MississippiCAN
Hospital Inpatient Transition

October 26, 2015

MISSISSIPPI DIVISION OF MEDICAID

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MississippiCAN
Hospital Inpatient Transition

Frequently Asked Questions (FAQ) will be available on Division of Medicaid's (DOM) website

Please submit all questions to:
inpatient@medicaid.ms.gov

Responses will be posted to the FAQ on our website at medicaid.ms.gov.

What Providers Need to Know

MS Code Section 43-13-117(H)(1)(d)
• Coordinated Care Organizations (CCO) are required to reimburse all providers in those organizations at rates **no less** than what Medicaid reimburses Fee-For-Service (FFS) Providers, if in-network providers
• All claims for services covered by the CCOs for MississippiCAN members **must** be submitted to the CCOs
• Claims for services excluded from MississippiCAN must be submitted to Medicaid

MississippiCAN Legislation

The Mississippi state legislature authorized the following major changes affecting the Division of Medicaid.

Major changes include:

- 297,054 Children were enrolled in MississippiCAN during May, June and July 2015. (House Bill 1275, 2014)
- Inpatient hospital roll-in to managed care by Dec. 1, 2015 (Senate Bill 2588, 2015)
- The Upper Payment Limit (UPL) program will be replaced with the Mississippi Hospital Access Payment (MHAP) (Senate Bill 2588, 2015)

Mississippi Hospital Access Payment

Mississippi Hospital Access Payment program (MHAP)
What is MHAP? This is a new way to make Medicaid payments to hospitals, created to protect patient access to hospital inpatient care.
When does this start? It begins this year – Fiscal Year (FY) 2016. Effective with hospital inpatient admission dates of service on or after Dec. 1, 2015, DOM will provide increased capitation payments per member per month to CCOs contracted with DOM.
Who does this affect? In-state hospitals and the out-of-state hospital authorized by federal law to submit intergovernmental transfers to the state of Mississippi, and is classified as a Level I trauma center located in a county contiguous to the state line. (The same hospitals participating in the UPL program.)
How will hospitals receive payments? The CCOs are expected to contract with a third party to distribute 100% of MHAP payments to hospitals.
How much will it pay? The full year of MHAP funds will be paid monthly between Dec. 1, 2015 and June 30, 2016, based on the Centers for Medicare and Medicaid Services (CMS)-approved FY 2015 UPL calculation. For future years, it will be paid out monthly over 12 months.

Upper Payment Limit

Upper Payment Limit (UPL)
UPL Program:
• The hospital inpatient UPL program began transitioning to the MHAP program July 1, 2015 and will be completed by Dec. 1, 2015.
• Proposed State Plan Amendment (SPA) 2015-012 was submitted to the CMS Sept. 30, 2015. It removes all UPL language (CMS approval is pending).
• In the event CMS does not approve SPA 2015-012 and/or the MHAP program, DOM will continue the UPL program under the previous method.
Disproportionate Share Payment (DSH) Program:
• No changes will be made to the DSH program.
• The DSH program will continue with payments being made in Dec. 2015, March 2016 and June 2016**.**
• Provider Statistical and Reimbursement Reports (PS&Rs) will be provided by DOM and the CCOs.

Assessments

Information about tax assessments owed to DOM by hospitals

What type of assessments will be collected?

DOM will collect three types of assessments throughout the year:

- $104 million assessment
- DSH state match assessment
- MHAP state match assessment

How are assessments remitted to DOM?

No change - Payments can be made via check or electronic funds transfer.

When?

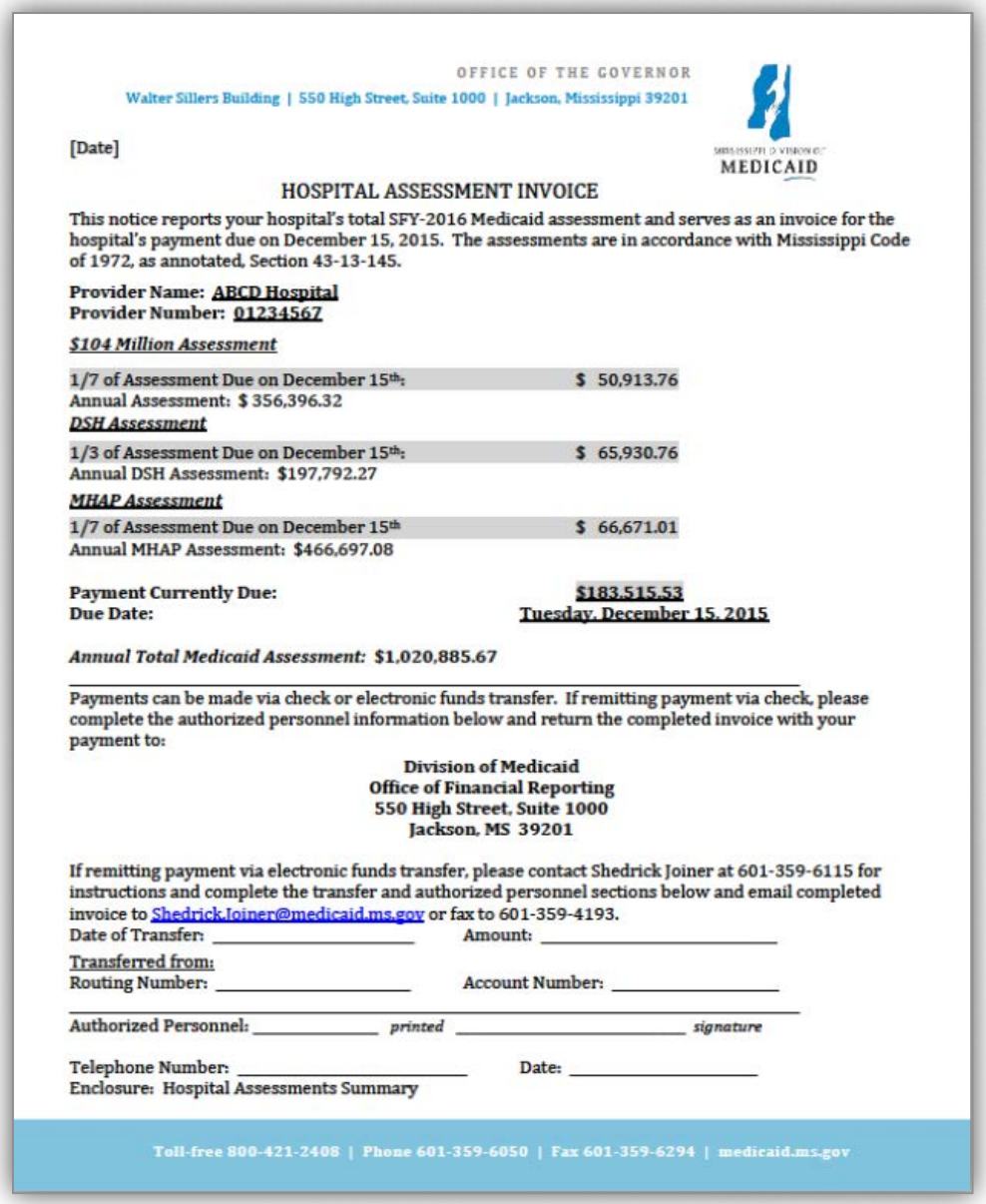
During this first transition year only:

- $104 Million – 7 equal installments from December – June
- DSH – 3 equal installments in December, March, and June
- MHAP – 7 equal installments from December – June

Future years:

- $104 Million and MHAP – 12 equal installments from July – June
- DSH – 3 equal installments in December, March, and June

New Assessment Invoice Example



OFFICE OF THE GOVERNOR
Walter Sillers Building | 550 High Street, Suite 1000 | Jackson, Mississippi 39201

MEDICAID

[Date]

HOSPITAL ASSESSMENT INVOICE

This notice reports your hospital's total SFY-2016 Medicaid assessment and serves as an invoice for the hospital's payment due on December 15, 2015. The assessments are in accordance with Mississippi Code of 1972, as annotated, Section 43-13-145.

Provider Name: ABCD Hospital
Provider Number: 01234567

$104 Million Assessment

1/7 of Assessment Due on December 15th: $ 50,913.76
Annual Assessment: $ 356,396.32

DSH Assessment

1/3 of Assessment Due on December 15th: $ 65,930.76
Annual DSH Assessment: $197,792.27

MHAP Assessment

1/7 of Assessment Due on December 15th $ 66,671.01
Annual MHAP Assessment: $466,697.08

Payment Currently Due: **$183,515.53**
Due Date: **Tuesday, December 15, 2015**

Annual Total Medicaid Assessment: **$1,020,885.67**

Payments can be made via check or electronic funds transfer. If remitting payment via check, please complete the authorized personnel information below and return the completed invoice with your payment to:

Division of Medicaid
Office of Financial Reporting
550 High Street, Suite 1000
Jackson, MS 39201

If remitting payment via electronic funds transfer, please contact Shedrick Joiner at 601-359-6115 for instructions and complete the transfer and authorized personnel sections below and email completed invoice to Shedrick.Joiner@medicaid.ms.gov or fax to 601-359-4193.

Date of Transfer: _____ Amount: _____

Transferred from:
Routing Number: _____ Account Number: _____

Authorized Personnel: _____ *printed* _____ *signature*

Telephone Number: _____ Date: _____
Enclosure: Hospital Assessments Summary

Toll-free 800-421-2408 | Phone 601-359-6050 | Fax 601-359-6294 | medicaid.ms.gov

Inpatient Claims

Information about Inpatient claims
Who do providers bill for claims with admission dates beginning on or after Dec. 1, 2015?
• For all members enrolled in MississippiCAN, providers will submit claims to the member's coordinated care insurer.
How will providers bill claims that span a lock-in segment? (*i.e., for admissions beginning before a member's enrollment date in MississippiCAN and having a discharge date after the enrollment date.)*
• For these claims, the provider will bill Xerox, Medicaid's fiscal agent, on a FFS basis.
What will the timely filing requirement be for MississippiCAN member claims?
• Providers must file an initial claim within six months of discharge date. If a claim is denied, the provider has 90 days from the denial date to resubmit the claim.

Inpatient Claims *(continued)*

Information about Inpatient claims

What are the claims payment and denial parameters allowed by DOM for the MississippiCAN insurer (contractor)?

- The contractor must pay at least 90% of all clean claims (as defined by Miss. Code Ann. § 83-9-5) for covered services within 30 calendar days of receipt and pay at least 99% of all clean claims within 90 calendar days of receipt, except to the extent an alternative payment schedule has been agreed to in the provider agreement.

- For other claims, the contractor shall notify the provider of the status (e.g., pend, deny, or other reason) of the claim and if applicable, the reason the claim cannot be paid within 30 calendar days of the adjudication of the claim. The contractor must pay all other claims, except those from providers under investigation for fraud, waste and abuse, within 12 months of the date of receipt.

Inpatient Claims *(continued)*

Information about Inpatient claims

What are the claims payment and denial parameters allowed by DOM for the MississippiCAN insurer (contractor)?

- Claims pending or suspended for additional information must be processed (paid or denied) by the 30th calendar day following the receipt of information requested, otherwise the contractor must close (pay or deny) any other suspended claim if all requested information is not received prior to the expiration of the 30 calendar day period.

- The contractor shall send providers written notice for each claim that is denied, including the reason(s) for the denial.

DOM Hospital Inpatient Oversight

Information about Inpatient claims

How will DOM monitor claims denials by MississippiCAN providers?

- DOM will monitor denials through required monthly reporting from the CCOs.
- An explanation will be required for any percentage of denial in excess of 2 percent of total claims. Any denials for prior-authorization in excess of 1 percent of total claims processed with prior-authorization should be specifically explained.

Quality Improvement Organization (QIO) Oversight

- eQHealthSolutions (eQHS) will remain the Quality Improvement Organization responsible for oversight and all utilization management and reimbursement reviews, including for MississippiCAN beneficiaries. This includes the following:
    - Clinical quality review
    - Utilization Management determination review
    - APR-DRG coding validation
    - Claims Adjudication logic validation

DOM Hospital Inpatient Oversight (continued)

Information about Inpatient claims

Clinical/Medical Oversight

- Specific DOM contractors are required to have the capacity and procedures to perform clinical consultations in order to assist DOM in addressing the following areas:
    - Medical necessity issues
    - Researching new technology
    - Developing medical policies
    - Addressing quality issues

- Clinical oversight is performed by a provider of equal or greater specialty or licensure for the various types of healthcare practitioners participating in the MS Medicaid program

Inpatient Claims

Information about Inpatient claims

How will MississippiCAN payments compare to current FFS payments from DOM?

- Both MississippiCAN and DOM pay for hospital inpatient services based on the APR-DRG payment methodology using the approved State Plan parameters.

How often are the APR-DRG payments updated by DOM and MississippiCAN contractors?

- The FFS APR-DRG payments are updated at least once annually by DOM and Xerox.

- The MississippiCAN contractors will be notified by DOM of the updated APR-DRG payments and parameters and are required to implement these updates on the effective date.

Newborns

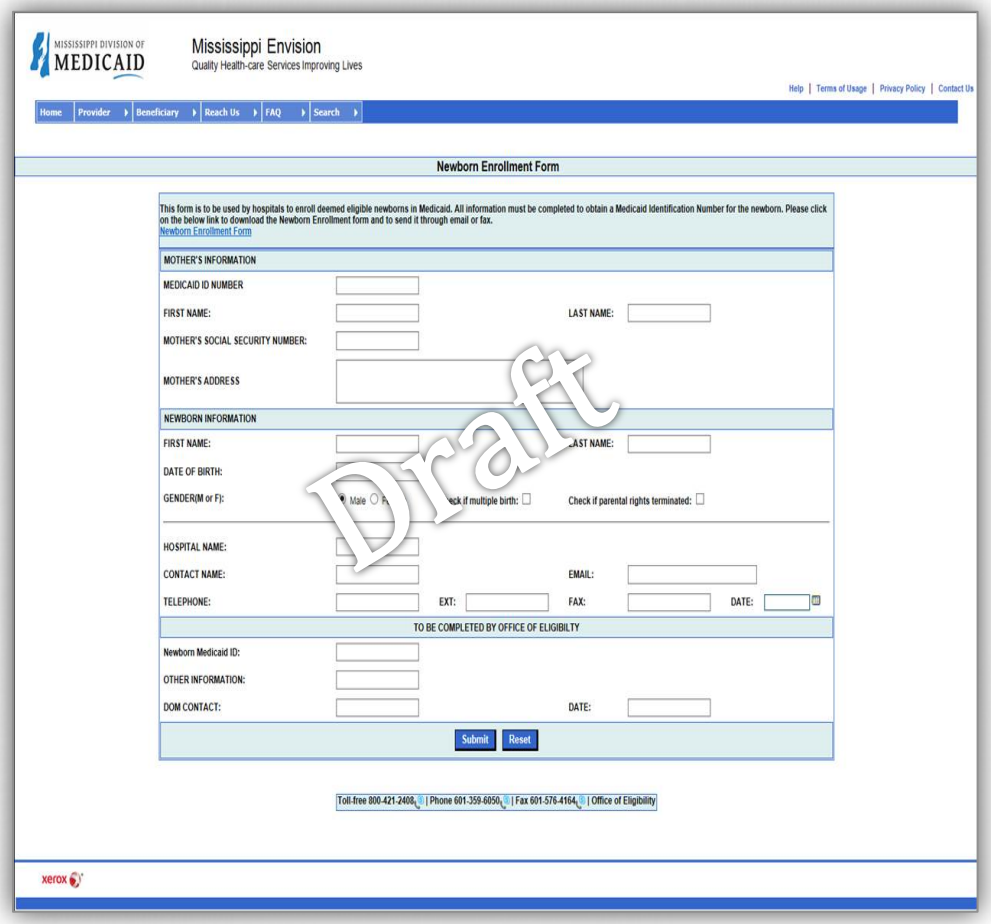
MississippiCAN Inpatient Coverage for Newborns

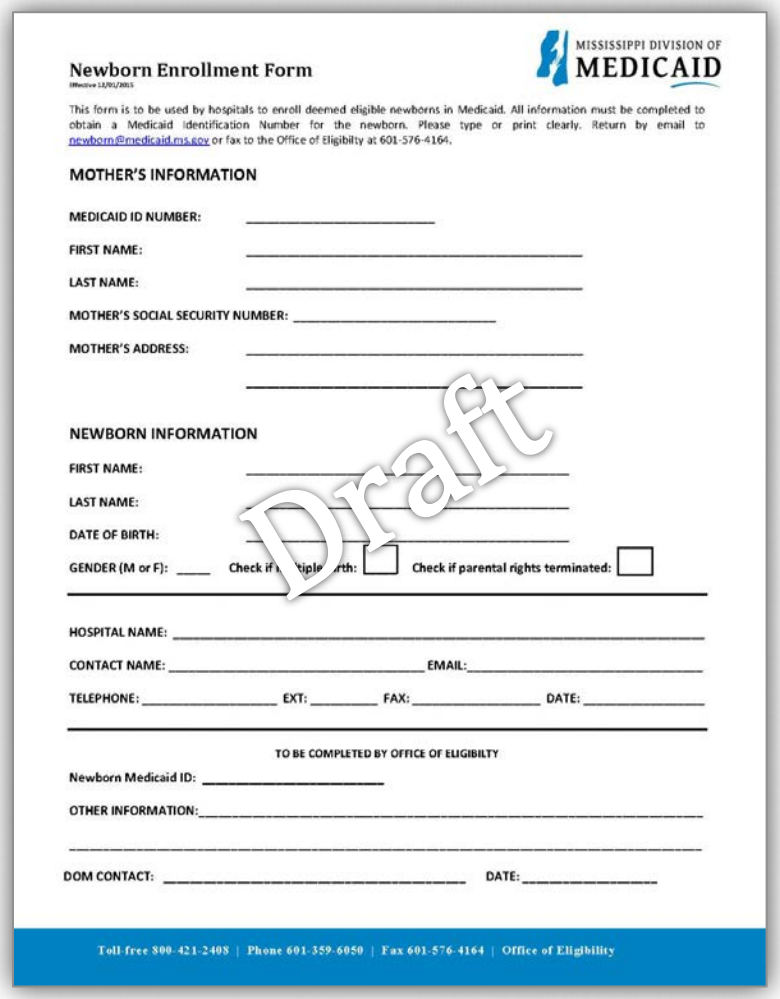
Newborn Reporting for Medicaid Identification Number Assignment

- Hospitals will notify DOM within 5 calendar days of an infant's birth using the Newborn Enrollment Form.
- The enrollment form is available on the Envision web portal (ms-medicaid.com) for electronic submission. A fillable PDF is available on the Division of Medicaid's website (medicaid.ms.gov) for submission by fax or email to newborn@medicaid.ms.gov mailbox (effective Dec. 1, 2015).
- DOM's Office of Eligibility will determine newborn eligibility, assign the newborn's permanent Medicaid ID number, and notify the hospital within 5 business days.

Newborn Enrollment Forms

Envision web portal at ms-medicaid.com





Newborns

MississippiCAN Inpatient Coverage for Newborns

Is an application necessary for newborns?

- If the mother has Medicaid coverage at the time of birth or subsequently becomes eligible for Medicaid retroactively for the birth month, the infant is deemed eligible for the first year of life and the Newborn Enrollment Form serves as the application.
- If the mother is not Medicaid-eligible at the time of birth, an application can be filed at any of the 30 Medicaid regional offices for an eligibility decision.

To whom should claims for newborns be billed?

- Upon enrollment in Medicaid, newborns of a MississippiCAN mother on or after Dec. 1, 2015 will be automatically assigned to the same CCO of the mother. Therefore, the provider should bill the plan to which the mother has been assigned.
- For newborns of mothers who are not Medicaid-eligible, an application should be submitted to the appropriate Medicaid regional office.

Third Party Liability

Third Party Liability (TPL)

Does Third Party Liability Apply Under Managed Care?

- *Yes*. Third Party Liability (TPL) refers to the legal obligation of third parties (e.g., certain individuals, entities, insurers, or programs) to pay part or all of the expenditures for medical assistance furnished under a Medicaid state plan including Medicaid CCOs.

Does the beneficiary's third party insurance information affect the payment of in- patient hospital claims?

- *Yes*. A method of avoiding payment of Medicaid claims when other insurance resources are available to the Medicaid beneficiary is called **Cost Avoidance**. Whenever the Medicaid agency is billed first, claims are denied and returned to the provider who is required to bill and collect from liable third parties. CCOs will follow these same guidelines.

Will DOM conduct a third party liability audit?

- *Yes*. An annual audit will be conducted by the Office of Recovery. The purpose of the review is to ensure CCOs are accurately cost avoiding expenditures and recovering monies from any third party sources responsible for paying claims of Medicaid beneficiaries. CCOs will receive a list of randomly selected beneficiaries with dates of service within the specific fiscal year. A report of all claim activity for the beneficiaries must be submitted for review within 30 days from the date of the listing. DOM will notify CCOs of findings.


MISSISSIPPI DIVISION OF
MEDICAID

magnolia health™

INPATIENT

Provider Education

magnolia health™

Welcome to Magnolia Health!

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

This presentation is only intended to provide guidance to providers regarding Magnolia's policies and procedures related to inpatient services for the MississippiCAN Program. It is always the responsibility of the provider to determine member eligibility and also determine and submit the appropriate codes, modifiers and charges for the services provided to Magnolia members.

Agenda Topics

- Provider Enrollment
- Credentialing Requirements
- MississippiCAN Eligibility
- Cultural Awareness
- Inpatient Regulatory Requirements
- Medical Management
  - Prior Authorization
  - Medical Necessity
  - Review Criteria
  - Admissions
  - Notification of Newborn Delivery
  - Observation Guidelines
  - Concurrent Review
  - Care Management
  - Clinical Protocols
- APR-DRG
- Claims
- Waste, Abuse and Fraud (WAF)
- Complaints and Grievances
- Magnolia Health Website
- Behavioral Health
- PaySpan Health
- Provider Services
- Provider Relations
- Quality Coordinators

Provider Enrollment

- Providers must be enrolled as a Medicaid Provider and have an active Mississippi Medicaid ID #. Providers must also be properly credentialed by Magnolia or other designated authority prior to treating Magnolia members.

- Prior Authorizations must be obtained for services provided by out of network providers, except for emergency and post-stabilization services, and these services will only be reimbursed at 80% of the Medicaid fee schedule.

- Contract request forms can be found on Magnolia's website at www.magnoliahealthplan.com and should be completed and faxed to 866-480-3227 in order to begin the contracting process.

- Upon receipt of the contract request form, a Magnolia Contract Negotiator will send you a MississippiCAN agreement to review along with a list of information required to complete credentialing.

- Magnolia's credentialing team is required to render a decision on all credentialing applications within ninety (90) calendar days of receipt of a complete credentialing package.

- Providers will be designated in Magnolia's claims payment system as a participating provider within thirty (30) days of approval of their credentialing application by Magnolia's Credentialing Committee.

Required Items for Facility Credentialing

- Hospital/Ancillary Credentialing Application
- State Operational License
- Other applicable State/Federal licensures (e.g. Clinical Laboratory Improvement Amendment (CLIA), Drug Enforcement Administration (DEA), Pharmacy, Department of Health, etc.)
- Accreditation/certification by a nationally-recognized accrediting body (i.e. The Joint Commission (TJC), Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or other designated authority)
  - If not accredited by a nationally-recognized accrediting body, please include site evaluation results from a governmental agency
- Current general liability coverage (showing the amounts and dates of coverage)
- Medicaid/Medicare certification
  - If not certified, please provide proof of participation
- W-9
- Ownership and Disclosure form

MississippiCAN Eligibility

Eligibility for MississippiCAN will be determined by the Division of Medicaid (DOM) according to rules approved by the Division of Medicaid. DOM follows eligibility rules mandated by federal law.

Categories of Eligibility (COE):

Mandatory Populations	COE	New COE	Age
SSI - Supplemental Security Income	001	001	19 – 65
Working Disabled	025	025	19 – 65
Breast and Cervical Cancer	027	027	19 – 65
Parents and Caretakers (TANF)	085	075	19 – 65
Pregnant Women (below 194% FPL)	088	088	8 – 65
Newborns (below 194% FPL)	088	071	0 – 1
Children TANF	085	071 – 073	1 – 19
Children (< age 6) (< 143% FPL)	087, 085	072	1 – 5
Children (< age 19) (< 100% FPL)	091, 085	073	6 – 19
Quasi-CHIP (100% - 133% FPL) (age 6-19) (previously qualified for CHIP)	099	074	6 – 19
CHIP (age 0-19) (< 209% FPL)	099	099	1 – 19
Optional Populations*	**COE**	**New COE**	**Age**
SSI - Supplemental Security Income	001	001	0 – 19
Disabled Child Living at Home	019	019	0 – 19
DHS – Foster Care Children – IV-E	003	003	0 – 19
DHS – Foster Care Children – CWS	026	026	0 – 19

*Native Americans are allowed to opt out of MississippiCAN, as well.

Verify Eligibility

It is the provider's responsibility to verify member eligibility on the date services are rendered 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 and/or Payment.

Cultural Awareness and Sensitivity

Providers must ensure that:

- Members understand that they have access to medical interpreters, signers, and TDD/TTY services to facilitate communication without cost to them.

- Medical care is provided without consideration to the member's race/ethnicity or language and its impact/influence of the member's health or illness.

Inpatient Regulatory Requirements

Providers must adhere to all requirements outlined in applicable State Plan Amendments and the Administrative Code.

State Plan Amendments (SPAs)

- The following SPAs are mandated by the Division of Medicaid and are available for viewing on its website:
  - SPA 15-002 Increased Primary Care Provider Payment
  - SPA 15-005 Physician Upper Payment Limit (UPL)
  - SPA 15-008 All Patient Refined Diagnosis Related Groups (APR-DRG) Public Commenting Period
  - SPA 14-009 Health Care Acquired Conditions (HCAC)
  - SPA 15-010 Mississippi Coordinated Access Network (MSCAN)
  - SPA 15-012 Mississippi Hospital Access Program (MHAP) Transition Payment and Inpatient Hospital UPL Program Elimination
  - SPA 14-016 All Patient Refined Diagnosis Related Groups (APR-DRG)

Administrative Code

- Title 23, Part 202, Inpatient Services
- Miss. Admin. Code Part 300, Rule 1.1
- Miss. Code Ann. §§ 43-13-117, 43-13-121
- Magnolia's policies strictly comply with all Division of Medicaid State Plan Amendments and Administrative Code. http://www.magnoliahealthplan.com/for-providers/provider-resources/

Medical Management

- Hours of operation are Monday through Friday from 8:00 a.m. to 5:00 p.m., CST (excluding holidays).
- Services include utilization management, case management, disease management, pharmacy management, and quality review.
- Clinical services are overseen by the Magnolia Medical Director (Medical Director). The Vice President of Medical Management is responsible for direct supervision and operation of the department.

To reach the Medical Director or Vice President of Medical Management, please contact:

Magnolia Health Plan Utilization Management

1-866-912-6285

Fax 1-855-684-6746

www.magnoliahealthplan.com

Prior Authorization

Prior Authorization is a request to the Magnolia Utilization Management (UM) department for medical necessity determination of services on the prior authorization list before the service is rendered.

- All out of network services require prior authorization except basic laboratory chemistries and basic radiology.
- Authorization must be obtained prior to the delivery of services listed on Magnolia's Prior Authorization List, which can be found at http://www.magnoliahealthplan.com/for-providers/provider-resources/. Failure to obtain authorization may result in an administrative claim denial.
- All hospital inpatient stays require notification via an authorization request within one (1) business day of the admission.
- Please initiate the Authorization process at least five (5) calendar days in advance for non-emergent outpatient services. Initiate Authorization for pre-scheduled hospital inpatient services at least 14 calendar days in advance and no later than five (5) calendar days in advance.
- The Provider should contact the UM department via telephone, fax, mail, secure email or through our website with the appropriate clinical information to request an authorization.
- Expedited requests can be requested from the UM department as needed.
- Prior Authorization is NOT required for emergent or urgent care services.
- Prior Authorization is NOT required for post-stabilization services. Once the member's emergency medical condition is stabilized, certification for hospital admission or authorization for follow-up care is required as stated above.

Failure to obtain authorization for hospital inpatient care may result in denial of the claim!

Prior Authorization (cont.)

A prior authorization request must be submitted prior to services being rendered except for emergent or post-stabilization services.

It is highly recommended that providers utilize Magnolia's "Smart Sheet" to assist with Prior Authorization requests.

http://www.magnoliahealthplan.com/files/2010/11/PA-Smart-Sheet-How-To-PDF.pdf

Prior Authorization list is located at:

http://www.magnoliahealthplan.com/files/2010/11/Prior-Authorization-List-PDF1.pdf

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

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

Requests can be faxed to:
1-877-291-8059 (Hospital Inpatient)
1-877-650-6943 (Outpatient)

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

Requests can be phoned in to:
1-866-912-6285

Prior Authorization (cont.)

- For hospital inpatient services, if authorization for level of care cannot be determined at first level review by the UM nurse, the care will be reviewed by a Mississippi licensed Medical Director. The attending physician may request a peer-to-peer discussion with said Medical Director.

- Magnolia will make standard pre-service authorization decisions and provide notice within three (3) calendar days and/or two (2) business days following the receipt of the request for services. Magnolia will make determination for urgent concurrent, expedited continued stay, and/or post-stabilization review within twenty-four (24) hours of receipt of the request for services.

- If all necessary clinical information has been received from the provider and Magnolia is still unable to make a determination within these timeframes, it may be extended up to fourteen (14) additional calendar days upon the request of the member or provider, or if Magnolia and the Division of Medicaid determine that the extension is in the member's best interest.

CLINICAL DECISIONS: Magnolia affirms that utilization management decision-making is based only on appropriateness of care and service and existence of coverage. The treating provider, in conjunction with the member, is responsible for making all clinical decisions regarding the care and treatment of the member.

Review Criteria

- Magnolia has adopted utilization review criteria developed by McKesson InterQual® products to determine DOM approved medical necessity for healthcare services.

- Magnolia's Medical Director reviews all potential medical necessity denials and will make a decision in accordance with currently accepted medical or healthcare practices, taking into account special circumstances of each case that may require deviation from the norm in screening criteria. Denial notification will include the reason(s) for denial per section 17.A. of the contract.

- Providers may obtain the criteria used to make specific determinations by contacting the Medical Management department at 1-866-912-6285.

Review Criteria (cont.)

- Members, authorized representatives or healthcare professionals with the member's consent, may request an appeal with Magnolia related to a medical necessity decision made during the authorization or concurrent review process orally or in writing to:

Magnolia Health Clinical Appeals Coordinator
111 East Capitol Street, Suite 500
Jackson, MS 39201
1-866-912-6285
Fax: 1-877-851-3995

Emergent and Weekend and Holiday Admissions

- Emergency and urgent care services never require prior authorization.
- All hospital inpatient admissions require notification via a request for authorization to Magnolia by close of business on the next business day following admission. (Failure to notify may result in denial of payment.)
- Prior Authorization is NOT required for post-stabilization services. Once the member's emergency medical condition is stabilized, certification for hospital admission or authorization for follow-up care is required as stated above.
- Non-emergent hospital inpatient admissions always require a prior authorization.

Observation Guidelines

- In the event that a member's clinical symptoms do not meet the criteria for an inpatient admission, but the physician believes that allowing the patient to leave the facility would likely put the member at serious risk, the member may be admitted to the facility for an observation period.

- An observation stay may last up to a maximum of twenty-three (23) hours. (Stays less than 8 hours of observation or greater than 23 hours are not allowed.)

- Providers are required to notify Magnolia's Medical Management department of an observation stay by the next business day after discharge.

- A medical necessity determination will be made within three (3) calendar days/two (2) business days of receiving all required information.

Concurrent Review

- Magnolia's Medical Management department will concurrently review the treatment and status of all members who are inpatient through contact with the hospital's Utilization and Discharge Planning departments and when necessary, the member's attending physician. The individual identified on the Prior Authorization form will be considered the appropriate point-of-contact for all discharge planning.

- An inpatient stay will be reviewed as indicated by the member's diagnosis and response to treatment.

- The review will include evaluation of the member's current status, proposed plan of care, discharge plans, and any subsequent diagnostic testing or procedures.

Care Management

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

Accessing Care Management

All Magnolia Health Plan members have access to Care Management services. Referrals from Providers can be made in any of the following ways:

- Effective July 23, 2015, providers may log in to our Provider Portal and complete the Provider Referral Form for Care Management and Disease Management.
- Go to our website www.magnoliahealthplan.com and fill out the Provider Referral Form for Care Management and Disease Management which is located under the Practice Improvement Resource Center (PIRC) section. Fax the completed form to 1-866-901-5813.
- Call Magnolia Health at 1-866-912-6285, ext. 66415 to speak with the Care Management Department.
- Call Magnolia Health at 1-866-912-6285 and choose the Provider prompt to speak with a Provider Services Representative who can assist you.
- For assistance with **Prior Authorizations**, call 1-866-912-6215, ext. 66408 to speak with the Prior Authorization Department.
- Magnolia Health Care Managers will contact the member and offer Care Management within 72 hours. Members who agree to Care Management services will be enrolled for the time necessary to address and stabilize the condition. Providers will be asked to provide a Plan of Care so our Care Management Team can target the Care Management to the specific needs of each member.

Clinical Protocols

Magnolia affirms that utilization management decision making is based only on appropriateness of care and service and the existence of coverage. Magnolia does not specifically reward practitioners or other individuals for issuing denials of service or care. Consistent with 42 CFR 438.6(h) and 422.208, delegated providers must ensure that compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any member.

Magnolia has adopted DOM approved utilization review criteria developed by McKesson InterQual® products to determine medical necessity for healthcare services. InterQual appropriateness criteria are developed by specialists representing a national panel from community-based and academic practice. InterQual criteria cover medical and surgical admissions, outpatient procedures, referrals to specialists, and ancillary services. Criteria are established and periodically evaluated and updated with appropriate involvement from providers. InterQual is utilized as a screening guide and is not intended to be a substitute for practitioner judgment. Magnolia's Medical Director reviews all potential medical necessity denials and will make a decision in accordance with currently accepted medical or healthcare practices, taking into account special circumstances of each case that may require deviation from the norm in the screening criteria.

Please visit the Practice Improvement Resource Center (PIRC) at
www.magnoliahealthplan.com
for Clinical Practice Guideline and Preventative Guidelines

APR-DRG

- Magnolia uses an APR-DRG payment methodology to reimburse inpatient hospital services. Magnolia's goal is to promote access to care, reward efficiency, enable clarity, and minimize administrative burden for our self and our hospital partners.

- APR-DRGs classify each case based on information contained on the inpatient claim including diagnosis, procedures performed, patient age, patient sex, and discharge status. The APR-DRG payment is determined by multiplying the APR-DRG relative weight by the APR-DRG base rate.

- Every inpatient stay is assigned a single DRG that reflects the typical resource use of that case.

- Magnolia's DRG calculator is based off of the same parameters including base rates, outlier methods and groupers currently used by Mississippi Division of Medicaid (DOM).

Claims Filing

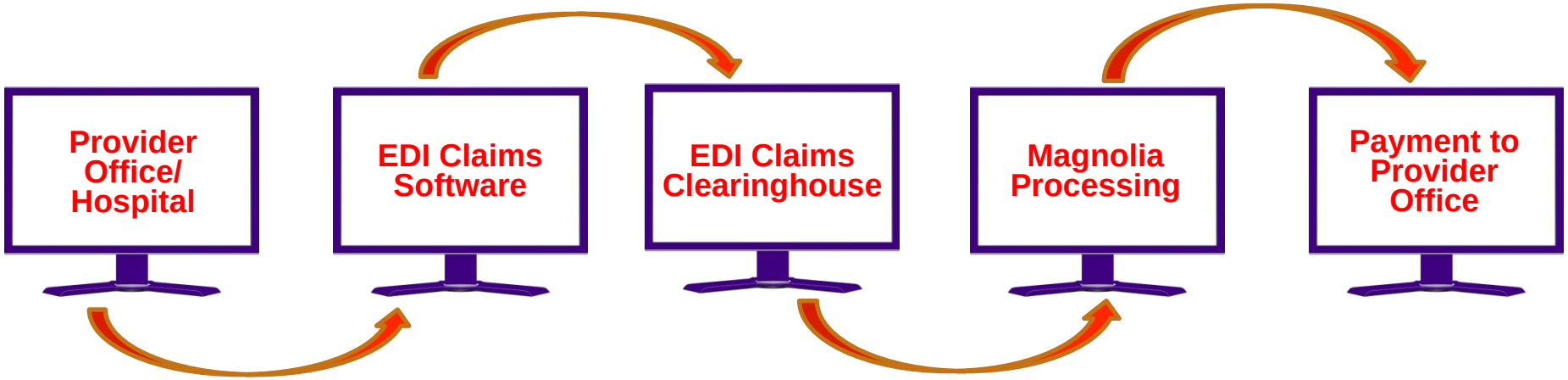
- ALL Claims must be filed within six (6) months of discharge date.
- ALL requests for correction, reconsideration, retroactive eligibility, or adjustment must be received within ninety (90) days from the date of notification of denial.
- Option to file electronically through the clearinghouse
- Option to file directly through the Magnolia website
- All member and provider information must be complete and accurate.

File online at www.magnoliahealthplan.com

- Option to file on paper claim, please mail to:
  Magnolia Health Plan MSCAN
  Attn: CLAIMS DEPARTMENT
  P.O. Box 3090
  Farmington, MO 63640
- Paper claims are to be filed on approved UB-04 (CMS 1450) claim forms (No handwritten or black and white copies)
- To assist our mail center improve the speed and accuracy of complete scanning, please take the following steps when filing paper claims:
  - ✓ Remove all staples from pages
  - ✓ Do not fold the forms
  - ✓ Make sure claim information is dark and legible
  - ✓ Please use a 12pt font or larger
  - ✓ Red and White approved claim forms are required when filing paper claims as our Optical Character Recognition ORC scanner system will put the information directly into our system. This speeds up the process and eliminates potential sources for errors and helps get your claims processed faster.

Electronic Clearinghouse

If a provider uses Electronic Data Interchange (EDI) software but is not setup with a clearinghouse, Magnolia must be billed via paper claims or through our website until the provider has established a relationship with a clearinghouse listed on our website.



- Centene (Magnolia) EDI Help desk: 1-800-225-2573, ext. 25525 or www.ediba@centene.com
- Acceptance of Coordination of Benefits (COB)
- 24/7 Submission
- 24/7 Status

For a complete listing of approved EDI clearinghouse partners, please refer to www.magnoliahealthplan.com

Prepayment Claims Review

- Magnolia uses code-auditing software to assist in improving accuracy and efficiency in claims processing, payment, and reporting, as well as meeting HIPAA compliance regulations.

- The software will detect coding errors on provider claims prior to payment by analyzing the following:
  - CPT
  - HCPCS
  - modifier, and
  - place of service codes

  against rules that have been established by the
  - American Medical Association (AMA),
  - Centers for Medicare and Medicaid Services (CMS),
  - Mississippi Division of Medicaid rules and regulations,
  - public-domain specialty society guidance,
  - and clinical consultants who research, document and provide edit recommendations based on the most common clinical scenario.

- Codes billed in a manner that does not adhere to these standard coding conventions will be denied.

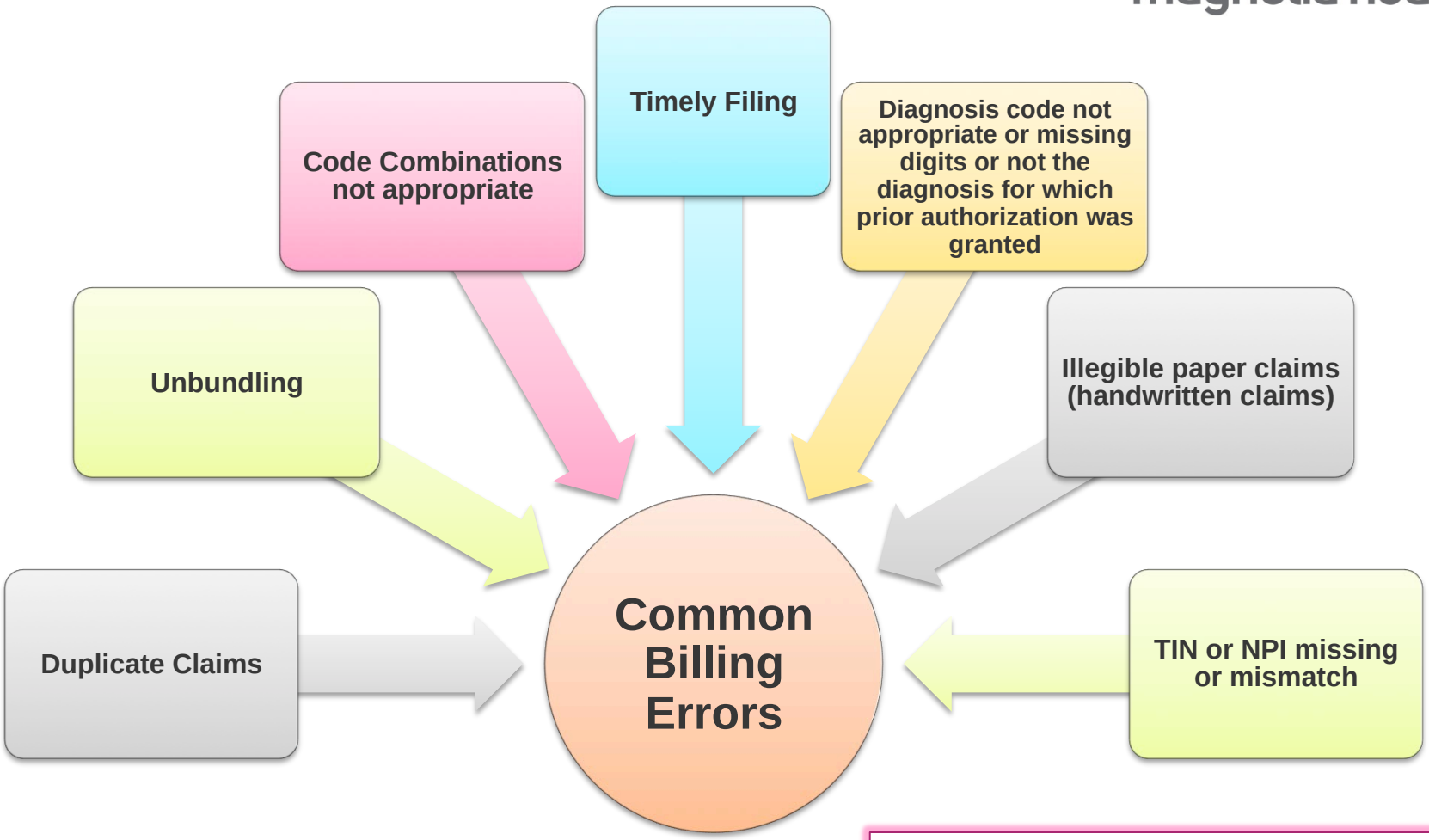
Rejections and Denials

- A rejection is defined as an unclean claim that contains invalid or missing data elements required for acceptance of the claim into the claim processing system.

- A denial is defined as a claim that has passed minimum edits and is entered into the system for processing, but has been billed with invalid or inappropriate information causing the claim to deny. An EOP (Explanation of Payment) will be sent including the denial reason.

*Clean Claim - A claim that has no defect, impropriety, incompleteness, or special circumstance that requires special handling including any factor that would cause Magnolia Health to obtain further information from the provider or other third party, or conduct further investigation.

Common Billing Errors



For a complete list of common billing errors, please refer to the Magnolia Provider Manual.

Corrected Claim, Reconsideration, Claim Dispute

All requests for corrected claims must be received within ninety (90) days of the original Plan notification (i.e. EOP). All reconsiderations and claims disputes must be received within ninety (90) days of the last written notification of the denial.

Corrected Claims	Reconsideration	Claim Dispute
•Submit via Secure Web Portal •Submit via an EDI Clearinghouse •Submit via paper claim: **•Magnolia Health Plan MSCAN** **•PO BOX 3090** **•Farmington, MO 63640** **•(Include original EOP)**	•Written communication (i.e. letter) outlining disagreement of claim determination •Indicate "Reconsideration of (original claim number)" •Submit reconsideration to: **•Magnolia Health Plan MSCAN** **•Attn: Reconsideration** **•PO BOX 3090** **•Farmington, MO 63640**	•ONLY used when disputing determination of Reconsideration request •Must complete Claim Dispute form located on www.magnoliahealthplan.com •Include original request for reconsideration letter and the Plan response •Send Claim Dispute form and supporting documentation to: **•Magnolia Health Plan MSCAN** **•Attn: Claim Dispute** **•PO BOX 3000** **•Farmington, MO 63640**

Must be submitted within ninety (90) days of adjudication

Waste, Abuse, and Fraud (WAF) System

Magnolia takes the detection, investigation, and prosecution of fraud and abuse very seriously. Our WAF program complies with MS and Federal laws, and in conjunction with Centene, we successfully operate a WAF unit. Centene's Special Investigation Unit (SIU) performs back end audits which may result in taking appropriate action against those who commit waste, abuse, and/or fraud either individually or as a practice. These actions may include but are not limited to:

- Remedial education and/or training around eliminating the egregious action
- More stringent utilization review
- Recoupment of previously paid monies
- Termination of provider agreement or other contractual arrangement
- Civil and/or criminal prosecution
- Any other remedies available

If you suspect or witness a provider inappropriately billing or a member receiving inappropriate services, please call our anonymous and confidential hotline at 1-866-685-8664

Some of the most common WAF submissions seen are:

- Unbundling of codes
- Up-coding
- Add-on codes without primary CPT
- Use of exclusion codes
- Excessive use of units
- Diagnosis and/or procedure code not consistent with the member's age and/or gender
- Misuse of benefits
- Claims for services not rendered

Complaints/Grievances

A Complaint/Grievance is a verbal or written expression by a provider which indicates dissatisfaction or dispute with Magnolia Health's policies, procedures, or any aspect of Magnolia Health's functions. Magnolia logs and tracks all Complaints/Grievances. A provider has thirty (30) calendar days from the date of the incident, such as the date of the EOP, to file a Complaint/Grievance.

A Complaint is a verbal or written expression of dissatisfaction that is capable of being resolved within one (1) business day of receipt. Magnolia will resolve all Complaints and provide appropriate notification to providers.

A Grievance requires more than one (1) business day to resolve. Grievances must be confirmed within one (1) business day, and an expected date of resolution must be given within five (5) business days. Magnolia will provide a written determination to the provider within thirty (30) calendar days upon receipt of complete documentation.

The reconsideration and/or claim dispute process must be followed first for a Complaint/Grievance related to a claim determination.

Full details of the claim reconsideration, claim dispute, complaints/grievances and appeals processes can be found in our Provider Manual at www.magnoliahealthplan.com.

Magnolia Health Website

www.magnoliahealthplan.com/for-providers

Submit:

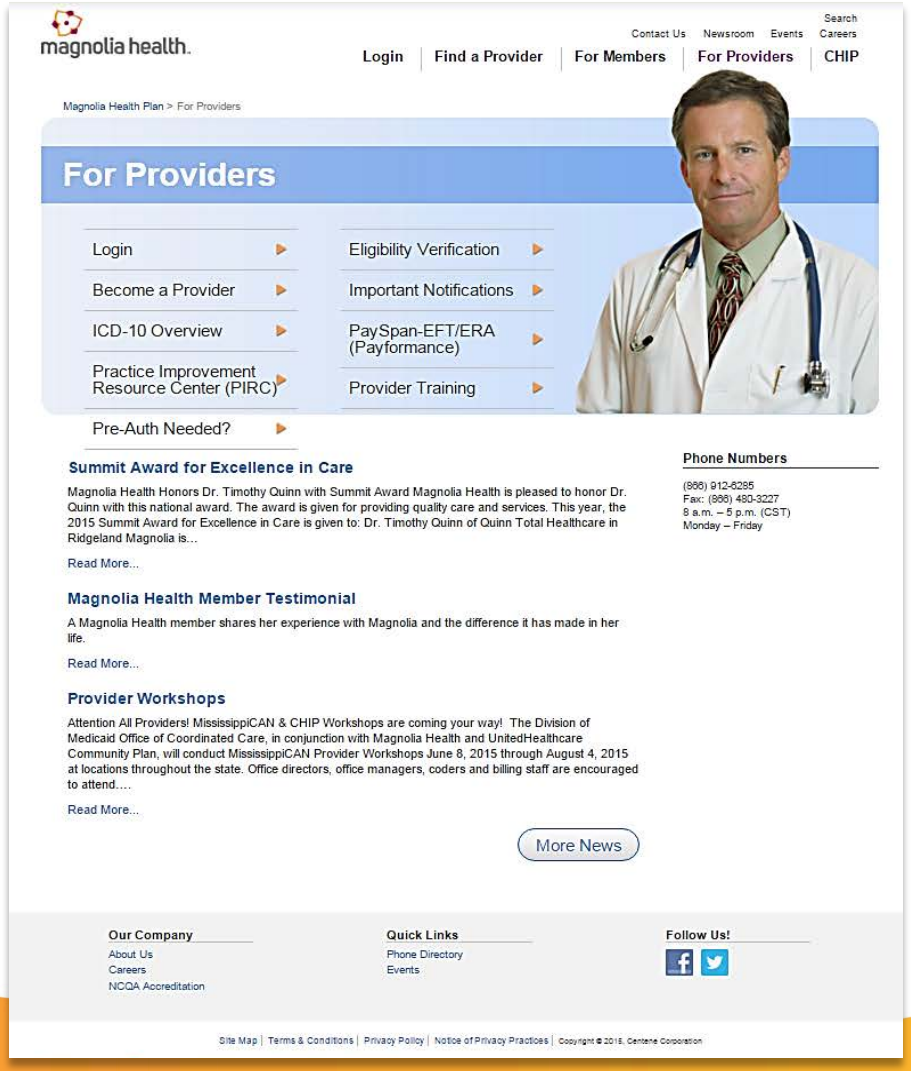
- Claims
- Provider Complaints
- Demographic Updates

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



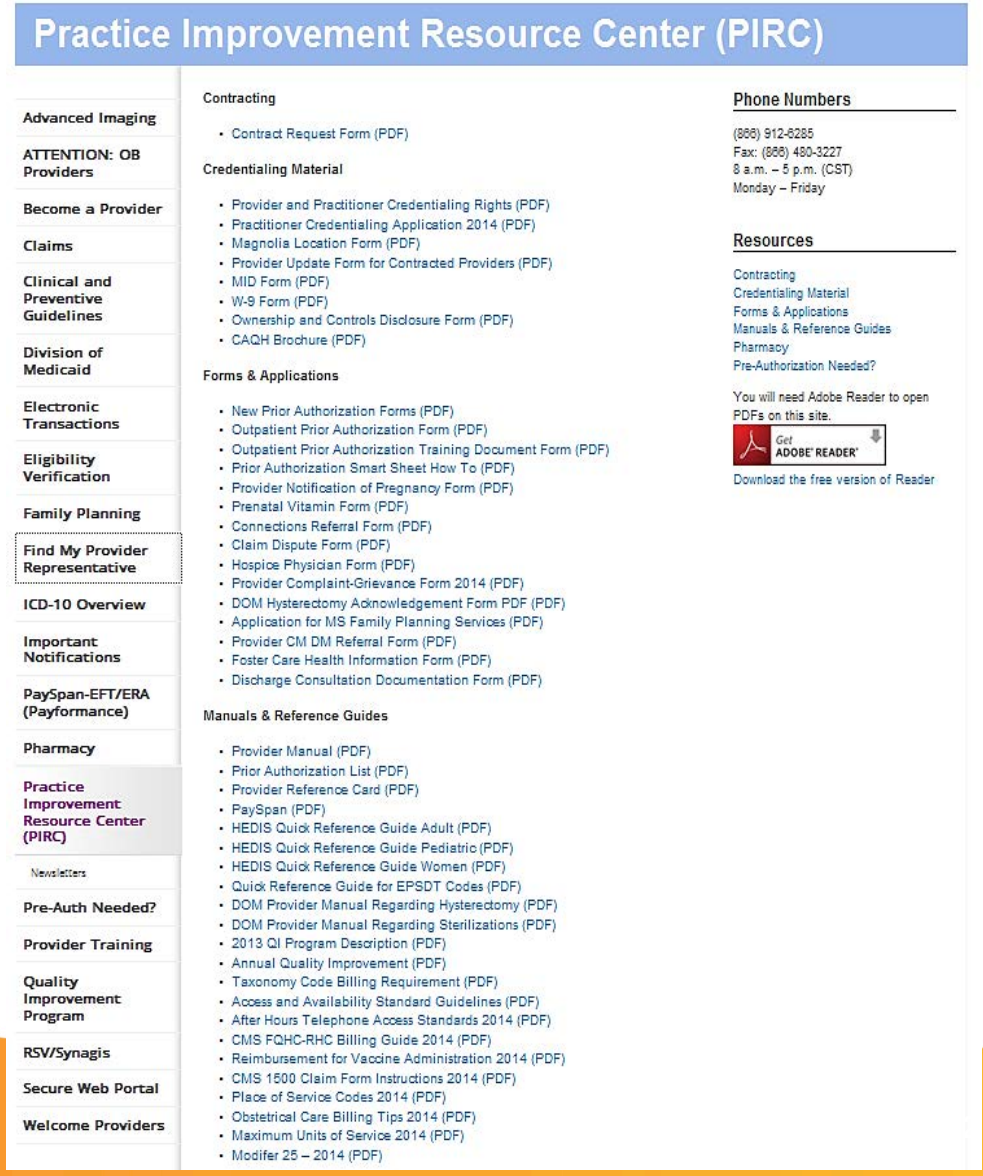
Practice Improvement Resource Center (PIRC)

magnolia health

The Practice Improvement Resource Center (PIRC) offers information to assist providers be more efficient. Resources are available twenty-four (24) hours a day.

PIRC includes these Forms and Guides:

- 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!!



Practice Improvement Resource Center (PIRC)

Advanced Imaging
ATTENTION: OB Providers
Become a Provider
Claims
Clinical and Preventive Guidelines
Division of Medicaid
Electronic Transactions
Eligibility Verification
Family Planning
Find My Provider Representative
ICD-10 Overview
Important Notifications
PaySpan-EFT/ERA (Payformance)
Pharmacy
Practice Improvement Resource Center (PIRC)
Newsletters
Pre-Auth Needed?
Provider Training
Quality Improvement Program
RSV/Synagis
Secure Web Portal
Welcome Providers

Contracting

- Contract Request Form (PDF)

Credentialing Material

- Provider and Practitioner Credentialing Rights (PDF)
- Practitioner Credentialing Application 2014 (PDF)
- Magnolia Location Form (PDF)
- Provider Update Form for Contracted Providers (PDF)
- MID Form (PDF)
- W-9 Form (PDF)
- Ownership and Controls Disclosure Form (PDF)
- CAQH Brochure (PDF)

Forms & Applications

- New Prior Authorization Forms (PDF)
- Outpatient Prior Authorization Form (PDF)
- Outpatient Prior Authorization Training Document Form (PDF)
- Prior Authorization Smart Sheet How To (PDF)
- Provider Notification of Pregnancy Form (PDF)
- Prenatal Vitamin Form (PDF)
- Connections Referral Form (PDF)
- Claim Dispute Form (PDF)
- Hospice Physician Form (PDF)
- Provider Complaint-Grievance Form 2014 (PDF)
- DOM Hysterectomy Acknowledgement Form PDF (PDF)
- Application for MS Family Planning Services (PDF)
- Provider CM DM Referral Form (PDF)
- Foster Care Health Information Form (PDF)
- Discharge Consultation Documentation Form (PDF)

Manuals & Reference Guides

- Provider Manual (PDF)
- Prior Authorization List (PDF)
- Provider Reference Card (PDF)
- PaySpan (PDF)
- HEDIS Quick Reference Guide Adult (PDF)
- HEDIS Quick Reference Guide Pediatric (PDF)
- HEDIS Quick Reference Guide Women (PDF)
- Quick Reference Guide for EPSDT Codes (PDF)
- DOM Provider Manual Regarding Hysterectomy (PDF)
- DOM Provider Manual Regarding Sterilizations (PDF)
- 2013 QI Program Description (PDF)
- Annual Quality Improvement (PDF)
- Taxonomy Code Billing Requirement (PDF)
- Access and Availability Standard Guidelines (PDF)
- After Hours Telephone Access Standards 2014 (PDF)
- CMS FQHC-RHC Billing Guide 2014 (PDF)
- Reimbursement for Vaccine Administration 2014 (PDF)
- CMS 1500 Claim Form Instructions 2014 (PDF)
- Place of Service Codes 2014 (PDF)
- Obstetrical Care Billing Tips 2014 (PDF)
- Maximum Units of Service 2014 (PDF)
- Modifer 25 – 2014 (PDF)

Phone Numbers

(866) 912-6285
Fax: (866) 480-3227
8 a.m. – 5 p.m. (CST)
Monday – Friday

Resources

Contracting
Credentialing Material
Forms & Applications
Manuals & Reference Guides
Pharmacy
Pre-Authorization Needed?

You will need Adobe Reader to open PDFs on this site.

Get ADOBE READER

Download the free version of Reader

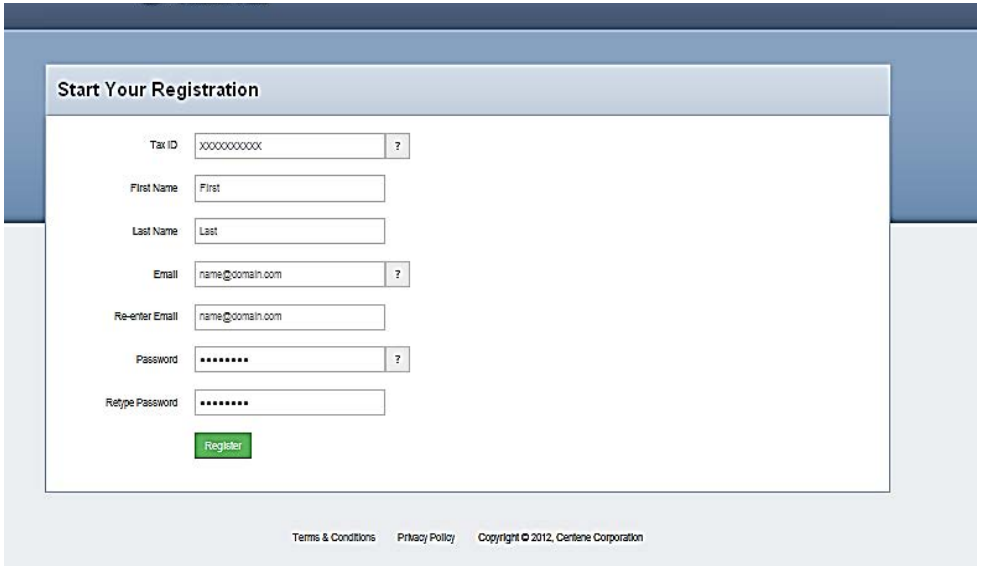
Magnolia Secure Web Portal

To register for the secure web portal, please refer to www.magnoliahealthplan.com.

- Once logged in, please select **For Medical Professionals** < **Medicaid**.
- Once you are on the **For Providers** screen, you will select **Login**. This screen will give the provider the option to register.

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

- Cenpatico is the behavioral health vendor for Magnolia Health. Cenpatico is a wholly-owned subsidiary of Centene Corporation, which has been nationally recognized for innovative service programs and contemporary approach in handling the needs of the diverse populations in the markets proudly served.

- To partner with Cenpatico or for more information, please call 866-324-3632 or visit www.cenpatico.com .

- Prior Authorizations for Behavioral Health can be faxed to 1-866-694-3649

- Claim submissions for Behavioral Health can be mailed to:
  Cenpatico – PO BOX 7600 – Farmington, MO 63640-3834

CONTACTS:

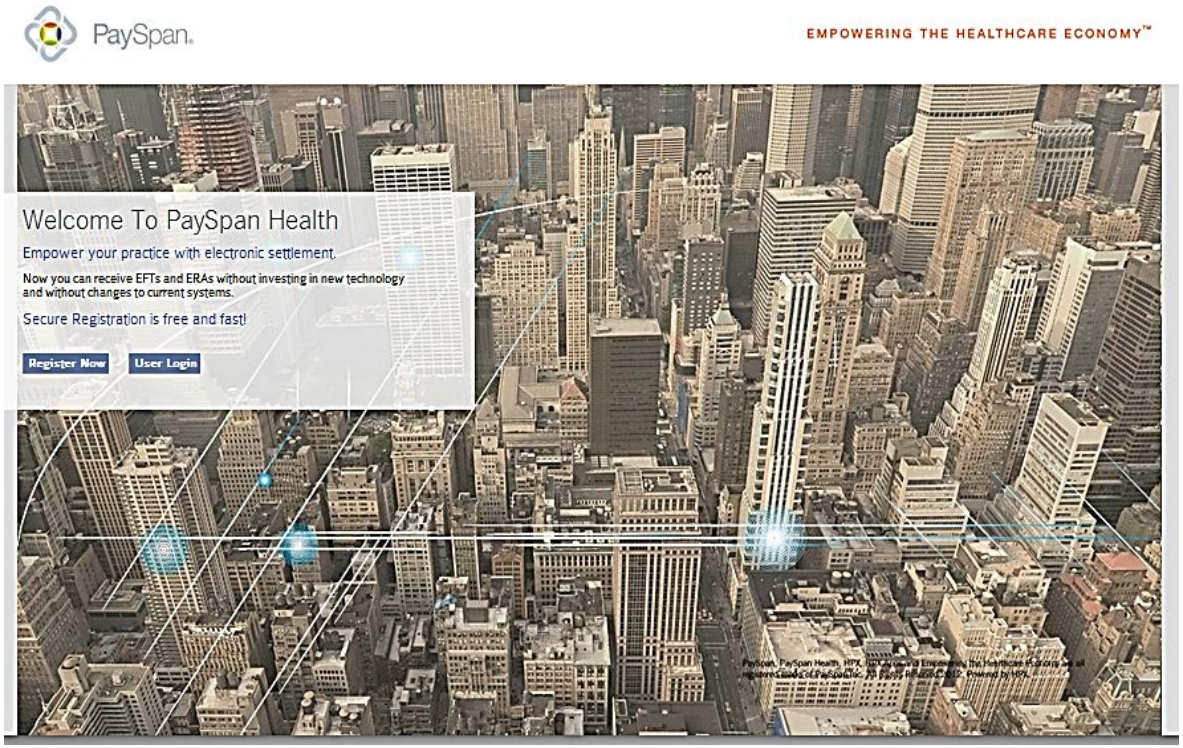
Network Manager: Angela Stewart | anstewart@cenpatico.com | (601) 863-0738

Provider Relations Specialist: Nakisha Montgomery | nmontgomery@cenpatico.com | (601) 863-0745

PaySpan Health

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 for download directly to HIPAA-compliant Practice Management or Patient Accounting System
- Register at: **www.PaySpanHealth.com**



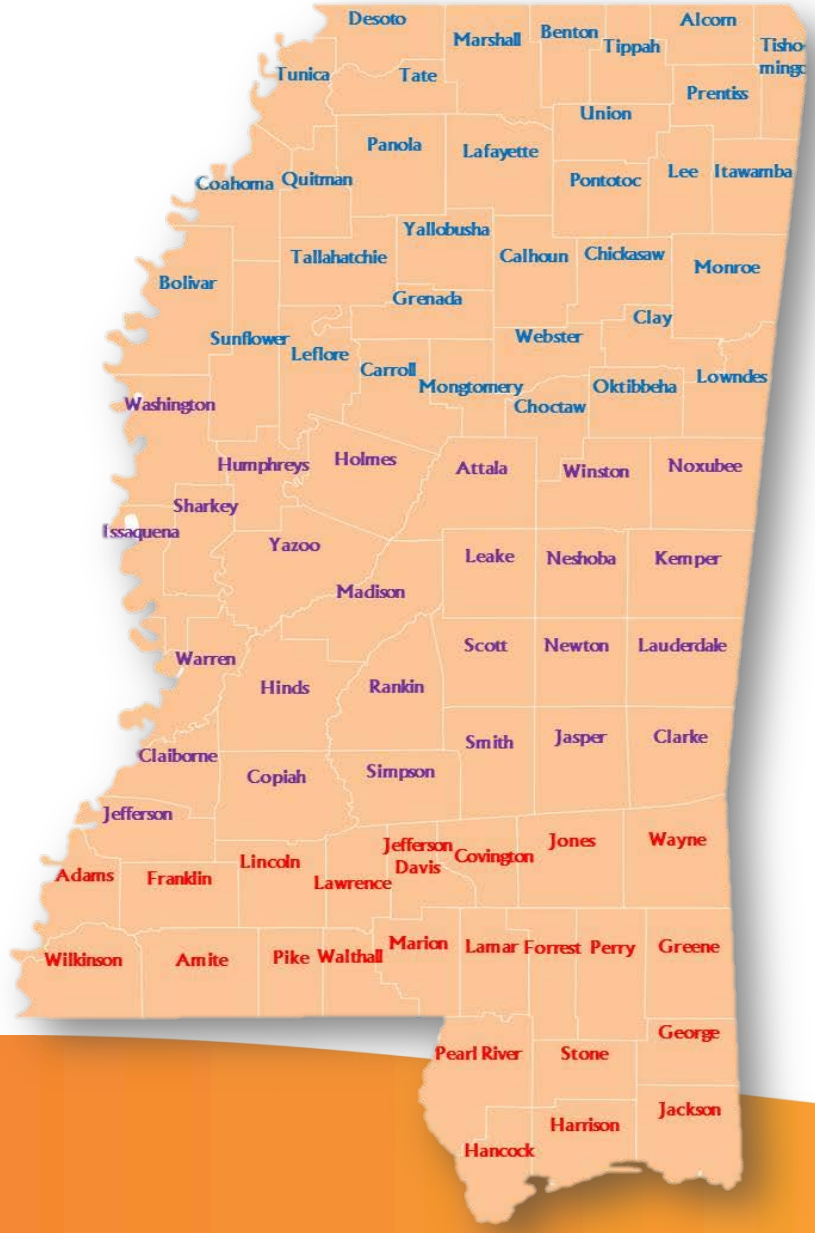
For further information contact 1-877-331-7154, or email providerssupport@payspanhealth.com

Provider Services (Call Center)

Mississippi Based Provider Services Call Center:

- Provides phone support
- **First line of communication**
- Answer questions regarding eligibility, authorizations, claims, payment inquiries
- Available Monday through Friday, 8am to 5pm CST at **1-866-912-6285**

Provider Relation Contacts



NORTH TERRITORY – ASHLEY ARMSTRONG

662-372-0209

AARMSTRONG@CENTENE.COM

CENTRAL TERRITORY – ANGEL SHIVERS

601-862-5439

ASHIVERS@CENTENE.COM

SOUTH TERRITORY – POSITION OPEN / SEARCH IN PROCESS

***SUPERVISOR, PROVIDER RELATIONS – JENNIFER HOBOCK**

601-863-0699

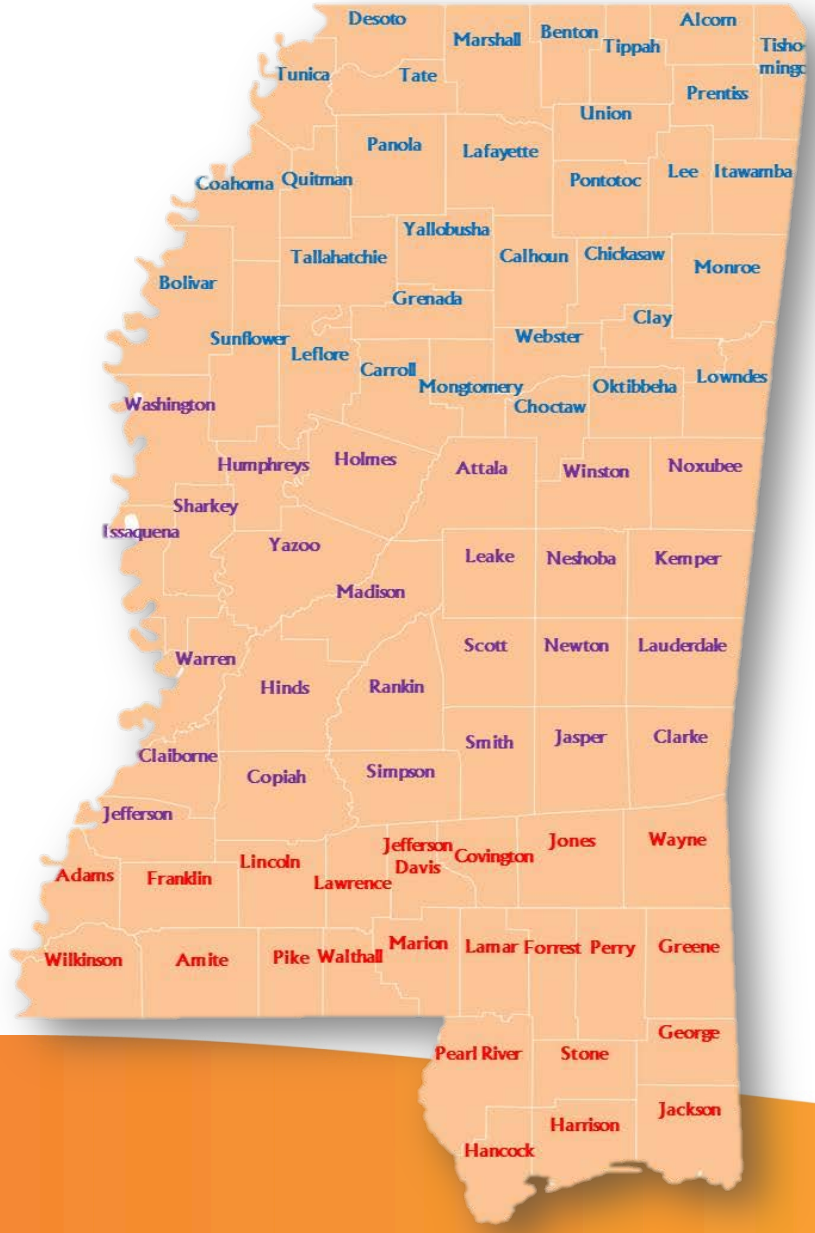
JHOBOCK@CENTENE.COM

Provider Relations

Provider Education

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

Quality Coordinators



magnolia health™

NORTH TERRITORY – DIANN SWANN
601-966-5198
DSWANN@CENTENE.COM

CENTRAL TERRITORY – EMILY NOBILE
601-331-6848
ENOBILE@CENTENE.COM

SOUTH TERRITORY – MELINDA HINTON
601-317-8119
MHINTON@CENTENE.COM

*DIRECTOR, QUALITY IMPROVEMENT – CARRIE MITCHELL
601-862-2604
CARMITCHELL@CENTENE.COM

magnolia health™

Thank you!


MISSISSIPPI DIVISION OF
MEDICAID

UnitedHealthcare
Community Plan of Mississippi

MSCAN Hospital Inpatient

Provider Education

Effective 12.01.2015

UnitedHealthcare®
Community Plan

Mission & 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.

Agenda

UnitedHealthcare Community Plan

1. Provider Enrollment
2. Provider Relations Service Model
3. Provider Advocates
4. Eligibility Requirements
5. Hospital Inpatient Regulatory Requirements
6. Prior Authorization & Notifications
7. Prior Authorization Timeframes
8. Initial Clinical Review
9. Person Centered Care Management Model
10. Observation Care
11. Peer to Peer Review
12. Complaints, Grievances & Appeals
13. Claims Filing & Reconsideration
14. Inpatient Facility Fraud Waste and Abuse
15. Contact Information
16. Questions

UHC in Mississippi!

UnitedHealthcare Community Plan

Over 300 state residents employed by UnitedHealthcare

Contracted with over 8000 providers and over 100 hospitals

Community investment, contributed over $200,000 in 2014

Nearly $800,000 paid out in provider incentives

UHC Community Plan of MS in Action!

UnitedHealthcare Community Plan

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 to 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 Turkey Giveaway:

We gave away 500+ turkeys and bags of produce to members across the state.

Community Activism:

We participated in health fairs and partnered with community organizations to promote health awareness.

Provider Enrollment

UnitedHealthcare Community Plan

- United has mailed contracts to all of our in network hospital providers.
- Contracts are based on Medicaid rates.
- **UHC will calculate reimbursement based on All Patient Refined – Diagnosis Related Group version 32 (APR-DRG v32) with version 33 mapper methodology in alignment with state regulations.**
- If you have not already please sign your contract amendment and send back to UHC at your earliest convenience.

  UnitedHealthcare Network Management
  Attn: Tony Cahn
  33 Inverness Center Parkway, Suite 350
  Hoover, AL 35242
  1-877-842-3210
  National_credentialing@uhc.com

- Providers will be loaded into UnitedHealthcare's claims system within 30 days after receipt of a fully executed contract, including completed disclosure form.

Provider Relations Service Model

UnitedHealthcare Community Plan

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 UHConline.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.

Provider Advocates

Provider Advocates

Celeste Love
Northwest MS

Tommy Adams
Northeast MS

Stephanie Bullock
Central MS

Tina Price
South MS

Tonya Daves - Hospitals

Jason Nichols - FQHCs/RHCs

Teresa Morris - DME/Internal

ms_providerrelations_medicaid@uhc.com
UHC MS Community Plan, Provider Relations mailbox

877.743.8734 – If Provider Services cannot satisfy/resolve the provider's issue, request to be contacted by a Provider Advocate.

Category of Eligibility – MSCAN Mandatory Enrollment

UnitedHealthcare Community Plan

Category of Eligibility	COE	New COE	Age
SSI -Supplemental Security Income	001	001	19-65
Working Disabled	025	025	19-65
Breast and Cervical Cancer	027	027	19-65
Parents and Caretakers (TANF)	085	075	19-65
Pregnant Women (below 194% FPL)	088	088	8-65
Newborns (below 194% FPL)	088	071	0-1
Children (TANF)	085	Below	1-19
Children (< age 6) (< 143% FPL)	087, 085	072	1-5
Children (< age 19) (<100% FPL)	091, 085	073	6-19
Quasi-CHIP (100%-133% FPL) (age 6-19) (previously qualified for CHIP)	099	074	6-19
Children (Beginning SFY 2015)	085, 091	072 - 074	1-19
CHIP (age 0-19) (<209% FPL)	099	099	1-19

Category of Eligibility – MSCAN Optional Enrollment

UnitedHealthcare Community Plan

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

Verify Eligibility

- Log on to the Medicaid Envision website at: www.ms-medicaid.com/msenvision
- Log on to the secure provider portal at www.unitedhealthcareonline.com
- Contact UHC Provider Services: 877-743-8734

Hospital Inpatient Regulatory Requirements

UnitedHealthcare Community Plan

Mississippi Division of Medicaid State Plan Amendments:

http://www.medicaid.ms.gov/about/state-plan/

Mississippi Division of Medicaid Administrative Code:

http://www.medicaid.ms.gov/providers/administrative-code/

UnitedHealthcare Community Plan of Mississippi Policies:

http://www.uhccommunityplan.com

Prior Authorization & Notification

- Prior Authorizations Requirements
  - Non-participating providers
  - Elective inpatient requests and
  - non-urgent/emergent holiday and weekend admissions

For a complete list of services requiring prior authorization, go to UHCCommunityPlan.com

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

- Notification Requirements:
  - Post-stabilization care *does not require prior authorization* but will require notification within one (1) business day
  - Urgent or emergent admissions require notification even if occurring during the weekend or on a holiday within one (1) business day

Prior Authorization & Notification

- A PA nurse will conduct a Medical Necessity Review using the Clinical Review Hierarchy.
- When conducting Medical Necessity Review, the PA nurse reviews inpatient admissions to determine the appropriate Level of Care using MCG Care Guidelines.
- When the PA nurse cannot approve a request, they task the case to the prior authorization Mississippi licensed Medical Director to make the Determination per standard workflows.
- When a decision is rendered, the PA nurse will provide notice to the provider and the case is tasked to the applicable inpatient work queue.
- All denials are made by a MS Licensed Physician.
- Claims may be denied if notification is not received.

Non-emergent out of network services will be reimbursed at 80% of the Medicaid fee schedule.

Prior Authorization Timeframes

- UHC is required to notify the requesting Provider and the member in writing of any decision to deny or reduce any authorization request.
- UHC is required to make standard authorization decisions and provide notice within **two (2) business days** upon receipt of all clinical information.
- UHC must expedite authorization for services when the Provider indicates or UHC determines that following the standard authorization decision time frame could seriously jeopardize the member's life, health, or ability to attain, maintain, or regain maximum function.
    - UHC must provide decision notice no later than twenty-four hours after receipt of the expedited authorization request.

Initial Clinical Review

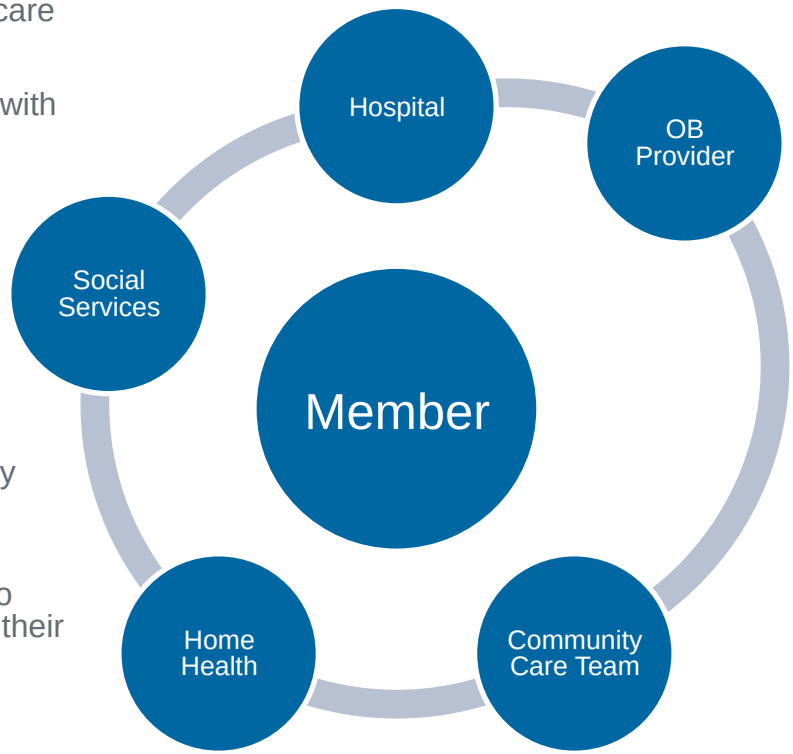
- Dedicated staff conduct intake and initial screening to prepare for initial Clinical Review.
- Nurses establish appropriateness of requested services to determine benefit coverage on cases that require evaluation or interpretation.
- Nurses are able to approve all cases that meet medical necessity guidelines.
- Cases that are not approved at nurse level are referred to a MS licensed Physician for medical necessity review and clinical determination.
- Following initial clinical review, cases are either closed, returned to a non-clinical staff member for follow up activity, or, if the level of care requires concurrent clinical review, the clinical reviewer will keep the case open for concurrent review until no further services are required.

Person Centered Care Management Model

UnitedHealthcare Community Plan

Program specialized to provide specialized Person Centered program

- **Care Management Program Team**
  - Facilitate coordination, continuity and appropriateness of care and services to meet the enrollees health care needs
  - Develop person centered plan of care plan in conjunction with the enrollee and enrollees health care delivery team
  - Integration of Behavioral and Medical Management
  - 12 Community Health Workers "Feet on the Street"
    - May accompany a fragile member to a Provider appointment and assist member with social needs
    - Ensuring continuity of care and linking members to appropriate care
- **Discharge Planning/Transitional Case Management**
  - 3 Discharge Planners Embedded in Hospitals and virtually throughout Mississippi
  - Discharge Planners link members to Transitional Case management establishing contact with the member prior to discharge to build a relationship and proactively schedule their first post discharge visit



Observation Care

- In the event that a member's clinical symptoms do not meet the criteria for an inpatient admission, but the physician believes that allowing the patient to leave the facility would likely put the member at serious risk, the member may be admitted to the facility for an observation period.
- An observation stay may last up to a maximum of twenty-three (23) hours. (Stays less than 8 hours of observation or greater than 23 hours are not allowed.)
- Notification of the observation hospital stay requires notification the next business day.
- Observation rules have not changed from UnitedHealthcare's current process.

Peer-to-Peer Post Adverse Determination

- In the event of a clinical denial the ordering Physician may request a Peer-to-Peer review.
- Concurrent review: Fourteen (14) calendar days to request
- Post discharge: Three (3) business days
- Medical Director will respond to a peer-to-peer request within one business day.

Complaints & Grievances

UnitedHealthcare Community Plan

- Complaint: An expression of dissatisfaction received orally or in writing that is of a less serious or formal nature that is resolved within one (1) business day of receipt.
  - Complaints may be submitted orally or in writing within 30 calendar days of the date of the event causing the dissatisfaction. Any Complaints not resolved within one (1) business day shall be reclassified as a Grievance and will follow the acknowledgment and resolution guidelines as set forth below.

- Grievance: An expression of dissatisfaction about any matter or aspect of UnitedHealthcare or its operation, other than a UnitedHealthcare Action as defined in the Provider manual.

Complaints & Grievances

UnitedHealthcare Community Plan

- Grievances (standard or expedited) may be submitted orally or in writing within thirty (30) calendar days of the date of the event causing the dissatisfaction. Within five (5) business days of receipt of a standard Grievance, UnitedHealthcare shall provide a written notice to the Provider acknowledging receipt and advising of the expected date of resolution. Resolution of standard Grievances shall be made within thirty (30) calendar days of receipt.

- Expedited Grievances shall be resolved as expeditiously as the Member's health requires not to exceed seventy-two hours (72). Expedited Grievance resolution shall be communicated to the Provider telephonically. Written resolution shall also be provided if requested by the Provider.

Appeals & Filing Timeframe

- Timeframe to file an appeal is thirty (30) calendar days from notice.
- UnitedHealthcare (UHC) will send an acknowledgment letter within ten (10) calendar days of receipt.
- Once determination has been made UHC will send a second resolution letter within thirty (30) calendar days.
- Expedited appeals require resolution within three (3) calendar days.
- Providers may request a State Administrative Hearing through Division of Medicaid within thirty (30) calendar days of UHC final determination.
- The Division of Medicaid has ninety (90) calendar days to respond to a providers request for a State Administrative Hearing. .

Timely Filing

UnitedHealthcare Community Plan

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.

Claims Filing

UnitedHealthcare Community Plan

Claim Processing Time:

UHC usually processes clean claims within ten (10) business days generating a weekly payment cycle.

Claims Submission Rules:

The following claims MUST be submitted on paper due to required attachments:

- Timely filing reconsideration requests
- Medicaid National Correct Coding Initiative (NCCI) edit reconsideration
- Unlisted procedure codes if sufficient information is not sent in the notes field.

*Note: Please do not send claims on paper with attachments unless requested by the health plan.

Paper claim specific rules include:

- Corrected Claims may be submitted electronically; however the words “corrected claim” must be in the notes field.
- Unlisted Procedure Codes may be submitted with a sufficient description in the notes field.
- We follow CMS National Uniform Claim Committee (NUCC) Manual guidelines for placement of data for both CMS 1500 and UB04. The health plan does not accept span dates for these types of claims.

Claims Reconsideration

UnitedHealthcare Community Plan

This is the fastest way to determine if your claim has been paid correctly!

Reconsideration requests can be submitted in a few ways:

1. Electronically via the *Optum Cloud* Dashboard
2. Electronically (without attachments) via UnitedHealthcareOnline.com.
3. Or Paper Claim Reconsideration requests can be mailed to us once you complete the "Claim Reconsideration form" located in the Tools & Resources section of UnitedHealthcareonline.com

   Mailing address:

   UnitedHealthcare Community Plan

   PO Box 5032

   Kingston, NY 12402

Inpatient Facility Fraud Waste and Abuse

UnitedHealthcare Community Plan

Policy: Retrospective reviews of inpatient claims are performed periodically.

Procedure:

- Proprietary algorithms are applied to the claim data.
- Anomalies are then reviewed for further indication that a medical record review may be needed.
- Once it is determined a medical record review is appropriate, a medical record request letter is sent to the provider who submitted the claim.
- When those records are received from the provider a qualified professional then reviews those records for proper billing and coding based on a comparison of the record and the submitted claim.
- If the documentation received does not support the codes billed, then a determination is made as to what code should have been billed.
- This information is sent back to the provider in a findings letter.
- Providers are given a set amount of time to respond as defined in written communication to the provider.

Contact Information

UnitedHealthcare Community Plan

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.

Appeals:

Written appeals can be filed to:

P.O. Box 5032 Kingston, NY 12402-5032

Provider Services can assist with verbal appeals: 877-743-8734

Reimbursement Policies:

- All reimbursement policies are readily available for your reference at: uhccommunityplan.com.

Claim Reconsideration Request:

- Please visit unitedhealthcareonline.com to learn more about and submit a claims reconsideration request.

Thank you!

UnitedHealthcare®
Community Plan

MississippiCAN
Hospital Inpatient Transition

Frequently Asked Questions (FAQ) are on Division of Medicaid's (DOM) website

Please submit all questions to:
inpatient@medicaid.ms.gov

Responses will be added to the FAQ on our website at www.medicaid.ms.gov