magnolia health™

# Provider Manual

June 2018

1-866-912-6285

MagnoliaHealthPlan.com

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

## Welcome

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

## About Us

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

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

Magnolia is a provider-driven organization that is committed to building collaborative partnerships with providers. Magnolia serves our members consistently with our core philosophy that quality health care is best delivered locally.

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

## Mission

Magnolia strives to provide improved health status, successful outcomes, and member and provider satisfaction in a coordinated care environment. Magnolia strives to achieve the following goals:

- Ensure access to primary and preventive care services
- Ensure care is delivered in the best setting to achieve an optimal outcome
- Improve access to all necessary health care services
- Encourage quality, continuity, and appropriateness of medical care
- Provide medical coverage in a cost-effective manner

All of our programs, policies, and procedures are designed with these goals in mind. We hope that you will actively assist Magnolia in reaching these goals.

## How to Use This Manual

Magnolia is committed to working with our provider community and members to provide a high level of satisfaction in delivering quality health care benefits. This manual aims to provide comprehensive information to providers regarding Magnolia's operations, benefits, and policies and procedures. Please contact the provider services department ("Provider Services") at 1-866-912-6285 if you need further explanation on any of the topics discussed in this manual.

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

### KEY CONTACTS

The following chart includes several important telephone and fax numbers available for your office. When calling Magnolia, please have the following information available:

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

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|  | www.magnoliahealthplan.com | Access Magnolia Health's website for the following information: contact us, provider directory, important notifications, provider newsletter, patient eligibility, claim submission and status, authorization submission and status |
| Provider Services | 1-866-912-6285<br>Fax: 1-877-811-5980<br>Hours of Operation:<br>Monday through Friday<br>8:00 a.m. to 5:00 p.m. CST | Answers to questions concerning member eligibility status;<br>prior authorization and referral procedures;<br>claims payment procedures and handling of provider disputes and issues;<br>transfer of member medical records among medical providers; the<br>list of members who are under a PCP's care, updated monthly; and<br>the Fraud and Abuse Hotline |
| Member Services | 1-866-912-6285<br>(TDD/TTY) 1-877-725-7753<br>Fax: 1-877-779-5219 | Available to answer a wide range of member questions including, but not limited to: eligibility, claims, authorizations, and available providers in their area. |

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| | Hours of Operation:<br>Monday through Friday<br>8:00 a.m. to 5:00 p.m. CST | |
| Authorization Request Discharge Planning/Care Management | 1-866-912-6285<br>Fax: 1-855-684-6747 | |
| Inpatient Admissions | 1-866-912-6285<br>Fax: 1-877-291-8059 | |
| Prior Authorization for Outpatient Services | 1-866-912-6285<br>Fax: 1-877-650-6943 | |
| US Script Prior Authorization | 1-866-399-0928<br>Fax: 1-866-399-0929 | Magnolia Health's Pharmacy Benefits Management; assistance with pharmacy prior authorizations |
| US Script Pharmacy Relations and Provider Help Desk | 1-800-460-8988 | Pharmacy |
| Magnolia Pharmacy Department<br>Jackson, MS | 1-866-912-6285, ext. 66409<br>Fax: 1-866-595-8117 | Pharmacy Help Desk |
| Behavioral Health (Cenpatico) | 1-866-324-3632<br>Fax: 1-866-694-3649<br>www.cenpatico.com<br>Hours of Operation:<br>24 hours/7 days a week | Assistance with behavioral health questions and services |
| NurseWise (24/7 Availability) | 1-866-912-6285 | 24-hour free health information phone line. The nurse triage service provides access to a broad range of health-related services including health education and crisis intervention. |
| Vision (OptiCare) | 1-800-531-2818 | Assistance with routine and medical vision services |
| High Tech Radiology (National Imaging Associates) | 1-800-642-7554<br>www.RadMd.com | Radiology Benefits Manager (CT/CTA/CCTA/MRI/MRA/PET Scan) |
| Dental (Dental Health & Wellness) | 1-844-464-5636<br>www.dentalhw.com | Assistance with Dental questions and services |
| Magnolia Health EDI Department | 1-800-225-2573, ext. 25525<br>Email: EDIBA@centene.com | Assistance with electronic data submissions with Magnolia Health |
| PaySpan Health | 1-877-331-7154<br>www.payspanhealth.com | Electronic EFT/ERA<br>Register |
| Division of Medicaid | 1-866-635-1347 | |

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|---|---|---|
| | www.medicaid.ms.gov | |

# ELIGIBILITY

**PRODUCT ELIGIBILITY SUMMARY**

**For purposes of this program, MississippiCAN beneficiaries include:**

| Mandatory Populations (Age): | Optional Populations (Age): |
|---|---|
| Supplemental Security Income (SSI) (19 - 65) | SSI (0-19) |
| Working Disabled (19-65) | Disabled Child Living at Home (0-19) |
| Breast and Cervical Cancer (19-65) | Department of Human Services - foster children (0-19) |
| Pregnant Women (8-65) and Infants (0-1) | Department of Human Services – adoption assistance (0-19) |
| All Newborns (0-1) | Native Americans (0-65) |
| TANF Family/Children (0-19) Adults 19-65) | |

**Ineligible MississippiCAN beneficiaries**

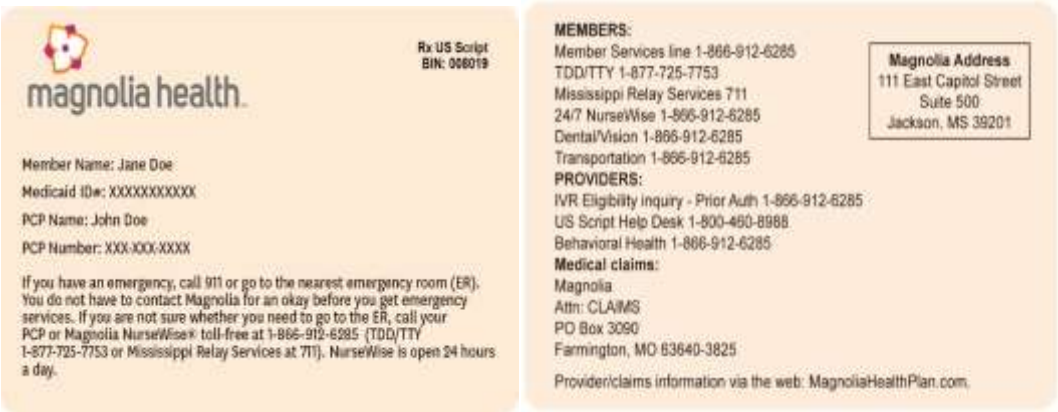
The following individuals cannot be a part of MississippiCAN:

- Beneficiaries in any waiver program: Elderly and Disabled (E&D), Independent Living (IL), Traumatic Brain Injury/Spinal Cord Injury (TBI-SCI), Assisted Living (AL), Intellectual and Developmental Disabilities (IDD), Mississippi Youth Programs Around the Clock (MYPAC), Family Planning Waiver (FPW), and Healthier MS Waiver
- Beneficiaries who have both Medicare and Medicaid
- Beneficiaries who are in institutions such as a Nursing Facility, Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID), Correctional Facility, etc.Magnolia does not determine eligibility. Eligibility is determined by DOM. To locate your DOM Regional Office, please visit http://www.medicaid.ms.gov/wp-content/uploads/2015/05/2015-DOM-Regional-Office-Map.pdf. You may also call Medicaid's toll-free telephone number at 1-800-421-2408.

## Member Identification (ID) Card

All new Magnolia members receive a Magnolia member ID card. However, Magnolia member ID cards are not a guarantee of eligibility; providers must verify members' eligibility on each date of service.

Members must present a member ID card each time services are rendered by a provider. If you are not familiar with the person seeking care as a member of our health plan, please ask to see photo ID. If you suspect fraud, please contact provider services at 1-866-912-6285 immediately.




**Providers must verify that their Magnolia members are eligible for services on the date the member presents for care. By doing this online, providers can reduce claim denials for eligibility reasons and improve office efficiency by reducing time on the phone checking member eligibility.**

## Member Eligibility Verification

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

1. Log onto DOM's Envision website to verify member's eligibility with Magnolia MississippiCAN. We encourage providers to first use this method to verify eligibility.
2. Log onto our secure provider portal at www.magnoliahealthplan.com. Using this secure provider website, you can check member eligibility. You can search by date of service plus any one of the following: member name, date of birth or Medicaid ID number. You can submit multiple member ID numbers in a single request.
3. Call our automated member eligibility interactive voice response (IVR) system. Call 1-866-912-6285 from any touch-tone phone and follow the appropriate menu options to reach our automated member eligibility-verification system, twenty-four (24) hours a day. The automated system will prompt you to enter the member ID number and the month of service to check eligibility.
4. Call Magnolia provider services. If you cannot confirm a member's eligibility using the methods above, call our toll-free number at 1-866-912-6285. Follow the menu prompts to speak to a provider services representative to verify eligibility before rendering services. Provider services will need the member name or member ID number to verify eligibility.

Through Magnolia's secure provider web portal, Primary Care Providers (PCP) are able to access a list of eligible members who have selected or were assigned to them. The list also provides other important information including date of birth and indicators for patients who are due for a well-baby and well-child care assessment. To view this member list, log onto the Magnolia website at www.magnoliahealthplan.com. Since eligibility changes may occur throughout the month and the member list does not confirm eligibility for benefits or guarantee coverage, please use one of the above methods to verify member eligibility on the date of service.

## Magnolia Website

Utilizing Magnolia's website can significantly reduce the number of telephone calls providers need to make to the health plan. Magnolia's website is located at www.magnoliahealthplan.com. Providers can find the following information on the website:

- Member benefits
- Magnolia news
- Clinical guidelines
- Wellness information
- Provider manual and forms
- Provider newsletters
- Provider Directory
- Link to Magnolia's PDL

## Secure Website

Magnolia's web portal allows providers to check member eligibility and benefits, submit and check status of claims, request authorizations, and communicate directly with Magnolia staff. Here, we offer tools which make obtaining and sharing information easy. It's simple and secure! Please visit www.magnoliahealthplan.com to register. On the home page, select the Login link on the top right to start the registration process.

Through our secure site, you may:

- View the PCP panel (patient list)
- Update provider demographics
- View and submit claims and adjustments
- View and submit authorizations
- View payment history/remittance advice
- View member gaps in care
- Check member eligibility
- Contact us securely and confidentially

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

## Interactive Voice Response (IVR)

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

- Check member eligibility

- Check claims status
- Access twenty-four (24) hours a day, seven (7) days a week, three hundred and sixty five (365) days a year

**PROVIDER RESPONSIBILITIES**

## Primary Care Provider (PCP) Responsibilities

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

## Provider Types That May Serve As PCPs

Magnolia offers a robust network of PCPs to ensure every member has access to a medical home within DOM required travel distance standards. These standards are fifteen (15) miles for urban areas and thirty (30) miles for rural areas. Providers who may serve as PCPs include any physician or health care practitioner, operating within the scope of his or her licensure, who is responsible for supervising, prescribing and providing primary care and primary care management services and whose practice is limited to the general practice of medicine. PCPs include Internists, Pediatricians, Obstetricians, Gynecologists, Family Practitioners, General Practitioners, Certified Nurse Practitioners whose specialty is pediatrics, adult, family, or obstetrics/gynecology, Certified Nurse Midwives, or Physician Assistants. Providers at Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs) may also serve as PCPs.

Members with disabling conditions, chronic illnesses, or children with special health care needs may request that their PCP be a specialist. The designation of a specialist as a PCP must be pursuant to a treatment plan approved by Magnolia and made in consultation with the PCP to which the member is currently assigned, the member and, as appropriate, the specialist. When possible, the specialist must be a provider participating in Magnolia's provider network.

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

**PCP requirements:**

- *Approved EPSDT PCPs, as defined in DOM Administrative Code Title 23, who serve members under the age of twenty-one (21) are responsible for conducting all EPSDT screens for individuals on their Panel under the age of twenty-one (21). Should the PCP be unable to conduct the necessary EPSDT screens, the PCP is responsible for arranging to have the necessary EPSDT screens conducted by another Magnolia network EPSDT provider and ensuring that all relevant medical information, including the results of the EPSDT screens, are incorporated into the member's PCP medical record.*

- *PCPs who serve members under the age of twenty one (21) are required to report encounter data associated with EPSDT screens, using a format approved by DOM, to Magnolia within one hundred and eighty (180) calendar days from the date of service.*

- *PCPs are responsible for contacting new panel members who have not had an encounter during*

*the first six (6) months of enrollment, as identified in the quarterly encounter list sent by Magnolia.*

- *Magnolia also requires the PCP to:*
    - Contact members identified in the quarterly encounter lists as not complying with EPSDT and immunization schedules for children
    - Identify to Magnolia any such members who have not come into compliance with EPSDT and immunization schedules within one (1) month of such notification from Magnolia
    - Document the reasons for noncompliance, where possible, and document its efforts to bring the member's care into compliance with the standards
- Be available for or provide on-call coverage through another source twenty-four (24) hours a day for management of member care.
- Educate members on how to maintain healthy lifestyles and prevent serious illness.
- Provide culturally-competent care.
- Maintain confidentiality of medical information.
- Obtain prior authorizations for selected outpatient services as listed on the current prior authorization list, except for emergency services up to the point of stabilization.
- Provide screening, well care, and referrals to community health departments and other agencies in accordance with DOM provider requirements and public health initiatives.
- Follow up with members who receive emergency care from other providers.

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

## Assignment of Medical Home

As part of the application process for coverage under MississippiCAN, a member shall select a PCP within thirty (30) calendar days of enrollment with Magnolia. For members who have not selected a PCP within thirty (30) days of enrollment, Magnolia will use an auto-assignment algorithm to assign an initial PCP. The algorithm assigns members to a PCP according to the following criteria, and in the sequence presented below:

1. Member history with a PCP. The algorithm will first look for previous relationship with a network PCP.
2. Family history with a PCP. If the member has no previous relationship with a PCP, the algorithm will look for a PCP to which someone in the member's family, such as a sibling, is or has been assigned.
3. Appropriate PCP type. The algorithm will use age, gender, and other criteria to ensure an appropriate match, such as children assigned to pediatricians and pregnant females assigned to OB/GYNs.
4. Geographic proximity of PCP to member residence. The auto-assignment logic will ensure members travel no more than thirty (30) minutes or thirty (30) miles in rural regions and fifteen (15) minutes or fifteen (15) miles in urban regions.

Providers may notify Magnolia to request an assigned member be assigned to an alternate PCP using Magnolia's Primary Care Provider (PCP) Form located at www.magnoliahealthplan.com with the member or authorized representative's approval/signature.

If a provider terminates from the network, the member will be reassigned a new PCP. The member will receive a letter stating the provider is no longer participating in the Magnolia network and as a result, the provider will no longer be able to provide medical services to them. Magnolia will assign the member a new PCP. To select a different PCP, the member will contact Member Services at 1-866-912-6285.

## Supplemental Security Income (SSI) Member Assignment

Members identified on the enrollment file as SSI eligible who have not yet selected a PCP will be removed from the auto-assignment process if no PCP match is made after the first step described above in the Assignment of Medical Home section. A PCP will be assigned to these members manually within 30 days of receiving the enrollment file. The enrollment specialist will identify whether the state file indicates a previous relationship with a non-network PCP. If a previous relationship with a non-network PCP exists, the enrollment specialist will work with the Provider Relations department (Provider Relations) to outreach to the non-network provider to attempt to contract with them so that they may serve as the member's medical home. If the non-network provider agrees to contract, the member will be assigned to that provider. If the non-network PCP declines to contract, the member will be assigned using the regular auto-assignment process described above. As with other auto-assigned members, any auto-assigned SSI member will be informed of their right to select a different PCP at any time.

## Specialist Responsibilities

The PCP is required to coordinate members' healthcare services and make referrals to specialty providers when medically necessary care is needed that is beyond the scope of the PCP. The specialty provider may order diagnostic tests without PCP involvement by following Magnolia referral guidelines and prior authorization requirements. However, the specialist may not refer to other specialists or admit to the hospital without the approval of a PCP, except in a true emergency. All non-emergency inpatient admissions require prior authorization.

**The specialist provider must:**

- Maintain contact with the PCP
- Obtain referral or authorization from the member's PCP and/or Magnolia medical management department (medical management) as needed before providing services
- Coordinate the member's care with the PCP
- Provide the PCP with consult reports and other appropriate records within five (5) business days
- Be available for or provide on-call coverage through another source twenty-four (24) hours a day for management of member care
- Maintain the confidentiality of medical information

## Hospital Responsibilities

Magnolia has established a comprehensive network of hospitals to provide services to members. Hospital-based providers must be qualified to provide services under the program. All services must be

provided in accordance with applicable state and federal laws and regulations and adhere to the requirements set forth by Magnolia and any applicable accrediting agencies.

Hospitals must:

- Notify the PCP no later than the close of the next business day after the member's emergency room (ER) visit;
- Obtain authorizations for selected outpatient services listed on the current prior authorization list, except for emergency care and post-stabilization services;
- Notify the Medical Management Department of all ER admissions for the previous business day by sending a daily electronic file of all ER admissions, to include the member's name, Magnolia member ID, presenting symptoms/diagnosis, date of service, and member's phone number;
- Notify the Medical Management Department by secure web portal of all normal (well-baby nursery) newborn deliveries within five (5) calendar days of the delivery via the DOM Newborn Enrollment Form; If complications develop with mother or baby that may necessitate additional hospital days or non well-baby or NICU admission, a prior authorization should be submitted along with clinical information to support the stay within one (1) business day of the decision that the higher level of care is needed.
- Follow the Inpatient Notification Process outlined below.

Magnolia providers should refer to their contract for complete information regarding hospital obligations and reimbursement.

## Inpatient Notification Process

Inpatient facilities are required to notify Magnolia of emergent and urgent inpatient admissions within one (1) business day following the admission. Authorization requests are required to be submitted within two (2) business days.

Notification of normal (well-baby nursery) newborn delivery is required within five (5) calendar days of delivery via DOM's Newborn Enrollment Form, found on the Division of Medicaid provider web portal. If complications develop with mother or baby that may necessitate additional hospital days or non well-baby or NICU admission, a prior authorization should be submitted along with clinical information to support the stay within one (1) business day of the decision that the higher level of care is needed. This Newborn Enrollment Form includes, among other things, the following information necessary to receive claim reimbursement:

- Mother's name, Medicaid number, and Admit Date
- Newborn name and date of birth (In the event, a name has not been selected at the time of discharge, please submit with the newborn's gender (Baby boy or Baby girl) and Last Name (ex. Baby boy Smith)
- Facility name, Physician name
- Delivery date, type of delivery, birth status (ex. Healthy, sick, stillborn, expired)
- Gender, weight, Apgar score, and gestational age of the newborn

Notification is required to track inpatient utilization, enable care coordination and discharge planning, and ensure timely claim payment. For questions regarding notification and, when applicable, to obtain prior authorization, please contact the Magnolia Medical Management Department by phone at:

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

## Emergency Services

### Routine, Urgent and Emergency Care Services Defined

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

The following are definitions for levels of service:

Routine - Services to treat a condition that would have no adverse effects if not treated within twenty-four (24) hours or could be treated in a less acute setting (e.g., physician's office) or by the patient. Examples include treatment of a cold, flu, or mild sprain.

Urgent* - Services furnished to treat an injury, illness, or another type of condition, including a behavioral health condition, usually not considered life-threatening, which should be treated within twenty-four (24) hours.

Emergency* - Services furnished to evaluate and/or stabilize an emergency medical condition that is found to exist using the prudent layperson standard. An emergency medical condition is a medical or mental health condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Placing the physical or mental health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment to bodily functions;
- Serious dysfunction of any bodily organ or part;
- Serious harm to self or others due to an alcohol or drug abuse emergency; Injury to self or bodily harm to others; or
- With respect to a pregnant woman having contractions; (i) that there is not adequate time to effect a safe transfer to another hospital before delivery, or (ii) that transfer may pose a threat to the health or safety of the woman or unborn child

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

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

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

- A participating physician with privileges at the treating hospital assumes responsibility for the

member's care;

- A participating physician assumes responsibility for the member's care through transfer; or
- The member is discharged.

Stabilized: With respect to an emergency medical condition, that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility, or, with respect to a woman in labor, the woman has delivered (including the placenta).

Discharge: Point at which member is formally released from hospital by treating physician, an authorized member of the physician's staff or by the member after they have indicated in writing their decision to leave the hospital contrary to the advice of their treating physician.

*Urgent, Emergency, or/and Post-Stabilization Services do not require prior authorization or pre-certification. Emergency and Post-Stabilization Services can be provided by a qualified Provider regardless of network participation. Magnolia is financially responsible for emergency and post-stabilization services regardless of network participation. For members admitted to the hospital, providers must notify Magnolia by the next business day, although no prior authorization is required.

The PCP plays a major role in educating Magnolia members about appropriate and inappropriate use of hospital emergency rooms. The PCP is responsible for following up with members who receive emergency care from other providers.

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

The attending emergency room physician, or the Provider actually treating the member, is responsible for determining when the Member is sufficiently stabilized for transfer or discharge, and that determination is binding on Magnolia. However, Magnolia may establish arrangements with a hospital whereby Magnolia may send one of its own physicians with appropriate emergency room privileges to assume the attending physician's responsibilities to stabilize, treat, and transfer the member, provided that such arrangement does not delay the provision of emergency services.

Magnolia will not retroactively deny a physician claim for an emergency screening examination because the condition, which appeared to be an emergency medical condition under the prudent layperson standard, turned out to be non-emergent in nature. However, the prudent layperson test will be applied to the payment to the facility for charges which fall outside of the diagnoses codes identified as an emergency.

For specific required information to submit, see the Inpatient Notification section of this manual.

## Voluntarily Leaving the Network

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

Magnolia will notify affected members in writing of a provider's termination at least sixty (60) days before the provider's disenrollment. If the terminating provider is a PCP, Magnolia will request that the member elect a new PCP. If a member does not elect a PCP prior to the provider's termination date, Magnolia will automatically assign a new PCP to the member.

Providers must continue to render covered services to members who are existing patients at the time of termination until the later of sixty (60) calendar days, the anniversary date of the member's coverage, or until Magnolia can arrange for appropriate health care for the member with a participating provider.

**Upon request from a member undergoing active treatment related to a chronic or acute medical condition, Magnolia will reimburse the provider for the provision of covered services for up to ninety (90) calendar days from the termination date. In addition, Magnolia will reimburse providers for the provision of covered services to members who are in the second or third trimester of pregnancy extending through the completion of postpartum care relating to the delivery. Exceptions may include:**

- Members requiring only routine monitoring
- Providers unwilling to continue to treat the member or accept payment from Magnolia

## Provider Standards and Procedures

**As specified by DOM, Magnolia providers will make PCP services available in accordance with the following standards:**

- Urgent care – Not to exceed twenty-four (24) hours.
- Routine sick patient care – Not to exceed seven (7) calendar days.
- Well care – Not to exceed thirty (30) calendar days.

Network providers must be accessible to members and maintain reasonable operating hours.

**Magnolia's standards for OB/GYN access are:**

- Initial appointment for a pregnant member within three (3) weeks of learning of pregnancy.
- Ongoing prenatal care during the first and second trimesters.
- Ongoing prenatal care during the third trimester.

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

| Type | Appointment Scheduling Time Frames |
|---|---|
| PCPs (well care visit) | Not to exceed thirty (30) calendar days |
| PCPs (routine sick visit) | Not to exceed seven (7) calendar days |
| PCPs (urgent care visit) | Not to exceed twenty-four (24) hours |
| Specialists | Not to exceed forty-five (45) calendar days |
| Dental Providers (routine visits) | Not to exceed forty-five (45) calendar days |

| Type | Appointment Scheduling Time Frames |
|---|---|
| Dental Providers (urgent care) | Not to exceed forty-eight (48) hours |
| Behavioral Health Providers (routine visit) | Not to exceed twenty-one (21) calendar days |
| Behavioral Health Providers (urgent visit) | Not to exceed twenty-four (24) hours |
| Behavioral Health Providers (post-discharge from an acute psychiatric hospital when Contractor is aware of the Member's discharge) | Not to exceed seven (7) calendar days |
| Urgent Care Providers | Not to exceed twenty-four (24) hours |
| Emergency Providers | Immediately (twenty-four (24) hours a day, seven (7) days a week) and without Prior Authorization |

**Telephone Arrangements**

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

- During after-hours, a provider must have arrangements for:
- Access to a covering provider
- An answering service
- A triage service
- A voice message that provides a phone number for after-hours assistance

The answering service must connect the caller to someone who can render a clinical decision or reach the PCP or specialist for a clinical decision. The PCP, specialty provider, or covering medical professional must return the call within thirty (30) minutes of the member's initial contact. Such after-hours coverage must be accessible using the medical office's daytime telephone number.

PCPs and Specialists must:

- Answer the member's telephone inquiries on a timely basis
- Schedule a series of appointments and follow-up appointments as needed by the member
- Identify and reschedule broken and no-show appointments
- Identify special member needs while scheduling an appointment (e.g., wheelchair and interpretive linguistic needs, non-compliant individuals, or those people with cognitive impairments)
- Adhere to the following response time for telephone call-back waiting times:
- After-hours telephone care for non-emergent, symptomatic issues within thirty (30) minutes

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

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

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

Magnolia will remind members of upcoming appointments when schedule by the care management department. If the member is obtaining transportation services through MTM and is not picked up, Magnolia will make outreach to the member to discuss.

## Covering Providers

Providers are to schedule continuous availability and accessibility of professional, allied health, and supportive personnel to provide covered services within normal working hours. Protocols shall be in place to provide coverage in the event of a provider's absence. PCPs and specialty providers must arrange for coverage with another Magnolia network provider during scheduled or unscheduled time off. In the event of unscheduled time off, please notify Provider Relations of coverage arrangements.

The covering provider must have an active Mississippi Medicaid ID number matching the active National Provider Identifier (NPI) number on file with DOM and Magnolia in order to receive payment.

If the participating provider is paid a fee-for-service by Magnolia, the covering provider is compensated in accordance with the fee schedule in the participating provider's agreement.

## Referrals

PCPs will coordinate all member healthcare services. PCPs are encouraged to refer a member to another Magnolia network provider whenever necessary. In most circumstances paper or electronic referrals are not required.

Magnolia encourages specialists to communicate with the member's PCP when a referral to another specialist is necessary, rather than making such a referral themselves. This allows the PCP to better coordinate their members' care and ensure that the referred specialty provider is a participating provider within the Magnolia network.

Providers are prohibited from making referrals for designated health services to healthcare entities with which the provider or a member of the providers' family has a financial relationship.

**To verify whether an authorization is necessary or to obtain a prior authorization, call:**

**Utilization Management/Prior Authorization Department**
Telephone 1-866-912-6285
Inpatient Fax: 1-877-291-8059

Outpatient Fax: 1-877-650-6943

www.magnoliahealthplan.com

Magnolia has the capability to perform the ANSI X 12N 278 referral certification and authorization transaction through Centene. **For more information on conducting this transaction electronically contact:**

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

**The following services do not require PCP authorization or referral:**

- Prescription drugs, including certain prescribed over-the-counter drugs
- Emergency services, including emergency ambulance transportation
- OB/GYN services with a participating provider
- Women's health services provided by a Federally Qualified Health Center (FQHC) or Certified Nurse Practitioner (CNP)
- Family planning services and supplies from a qualified DOM family planning provider
- Except for emergency and family planning services, the services above must be rendered by Magnolia's network providers

## Member Panel Capacity

Magnolia cannot guarantee that any PCP will maintain a minimum amount of members. However, all PCPs reserve the right to limit the number of members included in their panel. If a PCP does declare a specific capacity for their practice and wants to make a change to that capacity, the PCP must contact Magnolia provider services at 1–866-912-6285. A PCP shall not refuse to treat members as long as the provider has not reached their maximum panel size.

Providers shall notify Magnolia in writing at least forty-five (45) calendar days in advance of their inability to accept additional MississippiCAN members under their Magnolia agreements. In no event shall any established patient who becomes a covered person be considered a new patient.

## Advance Directives

Magnolia is committed to ensuring that its members are aware of and able to execute advance directives. Magnolia is equally committed to ensuring that its providers and staff are aware of and comply with their responsibilities under federal and state law regarding advance directives.

Providers delivering care to Magnolia members must ensure that members eighteen (18) years of age and older are informed of their right to execute advance directives. Providers must document such information in the member's permanent medical record.

**Magnolia recommends the following regarding advance directives:**

- The member's first point of contact in the provider's office should ask if the member has executed an advance directive, and the member's response should be documented in the medical record.
- If the member has executed an advance directive, the first point of contact should ask the member to bring a copy of the advance directive to the provider's office and document this request in the member's medical record.
- Once an advance directive is received, it should be included as a part of the member's medical record and should include mental health directives.

If an advance directive exists, the provider should discuss potential medical emergencies with the member and/or designated family member/significant other (if named in the advance directive and if available) and with the referring provider, if applicable. Any such discussion should be documented in the medical record.

**CULTURAL COMPETENCY**

At Magnolia, cultural competency is defined as the willingness and ability to value the importance of culture in the delivery of services to all segments of the population. Cultural competency is developmental, community-focused and family-oriented. In particular, it is the appreciation of differences and integration of cultural attitudes, beliefs and practices into diagnostic and treatment methods and throughout the healthcare system to support the delivery of culturally relevant and competent care to all racial and ethnic groups. It is also the development and continued promotion of skills among providers and staff to ensure that services are delivered in a culturally-competent manner.

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

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

**Providers must ensure that:**

- Members understand they have access to medical interpreters, signers, and TDD/TTY services to facilitate communication without cost to them.
- Medical care is provided with consideration of the member's race/ethnicity and language and its influences on the member's health or illness.
- Office staff that routinely interacts with members has access to and are encouraged to participate in cultural competency training and development.
- Office staff responsible for data collection makes reasonable attempts to collect race and language-specific member information. Staff will also explain race/ethnicity categories to a member so that the member is able to identify the race/ethnicity of themselves and their children.
- Treatment plans are developed and clinical guidelines are followed with consideration of the member's race, country of origin, native language, social class, religion, mental or physical abilities, heritage, acculturation, age, gender, sexual orientation, and other characteristics that may result in a different perspective or decision-making process.
- Office sites have posted and printed materials in English, and if required by DOM, any other required non-English language.

**BENEFIT EXPLANATION AND LIMITATIONS**

## Magnolia Health Plan Benefits

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

The following benefits are not covered under Magnolia Health Plan:

| NON-Covered Services: | Comments |
|---|---|
| Bariatric Surgery | |
| Cosmetic or Experimental Services | Phase I & II Clinical Trials are considered |
| Home Dialysis Equipment | |
| Infertility Diagnostics and Treatment | |

**MEDICAL MANAGEMENT**

## Overview and Medical Necessity

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

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

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

## Utilization Management

The Magnolia Utilization Management Program (UMP) is designed to ensure members receive access to the right care at the right place and right time. Our program is comprehensive and applies to all eligible members across all product types, age categories, and range of diagnoses. The UMP incorporates all care settings including preventive care, emergency care, primary care, specialty care, acute care, short term care, long term care, and ancillary care services.

Magnolia's UMP seeks to optimize a member's health status, sense of well-being, productivity, and access to quality health care, while at the same time actively managing cost trends. The UMP aims to provide services that are a covered benefit, medically necessary, appropriate to the patient's condition, rendered in the appropriate setting, and meet professionally recognized standards of care.

**Our program goals include:**

- Monitoring utilization patterns to guard against over or under utilization
- Development and distribution of clinical practice guidelines to providers to promote improved clinical outcomes and satisfaction
- Identification and provision of intensive care and/or disease management for members at risk for significant health expenses or ongoing care
- Development of an infrastructure to ensure that all Magnolia members establish relationships with their PCPs to obtain preventive care
- Implementation of programs that encourage preventive services and chronic condition self-management
- Creation of partnerships with members/providers to enhance cooperation and support for UMP goals

## Prior Authorization and Notifications

A Prior Authorization is a request to the Magnolia UM department for a medical necessity determination for services to be rendered. Prior authorization is required for all services included in the prior authorization list prior to the delivery of such services. Additionally, all services performed by non-participating providers, with the exception of basic laboratory chemistries and basic radiology, require prior authorization. Services that require prior authorization by Magnolia are listed in the Prior Authorization List found at www.magnoliahealthplan.com under provider/practice improvement resource center/manuals and reference guides. The provider should contact the UM department via fax, mail, secure email or through Magnolia's secure web portal with appropriate supporting clinical information to request an authorization.

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

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

Emergent, urgent care, and post-stabilization services do not require prior authorization. For emergent and urgent inpatient admissions, providers must notify Magnolia within one (1) business day following admission and submit clinical information before the end of two (2) business days following the admission. Providers should notify Magnolia of post-stabilization services such as, but not limited to, the weekend or holiday provision of home health, durable medical equipment, or urgent outpatient surgery within two (2) business days of the service initiation. Failure to notify may result in denial of payment.

Failure to obtain authorization may result in administrative claim denials. Magnolia providers are contractually prohibited from holding any Magnolia member financially liable for any service administratively denied by Magnolia for the failure of the provider to obtain timely authorization.

Please note that, to ensure claims payment, the final claim submission diagnosis must be the same primary diagnosis for which prior authorization was granted.

## Authorization Time Frames for Outpatient Services

For non-emergent outpatient services, prior authorization should be requested at least five (5) calendar days before the requested service delivery date. For pre-scheduled inpatient services, prior authorization should be requested at least fourteen (14) calendar days and no later than five (5) calendar days in advance.

Prior authorization determinations for standard outpatient services will be made within three (3) calendar days and/or two (2) business days following receipt of the request per Minimum Standards for Utilization Review Agents issued by the Mississippi State Department of Health (MSDH). If Magnolia requires additional medical information in order to make a decision, Magnolia will notify the requesting provider of additional medical information needed. Magnolia will allow three (3) calendar days and/or two (2) business days for the requesting provider to submit the medical information. If Magnolia does not receive the additional medical information, Magnolia will make a second attempt to notify the requestor of the additional medical information needed, and allow one (1) business day or three (3) calendar days for the requestor to submit medical information to Magnolia.

Once all information is received from the provider, if Magnolia cannot make a decision, the three (3) calendar day and/or two (2) business day period may be extended up to fourteen (14) additional calendar days upon request of the member or the provider to Magnolia, or if Magnolia justifies to DOM a need for additional information and how the extension is in the member's best interest. The extension request to DOM applies only after Magnolia has received all necessary medical information to render a decision and Magnolia requires additional calendar days to make a decision. Magnolia must provide to DOM the reason(s) justifying the additional calendar days needed to render a decision. DOM will evaluate Magnolia's extension request and notify Magnolia of decision within three (3) calendar days and/or two (2) business days of receiving Magnolia's request for extension.

Magnolia must expedite authorization for services when the provider indicates or Magnolia determines that following the standard authorization decision time frame could seriously jeopardize the member's life, health, or ability to attain, maintain, or regain maximum function. Magnolia must provide an Expedited Authorization Decision notice no later than twenty-four (24) hours after receipt of the expedited request. This twenty-four (24) hour period may be extended up to fourteen (14) additional calendar days upon request of the member, provider, or if Magnolia justifies to DOM a need for additional information and how the extension is in the member's best interest.

Requested information includes the results of any face-to-face clinical evaluation (including diagnostic testing) or second opinion that may be required. Failure to submit necessary clinical information may result in an administrative denial of the requested service.

**Authorization Timeframes for Inpatient Medical and Surgical Services**

Magnolia will determine medical necessity for urgent/emergent and non-emergency inpatient admission prior authorizations, continued stays, retroactive eligibility reviews and retrospective reviews for inpatient medical/surgical services provided to eligible Magnolia members. All hospital inpatient stays, except for emergent, urgent care, and post-stabilization services, require notification via an authorization request within two (2) business days of the admission. *(Please see specific requirements for emergent, urgent care, post stabilization services and OB/Newborn care which differ slightly for normal uncomplicated care)*

Prior authorization requests for pre-scheduled hospital inpatient services should be submitted at least fourteen (14) calendar days in advance and no later than five (5) calendar days in advance. Magnolia will ensure that determinations for non-emergency reviews are completed within twenty-four (24) hours of receipt.

Prior authorization is NOT required for emergent or urgent care services. If these services result in an admission then Magnolia must be notified within two (2) business days of admission. Magnolia will ensure that determinations for emergent or urgent care services are completed within twenty-four (24) hours (one business day) of receipt.

Magnolia must receive prior authorization requests for weekend and holiday admissions within two (2) business days of admission and will ensure that determinations for weekend and holiday reviews are completed within twenty-four (24) hours (one business day) of receipt.

Prior authorization requests for previously certified admissions must be submitted to Magnolia prior to the last certified day. Magnolia will ensure that determinations for continued stay reviews are completed within twenty-four (24) hours (one business day) of receipt.

Determinations regarding all retroactive eligibility reviews and retroactive inpatient hospital reviews will be completed within twenty (20) business days of receipt.

## Clinical Information

When calling our prior authorization department, a referral specialist will enter the demographic information and then transfer the call to a Magnolia nurse for the completion of medical necessity screening. During heavy call volumes, a nurse may answer the telephone and complete the medical necessity screening during the call. For all services on the prior authorization list, documentation supporting medical necessity will be required.

Magnolia clinical staff request clinical information minimally necessary for clinical decision making. All clinical information is collected according to federal and state regulations regarding the confidentiality of medical information. Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Magnolia is entitled to request and receive protected health information (PHI) for purposes of treatment, payment, and healthcare operations, with the authorization of the member.

**Information necessary for authorization of covered services may include, but is not limited to:**

- Member's name
- Member ID number
- Provider's name and telephone number
- Provider location if the request is for an ambulatory or office procedure
- Reason for the authorization request (e.g., primary and secondary diagnoses, planned surgical procedures, surgery date)
- Relevant clinical information (e.g., past/proposed treatment plan, surgical procedure, and diagnostic procedures to support the appropriateness and level of service proposed)
- Inpatient admission notification
- Discharge plans
- Notification of newborn deliveries should include the date and method of delivery, and information related to the newborn or neonate for outcomes reporting.

If additional clinical information is required, a Magnolia nurse or medical service representative will notify the caller of the specific information needed to complete the authorization process.

## Clinical Decisions

Magnolia affirms that utilization management decision-making is based only on appropriateness of care and service and the existence of coverage. Magnolia does not specifically reward practitioners or other individuals for issuing denials of service or care. Consistent with 42 CFR 438.6(h) and 422.208, delegated providers must ensure that compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any member.

The treating provider, in conjunction with the member, is responsible for making all clinical decisions regarding the care and treatment of the member. The PCP, in consultation with the Magnolia Medical Director and other clinical staff, is responsible for making utilization management (UM) decisions in accordance with the member's covered benefits and established medical necessity criteria. Failure to obtain authorization for services that require plan approval may result in payment denials.

## Medical Necessity

### Medical Necessity

**Medical necessity is defined for Magnolia members the most appropriate services that help achieve age-appropriate growth and development and will allow a member to attain, maintain or regain capacity.**

Medically Necessary services for children are limited in that such services must be necessary to correct or ameliorate defects, physical and mental illnesses, or conditions that are discovered during an EPSDT screen, periodic or inter-periodic, whether or not such services are covered or exceed the benefit limits in the Mississippi Medicaid state plan. All services for children that are determined to be medically necessary are covered.

## Review Criteria

Magnolia has adopted utilization review criteria developed by McKesson InterQual® products to determine medical necessity for healthcare services. InterQual appropriateness criteria are developed by specialists representing a national panel from community-based and academic practice. InterQual criteria cover medical and surgical admissions, outpatient procedures, referrals to specialists, and ancillary services. Criteria are established and periodically evaluated and updated with appropriate involvement from providers. InterQual is utilized as a screening guide and is not intended to be a substitute for practitioner judgment. Magnolia's Medical Director reviews all potential medical necessity denials and will make a decision in accordance with currently accepted medical or healthcare practices, taking into account special circumstances of each case that may require deviation from the norm in the screening criteria.

Providers may obtain the criteria used to make a specific adverse determination by contacting the medical management department at 1-866-912-6285. Practitioners also have the opportunity to discuss any medical or pharmaceutical UM denial decisions with a provider or other appropriate reviewer at the time of notification to the requesting practitioner/facility of an adverse determination. The Medical Director may be contacted by calling Magnolia at 1-866-912-6285 and asking for the Medical Director. A care manager may also coordinate communication between the Medical Director and requesting practitioner.

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

**Magnolia Health Clinical Appeals Coordinator**
111 East Capitol Street, Suite 500
Jackson, MS 39201
1-866-912-6285
Fax 1-877-851-3995

## MRI, CT and PET Scan Authorization

A prior authorization is required for MRI, CT and PET scans in an outpatient setting. Inpatient and ER procedures do not require authorization. National Imaging Associates (NIA) has been selected by Magnolia to administer this program. The servicing provider (PCP or Specialist) is responsible for obtaining the authorization for these procedures.

Servicing providers may request an authorization and check the status of an authorization request by visiting www.radmd.com or by calling 1-800-642-7554. All claims should be submitted to Magnolia through the normal claims process.

## New Technology

Magnolia evaluates the inclusion of new technology and the new application of existing technology for coverage determination. This may include medical procedures, drugs and/or devices. The Medical Director and/or medical management staff may identify relevant topics for review pertinent to the Magnolia population. The Clinical Policy Committee (CPC) reviews all requests for coverage and makes a determination regarding any benefit changes that are indicated.

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

## Concurrent Review

Magnolia's Medical Management Department will concurrently review the treatment and status of all inpatient members through contact with the hospital's Utilization and Discharge Planning Departments and when necessary, the member's attending physician. 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. Magnolia's Medical Management Department may contact the member's admitting physician's office prior to the discharge date established during the authorization process, to check on the member's progress, and to make certain that the member receives medically necessary follow up services.

## Discharge Planning

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

## Retrospective Review

Retrospective review is an initial review of services provided to a member, but for which authorization and/or timely notification to Magnolia was not obtained due to extenuating circumstances related to the member (i.e., member was unconscious at presentation, member did not have their Magnolia card or otherwise indicated Magnolia coverage, services authorized by another payer who subsequently determined member was not eligible at the time of service).

Requests for retrospective review, for services authorized by Magnolia, must be submitted promptly upon identification but no later than ninety (90) days from the first date of service. A decision will be made within 30 calendar days following receipt of all necessary information for any qualifying service cases.

## 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. Observation Bed Services are those services furnished on a hospital's premises, including use of a bed and periodic monitoring by a hospital's nurse or other staff. These services may be reasonable and necessary to:

- Evaluate an acutely ill patient's condition
- Determine the need for a possible inpatient hospital admission
- Provide aggressive treatment for an acute condition

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

Providers are required to notify Magnolia's Medical Management Department of an observation stay by the next business day. Notification is required to track inpatient utilization, enable care coordination, discharge planning, and ensure timely claim payment. The notification must include complete clinical information supporting the observation with a discharge date. A medical necessity determination will be made within three (3) calendar days/two (2) business days of receiving all required information. To provide notification and obtain prior authorization, please contact Magnolia's Medical Management Department at:

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

In those instances where a member begins hospitalization in an observation status and is subsequently upgraded to an inpatient admission, all incurred observation charges and services will be rolled into the acute reimbursement rate, or as designated by the contractual arrangement with Magnolia, and cannot be billed separately. It is the responsibility of the hospital to notify Magnolia of the inpatient admission by the next business day after admission with clinical information.

Providers should not substitute outpatient observation services for medically-appropriate inpatient hospital admissions.

## Second Opinion

Members, or a healthcare professional with the member's consent, may request and receive a second opinion from a qualified professional within the Magnolia network. If there is not an appropriate provider to render the second opinion within the Magnolia network, the member may obtain the second opinion from an out-of-network provider at no cost to the member.

## Assistant Surgeon

Assistant surgeon reimbursement is provided when medically necessary. Magnolia utilizes guidelines for assistant surgeons as set forth by the American College of Surgeons.

Hospital medical staff by-laws that require an assistant surgeon be present for a designated procedure are not grounds for reimbursement. Medical staff by-laws alone do not constitute medical necessity, nor is reimbursement guaranteed when the patient or family requests that an assistant surgeon be present for the surgery. Coverage and subsequent reimbursement for an assistant surgeon's service is based on the medical necessity of the procedure itself and the assistant surgeon's presence at the time of the procedure.

## Notification of Pregnancy (NOP)

Members that become pregnant while covered by Magnolia may remain a Magnolia member during their pregnancy. The managing provider should notify the Magnolia prenatal team by completing the NOP Form within five (5) days of the first prenatal visit. The NOP Form can be found on the Magnolia website at www.magnoliahealthplan.com under provider/practice improvement resource center/forms and applications. Providers should identify the estimated date of confinement and delivery facility. The NOP includes an optional prenatal vitamin order form. Magnolia will facilitate the provider's order of a ninety (90) day supply of prenatal vitamins for the member to be delivered to the managing provider's office by the member's next prenatal visit. See the Care Management section for information related to our Start Smart for Your Baby® Program and our 17-P Program for women with a history of early delivery.

## Newborns

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.

The Division of Medicaid Newborn Enrollment Form serves as notification for all normal (well baby nursery) deliveries. All other newborns (anything other than well baby) must notify Magnolia within one business day of admission.

For mothers the Division of Medicaid Newborn Enrollment Form serves as notification of delivery unless the mother has some complication that extends a routine vaginal delivery beyond 3 days or a C-section delivery beyond 5 days. In that case Magnolia must be notified within one business day of the day that the complication necessitating additional days was noted.

# PHARMACY

## Pharmacy Program

Magnolia is committed to providing appropriate, high-quality, and cost-effective drug therapy to all Magnolia members. Magnolia works with providers and pharmacists to ensure that medications used to treat a variety of conditions and diseases are covered. Magnolia covers prescription drugs and certain over-the-counter (OTC) drugs when ordered by a provider registered with DOM; however, the pharmacy program does not cover all medications. Some medications require prior authorization or have limitations on age, dosage and/or maximum quantities. DOM decides which medications are preferred and non-preferred for Magnolia.

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

## Preferred Drug List

Magnolia has a list of covered medications called the Preferred Drug List (PDL). This PDL is developed by DOM and is consistent across all coordinated care organizations and DOM fee for service. DOM reviews the PDL regularly and determines what, if any, changes should be made. This process is coordinated with Magnolia.

Medications currently listed on the PDL should be appropriate to treat the vast majority of medical conditions encountered by Magnolia providers.

For the most current PDL, please visit Magnolia's website at www.magnoliahealthplan.com under provider/pharmacy.

## Working with Magnolia's Pharmacy Benefit Manager (PBM)

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

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

**Follow these steps for efficient processing of your PA requests:**

1. Complete the Magnolia/US Script form: Medication Prior Authorization Request Form that can be found on the Magnolia website at www.magnoliahealthplan.com under provider/practice information resource center/pharmacy.
2. Fax completed forms to US Script at 1-866-399-0929
3. Once approved, US Script notifies the prescriber by fax
4. If the clinical information provided does not explain the reason for the requested prior authorization medication, US Script responds to the prescriber by fax, offering DOM PDL alternatives
5. For urgent or after-hours requests, a pharmacy can provide up to a seventy-two (72) hour supply of most medications by calling the US Script Pharmacy Help Desk at: 1-800-460-8988.

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

US Script Contacts:

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

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

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

Providers are requested to utilize the DOM PDL when prescribing medication to Magnolia members. If a pharmacist receives a prescription for a drug that requires a prior authorization request, the pharmacist should attempt to contact the provider to submit a prior authorization to US Script for review.

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

## Emergency Drug Supply

Magnolia follows the seventy-two (72) hour emergency supply policy: state and federal law require that a pharmacy dispense a seventy-two (72) hour (three [3] day) supply of medically necessary medication to any member awaiting a prior authorization determination. The purpose of providing members this emergency drug supply is to avoid interruption of current therapy or delay the initiation of therapy. All participating pharmacies are authorized to provide a seventy-two (72) hour supply of medication and will be reimbursed for the ingredient cost and dispensing fee of the seventy-two (72) hour supply of medication, whether the prior authorization request is ultimately approved or denied.

## Working with Magnolia's Specialty Pharmacy Providers

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

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

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

## Over-the-Counter Medications

The Magnolia pharmacy program covers a variety of OTC medications. All OTC medications must be written on a valid prescription, by a licensed provider.

## Quantity Limitations

Quantity limitations have been implemented on certain medications to ensure the safe and appropriate use of the medications. Quantity limitations are approved by DOM and noted throughout the PDL.

## Step Therapy

Medications requiring step therapy are listed with a "ST" notation throughout the PDL. The US Script claims system will automatically check the member profile for evidence of prior or current usage of the required agent. If there is evidence of the required agent on the member's profile, the claim will automatically process. If not, the claims system will notify the pharmacist that a prior authorization is required.

### Age Limits

Some medications on the DOM PDL may have age limits. These are set for certain drugs based on FDA-approved labeling and for safety concerns and quality standards of care. Age limits align with current FDA alerts for the appropriate use of pharmaceuticals.

### Newly Approved Products

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

### Unapproved Use of Preferred Medication

Medication coverage under this program is limited to non-experimental indications as approved by the FDA. Other indications may also be covered if they are accepted as safe and effective using current medical and pharmaceutical reference texts and evidence-based medicine. Reimbursement decisions for specific non-approved indications will be made by DOM. Experimental drugs, investigational drugs, and drugs used for cosmetic purposes are excluded from coverage.

### Take Home Drugs, Supplies, and Equipment

Drugs for use in a hospital that are ordinarily furnished by the hospital for the care and treatment of the member are covered. However, take home drugs are not covered. If continued administration is necessary, a member may, upon discharge from the hospital, take home remaining amounts of drugs that have been supplied either on prescription or doctor's order, since the drugs would have been charged to the member's account by the hospital.

Supplies and appliances furnished to a member solely for use outside the hospital are not covered. Thus, the reasonable cost of oxygen furnished for treatment of the member solely during the inpatient stay is covered, but oxygen furnished solely for use outside the hospital is not covered. Durable medical equipment (DME) furnished by the hospital solely during the inpatient stay is covered, but equipment furnished solely for use outside the hospital is not.

Supplies ordinarily furnished by the hospital for the care and treatments of the member solely during the member's stay in the hospital are covered. Additionally, under circumstances where it would be unreasonable or impossible from a medical standpoint to limit supplies to the inpatient stay, supplies received during the hospital stay are covered even though the member is discharged with these supplies. Examples of items covered under this exception are cardiac valves, cardiac pacemakers, and items such as tracheotomy or drainage tubes which are temporarily installed in or attached to the member's body and which are necessary to permit or facilitate the member's discharge.

## EPSDT

The Early Periodic Screening, Diagnosis, and Treatment (EPSDT) service is Medicaid's comprehensive and preventive child health program for individuals under the age of twenty-one (21), the provision of which is mandated by state and federal law. EPSDT services include periodic screening, vision, dental, and hearing services. In addition, the need for corrective treatment disclosed by such child health screenings must be arranged (directly or through referral), even if the service is not available under the State's Medicaid plan to the rest of the Medicaid population.

Magnolia provides the full range of EPSDT services as defined in, and in accordance with, DOM policies and procedures. Such services shall include, without limitation, periodic health screenings and appropriate up-to-date immunization using the Advisory Committee on Immunization Practices (ACIP) recommended immunization schedule and the American Academy of Pediatrics periodicity schedule for pediatric preventative care.

**Periodic Health Screening must include:**

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

**Periodic Schedule:**

Frequency of periodic health screening is as follows:

• 0 – 1 month
• 2 months
• 4 months
• 6 months
• 9 months
• 12 months
• 15 months
• 18 months

Provision of all components of the EPSDT service must be clearly documented in the PCP's medical record for each member. Further, PCPs are required to report encounter data associated with EPSDT screens to Magnolia within one hundred and eighty (180) days from the date of service.

Magnolia requires that providers cooperate to the maximum extent possible with efforts to improve the health status of Mississippians, and to actively participate in the increase in percentage of eligible members obtaining EPSDT services in accordance with the adopted periodicity schedules. Should the PCP be unable to conduct the necessary EPSDT screens, the PCP is responsible for arranging to have the necessary EPSDT screens conducted by another Magnolia network provider and ensure that all relevant medical information, including the results of the EPSDT screens, are incorporated into the member's PCP medical record.

Magnolia will cooperate and assist providers to identify and immunize all members whose medical records do not indicate up-to-date immunizations. Providers are responsible to follow up with Members who are not in compliance with the EPSDT screening requirements and EPSDT services to include missed appointments. Providers are required to document the reason for noncompliance, where possible, and to document their efforts to bring the member's care into compliance with the standards.

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

Please see the Billing and Claims Submission section for information on submitting claims for EPSDT services.

**VALUE ADDED SERVICES**

## NURSEWISE

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

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

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

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

## CentAccount® Program

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

How does it work? Members will receive a prepaid debit card. Credit will be added to the account balance once the member completes healthy behaviors. These healthy behaviors begin with members completing the Health Information Form included in the member welcome packet.

The CentAccount card can be used at participating stores to pay for items such as:

- Baby care
- Diabetes care
- Eye care
- Groceries
- Over-the-counter medicines
- Personal care items
- Wellness items

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

## CARE MANAGEMENT PROGRAM

Magnolia's care management program is designed to help Magnolia members obtain needed services, whether the services are available within the Magnolia array of covered benefits, from their local community, or from other non-covered venues. Our care management model supports the entire range of our provider network, from an individual practice to a large multi-specialty group setting.

The program is based upon a coordinated care model that uses a multi-disciplinary care management team, recognizing that multiple co-morbidities will be common among our membership. The goal of our program is to help members achieve the highest possible levels of wellness, functioning, and quality of life, while decreasing the need for ongoing disruption at the provider's office with administrative work.

The program includes a systematic approach for early identification of eligible members, a needs assessment, and development and implementation of an individualized care plan. This plan includes member/family education, as well as outcome monitoring and reporting back to the PCP, and actively links the member to both providers and support services,. Our care management team integrates covered and non-covered services and provides a holistic approach to a member's medical and, when available, behavioral health care, as well as functional, social, and other needs. Our program incorporates clinical determinations of need, functional status, and barriers to care such as lack of caregiver supports, impaired cognitive abilities and transportation needs.

In order to ensure that appropriate referrals and connections are made for the members, Magnolia provides continuity of care services. Continuity of care synchronizes medical, social, and financial services and may include management across payer sources.

We proactively identify new members receiving services from non-contracted providers, educate members and providers to ensure providers continue providing necessary services, and develop transition plans for incoming and outgoing members by providing all care management history and six (6) months of claims history and other pertinent information related to any special needs.

In the event a Medicaid or Magnolia eligible member is receiving medically necessary covered services at the time of enrollment, Magnolia will honor a transition period of up to thirty (30) calendar days if the existing provider is nonparticipating. If the new enrollee is in her second or third trimester of pregnancy, Magnolia will provide continued access to the prenatal care provider regardless of whether that provider is participating in Magnolia's network.

Magnolia's transitional care process identifies members who are most at risk for hospital readmission and deploys specific interventions aimed at addressing the barriers known to contribute to readmission. The transitional care team coordinates care for high and moderate risk members transitioning from one setting to another and assists them with accessing services that help them remain in an optimal setting for health and wellness. The team accomplishes this by collaborating with concurrent review and hospital staff to identify these members as soon as possible to complete a comprehensive assessment of the member's post-discharge needs. Key areas of focus include communication with attending providers, the member's PCP, treating behavioral health providers and other outpatient providers; post-discharge appointment scheduling with providers and for tests and services; member and caregiver understanding of the condition and its management as well as early recognition of symptoms; medication reconciliation; caregiver support; and coordination with appropriate community agencies.

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

**To contact a care manager call:**

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

## High Risk Pregnancy Program:

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

## The SSI/Complex Teams

Care managers are familiar with evidence-based resources and best practice standards specific to conditions common among adults and children. These care management teams will be led by clinical licensed care managers with either adult or pediatric expertise, as applicable. For both adult and pediatric teams, the staff has experience with the population, the barriers and obstacles they face, and the socioeconomic impacts on their ability to access services. The teams will manage care for members whose needs are primarily functional as well as those with such complex conditions as breast or cervical cancer, trauma, organ transplants, and renal dialysis. Foster care members and children with special health care needs are at special risk and are also eligible for enrollment in care management. Magnolia will use a holistic approach by integrating referral and access to community resources, transportation, follow-up care, medication review, specialty care, and education to assist members in making better health care choices.

A Transplant Coordinator will provide support and coordination for members who need organ transplants. All members considered as potential transplant candidates should be immediately referred to the Magnolia care management department for assessment and care management services. Each candidate is evaluated for coverage requirements and will be referred to the appropriate agencies and transplant centers.

## MemberConnections® Program

MemberConnections is Magnolia's outreach program designed to provide education to our members on how to access healthcare and develop healthy lifestyles in a setting where they feel most comfortable. The program components are integrated as a part of our care management program in order to link Magnolia and the community served. The program recruits staff from the communities serviced to establish grassroots support and awareness of Magnolia within the community. The program has various components depending on the needs of the member.

Members can be referred to MemberConnections through numerous sources. Members who call Magnolia to talk with the member services department may be referred to MemberConnections for a more personalized discussion. Additionally, care managers may identify members who would benefit from one of the many MemberConnections resources available through completion of a referral request. Providers may also request MemberConnections referrals directly from the connections representative or their assigned care manager.

Program components include:

- Community Connections: Connection representatives are available to present during events initiated by state entities, community groups, clinics, or during any other approved setting. This form of community connections is extremely useful in rural areas where home visits may be the only mode of communication. Presentations typically include information on DOM's coordinated care program,, an overview of services offered by Magnolia, how to access Magnolia services, the importance of obtaining primary preventive care, and other valuable information related to obtaining services from Magnolia and its providers.
- Home Connections: Connection representatives are available on a full-time basis at the request of members and providers and whenever a need arises. All home visits are pre-scheduled with the member unless the visit is a result of being unable to locate a member. Topics covered during a home visit include overview of covered benefits, how to schedule an appointment with the PCP, the importance of preventive health care, appropriate use of preventive, urgent, and emergency care services, obtaining medically necessary transportation, and how to contact Magnolia for assistance.
- Phone Connections: Connection representatives may contact new members or members in need of more personalized information to review Magnolia's material over the telephone. All the topics listed above may be covered and any additional questions will be answered.
- Connections Plus®: Connections representatives work together with the high risk OB care management team for high risk members who do not have safe, reliable phone access. When a member qualifies, a connections representative visits the member's home and gives them a free, pre-programmed cell phone with limited use. Members may use this cell phone to call a Magnolia care manager, PCP, specialty provider, NurseWise, 911, or other members of their health care team. In some cases, Magnolia may provide MP-3 players with pre-programmed education programs for those with literacy issues or in need of additional education.

**To contact the MemberConnections Team call:**

**Magnolia Health**
MemberConnections
1-866-912-6285

## Disease Management (DM) Programs

DM program components include:

- Increasing coordination between medical, social, and educational communities
- Severity and risk assessments of the population
- Profiling the population and providers for appropriate referrals
- Ensuring active and coordinated provider/specialist participation
- Identifying modes of delivery for coordination of care services such as home visits, clinic visits, and phone contacts depending on the circumstances and needs of the member and his/her family
- Increasing the member's and caregiver's ability to manage chronic conditions; and coordination with a Magnolia care manager for care management services

The DM programs target members with selected chronic diseases which may not be under control. New members are assessed and stratified in order to accurately assign them to the most appropriate level of intervention. Interventions may include mailed information for low intensity cases, telephone calls and mailings for moderate cases, or home visits by a health coach for members categorized as high risk.

Magnolia's affiliated DM company, Nurtur, will administer DM programs which include services for chronic diseases such as asthma, diabetes, hypertension, heart failure and obesity.

**To refer a Member for disease management call:**

**Magnolia Heath**
Health Coach
1-866-912-6285

**Behavioral Health Services**

Magnolia offers our members access to all covered, medically necessary behavioral health services through Cenpatico Behavioral Health, LLC® (CBH).

Magnolia members seeking mental health or substance abuse services may self-refer to a network provider for thirty (30) standard outpatient sessions per member, but prior authorization is required for subsequent visits. For assistance in identifying a behavioral health provider or for prior authorization for inpatient or outpatient services, CBH may be reached at 1-866-912-6285 or via their website at www.cenpatico.com .

In the event that a physician or practitioner is unable to provide timely access for a member, CBH will assist in securing authorization to a physician or practitioner to meet the member's needs in a timely manner.

**CREDENTIALING and RE-CREDENTIALING**

The credentialing and re-credentialing process exists to ensure that participating providers meet the criteria established by Magnolia, as well as government regulations and standards of accrediting bodies. All providers who participate in the Magnolia MississippiCAN Program must have an active Medicaid ID number, and credentialing cannot begin without this active Medicaid ID.

*Note: In order to maintain a current provider profile, providers are required to notify Magnolia of any relevant changes to their credentialing information in a timely manner.*

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

- Complete signed and dated Mississippi Uniform Credentialing application or authorization for Magnolia to access CAQH (Council for Affordable Quality Health Care) for the completed Mississippi Uniform Credentialing application
- Signed attestation of the correctness and completeness of the application, history of loss of license and/or clinical privileges, disciplinary actions, and/or felony convictions; lack of current illegal substance registration and/or alcohol abuse; mental and physical competence; and ability to perform the essential functions of the position, with or without accommodation

- Copy of current malpractice insurance policy face sheet that includes expiration date, amount of coverage and provider's name, or evidence of compliance with Mississippi regulations regarding malpractice coverage
- Copy of current Mississippi Controlled Substance registration certificate (if applicable)
- Copy of current Drug Enforcement Administration (DEA) registration certificate
- Copy or original of completed Internal Revenue Service Form W-9
- Copy of Educational Commission for Foreign Medical Graduates (ECFMG) certificate, if applicable
- Copy of cultural competency training certificate, if applicable
- Copy of current unrestricted medical license to practice in the state of Mississippi
- Current copy of specialty/board certification, if applicable
- Curriculum vitae listing to include, at a minimum, a five (5) year work history (not required if work history is completed on the application)
- Signed and dated release of information form (not older than 120 calendar days)
- Proof of highest level of education – copy of certificate or letter certifying formal post-graduate training
- Copy of current Patient Care Compensation Fund (PCCF), if applicable
- Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable
- Copy of enumeration letter issued by National Plan and Provider Enumeration System (NPPES), depicting the providers' unique National Provider Identifier (NPI)

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

- Mississippi license through appropriate licensing agency
- Board certification, residency training, or medical education
- National Practitioner Data Bank (NPDB) for malpractice claims and license agency actions
- Hospital privileges in good standing at a participating Magnolia hospital
- Five (5) year work history

Federal sanction activity including Medicare/Medicaid sanctions, Office of Inspector General (OIG) exclusions, and the Excluded Parties List System (EPLS)Once a complete application is received and reviewed, the Magnolia Credentialing Committee (Credentialing Committee) will render a final decision on network acceptance during its next regularly scheduled meeting**. Providers must be credentialed prior to accepting or treating members unless a prior authorization is obtained. Further, PCPs cannot accept member assignments until they are fully credentialed.**

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

All credentialing and re-credentialing applications will be reviewed and properly adjudicated by Magnolia no later than ninety (90) days after receipt of a complete application.

## Credentialing Committee

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

## Re-Credentialing

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

## Ongoing Monitoring

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

Additionally, between credentialing cycles, a provider may be required to supply current proof of credentials such as Mississippi licensure, malpractice insurance, DEA registration, a copy of certificate of cultural competency training, or other credentials that have expiration dates prior to the next review.

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

A provider's agreement may be terminated if at any time Magnolia's Credentialing Committee determines that credentialing requirements are no longer being met.

## Right to Review and Correct Information

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

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

## Right to Be Informed of Application Status

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

## Right to Appeal Adverse Credentialing Determinations

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

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

### MEMBER RIGHTS AND RESPONSIBILITIES

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

- To receive information about Magnolia, its benefits, its services, its network providers, and member rights and responsibilities.
- To be treated with respect and with due consideration for their dignity and the right to privacy and non-discrimination as required by law.
- To access all covered services, including certified nurse midwife services and pediatric or family nurse practitioner services.
- To participate with their physicians in making decisions regarding their healthcare, including the right to refuse treatment.
- To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, as specified in the Federal regulations on the use of restraints and seclusion.
- To receive healthcare services that are accessible, comparable in amount, duration, and scope to those provided to other members under Magnolia and are sufficient in amount, duration, and scope to reasonably be expected to achieve the purpose for which the services are furnished.
- To receive services that are appropriate and not denied or reduced solely because of diagnosis, type of illness, or medical condition.

- To receive assistance from Magnolia in understanding the requirements and benefits of Magnolia.
- To receive family planning services from any participating Magnolia physician without prior authorization.
- To have a candid discussion about appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.
- To receive information on the Grievance and Appeal procedures.
- To voice grievances or file appeals about Magnolia decisions that affect their privacy, benefits, or the care provided.
- To request and receive a copy of their medical record.
- To make recommendations regarding Magnolia's member rights and responsibilities policies.
- To request that their medical record be corrected.
- To expect their medical records and care be kept confidential as required by law.
- To receive Magnolia's policy on referrals for specialty care and other benefits not provided by the member's PCP.
- To privacy of healthcare needs and information as required by federal law (Standards for Privacy of Individually Identifiable Health Information).
- To exercise these rights without adversely affecting the way Magnolia and its network providers treat them.
- To allow or refuse their personal information to be sent to another party for other uses unless the release of information is required by law.
- To choose a PCP and to change to another PCP in Magnolia's network.
- To receive timely access to care, including referrals to specialists when medically necessary, without barriers.
- To receive materials – including enrollment notices, information materials, instructional materials, and available treatment options and alternatives – in a manner and format that may be easily understood.
- To make an advance directive, such as a living will.
- To choose a person to represent them regarding the use of their information by Magnolia if they are unable to do so.
- To get a second opinion from a qualified healthcare professional.
- To receive oral interpretation services for all non-English languages free of charge.
- To be notified that oral interpretation is available and how to access those services.
- As a potential member, to receive information about the basic features of managed care, which populations may or may not enroll in the program, and Magnolia's responsibilities for coordination of care in a timely manner.
- To receive information on the following:
    - Benefits covered
    - Procedures for obtaining benefits, including any authorization requirements

- Cost sharing requirements
- Service area
- Names, locations, telephone numbers and non-English language spoken by current Magnolia providers, including at a minimum, PCPs, specialists, and hospitals
- Any restrictions on freedom of choice among network providers
- Doctors who are not accepting new patients
- Benefits not offered by Magnolia and how to obtain those benefits

- To receive a complete description of disenrollment rights at least annually.
- To receive notice of any significant changes in the Benefits Package at least thirty (30) days before the intended effective date of the change.
- To receive detailed information on emergency and after-hours coverage, including, but not limited to:
  - What constitutes an emergency medical condition, emergency services, and post-stabilization services
  - Those emergency services that do not require prior authorization, including the process and procedures for obtaining emergency services
  - The locations of any emergency settings and other locations at which physicians and hospitals furnish emergency services and post-stabilization services covered under the contract
  - Their right to use any hospital or other setting for emergency care
  - Post-stabilization care services rules in accordance with Federal guidelines

**Magnolia members have the following responsibilities:**

- To inform Magnolia of the loss or theft of their ID card.
- To present their ID card when using healthcare services.
- To be familiar with Magnolia procedures to the best of their ability.
- To call or contact Magnolia to obtain information and have questions clarified.
- To provide information (to the extent possible) that Magnolia and its physicians need in order to provide care.
- To follow the prescribed treatment plans and instructions for care that have been agreed upon with their physicians.
- To inform their physician on reasons they cannot follow the prescribed treatment of care
- To understand their health problems and participate in developing mutually agreed-upon treatment goals.
- To keep their medical appointments and follow-up appointments.
- To access preventive care services.
- To follow the policies and procedures of Magnolia.
- To be honest with physicians and treat them with respect and kindness.
- To get regular medical care from their PCP before seeing a specialist.

- To follow the steps of the appeal process.
- To notify Magnolia, DOM, and their physicians of any changes that may affect their membership, healthcare needs, or their access to benefits. **Some examples may include:**
    - If they have a baby
    - If their address changes
    - If their telephone number changes
    - If they or one of their children are covered by another plan
    - If they have a special medical concern
    - If their family size changes
    - To be on time for their scheduled appointments.
- To cancel their scheduled appointments at least twenty-four (24) hours in advance if they cannot keep an appointment.
- To access care by following Magnolia rules, as failure to do so may cause them to be responsible for the charges.

## Provider Rights and Responsibilities

**Magnolia providers have the following rights:**

- To be treated by Magnolia members and other health care workers with dignity and respect.
- To receive accurate and complete information and medical histories for members' care.
- To have Magnolia members act in a way that supports the care given to other patients and that helps keep the provider's office, hospital, or other offices running smoothly.
- To expect other network providers to act as partners in members' treatment plans.
- To expect members to follow their directions, such as taking the right amount of medication at the right times.
- To file a grievance with Magnolia on behalf of a member, with the member's consent.
- To file claim reconsideration, claim appeal and claim dispute requests.
- To file a grievance or complaint regarding dissatisfaction with any matter other than an adverse action.
- To access information about Magnolia's QI programs, including program goals, processes, and outcomes that relate to member care and services, including information on safety issues.
- To contact Magnolia's provider services with any questions, comments, or problems, including suggestions for changes in the QI Program's goals, processes, and outcomes related to member care and services.
- To allow members to request restriction on the use and disclosure of their personal health information.
- To make a complaint or file an appeal against Magnolia and/or a Magnolia member.
- To collaborate with other health care professionals who are involved in the care of members.
- To review clinical practice guidelines distributed by Magnolia.

- To invite member participation, to the extent possible, in understanding any medical or behavioral health problems that the member may have and to develop mutually agreed upon treatment goals.
- Not to be excluded, penalized, or terminated from network participation for accumulating a substantial number of Magnolia members with high-cost medical conditions.
- To object to providing relevant or medically necessary services on the basis of the provider's moral or religious beliefs or other similar grounds.

**Magnolia providers have the following responsibilities:**

- To ensure awareness of and compliance with their personal and staff responsibilities under federal and state law regarding advance directives. (See Advance Directives section)
- To help or advocate for members to make decisions within the provider's scope of practice about the member's relevant and/or medically necessary care and treatment, including the right to:
    - Recommend new or experimental treatments
    - Provide information regarding the nature of treatment options
    - Provide information about the availability of alternative treatment options, therapies, consultations, and/or tests, including those that may be self- administered
    - Be informed of the risks and consequences associated with each treatment option or choosing to forego treatment
- To treat members with fairness, dignity, and respect.
- Not to discriminate against members on the basis of race, color, national origin, disability, age, religion, mental or physical disability, or limited English proficiency.
- To maintain the confidentiality of members' personal health information, including medical records and histories, and adhere to state and federal laws and regulations regarding confidentiality.
- To give members a notice that clearly explains their privacy rights and responsibilities as it relates to the provider's practice.
- To provide members with an accounting of the use and disclosure of their personal health information in accordance with HIPAA.
- To provide members, upon request, access to inspect and receive a copy of their personal health information, including medical records.
- To provide clear and complete information to members, in a language they can understand, about their health condition and treatment, regardless of cost or benefit coverage, and allow the member to participate in the decision-making process.
- To tell a member if the proposed medical care or treatment is part of a research experiment and give the member the right to refuse experimental treatment.
- To allow a member who refuses or requests to stop treatment the right to do so, as long as the member understands that by refusing or stopping treatment the condition may worsen or be fatal.
- To respect members' advance directives and include these documents in the members' medical record.

- To allow members to appoint a parent, guardian, family member, or other representative if they cannot fully participate in their treatment decisions.
- To allow members to obtain a second opinion, and answer members' questions about how to access healthcare services appropriately.
- To obtain and report to Magnolia information regarding other insurance coverage.
- To follow all state and federal laws and regulations related to patient care and patient rights.
- To participate in Magnolia data collection initiatives, such as HEDIS and other contractual or regulatory programs.
- To comply with Magnolia's Medical Management program as outlined in this manual.
- To notify Magnolia in writing if the provider is leaving or closing a practice.
- To contact Magnolia to verify member eligibility or coverage for services, if appropriate.
- To disclose overpayments or improper payments to Magnolia.
- To provide members, upon request, with information regarding office location, hours of operation, accessibility, and languages, including the ability to communicate with sign language.
- To provide members, upon request, with information regarding the provider's professional qualifications, such as specialty, education, residency, and board certification status.
- To disclose to Magnolia, on an annual basis, any physician incentive plan (PIP) or risk arrangements the provider or provider group may have with providers either within its group practice or other providers not associated with the group practice, even if there is no substantial financial risk between Magnolia and the provider or provider group.
- To give Magnolia appropriate notice prior to voluntarily leaving the network at the end of the initial term or at the end of any renewal term in accordance with the "Term and Termination" section of the provider agreement. Providers are advised to send termination notices via certified mail (return receipt requested) or overnight courier for the request to be valid. In addition, providers are required to supply copies of medical records to the member's new provider and facilitate the member's transfer of care at no charge to Magnolia or the member.
    - To continue to render covered services to members who are existing patients at the time of termination until the later of 60 calendar days, the anniversary date of the member's coverage, or until Magnolia can arrange for appropriate healthcare for the member with a participating provider. Upon request from a member undergoing active treatment related to a chronic or acute medical condition, Magnolia will reimburse the provider for the provision of covered services for up to 90 calendar days from the termination date. In addition, Magnolia will reimburse providers for the provision of covered services to members who are in the second or third trimester of pregnancy extending through the completion of postpartum care relating to the delivery.
    - Exceptions may include members requiring only routine monitoring or providers unwilling to continue to treat the member or accept payment from Magnolia.

## COMPLAINT, GRIEVANCE, AND APPEALS PROCESS

### Member Complaints, Grievances and Appeals

Magnolia has steps for handling any problems the member may have. Magnolia offers all of our members the following processes to achieve member satisfaction:

1. Internal grievance and complaint process
2. Internal appeal process
3. Access to Medicaid State Fair Hearing

Magnolia maintains records of each grievance and appeal filed by our members or by their authorized representatives, and the responses to each grievance and appeal, for a period of seven (7) years.

**Internal Grievance and Complaint Process**

**A grievance is an expression of dissatisfaction about any matter or aspect of Magnolia or its operation.** Grievances may be received orally or in writing and may be submitted to Magnolia by the member or the member's authorized representative, including the member's provider. Grievances must be submitted to Magnolia within 30 days of the date of the event causing dissatisfaction.

Examples of a grievance:

- Failure to respect the member's rights
- When a provider bills the member for unpaid claims (balance billing)
- Transportation issues

**A complaint is an expression of dissatisfaction about any matter or aspect of Magnolia or its operation that can be resolved in one (1) business day.** Complaints may be received orally or in writing and may be submitted to Magnolia by the member or the member's authorized representative, including the member's provider. Complaints must be submitted to Magnolia within 30 days of the date of the event causing dissatisfaction.

**How to File a Grievance or Complaint**

Filing a grievance or complaint will not affect the member's healthcare services. We want to know the their concerns so we can improve our services.

To file a grievance or complaint, the member can call member services at 1-866-912-6285. Magnolia will provide reasonable assistance to members in filing a grievance or complaint. The member can also write a letter and mail or fax their grievance or complaint to Magnolia at 1-877-851-3995. The member will need to to include:

- Their first and last name
- Their Medicaid ID number
- Their address and telephone number
- What they are not pleased with
- What they would like to have happen

**Magnolia Health**

**How to File a Grievance or Complaint, continued.**

A grievance or complaint may be filed in writing or by mailing it to the address below or by faxing it to 1-877-851-3995. You can also call us at 1-866-912-6285 or file the grievance or complaint in person at:

**Magnolia Health**

**Grievance and Appeal Coordinator**

**111 East Capitol Street, Suite 500**

**Jackson, MS 39201**

If the member files a written grievance, the Grievance and Appeal Coordinator (GAC) will send the member a letter within five (5) business days letting the member know that we have received their grievance.

If the member filed a complaint, there is no need for written acknowledgement.

If someone else is going to file a grievance or complaint for the member, we must have the member's written permission for that person to file their grievance or complaint. The member can call member services to receive a form or go to www.MagnoliaHealthPlan.com. This form gives the member right to file a grievance or complaint to someone else. A provider acting for the member can file a grievance or complaint for the member with the member's written consent.

If the member has any proof or information that supports their grievance, they may send it to us and we will add it to their case. The member may supply this information to Magnolia by including it with a letter, by sending us an email or a fax, or by bringing it to Magnolia in person. The member may also request to receive copies of any documentation that Magnolia used to make the decision about their grievance.

To review the member's request, we may need to obtain additional information. If a signed Authorization to Release Information Form is not included with the member's grievance, a form will be sent to them for signature. If a signed authorization is not provided within 30 business days of the request, Magnolia may issue a decision on the grievance without review of some or all of the information. When a signed request is received by the member's authorized representative, appropriate proof of the member's designation must be provided.

The member can expect a resolution and a written response from Magnolia within 30 days of receiving the their grievance. If Magnolia needs more than 30 days to resolve the grievance, we will send a letter to the member within two (2) working days of the decision to extend the timeframe. The extra time may be better for the member's case. Magnolia will ask for the extra 14 days in writing. The letter will say why we need more time.

There will be no retaliation against the member or the their representative for filing a grievance or compliant with Magnolia.

Filing a grievance or complaint will not affect the member's health care services.

Expedited Grievances

The member or their provider may want us to make a fast decision. The member can ask for an expedited review if the member or their provider feels that the member's health is at risk. If the member feels this is needed.,the member will need to contact Magnolia for a review and investigation by the appropriate clinical staff. Clinically urgent grievances will be resolved within 72 hours of receipt.

**Internal Appeal Process**

**Filing an Appeal**

An appeal is a request for Magnolia to review an action. The member can request this review by phone or in writing.

An action occurs when Magnolia:

- Denies or limits authorization of a service the member wants
- Reduces, suspends or terminates payment for a service the member is already getting
- Fails to authorize a service in the required timeframe
- Fails to decide a grievance, complaint or appeal in the required time frame

The member will know that Magnolia is taking an action because we will send them a letter. The letter is called a Notice of Action. If the member does not agree with the action, they may request an appeal.

**Who may file an Appeal?**

- The member (or the parent or guardian of a minor member)
- A person named by the member
- A provider acting for the member

The member must give written permission if someone else files an appeal for them. Magnolia will include a form in the Notice of Action letter. The member can Contact member services at 1-866-912-6285 if they need help. We can assist the member in filing an appeal.

**When Does an Appeal Have to be Filed?**

The Notice of Action will tell the member about this process. The member may file an appeal within 30 days of the receipt of the Notice of Action. If the member makes their request by phone or in person, the member must also send Magnolia a letter confirming their request for standard appeals.

The may ask to keep getting care related to their review while we decide. The member may have to pay for this care if the decision is not in their favor.

Magnolia will give the member a written decision within 30 days from the date of their request. The decision will be made by a reviewer with the appropriate expertise. If more than 30 days is needed to make a decision, we will send a letter to the member. Magnolia will ask for extra time if more information is needed. The extra time may be better for your case. Magnolia will ask for the extra 14 days in writing. The letter will say why we need more time.

**Magnolia Health**

**Expedited Appeals**

The member or their provider may want us to make a fast decision. The member can ask for an expedited review if the member or their provider feel that their health is at risk. If the member feels this is needed, they can call our Clinical Appeals Coordinator at 1-866-912-6285.

We will decide within 72 hours of receipt of the appeal request. However, the review period may be up to 14 days. Magnolia may extend up to 14 days if member requests an extension, or if Magnolia determines that the extension is in their best interest. The member will also receive a letter telling the reason for the decision and what to do if they don't like the decision.

Expedited appeals do not require a signed authorization form.

**Medicaid State Fair Hearing**

**What if I am still not pleased?**

If the member is still dissatisfied with the outcome of their appeal with Magnolia, the member may request a State Fair Hearing conducted by the DOM only after they have received their final appeal resolution from Magnolia. This request must be submitted in writing within 30 days of receiving the Notice of Appeal

Resolution from Magnolia. The DOM will make a decision within 90 days from the date they request a State Fair Hearing.

The member may request a State Fair Hearing within 30 days of receiving the Notice of Action or resolution. If the member requests a State Fair Hearing and they want their benefits to continue, they must file their request within 10 days from the date they received our decision. If the State Fair Hearing finds that Magnolia's decision was right, they may be responsible for the cost of the continued benefits.

To request a State Fair Hearing, please write to:

Division of Medicaid, Office of the Governor

Attn: Office of Appeals

550 High Street, Suite 1000

Jackson, Mississippi 39201

Ph: 601-359-6050 or 1-800-884-3222

Fax: 601-359-9153

## Provider Complaints, Grievances and Appeals

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

A provider grievance is an oral or written expression of dissatisfaction about any matter or aspect of Magnolia or its operation. A provider grievance includes, but is not limited to, the quality of care or services provided or aspects of interpersonal relationships such as rudeness of a provider or an employee.

Providers have thirty (30) calendar days from the date of the incident, such as the date of the Explanation of Payment (EOP), to file a complaint/grievance. Please note that the reconsideration and/or claims dispute process must be followed prior to the initiation of a complaint/grievance based on a claim determination.

## Acknowledgement

Upon receipt of a grievance Magnolia staff will acknowledge the grievance, document the substance of the grievance, and attempt to resolve it immediately. For written grievances, Magnolia will notate the date received and send an acknowledgment letter, which includes a description of the grievance procedures and resolution time frames, within five (5) business days of receipt.

## Grievance Resolution Time Frame

Provider grievance resolution will occur as expeditiously as deemed appropriate, not to exceed thirty (30) calendar days from the date of receipt of all requisite information. Magnolia may extend the time frame up to fourteen (14) calendar days. In our experience, most grievances are resolved at the staff

level to the satisfaction of the provider filing the grievance. Expedited grievance reviews will be available for providers in situations deemed urgent, such as a denial of an expedited appeal request, and will be resolved within twenty-four (24) hours.

## Notice of Resolution

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

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

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

## Provider Appeal

Magnolia must resolve a provider appeal within forty-five (45) calendar days from the receipt of the provider appeal or as expeditiously as the member's health condition requires. Expedited provider appeals are to be resolved within three (3) business days from the receipt of the expedited resolution request. Magnolia may extend the time frame for this request up to fourteen (14) calendar days upon receipt of information required to make a determination. An Oral request for an expedited appeal does not require a written follow-up.

**WASTE, ABUSE, AND FRAUD**

## Waste, Abuse, and Fraud (WAF) System

Magnolia takes the detection, investigation, and prosecution of fraud and abuse very seriously, and has a WAF program that complies with Mississippi and federal laws. Magnolia, in conjunction with Centene, successfully operates a WAF unit. Magnolia performs front and back-end audits to ensure compliance with billing regulations. Our sophisticated code editing software performs systematic audits during the claims payment process. To better understand this system, please review the Billing and Claims section of this manual. Centene's Special Investigation Unit (SIU) performs back-end audits, which may result in actions against those who, individually or as a practice, commit waste, abuse, and/or fraud, including, but not limited to:

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

**Some of the most common WAF submissions are:**

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

If you suspect or witness a provider inappropriately billing or a member receiving inappropriate services, please call our anonymous and confidential hotline at 1-866-685-8664. Magnolia and Centene take all reports of potential WAF very seriously and investigate all reported issues.

## Authority and Responsibility

Magnolia's Director of Compliance and Regulatory Affairs has overall responsibility and authority for carrying out the provisions of Magnolia's compliance program. Magnolia is committed to identifying, investigating, sanctioning, and prosecuting suspected WAF.

Magnolia's providers will cooperate fully in making personnel and/or subcontractor personnel available in person for interviews, consultation, grand jury proceedings, pre-trial conferences, hearings, trials, and in any other process, including investigations.

## Audit/Monitoring Review Overview

1. Audits/Monitoring reviews will involve the examination of the provider's medical and/or financial records. Providers must maintain appropriate documentation in the client's medical or health care service records to verify the level, type, and extent of services provided. Providers must:

a) Keep legible, accurate, and complete charts and records to justify the services provided to each client,

b) Assure charts are authenticated by the person who gave the order, provided the care, or performed the observation, examination, assessment, treatment or other service to which the entry pertains, and

c) Make charts and records available to Medicaid staff, other State and Federal agencies, and its contractors thereof, upon request. Records shall be maintained in accordance with MS Administrative Code, Part 200, Chapter 1, Rule 1.3.

2. A provider's bill for services, appointment books, accounting records, or other similar documents alone do not qualify as appropriate documentation for services rendered.

3. If a provider fails to participate or comply with the Magnolia's audit process or unduly delays the audit process, the provider's actions or lack thereof, are considered as abandonment of the audit.

4. If the Magnolia suspects a provider of fraud, abusive practice, audit abandonment, or present a risk of imminent danger to clients, Magnolia shall take one or more of the actions listed below.

a) Immediately issue a final report,

b) Terminate the provider's agreement with Magnolia

c) Refer the provider to the MS Division of Medicaid for the appropriate actions.

**QUALITY IMPROVEMENT**

Magnolia's culture, systems, and processes are structured around its mission to improve the health of its members. The Quality Improvement (QI) program utilizes a systematic approach to quality, employing reliable and valid methods of monitoring, analysis, evaluation, and improvement in the delivery of healthcare provided to all members, including those with special needs. This system provides a continuous cycle for assessing the quality of care and service among plan initiatives including preventive health, acute and chronic care, behavioral health, over- and under-utilization, continuity and coordination of care, patient safety, and administrative and network services. This includes the implementation of appropriate interventions and designation of adequate resources to support the interventions.

Magnolia recognizes its legal and ethical obligation to provide members with a level of care that meets recognized professional standards and is delivered in the safest, most appropriate settings. To that end, Magnolia will provide for the delivery of quality care with the primary goal of improving the health status of its members. Where the member's condition is not amenable to improvement, Magnolia will implement measures to prevent any further decline in condition or deterioration of health status or provide for comfort measures as appropriate and requested by the member.

## Program Structure

Magnolia's Board of Directors (BOD) has the ultimate authority and accountability for the oversight of the quality of care provided to members. The BOD oversees the QI program and has established various standing and ad-hoc committees to monitor and support it.

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

**The following sub-committees report directly to the QIC:**

- Credentialing Committee
- UM Committee

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

## Practitioner Involvement

Magnolia recognizes the integral role provider involvement plays in the success of its QI program. Provider involvement in various levels of the process is highly encouraged through provider representation. Magnolia encourages PCP, behavioral health, specialty, and OB/GYN representation on key quality committees such as the QIC, Credentialing Committee, and select ad-hoc committees.

## Quality Improvement Program Scope and Goals

The scope of the QI program is comprehensive and addresses the quality of both clinical care and other services provided to Magnolia's members. Magnolia's QI program integrates all demographic groups, care settings, and services in QI activities, including preventive care, primary care, specialty care, acute care, short-term care, long-term, ancillary services, and Magnolia's operations.

Magnolia's primary QI goal is to improve members' health status through a variety of meaningful QI activities implemented across all care settings and aimed at improving quality of care and services delivered.

**To that end, the Magnolia QI program monitors the following:**

- Compliance with preventive health guidelines (see Attachment A) and practice guidelines (see Attachment B)
- Acute and chronic care management
- Provider network adequacy and capacity
- Selection and retention of providers (credentialing and re-credentialing)
- Behavioral healthcare and Magnolia benefits
- Delegated entity oversight
- Continuity and coordination of care
- UM, including under and over-utilization
- Compliance with member confidentiality laws and regulations
- Employee and provider cultural competency
- Provider appointment availability
- Provider and Magnolia after-hours telephone accessibility
- Member satisfaction
- Provider satisfaction
- Member grievance system
- Provider complaint system
- Member enrollment and disenrollment
- PCP changes

- Department performance and service
- Patient safety
- Pharmacy
- Marketing practices

## Performance Improvement Process

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

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

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

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

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

## Healthcare Effectiveness Data and Information Set (HEDIS)

HEDIS is a set of standardized performance measures, developed by the National Committee for Quality Assurance (NCQA), which allows comparison across health plans. HEDIS gives purchasers and consumers the ability to distinguish between health plans based on comparative quality instead of simply cost differences. HEDIS rates demonstrate the effectiveness of a health insurance company's efforts to improve preventive health outreach to its members. HEDIS reporting is a required part of both NCQA Health Plan Accreditation and Magnolia's contract with DOM for the provision of coordinated care services within the MississippiCAN program.

As state and federal governments move toward a healthcare industry that is driven by quality, HEDIS rates are becoming more and more important, not only to Magnolia, but to its providers as well.

## How Are HEDIS Rates Calculated?

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

Administrative data: consists of claim or encounter data submitted to the health plan. Measures typically calculated using administrative data include: mammogram, annual chlamydia screening, pap test, appropriate treatment of asthma, cholesterol management, antidepressant medication management, access to PCP services, and utilization of acute and mental health services.

Hybrid data: consists of both administrative data and a sample of medical record data. Hybrid data requires review of a random sample of member medical records to extract data for services rendered but that were not reported to the health plan through claims/encounter data. Accurate and timely claim/encounter data and submission of appropriate CPT II codes can reduce the necessity of medical record reviews (see Magnolia's website and HEDIS brochure for more information on reducing HEDIS medical record reviews). Measures typically requiring medical record review include: diabetic HgA1c testing and results, , controlling high-blood pressure, and postpartum care, immunizations, colorectal rectal cancer screening.

## What Can Be Done to Improve My HEDIS Scores?

Understand the specifications established for each HEDIS measure

Submit claim/encounter data for each and every service rendered. All providers must bill (or report by encounter submission) for services delivered, regardless of contract status. Claim/encounter data is the cleanest and most efficient way to report HEDIS. If services are not billed, or not billed accurately, they are not included in the calculation. Accurate and timely submission of claim/encounter data will positively reduce the number of medical record reviews required for HEDIS rate calculation.

Ensure chart documentation reflects all services provided

Bill CPT II codes related to HEDIS measures such as diabetes, eye exam, and blood pressure

Submit a claim for all diagnosis and comorbidities for each visit not just one diagnosis. Exclusions apply to certain comorbidities or coexisting conditions.

Have members come in for a head to toe physical each year capturing all conditions, surgeries and procedures for an accurate overall picture of health.

Ensuring that members have plenty of refills on their medications and they are properly taking them

If you have any questions, comments, or concerns related to the annual HEDIS project or the medical record reviews, please contact the Magnolia QI department at 1-866-912-6285.

**Examples of HEDIS measures for Body Mass Index (BMI) and Nutrition/Physical Counseling are as follows:**

**ICD-10 Codes to report BMI percentiles:**

**Example Coding for nutrition and physical activity counseling:**

| CPT | | ICD-10 | CHPCS Diagnosis | Procedure |
|---|---|---|---|---|
| Pec Nutrition Counseling | Z68.51 | Z71.3 | BMI less than 5th percentile for a | S9470, S9452, S9449, G0270-G0271 |
| | Z68.52 | BMI between 5th percentile to 85th percentile | | G0447e |
| Physical Activity Counseling | Z68.53 | BMI between 85th perc | 93.11,93.13, than 9 | S9451, H2032 G0447, |
| | Z68.54 | Z71.89 BMI greater than | 93.19, 93.31 5th percentile | S9451, |
| | Z68.1 | | BMI less than 19 | |
| Adult | Z68.20-Z68.24 | BMI between 20 – 24 | | |
| | Z68.25-Z68.29 | BMI between 25 – 29 (requires 5th digit) | | |
| | Z68.30-Z68.39 | BMI between 30 – 39 (requires 5th digit) | | |
| | Z68.4-Z68.54 | BMI between 40 and over (requires 5th digit) | | |

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

## Provider Satisfaction Survey

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

## Consumer Assessment of Healthcare Provider and Systems (CAHPS) Survey

The CAHPS survey is a member satisfaction survey that is included as a part of HEDIS and NCQA **accreditation. It is a standardized survey administered annually to members by an NCQA-certified survey vendor. The survey provides information on the experiences of Magnolia members with health plan and provider services and gives a general indication of how well we are meeting members' expectations. Member responses to the CAHPS survey are used in various aspects of the QI program including monitoring of provider access and availability.**
**MEDICAL RECORDS REVIEW**

## Medical Records

Magnolia providers must keep accurate and complete medical records. Such records will enable providers to render the highest quality healthcare service to members. They will also enable Magnolia to review the quality and appropriateness of the services rendered. To ensure the member's privacy, medical records should be kept in a secure location. Magnolia requires providers to maintain records for ten (10) years for adult patients and thirteen (13) years for minors. See the Member Rights section of this manual for policies on member access to medical records.

## Required Information

Medical records as used herein is defined as the complete, comprehensive member records including, but not limited to, x-rays, laboratory tests, results, examinations and notes, that are accessible at the site of the member's PCP or provider, that document all medical services received by the member, including inpatient, ambulatory, ancillary, and emergency care, prepared in accordance with all applicable state rules and regulations, and signed by the medical professional rendering the services.

**Providers must maintain complete medical records for members in accordance with the following standards:**

- Member's name and/or medical record number is found on all chart pages.
- Personal/biographical data is present (i.e., employer, home telephone number, spouse, next of kin, legal guardianship, primary language, etc.).
- Prominent notation of any spoken language translation or communication assistance is included.
- All entries must be legible and maintained in detail.
- All entries must be dated and signed, or dictated by the provider rendering the care.
- Significant illnesses and/or medical conditions are documented on the problem list along with all past and current diagnoses.
- Medication, allergies, and adverse reactions are prominently documented in a uniform location in the medical record; no known allergies (NKA) or no known drug allergies (NKDA) is to be documented, as well.
- An up-to-date immunization record is established for pediatric members or, for adults, an appropriate history is made in the chart.
- Evidence that preventive screening and services are offered in accordance with Magnolia Practice Guidelines is documented.
- Appropriate subjective and objective information pertinent to the member's presenting complaints are documented in the history and physical.
- For adults, past medical history (for members seen three [3] or more times) is easily identified and includes any serious accidents, operations and/or illnesses, discharge summaries, and ER encounters.
- For children and adolescents (eighteen [18] years and younger), past medical history relating to prenatal care, birth, any operations and/or childhood illnesses is included.
- Working diagnosis is consistent with findings.
- Treatment plan is appropriate for diagnosis.
- Treatment prescribed, therapy prescribed, and drug administered or dispensed, including instructions to the member, are documented.
- Documentation of prenatal risk assessment for pregnant women or infant risk assessment for newborns is included.
- Required consent forms are signed and dated.
- Unresolved problems from previous visits are addressed in subsequent visits and documented.
- Laboratory and other studies ordered as appropriate are documented.

- Abnormal lab and imaging study results have explicit notations in the record for follow-up plans; all entries should be initialed by the PCP to signify review.
- Referrals to specialists and ancillary providers are documented, including follow-up of outcomes and summaries of treatment rendered elsewhere including family planning services, preventive services, and services for the treatment of sexually transmitted diseases.
- Health teaching and/or counseling is documented.
- For members ten (10) years and over, appropriate notations are included concerning use of tobacco, alcohol and substance use (for members seen three [3] or more times substance abuse history should be queried).
- Documentation of failure to keep an appointment is included.
- Encounter forms or notes have a notation, when indicated, regarding follow-up care calls or visits. The specific time of return should be noted as weeks, months or as needed.
- Evidence that the member is not placed at inappropriate risk by a diagnostic or therapeutic problem is documented.
- Confidentiality of member information and records are protected.
- Evidence that an advance directive has been offered to adults eighteen (18) years of age and older is documented.

## Medical Records Release

All member medical records shall be confidential and shall not be released without the written authorization of the covered person or a responsible covered person's legal guardian. When the release of medical records is appropriate, the extent of that release should be based upon medical necessity or on a need-to-know basis.

## Medical Records Transfer for New Members

All PCPs are required to document in the member's medical record attempts to obtain historical medical records for all newly-assigned Magnolia members. If the member or member's guardian is unable to remember where they obtained medical care, or they are unable to provide addresses of the previous providers, then this should also be noted in the medical record. When a member changes his or her PCP, the member's medical records must be made available to the new PCP within fourteen (14) business days from receipt of the request.

## Medical Records Audits

Magnolia will conduct random medical record audits as part of its QI program to monitor compliance with the medical record documentation standards noted herein. The coordination of care and services provided to members, including over/under utilization of specialists, as well as the outcome of such services also may be assessed during a medical record audit. Magnolia will provide written notice prior to conducting a medical record review.

### PROVIDER RELATIONS DEPARTMENT

Magnolia's provider relations department is designed to provide providers with an advocate within Magnolia. Provider relations representatives are responsible for providing the services listed below including, but not limited to:

- Provider issue resolution

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

The goal of this department is to furnish you and your staff with the necessary tools to provide the highest quality of healthcare to Magnolia members. To contact the provider relations representative for your area, contact our provider services at 1-866-912-6285. Provider services representatives work as your advocates to ensure that you receive the assistance that you need to ensure that Magnolia satisfactorily meets its obligations to you and your practice.

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

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

## BILLING AND CLAIMS SUBMISSION

### General Billing Guidelines

**Magnolia is required by state and federal regulations to capture specific data regarding services rendered to its members. The provider must adhere to all billing requirements in order to ensure timely processing of claims and to avoid unnecessary rejections and/or denials. Claims will be rejected or denied if not submitted correctly. In general, Magnolia follows the CMS (Centers for Medicare & Medicaid Services) billing requirements. For questions regarding billing requirements, contact a Magnolia provider services representative at 1-866-912-6285.**

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

> Rejections happen prior to the claims being received in the claims adjudication system and will be sent to the provider with a letter detailing the reason for the rejection.

Denials happen once the claim has been received into the claims adjudication system and will be sent to the provider via an Explanation of Payment (EOP).

Claims for billable services provided to Magnolia members must be submitted by the provider who performed the services or by the provider's authorized billing vendor.

To avoid delays in processing of a CMS 1500, providers must bill with their NPI number in box 24Jb, their taxonomy code in box 24Ja, their group NPI in box 33a and taxonomy code in box 33b. To avoid delays in processing of a UB-04, providers must include the appropriate bill type in box 4, their tax identification number in box 5, the admission date in box 12, and the group NPI in box 56. Claims missing required information will be returned, with a notice sent to the provider, thus creating payment delays. Such claims are not considered "clean" and therefore cannot be accepted into our system.

**Claims eligible for payment must meet the following non-exhaustive list of requirements*:**

- The member is effective on the date of service**
- The service provided is a covered benefit under the member's contract on the date of service, and
- Applicable referral and prior authorization processes were followed.

*Please note that payment is contingent upon compliance with referral and prior authorization policies and procedures, as well as the billing guidelines outlined in this manual.

**** Providers are responsible for confirming Magnolia member eligibility and verifying the identity of the person presenting the Magnolia ID at the time of service. Providers are recommended to verify member eligibility using DOM's eligibility verification website (MS Envision) or by contacting Magnolia at 1-866-912-6285.**

## *Accurate Billing Information*

For claims payment purposes, it is important that Magnolia has accurate billing information on file. **Please confirm with the provider relations department that the following information is current in our files:**

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

We recommend that providers notify Magnolia at least thirty (30) days in advance of changes pertaining to billing information. Please submit this information on a W-9 form and in writing to the Provider Relations department. Changes to a provider's TIN and/or address are NOT acceptable when conveyed via a claim form.

To prevent claim payment delays or denials, it is recommended that providers verify that the Tax Id and NPI number on file with Magnolia matches the one on file with DOM.

## Encounters

Providers are required to submit an encounter or claim for each service that they render to a Magnolia member. A claim is an electronic or paper request for reimbursement for any medical service and must be filed on the proper form, such as the CMS 1500 or UB-04. Claims will be paid, rejected or denied and, for each claim processed, an EOP will be mailed to the provider who submitted the original claim. In the case of a claim denial, the reason for said denial will be provided in the EOP.

An encounter is contact between a patient and practitioner who has primary responsibility for assessing and treating the patient. Encounters occur in many different settings—ambulatory care, emergency care, home healthcare, in the field, or virtually (telemedicine). Magnolia captures encounter data – information showing use of provider services by health plan enrollees – through provider claims for reimbursement.

## Timely Filing

Providers must submit all claims and encounters within one hundred and eighty (180) calendar days of the date of service. When Magnolia is the secondary payer, claims must be received within three hundred and sixty five (365) calendar days of the final determination of the primary payer. Claims received after this time frame will be denied for failure to file timely.

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

Claims that have been denied due to erroneous or missing information must be resubmitted within ninety (90) calendar days from the date of denial. In order to be reconsidered the denied claim must be resubmitted with corrected information via clearinghouse, Magnolia's website or via paper.

*Please note that these timely filing deadlines apply to both paper and electronic claims.

## Claim Payment

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

- Within twenty-five (25) business days of the receipt of electronic filed clean claims.
- Within thirty-five (35) business days of the receipt of paper clean claims.

## Billing the Member

Magnolia only reimburses providers for services that are medically necessary and covered under the MississippiCAN program. Providers must agree to accept as payment in full the amount paid by Magnolia for all services covered under the MississippiCAN program. Providers may not charge a beneficiary the difference between the usual and customary charge and the provider's contracted reimbursement rate or otherwise "balance bill" the member.

There are limited circumstances in which a provider may bill a Magnolia member. Providers may bill members for services NOT covered by Magnolia, not authorized by Magnolia, or those denied as not being medically necessary. Providers can also bill a member where they provide proof that they attempted but failed to obtain member insurance ID information within sixty (60) calendar days of service. Additionally, a provider may bill a member if the member has exceeded the program limitations for a particular service. A provider may only bill a Magnolia member if the following condition is met:

Prior to the service being rendered, the provider has obtained and kept a written member acknowledgement statement signed by the client stating, I understand that, in the opinion of (provider's name), the services or items that I have requested to be provided to me on (dates of service) may not be covered under Magnolia as being reasonable and medically necessary for my care. I understand that Magnolia through its contract with DOM determines the medical necessity of the services or items that I request and receive. I also understand that I am responsible for payment of the services or items I request and receive if these services or items are determined not to be reasonable and medically necessary for my care.

### Nurse Practitioners and Physician Assistants

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

### Electronic Claims Submission

Network providers are encouraged to participate in Magnolia's electronic claims/encounter filing program. Magnolia has the capability to receive an ANSI X12N 837 professional, institution, or encounter transaction. In addition, it has the ability to generate an ANSI X12N 835 electronic remittance advice known as an EOP.

### PROCEDURES FOR ONLINE CLAIM SUBMISSION

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

You must request access to our secure site by registering for a user name and password and requesting claims access. To obtain an ID, please contact provider relations at 1-866-912-6285 or visit our website at www.magnoliahealthplan.com. Requests are processed within two (2) business days.

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

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

**Magnolia Health**
c/o Centene EDI Department
1-800-225-2573, extension 25525 or by e-mail at:
EDIBA@centene.com

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

Providers that bill electronically must monitor their error reports and EOPs to ensure all submitted claims and encounters appear on the reports. Providers are responsible for correcting any errors and resubmitting the relevant claims and encounters.

### Important Steps to Successful Submission of EDI Claims

1. Select clearinghouse to utilize.

2. Contact the clearinghouse to inform them you wish to submit electronic claims to Magnolia.
3. Inquire with the clearinghouse as to what data records are required.
4. Verify with your Magnolia Provider Relations Representative that the provider is set up in the Magnolia system before submitting EDI claims.
5 You will receive two (2) reports from the clearinghouse. ALWAYS review these reports daily. The first report shows the claims that were accepted by the clearinghouse and transmitted to Magnolia and those claims not meeting the clearinghouse requirements. The second report will be a claim status report showing claims accepted and rejected by Magnolia. ALWAYS review the acceptance and claim status reports for rejected claims. If rejections are noted, you must correct and resubmit.
6. MOST importantly, all claims must be submitted with the provider's identifying numbers. See the CMS 1500 (8/05) and UB-04 claim form instructions and claim forms for details.

**EFT and ERA**

Magnolia has partnered with PaySpan to provide an innovative web-based solution for Electronic Funds Transfers (EFTs) and Electronic Remittance Advices (ERAs). Through this free service, providers can settle claims electronically. For more information, please visit the provider home page on our website at www.magnoliahealthplan.com or, to sign up for this quick and efficient service, you may go directly to www.payspanhealth.com.

**Exclusions**

Certain claims are excluded from electronic billing. Please see the table below.

NOTE: Provider ID number validation is not performed at the clearinghouse level. The clearinghouse will reject claims for provider information only if the provider number fields are empty.

| Excluded Claim Categories |
|---|
| Claim records requiring supportive documentation or attachments. Note: COB claims can be filed electronically, but if they are not, the primary payer EOB must be submitted with the paper claim. |
| Claim records billing with miscellaneous codes |
| Claim records for medical, administrative, or claim reconsideration or dispute requests |
| Claim requiring documentation of the receipt of an informed consent form |
| Claim for services that are reimbursed based on purchase price (e.g. custom DME, prosthetics). Provider is required to submit the invoice with the claim. |
| Claim for services requiring clinical review (e.g., complicated or unusual procedure). Provider is required to submit medical records with the claim. |
| Claim for services needing documentation and requiring Certificate of Medical Necessity- oxygen, motorized wheelchairs |

**Paper Claims Submission**

**For Magnolia MississippiCAN members, all paper claims and encounters should be submitted to:**

**Magnolia Health**

ATTN: CLAIMS DEPARTMENT
P.O. Box 3090
Farmington, MO 63640-3825

**Important Steps to Successful Submission of Paper Claims**

1. Complete all required fields on an original, red and white CMS 1500 (02/12) or UB-04 form.
2. Ensure all Diagnosis, Procedure, Modifier, Location (Place of Service), Type of Admission, and Source of Admission Codes are valid for the date(s) of service.
3. Ensure all diagnosis and procedure codes are appropriate for the age and sex of the member.
4. Ensure all diagnosis codes are coded to the highest number of digits available (fourth and fifth digit).
5. Ensure member was eligible for services under Magnolia during the date(s) of service.
6. Ensure an authorization was given for services that require prior authorization by Magnolia.
7. Claim forms submitted without "Red" dropout OCR forms may cause unnecessary delays in processing.

**Requirements**

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

**Do's:**

- Do submit all dates of service and birthdates in a mm/dd/yyyy format
- Do use the correct P.O. Box number or address
- Do submit all claims in a 9" x 12" or larger envelope
- Do type all fields completely and correctly
- Do use typed black or blue ink only at 9-point font or larger
- Do include all other insurance information (policy holder, carrier name, ID number, and address) when applicable
- Do attach the EOP from the primary insurance carrier when applicable.
    - *Note: Magnolia is able to receive primary insurance carrier EOP [electronically]*
- Do submit on a proper original form - CMS 1500 or UB-04

**Don'ts**

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

- Don’t submit claims to the Magnolia Jackson, MS office – use P.O. Box only!

# CLAIM FORM REQUIREMENTS

### Clean Claim Definition

A clean claim means a claim received by Magnolia for adjudication, in a nationally accepted format in compliance with standard coding guidelines and which requires no further information, adjustment, or alteration by the provider of the services in order to be processed and paid by Magnolia.

### Non-Clean Claim Definition

Non-clean claims are submitted claims that require further documentation or development beyond the information contained therein. In addition, non-clean claims may involve issues regarding medical necessity and include claims not submitted within the filing deadlines. The errors or omissions in a claim will result in a request for additional information from the provider or other external sources to resolve or correct any data omitted from the bill; review of additional medical records; or the need for other information necessary to resolve discrepancies.

### REJECTIONS VS 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. These data elements are identified in the Companion Guide located on the website at www.magnoliahealthplan.com. A list of common upfront rejections is located below, and a more comprehensive list with explanations is located in Appendix 1. All paper claims sent to the Claims Office must first pass specific minimum edits prior to acceptance. Claim records that do not pass these minimum edits are invalid and will be rejected.

If all minimum edits pass and the claim is accepted, it will then be entered into the system for processing. A DENIAL is defined as a claim that has passed minimum edits and is entered into the system for processing, but has been billed with invalid or inappropriate information causing the claim to deny. An EOP (Explanation of Payment) will be sent that includes the denial reason. A list of common delays and denials is located below, and a more comprehensive list with explanations is included in Attachment C.

### Common Causes of Upfront Rejections

- Unreadable Information
- Missing Member Date of Birth
- Missing or Invalid Member Name or ID Number
- Missing or Invalid Provider Name, TIN, or NPI Number
- The Date of Service on the Claim is Not Prior to Receipt Date of the Claim
- Dates Are Missing from Required Fields
- Invalid or Missing Type of Bill
- Missing, Invalid or Incomplete Diagnosis Code(s)
- Missing Service Line Detail
- Member Not Eligible on The Date of Service

- Missing Admission Type
- Missing Patient Status
- Missing or Invalid Occurrence Code or Date
- Missing or Invalid Revenue Code
- Missing or Invalid Current Procedural Terminology (CPT)/Procedure Code
- Incorrect Form Type
- Missing Clinical Laboratory Improvement Amendments (CLIA) number when applicable

Magnolia will send providers written notice for each claim that is rejected explaining the reason for the rejection.

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

- Incorrect Form Type
- Diagnosis Code Missing 4th or 5th Digit
- Missing or Invalid Procedure or Modifier Codes
- Missing or Invalid Diagnosis Related Group (DRG) Code
- Explanation of Benefits from the Primary Carrier is Missing or Incomplete
- Invalid Member ID
- Invalid Place of Service Code
- Provider TIN and NPI Do Not Match what is on file with Magnolia or DOM provider files
- Invalid Revenue Code
- Dates of Service Span Do Not Match Listed Days/Units
- Missing Provider Signature
- Invalid TIN
- Missing or Incomplete Third Party Liability Information

Magnolia will send providers written notification via an EOP for each claim that is denied, which will include the reason(s) for the denial. Please see Attachment C for a list of EOP denial codes and explanations.

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

- All required fields are completed on an original CMS 1500, UB-04 paper claim form, or EDI electronic claim format.
- All Diagnosis, Procedure, Modifier, Location (Place of Service), Revenue, Type of Admission, and Source of Admission Codes are valid for the date of service.
- All Diagnosis, Procedure, Modifier, and Location (Place of Service) Codes are valid for provider type/specialty billing.

- All Diagnosis, Procedure, and Revenue Codes are valid for the age and/or sex for the date of the service billed.
- All Diagnosis Codes are to their highest number of digits available (4th or 5th digit).
- Principal Diagnosis billed reflects an allowed Principle Diagnosis as defined in the volume of ICD-10 CM or ICD-10 CM update for the date of service billed for dates of service on or after October 1 2015.
- Member is eligible for services under Magnolia during the time period in which services were provided.
- Services were provided by a participating provider, authorization has been received to provide services to the eligible member (excludes services by an "out of network" provider for an emergency medical condition; however authorization requirements apply for post-stabilization services).
- An authorization has been given for services that require prior authorization by Magnolia.
- Medicare coverage or other third party coverage.

**Claim Requests for Reconsideration, Claim Disputes, and Corrected Claims**

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

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

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

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

2. Submit an Adjusted or Corrected Claim to Magnolia Health, Attn: Corrected Claim, PO Box 3090, Farmington MO 63640-3800

   The paper claim submission must clearly be marked as "RE-SUBMISSION" and must include the original claim number or the original EOP must be included with the resubmission. Handwritten claims will not be accepted and will be rejected.

   Failure to mark the claim as a resubmission and include the original claim number (or include the EOP) may result in the claim being denied as a duplicate, a delay in the reprocessing, or denial for exceeding the timely filing limit. Handwritten claims will not be accepted and will be rejected.

3. Submit a "Request for Reconsideration" to Magnolia Health, Attn: Reconsideration, PO Box 3090, Farmington MO 63640-3800

   A request for reconsideration is a written communication from the provider disagreeing with the way a claim was processed but does not require a claim to be corrected and does not require medical records.

For more information about how to submit a medical necessity dispute, refer to the Grievances and Appeals section of this provider manual

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

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

4. Submit a "Claim Dispute Form" to Magnolia Health, Attn: Dispute, PO Box 3090, Farmington MO 63640-3800

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

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

If the corrected claim, the request for reconsideration, or the claim dispute results in an adjusted claim, the provider will receive a revised Explanation of Payment (EOP). If the original decision is upheld, the provider will receive a revised EOP or letter detailing the decision and steps for escalated reconsideration.

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

**Third Party Liability**

Third party liability refers to any other health insurance plan or carrier (e.g., individual, group, employer-related, self-insured or self-funded, commercial carrier, automobile insurance, and worker's compensation) or program that may be liable to pay all or part of the healthcare expenses of the member.

Magnolia providers shall make reasonable efforts to determine the legal liability of third parties to pay for services furnished to Magnolia members. If the provider is unsuccessful in obtaining necessary cooperation from a member to identify potential third party resources, the provider shall inform Magnolia that efforts have been unsuccessful. Magnolia will make every effort to work with the provider to determine liability coverage.

If third party liability coverage is determined after services are rendered, Magnolia will coordinate with DOM on eligibility requirements for members identified to have another carrier, which could impact members' eligibility for Magnolia.

# Claim Forms

Magnolia accepts the CMS 1500 (02/12) and UB-04 paper claim forms.

Professional providers and medical suppliers complete the CMS 1500 (02/12) form and institutional providers complete the CMS UB-04 claim form. Magnolia does not supply claim forms to providers; providers should purchase these from a supplier of their choice. If you have questions regarding what type of form to complete, contact a Magnolia provider services representative at 1-866-912-6285.

## Completing a CMS 1500 Form

Only CMS 1500 claim forms printed in Flint OCR Red and White, J6983 ink (or exact match) are acceptable. Although the CMS-1500 form can be downloaded and printed, copies of the form cannot be used for submission of claims, since the copy may not accurately replicate the scale or OCR color of the form. Paper claims submitted outside of this format will be rejected. Providers are highly encouraged to submit forms electronically via our Web Portal. See Attachment D for a sample CMS 1500 form. See Attachment E for CMS 1500 claim form instructions, including a table that outlines each field within the form.

## INSTRUCTIONS FOR SUPPLEMENTAL INFORMATION

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

**The following types of supplemental information are accepted in a shaded claim line of the CMS 1500 (02/12) form field 24A-G:**

- Anesthesia duration in hours and/or minutes with begin (start) and end times
- Narrative description of unspecified/miscellaneous/unlisted codes
- National Drug Codes (NDC) for drugs
- Vendor Product Number–Health Industry Business Communications Council (HIBCC)
- Product Number Health Care Uniform Code Council–Global Trade Item Number (GTIN), formerly Universal Product Code (UPC) for products
- Contract rate

**The following qualifiers are to be used when reporting these services.**

**7** Anesthesia information

**CTR** Contract rate

**ZZ** Narrative description of unspecified/miscellaneous/unlisted codes

**N4** National Drug Codes (NDC)

**The following qualifiers are to be used when reporting NDC units:**

**F2** International Unit

**GR** Gram

**ME** Milligram

**ML** Milliliter

**UN** Unit

**OZ** Product Number Health Care Uniform Code Council – Global Trade Item Number (GTIN)

**VP** Vendor Product Number- Health Industry Business Communications Council (HIBCC) Labeling Standard

To enter supplemental information, begin at 24A by entering the qualifier and then the information. Do not enter a space between the qualifier and the supplemental information. Do not enter hyphens or spaces within the NDC, HIBCC, or GTIN number/code.

When reporting a service that does not have a qualifier, enter two blank spaces before entering the information.

More than one (1) supplemental item can be reported in a single shaded claim line IF the information is related to the un-shaded claim line item it is entered on. When entering more than one (1) supplemental item, enter the first qualifier at the start of 24A followed by the number, code, or other information. Do not enter a space between the qualifier and the supplemental information. Do not enter hyphens or spaces within the NDC, HIBCC, or GTIN number/code. After the entry of the first supplemental item, enter three (3) blank spaces and then the next qualifier and number, code, or other information. Do not enter a space between the qualifier and the supplemental information. Do not enter hyphens or spaces within the NDC, HIBCC, or GTIN number/code.

**Examples: Anesthesia**

| 24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY | B. PLACE OF SERVICE | C. EMG | D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER | E. DIAGNOSIS POINTER | F. $ CHARGES | G. DAYS OR UNITS | H. EPSDT Family Plan | I. ID. QUAL. | J. RENDERING PROVIDER ID. # |
|---|---|---|---|---|---|---|---|---|---|
| 7Begin 1315 End 1445 Time 90 minutes | | | | | | | | NPI | |

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

| 24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY | B. PLACE OF SERVICE | C. EMG | D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER | E. DIAGNOSIS POINTER | F. $ CHARGES | G. DAYS OR UNITS | H. EPSDT Family Plan | I. ID. QUAL. | J. RENDERING PROVIDER ID. # |
|---|---|---|---|---|---|---|---|---|---|
| ZZLaparoscopic Ventral Hernia Repair Op Note Attached | | | | | | | | NPI | |

**NDC**

| 24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY | B. PLACE OF SERVICE | C. EMG | D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER | E. DIAGNOSIS POINTER | F. $ CHARGES | G. DAYS OR UNITS | H. EPSDT Family Plan | I. ID. QUAL. | J. RENDERING PROVIDER ID. # |
|---|---|---|---|---|---|---|---|---|---|
| N455513019001 Pegfilgrastim ML 0.6 | | | | | | | | NPI | |

**Vendor Product Number- HIBCC**

| 24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY | B. PLACE OF SERVICE | C. EMG | D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER | E. DIAGNOSIS POINTER | F. $ CHARGES | G. DAYS OR UNITS | H. EPSDT Family Plan | I. ID. QUAL. | J. RENDERING PROVIDER ID. # |
|---|---|---|---|---|---|---|---|---|---|
| VPA123ABC7D9E1F | | | | | | | | NPI | |

**Product Number Health Care Uniform Code Council – GTIN**

| 24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY | B. PLACE OF SERVICE | C. EMG | D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER | E. DIAGNOSIS POINTER | F. $ CHARGES | G. DAYS OR UNITS | H. EPSDT Family Plan | I. ID. QUAL. | J. RENDERING PROVIDER ID. # |
|---|---|---|---|---|---|---|---|---|---|
| OZ01234567891112 | | | | | | | | NPI | |

**No qualifier - More Than One (1) Supplemental Item**

**SUBMITTING CLAIMS FOR EPSDT SERVICES**

EPSDT services are limited to beneficiaries under age twenty one (21). Modifier EP is required to be billed in box 24d of CMS 1500 (02/12) claim form.

**Procedure Codes for Screenings:**

| Initial: | Periodic: | Hearing: | Vision: | Adolescent Counseling: |
|---|---|---|---|---|
| 99381 – EP (under the age of 1) | 99391 – EP (under the age of 1) | 92551 – EP (3-21 years of age) | 99173 – EP (3-21 years of age) | 99401 – EP (9-21 years of age) |
| 99382 – EP (1-4 years of age) | 99392 – EP (1-4 years of age) | | | |

| | | | | |
|---|---|---|---|---|
| 99383 – EP (5-11 years of age) | 99393 – EP (5-11 years of age) | | | |
| 99384 – EP (12-17 years of age) | 99394 – EP (12-17 years of age) | | | |
| 99385 – EP (18-21 years of age) | 99395 – EP (18-21 years of age) | | | |

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

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

**SUBMITTING CLAIMS FOR ANESTHESIA SERVICES**

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

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

**AA –** Anesthesia service performed personally by Anesthesiologist

AA modifier can only be billed by an Anesthesiologist

Do not use for Medical direction of CRNA's

**GC –** This service has been performed in part by a Resident under the direction of a Teaching Physician

GC can only be used by Anesthesiologist in a teaching facility

**QX –** CRNA Service: with medical direction by a physician

QX must be used by both the CRNA and the Anesthesiologist

Anesthesiologist may not bill for direction of more than four CRNA's at any one time

**QZ –** CRNA Service: without medical direction by a physician

QZ can only be used by the CRNA

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

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

**When filing for anesthesia services on the CMS-1500 (02/12) claim form, apply the following guidelines:**

Enter the correct CPT anesthesia code from the 00100 through 01999 range in box 24d.

The correct number of anesthesia time units must be entered in box 24g. One minute of anesthesia time will equal one unit.

## Reporting NDC on CMS 1500 claim form

The NDC is used to report prescribed drugs and biologics when required by government regulation, or as deemed by the provider to enhance claim reporting/adjudication process. The NDC for each service being billed should be entered in the shaded section of twenty four (24).

NDC should be entered in the shaded sections of item 24A through 24G. To enter NDC information, begin at 24A by entering the qualifier N4 and then the eleven (11) digit NDC information. Do not enter a space between the qualifier and the eleven (11) digit NDC number. Don't enter hyphen or space within number/code.

**The following qualifiers are used when reporting NDC units**

**F2 –** International unit

**GR –** Gram ML – Milliliter U

**N –** Unit

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

| 24. A. DATE(S) OF SERVICE From MM | DD | YY | To MM | DD | YY | B. PLACE OF SERVICE | C. EMG | D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS | MODIFIER | E. DIAGNOSIS POINTER | F. $ CHARGES | G. DAYS OR UNITS | H. EPSDT Family Plan | I. ID. QUAL. | J. RENDERING PROVIDER ID. # |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| N400026064871 Immune Globulin Intravenous | | | | | | | | UN2 | | | | | | 1B | 12345678901 |
| 10 | 01 | 05 | 10 | 01 | 05 | 11 | | J1563 | | 13 | 500 00 | 20 | N | NPI | 0123456789 |

# Hospital Billing

**** Effective December 1, 2015, Magnolia Health Plan will begin processing claims for Inpatient services for MississippiCAN members.**

### DRG Methodology

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

Every inpatient stay is assigned a single DRG that reflects the typical resource use of that case. Payments are based solely on the DRG billed for the patient's stay in the facility, regardless of length of stay or additional services rendered.

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

1.1.

- RELATIVE WEIGHT FOR THAT DRG X BASE PRICE = DRG BASE PAYMENT

Other questions regarding inpatient stays, prior authorizations, or claims payments can be directed to:

**Magnolia Provider Relations**
Phone #: 1-866-912-6285

Fax #: 1-866-480-3227

www.MagnoliaHealthPlan.com

## *Hospital Claim Form*

A UB-04 is the only acceptable claim form for submitting inpatient or outpatient hospital technical service charges for reimbursement by Magnolia. In addition, a UB-04 is required when billing for nursing home services, swing bed services with revenue and occurrence codes, inpatient hospice services, ambulatory surgery centers (ASC) and dialysis services. Incomplete or inaccurate information will result in the claim/encounter being rejected or denied.

Practitioners employed by or contracted with a hospital (e.g., hospitalists, lab directors, etc.) may not bill individually for services rendered to Magnolia beneficiaries. This includes services provided in the ER by practitioners employed on a full-time or part-time basis by the hospital and other practitioners employed by or under a contractual arrangement with the hospital. The hospital must bill for these services on the HCFA-1500 with the practitioner's individual NPI number as the servicing provider and the hospital's group NPI provider number as the billing provider.

### *Completing a UB-04 Claim Form*

A UB-04 is the only acceptable claim form for submitting inpatient or outpatient hospital (including hospital based ASCs and technical services) charges for reimbursement by Magnolia. Additionally, the following provider types should bill using the UB-04 claim form:

- Dialysis Centers
- Home Health Agencies
- Hospice Providers
- Nursing Facilities
- Swing-Bed Facilities
- Surgical Centers

  1.2.

Please see Attachment F for a sample UB-04 claim form. Please see attachment G for UB-04 claim form instructions, including a table outlining each field within the form.

**UB 04 Inpatient/Outpatient Documentation**
The following information should be submitted along with the UB 04:

• Consent forms for hysterectomies, abortions, and sterilizations

• Specific additional information upon request by Magnolia

**Exceptions:** Please refer to your provider contract with Magnolia or to the DOM Provider Administrative Code for revenue codes that do not require a CPT 4 code.

### Coding of Claims

Magnolia requires claims to be submitted using codes from the current version of ICD-10- CM, CPT4, and HCPCS Level II for the date the service was rendered. These requirements may be amended to comply with federal and state regulations as necessary. **Claims will be rejected or denied if billed with:**

- Missing, invalid, or deleted codes
- Codes inappropriate for the age or sex of the member
- An ICD-10 CM code missing the 4th or 5th digit

For more information regarding billing codes, coding, and code auditing and editing please see below or contact a Magnolia Provider Services representative at 1-866-912-6285.

### CPT® Category II Codes

CPT Category II Codes are supplemental codes developed to assist in the collection and reporting of information regarding performance measurement, including HEDIS. Submission of CPT Category II Codes allows data to be captured at the time of service, thus reducing the need for retrospective medical record review.

Use of these codes is optional; Category II Codes are not required for correct coding and may not be used as a substitute for Category I Codes. However, as noted above, submission of these codes can minimize the administrative burden on providers and health plans by greatly decreasing the need for medical record review.

### Code Auditing and Editing

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

Code editing software contains a comprehensive set of rules and addresses coding inaccuracies such as unbundling, fragmentation, up coding, duplication, invalid codes, and mutually-exclusive procedures. **The software offers a wide variety of edits that are based on:**

- Centers for Medicare & Medicaid Services' (CMS) National Correct Coding Initiative (NCCI) which includes column 1/column 2, mutually exclusive and outpatient code editor (OCE0 edits). In addition to using the AMA's CPT manual, the NCCI coding policies are based on national and local policies and edits, coding guidelines developed by national societies, analysis of standard medical and surgical practices, and a review of current coding practices.
- Clinical consultants who research, document, and provide edit recommendations based on the most common clinical scenario.
- In addition to nationally-recognized coding guidelines, the software has added flexibility to its rule engine to allow business rules that are unique to the needs of individual product lines.

### Code Editing Assistant

A web-based code auditing reference tool, designed to "mirror" how Magnolia code auditing product(s) evaluate code combinations during the auditing of claims, is available for participating providers. This allows Magnolia to share the claim auditing rules and clinical rationale we use to pay claims with our contracted providers. The code auditing reference tool is accessible by registering for Magnolia's secure provider portal at www.magnoliahealthplan.com.

**The Code Editing Assistant is intended for use as a 'what if' or hypothetical reference tool. It is meant to apply coding logic only. The tool does not take into consideration historical claims information that may have been used to determine an edit. The tool assumes all CPT codes are billed on a single claim. Further, the tool will not take into consideration individual fee schedule reimbursement, authorization requirements, or other coverage considerations.**

**This tool offers many benefits:**

Prospectively access the appropriate coding and supporting clinical edit clarifications for services before claims are submitted.
Proactively determine the appropriate code or code combination representing the service for accurate billing purposes.
The tool will review what was entered and will determine if the code or code combinations are correct based on the age, sex, location, modifier (if applicable), and other code(s) entered.

**The following provides conditions where the software will make a change on submitted codes:**

Unbundling of Services – identifies procedures that have been unbundled.

**Example:** Unbundling lab panels. If component lab codes are billed on a claim along with a more comprehensive lab panel code that more accurately represents the service performed, the software will bundle the component codes into the more comprehensive panel code. The software will also deny multiple claim lines and replace those lines with a single, more comprehensive panel code when the panel code is not already present on the claim.

| Code | Description | Status |
|---|---|---|
| 80053 | Comprehensive Metabolic Panel | Disallow |
| 85025 | Complete CBC, automated differential WBC count | Disallow |
| 84443 | Thyroid Stimulating Hormone | Disallow |
| 80050 | General Health Panel | Allow |

**Explanation**: 80053, 85025 and 84443 are included in the lab panel code 80050 and therefore are not separately reimbursable. Those claim lines containing the component codes are denied and only the comprehensive lab panel code is reimbursed.

| Code | Description | Status |
|---|---|---|
| 80053 | Comprehensive Metabolic Panel | Disallow |
| 85025 | Complete CBC, automated differential WBC count | Disallow |
| 84443 | Thyroid Stimulating Hormone | Disallow |
| 80050 | General Health Panel | Add |

Explanation: 80053, 85025 and 84443 are included in the lab panel code 80050 and therefore are not separately reimbursable. Those claim lines containing the component codes are denied and CPT code 80050 is added to a new service line and recommended for reimbursement.

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

| Code | Description | Status |
|---|---|---|
| 69436<br>DOS=01/01/10 | Tympanostomy | Disallow |
| 69436 50<br>DOS=01/01/10 | Tympanostomy billed with modifier 50 (bilateral procedure) | Allow |

Explanation: identifies the same code being billed twice, when reimbursement guidelines require the procedure to be billed once with a bilateral modifier. These should be billed on one line along with modifier 50 (bilateral procedure). Note: Modifiers RT (right), or LT (left) should not be billed for bilateral procedures.

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

| Code | Description | Status |
|---|---|---|
| 72010 | Radiologic exam, spine, entire, survey study, anteroposterior & lateral | Allow |
| 72010 | Radiologic exam, spine, entire, survey study, anteroposterior & lateral | Disallow |

**Explanation:**

Procedure 72010 includes radiologic examination of the lateral and anteroposterior views of the entire spine that allow views of the upper cervical vertebrae, the lower cervical vertebrae, the thoracic vertebrae, the lumbar vertebrae, the sacrum, and the coccyx.

It is clinically unlikely that this procedure would be performed twice on the same date of service.

Example: Evaluation and Management Services – The submission of an evaluation and management (E/M) service either within a global surgery period or on the same date of service of another E/M service.

**Global Surgery - Procedures that are assigned a ninety (90) day global surgery period are designated as major surgical procedures; those assigned a ten (10) day or zero (0) day global surgery period are designated as minor surgical procedures.**

- Evaluation and management services, submitted with major surgical procedures (90-day) and minor surgical procedures (10-day), are not recommended for separate reporting or reimbursement because they are part of the global service.
- Evaluation and management services, submitted with minor surgical procedures (0-day), are not recommended for separate reporting or reimbursement because these services are part of the global service unless otherwise indicated.

Example: global surgery period

| Code | Description | Status |
|---|---|---|
| 27447<br>DOS=05/20/09 | Arthroplasty, knee, condoyle and plateau; medial and lateral compartments with or without patella resurfacing (total knee arthroplasty). | Allow |
| 99213<br>DOS=06/02/09 | Office or other outpatient visit for the evaluation and management of an EST patient, which requires at least two of these three key components: an expanded problem focused history; an expanded problem focused examination; medical decision making of low complexity. Counseling & coordination of care w/other providers or agencies are provided consistent w/nature of problem(s) & patient's &/or family's needs. Problem(s) are low/moderate severity. Physicians spend 15 min face-to-face w/patient &/or family. | Disallow |

**Explanation:**

Procedure code 27447 has a global surgery period of ninety (90) days.
When a substantial diagnostic or therapeutic procedure is performed, the evaluation and management service is included in the global surgical period.

- Procedure code 99213 is submitted with a date of service that is within the ninety (90) day global period.

Example: evaluation and management service submitted with minor surgical procedures

| Code | Description | **Status** |
|---|---|---|
| 11000<br>DOS=01/23/10 | Debridement of extensive eczematous or infected skin; up to 10% of body surface. | Allow |
| 99213<br>DOS=01/23/10 | Office or other outpatient visit for the evaluation and management of an EST patient, which requires at least two of these three key components: an expanded problem focused history; an expanded problem focused examination; medical decision making of low complexity. Counseling and coordination of care with other providers or agencies are provided consistent w/ nature of problem(s) and patient's and/or family's needs. Problem(s) are low/moderate severity. Physicians spend fifteen (15) minutes face-to-face with patient and/or family. | Disallow |

**Explanation:**

- Procedure 11000 (0-day global surgery period) is identified as a minor procedure.
- Procedure 99213 is submitted with the same date of service.
- When a minor procedure is performed, the evaluation and management service is considered part of the global service.

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

| **Code** | **Description** | **Status** |
|---|---|---|
| 99215 | Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a comprehensive history; a comprehensive examination; medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent w/ nature of problem(s) and patient's and/or family's needs. Usually, problem(s) are moderate/high severity. Physicians spend forty (40) minutes face-to-face with patient and/or family. | Allow |
| 99242 | Office consultation for a new or established patient, which requires these three key components: an expanded problem focused history; an expanded problem focused examination; and straightforward medical decision making. Counseling/coordination of care with other providers or agencies are provided consistent with nature of problem(s) and patient's/family's needs. Presenting problem(s) are low severity. Physicians spend thirty (30) minutes face-to-face with patient/family. | Disallow |

**Explanation:**

- Procedure 99215 is used to report an evaluation and management service provided to an established patient during a visit.
- Procedure 99242 is used to report an office consultation for a new or established patient.

- Separate reporting of an evaluation and management service with an office consultation by a single provider indicates a duplicate submission of services. Interventions, provided during an evaluation and management service, typically include the components of an office consultation.

*NOTE:*

Modifiers - Modifiers are added to the main service or procedure code to indicate that the service has been altered in some way by a specific circumstance.

Modifier -24 is used to report an unrelated evaluation and management service by the same physician during a post-operative period.

Modifier -25 is used to report a significant, separately identifiable evaluation and management service by the same physician on the same day of a procedure.

Modifier -79 is used to report an unrelated procedure or service by the same physician during the post-operative period.

When modifiers -24 and -25 are submitted with an evaluation and management service on the same date of service or during the post-operative period by the same physician, the evaluation and management service is questioned and a review of additional information is recommended.

When modifier -79 is submitted with an evaluation and management service on the same date of service or during the post-operative period by the same physician, separate reporting of the evaluation and management service is recommended.

Modifier -26 (professional component)

Definition: Modifier -26 identifies the professional component of a test or study.

- If modifier -26 is not valid for the submitted procedure code, the procedure code is not recommended for separate reporting.
- When a claim line is submitted without the modifier -26 in a facility setting (for example, POS 21, 22, 23, 24), the rule will replace the service line with a new line with the same procedure code and the modifier -26 appended.

**Example:**

| Code | Description | Status |
|---|---|---|
| 78278<br>POS=Inpatient | Acute gastrointestinal blood loss imaging | Disallow |
| 78278-26<br>POS=Inpatient | Acute gastrointestinal blood loss imaging | Allow |

**Explanation:**

Procedure code 78278 is valid with modifier -26.

Modifier -26 will be added to procedure code 78278 when submitted without modifier -26.

Modifier -80, -81, -82, and -AS (assistant surgeon)

Definition: This edit identifies claim lines containing procedure codes billed with an assistant surgeon modifier that typically do not require an assistant surgeon.

Many surgical procedures require aid in prepping and draping the patient, monitoring visualization, keeping the wound clear of blood, holding and positioning the patient, and assisting with wound closure and/or casting (if required). This assistance does not require the expertise of a surgeon. A qualified nurse, orthopedic technician, or resident physician can provide the necessary assistance.

Example:

| Code | Description | Status |
|---|---|---|
| 42820-81 | Tonsillectomy and adenoidectomy; under age 12 | Disallow |

**Explanation:**

Procedure code 42820 is not recommended for Assistant Surgeon reporting because a skilled nurse or surgical technician can function as the assistant in the performance of this procedure.

**Billing Codes**

It is important that providers bill with codes applicable to the date of service on the claim. Billing with obsolete codes will result in a potential denial of the claim and a consequent delay in payment. Submit professional claims with current and valid CPT-4, HCPCS, or ASA codes and ICD-10 codes. Submit institutional claims with valid Revenue Codes and CPT-4 or HCPCS (when applicable), ICD-10 codes, and DRG codes (when applicable).

Providers will also improve the efficiency of their reimbursement through proper coding of a member's diagnosis. We require the use of valid ICD10 diagnosis codes, to the ultimate specificity, for all claims. This means that ICD-10 codes must be carried out to the fourth or fifth digit when indicated by the coding requirements in the ICD-10 manual (Note: not all codes require a fourth or fifth digit). Failure to code diagnoses to the appropriate level of specificity will result in denial of the claim and a consequent delay in payment.

In addition, written descriptions, itemized statements, and invoices may be required for non-specific types of claims or at the request of Magnolia.

## *Attachment A - EOP DENIAL CODES AND DESCRIPTIONS*

| DENIAL CODE | DENIAL DESCRIPTION |
|---|---|
| 07 | DENY: THE PROCEDURE CODE IS INCONSISTENT WITH THE PATIENT'S SEX |
| 09 | DENY: THE DIAGNOSIS IS INCONSISTENT WITH THE PATIENT'S AGE |
| 10 | DENY: THE DIAGNOSIS IS INCONSISTENT WITH THE PATIENT'S SEX |
| 16 | DENY: REVENUE CODE NOT REIMBURSABLE - CPT/HCPCS CODE REQUIRED |
| 18 | DENY: DUPLICATE CLAIM/SERVICE |
| 1K | DENY: CPT OR DX CODE IS NOT VALID FOR AGE OF PATIENT |
| | DENY: VISIT & PREVEN CODES ARE NOT PAYABLE ON SAME DOS W/O DOCUMENTATION |
| 20 | DENY: THIS INJURY IS COVERED BY THE LIABILITY CARRIER |
| 21 | DENY: CLAIM THE RESPONSIBILITY OF THE NO-FAULT CARRIER |
| 22 | DENY: THIS CARE IS COVERED BY A COORDINATION OF BENEFITS CARRIER |
| 23 | DENY: CHARGES HAVE BEEN PAID BY ANOTHER PARTY-COB |
| 24 | DENY: CHARGES COVERED UNDER CAPITATION |
| 25 | DENY: YOUR STOP LOSS DEDUCTIBLE HAS NOT BEEN MET |
| 26 | DENY: EXPENSES INCURRED PRIOR TO COVERAGE |
| 27 | DENY: EXPENSES INCURRED AFTER COVERAGE WAS TERMINATED |
| 28 | DENY: COVERAGE NOT IN EFFECT WHEN SERVICE PROVIDED |
| 29 | DENY: THE TIME LIMIT FOR FILING HAS EXPIRED |
| 35 | DENY: BENEFIT MAXIMUM HAS BEEN REACHED |
| 3D | DENY: NON-SPECIFIC DIAGNOSIS- REQUIRES 4TH DIGIT PLEASE RESUBMIT |
| 46 | DENY: THIS SERVICE IS NOT COVERED |
| 48 | DENY: THIS PROCEDURE IS NOT COVERED |
| 4D | DENY: NON-SPECIFIC DIAGNOSIS- REQUIRES 5TH DIGIT PLEASE RESUBMIT |
| 6L | EOB INCOMPLETE-PLEASE RESUBMIT WITH REASON OF OTHER INSURANCE DENIAL |
| 86 | DENY: THIS IS NOT A VALID MODIFIER FOR THIS CODE |
| 99 | DENY: MISC/UNLISTED CODES CAN NOT BE PROCESSED W/O DESCRIPTION/REPORT |
| 9I | INFORMATION REQUESTED WAS NOT RECEIVED WITHIN THE TIME FRAME SPECIFIED |
| A1 | DENY: AUTHORIZATION NOT ON FILE |
| BG | DENY: TYPE OF BILL MISSING OR INCORRECT ON CLAIM, PLEASE RE-SUBMIT |
| BI | DENY: CLAIM CANNOT BE PROCESSED WITHOUT AN ITEMIZED BILL |

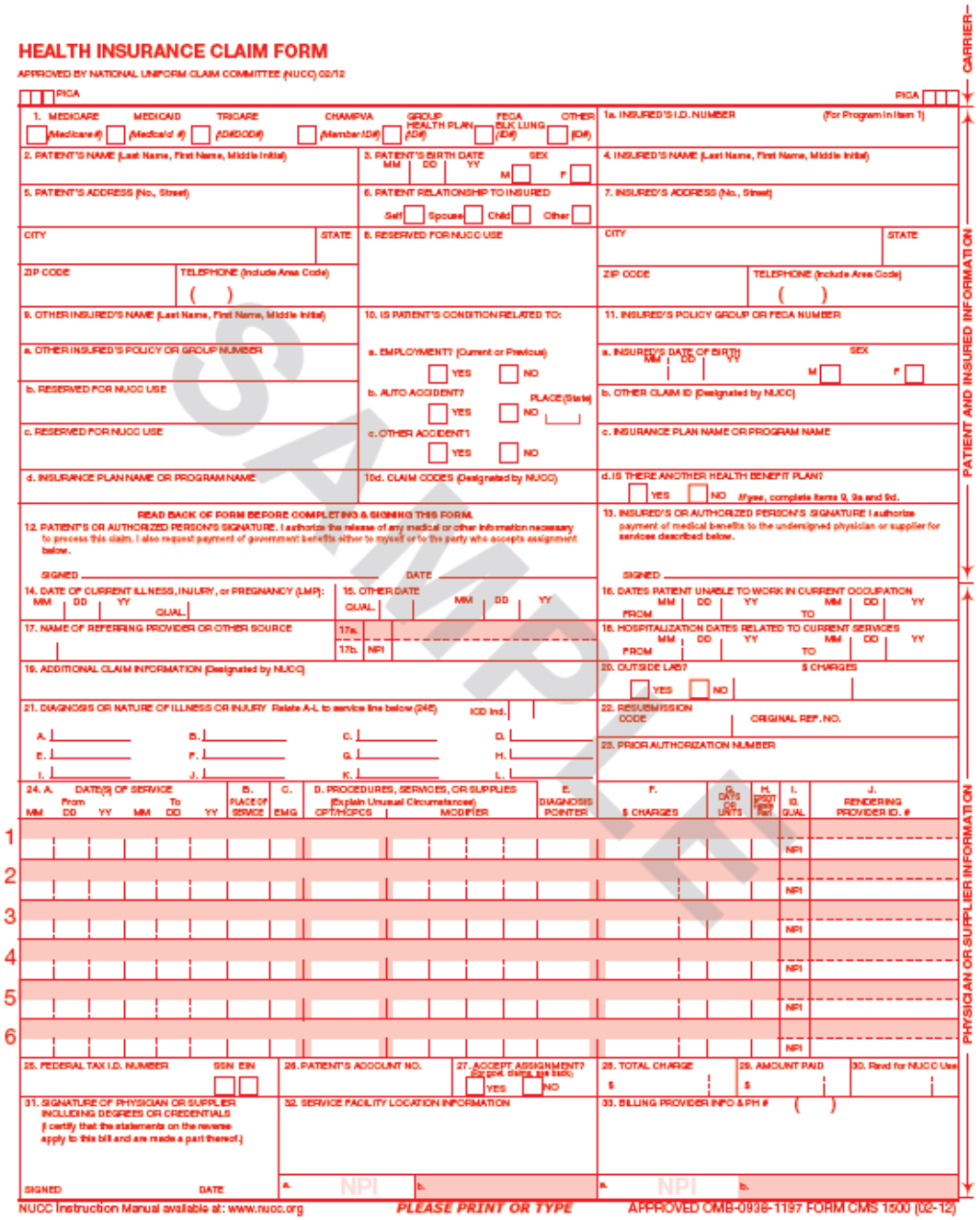
| | DENIAL DESCRIPTION |
|---|---|
| C2 | CPT HAS BEEN REBUNDLED ACCORDING TO CLAIM AUDIT |
| C6 | CPT HAS BEEN REPLACED ACCORDING TO CLAIM AUDIT |
| C8 | CPT HAS BEEN DENIED ACCORDING TO CLAIM AUDIT |
| CV | DENY: BILL WITH SPECIFIC VACCINE CODE |
| DD | DENY: SIGNED CONSENT FORM HAS NOT BEEN RECEIVED |
| DJ | DENY: INAPPROPRIATE CODE BILLED, CORRECT & RESUBMIT |
| DS | DENY: DUPLICATE SUBMISSION-ORIGINAL CLAIM STILL IN PEND STATUS |
| DT | DENY: PLEASE FORWARD TO THE DENTAL VENDOR FOR PROCESSING. |
| DW | DENY: INAPPROPRIATE DIAGNOSIS BILLED, CORRECT AND RESUBMIT |
| DX | DIAGNOSIS BILLED IS INVALID, PLEASE RESUBMIT WITH CORRECT CODE. |
| DY | DENY: APPEAL DENIED |
| DZ | DENY: SERVICE HAS EXCEEDED THE AUTHORIZED LIMIT |
| EB | DENY: DENIED BY MEDICAL SERVICES |
| EC | DIAGNOSIS CANNOT BE USED AS PRIMARY DIAGNOSIS, PLEASE RESUBMIT |
| FP | DENY: CLAIMS DENIED FOR PROVIDER FRAUD. |
| | |
| GL | SERVICE COVERED UNDER GLOBAL FEE AGREEMENT |
| | |
| H1 | DENY: PROVIDER MUST USE HCPC/CPT FOR CORRECT PRICING |
| HL | DENY: CLAIM AND AUTH LOCATIONS DO NOT MATCH |
| HP | DENY: CLAIM AND AUTH SERVICE PROVIDER NOT MATCHING |
| HQ | DENY: EDI CLAIM MUST BE SUBMITTED IN HARD COPY W/CONSENT FORM ATTACHED |
| HS | DENY: CLAIM AND AUTH PROVIDER SPECIALTY NOT MATCHING |
| HT | DENY: CLAIM AND AUTH TREATMENT TYPE NOT MATCHING |
| I1 | OTHER INSURANCE EOB SUBMITTED DOES NOT MATCH BILLED, PLEASE RESUBMIT |
| I9 | DENY: DIAGNOSIS IS AN INVALID OR DELETED ICD9 CODE |

| | |
|---|---|
| IE | CPT NOT REIMBURSED SEPARATELY. INCLUDED AS PART OF INCLUSIVE PROCEDURE |
| **DENIAL CODE** | **DENIAL DESCRIPTION** |
| IK | DENY: 2ND EM NOT PAYABLE W/O MODIFIER 25 & MED RECORDS, PLEASE RESUBMIT |
| IL | VERIFY THE CORRECT LOCATION CODE FOR SERVICE BILLED AND RESUBMIT |
| IM | DENY: RESUBMIT WITH MODIFIER SPECIFIED BY STATE FOR PROPER PAYMENT |
| IV | DENY: INVALID/DELETED/MISSING CPT CODE |
| L0 | PLEASE RESUBMIT WITH THE PRIMARY MEDICARE EXPLANATION OF BENEFITS |
| L6 | DENY: BILL PRIMARY INSURER 1ST. RESUBMIT WITH EOB. |
| LO | DENY: CPT & LOCATION ARE NOT COMPATIBLE, PLEASE RESUBMIT. |
| M5 | DENY: IMMUNIZATION ADMINISTRATION INCLUDED IN INJECTION FEE |
| | |
| MG | DENY: SIGNATURE MISSING FROM BOX 31, PLEASE RESUBMIT |
| MH | DENY: PLEASE SUBMIT TO MENTAL HEALTH PLAN FOR PROCESSING |
| MO | MODIFIER BILLED IS NOT VALID, PLEASE RESUBMIT WITH CORRECT CODE. |
| MQ | DENY: MEMBER NAME/NUMBER/DATE OF BIRTH DO NOT MATCH, PLEASE RESUBMIT |
| MY | DENY: MEMBER'S PCP IS CAPITATED - SERVICE NOT REIMBURSABLE TO OTHER PCPS |
| | DENY: NAME OF DRUG, NDC NUMBER AND QUANTITY IS REQUIRED TO PROCESS CLAIM |
| ND | DENY: THIS IS A DELETED CODE AT THE TIME OF SERVICE |
| NT | DENY: PROVIDER NOT CONTRACTED FOR THIS SERVICE-DO NOT BILL PATIENT |
| NV | DENY: STERILIZATION CONSENT FORM IS NOT VALID OR IS MISSING INFORMATION |
| NX | DENY: INVALID OR NO TAX ID NUMBER SUBMITTED ON CLAIM, PLEASE RESUBMIT |
| OX | DENY: CODE IS CONSIDERED AN INTEGRAL COMPONENT OF THE E/M CODE BILLED |
| PF | DENY: PROFESSIONAL FEE MUST BE BILLED ON HCFA FORM |
| RC | DENY: REQUIRED REFERRAL CODE FOR HEALTH CHECK VISIT INVALID OR MISSING |
| RD | DENY: REVENUE CODE AND DIAGNOSIS ARE NOT COMPATIBLE. PLEASE RESUBMIT. |
| RX | DENY: PLEASE SUBMIT TO THE PHARMACY VENDOR FOR PROCESSING. |

| | |
|---|---|
| TM | TO COMPLETE PROCESSING, WE NEED THE TIME UNITS, PLEASE RESUBMIT. |
| U1 | CLAIM CANNOT BE PROCESSED WITHOUT MEDICAL RECORDS |
| U5 | DENY: UNLISTED / UNSPECIFIC CODE -RE-BILL MORE SPECIFIC CODE |
| **DENIAL CODE** | **DENIAL DESCRIPTION** |
| V3 | MED RECORDS RECEIVED FOR WRONG DATE OF SERVICE |
| V4 | MED RECORDS RECEIVED NOT LEGIBLE |
| V5 | MED RECORDS RECEIVED FOR WRONG PATIENT |
| V6 | MED RECORDS WITHOUT LEGIBLE PATIENT NAME AND/OR DOS |
| V8 | MED RECORDS RECEIVED WITHOUT DOS |
| VC | DENY - PLEASE RESUBMIT ACCORDING TO VACCINES FOR CHILDREN GUIDELINES |
| VS | DENY: PLEASE SUBMIT TO THE VISION VENDOR FOR PROCESSING. |
| x3 | PROCEDURE CODE UNBUNDLED FROM GLOBAL PROCEDURE CODE |
| x4 | PROCEDURE CODE/ICD-9 CODE INCONSISTENT WITH MEMBERS GENDER |
| x5 | PROCEDURE CODE CONFLICTS WITH MEMBER'S AGE |
| x6 | ADD-ON CODE REQUIRED WITH PRIMARY CODE FOR QUANTITY GREATER THAN ONE |
| x7 | ADD-ON CODE CANNOT BE BILLED WITHOUT PRIMARY CODE |
| x8 | MODIFIER INVALID FOR PROCEDURE OR MODIFIER NOT REPORTED |
| x9 | PROCEDURE CODE PAIRS INCIDENTAL, MUTUALLY EXCLUSIVE OR UNBUNDLED |
| xa | CODE IS A COMPONENT OF A MORE COMPREHENSIVE CODE |
| xb | PROCEDURE CODE NOT ELIGIBLE FOR ANESTHESIA |
| xc | PROCEDURE/DIAGNOSIS CODE DELETED, INCOMPLETE OR INVALID |
| xd | PROCEDURE CODE PREVIOUSLY BILLED ON HISTORICAL CLAIM |
| xe | PROCEDURE CODE INCONSISTENT WITH MEMBER'S AGE |
| xf | MAXIMUM ALLOWANCE EXCEEDED |
| xg | SINGLE/UNILATERAL PROCEDURE SUBMITTED MORE THAN ONCE ON THE SAME DOS |
| xh | SERVICE LINE REPRESENTS DENIAL OF ADDITIONAL UNITS BILLED |

| | |
|---|---|
| ZC | DENY: PROCEDURE IS INAPPROPRIATE FOR PROVIDER SPECIALTY |

## ATTACHMENT B: SAMPLE CMS 1500 CLAIM FORM



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE (ID/DOD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code)

ZIP CODE TELEPHONE (Include Area Code)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? PLACE (State) YES NO

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP): MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

| 24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY | B. PLACE OF SERVICE | C. EMG | D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS | MODIFIER | E. DIAGNOSIS POINTER | F. $ CHARGES | G. DAYS OR UNITS | H. EPSDT Family Plan | I. ID. QUAL. | J. RENDERING PROVIDER ID. # |
|---|---|---|---|---|---|---|---|---|---|---|
| 1 | | | | | | | | | NPI | |
| 2 | | | | | | | | | NPI | |
| 3 | | | | | | | | | NPI | |
| 4 | | | | | | | | | NPI | |
| 5 | | | | | | | | | NPI | |
| 6 | | | | | | | | | NPI | |

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM CMS 1500 (02-12)

SAMPLE

### *Attachment C - CMS 1500 Claim Form Instructions*

The following table outlines each field within a CMS 1500 form. Please note:

• Required fields (indicated as “R”) must be completed on all claims. Claims with missing or invalid required field information will be rejected or denied.

• Conditional fields (indicated as “C”) must be completed if the information applies to the situation or the service provided.

• **Not Required field (indicated as “Not Required”) do not need to be completed.**

| Field # | Field Description | Instruction or Comments | Required or Conditional |
|---|---|---|---|
| 1 | Insurance Program Identification | Check only the type of health coverage applicable to the claim. This field indicates the payer to whom the claim is being filed. Select "D", other. | Not Required |
| 1a | Insured ID Number | The 10 digit Medicaid ID number on the member's Superior ID card. | R |
| 2 | Patient's Name (Last Name, First Name, Middle Initial) | Enter the patient's name as it appears on the member's Superior ID card. Do not use nicknames. | R |
| 3 | Patient's Birth Date / Sex | Enter the patient's 8 digit date of birth (MM/DD/YYYY) and mark the appropriate box to indicate the patient's sex/gender. M = male F = female | R |
| 4 | Insured's Name | Enter the patient's name as it appears on the member's Superior ID card. | R |
| 5 | Patient's Address (Number, Street, City, State, Zip code), Telephone (include area code) | Enter the patient's complete address and telephone number including area code on the appropriate line.<br>First line – Enter the street address. Do not use commas, periods, or other punctuation in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101).<br>Second line – In the designated block, enter the city and state.<br>Third line – Enter the zip code and phone number. When entering a 9-digit zip code (zip+4 codes), include the hyphen. Do not use a hyphen or space as a separator within the telephone number (i.e. (803)5551414).<br>Note: Patient's telephone does not exist in the electronic 837 Professional 4010A1. | R |
| 6 | Patient's Relation to Insured | Always mark to indicate self. | C |
| 7 | Insured's Address (Number, Street, City, State, Zip code), Telephone (include area code) | Enter the patient's complete address and telephone number including area code on the appropriate line.<br>First line – Enter the street address. Do not use commas, periods, or other punctuation in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101).<br>Second line – In the designated block, enter the city and state.<br>Third line – Enter the zip code and phone number. When entering a 9-digit zip code (zip+4 codes), include the hyphen. Do not use a hyphen or space as a separator within the telephone number (i.e. (803)5551414).<br>Note: Patient's telephone does not exist in the electronic 837 Professional 4010A1. | Not Required |
| 8 | Reserved for NUCC use | | Not Required |
| 9 | Other Insured's Name (Last Name, First Name, Middle Initial) | Refers to someone other than the patient. Required if patient is covered by another insurance plan. Enter the complete name of the insured.<br>NOTE: COB claims that require attached EOBs must be submitted on paper. | C |
| 9a | Other Insured's Policy or Group Number | Required if # 9 is completed. Enter the policy or group number of the other insurance plan. | C |
| 9b | Reserved for NUCC use | This field was previously used to report "Other Insured's Date of Birth, Sex" but it does not exist in 5010A1. The NUCC will provide instructions for any use of this field. | Not Required |
| 9c | Reserved for NUCC use | This field was previously used to report "Employers Name or School Name" but it does not exits in 5010A1. The NUCC will provide instructions for any use of this field. | Not Required |
| 9d | Insurance Plan Name or Program Name | Required if # 9 is completed. Enter the other insured's (name of person listed in box 9) insurance plan or program name. | C |
| 10a, b, c | Is Patient's Condition Related To: | Enter a yes or no for each category/line (a, b, and c). Do not enter a yes and no in the same category/line. | R |
| 10d | Reserved for Local Use | | Not Required |

| Field # | Field Description | Instruction or Comments | Required or Conditional |
|---|---|---|---|
| 11 | Insured's policy group or FECA number | Required when other insurance is available. Enter the policy, group, or FECA number of the other insurance. | C |
| 11a | Insured's Date of Birth / Sex | Same as field 3. | C |
| 11b | Other Claim ID (Designated by NUCC) | The "Other Claim ID" is another identifier applicable to the claim. | |
| 11c | Insurance Plan Name or Program Name | Enter name of the insurance health plan or program. | C |
| 11d | Is There Another Health Benefit Plan | Mark yes or no. If yes, complete # 9a-d and #11c. | R |
| 12 | Patient's or Authorized Person's Signature | Enter "Signature on File," "SOF," or the actual legal signature. The provider must have the member's or legal guardian's signature on file or obtain their legal signature in this box for the release of information necessary to process and/or adjudicate the claim. | Required |
| 13 | Patient's or Authorized Person's Signature | | Not Required |
| 14 | Date of Current Illness), or Injury (), or Pregnancy (LMP) | Enter the 6 digit (MM/DD/YY) or 8 digit (MM/DD/YYYY) date reflecting the first date of onset for the Present Illness, Injury or LMP (last menstrual period) if pregnant. Enter the applicable qualifier to identify which date is being reported:<br>431 Onset of Current Symptoms or Illness<br>484 Last Menstrual Period<br><br>Enter the qualifier to the right of the vertical, dotted line. | C |
| 15 | Other Date | Enter another date related to the patient's condition or treatment. Enter the date in the 6-digit (MM\|DD\|YY) or 8-digit (MM\|DD\|YYYY) format. Enter the applicable qualifier to identify which date is being reported:<br>454 Initial Treatment<br>304 Latest visit or Consultation<br>453 Acute manifestation of a Chronic Condition<br>439 Accident<br>455 Last X-ray<br>471 Prescription<br>090 Report Start (Assumed Care Date)<br>091 Report End (Relinquished Care Date)<br>444 First Visit or Consultation<br><br>Enter the qualifier between the left-hand set of vertical, dotted lines. The "Other Date" identifies additional date information about the patient's condition or treatment. | C |
| 16 | Dates Patient Unable to Work in Current Occupation | If the patient is employed and is unable to work in current occupation, a 6-digit (MM/DD/YY) or 8-digit (MM/DD/YYYY) date must be shown for the "from–to" dates that the patient is unable to work. An entry in this field may indicate employment-related insurance coverage. | C |
| 17 | Name of Referring Physician or Other Source | Enter the name (First Name, Middle Initial, Last Name) followed by the credentials of the professional who referred or ordered the service(s) or supply(ies) on the claim. If multiple providers are involved, enter one provider using the following priority order:<br>1. Referring provider<br>2. Ordering provider<br>3. Supervising provider<br><br>Do not use periods or commas. A hyphen can be used for hyphenated names. Enter the applicable qualifier to identify which provider is being reported:<br>DN Referring provider<br>DK Ordering provider<br>DQ Supervising provider<br><br>Enter the qualifier to the left of the vertical, dotted line. | C |

| Field # | Field Description | Instruction or Comments | Required or Conditional |
|---|---|---|---|
| 17a | ID Number of Referring Physician | Required if 17 is completed. Use ZZ qualifier for taxonomy code. | C |
| 17b | NPI Number of Referring Physician | Required if 17 is completed. If unable to obtain referring NPI, servicing NPI may be used. | C |
| 18 | Hospitalization Dates Related to Current Services | | Not Required |
| 19 | Supervising Physician for Referring Physician | If there is a Supervising Physician for the referring or ordering provider that is listed in Block 17, the name and NPI of the supervising provider must go in Block 19. | Not Required |
| 20 | Outside Lab/Charges | Check the appropriate box. The information may be requested for retrospective review. If "yes," enter the provider identifier of the facility that performed the service in block 32 | Not Required |
| 21 | Diagnosis or Nature of Illness or Injury. (Relate Items A-L to service line below (24E) | The "ICD Indicator" identifies the version of the ICD code set being reported. The "Diagnosis or Nature of Illness or Injury" is the sign, symptom, complaint, or condition of the patient relating to the service(s) on the claim.<br><br>Enter the applicable ICD indicator to identify which version of ICD codes is being reported:<br>9 ICD-9-CM<br>0 ICD-10-CM<br><br>Enter the indicator between the vertical, dotted lines in the upper right-hand portion of the field. Enter the codes to identify the patient's diagnosis and/or condition. List no more than 12 ICD-9-CM or ICD-10-CM diagnosis codes. Relate lines A - L to the lines of service in 24E by the letter of the line. Use the highest level of specificity. Do not provide narrative description in this field.<br><br>Claims missing or with invalid diagnosis codes will be denied for payment. | R |
| 22 | Resubmission Code / Original Reference Number | For resubmissions or adjustments, enter the 12 character document control number (DCN ) of the original claim..<br>Note: For resubmissions submitted via EDI, the CLM05-3 must be "7" and in the web loop a RED "F8" must be sent with the original claim number. | R |
| 23 | Prior Authorization Number | Superior does not require the Prior Authorization Number on the Claims form; it is stored with the case internally, so must still be requested as needed.<br>Providers are encouraged to enter their Clinical Laboratory Improvement Amendments (CLIA) Number as assigned.<br><br>Enter any of the following: prior authorization number, referral number, mammography pre-certification number, or Clinical Laboratory Improvement Amendments (CLIA) number, as assigned by the payer for the current service. Do not enter hyphens or spaces within the number | C |
| 24A -J | General Information | Box 24 contains 6 claim lines. Each claim line is split horizontally into shaded and unshaded areas. Within each unshaded area of a claim line there are 10 individual fields labeled A-J. Within each shaded area of a claim line there are 4 individual fields labeled 24A-G, 24H, 24J and 24Jb. Fields 24A-G are a continuous field for the entry of supplemental information. Instructions are provided for shaded and unshaded fields.<br>The shaded area for a claim line is to accommodate the submission of supplemental information, EPSDT qualifier, Provider Medicaid number qualifier, and provider Medicaid number.<br>Shaded boxes A-G is for line item supplemental information and is a continuous line that accepts up to 61 characters.<br>The un-shaded area of a claim line is for the entry of claim line item detail. | See Below |

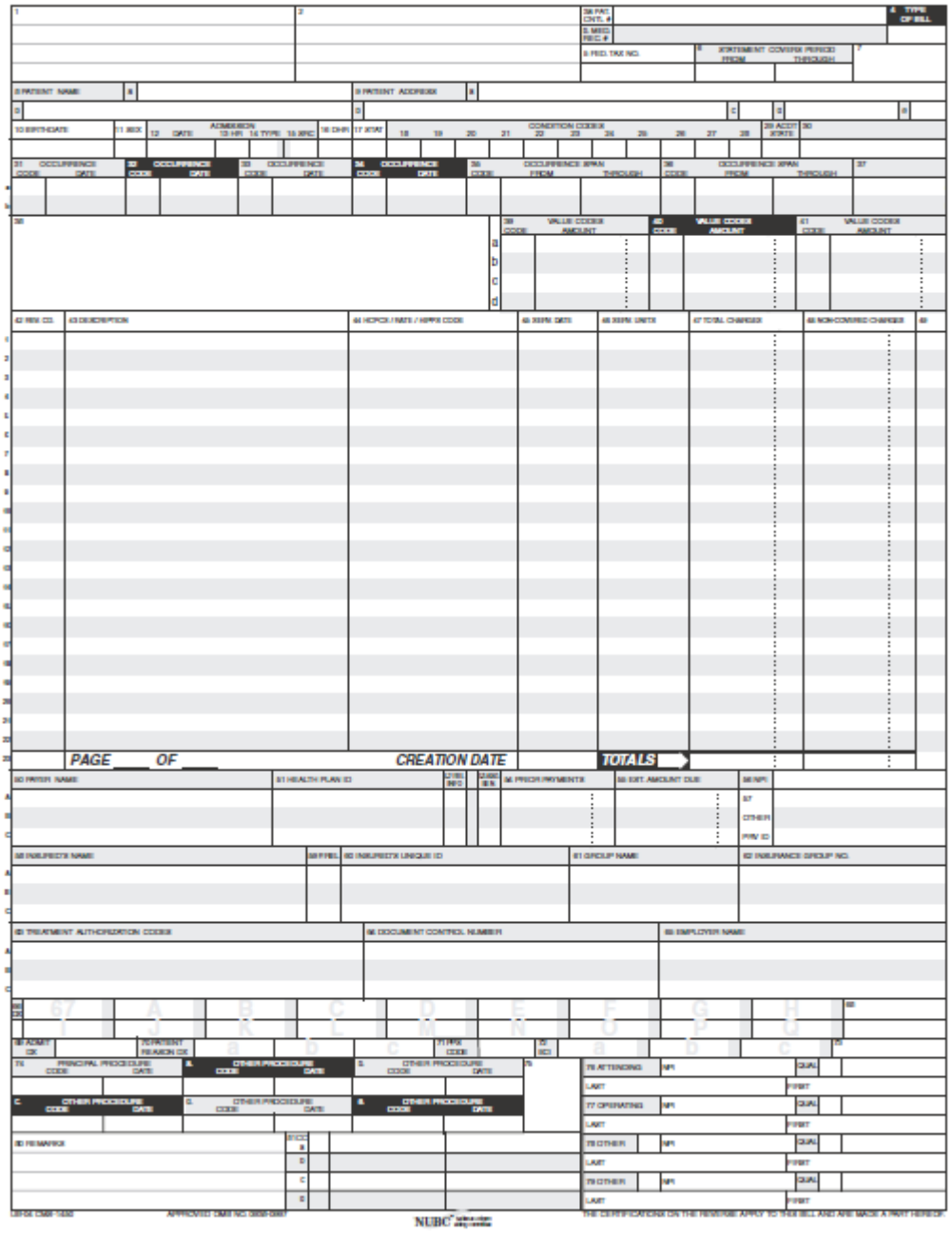
<table>
<tr><th>Field #</th><th>Field Description</th><th>Instruction or Comments</th><th>Required or Conditional</th></tr>
<tr><td>24A-G Shaded</td><td>Supplemental Information</td><td>The shaded top portion of each service claim line is used to report supplemental information for:<ul><li>Qualifier along with NDC, units and base measurement code are required where applicable</li><li>Compound drug elements</li><li>Anesthesia start/stop time and duration</li><li>Unspecified, miscellaneous, or unlisted CPT and HCPC code descriptions</li><li>HIBCC or GTIN number/code</li></ul></td><td>C</td></tr>
<tr><td>24A Unshaded</td><td>Date(s) of Service</td><td>Enter the date the service listed in 24D was performed (MM/DD/YY). If there is only one date, enter that date in the From field. The To field may be left blank or populated with the From date. If identical services (identical CPT/ HCPC code(s)) were performed, each date must be entered on a separate line.</td><td>R</td></tr>
<tr><td>24B Unshaded</td><td>Place of Service</td><td>Enter the appropriate 2 digit CMS standard place of service (POS) code. A list of current POS codes may be found on the CMS website or the following link: www.cms.hhs.gov/PlaceofServiceCodes/Downloads/placeofservice.pdf.</td><td>R</td></tr>
<tr><td>24C Unshaded</td><td>EMG</td><td>Enter Y (yes) or N (no) to indicate if the service was an emergency.</td><td>R</td></tr>
<tr><td>24D Unshaded</td><td>Procedures, Services or Supplies CPT/ HCPCS Modifier</td><td>Enter the 5 digit CPT or HCPC code and 2 character modifier if applicable. Only one CPT or HCPC and up to 4 modifiers may be entered per claim line. Codes entered must be valid for date of service. Missing or invalid codes will be denied for payment.<br>Only the first modifier entered is used for pricing the claim. Failure to use modifiers in the correct position or combination with the procedure code, or invalid use of modifiers, will result in a rejected, denied, or incorrectly paid claim. The following national modifiers are recognized as modifiers that will impact the pricing of your claim.
<table>
<tr><td>26</td><td>50</td><td>54</td><td>55</td><td>62</td></tr>
<tr><td>66</td><td>76</td><td>80</td><td>81</td><td>82</td></tr>
<tr><td>AA</td><td>AD</td><td>AS</td><td>ET</td><td>FP</td></tr>
<tr><td>GN</td><td>GO</td><td>GP</td><td>NU</td><td>QK</td></tr>
<tr><td>QX</td><td>QY</td><td>QZ</td><td>RR</td><td>SA</td></tr>
<tr><td>TC</td><td>TD</td><td>TE</td><td>TF</td><td>TG</td></tr>
<tr><td>TH</td><td>U1</td><td>U5</td><td>U6</td><td>U7</td></tr>
</table></td><td>R</td></tr>
<tr><td>24E Unshaded</td><td>Diagnosis Pointer</td><td>In 24E, enter the diagnosis code reference letter (pointer) as shown in Item Number 21 to relate the date of service and the procedures performed to the primary diagnosis. When multiple services are performed, the primary reference letter for each service should be listed first, other applicable services should follow. The reference letter(s) should be A – L or multiple letters as applicable. ICD-9-CM (or ICD-10-CM, once mandated) diagnosis codes must be entered in Item Number 21 only. Do not enter them in 24E.</td><td>R</td></tr>
<tr><td>24F Unshaded</td><td>Charges</td><td>Enter the charge amount for the claim line item service billed. Dollar amounts to the left of the vertical line should be right justified. Up to 8 characters are allowed (i.e. 199,999.99). Do not enter a dollar sign ($). If the dollar amount is a whole number (i.e. 10.00), enter 00 in the area to the right of the vertical line.</td><td>R</td></tr>
<tr><td>24G Unshaded</td><td>Days or Units</td><td>Enter the number of days or units. This field is most commonly used for multiple visits, units of supplies, anesthesia units or minutes, or oxygen volume. If only one service is performed, the numeral 1 must be entered.<br>Enter numbers left justified in the field. No leading zeros are required. If reporting a fraction of a unit, use the decimal point.<br>Anesthesia services must be reported as minutes. Units may only be reported for anesthesia services when the code description includes a time period (such as "daily management").</td><td>R</td></tr>
</table>

| Field # | Field Description | Instruction or Comments | Required or Conditional |
|---|---|---|---|
| 24H | Shaded EPSDT (Chcup) Family Planning | Leave blank. | Not Required |
| 24H Unshaded | EPSDT (Chcup) Family Planning | For Early & Periodic Screening, Diagnosis, and Treatment related services, enter the response in the shaded portion of the field as follows:<br><br>If there is no requirement (e.g., state requirement) to report a reason code for EPDST, enter Y for "YES" or N for "NO" only.<br><br>If there is a requirement to report a reason code for EPDST, enter the appropriate reason code as noted below. (A Y or N response is not entered with the code.) The two character code is right justified in the shaded area of the field.<br><br>The following codes for EPSDT are used in 5010A1:<br>AV Available – Not Used (Patient refused referral.)<br>S2 Under Treatment (Patient is currently under treatment for referred diagnostic or corrective health problem.)<br>ST New Service Requested (Referral to another provider for diagnostic or corrective treatment/scheduled for another appointment with screening provider for diagnostic or corrective treatment for at least one health problem identified during an initial or periodic screening service, not including dental referrals.)<br>NU Not Used (Used when no EPSDT patient referral was given.)<br><br>If the service is Family Planning, enter Y ("YES") or N ("NO") in the bottom, unshaded area of the field. | C |
| 24I Shaded | ID Qualifier | Use ZZ qualifier for taxonomy.<br>Use 1D qualifier for Medicaid ID, if an atypical provider. | R |
| 24J Shaded | Non-NPI Provider ID | Enter taxonomy code. Typical providers:<br>Enter the provider taxonomy code or Medicaid provider ID number that corresponds to the qualifier entered in 24I shaded. Use ZZ qualifier for taxonomy code. | R |
| 24J Unshaded | NPI Provider Id | Typical providers only: Enter the 10 character NPI ID of the provider who rendered services. If the provider is billing as a member of a group, the rendering individual provider's 10 character NPI ID may be entered. . Enter the billing NPI if services are not provided by an individual (e.g. DME, independent lab, home health, RHC/FQHC general medical exam, etc.) | R |
| 25 | Federal Tax ID Number SSN/EIN | Enter the provider or supplier 9 digit federal Tax ID number and mark the box labeled EIN. | R |
| 26 | Patient's Account Number | Enter the provider's billing account number. | Not Required |
| 27 | Accept Assignment | Enter an X in the YES box. Submission of a claim for reimbursement of services provided to a Medicaid recipient using Medicaid funds indicates the provider accepts Medicaid assignment. Refer to the back of the CMS 1500 (12-90) form for the section pertaining to Medicaid payments. | R |
| 28 | Total Charges | Enter the total charges for all claim line items billed – claim lines 24F. Dollar amounts to the left of the vertical line should be right justified. Up to 8 characters are allowed (i.e. 199,999.99). Do not enter a dollar sign ($). If the dollar amount is a whole number (i.e. 10.00), enter 00 in the area to the right of the vertical line. | R |
| 29 | Amount Paid | Required when another carrier is the primary payer. Enter the payment received from the primary payer prior to invoicing Superior. Medicaid programs are always the payers of last resort.<br>Dollar amounts to the left of the vertical line should be right justified. Up to 8 characters are allowed (i.e. 199,999.99). Do not enter a dollar sign ($). If the dollar amount is a whole number (i.e. 10.00), enter 00 in the area to the right of the vertical line. | C |

| Field # | Field Description | Instruction or Comments | Required or Conditional |
|---|---|---|---|
| 30 | Reserved for NUCC Use | This field was previously used to report "Balance Due." "Balance Due" does not exist in 5010A1, so this field has been eliminated. | Not Required |
| 31 | Signature of Physician or Supplier Including Degrees or Credentials | Acceptable Signature Requirements for Submission include:<br>• Typed signature in box 31<br>• Name of group in box 33 is listed in box 31<br>• Handwritten signature in box 31<br>• Stamped signatrue in box 31<br>• Signature on file<br>This feature does not exist in the electronic 837P. | Required |
| 32 | Service Facility Location Information | Required if the location where services were rendered is different from the billing address listed in field 33.<br>Enter the name and physical location. (P.O. box numbers are not acceptable here.)<br>First line – Enter the business/facility/practice name.<br>Second line– Enter the street address. Do not use commas, periods, or other punctuation in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101).<br>Third line – In the designated block, enter the city and state.<br>Fourth line – Enter the zip code and phone number. When entering a 9 digit zip code (zip+4 codes), include the hyphen. | C |
| 32a | NPI – Services Rendered | Typical providers only: Required if the location where services were rendered is different from the billing address listed in field 33.<br>Enter the 10 character NPI ID of the facility where services were rendered. | R, if Field #32 is populated |
| 32b | Other Provider ID | Required if the location where services were rendered is different from the billing address listed in field 33.<br>Typical providers<br>Enter the 2 character qualifier ZZ followed by the taxonomy code (no spaces).<br>Atypical providers<br>Enter the 2 character qualifier ID followed by the 6 character Medicaid provider ID number (no spaces). | R, if Field #32 is populated |
| 33 | Billing Provider Info and Phone Number | Enter the billing provider's complete name, address (include the zip + 4 code), and phone number.<br>First line – Enter the business/facility/practice name.<br>Second line – Enter the street address. Do not use commas, periods, or other punctuation in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101).<br>Third line – In the designated block, enter the city and state.<br>Fourth line – Enter the zip code and phone number. When entering a 9 digit zip code (zip+4 codes), include the hyphen. Do not use a hyphen or space as a separator within the telephone number (i.e. (803)551414). | R |
| 33a | Group Billing NPI | Typical providers only: Required if the location where services were rendered is different from the billing address listed in field 33.<br>Enter the 10 character NPI ID. | R |
| 33b | Group Billing Other ID | Enter as designated below the Billing Group Medicaid ID number or taxonomy code.<br>Typical providers:<br>Enter the provider taxonomy code. Use ZZ qualifier.<br>Atypical providers:<br>Enter the 6 digit Medicaid provider ID number. | R |

## *ATTACHMENT D: SAMPLE UB-04 CLAIM FORM*

### 6.6.3 UB-04 CMS-1450 Blank Paper Claim Form



## *Attachment E - UB-04 Claim Instructions*

The following table outlines each field within a UB-04 claim form. Please note that:
• Required fields (indicated as “R”) must be completed on the claim form.
• Conditional fields (indicated as “C”) must be completed if the information applies to the situation or the service provided.
• Not Required fields (indicated as “Not Required”) do not need to be completed.

| Field # | Field Description | Instruction or Comments | Required or Conditional |
|---|---|---|---|
| 1 | (Unlabeled Field) | Line 1: Enter the complete provider name.<br>Line 2: Enter the complete mailing address.<br>Line 3: Enter the city, state, and zip+4 code (include hyphen).<br>Line 4: Enter the area code and phone number. | R |
| 2 | (Unlabeled Field) | Enter the pay-to name and address. | Not Required |
| 3a | Patient Control Number | Enter the facility patient account/control number | Not Required |
| 3b | Medical Record Number | Enter the facility patient medical or health record number. | R |
| 4 | Type of Bill | Enter the appropriate 3 digit type of bill (TOB) code as specified by theNUBC UB-04/CMS 1450 Uniform Billing Manual minus the leading "0" (zero). A leading "0" is not needed. Digits should be reflected as follows:<br>1st digit - Indicating the type of facility.<br>2nd digit - Indicating the type of care.<br>3rd digit - Indicating the billing sequence. | R |
| 5 | Federal Tax ID Number | Enter the 9 digit number assigned by the federal government for tax reporting purposes. | R |
| 6 | Statement Covers Period From/ Through | Enter begining and ending or admission and discharge dates for the services billed. Inpatient and outpatient observation stays must be billed using the admission date and discharge date. Outpatient therapy, chemotherapy, laboratory, pathology, radiology and dialysis may be billed using a date span. All other outpatient services must be billed using the actual date of service (MM/DD/YY). | R |
| 7 | (Unlabeled Field) | Not used. | Not Required |
| 8 a-b | Patient Name | 8a – Enter the patient's 10 digit Medicaid ID number on the member's Superior ID card.<br>8b – Enter the patient's last name, first name, and middle initial as it appears on the Superior ID card. Use a comma or space to separate the last and first names.<br>Titles: (Mr., Mrs., etc.) should not be reported in this field.<br>Prefix: No space should be left after the prefix of a name e.g. McKendrick.<br>Hyphenated names: Both names should be capitalized and separated by a hyphen (no space).<br>Suffix: A space should separate a last name and suffix. | Not Required<br>R |
| 9 a-e | Patient Address | Enter the patient's complete mailing address.<br>Line a: Street address<br>Line b: City<br>Line c: State<br>Line d: ZIP code<br>Line e: Country code (not required) | R |
| 10 | Birthdate | Enter the patient's date of birth (MM/DD/YYYY) | R(except line 9e) |
| 11 | Sex | Enter the patient's sex. Only M or F is accepted. | R |
| 12 | Admission Date | Enter the date of admission for inpatient claims and date of service for outpatient claims. | R |

| Field # | Field Description | Instruction or Comments | Required or Conditional |
|---|---|---|---|
| 13 | Admission Hour | Enter the time using 2 digit military time (00-23) for the time of inpatient admission or time of treatment for outpatient services.<br>00-12:00 midnight to 12:59 12- 12:00 noon to 12:59<br>01- 01:00 to 01:59 13- 01:00 to 01:59<br>02- 02:00 to 02:59 14- 02:00 to 02:59<br>03- 03:00 to 03:39 15- 03:00 to 03:59<br>04- 04:00 to 04:59 16- 04:00 to 04:59<br>05- 05:00 to 05:59 17- 05:00 to 05:59<br>06- 06:00 to 06:59 18- 06:00 to 06:59<br>07- 07:00 to 07:59 19- 07:00 to 07:59<br>08- 08:00 to 08:59 20- 08:00 to 08:59<br>09- 09:00 to 09:59 21- 09:00 to 09:59<br>10- 10:00 to 10:59 22- 10:00 to 10:59<br>11- 11:00 to 11:59 23- 11:00 to 11:59 | R |
| 14 | Admission Type | Required for inpatient admissions TOB 11X, 118X, 21X, 41X. Enter the 1 digit code indicating the priority of the admission using one of the following codes:<br>1 Emergency<br>2 Urgent<br>3 Elective<br>4 Newborn<br>5 Trauma | C |
| 15 | Admission Source | Enter the 1 digit code indicating the source of the admission or outpatient service using one of the following codes:<br>For Type of admission 1,2,3 or 5:<br>1 Physician referral<br>2 Clinic referral<br>3 Health maintenance referral (HMO)<br>4 Transfer from a hospital<br>5 Transfer from skilled nursing facility (SNF)<br>6 Transfer from another health care facility<br>7 Emergency room<br>8 Court/law enforcement<br>9 Information not available<br><br>For type of admission 4 (newborn):<br>1 Normal delivery<br>2 Premature delivery<br>3 Sick baby<br>4 Extramural birth<br>5 Information not available | C |
| 16 | Discharge Hour | Enter the time using 2 digit military time (00-23) for the time of inpatient or outpatient discharge.<br>00-12:00 midnight to 12:59 12- 12:00 noon to 12:59<br>01- 01:00 to 01:59 13- 01:00 to 01:59<br>02- 02:00 to 02:59 14- 02:00 to 02:59<br>03- 03:00 to 03:39 15- 03:00 to 03:59<br>04- 04:00 to 04:59 16- 04:00 to 04:59<br>05- 05:00 to 05:59 17- 05:00 to 05:59<br>06- 06:00 to 06:59 18- 06:00 to 06:59<br>07- 07:00 to 07:59 19- 07:00 to 07:59<br>08- 08:00 to 08:59 20- 08:00 to 08:59<br>09- 09:00 to 09:59 21- 09:00 to 09:59<br>10- 10:00 to 10:59 22- 10:00 to 10:59<br>11- 11:00 to 11:59 23- 11:00 to 11:59 | Not Required |

| Field # | Field Description | Instruction or Comments | Required or Conditional |
|---|---|---|---|
| 17 | Patient Status | Required for inpatient claims. Enter the 2 digit disposition of the patient as of the "through" date for the billing period listed in field 6 using one of the following codes:<br>01 Routine discharge<br>02 Discharged to another short-term general hospital for inpatient care<br>03 Discharged to SNF<br>04 Discharged to ICF<br>05 Discharged/transferred to a designated cancer center or children's hospital<br>06 Discharged to care of home health service organization<br>07 Left against medical advice<br>08 Reserved for national assignment<br>09 Admitted as an inpatient to this hospital (only for use on Medicare outpatient hospital claims)<br>20 Expired or did not recover<br>30 Still patient (to be used only when the client has been in the facility for 30 consecutive days if payment is based on DRG)<br>40 Expired at home (hospice use only)<br>41 Expired in a medical facility (hospice use only)<br>42 Expired—place unknown (hospice use only)<br>43 Discharged/transferred to a federal hospital (such as a veteran's administration [VA] hospital or VA skilled nursing facility)<br>50 Hospice—home<br>51 Hospice—medical facility (includes patient who is discharged from acute hospital care but remains at the same hospital under hospice care)<br>61 Discharged/transferred within this institution to a hospital-based Medicare approved swing bed<br>62 Discharged/transferred to an inpatient rehabilitation facility (IRF), including rehabilitation distinct part units of a hospital<br>63 Discharged/transferred to a Medicare certified long term care hospital (LTCH)<br>64 Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare<br>65 Discharged/ Transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital<br>66 Discharged/transferred to a critical access hospital (CAH)<br>71 Discharged to another institution of outpatient services<br>72 Discharged to another institution | C |
| 18-28 | Condition Codes | Required when applicable. Condition codes are used to identify conditions relating to the bill that may affect payer processing.<br>Each field (18-24) allows entry of a 2 character code. Codes should be entered in alphanumeric sequence (numbered codes precede alphanumeric codes).<br>For a list of codes and additional instructions refer to the NUBC UB-04/ CMS 1450 Uniform Billing Manual. | |
| 29 | Accident State | **Optional**: Accident state | |
| 30 | (Unlabeled Field) | Not used. | |

| Field # | Field Description | Instruction or Comments | Required or Conditional |
|---|---|---|---|
| 31-34 a-b | Occurrence Code And Occurence Date | Occurrence Code: Required when applicable. Occurrence codes are used to identify events relating to the bill that may affect payer processing.<br>Each field (31-34a) allows entry of a 2 character code. Codes should be entered in alphanumeric sequence (numbered codes precede alphanumeric codes).<br>For a list of codes and additional instructions refer to the NUBC UB-04/ CMS 1450 Uniform Billing Manual.<br>Occurrence Date: Required when applicable or when a corresponding Occurrence Code is present on the same line (31a-34a). Enter the date for the associated occurrence code in MM/DD/YYYY format.<br>Enter the appropriate occurrence code(s) and date(s). Blocks 54, 61,62, and 80 must also be completed as required.<br>Refer to Subsection 6.6.5, Occurrence Codes, in this section. Use one of the following codes if applicable:<br>01 Auto accident/auto liability insurance involved<br>02 Auto or other accident/no fault involved<br>03 Accident/tort liability<br>04 Accident/employment related<br>05 Other accident<br>06 Crime victim<br>10 Last menstrual period<br>11 Onset of symptoms<br>16 Date of last therapy<br>17 Date outpatient OT plan established or last reviewed<br>24 Date other insurance denied<br>25 Date benefits terminated by primary payer<br>27 Date home health plan of treatment was established<br>29 Date outpatient PT plan established or last reviewed<br>30 Date outpatient speech pathology plan established or last reviewed<br>35 Date treatment started for PT<br>44 Date treatment started for OT<br>45 Date treatment started for speech language pathology (SLP)<br>50 Date other insurance paid<br>51 Date claim filed with other insurance<br>52 Date renal dialysis initiated | C |
| 35-36 a-b | Occurrence Span Code And Occurrence Date | Occurrence Span Code: Required when applicable. Occurrence codes are used to identify events relating to the bill that may affect payer processing.<br>Each field (31-34a) allows entry of a 2 character code. Codes should be entered in alphanumeric sequence (numbered codes precede alphanumeric codes).<br>For a list of codes and additional instructions refer to the NUBC UB-04/ CMS 1450 Uniform Billing Manual.<br>Occurrence Span Date: Required when applicable or when a corresponding Occurrence Span Code is present on the same line (35a-36a). Enter the date for the associated occurrence code in MM/DD/ YYYY format.<br>For inpatient claims, enter code 71 if this hospital admission is a readmission within seven days of a previous stay. Enter the dates of the previous stay. | C |
| 37 | (Unlabeled Field) | Required for resubmissions or adjustments. Enter the 12 character document control number (DCN) of the original claim. A resubmitted claim MUST be marked using large bold print within the body of the claim form with "resubmission" to avoid denials for duplicate submission.<br>Note: For resubmissions submitted via EDI, the CLM05-3 must be "7" and in the 2300 loop a REF "F8" must be sent with the original claim number. | R |
| 38 | Responsible Party Name and Address | | Not Required |

| Field # | Field Description | Instruction or Comments | Required or Conditional |
|---|---|---|---|
| 39-41 a-d | Value Codes<br>Codes and Amounts | Code: Required when applicable. Value codes are used to identify events relating to the bill that may affect payer processing.<br>Each field (39-41) allows entry of a 2 character code. Codes should be entered in alphanumeric sequence (numbered codes precede alphanumeric codes).<br>Up to 12 codes can be entered. All "a" fields must be completed before using "b" fields, all "b" fields before using "c" fields, and all "c" fields before using "d" fields.<br>For a list of codes and additional instructions refer to the NUBC UB-04/ CMS 1450 Uniform Billing Manual.<br>Amount: Required when applicable or when a Value Code is entered.<br>Enter the dollar amount for the associated value code. Dollar amounts to the left of the vertical line should be right justified. Up to 8 characters are allowed (i.e. 199,999.99). Do not enter a dollar sign ($) or a decimal. A decimal is implied. If the dollar amount is a whole number (i.e. 10.00), enter 00 in the area to the right of the vertical line.<br>Accident hour: For inpatient claims, if the patient was admitted as the result of an accident, enter value code 45 with the time of the accident using military time (00 to 23). Use code 99 if the time is unknown.<br>For inpatient claims, enter value code 80 and the total days represented on this claim that are to be covered. Usually, this is the difference between the admission and discharge dates. In all circumstances, the number in this block is equal to the number of covered accommodation days listed in Block 46.<br>For inpatient claims, enter value code 81 and the total days represented on this claim that are not covered.<br>The sum of Blocks 39–41 must equal the total days billed as reflected in Block 6. | C |
| General | Revenue Codes and Description | For inpatient hospital services, enter the description and revenue code for the total charges and each accommodation and ancillary provided. List accommodations in the order of occurrence.<br>List ancillaries in ascending order. The space to the right of the dotted line is used for the accommodation rate.<br>NDC: Enter N4 and the 11 digit NDC number (number on packaged or container from which the medication was administered).<br>Optional: The unit of measurement code and the unit quantity with a floating decimal for fractional units (limited to 3 digits) can also be submitted but they are not required.<br>Do not enter hyphens or spaces within this number. Example: N400409231231GR0.025<br>Refer to: Subsection 6.3.4, National Drug Code (NDC), in this section. | C |
| 42 Line 1-22 | Rev CD | Enter the appropriate 4 digit revenue codes itemizing accommodations, services, and items furnished to the patient. Refer to the NUBC UB-04/ CMS 1450 Uniform Billing Manual for a complete listing of revenue codes and instructions.<br>Enter accommodation revenue codes first followed by ancillary revenue codes. Enter codes in ascending numerical value. | R |
| 42 Line 23 | Rev CD | Enter 0001 for total charges. | R |
| 43 Line 1-22 | Description | Enter a brief description that corresponds to the revenue code entered in the service line of field 42.<br>Qualifier along with NDC, units and base measurement code are required where applicable, compound drug elements. | R |
| 43 Line 23 | Page ___ of ___ | Enter the number of pages. Indicate the page sequence in the "PAGE" field and the total number of pages in the "OF" field. If only one claim form is submitted enter a "1" in both fields (i.e. PAGE "1" OF "1"). | R |

| Field # | Field Description | Instruction or Comments | Required or Conditional |
|---|---|---|---|
| 44 | HCPCS/Rates | Required for outpatient claims when an appropriate CPT/HCPCS code exists for the service line revenue code billed. The field allows up to 9 characters. Only one CPT/HCPC and up to two modifiers are accepted. When entering a CPT/HCPCS with a modifier(s) do not use spaces, commas, dashes or the like between the CPT/HCPC and modifier(s). Refer to the NUBC UB-04/CMS 1450 Uniform Billing Manual for a complete listing of revenue codes and instructions. Please refer to your current provider Contract with Superior or to the Texas Medicaid Provider Procedures Manual.<br>Inpatient: Enter the accommodation rate per day. Match the appropriate diagnoses listed in Blocks 67A through 67Q corresponding to each procedure. If a procedure corresponds to more than one diagnosis, enter the primary diagnosis. Each service and supply must be itemized on the claim form. Home Health Services Outpatient claims must have the appropriate revenue code and, if appropriate, the corresponding HCPCS code or narrative description.<br>Outpatient: Outpatient claims must have the appropriate Healthcare Common Procedure Coding System (HCPCS) code. Each service, except for medical/surgical and intravenous (IV) supplies and medication, must be itemized on the claim form or an attached statement.<br>**Note:** The UB-04 CMS-1450 paper claim form is limited to 28 items per outpatient claim. This limitation includes surgical procedures from Blocks 74 and 74a-e.<br>If necessary, combine IV supplies and central supplies on the charge detail and consider them to be single items with the appropriate quantities and total charges by dates of service. Multiple dates of service may not be combined on outpatient claims. | C |
| 45 Line 1-22 | Service Date | Required on all outpatient claims. Enter the date of service for each service line billed (MM/DD/YY). Multiple dates of service may not be combined for outpatient claims. | C |
| 45 Line 23 | Creation Date | Enter the date the bill was created or prepared for submission on all pages submitted (MM/DD/YY). | R |
| 46 | Service Units | Provide units of service, if applicable. For inpatient room charges, enter the number of days for each accommodation listed. If applicable, enter the number of pints of blood.<br>When billing for observation room services, the units indicated in this block should always represent hours spent in observation. | R |
| 47 Line 1-22 | Total Charges | Enter the total charge for each service line.<br>**Note**: For multi-page claims enter "continue" on initial and subsequent claim forms. Indicate the total of all charges on the last claim and the page number of the attachment (for example, page 2 of 3) in the top right-hand corner of the form. | R |
| 47 Line 23 | Totals | Enter the total charges for all service lines. | R |
| 48 Line 1-22 | Non-Covered Charges | Enter the non-covered charges included in field 47 for the revenue code listed in field 42 of the service line. Do not list negative amounts. | C |
| 48 Line 23 | Totals | Enter the total non-covered charges for all service lines. | C |
| 49 | (Unlabeled Field) | Not used. | Not Required |

| Field # | Field Description | Instruction or Comments | Required or Conditional |
|---|---|---|---|
| 50 a-c | Payer | Enter the name for each payer from which reimbursement is being sought in the order of the payer liability. Line A refers to the primary payer, B - secondary, and C - tertiary. | R |
| 51 a-c | Health Plan Identification Number | | Not Required |
| 52 a-c | Related Information | Required for each line (A, B, C) completed in field 50, Release of Information Certification Indicator. Enter "Y" (yes) or "N" (no).<br>Providers are expected to have necessary release information on file. It is expected that all released invoices contain "Y". | R |
| 53 | Asg. Ben. | Enter "Y" (yes) or "N" (no) to indicate a signed form is on file authorizing payment by the payer directly to the provider for services. | R |
| 54 | Prior Payments | Enter the amount received from the primary payer on the appropriate line when Medicaid/Superior is listed as secondary or tertiary. | C |
| 55 | Estimated Amount Due | | Not Required |
| 56 | National Provider Identifier or Provider ID | Enter the provider's 10 character NPI ID. | R |
| 57 | Other Provider ID | Enter the TPI number (non NPI number) of the billing provider. | Not Required |
| 58 | Insured's Name | For each line (A, B, C) completed in field 50, enter the name of the person who carries the insurance for the patient. In most cases this will be the patient's name. Enter the name as last name, first name, middle initial. | R |
| 59 | Patient Relationship | | Not Required |
| 60 | Insured's Unique ID | Required: Enter the patient's insurance/Medicaid ID exactly as it appears on the patient's ID card. Enter the insurance /Medicaid ID in the order of liability listed in field 50. | R |
| 61 | Group Name | | Not Required |
| 62 | Insurance Group Number | | Not Required |
| 63 | Treatment Authorization Codes | | Not Required |
| 64 | Document Control Number | Enter the 12 character document control number (DCN), which is the original (corrected) claim number, of the paid health claim when submitting a replacement or void on the corresponding A, B, C line reflecting Superior from field 50.<br>Applies to claim submitted with a Type of Bill (field 4) Frequency of "7" (Replacement of Prior Claim) or Type of Bill Frequency of "8" (Void/Cancel of Prior Claim).<br>* Please refer to appeals/corrected claims section. | C |
| 65 | Employer Name | | Not Required |
| 66 | Dx | | Not Required |
| 67 | Principal Diagnosis Code and Present On Admission (POA) Indicator | Enter the principal/primary diagnosis or condition using the appropriate release/update of ICD-9-CM Volume 1 and 3 (or ICD-10-CM, once mandated) for the date of service.<br>Diagnosis code submitted must be a valid ICD-9 (or ICD-10-CM code, once mandated) code for the date of service and carried out to its highest level of specificity – 4 or 5 digit. "E" and most "V" codes are not acceptable as a primary diagnosis.<br>Claims with missing or invalid diagnosis codes will be denied<br>Enter the applicable POA indicator in the shaded area for inpatient claims.<br>Note: All hospital providers are required to submit a POA value for each diagnosis on the claim form and no hospital will be exempt from this POA requirement. Medicare crossover hospital claims with dates of admission on or after September 1, 2012, must also comply with the Medicaid requirement to include the POA values. Claims submitted without the POA indicators will be denied. | R |

| Field # | Field Description | Instruction or Comments | Required or Conditional |
|---|---|---|---|
| 67 a-q | Other Diagnosis Code and POA Indicator | Enter additional diagnosis or conditions that coexist at the time of admission or that develop subsequent to the admission and have an effect on the treatment or care received using the appropriate release/update of ICD-9-CM Volume 1 and 3 (or ICD-10-CM code, once mandated) for the date of service.<br>Diagnosis codes submitted must be valid ICD-9 codes (or ICD-10-CM code, once mandated) for the date of service and carried out to its highest level of specificity – 4 or 5 digit. "E" and most "V" codes are not acceptable as a primary diagnosis.<br>Claims with incomplete or invalid diagnosis codes will be denied.<br>Enter the applicable POA indicator in the shaded area for inpatient claims.<br>Note: All hospital providers are required to submit a POA value for each diagnosis on the claim form and no hospital will be exempt from this POA requirement. Medicare crossover hospital claims with dates of admission on or after September 1, 2012, must also comply with the Medicaid requirement to include the POA values. Claims submitted without the POA indicators will be denied. | C |
| 68 | (Unlabeled) | Not used. | Not Required |
| 69 | Admitting Diagnosis Code | Enter the diagnosis or condition provided at the time of admission as stated by the physician using the appropriate release/update of ICD-9-CM Volume 1 and 3 (or ICD-10-CM code, once mandated) for the date of service.<br>Diagnosis codes submitted must be valid ICD-9 codes (or ICD-10-CM code, once mandated) for the date of service and carried out to its highest level of specificity – 4 or 5 digit. "E" codes and most "V" are not acceptable as a primary diagnosis.<br>Claims with missing or invalid diagnosis codes will be denied. | R |
| 70 a,b,c | Patient Reason Code | Enter the ICD-9-CM (or ICD-10-CM code, once mandated) code that reflects the patient's reason for visit at the time of outpatient registration. 70a requires entry, 70b-70c are conditional.<br>Diagnosis codes submitted must be a valid ICD-9 code for the date of service and carried out to its highest digit – 4 or 5 (ICD-10-CM codes will replace ICD-9, once mandated). "E" codes and most "V" are not acceptable as a primary diagnosis.<br>Claims with missing or invalid diagnosis codes will be denied. | R |
| 71 | PPS / DRG Code | | Not Required |
| 72 a,b,c | External Cause Code | | Not Required |
| 73 | (Unlabeled) | | Not Required |
| 74 | Principal Procedure Code / Date | Required on inpatient claims when a procedure is performed during the date span of the bill.<br>Code: Enter the ICD-9 procedure code (or ICD-10-CM procedure code, once mandated) that identifies the principal/primary procedure performed. Do not enter the decimal between the 2nd or 3rd digits of code. It is implied.<br>Date: Enter the date the principal procedure was performed (MM/DD/YY). Required for EDI submissions. | C |
| 74 a-e | Other Procedure Code / Date | Required on inpatient claims when a procedure is performed during the date span of the bill.<br>Code: Enter the ICD-9 procedure code(s) (or ICD-10-CM procedure code(s), once mandated) that identify a significant procedure(s) performed other than the principal/primary procedure. Up to 5 ICD-9 procedure codes (or ICD-10-CM code, once mandated) may be entered. Do not enter the decimal between the 2nd or 3rd digits of code. It is implied.<br>Date: Enter the date the principal procedure was performed (MM/DD/YY). | C |
| 75 | (Unlabeled) | | Not Required |