

# MS Medicaid PROVIDER BULLETIN



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*Executive Director  
MS Division of Medicaid*

## Alliant to Replace eQHealth as Medicaid's UM/QIO Vendor

Earlier this year, the Mississippi Division of Medicaid (DOM) named a new Utilization Management and Quality Improvement Organization (UM/QIO) vendor, capping a long re-procurement process for a very important contract. Most providers in Mississippi

will be familiar with the current UM/QIO contractor, eQHealth, which has served the state for a number of years. Alliant Health Solutions was awarded the new contract and kicked off the lengthy implementation process on Feb. 5. We expect Alliant to begin processing prior authorization (PA) requests from providers on Aug. 1, 2019, and the implementation will be complete by Sept. 1, 2019.

To go into a little more detail, all prior authorization reviews in process before Aug. 1 will be completed by eQHealth Solutions as part of the transition to Alliant. Therefore, any requests submitted on or before July 31 that are pended for additional information will be handled by eQHealth Solutions, and providers will submit related inquiries and requested information/documentation to eQHealth Solutions during the month of August. This UM/QIO transition applies to all prior authorization services currently reviewed by eQHealth

Solutions, except advanced imaging services, which will continue to be handled by eQHealth Solutions. Prior authorizations for beneficiaries enrolled in MississippiCAN will continue to be handled by the respective coordinated care organizations.

But exactly what is a UM/QIO, and why is it important? DOM is required to have a system in place to safeguard against unnecessary utilization of care and services. That means we must have experts continuously monitor and analyze the services we pay for to ensure every taxpayer dollar is spent responsibly and in ways that produce the greatest value. The most obvious function of the UM/QIO is to review and process prior authorizations (PAs) for fee-for-service (FFS) Medicaid. But the vendor also looks for ways to improve the quality of care by examining utilization trends.

Certainly, the transition from eQHealth Solutions to Alliant will require an adjustment for both DOM and the provider community. However, the new UM/QIO comes with additional resources that have the potential to enhance our program integrity efforts, data analysis and reporting, and even some case management initiatives. It is important for providers to be aware that they will soon be working with Alliant and to be on the lookout for any communications or correspondence from the

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company. Both DOM and Alliant will provide more information and updates as they become available. Additionally, instructions and educational materials will be developed and shared through a variety of communications avenues to ensure no provider lacks access to the necessary resources.

Successfully implementing this contract will require a great deal of effort and coordination between DOM, Alliant and all other stakeholders, but once in place the agency will be positioned to deliver even greater value to the beneficiaries we serve.

If you have any questions about this upcoming transition, please contact please contact the Office of Medical Services at 601-359-6150.



## WEB PORTAL REMINDER

For easy access to up-to-date information, providers are encouraged to use the **Mississippi Envision Web Portal**. The Web Portal is the electronic approach to rapid, efficient information exchange with providers including eligibility verification, claim submission, electronic report retrieval, and the latest updates to provider information. The **Mississippi Envision Web Portal** is available 24 hours a day, 7 days a week, 365 days a year via the Internet at [www.ms-medicaid.com](http://www.ms-medicaid.com).

# PHARMACY NEWS

## Voluntary 90-Day Drug Maintenance List Update for Providers

Effective April 1, 2019, the Mississippi Division of Medicaid (DOM) updated its Voluntary 90-Day Drug Maintenance List for prescribing/pharmacy providers. The Voluntary 90-Day Drug Maintenance List is a resource giving providers the option of prescribing and dispensing certain widely-used drugs for common disease states in 90-day supplies in order to schedule the refilling of those drugs on different months. This helps clinicians manage a Medicaid beneficiary's monthly prescription drug limit, unless clinically contraindicated.

Last updated in 2012, DOM carefully updated the list in consultation with physicians and pharmacists, as well as members of the Pharmacy and Therapeutics Committee. With new drug therapies introduced to the market every year, the new list includes a significant number of new drugs used to treat chronic conditions. In addition, two major classes of drugs have been added: cystic fibrosis agents and the antiretroviral drugs used to treat human immunodeficiency virus (HIV).

This list is available in two formats, one arranged alphabetically, and one arranged by disease state, and is located on the DOM website at <https://medicaid.ms.gov/providers/pharmacy/pharmacy-resources/>.

## Prescription Drug Limit Increase to Take Effect July 1, 2019

Effective July 1, 2019, the Mississippi Division of Medicaid (DOM) will cover more prescription drugs per month for Medicaid beneficiaries. DOM will increase the monthly prescription drug limit from five (5) to six (6) prescriptions.

The two (2) brand monthly prescription limit remains unchanged. Preferred brand drugs listed on the Universal Preferred Drug List do not count toward this two (2) brand monthly limit.

## CDC Guidelines for Prescribing Opioids for Chronic Pain: Drug Utilization Review (DUR) Board Recommendations – UPDATE

Implementation of the Centers for Disease Control and Prevention (CDC) Guidelines for Prescribing Opioids for Chronic Pain: DUR Board Recommendations, referenced in the March 2019 MS Medicaid Provider Bulletin, has been changed from June 1, 2019 to August 1, 2019.

These initiatives will be applicable for both fee-for-service and the Mississippi Coordinated Access Network (MSCAN) program.

Details of these opioid initiatives will be posted on the Division of Medicaid (DOM) website. In addition, DOM will also share important provider notices, as needed, to all professional medical and pharmacy associations for dissemination to their membership.



# PROVIDER COMPLIANCE

## Attention: Nursing Facilities

Effective June 1, 2019, pursuant to its authority under Attachment 4.19-D to the State Plan, Sections 1-7, Subsection B, paragraphs 17 and 18, the Division of Medicaid will assess and impose a sanction against any nursing facility that submits untimely, inaccurate or false information related to resident assessments in order to increase reimbursement above what is allowed under the State Plan. You may read more about this policy on our website at the following link: <https://medicaid.ms.gov/wp-content/uploads/2019/05/Case-Mix-Sanction-Policy-for-Inaccurate-Assessments.pdf>. Any questions regarding this policy may be directed to the Office of Program Integrity at 601-576-4162.

## Attention Family Planning Waiver Providers

Effective April 1, 2019, the Division of Medicaid (DOM) no longer reimburses for CPT code 99211 (Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care profession). Usually the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services under the Family Planning Waiver (FPW). All FPW visits should include, at a minimal, an evaluation of the participant's contraceptive program, renewal or change of the contraceptive prescription or supplies, and counseling and education.

FPW participants are allowed four (4) visits a year for family planning and family planning related services, which includes one (1) annual/initial visit and three (3) subsequent visits. Participants cannot exceed a total of four (4) visits per calendar year (Jan. 1 – Dec. 31). FPW initial/annual visits must be billed with the appropriate preventive medicine code (99384, 99385, 99386, 99394, 99395, or 99396) and follow-up visits must be billed with the appropriate evaluation and management code (99201-99205 or 99213-99215).

If you have any questions, please contact the Office of Medical Services at (601) 359-6150.

## Attention: Elderly & Disabled Waiver Personal Care and In-Home Respite Providers

As a reminder, all Elderly and Disabled (E&D) Waiver providers must establish an office in the state of Mississippi with a physical address prior to enrollment and maintain the office's physical address until the provider agreement is terminated, in accordance with Title 23, Part 208, Chapter 1, Rule 1.3(B)(5) of the Mississippi Administrative Code. Additionally, Part 208, Chapter 1, Rule 1.3 identifies specific requirements of Personal Care Service providers in subpart (D)(3) and In-Home Respite providers in subpart (D)(4). These regulations require providers to comply with the provider type specific Quality Assurance Standards, which outline the specifications for physical offices as follows:

The physical office must be/have:

- Located in Mississippi,
- Accessible to participants, caregivers, and employees,
- No more than sixty (60) minutes from counties served or a satellite office will be required,
- Located in a non-residential building zoned for business (provider holds a current business-privilege license from the city/county),
- Maintained until the provider agreement is terminated,
- Signage matching the business name on the proposal,
- A working landline phone,
- Open daily, 8 a.m. – 5 p.m., Monday-Friday,
- Secure Health Insurance Portability and Accountability Act (HIPAA) compliant storage for participant records.

The referenced chapter of the Administrative Code is available for review at <https://medicaid.ms.gov/wp-content/uploads/2014/01/Admin-Code-Part-208.pdf>, and the provider type specific Quality Assurance Standards are available for review at <https://medicaid.ms.gov/long-term-care-waiver-providers/>.

## Attention: Home and Community Based Services (HCBS) Waiver Providers

In an effort to increase communication and education, the Division of Medicaid (DOM) has created a new page on our website for sharing information specific to HCBS Waiver providers. The page can be accessed at <https://medicaid.ms.gov/hcbs-waiver-providers/>, and will include information on provider enrollment for the Elderly & Disabled Waiver and the Assisted Living Waiver, as well as any new training reference materials or guidance issued to providers of waiver services.

Additionally, a new email address has been created for this provider type to allow for streamlined communication with providers. Provider questions or feedback can now be emailed to [HCBSProviders@medicaid.ms.gov](mailto:HCBSProviders@medicaid.ms.gov). Providers who have not previously received emails from DOM's Office of Long-Term Care are asked to please send an email to the above address to be added to the list serv to receive the most up to date communication.

## Hospital Inpatient APR-DRG Alert – July 1, 2019 Updates

The Mississippi Division of Medicaid (DOM) is proposing the following changes to the hospital inpatient APR-DRG payment methodology effective for the payment of hospital inpatient claims for discharges on and after July 1, 2019:

- The following APR-DRG parameters will be updated:
- Base Payment – will change from \$6,585 to \$6,731
  - Neonate policy adjustor – will change from 1.40 to 1.25
  - Pediatric mental health policy adjustor – will change from 2.00 to 1.85
  - Adult mental health policy adjustor – will change from 1.60 to 1.50
  - DRG Cost Outlier Threshold – will change from \$45,000 to \$48,500
  - DRG Day Outlier per diem – will change from \$450 to \$675

DOM estimates the overall impact of the above changes will be a savings of \$26,282 in state and federal funds.

Due to significant changes in the clinical logic and relative weights from version 35 to version 36 of the 3M APR-DRG grouper, DOM will not update to version 36 on July 1, 2019. The changes to the logic and weights in version 36 would

have a substantial impact on hospital reimbursement; as a result DOM has decided to remain on version 35 of the APR-DRG grouper and weights for an extra year in order to study how best to adapt to the new logic and weights. DOM will begin educating hospitals on the potential impacts on reimbursement resulting from version 36 during the APR-DRG training sessions for the July 1, 2019 updates. Additional claims analysis will then be performed using the version 37 grouper when it becomes available, to determine changes in APR-DRG parameters that will be necessary for the July 1, 2020 APR-DRG updates.

Please keep in mind that hospitals are not required to purchase 3M software for payment of claims; however, all hospitals that have purchased the 3M software should ensure their internal systems are updated to reflect all changes that occur for hospital discharges beginning on and after July 1, 2019.

Training will be scheduled with dates to be provided. Hospitals will be notified via e-mail and the DOM website [www.medicicaid.ms.gov](http://www.medicicaid.ms.gov).

## American Indian Cost-Sharing Exemption

Pursuant to 42 C.F.R. § 447.56, American Indians are exempt from cost-sharing. Effective January 1, 2018, the Division of Medicaid will not reduce reimbursement to providers for cost-sharing for services rendered to American Indians. Providers are prohibited from collecting cost-sharing from an American Indian.

## Provisional Licensed Professional Counselor (P-LPC)

Pursuant to Administrative Code Part 206, Chapter 1, Rule 1.3.F. for Community Mental Health Centers (CMHC)/Private Mental Health Centers (PMHC), a provisionally certified licensed professional counselor (P-LPC) rendering appropriate services is recognized to provide services in a CMHC/PMHC. These providers must follow the same documentation guidelines as other provisionally licensed therapists.

Administrative Code, Part 206 is accessible at the following link: [https://medicaid.ms.gov/wp-content/uploads/2014/10/AdminCode-Part\\_206.pdf](https://medicaid.ms.gov/wp-content/uploads/2014/10/AdminCode-Part_206.pdf).

Should you have any questions about this information, contact the Office of Mental Health at 601-359-9545.

# COORDINATED CARE NEWS



## Support for Language Services

UnitedHealthcare Community Plan serves a diverse group of members who have a variety of cultural and language needs. UnitedHealthcare supports care providers in providing competent cultural and language services to its members in a variety of ways.

Here's what care providers need to know:

- Although the predominant language spoken by Mississippians is English, we have a significant Hispanic population.
- We provide language assistance to help you communicate with our members that includes a telephone language line, in-person interpreters and video services.
- We have tools to promote cultural awareness and assist care providers in recognizing and treating health disparities.
- Resources and tools are available at [UHCommunityPlan.com/health-professionals/MS/cultural-competency-library.html](http://UHCommunityPlan.com/health-professionals/MS/cultural-competency-library.html)
  - A Quick Reference Guide – Understanding Cultural Competency and the American with Disabilities Act
  - Cross Cultural Health Care Program
  - Cultural Orientation Resource Center

In addition to spoken languages, we also offer assistance for the hearing impaired.

## Shared Decision Making in Mental Health: Allowing Your Patient's Participation in the Treatment Planning Process Improves Outcomes

Recommended by the Institute of Medicine, shared decision making is an emerging best practice in health care and is consistent with empowerment, self-determination, and recovery.

By combining transparent information and decision-making tools with a respectful, two-way conversation between patients and providers, shared decision making helps balance information about mental health conditions and treatment options with an individual's preferences, goals, and cultural values and beliefs. During this process it is your role to gather as much information possible regarding the patient and about complex care, have an open discussion with your patient and include the patient in the treatment plan decision making process.

The US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration recommend four steps of shared decision making:

1. **Establish a partnership** - Individualized care decisions are made when patients have the right information and input from others. Providers can offer the information and support needed throughout the process.
2. **Exchange information** - Patients should be encouraged to discuss their experiences, history, preferences, values and cultural beliefs. Providers should be receptive to that information and describe treatment and service options in detail.
3. **Weigh the options** - Together, patients and providers evaluate the pros and cons of each option based on preferences, values, and cultural beliefs.
4. **Make a decision** - The process of decision making is shared, but the final decision rests with the person using the services. However, both patients and providers can review and revise the decision, if needed.

Engaging in the shared decision making process can result in numerous benefits such as better communication, more effective treatment, greater treatment adherence, and less missed appointments. Further, momentum is currently advancing toward including shared decision making in National Quality Initiatives (i.e. CAHPS® Surveys) which incentivizes providers to adopt shared decision making as a best practice.

#### References:

1. US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. Shared decision making: making recovery real in mental health.
2. Mental Health America. You're on the team: help for providers. <http://mentalhealthamerica.net/youre-team-help-providers>. Published 2017.
3. National Alliance on Mental Illness. Engagement: A New Standard for Mental Health

## Vision Problems Following a Head Injury

A bump on the head is a common occurrence. A fall on the ice, a person-to-person collision playing sports, or a minor fender bender may result in a direct blow to the head or a whiplash injury. Health care providers need to question the patient or family members about vision related symptoms after any head injury. These include: blurred vision, light sensitivity, double vision or problems with near related tasks such as reading, and/or using a cellphone or computer.

Any new vision symptoms following a head injury can signal a concussion or mild traumatic brain injury (mTBI). These vision symptoms can be delayed and may become chronic as part of Post-Concussion Syndrome.

Children are more vulnerable to these types of injuries because their necks are smaller and less resilient. Heading of a soccer ball by children, especially young girls, may create life-long visual symptoms. The brain houses the visual pathway as well as the nerves that control eye movement, eye tracking and coordination. Any violent shake, rattle or hard contact to the head can easily disrupt these connections and result in vision problems.

These problems should be managed early and treated with a comprehensive rehabilitation program that includes a rehab or neuro-optometrist. These providers work as part of a team and use lenses, prisms, filters and vision therapy to re-establish normal visual input. Early diagnosis and proper intervention can reduce and often eliminate vision symptoms and facilitate ongoing learning and development.

*Contributed by Scott A. Edmonds, O.D.  
March Vision, Chief Medical Officer*

## Human Papilloma Virus (HPV) Vaccines: Information for Your Patients

Mississippi has historically been one of the best performing states for vaccines. However, our state lags at the bottom of vaccine rates for HPV. Patients, parents, clinicians, and policy makers all struggle with improving these rates. The American Cancer Society has supplied a list of facts to dispel common misconceptions about the vaccine. The facts below come from "HPV VACs: Just the Facts for Providers" and we encourage you to share these with your patients.

**Fact 1:** HPV Vaccines are safe: HPV vaccine safety is monitored on a consistent basis and current studies continue to show that the HPV vaccine is very safe. Over 270 million doses have been distributed to date worldwide and over 100 million doses in the US. The most common side effects with HPV are mild and similar to what is seen with other diseases.

**Fact 2:** HPV Vaccine does NOT cause fertility issues. There is no data that suggests the vaccine negatively effects future fertility. In fact, receiving the vaccine and protecting against cervical cancer may improve a woman's ability to get pregnant and have healthy babies.

**Fact 3:** HPV does NOT contain harmful ingredients. People are exposed to aluminum daily through food and cooking utensils. Vaccines containing aluminum have been used for decades and have been given to more than 1 billion people without problems.

**Fact 4:** The HPV Vaccine is necessary regardless of sexual activity. Vaccination occurs well before they are exposed

to a vaccine. Similarly, vaccinating at 11 or 12 offers the most HPV cancer prevention. Studies show there is no correlation between the vaccine administration and increased rates of, or earlier engagement in, sexual activity.

**Fact 5:** HPV Vaccine is for boys and girls. The vaccine is strongly recommended for boys and girls. Both males and females can get HPV and scientists estimate that between 80-90% will be infected with at least one type in their lifetime.

**Fact 6:** HPV Vaccine is effective and helps prevent cancer. The vaccine has been proven to prevent infections that can cause multiple HPV cancers through numerous studies.

**Fact 7:** An effective recommendation from a clinician matters: American Cancer Society suggests offering Your child needs three vaccines today to protect against meningitis, HPV cancers, and pertussis.

**Fact 8:** The effectiveness of the HPV vaccine does not decrease over time. Studies indicate that protection lasts more than 10 years with no signs of the protection weakening.

<https://www.cancer.org/content/dam/cancer-org/online-documents/en/pdf/flyers/hpv-vacs-just-the-facts-for-providers.pdf>

<https://www.cdc.gov/hpv/infographics/vacc-coverage.jpg>

Tips on improving rates in rural areas can be found at: <https://www.cdc.gov/ruralhealth/vaccines/>

## Prior Authorization Update for Dental Procedures: What the PCP Needs to Know

Effective March 1, 2019, a new Prior Authorization (PA) process started for dental care services in an operating room or ambulatory surgery center (OR/ASC). This PA form complements the recent Mississippi Division of Medicaid's revision (eff. 12/1/2018) to the Administrative Code Title 23, Part 204, Rule 1.11: Dental Services Provided in the Hospital or Ambulatory Surgical Center (ASC) Setting, MS Code Ann 43-13-121.

Dentists have been informed of this but it is important that you know of the requirement for a medical evaluation prior to services being rendered in an ASC or OR. To substantiate the site of service need, which is usually accompanied by anesthesia, a physician letter or consultation document must validate the member has a condition that warrants a site of service other than the office setting. When the OR or ASC is requested, we are looking to see that a patient has a condition that necessitates a higher-level setting. These medically compromising conditions can be behavioral health-oriented, a physical disability, significant behavioral or cognitive impairment, complexity of dental conditions, or any other condition requiring a special accommodation.

Dentists can access additional information at:

Visit [UHCProvider.com](https://www.uhcprovider.com) >> [Policies and Protocols](#) >> [Additional Resources](#) >> [Dental Clinical Policies and Coverage Guidelines](#) >> [Dental Care Services in an Operating Room or Ambulatory Surgery Center–Dental Coverage Guideline](#)

*Contributed by Ted Wong, DDS  
UnitedHealthcare, Chief Dental Officer*

## Prior Authorization for Speech-Language Pathology Services

We now require prior authorization for Speech Therapy (CPT 92507). This was implemented to justify medical necessity for services being rendered to MississippiCAN and Mississippi CHIP members.

Evidence-based clinical criteria will be applied to all requests to help validate that services meet medical necessity guidelines. For MSCAN, the review criteria are based on standards established by the Mississippi Division of Medicaid and provided within Administrative Code Part 213 Therapy Services, Chapter 3 Outpatient Speech-Language Pathology (Speech Therapy). For MS CHIP, the review criteria are the UnitedHealthcare Policy for Speech Language Pathology Services Effective June 1, 2018.

When processing claims, we will validate that authorization was obtained. If the authorization is on file, the claim will be considered for reimbursement. If the authorization is not on file, the claim will be denied with an explanation that the service had not been reviewed and approved.

### What This Means for You

Rendering providers should seek prior authorization for CPT 92507. The process for obtaining prior authorization can be found at [UHCProvider.com >> Plan by State >> MS >> Prior Authorization & Notification Resources](#).

A temporary FAQ document is posted at [UHCProvider.com >> Plan by State >> MS >> Current News, Bulletins and Alerts >> Speech-Language Pathology Services Frequently Asked Questions...](#)

## Claim Edits Help Verify a Care Provider's Mississippi Medicaid Participation Status

This is reminder that starting Sept. 22, 2018, we made a change to how we process UnitedHealthcare MississippiCAN claims. We use additional claim edits to help ensure that the care providers who submit a claim are also enrolled with the Mississippi Division of Medicaid (DOM). This enrollment is required for participation in the Mississippi Medicaid program and MississippiCAN.

### What This Means for You

MississippiCAN requires that all care providers listed on a claim are enrolled with DOM and have a valid Medicaid ID. Our claims process will match the care provider National Provider Identifier (NPI) number and Medicaid ID used on a claim and the NPI number, Medicaid ID, and taxonomy code in the DOM enrollment database.

If the care provider enrollment information matches, we'll process the claim as usual.

If the care provider information doesn't match, we'll return the claim to the submitter electronically with a 277 claim status response. If a paper claim was submitted, we'll mail a letter to the submitter with the reasons for the claim return.

### If a Claim is Returned

When a claim is returned because the care provider information didn't match, you'll have the chance to resubmit the claim within 180 days of the date of service. Before resubmitting, the claim submitter should verify that the NPI numbers listed on a claim will match the Mississippi DOM enrollment information.

#### Verifying NPI Number and Mississippi DOM Enrollment Information

If the care provider doesn't have a valid Medicaid ID, instructions on how to enroll with DOM are at [medicaid.ms.gov/providers](#).

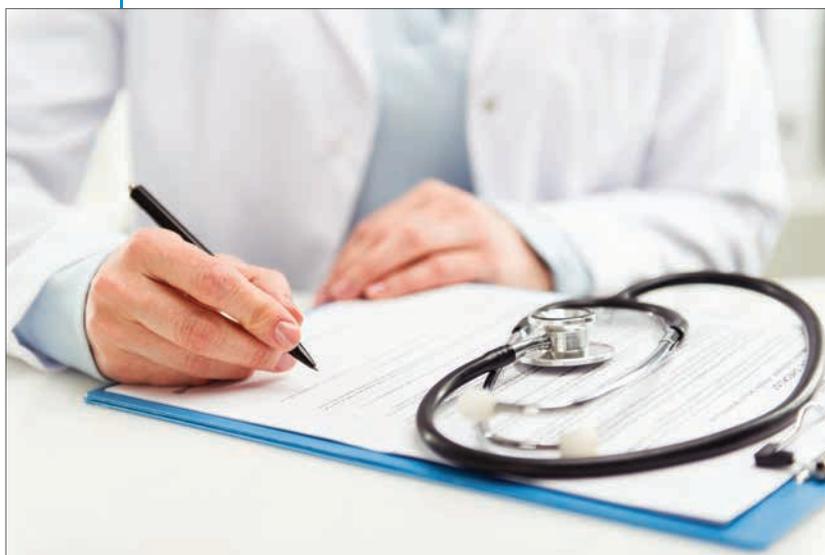
Care providers enrolled with DOM can verify their enrollment status and NPI number by logging into DOM's provider portal at [medicaid.ms.gov/providers](#).

Enrolled care providers can call DOM to verify the registered NPI number at 601-359-6050.

Additional information is temporarily available at [UHCProvider.com >> Plan by State >> MS >> Current News, Bulletins and Alerts >> New Claim Edits to Help Verify Medicaid Participation](#)

These articles and many others can be found in UnitedHealthcare's Bulletins and Newsletters section of the provider website found at:

<https://www.uhcprovider.com/en/health-plans-by-state/mississippi-health-plans/ms-comm-plan-home.html>





## Molina Healthcare Appeals Quick Reference for Providers

### Pre-Service Appeals

- For providers seeking to appeal a denied Prior Authorization (PA) on behalf of a member only, fax *Member Appeals* at **(844) 808-2407**.

### Post-Service Appeals

- For providers seeking to appeal a denied claim only, fax *Provider Claim Disputes/Appeals* at **(844) 808-2409**.

If a provider rendered services without getting an approved PA first, **providers must submit the claim and wait for a decision on the claim first** before submitting a dispute/appeal to Molina.

Molina Healthcare Member Resolution Team (MRT) and Provider Resolution Team (PRT) will continue working together to re-route any misdirected requests. However, participating providers sending disputes/appeal requests to the wrong department could delay response times.

## Molina Healthcare Primary Care Provider (PCP) Member Roster

As a PCP for Molina Healthcare of Mississippi, you have access to your Member Roster which is available on our secure provider portal. It is your responsibility to review your Member Roster frequently to identify new and current members. To register for the secure provider portal or to view your Member Roster, please follow the provided instructions below.

If you need additional assistance, please contact your Provider Services Representative.

### How to Register

- Go to <https://Provider.MolinaHealthcare.com>.
- Click on the "Register now" link under the Provider Web Portal Login box.
- Under Admin User Responsibility, select "To continue with registration, click here" and you will be taken to the registration page.

### Registration is easy as 1, 2, 3!

- Select your Line of Business (If choosing "Other Line of Business" also select your state).

Users who are rendering services for Medicare programs as well as other Lines of Business, such as Marketplace and Medicaid products, can register for one Line of Business and then add the additional lines using the Manage Provider Tool within the Account Tools menu.

- Select your Provider Type.

### What Provider Type Should I Select?

**Facility/Group** can be used by any Provider, including solo practitioners. This registration type allows users to submit claims and service request/authorizations. To register as a Facility/Group you must have both the Molina Healthcare Provider ID and the associated TIN. *This is the preferred primary method of registration.*

**Individual Physician** is recommended for use when a Provider does not need to submit new or corrected claims. Providers who participate with multiple provider groups and want to see information pertaining to each group should register with the Individual Physician type. If the Provider is registered only as a Facility/Group, they will be limited to information for that registered group only.

**Note:** Users can register with both the Facility/Group and the Individual Physician Provider Types and link the accounts. When using the Portal, they simply select the appropriate account for the transactions needed.

- Tax ID Number & Molina Provider ID

If you do not know your Provider ID, please contact the Provider Services Department at **(844) 826-4335**.

Completing this step will take you to the Authentication Details screen of the registration process. You must enter your Name, Email Address, Username, Password, Security Questions and Answers and you must accept the Terms of Agreement.

### Role of the Administrator

If you are the first user to register with this Provider ID, you become the primary administrator of the account. You can navigate to the Account Tools page and click on 'Manage Users' to view other users or administrators. As the administrator of an account, you are entitled to designate or promote a user to administrator, manage users by granting different levels of access, and add other user accounts onto your account. You are also able to invite others to join your provider's account (See Account Tools section on page 16 for more details).

### Requesting Access

Other users may request access to an existing account by going to the Provider Web Portal, clicking on the "Request Access for New User" link under the Login section, and providing the following information:

- NPI or Provider Name
- Requester's First & Last Name
- Position Title
- Email Address
- Phone Number (and extension if applicable)
- Reason for Requesting Access.

A request will be sent to the administrator of the account specified and they will have to take action within 3 days or the request will expire.

### How to Review Member Roster

1. Once you login to the Provider Portal, go to the Provider Portal Panel on the left hand side and select Member Roster.
2. The Member Roster application enables the registered user to view and navigate through a list of Members assigned to a Primary Care Provider (PCP).

### You will be able to:

- Customize Member search with built-in filters and sorting functions.
- View various statuses (e.g. needed services, in-patient, new Members, etc.) for Members.
- Check Member eligibility.
- Easily access other functions to view Member details, submit claims and request service authorizations.

## Molina Healthcare Provider e-Newsletter

Molina Healthcare of Mississippi's Provider e-Newsletter is a great way for providers in Mississippi to receive helpful information, education, important updates and more! Our goal is to reach everyone in your organization, and you can help by sharing and recommending this newsletter to your colleagues and partners. It is a pleasure to partner with you and we encourage you to stay connected with us.

To subscribe to receive this quarterly newsletter by email visit <https://www.molinahealthcare.com/providers/ms/medicaid/comm/Pages/newsletters.aspx>.

## Molina Healthcare Newborn Delivery Prior Authorization Process Update

In order to help streamline our Newborn Delivery Prior Authorization (PA) process, Molina Healthcare of Mississippi no longer requires that a PA form is filled out and sent to us for a "normal newborn delivery" (CPT codes 59410 and 59515). Molina will now follow similar practices conducted by the other Coordinated Care Organizations (CCOs) contracted with the Mississippi Division of Medicaid (DOM) by creating an authorization number using the Newborn Enrollment Form sent to DOM.

If the expected stay of the member should exceed the "normal" three-day stay for vaginal delivery or a five-day C-Section stay, then a Molina PA form must be completed online at <https://Provider.MolinaHealthcare.com> or faxed to Molina at **(844) 207-1622**.

We expect this small change to have a significant impact on provider workflow efficiency and Molina's timely response. If you have any questions regarding the change in process, please feel free to reach out to our Utilization Management Department at **(844) 826-4335**.



**Attention All Providers!!!**  
**FFS, MississippiCAN & CHIP**

**2019 Workshops**  
**are coming your way!!!**

The Division of Medicaid, in conjunction with its contractors Conduent, Alliant UM/QIO, and the MSCAN plans – Magnolia Health, Molina Healthcare and UnitedHealthcare Community Plan, will conduct “FREE” Medicaid Provider Workshops June 11, 2019 through July 30, 2019 at varied locations throughout the state.

These workshops are designed to provide information and changes related to Medicaid and managed care programs. Office directors, office managers, coders, practitioners, and billing staff are encouraged to attend.

**RSVP SPACE IS LIMITED!**

**Complete your RSVP information below**

Number of Attendees from Facility:

**PLEASE FORWARD ALL RSVP REPLIES TO:**  
**Office of Client Relations**  
**Email: [ProviderWkspReply@medicaid.ms.gov](mailto:ProviderWkspReply@medicaid.ms.gov)**  
**Fax: 601-359-4185**

Medicaid 2019 Provider Workshop			
Date	Location	Topics of Discussion	
Tuesday June 11, 2019	Embassy Suites by Hilton 200 Township Ave. Ridgeland, MS 39157	Morning Session	New Providers General Medicaid Top Issues Managed Care Top Issues
		Afternoon Session	Non-Emergency Transportation Third Party Liability Program Integrity
Tuesday June 18, 2019	Eagle Ridge Conference Center 1500 Raymond Lake Road Raymond, MS 39154	Morning Session	Vision Durable Medical Equipment
		Afternoon Session	Dental
Thursday June 20, 2019	Eagle Ridge Conference Center 1500 Raymond Lake Road Raymond, MS 39154	Morning Session	Prior Authorizations Claims Review – Retro Reviews
		Afternoon Session	Hospital Services Newborns
Tuesday June 25, 2019	Embassy Suites by Hilton 200 Township Ave. Ridgeland, MS 39157	Morning Session	Home Health Waiver Services
		Afternoon Session	Therapy Services (Physical- Occupational- Speech)
Thursday June 27, 2019	Eagle Ridge Conference Center 1500 Raymond Lake Road Raymond, MS 39154	Morning Session	Rural Health Clinic Federal Qualified Health Centers
		Afternoon Session	Behavioral Health
Wednesday July 10, 2019	Courtyard Gulfport Beachfront Marriot 1600 East Beach Boulevard Gulfport, MS 39501	Morning Session	New Providers General Medicaid Top Issues Managed Care Top Issues
		Afternoon Session	Non-Emergency Transportation Third Party Liability Program Integrity
Tuesday July 16, 2019	MSU Riley Center 2200 5 <sup>th</sup> Street Meridian, MS 39301	Morning Session	Rural Health Clinic Federal Qualified Health Centers
		Afternoon Session	Behavioral Health
Thursday July 18, 2019	Holiday Inn Hattiesburg – North 6553 US Hwy 49 Hattiesburg, MS 39401	Morning Session	Vision Durable Medical Equipment
		Afternoon Session	Dental
Wednesday July 24, 2019	Bancorp South Arena 375 Main Street Tupelo, MS 39120	Morning Session	Prior Authorizations Claims Review – Retro Reviews
		Afternoon Session	Hospital Services Newborns
Tuesday	Landers Center	Morning Session	Home Health Waiver Services

**Workshop Agenda**

9:15 a.m.	11:00 a.m.	Morning Topics of Discussion
11:30 p.m.	12:30 p.m.	HELP DESK
1:30 p.m.	2:30 p.m.	Afternoon Topics of Discussion

**HELP US HELP YOU!**

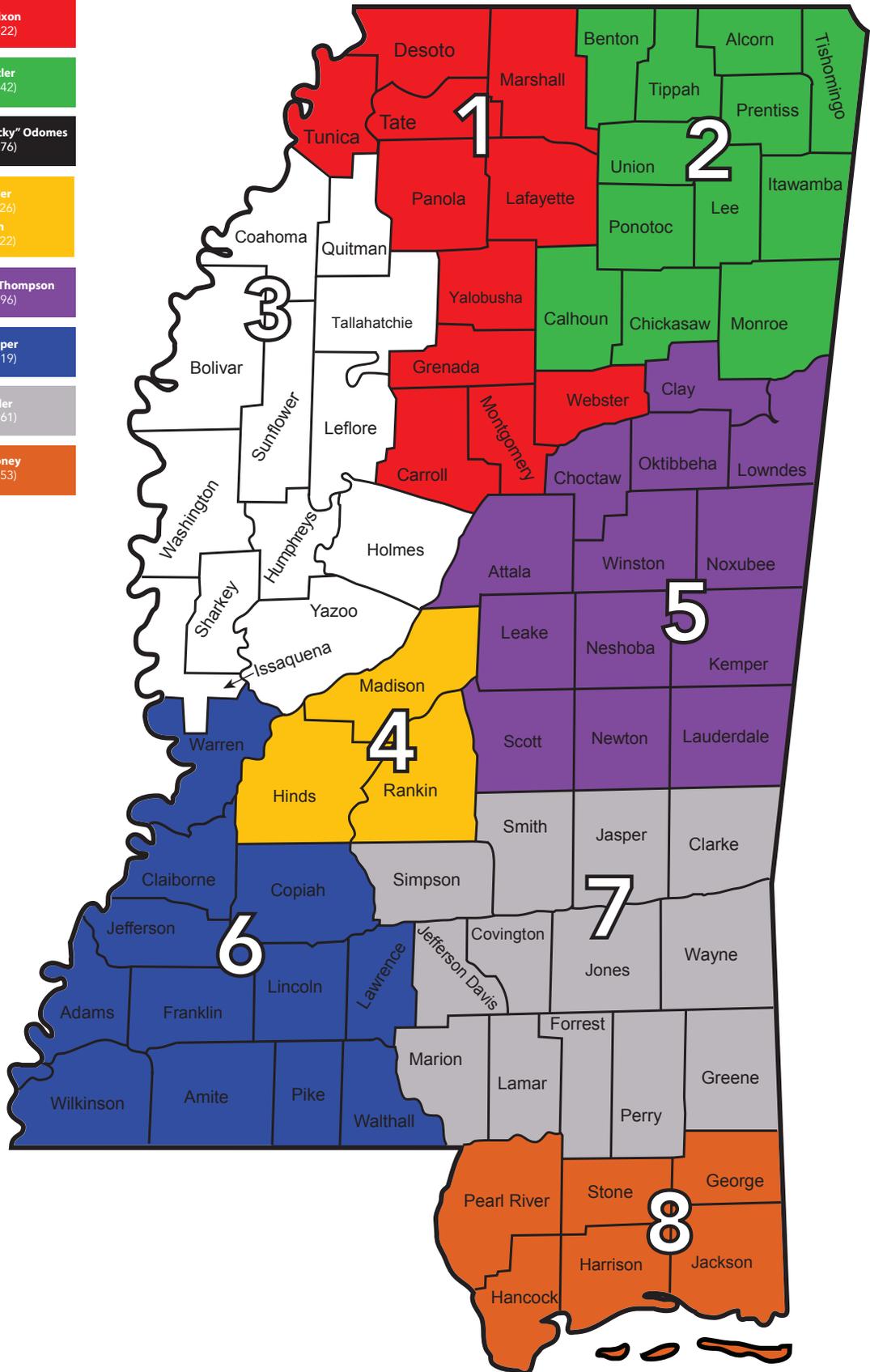
Please bring copies of claims and any issues your facility is experiencing to the workshops. The Division of Medicaid and all subcontractors will have a “Help Desk” available to assist and resolve issues.

**CONTACT INFORMATION**

For questions and/or concerns regarding your attendance to the 2019 Provider Workshops please email [ProviderWkspReply@medicaid.ms.gov](mailto:ProviderWkspReply@medicaid.ms.gov) or call 601-359-3789.

# FIELD REPRESENTATIVE REGIONAL MAP

- 1** Jonathan Dixon  
(601.206.3022)
- 2** Prentiss Butler  
(601.206.3042)
- 3** Claudia "Nicky" Odomes  
(601.572.3276)
- 4** Randy Ponder  
(601.206.3026)  
Justin Griffin  
(601.206.2922)
- 5** LaShundra Thompson  
(601.206.2996)
- 6** Erica G. Cooper  
(601.206.3019)
- 7** Porscha Fuller  
(601.206.2961)
- 8** Connie Mooney  
(601.572.3253)



# PROVIDER FIELD REPRESENTATIVES

## PROVIDER FIELD REPRESENTATIVE AREAS BY COUNTY

<b>AREA 1</b> Jonathan Dixon (601.206.3022) <a href="mailto:jonathan.dixon@conduent.com">jonathan.dixon@conduent.com</a>	<b>AREA 2</b> Prentiss Butler (601.206.3042) <a href="mailto:prentiss.butler@conduent.com">prentiss.butler@conduent.com</a>	<b>AREA 3</b> Claudia "Nicky" Odomes (601.572.3276) <a href="mailto:claudia.odomes@conduent.com">claudia.odomes@conduent.com</a>
<b>County</b>	<b>County</b>	<b>County</b>
Desoto	Benton	Coahoma
Tunica	Tippah	Quitman
Tate	Alcorn	Bolivar
Panola	Tishomingo	Sunflower
Marshall	Prentiss	Leflore
Lafayette	Union	Tallahatchie
Yalobusha	Lee	Washington
Grenada	Pontotoc	Sharkey
Carroll	Itawamba	Humphreys
Montgomery	Calhoun	Yazoo
Webster	Chickasaw	Holmes
	Monroe	Issaquena
<b>*Memphis</b>		
<b>AREA 4</b> Justin Griffin (601.206.2922) <a href="mailto:justin.griffin@conduent.com">justin.griffin@conduent.com</a> Randy Ponder (601.206.3026) <a href="mailto:randy.ponder@conduent.com">randy.ponder@conduent.com</a>	<b>AREA 5</b> LaShundra Thompson (601.206.2996) <a href="mailto:lashundra.othello@conduent.com">lashundra.othello@conduent.com</a>	<b>AREA 6</b> Erica G. Cooper (601.206.3019) <a href="mailto:ERICA.Cooper@conduent.com">ERICA.Cooper@conduent.com</a>
<b>County</b>	<b>County</b>	<b>County</b>
Hinds	Clay	Warren
Rankin	Oktibbeha	Claiborne
Madison	Choctaw	Jefferson
	Attala	Adams
	Leake	Franklin
	Scott	Wilkinson
	Lowndes	Amite
	Winston	Copiah
	Noxubee	Lincoln
	Neshoba	Pike
	Kemper	Lawrence
	Newton	Walthall
	Lauderdale	
<b>AREA 7</b> Porscha Fuller (601.206.2961) <a href="mailto:porscha.fuller@conduent.com">porscha.fuller@conduent.com</a>		<b>AREA 8</b> Connie Mooney (601.572.3253) <a href="mailto:connie.mooney@conduent.com">connie.mooney@conduent.com</a>
<b>County</b>		<b>County</b>
Simpson		Pearl River
Jefferson Davis		Stone
Marion		George
Lamar		Hancock
Covington		Harrison
Smith		Jackson
Jasper		
Jones		
Forrest		<b>Slidell, LA</b>
Perry		<b>Mobile, AL</b>
Greene		
Wayne		
Clarke		
<b>OUT OF STATE PROVIDERS</b>	Latasha Ford (601) 572-3298 <a href="mailto:Latasha.Ford@conduent.com">Latasha.Ford@conduent.com</a>	

**CONDUENT**  
P.O. BOX 23078  
JACKSON, MS 39225

*If you have any questions related to the topics in this bulletin, please contact Conduent at 800 - 884 -3222*

Mississippi Medicaid Administrative Code and Billing Handbook are on the Web  
[www.medicaid.ms.gov](http://www.medicaid.ms.gov)

Medicaid Provider Bulletins are located on the Web Portal  
[www.ms-medicaid.com](http://www.ms-medicaid.com)

## JUNE 2019

MON, JUNE 3	Checkwrite
THURS, JUNE 6	EDI Cut Off - 5:00 p.m.
MON, JUNE 10	Checkwrite
TUES, JUNE 11	Provider Workshop Ridgeland, MS
THURS, JUNE 13	EDI Cut Off - 5:00 p.m.
MON, JUNE 17	Checkwrite
TUES, JUNE 18	Provider Workshop Raymond, MS
THURS, JUNE 20	EDI Cut Off - 5:00 p.m.
MON, JUNE 24	Checkwrite
TUES, JUNE 25	Provider Workshop Ridgeland, MS
THURS, JUNE 27	EDI Cut Off - 5:00 p.m. Provider Workshop Raymond, MS

## JULY 2019

MON, JULY 1	Checkwrite
THURS, JULY 4	Independence Day DOM Closed
FRI, JULY 5	State Holiday DOM Closed
MON, JULY 8	Checkwrite
WED, JULY 10	Provider Workshop Gulfport, MS
THURS, JULY 11	EDI Cut Off – 5:00 p.m.
MON, JULY 15	Checkwrite
TUES, JULY 16	Provider Workshop Meridian, MS
THURS, JULY 18	EDI Cut Off – 5:00 p.m. Provider Workshop Tupelo, MS
MON, JULY 22	Checkwrite
WED, JULY 24	Provider Workshop Natchez, MS
THURS, JULY 25	EDI Cut Off – 5:00 p.m.
MON, JULY 29	Checkwrite
TUES, JULY 30	Provider Workshop Southaven, MS

## AUGUST 2019

THURS, AUG 1	EDI Cut Off – 5:00 p.m.
MON, AUG 5	Checkwrite
THURS, AUG 8	EDI Cut Off – 5:00 p.m.
MON, AUG 12	Checkwrite
THURS, AUG 15	EDI Cut Off – 5:00 p.m.
MON, AUG 19	Checkwrite
THURS, AUG 22	EDI Cut Off – 5:00 p.m.
MON, AUG 26	Checkwrite
THURS, AUG 29	EDI Cut Off – 5:00 p.m.

Checkwrites and Remittance Advices are dated every Monday. Provider Remittance Advice is available for download each Monday morning at [www.ms-medicaid.com](http://www.ms-medicaid.com). Funds are not transferred until the following Thursday.