111 E. Capitol St.
Suite 500
Jackson, MS 39201

MSCAN Claims:

1. What is the timely filing limit for original claim submissions? Within 180 days of the date of service.

2. What is the timely filing limit for corrected claims, reconsiderations, and claim disputes? 90 days from the date of notification of payment or denial issued.

3. If I choose to submit an original claim via paper, where should I send it to?

Magnolia Health Attn: Claim Department PO Box 3090 Farmington, MO 63640-3825

4. If I choose to submit my corrected claims, reconsiderations, and claim disputes, where should I send it to?

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

5. What is the difference between a Corrected Claim, Reconsideration, and Dispute?

    a. Corrected Claim – A corrected claim is a replacement of a previously submitted claim (e.g., changes or corrections to charges, diagnosis or **procedure codes**, dates of service, member information, etc.).
    b. Reconsideration – 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.
    c. Claim Dispute - 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 resource section at www.MagnoliaHealthPlan.com.*

6. What is the difference between a claim rejection and a claim denial?

    a. Rejection - 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. Please refer to our Provider Manual for a list of common upfront rejections.

b. Denial - 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. Please refer to our Provider Manual for a list of common denials.

7. What are the definitions of Complaint and Grievance?

   a. Complaint – A complaint is any provider expression of dissatisfaction expressed by a complainant to the Plan orally or in writing that is of a less serious or formal nature that is resolved within one (1) business day of receipt, about any matter related to the Plan other than a determination of Medical Necessity for a service. A complaint also includes matters of misunderstanding or misinformation that can be promptly resolved by clearing up the misunderstanding, or providing accurate information to the provider.
   b. Grievance – An expression of dissatisfaction expressed by a grievant to the Plan orally or in writing about any matter or aspect of the Plan or its operation, other than a Plan Action or determination of Medical Necessity for a service. A grievance does not include matters of misunderstanding or misinformation that can be promptly resolved by clearing up the misunderstanding or by providing accurate information to the provider. A grievance includes, but is not limited to, the quality of care or services provided, or aspects of interpersonal relationships.

8. When should a Complaint or Grievance be filed?
   a. Complaint – A complaint can be filed within thirty (30) calendar days of the date of the event causing the dissatisfaction.
   b. Grievance - A grievance can be filed within thirty (30) calendar days of the date of the event causing the dissatisfaction.

9. How should I submit a Complaint or Grievance?
   a. Complaint/Grievance – A complaint or grievance can be filed through Provider Services at 1-866-912-6285 or mailed to the following address:

Magnolia Health Attn: Provider Complaints/Grievances 111 East Capitol St., Suite 500 Jackson MS 39201

10. What is the process for updating our financial address? Please submit your request on company letterhead via fax to 1-866-480-3227. The request must include the TIN, Group NPI, and accompany a W9 with the appropriate financial address.

11. Where can I obtain a copy of my EOP?

a. Payspan – to register for EFT/ERA, please click here: https://www.magnoliahealthplan.com/content/dam/centene/Magnolia/medicaid/pdfs/How-to-Register-for-PaySpan-PDF.pdf
b. Our Secure Webportal – to register, please click here: https://www.magnoliahealthplan.com/providers/login.html
c. Mail – If you are not signed up for Payspan, your EOPs will be issued through the mail. You will still be able to locate them via our Secure Webportal.

12. What documentation is required to be included in an invoice or quote for DME equipment/supplies?
    a. Date
    b. Manufactures name
    c. MSRP or provider cost of the DME

    The date must be prior to the purchase or rental, but cannot be over a year prior to the rental or purchase.

    Magnolia also accepts price lists and catalog pages of the product. They must also include the items reference above.