

Office of the Governor | Mississippi Division of Medicaid

# **MississippiCAN**

## **Hospital Inpatient Behavioral Health Transition**

November 17, 2015



## Moderator

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# MississippiCAN

## Hospital Behavioral Health 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](mailto:inpatient@medicaid.ms.gov)

*Responses will be posted to the FAQ on our website at [medicaid.ms.gov](http://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



[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 15<sup>th</sup>: \$ 50,913.76

Annual Assessment: \$ 356,396.32

### DSH Assessment

1/3 of Assessment Due on December 15<sup>th</sup>: \$ 65,930.76

Annual DSH Assessment: \$197,792.27

### MHAP Assessment

1/7 of Assessment Due on December 15<sup>th</sup>: \$ 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](mailto: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](http://medicaid.ms.gov)

# Inpatient Behavioral Health Settings

## What are the inpatient settings for behavioral health?

### **Psychiatric Units at General Hospitals**

- All beneficiaries (including those in DHS custody)
- Prior authorization required

### **Acute Freestanding Psychiatric Facilities**

- Beneficiaries (including those in DHS custody) up to age twenty-one (21)
- Prior authorization required

# Inpatient Behavioral Health 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 Behavioral Health 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 Behavioral Health 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 30<sup>th</sup> 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 Behavioral Health 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.

# 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.

# Inpatient Behavioral Health

## Where can I find resources for inpatient behavioral health?

### Administrative Code and State Plan Amendment (SPA) for Behavioral Health

- MS Administrative Code Title 23, Part 202, Rule 1.4.9 Inpatient Psychiatric Services
- MS Administrative Code Title 23, Part 202, Rule 1.5.A Non-Covered Services
- State Plan Amendment Attachment 3.1-A, Exhibit 16, Inpatient Psychiatric Services



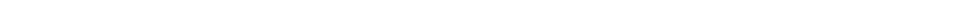
MISSISSIPPI DIVISION OF  
**MEDICAID**



# INPATIENT

***Provider Education***

*Behavioral Health*







## *Welcome to Magnolia Health/Cenpatico!*

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.*

# Cenpatico (CBH)



- Cenpatico is the Behavioral Health Network that services the members of Magnolia Health. Cenpatico is a division of Centene Corporation. We have managed Medicaid and other public sector benefits since 1994, and operate in multiple states with an active local presence. Our members receive care from **local teams** that truly understand the specific needs of their communities. We continually introduce innovative clinical initiatives and network strategies in all markets, designed to create quality service delivery systems.
- **Cenpatico's expertise lies in managing benefits for vulnerable populations.**



- To learn more, visit our website at [www.cenpatico.com](http://www.cenpatico.com)

# Clinical Protocols



Cenpatco 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.

Cenpatco has adopted DOM approved utilization review criteria developed by McKesson InterQual® products to determine medical necessity for behavioral healthcare services. InterQual appropriateness criteria are developed by specialists representing a national panel from community-based and academic practice. InterQual criteria cover medical, behavioral health 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. Cenpatco'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.

# Agenda Topics



- Provider Enrollment
- Credentialing Requirements
- MississippiCAN Eligibility
- Cultural Awareness
- Inpatient Regulatory Requirements
- Care Coordination
  - Inpatient Prior Authorization
  - Clinical Documentation
  - Initial Review- Examples
  - Precipitating Events- Examples
  - Initial Review- Additional Questions
  - Concurrent Review
  - Inpatient Summary
  - Review Criteria/Clinical Appeals
  - Emergent/Weekend/Holiday Admissions
  - Observation
- Claims Submission
- Contact Information
- Accessing Medical Care Management
- Quick Reference

# 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. Behavioral Health Providers must also be credentialed by Cenpatico 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 Cenpatico's website at [www.cenpatico.com](http://www.cenpatico.com) click on Mississippi then Join Our Network and follow the prompts.
- Cenpatico'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 Cenpatico's claims payment system as a participating provider within **thirty (30) days** of approval of their credentialing application.

# 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/](http://www.ms-medicaid.com/msenvision/)

Log on to the secure provider portal at [www.magnoliahealthplan.com](http://www.magnoliahealthplan.com)

Call our automated member eligibility interactive voice response (IVR) system at 1-866-912-6285

Call 866-912-6285 to reach a Cenpatico team member

***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/>

## Cenpatico- What We Do For Members



Our staff is available 24 hours a day, 365 days a year by calling the following number:

**(866) 912-6285**

### Customer Service Center in Mississippi

- Staff available 8 a.m. - 5 p.m. CST
- Eligibility Verification
- Referrals
- Integrated Case Management between providers of varying levels of care
- Care Coordination to assure Members have adequate access to providers

### NurseWise

- Nurse triage & other services available 24/7/365 (may issue authorizations after hours with follow up from local care coordinator the next business day)

# Care Coordination



We recognize that multiple co-morbidities will be common among our membership. The goal of our program is to collaborate with the member and all treating providers to achieve the highest possible levels of wellness, functioning and quality of life.

## **Cenpatico's care coordination model uses an integrated team of:**

- Licensed mental health professionals
- Registered nurses
- Social workers
- Non-clinical staff

## **Cenpatico's care coordination model is designed to:**

- Educate members on the importance of treatment compliance;
- Help members obtain needed services;
- Assist in coordination of covered services, community services, or other non-covered venues;
- Identify members with complex or chronic behavioral health conditions that require coordination of services and periodic monitoring in order to achieve desired outcomes;
- Work collaboratively with the facility, physician, member, family / significant other and support services to implement and individualize a plan of care.

# PRIOR AUTHORIZATION



The authorization process ensures that members are receiving the proper treatment and intensity of services on the inpatient unit while addressing their ongoing outpatient needs.

**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.



# Prior Authorization (cont.)



- For hospital Behavioral Health (BH) inpatient services, if authorization for level of care cannot be determined at first level review by the UM reviewer, 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.
- Cenpatco 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 Cenpatco 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 Cenpatco, Magnolia Health Plan and the Division of Medicaid determine that the extension is in the member's best interest.

# Inpatient Authorization Process



Provider must contact CBH **within 24 hours** of an emergent inpatient admission. The Provider should contact Cenpatco via telephone (preferred), fax, mail, secure email or through our website with the appropriate clinical information to request an authorization. After-hours calls will be taken by Nursewise and authorized next business day when a live review is done.

All inpatient reviews are conducted via live telephonic review. InterQual medical necessity criteria are applied to all mental health cases, and ASAM criteria are applied to all chemical dependency cases.

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

# CLINICAL DOCUMENTATION- INITIAL REVIEW



- Detailed clinical information is essential for determining medical necessity. The **Initial Review** documentation must include:
- Facility
- Name and contact number of Utilization Reviewer
- Date of admission
- Legal status – voluntary vs. court commit admission
- Member's guardian, if any

# Initial Review-continued



- **Precipitating Event**

Clear details are needed regarding symptoms and behaviors of the member leading to admission.

For example:

- Triggers to the episode, if known
- Actual physical injury of self or others
- Medical treatment needed
- Termination of the behavior – did they stop on their own or did someone else intervene?
- Objects or actions used
- Time frames – how long ago did the precipitating event occur, and how is the member presenting now?

# Precipitating Events-examples



- **Suicide Attempt**

**Example 1:** A member presents status post suicide attempt by overdose on medications.

Important questions to be answered:

What kind of pills and the approximate number of pills ingested?

What events led up to the attempt?

What happened afterward - did someone find the member, did member call for help?

What treatment was administered in the ER – charcoal, lavage?

Does the member regret the overdose?

**Example 2:** A member presents status post suicide attempt by hanging.

Important questions to be answered:

Did the member actually hang himself?

How far did he/she get in the process?

What materials did he/she use?

What interrupted the attempt?

Were there any injuries from the attempt?

## Precipitating Event – Aggression



**Example :** A child presents for admission due to aggressive behavior.

- What are the specific aggressive behaviors?
- Who is the member targeting?
- Does the behavior occur in more than one setting?
- When did this behavior start?
- Has there been a recent change in intensity and frequency of the behavior? When did this occur?
- Are there certain circumstances that trigger the aggression?
- Is the behavior so severe that it can't be managed on an outpatient basis?

# Precipitating Event – Psychosis



**Example :** An adult presents for admission due to psychotic behavior.

Important questions to be answered:

- Are there auditory or visual hallucinations?
- Are they command in nature?
- What is the content?
- When did these symptoms begin?
- Are they constant or fleeting?
- Are these symptoms stressful for the member?
- Are there delusions present?
- Are these delusions fixed? When did they start?
- Is there imminent danger to the member or others due to the psychosis?



# Additional Questions for Initial Review



- Treatment history
- Medications prior to admission (both behavioral and medical), and compliance
- Substance use history
  - Past treatment, use pattern, drug screen results and alcohol level results on admission
- Social Factors impacting admission including:
  - Family history of substance abuse or behavioral health concerns, trauma or loss history
- Medical concerns of the member
  - Focus on integrated care

# Additional Questions for Initial Review-cont.



- Height and weight
- Legal issues
- Education history
- Employment information
- Trauma History
- Cultural considerations: Ethnicity, Language preference, Sexual preference
- Current living situation
  - Foster Care placement status and any issues
- Contact information for the member
  - Or DHS social worker for children in foster care

# Additional Questions for Initial Review-cont.



- Mental Status Exam (MSE) to focus on member's current state of mind at time of admission:
  - Appearance
  - Attitude
  - Behavior
  - Mood and affect
  - Speech
  - Thought process and content
  - Perception
  - Cognition
  - Insight
  - Judgment

# Treatment Plan Considerations



- What is the focus of treatment for this member?
- What are the primary goals for this admission?
- Are the goals member-set and member-focused? Is Motivational Interviewing being utilized?
- Are the goals based on a model of recovery?
- Are the goals based on a model of integrated care?
- Are the member's strengths being identified, and how are these strengths reflected in their treatment plan?

# S.M.A.R.T. Goal Development



- As you are creating member centered goals, ask yourself if the goals are...
- **S**pecific: What exactly are you expecting the outcome to be?
- **M**easureable: How are you going to be able to evaluate if the outcome was achieved?
- **A**ttainable: Is the member able to reach the desired outcome at some point in time?
- **R**ealistic: Can the member achieve the outcome in the time allotted?
- **T**ime Limited: Is there a clear time frame set for completing the goal?

# Discharge Planning



- Has the discharge planner been identified?
- Where will the member be living at discharge?
- Who will they see for outpatient follow up? Do they already have an appointment scheduled?
- Are there problem areas that our Care Coordination or Case Management staff may be able to assist with?
- Are there any cultural or religious factors that play a role in this member's discharge plan?

**Cenpatico requires a follow-up appointment be scheduled and the member attend within 7 calendar days of discharge from the hospital.**

# Concurrent Review



- Cenpatco's clinical team 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 Initial Review 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



# Concurrent Reviews - Medications



## **Documentation:**

- Documentation of start date, change date, discontinuation date
- Documented monitoring of medication levels
- Detailed documentation of PRN and emergency meds

## **Additional questions:**

- What is the MDs plan for the upcoming days?
- If MD is not making med changes, why?
- If MD is only giving PRNS, why?
- If the member is on a medication that requires a blood test to determine efficacy, when is that going to be drawn?

## **Especially for Fax Reviews:**

- Med orders need to be VERY clear
- Can the reviewing UM easily tell what the medication regimen is and any updates that have been made to the medication regime?

# Concurrent Reviews – Notes



- Are all modalities (MD, RN, group therapy, individual therapy, family therapy) being provided and documented?
- Does the MD note clearly document symptomology?
- Is there specific documentation regarding:
  - Suicidal/Homicidal ideation and plan or absence of plan?
  - Hallucinations – specifics regarding type and content?
  - Delusions – details about content?
  - Are symptoms fixed or expected to improve?
- Why does the member need to continue in acute care?

# Concurrent Reviews – Notes-cont.



- What places the member at risk if discharged now?
- Did the MD document ongoing plan for treatment?
  - If the member is not improving, what is the detailed plan to facilitate improvement?
- Is there a discrepancy between MD and RN notes?
  - If the MD and RN notes on the same day are incongruent, this should be explained.

# Inpatient Summary



## Opportunities for Gathering Information

- Initial clinical review
- RN / MD notes
- Therapy / staff notes

## Documentation

- Detailed
- Give examples
- Be specific
- Current

## Discharge Planning

- Begins upon admission
- Coordinate with case management
- 7 day follow up appointment addressed

## Treatment Planning

- Member driven
- Recovery based
- S.M.A.R.T. goal oriented
- Strengths and barriers identified and addressed

# Review Criteria



- Cenpatico has adopted utilization review criteria developed by McKesson InterQual® products to determine DOM approved medical necessity for behavioral health services.
- Cenpatico's Medical Director reviews all potential medical necessity denials and will make a decision in accordance with currently accepted medical or behavioral health 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 Cenpatico at 1-866-912-6285.

# CLINICAL APPEALS



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

**Cenpatico**

**Attn: Appeals Coordinator**

12515-8 Research Blvd. Suite 400

Austin, TX 78759

Fax: 1-866-694-3649

## 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 Cenpatco by the close of business on the **next business day** following admission. **(Failure to notify may result in denial of payment.)**
- Non-emergent hospital Behavioral Health 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 Cenpatico's Clinical Team of an observation stay by the next business day after discharge.
- A medical necessity determination will be made within twenty-four (24) hours of receiving all required information.

# CLAIMS SUBMISSIONS



Claims Customer Service: (866) 324-3632

## Ways to submit Claims:

**Online**                      [www.cenpatico.com](http://www.cenpatico.com) (Will need logon information)

**Emdeon**                      Payor ID 68068

**Paper Claims**              Cenpatico  
PO Box 7600  
Farmington MO 63640-3809

Claims must be submitted within **180** days of the date of service.

Appeals must be submitted within **90** days of the denial.

**Appeals:** mail      Cenpatico Appeals  
PO Box 7600  
Farmington MO 63640-3809

# IMPORTANT Contact information and phone numbers



- **\*\*Please go to [WWW.CENPATICO.COM](http://WWW.CENPATICO.COM) for Covered Services and Authorization Grid\*\***
- **Provider Relations -1<sup>ST</sup> Point of Contact**  
(866) 912-6285
- **Authorizations** (Inpatient and Outpatient)  
(866) 912-6285
- **Care Management/Quality Improvement**  
(866) 912-6285
- **Claims Customer Service**  
(866) 324-3632

# Local Network Contacts



- **Angela Stewart**
  - Network Manager [anstewart@cenpatico.com](mailto:anstewart@cenpatico.com)  
601-863-0738
- **Nakisha Montgomery**
  - Provider Relations Specialist (Central and Southern MS)  
[nmontgomery@cenpatico.com](mailto:nmontgomery@cenpatico.com)  
601-863-0745
- **Diandra Lee**
  - Provider Relations Specialist (North MS and Hattiesburg)  
[dilee@cenpatico.com](mailto:dilee@cenpatico.com)  
601-863-2507

# Accessing Care Management (Medical)



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](http://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.

# QUICK REFERENCE



- ***Please visit the Practice Improvement Resource Center (PIRC) at [www.magnoliahealthplan.com](http://www.magnoliahealthplan.com) Clinical Practice and Preventative Guidelines and other helpful information.***
- This powerpoint will be posted there for quick reference.



- Thank you for assisting Cenpatco to coordinate holistic mental health care for our Magnolia Health Plan members.

# Thank you!







# **UnitedHealthcare Community Plan of Mississippi**

*Behavioral Health*

*MSCAN Hospital Inpatient*

*Provider Education*

*Effective 12.01.2015*

## 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

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. Coordination of Care Responsibilities
11. Complaints, Grievances & Appeals
12. Appeals & Filing Timeframe
13. Claims Filing & Reconsideration
14. Inpatient Facility Fraud Waste and Abuse
15. Contact Information
16. Questions



## Provider Enrollment

- Optum has e-mailed contracts to all of our in network hospital providers.
- Contracts are based on Medicaid APR/DRG 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 Optum at your earliest convenience.
- Optum's point of contact for facility contracting is Connie McClanan.
- Credentialing process may take up to 90 days.
- 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**

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 UHOnline.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

### Optum Behavioral MS Provider Relations Information:

Michael Strazi, LPC—612-632-5727 (phone), or 877-331-5852 (fax)

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

Recruiting for an additional provider advocate.

Optum Behavioral National Provider Relations Team:

877-614-0484 (phone) or 855-228-3939 (fax)

[ms\\_providerrelations\\_medicaid@uhc.com](mailto: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.

## Verify Eligibility

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



# Hospital Inpatient Regulatory Requirements



**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
- Non-urgent/emergent holiday and weekend admissions

**For a complete list of services requiring prior authorization, go to [UHCCommunityPlan.com](http://UHCCommunityPlan.com)**

**Call 866-604-3267**

- **Monday-Friday 8 a.m. – 5 p.m. CST**
- **24 hours a day for emergencies**

### **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

- An Assessment and Triage Care Advocate will conduct a Medical Necessity Review using the Clinical Review Guidelines.
- When conducting Medical Necessity Review, the Care Advocate reviews inpatient admissions to determine the appropriate Level of Care using UBH/Optum Health Level of Care Guidelines.
- When the Care Advocate cannot approve a request, the case is tasked to a Behavioral Health Medical Director to ensure a determination is made per standard workflows.
- When a decision is made Optum BH will provide notice to the provider.
- All denials are rendered by a MS Licensed Psychiatrist.
- Claims will be denied if notification is not received.

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

## 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 within one (1) business day of determination.
- UHC is required to make standard authorization decisions and provide notice within two (2) business days upon receipt of all required 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 (24) hours after receipt of the expedited authorization request.

## Initial Clinical Review

- Clinical Care Advocates (licensed behavioral clinicians or registered nurses) conduct intake and initial screening to prepare for initial Clinical Review.
- Care Advocates establish appropriateness of requested services to determine benefit coverage on cases that require evaluation or interpretation.
- Care Advocates are able to approve all cases that meet medical necessity guidelines.
- Cases that are not approved at Care Advocate level are referred to a Medical Director for medical necessity review and clinical determination. Adverse Benefit Determinations are made by a MS Licensed Physician.
- 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 Care Advocate will keep the case open for concurrent review until no further services are required at that level of care.

# Person Centered Care Management Model

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/Behavioral Health Care Advocates**
  - Discharge planning begins on admission
  - Members will be referred to a MS based Behavioral Health Care Advocate for coordination and follow-up after discharge from both inpatient hospital admissions and Psychiatric Residential Treatment Facilities (PRTF)
  - Behavioral Health Care Advocates work with the hospital/PRTF and/or member and family/supports to establish agreed upon discharge plan
  - Behavioral Health Advocates will work with the member and/or family/supports after discharge from the hospital/PRTF for follow-up needs and person centered care planning



## Behavioral Health Coordination of Care Responsibilities



- In the event a member is admitted for an acute inpatient behavioral health stay or to a Psychiatric Residential Treatment Facility (PRTF), care coordination and discharge planning is the responsibility of the health plan
- The member will be assigned to a Behavioral Health Care Advocate (BHCA) (if not already assigned prior to admission) who will be responsible for assisting with the inpatient/PRTF discharge planning
- The Behavioral Health Care Advocate (BHCA) will enroll the member in the high risk care management program (if not already) and will follow protocols for telephonic and face to face (if applicable) outreach following the admission and on an ongoing basis

# Behavioral Health Complaints & Grievances: Key Definitions



- **Complaint:** An expression of dissatisfaction received orally or in writing by a member or provider that is of a less serious or formal nature that is resolved within one (1) business day of receipt. A complaint includes, but is not limited to, inquiries, matters, misunderstandings, or misinformation that can be promptly resolved by clearing up the misunderstanding or providing accurate information.
  - A complaint is not the same as an appeal or grievance. In situations in which a member or provider requests to file a complaint about the outcome of a previously issued non-coverage determination or action, the issue is to be processed as an appeal.
- **Grievance:** Under the terms of the MississippiCAN contract, an expression of dissatisfaction received orally or in writing, not resolved within one (1) business day, about any matter or aspect of UBH or its operation by a member or provider other than a UBH action, is considered to be a grievance.
- **Appeal:** A request for review by the Contractor of a Contractor Action related to a Member or Provider. In the case of a Member, the Contractor Action may include determinations on the health care services a Member believes he or she is entitled to receive, including delay in providing, arranging for, or approving the health care services (such that a delay would adversely affect the health of the Member). In the case of a Provider, the Contractor Action may include, but is not limited to, delay or non-payment for covered services
- **Quality of Care (QOC) Concerns:** Grievances related to the quality of clinical treatment services provided by a practitioner or facility.

# Behavioral Health Complaints & Grievances: Timeframes



- Under the terms of the MississippiCAN contract, a member, member representative, or provider may file a grievance either orally or in writing with UBH within 30 calendar days of the date of the event causing the dissatisfaction.
- **Non-QOC grievances:** In accordance with the terms of the MississippiCAN contract, within 5 calendar days of receipt of the non-QOC grievance, UBH provides the grievant (member, member representative or provider) with oral or written notice that the grievance has been received and the expected date of its resolution. This is considered the acknowledgement of the non-QOC grievance.
- **QOC grievances:** UBH provides the grievant (member, member representative or provider) with written notice that the grievance has been received within 5 calendar days.
  - The acknowledgement letter is to advise of the grievance investigation and that the subsequent outcome of such investigation will be subject to peer review protection.
  - The acknowledgement letter informs the grievant that action will be taken as appropriate to address the grievance.
- **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.
- Under the terms of the MississippiCAN contract, the investigation and final resolution process for all grievances, including both QOC and non-QOC grievances, are to be completed within 30 calendar days of receipt of the grievance by UBH or as expeditiously as the member's health condition requires.



## Appeals & Filing Timeframe

- Timeframe to file an appeal is thirty (30) calendar days from the receipt of notice of action.
- UnitedHealthcare (UHC) will send an acknowledgment letter within ten (10) calendar days of receipt.
- Once determination has been made UHC will send a 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

### Electronic vs. Paper

- Electronic claims can help reduce errors and shorten payment cycles.
- Learn more about electronic claims submission at [UnitedHealthcareOnline.com](http://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:  
United Healthcare  
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 (6) months from the date of service.
- Mississippi CHIP: Effective Jan. 1, 2015, claims must be filed within six (6) months from the date of service.

## Claims Filing

### **Claim Processing Time:**

Optum Behavioral Health generally 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

### **Paper claim specific rules include:**

- Corrected Claims may be submitted electronically; however the words “corrected claim” must be in the notes field.
- We follow CMS National Uniform Claim Committee (NUCC) Manual guidelines for placement of data for both CMS 1500 and UB04.

## Claims Reconsideration

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

**Reconsideration requests can be submitted in a few ways:**

- Electronically via the *Optum Cloud* Dashboard (aka Optum Link)
- Electronically (without attachments) via [UnitedHealthcareOnline.com](https://UnitedHealthcareOnline.com).
- 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](https://UnitedHealthcareonline.com)
  - Mailing address:
  - UnitedHealthcare Community Plan
  - PO Box 5032
  - Kingston, NY 12402

## Inpatient Facility Fraud Waste and Abuse

**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

### Prior Authorization:

- Call 866-604-3267
  - Monday-Friday 8 a.m. – 5 p.m. CST
  - 24 hours a day for emergencies
- Authorizations may be submitted online at [uhconline.com](http://uhconline.com).

### Written appeals can be filed to:

United Behavioral Health - Appeals and Grievances

P.O. Box 30512

Salt Lake City, UT 84130-0512

Fax: 1-855-312-1470

Phone: 1-866-556-8166

### Reimbursement Policies:

- All reimbursement policies are readily available for your reference at: [uhccommunityplan.com](http://uhccommunityplan.com).

### Claim Reconsideration Request:

- Please visit [unitedhealthcareonline.com](http://unitedhealthcareonline.com) to learn more about and submit a claims reconsideration request.

**Thank you!**

