2026 CHIP Provider Manual

magnolia health

MagnoliaHealthplan.com

1-877-236-0751
Relay 711

WELCOME

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

ABOUT US

Magnolia is a Coordinated Care Organization (CCO) contracted with the Mississippi Division of Medicaid (DOM) to serve Mississippi members through the Mississippi Children's Health Insurance Program (MS CHIP). For more information about MS CHIP, visit www.medicaid.ms.gov/programs/childrens-health-insurance-program-chip/. Magnolia has the expertise to collaborate with members to improve their health status and quality of life. Magnolia's parent company, Centene Corporation (Centene), has been providing comprehensive managed care services to individuals receiving benefits under Medicaid, state Children's Health Insurance Program's and other government-sponsored health care programs for more than thirty (30) years. Centene operates local health plans and offers a wide range of health insurance solutions to individuals and to the rising number of uninsured Americans. It also contracts with other healthcare and commercial organizations to provide specialty services. For more information about Centene, visit www.centene.com.

Magnolia adheres to DOM's requirements that a provider is not required to agree to a non-exclusivity requirement nor to participate in Magnolia's other lines of business to participate in Magnolia's MS CHIP network.

Magnolia is a provider-driven organization that is committed to building collaborative partnerships with providers. Magnolia will serve our members consistently with our core philosophy that quality health care 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 1-877-236-0751, 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:

Magnolia Health Grievance 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 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 ka, Magnolia Health imma ná ponaklo hachim ashah ihokma. Apíla hicha ńan annówa ya chim annopa anóli ako hashísha hin ah kat. Ahíkachih kiyoh. Annopa tishóli imanópolih chinnakma, holhtina yappa ip ayah 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. ર/ો હોય તેમને, Magnolia Health વવશે કોઈ 56 હોય તો તમને, કોઈ ખચ9 વવના તમાર. ભાષામાાં મદદ અને માહહતી 5ો=ત કરવાનો અાવકાર છે. દુભાવષયા સાથે વાત કરવા 1-866-912-6285, Relay 711 ઉપર કોલ 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" ਤuਹਾਡ", ਜ(ਤuਹਾਡੀ ਮਦਦ ਲ- ਰਹ" ਿ◌ਕਸ" ਿ◌ਵਅਕਤੀ 4 ਮਨ ਿ◌ਵਚ Magnolia Health 4 ਬਾਰ" ਕ8ਈ ਸਵਾਲ ਹਨ. ਤ(ਤuਹਾ: ਆਪਣੀ ਭਾਸ਼ਾ ਿ◌ਵਚ ਮuਫਤ ਮਦਦ ਲ-ਣ ਦਾ ਪAਰਾ ਹBਕ C। ਦuਭਾਸ਼ੀਏ 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 ि◌जसक* आप मदद कर रहे ह0 उनके, Magnolia Health केबारे म4 कोई सवाल ह9, तो आपको ;बना <कसी खच@ केअपनी भाषा म4 मदद और जानकारE FोIGत 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 health care services
- Encourage quality, continuity, and appropriateness of medical care
- Provide medical coverage in a cost-effective manner

All our programs, policies, and procedures are designed with these goals in mind. We hope that you will assist Magnolia in reaching these goals and look forward to your active participation.

HOW TO USE THIS MANUAL

Magnolia is committed to collaborating with our provider community and members to provide a high level of satisfaction in delivering quality health care benefits. We are committed to providing comprehensive information through this Magnolia MS CHIP Provider Manual as it relates to Magnolia operations, benefits, policies, and procedures to providers. Please contact the provider services department ("provider services") at 1-877-236-0751 if you need further explanation on any topics discussed in this 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. 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.

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 CHIP ID number

Magnolia's Website www.magnoliahealthplan.com		Access Magnolia Health's website for the following benefits and features: 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: 1-877-779-5219 **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: 1-833-747-1706	
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). Contact GWT for assistance with pharmacy prior authorizations.
Gainwell Technologies Pharmacy (GWT) Help Desk	1-833-660-2402	Pharmacy claims and prior authorizations
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
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
High-Tech Radiology Evolent Specialty Services	1-800-642-7554 www.RadMD.com	Radiology Benefits Manager (CT/CTA/CCTA/ IPM MRI/MRA/PET Scan/Physical Medicine)
Vision Services	1-888-241-0663 centenevision.com/logon	Assist with routine and medical vision services
Dental Services	1-844-464-5636 Email: EDIBA@centene.com	Assist 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	

PRODUCT SUMMARY

Magnolia Health Mississippi Children's Health Insurance Program (MS CHIP)

Magnolia is contracted to provide high quality, medically necessary services to its assigned MS CHIP members, as designated in the MS CHIP Member Handbook that is provided to every MS CHIP member. These medically necessary health services must be:

- Furnished in the most appropriate and least restrictive setting in which services can be safely provided
- Provided at the most appropriate level or supply of service which can be safely provided and could not be omitted without adversely affecting the member's physical health or quality of life.

There is no lifetime maximum on benefits; however, enrollment period (twelve [12]-month period) or limitations apply to certain services, as specified in the listings on the following pages. Magnolia will not impose any pre-existing condition limitations or exclusions or require evidence of insurability to provide coverage to any MS CHIP eligible member.

Some MS CHIP members may have copayments and, in this case, copayments apply until the member reaches their annual out-of-pocket maximum.

MS CHIP provides insurance coverage for uninsured children up to age 19 whose family income does not exceed 209% of federal poverty level (FPL). A child must be determined ineligible for Medicaid before eligibility for MS CHIP can be considered. Children with current health insurance coverage at the time of application are not eligible for MS CHIP. Children who qualify for Medicaid cannot be approved for MS CHIP.

Copayments & Out-of-Pocket Maximum

A copayment, or copay, is a fee that is paid each time a visit is made to the doctor or emergency room (ER). There are three (3) levels of coverage (as referenced in the table below) for MS CHIP. There are different amounts for each coverage plan, depending on the member's federal poverty level (FPL). A member's MS CHIP ID card will indicate the copay maximum.

Out-of-Pocket maximum represents a member's portion of payment for services furnished by a provider. The coverage period for members is one (1) year. There may be a limit to what the member is liable to pay during a coverage period. This is known as an out-of-pocket maximum. Providers will receive a letter when a member reaches their out-of-pocket maximum indicating a copayment should not be charged or billed to the member. The member's out-of-pocket maximum will also be indicated on the member's MS CHIP ID card.

Listed below are the three (3) levels of coverage to indicate the copay or out-of-pocket maximum for MS CHIP:

Coverage Plan	Doctor Visit	Emergency Room Visits	Out-of-Pocket Maximum
MSCHP 01 [<150% FPL]	$0	$0	$0
MSCHP 02 [151% to 175% FPL]	$5 per visit	$15 per visit	$800 per coverage period
MSCHP 03 [176% to 209% FPL]	$5 per visit	$15 per visit	$950 per coverage period

There are no cost sharing requirements for all behavioral health services, routine well baby and well-child care visits, including administration of immunizations, vision and hearing examinations, eyeglasses, hearing aids and preventive and diagnostic dental care and routine dental fillings. Also, under federal law, the total amount of copayments for all covered members cannot exceed 5% of the family income in any benefit period. The out-of-pocket maximums have been designed to comply with the federal limits on cost sharing.

ELIGIBILITY

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

Populations who are eligible for MS CHIP:

Populations	Income Level
Birth to Age One (1) Year	194% FPL to 209% FPL
Ages One (1) to Six (6) Years	133% FPL to 209% FPL
Age Six (6) to Nineteen (19) Years	133% FPL to 209% FPL

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.

Health Plan Assignment
Eligible members have the option to select the health plan of their choice from the Coordinated Care Organizations approved by DOM to manage the MSCHIP product.

If a member does not select a health plan within the allotted thirty (30) day period, DOM will enroll eligible members into a health plan that is participating in MS CHIP, and members will have the option to disenroll once within ninety (90) days of initial enrollment period.

As part of the application process for coverage under MS CHIP, Members have thirty (30) calendar days to select a health plan.

Members who fail to make a voluntary health plan selection will be subject to Auto Enrollment with a Plan by DOM. Auto Enrollment rules will include provisions to consider the following in the order listed below.

1. **Family History and Prior Enrollment in CHIP:** DOM will assign the MS CHIP member to a health plan if the member and/or individuals in the member's case ID number are or were enrolled with a particular CCO as part of MS CHIP within the previous sixty (60) calendar days.
2. **Prior Enrollment in the CHIP Program:** DOM will assign a member to a CCO if the member was enrolled with a particular CHIP CCO with the previous sixty (60) calendar days.
3. **Prior Claims History:** DOM will review claims data and encounters from MS CHIP, MississippiCAN Program, and Medicaid Fee-for-Service Program during the last six (6) months.
4. **Proximity:** If there is no previous assignment within sixty (60) calendar days and no immediate family members already enrolled, or if the Member does not have a prior history with a PCP, then assign the Member to CCO with a PCP closest to Member's home address.
5. **Value-Based Purchasing:** If multiple CCOs meet the Proximity standard, then assignment will occur based on Value-Based Purchasing (VBP) performance measures as defined by the Division, unless assignment is needed during the Special Open Enrollment described below.

Special Open Enrollment: If passive auto assignment is needed during the Special Open Enrollment period, assignment will be made using an auto-assignment algorithm.

DOM reserves the right to modify the enrollment and auto enrollment rules at its discretion. DOM may, at its discretion, set and make subsequent changes to a threshold for the percentage of members who can be enrolled with a single CCO. Members will not be auto enrolled to a CCO that exceeds this threshold unless a family member is enrolled in the CCO, or a historical provider relationship exists with a provider that does not participate in any other CCO. DOM will provide the CCOs with a minimum of fourteen (14) calendar days advance notice in writing when changing the threshold percentage.

DOM will notify members and Magnolia within five (5) business days of the selection or auto enrollment. DOM's notice to the member will be made in writing and sent via surface mail. Notice to Magnolia will be made via the member listing report.

MEMBER ELIGIBILITY VERIFICATION

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

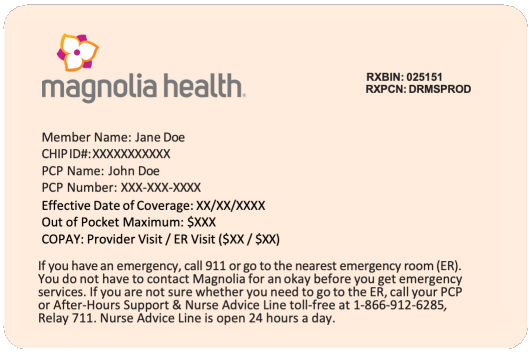
1. Log onto DOM's MESA portal https://medicaid.ms.gov/mesa-portal-for-providers/ to verify member's eligibility with MS CHIP.
2. Log onto the secure provider portal at www.magnoliahealthplan.com. Using our secure provider website, you can check member eligibility. You can search by date of service plus any one of the following: member name and date of birth or MS CHIP 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 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 MS CHIP 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's name or member MS CHIP ID number to verify eligibility.

Through Magnolia's secure provider web portal, PCPs can access a list of eligible members who have selected their services or were assigned to the PCP as of the first day of the month in which the PCP receives such a list. The list also provides other important information including date of birth and indicators for patients who are due for a well-baby and well-childcare assessment. To view this member list, log onto the Magnolia website at www.magnoliahealthplan.com. Since eligibility changes may occur throughout the month and the member list does not prove eligibility for benefits or guarantee coverage, please use one of the above methods to verify member eligibility on the date of service.

Once eligibility is confirmed, all new MS CHIP members receive a MS CHIP member ID card. MS CHIP member ID cards are not a guarantee of eligibility; providers must verify members' eligibility on each date of service.

MEMBER IDENTIFICATION (ID) CARD

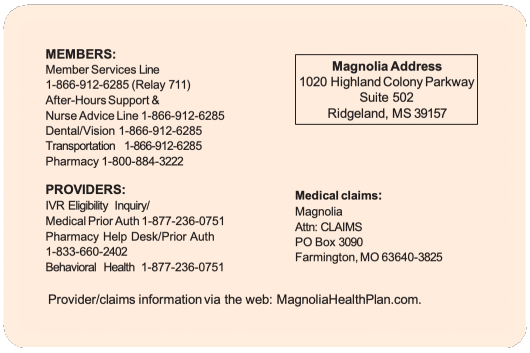
Members must present a MS CHIP member ID card each time services are rendered by a provider. If you are not familiar with the person seeking care as a member of our health plan, please ask to see photo ID. If you suspect fraud, please contact provider services at 1-877-236-0751 immediately.


magnolia health

RXBIN: 025151
RXPCN: DRMSPROD

Member Name: Jane Doe
CHIP ID#: XXXXXXXXXXX
PCP Name: John Doe
PCP Number: XXX-XXX-XXXX
Effective Date of Coverage: XX/XX/XXXX
Out of Pocket Maximum: $XXX
COPAY: Provider Visit / ER Visit ($XX / $XX)

If you have an emergency, call 911 or go to the nearest emergency room (ER). You do not have to contact Magnolia for an okay before you get emergency services. If you are not sure whether you need to go to the ER, call your PCP or After-Hours Support & Nurse Advice Line toll-free at 1-866-912-6285, Relay 711. Nurse Advice Line is open 24 hours a day.


MEMBERS:
Member Services Line
1-866-912-6285 (Relay 711)
After-Hours Support &
Nurse Advice Line 1-866-912-6285
Dental/Vision 1-866-912-6285
Transportation 1-866-912-6285
Pharmacy 1-800-884-3222

Magnolia Address
1020 Highland Colony Parkway
Suite 502
Ridgeland, MS 39157

PROVIDERS:
IVR Eligibility Inquiry/
Medical Prior Auth 1-877-236-0751
Pharmacy Help Desk/Prior Auth
1-833-660-2402
Behavioral Health 1-877-236-0751

Medical claims:
Magnolia
Attn: CLAIMS
PO Box 3090
Farmington, MO 63640-3825

Provider/claims information via the web: MagnoliaHealthPlan.com.

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 verifying eligibility through the MESA portal, providers can reduce claim denials related to eligibility and improve office efficiency by decreasing the amount of time spent on the phone verifying member eligibility.

PROVIDER RESOURCES

INTERACTIVE VOICE RESPONSE (IVR)

What is great about the IVR system? It is 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

MAGNOLIA WEBSITE

Utilizing Magnolia's website can significantly reduce the number of telephone calls providers need to make to the health plan, which enables Magnolia staff to effectively and efficiently perform daily tasks. 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 newsletters
- Provider Directory
- Update Demographic Information
- Submit a contract request form or add a new TIN
- Access to link to Magnolia's Preferred Drug List (PDL)

SECURE WEBSITE

Magnolia web portal services allow providers to check member eligibility and benefits, submit and check status of claims, request authorizations, and send/receive messages to communicate with Magnolia staff. Magnolia's providers and their office staff have the opportunity to register for our secure provider website in just four (4) easy steps. Here, we offer tools which make obtaining and sharing information easy! It's simple and secure! Go to www. magnoliahealthplan.com to register. On the home page, select the Logon link on the top right to start the registration process.

Through the secure site, you can 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
- Contact us securely and confidentially

We are continually updating our website with the latest news and information, so save www. magnoliahealthplan.com to your internet "Favorites" list and check it often. Please contact a provider relations representative for a tutorial on the secure site.

PROVIDER RELATIONS DEPARTMENT

Magnolia's provider relations department is designed around the concept of making your experience a positive one by 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

The goal of this department is to furnish you and your staff with the necessary tools to provide the highest quality of healthcare to MS CHIP members. To contact the provider relations representative for your area, contact our provider services at 1-877-236-0751 or review the Provider Relations Territory map found at www.magnoliahealthplan.com.

Provider services representatives' work with provider relations representatives to serve as your advocates to ensure that you receive necessary assistance and maintain satisfaction with Magnolia.

Reasons to contact your 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.

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 Independent External Review procedures
- To make recommendations regarding the organization's member rights and responsibilities

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 RIGHTS AND RESPONSIBILITES

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.
- To follow up with members who are not in compliance with Well-Baby and Well-Child Care Services in accordance with the Advisory Committee on Immunization Practices (ACIP) Immunization Schedule.

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 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.

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 nineteen (19), are responsible for conducting all EPSDT screens for individuals on their panel under the age of nineteen (19). 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 nineteen (19) 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 quarterly encounter lists 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.

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 CHIP, 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 utilizes a MS CHIP network of hospitals to provide services to MS CHIP 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, MS CHIP ID number, presenting symptoms/diagnosis, date of service (DOS), and member's phone number.
- Notify Magnolia's medical management department of all newborn deliveries on the same day as the delivery

Magnolia hospitals should refer to their contract for complete information regarding the hospitals' obligations and reimbursement.

PROVIDER STANDARDS AND PROCEDURES

CULTURAL COMPENTENCY

At Magnolia, cultural competency is defined as the willingness and ability of a system to value the importance of culture in the delivery of services to all segments of the population. It is the use of a systems perspective which values differences and is responsive to diversity at all levels in an organization. Cultural competency is developmental, community focused and family oriented. It is the promotion of quality services to understand racial/ethics groups through the valuing of differences and integration of cultural attitudes, beliefs and practices into diagnostic and treatment methods and throughout the system to support the delivery of culturally relevant and competent care. It is also the development and continued promotion of skills and practices important in clinical practice, cross-cultural interactions and systems practices

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 are entitled to dignified, appropriate and quality care. When health care services are delivered without regard for cultural differences, members are at risk for sub-optimal care. Members may be unable or unwilling to communicate their health care needs in a culturally insensitive environment, reducing effectiveness of the entire health care process.

Magnolia, as part of its credentialing processes, will evaluate the cultural competency level of its providers and provide access to training and tools to assist providers in developing culturally competent and culturally proficient practices.

Providers must ensure that:
Members understand 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 interacts with members are to have access to and are encouraged to participate in cultural competency training and development.
- Office staff responsible for data collection makes 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 the race/ethnicity of themselves and their children.
- 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 required non-English language.

APPOINTMENT AVAILABILITY STANDARDS

Magnolia follows the appointment availability 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

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 a member
- Identify and reschedule broken and no-show appointments
- Identify special member needs while scheduling an appointment (e.g., wheelchair and interpretive linguistic needs, non-compliant individuals, or those people with cognitive impairments)

Adhere to the following response time for telephone call-back waiting times:

- After-hours telephone care for non-emergent, symptomatic issues within thirty (30) minutes
- Same day for non-symptomatic concerns
- Crisis situations within fifteen (15) minutes
- After-hours calls must be documented in a written format in either an after-hour call log or some other similar method and then transferred to the member's medical record.

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

Magnolia will monitor appointment and after-hours availability on an on-going basis through its Quality Improvement Program (QIP).

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.

24- HOUR ACCESS

Magnolia's PCPs and specialty providers are required to maintain sufficient access to facilities and personnel to provide covered provider services and shall ensure that such services are accessible to members as needed twenty-four (24) hours a day, three hundred and sixty-five (365) days a year as follows:

- A provider's office phone must be answered during normal business hours.
- During after-hours, a provider must have arrangements for:
    - Access to a covering provider
    - An answering service
    - Triage service
    - A voice message that provides a second phone number that is answered

The selected method of twenty-four (24) hour coverage chosen by the member 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 initial contact. After-hours coverage must be accessible using the medical office's daytime telephone number. Magnolia provider relations staff will collaborate with provider office personnel for scheduled visits and may occasionally make unscheduled visits if a provider relations representative is in the area.

REFERRALS

PCPs will coordinate all member healthcare services. PCPs are encouraged to refer a member to another MS CHIP network provider whenever necessary and in most circumstances paper or electronic referrals are not required. A provider is also required to promptly notify Magnolia when prenatal care is rendered using the Notification of Pregnancy Form on the Magnolia web portal.

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

The Provider is prohibited from making referrals for designated health services to healthcare entities with which the provider, or a member of the providers' 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
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

All PCPs reserve the right to state the number of members they are willing to accept into their panel. Magnolia does not guarantee that any provider will receive a certain number of members.

If a PCP does declare a specific capacity for their practice and wants to make a change to that capacity, the PCP must contact Magnolia provider services at 1-877-236-0751. 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 MS CHIP covered persons under Magnolia agreements. In no event shall any established patient who becomes a covered person be considered a new patient. Magnolia prohibits all providers from intentionally segregating members from fair treatment and covered services provided to other Non-MS CHIP members.

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.

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

BENEFIT EXPLANATION AND LIMITATIONS

MISSISSIPPI CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP) COVERED BENEFITS

Magnolia is contracted to provide the following coverage to eligible children under the MS CHIP program:

Covered Services	Comments and Limitations
Well-Baby Services	
Well-Child Services	
Immunizations	
Ambulatory Surgery Center	
Behavioral health/Substance Abuse services	A comprehensive range of services are covered, including substance use disorder treatment, MYPAC services, community support programs (CSP) care management services, and PRTF
Emergency ambulance	Prior authorization required when using a Fixed Wing Airplane only
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	Dental services are limited per member per calendar year to $2,000. Periodic and comprehensive oral exams, cleanings, fluoride, and bitewings must be rendered six months apart. *Orthodontia coverage for CHIP members is considered only for severe craniofacial anomalies or full cusp Class III malocclusion. Benefits will be provided for preventive and diagnostic dental care as recommended by the American Academy of Pediatric Dentistry (AAPD): a. 2 routine exams per benefit year (six months apart) b. 2 cleanings per benefit year (six months apart) c. Fluoride twice per benefit year (six months apart) d. Bitewings twice per benefit year (six months apart) e. Full-mouth radiograph series (D0210 includes bitewings) or panoramic x-rays (D0330) once per 24 months f. Periodontal services including scaling and root planning g. Sealants up to age 14 (one per permanent molar tooth per 36 months) h. Minor restorative services such as fillings i. Major restorative services such as crowns j. Orthodontia (based on medical necessity) * k. Dentures, partials, and repairs (with limits) l. Oral surgery services including extractions (based on necessity) m. Emergency dental services
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 with prior authorization.
ER services	Emergency room visits should only be used for true emergencies that cannot wait to be seen by your PCP. 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

Covered Services	Comments and Limitations
Eyeglasses	1 eye exam and 1 pair of eyeglasses annually
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	May require prior authorization. Includes cochlear implants
Home healthcare services	Limited to 36 visits per benefit year
Hospice care	Requires prior authorization
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
Laboratory services	Basic laboratory services do not require prior authorization
Neuro-Psychiatric services	May require prior authorization
Non-emergency transportation	1-877-236-0751
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 therapy, 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 determined to be medically necessary. Diabetic supplies do not count toward benefit limit.
Preventive Care	
Radiology services	Basic radiology services do not require prior authorization
Sleep Study	Outpatient only
Specialty injection/infusion (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
Substance Use Disorder Treatment	Treatment is covered as part of a written plan. It includes inpatient and outpatient care. Benefit also includes Screenings, Brief, Intervention, and Referral to Treatment (SBIRT).
Surgery-elective-potentially-cosmetic	Including, but not limited to, breast reduction surgery and varicose vein treatments
Swing bed services	Covered and authorized by the DOM
Transplants	Magnolia requires prior authorization for all transplants, except cornea

WELL-BABY AND WELL-CHILD CARE AND IMMUNIZATIONS

Well-Baby and Well-Child Care services, including but not limited to vision screenings, laboratory tests, and hearing screenings, are covered and copayments are not required for well-child checkups or preventative visits.

Providers are encouraged to assess physical, emotional and social development of infants and children, in accordance with The Bright Futures/American Academy of Pediatrics (AAP), Recommendations for Preventive Pediatric health Care, also known as the "Periodicity Schedule". Magnolia's Secure Provider Portal is a user-friendly resource for providers to identify patients who are non-compliant with the Periodicity and Immunization schedules. Magnolia's Provider Engagement Representatives are available to assist provider practices with navigating the Secure Provider Portal or sharing a quarterly non-complaint list. Providers are required to make every effort to identify and outreach to patients who need and are non-compliant with well child appointments or vaccinations.

WELL-BABY AND WELL-CHILD CARE ASSESSMENT BILLING

Well-baby and well-child assessment services are limited to beneficiaries under age twenty-one (21).

Modifier EP is required to be billed in box 24d of CMS 1500 (02/12) claim form

Procedure Codes for Screenings:	
Initial:	
99381	EP (under the age of 1)
99382	EP (1-4 years of age)
99383	EP (5-11 years of age)
99384	EP (12-17 years of age)
99385	EP (18-21 years of age)
Periodic:	
99391	EP (under the age of 1)
99392	EP (1-4 years of age)
99393	EP (5-11 years of age)
99394	EP (12-17 years of age)
99395	EP (18-21 years of age)
Hearing:	
92551	EP (3-21 years of age)
Vision:	
99173	EP (3-21 years of age)
Adolescent Counseling:	
99401	EP (9-21 years of age)

Note: All well-baby and well-child assessment CPT codes must be billed with modifier EP in box 24d of the CMS 1500 (02/12) claim form. The vision, hearing, and adolescent counseling CPT codes must also be billed in conjunction with the comprehensive age-appropriate screening.

Hemoglobin and/or Hematocrit & Urine Dipstick for Sugar & Protein are included in the screening reimbursement and cannot be billed separately.

Best Practices for Improving Well Visits

- Make every office visit count. Children will often only visit when they are sick, or caregivers may experience barriers to scheduling a well visit. Completing a well visit during a sick visit on the same is payable. Add a modifier 25 to the visit and bill for the appropriate preventative visit.
- Consider setting up care opportunity reminders in your electronic medical records (EMR) system
- Give appointment reminders via phone call, automated phone messaging, text and email.
- Schedule multiple children in the family
- Evaluate missed appointments and non-compliant patients for follow-up outreach
- Educate parents or guardians and patients on the importance of well-child visits, even for older children.
- Reminder parents or guardians that well-child visits are free.

For more information about Periodicity and Immunization Schedules visit the American Academy of Pediatrics found at www.aap.org or Preventive Care/Periodicity Schedule and the Advisory Committee on Immunization Practices (ACIP) at www.cdc.gov/acip/vaccine-recommendations/index.html.

VALUE ADDED SERVICES

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.

POPULATION HEALTH AND MEDICAL MANAGEMENT

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, disease management, pharmacy management, and disease management. Magnolia's Medical Director (Medical Director) oversees the Population Health and Clinical Health Department's clinical services. 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 Medical Management, 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 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

SECOND OPINION

A second opinion may be requested when there is a question concerning diagnosis, options for surgery, or other treatment of a health condition, or when requested by a member of the member's health care team, including the member, parent, guardian, or others with custodial responsibilities.

Members, or a healthcare professional with the member's consent, may request and receive a second opinion from a qualified professional within the MS CHIP network. If there is not an appropriate provider to render the second opinion within the MS CHIP network, the member may obtain the 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.

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 MS CHIP ID number
- Provider's name and telephone number
- Provider 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 procedure, 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 MS CHIP members as services, supplies, and equipment provided by an appropriately licensed practitioner and documented in the member's record in a reasonable manner, including the relationship of the diagnosis to the treatment that are:

- The most appropriate services that help achieve age-appropriate growth and development and will allow a member to attain, maintain, or regain capacity.
- Made in accordance with the standards of good medical practice consistent with the member's condition(s).

- Not primarily for the personal comfort or convenience of the member, family, or provider.
- The most appropriate services, supplies, equipment, or level of care that can be safely and efficiently provided to the member.
- Furnished in a setting appropriate to the member's need and condition and, when applied to the care of an inpatient, further mean that the member's medical symptoms or conditions require that the services cannot be safely provided to the member as an outpatient.
- Services for Members that are necessary to correct or ameliorate disorders and physical and behavioral/mental illnesses and conditions, whether such services are covered or exceed the benefit limits in the Medicaid State Plan and Title 23 of Mississippi Administrative Code
- Not experimental or investigational or for research or education.

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 make a decision 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 decisions 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.

A care manager may also coordinate communication between the Medical Director and requesting practitioner.

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

Medical:

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
Attn: Appeals Coordinator
PO Box 10378
Van Nuys, CA 91410-0378
Phone: 1-877-236-07511-866-912-6285
Fax: 1-866-714-7991

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 MS CHIP population. The Clinical Policy Committee (CPC) reviews all requests for coverage and decides 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.

EMERGENCY SERVICES (ROUTINE AND URGENT)

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 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 affect 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 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. If a member's urgent or emergency visit, 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.

For billing information, please refer to the General Billing Information and Guidelines section.

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.

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

PRIOR AUTHORIZATION AND NOTIFICATIONS

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 on 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 phone, 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.

The 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 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. MS CHIP providers are contractually prohibited from holding any MS CHIP member financially liable for any service administratively denied by Magnolia due to the failure of the provider to obtain timely authorization.

AUTHORIZATION TIMEFRAMES

For non-emergent outpatient services, prior authorization should be requested at least five (5) calendar days before the requested service delivery date. Prior authorization determinations for standard outpatient services will be made within three (3) calendar days and/or two (2) business days following receipt of request, per Minimum Standards for Utilization Review Agents issued by the Mississippi State Department of Health (MSDH). If Magnolia requires additional medical information to decide, 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 shall make a second attempt to notify the requesting provider of the additional medical information needed and Magnolia will allow one (1) business day or three (3) calendar days for the requesting provider to submit medical information to Magnolia.

Once all information is received from the child's 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 child's provider to Magnolia, or if Magnolia justifies to DOM a need for additional information and how the extension is in the child'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 decide. 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 decision within three (3) calendar days and/or two (2) business days of receiving Magnolia's request for an 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, 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 evaluation (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.

NOTIFICATION OF PREGNANCY (NOP)

A member that becomes pregnant while covered by MS CHIP are to notify Magnolia as soon as possible, as the member may be eligible for Medicaid. The managing provider should notify the Magnolia prenatal team by completing the Notification of Pregnancy Form (NOP) within five (5) days of the first prenatal visit. The NOP Form can be found on the Magnolia 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.

MAGNOLIA HEALTH PLAN SERVICES REQUIRING PLAN AUTHORIZATION

The latest version of the Prior Authorization Table, go to www.magnoliahealthplan.com and click on the Provider/Practice Improvement Resource Center/Manuals and Reference Guides.

The Prior Authorization Table list is not intended to be an all-inclusive list of covered services, but it substantially provides current prior authorization instructions. All services are subject to benefit coverage, limitations and exclusions as described in applicable plan coverage guidelines. Prior authorization cannot be retroactive without additional review.

DISCHARGE PLANNING

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

RETROSPECTIVE REVIEW

Retrospective review is an initial review of services provided to a member, but 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 MS CHIP card or otherwise indicated MS CHIP coverage, services authorized by another payer who subsequently determined member was not eligible at the time of service).
Requests for retrospective review, for services authorized by Magnolia, must be submitted promptly upon identification but no later than ninety (60) days from the first date of service. A decision will be made within 30 calendar days following receipt of all necessary information for any qualifying service.

MRI, CT, AND PET SCAN AUTHORIZATION

Evolent has been selected by Magnolia to provide prior authorization services and utilization management for advanced imaging and radiology services. Evolent 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 NIA and obtain authorization, please call 1-877-864-7237 and follow the prompt for radiology authorizations. NIA 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.

PHARMACY

PHARMACY PROGRAM

Mississippi Medicaid utilizes a single pharmacy claims processor for all prescription claims filled by Mississippi Medicaid beneficiaries. Pharmacy claims and prior authorizations are 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 MS CHIP 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. 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 for Magnolia.

This section provides an overview of the Magnolia pharmacy program. For more detailed information, please visit our website at www.magnoliahealthplan.com.

PREFERRED DRUG LIST

The DOM has a list of covered medications called 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. Medications currently listed on the PDL should be appropriate to treat most medical conditions encountered by Medicaid providers. This process is coordinated with Magnolia.
For the most current PDL, please visit Magnolia's website at www.magnoliahealthplan.com.

PHARMACY PRIOR AUTHORIZATIONS (PA)

GWT is responsible for processing all prior authorization requests for prescription drugs. Certain drugs require prior authorization to be approved for payment. 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 the member's 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 medications 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.

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

OVER-THE-COUNTER MEDICATIONS

The pharmacy program covers a variety of 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 noted throughout the PDL.

EMERGENCY DRUG SUPPLY

The seventy-two (72) hour emergency supply policy: state and federal law require that a pharmacy dispense a seventy-two (72) hour (three [3] day) supply of medically necessary medication to any member awaiting a prior authorization determination. The purpose of providing members this emergency drug supply is to avoid interruption of current therapy or 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.

STEP THERAPY

Medications requiring step therapy are listed with an "ST" notation throughout the preferred drug list.

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.

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 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.

Outcome monitoring and reporting back to the PCP 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.
In order 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.

THE SSI/COMPLEX TEAMS

Care managers are familiar with evidence-based resources and best-practice standards specific to conditions common 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® PROGRAM

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 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.

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 in order 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, Envolve PeopleCare™, 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
Health Coach
1-877-236-0751

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 using 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 designation of adequate resources to support the interventions.

Magnolia recognizes its legal and ethical obligation 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. Where the 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 provide for comfort measures as appropriate and requested by the member. This will include the identification of members at risk of developing conditions, the implementation of appropriate interventions, and 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, which 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:

- Utilization Management 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 both the quality of clinical care and the quality of service provided to Magnolia's members. Magnolia's QI program incorporates 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 (depending upon Magnolia's products), 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 re-credentialing)
- 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 regulation
- 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
- Health Equity
- Marketing practices

PERFORMANCE IMPROVEMENT PROCESS

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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.

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HEALTH EMPLOYER DATA 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 Division of Medicaid for the provision of coordinated care services within the MississippiCHIP 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. Electronic data collection will be mandatory for all NCQA HEDIS measures by 2027. Electronic data can come from EMR connectivity with Magnolia, Supplemental files extracted from a providers EMR and submitted monthly to Magnolia, and CPT II code submission.

How Are HEDIS Rates Calculated?

Until 2027, HEDIS rates can be calculated in two (2) ways, administrative data or hybrid data, as follows:

- Administrative data: Consists of claim or encounter data submitted to the health plan. Measures typically calculated using administrative data include annual mammogram, annual chlamydia screening, annual pap test, appropriate treatment of asthma, cholesterol management, antidepressant medication management, access to PCP services, and utilization of acute and mental health services.
- Hybrid data: Consists of both administrative data and a sample of medical record data. Hybrid data requires review of a random sample of member medical records to abstract 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 HEDIS brochure for more information on reducing HEDIS medical record reviews). Measures typically requiring medical record review include diabetic HgA1c, LDL, eye exam and nephropathy, controlling high-blood pressure, and prenatal care and postpartum care.

Who Will Be Conducting the Medical Record Reviews (MRR) for HEDIS?

Magnolia will contract with a national medical record review vendor to conduct the HEDIS medical record reviews on its behalf. Medical record review audits for HEDIS are usually conducted February through May each year. At that time, you may receive a call from a medical record reviewer representative if any of your patients are selected into HEDIS samples for Magnolia. Your prompt cooperation with the representative is needed and appreciated.

As a reminder, protected health information (PHI) that is used or disclosed for purposes of treatment, payment, or healthcare operations is permitted by HIPAA Privacy Rules (45 CFR 164.506) and does not require consent or authorization from the member or patient. The medical record review vendor will sign a HIPAA compliant Business Associate Agreement with Magnolia which allows them to collect PHI on our behalf.

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
- Electronic Medical Records connectivity with the health plan or submit supplemental files from your EMR.
- Bill CPT II codes related to HEDIS measures such as diabetes, eye exam, and blood pressure

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.

Provider Satisfaction Survey

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

Consumer Assessment of Healthcare Provider 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 health plan and provider services and gives a general indication of how well we are 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 RECORDS 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 the 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 manual for policies on member access to medical records.

Required Information

Medical records means the complete, comprehensive member records including, but not limited to, x-rays, laboratory tests, results, examinations and notes, accessible at the site of the member's participating PCP or provider, that document all medical services received by the member, including inpatient, ambulatory, ancillary, and emergency care, prepared in accordance with all applicable state rules and regulations, and 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 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.
- 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 and all past and current diagnoses.
- Medication, allergies, and adverse reactions are prominently documented in a uniform location in the medical record, if no known allergies (NKA) or no known drug allergies (NKDA) are to be documented.
- An up-to-date immunization record is established for pediatric members, or an appropriate history is made in chart for adults.
- Evidence that preventive screening and services are offered in accordance with Magnolia Practice Guidelines.
- Appropriate subjective and objective information pertinent to the member's presenting complaints are 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 (eighteen [18] years and younger), past medical history relating to prenatal care, birth, any operations and/or childhood illnesses.
- Working diagnosis is consistent with findings.
- Treatment plan is appropriate for diagnosis.
- Documented treatment prescribed, therapy prescribed, and drug administered or dispensed including instructions to the member.
- Documentation of prenatal risk assessment for pregnant women or infant risk assessment for newborns.
- Signed and dated required consent forms.
- Unresolved problems from previous visits are addressed in subsequent visits.
- Laboratory and other studies ordered as appropriate.
- Abnormal lab and imaging study results have explicit notations in the record for follow up plans; the PCP should initial all entries to signify review.
- Referrals to specialists and ancillary providers are documented including follow up of outcomes and summaries of treatment 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 concerning use of tobacco, 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.
- 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.
- Confidentiality of member information and records protected.
- Evidence that an advance directive has been offered to adults eighteen (18) years of age and older.

Medical Records Release for Non-HEDIS Plan Use

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 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, Access to Medical Records, and Data Exchange

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/under utilization of specialists, as well as the outcome of such services also may be assessed during a medical record audit. Magnolia will provide written notice prior to conducting a medical record review.

Access to Records and Audits by Magnolia Medical Records shall be made accessible and available by practitioners providing services to members enrolled in the CHIP program. For any services billed by a provider for which the medical record cannot be provided to support services rendered, Magnolia Health is instructed to recoup the reimbursement paid to the provider for those purposes. 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, to audit, inspect, review, perform chart reviews, and duplicate such records. This includes medical records for HEDIS quality measures.

Access to medical records for HEDIS quality measures will follow state and federal timelines and should be made available to the health plan as expeditiously as possible and no less than thirty (30) calendar days of the request. A medical request for a quality-of-care investigation should be provided as soon as possible and no less than 14 business days of the request. Audits 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 and Data Exchange

Provider will grant Magnolia Health access to Provider's Electronic Medical Record (EMR) system 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. The three (3) Coordinated Care Organizations have collaborated and agreed upon one set of Clinical Practice Guidelines for ease of use by providers. The MS Division of Medicaid has approved of these Clinical Practice Guidelines, and they can be found on the Magnolia Health website at www.magnoliahealthplan.com.

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.

CREDENTIALING AND RECREDENTIALING

Effective Oct. 3, 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 CHIP are now required to be enrolled, credentialed, and screened by DOM.

Providers interested in participating in Magnolia's CHIP 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. Providers with an active Magnolia CHIP contract who selected Magnolia as a CCO during the Gainwell process will automatically be enrolled in Magnolia's CHIP network. Providers not contracted with Magnolia will receive outreach from Magnolia's Contracting Department 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

A member complaint is an expression of dissatisfaction received orally or in writing that is of a less serious or formal nature that is resolved within one (1) business day of receipt. Any member complaint not resolved within one (1) business day shall be treated as a Grievance. A member complaint includes, but is not limited to inquiries, matters, misunderstandings, or misinformation that can be promptly resolved by clearing up the misunderstanding or providing accurate information.

A member grievance is defined as: An expression of dissatisfaction, regardless of whether identified by the Member as a "Grievance," received by any employee of the Contractor orally or in writing about any matter or aspect of the Contractor or its operation, other than a Contractor Adverse Benefit Determination as defined in this Contract. Grievances may include but are not limited to the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee's rights regardless of whether remedial action is requested. Grievance includes an enrollee's right to dispute an extension of time proposed by the Contractor, PIHP or PAHP to make an authorization decision.

A member may file a grievance either orally or in writing at any time. The legal guardian of the member (for a minor or an incapacitated adult), a representative of the member as designated in writing to Magnolia, or a provider acting on behalf of the member and with the member's written consent, have the right to file a grievance on behalf of the member. Individuals that make decisions on grievances will not be involved in any previous level of review or decision making. Magnolia values its providers and will not take punitive action, including and up to termination of a provider agreement or other contractual arrangements, for providers who file a grievance on a member's behalf.

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

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

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

ACKNOWLEDGMENT

Upon receipt of a complaint or grievance, Magnolia staff receiving complaints or grievances will acknowledge the complaint or grievance and attempt to resolve them 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. Otherwise, Magnolia will provide the grievant with a written acknowledgement 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

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. Clinically urgent grievances will be resolved within seventy-two (72) hours of receipt. Grievances will be resolved by the Grievance and Appeals Coordinator (GAC), in collaboration with other Magnolia staff as needed.

Magnolia may extend by of up to fourteen (14) calendar days if the Member requests the extension, or the Contractor 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, the Contractor 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. Upon resolution of the Grievance, the Contractor shall

mail a resolution letter to the Member. This resolution letter may not take the place of the acknowledgment letter referred above, unless the resolution of the Grievance has been completed and can be communicated to the Member in the same correspondence acknowledging receipt of the Grievance.

MEMBER APPEAL

An appeal is a request for review by Magnolia Health of an adverse benefit determination related to the member. In the case of a Member, the Contractor Adverse Benefit Determination may include determinations on the health care services a member believes the Member is entitled to receive, including delay in providing, arranging for, or approving the health care services (such that a delay would adversely affect the health of the Member).

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.

ACKNOWLEDGEMENT

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.

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 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 independent external review is pending, the benefits must be continued until one of the following occurs:

1. The member withdraws the appeal or request for independent external review
2. The member fails to request an independent external review 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. An independent external review office issues a hearing decision adverse to

the enrollee. Continuation of Benefit Request can be mailed or faxed to:

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

If the final resolution of the appeal or independent external review 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 independent external review 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.

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:

- A request from the member;
- A provider's support of the member's request;
- A provider's request on behalf of the member; or
- 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 timeframe.

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 days timeframe 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.

Independent External Review

At the end of the appeal process with Magnolia, if a member or authorized representative does not agree with the decision that Magnolia makes on an appeal, a member or authorized representative can ask for an Independent External Review. The request must be made in writing within 120 calendar days from the date of Magnolia's notice of resolution (appeal denial letter). An Independent External Review may not be requested until the member or authorized representative has completed all of Magnolia's Appeal process. Please include the member's name, address, phone number, and reason(s) for the Independent External Review request. A member or the member's authorized representative can request an Independent External Review by contacting Magnolia Health at:

Magnolia Health
Attn: Appeals Coordinator
1020 Highland Colony Parkway, Suite 502
Ridgeland, MS 39157
Ph: 1-866-912-6285
Fax: 1-877-264-6519

Asking for an Independent External Review will not cause the member or authorized representative to be treated differently by Magnolia.

PROVIDER COMPLAINTS, GRIEVANCES, AND APPEALS

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.

NOTICE OF RESOLUTION

The Plan will provide written resolution to the provider within thirty (30) calendar days of receipt. Complaints and/or Grievances may be submitted by written notification to:

Magnolia Health
Attn: Grievances and Appeals Coordinator
1020 Highland Colony Parkway
Ridgeland, MS 39157
1-877-236-0751

APPEALS

An appeal is a written request for a review of an adverse provider's determination. An adverse provider determination may include, but is not limited to, for cause termination by Magnolia or claim or payment determination such as a reduction in payment or a full claim denial. An appeal related to a claim must be accompanied by the Claim Appeal Form found on our website at www.magnoliahealthplan.com.

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

Appeals can be submitted through Magnolia's Secure Provider Portal, mail, or fax. Magnolia's Secure Provider Portal can be accessed by visiting www.magnoliahealthplan.com

Please note: For pre-service appeals related to medical necessity or the outcome of a clinical review, please see the Population Health and Medical Management section of the manual for details.

Secure Provider Portal:

www.magnoliahealthplan.com.

Fax:

833-950-3857

Mail:

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

An appeal 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 the results in a claim 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.

State Administrative Hearing

A hearing conducted by the Division of an appeal that is not resolved wholly in favor of the provider by Magnolia. A provider can request a hearing once the provider has exhausted Magnolia's dispute process.

A request for a State Administrative Hearing must be submitted within thirty (30) calendar days of the final decision by Magnolia Health. Requests should be submitted to the Division at the following address:

Division of Medicaid, Office of the Governor
Attn: Office of Appeals
P.O. Box 2222
Jackson, MS 39225
Phone: 601-359-6050 or 1-800-884-3222
Fax: 601-359-9153

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 the 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 administrative 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~~ P.O. Box 2222, Jackson, MS 39225
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 Mississippi 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 claim's payment process. To better understand this system, please review the Billing and Claims section of this manual.

Centene's Special Investigation Unit (SIU) performs back-end audits which in some cases may result in taking appropriate 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 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

Some of the most common WAF submissions seen are:

- Unbundling of codes
- Up-coding
- 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.

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 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 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 them to the following address:

   Magnolia Health
   Corrected Claims Post
   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 comprehensive medical records- please follow the instructions in the letter on 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.

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, consultation, grand jury proceedings, pre-trial conferences, hearings, trials, and in any other process, including investigations.

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.

CLAIMS

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 treating the patient. Encounters occur in 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 provider 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 admission 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 authorization 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 procedures, 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 1-877-236-07511-866-912-6285.

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, including ZIP+4)
7. Physical location address (as registered with Gainwell, including ZIP+4); and
8. Billing name and address (as registered with Gainwell, including ZIP+4).

We recommend that providers notify Magnolia at least thirty (30) days in advance of changes pertaining to billing information. Please submit this information on a W-9 form and in writing to the Credentialing Department utilizing the magnoliacredentialing@centene.com mailbox. The group TIN and NPI must be included with request. Changes to a provider's TIN and/or address are NOT acceptable when conveyed via a claim form. Please note, the billing information should also match what is registered with Gainwell.

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 processed 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 deadlines. 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 Standards

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

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

REJECTIONS VERSUS DENIALS

UPFRONT REJECTION

A rejection is defined as an unclean claim that contains invalid or missing data elements required 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 paper claims sent to the claims office must first pass specific minimum edits prior to acceptance. Claim records that do not pass these minimum edits are invalid and will be rejected.

CLAIM 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 & Corrected Claims		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	365 days from the primary payer's EOP date to the date received	365 days from the primary payer's EOP date to the date

- 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.

ELECTRONIC CLAIMS SUBMISSION

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

For more information on electronic filing and which clearinghouses Magnolia has partnered with, contact:

Magnolia Health
c/o Centene EDI Department
1-800-225-2573, extension 60725525 or by e-mail at:
EDIBA@centene.com

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

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

Providers that 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.

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.

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

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

PROCEDURES FOR ELECTRONIC SUBMISSION

Electronic Data Interchange (EDI) allows faster more efficient and cost-effective claim submission for providers. EDI, performed in accordance with nationally recognized standards, supports the healthcare industry's efforts to reduce administrative costs.

The benefits of billing electronically include:

- Reduction of overhead and administrative costs. EDI eliminates the need for paper claim submission. It has also been proven to reduce claim re-work (adjustments).
- Receipt of clearinghouse reports as proof of claim receipt. This makes it easier to track the status of claims.
- Faster transaction time for claims submitted electronically. An EDI claim averages about 24 to 48 hours from the time it is sent to the time it is received. This enables providers to easily track their claims.
- Validation of data elements on the claim format. By the time a claim is successfully received electronically, information needed for processing is present. This reduces the chance of data entry errors that occur when completing paper claim forms.
- Quicker claim completion. Claims that do not need additional investigation are processed quicker. Reports have shown that a large percentage of EDI claims are processed within 10 to 15 days of their receipt.

All the same requirements for paper claim filing apply to electronic claim filing. Claims that are not submitted correctly or containing the allowed field data will be rejected and/or denied.

The following sections describe the procedures for electronic submission for hospital and medical claims. Included are a high-level description of claims and report process flows, information on unique electronic billing requirements, and various electronic submission exclusions.

Electronic Claim Flow Description & Important General Information

To send claims electronically to Magnolia, all EDI claims must first be forwarded to one of Magnolia's clearinghouses. This can be completed via a direct submission to a clearinghouse or through another EDI clearinghouse.

Once the clearinghouse receives the transmitted claims, they are validated against their proprietary specifications and Plan-specific requirements. Claims not meeting the requirements are immediately rejected and sent back to the sender via a clearinghouse error report. It is very important you review this error report daily to identify any claims that were not transmitted to Magnolia. The name of this report can vary based upon the provider's contract with their intermediate EDI clearinghouse. Accepted claims are passed to Magnolia, and the clearinghouse returns an acceptance report to the sender immediately.

Claims forwarded to Magnolia by a clearinghouse are validated against provider and member eligibility records. Claims that do not meet provider and/or member eligibility requirements are rejected and sent back daily to the clearinghouse. The clearinghouse in turn forwards the rejection back to its trading partner (the intermediate EDI clearinghouse or provider). It is particularly important you review this report daily. The report shows rejected claims, and these claims need to be reviewed and corrected timely. Claims passing eligibility requirements are then passed to the claim processing queues.

Providers are responsible for verification of EDI claims receipts. Acknowledgements for accepted or rejected claims received from the clearinghouse must be reviewed and validated against transmittal records daily.

Since the clearinghouse returns acceptance reports directly to the sender, submitted claims not accepted by the clearinghouse are not transmitted to Magnolia.

If you would like assistance in resolving submission issues reflected on either the acceptance or claim status reports, please contact your clearinghouse or vendor customer service department.

Action	Contact
If you would like to transmit claims electronically...	Contact one of the clearinghouses for Magnolia's payer ID.
If you have a general EDI question...	Contact EDI Support at 1-800-225-2573 Ext. 25525 or via e-mail at EDIBA@centene.com.
If you have questions about specific claims transmissions or acceptance Claim Status reports...	Contact your clearinghouse technical support area
If you have questions about your Claim Status (if claim has been accepted or rejected by the clearinghouse)	Contact EDI Support at 1-800-225-2573 Ext. 25525 or via e-mail at EDIBA@centene.com.
If you have questions about claims that are reported on the Remittance Advice...	Contact provider services at 1-877-236-0751
If you would like to update provider, payee, UPIN, TIN number, or payment address information...	Notify provider services in writing at: magnoliapdm@centene.com or Magnolia Health MS CHIP
	1020 Highland Colony Parkway, Suite 502 Ridgeland, MS 39157
For questions about changing or verifying provider information...	Magnolia Health MS CHIP Attn: Provider Services 1020 Highland Colony Parkway, Suite 502 Ridgeland, MS 39157

Rejected electronic claims may be resubmitted electronically once the error has been corrected.

Invalid Electronic Claim Record Rejections/Denials

All claim records sent to Magnolia must first pass the clearinghouse proprietary edits and Plan-specific edits prior to acceptance. Claim records that do not pass these edits are invalid and will be rejected without being recognized as received by Magnolia. In these cases, the claim must be corrected and re¬submitted within the required filing deadline of ninety (90) calendar days from the date of service. It is important that you review the acceptance or claim status reports received from the clearinghouse to identify and re-submit these claims accurately.

Our companion guides to billing electronically are available on our website at www.magnoliahealthplan.com. See the section on electronic claim filing for more details.

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.

PROCEDURES FOR ONLINE CLAIM SUBMISSION

For participating providers who have less than five (5) claims in a calendar month and have internet access and choose not to submit claims via EDI, Magnolia has made it easy and convenient to submit claims directly to us on our website at www.magnoliahealthplan.com.

You must request access to our secure site by registering for a username and password and have requested claims access. To obtain an ID, please contact provider relations at 1-877-236-0751 or visit our website at www.magnoliahealthplan.com. Requests are processed within two (2) business days.

Once you have access to the secure portal, you may view web claims, allowing you to re-open and continue working on saved, un-submitted claims. This feature allows you to track the status of claims submitted using the website.

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 take advantage of EFTs and ERAs to settle claims electronically. For more information, please visit our 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

For MS CHIP members, all claims and encounters should be submitted to:

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

Requirements

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

Important Steps to a Successful Submission of Paper Claims

1. Complete all required fields on an original, red CMS 1500 (02/12) or UB-04 form.
2. Ensure all Diagnosis, Procedure, Modifier, Location (Place of Service), Type of Admission, and Source of Admission Codes are valid for the date of service.
3. Ensure all diagnosis and procedure codes are appropriate for the age and sex of the member.
4. Ensure all diagnosis codes are coded to their highest number of digits available.
5. Ensure member is eligible for services under Magnolia during the time in which services were provided.
6. Ensure an authorization has been given for services that require prior authorization by Magnolia.

Claim forms submitted without “Red” dropout OCR forms may cause unnecessary delays to processing.

Do

- Do submit all DOS and birthdates in a mm/dd/yyyy format
- Do use the correct P.O. Box number
- 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 large
- 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 UB04

Don't

- 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 the Magnolia Jackson office

Common Causes of Upfront Rejections

- Unreadable Information
- Missing Member Date of Birth
- Missing or Invalid Member Name or ID Number
- Missing or Invalid Provider Name, TIN, or NPI Number
- The Date of Service on the Claim is Not Prior to Receipt Date of the Claim
- Dates Are Missing from Required Fields
- Invalid of Missing Type of Bill
- Missing, Invalid or Incomplete Diagnosis Code
- Missing Service Line Detail
- Member Not Effective on The Date of Service
- Admission Type is Missing
- Missing Patient Status
- Missing or Invalid Occurrence Code or Date
- Missing or Invalid Revenue Code
- Missing or Invalid Current Procedural Terminology (CPT)/Procedure Code
- Incorrect Form Type
- Missing Clinical Laboratory Improvement Amendments (CLIA) number when applicable

Magnolia will send providers a detailed letter for each claim that is rejected explaining the reason for the rejection.

Common Causes of Claim Processing Delays and Denials

- Incorrect Form Type
- Diagnosis Code Missing Digit
- Missing or Invalid Procedure or Modifier Codes
- Missing or Invalid Diagnosis Related Group (DRG) Code
- Explanation of Benefits from the Primary Carrier is Missing or Incomplete
- Invalid Member ID
- Invalid Place of Service Code
- Provider TIN and NPI Do Not Match what is on file with Magnolia or DOM provider files
- Invalid Revenue Code
- Dates of Service Span Do Not Match Listed Days/Units
- Missing Provider Signature
- Invalid TIN
- Missing or Incomplete Third-Party Liability Information

Magnolia will send providers written notification via the Explanation of Benefit (EOP) for each claim that is denied, which will include the reason(s) for the denial.

Billing Forms
Submit claims for professional services and durable medical equipment on a CMS 1500. Submit claims for hospital-based inpatient and outpatient services as well as swing bed services on a UB-04 form.

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, or commercial carrier, automobile insurance, and worker's compensation) or program that is or 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 MS CHIP 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 to have another carrier, which could impact members' eligibility for MS CHIP.

Billing the Member
Magnolia reimburses only services that are medically necessary and covered through MS CHIP. 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.

A provider may bill a member for a claim denied as not being medically necessary, not a covered benefit or the member has exceeded the program limitations for a particular service only 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 client 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 covered under MS CHIP as being reasonable and medically necessary for my care. I understand that Magnolia through its contract with DOM determines the medical necessity of the services or items that I request and receive. I also understand that I am responsible for payment of 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.

Claim Request for Reconsideration and 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 Claims
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 RECONSIDERATIONS AND APPEALS

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, or 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 Mailing Address:

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

Behavioral Health 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.

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. Claim appeals can be filed by mail, fax, or through Magnolia's Secure Provider Portal.

Medical Appeal Mailing Address:

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

Behavioral Health Appeal Mailing Address:

Magnolia Health
Attn: BH Appeals
P.O. Box 6000
Farmington, MO 63640

Medical and Behavioral Health providers can submit a claim appeal by fax to: (833) 950-2857

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 administrative hearing.

STATE ADMINISTRATIVE HEARING

A hearing conducted by the Division of an appeal that is not resolved wholly in favor of the provider by Magnolia. A provider can request a hearing once the provider has exhausted Magnolia's dispute process.

A request for a State Administrative Hearing must be submitted within thirty (30) calendar days of the final decision by Magnolia Health. Requests should be submitted to the Division at the following address:

Division of Medicaid, Office of the Governor
Attn: Office of Appeals
P.O. Box 2222
Jackson, MS 39225
Phone: 601-359-6050 or 1-800-884-3222
Fax: 601-359-9153

EFT AND ERA

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CLAIM FORMS

Magnolia accepts the CMS 1500 (02/12) and CMS 1450 (UB-04) paper claim forms. 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. All paper claim forms submitted must be completed in black or blue ink. If you have questions regarding what type of form to complete, contact a Magnolia provider services representative at 1-877-236-07511-866-912-6285.

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:

CODE EDITING

Magnolia uses code-auditing software to assist in improving accuracy and efficiency in claims processing, payment, and reporting, as well as meeting HIPAA compliance regulations. The software will detect, correct, and document coding errors on provider claims prior to payment by analyzing CPT, HCPCS, modifier, and place of service codes against rules that have been established by the American Medical Association (AMA), Center for Medicare and Medicaid Services (CMS), public-domain specialty society guidance, and clinical consultants who research, document, and provide edit recommendations based on the most common clinical scenario and the state of Mississippi. Claims billed in a manner that does not adhere to these standard coding conventions will be denied.

Code editing software contains a comprehensive set of rules and address coding inaccuracies such as unbundling,

fragmentation, up coding, duplication, invalid codes, and mutually exclusive procedures. The software offers a wide variety of edits that are based on:

- American Medical Association (AMA) – the software utilizes the CPT Manuals, CPT Assistant, CPT Insider's View, the AMA web site, and other sources.
- Centers for Medicare & 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.
- Public domain specialty society guidance (i.e., American College of Surgeons, American College of Radiology, American Academy of Orthopedic Surgeons).
- 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.
- 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.

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	Add

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 CPT code 80050 is added to a new service line and recommended for reimbursement.

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

Example:

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: 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.

Duplicate services – The submission of the same procedure more than once on the same date for services that cannot be or are normally not performed more than once on the same date.
Example: excluding a duplicate CPT

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.
- 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) days or zero (0) day global surgery period are designated as minor surgical procedures.
- Evaluation and management services, submitted with major surgical procedures (90-day) and minor surgical procedures (10-day), are not recommended for separate reporting because they are part of the global service.
- Evaluation and management services, submitted with minor surgical procedures (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, condyle 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 & coordination of care w/other providers or agencies are provided consistent w/nature of problem(s) & patient's &/or family's needs. Problem(s) are low/moderate severity. Physicians spend 15 min face-to-face w/patient &/or family.	Disallow

Explanation:

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

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

Explanation:

- Procedure 11000 (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.

Same Date of Service- One (1) evaluation and management service is recommended for reporting on a single date of service.

Example: same 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:

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.

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-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.

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 and 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 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 with our contracted providers the claim auditing rules and clinical rationale we use to pay claims.
- The code auditing reference tool is available on Magnolia’s secure provider portal and is accessible by registering for Magnolia’s secure provider portal at www.magnoliahealthplan.com.
- 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/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), or 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 have been used to determine an edit. The tool assumes all CPT codes are billed on a single claim.
- The tool will not take into consideration individual fee schedule reimbursement, authorization requirements, or other coverage considerations.

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-4, HCPCS, or ASA codes and ICD-10 codes. Submit institutional claims with valid Revenue Codes and CPT-4 or 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. The highest degree of specificity, or detail, can be determined by using the Tabular List (Volume One) of the ICD-10 coding manual in addition to the Alphabetic List (Volume Two) when locating and designating diagnosis codes. The Tabular List gives additional information such as exclusions and subdivisions of codes not found elsewhere in the manual. Any three-digit code that has subdivisions must be billed with the appropriate subdivision code(s) and be conducted to the highest digit, if appropriate. Ancillary providers (e.g., Labs, Radiologists, etc.) and those physicians interpreting diagnostic testing may use V72.6 for Laboratory Exam, V72.5 for Radiological Exam, NEC, and V72.85 for Other Specified Exam as the principal diagnosis on the claim. Please consult your ICD-10 manual for further instruction. 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.

APPENDIX I: COMMON REJECTIONS FOR PAPER CLAIMS

- Member DOB missing from the claim.
- Member Name or Id Number missing or invalid from the claim.
- Provider Name, TIN, or NPI Number missing from claim.
- Claim data is unreadable due to either too light (insufficient toner), dot-matrix printers, or too small font to allow for clear electronic imaging of claim.
- Diagnosis Code missing or invalid.
- REV Code missing or invalid.
- CPT/Procedure Code missing or invalid.
- Dates missing from required fields. Example: "Statement From" UB-04 & "Service From" 1500 (02/12). "To Date" before "From Date".
- DOS on claim is not prior to receipt of claim (future date of services).
- DOS prior to effective date of Health Plan or prior to member eligibility date.
- Incorrect Form Type Used (approved form types are CMS 1500 (02/12) for professional medical services or the UB-04 for all facility claims).
- Invalid TOB or invalid type of bill.
- No detail service line submitted.
- Admission Type missing (when Inpatient Facility Claim only).
- Patient Status missing (when Inpatient Facility Claim only).
- Handwriting on claim.

APPENDIX II: COMMON CAUSES OF PAPER CLAIM PROCESSING DELAYS OR DENIALS

- Billed Charges Missing or Incomplete – A billed charge amount must be included for each service/procedure/supply on the claim form.
- Claims not submitted on "Red" dropout OCR forms – Claim forms submitted without red dropout may cause unnecessary delays to processing.
- Diagnosis Code Missing Digit – Diagnosis should be billed to the highest intensity for proper coding and processing. Review the ICD-10-CM manual for coding to the digit.
- DRG Codes Missing or Invalid – Hospitals contracted for payment based on DRG (Diagnosis Related Grouping) codes should include this information on the claim form for accurate payment. Invalid DRG codes will result in denial.
- Primary Insurers EOB (Explanation of Benefits) is Missing or Incomplete – Claims for Members who have OIC (other insurance carrier) must be billed along with a copy of the primary EOB from the OIC (either paid or denied). Include pages with run dates, coding explanations, and messages.
- Member ID Invalid – The member ID does not match Name or DOB submitted.
- Place of Service Code Invalid – A valid and appropriate two-digit numeric code must be included on the claim form. Refer to CMS 1500 coding manuals for a complete list of places of service codes.
- Procedure or Modifier Codes Invalid or Missing- Coding from the most current coding manuals (CPT or HCPCS) is required in order to accurately complete processing. All applicable diagnosis, procedure, and modifier fields must be completed.
- Provider TIN and NPI Do Not Match – The submitted NPI does not match Provider's TIN on file or NPI on file with DOM.
- Revenue Codes Missing or Invalid – Facility claims must include a valid three or four-digit numeric revenue code. Refer to UB-92 coding manual for a complete list of revenue codes.
- Date Span Billed does not match Days/Units Billed – spanned dates of service can only be billed for consecutive days along with matching number of days/units (i.e. Date Span of 01/01 to 01/03 and days/units = 3).
- Signature Missing – The signature of the provider of service, or an authorized representative must be present on the claim form.
- TIN Missing or Invalid- Provider's TIN number must be present and must match the service provider name and payment entity (vendor) on file with Magnolia.

APPENDIX III: EOP DENIAL CODES AND 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
	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 RE-SUBMIT
BI	DENY: CLAIM CANNOT BE PROCESSED WITHOUT AN ITEMIZED BILL
	CPT HAS BEEN REBUNDLED ACCORDING TO CLAIM AUDIT
	CPT HAS BEEN REPLACED ACCORDING TO CLAIM AUDIT
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
DD	DENY: SIGNED CONSENT FORM HAS NOT BEEN RECEIVED
DJ	DENY: INAPPROPRIATE CODE BILLED, CORRECT & 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

Denial Code	Denial Description
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 HCPC/CPT FOR CORRECT PRICING
HL	DENY: CLAIM AND AUTH LOCATIONS DO NOT MATCH
HP	DENY: CLAIM AND AUTH SERVICE PROVIDER NOT MATCHING
HQ	DENY: EDI CLAIM MUST BE SUBMITTED IN HARD COPY W/CONSENT FORM ATTACHED
HS	DENY: CLAIM AND AUTH PROVIDER SPECIALTY NOT MATCHING
HT	DENY: CLAIM AND AUTH TREATMENT TYPE NOT MATCHING
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
	DENY: INVALID/DELETED/MISSING CPT CODE
	PLEASE RESUBMIT WITH THE PRIMARY MEDICARE EXPLANATION OF BENEFITS
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
	DENY: NAME OF DRUG, NDC NUMBER AND QUANTITY IS REQUIRED TO PROCESS CLAIM
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
	PROCEDURE CODE/ICD-9 CODE INCONSISTENT WITH MEMBER'S GENDER
	PROCEDURE CODE CONFLICTS WITH MEMBER'S AGE
	ADD-ON CODE REQUIRED WITH PRIMARY CODE FOR QUANTITY GREATER THAN ONE

Denial Code	Denial Description
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-10 CODE INCONSISTENT WITH MEMBERS 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

APPENDIX IV: INSTRUCTIONS FOR SUPPLEMENTAL INFORMATION

CMS 1500 (02/12) Form, Shaded Field 24A-G

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 Health Care 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 un-shaded 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	

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

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 claim reporting/adjudication process. The NDC for each service being billed should be entered in the shaded section of twenty-four (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 eleven (11) digit NDC information. Do not enter a space between the qualifier and the eleven (11) digit NDC number. Don't enter hyphen or space within 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

APPENDIX V: HIPAA COMPLIANT EDI REJECTION CODES

These codes are the standard national rejection codes for EDI submissions. All errors indicated for the code must be corrected before the claim is resubmitted.

Please see Magnolia's list of common EDI rejections to determine specific actions you may need to take to correct your claims submission.

Denial Code	Denial Description
01	Invalid Mbr DOB
02	Invalid Mbr
06	Invalid Prv
07	Invalid Mbr DOB & Prv
08	Invalid Mbr & Prv
09	Mbr not valid at DOS
10	Invalid Mbr DOB; Mbr not valid at DOS
12	Prv not valid at DOS
13	Invalid Mbr DOB; Prv not valid at DOS
14	Invalid Mbr; Prv not valid at DOS
15	Mbr not valid at DOS; Invalid Prv
16	Invalid Mbr DOB; Mbr not valid at DOS; Invalid Prv
17	Invalid Diag
18	Invalid Mbr DOB; Invalid Diag
19	Invalid Mbr; Invalid Diag
21	Mbr not valid at DOS; Prv not valid at DOS
22	Invalid Mbr DOB; Mbr not valid at DOS; Prv not valid at DOS
23	Invalid Prv; Invalid Diag
24	Invalid Mbr DOB; Invalid Prv; Invalid Diag
25	Invalid Mbr; Invalid Prv; Invalid Diag
26	Mbr not valid at DOS; Invalid Diag
27	Invalid Mbr DOB; Mbr not valid at DOS; Invalid Diag
29	Prv not valid at DOS; Invalid Diag
30	Invalid Mbr DOB; Prv not valid at DOS; Invalid Diag
31	Invalid Mbr; Prv not valid at DOS; Invalid Diag
32	Mbr not valid at DOS; Prv not valid; Invalid Diag
33	Invalid Mbr DOB; Mbr not valid at DOS; Invalid Prv; Invalid Diag
34	Invalid Proc
35	Invalid Mbr DOB; Invalid Proc
36	Invalid Mbr; Invalid Proc
38	Mbr not valid at DOS; Prv not valid at DOS; Invalid Diag
39	Invalid Mbr DOB; Mbr not valid at DOS; Prv not valid at DOS; Invalid Diag
40	Invalid Prv; Invalid Proc
	CPT HAS BEEN DENIED ACCORDING TO CLAIM AUDIT
41	Invalid Mbr DOB, Invalid Prv; Invalid Proc
42	Invalid Mbr; Invalid Prv; Invalid Proc
43	Mbr not valid at DOS; Invalid Proc
44	Invalid Mbr DOB; Mbr not valid at DOS; Invalid Proc

46	Prv not valid at DOS; Invalid Proc
48	Invalid Mbr; Prv not valid at DOS; Invalid Proc
49	Mbr not valid at DOS; Invalid Prv; Invalid Proc
51	Invalid Diag; Invalid Proc
52	Invalid Mbr DOB; Invalid Diag; Invalid Proc
53	Invalid Mbr; Invalid Diag; Invalid Proc
55	Mbr not valid at DOS; Prv not valid at DOS; Invalid Proc
57	Invalid Prv; Invalid Diag; Invalid Proc
58	Invalid Mbr DOB; Invalid Prv; Invalid Diag; Invalid Proc
59	Invalid Mbr; Invalid Prv; Invalid Diag; Invalid Proc
60	Mbr not valid at DOS; Invalid Diag; Invalid Proc
61	Invalid Mbr DOB; Mbr not valid at DOS; Invalid Diag; Invalid Proc
63	Prv not valid at DOS; Invalid Diag; Invalid Proc
64	Invalid Mbr DOB; Prv not valid at DOS; Invalid Diag; Invalid Proc
65	Invalid Mbr; Prv not valid at DOS; Invalid Diag; Invalid Proc
66	Mbr not valid at DOS; Invalid Prv; Invalid Diag; Invalid Proc
67	Invalid Mbr DOB; Mbr not valid at DOS; Invalid Prv; Invalid Diag; Invalid Proc
72	Mbr not valid at DOS; Prv not valid at DOS; Invalid Diag; Invalid Proc
73	Invalid Mbr DOB; Mbr not valid at DOS; Prv not valid at DOS; Invalid Diag; Invalid Proc
74	Services performed prior to Contract Effective Date
75	Invalid units of service
76	Original Claim Number Required
81	Invalid units of service, Invalid Pvr
83	Invalid units of service, Invalid Pvr, Invalid Mbr

APPENDIX VI: ANESTHESIA SERVICES

Anesthesia CPT Codes fall within the range of 00100 – 01999.

All Anesthesia Providers are required to bill one of the following modifiers to each CPT Anesthesia code:

AA – Anesthesia service performed personally by Anesthesiologist
AA modifier can only be billed by an Anesthesiologist
Do not use for medical direction of CRNA

GC – This service has been performed in part by a Resident under the direction of a Teaching Physician
GC can only be used by Anesthesiologist in a teaching facility

QX – CRNA Service: with medical direction by a physician
QX must be used by both the CRNA and the Anesthesiologist

Anesthesiologist may not bill for direction of more than four CRNAs at any one-time
QZ – CRNA Service: without medical direction by a physician
QZ can only be used by the CRNA

MS CHIP defines one (1) anesthesia time unit as one (1) minute. Anesthesia time begins when the anesthesiologist begins to prepare the patient for anesthesia care in the operating room or in an equivalent area and ends when the anesthesiologist is no longer in attendance. That is when the patient may be safely placed under post-operative supervision.

Reimbursement will not be made for additional modifying units for physical status, extreme age, utilization of total body hypothermia, or controlled hypotension, or emergency conditions.

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.