2025 MSCAN Provider Manual

magnolia health

MagnoliaHealthplan.com

1-877-236-0751
Relay 711

The practices, policies, and benefits described herein may be modified or discontinued from time to time. Every attempt will be made to inform you of any changes as they occur. Sign-up for Magnolia's weekly email blast by visiting www.magnoliahealthplan.com, or call 1-877-236-0751, for the most up-to-date information.

WELCOME

Welcome to Magnolia Health (Magnolia). We thank you for being a part of Magnolia's network of participating providers, hospitals, and other healthcare professionals. Our number one priority is the promotion of healthy lifestyles through preventive healthcare. Magnolia works to accomplish this goal by partnering with the providers who oversee the healthcare of Magnolia members.

ABOUT US

Magnolia is a Coordinated Care Organization (CCO) contracted with the Mississippi Division of Medicaid (DOM) to serve Mississippi Medicaid beneficiaries through the Mississippi Coordinated Access Network (MississippiCAN) program. For more information about MississippiCAN, visit http://medicaid.ms.gov/programs/managed-care/. Magnolia has the expertise to work with members to improve their health status and quality of life. Magnolia's parent company, Centene Corporation, a Fortune 500 company, is a leading healthcare enterprise that is committed to helping people live healthier lives. The company takes a local approach — with local brands and local teams — to provide fully integrated, high-quality, cost-effective services to government-sponsored and commercial healthcare programs, focusing on underinsured and uninsured individuals. Centene offers affordable and high-quality products to nearly 1 in 15 individuals across the nation, including Medicaid and Medicare members (including Medicare Prescription Drug Plans) as well as individuals and families served by the Health Insurance Marketplace.

Centene uses its investor relations website to publish important information about the company, including information that may be deemed material to investors. Financial and other information about Centene is routinely posted and is accessible on Centene's investor relations website, http://investors.centene.com/.

Magnolia adheres to the DOM's stipulation that a provider cannot be required to agree to a non-exclusivity requirement, nor can the provider be required to participate in Magnolia's other lines of business, to participate in Magnolia's MississippiCAN network.

Magnolia is a provider-driven organization that is committed to building collaborative partnerships with providers. Magnolia serves our members consistently with our core philosophy that quality healthcare is best delivered locally.

Statement of Non-Discrimination

Magnolia Health complies with applicable Federal civil rights laws and does not discriminate based on race, color, national origin, age, disability, or sex (including pregnancy, sexual orientation, and gender identity). Magnolia Health does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex (including pregnancy, sexual orientation, and gender identity).

Magnolia Health:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to those whose primary language is not English, such as:
- Qualified Interpreters
- Information written in other languages

If you need these services, contact Magnolia Health Member Services at 1-866-912-6285, Relay 711.

If you believe that Magnolia Health has failed to provide these services or discriminated in another way based on race, color, national origin, age, disability, or sex (including pregnancy, sexual orientation, and gender identity), you can file a grievance with:

1557 Coordinator
PO Box 31384
Tampa, FL 33631
855-577-8234, Relay 711
Fax: 866-388-1769
SM_Section1557Coord@centene.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Provider Services team is available to help you at 1-877-236-0751. our 1557 Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue
SW, Room 509F, HHH Building, Washington, DC 20201
1-800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at http://www.hhs.gov/ocr/complaints/index.html.

This notice is available on **Magnolia Health's** website:
https://www.magnoliahealthplan.com/members/medicaid/resources/non-discrimination-notice.html

Other Translation Information

Spanish: Si usted, o alguien a quien está ayudando, tiene preguntas acerca de Magnolia Health, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-866-912-6285, Relay 711.

Vietnamese: Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Magnolia Health, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-866-912-6285, Relay 711.

Chinese: 如果您，或是您正在協助的對象，有關於Magnolia Health方面的問題，您有權利免費以您的母語得到幫助和訊息。如果要與一位翻譯員講話，請撥電話1-866-912-6285, Relay 711。

French: Si vous-même ou une personne que vous aidez avez des questions à propos d'Magnolia Health, vous avez le droit de bénéficier gratuitement d'aide et d'informations dans votre langue. Pour parler à un interprète, appelez le 1-866-912-6285, Relay 711.

Arabic: إذا كان لديك أو لدى شخص تساعده أسئلة حول Magnolia Health، لديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية تكلفة. للتحدث مع مترجم اتـ بـ 1-866-912-6285,Relay 711 .

Choctaw: Chim ayalhpísah ihokih Chishno kiyokmat kanah ish apíla kạ, Magnolia Health imma ná ponaklo hachim ạshah ihokmạ. Apíla hicha ńan annówa yạ chim annọpa anóli akọ hashísha hi̱nah kat. Ahíkachih kiyoh. Annọpa tishóli imanópolih chinnakma, holhtina yappạ i̱pạyah 1-866-912-6285, Relay 711.

Tagalog: Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Magnolia Health, may karapatan ka na makakuha nang tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-866-912-6285, Relay 711.

German: Falls Sie oder jemand, dem Sie helfen, Fragen zu Magnolia Health hat, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-866- 912-6285, Relay 711 an.

Korean: 만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Magnolia Health에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는1-866-912-6285, Relay 711 로 전화하십시오.

Gujarati: જે તમને અથવા તમે જેમની મદદ કર. ૨/ા હોય તેમને, Magnolia Health વવશે કોઈ 56 હોય તો તમને, કોઈ ખચ9 વવના તમાર. ભાષામાાં મદદ અને માહહતી 5ા=ત કરવાનો આંવકાર છે. દુભાવષયા સાથે વાત કરવા 1-866-912-6285, Relay 711 ઉપર કૉલ કરો.

Japanese: Magnolia Health について何かご質問がございましたらご連絡ください。 ご希望の言語によるサポートや情報を無料でご提供いたします。通訳が必要な場合は、1-866-912-6285, Relay 711 までお電話ください。

Russian: В случае возникновения у вас или у лица, которому вы помогаете, каких-либо вопросов о программе страхования Magnolia Health вы имеете право получить бесплатную помощь и информацию на своем родном языке. Чтобы поговорить с переводчиком, позвоните по телефону 1-866-912-6285, Relay 711.

Punjabi: ਜ"ਤਪਹਾਡ", ਜ(ਤਪਹਾਡੀ ਮਦਦ ਲ- ਰਹ"ਕਿਸ"ਵਿਅਕਤੀ 4 ਮਨ ਵਿਚ Magnolia Health 4 ਬਾਰ"ਕ8ਈ ਸਵਾਲ ਹਨ. ਤ(ਤਪਹਾ: ਆਪਣੀ ਭਾਸ਼ਾ ਵਿਚ ਮਪਫਤ ਮਦਦ ਲ-ਣ ਦਾ ਪAਰਾ ਹBਕ CI ਦਪਭਾਸ਼ੀਏ ਨਾਲ ਗBਲ ਕਰਨ ਲਈ 1-866-912-6285, Relay 711 'F ਕਾਲ ਕਰ8।

Italian: Se lei, o una persona che lei sta aiutando, avesse domande su Magnolia Health, ha diritto a usufruire gratuitamente di assistenza e informazioni nella sua lingua. Per parlare con un interprete, chiami l'1-866-912-6285, Relay 711.

Hindi: आप या जिसक* आप मदद कर रहे ह0 उनके, Magnolia Health के बारे म4 कोई सवाल ह9, तो आपको ;बना <कसी खच@ के अपनी भाषा म4 मदद और जानकारE FIGत करने का अHधकार है। <कसी दभ कर4।

MISSION

Magnolia strives to provide improved health status, successful outcomes, and member and provider satisfaction in a coordinated care environment. Magnolia strives to achieve the following goals:

- Ensure access to primary and preventive care services
- Ensure care is delivered in the best setting to achieve an optimal outcome
- Improve access to all necessary healthcare services
- Encourage quality, continuity, and appropriateness of medical care
- Provide medical coverage in a cost-effective manner

All of our programs, policies, and procedures are designed with these goals in mind. We hope that you will actively assist Magnolia in reaching these goals.

HOW TO USE THIS MANUAL

Magnolia is committed to working with our provider community and members to provide a high level of satisfaction in delivering quality healthcare benefits. This provider manual aims to deliver comprehensive information to providers regarding Magnolia's operations, benefits, and policies and procedures. Please contact the Provider Services Department at 1-877-236-0751 if you need further explanation of any of the topics discussed in this Provider Manual. The practices, policies, and benefits described herein may be modified or discontinued from time to time. Every attempt will be made to inform you of any changes as they occur. Please visit www.magnoliahealthplan.com and sign-up for our weekly email blast or or call 1-866-912-6285 for the most up-to-date information.

KEY CONTACTS

The following chart includes several important telephone and fax numbers that may be of use to you and your staff. When calling Magnolia, please have the following information available:

- National Provider Identifier (NPI) number
- Tax Identification Number (TIN)
- Member's Magnolia MSCAN ID number

www.magnoliahealthplan.com		Access Magnolia Health's website for the following information: contact us, provider directory, important notifications, provider newsletter, patient eligibility, claim submission and status, authorization submission and status
Provider Services	1-877-236-0751 Relay 711 Fax: 1-877-811-5980 **Hours of Operation:** Monday through Friday 7:30 a.m. to 5:30 p.m. CST	Can assist with the following and more, • Member eligibility status • Prior authorization and referral procedures • Claims payment procedures and handling of provider issues • Transfer of member medical records among medical providers • Member Panel List • Fraud and Abuse Hotline • Care Management Referrals
Member Services	1-866-912-6285 Relay 711 Fax: 1-877-779-5219 **Hours of Operation:** Monday through Friday 7:00 a.m. to 8:00 p.m. CST	Available to answer a wide range of member questions on topics including, but not limited to, eligibility, claims, authorizations, and available providers in their area
Authorization Request/ Discharge Planning/Care Management	1-877-236-0751 Fax: 1-855-684-6747	
Medical Inpatient Admissions	1-877-236-0751 Fax: 1-877-291-8059	
Behavioral Health Inpatient Admissions	1-877-236-0751 Email: Augmississippi@cenpatico.com Fax: 1-866-535-6974	
Medical Outpatient Services Authorization	1-877-236-0751 Fax: 1-877-650-6943	
Behavioral Health Outpatient Authorization	1-877-236-0751 Fax: 1-866-694-3649	
Gainwell Technologies (GWT) Prior Authorization	1-833-660-2402 Fax: 1-866-644-6147	GWT is Medicaid's Pharmacy Benefits Administrator (PBA), effective 7/1/2024; Contact GWT for assistance with pharmacy prior authorizations.
Gainwell Technologies Pharmacy (GWT) Help Desk	1-833-660-2402	Pharmacy claims and prior authorizations

Turning Point Healthcare Solutions Authorization Request	Web Portal Intake: https://myturning-point-healthcare.com Local Phone: 601-910-2052 Toll-Free Phone: 866-241-8731 Facsimile Intake: 601-863-8668	For musculoskeletal, orthopedic surgical, and spinal surgical procedure pre-authorization request submissions
Magnolia Behavioral Health	1-866-912-6285 Fax: 1-866-694-3649 www.magnoliahealthplan.com Hours of Operation: 24 hours/7 days a week	Assistance with pharmacy questions and services, available 24 hours a day/7 days a week
After-Hours Support & Nurse Advice Line (24/7 Availability)	1-877-236-0751	24-hour free health information phone line; nurse triage service provides access to a broad range of health-related services, including health education and crisis intervention
Vision	1-800-531-2818 centenevision.com/logon	Assistance with routine and medical vision services
High-Tech Radiology (National Imaging Associates)	1-800-642-7554 www.RadMD.com	Radiology Benefits Manager (CT/CTA/CCTA/MRI/MRA/PET Scan)
Dental	1-844-464-5636 centenedental.com/logon	Assistance with dental questions and services
Magnolia Health EDI Department	1-800-225-2573, ext. 25525 Email: EDIBA@centene.com	Assistance with electronic data submissions with Magnolia Health
PaySpan Health	1-877-331-7154 www.payspanhealth.com	Electronic EFT/ERA Register
Division of Medicaid (DOM)	1-866-635-1347 www.medicaid.ms.gov	

ELIGIBILITY

Product Eligibility Summary

To be eligible to enroll with Magnolia, a CCO for the DOM's MississippiCAN program, a person must be a beneficiary of Mississippi Medicaid. In addition, a beneficiary must be a resident of the state of Mississippi.

For purposes of this program, MississippiCAN beneficiaries include:

Mandatory Populations (Age):

Mandatory Populations	Age
Supplemental Security Income (SSI)	19-65
Working disabled	19-65
Breast and cervical cancer	19-65
Parents and Caretakers (TANF)	19-65
Pregnant women (below 194% FPL)	8-65
Newborns (below 194% FPL)	0-1
Transition children (beginning state fiscal year 2015)	0-19
Children (TANF)	0-19
Children (below age 6, below 143% FPL)	1-5
Children (below age 19, below 100% FPL)	6-19
Quasi-CHIP (previously qualified for CHIP, age 6-19, 100-133% FPL)	6-19
Children (age 0-19, below 209% FPL)	1-19

Optional Populations (Age):

Optional Populations	Age
Supplemental Security Income (SSI)	0-19
Disabled child living at home	0-19
Department of Human Services – foster care children IV-E	0-19
Department of Human Services – foster care children – CWS	0-19

Eligibility is determined by the Mississippi Medicaid Regional Office that serves your area. To locate your Mississippi Medicaid Regional Office, please visit www. medicaid.ms.gov/about/office-locations/. You may also call Medicaid's toll-free telephone number at 1-800-421-2408.

Who cannot be a part of MississippiCAN:

- Beneficiaries in any of these waiver programs:
  - Elderly and Disabled (E&D)
  - Independent Living (IL)
  - Traumatic Brain Injury/Spinal Cord Injury (TBI-SCI)
  - Assisted Living (A&L)
  - Intellectual Disabilities/Development Disabilities (IDDD)
- Beneficiaries who have both Medicare and Medicaid
- Beneficiaries who are in:
  - Nursing facilities
  - Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID)
  - Correctional facilities

Open Enrollment

There will be an annual open enrollment period for MississippiCAN members. Open enrollment occurs every year between October 1 – December 15. During this period, a member may choose another CCO health plan for any reason. If a member wants to change their health plan during open enrollment, they should contact MississippiCAN Enrollment at 1-800-884-3222. They can also visit the state website at www.medicaid.ms.gov.

Disenrollment

The DOM has mandated that members in specific categories of eligibility be enrolled with a CCO under the MississippiCAN program. If they are in one of these categories of eligibility, then they can change CCOs within ninety (90) days of enrollment, but they must be enrolled with a CCO.

A member may request to disenroll from Magnolia with or without cause if they are in an optional category. Once they are enrolled with Magnolia, they have ninety (90) days to stop their enrollment. After that, they will be a member of our plan for the next year or until the next open enrollment period. A member can change for any reason in the first ninety (90) days of their membership. They can call the DOM to stop their membership during this period.

Magnolia will let the DOM know, in writing, within three (3) calendar days if one of the following occurs:

- Member no longer resides in the state of Mississippi
- Member dies
- Member no longer qualifies for medical assistance under one of the Medicaid eligibility categories in the targeted population
- Member becomes eligible for Medicare coverage
- Member is diagnosed with hemophilia
- Member enrolled in a waiver program
- Member becomes a nursing home resident or a resident of an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID)

Magnolia shall not disenroll a member for the following reasons:

- Adverse change in a member's health status
- Utilization of medical services
- Diminished mental capacity
- Uncooperative or disruptive behavior resulting from his or her special needs

A member may request disenrollment from Magnolia if:

- Magnolia does not, because of moral or religious objections, cover the service the member seeks. Magnolia is required to provide for all Medicaid covered services.
- Not all related services are available within the network
- Member's PCP or another provider determines receiving the services separately would subject the member to unnecessary risk or poor quality of care
- Lack of access to services covered by Magnolia
- Lack of access to providers experienced in treating the member's healthcare needs

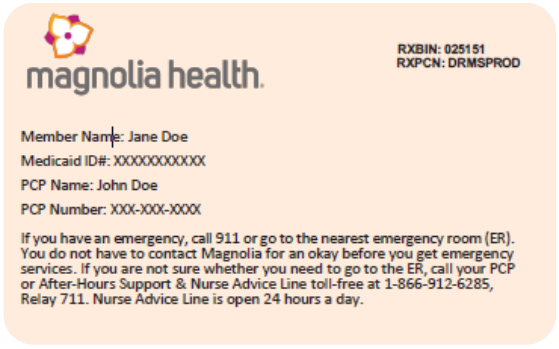
Member requests for disenrollment must be directed to the DOM either by phone or in writing. The DOM's address and phone number is:

Mississippi Division of Medicaid
550 High Street, Suite 1000
Jackson, MS 39201
Ph: 601-359-6050 or 1-800-421-2408
TTY/TTD Line: 711
Fax: 601-359-4185

MEMBER IDENTIFICATION (ID) CARD

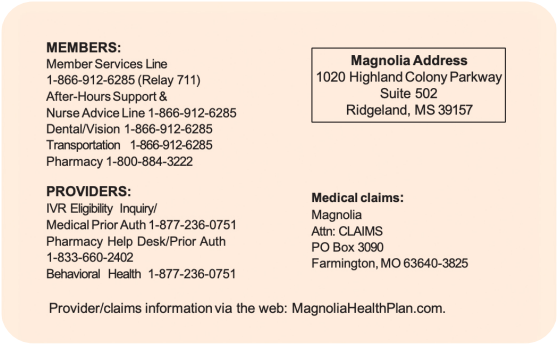
FRONT

Name
Medicaid ID number PCP name/number
Pharmacy vendor information



BACK

Important member & provider phone numbers
Medical claims address Website address



Each new Magnolia member shall receive a Magnolia member ID card. However, Magnolia member ID cards are not a guarantee of eligibility; providers must verify each member's eligibility on each date of service.
Members must present a member ID card each time services are rendered by a provider. If you are not familiar with the person seeking care as a member of our health plan, please ask to see photo ID. If you suspect fraud, please contact Provider Services immediately by calling 1-877-236-0751.

Providers must verify that each Magnolia member is eligible for service on the date the member presents for care. The suggested method of verification is the DOM's MESA provider portal . By using this online tool, providers can reduce claim denials for eligibility reasons and improve office efficiency by decreasing the amount of time spent on the phone verifying member eligibility.

MEMBER ELIGIBILITY VERIFICATION

To verify member eligibility, please use one of the following methods:

1. Log onto DOM's provider portal known as MESA: Medicaid Enterprise System Assistance to verify a member's eligibility with Magnolia Health MississippiCAN. We encourage providers to use this method first when attempting to verify eligibility.
2. Log on to our secure Provider Portal at www.magnoliahealthplan.com. Using this secure website, you can check member eligibility. You will have the ability to search by date of service, plus any one of the following: member name, date of birth, or Medicaid ID number. You can submit multiple member ID numbers in a single request.
3. Call our automated member eligibility Interactive Voice Response (IVR) system. Call 1-877-236-0751 from any touch-tone phone and follow the prompts to select the appropriate menu options to reach our automated member eligibility verification system, twenty-four (24) hours a day. The automated system will prompt you to enter the member ID number and the month of service, to check eligibility.
4. Call Magnolia Provider Services. If you cannot confirm a member's eligibility using the methods above, call our toll-free number at 1-877-236-0751. Follow the menu prompts to speak to a Provider Services representative to verify eligibility before rendering services. Provider Services will need the member name or member ID number to verify eligibility.

Through Magnolia's secure Provider Portal, primary care providers (PCPs) are able to access a list of eligible members who have either selected them or were assigned to them. The list also provides other important information, including date of birth and indicators for patients who are due for well-baby and well-child care assessments. To view this member list, log on to the Magnolia website at www.magnoliahealthplan.com. Since eligibility changes may occur throughout the month, and as the member list does not confirm eligibility for benefits or guarantee coverage, please use one of the above methods to verify member eligibility on the date of service.

MAGNOLIA WEBSITE

Utilizing Magnolia's website can significantly reduce the number of telephone calls providers need to make to the health plan. Magnolia's website is located at www.magnoliahealthplan.com. Providers can find the following information on the website:

- Member benefits
- Magnolia news
- Clinical guidelines
- Wellness information
- Provider manual and forms
- Provider Newsletter
- Find a provider
- Link to Magnolia's PDL
- Submit a contract request form/adding new TIN

SECURE WEBSITE

Magnolia's secure provider portal allows providers to check member eligibility and benefits, submit and check status of claims, request authorizations, and communicate directly with Magnolia staff. Here, we offer tools that make obtaining and sharing information easy. It's simple and secure. Please visit www. magnoliahealthplan.com to register. On the home page, select the login link on the top right to begin the registration process.

Through our secure site, you may:

- View the PCP panel (patient list)
- Update provider demographics
- View and submit claims and adjustments
- View and submit authorizations
- View payment history/remittance advice
- View member gaps in care
- Check member eligibility
- Make a referral to Care Management
- Contact us securely and confidentially
- View and submit reconsiderations

We are continually updating our website with the latest news and information, so we suggest saving www. magnoliahealthplan.com to your internet "favorites" list and checking it often. Please contact Provider Services to have a Provider Relations Representative reach out to you for a tutorial on how to navigate the secure site.

INTERACTIVE VOICE RESPONSE (IVR)

- What's great about the IVR system? It's free and easy to use by calling 1-877-236-0751; Relay 711. The IVR provides you with greater access to information. Through the IVR you can:
- Check member eligibility
- Check claims status
- Access the service twenty-four (24) hours a day, seven (7) days a week, three hundred sixty-five (365) days a year

MEMBER RIGHTS AND RESPONSIBILITIES

Magnolia members have the following rights:

- To receive information on available treatment options and alternatives, presented in a manner appropriate to the member's ability to understand
- To participate in decisions regarding his/her healthcare, including the right to refuse treatment
- To seek second opinions
- To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in the federal regulations on the use of restraints and seclusion
- To express a concern or appeal about Magnolia or the care it provides and receive a response in a reasonable period
- To be able to request and receive a copy of his/her medical records (one copy free of charge) and request that they be amended or corrected by calling Member Services at 1-866-912-6285
- To request and obtain information on any limits of your freedom of choice among network providers
- To receive healthcare services that are accessible, are comparable in amount, duration, and scope to those provided under Medicaid fee-for-service and are sufficient in amount, duration, and scope to reasonably be expected to achieve the purpose for which the services are furnished
- To receive services that are appropriate and are not denied or reduced solely because of diagnosis, type of illness, or medical condition
- To a candid discussion of appropriate or medically necessary treatment options for their condition, regardless of cost or benefit coverage
- To receive materials — including enrollment notices, informational materials, instructional materials, and available treatment options and alternatives — in a manner and format that may be easily understood
- To receive oral interpretation services free of charge for all non-English languages, not just those identified as prevalent
- To be notified that interpretation services are available and how to access those services
- To receive information about the structure and operation of Magnolia
- To receive information about physician incentive plans
- To be free to exercise these rights without retaliation
- To be treated with respect and with due consideration of dignity and the right to privacy and non-discrimination as required by law
- To privacy of healthcare needs and information as required by federal law (Standards for Privacy of Individually Identifiable Health Information)
- To be furnished healthcare services in accordance with 42 C.F.R. 438.206 through 438.210
- To receive information in a manner and format that may be easily understood in accordance with 42 C.F.R. 438.10
- To voice complaints/grievances or file appeals about Magnolia's decisions that affect the member's privacy, medical care provided, services received, and/or benefits
- To receive information about Magnolia, its benefits, its services, its network providers, and member rights and responsibilities.
- To receive information on the Grievance, Appeal, and Medicaid's State Fair Hearing procedures.
- To make recommendations regarding the organization's member rights and responsibilities

Magnolia members have the following responsibilities:

- To inform Magnolia of the loss or theft of a Magnolia member ID card
- To present the Magnolia member ID card when using healthcare services
- To be familiar with Magnolia procedures to the best of the member's abilities
- To call or contact Magnolia to obtain information and have questions clarified
- To provide participating network providers with accurate and complete medical information
- To follow the prescribed treatment of care recommended by the provider or let the provider know the reason(s) the treatment cannot be followed as soon as possible

- To understand their health problems and participate in developing mutually agreed-upon treatment goals to the degree possible
- To make every effort to keep any agreed-upon appointments, scheduled follow-up appointments, and accessing and scheduling appointments for preventive healthcare services
- To live healthy lifestyles and avoid behaviors known to be detrimental
- To provide accurate and complete information to all healthcare providers
- To show courtesy and respect to all healthcare providers and staff
- To become knowledgeable about Magnolia coverage provisions, rules, and restrictions
- To ask questions of providers to determine the potential risks, benefits, and costs of treatment alternatives, and then make care decisions after carefully weighing all pertinent factors
- To follow the grievance and complaint process established by Magnolia (and outlined in the member handbook) if there is a disagreement with a provider
- To report truthful and accurate information when applying for Medicaid. If inaccurate information is reported which results in enrollment being discontinued, the member will be responsible for repayment of capitation premium payments. Magnolia providers are informed of their rights and responsibilities through the Provider Manual after joining the network and annually

Magnolia providers have the following rights:

- To be treated by Magnolia members, and other healthcare workers, with dignity and respect
- To receive accurate and complete information and medical histories for members' care
- To have Magnolia members act in a way that supports the care given to other patients and that helps keep the provider's office, hospital, or other offices running smoothly
- To expect other network providers to act as partners in members' treatment plans
- To expect members to follow their directions, such as taking the right amount of medications at the right times
- To file a grievance with Magnolia on behalf of a member, with the member's consent

PROVIDER RESPONSIBILITIES

Providers have the following rights:

- To file Claim Appeals
- To file a grievance or complaint regarding dissatisfaction about any matter other than an adverse benefit determination
- To access information about Magnolia's QI programs, including program goals, processes, and outcomes that relate to member care and services, including information on safety issues
- To contact Magnolia's Provider Relations Department with any questions, comments, or problems, including suggestions for changes in the QI Program's goals, processes, and outcomes related to member care and services
- To allow members to request restriction on the use and disclosure of their personal health information
- To make a complaint or file an appeal against Magnolia and/or a Magnolia member
- To collaborate with other healthcare professionals who are involved in the care of members
- To review clinical practice guidelines distributed by Magnolia
- To invite member participation, to the extent possible, in understanding any medical or behavioral health problems that the member may have and to develop mutually agreed-upon treatment goals
- Not to be excluded, penalized, or terminated from network participation for accumulating a substantial number of Magnolia members with high-cost medical conditions
- To object to providing relevant or medically necessary services based on the provider's moral or religious beliefs or other similar grounds

Magnolia providers have the following responsibilities:

- To ensure awareness of, and compliance with, their personal and staff responsibilities, under federal and state law regarding advance directives (See Advance Directives section)
- To help or advocate for each member to make decisions within the provider's scope of practice about the member's relevant and/or medically necessary care and treatment, including the rights:
- To recommend new or experimental treatments
- To provide information regarding the nature of treatment options
- To provide information about the availability of alternative treatment options, therapies, consultations, and/or tests, including those that may be self-administered
- To be informed of the risks and consequences associated with each treatment option or choosing to forego treatment
- To treat members with fairness, dignity, and respect
- To not discriminate against members based on race, color, national origin, disability, age, religion, mental or physical disability, or limited English proficiency
- To maintain the confidentiality of members' personal health information, including medical records and histories, and adhere to state and federal laws and regulations regarding confidentiality
- To give members a notice that clearly explains their privacy rights and responsibilities as it relates to the provider's practice
- To provide members with an accounting of the use and disclosure of their personal health information in accordance with HIPAA
- To provide members, upon request, access to inspect and receive a copy of their personal health information, including medical records
- To provide clear and complete information to members, in a language they can understand, about their health condition and treatment, regardless of cost or benefit coverage, and allow members to participate in the decision-making process
- To tell a member if the proposed medical care or treatment is part of a research experiment, and give the member the right to refuse experimental treatment
- To allow a member who refuses or requests to stop treatment the right to do so, if the member understands that, by refusing or stopping treatment, the condition may worsen or be fatal
- To respect members' advance directives and include these documents in the members' medical records

- To allow members to appoint a parent, guardian, family member, or other representative if they cannot fully participate in their treatment decisions
- To allow members to obtain a second opinion, and answer members' questions about how to access healthcare services appropriately
- To obtain and report to Magnolia information regarding other insurance coverage
- To follow all state and federal laws and regulations related to patient care and patient rights
- To participate in Magnolia data collection initiatives, such as HEDIS and other contractual or regulatory programs
- To comply with Magnolia's Population Health and Clinical Operations program, as outlined in this Provider Manual
- To notify Magnolia in writing if the provider is leaving or closing a practice
- To contact Magnolia to verify member eligibility or coverage for services, if appropriate
- To disclose overpayments or improper payments to Magnolia
- To provide members, upon request, with information regarding office location, hours of operation, accessibility, and languages, including the ability to communicate with sign language
- To provide members, upon request, with information regarding the provider's professional qualifications, such as specialty, education, residency, and board certification status
- To disclose to Magnolia, on an annual basis, any physician incentive plan (PIP) or risk arrangements the provider or provider group may have with providers either within its group practice or other providers not associated with the group practice, even if there is no substantial financial risk between Magnolia and the provider or provider group
- To give Magnolia appropriate notice prior to voluntarily leaving the network at the end of the initial term or at the end of any renewal term, in accordance with the Term and Termination section of the provider agreement. Providers are advised to send termination notices via certified mail (return receipt requested), overnight courier, or some other traceable method, for the request to be considered valid. In addition, for each member, providers must supply copies of medical records to the member's new provider and must facilitate the member's transfer of care, at no charge to Magnolia or the member
- To continue to render covered services to members who are existing patients at the time of termination until the later of sixty (60) calendar days, the anniversary date of the member's coverage, or until Magnolia can arrange for appropriate healthcare for members with participating providers. Upon request from a member undergoing active treatment related to a chronic or acute medical condition, Magnolia will reimburse the provider for the provision of covered services for up to ninety (90) calendar days from the termination date. In addition, Magnolia will reimburse providers for the provision of covered services to members who are in the second or third trimester of pregnancy extending through the completion of postpartum care relating to the delivery. Exceptions may include members requiring only routine monitoring or providers unwilling to continue to treat the member or accept payment from Magnolia

PRIMARY CARE PROVIDER (PCP)

The PCP/PCMH is the cornerstone of Magnolia's service delivery model. The PCP/PCMH serves as the "medical home" for the member. The medical home concept assists in establishing a member-provider relationship, supports continuity of care, leads to elimination of redundant services, and ultimately leads to more cost- effective care and improved health outcomes.

PATIENT CENTERED MEDICAL HOME (PCMH)

The role of a Patient Centered Medical Home

The Patient-Centered Medical Home (PCMH) model is a health care model that provides comprehensive, coordinated and patient-centered primary care to patients of all ages. The PCMH emphasizes the partnership between a patient and his or her personal healthcare provider, and when appropriate, family members. PCMHs build better relationships between patients and their clinical care teams. Research shows that PCMHs improve quality, the patient experience and staff satisfaction, while reducing health care costs. Practices that earn recognition show that they have made a commitment to providing quality improvement within their practice and a patient-centered approach to care.

The hallmarks of the PCMH:
The hallmarks of the PCMH model include comprehensive, patient-centered and coordinated care, accessible services, quality and safety.

- **COMPREHENSIVE CARE**: The PCMH is accountable for meeting each patient's physical and mental care needs, including prevention and wellness, acute care, and chronic care. Providing comprehensive care requires a team of care providers. This team may include physicians, dentists, dental hygienists, advanced practice nurses, physician assistants, nurses, nutritionists, social workers, educators, and care coordinators.
- **PATIENT-CENTERED**: The PCMH provides primary health care that is relationship-based with an orientation toward the whole person. Partnering with patients and their families requires understanding and respecting each patient's unique needs, culture, values, and preferences. The PCMH actively supports patients in learning to manage and organize their own care at the level the patient chooses. Recognizing that patients and families are core members of the care team, medical home practices ensure that they are fully informed partners in establishing care plans.
- **COORDINATED CARE**: The PCMH coordinates care across all elements of the broader health care system, including specialty care, hospitals, home health care, and community services and supports. Such coordination is particularly critical during transitions between sites of care, such as when patients are being discharged from the hospital. Medical home practices also excel at building clear and open communication.
- **ACCESSIBLE SERVICES**: The PCMH delivers accessible services with shorter waiting times for urgent needs, enhanced in-person hours, around-the-clock telephone access to a member of the care team, and alternative methods of communication, such as telephone and electronic care.
- **QUALITY AND SAFETY**: The PCMH demonstrates a commitment to quality and quality improvement by ongoing engagement in activities such as using evidence-based medicine and clinical decision-support tools to guide shared decision making with patients and families, engaging in performance measurement and improvement, measuring and responding to patient experiences and patient satisfaction, and practicing population health management.

PROVIDER TYPES THAT MAY SERVE AS PCP/PCMH

Magnolia offers a robust network of PCPs to ensure that every member has access to a medical home within the DOM's required travel distance standards. These standards are fifteen (15) miles for urban areas and thirty (30) miles for rural areas. Providers who may serve as PCPs include any physicians or healthcare practitioners, operating within the scope of their licensure, who are responsible for supervising, prescribing, and providing primary care and primary care management services and whose practices are limited to the general practice of medicine. PCPs include internists, pediatricians, obstetricians, gynecologists, family practitioners, and general practitioners; certified nurse practitioners specializing in pediatrics, adult care, family medicine, or obstetrics/gynecology; certified nurse midwives; and physician assistants.

Providers at Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs) may also serve as PCP/PCMH Members with disabling conditions, chronic illnesses, or children with special healthcare needs may request that their PCP be a specialist. The designation of a specialist as a PCP must be pursuant to a treatment plan approved by Magnolia and must be made in consultation with the PCP to which the member is currently assigned, the member and, as appropriate, the specialist. When possible, the specialist must be a provider participating in Magnolia's provider network.

The specialist, as a PCP, must agree to provide or arrange for all primary care, including routine preventive care, and to provide those specialty medical services consistent with the member's disabling condition, chronic illness, or special healthcare needs, in accordance with Magnolia's standards and within the scope of the specialty training and clinical expertise. To accommodate the full spectrum of care, the specialist, as a PCP, must also have admitting privileges at a hospital in Magnolia's provider network.

PCP requirements:

- Approved EPSDT PCPs, as defined in DOM Administrative Code Title 23, who serve members under the age of twenty-one (21), are responsible for conducting all EPSDT screens for individuals on their Panel under the age of twenty-one (21). Should the PCP be unable to conduct the necessary EPSDT screens, the PCP is responsible for arranging to have

the necessary EPSDT screens conducted by another Magnolia network EPSDT provider and ensuring that all relevant medical information, including the results of the EPSDT screens, are incorporated into the member's PCP's medical record.

- PCPs who serve members under the age of twenty-one (21) are required to report claims data associated with EPSDT screens to Magnolia within one hundred eighty (180) calendar days from the date of service.
- PCPs are responsible for contacting new panel members who have not had an encounter during the first six (6) months of enrollment, as identified in the Secure Provider Portal.
- PCPs are responsible for contacting members who have missed appointments within twenty-four (24) hours to reschedule appointments. Providers must:
  - Make reasonable attempts to contact the patient: This could include a phone call or letter and should be documented.
  - Reschedule the appointment

Magnolia also requires the PCP to:

- Contact members identified in the Secure Provider Portal as not complying with EPSDT and immunization schedules for children.
- Identify to Magnolia any such members who have not come into compliance with EPSDT and immunization schedules within one (1) month of such notification from Magnolia.
- Document the reasons for noncompliance, where possible, and document its efforts to bring the care of these members into compliance with the standards.
- Be available for, or provide through another source, on-call coverage twenty-four (24) hours a day for management of member care.
- Educate members on how to maintain healthy lifestyles and prevent serious illnesses.
- Provide culturally competent care.
- Maintain confidentiality of medical information.
- Obtain prior authorizations for select outpatient services, as listed on the current prior authorization list, except for emergency services up to the point of stabilization.
- Provide screening, well care, and referrals to community health departments and other agencies, in accordance with DOM provider requirements and public health initiatives.
- Follow up with members who receive emergency care from other providers.
- Have appointments available for members, in accordance with the Appointment Availability Standards section of this manual.

Magnolia providers should refer to their contracts for complete information regarding providers' obligations and mode(s) of reimbursement.

ASSIGNMENT OF PCMH or MEDICAL HOME

As part of the application process for coverage under MississippiCAN, a member shall select a PCP/PCMH within thirty (30) calendar days of enrollment with Magnolia. For members who have not selected a PCP/PCMH within thirty (30) days of enrollment, Magnolia will use an auto-assignment algorithm to assign an initial PCP/PCMH. The algorithm assigns a member to a PCP/PCMH according to the following criteria, and in the sequence presented below:

1. Member history with a PCP/PCMH: The algorithm will first look for a previous relationship with a network PCP/PCMH.
2. Family history with a PCP/PCMH: If the member has no previous relationship with a PCP/PCMH, the algorithm will look for a PCP/PCMH to which someone in the member's family, such as a sibling, has been assigned.
3. Appropriate PCP/PCMH type: The algorithm will use age, gender, and other criteria to ensure an appropriate match, such as children assigned to pediatricians and pregnant females assigned to OB-GYNs.
4. Geographic proximity of a PCP/PCMH to the member's residence: The auto-assignment logic will ensure that a member travels no more than thirty (30) minutes or thirty (30) miles in rural regions and fifteen (15) minutes or fifteen (15) miles in urban regions.

Providers may contact Magnolia to request an assigned member be assigned to an alternate PCP/PCMH, using Magnolia's Primary Care Provider (PCP) Form, located at www.magnoliahealthplan.com, with the member or authorized representative's approval/signature.

If a provider terminates from the network, the member will be reassigned a new PCP/PCMH. The member will receive a letter stating the provider is no longer participating in Magnolia's network, and as a result, the provider will no longer be able to provide medical services to them. Magnolia will assign the member a new PCP/PCMH. To select a different PCP/PCMH, the member will contact Member Services at 1-866-912-6285.

SPECIALIST RESPONSIBILITIES

The PCP is required to coordinate the member's healthcare services and make referrals to specialty providers, when medically necessary care that is beyond the scope of the PCP is needed. The specialty provider may order diagnostic tests without PCP involvement by following Magnolia's referral guidelines and prior authorization requirements.
However, the specialist may not refer to other specialists or admit to the hospital without the approval of a PCP except in a true emergency. All non-emergency inpatient admissions require prior authorization.

The specialist provider must:

- Maintain contact with the PCP
- Obtain referral or authorization from the member's PCP and/or Magnolia's Population Health and Clinical Operations Department, formally Medical Management, as needed, before providing services
- Coordinate the member's care with the PCP
- Provide the PCP with consult reports and other appropriate records within five (5) business days
- Be available for, or provide, on-call coverage through another source twenty-four (24) hours a day for management of the member's care
- Maintain the confidentiality of medical information

HOSPITAL RESPONSIBILITIES

Magnolia has established a comprehensive network of hospitals to provide services to members. Hospital-based providers must be qualified to provide services under the program. All services must be provided in accordance with applicable state and federal laws and regulations and must adhere to the requirements set forth by Magnolia and any applicable accrediting agencies.

Hospitals must:

- Notify the PCP no later than the close of the next business day after the member's emergency room (ER) visit.
- Obtain authorizations for selected outpatient services listed on the current prior authorization list, except for emergency care and post-stabilization services.
- Notify the Population Health and Clinical Operations Department, formally Medical Management, of all ER admissions for the previous business day by sending a daily electronic file of all ER admissions. This file should include, for each member, the member's name and Magnolia member ID number, the presenting symptoms/diagnosis, the date(s) of service, and the member's phone number.
- Using the secure provider portal, notify the Population Health and Clinical Operations Department, formally known as Medical Management, of all normal (well-baby nursery) newborn deliveries within five (5) calendar days of delivery, via the DOM Newborn Enrollment Form. If complications develop, with either the mother and/or the baby, which may necessitate additional hospital days or sick baby or NICU admission, a prior authorization should be submitted, along with clinical information to support the stay, within one (1) business day of the decision that the higher level of care is needed.
- Follow the Inpatient Notification Process outlined below.

Magnolia providers should refer to their contracts for complete information regarding hospital obligations and reimbursement.

INPATIENT NOTIFICATION PROCESS

Inpatient facilities are required to notify Magnolia of emergent and urgent inpatient admissions within one (1) business day following the admission. Authorization requests are required to be submitted within two (2) business days.

Notification of normal (well-baby nursery) newborn delivery is required within five (5) calendar days of delivery via DOM's Newborn Enrollment Form, found on the DOM's provider web portal.

If complications develop, with either the mother and/or the baby, which may necessitate additional hospital days or non-well baby or NICU admission, a prior authorization should be submitted, along with clinical information to support the stay, within one (1) business day of the decision that the higher level of care is needed. This Newborn Enrollment Form includes, among other things, the following information necessary to receive claim reimbursement:

- Mother's name, Medicaid number, and admit date
- Newborn's name and date of birth (In the event that a name has not been selected at the time of discharge, please submit the newborn's gender [Baby Boy or Baby Girl] and last name [ex. Baby Boy Smith].)
- Facility name, physician name
- Delivery date, type of delivery, birth status (ex. healthy, sick, stillborn, expired)
- Gender, weight, Apgar score, gestational age of the newborn

Notification is required to track inpatient utilization, enable care coordination and discharge planning, and ensure timely claim payment. For questions regarding notification and, when applicable, to obtain prior authorization, please contact the Magnolia Population Health and Clinical Programs Department by phone at:

Magnolia Health Population Health and Clinical Programs
1-877-236-0751
Fax 1-877-291-8059
www.magnoliahealthplan.com

EMERGENCY SERVICES

Routine, Urgent, and Emergency Care Services Defined

Members are encouraged to contact their PCPs prior to seeking care, except in an emergency. The following are definitions for levels of service:

Routine - Services to treat a condition that would have no adverse effects if not treated within twenty- four (24) hours or that could be treated in a less acute setting (e.g., physician's office) or by the patient. Examples include treatment of a cold, flu, or mild sprain.

Urgent* - Services furnished to treat an injury, illness, or another type of condition, including a behavioral health condition, not usually considered life-threatening, which should be treated within twenty-four (24) hours.

Emergency* - Services furnished to evaluate and/or stabilize an emergency medical condition that is found to exist using the prudent layperson standard. An emergency medical condition is a medical or mental health condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, possessing an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Placing the physical or mental health of the individual (or, with respect to a pregnant woman, the health of the woman and/or her unborn child) in serious jeopardy
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part
- Serious harm to self or others due to an alcohol or drug abuse emergency, or injury to self or bodily harm to others
- With respect to a pregnant woman having contractions; (i) that there is not adequate time to effect a safe transfer to another hospital before delivery, or (ii) that transfer may pose a threat to the health or safety of the woman or unborn child

An emergency medical condition shall not be defined or limited based on a list of diagnoses or symptoms.

Post-Stabilization Services*: Covered services related to an emergency medical condition that are provided after a member is stabilized in order to maintain the stabilized condition or to improve or resolve the member's condition. Post-stabilization services will be considered complete when the following occurs:

- A participating physician with privileges at the treating hospital assumes responsibility for the member's care;
- A participating physician assumes responsibility for the member's care through transfer; or
- The member is discharged.

Stabilized: With respect to an emergency medical condition, that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility, or, with respect to a woman in labor, the woman has delivered (including the placenta).

Discharge: The point at which the member is formally released from hospital by the treating physician, an authorized member of the physician's staff, or by the member (after they have indicated, in writing, their decision to leave the hospital contrary to the advice of their treating physician).

*Urgent, emergency, and/or post-stabilization services do not require prior authorization or pre-certification. Emergency and post-stabilization services can be provided by a qualified provider, regardless of network participation. Magnolia is financially responsible for emergency and post- stabilization services, regardless of network participation. Once a member has been stabilized, if their hospital stay results in an inpatient admission, the facility must notify Magnolia on the next business day and submit a request for authorization within two (2) business days.

The PCP plays a major role in educating Magnolia members about appropriate and inappropriate use of hospital emergency rooms. The PCP is responsible for following up with members who receive emergency care from other providers.

The attending emergency room physician, or the provider treating the member, is responsible for determining when the member is sufficiently stabilized for transfer or discharge, and that determination is binding with Magnolia. However, Magnolia may plan with a hospital whereby Magnolia may send one of its own physicians, with appropriate emergency room privileges, to assume the attending physician's responsibilities to stabilize, treat, and transfer the member, provided that such arrangements do not delay the provision of emergency services.

Magnolia will not retroactively deny a physician claim for an emergency screening examination because the condition, which appeared to be an emergency medical condition under the prudent layperson standard, turned out to be non-emergent in nature. However, the prudent layperson test will be applied to the payment to the facility for charges that fall outside of the diagnosis code(s) identified as an emergency.

For a specific list of the required information to submit, see the Inpatient Notification section of this Provider Manual.

VOLUNTARILY LEAVING THE NETWORK

Providers must give Magnolia sixty-five (65) calendar days' notice before voluntarily leaving the network, for any reason or in accordance with the terms of the provider agreement. Please refer to your individual provider agreement, under "Term and Termination" for the applicable time frame for giving notice. Providers are advised to send termination notices via certified mail (return receipt requested), overnight courier, or some other traceable method, for the request to be considered valid. In addition, for each member, providers must supply copies of medical records to the member's new provider and must facilitate the member's transfer of care, at no charge to Magnolia or the member.

Magnolia will notify an affected member, in writing, of a provider's termination within fifteen (15) calendar days of notice or issuance of termination of a provider. If the terminating provider is a PCP, Magnolia will request that the member select a new PCP. If a member does not select a PCP prior to the provider's termination date, Magnolia will automatically assign a new PCP to the member.

Providers must continue to render covered services to any member who is an existing patient at the time of termination until the later of sixty (60) calendar days from the date of the letter sent by Magnolia notifying the member of termination

or for up to sixty (60) calendar days from the date of Provider termination or until Magnolia can arrange for appropriate healthcare for the member with a participating provider.

Upon request from a member undergoing active treatment related to a chronic or acute medical condition, Magnolia will reimburse the provider for the provision of covered services for up to ninety (90) calendar days from the termination date. In addition, Magnolia will reimburse the provider for the provision of covered services to a member who is in the second or third trimester of pregnancy extending through the completion of postpartum care relating to the delivery. Exceptions may include:

- A member requiring only routine monitoring
- A provider unwilling to continue to treat the member or accept payment from Magnolia

PROVIDER STANDARDS AND PROCEDURES

As specified by DOM, Magnolia providers will make PCP services available in accordance with the following standards:

- Urgent care- Not to exceed twenty-four (24) hours
- Routine sick patient care- Not to exceed seven (7) calendar days
- Well care- Not to exceed thirty (30) calendar days

Network providers must be accessible to members and maintain reasonable operating hours.
Magnolia's internal standards for pregnant women care are:

- Initial appointment for a pregnant member during the first trimester within three (3) weeks
- Initial prenatal care during the second trimester within seven (7) days
- Initial prenatal care during the third trimester within three (3) days

Appointment Availability Standards

Magnolia follows the accessibility requirements set forth by applicable regulatory and accrediting agencies. Magnolia monitors compliance with these standards on an annual basis.

Type	Appointment Scheduling Time Frames
PCPs (well care visit)	Not to exceed thirty (30) calendar days
PCP (routine sick visit)	Not to exceed seven (7) calendar days with an Urgent Care visit schedule (see below): otherwise, not to exceed twenty-four (24) hours
PCP (Urgent Care visit)	Not to exceed twenty-four (24) hours
Specialists	Not to exceed forty-five (45) calendar days
Dental Providers (routine visits)	Not to exceed forty-five (45) calendar days
Dental Providers (Urgent Care)	Not to exceed forty-eight (48) hours
Behavioral Health Providers (routine visit)	Not to exceed fourteen (14) calendar days
Behavioral Health Providers (urgent visit)	Not to exceed twenty-four (24) hours
Behavioral Health Providers (post-discharge from an acute psychiatric hospital when Contractor is aware of the Member's discharge)	Not to exceed seven (7) calendar days
Urgent Care Providers	Not to exceed twenty-four (24) hours
Emergency Providers	Immediately (twenty-four (24) hours a day, seven (7) days a week) and without Prior Authorization
Urgent Care Providers	Not to exceed twenty-four (24) hours
Emergency Providers	Immediately (twenty-four (24) hours a day, seven (7) days a week) and without Prior Authorization

After-Hours Availability

Magnolia's PCPs and specialty providers are required to maintain sufficient access to facilities and personnel to ensure that covered services are accessible to members twenty-four (24) hours a day, three hundred sixty-five (365) days a year. During after hours, a provider must have arrangements for one of the following mechanisms:

- Answering service or system that will page a physician
- Answering system with option to page a physician
- Advice nurse that will page a physician
- Answering service that will page a physician after message is left

The answering service must connect the caller to someone who can render a clinical decision or reach the PCP or specialist for a clinical decision. The PCP, specialty provider, or covering medical professional must return the call within thirty (30) minutes of the member's initial contact. Such after-hours coverage must be accessible using the medical office's daytime telephone number.

Telephone Arrangements

PCPs and Specialists must:

- Answer the member's telephone inquiries on a timely basis
- Schedule a series of appointments and follow-up appointments as needed by the member
- Identify and reschedule broken and no-show appointments
- Identify special member needs when scheduling appointments (e.g., wheelchair and interpretive linguistic needs, noncompliant individuals, or those people with cognitive impairments)

Adhere to the following response times for member-initiated telephone calls:

- After-hours telephone care for non-emergent, symptomatic issues within thirty (30) minutes
- Non-symptomatic concerns within the same day
- Crisis situations within fifteen (15) minutes
- Document all after-hours calls in a written format, such as an after-hours call log, and then transfer call-log records to the member's permanent medical record

***NOTE:** If after-hours urgent or emergent care is needed, the PCP or his/her designee should contact the urgent care center or ER in order to notify the facility. Providers are not required to notify Magnolia prior to a member receiving urgent or emergent care.*

Magnolia will monitor appointment and after-hours availability on a quarterly basis by conducting telephonic audits to assess compliance with Appointment Availability and After-Hours Standards. Providers who are non-compliant with appointment scheduling timeframes will receive a corrective action notice and be audited again within 60 calendar days. Audit results will be reviewed by Magnolia's Quality Improvement Program (QIP) and Provider Relations team for additional interventions.

Magnolia will remind the member of upcoming appointments when scheduled by the Care Management Department. If the member is obtaining transportation services through MTM and is not picked up, Magnolia will reach out to the member to follow up.

COVERING PROVIDERS

Providers are to schedule continuous availability and accessibility of professional, allied health, and supportive personnel to provide covered services within normal working hours. Protocols shall be in place to provide coverage in the event of a provider's absence. PCPs and specialty providers must arrange for coverage with another Magnolia network provider during scheduled or unscheduled time off. In the event of extended unscheduled time off, please notify the Health Plan of coverage arrangements.

The covering provider must have an active Mississippi Medicaid ID number, matching the active National Provider Identifier (NPI) number on file with DOM and Magnolia, to receive payment.

REFERRALS

PCPs/PCMHs will coordinate all member healthcare services. PCPs/PCMHs are encouraged to refer a member to another Magnolia network provider whenever necessary. In most circumstances, paper or electronic referrals are not required.

Magnolia encourages specialists to communicate with the member's PCP/PCMH when a referral to another specialist is necessary, rather than the specialist making the referral themselves without consulting the PCP/PCMH. This allows the PCP/PCMH to better coordinate their member's care and ensure that the referred specialty provider is a participating provider within the Magnolia network.

The provider is prohibited from making referrals for designated health services to healthcare entities with which the provider, or a member of the provider's family, has a financial relationship.
To verify whether an authorization is necessary, or to obtain a prior authorization, call:

Utilization Management/Prior Authorization Department Telephone: 1-877-236-0751
Inpatient Fax: 1-877-291-8059 Outpatient Fax: 1-877-650-6943
or https://www.magnoliahealthplan.com/providers/preauth-check.html

Magnolia has the capability to perform the ANSI X 12N 278 referral certification and authorization transaction through Centene. For more information on conducting this transaction electronically, contact:

Magnolia Health
c/o Centene EDI Department
1-800-225-2573, extension 25525
or by e-mail at: EDIBA@centene.com

The following services do not require PCP authorization or referral:

- Prescription drugs, including certain prescribed over-the-counter drugs
- Emergency services, including emergency ambulance transportation
- OB-GYN services with a participating provider
- Women's health services provided by a Federally Qualified Health Center (FQHC) or Certified Nurse Practitioner (CNP)
- Family planning services and supplies from a qualified DOM family planning provider
- Except for emergency and family planning services, the services listed above must be rendered by Magnolia's network providers

MEMBER PANEL CAPACITY

Magnolia cannot guarantee that any PCP will maintain a minimum number of members. However, all PCPs reserve the right to limit the number of members included in their panels. If a PCP does declare a specific capacity for their practice and wants to make a change to that capacity, the PCP can make a request through Magnolia's Online Demographic Update Tool at www.magnoliahealth.com.

A PCP shall not refuse to treat members if the provider has not reached their maximum panel size.
Providers shall notify Magnolia in writing at least forty-five (45) calendar days in advance of their inability to accept additional MississippiCAN members or to request member be reassigned to an alternate PCP/PCMH as per their agreement with Magnolia. In no event shall any established patient who becomes a covered person be considered a new patient.

A PCP/PCMH can request a member to be released or reassigned to an alternate PCP/PCMH, in the following circumstances:

- Request for non-medically necessary services
- Abusive or disruptive behavior
- Failure to comply with medical advice
- Missed appointments/now show
- No longer appropriate age for practice

Requests for moves due to member no shows and/or member abuse must be accompanied by supporting evidence from the requesting provider such as outreach attempts for member no shows or a summation of the member abuse for evaluation of these move requests.

Request to release or reassign members from a PCP/PCMC's panel, will be rejected if the request is in relation to the following:

- A change in the member's health status or need for medical treatment
- A member's diminished mental capacity or disruptive behavior that results from the member's special health care needs unless the behavior impairs the ability of the PCP/PCHM to furnish services to the member or others
- Transfer request should not be based on race, color, national origin, handicap, age, or gender.

ADVANCE DIRECTIVES

Magnolia is committed to ensuring that each member is aware of and able to execute advance directives. Magnolia is equally committed to ensuring that its providers and staff are aware of and comply with their responsibilities under federal and state laws regarding advance directives.

Providers delivering care to Magnolia members must ensure that members eighteen (18) years of age and older are informed of their right to execute advance directives. Providers must document such information in each member's permanent medical record.

Magnolia recommends the following regarding advance directives:

- The member's first point of contact in the provider's office should ask if the member has executed an advance directive, and the member's response should be documented in the medical record.

- If the member has executed an advance directive, the first point of contact should ask the member to bring a copy of the advance directive to the provider's office and document this request in the member's medical record.
- Once an advance directive is received, it should be included as a part of the member's medical record and should include mental health directives.

If an advance directive exists, the provider should discuss potential medical emergencies with the member and/or designated family member/significant other (if named in the advance directive and if available) and with the referring provider, if applicable. Any such discussion should be documented in the medical record.

CULTURAL COMPETENCY

Cultural Competency

At Magnolia, cultural competency is defined as the willingness and ability to value the importance of culture in the delivery of services to all segments of the population. Cultural competency is developmental, community-focused, and family-oriented. It is the appreciation of differences and the integration of cultural attitudes, beliefs, and practices into diagnostic and treatment methods and throughout the healthcare system to support the delivery of culturally relevant and competent care to all racial and ethnic groups. It is also the development and continued promotion of skills among providers and staff to ensure that services are delivered in a culturally competent manner.

Magnolia is committed to developing, strengthening, and sustaining provider/member relationships. Members may be unable or unwilling to communicate their healthcare needs in a culturally insensitive environment, reducing the effectiveness of the entire healthcare process. Members are entitled to dignified, appropriate, and quality care. When healthcare services are delivered without regard for cultural differences, members are at risk for sub-optimal care.

Magnolia will evaluate the cultural competency of its providers and offer access to training and tools to assist providers in developing culturally competent and culturally proficient practices.

Providers must ensure that:

- The member understands that they have access to medical interpreters, signers, and TDD/TTY services to facilitate communication without cost to them.
- Medical care is provided with consideration of the member's race/ethnicity and language and its influences on the member's health or illness.
- Office staff that routinely interact with members have access to, and are encouraged to participate in, cultural competency training and development.
- Office staff responsible for data collection are to make reasonable attempts to collect race and language-specific member information. Staff will also explain race/ethnicity categories to a member so that the member is able to identify their race/ethnicity (and that of their child, if necessary).
- Treatment plans are developed and clinical guidelines are followed with consideration of the member's race, country of origin, native language, social class, religion, mental or physical abilities, heritage, acculturation, age, gender, sexual orientation, and other characteristics that may result in a different perspective or decision-making process.
- Office sites have posted and printed materials in English, and if required by DOM, any other non- English language.

For additional information regarding resources and training, visit:

- On the Office of Minority Health's website, you will find "A Physician's Practical Guide to Culturally Competent Care." By taking this course online, you can earn up to nine CME credits, or nine contact hours for free. The course may be found at: https://cccm.thinkculturalhealth.hhs.gov/
- Think Cultural Health's website includes classes, guides and tools to assist you in providing culturally competent care. The website is: https://cccm.thinkculturalhealth.hhs.gov/
- The Health Care Literacy website offers a toolkit as a way for primary care practices to assess their services for health literacy considerations, raise awareness of their entire staff, and work on specific areas. The toolkit can be found at https://www.ahrq.gov/health-literacy/index.html

BENEFIT EXPLANATION AND LIMITATIONS

MAGNOLIA HEALTH BENEFITS

Magnolia providers supply a variety of medical benefits and services. For specific information not covered in this Provider Manual, please contact Provider Services at 1-877-236-0751, from 7:30 a.m. to 5:30 p.m. CST, Monday through Friday (excluding holidays). A Provider Services Representative will assist you in understanding health plan benefits.

The following benefits are covered under Magnolia Health:

Covered Services	Comments and Limitations
Ambulatory Surgery Center	
Behavioral health services	A comprehensive range of services are covered, including substance use disorder treatment, MYPAC services, and PRTF
Emergency ambulance	Prior authorization required when using a Fixed Wing Airplane only
Chiropractic services	$700 per benefit year
Dialysis	Home and free-standing dialysis center services
Dental Anesthesia	Covered in an office setting, outpatient, and inpatient setting. Prior authorization required.
Dental services under 21 years of age	$2,500 per state fiscal year (July 1 – June 30) provided through Centene Dental; $620 per lifetime for orthodontia under age 21 through Centene Dental. Members strongly encouraged to see your dental provider yearly. All medically necessary services are covered for EPSDT-eligible members with prior authorization.
Dental services over 21 years of age	Emergent and pain relief only; $2,500 per year provided through Envolve Dental
Durable Medical Equipment (DME)	Covered in the member's place of residence and may require prior authorization. All medically necessary DME and medical supplies are covered for EPSDT-eligible members with prior authorization.
ER services	ER visits do not require prior authorization and have no benefit limit.
Enteral and Parenteral Nutrition for home use	Available through pharmacy and medical benefit
EPSDT	Limited to children under 21 years of age
Expanded EPSDT services	Prior authorization required for services not covered, or any service that exceeds service limits. Limited to children under 21 years of age
Eyeglasses	Members 21 & over: One routine eye exam every state fiscal year (July 1 –June 30) provided through Centene Vision Members under 21: Two routine eye exams every state fiscal year (July 1 – June 30) provided through Centene Vision EPSDT-eligible members are eligible for more services if determined to be medically necessary.
Family planning	Over-the-counter contraceptives are not covered
Covid-19, Flu and Pneumonia vaccines	Available through pharmacy and medical benefit. Limited to one flu shot per 12 months.
Services from Federally Qualified Health Centers (FQHC) & Rural Health Clinics (RHC)	
Genetic testing	May require prior authorization. Check with Magnolia prior to genetic testing.
Hearing services	
Home healthcare services	Limited to 36 visits per benefit year
Hospice care	Requires prior authorization
Hysterectomy	Must include Sterilization Consent Form with claim
Inpatient hospital services	Inpatient hospital care needed for the treatment of an illness or injury that can only be provided safely and adequately in a hospital setting, including those basic services a hospital is expected to provide

Covered Services	Comments and Limitations
Laboratory services	Basic laboratory services do not require prior authorization
Neuro-Psychiatric services	May require prior authorization
Non-emergency transportation	1-877-236-0751
Nuclear Cardiology	Including, but not limited to, Thallium stress test or nuclear stress test
Oral Surgeon	Covered for inpatient and outpatient setting. Prior authorization is required.
Orthotics and Prosthetics	May require prior authorization
Out-of-network physician/facility/services	Not allowed, except for ER or Emergency Services, including but not limited to dialysis and dialysis access services.
Observation	No authorization required
Outpatient Therapy (occupational therapy, physical thera-py, and speech therapy)	Therapy in the home setting is only a covered benefit for EPSDT-eligible members
Pain management services	Includes office visits, consultations, services, treatments, and procedures
Physician Assistant & Nurse Practitioner office visits	No Limit
Physician office services	No Limit
Plastic Surgeon	Services that are for cosmetic purposes only are not a covered benefit
Podiatrist services	May require prior authorization
Prescription drugs	Effective 7/1/2024, all prescription claims will be processed by GWT.
Limit of 6 per month. EPSDT-eligible members are eligible for more prescriptions if deter-mined to be medically necessary. Diabetic supplies do not count toward benefit limit.	Services for children and adults include, but are not limited to: preventive health assessment visits, well-child care up to age 21, dental exams for ages up to 21 (members should be referred to a plan participating dental provider at the eruption of the first tooth, but no later than 12 months of age), immunizations, screenings (i.e. lead screenings, pap smears, mammograms, dilated eye exams for diabetics, kidney function tests, other lab work for diabetics, total serum cholesterol, etc.), flu shots, and many other preventive health services
Preventive care	Services for children and adults include, but are not limited to: preventive health as-sessment visits, well-child care up to age 21, dental exams for ages up to 21 (members should be referred to a plan participating dental provider at the erup-tion of the first tooth, but no later than 12 months of age), immunizations, screen-ings (i.e. lead screenings, pap smears, mammograms, dilated eye exams for dia-betics, kidney function tests, other lab work for diabetics, total serum cholesterol, etc.), flu shots, and many other preventive health services
Radiology services	Basic radiology services do not require prior authorization
Sleep study	Outpatient only
Specialty injection/infusion	Prior authorization is required
(Infusion in home setting applies to home health benefit limits)	Biopharmaceutical drugs may require a prior authorization when done in the home setting
Stereotactic Radiosurgery	Prior authorization is required
Sterilization procedures	No prior authorization required except for hysterectomy; Sterilization Consent Form must be submitted with claim
Substance use disorder treatment	Treatment is covered as part of a written plan. It includes inpatient and outpa-tient care. Benefit also includes SBIRT.
Surgery-elective-potentially cosmetic	Including, but not limited to, breast reduction surgery and varicose vein treat-ments
Swing bed services	Covered and authorized by the DOM
Transplants	Magnolia requires prior authorization for all transplants, except cornea

Value-Added Benefits Provided by Magnolia Include:

- Unlimited office visits
- Adults get one (1) pair of glasses per year and one (1) eye exam per year; children get two (2) eye exams per year and two (2) pairs of glasses every year (children under 21 are eligible for more services if determined to be medically necessary)
- The My Health Pays® rewards program provides rewards on a My Health Pays card each time you receive select screenings and preventive care
- 24-hour Nurse Advice Line
- Start Smart for Your Health programs help members with chronic illnesses, complex conditions, disabilities, weight loss, and more, manage and improve their health
- Start Smart for Your Baby® is a program for expecting and new mothers
- Connections Plus cell phone for high-risk members in Care Management
- Weight Watchers program for certain members in Care Management
- Magnolia Health offers Medicaid-eligible pregnant women age 21 and over supplemental dental benefits up to 12 months postpartum, including cleanings, restorations, and limited periodontal services. Medicaid-eligible pregnant women under age 21 receive complete EPSDT Medicaid dental coverage up to 12 months postpartum.
- Magnolia Health also offers a value-added dental benefit to help members with special healthcare needs feel comfortable in the dental office setting. The benefit should be billed with D9430—office visit for observation. It is promoted to members as a “practice visit,” where members go to the office to simulate a dental exam. The benefit may be utilized four times per member, per lifetime. D9430 may not be billed on the same date of service as an exam, cleaning, or any other procedure.

POPULATION HEALTH AND CLINICAL OPERATIONS

Non-Covered Services

Non-Covered Services	Comments and Limitations
Reversal of voluntary sterilization	
Infertility services	Non-coverage includes any services, supplies, or drugs related to the diagnosis or treatment of infertility
Pregnancy surrogate	Non-coverage includes any services or fees related to using a surrogate to achieve pregnancy
Birth control supplies without a prescription	Non-coverage includes birth control devices, agents, or preparations that by law do not require a prescription (except when given to you by a network provider during an office visit)
Experimental treatment	Non-coverage includes all services, procedures, supplies, or drugs that are still being tested for safety and are considered under investigation or experimental
Cosmetic procedures	Non-coverage includes all cosmetic surgeries and procedures, such as gastric surgery
All other services not specifically listed or defined by Medicaid	

OVERVIEW AND MEDICAL NECESSITY

Magnolia's Population Health and Clinical Operations Department hours of operation are Monday through Friday, from 8:00 a.m. to 5:00 p.m., CST (excluding holidays). Clinical Operations services include the areas of utilization management, care management, and disease management. The Population Health and Clinical Operations Department's clinical services are overseen by Magnolia's Medical Director (Medical Director). The Vice President of Population Health and Clinical Operations has responsibility for direct supervision and operation of this department.

To reach the Medical Director or Vice President of Population Health and Clinical Operations, please contact:

Magnolia Health Utilization Management
1-877-236-0751
Fax 1-877-291-8059
www.magnoliahealthplan.com

UTILIZATION MANAGEMENT

The Magnolia Utilization Management Program (UMP) is designed to ensure members receive access to the right care, in the right place, and at the right time. Our program is comprehensive and applies to all eligible members across all product types, age categories, and range of diagnoses. The UMP incorporates all care settings, including preventive care, emergency care, primary care, specialty care, acute care, short-term care, long-term care, and ancillary care services.

Magnolia's UMP seeks to optimize a member's health status, sense of well-being, productivity, and access to quality healthcare, while at the same time actively managing cost trends. The UMP aims to provide services that are covered benefits, medically necessary, appropriate to the patient's condition, rendered in the appropriate setting, and which meet professionally recognized standards of care.

Our program goals include:

- Monitoring of utilization patterns to guard against over- or under-utilization
- Development and distribution of clinical practice guidelines to providers to promote improved clinical outcomes and satisfaction
- Identification and provision of intensive care and/or disease management for members at risk for significant health expenses or ongoing care

- Development of an infrastructure to ensure that all Magnolia members establish relationships with their PCPs to obtain preventive care
- Implementation of programs that encourage preventive services and chronic condition self- management
- Creation of partnerships with members/providers to enhance cooperation and support for UMP goals

PRIOR AUTHORIZATION AND NOTIFICATIONS

A prior authorization is a request to the Magnolia UM Department for a medical necessity determination for services to be rendered. Prior authorization is required for all services included in the prior authorization list prior to the delivery of such services. Services that require prior authorization by Magnolia are listed in the prior authorization list, found at www.magnoliahealthplan.com, under "For Providers" → "Provider Resources" → "Practice Improvement Resource Center" → "MEDICAID" → "Prior Authorization List" (under "Forms & Applications" The provider should contact the UM Department via fax, mail, secure email, or through Magnolia's secure Provider Portal, with appropriate supporting clinical information to request an authorization.

The Prior Authorization List is not intended to be an all-inclusive list of covered services, but it does provide significant current prior authorization instructions. All services are subject to benefit coverage limitations and exclusions, as described in applicable plan coverage guidelines. Certification acknowledges only the medical necessity and appropriateness of the setting and does not guarantee payment. Prior authorization cannot be retroactive without additional review.

Prior authorization requests may be submitted electronically using our secure Provider Portal (using the ANSI X 12N 278 transaction code specifications). For more information on filing prior authorizations electronically, or if you have any other questions regarding the secure Provider Portal, please contact your Provider Relations representative.

Emergent, urgent care, and post-stabilization services do not require prior authorization. For emergent and urgent inpatient admissions, providers must notify Magnolia within one (1) business day following admission and must submit an authorization request within two (2) business days following the admission. Failure to notify Magnolia may result in denial of payment.

Failure to obtain authorization may result in administrative claim denials. Magnolia providers are contractually prohibited from holding any Magnolia member financially liable for any service
administratively denied by Magnolia due to the failure of the provider to obtain timely authorization.

AUTHORIZATION TIME FRAMES

Authorization Time Frames for Outpatient Services

For non-emergent outpatient services, prior authorization should be requested at least five (5) calendar days before the requested service delivery date. For pre-scheduled inpatient services, prior authorization should be requested at least fourteen (14) calendar days, and no later than five (5) calendar days, in advance.

Prior authorization determinations for standard outpatient services will be made within three (3) calendar days and/or two (2) business days following receipt of the request, per Minimum Standards for Utilization Review Agents issued by the Mississippi State Department of Health (MSDH). If Magnolia requires additional medical information to make a determination, Magnolia will notify the requesting provider that additional medical information is needed. Magnolia will allow three (3) calendar days and/or two (2) business days for the requesting provider to submit the medical information. If Magnolia does not receive the additional medical information, Magnolia will make a second attempt to notify the requesting provider of the additional medical information needed and allow one (1) business day or three (3) calendar days for the requesting provider to submit the medical information to Magnolia.

Once all information is received from the provider, if Magnolia cannot make a decision, the three (3) calendar day and/or two (2) business day period may be extended up to fourteen (14) additional calendar days, upon request of the member or the provider to Magnolia, or if Magnolia justifies to DOM a need for additional information and how the extension is in the member's best interest. The extension request to DOM applies only after Magnolia has received all necessary medical information to render a decision and Magnolia requires additional calendar days to make a determination. Magnolia must provide to DOM the reason(s) justifying the additional calendar days needed to render a decision. DOM will evaluate

Magnolia's extension request and notify Magnolia of a decision within three (3) calendar days and/or two (2) business days of receiving Magnolia's request for extension.

Magnolia must expedite authorization for services when the provider indicates, or Magnolia determines, that following the standard authorization decision time frame could seriously jeopardize the member's life, health, or ability to attain, maintain, or regain maximum function. Magnolia must provide an Expedited Authorization Decision notice no later than twenty-four (24) hours after receipt of the expedited request. This twenty-four (24) hour period may be extended up to fourteen (14) additional calendar days, upon request of the member or provider, or if Magnolia justifies to DOM a need for additional information and how the extension is in the member's best interest.

Requested information includes the results of any face-to-face clinical evaluations (including diagnostic testing) or second opinion that may be required. Failure to submit necessary clinical information may result in an administrative denial of the requested service.

Authorization Time Frames for Inpatient Medical and Surgical Services

Magnolia will determine medical necessity for urgent/emergent and non-emergency inpatient admission prior authorizations, continued stays, retroactive eligibility reviews, and retrospective reviews for inpatient medical/surgical services provided to eligible Magnolia members. All hospital inpatient stays, except for emergent, urgent care, and post-stabilization services, require notification within one (1) business day and a request for an authorization within two (2) business days of the admission. (Please see specific requirements for emergent, urgent care, post stabilization services, and for OB/Newborn care, which differ slightly from normal uncomplicated care.)

Prior authorization requests for pre-scheduled hospital inpatient services should be submitted at least fourteen (14) calendar days in advance and no later than five (5) calendar days in advance. Magnolia will ensure that determinations for non-emergency reviews are completed within twenty-four (24) hours of receipt if all necessary clinical information is submitted at the time of the request.

Prior authorization is NOT required for emergent or urgent care services. If these services result in an admission, Magnolia must be notified within two (2) business days of admission. Magnolia will ensure that determinations for emergent or urgent care services are completed within twenty-four (24) hours (one business day) of receipt.

Magnolia must receive prior authorization requests for weekend and holiday admissions within two (2) business days of admission and will ensure that determinations for weekend and holiday reviews are completed within twenty-four (24) hours (one business day) of receipt if all necessary clinical information is submitted at the time of the request.

Prior authorization requests for previously certified admissions must be submitted to Magnolia prior to the last certified day. Magnolia will ensure that determinations for continued stay reviews are completed within twenty-four (24) hours (one business day) of receipt.

Determinations regarding all retroactive eligibility reviews and retroactive inpatient hospital reviews will be completed within twenty (20) business days of receipt.

CLINICAL INFORMATION

When calling our Prior Authorization Department, a referral specialist will enter the demographic information and then transfer the call to a Magnolia nurse for the completion of medical necessity screening. During heavy call volumes, a nurse may answer the telephone and complete the medical necessity screening during the call. For all services on the prior authorization list, documentation supporting medical necessity will be required.

Magnolia clinical staff request clinical information minimally necessary for clinical decision-making. All clinical information is collected according to federal and state regulations regarding the confidentiality of medical information. Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Magnolia is entitled to request and receive protected health information (PHI) for purposes of treatment, payment, and healthcare operations, with the authorization of the member.

Information necessary for authorization of covered services may include, but is not limited to:

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

If additional clinical information is required, a Magnolia nurse or medical service representative will notify the caller of the specific information needed to complete the authorization process.

CLINICAL DECISIONS

Magnolia affirms that utilization management decision-making is based only on appropriateness of care and service and the existence of coverage. Magnolia does not specifically reward practitioners or other individuals for issuing denials of service or care. Consistent with 42 CFR 438.6(h) and 422.208, delegated providers must ensure that compensation to individuals or entities that conduct utilization management activities is not structured to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any member.

The treating provider, in conjunction with the member, is responsible for making all clinical decisions regarding the care and treatment of the member. The PCP, in consultation with the Magnolia Medical Director and other clinical staff, is responsible for making utilization management (UM) decisions in accordance with the member's covered benefits and established medical necessity criteria. Failure to obtain authorization for services that require plan approval may result in payment denials.

MEDICAL NECESSITY

Medical necessity is defined for Magnolia members as the review of covered services prescribed and ensures that decisions for authorization are based on generally accepted medical practices considering conditions at the time of treatment.

Medically necessary services for children are limited in that such services must be necessary to correct or ameliorate defects, physical and mental illnesses, or conditions that are discovered during an EPSDT screen, periodic or inter-periodic, whether such services are covered or exceed the benefit limits in the Mississippi Medicaid state plan. All services for children that are determined to be medically necessary are covered.

REVIEW CRITERIA

Magnolia has adopted utilization review criteria developed by Change Healthcare InterQual® products to determine medical necessity for healthcare services. InterQual appropriateness criteria are developed by specialists representing a national panel from community-based and academic practice. InterQual criteria cover medical and surgical admissions, outpatient procedures, referrals to specialists, and ancillary services. Criteria are established and periodically evaluated and updated with appropriate involvement from providers. InterQual is utilized as a screening guide and is not intended to be a substitute for practitioner judgment. Magnolia's Medical Director reviews all potential medical necessity denials and will decide, in accordance with currently accepted medical or healthcare practices, considering special circumstances of each case that may require deviation from the norm in the screening criteria.

Providers may obtain the criteria used to make a specific adverse determination by contacting the Population Health and

Clinical Operations department at 1-877-236-0751. Practitioners can also discuss UM denial decision with a provider or other appropriate reviewer at the time of notification to the requesting practitioner/facility of an adverse determination. The Medical Director may be contacted by calling Magnolia at 1-877-236-0751 and asking for the Medical Director or completing the Peer to Peer Request form found at www.MagnoliaHealth.com. A care manager may also coordinate communication between the Medical Director and the requesting practitioner.

A member, or a healthcare professional with the member's consent, may request an appeal related to a medical necessity decision made during the authorization or concurrent review process, either orally or in writing to:

Medical Providers:

Magnolia Health Clinical Appeals Coordinator
1020 Highland Colony Parkway, Suite 502
Ridgeland, MS 39157
1-877-236-0751
Fax 1-877-851-3995

Behavioral Health Providers:

Magnolia Health Clinical Appeals
Attn: Appeals Coordinator
PO Box 10378
Van Nuys, CA 91410-0378
Phone: 1-877-236-0751
Fax: 1-866-714-7991

MRI, CT, AND PET SCAN AUTHORIZATION

National Imaging Associates (NIA) has been selected by Magnolia to provide prior authorization services and utilization management for advanced imaging and radiology services. NIA focuses on radiation awareness designed to assist providers in managing imaging services in the safest and most effective way possible.

Prior authorization is required for the following outpatient radiology procedures:

- CT/CTA/CCTA,
- MRI/MRA, and
- PET.

Key Provisions:

- Emergency room, observation, and inpatient imaging procedures do not require authorization;
- It is the responsibility of the ordering physician to obtain authorization; and
- Providers rendering the above services should verify that the necessary authorization has been obtained; failure to do so may result in denial of all or a portion of the claim.

In addition to the services above, the following cardiac procedures also require prior authorization:

- Myocardial Perfusion Imaging (MPI)
- MUGA Scan
- Echocardiography
- Stress Echocardiography

The following services do not require authorization through NIA Magellan:

- Inpatient advanced radiology services
- Observation setting advanced radiology services
- Emergency Room radiology services

To reach Evolent and obtain authorization, please call 1-877-864-7237 and follow the prompt for radiology authorizations. Evolent also provides an interactive website which may be used to obtain on-line authorizations. Please visit RadMD.com for more information or call our Provider Services department.

NEW TECHNOLOGY

Magnolia evaluates the inclusion of new technology and the new application of existing technology for coverage determination. This may include medical procedures, drugs, and/or devices. The Medical Director and/or Population Health and Clinical Operations staff may identify relevant topics for review pertinent to the Magnolia population. The Clinical Policy Committee (CPC) reviews all requests for coverage and makes a determination regarding any benefit changes that are indicated.

If you need a new technology benefit determination or have an individual case review for new technology, please contact the Medical Management Department at 1-877-236-0751.

CONCURRENT REVIEW

Magnolia's Population Health and Clinical Operations Department will concurrently review the treatment and status of an inpatient member through contact with the hospital's utilization and discharge planning departments and, when necessary, the member's attending physician. An inpatient stay will be reviewed, as indicated by the member's diagnosis and response to treatment. The review will include evaluation of the member's status, proposed plan of care, discharge plans, and any subsequent diagnostic testing or procedures. Magnolia's Population Health and Clinical Operations Department may contact the member's admitting physician's office prior to the discharge date established during the authorization process, to check on the member's progress, and to make certain that the member receives medically necessary follow-up services.

DISCHARGE PLANNING

The Magnolia UM staff will coordinate discharge planning efforts with the hospital's UM and discharge planning departments and, when necessary, the member's attending provider/PCP, to ensure that the member receives appropriate post-hospital discharge care.

RETROSPECTIVE REVIEW

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).

A decision will be made within twenty (20) business days following receipt of all necessary information for any qualifying service cases.

OBSERVATION GUIDELINES

In the event that a member's clinical symptoms do not meet the criteria for an inpatient admission, but the physician believes that allowing the patient to leave the facility would likely put the member at serious risk, the member may be admitted to the facility for an observation period. Observation Bed Services are those services furnished on a hospital's premises, including use of a bed and periodic monitoring by the hospital's nurse or other staff. These services may be reasonable and necessary to:

- Evaluate an acutely ill patient's condition
- Determine the need for a possible inpatient hospital admission
- Provide aggressive treatment for an acute condition

Observation stays do not require authorization.

Outpatient hospital observation billing and reimbursement is as follows:

Magnolia considers the seventy-two (72) outpatient hospital observation stay as an outpatient service when the stay does not result in an inpatient hospital admission.

Magnolia reimburses observation stays in accordance with the DOM's Administrative Code, Title 23: Medicaid Part 202 Hospital Services. Magnolia reimburses the outpatient hospital observation Healthcare Common Procedure Coding System (HCPCS) code G0378 using an hourly fee for hours eight (8) through twenty-three (23). A reimbursed bundled rate of zero dollars ($0.00) for hours one (1) through seven (7) and for hours twenty-four (24) through seventy-two (72).

In those instances where a member begins hospitalization in an observation status and is subsequently upgraded to an inpatient admission, all incurred observation charges and services will be rolled into the acute reimbursement rate, or as designated by the contractual arrangement with Magnolia, and cannot be billed separately. It is the responsibility of the hospital to notify Magnolia of the inpatient admission within (1) business day and submit a request for authorization within two (2) business days after admission.

SECOND OPINION

The member, or a healthcare professional with the member's consent, may request and receive a second opinion from a qualified professional within the Magnolia network, or Magnolia can arrange for the member to receive a second opinion from an out-of-network provider at no cost to the member.

ASSISTANT SURGEON

Assistant surgeon reimbursement is provided when medically necessary. Magnolia utilizes guidelines for assistant surgeons as set forth by the American College of Surgeons. Hospital medical staff by-laws that require an assistant surgeon be present for a designated procedure are not grounds for reimbursement. Medical staff by-laws alone do not constitute medical necessity, nor is reimbursement guaranteed when the patient or family requests that an assistant surgeon be present for the surgery. Coverage and subsequent reimbursement for an assistant surgeon's service is based on the medical necessity of the procedure itself and the assistant surgeon's presence at the time of the procedure.

NOTIFICATION OF PREGNANCY (NOP)

A member who becomes pregnant while covered by Magnolia may remain a Magnolia member during her pregnancy. The managing provider should notify the Magnolia prenatal team by completing the Provider Notification of Pregnancy Form within five (5) days of the first prenatal visit. The NOP Form can be found on the Magnolia Health's website at www.magnoliahealthplan.com, by clicking on "For Providers"-→ "Provider Resources"-→ "Practice Improvement Resource Center"-→ "MEDICAID"-→ "Provider Notification of Pregnancy Form" (under the "Forms & Applications" heading). Providers should identify the estimated date of confinement and delivery facility. The NOP includes an optional prenatal vitamin order form. Magnolia will facilitate the provider's order of a ninety (90) day supply of prenatal vitamins for the member, to be delivered to the managing provider's office by the member's next prenatal visit. See the Care Management section for information related to our Start Smart for Your Baby® Program and our Makena Program for women with a history of early delivery.

Newborns

Magnolia Health requires maternal information to acknowledge maternity admission. The DOM's Newborn Enrollment Form includes all of the necessary information for routine deliveries and well-baby care (standard 3-day stay for vaginal deliveries, 5-day stay for C-sections). The Newborn Enrollment Form must be fully completed and submitted to the DOM within five (5) days of delivery. If the Newborn Enrollment Form is completed and submitted timely, Magnolia Health does not require any additional information for mother or newborn, unless complications develop during the stay. If complications develop with mother or baby that may necessitate additional hospital days or a non-well baby or NICU admission, a prior authorization request should be submitted, along with clinical information to support the request. The DOM's Newborn Enrollment Form serves as a notification for all normal (well-baby nursery) deliveries. For all other newborns (anything other than well-baby), the hospital must notify Magnolia within one (1) business day of admission. For mothers, the DOM's Newborn Enrollment Form serves as notification of delivery, unless the mother has

some complication that extends a routine vaginal delivery beyond three (3) days or a C-section delivery beyond five (5) days. In such cases, Magnolia must be notified within one (1) business day of the day that the complication necessitating additional days was noted.

Hospice Election, Transfer, Revocation and Discharge/Death Reporting Requirements:

- Election- A member that meets hospice care eligibility requirements or the member's legal guardian/ representative must file an election statement with a Medicaid-approved hospice. The hospice provider must submit the election statement to the Plan with the request for prior authorization.
- Transfer- A member or legal guardian/representative may change, once per election period, the designation of the hospice from which hospice care will be received. The change of the designated hospice is not considered a revocation of the election or discharge from hospice services but is a transfer. The new hospice provider chosen by the member or legal guardian/representative must submit the transfer notice to the Plan and complete all assessments as required by the hospice Conditions of Participation and any federal and state laws.

PROVIDER PREVENTABLE CONDITIONS

Consistent with the Affordable Care Act administered through the Centers for Medicare and Medicaid Services (CMS) and 42 CFR 434.6, 438.6, 447.26 and 1902(a)(4), 1902(a)(6), and 1903 of the Social Security Act, Magnolia has implemented the requirements related to the "Provider Preventable Conditions" (PPC) initiative, which includes:
2) Adjustment of reimbursement for Healthcare-Acquired Conditions (HCAC); 2) Present on Admission (POA) indicator requirements; 3) No reimbursement for Never Events and 4) Other Provider Preventable Conditions (OPPC) as defined by any additional State Regulations that are in place that expand or further define the CMS regulations.

Magnolia identifies Never Events and PPCs in several ways, including referrals, claims data, member and provider complaints, medical record review, and utilization management activities. All Magnolia staff (including Population Health and Clinical Operations, , Member Services, Provider Services, Provider Relations, CommunityConnections® outreach, and Grievance and Appeal staff), independent, facility and ancillary providers, members, Medical Directors, and the Board of Directors may advise the Quality Management (QM) Department of potential PPCs.

Never Events are identified by the following ICD-10 diagnosis codes:

- Y65.51 (ICD-10) Performance of wrong operation (procedure) on correct patient
- Y65.52 (ICD-10) Performance of operation (procedure) on patient not scheduled for surgery
- Y65.53 (ICD-10) Performance of correct operation (procedure) on the wrong side/body part

PHARMACY

PHARMACY PROGRAM

Effective July 1, 2024, Mississippi Medicaid is moving to a single pharmacy claims processor for all prescription claims filled by Mississippi Medicaid beneficiaries. Pharmacy claims and prior authorizations will be processed by Gainwell Technologies (GWT). GWT will review all prior authorization requests for prescription drugs. The GWT pharmacy call center number is 833-660-2402

Magnolia is committed to providing appropriate, high quality, and cost-effective drug therapy to all Magnolia members. Magnolia works with providers and pharmacists to ensure that medications used to treat a variety of conditions and diseases are covered. Medicaid covers prescription drugs and certain over the counter (OTC) drugs when ordered by a provider registered with DOM; however, the pharmacy program does not cover all medications. Some medications require prior authorization or have limitations on age, dosage, and/or maximum quantities. DOM decides which medications are preferred and non-preferred.

This section provides an overview of the Magnolia pharmacy program. For more detailed information, please visit our website at www.magnoliahealthplan.com. Choose the "For Providers" tab, and then select "Pharmacy."

PREFERRED DRUG LIST

The DOM's list of covered medications is referred to as the Preferred Drug List (PDL). The PDL is developed by DOM and is consistent across all coordinated care organizations and DOM fee-for-service. DOM reviews the PDL regularly and determines what, if any, changes should be made. This process is coordinated with Magnolia. Medications currently listed on the PDL should be appropriate to treat most medical conditions encountered by Medicaid providers.

For the most current PDL, please visit Magnolia's website at www.magnoliahealthplan.com, log in to the secure provider portal, and choose the "Pharmacy" menu option.

PHARMACY PRIOR AUTHORIZATIONS (PA)

On July 1, 2024, Medicaid is moving to a single pharmacy claims processor for all prescription claims filled by all beneficiaries. GWT will process all prior authorization requests for prescription drugs. 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:

Providers may submit pharmacy PA requests to GWT electronically via the MESA provider portal or by fax.

- Electronically: https://portal.MS-Medicaid-MESA.com/MS/Provider
- Fax: 1-866-644-6147

For urgent or after-hours requests, a pharmacy can provide up to a seventy-two (72) hour supply of most medications. For questions regarding pharmacy prior authorizations, please contact Gainwell at 1-833-660-2402.

When calling, please have member information, including Magnolia ID number, complete diagnosis, medication history, and current medications readily available.

- If the request is approved, information in the online pharmacy claims processing system will be changed to allow the specific member to receive this specific drug.
- If the request is denied, information about the denial will be provided to the provider.

Providers are requested to utilize the DOM PDL when prescribing medication to Magnolia members. If a pharmacist receives a prescription for a drug that requires a prior authorization request, the pharmacist should attempt to contact the provider to submit a prior authorization to GWT for review.

In the event that a provider or member disagrees with the decision regarding coverage of a medication, the provider may submit an appeal to GWT.

EMERGENCY DRUG SUPPLY

Medicaid follows the seventy-two (72) hour emergency supply policy. The purpose of providing members with this emergency drug supply is to avoid either the interruption of current therapy or a delay in the initiation of therapy. All participating pharmacies are authorized to provide a seventy-two (72) hour supply of medication and will be reimbursed for the ingredient cost and dispensing fee of the seventy-two (72) hour supply of medication, whether the prior authorization request is ultimately approved or denied.

OVER-THE-COUNTER MEDICATIONS

The pharmacy program covers a variety of over-the-counter (OTC) medications. All OTC medications must be written on a valid prescription by a licensed provider.

QUANTITY LIMITATIONS

Quantity limitations have been implemented on certain medications to ensure the safe and appropriate use of the medications. Quantity limitations are approved by DOM and noted throughout the PDL.

STEP THERAPY

Medications requiring step therapy are listed with an "ST" notation throughout the PDL.

AGE LIMITS

Some medications on the DOM PDL may have age limits. These are set for certain drugs, based on FDA- approved labeling and for safety concerns and quality standards of care. Age limits align with current FDA alerts for the appropriate use of pharmaceuticals.

UNAPPROVED USE OF PREFERRED MEDICATION

Medication coverage under this program is limited to non-experimental indications, as approved by the FDA. Other indications may also be covered if they are accepted as safe and effective, using current medical and pharmaceutical reference texts and evidence-based medicine. Reimbursement decisions for specific non-approved indications will be made by DOM. Experimental drugs, investigational drugs, and drugs used for cosmetic purposes are excluded from coverage.

Take-Home Drugs, Supplies, and Equipment

Drugs for use in a hospital that are ordinarily furnished by the hospital for the care and treatment of the member are covered; however, take-home drugs are not covered. If continued administration is necessary, a member may, upon discharge from the hospital, take home remaining amounts of drugs that have been supplied either on prescription or doctor's order, since the drugs would have been charged to the member's account by the hospital.

Supplies and appliances furnished to a member solely for use outside the hospital are not covered. Thus, the reasonable cost of oxygen furnished for treatment of the member solely during the inpatient stay is covered, but oxygen furnished solely for use outside the hospital is not covered. Durable medical equipment (DME) furnished by the hospital solely during the inpatient stay is covered, but equipment furnished solely for use outside the hospital is not. Supplies ordinarily furnished by the hospital for the care and treatment of the member solely during the member's stay in the hospital are covered. Additionally, under circumstances where it would be unreasonable or impossible from a medical standpoint to limit supplies to the inpatient stay, supplies received during the hospital stay are covered even though the member is discharged with these supplies. Examples of items covered under this exception are cardiac valves, cardiac pacemakers, and items such as tracheotomy or drainage tubes, which are temporarily installed in or attached to the member's body, and which are necessary to permit or facilitate the member's discharge.

EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT)

All children and adolescents under age twenty-one (21) who are Magnolia members are eligible to receive Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services. Magnolia provides the full range of EPSDT services, without limitation. This includes periodic health screenings according to the American Academy of Pediatrics (AAP) Bright Futures' Periodicity Schedule, appropriate immunizations using the Advisory Committee on Immunization Practices' (ACIP) Recommended Immunization Schedule, and examinations for vision, dental, hearing, and all medically necessary services.

Periodic Health Screening

- Comprehensive health and developmental history
- Comprehensive unclothed physical exam
- Appropriate immunizations
- Measurements, including, but not limited to, length/height, weight, head circumference, body mass index (BMI) and blood pressure
- Developmental/behavioral assessment, as appropriate
- Autism screening
- Developmental surveillance
- Psychosocial/behavioral assessment
- Tobacco, alcohol, and drug use assessment
- Maternal depression screening
- Depression screening
- Sexually transmitted infection
- Human immunodeficiency virus (HIV) testing
- Cervical dysplasia screening
- Dental assessment and counseling
- Anticipatory guidance
- Nutritional assessment
- Supplemental Nutrition Assistance Program (SNAP) and Women, Infants, and Children (WIC) status
- Appropriate laboratory tests
- Health education (including child development, healthy lifestyles, and accident and disease prevention)
- Vision services- diagnosis and treatment for defects in vision, including eyeglasses
- Dental services- relief of pain and infections, restoration of teeth, and maintenance of dental health
- Hearing services- diagnosis and treatment for defects in hearing, including hearing aids
- Diagnostic services and treatment- When a screening examination indicates the need for further evaluation, your provider will make the necessary referrals and follow up to ensure you receive a complete diagnostic evaluation. Treatment for all physical and mental illnesses or conditions discovered by any screening or diagnostic procedure will be made available.

Periodic Schedule

Screening Codes		Modifier	Age of Child	Unit
99460, 99461,99463		EP	Newborn	1
New Patient	Established Patient			
99381	99391	EP	3-5 days	1
99381	99391	EP	0-1 months	1
99381	99391	EP	2 months	1
99381	99391	EP	4 months	1
99381	99391	EP	6 months	1
99381	99391	EP	9 months	1
99382	99392	EP	12 months	1
99382	99392	EP	15 months	1
99382	99392	EP	18 months	1
99382	99392	EP	24 months	1
99382	99392	EP	30 months	1
99382	99392	EP	3-4 years*	1
99383	99393	EP	5-11 years*	1
99384	99394	EP	12-17 years*	1
99385	99395	EP	18- 20 years*	1

Beginning at 3 years of age EPSDT screenings must be done annually up to the age of 20.

VALUE-ADDED SERVICES

Sensory screenings and developmental/behavioral assessments

Screening Code	EPSDT Service	Age of Child	Unit
99173-EP	Vision Screen	3, 4, 5, 6, 8, 10, 12 & 15 Years of Age	1 Per Year
92551-EP	Hearing Screen	Newborn, 4, 5, 6, 8, 10, Once between 11-14, 15-17 & 18-20 Years of Age	1 Per Year
96110-EP	Developmental Screen	9, 18, & 30 Months	1 Per Month
96110-EP	Autism Screen	18 & 24 Months	1 Per Month
96160-EP	Depression Screen	12-20 Years	1 Per Year
96161-EP	Maternal Depression Screen	1, 2, 4, and 6 Months	1 Per Year

Provision of all components of the EPSDT service must be clearly documented in the PCP/PCMH's medical record for each member. Further, PCP/PCMHs are required to report encounter data associated with EPSDT screens to Magnolia within one hundred eighty (180) days from the date of service.

Magnolia requires that providers cooperate, to the maximum extent possible, with efforts to improve the health status of Mississippians, and that providers actively participate in the increase in percentage of eligible members obtaining EPSDT services in accordance with the adopted periodicity schedules.

Should a PCP/PCMH be unable to conduct the necessary EPSDT screens, the PCP/PCMH is responsible for arranging to have the necessary EPSDT screens conducted by another Magnolia network provider and for ensuring that all relevant medical information, including the results of the EPSDT screens, is incorporated into the member's PCP/PCMH's medical record.

Magnolia will cooperate with and assist providers in identifying and immunizing each member whose medical records do not indicate up-to-date immunizations. Providers are responsible for following up with each member who is not in compliance with the EPSDT screening requirements and EPSDT services, including missed appointments.
Providers are required to document the reason for noncompliance, where possible, and to document their efforts to bring the member's care into compliance with the standards.

Providers are encouraged to also participate in the Vaccines for Children (VFC) program. Vaccines from VFC should be billed with the specific antigen codes for administrative reimbursement. No payment will be made on the administration codes alone.

Please see the Billing and Claims Submission section for information on submitting claims for EPSDT services.

CARE MANAGEMENT PROGRAM

24-Hour Nurse advice line

Our members have many questions about their health, their PCPs, and/or access to emergency care. Magnolia offers a nurse advice line service to encourage members to talk with their providers and to promote education and preventive care.

The 24-hour Nurse Advice Line is our twenty-four (24) hour, seven (7) days per week nurse advice line for members. Our 24-hour Nurse Advice Line's registered nurses provide basic health education and nurse triage and answer questions about urgent or emergency access. 24-hour Nurse Advice Line staff often answer basic health questions, but they are also available to triage more complex health issues, using nationally recognized protocols. Members with chronic problems, like asthma or diabetes, are referred to Care Management for education and encouragement to improve their health.

Members may use 24-hour Nurse Advice Line to request information about providers and services available in their community after hours, when the Magnolia Member Services Department (Member Services) is closed. The 24-hour Nurse Advice Line staff is fluent in both English and Spanish and can provide additional translation services, if necessary.

We provide this service to support your practice and offer our members access to a registered nurse on a daily basis. If you have any additional questions, please call Provider Services at 1-877-236-0751, or the 24-Hour Nurse Advice Line at 1-877-236-0751.

MY HEALTH PAYS® REWARDS PROGRAM

Members can earn My Health Pays rewards from Magnolia Health when they complete healthy activities. These healthy activities begin with completing the Health Information Form included in their welcome packet. New rewards are added to their My Health Pays Visa® Prepaid Card once they complete each healthy activity.

Members earn My Health Pays rewards when they complete healthy activities like a yearly wellness exam, annual screenings, tests, and other ways to protect their health.

Members can use their My Health Pays rewards to help pay for:

- Everyday items at Walmart (restrictions apply; cannot be used to purchase alcohol, firearms, or tobacco products)
- Utilities
- Telecommunications (Cell phone bill)
- Transportation
- Childcare
- Education
- Rent

Detailed information on the My Health Pays rewards program is provided on our website at www.MagnoliaHealthPlan.com.

CARE MANAGEMENT PROGRAM

Magnolia's Care Management program is designed to help Magnolia members obtain needed services, whether the services are available within Magnolia Health's array of covered benefits, from their local community, or from other non-covered venues. Our Care Management model supports the entire range of our provider network, from an individual practice to a large multi-specialty group setting.

The program is based upon a coordinated care model that uses a multi-disciplinary Care Management team, recognizing that multiple comorbidities will be common among our membership. The goal of our program is to help members achieve the highest possible levels of wellness, functioning, and quality of life, while decreasing the need for ongoing disruption at the provider's office with administrative work.

The program includes a systematic approach for early identification of an eligible member, a needs assessment, and development and implementation of an individualized care plan. This plan includes member/family education, as well as

outcome monitoring and reporting back to the PCP/PCMH and actively links the member to both providers and support services. Our Care Management team integrates covered and non-covered services and provides a holistic approach to a member's medical care (and, when available, behavioral healthcare), as well as functional, social, and other needs.

Our program incorporates clinical determinations of need, functional status, and barriers to care, such as lack of caregiver support, impaired cognitive abilities, and transportation needs.

To ensure that appropriate referrals and connections are made for the members, Magnolia provides continuity- of-care services. Continuity of care synchronizes medical, social, and financial services and may include management across payer sources.

We proactively identify new members receiving services from non-contracted providers, educate members and providers to ensure providers continue offering necessary services, and develop transition plans for incoming and outgoing members by providing all care management history and six (6) months of claims history and other pertinent information related to any special needs.

If a Medicaid- or Magnolia-eligible member is receiving medically necessary covered services at the time of enrollment, Magnolia will honor a transition period of up to thirty (30) calendar days if the existing provider is nonparticipating. If the new enrollee is in her second or third trimester of pregnancy, Magnolia will provide continued access to the prenatal care provider regardless of whether that provider is participating in Magnolia's network.

Magnolia's transitional care process identifies members who are most at risk for hospital readmission and deploys specific interventions aimed at addressing the barriers known to contribute to readmission. The transitional care team coordinates care for high- and moderate-risk members, transitioning from one setting to another, and assists them with accessing services that help them remain in an optimal setting for health and wellness. The team accomplishes this by collaborating with Concurrent Review and hospital staff to identify these members as soon as possible and to complete a comprehensive assessment of each member's post-discharge needs. Key areas of focus include communication with attending providers, the member's PCP, treating behavioral health providers, and other outpatient providers; post-discharge appointment scheduling with providers for tests and services; member and caregiver understanding of the condition and its management, as well as early recognition of symptoms; medication reconciliation; caregiver support; and coordination with appropriate community agencies.

The Care Management team is available to help providers manage their Magnolia members. Listed below are programs and components of special services that can be accessed through the Care Management team. We look forward to hearing from you about any Magnolia members that you think can benefit from the assistance of a Magnolia Care Management team member.

To make a referral or contact a Care Manager, call:

Magnolia Health
Care Management Department
1-877-236-0751

HIGH-RISK PREGNANCY PROGRAM:

Magnolia's Start Smart for Your Baby® (Start Smart) is a unique prenatal program with a goal of improving maternal and child health outcomes by providing pregnancy and parenting education to each pregnant member and by providing care management to high- and moderate-risk members through the postpartum period. The obstetrician (OB) is responsible for implementing the Start Smart for Your Baby program, which incorporates care management, care coordination, and disease management with the aim of decreasing preterm delivery and improving the health of mothers and their babies. A care manager with obstetrical nursing experience will serve as the lead care manager for a member at high risk of early delivery or who experiences complications from pregnancy. The OB team has providers advising the team on overcoming obstacles, helping to identify high-risk members, and recommending interventions. These providers will provide input to Magnolia's Medical Director on obstetrical care standards and use of newer preventive treatments such as Makena.

THE SSI/COMPLEX TEAMS

among adults and children. Care management teams will be led by clinical licensed care managers, with either adult or pediatric expertise, as applicable. For both adult and pediatric teams, the staff has experience with the population, the barriers and obstacles they face, and the socioeconomic impacts on their ability to access services. The teams will manage care for members whose needs are primarily functional, as well as those with such complex conditions as breast or cervical cancer, trauma, organ transplants, and renal dialysis. Foster care members and children with special healthcare needs are at special risk and are also eligible for enrollment in Care Management. Magnolia will use a holistic approach by integrating referral and access to community resources, transportation, follow-up care, medication review, specialty care, and education to assist members in making better healthcare choices.

A Transplant Coordinator will provide support and coordination for members who need organ transplants. All members considered to be potential transplant candidates should be immediately referred to the Magnolia Care Management Department for assessment and care management services. Each candidate is evaluated for coverage requirements and will be referred to the appropriate agencies and transplant centers.

COMMUNITY CONNECTIONS

Community Connections is Magnolia's outreach program, designed to provide education to our members on how to access healthcare and develop healthy lifestyles in a setting where they feel most comfortable. The program's components are integrated as a part of our Care Management program in order to link Magnolia and the community served. The program recruits staff from the communities serviced to establish grassroots support and awareness of Magnolia within the community. The program has various components depending on the needs of the members.

Members can be referred to Community Connections through numerous sources. Members who call Magnolia to talk with the Member Services Department may be referred to Community Connections for a more personalized discussion. Additionally, care managers may identify members who would benefit from one of the many Community Connections resources available through completion of a referral request.

Providers may also request Community Connections referrals directly from the Community Connections representative or their assigned care manager.

Program components include:

- Community Connections: Connections representatives are available to present during events initiated by state entities, community groups, clinics, or during any other approved setting. This form of community connection is extremely useful in rural areas where home visits may be the only mode of communication. Presentations typically include information on DOM's coordinated care program, an overview of services offered by Magnolia, how to access Magnolia services, the importance of obtaining primary preventive care, and other valuable information related to obtaining services from Magnolia and its providers.
- Home Connections: Connections representatives are available on a full-time basis at the request of members and providers and whenever a need arises. All home visits are pre-scheduled with the individual member, unless the visit is a result of being unable to locate a member. Topics covered during a home visit include an overview of covered benefits; how to schedule an appointment with the PCP; the importance of preventive healthcare; appropriate use of preventive, urgent, and emergency care services; obtaining medically necessary transportation; and how to contact Magnolia for assistance.
- Phone Connections: Connections representatives may contact new members, or members in need of more personalized information, to review Magnolia's material over the telephone. All the topics listed above may be covered and any additional questions will be answered.
- Connections Plus®: Connections representatives work together with the high-risk OB care management team for high-risk members who do not have safe, reliable phone access. When a member qualifies, a Connections representative visits the member's home and gives them a free, preprogrammed cell phone with limited use. The member may use this cell phone to call their Magnolia care manager, their PCP, a specialty provider, the After-Hours Support & Nurse Advice Line, 911, or other members of their healthcare team. In some cases, Magnolia may provide MP-3 players preprogrammed with educational materials for those with literacy issues or who may be in need of additional education.

To contact the Community Connections team, call:

Magnolia Health
Community Connections
1-877-236-0751

DISEASE MANAGEMENT (DM) PROGRAMS

DM program components include:

- Increasing coordination between medical, social, and educational communities
- Severity and risk assessments of the population
- Profiling the population and providers for appropriate referrals
- Ensuring active and coordinated provider/specialist participation
- Identifying modes of delivery for coordination of care services, such as home visits, clinic visits, and phone contacts, depending on the circumstances and needs of the member and his/her family
- Increasing the member's and/or caregiver's ability to manage chronic conditions, and coordination with a Magnolia care manager for Care Management services

The DM programs target members with select chronic diseases which may not be under control. New members are assessed and stratified to accurately assign them to the most appropriate level of intervention. Interventions may include mailed information for low-intensity cases, telephone calls and mailings for moderate cases, or home visits by a health coach for members categorized as high-risk.

Magnolia's affiliated DM Company will administer DM programs which include services for chronic diseases such as asthma, diabetes, hypertension, heart failure, and obesity.

To refer a member for Disease Management, call: **Magnolia Health at 1-877-236-0751**.

BEHAVIORAL HEALTH SERVICES

Magnolia offers our members access to all covered, medically necessary behavioral health services.

Magnolia members seeking mental health or substance abuse services may self-refer to a network provider for thirty (30) standard outpatient sessions per member, but prior authorization is required for subsequent visits. For assistance in identifying a behavioral health provider, or for prior authorization for inpatient or outpatient services, CBH may be reached at 1-877-236-0751, or via their website at www.magnoliahealthplan.com.

If a physician or practitioner is unable to provide timely access for a member, Magnolia will assist in securing authorization to a physician or practitioner to meet the member's needs in a timely manner

CREDENTIALING AND RECREDENTIALING

CREDENTIALING AND RECREDENTIALING

Effective July 1, 2022, DOM implemented a new centralized credentialing process along with NCQA certified Centralized Verification Organization (CVO) that will be responsible for credentialing and recredentialing. All providers who wish to participate in the Mississip-piCAN are now required to be enrolled, credentialed, and screened by DOM.

Providers interested in participating in Magnolia's MississippiCAN network should select Magnolia Health as a Coordinated Care Organization (CCO) on their Gainwell application. Once credentialing is complete with Gainwell, Magnolia will be notified by Gainwell. Pro-viders with an active Magnolia MSCAN contract who selected Magnolia as a CCO during the Gainwell process will automatically be enrolled in Magnolia's MSCAN network. Provid-ers not contracted with Magnolia will receive outreach from Magnolia's Contracting De-partment within 7 days of intent to contract.

For more information regarding the new centralized credentialing process, please visit https://medicaid.ms.gov/.

Please note that Centralized credentialing does not apply to the Marketplace or Medicare Advantage Line of business.

RIGHT TO BE INFORMED OF APPLICATION STATUS

Providers who have requested to contract with Magnolia have the right to be informed of the status of their request. To obtain status, contact Magnolia's Contracting Department at MagnoliaContracting@Centene.com.

COMPLAINT, GRIEVANCE, AND APPEALS PROCESS

MEMBER COMPLAINTS, GRIEVANCES, AND APPEALS

Magnolia has steps for handling any problems a member might have. Magnolia offers all of our members the following processes to achieve member satisfaction:

1. Internal grievance and complaint process
2. Internal appeal process
3. Access to Medicaid State Fair Hearing

Magnolia maintains records of each grievance and appeal filed by our members or by their authorized representatives, and the responses to each grievance and appeal, for a period of ten (10) years.

Pharmacy complaints and grievances related to claims processed on or after July 1, 2024, will be handled by Medicaid's Pharmacy Vendor Gainwell Technologies. Pharmacy appeals related to prior authorizations decisioned on or after July 1, 2024, will be reviewed by GWT. The Gainwell Technologies pharmacy call center number is 833-660-2402.

Grievance and Complaint Process

A grievance is an expression of dissatisfaction about any matter other than an adverse benefit determination. An adverse benefit determination is Magnolia's decision to deny or limit authorization or payment (in whole or in part) for healthcare services, including new authorizations and previously authorized services, the reduction, suspension, or termination of a previously authorized service; Magnolia's failure to provide services in a timely manner; or a failure to resolve complaints, grievances, or appeals within the time frames specified in the contract. A member may file a grievance either orally or in writing with Magnolia any time after the grievance has occurred.

Examples of a grievance:

- Failure to respect the member's rights
- When a provider bills the member for unpaid claims (balance billing)
- Transportation issues

A complaint is an expression of dissatisfaction received orally or in writing, that is of a less serious or informal nature, and that is resolved within one (1) calendar day of receipt. Complaints may be submitted to Magnolia by the member or the member's authorized representative, including the member's provider. Complaints must be submitted to Magnolia within thirty (30) days of the date of the event causing dissatisfaction.

How to file a grievance or complaint

Filing a grievance or complaint will not affect the member's healthcare services. We want to know their concerns so we can improve our services.

To file a grievance or complaint, the member can call Member Services at 1-877-236-0751. Magnolia will provide reasonable assistance to the member in filing a grievance or complaint. The member will need to include:

- Their first and last name
- Their Medicaid ID number
- Their address and telephone number
- The reason for their dissatisfaction
- What they would like to have happen to resolve or correct the issue

A grievance or complaint may be filed in writing by mailing it to the address below or by faxing it to 1-877- 851-3995. You can also call us at 1-877-236-0751 or file the grievance or complaint in person at:

Magnolia Health
Attn: Grievance Coordinator
1020 Highland Colony Parkway, Suite 502
Ridgeland, MS 39157

ACKNOWLEDGMENT

Upon receipt of a complaint or grievance, Magnolia staff will acknowledge the complaint or grievance, document the substance of the complaint or grievance, and attempt to resolve it immediately. For complaints, defined as those received orally and resolved within one (1) business day to the satisfaction of the member, Magnolia will document the resolution details. If the member files a complaint, there is no need for written acknowledgment. Otherwise, Magnolia will provide the grievant with a written acknowledgment letter that the grievance has been received and the expected date of its resolution within five (5) calendar days of receipt of the grievance.

GRIEVANCE RESOLUTION TIME FRAME

Grievance resolution will occur as expeditiously as the member's health condition requires, not exceeding thirty (30) calendar days from the date of the initial receipt of the grievance. Expedited grievance reviews will be available for members in situations deemed urgent, such as a denial of an expedited appeal request, and will be resolved within 72 hours. Grievances will be resolved by the Grievance and Appeals Coordinator (GAC), in collaboration with other Magnolia staff as needed.

NOTICE OF RESOLUTION

If the member files a grievance, either oral or written, the Grievance and Appeal Coordinator (GAC) will send the member a letter within five (5) calendar days letting the member know the grievance has been received and include the expected date of resolution. The GAC will provide a written resolution within thirty (30) calendar days of receipt.

The letter will include, but will not be limited to, the resolution details and DOM requirements. Magnolia may extend up to fourteen (14) calendar days if the member requests the extension or Magnolia determines that there is need for additional information and the extension is in the member's interest. For any extension not requested by the member, Magnolia shall give the member written notice of the reason for the extension within two (2) calendar days of the decision to extend the time frame.

A copy of verbal complaint logs and records of disposition shall be retained for ten (10) years.

If someone else is going to file a grievance or complaint on behalf of the member, Magnolia must have the member's written permission for that person to file their grievance or complaint. The member can call Member Services to receive the Authorized Representative Form, or they can go to www.magnoliahealthplan.com to access the Authorized Representative Form. This form gives the member the right to have someone else file a grievance or complaint on their behalf. A provider acting for the member can file a grievance or complaint for the member if the required authorized representative form is completed and signed by the member, giving their consent.

If the member has any proof or information that supports their grievance, they may send it to Magnolia, and the information will be added to their case file. The member may supply this information to Magnolia by including it with a letter, by sending it via email or fax, or by bringing it in person to Magnolia. The member may also request to receive copies of any documentation that Magnolia uses to make the decision about their grievance.

There will be no retaliation against the member or the representative for filing a grievance or complaint with Magnolia. Filing a grievance or complaint will not affect the member's healthcare services.

Expedited Grievances

The member or their provider may request an expedited decision from Magnolia. The member can ask for an expedited review if the member or their provider feels that the member's health is at risk. If the member believes an expedited decision is needed, the member will need to contact Magnolia for a review and investigation by the appropriate clinical staff. Clinically urgent grievances will be resolved within seventy-two (72) hours of receipt.

MEMBER APPEAL PROCESS

An appeal is a request for review by Magnolia Health of an adverse benefit determination.

Adverse benefit determination means any of the following:

1. The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.
2. The reduction, suspension, or termination of a previously authorized service.
3. The denial, in whole or in part, of payment for a service. (See Provider Complaint, Grievance, Appeals, and State Administrative Hearing Process section.)
4. The failure to provide services in a timely manner, as defined by the state.
5. The failure of an MCO, PIHP, or PAHP to act within the time frames provided in § 438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals.
6. For a resident of a rural area with only one MCO, the denial of an enrollee's request to exercise his or her right, under § 438.52(b)(2)(ii), to obtain services outside the network.
7. The denial of an enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities. The member may be responsible for non-covered item(s) and/or service(s), only if the provider ensures that written documentation in compliance with the advance beneficiary notification (ABN) is received from the member that an item or service rendered is a non-covered item and/or service and that the member will be financially responsible for the item and/or service.

A member or authorized representative (a person or entity acting on behalf of a member with the member's written consent or through the appointment by a court, legal guardian, or other body holding legal standing to act on behalf of the member) may file an appeal either orally, by phone, or in writing of an adverse benefit determination within sixty (60) calendar days of date on the notice of adverse benefit determination from Magnolia Health.

Magnolia has thirty (30) calendar days from the date the initial verbal or written appeal is received to resolve the appeal, or as expeditiously as the member's health condition requires. Magnolia will appoint at least one (1) person to review the appeal who was not involved in the initial decision and who is not the subordinate of any person involved in the initial decision. Within this same thirty (30) calendar day timeframe, Magnolia shall provide written notice of the resolution of the appeal to the member and/or provider, if the provider filed the appeal.

Within ten (10) calendar days of receipt of the appeal, Magnolia will provide the member and/or provider, if the provider filed the appeal, with written notice that the appeal has been received and the expected date of its resolution. Magnolia will confirm in writing receipt of verbal appeals, unless the member or the service provider requests an expedited resolution.

A verbal or written inquiry from a member seeking to appeal an adverse benefit determination is treated as an appeal (to establish the earliest possible filing date for the appeal).

Magnolia will use its best efforts to assist members as needed with the verbal or written appeal and may continue to process the appeal.

The thirty (30) calendar day timeframe may be extended by fourteen (14) calendar days if the member requests the extension, or if Magnolia determines that there is need for additional information, and the extension is in the member's interest. For any extension not requested by the member, Magnolia will give the member written notice of the extension and the reason for the extension within two (2) calendar days of the decision to extend the time frame. If the member disagrees with Magnolia's decision for an extension, the member may file a grievance regarding the dissatisfaction. A reasonable opportunity to present evidence of the facts or law, in person as well as in writing, will be given to the member or the member's representative.

The member or the representative will have the opportunity, before and during the appeal process, to examine the member's case file, including medical or clinical records (subject to HIPAA requirements), and any other documents and records considered during the appeal process.

To file an appeal verbally, call Magnolia Health at 1-877-236-0751 and ask to speak to the Appeal Coordinator. To file in writing, mail or fax the written appeal to:

Magnolia Health
Attn: Appeals Coordinator
1020 Highland Colony Parkway, Suite 502
Ridgeland, MS 39157
Fax Number: 1-877-264-6519

Continuation of Benefits

While awaiting results of the appeal, the member's benefits may be continued if all of the following are met:

1. Member files a timely appeal of an adverse benefit determination. Timely filing means filing for continuation of benefits on or before the later of ten (10) calendar days from the date on the Notice of Adverse Benefit Determination or the intended effective date of Magnolia's proposed adverse benefit determination;
2. The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;
3. The services were ordered by an authorized service provider;
4. The time period covered by the original authorization has not expired; and
5. Member requests extension of the benefits

If, at the member's request, Magnolia Health continues or reinstates the member's benefits while the appeal or state fair hearing is pending, the benefits must be continued until one of following occurs:

1. The member withdraws the appeal or request for state fair hearing
2. The member fails to request a state fair hearing and continuation of benefits within ten (10) calendar days after Magnolia sends the notice of an adverse resolution to the enrollee's appeal under § 438.408(d)(2)
3. A state fair hearing office issues a hearing decision adverse to the enrollee.

If the final resolution of the appeal or state fair hearing is adverse to the member, that is, upholds Magnolia Health's adverse benefit determination, Magnolia may, consistent with the state's usual policy on recoveries under § 431.230(b) of this chapter and as specified in Magnolia's contract, recover the cost of services furnished to the member while the appeal and state fair hearing was pending, to the extent that they were furnished solely because of the requirements of this section.

If Magnolia or the Division reverses a decision to deny, limit, or delay services, and these services were not furnished while the appeal was pending, Magnolia will authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires, but no later than 72 hours from the date it receives notice reversing the determination. If Magnolia or the DOM reverses a decision to deny, limit, or delay services and the member received the disputed services while the appeal was pending, Magnolia will pay for these services.
Request for Continuation of Benefits can be mailed or faxed to:

Magnolia Health
Attn: Grievance and Appeals Coordinator
1020 Highland Colony Parkway, Suite 502
Ridgeland, MS 39157
Fax Number: 1-877-264-6519

Expedited Resolution of Appeals

Magnolia Health has an expedited review process for appeals when it is determined that allowing the time for a standard resolution could seriously jeopardize the member's life, health, or ability to attain, maintain, or regain maximum function. Such a determination is based on:

1. A request from the member;
2. A provider's support of the member's request;
3. A provider's request on behalf of the member; or
4. Magnolia Health's independent determination.

The expedited review process is convenient and efficient for the member.

An expedited appeal will be resolved within seventy-two (72) hours of receipt of the request. In addition to written resolution notice, reasonable efforts are made to provide and document verbal notice.

The time frame for resolution of an appeal may be extended by up to fourteen (14) calendar days if the member requests the extension, or there is need for additional information and the extension is in the member's interest.

If the member disagrees with Magnolia's decision for an extension, they may file a grievance regarding the dissatisfaction. For any extension not requested by the member, Magnolia will give the member written notice of the reason for the delay within two (2) calendar days of the decision to extend the time frame.

Punitive action will not be taken against a member or a service provider who requests an expedited resolution or supports a member's expedited appeal. Magnolia will provide an expedited resolution, if the request meets the definition of an expedited appeal, in response to a verbal or written request from the member or service provider on behalf of the member.

If a request for an expedited resolution of an appeal is denied, Magnolia Health will:

1. Transfer the appeal to the thirty (30) calendar daytime frame for standard resolution, in which the thirty (30) calendar day period begins on the date the health plan received the original request for appeal; and
2. Make reasonable efforts to give the member prompt verbal notice of the denial and follow up with a written notice within two (2) calendar days.

Magnolia will document in writing all verbal requests for expedited resolution and will maintain the documentation in the case file.

State Fair Hearing:

A state fair hearing is a hearing conducted by the DOM or its subcontractor in accordance with 42 C.F.R. Part 431, Subpart E.

A State Fair Hearing is a hearing conducted by the DOM in accordance with 42 C.F.R. Part 431, Subpart E.
A member or authorized representative may request a State Fair Hearing if he or she is dissatisfied with an adverse benefit determination that has been taken by Magnolia. This request must be made within one hundred twenty (120) calendar days of the notice of appeal resolution. Prior to requesting a State Fair Hearing with the DOM, the member must exhaust all appeal level procedures through Magnolia Health.

Any Adverse Benefit Determination or Appeal that is not resolved wholly in favor of the member by Magnolia may be appealed by the member or the member's authorized representative to the Division for a State Fair Hearing conducted in accordance with 42 C.F.R. § 431, Subpart E. Adverse Benefit Determinations include reductions in service, suspensions, terminations, and denials. The contractor's denial of payment for covered services and failure to act on a request for services within required time frames may also be appealed. State Fair Hearing Request must be requested by the member or the member's representative within one hundred twenty (120) calendar days of the member's receipt of notice of an adverse benefit determination unless an acceptable reason for delay exists. Requests must be made by writing or fax. An acceptable reason shall include, but not be limited to, situations or events where:

1. Appellant was seriously ill and was prevented from contacting Magnolia.
2. Appellant did not receive notice of Magnolia's decision.
3. Appellant sent the request for appeal to another government agency in good faith within the time limit, and
4. Unusual or unavoidable circumstances prevented a timely filing.

Magnolia will comply with the Division's state fair hearing decision. The Division's decision in these matters shall be final and shall not be subject to appeal by the contractor.

If the member requests a state fair hearing and would like for their benefits to continue, the request to continue benefits must be made within ten (10) days from the date the decision was made by Magnolia. If the state fair hearing finds that Magnolia's decision was correct, the member may be responsible for the cost of the continued benefits.

To request a state fair hearing, send the request in writing or fax to:

Division of Medicaid, Office of the Governor
Attn: Office of Appeals
550 High Street, Suite 1000
Jackson, Mississippi 39201
Phone: 601-359-6050 or 1-800-884-3222 | Fax: 601-359-9153

PROVIDER COMPLAINT, GRIEVANCE, APPEALS, AND STATE ADMINISTRATIVE HEARING PROCESS

Magnolia Health takes provider complaints (grievances) seriously. Complaints are an important mechanism for identifying concerns and dissatisfaction within our provider network. Provider grievances are processed to ensure a timely and thorough investigation.

A provider complaint or grievance is defined as any provider expression of dissatisfaction expressed by the provider to the Plan orally or in writing about any matter or aspect of the Plan or its operation, other than an adverse benefit determination.

Examples of complaints and grievances include:

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

A complaint or grievance should be filed in writing or by phone within thirty (30) calendar days of the date of the event causing the dissatisfaction.

If in writing, the complaint or grievance should be submitted to Magnolia Health: Medical and BH providers:

Magnolia Health
Attn: Provider Services-Complaints/Grievances
1020 Highland Colony Parkway, Suite 502
Ridgeland, MS 39157
Phone: 1-877-236-0751

Acknowledgement

Upon receipt of a grievance, Magnolia staff will acknowledge the grievance, document the substance of the grievance, and attempt to resolve it immediately. For written grievances, Magnolia will notate the date received and send an acknowledgment letter, which includes a description of the grievance procedures resolution time frames, within five (5) business days of receipt.

Grievance Resolution Time Frame

Provider grievance resolution will occur as expeditiously as deemed appropriate, not to exceed thirty (30) calendar days from the date of the initial receipt of the grievance. Magnolia may extend the time frame up to fourteen (14) calendar days. Grievances will be resolved by Magnolia, in coordination with other Magnolia staff as needed. In our experience, most grievances are resolved at the staff level to the satisfaction of the provider filing the grievance. Expedited grievance reviews will be available for providers in situations deemed urgent, such as a denial of an expedited appeal request, and will be resolved within seventy-two (72) hours.

CLAIM APPEALS

A claim appeal is a written request for review of a claim or payment determination such as a reduction in payment or a full claim denial. A claim appeal must be accompanied by the Claim Appeal Form found on our website at www.magnoliahealthplan.com.

The claim appeal should be filed within thirty (30) calendar days of receiving Magnolia's notice of adverse benefit determination.

Medical and Behavioral Health providers may submit their claim appeal to:

Magnolia Health
Attn: Appeals
P.O. Box 3090
Farmington, MO 63640-3825

A claim appeal acknowledgment letter will be issued to the provider within ten (10) days of receipt. A resolution letter will be issued to the provider within thirty (30) days of receipt.

If the appeal of a claim results in an adjustment, the provider will receive a revised Explanation of Payment (EOP) and a letter detailing the results of the appeal. If the original decision is upheld, the provider will receive a revised EOP and letter detailing the decision and steps for a state fair hearing.

State Administrative Hearing
A hearing conducted by the Division. Any claim appeal that is not resolved wholly in favor of the provider by the contractor may be appealed by the provider or the provider's authorized representative to the Division for a state administrative hearing once the provider is deemed to have exhausted the contractor's appeals process.

A request for a state administrative hearing should be submitted within thirty (30) calendar days of the final decision by Magnolia Health to the DOM at the following address:

Division of Medicaid, Office of the Governor
Attn: Office of Appeals
550 High Street, Suite 1000
Jackson, Mississippi 39201
Phone: 601-359-6050 or 1-800-884-3222 | Fax: 601-359-9153

WASTE, ABUSE, AND FRAUD

WASTE, ABUSE, AND FRAUD (WAF) SYSTEM

Magnolia takes the detection, investigation, and prosecution of fraud and abuse very seriously, and has a WAF program that complies with both state and federal laws. Magnolia, in conjunction with Centene, successfully operates a WAF unit. Magnolia performs front- and back-end audits to ensure compliance with billing regulations. Our sophisticated code-editing software performs systematic audits during the claims payment process. To better understand this system, please review the Billing and Claims section of this Provider Manual. Centene's Special Investigation Unit (SIU) performs back-end audits, which may result in actions against those who, individually or as a practice, commit waste, abuse, and/or fraud, including, but not limited to:

- Remedial education and/or training around eliminating the egregious action
- More stringent utilization review
- Recoupment of previously paid monies
- Termination of provider agreement or other contractual arrangement
- Civil and/or criminal prosecution
- Any other remedies available to rectify the WAF

The Special Investigations Unit conducts two types of reviews:

1. Prepay – claims are pended for services to be reviewed and medical records will have to be submitted in order for the claim to be considered for payment – you will find the pended claims on your Explanation of Payment (EOP). Claims pended for review will show the EXye code.

   If you receive a prepay notification letter advising that claim services will be pended EXye, please follow the instructions on the letter as to how to resubmit the claims and the medical records. Do NOT submit those to Magnolia Health Plan in Jackson, please submit to the following address:

   Magnolia Health
   Attn: Corrected Claims
   Post Office Box 3090
   Farmington, MO 63640-3825

   Once a prepay review has been completed, a letter outlining the findings will be sent. Also, during the prepay review, if a service is denied by SIU clinical and that denial is supported by a peer review conducted by a Mississippi licensed physician, a letter will be sent to the provider explaining why the service was denied and how they can appeal that denial.

2. Retrospective review – comprehensive review of member medical records

   You may also receive a request for a comprehensive list medical records- please follow the instructions in the letter how to submit. **Do NOT send them directly to Magnolia Health Plan in Jackson**, please follow the instructions in the letters for obtaining access to a secure FTP site, or mail copies of the records to the following address:

   Centene
   Attn: SIU Records Unit
   1570 Timberlake Manor Parkway
   Chesterfield, MO 63017
   Fax: (877) 851-3996

Once a retrospective review has been completed by SIU clinical and gone through peer review with a Mississippi licensed physician, providers will be notified of the results. If a provider does not agree with those results, the provider has thirty (30) calendar days to submit their appeal to Magnolia. Please send appeal information to the following address:

Centene
Attn: SIU Records Unit
1370 Timberlake Manor Parkway
Chesterfield, MO 63017
Fax: (877) 851-3996

When the appeal has been completed by SIU clinical, the appeal will go for peer review with a Mississippi licensed physician. Once the peer review has been completed, the provider will be notified of the findings.

Disagreement of Determination

If the provider does not agree with the appeal findings, the provider has the right to appeal. This process includes a provider appeal with Magnolia Health Plan and a state administrative hearing with the Mississippi DOM. Providers must exhaust all appeal rights with Magnolia Health before requesting a state administrative hearing.

Provider Appeal

If you are requesting that Magnolia reviews the payment determination, the request must be submitted in writing and mailed or delivered no later than 30 calendar days of receipt of the payment determination to the address below:

Centene
Attn: SIU Records Unit
1370 Timberlake Manor Parkway
Chesterfield, MO 63017
Fax: (877) 851-3996

What happens next?

Upon receipt of your appeal letter and supporting documents, Magnolia will acknowledge your appeal request within ten (10) calendar days. Magnolia will review the payment determination, and any additional information submitted to support your request and make every effort to provide an appeal resolution notice on your appeal in writing no later than (30) calendar days of receipt. If you are not satisfied with the results of the provider appeal process, you have the right to request a Medicaid state administrative hearing.

State Administrative Hearing

You may request a state administrative hearing after you have completed the Magnolia provider appeal process and received Magnolia's results of the provider appeal. A state administrative hearing is conducted with the DOM. An appeal that is not resolved wholly in favor of the provider by the contractor may be appealed by the provider or the provider's authorized representative to the DOM for a state administrative hearing. To request a state administrative hearing, you must submit the request in writing to the Mississippi DOM within thirty (30) calendar days from the date of the notice. Please write to:

Mississippi Division of Medicaid
Attn: Appeals
550 High Street, Suite 1000 Jackson, MS 39201
Phone: 601-359-6050 or 800-884-3222
Fax: 601-359-9153

Some of the most common WAF submissions are

- Unbundling of codes
- Upcoding
- Add-on codes without primary CPT
- Diagnosis and/or procedure code not consistent with the member's age and/or gender
- Use of exclusion codes
- Excessive use of units
- Misuse of benefits
- Claims for services not rendered

If you suspect or witness a provider inappropriately billing or a member receiving inappropriate services, please call our anonymous and confidential hotline at 1-866-685-8664. Magnolia and Centene take all reports of potential WAF very seriously and investigate all reported issues.

AUTHORITY AND RESPONSIBILITY

Magnolia's Director of Compliance and Regulatory Affairs has overall responsibility and authority for carrying out the provisions of Magnolia's compliance program. Magnolia is committed to identifying, investigating, sanctioning, and prosecuting suspected WAF. Magnolia's providers will cooperate fully in making personnel and/or subcontractor personnel available in person for interviews, consultations, grand jury proceedings, pre-trial conferences, hearings, trials, and in any other processes, including investigations.

Audits/Monitoring Review Overview

1. Audits/Monitoring reviews will involve the examination of the provider's medical and/or financial records. Providers must maintain appropriate documentation in the member's medical or healthcare service records to verify the level, type, and extent of services provided. Providers must:
    - Keep legible, accurate, and complete charts and records to justify the services provided to each member.
    - Assure charts are authenticated by the person who gave the order, provided the care, or performed the observation, examination, assessment, treatment, or other service to which the entry pertains, and make charts and records available to Medicaid staff, other state and federal agencies, and its contractors thereof, upon request. Records shall be maintained in accordance with MS Administrative Code, Part 200, Chapter 1, Rule 1.3.
2. A provider's bill for services, appointment books, accounting records, or other similar documents alone do not qualify as appropriate documentation for services rendered.
3. If a provider fails to participate or comply with Magnolia's audit process or unduly delays the audit process, the provider's actions, or lack thereof, are considered as abandonment of the audit.
4. If Magnolia suspects a provider of fraud, abusive practice, or audit abandonment, or if Magnolia suspects the provider presents a risk of imminent danger to members, Magnolia shall take one or more of the actions listed below:
    - Immediately issue a final report
    - Terminate the provider's agreement with Magnolia
    - Refer the provider to the Mississippi DOM for the appropriate actions which may include an investigation conducted by the Medicaid Fraud Control Unit (MFCU), a division of the Mississippi State Attorney General's Office

QUALITY IMPROVEMENT

Magnolia's culture, systems, and processes are structured around its mission to improve the health of its members. The Quality Improvement (QI) program utilizes a systematic approach to quality, employing reliable and valid methods of monitoring, analysis, evaluation, and improvement in the delivery of healthcare provided to all members, including those with special needs. This system provides a continuous cycle for assessing the quality of care and service among plan initiatives, including preventive health, acute and chronic care, behavioral health, over- and under-utilization, continuity and coordination of care, patient safety, and administrative and network services. This includes the implementation of appropriate interventions and the designation of adequate resources to support these interventions. Magnolia requires all practitioners and providers to cooperate with all QI activities and allow Magnolia to use practitioner and/or provider performance data to ensure success of the QAPI program.

Magnolia recognizes its legal and ethical obligations to provide members with a level of care that meets recognized professional standards and is delivered in the safest, most appropriate settings. To that end, Magnolia will provide for the delivery of quality care with the primary goal of improving the health status of its members. When a member's condition is not amenable to improvement, Magnolia will implement measures to prevent any further decline in condition or deterioration of health status or will provide for comfort measures as appropriate and as requested by the member. This will include the identification of members at risk of developing certain conditions, the implementation of appropriate interventions, and the designation of adequate resources to support the interventions. Whenever possible, the Magnolia QI program supports these processes and activities that are designed to achieve demonstrable and sustainable improvement in the health status of its members.

PROGRAM STRUCTURE

Magnolia's Board of Directors (BOD) has the ultimate authority, responsibility, and accountability for the oversight of the quality of care and services provided to members. The BOD oversees the QI program and has established various standing and ad hoc committees to monitor and support it.

The Quality Improvement Committee (QIC) is a senior management committee, with provider representation, that is directly accountable to the BOD. The purpose of the QIC is to provide oversight and direction in assessing the appropriateness of care and to continuously enhance and improve the quality of care and services provided to members. This is accomplished through a comprehensive, plan-wide system of ongoing, objective, and systematic monitoring; the identification, evaluation, and resolution of process problems; the identification of opportunities to improve member outcomes; and the education of members, providers, and staff regarding the QI, UM, and Credentialing programs.

The following sub-committees report directly to the QIC:

- Credentialing Committee
- UM Committee
- Performance Improvement Team
- Member and Community Advisory Committees
- Peer Review Committee (ad hoc committee)

PRACTITIONER INVOLVEMENT

Magnolia recognizes the integral role provider involvement plays in the success of its QI program. Provider involvement in various levels of the process is highly encouraged through provider representation.
Magnolia encourages PCP, behavioral health, specialty, and OB-GYN representation on its key quality committees, such as the QIC, the Credentialing Committee, and select ad hoc committees.

QUALITY IMPROVEMENT PROGRAM SCOPE AND GOALS

The scope of the QI program is comprehensive and addresses the quality of both clinical care and other services provided to Magnolia's members. Magnolia's QI program integrates all demographic groups, care settings, and services in QI activities, including preventive care, primary care, specialty care, acute care, short-term care, long-term care, ancillary services, and Magnolia's operations.

Magnolia's primary QI goal is to improve members' health status through a variety of meaningful QI activities, implemented across all care settings, and aimed at improving quality of care and services delivered.
To that end, the Magnolia QI program monitors the following:

- Compliance with preventive health guidelines and practice guidelines
- Acute and chronic care management
- Provider network adequacy and capacity
- Selection and retention of providers (credentialing and recredentialing)
- Behavioral healthcare and Magnolia benefits
- Delegated entity oversight
- Continuity and coordination of care
- UM, including under- and over-utilization
- Compliance with member confidentiality laws and regulations
- Employee and provider cultural competency
- Provider appointment availability
- Provider and Magnolia after-hours telephone accessibility
- Member satisfaction
- Provider satisfaction
- Member grievance system
- Provider complaint system
- Member enrollment and disenrollment
- PCP changes
- Department performance and service
- Patient safety
- Pharmacy
- Marketing practices

PERFORMANCE IMPROVEMENT PROCESS

Magnolia's QIC reviews and adopts an annual Quality Improvement Program and work plan, based on appropriate industry standards. The QIC adopts traditional quality/risk/utilization management approaches to problem identification with the objective of identifying improvement opportunities. Most often, initiatives are selected based on data that indicates the need for improvement in a particular clinical or non-clinical area and includes targeted interventions that have the greatest potential for improving health outcomes or service.

Performance improvement projects, focused studies, and other QI initiatives are designed and implemented in accordance with principles of sound research design and appropriate statistical analysis. Results of these studies are used to evaluate the appropriateness and quality of care and services delivered against established standards and guidelines for the provision of that care or service. Each QI initiative is also designed to allow Magnolia to monitor improvement over time.

Annually, Magnolia develops a Quality Assessment Performance Improvement (QAPI) work plan for the upcoming year. The QAPI work plan serves as a working document to guide QI efforts on a continuous basis. The work plan integrates QI activities, reporting, and studies from all areas of the organization (clinical and service) and includes timelines for completion and reporting to the QIC, as well as requirements for external reporting. Studies and other performance measurement activities and issues to be tracked over time are scheduled in the QAPI Work Plan.

Magnolia communicates activities and outcomes of its QI program to both members and providers via the member newsletter, the provider newsletter, and the Magnolia web portal at www.magnoliahealthplan.com.

At any time, Magnolia providers may contact the Magnolia QI Department to request additional information regarding Magnolia programs, including a description of the QI program and a report on Magnolia's progress in meeting the QAPI program goals.

HEALTHCARE EFFECTIVENESS DATA AND INFORMATION SET (HEDIS)

HEDIS is a set of standardized performance measures, developed by the National Committee for Quality Assurance (NCQA), which allows comparison across health plans. HEDIS gives purchasers and consumers the ability to distinguish between health plans based on comparative quality instead of simply on cost differences. HEDIS rates demonstrate the effectiveness of a health insurance company's efforts to improve preventive health outreach to its members.
HEDIS reporting is a required part of both NCQA Health Plan Accreditation and Magnolia's contract with DOM for the provision of coordinated care services within the MississippiCAN program.

As state and federal governments move toward a healthcare industry that is driven by quality, HEDIS rates are becoming more and more important, not only to Magnolia, but to its providers as well.

HOW ARE HEDIS RATES CALCULATED?

HEDIS rates can be calculated in two (2) ways, via administrative data or hybrid data, as follows:

1. Administrative data consists of claim or encounter data submitted to the health plan. Measures typically calculated using administrative data include mammogram, annual chlamydia screening, pap test, appropriate treatment of asthma, cholesterol management, antidepressant medication management, access to PCP services, and utilization of acute and mental health services.
2. Hybrid data consists of both administrative data and a sample of medical record data. Hybrid data requires the review of a random sample of member medical records to extract data for services rendered but that were not reported to the health plan through claims/encounter data. Accurate and timely claim/encounter data and submission of appropriate CPT II codes can reduce the necessity of medical record reviews. (See Magnolia's website and the HEDIS brochure for more information on reducing HEDIS medical record reviews.) Measures typically requiring medical record review include diabetic HgA1c testing and results, controlling high blood pressure, post- partum care, immunizations, and colorectal cancer screening.

WHAT CAN BE DONE TO IMPROVE MY HEDIS SCORES?

- Understand the specifications established for each HEDIS measure.
- Submit claim/encounter data for every service rendered. All providers must bill (or report by encounter submission) for services delivered, regardless of contract status. Claim/ encounter data is the cleanest and most efficient way to report HEDIS. If services are not billed, or not billed accurately, they are not included in the calculation. Accurate and timely submission of claim/encounter data will positively reduce the number of medical record reviews required for HEDIS rate calculation.
- Ensure chart documentation reflects all services provided.
- Bill CPT II codes related to HEDIS measures such as diabetes, eye exam, and blood pressure.
- Submit a claim for all diagnoses and comorbidities for each visit, not just one diagnosis. Exclusions apply to certain comorbidities or coexisting conditions.
- Have members come in for head-to-toe physicals each year, capturing all conditions, surgeries, and procedures for an accurate overall picture of health.
- Ensure that members have plenty of refills on their medications and that they are taking all medications properly and as prescribed.

If you have any questions, comments, or concerns related to the annual HEDIS project or the medical record reviews, please contact the Magnolia QI Department at 1-877-236-0751.

Examples of HEDIS measures for Body Mass Index (BMI) and Nutrition/Physical Counseling are as follows:
ICD-10 Codes to report BMI percentiles:

Age Range	ICD-10 Diagnosis	Description
Pediatric	Z68.51	BMI less than 5th percentile for age
	Z68.52	BMI between 5th percentile to 85th percentile for age
	Z68.53	BMI between 85th percentile to less than 95th percentile for age
	Z68.54	BMI greater than or equal to 95th percentile for age
Adult	Z68.1	BMI less than 19
	Z68.20-Z68.24	BMI between 20 – 24
	Z68.25-Z68.29	BMI between 25 – 29 (requires 5th digit)
	Z68.30-Z68.39	BMI between 30 – 39 (requires 5th digit)
	Z68.4-Z68.54	BMI between 40 and over (requires 5th digit)

Example Coding for Nutrition and Physical Activity Counseling:

CPT		ICD-10	CHPCS Diagnosis	Procedure
Nutrition Counseling	97802-97804	Z71.3		S9470, S9452, S9449, G0270-G0271 G0447
	Z68.52	BMI between 5th percentile to 85th percentile for age	93.11, 93.13, 93.19, 93.31	S9451, H2032 G0447

Call Magnolia to refer a member for our Weight Management Program.

PROVIDER SATISFACTION SURVEY

Magnolia conducts an annual provider satisfaction survey that includes questions to evaluate provider satisfaction with our services, such as claims, communications, UM, and provider relations. The survey is conducted by an external vendor. Participants meeting specific requirements determined by Magnolia are randomly selected by the vendor.
All participants are kept anonymous. We encourage you to respond to the survey timely, as the results of the survey are analyzed and used as a basis for forming provider-related QI initiatives.

CONSUMER ASSESSMENT OF HEALTHCARE PROVIDER AND SYSTEMS (CAHPS) SURVEY

The CAHPS survey is a member satisfaction survey that is included as a part of HEDIS and NCQA accreditation. It is a standardized survey administered annually to members by an NCQA-certified survey vendor. The survey provides information on the experiences of Magnolia members with the health plan and provider services and gives a general indication of how well Magnolia is meeting members' expectations. Member responses to the CAHPS survey are used in various aspects of the QI program, including monitoring of provider access and availability.

MEDICAL RECORD REVIEW

MEDICAL RECORDS

Magnolia providers must keep accurate and complete medical records. Such records will enable providers to render the highest quality healthcare service to members. They will also enable Magnolia to review the quality and appropriateness of the services rendered. To ensure each member's privacy, medical records should be kept in a secure location. Magnolia requires providers to maintain records for ten (10) years for adult patients and thirteen (13) years for minors. See the Member Rights section of this Provider Manual for policies on member access to medical records.

REQUIRED INFORMATION

Medical Records, as used herein, is defined as the complete, comprehensive member record, including, but not limited to, X-rays, laboratory tests, results, examinations, and notes that: are accessible at the site of the member's PCP or provider; document all medical services received by the member, including inpatient, ambulatory, ancillary, and emergency care; are prepared in accordance with all applicable state rules and regulations; and are signed by the medical professional rendering the services.

Providers must maintain complete medical records for members in accordance with the following standards:

- Member's name and/or medical record number is/are found on all chart pages.
- Personal/biographical data is present (i.e., employer, home telephone number, spouse, next of kin, legal guardianship, primary language, etc.).
- Prominent notation of any spoken-language translation or communication assistance is included.
- All entries must be legible and maintained in detail.
- All entries must be dated and signed or dictated by the provider rendering the care.
- Significant illnesses and/or medical conditions are documented on the problem list, along with all past and current diagnoses.
- Medications, allergies, and adverse reactions are prominently documented in a uniform location in the medical record. If there are no allergies, "no known allergies" (NKA) or "no known drug allergies" (NKDA) should be documented.
- An up-to-date immunization record is established for pediatric members, or an appropriate history is made in the chart for adults.
- Evidence that preventive screening and services are offered in accordance with Magnolia Practice Guidelines is documented.
- Appropriate subjective and objective information pertinent to the member's presenting complaints is documented in the history and physical.
- For adults, past medical history (for members seen three (3) or more times) is easily identified and includes any serious accidents, operations and/or illnesses, discharge summaries, and ER encounters.
- For children and adolescents (nineteen (19) years and younger), past medical history relating to prenatal care, birth, any operations, and/or childhood illnesses is included.
- Working diagnosis is consistent with findings.
- Treatment plan is appropriate for diagnosis.
- Treatment prescribed, therapy prescribed, and drug(s) administered or dispensed, including instructions to the member, are documented.
- Documentation of prenatal risk assessment for pregnant women or infant risk assessment for newborns is included.
- Required consent forms are signed and dated.
- Unresolved problems from previous visits are addressed in subsequent visits and documented.
- Laboratory, and other studies ordered as appropriate, are documented.
- Abnormal lab and imaging study results have explicit notations in the record for follow-up plans; all entries should be initialed by the PCP to signify review.
- Referrals to specialists and ancillary providers are documented, including follow-up of outcomes and summaries of treatment(s) rendered elsewhere, including family planning services, preventive services, and services for the treatment of sexually transmitted diseases.

- Health teaching and/or counseling is documented.
- For members ten (10) years and over, appropriate notations are included concerning use of tobacco and alcohol and substance use (for members seen three (3) or more times, substance abuse history should be queried).
- Documentation of failure to keep an appointment is included.
- Encounter forms or notes have a notation, when indicated, regarding follow-up care calls or visits. The specific time of return should be noted as weeks, months, or as needed.
- Evidence that the member is not placed at inappropriate risk by a diagnostic or therapeutic problem is documented.
- Confidentiality of member information and records is protected.
- Evidence that an advance directive has been offered to adults eighteen (18) years of age and older is documented.

MEDICAL RECORDS RELEASE

All member medical records shall be confidential and shall not be released without the written authorization of the covered person or a responsible covered person's legal guardian. When the release of medical records is appropriate, the extent of that release should be based upon medical necessity or on a need-to-know basis.

MEDICAL RECORDS TRANSFER FOR NEW MEMBERS

All PCPs are required to document in the member's medical record attempts to obtain historical medical records for all newly assigned Magnolia members. If the member or member's guardian is unable to remember where they obtained medical care, or if they are unable to provide addresses of the previous providers, then this should also be noted in the medical record. When a member changes his or her PCP, the member's medical records must be made available to the new PCP within fourteen (14) business days from receipt of the request.

MEDICAL RECORDS AUDITS

Magnolia will conduct random medical record audits as part of its QI program to monitor compliance with the medical record documentation standards noted herein. The coordination of care and services
provided to members, including over- and under-utilization of specialists, as well as the outcomes of such services, may also be assessed during a medical record audit.

Access to Records and Audits by Magnolia Health

Subject only to applicable state and federal confidentiality or privacy laws, provider shall permit Magnolia Health or its designated representative access to provider's records, at provider's place of business during normal business hours, or remote access to such records, in order to audit, inspect, review, perform chart reviews, and duplicate such records. If performed on site, access to records for the purpose of an audit shall be scheduled at a mutually agreed-upon time, upon at least thirty (30) business days prior written notice by Magnolia Health or its designated representative, but not more than sixty (60) days following such written notice.

EMR Access

Provider will grant Magnolia Health access to Provider's Electronic Medical Record (EMR) system in order to effectively case manage members and capture medical record data for risk adjustment and quality reporting. There will be no fees charged to Magnolia Health for this access.

Preventive Health and Clinical Practice Guidelines

Preventive health and clinical practice guidelines are based on the health needs and opportunities for improvement identified as part of the Quality Assessment Performance Improvement (QAPI) program. Whenever possible, Magnolia Health adopts preventive and clinical practice guidelines that are published by nationally recognized organizations or government institutions, as well as statewide collaborative efforts and/or a consensus of healthcare professionals in the applicable field. Annually, Magnolia monitors practitioner adherence to these guidelines through review of our HEDIS measures, such as, but not limited to, diabetes care, prenatal and postpartum care, childhood immunizations, and annual child wellness exams. For a full list of preventive health and clinical practice guidelines, please visit our website www.magnoliahealthplan.com. Select For Providers, Provider Resources, QI Program, and Practice Guidelines.

PROVIDER RELATIONS DEPARTMENT

Provider Relations Department

Magnolia's Provider Relations department is designed to equip providers with an advocate within Magnolia. Provider relations representatives are responsible for providing services including, but not limited to, those listed below:

- Build strong working relationships with providers
- Assist in the resolution of operational issues
- Share and disseminate best practices
- Promote mutual values and goals
- Ongoing provider education, updates, and training
- Development of alternative reimbursement strategies
- Education on claim denial trends
- Network performance profiling
- Individual provider performance profiling
- Provider and office staff orientation
- Practice Performance

The goal of this department is to furnish you and your staff with the necessary tools to provide the highest quality of healthcare to Magnolia members. To speak with the Provider Relations representative for your area, contact Provider Services at 1-877-236-0751. Provider Relations representatives work as your partner to make certain that you receive the assistance you need to ensure that Magnolia satisfactorily meets its obligations to you and your practice

REASONS TO CONTACT A PROVIDER RELATIONS REPRESENTATIVE

1. To schedule an in-service training for new staff.
2. To conduct ongoing education for existing staff.
3. To obtain clarification of policies and procedures.
4. To request fee schedule information.
5. To assist with claims, enrollment, credentialing, and all other areas
6. To learn how to use electronic solutions for web authorizations, claims submissions, and to check member eligibility.

BILLING AND CLAIMS SUBMISSION

General Billing Guidelines

Magnolia is required by state and federal regulations to capture specific data regarding services rendered to its members. The provider must adhere to all billing requirements to ensure timely processing of claims and to avoid unnecessary rejections and/or denials. Claims will be rejected or denied if not submitted correctly. In general, Magnolia follows the CMS (Centers for Medicare & Medicaid Services) billing requirements. For questions regarding billing requirements, contact a Magnolia Provider Services representative at 1-877-236-0751.

ENCOUNTERS

Providers are required to submit an encounter or claim for each service that they render to a Magnolia member. A claim is an electronic or paper request for reimbursement of any medical service and must be filed on the proper form, such as the CMS 1500 or UB-04. Claims will be paid, rejected, or denied, and, for each claim processed, an EOP will be mailed or sent electronically PaySpan to the provider who submitted the original claim. In the case of a claim denial, the reason for said denial will be provided in the EOP.

An encounter is a contact between a patient and a practitioner who has primary responsibility for assessing and treat-ing the patient. Encounters occur in many different settings, including ambulatory care, emergency care, home healthcare, in the field, or virtually (telemedicine). Magnolia captures encounter data – information showing use of provider services by health plan enrollees – through provider claims for reimbursement.

When required data elements are missing or are invalid, claims will be rejected or denied by Magnolia for correction and resubmission.

- Rejections happen prior to the claims being received in the claims adjudication system and will be sent to the pro-vider with a letter detailing the reason for the rejection.
- Denials happen once the claim has been received into the claims adjudication system and will be sent to the provider via an Explanation of Payment (EOP).

Claims for billable services provided to Magnolia members must be submitted by the provider who performed the services or by the provider's authorized billing vendor.

To avoid delays in processing of a CMS 1500, providers must bill with their NPI number in box 24Jb, their taxonomy code in box 24Ja, their group NPI in box 33a, and their taxonomy code in box 33b. To avoid delays in processing of a UB-04, providers must include the appropriate bill type in box 4, their tax identification number in box 5, the ad-mission date in box 12, and the group NPI in box 56. Claims missing required information will be returned with a notice sent to the provider, thus creating payment delays.

Such claims are not considered "clean" and therefore cannot be accepted into our system.

Claims eligible for payment must meet the following non-exhaustive list of requirements*:

- The member is effective on the date of service.
- The service provided is a covered benefit under the member's contract on the date of service, and prior authoriza-tion processes are followed.
- Payment for services is contingent upon compliance with referral and prior authorization policies and procedures, as well as the billing guidelines outlined in the guide

*Please note that payment is contingent upon compliance with referral and prior authorization policies and proce-dures, as well as the billing guidelines outlined in this Provider Manual.

** Providers are responsible for confirming Magnolia member eligibility and verifying the identity of the person presenting the Magnolia ID at the time of service. Providers are recommended to verify member eligibility using the DOM's MESA provider portal or by contacting Magnolia Health at 1-877-236-0751.

Who Can File Claims?

All providers who have rendered services for Magnolia members can file claims. It is important that providers ensure Magnolia has accurate and complete information on file. Please confirm with the Provider Services department or your dedicated Provider Relations Representative that the following information is current in our files:

1. Provider Name (as registered with Gainwell);
2. National Provider Identifier (NPI);
3. Group National Provider Identifier (NPI) (if applicable);
4. Tax Identification Number (TIN);
5. Taxonomy code (This is a REQUIRED field when submitting a claim);
6. Service Facility Location (as registered with Gainwell)
7. Physical location address (as registered with Gainwell); and
8. Billing name and address (as noted on current W-9 form).

We recommend that providers notify Magnolia at least thirty (30) days in advance of changes pertaining to billing information. Updates can be submitted through our website's Demographic Update Tool at www.magnoliahealthplan.com/providers/resources/demographic-update-tool.html.

To prevent claim payment delays or denials, it is recommended that providers verify that the Tax ID and NPI number on file with Magnolia match the ones on file with DOM.

CLEAN CLAIM DEFINITION

Clean claims are claims received by Magnolia for adjudication, in a nationally accepted format, in compliance with standard coding guidelines, and which require no further information, adjustment, or alteration by the provider of the services, to be pro-cessed and paid by Magnolia.

NON-CLEAN CLAIM DEFINITION

Non-clean claims are submitted claims that require further documentation or development beyond the information contained therein. In addition, non-clean claims may involve issues regarding medical necessity and may include claims not submitted within the filing dead-lines. The errors or omissions in a claim will result in a request for additional information from the provider or other external sources, to resolve or correct any data omitted from the bill, review of additional medical records, or the need for other information necessary to resolve discrepancies.

CLAIM PAYMENT

Clean claims will be adjudicated (finalized as paid or denied) at the following levels:

- 90% within thirty (30) business days of receipt of clean claims
- 99% within ninety (90) business days of receipt of clean claims

Claim payments will be contingent upon Magnolia receiving their monthly reimbursement from DOM.

REJECTIONS VS DENIALS

Upfront Rejection

A rejection is defined as an unclean claim that contains invalid or missing data elements re-quired for acceptance of the claim into the claim processing system. These data elements are identified in the Companion Guide located on the website at www.magnoliahealthplan.com. A list of common upfront rejections is located below. All pa-per claims sent to the claims office must first pass specific minimum edits prior to ac-ceptance. Claim records that do not pass these minimum edits are invalid and will be rejected.

Denial

If all minimum edits pass and the claim is accepted, it will then be entered into the system for processing. A denial is defined as a claim that has passed minimum edits and is entered into the system for processing, but has been billed with invalid or inappropriate information, causing the claim to deny. An EOP (Explanation of Payment) will be sent that includes the denial reason. A list of common delays and denials is located below, and a more comprehensive list with explanations is included in Attachment A.

TIMELY FILING

Initial Claims		Claim Reconsiderations		Coordination of Benefits	
Calendar Days		Calendar Days		Calendar Days	
Par	Non-Par	Par	Non-Par	Par	Non-Par
180 days	180 days	90 days	90 days	90 days from the primary payer's EOP date to the date received	90 days from the primary payer's EOP date to the date received

- **Initial Claims**- Days are calculated from the Date of Service (DOS) to the date received by Magnolia or from the EOP date. For observation and inpatient stays, the date is calculated from the date of discharge.
- **Claim Reconsiderations/Corrected Claims** - Days are calculated from the date of the Explanation of Payment issued by Magnolia to the date received.
- **Coordination of Benefits**- Days are calculated from the date of Explanation of Payment from the primary payers to the date received.

Please note that these timely filing deadlines apply to both paper and electronic claims.

ELECTRONIC CLAIMS SUBMISSION

Providers are encouraged to participate in Magnolia's electronic claims/encounter filing program. Magnolia has the capability to receive an ANSI X12N 837 professional, institutional, or encounter transaction. In addition, Magnolia can generate an ANSI X12N 835 electronic remittance advice known as an Explanation of Payment (EOP).

Magnolia Health
c/o Centene EDI Department
1-800-225-2573, extension
6075525 or via email at
EDIBA@centene.com

Providers may also reference www.magnoliahealthplan.com for a complete listing of Magnolia's clearinghouse partners.

Providers who bill electronically are responsible for filing claims within the same filing deadlines as providers filing paper claims.

Providers who bill electronically must monitor their error reports and evidence of payments to ensure all submitted claims and encounters appear on the reports. Providers are responsible for correcting any errors and resubmitting the affiliated claims and encounters.

Magnolia can receive coordination of benefits (COB or secondary) claims electronically.

The **Magnolia Payer ID** for Medical services is **68069** and for Behavioral Health Services is **68068**.

Providers that bill electronically must monitor their error reports and EOPs to ensure all submitted claims and encounters appear on the reports. Providers are responsible for correcting any errors and resubmitting the relevant claims and encounters.

Important steps to successful submission of EDI claims

1. Select a clearinghouse to utilize.
2. Contact the clearinghouse to inform them you wish to submit electronic claims to Magnolia.
3. Inquire with the clearinghouse as to what data records are required.
4. Verify with your Magnolia Provider Services representative that the provider is set up in the Magnolia system before submitting EDI claims.
5. You will receive two (2) reports from the clearinghouse. ALWAYS review these reports daily. The first report shows the claims that were accepted by the clearinghouse and transmitted to Magnolia and those claims not meeting the clearinghouse requirements. The second report will be a claim status report showing claims accepted and rejected by Magnolia. ALWAYS review the acceptance and claim status reports for rejected claims. If rejections are noted, you must correct and resubmit them.
6. MOST importantly, all claims must be submitted with the provider's identifying numbers. See the CMS 1500 (8/05) and UB-04 claim form instructions and claim forms for details.

EXCLUSIONS

Certain claims are excluded from electronic QX billing. Please see the table below:

Excluded Claim Categories
Claim records requiring supportive documentation or attachments. Note: COB claims can be filed electronically, but if they are not, the primary payer EOB must be submitted with the paper claim.
Claim records billing with miscellaneous codes.
Claim records for medical, administrative, or claim appeals.
Claim requiring documentation of the receipt of an informed consent form.
Claim for services that are reimbursed based on purchase price (e.g. custom DME, prosthetics).
Provider is required to submit the invoice with the claim.
Claim for services needing documentation and requiring Certificate of Medical Necessity (e.g., oxygen, motorized wheelchairs).

NOTE: Provider ID number validation is not performed at the clearinghouse level. The clearinghouse will reject claims for provider information only if the provider number fields are empty.

ONLINE CLAIM SUBMISSION

For participating providers Magnolia has made it easy and convenient to submit claims via our website at www.magnoliahealthplan.com.

You must request access to our secure site by registering for a username and password and requesting claims access. To obtain an ID, please contact Provider Services at 1-877-236-0751, your designated Provider Relations Representative, or visit our website at www.magnoliahealthplan.com.

Once you have access to the secure Provider Portal, you may view web claims and reopen and continue working on saved, un-submitted claims. This feature also allows you to track the status of claims, submit corrected claims, claim reconsiderations, and claim appeals. For more information on electronic filing and which clearinghouses Magnolia has partnered with, contact:

EFT and ERA

Magnolia has partnered with PaySpan to provide an innovative web-based solution for Electronic Funds Transfers (EFTs) and Electronic Remittance Advices (ERAs). Through this free service, providers can settle claims electronically. For more information, please visit the provider home page on our website at www.magnoliahealthplan.com. Or, to sign up for this quick and efficient service, you may go directly to www.payspanhealth.com.

PAPER CLAIMS SUBMISSION

Please submit clean claims on a CMS-1500 Form or a CMS-1450 Form ("UB-04") or their successors. A Clean Claim is one in which every line item is completed in its entirety.

Medical Providers:

Magnolia Health
ATTN: CLAIMS DEPARTMENT
P.O. Box 3090
Farmington, MO 63640-3825

Behavioral Health Providers:

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

REQUIREMENTS

Magnolia uses an imaging process for paper claims retrieval. To ensure accurate and timely claims capture, please observe the following claims submission rules:

Do's:

- Do submit all dates of service and birthdates in the MM/DD/YYYY format.
- Do use the correct P.O. Box number or address.
- Do submit all claims in a 9" x 12" or larger envelope.
- Do type all fields completely and correctly.
- Do use typed black or blue ink only at 9-point font or larger.
- Do include all other insurance information (policy holder, carrier name, ID number, and address), when applicable.
- Do attach the EOP from the primary insurance carrier when applicable.
- Note: Magnolia can receive primary insurance carrier EOP [electronically].
- Do submit on a proper original form- CMS 1500 or UB-04.

Don'ts

- Don't submit handwritten claim forms.
- Don't use red ink on claim forms.
- Don't circle any data on claim forms.
- Don't add extraneous information to any claim form field.
- Don't use highlighter on any claim form field.
- Don't submit photocopied claim forms (no black and white claim forms).
- Don't submit carbon copied claim forms.
- Don't submit claim forms via fax.
- Don't submit claims to Magnolia Health's Jackson, MS office – use P.O. Box 3090 Farmington, MO 63640-3825

ACCEPTABLE CLAIM FORMS

Magnolia accepts the CMS 1500 (02/12) and CMS 1450 (UB-04) paper claim forms. Other claim form types will be rejected upfront and returned to the provider.

Professional providers and medical suppliers complete the CMS 1500 (02/12) form, and institutional providers complete the CMS 1450 UB-04 claim form. Magnolia does not supply claim forms to providers; providers should purchase these from a supplier of their choice. If you have questions regarding what type of form to complete, contact a Magnolia Provider Services representative at 1-877-236-0751.

See Attachment C for CMS 1500 claim form instructions, including a table that outlines each field within the form.

IMPORTANT STEPS TO SUCCESSFUL SUBMISSION OF PAPER CLAIMS

1. Providers must file claims using standard claims forms (CMS 1450 (UB-04) for hospitals and facilities, CMS 1500 for physicians or practitioners).
2. Complete all required fields on an original, red CMS 1500 (Version 02/12) or CMS 1450 (UB-04) Claim Form. NOTE: Non-red, nonstandard, and handwritten claim forms will be rejected back to the provider.
3. Enter the provider's NPI number in the "Rendering Provider ID#" section of the CMS 1500 form (see box 24J).
4. Providers must include their Rendering and Group taxonomy code (e.g., 207Q00000X for Family Practice) and corresponding ID qualifier in this section for correct processing of claims.
5. Ensure all Diagnosis Codes, Procedure Codes, Modifier, Location (Place of Service); Type of Bill, Type of Admission, and Source of Admission Codes are valid for the date of service. Refer to Ambetter Taxonomy (PDF) located on our website www.ambetter.magnoliahealthplan.com
6. Ensure all Diagnosis and Procedure Codes are appropriate for the age of sex of the member.
7. Ensure all Diagnosis Codes are coded to their highest number of digits available.
8. Ensure member is eligible for services during the time in which services were provided.
9. Ensure provider receives authorization to provide services to the eligible member, when appropriate.
10. Ensure an authorization is given for services that require prior authorization by Ambetter.
11. Providers billing CLIA services on a CMS 1500 paper form must enter the CLIA number in Box 23 of the CMS 1500 form.
12. Ensure all paper claim forms are typed or printed with either 10- or 12-point Times New Roman font. Do not use highlights, italics, bold text, ink stamps, or staples for multiple page submissions.
13. Ensure print is properly aligned on the form. Magnolia utilizes OCR software to convert paper forms to EDI transactions and improperly aligned information may not process correctly and result in a rejected claim.

Claims missing the necessary requirements are not considered "clean claims" and will be returned to providers with a written notice describing the reason for return.

DURABLE MEDICAL EQUIPMENT AND MANUAL PRICING

Magnolia Health uses two (2) methods for manual pricing:

A. Most manually priced items are priced at the Manufacturer's Suggested Retail Price (MSRP) minus twenty percent (20%).

1. It is expected that most items will have a retail price; therefore, providers should request MSRP pricing for all manually priced items unless there is absolutely no retail price.
2. Other acceptable terms that represent MSRP include suggested list price, retail price, or price.
3. The provider must submit clear, written, dated documentation from a manufacturer or distributor that specifically states the MSRP for the item. This documentation must be provided with an offi- cial manufacturer's or distributor's letterhead, price list, catalog page, or other forms that clearly show the MSRP. Please highlight or place an asterisk by the item being billed.
4. A manufacturer's or distributor's quote may be substituted for an MSRP if the manufacturer does not make an MSRP available. The quote must be in writing from the manufacturer or distributor and must be dated.

B. Items that do not have a fee or MSRP may be priced at the provider's cost plus twenty percent (20%).

1. The provider must attach a copy of a current invoice indicating the cost to the provider for the item dispensed and a statement that there is no MSRP available for the item. Please highlight or place an asterisk by the item being billed.
2. If the provider purchases from the manufacturer, a manufacturer's invoice must be provided.
3. If the provider purchases from a distributor and not directly from the manufacturer, the invoice from the distributor must be provided.
4. Quotes, price lists, catalog pages, computer printouts, or any form of documentation other than an invoice are not acceptable for this pricing solution.
5. The invoice must not be older than one (1) year prior to the date of the request. Exceptions to the one (1) year requirement may be approved only for unusual circumstances.

SPAN BILLING

Magnolia requires claim statements that cover from/through dates to be split by date of service on each claim line with the actual units billed per day, see Example 1. Date span billing, as seen in Example 2, will result in improper claim payment or claim denial.

Example 1: Acceptable billing

	MM	DD	YY	MM	DD	YY	SERVICE	EMG	CPT/HCPCS	MODIFIER			POINTER	$ CHARGES		UNITS	Plan	QUAL
1	07	09	19				12		S9123	TG			ABCD	1440	00	24		NPI
2	07	10	19				12		S9123	TG			ABCD	900	00	15		NPI
3																		NPI

Example 2: The below billing will result in claim denial or incorrect claim payment when date span billed.

	24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER			E. DIAGNOSIS POINTER	F. $ CHARGES		G. DAYS OR UNITS	H. EPSDT Family Plan	I. QU
1	07	30	19	08	08	19	12		S9123	TG			AB	10640	00	152		NI
2																		

All claims filed with Magnolia are subject to verification procedures. These include, but are not limited to, verification of the following:

- All required fields are completed on an original CMS 1500, UB-04 paper claim form, or EDI electronic claim format.
- All diagnosis, procedure, modifier, location (place of service), revenue, type of admission, and source of admission codes are valid for the date of service.
- All diagnosis, procedure, modifier, and location (place of service) codes are valid for provider type/specialty billing.
- All diagnosis, procedure, and revenue codes are valid for the age and/or sex for the date of the service billed.
- All diagnosis codes are to their highest number of digits available (4th or 5th digit).
- Principal diagnosis billed reflects an allowed principal diagnosis, as defined in the current volume of ICD-10 CM or ICD-10 CM update for the date of service billed, for dates of service on or after October 1, 2015.
- Member is eligible for services under Magnolia during the time period in which services were provided.
- Services have been provided by a participating provider, and authorization has been received to provide services to the eligible member (excludes services by an “out of network” provider for an emergency medical condition; however, authorization requirements apply for post-stabilization services).
- An authorization has been given for services that require prior authorization by Magnolia.
- Medicare coverage or other third-party coverage.

THIRD-PARTY LIABILITY

Third-party liability refers to any other health insurance plan or carrier (e.g., individual, group, employer- related, self-insured or self-funded, commercial carrier, automobile insurance, and worker’s compensation) or program that may be liable to pay all or part of the healthcare expenses of the member.

Magnolia providers shall make reasonable efforts to determine the legal liability of third parties to pay for services furnished to Magnolia members. If the provider is unsuccessful in obtaining necessary cooperation from a member to identify potential third-party resources, the provider shall inform Magnolia that efforts have been unsuccessful. Magnolia will make every effort to work with the provider to determine liability coverage.

If third-party liability coverage is determined after services are rendered, Magnolia will coordinate with DOM on eligibility requirements for members identified as having another carrier, which could impact members’ eligibility with Magnolia.

BILLING THE MEMBER

Magnolia reimburses only services that are medically necessary and covered through MSCAN. Providers can bill a member only if they provide proof that they attempted to obtain member insurance ID information within sixty (60) calendar days of service. Provider is not allowed to "balance bill" for covered services if the provider's usual and customary charge for covered services is greater than the provider's contracted rate. Providers may bill members for services NOT covered by Magnolia or not authorized by Magnolia.

There are limited circumstances in which a provider may bill a Magnolia member. A provider may bill a member for services NOT covered by Magnolia, not authorized by Magnolia, or those denied as not being medically necessary. If the member wishes to receive services that are not covered by Magnolia Health, it is the provider's responsibility to ensure that the member has reviewed and signed an Advanced Beneficiary notice. Additionally, a provider may bill a member if the member has exceeded the program limitations for a particular service. A provider may only bill a Magnolia member if the following condition is met:

Prior to the service being rendered, the provider has obtained and kept a written member acknowledgement statement signed by the member stating, "I understand that, in the opinion of (provider's name), the services or items that I have requested to be provided to me on (dates of service) may not be deemed reasonable and medically necessary for my care and therefore may not be covered. I understand that Magnolia, through its contract with the DOM, determines the medical necessity of the services or items that I request and receive. I also understand that I am responsible for payment for the services or items I request and receive if these services or items are determined not to be reasonable and medically necessary for my care."

CORRECTED CLAIMS

All corrected claims, must be received within ninety (90) calendar days from the date the notification of payment or denial is issued.

Submit a corrected claim to: Medical Provider:

Magnolia Health
ATTN: Corrected Claim
P.O. Box 3090
Farmington, MO 63640-3800

Behavioral Health Provider:

Magnolia Health
ATTN: Behavioral Health Corrections
P.O. Box 7600
Farmington, MO 63640

The paper claim submission must clearly be marked as "RESUBMISSION" and must include the original claim number, or the original EOP must be included with the resubmission. Handwritten claims will not be accepted and will be rejected.

Failure to mark the claim as a resubmission and include the original claim number (or include the EOP) may result in the claim being denied as a duplicate, a delay in the reprocessing, or denial for exceeding the timely filing limit. Handwritten claims will not be accepted and will be rejected.

If the corrected claim results in an adjusted claim, the provider will receive a revised Explanation of Payment (EOP).

CLAIM DISPUTE PROCESS

Claim Reconsideration

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.

Reason for Claim Reconsideration:

- Claim was denied for no authorization, but authorization was obtained.
- Claim was denied for no authorization, but no authorization is required for this service.
- Claim was denied for untimely filing in error (proof of timely filing should be attached).
- Claim was paid to wrong provider.
- Claim was paid for incorrect amount.

Claims filed within the appropriate time frame may be resubmitted for reconsideration via mail or the secure Provider Portal. Magnolia's secure Provider Portal is the preferred method for submission, correction, reconsideration, and appeal of a claim. Reconsiderations should be written communication outlining the disagreement. Reconsiderations should be submitted to Magnolia within ninety (90) days from the date of denial.

Medical Provider Mailing Addresses:

Magnolia Health
Attn: Claim Reconsideration
PO Box 3090
Farmington, MO 63640-3800

Behavioral Health Provider Mailing Address:

Magnolia Health
Attn: BH Claim Reconsideration
PO Box 7600
Farmington, MO 63640-384

If the claim reconsideration results in an adjustment, the provider will receive a revised Explanation of Payment (EOP). If the original decision is upheld, the provider will receive a revised EOP or letter detailing the decision and steps for a claim appeal.

Provider Appeals, Administrative Hearing, Complaint and Grievance Process

Claim Appeal
A claim appeal is a written request for review of an adverse benefit determination and must be accompanied by the claim appeal form which can be obtained at www.magnoliahealthplan.com.

The claim appeal should be filed within thirty (30) calendar days of receiving Magnolia's notice of adverse benefit determination.

How to Submit a Claim Appeal
Medical and Behavioral Health providers can submit claim appeals through the secure provider portal, mail, or fax.

Medical providers may submit their claim appeal to:

Magnolia Health Claim Appeal
P.O. Box 3090
Farmington, MO 63640-3825

Behavioral Health Provider Claim Appeal Mailing Address:

Magnolia Health
Attn: BH Appeals
PO Box 6000
Farmington, MO 63640-3809

Medical and Behavioral Health Provider Claim Appeal Fax Number: (833) 950-3857

A claim appeal acknowledgment letter will be issued to the provider within ten (10) days of receipt. A resolution letter will be issued to the provider within thirty (30) days of receipt. If the claim appeal results in an adjustment, the provider will receive a revised Explanation of Payment (EOP) and a letter detailing the results of the appeal. If the original decision is upheld, the provider will receive a revised EOP and letter detailing the decision and steps for a state fair hearing.

INSTRUCTIONS FOR SUPPLEMENTAL INFORMATION

The following types of supplemental information are accepted in a shaded claim line of the CMS 1500 (02/12) form field 24A-G:

- Anesthesia duration in hours and/or minutes with begin (start) and end times
- Narrative description of unspecified/miscellaneous/unlisted codes
- National Drug Codes (NDC) for drugs
- Vendor Product Number – Health Industry Business Communications Council (HIBCC)
- Product Number Healthcare Uniform Code Council – Global Trade Item Number (GTIN), formerly Universal Product Code (UPC) for products
- Contract rate

The following qualifiers are to be used when reporting these services:

7	Anesthesia information
CTR	Contract rate
ZZ	Narrative description of unspecified/miscellaneous/unlisted codes
ZZ	National Drug Codes (NDC)

The following qualifiers are to be used when reporting NDC units:

F2	International Unit
GR	Gram
ME	Milligram
ML	Milliliter
UN	Unit
OZ	Product Number Healthcare Uniform Code Council- Global Trade Item Number (GTIN)
VP	Vendor Product Number- Health Industry Business Communications Council (HIBCC) Labeling Standard

To enter supplemental information, begin at 24A by entering the qualifier and then the information. Do not enter a space between the qualifier and the supplemental information. Do not enter hyphens or spaces within the NDC, HIBCC, or GTIN number/code.

When reporting a service that does not have a qualifier, enter two blank spaces before entering the information.
More than one (1) supplemental item can be reported in a single shaded claim line IF the information is related to the unshaded claim line item it is entered on. When entering more than one (1) supplemental item, enter the first qualifier at the start of 24A followed by the number, code, or other information. Do not enter a space between the qualifier and the supplemental information. Do not enter hyphens or spaces within the NDC, HIBCC, or GTIN number/code. After the entry of the first supplemental item, enter three (3) blank spaces and then the next qualifier and number, code, or other

information. Do not enter a space between the qualifier and the supplemental information. Do not enter hyphens or spaces within the NDC, HIBCC, or GTIN number/code.

Examples:

Anesthesia

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
7Begin 1315 End 1445 Time 90 minutes										NPI	

Unlisted, Non-specific, or Miscellaneous CPT or HCPCS Code

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
ZZLaparoscopic Ventral Hernia Repair Op Note Attached										NPI	

NDC

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
N455513019001 Pegfilgrastim ML 0.6										NPI	

Vendor Product Number - HIBCC

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
VPA123ABC7D9E1F										NPI	

Unlisted, Non-specific, or Miscellaneous CPT or HCPCS Code Product Number Healthcare Uniform Code Council - GTIN

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
OZ01234567891112										NPI	

No qualifier - More Than One (1) Supplemental Item

When filing for anesthesia services on the CMS 1500 (02/12) claim form, apply the following guidelines:

Enter the correct CPT anesthesia code from the 00100 through 01999 range in box 24d.
The correct number of anesthesia time units must be entered in box 24g. One minute of anesthesia time will equal one unit.

Reporting NDC on CMS 1500 Claim Form

The NDC is used to report prescribed drugs and biologics when required by government regulation, or as deemed by the provider to enhance the claim reporting/adjudication process. The NDC for each service being billed should be entered in the shaded section of 24.

NDC should be entered in the shaded sections of item 24A through 24G. To enter NDC information, begin at 24A by entering the qualifier N4 and then the 11-digit NDC number. Do not enter a space between the qualifier and the eleven (11) digit NDC number. Do not enter a hyphen or space within the number/code.

The following qualifiers are used when reporting NDC units:

F2 – International unit GR – Gram
ML – Milliliter
UN – Unit

Example of entering the identifier N4 and the NDC number on the CMS 1500 (02/12) claim form:

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
N400026064871 Immune Globulin Intravenous									UN2					1B	12345678901
10	01	05	10	01	05	11		J1563		13	500 00	20	N	NPI	0123456789

Hospital Billing

DRG Methodology

Magnolia uses an APR-DRG payment method to reimburse inpatient hospital services. Magnolia's goal is to promote access to care, reward efficiency, enable clarity, and minimize administrative burden for Magnolia and our hospital providers.

Every inpatient stay is assigned a single DRG that reflects the typical resource use of that case. Payments are based solely on the DRG billed for the patient's stay in the facility, regardless of length of stay or additional services rendered. Magnolia's DRG calculator is based off of the same metrics, including base rates, outlier methods, and groupers, currently used by the Mississippi DOM:

- RELATIVE WEIGHT FOR THAT DRG X BASE PRICE = DRG BASE PAYMENT

Other questions regarding inpatient stays, prior authorizations, or claims payments can be directed to:

Magnolia Provider Services
Phone #: 1-877-236-07511-866-912-6285
Fax #: 1-866-480-3227
www.magnoliahealthplan.com
Hospital Claim Form

A UB-04 is the only acceptable claim form for submitting inpatient or outpatient hospital technical service charges for reimbursement by Magnolia. In addition, a UB-04 is required when billing for nursing home services, swing bed services with revenue and occurrence codes, inpatient hospice services, ambulatory surgery centers (ASC), and dialysis services. Incomplete or inaccurate information will result in the claim/encounter being rejected or denied.

Practitioners employed by or contracted with a hospital (e.g., hospitalists, lab directors, etc.) may not bill individually for services rendered to Magnolia beneficiaries. This includes services provided in the ER by practitioners employed on a full-time or part-time basis by the hospital and other practitioners employed by or under a contractual arrangement with the hospital. The hospital must bill for these services on the HCFA-1500 with the practitioner's individual NPI number as the servicing provider and the hospital's group NPI provider number as the billing provider.

Completing a UB-04 Claim Form

A UB-04 is the only acceptable claim form for submitting inpatient or outpatient hospital (including hospital-based ASCs and technical services) charges for reimbursement by Magnolia. Additionally, the following provider types should bill using the UB-04 claim form:

- Dialysis Centers
- Home Health Agencies
- Hospice Providers
- Nursing Facilities
- Swing-Bed Facilities
- Surgical Centers

Please see Attachment D for a sample UB-04 claim form. Please see Attachment E for UB-04 claim form instructions, including a table outlining each field within the form.

UB-04 Inpatient/Outpatient Documentation

The following information should be submitted along with the UB-04:

- Consent forms for hysterectomies, abortions, and sterilizations
- Specific additional information, upon request by Magnolia

Exceptions: Please refer to your provider contract with Magnolia or to the DOM Provider Administrative Code for revenue codes that do not require a CPT code.

CODING OF CLAIMS

Magnolia requires claims to be submitted using codes from the current version of ICD-10 CM, CPT-4, and HCPCS Level II for the date the service was rendered. These requirements may be amended to comply with federal and state regulations as necessary. Claims will be rejected or denied if billed with:

- Missing, invalid, or deleted codes
- Codes inappropriate for the age or sex of the member
- An ICD-10 CM code missing the 4th or 5th digit

For more information regarding billing codes, coding, and code auditing and editing, please see below, or contact a Magnolia Provider Services representative at 1-877-236-0751.

CPT® CATEGORY II CODES

CPT Category II Codes are supplemental codes developed to assist in the collection and reporting of information regarding performance measurement, including HEDIS. Submission of CPT Category II Codes allows data to be captured at the time of service, thus reducing the need for retrospective medical record review.

Use of these codes is optional; Category II Codes are not required for correct coding and may not be used as a substitute for Category I Codes. However, as noted above, submission of these codes can minimize the administrative burden on providers and health plans by greatly decreasing the need for medical record review.

CODE EDITING

Magnolia uses code-auditing software to assist in improving accuracy and efficiency in claims processing, payment, and reporting. The software will detect, correct, and document coding errors on provider claims prior to payment by analyzing CPT, HCPCS, ICD-10 modifier, and place of service codes against rules that have been established by the American Medical Association (AMA), the Center for Medicare and Medicaid Services (CMS), the State of Mississippi, public- domain specialty society guidance, and clinical consultants who research, document, and provide edit recommendations based on the most common clinical scenario. Claims which are billed in a manner that does not adhere to these standard coding conventions will be denied. Magnolia may request medical records or other documentation to verify that all procedures and/or services billed are properly supported in accordance with correct coding guidelines.

Code editing software contains a comprehensive set of rules and addresses coding inaccuracies, such as unbundling, fragmentation, upcoding, duplication, invalid codes, and mutually exclusive procedures.

The software offers a wide variety of edits that are based on:

- Centers for Medicare and Medicaid Services' (CMS) National Correct Coding Initiative (NCCI) which includes column 1/column 2, mutually exclusive and outpatient code editor (OCE0 edits). In addition to using the AMA's CPT manual, the NCCI coding policies are based on national and local policies and edits, coding guidelines developed by national societies, analysis of standard medical and surgical practices, and a review of current coding practices.
- Clinical consultants who research, document, and provide edit recommendations based on the most common clinical scenario.
- In addition to nationally recognized coding guidelines, the software has added flexibility to its rule engine to allow business rules that are unique to the needs of individual product lines.

CODE AUDITING ASSISTANT

A web-based code auditing reference tool, designed to "mirror" how Magnolia code auditing product(s) evaluate code combinations during the auditing of claims, is available for participating providers. This allows Magnolia to share the claim auditing rules and clinical rationale we use to pay claims with our contracted providers. The code auditing reference tool is accessible by registering for Magnolia's secure Provider Portal at www.magnoliahealthplan.com.

Magnolia may request medical records or other documentation to assist in the determination of medical necessity, appropriateness of the coding submitted, or review of the procedure billed.

The code auditing assistant is intended for use as a "what if" or hypothetical reference tool. It is meant to apply coding logic only. The tool does not take into consideration historical claims information that may have been used to determine an edit. The tool assumes all CPT codes are billed on a single claim. Further, the tool will not take into consideration individual fee schedule reimbursement, authorization requirements, or other coverage considerations.

This tool offers many benefits:

- Prospectively access the appropriate coding and supporting clinical edit clarifications for services before claims are submitted.
- Proactively determine the appropriate code or code combination representing the service for accurate billing purposes.
- The tool will review what was entered and will determine if the code or code combinations are correct based on the age, sex, location, modifier (if applicable), and other code(s) entered.

The Code Editing Assistant is intended for use as a "what if" or hypothetical reference tool. It is meant to apply coding logic only. The tool does not take into consideration historical claims information which may be used to determine if an edit is appropriate.

The code editing assistant can be accessed from the Secure Provider Portal.

Disclaimer: This tool is used to apply coding logic only. It will not consider individual fee schedule reimbursement, authorization requirements, or other coverage considerations. Whether a code is reimbursable or covered is separate and outside of the intended use of this tool.

The following provides conditions where the software will make a change on submitted codes:

Unbundling of Services – identifies procedures that have been unbundled.

Example: Unbundling lab panels- If component lab codes are billed on a claim along with a more comprehensive lab panel code that more accurately represents the service performed, the software will bundle the component codes into the more comprehensive panel code. The software will also deny multiple claim lines and replace those lines with a single, more comprehensive panel code when the panel code is not already present on the claim.

Code	Description	Status
80053	Comprehensive Metabolic Panel	Disallow
85025	Complete CBC, automated differential WBC count	Disallow
84443	Thyroid Stimulating Hormone	Disallow
80050	General Health Panel	Allow

Explanation: 80053, 85025 and 84443 are included in the lab panel code 80050 and therefore are not separately reimbursable. Those claim lines containing the component codes are denied and only the comprehensive lab panel code is reimbursed.

Example: Bilateral surgery – bilateral surgeries are identical procedures performed on bilateral anatomical sites during the same operative session.

Code	Description	Status
69436 DOS=01/01/10	Tympanostomy	Disallow
69436 50 DOS=01/01/10	Tympanostomy billed with modifier 50 (bilateral procedure)	Allow

Explanation: Software identifies the same code being billed twice, when reimbursement guidelines require the procedure to be billed once with a bilateral modifier. These should be billed on one line along with modifier 50 (bilateral procedure).
Note: Modifiers RT (right) or LT (left) should not be billed for bilateral procedures.
Example: Duplicate services – The submission of the same procedure more than once on the same date for services that cannot be or are not normally performed more than once on the same date.

Code	Description	Status
72010	Radiologic exam, spine, entire, survey study, anteroposterior & lateral	Allow
72010	Radiologic exam, spine, entire, survey study, anteroposterior & lateral	Disallow

Explanation: Procedure 72010 includes radiologic examination of the lateral and anteroposterior views of the entire spine that allow views of the upper cervical vertebrae, the lower cervical vertebrae, the thoracic vertebrae, the lumbar vertebrae, the sacrum, and the coccyx. It is clinically unlikely that this procedure would be performed twice on the same date of service.

Example: Evaluation and Management Services – The submission of an evaluation and management (E/M) service either within a global surgery period or on the same date of service of another E/M service.

Global Surgery- Procedures that are assigned a ninety (90) day global surgery period are designated as major surgical procedures; those assigned a ten (10) day or zero (0) day global surgery period are designated as minor surgical procedures.

- Evaluation and management services, submitted with major surgical procedures ninety (90) day and minor surgical procedures ten (10) day, are not recommended for separate reporting or reimbursement because they are part of the global service.
- Evaluation and management services, submitted with minor surgical procedures zero (0) day, are not recommended for separate reporting or reimbursement because these services are part of the global service, unless otherwise indicated.

Example: Global surgery period

Code	Description	Status
27447 DOS=05/20/09	Arthroplasty, knee, condoyle and plateau; medial and lateral compartments with or without patella resurfacing (total knee arthroplasty).	Allow
99213 DOS=06/02/09	Office or other outpatient visit for the evaluation and management of an EST patient, which requires at least two of these three key components: an expanded, problem-focused history; an expanded, problem-focused examination; medical decision-making of low complexity. Counseling and coordination of care w/other providers or agencies are provided consistent w/nature of problem(s) and patient's and/or family's needs. Problem(s) are low/moderate severity. Physicians spend 15 min face-to-face w/patient and/or family.	Disallow

Explanation: Procedure code 27447 has a global surgery period of ninety (90) days. When a substantial diagnostic or therapeutic procedure is performed, the evaluation and management service is included in the global surgical period. Procedure code 99213 is submitted with a date of service that is within the ninety (90) day global period.

Example: Evaluation and management service is submitted with minor surgical procedures.

Code	Description	Status
11000 DOS=01/23/10	Debridement of extensive eczematous or infected skin; up to 10% of body surface.	Allow
99213 DOS=01/23/10	Office or other outpatient visit for the evaluation and management of an EST patient, which requires at least two of these three key components: an expanded, problem-focused history; an expanded, problem-focused examination; medical decision-making of low complexity. Counseling and coordination of care with other providers or agencies are provided consistent w/nature of problem(s) and patient's and/or family's needs. Problem(s) are low/moderate severity. Physicians spend fifteen (15) minutes face-to-face with patient and/or family.	Disallow

Explanation: Procedure 11000 (zero (0) day global surgery period) is identified as a minor procedure.

Procedure 99213 is submitted with the same date of service. When a minor procedure is performed, the evaluation and management service is considered part of the global service.

Example: Same date of service- one (1) evaluation and management service is recommended for reporting on a single date of service.

Code	Description	Status
99215	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a comprehensive history, a comprehensive examination, medical decision-making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent w/nature of problem(s) and patient's and/or family's needs. Usually, problem(s) are moderate/high severity. Physicians spend forty (40) minutes face-to-face with patient and/or family.	Allow
99242	Office consultation for a new or established patient, which requires these three key components: an expanded, problem-focused history, an expanded, problem-focused examination, and straightforward medical decision-making. Counseling/ coordination of care with other providers or agencies are provided consistent with nature of problem(s) and patient's/ family's needs. Presenting problem(s) are low severity. Physicians spend thirty (30) minutes face-to-face with patient/family.	Disallow

Explanation: Procedure 99215 is used to report an evaluation and management service provided to an established patient during a visit. Procedure 99242 is used to report an office consultation for a new or established patient. Separate reporting of an evaluation and management service with an office consultation by a single provider indicates a duplicate submission of services. Interventions provided during an evaluation and management service typically include the components of an office consultation.

NOTE:
Modifiers- Modifiers are added to the main service or procedure code to indicate that the service has been altered in some way by a specific circumstance.

Modifier-24 is used to report an unrelated evaluation and management service by the same physician during a post-operative period.

Modifier-25 is used to report a significant, separately identifiable evaluation and management service by the same physician on the same day of a procedure.

Modifier-79 is used to report an unrelated procedure or service by the same physician during the post- operative period. When modifiers-24 and-25 are submitted with an evaluation and management service on the same date of service or during the post-operative period by the same physician, the evaluation and management service is questioned and a review of additional information is recommended.

When modifier-79 is submitted with an evaluation and management service on the same date of service or during the post-operative period by the same physician, separate reporting of the evaluation and management service is recommended.

Modifier-26 (professional component)
Definition: Modifier-26 identifies the professional component of a test or study.

- If modifier-26 is not valid for the submitted procedure code, the procedure code is not recommended for separate reporting.
- When a claim line is submitted without the modifier-26 in a facility setting (for example, POS 21, 22, 23, 24), the rule will replace the service line with a new line with the same procedure code and the modifier-26 appended.

Example:

Code	Description	Status
78278 POS=Inpatient	Acute gastrointestinal blood loss imaging	Disallow
78278-26 POS=Inpatient	Acute gastrointestinal blood loss imaging	Allow

Explanation: Procedure code 78278 is valid with modifier-26. Modifier-26 will be added to procedure code 78278 when submitted without modifier-26.

Modifier-80,-81,-82, and-AS (assistant surgeon).

Definition: This edit identifies claim lines containing procedure codes billed with an assistant surgeon modifier that typically do not require an assistant surgeon.

Many surgical procedures require aid in prepping and draping the patient, monitoring visualization, keeping the wound clear of blood, holding and positioning the patient, and assisting with wound closure and/or casting (if required). This assistance does not require the expertise of a surgeon. A qualified nurse, orthopedic technician, or resident physician can provide the necessary assistance.

Example:

Code	Description	Status
42820-81	Tonsillectomy and adenoidectomy; under age 12	Disallow

Explanation: Procedure code 42820 is not recommended for assistant surgeon reporting because a skilled nurse or surgical technician can function as the assistant in the performance of this procedure.

ATTACHMENTS A-F

BILLING CODES

It is important that providers bill with codes applicable to the date of service on the claim. Billing with obsolete codes will result in a potential denial of the claim and a consequent delay in payment. Submit professional claims with current and valid CPT, HCPCS, or ASA codes and ICD-10 codes. Submit institutional claims with valid revenue codes and CPTor HCPCS (when applicable), ICD-10 codes, and DRG codes (when applicable).

Providers will also improve the efficiency of their reimbursement through proper coding of a member's diagnosis. We require the use of valid ICD-10 diagnosis codes, to the ultimate specificity, for all claims.
This means that ICD-10 codes must be carried out to the 4th or 5th digit when indicated by the coding requirements in the ICD-10 manual. (Note: not all codes require a 4th or 5th digit.) Failure to code diagnoses to the appropriate level of specificity will result in denial of the claim and a consequent delay in payment.

In addition, written descriptions, itemized statements, and invoices may be required for non-specific types of claims or at the request of Magnolia.

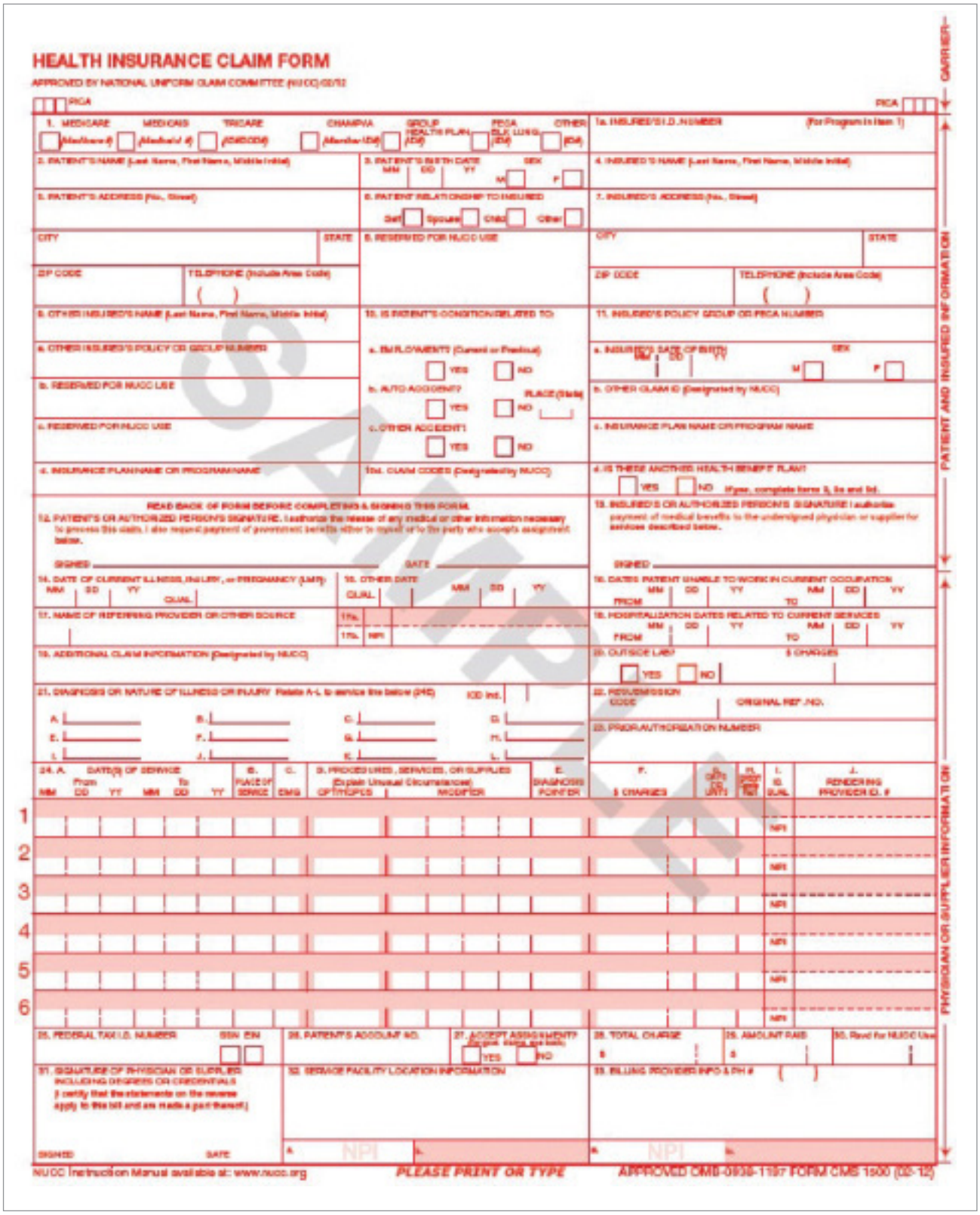
ATTACHMENT A: EXAMPLES OF DENIAL CODES AND DENIAL CODE DESCRIPTIONS

Denial Code	Denial Description
07	DENY: THE PROCEDURE CODE IS INCONSISTENT WITH THE PATIENT'S SEX
09	DENY: THE DIAGNOSIS IS INCONSISTENT WITH THE PATIENT'S AGE
10	DENY: THE DIAGNOSIS IS INCONSISTENT WITH THE PATIENT'S SEX
16	DENY: REVENUE CODE NOT REIMBURSABLE- CPT/HCPCS CODE REQUIRED
18	DENY: DUPLICATE CLAIM/SERVICE
1K	DENY: CPT OR DX CODE IS NOT VALID FOR AGE OF PATIENT
1L	DENY: VISIT & PREVEN CODES ARE NOT PAYABLE ON SAME DOS W/O DOCUMENTATION
20	DENY: THIS INJURY IS COVERED BY THE LIABILITY CARRIER
21	DENY: CLAIM THE RESPONSIBILITY OF THE NO-FAULT CARRIER
22	DENY: THIS CARE IS COVERED BY A COORDINATION OF BENEFITS CARRIER
23	DENY: CHARGES HAVE BEEN PAID BY ANOTHER PARTY- COB
24	DENY: CHARGES COVERED UNDER CAPITATION
25	DENY: YOUR STOP LOSS DEDUCTIBLE HAS NOT BEEN MET
26	DENY: EXPENSES INCURRED PRIOR TO COVERAGE
27	DENY: EXPENSES INCURRED AFTER COVERAGE WAS TERMINATED
28	DENY: COVERAGE NOT IN EFFECT WHEN SERVICE PROVIDED
29	DENY: THE TIME LIMIT FOR FILING HAS EXPIRED
35	DENY: BENEFIT MAXIMUM HAS BEEN REACHED
3D	DENY: NON-SPECIFIC DIAGNOSIS- REQUIRES 4TH DIGIT, PLEASE RESUBMIT
46	DENY: THIS SERVICE IS NOT COVERED
48	DENY: THIS PROCEDURE IS NOT COVERED
4D	DENY: NON-SPECIFIC DIAGNOSIS- REQUIRES 5TH DIGIT, PLEASE RESUBMIT
6L	EOB INCOMPLETE- PLEASE RESUBMIT WITH REASON OF OTHER INSURANCE DENIAL
86	DENY: THIS IS NOT A VALID MODIFIER FOR THIS CODE
99	DENY: MISC/UNLISTED CODES CAN NOT BE PROCESSED W/O DESCRIPTION/ REPORT
9I	INFORMATION REQUESTED WAS NOT RECEIVED WITHIN THE TIME FRAME SPECIFIED
A1	DENY: AUTHORIZATION NOT ON FILE
BG	DENY: TYPE OF BILL MISSING OR INCORRECT ON CLAIM, PLEASE RESUBMIT

BI	DENY: CLAIM CANNOT BE PROCESSED WITHOUT AN ITEMIZED BILL
C2	CPT HAS BEEN REBUNDLED ACCORDING TO CLAIM AUDIT
C6	CPT HAS BEEN REPLACED ACCORDING TO CLAIM AUDIT
C8	CPT HAS BEEN DENIED ACCORDING TO CLAIM AUDIT
CV	DENY: BILL WITH SPECIFIC VACCINE CODE
	DENY: SIGNED CONSENT FORM HAS NOT BEEN RECEIVED
DJ	DENY: INAPPROPRIATE CODE BILLED, CORRECT AND RESUBMIT
DS	DENY: DUPLICATE SUBMISSION- ORIGINAL CLAIM STILL IN PEND STATUS
DT	DENY: PLEASE FORWARD TO THE DENTAL VENDOR FOR PROCESSING
DW	DENY: INAPPROPRIATE DIAGNOSIS BILLED, CORRECT AND RESUBMIT
DX	DIAGNOSIS BILLED IS INVALID, PLEASE RESUBMIT WITH CORRECT CODE
DY	DENY: APPEAL DENIED
DZ	DENY: SERVICE HAS EXCEEDED THE AUTHORIZED LIMIT
EB	DENY: DENIED BY MEDICAL SERVICES
EC	DIAGNOSIS CANNOT BE USED AS PRIMARY DIAGNOSIS, PLEASE RESUBMIT
FP	DENY: CLAIMS DENIED FOR PROVIDER FRAUD
GL	SERVICE COVERED UNDER GLOBAL FEE AGREEMENT
H1	DENY: PROVIDER MUST USE HCPCS/CPT FOR CORRECT PRICING
HL	DENY: CLAIM AND AUTH LOCATIONS DO NOT MATCH
HP	DENY: CLAIM AND AUTH SERVICE PROVIDER DO NOT MATCH
HQ	DENY: EDI CLAIM MUST BE SUBMITTED IN HARD COPY W/CONSENT FORM ATTACHED
HS	DENY: CLAIM AND AUTH PROVIDER SPECIALTY DO NOT MATCH
HT	DENY: CLAIM AND AUTH TREATMENT TYPE DO NOT MATCH
I1	OTHER INSURANCE EOB SUBMITTED DOES NOT MATCH BILLED, PLEASE RESUBMIT
I9	DENY: DIAGNOSIS IS AN INVALID OR DELETED ICD9 CODE
IE	CPT NOT REIMBURSED SEPARATELY, INCLUDED AS PART OF INCLUSIVE PROCEDURE
IK	DENY: 2ND EM NOT PAYABLE W/O MODIFIER 25 & MED RECORDS, PLEASE RESUBMIT
IL	VERIFY THE CORRECT LOCATION CODE FOR SERVICE BILLED AND RESUBMIT
IM	DENY: RESUBMIT WITH MODIFIER SPECIFIED BY STATE FOR PROPER PAYMENT
IV	DENY: INVALID/DELETED/MISSING CPT CODE
L0	PLEASE RESUBMIT WITH THE PRIMARY MEDICARE EXPLANATION OF BENEFITS
L6	DENY: BILL PRIMARY INSURER 1ST, RESUBMIT WITH EOB
LO	DENY: CPT & LOCATION ARE NOT COMPATIBLE, PLEASE RESUBMIT
M5	DENY: IMMUNIZATION ADMINISTRATION INCLUDED IN INJECTION FEE
MG	DENY: SIGNATURE MISSING FROM BOX 31, PLEASE RESUBMIT
MH	DENY: PLEASE SUBMIT TO MENTAL HEALTH PLAN FOR PROCESSING
MO	MODIFIER BILLED IS NOT VALID, PLEASE RESUBMIT WITH CORRECT CODE
MQ	DENY: MEMBER NAME/NUMBER/DATE OF BIRTH DO NOT MATCH, PLEASE RESUBMIT
MY	DENY: MEMBER'S PCP IS CAPITATED- SERVICE NOT REIMBURSABLE TO OTHER PCPS
ND	DENY: THIS IS A DELETED CODE AT THE TIME OF SERVICE
NT	DENY: PROVIDER NOT CONTRACTED FOR THIS SERVICE- DO NOT BILL PATIENT
NV	DENY: STERILIZATION CONSENT FORM IS NOT VALID OR IS MISSING INFORMATION
NX	DENY: INVALID OR NO TAX ID NUMBER SUBMITTED ON CLAIM, PLEASE RESUBMIT
OX	DENY: CODE IS CONSIDERED AN INTEGRAL COMPONENT OF THE E/M CODE BILLED
PF	DENY: PROFESSIONAL FEE MUST BE BILLED ON HCFA FORM
RC	DENY: REQUIRED REFERRAL CODE FOR HEALTH CHECK VISIT INVALID OR MISSING

RD	DENY: REVENUE CODE AND DIAGNOSIS ARE NOT COMPATIBLE, PLEASE RESUBMIT
RX	DENY: PLEASE SUBMIT TO THE PHARMACY VENDOR FOR PROCESSING
TM	TO COMPLETE PROCESSING, WE NEED THE TIME UNITS, PLEASE RESUBMIT
U1	CLAIM CANNOT BE PROCESSED WITHOUT MEDICAL RECORDS
U5	DENY: UNLISTED /UNSPECIFIC CODE, RE-BILL MORE SPECIFIC CODE
V3	MED RECORDS RECEIVED FOR WRONG DATE OF SERVICE
V4	MED RECORDS RECEIVED NOT LEGIBLE
V5	MED RECORDS RECEIVED FOR WRONG PATIENT
V6	MED RECORDS WITHOUT LEGIBLE PATIENT NAME AND/OR DOS
V8	MED RECORDS RECEIVED WITHOUT DOS
VC	DENY- PLEASE RESUBMIT ACCORDING TO VACCINES FOR CHILDREN GUIDELINES
VS	DENY: PLEASE SUBMIT TO THE VISION VENDOR FOR PROCESSING
x3	PROCEDURE CODE UNBUNDLED FROM GLOBAL PROCEDURE CODE
x4	PROCEDURE CODE/ICD-9 CODE INCONSISTENT WITH MEMBER'S GENDER
x5	PROCEDURE CODE CONFLICTS WITH MEMBER'S AGE
x6	ADD-ON CODE REQUIRED WITH PRIMARY CODE FOR QUANTITY GREATER THAN ONE
x7	ADD-ON CODE CANNOT BE BILLED WITHOUT PRIMARY CODE
x8	MODIFIER INVALID FOR PROCEDURE OR MODIFIER NOT REPORTED
x9	PROCEDURE CODE PAIRS INCIDENTAL, MUTUALLY EXCLUSIVE, OR UNBUNDLED
xa	CODE IS A COMPONENT OF A MORE COMPREHENSIVE CODE
xb	PROCEDURE CODE NOT ELIGIBLE FOR ANESTHESIA
xc	PROCEDURE/DIAGNOSIS CODE DELETED, INCOMPLETE, OR INVALID
xd	PROCEDURE CODE PREVIOUSLY BILLED ON HISTORICAL CLAIM
xe	PROCEDURE CODE INCONSISTENT WITH MEMBER'S AGE
xf	MAXIMUM ALLOWANCE EXCEEDED
xg	SINGLE/UNILATERAL PROCEDURE SUBMITTED MORE THAN ONCE ON THE SAME DOS
xh	SERVICE LINE REPRESENTS DENIAL OF ADDITIONAL UNITS BILLED
ZC	DENY: PROCEDURE IS INAPPROPRIATE FOR PROVIDER SPECIALTY
xe	PROCEDURE CODE INCONSISTENT WITH MEMBER'S AGE
xf	MAXIMUM ALLOWANCE EXCEEDED
xg	SINGLE/UNILATERAL PROCEDURE SUBMITTED MORE THAN ONCE ON THE SAME DOS
xh	SERVICE LINE REPRESENTS DENIAL OF ADDITIONAL UNITS BILLED
ZC	DENY: PROCEDURE IS INAPPROPRIATE FOR PROVIDER SPECIALTY

ATTACHMENT B: SAMPLE CMS 1500 CLAIM FORM



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | TRICARE (ID/DoD#) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (ID#) | FECA BLK LUNG (ID#) | OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY | SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. RESERVED FOR NUCC USE

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES | NO

a. INSURED'S DATE OF BIRTH MM DD YY | SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES | NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES | NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES | NO If yes, complete items 9, 9a and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES | NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1									NPI	
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES | NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

PATIENT AND INSURED INFORMATION — PHYSICIAN OR SUPPLIER INFORMATION — CARRIER

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM CMS 1500 (02-12)

SAMPLE

ATTACHMENT C: CMS 1500 CLAIM FORM INSTRUCTIONS

The following table outlines each field within a CMS 1500 form. Please note:

- Required fields (indicated as "R") must be completed on all claims. Claims with missing or invalid required field information will be rejected or denied.
- Conditional fields (indicated as "C") must be completed, if the information applies to the situation or the service provided.
- Not Required fields (indicated as "Not Required") do not need to be completed.

Field #	Field Description	Instruction or Comments	Required or Conditional
1	INSURANCE PROGRAM IDENTIFICATION	Check only the type of health coverage applicable to the claim. This field indicated the payer to whom the claim is being field. Enter "X" in the box noted "Other."	R
1a	INSURED'S ID NUMBER	The 9-digit identification number on the member's ID card.	R
2	PATIENT'S NAME (Last Name, First Name, Middle Initial)	Enter the patient's name as it appears on the member's ID card. Do not use nicknames.	R
3	PATIENT'S BIRTH DATE/SEX	Enter the patient's 8-digit date of birth (MM/DD/YYYY) and mark the appropriate box to indicate the patient's sex/ gender. M=Male F=Female	R
4	INSURED'S NAME	Enter the patient's name as it appears on the member's I.D. Card.	C
5	PATIENT'S ADDRESS	(Number, Street, City, State, ZIP Code) Telephone (include area code) Enter the patient's complete address and telephone number, including area code, on the appropriate line. First line – Enter the street address. Do not use commas, periods, or other punctuation in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). Second line – In the designated block, enter the city and state. Third line – Enter the ZIP code and phone number. When entering a 9-digit ZIP code (ZIP+4 codes), include the hyphen. Do not use a hyphen or space as a separator within the telephone number (i.e. (803)5551414). Note: Patient's telephone does not exist in the electronic 837 Professional 4010A1.	C
6	PATIENT'S RELATION TO INSURED	Always mark to indicate self.	C
7	INSURED'S ADDRESS	(Number, Street, City, State, ZIP Code) Telephone (include area code) Enter the patient's complete address and telephone number, including area code, on the appropriate line. First line – Enter the street address. Do not use commas, periods, or other punctuation in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). Second line – In the designated block, enter the city and state. Third line – Enter the ZIP code and phone number. When entering a 9-digit ZIP code (ZIP+4 codes), include the hyphen. Do not use a hyphen or space as a separator within the telephone number (i.e. (803)5551414). Note: Patient's telephone does not exist in the electronic 837 Professional 4010A1.	C
8	RESERVED FOR NUCC USE		Not Required
9	OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	Refers to someone other than the patient. REQUIRED if patient is covered by another insurance plan. Enter the complete name of the insured.	C

9a	*OTHER INSURED'S POLICY OR GROUP NUMBER	REQUIRED if field 9 is completed. Enter the policy or group number of the other insurance plan.	C
9b	RESERVED FOR NUCC USE		Not Required
9c	RESERVED FOR NUCC USE		Not Required
9d	INSURANCE PLAN NAME OR PROGRAM NAME	REQUIRED if field 9 is completed. Enter the other insured's (name of person listed in field 9) insurance plan or program name.	C
10 a, b, c	IS PATIENT'S CONDITION RELATED TO	Enter a Yes or No for each category/line (a, b, and c). Do not enter a Yes and No in the same category/line. When marked Yes, primary insurance information must then be shown in Item Number 11.	R
10d	CLAIM CODES (Designated by NUCC)	When reporting more than one code, enter three blank spaces and then the next code.	C
11	INSURED POLICY OR FECA NUMBER	REQUIRED when other insurance is available. Enter the policy, group, or FECA number of the other insurance. If item numbers 10abc are marked Yes, this field should be populated.	C
11a	INSURED'S DATE OF BIRTH/ SEX	Enter the 8-digit date of birth (MM/DD/YYYY) of the insured and an X to indicate the sex (gender) of the insured. Only one box can be marked. If gender is unknown, leave blank.	C
11b	OTHER CLAIM ID (Designated by NUCC)	The following qualifier and accompanying identifier has been designated for use: Y4 Property Casualty Claim Number FOR WORKERS' COMPENSATION OR PROPERTY & CASUALTY: Required if known. Enter the claim number assigned by the payer.	C
11c	INSURANCE PLAN NAME OR PROGRAM NUMBER	Enter name of the insurance health plan or program.	C
11d	IS THERE ANOTHER HEALTH BENEFIT PLAN	Mark Yes or No. If Yes, complete fields 9a-d and 11c.	R
12	PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE	Enter "Signature on File," "SOF," or the actual legal signature. The provider must have the member's or legal guardian's signature on file or obtain their legal signature in this box for the release of information necessary to process and/or adjudicate the claim.	C
13	INSURED'S OR AUTHORIZED PERSONS SIGNATURE	Obtain signature if appropriate.	Not Required
14	DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR Pregnancy (LMP)	Enter the 6-digit (MM/DD/YY) or 8-digit (MM/DD/YYYY) date of the first date of the present illness, injury, or pregnancy. For pregnancy, use the date of the last menstrual period (LMP) as the first date. Enter the applicable qualifier to identify which date is being reported. 431 Onset of Current Symptoms or Illness 484 Last Menstrual Period	C
15	IF PATIENT HAS SAME OR SIMILAR ILLNESS GIVE FIRST DATE	Enter another date related to the patient's condition or treatment. Enter the date in the 6-digit (MM/DD/YY) or 8-digit (MM/DD/YYYY) format	C
16	DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION		C
17	NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	Enter the name of the referring physician or professional (first name, middle initial, last name, and credentials).	C
17a	ID NUMBER OF REFERRING PHYSICIAN	Required if field 17 is completed, use ZZ qualifier for taxonomy code.	C
17b	NPI NUMBER OF REFERRING PHYSICIAN	Required if field 17 is completed. If unable to obtain referring NPI, servicing NPI may be used.	C
18	HOSPITALIZATION DATES RELATED TO CURRENT SERVICES		C

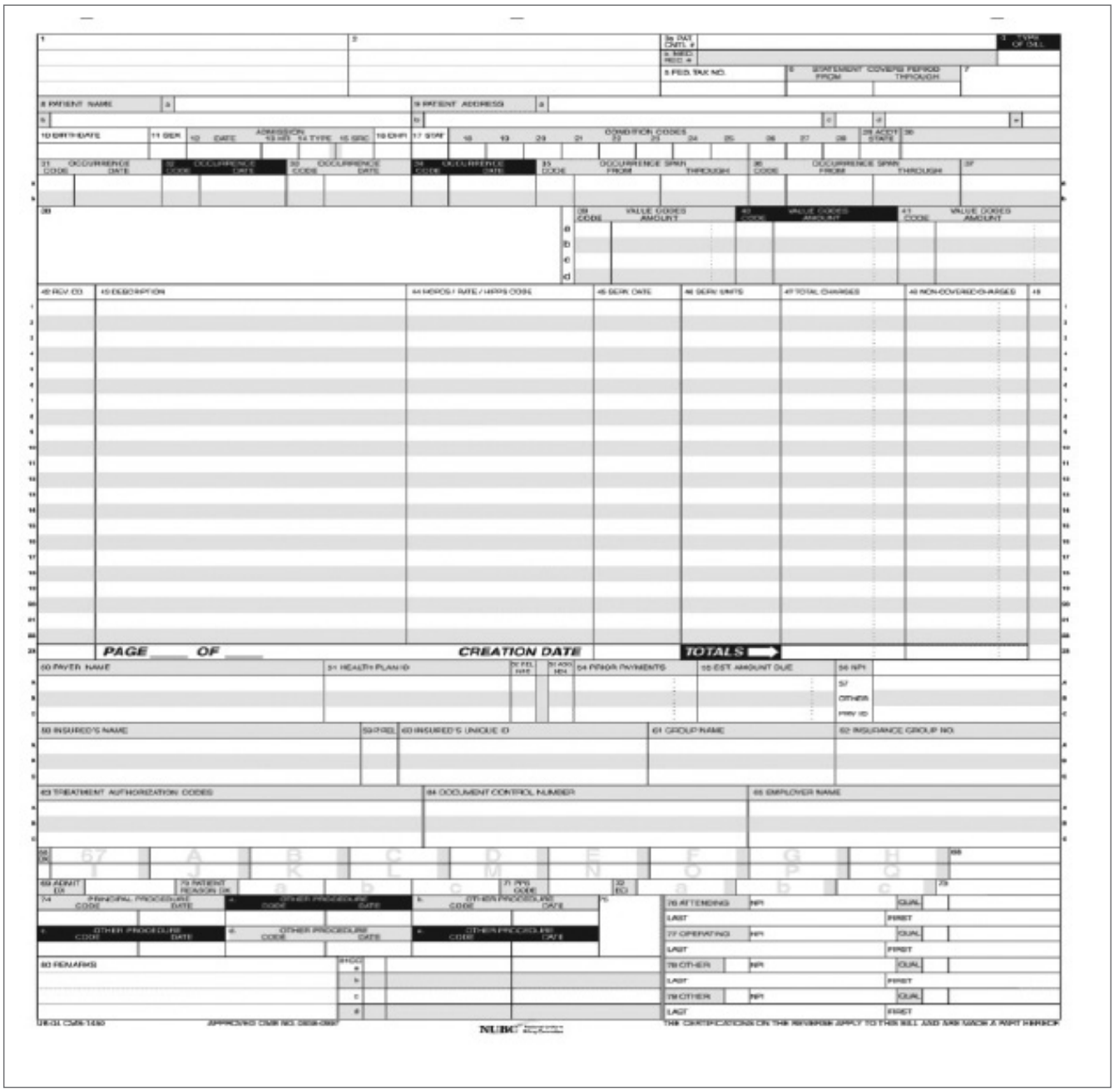
19	RESERVED FOR LOCAL USE – NEW FORM: ADDITIONAL CLAIM INFORMATION		C
20	OUTSIDE LAB/CHARGES		C
21	DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS A-L TO ITEM 24E BY LINE). NEW FORM ALLOWS UP TO 12 DIAGNOSES, AND ICD INDICATOR	Enter the codes to identify the patient's diagnosis and/or condition. List no more than 12 ICD-9-CM or ICD-10-CM diagnosis codes. Relate lines A- L to the lines of service in 24E by the letter of the line. Use the highest level of specificity. Do not provide narrative description in this field. Note: Claims missing or with invalid diagnosis codes will be rejected or denied for payment.	R
22	RESUBMISSION CODE/ ORIGINAL REF. NO.	For resubmissions or adjustments, enter the original claim number of the original claim. New form – for resubmissions only: 7 – Replacement of prior claim 8 – Void/cancel prior claim	R
23	PRIOR AUTHORIZATION NUMBER or CLIA NUMBER	Enter the authorization or referral number. Refer to the Provider Manual for information on services requiring referral and/or prior authorization. CLIA number for CLIA waived or CLIA certified laboratory services	If auth = C If CLIA = R (If both, always submit the CLIA number)
24a-j Gen. Info.	Box 24 contains six claim lines. Each claim line is split horizontally into shaded and unshaded areas. Within each unshaded area of a claim line there are 10 individual fields labeled A-J. Within each shaded area of a claim line there are four individual fields labeled 24A-24G, 24H, 24J, and 24Jb. Fields 24A-24G are a continuous field for the entry of supplemental information. Instructions are provided for shaded and unshaded fields. The shaded area for a claim line is to accommodate the submission of supplemental information, EPSDT qualifier, and provider number. Shaded boxes 24A-24G are for line item supplemental information and provide a continuous line that accepts up to 61 characters. Refer to the instructions listed below for information on how to complete. The unshaded area of a claim line is for the entry of claim line item detail.		
24 A-G Shaded	SUPPLEMENTAL INFORMATION	The shaded top portion of each service claim line is used to report supplemental information for: NDC Narrative description of unspecified codes contract rate For detailed instructions and qualifiers, refer to Appendix IV of this guide.	C
24A Unshaded	DATE(S) OF SERVICE	Enter the date the service listed in field 24D was performed (MM/ DD/YYYY). If there is only one date, enter that date in the "From" field. The "To" field may be left blank or populated with the "From" date. If identical services (identical CPT/HCPCS code(s)) were performed, each date must be entered on a separate line.	R
24B Unshaded	PLACE OF SERVICE	Enter the appropriate 2-digit CMS Standard Place of Service (POS) Code. A list of current POS Codes may be found on the CMS website.	R
24C Unshaded	EMG	Enter Y (Yes) or N (No) to indicate if the service was an emergency.	Not Required

24D Unshaded	PROCEDURES, SERVICES OR SUPPLIES CPT/HCPCS MODIFIER	Enter the 5-digit CPT or HCPCS code and 2-character modifier, if applicable. Only one CPT or HCPCS and up to four modifiers may be entered per claim line. Codes entered must be valid for date of service. Missing or invalid codes will be denied for payment. Only the first modifier entered is used for pricing the claim. Failure to use modifiers in the correct position or combination with the procedure code, or invalid use of modifiers, will result in a rejected, denied, or incorrectly paid claim.	R
24E Unshaded	DIAGNOSIS CODE	In 24E, enter the diagnosis code reference letter (pointer) as shown in Item Number 21 to relate the date of service and the procedures performed to the primary diagnosis. When multiple services are performed, the primary reference letter for each service should be listed first, other applicable services should follow. The reference letter(s) should be A–L or multiple letters as applicable. ICD-9-CM (or ICD-10- CM, once mandated) diagnosis codes must be entered in item number 21 only. Do not enter them in 24E. Do not use commas between the diagnosis pointer numbers. Diagnosis codes must be valid ICD- 9/10 codes for the date of service or the claim will be rejected/denied.	R
24F Unshaded	CHARGES	Enter the charge amount for the claim line item service billed. Dollar amounts to the left of the vertical line should be right justified. Up to eight characters are allowed (i.e. 199,999.99). Do not enter a dollar sign ($). If the dollar amount is a whole number (i.e. 10.00), enter 00 in the area to the right of the vertical line.	R
24G Unshaded	DAYS OR UNITS	Enter quantity (days, visits, units). If only one service provided, enter a numeric value of one.	R
24H Shaded	EPSDT (Family Planning)	Leave blank or enter “Y” if the services were performed as a result of an EPSDT referral.	C
24H Unshaded	EPSDT (Family Planning)	Enter the appropriate qualifier for EPSDT visit.	C
24I Shaded	ID QUALIFIER	Use ZZ qualifier for Taxonomy. Use 1D qualifier for ID, if an atypical provider.	R
24 J Shaded	NON-NPI PROVIDER ID#	Typical providers: Enter the provider taxonomy code that corresponds to the qualifier entered in field 24I shaded. Use ZZ qualifier for taxonomy code. Atypical providers: Enter the provider ID number.	R
24 J Unshaded	NPI PROVIDER ID	Typical providers ONLY: Enter the 10-character NPI ID of the provider who rendered services. If the provider is billing as a member of a group, the rendering individual provider’s 10-character NPI ID may be entered. Enter the billing NPI if services are not provided by an individual (e.g., DME, independent lab, home health, RHC/FQHC general medical exam, etc.).	R
25	FEDERAL TAX ID NUMBER SSN/EIN	Enter the provider or supplier 9-digit Federal Tax ID number and mark the box labeled EIN.	R
26	PATIENT’S ACCOUNT NO.	Enter the provider’s billing account number.	C
27	ACCEPT ASSIGNMENT?	Enter an X in the YES box. Submission of a claim for reimbursement of services provided to a Magnolia recipient using state funds indicates the provider accepts assignment. Refer to the back of the CMS 1500 (02-12) Claim Form for the section pertaining to Payments.	C

28	TOTAL CHARGES	Enter the total charges for all claim line items billed – claim lines 24F. Dollar amounts to the left of the vertical line should be right justified. Up to eight characters are allowed (i.e. 199999.99). Do not use commas. Do not enter a dollar sign ($). If the dollar amount is a whole number (i.e. 10.00), enter 00 in the area to the right of the vertical line.	R
29	AMOUNT PAID	REQUIRED when another carrier is the primary payer. Enter the payment received from the primary payer prior to invoicing Magnolia. Dollar amounts to the left of the vertical line should be right justified. Up to eight characters are allowed (i.e. 199999.99). Do not use commas. Do not enter a dollar sign ($). If the dollar amount is a whole number (i.e. 10.00), enter 00 in the area to the right of the vertical line.	C
30	BALANCE DUE	REQUIRED when field 29 is completed. Enter the balance due (total charges minus the amount of payment received from the primary payer). Dollar amounts to the left of the vertical line should be right justified. Up to eight characters are allowed (i.e. 199999.99). Do not use commas. Do not enter a dollar sign ($). If the dollar amount is a whole number (i.e. 10.00), enter 00 in the area to the right of the vertical line.	C
31	SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS	If there is a signature waiver on file, you may stamp, print, or computer-generate the signature; otherwise, the practitioner or practitioner's authorized representative MUST sign the form. If signature is missing or invalid, the claim will be returned unprocessed. Note: Does not exist in the electronic 837P.	R
32	SERVICE FACILITY LOCATION INFORMATION	REQUIRED if the location where services were rendered is different from the billing address listed in field 33. Enter the name and physical location. (P.O. Box numbers are not acceptable here.) First line – Enter the business/facility/practice name. Second line– Enter the street address. Do not use commas, periods, or other punctuation in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). Third line – In the designated block, enter the city and state. Fourth line – Enter the ZIP code and phone number. When entering a 9-digit ZIP code (ZIP+4 codes), include the hyphen.	C
32a	NPI – SERVICES RENDERED	Typical providers ONLY: REQUIRED if the location where services were rendered is different from the billing address listed in field 33. Enter the 10-character NPI ID of the facility where services were rendered.	C
32b	OTHER PROVIDER ID	REQUIRED if the location where services were rendered is different from the billing address listed in field 33. Typical providers: Enter the 2-character qualifier ZZ followed by the taxonomy code (no spaces). Atypical providers: Enter the 2-character qualifier 1D (no spaces)	C

33	BILLING PROVIDER INFO AND PH TELEPHONE	Enter the billing provider's complete name, address (include the ZIP+4 code), and phone number. First line- Enter the business/facility/practice name. Second line- Enter the street address. Do not use commas, periods, or other punctuation in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). Third line- In the designated block, enter the city and state. Fourth line- Enter the ZIP code and phone number. When entering a 9-digit ZIP code (ZIP+4 code), include the hyphen. Do not use a hyphen or space as a separator within the telephone number (i.e. (555)555-5555). NOTE: The 9-digit ZIP code (ZIP+4 code) is a requirement for paper and EDI claim submission.	R
33a	GROUP BILLING NPI	Typical providers ONLY: REQUIRED if the location where services were rendered is different from the billing address listed in field 33. Enter the 10-character NPI ID.	R
33b	GROUP BILLING OTHERS ID	Enter as designated below the billing group taxonomy code Typical providers: Enter the provider taxonomy code. Use ZZ qualifier. Atypical Providers: Enter the provider ID number.	R

ATTACHMENT D: SAMPLE UB-04 CLAIM FORM



ATTACHMENT E: SAMPLE UB-04 CLAIM INSTRUCTIONS

The following table outlines each field within a UB-04 claim form. Please note:

- Required fields (indicated as "R") must be completed on the claim form.
- Conditional fields (indicated as "C") must be completed, if the information applies to the situation or the service provided.
- Not Required fields (indicated as "Not Required") do not need to be completed.

Field #	Field Description	Instruction or Comments	Required or Conditional
1	UNLABELED FIELD	LINE 1: Enter the complete provider name. LINE 2: Enter the complete mailing address. LINE 3: Enter the City, State, and ZIP+4 codes (include hyphen). NOTE: The 9-digit ZIP (ZIP+4 codes) is a requirement for paper and EDI claims. LINE 4: Enter the area code and phone number.	R
2	UNLABELED FIELD	Enter the pay-to name and address Not Required	Not Required
3a	PATIENT CONTROL NO.	Enter the facility patient account/control number.	Not Required
3b	MEDICAL RECORD NUMBER	Enter the facility patient medical or health record number.	R
4	TYPE OF BILL	Enter the appropriate Type of Bill (TOB) code as specified by the NUBC UB-04 Uniform Billing Manual minus the leading zero (0). Digits should be reflected as follows: 1st Digit – Indicating the type of facility. 2nd Digit – Indicating the type of care. 3rd Digit- Indicating the bill sequence (Frequency code).	R
5	FED. TAX NO	Enter the 9-digit number assigned by the federal government for tax reporting purposes.	R
6	STATEMENT COVERS PERIOD FROM/THROUGH	Enter begin and end, or admission and discharge dates, for the services billed. Inpatient and outpatient observation stays must be billed using the admission date and discharge date. Outpatient therapy, chemotherapy, laboratory, pathology, radiology, and dialysis may be billed using a date span. All other outpatient services must be billed using the actual date of service (MM/DD/YY).	R
7	UNLABELED FIELD	Not used	Not Required
8a-8b	PATIENT NAME	8a – Enter the first 9 digits of the identification number on the member's ID card 8b – Enter the patient's last name, first name, and middle initial as it appears on the ID card. Use a comma or space to separate the last and first names. Titles: (Mr., Mrs., etc.) should not be reported in this field. Prefix: No space should be left after the prefix of a name (e.g. McKendrick. H) Hyphenated names: Both names should be capitalized and separated by a hyphen (no space) Suffix: a space should separate a last name and suffix. Enter the complete mailing address of the patient.	Not Required 5

9	PATIENT ADDRESS	Enter the complete mailing address of the patient. Line a: Street address Line b: City Line c: State Line d: ZIP code Line e: Country code (NOT REQUIRED)	
10	BIRTHDATE	Enter the patient's date of birth (MM/DD/YYYY)	
11	SEX	Enter the patient's sex. Only M or F is accepted.	
12	ADMISSION DATE	Enter the date of admission for inpatient claims and date of service for outpatient claims.	
13	ADMISSION HOUR	Enter the time using 2-digit military time (00-23) for the time of inpatient admission or time of treatment for outpatient services. 00-12:00 midnight to 12:59 12-12:00 noon to 12:59 01-01:00 to 01:59 13-01:00 to 01:59 02-02:00 to 02:59 14-02:00 to 02:59 03-03:00 to 03:39 15-03:00 to 03:59 04-04:00 to 04:59 16-04:00 to 04:59 05-05:00:00 to 05:59 17-05:00:00 to 05:59 06-06:00 to 06:59 18-06:00 to 06:59 07-07:00 to 07:59 19-07:00 to 07:59 08-08:00 to 08:59 20-08:00 to 08:59 09-09:00 to 09:59 21-09:00 to 09:59 10-10:00 to 10:59 22-10:00 to 10:59 11-11:00 to 11:59 23-11:00 to 11:59	
14	ADMISSION TYPE	Required for inpatient and outpatient admissions. Enter the 1-digit code indicating the type of the admission using the appropriate following codes: 1 Emergency 2 Urgent 3 Elective 4 Newborn 5 Trauma	
15	ADMISSION SOURCE	Required for inpatient and outpatient admissions. Enter the 1-digit code indicating the source of the admission or outpatient service using one of the following codes. For type of admission 1,2,3, or 5: 1 Physician Referral 2 Clinic Referral 3 Health Maintenance Referral (HMO) 4 Transfer from a hospital 5 Transfer from Skilled Nursing Facility 6 Transfer from another healthcare facility 7 Emergency Room 8 Court/Law Enforcement 9 Information not available For type of admission 4 (newborn): 1 Normal Delivery 2 Premature Delivery 3 Sick Baby 4 Extramural Birth 5 Information not available	R

16	DISCHARGE HOUR	Enter the time using 2-digit military times (00-23) for the time of the inpatient or outpatient discharge. 00-12:00 midnight to 12:59 12-12:00 noon to 12:59 01-01:00 to 01:59 13-01:00 to 01:59 02-02:00 to 02:59 14-02:00 to 02:59 03-03:00 to 03:39 15-03:00 to 03:59 04-04:00 to 04:59 16-04:00 to 04:59 05-05:00:00 to 05:59 17-05:00:00 to 05:59 06-06:00 to 06:59 18-06:00 to 06:59 07-07:00 to 07:59 19-07:00 to 07:59 08-08:00 to 08:59 20-08:00 to 08:59 09-09:00 to 09:59 21-09:00 to 09:59 10-10:00 to 10:59 22-10:00 to 10:59 11-11:00 to 11:59 23-11:00 to 11:59	C
17	PATIENT STATUS	REQUIRED for inpatient and outpatient claims. Enter the 2-digit disposition of the patient as of the "through" date for the billing period listed in field 6 using one of the following codes: 1 Routine Discharge 2 Discharged to another short-term general hospital 3 Discharged to SNF 4 Discharged to ICF 5 Discharged to another type of institution 6 Discharged to care of home health service organization 7 Left against medical advice 8 Discharged/transferred to home under care of a Home IV provider 9 Admitted as an inpatient to this hospital (only for use on Medicare outpatient hospital claims) 20 Expired or did not recover 30 Still patient (To be used only when the member has been in the facility for thirty consecutive days if payment is based on DRG) 40 Expired at home (hospice use only) 41 Expired in a medical facility (hospice use only) 42 Expired — place unknown (hospice use only) 43 Discharged/Transferred to a federal hospital (such as a Veteran's Administration [VA] hospital) 50 Hospice — Home 51 Hospice — Medical Facility 61 Discharged/Transferred within this institution to a hospital-based Medicare approved swing bed 62 Discharged/Transferred to an Inpatient rehabilitation facility (IRF), including rehabilitation distinct part units of a hospital 63 Discharged/Transferred to a Medicare certified long-term care hospital (LTCH) 64 Discharged/Transferred to a nursing facility certified under Medicaid but not certified under Medicare 65 Discharged/Transferred to a Psychiatric hospital or Psychiatric distinct part unit of a hospital 66 Discharged/Transferred to a critical access hospital (CAH)	R
18-28	CONDITION CODES	REQUIRED when applicable. Condition codes are used to identify conditions relating to the bill that may affect payer processing. Each field (18-24) allows entry of a 2-character code. Codes should be entered in alphanumeric sequence (numbered codes precede alphanumeric codes). For a list of codes and additional instructions refer to the NUBC UB-04 Uniform Billing Manual.	C
29	ACCIDENT STATE		Not Required

30	UNLABELED FIELD	NOT USED	Not Required
31-34 a-b	OCCURRENCE CODE and OCCURRENCE DATE	Occurrence code: REQUIRED when applicable. Occurrence codes are used to identify events relating to the bill that may affect payer processing. Each field (31-34a) allows for entry of a two-character code. Codes should be entered in alphanumeric sequence (numbered codes precede alphanumeric codes). For a list of codes and additional instructions refer to the NUBC UB-04 Uniform Billing Manual. Occurrence date: REQUIRED when applicable or when a corresponding occurrence Code is present on the same line (31a-34a). Enter the date for the associated occurrence code in MM/DD/YYYY format.	C
35-36 a-b	OCCURRENCE CODE and OCCURRENCE DATE	Occurrence span code: REQUIRED when applicable. Occurrence codes are used to identify events relating to the bill that may affect payer processing. Each field (31-34a) allows for entry of a 2-character code. Codes should be entered in alphanumeric sequence (numbered codes precede alphanumeric codes). For a list of codes and additional instructions refer to the NUBC UB-04 Uniform Billing Manual. Occurrence span date: REQUIRED when applicable or when a corresponding occurrence span code is present on the same line (35a-36a). Enter the date for the associated occurrence code in MM/DD/YYYY format.	C
37	(UNLABELED FIELD)	REQUIRED for resubmissions or adjustments. Enter the DCN (Document Control Number) of the original claim.	C
38	RESPONSIBLE PARTY NAME AND ADDRESS		Not Required
39-41 a-d	VALUE CODES CODES and AMOUNTS	Code: REQUIRED when applicable. Value codes are used to identify events relating to the bill that may affect payer processing. Each field (39-41) allows for entry of a 2-character code. Codes should be entered in alphanumeric sequence (numbered codes precede alphanumeric codes). Up to 12 codes can be entered. All “a” fields must be completed before using “b” fields, all “b” fields before using “c” fields, and all “c” fields before using “d” fields. For a list of codes and additional instructions refer to the NUBC UB-04 Uniform Billing Manual. Amount: REQUIRED when applicable or when a value code is entered. Enter the dollar amount for the associated value code. Dollar amounts to the left of the vertical line should be right justified. Up to eight characters are allowed (i.e. 199,999.99). Do not enter a dollar sign ($) or a decimal. A decimal is implied. If the dollar amount is a whole number (i.e. 10.00), enter 00 in the area to the right of the vertical line.	C
General Information Fields 42-47	SERVICE LINE DETAIL	The following UB-04 fields – 42-47: Have a total of 22 service lines for claim detail information. Fields 42, 43, 45, 47, 48 include separate instructions for the completion of lines 1-22 and line 23.	

42 Line 1-22	REV CD	Enter the appropriate revenue codes itemizing accommodations, services, and items furnished to the patient. Refer to the NUBC UB-04 Uniform Billing Manual for a complete listing of revenue codes and instructions. Enter accommodation revenue codes first followed by ancillary revenue codes. Enter codes in ascending numerical value.	R
42 Line 23	Rev CD	Enter 0001 for total charges.	R
43 Line 1-22	DESCRIPTION	Enter a brief description that corresponds to the revenue code entered in the service line of field 42.	R
43 Line 23	PAGE __OF_	Enter the number of pages. Indicate the page sequence in the "PAGE" field and the total number of pages in the "OF" field. If only one claim form is submitted, enter a "1" in both fields (i.e. PAGE "1" OF "1"). (Limited to 4 pages per claim)	C
44	HCPCS/RATES	REQUIRED for outpatient claims when an appropriate CPT/ HCPCS Code exists for the service line revenue code billed. The field allows up to 9 characters. Only one CPT/HCPCS and up to two modifiers are accepted. When entering a CPT/HCPCS with a modifier(s) do not use spaces, commas, dashes, or the like between the CPT/HCPCS and modifier(s). Refer to the NUBC UB-04 Uniform Billing Manual for a complete listing of revenue codes and instructions. Please refer to your current provider contract.	C
45 Line 1-22	SERVICE DATE	REQUIRED on all outpatient claims. Enter the date of service for each service line billed. (MM/DD/YY) Multiple dates of service may not be combined for outpatient claim	C
45 Line 23	CREATION DATE	Enter the date the bill was created or prepared for submission on all pages submitted (MM/DD/YY).	R
46	SERVICE UNITS	Enter the number of units, days, or visits for the service. A value of at least "1" must be entered. For inpatient room charges, enter the number of days for each accommodation listed.	R
47 Line 1-22	TOTAL CHARGES	Enter the total charge for each service line.	R
47 Line 23	TOTALS	Enter the total charges for all service lines.	R
48 Line 1-22	NON-COVERED CHARGES	Enter the non-covered charges included in field 47 for the revenue code listed in field 42 of the service line. Do not list negative amounts.	C
48 Line 23	TOTALS	Enter the total non-covered charges for all service lines.	C
49	(UNLABELED FIELD)	Not Used	Not Required
50 A-C	PAYER	Enter the name of each payer from which reimbursement is being sought in the order of the payer liability. Line A refers to the primary payer; B, secondary; and C, tertiary.	R
51 A-C	HEALTH PLAN IDENTIFCATION NUMBER		Not Required
52 A-C	REL INFO	REQUIRED for each line (A, B, C) completed in field 50. Release of information certification indicator. Enter "Y" (yes) or "N" (no). Providers are expected to have necessary release information on file. It is expected that all released invoices contain "Y."	R
53	ASG. BEN.	Enter 'Y' (yes) or 'N' (no) to indicate a signed form is on file authorizing payment by the payer directly to the provider for services.	R

54	PRIOR PAYMENTS	Enter the amount received from the primary payer on the appropriate line when Magnolia is listed as secondary or tertiary.	C
55	EST. AMOUNT DUE		Not Required
56	NATIONAL PROVIDER IDENTIFIER OR PROVIDER ID	Required: Enter provider's 10-character NPI ID.	R
57	OTHER PROVIDER ID	Enter the numeric provider identification number. Enter the TPI number (non-NPI number) of the billing provider.	R
58	INSURED'S NAME	For each line (A, B, C) completed in field 50, enter the name of the person who carries the insurance for the patient. In most cases this will be the patient's name. Enter the name as last name, first name, middle initial.	R
59	PATIENT RELATIONSHIP		Not Required
60	INSURED'S UNIQUE ID	REQUIRED: Enter the patient's Insurance ID exactly as it appears on the patient's ID card. Enter the Insurance ID in the order of liability listed in field 50.	R
61	GROUP NAME		Not Required
62	INSURANCE GROUP NO.		Not Required
63	TREATMENT AUTHORIZATION CODES	Enter the prior authorization or referral when services require pre-certification.	C
64	DOCUMENT CONTROL NUMBER	Enter the 12-character original claim number of the paid/ denied claim when submitting a replacement or void on the corresponding A, B, C line reflecting Magnolia from field 50. Applies to claim submitted with a type of bill (field 4) Frequency of "7" (replacement of prior claim) or type of bill Frequency of "8" (void/cancel of prior claim). * Please refer to reconsider/corrected claims section.	C
65	EMPLOYER NAME		Not Required
66	DX VERSION QUALIFIER		Not Required
67	PRINCIPAL DIAGNOSIS CODE	Enter the principal/primary diagnosis or condition using the appropriate release/update of ICD-9/10-CM Volumes 1 and 3 for the date of service.	R
67 A-Q	OTHER DIAGNOSIS CODE	Enter additional diagnosis or conditions that coexist at the time of admission or that develop subsequent to the admission and have an effect on the treatment or care received using the appropriate release/update of ICD- 9/10- CM Volumes 1 and 3 for the date of service. Diagnosis codes submitted must be valid ICD-9/10 codes for the date of service and carried out to the highest level of specificity – 4th or 5th digit. "E" and most "V" codes are NOT acceptable as a primary diagnosis. Note: Claims with incomplete or invalid diagnosis codes will be denied.	C
68	PRESENT ON ADMISSION INDICATOR		R
69	ADMITTING DIAGNOSIS CODE	Enter the diagnosis or condition provided at the time of admission as stated by the physician using the appropriate release/update of ICD-9/10-CM Volumes 1 and 3 for the date of service. Diagnosis codes submitted must be valid ICD-9/10 codes for the date of service and carried out to the highest level of specificity – 4th or 5th digit. "E" codes and most "V" are NOT acceptable as a primary diagnosis. Note: Claims with missing or invalid diagnosis codes will be denied.	R

70	PATIENT REASON CODE	Enter the ICD-9/10-CM code that reflects the patient's reason for visit at the time of outpatient registration. Field 70a requires entry, fields 70b-70c are conditional. Diagnosis codes submitted must be valid ICD-9/10 codes for the date of service and carried out to the highest digit – 4th or 5th. "E" codes and most "V" codes are NOT acceptable as a primary diagnosis. NOTE: Claims with missing or invalid diagnosis codes will be denied.	R
71	PPS/DRG CODE		Not Required
72 a, b, c	EXTERNAL CAUSE CODE		Not Required
73	UNLABELED		Not Required
74	PRINCIPAL PROCEDURE CODE/ DATE	CODE: Enter the ICD-9/10 procedure code that identifies the principal/primary procedure performed. Do not enter the decimal between the 2nd or 3rd digits of code, as it is implied. DATE: Enter the date the principal procedure was performed (MM/ DD/YY).	C
74 a-e	OTHER PROCEDURE CODE DATE	REQUIRED on inpatient claims when a procedure is performed during the date span of the bill. CODE: Enter the ICD-9/ICD-10 procedure code(s) that identify the significant procedure(s) performed, other than the principal/ primary procedure. Up to five ICD-9/ICD-10 procedure codes may be entered. Do not enter the decimal, as it is implied. DATE: Enter the date the principal procedure was performed (MM/ DD/YY).	C
75	UNLABELED		Not Required
76	ATTENDING PHYSICIAN	Enter the NPI and name of the physician in charge of the patient care. NPI: Enter the attending physician 10-character NPI ID Taxonomy code: Enter valid taxonomy code. QUAL: Enter one of the following qualifiers and ID number: 0B – State license #. 1G – Provider UPIN. G2 – Provider commercial #. B3 – Taxonomy code. LAST: Enter the attending physician's last name. FIRST: Enter the attending physician's first name.	R
77	OPERATING PHYSICIAN	REQUIRED when a surgical procedure is performed. Enter the NPI and name of the physician in charge of the patient care. NPI: Enter the attending physician's 10-character NPI ID. Taxonomy code: Enter valid taxonomy code. QUAL: Enter one of the following qualifiers and ID number: 0B – State license #. 1G – Provider UPIN. G2 – Provider commercial #. B3 – Taxonomy code. LAST: Enter the attending physician's last name. FIRST: Enter the attending physician's first name.	C

78 & 79	OTHER PHYSICIAN	Enter the provider type qualifier, NPI, and name of the physician in charge of the patient care. (Blank Field): Enter one of the following provider type qualifiers: DN – Referring provider ZZ – Other operating MD 82 – Rendering provider NPI: Enter the other physician 10-character NPI ID. QUAL: Enter one of the following qualifiers and ID number: 0B- State license #. 1G- Provider UPIN G2- Provider commercial #.	C
80	REMARKS		Not Required
81	CC	A: Taxonomy of billing provider. Use B3 qualifier.	R
82	Attending Physician	Enter name or 7-digit provider number of ordering physician	R