



magnolia health™

INPATIENT

Provider Education



Welcome to Magnolia Health!

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

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

Agenda Topics



- Provider Enrollment
- Credentialing Requirements
- MississippiCAN Eligibility
- Cultural Awareness
- Inpatient Regulatory Requirements
- Medical Management
 - Prior Authorization
 - Prior Authorization vs. Notification
 - Emergent Weekend/Holiday Admissions
 - Medical Necessity
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- Quality Coordinators
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Provider Enrollment



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

Required Items for Facility Credentialing



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

MississippiCAN Eligibility



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

Categories of Eligibility (COE):

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

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

Verify Eligibility



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

Log on to the Medicaid Envision website at: www.ms-medicaid.com/msenvision/

Log on to the secure provider portal at www.magnoliahealthplan.com

Call our automated member eligibility interactive voice response (IVR) system at 1-866-912-6285

Call Magnolia Provider Services at 1-866-912-6285

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

Cultural Awareness and Sensitivity



Providers must ensure that:

- Members understand that they have access to medical interpreters, signers, and TDD/TTY services to facilitate communication without cost to them.
- Medical care is provided without consideration to the member's race/ethnicity or language and its impact/influence of the member's health or illness.

Inpatient Regulatory Requirements



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

State Plan Amendments (SPAs)

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

Administrative Code

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

Medical Management



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

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

Magnolia Health Plan Utilization Management

1-866-912-6285

Fax 1-855-684-6746

www.magnoliahealthplan.com

Prior Authorization



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

- All out of network services require prior authorization except basic laboratory chemistries and basic radiology.
- Authorization must be obtained prior to the delivery of services listed on Magnolia's Prior Authorization List, which can be found at <http://www.magnoliahealthplan.com/for-providers/provider-resources/>. Failure to obtain authorization may result in an administrative claim denial.
- All hospital inpatient stays require notification via an authorization request within **one (1) business day** of the admission. *(Please see specific requirements for OB/Newborn care which differ slightly for normal uncomplicated care.)*
- Please initiate the Authorization process at least **five (5) calendar days** in advance for non-emergent outpatient services. Initiate Authorization for pre-scheduled hospital inpatient services at least **14 calendar days** in advance and no later than **five (5) calendar days** in advance.
- The Provider should contact the UM department via telephone, fax, mail, secure email or through our website with the appropriate clinical information to request an authorization.
- Expedited requests can be requested from the UM department as needed.
- Prior Authorization is NOT required for emergent or urgent care services. *(If these services result in admission Magnolia must be notified within **one (1) business day** of admission.)*
- Prior Authorization is NOT required for post-stabilization services. Once the member's emergency medical condition is stabilized, certification for hospital admission or authorization for follow-up care is required as stated above.

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

Prior Authorization (cont.)



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

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

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

Prior Authorization list is located at:

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

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

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

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

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

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

Prior Authorization vs. Notification

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

Prior Authorization vs. Notification (cont.)

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

Emergent and Weekend and Holiday Admissions



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

Prior Authorization (cont.)



- For hospital inpatient services, if authorization for level of care cannot be determined at first level review by the UM nurse, the care will be reviewed by a Mississippi licensed Medical Director. The attending physician may request a peer-to-peer discussion with said Medical Director.
- Magnolia will make standard pre-service authorization decisions and provide notice within **three (3) calendar days** and/or **two (2) business days** following the receipt of the request for services. Magnolia will make determination for urgent concurrent, expedited continued stay, and/or post-stabilization review within **twenty-four (24) hours** of receipt of the request for services.
- If all necessary clinical information has been received from the provider and Magnolia is still unable to make a determination within these timeframes, it may be extended up to **fourteen (14) additional calendar days** upon the request of the member or provider, or if Magnolia and the Division of Medicaid determine that the extension is in the member's best interest.

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

Review Criteria



- Magnolia has adopted utilization review criteria developed by McKesson InterQual® products to determine DOM approved medical necessity for healthcare services.
- Magnolia's Medical Director reviews all potential medical necessity denials and will make a decision in accordance with currently accepted medical or healthcare practices, taking into account special circumstances of each case that may require deviation from the norm in screening criteria. Denial notification will include the reason(s) for denial per section 17.A. of the contract.
- Providers may obtain the criteria used to make specific determinations by contacting the Medical Management department at 1-866-912-6285.

Review Criteria (cont.)



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

Magnolia Health Clinical Appeals Coordinator

111 East Capitol Street, Suite 500

Jackson, MS 39201

1-866-912-6285

Fax: 1-877-851-3995

Observation Guidelines



- In the event that a member's clinical symptoms do not meet the criteria for an inpatient admission, but the physician believes that allowing the patient to leave the facility would likely put the member at serious risk, the member may be admitted to the facility for an observation period.
- An observation stay may last up to a maximum of **twenty-three (23) hours**. (Stays less than 8 hours of observation or greater than 23 hours are not allowed.)
- Providers are required to notify Magnolia's Medical Management department of an observation stay by the **next business day** after discharge.
- A medical necessity determination will be made within **three (3) calendar days/two (2) business days** of receiving all required information.

Concurrent Review



- Magnolia's Medical Management department will concurrently review the treatment and status of all members who are inpatient through contact with the hospital's Utilization and Discharge Planning departments and when necessary, the member's attending physician. The individual identified on the Prior Authorization form will be considered the appropriate point-of-contact for all discharge planning.
- An inpatient stay will be reviewed as indicated by the member's diagnosis and response to treatment.
- The review will include evaluation of the member's current status, proposed plan of care, discharge plans, and any subsequent diagnostic testing or procedures.

Care Management



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



Accessing Care Management



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

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

Clinical Protocols



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

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

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

APR-DRG



- Magnolia uses an APR-DRG payment methodology to reimburse inpatient hospital services. Magnolia's goal is to promote access to care, reward efficiency, enable clarity, and minimize administrative burden for our self and our hospital partners.
- APR-DRGs classify each case based on information contained on the inpatient claim including diagnosis, procedures performed, patient age, patient sex, and discharge status. The APR-DRG payment is determined by multiplying the APR-DRG relative weight by the APR-DRG base rate.
- Every inpatient stay is assigned a single DRG that reflects the typical resource use of that case.
- Magnolia's DRG calculator is based off of the same parameters including base rates, outlier methods and groupers currently used by Mississippi Division of Medicaid (DOM).



Claims Filing



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

File online at
www.magnoliahealthplan.com

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

Electronic Clearinghouse



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



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

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

Prepayment Claims Review



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

Rejections and Denials



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

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

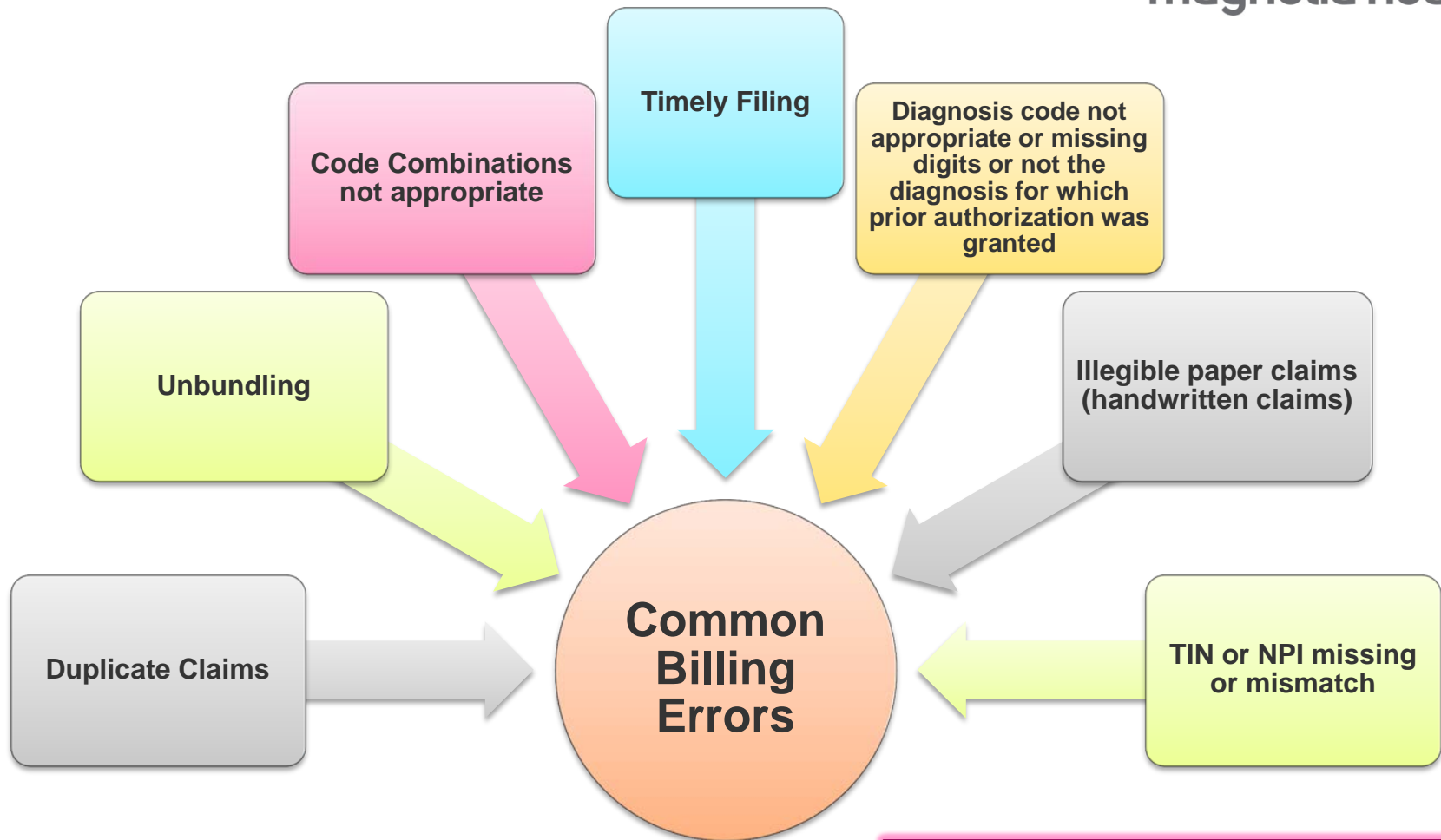
Retrospective Reviews



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



Common Billing Errors



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



Corrected Claim, Reconsideration, Claim Dispute



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

Corrected Claims	Reconsideration	Claim Dispute
<ul style="list-style-type: none"> •Submit via Secure Web Portal •Submit via an EDI Clearinghouse •Submit via paper claim: <ul style="list-style-type: none"> •Magnolia Health Plan MSCAN •PO BOX 3090 •Farmington, MO 63640 •(Include original EOP) 	<ul style="list-style-type: none"> •Written communication (i.e. letter) outlining disagreement of claim determination •Indicate “Reconsideration of (original claim number)” •Submit reconsideration to: <ul style="list-style-type: none"> •Magnolia Health Plan MSCAN •Attn: Reconsideration •PO BOX 3090 •Farmington, MO 63640 	<ul style="list-style-type: none"> •ONLY used when disputing determination of Reconsideration request •Must complete Claim Dispute form located on www.magnoliahealthplan.com •Include original request for reconsideration letter and the Plan response •Send Claim Dispute form and supporting documentation to: <ul style="list-style-type: none"> •Magnolia Health Plan MSCAN •Attn: Claim Dispute •PO BOX 3000 •Farmington, MO 63640

Must be submitted within ninety (90) days of adjudication

Waste, Abuse, and Fraud (WAF) System



Magnolia takes the detection, investigation, and prosecution of fraud and abuse very seriously. Our WAF program complies with MS and Federal laws, and in conjunction with Centene, we successfully operate a WAF unit. Centene's Special Investigation Unit (SIU) performs back end audits which may result in taking appropriate action against those who commit waste, abuse, and/or fraud either individually or as a practice. These actions may include but are not limited to:

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

Some of the most common WAF submissions seen are:

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

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



Complaints/Grievances



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

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

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

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

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

Magnolia Health Website



www.magnoliahealthplan.com/for-providers

Submit:

- Claims
- Provider Complaints
- Demographic Updates

Verify:

- Eligibility
- Claim Status

View:

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

The screenshot shows the Magnolia Health website for providers. The header includes the Magnolia Health logo, navigation links (Login, Find a Provider, For Members, For Providers, CHIP), and utility links (Contact Us, Newsroom, Events, Careers, Search). The main content area features a 'For Providers' section with a grid of links: Login, Become a Provider, ICD-10 Overview, Practice Improvement Resource Center (PIRC), Pre-Auth Needed?, Eligibility Verification, Important Notifications, PaySpan-EFT/ERA (Payformance), and Provider Training. A large image of a doctor is on the right. Below the grid, there are three news items: 'Summit Award for Excellence in Care', 'Magnolia Health Member Testimonial', and 'Provider Workshops'. A 'More News' button is at the bottom right. The footer contains 'Our Company', 'Quick Links', and 'Follow Us!' with social media icons.

Practice Improvement Resource Center (PIRC)



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

PIRC includes these Forms and Guides:

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

Practice Improvement Resource Center (PIRC)

<ul style="list-style-type: none"> Advanced Imaging ATTENTION: OB Providers Become a Provider Claims Clinical and Preventive Guidelines Division of Medicaid Electronic Transactions Eligibility Verification Family Planning <li style="border: 1px dashed gray; padding: 2px;">Find My Provider Representative ICD-10 Overview Important Notifications PaySpan-EFT/ERA (Payformance) Pharmacy <li style="background-color: #e0e0e0;">Practice Improvement Resource Center (PIRC) Newsletters Pre-Auth Needed? Provider Training Quality Improvement Program RSV/Synagis Secure Web Portal Welcome Providers 	<p>Contracting</p> <ul style="list-style-type: none"> • Contract Request Form (PDF) <p>Credentialing Material</p> <ul style="list-style-type: none"> • Provider and Practitioner Credentialing Rights (PDF) • Practitioner Credentialing Application 2014 (PDF) • Magnolia Location Form (PDF) • Provider Update Form for Contracted Providers (PDF) • MID Form (PDF) • W-9 Form (PDF) • Ownership and Controls Disclosure Form (PDF) • CAQH Brochure (PDF) <p>Forms & Applications</p> <ul style="list-style-type: none"> • New Prior Authorization Forms (PDF) • Outpatient Prior Authorization Form (PDF) • Outpatient Prior Authorization Training Document Form (PDF) • Prior Authorization Smart Sheet How To (PDF) • Provider Notification of Pregnancy Form (PDF) • Prenatal Vitamin Form (PDF) • Connections Referral Form (PDF) • Claim Dispute Form (PDF) • Hospice Physician Form (PDF) • Provider Complaint-Grievance Form 2014 (PDF) • DOM Hysterectomy Acknowledgement Form PDF (PDF) • Application for MS Family Planning Services (PDF) • Provider CM DM Referral Form (PDF) • Foster Care Health Information Form (PDF) • Discharge Consultation Documentation Form (PDF) <p>Manuals & Reference Guides</p> <ul style="list-style-type: none"> • Provider Manual (PDF) • Prior Authorization List (PDF) • Provider Reference Card (PDF) • PaySpan (PDF) • HEDIS Quick Reference Guide Adult (PDF) • HEDIS Quick Reference Guide Pediatric (PDF) • HEDIS Quick Reference Guide Women (PDF) • Quick Reference Guide for EPSDT Codes (PDF) • DOM Provider Manual Regarding Hysterectomy (PDF) • DOM Provider Manual Regarding Sterilizations (PDF) • 2013 QI Program Description (PDF) • Annual Quality Improvement (PDF) • Taxonomy Code Billing Requirement (PDF) • Access and Availability Standard Guidelines (PDF) • After Hours Telephone Access Standards 2014 (PDF) • CMS FQHC-RHC Billing Guide 2014 (PDF) • Reimbursement for Vaccine Administration 2014 (PDF) • CMS 1500 Claim Form Instructions 2014 (PDF) • Place of Service Codes 2014 (PDF) • Obstetrical Care Billing Tips 2014 (PDF) • Maximum Units of Service 2014 (PDF) • Modifier 25 – 2014 (PDF) 	<p>Phone Numbers</p> <p>(888) 912-6285 Fax: (888) 480-3227 8 a.m. – 5 p.m. (CST) Monday – Friday</p> <p>Resources</p> <p>Contracting Credentialing Material Forms & Applications Manuals & Reference Guides Pharmacy Pre-Authorization Needed?</p> <p>You will need Adobe Reader to open PDFs on this site.</p> <div style="border: 1px solid black; padding: 2px; text-align: center;"> Get ADOBE READER </div> <p style="font-size: x-small;">Download the free version of Reader</p>
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Magnolia Secure Web Portal



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

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

BENEFITS INCLUDE:

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

Start Your Registration

Tax ID ?

First Name

Last Name

Email ?

Re-enter Email

Password ?

Retype Password

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Behavioral Health



- Cenpatico is the behavioral health vendor for [Magnolia Health](#). Cenpatico is a wholly-owned subsidiary of Centene Corporation, which has been nationally recognized for innovative service programs and contemporary approach in handling the needs of the diverse populations in the markets proudly served.
- To partner with Cenpatico or for more information, please call 866-324-3632 or visit www.cenpatico.com .
- Prior Authorizations for Behavioral Health can be faxed to 1-866-694-3649
- Claim submissions for Behavioral Health can be mailed to:
Cenpatico – PO BOX 7600 – Farmington, MO 63640-3834



CONTACTS:

Network Manager: Angela Stewart | anstewart@cenpatico.com | (601) 863-0738

Provider Relations Specialist: Nakisha Montgomery | nmontgomery@cenpatico.com | (601) 863-0745

PaySpan Health

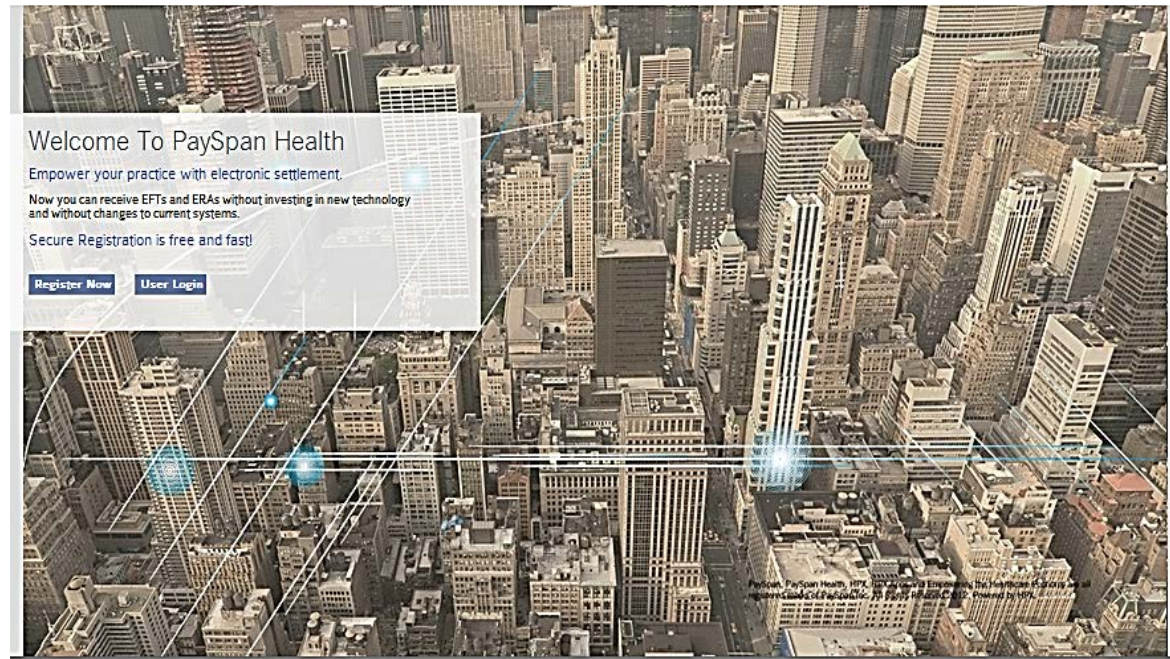


Magnolia has partnered with PaySpan Health to offer expanded claim payment services:

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



EMPOWERING THE HEALTHCARE ECONOMY™



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



Provider Services (Call Center)

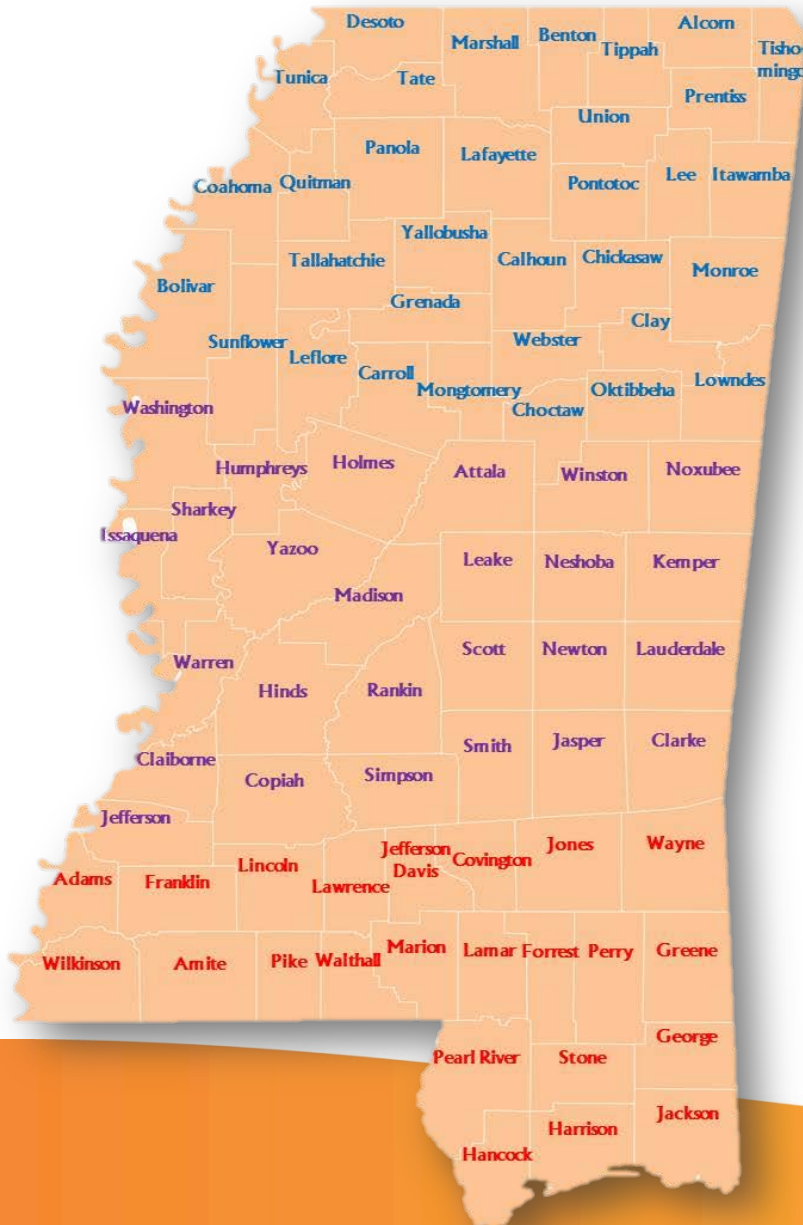


Mississippi Based Provider Services Call Center:

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



Provider Relation Contacts



NORTH TERRITORY – ASHLEY ARMSTRONG

662-372-0209

AARMSTRONG@CENTENE.COM

CENTRAL TERRITORY – ANGEL SHIVERS

601-862-5439

ASHIVERS@CENTENE.COM

**SOUTH TERRITORY – POSITION OPEN /
SEARCH IN PROCESS**

***SUPERVISOR, PROVIDER RELATIONS –
JENNIFER HOBOCK**

601-863-0699

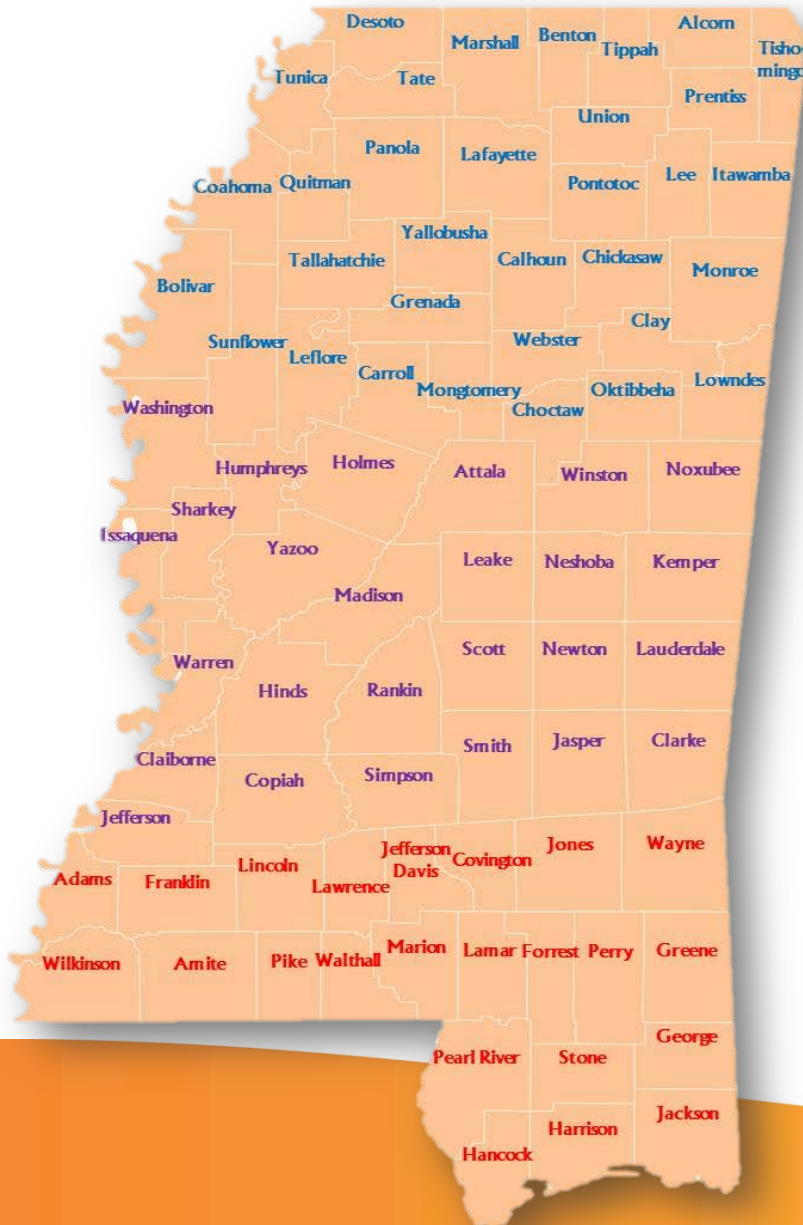
JHOBOCK@CENTENE.COM



Provider Relations



Quality Coordinators



NORTH TERRITORY – DIANN SWANN

601-966-5198

DSWANN@CENTENE.COM

CENTRAL TERRITORY – EMILY NOBILE

601-331-6848

ENOBILE@CENTENE.COM

SOUTH TERRITORY – MELINDA HINTON

601-317-8119

MHINTON@CENTENE.COM

***DIRECTOR, QUALITY IMPROVEMENT –
CARRIE MITCHELL**

601-862-2604

CARMITCHELL@CENTENE.COM

Thank you!





Inpatient Provider Information

Maternity/Newborn/NICU

Newborn PA Requirements



Magnolia Health Plan requires maternal information to acknowledge maternity admission. The Division of Medicaid Newborn Enrollment Form includes all of the necessary information for routine deliveries and well-baby care (standard 3 day stay for vaginal deliveries, 5 day stay for C sections). The Newborn Enrollment Form must be fully completed and submitted to the Division of Medicaid within 5 days of delivery. If the Newborn Enrollment Form is completed and submitted timely, Magnolia Health Plan does not require any additional information for mother or newborn, unless complications develop during the stay. If complications develop with mother or baby that may necessitate additional hospital days or a non well-baby or NICU admission, a prior authorization should be submitted along with clinical information to support the stay within one business day of the decision that the higher level of care is needed.

Maternity Observation Stays



- Magnolia follows the APC Methodology and Observation stays are recognized as 8-23 hours. The APC rule states that if a patient is admitted for less than 8 hours the stay should be billed for diagnostic services using the appropriate revenue codes and procedure codes. If the stay is greater than 8 hours and up to 23 hours the stay can be processed and billed as Observation and a request for authorization should be submitted.
- Imaging studies that are ordered during an Observation stay do NOT require Prior Authorization.
- If the Observation stay results in an inpatient admission and delivery, then the overall service type should be changed to c-section or vaginal delivery.

Magnolia NICU PA and Concurrent Review Process



- Provider submits PA form and all supporting clinical documentation within 1 business day of admission.
- If all necessary supporting clinical documentation is submitted and the nurse can make a determination, notification will be sent to the provider within 1 business day of receipt of PA.
- Magnolia requires clinical information every 5 days; however this may vary on a case by case basis

Thank you!

