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The practices, policies, and benefits described herein may be modified or discontinued from time to time. Every attempt will be made to inform you of any changes as they occur. Please visit www.magnoliahealthplan.com or call 1-866-912-6285 for the most updated information.

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 work 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.

Magnolia will not discriminate based on health status, need for health care services, race, color, age, religion, sex, national origin, limited English proficiency, marital status, political affiliation or level of income.

Mission

Magnolia strives to provide improved health status, successful outcomes, and member and provider satisfaction in a coordinated care environment. Magnolia has been designed 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 of 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 working 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 1-866-912-6285 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. Please visit www.magnoliahealthplan.com or call 1-866-912-6285 for the most updated information.
## KEY CONTACTS

The following chart includes several important telephone and fax numbers available for your office.

<table>
<thead>
<tr>
<th>Provider Services</th>
<th>1-866-912-6285</th>
<th>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</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fax: 1-877-811-5980</td>
<td></td>
<td>Assisting providers with questions concerning member eligibility status Assisting providers with prior authorization and referral procedures Assisting providers with claims payment procedures and handling provider disputes and issues Facilitating transfer of member medical records among medical providers, as necessary Providing to PCPs a monthly list of members who are under their care, including identification of new and deleted members; an explanation guide detailing use of the list must also be provided to the PCP Referring providers to the Fraud and Abuse Hotline Developing a process to respond to provider inquiries regarding current enrollment</td>
</tr>
<tr>
<td>Hours of Operation: Monday through Friday</td>
<td>8:00 a.m. to 5:00 p.m. CST</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Member Services</th>
<th>1-866-912-6285</th>
<th>Assisting member with questions to include but not limited to: eligibility, claims, auths, issues</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fax: 1-855-684-6747</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TDD/TTY 1-877-725-7753 Fax: 1-877-779-5219</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hours of Operation: Monday through Friday</td>
<td>8:00 a.m. to 5:00 p.m. CST</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Authorization Request Discharge Planning/Care Management</th>
<th>1-866-912-6285</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Fax: 1-855-684-6747</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Inpatient Admissions</th>
<th>1-866-912-6285</th>
<th>Magnolia Health Pharmacy PBM; assistance with pharmacy prior authorizations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fax: 1-855-684-6747</td>
<td></td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>US Script Prior Authorization</th>
<th>1-800-460-8988; 1-866-399-0928 Fax: 1-866-399-0929</th>
<th>Pharmacy Help Desk</th>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Magnolia Pharmacy Department</th>
<th>1-866-912-6285</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Fax: 1-866-595-8117</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Behavioral Health (Cenpatico)</th>
<th>1-866-324-3632 Fax: 1-866-694-3649 <a href="http://www.cenpatico.com">www.cenpatico.com</a></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>24 hours / 7 days a week</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>NurseWise (24/7 Availability)</th>
<th>1-866-912-6285</th>
<th>NurseWise is a 24 hour free health information phone line. The nurse triage service provides access to a broad range of health-related services including health education and crisis intervention.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Vision (OptiCare)</th>
<th>1-800-531-2818</th>
<th>Assist with routine and medical vision services</th>
</tr>
</thead>
</table>

Provider Services Department | 866-912-6285 or www.magnoliahealthplan.com
When calling Magnolia, please have the following information available:

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

### NURSEWISE

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

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

Members may use NurseWise to request information about providers and services available in your community after hours, when the Magnolia member services department (member services) is closed. The NurseWise staff is available in both English and Spanish and can provide additional translation services, if necessary.

We provide this service to support your practice and offer our members access to a registered nurse on a daily basis. If you have any additional questions, please call provider services or NurseWise at 1-866-912-6285.
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.

Mississippi Children’s Health Insurance Program (CHIP) – Copayments or Out-of-Pocket Maximum

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:

<table>
<thead>
<tr>
<th>Coverage Plan</th>
<th>Doctor Visit</th>
<th>Emergency Room Visit</th>
<th>Out-of-Pocket Maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td>MSCHP 01 [≤150% FPL]</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>MSCHP 02 [151% to 175% FPL]</td>
<td>$5 per visit</td>
<td>$15 per visit</td>
<td>$800 per coverage period</td>
</tr>
<tr>
<td>MSCHP 03 [176% to 209% FPL]</td>
<td>$5 per visit</td>
<td>$15 per visit</td>
<td>$950 per coverage period</td>
</tr>
</tbody>
</table>

**ELIGIBILITY**

Magnolia does not determine eligibility for MS CHIP members, as eligibility and assignment will be determined by DOM. 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/RegionalOffices.aspx](http://www.medicaid.ms.gov/RegionalOffices.aspx). You may also call Medicaid’s toll-free telephone number at 1-866-635-1347.

Populations who are eligible for MS CHIP:

<table>
<thead>
<tr>
<th>Populations</th>
<th>Income Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birth to Age One (1) Year</td>
<td>194% FPL to 209% FPL</td>
</tr>
<tr>
<td>Ages One (1) to Six (6) Years</td>
<td>133% FPL to 209% FPL</td>
</tr>
<tr>
<td>Age Six (6) to Nineteen (19) Years</td>
<td>133% FPL to 209% FPL</td>
</tr>
</tbody>
</table>

MS CHIP eligibility criteria will be based on criteria including citizenship, residency, age, and income requirements. Members must also meet additional requirements for enrollment as described below and in accordance with 42 C.F.R. § 457.305(a), 42 C.F.R. § 457.320(a), and the State Child Health Plan.

MS CHIP will operate on a statewide basis. DOM reserves the right to assign a member to a specific health plan.

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. Members that disenroll and do not choose another health plan under MS CHIP may enroll in DOM’s Medicaid program if they meet Medicaid eligibility requirements or pursue private insurance independently from DOM.
Member Eligibility Verification

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

1. Log onto DOM’s Envision website 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 1-866-912-6285 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 1-866-912-6285. Follow the menu prompts to speak to a provider services representative to verify eligibility before rendering services. Provider services will need the member name or member MS CHIP ID number to verify eligibility.

Through Magnolia’s secure provider web portal, PCPs are able to 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-child care 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 1-866-912-6285 immediately.

Interactive Voice Response (IVR)

What's great about the IVR system? It's free and easy to use by calling 1-866-912-6285! The IVR provides you with greater access to information. **Through the IVR you can:**

- Check member eligibility
- Check claims status
- Access twenty four (24) hours a day, seven (7) days a week, three hundred and 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](http://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
- Access to link to Magnolia’s Preferred Drug List (PDL)
Secure Website

Magnolia web portal services allows 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 RESPONSIBILITIES

Primary Care Provider (PCP) Responsibilities

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

Provider Types That May Serve As PCPs

Magnolia offers a robust network of PCPs to ensure every member has access to a medical home within the required travel distance standards. These standards are fifteen (15) miles or fifteen (15) minutes for urban areas and thirty (30) miles or thirty (30) minutes in rural areas. Providers who may serve as PCPs include any physician or health care practitioner or group operating within the scope of his or her licensure who is responsible for supervising, prescribing and providing primary care and primary care management services in MS CHIP, whose practice is limited to the general practice of medicine or who is an Internist, Pediatrician, Obstetrician, Gynecologist, Family Practitioner, General Practitioner, Certified Nurse Practitioners whose specialty is pediatrics, adult, family, certified nurse midwife, obstetrics/gynecology, or a physician assistant. Providers at Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs) may also serve as PCPs.

Members with disabling conditions, chronic illnesses, or children with special health care 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; 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 MS CHIP provider network.
The specialist as a PCP must agree to provide or arrange for all primary care, including routine preventative care, and to provide those specialty medical services consistent with the member’s disabling condition, chronic illness, or special health care need in accordance with Magnolia’s standards and with the scope of the specialty training and clinical expertise. In order to accommodate the full spectrum of care, the specialist as a PCP must also have admitting privileges at a hospital in Magnolia’s MS CHIP provider network.

- **PCPs who serve members under the age of nineteen (19) are responsible for conducting all well-baby and well-child care services.** Should the PCP be unable to conduct the necessary well-baby and well-child care service assessments, the PCP is responsible for arranging to have the necessary well-baby and well-child care service assessments conducted by another MS CHIP network provider and ensure that all relevant medical information, including the results of the well-baby and well-child Care service assessments, are incorporated into the member’s PCP medical record.

- **PCPs who serve members under the age of nineteen (19) report encounter data associated with well-baby and well-child care services, using a format approved by DOM, to Magnolia within one hundred and eighty (180) calendar days from the date of service.**

- **PCPs are responsible for contacting new members identified in the quarterly encounter list sent by Magnolia that indicate who has not had an encounter during the first six (6) months of enrollment.** Magnolia requires the PCP to:
  - Contact members identified in the quarterly encounter lists as not complying with well-baby, well-child care, and immunization schedules for children
  - Identify to Magnolia any such members who have not come into compliance with well-baby, well-child care, and immunization schedules within one (1) month of such notification to Magnolia
  - Document the reasons for noncompliance, where possible, and to document its efforts to bring the member’s care into compliance with the standards

The PCP is requested to:

- Be available for or provide on-call coverage through another source twenty four (24) hours a day for management of member care.
- Educate members on how to maintain healthy lifestyles and prevent serious illness.
- Provide culturally competent care.
- Maintain confidentiality of medical information.
- Obtain prior authorizations for selected 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.

Magnolia MS CHIP providers should refer to their contract for complete information regarding providers’ obligations and mode of reimbursement.
Assignment of Medical Home

As part of the application process for coverage under MS CHIP, a member shall select a Coordinated Care Organization (CCO). DOM will send members identified through the federal facilitated marketplace an enrollment form. Members will have thirty (30) calendar days to select a CCO.

Members who fail to make a voluntary CCO 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 CCO 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 past two (2) months. If DOM does not identify that the member and/or individuals in the member’s case ID number were enrolled in a CCO under MS CHIP, DOM will check if the member was enrolled previously in the MississippiCAN Program with a particular CCO.

2. **Prior Enrollment in the MississippiCAN Program:** DOM will assign a member to a CCO if the member was enrolled with a particular MississippiCAN CCO within the past two (2) months. If DOM does not identify prior MississippiCAN enrollment, DOM will review the member’s prior claims history.

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. DOM will assign each member to the CCO with the highest number of claims for a participating CCO. In cases where the number of highest claims is equal across more than one CCO, DOM will perform a review for the most recent date of service.

   a. **Date of Service:** DOM will assign the member to the CCO with the most recent date of service for a participating CCO. If there are identical most recent dates of service across more than one CCO, DOM will perform a review for the most recent transaction control number, which uniquely identifies each claim.

   b. **Transaction Control Number:** DOM will assign the member to the CCO with the most recent transaction control number, which is a unique seventeen (17) digit identifier for a claim assigned by the Medicaid Management Information System (MMIS).

4. If multiple Plans meet the requirements above, then assignment will occur using a random assignment.

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.

For members who have not selected a PCP by the enrollment effective date, Magnolia will use an auto-assignment algorithm to assign an initial PCP. The algorithm assigns members to a PCP according to the following criteria, and in the sequence presented below:

1. **Member history with a PCP.** The algorithm will first look for previous relationship with a network PCP.

2. **Family history with a PCP.** If the member has no previous relationship with a PCP, the algorithm will look for a PCP to which someone in the member’s family, such as a sibling, is or has been assigned.
3. Appropriate PCP 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 PCP to member residence. The auto-assignment logic will ensure members travel 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 notify Magnolia to request an assigned member be assigned to an alternate PCP using Magnolia’s Primary Care Provider (PCP) Form located at www.magnoliahealthplan.com with the member or authorized representative’s approval/signature.

Specialist Responsibilities

The PCP is responsible to coordinate members’ healthcare services and make referrals to specialty providers when medically necessary care is needed that are beyond the scope of the PCP. The specialty provider may order diagnostic tests without PCP involvement by following Magnolia referral guidelines. The specialty providers must abide by the prior authorization requirements when ordering diagnostic tests.

The specialist provider must:

- Maintain contact with the PCP
- Obtain referral or authorization from the member’s PCP and/or Magnolia medical management department (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 member care
- Maintain the confidentiality of medical information

Magnolia MS CHIP providers should refer to their contract for complete information regarding providers’ obligations and mode of reimbursement.

Voluntarily Leaving the Network

Providers must give Magnolia appropriate notice before voluntarily leaving the network at the end of the initial term or at the end of any renewal term or in accordance with the terms of the provider agreement. Please refer to your individual or organizational provider agreement, under "Term and Termination" for the applicable timeframe for giving notice. For a termination to be considered valid, providers are required to send termination notices via certified mail (return receipt requested) or other traceable method. In addition, providers must supply copies of medical records to the member’s new provider and facilitate the member’s transfer of care at no charge to Magnolia or the member in accordance with the terms of their provider agreement.

Magnolia will notify affected members in writing of a provider’s termination, as applicable, at least fifteen (15) days before the member disenrollment. If the terminating provider is a PCP, Magnolia will request that the member elect a new PCP. If a member does not elect 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 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 health care 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 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
- Providers unwilling to continue to treat the member or accept payment from Magnolia
Accessibility Standards

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

<table>
<thead>
<tr>
<th>Type</th>
<th>Appointment Scheduling Time Frames</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCPs (well care visit)</td>
<td>Not to exceed thirty (30) calendar days</td>
</tr>
<tr>
<td>PCP (routine sick visit)</td>
<td>Not to exceed seven (7) calendar days</td>
</tr>
<tr>
<td>PCP (Urgent Care visit)</td>
<td>Not to exceed twenty-four (24) hours</td>
</tr>
<tr>
<td>Specialists</td>
<td>Not to exceed forty-five (45) calendar days</td>
</tr>
<tr>
<td>Dental Providers (routine visits)</td>
<td>Not to exceed forty-five (45) calendar days</td>
</tr>
<tr>
<td>Dental Providers (Urgent Care)</td>
<td>Not to exceed forty-eight (48) hours</td>
</tr>
<tr>
<td>Behavioral Health Providers (routine visit)</td>
<td>Not to exceed twenty-one (21) calendar days</td>
</tr>
<tr>
<td>Behavioral Health Providers (urgent visit)</td>
<td>Not to exceed twenty-four (24) hours</td>
</tr>
<tr>
<td>Behavioral Health Providers (post-discharge from an acute psychiatric hospital when Contractor is aware of the Member’s discharge)</td>
<td>Not to exceed seven (7) calendar days</td>
</tr>
<tr>
<td>Urgent Care Providers</td>
<td>Not to exceed twenty-four (24) hours</td>
</tr>
<tr>
<td>Emergency Providers</td>
<td>Immediately (twenty-four (24) hours a day, seven (7) days a week) and without Prior Authorization</td>
</tr>
</tbody>
</table>

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
• 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.

• 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, in order 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).

Covering Providers

PCPs and specialty providers must arrange for coverage with another MS CHIP network provider
during scheduled or unscheduled time off. In the event of unscheduled time off, please notify provider
relations 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 making such a referral themselves. 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 and that the PCP is aware of the additional service request.

Providers are 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:
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 Plan  
C/o Centene EDI Department  
1-800-225-2573, extension 25525  
or by e-mail at: EDIBA@centene.com

Self-Referrals

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 above services must be obtained through Magnolia’s MS CHIP 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 1–866-912-6285. A PCP shall not refuse to treat members as long as the provider has not reached their requested 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.

Hospital Responsibilities

Magnolia utilizes a MS CHIP network of hospitals to provide services to MS CHIP members. Hospitals are requested to:

- Notify the PCP immediately or no later than the close of the next business day after the member’s appearance in the ER.

- Obtain authorizations for selected outpatient services as listed on the current prior authorization list, except for emergency care and post-stabilization services.

- Notify Magnolia’s medical management department by sending an electronic file daily of all ER admissions for the previous business day. The electronic file should include 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.
Emergency Services (Routine and Urgent)

Routine, Urgent and Emergency Care Services Defined

Members are encouraged to contact their PCP prior to seeking care, except in an emergency.

The following are definitions for routine, urgent, and emergency services.

Routine - Services to treat a condition that would have no adverse effects if not treated within twenty four (24) hours or could be treated in a less acute setting (e.g., issues that could be treated in a physician clinic or persons seeking care or 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, usually not 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, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Placing the physical or mental health of the individual (or, with respect to a pregnant woman, the health of the woman 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
- Injury to self or bodily harm to others; or
- With respect to a pregnant woman having contractions; (i) that there is not adequate time to effect a safe transfer to another hospital before delivery, or (ii) that transfer may pose a threat to the health or safety of the woman or unborn child

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

Post-Stabilization Services: Covered services, related to an emergency medical condition that are provided after a member is stabilized in order to maintain the stabilized condition or to improve or resolve the members condition.

Post stabilization services will be considered complete when the following occurs:

- A plan physician with privileges at the treating hospital assumes responsibility for the enrollee at the treating
- A plan physician assumes responsibility for the enrollee’s care through transfer
- Or the enrollee (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: Point at which member is formally released from hospital by treating physician or authorized designee of physician, or by the individual member after they have indicated in writing, their decision to leave the hospital contrary to the advice of their treating physician.

*Urgent, Emergency, or/and Post Stabilization Services does 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 regardless of network participation. Notification is require by next business day for members admitted in to the hospital, no prior authorization is required.

The PCP plays a major role in educating Magnolia members about appropriate and inappropriate use of hospital emergency rooms. The PCP is responsible to follow up on 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 actually treating the member, is responsible for determining when the Member is sufficiently stabilized for transfer or discharge, and that determination is binding on Magnolia. However, Magnolia may establish arrangements with a hospital whereby Magnolia may send one of its own physicians with appropriate emergency room privileges to assume the attending physician or appropriate emergency room privileges to assumed transfer the member, provided that such arrangement does 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-emergency in nature. However, the prudent layperson test will be applied to the payment to the facility for charges which fall outside of the diagnoses codes identified as an emergency.

When a member is admitted from the emergency room, notification and clinical information is required within twenty four (24) hours or by the next business day of the admission. For specific necessary information to submit, see the Inpatient Notification section of this manual.

Advance Directives

Magnolia is committed to ensure that its members are aware of and are able to avail themselves of their rights 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 law regarding advance directives.

PCPs and providers delivering care to MS CHIP members must ensure adult members 18 years of age and older receive information on advance directives and are informed of their right to execute advance directives. Providers must document such information in the member’s permanent medical record.

Magnolia recommends the following regarding advance directives:

- The first point of contact for the member in the provider’s office should ask if the member has executed an advance directive, and the member’s response should be documented in the medical record.
- If the member has executed an advance directive, the first point of contact should ask the member to bring a copy of the advance directive to the provider’s office and document this request in the member’s medical record.
- Once an advance directive is received, it should be included as a part of the member’s medical record and should include mental health directives.
If an advance directive exists, the provider should discuss potential medical emergencies with the member and/or designated family member/significant other (if named in the advance directive and if available) and with the referring provider, if applicable. Any such discussion should be documented in the medical record.

CULTURAL COMPETENCY

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. In particular, it is the promotion of quality services to understand racial/ethnic 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.
BENEFIT EXPLANATION AND LIMITATIONS

Magnolia Health Mississippi Children’s Health Insurance Program Benefits

Magnolia providers supply a variety of medical benefits and services. For specific information not covered in this MS CHIP provider manual, please contact provider services at 1-866-912-6285 from 8:00 a.m. to 5:00 p.m. CST, Monday through Friday (excluding holidays). A provider services representative will assist you in understanding the benefits.

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:

- Inpatient Services:

  The services must be pre-authorized as medically necessary and includes the following:

  (1) Hospital room and board (including dietary and general nursing services)
  (2) Use of operating or treatment rooms
  (3) Anesthetics and their administration
  (4) Intravenous injections and solutions
  (5) Physical therapy
  (6) Radiation therapy
  (7) Oxygen and its administration
  (8) Diagnostic services, such as x-rays, clinical laboratory examination, electrocardiograms, and electroencephalograms
  (9) Drugs and medicines, sera, biological and pharmaceutical preparations used during hospitalization which are listed in the hospital's formulary at the time of hospitalization, including charges for "take home" drugs
  (10) Dressings and supplies, sterile trays, casts, and orthopedic splints
  (11) Blood transfusions, including the cost of whole blood, blood plasma and expanders, processing charges, administrative charges, equipment, and supplies
  (12) Psychological testing when ordered by the physician and performed by a full-time employee of the hospital, subject to limitations
  (13) Intensive, coronary, and burn care unit services
  (14) Occupational therapy
  (15) Speech therapy

- Medical Services

  Includes the following:

  (1) In-hospital medical care
  (2) Medical care in the physician's office, enrollee's home, or elsewhere
  (3) Surgery
(4) Dental care, treatment, dental surgery, and dental appliances made necessary by accidental bodily injury to sound and natural teeth (which are free from effects of impairment or disease) effected solely through external means occurring while the enrolled child is covered under the program. Injury to teeth as a result of chewing or biting is not considered an accidental injury. Covered medical expense must be incurred as a direct result of an accidental injury to natural teeth and medical treatment must begin within ten days of the accidental injury.

(5) Administration of anesthesia

(6) Diagnostic services, such as clinical laboratory examinations, x-ray examinations, electrocardiograms, electroencephalograms, and basal metabolism tests

(7) Radiation therapy

(8) Consultations

(9) Psychiatric and psychological service for nervous and mental conditions

(10) Physicians assisting in surgery, where appropriate

(11) Emergency care or surgical services rendered in a practitioner’s office including but not limited to surgical and medical supplies, dressings, casts, anesthetic, tetanus, serum, and x-rays

(12) Well child assessments, including vision screening, laboratory tests and hearing screening, according to recommendations of the U.S. Preventive Service Task Force. Vision and hearing screening are to be included as part of the periodic well child assessments.

(13) Routine immunizations (according to ACIP guidelines) vaccine is purchased and distributed through the state department of health. The health plan will reimburse providers for the administration of the vaccine.

(14) Clinic services (including health center services) and other ambulatory health care services.

• Surgical Services:

Benefits are considered for the following covered medical services provided to Magnolia MS CHIP members by an ambulatory surgical facility (some surgeries must be pre-authorized for medical necessity):

(1) Services consisting of routine pre-operative laboratory procedures directly related to the surgical procedure

(2) Pre-operative preparation

(3) Use of facility (operating rooms, recovery rooms, and all surgical equipment)

(4) Anesthesia, drugs and surgical supplies

• Prescription Drugs:

Prior authorization is required for selected drugs. A preferred drugs list will be implemented with provisions for medically necessary exceptions.

The following drugs and medical supplies, if medically necessary, U.S. Food and Drug
Administration (FDA) approved, non-experimental drugs prescribed by a licensed practitioner, and prescribed for the medical treatment of illness and/or injuries, are covered:

(1) Legend drugs (federal law requires these drugs be dispensed by prescription only)
(2) Compounded medication of which at least one ingredient is a legend drug
(3) Disposable blood/urine glucose/acetone testing agents (e.g., Chemstrips, Acetest tablets, Clinitest tablets, Diastix Strips and Tes-Tape)
(4) Disposable insulin needles/syringes
(5) Growth hormones
(6) Insulin
(7) Lancets
(8) Legend contraceptives
(9) Retin-A
(10) Fluoride supplements (e.g., Gel-Kam, Luride, Prevident, sodium fluoride tablets)
(11) Vitamin and mineral supplements, when prescribed as replacement therapy

The following are excluded:

(1) Anabolic steroids
(2) Drugs used for the purpose of weight loss
(3) Charges for the administration or injection of any drug
(4) Drugs when used to promote fertility
(5) Over-the-counter (OTC) items except those specifically listed as covered
(6) Drugs used for cosmetic purposes or hair growth, including, but not limited to anti-wrinkle agents, drugs used to treat alopecia, and pigmenting/depigmenting agents
(7) Therapeutic devices or appliances, including needles, syringes, support garments and other non-medicinal substances, regardless of intended use, except those listed as covered
(8) Drugs used for off-label indications which are not found in official compendia or generally accepted in peer reviewed literature
(9) Investigative drugs and drugs used other than for the FDA approved diagnosis
(10) Refills in excess of the number specified by the practitioner or any refills dispensed more than one (1) year after the date of practitioner’s original prescription

- Laboratory and radiological services:
  Specified diagnostic tests must be pre-authorized

- Prenatal care and pre-pregnancy family services and supplies:

Infertility services are excluded to include: infertility treatments, reproductive services other than prenatal care, labor and delivery, and care related to diseases illnesses or abnormalities related to the reproductive system
• Inpatient mental health services (excluding inpatient and residential substance abuse treatment), including services provided in a state-operated mental hospital and including residential or other twenty four (24) hour therapeutically planned structural services:

(1) Benefits for covered medical expenses are paid for medically necessary inpatient psychiatric treatment of an enrollee
(2) Benefits for covered medical expenses are provided for partial hospitalization
(3) Certification of medical necessity by the insurer’s utilization review program is required for admission to a hospital

Benefits for mental/nervous conditions do not include services where the primary diagnosis is substance abuse

• Outpatient mental health services (excluding outpatient and community substance abuse treatment), including services provided in a state-operated mental hospital and including community-based services:

(1) Benefits for covered medical expenses for treatment of nervous and mental conditions on an outpatient basis
(2) Benefits for mental/nervous conditions do not include services where the primary diagnosis is substance abuse

• Durable medical equipment and other medically related or remedial devices (prosthetic devices, eyeglasses, hearing aids, dental devices, and adaptive devices):

(1) Rental of durable medical equipment is covered for temporary therapeutic use; provided, however, at the insurer’s discretion, the purchase price of such equipment may be allowed. To be durable medical equipment, an item must be:
   a. Made to withstand repeated use
   b. Be primarily used to serve a medical purpose
   c. Be generally un-useful to a person in the absence of illness, injury or disease
   d. Be appropriate for use in the enrollee’s home

(2) Prosthetic or orthotic devices necessary for the alleviation or correction of conditions arising from accidental injury, illness, or congenital abnormalities are covered services. Benefits are available for the initial placement, fitting, and purchase of prosthetic or orthotic devices that require a prescription by a physician and for the repair or replacement when medically necessary. Shoes are not covered except for the following:
   a. A surgical boot which is part of an upright brace
   b. One pair of mismatched shoes annually in instances where a foot size disparity is greater than two sizes
   c. And a custom fabricated shoe in the case of a significant foot deformity

(3) Eyeglasses (limited to one [1] per year) and hearing aids (limited to one [1] every three [3] years) are covered services.
• Disposable medical supplies:

Supplies provided under MS CHIP that are medically necessary disposable items, primarily serve a medical purpose, have therapeutic or diagnostic characteristics essential to enabling an enrollee to effectively carry out a practitioner’s prescribed treatment for illness, injury, or disease, and are appropriate for use in the enrollee’s home.

• Home and community-based health care services:

(1) Services and supplies required for the administration of home infusion therapy regimen must be medically necessary for the treatment of the disease, ordered by a practitioner, as determined by the insurer’s utilization review program capable of safe administration in the home, provided by a licensed home infusion therapy provider coordinated and pre-certified by the insurer’s utilization review program, ordinarily in lieu of inpatient hospital therapy, and more cost effective than inpatient therapy.

(2) Benefits for home health nursing services must be approved by the insurer’s utilization review program in lieu of hospitalization. Benefits for nursing services are limited to $10,000 annually.

• Nursing care services:

(1) Benefits include nursing services of an actively practicing registered nurse (RN) or licensed practical nurse (LPN) when ordered and supervised by a practitioner and when the services rendered require the technical skills of an RN or LPN.

(2) Benefits are provided for covered medical expense when performed by a nurse practitioner practicing within the scope of his or her license at the time and place service is rendered.

(3) Benefits for private duty nursing services are provided for an illness or injury that the insurer’s utilization review program determines to be of such a nature and complexity that the skilled nursing services could not be provided by the hospital’s nursing staff. A shift of eight (8) continuous hours or more is required for private duty nursing services. Benefits are also provided for nursing services in the home for illness or injury that the insurer’s utilization review program determines to require the skills of an RN or LPN. Benefits for nursing services provided in an enrollee’s home must be approved by the insurer’s utilization review program in lieu of hospitalization. Benefits for nursing services are limited to $10,000 annually. (This limit does not apply to nurse practitioner services.)

No nursing benefits are provided for:

(1) Services of a nurse who ordinarily lives in the child’s home or is a member of the child’s family
(2) Services of an aide, orderly or sitter, or
(3) Nursing services provided in a personal care facility
Benefits are provided for confinement in a skilled nursing facility for up to sixty (60) days per benefit period, subject to utilization management requirements.

- Abortion:
  
  (1) Coverage only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest
  
  (2) Benefits are allowed for elective abortion only when documented to be medically necessary in order to preserve the life or physical health of the mother

- Dental Services:
  
  o Dental Services for MS CHIP will be administered by the contracted vendor, Dental Health and Wellness. Please call 1-844-464-5636 for questions concerning dental benefits and/or questions.

  (1) Covered dental services are limited to $2000 each calendar year.

  (2) Benefits will be provided for preventive and diagnostic dental care as recommended by the American Academy of Pediatric Dentistry (AAPD):
    
    a. Bitewing x-rays as needed, but no more frequently than once every six (6) months
    
    b. Complete mouth x-ray and panoramic x-ray as needed, but no more frequently than once every twenty four (24) months
    
    c. Prophylaxis - one every six (6) months; must be separated by six (6) full months
    
    d. Fluoride treatment - limited to one each six (6) month period
    
    e. Space maintainers - limited to permanent teeth through age fifteen (15) years
    
    f. Sealants - covered up to age fourteen (14) years, every thirty six (36) months

  (3) Benefits are provided for restorative, endodontic, periodontic, and surgical dental services, as indicated below, and are limited to $2000 each calendar year.
    
    a. Amalgam, silicate, sedative and composite resin fillings including the replacement of an existing restoration
    
    b. Stainless steel crowns to posterior and anterior teeth
    
    c. Porcelain crowns to anterior teeth only
    
    d. Simple extraction
    
    e. Extraction of an impacted tooth
    
    f. Pulpotomy, pulpectomy, and root canal, and
    
    g. Gingivectomy, gingivoplasty and gingival curettage

Other dental services (the calendar year maximum does not apply to these services)

(1) Benefits are provided for dental care, treatment, dental surgery, and dental appliances made necessary by accidental bodily injury to sound and natural teeth (which are free from effects of impairment or disease) effected solely through
external means occurring while the enrolled child is covered under the Program. Injury to teeth as a result of chewing or biting is not considered an accidental injury.

(2) Benefits are provided for anesthesia and for associated facility charges when the mental or physical condition of the enrolled child requires dental treatment to be rendered under physician-supervised general anesthesia in a hospital setting, surgical center or dental office. These services must be prior authorized.

(3) No benefits will be provided for orthodontics, dentures, occlusion reconstruction, or for inlays unless such services are provided pursuant to an accidental injury as described above or when such services are recommended by a physician or dentist for the treatment of severe craniofacial anomalies or full cusp class III malocclusions. Diagnosis and surgical treatment for temporomandibular joint disorder or syndrome and craniomandibular disorder, whether such treatment is rendered by a practitioner or dentist, is subject to a lifetime maximum benefit of $5,000 per member. This lifetime maximum will apply regardless of whether the temporomandibular / craniomandibular joint disorder was caused by an accidental injury or was congenital in nature.

• Inpatient and residential substance abuse treatment services:

(1) Benefits for covered medical expenses are provided for medically necessary inpatient stabilization and residential substance abuse treatment.

(2) Benefits for covered medical expenses are provided for the treatment of substance abuse, whether for alcohol abuse, drug abuse, or a combination of alcohol and drug abuse.

(3) Certification of medical necessity by the insurer’s utilization review program is required for admissions to a hospital or residential treatment center.

(4) Benefits for substance abuse do not include services for treatment of nervous and mental conditions.

• Outpatient substance abuse treatment services:

(1) Benefits are provided for covered medical expenses for medically necessary intensified outpatient programs in a hospital, an approved licensed alcohol abuse or chemical dependency facility, or an approved drug abuse treatment facility.

(2) Benefits are provided for covered medical expenses for substance abuse treatment while not confined as a hospital inpatient.

(3) Benefits for substance abuse do not include services for treatment of nervous and mental conditions.

• Care management services:
(1) Medical care management may be performed by the utilization review program for those children who have a catastrophic or chronic condition. Through medical care management, the utilization review program may elect to (but is not required to) extend covered benefits beyond the benefit limitations and/or cover alternative benefits for cost-effective health care services and supplies which are not otherwise covered.

(2) The decision to provide extended or alternative benefits is made on a case-by-case basis to covered children who meet the utilization review program’s criteria then in effect. Any decision regarding the provision of extended or alternative benefits is made by the utilization review program.

• Therapy (physical, occupational, and speech):

  (1) Benefits are provided for physical therapy services specified in a plan of treatment prescribed by the enrollee’s practitioner and provided by a licensed physical therapist.

  (2) Benefits are provided for medically necessary occupational therapy services prescribed by the enrollee’s practitioner and specified in a treatment plan. Occupational therapy services must be provided by a licensed occupational therapist.

  (3) Benefits are provided for medically necessary speech therapy services prescribed by the enrollee’s practitioner and specified in a treatment plan. Speech therapy is not covered for maintenance speech, delayed language development, or articulation disorders.

  (4) Benefits are provided for an annual hearing examination, if indicated by the results of a hearing screening.

• Hospice care:

  Benefits are provided for inpatient and home hospice services, subject to utilization management requirements. Benefits for hospice services are limited to an overall lifetime maximum of $15,000.

• Anesthesia services:

  Benefits are provided for general anesthesia service when requested by the attending physician and performed by an anesthesiologist or a certified registered nurse anesthetist practicing within the scope of his or her license at the time and place service is rendered.

• Transplant services:
(1) Any human solid organ or bone marrow/stem cell transplant is covered, provided the following applies:

   i. The enrollee or provider obtains prior approval from the insurer’s utilization management program; and
   ii. The condition is life-threatening; and
   iii. Such transplant for that condition is the subject of an ongoing phase III clinical trial; and
   iv. Such transplant for that condition follows a written protocol that has been reviewed and approved by an institutional review board, federal agency or other such organization recognized by medical specialists who have appropriate expertise; and
   v. The enrollee is a suitable candidate for the transplant under the medical protocols used by the insurer’s utilization management program.

(2) Benefits are provided for surgical, storage, and transportation expenses incurred and directly related to the donation of an organ or tissue used in a covered organ transplant procedure.

(3) Benefits are provided for transportation costs of recipient and two other individuals to and from the site of the transplant surgery and reasonable and necessary expenses for meals and lodging of two (2) individuals at the site of transplant surgery. Reasonable and necessary expenses for transportation, meals, and lodging of two other individuals are provided. Only those expenses which are incurred at the time of the transplant surgery are eligible for reimbursement. Travel expenses incurred as a result of pre-operative and post-operative services are not eligible for reimbursement. Only actual travel expenses supported by receipts are reimbursed. In any event, the total benefits for transportation, meals, and lodging are limited to $10,000.

(4) If a covered solid organ or tissue transplant is provided from a living donor to a human transplant recipient:

   i. The following expenses are covered:
      a. A search for matching tissue, bone marrow or organ
      b. Donor’s transportation
      c. Charges for removal, withdrawal and preservation
      d. Donor’s hospitalization
   ii. When only the recipient is enrolled in the program, the donor is entitled to donor coverage benefits. The donor benefits are limited to only those not available to the donor from any other source. This includes, but is not limited to, other insurance coverage or any government program. Benefits provided to the donor will be paid under the recipient’s contract.
   iii. When both the recipient and the donor are enrolled in the program, the donor is entitled to benefits under the donor’s contract.
   iv. When only the donor is an enrollee, the donor is not entitled to donor coverage benefits. No benefits are provided to the non-member transplant recipient.
v. If any organ or tissue is sold rather than donated to the enrollee, no benefits are payable for the purchase price of such organ or tissue;

- Medical Transportation:

  Professional ambulance services to the nearest hospital, which is equipped to handle the enrollee’s condition in connection with covered hospital inpatient care; or when related to and within seventy two (72) hours after accidental bodily injury or medical emergency whether or not inpatient care is required.

  Non-Emergency transportation is an excluded benefit.

The following benefits are not covered under MS CHIP.

Exclusions & Limitations

Notwithstanding any other provisions of these rules and regulations, benefits will be limited, excluded, and conditioned as follows:

No benefits shall be provided for services or supplies which are provided for the following:

A. Convalescent, custodial, or domiciliary care or rest cures, including room and board, with or without routine nursing care, training in personal hygiene and other forms of self-care or supervisory care by a provider for an enrolled child who is mentally or physically disabled as a result of retarded development or body infirmity, or who is not under specific medical, surgical or psychiatric treatment to reduce his disability to the extent necessary to enable him to live outside an institution providing care; neither shall benefits be provided if the enrolled child was admitted to a hospital for his or her own convenience or the convenience of his or her provider, or that the care or treatment provided did not relate to the condition for which the enrolled child was hospitalized, or that the hospital stay was excessive for the nature of the injury or illness, it being the intent to provide benefits only for the services required in relation to the condition for which the enrolled child was hospitalized and then only during such time as such services are medically necessary

B. Cosmetic purposes, except for correction of defects incurred by the enrolled child while covered under the program through traumatic injuries or disease requiring surgery

C. Sex therapy or marriage or family counseling

D. Custodial care, including sitters and companions

E. Elective abortion unless documented to be medically necessary in order to preserve the life or physical health of the mother

F. Equipment that has a non-therapeutic use (such as humidifiers, air conditioners or filters, whirlpools, wigs, vacuum cleaners, fitness supplies, and so forth)

G. Procedures which are experimental/investigative in nature

H. Palliative or cosmetic foot care including flat foot conditions, supportive devices for the foot, the treatment for subluxations of the foot, care of corns, bunions (except...
capsular or bone surgery), calluses, toenails, fallen arches, weak feet, chronic foot strain, and symptomatic complaints of the feet
I. Services and supplies related to infertility, artificial insemination, intrauterine insemination and in vitro fertilization regardless of any claim to be medically necessary
J. Services which the health plan determines are not medically necessary for treatment of injury or illness
K. Services provided under any federal, state, or governmental plan or law
L. Nursing or personal care facility services, e.g. extended care facility, nursing home, or personal care home, except as specifically provided otherwise
M. Treatment or care for obesity or weight control including all diet treatments, gastric or intestinal bypass or stapling, or related procedures regardless of degree of obesity or any claim to be medically necessary
N. For refractive surgery such as radial keratotomy and other procedures to alter the refractive properties of the cornea
O. Inpatient rehabilitative services consisting of the combined use of medical, social, educational or vocational services, or any such services designed to enable enrolled children disabled by disease or injury to achieve functional ability, except for acute short-term care in a hospital or rehabilitation hospital as approved by the utilization management program
P. Outpatient rehabilitative services consisting of pulmonary rehabilitation, or the combined use of medical, social, educational or vocational services, or any such services designed to enable enrolled children disabled by disease or injury to achieve functional ability, except for physical, occupational, or speech therapy services specified in a plan of treatment prescribed by the enrolled child’s provider and provided by a licensed therapist
Q. Care rendered by a provider, who is related to the enrolled child by blood or marriage or who regularly resides in the enrolled child’s household
R. Services rendered by a provider not practicing within the scope of his license at the time and place service is rendered
S. Treatment related to sex transformations regardless of claim of medical necessity or for sexual function, sexual dysfunction or inadequacies not related to organic disease
T. Reversal of sterilization regardless of claim of medical necessity
U. Charges for telephone consultations, failure to keep a scheduled visit, completion of a claim form, or to obtain medical records or information required to adjudicate a claim
V. Travel, whether or not recommended by a provider, except as provided for under transplant benefits
W. Services related to diseases contracted or injuries sustained as a result of war, declared or undeclared, or any act of war
X. Treatment of any injury arising out of or in the course of employment or any sickness entitling the enrolled child to benefits under any workers’ compensation or employer liability law
Y. Any injury growing out of a wrongful act or omission of another party for which injury that party or some other party makes settlement or is legally responsible; provided, however, that if the enrolled child is unable to recover from the responsible party, benefits of the program shall be provided.
MEDICAL MANAGEMENT

Overview and Medical Necessity

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

To reach the Medical Director or Vice President of Medical Management, please contact:

Magnolia Health Plan Utilization Management
1-866-912-6285
Fax 1-855-684-6747
www.magnoliahealthplan.com

Utilization Management

The Magnolia Utilization Management Program (UMP) is designed to ensure members receive access to the right care at 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 health care, while at the same time actively managing cost trends. The UMP aims to provide services that are a covered benefit, medically necessary, appropriate to the patient’s condition, rendered in the appropriate setting, and meet professionally recognized standards of care.

Our program goals include:

- Monitoring 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

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 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)
- 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 so as 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 healthcare services, supplies, or equipment provided by a licensed healthcare professional that are:

- Appropriate and consistent with the diagnosis or treatment of the member’s condition, illness, or injury;
- 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 medical need and condition and, when supplied 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;
- Not experimental or investigational or for research or education;
- Provided by an appropriately licensed practitioner; and
- Documented in the member’s medical record in a reasonable manner, including the relationship of the diagnosis to the service.

Services for children are limited in that such services are necessary to correct or ameliorate defects, physical and mental illnesses, and conditions that are discovered during a well-baby, well-child care assessment, periodic or inter-periodic, whether or not such services are covered or exceed the benefit limits in the MS CHIP state plan. All services determined to be medically necessary must be covered.

Review Criteria

Magnolia has adopted utilization review criteria developed by McKesson 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, taking into account 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 medical management department at 1-866-912-6285. Practitioners also have the opportunity to discuss any medical or pharmaceutical 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 1-866-912-6285 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:

Magnolia Health Clinical Appeals Coordinator
111 East Capitol Street, Suite 500
Jackson, MS 39201
1-866-912-6285
Fax 1-877-851-3995
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 medical management staff may identify relevant topics for review pertinent to the MS CHIP population. The Clinical Policy Committee (CPC) reviews all requests for coverage and makes a determination regarding any benefit changes that are indicated.

If you need a new technology benefit determination or have an individual case review for new technology, please contact the medical management department at 1-866-912-6285.

Prior Authorization and Notifications

Prior authorization is a request to the Magnolia UM department for approval of services on the prior authorization list before the service is delivered. Authorization must be obtained prior to the delivery of certain elective and scheduled services. Services that require prior authorization by Magnolia are listed in the Prior Authorization Table found on www.magnoliahealthplan.com under provider/practice improvement resources center/manuals and reference guides. The PCP should contact the UM department via telephone, fax, secure email or through our website with appropriate supporting clinical information to request an authorization.

Prior authorization requests may be done electronically on our provider portal (using the ANSI X 12N 278 transaction code specifications). For more information on filing prior authorizations electronically, or any other questions regarding the provider portal, please contact your provider relations representative.

ER and urgent care services never require prior authorization. Providers should notify Magnolia of post-stabilization services such as, but not limited to, the weekend or holiday provision of home health, durable medical equipment, or urgent outpatient surgery within one (1) business day of the service initiation. Clinical information is required for ongoing care authorization of the service.

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 for the failure of the provider to obtain timely authorization.

Authorization Time Frames

Prior authorization should be requested at least five (5) calendar days before the requested service delivery date. Magnolia decisions for requests for standard services will be made within three (3) calendar days and/or two (2) business days per Minimum Standards for Utilization Review Agents issued by the Mississippi State Department of Health (MSDH) following receipt of the request for services. If Magnolia requires additional medical information in order to make a decision, Magnolia will notify the requesting provider of additional medical information needed and Magnolia must 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 requestor of the additional medical information needed and Magnolia must allow one (1) business day or three (3) calendar days for the requestor 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 make a decision. 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
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 can result in an administrative denial of the requested service.

Notification of Pregnancy (NOP)

Members that become 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 NOP Form within five (5) days of the first prenatal visit. The NOP Form can be found on the Magnolia website at www.magnoliahealthplan.com. Providers are expected to 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 17-P Program for women with a history of early delivery.

Magnolia Health Plan Services Requiring Plan Authorization

For 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 the discharge planning efforts with the hospitals UM and discharge planning departments and, when necessary, the member’s attending provider/PCP in order to ensure that Magnolia members receive 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 (90) 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 cases.
PHARMACY

Pharmacy Program

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. Magnolia 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

Magnolia has a list of covered medications called the Preferred Drug List (PDL). DOM reviews current, as well as, all new medications that can be added or changed from the PDL. This process is coordinated with Magnolia.

If a patient requires medication that does not appear on the DOM PDL website, the provider can submit a prior authorization request for a non-preferred medication. It is anticipated that such exceptions will be rare and that currently available PDL medications will be appropriate to treat the vast majority of medical conditions encountered by Magnolia providers.

For the most current PDL, please visit Magnolia’s website at www.magnoliahealthplan.com.

Specific Exclusion

The following drug categories are not part of the Magnolia PDL:

- Fertility enhancing drugs
- Anorexia, weight loss, or weight gain drugs
- Experimental or investigational drugs
- Immunizations and vaccines (except flu vaccine)
- Drug Efficacy Study Implementation (DESI) and Identical, Related and Similar drugs that are classified as ineffective
- Infusion therapy and supplies
- Oral vitamins and minerals (except those listed in the PDL)
- Drugs and other agents used for cosmetic purposes or for hair growth
- Erectile dysfunction drugs prescribed to treat impotence
- Drugs eligible for coverage under Medicare Part D
- OTC drugs (except those listed in the PDL)

Over-the-Counter Medications

The Magnolia 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 or not 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. The US Script claims system will automatically check the member profile for evidence of prior or current usage of the required agent. If there is evidence of the required agent on the member’s profile, the claim will automatically process. If not, the claims system will notify the pharmacist that a prior authorization is required.

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.

Newly Approved Products
Newly approved drug products will not normally be placed on the PDL during their first six (6) months on the market. During this period, access to these medications will be considered through the prior authorization review process.

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.

Working with Magnolia’s Pharmacy Benefit Manager (PBM)
Magnolia works with US Script to administer pharmacy benefits, including prior authorization process. Certain drugs require prior authorization to be approved for payment by Magnolia as determined by DOM. These include:

- All medications not listed on the PDL
- Some DOM preferred drugs (designated prior authorization on the PDL)

Follow these guidelines for efficient processing of your PA requests:
1. Complete the Magnolia/US Script form: Medication Prior Authorization Request Form that can be found on the Magnolia website at www.magnoliahealthplan.com
2. Fax to US Script at 1-866-399-0929
3. Once approved, US Script notifies the prescriber by fax
4. If the clinical information provided does not explain the reason for the requested prior authorization medication, US Script responds to the prescriber by fax, offering the DOM PDL alternatives.

5. For urgent or after-hours requests, a pharmacy can provide up to a seventy two (72) hour supply of most medications by calling the US Script Pharmacy Help Desk at: 1-800-460-8988.

A phone or fax-in process is available for prior authorization requests:

US Script Contacts
Prior Authorization Fax 1-866-399-0929
Prior Authorization Phone 1-866-399-0928
Clinical Hours  Monday - Friday 10:00 a.m.-8:00 p.m. (EST)
Mailing Address  US Script, 2425 W Shaw Ave, Fresno, CA 93711

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

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

Providers are requested to utilize the DOM PDL when prescribing medication to MS CHIP 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 US Script for review.

In the event that a provider or member disagrees with the decision regarding coverage of a medication; the provider may submit an appeal, verbally or in writing. For additional information about appeals, please refer to the Appeals section herein.

Working with Magnolia’s Specialty Pharmacy Providers

Magnolia works with a number of specialty pharmacy providers. Specialty pharmacy medications require Prior Authorization. Prescribers should submit requests for specialty medications to US Script on the Magnolia/US Script Specialty Pharmacy Prior Authorization Form.

Follow these guidelines for efficient processing of your Specialty Pharmacy medication prior authorization requests:

- Complete the Magnolia/US Script Specialty Pharmacy Prior Authorization Form that can be found on the Magnolia website at www.magnoliahealthplan.com
- Fax to US Script at 1-866-399-0929
- Once approved, US Script notifies the prescriber by fax
- If the clinical information provided does not explain the reason for the requested prior authorization medication, US Script responds to the prescriber by fax, offering the DOM PDL alternatives
- For urgent or after-hours requests, providers should contact the US Script Pharmacy Help Desk at 1-800-460-8988

Well-Baby and Well-Child Care

Magnolia provides all children and adolescents under age nineteen (19) through the MS CHIP program who are Magnolia members and are eligible to receive routine well baby and well child care visits including administration of immunizations. Magnolia provides the full range of well child services, without limitation. This includes periodic health screenings and appropriate and up-to-date
immunizations using the Advisory Committee on Immunization Practices’ (ACIP) Recommended Immunization Schedule for all eligible enrollees including examinations for vision, dental, and hearing, and all medically necessary services.

**Periodic Health Screening:**
- Comprehensive health and development history (including assessments of both)
- Physical and mental development
- Comprehensive unclothed physical examination
- Immunizations appropriate to age and health history
- Assessment of nutritional status
- Laboratory tests (including finger stick hematocrit and urinalysis (dip-stick) and sickle cell screening, if not previously performed); Blood lead levels must be tested pursuant to the EPSDT provider manual. Tuberculosis (TB) skin testing and Rapid Plasma Reagin (RPR) serology testing must be done if indicated
- Developmental and behavioral assessment
- Health education and anticipatory guidance
- Measurements (including head circumference for infants)
- Vision screening
- Hearing screening
- Dental and oral health assessment

**Periodic Schedule:**

Frequency is as follows:
- 0 – 1 month
- 2 months
- 4 months
- 6 months
- 9 months
- 12 months
- 15 months
- 18 months

The schedule follows a yearly basis beginning at the age of two (2), up to age twenty one (21).

If you need help accessing well-child services for children, please call 1-866-912-6285 and speak to a well-child coordinator.

Dental checkups are important to children’s health as they help stop cavities and gum disease. For assistance in locating a dental provider or referrals to a dental provider for the MS CHIP program, please call provider services at 1-866-912-6285. Dental benefits for MS CHIP are limited to $2,000 per calendar year.

- Well-baby and well-child assessments are the comprehensive and preventative child health program as part of the MS CHIP program. PCPs are required to contact non-compliant members identified for periodicity and immunization schedules in the quarterly encounter list for the Well-Baby and Well-Child Care assessment. Additionally, providers must notify Magnolia within one (1) month with documentation for the reasons of noncompliance, where possible, and documented efforts to bring the member’s care into compliance according to standards. Magnolia providers should refer to their contract for complete information regarding providers’ obligations and mode of reimbursement.

Provider shall participate in the Vaccines for Children (VFC) program. Vaccines from VFC should be billed with the specific antigen codes for administrative reimbursement. No payment will be made on the administration codes alone.
VALUE ADDED SERVICES

CentAccount® Program

The goal of the CentAccount program is to increase appropriate utilization of preventive services by rewarding members for practicing a targeted healthy behavior. The program will strengthen the relationship with the medical home as members regularly access preventive services, and will promote personal responsibility for and ownership of the member’s own health care.

CentAccount also benefits members because it provides them with credits to purchase health care items, such as OTC medications that they might otherwise not be able to afford. Services that will qualify for rewards through the program include completion of an initial health risk screening, primary care medical home visits within ninety (90) days of enrollment, annual adult well visits, well-baby and well-child assessments, certain disease-specific screenings, and completion of prenatal and postpartum care.

How does it work? Members will receive a prepaid debit card. Credit will be added to the account balance once the member receives certain screenings or preventive care. Members may use the cards to purchase approved health care goods and services online or at any retailer that accepts debit cards. CentAccount goods and services are those recognized by the Internal Revenue Service as health care expenses for flexible spending accounts.

For more information on the CentAccount Program, please visit our website at www.magnoliahealthplan.com.

CARE MANAGEMENT PROGRAM

Magnolia’s care management model is designed to help MS CHIP members obtain needed services, whether they are covered within the Magnolia array of covered services, from the community, or from other non-covered venues. Our model will support our provider network whether you work in an individual practice or 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 co-morbidities 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 PCP or specialist office with administrative work.

The program includes a systematic approach for early identification of eligible members, needs assessment, and development and implementation of an individualized care plan that includes member/family education and actively links the member to providers and support services as well as outcome monitoring and reporting back to the PCP. Our care management team will integrate covered and non-covered services and provide a holistic approach to a member’s medical and, when available, behavioral health care, 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 supports, impaired cognitive abilities and transportation needs.

In order to ensure that appropriate referrals and linkages 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 providing necessary services, and develop transition plans for incoming and outgoing members. Magnolia will do this by providing all care management history and 6 months of claims history and pertinent info related to any special needs.

In the event a Medicaid or MS CHIP eligible member enters the plan and is receiving medically necessary covered services at the time of enrollment, the plan will honor a transition period of up to 30
calendar days. If the new enrollee is in her second or third trimester of pregnancy, the plan will provide continued access to the prenatal care provider regardless of the participating status of the provider.

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 to complete a comprehensive assessment of the member’s needs post-discharge. 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 and 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.

A care management team is available to help providers manage their MS CHIP members. Listed below are programs and components of special services that are available and can be accessed through the care management team. We look forward to hearing from you about any MS CHIP members that you think can benefit from the addition of a Magnolia care management team member.

To contact a care manager call:

Magnolia Health
Care Management Department
1-866-912-6285

High Risk Pregnancy Program:

The OB will implement our Start Smart for Your Baby (Start Smart) 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. Start Smart is a unique prenatal program with a goal of improving maternal and child health outcomes by providing pregnancy and parenting education to all pregnant members and providing care management to high and moderate risk members through the postpartum period. A care manager with obstetrical nursing experience will serve as lead care manager for members at high risk of early delivery or who experience complications from pregnancy. The OB team has providers advising the team on overcoming obstacles, helping identify high risk members, and recommending interventions. These providers will provide input to Magnolia’s Medical Director on obstetrical care standards and use of newer preventive treatments such as 17 alpha-hydroxyprogesterone caproate (17-P).

Magnolia offers a premature delivery prevention program by supporting the use of 17-P. When a provider determines that a member is a candidate for 17-P, which use has shown a substantial reduction in the rate of preterm delivery, he/she will write a prescription for 17-P. This prescription is sent to the Magnolia care manager who will check for eligibility. The care manager will coordinate the ordering and delivery of the 17-P directly to the provider’s office. A prenatal care manager will contact the member and do an assessment regarding compliance. The nurse will remain in contact with the member and the prescribing provider during the entire treatment period. Contact the Magnolia High Risk Pregnancy department at 1-866-912-6285 for enrollment in the 17-P program.

Members that become pregnant while covered by MS CHIP are to notify Magnolia as soon as possible, as the member may be eligible for Medicaid.

The Complex Teams

A Transplant Coordinator will provide support and coordination for members who need organ transplants. All members considered as 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.
MemberConnections® Program

MemberConnections 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 components are integrated as a part of our care management program in order to link Magnolia and the community served. The program recruits staff from the communities serviced to establish a grassroots support and awareness of Magnolia within the community. The program has various components that can be provided depending on the need of the member.

Members can be referred to MemberConnections through numerous sources. Members who phone Magnolia to talk with Magnolia’s member services department may be referred for more personalized discussion on the topic they are inquiring about. Care managers may identify members who would benefit from one of the many MemberConnections components and complete a referral request. Providers may request MemberConnections referrals directly to the connections representative or their assigned care manager. Community groups may request that a connections representative come to their facility to present to groups they have established or at special events or gatherings. Various components of the program are described as follows:

- **Community Connections:** Connection representatives are available to present to group setting during events initiated by state entities, community groups, clinics, or any other approved setting. This form of community connections is extremely useful in rural areas where home visits may be the only mode of communication. Presentations may typically include what DOM’s coordinated care program is all about, overview of services offered by Magnolia, how to use the health plan and access services, the importance of obtaining primary preventive care, and other valuable information related to obtaining services from Magnolia and its providers.

- **Home Connections:** Connection representatives are available on a full-time basis whenever a need or request from a member or provider arises. All home visits are pre-scheduled with the member unless the visit is a result of being unable to locate a member. Topics covered during a home visit include overview of covered benefits, how to schedule an appointment with the PCP, the importance of preventive health care, appropriate use of preventive, urgent, and emergency care services, obtaining medically necessary transportation, and how to contact Magnolia for assistance.

- **Phone Connections:** Connection representatives may contact new members or members in need of more personalized information to review Magnolia’s material over the telephone. All the previous topics may be covered and any additional questions 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, pre-programmed cell phone with limited use. Members may use this cell phone to call Magnolia case manager, PCP, specialty provider, NurseWise, 911, or other members of their health care team. In some cases, Magnolia may provide MP-3 players with pre-programmed education programs for those with literacy issues or in need of additional education.

**To contact the MemberConnections Team call:**

Magnolia Health
MemberConnections
1-866-912-6285

Disease Management (DM) Programs

As a part of Magnolia’s services, DM programs are offered to members. A health coach is located in the office and may be contacted for services. Components of DM programs available include:

- Increasing coordination between medical, social, and educational communities

- Severity and risk assessments of the population
• Profiling the population and providers for appropriate referrals to providers
• Ensuring active and coordinated provider/specialist participation
• Identifying modes of delivery for coordination 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 member’s caregiver ability to self-manage chronic conditions; and coordination with a Magnolia care manager for care management services

The DM programs target members with selected 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 include home visits by a health coach for members categorized as high risk.

Magnolia’s affiliated DM company, Nurtur, will administer DM programs which include services for chronic diseases such as asthma and diabetes. To refer a Member for disease management call:

Magnolia Heath
Health Coach
1-866-912-6285

BILLING AND CLAIMS SUBMISSION

General Billing Guidelines

Providers, other licensed health professionals, facilities, and ancillary provider’s contract directly with Magnolia for payment of covered services.

It is important that providers ensure Magnolia has accurate billing information on file. **Please confirm with the provider relations department that the following information is current in our files:**

• Provider name (as noted on current W-9 form)
• NPI
• TIN
• Taxonomy code
• Physical location address (as noted on current W-9 form)
• Billing name and address

Providers must bill with their NPI number in box 24Jb. We encourage our providers to also bill their taxonomy code in box 24Ja to avoid possible delays in processing, along with their group Taxonomy code in box 33b. Claims missing the requirements in bold will be returned, and a notice sent to the provider, creating payment delays. Such claims are not considered “clean” and therefore cannot be accepted into our system.

To assist and prevent claim payment delays or denials, it is advised that the providers NPI number on file with Magnolia be verified to be the same NPI on file with DOM.

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. Changes to a provider’s TIN and/or address are NOT acceptable when conveyed via a claim form.

**Claims eligible for payment must meet the following 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

- Referral and prior authorization processes were followed, if applicable

Payment for service is contingent upon compliance with referral and prior authorization policies and procedures, as well as the billing guidelines outlined in this manual.

**Timely Filing**

Providers must submit all claims and encounters within one hundred and eighty (180) calendar days of the date of service. The filing limit may be extended where the eligibility has been retroactively received by Magnolia up to a maximum of one hundred and eighty (180) days. When Magnolia is the secondary payer, claims must be received within three hundred and sixty five (365) calendar days of the final determination of the primary payer.

All claim requests for reconsideration, corrected claims, or claim disputes must be received within ninety (90) calendar days from the date of notification of payment or denial is issued. **It is the provider’s responsibility to advise Magnolia within ninety (90) days from the date of the EOP.**

**Electronic Claims Submission**

Network 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, institution, or encounter transaction. In addition, it 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 25525 or by e-mail at:

EDIBA@centene.com

Providers may also reference [www.magnoliahealthplan.com](http://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.

**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 5040

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:**
Do’s

- 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 is able to receive primary insurance carrier EOP electronically
- Do submit on a proper original form - CMS 1500 or UB04

Don’ts

- Don’t submit handwritten claim forms
- Don’t use red ink on claim forms
- Don’t circle any data on claim forms
- Don’t add extraneous information to any claim form field
- Don’t use highlighter on any claim form field
- Don’t submit photocopied claim forms (no black and white claim forms)
- Don’t submit carbon copied claim forms
- Don’t submit claim forms via fax
- Don’t submit claims to the Magnolia Jackson office

Clean Claim Definition

A clean claim means a claim received by Magnolia for adjudication, in a nationally accepted format in compliance with standard coding guidelines and which requires no further information, adjustment, or alteration by the provider of the services in order 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. The errors or omissions in claims result in the request for additional information from the provider or other external sources to resolve or correct data omitted from the bill; review of additional medical records; or the need for other information necessary to resolve discrepancies. In addition, non-clean claims may involve issues regarding medical necessity and include claims not submitted within the filing deadlines.

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
• 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 4th or 5th 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.

ENCOUNTERS

What is an Encounter Versus a Claim?

Any interaction with a member is an encounter. Based on that encounter, you may provide services for that member that will result in a claim. A claim is a request for reimbursement either electronically or by paper for any medical service. Providers are required to submit a claim for each service rendered to a MS CHIP member. A claim must be filed on the proper form, such as CMS 1500 or UB04. A claim will be paid or, in some cases, denied with an explanation for the denial. For each claim processed, an EOP will be mailed to the provider who submitted the original claim.

Procedures for Filing a Claim/Encounter Data

Magnolia encourages all providers to file claims/encounters electronically. See the Electronic Claims Submission section and for more information on how to initiate electronic claims/encounters.

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.
CREDENTIALING and RE-CREDENTIALING

Magnolia has a contracted relationship with Mississippi Physicians Care Network (MPCN) to utilize MPCN’s network of practitioners for the MS CHIP product. MPCN will manage the credentialing and re-credentialing processes for practitioners that have a relationship with MPCN for the MS CHIP product.

For additional information about MPCN, please contact 1-800-931-8533 to speak to a representative.

For practitioners that have been credentialed through a facility or other entity, the facility or entity will manage the credentialing and re-credentialing processes for these practitioners.

Practitioners and/or facilities that are contracted directly through Magnolia will adhere to guidelines and processes below for credentialing and re-credentialing:

The credentialing and re-credentialing process exists to ensure that participating providers meet the criteria established by Magnolia, and government regulations and standards or accrediting bodies.  

Note: In order to maintain a current provider profile, providers are required to notify Magnolia of any relevant changes to their credentialing information in accordance with the terms of their contract.

Providers must submit, at a minimum, the following information when applying for participation with Magnolia:

- Complete signed and dated Mississippi Uniform Credentialing application or authorize Magnolia access to the CAQH (Council for Affordable Quality Health Care) for the Mississippi Uniform Credentialing application
- Signed attestation of the correctness and completeness of the application, history of loss of license and/or clinical privileges, disciplinary actions, and/or felony convictions; lack of current illegal substance registration and/or alcohol abuse; mental and physical competence, and ability to perform the essential functions of the position, with or without accommodation
- Copy of current malpractice insurance policy face sheet that includes expiration dates, amounts of coverage and provider’s name, or evidence of compliance with Mississippi regulations regarding malpractice coverage
- Copy of current Mississippi Controlled Substance registration certificate (if applicable)
- Copy of current Drug Enforcement Administration (DEA) registration certificate
- Copy or original of completed Internal Revenue Service Form W-9
- Copy of Educational Commission for Foreign Medical Graduates (ECFMG) certificate, if applicable
- Copy of cultural competency training certificate, if applicable
- Copy of current unrestricted medical license to practice in the state of Mississippi
- Current copy of specialty/board certification certificate, if applicable
- Curriculum vitae listing, at a minimum, with a five (5) year work history (not required if work history is completed on the application)
- Signed and dated release of information form not older than one hundred and twenty (120) calendar days
- Proof of highest level of education – copy of certificate or letter certifying formal post-graduate training
- Copy of current Patient Care Compensation Fund (PCCF), if applicable
- Copy of Clinical Laboratory Improvement Amendments certificate (CLIA), if applicable
• Copy of enumeration letter issued by National Plan and Provider Enumeration System (NPPES), depicting the providers' unique NPI

**Magnolia will verify the following information submitted for credentialing and/or re-credentialing:**

• Mississippi license through appropriate licensing agency
• Board certification, residency training, or medical education
• National Practitioner Data Bank (NPDB) for malpractice claims and licensing agency actions
• Hospital privileges in good standing at a participating Magnolia hospital
• Review five (5) year work history
• Review federal sanction activity including Medicare/Medicaid services (Office of Inspector General [OIG] and Excluded Parties Listing [EPLS])

Once the application is completed, the Magnolia Credentialing Committee (Credentialing Committee) will render a final decision on acceptance following its next regularly scheduled meeting. **Providers must be credentialed prior to accepting or treating members. PCPs cannot accept member assignments until they are fully credentialed.**

**Credentialing Committee**

The Credentialing Committee has the responsibility to establish and adopt as necessary, criteria for provider participation, termination, and direction of the credentialing procedures, including provider participation, denial, and termination. Committee meetings are held monthly but no less than ten (10) times per year.

*Note: Failure of an applicant to adequately respond to a request for missing or expired information may result in termination of the application process prior to committee decision.*

Site visits are performed at provider offices within forty five (45) calendar days of any member complaints related to physical accessibility, physical appearance, and adequacy of waiting and examining room space. If the provider’s site visit score is less than eighty percent (80%), the provider may be subject to termination and/or continued review until compliance is achieved. A site review evaluates appearance, accessibility, record keeping practices, safety procedures, and compliance with External Quality Review Organizations (EQRO) guidelines.

**Re-Credentialing**

To comply with accreditation standards, Magnolia conducts the re-credentialing process for providers at least every three (3) years from the date of the initial credentialing decision. The purpose of this process is to identify any changes in the provider’s licensure, sanctions, certification, competence, or health status which may affect the ability to perform services the provider is under contract to provide. This process includes all providers, PCPs, specialists, ancillary providers and facilities previously credentialed in the Magnolia network.

In between credentialing cycles, Magnolia conducts ongoing sanction monitoring activities on all network providers. This includes an inquiry to the appropriate Mississippi state licensing agency, board, or commission for a review of newly-disciplined providers and providers with a negative change in their current licensure status. This monthly inquiry ensures providers are maintaining a current, active, unrestricted license to practice in between credentialing cycles. Additionally, Magnolia reviews monthly reports released by the Office of Inspector General (OIG) to review for network providers who have been newly sanctioned or excluded from participation in state or government programs.

Additionally, between credentialing cycles, a provider may be requested to supply current proof of any credentials such as Mississippi licensure, malpractice insurance, DEA registration, a copy of certificate of cultural competency training, or other credentials that have expiration dates prior to the next review.
A provider’s agreement may be terminated if at any time it is determined by Magnolia’s Credentialing Committee that credentialing requirements are no longer being met.

Right to Review and Correct Information

All providers participating in the Magnolia MS CHIP network have the right to review information obtained by Magnolia to evaluate their credentialing and/or re-credentialing application. This includes information obtained from any outside primary source such as the National Practitioner Data Bank-Healthcare Integrity and Protection Data Bank, malpractice insurance carriers and state licensing agencies. This does not allow a provider to review references, personal recommendations or other information that is peer review protected.

Should a provider believe any of the information used in the credentialing/re-credentialing process to be erroneous, or should any information gathered as part of the primary source verification process differ from that submitted by a practitioner, the practitioner has the right to correct any erroneous information submitted by another party. To request release of such information, a written request must be submitted to the Magnolia credentialing department. Upon receipt of this information, the provider will have fourteen (14) calendar days to provide a written explanation detailing the error or the difference in information which Magnolia has in its business systems. The Credentialing Committee will then include this information as part of the credentialing/re-credentialing documentation.

Right to Be Informed of Application Status

All providers who have submitted an application to join Magnolia have the right to be informed of the status of their application upon request. To obtain status, contact the Magnolia provider relations department at 1-866-912-6285.

Right to Appeal Adverse Credentialing Determinations

Existing provider applicants who are declined for any reason have the right to request a reconsideration of the decision in writing within fourteen (14) calendar days of formal notice of denial. All written requests should include additional supporting documentation in favor of the applicant’s reconsideration for participation in the Magnolia MS CHIP network. Reconsiderations will be reviewed by the Credentialing Committee at the next regularly scheduled meeting, but in no case later than 60 calendar days from the receipt of the additional documentation. The applicant will be sent a written response to his/her request within two (2) weeks of the final decision.

For any questions about credentialing or re-credentialing, please call 1-866-912-6285 to speak with a network development and contracting representative.

RIGHTS AND RESPONSIBILITIES

Member Rights and Responsibilities

Members are informed of their rights and responsibilities through the MS CHIP Member Handbook. Magnolia providers are also expected to respect and honor member’s rights. MS CHIP members have the following rights:

- To receive information about MS CHIP, its benefits, its services, its network providers, and member rights and responsibilities.
- To be treated with respect and with due consideration for their dignity and the right to privacy and non-discrimination as required by law.
- To access all covered services, including certified nurse midwife services and pediatric or family nurse practitioner services.
• To participate with their physicians in making decisions regarding their healthcare, including the right to receive information on available treatments and alternatives as well as the right to refuse treatment.

• 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 receive healthcare services that are accessible, are comparable in amount, duration, and scope to those provided under MS CHIP 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 receive assistance from Magnolia in understanding the requirements and benefits of MS CHIP.

• To receive family planning services from any participating MS CHIP physician without prior authorization.

• To have a candid discussion about appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.

• To receive information on the Grievance and Appeal procedures.

• To voice grievances or file appeals about Magnolia decisions that affect their privacy, benefits, or the care provided.

• To request and receive a copy of their medical record.

• To make recommendations regarding Magnolia’s member rights and responsibilities policies.

• To request that their medical record be corrected.

• To expect their medical records and care be kept confidential as required by law.

• To receive Magnolia’s policy on referrals for specialty care and other benefits not provided by the member’s PCP.

• To privacy of healthcare needs and information as required by federal law (Standards for Privacy of Individually Identifiable Health Information).

• To exercise these rights without adversely affecting the way Magnolia and its network providers treat them.

• To allow or refuse their personal information to be sent to another party for other uses unless the release of information is required by law.

• To choose a PCP and to change to another PCP in Magnolia’s network.

• To receive timely access to care, including referrals to specialists when medically necessary without barriers.

• To receive materials – including enrollment notices, information materials, instructional materials, and available treatment options and alternatives - in a manner and format that may be easily understood.

• To make an advance directive, such as a living will.

• To choose a person to represent them for the use of their information by Magnolia if they are unable to.

• To get a second opinion from a qualified healthcare professional.

• To receive oral interpretation services free of charge for all non-English languages.
To be notified that oral interpretation is available and how to access those services.

As a potential member, to receive information about the basic features of managed care; which populations may or may not enroll in the program and Magnolia’s responsibilities for coordination of care in a timely manner in order to make an informed choice.

To receive information on the following:
- Benefits covered
- Procedures for obtaining benefits, including any authorization requirements
- Cost sharing requirements
- Service area
- Names, locations, telephone numbers and non-English language spoken by current Magnolia doctors, including at a minimum, PCPs, specialists, and hospitals
- Any restrictions on your freedom of choice among network providers
- Doctors who are not accepting new patients
- Benefits not offered by Magnolia, but available to them and how to obtain those benefits, including how transportation is provided

To receive a complete description of disenrollment rights at least annually.

To receive notice of any significant changes in the Benefits Package at least thirty (30) days before the intended effective date of the change.

To receive detailed information on emergency and after-hours coverage, to include, but not limited to:
- What constitutes an emergency medical condition, emergency services, and post-stabilization services
- Those emergency services that do not require prior authorization. The process and procedures for obtaining emergency services
- The locations of any emergency settings and other locations at which physicians and hospitals furnish emergency services and post-stabilization services covered under the contract
- Their right to use any hospital or other setting for emergency care
- Post-stabilization care services rules in accordance with Federal guidelines

MS CHIP members have the following responsibilities:
- To inform Magnolia of the loss or theft of their ID card.
- To present their ID card when using healthcare services.
- To be familiar with Magnolia procedures to the best of their ability.
- To call or contact Magnolia to obtain information and have questions clarified.
- To provide information (to the extent possible) that Magnolia and its physicians need in order to provide care.
- To follow the prescribed treatment (plans and instructions) for care that has been agreed upon with their physicians.
- To inform their physician on reasons they cannot follow the prescribed treatment of care recommended by their physician.
• To understand their health problems and participate in developing mutually agreed-upon treatment goals to the degree possible.
• To keep their medical appointments and follow-up appointments.
• To access preventive care services.
• To follow the policies and procedures of Magnolia and MS CHIP.
• To be honest with physicians and treat them with respect and kindness.
• To get regular medical care from their PCP before seeing a specialist.
• To follow the steps of the appeal process.
• To notify Magnolia, DOM, and their physicians of any changes that may affect their membership, healthcare needs, or their access to benefits. **Some examples may include:**
  o If they have a baby
  o If their address changes
  o If their telephone number changes
  o If they or one of their children are covered by another plan
  o If they have a special medical concern
  o If their family size changes
• To keep all their scheduled appointments.
• To be on time for their scheduled appointments.
• To cancel their scheduled appointments at least twenty four (24) hours in advance if they cannot keep an appointment.
• To access care by following Magnolia rules; failure to do so may cause them to be responsible for the charges.

**Provider Rights and Responsibilities**

**Magnolia providers have the following rights:**

• Be treated by Magnolia members and other health care workers with dignity and respect.
• Receive accurate and complete information and medical histories for members’ care.
• 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.
• Expect other network providers to act as partners in members’ treatment plans.
• Expect members to follow their directions, such as taking the right amount of medication at the right times.
• File a grievance with Magnolia on behalf of a member, with the member’s consent.
• Have the right to file claim reconsideration, claim appeal and claim dispute requests.
• May file a grievance or complaint for any dissatisfaction about any matter other than an adverse action.
• Have access to information about Magnolia’s QI programs, including program goals, processes, and outcomes that relate to member care and services, including information on safety issues.
• Contact Magnolia’s provider services 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.

• Allow members to request restriction on the use and disclosure of their personal health information.

• Make a complaint or file an appeal against Magnolia and/or a Magnolia member.

• Collaborate with other health care professionals who are involved in the care of members.

• Review clinical practice guidelines distributed by Magnolia.

• 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, to the extent possible.

• Not be excluded, penalized, or terminated from participating with Magnolia for having developed or accumulated a substantial number of patients in the Magnolia with high-cost medical conditions.

• Object to providing relevant or medically necessary services on the basis of the provider’s moral or religious beliefs or other similar grounds.

**Magnolia providers have the following responsibilities:**

• Ensure they are aware of and comply with their personal and staff’s responsibilities under federal and state law regarding advance directives. (See Advance Directives)

• Help members, or advocate for members, to make decisions within their scope of practice about their relevant and/or medically necessary care and treatment, including the right to:
  o Recommend new or experimental treatments
  o Provide information regarding the nature of treatment options
  o Provide information about the availability of alternative treatment options, therapies, consultations, and/or tests, including those that may be self-administered
  o Be informed of the risks and consequences associated with each treatment option or choosing to forego treatment

• Treat members with fairness, dignity, and respect.

• Not discriminate against members on the basis of race, color, national origin, disability, age, religion, mental or physical disability, or limited English proficiency.

• Maintain the confidentiality of members’ personal health information, including medical records and histories, and adhere to state and federal laws and regulations regarding confidentiality.

• Give members a notice that clearly explains their privacy rights and responsibilities as it relates to the provider’s practice/office/facility.

• Provide members with an accounting of the use and disclosure of their personal health information in accordance with HIPAA.

• Provide members, upon request, access to inspect and receive a copy of their personal health information, including medical records.

• 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 the member to participate in the decision-making process.

• 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.
• Allow a member who refuses or requests to stop treatment the right to do so, as long as the member understands that by refusing or stopping treatment the condition may worsen or be fatal.
• Respect members’ advance directives and include these documents in the members’ medical record.
• Allow members to appoint a parent, guardian, family member, or other representative if they cannot fully participate in their treatment decisions.
• Allow members to obtain a second opinion, and answer members’ questions about how to access healthcare services appropriately.
• Obtain and report to Magnolia information regarding other insurance coverage.
• Follow all state and federal laws and regulations related to patient care and patient rights.
• Participate in Magnolia data collection initiatives, such as HEDIS and other contractual or regulatory programs.
• Comply with Magnolia’s Medical Management program as outlined in this manual.
• Notify Magnolia in writing if the provider is leaving or closing a practice.
• Contact Magnolia to verify member eligibility or coverage for services, if appropriate.
• Disclose overpayments or improper payments to Magnolia.
• Provide members, upon request, with information regarding office location, hours of operation, accessibility, and languages, including the ability to communicate with sign language.
• Provide members, upon request, with information regarding the provider’s professional qualifications, such as specialty, education, residency, and board certification status.
• 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.
• Providers are advised 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. Please refer to your individual or organizational provider agreement, under “Term and Termination” for the applicable timeframe for giving notice. Providers are advised to send termination notices via certified mail (return receipt requested) or overnight courier for the request to be valid. In addition, providers are advised to supply copies of medical records to the member’s new provider and facilitate the member’s transfer of care at no charge to Magnolia or the member.
• Magnolia will notify affected members in writing of a provider’s termination, as applicable, at least 15 days before the disenrollment. If the terminating provider is a PCP, Magnolia will request that the member elect a new PCP. If a member does not elect a PCP prior to the provider’s termination date, Magnolia will automatically assign one to the member.
• Providers are advised to continue to render covered services to members who are existing patients at the time of termination until the later of 60 calendar days, the anniversary date of the member’s coverage, 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 90 calendar days from the termination date. In addition, Magnolia will reimburse providers for the provision of covered services to members who are in the second or third trimester of pregnancy extending through the completion of postpartum care relating to the delivery.
• Exceptions may include members requiring only routine monitoring or providers unwilling to continue to treat the member or accept payment from Magnolia.

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 received orally or in writing of dissatisfaction about any matter other than an action. A member may file a grievance either orally or in writing within forty five (45) calendar days of the date of the event causing dissatisfaction. 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.

Acknowledgement

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 Time Frame

Grievance resolution will occur as expeditiously as the member’s health condition requires, not exceeding fifteen (15) 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.

Notice of Resolution

The GAC will provide written resolution to the grievant within fifteen (15) calendar days of receipt. The letter will include, but not be limited to, the resolution details and DOM requirements, including the right to a Level II Grievance Review by Magnolia, if the member is not satisfied.

A copy of verbal complaint logs and records of disposition shall be retained for five (5) years.

Grievances may be submitted by written notification to:

Magnolia Health Grievances and Appeals Coordinator
111 East Capitol St., Suite 500
Jackson MS 39201
1-866-912-6285
Fax 1-877-851-3995
Member Appeal

Magnolia’s grievance procedures shall provide for a three (3) step appeal process. Step one (1) in the process is considered a Grievance Review. Step two (2) is considered a Grievance Reconsideration. Step three (3) is a Grievance Review by an independent external review organization. Magnolia will utilize the expertise of its designated independent external review organization for any expedited review where a denial has been proposed by Magnolia staff.

Magnolia’s standard member grievance procedures must provide for completion of the entire three (3) step process within ninety (90) calendar days and completion of expedited review within seventy two (72) hours. Upon member request and Magnolia agreement, these timeframes may be extended.

If a member grievance is filed orally, Magnolia’s member services staff must obtain and document all pertinent information and promptly send documentation in writing to the Magnolia’s designated Grievance and Appeals Coordinator. If a member grievance is filed in writing, it must be referred upon receipt to Magnolia’s Grievance and Appeals Coordinator.

If the member grievance involves an urgent or emergency medical situation such that an expedited review is appropriate, it must be immediately referred to a designated Magnolia representative.

Magnolia’s Grievance and Appeals Coordinator must thoroughly investigate each member grievance using applicable statutory, regulatory, and contractual provisions, as well as Magnolia’s written policies and procedures. All pertinent facts must be collected during the investigation through telephone or face-to-face contact.

Provider Complaints, Grievances and Appeals

A provider 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 provider complaint not resolved within one (1) business day shall be treated as a grievance. A provider 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 provider grievance is an expression of dissatisfaction received orally or in writing about any matter or aspect of Magnolia or its operation, other than a Magnolia action. A provider grievance includes, but is not limited to, the quality of care or services provided, aspects of interpersonal relationships such as rudeness of a provider or an employee.

Acknowledgement

Magnolia staff receiving grievances will acknowledge the grievance and attempt to resolve them immediately. Staff will document the substance of the grievance. Magnolia will notate date received for written grievances upon initial receipt and send an acknowledgment letter, which includes a description of the grievance procedures and resolution time frames, within ten (10) Calendar 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 twenty four (24) hours.

Notice of Resolution
The Plan will provide written resolution to the provider within thirty (30) calendar days of receipt. The letter will include the resolution and DOM requirements, including the right to a Level II Grievance Review by Magnolia Health Plan, if the provider is not satisfied. The grievance response shall include, but not be limited to, the decision reached by Magnolia, the reason(s) for the decision, the policies or procedures which provide the basis for the decision, and a clear explanation of any further rights available to the enrollee. A copy of verbal complaints logs and records of disposition or written grievances shall be retained for five (5) years.

Complaints and/or Grievances may be submitted by written notification to:

Magnolia Health Grievances and Appeals Coordinator
111 East Capitol St., Suite 500
Jackson MS 39201
1-866-912-6285
Fax 1-877-851-3995

Provider Appeal

Magnolia is to resolve a provider appeal within forty five (45) calendar days from the receipt of the provider appeal or as expeditiously as the member's health condition requires. Expedited provider appeals are to be resolved within three (3) business days from the receipt of the expedited resolution request. Magnolia may extend the time frame for this request up to fourteen (14) calendar days upon information required to make a determination.

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

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.

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.

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

- Credentialing Committee
- UM Committee
- Performance Improvement Team
- Member and Community Advisory Committees
- Peer Review Committee (Ad Hoc Committee)

Practitioner Involvement

Magnolia recognizes the integral role provider involvement plays in the success of its QI program. Provider involvement in various levels of the process is highly encouraged through provider representation. Magnolia encourages PCP, behavioral health, specialty, and OB/GYN representation on key quality committees such as, but not limited to, the QIC, 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
• Pharmacy
• Marketing practices

Performance Improvement Process

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

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

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

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

At any time, Magnolia providers may request additional information on Magnolia programs including a description of the QI program and a report on the Magnolia’s progress in meeting the QAPI program goals by contacting Magnolia QI department.

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 cost differences. HEDIS reporting is a required part of NCQA Health Plan Accreditation and Magnolia’s contract with DOM for the provision of coordinated care services within MS CHIP.

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. Mississippi purchasers of healthcare use the aggregated HEDIS rates to evaluate the effectiveness of a health insurance company’s ability to demonstrate an improvement in preventive health outreach to its members. Provider-specific scores are being used as evidence of preventive care from PCPs. The rates then serve as a basis for Magnolia’s “pay for performance” program which pays providers an increased premium based on scoring of such quality indicators used in HEDIS.
How Are HEDIS Rates Calculated?

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 greatly 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 each and every service rendered. All providers must bill (or report by encounter submission) for services delivered, regardless of contract status. Claim/encounter data is the cleanest and most efficient way to report HEDIS. If services are not billed, or not billed accurately, they are not included in the calculation. Accurate and timely submission of claim/encounter data will positively reduce the number of medical record reviews required for HEDIS rate calculation.
- Ensure chart documentation reflects all services provided
- Bill CPT II codes related to HEDIS measures such as diabetes, eye exam, and blood pressure

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 1-866-912-6285.
Examples of HEDIS measures for Body Mass Index (BMI) and Nutrition/Physical Counseling are as follows:

<table>
<thead>
<tr>
<th>Age Range</th>
<th>ICD-9 Diagnosis</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pediatric</td>
<td>V85.51</td>
<td>BMI less than 5th percentile for age</td>
</tr>
<tr>
<td></td>
<td>V85.52</td>
<td>BMI between 5th percentile to 85th percentile for age</td>
</tr>
<tr>
<td></td>
<td>V85.53</td>
<td>BMI between 85th percentile to less than 95th percentile for age</td>
</tr>
<tr>
<td></td>
<td>V85.54</td>
<td>BMI greater than or equal to 95th percentile for age</td>
</tr>
<tr>
<td>Adult</td>
<td>V85.0</td>
<td>BMI less than 19</td>
</tr>
<tr>
<td></td>
<td>V85.1</td>
<td>BMI between 19 – 24</td>
</tr>
<tr>
<td></td>
<td>V85.2</td>
<td>BMI between 25 – 29 (requires 5th digit)</td>
</tr>
<tr>
<td></td>
<td>V85.3</td>
<td>BMI between 30 – 39 (requires 5th digit)</td>
</tr>
<tr>
<td></td>
<td>V85.4</td>
<td>BMI between 40 and over (requires 5th digit)</td>
</tr>
</tbody>
</table>

ICD-9 Codes to report BMI percentiles:

Example Coding for nutrition and physical activity counseling:

<table>
<thead>
<tr>
<th>CPT</th>
<th>ICD-9 Diagnosis</th>
<th>ICD-9</th>
<th>CHPCS Diagnosis</th>
<th>Procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nutrition Counseling</td>
<td>97802-97804</td>
<td>V65.3</td>
<td>S9470, S9452, S9449, G0270-G0271</td>
<td></td>
</tr>
<tr>
<td>Physical Activity Counseling</td>
<td>V65.41</td>
<td>93.11, 93.13, 93.19, 93.31</td>
<td>S9451, H2032</td>
<td></td>
</tr>
</tbody>
</table>

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

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; all entries should be initialed by the PCP to signify review.
• Referrals to specialists and ancillary providers are documented including follow up of outcomes and summaries of treatment 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

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

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.
PROVIDER RELATIONS DEPARTMENT

Magnolia’s provider relations department is designed around the concept of making your experience a positive one by being your advocate within Magnolia. Provider relations is responsible for providing the services listed below including, but not limited to:

- Maintenance of existing Magnolia provider manual
- Development of alternative reimbursement strategies
- Researching of trends in claims inquiries to Magnolia
- Pool settlement updates/status
- Network performance profiling
- Individual provider performance profiling
- Provider and office staff orientation
- Hospital and ancillary staff orientation
- Ongoing provider education, updates, and training

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 1-866-912-6285. 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.

Top Ten (10) Reasons to Contact a Provider Relations Representative

1. To report any change to your practice (i.e., practice TIN, name, phone numbers, fax numbers, address, and addition or termination of providers, or patient acceptance).
2. To initiate credentialing of new providers.
3. To schedule an in-service training for new staff.
4. To conduct ongoing education for existing staff.
5. To obtain clarification of policies and procedures.
6. To obtain clarification of a provider contract.
7. To request fee schedule information.
8. To obtain responses to membership list questions.
9. To obtain responses to claims questions.
10. To learn how to use electronic solutions on web authorizations, claims submissions, and check eligibility.
PROCEDURES FOR CLAIM SUBMISSION

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 in order 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 1-866-912-6285.

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

- 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 MS CHIP members must be submitted by the provider who performed the services or by the provider’s authorized billing vendor.

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

- All required fields are completed on an original CMS 1500, UB-04 paper claim form, or EDI electronic claim format.
- All Diagnosis, Procedure, Modifier, Location (Place of Service), Revenue, Type of Admission, and Source of Admission Codes are valid for the date of service.
- All Diagnosis, Procedure, Modifier, and Location (Place of Service) Codes are valid for provider type/specialty billing.
- All Diagnosis, Procedure, and Revenue Codes are valid for the age and/or sex for the date of the service billed.
- All Diagnosis Codes are to their highest number of digits available (4th or 5th digit).
- Principal Diagnosis billed reflects an allowed Principle Diagnosis as defined in the volume of ICD-9 CM or ICD-9 CM update for the date of service billed.
- Member is eligible for services under Magnolia during the time period in which services were provided.
- Services were provided by a participating provider, authorization has been received to provide services to the eligible member (excludes services by an “out of network” provider for an emergency medical condition; however authorization requirements apply for post-stabilization services).
• An authorization has been given for services that require prior authorization by Magnolia.

• Medicare coverage or other third party coverage.

Claims Filing Deadlines

Original claims must be submitted to Magnolia within one hundred and eighty (180) calendar days from the date services were rendered or compensable items were provided. The filing limit may be extended where the eligibility has been retroactively received by Magnolia up to a maximum of one hundred and eighty (180) calendar days. When Magnolia is the secondary payer, claims must be received within three hundred and sixty five (365) calendar days of the final determination of the primary payer. Claims received outside of this timeframe will be denied for untimely submission.

All corrected claims, requests for reconsideration, or claim disputes must be received within ninety (90) calendar days from the date of notification of payment or denial. Prior processing will be upheld for corrected claims or provider claim requests for reconsideration or disputes received outside of the ninety (90) day timeframe, unless a qualifying circumstance is offered and appropriate documentation is provided to support the qualifying circumstance. Qualifying circumstances include:

- A catastrophic event that substantially interferes with normal business operations of the provider or damage or destruction of the provider’s business office or records by a natural disaster.

- A mechanical or administrative delay or error by Magnolia or DOM.

- The member was eligible; however the provider was unaware that the member was eligible, for services at the time services were rendered. Consideration is granted in this situation only if all of the following conditions are met:
  o The provider’s records document that the member refused or was physically unable to provide their ID card or information
  o The provider can substantiate that he continually pursued reimbursement from the patient until eligibility was discovered or Health Safety Net, if applicable
  o The provider can substantiate that a claim was filed within one hundred and eighty (180) days of discovering health plan eligibility
  o The provider has not filed a claim for this member prior to the filing of the claim under review

Claim Requests for Reconsideration, Claim Disputes, and Corrected Claims

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

If a provider has a question or is not satisfied with the information they have received related to a claim, there are four (4) effective ways in which the provider can contact Magnolia.

1. Contact a Magnolia provider service representative at 1-866-912-6285

   • Providers may discuss questions with Magnolia provider services representatives regarding amount reimbursed or denial of a particular service.

2. Submit an Adjusted or Corrected Claim to Magnolia Health MS CHIP, Attn: Corrected Claim, PO Box 5040, Farmington MO 63640-3800
The paper claim submission must clearly be marked as “RE-SUBMISSION” 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.

3. Submit a “Request for Reconsideration” to Magnolia Health MS CHIP, Attn: Reconsideration, PO Box 5040, Farmington MO 63640-3800

   A request for reconsideration is a written communication from the provider about a disagreement in the way a claim was processed but does not require a claim to be corrected and does not require medical records.
   - For more information about how to submit a medical necessity dispute, refer to the Grievances and Appeals section of this provider manual

   The request must include sufficient identifying information which includes, at minimum, the patient name, patient ID number, date of service, total charges and provider name.

   The documentation must also include a detailed description of the reason for the request.

4. Submit a “Claim Dispute Form” to Magnolia Health MS CHIP, Attn: Dispute, PO Box 5040, Farmington MO 63640-3800

   A claim dispute is to be used only when a provider has received an unsatisfactory response to a request for reconsideration.

   The Claim Dispute Form can be located on the provider website at www.magnoliahealthplan.com.

If the corrected claim, the request for reconsideration, or the claim dispute results in an adjusted claim, 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 escalated reconsideration.

Magnolia shall process and finalize all adjusted claims, requests for reconsideration, and disputed claims to a paid or denied status within forty five (45) business days of receipt of the corrected claim, request for reconsideration, or claim dispute.

Claim Payment

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

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

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 generally 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.

Filing Claims Electronically

How to Start

• First, the provider will need to meet specific hardware/software requirements. There are many different products that can be used to bill electronically. As long as you have the capability to send EDI claims, whether through direct submission to the clearinghouse or through another clearinghouse, you can submit claims electronically.

• Second, the provider needs to contact their clearinghouse and confirm they will transmit the claims to one of the clearinghouses used by Magnolia. For a list of vendors used by Magnolia, please visit our website at www.magnoliahealthplan.com. Go to the Provider page and click on EDI.

• Third, the provider should confirm with their clearinghouse the accurate location of the Magnolia Payer ID number.

• Last, the provider needs to verify with Magnolia that their provider record is set up within the claim adjudication system (Amisys).

Questions regarding electronically submitted claims should be directed to our EDI BA Support at 1-800-225-2573 Ext. 25525 or via e-mail at EDIBA@centene.com. At times, a voicemail will have to be left on the EDI line. You will receive a return call within twenty four (24) business hours.

The companion guides and clearinghouse options are on the Magnolia website at www.magnoliahealthplan.com.

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.

Specific Data Record Requirements

Claims transmitted electronically must contain all the same data elements identified within the Claim Filing section of this manual. Please contact the clearinghouse you intend to use and ask if they require additional data record requirements. The companion guide is located on the Magnolia website at www.magnoliahealthplan.com

Electronic Claim Flow Description & Important General Information
In order 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 on a daily basis to the clearinghouse. The clearinghouse in turn forwards the rejection back to its trading partner (the intermediate EDI clearinghouse or provider). It is very 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.

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 in order to identify and re-submit these claims accurately.

Our companion guides to billing electronically are available on our website at [www.magnoliahealthplan.com](http://www.magnoliahealthplan.com). See the section on electronic claim filing for more details.

**Exclusions**

Certain claims are excluded from electronic billing.

- Excluded Claim Categories – At this time, these claim records must be submitted on paper.
- These exclusions apply to inpatient and outpatient claim types.
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.

**Electronic Billing Inquiries**

Please direct inquiries as follows:

<table>
<thead>
<tr>
<th>Action</th>
<th>Contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you would like to transmit claims electronically…</td>
<td>Contact one of the clearinghouses for Magnolia’s payer ID.</td>
</tr>
<tr>
<td>If you have a general EDI question…</td>
<td>Contact EDI Support at 1-800-225-2573 Ext. 25525 or via e-mail at <a href="mailto:EDIBA@centene.com">EDIBA@centene.com</a>.</td>
</tr>
<tr>
<td>If you have questions about specific claims transmissions or acceptance Claim Status reports…</td>
<td>Contact your clearinghouse technical support area</td>
</tr>
<tr>
<td>If you have questions about your Claim Status (if claim has been accepted or rejected by the clearinghouse)…</td>
<td>Contact EDI Support at 1-800-225-2573 Ext. 25525 or via e-mail at <a href="mailto:EDIBA@centene.com">EDIBA@centene.com</a>.</td>
</tr>
<tr>
<td>If you have questions about claims that are reported on the Remittance Advice…</td>
<td>Contact provider services at 1-866-912-6285</td>
</tr>
<tr>
<td>If you would like to update provider, payee, UPIN, TIN number, or payment address information…</td>
<td>Notify provider services in writing at: <a href="mailto:magnoliapdm@centene.com">magnoliapdm@centene.com</a> or Magnolia Health MS CHIP 111 East Capitol Street, Suite 500 Jackson, MS 39201</td>
</tr>
</tbody>
</table>
| For questions about changing or verifying provider information…         | Magnolia Health MS CHIP  
Attn: Provider Services  
111 East Capitol Street, Suite 500  
Jackson MS 39201 1-866-912-6285  
Or By Fax: 1-877-811-5980 |
Important Steps to a Successful Submission of EDI Claims

1. Select clearinghouse to utilize.
2. Contact the clearinghouse to inform them you wish to submit electronic claims to Magnolia.
3. Inquire with the clearinghouse what data records are required.
4. Verify with provider relations at Magnolia 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 will be a report showing the claims that were accepted by the clearinghouse and are being 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.
6. MOST importantly, all claims must be submitted with provider’s identifying numbers. See the CMS 1500 (8/05) and UB-04 1450 claim form instructions and claim forms for details.

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.

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 user name and password and have requested claims access. To obtain an ID, please contact provider relations at 1-866-912-6285 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.

CLAIM FORM REQUIREMENTS

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 1-866-912-6285.

Coding of Claims

Magnolia requires claims to be submitted using codes from the current version of ICD-9- CM, CPT4, and HCPCS Level II for the date the service was rendered. These requirements may be amended to comply with federal and state regulations as necessary. Claims will be rejected or denied if billed with:
• Missing, invalid, or deleted codes
• Codes inappropriate for the age or sex of the member
• An ICD-9 CM code missing the 4th or 5th digit

For more information regarding billing codes, coding, and code auditing and editing refer to your Magnolia MS CHIP Provider Manual or contact a Magnolia Provider Services representative at 1-866-912-6285.

Code Auditing and 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, upcoding, 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.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>80053</td>
<td>Comprehensive Metabolic Panel</td>
<td>Disallow</td>
</tr>
<tr>
<td>85025</td>
<td>Complete CBC, automated differential WBC count</td>
<td>Disallow</td>
</tr>
<tr>
<td>84443</td>
<td>Thyroid Stimulating Hormone</td>
<td>Disallow</td>
</tr>
<tr>
<td>80050</td>
<td>General Health Panel</td>
<td>Allow</td>
</tr>
</tbody>
</table>

**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.

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<tr>
<td>80050</td>
<td>General Health Panel</td>
<td>Add</td>
</tr>
</tbody>
</table>

**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:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>69436 DOS=01/01/10</td>
<td>Tympanostomy</td>
<td>Disallow</td>
</tr>
<tr>
<td>69436 50 DOS=01/01/10</td>
<td>Tympanostomy billed with modifier 50 (bilateral procedure)</td>
<td>Allow</td>
</tr>
</tbody>
</table>

**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

<table>
<thead>
<tr>
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<th>Description</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>72010</td>
<td>Radiologic exam, spine, entire, survey study, anteroposterior &amp; lateral</td>
<td>Allow</td>
</tr>
<tr>
<td>72010</td>
<td>Radiologic exam, spine, entire, survey study, anteroposterior &amp; lateral</td>
<td>Disallow</td>
</tr>
</tbody>
</table>

**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) day 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

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>27447</td>
<td>Arthroplasty, knee, condyle and plateau; medial and lateral compartments with or without patella resurfacing (total knee arthroplasty).</td>
<td>Allow</td>
</tr>
<tr>
<td>99213</td>
<td>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 &amp; coordination of care w/other providers or agencies are provided consistent w/nature of problem(s) &amp; patient's &amp;/or family's needs. Problem(s) are low/moderate severity. Physicians spend 15 min face-to-face w/patient &amp;/or family.</td>
<td>Disallow</td>
</tr>
</tbody>
</table>

**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

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>99213</td>
<td>Office or other outpatient visit for the evaluation and management of an EST patient, which requires at least two of these three key components: an expanded problem focused history; an expanded problem focused examination; medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with nature of problem(s) and patient's and/or family's needs. Usually, problem(s) are low/moderate severity. Physicians spend fifteen (15) minutes face-to-face with patient and/or family.</td>
<td>Disallow</td>
</tr>
</tbody>
</table>

**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

<table>
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<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>99215</td>
<td>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 with 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.</td>
<td>Allow</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>99242</td>
<td>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.</td>
<td>Disallow</td>
</tr>
</tbody>
</table>

**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:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>78278</td>
<td>Acute gastrointestinal blood loss imaging</td>
<td>Disallow</td>
</tr>
<tr>
<td>POS=Inpatient</td>
<td></td>
<td></td>
</tr>
<tr>
<td>78278-26</td>
<td>Acute gastrointestinal blood loss imaging</td>
<td>Allow</td>
</tr>
<tr>
<td>POS=Inpatient</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**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:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>42820-81</td>
<td>Tonsillectomy and adenoidectomy; under age 12</td>
<td>Disallow</td>
</tr>
</tbody>
</table>

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-9 codes. Submit institutional claims with valid Revenue Codes and CPT-4 or HCPCS (when applicable), ICD-9 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-9 diagnosis codes, to the ultimate specificity, for all claims. This means that ICD-9 codes must be carried out to the fourth or fifth digit when indicated by the coding requirements in the ICD-9 manual (Note: not all codes require a fourth or fifth digit). The highest degree of specificity, or detail, can be determined by using the Tabular List (Volume One) of the ICD-9 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 carried out to the fifth 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-9 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.

Claims Mailing Instructions

Submit claims to Magnolia at the following address:

First Time Claims, Corrected Claims and Requests for Reconsiderations:
Magnolia Health MS CHIP
Claim Processing Department
P. O. Box 5040
Farmington, MO 63640-3825

Claim Disputes must be submitted to:
Magnolia Health MS CHIP
Attn: Claim Disputes
P. O. Box 5040
Farmington, MO 63640-3800

Please do not use any other post office box that you may have for Magnolia as it may cause a delay in processing. Magnolia encourages all providers to submit claims electronically. Our companion guides to billing electronically are available on our website at www.magnoliahealthplan.com. See section on electronic claim filing for more details. You may also submit claims on-line using our secure website at www.magnoliahealthplan.com.

Claim Form Instructions

Our companion guides to billing are available on our website at www.magnoliahealthplan.com.

REJECTIONS VS DENIALS

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 or denied.
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 can be found listed below and a more comprehensive list with explanations can be located in Appendix 1.

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, 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 can be found listed below and a more comprehensive list with explanations can be located in Appendix 2.

**Common Causes of Upfront Rejections**

- Unreadable Information - Information within the claim form cannot be read. The ink is faded, too light, or too bold (bleeding into other characters or beyond the box), the font is too small.

- Member DOB (date of birth) is missing.

- Member Name or ID number is missing.

- Provider Name, TIN, or NPI number is missing.

- DOS - The DOS (date of service) on the claim is not prior to receipt of claim (future date of service).

- DATES –A date or dates are missing from required fields. Example: "Statement From" UB-04 & "Service From" CMS 1500 (8/05); "To Date" before "From Date".

- TOB - Invalid TOB (Type of Bill) entered.

- Diagnosis Code is missing, invalid, or incomplete.

- Service Line Detail - No service line detail submitted.

- DOS (date of service) entered is prior to the member’s effective date.

- Admission Type is missing (Inpatient Facility Claims – UB-04, field 14).

- Patient Status is missing (Inpatient Facility Claims – UB-04, field 17).

- Occurrence Code/Date is missing or invalid.

- RE Code (revenue code) is missing or invalid.

- CPT/Procedure Code is missing or invalid.

- Incorrect Form Type – The form is not a form accepted by Magnolia or not allowed for the provider type.

**Common Causes of Claim Processing Delays and Denials**

- Wrong Form Type - The paper claim form submitted is not on a "Red" dropout OCR form.

- Diagnosis Code is missing the 4th or 5th digit.
• Procedure or Modifier Codes entered are invalid or missing.

• DRG code is missing or invalid.

• EOB (Explanation of Benefits) from the Primary insurer is missing or incomplete.

• Member ID is invalid.

• Place of Service Code is invalid.

• Provider TIN and NPI do not match.

• Revenue Code is invalid.

• Dates of Service span do not match the listed Days/Units.

• Physician Signature is missing.

• TIN is invalid.

• Third Party Liability (TPL) information is missing or incomplete.

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 (fourth and fifth digit).
5. Ensure member is eligible for services under Magnolia during the time period in which services were provided.
6. Ensure an authorization has been given for services that require prior authorization by Magnolia.
7. Claim forms submitted without “Red” dropout OCR forms may cause unnecessary delays to processing.

Resubmitted Claims
All requests for reconsideration, claim disputes, or corrected claims must be received within ninety (90) calendar days from the date of notification of payment or denial.

Paper claims submitted for review or reconsideration, must include a clear indication that the claims are “RE-SUBMISSION and/or CORRECTED CLAIM”, and must include the original claim number, or a copy of the EOP. Failure to do this could allow a claim to deny as a duplicate or deny for non-timely filing. Handwritten claims will not be accepted and will be rejected.
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 4th or 5th Digit – Diagnosis should be billed to the highest intensity for proper coding and processing. Review the ICD-9-CM manual for coding to the 4th and 5th 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 place 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

<table>
<thead>
<tr>
<th>DENIAL CODE</th>
<th>DENIAL DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>07</td>
<td>DENY: THE PROCEDURE CODE IS INCONSISTENT WITH THE PATIENT'S SEX</td>
</tr>
<tr>
<td>09</td>
<td>DENY: THE DIAGNOSIS IS INCONSISTENT WITH THE PATIENT'S AGE</td>
</tr>
<tr>
<td>10</td>
<td>DENY: THE DIAGNOSIS IS INCONSISTENT WITH THE PATIENT'S SEX</td>
</tr>
<tr>
<td>16</td>
<td>DENY: REVENUE CODE NOT REIMBURSABLE - CPT/HCPCS CODE REQUIRED</td>
</tr>
<tr>
<td>18</td>
<td>DENY: DUPLICATE CLAIM/SERVICE</td>
</tr>
<tr>
<td>1K</td>
<td>DENY: CPT OR DX CODE IS NOT VALID FOR AGE OF PATIENT</td>
</tr>
<tr>
<td></td>
<td>DENY: VISIT &amp; PREVEN CODES ARE NOT PAYABLE ON SAME DOS W/O DOCUMENTATION</td>
</tr>
<tr>
<td>20</td>
<td>DENY: THIS INJURY IS COVERED BY THE LIABILITY CARRIER</td>
</tr>
<tr>
<td>21</td>
<td>DENY: CLAIM THE RESPONSIBILITY OF THE NO-FAULT CARRIER</td>
</tr>
<tr>
<td>22</td>
<td>DENY: THIS CARE IS COVERED BY A COORDINATION OF BENEFITS CARRIER</td>
</tr>
<tr>
<td>23</td>
<td>DENY: CHARGES HAVE BEEN PAID BY ANOTHER PARTY-COB</td>
</tr>
<tr>
<td>24</td>
<td>DENY: CHARGES COVERED UNDER CAPITATION</td>
</tr>
<tr>
<td>25</td>
<td>DENY: YOUR STOP LOSS DEDUCTIBLE HAS NOT BEEN MET</td>
</tr>
<tr>
<td>26</td>
<td>DENY: EXPENSES INCURRED PRIOR TO COVERAGE</td>
</tr>
<tr>
<td>27</td>
<td>DENY: EXPENSES INCURRED AFTER COVERAGE WAS TERMINATED</td>
</tr>
<tr>
<td>28</td>
<td>DENY: COVERAGE NOT IN EFFECT WHEN SERVICE PROVIDED</td>
</tr>
<tr>
<td>29</td>
<td>DENY: THE TIME LIMIT FOR FILING HAS EXPIRED</td>
</tr>
<tr>
<td>35</td>
<td>DENY: BENEFIT MAXIMUM HAS BEEN REACHED</td>
</tr>
<tr>
<td>3D</td>
<td>DENY: NON-SPECIFIC DIAGNOSIS- REQUIRES 4TH DIGIT PLEASE RESUBMIT</td>
</tr>
<tr>
<td>46</td>
<td>DENY: THIS SERVICE IS NOT COVERED</td>
</tr>
<tr>
<td>48</td>
<td>DENY: THIS PROCEDURE IS NOT COVERED</td>
</tr>
<tr>
<td>4D</td>
<td>DENY: NON-SPECIFIC DIAGNOSIS- REQUIRES 5TH DIGIT PLEASE RESUBMIT</td>
</tr>
<tr>
<td>6L</td>
<td>EOB INCOMPLETE-PLEASE RESUBMIT WITH REASON OF OTHER INSURANCE DENIAL</td>
</tr>
<tr>
<td>86</td>
<td>DENY: THIS IS NOT A VALID MODIFIER FOR THIS CODE</td>
</tr>
<tr>
<td>99</td>
<td>DENY: MISC/UNLISTED CODES CAN NOT BE PROCESSED W/O DESCRIPTION/REPORT</td>
</tr>
<tr>
<td>9I</td>
<td>INFORMATION REQUESTED WAS NOT RECEIVED WITHIN THE TIME FRAME SPECIFIED</td>
</tr>
<tr>
<td>A1</td>
<td>DENY: AUTHORIZATION NOT ON FILE</td>
</tr>
<tr>
<td>BG</td>
<td>DENY: TYPE OF BILL MISSING OR INCORRECT ON CLAIM, PLEASE RE-SUBMIT</td>
</tr>
<tr>
<td>BI</td>
<td>DENY: CLAIM CANNOT BE PROCESSED WITHOUT AN ITEMIZED BILL</td>
</tr>
<tr>
<td>DENIAL CODE</td>
<td>DENIAL DESCRIPTION</td>
</tr>
<tr>
<td>-------------</td>
<td>--------------------</td>
</tr>
<tr>
<td>C2</td>
<td>CPT HAS BEEN REBUNDLED ACCORDING TO CLAIM AUDIT</td>
</tr>
<tr>
<td>C6</td>
<td>CPT HAS BEEN REPLACED ACCORDING TO CLAIM AUDIT</td>
</tr>
<tr>
<td>C8</td>
<td>CPT HAS BEEN DENIED ACCORDING TO CLAIM AUDIT</td>
</tr>
<tr>
<td>CV</td>
<td>DENY: BILL WITH SPECIFIC VACCINE CODE</td>
</tr>
<tr>
<td>DD</td>
<td>DENY: SIGNED CONSENT FORM HAS NOT BEEN RECEIVED</td>
</tr>
<tr>
<td>DJ</td>
<td>DENY: INAPPROPRIATE CODE BILLED, CORRECT &amp; RESUBMIT</td>
</tr>
<tr>
<td>DS</td>
<td>DENY: DUPLICATE SUBMISSION-ORIGINAL CLAIM STILL IN PEND STATUS</td>
</tr>
<tr>
<td>DT</td>
<td>DENY: PLEASE FORWARD TO THE DENTAL VENDOR FOR PROCESSING.</td>
</tr>
<tr>
<td>DW</td>
<td>DENY: INAPPROPRIATE DIAGNOSIS BILLED, CORRECT AND RESUBMIT</td>
</tr>
<tr>
<td>DX</td>
<td>DIAGNOSIS BILLED IS INVALID, PLEASE RESUBMIT WITH CORRECT CODE.</td>
</tr>
<tr>
<td>DY</td>
<td>DENY: APPEAL DENIED</td>
</tr>
<tr>
<td>DZ</td>
<td>DENY: SERVICE HAS EXCEEDED THE AUTHORIZED LIMIT</td>
</tr>
<tr>
<td>EB</td>
<td>DENY: DENIED BY MEDICAL SERVICES</td>
</tr>
<tr>
<td>EC</td>
<td>DIAGNOSIS CANNOT BE USED AS PRIMARY DIAGNOSIS, PLEASE RESUBMIT</td>
</tr>
<tr>
<td>FP</td>
<td>DENY: CLAIMS DENIED FOR PROVIDER FRAUD.</td>
</tr>
<tr>
<td>GL</td>
<td>SERVICE COVERED UNDER GLOBAL FEE AGREEMENT</td>
</tr>
<tr>
<td>H1</td>
<td>DENY: PROVIDER MUST USE HCPC/CPT FOR CORRECT PRICING</td>
</tr>
<tr>
<td>HL</td>
<td>DENY: CLAIM AND AUTH LOCATIONS DO NOT MATCH</td>
</tr>
<tr>
<td>HP</td>
<td>DENY: CLAIM AND AUTH SERVICE PROVIDER NOT MATCHING</td>
</tr>
<tr>
<td>HQ</td>
<td>DENY: EDI CLAIM MUST BE SUBMITTED IN HARD COPY W/CONSENT FORM ATTACHED</td>
</tr>
<tr>
<td>HS</td>
<td>DENY: CLAIM AND AUTH PROVIDER SPECIALTY NOT MATCHING</td>
</tr>
<tr>
<td>HT</td>
<td>DENY: CLAIM AND AUTH TREATMENT TYPE NOT MATCHING</td>
</tr>
<tr>
<td>I1</td>
<td>OTHER INSURANCE EOB SUBMITTED DOES NOT MATCH BILLED, PLEASE RESUBMIT</td>
</tr>
<tr>
<td>I9</td>
<td>DENY: DIAGNOSIS IS AN INVALID OR DELETED ICD9 CODE</td>
</tr>
<tr>
<td>IE</td>
<td>CPT NOT REIMBURSED SEPARATELY. INCLUDED AS PART OF INCLUSIVE PROCEDURE</td>
</tr>
<tr>
<td>DENIAL CODE</td>
<td>DENIAL DESCRIPTION</td>
</tr>
<tr>
<td>-------------</td>
<td>--------------------</td>
</tr>
<tr>
<td>IK</td>
<td>DENY: 2ND EM NOT PAYABLE W/O MODIFIER 25 &amp; MED RECORDS, PLEASE RESUBMIT</td>
</tr>
<tr>
<td>IL</td>
<td>VERIFY THE CORRECT LOCATION CODE FOR SERVICE BILLED AND RESUBMIT</td>
</tr>
<tr>
<td>IM</td>
<td>DENY: RESUBMIT WITH MODIFIER SPECIFIED BY STATE FOR PROPER PAYMENT</td>
</tr>
<tr>
<td>IV</td>
<td>DENY: INVALID/DELETED/MISSING CPT CODE</td>
</tr>
<tr>
<td>L0</td>
<td>PLEASE RESUBMIT WITH THE PRIMARY MEDICARE EXPLANATION OF BENEFITS</td>
</tr>
<tr>
<td>L6</td>
<td>DENY: BILL PRIMARY INSURER 1ST. RESUBMIT WITH EOB.</td>
</tr>
<tr>
<td>LO</td>
<td>DENY: CPT &amp; LOCATION ARE NOT COMPATIBLE, PLEASE RESUBMIT.</td>
</tr>
<tr>
<td>M5</td>
<td>DENY: IMMUNIZATION ADMINISTRATION INCLUDED IN INJECTION FEE</td>
</tr>
<tr>
<td>MG</td>
<td>DENY: SIGNATURE MISSING FROM BOX 31, PLEASE RESUBMIT</td>
</tr>
<tr>
<td>MH</td>
<td>DENY: PLEASE SUBMIT TO MENTAL HEALTH PLAN FOR PROCESSING</td>
</tr>
<tr>
<td>MO</td>
<td>MODIFIER BILLED IS NOT VALID, PLEASE RESUBMIT WITH CORRECT CODE.</td>
</tr>
<tr>
<td>MQ</td>
<td>DENY: MEMBER NAME/NUMBER/DATE OF BIRTH DO NOT MATCH, PLEASE RESUBMIT</td>
</tr>
<tr>
<td>MY</td>
<td>DENY: MEMBER'S PCP IS CAPITATED - SERVICE NOT REIMBURSABLE TO OTHER PCPS</td>
</tr>
<tr>
<td>ND</td>
<td>DENY: NAME OF DRUG, NDC NUMBER AND QUANTITY IS REQUIRED TO PROCESS CLAIM</td>
</tr>
<tr>
<td>NT</td>
<td>DENY: THIS IS A DELETED CODE AT THE TIME OF SERVICE</td>
</tr>
<tr>
<td>NV</td>
<td>DENY: MODIFIER BILLED IS NOT VALID, PLEASE RESUBMIT WITH CORRECT CODE.</td>
</tr>
<tr>
<td>NX</td>
<td>DENY: STERILIZATION CONSENT FORM IS NOT VALID OR IS MISSING INFORMATION</td>
</tr>
<tr>
<td>OX</td>
<td>DENY: CODE IS CONSIDERED AN INTEGRAL COMPONENT OF THE E/M CODE BILLED</td>
</tr>
<tr>
<td>PF</td>
<td>DENY: PROFESSIONAL FEE MUST BE BILLED ON HCFA FORM</td>
</tr>
<tr>
<td>RC</td>
<td>DENY: REQUIRED REFERRAL CODE FOR HEALTH CHECK VISIT INVALID OR MISSING</td>
</tr>
<tr>
<td>RD</td>
<td>DENY: REVENUE CODE AND DIAGNOSIS ARE NOT COMPATIBLE. PLEASE RESUBMIT.</td>
</tr>
<tr>
<td>RX</td>
<td>DENY: PLEASE SUBMIT TO THE PHARMACY VENDOR FOR PROCESSING.</td>
</tr>
<tr>
<td>TM</td>
<td>TO COMPLETE PROCESSING, WE NEED THE TIME UNITS, PLEASE RESUBMIT.</td>
</tr>
<tr>
<td>U1</td>
<td>CLAIM CANNOT BE PROCESSED WITHOUT MEDICAL RECORDS</td>
</tr>
<tr>
<td>U5</td>
<td>DENY: UNLISTED / UNSPECIFIC CODE -RE-BILL MORE SPECIFIC CODE</td>
</tr>
<tr>
<td>DENIAL CODE</td>
<td>DENIAL DESCRIPTION</td>
</tr>
<tr>
<td>-------------</td>
<td>--------------------</td>
</tr>
<tr>
<td>V3</td>
<td>MED RECORDS RECEIVED FOR WRONG DATE OF SERVICE</td>
</tr>
<tr>
<td>V4</td>
<td>MED RECORDS RECEIVED NOT LEGIBLE</td>
</tr>
<tr>
<td>V5</td>
<td>MED RECORDS RECEIVED FOR WRONG PATIENT</td>
</tr>
<tr>
<td>V6</td>
<td>MED RECORDS WITHOUT LEGIBLE PATIENT NAME AND/OR DOS</td>
</tr>
<tr>
<td>V8</td>
<td>MED RECORDS RECEIVED WITHOUT DOS</td>
</tr>
<tr>
<td>VC</td>
<td>DENY - PLEASE RESUBMIT ACCORDING TO VACCINES FOR CHILDREN GUIDELINES</td>
</tr>
<tr>
<td>VS</td>
<td>DENY: PLEASE SUBMIT TO THE VISION VENDOR FOR PROCESSING.</td>
</tr>
<tr>
<td>x3</td>
<td>PROCEDURE CODE UNBUNDLED FROM GLOBAL PROCEDURE CODE</td>
</tr>
<tr>
<td>x4</td>
<td>PROCEDURE CODE/ICD-9 CODE INCONSISTENT WITH MEMBERS GENDER</td>
</tr>
<tr>
<td>x5</td>
<td>PROCEDURE CODE CONFLICTS WITH MEMBER'S AGE</td>
</tr>
<tr>
<td>x6</td>
<td>ADD-ON CODE REQUIRED WITH PRIMARY CODE FOR QUANTITY GREATER THAN ONE</td>
</tr>
<tr>
<td>x7</td>
<td>ADD-ON CODE CANNOT BE BILLED WITHOUT PRIMARY CODE</td>
</tr>
<tr>
<td>x8</td>
<td>MODIFIER INVALID FOR PROCEDURE OR MODIFIER NOT REPORTED</td>
</tr>
<tr>
<td>x9</td>
<td>PROCEDURE CODE PAIRS INCIDENTAL, MUTUALLY EXCLUSIVE OR UNBUNDLED</td>
</tr>
<tr>
<td>xa</td>
<td>CODE IS A COMPONENT OF A MORE COMPREHENSIVE CODE</td>
</tr>
<tr>
<td>xb</td>
<td>PROCEDURE CODE NOT ELIGIBLE FOR ANESTHESIA</td>
</tr>
<tr>
<td>xc</td>
<td>PROCEDURE/DIAGNOSIS CODE DELETED, INCOMPLETE OR INVALID</td>
</tr>
<tr>
<td>xd</td>
<td>PROCEDURE CODE PREVIOUSLY BILLED ON HISTORICAL CLAIM</td>
</tr>
<tr>
<td>xe</td>
<td>PROCEDURE CODE INCONSISTENT WITH MEMBER'S AGE</td>
</tr>
<tr>
<td>xf</td>
<td>MAXIMUM ALLOWANCE EXCEEDED</td>
</tr>
<tr>
<td>xg</td>
<td>SINGLE/UNILATERAL PROCEDURE SUBMITTED MORE THAN ONCE ON THE SAME DOS</td>
</tr>
<tr>
<td>xh</td>
<td>SERVICE LINE REPRESENTS DENIAL OF ADDITIONAL UNITS BILLED</td>
</tr>
<tr>
<td>ZC</td>
<td>DENY: PROCEDURE IS INAPPROPRIATE FOR PROVIDER SPECIALTY</td>
</tr>
</tbody>
</table>
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
N4  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 Health Care 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

<table>
<thead>
<tr>
<th>Item</th>
<th>Date of Service</th>
<th>D.O.</th>
<th>C.D.</th>
<th>D. Procedures, Services, or Supplies</th>
<th>E. Diagnosis Pointers</th>
<th>F. Charges</th>
<th>G. Date of Service</th>
<th>H. Number of Units</th>
<th>I. Qual.</th>
<th>J. Rendering Provider ID #</th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
<td>Begin 1:30 End 1:45 Time 30 minutes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Item</th>
<th>Date of Service</th>
<th>D.O.</th>
<th>C.D.</th>
<th>D. Procedures, Services, or Supplies</th>
<th>E. Diagnosis Pointers</th>
<th>F. Charges</th>
<th>G. Date of Service</th>
<th>H. Number of Units</th>
<th>I. Qual.</th>
<th>J. Rendering Provider ID #</th>
</tr>
</thead>
<tbody>
<tr>
<td>22</td>
<td>Laparoscopic Ventral Hernia Repair Op Note Attached</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

NDC

<table>
<thead>
<tr>
<th>Item</th>
<th>Date of Service</th>
<th>D.O.</th>
<th>C.D.</th>
<th>D. Procedures, Services, or Supplies</th>
<th>E. Diagnosis Pointers</th>
<th>F. Charges</th>
<th>G. Date of Service</th>
<th>H. Number of Units</th>
<th>I. Qual.</th>
<th>J. Rendering Provider ID #</th>
</tr>
</thead>
<tbody>
<tr>
<td>N45518019001 Pedigrastin 0.6</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Vendor Product Number- HIBCC

<table>
<thead>
<tr>
<th>Item</th>
<th>Date of Service</th>
<th>D.O.</th>
<th>C.D.</th>
<th>D. Procedures, Services, or Supplies</th>
<th>E. Diagnosis Pointers</th>
<th>F. Charges</th>
<th>G. Date of Service</th>
<th>H. Number of Units</th>
<th>I. Qual.</th>
<th>J. Rendering Provider ID #</th>
</tr>
</thead>
<tbody>
<tr>
<td>YP/A123456789</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Product Number Health Care Uniform Code Council – GTIN

<table>
<thead>
<tr>
<th>Item</th>
<th>Date of Service</th>
<th>D.O.</th>
<th>C.D.</th>
<th>D. Procedures, Services, or Supplies</th>
<th>E. Diagnosis Pointers</th>
<th>F. Charges</th>
<th>G. Date of Service</th>
<th>H. Number of Units</th>
<th>I. Qual.</th>
<th>J. Rendering Provider ID #</th>
</tr>
</thead>
<tbody>
<tr>
<td>020123456789112</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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 U
- **N** – Unit

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

<table>
<thead>
<tr>
<th>Item</th>
<th>Date of Service</th>
<th>D.O.</th>
<th>C.D.</th>
<th>D. Procedures, Services, or Supplies</th>
<th>E. Diagnosis Pointers</th>
<th>F. Charges</th>
<th>G. Date of Service</th>
<th>H. Number of Units</th>
<th>I. Qual.</th>
<th>J. Rendering Provider ID #</th>
</tr>
</thead>
<tbody>
<tr>
<td>N400020964881 Immunoglobulin Intravenous</td>
<td>10</td>
<td>01</td>
<td>02</td>
<td>10</td>
<td>01</td>
<td>05</td>
<td>LN2</td>
<td>13</td>
<td>500.00</td>
<td>20</td>
</tr>
</tbody>
</table>
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.

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
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: ADOPTED PREVENTIVE HEALTH GUIDELINES

<table>
<thead>
<tr>
<th>Condition/Disease</th>
<th>Guideline Title</th>
<th>Recognized Source</th>
<th>URL</th>
<th>Review Dates</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Immunizations</strong></td>
<td>General Recommendations on Immunization January 28, 2011 / 60(RR02):1-60</td>
<td>Advisory Committee on Immunization Practices (ACIP)</td>
<td><a href="http://www.cdc.gov/mmwr/preview/mmwrhtml/rr6002a1.htm?s_cid=rr6002a1_w">http://www.cdc.gov/mmwr/preview/mmwrhtml/rr6002a1.htm?s_cid=rr6002a1_w</a></td>
<td>August 2012</td>
</tr>
<tr>
<td></td>
<td>Recommended Adult Immunization Schedule (2012)</td>
<td></td>
<td><a href="http://www.cdc.gov/vaccines/recs/schedules/adult-schedule.htm">http://www.cdc.gov/vaccines/recs/schedules/adult-schedule.htm</a></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Recommended Schedule for Persons Age 0-6 And Recommended Schedule for 7-18 years old and “catch up schedule” (2012)</td>
<td></td>
<td><a href="http://www.cdc.gov/vaccines/recs/schedules/child-schedule.htm#printable">http://www.cdc.gov/vaccines/recs/schedules/child-schedule.htm#printable</a></td>
<td></td>
</tr>
<tr>
<td><strong>Lead Screening</strong></td>
<td>Recommendations for blood lead screening of children aged 1-5 years: an updated approach to targeting a group at high risk. (Aug 2009)</td>
<td>Centers for Disease Control; Centers for Medicare and Medicaid</td>
<td><a href="http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5809a1.htm">http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5809a1.htm</a></td>
<td>August 2011</td>
</tr>
<tr>
<td></td>
<td>Mississippi State Department of Health</td>
<td></td>
<td><a href="http://msdh.ms.gov/msdhsite/statistic/41,0,164.html">http://msdh.ms.gov/msdhsite/statistic/41,0,164.html</a></td>
<td></td>
</tr>
</tbody>
</table>
## APPENDIX VII: ADOPTED CLINICAL PRACTICE GUIDELINES

<table>
<thead>
<tr>
<th>Condition/ Disease</th>
<th>Guideline Title</th>
<th>Recognized Source</th>
<th>URL</th>
<th>Review Dates</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Treatment of the School-Aged Child with Attention-Deficit/Hyperactivity Disorder (Published October 2001)</td>
<td></td>
<td><a href="http://aappolicy.aappublications.org/cgi/reprint/pediatrics;108/4/1033.pdf">http://aappolicy.aappublications.org/cgi/reprint/pediatrics;108/4/1033.pdf</a></td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td>Standards of Medical Care in Diabetes (2011)</td>
<td>American Diabetes Association</td>
<td>[<a href="http://care.diabetesjournals.org/content/34/Supplement">http://care.diabetesjournals.org/content/34/Supplement</a> 1/S11.full](<a href="http://care.diabetesjournals.org/content/34/Supplement">http://care.diabetesjournals.org/content/34/Supplement</a> 1/S11.full)</td>
<td>August 2011</td>
</tr>
<tr>
<td>Condition/Disease</td>
<td>Guideline Title</td>
<td>Recognized Source</td>
<td>URL</td>
<td>Review Dates</td>
</tr>
<tr>
<td>-------------------</td>
<td>-----------------</td>
<td>-------------------</td>
<td>-----</td>
<td>--------------</td>
</tr>
<tr>
<td><strong>Perinatal Care</strong></td>
<td>Guidelines for Perinatal Care, Sixth Edition (Published October 2007)</td>
<td>American Academy of Pediatrics; The American College of Obstetricians and Gynecologists</td>
<td>Available online for ACOG members only. Hard Copy at Centene Corporate Office <a href="http://www.acog.org/bookstore/Guidelines_for_Perinatal_CareP262.cfm">http://www.acog.org/bookstore/Guidelines_for_Perinatal_CareP262.cfm</a></td>
<td>August 2011</td>
</tr>
</tbody>
</table>
APPENDIX VIII: SUBMITTING Well-Baby and Well-Child Care Assessment SERVICES

Well-baby and well-child care 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.
APPENDIX IX: 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’s

**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 CRNA’s 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.
APPENDIX X: NURSE PRACTITIONERS AND PHYSICIAN ASSISTANTS

Nurse practitioners and physician assistants, as licensed by the state of Mississippi, may bill for the covered services within the scope of practice allowed by their respective protocols. All services and procedures provided by nurse practitioners and physician assistants should be billed in the same manner and following the same policy and guidelines as like physician services.