Mississippi Division Of Medicaid

Provider Workshops

Wednesday, May 8, 2024
10:00 a.m. – 2:00 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

Prior Authorizations
(Telligen, Molina, United, Magnolia)

---REFRESHMENT BREAK 10 Mins---

Claims
(Gainwell, United, Magnolia, & Molina)

---LUNCH ON YOUR OWN ---

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

Questions & Answer Session

Division of Medicaid Managed Care Team

Lucretia Causey
Deputy Director of Managed Care

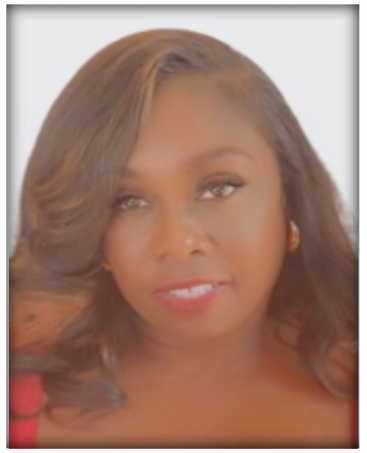
Patricia Collier
Managed Care – Provider Services

Michelle Robinson
Managed Care – Member Service

Charlotte McNair
Managed Care Enrollment & Eligibility

Ajanda Thomas
Webinar Navigator

Takia Robinson
Managed Care – Document Review



Nicky Odomes
Gainwell Technologies- Provider Service Rep

Katrina Merriwether
Education Manager, State Health Solutions

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

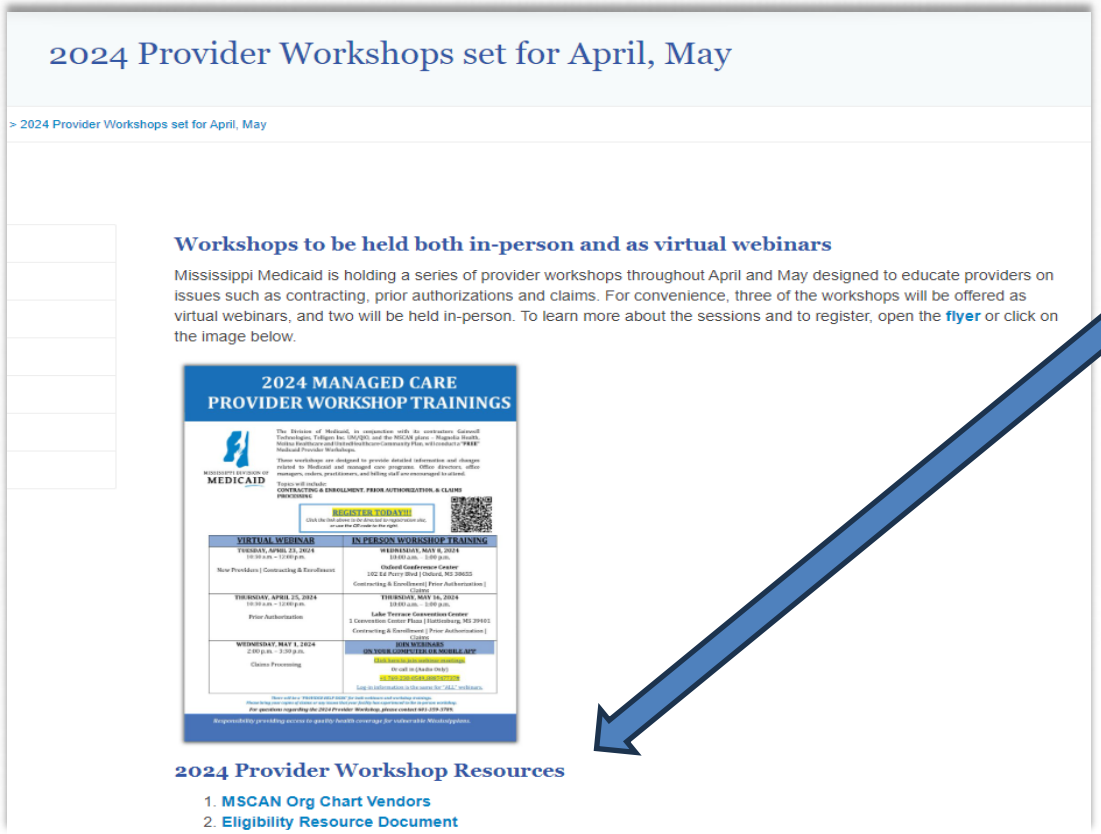
Stacy McGrew
Provider Engagement Administrator

UnitedHealth Provider Service Team

Rhona Waldrep

Curtis Burroughs

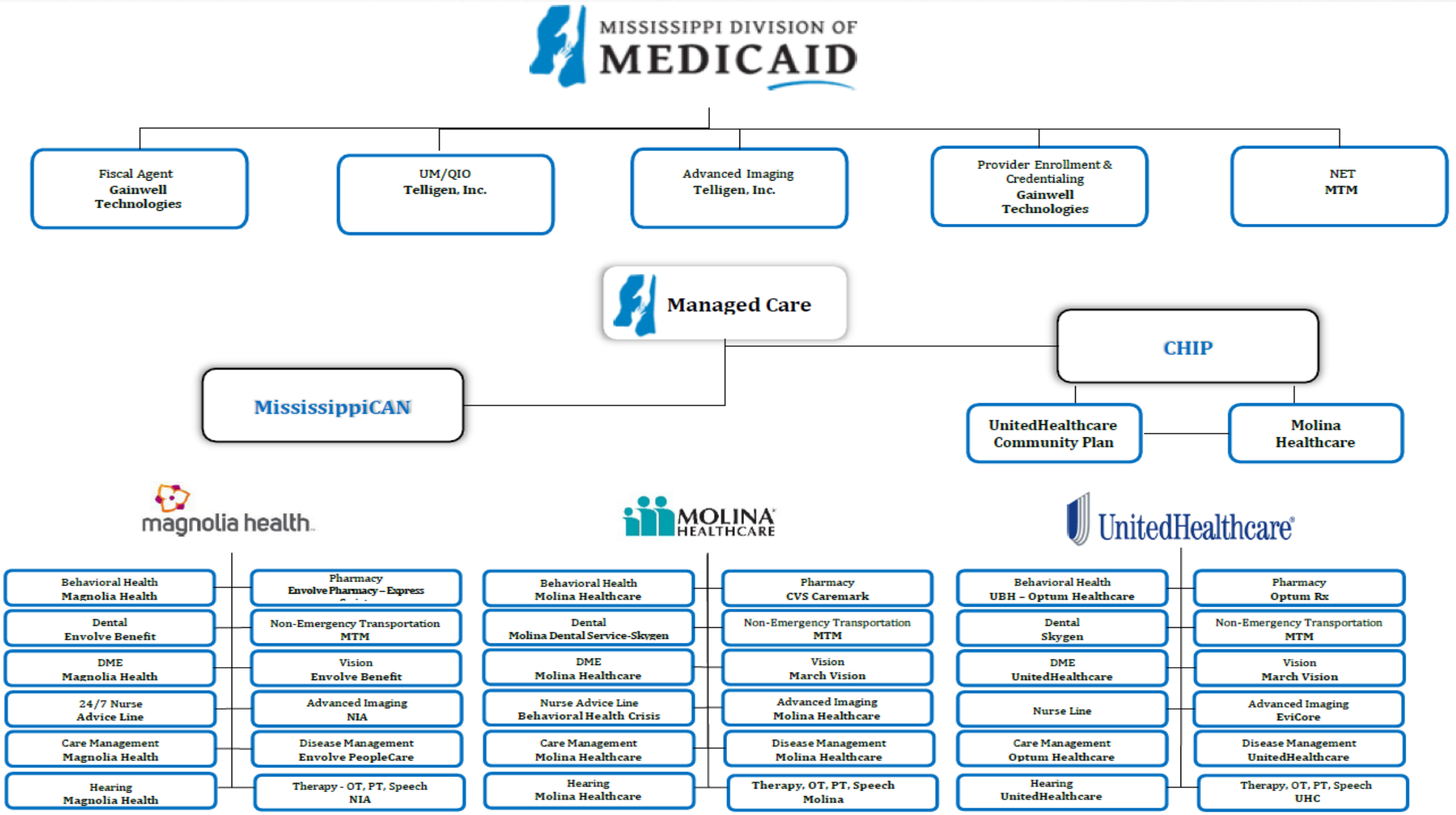
How Providers can Access the Provider Workshop Resources



- 2024 Provider 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

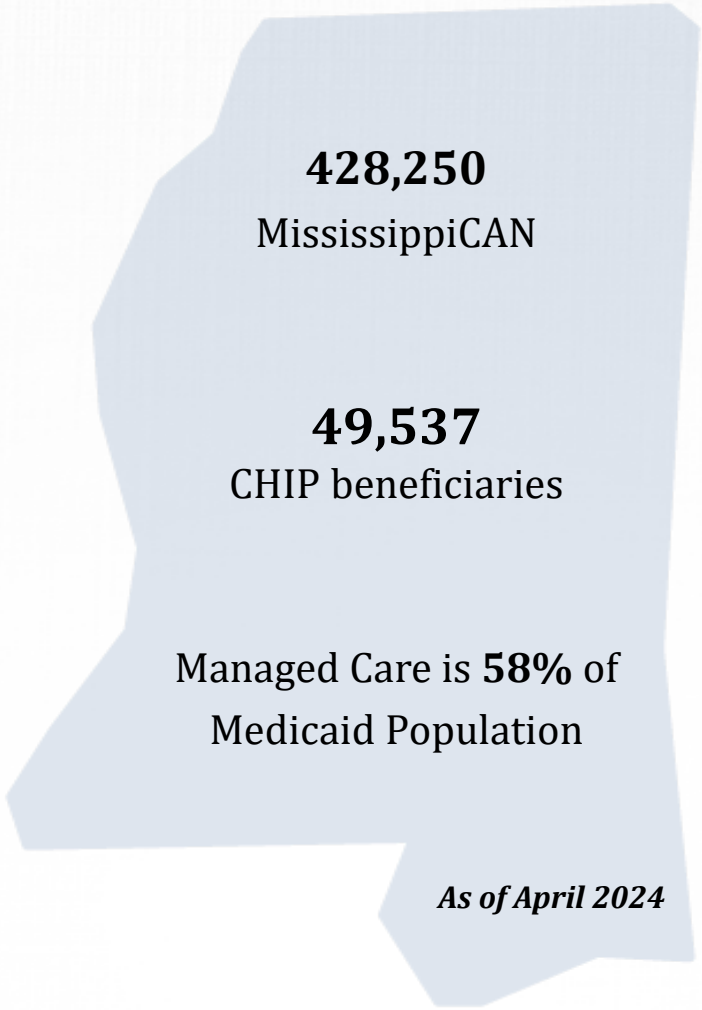
Total Enrollment - 800,539 (includes Medicaid and CHIP)

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

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.

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.

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

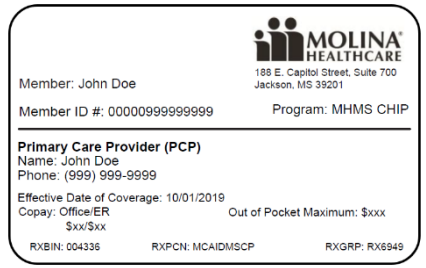
MOLINA HEALTHCARE

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



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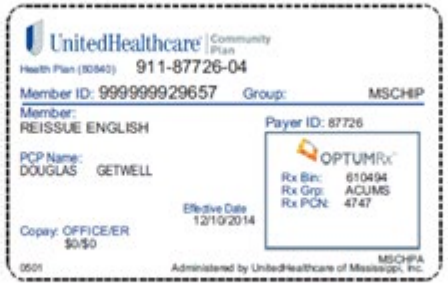


Note: Providers are required to check eligibility for each date of service. DOM encourages all beneficiaries to present their blue Medicaid card and CCO card.

DOM Spring Provider Workshops

2024

Contact Us

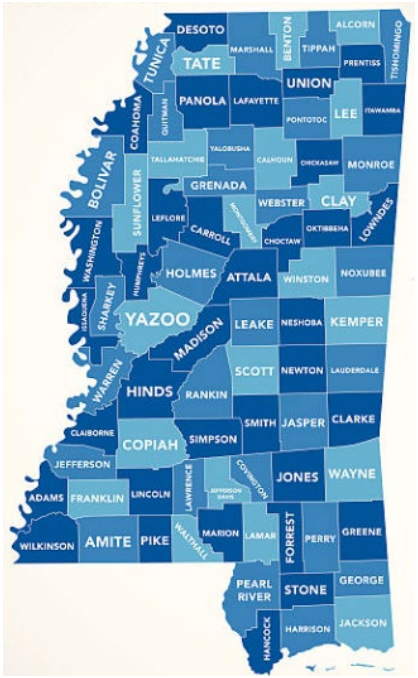
Education Manager – Primary Point of Contact
Katrina Merriwether

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

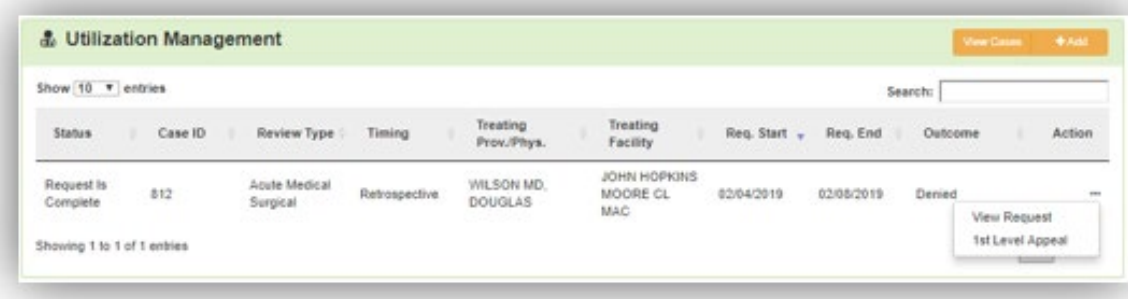
Review Processing Times for Dental Services			
General Services	**Prospective**	**Concurrent**	**Retrospective**
General Dental	7	NA	10
Dental Surgery	7	NA	10
Orthodontia	7	NA	10

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

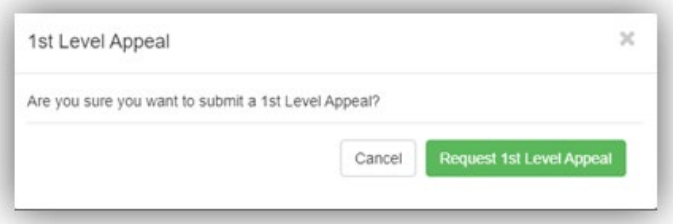
Reconsiderations: 1st Level Appeal & Peer-to-Peer Review

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 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

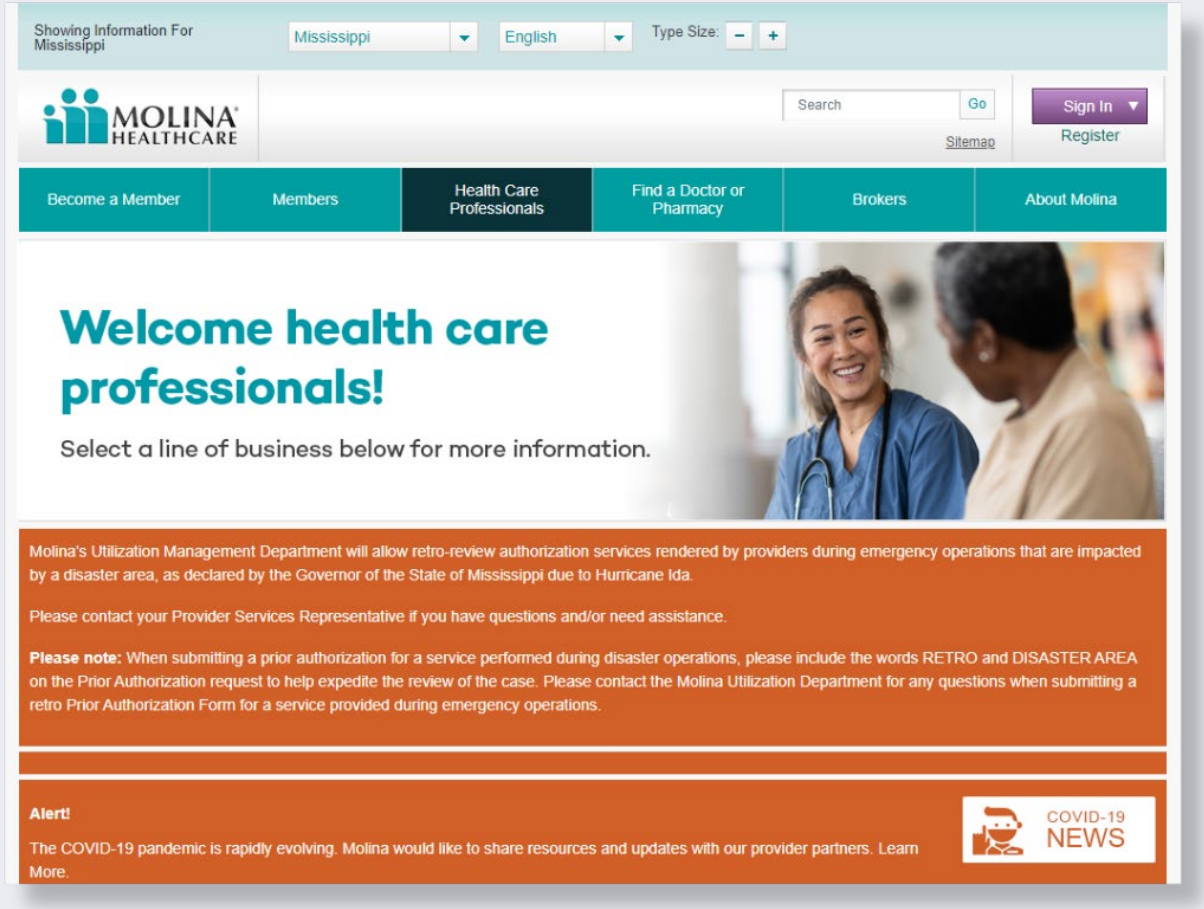
For Access Visit:

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

MOLINA HEALTHCARE

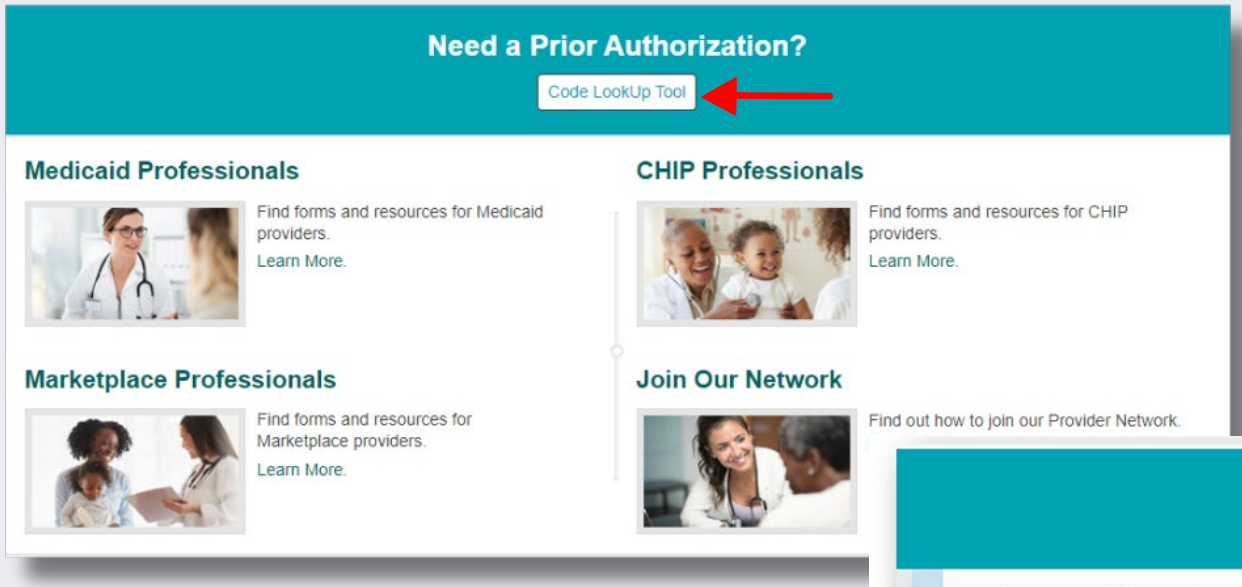
PA Look Up Tool

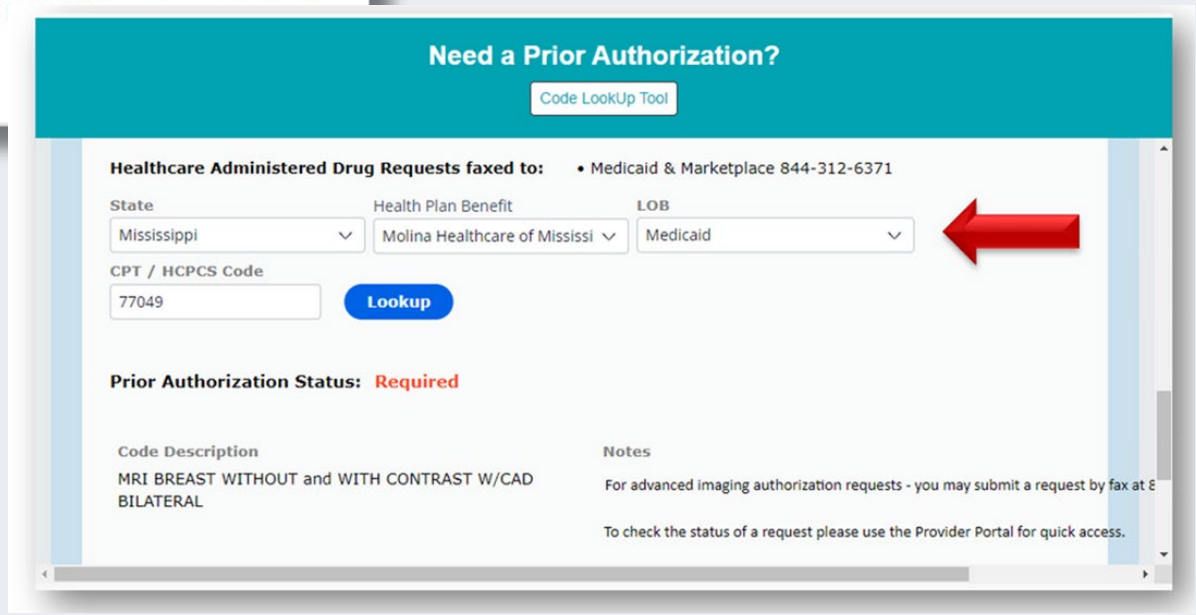
Our Prior Authorization Look Up Tool allows providers to search specific CPT codes to determine if prior authorization is required.



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

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- 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

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

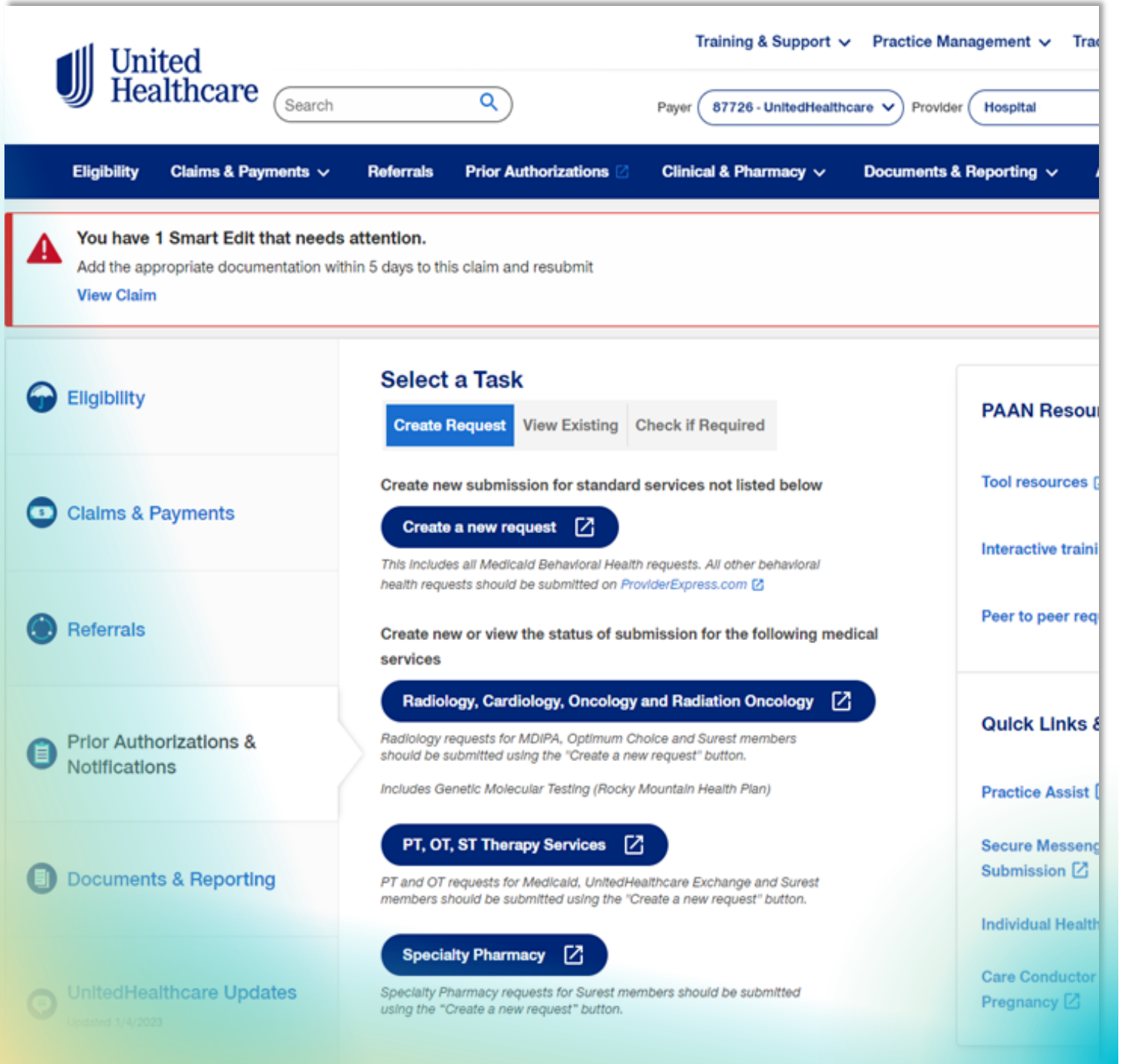
Dental

- **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."

5/15/2024

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/

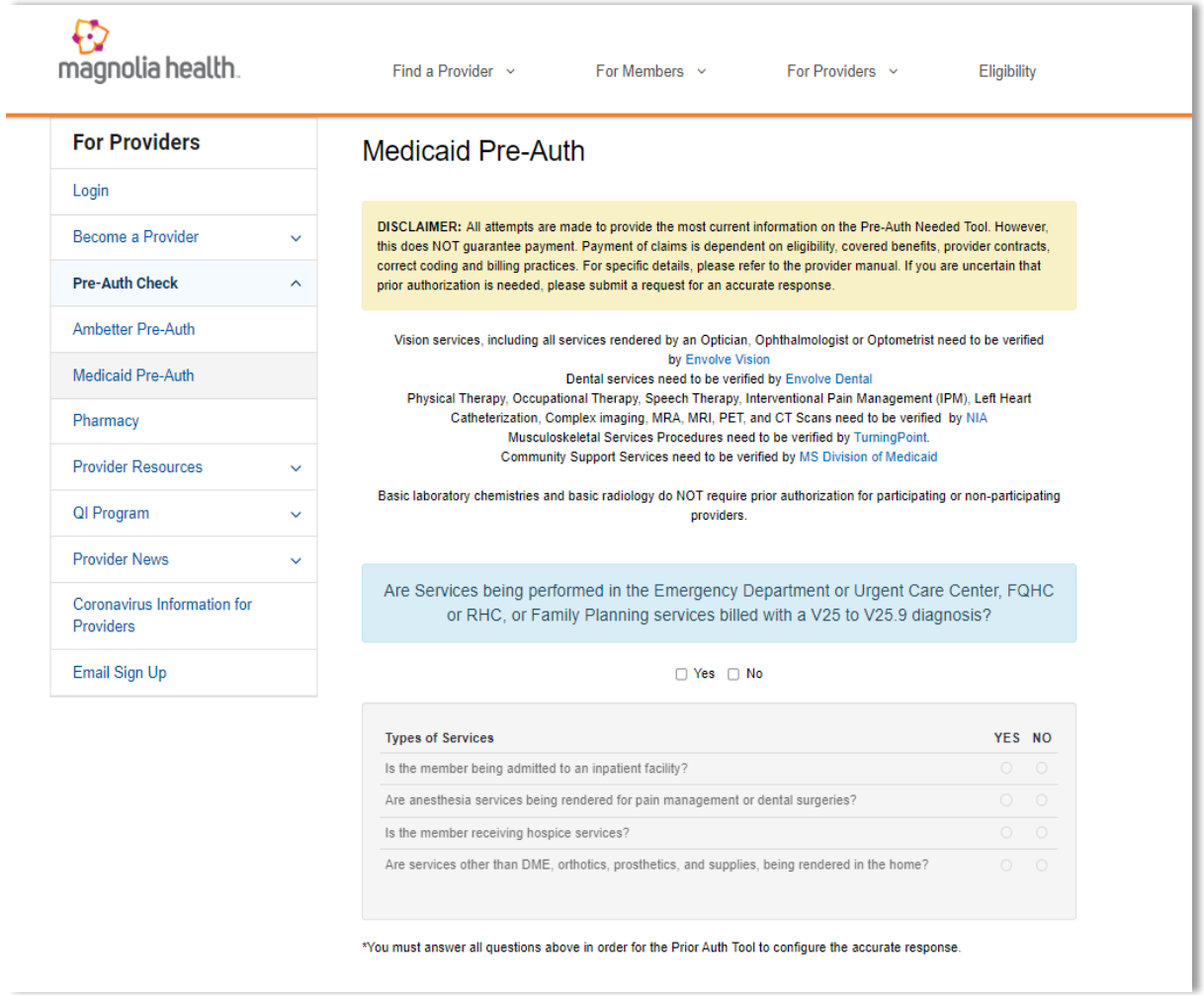
Evolent/National Imaging Associates (NIA)- (866) 912-6285

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/

Break & Refreshments
10 minutes

gainwell®

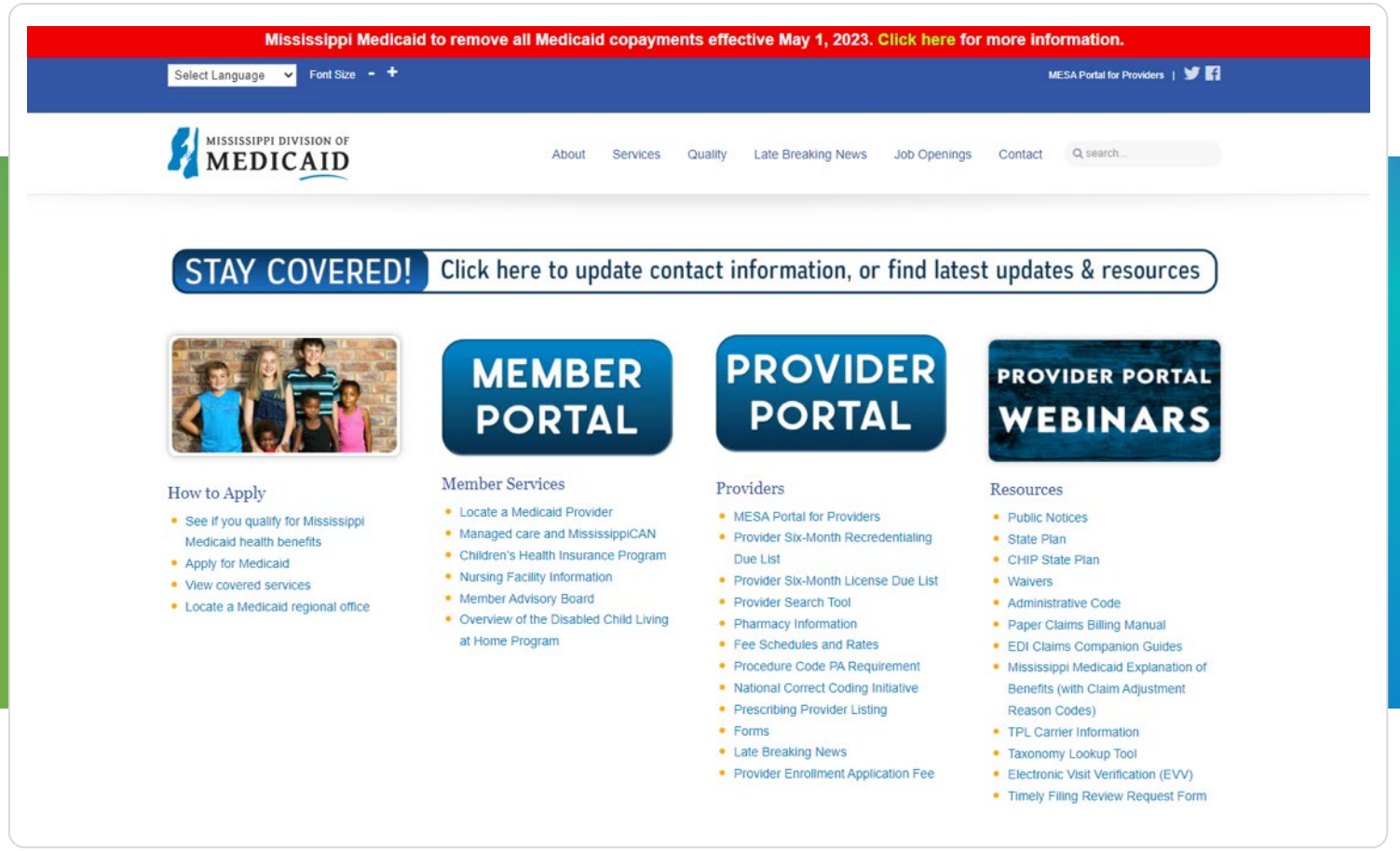
Agenda

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

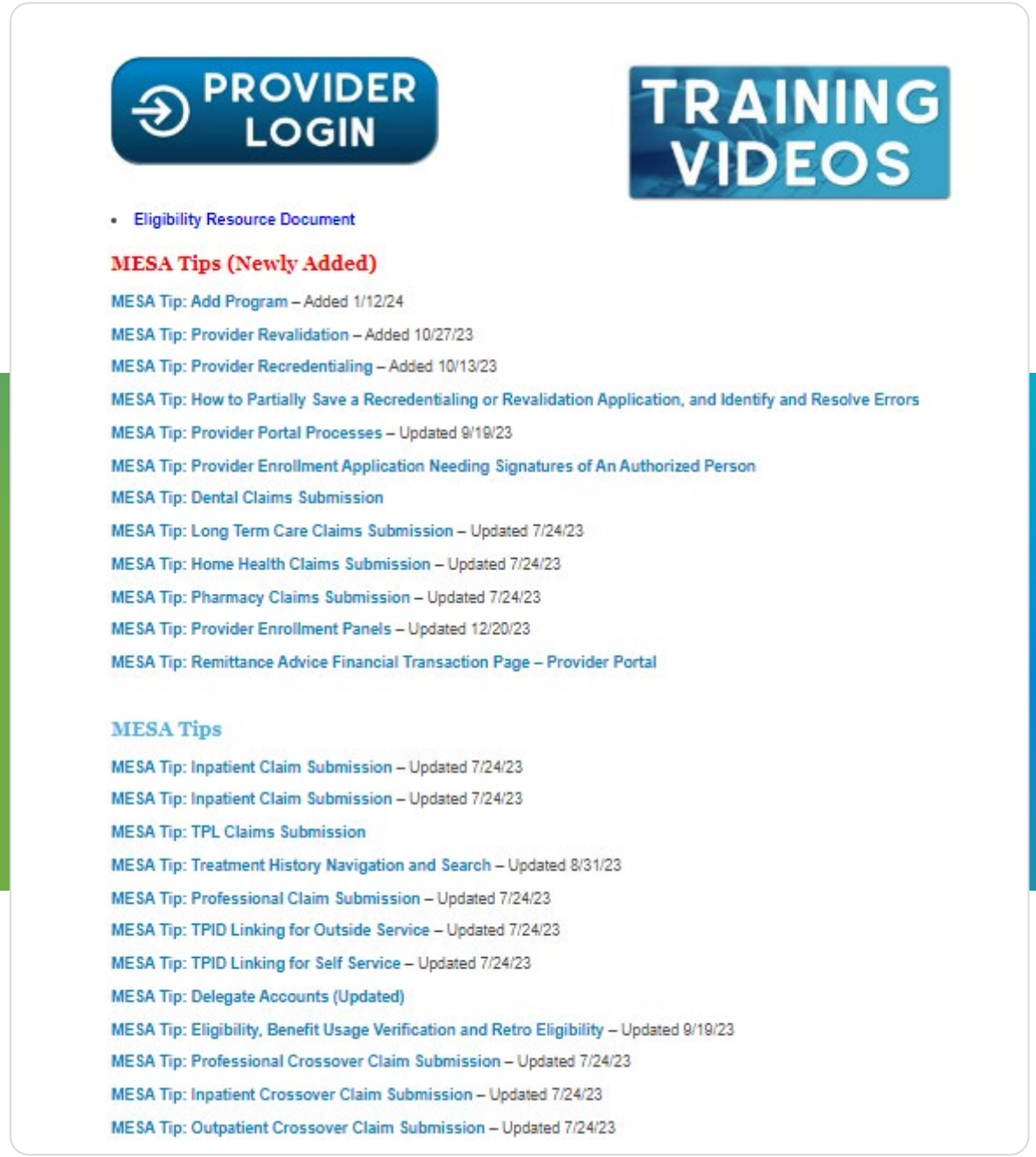


Mesa Web Portal

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.

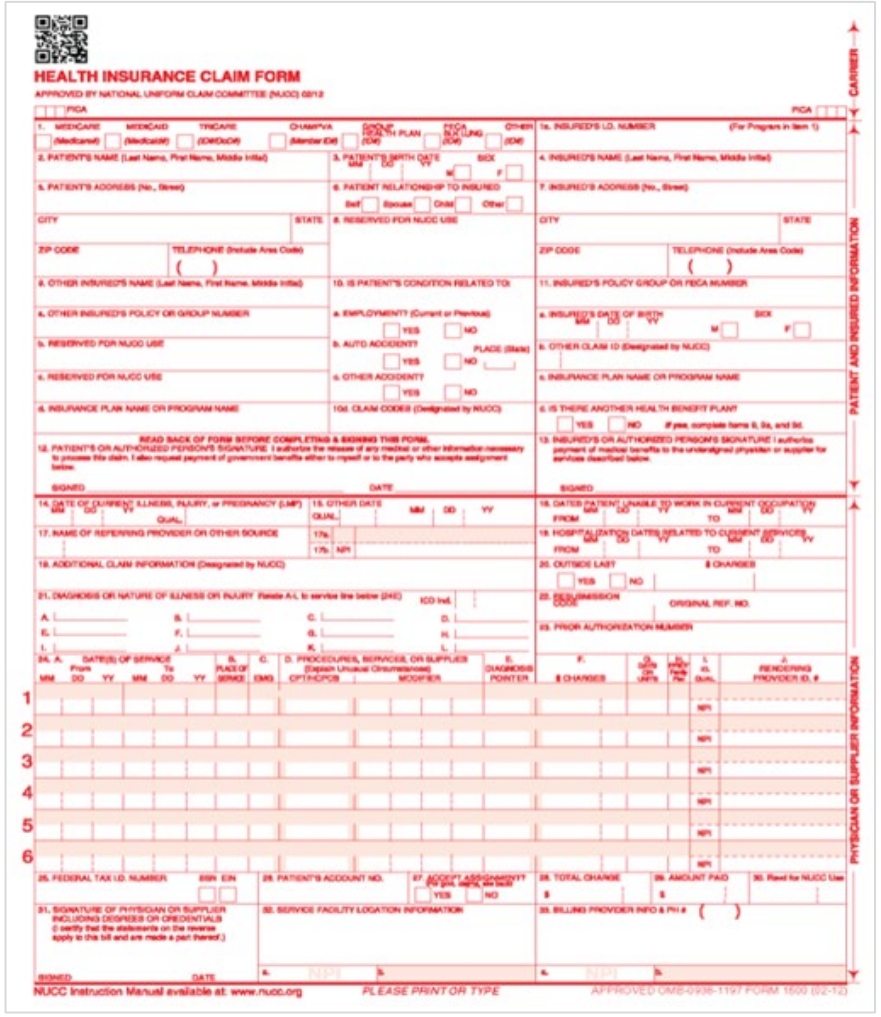
The MISSISSIPPI CROSSOVER CLAIM FORM will no longer be accepted.

Please mail claim forms to:

Mississippi Medicaid Program

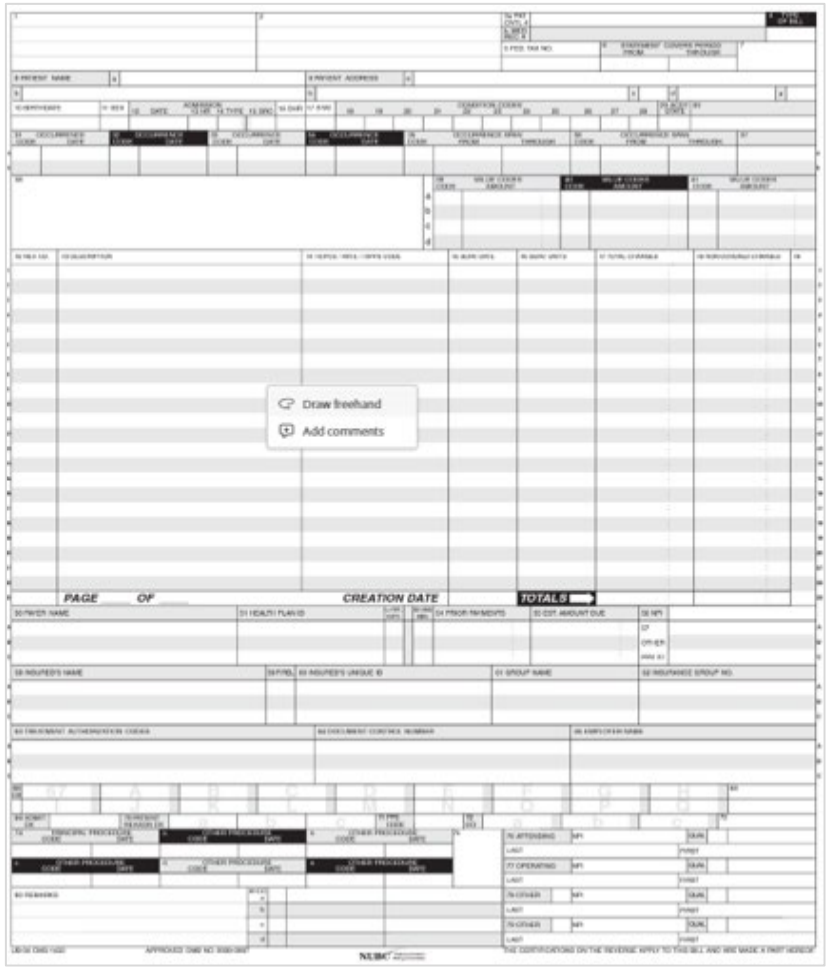
PO Box 23076

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)

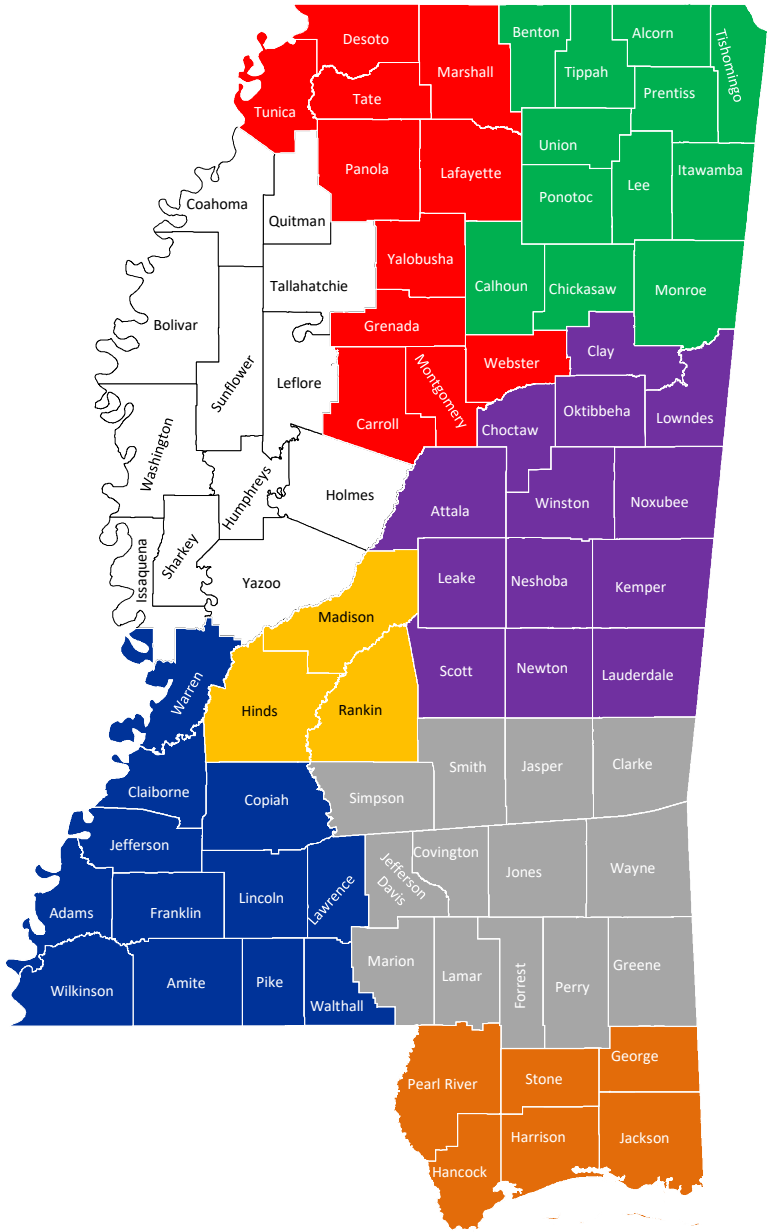
Key Contacts

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

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

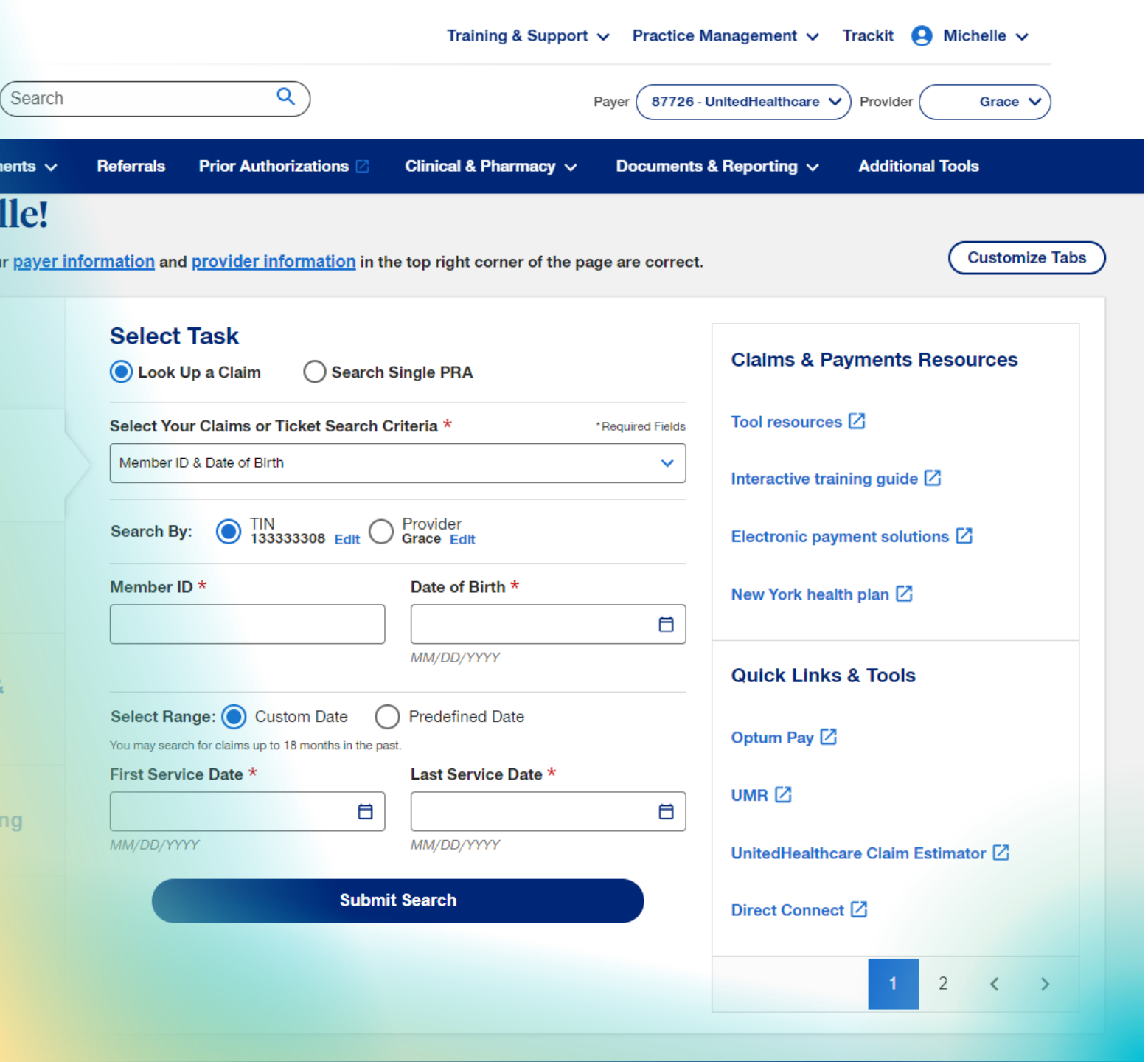
Vision

- **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

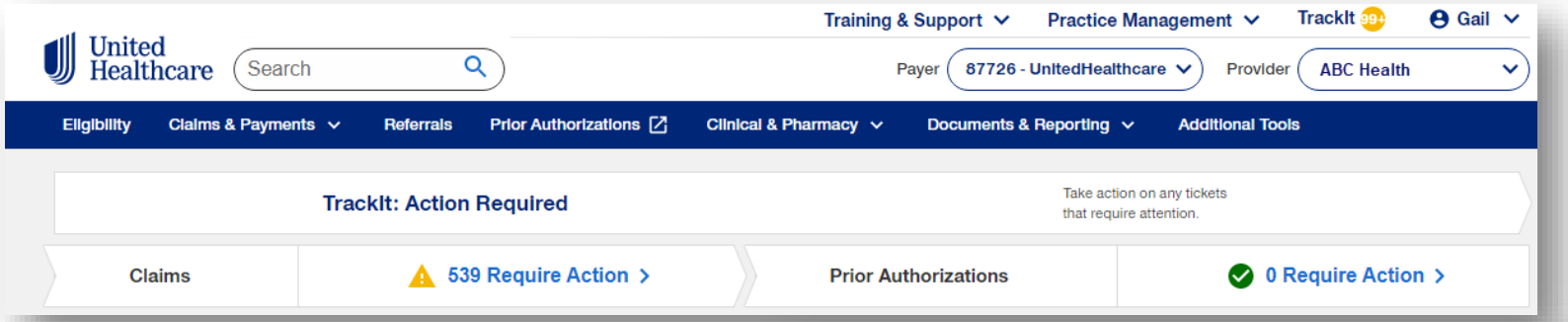
- UMR
- All Savers
- Optum VA Community Care Network
- Optum Physical Health

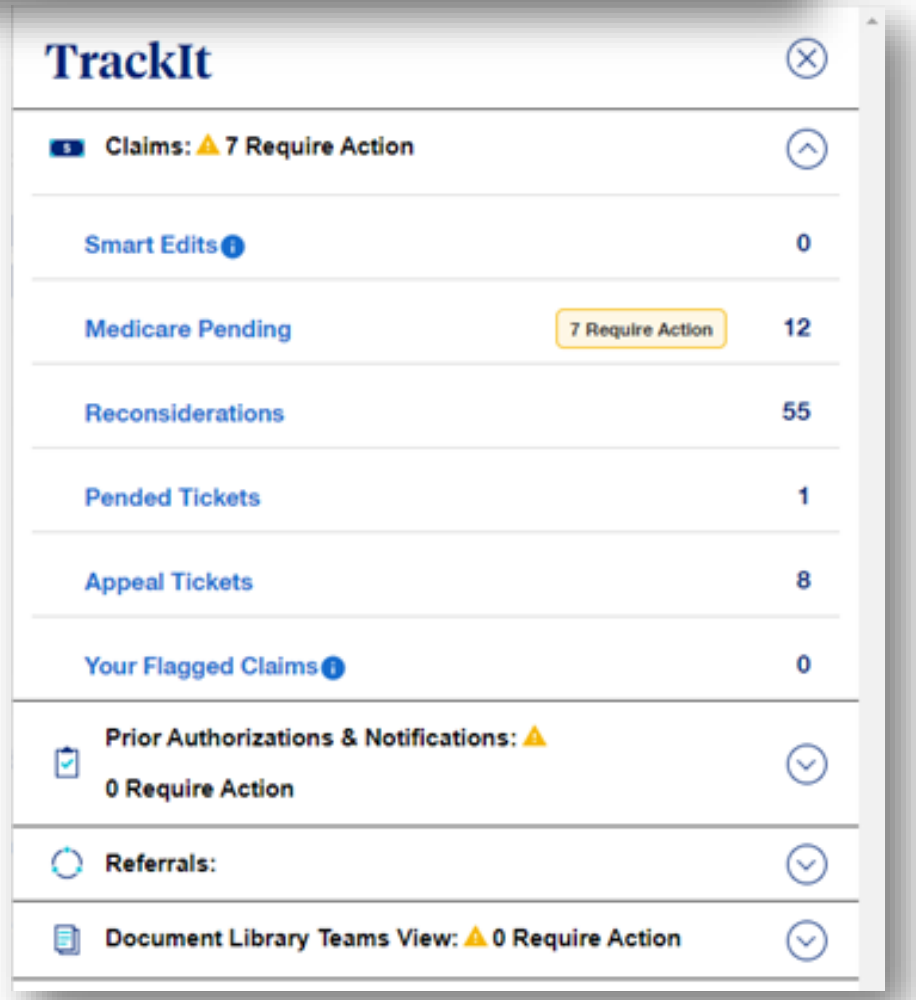
1 2

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

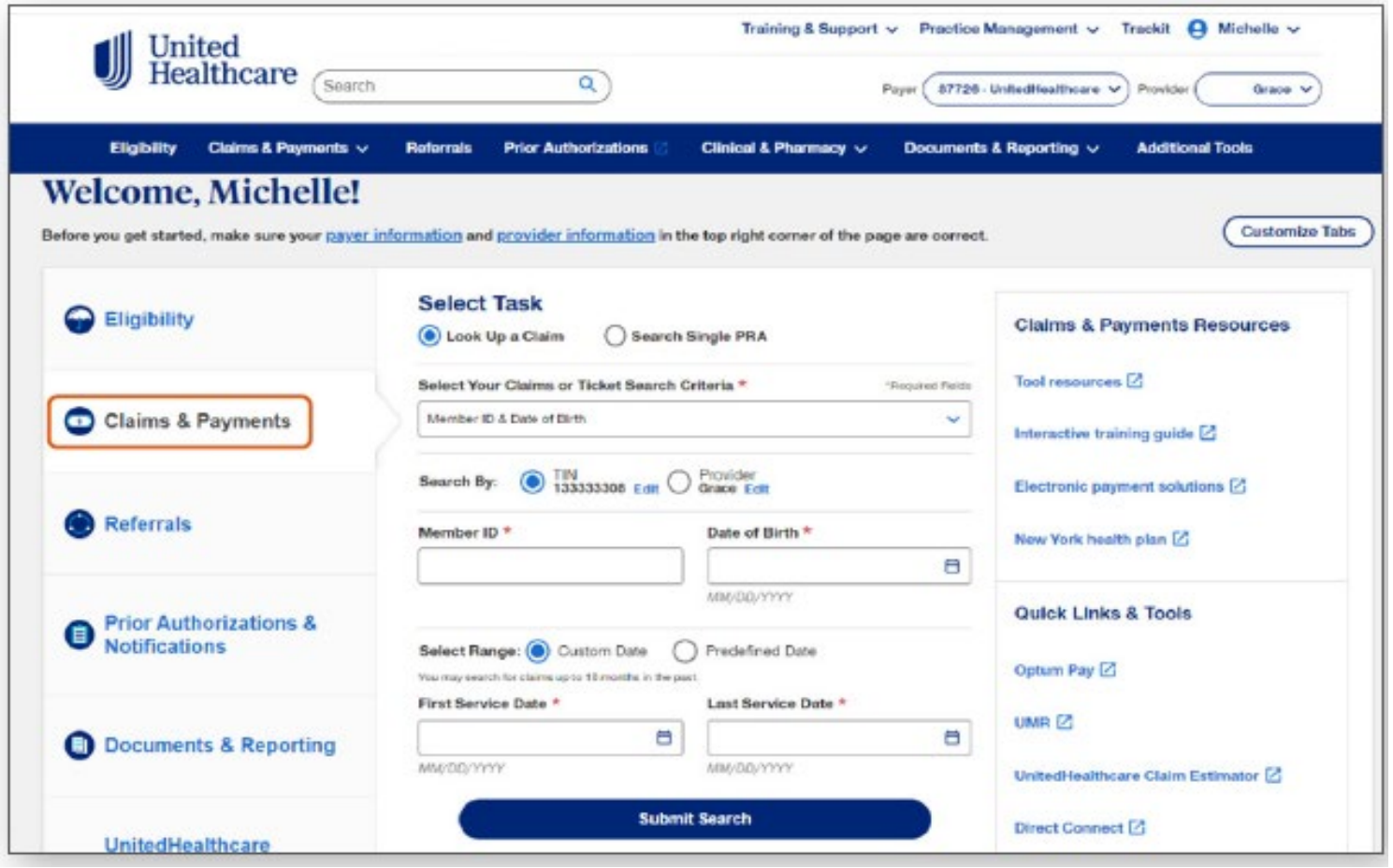
1. Sign in at **UHCprovider.com**

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

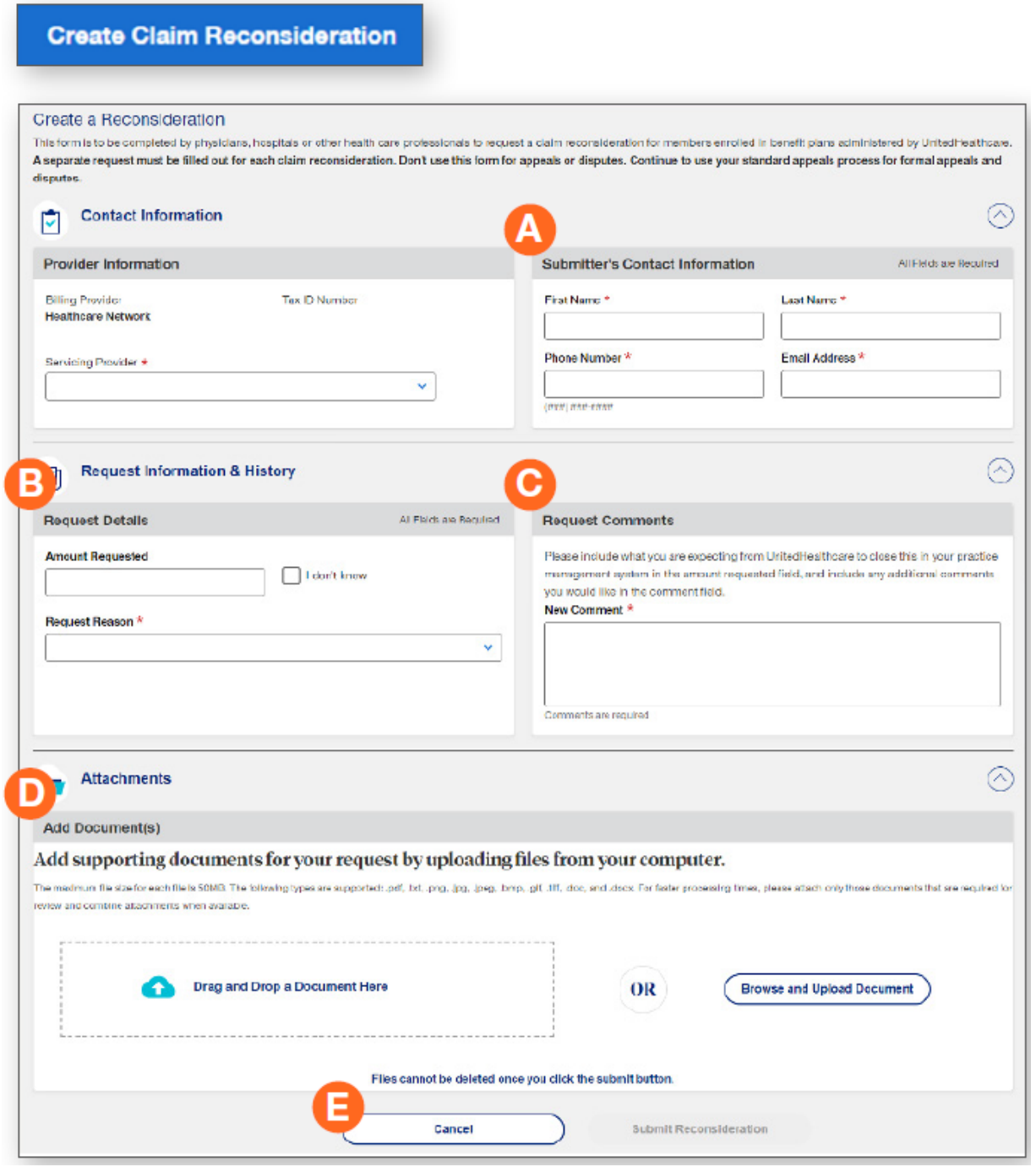
- State how the claim was processed
- Give your evidence of why it should be processed differently

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

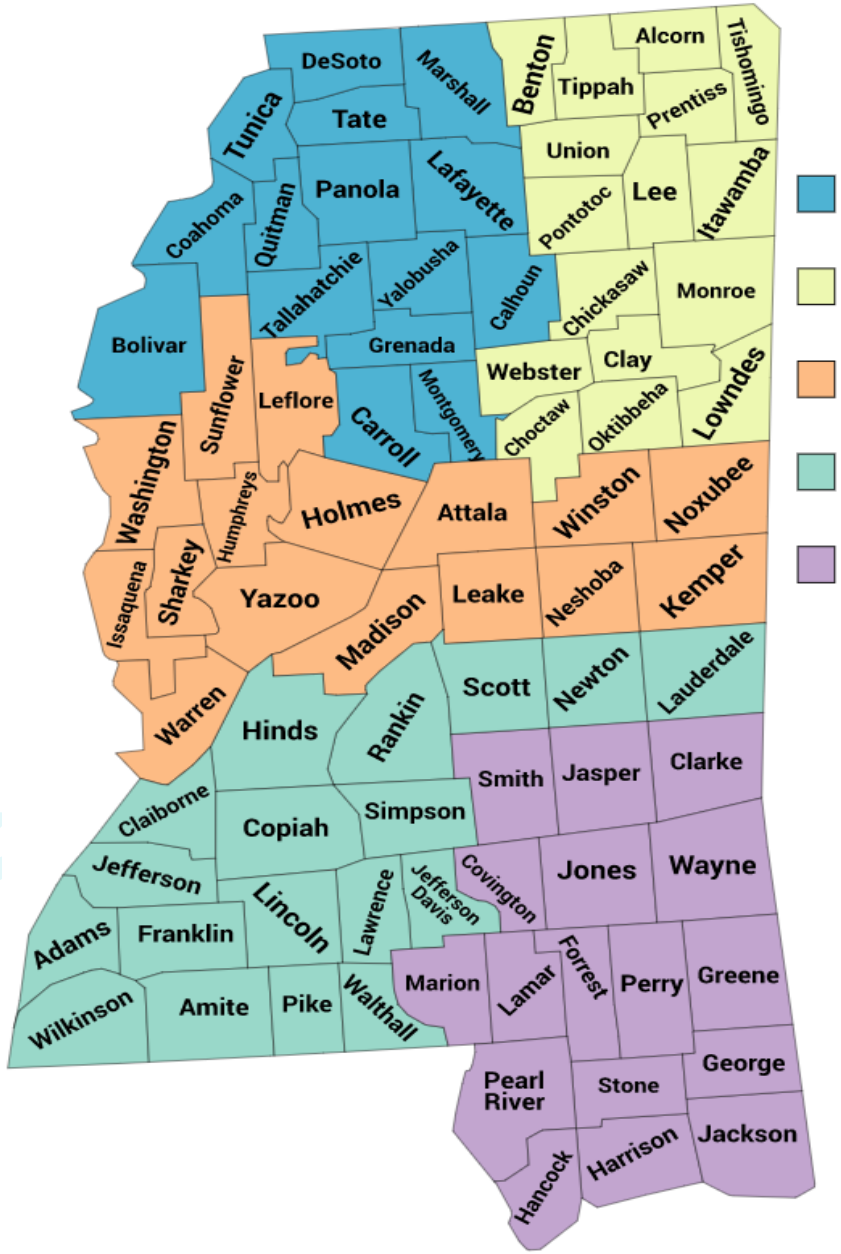
Support is just a click away at **UHCprovider.com/chat**.

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



Jamille Bernard
jamille_bernard@uhc.com

Adrian Hagan
adrian_d_hagan@uhc.com

Jenny Ford
jennyt_ford@uhc.com

Tekima Beamon
tekima_beamon@uhc.com

Ashley Clarke
ashley_clarke@uhc.com

FQHC | RHC Statewide

Curtis Burroughs
curtis_burroughs@uhc.com

magnolia health™

2024 Division of Medicaid
Provider Workshops

Claim Filing

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

5/15/2024

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:

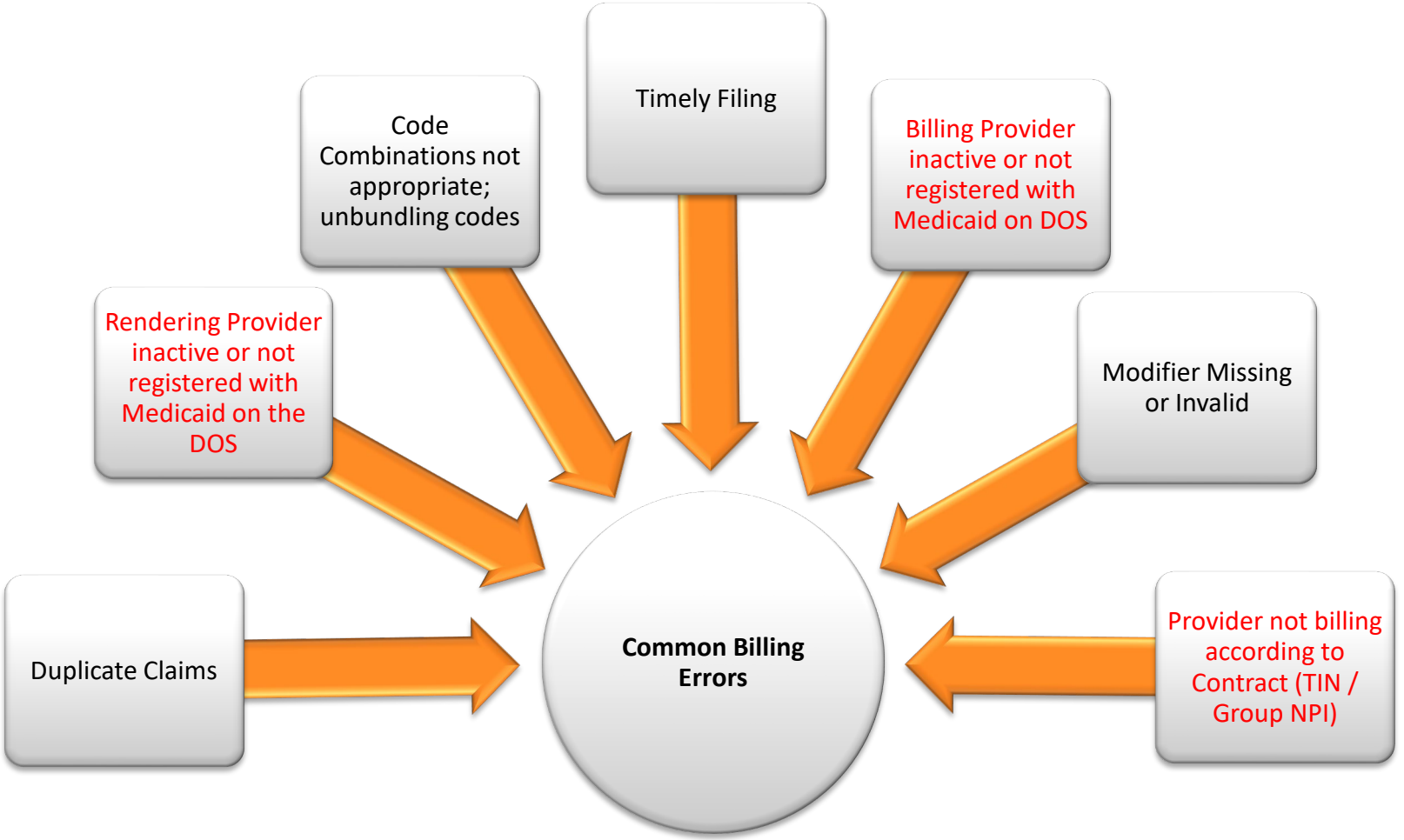
- Secure Provider Portal at: Provider.MagnoliaHealthPlan.com
- Call Magnolia Health at 866-912-6285

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/

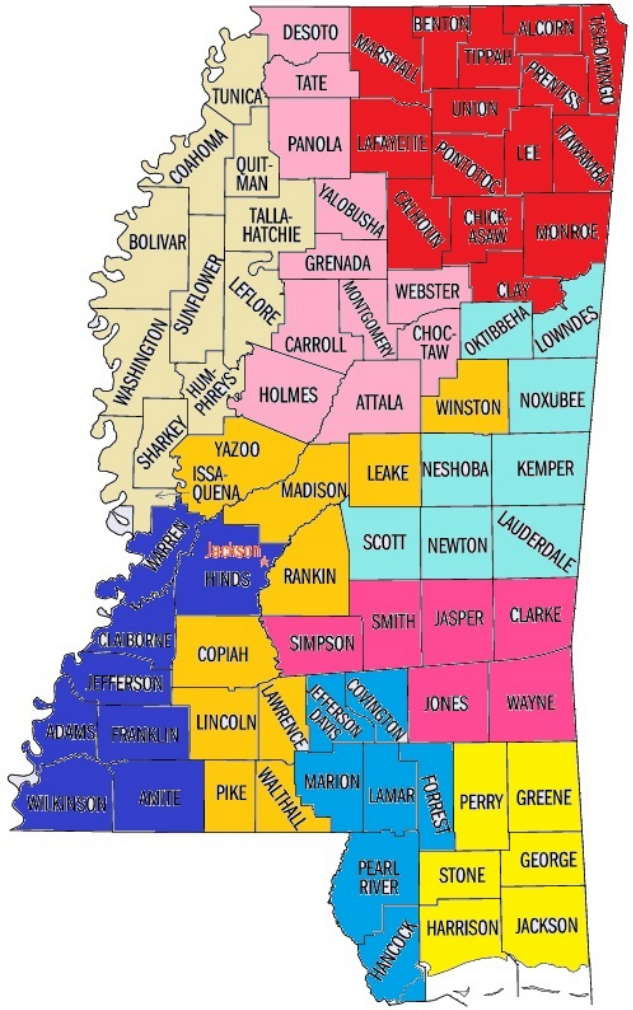


For a complete list of common billing errors refer to the claims filing manual and provider manual

Claims Filing Tips

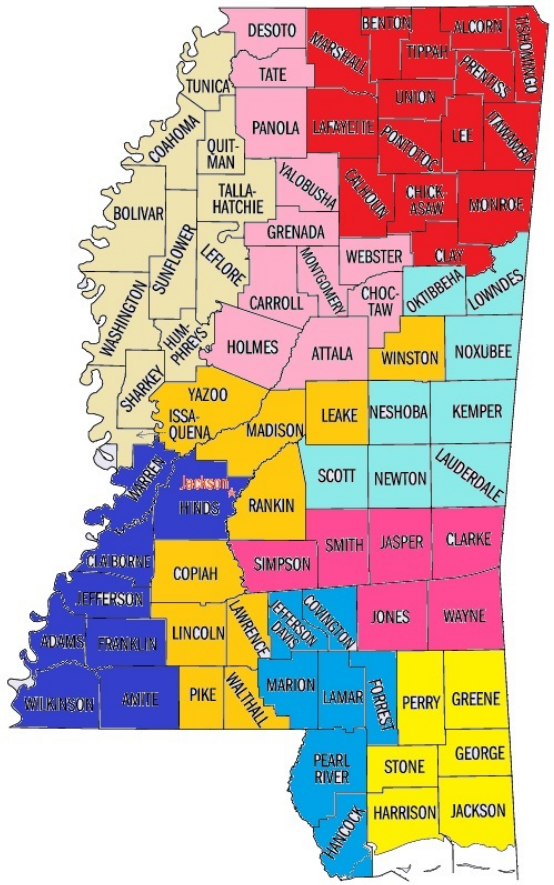
- ✓ Do **not** hold claims for any reason. You will be subject to timely filing guidelines, regardless if you are going through contracting or enrollment.
- ✓ Ensure your group and rendering providers are **active** providers with Gainwell or your claim will be denied.
- ✓ If your claim denied due to 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

5/15/2024

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

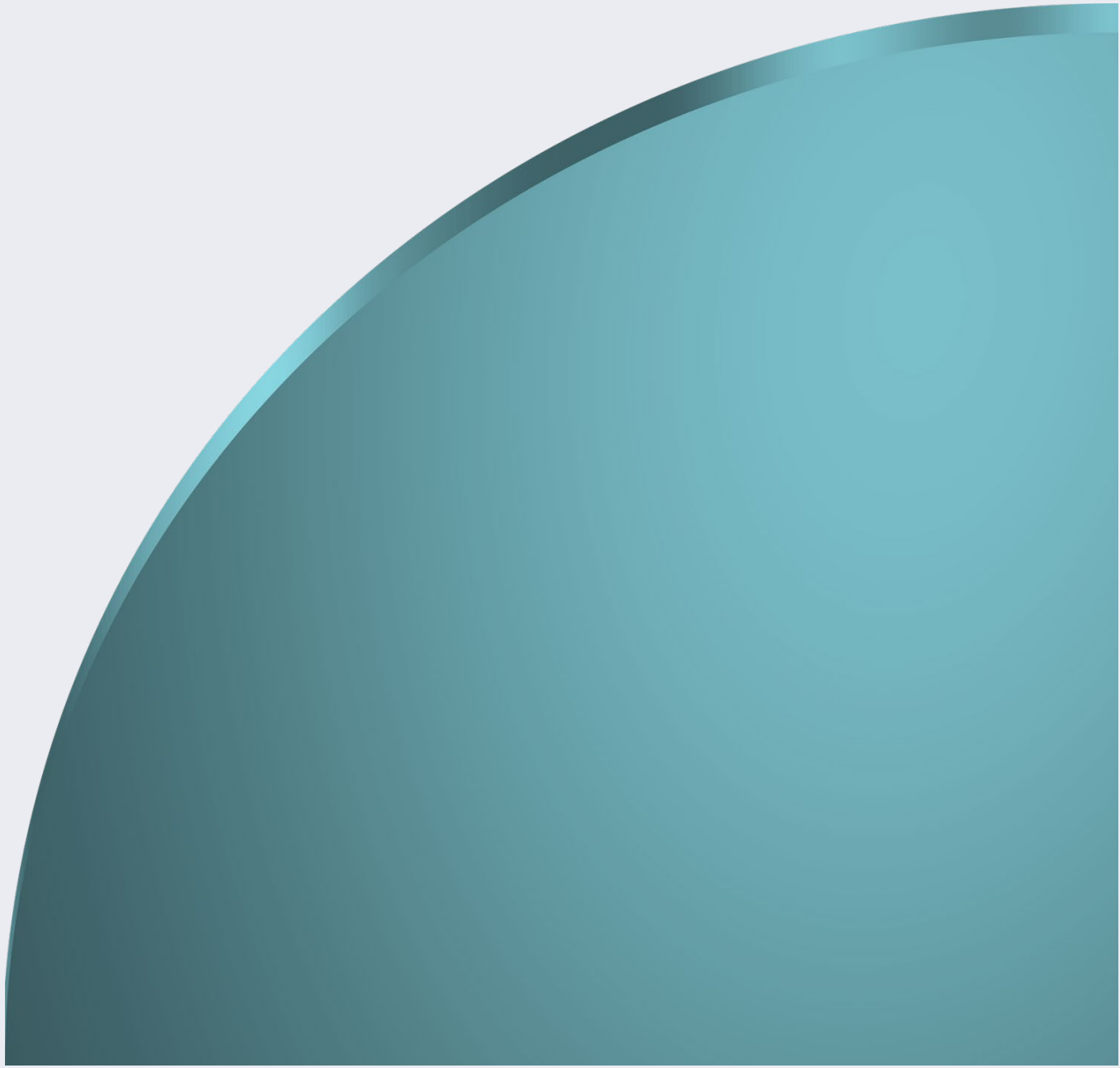
- **Magnolia Provider Services Line**
  Call: (866) 912-6285
  Fax: (877) 811-5980
- **Magnolia Member Services Line**
  Call: (866) 912-6285
  Fax: (877) 779-5219
- **Magnolia Prior Authorizations**
  Call: (866) 912-6285
  Fax: (877) 650-6943
- **Magnolia EDI Department**
  Call: (800) 225-2573, ext. 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:

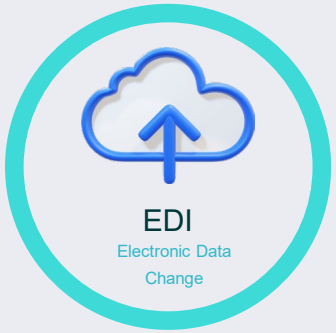
- To register for EFT/ERAs with Change Healthcare go to: https://providernet.adminisource.com/Start.aspx
- Step-by-step registration instructions are available on Molina’s website (www.molinahealthcare.com/provider) under the “EDI, ERA/EFT” tab.

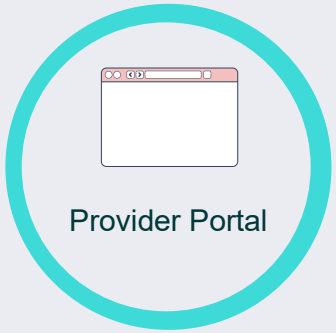
MOLINA HEALTHCARE

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.

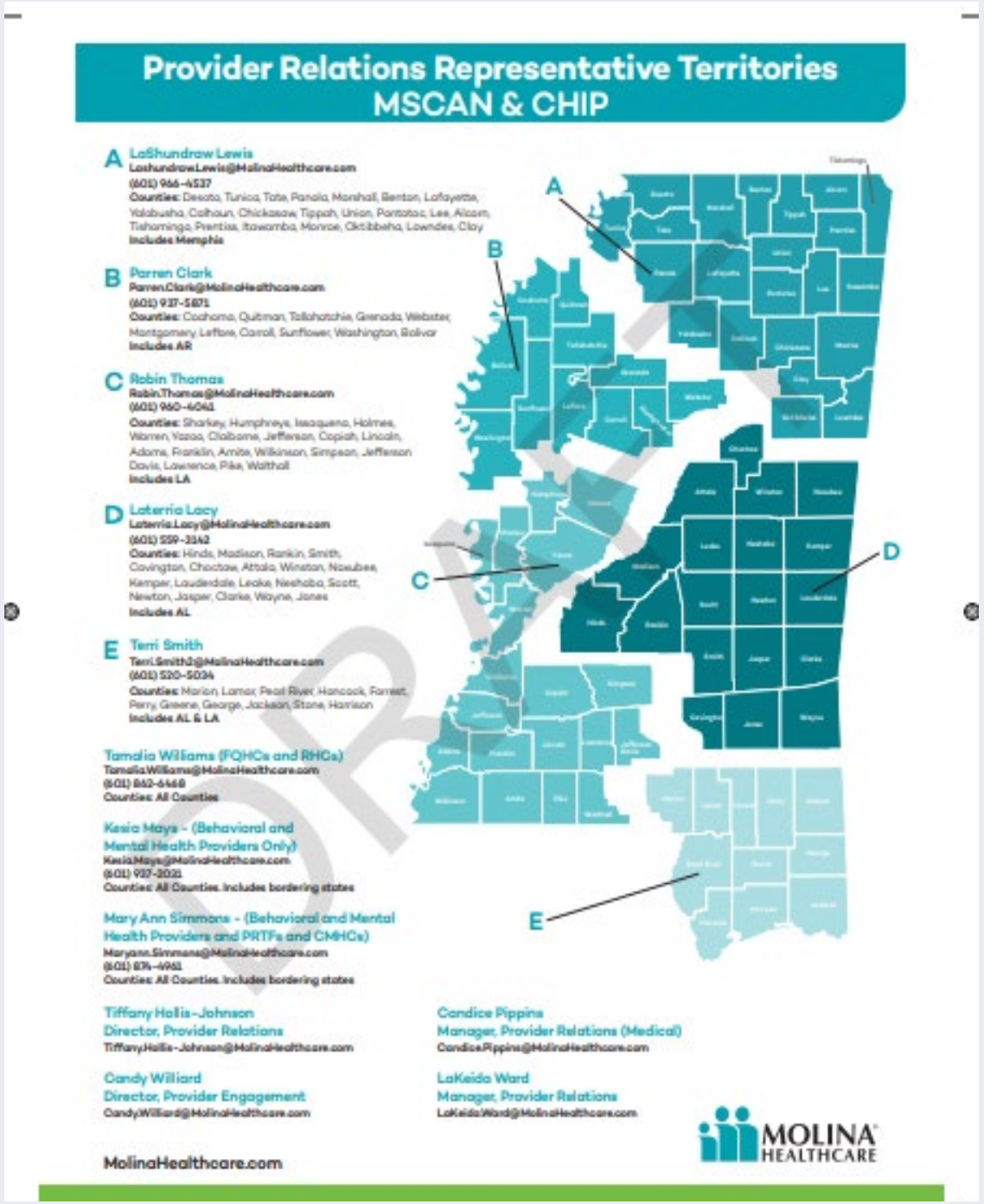
MOLINA® HEALTHCARE

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 LaShundraw Lewis
LashundrawLewis@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) 960-4041
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) 559-3342
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
TerriSmith2@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) 862-6660
Counties: All Counties

Kesia Mays - (Behavioral and Mental Health Providers Only)
KesiaMays@MolinaHealthcare.com
(601) 937-2021
Counties: All Counties. Includes bordering states

Mary Ann Simmons - (Behavioral and Mental Health Providers and PRTFs and CMHCs)
MaryannSimmons@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

Break

Lunch on Your Own

Provider Enrollment

gainwell®

Agenda

1. Provider Recredentialing
2. Verisys
3. Credentialing Information
4. Initial Enrollment
5. Liability Insurance
06. Hospital Admittance
07. Supporting Documentation
08. Revalidation/Recredentialing
09. Questions

Provider Recredentialing

Provider Recredentialing

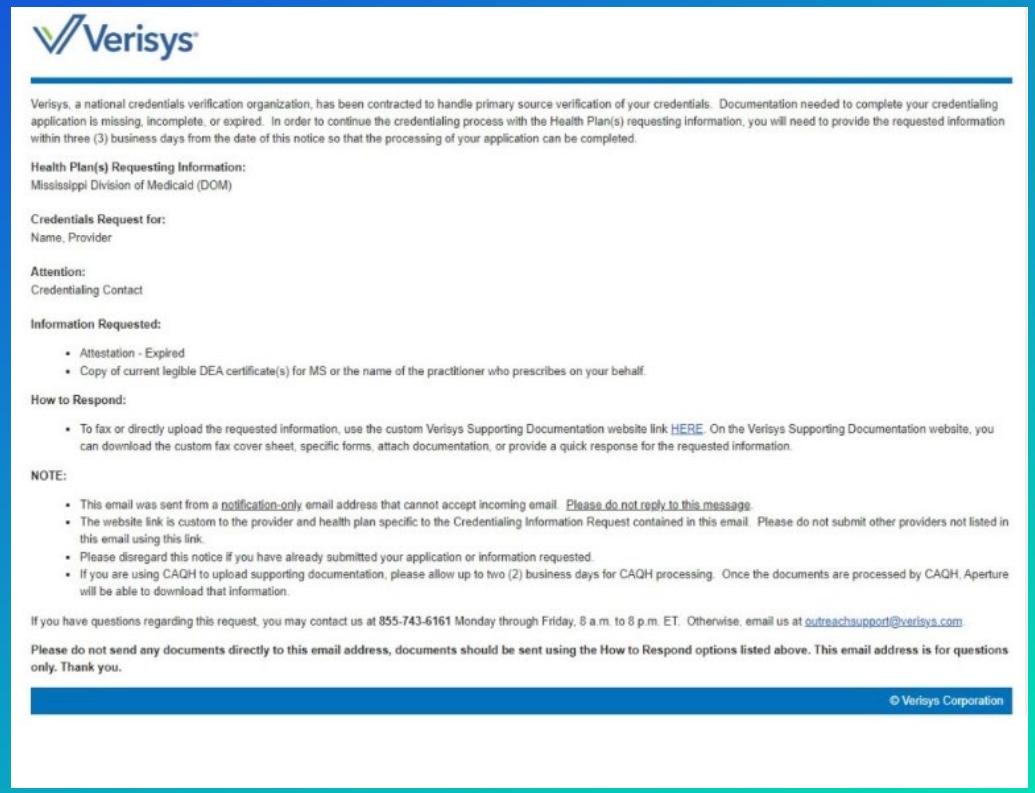
Beginning October 1, 2022, providers seeking participation in MississippiCAN and/or CHIP are now required to be enrolled, credentialed, and screened by DOM and subsequently contract with their CCO of choice.

The CVO will perform recredentialing for both current providers and new providers every three (3) years unless the provider is credentialed by a DOM-approved Delegated Credentialing Entity. Providers identified for recredentialing will receive notification from Gainwell Technologies by letter, which is sent to the provider's "mail to" address on their provider record. This letter is generated six months in advance of the recredentialing due date on the provider's record in MESA, and a link will be available in the portal to start the process.

Verisys

Verisys

- For providers enrolling with any MississippiCAN or Children's Health Insurance Program (CHIP) for our Coordinated Care Organizations, providers will choose during the MESA application process for both credentialing and recredentialing if they are currently credentialed through a Mississippi Division of Medicaid-approved delegated credentialing entity or if they will credential through the state's Credentials Verification Organization (CVO). Verisys is contracted to perform credentialing for DOM's Fiscal Agent, Gainwell Technologies.
- The side image is an example of an email notification a provider will receive from Verisys if additional information is required. Please contact Verisys directly if you have any questions pertaining to the information being requested at 855-743-6161, Monday-Friday, 8 a.m. to 8 p.m. ET, or via email at outreachsupport@verisys.com.



Verisys

Verisys, a national credentials verification organization, has been contracted to handle primary source verification of your credentials. Documentation needed to complete your credentialing application is missing, incomplete, or expired. In order to continue the credentialing process with the Health Plan(s) requesting information, you will need to provide the requested information within three (3) business days from the date of this notice so that the processing of your application can be completed.

Health Plan(s) Requesting Information:
Mississippi Division of Medicaid (DOM)

Credentials Request for:
Name, Provider

Attention:
Credentialing Contact

Information Requested:

- Attestation - Expired
- Copy of current legible DEA certificate(s) for MS or the name of the practitioner who prescribes on your behalf.

How to Respond:

- To fax or directly upload the requested information, use the custom Verisys Supporting Documentation website link HERE. On the Verisys Supporting Documentation website, you can download the custom fax cover sheet, specific forms, attach documentation, or provide a quick response for the requested information.

NOTE:

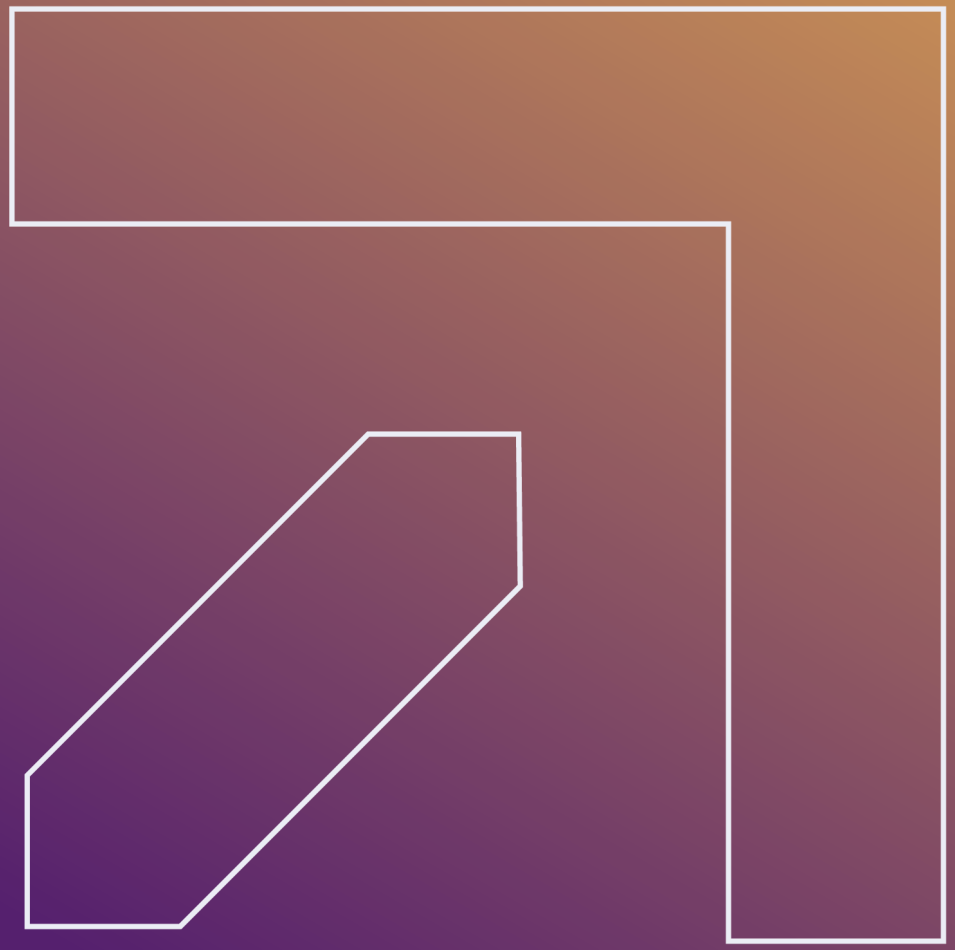
- This email was sent from a notification-only email address that cannot accept incoming email. Please do not reply to this message.
- The website link is custom to the provider and health plan specific to the Credentialing Information Request contained in this email. Please do not submit other providers not listed in this email using this link.
- Please disregard this notice if you have already submitted your application or information requested.
- If you are using CAQH to upload supporting documentation, please allow up to two (2) business days for CAQH processing. Once the documents are processed by CAQH, Aperture will be able to download that information.

If you have questions regarding this request, you may contact us at **855-743-6161** Monday through Friday, 8 a.m. to 8 p.m. ET. Otherwise, email us at outreachsupport@verisys.com.

Please do not send any documents directly to this email address, documents should be sent using the How to Respond options listed above. This email address is for questions only. Thank you.

© Verisys Corporation

Credentialing Information



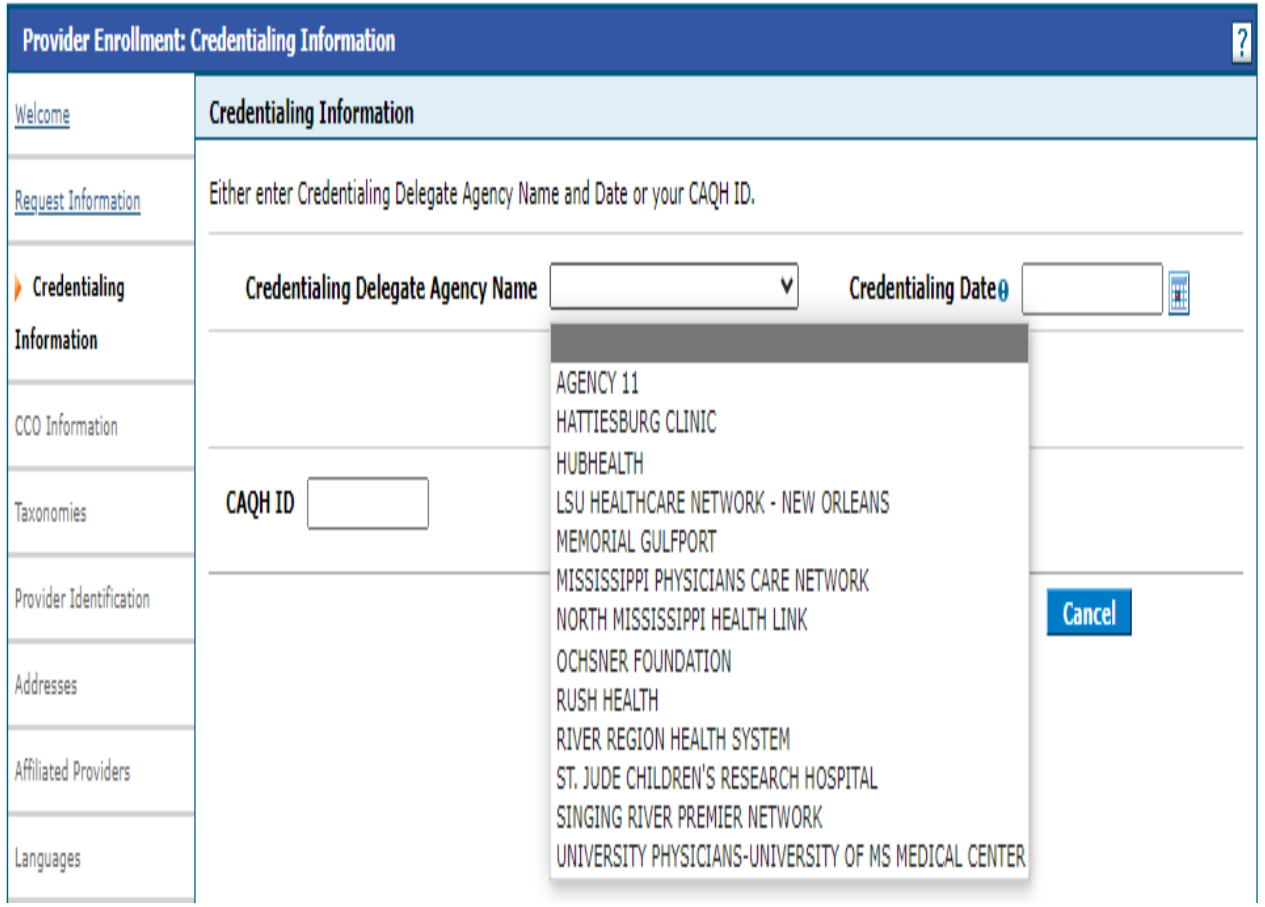
Credentialing Information

You will be able to enter a CAQH ID or choose a Delegated Credentialing Agency from the dropdown list.

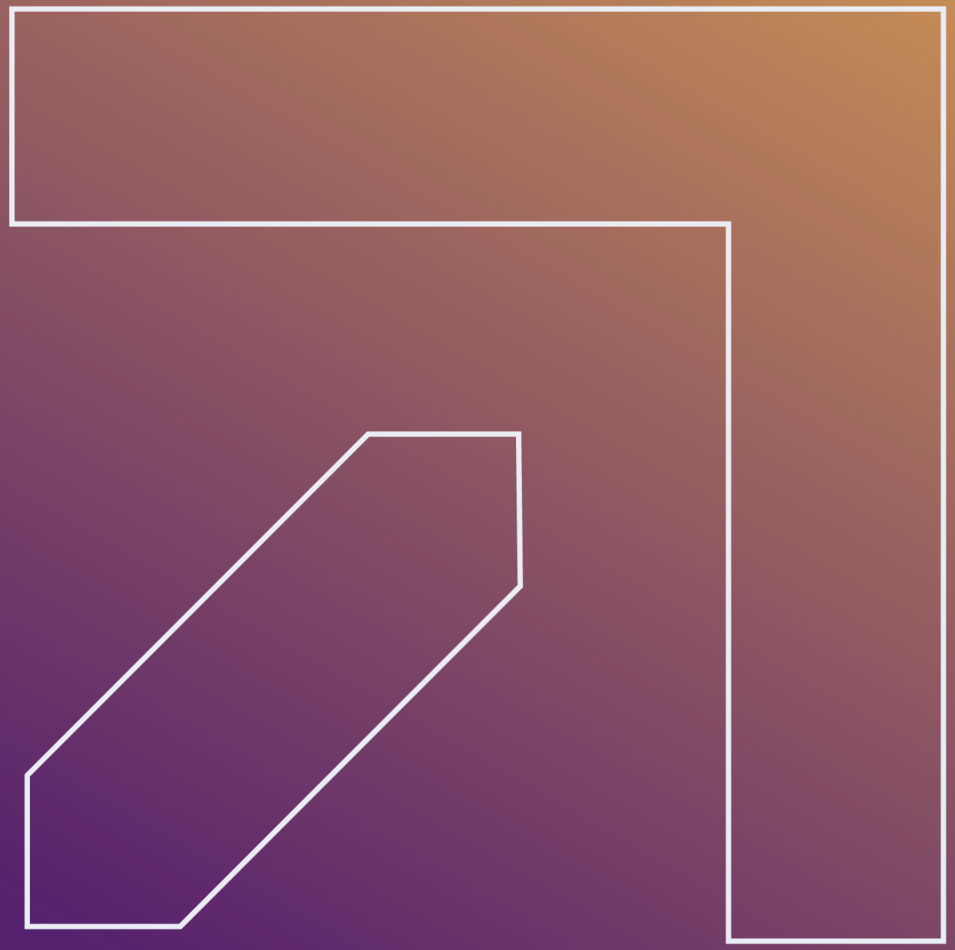
If CAQH ID is entered, Gainwell must have the provider's authorization to be added to our roster for credentialing purposes and the profile must be complete and attested.

If you choose Delegated Credentialing Agency, you must enter your last credentialing date.

Select **Continue**, to the CCO Information page.

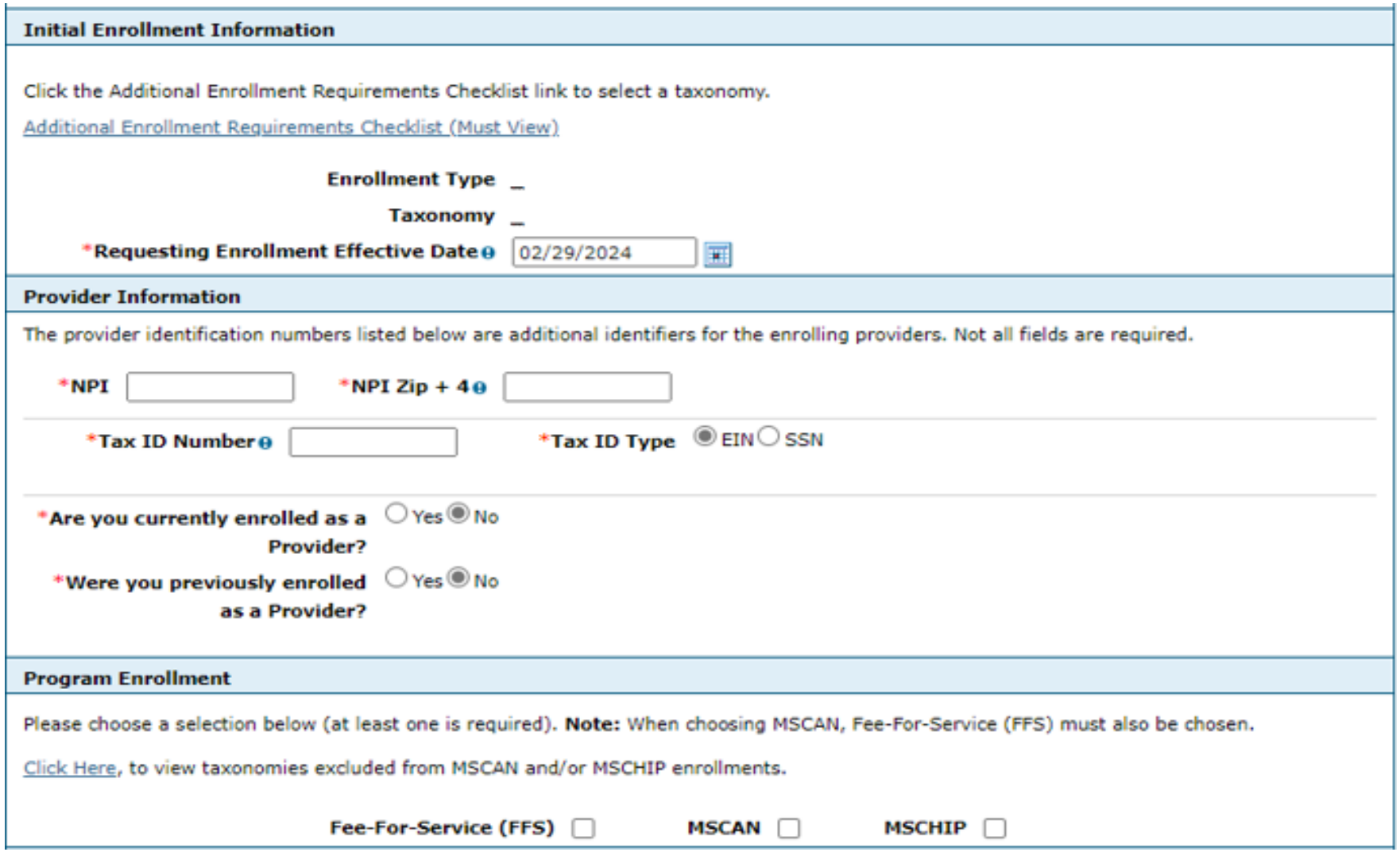


Initial Enrollment



Initial Enrollment: Request Information

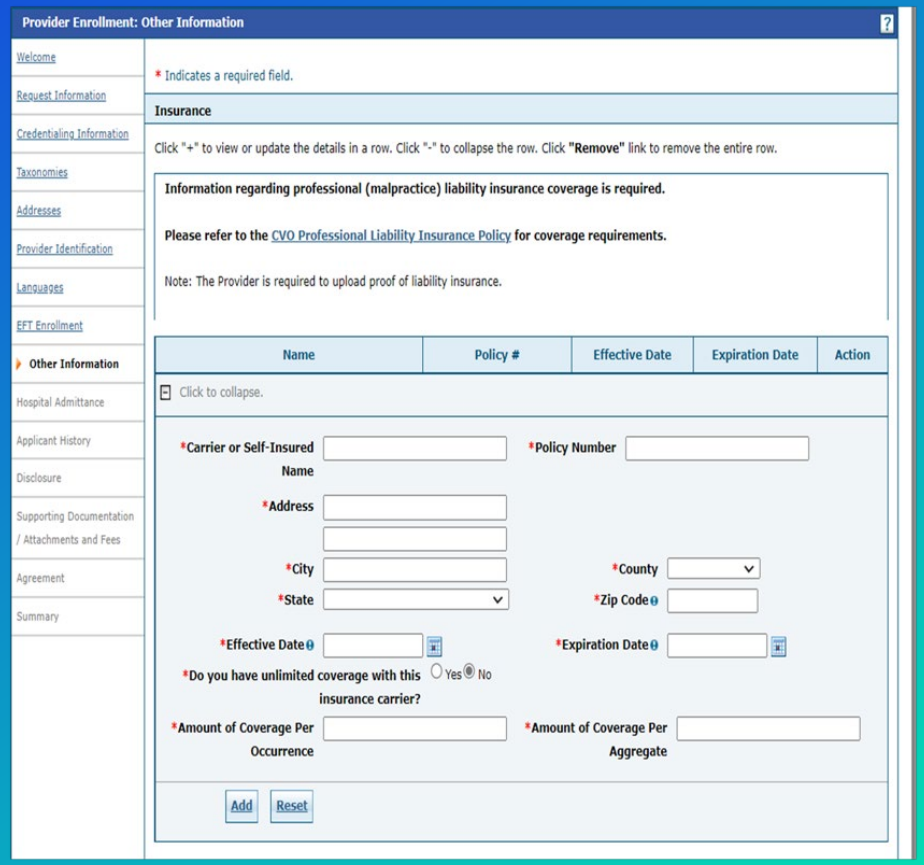
- When choosing your Program Enrollment, you have the option to enroll in Fee-For-Service (FFS), Managed Care programs MSCAN and/or MSCHIP.
- If MSCAN is chosen, you must choose FFS.
- Choosing MSCAN or MSCHIP means the application will require credentialing.



CVO Professional Liability Insurance

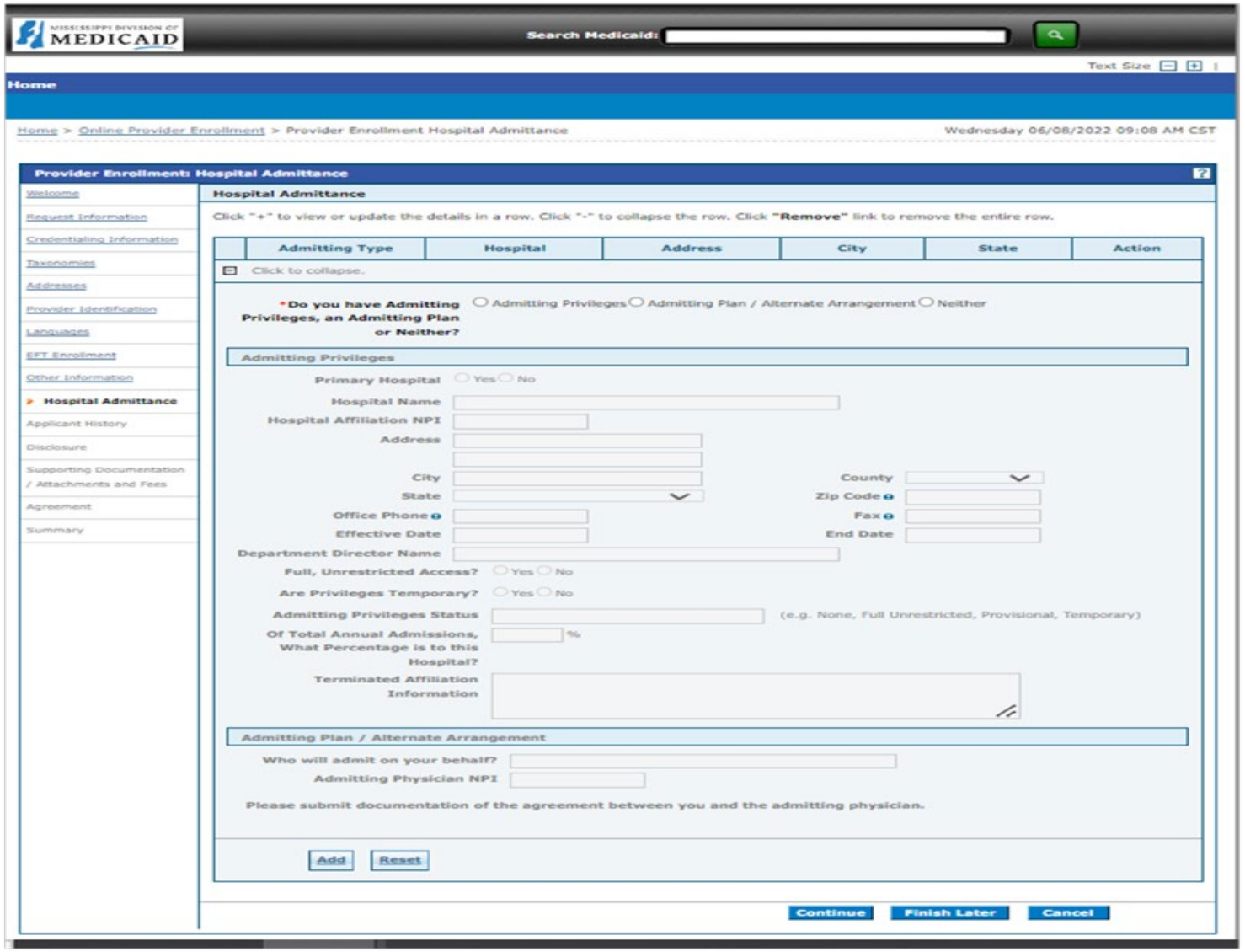
Effective immediately, the Minimum Malpractice Coverage Requirement for the Mississippi Division of Medicaid are as follows:

- **Physician (MD/DO), Nurse Practitioner, Certified Nurse Midwife, Oral Surgeon, Physician Assistant, Podiatrist, all non-physician Behavioral Health practitioners, Naturopaths, and Optometrists - $500,000 per occurrence/$1,000,000 per aggregate.**
- **Acupuncture, Chiropractor, Massage Therapy, Occupational Therapy, Physical Therapy, and Speech Language Pathology remain unchanged at $200,000 per occurrence and $600,000 per aggregate.**



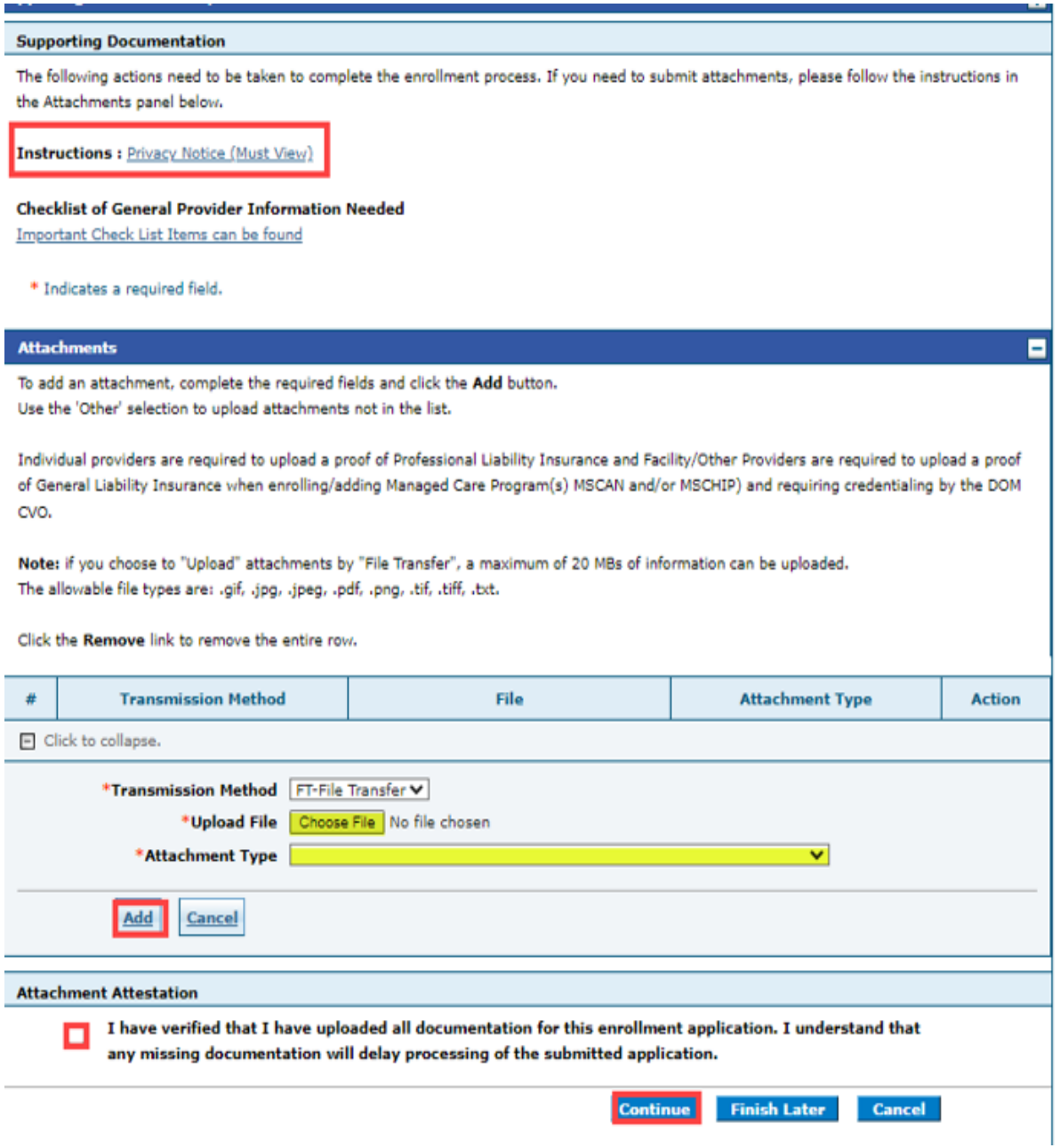
Hospital Admittance

- If the provider selects Hospital Admittance, they must show proof of such. The provider must upload supporting documentation in the supporting documentation section.



Supporting Documentation

Select	You must select the "**Instructions = Privacy Notice Link**." A separate window will open to the Mississippi Division of Medicaid website. Once you have read the notice the window can be closed. If this is not selected, you cannot move to the next page.
Drop-down	Select "**Choose File**" to locate the appropiate file to be added. Select the "**Attachment Type"** drop-down that matches your file attachment. If your documents are saved in one document, select "**All"** for the type. If not, select the appropiate type.
Add	Select "**Add**" to attach the document. It must be in PDF format to be added. If additional documents need to be attached, select **"+ Click to add attachment**".
Attest	Select the **box** for the **Attachment Attestation statement**. Select "Continue" on the Agreement page.



Recredentialing/ Revalidation Tips

- Letters for revalidations and recredentialing go out 180 days prior to the due dates.
- Letters are sent out early to allow providers ample time to submit and to allow processing time so provider contracts do not terminate for failure to recredential or revalidate.
- Providers that are Fee-For-Service (FFS) or Medicaid Only do not recredential.
- Providers with MSCAN or MS CHIP will recredential
- Providers with FFS, MSCAN and CHIP will revalidate.
- Revalidation is every 5 years.
- Recredentialing is every 3 years.
- Groups do not recredential.
- If a provider fails to recredential **ONLY the MSCAN and CHIP contracts will terminate. The FFS contract remains active.** They will need to submit an add program app to have the MSCAN/CHIP added back. *Note: A provider must be FFS to add MSCAN.

Recredentialing/ Revalidation Tips

- If you recredential a provider ID, the revalidation due date is extended 3 years.
- Recredentialing can take up to 30 days because the applications go to our credentialing vendor, Verisys.
- Unless you are a CHIP provider, for revalidations, we require minimal documents, such as a provider's license, to be uploaded. CHIP providers still need to upload W-9 and Civil Rights Compliance forms.
- For recreds and revals, the portal will list the documents you need to upload on the supporting documents page. Click the dropdown to see each type.
- Information on recreds and revals are posted on the division of Medicaid's website under late-breaking news
- Here are job aids on how to complete both.
  - https://medicaid.ms.gov/wp-content/uploads/2023/10/Provider-Recredentialing-v.1.pdf
  - https://medicaid.ms.gov/wp-content/uploads/2023/10/Provider-Revalidation-Process-v.1.pdf
  - https://medicaid.ms.gov/wp-content/uploads/2023/08/Partial-Save-Identify-and-Resolve-Errors-on-an-Enrollment-App_v1.0.pdf

magnolia health™

2024 Division of Medicaid
Provider Workshops

Contracting and Enrollment

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

5/15/2024

Contracting

To join Magnolia Health's network, please click on the link below to complete the contract request form:

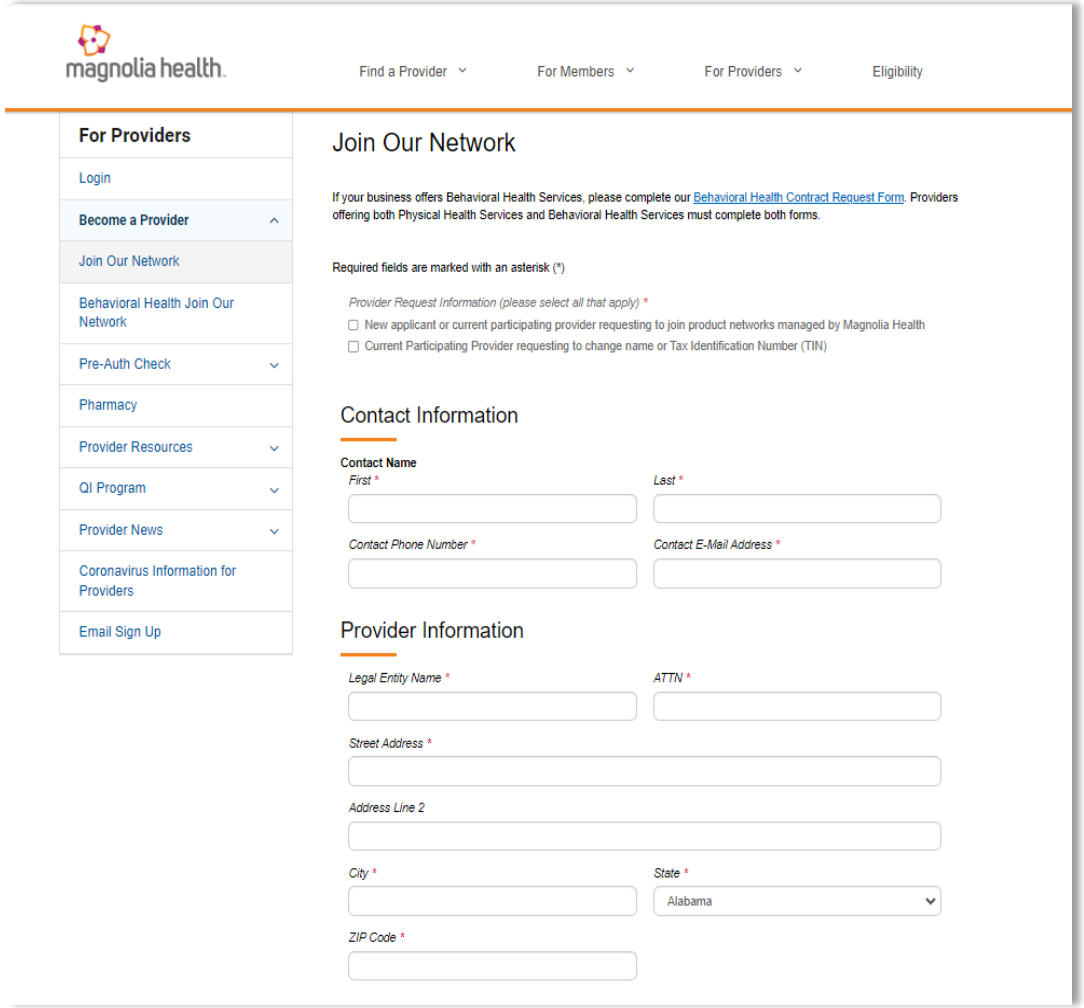
Medical - Join Our Network

BH - Behavioral Health - Join our Network

Applicants will receive an email from the Contracting Department within **approximately 1 week** of receipt of the contract request containing an application packet to complete and submit back to the Health Plan. Once the complete application is received, a draft contract will be sent to the provider within **30 days**.

Providers must be enrolled as a Medicaid Provider and have an active Mississippi Medicaid ID #. Providers must also be properly credentialed by Gainwell Technology or other delegated authority.

Magnolia Health
ATTN: Contracting Department
1020 Highland Colony PKWY Suite 502
Ridgeland, MS 39157



FQHC New Group Contract Process

Magnolia requires an FQHC contract be accompanied by:

- IRS Form W-9
- PPS Encounter Rate Letter
- Provider Data Form*
- Ancillary/Clinic Credentialing Application* (1st section only)

* These forms are available at www.magnoliahealthplan.com on the Provider Resources page.

Rates:

- FQHCs can obtain their current "per visit rate" by reviewing https://medicaid.ms.gov/providers/fee-schedules-and-rates/# .Please make sure to submit updated rate letter or changes timely to ensure proper claims reimbursement.
- Payment rates may be adjusted by the Division of Medicaid pursuant to changes in federal and/or state laws or regulations.
- In-network providers/schools will be reimbursed at 100% of their current encounter rate, unless otherwise stated in your contract
- All services provided in an inpatient hospital setting, outpatient hospital setting or a hospital's emergency room will be reimbursed on a fee-for-service basis.

For information on EPSDT services, please click **here**. For additional questions, please contact Provider Services at 1-866-912-6285

NOTE: This process CANNOT be used to start the Credentialing process for individual physicians

RHC New Group Contract Process

Magnolia requires an RHC contract be accompanied by:

- IRS Form W-9
- PPS Encounter Rate Letter
- Provider Data Form*
- Ancillary/Clinic Credentialing Application* (1st section only)

*These forms are available at www.magnoliahealthplan.com on the Provider Resources page.

Rates:

Service Limits Reimbursement to an RHC is limited to no more than four (4) encounters, also referred to as a "visit", per beneficiary per day, provided that each encounter represents a different provider type. https://medicaid.ms.gov/providers/fee-schedules-and-rates/#

Medically necessary services rendered by an RHC employee or contractual worker for an RHC beneficiary can be billed as an RHC encounter in multiple sites:

- Rural Health Clinic
- Skilled Nursing Facility
- Nursing Facility
- Residential Facility

For information on EPSDT services, **click here**. For additional questions, please contact Provider Services at 1-866-912-6285

NOTE: This process CANNOT be used to start the Credentialing process for individual physicians.

Provider Value Based Contracting

Value Based Contracts are partnerships between providers and the health plan to incentivize high quality care, cost effectiveness, while emphasizing the use of preventative services.

Magnolia's current Value Based Program focuses on Primary Care Providers.
New VBC incentive programs will be made available to additional providers later this year.

For more information on Value base Contracting,
magnoliacontracting@centene.com

Contracting Issue Resolution

- ✓ Magnolia contracts at the Tax ID level. Magnolia does not contract with individual physicians.
- ✓ Providers must be credentialed with Gainwell and have an active Medicaid ID with a MississippiCAN designation before the contracting process can begin.
- ✓ Contract effective dates are **30** days from the date of the provider's signature on the contract.
- ✓ If a provider wishes to enroll practitioners with their new contract, each practitioner must be credentialed with Gainwell and have an active Medicaid ID with a MississippiCAN designation at the time of contract execution in order to receive the same effective date as the contract effective date.
- ✓ For any practitioners or locations that are added/enrolled in the future (after contract execution), the effective date will be the date the request was received by the Health Plan, given the specific location and/or practitioners are registered as a MississippiCan provider with Gainwell.
- ✓ If a provider is contracted as a physician group and later converts to an RHC or FQHC, the provider must notify the Health Plan and request a contract amendment by emailing Magnolia's Contracting Department at MagnoliaContracting@centene.com.
- ✓ To change a contracted provider's name or tax ID number, complete the *Provider Update Form* located on https://www.magnoliahealthplan.com/providers/resources/forms-and-resources.html

  Note: Request for a change of tax ID or legal name may require a contract amendment, which may take up to 30 days to complete.

Enrollment

Effective October 1, 2022, providers seeking participation in MississippiCan and/or CHIP are required to be enrolled, credentialed, and screened by DOM, and subsequently contract their Group with their CCO of choice. **Please note,** however, that Magnolia may require that you credential separately if you choose to participate in a different line of business that Magnolia offers outside of Medicaid. Find more details visit Recredentialing and Revalidation - Mississippi Division of Medicaid (ms.gov)

Important Recredentialing Information

- Each provider must register for access to the MESA Provider Portal to recredential electronically.
- Recredentialing is required every three years.
- Provider should review information on file with Gainwell for accuracy and make any necessary updates
- Providers will receive a letter 180 days prior to their recredential due date and their recredentialing link will be available on the Home Page of the MESA Provider Portal.
- **Providers will have 60 days to submit your recredentialing application.**
- Providers who fail to recredential or submit supporting documentation by the deadline **will be terminated** and will no longer be able to participate in a Coordinated Care Organization (CCO) network.

Enrollment

An **enrollment request** is when the group has an existing agreement/contract with Magnolia Health and wishes to add additional practitioners or facilities to an existing agreement. This requires data updates to ensure claims, portal, and directory recognize this practitioner as participating and affiliated with the appropriate group contract.

Providers should contact Magnolia's Provider Data Management department at magnoliacredentialing@centene.com after receiving approval from the Gainwell's Credentialing Committee. Providers are considered **out of network** and may receive a lower reimbursement rate or denial until entering into a contract or enrolling with Magnolia Health.

To link a new practitioner and/or new Group NPI to your existing contract or additional locations to an existing practitioner and/or existing Group NPI, please email the following documents to magnoliacredentialing@centene.com.

- **Provider Data Form (Practitioner)**
- **Hospital/Ancillary Cred App (Provider)**

These documents can be found at www.magnoliahealthplan.com For Providers > Provider Resources > Become a Provider

Please note:

- Groups and practitioners MUST have an active Medicaid ID and been credentialed through Gainwell and selected Magnolia as a CCO, prior to submitting an enrollment request.
- Delegated providers should continue to utilize the established roster process.
- If you select multiple lines of business on the Provider Data Form or Hospital/Ancillary Cred App, you will be required to complete all of the requested documentation to be credentialed for our other lines of business. For the practitioner, you will need to complete the Magnolia Credentialing Application Packet under the link referenced above.
- **Magnolia Enrollment Guidance Reminder**
  - ✓ Practitioner's start date cannot precede the contract effective date
  - ✓ Practitioner's contracted payment eligibility cannot precede state Medicaid eligibility
  - ✓ Practitioner's start date should be the date the provider group or practitioner notified the health plan that they have joined a contracted group via a roster submission or enrollment process. Magnolia will not grant retro effective participation or credentialing request.
  - ✓ **Important Note for Roster Submitters: Roster submission which include Medical and Behavioral Health Practitioners must include an indicator to ensure practitioner will be enrolled properly.**

Enrollment Issue Resolution

Prior to contacting Magnolia Health for Contracting and/or enrollment, make sure you are credentialed through Gainwell and have requested to be a Magnolia provider.

Ensure that the taxonomy you utilized to enroll with Gainwell matches what is submitted on the request to Magnolia and NPPES.

If you are not an active Fee-for-Service and/or MississippiCan provider at the time of claim submission, your claim will be denied regardless of your network status with Magnolia. Please contact Gainwell to discuss further.

- EX1T: RENDERING PROV INACTIVE / NOT REGISTERED W/ STATE ON DOS
- EX1n: BILLING PROV INACTIVE / NOT REGISTERED W/ STATE ON DOS

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.

To be reimbursed for EPSDT, services, you must complete the appropriate application with Medicaid to receive reimbursement

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.

If you need to make changes to any of the following, **please submit your request to** magnoliacredentialing@centene.com:

- ✓ Office relocation, Change Primary Location
- ✓ Change Primary Location, Service Location Office Hours, Phone Number
- ✓ Updating a Financial Address – W9 required
- ✓ Updating Member Assignment Limitations
- ✓ Panel Size (PCP only), Age Restrictions, Accepting New Patients, etc.
- ✓ Add an additional location to a practitioner or group - Complete the Provider Update Form located on **https://www.magnoliahealthplan.com/providers/resources/forms-and-resources.html**
- ✓ Remove practitioner from existing location – Include reason for termination and effective date

Enrollment and Contracting Contacts

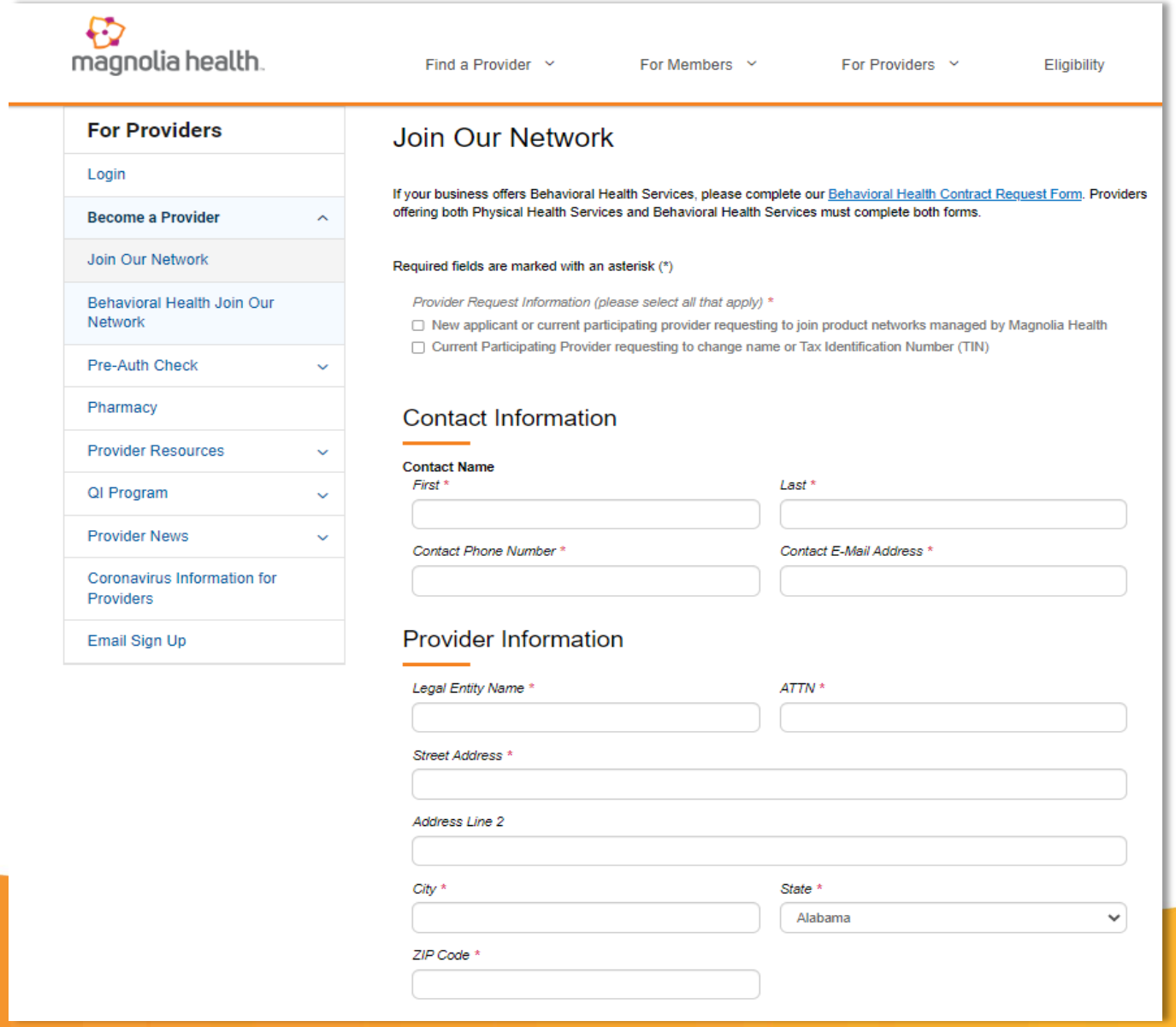
Medical - Join Our Network

BH - Behavioral Health - Join our Network

Magnolia Health Provider Services- 1-866-912-6285

Contracting Department- magnoliacontracting@centene.com

Credentialing- magnoliacredentialing@centene.com



MOLINA HEALTHCARE OF MISSISSIPPI

2024 Medicaid Provider Workshop

MOLINA® HEALTHCARE

About Molina

For over 40 years, Molina Healthcare has been a purpose-driven company committed to improving the lives and well-being of our members, while making a positive impact in the communities we serve. Our mission, vision and values help lead every decision we make – from the office of the CEO to our valued call center representatives

Our Mission

To improve the health and lives of our members by delivering quality government-sponsored healthcare.

Location

1020 Highland Colony Pkwy

Suite 602

Ridgeland, MS 39157

MOLINA HEALTHCARE

Molina Values

Integrity First

We always do the right thing.

Absolute Accountability

You can hold us accountable.

Open & Honest Communication

We listen and we respond.

MOLINA HEALTHCARE

Provider Contact Center

- **The Provider Contact Center is the first line of communication for providers.**
- **Provider Contact Center can verify eligibility, answer claims related questions, check Prior Authorizations status, etc.**
- **Phone**: (844) 826-4335
- **Hours of Operations**

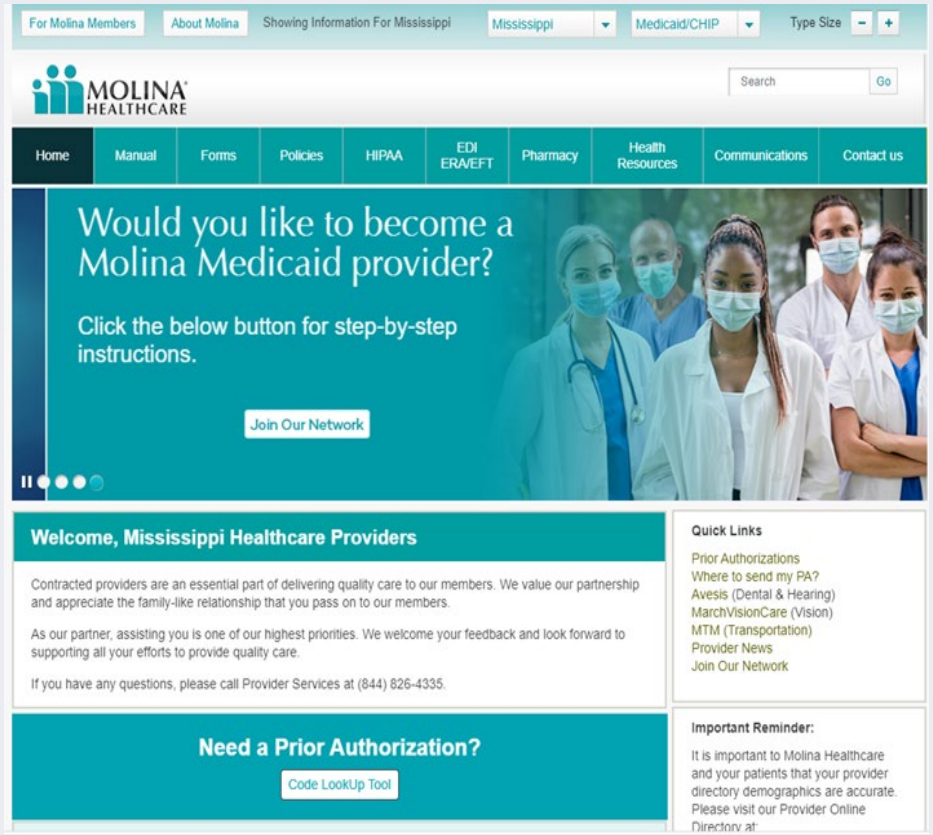
  7:30 am - 6:00 pm CST

MOLINA® HEALTHCARE

Provider Website - MSCAN & CHIP

https://www.molinahealthcare.com/providers

- Provider Manual
- COVID-19 Updates
- Provider News
- Provider Training and Resources
- Contracting and Credentialing Forms
- Prior Authorization Guide and Forms
- Clinical Practice and Preventive Health Guidelines
- Health Management Programs for Asthma, Diabetes, Hypertension, CAD, CHF & Pregnancy
- Quality Improvement Programs
- Member Rights & Responsibilities
- Privacy Notices
- Claims/Denials Decision Information
- Current Preferred Drug List & Updates
- Pharmaceutical Management Procedures
- How to Contact UM Staff & Medical Reviewer
- How to access language services
- Prior Authorization Tool
- And more!



Available to You 24/7!

Contact Information - MS CAN & CHIP

Contact Information

Molina Healthcare of Mississippi, Inc.

1020 Highland Colony Pkwy Suite 602

Ridgeland, MS 39157

Phone Numbers

Main Line Toll Free	(844) 826-4333
Member Eligibility Verification	(844) 809-8438
Member Services	(844) 809-8438
Provider Services	(844) 826-4335
Behavioral Health Authorizations	(844) 826-4335
Pharmacy Authorizations	(844) 826-4335
Radiology/Transplant/NICU Authorizations	(855) 714-2415

Fax Numbers

Main Fax	(844) 303-5188
Prior Auth – Inpatient Fax	(844) 207-1622
Prior Auth – All Non-Inpatient Fax	(844) 207-1620
Behavioral Health - Inpatient Fax	(844) 207-1622
Behavioral Health - All Non-Inpatient Fax	(844) 206-4006
Pharmacy Authorizations Fax	(844) 312-6371
Physician Administered Drugs	(844) 312-6371
Radiology Authorizations Fax	(877) 731-7218
Transplant Authorizations Fax	(877) 813-1206
NICU Authorizations Fax	(833) 734-1509

Vendors

- **MTM (Non Emergent Transportation)**
  Toll Free: (888) 597-1206
  Toll Free: (844) 826-4335
  https://memberportal.net/?planCode=MOL
- **CVS Caremark (Pharmacy)**
  Toll Free: (844) 826-4335
  PA submissions Fax: (844) 312-6371
- **March Vision (Vision)**
  Toll Free: (844) 606-2724
  Toll Free: (844) 826-4335
  www.marchvisioncare.com

Claims Department

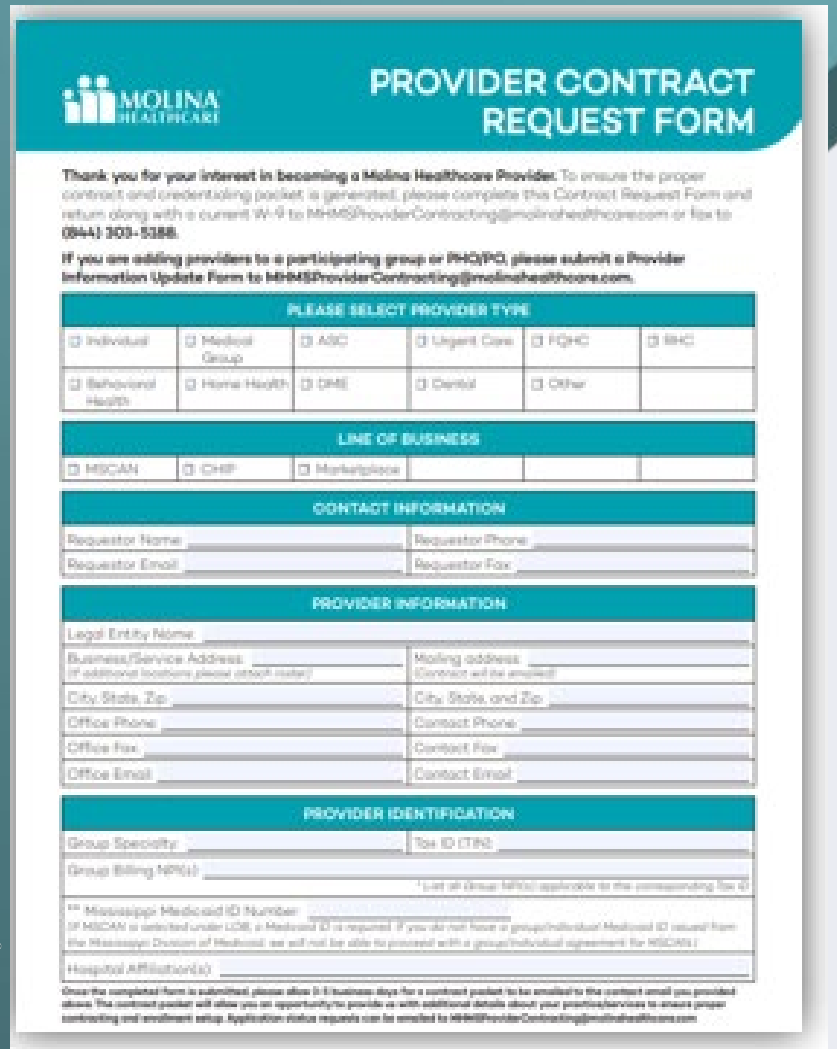
The Claims Department is located at our corporate office in Long Beach, CA. All hard copy (CMS-1500, UB-04) claims must be submitted by mail to the address listed below. Electronically filed claims must use EDI Claims/ Payor ID number - 77010. To verify the status of your claims, please call our Provider Claims Representatives at the numbers listed below. For Dental Claim information, please click here.

MOLINA HEALTHCARE

Contracting

Presented by: Cody Greer, Director Provider Contracts

How To Join Our Network



MOLINA HEALTHCARE

PROVIDER CONTRACT REQUEST FORM

Thank you for your interest in becoming a Molina Healthcare Provider. To ensure the proper contract and credentialing packet is generated, please complete this Contract Request Form and return along with a current W-9 to MHMSProviderContracting@molinahealthcare.com or fax to **(844) 303-5388.**

If you are adding providers to a participating group or PHO/IPO, please submit a Provider Information Update Form to MHMSProviderContracting@molinahealthcare.com.

PLEASE SELECT PROVIDER TYPE

☐ Individual	☐ Medical Group	☐ ASC	☐ Urgent Care	☐ FQHC	☐ RHC
☐ Behavioral Health	☐ Home Health	☐ DME	☐ Dental	☐ Other	

LINE OF BUSINESS

☐ MSCAN	☐ CHIP	☐ Marketplace			

CONTACT INFORMATION

Requestor Name:	Requestor Phone:
Requestor Email:	Requestor Fax:

PROVIDER INFORMATION

Legal Entity Name:	
Business/Service Address: (If additional locations please attach roster)	Mailing address: (Contract will be emailed)
City, State, Zip:	City, State, and Zip:
Office Phone:	Contact Phone:
Office Fax:	Contact Fax:
Office Email:	Contact Email:

PROVIDER IDENTIFICATION

Group Specialty:	Tax ID (TIN):
Group Billing NPI(s): * List all Group NPI(s) applicable to the corresponding Tax ID	
** Mississippi Medicaid ID Number: If MSCAN is selected under LOB, a Medicaid ID is required. If you do not have a group/individual Medicaid ID issued from the Mississippi Division of Medicaid, we will not be able to proceed with a group/individual agreement for MSCAN.)	
Hospital Affiliation(s):	

Once the completed form is submitted, please allow 3-5 business days for a contract packet to be emailed to the contact email you provided above. The contract packet will allow you an opportunity to provide us with additional details about your practice/services to ensure proper contracting and enrollment setup. Application status requests can be emailed to MHMSProviderContracting@molinahealthcare.com

To join our network, please complete and follow instructions given on the Contract Request Form found on our website:

https://www.molinahealthcare.com/providers/ms/medicaid/comm/Join-Molina-Healthcare-of-Mississippi-Network.aspx

After completing, a representative from our Provider Contracting Department will reach out to you regarding the enrollment process.

For additional information, email:
MHMSProviderContracting@MolinaHealthCare.Com

MOLINA HEALTHCARE

MOLINA HEALTHCARE

How To Join Our Network FAQ

- What is needed to become a contracted provider?

  To become a contracted provider with Molina for the MSCAN & CHIP Products, a Provider Group must have an active MESA ID and be credentialed through Gainwell. A completed credentialing packet will be necessary only if the group decides to join Molina's Marketplace Product.

- What will be my effective date?

  The effective date of a new group contract will be 30 days after the Provider Group signs the Contract. Any providers submitted during the original contract loading process shall receive the same effective date. Any claims submitted before your contractual effective date will be considered out of network.

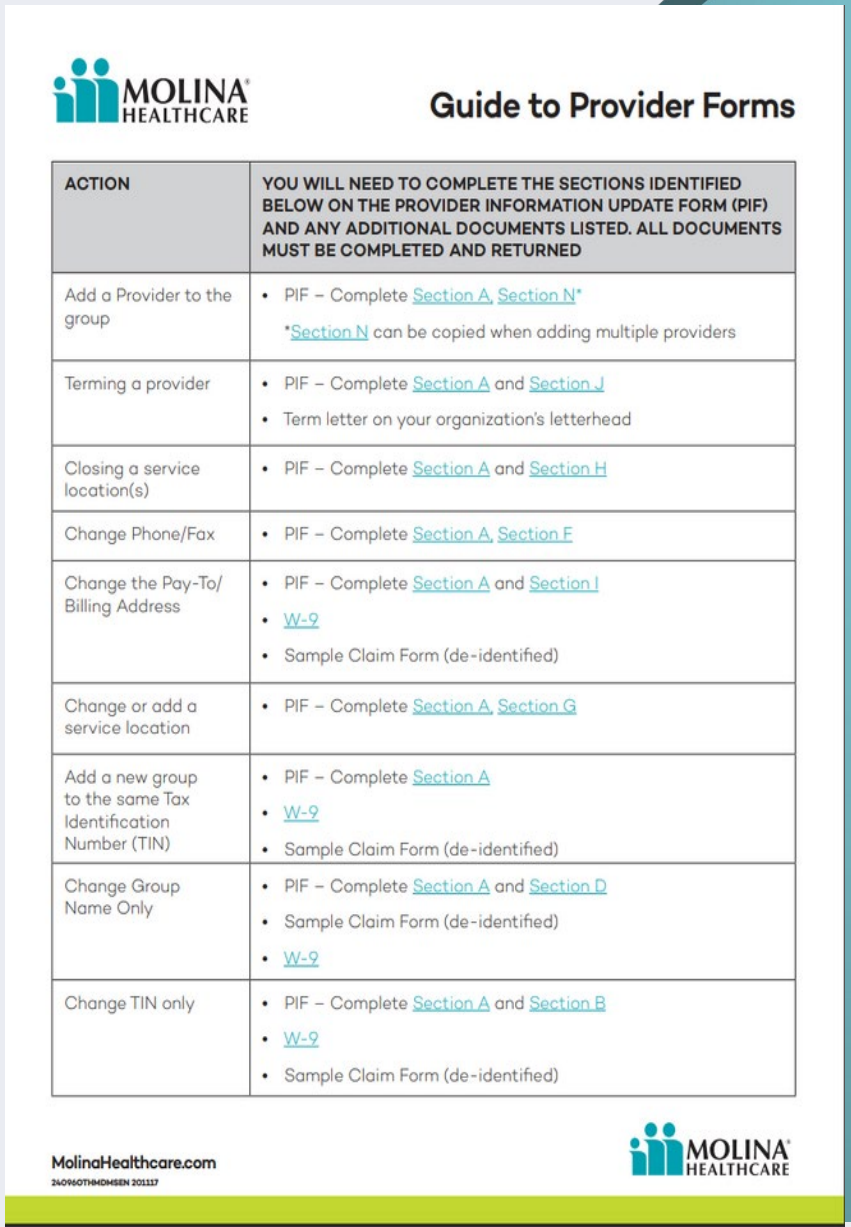
MOLINA HEALTHCARE

Please notate that the effective date given by Gainwell will not be the effective date of the newly contracted group.

How to Add a Practitioner/Make an Update

In order to add a Practitioner to an existing Molina Contract or make an update, please complete a Provider Information Update Form, which can be found at the following link: https://www.molinahealthcare.com/-/media/Molina/PublicWebsite/PDF/Providers/ms/medicaid/provider-information-update-form.pdf

After completion, please send the form to: MHMSProviderUpdates@molinahealthcare.com and a representative will make outreach to you regarding next steps.



MOLINA HEALTHCARE

Guide to Provider Forms

ACTION	YOU WILL NEED TO COMPLETE THE SECTIONS IDENTIFIED BELOW ON THE PROVIDER INFORMATION UPDATE FORM (PIF) AND ANY ADDITIONAL DOCUMENTS LISTED. ALL DOCUMENTS MUST BE COMPLETED AND RETURNED
Add a Provider to the group	• PIF – Complete Section A, Section N* *Section N can be copied when adding multiple providers
Terming a provider	• PIF – Complete Section A and Section J • Term letter on your organization's letterhead
Closing a service location(s)	• PIF – Complete Section A and Section H
Change Phone/Fax	• PIF – Complete Section A, Section F
Change the Pay-To/ Billing Address	• PIF – Complete Section A and Section I • W-9 • Sample Claim Form (de-identified)
Change or add a service location	• PIF – Complete Section A, Section G
Add a new group to the same Tax Identification Number (TIN)	• PIF – Complete Section A • W-9 • Sample Claim Form (de-identified)
Change Group Name Only	• PIF – Complete Section A and Section D • Sample Claim Form (de-identified) • W-9
Change TIN only	• PIF – Complete Section A and Section B • W-9 • Sample Claim Form (de-identified)

MolinaHealthcare.com

MOLINA HEALTHCARE

FAQs on How To Add A Practitioner or Make and Update

- **What credentialing information is needed?**
  In order to become an in-network practitioner with Molina for the MSCAN & CHIP Products, a practitioner must have an active MESA ID and be credentialed through Gainwell. A completed credentialing packet may be necessary only if the practitioner is joining Molina's Marketplace Product.

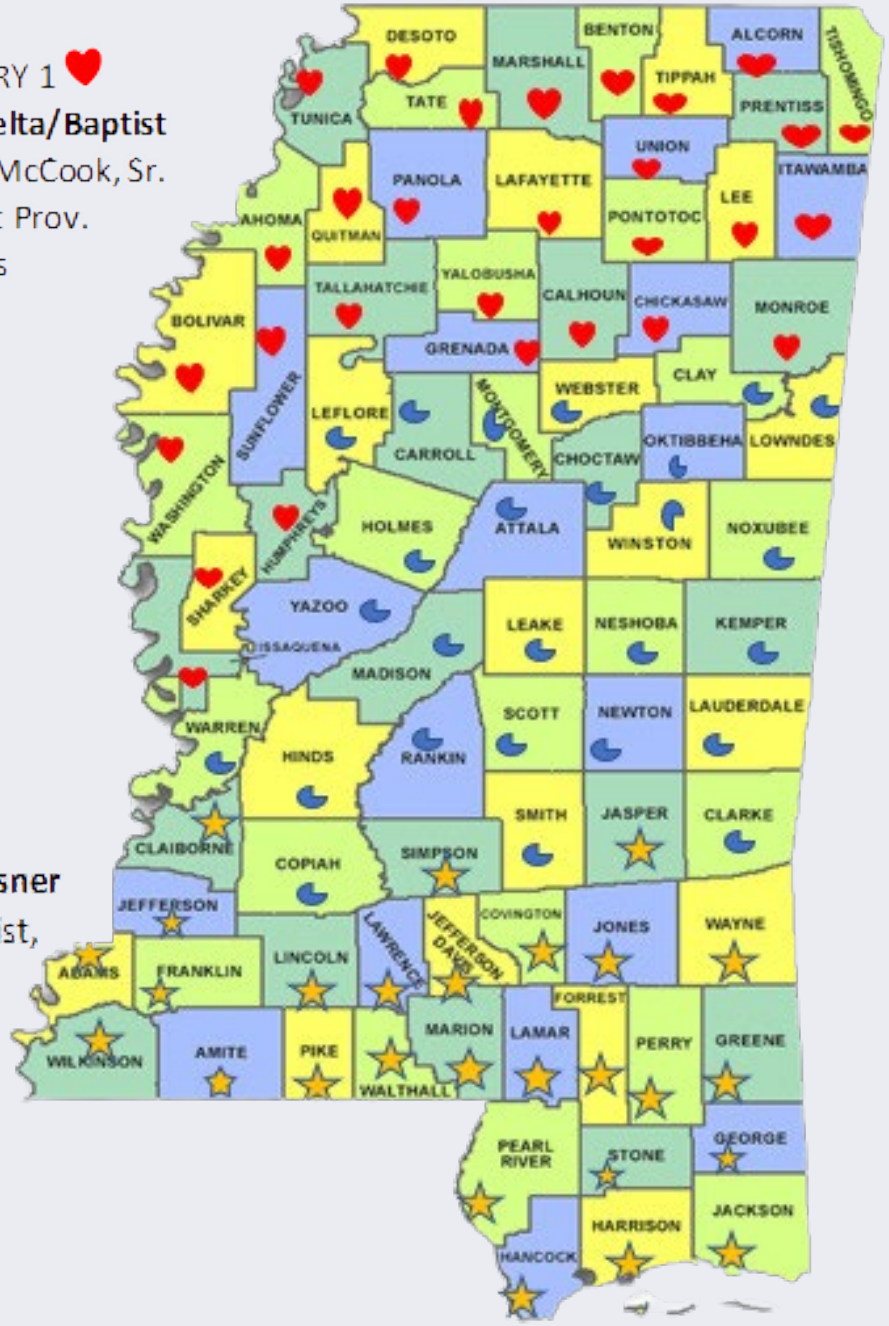
- **Demographic Updates:**
  Please timely submit demographic updates such as: banking information, address changes, phone number changes, etc.

- **What will be my effective date of a newly added practitioner?**
  The effective date given by Gainwell will not be the effective date given by Molina. The effective date of a new practitioner addition will be the date in which it is received by Molina.

MOLINA HEALTHCARE

Contracting Map

TERRITORY 1
North-Delta/Baptist
Candice McCook, Sr. Specialist Prov. Contracts



FLOATING
Katrina McKinney – Associate Specialist, Provider Contracts
Cody Greer – Director, Provider Contracts

TERRITORY 2
Central/Merit Health
Katrina Stroud, Specialist Prov. Contracts

TERRITORY 3
South-Gulf Coast/Ochsner
Garrett Kalem, Specialist, Prov. Contracts

MOLINA HEALTHCARE

Managed Care Provider Workshops

Mississippi Division of Medicaid

2024

United Healthcare

Contracting

Contact Us

As a health care professional, you can get the support and information you need from UnitedHealthcare in a variety of ways. You can choose from chat, the UnitedHealthcare Provider Portal and more to help you find the information you need. From technical support and provider network management to a specific state's health plan, you can select the options that work best for your needs.

UnitedHealthcare Community Plan

- **Provider Services (MSCAN):** 877–743–8734
- **Provider Services (CHIP):** 800–557–9933
- **Online:** uhccommunityplan.com
- **Physical Address:**
  795 Woodlands Parkway, Suite 301
  Ridgeland, MS 39157

UHCprovider.com

- UHCprovider.com/join-our-network

Chat with Us, for Real Time Answers!

- To start a chat, sign in to the Provider Portal.
- Credentialing
- Onboarding Processes

Contact Us

We're here to help with United Healthcare Provider Portal self-service tools and a new live chat option using your One Healthcare ID. Don't have one? Get one now.

Self-service options

Want answers quickly?

The Provider Portal provides patient and practice-specific information for:

- Eligibility and coverage
- Claims and payments
- Prior authorizations
- Referrals, reports and more

Sign in

Need contracting or credentialing help?

Use your One Healthcare ID to:

- Update your application to join our network
- Access self-service tools
- Check your credentialing status
- Chat with an advocate

Connect now

Frequently requested contacts

I'm looking for....	Contact us
Members	Myuhc.com

Pharmacy	**OptumRx fax (non-specialty medications)** 800-527-0531 **OptumRx fax (specialty medications)** 800-853-3844
24/7 behavioral health and substance use support line	877-614-0484
Technical support for providers and staff	**UnitedHealthcare Provider Portal support** Provider portal help for login, access, and functionality questions is available 7 am – 7 pm CT, Monday – Friday via chat. Sign in with your One Healthcare ID to chat with an advocate. Support is also available by calling 866-842-3278, option 1. **Electronic Data Interchange (EDI) support** For **Electronic Data Interchange (EDI)** inquiries, complete automated transaction support form or email supportedi@uhc.com **Community Plan EDI support** ac_edi_ops@uhc.com 800-210-8315 **API support** General API support APIconsultant@uhc.com API Extended X12 support supportedi@uhc.com Optum Technical support
Payment assistance	**Optum Pay** Sign in or learn how to enroll
UnitedHealthcare Premium® Program designation	UnitedHealthPremium.uhc.com
Clinical assistance	866-889-8054
General provider assistance	877-842-3210

How to Request a Contract – Medical Provider

- **Step 1:** You must successfully complete Centralized Credentialing through the Mississippi Division of Medicaid's fiscal agent Gainwell.
  - Applies to all MississippiCAN and CHIP providers
  - Gainwell Provider Portal: **Medicaid Enterprise System Assistance** (MESA)

- **Step 2: All MississippiCAN and CHIP Providers**: Once your Medicaid credentialing is complete with the Mississippi Division of Medicaid and you have an active MS Medicaid ID number, please submit your practice's letter of intent or request for participation by email to **hpdemo@uhc.com**.
  - **Please include the following with your request:**
    - A statement that the practice is requesting a new medical group agreement
    - Medical group specialty,
    - Practice roster
    - Copy of Form W-9

- **Step 3:** **Set up** your online tools, paperless options and complete your training.

Federally Qualified Health Centers (FQHC)
Rural Health Clinics (RHC)

UnitedHealthcare Community Plan must have these items when completing a contract with a FQHC/RHC.

1. You must successfully complete Centralized Credentialing through the Mississippi Division of Medicaid's fiscal agent Gainwell.

2. The following items are contracting requirements for FQHC/RHC:

- Provider Roster ***(This is a specific Roster Template for FQHC/RHCs.)***
- W9
- General and Professional Liability Insurances
- Rate Letter for Medicaid

FQHC/RHC Email Box: MS-FQHC-RHC@uhc.com

- Request the Provider Roster Template
- Submit questions
- Submit Updates, Changes, Additions to your Physician Roster

Behavioral Health Providers

Learn how to join the Behavioral Health Network, review Community Plan Behavioral Health information, or submit demographic changes at **Community Plan Behavioral Health**.

March Vision Care

Once your credentialing is complete with the Mississippi Division of Medicaid and you have an active MS Medicaid ID, please go to **March Vision Care/become provider** where you will complete the form by filling in the requested information. Once submitted, you will be contacted by a representative from our Network team.

Optum Physical Health

Current Participating Providers – Send Letter of Interest by email to **netdevpubsec@optum.com** or **Fax:** 855–277–9173. **Include:** Group/Provider Name – Tax ID – NPI – POS Address – Phone – Fax – Email

Non–Participating Providers – Please submit your request for participation on our website. **myoptumhealthphysicalhealth.com** and select “Interested in becoming a Provider” or **Call:** 800–873–4575

Dental

Once your credentialing is complete with the Mississippi Division of Medicaid (Gainwell) and you have your welcome letter for your provider(s) and/or office(s); please follow the below steps to submit your request for participation with UnitedHealthcare Dental:

- Please visit us online: **www.uhcdental.com**
- Once on the website, please click on “Join Our Network”.
- On the Join Our Network page, under “Get Started”, number 2 (Southeast Region); click on “Contact us”.
- This should bring up your email, please make sure to fill this out in its entirety and include a copy of your Provider’s Gainwell Welcome Letter. Please make sure to identity that this is for MS Medicaid (MSCAN/MSCHIP).

Value Based Incentives

PATH Program

The PATH program includes resources that assist the Providers with meeting their quality scores which will also increase their earning potential with the measures tied to the incentive program.

- UHCprovider.com/PATH Program
  - **Includes the following resources for Providers:**
    - PCOR (Patient Care Opportunity Report)
    - Coding Resources
    - HEDIS® Reference Guides
- **Provider Services: 877-743-8734**

Provider Incentive Program – CP PCPI

UnitedHealthcare Community Plan Primary Care Professional Incentive Program

- Rewards qualifying physician practices for performance tied to addressing patient care opportunities for members attributed to their panel. Measures targeted for this program are in the table below.

Health Equity

- This program offers an additional opportunity to earn bonuses by closing care gaps and reducing health inequities sorted by race, ethnicity, and gender identity.

CP PCPI Target Measures 2024	
Antidepressant Medication Management (Effective Acute)	Asthma Medication Ratio (Total)
Blood Pressure Control for Diabetic Patients	Eye Exam for Diabetic Patients
HbA1C Control for Diabetic Patients	Immunizations for Adolescents (Combo 2)
Well Child Visits- First 15 Months	Well Child Visits- Ages 12-17
Well Child Visit- Ages 3-11	General SDOH Assessment

Provider Incentive Program – CP PCPI

Social Determinants of Health (SDOH) are non-clinical societal and environmental conditions, such as lack of access to:

- Adequate food and health care
- Housing
- Transportation
- Adequate social support that prevent individuals from accessing health care they need.

- Identifying these non-clinical barriers to care allow health care providers and insurers to identify non-clinical conditions that present obstacles for patients' access to the health care they need.
- Health care providers are strongly encouraged to routinely screen, document, and submit the appropriate ICD-10 code(s) when a patient is impacted by SDOH.
- Providers participating in CP PCPI can earn an incentive by documenting a completed SDOH assessment with use of a Z code (max incentive $5 per member per year).

Social Drivers of Health Z-Code Provider Guide found at link below:
Social Drivers of Health Z-code Provider Guide - UnitedHealthcare (uhcprovider.com)

Recredentialing

Recredentialing

All Credentialing and recredentialing activities will be conducted by the Division of Medicaid and Gainwell Technologies.

- Medicaid Status must remain active to maintain an In Network Status with the CHIP and MSCAN benefit plans.
- Contract is valid through the agreed upon date (see signed contract.)

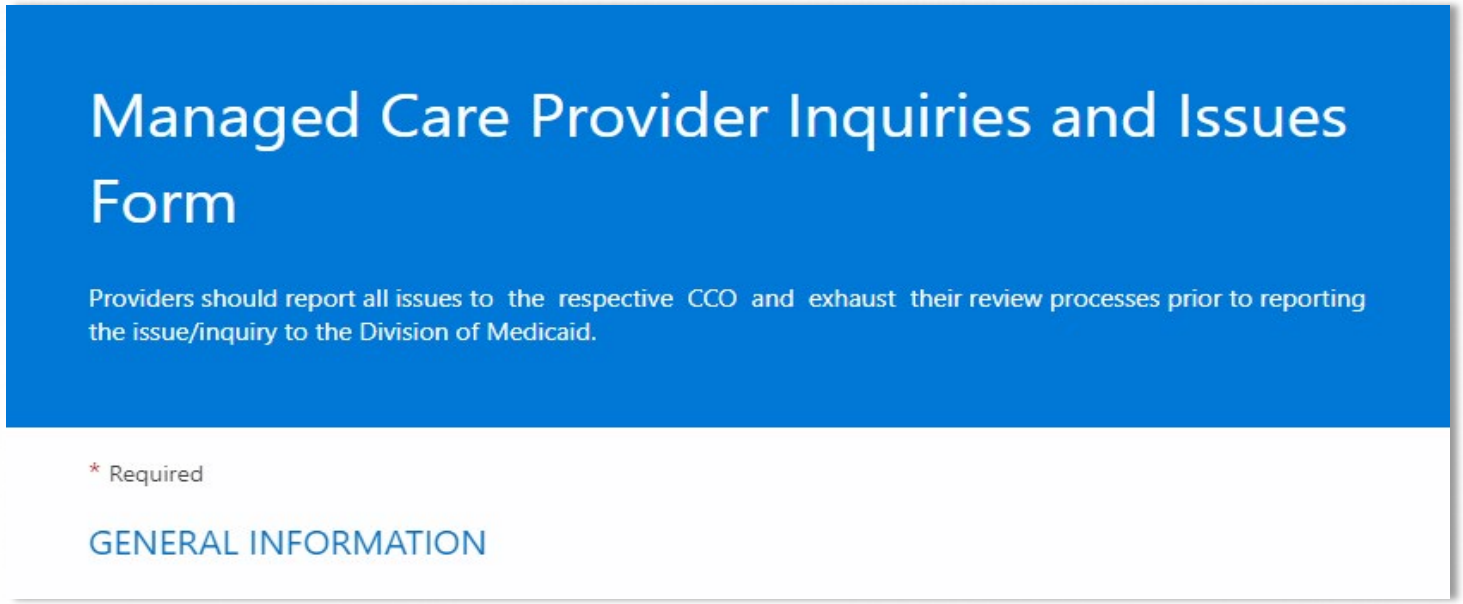
- **To access a credentialing application through Gainwell:**
  - **MESA Portal:** Mississippi Medical Assistance Portal for Providers → **Home**

Managed Care Inquiries and Complaints

HELP US, HELP YOU

Please forward all provider issues and complaints to:

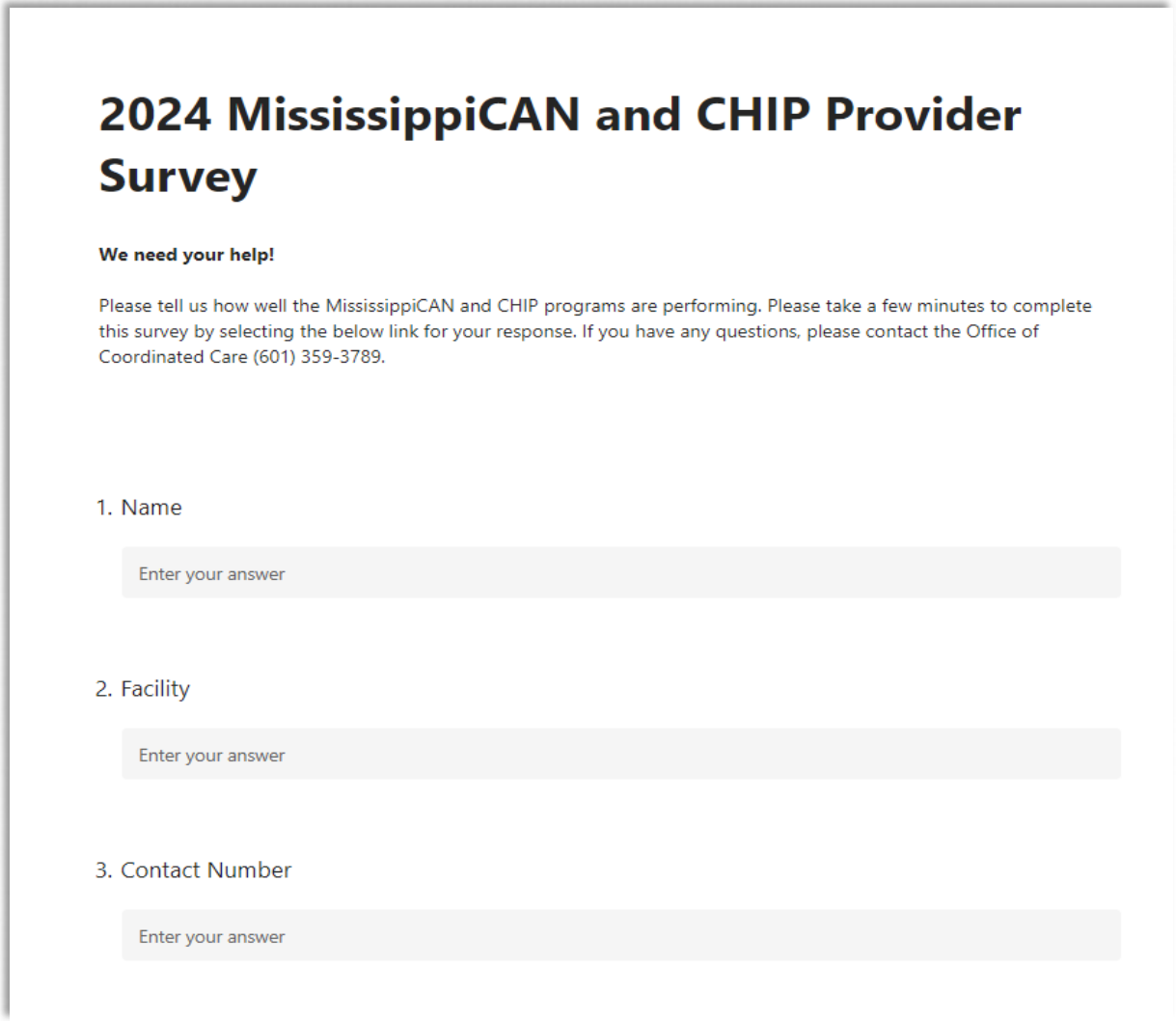
https://forms.office.com/g/WXj92sN1MH



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

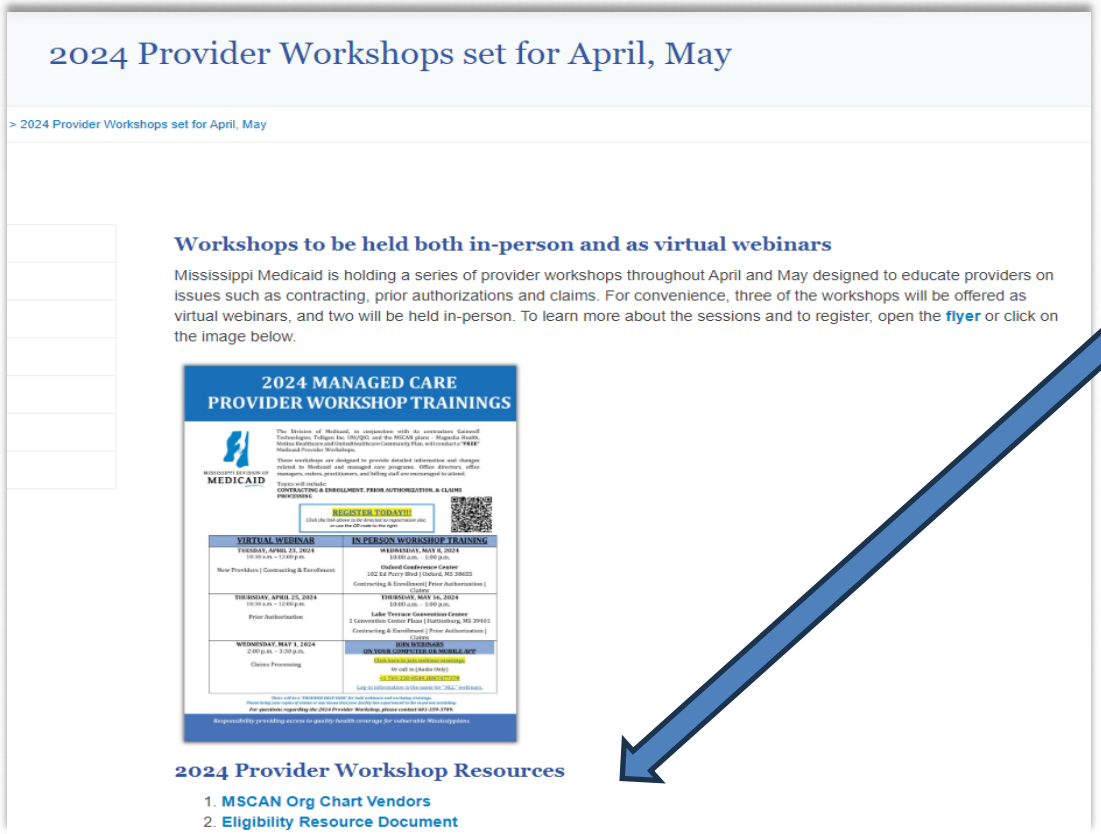
Enter your answer

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.