Magnolia Health

2025 New Provider Orientation

Agenda

Managed Care Overview	Provider Responsibilities
Magnolia Health Overview	Joining Our Network
Member Enrollment and Benefits	Prior Authorization
Provider Resources	Quality Practice Management
Member ID Cards	HEDIS & Medicaid Focused Measures
Membership & Value-Added Benefits	EPSDT & Screenings
Member Grievances, Appeals, and State Fair Hearings	Care Management
Billing and Claims	Provider Disputes & Grievances

Magnolia Health Overview

About Us

Magnolia Health is a managed care health plan, serving Mississippians since 2011.

Magnolia is a wholly-owned subsidiary of Centene Corporate, a multi-line healthcare enterprise committed to helping people live healthier lives.

OUR PURPOSE: **Transforming the health of the community, one person at a time**

OUR MISSION: **Better health outcomes at lower cost**

OUR PILLARS:

Focus on the Individual **+**

Whole Health **+**

Active Local Involvement

OUR BELIEFS

We believe health individuals create more vibrant families and communities

We believe treating people with kindness, respect and dignity empowers healthy decisions.

We believe we have a responsibility to remove barriers and make it simple to get well, stay well, and be well.

We believe in treating the whole person, not just the physical body.

We believe local partnerships enable meaningful accessible healthcare.

OUR PRODUCTS

Medicaid and CHIP

Magnolia is a quality health plan offering members coverage through the Division of Medicaid's Coordinated Care program.

Medicare

WellCare is a Medicare Advantage HMO/PPO plan. WellCare currently serves Mississippians in 63 counties. WellCare began operations in 1985 and became a subsidiary of Centene in January 2020.

Marketplace

Ambetter by Magnolia is a qualified health plan on the federally facilitated health insurance marketplace. Member plan options vary between costs for monthly premium payments versus out-of-pocket expenses. Subsidies are dependent on the member's income level. Ambetter Virtual requires a referral PCP to see specialist.

Managed Care Overview

Coordinated Care Organization (CCO)

Managed Care Overview

MAGNOLIA HEALTH IS ONE OF THREE CCO'S CONTRACTED WITH THE DIVISION OF MEDICAID TO ADMINISTER MSCAN AND CHIP BENEFITS FOR ELIGIBLE BENEFICIARIES.

MSCAN

Mississippi Coordinated Access Network (MississippiCAN) implemented on January 1, 2011, is a statewide care coordination program designed to:

- Improve beneficiary access to needed medical services;
- Improve the quality of care; and
- Improve program efficiencies as well as cost effectiveness

MSCHIP

The Children's Health Insurance Program (CHIP) provides health coverage for uninsured children up to age 19.

- To be eligible for CHIP, a child cannot be eligible for Medicaid.
- At the time of application, children with health insurance are not eligible for CHIP.

Member Enrollment and Benefits

Who Qualifies for MSCAN

Magnolia does not determine eligibility. Eligibility is determined by the Mississippi Medicaid Regional Office that serves your area. To locate your Mississippi Medicaid Regional Office, please visit www.medicaid.ms.gov/about/office-locations/. You may also call Medicaid's toll-free telephone number at 1-800-421-2408.

Mandatory Populations

Members may select or be automatically enrolled with a CCO but may not opt out of MississippiCAN. Members may change their CCO within the first ninety (90) calendar days of enrollment.	
Category of Eligibility	**Age**
Supplemental Security Income (SSI)	19-65
Working Disabled	19-65
Breast and Cervical Cancer	19-65
Parents and Caretakers	19-65
Pregnant women	8-65
Medical Assistance Children	0-19

Voluntary Populations

Members may voluntarily enroll in MississippiCAN, and members will have the option to disenroll within ninety (90) calendar days.	
Category of Eligibility	**Age**
Supplemental Security Income (SSI)	0-19
Disabled Child Living at Home	0-19
Dept. of Human Services-Foster Care Children	0-19
Department of Human Services-Foster Care Children (Adoption Assistance)	0-19
American Indians	0-65

MSCAN Benefits and Cost-Sharing

MSCAN offers coverage for a wide range of services, here are a few :

- EPSDT Services
- Shots and Immunizations
- Hospital and Emergency care
- Prescription drugs
- Dental, Vision, and Hearing Care
- Equipment and Medical Supplies
- Chiropractic Services
- Lab and X-ray Services
- Behavioral Health Services
- Physical, Speech, or Occupational Therapy
- Annual check-ups and Screenings
- Urgent, Routine and Preventive Care
- Orthotics and Prosthetics
- OB/GYN Services

A complete list of covered services and benefit limits can be found in Magnolia's MSCAN Provider Manual {Insert Link}

No Cost Sharing

No Co-pay

No Out-of-Pocket

Who Qualifies for CHIP

Magnolia does not determine eligibility. Eligibility is determined by the Mississippi Medicaid Regional Office that serves your area. To locate your Mississippi Medicaid Regional Office, please visit www.medicaid.ms.gov/about/office-locations/. You may also call Medicaid's toll-free telephone number at 1-800-421-2408.

Populations that must enroll in CHIP

The Division will enroll eligible Members within these categories into one of the Contractors participating in CHIP, and Members will have the option to disenroll or change Contractors within ninety (90) days of initial Enrollment. Members who disenroll and do not choose another Contractor under CHIP may enroll in the Division's Medicaid program if they meet Medicaid eligibility requirements or pursue private insurance.

Populations Who Are Eligible for CHIP	
Populations	**Income Level**
Birth - Nineteen (19) Years	194% FPL to 209% FPL
	133% FPL to 209% FPL
	133% FPL to 209% FPL

CHIP Benefits and Cost-Sharing

CHIP offers coverage for a wide range of services, here are a few :

- Well-Baby and Well-Child Services
- Shots and Immunizations
- Hospital and Emergency care
- Prescription drugs
- Dental, Vision, and Hearing Care
- Equipment and Medical Supplies
- Chiropractic Services
- Lab and X-ray Services
- Behavioral Health Services
- Physical, Speech, or Occupational Therapy
- Annual check-ups and Screenings
- Urgent, Routine and Preventive Care
- Orthotics and Prosthetics
- OB/GYN Services

A complete list of covered services and benefit limits can be found in Magnolia's CHIP Provider Manual {Insert Link}

Financial Liability – Allowable Cost Sharing

Requirement	≤150% FPL	151% to 175% FPL	176% to 209% FPL
Per Physician Visit	None	$5.00	$5.00
Per Emergency Room Visit	None	$15.00	$15.00
Out-of-Pocket Maximum	N/A	$800.00	$950.00

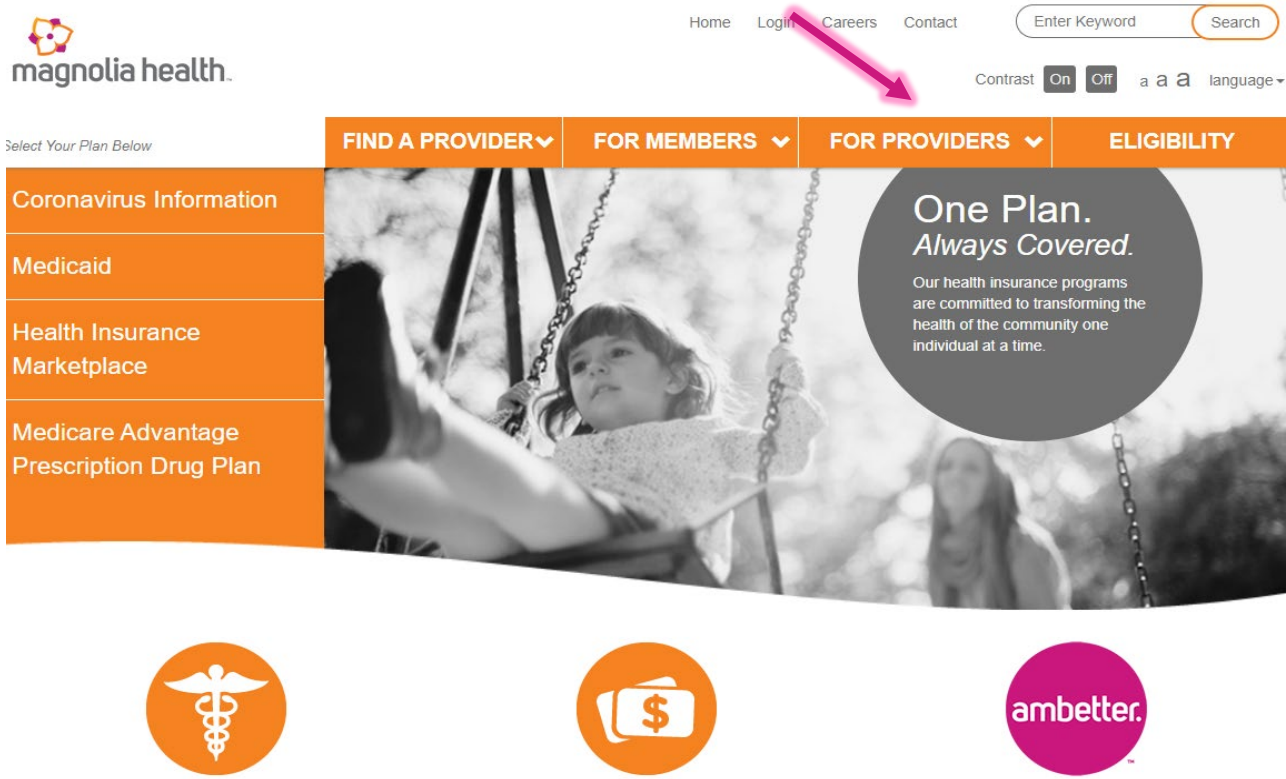
- Co-Payment or Cost Sharing does not apply to the following services: preventive services, including immunizations, Well-Baby and Well-Child Care Services, routine preventive and diagnostic dental services, routine dental fillings, routine eye exams, eyeglasses, and hearing aids.
- Providers should collect Co-Payments from members in accordance with the Financial Liability –Allowable Cost Sharing Table.
- Providers should check member's benefits and copay amounts prior to each visit.
- When a member meets their Out-of-Pocket max, Magnolia will send a letter indicating that no further co-payments should be paid for the remainder of the year. Members may present this letter when future healthcare services are sought.

Provider Resources

Provider Website (Public)

The Magnolia Health website is designed to allow providers to have 24/7 access to key information for timely service

- Prior Authorization Checker
- Clinical Guidelines and Payment Policies
- Provider Manuals
- Contract Request Forms
- Provider Bulletins and News
- Preferred Drug List
- Provider Education Material and Trainings
- Weekly Provider Email Blast Sign-Up
- Quality Improvement Program Information
- Forms and other Provider Resource Materials

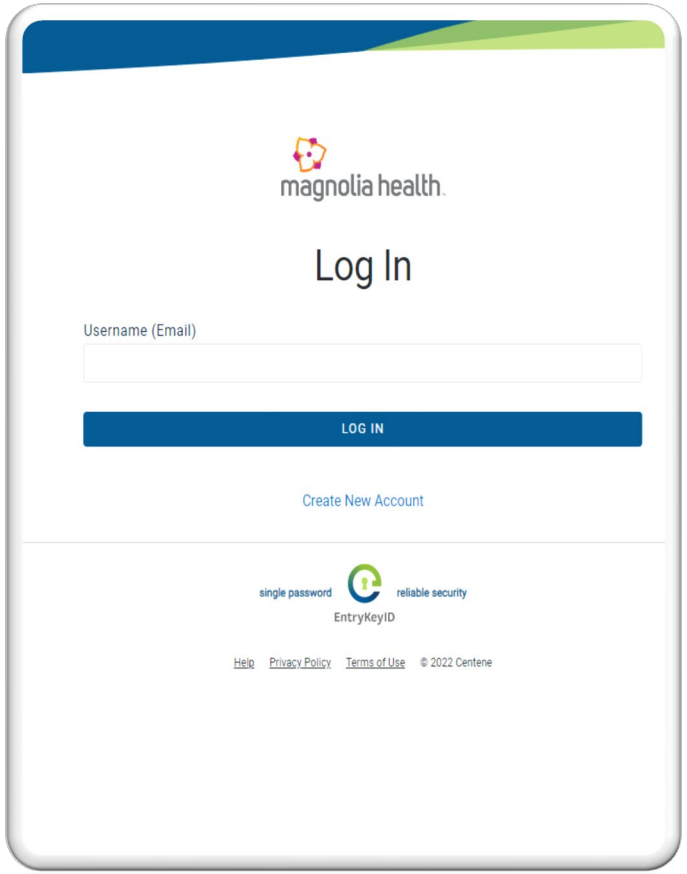


Visit the Magnolia Health's Website: [Mississippi Medicaid & Health Plans For Providers | Magnolia Health (magnoliahealthplan.com)]

Provider Portal (Secure)

After registering to access the secure provider portal, the following tools are available to easily view and share information:

- Check member eligibility
- View the PCP panel (patient list)
- View and submit Prior Authorizations
- View member health records
- View member health records and care gaps
- Z- Code Dashboard
- Determine payment/check clear dates
- View and print Explanation of Payments (EOPs)
- Access payment history
- Submit claims and adjustments, view claims status
- Submit claims disputes
- Secure Messaging



To register, go to www.magnoliahealthplan.com/login.html.
Need assistance setting-up or navigating your account?

Contact your Provider Engagement Administrator or Provider Services at 1.877.236.0751 (TTY: 711)

Keep up with the latest news

Magnolia Health will keep providers aware of medical policy changes, payment, and operational updates and announcements using the following communication channels:

Sign-up to receive Magnolia's weekly **Email Blast** for the latest news and updates. Sign-up here: Email Sign Up (magnoliahealthplan.com)

Provider Services Contact Center

By calling 1.877-236-0751 (TTY: 711) Monday through Friday 7:30 a.m. – 5:30 p.m., providers can access real-time assistance including, but not limited to:

- Credentialing/Network Participation Status
- Claims Status Inquires
- Facilitate request for adding/deleting physicians to an existing group
- Magnolia Health website review and portal questions including registration help
- Facilitate inquiries related to administrative policies, procedures, and operational issues
- Claim resolution guidance
- Accept Referrals for Care Management
- Navigating prior authorizations

When calling Provider Services, please have the following information available:

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

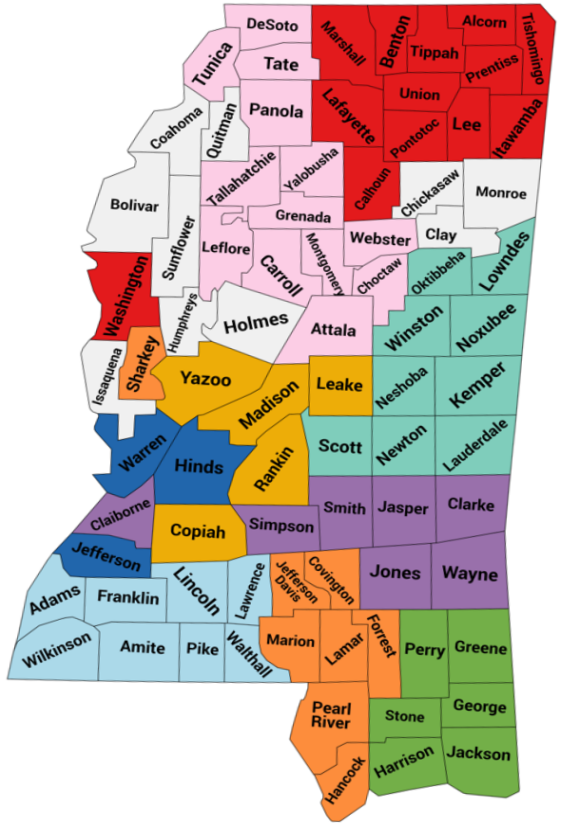
Provider Engagement

Primary Care Provider Engagement Map

- Northeast - Kiri Parson
  kiri.l.parson@centene.com
- North Central - Billie Snow
  billie.snow@centene.com
- Northwest - Latoya Hemphill
  latoya.hemphill@centene.com
- Central - Vanika Hogan
  vanika.hogan@wellcare.com
- East Central - Bethany Peters
  bethany.peters@centene.com
- South Central - Tarkan Weston
  tarkan.weston@centene.com
- Southwest - Tiffany Sanders
  tiffany.sanders@centene.com
- Southeast Central - Stacy McGrew
  stacy.mcgrew@centene.com
- Southern Central - Donna Ramirez
  donna.ramirez@centene.com
- Southern - Belinda Turner
  belinda.turner@centene.com

Provider Network Support Specialists

Supports all Ancillary, Hospital, DME, and other Non-PCP Providers



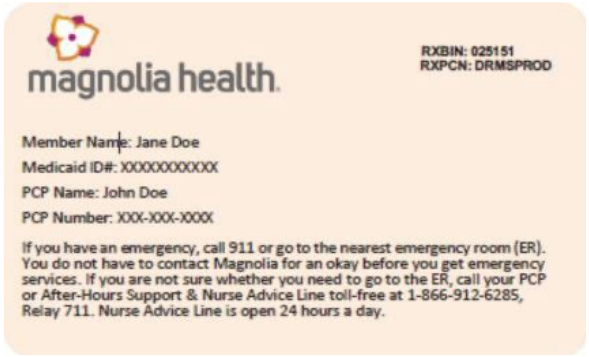
- Zone 1 - Kenisha Byrd
  magnoliazone1@centene.com
- Zone 2 - Anna Owens
  magnoliazone2@centene.com
- Zone 3 - Brittany Cole
  magnoliazone3@centene.com
- Zone 4 - Yashieka Brookins
  magnoliazone4@centene.com
- Zone 5 - Heather Samuels
  magnoliazone5@centene.com
- Zone 6 - Katherine St. Paul
  magnoliazone6@centene.com
- Zone 7 - Ericka Hunter
  magnoliazone7@centene.com
- Zone 8 - LaKisha Brooks
  magnoliazone8@centene.com
- Zone 10 - Meg Duke
  magnoliazone10@centene.com
- Zone 11 - Jemessia Johnson
  Jemessia.Johnson@centene.com

Membership ID Cards

MSCAN and MSCHIP Eligibility and ID Card

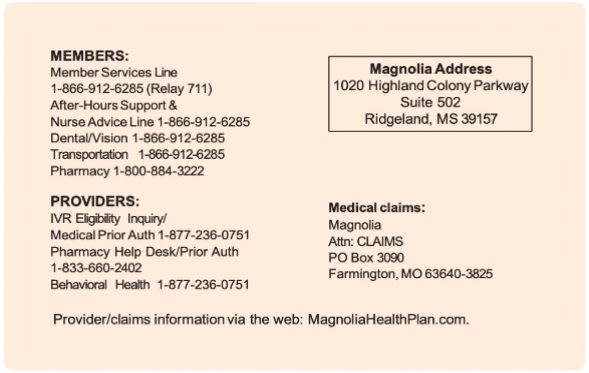
FRONT:

- Name
- Medicaid ID number
- PCP name/number
- Pharmacy vendor information



BACK:

- Important member & provider phone numbers
- Medical claims address
- Website address



For CHIP: Notice Copay Amounts on Member ID Card

Providers should verify eligibility before and on the date of service.

To verify member eligibility, please use the following methods:

- Log on to DOM's MESA website to verify a member's eligibility with Magnolia Health MississippiCAN. We encourage providers to use this method first when attempting to verify eligibility.
- Log on to our secure Provider Portal at www.magnoliahealthplan.com
- Call our automated member eligibility Interactive Voice Response (IVR) system. Call 1.877.236.0751(TTY: 711).
- Speak with a Magnolia Provider Services Representative at 1.877.236.0751 (TTY: 711).
- https://www.magnoliahealthplan.com/providers/resources/eligibility-verification.html

MEMBER ID CARDS ARE NOT A GUARANTEE OF ELIGIBILITY AND/OR PAYMENT

Membership Value Added Benefits

Value Added Services and Rewards

MississippiCAN and CHIP plan offers the same services Medicaid offers with extra benefits called value-added services and rewards for our members and your patients

SafeLink Wireless
No cost Magnolia members
Free Smartphone
Up to 350 minutes a month
Unlimited texting

Nurse Advice Line
24-hour service by calling
1.877.236.0751 say "Nurse"

Registered Nurse available to provide education and nurse triage for complex health issues

My Health Rewards Program
A healthy rewards account program to promote utilization of preventative services

Innovative approach to encourage healthy behaviors through financial incentives

Start Smart for Your Baby
Prenatal and Postpartum program
Smoking and Addiction Pregnancy Programs
At no cost, an electric breast pump is provided through Medline

To learn more about these Value-Added Services, visit: https://www.magnoliahealthplan.com and review 'For Members' section.

MY HEALTH Rewards CATEGORY	REWARD	REWARD DETAILS (Medicaid)
Flu Vaccine	**$20**	Annual
Health Risk Screening	**$25**	One Time Reward
Dental Exam	$25	1 annual benefit for MSCAN members under age 21
Immunization for Adolescents	$20	One time reward both TDaP, Meningococcal between the age of 10-12
Follow-Up after Inpatient Hospitalization for Mental Illness	$20	1 per calendar year for ages 6-17, within 7 days of the discharge date
In Home Assessment	$15	Annual, All members who are included in our Risk Adjustment Member Assessment program are eligible
PCP visit within 90 days of Eligibility	**$20**	One time reward for new members
$20 Adult Annual Wellness Visit	**$20**	Annual
Notification of Pregnancy: 1st Trimester	**$30**	1 per pregnancy
Notification of 2nd Trimester	**$15**	1 per pregnancy, if not completed in the 1st trimester
Postpartum Visit	**$50**	1 per pregnancy between 7 & 84 days from date of delivery, claims only
Postpartum Depression Screening	**$50**	1 per pregnancy, must be on a claim

Non-Emergency Medical Transportation (NEMT)

IMPORTANT DETAILS FOR SCHEDULING A RIDE

- All rides must be for a covered medical service
- Rides can be scheduled Monday through Friday from 7 a.m. to 8 p.m.
- Contact MTM at least three business days before scheduled appointment
- Have your trip information ready
- Be ready at least 15 minutes before scheduled arrival of ride

Important Toll-Free Phone Numbers

To schedule a ride, call 1-866-331-6004

To file a complaint, call 1-866-436-0457

If your ride is late, call 1-866-334-3794

Magnolia Health can arrange and pay for member transportation to and from appointments for Medicaid Covered Service through Transportation Vendor, MTM

Member Grievances and Appeals

Member Grievances

A member grievance is an expression of dissatisfaction received orally or in writing about any matter or aspect of the health plan or its operations, other than an adverse benefit determination.

- A member, provider on behalf of a member, or authorized representative can file a Grievance.
- Grievances can be filed anytime after the grievance has occurred

Grievance Incident Occurs

Examples of a Grievance

Quality of Care or Services

Rudeness of a provider or employee

Failure to respect the member's rights

File a Grievance

Mail:

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

Phone: 1-877-236-0751
Fax: 1-877-264-6519

Confirmation of Receipt

- Magnolia will acknowledge grievance **within five (5) calendar days** of receipt.
- Confirmation will be writing and include the expected date of resolution

Grievance Resolution

- Magnolia will resolve all grievances **within thirty (30) calendar days** but may extend the time frame by up to fourteen (14) days if additional time is needed to resolve.
- Grievance outcome will be sent in writing.

Member Appeals

A **member appeal** is a member's request for review of an adverse benefit determination for services that the member believes they are entitled to receive. An appeal can be filed by the member or authorized representative **within 60 calendar days** from the date of the adverse benefit determination

Adverse Benefit Determination

An adverse benefit determination may include determination about health care services a member believes they are entitled to receive, including:

Delay in providing, arranging for, or approving the health care services (such that a delay would adversely affect the health of the member)

Appeal Request

Mail:

Magnolia Health

Attn: Grievance and Appeals Coordinator

1020 Highland Colony Parkway, Suite 502
Ridgeland, MS 39157

Phone: 1-877-236-0751

Fax: 1-877-264-6519

Confirmation of Receipt

- Magnolia will acknowledge appeal request **within ten (10) calendar days** of receipt.
- Confirmation will be writing and include the expected date of resolution

Grievance Resolution

- Magnolia will resolve appeal request within **thirty (30) calendar days** but may extend the time frame by up to fourteen (14) days if additional time is needed to resolve.
- Expedited Grievances will be resolved no longer than 72 hours of request

Member State Administrative Hearing - MSCAN

If, at the end of the appeal process with Magnolia, a member does not agree with the decision that Magnolia makes on an appeal, a member or authorized representative may ask for a State Fair Hearing with the Division of Medicaid.

A State Fair Hearing must be requested in writing within **120 calendar days from the date of notice of an appeal resolution.**

Office of Appeals Mississippi Division of Medicaid
550 High Street, Suite 1000
Jackson, MS 39201
Phone: 601-359-6050 or 1-800-421-2408
Fax: 601-359-9153

Independent External Review- MSCHIP

At the end of the appeal process with Magnolia, if a member or authorized representative does not agree with the decision that Magnolia makes on an appeal, a member or authorized representative can ask for an Independent External Review.

- The request must be made in writing within 120 calendar days from the date of the appeal outcomes notice.

- An Independent External Review may not be requested until the member or authorized representative has completed **all** of Magnolia's Appeal process.

A member or the member's authorized representative can request an Independent External Review by contacting Magnolia Health at:

Magnolia Health
Attn: Appeals Coordinator
1020 Highland Colony Parkway, Suite 502 Ridgeland, MS 39157
Ph: 1-866-912-6285 Fax: 1-877-264-651

Please include the member's name, address, phone number, and reason(s) for the Independent External Review request.

Provider Responsibilities

Provider Responsibilities

Credentialing and Re-credentialing through Gainwell, the Division of Medicaid's Fiscal Agent, effective Oct.3, 2022

ADA compliance (including parking and entry pathways)

Billing Primary Insurance prior to Magnolia Health

Obtain referral or authorization, as needed, before providing services

Member non-discrimination based on race, color, national origin, disability, age, sex religion, mental or physical disability, or limited English proficiency

Maintain **accurate and complete medical records**

Render **medically necessary and appropriate levels of care** to members

Maintain confidentiality of medical information

Maintain contact and coordinate care with member's PCP. PCPs are responsible for coordinating care with specialist

Timely communication of change of address, addition and termination of practitioners and other important notification

Cultural Competency

“The ability of systems to provide care to patients with diverse values, beliefs, and behaviors, including tailoring delivery to meet patients’ social, cultural, and linguistic needs” (Betancourt et al. 2002)

As a member’s physician, it is important members understand that they have access to medical interpreters, signers, and TDD/TTY services to facilitate communication without cost.

Medical care must be provided with consideration of the member’s race/ethnicity and language and its impact/influence on the member’s health or illness.

For additional information, resources, and training, visit:

- https://cccm.thinkculturalhealth.hhs.gov/ for “A Physician’s Practical Guide to Culturally Competent Care” and additional classes, guides and tools to assist you in providing culturally competent care.
- https://www.ahrq.gov/health-literacy/index.html for Health Care Literacy toolkit
- Why culturally and linguistically appropriate (CLAS) matter video
- Centene Institute – Training and CEU credits

Magnolia offers resources to assist providers in supporting members with social, cultural, and linguistic needs. Contact us @ 1.877.236.0751, relay 711

Social Determinants of Health

Social Determinant of Health (SDOH) are non-medical factors that influence health outcomes.

What Are Z Codes?

- SDOH- related Z codes range from ICD-10-CM categories Z55- Z65 and are used to document SDOH data (e.g., housing, food insecurity, lack of transportation.
- Z Codes refer to factors influencing health services that are not classifiable elsewhere as diseases, injuries, or external causes

What are SDOH & Why Collect Them?

- SDOH are the conditions in the environment where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risk

Collecting SDOH can improve equity in health care delivery and research by:

- Empowering provider to identify and address health disparities (e.g., care coordination and referrals)
- Identifying community and population needs
- Supporting quality measurement

Using Z Codes for SDOH

- SDOH information can be collected before, during, or after a health care encounter through structured health risk assessments and screening tools
- It is important to screen for SDOH information at each health care encounter to understand circumstances that may have changed in the patient's status.

- Magnolia's Secure Provider Portal now features a Z-Code Dashboard
- Incentives for properly assessing and coding Z-Codes are available, for more details visit [insert website link]
- Additional Learning: Visit CMS.GOV USING Z CODES -

SDOH Enhanced Payment Incentive (PCP's Only)

When does it begin?

- July 1, 2025

How often can providers receive the incentive?

- 1x per year, per member

When should members be screened?

- We encourage providers to screen members at every visit, or at least to inquire if the member has been screened.

How is the incentive reimbursed?

- The incentive will be reimbursed 1x per year in the order claims were billed.

How is the incentive earned?

- Please note positive results should include procedure codes for interventions.
- **$10** Provider incentive for reporting a positive SDOH screening and referral along with the appropriate Z Codes for enrollees.
- **$10** Provider incentive for reporting a negative SDOH screening along with the appropriate Z Codes for enrollees.

SDOH Coding and Best Practices

Best practice is for providers to ask the member if they have recently received a screening at each visit.

Providers should use one of the two G codes below to indicate the screening was performed and to indicate the outcome:

- Screening Performed and Negative: **G9920**
- Screening Performed and Positive and Provision of Recommendations: **G9919**

Positive results should include procedure codes for interventions:

- Food Insecurities: **96160**
- Housing Instability: **96156**
- Transportation Insecurity: **96161**

Referrals to Case Management can be done via the Secure Provider Portal under the member's account.

Quick Guide to Social Determinants of Health ICD-10 Z Codes

ICD-10 Code Category	Problems/Risk Factors Included in Category
Z55 – Problems related to education and literacy	Illiteracy, schooling unavailable, underachievement in a school, educational maladjustment and discord with teachers and classmates.
Z56 – Problems related to employment and unemployment	Unemployment, change of job, threat of job loss, stressful work schedule, discord with boss and workmates, uncongenial work environment, sexual harassment on the job, and military deployment status.
Z57 – Occupational exposure to risk factors	Occupational exposure to noise, radiation, dust, environmental tobacco smoke, toxic agents in agriculture, toxic agents in other industries, extreme temperature, and vibration.
Z59 – Problems related to housing and economic circumstances	Homelessness, inadequate housing, discord with neighbors, lodgers and landlord, problems related to living in residential institutions, lack of adequate food and safe drinking water, extreme poverty, low income, insufficient social insurance and welfare support.
Z60 – Problems related to social environment	Adjustment to life-cycle transitions, living alone, acculturation difficulty, social exclusion and rejection, target of adverse discrimination and persecution.
Z62 – Problems related to upbringing	Inadequate parental supervision and control, parental overprotection, upbringing away from parents, child in welfare custody, institutional upbringing, hostility towards and scapegoating of child, inappropriate excessive parental pressure, personal history of abuse in childhood, personal history of neglect in childhood, personal history of unspecified abuse in childhood, Parent-child conflict, and sibling rivalry.
Z63 – Other problems related to primary support group, including family circumstances	Absence of family member, disappearance and death of family member, disruption of family by separation and divorce, dependent relative needing care at home, stressful life events affecting family and household, stress on family due to return of family member from military deployment, alcoholism and drug addiction in family.
Z64 – Problems related to certain psychosocial circumstances	Unwanted pregnancy, multiparity, and discord with counselors.
Z65 – Problems related to other psychosocial circumstances	Conviction in civil and criminal proceedings without imprisonment, imprisonment and other incarceration, release from prison, other legal circumstances, victim of crime and terrorism, and exposure to disaster, war and other hostilities

Appointment Availability Standards

- Network providers are required to provide timely access to care and comply with appointment availability standards.
- Magnolia utilizes Faneuil to conduct quarterly outreach to determine if your clinic is complaint with appointment standards.

Appointment Type	Appointment Scheduling Timeframe
PCP (Well Care Visit)	Not to exceed thirty (30) calendar days
PCP (Routine Sick Visit)	Not to exceed seven (7) calendar days with an Urgent Care visit schedule (see below); otherwise, not to exceed twenty-four (24) hours
PCP (Urgent Care Visit)	Not to exceed twenty-four (24) hours
Specialists	Not to exceed forty-five (45) Calendar days
Behavioral Health/Substance Use Disorder Providers (routine visit)	Not to exceed fourteen (14) calendar days
Behavioral Health/Substance Use Disorder Providers (urgent visit)	Not to exceed twenty-four (24) hours
Behavioral Health/Substance Use Disorder Providers (post-discharge from an acute psychiatric hospital)	Not to exceed seven (7) calendar days
Urgent Care Providers	Not to exceed twenty-four (24) hours
Emergency Providers	Immediately (twenty-four (24) hours a day, seven (7) days a week) and without Prior Authorization
After-hours	Available by phone 24 hours a day, seven days a week.

Availability Standards

After – Hours Requirements

- **Answering service** with a live agent that offer the option of speaking with or being contacted by a physician
- **Automated message** that includes an option to speak to or reach a physician
- **Recorded message** with clear instructions on how to reach a provider or direct phone number of a provider.
- **Recorded message** with an option to leave a number/message for an after-hours phone call from an appropriate practitioner within an hour of the member contacting the organization.

Voicemail alone after hours is not acceptable.

- There must be a means to reach a live person.
- At the beginning of a recorded after-hours message, there must be instructions for patients with life threatening conditions and separate instructions for urgent conditions. This includes calling 911 or going to the nearest emergency room.

Demographic & Directory Updates

Having access to accurate provider information is vitally important to Magnolia members. To ensure a member's health is not compromised, providers are required to have their contact and demographic information up-to-date.

Providers should:

1. Notify Magnolia of any changes (ex. address or telephone number updates), if they can no longer accept new patients or are leaving the network.

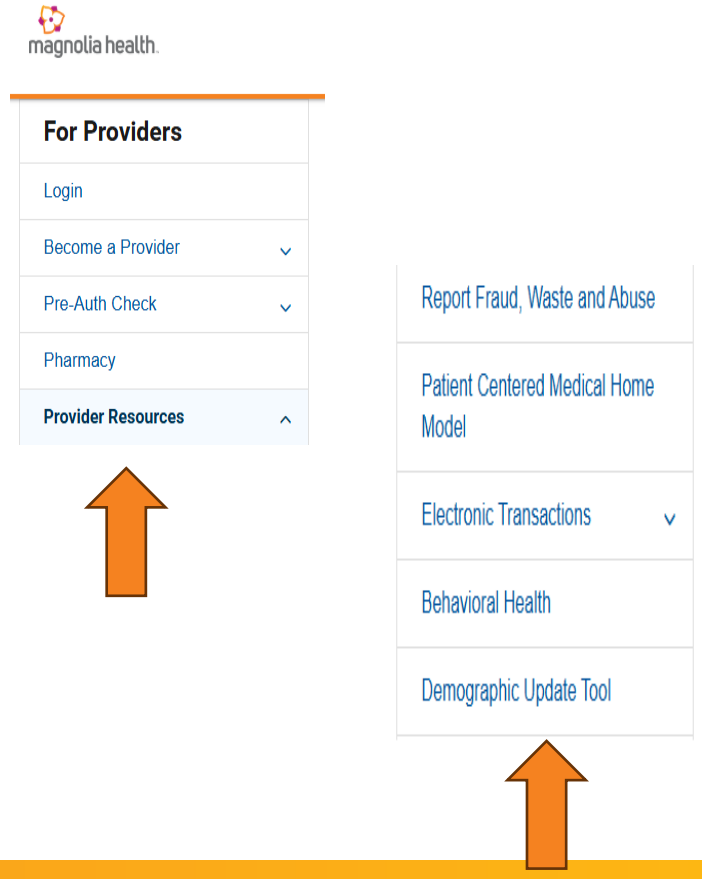
2. Review Magnolia's Provider Directory regularly to verify contact and demographic information is accurate.

How make Updates:

Easy Self-Service Option: Magnolia's Demographic Update Tool Deomographic Update Tool

By Phone: 1-877.236.0751

- Make an Address Change
- Make a Demographic Change
- Update Member Assignment Limitations
- Term an Existing Provider
- Make a Change to an IRS Number or NPI Number



Waste, Abuse, and Fraud

Magnolia takes the detection, investigation, and prosecution of fraud and abuse seriously. Our WAF program complies with MS and Federal laws, in conjunction with Centene, we successfully operate a WAF unit.

Centene's Special Investigation (SIU) performs back-end and onsite 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:

- 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
- Prepayment Review
- Any other remedies available

MOST COMMON WASTE, ABUSE, AND FRAUD

- Unbundling of codes
- Up-coding
- Add-on codes without primary HCPC
- 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

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

Joining our Network

Uniform Credentialing

As of October 1, 2022, providers seeking participation in MississippiCAN and/or CHIP are required to be enrolled, credentialed, and screened by DOM, and subsequently contract with their CCO of choice. Please note, however, that each CCO may require providers to credential separately if the provider wants to participate in a different line of business the company may offer outside of Medicaid. Find more details visit Recredentialing and Revalidation - Mississippi Division of Medicaid (ms.gov)

Gainwell Technologies is the Division of Medicaid's Centralized Credentialing Agency. For credentialing or recredentialing question please contact 800.884.3222.

Providers must credential and enroll as a MS Medicaid provider before contracting and enrolling with Magnolia Health MSCAN and/or CHIP

- To credential and enroll as a Mississippi Medicaid provider
- Submit your application with the appropriate taxonomy through the MESA portal located at https://medicaid.ms.gov/mesa-portal-for-providers/.
- Select Magnolia Health as your CCO of choice
    - To check your provider enrollment status
        - Visit the MESA portal and enter your Application Tracking Number (ATN) and SSN or Tax ID (depending on enrollment type).
        - For questions about your enrollment application process, please contact the Division of Medicaid's fiscal agent, Gainwell Technologies, at 800-884-3222.

Contracted Already – Next Steps

Applies to providers who are already contracted with Magnolia Health MSCAN and/or CHIP and have completed the credentialing process with Gainwell but may be adding a location or new physician to their practice.

- Providers credentialed with Gainwell after July 1, 2025, will not be required to submit a Provider Data Management form to enroll with Magnolia.
- Magnolia will utilize Gainwell's daily fil to enroll contracted providers
- Providers should allow 21 days for practitioner enrollment to complete

For Enrollment Questions

Provider Services @ 1.877.236.0751

www.magnoliacredentialing@centene.com

Not Contracted – Next Steps

Applies to providers who are not contracted with Magnolia Health MSCAN and/or CHIP and have completed the credentialing process with Gainwell .

- To begin the contracting process, Magnolia will contact you upon receiving information from Gainwell of your intent to contract.
- Please remember to select Magnolia Health as your CCO of choice, if you intend to participate in our Network for MSCAN and CHIP.

For Contracting Questions

Provider Services @ 1.877.236.0751

MAGNOLIACONTRACTING@CENTENE.COM

Prior Authorization

Prior Authorizations

Magnolia Health uses prior authorizations to ensure that all care delivered to our members is medically necessary and appropriate based on the member's type and severity of condition. We work with providers to review certain testing and treatment decisions and verify that they are consistent with our clinical policies and philosophy of care.

Medical Necessity is a review of covered services prescribed that ensures decisions for treatment or care are based on generally accepted medical practices considering conditions at the time of treatment.

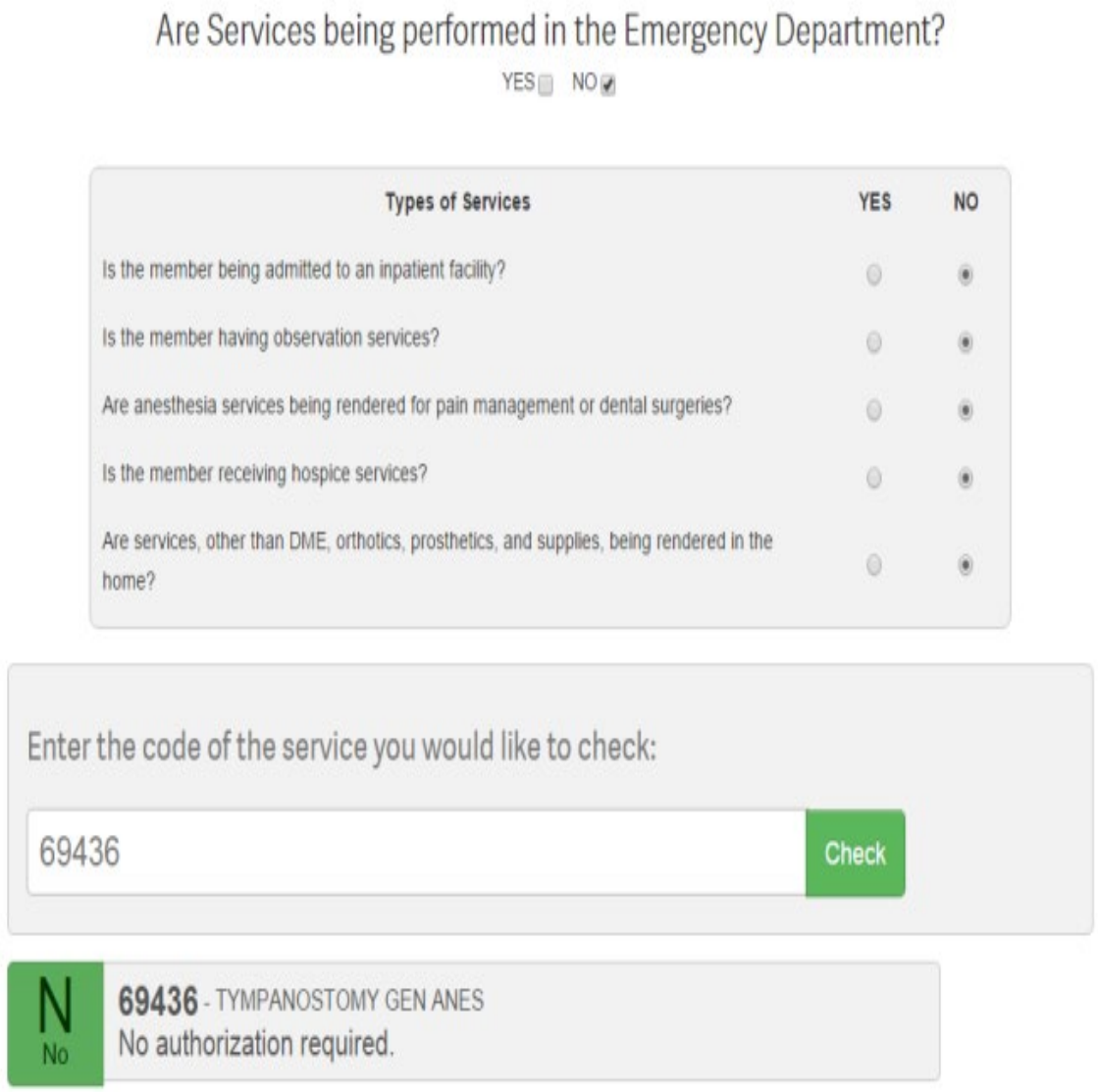
- **Failure to obtain a Prior Authorization may result in claim denials**
  - Members cannot be billed for services denied for lack of prior authorization.
- **Non-Par Providers must have all services prior authorized except for:**
  - Emergency and post stabilization services
    - Service is also excluded for par provider authorization requirements
- **Referrals are not required for MSCAN and CHIP but when referrals are necessary providers should refer to an In-Network physician if possible.**
- **An authorization is not a guarantee of payment**
  - Members must be eligible at the time of service
  - Service must be a covered benefit
  - Service must be medically necessary as per plan policies and procedures
- **Non- Par Providers require authorization**

Is Prior Authorization Needed?

Use the **Pre-Auth Needed Tool** to quickly determine if a service or procedure requires prior authorization

Providers must answer each listed question appropriately for accurate result

https://www.magnoliahealthplan.com/providers/pre auth-check/medicaid-pre-auth.html



How to Request a Prior Authorization

Secure Provider Portal : www.magnoliahealthplan.com/login
This is the preferred and fastest method

Fax : Using the appropriate Treatment Request Form on the website under Prior Authorization.

- ***Outpatient:*** **1.877.650.6943**
- ***Inpatient*****: 1.877.291.8059**
- ***Transplant*****: 1.833.589.1239**
- ***BH Outpatient:*** **1.833.694.3649**
- ***BH Inpatient:*** **1.866.535.6974**

Phone : 1.877.236.0751

Request received after normal business hours will be processed the next business day.

✓ **Check service codes for Authorization requirements before providing services**

https://www.magnoliahealthplan.com/providers/preauth-check/medicaid-pre-auth.html

PA REQUEST FORM: Mississippi Medicaid Pre-Authorization Form | Magnolia Health (magnoliahealthplan.com)

Submission and Response Timeframes

REQUEST TYPE	PROVIDER SUBMISSION	• HEALTHPLAN RESPONSE
Services	Timeframes	Timeframes
Non-emergent Outpatient	**5 calendar days**	**2** business days
Pre-scheduled Inpatient	At least **14 calendar days**, and no later than **5 calendar days**, in advance	**24 hours** of receipt if all necessary clinical information is submitted at the time of the request.
Hospital inpatient stays, except for emergent, urgent care, and post-stabilization	Require notification within **1 business day** & request for an authorization within **2 business days** of the admission	**1** business day
Emergent or urgent care	Within **2 business days** of admission	**1** business day

Important

- Failure to obtain Prior Authorizations may result in claim denials.
- EPSDT eligible members may receive medically necessary services over the benefit limit with approved authorization.

Retrospective Authorization Request

•Applies to authorizations not obtained timely due to extenuating circumstances (e.g., member unconscious)

•Submit promptly but no later than **90 calendar days** from date of service

•Magnolia will make a decision **30 calendar days** from the date of request contingent on submission timings being met**.**

Peer to Peer

If a **pre-service authorization** request results in a denial or limited authorization or a reduction or suspension of a previously authorized service, also known as an adverse benefit determination, and the treating practitioner disagrees. In that case, a peer review can be requested. Peer reviews should be requested within **14 calendar days** of the notification of the adverse benefit determination.

Peer review or peer-to-peer can be requested by calling Provider Services at 1.877.236.0751. Request to speak to the UM Department to set up a Peer-to-Peer or submit request through our electronic Peer-to-Peer request form found at www.magnoliahealthplan.com

Quality and Practice Management

Quality Improvement Program

- **Goal of Quality Program**

  Is to improve members' health status through a variety of meaningful quality improvement activities implemented across all care settings and aimed at improving quality of care and services delivered.

  Patient safety is integrated throughout many activities across the plan, but primarily through identification of potential and/or actual quality of care events.

- **Quality of Care Issues**

  Require investigation of the factors surrounding the event to make a determination of their severity and need for corrective action, up to and including review by the Peer Review Committee as indicated.

  Received in the QI department are tracked and monitored for trends in occurrence, regardless of their outcome or severity level.

Quality Improvement Resources for Providers

Mississippi Medicaid & Health Insurance | Magnolia Health

Clinical Practice Guidelines

Magnolia Health adopts preventative and clinical practice guidelines (CPG) from recognized sources for the provision of acute, chronic, and behavioral health services relevant to the populations served.

Guidelines are based on the population's health needs and/or opportunities for improvement as identified through the Quality Assessment and Performance Improvement (QAPI) Program.

These guidelines include recommendations that aim to optimize patient care and are based on a systematic review of evidence.

Clinical Practice Guidelines can be found on Magnolia's website Mississippi Medicaid & Health Insurance | Magnolia Health

HEDIS & Medicaid Focused Measures

Measuring Performance

Healthcare Effective Data Information Set (HEDIS)

HEDIS is a set of performance measures developed by the National Committee for Quality Assurance (NCQA) as a tool for measuring the performance of managed healthcare plans.

What is the Provider's Role in HEDIS?

- Using available tools and resources
  - Use and collaborate with your Provider Engagement Representative
  - Secure Provider Portal – Analytics
  - Member Panel Reports
  - Gaps and Care Flags
  - New Patient Flags

- Understand Measure Timelines
  - Schedule the next appointment before the patient leaves the office

- Know Gaps in Care Before Patient Arrives
  - Conduct and bill a well visit with a sick visit for member who has not had his/her annual physical
  - Contact patients that are delinquent in needed care and schedule services

- Code Correctly
  - CPT II billing codes to help increase scores for BMI's, BMI percentiles, labs, etc.
  - Document clearly and completely

Measuring Performance

2025 Medicaid Focus Measures

Measure	Description	Coding and Tips
Developmental Screening in the First Three Years of Life (DEV-CH)	Children screened for risk of developmental, behavioral, and social delays using a standardized screening tool in the 12 months preceding or on their 1st, 2nd, or 3rd birthday.	CPT → 96110
Immunizations for Adolescents (IMA)	Adolescents 13 years of age who had the following immunizations between the 10th and 13th birthday	Meningococcal (1 dose) → CPT – 90733, 90734, 90619 Tdap (1 dose) → CPT – 90715
Prenatal and Postpartum Care (PPC)	Members with a live birth on or between October 8 of the year prior to the measurement year and October 7 of the measurement year. Postpartum Care – percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery.	CPT → 57170, 58300, 59430, 99501 Modifier → TS
Postpartum Depression Screening and Follow-up (PDS)	Percentage of deliveries in which members were screened for clinical depression during the postpartum period, and if screened positive, received follow-up care.	
Follow-Up After Hospitalization for Mental Illness (FUH)	Members 6 – 17years of age who were hospitalized for a principal diagnosis of mental illness, or any diagnosis of intentional self-harm, and had a mental health follow-up service: Follow-up within 30 days after discharge PCP can close the gap with any diagnosis of mental health disorder Telehealth can close the gap	If the follow-up visit is with a PCP there must be a BH Diagnosis on the claim . *Tips for Rate Improvement:* • Schedule member's 7-day or 30-day follow-up appointment prior to the member being discharged from the hospital. • Maintain appointment availability in your office for patients with recent hospital discharges. • Complete appointment reminder calls 24 hours prior to the scheduled follow-up appointment.

Measuring Performance

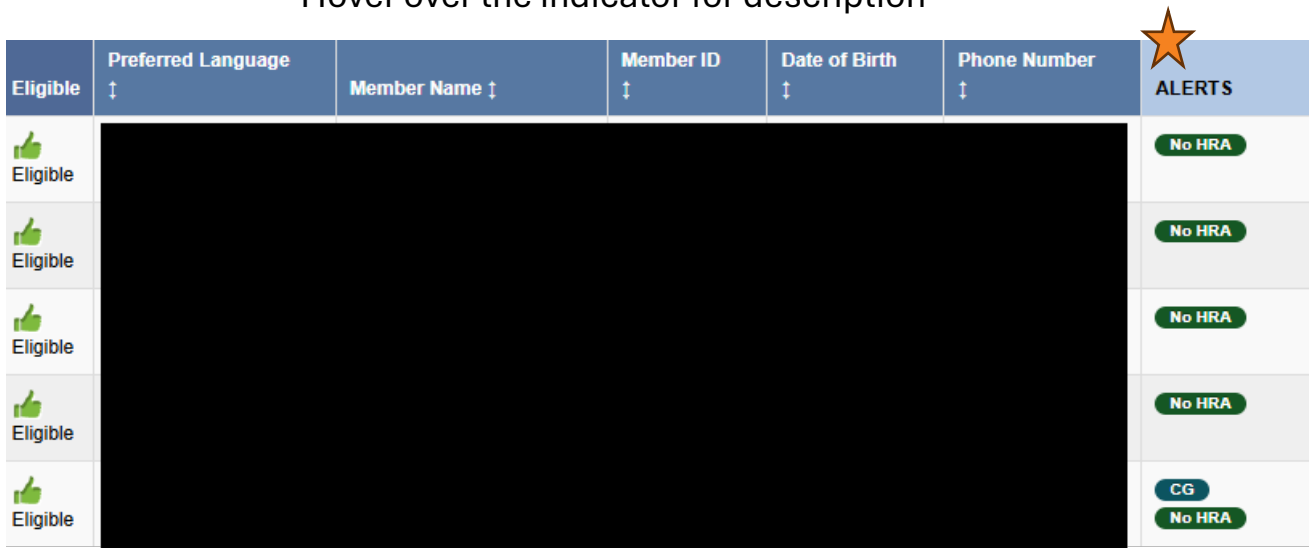
2025 Medicaid Focus Measures

Measure	Description	Coding and Tips
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)	Children and adolescents 1–17 years of age who had two or more antipsychotic prescriptions and had metabolic testing. Three rates are reported: • Blood Glucose Testing • Cholesterol Testing • Both blood glucose and cholesterol testing	Blood glucose testing CPT – 80047, 80048, 80050, 80053, 80069, 82947, 82950, 82951 Cholesterol testing CPT – 82465, 83718, 83722, 84478 Both blood glucose *and* cholesterol testing
Antidepressant Medication Management (AMM)	Members 18+ who were treated with antidepressant medication, had a diagnosis of major depression and who remained on an antidepressant medication treatment. Acute Phase – remained on an antidepressant for at least 84 days Continuation Phase – remained on an antidepressant for at least 6 months	*Tips for Rate Improvement:* Utilize 90-day prescriptions Educate member on expected length of time before the medication becomes effective Educate member not to discontinue medication abruptly or without consulting you first Schedule follow-up visit within 3 months of diagnosis or initiating treatment Schedule next follow-up visit prior to member leaving the office
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis	Members ages 3 months to 17 years of age with a diagnosis of acute bronchitis/bronchiolitis that *did not* result in an antibiotic dispensing event.	CPT → 57170, 58300, 59430, 99501 Modifier → TS
Adults Pharmacotherapy Management COPD Exacerbation (PCE)	COPD exacerbations for members 40 years of age and older who had an acute inpatient discharge or ED visit on or between January 1–November 30 of the measurement year and who were dispensed appropriate medications. Dispensed a Systemic Corticosteroid (or there was evidence of an active prescription) within 14 days of the event	Systemic Corticosteroid Medications • Cortisone • Dexamethasone • Hydrocortisone • Methylprednisolone • Prednisolone • Prednisone

EPSDT & Screenings

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)

- EPSDT benefits provide comprehensive and preventive health care services for children for children under age 21 who are enrolled in Medicaid, MSCAN, or CHIP
- EPSDT is key to ensuring that children and adolescents receive appropriate preventive, dental, mental health, and specialty services
- Alerts in the **Secure Provider Portal** will display Gaps in Care, including EPSDT screenings that are due
  - CG- Care Gaps
  - HRA- Health Risk Assessment Needed
  - Hover over the indicator for description



Eligible	Preferred Language	Member Name	Member ID	Date of Birth	Phone Number	ALERTS
Eligible	[redacted]					No HRA
Eligible						No HRA
Eligible						No HRA
Eligible						No HRA
Eligible						CG, No HRA

When should Check-ups be done?

Babies Need checkups at:

- ✓ 3-5 days
- ✓ Birth to 1 month
- ✓ 2 months
- ✓ 4 months
- ✓ 6 months
- ✓ 9 months
- ✓ 12 months

Toddlers need checkups at:

- ✓ 15 months
- ✓ 18 months
- ✓ 24 months (2 years)
- ✓ 30 months

Ages 3- 20 need a checkup every year

How to get credit for EDPST services?

Bill appropriate CPT codes with EP modifier

- ✓ New Patient -99381 -99385
- ✓ Established – 99391-99395

Resources

- EPSDT Periodicity Examination Schedule
- Bright Futures/American Academy of Pediatrics Periodicity Schedule
- Become an EPSDT approved provider

Developmental Delays in Children

The Critical Role of Early Intervention for Developmental Delays

Early intervention is a system of services designed to help children experiencing developmental delays or diagnosed with a condition that affects development. These services are critical because early childhood undergoes rapid growth and brain development. The sooner a child receives support, the more progress they make in overcoming delays.

How Early Intervention Helps

Early intervention services focus on helping children acquire the needed skills in areas where they lag, provided by specialists, including speech therapists, occupational therapists, physical therapists, and developmental pediatricians. The goal is to provide individualized support tailored to the child's specific needs, whether involving speech, motor skills, social interactions, or cognitive development.

Key Benefits of Early Intervention:

- Enhanced brain development
- Better School Readiness
- Improved Social Skills
- Increased Independence
- Better long-term outcomes

Common Developmental Delays in Children

- Speech and Language Delays
- Gross and Fine Motor Skill Delays
- Cognitive Delays
- Social and Emotional Delays
- Adaptive Delays

Effective Early Intervention Strategies: How to Support Developmental Delays?

✓ Specialist Referral
- Speech and Language Therapy
- Occupational Therapy
- Physical Therapy
- Applied Behavior Analysis (ABA)

Free consult line for primary care providers

Call **601.984.2080** to consult with a UMMC child psychiatrist or child psychologist for mental health issues regarding ADHD, anxiety, depression and other emotional or behavioral health concerns for children age 21 and under.

- Diagnostic clarification
- Medication consultation
- Resources and referrals

Families as Allies

Our partner organization, Families as Allies also provides support for:

- Families, including school issues
- Professionals in family partnerships
- Coordinating systems of care to better respond to children

Consult line: 601.984.2080
9 am – 5 pm, Mon – Fri

champms.org

Child Access to Mental Health and Psychiatry
University of Mississippi Medical Center

UMMC
Department of Psychiatry and Human Behavior

magnolia health

Screenings and Assessments

Sensory Screenings and Developmental/ Behavioral Assessments

Screening Code	Assessment	Age of Child	Units
99173-EP	**Vision**	3,4,5,6,8,10,12 & 15 Years	1
92551-EP	**Hearing Screen**	Newborn, 4, 5, 6,. 8, 10 Once between 11-14, 15-17, & 18-21 Years	1
96110-EP	**Developmental Screen**	9,18, & 30 Months	1
96110-EP	**Autism Screen**	18 & 24 months	
96160-EP	**Depression Screen**	12-20 Years	1
96161-EP	**Manual Depression Screen**	1,2,4 & 6 Months	1

Acceptable Standardized Screening Tools for Development, Behavioral and Social Delays	Examples of standardized screening tools cited in Bright Futures/American Academy of Pediatrics for developmental, behavioral and social delays that meet the measure criteria include:
	• Survey of Well-Being in Young Children (SWYC) • Ages and Stages Questionnaire – 3rd Edition (ASQ-3) • Battelle Developmental Inventory Screening Tool (BDI-ST) – Birth to 95 months • Bayley Infant Neuro-developmental Screen (BINS) – 3 months to 2 years • Brigance Screens-II – Birth to 90 months • Child Development Inventory (CDI) – 18 months to 6 years • Infant Development Inventory – Birth to 18 months • Parents' Evaluation of Developmental Status (PEDS) – Birth to 8 years • Parent's Evaluation of Developmental Status – Developmental Milestones (PEDS-DM)

Practice Performance Support

Magnolia's primary quality goal is to improve the health status of our members through quality improvement efforts. We focus on collaborating with providers to improve health outcomes.

To assist in providing quality health outcomes, Magnolia Health has dedicated Quality Practice Advisors and Provider Engagement Representatives available to assist with the following:

- Risk Adjustment
- Education on HEDIS Measures
- Medicaid Measures
- CPT II Education
- EPSDT Training
- Member Panels
- Medication Adherence
- Provider Performance Initiatives
- Care Gap Closure
- Health Risk Assessments
- Staff Training

Primary Care Provider Engagement Map

Care Management

Care Management

Magnolia Health Plan's **Integrated Care Management team** is comprised of **Care Managers** (Nurses/Licensed BH staff), **Care Navigators** (Social Workers), **Care Coordinators**, **Community Connections Representatives**, and **Disease Managers** (RN, RT, Licensed Counselors). Through collaboration among our staff, each member has access to a variety of Care Management and Care Coordination services.

- Our Care Managers help members understand major health problems and assist in arranging members' health care needs.
- Members enrolled in care management often see several doctors. Magnolia's Care Managers can assist members in coordinating aspects of their care. Members enrolled in Care Management often have conditions such as, Organ Transplants, Cancer, Hemophilia, Depression, Bipolar Disorder, Autism, and/or Breathing Problems.
- In addition to Care Managers, Magnolia has Coordinators who specialize and work with Care Managers in coordinating care. These coordinators are dedicated to the following issues: Developmental Disabilities, Special Care Needs, and Social Determinants of Health Needs.
- Through our Transition Services program, Coordinators also contact members who have admitted or readmitted to acute care hospitals to make sure members have a successful transition back into the community.

To make a referral or contact a Care Manager, **call Magnolia Health Care Management Department**

1-877-236-0751 or submit a referral through the Provider Portal.

Pharmacy

Pharmacy Prior Authorization

On July 1, 2024, the Division of Medicaid moved to a single pharmacy claims processor for all prescription claims filled by all beneficiaries. Gainwell (GWT) is responsible for processing all prior authorization requests for prescription drugs. Certain drugs require prior authorization to be approved for payment. These include:

- All medications listed as non-preferred on the PDL
- Some DOM preferred drugs (designated "prior authorization" on the PDL)

Pharmacy PA Request:

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

- **Electronically:** *https://portal.MS-Medicaid-MESA.com/MS/Provider*
- **Fax:** 1.866.644.6147

For urgent or after-hours requests, a pharmacy can provide up to a seventy-two (72) hour supply of most medications.

For questions regarding pharmacy prior authorizations, please contact **Gainwell at 1.833.660.2402.**

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

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

Billing and Claims

Clean and Rejected Claims

CLEAN CLAIM

A **clean claim** is 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 for services to be processed by Magnolia.

Must be submitted **within 180 calendar days** from the service date**.**

Tips reduce denial and rejected claim rates:

- Keep updated patient information
- Verify patient eligibility up front and every time
- Review Coding Quality and Accuracy before submission
- Know claim submission and prior authorization requirements

REJECTED CLAIM

A rejection is an **unclean claim** that contains invalid or missing data elements required to accept the claim in Magnolia's claim processing system.

Rejected claims should be resubmitted after making proper corrections.

Rejected claims must be submitted as a new clean claim within **180 calendar days** from the service date.

Examples of rejected claims:

- Invalid member ID number
- Invalid Provider ID
- Invalid Member Date of Birth
- Invalid or Missing NPI
- Incorrect type of bill for the service or location
- Missing or invalid modifier

Clean Submissions and Timeframes

CLAIM SUBMISSIONS

Convenient and easy way to submit and check status: Magnolia's Secure Provider Portal

Magnolia Healthcare Portal for Members | Login | Magnolia Health (magnoliahealthplan.com)

ELECTRONIC SUBMISSION INQUIRIES

For Inquiries related to electronic or paper submissions, contact our EDI team at EDIBA@centene.com

ELECTRONIC FUNDS TRANSFER AND REMITTANCE ADVICE

Register online using the simplified, enhanced provider registration process at **payspanhealth.com** or call **1-877-331-7154 (option1).**

CLEARINGHOUSE CONNECTIVITY

Magnolia has partnered with Availity as our preferred EDI Clearinghouse. You may connect directly to Availity or continue to use your existing vendor/biller/clearinghouse. If you need assistance in making a connection with Availity or have any questions, please contact Availity client services at:

MSCAN & CHIP, PAYER ID: 68069
BEHAVIORAL HEALTH, PAYER ID: 68068

Mail Paper Claim Submissions to: Magnolia Health Plan PO Box 7600 Farmington MO 63640-3809

SUBMISSION TIMEFRAMES

- **New Claim** – 180 calendar days from service date
- **Corrected Claim**- 90 calendar days for EOP date
- **Retroactive Eligibility** – 365 calendar days from notice date
- **Secondary Payer-** 365 calendar days from final primary payer determination date
- **Claim Reconsideration** (optional) – 90 days from the date of the EOP
- **Claim Appeal** – 30 days from the date of EOP or Reconsideration determination date

Electronic Payment

Enjoy greater convenience and timely payment by switching from paper checks to electronic funds transfer (EFT). EFT is fast, easy, and secure.

It's easy to get started with Zelis/Payspan, here's how:

1. Obtain a registration code and PIN by calling PaySpan Provider Services at **877-331-7154 (option 1)** or by visiting payspanhealth.com/RequestRegCode/
2. Have your bank name, routing number, account number, and TIN/NPI handy
3. Follow the step-by-step registration instructions on the Payspan registration website
4. In the payer drop-down list select the plan you would like to Register for Electronic Payment

Important note on NPI: Leaving the NPI field blank or inputting an incorrect number during registration may interfere with your clearinghouse's ability to process your ERA/835. The NPI you enter during registration will appear in the header of your ERA/835. If you leave the field blank, your NPI will later appear as "9999999999."

PaySpan Contact Information

Phone:
1-877-331-7154 x 1
(Mon.-Fri, 7 a.m. – 7 p.m.)

Email:
providersupport@payspanhealth.com

Claim Dispute Process

RECONSIDERATION (Optional)

A **claim reconsideration** is an *optional* step in Magnolia's claim dispute process. Providers may choose to bypass a claim reconsideration by submitting a claim appeal first.

To Request a Claim Reconsideration:

Preferred Method: Secure Provider Portal

Or

By Mail:

1. Complete
2. Send Completed Form to: Claim Reconsideration Form

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

Timeframe: 90 calendar days from the EOP (Explanation of Payment) or PRA (Provider Remittance Advice)

CLAIM APPEAL

Providers can request to have the outcome of a finalized claim, or the outcome of a reconsideration reviewed by submitting a **claim appeal**.

Please note: Provider documentation must clearly state APPEAL at the top of the documentation.

To Request a Claim Appeal:
Preferred Method: Secure Provider Portal
Fax: (833) 950-3857
By Mail:

1. Complete Claim Appeal Form to:
2. Send Completed Form:

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

A **claim reconsideration** cannot be submitted after the submission of a claim appeal.

Timeframe: 30 calendar days from the EOP or Reconsideration determination date.

Claim Dispute Process

STATE ADMINISTRATIVE HEARING

A **State Administrative Hearing** is a hearing conducted by the Division of Medicaid when a provider disagrees with the outcome of Magnolia's claim dispute process.

- ✓ Providers must exhaust Magnolia's claim dispute process before requesting a state administrative hearing

To Request a State Administrative Hearing:

Division of Medicaid, Office of the Governor
Attn: Office of Appeals
550 High Street, Suite 1000
Jackson, Mississippi 39201

Phone: 601-359-6050 **or** 1-800-884-3222 **Fax:** 601-359-9153

Timeframe : Within **thirty (30) calendar** days of the final decision by Magnolia Health

Provider Grievances

Provider Grievances

A provider grievance is an expression of dissatisfaction received orally or in writing about any matter or aspect of the health plan or its operations, other than an adverse benefit determination.

- Must be filed within **thirty (30) calendar days** of the date of the event causing the dissatisfaction

Grievance Incident Occurs

Examples of a Provider Grievance

Difficulty contacting the health plan

Disrespectful or rude behavior by health plan staff

Failure to respect provider's rights

File a Grievance

Mail:

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

Phone: 1-877-236-0751

Fax: 1-877-264-6519

Confirmation of Receipt

- Magnolia will acknowledge grievance **within five (5) calendar days** of receipt.
- Confirmation will be writing and include the expected date of resolution

Grievance Resolution

- Magnolia will resolve all grievances **within thirty (30) calendar days** but may extend the time frame by up to fourteen (14) days if additional time is needed to resolve.
- Grievance outcome will be sent in writing.

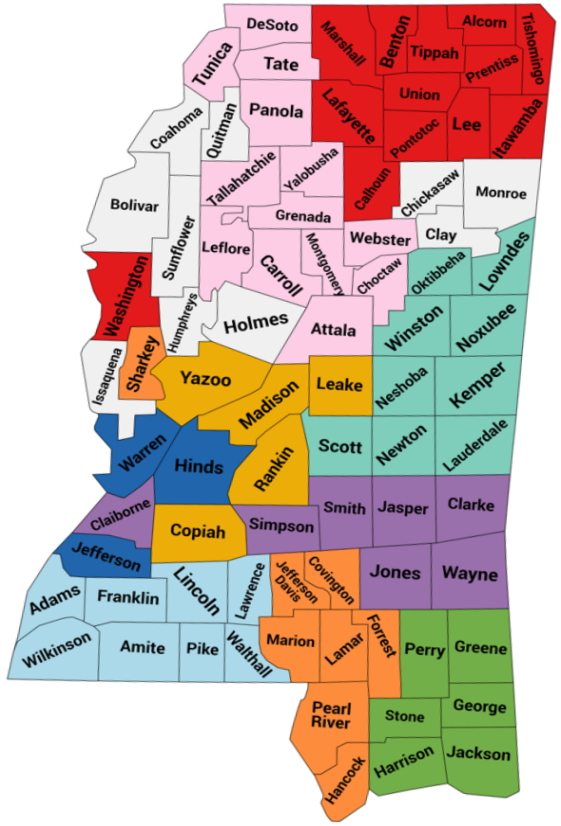
Provider Engagement

Primary Care Provider Engagement Map

- Northeast - Kiri Parson
  kiri.l.parson@centene.com
- North Central - Billie Snow
  billie.snow@centene.com
- Northwest - Latoya Hemphill
  latoya.hemphill@centene.com
- Central - Vanika Hogan
  vanika.hogan@wellcare.com
- East Central - Bethany Peters
  bethany.peters@centene.com
- South Central - Tarkan Weston
  tarkan.weston@centene.com
- Southwest - Tiffany Sanders
  tiffany.sanders@centene.com
- Southeast Central - Stacy McGrew
  stacy.mcgrew@centene.com
- Southern Central - Donna Ramirez
  donna.ramirez@centene.com
- Southern - Belinda Turner
  belinda.turner@centene.com

Provider Network Support Specialists

Supports all Ancillary, Hospital, DME, and other Non-PCP Providers



- Zone 1 - Kenisha Byrd
  magnoliazone1@centene.com
- Zone 2 - Anna Owens
  magnoliazone2@centene.com
- Zone 3 - Brittany Cole
  magnoliazone3@centene.com
- Zone 4 - Yashieka Brookins
  magnoliazone4@centene.com
- Zone 5 - Heather Samuels
  magnoliazone5@centene.com
- Zone 6 - Katherine St. Paul
  magnoliazone6@centene.com
- Zone 7 - Ericka Hunter
  magnoliazone7@centene.com
- Zone 8 - LaKisha Brooks
  magnoliazone8@centene.com
- Zone 10 - Meg Duke
  magnoliazone10@centene.com
- Zone 11 - Jemessia Johnson
  Jemessia.Johnson@centene.com

Thank You For Being the Best Part of Magnolia Health!