Volume 28, Issue 2 June 2022

MS Medicaid PROVIDER BULLETIN

MISSISSIPPI DIVISION OF MEDICAID

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MS Division of Medicaid

DOM to Launch Implementation for Centralized Credentialing Process on July 1, 2022

In the last issue of the Provider Bulletin, I gave an overview of our upcoming Medicaid Management Information System (MMIS), which is currently in the late stages of development. I explained how the new system – MESA –will replace outdated technology with a more efficient version that will also have some distinct advantages over the current system.

One of the key advantages to the new system is that it will allow for a centralized credentialing process, which will significantly reduce red tape and wait times for providers who want to enroll or re-credential with any MississippiCAN or Children's Health Insurance Program (CHIP) coordinated care organization (CCO).

Centralized credentialing is something we've been working toward for some time as part of an on-going effort to reduce administrative burdens for health care providers. Although the new MMIS will create the technical infrastructure to achieve that process, DOM recently announced that it will launch an implementation period for centralized credentialing on July 1, 2022, before MESA goes live.

Currently, MississippiCAN is administered by three CCOs – Magnolia Health, UnitedHealthcare Community Plan, and Molina Healthcare – while CHIP is administered by Molina Healthcare and UnitedHealthcare Community Plan. Providers who wish to enroll in those networks are required to complete a separate credentialing process with each plan to verify that they are qualified providers. Additionally, they must undergo re-credentialing every three years to ensure their information is still accurate and up to date.

Beginning July 1, 2022, providers seeking to join as providers in MississippiCAN will no longer have to credential individually with each CCO. For an interim period from July 1-Aug. 15, 2022, providers will simply need to follow DOM's screening process used for Medicaid fee-for-service instead of completing managed care-specific credentialing. (For technical reasons, CHIP providers will have to enroll with each CHIP CCO during the interim period.) This approach will offer immediate administrative relief as the new system is configured to handle all credentialing.

Providers seeking to enroll during that interim period will be required to submit all necessary screening documentation to the current system, Envision, by Aug. 15, 2022. In order to ensure a smooth transition, DOM will temporarily suspend enrollment from Aug. 15 until the new system MESA goes live.

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Once the switch from Envision to MESA is completed, providers will have a centralized hub for credentialing in Medicaid-related benefit programs.

The traditional "credentialing" process, which is required of all health plans by the National Committee for Quality Assurance (NCQA), can be arduous and lengthy as completion often requires the submission of additional documentation and related paperwork. Also, providers must currently credential with multiple entities as described above.

However, with support from the state Legislature, DOM is working to simplify the operation by enabling providers to credential through a single avenue that will qualify them, and then allow them to contract with any CCO. DOM screens providers enrolling in fee-for-service Medicaid but has not been required to credential.

In recent years, DOM has made it a priority to better understand the challenges voiced by providers and sought to work together toward meaningful change in support of our shared goal of better outcomes for beneficiaries. Streamlining provider credentialing will be a huge step toward focusing on patients instead of processes, and we are grateful to the Legislature and provider community for their partnership on this initiative.

DOM will share more information about the credentialing process as those details develop.

WEB PORTAL REMINDER

For easy access to up-to-date information, providers are encouraged to use the **Mississippi Envision Web Portal.** The Web Portal is the electronic approach to rapid, efficient information exchange with providers including eligibility verification, claim submission, electronic report retrieval, and the latest updates to provider information. The **Mississippi Envision Web Portal** is available 24 hours a day, 7 days a week, 365 days a year via the Internet at www.ms-medicaid.com.

PROVIDER COMPLIANCE

Psychiatric Residential Treatment Facility/Mental Health Provider Update

Minor Corrections to Language in Rule 4.9: Treatment Planning

Effective May 1, 2022, Title 23, Part 207: Institutional Long-Term Care, Chapter 4: Psychiatric Residential Treatment Facilities, Rule 4.9: Treatment Planning has been revised to reflect minor corrections, including corrections to correspond with the MS Department of Health Minimum Standards. In addition, the lifting of the rate freeze was effective on the same date.

Please contact Kimberly Evans or Charlene Craft at **601-359-9545**, should you have questions.

Outpatient Hospital/Mental Health Provider Billing Update

PA Required for All Outpatient Hospital Mental Health Services

Effective May 1, 2022, Title 23, Part 202: Hospital Services, Chapter 2: Outpatient Hospital, Rule 2.6: Mental Health Services has been revised to reflect the requirement for prior authorization of all mental health services provided in the outpatient hospital setting.

Please contact Kimberly Evans or Charlene Craft at **601-359-9545**, should you have questions.

Attention: Hospice Providers

Effective January 1, 2022, the Mississippi Administrative Code Title 23: Medicaid Part 205: Hospice Services was updated to 1) add language clarifying the prior authorization and notice of election requirements, 2) add language that late documentation will result in the hospice effective date beginning on the date the completed documentation is received, and 3) add exceptions to the timely submission of documentation requirements. The Hospice Administrative Code can be viewed in its entirety at **Administrative Code (ms.gov)**.

The Division of Medicaid (DOM) will be collaborating with Alliant Health Solutions to host virtual training opportunities for Medicaid Hospice providers to review the Administrative Code and other requirements. Alliant Health Solutions will be notifying Hospice providers about the upcoming virtual trainings and how to register.

Reminders Regarding Election and Discharge Procedures

Medicaid Only Beneficiaries:
DOM requires hospice providers to submit the election statement to the Utilization Management/Quality Improvement Organization (UM/QIO), currently Alliant Health Solutions, or designated entity within five (5) calendar days of a beneficiary's admission to hospice. Providers should file discharge notices within five (5) calendar days after the effective date of discharge.

Dual Eligible Beneficiaries:
DOM requires the hospice provider to notify DOM's Utilization Management/Quality Improvement Organization (UM/QIO), currently Alliant Health Solutions, or designated entity, within five (5) calendar days of the beneficiary's hospice election or discharge date. Please refer to Alliant Health Solutions' provider portal at: **https://ms.allianthealth.org/**, or call Alliant directly at **1-888-224-3067**, for assistance from the UM/QIO.

Required Forms:
Medicaid Only Beneficiaries:
Election Notice Form (DOM 1165 A-B)
Physician Certification/Recertification of Terminal Illness (DOM 1165 C)
Hospice Discharge/Hospice Revocation Form (DOM 1166 A)

Dual Eligible Beneficiaries:
Notice of Hospice Election or Discharge for Dual Eligible Beneficiaries (DOM 1166 C)
Hospice Forms are located on DOM's website on the Hospice page at **https://medicaid.ms.gov/programs/hospice/**.

PROVIDER COMPLIANCE

Questions concerning Hospice services, that are not covered by Mississippi CAN, should be directed to the Office of Medical Services at **(601) 359-6150**.

MEDICAL CLAIMS

Physician Administered Drugs and Federal Rebate Requirement

Zoladex No Longer Covered

Medicaid does not cover drugs produced by manufacturers that do not have signed rebate agreements with the Centers for Medicare and Medicaid Services (CMS), as required by the Omnibus Budget Reconciliation Act (OBRA) of 1990, unless provided through expanded Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services outlined in Miss. Admin. Code Part 223.

The manufacturer of Zoladex, TerSera Therapeutics LLC, has voluntarily withdrawn from participation in the Medicaid Drug Rebate Program, effective October 1, 2021. As a result, Zoladex will no longer be a Mississippi Medicaid covered product. For those beneficiaries previously on and needing to continue Zoladex therapy, please utilize TerSera's patient assistance program for program applications and additional information: **https://www.needymeds.org/brand-drug/name/Zoladex** or contact TerSera Support Source at **855-686-8725**.

Before billing any physician administered drug, providers should check the following:

- beneficiary's eligibility
- whether the drug requires prior authorization
- the drug's rebate status by using the Provider- Physician Administered Drug Inquiry tool found at **Mississippi Envision (ms-medicaid.com)**.

To check the rebate status of a Physician Administered Drug:

- Hover over, Provider—Inquiry Options— and click on Physician Administered Drug Inquiry
- Enter the drug's NDC# and Date of Service

The following screenshot is an example of an inquiry performed for Zoladex 10.8 mg, NDC 70720095130, for a date of service on 11/29/2021. The information returned indicates a rebate status of 'No' which means the drug is not covered by Medicaid.

PROVIDER COMPLIANCE

Billing Requirements Regarding Medicare Advantage Plan/ Traditional Medicare EOBs

The MS Division of Medicaid and Conduent State Healthcare have completed a recent review of Medicare claims submitted by paper or through the Envision web portal and discovered that there is a vast inconsistency in the information presented as Medicare reimbursement data on the Explanations of Benefits (EOB). Many of the presented EOBs fail to provide adequate and correct information. Therefore, the MS Division of Medicaid is requiring that the EOB for Medicare and Medicare Part C services billed to Medicaid **must** include the following fields:

- Medicaid Beneficiary Name
- Medicare ID or HIC
- Payer name (i.e., Novitas, Wellcare, United Healthcare, etc.)
- Paid Date (date Medicare or Medicare Advantage plan paid)
- Paid Amount (payment received from Medicare or Medicare Advantage plan)
- Allowed or Approved Amount- (amount Medicare or Medicare Advantage plan allows for the service)
- Co-insurance (as specified by Medicare or Medicare Advantage plan)
- Co-Pay (as specified by Medicare or Medicare Advantage plan)
- Deductible (a specified amount of money for which the patient is responsible)
- Blood deductible (if indicated – is in addition to any other applicable deductible and coinsurance amounts for which the patient is responsible)
- Sequestration (amounts are not covered by Medicaid and are not considered patient's responsibility)
- Contractual Adjustment (the amount agreed upon between the provider and the Medicare Advantage plan)
- Service Level Information – (line level claims specific information)

Failure to adhere to the above guidelines may result in denial or delays to claims payment. For additional questions and assistance, contact Conduent Provider Services Call Center at 1-800-884-3222.

COORDINATED CARE NEWS

Prior Authorization Reminders

A Prior Authorization is a request to the Magnolia UM Department for a medical necessity determination for services to be rendered. Information necessary for authorization of covered services may include, but is not limited to:

- Member's name
- Member's ID number
- Provider's name and telephone number
- Provider's location, if the request is for an ambulatory or office procedure
- Reason(s) for the authorization request (e.g., primary and secondary diagnoses, planned surgical
- Procedures, surgery date
- Relevant clinical information (e.g., past/proposed treatment plan, surgical procedures)
- Diagnostic procedures, to support the appropriateness and level of service proposed
- Inpatient admission notification
- Discharge plans
- Notification of newborn deliveries should include the date and method of delivery, and
- Information related to the newborn or neonate for outcomes reporting.

*Please ensure that you are completing the PA request completely and providing the necessary medical necessity documents when requesting a Prior Authorization.

Medically Necessary

Medically Necessary means any medical service, supply, or treatment authorized by a physician to diagnose and treat a member's illness or injury which:

- Is consistent with the symptoms or diagnosis;
- Is provided according to generally accepted medical practice standards;
- Is not custodial care;
- Is not solely for the convenience of the physician or the member;
- Is not experimental or investigational;
- Is provided in the most cost effective care facility or setting;
- Does not exceed the scope, duration, or intensity of that level of care that is needed to provide safe, adequate, and appropriate diagnosis or treatment; and
- When specifically applied to a hospital confinement, it means that the diagnosis and treatment of the medical symptoms or conditions cannot be safely provided as an outpatient.

Pre-Auth Tool Check:

Magnolia:
https://www.magnoliahealthplan.com/providers/preauth-check.html
Ambetter:
http://ambetter.magnoliahealthplan.com/

The following options are how providers can submit Prior Authorization requests:

- Magnolia's Secure Provider Portal provider.magnoliahealthplan.com (Preferred Method)
- Contacting the Utilization Management/Prior Authorization Department at 1-866-912-6285
- Magnolia Inpatient Fax: 1-877-291-8059
- Magnolia Outpatient Fax: 1-877-650-6943
- Ambetter Inpatient Fax: 855-300-2618
- Ambetter Outpatient Fax: 855-300-2618

COORDINATED CARE NEWS

Appointment Access and Availability

Molina Healthcare monitors compliance and conducts ongoing evaluations regarding the availability and accessibility of services to Members. Providers must ensure adherence to these regulatory standards to ensure that health care services are provided in a timely manner. To view the most current regulatory standards regarding Access to Care and Appointment Access, please view the current Provider Manual at the following link: **https://www.molinahealthcare.com/providers/ms/medicaid/manual/medical.aspx**.

Balance Billing

Balance billing Molina members for covered services is prohibited other than the member's applicable copayment for CHIP, and non-Medicaid covered services. The provider is responsible for verifying eligibility and obtaining approval for those services that require prior authorization.

Providers agree that under no circumstance shall a Molina member be liable to the provider for any sums owed that are the legal obligation of Molina to the provider. Examples of balance billing include:

- Requiring Molina members to pay the difference between the discounted and negotiated fees, and the provider's usual and customary fees.
- Charging Molina members fees for covered services beyond copayments (CHIP).

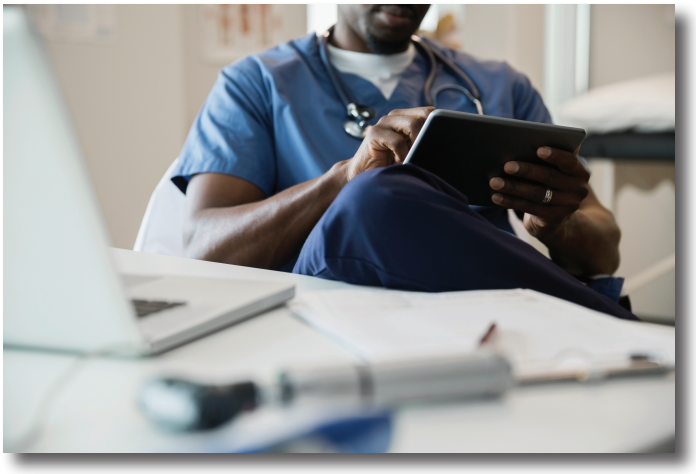
Molina Healthcare and PsychHub Partner for Mental Health Resources

Because good behavioral health is vitally important for everyone, Molina Healthcare is committed to doing all we can to support mental wellbeing for providers and members. By joining PsychHub's coalition partnership, Molina can now offer providers and members access to the Mental Wellbeing Resource Hub. This free library of resources helps address mental health issues during the COVID-19 pandemic and beyond. Members and providers can search for resources by keyword, topic, and audience.

To access the Mental Wellbeing Resources Hub, go to: **https://psychhub.com/initiatives/resource-hub/**.

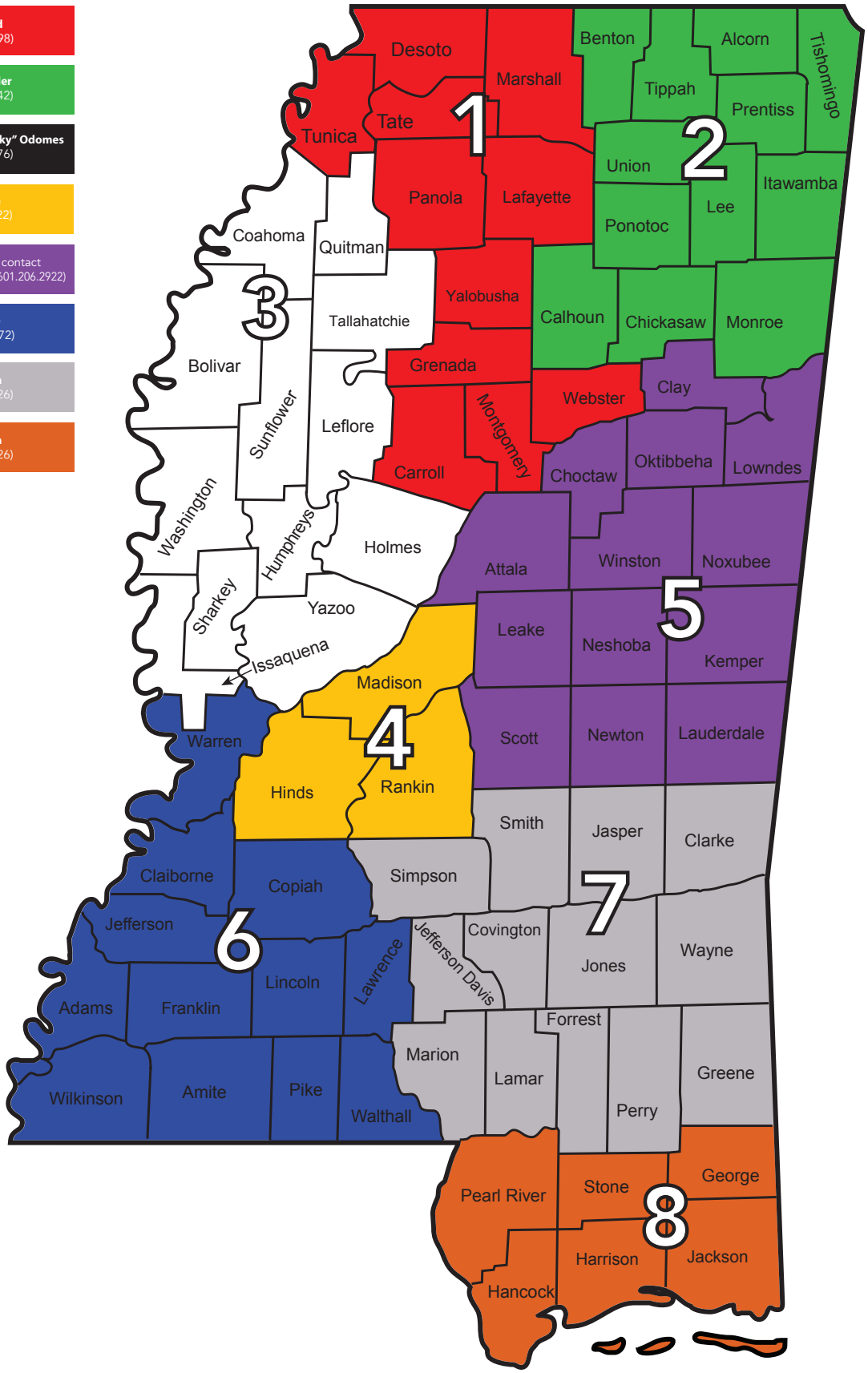
New Clinical Policy Website Available to Providers

In February 2022, Molina Healthcare Inc. (Molina) launched an online provider tool for clinical policies—a new, dedicated website **MolinaClinicalPolicy.com**. The site includes Molina Clinical Policies (MCPs) and Molina Clinical Reviews (MCRs), which are used by providers as well as Molina's Medical Directors and internal reviewers to make Medical Necessity determinations. The website will ensure that Providers have access to the most current MCPs and MCRs. Routine updates will be made following approval by the Molina Clinical Policy Committee. We are excited to share this new tool with our providers.



FIELD REPRESENTATIVE REGIONAL MAP

1	**Latasha Ford** (601.572.3298)
2	**Prentiss Butler** (601.206.3042)
3	**Claudia "Nicky" Odomes** (601.572.3276)
4	**Justin Griffin** (601.206.2922)
5	**TBA** (interim contact Justin Griffin 601.206.2922)
6	**Latrece Pace** (601-473-5172)
7	**Erica Guyton** (601.206.3026)
8	**Erica Guyton** (601.206.3026)



PROVIDER FIELD REPRESENTATIVES

PROVIDER FIELD REPRESENTATIVE AREAS BY COUNTY

AREA 1 Latasha Ford (601.572.3298) Latasha.Ford@conduent.com	AREA 2 Prentiss Butler (601.206.3042) prentiss.butler@conduent.com	AREA 3 Claudia "Nicky" Odomes (601.572.3276) claudia.odomes@conduent.com
County	**County**	**County**
Desoto	Benton	Coahoma
Tunica	Tippah	Quitman
Tate	Alcorn	Bolivar
Panola	Tishomingo	Sunflower
Marshall	Prentiss	Leflore
Lafayette	Union	Tallahatchie
Yalobusha	Lee	Washington
Grenada	Pontotoc	Sharkey
Carroll	Itawamba	Humphreys
Montgomery	Calhoun	Yazoo
Webster	Chickasaw	Holmes
	Monroe	Issaquena
***Memphis**		

AREA 4 Justin Griffin (601.206.2922) justin.griffin@conduent.com	AREA 5 Justin Griffin (601.206.2922) justin.griffin@conduent.com Interim Contact	AREA 6 Latrece Pace (601.473.5172) Latrece.Pace@conduent.com
County	**County**	**County**
Hinds	Clay	Warren
Rankin	Oktibbeha	Claiborne
Madison	Choctaw	Jefferson
	Attala	Adams
	Leake	Franklin
	Scott	Wilkinson
	Lowndes	Amite
	Winston	Copiah
	Noxubee	Lincoln
	Neshoba	Pike
	Kemper	Lawrence
	Newton	Walthall
	Lauderdale	

AREA 7 Erica Guyton (601.206.3026) erica.guyton@conduent.com		AREA 8 Erica Guyton (601.206.3026) erica.guyton@conduent.com
County		**County**
Simpson		Pearl River
Jefferson Davis		Stone
Marion		George
Lamar		Hancock
Covington		Harrison
Smith		Jackson
Jasper		
Jones		**Slidell, LA**
Forrest		**Mobile, AL**
Perry		
Greene		
Wayne		
Clarke		

OUT OF STATE PROVIDERS	**Justin Griffin (601.206.2922)** justin.griffin@conduent.com

CONDUENT
P.O. BOX 23078
JACKSON, MS 39225

If you have any questions related to the topics in this bulletin, please contact Conduent at 800 - 884 -3222

Mississippi Medicaid Administrative Code and Billing Handbook are on the Web
www.medicaid.ms.gov

Medicaid Provider Bulletins are located on the Web Portal
www.ms-medicaid.com

JUNE 2022

THURS, JUNE 2	EDI Cut Off – 5:00 p.m.
MON, JUNE 5	Checkwrite
THURS, JUNE 9	EDI Cut Off – 5:00 p.m.
MON, JUNE 12	Checkwrite
THURS, JUNE 16	EDI Cut Off – 5:00 p.m.
MON, JUNE 19	Checkwrite
THURS, JUNE 23	EDI Cut Off – 5:00 p.m.
MON, JUNE 26	Checkwrite
THURS, JUNE 30	EDI Cut Off – 5:00 p.m.

JULY 2022

MON, JULY 4	Independence Day DOM Closed
THURS, JULY 7	EDI Cut Off – 5:00 p.m.
MON, JULY 11	Checkwrite
THURS, JULY 14	EDI Cut Off – 5:00 p.m.
MON, JULY 18	Checkwrite
THURS, JULY 21	EDI Cut Off – 5:00 p.m.
MON, JULY 25	Checkwrite
THURS, JULY 28	EDI Cut Off – 5:00 p.m.

AUGUST 2022

MON, AUGUST 1	Checkwrite
THURS, AUGUST 4	EDI Cut Off – 5:00 p.m.
MON, AUGUST 8	Checkwrite
THURS, AUGUST 11	EDI Cut Off – 5:00 p.m.
MON, AUGUST 15	Checkwrite
THURS, AUGUST 18	EDI Cut Off – 5:00 p.m.
MON, AUGUST 22	Checkwrite
THURS, AUGUST 25	EDI Cut Off – 5:00 p.m.
MON, AUGUST 29	Checkwrite

Checkwrites and Remittance Advices are dated every Monday. Provider Remittance Advice is available for download each Monday morning at www.ms-medicaid.com. Funds are not transferred until the following Thursday.