This document lists the questions raised during the TrueCare™ Provider Orientation sessions held May 2025, and our responses.

# Benefits

Q: Sports physicals are required for all kids who participate in sports. Will TrueCare cover the cost? Other coordinated care organizations (CCOs) do not cover them.

A: Sports physicals are not a covered benefit. There is no value-added benefit (VAB) available for this purpose.

Q: Does TrueCare cover recreational therapy?

A: This is not a covered benefit.

Q: Does TrueCare cover physical therapy (PT)/occupational therapy (OT)/speech language therapy (ST)?

A: PT/OT/ST are covered with a prior authorization. The initial referral order is completed by the prescribing provider prior to the physical therapy evaluation per Administrative Code 23, Part 213.

Q: Can providers and members continue to use the lab of their choice?

A: Yes, if the lab is in-network.

Q: Can the $10 OTC member benefit be used anywhere, and it is in the form of a debit card?

A: It is a debit card that can be reloaded. Note that this benefit is available only to Mississippi Coordinated Access Network (MSCAN) members.

Q: What are the benefit limitations on outpatient therapy?

A: MSCAN: No restrictions on programs for age 20 and under TrueCare™ MississippiCAN Benefits | Mississippi | TrueCare.

(Children's Health Insurance Plan) CHIP: No restrictions on programs for age 20 and under Children's Health Insurance Program (CHIP) Benefits | Mississippi | TrueCare.

Q: For transportation services, do we need to get approval from MTM for non-emergent trips via ambulance? For example, we have to send out patients from our hospital for acute psychiatric needs. Or is there a prior authorization process for this?

A: You will work with MTM to arrange this type of transportation.

Q: Is there a limit to how many sick visits allowed per year?

A: There is no limit.

Q: Will patients be covered to receive durable, medical equipment (DME) services in Alabama?

A: Coverage depends on whether the service is a covered benefit, and if the provider is enrolled with Medicaid Enterprise System Assistance (MESA) and in-network with TrueCare.

Q: What is the guideline on limits on refraction? Lenses and frames? Office visits?

A: Refer to the EyeMed Manual.

Q: What is the coverage for ST for the CHIP program? Will it only be covered for autism and dysphasia?

A: There are no restrictions on coverage for ST.

Q: What is the observation policy?

A: Per Admin Code Title 23, "The Division of Medicaid covers outpatient hospital observation services for no more than 72 hours and must be documented in the physician's orders by the evaluating physician or other physician authorized by hospital bylaws to order outpatient hospital diagnostic tests or treatment, or an inpatient hospital admission".

Q: Are diagnostic hearing exams covered?

A: Preventive Services/Screenings for hearing (EPSDT Services for beneficiaries aged 20 years and under) are a covered benefit and claims should be submitted to TrueCare.

# Claims

Q: Will TrueCare process claims for members if the provider is not added to the plan until after the claim is submitted?

A: Claims processing is dependent on the contract start date (i.e., claim will process if the provider contract start date is July 1 even if not loaded until July 25).

Q: What is the Federally Qualified Health Center (FQHC) Place of Service (POS) code?

A: POS 50.

Q: Can claims be submitted electronically? What is the payer ID?

A: MSMCDCS1 is the payer ID we have established with our contracted clearinghouse, Availity. It will be ready for deployment/use July 1, 2025. We would not expect to receive any claims for service dates prior to July 1, 2025. Any updates TrueCare receives from Availity will be published on **MSTrueCare.com**.

The payer ID has been created on our side and is waiting for deployment at Availity. Availity has reached out to other clearinghouses to complete their configuration. Other clearinghouses such as Experian, Transunion/Finthrive and Waystar (not an exhaustive list) have been instructed to update their systems for TrueCare go-live July 1, 2025. Please seek out your specific clearinghouse for their payer ID assignments or look for their online payer ID resource lists to be updated by or on July 1, 2025, to obtain the proper ID.

Q: If we elect to submit claims through the TrueCare Provider Portal, does the portal accept 837P file uploads if we want to upload claims in bulk instead of keying in individual claim entries?

A: TrueCare does not accept 837 files through our Provider Portal. The portal enables providers and their billing agents with the ability to complete Direct Data Entry claims as well as Upload claim images. If a provider or billing agent wants to submit 837 files, they are required to submit them through a clearinghouse. Our contracted clearinghouse is Availity, but another clearinghouse can be used as long as they transmit to Availity.

Q: Does TrueCare charge a copay?

A: No copays for TrueCare members.

Q: With regard to the Medicaid fee schedule, is the provider paid as a default provider or primary care provider (PCP)?

A: The provider is paid as a default provider unless they have the PCP indicator on their profile/record.

Q: Why is Mississippi not found under the list to select state when signing up for the TrueCare Provider Portal?

A: Mississippi will be an option when the portal is live July 1, 2025.

Q: Will we be notified via email when the portal is fully ready?

A: No, the portal will be live on July 1, 2025. If this changes, TrueCare will send a notice and post on **MSTrueCare.com**.

Q: Will we be able to send secondary claims electronically? How do we submit crossover claims (secondary claims)?

A: TrueCare accepts claims with coordination of benefits (COB)/primary payer detail through all of our standard platforms, EDI, portal and paper claims. If sending a paper claim or completing a Direct Data Entry claim through the portal, the submitter is required to include a copy of the primary coverage EOB. If sending electronically using EDI 837 format, the primary payer payment detail should be outlined in the appropriate segments. TrueCare does not accept paper attachments using the 275 X12 format. If additional information is needed for adjudication that was not included in the COB Segments in the 837 submissions, a request will be made to the provider to supply the information.

Q: We can pull remittances from ECHO; will we be able to pull them from TrueCare as well?

A: No. Providers will have to go to ECHO for remittances, but they can click a link in our Provider Portal to link them over to ECHO from the Payment History page.

Q: Medicaid requires sterilization papers to be filled out, signed and sent with the claims. The other CCOs do not. Will TrueCare require these papers?

A: Yes, sterilization forms should be sent with the claim unless the procedure requires the consent as part of the medically necessary requirement, then it should be submitted with the requirements to TrueCare.

Q: What is the timely filing requirement on corrected claims?

A: 180 days from the date of service or discharge date, or 90 days from the denial date.

Q: Are electronic adjustments/void allowed? All lines need to be sent back or just the line being corrected. Will this also be allowed to be done in TrueCare Provider Portal?

A: Yes, corrected claims can be submitted on the portal but not voids.

Corrected claims - Submit corrected claim transactions using the frequency code 7 and referencing the original claim ID we created in our system, providing that the first claim iteration was submitted through the FirstSource portal.

Voids - Voids may be submitted using FirstSource (use a single sign on from the portal to access FirstSource). User guides for FirstSource are available on the portal under Claims > FirstSource Claims User Guide. Providers can submit voided claim transactions using the frequency code 8 and referencing the original claim ID we created in our system, as long as the provider sent the first claim iteration through the FirstSource portal. All lines must be completed. Providers must submit another claim (referencing the original claim) to void the original claim that was submitted.

Q: It was mentioned on the appeals sections that they can be submitted to TrueCare; will that not be handled in the TrueCare Provider Portal?

A: Appeals may be submitted via the portal or U.S. mail (using the Provider Appeal Form available on **MSTrueCare.com**) within 30 calendar days of the date of denial.

Q: Will Behavioral Diagnosis codes have to be billed to another carrier or payer ID such as MHP makes us do such as Cenpatico?

A: No

Q: Can our PT see the patient but bill under the provider's name?

A: Mississippi Medicaid allows both individual practitioners and group practices to enroll and bill for physical therapy services, but the requirements and billing structure depend on the provider's enrollment status. Claims may be submitted under the individual physical therapist's NPI or under a group NPI if the therapist is part of a group practice.

Q: Will dental offices use the TrueCare Provider Portal to verify benefits and enter claims?

A: You can enter claims on the TrueCare Provider Portal. Since dental is a vendor, which the portal re-directs to, the benefits will have to be verified on the Avesis portal.

Q: How will TPL's be handled if COB needs to be updated?

A: If a claim is denied for COB information needed, the provider must submit the primary payer's Explanation of Benefits (EOB) for paper claims or primary carrier's payment information in Electronic Data Interchange (EDI).

Q: If we are not a contracted provider, will we still have access to the portal?

A: Non-participating providers will have limited access to the portal.

Q: We use Instamed as our clearinghouse to submit claims how do we go about getting set up with them?

A: Instamed will need connect/reach out to Availity.

Q: What is the EDI?

A: Electronic Data Interchange.

Q: If Nations Hearing is the third-party vendor for hearing benefits, does that mean that we can't directly submit a claim for routine hearing exams or is that just for hearing aids?

A: Preventive Services/Screenings for hearing (EPSDT Services for beneficiaries aged 20 years and under) are a covered benefit and claims should be submitted to TrueCare. Hearing devices will be managed by Nations Hearing.

Q: We use Office Ally as our clearinghouse to submit our claims electronically. Will we be able to use them to submit claims to TrueCare or do we have to use Availity?

A: TrueCare accepts electronic claims through our clearinghouse, Availity. A list of EDI vendors can be found online at: www.availity.com/ediclearinghouse.

If the provider is using a different clearinghouse or billing agency, they may use a smaller (five-digit) ID to pass claims from the upstream clearinghouse to Availity. This info will be available from Availity.

# Contracting & Credentialing

Q: Will providers who were credentialed two years ago and submitted on original roster retain their credentialing status?

A: Yes

Q: How do providers know their contract status?

A: Status updates are available in the Provider Portal for updates. Providers receive a Welcome letter after they are uploaded to our systems.

Q: What is the turnaround time for credentialing with TrueCare?

A: All credentialing is completed through the Division of Medicaid (DOM). Providers must be credentialed with the State prior to becoming a TrueCare provider.

Q: Will the Alabama Hospital - USA be in-network?

A: They are in active contract discussions.

Q: Does Avesis handle their own enrollments or are dental provider enrollments handled through TrueCare?

A: Dental providers contract directly with Avesis.

Q: I received a letter from Mississippi Physicians Care Network (MPCN) stating we will be automatically credentialed with TrueCare since we are an MPCN provider. Do you know if this is accurate?

A: If you did not choose to opt out, then yes, you will be in through the MPCN network.

Q: As a provider of Medicaid and EyeMed, do we need to credential with TrueCare or are you automatic in network?

A: If the provider is actively credentialed with the State and is contracted for EyeMed's MS Medicaid network, they don't need to do anything at the moment. Our approved readiness communications are starting to be sent out to these in-network providers today. Five separate emails will go out over the next several weeks notifying the providers to get ready to see TrueCare members, share resource links and lab information if utilizing EyeMed's lab, etc.

However, if there are medical claims involved, you need a contract with TrueCare.

Q: Once we have a contract, how do we add a new provider to our group?

A: Providers should submit changes to DOM using the MESA portal.

Q: Since we have a group contract, do we need to do anything when a new individual provider joins the group other than credential them with Medicaid?

A: No, just make sure they are added on the roster submitted to Medicaid.

# Enrollment

## Member Enrollment

Q: When will Members receive notification that they now have TrueCare? When will they receive their ID card?

A: We will receive the first member file June 16, 2025; the Welcome pack will be generated soon thereafter.

Q: Will former United members roll over to TrueCare or be randomly assigned to a CCO?

A: They will be randomly assigned to a CCO unless they select a plan in the first 20 days of enrollment.

Q: Are members assigned to an individual provider or a provider group?

A: Members are assigned an individual provider, although they may see any in-network provider.

Q: Will providers have access to July 1, 2025, MCO/CCO member changeovers prior to July 1, 2025?

A: Member lists will be available in the Provider Portal on July 1, 2025.

Q: Will TrueCare be primary insurance only, or be secondary to any other policy, or can it be primary and still have secondary coverage with another carrier?

A: TrueCare could be primary or secondary insurance.

## Provider Enrollment

Q: Do providers already in network with Mississippi Medicaid need to do anything else?

A: Providers will still need a TrueCare contract to be considered a participating network provider.

Q: Do all areas of Mississippi have access to in-network providers?

A: Yes

Q: If already enrolled with ECHO for payments, how does a provider add TrueCare?

A: New and current providers will need to enroll with ECHO. Follow this link.

Or providers can wait to enroll until they receive an ECHO letter with an enrollment code.

Q: When I submitted a request for joining TrueCare, the first requirement was to attend one of the onboarding sessions. What are my next steps to ensure our network participation?

A: Please reach out to MS_Network@CareSource.com.

Q: Just to clarify we will still need to fill out a direct contract from your website even though we are a network provider for all Medicaid products?

A: Yes

# Prior Authorizations

Q: Do offices have a grace period for submitting a new prior authorization for members with one already in place prior to July 1, 2025?

A: TrueCare will honor prior authorizations that were approved by the member's original managed care organization (MCO) for up to 90 days during transition.

Q: Where can a provider find the authorization requirements for services?

A: Using the Procedure Code Lookup Tool on our website.

Q: When will the Procedure Code Lookup Tool be available?

A: July 1, 2025. We are awaiting final approval from DOM on our code level requirements.

Q: Is contact information available for EyeMed and Avesis?

A: EyeMed: 1-833-918-0861 for member and provider

Avesis: 1-844-391-6671 for TrueCare providers (both CHIP and MSCAN)

Q: Is a referral required for a specialist?

A: No referral is required, but record the referral in the patient record and ensure the referral is to an in-network provider.

Q: How will authorizations be handled if a member moves from one plan to TrueCare on July 1, 2025?

A: We will honor the original prior authorization for up to 90 days.

Q: How will authorizations be handled if the previous MCO/CCO did not require authorizations for outpatient therapy?

A: TrueCare will cover for 30 days to ensure continuity of care while the prior authorization is being processed. A prior authorization must be submitted within those 30 days.

Q: Will a prior authorization be required for therapy services if the patient has primary insurance?

A: If the primary insurance does not require authorization, TrueCare will follow the rules of the primary.

Q: What is the hierarchy of clinical need used for authorizations?

A: When a request for a service, procedure or product is under review, the review criteria is based on the following hierarchy:

1. Benefit contract language
2. Federal and/or State Regulation, including state waiver regulations when applicable
3. Nationally accepted evidence-based clinical guidelines (i.e.: MCG, ASAM)
4. TrueCare Medical Policy Statements

Q: Can the hospital obtain prior authorization for outpatient radiology diagnostic tests for the ordering physician?

A: The request can be submitted by either the treating provider or servicing provider, granted they are both contracted.

Q: Is prior authorization required for PT/OT/ST of all ages? What is the score range for a child to qualify for ST and OT services?

A: Yes; prior authorizations are submitted via the Provider Portal. Requirements/criteria will be based on the procedure code requested. Administrative Code 23, Part 213 is the basis for therapy reviews.

Q: Does TrueCare allow retro authorization for PT/OT or ST?

A: Yes, retro authorization is allowed when requests are submitted within 60 days of the date of service.

Q: What is the retro authorization time frame once services have been rendered?

A: 20 business days.

Q: Could you please confirm if there is an option for Prescribed Pediatric Extended Care (PPEC) prior authorization?

A: Yes, there is an option for PPEC.

Q: Is prior authorization for outpatient radiology diagnostic tests required if TrueCare is secondary insurance?

A: No, we will honor the primary's approval.

Q: For OB/GYN services, is there a prior authorization requirement list or a number to call to confirm a procedure code prior authorization requirement?

A: Authorization requirements can be located using the Procedure Code Lookup Tool.

Q: Where do we obtain authorizations for outpatient radiation therapy and outpatient administered infusion drugs?

A: Submit prior authorizations for radiation therapy and outpatient infusions via the Provider Portal. Provider-administered drug prior authorization requests are reviewed by TrueCare, and determinations are made within 72 hours of receipt.

Q: Is prior authorization required for chemotherapy services when TrueCare is secondary? If the primary requires authorization for drugs (chemotherapy) given in the office, we are to get an authorization from TrueCare also?

A: If a provider already has a prior authorization from the primary insurance, TrueCare does not require a prior authorization submission. If the primary denies service and the provider would like to submit to TrueCare for review, then evidence of primary denial must be submitted on the prior authorization request. The exception is for members under 21 years of age - TrueCare still requires an authorization to be submitted. There is an EPSDT requirement, however, this would only be applicable to TrueCare if the primary denies coverage.

Q: Is there any information about day-treatment services for children behavioral health agencies? Especially with submitting prior authorizations and what is required?

A: Prior authorizations are required for day-treatment for behavioral health services. Requirements will be available via the Provider Portal.

Q: Will there be an orientation on how to submit a prior authorization on the portal?

A: Education is available on **HealthPlanResources.com** and in the Provider Portal.

Q: Will this training include information on getting prior authorization on dental services and/or dental services in a surgery setting?

A: No but a provider dental manual will be available on **MSTrueCare.com**.

Q: Will a CMN and last MD visit be required for prior authorization for therapy?

A: Yes, each modality needs a certificate of medical need and a physician visit within 30 days prior to the doctor's order per Administrative Code 23, Part 213.

Q: Following up on the authorization requirement of the patient has a primary, do we get authorization if they run out of visits or it's not a covered service?

A: The COB process varies depending upon several factors, including if the member is under/over the age of 21, the procedure code and if continuity of care applies. If a prior authorization is required, a medical necessity review will be completed and the following will be requested from the primary insurance: proof of denial or approval, EOB or explanation of payment (EOP). The COB process can be referenced in the Provider Manual.

Q: Will we need to fax NICU authorization requests?

A: Fax a paper authorization form. The NICU request fax number is 937-396-3499.

Q: Do you require prior authorization for vaginal and cesarean section deliveries, or do you follow two-to-four-day federal guidelines after delivery? What if the mother is admitted one day prior to delivery?

A: Prior authorization is not required for the following: Vaginal deliveries with a length of stay two days or less, Cesarean deliveries with a length of stay four days or less and well-newborns with a length of stay of five days.

Q: Can I get clarification on authorizations transferring over? If a patient has a current authorization for ABA therapy, will it be honored?

A: Approved authorizations will be honored for up to 90 days.

Q: Will authorizations from another provider be honored in this transition period? For example, will prior authorizations from UHC for MYPAC/Wraparound be honored? Or will we have to request new authorizations and submit new packets for those?

A: TrueCare will honor prior authorizations that were approved by the member's original coordinated care organization (CCO) for at least 90 days during transition to TrueCare. This includes existing and incomplete care treatment plans and scheduled services with non-participating providers. Coordination of Care services may be subject to a medical necessity review. Requests will be accepted from a member or a provider on behalf of a member.

Q: Is there a grace period for retroactive authorizations for outpatient surgery and/or radiology/cardio testing? If for example, the incorrect CPT code was submitted in error, we are allowed 60 days to submit a new request?

A: The grace period for submission of a retroactive auth is 60 calendar days of the date of service. Corrected claims should not be submitted as an appeal. Electronic adjustments are allowed if submitted in a timely manner - 180 days from the date of service or discharge date, or 90 days from the denial date. When billing corrected claims, be sure to use the most recent claim number in the original claim ID (segment REF*F8).

Q: Is Availity the clinical portal for hospital authorizations?

A: Submit hospital authorization requests using the TrueCare Provider Portal. For Cardiac Surgeries and Procedures, Orthopedic Surgical Procedures and Spinal Surgical Procedures, use TurningPoint.

Q: What is the service level agreement (SLA)/turnaround times for receiving authorization?

A: Urgent request-24 hours turnaround time. Standard outpatient requests are three calendar days and/or two business days.

Q: Will transplant go to TrueCare or will there be a separate contract for those services?

A: Transplant requests should be submitted through the portal and will be reviewed by TrueCare.

## Provider Representatives

Q: Will TrueCare be hiring additional staff?

A: Yes, and will assign a FQHC-specific Provider Representative.

Q: When will we know who the assigned provider representatives are?

A: The team is currently making those decisions. State geographical territories are under development and the Provider Representatives are participating in a TrueCare onboarding and training plan. Territory assignments will be available in June.

Q: Is there a separate provider rep assigned to dental offices?

A: Yes, a representative from Avesis will be assigned.

Q: If a provider cannot reach a patient, can they reach out to TrueCare for help?

A: Yes; call Member Services **1-833-230-2050** (TDD/TTY: 711), Monday through Friday, 7 a.m. to 8 p.m. Central Time (CT).

## Utilization Management

Q: When will Provider policies be available for review?

A: Policies are available now on **MSTrueCare.com**:

Provider Policies | Mississippi – CHIP | TrueCare

Provider Policies | Mississippi – MSCAN | TrueCare

Q: What are the qualifications of the employees working authorization requests?

A: Non-clinical staff (intake specialists) and clinical staff (RNs, LPNs and MDs).

Q: Do you use MCG or InterQual as your clinical guidelines?

A: MCG.

## Miscellaneous

Q: When will **MSTrueCare.com** be updated with items like the Provider Manual, etc.?

A: TrueCare will publish them as soon as possible following approval by DOM.

Q: As a Children's hospital, we make many reports to CPS. We now have to notify TrueCare as well?

A: Yes. Per our Compliance department, this is a best practice for TrueCare.

Q: We are a pediatric clinic. If EPSDT visits are only covered through the MSCAN plan, will we see any CHIP patients?

A: EPSDT terminology is specific to MSCAN (Medicaid) and should not be used in CHIP communications. CHIP members receive similar services, but under a different program structure. Referring to these visits as "well-child" for CHIP is the compliant and member-friendly approach.

Q: When referring a patient, is it the PCP's responsibility to get the authorization before referring them?

A: If the referral is to a non-participating provider, prior authorization is required. Otherwise, no referral is required.

Q: If we are credentialed with Medicaid already, are we able to sign up for the portal with no issue?

A: You will still require a TrueCare contract to service TrueCare members. Welcome letters will be sent to any providers who have contracted with TrueCare. You will use content from your Welcome letter to create/link your portal access. Welcome letters are pending but will be sent as soon as loading activities are completed. The portal will go live July 1, 2025.

Q: What is the appeal process for concurrent (time of service) denials for inpatient medical necessity?

A: Clinical Appeals -
Pre-Service: A request to change the decision on any case or services that must be made in whole or in part in advance of the member obtaining medical care or services. Providers have 60 days to file an appeal with a member written consent. A decision will be made within 30 days.
Expedited Pre-Service: A request to change an urgent care request where the decision could seriously jeopardize the life or health of the member, jeopardize the member's ability to regain maximum function or subject the member to sever pain, not managed without the requested care. An appeal must be submitted within 60 calendar days. Member consent is required. A decision will be made within 72 hours.
Post-Service: A request to change a decision on any review for care or services that have already been received 60 calendar days to file an appeal from the date of the initial denial letter. A decision will be made within 30 calendar days.

Q: What is a dispute versus an appeal?

A: A **dispute** is a disagreement with the payment decision made by TrueCare. File within 30 days of original denial or claim rejections. A decision will be made within 30 calendar days.

An **appeal** is the provider's disagreement with a claim denial. Both may be submitted to TrueCare via mail or the Provider Portal. Submit with an appeal letter and medical records within 30 days of the dispute date. A decision will be made within 30 calendar days.

Q: Does TrueCare share our member files with our vendors?

A: Yes

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