magnolia health™

Provider Manual

1-866-912-6285

MagnoliaHealthPlan.com

Table of Contents

Table of Contents

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 healthcare professionals. Our number one priority is the promotion of healthy lifestyles through preventive healthcare. Magnolia works to accomplish this goal by partnering with the providers who oversee the healthcare of Magnolia members.

About Us

Magnolia is a Coordinated Care Organization (CCO) contracted with the Mississippi Division of Medicaid (DOM) to serve Mississippi members through the Mississippi Coordinated Access Network (MississippiCAN) program. For more information about MississippiCAN, visit www.medicaid.ms.gov/mscan/Welcome.aspx. Magnolia has the expertise to work with members to improve their health status and quality of life. Magnolia's parent company, Centene Corporation (Centene), has been providing comprehensive managed care services to individuals receiving benefits under Medicaid and other government-sponsored healthcare programs for more than twenty-five (25) 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 Health adheres to the Division of Medicaid's requirements that does not require a Provider 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 will serve our members consistent with our core philosophy that quality healthcare is best delivered locally.

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

Mission

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

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

All of our programs, policies, and procedures are designed with these goals in mind. We hope that you will assist Magnolia in reaching these goals and look forward to your active participation.

Please contact the Provider Services department at 1-866-912-6285 if you need further explanation on any topics discussed in this manual.

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 healthcare benefits. We are committed to provide comprehensive information through this Provider Manual as it relates to Magnolia operations, benefits, policies, and procedures to providers. Please contact the Provider Services department ("Provider Services") at 1-866-912-6285 if you need further explanation on any topics discussed in this manual.

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

Key Contacts

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

- NPI (National Provider Identifier) number
- Tax ID Number ("TIN") number
- Member's Magnolia ID number or Medicaid ID number

Health Plan Information

Magnolia Health
111 East Capitol St, Suite 500
Jackson, MS 39201
www.magnoliahealthplan.com

Department	Telephone Number	Fax Number
Provider Services Hours of Operation: 8:00 a.m. to 5:00 p.m. CST, Monday Through Friday	1-866-912-6285	1-877-811-5980

Provider Services functions include but are not limited to the following:

- Assisting Providers with questions concerning Member eligibility status
- Assisting Providers with Prior Authorization and referral procedures
- Assisting Providers with claims payment procedures and handling Provider dispute and issues
- Facilitating transfer of Member Medical Records among medical Providers, as necessary
- Providing to PCPs a monthly list of Members who are under their care, including identification of new and deleted Members; An explanation guide detailing use of the list must also be provided to the PCP
- Referring Providers to the Fraud and Abuse Hotline
- Developing a process to respond to Provider inquiries regarding current Enrollment
- Coordinating the administration of out-of-network services

Department	Telephone Number	Fax Number
Member Services	1-866-912-6285 or (TDD/TTY) 1-877-725-7753	1-877-779-5219
Authorization Request/Discharge Planning/Care management	1-866-912-6285	1-877-650-6943 1-877-725-7745 1-866-901-5813
Inpatient Admissions	eQHealth Solutions 1-866-740-2221	www.eqhs.org
US Script Prior Authorization	1-800-460-8988 1-866-399-0928	1-866-399-0929
Magnolia Pharmacy Dept	1-866-912-6285	1-866-595-8117
Behavioral Health	1-866-912-6285	
NurseWise (24/7 Availability)	1-866-912-6285	
Transportation	1-866-912-6285	
Division of Medicaid	1-800-421-2408	

Medical Claims

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

Reimbursement Rate Dispute

Magnolia Health
Attn: Claim Disputes
PO Box 3000
Farmington, MO 63640-3800

Medical Necessity Appeal

Magnolia Health
Attn: Medical Necessity
111 East Capitol St., Suite 500
Jackson, MS 39201

Pharmacy Claims

US Script PBM
2425 W. Shaw Ave
Fresno, CA 93711

DME, HH, and HIT Claims

Univita Health
Attn: Claims Department
3700 Commerce Parkway
Miramar, FL 33025

Electronic Claims Submission

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

NurseWise®

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

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

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

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

To locate your Mississippi Medicaid Regional Office, please visit www.medicaid.ms.gov/about/office-locations

For purposes of this program, MississippiCAN beneficiaries include:

Required Mandatory Populations (Age)	Optional Populations (Age)
SSI (19 – 65)	SSI (0-19)
Working Disabled (19-65)	Disabled Child Living at Home (0-19)
Breast and Cervical Cancer (19-65)	Foster Care and Foster Care Adoption Assistance (0-19)
Pregnant Women (8-65) Infants (0-1)	Native Americans (0-65)
Children (0-1)	
TANF Adults (19-65)	

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

Individuals in an institution such as a skilled nursing facility, an Intermediate Care Facility for the Mentally Retarded (ICF/MR), or a Psychiatric Residential Treatment Facility (PRTF); dually-eligible for Medicare and Medicaid; and Home and Community Based Services (HCBS) waiver members are excluded from the program regardless of the category of eligibility.

Member Eligibility Verification

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

1. Log onto the Mississippi Division of Medicaid's (DOM) Envision website to verify member's eligibility with Magnolia Health.
2. Log onto the secure provider portal at www.MagnoliaHealthPlan.com. Using our secure provider website, you can check member eligibility. You can search by date of service plus any one of the following: member name and date of birth; Medicaid ID number; or Magnolia member 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, 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.

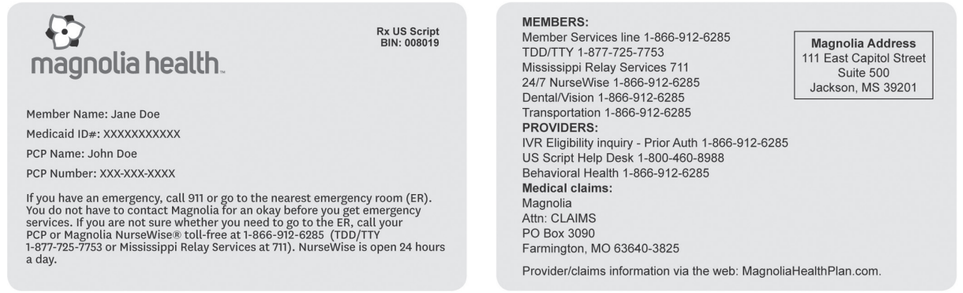
Log onto the secure provider portal at www.MagnoliaHealthPlan.com to verify member eligibility.

Through Magnolia's secure provider web portal, primary care providers (PCP) are able to access a list of eligible members who have selected their services or were assigned to the PCP as of the first day of the month in which the PCP receives such a list. The list also provides other important information including date of birth and indicators for patients who are due for an Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) exam. To view this list, log onto the Magnolia website. Since eligibility changes may occur throughout the month and the member list does not prove eligibility for benefits or guarantee coverage, please use one of the above methods to verify member eligibility on the date of service.

Once eligibility is confirmed, all new Magnolia members receive a Magnolia member ID card. Members will keep their DOM-issued ID card to receive services not covered by the plan (such as Inpatient Hospital Services). A new card is issued only when the information on the card changes, if a member loses a card, or if a member requests an additional card. Since member ID cards are not a guarantee of eligibility, providers must verify members' eligibility on each date of service.

Member Identification Card

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 identification. If you suspect fraud, please contact Provider Services at 1-866-912-6285 immediately.


magnolia health

Rx US Script
BIN: 008019

Member Name: Jane Doe

Medicaid ID#: XXXXXXXXXX

PCP Name: John Doe

PCP Number: XXX-XXX-XXXX

If you have an emergency, call 911 or go to the nearest emergency room (ER). You do not have to contact Magnolia for an okay before you get emergency services. If you are not sure whether you need to go to the ER, call your PCP or Magnolia NurseWise® toll-free at 1-866-912-6285 (TDD/TTY 1-877-725-7753 or Mississippi Relay Services at 711). NurseWise is open 24 hours a day.

MEMBERS:
Member Services line 1-866-912-6285
TDD/TTY 1-877-725-7753
Mississippi Relay Services 711
24/7 NurseWise 1-866-912-6285
Dental/Vision 1-866-912-6285
Transportation 1-866-912-6285
PROVIDERS:
IVR Eligibility inquiry - Prior Auth 1-866-912-6285
US Script Help Desk 1-800-460-8988
Behavioral Health 1-866-912-6285
Medical claims:
Magnolia
Attn: CLAIMS
PO Box 3090
Farmington, MO 63640-3825

Magnolia Address
111 East Capitol Street
Suite 500
Jackson, MS 39201

Provider/claims information via the web: MagnoliaHealthPlan.com.

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

We encourage providers to first check the Mississippi Division of Medicaid's Envision website to verify eligibility. Another way to check eligibility is by using the secure provider portal section of our website at www.MagnoliaHealthPlan.com. Providers may also call Provider Services at 1-866-912-6285 and follow the appropriate menu options to use our automated Interactive Voice Response (IVR) member-eligibility verification system.

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:

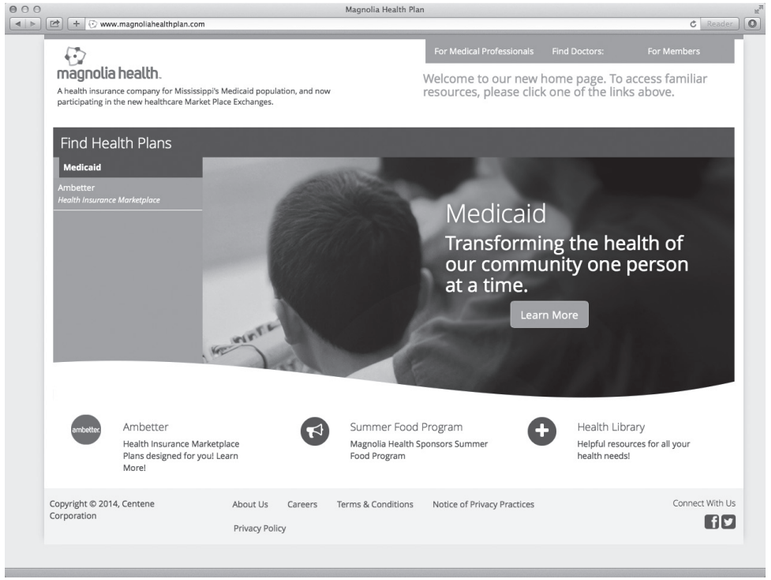
- Check member eligibility
- Check claims status
- Access 24 hours a day, seven (7) days a week, 365 days a year

Magnolia Website

Utilizing Magnolia's website can significantly reduce the number of telephone calls providers need to make to the health plan which enables Magnolia staff to effectively and efficiently perform daily tasks.

Magnolia's website is located at www.MagnoliaHealthPlan.com. **Providers can find the following information on the website:**

- Member benefits
- Magnolia news
- Clinical guidelines
- Wellness information
- Provider Manual and Forms
- Provider newsletters
- Provider Directory
- Access to link to the State's PDL



Register for our secure provider website at www.MagnoliaHealthPlan.com

Secure Website

Magnolia web portal services allows providers to check member eligibility and benefits, submit and check status of claims, request authorizations, and send/receive messages to communicate with Magnolia staff. Magnolia's providers and their office staff have the opportunity to register for our secure provider website in just four (4) easy steps. Here, we offer tools which make obtaining and sharing information easy! It's simple and secure! Go to www.MagnoliaHealthPlan.com to register. On the home page, select the Logon link on the top right to start the registration process.

Through the secure site, you can:

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

We are continually updating our website with the latest news and information, so save www.MagnoliaHealthPlan.com to your internet "Favorites" list and check it often. Please contact a Provider Relations Representative for a tutorial on the secure site.

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 primary care providers to ensure every member has access to a medical home within the required travel distance standards. These standards are 15 miles or 15 minutes for urban areas and 30 miles or 30 minutes in rural areas. Providers who may serve as PCPs include Internists, Pediatricians, Obstetrician/Gynecologists, Family and General Practitioners, Physician Assistants and Nurse Practitioners. Other PCPs include Physician Assistants and Nurse Practitioners. Providers at Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs) may also serve as PCPs.

Members with disabling conditions, chronic illnesses, or child(ren) with special healthcare needs may request that their PCP be a specialist. The designation of a specialist as a PCP must be pursuant to a treatment plan approved by Magnolia; in consultation with the PCP to which the Member is currently assigned, the Member and, as appropriate, the specialist. When possible, the specialist must be a Provider participating in Magnolia's 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 healthcare need in accordance with Magnolia's standards and with the scope of the specialty training and clinical expertise. In order to accommodate the full spectrum of care, the specialist as a PCP must also have admitting privileges at a Hospital in Magnolia's provider network.

!

Providers who may serve as PCPs include Internists, Pediatricians, Obstetrician/Gynecologists, Family and General Practitioners, Physician Assistants and Nurse Practitioners.

The PCP must:

- Be available for or provide on-call coverage through another source 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 (Inpatient reviews will continue to be conducted through DOM's current vendor, HealthSystems of Mississippi)
- Provide screening, well care, and referrals to community health departments and other agencies in accordance with DOM provider requirements and public health initiatives
- PCPs 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 provider and ensure 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) report encounter data associated with EPSDT screens, using a format approved by the Division of Medicaid, to Magnolia within ninety (90) calendar days from the date of service

PCPs are responsible for contacting new Members identified in the quarterly encounter lists sent by Magnolia that indicate who has not had an encounter during the first six (6) months of enrollment. PCPs are required to contact non-compliant Members identified in the quarterly Encounter list for EPSDT periodicity and immunization schedules for children and notify Magnolia within one (1) month with documentation for the reasons of noncompliance, where possible, and documented efforts to bring the Member's care into compliance according to standards. Magnolia providers should refer to their contract for complete information regarding providers' obligations and mode of reimbursement.

Assignment of Medical Home

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

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

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 as identified in the Assignment of Medical Home section listed herein. 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 files indicate 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 responsible to coordinate members' healthcare services and make referrals to specialty providers when medically necessary care is needed that are beyond the scope of the PCP. The specialty provider may order diagnostic tests without PCP involvement by following Magnolia referral guidelines. The specialty providers must abide by the prior authorization requirements when ordering diagnostic tests; 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 situation. Inpatient hospital concurrent review will continue to be authorized through DOM's current vendor, HealthSystems of Mississippi.

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 24 hours a day for management of member care
- Maintain the confidentiality of medical information

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

Voluntarily Leaving the Network

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

Magnolia will notify affected members in writing of a provider's termination, as applicable, at least 15 days before the member disenrollment. If the terminating provider is a PCP, Magnolia will request that the member elect a new PCP. If a member does not elect a PCP prior to the provider's termination date, Magnolia will automatically assign a new PCP to the member.

Providers must continue to render covered services to members who are existing patients at the time of termination until the later of 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
- Providers unwilling to continue to treat the member or accept payment from Magnolia

Provider Standards and Procedures

As specified by DOM, Magnolia 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 internal standards for OB/GYN access are:

- Initial appointment for a pregnant member within three (3) weeks.
- Ongoing prenatal care during the first and second trimesters within seven (7) days.
- Ongoing prenatal care during the third trimester within three (3) days.

Accessibility Standards

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

Type of Appointment	Scheduling Time Frame
Primary Care Providers	Please see above
Preventive Care	Within thirty (30) calendar days
Regular and Routine Care	Within seven (7) calendar days
Initial Health Check (EPSDT)	Within 90 calendar days of enrollment
Urgent Care	Within twenty-four (24) hours
Emergency Care	Immediate, or refer to Emergency Room (ER) and with no Prior Authorization required
Specialty Care Providers	Within forty-five (45) calendar days
Pregnant Women Care	Initial visit within three (3) weeks; ongoing prenatal care during the first and second trimesters within seven (7) days, and within three (3) days during the third trimester.
Behavioral Health Providers (Routine Care)	Within ten (10) working days (14 calendar days)
Behavioral Health Providers (Urgent Care)	Within twenty-four (24) hours
Behavioral Health Providers (Non life-threatening emergencies)	Within six (6) hours
Behavioral Health Providers (post-discharge from an acute psychiatric hospital when Magnolia is aware of the Member's discharge)	Within seven (7) calendar days
Dental Providers (Routine)	Within forty-five (45) calendar days
Dental Providers (Urgent Care)	Within forty-eight (48) hours

Telephone Arrangements

PCPs and Specialists must:

- Answer the member's telephone inquiries on a timely basis
- Schedule a series of appointments and follow-up appointments as needed by a member
- Identify and reschedule broken and no-show appointments
- Identify special member needs while scheduling an appointment (e.g., wheelchair and interpretive linguistic needs, non-compliant individuals, or those people with cognitive impairments)
- Adhere to the following response time for telephone call-back waiting times:
- After-hours telephone care for non-emergent, symptomatic issues within 30 minutes
- Same day for non-symptomatic concerns
- Crisis situations within fifteen (15) minutes
- Schedule continuous availability and accessibility of professional, allied health, and supportive personnel to provide covered services within normal working hours. Protocols shall be in place to provide coverage in the event of a provider's absence
- After-hours calls must be documented in a written format in either an after-hour call log or some other similar method, and then transferred to the member's medical record

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

Magnolia will monitor appointment and after-hours availability on an on-going basis through its Quality Improvement program (QIP).

Magnolia's PCPs and specialty providers are required to maintain sufficient access to facilities and personnel to provide covered provider services 24 hours a day, 365 days a year.

Covering Providers

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 NPI number on file with the Division of Medicaid 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 their agreement.

24-Hour Access

Magnolia's PCPs and specialty providers are required to maintain sufficient access to facilities and personnel to provide covered provider services and shall ensure that such services are accessible to members as needed 24 hours a day, 365 days a year as follows:

- A provider's office phone must be answered during normal business hours
- During after-hours, a provider must have arrangements for:
  - Access to a covering provider,
  - An answering service,
  - Triage service, or
  - A voice message that provides a second phone number that is answered.

The selected method of 24-hour coverage chosen by the member must connect the caller to someone who can render a clinical decision or reach the PCP or specialist for a clinical decision. The PCP, specialty provider, or covering medical professional must return the call within 30 minutes of the initial contact. After-hours coverage must be accessible using the medical office's daytime telephone number.

Magnolia Provider Relations staff will collaborate with provider office personnel for scheduled visits and may occasionally make unscheduled visits if a Provider Relations Representative is in the area.

Referrals

PCPs will coordinate all member healthcare services. PCPs are encouraged to refer a member to another Magnolia network provider whenever necessary and in most circumstances paper or electronic referrals are not required. PCPs must obtain prior authorization from Magnolia, however, for referral to certain specialty providers as noted on the prior authorization list. All out-of-network services require prior authorization as further described herein. A provider is also required to promptly notify Magnolia when prenatal care is rendered using the Notification of Pregnancy Form on the Magnolia web portal.

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

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

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

Medical Management/Authorization Department

Telephone 1-866-912-6285
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

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

Self-Referrals

The following services do not require PCP authorization or referral:

- Prescription drugs, including certain prescribed over-the-counter drugs
- Emergency services including emergency ambulance transportation
- OB/GYN services with a participating provider
- Women's health services provided by a FQHC or Certified Nurse Practitioner (CNP)
- Family planning services and supplies from a qualified DOM family planning provider

Except for emergency and family planning services, the above services must be obtained through Magnolia's network providers.

Member Panel Capacity

All PCPs reserve the right to state the number of members they are willing to accept into their panel. Magnolia does not guarantee that any provider will receive a certain number of members.

If a PCP does declare a specific capacity for their practice and wants to make a change to that capacity, the PCP must contact Magnolia Provider Services at 1–866-912-6285. A PCP shall not refuse to treat members as long as the provider has not reached their requested panel size.

Providers shall notify Magnolia in writing at least 45 calendar days in advance of their inability to accept additional Medicaid covered persons under Magnolia agreements. In no event shall any established patient who becomes a covered person be considered a new patient. Magnolia prohibits all providers from intentionally segregating members from fair treatment and covered services provided to other non-Medicaid members.

Hospital Responsibilities

Magnolia utilizes a network of hospitals to provide services to Magnolia members. Hospitals must:

- Notify the PCP immediately or no later than the close of the next business day after the member's appearance in the emergency department (ED)
- Obtain authorizations for selected outpatient services as listed on the current prior authorization list, except for emergency care and post-stabilization services
- Notify Magnolia's Medical Management department by sending an electronic file daily of all emergency room admissions for the previous business day. The electronic file should include the member's name, Medicaid ID, presenting symptoms/diagnosis, date of service (DOS), and member's phone number
- Notify Magnolia's Medical Management department of all newborn deliveries on the same day as the delivery

Magnolia hospitals should refer to their contract for complete information regarding the hospitals' obligations and reimbursement.

Advance Directives

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

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

Magnolia recommends the following regarding Advance Directives:

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

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

Cultural Competency

At Magnolia, cultural competency is defined as the willingness and ability of a system to value the importance of culture in the delivery of services to all segments of the population. It is the use of a systems perspective which values differences and is responsive to diversity at all levels in an organization. Cultural competency is developmental, community focused and family oriented. In particular, it is the promotion of quality services to understand racial/ethics groups through the valuing of differences and integration of cultural attitudes, beliefs and practices into diagnostic and treatment methods and throughout the system to support the delivery of culturally relevant and competent care. It is also the development and continued promotion of skills and practices important in clinical practice, cross-cultural interactions and systems practices among providers and staff to ensure that services are delivered in a culturally competent manner.

Magnolia is committed to the development, strengthening, and sustaining provider/member relationships. 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. Members may be unable or unwilling to communicate their healthcare needs in a culturally insensitive environment, reducing effectiveness of the entire healthcare process.

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

Providers must ensure that:

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

Notes:

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 the benefits.

The following benefits are not covered under Magnolia Health Plan; however, we will assist to coordinate transportation services for Magnolia members.

NON-Covered Services	Comments
Bariatric Surgery	
Cosmetic or Experimental Services	Phase I & II Clinical Trials are considered experimental
Home Dialysis Equipment	
Infertility Diagnostics and Treatment	
Inpatient Facility Fees	Facility fees covered under FFS Medicaid;Authorization through HealthSystems of Mississippi.

Notes:

Overview and Medical Necessity

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

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

Magnolia Health Utilization Management

1-866-912-6285
Fax 1-866-534-5979
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 healthcare, 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

The Magnolia Utilization Management Program (UMP) is designed to ensure members receive access to the right care at the right place and right time.

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 network, the member may obtain the second opinion from an out-of-network provider at no cost to the member. Out-of-network and in-network specialty provider types on the prior authorization list will require prior authorization by Magnolia.

Assistant Surgeon

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

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

Clinical Information

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

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

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

- Member's name
- Member ID number
- Provider's name and telephone number
- Provider location if the request is for an ambulatory or office procedure
- Reason for the authorization request (e.g., primary and secondary diagnoses, planned surgical procedures, surgery date)
- Relevant clinical information (e.g., past/proposed treatment plan, surgical procedure, and diagnostic procedures to support the appropriateness and level of service proposed)
- Discharge plans

Notification of newborn deliveries should include the date and method of delivery, and information related to the newborn or neonate for outcomes reporting.

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

Clinical Decisions

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

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

Medical Necessity

Medical necessity is defined for Magnolia members as healthcare services, supplies, or equipment provided by a licensed healthcare professional that are:

- Appropriate and consistent with the diagnosis or treatment of the member's condition, illness, or injury;
- In accordance with the standards of good medical practice consistent with the member's conditions(s);
- Not primarily for the personal comfort or convenience of the member, family, or provider;
- The most appropriate services, supplies, equipment, or level of care that can be safely and efficiently provided to the member;
- Furnished in a setting appropriate to the member's medical need and condition and, when supplied to the care of an inpatient, further mean that the member's medical symptoms or conditions require that the services cannot be safely provided to the member as an outpatient;
- Not experimental or investigational or for research or education;
- Provided by an appropriately licensed practitioner; and
- Documented in the member's medical record in a reasonable manner, including the relationship of the diagnosis to the service.

Services for children are limited in that such services are necessary to correct or ameliorate defects, physical and mental illnesses, and conditions that are discovered during 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 determined to be medically necessary must be covered.

Review Criteria

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

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

111 East Capitol Street, Suite 500
Jackson, MS 39201
1-866-912-6285
Fax 1-877-851-3995

New Technology

Magnolia evaluates the inclusion of new technology and the new application of existing technology for coverage determination. This may include medical procedures, drugs and/or devices. The Medical Director and/or Medical Management staff may identify relevant topics for review pertinent to the 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.

Prior Authorization and Notifications

Prior authorization is a request to the Magnolia UM department for approval of services on the prior authorization list before the service is delivered. Authorization must be obtained prior to the delivery of certain elective and scheduled services. Services that require prior authorization by Magnolia are listed in the Prior Authorization Table found on www.MagnoliaHealthPlan.com under provider tab/documents. The PCP should contact the UM department via telephone, fax, or through our website with appropriate supporting clinical information to request an authorization. All out-of-network services require prior authorization and will require Magnolia's Medical Director review and approval.

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.

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

Failure to obtain authorization may result in administrative claim denials. 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.

Authorization Timelines

For all pre-scheduled services requiring prior authorization, providers should notify Magnolia fourteen (14) calendar days but no later than five (5) calendar days prior to the requested service date. Magnolia will make determinations and provide notice of the decision to the provider and the member for requests for standard services within three (3) calendar days and/or two (2) business days of receiving the necessary clinical information but not to exceed 14 calendar days of receipt of the request. "Necessary 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 will result in a determination being made by the Medical Director based on the available information. For urgent/expedited requests, a decision is made and communicated to the provider and the member within 24-hours after receipt of all necessary information, not to exceed 72-hours from receipt of the request.

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. Providers are expected to identify the estimated date of confinement and delivery facility. The NOP includes an optional prenatal vitamin order form. Magnolia will facilitate the provider's order of a 90-day supply of prenatal vitamins for the member to be delivered to the managing provider's office by the member's next prenatal visit. See the Care Management section for information related to our Start Smart for Your Baby® Program and our 17-P Program for women with a history of early delivery.

Magnolia Health Services Requiring Plan Authorization

For the latest version of the Prior Authorization Table, go to www.MagnoliaHealthPlan.com and click on the Provider Tab/Documents.

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

For the latest version of the Prior Authorization Table, go to www.MagnoliaHealthPlan.com and click on the Provider Tab/Documents.

Discharge Planning

As noted above, concurrent review for hospital inpatient admissions will continue to be authorized through DOM's current vendor, HealthSystems of Mississippi (HSM). Magnolia will conduct discharge planning activities upon notification by HSM of the admission. The Magnolia UM staff will coordinate the discharge planning efforts with the hospitals UM and discharge planning departments and, when necessary, the member's attending provider/PCP in order to ensure that Magnolia members receive appropriate post-hospital discharge care.

Retrospective Review

Retrospective review is an initial review of services provided to a member, but for which authorization and/or timely notification to Magnolia was not obtained due to extenuating circumstances related to the member (i.e., member was unconscious at presentation, member did not have their Medicaid card or otherwise indicated Medicaid 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 90 days from the first date of service. A decision will be made within 30 calendar days following receipt of all necessary information for any qualifying service cases.

Pharmacy 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 Magnolia provider. The pharmacy program does not cover all medications. Some medications require prior authorization (PA) or have limitations on age, dosage and/or maximum quantities.

This section provides an overview of Magnolia pharmacy program. For more detailed information, please visit our website at www.MagnoliaHealthPlan.com.

Preferred Drug List

The Magnolia Preferred Drug List (PDL) describes the circumstances under which contracted pharmacy providers will be reimbursed for medications dispensed to members covered by Magnolia. **The PDL does not:**

- Require or prohibit the prescribing or dispensing of any medication
- Substitute for the independent professional judgment of the provider or pharmacist, or
- Relieve the provider or pharmacist of any obligation to the member or others.

The Magnolia PDL includes a broad spectrum of generic and brand name drugs. Some preferred drugs require prior authorization (PA). Medications requiring PA are listed with a “PA” notation throughout the PDL.

Magnolia’s Pharmacy & Therapeutics (P&T) Committee has reviewed and approved, with input from its members and in consideration of medical evidence, the list of drugs requiring prior authorization (PA). The PDL attempts to provide appropriate and cost-effective drug therapy to all participants covered under the Magnolia pharmacy program. If a patient requires medication that does not appear on the PDL, the provider can submit a PA request for a non-preferred medication. It is anticipated that such exceptions will be rare and that currently available PDL medications will be appropriate to treat the vast majority of medical conditions encountered by Magnolia providers.

Pharmacy and Therapeutics (P&T) Committee

The Magnolia P&T Committee continually evaluates the therapeutic classes included in the PDL. The committee is composed of the Magnolia Medical Director, the Magnolia pharmacy program director (Pharmacy Program Director), and several community-based PCPs and specialists. The primary purpose of the P&T Committee is to assist in developing and monitoring the PDL and to establish programs and procedures that promote the appropriate and cost-effective use of medications. The P&T Committee schedules meetings at least quarterly during the year and coordinates therapeutic class reviews with Centene’s national P&T Committee.

Specific Exclusion

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

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

Over-the-Counter Medications

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

Tobacco Cessation Medications

The following types of tobacco cessation medications will be covered by Magnolia: nicotine replacement products, Bupropion Hydrochloride, and Varenicline Tartrate (Chantix). A licensed provider prescription will be required for all tobacco cessation medications.

Emergency Drug Supply

The 72-hour emergency supply policy: State and Federal law require that a pharmacy dispense a 72-hour (3-day) supply of medically necessary medication to any member awaiting a prior authorization (PA) determination. The purpose of providing members this emergency drug supply is to avoid interruption of current therapy or delay in the initiation of therapy. All participating pharmacies are authorized to provide a 72-hour supply of medication and will be reimbursed for the ingredient cost and dispensing fee of the 72-hour supply of medication, whether or not the PA request is ultimately approved or denied.

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 the Magnolia P&T Committee and noted throughout the PDL.

Step Therapy

Medications requiring step therapy are listed with an “ST” notation throughout the preferred drug list. The US Script claims system will automatically check the member profile for evidence of prior or current usage of the required agent. If there is evidence of the required agent on the member’s profile, the claim will automatically process. If not, the claims system will notify the pharmacist that a PA is required.

Age Limits

Some medications on the Magnolia 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.

Medications requiring step therapy are listed with an “ST” notation throughout the preferred drug list.

Newly Approved Products

Newly approved drug products will not normally be placed on the PDL during their first six months on the market. During this period, access to these medications will be considered through the PA 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 Magnolia. Experimental drugs, investigational drugs, and drugs used for cosmetic purposes are excluded from coverage.

Mandatory Generic Substitution

Magnolia requires that generic substitution be made when a generic equivalent is available. The prescription benefit is limited to six (6) prescriptions per month with a maximum of two (2) being branded products. All branded products that have an A-rated generic equivalent will be reimbursed at the maximum allowable cost (MAC). The provision is waived for the following products due to their narrow therapeutic index: Aminophylline, Amiodarone, Carbamazepine, Clozapine, Cyclosporine, Digoxin, Disopyramide, Ethosuximide, Flecainide, L-thyroxine, Lithium, Phenytoin, Procainamide, Propafenone, Theophylline, Thyroid, Valproate Sodium, Valproic Acid, and Warfarin.

Working with Magnolia’s Pharmacy Benefit Manager (PBM)

Magnolia works with US Script to administer pharmacy benefits, including PA process. Certain drugs require PA to be approved for payment by Magnolia.
These include:

- All medications not listed on the PDL
- Some Magnolia preferred drugs (designated PA on the PDL)

Follow these guidelines for efficient processing of your PA requests:

1. Complete the Magnolia/US Script form: Medication Prior Authorization Request Form that can be found on the Magnolia website at www.MagnoliaHealthPlan.com
2. Fax to US Script at 1-866-399-0929
3. Once approved, US Script notifies the prescriber by fax.
4. If the clinical information provided does not explain the reason for the requested PA medication, US Script responds to the prescriber by fax, offering PDL alternatives.
5. For urgent or after-hours requests, a pharmacy can provide up to a 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 PA 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 Medicaid 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 PDL when prescribing medication to Magnolia members. If a pharmacist receives a prescription for a drug that requires a PA request, the pharmacist should attempt to contact the provider to request a change to a product included in the Magnolia PDL.

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

Working with Magnolia's Specialty Pharmacy Providers

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

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

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

EPSDT

The Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) service is Medicaid's comprehensive and preventive child health program for individuals under the age of 21, 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 for EPSDT services. 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. **The following minimum elements are to be included in the periodic health screening assessment:**

- Comprehensive health and development history (including assessment of both physical and mental development);
- Comprehensive unclothed physical examination;
- Immunizations appropriate to age and health history;
- Assessment of nutritional status;
- Laboratory tests (including finger stick hematocrit, urinalysis [dip-stick]),
- Sickle cell screen, TB skin testing and RPR serology (if not previously performed); Blood lead levels must be tested pursuant to the EPSDT provider manual;
- Developmental assessment;
- Vision screening and services, including at a minimum, diagnosis and treatment for defects in vision, including eyeglasses;
- Dental screening and services, including at a minimum, relief of pain and infections, restoration of teeth and maintenance of dental health. Although an oral screening may be part of a provider examination, it does not substitute for examination through direct referral to a dentist;
- Hearing screening and services, including at a minimum, diagnosis and treatment for defects in hearing, including hearing aids; and
- Health education and anticipatory guidance.

EPSDT services include periodic screening, vision, dental, and hearing services.

Provision of all components of the EPSDT service must be clearly documented in the PCP's medical record for each member.

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 of percentage of eligible members obtaining EPSDT services in accordance with the adopted periodicity schedules. 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.

Provider may 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.

CentAccount® Program

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

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

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

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

Notes:

Care Management Program

Magnolia's care management model is designed to help Magnolia members obtain needed services, whether they are covered within the Magnolia array of covered services, from the community, or from other non-covered venues. Our model will support our provider network whether you work in an individual practice or large multi-specialty group setting.

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

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

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

To contact a case manager call:

Magnolia Health

Care Management Department
1-866-912-6285

A care management team is available to help providers manage their Magnolia members.

To contact a case manager call: 1-866-912-6285

High Risk Pregnancy Program:

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

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

The SSI/Complex Teams

Case managers are familiar with evidence-based resources and best practice standards specific to conditions common among adults or children. These teams will be led by clinical licensed case managers with either adult or pediatric expertise, as applicable. For both adult and pediatric teams, the staff will have experience with the population, the barriers and obstacles they face, and the socioeconomic impacts on their ability to access services. The SSI/complex 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 healthcare 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 healthcare 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 a grassroots support and awareness of Magnolia within the community. The program has various components that can be provided depending on the need of the member.

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

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

MemberConnections
1-866-912-6285

Disease Management (DM) Programs

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

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

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

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

Magnolia Heath

Health Coach
1-866-912-6285

The Disease Management programs target members with selected chronic diseases which may not be under control.

Notes:

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 Health Program must have an active Medicaid ID number.**

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 authorize Magnolia access to the CAQH (Council for Affordable Quality Healthcare) for the Mississippi Uniform Credentialing application
- Signed attestation of the correctness and completeness of the application, history of loss of license and/or clinical privileges, disciplinary actions, and/or felony convictions; lack of current illegal substance registration and/or alcohol abuse; mental and physical competence, and ability to perform the essential functions of the position, with or without accommodation
- Copy of current malpractice insurance policy face sheet that includes expiration dates, amounts of coverage and provider's name, or evidence of compliance with Mississippi regulations regarding malpractice coverage
- Copy of current Mississippi Controlled Substance registration certificate (if applicable)
- Copy of current Drug Enforcement Administration (DEA) registration certificate
- Copy or original of completed Internal Revenue Service Form W-9
- Copy of Educational Commission for Foreign Medical Graduates (ECFMG) certificate, if applicable
- Copy of cultural competency training certificate, if applicable
- Copy of current unrestricted medical license to practice in the state of Mississippi

All providers who participate in the Magnolia Health Program must have an active Medicaid ID number.

- Current copy of specialty/board certification certificate, if applicable
- Curriculum vitae listing, at a minimum, with a five (5) year work history (not required if work history is completed on the application)
- Signed and dated release of information form not older than 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), if applicable
- Copy of enumeration letter issued by National Plan and Provider Enumeratio 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
- Review five (5) year work history
- Review federal sanction activity including Medicare/Medicaid services (OIG-Office of Inspector General and EPLS — Excluded Parties Listing)

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

Credentialing Committee

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

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

Site visits are performed at provider offices within 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, and safety procedures.

Re-Credentialing

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

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

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

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

To obtain your application status, contact the Magnolia Provider Relations department at 1-866-912-6285.

Right to Review and Correct Information

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

Should a provider believe any of the information used in the credentialing/re-credentialing process to be erroneous, or should any information gathered as part of the primary source verification process differ from that submitted by a practitioner, they have the right to correct any erroneous information submitted by another party. To request release of such information, a written request must be submitted to the Magnolia credentialing department. Upon receipt of this information, the provider will have thirty (30) days to provide a written explanation detailing the error or the difference in information to the Magnolia. The Credentialing Committee will then include this information as part of the credentialing/re-credentialing process.

Right to Be Informed of Application Status

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

Right to Appeal Adverse Credentialing Determinations

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

Member Rights and Responsibilities

Members are informed of their rights and responsibilities through the Member Handbook. Magnolia providers are also expected to respect and honor member's rights. 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 your 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 your physicians in making decisions regarding your 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, are comparable in amount, duration, and scope to those provided under Medicaid Fee-For-Service (FFS) and are sufficient in amount, duration, and scope to reasonably be expected to achieve the purpose for which the services are furnished.
- To receive services that are appropriate and are not denied or reduced solely because of diagnosis, type of illness, or medical condition.
- To receive assistance from both Medicaid and Magnolia in understanding the requirements and benefits of Magnolia.
- To receive family planning services from any participating Medicaid physician without prior authorization.
- To a candid discussion of appropriate or medically necessary treatment options for your conditions, regardless of cost or benefit coverage.
- To receive information on the Grievance, Appeal and Medicaid's State Fair Hearing procedures.
- To voice grievances or file appeals about Magnolia decisions that affect your privacy, benefits, or the care provided.
- To request and receive a copy of your medical record.
- To make recommendations regarding Magnolia's member rights and responsibilities policies.
- To request that your medical records be corrected.
- To expect your 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 you.
- To allow or refuse your personal information 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 file for a Medicaid State Fair Hearing.
- 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 you for the use of your information by Magnolia if you are unable to.
    - To get a second opinion from a qualified healthcare professional.
    - To receive oral interpretation services free of charge for all non-English languages.
    - To be notified that oral interpretation is available and how to access those services.
- As a potential member, to receive information about the basic features of managed care; which populations may or may not enroll in the program and Magnolia's responsibilities for coordination of care in a timely manner in order to make an informed choice.

Magnolia members have the following rights (cont'd):

- **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 your freedom of choice among network providers.
  - Providers who are not accepting new patients.
  - Benefits not offered by Magnolia, but available to you and how to obtain those benefits, including how transportation is provided.
- To receive a complete description of disenrollment rights at least annually.
- To receive notice of any significant changes in the Benefits Package at least 30 days before the intended effective date of the change.
- **To receive detailed information on emergency and after-hours coverage, to include, but not limited to:**
  - What constitutes an emergency medical condition, emergency services, and post-stabilization services.
  - Those emergency services that do not require prior authorization. The process and procedures for obtaining emergency services.
  - The locations of any emergency settings and other locations at which providers furnish emergency services and post-stabilization services covered under the contract.
  - Your 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 your ID card when using healthcare services.
- To be familiar with Magnolia procedures to the best of your ability.
- To call or contact Magnolia to obtain information and have questions clarified.
- To provide information (to the extent possible) that Magnolia and its providers need in order to provide care.
- To follow the prescribed treatment (plans and instructions) for care that has been agreed upon with your providers.
- To inform your provider on reasons you cannot follow the prescribed treatment of care recommended by your provider.
- To understand your health problems and participate in developing mutually agreed-upon treatment goals to the degree possible.
- To keep your medical appointments and follow-up appointments.
- To access preventive care services.
- To follow the policies and procedures of Magnolia and Medicaid.
- To be honest with providers and treat them with respect and kindness.
- To get regular medical care from your PCP before seeing a specialist.
- To follow the steps of the appeal process.
- To notify Magnolia, Medicaid, and your providers of any changes that may affect your membership, your healthcare needs, or your access to benefits.
  Some examples may include:
  - If you have a baby.
  - If your address changes.
  - If your telephone number changes.
  - If you or one of your children are covered by another plan.
  - If you have a special medical concern.
  - If your family size changes.
- To keep all your scheduled appointments.
- To be on time for your scheduled appointments.
- To cancel your scheduled appointments at least twenty-four (24) hours in advance if you cannot keep an appointment.
- To access care by following Magnolia rules; failure to do so may cause you may be responsible for the charges.

Provider Rights and Responsibilities

Magnolia providers have the following rights:

- Be treated by Magnolia members and other healthcare workers with dignity and respect.
- Receive accurate and complete information and medical histories for members' care.
- Have Magnolia members act in a way that supports the care given to other patients and that helps keep the provider's office, hospital, or other offices running smoothly.
- Expect other network providers to act as partners in members' treatment plans.
- Expect members to follow their directions, such as taking the right amount of medication at the right times.
- File a grievance with Magnolia on behalf of a member, with the member's consent.
- Have the right to file claim reconsideration, claim appeal and claim dispute requests.
- May file a grievance or complaint for any dissatisfaction about any matter other than an adverse action.
- Have access to information about Magnolia's QI programs, including program goals, processes, and outcomes that relate to member care and services, including information on safety issues.
- Contact Magnolia's Provider Services with any questions, comments, or problems, including suggestions for changes in the QI Program's goals, processes, and outcomes related to member care and services.
- Allow members to request restriction on the use and disclosure of their personal health information
- Make a complaint or file an appeal against Magnolia and/or a Magnolia member.
- Collaborate with other healthcare professionals who are involved in the care of members.
- Review clinical practice guidelines distributed by Magnolia.
- Invite member participation, to the extent possible, in understanding any medical or behavioral health problems that the member may have and to develop mutually agreed upon treatment goals, to the extent possible.
- Not be excluded, penalized, or terminated from participating with Magnolia for having developed or accumulated a substantial number of patients in the Magnolia with high-cost medical conditions.
- Object to providing relevant or medically necessary services on the basis of the provider's moral or religious beliefs or other similar grounds.

Magnolia providers have the following responsibilities:

- Ensure they are aware of and comply with their personal and staff's responsibilities under federal and state law regarding advance directives (See Advance Directives).
- **Help members, or advocate for members, to make decisions within their scope of practice about their relevant and/or medically necessary care and treatment, including the right to:**
  - 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
- Treat members with fairness, dignity, and respect.
- Not discriminate against members on the basis of race, color, national origin, disability, age, religion, mental or physical disability, or limited English proficiency.
- Maintain the confidentiality of members' personal health information, including medical records and histories, and adhere to state and federal laws and regulations regarding confidentiality.
- Give members a notice that clearly explains their privacy rights and responsibilities as it relates to the provider's practice/office/facility.
- Provide members with an accounting of the use and disclosure of their personal health information in accordance with HIPAA.
- Provide members, upon request, access to inspect and receive a copy of their personal health information, including medical records.

- Provide clear and complete information to members, in a language they can understand, about their health condition and treatment, regardless of cost or benefit coverage, and allow the member to participate in the decision-making process.
- Tell a member if the proposed medical care or treatment is part of a research experiment and give the member the right to refuse experimental treatment.
- Allow a member who refuses or requests to stop treatment the right to do so, as long as the member understands that by refusing or stopping treatment the condition may worsen or be fatal.
- Respect members' advance directives and include these documents in the members' medical record.
- Allow members to appoint a parent, guardian, family member, or other representative if they cannot fully participate in their treatment decisions.
- Allow members to obtain a second opinion, and answer members' questions about how to access healthcare services appropriately.
- Obtain and report to Magnolia information regarding other insurance coverage.
- Follow all state and federal laws and regulations related to patient care and patient rights.
- Participate in Magnolia data collection initiatives, such as HEDIS and other contractual or regulatory programs.
- Comply with Magnolia's Medical Management program as outlined in this manual.
- Notify Magnolia in writing if the provider is leaving or closing a practice.
- Contact Magnolia to verify member eligibility or coverage for services, if appropriate.
- Disclose overpayments or improper payments to Magnolia.
- Provide members, upon request, with information regarding office location, hours of operation, accessibility, and languages, including the ability to communicate with sign language.
- Provide members, upon request, with information regarding the provider's professional qualifications, such as specialty, education, residency, and board certification status.

- Disclose to Magnolia, on an annual basis, any physician incentive plan (PIP) or risk arrangements the provider or provider group may have with providers either within its group practice or other providers not associated with the group practice even if there is no substantial financial risk between Magnolia and the provider or provider group.
- Providers are advised to give Magnolia appropriate notice prior to voluntarily leaving the network at the end of the initial term or at the end of any renewal term. Please refer to your individual or organizational provider agreement, under "Term and Termination" for the applicable timeframe for giving notice.
- Providers are advised to send termination notices via certified mail (return receipt requested) or overnight courier for the request to be valid. In addition, providers are advised to supply copies of medical records to the member's new provider and facilitate the member's transfer of care at no charge to Magnolia or the member.
- Magnolia will notify affected members in writing of a provider's termination, as applicable, at least 15 days before the disenrollment. If the terminating provider is a PCP, Magnolia will request that the member select a new PCP. If a member does not select a PCP prior to the provider's termination date, Magnolia will automatically assign one to the member.
- Providers are advised to continue to render covered services to members who are existing patients at the time of termination until the later of 60 calendar days, the anniversary date of the member's coverage, or until Magnolia can arrange for appropriate healthcare for the member with a participating provider. Upon request from a member undergoing active treatment related to a chronic or acute medical condition, Magnolia will reimburse the provider for the provision of covered services for up to 90 calendar days from the termination date. In addition, Magnolia will reimburse providers for the provision of covered services to members who are in the second or third trimester of pregnancy extending through the completion of postpartum care relating to the delivery.
- Exceptions may include members requiring only routine monitoring or providers unwilling to continue to treat the member or accept payment from Magnolia.

Member Grievances and Complaints

A member grievance is defined as an expression of dissatisfaction about any matter other than an action. A member may file a grievance either orally or in writing within (thirty) 30 calendar days of the date of the event causing dissatisfaction. The legal guardian of the member (for a minor or an incapacitated adult), a representative of the member as designated in writing to Magnolia, or a provider acting on behalf of the member and with the member's written consent, have the right to file a grievance on behalf of the member. Individuals that make decisions on grievances will not be involved in any previous level of review or decision making. Magnolia values its providers and will not take punitive action, including and up to termination of a provider agreement or other contractual arrangements, for providers who file a grievance on a member's behalf.

Acknowledgment

Magnolia staff receiving grievances will acknowledge the grievance and attempt to resolve them immediately. For complaints, defined as those received orally and resolved within one (1) business day to the satisfaction of the member, Magnolia will document the resolution details. Otherwise, Magnolia will provide the grievant with a written acknowledgment letter that the grievance has been received and the expected date of its resolution within five (5) working days of receipt of the grievance.

Grievance Resolution Time Frame

Grievance resolution will occur as expeditiously as the member's health condition requires, not to exceed thirty (30) calendar days from the date of the initial receipt of the grievance. Clinically urgent grievances will be resolved within 72 hours of receipt. Grievances will be resolved by the Grievance and Appeals Coordinator (GAC), in collaboration with other Magnolia staff as needed.

Notice of Resolution

The GAC will provide written resolution to the grievant within (thirty) 30 calendar days of receipt. The letter will include, but not be limited to, the resolution details and Division of Medicaid (DOM) requirements, including the right to a Level II Grievance Review by Magnolia Health, if the member is not satisfied.

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

A member grievance is defined as an expression of dissatisfaction about any matter other than an action.

Grievances may be submitted by written notification to the Grievances and Appeals Coordinator.

Grievances may be submitted by written notification to:

Magnolia Health
Grievances and Appeals Coordinator (GAC)
111 East Capitol St., Suite 500
Jackson MS 39201
1-866-912-6285

Appeals

An appeal is the request for review of a "Notice of Adverse Action". *A Notice of Adverse Action* is:

- The denial or limited authorization of a requested service, including the type or level of service
- The reduction, suspension, or termination of a previously authorized service
- The denial, in whole or part of payment for a service excluding technical reasons
- The failure to render a decision within the required timeframes
- The denial of a member's request to exercise his/her right under 42 CFR 438.52(b)(2)(ii) to obtain services outside the Magnolia network

The review may be requested orally or in writing; however if the appeal is requested orally, written statement of appeal is required within thirty (30) calendar days of the oral request for standard appeals. Appeals requested within the standard timeframe must be resolved within thirty (30) calendar days of receipt of the appeal, with a fourteen (14) calendar day extension possible if additional information is needed. Individuals who make decisions on appeals will not be involved in any previous level of review or decision making. Members may request that Magnolia review the Notice of Adverse Action to verify if the right decision has been made.

Expedited Appeals

Expedited appeals may be filed when either Magnolia or the member's provider determines that the time expended in a standard resolution could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function. No punitive action will be taken against a provider that requests an expedited resolution or supports a member's appeal. In instances where the member's request for an expedited appeal is denied, the appeal will be transferred to the timeframe for standard resolution of appeals.

Decisions for expedited appeals are issued as expeditiously as the member's health condition requires, not exceeding 72 hours from the initial receipt of the appeal. Magnolia may extend this timeframe by up to an additional fourteen (14) calendar days if the member requests the extension or if Magnolia provides evidence satisfactory to the DOM that a delay in rendering the decision is in the member's interest. For any extension not requested by the member, Magnolia shall provide written notice to the member of the reason for the delay. Magnolia shall make reasonable efforts to provide the member with prompt verbal notice of any decisions that are not resolved wholly in favor of the member and shall follow-up within two (2) calendar days with a written notice of action.

Written notice shall include the following information:

- The decision reached by Magnolia;
- The date of decision;
- For appeals not resolved wholly in favor of the member, the right to request a State Fair Hearing and information as to how to do so; and
- The right to request to receive benefits while the hearing is pending and how to make the request, explaining that the member may be held liable for the cost of those services if the hearing decision upholds the Magnolia decision.

Call or mail all appeals to:

Magnolia Health
Grievances and Appeals Coordinator (GAC)
111 East Capitol St., Suite 500
Jackson MS 39201
1-866-912-6285

State Fair Hearing Process

A Provider or Member may request a State Fair Hearing if he or she is dissatisfied with an action that has been taken by Magnolia, within thirty (30) days of receiving notice of the action or within thirty (30) days of the final decision by Magnolia. All levels of Magnolia Complaint, Grievance, and Appeals procedures must be exhausted prior to requesting a State Fair Hearing with the Division of Medicaid.

All documents supporting Magnolia's action must be received by the DOM no later than five (5) days from the date Magnolia receives notice from the DOM that a State Fair Hearing has been filed. These records shall be made available to the member upon request by either the member or the member's legal counsel. The DOM will provide the member with a hearing process that shall adhere to 42 CFR 438 Subpart F and 42 CFR 431 Subpart E.

Failure of Magnolia to comply with the State Fair Hearing requirements of the state and federal Medicaid law in regard to an action taken by Magnolia or to appear and present evidence will result in an automatic ruling in favor of the member.

Reversed Appeal Resolution

In accordance with 42 CFR §438.424, if Magnolia's or the State Fair Hearing decision reverses a decision to deny, limit, or delay services, where such services were not furnished while the appeal was pending, Magnolia will authorize the disputed services promptly and as expeditiously as the member's health condition requires. Additionally, in the event that services were continued while the appeal was pending, Magnolia will provide reimbursement for those services in accordance with the terms of the final decision rendered by the DOM and applicable regulations.

To File a Medicaid State Fair Hearing:

Division of Medicaid
The Office of Appeal Hearings
550 High St., Suite 1000
Jackson, MS 39201
1-800-421-2408

Provider Grievances and Provider Complaints

A provider grievance is defined as any provider expression of dissatisfaction expressed by a grievant to the Plan orally or in writing about any matter or aspect of the Plan or its operation, other than a Plan Action or determination of Medical Necessity for a service. A grievance does not include matters of misunderstanding or misinformation that can be promptly resolved by clearing up the misunderstanding or by providing accurate information to the provider. A grievance includes, but is not limited to, the quality of care or services provided, or aspects of interpersonal relationships. A grievance can be filed within thirty (30) calendar days of the date of the event causing the dissatisfaction. A provider complaint is any provider expression of dissatisfaction expressed by a complainant to the Plan orally or in writing that is of a less serious or formal nature that is resolved within one (1) business day of receipt, about any matter related to the Plan other than a determination of Medical Necessity for a service. A complaint also includes matters of misunderstanding or misinformation that can be promptly resolved by clearing up the misunderstanding, or providing accurate information to the provider. A complaint can be filed within thirty (30) calendar days of the date of the event causing the dissatisfaction. In any case where the reason for the grievance involves clinical issues or relates to denial of expedited resolution of an appeal, Magnolia shall ensure that the decision makers are healthcare professionals with the appropriate clinical expertise in treating the member's condition or disease [see 42 CFR § 438.406]. Magnolia values its providers and will not take punitive action, including and up to termination of a provider agreement or other contractual arrangements, for providers who file a grievance.

Acknowledgment

Staff receiving grievances will acknowledge the grievance and attempt to resolve them immediately. Staff will document the substance of the grievance. The Plan will notate date received for written grievances upon initial receipt and send an acknowledgment letter, which includes a description of the grievance procedures and resolution time frames, within ten (10) calendar days of receipt.

A provider grievance is defined as any provider expression of dissatisfaction expressed by a grievant to the Plan orally.

Grievances may be submitted by written notification to the Provider Complaints/Grievances department.

Grievance Resolution Time Frame

Provider grievance resolution will occur as expeditiously as deemed appropriate, not to exceed 30 calendar days from the date of the initial receipt of the grievance. The Plan may extend the time frame up to fourteen (14) calendar days. Grievances will be resolved by the Plan, in coordination with other Magnolia staff as needed. In our experience, most grievances are resolved at the staff level to the satisfaction of the provider filing the grievance. Expedited grievance reviews will be available for providers in situations deemed urgent, such as a denial of an expedited appeal request, and will be resolved within 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, if the provider is not satisfied. The grievance response shall include, but not be limited to, the decision reached by Magnolia, the reason(s) for the decision, the policies or procedures which provide the basis for the decision, and a clear explanation of any further rights available to the enrollee. A copy of verbal complaints logs and records of disposition or written grievances shall be retained for five (5) years. Complaints and/or **Grievances may be submitted by written notification to:**

Magnolia Health

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

Waste, Abuse, and Fraud (WAF) System

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

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

Some of the most common WAF submissions seen are:

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

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

!

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.

Authority and Responsibility

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

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

Quality Improvement

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

Magnolia recognizes its legal and ethical obligation to provide members with a level of care that meets recognized professional standards and is delivered in the safest, most appropriate settings. To that end, Magnolia will provide for the delivery of quality care with the primary goal of improving the health status of its members. Where the member's condition is not amenable to improvement, Magnolia will implement measures to prevent any further decline in condition or deterioration of health status or provide for comfort measures as appropriate and requested by the member. This will include the identification of members at risk of developing conditions, the implementation of appropriate interventions, and designation of adequate resources to support the interventions. Whenever possible, the Magnolia QI program supports these processes and activities that are designed to achieve demonstrable and sustainable improvement in the health status of its members.

Magnolia's culture, systems, and processes are structured around its mission to improve the health of its members.

Program Structure

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

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

The following sub-committees report directly to the QIC:

- Credentialing Committee
- P&T Committee
- UM Committee
- Performance Improvement team
- Member and Community Advisory Committees
- Peer Review Committee (Ad Hoc Committee)

Practitioner Involvement

Magnolia recognizes the integral role provider involvement plays in the success of its QI program. Provider involvement in various levels of the process is highly encouraged through provider representation. Magnolia encourages PCP, behavioral health, specialty, and OB/GYN representation on key quality committees such as, but not limited to, the QIC, Credentialing Committee, P&T Committee, and select ad-hoc committees.

Quality Improvement Program Scope and Goals

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

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

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

- Compliance with preventive health guidelines and practice guidelines
- Acute and chronic care management
- Provider network adequacy and capacity
- Selection and retention of providers (credentialing and re-credentialing)
- Behavioral healthcare and Magnolia benefits
- Delegated entity oversight
- Continuity and coordination of care
- UM, including under and over utilization
- Compliance with member confidentiality laws and regulation

- Employee and provider cultural competency
- Provider appointment availability
- Provider and Magnolia after-hours telephone accessibility
- Member satisfaction
- Provider satisfaction
- Member grievance system
- Provider complaint system
- Member enrollment and disenrollment
- PCP changes
- Department performance and service
- Patient safety
- Pharmacy
- Marketing practices

Performance Improvement Process

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

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

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

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

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

Healthcare Effectiveness Data and Information Set (HEDIS)

HEDIS reporting is a required part of NCQA Health Plan Accreditation and Magnolia's contract with DOM for the provision of coordinated care services within the MississippiCAN program.

HEDIS is a set of standardized performance measures developed by the National Committee for Quality Assurance (NCQA) which allows comparison across health plans. HEDIS gives purchasers and consumers the ability to distinguish between health plans based on comparative quality instead of simply cost differences. HEDIS reporting is a required part of NCQA Health Plan Accreditation and Magnolia's contract with DOM for the provision of coordinated care services within 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. Mississippi purchasers of healthcare use the aggregated HEDIS rates to evaluate the effectiveness of a health insurance company's ability to demonstrate an improvement in preventive health outreach to its members. Provider-specific scores are being used as evidence of preventive care from PCPs.

How Are HEDIS Rates Calculated?

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

- Administrative data: Consists of claim or encounter data submitted to the health plan. Measures typically calculated using administrative data include: annual mammogram, annual chlamydia screening, annual pap test, appropriate treatment of asthma, cholesterol management, antidepressant medication management, access to PCP services, and utilization of acute and mental health services.
- Hybrid data: Consists of both administrative data and a sample of medical record data. Hybrid data requires review of a random sample of member medical records to abstract data for services rendered but that were not reported to the health plan through claims/encounter data. Accurate and timely claim/encounter data and submission of appropriate CPT II codes can reduce the necessity of medical record reviews (see Magnolia's website and HEDIS brochure for more information on reducing HEDIS medical record reviews). Measures typically requiring medical record review include: diabetic HgA1c, LDL, eye exam and nephropathy, controlling high-blood pressure, and prenatal care and postpartum care.

Who Will Be Conducting the Medical Record Reviews (MRR) for HEDIS?

Magnolia will contract with a national medical record review vendor to conduct the HEDIS medical record reviews on its behalf. Medical record review audits for HEDIS are usually conducted February through May each year. At that time, you may receive a call from a medical record reviewer representative if any of your patients are selected into HEDIS samples for Magnolia. Your prompt cooperation with the representative is greatly needed and appreciated.

As a reminder, protected health information (PHI) that is used or disclosed for purposes of treatment, payment, or healthcare operations is permitted by HIPAA Privacy Rules (45 CFR 164.506) and does not require consent or authorization from the member or patient. The medical record review vendor will sign a HIPAA compliant Business Associate Agreement with Magnolia which allows them to collect PHI on our behalf.

!

You may receive a call from a medical record reviewer representative if any of your patients are selected into HEDIS samples for Magnolia.

What Can Be Done to Improve My HEDIS Scores?

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

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

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

ICD-9 Codes to report BMI percentiles:

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

CPT	ICD-9	ICD-9	CHPCS Diagnosis	Procedure
Nutrition Counseling	97802-97804	V65.3		S9470, S9452, S9449, G0270-G0271
Physical Activity Counseling		V65.41	93.11, 93.13, 93.19, 93.31	S9451, H2032

Coding for nutrition and physical activity counseling:

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

The CAHPS survey is a member satisfaction survey that is included as a part of HEDIS and NCQA accreditation.

Provider Satisfaction Survey

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

Consumer Assessment of Healthcare Provider Systems (CAHPS) Survey

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

Medical Records

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

Required Information

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

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

- Member's name, and/or medical record number on all chart pages.
- Personal/biographical data is present (i.e., employer, home telephone number, spouse, next of kin, legal guardianship, primary language, etc.).
- Prominent notation of any spoken language translation or communication assistance.
- All entries must be legible and maintained in detail.
- All entries must be dated and signed, or dictated by the provider rendering the care.
- Significant illnesses and/or medical conditions are documented on the problem list and all past and current diagnoses.
- Medication, allergies, and adverse reactions are prominently documented in a uniform location in the medical record; if no known allergies, NKA or NKDA are documented.
- An up-to-date immunization record is established for pediatric members or an appropriate history is made in chart for adults.
- Evidence that preventive screening and services are offered in accordance with Magnolia Practice Guidelines.

Magnolia providers must keep accurate and complete medical records.

- 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 (18 years and younger), past medical history relating to prenatal care, birth, any operations and/or childhood illnesses.
- Working diagnosis is consistent with findings.
- Treatment plan is appropriate for diagnosis.
- Documented treatment prescribed, therapy prescribed, and drug administered or dispensed including instructions to the member.
- Documentation of prenatal risk assessment for pregnant women or infant risk assessment for newborns.
- Signed and dated required consent forms.
- Unresolved problems from previous visits are addressed in subsequent visits.
- Laboratory and other studies ordered as appropriate.
- Abnormal lab and imaging study results have explicit notations in the record for follow up plans; all entries should be initialed by the PCP to signify review.
- Referrals to specialists and ancillary providers are documented including follow up of outcomes and summaries of treatment rendered elsewhere including family planning services, preventive services, and services for the treatment of sexually transmitted diseases.
- Health teaching and/or counseling is documented.
- For members ten (10) years and over, appropriate notations concerning use of tobacco, alcohol and substance use (for members seen three [3] or more times substance abuse history should be queried).
- Documentation of failure to keep an appointment.
- Encounter forms or notes have a notation, when indicated, regarding follow-up care calls or visits. The specific time of return should be noted as weeks, months or as needed.
- Evidence that the member is not placed at inappropriate risk by a diagnostic or therapeutic problem.
- Confidentiality of member information and records protected.
- Evidence that an advance directive has been offered to adults 18 years of age and older.

Medical Records Release

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

Medical Records Transfer for New Members

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

Notes:

Provider Relations Department

Magnolia's Provider Relations department is designed around the concept of making your experience a positive one by being your advocate within Magnolia. **Provider Relations are responsible for providing the services listed below which include but are not limited to:**

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

The goal of this department is to furnish you and your staff with the necessary tools to provide the highest quality of healthcare to Magnolia members. To contact the Provider Relations Representative for your area, contact our Provider Services at 1-866-912-6285. Provider Services Representatives work with Provider Relations Representatives to serve as your advocates to ensure that you receive necessary assistance and maintain satisfaction with Magnolia.

Magnolia's Provider Relations department is designed around the concept of making your experience a positive one.

Top 10 Reasons to Contact a Provider Relations Representative

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

General Billing Guidelines

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

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

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

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

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

Claims eligible for payment must meet the following requirements:

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

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

Timely Filing

Providers must submit all claims and encounters within180 calendar days of the date of service. The filing limit may be extended where the eligibility has been retroactively received by Magnolia up to a maximum of 180 days. When Magnolia is the secondary payer, claims must be received within 365 calendar days of the final determination of the primary payer.

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

Electronic Claims Submission

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

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

Magnolia Health Plan

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

Providers that bill electronically are responsible for filing claims within the same filing deadlines as providers filing paper claims.

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

Paper Claims Submission

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

Magnolia Health Plan

Attn: Claims Department
P.O. Box 3090
Farmington, MO 63640-3825

Requirements

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

Do's

- Do submit all DOS and birthdates in a mm/dd/yyyy format
- Do use the correct P.O. Box number
- Do submit all claims in a 9" x 12" or larger envelope
- Do type all fields completely and correctly
- Do use typed black or blue ink only at 9-point font or large
- Do include all other insurance information (policy holder, carrier name, ID number, and address) when applicable
- Do attach the EOP from the primary insurance carrier when applicable. *Note: Magnolia is able to receive primary insurance carrier EOP [electronically]*
- Do submit on a proper original form — CMS 1500 or UB04

Don'ts

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

Clean Claim Definition

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

Non-Clean Claim Definition

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

Common Causes of Upfront Rejections

- Unreadable Information
- Missing Member Date of Birth
- Missing Member Name or Identification Number
- Missing Provider Name, Tax ID, 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
- Missing Service Line Detail
- Member Not Effective on The Date of Service
- Admission Type is Missing
- Missing Patient Status
- Missing or Invalid Occurrence Code or Date
- Missing or Invalid Revenue Code
- Missing or Invalid CPT/Procedure Code
- Incorrect Form Type
- Missing CLIA number when applicable

Magnolia will send providers a detailed letter for each claim that is rejected explaining the reason for the rejection.

Common Causes of Claim Processing Delays and Denials

- Incorrect Form Type
- Diagnosis Code Missing 4th or 5th Digit
- Missing or Invalid Procedure or Modifier Codes
- Missing or Invalid 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
- 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
- Mississippi Provider Medicaid ID Number is Missing or not Valid with the State.

Magnolia will send providers written notification via the EOP for each claim that is denied, which will include the reason(s) for the denial.

Billing Forms

Submit claims for professional services and durable medical equipment on a CMS 1500. Submit claims for hospital based inpatient and outpatient services as well as swing bed services on a UB-04 form.

Third Party Liability

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

Magnolia, like all Medicaid programs, is always the payer of last resort. 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 the provider to pay any claims that may have been denied for payment due to third party liability.

What is an Encounter Versus a Claim?

You are required to submit an encounter or claim for each service that you render to a Magnolia member. A claim is a request for reimbursement either electronically or by paper for any medical service. An encounter is contact between a patient and a practitioner who has primary responsibility for assessing and treating the patient. Encounters occur in many different settings—ambulatory care, emergency care, home healthcare, field and virtual (telemedicine). A claim must be filed on the proper form, such as CMS 1500 or UB04. A claim will be paid or denied with an explanation for the denial. For each claim processed, an EOP will be mailed to the provider who submitted the original claim.

A claim is a request for reimbursement either electronically or by paper for any medical service.

Procedures for Filing a Claim/ Encounter Data

Magnolia encourages all providers to file claims/encounters electronically. Magnolia captures encounter data—information showing use of provider services by health plan enrollees. See the Electronic Claims Submission section and for more information on how to initiate electronic claims/encounters.

Billing the Member

Magnolia reimburses only services that are medically necessary and covered through the MississippiCAN program. Provider is not allowed to “balance bill” for covered services if the provider’s usual and customary charge for covered services is greater than DOM’s fee schedule. A provider may bill a member for a claim denied as not being medically necessary, not a covered benefit, or the member has exceeded the program limitations for a particular service only if the following condition is met:

Prior to the service being rendered, the provider has obtained and kept a written member acknowledgment 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 the MississippiCAN program as being reasonable and medically necessary for my care. I understand that Magnolia Health Plan through its contract with the Mississippi Division of Medicaid (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.

Procedures For Claim Submission

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

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

- Rejections happen prior to the claims being received in the claims adjudication system and will be sent to the provider with a letter detailing the reason for the rejection.
- Denials happen once the claim has been received into the claims adjudication system and will be sent to the provider via an Explanation of Payment (EOP).

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

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

- All required fields are completed on an original CMS 1500, UB-04 paper claim form, or EDI electronic claim format.
- All Diagnosis, Procedure, Modifier, Location (Place of Service), Revenue, Type of Admission, and Source of Admission Codes are valid for the date of service.
- All Diagnosis, Procedure, Modifier, and Location (Place of Service) Codes are valid for provider type/specialty billing.
- All Diagnosis, Procedure, and Revenue Codes are valid for the age and/or sex for the date of the service billed.
- All Diagnosis Codes are to their highest number of digits available (4th or 5th digit).
- Principal Diagnosis billed reflects an allowed Principle Diagnosis as defined in the volume of ICD-9 CM or ICD-9 CM update for the date of service billed.
- Member is eligible for services under Magnolia during the time period in which services were provided.
- Services were provided by a participating provider or if provided by an "out of network" 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).

Magnolia is required by State and Federal regulations to capture specific data regarding services rendered to its members.

- An authorization has been given for services that require prior authorization by Magnolia.
- Medicare coverage or other third party coverage.

Claims Filing Deadlines

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

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

- Catastrophic event that substantially interferes with normal business operations of the provider or damage or destruction of the provider's business office or records by a natural disaster.
- Mechanical or administrative delays or errors by Magnolia or the Mississippi Division of Medicaid (DOM).
- **The member was eligible however the provider was unaware that the member was eligible for services at the time services were rendered. Consideration is granted in this situation only if all of the following conditions are met:**
  - The provider's records document that the member refused or was physically unable to provide their ID card or information.
  - The provider can substantiate that he continually pursued reimbursement from the patient until eligibility was discovered or Health Safety Net, if applicable.
  - The provider can substantiate that a claim was filed within 180 days of discovering Plan eligibility.
  - The provider has not filed a claim for this member prior to the filing of the claim under review.

Claim Requests for Reconsideration, Claim Disputes, and Corrected Claims

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

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

1. Contact a Magnolia Provider Service Representative at 1-866-912-6285
   - Providers may discuss questions with Magnolia Provider Services Representatives regarding amount reimbursed or denial of a particular service.
2. Submit an Adjusted or Corrected Claim to

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

   - The claim must clearly be marked as “RE-SUBMISSION” and must include the original claim number or the original EOP must be included with the resubmission.
   - 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.
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 about a disagreement in the way a claim was processed but does not require a claim to be corrected and does not require medical records.
     - For more information about how to submit a medical necessity dispute, refer to the Grievances and Appeals section of this provider manual.
   - The request must include sufficient identifying information which includes, at minimum, the patient name, patient ID number, date of service, total charges and provider name.
   - The documentation must also include a detailed description of the reason for the request.
4. Submit a “Claim Dispute Form” to

   Magnolia Health
   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 resource section 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 45 business days of receipt of the corrected claim, request for reconsideration, or claim dispute.

Claim Payment

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

- 98% within 30 business days of the receipt of the electronically filed claim
- 98% within 45 business days of the receipt of paper claims.

Claim payments will be contingent on Magnolia receiving their monthly reimbursement from the Mississippi Division of Medicaid.

Electronic Data Interchange (EDI) allows faster, more efficient and cost-effective claim submission for providers. EDI, performed in accordance with nationally recognized standards, supports the healthcare industry’s efforts to reduce administrative costs.

The benefits of billing electronically include:

- Reduction of overhead and administrative costs. EDI eliminates the need for paper claim submission. It has also been proven to reduce claim re-work (adjustments).
- Receipt of clearinghouse reports as proof of claim receipt. This makes it easier to track the status of claims.
- Faster transaction time for claims submitted electronically. An EDI claim averages about 24 to 48 hours from the time it is sent to the time it is received. This enables providers to easily track their claims.
- Validation of data elements on the claim format. By the time a claim is successfully received electronically, information needed for processing is present. This reduces the chance of data entry errors that occur when completing paper claim forms.
- Quicker claim completion. Claims that do not need additional investigation are generally processed quicker. Reports have shown that a large percentage of EDI claims are processed within 10 to 15 days of their receipt.

All the same requirements for paper claim filing apply to electronic claim filing. Claims that are not submitted correctly or containing the allowed field data will be rejected and/or denied.

Filing Claims Electronically

How to Start

- First, the provider will need to meet specific hardware/software requirements. There are many different products that can be used to bill electronically. As long as you have the capability to send EDI claims, whether through direct submission to the clearinghouse or through another clearinghouse, you can submit claims electronically.
- Second, the provider needs to contact their clearinghouse and confirm they will transmit the claims to one of the clearinghouses used by Magnolia. For a list of vendors used by Magnolia, please visit our website at www.MagnoliaHealthPlan.com. Go to the Provider page and click on EDI.
- Third, the provider should confirm with their clearinghouse the accurate location of the Magnolia Payer ID number.
- Last, the provider needs to verify with Magnolia that their provider record is set up within the claim adjudication system (Amisys).

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

To file claims electronically, please visit our website at www.MagnoliaHealthPlan.com

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

The following sections describe the procedures for electronic submission for hospital and medical claims. Included are a high level description of claims and report process flows, information on unique electronic billing requirements, and various electronic submission exclusions.

Specific Data Record Requirements

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

Electronic Claim Flow Description & Important General Information

In order to send claims electronically to Magnolia, all EDI claims must first be forwarded to one of Magnolia's clearinghouses. This can be completed via a direct submission to a clearinghouse or through another EDI clearinghouse.

Once the clearinghouse receives the transmitted claims, they are validated against their proprietary specifications and Plan-specific requirements. Claims not meeting the requirements are immediately rejected and sent back to the sender via a clearinghouse error report. It is very important you review this error report daily to identify any claims that were not transmitted to Magnolia. The name of this report can vary based upon the provider's contract with their intermediate EDI clearinghouse. Accepted claims are passed to Magnolia, and the clearinghouse returns an acceptance report to the sender immediately.

Claims forwarded to Magnolia by a clearinghouse are validated against provider and member eligibility records. Claims that do not meet provider and/or member eligibility requirements are rejected and sent back on a daily basis to the clearinghouse. The clearinghouse in turn forwards the rejection back to its trading partner (the intermediate EDI clearinghouse or provider). It is very important you review this report daily. The report shows rejected claims and these claims need to be reviewed and corrected timely. Claims passing eligibility requirements are then passed to the claim processing queues.

Providers are responsible for verification of EDI claims receipts. Acknowledgments for accepted or rejected claims received from the clearinghouse must be reviewed and validated against transmittal records daily.

Since the clearinghouse returns acceptance reports directly to the sender, submitted claims not accepted by the clearinghouse are not transmitted to Magnolia.

- If you would like assistance in resolving submission issues reflected on either the acceptance or claim status reports, please contact your clearinghouse or vendor customer service department.

Rejected electronic claims may be resubmitted electronically once the error has been corrected.

Invalid Electronic Claim Record Rejections/Denials

All claim records sent to Magnolia must first pass the clearinghouse proprietary edits and Plan-specific edits prior to acceptance. Claim records that do not pass these edits are invalid and will be rejected without being recognized as received by Magnolia. In these cases, the claim must be corrected and re-submitted within the required filing deadline of 90 calendar days from the date of service. It is important that you review the acceptance or claim status reports received from the clearinghouse in order to identify and re-submit these claims accurately.

Our companion guides to billing electronically are available on our website at www.MagnoliaHealthPlan.com. See the section on electronic claim filing for more details.

Exclusions

Certain claims are excluded from electronic billing.

- Excluded Claim Categories — At this time, these claim records must be submitted on paper.

These exclusions apply to inpatient and outpatient claim types:

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

NOTE: Provider identification 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.

Procedures For Electronic Submission

Electronic Billing Inquiries

Please direct inquiries as follows:

Action	Contact
If you would like to transmit claims electronically...	Contact one of the clearinghouses for Magnolia's payer ID.
If you have a general EDI question...	Contact EDI Support at 1-800-225-2573 Ext. 25525 or via e-mail at EDIBA@centene.com.
If you have questions about specific claims transmissions or acceptance Claim Status reports...	Contact your clearinghouse technical support area
If you have questions about your Claim Status (if claim has been accepted or rejected by the clearinghouse)...	Contact EDI Support at 1-800-225-2573 Ext. 25525 or via e-mail at EDIBA@centene.com.
If you have questions about claims that are reported on the Remittance Advice...	Contact Provider Services at 1-866-912-6285
If you would like to update provider, payee, UPIN, Tax ID number, or payment address information...	Notify Provider Services in writing at: magnoliapdm@centene.com or **Magnolia Health** 111 East Capitol Street, Suite 500 Jackson, MS 39201
For questions about changing or verifying provider information...	**Magnolia Health** Attn: Provider Services 111 East Capitol Street, Suite 500 Jackson MS 39201 1-866-912-6285 or by fax: 1-877-811-5980

Important Steps to a Successful Submission of EDI Claims

1. Select clearinghouse to utilize.
2. Contact the clearinghouse to inform them you wish to submit electronic claims to Magnolia.
3. Inquire with the clearinghouse what data records are required.
4. Verify with Provider Relations at Magnolia that the provider is set up in the Magnolia system before submitting EDI claims.
5. You will receive two (2) reports from the clearinghouse. ALWAYS review these reports daily. The first report will be a report showing the claims that were accepted by the clearinghouse and are being transmitted to Magnolia and those claims not meeting the clearinghouse requirements. The second report will be a claim status report showing claims accepted and rejected by Magnolia. ALWAYS review the acceptance and claim status reports for rejected claims. If rejections are noted, you must correct and resubmit.
6. MOST importantly, all claims must be submitted with provider's identifying numbers. See the CMS 1500 (8/05) and CMS 1450 (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 take advantage of EFTs and ERAs to settle claims electronically. For more information, please visit our provider home page on our website at www.MagnoliaHealthPlan.com or, to sign up for this quick and efficient service, you may go directly to www.payspanhealth.com.

Procedures For Online Claim Submission

For participating providers who have less than 5 claims in a calendar month and have internet access and choose not to submit claims via EDI, Magnolia has made it easy and convenient to submit claims directly to us on our website at www.MagnoliaHealthPlan.com.

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

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

Notes:

Claim Forms

Magnolia accepts the CMS 1500 (8/05) and CMS 1450 (UB-04) paper claim forms. Note: In 2014, CMS will be implementing the CMS 1500 (02/12) paper claim form to align and accommodate the ICD-10 update.

Professional providers and medical suppliers complete the CMS 1500 (8/05) or CMS 1500 (02/12) form and institutional providers complete the CMS 1450 (UB-04) claim form. Magnolia does not supply claim forms to providers. Providers should purchase these from a supplier of their choice. All paper claim forms submitted must be completed in black or blue ink. If you have questions regarding what type of form to complete, contact a Magnolia Provider Services Representative at 1-866-912-6285.

Coding of Claims

Magnolia requires claims to be submitted using codes from the current version of ICD-9-CM, CPT4, and HCPCS Level II for the date the service was rendered. These requirements may be amended to comply with federal and state regulations as necessary. **Claims will be rejected or denied if billed with:**

- Missing, invalid, or deleted codes
- Codes inappropriate for the age or sex of the member
- An ICD-9 CM code missing the 4th or 5th digit

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

Code Auditing and Editing

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

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

- American Medical Association (AMA) — the software utilizes the CPT Manuals, CPT Assistant, CPT Insider's View, the AMA web site, and other sources.
- Centers for Medicare & Medicaid Services' (CMS) National Correct Coding Initiative (NCCI) which includes column 1/column 2, mutually exclusive and outpatient code editor (OCEo edits). In addition to using the AMA's CPT manual, the NCCI coding policies are based on national and local policies and edits, coding guidelines developed by national societies, analysis of standard medical and surgical practices, and a review of current coding practices.
- Public-domain specialty society guidance (i.e., American College of Surgeons, American College of Radiology, American Academy of Orthopedic Surgeons).
- Clinical consultants who research, document, and provide edit recommendations based on the most common clinical scenario.
- In addition to nationally-recognized coding guidelines, the software has added flexibility to its rule engine to allow business rules that are unique to the needs of individual product lines.

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

Unbundling of Services — identifies procedures that have been unbundled.

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

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.

Bilateral Surgery — bilateral surgeries are identical procedures performed on bilateral anatomical sites during the same operative session.

Example:

Code	Description	Status
69436 DOS=01/01/10	Tympanostomy	Disallow
69436 50 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.

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

Example: excluding a duplicate CPT

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.

Evaluation and Management Services — 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 90-day global surgery period are designated as major surgical procedures; those assigned a 10-day or 0-day global surgery period are designated as minor surgical procedures.

- Evaluation and management services, submitted with major surgical procedures (90-day) and minor surgical procedures (10-day), are not recommended for separate reporting because they are part of the global service.
- Evaluation and management services, submitted with minor surgical procedures (0-day), are not recommended for separate reporting or reimbursement because these services are part of the global service unless the service is a service listed on the Mississippi Medicaid Fee Schedule with an asterisk.

Example: global surgery period

Code	Description	Status
27447 DOS=05/20/09	Arthroplasty, knee, condoyle and plateau; medial and lateral compartments with or without patella resurfacing (total knee arthroplasty).	Allow
99213 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 90 days.
- Procedure code 99213 is submitted with a date of service that is within the 90-day global period.
- When a substantial diagnostic or therapeutic procedure is performed, the evaluation and management service is included in the global surgical period.

Example: evaluation and management service submitted with minor surgical procedures

Code	Description	Status
11000 DOS=01/23/10	Debridement of extensive eczematous or infected skin; up to 10% of body surface.	Allow
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 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.

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

Example: same date of service

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 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 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:

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

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

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

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

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

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

Modifier -26 (professional component)

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

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

Example:

Code	Description	Status
78278 POS=Inpatient	Acute gastrointestinal blood loss imaging	Disallow
78278-26 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.

CPT® Category II Codes

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

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

Code Editing Assistant

A web-based code auditing reference tool designed to “mirror” how Magnolia code auditing product(s) evaluate code combinations during the auditing of claims is available for participating providers. This allows Magnolia to share with our contracted providers the claim auditing rules and clinical rationale we use to pay claims.

This tool offers many benefits:

- Prospectively access the appropriate coding and supporting clinical edit clarifications for services before claims are submitted
- Proactively determine the appropriate code/code combination representing the service for accurate billing purposes

The tool will review what was entered and will determine if the code or code combinations are correct based on the age, sex, location, modifier (if applicable), or other code(s) entered.

The Code Editing Assistant is intended for use as a ‘what if’ or hypothetical reference tool. It is meant to apply coding logic only. The tool does not take into consideration historical claims information which may have been used to determine an edit. The tool assumes all CPT codes are billed on a single claim.

The tool will not take into consideration individual fee schedule reimbursement, authorization requirements, or other coverage considerations.

Billing Codes

It is important that providers bill with codes applicable to the date of service on the claim. Billing with obsolete codes will result in a potential denial of the claim and a consequent delay in payment. Submit professional claims with current and valid CPT-4, HCPCS, or ASA codes and ICD-9 codes. Submit institutional claims with valid Revenue Codes and CPT-4 or HCPCS (when applicable), ICD-9 codes, and DRG codes (when applicable).

Providers will also improve the efficiency of their reimbursement through proper coding of a member’s diagnosis. We require the use of valid ICD-9 diagnosis codes, to the ultimate specificity, for all claims. This means that ICD-9 codes must be carried out to the fourth or fifth digit when indicated by the coding requirements in the ICD-9 manual (Note: not all codes require a fourth or fifth digit). The highest degree of specificity, or detail, can be determined by using the Tabular List (Volume One) of the ICD-9 coding manual in addition to the Alphabetic List (Volume Two) when locating and designating diagnosis codes. The Tabular List gives additional information such as exclusions and subdivisions of codes not found elsewhere in the manual. Any three-digit code that has subdivisions must be billed with the appropriate subdivision code(s) and be carried out to the fifth digit, if appropriate. Ancillary providers (e.g., Labs, Radiologists, etc.) and those physicians interpreting diagnostic testing may use V72.6 for Laboratory Exam, V72.5 for Radiological Exam, NEC, and V72.85 for Other Specified Exam as the principal diagnosis on the claim. Please consult your ICD-9 manual for further instruction. Failure to code diagnoses to the appropriate level of specificity will result in denial of the claim and a consequent delay in payment.

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

Claims Mailing Instructions

Submit claims to Magnolia at the following address:

First Time Claims, Corrected Claims and Requests for Reconsiderations:

Magnolia Health Plan, Inc.
Claim Processing Department
P. O. Box 3090
Farmington, MO 63640-3825

Claim Disputes must be submitted to:

Magnolia Health Plan, Inc.
Attn: Claim Disputes
P. O. Box 3000
Farmington, MO 63640-3800

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

Claim Form Instructions

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

Although Magnolia encourages all providers to submit claims electronically, claims and disputes can also be submitted by mail.

Companion guides to billing are available at www.MagnoliaHealthPlan.com.

Notes:

Rejections Vs. Denials

All paper claims sent to the Claims Office must first pass specific minimum edits prior to acceptance. Claim records that do not pass these minimum edits are invalid and will be rejected or denied.

A REJECTION is defined as an unclean claim that contains invalid or missing data elements required for acceptance of the claim into the claim processing system. These data elements are identified in the Companion Guide located on the website at www.MagnoliaHealthPlan.com. A list of common upfront rejections can be found listed below and a more comprehensive list with explanations can be located in Appendix 1.

If all minimum edits pass and the claim is accepted, it will then be entered into the system for processing. **A DENIAL is defined as a claim that has passed minimum edits and is entered into the system, but has been billed with invalid or inappropriate information causing the claim to deny.** An EOP (Explanation of Payment) will be sent that includes the denial reason. A list of common delays and denials can be found listed below and a more comprehensive list with explanations can be located in Appendix 2.

Common Causes of Upfront Rejections

- Unreadable Information — Information within the claim form cannot be read. The ink is faded, too light, or too bold (bleeding into other characters or beyond the box), the font is too small, or hand written information is not legible.
- Member DOB (date of birth) is missing.
- Member Name or identification (ID) number is missing.
- Provider Name, Taxpayer Identification Number (TIN), or National Practitioner Identification (NPI) number is missing.
- DOS — The DOS (date of service) on the claim is not prior to receipt of claim (future date of service).
- DATES — A date or dates are missing from required fields. Example: “Statement From” UB-04 & “Service From” CMS 1500 (8/05); “To Date” before “From Date”.
- TOB — Invalid TOB (Type of Bill) entered.
- Diagnosis Code is missing, invalid, or incomplete.
- Service Line Detail — No service line detail submitted.
- DOS (date of service) entered is prior to the member’s effective date.
- Admission Type is missing (Inpatient Facility Claims — UB-04, field 14)
- Patient Status is missing (Inpatient Facility Claims — UB-04, field 17).
- Occurrence Code/Date is missing or invalid.
- RE Code (revenue code) is missing or invalid.
- CPT/Procedure Code is missing or invalid.
- Incorrect Form Type — The form is not a form accepted by Magnolia or not allowed for the provider type.

Common Causes of Claim Processing Delays and Denials

- Wrong Form Type — The paper claim form submitted is not on a “Red” dropout OCR form.
- Diagnosis Code is missing the 4th or 5th digit.
- Procedure or Modifier Codes entered are invalid or missing.
- DRG code is missing or invalid.
- EOB (Explanation of Benefits) from the Primary insurer is missing or incomplete.
- Member ID is invalid.
- Place of Service Code is invalid.
- Provider TIN and NPI do not match.
- Revenue Code is invalid.
- Dates of Service span do not match the listed Days/Units.
- Physician Signature is missing.
- Tax Identification Number (TIN) is invalid.
- Third Party Liability (TPL) information is missing or incomplete.

Important Steps to a Successful Submission of Paper Claims

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

Resubmitted Claims

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

Paper claims submitted for review or reconsideration, must be clearly and boldly marked with “RE-SUBMISSION and/or CORRECTED CLAIM”, and must include the original claim number, or a copy of the EOP. Failure to do this could allow a claim to deny as a duplicate or deny for non-timely filing.

Notes:

Member DOB missing from the claim.

Appendix I: Common Rejections for Paper Claims

- Member Name or ID Number missing or invalid from the claim.
- Provider Name, TIN, or NPI Number missing from claim.
- Claim data is unreadable due to either too light (insufficient toner), dot-matrix printers, or too small font to allow for clear electronic imaging of claim.
- Diagnosis Code missing or invalid.
- REV Code missing or invalid.
- CPT/Procedure Code missing or invalid.
- Dates missing from required fields. Example: “Statement From” UB-04 & “Service From” 1500 (8/05). “To Date” before “From Date.”
- DOS on claim is not prior to receipt of claim (future date of services).
- DOS prior to effective date of Health Plan or prior to member eligibility date.
- Incorrect Form Type Used (approved form types are CMS 1500 (8/05, 02/12) for professional medical services or the UB-04 for all facility claims).
- Invalid TOB or invalid type of bill.
- No detail service line submitted.
- Admission Type missing (when Inpatient Facility Claim only).
- Patient Status missing (when Inpatient Facility Claim only).

Notes:

- Billed Charges Missing or Incomplete — A billed charge amount must be included for each service/procedure/supply on the claim form.
- Claims not submitted on "Red" dropout OCR forms — Claim forms submitted without red dropout may cause unnecessary delays to processing.
- Diagnosis Code Missing 4th or 5th Digit — Diagnosis should be billed to the highest intensity for proper coding and processing. Review the ICD-9-CM manual for coding to the 4th and 5th digit.
- DRG Codes Missing or Invalid — Hospitals contracted for payment based on DRG (Diagnosis Related Grouping) codes should include this information on the claim form for accurate payment. Invalid DRG codes will result in denial.
- Primary Insurers EOB (Explanation of Benefits) is Missing or Incomplete — Claims for Members who have OIC (other insurance carrier) must be billed along with a copy of the primary EOB from the OIC (either paid or denied). Include pages with run dates, coding explanations, and messages.
- Member ID Invalid — The member ID does not match Name or DOB submitted.
- Place of Service Code Invalid — A valid and appropriate two digit numeric code must be included on the claim form. Refer to CMS 1500 coding manuals for a complete list of place of service codes.
- Procedure or Modifier Codes Invalid or Missing — Coding from the most current coding manuals (CPT or HCPCS) is required in order to accurately complete processing. All applicable diagnosis, procedure, and modifier fields must be completed.
- Provider TIN and NPI Do Not Match — The submitted NPI does not match Provider's Tax ID number on file.
- Revenue Codes Missing or Invalid — Facility claims must include a valid three or four-digit numeric revenue code. Refer to UB-92 coding manual for a complete list of revenue codes.
- Date Span Billed does not match Days/Units Billed — spanned dates of service can only be billed for consecutive days along with matching number of days/units (i.e. Date Span of 01/01 to 01/03 and days/units = 3).
- Signature Missing — The signature of the provider of service, or an authorized representative must be present on the claim form.
- Tax Identification Number (TIN) Missing or Invalid — Provider's Tax ID number must be present and must match the service provider name and payment entity (vendor) on file with Magnolia.

Appendix III: EOP Denial Codes and Descriptions

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
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.
FQ	DENY: RESUBMIT CLAIM UNDER FQHC/RHC CLINIC MEDICAID NUMBER
GL	SERVICE COVERED UNDER GLOBAL FEE AGREEMENT
GM	DENY: RESUBMIT W/ MEDICAID# OF INDIVIDUAL SERVICING PROVIDER IN BOX 24K
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

Denial Code	Denial Description
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
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
Lo	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
MA	MEDICAID# MISSING OR NOT ON FILE, PLEASE CORRECT AND RESUBMIT
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
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

CMS-1500 (8/05) Form, Shaded Field 24A-G

The following types of supplemental information are accepted in a shaded claim line of the CMS 1500 (8/05) 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

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 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 11 digit NDC information. Do not enter a space between the qualifier and the 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 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

Appendix V: HIPAA Compliant EDI Rejection Codes

These codes are the standard national rejection codes for EDI submissions. All errors indicated for the code must be corrected before the claim is resubmitted.

Please see Magnolia's list of common EDI rejections to determine specific actions you may need to take to correct your claims submission.

Rejection Code	Rejection Description
01	Invalid Mbr DOB
02	Invalid Mbr
06	Invalid Prv
07	Invalid Mbr DOB & Prv
08	Invalid Mbr & Prv
09	Mbr not valid at DOS
10	Invalid Mbr DOB; Mbr not valid at DOS
12	Prv not valid at DOS
13	Invalid Mbr DOB; Prv not valid at DOS
14	Invalid Mbr; Prv not valid at DOS
15	Mbr not valid at DOS; Invalid Prv
16	Invalid Mbr DOB; Mbr not valid at DOS; Invalid Prv
17	Invalid Diag
18	Invalid Mbr DOB; Invalid Diag
19	Invalid Mbr; Invalid Diag
21	Mbr not valid at DOS; Prv not valid at DOS
22	Invalid Mbr DOB; Mbr not valid at DOS; Prv not valid at DOS
23	Invalid Prv; Invalid Diag
24	Invalid Mbr DOB; Invalid Prv; Invalid Diag
25	Invalid Mbr; Invalid Prv; Invalid Diag
26	Mbr not valid at DOS; Invalid Diag
27	Invalid Mbr DOB; Mbr not valid at DOS; Invalid Diag
29	Prv not valid at DOS; Invalid Diag
30	Invalid Mbr DOB; Prv not valid at DOS; Invalid Diag
31	Invalid Mbr; Prv not valid at DOS; Invalid Diag
32	Mbr not valid at DOS; Prv not valid; Invalid Diag
33	Invalid Mbr DOB; Mbr not valid at DOS; Invalid Prv; Invalid Diag
34	Invalid Proc
35	Invalid Mbr DOB; Invalid Proc
36	Invalid Mbr; Invalid Proc
38	Mbr not valid at DOS; Prv not valid at DOS; Invalid Diag
39	Invalid Mbr DOB; Mbr not valid at DOS; Prv not valid at DOS; Invalid Diag
40	Invalid Prv; Invalid Proc
41	Invalid Mbr DOB, Invalid Prv; Invalid Proc
42	Invalid Mbr; Invalid Prv; Invalid Proc
43	Mbr not valid at DOS; Invalid Proc
44	Invalid Mbr DOB; Mbr not valid at DOS; Invalid Proc
46	Prv not valid at DOS; Invalid Proc
48	Invalid Mbr; Prv not valid at DOS; Invalid Proc
49	Mbr not valid at DOS; Invalid Prv; Invalid Proc
51	Invalid Diag; Invalid Proc
52	Invalid Mbr DOB; Invalid Diag; Invalid Proc
53	Invalid Mbr; Invalid Diag; Invalid Proc
55	Mbr not valid at DOS; Prv not valid at DOS; Invalid Proc
57	Invalid Prv; Invalid Diag; Invalid Proc
58	Invalid Mbr DOB; Invalid Prv; Invalid Diag; Invalid Proc
59	Invalid Mbr; Invalid Prv; Invalid Diag; Invalid Proc
60	Mbr not valid at DOS; Invalid Diag; Invalid Proc
61	Invalid Mbr DOB; Mbr not valid at DOS; Invalid Diag; Invalid Proc
63	Prv not valid at DOS; Invalid Diag; Invalid Proc
64	Invalid Mbr DOB; Prv not valid at DOS; Invalid Diag; Invalid Proc
65	Invalid Mbr; Prv not valid at DOS; Invalid Diag; Invalid Proc
66	Mbr not valid at DOS; Invalid Prv; Invalid Diag; Invalid Proc
67	Invalid Mbr DOB; Mbr not valid at DOS; Invalid Prv; Invalid Diag; Invalid Proc
72	Mbr not valid at DOS; Prv not valid at DOS; Invalid Diag; Invalid Proc
73	Invalid Mbr DOB; Mbr not valid at DOS; Prv not valid at DOS; Invalid Diag; Invalid Proc
74	Services performed prior to Contract Effective Date
75	Invalid units of service
76	Original Claim Number Required
81	Invalid units of service, Invalid Pvr
83	Invalid units of service, Invalid Pvr, Invalid Mbr

Appendix VI: Adopted Preventive Health Guidelines

Condition/ Disease	Guideline Title	Recognized Source	URL	Review Dates
Adult Preventive	Topic Index: A-Z. U.S. Preventive Services Task Force (Publication dates vary)	U.S. Preventive Services Task Force (USPSTF)	http://www.uspreventiveservicestaskforce.org/uspstopics.htm	2011
	American Cancer Society Guidelines for the Early Detection of Cancer (Last revised June 2011)	American Cancer Society (ACS)	http://www.cancer.org/docroot/PED/content/ped_2_3x_ACS_Cancer_Detection_Guidelines_36.asp	
Immuni-zations	General Recommendations on Immunization January 28, 2011 / 60(RR02);1-60	Advisory Committee on Immunization Practices (ACIP)	http://www.cdc.gov/mmwr/preview/mmwrhtml/rr6002a1.htm?s_cid=rr6002a1_w	2012
	Recommended Adult Immunization Schedule (2012)		http://www.cdc.gov/vaccines/recs/schedules/adult-schedule.htm	
	Recommended Schedule for Persons Age 0-6 And Recommended Schedule for 7-18 years old and "catch up schedule" (2012)		http://www.cdc.gov/vaccines/recs/schedules/child-schedule.htm#printable	
Lead Screening	Recommendations for blood lead screening of Medicaid-eligible children aged 1-5 years: an updated approach to targeting a group at high risk. (Aug 2009)	Centers for Disease Control; Centers for Medicare and Medicaid	http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5809a1.htm	2011
	Medicaid Early & Periodic Screening & Diagnostic Treatment Benefit 12/14/05		http://www.cms.hhs.gov/MedicaidEarlyPeriodicScrn/02_Benefits.asp#TopOfPage	
Pediatric Preventive	Recommendation for Preventive Pediatric Health Care	American Academy of Pediatrics (AAP)	http://brightfutures.aap.org/pdfs/AAP%20Bright%20Futures%20Periodicity%20Sched%20101107.pdf	2011
	Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT)	Mississippi State Department of Health	http://msdh.ms.gov/msdhsite/_static/41,0,164.html	
	Cool Kids Program – Health Checkups for Children Enrolled in Medicaid	Mississippi Division of Medicaid	http://www.medicaid.ms.gov/MaternalChildHealth.aspx	
Perinatal Care	Guidelines for Perinatal Care, Sixth Edition (Published October 2007)	American Academy of Pediatrics; The American College of Obstetricians and Gynecologists	Available online for ACOG members only. Hard Copy at Centene Corporate Office. http://www.acog.org/bookstore/Guidelines_for_Perinatal_CareP262.cfm	2012

Appendix VII: Adopted Clinical Practice Guidelines

Condition/ Disease	Guideline Title	Recognized Source	URL	Review Dates
ADHD	Diagnosis and Evaluation of the Child With Attention-Deficit/ Hyperactivity Disorder (Published May 2000)	American Academy of Pediatrics	http://aappolicy.aappublications.org/cgi/reprint/pediatrics;105/5/1158.pdf	2011
	Treatment of the School-Aged Child with Attention- Deficit/Hyperactivity Disorder (Published October 2001)		http://aappolicy.aappublications.org/cgi/reprint/pediatrics;108/4/1033.pdf	
Asthma	Expert Panel Report 3: Guidelines for the Diagnosis and Management of Asthma (Published July 2007)	U.S. Department of Health and Human Services; National Institute of Health; National Heart, Lung, and Blood Institute; National Asthma Education and Prevention Program; National Institutes of Health	http://www.nhlbi.nih.gov/guidelines/asthma/index.htm	2011
	New Approaches for Monitoring Asthma Control, Expanded Recommendations for Children		http://www.nih.gov/news/pr/aug2007/nhbli-29.htm	
Bipolar Disorder	Guideline Watch – Practice Guideline for the Treatment of Patients With Bipolar Disorder Second Edition (Nov 2005)	American Psychiatric Association	http://www.psychiatryonline.com/pracGuide/pracGuideTopic_8.aspx	2011
Diabetes	Standards of Medical Care in Diabetes (2011)	American Diabetes Association	http://care.diabetesjournals.org/content/34/Supplement_1/S11.full	2011
Major Depressive Disorder	Practice Guideline for the Treatment of Patients With Major Depressive Disorder. Third Edition. (Nov 2010)	American Psychiatric Association	http://www.psychiatryonline.com/pracGuide/pracGuideTopic_7.aspx	2011
Obesity	Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults — The Evidence Report (Published September 1998)	National Heart, Lung, and Blood Institute, in cooperation with the National Institute of Diabetes and Digestive and Kidney Diseases	http://www.nhlbi.nih.gov/guidelines/obesity/ob_gdlns.pdf	2010
Perinatal Care	Guidelines for Perinatal Care, Sixth Edition (Published October 2007)	American Academy of Pediatrics; The American College of Obstetricians and Gynecologists	Available online for ACOG members only. Hard Copy at Centene Corporate Office. http://www.acog.org/bookstore/Guidelines_for_Perinatal_CareP262.cfm	2011
Sickle Cell	The Management of Sickle Cell Disease, Fourth Edition (Revised June 2002)	National Institutes of Health; National Heart, Lung, and Blood Institute (NHLBI)	http://www.nhlbi.nih.gov/health/prof/blood/sickle/sc_mngt.pdf	2011

Appendix VIII: Submitting EPSDT Services

EPSDT (Early and Periodic Screening, Diagnosis, and Treatment) services are limited to beneficiaries under age 21.

Modifier EP is required to be billed in box 24d of CMS 1500 claim form

Procedure Codes for Screenings

Initial:	
99381	EP (under the age of 1)
99382	EP (1-4 years of age)
99383	EP (5-11 years of age)
99384	EP (12-17 years of age)
99385	EP (18-21 years of age)
Periodic:	
99391	EP (under the age of 1)
99392	EP (1-4 years of age)
99393	EP (5-11 years of age)
99394	EP (12-17 years of age)
99395	EP (18-21 years of age)
Hearing:	
92551	EP (3-21 years of age)
Vison:	
99173	EP (3-21 years of age)
Adolescent Counseling:	
99401	EP (9-21 years of age)

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

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

Appendix IX: Anesthesia Services

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

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

AA — Anesthesia service performed personally by Anesthesiologist

- AA modifier can only be billed by an Anesthesiologist
- Do not use for Medical direction of CRNA's

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

- GC can only be used by Anesthesiologist in a teaching facility

QX — CRNA Service: with medical direction by a physician

- QX must be used by both the CRNA and the Anesthesiologist
- Anesthesiologist may not bill for direction of more than four CRNA's at any one time

QZ — CRNA Service: without medical direction by a physician

- QZ can only be used by the CRNA

Mississippi Medicaid 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 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.

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

Appendix X: Nurse Practitioners and Physician Assistants

Notes:

111 E Capitol Street
Suite 500
Jackson, MS 39201