Mississippi Division Of Medicaid

Provider Workshops

Tuesday, May 1, 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

Claims
(Gainwell, Magnolia, Molina, & United)

Webinar Resources

Questions & Answer Session

Division of Medicaid Managed Care Team

Lucretia Causey
Deputy Director of Managed Care

Patricia Collier
Managed Care – Provider Services

Michelle Robinson
Managed Care – Member Service

Charlotte McNair
Managed Care Enrollment & Eligibility

Ajanda Thomas
Webinar Navigator

Takia Robinson
Managed Care – Document Review

Jasmine Wilkerson
Gainwell Technologies- Provider Services

Molina Health Provider Service Team

Robin Thomas

Cody Greer

Terri Smith

LaShundra Lewis

Chris Cauthen

Candice McCook

Magnolia Health Provider Service Team

Angela Brown
Senior Utilization Management

Anna Owens
Provider Network Specialist

Katherine St. Paul
Provider Engagement Administrator

Leslie Cain
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

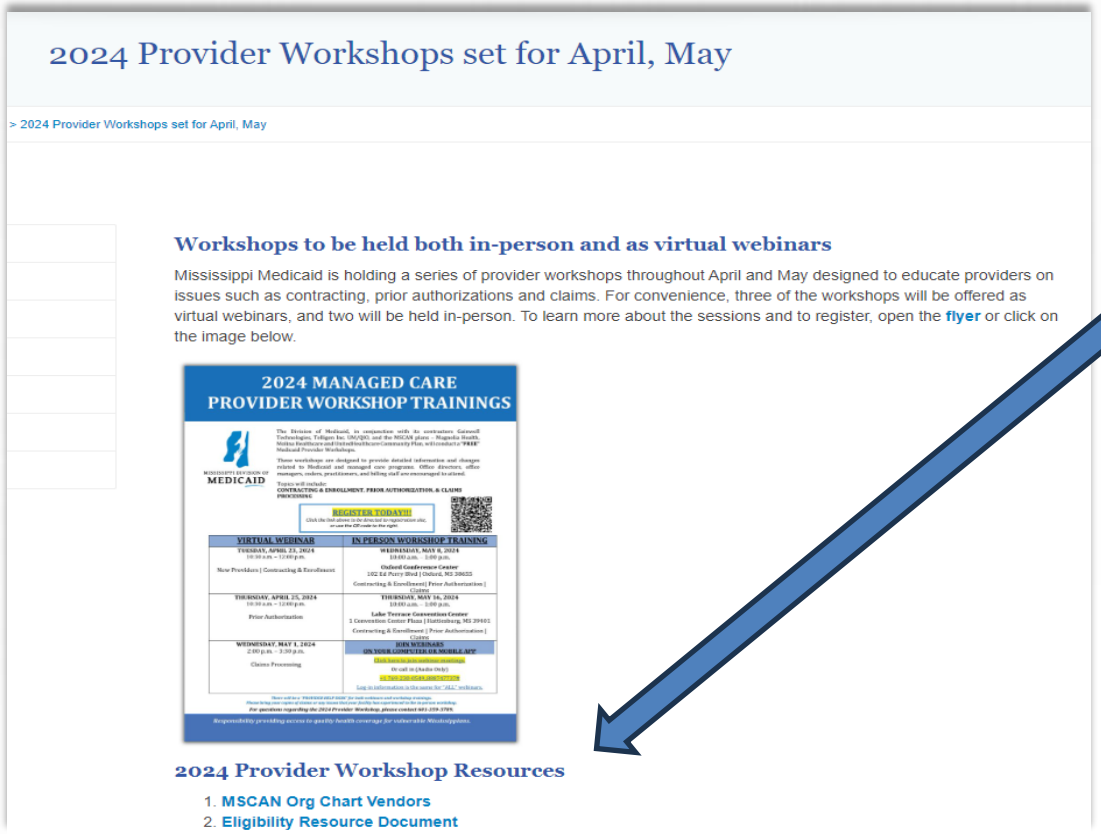
Stacy McGrew
Provider Engagement Administrator

UnitedHealth Provider Service Team

Rhona Waldrep

Curtis Burroughs

How Providers can Access the Provider Workshop Resources



2024 Provider Workshops set for April, May

> 2024 Provider Workshops set for April, May

Workshops to be held both in-person and as virtual webinars

Mississippi Medicaid is holding a series of provider workshops throughout April and May designed to educate providers on issues such as contracting, prior authorizations and claims. For convenience, three of the workshops will be offered as virtual webinars, and two will be held in-person. To learn more about the sessions and to register, open the **flyer** or click on the image below.

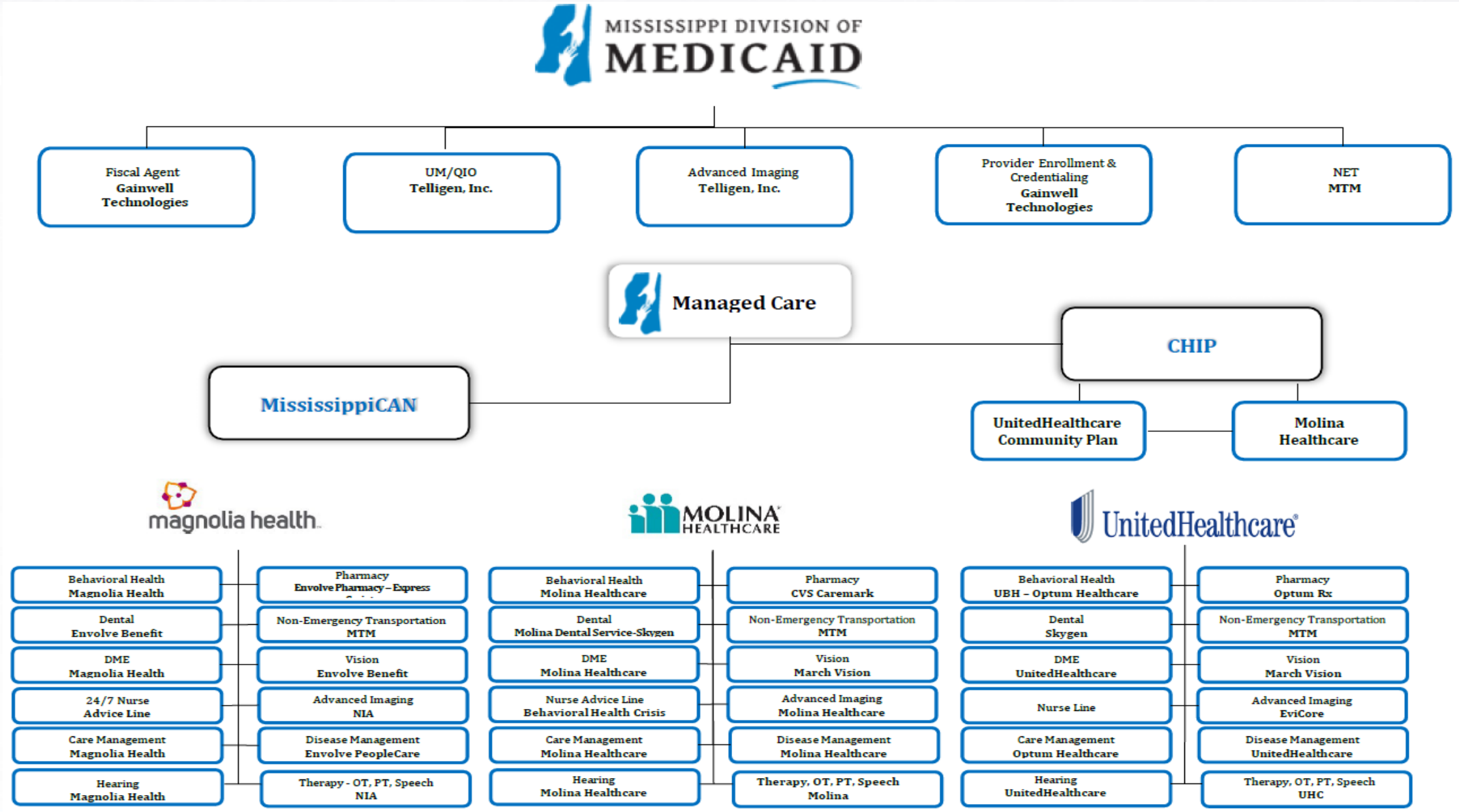
2024 Provider Workshop Resources

1. MSCAN Org Chart Vendors
2. Eligibility Resource Document

- 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

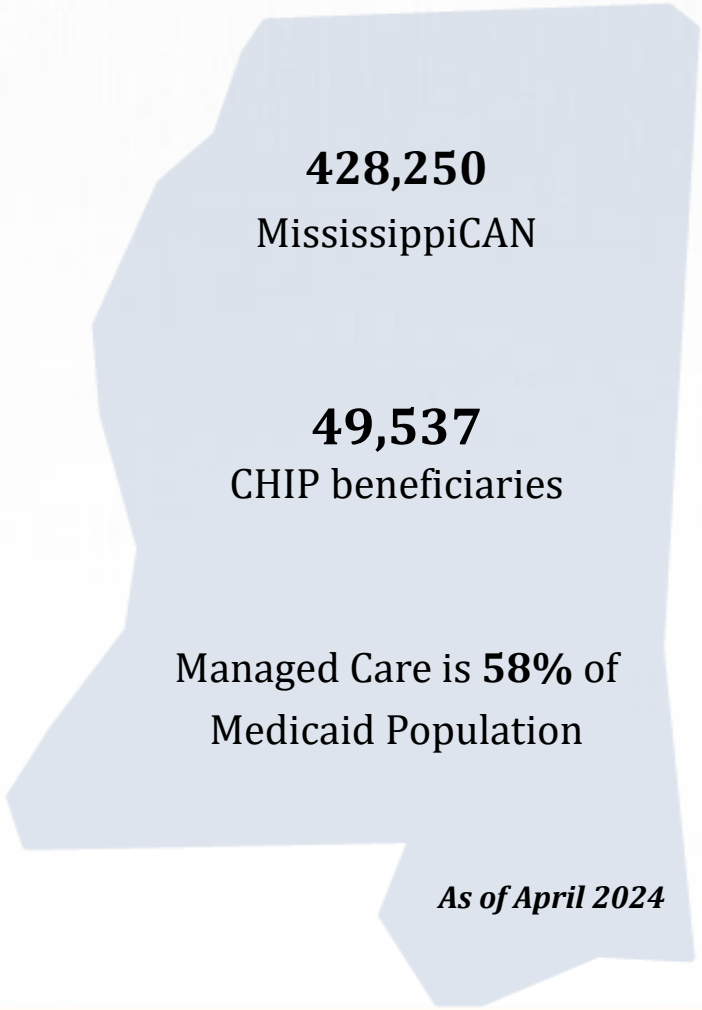
Total Enrollment - 800,539 (includes Medicaid and CHIP)

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

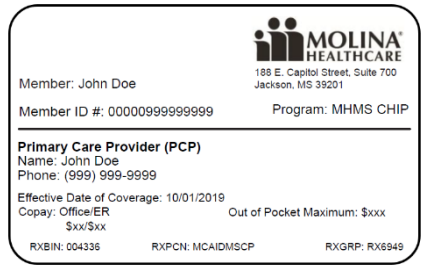
MOLINA HEALTHCARE

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.

gainwell®

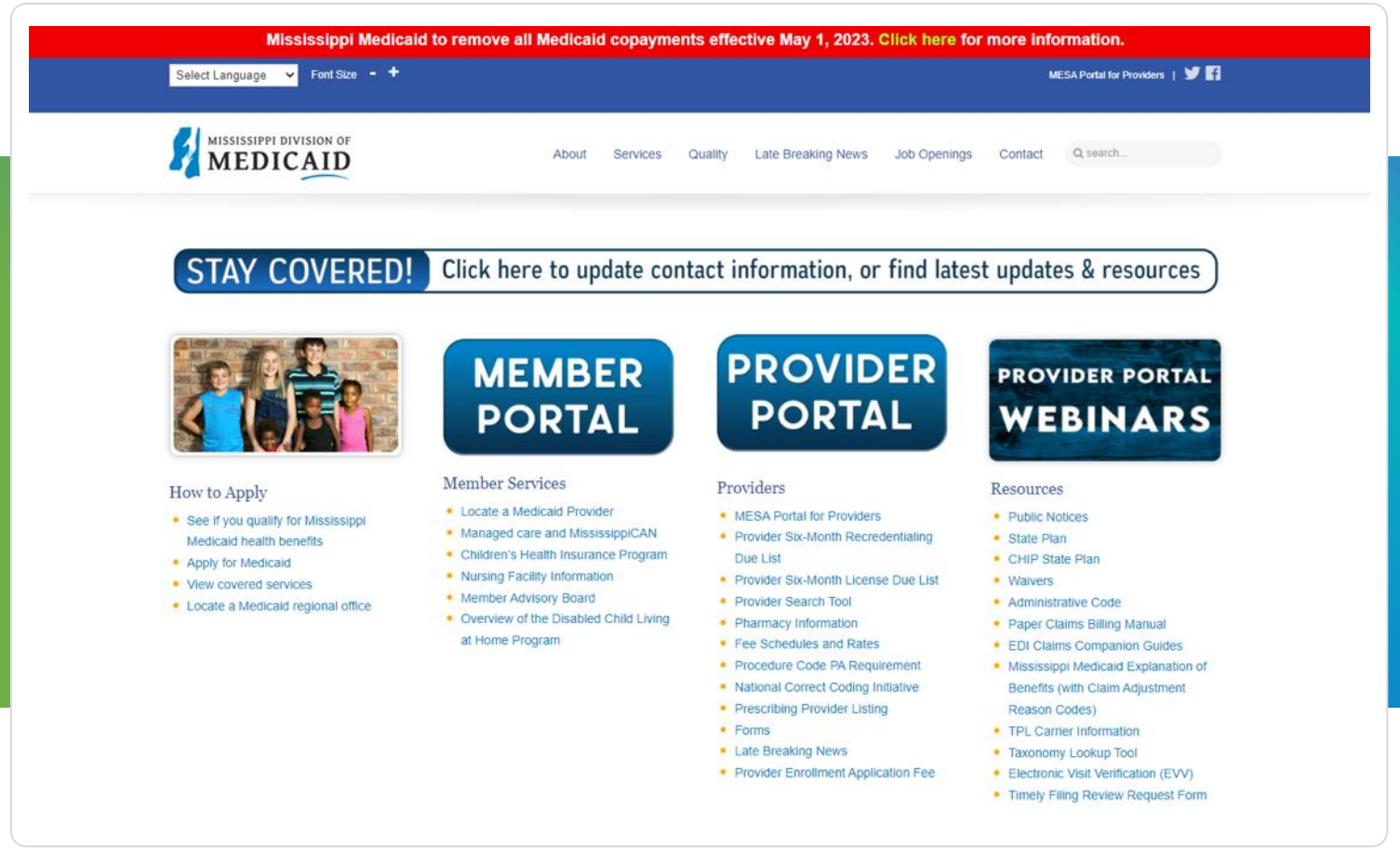
Agenda

1. DOM Website
2. MESA Portal
3. Medicare Claim Processing
4. Common Edits
5. Key Contacts
06. Representative Map
07. FAQs
08. Questions

Mississippi Division of Medicaid Website

Division of Medicaid Website

- Late Breaking News
- Provider Portal
- Administrative Code
- Taxonomy Lookup Tool
- Forms
- Fee Schedule
- Paper Billing Manual
- EDI Companion Guide

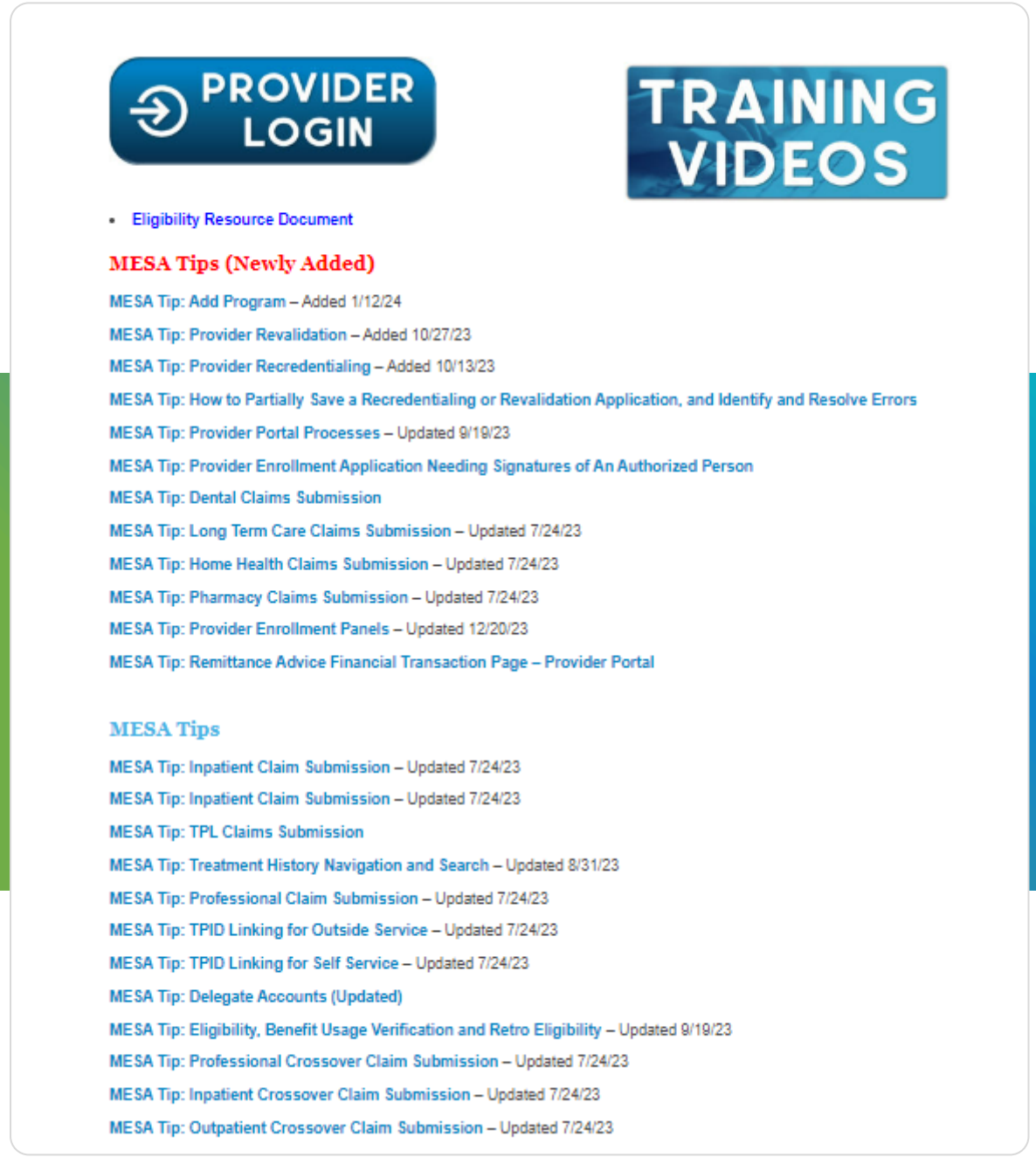


Mesa Web Portal

Provider Portal

Mesa Tips

Step-by-step how-to guides on various processes



Claim Submission Methods

Mesa Web Portal / EDI / Paper Submission

- **Mesa Web Portal** – Utilizing Gainwell's Provider portal to submit claims for various provider types. See link: Mississippi Medical Assistance Portal for Providers > Home (ms-medicaid-mesa.com)
- **EDI** – Submitting claims through clearinghouse or software vender directly to Gainwell's system. See link: EDI Technical Documents - Mississippi Division of Medicaid (ms.gov)
- **Paper (Hardcopy)** – Submitting claims by mailing in to Gainwell.

2.3. Mailing Contact Information

Providers may contact Gainwell via the mail at the addresses listed in Table 2. These post office boxes should be used for claim submittals, adjustments, and void requests. Correspondences should be sent to the appropriate post office box to lessen the chance for errors and shorten the time required to complete transactions.

Table 2. PO Box by Mail Type - Jackson

Jackson — Post Office™	Mail Type
PO Box 23076 Jackson, MS 39225	Paper Claims CMS-1500, UB-04, and Dental (including crossover claims)
PO Box 23077 Jackson, MS 39225	Paper Adjustment/Void Requests


Login
*User ID
Log In
Forgot User ID?
Register Now
Where do I enter my password?
Protect Your Privacy!
Always log off and close all of your browser windows
Privacy Policy
Provider Enrollment Access
Enrollments Forms
340B Program Information
Trading Partner Enrollment
Late Breaking News
Provider Bulletins
UM/QIO
Provider Rates
Report Fraud
Search Providers
Search Fee Schedule
Other Resources
OIG Excluded Providers
Resources Links
Provider Appeals
Advanced Imaging Prior Authorization requests should be submitted to
MESA
MEDICAID ENTERPRISE SYSTEM ASSISTANCE
What you can do in the Medicaid Portal for Providers
Through this secure and easy to use internet portal, health care providers can submit claims and inquire on the status of their claims, inquire on a patient's eligibility, upload files, and search for other providers. In addition, health care providers can use this site to locate claim forms, provider participation materials and other Medicaid information and resources.
Call Center Hours!
8:00 a.m. - 5:00 p.m.
1-800-884-3222
Did you know?
The Mississippi Division of Medicaid values all types of health care providers enrolled in the Medicaid program. Medicaid is a federal and state program created to provide medical assistance to eligible, low income populations. This service is in place to provide access to quality health care coverage for vulnerable Mississippians. To enroll as a Mississippi Medicaid provider, click here.
Website Requirements

Medicare Claims Processing

Medicare Primary Claims

Paper Claim Submission-CMS 1500

4.9. Filing Medicare Crossover Claims on the CMS-1500

Beneficiaries that are both Medicare and Medicaid eligible require a slightly different approach to claims submission. Complying with the following instructions expedites claims adjudication:

- In FL 1 (Figure 1), enter X in the box labeled "Medicare" when submitting a crossover claim and enter X in the box labeled "Medicaid" for non-crossover claims.
- Ensure that the beneficiary's nine-digit Medicaid number is in FL 1a (Figure 2).
- Enter the NPI number of the billing provider who is the one to which Medicaid payment will be made in FL 33 (Figure 57). If FL 33 contains a group NPI provider number, enter the ten-digit NPI of the servicing/ rendering provider in FL 24j (Figure 46).
- Circle the corresponding claim information on the Explanation of Medicare Benefits (EOMB). Attach the EOMB to the back of the claim.
- The claim detail information should match the individual EOMB detail level information.

The Medicare EOMB must be completely legible and copied in its entirety. The only acceptable alterations or entries on a Medicare EOMB are as follows:

- The provider may line out patient data not applicable to the claim submitted.
- The provider may line out any claim line that has been previously paid by Medicaid that the provider chooses not to bill Medicaid, or that has been paid in full by Medicare.
- If the claim lines on the EOMB have been lined out, the "claim totals" line on the EOMB must be changed to reflect the deleted line(s).
- The claim lines or "recipient section" on the EOMB that are being submitted for reimbursement must be circled and never highlighted.

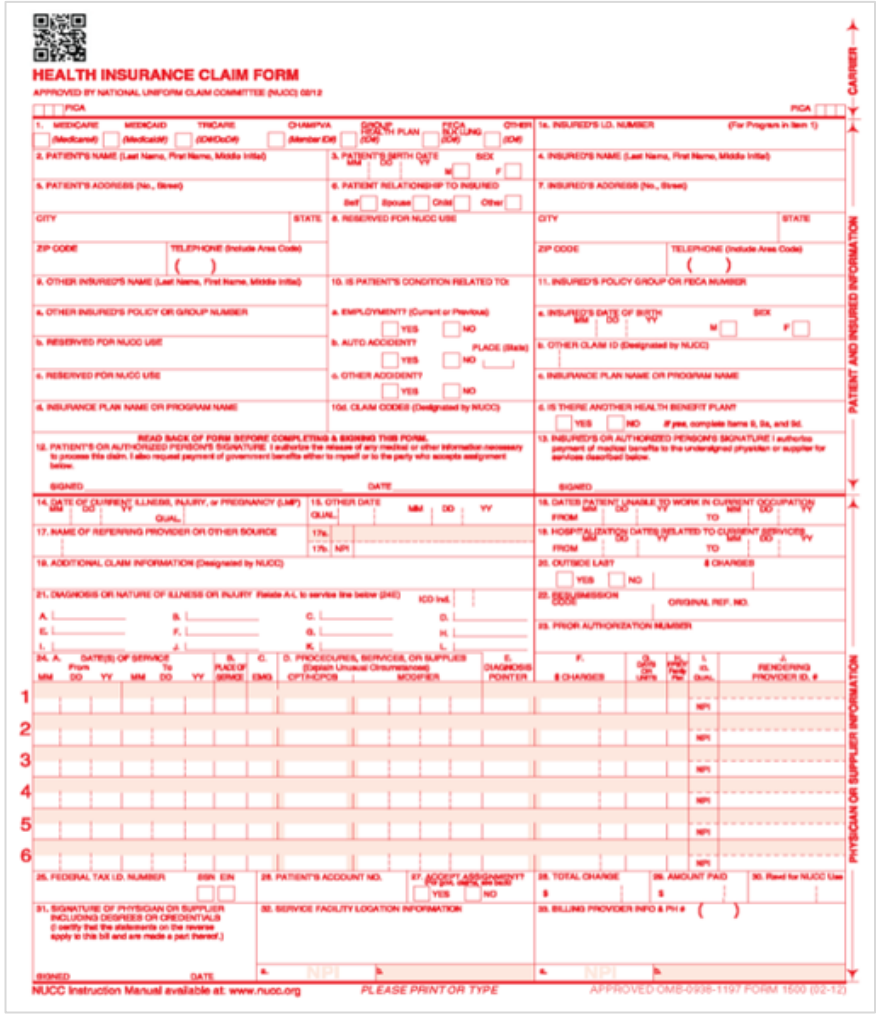
The MISSISSIPPI CROSSOVER CLAIM FORM will no longer be accepted.

Please mail claim forms to:

Mississippi Medicaid Program

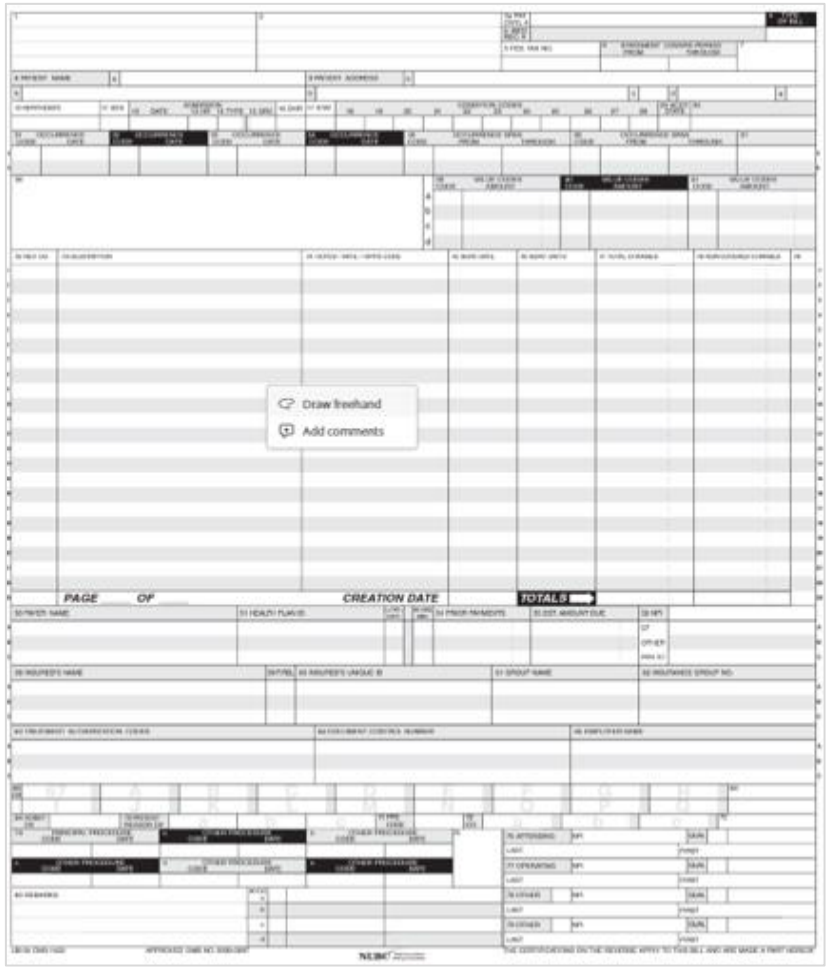
PO Box 23076

Jackson, MS 39225-3076



Medicare Primary Claims

Paper Claim Submission-UB04



5.9. Filing Medicare Part, A Crossover Claims on the UB-04

Beneficiaries that are both Medicare and Medicaid eligible require a slightly different approach to claims submission. Complying with the following instructions expedites claims adjudication:

- The word "**Medicare**" should be entered in FL 38 (Figure 83).
- The beneficiary's Medicare number should be entered in FL 60 (Figure 103).
- The beneficiary's nine-digit Medicaid number should be entered in FL 60 (Figure 93).
- The ten-digit NPI number should be entered in FL 56 (Figure 99).
- Optional: The nine-digit Medicaid provider number should be entered in FL 57 (Figure 100).
- The corresponding claim information should be circled on the EOMB and the EOMB attached to the back of the claim.
- The claim detail information should match the individual EOMB detail level information.
- Any prior payer payments should be reported in FL 54 (Figure 97) of the UB-04.

The Medicare EOMB must be completely legible and copied in its entirety. The only acceptable alterations or entries on a Medicare EOMB are as follows:

- The provider may line out patient data not applicable to the claim submitted.
- The provider may line out any claim line that has been previously paid by Medicaid that the provider chooses not to bill Medicaid, or that has been paid in full by Medicare.
- If the claim lines on the EOMB have been lined out, the "claim totals" line on the EOMB must be changed to reflect the deleted line(s).
- The claim lines or "recipient section" on the EOMB that are being submitted for reimbursement must be circled and never highlighted.

Note: The MISSISSIPPI CROSSOVER CLAIM FORM is no longer accepted.

Secondary Claim Reminders

- Professional Crossover Claims (Medicare and Medicaid)
- Institutional Crossover Claims (Medicare and Medicaid)
- Attach EOMB
  (Unless submitted via EDI)

- TPL (Commercial Primary) Claims
  - Submit as usual under professional or institutional with OI
    (other insurance information entered).
  - Attach EOB
    (Unless submitted via EDI) Indicator CI

Common Issues and Edits

Common Edits

1945/1347 (EOB)

Billing Provider Number is not found or is not valid for Dates of Service

- NPI on provider file
- Taxonomy of provider file
- Billing 5-digit zip code
- Billing +4 added to 5-digit zip code

The system will seek to find a unique match using the 4 data elements above submitted on your claim to a specific record in our system.

1946/1504 (EOB)

Performing Provider Number Not found

- NPI on provider file
- Taxonomy on provider file

Essentially, the system will seek to find a unique match using the two data elements (see above) that were submitted on your claim to a specific provider record in our system. If a unique match is not found – the edit is set, and you will receive the EOB code.

Common Edits (continued)

EOB	Description
2480	EOMB INFORMATION IS UNDER REVIEW
4502	MEDICARE EOMB IS MISSING OR DOES NOT MATCH THE SERVICES ON THE CLAIM. RESUBMIT
4504	MEDICARE EOMB INFORMATION IS MISSING AT THE CLAIM DETAIL. RESUBMIT THE CLAIM WI
4505	THE CLAIM ATTACHMENT IS CORRUPTED OR UNREADABLE. RESUBMIT THE CLAIM WITH VALID
4512	MEDICARE EOMB HAS MORE DETAILS THAN ON CLAIM OR MEMBERS LISTED DO NOT MATCH. C
4522	MEDICARE EOMB PROCEDURE/REVENUE CODE/DOS, MEDICARE PAID DATE OR MEMBER'S NAME D
4532	MEDICARE EOMB SUBMITTED AMOUNTS ON THE CLAIM DO NOT MATCH THE SUBMITTED MEDICAR

(Please see EOB codes on RA which give more detail as why the claim denied)

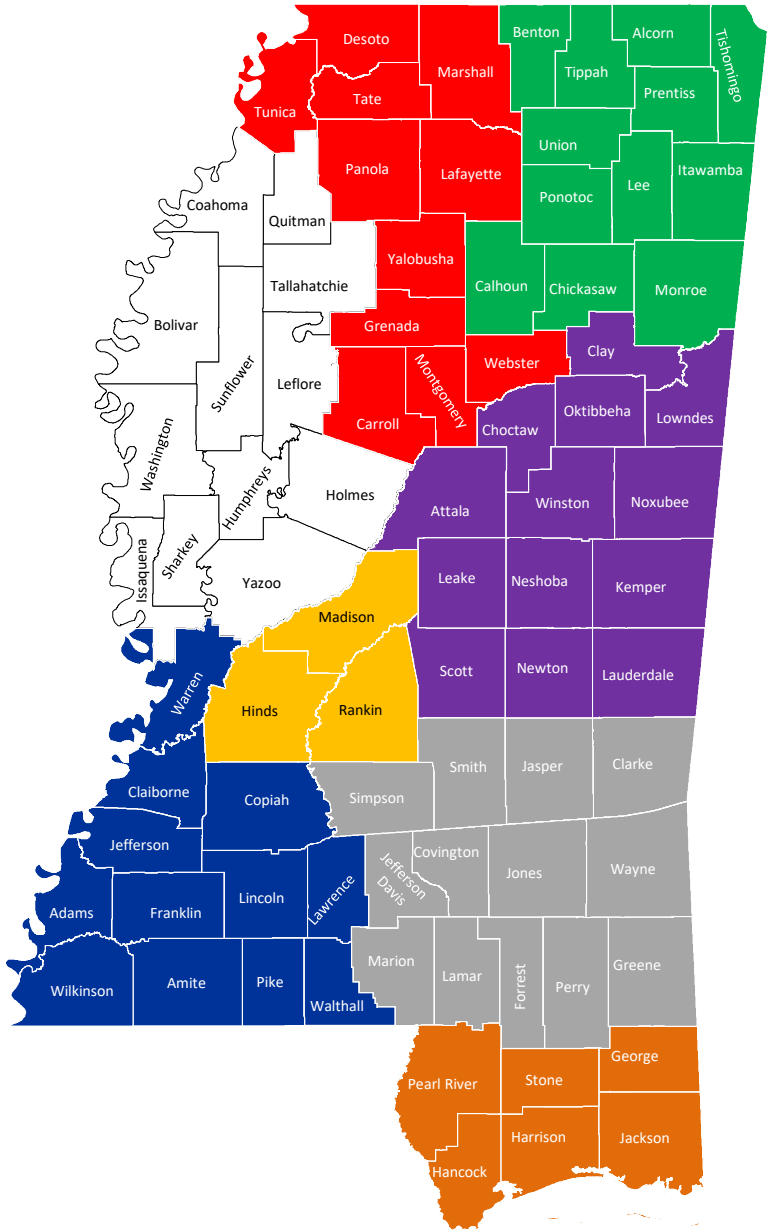
Key Contacts

Key Contacts

Contact/Office	Telephone Number
Provider/Beneficiary Services	1-800-884-3222
Provider Services Fax Number	1-866-644-6148
Member Services Fax Number	1-866-644-6050
Automated Voice Response System (AVRS)	1-800-884-3222
Electronic Data Interchange (EDI)	1-800-884-3222
Pharmacy Call Center	1-833-660-2402
Pharmacy Service Fax Center	1-866-644-6147

Field Representative Regional Map

AREA 1	Claudia (Nicky) Odomes 769-567-9660
AREA 2	Latrece Pace 601-345-3479
AREA 3	Jasmine Wilkerson 601-937-0559
AREA 4	Justin Griffin 601-874-4296
AREA 5	Latasha Ford 601-292-9352
AREA 6	Tuwanda Williams 601-345-1558
AREA 7	Erica Guyton 601-345-3619
AREA 8	Jonathan Dixon 501-603-5219
Out of State Provider	Dominquea Anderson 601-345-3271



Frequently Asked Questions

magnolia health™

2024 Division of Medicaid
Provider Workshops

Claim Filing

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

5/1/2024

Clean Claim: A clean claim is a claim received by Magnolia for adjudication in a nationally accepted format in compliance with standard coding guidelines and which requires no further information, adjustment, or alteration by the provider for services to be processed by Magnolia.

Claim Rejection: A rejection is an **unclean claim** that contains invalid or missing data elements required to accept the claim in Magnolia's claim processing system. Rejected claims should be resubmitted after making proper corrections as an original claim and must meet a new clean claim submission timeframe of **180 days** from the service date.

Examples of rejected claims:

- Invalid member ID number
- Invalid Provider ID
- Invalid Member Date of Birth
- Invalid or Missing NPI
- Incorrect type of bill for the service or location
- Missing or invalid modifier

Claim Filing

- First time claims should be submitted within **180** days from DOS
- If the member has primary insurance, claims should be submitted within ninety (**90)** days from the primary payer's EOP
- All requests for corrected claims and claim reconsiderations (optional) must be received within ninety **(90)** days of the last written notification of the denial or original submission date.
- Claim appeals must be received within thirty **(30)** days of the denial or outcome of reconsideration request.

First time, corrected, and reconsideration requests can be submitted in the following ways:

Magnolia Health Secure Web-Portal (preferred method) www.provider.magnoliahealthplan.com
Electronic Claim Submission via one of our EDI trading partners on www.magnoliahealthplan.com

Paper Claims Medical
Magnolia Health
Attn: CLAIMS DEPARTMENT
P.O. Box 3090 (MSCAN)
Farmington, MO 63640
Magnolia Health Provider Manual https://www.magnoliahealthplan.com/providers.html

Paper Claims Behavioral Health
Magnolia Health
ATTN: BH Claims
P.O. Box 7600 Farmington, MO 63640-3834

Provider Services can assist most Provider Related Inquiries

By calling 1.866.912.6285 (TTY: 711) between the hours of 7:30 a.m. – 5:30 p.m., providers can access real time assistance including, but not limited to:

- Claim resolution guidance
- Credentialing/Network Participation Status
- Claims Status Inquires
- Facilitate request for adding/deleting physicians to an existing group
- Magnolia Health website review and portal questions including registration help
- Facilitate inquiries related to administrative policies, procedures, and operational issues
- Accept Referrals for Care Management
- Navigating prior authorizations

A claim **reconsideration** is an **optional** step in Magnolia's claim dispute process. Providers may choose to bypass the reconsideration process by submitting a claim appeal in lieu of a reconsideration. If a provider chooses to submit a claim appeal in lieu of a reconsideration, the reconsideration step will be exhausted, and the provider cannot request a reconsideration after the submission of an appeal

All requests for corrected claims or claim reconsiderations must be received within **ninety (90) days** of the last written denial/adjudication notification, example: Date of EOP.

The preferred submission method for a claim reconsideration is through Magnolia Health's secure portal at: www.provider.magnoliahealthplan.com. The secure portal will allow attachments and supporting documentation to accompany your request.

Claim reconsiderations submitted in writing or mail are accepted, but not preferred. When submitting a mailed reconsideration please include the following:

- Written communication (i.e. letter) outlining disagreement of claim determination
- Indicate "Reconsideration of (original claim number)"

Medical Claim Reconsideration
Magnolia Health Plan
Attn: Reconsideration
PO BOX 3090 Farmington, MO 63640

Behavioral Health Claim Reconsideration
Magnolia Health
Attn: BH Claim Reconsideration
PO Box 7600
Farmington, MO 63640-3834

Any retrospective review denials that fall outside of the guidelines as stated in the "Retrospective Review" section, claim denials that are in relation to prior authorization denials, as well as post service medical denials should follow the claim reconsiderations and appeals process.

A Claim Appeal is the next step of the claim dispute process following the outcome of a claim reconsideration.

Claim appeals must be received within **thirty (30) days** of the denial or outcome of a reconsideration request.

Claim appeals **cannot** be submitted via the Secure Provider Portal and must be mailed to the address below along with supporting documentation and the required claim appeal form located on www.magnoliahealthplan.com.

Medical Claim Appeal
Magnolia Health
Attn: CLAIMS DEPARTMENT
P.O. Box 3090 (MSCAN)
Farmington, MO 63640

Behavioral Health Claim Appeal
Magnolia Health
Attn: BH Appeals
P.O. Box 6000
Farmington, MO 63640-3809

For more information regarding the claim dispute please visit Magnolia's Provider Manual found here:

- https://www.magnoliahealthplan.com/providers.html
- Provider Services at 1.866.912.6285

Providers have the right to file a complaint or grievance with Magnolia Health.

A provider complaint or grievance is defined as any provider expression of dissatisfaction expressed by the provider to the Plan orally or in writing regarding policies, procedures, administrative processes, or adverse benefit determination.

Examples of Complaints and Grievances include:

- Aspects of interpersonal relationships, such as rudeness of health plan staff, a provider, or an employee
- Failure to respect the provider's rights, regardless of whether remedial action is requested

Timeframes

- Provider complaints and grievances should be filed in writing or by phone within **thirty (30) calendar days** from the date of the incident causing dissatisfaction.
- Magnolia will provide a written determination within **thirty (30) calendar days** upon receipt of complete documentation.
- For written grievances, Magnolia will notate the date received and send an acknowledgment letter, which includes a description of the grievance, procedures, and resolution time frames, within **five (5) business** days of receipt.
- Magnolia may extend the determination time frame up to fourteen **(14) calendar days**. Extensions must be requested within five (5) calendar days of original resolution date.

Call:
1.866.912.6285
Monday – Friday
7:30 a.m. to 5:30 pm

Mail:
Magnolia Health
Attn: Provider Complaints/Grievances
1020 Highland Colony Parkway,
Suite 502
Ridgeland, MS 39157

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

Per the Medicaid Provider Agreement and the Administrative Code **Title 23: Medicaid Part 200: General Provider Information, Chapter 1, Rule 3.8- Charges Not Beneficiary's Responsibility,** which states that providers who have agreed to be Medicaid providers are expected to bill Medicaid for Medicaid covered services and accept Medicaid payment as payment in full.

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.

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.

Magnolia Health members:

- May not be balance billed
- May not be billed for missed appointments
- May not be billed for failure to obtain prior authorization or adhering to timely filing guidelines
  - Contact Providers Services at1-866-912-6285
  - Provide Education to members

If a member asks for a service that is not covered, you must ask the member to sign a statement indicating that they will pay for the specific service.

For more information, visit:
https://www.magnoliahealthplan.com/providers/resources/forms-and-resources.html

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 in the following ways:

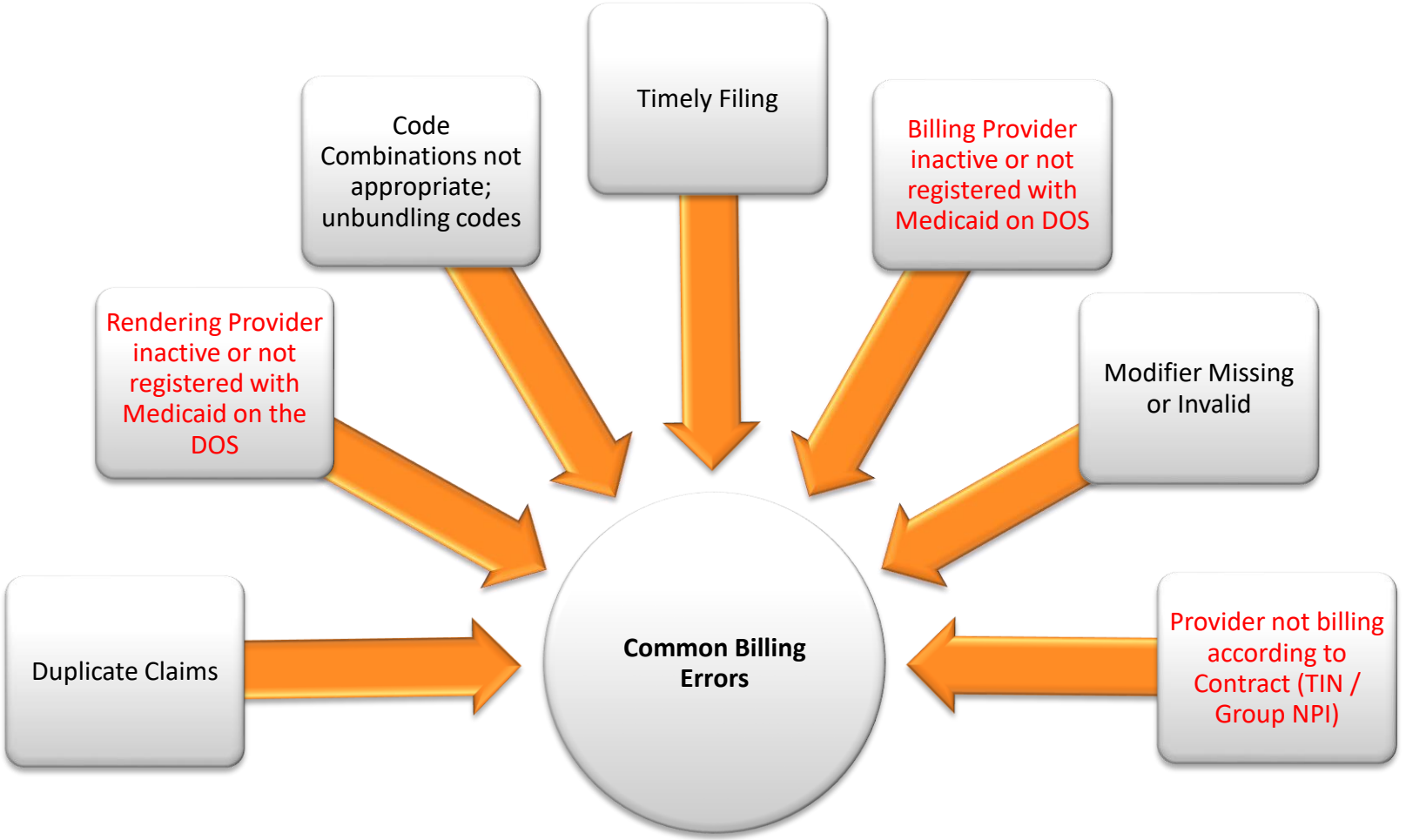
- Secure Provider Portal at: Provider.MagnoliaHealthPlan.com
- Call Magnolia Health at 866-912-6285

OR

Eligibility can also be accessed by Logging onto DOM's MESA website: https://medicaid.ms.gov/mesa-portal-for-providers/

Retro-Active Eligibility

- The Division of Medicaid may assign retroactive eligibility to a member and assign the member to Magnolia Health. 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
- For more information on Retro-Active Eligibility, please review The Division of Medicaid's Website https://medicaid.ms.gov/mesa-portal-for-providers/

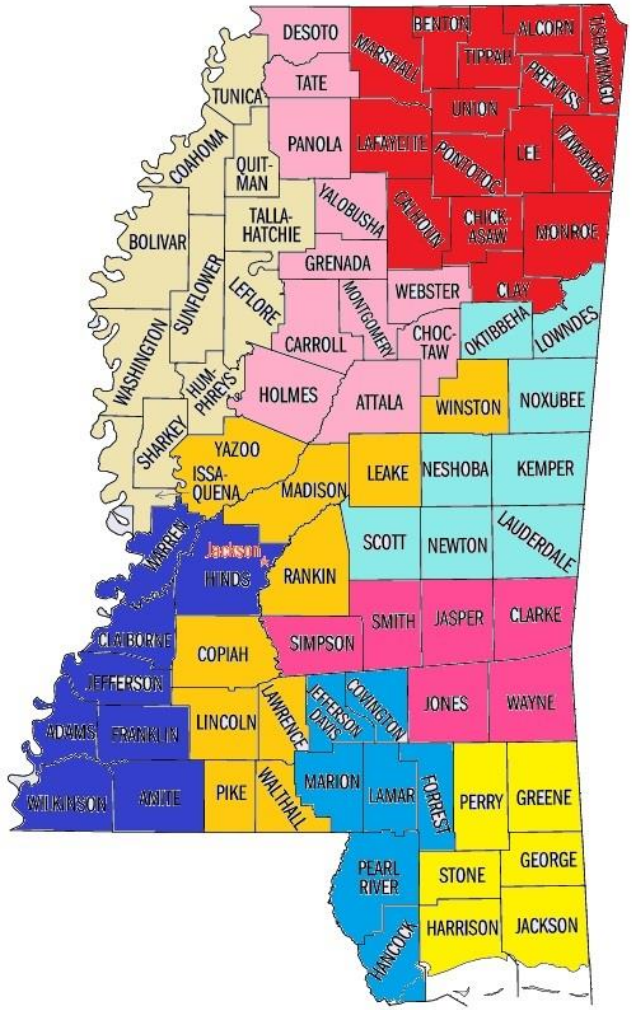


For a complete list of common billing errors refer to the claims filing manual and provider manual

Claims Filing Tips

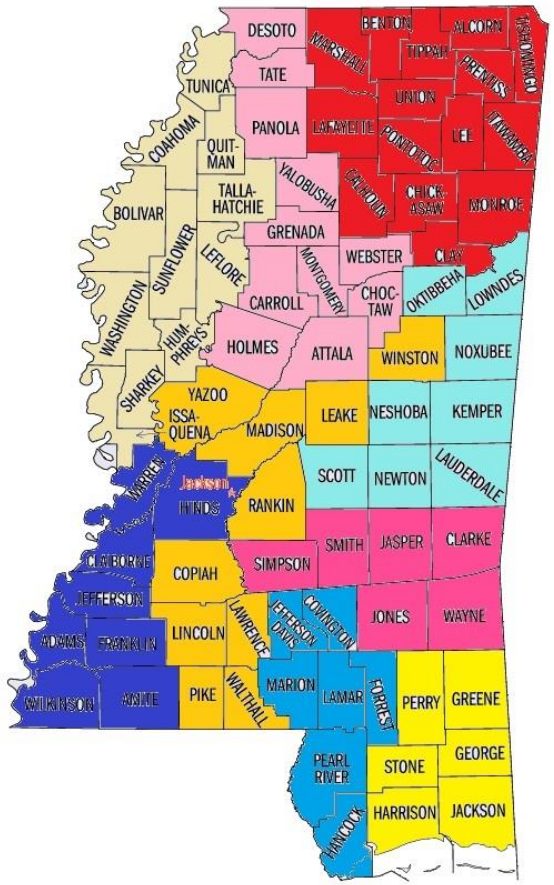
- ✓ Do **not** hold claims for any reason. You will be subject to timely filing guidelines, regardless if you are going through contracting or enrollment.
- ✓ Ensure your group and rendering providers are **active** providers with Gainwell or your claim will be denied.
- ✓ If your claim denied due to a coding edit, medical records and/or supporting documentation should be submitted via the claim **reconsideration and/or appeal process.**
- ✓ If your claim is pending, it may require a **corrected claim, claim reconsideration and/or appeal**, please wait until the claim has finalized before submitting your new request. Failure to do so may result in a claim denial or the incorrect claim be processed.
- ✓ If your group has multiple Group NPIs and your practitioners will be practicing under each Group NPI, you must submit a request to link them to each Group NPI or it may result in a **non-par payment or claim denial**.
- ✓ Ensure that you are billing according to your contract. If the contract has a TIN and Group NPI and there are rendering providers associated, you must bill accordingly. The rendering provider should **not bill** their Rendering NPI as the Group.
- ✓ If you are a medical group that has switched to an **RHC or FQHC**, once your contract has been amended, you will be required to file corrected claims with the appropriate place of treatment to receive proper reimbursement.
- ✓ Prior to performing services, review the **pre-auth check tool** to verify if authorization is required. If authorization is required and not obtained, your claim will deny.
- ✓ If you have an authorization and it has expired or need additional units, please obtain prior to rendering services and filing a claim or your claim will deny.

Provider Engagement Administrator (PEA)
Supports Primary Care Providers



Territory	Counties	Provider Engagement Administrator
Tan	Tunica, Coahoma, Quitman, Bolivar, Sunflower, Washington, Sharkey, Humphreys, Leflore	Latoya Hemphill Latoya.Hemphill@centene.com
Light Pink	Desoto, Tate, Panola, Yalobusha, Grenada, Webster, Choctaw, Attala, Holmes, Carroll, Montgomery, Tallahatchie	Jill Dean Amanda.Dean@CENTENE.COM
Turquoise	Oktibbeha, Lowndes, Noxubee, Kemper, Neshoba, Lauderdale, Scott and Newton	Bethany Peters Bethany.Peters@centene.com
Dark Blue	Warren, Hinds, Claiborn, Jefferson, Adams, Franklin, Wilkinson, Amite	Tiffany Sanders Tiffany.Sanders@centene.com
Gold	Rankin, Copiah, Madison, Leake, Yazoo, Winston, Lincoln, Pike, Wathall, Lawrence, Isaquena	Tarkan West Tarkan.Weston@centene.com
Light Blue	Jefferson Davis, Covington, Marion, Lamar, Forest, Pearl River Hancock	Donna Ramirez Donna.Ramirez@CENTENE.COM
Yellow	Perry, Greene, Stone, Harrison, Jackson, George, Harrison	Belinda Turner Belinda.Turner@centene.com
Red	Tishomingo, Prentiss, Itawamba, Monroe, Clay, Chickasaw, Calhoun, Pontotoc, Union, Tippah, Alcorn, Benton, Marshall,	Kiri Parson kiri.l.parson@centene.com
Dark Pink	Simpson, Smith, Jones, Wayne, Clarke, Jasper	Stacy Mcgrew Stacy.Mcgrew@centene.com

Provider Network Support Specialists (PNSS)
Supports all Ancillary, Hospitals, DME, and other Non-PCP Providers



Brittany Cole magnoliazone3@centene.com -Coahoma, Quitman, Bolivar, Sunflower, Humphreys, Monroe, Clay, Chickasaw, Holmes

Kenisha Byrd magnoliazone1@centene.com - Desoto, Tate, Panola, Yalobusha, Grenada, Webster, Choctaw, Attala, Carroll, Montgomery, Leflore, Tallahatchie, Tunica, and state of Tennessee

Heather Samuel magnoliazone5@centene.com - Winston, Kemper, Newton, Scott, Noxubee, Lowndes, Oktibbeha, Lauderdale, Neshoba

Yashieka Brookins magnoliazone4@centene.com - Jefferson, Warren, Hinds

Ericka Hunter magnoliazone7@centene.com -Rankin, Copiah, Madison, Leake, Yazoo

Meg Duke magnoliazone10@centene.com **-** Jefferson Davis, Marion, Pearl River, Hancock, Lamar, Forrest, Covington, Sharkey

Shelby Sloan magnoliazone8@centene.com - Perry, Greene, Stone, Harrison, Jackson, George

Anna Owens magnoliazone2@centene.com - Tishomingo, Prentiss, Itawamba, Washington, Calhoun, Pontotoc, Union, Tippah, Alcorn, Benton, Marshall, Lafayette, Lee

Jemessia Johnson Jemessia.Johnson@centene.com -Simpson, Smith, Jones, Wayne, Clarke, Jasper, Claiborne

Katharine St. Paul magnoliazone6@centene.com - Adams, Franklin, Lincoln, Wilkinson, Amite, Pike, Lawrence, Walthall

Magnolia's Dedicated Behavioral Health Provider Network Support Specialist:

Valencia Bennett, RN, BSN
Email- vbennett@centene.com

5/1/2024

magnolia health™

Provider Services Call Center:

- Provides phone support
- **First line of communication**
- Answer questions regarding eligibility, authorizations, claims, and payment inquiries
- Available Monday through Friday, 7:30 a.m. to 5:30 p.m. CST **1-866-912-6285**

Contact Magnolia

- **Magnolia Provider Services Line**
  Call: (866) 912-6285
  Fax: (877) 811-5980
- **Magnolia Member Services Line**
  Call: (866) 912-6285
  Fax: (877) 779-5219
- **Magnolia Prior Authorizations**
  Call: (866) 912-6285
  Fax: (877) 650-6943
- **Magnolia EDI Department**
  Call: (800) 225-2573, ext. 25525
  Email: EDIBA@centene.com
- **PaySpan**
  Call: (877) 331-7154
  providersupport@payspanhealth.com
- **24 Hour Nurse Advise Line- 866-9126285**
- **MTM (Transportation)** https://www.mtm-inc.net/mississippi/
- **Magnolia Contracting**
  Call: (866) 912-6285
- **Magnolia Credentialing**
  Call: (866) 912-6285
  For Gainwell inquiries Call: (800) 884-3222
- **Envolve Dental**
  Call: (844) 464-5636
  www.envolvedental.com
- **Envolve Vision**
  Call: 1-844-464-5636
  www.visionbenefits.envolvehealth.com
- **MTM (Non-Emergency Transportation)**
  Scheduling: (866) 331-6004
  Complaint: (866) 436-0457
  Where's My Ride: (866) 334-3794
- **Evolent formally National Imaging Associates (NIA)**
  Call: (800) 642-7554
  Online: www.RADMD.com
- **Pharmacy**
  Call: (866) 399-0928
  Help Desk Phone: 1-833-750-2773
  https://www.covermymeds.com

MOLINA HEALTHCARE OF MISSISSIPPI

2024 DOM Workshop Presentation

MOLINA® HEALTHCARE

Claims

MOLINA® HEALTHCARE

Claims Submission Methods

Electronic Claims

The Provider Portal

https://www.availity.com/molinahealthcare is available free of charge and allows for attachments to be included.

Clearinghouse

Providers may use the Clearinghouse of their choosing. (NOTE: fees may apply).

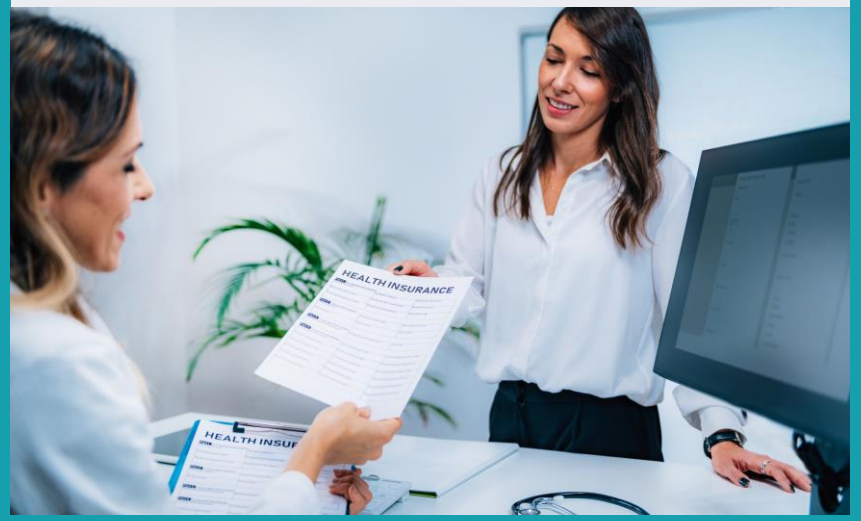
ClaimsNet is Molina Healthcare's chosen clearinghouse. When submitting EDI Claims (via a clearinghouse) to Molina Healthcare, providers must use the applicable payer ID #77010

*Preferred Method

Paper Claims

Claims Mailing Address

Molina Healthcare of Mississippi, Inc.
PO Box 22618
Long Beach, CA 90801



MOLINA HEALTHCARE

Claims Submission Timeframes MSCAN & CHIP

Claims Submission	Time Frame
Initial Claim →	180 days from the DOS/180 Days from the Date of Discharge
Reconsideration, Correction, or Adjustment →	90 Days from the date of denial/EOP
COB →	180 Days from the Primary Payer's EOP

MOLINA HEALTHCARE

EDI Claims Submission Information

- Molina Healthcare of Mississippi uses ClaimsNet as its gateway clearinghouse. ClaimsNet has relationships with hundreds of other clearinghouses. Typically, Providers can continue to submit Claims to their usual clearinghouse.
- Molina accepts EDI transactions through our gateway clearinghouse for Claims via the 837P for Professional and 837I for institutional. In order to ensure that all data being submitted to our gateway is received properly your submitter must utilize the latest version of the 837 standard. It is important to track your electronic transmissions using your acknowledgement reports. The reports assure Claims are received for processing in a timely manner.

ClaimsNet Payer ID# 77010

MOLINA HEALTHCARE

EDI Frequently Asked Questions

- **Can I submit COB claims electronically?**

-Yes, Molina and our connected Clearinghouses fully support electronic COB.

- **Do I need to submit a certain volume of claims to send EDI?**

-No, any number of claims via EDI saves both time and money.

- **Which Clearinghouses are currently available to submit EDI claims to Molina?**

https://www.molinahealthcare.com/providers/common/medicaid/ediera/edi/Pages/chinfo.aspx

- **What claims transactions are currently accepted for EDI transmission?**

-837P (Professional claims), 837I (Institutional claims).

- **Where can I find more information on the HIPAA transactions?**

https://www.molinahealthcare.com/providers/common/medicaid/ediera/edi/Pages/guidanceinfo.aspx

- **How do I exchange the 270/271 Eligibility Inquiry?**

-Molina does not directly exchange the Eligibility transactions. The transactions may be sent to Molina's contracted clearinghouse Change Healthcare to verify Eligibility.

- **How do I exchange the 276/277 Claim Status Inquiry/Response?**

-Molina does not directly exchange the Claim Status transactions. The transactions may be sent to Molina's contracted clearinghouse Change Healthcare to verify Claim Status.

MOLINA HEALTHCARE

EDI Claims Contact Information

Submitting Electronic: Claims, Referral Certification and Authorization

1-866-409-2935

Email Directly: EDI.Claims@MolinaHealthcare.com

Submitting Electronic: Encounters

1-866-409-2935

Email Directly: EDI.Encounters@MolinaHealthcare.com

Receiving 835/ERAs

1-866-409-2935

Email Directly: EDI.eraeft@MolinaHealthcare.com

MOLINA HEALTHCARE

Electronic Funds Transfer & Remittance Advice (EFT & ERA)

Contracted Providers are required to register for EFT within 30 days of entering the Molina Network. Providers enrolled in EFT payments will automatically receive ERAs as well. Molina partners with Change Healthcare/ECHO for EFT and ERA services. Additional information regarding EFTs and ERAs will be available under the “EDI, ERA/EFT” tab on the Molina website at: https://www.molinahealthcare.com/providers/common/medicaid/ediera/era/enrollERAEFT.aspx

Benefits of EFT/ERA:

- Faster payment (as little as 3 days from the day the claim was electronically submitted)
- Search historical ERAs by claim number, member name, etc.
- View, print, download and save PDF ERAs for easy reference
- Providers can have files routed to their ftp and/or their associated clearinghouse

How to Enroll:

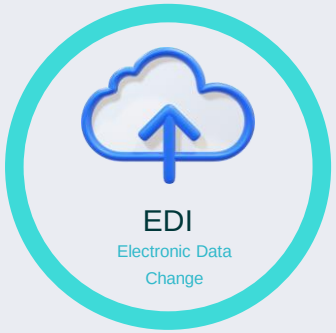
- To register for EFT/ERAs with Change Healthcare go to: https://providernet.adminisource.com/Start.aspx
- Step-by-step registration instructions are available on Molina’s website (www.molinahealthcare.com/provider) under the “EDI, ERA/EFT” tab.

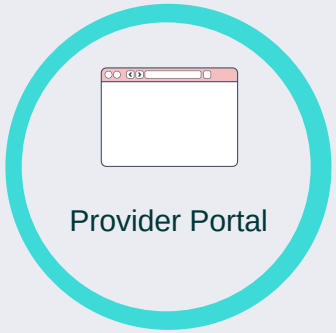
MOLINA HEALTHCARE

Corrected Claims

A corrected claim is a claim that has already been processed, whether paid or denied, and is resubmitted with additional charges, different procedure or diagnosis codes or any information that would change the way the claim originally processed. Claims returned requesting additional information or documentation should not be submitted as corrected claims. Corrected claims are treated as new claims.

Providers can submit corrected claims by the following:





MOLINA HEALTHCARE

Corrected Claims Billing Requirements - Paper Claims

CMS 1500

- Providers should submit with resubmission code 7 in Box 22.
- For Paper CMS 1500 claim form: Enter “RESUBMISSION” on the claim in the Additional Claim Information section (Box 19) of the form.

UB04

- Types of bill XX7 (replacement of prior claim).
- Enter “RESUBMISSION” in the Remarks section (Box 80) of the form.

MOLINA HEALTHCARE

Claims Reconsideration

A Claims Reconsideration is written communication advising of the disagreement or dissatisfaction of claim determination.

Reconsideration must be accompanied by the following:

- Member demographic information.
- Supporting documentation outlining the specifics regarding the reason for the request.
- Refer to Molina Provider Manual for additional information:

  https://www.molinahealthcare.com/providers/ms/medicaidmanual/medical.aspx

MOLINA HEALTHCARE

Claims Reconsiderations, Disputes, and Appeals Important Definitions

Adverse Benefit Determination

The denial or limited authorization of a requested service, including determinations on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit; the reduction, suspension, or termination of a previously authorized services; the denial, in whole or in part, of payment for a service; the failure to provide services in a timely manner, as defined by the Division of Medicaid.

Provider Appeal

Requests for Molina to review an Adverse Benefit Determination related to Provider, which may include, but is not limited to, for cause termination by Molina, or delay or non-payment for Covered Services.

How to file A Claim Dispute, Appeal, or Reconsideration.

Preferred Method:

online via Molina's Provider Portal:

https://www.availity.com/molinahealthcare

Fax:

(844) 808-2409

Mail:

Molina Healthcare of Mississippi, Inc.

Attention: Provider Grievance & Appeals

1020 Highland Colony Pkwy

Suite 602

Ridgeland, MS 39157

MOLINA HEALTHCARE

Documentation Needed for Submission of Reconsiderations, Disputes, or Appeals

- All Claim Reconsiderations, Disputes or Appeals must be submitted on the Molina Claims Request for Reconsideration Form (CRRF) found on Molina's Provider website and the Provider Portal.
- The form must be filled out completely to be processed.
- Any documentation to support the reconsideration, dispute or appeal must be included, ex. include Medical Records, copy of Explanation of Payment, copy of Authorization Form.
- If submitting voluminous Medical Records, please indicate where Molina can find pertinent information to support the medical necessity for the service.

Appeals Quick Reference

Molina Healthcare Member Resolution Team (MRT) and Provider Resolution Team (PRT) are working together to re-route any misdirected requests. However, participating providers sending disputes/appeal requests to the wrong department could delay response times.

Pre-Service Appeals

For providers seeking to appeal a denied Prior Authorization (PA) on behalf of a member only, fax Member Appeals at (844) 808-2407.

Post-Service Appeals

For providers seeking to appeal a denied claim only, fax Provider Claim Disputes/Appeals at (844) 808-2409.

If a provider rendered services without getting an approved PA first, providers must submit the claim and wait for a decision on the claim first before submitting a dispute/appeal to Molina.

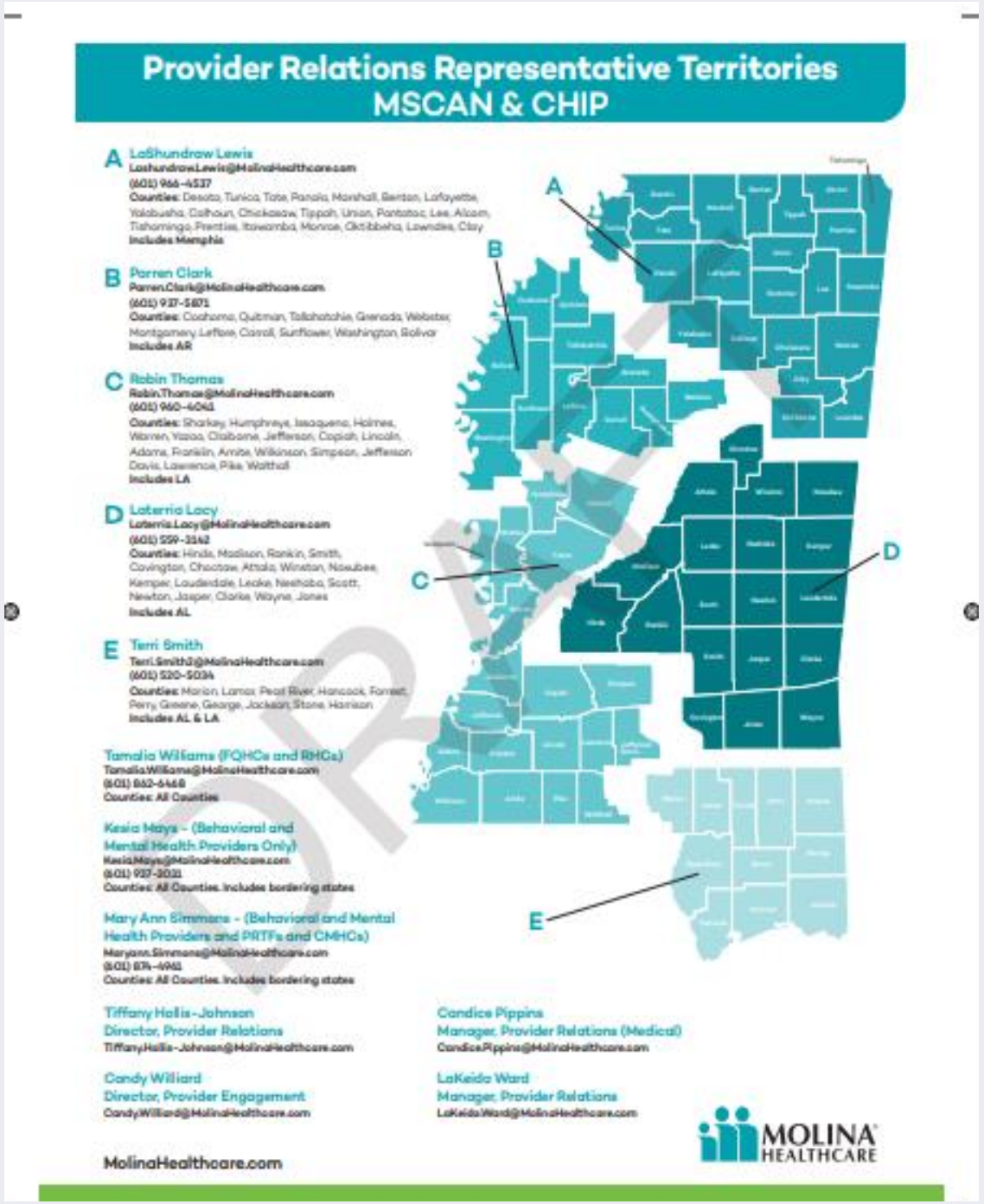
MOLINA® HEALTHCARE

Top 3 Issues Related to Claims Submission

- Duplicate Claim/Services
- Pay-To or Rendering NPI is not effective on claim DOS
- Timely Filing

MOLINA HEALTHCARE

Provider Relations Representatives Territories



Provider Relations Representative Territories
MSCAN & CHIP

A LaShundrow Lewis
LashundrowLewis@MolinaHealthcare.com
(601) 966-4537
Counties: Desoto, Tunica, Tate, Panola, Marshall, Benton, Lafayette, Yalobusha, Calhoun, Chickasaw, Tippah, Union, Pontotoc, Lee, Alcorn, Tishomingo, Prentiss, Itawamba, Monroe, Oktibbeha, Lowndes, Clay
Includes Memphis

B Perren Clark
PerrenClark@MolinaHealthcare.com
(601) 937-5871
Counties: Coahoma, Quitman, Tallahatchie, Grenada, Webster, Montgomery, Leflore, Carroll, Sunflower, Washington, Bolivar
Includes AR

C Robin Thomas
RobinThomas@MolinaHealthcare.com
(601) 960-6043
Counties: Sharkey, Humphreys, Issaquena, Holmes, Warren, Yazoo, Claiborne, Jefferson, Copiah, Lincoln, Adams, Franklin, Amite, Wilkinson, Simpson, Jefferson Davis, Lawrence, Pike, Walthall
Includes LA

D Laterria Lacy
LaterriaLacy@MolinaHealthcare.com
(601) 559-3362
Counties: Hinds, Madison, Rankin, Smith, Covington, Choctaw, Attala, Winston, Noxubee, Kemper, Lauderdale, Leake, Neshoba, Scott, Newton, Jasper, Clarke, Wayne, Jones
Includes AL

E Terri Smith
TerriSmith3@MolinaHealthcare.com
(601) 520-5034
Counties: Marion, Lamar, Pearl River, Hancock, Forrest, Perry, Greene, George, Jackson, Stone, Harrison
Includes AL & LA

Tamalia Williams (FQHCs and RHCs)
TamaliaWilliams@MolinaHealthcare.com
(601) 862-6468
Counties: All Counties

Kesia Mays - (Behavioral and Mental Health Providers Only)
KesiaMays@MolinaHealthcare.com
(601) 937-3021
Counties: All Counties. Includes bordering states

Mary Ann Simmons - (Behavioral and Mental Health Providers and PRTFs and CMHCs)
MaryAnn.Simmons@MolinaHealthcare.com
(601) 874-4961
Counties: All Counties. Includes bordering states

Tiffany Hollis-Johnson
Director, Provider Relations
TiffanyHollis-Johnson@MolinaHealthcare.com

Candy Willard
Director, Provider Engagement
CandyWillard@MolinaHealthcare.com

Candice Pippins
Manager, Provider Relations (Medical)
CandicePippins@MolinaHealthcare.com

LaKeida Ward
Manager, Provider Relations
LaKeidaWard@MolinaHealthcare.com

MolinaHealthcare.com

MOLINA HEALTHCARE

MOLINA HEALTHCARE

Claims Filing Tips

Accurate Coding

- Correct coding is key to submitting valid claims. To ensure that claims are as accurate as possible, use current, valid Diagnosis and Procedure Codes and code them to the highest level of specificity.

Secondary/TPL Claims

- Collect up-to-date information about the patient including demographics and insurance plan
- Check eligibility, verify benefits and confirm other insurance plans
- When submitting a claim include a legible explanation of benefits (EOB) from other primary insurance to avoid denials

Timely Filing

- Submit claims as quickly as possible, meeting timely filing deadlines
- Timely Filing Requirements:
  - -First Time: ***180*** calendar days
  - -Corrected claims: ***90*** days from the date of denial
  - -Second Payer: ***180*** calendar days after final determination by primary payer

Missing incomplete/invalid payer claim control number

- Corrected or Void/Replacement claims must include the correct coding to denote if the claim is Replacement or Corrected along with the ICN/DCN (original claim ID

Paper Claim Rejections

- To avoid a delay in receiving claim payment, ensure the information provided on a paper claim submission is readable, legible, and does not contain white out (correction fluid/tape)

MOLINA HEALTHCARE

Managed Care Provider Workshops

Mississippi Division of Medicaid

2024

United Healthcare

Claims

Contact Us

Medical, Behavioral/Therapy

- **Electronic:** UHCprovider.com/ClaimsBilling&Payments
- **Mailing Address:**

  UnitedHealthcare
  P.O. Box 5032
  Kingston, NY 12402–5032

Dental

- **Online:** UHCdentalprovider.com
- **Mailing Address:**

  Claims
  P.O. Box 481
  Milwaukee, WI 53201

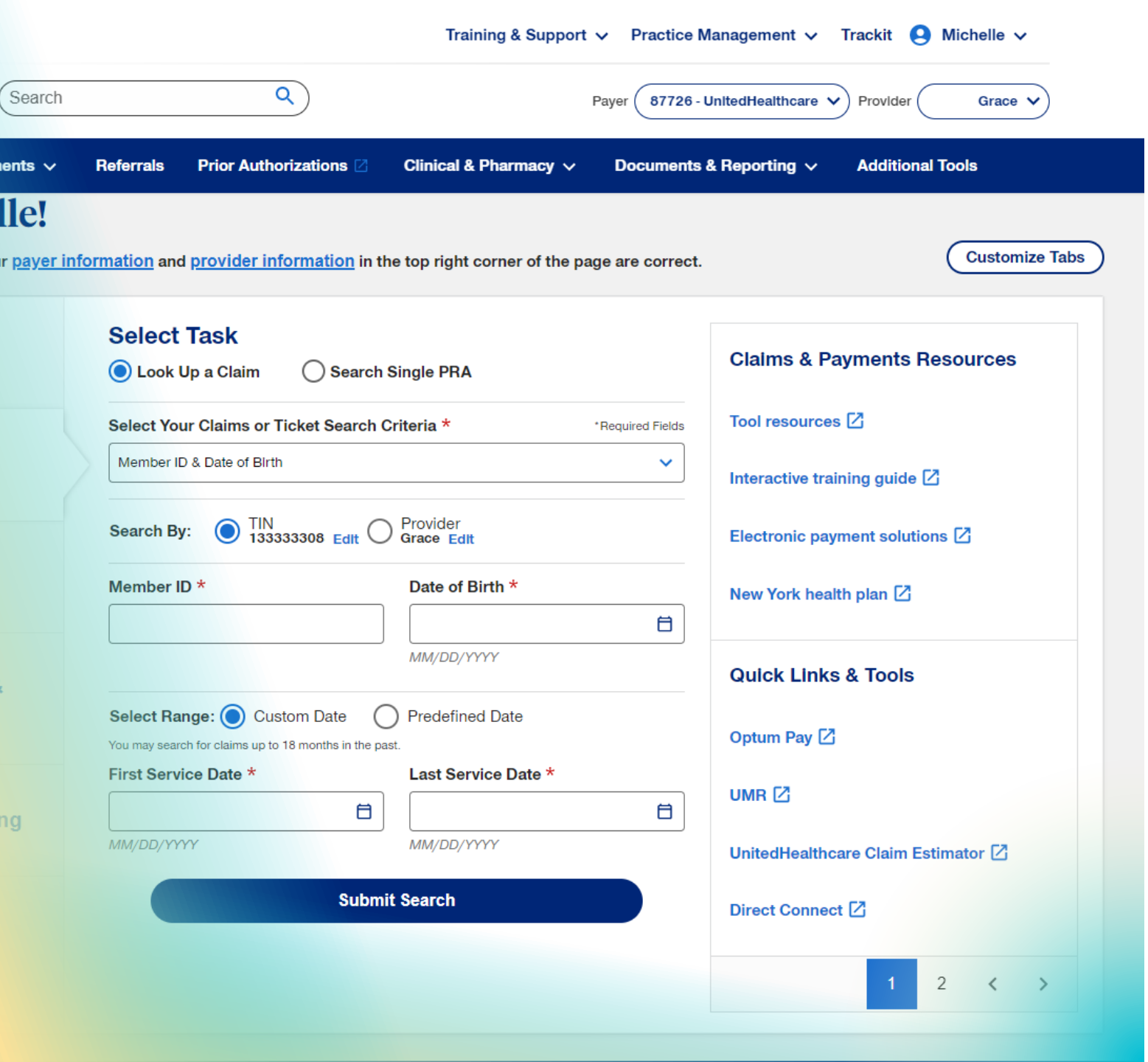
Vision

- **Online:** providers.eyesynergy.com
- **Mailing Address:**

  UnitedHealthcare – March Vision Care
  ATTN: Medicaid Vision Claims
  P.O. Box 30989
  Salt Lake City, UT 84130

Claim Submission

Physician Claims (1500)



Claims

Benefits and Features

- View claims information for multiple UnitedHealthcare® plans
- Access letters, remittance advice documents and reimbursement policies
- Submit additional information requested on pended claims
- Flag claims for future viewing
- Submit corrected claims or claim reconsideration requests
- Receive instant printable confirmation for your submissions
- And more

Claim Status

Training & Support | Practice Management | Trackit | Michelle

Search

Payer 87726 - UnitedHealthcare | Provider Grace

Eligibility | Claims & Payments | Referrals | Prior Authorizations | Clinical & Pharmacy | Documents & Reporting | Additional Tools

Welcome, Michelle!

Before you get started, make sure your payer information and provider information in the top right corner of the page are correct.

Customize Tabs

- Eligibility
- Claims & Payments
- Referrals
- Prior Authorizations & Notifications
- Documents & Reporting
- UnitedHealthcare Updates

Updated 08/26/2022

Verify Eligibility & Benefits

Select Your Eligibility Search Criteria* *Required Fields

Member ID & Date of Birth

Member ID*

Date of Birth*

MM/DD/YYYY

Search for Multiple Members

Search Range: Predefined Date | Custom Date

Select a Policy Date Range*

Today's Date 08/27/2022

Verify Eligibility

Eligibility & Benefits Resources

- Tool resources
- Interactive training guide
- Drug lists and pharmacy
- New York health plan

Quick Links & Tools

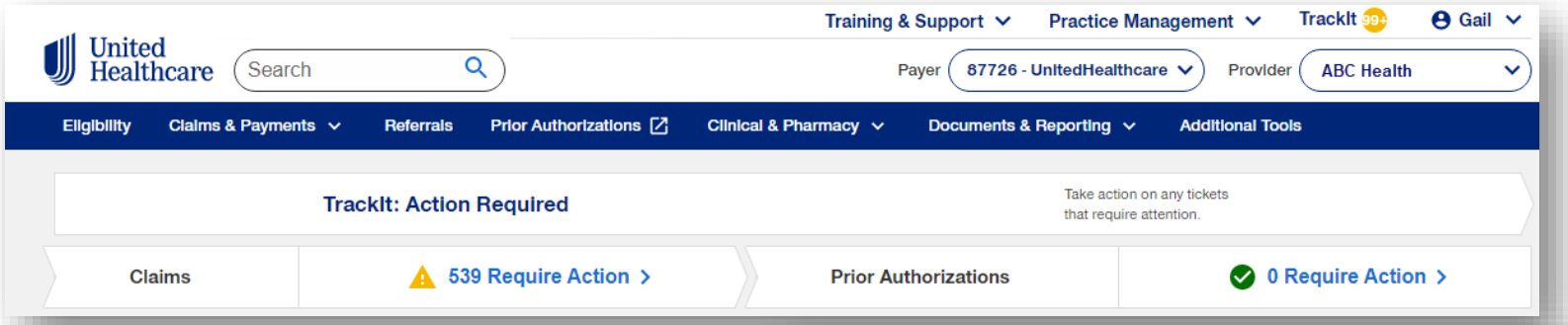
- UMR
- All Savers
- Optum VA Community Care Network
- Optum Physical Health

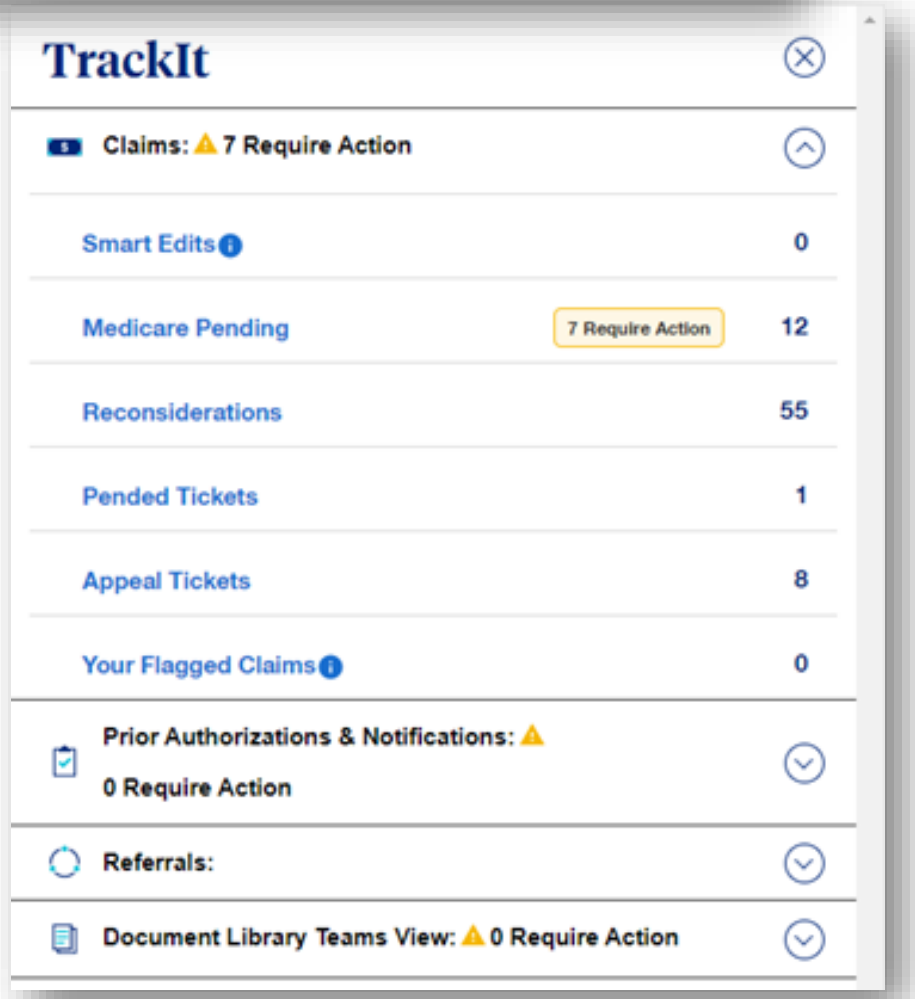
1 2

Training Tips

Feedback

TrackIt





TrackIt

Benefits and Features

- Serves as your daily to-do list
- Your personal assistant where you manage email notifications
- An automatic reminder tells you we are missing some information
- View appeal decision letters, prior authorization and clinical letters
- Take action on claims, prior authorizations, referrals
- Upload documents
- And more
- Access from your Action Required Bar or the TrackIt icon

Claim Reconsideration

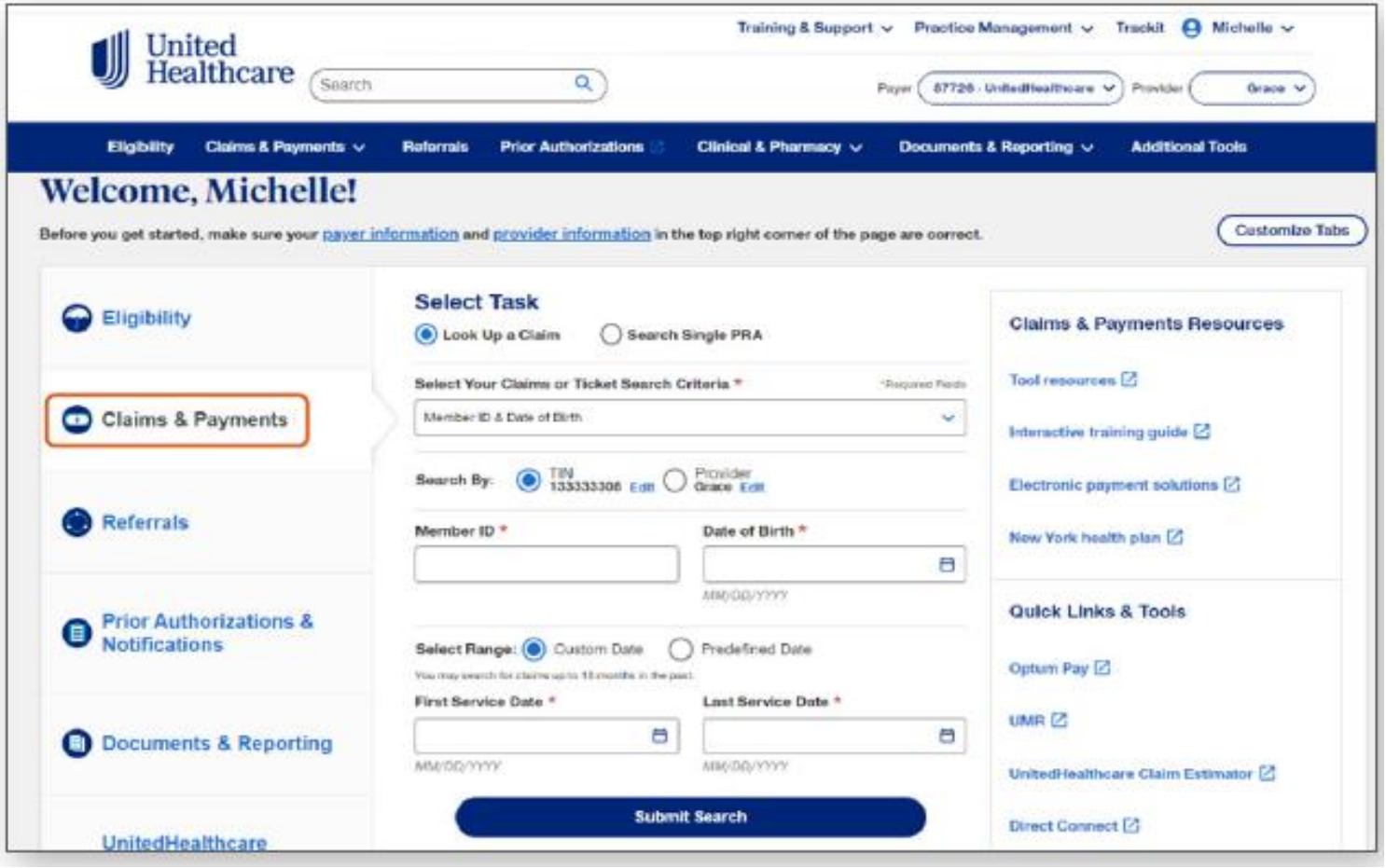
1. Sign in at **UHCprovider.com**

2. Select **Claims & Payments** from the Provider Portal
   - If not yet registered, consult **UHCprovider.com/access**

3. Enter the criteria and **Submit Search**

4. Select a claim from the Search Results

5. Review the claim



Reconsideration

Reconsideration

If desired, under **Take Action** select the **Create Claim Reconsideration** button.

Complete the following:

A. Contact Information

B. Request Details

- **Amount Requested** – enter the full amount you expect, not the difference between expected and received
- **Request Reason**

C. Request Comments

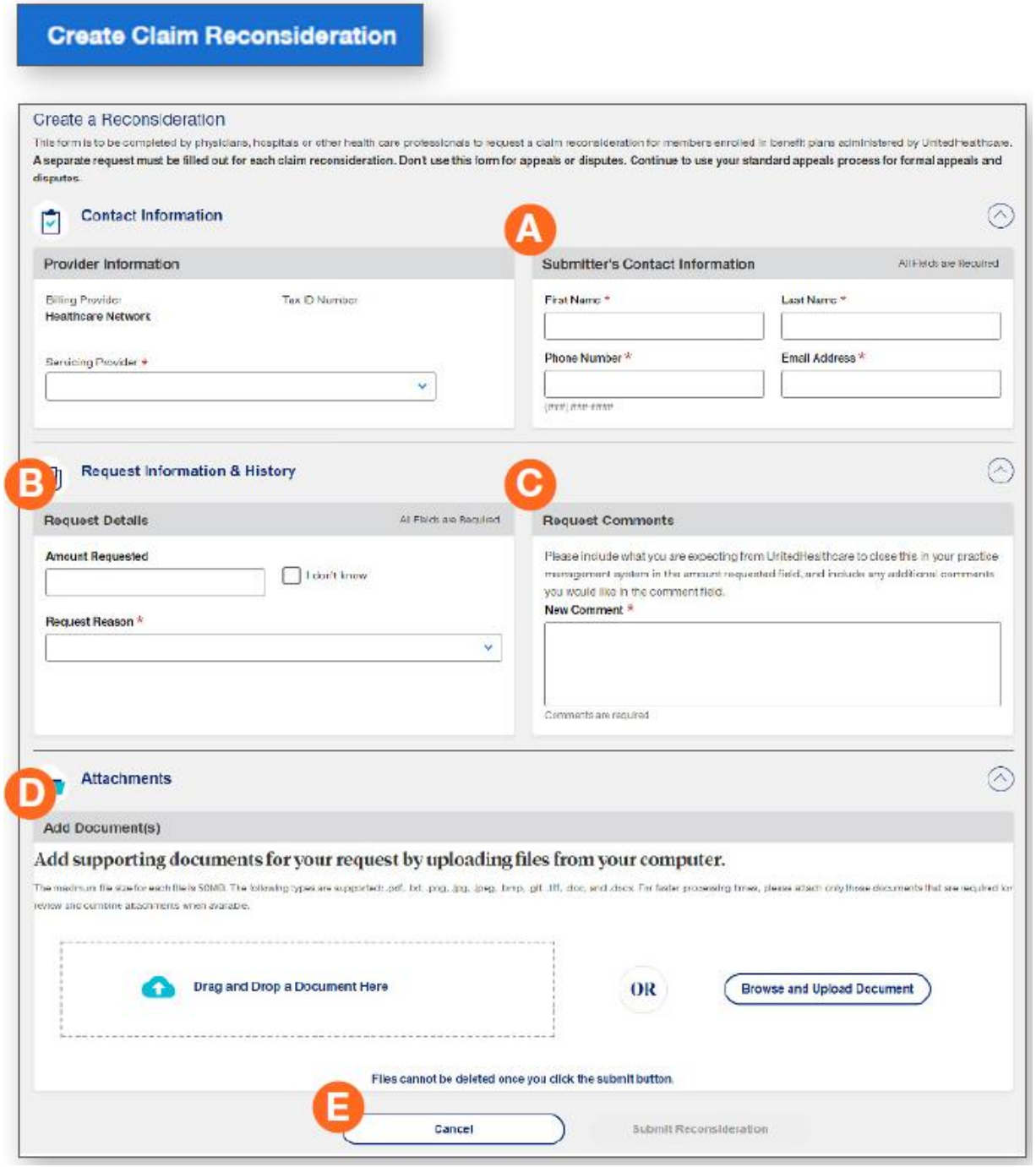
- State how the claim was processed
- Give your evidence of why it should be processed differently

D. Add documents

- No limit to the number of attachments
- Each file must be less than 50 MB

E. Submit

- You will immediately receive a confirmation
- The standard reprocessing time is 30 calendar days/20 business days



Digital Solutions

Digital Solutions Overview

Electronic Data Interchange (EDI)	UnitedHealthcare Provider Portal	Application Programming Interface (API)
Electronic interchange of information between partners using an industry	Public and secure website to obtain information and conduct transactions	Automated solution accessing real-time data in a secure environment
• Fully automated	• Partially automated	• Fully automated
• Integrate through clearinghouse	• Access with One Healthcare ID	• Direct automated data requests returned real-time
• HIPAA industry standard information	• Detailed information with extended attributes	• Detailed information with extended attributes
• Medium to high volume	• Low volume	• Medium to high volume
• Cost – Varies	• Cost – Free	• Cost – Free

Learn more at UHCprovider.com. Go Digital!

Claim Resolution Service Model

Step 1

Submit your claim reconsideration online or by phone.

- Obtain the online ticket or call reference number of your original claim
  - **Online (preferred method):** Sign in to the Provider Portal at UHCprovider.com/claims
  - **Phone:** Call Provider Services at **877-842-3210**
- Allow up to 30 days for processing

Step 2

Check the status of your reconsideration request.

- You should receive notice of our decision within 30 days
- If you haven't received a notice, check its status at UHCprovider.com/claims

Step 3

Don't agree? Contact Provider Relations via chat function.

- Get real-time answers to your questions about your claim reconsideration. To chat with a live advocate, go to UHCprovider.com and click Sign In at the top-right corner. Chat is accessed from the Contact Us page and is available 6 a.m.–6 p.m. MT, Monday–Friday.
- Please have the following information ready for the chat:
  - Member name, date of birth, ID number and plan name
  - Claim number, date of service and billed amount
  - Reason for escalation
  - Rendering care provider name, tax ID number
  - Call reference or online ticket number
- Allow up to 30 days for processing

Step 4

Don't agree? Submit a final appeal.

- If you don't agree with the response from Provider Relations, you may submit a final appeal
  - Use the File Appeal button in the Claims tool at UHCprovider.com/claimsportal
  - Attach all supporting materials
- Allow up to 60 days for processing

Unlock the Power of Chat

Do you need answers quickly but not sure where to find them? Are you looking for a way to lessen the time you spend on administrative tasks, so you can free up more time to focus on your patients? Our chat feature in the UnitedHealthcare Provider Portal has you covered.

Our knowledgeable advocates are ready to offer support when you're not sure of your next steps or need help finding information. When you pop into chat, not only will you get the support you need, you also may streamline your administrative processes.

Our chat feature currently offers support on the following:

- Claims
- Eligibility & benefits
- Prior authorization
- Credentialing
- Technical support

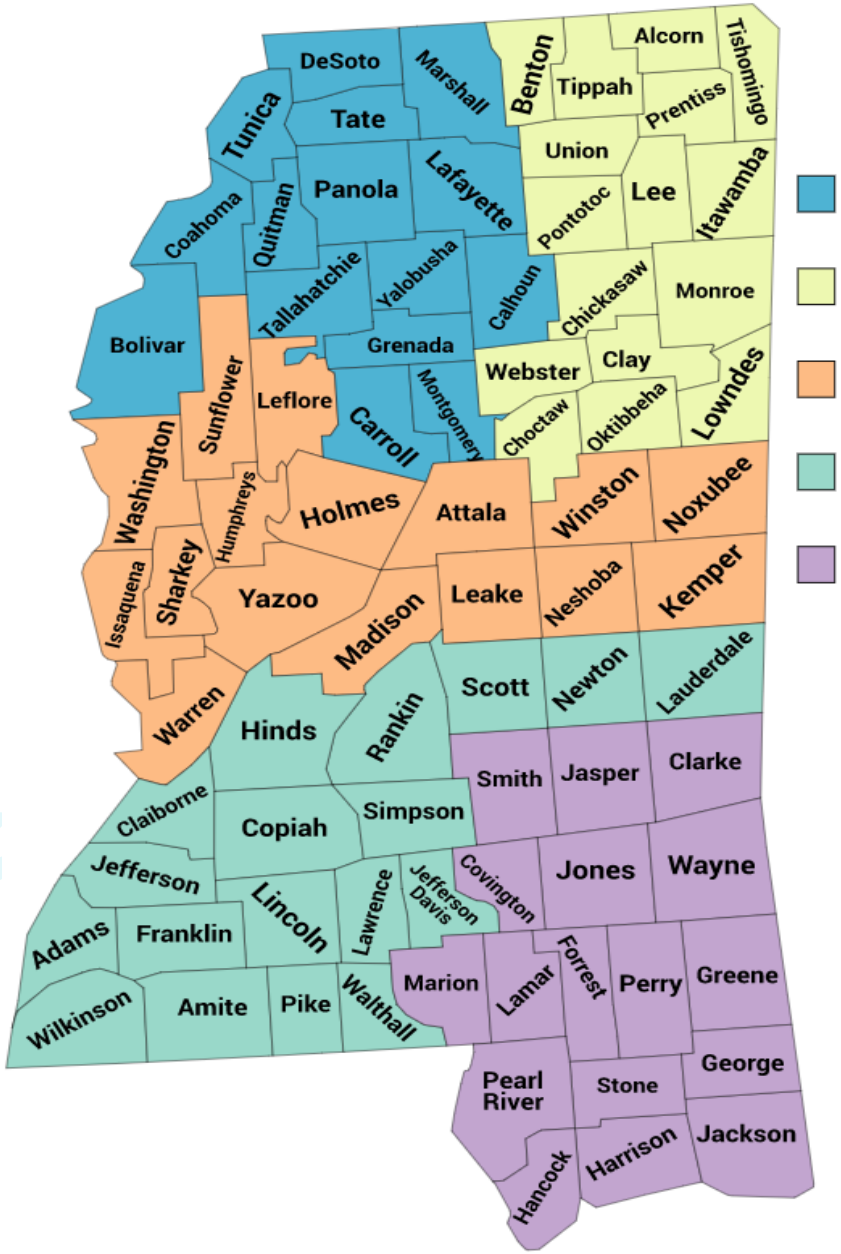
Support is just a click away at **UHCprovider.com/chat**.

How and where to access chat

To sign in to the portal, go to **UHCprovider.com** and click Sign In at the top-right corner. Then, enter your One Healthcare ID. Have a team member who doesn't have a One Healthcare ID yet? Have them go to **UHCprovider.com/access** to get started.

After signing in to the portal, chat can be accessed on the Contact Us page, 7 a.m.–7 p.m. CT, Monday–Friday.

UnitedHealthcare
Provider Advocate Account Managers



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FQHC | RHC Statewide

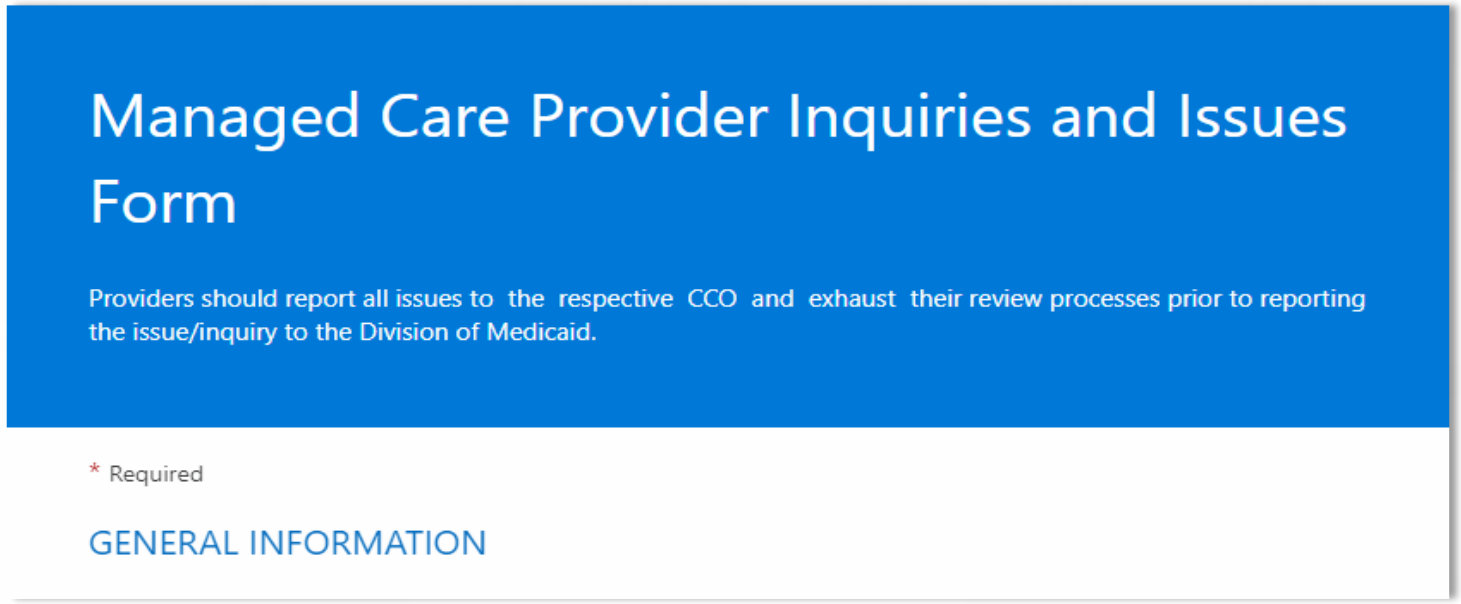
Curtis Burroughs
curtis_burroughs@uhc.com

Managed Care Inquiries and Complaints

HELP US, HELP YOU

Please forward all provider issues and complaints to:

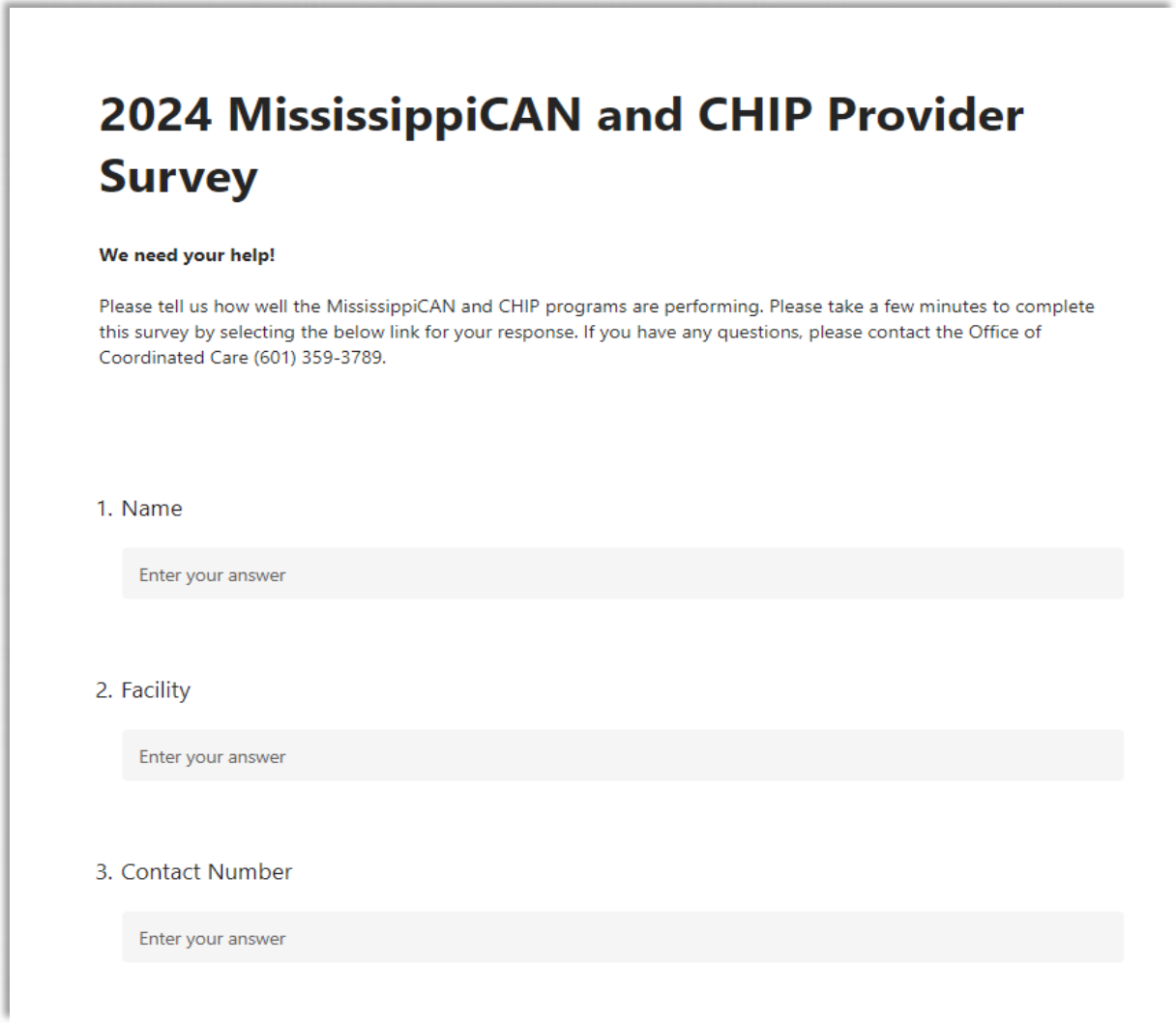
https://forms.office.com/g/WXj92sN1MH



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

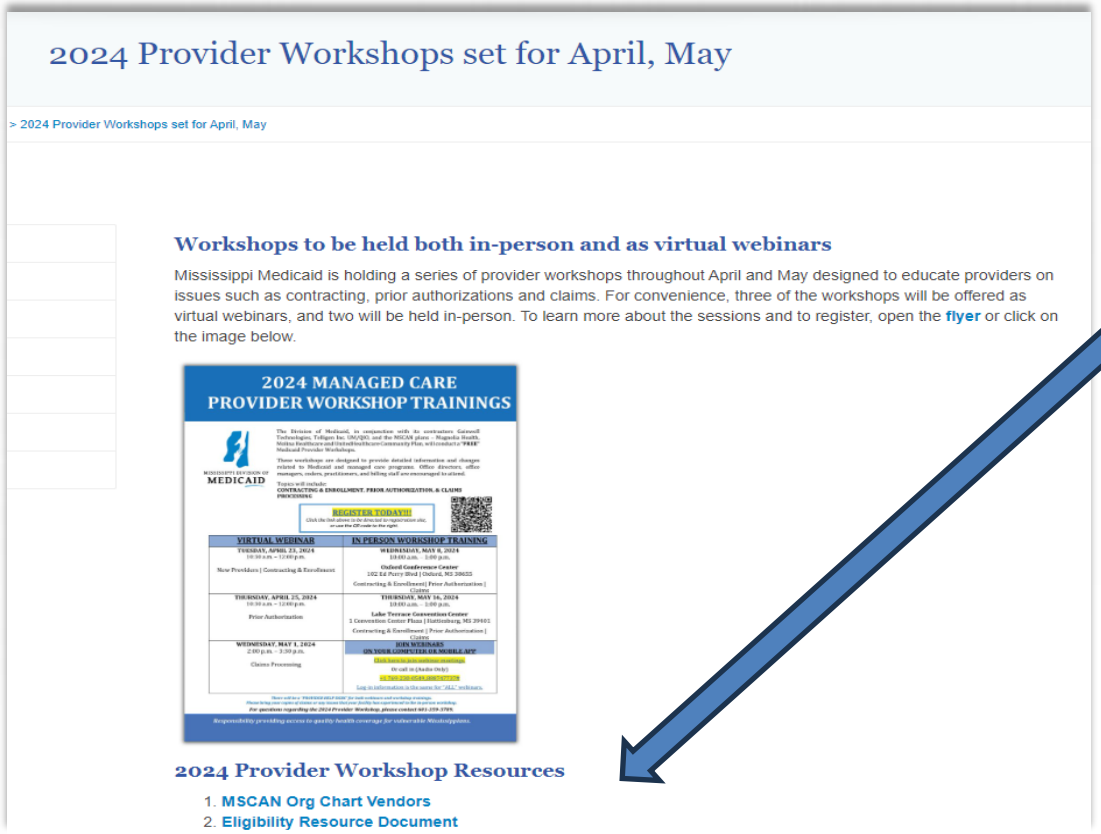
Enter your answer

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.