Mississippi Division Of Medicaid

Provider Workshops

Thursday, April 25, 2024
10:30 a.m. – 12:00 p.m.

MISSISSIPPI DIVISION OF MEDICAID

Purpose of the Managed Care Provider Workshop

The purpose of today's Managed Care Provider webinar training is to provide clarity and understanding for Mississippi Division of Medicaid, MississippiCAN and CHIP processes for both member and providers.

Mission Statement: The Mississippi Division of Medicaid responsibly provides access to quality health coverage for vulnerable Mississippians.

Agenda

Welcome & Introductions

Medicaid Overview

Provider Contracting & Provider Enrollment
(Telligen, United, Magnolia & Molina)

Webinar Resources

Questions & Answer Session

Division of Medicaid Managed Care Team

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Deputy Director of Managed Care

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Managed Care – Provider Services

Michelle Robinson
Managed Care – Member Service

Charlotte McNair
Managed Care Enrollment & Eligibility

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Managed Care – Document Review

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UnitedHealth Provider Service Team

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Magnolia Health Provider Service Team

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Provider Network Specialist

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Provider Engagement Administrator

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Behavioral Health Unitization Management

Tarkan Weston
Provider Engagement Administrator

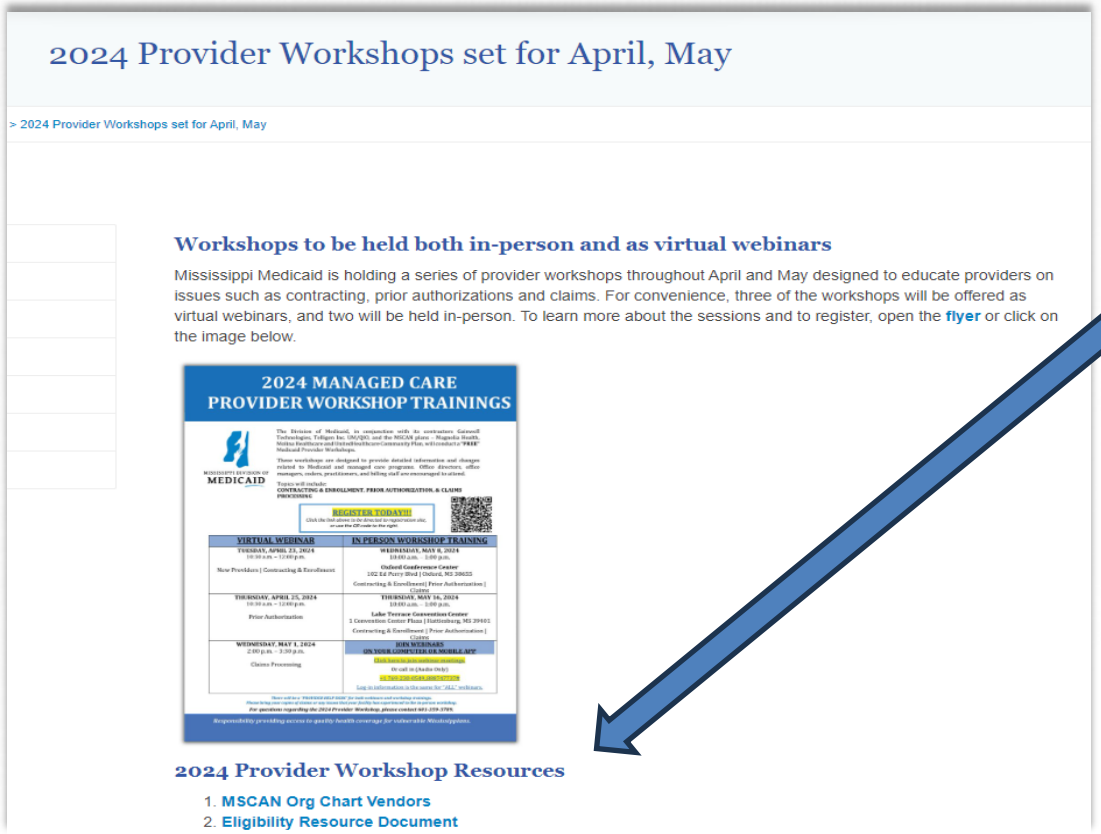
Bethany Peters
Provider Engagement Administrator

Brittany Cole
Provider Network Support Specialist

Kiri Parson
Provider Engagement Administrator

Stacy McGrew
Provider Engagement Administrator

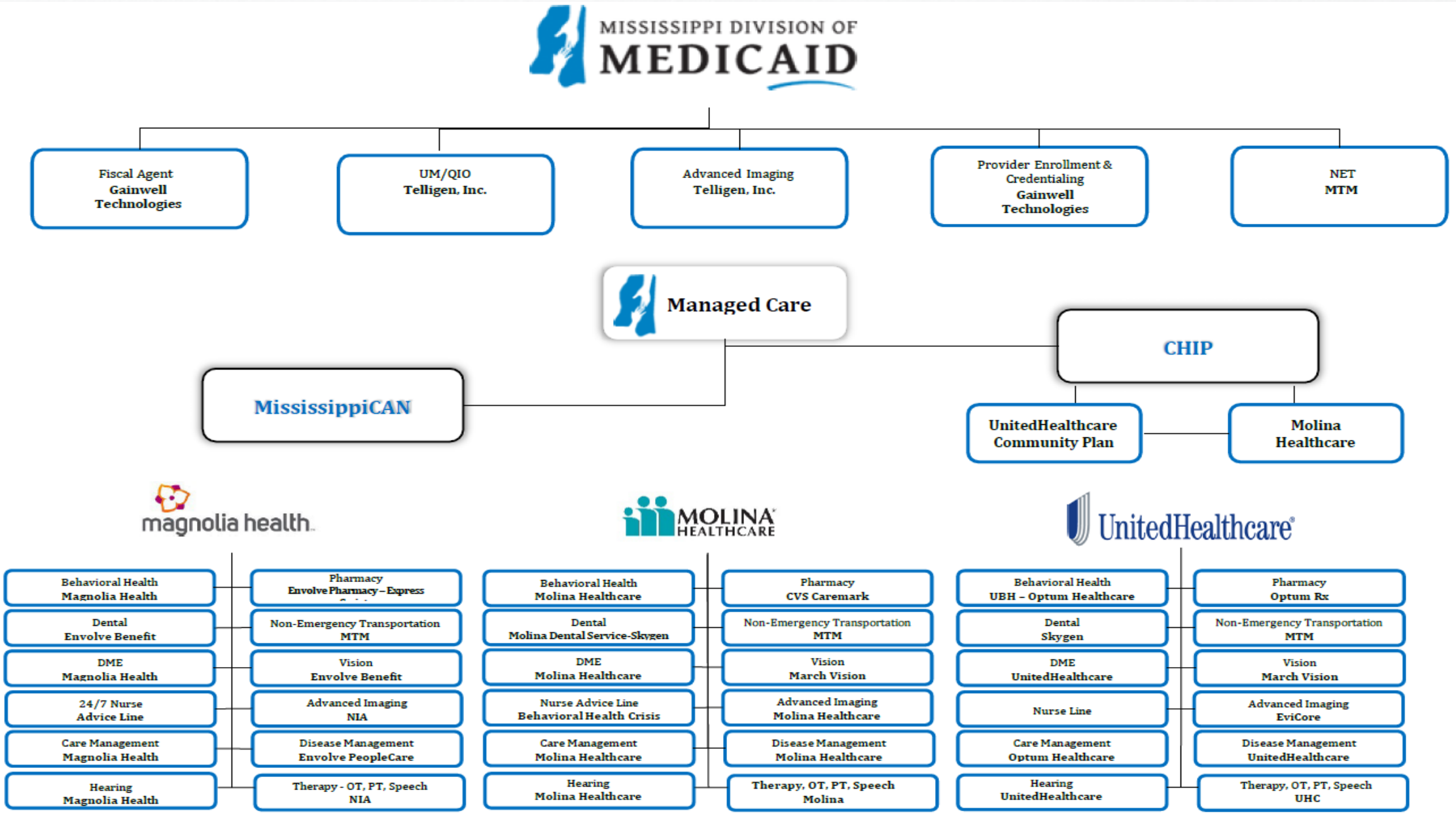
How Providers can Access the Provider Workshop Resources



- 2024 Provider Workshop Presentation
  - Provider Contracting & Enrollment
  - Prior Authorizations
  - Claims
- Mississippi Medicaid Eligibility
- Comparison Chart
  - MississippiCAN
  - CHIP
- Managed Care Org Chart
- Managed Care Contact List
- Gainwell & CCO Provider Reps

https://medicaid.ms.gov/2024-provider-workshops-set-for-april-may/

Managed Care Overview


MISSISSIPPI DIVISION OF MEDICAID
Fiscal Agent
Gainwell Technologies
UM/QIO
Telligen, Inc.
Advanced Imaging
Telligen, Inc.
Provider Enrollment & Credentialing
Gainwell Technologies
NET
MTM
Managed Care
MississippiCAN
CHIP
UnitedHealthcare Community Plan
Molina Healthcare
magnolia health
Behavioral Health
Magnolia Health
Dental
Envolve Benefit
DME
Magnolia Health
24/7 Nurse
Advice Line
Care Management
Magnolia Health
Hearing
Magnolia Health
Pharmacy
Envolve Pharmacy – Express
Non-Emergency Transportation
MTM
Vision
Envolve Benefit
Advanced Imaging
NIA
Disease Management
Envolve PeopleCare
Therapy - OT, PT, Speech
NIA
MOLINA HEALTHCARE
Behavioral Health
Molina Healthcare
Dental
Molina Dental Service-Skygen
DME
Molina Healthcare
Nurse Advice Line
Behavioral Health Crisis
Care Management
Molina Healthcare
Hearing
Molina Healthcare
Pharmacy
CVS Caremark
Non-Emergency Transportation
MTM
Vision
March Vision
Advanced Imaging
Molina Healthcare
Disease Management
Molina Healthcare
Therapy, OT, PT, Speech
Molina
UnitedHealthcare
Behavioral Health
UBH – Optum Healthcare
Dental
Skygen
DME
UnitedHealthcare
Nurse Line
Care Management
Optum Healthcare
Hearing
UnitedHealthcare
Pharmacy
Optum Rx
Non-Emergency Transportation
MTM
Vision
March Vision
Advanced Imaging
EviCore
Disease Management
UnitedHealthcare
Therapy, OT, PT, Speech
UHC

Medicaid Fee For Service Enrollment Statistics

Medicaid Enrollment

- Total Children - 429,164 (Medicaid and CHIP)
- Total Adults - 371,375

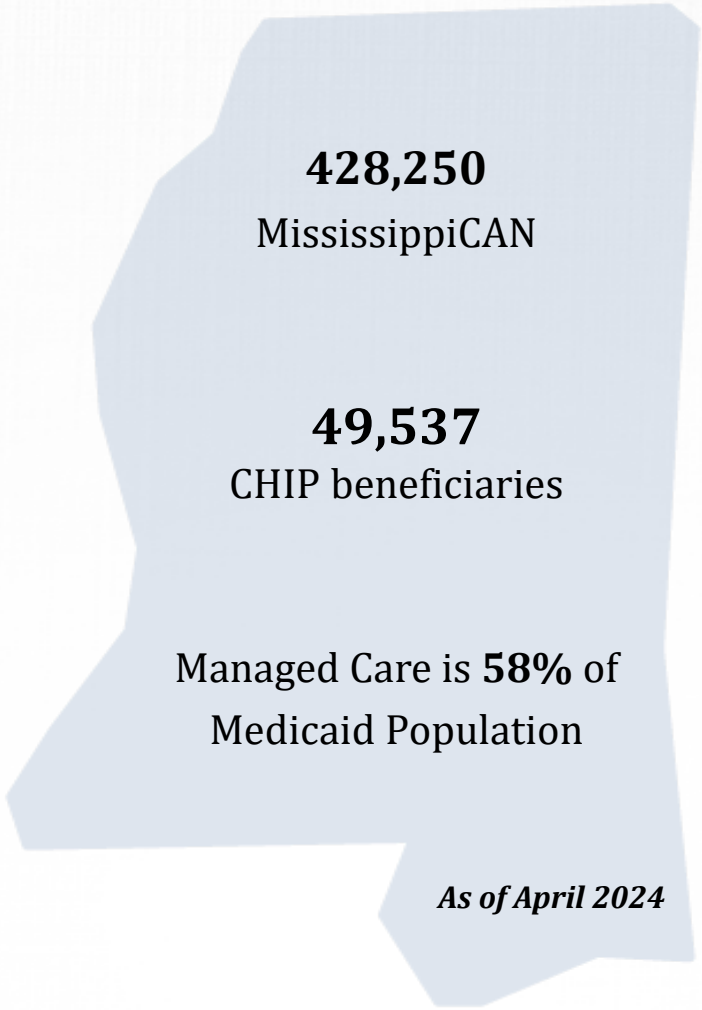
Total Enrollment - 800,539 (includes Medicaid and CHIP)

Medicaid Beneficiaries

- 381,494 - below age 19
- 371,375 - 19 and above in age

Medicaid Beneficiaries – 752,869 (excluding CHIP)

MississippiCAN and CHIP Enrollment Statistics



428,250
MississippiCAN

49,537
CHIP beneficiaries

Managed Care is **58%** of Medicaid Population

As of April 2024

Managed Care Eligibility

Category of Eligibility	Age	Population
SSI – Supplemental Security Income	19 – 65	Mandatory
SSI – Supplemental Security Income	0-19	Optional
DCLH Disabled Child Living at Home	0-19	Optional
CPS – Foster Care Children IV-E	0-19	Optional
CPS – Foster Care Children CWS	0-19	Optional
Working Disabled	19 – 65	Mandatory
Breast and Cervical Cancer	19 – 65	Mandatory
Parent and Care Takers (TANF)	19 – 16	Mandatory
Pregnant Women	8 - 65	Mandatory
Newborns	0 - 1	Mandatory
Children	1 - 19	Mandatory
CHIP	0 - 19	Mandatory

MississippiCAN Enrollment

Mandatory Population:

- Beneficiaries in the mandatory population **are required** to enroll in the program.
- Beneficiaries are encouraged to check with their doctor to see which plan they accept. Then the beneficiary's selection is made on the back of the enrollment letter of the CCO of his/her choice.
- If DOM **does not receive the enrollment form** within 30 days of the member's enrollment, a CCO will be picked for them. Beneficiaries will have 90 days from the initial enrollment date into MSCAN, to switch CCOs.
- After 90 days, they will be locked into the program and will not be able to change from CCOs or "opt-out", except during the annual open enrollment.

MississippiCAN Enrollment

Optional Population:

- Beneficiaries in the optional population **do not have to join** the MississippiCAN program. They may choose to keep regular Medicaid.
- Beneficiaries that do not want to join, they must put a **check mark by "Opt Out"** on the form on the back of their letter.
- If DOM does not receive an enrollment form in **30 days selecting a choice**, a CCO will be picked for them.
- Beneficiaries will have **90 days to pick a different CCO or to "opt out"** of the program.
- After the **90 days they will be locked** into the program and will not be eligible to change from CCOs or "opt out" except during annual open enrollment.

Open Enrollment
MississippiCAN & CHIP

- MississippiCAN and CHIP Open enrollment is available to members annually from October 1 to December 15. Members may choose 1 of 3 CCOs.

- Beneficiaries can only switch once. DOM will only acknowledge the first open enrollment form submitted.

- Members can only change health plans during their initial 90-day window or during open enrollment.

- If a Medicaid beneficiary is at your office requesting to change or needing an enrollment form, direct them to Office of Coordinated Care:

Toll Free: 1-800-421-2408
Local: 601-359-3789

Member Recertification and How it Effects Eligibility

- Mississippi Medicaid Members **are required to respond to recertification** and redetermination requests from DOM annually to ensure continued Medicaid coverage for health services.

- Mississippi Medicaid Members **are required to provide updated address information**, as well as demographic, household, and income changes to the DOM.

- This is to ensure that accurate information is on file, and notices are mailed to correct member address.

- If a member does not complete their recertification this will lead to the member losing Medicaid eligibility and their managed care CCO plan.

How Can a Members Plan Change?

- If a member loses Medicaid coverage, then they will also lose MississippiCAN coverage.
  - If a beneficiary has a temporary **loss of eligibility <u>of less than 60 days</u>**, then DOM will automatically re-assign the member back to the CCO they were previously assigned to.
  - If a beneficiary has a temporary **loss of eligibility of <u>more than 60 days</u>**, then DOM will not automatically re-assign the beneficiary to the CCO they were previously assigned to.
    - The beneficiary will be sent a new enrollment form to select a CCO. The beneficiary will may or may not choose to select the CCO they were previously with.
  - Each managed care member/beneficiary has 90 days to make a change from their initial enrollment.
- Providers are required to **verify member eligibility** at the time of service and verify payer because members may be terminated or retroactively enrolled.

Services covered by the Health Plan

The health plans will pay for the following:

All services currently covered by Medicaid are included but the limits may be different for some services.

- Physician Office Visits (more than what Medicaid provides)
- Durable Medical Equipment (DME)
- Vision (more than what Medicaid provides)
- Dental (limited over 21)
- Therapy Services
- Hospice Services
- Pharmacy Services
- Mental Health Services
- Outpatient hospital services (Chemotherapy, ER visits, x-rays, etc.)

All MississippiCAN beneficiaries must always present your new health plan card and your Blue Medicaid card for all health plan services.

Beneficiaries Not Eligible for MississippiCAN

Not Eligible for MSCAN
Dual Eligible (Medicare/Medicaid)
Waiver Program Enrollees (ex. HCBS, TBI, IL, etc.)
Institutionalized Residents (ex. Nursing Facility, ICF-MR, Correctional Facilities)
American Indians (They may choose to opt into the program)

Pregnant Women

As of April 2023, **pregnant women receive benefits twelve months** postpartum.

Any child born to a Medicaid eligible mother will automatically receive benefits for one subsequent year.

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

- **Deemed Newborns -** Retroactively enroll newborn to the first of the month in which Medicaid at the time of birth.

- **Non-Deemed Newborns –** Newborns whose mothers are not enrolled in Medicaid, may be retroactively enrolled up to 3 months from date of application.

Public Health Emergency

Medicaid Continuous Coverage and Enrollment

Near the start of the COVID-19 pandemic, Congress enacted a federal requirement that states continue to cover every person who became eligible for Medicaid on or after March 18, 2020, until the federal public health emergency (PHE) ended, even if the person's income or other circumstances changed. This requirement became known as the continuous coverage or continuous enrollment condition.

Medicaid members remained enrolled during the PHE, and were not terminated from coverage, even though no longer qualified.

Medicaid members could only be disenrolled from Medicaid for the following reasons:

- Death,
- Moved Out of State, or
- Member asked to be removed from Medicaid.

May 11, 2023 - The federal government declared under the Public Health Service (PHS) Act to end the PHE on this date, May 11, 2023.

Member Rights and Responsibilities

Member Payments

- As of May 1, 2023, Medicaid FFS members are not required to pay a co-pay to providers. **MississippiCAN members are also not required to pay a co-pay for covered services.** DOM encourages the member to contact their CCO for further assistance.

- If a member receives an **outstanding bill for covered services**, DOM encourages the member to contact the provider to verify whether claims were filed correctly. If not, member must contact CCO or Division of Medicaid for assistance.

- The **member cannot be balance billed for any covered charges,** 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.

Please refer to DOM Administrative Code, General Provider Information. Rule 3.8

Charges Not Beneficiary's Responsibility states:

> *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.*

Managed Care Member Services

Prior Authorizations

- **Service authorization requests** are submitted by providers to CCOs for approval of services ordered for members.
- CCOs must respond to requests with an approval or denial within 3 business days, and respond to expedited authorization requests within 1 business day.
- CCOs cannot require authorizations for emergent care. CCOs may process Retroactive Eligibility Reviews and Retrospective Inpatient Hospital Reviews.
- CCO prior authorization policies cannot be more stringent than DOM authorization policies.

MississippiCAN Provider Enrollment

Difference between Credentialing and Contracting

Credentialing

Credentialing is the process of review and verification of the information of a health care provider who is interested in participating with a managed care organization.

- Review and verification includes: current professional license(s), current DEA certificates, verification of education, post-graduate training, hospital staff privileges and levels of liability insurance.
- Delegated Credentialing Providers include large health systems, who contract with DOM and managed care organizations to perform credentialing for their providers. These Delegated Credentialing Providers are audited annually by the managed care organizations.

Contracting

A managed care contract is an agreement between a healthcare professional and a managed care organization that defines the relationship (both financially and care-wise).

- Healthcare professionals contracting include, individual practitioners, private practices, FQHCs, RHCs, Hospitals, and individual practitioners.
- The Mississippi CCOs primarily contract with groups and facilities, and require

Medicaid Member Cards

New Blue Medicaid ID Card

New Yellow Family Planning Waiver ID Card

Identifying MississippiCAN Member Cards

magnolia health

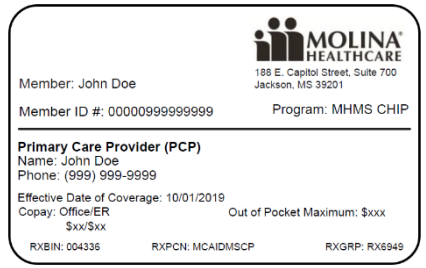
MOLINA HEALTHCARE

UnitedHealthcare®

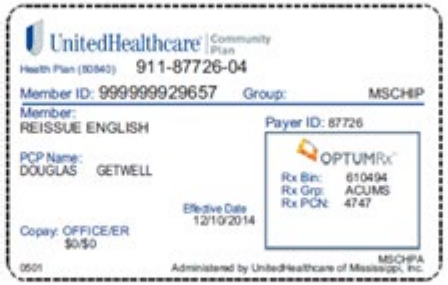
Note: Providers are required to check eligibility for each date of service. DOM encourages all beneficiaries to present their blue Medicaid card and CCO card.

Identifying CHIP Member Cards

MOLINA HEALTHCARE



UnitedHealthcare®



Note: Providers are required to check eligibility for each date of service. DOM encourages all beneficiaries to present their blue Medicaid card and CCO card.

DOM Spring Provider Workshops

2024

Contact Us

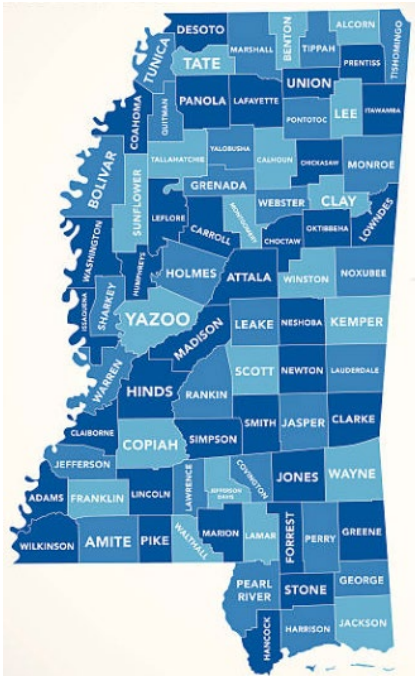
Education Manager – Primary Point of Contact
Katrina Merriwether

Website: https://msmedicaid.telligen.com/

Mississippi Call Center & Provider Help Desk
- Email: msmedicaidum@telligen.com
- Toll-Free Phone: 855-625-7709
- Fax: 800-524-5710

Mailing Address:
715 South Pear Orchard Rd, Suite 400
Ridgeland, MS 39157

Assistant Program Manager
AJae Devine



Prior Authorization and Retrospective Review Process

Prospective Review - Includes the review of medical necessity for the performance of services or scheduled procedures before the service is rendered or before admission. Also referred to as prior authorization or precertification

Concurrent Review - Includes a review of medical necessity decisions made while the patient is currently in an acute or post-acute setting or when an episode of care needs to continue beyond the initial authorization period. Also referred to as a continued stay review or continuing authorizations, which may include Member authorizations obtained from a Coordinated Care Organization (CCO).

Retrospective Review - Reserved for medical emergent conditions or situations where the provider has insufficient information required to submit a prospective review. Retrospective reviews shall include review of service documentation to confirm medical emergent condition or situation along with medical necessity

Reviews related to Retroactive Eligibility - Includes a review for a beneficiary that was not eligible for Medicaid benefits at the time of service in which the authorization request is submitted within ninety (90) days of the system add date of the eligibility determination, in accordance with Administrative Code Part 200, Rule 3.3.

Overview

To verify if the service being rendered requires prior authorization, please consult the MS Prior Authorization list available at the following link: https://msmedicaid.telligen.com/

Telligen complies with the guidance listed in the Mississippi Medicaid Administrative Code. https://medicaid.ms.gov/providers/administrative-code/

Prior authorizations for members enrolled in MississippiCAN and CHIP will continue to be handled by the respective coordinated care organization. If we receive an authorization request for a MississippiCAN or CHIP member, providers will receive a decision of Outcome Not Rendered. The authorization will then need to be submitted to the respective coordinated care organization.

Important: Prior Authorization is not a guarantee of payment for services. Payment is made in accordance with a determination of the member's eligibility, benefit limitation/exclusions, evidence of medical necessity and other applicable standards during the claim review process.

Authorization Processing Timelines

Review Processing Times for Medical Services			
	Review Type Time Standard (based on business days)		
General Services	**Prospective**	**Concurrent**	**Retrospective**
Inpatient Hospital Medical/Surgical	1	1	20
Outpatient Services and Surgical Procedures	2	N/A	10
Organ Transplant Services	3	3	10
Hospice Services	3	3	N/A
Durable Medical Equipment, Appliances, Medical Supplies, and Orthotics and Prosthetics	2	N/A	10
Vision Services	2	N/A	10
Hearing Services	2	N/A	10
Outpatient Physical Therapy, Occupational Therapy and Speech Therapy	2	2	10
EPSDT	2	N/A	10
Expanded Physician Services/Office Visits	2	N/A	10
Expanded Home Health Services	2	2	10
Private Duty Nursing	3	10	10
Prescribed Pediatric Extended Care	3	10	10
Physician Administered Drugs and Implantable Drug System Devices	2	N/A	10
Molecular (Genetic) Testing	3	N/A	10
Continuous Glucose Monitoring Service and Remote Patient Monitoring Services	3	N/A	10
Diabetes Self-Management Training	3	N/A	10
Cardiac Rehabilitation Services	3	N/A	10
Non-Emergency Outpatient Advanced Imaging Services	2	N/A	5
Innovative Programs, Services, or Items	3	N/A	10

Review Processing Times for Behavioral Health Medical Services			
General Services	**Prospective**	**Concurrent**	**Retrospective**
Inpatient Psychiatric	1	1	10
Hospital Outpatient Mental Health	2	2	10
Community Mental Health and Substance Use Disorder Services *(Crisis Residential)	3 * (Crisis Residential:1)	2	10
Psychiatric Residential Treatment Facility Services	3	2	10
Autism Spectrum Disorder Services	3	2	10
Opioid Treatment Program Services	3	2	10

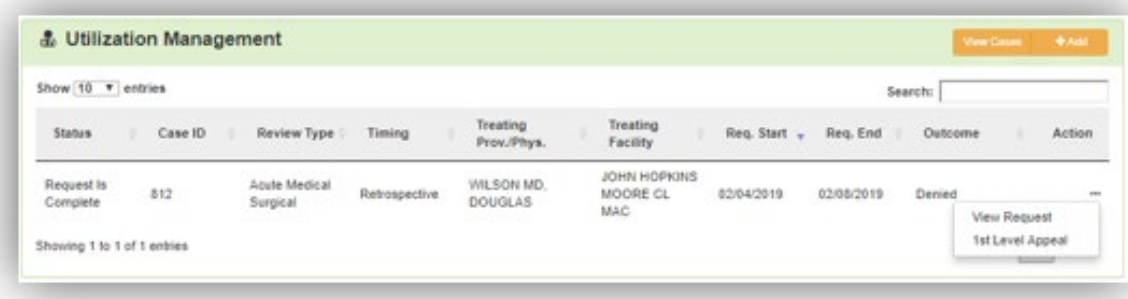
Review Processing Times for Dental Services			
General Services	**Prospective**	**Concurrent**	**Retrospective**
General Dental	7	NA	10
Dental Surgery	7	NA	10
Orthodontia	7	NA	10

Turn Around Times Based on Receipt of Requested and/or Necessary Information

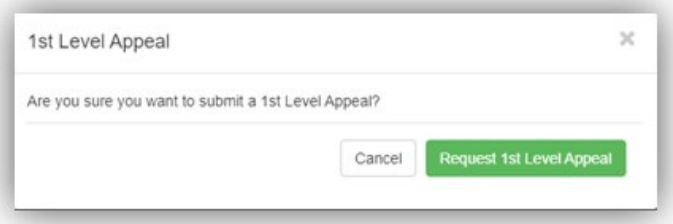
Reconsiderations: 1st Level Appeal & Peer-to-Peer Review

Reconsideration: When a prospective, concurrent or retrospective review has an initial determination of denied or partially denied, the provider can submit a request for a 1st Level Appeal (Reconsideration).

Submitting a Reconsideration (1st Level Appeal) To submit a reconsideration for a denied review: 1. Go to **the UM Panel** in the member hub 2. Click on the blue ellipsis within the denied case to open the action menu 3. Once there, select **1st Level Appeal** from the menu. 4. Follow the system prompts to complete.



Peer to Peer Review: If the reconsideration determination was upheld or any portion was not approved as requested, the provider can request a Peer to Peer Review. A second physician not involved in the initial decision reviews the reconsideration request, the original information, and any additional information submitted. The provider will have 30 calendar days from the date and time of the initial determination being rendered to submit the request.



Submitting a Peer to Peer: 1. Go to the UM Panel in the member hub 2. Click on the denied review 3. Click on the blue ellipsis within the denied case to open the action menu. 4. Once there, select Peer to Peer from the menu. 4. Follow the system prompts to complete. 5. If the provider desires to request a peer-to-peer via phone, they need to call Customer Service at 1-855-625-7709. They will need the case or member ID when they call in and the customer service rep will be able to create the task in the system. A representative will contact the requesting provider with scheduling details within five business days of making the request.

Written notification will be provided of reconsideration determinations within 10 business days of receipt of the request for a standard reconsideration.

Prior Authorization Types – Requirements and Documentation

Telligen®

Inpatient

- Inpatient Medical-Surgical
- Inpatient Psychiatric
- Crisis Residential
- PRTF

- Emergent admissions and urgent admissions must be authorized on the next working day after admission.
- Inpatient hospital stays that exceed the DRG Long Stay Threshold (19 days) require a continued stay/concurrent review for the additional inpatient days that exceed the threshold.

DOCUMENTATION

Prospective/Concurrent
- Emergency room notes and/or admission assessment
- Physician orders

Continued Stay Reviews
- Dates of service
- Comprehensive History and Physical Exam
- Diagnoses
- Diagnostic studies and results
- Documentation of any consults
- Medication listing including route, dose frequency and indication
- Discharge planning and instructions

Outpatient

- Medical Services
- Advanced Imaging
- Surgical procedures

DOCUMENTATION

- Results of recent clinical evaluation
- Diagnosis or clinical condition which the imaging eval is being ordered
- Treatment history related to the stated diagnosis or clinical condition
- Treatment plan related to the stated diagnosis or clinical condition

- Previous imaging results related to the stated diagnosis or clinical

- All documentation must include 2 patient identifiers

For example – patient name and Medicaid ID number or patient name and date of birth (DOB).

Newborns

DOCUMENTATION

Report all admissions for deliveries to DOM and Telligen via the Newborn Enrollment form.

A prior authorization is required for maternal–infant admissions when:
- **obstetrical deliveries:** vaginal deliveries with a length of stay of three (3) or more days cesarean deliveries with a length of stay of five (5) or more days

- **sick newborns with a length of stay six (6) or more days**

Obstetrical deliveries and sick newborn stays that exceed nineteen (19) days require a continued stay/concurrent review.

Physician Administered Drugs (PAD)

DOCUMENTATION

Patient Demographics
- History and Physical
- Diagnostic studies and results
- Treatment plan
- Any medications that have already been tried and documentation of why it was ineffective, if applicable
- All documentation must be dated and signed (electronic signatures are accepted).
- All documentation must include 2 patient identifiers
- For example – patient name and Medicaid ID number or patient name and date of birth (DOB).

Therapy

Prior Authorization for outpatient therapy services is only required for certain codes when the services fall into one of the following categories:

1. Therapy services are provided in an individual therapist office or in a therapy clinic.
2. Therapy services are provided in outpatient departments of hospitals.
3. Therapy services are provided in physician offices/clinics.
4. Therapy services are provided in nursing facilities.
5. Therapy services covered under regular benefits and provided to beneficiaries also enrolled in Home and Community-Based Services (HCBS) waiver programs

- ID/DD Waiver: All therapy requests would require a PA. Exceptions: For persons over the age of 21 who receive therapy in their home. Therapy services should only be provided in the beneficiary's home when the beneficiary is home bound or there is a medical reason that services cannot be rendered in a provider's office, clinic, or hospital setting

1. Therapy services provided to beneficiaries covered by Medicare and Medicaid, if the Medicare benefits have exhausted
2. Therapy services billed by school providers

DOCUMENTATION
- Certificate of Medical Necessity
- Plan of Care
- Documented face-to-face encounter
- Copy of the Initial or Re-evaluation
- Progress notes which include treatment modalities and progress towards goals
- Discharge summary, if applicable Each discipline requires a separate request.
- All documentation must include 2 patient identifiers

Dental

DOCUMENTATION
- Date of service
- History taken on initial visit
- Chief complaint on each visit
- Test, radiographs and results must have the beneficiary's name, the date, must be legible, and must be maintained on file with the beneficiary's dental records.
- Diagnosis
- Treatment, including prescriptions
- Signature or initials of dentist after each visit
- Copies of hospital and/or emergency room records if available
- Orthodontic criteria checklist, if applicable
- Dental Scoring tool, if applicable.

***All forms can be found on the provider website: https://msmedicaid.telligen.com/*

Prior Authorization Types – Requirements and Documentation

Hospice	Behavioral Health	DME	Other Services
DOCUMENTATION ▪ Signed notice of election ▪ Signed Physician Certification/Recertification of Terminal Illness ▪ Clinical/medical information supporting the terminal diagnosis ▪ Physician orders ▪ Current medication list ▪ Hospice provider plan of care ▪ Election forms and supporting documentation must be submitted within five (5) calendar days of a beneficiary's admission to hospice. ▪ Discharge notices should be submitted within five (5) calendar days after the effective date of discharge. ▪ All forms can be found on the provider website at: https://msmedicaid.telligen.com/ ▪ All documentation must be dated and signed (electronic signatures are accepted). ▪ All documentation must include 2 patient identifiers For example – patient name and Medicaid ID number or patient name and date of birth (DOB). ▪ Additional documentation requested by Telligen that is not received timely will result in the effective date beginning when completed, required documentation is received.	**DOCUMENTATION** ▪ A signed and dated treatment plan ▪ Initial evaluation ▪ Goals ▪ 3-5 Progress notes for a continued stay review ▪ All progress notes for a retrospective review ▪ Progress notes must include therapeutic interventions and documented progress or lack of progress towards goals. ▪ All documentation must be dated and signed (electronic signatures are accepted). ▪ All documentation must include 2 patient identifiers **Wraparound**: **Prospective/Concurrent** ▪ An initial generic treatment plan with goals should be provided prior to service provision. **Continued Stay Requests** • The Wraproud Plan - a treatment plan tailored specifically to the child/youth and family.	**DOCUMENTATION** ▪ Documentation of a Face-to-Face Encounter ▪ A copy of the completed Certificate of Medical Necessity & Plan of care for each item ▪ A copy of the original signed prescription for each item ▪ Copies of any specialized documentation, such as: An environmental assessment, if needed Teaching, training or instruction given to beneficiary/caregiver & their response ▪ Records of any maintenance supplies delivered and/or used ▪ Documentation that the beneficiary's need for the DME is reviewed annually by a Medicaid enrolled physician ▪ *All documentation must include 2 patient identifiers (Medicaid ID and DOB)	**DOCUMENTATION** ▪ Vision (Date of service ▪ Medical history ▪ Examination and/or treatment ▪ All diagnostic studies and results ▪ Prescriptions must include lens specifications such as power, size, curvature, flexibility, and gas permeability for contact lenses ▪ Contact lenses request must reflect why eyeglasses are not an acceptable method of correction ▪ Orders for lens coating must include appropriate diagnosis and/or narrative diagnosis) ▪ Hearing ▪ Molecular (Genetic) Testing (An overview of the medical condition and medical history of any conditions caused or aggravated by the condition ,Detailed discussion of how the results could have a direct and significant impact on patient's care going forward, A description of the procedure being requested including any plan to perform the procedure if it requires a staged process, Clinical documentation to support the medical necessity of service(s), Appropriate diagnosis code for service(s) requested, Detailed discussion of genetic counseling provided to the patient/family, Proof of completion of conventional diagnostic studies, Has there been prior genetic testing, Did the patient give informed consent) ▪ Continuous Glucose Monitoring Service and Remote Patient Monitoring Services ▪ Diabetes Self-Management Training ▪ Cardiac Rehabilitation Services ▪ Innovative programs, Services, or Items ▪ EPSDT ▪ Expanded Physician Services/Office Visits ▪ Expanded Home Health Services ▪ Private Duty Nursing ▪ Prescribed Pediatric Extended Care ▪ Organ Transplant

Prior Authorization

Medical

- **Phone:** 866–604–3267
- **Fax:** 888–310–6858
- **Online:** UHCprovider.com/Prior Auth & Notification
- **PA Form:** UHCprovider.com/Provider Forms

Behavioral/Therapy Services

- **Phone:** 877–743–8734
- **Online:** providerexpress.com/BehavioralHealthPA

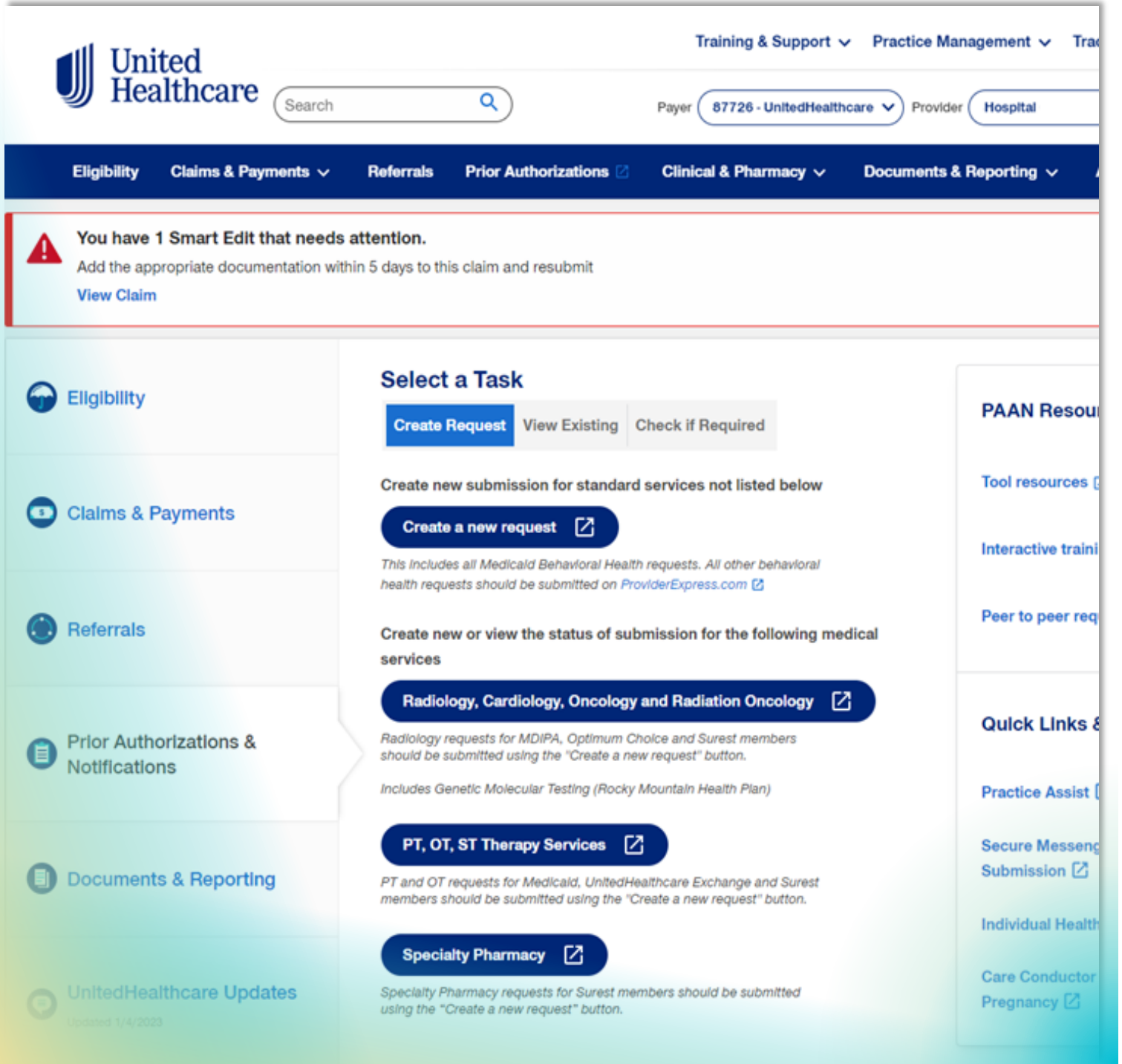
Dental

- **Phone:** 800–508–4862
- **Online:** uhcdentalprovider.com

Pharmacy

- **Phone Gainwell:** 833–660–2402
- **Fax:** 866–644–6147
- **Online:** Pharmacy Prior Authorization - Mississippi Division of Medicaid (ms.gov)

PAAN Tool



Prior Authorizations/Notifications

Benefits and Features

- Determine if notification or prior authorization is required
- Submit a new request
- Check the status or update a request
- Upload clinical notes or attach medical records
- Provide pertinent clinical information
- And more

Retrospective Review

Online: UHCprovider.com

Phone: 866–604–3267

Fax: 888–310–6858

Newborn Authorization

Newborn Authorization

- 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.
- Newborn Notification is required within **one (1) business day** for NICU admissions, if mother is covered by UHC MSCAN
  - **Online:** UHCprovider.com/PriorAuthorization&Notifications
  - **Phone:** 866-604-3267
  - **Fax:** 888-310-6858

Appeals

Claim Number: 012101210 J Smith • Member ID: 987987987 • Patient Account Number: 00070007RRU

Flag Claim | New Search

Current Claim Status: Finalized • First Date of Service: 06/09/2020 • Total Billed: $4,962.50

Adjudication Status: In-Network

Patient & Provider Details | Claim Details | Line Items | Payments | Related Documents | Act on Claim

View Patient's Eligibility & Benefits ›

Related Documents

Letters

There are no letters associated with the claim at this time.

Note: Letters are displayed for UnitedHealthcare commercial and Medicare Advantage claims only.

Remittance Advice Documents

07/02/2020

Act on Claim

Corrected Claim

This is not available for this claim.

Submit Corrected Claim

Claim Reconsideration

When should you submit a claim reconsideration request?

Create Claim Reconsideration

File Appeal/Dispute

When should you submit an Appeal/Dispute?

File Appeal/Dispute

Contact Us

Medical, Behavioral/Therapy

- **Phone:** 800–557–9933
- **Fax:** 801– 994–1082
- **Mailing Address:**
  UnitedHealthcare Community Plan
  ATTN: Appeals
  P.O. Box 31364
  Salt Lake City, UT 84131–0364

Dental

- **Phone:** 800–508–4862
- **Mailing Address:**
  UnitedHealthcare
  P.O. Box 1391
  Milwaukee, WI 53201

Vision

- **Phone:** 844–606–2724
- **Online:** forms.marchvisioncare.com
- **Mailing Address:**
  UnitedHealthcare | March Vision Care
  ATTN: Medicaid Vision Appeals
  P.O. Box 30988
  Salt Lake City, UT 84130

Peer to Peer

United Healthcare Peer-to-Peer Scheduling Request Form

What to know before making your request

Estimated time to complete:

Peer-to-Peer Scheduling Request Form

5-10 minutes

- Peer to peer requests can only be made prior to submitting an appeal. Don't fill out this form if your appeal has already been initiated.
- If you are submitting on behalf of a physician, please ensure they're willing to speak with the UnitedHealthcare clinical director that reviewed the prior authorization request
    - You will need to provide an actively monitored phone number that will be picked up by a member of your team leading up to and on the designated day and time
    - Please ensure the physician is aware of and available for the peer to peer review during the confirmed day and time

What's needed to request a review

Before beginning a peer to peer request, please have the following information ready:

- Member name and date of birth (DOB)
- Physician phone and email
- Physician availability (dates and times)

Start request

PA – Chat Support

Notification/prior authorization case: A226

Flag case

View and update — Verify — Confirm

Collapse all

A decision has already been rendered on this case, though some updates are permitted as indicated in the enabled fields below. To request an additional service for this member, please submit a new notification/prior authorization request for the member.

Case details

Notification/prior authorization number	Case status	Case status reason	Primary care physician
A226	**Closed**	**Case was managed and is now complete**	**---**

Advance notify date/time

01/24/2024, 2:14 PM CST

Coverage status

Test code	Test code review type	Overall coverage status	Decision date
94372	**Unproven**	**Not Covered/Not Approved**	**01/29/2024**

Procedure code associated with the test

Notification/prior authorization case: A226

Flag case

View and update — Verify — Confirm

A decision has already been rendered on this case, though some updates are permitted as indicated in the enabled fields below. To request an service for this member, please submit a new notification/prior authorization request for the member.

Case details

Notification/prior authorization number	Case status	Case status reason	Primary care physician
A226	**Closed**	**Case was managed and is now complete**	**—**

Advance notify date/time

01/24/2024, 2:14 PM CST

A

Coverage status

Test code	Test code review type	Overall coverage status	Decision date
94372	**Unproven**	**Not Covered/Not Approved**	**01/29/2024**

Procedure code associated with the test

Back to top

Cancel

Request case cancellation

C

Message us

Today

HI, I'm your United Healthcare virtual assistant.

To get started please select the topic you need help with.

Claims | Benefits & Eligibility | Prior Authorization | Portal Tech Support | Provider Onboarding

B

Type your message

Feedback

magnolia health™

2024 Division of Medicaid
Provider Workshops

Prior Authorizations

"Transforming the health of the community one person at a time."

4/24/2024

Standard prior authorization requests should be submitted for medical necessity review at least five **(5)** business days before the scheduled service delivery date or as soon as the need for service is identified.

Prior Authorization Form(s) can be located on our website at:
http://www.magnoliahealthplan.com/for-providers/provider-resources/

Authorization requests should include all necessary clinical information. Urgent requests for prior authorization should be called in as soon as the need is identified.

Medical

Authorizations can be submitted the following ways:

Inpatient Fax: 1-877-291-8059

Outpatient Fax: 1-877-650-6943

Secure Web Portal: www.provider.magnoliahealthplan.com

Phone: 1-866-912-6285

Email: magnoliaauths@centene.com

Behavioral Health

Authorizations can be submitted the following ways:

BH Inpatient and Outpatient Fax:1.866.694.3649

Secure Web Portal: www.magnoliahealthplan.com

Phone:

BH Outpatient: 1.866.912.6285

BH Inpatient: 1.800.864.1459

Email: AUGMississippium@cenpatico.com

Click on the link to use our **Prior Authorization Prescreen tool**. This tool will inform you if services require an authorization.

Inpatient Hospital Services

Inpatient

All hospital inpatient stays require notification within one **(1)** business day following the admission.
Facilities are required to submit a request for authorization within two **(2)** business days following the date of inpatient admissions that are not elective.
Please initiate the authorization process at least five **(5)** calendar days in advance for elective inpatient services.

Determination Timeframes

Standard pre-service *inpatient* review decisions and notifications occur within **24** hours or **1** business day IF all necessary information is received with the request.

Urgent pre-service review decisions and notifications occur within **24** hours IF all necessary information is received with the request.

If additional information is needed to make a determination, the above timeframes may be extended.

Emergency Services

Prior Authorization is NOT required for emergent services.

If these services result in an inpatient admission, Magnolia must be notified within one **(1)** business day and authorization must be requested within two **(2)** business days of admission as previously noted.

Discharge Planning

Concurrent review staff will work closely with hospital staff to ensure a comprehensive discharge plan is developed and in place prior to discharge.

For members in Care Management, the Concurrent Review Nurse or designated staff will engage the member's Care Manager to ensure appropriate discharge planning and follow-up.

Post Service Review - Requests for post service review will only be considered when prior authorization was not obtained due to extenuating circumstances such as retro active eligibility or natural disasters.

Post service review decisions and notifications occur within **20** business days from the receipt of the request.

Concurrent Review - Concurrent review decisions and notifications occur within **24** hours of the next review date. The next review date is communicated via the notification of approval letter.

Coordination of Benefits - In the event a member is transferring to Magnolia from another payer, Magnolia shall be responsible for the costs of continuation of medically necessary services.

Magnolia will honor authorizations from Medicaid and MSCAN CCO's. Please submit a copy of the approval with the request for authorization to Magnolia.

Outpatient

Prior to rendering services, check our Pre-Auth Tool at www.magnoliahealthplan.com to verify if prior-authorization is required for the service being performed.

Please initiate the Authorization process at least five **(5)** calendar days in advance for non-emergent outpatient services.

Determination Timeframes

- Standard pre-service *outpatient* review decisions and notifications occur within **2** business days or **3** calendar days IF all necessary information is received with the request.
- Urgent pre-service review decisions and notifications occur within **24** hours IF all necessary information is received with the request.
- If additional information is needed to make a determination, the above timeframes may be extended.

Emergency Services

- Prior Authorization is NOT required for emergent services.
- If these services result in an inpatient admission, Magnolia must be notified within one **(1)** business day and authorization must be requested within two **(2)** business days of admission as previously noted.

Discharge Planning

- Concurrent review staff will work closely with hospital staff to ensure a comprehensive discharge plan is developed and in place prior to discharge.
- For members in Care Management, the Concurrent Review Nurse or designated staff will engage the member's Care Manager to ensure appropriate discharge planning and follow-up.

Prior to rendering services, check our Pre-Auth Tool at www.magnoliahealthplan.com to verify if prior-authorization is required for the service being performed.

Effective 7/1/2021, routine maternity delivery stays with an admission date of **7/1/2021** or after no longer require an authorization regardless of the DRG on the claim as mandated by the DOM.

Authorizations continue to be required for:

- Maternity delivery stays that exceed the length of stay for the delivery type (3 days for vaginal, 5 days for c-section)
- Elective delivery before 39 weeks gestational age,
- Member requires higher level of care such as ICU.

Providers should wait to file a claim for the above stays until receiving a determination letter.

The Division of Medicaid (DOM) will continue to require providers to submit newborn enrollment forms **5 days of delivery.** Magnolia will continue to review newborn enrollment forms for deliveries that require an authorization, as noted above. If additional information is needed to complete the medical necessity review, we will make outreach.

Please note, Magnolia requires authorizations for scheduled deliveries (inductions of labor or C-sections) prior to 39 weeks gestation in alignment with the Mississippi Division of Medicaid Administrative Code Title 23: Medicaid Part 222 Maternity Services, Chapter 1, Rule 1.1.

Providers can contact the authorization department by contacting Provider Services at 1-866-912-6285
https://www.magnoliahealthplan.com/providers/resources/forms-and-resources.html

Retrospective Reviews

Retrospective review is an initial review of services provided to a member, for which authorization and/or timely notification to Magnolia was not obtained, due to extenuating circumstances related to the member (i.e., member was unconscious at presentation, member did not have their Magnolia ID card or indicate Magnolia coverage, services authorized by another payer who subsequently determined member was not eligible at the time of service, or natural disasters).

Retro authorizations should be requested if any of the qualifiers are met.

Requests can be submitted in the following ways:

Medical:

- Inpatient Fax: 1-877-291-8059
- Outpatient Fax: 1-877-650-6943
- Secure Web Portal: www.provider.magnoliahealthplan.com
- Phone: 1-866-912-6285
- Email: magnoliaauths@centene.com

Behavioral Health:

- BH Outpatient Fax:1.833.840.0479
- BH Inpatient Fax : 1.833.840.0463
- Secure Provider Portal : www.provider.magnoliahealthplan.com
- BH Outpatient: 1.866.912.6285
- BH Inpatient: 1.800.864.1459
- BH Inpatient Email: AUGMississippium@cenpatico.com

A decision will be made within thirty (30) business days following receipt of all necessary information for any qualifying service cases.

If you do not meet the qualifying reasons listed above, the claim dispute process should be followed.

If the member does not agree with the authorization determination, the member or anyone they designate can request an appeal within 60 calendar days from the date on the notification of adverse benefit determination letter.

Appeals for **pre-service** authorization determinations can be submitted by phone or in writing to:

Magnolia Health

Attention: Prior Auth Appeals Coordinator

1020 Highland Colony Pkwy Ridgeland, MS 39157

Phone: 1-866-912-6285/ Fax: 1-877-264-6519

***Post service appeals (If services have already been rendered) should be submitted via the claims reconsideration process and mailed to P.O. Box 3090 Farmington, MO 63640**

Peer to Peer - If the treating practitioner does not agree with the authorization determination, the practitioner may discuss the decision with the Medical Director who rendered the decision by contacting Provider Services. Providers have 14 calendars from the denial date to request a peer to peer.

Contact information:

1-866-912-6285

Request to speak to the UM Department to set up a Peer to Peer

More information can be found in the Magnolia Health provider manual:

https://www.magnoliahealthplan.com/providers/resources.html

 Magnolia will honor authorizations from Medicaid and MSCAN CCO's. Please submit a copy of the approval with the request for authorization to Magnolia.

Pharmacy Prior Authorizations

Express Scripts serves as Magnolia's Pharmacy Benefit Manager (PBM). Certain drugs require prior authorization to be approved for payment by Magnolia. These include:

- **All medications listed as non-preferred on the PDL**
- **Some DOM preferred drugs (designated "prior authorization" on the PDL)**

Pharmacy PA Requests:

1. Providers may submit pharmacy PA requests electronically or by fax.
2. Submit electronic PA requests through the **CoverMyMeds** online portal at https://www.covermymeds.com

Submit PA requests via fax following these steps:

1. Complete the **Magnolia/Centene Pharmacy Services Medication Prior Authorization Request** form, which can be found on the Magnolia Health website at www.magnoliahealthplan.com. Choose "For Providers" → "Pharmacy" → and then select MISSISSIPPICAN (MEDICAID).
2. Fax completed forms to **Centene Pharmacy Services at 1-844-205-3387**.

Once approved, Centene Pharmacy Services notifies the prescriber by fax. If the clinical information provided does not explain the reason for the requested prior authorization medication, Centene Pharmacy Services responds to the prescriber by fax, offering DOM PDL alternatives. For urgent or after-hours requests, a pharmacy can provide up to a seventy-two (72) hour supply of most medications by calling the **Centene Pharmacy Services Pharmacy Help Desk at: 1-833-750-2773** .

Centene Pharmacy Services Contacts:

Prior Authorization Fax: 1-844-205-3387

Prior Authorization Phone: 1-866-399-0928

Pharmacy Help Desk Phone: 1-833-750-2773

Clinical Hours: Monday through Friday, 7:30a.m. - 6:00 p.m. (CST)

Centene Pharmacy Mailing Address

Centene Retail Pharmacy

(Coverage Determination/Prior Authorization)

PO Box 31397

Tampa FL, 33631 – 3397

Envolve Vision- https://visionbenefits.envolvehealth.com

Envolve Dental- https://www.envolvedental.com/

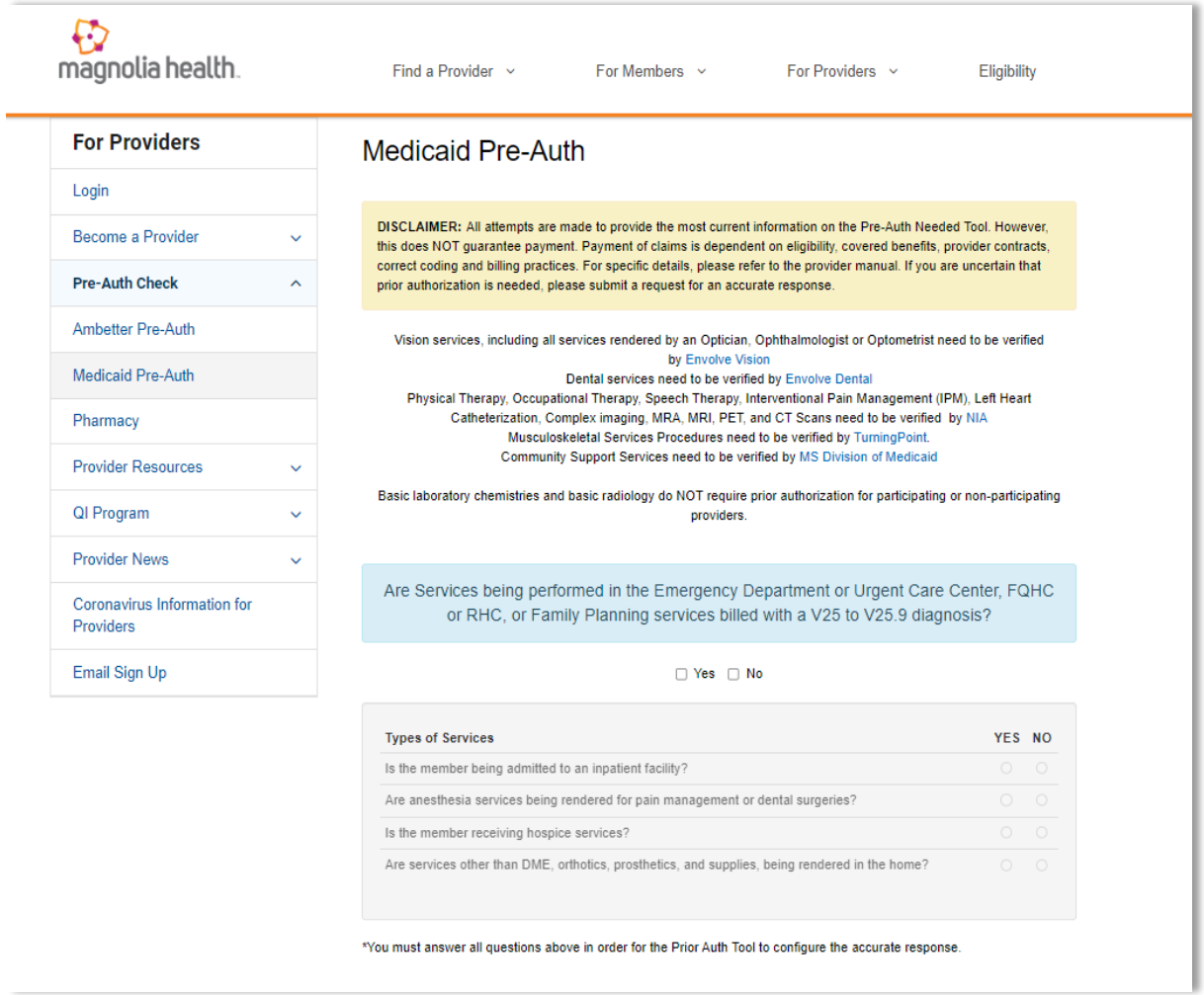
Evolent/National Imaging Associates (NIA)- (866) 912-6285

Online: www.RADMD.com

Physical Therapy, Occupational Therapy, Speech Therapy, Interventional Pain Management (IPM), Left Heart Catheterization, Complex imaging, MRA, MRI, PET, and CT Scans

Turning Point- https://www.myturningpoint-healthcare.com/

Musculoskeletal Services Procedures



Clinical policies are one set of guidelines used to assist in administering health plan benefits, either by prior authorization or payment rules. They include but are not limited to policies relating to evolving medical technologies and procedures, as well as pharmacy policies. Clinical policies help identify whether services are medically necessary based on information found in generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by the policy; and other available clinical information.

Payment policies are guidelines used to assist in administering payment rules based on generally accepted principles of correct coding. They are used to help identify whether health care services are correctly coded for reimbursement. Each payment rule is sourced by a generally accepted coding principle. They include, but are not limited to claims processing guidelines referenced by the Centers for Medicare and Medicaid Services (CMS), Publication 100-04, Claims Processing Manual for physicians/non-physician practitioners, the CMS National Correct Coding Initiative policy manual (procedure-to-procedure coding combination edits and medically unlikely edits), Current Procedural Technology guidance published by the American Medical Association (AMA) for reporting medical procedures and services, health plan clinical policies based on the appropriateness of health care and medical necessity, and at times state-specific claims reimbursement guidance.

Clinical policies can be found on Magnolia Health's website at: https://www.magnoliahealthplan.com/providers/resources/clinical-payment-policies.html

Payment policies can be found on Magnolia Health's website at: https://www.magnoliahealthplan.com/providers/resources/clinical-payment-policies.html

Issue Resolution:

- ✓ To prevent authorization denials, submit all necessary clinical information with the authorization request and/or respond to the Health Plan's outreach attempts for the necessary clinical information in order to make a determination on the authorization request.
- ✓ Prior to rendering services, check our Pre-Auth Tool at www.magnoliahealthplan.com to verify if prior-authorization is required for the service being performed.
- ✓ Please initiate the Authorization process at least five (5) calendar days in advance for non-emergent outpatient services.
- ✓ It is beneficial to send demographic information for the member when requesting a prior authorization request and when sending medical records. This will assist Case Management in prompt care of the member.
- ✓ Benefits of Case Management for the Provider and Member:
  -Reach out to the member within 3 days post-discharge to ensure follow up appointment(s) are made.
  -Ensure the member has medications, address any home health needs, consider the need for critical care management, and provide further member education.
  -Provide additional resources for any social determinants of health.
- ✓ Check Member Eligibility prior to and day of appointment via
  -Secure Provider Portal at: Provider.MagnoliaHealthPlan.com
  - Magnolia Health Provider Services at 866-912-6285
  -Eligibility can also be accessed on: Medicaid Envision web portal https://medicaid.ms.gov/mesa-portal-for-providers/

Prior Authorizations

MOLINA HEALTHCARE

Presented by: Chris Cauthen & Cassandra Herron

Prior Authorizations Referrals

Prior Authorization is a request for prospective review. It is designed to:

- Assist in benefit determination
- Prevent unanticipated denials of coverage
- Create a collaborative approach to determining the appropriate level of care for Members receiving services
- Identify Case Management and Disease Management opportunities
- Improve coordination of care

Referrals

- Made when medically necessary services are beyond the scope of the PCP's practice.
- Most referrals to in-network specialists do not require an authorization from Molina. Information is to be exchanged between the PCP and Specialist to coordinate care of the patient.

MOLINA HEALTHCARE

Prior Authorizations Submissions

Prior Authorization is required for non-covered codes, all elective service/procedure performed in the inpatient setting, some outpatient surgery and identified procedures, elective inpatient admissions to Acute Hospitals, Skilled Nursing Facilities (SNF), or Rehabilitation Facilities, hospice, some durable medical equipment, miscellaneous codes, and Out-of-Network Professional Services.

Molina requires notification of all emergent inpatient admissions within twenty-four (24) hours of admission or by the close of the next business day when emergent admissions occur on weekends or holidays.

- For emergency admissions, notification of the admission shall occur once the patient has been stabilized in the emergency department.

- Notification of admission is required to verify eligibility, authorize care, including level of care (LOC), and initiate inpatient review and discharge planning.

- Emergent inpatient admission services performed without meeting notification and Medical Necessity requirements or failure to include all of the needed documentation to support the need for an inpatient admission will result in a denial of authorization for the inpatient admission.

Requests for services listed on the Molina Healthcare Prior Authorization Online Look-Up Tool and Prior Authorization Guide are evaluated by licensed nurses and clinicians that have the authority to approve services.

MOLINA HEALTHCARE

Request Submissions for MSCAN & CHIP

Web Portal

https://www.availity.com/molinahealthcare

Note: Molina's preferred method for Prior Authorization submission.

Phone: (844)826-4335

Note: For telephonically submitted requests, it may be necessary to submit additional documentation before the authorization can be processed.

Fax

Prior Authorization requests may be faxed to the Healthcare Services Department using the Molina Healthcare Service Request Form which is available on our website at: MolinaHealthcare.com

Prior Authorizations:

Phone: 1 (844) 826-4335

Inpatient Requests Fax: 1 (844) 207-1622

All Non-Inpatient Fax: 1 (844) 207-1620

Behavioral Health Authorizations:

Phone: 1 (844) 826-4335

Inpatient Requests Fax: 1 (844) 207-1622

All Non-Inpatient Fax: 1 (844) 206-4006

Note: Please indicate on the fax if request is non-urgent or expedited/urgent. Please see the MHMS Provider Manual for definition of expedited/urgent.

Mail:

1020 Highland Colony Parkway
Suite 602
Ridgeland, MS 39157

MOLINA HEALTHCARE

Prior Authorization Review Guide - MSCAN & CHIP

MOLINA HEALTHCARE OF MISSISSIPPI MEDICAID
PRIOR AUTHORIZATION/PRE-SERVICE REVIEW GUIDE
EFFECTIVE: 06/01/2021

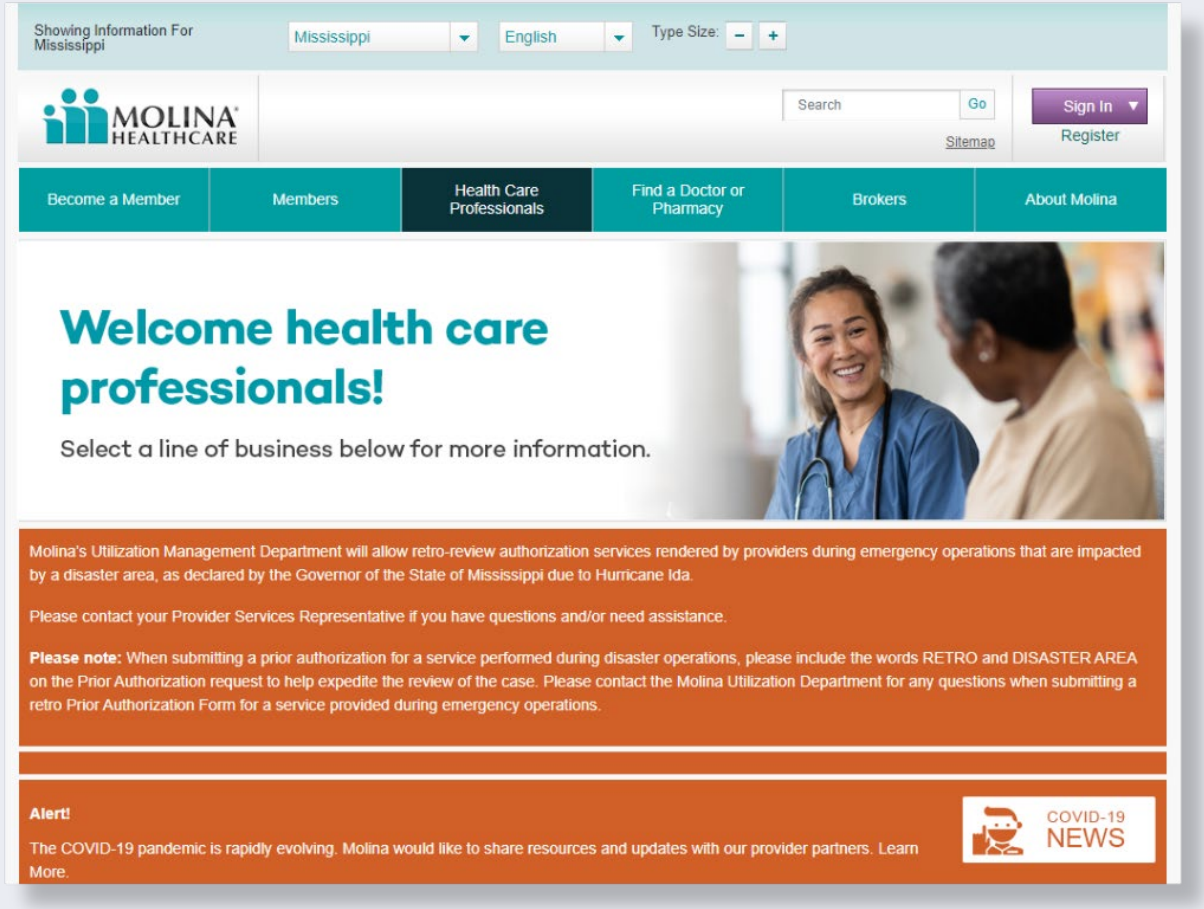
For Access Visit:

https://www.molinamarketplace.com/marketplace/ms/en-us/Providers/~/media/Molina/PublicWebsite/PDF/providers/ms/Marketplace/prior_authorization_request_form_mp.pdf

MOLINA HEALTHCARE

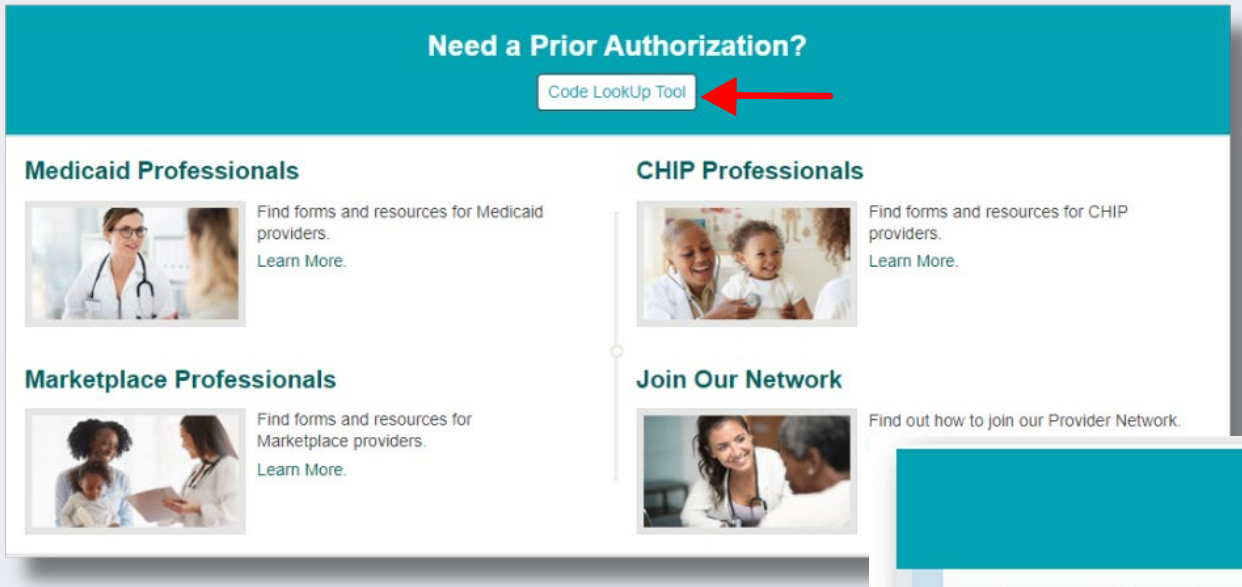
PA Look Up Tool

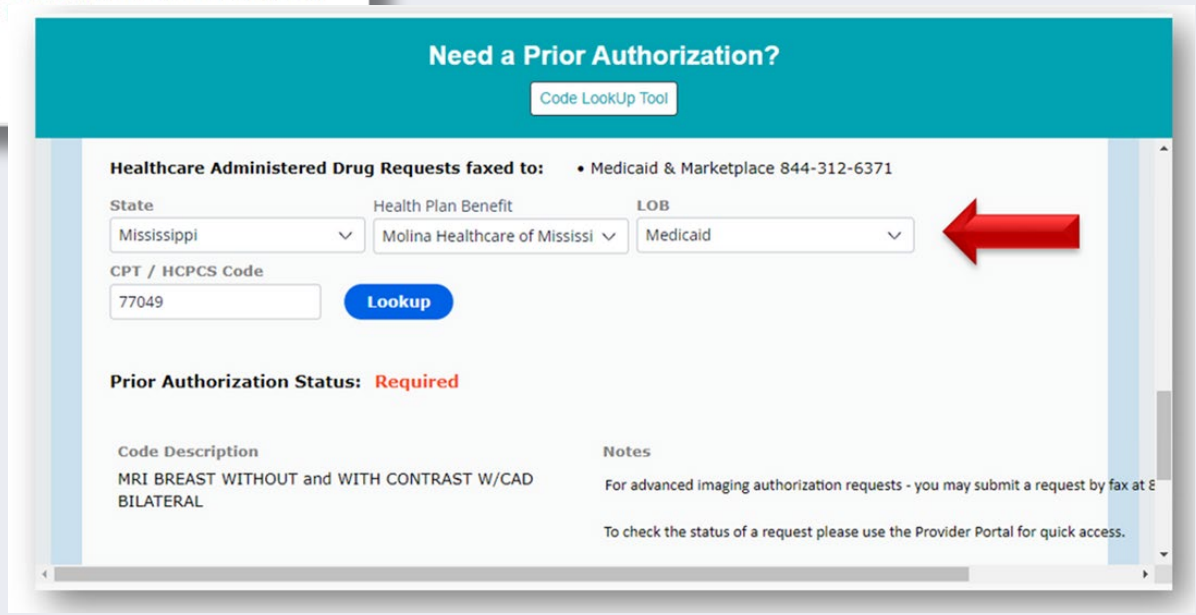
Our Prior Authorization Look Up Tool allows providers to search specific CPT codes to determine if prior authorization is required.



MOLINA HEALTHCARE

PA Look Up Tool





MOLINA HEALTHCARE

Post-Service Review

Post-Service Review applies when a Provider fails to seek authorization from Molina for services that require authorization.

►Failure to obtain authorization for an elective service that requires authorization may result in an administrative denial. Emergent services do not require authorization.

►Post service reviews related to retroactive eligibility (90 days from enrollment completion) are reviewed for medical necessity and will not be denied for failure to obtain prior authorization.

►Coverage of emergent services up to stabilization of the patient will be approved for payment. If the patient is subsequently admitted following emergent care services, authorization is required within one (1) business day or post stabilization stay will be denied.

►Failure to obtain authorization when required will result in denial of payment for those services.

►The only potential exception for payment as a result of post-service review is if information is received indicating the provider did not know nor reasonably could have known that patient was a Molina member or in the case of an error by Molina, a medical necessity review will be performed.

►Decisions, in this circumstance, will be based on the following:

- medical need; and
- appropriateness of care guidelines defined by UM policies and criteria;
- regulation and guidance; and
- evidence based criteria sets.

MOLINA® HEALTHCARE

MCG Criteria

MCG has provided Cite Guideline Transparency tool that allows providers to view all MCG guidelines that Molina currently uses:

With MCG for Cite Guideline Transparency, Molina can share the clinical indications with the providers. The tool operates as a secure extension of Molina's existing MCG investment and helps meet regulations around transparency for care delivery.

By following the instructions located at this link, you will have access to view MCG guidelines via the Legacy Provider Portal:
https://www.molinahealthcare.com/providers/ms/medicaid/comm/-/media/31A167A891774EE79669203E292C8FAD.ashx

By following the instructions located at this link, you will have access to view MCG guidelines via Availty:
https://www.molinahealthcare.com/providers/ms/medicaid/comm/-/media/31A167A891774EE79669203E292C8FAD.ashx

For additional information, please contact your Provider Representative or Molina Provider Contact Center at (844) 826-4335.

MOLINA® HEALTHCARE

Progeny - NICU

Molina Healthcare of Mississippi is happy to announce a partnership with ProgenyHealth, a company which specializes in Neonatal Care Management Services throughout the first year of life. This is an exciting opportunity. ProgenyHealth's care management program will enhance services to our members and support our mission to make a lasting difference in our members' lives by improving their health and well-being.

Under the agreement that began 7/1/2021, ProgenyHealth's Neonatologists, Pediatricians and Neonatal Nurse Care Managers are working closely with Molina Healthcare of Mississippi members, as well as attending physicians and nurses, to promote healthy outcomes for Molina Healthcare of Mississippi premature and medically complex newborns.

The benefits of this partnership to you:

- The support of a team who understands the complexity and stress of managing infants in the NICU and will work with you to achieve the best possible outcomes.
- A collaborative and proactive approach to care management that supports timely and safe discharge to home.
- A company that believes in sharing best practices and works with NICUs nationwide to improve the health outcomes of our next generation.

MOLINA HEALTHCARE

NICU Services - Management and Admissions

For NICU admissions, notification to ProgenyHealth must occur within one (1) business day for all sick newborns requiring inpatient hospitalization. Notification of admission is required to:

- Verify member eligibility;
- Authorize care, including level of care; and
- Initiate inpatient review and discharge planning.

Molina requires that notification includes Member demographic information, facility information, date of admission, requested level of care, and clinical information sufficient to document the Medical Necessity of the admission.

Hospitals are required to notify ProgenyHealth within one (1) business day of any sick newborn admission, regardless of the inpatient setting or length of stay.

All elective and emergent readmissions of members managed by ProgenyHealth that occur within 60 days of the initial discharge will be referred ProgenyHealth for utilization management.

NICU readmissions of members NOT managed by ProgenyHealth during the initial stay that occur within 30 days of the initial discharge will be referred to ProgenyHealth for utilization management and case management.

MOLINA® HEALTHCARE

Progeny - NICU

Your process for notifying Molina Healthcare of Mississippi of infants admitted to a NICU or special care nursery remains the same. Molina Healthcare of Mississippi will notify ProgenyHealth of admissions and their clinical staff will contact your designated staff to perform utilization management and discharge planning throughout the inpatient stay.

To learn more about ProgenyHealth's programs and services, call 1-888-832-2006 or visit progenyhealth.com. You may also call Molina at (844) 826-4335.

MOLINA® HEALTHCARE

Inpatient Services - Review & Status Determinations

- Molina performs ***concurrent reviews*** in order to ensure:
  - Patient safety;
  - Medical Necessity of ongoing inpatient services; and
  - Adequate progress of treatment and development of appropriate discharge plans.

- Performing these functions requires timely clinical information updates from the provider. We will request updated clinical records from the inpatient facility at regular intervals during the member's inpatient admission and ask that updates are provided ***within (1) business day*** of the request to better serve you and our members.

- Molina's Utilization Management staff determines if the collected medical records and requested clinical information are ***"reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of malformed body member"*** by meeting all coverage, coding and Medical Necessity requirements.

MOLINA HEALTHCARE

Prior Authorization - Appeals

Requests for authorization not meeting criteria must be reviewed by a designated Molina Medical Director or other appropriate clinical professional. Only a licensed physician (or pharmacist, psychiatrist, doctoral level clinical psychologist or certified addiction medicine specialist as appropriate) may determine to delay, modify or deny services to a Member for reasons of Medical Necessity.

Board certified licensed Providers from appropriate specialty areas must be utilized to assist in making determinations of Medical Necessity, as appropriate. All utilization decisions must be made in a timely manner to accommodate the clinical urgency of the situation, in accordance with regulatory requirements and NCQA standards.

Providers can contact Molina's Healthcare Services Utilization Management team at (844) 826-4335 to obtain Molina's UM Criteria or may access criteria through MCG Cite Guideline Transparency as discussed earlier in this presentation.

MOLINA® HEALTHCARE

Peer-to-Peer Review Process

- Peer to Peer review of an adverse determination may be requested if the Provider directing the Member's care wishes to provide additional information related to the authorization request.
- The requesting Provider has five (5) business days from the receipt of the denial notification to schedule the review.
- Requests can be made by contacting Molina at: (844) 826-4335

MOLINA HEALTHCARE

Prior Authorization - Appeals

A Provider may file a formal Appeal orally or in writing, requesting Molina to review an Adverse Benefit Determination related to a Provider.

Appeals must be filed within thirty (30) calendar days from the Adverse Benefit Determination or denial. A written acknowledgement letter mut be sent within ten (10) calendar days of receipt of the Appeal. Appeals must be resolved as expeditiously as possible, and no later than thirty (30) calendar days from receipt.

For decisions not resolved wholly in the Provider's favor, ***Providers have the right to request a State Administrative Hearing from the Division of Medicaid.***

MOLINA HEALTHCARE

TOP 5 Reasons for Delay In PA Request

Our #1 Goal is to ensure your PA Request is accurate and returned to your office as soon as possible.

- Incorrect Fax Number on the Submitted PA Request
- Not Enough clinical information to make a medical determination.
- Call to UM department to change dates of service or add CPT codes.
- Unreadable PA request or insufficient information (i.e. NPI #, CPT codes, TIN#)
- Incorrect use of URGENT/STANDARD PA request type.

The lack of critical information can create multiple phone calls or outreach attempts that can cause delays in obtaining a Prior Authorization number.

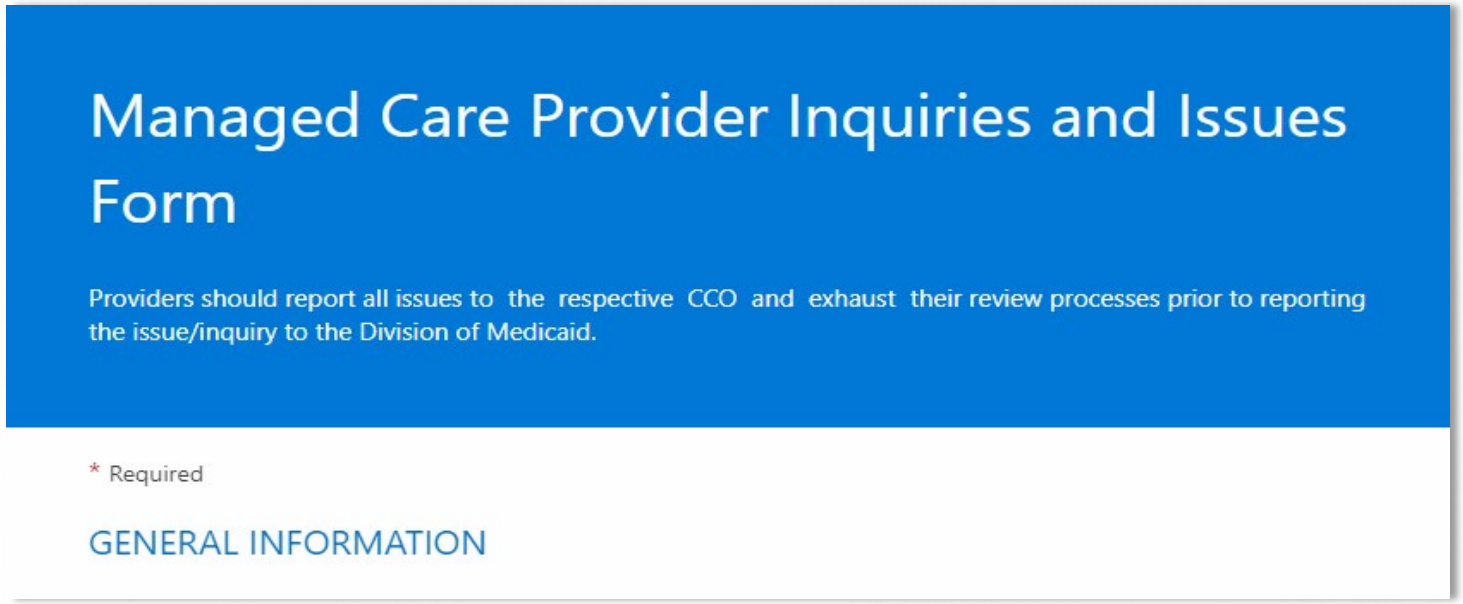
MOLINA HEALTHCARE

Managed Care Inquiries and Complaints

HELP US, HELP YOU

Please forward all provider issues and complaints to:

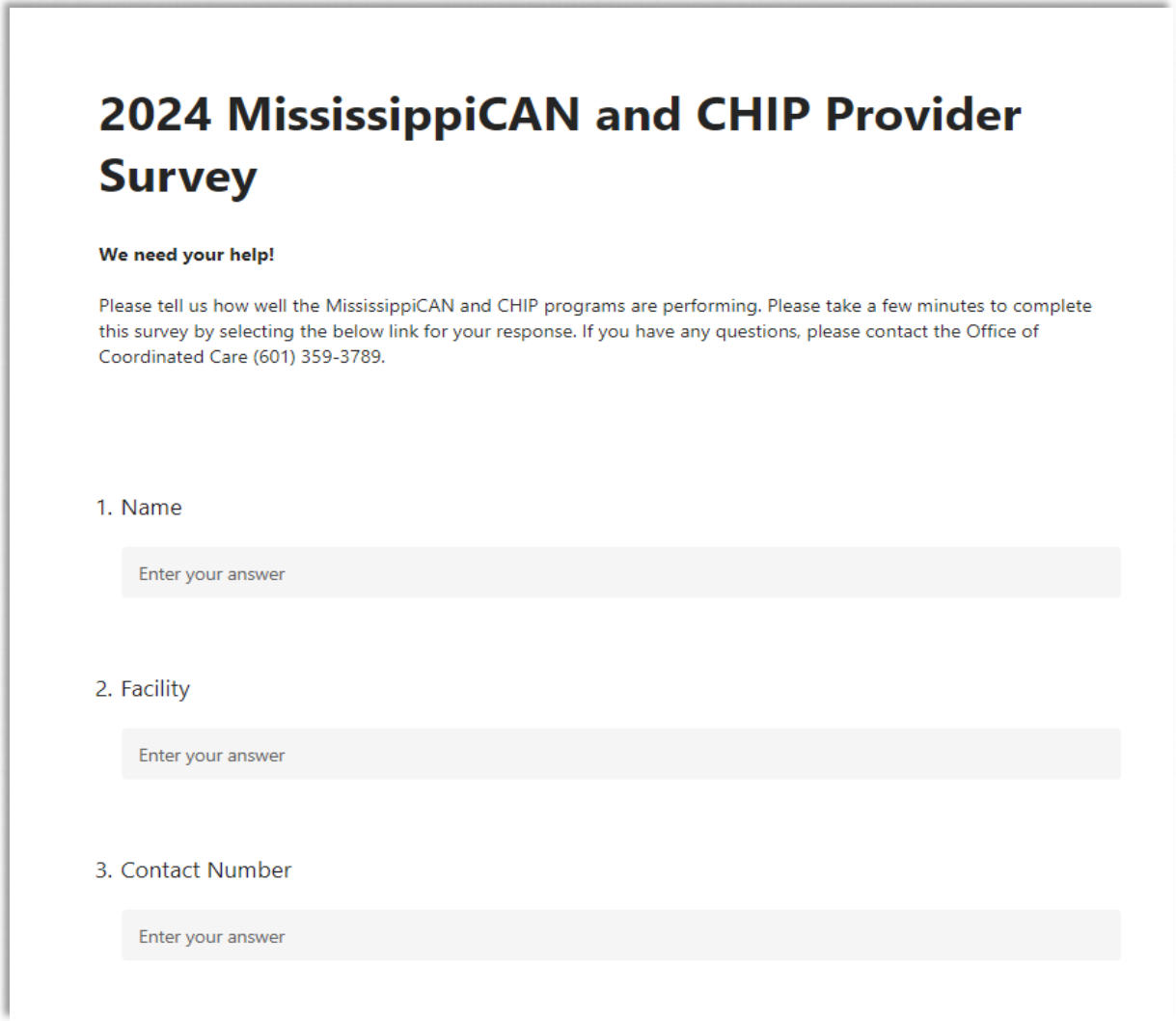
https://forms.office.com/g/WXj92sN1MH



Please allow seven (7) business days for the CCOs to respond to your inquires and complaints.

Office of Coordinated Care: Provider Services at (601) 359-3789.

Please Complete 2024 Provider Survey



2024 MississippiCAN and CHIP Provider Survey

We need your help!

Please tell us how well the MississippiCAN and CHIP programs are performing. Please take a few minutes to complete this survey by selecting the below link for your response. If you have any questions, please contact the Office of Coordinated Care (601) 359-3789.

1. Name

Enter your answer

2. Facility

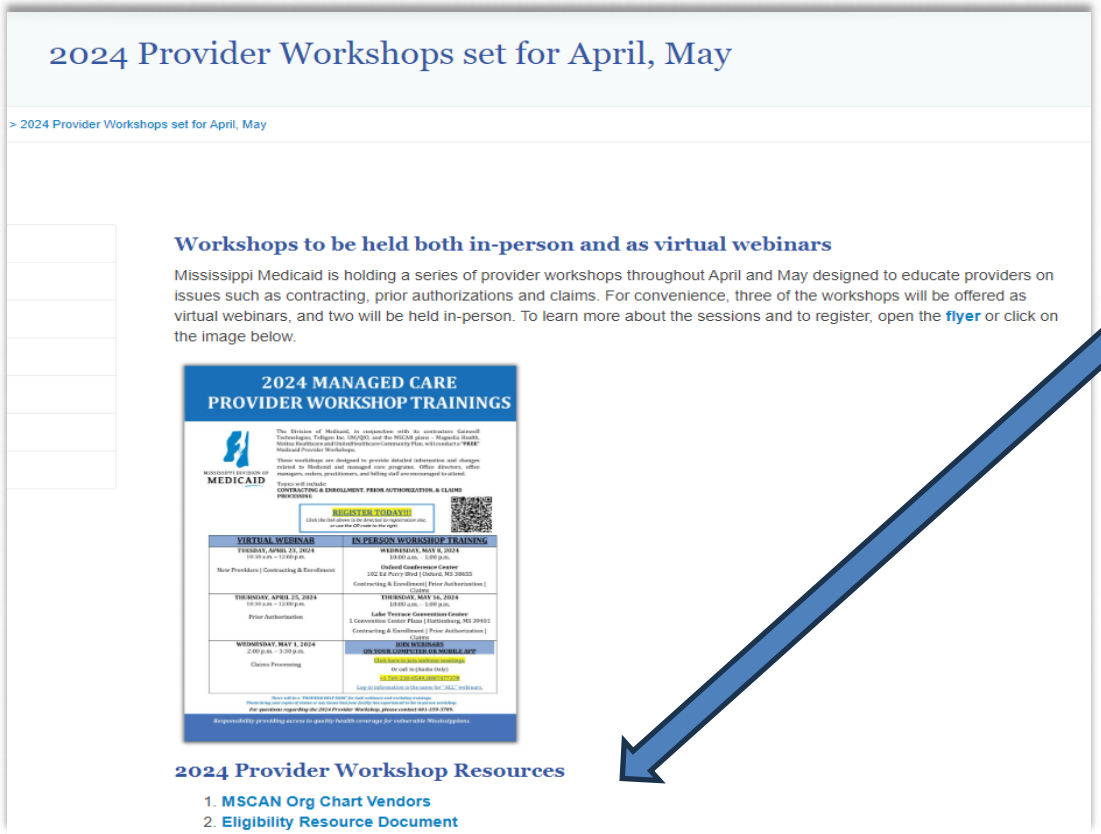
Enter your answer

3. Contact Number

Enter your answer

https://forms.office.com/g/aEU1J1jM6k

How Providers can Access the Provider Workshop Resources



- 2024 Provider Workshop Presentation
  - Provider Contracting & Enrollment
  - Prior Authorizations
  - Claims
- Mississippi Medicaid Eligibility
- Managed Care Comparison Chart
  - MississippiCAN
  - CHIP
- Managed Care Org Chart
- Managed Care Contact List
- Gainwell & CCO Provider Reps

https://medicaid.ms.gov/2024-provider-workshops-set-for-april-may/

Questions & Answers

Division of Medicaid

Lucretia Causey

Thank you attending the 2024 Provider Webinars.