Inpatient Provider Education

1/26/2016

Welcome to Magnolia Health!

We thank you for being part of Magnolia's network of providers, hospitals, and other healthcare professionals participating in the Mississippi Coordinated Access Network (MississippiCAN). Our number one priority is the promotion of healthy lifestyles through preventive healthcare. Magnolia works to accomplish this goal through close relationships with the providers who oversee the healthcare of Magnolia members.

This presentation is only intended to provide guidance to providers regarding Magnolia's policies and procedures related to inpatient services for the MississippiCAN Program. It is always the responsibility of the provider to determine member eligibility and also determine and submit the appropriate codes, modifiers and charges for the services provided to Magnolia members.

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- Provider Relations
- Quality Coordinators
- Behavioral Health Information

Provider Enrollment

- Providers must be enrolled as a Medicaid Provider and have an active Mississippi Medicaid ID #. Providers must also be properly credentialed by Magnolia or other designated authority prior to treating Magnolia members.
- Prior Authorizations must be obtained for services provided by out of network providers, except for emergency and post-stabilization services, and these services will only be reimbursed at 80% of the Medicaid fee schedule.
- Contract request forms can be found on Magnolia's website at www.magnoliahealthplan.com and should be completed and faxed to 866-480-3227 in order to begin the contracting process.
- Upon receipt of the contract request form, a Magnolia Contract Negotiator will send you a MississippiCAN agreement to review along with a list of information required to complete credentialing.
- Magnolia's credentialing team is required to render a decision on all credentialing applications within ninety (90) calendar days of receipt of a complete credentialing package.
- Providers will be designated in Magnolia's claims payment system as a participating provider within thirty (30) days of approval of their credentialing application by Magnolia's Credentialing Committee.

Required Items for Facility Credentialing

- Hospital/Ancillary Credentialing Application
- State Operational License
- Other applicable State/Federal licensures (e.g. Clinical Laboratory Improvement Amendment (CLIA), Drug Enforcement Administration (DEA), Pharmacy, Department of Health, etc.)
- Accreditation/certification by a nationally-recognized accrediting body (i.e. The Joint Commission (TJC), Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or other designated authority)
  - If not accredited by a nationally-recognized accrediting body, please include site evaluation results from a governmental agency
- Current general liability coverage (showing the amounts and dates of coverage)
- Medicaid/Medicare certification
  - If not certified, please provide proof of participation
- W-9
- Ownership and Disclosure form

MississippiCAN Eligibility

Eligibility for MississippiCAN will be determined by the Division of Medicaid (DOM) according to rules approved by the Division of Medicaid. DOM follows eligibility rules mandated by federal law.

Categories of Eligibility (COE):

Mandatory Populations	COE	New COE	Age
SSI - Supplemental Security Income	001	001	19 – 65
Working Disabled	025	025	19 – 65
Breast and Cervical Cancer	027	027	19 – 65
Parents and Caretakers (TANF)	085	075	19 – 65
Pregnant Women (below 194% FPL)	088	088	8 – 65
Newborns (below 194% FPL)	088	071	0 – 1
Children TANF	085	071 – 073	1 – 19
Children (< age 6) (< 143% FPL)	087, 085	072	1 – 5
Children (< age 19) (< 100% FPL)	091, 085	073	6 – 19
Quasi-CHIP (100% - 133% FPL) (age 6-19) (previously qualified for CHIP)	099	074	6 – 19
CHIP (age 0-19) (< 209% FPL)	099	099	1 – 19
Optional Populations*	**COE**	**New COE**	**Age**
SSI - Supplemental Security Income	001	001	0 – 19
Disabled Child Living at Home	019	019	0 – 19
DHS – Foster Care Children – IV-E	003	003	0 – 19
DHS – Foster Care Children – CWS	026	026	0 – 19

*Native Americans are allowed to opt out of MississippiCAN, as well.

Verify Eligibility

It is the provider's responsibility to verify member eligibility on the date services are rendered using one of the following methods:

- Log on to the Medicaid Envision website at: **www.ms-medicaid.com/msenvision/**
- Log on to the secure provider portal at **www.magnoliahealthplan.com**
- Call our automated member eligibility interactive voice response (IVR) system at 1-866-912-6285
- Call Magnolia Provider Services at 1-866-912-6285

Member ID Cards Are Not a Guarantee of Eligibility and/or Payment.

Cultural Awareness and Sensitivity

Providers must ensure that:

- Members understand that they have access to medical interpreters, signers, and TDD/TTY services to facilitate communication without cost to them.

- Medical care is provided without consideration to the member's race/ethnicity or language and its impact/influence of the member's health or illness.

Inpatient Regulatory Requirements

Providers must adhere to all requirements outlined in applicable State Plan Amendments and the Administrative Code.

State Plan Amendments (SPAs)

- The following SPAs are mandated by the Division of Medicaid and are available for viewing on its website:
  - SPA 15-002 Increased Primary Care Provider Payment
  - SPA 15-005 Physician Upper Payment Limit (UPL)
  - SPA 15-008 All Patient Refined Diagnosis Related Groups (APR-DRG) Public Commenting Period
  - SPA 14-009 Health Care Acquired Conditions (HCAC)
  - SPA 15-010 Mississippi Coordinated Access Network (MSCAN)
  - SPA 15-012 Mississippi Hospital Access Program (MHAP) Transition Payment and Inpatient Hospital UPL Program Elimination
  - SPA 14-016 All Patient Refined Diagnosis Related Groups (APR-DRG)

Administrative Code

- Title 23, Part 202, Inpatient Services
- Miss. Admin. Code Part 300, Rule 1.1
- Miss. Code Ann. §§ 43-13-117, 43-13-121
- Magnolia's policies strictly comply with all Division of Medicaid State Plan Amendments and Administrative Code. http://www.magnoliahealthplan.com/for-providers/provider-resources/

Medical Management

- Hours of operation are Monday through Friday from 8:00 a.m. to 5:00 p.m., CST (excluding holidays).
- Services include utilization management, case management, disease management, pharmacy management, and quality review.
- Clinical services are overseen by the Magnolia Medical Director (Medical Director). The Vice President of Medical Management is responsible 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 1-855-684-6746

www.magnoliahealthplan.com

Prior Authorization

Prior Authorization is a request to the Magnolia Utilization Management (UM) department for medical necessity determination of services on the prior authorization list before the service is rendered.

- All out of network services require prior authorization except basic laboratory chemistries and basic radiology.
- Authorization must be obtained prior to the delivery of services listed on Magnolia's Prior Authorization List, which can be found at http://www.magnoliahealthplan.com/for-providers/provider-resources/. Failure to obtain authorization may result in an administrative claim denial.
- All hospital inpatient stays require notification via an authorization request within two (2) business days of the admission. *(Please see specific requirements for OB/Newborn care which differ slightly for normal uncomplicated care.)*
- Please initiate the Authorization process at least five (5) calendar days in advance for non-emergent outpatient services. Initiate Authorization for pre-scheduled hospital inpatient services at least 14 calendar days in advance and no later than five (5) calendar days in advance.
- The Provider should contact the UM department via telephone, fax, mail, secure email or through our website with the appropriate clinical information to request an authorization.
- Expedited requests can be requested from the UM department as needed.
- Prior Authorization is NOT required for emergent or urgent care services.*(If these services result in admission Magnolia must be notified within two (2) business days of admission.)*
- Prior Authorization is NOT required for post-stabilization services. Once the member's emergency medical condition is stabilized, certification for hospital admission or authorization for follow-up care is required as stated above.

Failure to obtain authorization for hospital inpatient care may result in denial of the claim!

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Magnolia Health Services Requiring Prior Authorization (PA) *Effective 12/1/2015

This participating Provider PA List is not intended to be an all-inclusive list of covered services but it substantially provides current PA instructions. All services are subject to benefit coverage, limitations, and exclusions as described in applicable plan coverage guidelines. NON-PARTICIPATING PROVIDERS MUST RECEIVE PRIOR APPROVAL FOR ALL SERVICES EXCEPT OUTPATIENT BASIC LABORATORY CHEMISTRIES AND BASIC RADIOLOGY.

DOM-Division of Medicaid PA-Prior Authorization

Service	Benefit Limitation	PA Required	Comments
Ambulance - Airplane		YES	PA required for Fixed Wing (airplane) Ambulance Services
Ambulance – Non-emergent		YES	Contact MTM at 1-866-912-6285
Behavioral Health Prescriptions	See Prescription Drug limits below	See Comments	Covered by Magnolia. PA required for specific medications on the Preferred Drug List (PDL). Contact US Script at 1-800-460-8988 for PA
Behavioral Health Services		YES	Contact Cenpatico at 1-866-912-6285 for authorization
Cardiac Rehabilitation		YES	
Category III CPT Codes		YES	Temporary CPT codes for emerging technology require PA
Continuous Glucose Monitoring		YES	
CT/CTA (Non-inpatient/ Non-emergent)		YES	Contact National Imaging Associates (NIA) at 1-866-912-6285 or www.RadMd.com for authorization
Dental Anesthesia		YES	Anesthesia for dental procedures (D Codes) performed in a dental office is covered by Dental Health & Wellness at 1-866-912-6285. Anesthesia for dental procedures performed outside of a dental office (in a hospital or outpatient facility) requires PA by Magnolia.
Dental Services (Less than 21 years)	$2,500/year - dental $4,200/ lifetime-orthodontia	See Comments	Covered by Dental Health & Wellness at 1-866-912-6285. Routine preventive care does not require PA. Orthodontia, dentures and services performed in a hospital or outpatient facility require PA. See the Dental Health & Wellness Provider Manual for details.
Dental Services (21 years and older)	$2,500/year	YES	Covered by Dental Health & Wellness at 1-866-912-6285; Emergent and palliative
Durable Medical Equipment (DME)		YES	Codes identified at www.magnoliahealthplan.com under 'Pre-Auth Needed?'
Expanded EPSDT Services	Less than 21 years old	YES	PA required for any service that exceeds EPSDT benefit limit
Genetic/Molecular Diagnostic Testing		YES	
Hearing Aids and Cochlear Implants	Less than 21 years old	YES	
Home Health Care Services	25 visits/year	YES	Initial evaluation does not require PA for Par providers. Includes traditional home care, home therapies, home medical equipment and private duty nursing (not limited to 25 visits/year). NOTE: Home-based OT/PT/ST (therapies) are not covered benefits for adults 21 years and older.
Home Infusion		YES	
Hospice Care (Inpatient/Outpatient/ Hospital based/ home setting)		YES	Must submit all documentation listed in DOM's Administrative Code Title 23: Medicaid Part 205 Hospice Services
Hyperbaric Oxygen Therapy		YES	
Hysterectomy (Outpatient)		YES	Must submit copy of consent form with the claim
Inpatient Hospital Services		YES	Required for elective/scheduled admissions at least 14 calendar days and no later than five (5) business days prior to the scheduled admission except maternity admissions for vaginal deliveries with stays of three (3) calendar days or less, or cesarean section deliveries with stays of five (5) calendar days or less. Otherwise, all inpatient admissions require notification via an authorization request within one (1) business day of the admission. Prior Authorization is NOT required for emergent care, urgent care or post stabilization services. Once stabilized, certification for hospital admission or authorization for follow up care is required. Inpatient concurrent requests are required at least one (1) business day prior to the last day approved.

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Service	Benefit Limitation	PA Required	Comments
Medical Supplies		YES	Codes identified at www.magnoliahealthplan.com under 'Pre-Auth Needed?'
MRI/MRA (Non-inpatient/Non-emergent)		YES	Contact NIA at 1-866-912-6285 or www.RadMd.com for authorization
Neuro-Psychological Services		YES	Procedure code 96118 requires prior authorization by Magnolia
Nuclear Cardiology		YES	Contact NIA at 1-866-912-6285 or www.RadMd.com for authorization
Nutritional Supplements (oral) for Home Use		YES	Available through pharmacy benefit. Requires PA/Bill to US Script at 1-800-460-8988
Observation		YES	
Oral Surgeon Services		YES	Covered by Dental Health & Wellness at 1-866-912-6285
Oral Maxillofacial Surgeon Services		YES	Orthognathic Procedures require prior authorization by Magnolia
Orthotics & Prosthetics (O&P)	Less than 21 years old	YES	Codes identified at www.magnoliahealthplan.com under 'Pre-Auth Needed?'
Out-of-Network Physician & Facility Services		YES	Except emergency room (ER) services, family planning services, outpatient basic laboratory chemistries and basic radiology
Pain Management Services		YES	All treatments & procedures in office or outpatient setting
PET Scan (Non-inpatient/Non-emergent)		YES	Contact NIA at 1-866-912-6285 or www.RadMd.com for authorization
Plastic Surgeon		YES	Consultation or follow up office visits do not require prior authorization. All treatments & procedures in office or outpatient setting require prior auth. Services for cosmetic purposes only are not a covered benefit.
Prescribed Pediatric Extended Care (PPEC)		YES	
Prescription Drugs	6 prescriptions/month for age > 21 with no more than 2 of the 6 being brand name drugs	See Comments	Authorization is required for specific medications as noted in the Preferred Drug List (PDL). Contact US Script at 1-800-460-8988. More than six (6) prescriptions require PA. Diabetic supplies do not count toward limit. HIV medications are excluded from the two (2) monthly brand name drugs limit; however still count towards the monthly total of six (6) per month.
Qualitative & Quantitative Drug Test		YES	Codes identified at www.magnoliahealthplan.com under 'Pre-Auth Needed?'
Sleep Study	No inpatient	YES	Outpatient or home setting only
Specialty Injection and/or Infusion Services		YES	Drugs may be obtained from provider "Buy & Bill", vendor or other specialty pharmacy. Drugs given in home setting-PA/bill to US Script 1-800-460-8988. Drugs given in provider office or outpatient setting-PA/bill to Magnolia.
Stereotactic Radiosurgery and Specialized Radiation Therapy		YES	
Surgery: Potentially Cosmetic (Outpatient)		YES	Including but not limited to: Blepharoplasty, Breast Reconstruction, Breast Reduction Surgery, Septoplasty, Mastectomy for Gynecomastia, & Varicose Vein Treatments
Therapy (OT, PT, ST) Services (Outpatient)	Home-based therapy not covered for 21 years and older	YES	Initial evaluation does not require PA for Par providers. Submit treatment plan & goals for PA of continued services. MUST BE BILLED w/G MODIFIERS (GN, GO, GP).
Transplant Services		YES	All transplant services including pre- & post-transplant services

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INPATIENT MEDICAID Prior Authorization Fax Form

Complete and Fax to: 1-877-291-8059

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☐ Standard Request - Determination within 3 calendar days and/or 2 business days of receiving all necessary information.

☐ Expedited Request - I certify 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.

X _____ URGENT REQUESTS MUST BE SIGNED BY THE REQUESTING PHYSICIAN TO RECEIVE PRIORITY.

*** INDICATES REQUIRED FIELD**

MEMBER INFORMATION

Member ID/Medicaid ID *

Last Name, First

Date of Birth * (MMDDYYYY)

REQUESTING PROVIDER INFORMATION

Requesting NPI *

Requesting TIN *

Requesting Provider Contact Name

Requesting Provider Name

Phone

Fax

SERVICING PROVIDER / FACILITY INFORMATION

↳ ☐ ***Same as Requesting Provider***

Servicing NPI *

Servicing TIN *

Servicing Provider Contact Name

Servicing Provider/Facility Name

Phone

Fax

AUTHORIZATION REQUEST

Primary Procedure Code (CPT/HCPCS) (Modifier)

Start Date *OR* Admission Date * (MMDDYYYY)

Diagnosis Code * (ICD-10)

Additional Procedure Code (CPT/HCPCS) (Modifier)

End Date *OR* Discharge Date (MMDDYYYY)

INPATIENT SERVICE TYPE *

(Enter the service type number in the boxes)

Delivery		Inpatient Rehab		Transplant	
779	C-Section	479	Inpatient Rehab	209	Surgery
720	Vaginal Delivery			419	Work-up
		970	Medical		
		414	Premature/False Labor		
		492	Subacute (Swing bed)		
		411	Surgical		

ALL REQUIRED FIELDS MUST BE FILLED IN AS INCOMPLETE FORMS WILL BE REJECTED.
COPIES OF ALL SUPPORTING CLINICAL INFORMATION ARE REQUIRED. LACK OF CLINICAL INFORMATION MAY RESULT IN DELAYED DETERMINATION.

Prior Authorization (cont.)

- For hospital inpatient services, if authorization for level of care cannot be determined at first level review by the UM nurse, the care will be reviewed by a Mississippi licensed Medical Director. The attending physician may request a peer-to-peer discussion with said Medical Director.

- Magnolia will make standard pre-service authorization decisions within one (1) business day and provide notification to providers within two (2) business days following the receipt of the request for services and all necessary supporting documentation. Magnolia will make determination for urgent concurrent, expedited continued stay, and/or post-stabilization review within twenty-four (24) hours of receipt of the request for services and all necessary clinical information.

- If all necessary clinical information has been received from the provider and Magnolia is still unable to make a determination within these timeframes, it may be extended up to fourteen (14) additional calendar days upon the request of the member or provider, or if Magnolia and the Division of Medicaid determine that the extension is in the member's best interest.

CLINICAL DECISIONS: Magnolia affirms that utilization management decision-making is based only on appropriateness of care and service and existence of coverage. The treating provider, in conjunction with the member, is responsible for making all clinical decisions regarding the care and treatment of the member.

Prior Authorization (cont.)

A prior authorization request must be submitted prior to services being rendered except for emergent or post-stabilization services.

It is highly recommended that providers utilize Magnolia's "Smart Sheet" to assist with Prior Authorization requests.

http://www.magnoliahealthplan.com/files/2010/11/PA-Smart-Sheet-How-To-PDF.pdf

Prior Authorization list is located at:

http://www.magnoliahealthplan.com/files/2010/11/Prior-Authorization-List-PDF3.pdf

Prior Authorization Form(s) can be located on our website at the following address:

http://www.magnoliahealthplan.com/for-providers/provider-resources/

Requests can be faxed to:
1-877-291-8059 (Hospital Inpatient)
1-877-650-6943 (Outpatient)

Requests can be emailed securely to:
magnoliaauths@centene.com

Requests can be phoned in to:
1-866-912-6285

Prior Authorization vs. Notification

- A prior authorization (PA) is an authorization granted in advance of the rendering of a service after appropriate medical review. When related to an inpatient admission, this process may also be referred to as pre-certification. Magnolia Health Plan Inpatient Prior Authorization forms can be obtained from our website at www.magnoliahealthplan.com.

Prior Authorization vs. Notification (cont.)

- A notification is communication to the plan of member medical services rendered. These services may or may not require authorization. In reference to inpatient services, notification alone is not sufficient to create an authorization, as clinical information proving medical necessity of services would be required.
- Notification information should include member name, Medicaid ID number, date of admission and reason for admission. Notification should be submitted via secure email to magnoliaauths@centene.com.

Facilities can submit notification via a daily census report of Magnolia members to magnoliaauths@centene.com OR by fax at 1-877-291-8059.

Emergent and Weekend and Holiday Admissions

- Emergency and urgent care services never require prior authorization.
- All hospital inpatient admissions require notification as defined above to Magnolia by close of business on the next business day following admission. Prior Authorization request should be submitted within two business days.
- Failure to notify may result in denial of payment.
- Prior Authorization is NOT required for post-stabilization services. Once the member's emergency medical condition is stabilized, certification for hospital admission or authorization for follow-up care is required as stated above.
- Non-emergent hospital inpatient admissions always require a prior authorization.

Review Criteria

- Magnolia has adopted utilization review criteria developed by McKesson InterQual® products to determine DOM approved medical necessity for healthcare services.

- 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 screening criteria. Denial notification will include the reason(s) for denial per section 17.A. of the contract.

- Providers may obtain the criteria used to make specific determinations by contacting the Medical Management department at 1-866-912-6285.

Review Criteria (cont.)

- Members, authorized representatives or healthcare professionals with the member's consent, may request an appeal with Magnolia 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

Clinical Protocols

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.

Magnolia has adopted DOM approved 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.

Please visit the Practice Improvement Resource Center (PIRC) at
www.magnoliahealthplan.com
for Clinical Practice Guideline and Preventative Guidelines

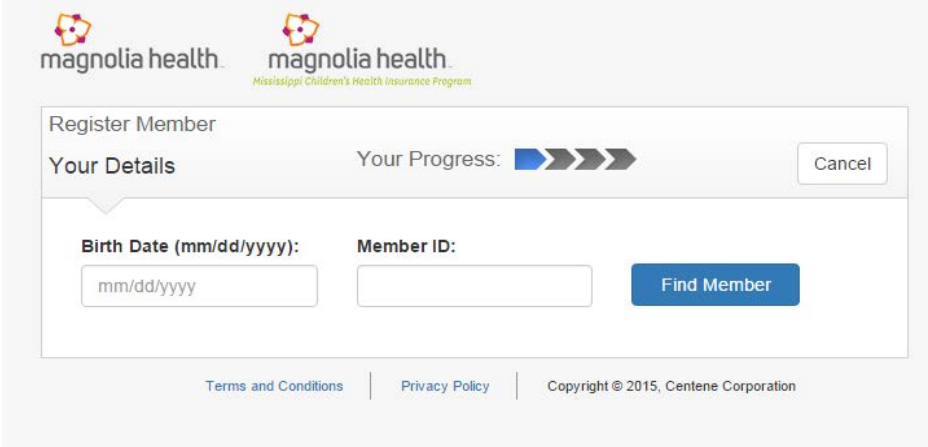
Magnolia Secure Web Portal

To register for the secure web portal, please refer to www.magnoliahealthplan.com.

- Once logged in, please select **For Medical Professionals** < **Medicaid**.
- Once you are on the **For Providers** screen, you will select **Login**. This screen will give the provider the option to register.

BENEFITS INCLUDE:

- Claim submission/corrections and status
- Prior Authorizations submission and status
- Patient Panel listing
- Care gap identification
- Member eligibility verification
- Updates….. and more!!



Prior Authorization Summary Information

Magnolia Health Plan Prior Authorization Timeframes

Type of Admission	Authorization Request Submission Requirement
Elective/Prescheduled	At least 14 days before but no later than 5 days prior to admission
Urgent Admission (not OB delivery or routine well baby newborn care)	Within two (2) business days of admission
Urgent Admission (OB delivery or routine well baby newborn care)	See Newborn enrollment for instructions
Emergent/Urgent/Post-Stabilization care less than 8 hrs that does not result in inpatient stay	No Authorization needed
Emergent/Urgent Care (that results in inpatient stay)	Within two (2) business days of admission

How and Where do I submit Magnolia Authorizations?

1. Prior Authorizations can be completed and submitted through our Magnolia Secure Provider Web Portal

**Not signed up yet for the Magnolia Secure Provider Web Portal?*

Secure portal website vignettes are located on the Magnolia Health Plan website in the Provider section. Your Magnolia Provider Representative can assist you in getting signed up.

2. The Prior Authorization form can be printed from the Magnolia website, completed and:

FAXED to 1-877-291-8059
OR
Emailed securely to magnoliaauths@centene.com

3. Prior Authorization requests can be Phoned In to 1-866-912-6285.

Observation Guidelines

- In the event that a member's clinical symptoms do not meet the criteria for an inpatient admission, but the physician believes that allowing the patient to leave the facility would likely put the member at serious risk, the member may be admitted to the facility for an observation period.

- An observation stay may last up to a maximum of twenty-three (23) hours. (Stays less than 8 hours of observation or greater than 23 hours are not allowed.)

- Providers are required to notify Magnolia's Medical Management department of an observation stay by the next business day after discharge.

- A medical necessity determination will be made within three (3) calendar days/two (2) business days of receiving all required information.

Concurrent Review

- Magnolia's Medical Management department will concurrently review the treatment and status of all members who are inpatient through contact with the hospital's Utilization and Discharge Planning departments and when necessary, the member's attending physician. The individual identified on the Prior Authorization form will be considered the appropriate point-of-contact for all discharge planning.
- An inpatient stay will be reviewed as indicated by the member's diagnosis and response to treatment.
- The review will include evaluation of the member's current status, proposed plan of care, discharge plans, and any subsequent diagnostic testing or procedures.
- Unlike EQ Health, which allowed 19 days for a medically necessary hospital stay, Magnolia Health will conduct concurrent reviews every 5 days.
- In order to decrease administrative burden for both facilities and Magnolia Health, facilities can submit a daily census report of Magnolia members by email to magnoliaauths@centene.com or by fax to 1-877-291-8059.

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Newborn Enrollment Form and Instructions

Maternity Observation Stays

- Magnolia follows the APC Methodology and Observation stays are recognized as 8-23 hours. The APC rule states that if a patient is admitted for less than 8 hours the stay should be billed for diagnostic services using the appropriate revenue codes and procedure codes. If the stay is greater than 8 hours and up to 23 hours the stay can be processed and billed as Observation and a request for authorization should be submitted.

- Imaging studies that are ordered during an Observation stay do NOT require Prior Authorization.

- If the Observation stay results in an inpatient admission and delivery, then the overall service type should be changed to c-section or vaginal delivery.

Newborn PA Requirements

Magnolia Health Plan requires maternal information to acknowledge maternity admission. The Division of Medicaid Newborn Enrollment Form includes all of the necessary information for routine deliveries and well-baby care (standard 3 day stay for vaginal deliveries, 5 day stay for C sections).

The Newborn Enrollment Form must be fully completed and submitted to the Division of Medicaid within 5 days of delivery. If the Newborn Enrollment Form is completed and submitted timely, Magnolia Health Plan does not require any additional information for mother or newborn, unless complications develop during the stay.

If complications develop with mother or baby that may necessitate additional hospital days or a non well-baby or NICU admission, a prior authorization should be submitted along with clinical information to support the stay within one business day of the decision that the higher level of care is needed.

Newborn Enrollment Form

Effective 12/01/2015

MISSISSIPPI DIVISION OF MEDICAID

This form is to be used by birth hospitals to enroll **all** deemed eligible newborns in Medicaid. All information must be completed by the birth hospital to obtain a Medicaid Identification Number for the newborn. Please type or print clearly. Return by email to newborn@medicaid.ms.gov or fax to the Office of Eligibilty at 601-576-4164.

MOTHER'S INFORMATION

MEDICAID ID NUMBER: _____-_____-_____

FIRST NAME: _____

LAST NAME: _____

MOTHER'S SOCIAL SECURITY NUMBER: _____-_____-_____

MOTHER'S DATE OF BIRTH (MM/DD/YY) _____-_____-_____

MOTHER'S ADDRESS: _____

_____

NEWBORN INFORMATION

FIRST NAME: _____ MIDDLE NAME: _____

LAST NAME: _____

DATE OF BIRTH (MM/DD/YY) _____-_____-_____ TIME OF BIRTH: _____

GENDER (M/F): _____ Birth order, if multiples: _____ Check if parental rights terminated: _____

FATHER'S NAME: _____

CONTINUE ENTERING MOTHER/CHILD INFORMATION BELOW

HOSPITAL NAME: _____ MEDICAID PROVIDER ID#_____

CONTACT NAME: _____ EMAIL:_____

TELEPHONE: _____ EXT: _____ FAX:_____ DATE: _____

TO BE COMPLETED BY DIVISION OF MEDICAID OFFICE OF ELIGIBILITY

Newborn Medicaid ID: _____ - _____ - _____

OTHER INFORMATION:_____

DOM CONTACT: _____ DATE: _____

MOTHER'S DATE OF LAST MENSTRUAL PERIOD: _____

DELIVERY TYPE: ___VAGINAL ___ V-BAC ___CESAREAN

SCHEDULED DELIVERY? ___YES ___NO

GESTATIONAL AGE: _____WEEKS _____DAYS

BIRTH WEIGHT: _____ LBS/OUNCES _____GRAMS

APGAR SCORES: _____ 1 MIN _____ 5 MIN

BIRTH STATUS:

____HEALTHY/DISCHARGED HOME WITH MOTHER

____HEALTHY/ADOPTED OR FOSTER CARE

____SICK HOSPITALIZED

____DETAINED BORDER BABY

____STILLBORN/EXPIRED

ADMISSION DATE, IF APPLICABLE: _____

DISCHARGE DATE, IF APPLICABLE: _____

IF TRANSPORTED TO ANOTHER FACILITY, FACILITY NAME: _____

DELIVERING PHYSICIAN'S NAME: _____

DELIVERING PHYSICIAN'S NPI/TIN: _____

PEDIATRICIAN NAME: _____

PEDIATRICIAN NPI/TIN: _____

Magnolia NICU PA and Concurrent Review Process

- **Provider submits PA form and all supporting clinical documentation within 2 business days of admission.**

- **If all necessary supporting clinical documentation is submitted and the nurse can make a determination, notification will be sent to the provider within 1 business day of receipt of PA.**

- **Magnolia requires clinical information every 5 days; however this may vary on a case by case basis**

Sterilization Procedures

- A consent form is required for sterilizations (tubal ligation or hysterectomy) per 42 CFR Part 441, Subpart F.

- Magnolia utilizes DOM's sterilization consent form, which **must** be submitted with the claim.

Maternity/Newborn/NICU Summary

Magnolia Health
Maternity/Newborn/NICU PA Timeframes

Type of Service	Prior Auth Requirement	Concurrent Review
Maternity Observation (8-23 hours) Not resulting in admission	Outpatient PA within 1 business day of discharge	None
Urgent Admission for Routine Deliveries (vaginal and C-section) and well baby care	Newborn enrollment form submitted to DOM within 5 days	None
Urgent Maternity Admission (complications prior to or following delivery that exceeds the allowed 3 days for vaginal and 5 days for C-section	Within 2 business of Admission	Every 5 days (may vary on case by case)
Urgent Newborn Admission (sick baby stay that exceeds 3 days for vaginal and 5 days for C-section, acute neonatal or newborn intensive care)	Within 2 business days of admission	Every 5 days (may vary on case by case)

Inpatient Example - Perfect Scenario

Magnolia member gets admitted to your hospital on a **Friday** and remains in the hospital until the following Thursday:

1) You must obtain authorization no later than close of business **Tuesday**. Notification can be sent in on Monday, but the completed authorization MUST be received by Magnolia on Tuesday. Authorization should include all clinical information available to support medical necessity (i.e. History and Physical, x-ray reports, labs, doctor's progress notes including Plan of Care)
2) Magnolia will make a decision within 1 business day of the completed authorization and will provide you notification **no later** than 2 business days.
3) If your facility will submit a daily census of Magnolia members to magnoliaauths@centene.com or fax to 1-877-291-8059, we will be able to close the case by seeing the discharge date on Thursday and prepare for claims payment.

Care Management

- Magnolia's Care Management program uses a multidisciplinary team approach to provide individualized process for assessment, goal planning and coordination of services.
- The Care Management program is available to **all** members, emphasizing prevention and continuity of care.
- Magnolia's Care Management team provides assistance with complex medical conditions, health coaching for chronic conditions, transportation assistance to appointments, interpreter services, location of community resources, and encouragement of self-management through disease education.
- The Care Management team will incorporate the provider's plan for the member into our Care Plan, so we can focus on the same problems and same care interventions.

Accessing Care Management

All Magnolia Health Plan members have access to Care Management services. Referrals from Providers can be made in any of the following ways:

- Effective July 23, 2015, providers may log in to our Provider Portal and complete the Provider Referral Form for Care Management and Disease Management.
- Go to our website www.magnoliahealthplan.com and fill out the Provider Referral Form for Care Management and Disease Management which is located under the Practice Improvement Resource Center (PIRC) section. Fax the completed form to 1-866-901-5813.
- Call Magnolia Health at 1-866-912-6285, ext. 66415 to speak with the Care Management Department.
- Call Magnolia Health at 1-866-912-6285 and choose the Provider prompt to speak with a Provider Services Representative who can assist you.
- For assistance with **Prior Authorizations**, call 1-866-912-6215, ext. 66408 to speak with the Prior Authorization Department.
- Magnolia Health Care Managers will contact the member and offer Care Management within 72 hours. Members who agree to Care Management services will be enrolled for the time necessary to address and stabilize the condition. Providers will be asked to provide a Plan of Care so our Care Management Team can target the Care Management to the specific needs of each member.

Claims and Payments

Payments - APR-DRG

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

- APR-DRGs classify each case based on information contained on the inpatient claim including diagnosis, procedures performed, patient age, patient sex, and discharge status. The APR-DRG payment is determined by multiplying the APR-DRG relative weight by the APR-DRG base rate.

- Every inpatient stay is assigned a single DRG that reflects the typical resource use of that case.

- Magnolia's DRG calculator is based off of the same parameters including base rates, outlier methods and groupers currently used by Mississippi Division of Medicaid (DOM).

Magnolia will mirror APR-DRG payment under the Fee-For-Service delivery payment methodology. Version 32 of the 3M™ grouper and the Version 33 mapper will be used under license from 3M Health Information Systems. Version 32 of the Health-Care Acquired Condition (HCAC) Utility and DOM APR-DRG payment parameters will also be used by Magnolia.

Third Party Liability Claims

- Third Party Liability (TPL) refers to the legal obligation of third parties (e.g., certain individuals, entities, insurers, or programs) to pay part or all of the expenditures for medical assistance furnished under a Medicaid state plan including Medicaid CCOs.
- DOM and its contracted CCOs, by law, are the “payer of last resort”; all other available third party sources must meet their legal obligation to pay claims before the Medicaid program pays for the care of an individual eligible for Medicaid.
- A method of avoiding payment of Medicaid claims when other insurance resources are available to the Medicaid beneficiary is called **Cost Avoidance**. If a Member has resources available for payment of expenses associated with the provision of covered services, other than those which are exempt under Title XIX of the Social Security Act, such resources are primary to the coverage provided by DOM and must be exhausted prior to payment. In accordance with DOM’s billing manual, Magnolia will reimburse for EPSDT, Title IV-D, and pregnancy-related services **prior** to billing of the third party source, and then pursue recovery of Medicaid payment, for practitioner services. Claims submitted for inpatient and outpatient hospital charges for labor and delivery and postpartum must be cost avoided. By law, all other hospital claims are excluded from the above exceptions. Hospital claims must be filed with the third party prior to billing the CCOs.
- The Division of Medicaid Office of Recovery will conduct an annual audit to document Magnolia’s compliance with the law.

Filing Claims when Magnolia is Secondary Coverage

- Magnolia will follow FFS Medicaid methodology. Providers are required to submit taxonomy numbers in box 3B.

- If the provider uses our web portal to submit claims, they can upload the EOPs from the primary insurer.

- If the provider files paper claims, a copy of the EOP should be included with the claim.

“3 Day” or 72 hour Rule

- Magnolia will mirror FFS Medicaid by following CMS “3 day Rule”, sometimes referred to as 72 hour rule regarding ER services, outpatient, and observation days prior to an admission.

- Date of Admission will be the date the patient is converted to inpatient status, as ordered by the physician.

- Magnolia will not change the date of admission to include the date the patient entered observation status. However, the APR-DRG reimbursement includes the three days of care (if any) **prior to** the inpatient admission

MHAP

- The Mississippi Hospital Access Program, or MHAP, is a program authorized by state legislation. The MHAP will apply to in-state hospitals and the out-of-state hospital that is authorized by federal law to submit intergovernmental transfers (IGTs) to the State of Mississippi and is classified as a Level I trauma center located in a county contiguous to the state line. It is DOM's intent that the MHAP will function to ensure patient access to hospital inpatient services for Mississippi Medicaid beneficiaries as provided in Mississippi Code Sections 43-13-117 and 43-13-145. Under MHAP, effective with hospital inpatient admit dates of service on or after December 1, 2015, a per-member-per-month (PMPM) add-on payment will be paid by DOM to the CCOs participating in MississippiCAN. This increased capitation payment is referred to as MHAP. The CCOs are responsible for ensuring the distribution of 100% of MHAP payments to hospitals. Magnolia's December 2015 distribution has already been paid to hospitals.

Claims Filing

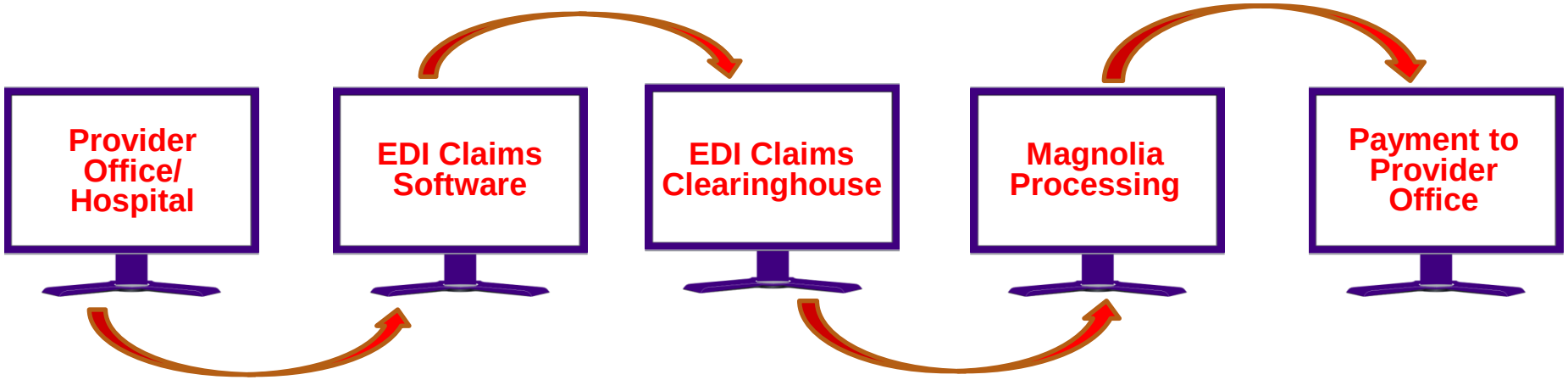
- ALL Claims must be filed within six (6) months of discharge date.
- ALL requests for correction, reconsideration, retroactive eligibility, or adjustment must be received within ninety (90) days from the date of notification of denial.
- Option to file electronically through the clearinghouse
- Option to file directly through the Magnolia website
- All member and provider information must be complete and accurate.

File online at www.magnoliahealthplan.com

- Option to file on paper claim, please mail to:
  Magnolia Health Plan MSCAN
  Attn: CLAIMS DEPARTMENT
  P.O. Box 3090
  Farmington, MO 63640
- Paper claims are to be filed on approved UB-04 (CMS 1450) claim forms (No handwritten or black and white copies)
- To assist our mail center improve the speed and accuracy of complete scanning, please take the following steps when filing paper claims:
  - ✓ Remove all staples from pages
  - ✓ Do not fold the forms
  - ✓ Make sure claim information is dark and legible
  - ✓ Please use a 12pt font or larger
  - ✓ Red and White approved claim forms are required when filing paper claims as our Optical Character Recognition ORC scanner system will put the information directly into our system. This speeds up the process and eliminates potential sources for errors and helps get your claims processed faster.

Electronic Clearinghouse

If a provider uses Electronic Data Interchange (EDI) software but is not setup with a clearinghouse, Magnolia must be billed via paper claims or through our website until the provider has established a relationship with a clearinghouse listed on our website.



- **Centene (Magnolia) EDI Help desk: 1-800-225-2573, ext. 25525 or www.ediba@centene.com**
- **Acceptance of Coordination of Benefits (COB)**
- **24/7 Submission**
- **24/7 Status**

For a complete listing of approved EDI clearinghouse partners, please refer to www.magnoliahealthplan.com

Prepayment Claims Review

- 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 coding errors on provider claims prior to payment by analyzing the following:
  - CPT
  - HCPCS
  - modifier, and
  - place of service codes

  against rules that have been established by the
  - American Medical Association (AMA),
  - Centers for Medicare and Medicaid Services (CMS),
  - Mississippi Division of Medicaid rules and regulations,
  - public-domain specialty society guidance,
  - and clinical consultants who research, document and provide edit recommendations based on the most common clinical scenario.

- Codes billed in a manner that does not adhere to these standard coding conventions will be denied.

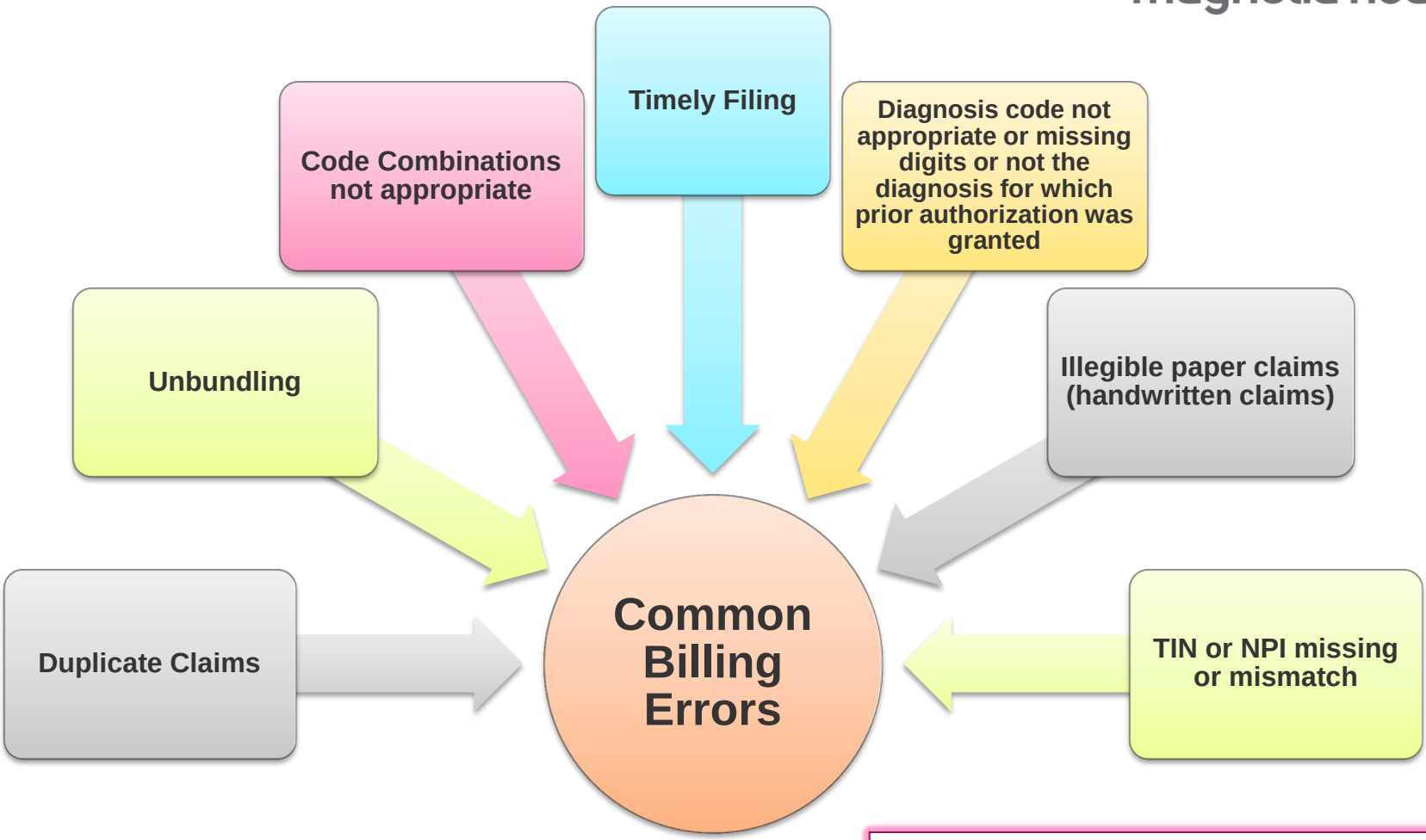
Rejections and Denials

- 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.

- A denial is defined as a claim that has passed minimum edits and is entered into the system for processing, but has been billed with invalid or inappropriate information causing the claim to deny. An EOP (Explanation of Payment) will be sent including the denial reason.

*Clean Claim - A claim that has no defect, impropriety, incompleteness, or special circumstance that requires special handling including any factor that would cause Magnolia Health to obtain further information from the provider or other third party, or conduct further investigation.

Common Billing Errors



For a complete list of common billing errors, please refer to the Magnolia Provider Manual.

Corrected Claim, Reconsideration, Claim Dispute

All requests for corrected claims must be received within ninety (90) days of the original Plan notification (i.e. EOP). All reconsiderations and claims disputes must be received within ninety (90) days of the last written notification of the denial.

Corrected Claims	Reconsideration	Claim Dispute
•Submit via Secure Web Portal •Submit via an EDI Clearinghouse •Submit via paper claim: **•Magnolia Health Plan MSCAN** **•PO BOX 3090** **•Farmington, MO 63640** **•(Include original EOP)**	•Written communication (i.e. letter) outlining disagreement of claim determination •Indicate "Reconsideration of (original claim number)" •Submit reconsideration to: **•Magnolia Health Plan MSCAN** **•Attn: Reconsideration** **•PO BOX 3090** **•Farmington, MO 63640**	•ONLY used when disputing determination of Reconsideration request •Must complete Claim Dispute form located on www.magnoliahealthplan.com •Include original request for reconsideration letter and the Plan response •Send Claim Dispute form and supporting documentation to: **•Magnolia Health Plan MSCAN** **•Attn: Claim Dispute** **•PO BOX 3000** **•Farmington, MO 63640**

Must be submitted within ninety (90) days of adjudication

Retrospective Reviews

- **Magnolia does not routinely retrospectively authorize services that have already been rendered. Request for retrospective reviews will only be considered in extenuating circumstances (i.e., retroactive eligibility of newborns, out of state non-Mississippi Medicaid provider) and for services when the member is still receiving the services requiring authorization delivered without prior authorization and/or without timely notification. These requests must be reviewed by the Magnolia Senior Leadership. Medical necessity post-service decisions and subsequent written member and provider notification will occur no later than 20 days from receipt of the request.**

- **Late Notifications of admissions (beyond the required 2 days for urgent admissions and 5 days for routine OB/Delivery admissions) will be denied.**

Waste, Abuse, and Fraud (WAF) System

Magnolia takes the detection, investigation, and prosecution of fraud and abuse very seriously. Our WAF program complies with MS and Federal laws, and in conjunction with Centene, we successfully operate a WAF unit. Centene's Special Investigation Unit (SIU) performs back end audits which may result in taking appropriate action against those who commit waste, abuse, and/or fraud either individually or as a practice. These actions may include but are 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

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

Some of the most common WAF submissions seen are:

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

Complaints/Grievances

A Complaint/Grievance is a verbal or written expression by a provider which indicates dissatisfaction or dispute with Magnolia Health's policies, procedures, or any aspect of Magnolia Health's functions. Magnolia logs and tracks all Complaints/Grievances. A provider has thirty (30) calendar days from the date of the incident, such as the date of the EOP, to file a Complaint/Grievance.

A Complaint is a verbal or written expression of dissatisfaction that is capable of being resolved within one (1) business day of receipt. Magnolia will resolve all Complaints and provide appropriate notification to providers.

A Grievance requires more than one (1) business day to resolve. Grievances must be confirmed within one (1) business day, and an expected date of resolution must be given within five (5) business days. Magnolia will provide a written determination to the provider within thirty (30) calendar days upon receipt of complete documentation.

The reconsideration and/or claim dispute process must be followed first for a Complaint/Grievance related to a claim determination.

Full details of the claim reconsideration, claim dispute, complaints/grievances and appeals processes can be found in our Provider Manual at www.magnoliahealthplan.com.

Magnolia Health Website

www.magnoliahealthplan.com/for-providers

Submit:

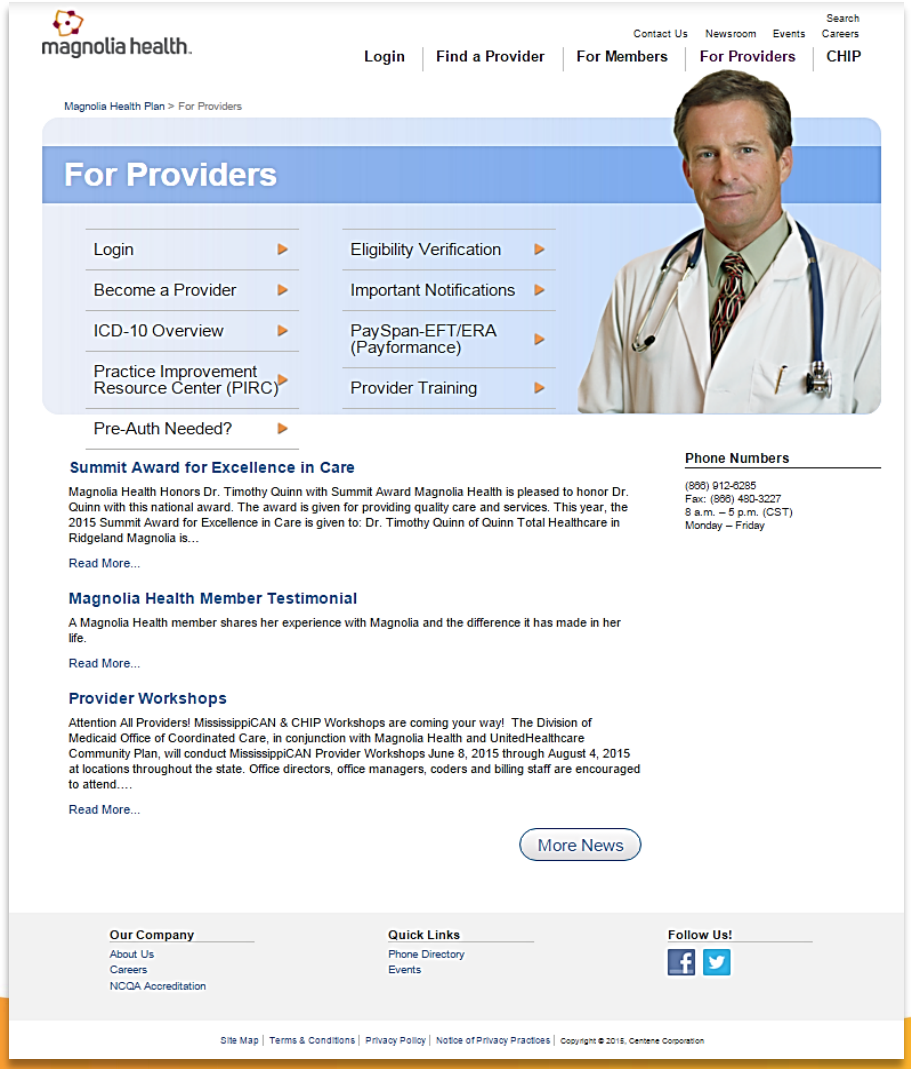
- Claims
- Provider Complaints
- Demographic Updates

Verify:

- Eligibility
- Claim Status

View:

- Provider Directory
- Important Notifications
- Provider Training Schedule
- Practice Improvement Resource Center (PIRC)
- Claim Editing Software
- Provider Newsletter
- Member Roster for PCPs
- Member Care Gaps

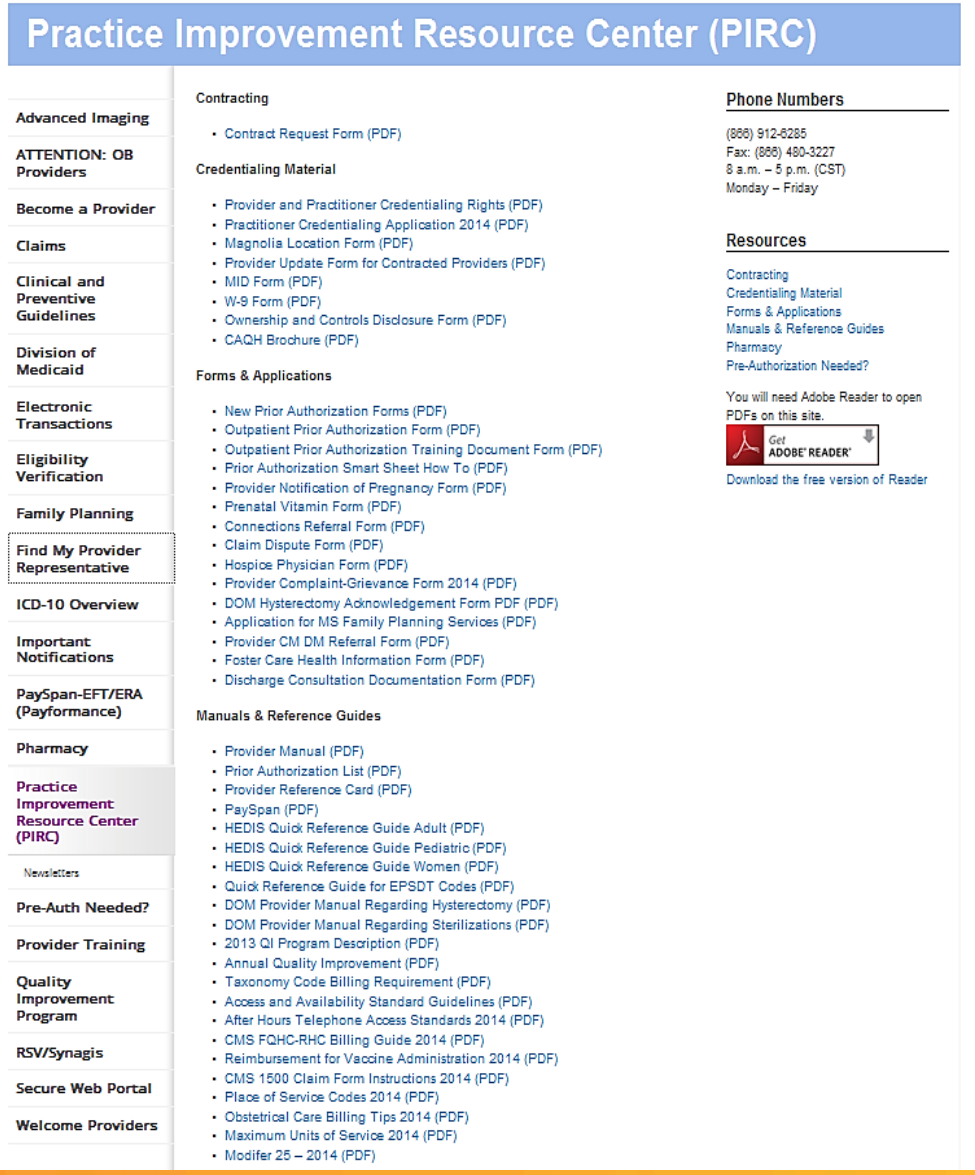


Practice Improvement Resource Center (PIRC)

The Practice Improvement Resource Center (PIRC) offers information to assist providers be more efficient. Resources are available twenty-four (24) hours a day.

PIRC includes these Forms and Guides:

- Contracting/Credentialing
- Prior Authorizations
- Claims
- Provider Manual
- Magnolia Vendors
- HEDIS Reference Guides
- Pharmacy PDL's and Guides
- Provider Training
- Clinical Practice Guidelines
- Updates….. and more!!



Practice Improvement Resource Center (PIRC)

Advanced Imaging
ATTENTION: OB Providers
Become a Provider
Claims
Clinical and Preventive Guidelines
Division of Medicaid
Electronic Transactions
Eligibility Verification
Family Planning
Find My Provider Representative
ICD-10 Overview
Important Notifications
PaySpan-EFT/ERA (Payformance)
Pharmacy
Practice Improvement Resource Center (PIRC)
Newsletters
Pre-Auth Needed?
Provider Training
Quality Improvement Program
RSV/Synagis
Secure Web Portal
Welcome Providers

Contracting

- Contract Request Form (PDF)

Credentialing Material

- Provider and Practitioner Credentialing Rights (PDF)
- Practitioner Credentialing Application 2014 (PDF)
- Magnolia Location Form (PDF)
- Provider Update Form for Contracted Providers (PDF)
- MID Form (PDF)
- W-9 Form (PDF)
- Ownership and Controls Disclosure Form (PDF)
- CAQH Brochure (PDF)

Forms & Applications

- New Prior Authorization Forms (PDF)
- Outpatient Prior Authorization Form (PDF)
- Outpatient Prior Authorization Training Document Form (PDF)
- Prior Authorization Smart Sheet How To (PDF)
- Provider Notification of Pregnancy Form (PDF)
- Prenatal Vitamin Form (PDF)
- Connections Referral Form (PDF)
- Claim Dispute Form (PDF)
- Hospice Physician Form (PDF)
- Provider Complaint-Grievance Form 2014 (PDF)
- DOM Hysterectomy Acknowledgement Form PDF (PDF)
- Application for MS Family Planning Services (PDF)
- Provider CM DM Referral Form (PDF)
- Foster Care Health Information Form (PDF)
- Discharge Consultation Documentation Form (PDF)

Manuals & Reference Guides

- Provider Manual (PDF)
- Prior Authorization List (PDF)
- Provider Reference Card (PDF)
- PaySpan (PDF)
- HEDIS Quick Reference Guide Adult (PDF)
- HEDIS Quick Reference Guide Pediatric (PDF)
- HEDIS Quick Reference Guide Women (PDF)
- Quick Reference Guide for EPSDT Codes (PDF)
- DOM Provider Manual Regarding Hysterectomy (PDF)
- DOM Provider Manual Regarding Sterilizations (PDF)
- 2013 QI Program Description (PDF)
- Annual Quality Improvement (PDF)
- Taxonomy Code Billing Requirement (PDF)
- Access and Availability Standard Guidelines (PDF)
- After Hours Telephone Access Standards 2014 (PDF)
- CMS FQHC-RHC Billing Guide 2014 (PDF)
- Reimbursement for Vaccine Administration 2014 (PDF)
- CMS 1500 Claim Form Instructions 2014 (PDF)
- Place of Service Codes 2014 (PDF)
- Obstetrical Care Billing Tips 2014 (PDF)
- Maximum Units of Service 2014 (PDF)
- Modifer 25 – 2014 (PDF)

Phone Numbers

(866) 912-6285
Fax: (866) 480-3227
8 a.m. – 5 p.m. (CST)
Monday – Friday

Resources

Contracting
Credentialing Material
Forms & Applications
Manuals & Reference Guides
Pharmacy
Pre-Authorization Needed?

You will need Adobe Reader to open PDFs on this site.

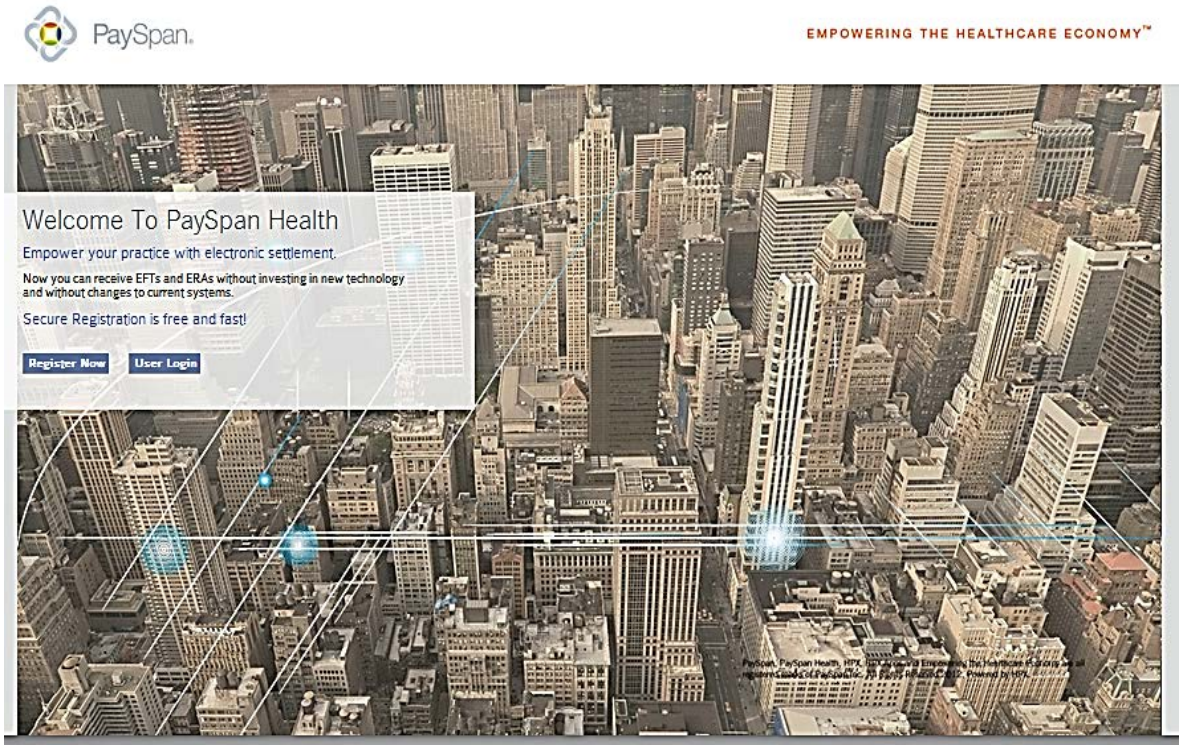
Get ADOBE READER

Download the free version of Reader

PaySpan Health

Magnolia has partnered with PaySpan Health to offer expanded claim payment services:

- Electronic Claim Payments (EFT)
- Online remittance advices (ERA's/EOPs)
- HIPAA 835 electronic remittance files for download directly to HIPAA-compliant Practice Management or Patient Accounting System
- Register at: **www.PaySpanHealth.com**



For further information contact 1-877-331-7154, or email providerssupport@payspanhealth.com

Provider Support

Provider Services (Call Center)

Mississippi Based Provider Services Call Center:

- Provides phone support
- **First line of communication**
- Answer questions regarding eligibility, authorizations, claims, payment inquiries
- Available Monday through Friday, 8am to 5pm CST at **1-866-912-6285**

Provider Relations

Behavioral Health

- Cenpatico is the behavioral health vendor for Magnolia Health. Cenpatico is a wholly-owned subsidiary of Centene Corporation, which has been nationally recognized for innovative service programs and contemporary approach in handling the needs of the diverse populations in the markets proudly served. We have managed Medicaid and other public sector benefits since 1994, and operate in multiple states with an active local presence. Our members receive care from **local teams** that truly understand the specific needs of their communities.

- To partner with Cenpatico or for more information, please call 866-324-3632 or visit www.cenpatico.com .

Clinical Protocols

Cenpatico 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.

Cenpatico has adopted DOM approved utilization review criteria developed by McKesson InterQual® products to determine medical necessity for behavioral healthcare services. InterQual appropriateness criteria are developed by specialists representing a national panel from community-based and academic practice. InterQual criteria cover medical, behavioral health 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. Cenpatico'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.

Provider Enrollment

- Providers must be enrolled as a Medicaid Provider and have an active Mississippi Medicaid ID #. Providers must also be properly credentialed by Magnolia or other designated authority prior to treating Magnolia members. Behavioral Health Providers must also be credentialed by Cenpatico prior to treating Magnolia members.

- Prior Authorizations must be obtained for services provided by out of network providers, except for emergency and post-stabilization services, and these services will only be reimbursed at 80% of the Medicaid fee schedule.

- Contract request forms can be found on Cenpatico's website at www.cenpatico.com click on Mississippi then Join Our Network and follow the prompts.

- Cenpatico's credentialing team is required to render a decision on all credentialing applications within ninety (90) calendar days of receipt of a complete credentialing package.

- Providers will be designated in Cenpatico's claims payment system as a participating provider within thirty (30) days of approval of their credentialing application.

Required Items for Facility Credentialing

- Hospital/Ancillary Credentialing Application
- State Operational License
- Other applicable State/Federal licensures (e.g. Clinical Laboratory Improvement Amendment (CLIA), Drug Enforcement Administration (DEA), Pharmacy, Department of Health, etc.)
- Accreditation/certification by a nationally-recognized accrediting body (i.e. The Joint Commission (TJC), Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or other designated authority)
  - If not accredited by a nationally-recognized accrediting body, please include site evaluation results from a governmental agency
- Current general liability coverage (showing the amounts and dates of coverage)
- Medicaid/Medicare certification
  - If not certified, please provide proof of participation
- W-9
- Ownership and Disclosure form

Cenpatico- What We Do For Members

Our staff is available 24 hours a day, 365 days a year by calling the following number:

(866) 912-6285

Customer Service Center in Mississippi

- Staff available 8 a.m. - 5 p.m. CST
- Eligibility Verification
- Referrals
- Integrated Case Management between providers of varying levels of care
- Care Coordination to assure Members have adequate access to providers

NurseWise

- Nurse triage & other services available 24/7/365 (may issue authorizations after hours with follow up from local care coordinator the next business day)

Care Coordination

We recognize that multiple co-morbidities will be common among our membership. The goal of our program is to collaborate with the member and all treating providers to achieve the highest possible levels of wellness, functioning and quality of life.

Cenpatico's care coordination model uses an integrated team of:

- Licensed mental health professionals
- Registered nurses
- Social workers
- Non-clinical staff

Cenpatico's care coordination model is designed to:

- Educate members on the importance of treatment compliance;
- Help members obtain needed services;
- Assist in coordination of covered services, community services, or other non-covered venues;
- Identify members with complex or chronic behavioral health conditions that require coordination of services and periodic monitoring in order to achieve desired outcomes;
- Work collaboratively with the facility, physician, member, family / significant other and support services to implement and individualize a plan of care.

PRIOR AUTHORIZATION

The authorization process ensures that members are receiving the proper treatment and intensity of services on the inpatient unit while addressing their ongoing outpatient needs.

CLINICAL DECISIONS: Magnolia affirms that utilization management decision-making is based only on appropriateness of care and service and existence of coverage. The treating provider, in conjunction with the member, is responsible for making all clinical decisions regarding the care and treatment of the member.

Prior Authorization (cont.)

- For hospital Behavioral Health (BH) inpatient services, if authorization for level of care cannot be determined at first level review by the UM reviewer, the care will be reviewed by a Mississippi licensed Medical Director. The attending physician may request a peer-to-peer discussion with said Medical Director.

- Cenpatico will make determination for urgent concurrent, expedited continued stay, and/or post-stabilization review within twenty-four (24) hours of receipt of the request for services.

- If all necessary clinical information has been received from the provider and Cenpatico is still unable to make a determination within these timeframes, it may be extended up to fourteen (14) additional calendar days upon the request of the member or provider, or if Cenpatico, Magnolia Health Plan and the Division of Medicaid determine that the extension is in the member's best interest.

CLINICAL DOCUMENTATION- INITIAL REVIEW

- Detailed clinical information is essential for determining medical necessity. The **Initial Revie**w documentation must include:

- Facility
- Name and contact number of Utilization Reviewer
- Date of admission
- Legal status – voluntary vs. court commit admission
- Member's guardian, if any

Initial Review-continued

- **Precipitating Event**

Clear details are needed regarding symptoms and behaviors of the member leading to admission.

For example:

- Triggers to the episode, if known
- Actual physical injury of self or others
- Medical treatment needed
- Termination of the behavior – did they stop on their own or did someone else intervene?
- Objects or actions used
- Time frames – how long ago did the precipitating event occur, and how is the member presenting now?

Precipitating Events-examples

- **Suicide Attempt**

Example 1: A member presents status post suicide attempt by overdose on medications.
Important questions to be answered:

What kind of pills and the approximate number of pills ingested?

What events led up to the attempt?

What happened afterward - did someone find the member, did member call for help?

What treatment was administered in the ER – charcoal, lavage?

Does the member regret the overdose?

Example 2: A member presents status post suicide attempt by hanging.
Important questions to be answered:

Did the member actually hang himself?

How far did he/she get in the process?

What materials did he/she use?

What interrupted the attempt?

Were there any injuries from the attempt?

Precipitating Event – Aggression

Example : A child presents for admission due to aggressive behavior.

- What are the specific aggressive behaviors?
- Who is the member targeting?
- Does the behavior occur in more than one setting?
- When did this behavior start?
- Has there been a recent change in intensity and frequency of the behavior? When did this occur?
- Are there certain circumstances that trigger the aggression?
- Is the behavior so severe that it can't be managed on an outpatient basis?

Precipitating Event – Psychosis

Example : An adult presents for admission due to psychotic behavior.

Important questions to be answered:

- Are there auditory or visual hallucinations?
- Are they command in nature?
- What is the content?
- When did these symptoms begin?
- Are they constant or fleeting?
- Are these symptoms stressful for the member?
- Are there delusions present?
- Are these delusions fixed? When did they start?
- Is there imminent danger to the member or others due to the psychosis?

Additional Questions for Initial Review

- Treatment history
- Medications prior to admission (both behavioral an medical), and compliance
- Substance use history
  - Past treatment, use pattern, drug screen results and alcohol level results on admission
- Social Factors impacting admission including:
  - Family history of substance abuse or behavioral health concerns, trauma or loss history
- Medical concerns of the member
  - Focus on integrated care

Additional Questions for Initial Review-cont.

- Height and weight
- Legal issues
- Education history
- Employment information
- Trauma History
- Cultural considerations: Ethnicity, Language preference, Sexual preference
- Current living situation
  - Foster Care placement status and any issues
- Contact information for the member
  - Or DHS social worker for children in foster care

Additional Questions for Initial Review-cont.

- Mental Status Exam (MSE) to focus on member's current state of mind at time of admission:
  - Appearance
  - Attitude
  - Behavior
  - Mood and affect
  - Speech
  - Thought process and content
  - Perception
  - Cognition
  - Insight
  - Judgment

Treatment Plan Considerations

- What is the focus of treatment for this member?
- What are the primary goals for this admission?
- Are the goals member-set and member-focused? Is Motivational Interviewing being utilized?
- Are the goals based on a model of recovery?
- Are the goals based on a model of integrated care?
- Are the member's strengths being identified, and how are these strengths reflected in their treatment plan?

S.M.A.R.T. Goal Development

- As you are creating member centered goals, ask yourself if the goals are...

- **S**pecific: What exactly are you expecting the outcome to be?
- **M**easureable: How are you going to be able to evaluate if the outcome was achieved?
- **A**ttainable: Is the member able to reach the desired outcome at some point in time?
- **R**ealistic: Can the member achieve the outcome in the time allotted?
- **T**ime Limited: Is there a clear time frame set for completing the goal?

Discharge Planning

- Has the discharge planner been identified?
- Where will the member be living at discharge?
- Who will they see for outpatient follow up? Do they already have an appointment scheduled?
- Are there problem areas that our Care Coordination or Case Management staff may be able to assist with?
- Are their any cultural or religious factors that play a role in this member's discharge plan?

Cenpatico requires a follow-up appointment be scheduled and the member attend within 7 calendar days of discharge from the hospital.

Concurrent Review

- Cenpatico's clinical team will concurrently review the treatment and status of all members who are inpatient through contact with the hospital's Utilization and Discharge Planning departments and when necessary, the member's attending physician. The individual identified on the Initial Review will be considered the appropriate point-of-contact for all discharge planning.

- An inpatient stay will be reviewed as indicated by the member's diagnosis and response to treatment.

- The review will include evaluation of the member's current status, proposed plan of care, discharge plans, and any subsequent diagnostic testing or procedures

Concurrent Reviews - Medications

Documentation:

- Documentation of start date, change date, discontinuation date
- Documented monitoring of medication levels
- Detailed documentation of PRN and emergency meds

Additional questions:

- What is the MDs plan for the upcoming days?
- If MD is not making med changes, why?
- If MD is only giving PRNS, why?
- If the member is on a medication that requires a blood test to determine efficacy, when is that going to be drawn?

Especially for Fax Reviews:

- Med orders need to be VERY clear
- Can the reviewing UM easily tell what the medication regimen is and any updates that have been made to the medication regime?

Concurrent Reviews – Notes

- Are all modalities (MD, RN, group therapy, individual therapy, family therapy) being provided and documented?

- Does the MD note clearly document symptomology?

- Is there specific documentation regarding:
  - Suicidal/Homicidal ideation and plan or absence of plan?
  - Hallucinations – specifics regarding type and content?
  - Delusions – details about content?
  - Are symptoms fixed or expected to improve?

- Why does the member need to continue in acute care?

Concurrent Reviews – Notes-cont.

- What places the member at risk if discharged now?
- Did the MD document ongoing plan for treatment?
  - If the member is not improving, what is the detailed plan to facilitate improvement?
- Is there a discrepancy between MD and RN notes?
  - If the MD and RN notes on the same day are incongruent, this should be explained.

Inpatient Summary

magnolia health™

Opportunities for Gathering Information

- Initial clinical review
- RN / MD notes
- Therapy / staff notes

Documentation

- Detailed
- Give examples
- Be specific
- Current

Discharge Planning

- Begins upon admission
- Coordinate with case management
- 7 day follow up appointment addressed

Treatment Planning

- Member driven
- Recovery based
- S.M.A.R.T. goal oriented
- Strengths and barriers identified and addressed

Review Criteria

- Cenpatico has adopted utilization review criteria developed by McKesson InterQual® products to determine DOM approved medical necessity for behavioral health services.

- Cenpatico's Medical Director reviews all potential medical necessity denials and will make a decision in accordance with currently accepted medical or behavioral health practices, taking into account special circumstances of each case that may require deviation from the norm in screening criteria. Denial notification will include the reason(s) for denial per section 17.A. of the contract.

- Providers may obtain the criteria used to make specific determinations by contacting Cenpatico at 1-866-912-6285.

CLINICAL APPEALS

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

Cenpatico
Attn: Appeals Coordinator
12515-8 Research Blvd. Suite 400
Austin, TX 78759
Fax: 1-866-694-3649

Emergent and Weekend and Holiday Admissions

- **Emergency and urgent care services never require prior authorization.**

- All hospital inpatient admissions require notification via a request for authorization to Cenpatico by the close of business on the **next business day** following admission. **(Failure to notify may result in denial of payment.)**

- Non-emergent hospital Behavioral Health inpatient admissions always require a prior authorization.

Observation Guidelines

- In the event that a member's clinical symptoms do not meet the criteria for an inpatient admission, but the physician believes that allowing the patient to leave the facility would likely put the member at serious risk, the member may be admitted to the facility for an observation period.

- An observation stay may last up to a maximum of twenty-three (23) hours. (Stays less than 8 hours of observation or greater than 23 hours are not allowed.)

- Providers are required to notify Cenpatico's Clinical Team of an observation stay by the next business day after discharge.

- A medical necessity determination will be made within twenty-four (24) hours of receiving all required information.

CLAIMS SUBMISSIONS

Claims Customer Service: (866) 324-3632

Ways to submit Claims:

Online www.cenpatico.com (Will need logon information)

Emdeon Payor ID 68068

Paper Claims Cenpatico
PO Box 7600
Farmington MO 63640-3809

Claims must be submitted within **180** days of the date of service.

Appeals must be submitted within **90** days of the denial.

Appeals: mail Cenpatico Appeals
PO Box 7600
Farmington MO 63640-3809

IMPORTANT Contact information and phone numbers

- ****Please go to WWW.CENPATICO.COM for Covered Services and Authorization Grid****

- **Provider Relations** -1ST Point of Contact
  (866) 912-6285

- **Authorizations** (Inpatient and Outpatient)
  (866) 912-6285

- **Care Management/Quality Improvement**
  (866) 912-6285

- **Claims Customer Service**
  (866) 324-3632

Local Network Contacts

- **Angela Stewart**
- Network Manager anstewart@cenpatico.com
  601-863-0738

- **Nakisha Montgomery**
- Provider Relations Specialist (Central and Southern MS)
  nmontgomery@cenpatico.com
  601-863-0745

- **Diandra Lee**
- Provider Relations Specialist (North MS and Hattiesburg)
  dilee@cenpatico.com
  601-863-2507

QUICK REFERENCE

- ***Please visit the Practice Improvement Resource Center (PIRC) at www.magnoliahealthplan.com Clinical Practice and Preventative Guidelines and other helpful information.***
- This powerpoint will be posted there for quick reference.

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Thank you!