1-866-912-6285.

Credentialing may take up to 90 days upon receipt of a complete application
The Practitioner Credentialing Application is located at www.magnoliahealthplan.com under the **Practice Improvement Resource Center (PIRC)**.
Completing the Forms

- Please follow the instructions located on page 1 of the “Credentialing Application Packet”.

- If you would like to register with CAQH (Council for Affordable Quality Healthcare), please contact your Contract Negotiator or Provider Relations Representative for a CAQH Provider Application and information on CAQH sponsorship.

- Credentialing documents should be forwarded directly to: magnoliacredentialing@centene.com
Credentialing Process: Prior Authorizations

Practitioners in the credentialing process are able to see Magnolia members but MUST obtain Prior Authorizations for all services rendered in order for claims to be considered for payment.

The Prior Authorization Form can be located on our website.

Go to www.MagnoliaHealthPlan.com > Select Medicaid >For Providers > Practice Improvement Resource Center (PIRC)
Recredentialing

- Recredentialing occurs every **36 months** from the month of initial credentialing approval.

- Providers and Practitioners failing to comply with requests for recredentialing documentation are automatically administratively terminated at the end of their current credentialing cycle.

- Recredentialing is taking place now. Please verify with your practitioners if they have received any recredentialing request(s) from Magnolia’s credentialing team.

- Once all items are received and verified, credentialing may take up to **90 days**. Please notify your local Provider Network Specialist of any new practitioners that will be joining your facility prior to rendering services to Magnolia Health members.

*Magnolia uses VerifPoint, an NCQA-certified company, to assist with obtaining missing and expired documentation for credentialing purposes.*
Top Claim Denials

Duplicate claims

Not filed timely (within 180 days of date of service/90 days of notice of adjudication)

No authorization obtained

Services not covered
Duplicate Claims

• Duplicate Claim is the #1 denial reason for Magnolia Health

• A common cause for duplicate claim denial is an attempt to file a corrected or reconsideration claim
Corrected Claim, Reconsideration, Claim Dispute

All Requests for corrected claims, reconsiderations or claim disputes must be received within 90 days of the original Plan notification (i.e. EOP). Original Plan determination will be upheld for requests received outside of the 90-day timeframe, unless justification is provided to the Plan to consider.

Corrected Claims
- Submit via Secure Web Portal
- Submit via an EDI Clearinghouse
- Submit via paper claim:
  
  Magnolia Health
  PO BOX 3090
  Farmington, MO 63640-3825
  *(Include original EOP)*

  Magnolia Health MS CHIP
  PO BOX 5040
  Farmington, MO 63640

Reconsideration
- Written communication *(i.e., letter)* outlining disagreement of claim determination
- Indicate “Reconsideration of *(original claim number)*”
- Submit reconsideration to:
  
  Magnolia Health
  Attn: Reconsideration
  PO BOX 3090
  Farmington, MO 63640-3825

  Magnolia Health MS CHIP
  Attn.: Reconsideration
  PO BOX 5040
  Farmington, MO 63640

Claim Dispute
- ONLY used when disputing determination of Reconsideration request
- Must complete Claim Dispute form located on MagnoliaHealthPlan.com
- Include original request for reconsideration letter and the Plan response
- Send Claim Dispute form and supporting documentation to:
  
  Magnolia Health
  Attn: Claim Dispute
  PO BOX 3090
  Farmington, MO 63640-3825

  Magnolia Health MS CHIP
  Attn.: Claim Dispute
  PO BOX 5040
  Farmington, MO 63640

Must be submitted within 90 days of adjudication
• All claims for Magnolia Health for the MississippiCAN and Mississippi CHIP products must be filed within **180 days** from the date of service (DOS)

• Options are available to file claims electronically through a clearinghouse, the Magnolia secure portal, or via paper submission

• All claims must be completed in accordance with accepted billing guidelines

• All member and provider information must be complete and accurate
Prior Authorization Process

ALL OUT OF NETWORK SERVICES REQUIRE AN AUTHORIZATION

Services that require authorizations can be found on Magnolia’s website. www.magnoliahealthplan.com

It is highly recommended to initiate the Authorization process at least 5 calendar days in advance for non-emergent services

The PCP should contact the UM department via telephone, fax, secure email, or through our website with the appropriate clinical information to request an authorization

Urgent requests can be requested from the Medical Management department as needed

(Emergency room and urgent care services never require prior authorization)

Prior Authorization Phone Requests:
MSCAN/MS CHIP – 1-866-912-6285
A prior authorization form must be submitted prior to services being rendered for services that require authorization. Providers should ensure to complete the applicable form for Inpatient and Outpatient services.

It is highly recommended that providers utilize Magnolia’s “Smart Sheet” to assist with Prior Authorization requests.


Prior authorization lists are located at:

Forms can be located on our websites at the following addresses:
http://www.magnoliahealthplan.com/for-providers/provider-resources/

Requests can be faxed to:
1-877-650-6943 (Magnolia)
1-855-684-6747 (MS CHIP)

Requests can be emailed securely to:
MagnoliaAuths@Centene.com
Verify Non Covered Services

- Services can be verified for coverage via the Mississippi Envision website [www.ms-medicaid.com/msenvision](http://www.ms-medicaid.com/msenvision)

- Magnolia Health’s Secure Provider Portal can also be utilized for service allowable and guidance
Magnolia Health Website

Submit:
• Claims
• Provider Complaints
• Demographic Updates

Verify:
• Eligibility
• Claim Status

View:
• Provider Directory
• Important Notifications
• Provider Training Schedule
• Practice Improvement Resource Center (PIRC)
• Claim Editing Software
• Provider Newsletter
• Member Roster for PCPs
• Member Care Gaps

www.magnoliahealthplan.com
Find a Provider

Finding a Provider is Quick and Easy
You can search by last name, facility name or by specialty.

We’ve Mapped Your Location
This helps us find a provider closer to you
If it’s not right, change it here

Search the Way You Want
- Provider - search the person’s first and/or last name
- Hospital - search the hospital by name
- Other - there are many other types of medical providers such as:
  FQHC - Federally Qualified Health Center
  RHC - Rural Health Clinic Health Departments, DMEs and Pharmacies and many more
Important Notifications are also sent to providers via e-blast. If you do not currently receive our e-blast communication, but are interested, please advise your Provider Network Specialist.
Resources are available 24 hours a day and include:

**Forms and Guides for the following:**
- Contracting/Credentialing
- Prior Authorizations
- Claims
- Provider Manual
- Magnolia Vendors
- HEDIS Reference Guides
- Pharmacy PDL’s and Guides
- Provider Training
- Clinical Practice Guidelines
- Updates….. and more!!
Register for the Secure Web Portal TODAY!

Benefits include:

• Claim submission/corrections and status
• Prior Authorizations submission and status
• Patient Panel listing
• Care Gap identification
• Member eligibility verification
• Updates..... and more!!
Behavioral Health Services are managed on behalf of Magnolia Health by Cenpatico.

Obtain authorization:

- Complete an authorization online at www.cenpatico.com
- Request an Outpatient Treatment Request (OTR) form from Utilization Management at 1-866-912-6285
- Find the Covered Services/Authorization Grid and OTR online at www.cenpatico.com/provider/mississippi/ms-provider-tools

Prior Auth required for the services below: (For CHIP-all services below, including Inpatient and Observation)

- Psychological Testing
- Crisis Residential
- Intensive Outpatient Program (IOP)
- Partial Hospitalization Program (PHP)
- Certain Injectable Medications
- Electroconvulsive Therapy (ECT)

- Authorization is no longer required for participating providers to provide psychotherapy services (Individual, Family or Group Therapy), due to mental health parity. Authorization is required for non-participating providers.
- Provider/Customer Service and Utilization Management: 1-866-912-6285 chose Mental Health
- Want to become a provider?-Visit our website at www.cenpatico.com/providers/provider-application-request and complete a Join Our Network application.

Angela Stewart, Network Manager
601-863-0738
anstewart@cenpatico.com

Nakisha Montgomery, Provider Network Specialist
601-863-0745
nmontgomery@cenpatico.com
Dental Services are managed on behalf of Magnolia Health by Dental Health & Wellness effective 01/01/2015.

**Dental Health & Wellness**

**Provider Services**
1-844-464-5636

**Claims Questions:** 1-844-464-5636

**Eligibility or Benefit Questions:** 1-866-912-6285

**Fax numbers:**
Claims to be Processed: 1-855-609-5154
Claims/payment issues: 1-855-609-5154

**Submit Electronic Claims to:**
Direct entry on the web –
https://portal.dentalhw.com//pwp
Or Via Clearinghouse –
Payer ID 46278

**Mail Claims to:**
Dental Health and Wellness
Claims: MS
PO Box 160
Milwaukee, WI 53201

**Provider Relations**
Reshemia Ratcliff
Rratcliff@dentalhw.com
1-601-559-2268
All eye care claims (Routine and Medical) with dates of service on or after September 1, 2014 must be remitted to OptiCare. OptiCare will assume duties and obligations to your current provider contract agreement with Magnolia Health.

There are three options for submitting your Magnolia Health MS CHIP claims to OptiCare:

**Electronic Claim Submission**
Emdeon Payer ID: 56190

**Paper Claim Submission**
OptiCare Managed Vision
PO Box 7548
Rocky Mount, NC  27804

**OptiCare’s Online Web Portal – Eye Health Manager**
Go to https://secure.opticare.com/logon.aspx

Additional Tools Available through the Eye Health Manager:
Member Benefits and Eligibility Verification
Claims Status Check
Download, Research, & Reprint EOB’s
Authorization Requests

Should you have any questions, please contact OptiCare’s Network Management Department at (800) 531-2818.
An authorization is required for MRI-CT SCAN-PET SCANS
National Imaging Associates (NIA) is selected by MHP to administer the program
The servicing provider (PCP or Specialist) will be responsible for obtaining authorization for the procedures
Servicing providers may request authorization and check status of an authorization by:
  * Accessing www.radmd.com
  * Utilizing the toll free number 1-800-642-7554
Inpatient and ER procedures will not require authorization

All claims should be submitted to MHP through the normal processes, www.magnoliahealthplan.com, electronic submission or paper claim submission

Providers can contact Charmaine Gaymon, Provider Relations Manager at 410-953-2615 or via email at Gaymon@magellanhealth.com
Magnolia has partnered with PaySpan Health to offer expanded claim payment services:

- Electronic Claim Payments (EFT)
- Online remittance advices (ERA’s/EOPs)
- HIPAA 835 electronic remittance files go download directly to HIPAA-compliant Practice Management or Patient Accounting System
- Register at: www.PaySpanHealth.com

ABOUT PAYSPAN

We are the largest healthcare payments and reimbursement network in the US. Serving both Payers and Providers we provide payment automation services that improves administrative efficiency, meets regulatory requirements, and enables payers and providers to manage new reimbursement strategies. We bring together healthcare expertise with proven financial services technology to empower a new generation of sustainable healthcare economics.

OUR PRODUCTS

Solutions for Payers
- Patient Centered Financial Home™
- Alternative Reimbursement Management
- Audit AMP™
- ClaimPay Card™
- Communicator
- Member Payments Automation
- Provider Payments Automation
- Quality Notices
- Unified Benefits Card™
- Voice

Solutions for Providers
Provider Services/Provider Network

Provider Services Call Center:
• Provides Phone Support / FIRST LINE OF COMMUNICATION
• Available Monday through Friday, 8am to 5pm CST at 1-866-912-6285

Provider Network 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.

Go to: Find My Representative – www.magnoliahealthplan.com

North Territory – Ashley Armstrong
662.372.0209
AARMSTRONG@CENTENE.COM

Central Territory – Senita Miller
601.863.2442
SEMILLER@CENTENE.COM

South Territory – Tina Price
228.239.3490
CHEPRICE@CENTENE.COM

FQHCs – Earl Robinson
601.863.0787
EAROBINSON@CENTENE.COM

Director, Provider Relations – Walter Pawlak
601.863.0717
WPAWLAK@CENTENE.COM
Questions?