Medicaid & MississippiCAN

Provider Desk Reference

2017

MISSISSIPPI DIVISION OF MEDICAID

Services	Medicaid Fee-for-Service	Magnolia Health	Unitedhealthcare Community Plan
Provider Enrollment			
Provider Credentialing/ Enrollment	**Provider Credentialing/Enrollment for MS Medicaid Providers is conducted by Conduent, and providers must submit applications for enrollment.** All providers must: • Complete provider agreements and/or provider enrollment application packages. • Be licensed and/or certified by the appropriate federal and/or state authority. • Agree to furnish required documentation of the provider's business transactions per 42 CFR §455.105(b) within thirty-five (35) days of the date on the request. Agree to abide by the requirements of 42 CFR, PARTS 405, 424, 438, 447, 455, 457, 498, and 1007 of the Affordable Care Act (ACA) concerning the following: a) Provider Screening Procedures (42 CFR §424.518) b) Provider Termination (42 CFR §455.416). c) Payment Suspensions (42 CFR §455.23). **MS Medicaid Administrative Code** https://medicaid.ms.gov/wp-content/uploads/2014/01/Admin-Code-Part-200.pdf **Medicaid Provider Enrollment Package** https://www.msmedicaid.com/msenvision/downloadenrollPackage.do	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 delegated authority. To become credentialed, Providers must submit: • Completed Credentialing Application • Updated and Attested CAQH • State Medical License • Collaborative Agreement for mid-level practitioners • DEA Registration • Professional Liability Policy • Board Certification Certificate (if applicable) • Certificate or Letter certifying formal post-graduate training • W-9 Form • Ownership and Disclosure Form • Hospital Privileges • Curriculum Vitae or Resume' • CLIA Certificate (if applicable) • Any gaps in time six (6) months or greater from professional school/training to present must be documented. https://www.magnoliahealthplan.com/providers/become-a-provider.html	**Call us!** First contact our Network team at **1-877-842-3210** and have your TIN/SSN ready. Option: "Request for Participation" **Credentialing** Profile must be created/maintained by the provider at: www.CAQH.org >CAQH ProView (888-599-1771) Provider must meet all **criteria for MS Medicaid** and have a valid Medicaid ID (see Medicaid FFS requirements) (not required for CHIP) Federally-required **"Disclosure of Ownership"** form found at: www.uhccommunityplan.com >Provider Forms Contract is sent once credentialing and disclosures are submitted. **Sign and return contract** quickly because UHC does not routinely retro-actively assign an effective date. UHC will return executed contract "Credentialed" is NOT the same as "contracted." Credentialing is performed before contract is executed. Contract status can be checked: 855-773-3156 HPDemo@uhc.com

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Provider Enrollment			
Re-Credentialing/ Revalidation	**The provider agrees to review, complete and submit a completed re-validation document as required by the policies of Division of Medicaid. All providers must undergo a revalidation screening process at least once every five years in accordance with 42 CFR §455.414.** Revalidation for MS Medicaid Providers began April 19, 2017. **MS Medicaid Provider Revalidation** https://medicaid.ms.gov/medicaid-providers-required-to-revalidate-credentials/ **MS Medicaid Provider Revalidation List** https://www.msmedicaid.com/msenvision/revalidationDueList.do	In accordance to Federal, State and Contract requirements and accreditation standards: • Magnolia formally recredentials practitioners every thirty six (36) months. • The recredentialing due date is calculated from the date of the initial credentialing decision. • Recredentialing process a minimum of 3 formal notices to the provider. • Notification timeline; ▪ 6 months out – Recredentialing flyer sent to provider ▪ 4 months out – Notice of missing documents sent via certified mail ▪ 2 months out – Close mail file for all practitioners non compliant with recredentialing. Intent to Terminate notice mailed to provider. ▪ Provider will be terminated on the last day of the month the recredentialing is due. • Complete credentialing and recredentialing information can be found our website: www.magnoliahealthplan.com **P. 59 of the provider manual** https://www.magnoliahealthplan.com/content/dam/centene/Magnolia/medicaid/pdfs/Provider-Manual-PDF3.pdf. **E-mail -** magnoliacredentialing@centene.com.	Credentialing cycle is **every three-years** (NCQA Standard) and providers should keep their CAQH profile current. UHC begins contacting providers via email (that's on file) and USPS 6 months before credentialing expires. www.CAQH.org >CAQH ProView (888-599-1771) **Disclosures Forms** are collected every 3 years from contract date or upon a notice of material change if within the 3 year cycle. www.uhccommunityplan.com >Provider Forms Medicaid Status must remain active (see Medicaid FFS) Contract is valid through the agreed upon date (see signed contract) 866-574-6088

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Provider Enrollment			
NPI and Medicaid Numbers	**DOM Administrative Code** https://medicaid.ms.gov/providers/administrative-code/ The National Provider Identifier (NPI) is a unique identification number for covered health care providers. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number). Healthcare providers must obtain their NPI through the National Plan and Provider Enumeration System (NPPES) **MS Medicaid Provider Billing Manual** https://medicaid.ms.gov/wp-content/uploads/2016/07/1.7-NPI-Provider-Enrollment.pdf	• Every practitioner enrolled with Magnolia Health Plan must have an NPI number. In addition Billing or Group NPI numbers are used to link practitioners with their appropriate contracts and service locations. • Every practitioner must have an active Medicaid ID# and NPI# matched on the Medicaid State File before contracting/credentialing can begin with Magnolia. Provider Manual https://www.magnoliahealthplan.com/content/dam/centene/Magnolia/medicaid/pdfs/Provider-Manual-PDF3.pdf	All state and federal identifiers and licenses are required to be current and without restrictions (NPI, DEA, Medicaid ID, etc.). Providers are assigned unique UHC Provider IDs which are usually the same for CAN, CHIP, Commercial, Medicare Supplement, DSNP, etc.) Sanctioned and restricted-practice providers are not permitted to participate with UHC unless provider successfully appeals

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Prior Authorization			
Prior Authorizations	Prior Authorization and Utilization Management is the review of appropriateness and medical necessity of care provided to patients. The UM/QIO vendor for Medicaid FFS is eQHealth Solutions, and providers must submit clinical documentation for services requested to obtain UM approval. **DOM Administrative Code – Utilization Management** **https://medicaid.ms.gov/providers/administrative-code/** **MS Medicaid Provider Billing Manual** https://www.medicaid.ms.gov/wp-content/uploads/2014/11/1.4-eQ-Health-Solutions.pdf **MS Medicaid – Vendor - Utilization Management/Quality Improvement Organization (UM/QIO)** http://ms.eqhs.org/Home.aspx Phone: 601-352-6353 Fax: 601-352-6358 education@eqhs.org Helpline (Toll Free): 866-740-2221	Prior authorization is a request for medical necessity determination of services on the Prior Authorization List before the service is rendered. Prior authorizations should be initiated at least five (5) calendar days prior to the planned service date. Emergent and urgent care services do not require prior authorization. All out of network providers must receive prior authorization for all services except basic lab chemistries and basic radiology. The Prior Authorization List and Prior Authorization Forms are located on our website at www.magnoliahealthplan.com. Authorizations may be submitted by fax, mail, phone, secure email or secure provider web-portal located on our website at www.magnoliahealthplan.com. **Contact Information:** Magnolia Health Plan Attention: Utilization Management 111 East Capitol Street, Suite 500 Jackson, MS 39201 1-866-912-6285 ext. 66771 MagnoliaAuths@centene.com Outpatient Fax: 1-877-650-6943 Inpatient Fax: 1-877-291-8059	**Prior Authorization** (PA) = Clinical review *prior to* elective or non-emergent services. Basic elements are same as Authorization. Ph: 866-604-3267 Fax: 888-310-6858 http://www.uhccommunityplan.com/health-professionals/ms.html This link contains lists, instructions, etc. **All Non-par providers must seek PA before rendering services to members** **Dental PA:** www.uhcproviders.com electronic submission via secure portal 1-800-508-4862 **Notification** = Process by which a hospital notifies UHC of an urgent/emergent hospital admissions and provides clinical information to support inpatient days beyond the day of admission. A notification is NOT a PA. See "Inpatient Hospital Services" section for details Always verify eligibility because PAs granted from other payors may not be recognized by UHC

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Prior Authorization			
Prior Authorization Reconsiderations, and Peer-to-Peer, and Appeals	Providers may request reconsideration of prior authorization denials. The process is stated in the manual below for Medicaid FFS by eQHealth. **MS Medicaid – Vendor - UM/QIO Reconsiderations** http://ms.eqhs.org/Portals/10/Manuals/Reconsideration%20Manual%202013.pdf	Providers are notified of the opportunity to discuss denial reasons with the Medical Director reviewer at the time of notification of adverse determination. Members, or healthcare professionals with member consent, may request an appeal related to a medical necessity decision made during the authorization process orally or in writing within 30 days of receipt of the determination. **Ph: 1-866-912-6285 ext. 66408** https://www.magnoliahealthplan.com/content/dam/centene/Magnolia/medicaid/pdfs/Provider-Manual-PDF3.pdf	Reconsideration requested within 90 days of determination http://www.uhccommunityplan.com/content/dam/communityplan/healthcareprofessionals/providerinformation/Reconsideration%20Request%20Form%202012.pdf Peer-to-Peer can be requested within 3 days of discharge/determination 866-604-3267 Appeal within 30 days of determination http://www.uhccommunityplan.com/content/dam/communityplan/healthcareprofessionals/providerinformation/MS-Provider-Information/MS_Appeal_Form.pdf
Inpatient Hospital Services	Inpatient Hospital services require prior authorization for services unless urgent/emergent care https://medicaid.ms.gov/inpatient-transition-information/ **Hospital Services, Part 202 Chapter 1 Inpatient Hospital** https://medicaid.ms.gov/wp-content/uploads/2015/09/AdministrativeCode.pdf **MS Medicaid – Vendor - Utilization Management/Quality Improvement Organization (UM/QIO)** http://ms.eqhs.org/Home.aspx	All inpatient hospital services require authorization within two (2) business days of admission. Authorizations for pre-scheduled/elective inpatient services should be submitted at least 14 calendar days but not later than five (5) calendar days in advance. All hospital inpatient admissions require notification within one (1) business day of admission. Notification and authorization can be done simultaneously if all clinical information to support medical necessity is submitted with the notification. Even though prior authorization is not required for emergent/urgent services, if a hospital admission results, notification and authorization should be submitted as noted above. **Ph: 1-866-912-6285 ext. 66408** https://www.magnoliahealthplan.com/content/dam/centene/Magnolia/medicaid/pdfs/Magnlia-Health-Inpatient-Provider-Education-PDF1.pdf	All inpatient hospital admissions require notification within one (1) business day Submit online via Link or UnitedHealthcareOnline.com > Notifications/Prior Authorizations Ph: 866-604-3267 Fax: 888-310-6858 Concurrent reviews are performed for extended stays that exceed authorized and/or generally accepted LOS. The provider initiates concurrent review the same as notification https://www.unitedhealthcareonline.com/b2c/CmaAction.do?viewKey=PreLoginMain&forwardToken=PreLoginMain

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Prior Authorization			
Retrospective Reviews	Retrospective review is a review that is conducted after services are provided to a Member. **MS Medicaid – Vendor - Utilization Management/Quality Improvement Organization (UM/QIO)** http://ms.eqhs.org/Home.aspx	Magnolia does not routinely retrospectively authorize services that have already been rendered. Requests for retrospective reviews will only be considered in extenuating circumstances (i.e. retroactive eligibility of newborns, out of state non-MS Medicaid provider). **Ph: 1-866-912-6285 ext. 66408** https://www.magnoliahealthplan.com/content/dam/centene/Magnolia/medicaid/pdfs/Provider-Manual-PDF3.pdf	Retrospective Review is a review for medical necessity after services are initiated or a member retroactively switches to UHC after services are initiated/rendered Submit online via Link or UnitedHealthcareOnline.com > Notifications/Prior Authorizations Ph: 866-604-3267 Fax: 888-310-6858

Services	Medicaid Fee-for-Service	Magnolia Health	Unitedhealthcare Community Plan
		Claims	
Claims Filing	**MS Medicaid Fiscal Agent - Conduent** https://www.ms-medicaid.com/msenvision/index.do **MS Medicaid Provider Billing Manual** https://medicaid.ms.gov/providers/billing-manual/ **Conduent Contact telephone numbers** https://www.ms-medicaid.com/Contact_Us.pdf Provider and Beneficiary Services (800) 884-3222 PO Box 23078 Jackson, MS 39225	**Magnolia Health Web-Portal** www.magnoliahealthplan.com https://provider.magnoliahealthplan.com/careconnect/registration?execution=e2s1 **Magnolia Health Provider Billing Manual** https://www.magnoliahealthplan.com/providers.html **Paper Claims** **Magnolia Health** **Attn: CLAIMS DEPARTMENT** **P.O. Box 3090 (MSCAN)** **P.O. Box 5040 (CHIP)** **Farmington, MO 63640**	A **Clean Claim** = No defect or impropriety, including any lack of substantiating documentation, or particular circumstance requiring special treatment that prevents timely payment from being made. Includes resubmitted claims with previously identified deficiencies corrected. Clean claim are further defined within state statute under §83-9-5. Use standard CMS-1500, CMS-1450/UB04 or respective electronic format Medicaid National Correct Coding Initiative (NCCI) edits are applied Electronic claims submission at: UnitedHealthcareOnline.com > Tools & Resources > EDI Education for Electronic Transactions or call 800-842-1109 Paper claims mailed to: UnitedHealthcare P.O. Box 5032 Kingston, NY 12402-5032
Timely Filing of Claims	Claims for covered services must be filed within 12 months from the through/ending date of service. Providers are encouraged to submit their claims as soon as possible after the dates of service. Claims are processed and paid in the order of submission and not by the date of service. **MS Medicaid Provider Billing Manual** https://medicaid.ms.gov/providers/billing-manual/	ALL claims must be filed within six (6) months of date of service. ALL requests for correction, reconsideration, retroactive eligibility, or adjustment must be received within ninety (90) days from the date of notification of denial. **Magnolia Health Provider Billing Manual** https://www.magnoliahealthplan.com/providers.html	To be considered for payment, a claim must be submitted within 180 days of the date of service. UHC processes claims daily with most being processed within 10 days of receipt

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	Claims		
Claims Reconsideration	**Claims Reconsideration** The claims reconsideration process is designed to address claim inquiries for: • Service not covered by Medicaid • Authorization denied or service not authorized within specified Medicaid guidelines • Service denied as not being medically necessary • Repayment of identified overpayments **For claim reconsideration contact:** **Conduent** P. O. Box 23076 Jackson, MS 39225 1-800-884-3222 https://ms-medicaid.com https://www.medicaid.ms.gov/wp-content/uploads/2014/11/Provider-Billing-Handbook.pdf Contact DOM/Conduent Provider Field Representatives for claims assistance. https://medicaid.ms.gov/wp-content/uploads/2017/03/March2017-Provider-Bulletin.pdf	**Reconsideration** The claims reconsideration process is designed to address claim inquiries for: • Service denied by Vercend (HCI/CXT) • Service denied as not covered by Medicaid • Authorization denied or service not authorized within specified Medicaid guidelines Written communication (i.e. letter) outlining disagreement of claim determination Indicate "reconsideration of (original claim number)" Submit reconsideration to: **Magnolia Health** **Attn: Reconsideration** **PO BOX 3090 (MSCAN)** **PO BOX 5040 (CHIP)** **Farmington, MO 63640** https://www.magnoliahealthplan.com/providers.html	Reconsideration requested within 90 days of determination Electronic claim reconsideration request using Link (preferred method) or www.UnitedHealthcareonline.com > Claims & Payments > Claim Reconsideration OR Fax/Mail form found at: http://www.uhccommunityplan.com/content/dam/communityplan/healthcareprofessionals/providerinformation/Reconsideration%20Request%20Form%202012.pdf

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	Claims		
Claims Appeals	**Within thirty (30) calendar days after an agency (DOM) decision has been made, the provider may request a formal administrative hearing.** https://medicaid.ms.gov/wp-content/uploads/2014/01/Admin-Code-Part-300.pdf **State Fair Hearing:** A hearing conducted by the Division of Medicaid or its Subcontractor in accordance with 42 C.F.R. § 431 Subpart E. Any adverse Action or Appeal that is not resolved wholly in favor of the Member by the Contractor may be Appealed by the Member or the Member's Authorized Representative to the Division for a State Fair Hearing conducted in accordance with 42 C.F.R. § 431 Subpart E. A Member or Authorized Representative may request a State Fair Hearing if he or she is dissatisfied with an Action that has been taken by the Contractor within thirty (30) calendar days of the final decision by the Contractor. The Member must exhaust all CCO level Grievance and Appeal procedures prior to requesting a State Fair Hearing with the Division of Medicaid. The Provider must exhaust all CCO level Grievance and Appeal procedures prior to requesting a State Administrative Hearing with the Division.	**Claim Dispute** 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 MSCAN** **Attn: Claim Dispute** **PO BOX 3000** **Farmington, MO 63640**	**Claim Appeal:** Within 30 days of determination http://www.uhccommunityplan.com/content/dam/communityplan/healthcareprofessionals/providerinformation/MS-Provider-Information/MS_Appeal_Form.pdf **Claim Reconsideration:** Within 90 days of determination http://www.uhccommunityplan.com/health-professionals/ms/claim-reconsideration-appeals1.html **Corrected Claim:** Within 90 days of determination Mail: Print the Claim Reconsideration form (above) and mark the box for Corrected Claims. In "comments" section list the specific changes made and rationale or other supporting information. Enter "Corrected Claim" in the comments field on the claim form. This will COMPLETELY replace the previous claim so if partial payment was made, it will be reversed and replaced with the new claim details State Hearing: See Medicaid FFS

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Claims			
Grievances	A State Grievance system is inclusive of grievances and appeals. Each MCO must have a system in place for enrollees that include a grievance process, an appeal process, and access to the State's fair hearing system. *Grievance* means an expression of dissatisfaction about any matter other than an action, as "action" is defined in this section. The term is also used to refer to the overall system that includes grievances and appeals handled at the MCO or PIHP level and access to the State fair hearing process. (Possible subjects for grievances include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee's rights.) https://www.ecfr.gov/cgi-bin/text-idx?tpl=/ecfrbrowse/Title42/42cfr431_main_02.tpl	A provider grievance is defined as any provider expression of dissatisfaction expressed by a grievant to the Plan orally or in writing about any matter or aspect of the Plan or its operation, other than a Plan Action or determination of Medical Necessity for a service. A grievance does not include matters of misunderstanding or misinformation that can be promptly resolved by clearing up the misunderstanding or by providing accurate information to the provider. A grievance includes, but is not limited to, the quality of care or services provided, or aspects of interpersonal relationships. A grievance can be filed within thirty (30) calendar days of the date of the event causing the dissatisfaction. A provider complaint is any provider expression of dissatisfaction expressed by a complainant to the Plan orally or in writing that is of a less serious or formal nature that is resolved within one (1) business day of receipt, about any matter related to the Plan other than a determination of Medical Necessity for a service. **P. 73 of the provider manual** https://www.magnoliahealthplan.com/content/dam/centene/Magnolia/medicaid/pdfs/Provider-Manual-PDF3.pdf	**Grievance:** An expression of dissatisfaction about a matter or aspect of the Contractor or its operation. *[Summarized, see Medicaid FFS]* Grievance are accepted through both the member and provider call centers 24/7 and anonymity can be requested. Detailed instructions can be found in the Provider Manual at: http://www.uhccommunityplan.com/health-professionals/ms/provider-admin-manual.html

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	Claims		
Balance Billing	Per the Medicaid Provider Agreement and the Administrative Code, the Medicaid Provider agrees to accept as payment in full the amount paid by the Medicaid program for Medicaid covered services with the exception of authorized deductibles, co-insurance, and co-payments. https://www.ms-medicaid.com/PE_PDFs/ParticipationAgreement.pdf **General Provider Information. Rule 3.8 Charges Not Beneficiary's Responsibility** https://medicaid.ms.gov/wp-content/uploads/2014/01/Admin-Code-Part-200.pdf	Per the Medicaid Provider Agreement and the Administrative Code, the Medicaid Provider agrees to accept as payment in full the amount paid by the Medicaid program for Medicaid covered services with the exception of authorized deductibles, co-insurance, and co-payments. Exclusions for CHIP are authorized co-payments. The member cannot be balance billed for any denied charges under circumstances including but not limited to failure to obtain a notification or prior authorization, either prospectively or retrospectively, clinical or administrative denial of the claim or service.	Per the MS CAN Provider Agreement/Amendment and Medicaid Administrative Code, the provider agrees to accept as payment in full the amount paid by UHC for Medicaid covered services Exclusions for CHIP are authorized co-payments. The member cannot be balance billed for any denied charges under circumstances including but not limited to failure to obtain a notification or prior authorization, either prospectively or retrospectively, clinical or administrative denial of the claim or service.

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Provider Information			
Verify Eligibility	Failure to verify eligibility on the date of service may result in non-payment of services because member is not eligible. Beneficiary Information. Rule 3.5 Verification of Eligibility https://medicaid.ms.gov/wp-content/uploads/2014/01/Admin-Code-Part-200.pdf **Access the Medicaid Envision web portal https://www.ms-medicaid.com/msenvision/index.do**	Failure to verify eligibility on the date of service may result in non-payment of services because member is not eligible. Eligibility can be checked on the Secure Provider Portal at: Provider.MagnoliaHealthPlan.com Or Call Magnolia Health at 866-912-6285 Eligibility can also be accessed on: **Medicaid Envision web portal https://www.ms-medicaid.com/msenvision/index.do**	Online: UnitedHealthcareOnline.com > Patient Eligibility & Benefits Medicaid's Envision website at msmedicaid.acs-inc.com Call Provider Services at: 877-743-8734
Retro-Active Eligibility	Division of Medicaid determines when a Member is retroactively eligible for Medicaid. Beneficiary Information. Rule 3.3 Beneficiary Retroactive Eligibility https://medicaid.ms.gov/wp-content/uploads/2014/01/Admin-Code-Part-200.pdf SSI (Supplemental Security Income) disability program does not pay retroactive disability benefits. SSI disability beneficiaries can receive disability benefits for all months including the month of filing but no earlier than the date of filing. http://www.ssdrc.com/definitions8.html	Division of Medicaid determines when a Member is retroactively eligible for Medicaid.	The Division of Medicaid may assign retro-active eligibility to a member and assign the member to UHC. These dates are recognized and claims are paid accordingly. Medical reviews may be performed retrospectively to assure medical necessity of services. Claims should be filed with accurate dates of services

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Provider Information			
Newborn Enrollment	Coverage is mandatory for infants born to Medicaid eligible mothers. The infant is deemed eligible for one (1) year from the date of birth. Deemed infants are enrolled with Medicaid from the date of birth. The hospital must notify the Division of Medicaid within five (5) calendar days of a Newborn's birth via the Newborn Enrollment Form located on the Division of Medicaid's Envision secure web portal. https://www.ms-medicaid.com/msenvision/index.do The Division of Medicaid will notify the provider within five (5) business days of the newborn's permanent Medicaid identification (ID) number. https://medicaid.ms.gov/wp-content/uploads/2014/01/Admin-Code-Part-100.pdf https://medicaid.ms.gov/wp-content/uploads/2015/11/Newborns-and-the-Inpatient-Transition-Presentation.pdf	Coverage is mandatory for infants born to Medicaid eligible mothers. The infant is deemed eligible for one (1) year from the date of birth. Deemed infants are enrolled with MississippiCAN from the date of birth. The hospital must notify the Division of Medicaid within five (5) calendar days of a newborn's birth via the Newborn Enrollment Form located on the Division of Medicaid's Envision secure web portal. https://www.ms-medicaid.com/msenvision/index.do Magnolia utilizes the Newborn Enrollment Form as notification for routine OB deliveries (standard 3 days stay for vaginal deliveries and 5 day stay for C-sections) and well baby DRG stays. Any claim submitted with a DRG other than routine delivery (vaginal or C-section) or well baby requires authorization. It is important that the information on the Newborn Enrollment Form is correct, as this information determines if the plan will create an authorization for newborns as indicated by the form.	Coverage is mandatory for infants born to Medicaid eligible mothers. The infant is deemed eligible for one (1) year from the date of birth. Deemed infants are enrolled with MississippiCAN from the date of birth. UHC accepts newborn member assignments from Medicaid. It should not be assumed that the baby will always follow the mother. See Medicaid FFS

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Provider Information			
Newborn PA's	The hospital must obtain a TAN for sick newborns requiring hospitalization whose length of stay is six (6) days or more. The baby's date of birth is the sick newborn's beginning date for certification. A sick newborn whose length of stay exceeds nineteen (19) days requires a concurrent review by the appropriate UM/QIO (eQHealth Solutions) http://ms.eqhs.org/Home.aspx The hospital can report the birth through eQSuite. When the provider reports the event in eQSuite, they should receive an instant TAN and see the information for the FFS beneficiary. The hospital must obtain authorization for newborns delivered outside the hospital and newborns admitted to accommodations other than well baby. **Hospital Services, Part 202, Rule 1.3 Prior Authorization of Hospital Services** https://medicaid.ms.gov/wp-content/uploads/2015/09/AdministrativeCode.pdf	Authorization is not required for well baby DRG stays. For all newborn admissions other than well baby DRG stays, Magnolia will begin the authorization process based on the information received on the Newborn Enrollment Form and will contact the facility for clinical information. There is no need to submit a separate authorization request. In the event that during a well baby DRG stay (as indicated by the Newborn Enrollment Form), an infant's DRG later changes to something other than well baby and/or the newborn is transferred to a higher level of care due to complications, please call Magnolia at **1-866-912-6285.**	Authorization is required for all **deliveries.** The processes for notification and authorization should be followed. Emergent deliveries should follow the notification process as PA is NOT required. All deliveries (vaginal & caesarean) follow guidelines set forth by the Medicaid Admin code for Maternity Services found at: https://medicaid.ms.gov/wp-content/uploads/2014/01/Admin-Code-Part-222.pdf Newborn **Notification** is required within one (1) business day for NICU admissions, if mother is covered by UHC MSCAN Submit via Link or at UnitedHealthcareOnline.com > Notifications/Prior Authorizations, follow the prompts and complete the inquiry form, click submit. Call: 866-604-3267 Fax: 888-310-6858 The Medicaid birth notification form, along with any additional information can be used if there is insufficient member information to submit all elements

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Provider Information			
MississippiCAN Member Enrollment	**MississippiCAN members must first be eligible for Medicaid prior to enrollment in the program.** **Members may call Enrollment Broker Conduent, and submit forms to Conduent.** **MississippiCAN Enrollment Contacts** P.O. Box 23078 Jackson, MS 39225 Phone: 1-800-884-3222 Fax: 1-888-495-8169 **Populations Who Have the Option to Disenroll** Category of Eligibility — Age Categories SSI — 0-19 Disabled Child at Home — 0-19 DHS-Foster Care Children — 0-19 DHS-Foster Care (Adoption) — 0-19 Native Americans — 0-65 **Populations Who May Not Disenroll** Category of Eligibility — Age Categories SSI — 19-65 Working Disabled — 19-65 Breast and Cervical — 19-65 Pregnant Women — 8-65 Parent/Caretakers — 19-65 Medical Assistance Children — 0-19	MCOs must report any enrollment changes to Medicaid. This includes deceased members, and other member enrollment requests.	MississippiCAN members must first be eligible for Medicaid prior to enrollment in the program. See Medicaid FFS for categories Upon enrollment with Medicaid, Members may chose UHC as their insurer. If no choice is made, Medicaid will assign to UHC or other CCO. Within 90 days of assignment (or during open enrollment Oct-Dec), a member may change CCOs and become a UHC member. MCOs must report any enrollment changes to Medicaid. This includes deceased members, and other member enrollment requests. Member Services: Ph: 877-743-8731 CAN 800-992-9940 CHIP Online: www.myuhc.com/member/prewelcome.do?currentLanguageFromPreCheck=en Chat real-time with “Missy” at: http://www.uhccommunityplan.com/ms.html > How Can I Help?

Services	Medicaid Fee-for-Service	Magnolia Health	Unitedhealthcare Community Plan
Benefits and Services			
Non-Emergency Transportation	Medical Transportation Management (MTM) is the state of Mississippi's non-emergency transportation (NET) manager. MTM provides rides free of charge for eligible Fee for Service (FFS) Medicaid and end-stage renal disease (ESRD) beneficiaries throughout the state. Beneficiaries must call to schedule rides to healthcare provider for covered medical services if beneficiaries have no other way to get there. Call MTM toll-free at 1-866-331-6004 at least three (3) business days in advance, unless the trip is urgent. **http://www.mtm-inc.net/mississippi/** **Transportation, Part 201, Chapter 2, NET** https://medicaid.ms.gov/wp-content/uploads/2015/09/AdministrativeCode.pdf	Medical Transportation Management (MTM) is the non-emergency transportation provider for Magnolia Health. MTM provides transportation services statewide for Magnolia Health members. Members must call MTM to schedule transportation to healthcare providers for covered medical services, if no other means of transportation is available. Call MTM toll-free at 1-866-331-6004 at least three (3) business days in advance, unless the trip is urgent. **http://www.mtm-inc.net/mississippi/**	Medical Transportation Management (MTM), UHC's non-emergency transportation vendor, provides rides free of charge for UHC CAN members. This can include transportation within the state and across state lines as necessary. Members or representatives, case managers, call MTM diorectly to schedule transportation if beneficiaries have no other way to get there. Call MTM toll-free at 1-866-331-6004 at least three (3) business days in advance, unless the trip is urgent. **http://www.mtm-inc.net/mississippi/** If a member chooses to use other forms of transportation, they may be personally compensated by calling 1-888-513-0703
Emergency Transportation	Emergency transportation includes ambulance, air transportation, and other. **Transportation, Part 201, Chapter 1, Ambulance** https://medicaid.ms.gov/wp-content/uploads/2014/01/Admin-Code-Part-201.pdf **Ambulance Fee Schedule** https://medicaid.ms.gov/providers/fee-schedules-and-rates/#	Emergency transportation via ambulance and helicopter do not require authorization. Airplane/Fixed wing ambulance transportation requires prior authorization.	Emergency and facility-to-facility transportation is handled by ambulance (air and ground) in accordance with Mississippi Medicaid (see Medicaid FFS). All generally-accepted billing and modifiers apply to claims Reimbursement is based on Medicaid rates and methodology

Services	Medicaid Fee-for-Service	Magnolia Health	Unitedhealthcare Community Plan
Benefits and Services			
Dental	**Dental Services, Part 204** https://medicaid.ms.gov/wp-content/uploads/2014/01/Admin-Code-Part-204.pdf **Dental Fee Schedule** https://medicaid.ms.gov/providers/fee-schedules-and-rates/#	**Envolve Dental Provider Web Portal** https://portal.dentalhw.com/pwp **Provider Services** 844-464-5636 **Credentialing** 855-844-0621 **Authorizations Address**: Envolve Dental, Authorizations PO Box 20724 Tampa ,FL 33622-0724 **Paper Claims Address**: Envolve MS Claims P O Box 20731 Tampa, FL 33622-0731	www.uhcproviders.com Ph: 1-800-508-4862 Prior Authorization and COC: Claims: Online via the provider portal above By mail to: P.O. Box 1391 - Milwaukee, WI 53201
Vision	**Vision Services, Part 217** https://medicaid.ms.gov/wp-content/uploads/2014/01/Admin-Code-Part-217.pdf **Vision Fee Schedule** https://medicaid.ms.gov/providers/fee-schedules-and-rates/#	**https://visionbenefits.envolvehealth.com/** **Customer Service:** (866) 842-6177 **Network Management:** (800) 531-2818	March Vision for routine vision, eye glasses, and primary eye care. Referrals are NOT needed. Online: www.MarchVisionCare.com Ph: 844-606-2724
Therapy Services **Speech** **Physical** **Occupational**	**Therapy Services, Part 213** https://medicaid.ms.gov/wp-content/uploads/2014/01/Admin-Code-Part-213.pdf **Envision Fee Schedule and Rates** https://medicaid.ms.gov/providers/fee-schedules-and-rates/ https://msmedicaid.acs-inc.com/msenvision/questionanswer.do?CATEGORY_TYPE=Therapy	Prior authorization is required for therapy services including speech, physical and occupational. Initial therapy evaluations do not require authorization for in network providers only. Home based therapy is not a covered benefit for members 21 years and older.	Therapy agreements are initiated by Optum Physical Health https://www.myoptumhealthphysicalhealth.com Existing UHC medical agreements can be amended to include any therapy services through UHC

Services	Medicaid Fee-for-Service	Magnolia Health	Unitedhealthcare Community Plan
Benefits and Services			
Medical Service Reconsideration	Providers may submit requests for reconsideration of closed or open procedure codes, maximum units allowed, and other medical service reconsiderations. The Fee-for-Services information is located on DOM website: **Reconsideration Process** Fee-for-Service Forms link: https://medicaid.ms.gov/resources/forms/ **Reconsideration form link:** https://medicaid.ms.gov/wp-content/uploads/2014/04/ClaimCheck_Reconsideration_Form.pdf **Appeals Process** Administrative Code Part 300 link (Provider Appeals): https://medicaid.ms.gov/wp-content/uploads/2014/01/Admin-Code-Part-300.pdf	All claim requests for reconsideration, corrected claims, or claim disputes must be received within 90 calendar days from the date of notification of payment or denial is issued. If a provider has a question or is not satisfied with the information they have received related to a claim. **Submit a Request for Reconsideration:** Magnolia Health Attn: Reconsideration PO Box 3090 Farmington, MO 63640-3800	UHC works in conjunction with Medicaid to consider services that are otherwise not covered or restricted by the Mississippi Medicaid fee schedule. A review for medical necessity should be obtained. For denied claims or authorizations, please contact provider services: 877-743-8734 Denied claims should be addressed in accordance with timely filing.
Pharmacy	DOM Pharmacy Preferred Drug List (PDL) is the same for Medicaid fee-for-service, MississippiCAN, and CHIP. **Pharmacy Services, Part 214** https://medicaid.ms.gov/wp-content/uploads/2014/01/Admin-Code-Part-214.pdf **DOM Pharmacy website** https://medicaid.ms.gov/providers/pharmacy/	DOM Pharmacy Preferred Drug List (PDL) is the same for Medicaid fee-for-service, MississippiCAN, and CHIP. **P. 41 -45 of the provider manual** https://www.magnoliahealthplan.com/content/dam/centene/Magnolia/medicaid/pdfs/Provider-Manual-PDF3.pdf	DOM Pharmacy Preferred Drug List (PDL) is the same for Medicaid fee-for-service, MississippiCAN, and CHIP. Benefit is administered by OptumRX RX Provider Services: 877-842-3210 Prior Authorization for non-preferred medications or for those requiring prior authorization (turnaround time is typically < 24 hours) Ph: 800-310-6826 Fax: 866-940-7328 Emergency 3-Day Supply is available

Services	Medicaid Fee-for-Service	Magnolia Health	Unitedhealthcare Community Plan
Contact Information			
Contact Information	Toll-free: 800-421-2408 **Mississippi Medicaid website** https://medicaid.ms.gov/ **Mississippi Medicaid Contacts** https://medicaid.ms.gov/contact/ Fiscal Agent Conduent website https://www.ms-medicaid.com/msenvision/	Toll-free: 866-912-6285 Magnolia Health Plan Medicaid website https://www.magnoliahealthplan.com/	Toll Free: 877-743-8734 www.UHCCommunityPlan.com Provider Manual: http://www.uhccommunityplan.com/health-professionals/ms/provider-admin-manual.html
Provider and Beneficiary Relations	**Providers and Beneficiaries may contact Medicaid for assistance.** Toll-free: 800-421-2408 Website: medicaid.ms.gov **Provider Field Representatives** **https://www.ms-medicaid.com/msenvision/servlet/DocumentViewerServlet?docType=ProviderBulletins&fileName=201703.pdf**	Providers and Members may contact Magnolia for assistance. Toll-free: 866-912-6285 https://www.magnoliahealthplan.com Providers can obtain resources at: https://www.magnoliahealthplan.com/providers/resources/forms-resources.html	Provider Services: Toll Free: 877-743-8734 Link portal at: www.UHCCommunityPlan.com Provider Advocates by Terriory Member Services: 877-743-8731 CAN 800-992-9940 CHIP Chat real-time with “Missy” at: www.uhccommunityplan.com/ms.html > How Can I Help?
General Inquiry Form	The General Inquiry Form may be faxed or mailed to DOM. **General Inquiry Form** https://medicaid.ms.gov/wp-content/uploads/2017/04/General-Inquiry-Form.pdf	The General Inquiries may be submitted via our website at: https://www.magnoliahealthplan.com/contact-us.html	Provider Services: Toll Free: 877-743-8734 Link portal at: www.UHCCommunityPlan.com Member Services: 877-743-8731 CAN 800-992-9940 CHIP Chat real-time with “Missy” at: www.uhccommunityplan.com/ms.html > How Can I Help? Provider Advocates assigned by territory

Services	Medicaid Fee-for-Service	Magnolia Health	Unitedhealthcare Community Plan
Contact Information			
Communications (Bulletins, LBNs Newsletters)	**Medicaid Provider Bulletin** https://www.ms-medicaid.com/msenvision/providerBulletins.do https://www.ms-medicaid.com/msenvision/servlet/DocumentViewerServlet?docType=ProviderBulletins&fileName=201703.pdf **Late Breaking News (LBN)** https://www.ms-medicaid.com/msenvision/servlet/DocumentViewerServlet?docType=lateBreakingNews&fileName=all_late_breaking_news.pdf	**Provider Resources:** Magnolia Health provides the tools and support you need to deliver the best quality of care. Please visit the **Magnolia Health Plan Medicaid website** https://www.magnoliahealthplan.com/ to gain access to forms, guidelines, helpful links, and training such as: **Magnolia Provider News:** https://www.magnoliahealthplan.com/providers/provider-news.html	Monthly Provider Bulletins: https://www.unitedhealthcareonline.com/b2c/CmaAction.do?channelId=efb74ccb4726b010VgnVCM100000c520720a___ (sign up to receive via email) Quarterly Provider Newsletters: http://www.uhccommunityplan.com/health-professionals/ms/provider-news.html Link for Proviers at: www.UHCCommunityPlan.com News For Members: www.uhccommunityplan.com/ms www.myuhc.com/communityplan
MississippiCAN Feedback	**MississippiCAN Inquiry Form** **https://medicaid.ms.gov/mississippican-feedback/** Fax 601-359-5252 **MississippiCAN Provider Survey** **https://medicaid.ms.gov/wp-content/uploads/2016/04/2015-MississippiCAN-Provider-Survey.pdf**	**Feedback may be submitted via our website at:** https://www.magnoliahealthplan.com/contact-us.html	UHC Contact Information: https://www.unitedhealthcareonline.com/b2c/CmaAction.do?viewKey=PreLoginMain&forwardToken=PreLoginMain Ph: 877-842-3210 Annual Provider Satisfaction Survey (Oct-Dec)

Services	Medicaid Fee-for-Service	Magnolia Health	Unitedhealthcare Community Plan
Contact Information			
MississippiCAN Contacts	DOM has contracted with two coordinated care organizations (CCOs), Magnolia Health and UnitedHealthcare Community Plan, responsible for providing services to beneficiaries who participate in the MississippiCAN program. There are certain beneficiaries that will qualify for this program, both mandatory and optional beneficiary populations. **MississippiCAN Contacts** **Conduent**: For MississippiCAN enrollment Toll-free: 800-884-3222 Website: www.ms-medicaid.com **Mississippi Division of Medicaid** Phone: 601-359-3789 Toll-free: 800-421-2408 Website: www.medicaid.ms.gov	**Magnolia Health** Toll-free: 866-912-6285 Website: www.magnoliahealthplan.com	**UnitedHealthcare Community Plan** Toll-free: 877-743-8731 Website: www.uhccommunityplan.com