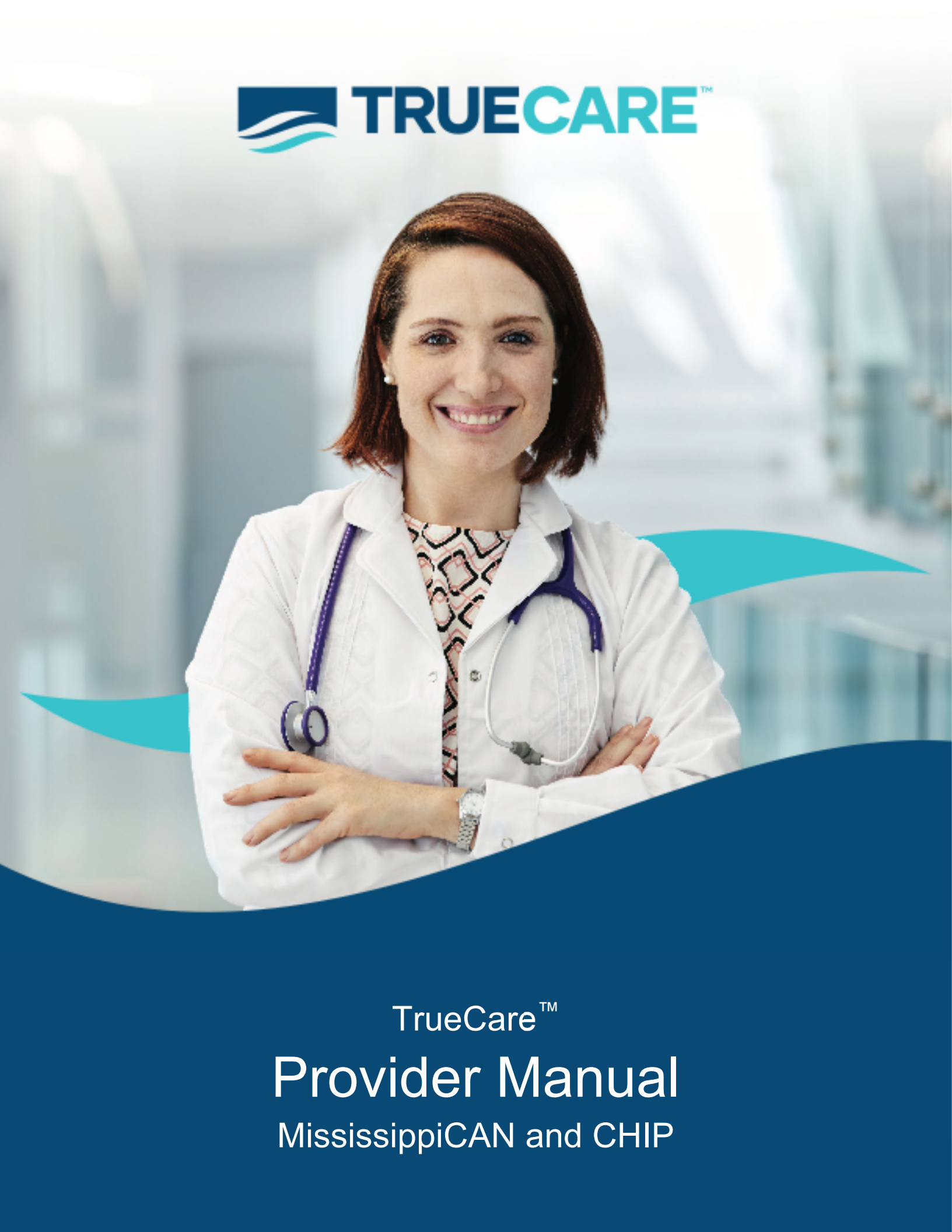


TrueCare™

Provider Manual

MississippiCAN and CHIP

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ABOUT US

Welcome

Welcome and thank you for participating with TrueCare™.

At TrueCare, we believe the best health care outcomes happen when providers and payors work together to improve members' health and well-being. As Mississippi's only nonprofit, provider-sponsored health plan, local providers' clinical perspectives are key to our decision making. We are a health maintenance organization that was formed by hospitals and health systems that have been serving patients in Mississippi for more than 100 years. TrueCare, licensed as Mississippi True, was created to improve the health of Mississippians by leveraging local provider experience to inform decisions, use population health data more effectively, and reduce the friction between the delivery and financing of health care.

At TrueCare, we call health care providers our health partners. A "health partner" is any health care provider who participates in TrueCare's provider network. You may find "health partner" and health care provider used interchangeably in our manual, agreements, and website.

We work together to ensure that your patients – our members – can improve their health and well-being. Because you're our partner, we strive to make it simple for you to do business with us. This manual directs you to the solutions you need, whether that's through convenient online self-service solutions, fast prior authorizations, or hassle-free claims payments. It's our strong partnership that allows us to work together to facilitate a high level of care and a respectful experience for our members.

We are a nonprofit, community-based health plan that focuses on helping people of all circumstances transform their lives through quality health care and other services. We focus on prevention and partnering with local providers to offer the services our members need to remain healthy.

As a coordinated care organization (CCO), we improve the health of our members by utilizing a contracted network of high-quality participating providers. Primary care providers (PCPs) within the network provide a range of services to our members and coordinate patient care by referring them to specialists when needed, ensuring that members have timely access to health care services and receive all appropriate preventive services.

TrueCare adheres to the Mississippi Division of Medicaid's (DOM) requirements that prohibit us from requiring a provider to agree to non-exclusivity requirements nor to participate in TrueCare's other lines of business in order to participate in TrueCare's Mississippi Coordinated Access Network (MississippiCAN) and Children's Health Insurance Program (CHIP) networks.

TrueCare also distributes the member rights and responsibility statements to members and providers upon enrollment and annually thereafter.

About this Manual

This manual includes information for all of TrueCare's plans/products in Mississippi:

- MississippiCAN
- CHIP

With the exception of information indicated as specific to one program, the information in this manual is applicable for all plans.

Plan Descriptions

It is important to note Mississippi Medicaid health benefits encompass multiple programs administered by the Mississippi DOM: Traditional (or Fee-for-Service) Medicaid, MississippiCAN, and CHIP.

Mississippi Coordinated Access Network (MississippiCAN)

The Mississippi DOM has implemented a managed care program called MississippiCAN. It is designed to get a better return on Mississippi's health care investment by improving the health and well-being of Medicaid beneficiaries. MississippiCAN Medicaid is for pregnant women, children, and adults who meet certain Medicaid eligibility requirements. MississippiCAN is a statewide coordinated care program designed to meet the following goals:

- Improve beneficiary access to needed medical services
- Improve quality of care
- Improve program efficiencies as well as cost predictability

Children's Health Insurance Program (CHIP)

CHIP provides health coverage for uninsured children up to 19 years old. To be eligible for CHIP, a child cannot be eligible for Medicaid. At the time of application, children with health insurance are not eligible for CHIP. It is possible that one child in a family may qualify for Medicaid while another may qualify for CHIP. Eligibility is based on family household income, the age of each child and the insured status of each child.

Administrative Structure

CareSource® will act as a third-party administrator for TrueCare. CareSource will provide operational support and services including claims processing and appeals, all member and provider services and managing the provider network. By being a TrueCare provider, you will interact with CareSource services when verifying member eligibility, submitting requests for prior authorization, using our **Find a Doctor** provider directory tool and our **Provider Portal**, or

interacting with some of our member services like our 24-Hour Nurse Advice Line. CareSource is a trusted partner with TrueCare and is here to support you whenever needed.

As a TrueCare provider, you are obligated to adhere to, and are bound by, all CareSource policies and procedures applicable to TrueCare providers in CareSource's capacity as TrueCare's third-party administrator.

Vision & Mission

Our vision is transforming lives through innovative health and life services.

Our mission is to improve the health of Mississippians by leveraging local provider experience to inform decision-making, aligning incentives, using data more effectively, and reducing friction between the delivery and financing of health care. By doing so, TrueCare will change the way health care is delivered in Mississippi.

Our Services

- Provider relations
- Provider services
- Member eligibility/enrollment information
- Claim processing, including appeals and grievances
- Decision-support informatics
- Quality improvement
- Regulatory/compliance
- Special investigations for fraud, waste, and abuse
- Member services, including a member call center with TrueCare as well as our benefit managers:
  - Dental: Avesis
  - Vision: EyeMed
  - Over-the-Counter (OTC) Monthly Allowance: Nations Benefits
  - Non-Emergency Medical Transportation: MTM Transit

In addition to the above, our care management programs include the following:

- High-risk case management
- Onsite case management in select clinics and facilities
- High emergency department (ED) utilization focus (targeted at members with frequent utilization)
- Transition of Care
  - Our team works with providers, members, and their families to coordinate care needs and make the transition to home or a lower level of care as successful as possible

- 24-Hour Nurse Advice Line
- Health home care
- Maternal and child health
  - Dedicated neonatal intensive care unit (NICU) care management nurses
  - Mom & Baby Beginnings™: TrueCare member-exclusive program designed to support mothers before, during, and for a period after pregnancy
  - Outreach programs in partnership with community agencies to target members at greatest risk for preterm birth or complications
- Disease management
- Behavioral health and substance use disorder (SUD)

Compliance & Ethics

At TrueCare, we serve a variety of stakeholders – members, providers, government regulators, community partners, and each other. We serve them best by working together with honesty, respect, and integrity. Our corporate compliance plan, along with state and federal regulations, outline the personal, professional, ethical, and legal standards we must all follow.

Our TrueCare Corporate Compliance Plan is an affirmation of TrueCare's ongoing commitment to conduct business in a legal and ethical environment. It has been established to:

- Formalize TrueCare's commitment to honest communication within the company and within the community
- Develop and maintain a culture that promotes integrity and ethical behavior
- Facilitate compliance with all applicable local, state, and federal laws and regulations
- Implement a system for early detection and reporting of noncompliance with laws, regulations, or TrueCare policy

This allows us to resolve problems promptly and minimize any negative impact on our members or business, such as financial losses, civil damages, penalties, and criminal sanctions.

TrueCare's Corporate Compliance Plan is a formal company policy that outlines how everyone who represents TrueCare must conduct himself or herself. This includes how we do our work and how we relate to each other in the workplace. It also includes the conduct of those we have business relationships with, such as providers, consultants, and vendors. All providers are required to review and comply with TrueCare's corporate compliance plan, located at **MSTrueCare.com** > About TrueCare > Legal > Corporate Compliance.

General Compliance and Ethics Expectations of Providers

- Act according to the standards of our compliance plan.
- Notify us about suspected violations or misconduct.
- Contact us if you have questions.

It is expected that providers will not intentionally segregate TrueCare members in any way from other patients receiving services. TrueCare will investigate complaints and take affirmative actions so that members are provided services without regard to any race, color, national origin, sex, sexual orientation, gender identity, disability, creed, religion, age, ancestry, marital status, language, health status, disease, or pre-existing condition, need for health care, or behavioral/mental health issues, except where medically indicated. Examples of prohibited practices include but are not limited to the following:

- Denying or not providing a member any Medicaid- or CHIP-covered service
- Subjecting a member to segregated, separate, or different treatment, including a different place or time from that provided to other patients
- The assignment of times or places for the provision of services based on the race, color, national origin, sex, sexual orientation, gender identity, disability, creed, religion, age, ancestry, marital status, income status, program membership, language, health status, disease or pre-existing condition, anticipated need for health care or physical or mental disability of the members to be served

For questions about provider expectations, please call Provider Services at 1-833-230-2174.

If you suspect potential violations, misconduct, or non-compliant conduct which impacts TrueCare or our members, please leverage one of the following methods to communicate the issue to TrueCare:

- Ethics and Compliance Hotline: 1-844-784-9583 or **truecare.ethicspoint.com**
- Compliance Department: **Medicaid.Compliance@TrueCare.com**

Any issues submitted to the Ethics and Compliance Hotline may be submitted anonymously.

The TrueCare Corporate Compliance Plan is posted for your reference on **MSTrueCare.com** > About Us > Legal > Corporate Compliance.

Please let us know if you have questions regarding the TrueCare Corporate Compliance Plan. We appreciate your commitment to corporate compliance.

Accreditation

The National Committee for Quality Assurance (NCQA) is a private, nonprofit organization dedicated to improving health care quality through measurement, transparency, and accountability. Accreditation status indicates that our service and clinical quality meet NCQA's rigorous requirements for consumer protection and quality improvement. Visit NCQA.org for more information.

TrueCare will pursue NCQA Health Plan Accreditation.

CLAIMS

Claims Information

In general, TrueCare follows the claims reimbursement policies and procedures set forth by the relevant regulations and regulating bodies. These can be found at **MSTrueCare.com** > Providers > Provider Policies. For expedited claims processing and payment delivery, please ensure addresses and phone numbers on file are up to date with the Mississippi Department of Medicaid (DOM).

Claim Submission Process

Timely Filing

For providers, claims must be submitted within 180 calendar days of the date of service (DOS) or discharge. Review the timely filing for the outlined scenarios below:

1. Original claims – 180 days from DOS
2. Original claims with primary Explanation of Benefit (EOB) attached – 180 days from DOS or 90 days from primary EOB date
3. Corrected claims – 180 days from DOS or 90 days from DOS from the claim denial date, when submitted timely

Information to Include in Claims

- Patient (member) name.
- Patient address.
- Insured's ID number – Be sure to provide the complete TrueCare member ID number of the patient.
- Patient's birth date – Always include the member's date of birth. This allows us to identify the correct member in case we have more than one member with the same name.
- Place of service – Use standard Centers for Medicare & Medicaid Services (CMS) (HCFA) location codes.
- International Classification of Diseases (ICD)-10 diagnosis code(s).
- Health Insurance Portability and Accountability Act (HIPAA)-compliant, Current Procedural Terminology (CPT), or Healthcare Common Procedure Coding System (HCPCS) code(s) and modifiers, where modifiers are applicable.
- Units, where applicable (anesthesia claims require minutes).
- DOS – Please include dates for each individual service rendered. A date range cannot be accepted, even though some claim forms contain from/to formats. Please enter each date individually.

- Prior authorization number, where applicable – A number is needed to match the claim to corresponding prior authorization information. This is only needed if the service provided required prior authorization.
- National Provider Identifier (NPI) – Please refer to other sections for professional and institutional claim information. NPI/Medicaid ID should be submitted for unique match to provider master file.
- Federal Tax ID Number (TIN) or physician Social Security number (SSN) – Every provider practice (e.g., legal business entity) has a different TIN.

Please note: Claims must be submitted in alignment with Mississippi Medicaid's requirements. TrueCare must be able to match claim data to the specific and unique member and provider enrollment data we receive from the Mississippi DOM.

Per the Mississippi DOM, all providers serving Medicaid beneficiaries must be enrolled in Medicaid Enterprise System Assistance (MESA). This is the state's online Medicaid enrollment and billing system. It ensures all providers who participate in Medicaid comply with federal and state regulations.

All Medicaid providers eligible to obtain an NPI must do so before enrolling in Medicaid. This unique identifier is required for billing purposes and must be used on all Medicaid claims. Atypical Provider Exception: Since atypical providers are not generally required to obtain an NPI, a Medicaid ID will be assigned at enrollment, and the provider is required to use the assigned Medicaid ID on all submissions for claims.

Claims submitted without this information could result in a claim rejection or recoupment of paid claims. A claim rejection occurs at the front-end of our claims processing system prior to the claim being accepted to proceed to claim adjudication (processing). If your claim is "rejected," you should review error messaging, correct the associated information, and resubmit the claim. Additional information for Medicaid Provider Enrollment and Data Maintenance Requirements and Process Overview can be found on the Mississippi DOM website.

Claim Processing Guidelines

If the claim is submitted after the timeline allotted, then the claim will receive denial for timely filing.

- If you do not agree with the decision of a claim, you can ask us to review the claim again. Please see the Grievance and Appeals section of this manual for additional information.
- If a member has other insurance and TrueCare is secondary, the provider may submit for secondary payment within 180 calendar days of the service date or 90 calendar days from the primary carrier's EOP, but not more than 12 months from the date of service or discharge. Claims that were filed within this time frame with a primary carrier, with no response from the carrier despite all reasonable actions taken, must be filed with

TrueCare not more than 12 months from the date of service or discharge indicating no response was received.

- If a claim is denied for Coordination of Benefits (COB) information needed, the provider must submit the primary payer's EOB for paper claims or primary carrier's payment information for Electronic Data Interchange (EDI) claims within the remainder of the initial claims timely filing period. If the initial timely filing period has elapsed, the EOB must be submitted to us within 180 days from the primary payer's EOB date. If a copy of the claim and EOB is not submitted within the required time frame, the claim will be denied for timely filing.
- There will be times when a member is hospitalized for a longer period of time. The provider will be able to submit interim bills, which TrueCare will pay at 30 percent of the billed charges submitted. When the patient is discharged, the provider will be required to submit a final bill, which includes the entire bill from date admitted to date discharged. TrueCare is not able to determine correct payment unless the full, final bill is submitted. The provider will have 180 calendar days from the date of discharge to submit the complete bill. If this information is not submitted within the timely filing guidelines, the claim will be denied, and previous payments will be recouped.
- All claims for newborns must be submitted using the newborn's TrueCare ID number. Do not submit newborn claims using the mother's ID number; the claim will be denied. Claims for newborns must include the birth weight. The same timely filing guidelines apply for newborns. Newborns receiving retroactive eligibility are subject to timely filing requirements. If retroactive eligibility delays the claim submission, a dispute may be needed.
- For prenatal or delivery services, the last menstrual period date is required on claims. Participating providers may estimate the last menstrual period date based on the gestational age of the child at birth.
- Claims indicating the provided services were the result of an injury will be considered as a case of possible subrogation. Any third-party liability will be determined. TrueCare will pay the provider for all covered services. Then, we will pursue recovery from any third parties involved.
- When processing a claim for emergency health care services, TrueCare considers, at the time that the claim is submitted, at minimum, the age of the patient, the time and day of the week the patient presented for services, the severity and nature of the presenting symptoms, the patient's initial and final diagnosis and any other criteria prescribed by DOM, including criteria specific to patients under 18 years of age.

Electronic Claim Submission

Clearinghouse

TrueCare prefers electronic claim submission. TrueCare currently accepts electronic claims through Availity. Please contact Availity to begin electronic claims submission.

- Phone: 1-800-282-4548
- Website: availity.com

Please provide the clearinghouse with the TrueCare payer ID number: MSMCDCS1.

Submitting Claims Through the Provider Portal

Providers may submit claims through the secure, online **Provider Portal**. Online submission saves you money by eliminating the costs associated with printing and mailing paper claims. Using the portal for claims submission also:

- Improves accuracy by decreasing the opportunities for transcription errors and missing or incorrect data.
- Allows tracking and monitoring of claims through a convenient online search tool.

Who Can Submit Claims Via the Portal?

TrueCare's traditional providers, community partners and delegates, and health homes all may submit claims through the **Provider Portal**.

What Types of Claims Can Be Submitted?

- Professional medical office claims
- Institutional claims
- Behavioral health claims

Submitting Claim Attachments on the Provider Portal

TrueCare providers may submit claims attachments on the **Provider Portal** to make processing the claim faster and easier. Supporting documentation can be uploaded on the Claim Information and Attachments page, under the Claims section of the left-hand menu on the portal. Attachment size is limited to 100 MB. If a file exceeds the upload limit, batch into smaller numbered files for uploading.

To upload documentation, do the following:

- If you have the claim number, search for the claim. After locating the claim, click View Detail, and then upload the documentation using the Document Upload tab.
- If you do not have the claim number, search for the member record. After searching for the member, enter the correct date of service for the claim you have submitted. Select the appropriate reason for submitting documentation and then upload your attachments.

Enter your contact information before submitting your attachments.

File Format

TrueCare accepts electronic claims in the 837 ANSI ASC X12N (005010X ERRATA version) file format for professional and hospital claims.

5010 Transactions

In 2009, the U.S. Department of Health and Human Services released a final rule that updated standards for electronic health care and pharmacy transactions. This was in preparation to implement ICD-10 CM codes in 2015. The new standard is the HIPAA 5010 format. All trading partners and payers should be 5010 compliant.

- 837 Health Care Claim/Encounter
- 276/277 Health Care Claim Status Request and Response
- 835 Health Care Claim Payments/Advice
- 270/271 Health Care Eligibility Benefit Inquiry and Response
- 278 Health Care Services Review (Prior Authorization Requests)
- 834 Benefit Enrollment and Maintenance
- 820 Group Premium Payment for Insurance Products
- NCPDP Version D.0

Please include the full physical address for billing 5010 transactions. P.O. boxes are no longer accepted for the billing address. However, a P.O. box or lock box can be used for the pay-to address (Loop 2010AB).

National Provider Identifier and Tax Identification Numbers

Your NPI and TIN are required on all claims. Claims submitted without these numbers will be rejected. Please contact your EDI vendor to find out where to use the appropriate identifying numbers on the forms you are submitting through the clearinghouse.

Please note: NPI and TIN is required except for atypical providers. Atypical providers are required to submit Medicaid ID.

On paper claims, the NPI number should be placed in the following box(es) based on form type:

- CMS 1500: Box 24J for the rendering provider's NPI and (if applicable) Box 33A for the group NPI
- UB04: Box 56
- ADA: Box 54 for the treating provider's NPI and (if applicable) Box 49 for the group NPI

Location of Provider Information on Professional Claims

On 837P professional claims (005010X222A1), the provider NPI should be in the following location:

- Medicaid: 2010AA Loop – Billing provider name
- Medicare: 2310B Loop – Rendering provider name
- 2010AA Loop – Billing provider name
  - Identification Code Qualifier – NM108 = XX
  - Identification Code – NM109 = Billing provider NPI

- 2010BB Loop – Ref – Billing Provider Secondary Identification (required for **atypical providers** when an NPI is not assigned)
  - Reference Identification Qualifier – REF01 = G2
  - Billing Provider Secondary Identifier – REF02 = Mississippi DOM provider numbers
- 2310B Loop – Rendering provider name
  - Identification Code Qualifier – NM108 = XX
  - Identification Code – NM109 = Rendering provider NPI

The billing provider TIN must be submitted as the secondary provider identifier using a REF segment, which is either the Employer Identification Number (EIN) for organizations or the SSN for individuals, see below:

- Reference Identification Qualifier – REF01 = EI (for EIN) or SY (for SSN)
- Reference Identification – REF02 = Billing provider TIN or SSN

Location of Provider Information on Institutional Claims

On 837I institutional claims (005010223A2), the billing provider NPI should be in the following location:

- 2010AA Loop – Billing provider name
  - Identification Code Qualifier – NM108 = XX
  - Identification Code – NM109 = Billing provider NPI
- 2010BB Loop – Ref – Billing Provider Secondary Identification (required for **atypical providers** when an NPI is not assigned)
  - Reference Identification Qualifier – REF01 = G2
  - Billing Provider Secondary Identifier – REF02 = Mississippi DOM provider numbers

The billing provider TIN must be submitted as the secondary provider identifier using a REF segment, which is either the EIN for organizations or the SSN for individuals, see below:

- Reference Identification Qualifier – REF01 = EI (for EIN) or SY (for SSN)
- Reference Identification – REF02 = Billing provider TIN or SSN

On all electronic claims, the number should go on:

- 2010BA Loop – Subscriber name
- NM109 = Member ID number

On paper claims, the NPI number should be placed in the following boxes based on form type:

- CMS 1500: Box 24J for the rendering provider's NPI 24J and (if applicable) Box 33A for the group NPI
- UB04: Box 56

- ADA: Box 54 for the treating provider's NPI and (if applicable) Box 49 for the group NPI

Corrected Claims

We will not pay a claim with incomplete, incorrect, or unclean information. If this happens, providers have 180 calendar days from the date of service or discharge or 90 days from the claim denial date when submitted timely to submit a corrected claim. Corrected claims should not be submitted through appeal.

Correcting Electronic HCFA 1500 Claims

EDI 837P data should be sent in the 2300 Loop, segment CLM05 (with value of 7) along with an additional loop in the 2300 loop, segment REF*F8* with the most recent claim number for which the corrected claim is being submitted.

Correcting Electronic UB-04 Claims

EDI 837I data should be sent in the 2300 Loop, segment CLM05 (with value of 7) along with an additional loop in the 2300 loop, segment REF *F8* with the most recent claim number for which the corrected claim is being submitted.

Note: When billing corrected claims, providers must use the **most recent claim number** in the original claim ID (segment REF*F8*) or the claim will be rejected.

Paper Claims

For the most efficient processing of your claims, TrueCare recommends you submit all claims electronically.

Paper Claim Submission Guidelines

Paper claim forms are only encouraged for services that require clinical documentation or other forms to process. If you submit paper claims, please submit one of the following claim form types:

- CMS 1500
- AMA universal claim form also known as the National Standard Format (NSF)
- Standardized ADA J400 Dental Claim Form
- CMS 1450 (UB-04)

Paper claim submission must be done using the most current form version as designated by the CMS, National Uniform Claim Committee (NUCC), and the American Dental Association (ADA).

We cannot accept handwritten claims or SuperBills. Claims that have been modified must be submitted using a new claim form; correction made to a previously submitted claim using white-out or erasable ink, may not be processed.

Detailed instructions for completing each form type are available at the websites below:

- CMS 1500 Form Instructions: nucc.org
- UB-04 Form Instructions: cms.gov/Medicare/Billing/ElectronicBillingEDITrans/15_1450

Please note: On paper claims, the NPI number should be placed in the following box(es) based on form type:

- CMS 1500: Box 24J for the rendering provider's NPI and (if applicable) Box 33A for the group NPI
  - Three data elements are used for the standard NPI crosswalk to establish a one-to-one match:
    - Billing NPI
    - Billing taxonomy code
    - Billing provider service location zip code +4 on file in the Medicaid Management Information System (MMIS)
- UB04: Box 56
- ADA: Box 54 for the treating provider's NPI and (if applicable) Box 49 for the group NPI

Instructions for National Drug Code (NDC) on Paper Claims

All of the following information is required for each applicable code required on a claim:

- In the shaded area of 24A, enter the N4 qualifier (only the N4 qualifier is acceptable)
- 11-digit NDC (this excludes the N4 qualifier)
- A unit of measurement code – F2, GR, ML or UN (only acceptable codes)
- The metric decimal or unit quantity that follows the unit of measurement code
- Do not enter a space between the qualifier and the NDC or the qualifier and the quantity
- Do not enter hyphens or spaces with the NDC
- Use three spaces between the NDC number and the units on paper forms

Include the following on claims that require NDC:

- NDC and unit of measure: pill, milliliter (cc), international unit, or gram
- Quantity administered: the number of NDC units
- NDC unit price: detail charge divided by quantity administered
- HCPCS codes that will require NDCs on professional claims: submitted on the 837P format

Tips for Submitting Paper Claims

For the most efficient processing of your claims, TrueCare recommends you submit all claims electronically.

TrueCare uses an optical character recognition (OCR)/intelligent character recognition (ICR) system to capture claims information, which increases efficiency, improves accuracy and results in faster turnaround time.

To ensure optimal claims processing timelines:

- First consider submitting EDI claims. They are generally processed more quickly than paper claims.
- When submitting paper claims, we require the most current form version as designated by CMS, NUCC, and the ADA.
- Do not submit handwritten (including printed claims with any handwritten information) claims or SuperBills. They will not be accepted.
- Use only original claim forms; do not submit claims that have been photocopied or printed from a website.
- Ensure fonts are 10 to 14 point (capital letters preferred) with printing in black ink.
- Do not use liquid correction fluid, highlighters, stickers, labels, or rubber stamps.
- Ensure that printing is aligned correctly so that all data is contained within the corresponding boxes on the form.
- It is recommended that you submit your 12-digit TrueCare Provider ID, located in your welcome letter, in conjunction with your required NPI number.
- Submit NPI, Group NPI (if applicable), and federal TIN or physician SSN for all claim submissions.

Paper Claim Address

For your convenience, the **Provider Portal** is the fastest and most accurate way to submit claims, however paper claims can be mailed to TrueCare:

TrueCare
Attn: Claims Department
P.O. Box 1362
Dayton, OH 45401

Member Billing Policy

Providers may not bill members for any covered services. As an added benefit to our members, TrueCare doesn't charge any copayments. However, a provider may, upon accepting a patient as a Medicaid member, charge the member for non-covered services.

In order to charge the member for non-covered services, the provider must obtain written acknowledgement that the member is assuming financial responsibility prior to the service being rendered.

Providers may not charge members for services which TrueCare denied on the basis of lack of medical necessity or lack of compliance to contractual terms. Providers may not bill members for missed appointments. A member may not be billed for medically necessary emergency services.

Code Editing

TrueCare uses clinical editing software to help evaluate the accuracy of diagnosis and procedure codes on submitted claims to ensure claims are processed consistently, accurately, and efficiently.

TrueCare's code editing software finds any coding conflict or inconsistent information on claims. For example, a claim may contain a conflict between the patient's age or gender and diagnosis, such as a pregnancy diagnosis for a male patient. Our software resolves these conflicts or indicates a need for additional information from the provider.

TrueCare's code editing software helps evaluate the accuracy of the procedure code only, not the medical necessity of the procedure.

Explanation of Payment (EOP)

EOPs are statements of the status of your claims that have been submitted to TrueCare and entered into our system. EOPs are generated weekly. However, you may not receive an EOP each time they are generated, depending on your claim submission activity. Providers who receive electronic fund transfer (EFT) payments may elect to receive an electronic remittance advice (ERA) and can access it on the **Provider Portal**.

Information Included on EOPs

EOPs include paid and denied claims. Denied claims appear on the EOP with a HIPAA-compliant remark code indicating the reason the claim was denied. It is the provider's responsibility to resubmit claims with the correct or completed information needed for processing.

Coordination of Benefits (COB)

COB Information

TrueCare collects COB information for our members. This information helps us to ensure that we are paying claims appropriately.

While we try to maintain information as accurately as possible, we rely on numerous sources of information that are updated periodically, and some information may not always be fully reflected on the **Provider Portal**. Please ask TrueCare members for all health care insurance information at the time of service.

In general, we are required to comply with the federal regulations that Medicaid programs serve as the payer of last resort.

Searching Coordination of Benefits on the Provider Portal

Providers may search for COB on the **Provider Portal** by:

- Member number
- Medicaid number/MMIS number
- Member name and date of birth

Coordination of Benefit Overpayment

If a provider receives a payment from another carrier after receiving payment from TrueCare for the same items or services and it is determined the other carrier is primary, then this is considered an overpayment. Adjustments to the overpayment will be made on subsequent reimbursements to the provider, or the provider can issue refund checks to TrueCare for any overpayments. Providers should not refund any money received from a third party to a member.

Out-of-Network Claims

Non-participating providers may submit claims to TrueCare using the Non-Participating Provider Profile Form located on our Forms website at **MSTrueCare.com** > Providers > Tools & Resources > Forms, selecting Mississippi Medicaid from the drop-down menu. Please be sure to attach your W-9 form when you submit this online form. TrueCare is unable to process claims without this information.

Coding & Reimbursement Policies

TrueCare strives to be consistent with all Mississippi DOM, federal regulations, and national commercial standards regarding the acceptance, adjudication, and payment of claims. These standards apply to the code or code set(s) submitted and related clinical standards for claims received either as a paper copy or electronically. We apply HIPAA standards to all electronically received claims.

Accordingly, we accept only HIPAA-compliant code sets (HCPCS, CPT, ICD-10, and NDC). Specific contract language stipulating the receipt, processing and payment of specific codes and modifiers is honored, as would be any aspect of a provider contract.

In addition, CMS federal rules for Medicare and Medicaid coding standards are followed. Finally, generally accepted commercial health insurance rules regarding coding and reimbursement are also used when appropriate. TrueCare strives to follow the prevailing National Correct Coding Initiative (NCCI) edits as maintained by CMS.

To determine unit prices for a specific code or service, please refer to the listed links for details:

- Medicare: cms.gov
- Mississippi Medicaid: medicaid.ms.gov/providers/fee-schedules-and-rates/#

TrueCare uses coding industry standards, such as the American Medical Association (AMA) CPT manual, Correct Coding Initiative (CCI), and input from medical specialty societies to review multiple aspects of a claim for coding reasonableness, including, but not limited to:

- Bundling issues
- Diagnosis to procedure matching
- Gender and age appropriateness
- Maximum units of a code per day
- Currently valid CPT/HCPCS code or modifier usage

TrueCare seeks to apply fair and reasonable coding edits. We maintain a provider appeals function that will review, upon request, any claim that is denied based upon the use of a certain code, the relationship between two or more codes, unit counts, or the use of modifiers. This review will take into consideration all the previously mentioned DOM, Medicare, CCI, and national commercial standards when considering the appeal.

In order to ensure that all relevant information is considered, appropriate clinical information should be supplied with the claim appeal. This clinical information allows the TrueCare appeals team to consider why the code set(s) and modifier(s) being submitted are differing from the usual standards inherent in our edit logic. The clinical information may provide evidence to override the edit logic when the clinical information demonstrates a reasonable exception to the norm.

Any specific claim is subject to current TrueCare claim logic and other established coding benchmarks. Any consideration of a provider's claim payment concern regarding clinical edit logic will be based upon review of generally accepted coding standards and the clinical information particular to the specific claim in question.

TrueCare maintains reimbursement policies. To view medical, reimbursement, administrative, and pharmacy policies, visit **MSTrueCare.com** > Providers > Tools & Resources > Provider Policies.

CONTRACTING AND CREDENTIALING

Provider Contracting

Providers must enroll in the MississippiCAN and/or CHIP program(s) and choose "TrueCare" as a coordinated care organization (CCO) to add a CCO affiliation by submitting an application and the required supporting documentation through the Mississippi Division of Medicaid (DOM) portal at portal.ms-medicaid-mesa.com/MS/Provider. If you need assistance, please contact a Provider Enrollment Specialist toll-free at 1-800-884-3222.

To become a participating provider with TrueCare, providers may complete the New Health Partner Contract Form available at **MSTrueCare.com** > Providers > Tools & Resources > Forms, and should select Mississippi Medicaid from the drop-down menu, or call our Provider Services department at 1-833-230-2174.

After we receive the completed New Health Partner Contract Form, TrueCare coordinates with the state's credential verification organization (CVO) to confirm the credentialing status of the provider. Upon confirmation of a provider's approved credentialing status, we will send a TrueCare provider contract electronically for the provider to complete and submit.

Providers who submit a New Health Partner Contract Form **but** who are not yet enrolled as Mississippi Medicaid providers are referred to the Mississippi DOM to complete the enrollment and credentialing process.

For information on our contracting process, visit our **Become a Participating Provider** web page.

Credentialing/Recredentialing

To simplify the Medicaid, MississippiCAN, and CHIP enrollment process for TrueCare providers, and improve efficiencies by reducing administrative burden, the Mississippi DOM utilizes a CVO. The provider will either submit an electronic application and complete a Council of Affordable Quality Healthcare profile. DOM's fiscal agent and CVO will process the provider credentialing and recredentialing information to apply to fee-for-service, MississippiCAN, and CHIP delivery systems and create a credentialing portfolio for review by the credentialing committee. If credentialing is successful, the CVO sends a file with all the provider's enrollment data to the fiscal agent to update the Medicaid Management Information System (MMIS) to include the necessary provider information. The fiscal agent will send the provider a welcome letter and notify TrueCare.

TrueCare will not conduct its own credentialing and will accept the state-contracted CVO's credentialing determination. TrueCare cannot appeal the CVO's credentialing decision or require providers to submit supplemental or additional information for purposes of conducting a

second credentialing process. TrueCare will not pay for claims for dates of service outside CVO credentialing approval dates.

TrueCare will include in our network only those providers who:

- Have been appropriately credentialed by the CVO,
- Maintain a current license, and
- Have appropriate locations to provide covered services to our members.

TrueCare will not include any providers in our network who:

- Have been excluded by the U.S. Department of Health and Human Services,
- Have been excluded by the Office of Inspector General,
- Are on Mississippi's list of excluded providers, or
- Have not been credentialed by the state/their CVO.

TrueCare monitors the exclusions list monthly and immediately terminates any provider found to be excluded. We notify any impacted members as per contractual requirements.

The DOM is responsible for credentialing/recredentialing all providers that participate in MississippiCAN and CHIP managed care programs.

TrueCare will process provider contract applications submitted through **MSTrueCare.com**. An automated email is sent to providers once their application is submitted via the **Provider Portal**. This email directs them to contact Provider Services to obtain application status updates. Provider Service Representatives can inform providers if their application is completed and they are showing as participating in the TrueCare network, or if their contract is still in process while referencing the state-specific time frames. Practitioners can also check the status of their application by visiting the TrueCare website, signing into the **Provider Portal**, and entering their application and National Provider Identifier (NPI) numbers.

Providers have the right to review information submitted from outside sources (i.e., malpractice insurance carriers and state licensing boards) to support their credentialing application upon request to the TrueCare Credentialing department. TrueCare keeps all submitted information locked and confidential.

COVERED SERVICES AND EXCLUSIONS

This section describes some of the services and exclusions to benefits that are provided to our TrueCare members. TrueCare requires all covered services to be medically necessary. Covered services may require prior authorization. To check whether a procedure code requires prior authorization, visit **MSTrueCare.com** > Providers > Tools & Resources > Procedure Code Lookup Tool.

In addition, for Medicaid children under age 21, TrueCare covers medically necessary services to correct or ameliorate physical and behavioral health disorders and defects or conditions identified during Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) screenings or preventive visits, regardless of whether the services are included under the State plan, but are otherwise allowed pursuant to 1905 (a) of the Social Security Act.

CHIP: Well-Baby and Well-Child Care Services

TrueCare provides CHIP Well-Baby and Well-Child Care services, including vision and hearing screenings, laboratory tests, and immunizations, according to the U.S. Preventive Services Task Force recommendations. Services are targeted at children and adolescents under the age of 19 who qualify for CHIP and include periodic health screenings and up-to-date immunizations following the Advisory Committee on Immunization Practices (ACIP) Immunization Schedule. Providers are responsible for following up with members who are not in compliance with Well-Baby and Well-Child Care services and immunization schedules.

TrueCare is responsible for ensuring timely immunizations and follow-up outreach to members, including home visits for non-compliant individuals. Primary care providers (PCPs) must deliver or coordinate these services for members under 19, reporting all encounters to TrueCare. TrueCare also tracks immunization compliance, conducts outreach, and ensures that at least 85% of enrolled members receive required screenings and 90% receive required immunizations. These targets will be monitored through annual audits and reporting.

Well-Child Visits:

- First 30 months (zero to 30 months): Children should have well-child visits as follows:
  - Six or more visits by 15 months, and two or more visits between 15-30 months.

- Child and Adolescent Well-Care Visits (three to 19 years): One or more comprehensive well-care visits with a PCP or obstetrician/gynecologist (OB/GYN) during the measurement year.

Immunizations:

- Childhood immunizations (completed by second birthday): Includes vaccinations (or series of) such as DTaP, PCV, IPV, HiB, Hep B, RV, Flu, LAIV, VZV, MMR, and Hep A.

- Adolescent immunizations (or series of) (completed by 13th birthday): Includes Meningococcal, Tdap, and HPV vaccines.

Lead Screening:

- Lead testing: Children should have a capillary or venous lead blood test by their second birthday, with missed tests completed by age six.

These guidelines ensure the comprehensive care of CHIP children and adolescents through well-child visits and immunizations.

Abortion, Sterilization, and Hysterectomy Procedures

TrueCare covers abortions in very limited circumstances. TrueCare also covers hysterectomies and sterilizations. Please review the information below for specific information. Providers are required to maintain documentation of all sterilizations, hysterectomies, and abortions, as consistent with requirements in 42 CFR 441.200 and 42 CFR 441.208 and 42 CFR 441.250 through 42 CFR 441.259. TrueCare will not accept documentation for informed consent completed or altered after the service was rendered.

Abortion

Abortion services are covered in the following circumstances without prior authorization:

- When the abortion is medically necessary to prevent the death of the mother.
- When the abortion is being sought to terminate a pregnancy resulting from an alleged act of rape or incest.
- When there is a fetal malformation that is incompatible with the baby being born alive.

Abortion or abortion-related services are not covered when performed for family planning purposes. TrueCare will cover treatment of medical complications resulting from elective abortions and treatments for spontaneous, incomplete, or threatened abortions and for ectopic pregnancies.

Providers are required to maintain sufficient documentation in the medical record that supports the medical necessity for the abortion for one of the reasons outlined in the current State Administrative Code. An Abortion Necessity Form* is available through the Mississippi Division of Medicaid (DOM).

Sterilization

Sterilization procedures are covered if the following requirements are met:

- The member is at least 21 years of age at the time of the informed consent.

- The member is mentally competent and not institutionalized in a correctional facility, mental hospital, or other rehabilitative facility.
- Sterilization is the result of a voluntary request for services by a member legally capable of consenting to such a procedure.
- The member is given a thorough explanation of the procedure. In instances where the individual is blind, deaf, or otherwise handicapped or unable to understand the language of the consent, an interpreter must be provided for interpretation.
- The procedure is scheduled at least 30 calendar days before, but not more than 180 calendar days after, the consent is signed, except in the case of premature delivery or emergency abdominal surgery. A member may consent to be sterilized at the time of premature delivery or emergency abdominal surgery, if at least 72 hours have passed since informed consent for sterilization was signed. In the case of premature delivery, the informed consent must have been given at least 30 calendar days before the expected date of delivery (the expected date of delivery must be provided on the consent form).
- Sterilization Consent Form* must be completed and attached to the claim.

These requirements are applicable to all sterilizations when the primary intent of the sterilizing procedure is fertility control.

Hysterectomies

For hysterectomies, the following additional requirements must also be met:

- A hysterectomy is only rendered for medical necessity and not for the purpose of family planning, sterilization, hygiene, or mental retardation.
- Prior to the hysterectomy, the member must be informed orally and in writing that she will be permanently incapable of reproducing.
- The hysterectomy is not being performed for the purpose of cancer prophylaxis.
- Informed consent is not obtained while the individual to be sterilized is in labor or childbirth, seeking to obtain or obtaining an abortion, or under the influence of alcohol or other substances that affect the individual's state of awareness.
- Hysterectomy Acknowledgement Form* must be completed and attached to the claim.

*Forms can be found on the Mississippi DOM website under Useful Tools > Forms > Provider Forms or at medicaid.ms.gov/resources/forms/.

Annual Wellness Exams for Adults

All adults are eligible to receive a wellness exam from a PCP at the earliest opportunity upon enrollment with TrueCare. Refer to the Access and Availability tables for more information. Members may receive an annual wellness exam consisting of the following:

- Routine physical exam by the PCP or OB/GYN.
- Screening which consists of the following, as appropriate:

- Abdominal aortic aneurysm (AAA) ultrasound
- Alcohol misuse
- Blood pressure for adults
- Bone mass measurements
- Cardiovascular disease
- Cholesterol for adults
- Depression for adults
- Diabetes
- Hepatitis B
- Human immunodeficiency virus (HIV)
- Obesity
- Colorectal
- Electrocardiogram (ECG or EKG)
- Lung
- Mammogram
- Pap smear
- Prostate
- Sexually transmitted infections (STIs)
- Tobacco/smoking
- Vision exam for members age 21 and over

Please visit our website at **MSTrueCare.com** > Providers > Education > Patient Care> Health Care Links for up-to-date clinical and preventive care guidelines.

Behavioral Health

Behavioral Health Overview

Behavioral health is critical to each member's overall health, and TrueCare provides behavioral health benefits to our Medicaid members. TrueCare ensures that all members have access to behavioral health resources and that behavioral health is integrated across all interventions. Behavioral health providers (BHPs) are expected to assist members in accessing emergent, urgent, and routine behavioral services as expeditiously as the member's condition requires.

Members may self-refer to behavioral health services within our provider network without a referral from their PCP.

Screening & Evaluation

TrueCare requires that PCPs and specialists have screening and evaluation procedures for the detection and treatment of, or referral for, any known or suspected behavioral health problems and disorders. PCPs and specialists may provide clinically appropriate behavioral health services within the scope of their practice.

TrueCare provides training to network PCPs on how to screen for and identify behavioral health disorders, the referral process for behavioral health services and clinical coordination requirements for these services. Training includes coordination, quality of care, and new models of behavioral health interventions. Training may be found at **MSTrueCare.com** > Providers > Education > Patient Care, then going to the Behavioral Health page.

The DSM-5 diagnosis must be documented in the member's medical record.

Care Management

TrueCare members have access to specialty behavioral health care managers for assistance in obtaining both routine and higher complexity health care services.

PCPs can contact TrueCare for assistance in facilitating specialty behavioral health services for our members. We can assist members and PCPs with locating appropriate participating providers and with making appointments for members in need of therapy and/or psychiatric services.

Coordination of Care

TrueCare requires that BHPs refer members with known or suspected and untreated physical health problems or disorders to their PCP for examination and treatment, with the member's or the member's legal guardian's consent. BHPs may only provide physical health care services if they are licensed to do so.

TrueCare encourages communication and care coordination between PCPs and BHPs to achieve optimal health for our members. Communication is necessary to ensure continuity of care and member safety.

TrueCare encourages BHPs to send initial and at least quarterly status reports to PCPs, with the member's or the member's legal guardian's consent.

TrueCare requires every provider to ask and encourage members to sign a consent permitting release of substance use disorder information to TrueCare and to the PCP or BHP. The consent form can be found on **MSTrueCare.com** > Member Overview > Tools & Resources > Forms.

42 CFR Part 2 requires providers to obtain written consent from the member before releasing information related to substance use disorder services. This type of release of information also requires the provider to include a "Prohibition on Redisclosure" statement. TrueCare contractually requires that physical and BHPs document and reciprocally share the following information for each member:

- Primary and secondary diagnoses
- Findings from assessments
- Medication prescribed
- Psychotherapy prescribed
- Any other relevant information

TrueCare will notify both the BHP and PCP within five days when a member engaged in Care Management has an inpatient behavioral health admission or receives emergency treatment for all behavioral health conditions.

TrueCare facilitates coordination of care between BHPs and PCPs. TrueCare assures that behavioral health services are integrated with physical health care services and that behavioral health services are part of the treatment continuum of care. TrueCare has developed protocols:

- To address the needs of members in an integrated way, with attention to the physical health and chronic disease contributions to behavioral health.
- For providers to provide a written plan and evidence of ongoing increased communication between the PCP, the BHP, and TrueCare.
- To coordinate management of utilization of behavioral health care services with Medicaid Rehabilitation Option (MRO) and 1915(i) services and services for physical health.

Continuation of Treatment

TrueCare requires that all members receiving inpatient behavioral health services are scheduled for outpatient follow-up and/or continuing treatment prior to discharge. The outpatient treatment must occur within seven days after the date of discharge. If a member misses an outpatient follow-up appointment or continuing treatment, TrueCare requires the health provider to notify TrueCare through the **Provider Portal** and the care manager will contact the member within three business days of notification of the missed appointment to reschedule.

Provider Innovation Collaborative

BHPs have access to our unique Provider Innovation Collaborative (PIC). Regardless of a provider's size or location, the PIC partners with providers to develop local solutions and connects providers with a hub of resources, training, and technical assistance, which enables them to operate as fully accountable, quality-driven, innovative care partners who can adopt and scale evidence-based practices and participate in value-based payment programs.

The PIC is a formal gathering (virtual, in person, or combination) of providers and stakeholders where firsthand experience with service delivery, needs, gaps, successes, and lessons learned are shared in a collaborative forum. The PIC identifies areas for resource development, enhancements to current processes, and potential solutions to be developed. In addition to identifying needs for program, resource, and training development, this group also serves as a pilot group for testing, feedback, quality improvement, etc. to fine tune and support rollout of innovations to the broader provider community. The PIC aligns internal operational and clinical teams across our organization to provide new and existing resources through a framework of comprehensive provider tools and supports.

TrueCare Life Services

Starting July 2026, TrueCare Life Services provides in-person assistance in charting a pathway to full-time employment. Life Coaches provide coaching and skills training to help members complete their General Educational Development (GED) certificate, develop skills required for employment, draft a professional resume, and find employment opportunities that suit their skills and training. Members can reach out to Member Services at 1-833-230-2050 for more information.

Covered Services

Benefit Grid

All services provided must comply with medical necessity standards.

Benefits	Details
Ambulance and Air Ambulance	• Transportation for emergencies by ambulance or an air ambulance is covered. • Ambulance services to a doctor's office or clinic are not covered. It could be covered in certain cases. • Non-emergency ground and air transport requires prior authorization (PA).
Certified Nurse Midwife (CNM)	Nurses who help members with pregnancy, labor, and birth. Find a CNM in the **findadoctor.MSTrueCare.com** provider directory. Members can also ask their Care Manager or call Member Services.
Certified Nurse Practitioner (CNP)	Nurses who are trained in some of the medical care that doctors provide. Find a CNP in the **findadoctor.MSTrueCare.com** provider directory. Members can also ask their Care Manager or call Member Services.
Chiropractic Services	Involves adjustments (manipulations) to the spine or other parts of the body. Limit is $700 per fiscal year (July 1 - June 30) per beneficiary.
Dental	The following types of dental benefits are covered for members: • Preventive and diagnostic: full exams, routine cleanings, and x-rays • Basic: fillings and gum care • Major: full and partial dentures, root canals, and tooth removal • Urgent: dental care to treat pain, swelling, or an infection • Orthodontia (age 20 and under): treatment for tooth alignment (lifetime limits apply) MississippiCAN members get the following extra dental benefits: • Members under the age of 21: – Four extra cavity applications, in addition to fluoride benefits – Over age 12, tobacco or substance use counseling two sessions per calendar year

Benefits	Details
	• Members aged 21 and over: – One comprehensive oral evaluation per 180 days – One periodic oral evaluation per 180 days – One dental cleaning per 180 days – One fluoride varnish treatment for high-risk caries medical conditions – Tobacco or substance use counseling (two sessions per calendar year) – $300 that can be used toward services such as fillings, deep cleaning, or dentures TrueCare provides extra care for pregnant members, including: • One extra dental exam and cleaning (two exams each year are standard) • One extra comprehensive oral evaluation • Four quadrants of scaling Members may also earn MyKids or MyHealth rewards for routine dental exams.
Diagnostic Services	Lab work, x-rays, or tests ordered by a doctor. They help the doctor learn more about a specific condition. PA needed for: • Some bloodwork/lab testing • Scans (computed tomography [CT], magnetic resonance imaging [MRI], positron emission tomography [PET])
Durable Medical Equipment (DME) and Supplies	Medical equipment and supplies that can be used more than once for health services. These are covered: • Diabetic supplies • Enteral/parenteral nutrition and supplies • Incontinence supplies (ages three and older, six units of garments per day) • Orthotics/prosthetics (orthotics may not be replaced for 12 months from the date of purchase. Prosthetics may not be replaced for five years from the date of purchase) • Oxygen and supplies • Wheelchairs covered for those ages two and older – Those ages 20 and under get one wheelchair per two-year period – Those ages 21 and older gets one wheelchair per five-year period • Wound care The following services always need a PA: • Wheelchairs and some associated accessories • Insulin infusion device

Benefits	Details
	• Continuous glucose monitors • Prosthetic and orthotic devices • Patient transfer systems/Hoyer lifts • Phototherapy beds (Bili beds) • Power wheelchair repairs • Spinal cord stimulators • Oral nutrition (for medical purposes) and enteral nutritional therapy • Rental/lease items like: – Continuous positive airway pressure/bilevel positive airway pressure (CPAP/BiPAP) – Noninvasive positive pressure ventilation (NPPV) machines – Apnea monitors – Ventilators – Hospital beds – Specialty mattresses – High frequency chest wall oscillators – Cough assist/stimulating device – Pneumatic compression devices – Infusion pumps – Cochlear implants including most replacements – Wound vacs – Custom equipment – Repairs and/or replacements
Eye Care	Surgical evaluation for ptosis, congenital cataracts, exotropia, or vertical tropia between ages 12 and 21.
Family Planning Services and Supplies	• Birth control • Family planning exam • Sterilization (male and female) • Infertility diagnostic services (PA needed) • Family planning services (available from any provider, both in and out of the TrueCare network)
Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC)	Special offices to help people who live in rural or urban areas. Covered care includes: • Office visits with PCP • Specialist services • Physical therapy • Speech pathology • Audiology services • Podiatry • Mental health services Find an FQHC or RHC in the **findadoctor.MSTrueCare.com** provider directory. Members can also ask their Care Manager or call Member Services.

Benefits	Details
Hearing Services	Hearing exams are covered at no cost to you. Hearing aids and related items are covered for those under the age of 21. A PA is needed for hearing aid repairs.
Hospice Services	Inpatient hospice services require PA. Hospice is care for terminally ill patients. Hospice care is covered at no cost.
Inpatient Hospital Services	These services are medical procedures or tests done in a hospital or medical center. They usually need an overnight stay. All inpatient hospital services need a PA.
Maternity Care	Prenatal and postpartum care, including at-risk pregnancy services and gynecological services. A member may self-refer to any in-network women's health specialist. Or they may see their PCP. • Nurse midwife services • Prenatal and postnatal doctor visits • Lamaze • Parent education • Breastfeeding classes
Outpatient Services (Facility and Professional)	These services are medical procedures or tests. They are done in a medical center without an overnight stay. Some surgeries and procedures may need a PA. These are examples of covered outpatient services, but not limited to: • Blood services • Chemotherapy/radiation therapy • Dialysis • Emergency/urgent care services • Imaging (CT/PET/MRI) • Infusion therapy • Observation services • Outpatient hospital diagnostic procedures, labs, and tests • Outpatient hospital surgery and ambulatory surgical center (ASC) • X-rays and diagnostic imaging For additional information on coverage limitations, see coverage section below.
Out-of-Network Providers/American Indian/Alaskan Native Providers	Providers that have not signed a contract to give services to our members. PA is needed for any out-of-network providers or services, with the exception of American Indian/Alaskan Native members. Find providers in the **findadoctor.MSTrueCare.com** provider directory. Members can also ask their Care Manager or call Member Services.
Pain Management Services	These services help improve the quality of life for those living with chronic pain. These are covered: • Epidurals

Benefits	Details
	• Facets medial nerve branch • Implanted pain pumps • Joint fusions • Sacroiliac joint injections • Spinal code stimulators (SCS) • Trigger point injections Need a PA for: • Epidural steroid injections • Trigger point injections • Implantable pain pump • Implantable spinal cord stimulator • Most sacroiliac joint procedures • Sacroiliac joint fusion • Most facet joint interventions
Pharmacist Services	We cover medically necessary visits with a pharmacist to manage medications, give immunizations, or provide other medication services.
Physical, Speech, and Occupational Therapy	Physical, occupational, and speech therapy are three related fields in rehabilitation. No restrictions on programs for ages 20 and under. PA may be needed for some programs.
Podiatry Services	Services for the feet. No limits for medical visits (non-hospital setting) for ages 20 and under. PA may be needed for those ages 21 and over.
Prescription Drugs	Pharmacy benefits are provided by Gainwell Technologies, the single Pharmacy Benefit Administrator (PBA) for all Mississippi Medicaid members. Many drugs are covered by Medicaid. Some drugs may require PA before they are covered. Please call Gainwell at 1-800-884-3222 for questions.
Provider Administered Drugs	We cover medically necessary drugs that are typically infused or injected by a provider in an office or other clinical settings. These drugs may need PA before a provider can administer one of these medications to a member. Please use the **Procedure Code Lookup Tool** or contact TrueCare at 1-833-230-2174 to verify which services may require authorization. Note: All other pharmacy benefits are provided by Gainwell, the single PBA for all Mississippi Medicaid members.
Residential Treatment	Provides therapy for substance use disorder, mental illness, or other behavioral issues. This is done in a health care facility. PA is needed for residential treatment.
Screening and Counseling for Obesity	Obesity/Body Mass Index (BMI) screening and dietary counseling are covered. Providers can provide care if medically necessary.
Specialists	Specialists are dermatologists, cardiologists, and other specialty providers.

Benefits	Details
	Find specialists in the **findadoctor.MSTrueCare.com** provider directory. Members can also ask their Care Manager or call Member Services. Out-of-network specialists need a PA.
Vaccines and Immunizations	Vaccines and immunizations needed for wellness services.

Benefit Limits

In general, most benefit limits for services and procedures follow state and federal guidelines. The benefit period for MississippiCAN commences each July 1 and ends June 30 of each year. The benefit period for CHIP commences each January 1 and ends December 31 of each year. Please check that the member has not already exhausted benefit limits before providing services by checking our **Provider Portal** or calling Provider Services at 1-833-230-2174.

Covered services may require prior authorization. Please visit **MSTrueCare.com** > Provider > Provider Resources > Prior Authorization for the most up-to-date list of services that require prior authorization. Prior authorization requirements for members enrolled with TrueCare are determined and enforced by TrueCare.

Services Not Covered by TrueCare

TrueCare will not pay for services or supplies received that are not covered by Medicaid:

- All services or supplies that are not medically necessary
- Paternity testing
- Services to find cause of death (autopsy) or services related to forensic studies
- Assisted suicide services, defined as services for the purpose of causing, or assisting to cause, the death of an individual

Services Not Covered by TrueCare Unless Medically Necessary

TrueCare follows regulations and will conduct a medical necessity review if needed.

TrueCare will not pay for the following services that are not covered by Medicaid unless determined medically necessary:

- Abortions except in the case of a reported rape, incest, or to save the life of the mother
- Biofeedback services
- Experimental services and procedures, including drugs and equipment, not covered by Medicaid and not in accordance with customary standards of practice
- Infertility services for males or females, including reversal of voluntary sterilizations
- Inpatient treatment to stop using drugs and/or alcohol (in-patient detoxification services in a general hospital are covered)
- Plastic or cosmetic surgery
- Services for the treatment of obesity

- Services determined by Medicare or another third-party payer
- Sexual or marriage counseling
- Voluntary sterilization if under 21 years of age or cannot legally consent to the procedure

Pediatric Dental and Vision

All TrueCare pediatric members have access to dental and vision benefits.

Pediatric dental provides coverage for most dental services from dental exams and preventive services to major/comprehensive services, and even medically necessary orthodontic services. These benefits are provided exclusively through our Dental Benefits Manager, Avesis. Their Member Services number is 1-844-282-2418.

Pediatric vision services are provided exclusively through our Vision Benefits Manager, EyeMed. Their Member Services number is 1-822-918-0861. The benefit covers eye exams (no cost), eyewear including glasses or contact lenses (when medically necessary), as well as other value-add services through relationship such as low vision exams/aids and discounts on a wide array of materials and services. For coverage to apply to the vision services, members must see an EyeMed provider.

MississippiCAN Vision Benefits

TrueCare also offers MississippiCAN members a $100 allowance to be used toward glasses or contact lenses per calendar year. This also can be used to upgrade standard benefits. Exams are covered as long as the member has an available office visit.

Extra Dental Benefits

TrueCare offers extra dental benefits as well. For MississippiCAN members, this includes:

- Rewards for routine dental visits for all ages
- Extra dental coverage for pregnant members
- Four units of caries medicament per year and tobacco/substance use counseling for members under the age of 21
- Extra fluoride varnish treatment and $300 allowance toward dental services for members 21 and over

Emergency Services

TrueCare provides reimbursement for medically necessary emergency services when rendered by a qualified provider, in accordance with the provider's contract with TrueCare or in accordance with the Mississippi DOM fee-for-service reimbursement rates for providers that do not have a contract with TrueCare, less any applicable percentage.

TrueCare reimburses for all medically necessary emergency services that are provided to stabilize the member. After a member's condition is stabilized, providers must notify TrueCare as soon as reasonably possible for TrueCare to issue any needed authorization.

TrueCare will not:

- Deny or inappropriately reduce reimbursement for a provider's provision of emergency care services for any evaluation, diagnostics, or treatment provided to a member who needs emergency medical assistance, or
- Reimburse the stated emergency services criteria contingent upon the member or provider providing any notification, either before or after receiving emergency services.

Post-Stabilization Services

Post-stabilization services are covered services related to an emergency medical vondition that are provided after a member is stabilized to maintain the stabilized condition or to improve or resolve the member's condition.

Participating Providers

Prior authorization is not required for coverage of post-stabilization services when these services are provided in an emergency department or for services in an observation setting by a participating provider. Please call Provider Services at 1-833-230-2174 for any questions related to post-stabilization services.

Non-Participating Providers

To request prior authorization for observation services as a non-participating provider or to request authorization for inpatient admission, please call Provider Services at 1-833-230-2174. When calling, follow the prompt for post-stabilization. During regular business hours, your call will be answered by our Utilization Management department. If calling after regular business hours, the call will be answered by the 24-Hour Nurse Advice Line. Post-Stabilization Care Services are defined by 42 CFR 438.11.

Accessing Specialists

Members can access specialists in the TrueCare network through our provider directory at **findadoctor.MSTrueCare.com**, or by calling Member Services at 1-833-230-2050. TrueCare doesn't require members to have prior authorization or a referral for any office visits or procedures done at a provider's office (PCP or specialty provider) in the TrueCare network. TrueCare makes its Member Handbook available on the **MSTrueCare.com** website and mails a free copy to members, upon request. The Member Handbook provides information on specialty services, including a description of covered services and referral/prior authorization requirements.

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Overview

The EPSDT benefit includes a comprehensive array of preventive, diagnostic, and treatment services for MississippiCAN infants, children, and adolescents under age 21. TrueCare has an on-demand overview of the EPSDT program available on our Provider Learning Management System, **HealthPlanResources.com**.

Under the EPSDT benefit, TrueCare covers all medically necessary services needed to correct or ameliorate defects, physical and mental illnesses, and conditions discovered through screening, regardless of whether the service is included in the Mississippi Medicaid State Plan, if the service is permitted under Section 1905(a) of the Social Security Act.

The EPSDT benefit is designed to ensure that children receive early detection and care so that health problems are averted or diagnosed and treated as early as possible. The goal of the EPSDT benefit is to ensure that individual children get the health care they need when they need it. The EPSDT benefit also covers medically necessary diagnostic services.

The program provides reimbursement for preventive health services, interperiodic visits, developmental screenings, brief emotional/behavioral assessments, hearing and vision screenings, and immunizations under the EPSDT benefit. In addition to regularly scheduled EPSDT screenings, interperiodic screenings are covered when a provider, caregiver, or member identifies a need for further evaluation of a child's health status outside of the standard schedule.

Exam Components

The exam is a comprehensive assessment and is composed of the following required screening components:

- A comprehensive health, psychosocial, and developmental history
- Documentation of vital signs
- An unclothed comprehensive physical examination (unclothed means to the extent necessary to conduct a full, age-appropriate examination)
- Assessment of growth and nutritional status, including BMI percentile documentation
- Assessment of immunization status and provision of appropriate immunizations. Use the Advisory Committee on Immunization Practices (ACIP) schedules
- Screening for vision, hearing, lead poisoning, and development, as per the American Academy of Pediatrics (AAP) guidance (blood lead test is required, per federal mandate)
    - Examples of approved developmental screening tools include, but are not limited to, the Ages and Stages Questionnaire (ASQ), Parents' Evaluation of Developmental Status (PEDS), and the Modified Checklist for Autism in Toddlers (M-CHAT)
- Laboratory testing where appropriate to age and exam findings, and in line with AAP guidance

- Oral health screening, preventive counseling, and referral to a dentist for ongoing dental care
- Screening for and if suspected, reporting of child abuse and neglect
- Anticipatory guidance (health education)
- Referrals/follow-ups where appropriate based on history and exam findings

Exam Frequency

TrueCare's recommended schedule for EPSDT exams is as follows:

- Newborn screening
- Three to five days
- One month
- Two months
- Four months
- Six months
- Nine months
- 12 months
- 15 months
- 18 months
- 24 months
- 30 months
- Beginning at age 3, EPSDT screenings must be performed yearly up to age 20

The AAP Bright Futures "Recommendations for Pediatric Health Care" Periodicity Schedule is the periodicity schedule used for EPSDT visits and services. The schedule is available at downloads.aap.org/AAP/PDF/periodicity_schedule.pdf.

PCPs receive a list of eligible TrueCare members at the beginning of each month who have chosen or been assigned to the PCP as of that date. The list also includes indicators for members who appear not to have had their initial EPSDT exam and/or who do not comply with the EPSDT periodicity schedule. Initial EPSDT exams are to be completed within 90 days of the initial effective date of membership for new enrollees. You can find this list on our **Provider Portal**. Providers are responsible for following up with the members who are not in compliance with EPSDT screening requirements.

Initial preventive health exams are to be completed within 24 hours of birth for all newborns. PCPs are required to contact members via phone/mail to encourage them to schedule and keep their preventive health appointment.

EPSDT Referrals for Further Diagnosis and Treatment

If the PCP is unable to provide all the components of the preventive health exam, or if screenings indicate a need for evaluation by a specialist, a referral must be made to another

participating provider within TrueCare's provider network in accordance with TrueCare's referral procedures. The member's medical record must indicate where the member was referred.

Documentation & Billing

In order to receive proper payment for EPSDT services, you must use the appropriate preventive medicine Current Procedural Terminology (CPT) codes, diagnosis codes, and EPSDT referral indicators. TrueCare requires the appropriate referral field indicators to be populated on EPSDT claims. EPSDT screenings also include brief behavioral and emotional assessments using standardized tools appropriate for the child's age. Claims missing this information, or submitted with invalid combinations of this information, may be rejected or denied.

Use 99381-99385 for a new patient and use 99391-99395 for an established patient.

Age	Preventive Visit Code	HIPAA Modifier
Birth – 11 months	99381 or 99391	EP
12 months – 4 years	99382 or 99392	EP
5 years – 11 years	99383 or 99393	EP
12 years – 17 years	99384 or 99394	EP
18 years – 20 years	99385 or 99395	EP

PCP Preventive Visit International Classification of Diseases (ICD)-10 Diagnosis Codes

Providers must use appropriate CPT codes (99381-99385 for new patients and 99391-99395 for established patients) and corresponding ICD-10 Z-does (e.g., Z100.121, Z100.129) when billing for EPSDT preventive visits.

ICD-10 Code	At this Age
Z00.100	0 – 7 days
Z00.111	8 – 28 days
Z00.121 or Z00.129	29 days through 14 years
Z00.121 or Z00.129 Z00.00 or Z00.01	15 years through 17 years
Z00.00 or Z00.01	18 years through 20 years
Z02 – Z02.89	0 through 20 years

Screening	Timing	CPT Code	HIPAA Modifier	ICD-10 Diagnosis Code
Developmental Screen	9, 18, and 30 months	96110	EP	Z00.121 or Z00.129 Z02 – Z02.89
Autism Screening	18 and 24 months	96110	EP, Underage (UA) or EP, UA, Child/Adolescent Program (HA)	Z00.121 or Z00.129 Z02 – Z02.89
Brief Emotional/Behavioral Assessment	Annually ages 12 years – 20 years	96127	EP	Z00.121 or Z00.129 Z00.00 or Z00.01 Z02 – Z02.89
Alcohol, Tobacco, or Drug Use Assessment	Annually ages 11 years – 20 years	96160	EP	Z00.121 or Z00.129 Z00.00 or Z00.01 Z02 – Z02.89
Maternal Depression Screening	By one month 2 months 4 months 6 months	96161	EP	Z00.121 or Z00.129 Z00.00 or Z00.01 Z02 – Z02.89
Blood Lead Level Screening	12 months 24 months 36-72 months*	36415 or 36416		Z13.88
		83655	EP, 90 or EP, 91	

* If no record of previous blood lead level test

Referrals	
Box 24 of claim	
NU	No follow-up needed.
AV	Available, Not Used: Patient refused referral.
S2	Under Treatment: Patient is currently under treatment for health problem and has a return appointment.
ST	New Services Requested: Referral to another provider for diagnostic or corrective treatment/scheduled.

For more information about the EPSDT program, visit the EPDST website at Medicaid.gov > Medicaid > Benefits > Early Periodic Screening, Diagnostic and Treatment or the MS Administrative Code.

Immunization

Immunizations are an important part of preventive care for children and should be administered during EPSDT exams as needed.

Immunizations, flu vaccines, and pneumococcal vaccines can be obtained at the retail pharmacy for those members ages 19 and older. Some vaccines require a prescription. TrueCare pays for the administration of the vaccine only when billed with an appropriate immunization and administration CPT code.

TrueCare follows the most current immunization schedules as recommended by the ACIP. All members less than 21 years of age shall be provided with all vaccines and immunizations in accordance with the ACIP guidelines. Providers must administer immunizations obtained through the Vaccines for Children (VFC) program for all members 18 years of age and younger. TrueCare will not reimburse costs for vaccines obtained outside the VFC program when provided to children under age 19. Immunizations, flu vaccines, and pneumococcal vaccines can be obtained at the retail pharmacy for those members ages 19 and older. Some vaccines require a prescription. TrueCare pays for the administration of the vaccine only when billed with an appropriate immunization and administration CPT code.

Immunization Codes

Please bill TrueCare with the appropriate CPT and ICD-10 vaccination codes for the immunization(s) being administered and the appropriate administration code. Please refer to the code tables located on the Centers for Medicare and Medicaid Services (CMS) website at cms.gov/files/document/fy-2025-icd-10-cm-coding-guidelines.pdf.

To view the state's most recent list of VFC-covered vaccines, please refer to the Mississippi Division of Medicaid (DOM) "Administrative Code, Title 23: Medicaid, Part 224, Immunizations" Rule 1.4 – "Vaccines for Beneficiaries Nineteen (19) Years of Age and Older." Please watch for updates to this information through the DOM website. Billing with the vaccine codes along with the administration codes will help ensure that you are reimbursed properly for administration of the correct vaccine.

Vaccine Schedule

TrueCare endorses the same recommended childhood immunization schedule that is approved by the ACIP. The recommended schedule is updated annually, and the most current updates are located on cdc.gov/acip/index.html.

Vaccines for Children Program

The federal VFC program makes designated vaccines available at no cost to VFC-participating health care providers to administer to children through the age of 18 who are:

- Eligible for Medicaid
- Uninsured
- Underinsured
- American Indian/Alaskan native

TrueCare encourages providers to participate with the VFC program. Vaccines administered to children through the age of 18 must be obtained through the VFC program, which supplies vaccines to program participating providers at no cost. TrueCare will not reimburse costs for vaccines obtained outside the VFC program. TrueCare will pay for the administration of the vaccine only.

This program is administered by the Mississippi State Department of Health.

For more information about the Mississippi VFC program and how to enroll and obtain vaccines, please contact the Mississippi State Department of Health and fill out an enrollment form.

Website: Vaccines for Children Program (VFC)

Statewide Web-Based Immunization Registry

Participating providers must report all immunizations to the statewide web-based immunization registry, the Mississippi Immunization Information Exchange (MIIX), found at miixhealthyms.org.

The registry consolidates immunizations from multiple providers into one central record and provides reliable immunization history that is electronically accessible from multiple health care practice sites. The system is designed to save time and money, reduce paperwork and provide quick and efficient tracking of immunizations. It also assures that all people in Mississippi receive appropriate, timely immunizations to lead healthy, disease-free lives.

Care Goals for Mississippi Kids

Ensuring Mississippi kids are receiving the right early care supports a healthy base for them to grow. TrueCare will work with parents to help foster an understanding of the importance of kids attending these early visits.

The state has set the following targets for the populations below:

MississippiCAN Members – EPSDT Screening Rates	
Measure	Target Rates
Screenings	Eighty-five percent (85%) of enrolled members under age one (1) had required screenings; Seventy-five percent (75%) of

MississippiCAN Members – EPSDT Screening Rates	
Measure	Target Rates
	enrolled members between the ages of one (1) and twenty-one (21) had required screenings.
Immunizations	Eighty-five percent (85%) of enrolled members under age one (1) had required immunizations; Seventy-five percent (75%) of enrolled members between the ages of one (1) and twenty-one (21) had required immunizations.

CHIP Members – Well-Care Rates	
Measure	Target Rates
Screenings	Eighty-five percent (85%) of enrolled members had required screenings
Immunizations	Ninety percent (90%) of enrolled members had required immunizations

PHARMACY

Retail Pharmacy Coverage

Retail prescription drug coverage for MississippiCAN and CHIP members is provided through the state's Pharmacy Benefit Administrator, Gainwell Technologies. Refer to the Gainwell Preferred Drug List (PDL) located at medicaid.ms.gov/preferred-drug-list/ to determine which drugs need prior authorization. Providers may submit a prior authorization directly to Gainwell via:

Portal: portal.ms-medicaid-mesa.com/MS/Provider

Phone: 1-833-660-2402, Monday through Friday, 8 a.m. to 6 p.m., Central Time (CT)

Fax: 1-866-644-6147

Prior Authorization

Members may receive a minimum of a three-day emergency supply for drugs requiring prior authorization until the authorization is completed.

Provider-Administered Drug Coverage

Provider-administered drugs are covered by TrueCare instead of Gainwell. TrueCare covers all medically necessary Medicaid-covered drugs administered in a provider setting, such as a physician office, hospital outpatient department, clinic, dialysis, or infusion center. Some of these drugs require prior authorization.

TrueCare has an online search tool that contains information about prior authorization requirements and clinical coverage criteria for provider-administered drugs. This information may be found online at **MSTrueCare.com** > Providers > Tools and Resources > Procedure Code Lookup Tool.

Provider-administered drug prior authorization requests are reviewed by TrueCare, and determinations are made within 72 hours of receipt. If your request is urgent, please mark it as “expedited,” and a decision will be rendered within 24 hours of receipt. Please note that requests for prior authorization without clinical documentation submission to support review may experience a higher rate of denial due to incomplete policy requirements. Provider-administered drug prior authorization requests can be submitted via:

Portal (preferred): **Provider Portal**

Fax: 1-888-399-0271

Phone: If you experience technical difficulties or require assistance with prior authorization, you may call 1-833-230-2174 and follow the prompts for Provider > Prior Authorization > Pharmacy for help.

Specialty Pharmacy Program

To improve medication compliance and disease state and side effect management, our preferred specialty provider is Accredo. Accredo may provide certain specialty medications covered under the medical benefit directly to the member or the prescriber or servicing provider and coordinate nursing care, if required. Please visit our Pharmacy website at **MSTrueCare.com** > Providers > Education > Patient Care > Pharmacy, selecting the appropriate plan from the drop-down menu, to see more details about the Specialty Pharmacy program.

Extra Over-the-Counter (OTC) Benefit

TrueCare MississippiCAN members also receive an allowance of $10 per member per month to use toward OTC items, such as pain relievers, diapers, cold/cough medicine, and more. Members can select items through the OTC catalog and order for items to be shipped to them.

Copayment/Coinsurance Requirements

To ensure our members have access to the care they need, there are no copayments, deductibles, or cost-sharing for any service covered by TrueCare for MississippiCAN or CHIP members. There are no limitations to this benefit.

Medical Supplies/Durable Medical Equipment (DME)

Coverage of DME through the pharmacy benefit is limited to certain diabetic supplies and certain caloric agents as detailed on the Preferred Diabetic Supply List and the Preferred Drug List. More information about billing of preferred diabetic supplies under the pharmacy benefit can be found at medicaid.ms.gov/pharmacy.

Lock-In Program

TrueCare Beneficiary Health Management Program (BHMP)

TrueCare uses a data-driven approach to identify beneficiaries with patterns of utilization that may demonstrate a pattern of receiving services at a frequency or in an amount that exceeds medical necessity. This pattern would be best addressed through our program. Factors that may identify a beneficiary for this program include use of multiple pharmacies, multiple controlled substances, multiple visits to the emergency department, or a high volume of prescriptions. The BHMP requires beneficiaries to obtain certain services from a designated pharmacy and/or provider(s) for 12 months.

Criteria

We identify and enroll members for the BHMP when:

1. The beneficiary has one or more of the following:
    a) Receives services from four or more prescribers and/or four or more pharmacies relative to controlled substances in the past six months, including emergency department visits
    b) A history of substance use disorder within the past 12 months
    c) A diagnosis of drug abuse or narcotic poisoning within the past 12 months
    d) Utilizes cash payments to purchase controlled substances
2. Any written prescription is stolen, forged, or altered
3. The Division of Medicaid or TrueCare has received a proven report of fraud, waste, and/or abuse from one or more of the following:
    a) Prescriber
    b) Pharmacy
    c) Any medical provider
    d) Law enforcement entity

Exclusions

a) Beneficiaries with a diagnosis on file for cancer, sickle cell disease, and/or burns within the previous 12 months
b) Beneficiaries in hospice or receiving palliative care

GRIEVANCES & APPEALS

Member Grievances

A grievance is an expression of dissatisfaction, regardless of whether identified by the member as a “grievance,” received by any employee of the contractor orally or in writing about any matter or aspect of the contractor or its operation, other than a contractor Adverse Benefit Determination as defined in the contract. Grievances may include but are not limited to the quality of care or services provided, aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee’s rights regardless of whether remedial action is requested. Grievance includes an enrollee’s right to dispute an extension of time proposed by the contractor, prepaid inpatient health plan (PIHP), or prepaid ambulatory health plan (PAHP) to make an authorization decision.

Members are encouraged to call or write to TrueCare to let us know of any grievance regarding TrueCare or the health care services they receive. Members or providers, when designated in writing as the authorized representative by the member, may file a grievance with TrueCare. Detailed grievance procedures are explained in the member handbook. Members can contact TrueCare at 1-833-230-2050 (TTY: 711) to learn more about these procedures.

Time Frames and Requirements

The member can file a grievance at any time of the occurrence of the matter that is the subject of the grievance. For standard grievances, TrueCare investigates, resolves, and notifies the member of their resolution as expeditiously as the member's health condition requires or within 30 calendar days of receipt, whichever is sooner. Urgent grievances are resolved within 72 hours of receipt and are applicable when taking the time for a standard resolution could seriously jeopardize the member's life. This period may be extended to 14 calendar days if resolution of the matter requires additional time. A letter notifying the member of this extension is required.

Member Appeals

Members must exhaust TrueCare’s internal appeals process before requesting a State Fair Hearing (MississippiCAN members only) or External Review (CHIP members only). TrueCare notifies members in writing when a decision is made to:

- Deny or limit authorization of a requested service, including the type or level of service
- Reduce, suspend, or terminate services prior to the member receiving the services previously authorized
- Deny, in whole or part, payment for a service
- Fail to provide services in a timely manner
- Fail to act within the resolution time frame

Members have the right to appeal against the actions listed in the letter if they contact TrueCare within 60 calendar days from the date of the denial letter. TrueCare must send confirmation receipt of the appeal in writing to the member and an expected date of resolution within 10 calendar days of receipt in addition to the resolution of the appeal in 30 calendar days. This period may be extended to 14 calendar days if resolution of the matter requires additional time. TrueCare must give the member written notice of the reason for the extension. Members will receive the appeal decision and any additional appeal rights in writing. A member, the member's authorized representative, or a provider acting on behalf of the member and with the member's written consent may file an appeal in writing.

If the amount of time necessary to resolve a standard appeal could jeopardize the member's life, health, or ability to attain, maintain, or regain maximum function, the member may request an expedited appeal. If the request meets the expedited criteria, TrueCare will resolve the appeal as quickly as possible, not exceeding 72 hours after receiving the request. TrueCare will review the request and determine if the request meets the expedited criteria. If the expedited request is denied, TrueCare must:

- Transfer the request to a standard appeal for resolution.
- Make a reasonable effort to give the member prompt oral notice and follow up within two calendar days with a written notice of the decision.

State Fair Hearings

MississippiCAN members can request a state hearing through the Division of Medicaid after they have exhausted all of TrueCare's internal appeals processes. The member must submit the request in writing within 120 calendar days from the date of the appeal decision. Request a State Fair Hearing via:

Mail: Mississippi Division of Medicaid
Attn: Office of Appeals
P.O. Box 2222
Jackson, Mississippi 39225

Fax: 1-601-359-9153

Phone: 1-800-884-3222

External Reviews

TrueCare CHIP members can request an External Review through the Independent Review Organization (IRO) vendor after they have exhausted all of TrueCare's internal appeals processes. The member must submit the request within 120 calendar days from the date of the appeal decision. Request an External Review via:

Mail: TrueCare
Attn: Independent Review – Appeals Dept.

P.O. Box 8738
Dayton, OH 45401-8738

Fax: 1-937-531-2398

Phone: Call Member Services at 1-833-230-2050 (TTY: 711)

TrueCare's IRO vendor, MES, will complete the External Review.

Continuation of benefits while the appeal and the state fair hearing are pending (MississippiCAN members only. Not applicable to CHIP members):

In certain member appeals, TrueCare is required to continue the member's benefits pending the appeal, in accordance with 42 C.F.R 457.1260. If the final resolution of the appeal or hearing is adverse to the member then members may be required to pay the cost of services provided while the appeal or state hearing is pending.

Please note: If a provider files an appeal on the member's behalf, member consent is required, and the appeal will follow the member appeal process. Provider appeals filed by the provider, not on behalf of the member, will follow the provider appeal process. See "Provider Appeals Procedures" below for additional information on the provider appeal process.

Provider Grievances

Providers are permitted to submit grievances to TrueCare regarding TrueCare policies and procedures or any aspects of TrueCare administrative functions. All provider grievances should be clearly documented.

Providers have 30 calendar days from the date of the incident to file a provider grievance. TrueCare will confirm receipt of all providers grievances within five calendar days of receipt of the grievance and strives to resolve all provider grievances within 30 calendar days. TrueCare will thoroughly investigate each provider's grievance using applicable statutory, regulatory, and contractual provisions, collecting all pertinent facts from all parties and applying TrueCare policies and procedures.

TrueCare will conduct an additional provider office visit within 45 calendar days when a member grievance and/or appeal threshold (five within six months) has been met against a specific provider that relates to the provider office.

Provider Appeals Procedures

How to Submit Appeals

Time Frames and Requirements

- Dispute filing – 90 calendar days from Explanation of Payment (EOP)
- Dispute resolve in 30 days

- Appeal filing – 30 calendar days of Adverse Provider Determination or Dispute Resolution Letter
- Appeal resolve in 30 calendar days

The provider can file an appeal within 30 calendar days of the EOP or the Dispute Resolution Letter outcome. Both notices could qualify as Adverse Provider Determination, which is the denial of a provider's claim or other action taken by the contractor with which the provider may disagree and file a grievance and/or appeal. This definition only applies to providers and is not to be confused or conflated with an Adverse Benefit Determination. TrueCare must confirm receipt of the provider's appeal and expected date of resolution within 10 calendar days of receipt of the appeal. TrueCare responds to appeals within 30 calendar days of receipt of the request.

Provider Portal

The **Provider Portal** is the most efficient method of submission to ensure timely receipt and resolution of the appeal.

Writing

Use the Provider Dispute and Appeal Form located on **MSTrueCare.com** > Providers > Tools & Resources > Forms. Please include:

- The member's name and member Medicaid ID number
- The provider's name and ID number
- The code(s) or denied services and why the determination should be reconsidered
- If you are submitting a timely filing appeal, you must send proof of original receipt of the appeal by fax or electronic data information (EDI) for reconsideration
- If the appeal is regarding a clinical edit denial, the appeal must have all the supporting documentation as to the justification of reversing the determination

Completed forms should be returned to TrueCare via fax or mail using the contact information on the form.

For additional information, contact Provider Services at 1-833-230-2174.

State Administrative Hearing

Providers can request a state administrative hearing through the Division of Medicaid after they have exhausted all of TrueCare's internal appeals processes. The provider must submit the request in writing within 30 calendar days from the date of the appeal decision. Request a state fair hearing via:

Mail: Mississippi Division of Medicaid
Attn: Office of Appeals

P.O. Box 2222
Jackson, Mississippi 39225

Fax: 1-601-359-9153

Phone: 1-800-884-3222

MEMBER ENROLLMENT & ELIGIBILITY

Enrollment & Eligibility

The Mississippi Division of Medicaid (DOM) is solely responsible for member enrollment, including auto-assignment to a coordinated care organization (CCO), disenrollment, education on enrollment options, and outreach activities to those eligible to enroll in a CCO. DOM has implemented potential open enrollment and auto-assignment processes to enroll all members with selected CCOs.

Eligibility Verification

Providers are expected to verify member eligibility each time a service is rendered.

Providers may use the **Provider Portal** to verify member eligibility. Upon logging in to the Provider Portal, providers will be able to view member eligibility with:

- 24 months of history
- Member span information
- Multiple member look-up (up to 500)

You can also verify eligibility by calling Provider Services at 1-833-230-2174 and using our interactive voice response system.

Member ID Cards

The member ID card is used to identify a TrueCare member. However, having a member ID card does not guarantee eligibility or benefits coverage. Please verify member's eligibility prior to each service rendered.

You can use our secure **Provider Portal** or call Provider Services to check member eligibility. Verification of eligibility doesn't guarantee payment.

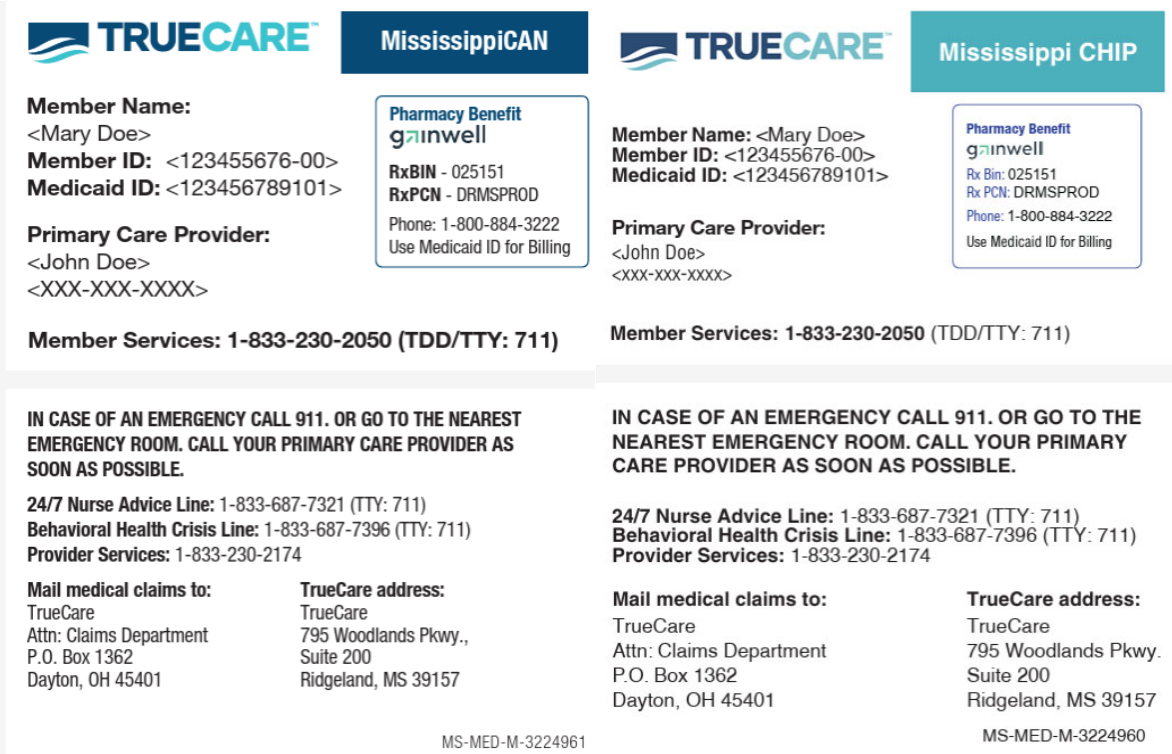
Provider Services

Call Provider Services at 1-833-230-2174 and follow the prompts.

Provider Portal

Click on "Member Eligibility" on the left, which is the first tab. Make sure to enter the full member ID number for the person.

Please have the member present their ID card each time services are accessed. If you are not familiar with the person seeking care and cannot verify the person as a member of our health plan, please ask to see photo identification.



TRUECARE

MississippiCAN

Member Name:
<Mary Doe>
Member ID: <123455676-00>
Medicaid ID: <123456789101>

Primary Care Provider:
<John Doe>
<XXX-XXX-XXXX>

Pharmacy Benefit
gainwell
RxBIN - 025151
RxPCN - DRMSPROD
Phone: 1-800-884-3222
Use Medicaid ID for Billing

Member Services: 1-833-230-2050 (TDD/TTY: 711)

IN CASE OF AN EMERGENCY CALL 911. OR GO TO THE NEAREST EMERGENCY ROOM. CALL YOUR PRIMARY CARE PROVIDER AS SOON AS POSSIBLE.

24/7 Nurse Advice Line: 1-833-687-7321 (TTY: 711)
Behavioral Health Crisis Line: 1-833-687-7396 (TTY: 711)
Provider Services: 1-833-230-2174

Mail medical claims to:
TrueCare
Attn: Claims Department
P.O. Box 1362
Dayton, OH 45401

TrueCare address:
TrueCare
795 Woodlands Pkwy.,
Suite 200
Ridgeland, MS 39157

MS-MED-M-3224961

TRUECARE

Mississippi CHIP

Member Name: <Mary Doe>
Member ID: <123455676-00>
Medicaid ID: <123456789101>

Primary Care Provider:
<John Doe>
<XXX-XXX-XXXX>

Pharmacy Benefit
gainwell
Rx Bin: 025151
Rx PCN: DRMSPROD
Phone: 1-800-884-3222
Use Medicaid ID for Billing

Member Services: 1-833-230-2050 (TDD/TTY: 711)

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Suite 200
Ridgeland, MS 39157

MS-MED-M-3224960

New Member Information Packets

Each household receives a Member Information Packet. Packets include:

- A Member Handbook Request Card
- An ID card for each person in the family who has joined TrueCare
- A quick start guide for how to get started with TrueCare
- Information on how to access or request a health assessment survey
- TrueCare's Notice of Privacy Practices as required by the Health Insurance Portability and Accountability Act (HIPAA)
- Other preventive health education materials and information, including how to select a primary care provider (PCP) and how to complete an initial health screening

Please note: Members will receive a Provider Directory only if they requested one at the time of enrollment or if they return a request postcard included in Member Information Packet that indicates they would like a printed copy. The Provider Directory lists participating TrueCare providers and facilities within a certain radius of the member's residence. As the contents of the printed directory are subject to change, we encourage members to call TrueCare or the provider directly to confirm they are in network.

Members are referred to the Provider Directory, which lists providers and facilities participating with TrueCare. A current list of providers can be found at any time on TrueCare's website, **findadoctor.MSTrueCare.com**.

American Indians/Alaska Natives (AI/AN)

American Indians and Alaska Natives (as defined by the Indian Health Care Improvement Act of 1976) may choose not to use managed care.

All AI/AN members can get care from Indian health care providers. This choice is offered regardless of network participation status. AI/AN members may choose to have an Indian health care provider as their PCP if they are in the TrueCare network, an eligible PCP, and they have the space to provide the services.

We will pay for services in the same way network providers are paid when getting treatment from out-of-network health care providers. Cost share requirements, prior authorizations, and benefit coverage is the same for network providers and Indian health care providers.

Newborn Enrollment

When a mother gives birth, the newborn child will automatically be enrolled into the mother's health plan starting on the baby's date of birth.

The mother will have the choice up to 90 days from the baby's date of birth to make a one-time change. If no change is made, the baby will stay on the mother's health plan until the next year.

Hospitals must notify DOM within five calendar days of a newborn's birth using the Newborn Enrollment Form located on the Envision web portal. The DOM Office of Eligibility will notify the provider within five business days of the newborn's permanent ID number. Questions about the newborn enrollment process should be directed to the DOM Office of Eligibility at 1-800-421-2408.

Copayments & Payment Responsibility

To ensure all members have no barriers to accessing health care, **TrueCare waives all copayments and cost sharing**. There are no copayments, deductibles, or cost-sharing for any services covered by TrueCare. Members and their families will not have to pay anything for office visits or hospital outpatient visits. By waiving copayments, we ensure that our members have access to preventive care when they need it.

Disenrollment

We understand that members may choose to select a different health plan from the CCO to which they were assigned by DOM. For various reasons, including reenrolling with a previous

CCO with which the member has an historical relationship, a member may choose to change their CCO. We support this decision by our members and provide judgement-free disenrollment assistance, including referring them to DOM.

If we choose to disenroll a member based on DOM-approved criteria, TrueCare will provide DOM with documentation of at least three interventions made over a period of 90 days that occurred through treatment, case management, and care coordination to resolve the issue.

Disenrollment Initiated by the Member

A member may request disenrollment or a change in CCO enrollment without cause during the 90 calendar days following the date of the member's initial enrollment with the CCO or the date DOM or its agent sends the member notice of the enrollment, whichever is later. A member may request a change in CCO enrollment without cause every 12 months thereafter.

A member may request disenrollment or a change in CCO enrollment for cause at any time. The following constitutes cause for requesting disenrollment:

- The member moves out of the CCO's service region.
- The CCO does not, because of moral or religious objections, provide the covered service the member seeks.
- The member needs related services and not all related services are available within the network. The member's or participant's provider or another provider has determined that receiving related services from in-network and out-of-network providers would subject the member to unnecessary risk.
- The member requests to be assigned to the same CCO as family member(s).

Other reasons for disenrollment initiated by the member, pursuant to 42 CFR 438.56(d)(2), include, but are not limited to, poor quality of care, lack of access to services covered under the contract, or lack of providers experienced in addressing the member's health care needs. DOM or its agent will make the determination of these reasons.

Disenrollment Initiated by TrueCare

TrueCare may request disenrollment if:

- The member's utilization of services is fraudulent or abusive.
- The member is placed in a long-term care nursing facility, state institution, or intermediate care facility for individuals with intellectual disabilities.
- The member loses eligibility.
- The member has died, been incarcerated, or moved out of state, thereby becoming ineligible for Medicaid.

Disenrollments will be processed as of the date the member eligibility category changes and will not be made retroactive, regardless of the effective date of the new eligibility category. Note that

an exception is when a member becomes eligible and enrolled in any retroactive program (such as Supplemental Security Income) after the date of an inpatient hospitalization.

MEMBER SUPPORT SERVICES

Member Services

Members access Member Services by calling our toll-free number at 1-833-230-2050 (TTY: 711), Monday through Friday, 7 a.m. to 8 p.m., Central Time (CT) and telling our interactive voice response system (IVR) what their question is regarding.

Holiday Hours

Representatives are available by telephone Monday through Friday, except on certain holidays. Please check the website for holiday hours.

Care Coordination and Health Insurance Portability and Accountability Act (HIPAA)

Care coordination is an approach to health care in which a patient's needs are coordinated with the assistance of a primary point of contact. Strong care coordination improves partnerships between the patients/members, providers, and TrueCare.

Per 42 CFR 438.208, providers are allowed to legally share patients' information with TrueCare for care coordination purposes.

- Contract requirements: Contracts between TrueCare and providers require providers to follow federal and state requirements and cooperate with the health plans' quality care delivery guidelines.
- HIPAA-required validation questions: If the identification of the caller is in question, the provider can ask HIPAA-approved validation questions such as date of birth, address, or Medicaid ID number.
- Communication among treating providers: Physical and behavioral health providers are required to coordinate care, including sending status reports to each other.

Per 45 CFR 164.506, a covered entity may, under certain circumstances, use or disclose protected health information without the written consent of the member.

- In general, a provider may share a patient's protected health information with TrueCare for purposes of care coordination and obtaining appropriate health or community-related services without a patient's consent.
- TrueCare may share a member's protected health information without the member's consent in cases of transition from one coordinated care organization (CCO) to another CCO for the purpose of coordinating member treatment or care (e.g., during Medicaid open enrollment period when a Medicaid recipient chooses a different CCO during an active course of treatment).

Telemedicine/Telehealth

Telehealth technology makes health care more accessible, cost effective, and can increase patient engagement. TrueCare wants to support patient engagement efforts by offering providers who do not currently have telehealth services embedded in their practices the ability to offer select telehealth services to their patients.

Health Education

TrueCare members receive health information from TrueCare through a variety of communication vehicles including easy-to-read newsletters, brochures, health sheets, TrueCare MyLife, phone calls, and personal interaction. TrueCare also sends preventive care reminder messages to members via mail and automated outreach messaging.

Member Incentives and Rewards

TrueCare is committed to providing members with services that help them achieve their health and wellness goals. We believe taking steps to improve health and well-being deserves recognition.

TrueCare rewards members for activities that lead to better health. Members can earn and redeem rewards by actively participating in TrueCare MyHealth or TrueCare MyKids.

Based on the rewards program, members can use their rewards to purchase a large variety of personal and wellness items and groceries or redeem their rewards for digital gift cards to a variety of retailers.

TrueCare MyHealth Rewards

To encourage all members 18 years and older to be active participants in their own health care journey, we have an incentive and rewards program available to members. This encourages engagement in preventive health activities and encourages ongoing management of chronic health conditions, including diabetes.

No enrollment is needed. As members complete eligible activities, we will add rewards to their MyHealth account. They can redeem earned points for digital gift cards to retailers like Walmart®, TJ Maxx®, Old Navy®, and more. Members can track progress, view balance, and redeem rewards through TrueCare MyLife.

Rewardable activities include:

Activity	Reward Frequency	Reward Earned	Who Is Eligible
Retinal eye exam		$25	Adults with diabetes diagnosis

Activity	Reward Frequency	Reward Earned	Who Is Eligible
Routine dental exam	2 times per calendar year	$10 each time	Ages 18+
Cervical cancer screening (pap smear)	1 time per year	$20	Females ages 21-64 years old
Breast cancer screening	1 time per year	$25	Females ages 40-74 years old
Flu shot	2 times per year	$10 each time	Ages 18+
Annual physical	1 time per year	$20	Ages 18+
Postpartum	1 time per delivery	$50	New mothers 7-84 days after delivery
Diabetic A1C testing	1 time per year	$25	Adults with diabetes diagnosis
Diabetic micro-albumin testing	1 time per year	$10	Adults with diabetes diagnosis
Kidney health evaluation	1 time per year	$10	Adults with diabetes diagnosis
Health risk screening	1 time per year	$25	Ages 18+

TrueCare MyKids Program

Our TrueCare MyKids program is for infant members through 17 years of age. It is an incentive and rewards wellness program that encourages wellness visits and other preventive activities to help ensure the necessary screenings and checkups during the early stages of life are completed.

Members must enroll their children in TrueCare MyKids at **MSTrueCare.com** or **TrueCare MyLife**. Once they complete an eligible activity, we will mail a reloadable TrueCare Rewards card, which can be used at a variety of retailers to purchase everyday items such as clothes, groceries, etc.

Rewardable activities include:

Activity	Reward Frequency	Reward Earned	Who Is Eligible
Attend a postpartum visit	1 reward per delivery	$50 for the visit	New moms
Attend 6 well-baby visits	1 reward per age range	$25	Newborn through 17 months
Routine dental exam	1 reward per visit, up to 2 visits per year (once every 6 months)	$10 per activity	Ages 3-17 years old
Well-child visit	1 reward per visit, up to 3 visits per age range	$10 per visit, up to $30	Children ages 18-30 months

Activity	Reward Frequency	Reward Earned	Who Is Eligible
Well-child visit	1 reward per visit, per year	$50	Children ages 3-17 years
Annual flu shot	1 reward per year	$25 per year	Children ages 18 months through 17 years old

Rewards Expiration

TrueCare MyKids rewards expire one year from date of issuance (i.e., rewards issued on August 1, 2026, will expire July 31, 2027, if no rewards have been redeemed).

TrueCare MyHealth rewards expire in December of the following year if no rewards are redeemed (i.e., rewards earned in 2026 will expire in December 2027).

Care Management

Care Management/Outreach

All TrueCare members have access to the Care Management team and will be assigned a Care Manager upon enrollment in the program and given their contact information. Members can reach out to their Care Manager during business hours for support. TrueCare provides the services of care management medical and behavioral health nurses, social workers and community health workers, licensed professional counselors, and outreach specialists to provide one-on-one, personal interaction with members. We have pharmacists on staff to assist with medication reconciliation and to function as a part of the interdisciplinary care team.

Please feel free to refer patients who might need individual attention to help them manage special health care problems. Care Management can provide a broad spectrum of educational and follow-up services for your patients. It can be especially effective for reducing admission and readmission risks, managing anticipatory transitions, encouraging treatment adherence, reinforcing medical instructions, assessing social and safety needs, and educating pregnant women on the importance of prenatal, childbirth, postpartum, and infant care. We also offer individualized education and support for many conditions.

In addition, members engaged in our Care Management program have access to extra TrueCare benefits to meet their needs when qualified, such as:

- Extra benefits for pregnant members
- Post-discharge home-delivered meals
- Asthma bedding
- Caregiver supports for foster care members
- 12-week Weight Watchers membership

You can refer a member to Care Management by calling Provider Services at 1-833-230-2174. Providers may also make referrals to Care Management on behalf of members by submitting them to the **Provider Portal**.

Cell Phones and Internet Connectivity

TrueCare members are eligible for the Federal Lifeline Program with a free Android phone. We work with Pulsewrx to assist members with enrollment, giving them access to a free smartphone, unlimited talk and text, and 4.5 GB of data. This helps to ensure members have access to all TrueCare resources, including Member Services, the 24-Hour Nurse Advice Line, the Behavioral Health Crisis Line, Care Management connections, and TrueCare MyLife and website. Members under the age of 18 must be enrolled by an adult.

Youth Activity Fund

All TrueCare members who are six to 18 years old can receive a voucher toward the Boys and Girls Club, YMCA, or other activity-based membership. **Note**: This benefit is limited to organizations with membership arrangements with TrueCare and may vary by location. This can be accessed via a Care Manager or Member Services.

MyResources

The MyResources search engine is a social service and community resource search tool. The MyResources tool connects members with local low- and no-cost community-based programs and social services.

The tool is easy to use and allows our staff and members to search for a wide category of resources like food, housing, transportation, and job training programs by simply entering a ZIP code.

The search information is provided in real time, including hours of operation, distance from the ZIP code entered, and other locations nearby. More than 100 languages are supported, resources can be updated, and new resources suggested directly from the site. Other features include the ability to send a resource to a friend via email or text.

Members can log into **TrueCare MyLife** to learn more or call Member Services at 1-833-230-2050 (TTY: 711).

Transportation

TrueCare provides non-emergency transportation to both MississippiCAN and CHIP members for rides to and from health care appointments with no copayment requirement. All non-emergency medical transportation (NEMT) trips involving medical appointments or procedures are covered as a medical benefit. We also offer up to five additional trips per month that can be used for grocery or food bank, eligibility appointments to Medicaid or Women, Infants, and

Children (WIC) offices, TrueCare-sponsored educational events, cardiopulmonary resuscitation (CPR) and parenting classes, and more.

Arrange transportation by calling 1-833-230-2050 (TTY: 711), Monday through Friday, 7 a.m. to 8 p.m., CT. Rides should be scheduled at least three business days in advance, when possible. Rides can be scheduled up to two months before appointments.

Have the following information available when scheduling transportation:

- Member's Medicaid ID number
- Date, name, address, and phone number for transportation needed
- Purpose of the request
- Appointment type
- Any mobility aides needed

Health Risk Screening (HRS)

TrueCare asks that all members complete the HRS. Through a few questions about their health and well-being, TrueCare can help identify health, housing, education, and employment concerns where we may be able to help.

Members can complete the HRS in one of the following ways:

1. Visit **MyLife.MSTrueCare.com/Assess**.
    a. Members can fill out the HRS without signing in or creating an account, or they can sign into their account to find their screening.
2. Call our Member Assessment Team at 1-844-542-2610 (TTY: 711).
3. New members can complete the printed copy of the HRS included with their new member packet. It can be returned in the enclosed self-addressed, postage paid envelope.

Members can earn a $25 reward when they complete the HRS. The HRS should be completed annually, and a reward can be earned once each year.

Complex Members/High Risk Members

TrueCare applies a particular community-based management model for our high-risk members. Utilizing nurses, social workers, and community health workers, this multi-disciplinary approach integrates the Case Management Society of America (CMSA) Standards of Practice into key processes to help ensure implementation of a best-practice program. Community health workers help patients overcome health care access barriers and strengthen our provider and community resource partnerships through collaboration.

Our services include meetings with our most at-risk members. Typical high-risk members served by this model may have multiple medical issues, socioeconomic challenges, and behavioral health care needs.

Care coordination efforts may include:

- Care transition planning
- Identifying gaps in care and collaborating with the care team to close gaps
- Facilitating member access to appropriate care and services
- Providing referrals to appropriate medical, behavioral, social, and community resources to address identified member needs
- Coordinating planned interventions, driven by a care coordination plan, consistent with evidence-based clinical guidelines

TrueCare encourages you to take an active role in your patients' care management programs and participate in assessment activities and development of individualized care plans to help meet their needs. Together, we can make a difference.

Mom & Baby Beginnings and NICU Care Management

TrueCare's Perinatal and Neonatal Care Management program utilizes a multi-disciplinary team with extensive obstetrics and neonatal intensive care unit (OB/NICU) clinical experience. Our team consists of nurses, nurse practitioners, social workers, behavioral health specialists, and lactation consultants who specialize in maternity and NICU care. Specialized nurses are available to help manage pregnant members and medically complex newborns by working in conjunction with providers and members. The expertise offered by our staff includes a focus on patient education and care coordination and involves direct telephone contact with members and providers.

All engaged pregnant members receive educational materials and support throughout their pregnancy and their fourth trimester. Members with high-risk pregnancies are offered additional support for their physical health, behavioral health, and social determinants of health (SDOH) needs. Pregnant members in the Care Management program will receive one-to-one perinatal education throughout their pregnancy and postpartum period.

To help reduce the infant mortality rate, we seek to support moms and families during their pregnancies and provide education, tools, and resources. Our Mom and Baby Beginnings™ program provides mothers and their newborns with additional benefits that promote health and wellness. This program aims to prevent prenatal and postpartum complications or adverse outcomes. The program also intends to mitigate the impact of SDOH and health disparities by making it easier for all parents to obtain critical information to support their health and the health of their children, regardless of their address or economic status. For members engaged in the Mom & Baby Beginnings Care Management program, these benefits may include:

- Electric breast pump
- Car seat for each baby
- Access to a national evidenced-based smoking cessation program with the goal of improving birth outcomes and long-term positive outcomes for women, children, and their families

Mom & Baby Beginnings is available to all pregnant and recently postpartum TrueCare members.

Notification of Pregnancy

TrueCare has a dedicated phone line and a submission form on the **Provider Portal** for notification of pregnancy (NOP). Please contact TrueCare at 1-844-542-2610 or submit an NOP within five days of the first prenatal visit.

Care Management Services

TrueCare's Care Management program is designed to support the care and treatment you provide and recommend to your patient.

We stress the importance of establishing the medical home, identifying barriers, and keeping appointments. We can assist in arranging transportation to the provider's office.

Members have access to the following enhanced non-emergency transportation benefits:

- Rides to grocery stores, food banks, and farmers markets
- High school equivalency programming
- Job training
- Driver's license and reinstatement assistance

One-on-one personal interaction with community health workers and professional case managers helps provide a comprehensive safety net to support your patient through initial and ongoing assessment activities, coordination of care, and education to promote self-management and healthy lifestyle decisions. In addition, we help connect your patient with additional needed community resources, such as assistance with housing and food.

TrueCare encourages you to take an active role in your patient's Care Management program through the Patient Profile feature on the **Provider Portal**. This profile provides member-specific information on pharmacy, inpatient, and emergency department utilization and scheduled or planned services. This information provides you with critical information necessary to make informed decisions pertaining to your patient.

In addition, we invite and encourage you to direct and provide input into patient assessment activity and participate in the development and monitoring of a care plan individualized to the needs of your patient. We believe communication, coordination, and collaboration are integral to ensure the best care for your patients.

We offer individualized education and support for many conditions and needs, including:

- Diabetes
- Prediabetes
- Asthma
- Hypertension

- Obesity
- Congestive heart failure (CHF)
- Chronic kidney disease (CKD)
- Solid organ transplant
- Attention deficit disorder (ADD)
- Serious mental illness (SMI)
- Substance use disorder (SUD)
- HIV/AIDs
- Sickle cell anemia

Disease Management

Disease Management Program Benefits

Members identified in the Disease Management program receive help finding the appropriate level of care for their chronic condition. They are encouraged to actively participate in the patient-provider relationship.

If you have a patient with a chronic condition who you believe would benefit from this program, please refer them to us via the **Provider Portal** or call 1-844-542-2610.

Interactive Health Library

All members have access to our online Interactive Health Library. The website offers self-service access to search for health and well-being topics, quizzes, and more.

24-Hour Nurse Advice Line

Members can call our nurse advice line 24 hours a day, seven days a week. With this advice line, members have unlimited access to talk with a caring and experienced staff of registered nurses about symptoms or health questions.

Nurses assess members' symptoms using the Schmitt-Thompson Clinical Content to determine the urgency of the complaint and direct members to the most appropriate place for treatment. Schmitt-Thompson is the "gold standard" in telephone triage, offering evidence-based triage protocols and decision support.

The nurses educate members about the benefits of preventive care and make referrals to our care management programs. The nurses promote the relationship with the primary care provider (PCP) by explaining the importance of their role in coordinating the member's care. For improved care coordination with PCPs, summaries of the call are posted on the **Provider Portal**, including a record of why the member called and what advice the nurse gave.

Key features of this service include nurses who:

- Assess member symptoms
- Advise on the appropriate level of care
- Answer health-related questions and concerns
- Provide information about other services
- Encourage the PCP-member relationship

Members may access the 24-Hour Nurse Advice Line anytime, night or day. The phone number is on the member's ID card.

Behavioral Health Crisis Line

Members experiencing a mental health or substance use crisis may also call the Behavioral Health Crisis Line at 1-833-687-7396 (TTY: 711) or the National Suicide and Crisis Hotline by dialing 988. Both the Behavioral Health Crisis Line and 988 are available 24 hours a day, seven days a week. When members call the Behavioral Health Crisis Line, they can connect with a licensed behavioral health professional who can coordinate crisis care utilizing local crisis resources and the member's safety plan, if available. Behavioral health professionals can make referrals for mental health or substance use treatment and coordinate with mobile crisis providers, where available. All members who utilize the Behavioral Health Crisis Line will be referred to TrueCare's Care Management program, if not already connected. We want to make sure the member receives the right services as soon as possible.

Members should call the Behavioral Health Crisis Line if they are:

- Feeling hopeless
- Feeling overwhelmed
- Feeling anxious
- Feeling alone
- Feeling depressed
- Feeling like there is no reason for living
- Using or abusing drugs or alcohol
- Having dramatic mood changes

If the member is actively suicidal, please call 911 for immediate assistance.

Emergency Department (ED) Diversion

TrueCare is committed to making sure our members access the most appropriate health care services at the appropriate time for their needs. We instruct members to call their PCP or the 24-Hour Nurse Advice Line if they are unsure if they need to go to an ED. TrueCare also educates members on the appropriate use of urgent care facilities and which urgent care sites they can access.

Members are informed to call 911 or go to the nearest ED if they feel they have an emergency. TrueCare covers all emergency services for our members.

Member ED utilization is tracked closely. If there is frequent ED utilization, members are referred to our Care Management department for analysis or intervention. Members are contacted via phone or mail. Intervention includes education as well as assistance with removing any identified health care access barriers. We appreciate your cooperation in educating your patients on the appropriate utilization of emergency services.

Appropriate use of ED involves situations where the member's urgent medical condition cannot be adequately treated through primary care appointments or other less intensive health care settings. This is usually because the situation requires immediate and/or complex care to resolve the life-threatening condition or to stabilize.

Inappropriate ED use encompasses non-urgent conditions that can normally be effectively managed through primary care appointments or less intensive health care settings. These are conditions that are not life-threatening and do not require immediate intervention. Members with these conditions can be safely offered primary care appointments or diverted to urgent care centers.

Care Transitions

When care transitions occur, TrueCare identifies members who require assistance as they transition from an inpatient stay. Our team works with members and their families to coordinate care needs and make the transition to home or a lower level of care as successful as possible.

Our Transitions of Care (TOC) program has focused outreach and discharge planning activities based on the Coleman Model, utilizing a team approach to coordinate post-discharge care needs for members at risk for readmission. Through these efforts, we strive to empower and educate members to help ensure all components of the member's discharge plan are in place.

When an at-risk member is discharged from an inpatient stay, our TOC team reaches out to ensure the member has a clear path to recovery, free from barriers to care. We can coordinate home care and medical equipment needs, assist with obtaining prescribed medications, and coordinate other medical care and services as needed.

We believe in the importance of partnership. That is why we collaborate with PCPs to provide our members with the services they need along the continuum of care.

A back transfer may occur in the following situations:

- When a member needs to transfer from a higher level of care back to a lower level of facility care, such as a rehabilitation center or skilled nursing facility
- When a child is sent to a facility that specializes in pediatric surgery and is then transferred back to a hospital closer to the parents' residence

A back transfer is subject to medical necessity review and the payment policies outlined in the provider's contract with TrueCare. The facility receiving the back transfer is eligible for

reimbursement if prior authorization is obtained from TrueCare in accordance with the provider's contract.

When the member is transitioned, TrueCare follows up with the facility and the member to confirm a smooth transition occurred and a care plan is in place that includes planning for discharge from the facility to the member's home.

KEY COMMUNICATION INFORMATION

TrueCare Provider Services

The Provider Services phone number is 1-833-230-2174. Representatives are available Monday through Friday, 7:30 a.m. to 5:30 p.m., Central Time (CT), except on observed holidays. Please visit **MSTrueCare.com** > About Us > Contact Us for the holiday schedule or contact Provider Services for more information.

Phone

Our interactive voice response (IVR) system will direct your call to the appropriate professional for assistance. We also provide telephone-based self-service applications that allow you to verify member eligibility.

TrueCare Department	Phone Number
Provider Services	1-833-230-2174
Prior Authorizations	1-833-230-2174
Claims	1-833-230-2174
Member Services	1-833-230-2050
24-Hour Nurse Advice Line	1-833-687-7321 (1-833-NURSE 21)
Fraud, Waste, and Abuse Hotline	1-833-230-2174
TTY for the Hearing Impaired	711
Notification of Pregnancy	1-844-542-2610
Member Behavioral Health Crisis Line	1-833-687-7396 (Suicide and Crisis Hotline: 988)

Benefit Manager	Phone Number
Dental – Avesis	1-844-391-6671
Vision – EyeMed	1-833-918-0861
Lab – Avalon	1-833-230-2174
Pharmacy - Gainwell	1-833-660-2402
Imaging - Evolent	1-888-879-5923

Fax

TrueCare Department	Phone Number
Fraud, Waste & Abuse	1-800-418-0248
Medical Drug Prior Authorization	1-888-399-0271
Medical Prior Authorization*	1-937-396-3677 Toll Free Fax: 1-844-794-1584
NICU Fax Line	1-937-396-3499
Provider Appeals	1-937-531-2398

* For convenient, centralized prior authorization submissions, visit **MSTrueCare.com** > Providers > Provider Resources > Prior Authorization.

Mail

Claims
TrueCare
Attn: Claims
P.O. Box 1362
Dayton, OH 45401

Provider Complaints
TrueCare
Attn: Provider Complaints – Mississippi
P.O. Box 1947
Dayton, OH 45401

Provider Appeals Mailing Address
TrueCare
Attn: Provider Appeals
P.O. Box 2000
Dayton, OH 45401

Member Appeals and Grievances Mailing Address
TrueCare
Attn: Member Appeals
P.O. Box 1947
Dayton, OH 45401

Fraud, Waste, and Abuse Address
TrueCare
Attn. Program Integrity
P.O. Box 1940
Dayton, OH 45401-1940

Utilization Management Address
TrueCare
Attn: Utilization Management
P.O. Box 1307
Dayton, OH 45401-1307

Information reported to us can be reported anonymously and is kept confidential to the extent permitted by law.

Website

Accessing our website, **MSTrueCare.com**, is quick and easy. On the Provider section of the site, you will find:

- Commonly used forms
- Newsletters, updates, and announcements
- The provider manual and other plan resources
- Claim information
- Frequently asked questions
- Clinical and preventive guidelines
- Behavioral health information
- Incentives and rewards
- And much more

Provider Portal

Our secure online Provider Portal allows you instant access at any time to valuable information. You can access the **Provider Portal** at **MSTrueCare.com** > Login > Provider > Provider Portal. Simply enter your username and password (if already a registered user) or submit your information to become a registered user. Assisting you is one of our top priorities to deliver better health outcomes for our members.

Benefits

- Free access to important resources.
- Available 24 hours a day, seven days a week.
- Secure, convenient access to time-saving services and critical information.
- Accessibility on any web browser without additional software.

Tools

We encourage you to take advantage of the following time-saving tools:

- Payment history – Search for payments by check number or claim number.
- Claim features
  - Submit Claims – Submit claims using online forms or upload a completed claim. Claim submission through the portal is available to traditional providers, community partners, delegates, and health homes.
  - Claim Status – Search for status of claims.
  - Claims Attachments – Submit documentation needed for claims processing.
  - Rejected Claims – Find claims that may have been rejected so that you can resubmit them.

- Claim dispute and appeals – Submit and search for claim appeals and disputes.
- Coordination of benefits (COB) – Confirm COB for patients.
- Prior authorization – Request prior authorization for medical and behavioral inpatient/outpatient services, as well as pharmacy and medical authorizations. Authorization for the following services should be submitted on the web portal:
  - Inpatient (POS21), outpatient (POS22), or ASC (POS24) setting services.
  - Durable medical equipment.
  - Children's intervention therapy services.
  - Notification of pregnancy (or by calling 1-844-542-2610).
  - Newborn notification.
  - Outpatient behavioral health.
- Eligibility termination dates – View the member's termination date (if applicable) under the eligibility tab.
- Care Management referrals – Submit automated Care Management forms on our **Provider Portal** for efficiency in enrolling members.
- Benefit limits – Track benefit limits electronically in real time before services are rendered for services like chiropractic visits.
- Care treatment plans – View care treatment plans for patients on our **Provider Portal**.
- Clinical Practice Registry (CPR) – Review member gaps in care. View and sort TrueCare members into actionable groups for improved focus on preventive care (e.g., well-baby visits, diabetes, asthma, and more). Look on the "Member Eligibility" page for alerts to notify you which tests a patient needs.
- Monthly membership lists – View and download current monthly panel lists.
- Member profile – Access a comprehensive view of patient medical/pharmacy utilization.
- Information exchange – Share relevant member information to facilitate better integration of complete physical and behavioral health care.

Registration

If you are not registered with the **Provider Portal**, please follow these easy steps:

1. Visit **MSTrueCare.com** > Login > Provider. Click "Sign Up" to create your secure username and password.
2. Connect your account to the appropriate provider account by completing the required information. Note: you will need to have your Tax ID Number and TrueCare Provider ID.
3. If you do not remember your username/password, please call Provider Services at 1-833-230-2174.

For information on our **Provider Portal**, TrueCare offers on-demand portal training through our Provider Learning Management System (LMS), **HealthPlanResources.com**. The Provider Education Series includes Provider Portal Overview, Prior Authorization Submission, and Managing User Access.

Policies

TrueCare has adopted some of the policies and procedures of its third-party administrator, CareSource, and TrueCare providers are thereby required to adhere to, and are bound by, such policies. Policies offer guidance on determination of medical necessity and appropriateness of care for approved benefits. TrueCare's medical, reimbursement, administrative, and pharmacy policies may be found at **MSTrueCare.com** > Providers > Tools & Resources > Provider Policies.

Newsletters

Our provider newsletter contains operational updates, clinical articles, and new initiatives underway at TrueCare. Our newsletter is both emailed and posted online at **MSTrueCare.com** > Education > Newsletters & Communications.

Network Notifications

We regularly communicate policy and procedure updates to TrueCare providers via network notifications. Network notifications are found on our website at **MSTrueCare.com** > Providers > Tools & Resources > Updates & Announcements.

Clinical Practice Guidelines (CPGs) & Preventive Guidelines

TrueCare approves and adopts evidence-based, nationally accepted standards and guidelines to help inform and guide providers about their clinical care or members. CPGs are available to providers on our **Provider Portal** under "Member Reports." They may be communicated to practitioners through newsletters, direct mailings, and focused meetings with TrueCare Provider Engagement Specialists.

Health literate member CPGs and other health resources are available on the member website, covering a broad range of health and wellness topics. Information may also be shared via newsletters or upon member request.

Guidelines are reviewed quarterly and updated, if indicated. They may be found at **MSTrueCare.com** > Providers > Education > Patient Care > Health Care Links. These guidelines assist in improving member health outcomes. Review and approval of CPGs are completed by the TrueCare Provider Advisory Committee (PAC), with final approval by the Enterprise PAC. The Quality Enterprise Committee (QEC) is notified of guideline approval.

CPG topics are chosen through analysis of our TrueCare member population demographics and state/national health priorities. Guidelines focus on key chronic diseases, preventive health measures, and recommended screenings for both medical and behavioral health concerns.

If you would like more information on our Quality Management and Improvement Program, please visit **MSTrueCare.com** > Provider Overview > Education > Quality Improvement or call Provider Services at 1-833-230-2174.

Patient Safety Program

TrueCare recognizes that patient safety is the cornerstone of high-quality health care, contributing to the overall health and welfare of our members. Our Patient Safety program evaluates patient safety trends with the goal of reducing avoidable harm. The program is developed in the context of our population health management approach and includes regulatory/accreditation, policies and procedures, training and implementation, continuous monitoring, and program evaluation and improvement. Safety events are monitored through real-time review of quality-of-care concerns and retrospective review of claims data. Data analysis of our provider and health system network ensures situational risks can be identified in a timely manner, then reviewed and mitigated by proactive corrective action or performance improvement steps.

Quality of Care Reviews

TrueCare ensures the provision of safe and quality care to members by investigating and mitigating potential quality-of-care concerns that include:

- Inappropriate or inconsistent treatment
- Delay of care
- Care that compromises member health, safety, or welfare

To properly assess quality-of-care concerns, Clinical Quality and Health Safety initiates contact with providers to request medical records using established processes and timelines. Per our policies and provider contracts, we are authorized to request protected health information for health care operations, which includes quality issue reviews. Medical record requests are forwarded to providers via mail, email, or fax and may be returned to TrueCare via these same mechanisms as detailed in the medical record request document.

All providers are expected to provide medical records related to quality-of-care concerns within 14 days from initial receipt of the request, unless otherwise defined by program guidelines or state or federal law requirements. If a state, federal or regulatory agency, or if the health and safety of a member requires that medical records must be submitted under a shorter time frame, providers are expected to comply with the shorter turnaround time. Providers and facilities that utilize third party health information management vendors are responsible for providing medical records to TrueCare or facilitating delivery of medical records to TrueCare by the identified contractor. We are legally bound to interact with providers only, and TrueCare is not subject to any fees charged by health information management companies for medical record retrieval or submission.

Your TrueCare Provider Engagement Specialist may contact you if medical records are not received within the 14-day time frame to ensure you received the request. In addition, our market Chief Medical Officer may also be in contact to facilitate and ensure receipt of the required medical records to complete the quality-of-care reviews. Providers or facilities who repeatedly fail to return requested medical records may face other directed intervention or penalties up to, and including, contract termination.

PROVIDER RESPONSIBILITIES

Provider Education

TrueCare's dedicated provider education team uses provider and state feedback to create and update a market-specific suite of provider resource materials. TrueCare offers live educational opportunities through in-person, on-site informational meetings and scheduled webinars with question and answer sessions. On-demand educational opportunities are also available on our website and within our **Provider Portal**. Visit **MSTrueCare.com** > Providers > Training & Events and Health Plan Resources to learn more.

Health Plan Resources

TrueCare houses and manages our education program resources on **HealthPlanResources.com**, our Learning Management System (LMS). All provider training is administered and tracked through this platform, providing us with the ability to:

- Conduct live training sessions,
- Track completed training,
- Generate attendance reports for state reporting purposes,
- Gather questions and feedback,
- Conduct feedback surveys, and
- Produce data to evaluate the success of the Education Program.

We know your time is valuable and that you are working with multiple insurance plans. To help improve access and understanding, we have developed a provider-facing LMS. All training on our **HealthPlanResources.com** platform is developed in-house and is specific to our organization. For any provider who is unable to attend a live education offering, TrueCare records all training sessions and posts them on this platform.

First Time Access: The first time you visit **HealthPlanResources.com**, you will use your National Provider Identifier (NPI)* and the generic password.

Single Sign-On: If you are registered to use our **Provider Portal**, you can single sign-on from that platform by choosing "Health Plan Resources" in the left menu bar.

Office Manager/Administrators*: Managing a group of providers? You can complete training and manage accounts for all providers in your Tax ID Number.

If you do not have an NPI number, no problem! When you visit **HealthPlanResources.com, you will set up a new account using a unique email address as your username. To use single sign-on in the future, you will need to make sure you use the same email address and password when accessing the Provider Portal.*

Access Standards

TrueCare promotes access to care by partnering with health care providers to ensure our members receive the best possible health care services. It includes evaluation of access and availability, as well as acceptability of services rendered to patients by participating providers.

TrueCare expects participating providers to have procedures in place to see patients within these time frames and to offer hours of operation to their TrueCare patients that are no less (in number or scope) than the hours of operation offered to any other patient.

Please keep in mind the following access standards for each level of care.

Primary Care Providers (PCPs)

Type of Visit	Time Frame
Well-care visit	Not to exceed 30 calendar days
Routine sick visit	Not to exceed 7 calendar days with an urgent care visit schedule; otherwise not to exceed 24 hours
PCP urgent care	Not to exceed 24 hours

Non-PCPs (Specialists)

Type of Visit	Time Frame
Specialists	Not to exceed 45 calendar days

Dental Care

Type of Visit	Time Frame
Routine visits	Not to exceed 45 calendar days
Urgent care needs	Not to exceed 24 hours

Urgent and Emergency Care Providers

Type of Visit	Time Frame
Urgent care providers	Not to exceed 24 hours
Emergency needs	Immediately upon presentation, 24 hours a day, 7 days a week and without prior authorization

Behavioral Health (BH) and Substance Use Disorder Providers

Type of Visit	Time Frame
Initial visit for routine care	Not to exceed 10 calendar days
Routine visit	Not to exceed 14 calendar days

Type of Visit	Time Frame
Follow-up routine care	Not to exceed 30 calendar days
Care for a non-life-threatening emergency	Not to exceed 6 hours
Urgent needs	Not to exceed 24 hours
Follow-up post-discharge from acute care psychiatric hospital (when TrueCare is aware of the member's discharge)	Not to exceed 7 calendar days

PCP/BH* and Back-Up Providers – 24-Hour Access

Type of Visit	Should be seen…
Telephone access	24 hours a day, 7 days a week

Providers should see members as expeditiously as the member's condition and severity of symptoms warrant. It is expected that if a provider is unable to see the member within the designated time frame, TrueCare will facilitate an appointment with another participating provider, or a non-participating provider, when necessary.

PCP and BH providers must provide 24-hour availability for their TrueCare patients by telephone. Whether through an answering machine or a taped message used after hours, patients should be given the means to contact their PCP/BH* provider or a back-up provider to be triaged for care. It is not acceptable to use a phone message that does not provide access to you or your back-up provider and only recommends emergency department use for after hours.

*BH providers may refer their patients to the 988 Suicide & Crisis Hotline or the TrueCare Crisis Line 1-833-687-7396 (TTY: 711) if a provider is not available for the call.

For the best interest of our members and to promote their positive health care outcomes, TrueCare supports and encourages continuity of care and coordination of care between medical care providers as well as between physical and behavioral health providers.

View the TrueCare Provider Education Series: Timely Access to Care training on **HealthPlanResources.com** and visit our Access & Availability Standards web page at **mstruecare.com/ms/providers/provider-portal/access-availability-standards** for additional information.

Appointment Wait Times

Providers are required to track wait times, which may be reviewed by DOM upon request.

Appointment Time	Waiting Time
Scheduled appointments	Waiting times shall not exceed 60 minutes. After 30 minutes, your patient must be given an update on waiting time with an option of waiting or rescheduling the appointment.
Work-in or walk-in appointments	Waiting times shall not exceed 90 minutes. After 45 minutes, your patient must be given an update on waiting time with an option of waiting or rescheduling the appointment.

Americans with Disabilities Act

Providers are required to comply with the Americans with Disabilities Act (ADA) standards, including but not limited to:

- Providing waiting room and exam room furniture that meet the needs of all enrollees, including those with physical and non-physical disabilities
- Accessibility along public transportation routes and/or providing enough parking
- Utilizing clear signage and way finding (e.g., color and symbol signage) throughout facilities
- Providing secure access for staff-only areas

ADA prohibits discrimination against people with disabilities in the areas of employment, public accommodations, state and local government services, and telecommunications. Both public and private hospitals and health care facilities must provide their services to people with disabilities in a nondiscriminatory manner. To do so, providers may have to modify their policies and procedures, provide auxiliary aids and services for effective communication, remove barriers from existing facilities, and follow ADA accessibility standards for new construction and alteration projects. Furthermore, providers' diagnostic equipment must accommodate individuals with disabilities.

The TrueCare provider network will reasonably accommodate people and ensure their services are as accessible to a member with disabilities as they are to a member without disabilities. TrueCare and its provider network will comply with the ADA (28 CFR 35.130) and the Rehabilitation Act of 1973 (29 U.S.C. 794) and maintain capacity to deliver services in a manner that accommodates the needs of its members.

For more information about the ADA, go to ada.gov.

ADA Policies and Procedures

Providers are required to modify policies and procedures when necessary to serve a person with a disability. The ADA, however, does not require providers to make changes that would fundamentally alter the nature of their service.

Cultural Competency

Cultural competency within TrueCare is defined as “the willingness and ability of a system to value the importance of culture in the delivery of services to all segments of the population.” It is the use of a system’s perspective which values differences and is responsive to diversity at all levels in an organization.

Cultural competency is developmental, community focused, and family oriented. It is the promotion of quality services to understand racial/ethnic groups by valuing differences and integrating cultural attitudes, beliefs, and practices into diagnostic and treatment methods and throughout the system to support the delivery of culturally relevant and competent care. It is also the development and continued promotion of skills important in clinical practice, cross-cultural interactions, and systems practices among providers and staff to ensure that services are delivered in a culturally competent manner.

Participating providers are expected to deliver services in a culturally competent manner, which includes removing all language barriers to service and accommodating the unique ethnic, cultural, and social needs of the member.

Providers can address racial and ethnic gaps in health care with an awareness of cultural needs and improving communication with their growing numbers of diverse patients. TrueCare recognizes cultural differences, including religious beliefs and ethical principles. In accordance with this, providers are not required to perform any treatment or procedure that is contrary to their religious or ethical principles.

Network 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 with consideration of the members’ race/ethnicity and language and its impact/influence on the members’ health or illness.
- The office staff responsible for data collection make reasonable attempts to collect race- and language-specific member information. Staff will also explain race/ethnicity categories to a member so that the member is able to identify their own race/ethnicity and that of their children.
- Treatment plans are developed and clinical guidelines are followed with consideration of the member’s race, country of origin, native language, social class, religion, mental or physical activities, heritage, acculturation, age, gender, sexual orientation, and other characteristics that may result in a different perspective or decision-making process.
- Participating providers meet the requirements of all applicable state and federal laws and regulations as they pertain to provision of services and care.

TrueCare encourages its participating providers to complete the U.S. Department of Health and Human Services' Cultural Competency Deployment Refresher training, which is a free online accredited educational program. We provide links to cultural competency training and our full Cultural Competency Plan for Mississippi online at **MSTrueCare.com** > Providers > Education > Health Equity > Health and Social Partnerships. For additional information, view the "TrueCare Provider Education Series: Cultural Competence in Health Care" available at **HealthPlanResources.com**.

Sign and Language Interpretation Assistance

TrueCare offers over-the-phone (OPI) and virtual in-office interpreting services*. These services are available to TrueCare members who are hearing impaired, do not speak English, or have limited English-speaking proficiency. These services are available at no cost to the member or provider. As a provider, you are required to identify the need for interpreter services for your TrueCare patients and offer assistance to them appropriately.

To arrange services, please contact our Provider Services department at 1-833-230-2174. We ask that you let us know of members in need of interpreter services and members who may receive interpreter services through another resource.

*TrueCare requires hospitals, emergency departments, and skilled nursing facilities, at their own expense, to offer sign and other language interpreters for members who are deaf or hard of hearing, do not speak English, or have limited English-speaking proficiency. This includes providers that perform in-office surgeries. These services should be available at no cost to members.

Propio is our interpretation vendor. Go to **HealthPlanResources.com** and select "Interpreter Services via Propio" from the Course Catalog to learn more about the partnership between TrueCare and Propio.

Key Contract Provisions

Provider Responsibilities

To make it easier for you, we have outlined key components of your contract. These key components strengthen our partnership with you and enable us to meet or exceed our commitment to improve the health care of the underserved. We appreciate your cooperation in carrying out our contractual arrangements and meeting the needs of underserved consumers. Participating providers are responsible for:

- Treating members with respect. TrueCare members should not be treated any differently than patients with any other health care insurance. Please refer to our Member Rights and Responsibilities.
- **Providing TrueCare with advance written notice of any intent to terminate an agreement with us.**

  - This must be done 60 calendar days prior to the date of the intended termination and submitted on your organization's letterhead.
- Submitting clean claims within 180 days of the date of service or discharge.
- Filing appeals within the required time frame from the date of service or discharge.
- Keeping demographic and practice information up to date.
- Having a system for following up with patients who miss scheduled appointments (PCPs).

TrueCare expects participating providers to verify member eligibility and ask for all health care insurance information before rendering services, except in an emergency. You can verify member eligibility and obtain information for other health care insurance coverage that we have on file by logging onto the **Provider Portal** from the menu options.

TrueCare Responsibilities

Our agreement also indicates that TrueCare is responsible for:

- Paying clean claims within 30 calendar days of receipt.
- Providing you with an appeals procedure for timely resolution of any requests to reverse a TrueCare determination regarding claims payment. Our appeal process is outlined in the Provider Appeals section of this manual.
- Offering a 24-Hour Nurse Advice Line for members to reach a medical professional at any time with questions or concerns.
- Coordinating benefits for members with primary insurance, which involves subtracting the primary payment from the lesser of the primary carrier allowable or the Medicaid allowable. If the member's primary insurer pays a provider equal to or more than TrueCare's fee schedule for a covered service, TrueCare will not pay the additional amount.
- Making available member details on coverage and benefits.

These are just a few of the specific terms of our agreement. In addition, we expect participating providers to follow standard practice procedures even though they may not be directly stated in our provider agreement.

As a reminder, CareSource will act as a third-party administrator in our TrueCare partnership. CareSource will provide operational support and services.

Provider Services

As a provider-sponsored health plan, it is our goal to make it simple to do business with us. We provide self-service tools through our **Provider Portal**, which are available to you on demand. In addition to our Provider Portal, we have locally based Provider Engagement Specialists and a locally based Provider Service Center. In the event you have a service issue, please reach out to your specific Provider Engagement Specialist or our Provider Services Center at 1-833-230-2174, Monday through Friday, 7:30 a.m. to 5:30 p.m., Central Time for immediate assistance. If

our self-service tools and/or representatives are unable to assist you to your satisfaction, please request to be escalated to the appropriate supervisor.

Member/Caregiver Rights & Responsibilities

As a TrueCare provider, you are required to respect the rights of our members. TrueCare informs our members of their rights and responsibilities via their Member Handbook. Our members' rights and responsibilities are listed below. All members are encouraged to take an active and participatory role in their own health and the health of their family.

Member rights, as stated in the Member Handbook, are as follows:

- To receive information about TrueCare, its services, its practitioners and providers, and member rights and responsibilities.
- To receive all services that TrueCare must provide.
- To be treated with respect and with regard for the member's dignity and privacy.
- To ensure medical records and personal information will be kept private.
- To be given information about the member's health. This information may also be available to someone whom the member has legally authorized to have the information or who the member has said should be reached in an emergency when it is not in the best interest of the member's health to give it to the member.
- To discuss any appropriate or medically necessary treatment options for the member's condition, regardless of cost or benefit coverage.
- To participate in decisions regarding the member's health care, including the right to refuse treatment.
- To voice complaints or appeals about the plan or the care it provides.
- To receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand.
- To be sure that others cannot hear or see the member when they are getting medical care.
- To be free from any form of restraint or seclusion used as a means of force, discipline, ease, or revenge as specified in federal regulations.
- To request and receive a copy of the member's medical records and request to amend or correct the record.
- To be able to say yes or no to having any information about the member given out unless TrueCare has to by law.
- To be able to say no to treatment or therapy. If the member says no, the doctor or TrueCare must talk to the member about what could happen and a note must be placed in their medical record about the treatment refusal.
- To be able to file an appeal, grievance (complaint), or state hearing/external review about TrueCare or the care it provides, and that the exercise of those rights will not adversely affect the way the member is treated.
- To be able to get all TrueCare written member information from TrueCare:
  - At no cost to the member.

  - In the prevalent non-English languages of members in TrueCare's service area.
  - In other ways, to help with the special needs of members who may have trouble reading the information for any reason.
- To be able to get help free of charge from TrueCare and its providers if the member does not speak English or needs help understanding information.
- To be able to get help with sign language if the member is hearing impaired.
- To be told if the health care provider is a student and to be able to refuse the provider's care.
- To be told of any experimental care and to be able to refuse to be part of the care.
- To make advance directives (a living will).
- To freely exercise the member's rights, including those related to filing a grievance or appeal, and that the exercise of these rights will not adversely affect the way the member is treated.
- To know that TrueCare must follow all federal and state laws and other laws about privacy that apply.
- To choose the provider that gives the member care whenever possible and appropriate.
- To be able to get a second opinion from a qualified provider on TrueCare's panel. If a qualified provider cannot see the member, TrueCare must set up a visit with a provider not on its panel.
- To not be held liable for the supplier's debts in the event of insolvency.
- To not be held liable for covered services provided to the member for which TrueCare does not pay the health care provider that furnishes the services.
- To not be held liable for payments of covered services furnished under a contract, referral, or other arrangement to the extent that those payments are more than the amount the member would owe if the supplier provided the services directly.
- To be responsible for cost sharing only in accordance with 42 CRF 447.50 through 42 CRF 447.60.
- To not be billed for any service covered by Medicaid.
- To make recommendations regarding TrueCare's member rights and responsibility policy.
- To contact the U.S. Department of Health and Human Services Office of Civil Rights at the address below with any complaint of discrimination based on race, color, religion, sex, sexual orientation, age, disability, national origin, veteran status, ancestry, health status, or need for health services:

  Mail: U.S. Department of Health and Human Services
  Office of Civil Rights
  200 Independence Avenue S.W.
  509F HHH Bldg.
  Washington, DC 20201

  Phone: 1-877-696-6775

  Email: OCRCompliant@hhs.gov

Website: hhs.gov/ocr/complaints/index.html

Members of TrueCare are also informed of the following responsibilities:

- Use only approved providers, except in emergencies or other situations approved by TrueCare.
- Keep scheduled doctor appointments, be on time, and call 24 hours in advance of a cancellation.
- Follow the advice and instructions for care the member has agreed upon with their doctors and other health care providers.
- Always carry their ID card and present it when receiving services.
- Never let anyone else use their ID card.
- Notify the Medicaid regional office and TrueCare of a change in phone number or address.
- Contact their PCP after going to an urgent care center or after getting medical care outside of TrueCare's covered counties or service area.
- Let TrueCare and the Medicaid regional office know if the member has other health insurance coverage.
- Provide the information that TrueCare and providers need to provide care.
- Understand as much as possible about their health issues and take part in reaching goals that the member and providers agree upon.
- Let us know if the member suspects fraud, waste, or abuse.

Notification of Practice Changes

Advance written notice of status changes (e.g., a change in address or phone, adding or deleting a provider to your practice) helps us keep our records current and are critical for claims processing. Additionally, it ensures our directories are up to date and reduces unnecessary calls to your practice.

How to Submit Changes

All demographic changes for Mississippi Medicaid providers must be made through the state portal. To update demographics, you can access the MESA Provider Portal or contact the MESA Provider Services line at 1-877-614-0484.

Timeline of Provider Changes

Providers should notify TrueCare of intent to terminate 60 calendar days prior to the intended date of termination.

Member Panel Capacity Changes

PCPs can limit the number of members assigned to their panel. To adjust the capacity of your panel, simply notify TrueCare of your need to increase or decrease the number of members assigned to your care. If you need to decrease the number, TrueCare requires notification 60 calendar days before the change. Capacity changes can be submitted by:

- Contacting Provider Services at 1-833-230-2174
- Sending an email to the maintenance mailbox **ProviderMaintenance@CareSource.com** including:
  - Name
  - NPI
  - Capacity change
  - Effective date (decreases must be at least 60 days from submission date)

Procedures for Dismissing Non-Compliant Members

Participating health care providers can request that a TrueCare member be involuntarily dismissed from their practice if a member does not respond to recommended patterns of treatment or behavior. Examples include non-compliance with medication schedules, skipping scheduled appointments, or failure to modify behavior as requested. Any time a member misses three or more consecutive appointments, providers are asked to notify our Care Management department for assistance.

TrueCare requires that a provider's office make at least three attempts to educate the member about non-compliant behavior and document them in the patient's record. Please remember that TrueCare's outreach staff can assist you in educating the member. After three attempts, providers may initiate the dismissal by following these guidelines:

- The provider office must notify the member of the dismissal by certified letter.
- A copy of the letter must be sent to TrueCare at the following address:

  TrueCare
  Attn: Member Services Manager
  P.O. Box 8730
  Dayton, OH 45401-1947
  Fax: 1-937-531-2398

- For PCPs only, the letter must contain specific language stating that:
  - The member must contact the Member Services department to choose another PCP.
  - The dismissing PCP will provide 30 days of emergency coverage to the patient from the date of dismissal.

Provider Directory Information Attestation

State and federal regulations require health plans to validate and update published information regarding their contracted provider network every 90 days. This validation ensures we have the most accurate information for claims payment and provider directories. This information is critical to process your claims. In addition, it ensures our provider directories are up to date and reduces unnecessary calls to your practice. This information is also reportable to Medicaid and Medicare. **Providers are required to attest to directory information every 90 days.**

What happens if I do not attest to my information?
The Centers for Medicare & Medicaid Services (CMS) requires health plans to verify the accuracy of provider directory information every 90 days. Not attesting to your information and/or providing updated information when applicable can result in claims payment issues and inaccurate provider data in our online and printed directories. With the No Surprises Act in effect as of January 1, 2022, providers who do not attest quarterly risk being suppressed in impacted provider directories.

Accurate provider directory information ensures we can connect the **right patients** to the **right provider**.

Personally Identifiable Information

In the day-to-day business of patient treatment, payment, and health care operations, TrueCare and its providers routinely handle large amounts of personally identifiable information (PII). In the face of increasing identity theft, there are various standards and industry best practices that guide PII be appropriately protected wherever it is stored, processed, and transferred while conducting normal business. As a provider, you should be taking measures to secure your sensitive provider data, and you are mandated by the Health Insurance Portability and Accountability Act (HIPAA) of 1996 to secure protected health information (PHI). There are many controls you should have in place to protect sensitive PII and PHI.

Here are a few important places to start:

- Utilize a secure message tool or service to protect data sent by email.
- Limit paper copies of PHI and PII left out in the open in your workspace and shred this content when no longer needed.
- Ensure conversations involving patient information cannot be overheard by others.
- Ensure all employees complete a HIPAA training program and understand the importance of safeguarding patient information.

There may be times when we share patient information with you or ask you to share with us. TrueCare, like you, is a covered entity under HIPAA. It is permissible for covered entities to share patient information when necessary for treatment, payment, or health care operations.

HIPAA Notice of Privacy Practices

Members are notified of TrueCare's privacy practices as required by HIPAA. TrueCare's privacy practices, available at **MSTrueCare.com** > About Us > Legal > HIPAA Privacy Practices, includes a description of how and when member information is used and disclosed within and outside of the TrueCare organization. The notice also informs members how they may obtain a statement of disclosures or request their medical claim information.

TrueCare takes measures internally across our organization to protect oral, written, and electronic PII and PHI of members. Please remember that as a provider/covered entity, you are obligated to follow the same HIPAA regulations as TrueCare and only make reasonable and appropriate uses and disclosures of PHI for treatment, payment, and health care operations.

Please remember that disclosures of a patient's PHI are permitted for treatment, payment, or health care operations in compliance with the HIPAA regulation 45 CFR 164. For example, providers may disclose patient information to TrueCare for quality assessment and improvement activities, population-based activities relating to improving health or reducing health care costs, or case management and care coordination, among others. Thank you for your assistance in providing requested information to TrueCare in a timely manner.

Sensitive Health Diagnoses

Consent is the member's written permission to share their information. Not all disclosures require the member's permission. Consent requirements pertain to sensitive health information (SHI) and substance use disorder (SUD) treatment.

- SHI is defined by the state (e.g., HIV/AIDS, mental health, sexually transmitted diseases).
- SUD 42 CFR Part 2 (Part 2), pertains to federal requirements that apply to all states.

While all member data is protected under the HIPAA Privacy Rules, Part 2 provides more stringent federal protection for individuals with SUD who could be subjected to discrimination and legal consequences in the event their information is inappropriately used or disclosed. The state requirements provide more stringent protection for the sharing of certain information determined to be SHI.

PRIMARY CARE PROVIDERS

Primary Care Provider Concept

All TrueCare members choose or are assigned to a primary care provider (PCP) upon enrollment in the plan. PCPs should help facilitate a medical home for members. This means that PCPs will help coordinate health care for members and provide additional health options to members for self-care or care from community partners.

Members select a PCP from our health plan's provider directory. Members have the option to change to another participating PCP during the first 90 days of enrollment and then annually after that. Members may initiate the change by utilizing their **TrueCare MyLife** account, using the **PCP Change Request Form**, or calling our Member Services department at 1-833-230-2050 (TTY:711).

Roles & Responsibilities

PCP care coordination responsibilities include, at a minimum:

- Assisting with coordination of the member's overall care, as appropriate for the member.
- Serving as the ongoing source of primary and preventive care.
- Recommending specialists.
- Triaging members.
- Participating in the development of case management care treatment plans and notifying TrueCare of members who may benefit from care management.

PCPs are responsible for:

- Treating TrueCare members with the same dignity and respect afforded to all patients. This includes high standards of care and the same hours of operation.
- Providing preventive care and teaching healthy lifestyle choices.
- Assessing the urgency of the member's medical needs and directing the member to the best place for that care.
- Identifying the member's health needs and taking appropriate action.
- Providing phone coverage for handling patient calls 24 hours a day, seven days a week.
- Following all referral and prior authorization policies and procedures as outlined in this manual.
- Complying with the quality standards of our health plan and the Division of Medicaid (DOM).
- Providing 30 days of emergency coverage to any TrueCare patient dismissed from the practice.
- Maintaining clinical records, including information about pharmaceuticals, referrals, inpatient history, etc.
- Obtaining patient records from facilities visited by TrueCare patients for emergency or urgent care if notified of the visit.

- Ensuring demographic and practice information is up to date for directory and member use.
- Reporting suspected fraud and/or abuse.

In addition, TrueCare PCPs play an integral part in coordinating health care for our members by providing:

- Availability of a personal health care practitioner to assist with coordination of a member's overall care, as appropriate for the member.
- Continuity of the member's total health care.
- Early detection and preventive health care services.
- Elimination of inappropriate and duplicate services.

Provider Selection

TrueCare allows for PCPs to include traditional provider types that have historically served as PCPs as well as alternative provider types, such as specialists and patient-centered medical homes (PCMH) with documented physician oversight and meaningful physician engagement. A member who has a primary diagnosis of a severe persistent mental illness may be permitted to have any physician, including a psychiatrist, as their PCP.

A member may select a PCP as a medical home from the following types of providers:

- Family practice physicians
- General practice physicians
- Pediatricians – for members up to age 19
- Internal medicine
- Obstetricians and gynecologists – optional
- Nurse practitioners-certified (NP-C) specializing in family practice or pediatrics.
  - **Note**: NP-Cs in independent practice must also have a current collaborative agreement with a licensed physician who is a network provider, who has hospital admitting privileges, and who oversees the provision of services furnished by NP-Cs.
- Psychiatrists who agree to serve as PCPs for members who have a primary diagnosis of severe persistent mental illness
- Physicians who provide medical services at Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)
- Providers who practice at Public Health Department clinics and hospital outpatient clinics when most of their practice is devoted to providing continuing comprehensive and coordinated medical care
- Physician assistants (physician will be listed as member's PCP)
- Retail Health Clinics, such as Walmart, Little Clinics, CVS, and Walgreens
- Specialists treating a member's chronic condition(s) who agree to act as their PCP

If a member does not select a PCP, TrueCare will assign them one.

Patient-Centered Medical Home

To facilitate total care integration for our members, TrueCare encourages a medical home care model. A medical home is a long-term partnership between the PCP/provider team, the patient, and the patient's family. The care model focuses on the whole patient, with support and advice for prevention, behavioral health, and dental health.

The model provides many benefits to the member and provider, including fewer hospital or emergency department visits, higher patient satisfaction, improved access for members in rural environments, and higher quality at a lower cost to the health care system.

TrueCare encourages providers to attain National Committee for Quality Assurance (NCQA) PCMH recognition. We offer financial incentives to providers who have NCQA PCMH recognition. To support providers working to attain NCQA PCMH accreditation, TrueCare offers free consultative assistance to navigate the recognition process with NCQA. Contact your Provider Engagement Specialist for more information.

Dental Providers

TrueCare supports the ongoing relationship between our network dentists and our members. Network dentists are contracted through Avesis. We want to ensure our members have access to a full array of dental services that deliver appropriate and timely dental care. We offer eligible members access to a comprehensive dental network throughout Mississippi that leverages the model of a "health home" to organize and coordinate access to dental care for all our qualified populations.

Dental Home

The dental home model includes all aspects of meeting adult or pediatric oral health needs and is a partnership between parents/caregivers, the patient, dentists, and dental and non-dental professionals. A dental home can be either a general dentist, or in the case of children, a pediatric dentist. For a list of covered services, please see the Covered Services section of this manual.

TrueCare communicates with its members to provide information about the importance of preventive dental care and selecting a dental home as early as possible. We encourage our members to select a primary dentist at the time of enrollment along with a PCP. If a member does not select a dentist to coordinate care at the time of enrollment, we will assign a dentist using the following criteria:

- Claims history, if the member has a historical dental relationship
- Geographic proximity, if the member does not make a selection

We notify members within 10 calendar days of their dental PCP assignments and provide the option to change their dental homes anytime during the first 30 days. A member can change their dental home at any time and can still go to any participating network dentist to receive treatment.

TrueCare continually assesses the quality of our network and health homes to ensure members have access to the dental care they need. We perform periodic quality checks of our network to guarantee the timely and high-quality treatment of our members.

Advance Directives

An advance directive is a written instruction, recognized under Mississippi law, relating to the provision of health care when a member is incapacitated.

Under Mississippi law, TrueCare members have the right to make decisions concerning their medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives.

Providers delivering medical care to TrueCare members must ensure all adult TrueCare members 18 years of age and older receive information on advance directives and are informed of their rights to execute advance directives. Information regarding advance directives should be made available in provider's offices and discussed with TrueCare members or provider's staff when questions arise.

Providers should discuss advance directives with adult TrueCare members during the member's initial office visit and document in the member's medical record whether the member has executed an advance directive.

Providers delivering medical care to TrueCare members shall not, as a condition of treatment, require a member to execute or waive an advance directive. In addition, providers shall not discriminate against TrueCare members based on whether the member has executed an advance directive.

Medical Records

Physicians shall prepare, maintain, and retain as confidential the health records of all members receiving health care services and members' other personally identifiable health information received from TrueCare, in a form and for time periods required by applicable state and federal laws, licensing requirements, accreditation and reimbursement rules and regulations to which physicians and providers are subject, and in accordance with accepted practices.

Providers are required to maintain member records on paper or in an electronic format. Member medical records shall be timely, legible, current, detailed, and organized to permit effective and confidential patient care and quality review.

Complete medical records include, but are not limited to, medical charts, applicable directives, prescription files, hospital records, provider specialist reports, consultant and other health care professionals' findings, appointment records, and other documentation sufficient to disclose the quantity, quality, appropriateness, and timeliness of services provided under the contract. Medical records shall be signed by the provider of service.

The PCP also must maintain a primary medical record for each member that contains sufficient medical information from all providers involved to ensure quality of care.

The medical chart organization and documentation shall, at a minimum, require the following:

- Member/patient identification information, on each page
- Personal/biographical data, including date of birth, age, gender, marital status, race or ethnicity, mailing address, home and work addresses and telephone numbers, employer, school name and telephone numbers (if no phone, contact name and number) of emergency contacts, consent forms, identification of language spoken, and guardianship information
- Date of data entry and date of encounter
- Provider identification by name
- Allergies, adverse reactions, and known allergies noted in a prominent location
- Past medical history, including serious accidents, operations, and illnesses (for children, past medical history includes prenatal care and birth information, operations, and childhood illnesses [e.g., documentation of chickenpox])
- Identification of current problems
- The consultation, laboratory, and radiology reports in the medical record shall contain the ordering provider's initials or other documentation indicating review
- Documentation of immunizations
- Identification and history of nicotine, alcohol, or substance use
- Documentation of reportable diseases and conditions submitted to the local health department serving the jurisdiction in which the patient resides or the Department for Public Health
- Follow-up visits provided and (secondary) reports of emergency department care
- Hospital discharge summaries
- Advance medical directives, for adults
- All written denials of service and the reason for the denial
- Record legibility to at least a peer of the writer (records judged illegible by one reviewer shall be evaluated by another reviewer)

A member's medical record shall include the following minimal detail for individual clinical encounters:

- History and physical examination for presenting complaints containing relevant psychological and social conditions affecting the patient's physical/behavioral health, including mental health and substance use status
- Unresolved problems, referrals, and results from diagnostic tests including results and/or status of preventive screening services (e.g., EPSDT) addressed from previous visits
- Plan of treatment including:
  - Medication history, medications prescribed, including strength, amount, directions for use, and refills
  - Therapies and other prescribed regimen
  - Follow-up plans including consultation and referrals and directions, including time to return

A member's medical record shall include the following minimal detail for hospitals and mental hospitals:

- Identification of the beneficiary
- Physician name
- Date of admission and dates of application for and authorization of Medicaid benefits, if application is made after admission; the plan of care (as required under 42 CFR 456.172 (mental hospitals) or 42 CFR 456.70 (hospitals)
- Initial and subsequent continued stay review dates (described under 42 CFR 456.233 and 42 CFR 465.234 (for mental hospitals) and 42 CFR 456.128 and 42 CFR 456.133 (for hospitals)
- Reasons and plan for continued stay if applicable
- Other supporting material the committee believes appropriate to include
- For non-mental hospitals only:
  - Date of operating room reservation
  - Justification of emergency admission, if applicable

FRAUD, WASTE, AND ABUSE

Overview

Health care fraud, waste, and abuse hurts everyone, including members, providers, taxpayers, and TrueCare. As a result, TrueCare has a comprehensive Fraud, Waste, and Abuse program in our Program Integrity department. Please help us by reporting questionable activities and potential fraud, waste, and abuse situations. To report fraud, waste, or abuse, call TrueCare at 1-833-230-2174.

Definition of Terms

Fraud is defined as “an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal or state law” (42 CFR, Part 455.2).

Waste involves taxpayers not receiving reasonable value for money in connection with any government funded activities due to an inappropriate act or omission by player with control over, or access to, government resources (e.g., executive, judicial or legislative branch employees, grantees, or other recipients). Waste goes beyond fraud and abuse, and most waste does not involve a violation of law. Waste relates primarily to mismanagement, inappropriate actions, and inadequate oversight (Inspector General).

Abuse is defined as “provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary costs to the Medicaid program” (42 CFR Part 455.2).

Improper Payment is any payment that should not have been made or that was made in an incorrect amount (including overpayments and underpayments) under statutory, contractual, administrative, or other legally applicable requirements. This includes any payment to an ineligible recipient, any payment for an ineligible good or service, any duplicate payment, any payment for a good or service not received (except for such payments where authorized by law), and any payment that does not account for credit for applicable discounts (Improper Payments Elimination and Recovery Act, IPERA). Any improper payment may constitute fraud, waste, and/or abuse. TrueCare has the right to recoup improper payments.

Examples of Member Fraud, Waste, and/or Abuse

- Inappropriately using services, such as selling prescribed narcotics, or seeking controlled substances from multiple providers or multiple pharmacies

- Altering or forging prescriptions (i.e., changing a prescription form to get more than the amount of medication prescribed by their physician)
- Sharing a member ID card
- Non-disclosure of other health insurance coverage
- Obtaining unnecessary equipment and supplies
- Member receiving services or picking up prescriptions under another person's name or ID (identity theft)
- Providing inaccurate symptoms and other information in order get treatment, drugs, etc.
- Any other action by a member that TrueCare considers to be fraud, waste, and/or abuse

Note: This is not an all-inclusive list.

Examples of Provider Fraud, Waste, and/or Abuse

- Prescribing drugs, equipment, or services that are not medically necessary
- Failing to provide patients with medically necessary services due to lower Medicaid/Medicare reimbursement rates
- Billing for services not rendered
- Requiring members to pay for TrueCare covered services
- Billing more than once for the same service
- Intentionally using improper medical coding to receive a higher rate of reimbursement
- Prescribing high quantities of controlled substances without medical necessity
- Unbundling services to obtain higher reimbursement
- Not checking member IDs, resulting in claims submitted for non-covered persons
- Scheduling more frequent return visits than are needed
- Billing for services outside of your medical qualifications
- Using member/enrollee lists for the purpose of submitting fraudulent claims
- Billing drugs for inpatients as if they were outpatients
- Accepting payments stemming from kickbacks or Stark violations
- Retaining overpayments made in error by TrueCare
- Preventing members from accessing eligible or covered services resulting in underutilization of services offered
- Failing to comply with federal and/or state laws

Note: This is not an all-inclusive list.

Examples of Pharmacy Fraud, Waste, and/or Abuse

- Dispensing prescription drugs not dispensed as written
- Submitting claims for a more expensive brand name drug when a less expensive generic prescription is dispensed

- Dispensing less than the prescribed quantity without arranging for the additional medication to be received with no additional dispensing fees
- Splitting prescriptions into two orders to seek higher reimbursement
- Dispensing expired, fake, diluted, tainted, or illegal drugs
- Billing prescriptions not filled or picked up

Examples of Employee Fraud, Waste, and/or Abuse

- Receiving gifts or kickbacks from vendors for goods or services
- Inappropriately marketing our company to potential members
- Behaving in an unethical or dishonest manner while performing company business

Note: It is also important for you to tell us if a TrueCare employee acts inappropriately.

Examples of Vendor Fraud, Waste, and/or Abuse

- Falsifying business data or reports
- Not reporting or taking action on employees that are debarred
- Billing for services not rendered
- Billing for a more expensive service, but providing a less expensive service

Corrective Actions

The TrueCare Program Integrity department routinely monitors potential fraud, waste, and abuse. We review claims data and medical records to look for billing discrepancies. When found, an investigation is initiated and, if warranted, corrective action is taken.

Corrective actions can include, but are not limited to:

- Member and/or provider education
- Written corrective action plan
- Provider termination with or without cause
- Provider summary suspension
- Recovery of overpaid funds
- Member disenrollment
- Reporting to one or more applicable state and federal agencies
- Contract termination
- Employee disciplinary actions
- Legal action

Refer to your Provider Agreement for specific information on each type of provider termination/suspension. Also, refer to the Fair Hearing Plan for the information on the appeal process. The TrueCare Fair Hearing Plan is available at **MSTrueCare.com** > Provider >

Education > Fraud, Waste & Abuse. The Fair Hearing Plan provides information on an appeal process for specific corrective actions.

The False Claims Act

Using the False Claims Act, you can help reduce fraud against the federal government. The Act allows everyone to bring “whistleblower” lawsuits on behalf of the government – known as “qui tam” suits – against businesses or other individuals that are defrauding the government through programs, agencies, or contracts.

As amended in 2009, the False Claims Act addresses those who:

- Knowingly* present, or cause to be presented, a false or fraudulent claim for payment or approval.
- Knowingly* make, use, or cause to be made or used, a false record or statement material to a false or fraudulent claim.
- Conspire to commit a violation of any other section of the False Claims Act.
- Have possession, custody, or control of property or money used, or to be used, by the government and knowingly deliver, or cause to be delivered, less than all of that money or property.
- Are authorized to make or deliver a document certifying receipt of property used, or to be used by the government, and intending to defraud the government, make or deliver the receipt without completely knowing that the information on the receipt is true.
- Knowingly* buy, or receive as a pledge of an obligation or debt, public property from an officer or employee of the government, or a member of the armed forces, who lawfully may not sell or pledge property.
- Knowingly* make, use, or cause to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the government, or knowingly conceal or knowingly and improperly avoid or decrease an obligation to pay or transmit money or property to the government.

*“Knowingly” means acting with actual knowledge or with reckless disregard or deliberate indifference to the truth or falsity of information.

An example would be if a provider, such as a hospital or a physician knowingly “upcodes” or overbills, resulting in overpayment of the claim using Medicaid and/or Medicare dollars.

The time period for a claim to be brought under the False Claims Act is the latter of:

- Within six years from the date of the illegal conduct, or
- Within three years after the date the government knows or should have known about illegal conduct, but in no event later than 10 years after the illegal activity.

Protection for Whistleblowers

Federal and state law and TrueCare's policy prohibit any retaliation or retribution against people who report suspected violations of these laws to law enforcement officials or who file "whistleblower" lawsuits on behalf of the government. Anyone who believes that he or she has been subject to any such retribution or retaliation should also report this to our Program Integrity department using one of the reporting methods outlined at the end of this section.

Individuals bringing the suit may receive a percentage of the proceeds of the action or settlement. Additional information on the False Claims Act and our fraud, waste, and abuse policies can be found at **MSTrueCare.com** > Providers > Education > Fraud, Waste & Abuse.

Anti-Kickback Statute

Under the Federal Anti-Kickback Statute, and subject to certain exceptions, it is a crime for anyone to knowingly and willfully solicit or receive, or pay anything of value, including a kickback, bribe, or rebate in return for referring an individual to a person for any item or service for which payment may be made in whole or in part under a federal health care program (42 U.S.C. §1320a-7b).

Stark Law

Under the Federal Stark Law, and subject to certain exceptions, providers are prohibited from referring federal health care program patients for certain designated health services to an entity with which the physician or an immediate family member has a financial relationship. The Stark Law imposes specific reporting requirements on entities that receive payment for services covered by federal health care programs (42 U.S.C. §1395nn).

Health Insurance Portability and Accountability Act

As part of the Health Insurance Portability and Accountability Act (HIPAA), the U.S. Criminal Code was amended, and it is a crime to knowingly and willfully execute, or attempt to execute a scheme or artifice to defraud any federal health care program or obtain by means of false or fraudulent pretenses, representations or promises, any money or property owned by or under the custody or control of any federal health care program. (18 U.S.C. §1347).

The Deficit Reduction Act of 2005

The Deficit Reduction Act of 2005 (DRA) contains many provisions reforming Medicare and Medicaid that are designed to reduce program spending. As an entity that offers Medicaid and Medicare coverage, TrueCare is required to comply with certain provisions of the DRA.

One such provision prompted this communication, as it requires us to provide you with information about the federal False Claims Act, state False Claims Acts, and other state laws

regarding Medicare and Medicaid fraud. In addition, the DRA requires you and your contractors and agents to adopt our policy on fraud, waste, and abuse when handling TrueCare business.

Mississippi Law

Mississippi law does address fraud with respect to the Medicaid program specifically and state or federally funded assistance programs generally.

1. Mississippi's Medicaid Fraud Control Act (Miss. Code Ann. 43-13-201) imposes the following prohibitions with respect to the Medicaid program:
    a. A person shall not knowingly make or cause to be made a false representation of a material fact in an application for Medicaid benefits.
    b. A person shall not knowingly make or cause to be made a false statement of a material fact for use in determining rights to a Medicaid benefit.
    c. A person, who having knowledge of the occurrence of an event affecting their initial or continued right to receive a Medicaid benefit, shall not conceal or fail to disclose that event with intent to obtain a Medicaid benefit to which the person or any other person is not entitled or in an amount greater than that to which the person or any other person is entitled.
    d. A person shall not solicit, offer, or receive a kickback or bribe in the furnishing of goods or services for which payment is or may be made in whole or in part pursuant to the Medicaid program, or make or receive any such payment, or receive a rebate of a fee or charge for referring an individual to another person for the furnishing of such goods and services.
    e. A person shall not knowingly and willfully make, induce, or seek to induce the making of a false statement or false representation of a material fact with respect to the conditions or operation of an institution or facility in order that the institution or facility may qualify, upon initial certification or recertification, to receive Medicaid benefits as a hospital, skilled nursing facility, intermediate care facility, or home health agency.
    f. A person shall not make, present, or cause to be made or presented a claim for Medicaid benefits knowing the claim to be false, fictitious, or fraudulent.
    g. A person who violates the Medicaid Fraud Control Act is guilty of a felony, and upon conviction, will be punished.

2. Section 43-13-129 of the Mississippi Code prohibits (1) knowingly making a false statement or false representation or failing to disclose a material fact in connection with an application for Medicaid benefits for oneself or for another person; and (2) for providers of services, knowingly making a false statement or false representation or failing to disclose a material fact to obtain or increase any Medicaid benefit or payment. A person who violates this section is guilty of a misdemeanor, and, upon conviction, is subject to imprisonment of up to one year and/or a fine of up to $500.

3. Section 97-19-71 of the Mississippi Code provides that a person is guilty of fraud for committing any of the following:

a. Knowingly failing, by false statement, misrepresentation, impersonation, or other fraudulent means, to disclose a material fact used in making a determination as to such person's qualification to receive aid or benefits or services under any state or federally funded assistance program.
b. Knowingly failing to disclose a change in circumstances in order to obtain or continue to receive under any such program aid or benefits or services to which he is not entitled or in an amount larger than that to which he is entitled, or knowingly aiding and abetting another person in the commission of any such act.
c. Knowingly using, transferring, acquiring, trafficking, altering, forging, or possessing (or attempting or aiding or abetting another in doing so) a certificate of eligibility for medical services, or a Medicaid identification card, for profit or in any manner not authorized by law or regulations issued by the agency responsible for the administration of the state or federally funded program.
d. With respect to persons having duties in the administration of a state or federally funded assistance program, fraudulently misappropriating (or attempting or aiding or abetting another in doing so) a certificate of eligibility for prescribed medicine, a Medicaid identification card, or assistance from any other state or federally-funded program with which he or she has been entrusted or of which he or she has gained possession by virtue of his position, or who knowingly fails to disclose any such fraudulent activity.
e. Knowingly filing, attempting to file, or aiding and abetting in the filing of a claim for services to a recipient of benefits under any state or federally funded assistance program for services which were not rendered; knowingly filing a false claim for nonauthorized items or services under such a program; or knowingly billing the recipient of benefits under such a program, or his family, for an amount in excess of that provided for by law or regulations; or in any way knowingly receiving, attempting to receive, or aiding and abetting in the receipt of unauthorized payment.
f. Knowingly signing or aiding and abetting any person to sign a false application for the replacement of benefits or aid to which that person is entitled claiming that person's benefits or aid was not received.
g. A person convicted of violating any of the above provisions of section 97-19-71 will be imprisoned for up to three years and fined up to $10,000 together with restitution of the value of money or services unlawfully received.

Prohibited Affiliations

TrueCare is prohibited by its federal and state contracts from knowingly having relationships with people who are debarred, suspended, or otherwise excluded from participating in federal procurement and non-procurement activities (42 CFR 438.610).

Relationships must be terminated with any trustee, officer, employee, provider, or vendor who is identified to be debarred, suspended, or otherwise excluded from participation in federal or state health care programs. If you become aware that your corporate entity, those with more than five percent ownership in your corporate entity, your office management staff, or you are a prohibited affiliation, you must notify us by emailing **ProviderMaintenance@CareSource.com**.

Disclosure of Ownership, Debarment and Criminal Convictions

Before TrueCare enters or renews an agreement with your practice or corporate entity, you must disclose any debarment or suspension status and any criminal convictions related to federal health care programs of yourself and your managing employees and anyone with an ownership or controlling interest in your practice or corporate entity.

You must also notify TrueCare of any federal or state government current or pending legal actions, criminal or civil, convictions, administrative actions, investigations, or matters subject to arbitration.

In addition, if the ownership or controlling interest of your practice or corporate entity changes, you have an obligation to notify us immediately. This also includes ownership and controlling interest by a spouse, parent, child, or sibling. Please contact us by emailing **ProviderMaintenance@CareSource.com**.

If you have ownership of a related medical entity where there are significant financial transactions, you may be required to provide information on your business dealings upon request.

If you fail to provide this information, we are prohibited from doing business with you. Please refer to 42 CFR 455.100-106 for more information and definitions of relevant terms.

How to Report Fraud, Waste, or Abuse

It is TrueCare's policy to detect and prevent any activity that may constitute fraud, waste, or abuse, including violations of the federal False Claims Act or any state Medicaid fraud laws.

If you have knowledge or information that any such activity may be or has taken place, please contact our Program Integrity department. Reporting fraud, waste, or abuse can be anonymous or not anonymous.

Options for reporting anonymously*:*

- **Call: 1-833-230-2174** and ask to report fraud.
- **Write**: TrueCare
  Attn: Program Integrity
  P.O. Box 1940
  Dayton, OH 45401-1940

Options for reporting that are not anonymous:

- **Fax:** 1-800-418-0248
- **Email*: Fraud@MSTrueCare.com**

**Most email systems are not protected from third parties. Please do not use email to send confidential information. If you will be sending confidential or health information, please use the form or phone number to report your concerns to help protect your privacy.*

Or you may choose to use the **Fraud, Waste, and Abuse Reporting Form** located on **MSTrueCare.com** > Providers > Tools & Resources > Forms.

When you report fraud, waste, or abuse, please give as many details as you can, including names and phone numbers. You may remain anonymous, but if you do, we will not be able to call you back for more information. Your reports will be kept confidential to the extent permitted by law. Thank you for helping TrueCare keep fraud, waste, and abuse out of health care.

Physician Education Materials

The Office of the Inspector General (OIG) has created free materials for providers to assist you in understanding the federal laws designed to protect Medicaid and Medicare programs and program beneficiaries from fraud, waste, and abuse. This brochure can be found on the Office of Inspector General's website at oig.hhs.gov/compliance/physician-education/index.asp.

QUALITY IMPROVEMENT

Quality Management

TrueCare is committed to providing evidence-based care in a safe, member-centered, timely, efficient, and equitable manner. The scope of the TrueCare Quality Management (QM) program is comprehensive, inclusive of both clinical and non-clinical services, and health, safety, and/or welfare concerns. TrueCare monitors and evaluates the quality and safety of the care and service delivered to our members emphasizing:

- Accessibility to care
- Availability of services and practitioners
- Medical and behavioral health services
- Internal monitoring, review, and evaluation of program areas, including Utilization Management, Care Management, and Pharmacy

Member and provider satisfaction and health outcomes are monitored through:

- Quality improvement activities
- Routine health plan reporting
- Annual Health Effectiveness Data and Information Set (HEDIS®), which measures the quality of our health plan
- Consumer Assessment of Healthcare Providers and Systems (CAHPS®), which measures patient experience with the health care system
- Member surveys
- Review of accessibility and availability standards
- Utilization trends

TrueCare assesses our performance against goals and objectives that are in keeping with industry standards. Annually, we complete an annual evaluation of our QM program.

TrueCare is pursuing interim accreditation by the National Committee for Quality Assurance (NCQA).

For more information about our survey process, TrueCare has an on-demand overview of Provider Satisfaction Surveys available on our Provider Learning Management System, **HealthPlanResources.com**. Click “Course Catalog” and select “Provider Education Series: Provider Satisfaction Survey.”

Program Purpose

The purpose of the QM program is to ensure that TrueCare has the necessary infrastructure to:

- Coordinate care using evidence-based tools
- Improve the health outcomes of our member population
- Promote quality care
- Ensure performance and efficiency on an ongoing basis

- Improve timely access to primary and specialty care, quality, safety, and equity of clinical care and services
- Address health equity needs

There are two guiding tenets for the program:

- Our mission is to make a lasting difference in our members' lives by improving their health and well-being. Our vision is to transform lives through innovative health and life services
- The Institute for Healthcare Improvement (IHI) Quintuple Aim: simultaneously improving the health of the population, enhancing the experience and outcomes of the patient, reducing the per capita cost of care for the benefit of communities, improving provider satisfaction, and advancing health equity.

The QM program includes both clinical and non-clinical services and is revised as needed to remain responsive to member needs, provider feedback, standards of care, and business needs.

Program Goals & Objectives

TrueCare strives to be a top performing health plan nationally. Performance goals are determined and aligned with national benchmarks where available.

The goals and objectives of the program are NCQA accreditation:

- Attain NCQA accreditation for Mississippi Medicaid in alignment with contract requirements
- Attain NCQA Commendable or Excellent accreditation status within three years of the operational start date
- Compliance with NCQA accreditation standards
- High level of HEDIS performance
- High level of CAHPS performance
- Comprehensive population health management program
- Comprehensive provider engagement program

Program Scope

The TrueCare QM program oversees quality improvement and assessment activities for TrueCare. The scope includes:

- Establishing safe clinical practices throughout our network of providers
- Provide quality oversight of all clinical services, including addressing all quality-of-care concerns
- Advocating for members across settings, including review and resolution of quality-of-care concerns
- Meeting member access and availability needs for physical and behavioral health care

- Determining interventions for HEDIS overall rate improvement that increase preventive care rates and facilitate support of member acute and chronic health conditions and other complex health, safety, or welfare needs
- Using the annual member CAHPS survey to capture member perspectives on health care quality and establish interventions based on results to enrich member and provider experience and satisfaction
- Ensuring TrueCare is effectively serving our members with cultural and linguistic needs, identifying disparities that may impact member receipt of health care services, and achieving positive member outcomes
- Monitoring important aspects of care to ensure the health, safety, and welfare of members across healthcare settings
- Ensuring that TrueCare is effectively serving members with complex health needs
- Ongoing assessment of member population health characteristics
- Regularly assessing the geographic availability and accessibility of primary and specialty care providers
- Partnering collaboratively with network providers, practitioners, regulatory agencies, and community agencies

Quality Strategy

TrueCare seeks to advance a culture of quality and safety that begins with our senior leadership and is cultivated throughout the organization. TrueCare utilizes the IHI framework developed to optimize health system performance.

The IHI Quintuple Aim for Populations

TrueCare aligns with the IHI framework to:

- Improve the member experience of care (including clinical quality and satisfaction)
- Improve the health of populations
- Reduce the per capita cost of health care
- Improve provider satisfaction (professional wellness)
- Advance health equity

In addition, TrueCare utilizes Six Sigma tools, when indicated, to focus on improving member experience and safety and ensuring our processes consistently deliver the desired results.

Centers for Medicare & Medicaid Services (CMS) National Quality Strategy

TrueCare aligns with the CMS National Quality Strategy to optimize health outcomes by leading clinical quality improvement and health system transformation. The CMS Quality Strategy vision for improving health care delivery can be summed up in three words: better, smarter, healthier.

The strategy corresponds to the four priorities from the Agency for Healthcare Research & Quality's National Quality Strategy. Each of these priorities is a goal in the CMS Quality Strategy:

- Equity and Engagement

  - Advance health equity and whole-person care
  - Engage individuals and communities to become partners in their care
- Outcomes and Alignment
  - Improve quality and health outcomes across the care journey
  - Align and coordinate across programs and care settings
- Safety and Resiliency
  - Achieve zero preventable harm
  - Enable a responsive and resilient health care system to improve quality
- Interoperability and Scientific Advancement
  - Accelerate and support the transition to a digital and data-driven health care system
  - Transform health care using science, analytics, and technology

External Quality Reviews

Through our contract with the Division of Medicaid (DOM), we are required to participate in periodic record reviews. DOM retains an External Quality Review Organization (EQRO) to conduct medical record review and analysis/evaluation for TrueCare Mississippi members.

You may periodically receive requests for medical record copies from TrueCare or from the DOM-contracted EQRO. Your contract with TrueCare requires that you furnish copies of patient medical records for this purpose.

EQRO and TrueCare reviews are a permitted disclosure of a member's personal health information in accordance with the Health Insurance Portability and Accountability Act (HIPAA).

TrueCare realizes that supplying medical records for review requires your staff's valuable time, and we appreciate your cooperation with our requests and associated timelines.

If you would like more information about the TrueCare Quality Management program, please call Provider Services at 1-833-230-2174.

Value-Based Reimbursement (VBR)

At TrueCare we value the role you play in providing the highest quality care to your patients – our members. We also understand that improving health outcomes requires a deeper collaboration that goes beyond the traditional managed care organization and participating network provider relationship. Our value-based programs provide the foundation for deepening the provider-payer relationship while focusing on improving the health outcomes of those we serve.

Along with our comprehensive value-based programs, we have the expertise, support, and access to tools and resources at TrueCare to help you achieve success. We will work in partnership with you and your staff to track your progress and identify opportunities to increase

member engagement, helping reposition you to achieve the highest available incentives through the program participation.

Contact your Provider Contracting Manager for more information about our VBR programs.

UTILIZATION MANAGEMENT

Referral Information

We retain a network of high-quality specialists. To make it administratively easy for providers to work with us, our members DO NOT NEED a referral to see these in-network providers. It is important to keep members in-network whenever possible and if it best serves the health care of members. In-network providers are better connected with TrueCare and have ready access to member information. If you have questions about prior authorizations, please call our Utilization Management department at 1-833-230-2174.

If you have difficulty finding a specialist for your TrueCare member, please use our online Find a Doctor tool at **findadoctor.mstruecare.com** or call Provider Services at 1-833-230-2174.

Referring Doctor – Document the referral in the patient's medical chart. You are not required to use a referral form or send a copy of it to our health plan. However, you must notify the specialist of your referral.

Specialist – Document in the patient's chart that the patient was referred to you for services. Referral numbers are not required on claims submitted for referred services. Generally, specialist-to-specialist referrals are not allowed. However, in some cases, specialists may provide services or make referrals in the same manner as a primary care provider (PCP). Documentation in the medical record should contain the number of visits or length of time of each referral. Medical records may be subject to random audits to ensure compliance with this referral procedure. TrueCare expects specialists to collaborate on the member's care and inform the member of treatment plan updates.

Standing Referrals – A PCP may request a standing referral to a specialist for a member with a condition or disease that requires specialized medical care over a prolonged period of time. The specialist may provide services in the same manner as the PCP for chronic or prolonged care. The period of time must be at least one year to be considered a standing referral.

Referrals to Non-Participating Providers – A member may be referred to an out-of-plan provider if the member needs medical care that can only be received from a doctor or other provider who is not participating with our health plan. Treating providers must get prior authorization from TrueCare before sending a member to an out-of-plan provider.

Referrals for Second Opinions – A second opinion is not required for surgery or other medical services. In accordance with 42 CFR 438.206(b)(3), TrueCare complies with all member requests for a second opinion from a qualified professional. If our network does not include a provider who is qualified to give a second opinion, TrueCare shall arrange for the member to obtain a second opinion from a provider outside the network, at no cost to the member.

The following criteria should be used when selecting a provider for a second opinion:

- The provider must be a participating provider. If not, prior authorization must be obtained to send the patient to a non-participating provider.
- The provider must not be affiliated with the member's PCP or the specialist practice group from which the first opinion was obtained.
- The provider must be in an appropriate specialty area.
- Results of laboratory tests and other diagnostic procedures must be made available to the provider giving the second opinion.

Services Not Requiring Referral

Services that do not require a referral include the following:

- Certified nurse practitioner (CNP) services
- Dental care (excluding oral surgery, orthodontic, endodontic, periodontics, prosthodontics, and some adjunctive services)
- Services to treat an emergency
- Family planning services
- Laboratory services (must be ordered by a participating provider)
- Podiatric care
- Psychiatric care at community mental health centers only
- Psychological care from private practitioners or at Community Mental Health Centers (CMHCs)
- Care at public health clinics
- Care at Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)
- Most radiology services (must be ordered by a participating provider)
- Speech and hearing services
- Care from obstetricians and gynecologists
- Care at urgent care centers after hours
- Services for children with medical handicaps

Note: Although TrueCare DOES NOT require that members obtain referrals for the providers below, the specific services rendered may still require prior authorization from TrueCare. In addition, all services rendered are still subject to benefit limits. PCPs or dental providers do not need to arrange or approve these services for members as long as any applicable benefit limits have not been exhausted.

Non-Participating Providers

Members may go to non-participating providers for:

- Emergent and urgent care
- Care at CMHCs
- Family planning services provided at qualified family planning providers
- Care at FQHCs and RHCs

Any provider who is not a participating provider with TrueCare must obtain prior authorization for all non-emergency services provided to a TrueCare member, with the exception of Family Planning services provided to TrueCare members.

Radiology Services

Ordering physicians must obtain a prior authorization for the following outpatient, non-emergent diagnostic imaging procedures:

- Magnetic resonance Imaging (MRI) and Magnetic Resonance Angiography (MRA)
- Computed Tomography (CT) and Computed Tomography Angiography (CTA) scans
- Positron Emission Tomography (PET) scans

Providers can obtain prior authorization from Evolent for an imaging procedure in the following ways:

- Online: www1.radmd.com
- By phone: 1-888-879-5923 (follow the options to obtain a prior authorization and select the option for advanced radiology prior authorization), Monday through Friday, 7 a.m. to 7 p.m., Central Time.

Authorization requests are approved at intake in most cases. If approval cannot be issued during the initial intake, more information may be required.

Please Note: Imaging procedures performed during an inpatient admission, hospital observation stay, or emergency department visit are not included in this program.

Utilization Management Information

Utilization management helps maintain the quality and appropriateness of health care services provided to TrueCare members. The Utilization Management department performs all utilization management activities including prior authorization, concurrent review, discharge planning, and other utilization activities. We monitor inpatient and outpatient admissions and procedures to ensure that appropriate medical care is rendered in the most appropriate setting using the most appropriate resources.

We also monitor the coordination of medical care to ensure its continuity. Referrals to the TrueCare Care Management team are made, if needed. TrueCare makes the utilization management criteria available to providers upon request. On an annual basis, TrueCare completes an assessment of satisfaction with the utilization management process and identifies any areas for improvement opportunities.

Utilization management criteria are available upon request:

Mail: TrueCare
P.O. Box 1307
Dayton, OH 45401-1307

Fax: 1-937-369-3677

Toll-Free Fax: 1-844-794-1584

NICU Fax: 1-937-396-3499

Email: **UMMississippi@MSTrueCare.com**

They are also available at **MSTrueCare.com** > Provider Overview > Tools & Resources > Provider Policies > Medical Policies.

Criteria

TrueCare utilizes nationally recognized, evidence-based criteria to determine medical necessity and appropriateness of inpatient hospital, rehabilitation, and skilled nursing facility admissions. The criteria are designed to assist providers in identifying the most efficient quality care practices in use today. They are not intended to serve as a set of rules or as a replacement for a physician's medical judgment about individual patients.

TrueCare defaults to all applicable state and federal guidelines regarding criteria for authorization of covered services. TrueCare also has medical policies developed to supplement nationally recognized criteria. If a patient's clinical information does not meet the criteria, the case is forwarded to a TrueCare Clinical Peer Reviewer for further review and determination. Clinical Peer Reviewers from TrueCare are available to discuss individual cases with attending physicians upon request. Criteria are also available upon request.

Utilization review determinations are based only on appropriateness of care and service and existence of coverage. TrueCare does not reward health care providers or our own staff for denying coverage or services. There are no financial incentives for our staff members that encourage them to make decisions that result in underutilization.

Our members' health is always our number one priority. Upon request, TrueCare will provide the clinical rationale or criteria used in making medical necessity determinations. You can also discuss an adverse decision with TrueCare's physician reviewer or request a peer-to-peer conversation.

If you are dissatisfied with a determination made by our Utilization Management department regarding a member's health care services or benefits, you may request a peer-to-peer conversation. Find more information in the Peer-To-Peer Process section. The Grievances & Appeals section has information about how to file a clinical appeal.

Prior Authorization Overview

Some services require prior authorization, which can be found in the **Procedure Code Lookup Tool**. Prior authorization is not a guarantee of payment. If a request for authorization is submitted, TrueCare will notify the provider and member in writing, and orally when required, of the determination. Authorizations can also be requested retroactively in certain situations.

If a service cannot be covered, providers and members may have the right to appeal the decision. The denial notification will include the reason that the service cannot be covered and how to request an appeal if necessary. Please see the Grievances and Appeals section for information on how to file an appeal.

Requesting Prior Authorization

Online: **MSTrueCare.com** > Login > Provider
Phone: 1-833-230-2174, then tell our interactive voice response (IVR) that you need to submit an authorization request
Fax: 1-844-794-1584
Email: **UMMississippi@MSTrueCare.com**
Mail: TrueCare
P.O. Box 1307
Dayton, OH 45401-1307

Information Required for Prior Authorization Submissions

When requesting prior authorization, please provide the following information:

- Member/patient name and member ID number
- Date of birth (DOB)
- Provider name, Tax ID Number (TIN), and National Provider Identifier (NPI)
- Anticipated date of service
- Diagnosis code and narrative
- Procedure, treatment, or service requested
- Number of visits requested, if applicable
- Reason for referring to an out-of-network provider, if applicable
- Clinical information to support the medical necessity for the service

View the Medical Prior Authorization Form at **MSTrueCare.com** > Providers > Tools & Resources > Forms.

Authorization Determination Time Frames

For standard prior authorization decisions, not including inpatient admissions, TrueCare provides notice to the provider and member as expeditiously as the member's health condition requires, but no later than three calendar days or two business days, whichever is less, after receipt of the request for service.

Urgent prior authorization decisions, not including inpatient admission, are made within 24 hours of receipt of the request for service. Please specify if you believe a request is urgent.

Authorization Type	Decision Time Frame	Extension Period
Inpatient Emergent Admission	1 Business Day	N/A
Non-Emergent Inpatient Admission	1 Business Day	N/A
Weekend/Holiday Inpatient Admission	1 Business Day	N/A
Continued Stay Review	1 Business Day	N/A
Urgent Prior Authorization	24 Hours of Request	Up to 14 Calendar Days
Standard Prior Authorization	3 Calendar Days/2 Business Days (whichever is less)	Up to 14 Calendar Days
Retrospective	20 Business Days	N/A
Urgent Transplant	72 Hours	N/A
Standard Transplant	3 Business Days	N/A

Note: Extensions may be granted if the member or provider requests it or if TrueCare justifies to the Division of Medicaid that additional information is needed and the extension is in the member's best interest.

Peer-To-Peer Process

TrueCare provides the opportunity for providers to discuss the utilization management medical necessity determination of an adverse determination with a TrueCare medical director who has appropriate clinical expertise in treating the member's condition, with the equivalent or higher credentials as the requesting provider. The peer-to-peer process is independent of the appeal process and has no adverse effect on the time frame allotted for an appeal. Please call the Utilization Management department at 1-833-230-2168 to discuss a case with a clinical peer reviewer.

Medical Necessity Standards

"Medical necessity" or "medically necessary" means services that are, as defined by the Social Security Act, Section 1905 (42 U.S.C. § 1396d(a)), the State Plan, the CHIP State Health Plan, and the Administrative Code. Medically Necessary Services are defined as services, supplies, and equipment provided by an appropriately licensed practitioner and documented in the member's record in a reasonable manner, including the relationship of the diagnosis to the

treatment. Medically Necessary Services are the most appropriate services that help achieve age-appropriate growth and development and will allow a member to attain, maintain, or regain capacity. Medically Necessary Services are made in accordance with standards of good medical practice consistent with the member's condition and not primarily for the comfort or convenience of the member, family, or provider. Medically Necessary Services are the most appropriate services, supplies, equipment, or levels of care that can be safely and efficiently provided to the member and are furnished in a setting appropriate to the members' need and condition. When applied to the care of an inpatient member, Medically Necessary Services further mean that the member's medical symptoms or conditions require that the services cannot be safely provided to the member as an outpatient service. Medically Necessary Services may also be services for members that are necessary to correct or ameliorate disorders and physical and behavioral/mental illnesses and conditions, whether such services are covered or exceed the benefit limits in the Medicaid State Plan and Title 23 of Mississippi Administrative Code. Medically Necessary Services are not experimental or investigational or for research or education.

Access to Staff

Health care providers and practitioners can call the Utilization Management department at 1-833-230-2174, Monday through Friday, 7:30 a.m. to 5:30 p.m., Central Time. Callers may leave voicemail messages after business hours.

Retrospective Authorization and Review

Retrospective authorization requests must be submitted within 60 calendar days of the service date where prior authorization was required but not obtained. TrueCare will provide a determination on the request within 20 business days of receiving all information reasonably necessary to make a determination. TrueCare completed determinations for retroactive eligibility review requests and retrospective authorization hospital reviews within 20 business days of receipt. Claims not meeting the requirements may be administratively denied.

All services that require prior authorization from TrueCare should be authorized before the service is delivered. TrueCare cannot pay claims for services in which prior authorization is required but not obtained by the provider.

A retrospective review is an authorization review conducted for anything other than inpatient hospital services when prior authorization was not obtained for the member services due to demonstrable circumstances outside of the provider's control. Prior authorization is required to ensure that services provided to our members are medically necessary and provided appropriately. A retroactive eligibility review is a review that is conducted after services are provided to a member and the member is retroactively determined to be eligible for Medicaid.

Request a retrospective review by contacting the Utilization Management department at 1-833-230-2174 and following the appropriate menu prompts or by faxing the request to 1-937-369-

3677 or the toll-free fax number at 1-844-794-1584. You must include clinical information supporting the request for services.

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