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MS Medicaid PROVIDER BULLETIN

MISSISSIPPI DIVISION OF MEDICAID

Medicaid Provider Enrollment and Data Maintenance: Requirements and Process Overview

As we have passed the two-year anniversary of the Division of Medicaid's implementation of its new Medicaid Management Information System (MMIS), MESA, we continue to prioritize the enrollment of providers into the Medicaid program for the State of Mississippi. MESA streamlines the enrollment process and enhances the integrity of claims management, ensuring that both billing and non-billing providers can deliver services efficiently and in compliance with federal and state regulations.

The Centers for Medicare & Medicaid Services (CMS) provides detailed guidance for state Medicaid agencies on the requirements for enrolling providers. This guidance is primarily outlined in federal regulations, including 42 CFR Part 455, Subparts B and E, and is further elaborated in the Medicaid Provider Enrollment Compendium (MPEC) and the Mississippi Division of Medicaid Administrative Code.

Enrolling as a Medicaid provider and maintaining your enrollment data are essential steps for healthcare professionals and organizations who wish to be reimbursed for the delivery of services to Medicaid beneficiaries. The Centers for Medicare & Medicaid Services (CMS) and state Medicaid agencies require providers to meet specific enrollment standards to ensure compliance with both federal and state regulations. Below is an overview of the key requirements and steps necessary for enrollment in Medicaid, including differences for billing and non-billing providers.

Why Enrollment is Important

Medicaid provider enrollment serves several purposes:

- **Program Integrity**: Screening and enrollment helps prevent fraud, waste, and abuse in Medicaid by ensuring only qualified providers can participate.
- **Compliance**: Enrolled providers must meet state and federal regulatory standards, including those set forth by CMS.
- **Access to Medicaid Beneficiaries**: Only enrolled providers can submit claims for

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WEB PORTAL REMINDER

VISIT DOM'S WEBSITE FOR LATEST UPDATES

Find the latest updates and important information on the DOM website under the Provider Portal at: **https://medicaid.ms.gov/mesa-portal-for-providers/**. The Provider Portal hosts many resources for providers such as webinars, FAQs, training videos, and Late Breaking News.

Click the links below to access portal resources.

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services rendered to Medicaid beneficiaries and receive reimbursement from Medicaid.

Enrollment Differences for Billing Providers vs. Non-Billing Performing Providers

Billing Providers

Billing providers are entities or individuals who submit claims to Medicaid for reimbursement of services provided to Medicaid beneficiaries. These providers are responsible for ensuring that claims are accurate and adhere to both federal and state Medicaid regulations.

- **Key Requirements for Billing Providers**:
  - ◊ Must enroll with Medicaid for each service location where services are rendered.
  - ◊ Must submit claims with the NPI and appropriate service location details in accordance with the published Mississippi Division of Medicaid (DOM) guidance, including but not limited to Companion Guides, Job Aids, Paper Billing Manual, Late Breaking News articles, etc.
  - ◊ Billing providers must also ensure that any individual practitioners included on a claim are properly enrolled and affiliated, if applicable.
  - ◊ Billing providers are subject to comprehensive screening as they have direct financial interactions with Medicaid, which may include moderate to high-risk screenings, depending on the provider's taxonomy.

Non-Billing Providers

Non-billing providers are individuals who render services but do not submit claims to Medicaid as well as those providers who Order, Refer, and Prescribe (ORP) services for Medicaid beneficiaries. Instead, these providers' identifying information is present on claims submitted to the Division of Medicaid by an enrolled billing provider (i.e. a hospital or group practice). These providers must still be enrolled in Medicaid to ensure compliance with program requirements, even though they are not responsible for billing.

- **Key Requirements for Non-Billing Providers**:
  - ◊ Non-billing providers are required to enroll in Medicaid to establish their credentials, **but they only need to enroll once per NPI and taxonomy combination**.
  - ◊ They must affiliate with the billing provider (e.g., a group practice) that will submit claims on their behalf at all practice locations at which the non-billing provider renders services.
  - ◊ Since non-billing providers do not submit claims, their screening may be less intensive compared to billing providers, though they are still subject to exclusion screening and credential verification.
  - ◊ Non-billing providers must ensure that the billing provider submits accurate claims that reflect the services rendered, including proper service location details if the service was performed at a location different from the billing provider.

Key Medicaid Provider Enrollment Requirements

1. National Provider Identifier (NPI)

All Medicaid providers eligible to obtain a National Provider Identifier (NPI), must do so before enrolling in Medicaid. This unique identifier, issued by the National Plan and Provider Enumeration System (NPPES), is required for billing purposes and must be used on all Medicaid claims.

- **How to Obtain a NPI:** Providers can apply for a NPI through the NPPES website. You will need to provide details such as your

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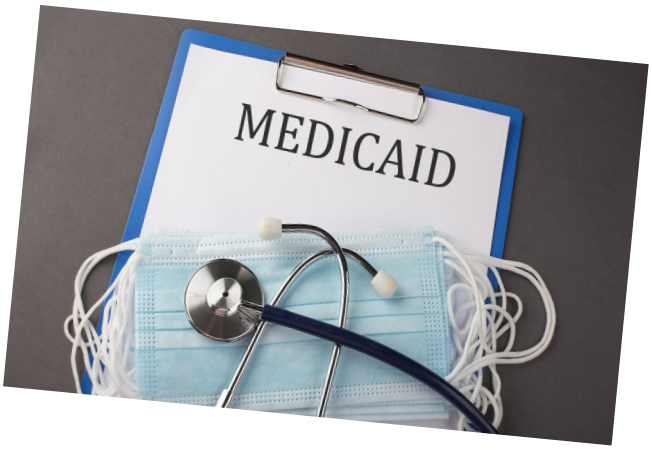
provider type, taxonomy(ies), and practice location(s).

- **Atypical Provider Exception:** Atypical providers are generally not eligible to obtain a NPI. Atypical providers are individuals or organizations that do not provide healthcare services as defined by the Health Insurance Portability and Accountability Act (HIPAA). These can include providers such as non-emergency medical transportation services, personal care services, or other support services not related to direct medical care. Since atypical providers are not generally required to obtain an NPI, a Medicaid ID will be assigned at enrollment and the provider is required to use the assigned Medicaid ID on all submissions for prior authorization requests, claims, etc.

2. CMS Application Fees

Under federal regulations, CMS requires that certain providers pay an application fee when enrolling in Medicaid. This fee helps cover the costs associated with the provider screening process. The application fee is reviewed and updated annually by CMS.

- **Who Must Pay the Fee**: Institutional providers (e.g., hospitals, skilled nursing facilities, and home health agencies) are typically subject to this fee. However, individual practitioners and small physician group practices are generally exempt.
- **Fee Waivers**: Providers may request a waiver if they can demonstrate hardship. If the provider has paid the application fee to Medicare or another state's Medicaid, the provider should choose the appropriate Application Fee option.
- **Consequences of Non-Payment**: Failure to pay the required application fee, unless exempt, may result in the denial of a provider's Medicaid enrollment application.



The enrollment application fee for institutional providers for the 2025 calendar year is $730. This application fee will be required in the following instances:

- Initial enrollment, reactivation, revalidation, or reenrollment of providers in Medicaid and the Children's Health Insurance Program (CHIP)
- Addition of New Owners – Change of Ownership
- Providers adding a new Medicaid practice location

Note: Simple changes to the provider enrollment information, that is, new phone numbers, new bank account information, new billing address, change in the name of the provider, or other such updates are not subject to the fee. Providers required to submit a fee can be found at https://medicaid.ms.gov/provider-enrollment-application-fee/.

3. Provider Screening and Risk Levels

Medicaid providers are subject to screening based on the level of risk they pose to the program. CMS classifies providers into three risk categories—**limited, moderate,** and **high**—each with corresponding screening requirements:

- **Limited Risk**: Providers such as physicians and clinics undergo basic screening, including license verification, and database checks.
- **Moderate Risk**: Providers such as ambulatory

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surgical centers, independent diagnostic testing facilities (IDTF), physical therapists enrolling as individual or group practices may require additional screening, such as on-site visits.

- **High Risk**: Providers such as skilled nursing facilities, home health agencies, and durable medical equipment (DME) suppliers must pass stringent checks, including fingerprint-based criminal background checks and on-site inspections.

The Mississippi Division of Medicaid is responsible for performing these screenings as part of the enrollment process.

4. Federal and State Exclusion Screening

Providers must pass exclusion screening to ensure they are not barred from participating in Medicaid. This includes checking the **Office of Inspector General (OIG)'s List of Excluded Individuals/Entities (LEIE)** and the **System for Award Management (SAM)** database.

- **Exclusion Consequences**: Providers excluded from federal healthcare programs are prohibited from enrolling or participating in Medicaid. Providers who fail to disclose exclusions risk severe penalties, including recoupment of payments and civil fines.

5. Service Location Enrollment

Billing providers must enroll each service location where Medicaid beneficiaries receive services whereas non-billing providers must affiliate to a billing provider at all locations where they render services to Medicaid beneficiaries. This ensures that all practice locations comply with Medicaid requirements and are licensed appropriately.

- Multiple Locations: If your billing provider practice has multiple locations, each location must be enrolled separately. The billing provider must list the correct service location when submitting claims to Medicaid.
- Individual providers (non-billing) must be affiliated with every service location of a group or practice where services are rendered.

While providers have the ability to add multiple servicing addresses on as single enrollment application, the portal has the ability for a provider to copy a previously submitted application eliminating the need to re-enter data multiple times. Using the copy previously submitted application process will copy all data from the previous application except the address and attachments. Once copied, the data in the new application is editable prior to submission. The provider will need to key the address information, make any changes based on variations across practice locations, and upload any necessary attachments. Incomplete documentation will lead to processing delays while the necessary documentation is requested from the provider. The Copy an Existing Provider Enrollment Application Job Aid provides a step-by-step guide for using this functionality.

6. Licensure and Credentialing

Under the guidelines of 42 CFR § 455.412, the Mississippi Division of Medicaid (DOM) is required to have current licenses in the provider file for both fee-for-service, MississippiCAN, and CHIP providers. Providers must submit and verify all relevant licensure and certifications as part of their enrollment application as well as submit updated licenses to DOM to maintain their enrollment status as licenses are renewed. This includes:

- Professional licenses (e.g., for physicians, nurses, dentists).
- Certification of compliance with state and federal regulations.
- Evidence of participation in any necessary accreditation programs.

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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. As part of the implementation of the Medicaid Enterprise System Assistance (MESA), DOM implemented a new centralized credentialing process along with NCQA certified Centralized Verification Organization (CVO) that will be responsible for credentialing and recredentialing Medicaid providers seeking to enroll or currently enrolled with our coordinated care programs (MSCAN/ CHIP). The CVO will perform recredentialing for both current providers and new providers at least 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 providers "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. It is crucial to submit the recredentialing application by the submission date in the notification letter to allow processing time before the deadline.

Facilities with multiple service locations and provider IDs will receive a recredentialing notice for each provider ID. Only one provider ID for the same tax ID and service location address will need to submit the recredentialing application which will pick up and credential all the taxonomies at that location under that tax ID. If recredentialing is either denied or not completed by the recredential due date, all the facility enrollments at that location under that tax ID that was due for recredentialing will no longer be eligible to participate in Managed Care; however, FFS eligibility may not be impacted.

Individual providers with multiple provider IDs sharing the same NPI will receive a recredentialing notice for each of the provider IDs. The provider will only need to recredential one of the IDs to satisfy the requirement for all. If recredentialing is either denied or not completed by the recredential due date, the provider will no longer be eligible to participate in Managed Care; however, FFS eligibility may not be impacted.

If the recredentialing is denied or not completed by the recredentialing due date and the provider has FFS eligibility on the provider file, the provider will then need to log into the provider's portal account and click on the "Add Programs" link under the Provider Section of the Home Page to complete and submit the Add Programs for the MSCAN and/or MSCHIP programs that were terminated. Resources for the Add Programs process are located under General on the DOM website at www.medicaid.ms.gov/mesa-portal-for-providers/.

7. Provider Disclosure of Ownership

Ownership disclosure helps Medicaid agencies identify and prevent fraud by ensuring transparency in the provider's operations. Medicaid providers are required, in accordance with 42 CFR 455.104, to disclose information about ownership and control. This includes any person or entity with a 5% or greater ownership interest in the provider, as well as managing employees and anyone with operational control over the practice.

8. Revalidation

In accordance with 42 C.F.R. § 455.414 of the Affordable Care Act (ACA), all state Medicaid agencies must revalidate provider enrollments at least every five years. This ensures that the provider's credentials, ownership, and other information remain up to date.

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Providers will receive a notice when it's time to revalidate. Providers can revalidate through the MESA Provider Portal using a step-by-step process. It is crucial to submit the revalidation by the submission date in the notification letter to allow processing time before the deadline. Failure to complete revalidation by the deadline will result in termination requiring the provider to reapply.

Maintaining Compliance After Enrollment

After enrollment, providers are responsible for maintaining compliance with Medicaid program rules, including but not limited to:

- Ensuring the accuracy of claims submissions, including the correct NPI and service location.
- Reporting any changes of provider information, including ownership, licensure, or service locations, to the state Medicaid agency within the required timeframes.
- Participating in regular revalidation and recredentialing efforts and responding promptly to any requests for information from the Medicaid agency.

Conclusion

Enrolling in Mississippi Medicaid requires careful attention to federal and state regulations. By ensuring compliance with the key requirements outlined above, both billing and non-billing performing providers can maintain their eligibility to participate in Medicaid and continue delivering services to beneficiaries. Providers should stay informed about changes to Medicaid policies and work closely with DOM to ensure their continued participation in the program.

PHARMACY NEWS

Thinking Smart About Asthma Treatment

In recent years, asthma treatment guidelines have been updated to reflect a shift away from the use of Short-Acting Beta-Agonists (SABA) as monotherapy in asthma patients due to increased risks of adverse events. The use of 3 or more SABA inhalers per year is associated with a higher risk of severe exacerbations, while the use of 12 or more SABA inhalers per year is associated with a higher risk of asthma-related death. Conversely, the use of Inhaled Corticosteroids (ICS) has been shown to significantly reduce the risks of adverse events such as emergency department visits, hospitalizations, and death. In general, Maintenance And Reliever Therapy (MART) or single-inhaler maintenance and reliever therapy (SMART) with an ICS-containing product is recommended as initial therapy for most individuals with asthma ages 6 years and above. Specifically, guidelines recommend the use of a single combination agent containing a low-dose ICS and the long-acting beta-agonist formoterol.

Medicaid's Drug Utilization Review (DUR) Board recently examined the use of ICS-containing products among members 6 years and older with an asthma diagnosis and a history of 3 or more SABA fills in the previous six months. Their analysis revealed that **56.9%** of members received only SABA inhalers for the treatment of their asthma. This indicates SABA monotherapy in a majority of members being treated for asthma for whom guidelines recommend the use of an ICS-containing product.

DOM supports and encourages providers to engage in shared clinical decision-making discussions with eligible members about the use of ICS-containing products, specifically ICS/formoterol products, as both maintenance and reliever therapy for the treatment of asthma when appropriate. To make it easier to prescribe SMART for Medicaid members, Medicaid's Universal Preferred Drug List (PDL) includes products that are preferred and available without prior authorization for both maintenance and reliever use.

PREFERRED AGENTS	NON-PREFERRED AGENTS
GLUCOCORTICOIDS (Inhaled) DUR+	
GLUCOCORTICOID/BRONCHODILATOR COMBINATIONS	
ADVAIR DISKUS (fluticasone/salmeterol)	AIRDUO Digihaler (fluticasone/salmeterol)
ADVAIR HFA (fluticasone/salmeterol)	AIRDUO Respiclick (fluticasone/salmeterol)
DULERA (mometasone/formoterol)	BREO ELLIPTA (fluticasone/vilanterol)
fluticasone/salmeterol (generic ADVAIR)	BREYNA (budesonide/formoterol)
fluticasone/salmeterol (generic AIRDUO)	budesonide/formoterol
SYMBICORT (budesonide/formoterol)	WIXELA INHUB (fluticasone/salmeterol)

Per the DUR Board's recommendation, DOM's DUR vendor, the University of Mississippi School of Pharmacy, is beginning a monthly provider mailing identifying members who are 6 years and older with an asthma diagnosis who received 3 or more SABA inhalers in the previous 6 months with no pharmacy claims for ICS-containing medications. This mailing aims to increase the proportion of Medicaid members with asthma who are treated with ICS-containing products. With your help, Medicaid hopes to improve the health of members experiencing asthma.

PROVIDER COMPLIANCE

Provider Recredentialing Mississippi Medicaid Managed Care Programs

All providers participating in MississippiCAN or the Children's Health Insurance Program (CHIP) are required to be credentialed by the Mississippi Division of Medicaid. Failure to complete credentialing/recredentialing will result in termination from these programs and will require reenrollment. There are a significant number of providers currently due for recredentialing that need to complete the process. Providers terminated for failing to recredential may reenroll for Medicaid's managed care programs (MSCAN/CHIP) through the MESA Provider Portal.

During the 2021 Mississippi Legislative Session, Senate Bill 2799 was enacted into law that requires the Medicaid Coordinated Care Organizations (CCO) to follow a uniform credentialing process for provider enrollment in the Managed Care Programs. On July 1, 2022, in accordance with this new requirement, the Mississippi Division of Medicaid (DOM) amended the CCO contracts to require the CCOs to accept DOM's provider enrollment and screening process, and not require providers be credentialed by CCOs for Medicaid or CHIP. 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. As part of the implementation of the Medicaid Enterprise System Assistance (MESA), DOM implemented a new centralized credentialing process along with NCQA certified Centralized Verification Organization (CVO) that will be responsible for credentialing and recredentialing Medicaid providers seeking to enroll or currently enrolled with our coordinated care programs (MSCAN/ CHIP). This new process eliminates the need for a provider to be credentialed or recredentialed multiple times.

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 providers "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.

Facilities with multiple service locations and provider IDs will receive a recredentialing notice for each provider ID. Only one provider ID for the same tax ID and service location address will need to submit the recredentialing application which will pick up and credential all the taxonomies at that location. If recredentialing is either denied or not completed by the recredential due date, all the facility enrollments at that location will be terminated and claims can no longer be paid. A new application for each taxonomy at that service location will be required to re-enroll in the Mississippi Medicaid program.

Individual providers with multiple provider IDs sharing the same NPI will receive a recredentialing notice for each of the provider IDs. The provider will only need to recredential one of the IDs to satisfy the requirement for all. If recredentialing is either denied or not completed by the recredential due date, all the individual provider's enrollments will be terminated, and

PROVIDER COMPLIANCE

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claims can no longer be paid. A new application for each service location will be required to re-enroll in the Mississippi Medicaid program.

To prepare for recredentialing, all Medicaid providers should take the following steps immediately:

- Each enrolled provider must register for access to the MESA Provider Portal to recredential electronically. This will streamline the process and allow providers to enter their own information. Providers can register now by going to https://portal.ms-medicaid-mesa.com/ and clicking the "Register Now" link.
- In addition to the notices mailed by Gainwell Technologies, providers can refer to DOM's website where we are posting the "Provider Six Month Recredentialing Due List" at https://medicaid.ms.gov/. This listing will be updated monthly.
- Review the Provider Recredentialing Presentation found under "MESA Tips" at https://medicaid.ms.gov/mesa-portal-for-providers/ which is a PowerPoint that includes a recredentialing walk through and tips for providers.
- Providers should verify that the address information on file is correct. The notifications will be mailed to the "Mail To" address on their file. To ensure each individual provider receives a notification, please validate your addresses on file, and correct them if necessary.
- If changes are needed, complete the Provider Change of Address form, located under Provider Forms at https://medicaid.ms.gov/resources/forms/.
- The Provider Change of Address form must be completed, signed by the individual provider or authorized official if enrolled provider is a business, and submitted to the Provider Enrollment Department of Gainwell Technologies via secure correspondence in the MESA Provider Portal, fax, or mail. The following correspondence information is provided:
  - Provider Services Fax Number:

    (866) 644-6148

    Attention: Provider Enrollment
  - Provider Services Mailing Address:

    Provider Enrollment/MississippiCAN/ MSCHIP

    PO Box 23078

    Jackson, MS 39225

Should you need assistance, please contact the Provider and Beneficiary Services Call Center at (800) 884-3222 or use the Provider Field Representative list on Medicaid's website to identify your designated representative. The Provider Field Representative list includes email addresses and phone numbers for each representative. This resource document is located https://medicaid.ms.gov/wp-content/uploads/2024/03/Provider-Field-Representatives-1.pdf.

PROVIDER COMPLIANCE

Provider Revalidation

Provider Revalidation

Effective October 1, 2023, DOM resumed provider revalidation.

Background: On May 11, 2023, the Health and Human Services Commission (HHSC) ended the extended revalidation dates for Medicaid providers that were implemented during the COVID-19 public health emergency (PHE). Following this, the Mississippi Division of Medicaid reinstated the revalidation process starting October 1, 2023. This requires all Mississippi Medicaid providers to verify the information in their provider files. According to 42 C.F.R. § 455.414 of the Affordable Care Act (ACA), all state Medicaid agencies must revalidate provider enrollments at least every five years.

Revalidation Requirements:

- Providers must verify or revalidate their current information.
- Providers must complete and sign a new Provider Disclosure form and a new Provider Agreement.
- The state will conduct a full screening according to the provider's risk level in compliance with 42 C.F.R. Part 455, Subparts B & E.
- Providers must comply with any state requests during the revalidation process within the specified timeframe.

Notification Process: Starting October 2023, notification letters were mailed to providers enrolled with Medicaid for five years or more. Revalidation notices will be issued on a staggered schedule until all providers due for revalidation have been notified. These letters will include instructions for completing the revalidation and the due date. Providers may need to submit additional documentation and/or meet other screening requirements, such as providing fingerprints or undergoing a site visit conducted by Medicaid's fiscal agent.

Application Fee: Certain providers must pay an enrollment application fee. For a list of institutional providers required to pay the fee, visit Provider Enrollment Application Fee. Providers who have already paid the application fee to Medicare or another state's CHIP or Medicaid program for the same provider type are exempt and should select the appropriate option when completing the revalidation application.

Revalidation Submission: Providers can revalidate through the MESA Provider Portal using a step-by-step process. It is crucial to submit the revalidation by the submission date in the notification letter to allow processing time before the deadline. Failure to complete revalidation by the deadline will result in termination requiring the provider to reapply.

Preparation Steps:

1. **Register for MESA Provider Portal Access:** All enrolled providers must register to revalidate electronically. Visit MESA Provider Portal and click "Register Now."
2. **Refer to DOM's Website:** Check the "Provider Six Month Revalidation Due List" at DOM's website. This list is updated monthly.
3. **Review Revalidation Presentation:** The Provider Revalidation Presentation, available under "MESA Tips" at MESA Portal for Providers, offers a walkthrough and tips for providers.

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4. **Verify Address Information and Submit Change of Address, if needed:** Login to the MESA Provider Portal, navigate to the Characteristics area and ensure the "Mail To" address on file is correct. If updates are needed, edit the address and save.

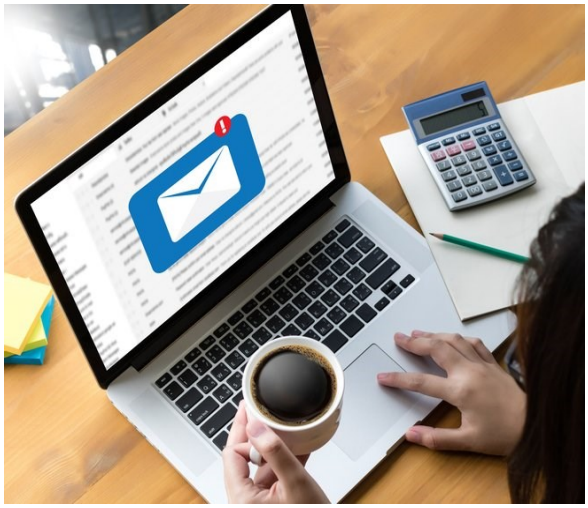
Assistance: For help, contact the Provider and Beneficiary Services Call Center at (800) 884-3222 or refer to the Provider Field Representative list on Medicaid's website, which includes email addresses and phone numbers for each representative. This list is available at https://medicaid.ms.gov/wp-content/uploads/2024/03/Provider-Field-Representatives-1.pdf.

New Email Address for Provider Document Submission

A new email address has been created for submission of supporting documents related to provider enrollment applications, revalidations, and recredentialing. If a Gainwell Provider Enrollment Analyst requests missing or corrected documents via email or by a Return-To-Provider (RTP) letter, please send them to the new email address: ms_pe_docs@gainwelltechnologies.com. This will ensure the provider enrollment team receives your documents should you encounter issues uploading them through the web portal.

Remember to include the Application Tracking Number (ATN) in the subject line of your email.

Note: This email address is for supporting documents only. For provider and claim inquiries, continue to use the email address of ms_provider.inquiry@mygainwell.onmicrosoft.com.



Wellness Program & Non-Covered Services

It is the mission of the Mississippi Division of Medicaid (DOM) to ensure compliance, efficiency, and accountability within the Mississippi Medicaid program by detecting and preventing fraud, waste, program abuse, and by ensuring that Medicaid dollars are paid appropriately by implementing tort recoveries, pursuing recoupment, and identifying avenues for cost avoidance.

Consequently, as a reminder, annual health screenings and physical examinations for children under the age of 21 may receive Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) for preventative and comprehensive health. Likewise, adults ages 21 and over may also receive annual health screening and physical examinations which are covered by DOM. However, DOM does **not** cover an annual physical examination for school entrance, sports, employment, or beneficiaries in an institutional setting including those that are in a nursing facility or intermediate care facility for individuals with intellectual disabilities.

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DOM appreciates your participation as a Mississippi Medicaid provider as you continue to provide quality health coverage for beneficiaries. As we continue error reduction initiatives, it is DOM's goal to work together to help stop fraud, waste, and abuse.

Mississippi Outcomes for Maternal Safety (MOMS) Initiative

The Mississippi Division of Medicaid (DOM) is pleased to announce the Mississippi Outcomes for Maternal Safety (MOMS) Initiative. The MOMS Initiative is a Value-Based Payment (VBP) program aimed at enhancing maternal health outcomes across the state. To address Mississippi's high rates of Severe Maternal Morbidity (SMM), the MOMS Initiative will support redesigned care delivery by incorporating new discharge protocols and requirements for post-discharge follow-up appointments. DOM has initiated and filed a preprint with the Centers for Medicare & Medicaid Services (CMS) to allow incentive payments to maternity hospitals and outpatient providers.

The MOMS assessment evaluates the real-time condition and factors linked to SMM risk of each patient. The MOMS assessment generates a numerical score that assigns the patient to a MOMS risk level ranging from Level 1 to Level 3. Risk levels determine the urgency of the patient's initial postpartum follow-up visit. Level 1 patients must be seen within 5 days, Level 2 patients within 10 days, and Level 3 patients within 30 days post discharge.

Hospitals play a pivotal role in assessing maternal health risk and identifying patients at heightened risk for adverse outcomes. To qualify for an incentive payment under the MOMS Initiative, for each managed care patient, hospitals will be eligible to receive a $250 incentive when completing a MOMS assessment and sharing the risk score prior to discharge. By integrating this assessment into routine procedures, hospitals contribute to early detection and proactive planning for postpartum care.

Outpatient providers also play a crucial role. To qualify for an incentive payment under the MOMS Initiative, for each managed care patient, outpatient providers will be eligible to receive a $250 incentive when a patient completes a postpartum follow-up visit within the timeframe specified by their MOMS risk score. These follow-up appointments are essential to ensuring that patients receive timely care during the critical postpartum period, reducing the likelihood of complications such as readmissions or emergency department visits. By tying financial incentives to timely follow-up visits, the program helps improve access to postpartum care and encourages providers to adopt practices that address patients' specific needs based on their risk profiles.

These incentives aim to promote better maternal health outcomes for Medicaid beneficiaries by encouraging comprehensive assessments and timely follow-up care. These measures are critical to reducing maternal morbidity statewide.

We have conducted a joint training session with the three CCOs to provide an overview of the program, including the MOMS Assessment form, ADT requirements, roles and responsibilities, best practices for discharge planning, and guidance on incentive payment allocation. A recording of the training webinar can be found at https://medicaid.ms.gov/value-based-incentives/.

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You can sign up for and access the webinar using the following link: MOMS Initiative Training Webinar.

This webinar will be recorded and made available on the DOM Website: Mississippi DOM VBP.

Should you have any questions regarding this new initiative, please send them to: QIPP@medicaid.ms.gov.

New Taxonomies for Provider Enrollment

Effective **July 1, 2024**, Mississippi Medicaid has introduced an additional 123 eligible taxonomies to better align with the services rendered and billed by providers. These taxonomies are now available for selection during enrollment through the MESA Web Portal. A complete list of all eligible taxonomies for Mississippi Medicaid enrollment can be found at: https://medicaid.ms.gov/wp-content/uploads/2024/10/MESA-Taxonomies-Listing-as-of-7-11-2024.xlsx.

Since these taxonomies were not previously available, **currently enrolled providers** may request an update to their existing taxonomy code if they wish to align with one of the new eligible taxonomies.

HOW TO REQUEST A TAXONOMY CODE UPDATE

Providers can submit taxonomy change requests through the following secure methods:

1. Online – MESA Provider Portal
    - Access the "Secure Correspondence" link on the MESA Provider Portal: https://medicaid.ms.gov/mesa-portal-for-providers.
    - For requests involving multiple Medicaid IDs, please attach a spreadsheet listing each update as a separate row.
    - Note: Preferred method for tracking purposes.
2. Fax
    - **Fax Number:** (866) 644-6148
    - **Attention:** Provider Enrollment
3. Mail
    - **Mailing Address:** Provider Enrollment, P.O. Box 23078, Jackson, MS 39225

When submitting your request, **please include the 9-digit Medicaid ID** and the **new taxonomy code** you are requesting.

Important:
The requested taxonomy code **must match the taxonomy reported in the NPPES NPI Registry** to ensure accuracy and compliance.

If you have any questions or need further assistance, please contact the Provider and Beneficiary Services Call Center at (800) 884-3222 or refer to the Provider Field Representative list on Medicaid's website, which includes email addresses and phone numbers for each representative. This list is available at https://medicaid.ms.gov/wp-content/uploads/2024/03/Provider-Field-Representatives-1.pdf.

PROVIDER COMPLIANCE

Expired Provider License Updates Required

It is imperative for providers to promptly provide their updated licensure information to Medicaid, as failure to do so will result in the closure of their Medicaid provider number and interruption of claim payments.

Who is impacted?
Under the guidelines of 42 CFR § 455.412, the Mississippi Division of Medicaid (DOM) is required to have current licenses in the provider file for both fee-for-service/MississippiCAN providers and CHIP providers.

When should licenses be updated?
As a part of this process, providers whose licenses have expired or are expiring will be notified via mailed notifications from Gainwell Technologies. We also encourage providers to consult DOM's official website, where the Provider Six-Month License Due List is available at https://medicaid.ms.gov/. This list will be refreshed monthly to ensure the latest information is accessible.

How can a provider submit the updated license?
To facilitate the submission of licensure information, Gainwell Technologies' Provider Enrollment Department offers multiple secure channels, including the MESA Provider Portal, fax, or mail. Here are the details for each method:

Online: MESA Provider Portal: https://medicaid.ms.gov/mesa-portal-for-providers (via the Secure Correspondence link)

Fax: Provider Services Fax Number: (866) 644 -6148
Attention: Provider Enrollment

Mail: Provider Services Mailing Address:
Provider Enrollment/MississippiCAN/MSCHIP
PO Box 23078
Jackson, MS 39225

Can a provider be reinstated if a provider fails to send in the updated license timely?
Complying with the provisions outlined in the Mississippi Administrative Code Part 200, Chapter 4, Rule 4.5 (B) (C), DOM will reinstate closed provider numbers due to license expiration, retroactive to the date of license renewal, provided the closure duration is under one (1) year and the provider is not past due for revalidation or recredentialing. For this to happen, the provider must furnish a current license copy and rectify any changed or inaccurate information. If a Medicaid provider number has been closed due to license expiration for a period exceeding one (1) year, re-enrollment as a Medicaid provider will be necessary.

For any assistance required between 8 a.m. and 5 p.m. CST, providers can contact the Provider and Beneficiary Services Call Center at (800) 884-3222.

PROVIDER COMPLIANCE

We Want Your Feedback: Help Us Improve the MESA Portal Claims Submission Process

At the Mississippi Division of Medicaid (DOM), we are committed to ensuring that the claims submission process is efficient, user-friendly, and meets the needs of our providers. To achieve this, we need your valuable input. We want to hear about your experiences with the claim's submission functionality of the MESA portal. Whether you use the portal regularly or rely on paper submission, your feedback is essential in identifying challenges and areas for improvement.

Your insights will help us:

- Understand the pain points your face when using the portal.
- Prioritize updates and changes to enhance your experience.
- Streamline the process to save you time and effort.

Please share your feedback and suggestions by emailing us at ProviderFeedback@medicaid.ms.gov. Be as specific as possible, and feel free to include examples of issues or ideas for improvement. Your input will directly influence future enhancements, and together we can make the MESA portal work better for everyone.

Thank you for partnering with us to improve the claims submission experience for all Medicaid providers!

Guidance for Retrospective Requests submitted to Telligen

The Mississippi Division of Medicaid (DOM) contracts with Telligen, as the Utilization Management/Quality Improvement Organization (UM/QIO) vendor, for fee-for-service Medicaid members. Prospective Reviews, also referred to as prior authorization or precertification, include the review of medical necessity for the performance of services or scheduled procedures ***before*** the service is rendered or ***before*** admission occurs. Concurrent Reviews are 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.

In certain circumstances, **Retrospective Review** may be allowed, which may include but is not limited to the following:

- Beneficiary receives retroactive eligibility - requests should be submitted as soon as possible but no later than 90 days of the system add date of the eligibility determination, in accordance with Administrative Code Part 200, Chapter 1, Rule 1.8.A.1.a.
- Advanced Imaging – limited to medically urgent procedures done before authorization could be obtained. Requests should be submitted as soon as possible but no later than five (5) calendar days after the date of service.
- Dental related requests – when additional services occur during a dental procedure that were not included in the initial authorization. Requests should be submitted as soon as possible but no later than five (5) calendar days after the date of service.
- Expanded Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Physician Office Visits for EPSDT-eligible members – limited to physician office visits that exceed the annual visit limit of 16. Requests should be submitted as soon as possible but no later

PROVIDER COMPLIANCE

Continued

than thirty (30) calendar days after the date of service. When a submitted claim denies that exceeds this 30-day timeframe, the provider will need to include a copy of the denied claim or denial posted to the remittance advice, when requesting the authorization.

- Managed Care Recoupments – If a claim payment was recouped by a managed care organization due to a change in payor (CCO to fee-for-service), the provider has ninety (90) days from the date of recoupment to request an authorization from the UM/QIO. Documentation (remittance advice) of the recoupment must be included with the request.
- Inpatient admissions:
  - ◊ Limited to emergent and urgent admissions and must be authorized on the next working day after admission, in accordance with Administrative Code Part 202, Chapter 1, Rule 1.3.A.1.a.
    - * **Retroactive requests** are used after the fact, typically when a service has already been provided or the patient has been discharged from inpatient care.
    - * **Concurrent reviews** are used while the patient is still receiving care, such as during an ongoing inpatient stay. If the patient has an approved authorization and the provider anticipates the need for extending the inpatient stay, a **continued stay request** should be submitted prior to the last approved day to get approval for the additional time.

Please refer to Telligen's website at https://msmedicaid.telligen.com/, or call Telligen directly at 1-855-625-7709 for assistance. To submit authorization requests, providers are encouraged to register for access to Telligen's provider portal, Qualitrac, by completing the Telligen Provider Portal Registration.

Submitting Authorization Requests to Telligen for Full-Benefit Dual Eligible Members

Authorization requests submitted to Telligen for full-benefit dual eligible members with Medicare should only occur when Medicare denied as non-covered service or when Medicare benefits have been exhausted. If Medicare denied the service for "Not Medically Necessary," the authorization will be denied by Telligen for the same reason. The Medicare EOMB must be included with the supporting clinical documentation at the time of request.

Attention Ambulatory Surgical Centers

The Division of Medicaid will no longer require Ambulatory Surgical Centers (ASCs) to obtain prior authorization for procedure code G0330. This change is effective for dates of service on and after December 1, 2024.

Attention EPSDT Providers

The Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Periodicity Schedule with Billing Period Limits chart has been updated and will be available on the Division of Medicaid's (DOM) public website at Early and Periodic Screening, Diagnosis, and Treatment - Mississippi Division of Medicaid . Providers who perform EPSDT screenings (well-child exams) must be an enrolled Mississippi Medicaid provider, sign the EPSDT provider agreement, and adhere to the American Academy of Pediatrics (AAP) Bright Futures Periodicity Schedule and Screening Recommendations.

The periodicity schedule is listed on the following pages and includes the age range for each required visit. Additional information regarding the EPSDT program can be found on DOM's public website at Administrative Code Part 223 EPSDT.

Continued

EPSDT Periodicity Schedule with Billing Period Limits			
EPSDT Screening Codes		**Age of Beneficiary (On Date of Service)**	**Billing Period Limits (Beneficiaries Age Range)**
New Patient	**Established Patient**		
99381-EP	99391-EP	0-1 months	Day of member's birth through day before member turns 2 months old. (2 visits allowed for this age range)
99381-EP	99391-EP	2 months	Day member turns 4 months old through day before member turns 6 months old
99381-EP	99391-EP	4 months	Day member turns 4 months old through day before member turns 6 months old
99381-EP	99391-EP	6 months	Day member turns 6 months old through day before member turns 9 months old
99381-EP	99391-EP	9 months	Day member turns 9 months old through day before member turns 12 months old
99382-EP	99392-EP	12 months	Day member turns 12 months old through day before member turns 15 months old
99382-EP	99392-EP	15 months	Day member turns 15 months old through day before member turns 18 months old
99382-EP	99392-EP	18 months	Day member turns 18 months old through day before member turns 24 months old
99382-EP	99392-EP	24 months	Day member turns 24 months old through day before member turns 30 months old
99382-EP	99392-EP	30 months	Day member turns 30 months old through day before member turns 36 months old
99382-EP	99392-EP	3 years	Day member turns 3 years old through day before member turns 4 years old
99382-EP	99392-EP	4 years	Day member turns 4 years old through day before member turns 5 years old
99383-EP	99393-EP	5 years	Day member turns 5 years old through day before member turns 6 years old
99383-EP	99393-EP	6 years	Day member turns 6 years old through day before member turn s7 years old
99383-EP	99393-EP	7 years	Day member turns 7 years old through day before member turns 8 years old
99383-EP	99393-EP	8 years	Day member turns 8 years old through day before member turns 9 years old

Continued

99383-EP	99393-EP	9 years	Day member turns 9 years old through day before member turns 10 years old
99383-EP	99393-EP	10 years	Day member turns 10 years old through day before member turns 11 years old
99383-EP	99393-EP	11 years	Day member turns 11 years old through day before member turns 12 years old
99384-EP	99394-EP	12 years	Day member turns 12 years old through day before member turns 13 years old
99384-EP	99394-EP	13 years	Day member turns 13 years old through day before member turns 14 years old
99384-EP	99394-EP	14 years	Day member turns 14 years old through day before member turns 15 years old
99384-EP	99394-EP	15 years	Day member turns 15 years old through day before member turns 16 years old
99384-EP	99394-EP	16 years	Day member turns 16 years old through day before member turns 17 years old
99384-EP	99394-EP	17 years	Day member turns 17 years old through day before member turns 18 years old

Updated 10/9/2024

PROVIDER COMPLIANCE

Letters Available in Provider Portal

Effective immediately, providers will be able to view copies of letters received by mail directly in the Provider Portal. Access to these letters will be determined by the status of the application and the age of the letter. Please refer to the following instructions for guidance on how to access letters within the Provider Portal. At this time, providers will continue to receive letters via mail, in addition to having the ability to view them online.

Accessing Letters for Enrolled Providers

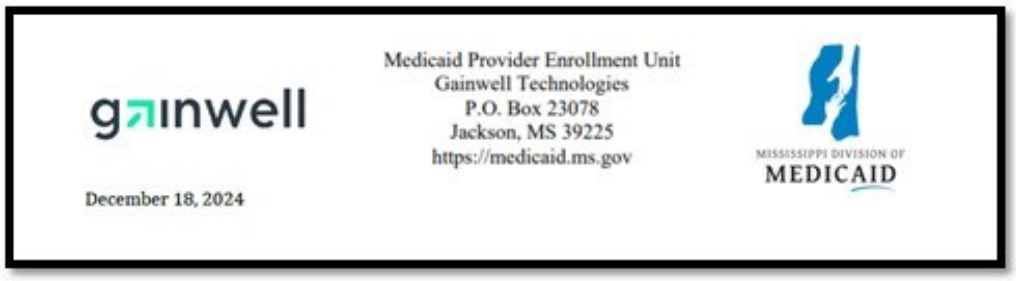
Once logged in, enrolled providers can access recent letters directly from the Provider Portal dashboard. Letters sent within the past 90 days will be available in a new section titled **View Letters**, located under the "Secure Correspondence" link on the right side of the page. A notification will appear below this link when new letters are available.

By clicking the "View Letters" link, providers can view letters generated in the last 90 days. Unviewed letters will be displayed in bold with a "New" status.

PROVIDER COMPLIANCE

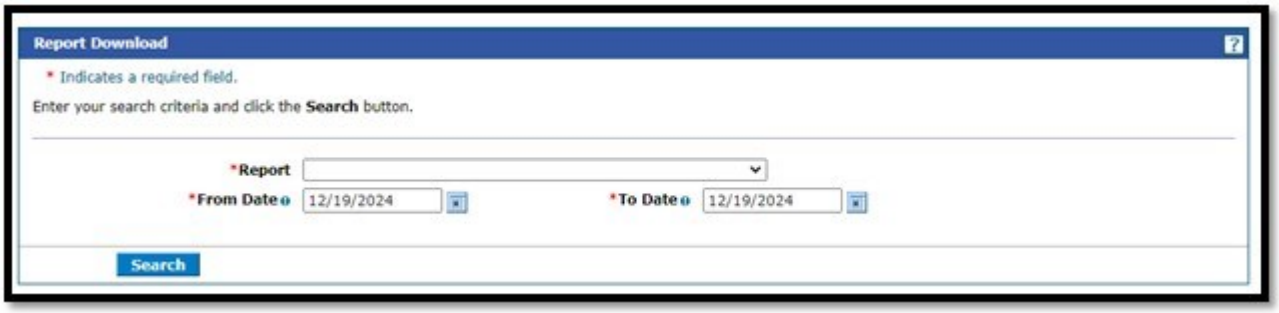
Continued

To view a letter, click Download. The letter will download and open in a PDF viewer.



After being viewed, the letter's status will change to "Viewed," and it will no longer appear in bold. These letters will remain accessible for 90 days.

Letters older than 90 days can be accessed via the Resources Tab through the Report Download functionality. Select the letter name from the Report dropdown menu and specify the desired date range.



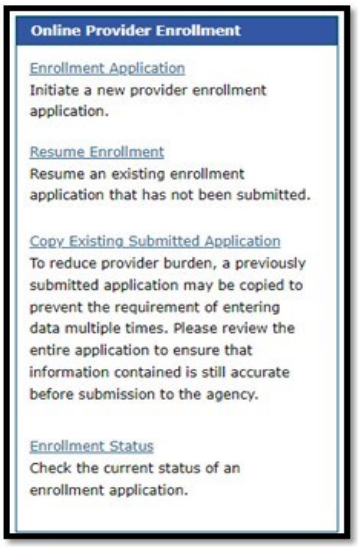
Note: This same functionality is available to Medicaid beneficiaries within the Medicaid Member Portal.

PROVIDER COMPLIANCE

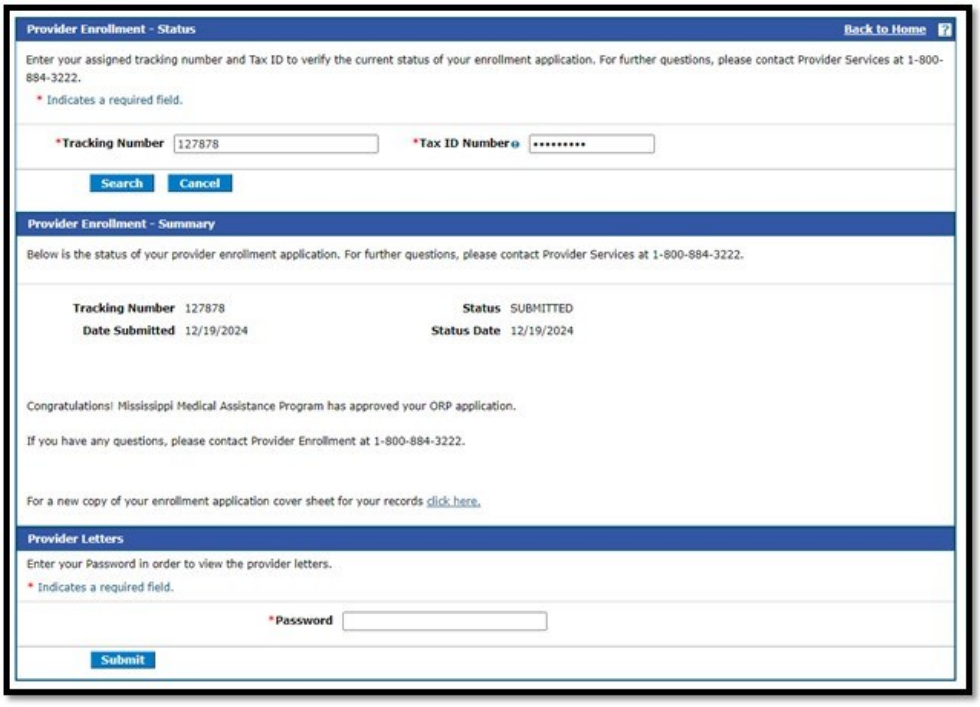
Continued

Accessing Letters for Applying Providers

Letters associated with enrollment applications can be accessed through the Enrollment Status search.



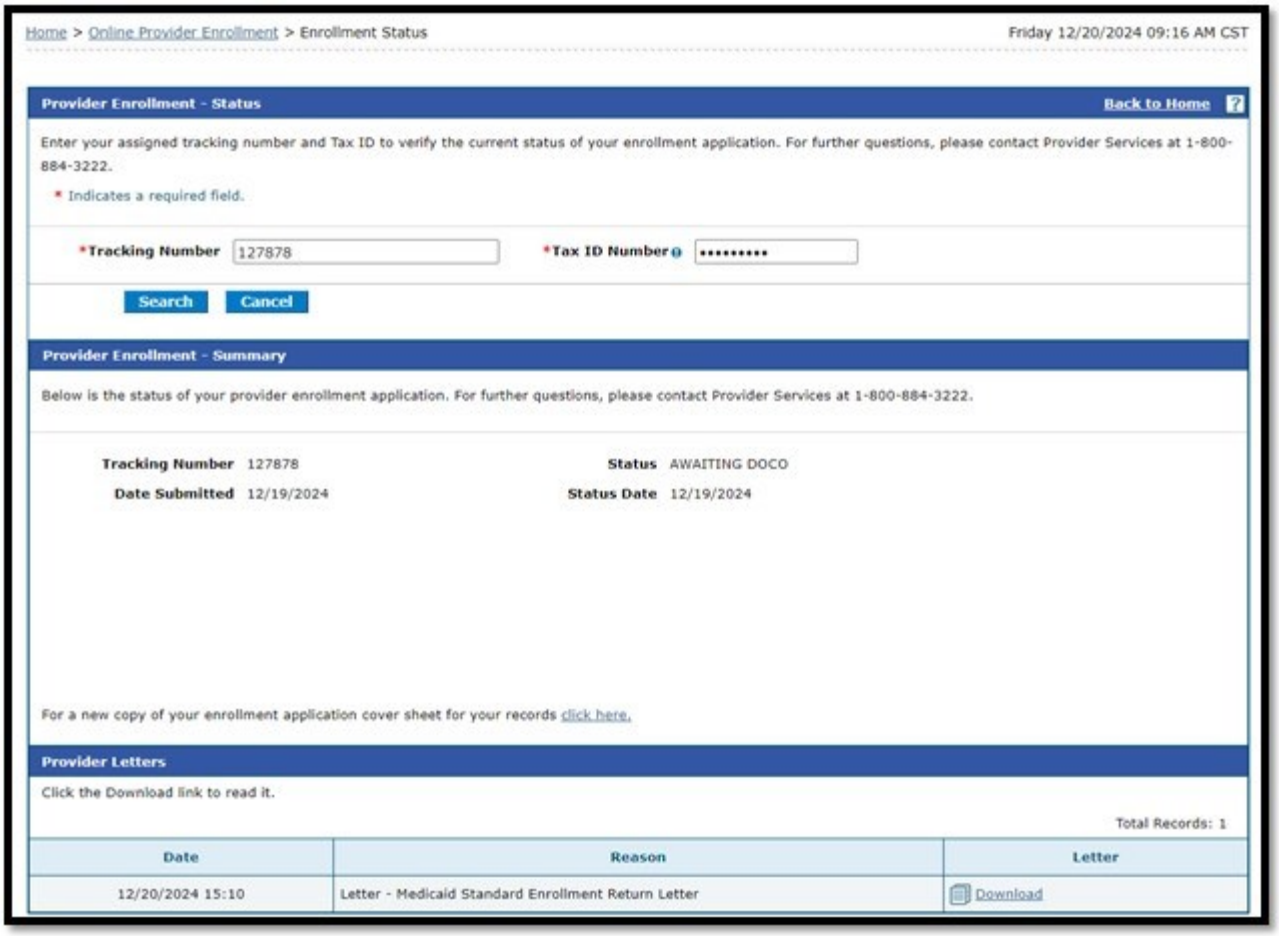
To view a letter related to a submitted application, enter the Tracking Number, Tax ID Number. Once the status is displayed, a new area titled Provider Letters will appear if the application has been submitted.



PROVIDER COMPLIANCE

Continued

Enter the Password for the application. All letters related to the application that have been mailed to the provider will be displayed.



For more information, call the Provider and Beneficiary Services Call Center at 1-800-884-3222 or your designated field representative: https://medicaid.ms.gov/wp-content/uploads/2024/03/Provider-Field-Representatives-1.pdf.

Provider Enrollment Application Fee Increased for 2025

The enrollment application fee for institutional providers for the 2025 calendar year has increased from $709 to $730. See the following announcement: https://www.federalregister.gov/documents/2024/12/02/2024-28127/medicare-medicaid-and-childrens-health-insurance-programs-provider-enrollment-application-fee-amount.

This application fee will be required in the following instances:

- Initial enrollment, reactivation, revalidation or reenrollment of providers in Medicaid and the Children's Health Insurance Program (CHIP)

PROVIDER COMPLIANCE

Continued

- Addition of New Owners – Change of Ownership
- Providers adding a new Medicaid practice location

Note: Simple changes to the provider enrollment information, that is, new phone numbers, new bank account information, new billing address, change in the name of the provider or other such updates are not subject to the fee.

Providers required to submit a fee are:

TAXONOMY	TAXONOMY DESCRIPTION
251E00000X	Home Health
251G00000X	Hospice Care, Community Based
261QA1903X	Clinic/Center – Ambulatory Surgical
261QE0700X	Clinic/Center – End-Stage Renal Disease (ESRD) Treatment
261QF0400X	Clinic/Center – Federally Qualified Health Center (FQHC)
261QM0801X	Clinic/Center – Mental Health (Including Community Mental Health Center)
261QR0400X	Clinic/Center – Rehabilitation
261QR0401X	Clinic/Center – Rehabilitation, Comprehensive Outpatient Rehabilitation Facility (CORF)
261QR1300X	Clinic/Center – Rural Health
273R00000X	Psychiatric Unit
273Y00000X	Rehabilitation Unit
282E00000X	Long Term Care Hospital
282N00000X	General Acute Care Hospital
282NC0060X	General Acute Care Hospital – Critical Access
282NC2000X	General Acute Care Hospital – Children

PROVIDER COMPLIANCE

Continued

TAXONOMY	TAXONOMY DESCRIPTION
282NR1301X	General Acute Care Hospital – Rural
282NW0100X	General Acute Care Hospital – Women
283Q00000X	Psychiatric Hospital
291U00000X	Clinical Medical Laboratory
292200000X	Dental Laboratory
293D00000X	Physiological Laboratory
314000000X	Skilled Nursing Facility
332B00000X	Durable Medical Equipment and Medical Supplies
332BC3200X	Durable Medical Equipment and Medical Supplies – Customized Equipment
332BP3500X	Durable Medical Equipment and Medical Supplies – Parenteral and Enteral Nutrition
332BX2000X	Durable Medical Equipment and Medical Supplies – Oxygen Equipment and Supplies
333600000X	Pharmacy
3336C0003X	Pharmacy – Community/Retail Pharmacy
3336H0001X	Pharmacy – Home Infusion Therapy Pharmacy
3336S0011X	Pharmacy – Specialty Pharmacy
335V00000X	Portable X-Ray Supplier
341600000X	Ambulance
3416L0300X	Ambulance – Land Transport

PROVIDER COMPLIANCE

Continued

Providers submitting their application fee should make their check out to the Mississippi Division of Medicaid, annotating on the check the Application Tracking Number (ATN) and mail to:

- Gainwell Technologies P.O. Box 6014 Ridgeland, MS 39158.

Providers who have already paid the application fee to Medicare or another state's CHIP or Medicaid program have fulfilled the requirement and do not have to pay the fee to Mississippi Medicaid.

For more information, call the Provider and Beneficiary Services Call Center at 1-800-884-3222 or your designated field representative: https://medicaid.ms.gov/wp-content/uploads/2024/03/Provider-Field-Representatives-1.pdf.

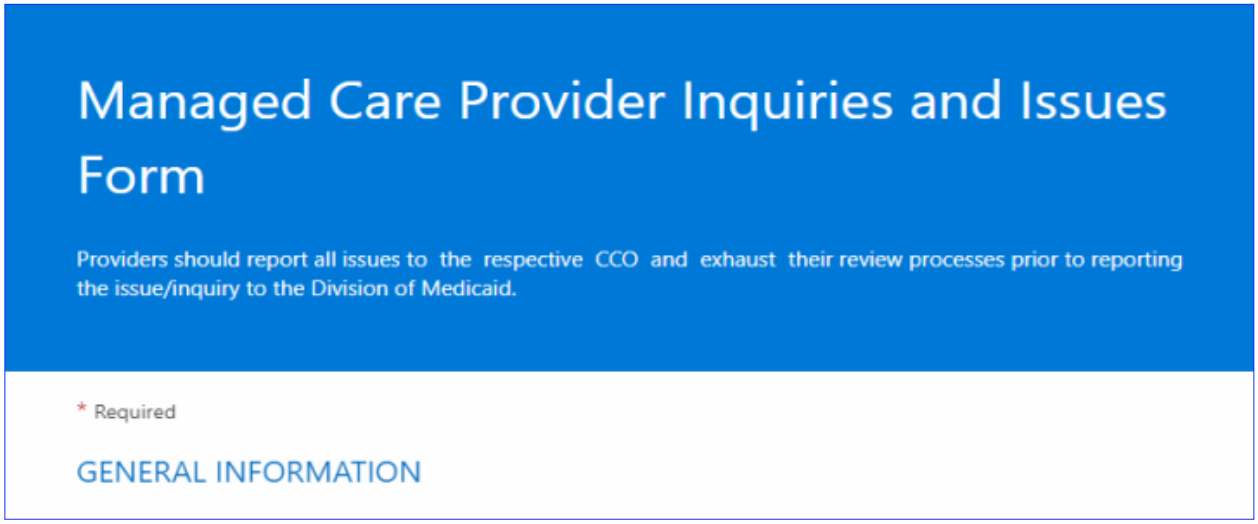
COORDINATED CARE NEWS

Managed Care Inquiries and Complaints

HELP US, HELP YOU

Please forward all provider issues and complaints related to Magnolia Health, UnitedHealthcare, and Molina Health Care:

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



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

COORDINATED CARE NEWS

MAGNOLIA

Magnolia MississippiCAN NEW Claim Denial for Provider Enrollment Issues

Effective January 1, 2025, Magnolia is implementing the following claim denial reasons. These denials will display on your EOP if you are currently participating with Magnolia but are not properly credentialed with Gainwell as a MississippiCAN provider. To remain a participating provider with Magnolia, your rendering NPI and billing NPI must be registered through Gainwell as a MississippiCAN provider and have selected Magnolia as a CCO.

Below are the denial reasons that will display on your EOP:

EX2I: DENY: In-Network RENDERING PROV NOT REGISTERED for MSCAN ON DOS - CONTACT GAINWELL

EX2m: DENY: In-Network BILLING PROV NOT REGISTERED for MSCAN on DOS - CONTACT GAINWELL

Please keep the following information in mind when enrolling through Gainwell:

- To become a participating provider with Magnolia, prior to contacting Magnolia Health for Contracting and/or enrollment, make sure the rendering provider as well as group are credentialed through Gainwell and have requested to be Magnolia providers.
- If your group has multiple 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 the taxonomy you utilized to enroll with Gainwell matches what is submitted on the request to Magnolia, as well as NPPES, and your claim image.
- Once you have made corrections through Gainwell, please resubmit the claims within 180 days of the date of service.

COORDINATED CARE NEWS

MAGNOLIA

Provider Enrollment/Claim Denial Issues

If the rendering provider and/or group is 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.

Below are the denial reasons that will display on your EOP:

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

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

Please keep the following information in mind when enrolling through Gainwell:

- To perform services on a Magnolia member, you must be an ***active*** Fee for Service or MississippiCan provider on the date of service.
- To become a participating provider with Magnolia, prior to contacting Magnolia Health for Contracting and/or enrollment, make sure the rendering provider as well as group are credentialed through Gainwell and have requested to be Magnolia providers.
- If your group has multiple 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 the taxonomy you utilized to enroll with Gainwell matches what is submitted on the request to Magnolia, as well as NPPES.
- Once you have made corrections through Gainwell, please resubmit the claims within 180 days of the date of service.

COORDINATED CARE NEWS

MAGNOLIA

Magnolia Health Transitions to Availity Essentials

Magnolia Health transitioned to using Availity Essentials as its new, secure provider portal! You can now validate eligibility and benefits, submit claims, check claim status, submit authorizations, and access Magnolia Health payer resources via Availity Essentials.

If you are already working in Essentials, you can log in to your existing Essentials account to enjoy these benefits for Magnolia Health.

- Use Availity Essentials to verify member eligibility and benefits, submit claims, check claim status, submit authorizations, and more.
- Look for additional functionality in Magnolia Health's payer space on Essentials and use the heart icon to add apps to My Favorites in the top navigation bar. Our current secure portal will still be available for other functions you may use today.
- Access Manage My Organization – to save provider information. You can then auto-populate that information repeatedly to eliminate repetitive data entry and reduce errors.

To register for a new account, select the link below and follow the registration process:
https://www.availity.com/essentials-portal-registration/

- Access the Help & Training tab at the top, for a list of available trainings.

Watch our provider newsletter for updates on trainings and additional functionality.

To sign up for the newsletter, select the link below:
https://www.magnoliahealthplan.com/providers/email-sign-up.html

COORDINATED CARE NEWS

MAGNOLIA

Risk Adjustment, Coding, and Documentation Education

Join us for discussions that include: an overview of risk adjustment and how it impacts you; tips to improve documentation and coding; and tips to stay compliant with regulatory requirements.

Webinars are open to providers, non-physician providers, coders, billers, and administrative staff.

Unpacking Healthcare Risk Adjustment	
February 4, 2025, at 10am EST	Register here!
February 20, 2025, at 12pm EST	Register here!
February 26, 2025, at 3pm EST	Register here!
Risk Adjustment 101: With Case Studies	
February 5, 2025, at 12pm EST	Register here!
February 18, 2025, at 10am EST	Register here!
February 27, 2025, at 3pm EST	Register here!
The Importance of Accurate Documentation and Coding: A Provider's Perspective	
February 6, 2025, at 3pm EST	Register here!
February 19, 2025, at 10am EST	Register here!
February 25, 2025, at 12pm EST	Register here!

Advance registration is required. Utilize the corresponding registration link provided for each topic to register (links are unique to each webinar). If you have questions or need assistance with registration, email us at: CDIWebinars@centene.com.

Watch for more CDI webinar notifications, throughout the year, in our provider newsletter!

TIP:
Ask your provider engagement representative about EMR connectivity to reduce administrative burdens including chart retrieval, HCC recapture and care gap closure.

COORDINATED CARE NEWS

MAGNOLIA

Partnering for Quality Care

HEDIS Hybrid Chart Chase to Begin in February

At Magnolia Health, we value everything you do to deliver quality care and ensure our members — your patients — have a positive healthcare experience. That's why each year, we are required to report on clinical quality measures to the Centers for Medicare & Medicaid Services (CMS). The quality measures are based on the Healthcare Effectiveness Data and Information Set (HEDIS®) specifications developed by the National Committee for Quality Assurance (NCQA) and other state-defined measures. In compliance with HEDIS, we request medical records regarding certain measures to collect information that typically cannot be found in a claim or an encounter.

Medical Record Collection Process

One or more vendors will contact your office to schedule medical record collection between **February 1 and April 28, 2025,** for member charts. They will contact you if we have identified you as the member's assigned or previous primary care provider (PCP), or, if you have submitted a claim or encounter that relates to a HEDIS measure that we are required to report to the state agency and CMS.

Due to the limited time frame to collect and abstract the medical records, we ask that your office accommodates this request for chart collection via fax, mail, or on-site sessions at the earliest mutually agreeable date, but ***no later than April 18, 2025***.

Improving Patient Outcomes- Primary Care Providers are Key

Start the new year off right by identifying your patient panel inside Magnolia's Secure Provider Portal!

This list includes newly assigned members as well. Early outreach is key to establishing a relationship and improving outcomes. Use the patient list to identify your patients in need of a well visit, find overdue screenings and identify chronic conditions in need of assessment.

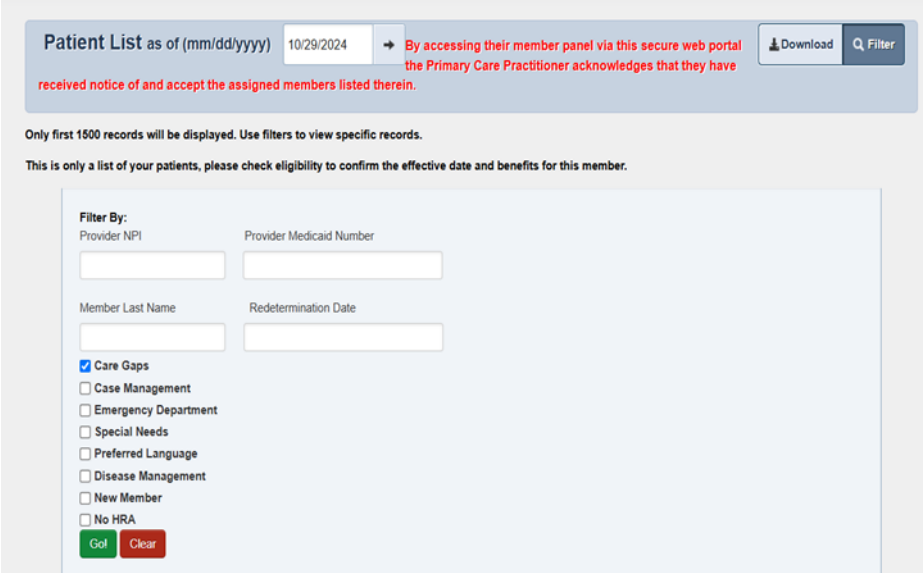
To view your patient list, log into Magnolia's Secure Provider Portal then select the Patients tab.

There are several filters, including "New Member" and "Care Gaps" to help you prioritize your outreach.

COORDINATED CARE NEWS

MAGNOLIA

Continued



For Provider Portal, HEDIS or Care Gap Training contact your local Provider Engagement Representative.

PRIMARY CARE PROVIDER ENGAGEMENT MAP

- **Kiri Parson** Kiri.L.Parson@centene.com
- **Jill Dean** - PR Supervisor amanda.dean@centene.com
- **Latoya Hemphill** latoya.hemphill@centene.com
- **Vanika Hogan** vanika.hogan@wellcare.com
- **Bethany Peters** bethany.peters@centene.com
- **Tarkan Weston** tarkan.weston@centene.com
- **Tiffany Sanders** tiffany.sanders@centene.com
- **Stacy McGrew** stacy.mcgrew@centene.com
- **Donna Ramirez** donna.ramirez@centene.com
- **Belinda Turner** belinda.turner@centene.com

COORDINATED CARE NEWS

MOLINA

Acute Inpatient Rehabilitation Prior Authorization

Here's a summary of the essential information and documentation required:

Supporting Documentation:

- **Diagnosis**: Include ICD-10 codes.
- **Medical History**: Provide detailed medical history and the most recent progress note. (all progress notes are not necessary)

  Include relevant lab results, imaging studies, and medications.
- **Treatment Plan**: Provide the rationale for the requested service and therapy evaluation. Indicate how often and length of time the patient will be treated by each therapist.
- **Acute Hospital Care Needs**: Indicate if current needs are met.
- **Patient Status**: Show that the patient can actively participate in and benefit from intensive rehabilitation. (current therapy progress notes with indicate this)
- **Admission Details**: Include the anticipated admission date and expected time for achieving goals.
- **Additional Documentation**: Any other documents supporting the need for the requested service.
- **Physician Assessments**: Indicate the frequency of in-person assessments while in the rehab facility.
- **Nursing Services**: Specify needed services like coordination of care, infusion therapy, pain management, wound management, and education.

Tips for a Smooth Process:

- Complete forms legibly.
- Include all required information and documentation.

COORDINATED CARE NEWS

MOLINA

Continued

- Use the electronic submission portal, Availity
- Respond promptly to additional information requests.

Providing complete and accurate information helps Molina Healthcare review requests promptly and deliver timely decisions for your patients. If you have any specific questions or need further assistance, please contact Molina Healthcare @ 844-826-4335.

COORDINATED CARE NEWS

UNITED HEALTHCARE

New follow-up after hospitalization for mental illness guidelines

Overview

Beginning Jan. 1, 2025, medical health care providers, in addition to behavioral health care providers can use qualified billing and diagnostic codes to close the follow-up after hospitalization for mental illness (FUH) HEDIS® gap.

How you can help

You can help close these gaps when you schedule an appointment within 7 days of discharge from an inpatient setting. We consider day 1 to be the day after discharge. If a situation arises when a patient is unable to be seen within 7 days, you can schedule an appointment within 30 days of discharge.

Submit qualified billing codes to help close HEDIS FUH gaps

Medical and mental health care providers can use the following codes to close FUH numerator gaps in care. However, these are not intended to be a directive of your billing practice.

Behavioral health outpatient visits with a mental health care provider OR with a diagnosis of mental health disorder	98960-98962, 99078, 99202-99205, 99211-99215, 99242-99245, 99341, 99342, 99344, 99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99483, 99492-99494 and 99510
Outpatient visit, in person or telehealth, with a mental health care provider OR with a diagnosis of mental health disorder, and with the appropriate service code (visit setting unspecified) billing codes	90791, 90792, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221-99223, 99231-99233, 99238, 99239 and 99252-99255
Psychiatric collaborative care management billing codes	99492, 99493, 99494; HCPCS: G0512

PCA-1-24-03277-UHN-FLYR_11222024

United Healthcare

COORDINATED CARE NEWS

UNITED HEALTHCARE

Continued

Transitional care management billing codes:	99495, 99496
Telephone visits billing codes[1]:	98966-98968, 99441-99443

You can find additional codes for this measure and other measures in the **PATH reference guide**. If you need to refer your patient to a network behavioral health care professional for further assessment and/or additional treatment, call the behavioral health number on the back of their member ID card.

Resources

- **Clinical Tools page**
- **Provider and Staff Toolkits**

Questions?

Connect with us through chat 24/7 in the **UnitedHealthcare Provider Portal**. For additional contact information, visit our **Contact us** page.

[1] These codes are for existing patients who initiate calls to provider.

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CALENDAR OF EVENTS

JANUARY 2025

THURS., JAN. 2	EDI Cut Off – 5 p.m.
MON., JAN. 6	Checkwrite
THURS., JAN. 9	EDI Cut Off – 5 p.m.
MON., JAN. 13	Checkwrite
THURS., JAN. 16	EDI Cut Off – 5 p.m.
MON., JAN. 20	Checkwrite
THURS., JAN. 23	EDI Cut Off – 5 p.m.
MON., JAN. 27	Checkwrite
THURS., JAN. 30	EDI Cut Off – 5 p.m.

FEBRUARY 2025

MON., FEB. 3	Checkwrite
THURS., FEB. 6	EDI Cut Off – 5:00 p.m.
MON., FEB. 10	Checkwrite
THURS., FEB. 13	EDI Cut Off – 5 p.m.
MON., FEB. 17	Checkwrite
THURS., FEB. 20	EDI Cut Off – 5 p.m.
MON., FEB. 24	Checkwrite
THURS., FEB. 27	EDI Cut Off – 5 p.m.

MARCH 2025

MON., MAR. 3	Checkwrite
THURS., MAR. 6	EDI Cut Off – 5 p.m.
MON., MAR. 10	Checkwrite
THURS., MAR. 13	EDI Cut Off – 5 p.m.
MON., MAR. 17	Checkwrite
THURS., MAR. 20	EDI Cut Off – 5 p.m.
MON., MAR. 24	Checkwrite
THURS., MAR. 27	EDI Cut Off – 5 p.m.
MON., MAR. 31	Checkwrite

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

UPCOMING DOM HOLIDAYS

MON, JAN 20	**MLK, Jr. Day**
MON, FEB 17	**President's Day**

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

Medicaid Provider Bulletins are located on the Web Portal at https://medicaid.ms.gov/providers/provider-resources/provider-bulletins/

CONTACT INFORMATION

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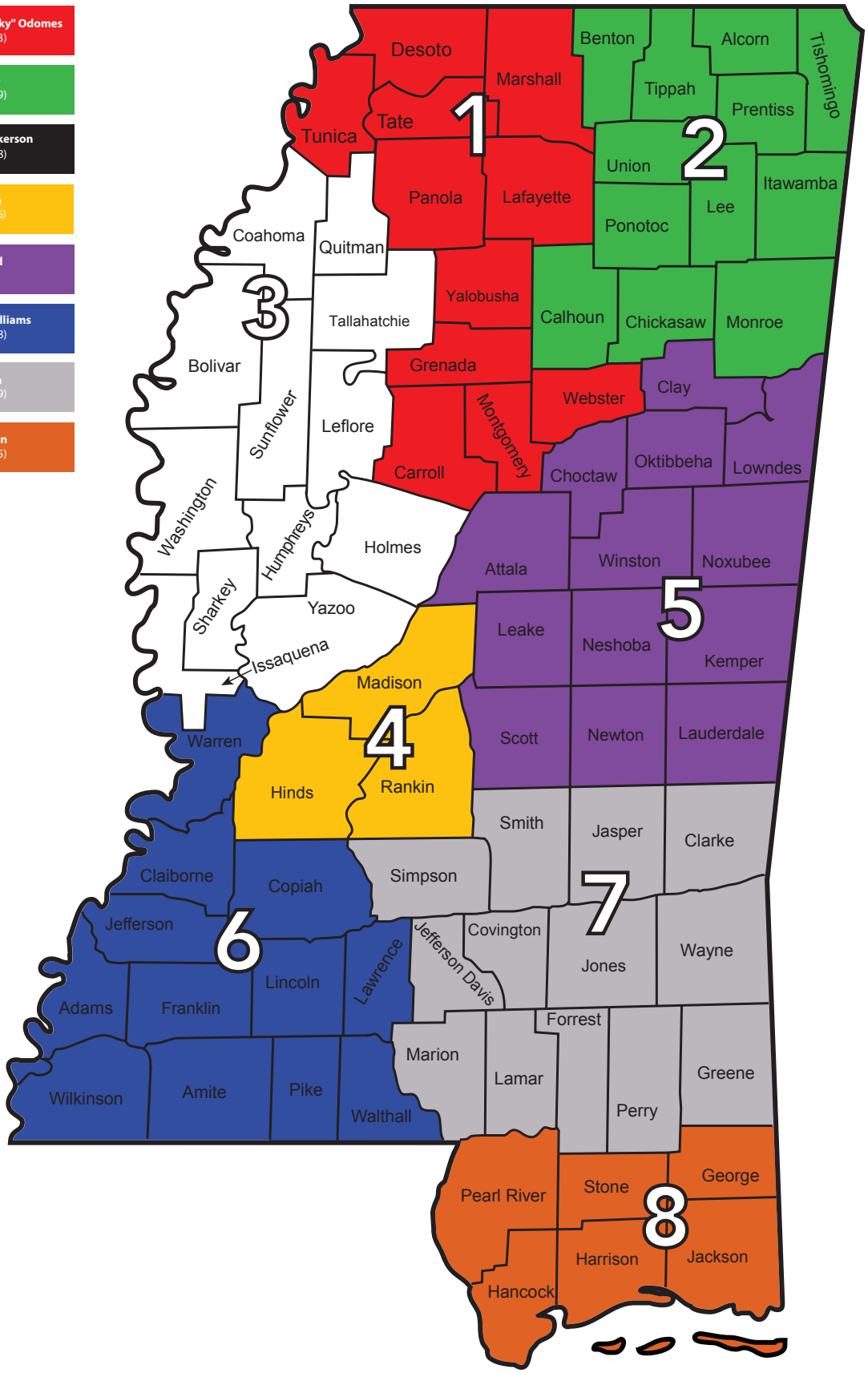
FIELD REPRESENTATIVE REGIONAL MAP

1	Claudia "Nicky" Odomes	(601.345.3953)
2	Latrece Pace	(601.345.3479)
3	Jasmine Wilkerson	(601.850.2768)
4	Justin Griffin	(601.874.4296)
5	Latasha Ford	(601.292.9352)
6	Tuwanda Williams	(601.345.1558)
7	Erica Guyton	(601.345.3619)
8	Earl Robinson	(601.647.2515)



PROVIDER FIELD REPRESENTATIVE AREAS BY COUNTY		
AREA 1 **Claudia (Nicky) Odomes** Claudia.Odomes@gainwelltechnologies.com 601-345-3953	**AREA 2** **Latrece Pace** Latrece.Pace@gainwelltechnologies.com 601-345-3479	**AREA 3** **Jasmine Wilkerson** Jasmine.Wilkerson@gainwelltechnologies.com 601-850-2768
County	**County**	**County**
Carroll	Alcorn	Bolivar
Desoto	Benton	Coahoma
Grenada	Calhoun	Holmes
Lafayette	Chickasaw	Humphreys
Marshall	Itawamba	Issaquena
Montgomery	Lee	Leflore
Panola	Monroe	Quitman
Tate	Pontotoc	Sharkey
Tunica	Prentiss	Sunflower
Webster	Tippah	Tallahatchie
Yalobusha	Tishomingo	Washington
	Union	Yazoo
AREA 4 **Justin Griffin** Justin.Griffin@gainwelltechnologies.com 601-874-4296	**AREA 5** Latasha Ford Latasha.Ford@gainwelltechnologies.com 601-292-9352	**AREA 6** **Tuwanda Williams** Tuwanda.Williams@gainwelltechnologies.com 601-345-1558
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Hinds	Attala	Adams
Madison	Choctaw	Amite
Rankin	Clay	Claiborne
	Kemper	Copiah
	Lauderdale	Franklin
	Leake	Jefferson
	Lowndes	Lawrence
	Neshoba	Lincoln
	Newton	Pike
	Noxubee	Walthall
	Oktibbeha	Warren
	Scott	Wilkinson
	Winston	
AREA 7 **Erica Guyton** Erica.Guyton@gainwelltechnologies.com 601-345-3619		**AREA 8** **Earl Robinson** earl.robinson@gainwelltechnologies.com 601-647-2515
County		**County**
Clarke		George
Covington		Hancock
Forrest		Harrison
Greene		Jackson
Jasper		Pearl River
Jefferson Davis		Stone
Jones		
Lamar		
Marion		
Perry		
Simpson		
Smith		
Wayne		
OUT OF STATE PROVIDERS	**Justin Griffin** **Justin.Griffin@gainwelltechnologies.com** **601-874-4296**	