MHS Health Wisconsin

Medicaid Provider Manual

mhs health wisconsin

2022

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MHS Health Wisconsin: At-a-Glance

The MHS Health Wisconsin (MHS Health) provider network includes more than 28,000 clinicians and 129 hospitals that serve MHS Health members through BadgerCare Plus, Medicaid SSI, and a Medicare Advantage Special Needs Plan (SNP) called Wellcare by Allwell.

MHS Health administers enrollment under Network Health's contract with the Wisconsin Department of Health Services for Network Health's BadgerCare Plus and Medicaid SSI members. Contact MHS Health for Network Health BadgerCare Plus and Medicaid SSI prior authorization and claim processing. *MHS Health/ Network Health refers to the BadgerCare Plus and Medicaid SSI members of MHS Health and Network Health.*

Medical and Behavioral Health Provider Services Line
1-800-222-9831

Behavioral Health Provider Claims Customer Service Line
1-877-730-2117

*Please have the **NPI** or **Medicaid ID** number plus the Tax Identification Number **(TIN)** ready when you call.*

www.mhswi.com
- Provider manuals
- Provider reference materials
- Pre-auth check tool
- Clinical and payment policies
- Secure provider portal access
  - Easily check patient eligibility.
  - View, manage and download patient lists.
  - View and submit claims including attachments.
  - View and submit service authorizations.
  - Maintain multiple TINs on one account.

24-hour Nurse Advice Line: 1-800-280-2348

Medicaid Medication Coverage
Pharmacy Benefit: Prescription medications, radiopharmaceuticals, biopharmaceuticals and other injectables administered in home health, provider's office, most outpatient (OP) settings and skilled nursing should be billed to Medicaid fee-for-service (FFS).

Medical Benefit: Hyaluronate derivatives and outpatient/inpatient hospital administered medication should be billed to MHS Health. Hyaluronate derivatives require prior authorization.

Prior Authorizations for Medical Services (FAX lines)
- Prior Authorization Requests Fax: 1-866-467-1316
- Notification of Pregnancy Form Fax: 1-866-671-3668

Medical Services Authorization Requirements
Please use the Pre-auth Check Tool on our website to determine if services require prior authorization.

Behavioral Health Authorization Requests
BadgerCare Plus/Medicaid SSI Outpatient Treatment
1-888-713-6180 (phone); 1-866-694-3649 (fax)

Behavioral Health Services Requiring Prior Authorization:
- Inpatient Hospitalization & Detoxification
- 23-Hour Observation
- ECT
- IOP
- Day Treatment
- Psychological Testing
- Neuropsychological Testing
- All Services by Out-of-Network Providers

Electronic Claim Submission
All behavioral health claim EDI transactions
Utilize payer ID 68068

All medical claim EDI transactions
Utilize payer ID 68069

For MHS Health/Centene EDI support call
1-800-225-2573, ext. 6075525; email: ediba@centene.com

Electronic Funds Transfer
MHS Health partners with PaySpan Health, a FREE solution that helps providers transition into electronic payments and automatic reconciliation. Visit **PaySpanHealth.com** and click "register." Registration assistance is available by calling 1-877-331-7154 or by emailing providersupport@payspanhealth.com.

Paper Claim Submissions and Corrections

Behavioral Health Claims
MHS Health Wisconsin
ATTN: Behavioral Health Claims
P.O. Box 6123
Farmington, MO 63640

Medical Claims
MHS Health Wisconsin
ATTN: Claims Department
P.O. Box 3001
Farmington, MO 63640-3801

Claim Appeal Addresses

Behavioral Health Claim Appeals
MHS Health Wisconsin
ATTN: Behavioral Health Claim Appeals
PO Box 6000
Farmington, MO 63640

Behavioral Health Medical Necessity Appeals
MHS Health Wisconsin
ATTN: Medical Necessity Appeals
12515-8 Research Blvd #400
Austin TX 78759

Medical Claim Appeals
MHS Health Wisconsin
ATTN: Appeals Department
PO Box 3000
Farmington, MO 63640-3800

Member Grievance & Appeal Addresses

Member Grievance & Appeals (Pre-Service)
MHS Health Wisconsin
ATTN: Grievance & Appeals
801 S. 60th St. Suite 200
West Allis, WI 53214

Other Addresses

Refund Overpayments (on your check stock)
MHS Health Wisconsin
PO Box 3657
Carol Stream, IL 60132-3657

Behavioral Health Refund Overpayments
(on your check stock)
MHS Health Wisconsin
ATTN: Behavioral Health Refund
PO Box 3656
Carol Stream, IL 60132-3656

Return Centene Checks to: MHS Health Wisconsin
ATTN: Returned Check
PO Box 3001
Farmington, MO 63640-3801

Medical Code Denial Reviews
MHS Health Wisconsin
ATTN: Medical Review Unit
PO Box 3001
Farmington, MO 63640-3800

MHS Health Wisconsin: History

MHS Health Wisconsin is one of the state's oldest Medicaid plans, created in 1984, solely to manage the healthcare of the Medicaid population.

Today, the MHS Health network consists of more than 28,000 clinicians and 129 hospitals. We serve our members through these programs:

- BadgerCare Plus
- Medicaid SSI
- Medicare Advantage Special Needs Plan (SNP)

MHS Health Wisconsin is a wholly owned subsidiary of Centene Corporation, St. Louis, MO.

Centene Corporation, is a diversified, multi-national Fortune 25 company that provides a portfolio of services to government-sponsored healthcare programs, focusing on underinsured and uninsured individuals. The company operates local health plans and offers a range of health insurance solutions. It also contracts with other healthcare and commercial organizations to provide specialty services including care management software, correctional healthcare services, dental benefits management, in-home health services, life and health management, vision benefits management, pharmacy benefits management, specialty pharmacy, and telehealth services.

Our Beliefs
MHS Health Wisconsin believes that successful managed care is the delivery of appropriate, medically necessary services and not the elimination of such services. We believe in providing healthcare that is managed by a local team to conveniently respond to your needs. Our philosophy is to provide access to high-quality, culturally sensitive healthcare services to our members. We do so by combining the talents of primary care providers, behavioral health providers, and specialty providers with an experienced, highly successful managed care administrator.

We Take Privacy Seriously
At MHS Health Wisconsin, we take the privacy and confidentiality of our members' health information seriously. We have processes, policies, and procedures that comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the HITECH amendment to HIPAA, and State privacy law requirements. HIPAA does permit providers to share information such as telephone numbers, addresses, and so forth when such information is regarding a current member. This is considered part of treatment, payment, and healthcare operations, and is allowable under HIPAA. It is the policy of MHS Health to conduct its business affairs in accordance with the standards and rules of ethical business conduct and to abide by all applicable federal and state laws. ***If you have any questions about our privacy practices, please call the MHS Health compliance officer at: 1-800-547-1647.***

MHS Health and Betty Brinn
MHS Health Wisconsin and the market have changed over the past 35 years. Yet, we are essentially the same organization that Maxicare Health Insurance and Family Hospital created in Milwaukee in 1984 under the leadership of Betty Brinn. In 1993, a year after Mrs. Brinn's death, the Elizabeth A. Brinn Foundation was established to improve the lives of disadvantaged children in the Milwaukee area. The foundation's best-known grants helped build the Betty Brinn Children's Museum and remodel the Betty Brinn Children's Room at the Milwaukee Public Library. We are proud to continue the practice of caring that Betty Brinn began with MHS Health Wisconsin.

Approved Service Area
MHS Health Wisconsin is certified to enroll members in all 72 Wisconsin counties.

Section 1 Secure Provider Portal

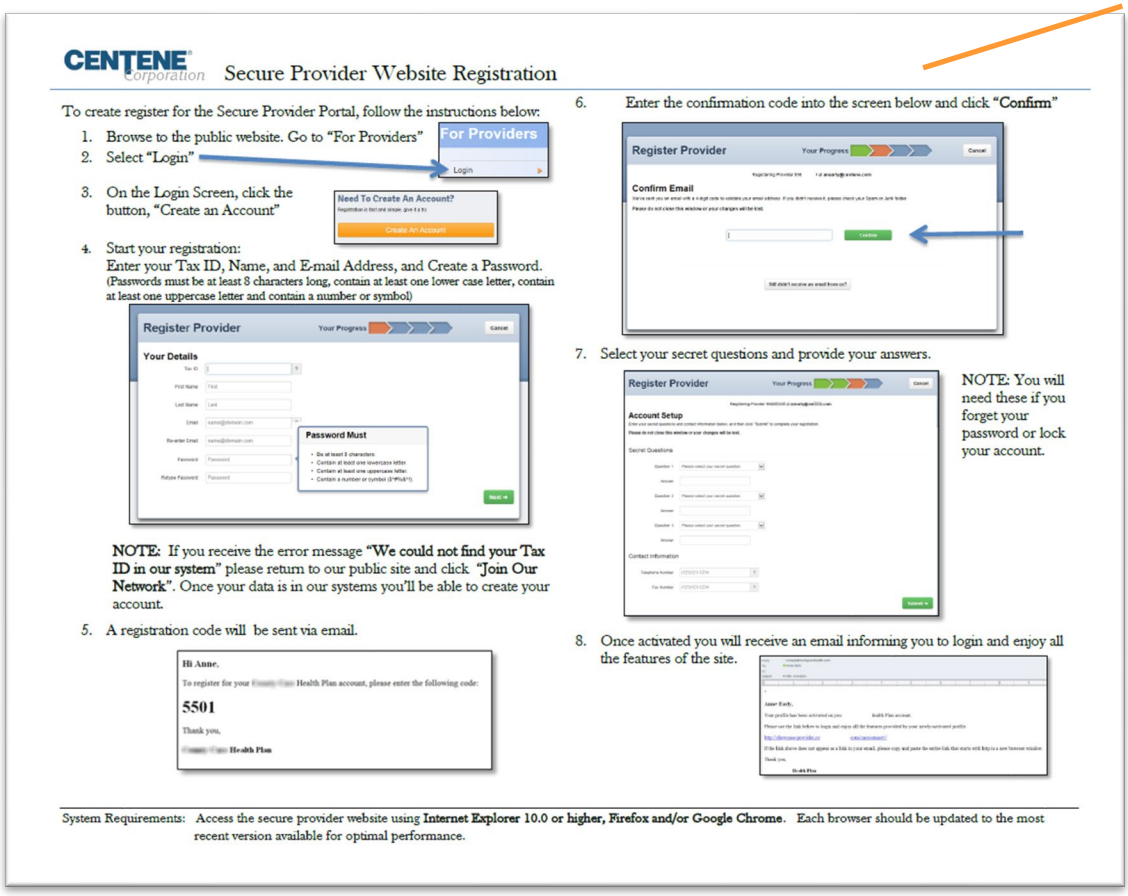
The MHS Health secure portal can be accessed at www.mhswi.com and via the following link: https://provider.mhswi.com.

Information found in the secure Provider Portal is updated frequently and should be used as a resource for the most current information. Providers are encouraged to always access the Provider Portal regularly.

Registration

To access the Provider Portal, begin by completing the online registration process that can be found on the login page. There is also a video link that may be helpful, located on the bottom right-hand side of the page.

Provider friendly & easy to use



CENTENE Corporation Secure Provider Website Registration

To create register for the Secure Provider Portal, follow the instructions below:

1. Browse to the public website. Go to "For Providers"
2. Select "Login"
3. On the Login Screen, click the button, "Create an Account"
4. Start your registration:
   Enter your Tax ID, Name, and E-mail Address, and Create a Password.
   (Passwords must be at least 8 characters long, contain at least one lower case letter, contain at least one uppercase letter and contain a number or symbol)

NOTE: If you receive the error message "We could not find your Tax ID in our system" please return to our public site and click "Join Our Network". Once your data is in our systems you'll be able to create your account.

5. A registration code will be sent via email.

Hi Anne,
To register for your Health Plan account, please enter the following code:
5501
Thank you,
Health Plan

6. Enter the confirmation code into the screen below and click "Confirm"
7. Select your secret questions and provide your answers.

NOTE: You will need these if you forget your password or lock your account.

8. Once activated you will receive an email informing you to login and enjoy all the features of the site.

System Requirements: Access the secure provider website using **Internet Explorer 10.0 or higher, Firefox and/or Google Chrome**. Each browser should be updated to the most recent version available for optimal performance.

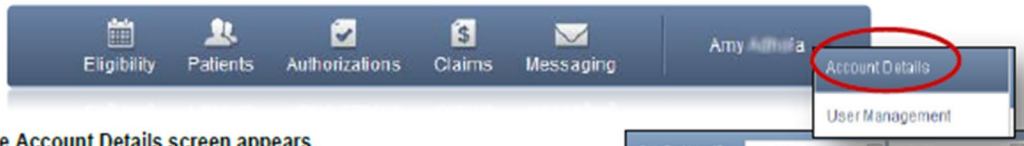
After completing online registration, users can enter the secure site to:

- Check member eligibility and eligibility history, including other insurance
- Identify potential gaps in care specific to a member
- For primary care providers, view, and print patient lists of your MHS Health/Network Health patients (PCPs only)
- Submit and view authorizations (may not be available to atypical providers)
- Use code-auditing tool
- View, submit, copy, and correct claims, regardless of how submitted
- Check claim status, payment history, payment amounts and dates
- View and download explanations of payment (EOP)
- Gives providers the ability to complete Medical Necessity Reviews via the portal when submitting an Authorization request.

Updating Provider Information on the Secure Provider Portal

Most provider information can be easily updated by providers using the following steps.

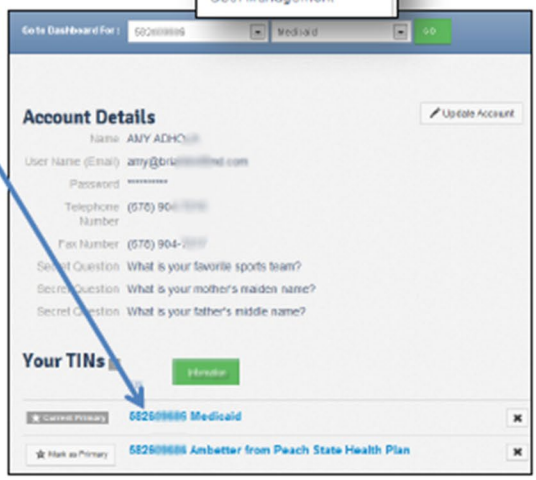
1. From the Main Tool Bar - select **Account Details** under the Users Name.



The Account Details screen appears.

2. To modify information about the Specific TIN, click on the individual TIN to update.

Under each TIN, a list of associate providers will appear.



3. To update information about one of the Associated Providers, click on the name.

A list of possible Service Locations will appear.

4. Click on the name associated to the address to update.

5. Click Edit Location to update the provider information – This information will update the Find A Provider website.

6. The following Transaction attributes will be available for edits - ***only one update within a transaction set is allowed per day.*** (If any additional updates are necessary – please contact your provider relations representative)

Transaction Set #1 - Provider Location Address
- Address1
- Address2
- City

Transaction Set #2 - Provider Location Phone
- Phone
- Fax

Transaction Set #3 - Provider Location Accessibility
- Accessibility (Yes or No)

Transaction Set #4 - Provider Office Hours
- Monday- Sunday (7 Data Attributes for each day)

Transaction Set #5 - Practitioner Gender
- Gender

Transaction Set #6 - Practitioner Office Hours
- Monday- Sunday (7 Data Attributes for each day).

For example: Changing the phone number and saving will cause a wait time of 24-36 hours in order to change the fax number. However, changing information in a different transaction set will not be limited to an additional wait time.

7. Save changes by clicking on the Save Location button at the bottom of the screen.

Section 2 Other Resources for Network Providers

Provider Inquiry Line
We handle your calls from 8 a.m. to 6 p.m., Monday – Friday. Call us for assistance with:

- ☑ Checking member eligibility
- ☑ Claims information (billing/claim questions/Provider Relations staff)
- ☑ Benefit information
- ☑ Checking authorizations status
- ☑ Requesting authorizations

Please note: The MHS Health Wisconsin Provider Inquiry Line is for use by providers and their staff only. Please advise your patients who are MHS Health or Network Health Plan members to call Customer Service at 1-888-713-6180.

Provider Inquiry Line
1-800-222-9831

Medical Services Fax Lines
Prior Authorization Requests:
Outpatient 1-866-467-1316
Inpatient hospital/census sheets.....1-800-354-6136
Concurrent Authorization
Pregnancy Notification.....1-866-681-3668

Contracting & Network Development Fax: 1-800-789-3843

After hours, weekends and holidays
When calling after hours, you have the option of having your call directed to the MHS Health Wisconsin 24-hour nurse advice line at 1-800-280-2348.

Behavioral Health Provider Services Line: 1-800-222-9831

Behavioral Health Outpatient Treatment prior authorization requests Fax: 1-866-694-3649

Pharmacy benefit: The Medicaid pharmacy benefit is covered by the State of Wisconsin under the Medicaid fee-for-service program. Prescription medications, radiopharmaceuticals, biopharmaceuticals, and other injectables administered in a home health setting, provider's office, skilled nursing facility, and most outpatient settings should be billed to Medicaid fee-for-service.

Claims
Claims can be researched easily via the secure provider portal 24-hours a day. Provider Services phone center representatives can assist with up to four claim status inquiries per call to the Provider Inquiry Line.

The following items are available for viewing or for downloading.

- **Link to the Provider Portal**
  A self-service tool to view claims eligibility, member benefits, coverage, and many other topics.

- **This Provider Manual**
  Available on our website at www.mhswi.com under Provider Resources. Print copies available upon request.

- **Directory of In-Plan Providers**
  The most current directory of our network primary care providers, specialists, and ancillary providers is available on our website www.mhswi.com.

- **Medical Practice Information Change Form**
  When providers notify us promptly of changes in information regarding their practices, we can immediately update our database. This helps us to:
    - Communicate your availability accurately to our members and other providers
    - Process your claims in a timelier manner

  When billing information submitted on claims does not match that which is currently in our files, MHS Health will return claims for corrections, which can create payment delays.

  For information on how to make updates, please see www.mhswi.com under Provider Resources (Medical Practice Information Change Form/Behavioral Health Provider Demographic Updates).

Section 3 Guidelines for Providers

Physician Feedback

We welcome your opinion. You are encouraged to contact MHS Health with your comments by calling the provider Inquiry Line at 1-800-222-9831 or by providing your feedback to us under the "contact us" section at www.mhswi.com

Primary Care Provider (PCP) General Responsibilities

Primary care providers (PCPs) serve as the medical home of MHS Health and Network Health Plan Medicaid members. The "medical home" concept helps establish patient-provider relationships and leads to better health outcomes. MHS Health considers clinicians in the following fields as PCPs: Family Practice, General Practice, Internal Medicine, Obstetrics/Gynecology (OB/GYN), and Pediatrics. OB/GYNs may elect to be considered a PCP or a specialist in the MHS Health network. To see a list of assigned members please visit our secure provider portal on our website.

MHS Health expects that PCPs:

- Have a 24-hour answering service or a telephone recording that instructs members about how they can access care after regular office hours. An answering machine directing callers to the nearest emergency room is not sufficient to meet this standard.
- Respond to all pages and telephone calls within two hours.
- Have hours of operation that do not discriminate against BadgerCare Plus and Medicaid SSI enrollees.
- Follow the appointment guidelines as set forth in this manual.
- Schedule office appointments so that the average waiting time in the office before being seen by a clinician is no more than 30 minutes from the time of the appointment.
- Ensure patients ages 18 years and older receive information on advance directives and are informed of their right to execute an advance directive. Providers must document such information in the patient's medical record.

PCP Appointment Availability Standards

Type of service	Appointment availability
Emergency Visit	Immediately upon request of appointment
Urgent Visit	Within 24 hours of request of appointment
Non-Urgent, Symptomatic Care	Within 7 calendar days of request of appointment
Foster Care Physicals	Within 48 hours of request of appointment
Routine Physical Exam/HealthCheck	Within 30 calendar days of request of appointment
High Risk Prenatal Care	Within 2 weeks of a request of appointment Within 3 weeks if the request is for a specific provider
Physical or Sexual Abuse Assessment	Immediately upon request of appointment

How Members Select a PCP

Members receive a welcome packet upon enrollment in the health plan instructing them to establish with a primary care provider. If they don't already have a provider, members can choose one by using the Find a Provider (FAP) directory located on our website. Members are reminded quarterly of the online Handbook and FAP and are offered a hard copy upon request. The handbook also encourages members to select a PCP and to inform MHS Health of their selection by:

- Calling MHS Health Customer Service at 1-888-713-6180
- Updating the information through the Member Portal

If a new member does not select a PCP within 30 days of enrollment, MHS Health will assign the member to a PCP.

MHS Health provides female members with direct access to in-network women's health specialists in addition to access to their designated primary care provider. Medicaid SSI members may select a PCP or a specialist as their PCP.

Changing a PCP

Members may change their PCP upon request. When members call MHS Health Customer Service to change their PCP, they are told that the change will be effective on the first day of the following month or at a requested date. Members are advised to continue to seek healthcare with their current PCP until the change is effective.

Selecting a Family Planning Provider

Federal guidelines require that members have the option of selecting a provider for family planning who is not their PCP. The family planning provider need not be contracted with MHS Health.

- The clinician selected for family planning services does not replace the PCP chosen by or assigned to the enrollee for all other medical services.
- The plan must allow adolescents to have their own PCP or to seek family planning services from a certified family planning agency.
- If a plan member selects a non-MHS Health network provider for family planning services, the state will cover the cost on a fee-for-service basis.

Second Opinions

Members may receive a second opinion from a qualified in-plan professional. If an appropriate provider is not available in the network, the member may obtain the second opinion from an out-of-plan provider at no cost to the member.

An Appointment for a Second Opinion Requires Prior Authorization When:

- The specialty requires prior authorization from MHS Health or the provider is out-of-plan.

Reassigning Care of a Member

A provider may become unwilling to continue to serve as a PCP for a member who repeatedly breaks appointments or fails to arrive at appointments, is abusive (physically or verbally) to the provider or office staff or fails to comply with a treatment plan. The provider may discontinue seeing the member after following these steps:

1. The incident must be documented in the patient chart.
2. A letter must be sent via certified mail to the patient documenting the reason for the termination.
3. The letter must indicate a termination date.
4. The letter must indicate the provider will be available for emergency care for the next 30 days.
5. The letter should direct the patient to call MHS Health Customer Service for help selecting a new provider.
6. A copy of the letter should be sent to MHS Health.
7. A copy of the letter should be kept in the patient chart.

Advance Directives

Wisconsin law allows persons ages 18 and older to execute an advance directive. An advance directive is a legal document instituted in advance of any incapacitating illness or injury. A Power of Attorney for Healthcare and a Living Will are advance directives.

- A *Living Will* tells a clinician/provider what life-sustaining procedures the patient does or does not want.
- In a Power of Attorney for Healthcare, an individual appoints another person (a healthcare agent) to make healthcare decisions for him or her should he or she be unable to do so.

The declarant is responsible for notifying his or her healthcare provider of the existence or revocation of an advance directive; the provider must then include the document or note that it was revoked in the patient's medical records.

MHS Health requires contracted providers to document in medical records whether or not their patients who are MHS Health/Network Health members have executed an advance directive.

Please review the following procedure to assure compliance:

- The first point of contact in the provider's office asks if the member has executed an advance directive.
- The member's response is documented in their medical record.
- If the member has already executed an advance directive, the first point of contact asks the member to bring a copy of the directive to the PCP's office and documents the request in the medical record. (When the member brings in a copy of the directive, it is placed in the member's medical record.)
- If the member has already executed an advance directive, the provider discusses potential medical emergencies with the member and/or family member/significant other (if named in the advance directive and if available) and with the referring physician, if applicable. The discussion is documented in the member's medical record.
- If the member has not executed an advance directive, the first point of contact in the provider's office asks the member if he or she wishes to receive information on advance directives. If the member replies "Yes," the office contact provides information. If the member replies "No," the office contact documents that on an Advance Directive Label or Declaration Sheet and includes it in the member's medical record.
- MHS Health Customer Service representatives will assist members with questions about advance directives, however; no employee of MHS Health may serve as witness to an advance directive or as a member's designated agent or representative.
- Providers' documentation of patient discussions about advance directives is reviewed during the medical record audit phase of the MHS Health re-credentialing process.

Tools Available to Assist in Achieving These Requirements

- A blank Power of Attorney for Healthcare
- A blank Living Will
- An Advance Directive Declaration Sheet identifying that advance directives have been addressed with the member and specifying whether an advance directive exists or has been revoked
- An advance directive label template to easily identify whether or not an advance directive is in the medical record and/or whether or not an advance directive has been revoked

These tools are available for download on the MHS Health members page.

Other PCP Responsibilities

- Educate patients on how to maintain healthy lifestyles and prevent serious illness
- Provide follow up on emergency care
- Maintain confidentiality of medical information
- Participate in utilization, quality management, and case management processes

Communication with Behavioral Health Providers and Primary Care Physicians

MHS Health encourages PCPs to consult with their members' behavioral health providers. In many cases, the PCP has extensive knowledge about the member's medical condition, mental status, psychosocial functioning, and family situation. Communication of this information at the point of referral or during the course of treatment is encouraged with member consent, when required.

Behavioral health providers should communicate not only with the member's PCP whenever there is a behavioral health problem or treatment plan that can affect the member's medical condition or the treatment being rendered by the PCP, but also with other behavioral health providers who may also be providing service to the member.

Examples of some of the items to be communicated include:

- Prescription medications
- The member is known to abuse over-the-counter (OTC), prescription, or illegal substances in a manner that can adversely affect medical or behavioral health treatment

- The member is receiving treatment for a behavioral health diagnosis that can be misdiagnosed as a physical disorder (such as panic disorder being confused with mitral valve prolapse)
- The member's progress toward meeting the goals established in their treatment plan
- A form to be used in communicating with the PCP and other behavioral health providers is on our website

Behavioral health providers should screen for the existence of co-occurring mental health and substance abuse conditions and make appropriate referrals. Providers should refer members with known or suspected untreated physical health problems or disorders to their PCP for examination and treatment.

To preserve the continuity of the treatment process, MHS Health requests that behavioral health providers report specific clinical information to the member's PCP. With appropriate written consent from the member, it is the behavioral health provider's responsibility to keep the member's PCP abreast of the member's treatment status and progress in a consistent and reliable manner. Such consent shall meet the requirements set forth in 42 CFR 2.00 et seq., when applicable. If the member requests that this information not be given to their PCP, the behavioral health provider must document this refusal in the member's treatment record, and if possible, the reason why.

The following information should be included in the report to the PCP:

- A copy or summary of the intake assessment,
- Written notification of member's noncompliance with treatment plan (if applicable),
- Member's completion of treatment.
- The results of an initial psychiatric evaluation, and initiation of and major changes in psychotropic medication(s) within 14 days of the visit or medication order; and
- The results of functional assessments.

Exercise caution in conveying information regarding substance abuse, which is protected under separate federal law.

MHS Health monitors communication with the PCP and other caregivers through audits. Failure to adhere to these requirements can be cause for termination from the network.

MHS Health providers should refer to his/her MHS Health Participating Provider Agreement for complete information regarding their obligations.

Specialist Responsibilities

Select specialty services require prior authorization. The specialist may order diagnostic tests by following MHS Health authorization guidelines *(See Section 9 Medical Management Section).*

However, the specialist may not refer to other specialists or admit to the hospital without the referral of a PCP, except in a true emergency. The specialist must maintain contact with the PCP. This could include telephone contact, written reports on consultations, or verbal reports if an emergency situation exists. The specialist must:

- Obtain applicable authorization from the patient's PCP before providing services.
- Coordinate the patient's care with the PCP.
- Provide the PCP with consult reports and other appropriate records within five business days.
- Be available or provide on-call coverage 24 hours a day.
- Have hours of operation that do not discriminate against BadgerCare Plus and Medicaid SSI enrollees.
- Maintain confidentiality of medical information.
- Participate in utilization, quality management, and case management processes.

Specialist Appointment Access Standards

Type of Service	Access Standard
Routine Referral Visits	Within 60 calendar days
After-Hours Coverage	24 hours per day, seven days per week
Office Wait Times	Within 30 minutes of scheduled appointment

Behavioral Health Appointment Access Standards

All members have direct access to mental health and substance abuse services and do not need a referral from their PCP. Caregivers or medical consenters also may refer members for mental health and substance abuse services.

MHS Health adheres to National Committee for Quality Assurance (NCQA) and State of Wisconsin accessibility standards for member appointments. MHS Health asks your help in providing appointments within the following timeframes:

Type of Service	Access Standard
Initial routine care – treatment of a condition that would have no adverse effects if not treated within 10 business days	10 business days per NCQA standards
Urgent – defined as a non-life-threatening situation that should be treated within 24 hours. Urgent care services are not subject to prior authorization or precertification.	Within 24 hours for services that are non-emergent urgent services.
Emergent/Non-life Threatening Care – defined as inpatient and outpatient services furnished by a qualified practitioner or provider that are needed to evaluate or stabilize a behavioral health condition manifesting itself by acute symptoms of sufficient severity that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical care to result in injury to self or bodily harm to others; placing the physical or mental health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; serious impairment to bodily functions; serious dysfunction to any bodily organ or part; serious harm to self or others due to an alcohol or drug abuse emergency; with respect to a pregnant woman having contractions (i) that there is not adequate time to affect a safe transfer to another hospital before delivery, or (ii) that transfer may pose a threat to the health or safety of the woman or unborn child.	Within six hours of request on a 24-hour basis, seven days a week MHS Health requests practitioners refer all members with an emergent non-life-threatening emergency to the Emergency Department
Follow-up routine care	Within 10 business days • No longer than 30 days for an appointment with a Mental Health Provider for follow-up after an inpatient mental health stay. • No more than 30 days for a non-psychiatric appointment.
Wait times – wait times in practitioner waiting rooms	Within 30 minutes of scheduled appointment
Outpatient – visit following discharge from hospital/acute care	Within 7 days of discharge
Follow-up post discharge visit	• Follow-up post discharge appointments are to be within 7 days or no longer than 30 days for an appointment with a Mental Health Provider for follow-up after an inpatient mental health stay.

If you cannot offer an appointment within these timeframes, please refer the member to MHS Health Customer Service (1-888-713-6180), so the member may be rescheduled with an alternative provider who can meet the access standards and member's needs. Adherence to these standards is monitored with telephone auditing through the MHS Health Quality Improvement Program.

In addition, all behavioral health providers are obliged by Agreement to ensure that services provided are available on a 24-hours a day, 7-days a week basis, as the nature of the member's behavioral health condition dictates. Behavioral health providers must offer hours of operation that are no less than the hours of operation offered to commercial insurance enrollees and shall ensure members with disabilities are afforded access to care by ensuring physical and communication barriers do not inhibit members from accessing services.

Behavioral health providers should call the MHS Health Provider Relations Department at 1-800-222-9831 if they are unable to meet these access standards on a regular basis. Please note that the repeated inability to accept new members or meet the access standards can result in suspension and/or termination from the network. All changes in a behavioral health provider's status will be considered in the re-credentialing process.

Telehealth Services
Telehealth services are similar to in-person services, and if members are offered like-services via telehealth, MHS Health and providers should follow ForwardHealth telehealth guidelines. Providers are obliged by Agreement to indicate if telehealth services are performed at their location(s), so it can be accurately documented in the Provider Directory.

Hospital Responsibilities
Inpatient facilities are required to notify MHS Health of admissions to enable care coordination and discharge planning, ensure timely claim payment, and track inpatient utilization. If it is determined that an inpatient admission is not medically necessary and services could be provided in another appropriate setting, the MHS Health Medical Director may authorize approval for an alternative level of care.

Notification timelines* are:	
Emergent and urgent admissions	• Within 2 business days following the admission • Within 24 hours for a psychiatric admission
Maternity admissions	At admission
All other admissions	By the close of the next business day

**Failure to notify within this timeframe may result in denial of payment for lack of timely notification.*

Authorization of Services
In-plan hospitals must request authorization from MHS Health *within two business days* for:

- All inpatient services.
- Selected services unless service is provided as an emergency. *See Section 9 - Medical Management or Network Provider Quick Reference Guide*.

PCP Notification After Member's Emergency Room Visit
In-plan hospitals must notify the plan member's PCP immediately (no later than the close of the next business day) after a member appears in the Emergency Room.

MHS Health Wisconsin Provider Inquiry Line
We handle your calls from 8 a.m. to 7 p.m., Monday – Friday. For Medical Management on the MHS Health Provider Inquiry Line, call the number at right and when prompted say "authorization request" and then "inpatient admission."

Provider Inquiry Line
1-800-222-9831

After-Hours, Weekends, and Holidays
During nonbusiness hours, members can call the MHS Health 24-hour Nurse Advice Line at 1-800-280-2348.

Cooperation with Quality Improvement (QI) Program
MHS Health requires providers and practitioners to cooperate with all QI activities. Contracted providers are required to participate in an after-hours care survey that is conducted annually to ensure members receive appropriate after-hours care from our PCP network. MHS Health partners with providers to gather performance data to ensure the success of the QI Program. This program is outlined in *Section 4 Quality Improvement Program* in more detail.

Billing Members
Wisconsin Medicaid prohibits MHS Health, its clinicians, and subcontractors from billing a member for medically necessary services covered under the Wisconsin BadgerCare Plus and SSI programs provided during the member's eligibility.

- A clinician may not bill a plan member for:
  - A service which was denied payment as a result of the clinician's failure to follow MHS Health processes, e.g., failure to obtain prior authorization, untimely (late) filing of claims, etc.
  - The difference between the clinician's billed charges and contracted reimbursement received for services.
- A clinician may bill a plan member for a non-BadgerCare Plus or Medicaid SSI-covered service if the member agrees in writing, in advance of the services being provided, to be financially responsible for the charges.
  - The clinician must have requested and been denied prior authorization from MHS Health before performing the service.
  - The member's written agreement must specify:
    - the service that is not covered by MHS Health;
    - the date the non-covered service will be provided; and
    - the amount for which the member will be responsible.

The standard Consent for Treatment release form that every patient signs at the time of services does not constitute informed consent for financial responsibility for non-BadgerCare Plus or Medicaid SSI-covered services.

Cultural Diversity and Inclusion
Cultural competency within the MHS Health network is defined as, "a set of interpersonal skills that allow individuals to increase their understanding, appreciation, acceptance and respect for cultural diversity and similarities within, among and between groups and the sensitivity to know how these differences influence relationships with members."

MHS Health is committed to the development, strengthening, and sustaining of healthy provider and member relationships. Members are entitled to dignified, appropriate, and quality care. When healthcare services are delivered without regard for cultural differences, members are at risk for sub-optimal care. Members may be unable or unwilling to communicate their healthcare needs in an insensitive environment, reducing the effectiveness of the entire healthcare process.

MHS Health provides resources on our website to assist our network providers in developing culturally competent and culturally proficient practices.

Resources
Please see our provider website for a list of translators and interpreters, facts on disparities in healthcare, an organizational self-assessment for you, and access to free education and CEU credits for education on culturally linguistically appropriate services and online training modules.

Cultural Considerations
If you have a patient who needs or would like an interpreter, MHS Health will pay for the services. A list of professional interpreter service providers is available on our website. Instruct interpreters to bill MHS Health for their services.

Family members and friends are not the same as a professional interpreter; they are more likely to modify what the patient has said in their effort to be helpful. Therefore, we require the use of professional interpreters. They will do more than interpret for the member. Their job is to help facilitate effective communication between you and your patient.

Working with Interpreters
- Plan to allow enough time for the interpreted sessions.
- Avoid jargon and technical terms.
- Keep your utterances short, pausing to allow for the interpretation. Say one longer sentence or three or four short ones, and then stop in a natural place to let the interpreter pass your message along. The interpreter may need to hear the whole sentence before she can even start to interpret it.
- Ask only one question at a time.
- Be prepared to repeat yourself in different words if your message is not understood. If a response doesn't seem to fit with what you said, go back and repeat what you said in different words.
- Check to see if the message is understood.

Reporting Requirements

Communicable Diseases
All certified clinicians must report the appearance, suspicion or diagnosis of a communicable disease or death resulting from a communicable disease to the local health department, according to Wisconsin Administrative Code HFS 145.
- Certified clinicians include physicians (MDs and DOs), physician assistants, podiatrists, nurses, nurse practitioners, midwives, clinical laboratories, physical therapists, dietitians, etc.
- A provider who treats a patient with a communicable disease or confirms a death due to a communicable disease must issue a communicable disease report within 24 hours of learning of the disease or death.
- Forms for reporting communicable diseases are available from local health departments.
- Reports of human immunodeficiency virus (HIV) are reported directly to the State epidemiologist.

Blood Lead Levels
All clinical laboratories in the state must report the results of all blood lead tests, according to Wisconsin Administrative Code HFS 181.
- The ordering clinician must report the results to the state's lead poisoning prevention program if the ordering clinician sends the specimen to a clinical laboratory outside of Wisconsin.
- The ordering clinician may report the blood levels to the program (instead of the clinical laboratory) if a written agreement addressing the issue exists between the clinical laboratory and the ordering clinician.
- Additional information about reporting is available from the Lead Poisoning Prevention Program office by calling 608-266-5817 or writing to:

  Lead Poisoning Prevention Program
  Division of Public Health
  PO Box 2659, Room 150
  Madison, WI 53701-2659

Child Abuse, Neglect and Exploitation
State and federal regulations require the reporting of known or suspected abuse, neglect or exploitation of a minor (a child under age 18) by all persons likely to become aware of such abuse in their professional contacts with the child.

- All providers must comply with these regulations.
- Reports should be made to the county welfare department, sheriff, or city police department in your area.
- The local county Child Protective Services agency and other local agencies have the legal responsibility to investigate and validate complaints of alleged abuse, neglect or exploitation of minors. These agencies provide specialized counseling and referral services to improve family functioning and prevent further abuse, neglect, or exploitation.
- Call MHS Health Customer Service at 1-888-713-6180 for a listing of the county agency or crisis intervention contacts in your area.

Domestic Abuse
State and federal regulations require the reporting of known or suspected instances of domestic abuse by all treatment facilities.

- All Medicaid-certified providers must comply with these regulations.
- Reports should be based on reasonable evidence of verbal and/or physical mistreatment, and the potential for such mistreatment to occur.
- Reports should be made to the county sheriff or city police departments in your area. The local law enforcement authorities can provide the victim(s) with initial protection from further harm, specialized counseling, and referral services to improve family functioning and prevent further abuse.
- Call MHS Health Customer Service at 1-888-713-6180 for a listing of the domestic abuse agencies in your area.

Fraud, Waste and Abuse
MHS Health is committed to identifying, investigating, sanctioning, and prosecuting suspected fraud and abuse. Its fraud and abuse plan complies with the State of Wisconsin and federal laws.

Fraud, Waste, and Abuse, (FWA) is an MHS Health initiative that systematically identifies, investigates, and addresses instances where billing errors, abuse, or fraud occur. The FWA program complies with State and federal law, and State Department of Health Services (DHS) guidelines. All MHS Health staff are trained to identify possible fraud, waste, and abuse.

Billing errors
Billing errors may occur if provider offices provide incorrect information on submitted claims. Provider Relations representatives will work with provider offices to correct these situations.

Abuse
Abuse involves billing errors that directly or indirectly lead to financial loss for MHS Health. Examples can include overcharging for services and billing for: an office visit and outpatient procedure the same day, unbundling charges, billing for non-covered services, diagnoses that are not adequately supported in the medical record, and medically inappropriate procedures and tests.

Fraud
Fraud is intentional deception or misrepresentation by patients, providers, billing services, or payer employees. Examples can include billing for services not rendered, misrepresenting diagnoses to justify payment, soliciting, offering or receiving a kickback, falsifying medical records to justify payment, and "up coding."

How You Can Help
Providers are in the best position to identify potential member fraud since the most common incidence involves members sharing their ForwardHealth card with family members and friends. If you suspect this is happening, please call the MHS Health Compliance Officer at 1-800-222-9831.

Post-Processing Claims Audit

A post-processing claims audit consists of a review of clinical documentation and claims submissions to determine whether the payment made was consistent with the services rendered. To start the audit, MHS Health/Centene auditors request medical records for a defined review period. Providers have two weeks to respond to the request. If no response is received, a second and final request for medical records is forwarded to the provider. If the provider fails to respond to the second and final request for medical records, or if services for which claims have been paid are not documented in the medical record, MHS Health will recover all amounts paid for the services in question.

MHS Health/Centene auditors review cases for common FWA practices including:

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

MHS Health/Centene auditors consider state and federal laws and regulations, provider contracts, billing histories, and fee schedules in making determinations of claims payment appropriateness. If necessary, a clinician of a like-specialty may also review specific cases to determine if billing is appropriate. Auditors issue an audit results letter to each provider upon completion of the audit, which includes a claims report identifying all records reviewed during the audit. If the auditor determines that clinical documentation does not support the claims payment in some or all circumstances, MHS Health will seek recovery of all overpayments. Depending on the number of services provided during the review period, MHS Health may calculate the overpayment using an extrapolation methodology. Extrapolation is the use of statistical sampling to calculate and project overpayment amounts. It is used by Medicare Program Safeguard Contractors, CMS Recovery Audit Contractors, and Medicaid Fraud Control Units in calculating overpayments, and is recommended by the OIG in its Provider Self-Disclosure Protocol (63 Fed. Reg. 58,399; Oct. 30, 1998).

Section 4 Quality Improvement Program

The MHS Health Quality Improvement (QI) Program is a comprehensive effort to protect, maintain, and improve the quality of care provided to our BadgerCare Plus, Medicaid SSI, and Medicare Advantage plan members.

MHS Health evaluates the overall effectiveness of our QI Program annually to determine whether the program has demonstrated improvement where needed in the quality of care and service provided to our members.

A QI work plan, approved by the MHS Health Quality Improvement Committee (QIC) and Board of Directors, outlines the scope of activity and the goals, objectives, and timelines of the QI Program. New goals and objectives are set annually based on findings from quality improvement activities and studies and results of member and provider satisfaction surveys and performance measures.

QI Program

The MHS Health QI Program is led by the plan chief medical officer, the QI director, and MHS Health's Quality Improvement Committee (QIC). The QI Program description is available by request. The following are components of the program:

- Quality improvement studies
- Investigating and tracking of risk management events and potential quality of care complaints
- Ongoing monitoring of key performance measures (i.e., immunization rates, mammography rates, cervical cancer screening rates, HealthCheck rates)
- Utilization management
- Compliance with preventive health and clinical practice guidelines
- Compliance with all applicable regulatory and accreditation agency rules, regulations, and standards, as well as state and federal laws
- Healthcare Effectiveness Data Information Set (HEDIS®) data reporting

Clinician Participation in Quality Initiatives

Clinician participation is an important component of the MHS Health QI Program. Providers are expected to monitor and evaluate their own compliance with performance requirements to assure the quality of care and service provided. Providers are expected to meet MHS Health performance requirements and ensure member treatment is efficient and effective by:

- Cooperating with medical record reviews,
- Cooperating with telephonic based surveys to evaluate appointment and after-hours accessibility,
- Cooperating with the complaint review process,
- Participating in provider satisfaction surveys, and
- Cooperating with reviews of quality of care issues and critical incident reporting.

In addition, providers are invited to participate in MHS Health QIC and in local focus groups conducted by MHS Health. Participation on the committees listed below provides network clinicians with a structured forum for input. Clinicians may also provide feedback to MHS Health via the Provider Relations Department. Call the MHS Health Provider Inquiry Line at 1-800-222-9831.

Network Practitioners and Providers are contractually required to cooperate with all Quality Improvement (QI) activities to improve the quality of care and services and member experience. This includes the collection and evaluation of performance data and participation in MHS Health's QI programs. Practitioner and Provider contracts, or a contract addendum, also require that Practitioners and Providers allow MHS Health to use their performance data for quality improvement activities.

CAHPS® Consumer Assessment of Healthcare Providers and Systems
MHS Health values the feedback of its members on their healthcare experience. In pursuit of continuous learning, a random sample of members/patients are surveyed annually about their experience with their providers, services, and health plan. It is an important component of ensuring that patients are satisfied with their overall healthcare experience. CAHPS® surveys allow patients to evaluate the aspects of care delivery that matter the most to them. MHS Health is committed to partnering with their providers to deliver an outstanding patient experience.

CAHPS® Goals – MHS Health strives to exceed national benchmarks as reported via National Committee for Quality Assurance's (NCQA) Quality Compass reports for member experience.

As a provider, you are the most critical component of the patient experience. The survey includes questions that evaluate the following areas:

- Getting Needed Care – Assesses the ease with which members received the care, tests, or treatment they needed. It also assesses how often they were able to get a specialist appointment scheduled when needed.
- Getting Care Quickly – Assesses how often members got the care they needed as soon as they needed it (urgent and non-urgent).
- How Well Doctors Communicate – Assesses members' perception of the quality of communication with their doctor. This also assesses how often their personal doctor explained things clearly, listened carefully, showed respect, and spent enough time with them. Consider using the Teach-Back Method to ensure patients understand their health information.
- Enrollee's Ratings – Using a 10-point scale, assesses the member's overall quality of their:
    - Healthcare
    - Personal doctor
    - Specialist
    - Health plan

CAHPS® Results
MHS Health analyzes survey results to gain insight into their members' experiences with their healthcare providers and the health plan. Providers may be requested to participate in focus groups to collaborate on identifying opportunities for improvement as a result of the analysis. Feedback from providers enables MHS Health to continuously improve systems, communication, policies, and procedures. MHS Health also collects feedback from providers during the QIC as well as Member/Community Advisory Committees.

Quality Improvement Committee (QIC)
The MHS Health QIC is a multidisciplinary team whose purpose is to develop, implement, and oversee the MHS Health QI Program and to ensure that quality improvement activities are fully integrated into all functional areas.

The QIC assesses the appropriateness of care delivered and works to continuously enhance and improve the quality of services provided to members. The committee reviews, evaluates, and approves the QI Program and recommends interventions and improvements.

Meetings are scheduled four times annually. Membership includes health plan management, network providers practicing in the areas of primary care and other specialties, a mid-level practitioner, a behavioral health provider, and an external member advocate.

Utilization Management Advisory Committee
This committee is responsible for monitoring the appropriateness of care, guarding against over- and under-utilization, and evaluating outcomes of disease and case management programs. The committee comprises providers from our network representing primary care and key specialty areas.

Credentialing Committee
This committee is responsible for credentialing and re-credentialing health plan practitioners and facilities and is a peer review committee. The committee comprises providers from our network who meet every two months.

Compliance Committee
The purpose of the Compliance Committee is to review compliance risks, monitor progress on any current corrective action plans and to receive and review regular status reports in areas such as timeliness of State reporting and encounter data pass rates. This committee includes representatives from all internal departments.

Special Investigation Unit (SIU)
The SIU Committee is responsible for ensuring that billing errors, abuse, and fraud issues are consistently identified and addressed in a systematic manner, in compliance with State and federal law, interpretations thereof, and State of Wisconsin Department of Health Services guidelines. The SIU Committee includes representation from both MHS Health and Centene Corporation.

Grievance and Appeals Committee
The Grievance and Appeals Committee is responsible for reviewing, categorizing, tracking, and trending grievances and appeals, and determining appropriate disposition and follow-up, in compliance with State and local requirements. This committee meets on a weekly basis, as needed.

Consumer Advisory Committee
The goal of the Consumer Advisory Committee is to solicit member input into the QI Program and to act as a focus group to facilitate member perspective on the quality of care and services offered by MHS Health and to offer recommendations for improvement.

Health Management Reminder Programs
MHS Health identifies members who may benefit from specific health screenings and periodically mails them age, gender, and topic-specific information and/or reminders to schedule tests. The program promotes practice standards and emphasizes member empowerment strategies. The goal is to encourage and help our members receive appropriate medical care and achieve their highest level of wellness.

Diabetes Guidance
Quality analytics is used to identify members with diabetes who may not be monitoring their diabetes or who are at high risk of complications. Members are reviewed for disease management and case management. Members may also receive mailings to remind them to participate in recommended screenings. A link to national, web-based clinical practice guidelines is in the Resources section on the MHS Health website.

HealthCheck
Through HealthCheck, Wisconsin Medicaid covers necessary healthcare, diagnostic services, treatment, and other measures to correct or ameliorate defects, physical and mental illnesses, and conditions discovered during the screening services. HealthChecks promote a comprehensive child health program of prevention and treatment.

- MHS Health mails reminders and/or calls members in need of a HealthCheck and encourages regular HealthCheck screenings.

You may obtain a copy of HealthCheck age-specific forms through a link in the resources section on the MHS Health website or by calling the MHS Health Provider Inquiry Line at 1-800-222-9831, or by downloading this PDF from the American Academy of Pediatrics. See *Section 8 HealthCheck Section* for more information.

Immunization Reminder Program
The MHS Health immunization program was developed to ensure our members receive the immunizations they need. The initial targeted group is children up to two years of age. Parents/guardians of children are periodically sent a reminder mailing and/or receive an outreach call to make an appointment with their doctor for any needed immunizations.

- Primary care providers receive the current immunization and catch-up schedules and information on the Wisconsin Immunization Registry each year. Providers are asked to use each healthcare encounter to review the immunization status of their patients.
- Immunization information is also distributed to members through the Start Smart For Your Baby® program.
- Member incentive programs are developed for children to become fully immunized.

A link to the most current Childhood and Adolescent Immunization and Catch-Up Schedules and Adult Immunization Schedule is on the Provider Resources page of MHS Health website. The following CDC website also includes the vaccination schedule that is required by MHS Health.

Pregnancy and Depression Program
MHS Health is committed to improve awareness of the symptoms of depression during pregnancy and postpartum and to link depressed members with appropriate treatment resources.

- All members identified as being pregnant receive a Start Smart for Your Baby® packet that includes a brochure about pregnancy and depression. The information includes MHS Health's phone number and the Edinburgh depression screening survey. Returned surveys are scored for depression risk level. Members whose scores indicate possible depression are contacted by a behavioral healthcare coordinator and referred to an appropriate provider for treatment. When scores do not indicate depression, the member receives a letter encouraging the member to call MHS Health if they feel they need help.
- Members receive a postpartum depression brochure and the Edinburgh screening survey after delivery.

Pregnant Women and Tobacco Use
MHS Health wants women to have a happy, healthy pregnancy. Smoking during pregnancy can lead to:

- Premature birth
- Miscarriages or stillbirths
- Sudden infant death syndrome
- Asthma in children
- Future school problems

Practitioners should screen every pregnant woman for tobacco use during their initial prenatal visit, regardless of when this visit occurs. Screening and counseling to stop smoking should be documented in the member's medical record, and the member should be referred to a smoking cessation program. The member's cessation efforts should be assessed at every prenatal visit and at the postpartum visit.

Other topics for mail or telephonic reminders may include:

- Adolescent immunizations and wellness
- Breast cancer screening
- Cervical screening
- Chlamydia screening
- Influenza
- Appropriate antibiotic use
- Controlling high blood pressure
- Asthma medication management

Social Determinants of Health

The CDC defines Social Determinants of Health (SDOH) as conditions in the places where people live, learn, work, and play that affect a wide range of health and quality of life risks and outcomes. MHS Health encourages providers to utilize tools within their electronic medical record systems to help them screen, document, and refer members to services targeting member (SDOH) needs.

Resources available include, but are not limited to:

- CMS Brochure on Using Z Codes to Improve outcomes
- American Academy of Family Physicians Screening Tool
- PRAPARE- Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences
- Epic Systems SDOH Wheel

Section 5 Medical Records

MHS Health network providers must maintain consistent and complete medical information for members. This will help enable clinicians to provide the highest quality medical care and continuity of care to members.

Records and Documentation
MHS Health network providers need to retain all books, records, and documentation related to services rendered to members as required by law and in a manner that facilitates audits for regulatory and contractual reviews.

Providers will provide to MHS Health and regulatory agencies access to these documents to assure financial solvency and healthcare delivery capability and to investigate complaints and grievances, subject to regulations concerning confidentiality of such information.

Access to documentation must be provided upon reasonable notice for all inpatient care. This provision shall survive the termination and or non-renewal of a Participating Provider Agreement with MHS Health.

Medical Records Requirements

General Standards
The following commonly accepted standards for medical record documentation are adopted from NCQA:

1. Each and every page in the record contains the patient's name or ID number.
2. Personal/biographical data includes address, employer, home, and work telephone numbers and marital status.
3. All entries in the medical record contain author identification.
4. All entries are dated.
5. The record is legible to someone other than the writer.
6. Significant illnesses and medical conditions are indicated on a problem list.
7. Any allergies (medication, food &/or tactile) and adverse reactions are prominently noted in the record. If the patient has no known allergies or history of adverse reactions, this is appropriately noted in the record. Medication information list includes instructions to member regarding dosage, initial date of prescription and number of refills.
8. Past medical history (for patients seen three or more times) are easily identified and include serious accidents, operations, and illnesses. For children and adolescents (18 years or younger), past medical history relates to prenatal care, birth, operations, and childhood illnesses.
9. For patients 14 years and older, there are appropriate notations concerning use of cigarettes, alcohol and substance abuse (for patients seen three or more times).
10. The history and physical exam records appropriate subjective and objective information for presenting complaints. Clinical findings and evaluations for each visit are documented in record.
11. Laboratory and other studies are ordered, as appropriate.
12. Working diagnoses are consistent with findings.
13. Treatment plans are consistent with diagnoses.
14. Encounter forms or notes have a notation, when indicated, regarding follow-up care, calls, or visits. The specific time of return is noted in weeks, months, or PRN.
15. Unresolved problems from previous office visits are addressed in subsequent visits.
16. No evidence of under- and over-utilization of consultants.
17. If a consultation is requested, there is a note from the consultant in the record.

18. Consultation, lab, imaging/diagnostic reports, ancillary and therapeutic reports are filed in the chart are initialed by the practitioner who ordered them to signify review. If the reports are presented electronically or by some other method, there is also representation of review by the ordering practitioner. Consultation and abnormal lab and imaging study results have an explicit notation in the record of follow-up plans.
19. No evidence that the patient is placed at inappropriate risk by a diagnostic or therapeutic procedure.
20. An immunization record has been initiated for children, or an appropriate history has been made in the medical record for adults.
21. Evidence that preventive screening and services are offered in accordance with the plan's practice guidelines.
22. Records are stored securely with access limited to authorized personnel and easily retrievable upon request. All member information is kept confidential.
23. Record format is organized and consistent.
24. Evidence of an advance directive for patients older than 18 years of age.

Confidentiality and Medical Records Release
All medical records of covered persons are confidential and cannot be released without the written authorization of the member or member's legal guardian.

Written consent is required for the transmission of the medical record information of a current plan member or former plan member to any physician not connected with MHS Health.

When the release of medical records is appropriate, the extent of that release should be based upon medical necessity or on a need-to-know basis.

MHS Health does not need the member's authorization to use or disclose his or her medical records for:

- Treatment
- Payment (claims)
- MHS Health healthcare operations (including but not limited to claims process, auditing, quality assurance)

Medical Records Transfer for New Patients
Providers must document in the member's medical record attempts to obtain old medical records for all new plan members. If the member or his or her guardian is unable to recall where previous medical care was obtained or is unable to provide an appropriate address, this information should be noted in the medical record.

Access to Records and Audits by MHS Health
Subject only to applicable state and federal confidentiality or privacy laws, providers shall permit MHS Health or its designated representative access to the provider's records, at the provider's place of business in this state during normal business hours, or remote access of such records (via fax, electronically submitted, or electronic medical record (EMR)), in order to audit, inspect, review, perform chart reviews, or duplicate such records. If performed on site, access to records for the purpose of an audit shall be scheduled at mutually-agreed-upon times, upon at least thirty (30) business days prior written notice by MHS Health or its designated representative, but not more than sixty (60) days following such written notice. In the event of a regulator audit/request and remote access of records is provided, providers must produce medical records to MHS Health within thirty (30) calendar days of request.

Medical records may be required for claims processing. The required documentation may be requested by letter or through a remittance advice. Medical records should be submitted with any claim billing a CPT code that is designated as an unlisted procedure code.

Electronic Medical Record (EMR) Access
Providers will grant MHS Health access to the provider's EMR system to effectively case manage members and capture medical record data for risk adjustment and quality reporting. There will be no other fees charged to MHS Health for this access. Electronic Medical Record ("EMR") means an electronic version of a Covered Person's medical history that is maintained by the Provider and includes the key administrative clinical data relevant to the Covered Person's care including demographics, progress notes, problems, medications, vital signs, past medical history, immunizations, laboratory data, and radiology reports.

Supplemental Data Submission
Providers agree to cooperate with MHS Health's Supplemental Data collection process including but not limited to submitting monthly Supplemental Data files in format specified by the Health Plan, reviewing medical and administrative records for identified Covered Persons, and submitting requested documentation to the Health Plan. Supplemental Data means provider's electronically generated files, including but not limited to, medical and laboratory data and information that shall be provided to MHS Health in accordance with the requirements of the Provider Manual.

Medical Records and Quality Improvement Initiatives
Contracts with practitioners specifically require that practitioners cooperate with QI activities including, but not limited to, disease management programs, adopted clinical practice guidelines, medical record audits, focus studies, provider profiling, and performance monitoring.

Scores
Audit scores are computed and documented for each PCP using a Medical Records Audit Tool. Results are reported for every provider audited in terms of overall performance of the medical records reviewed against MHS Health standards. Expectations regarding scoring are described below:

- A minimum score of 80% overall is required to achieve compliance with MHS Health guidelines.
- Providers receiving a score of 79% or below will be re-audited within six months to assess for improvement in identified deficiencies.

Medical record audit results are reported to MHS Health's QIC for tracking and for trending in the re-credentialing process, as appropriate. The provider also agrees to participate in and contribute required data to HMO Quality Assessment and Performance Improvement Programs as required in the BadgerCare Plus and Medicaid SSI MCO contract.

Please visit the provider section of our website to see a copy of the Medical Records Audit Tool.

Regulations
Provider shall maintain a complete and accurate permanent medical record for each person to whom they rendered services and shall include in that record all reports and all documentation required by applicable laws, contracts, and applicable accrediting agencies.

Behavioral Health Quality Improvement
As part of our ongoing quality improvement program, clinical records may be audited to assure the quality and consistency of provider documentation, as well as the appropriateness of treatment. Chart audits of member records will be evaluated in accordance with these criteria.

Clinical records require documentation of all contacts concerning the member, relevant financial and legal information, consents for release/disclosure of information, release of information to the member's PCP, documentation of member receipt of the Statement of Member's Rights and Responsibilities, the prescribed medications with refill dates and quantities, including clear evidence of the informed consent, and any other information from other professionals and

agencies. If the provider can dispense medication, the provider must conform to drug dispensing guidelines set forth in the State of Wisconsin Medicaid preferred drug list.

Providers shall retain clinical records for members for as long as is required by applicable law. These records shall be maintained in a secure manner, with only authorized personnel having access to the records, but must be retrievable upon request. Providers and the office staff must receive periodic training on confidentiality of member information.

MHS Health does not need the member's authorization to use or disclose his or her medical records for:

- Treatment
- Payment (claims)
- MHS Health healthcare operations (including but not limited to claims process, auditing, quality assurance)

Section 6 Eligibility Verification and Member Enrollment

Providers must verify current eligibility status and health plan enrollment every time a BadgerCare Plus and Medicaid SSI member schedules an appointment, as well as when a member arrives for services to determine enrollment status for the current date, and learn of any limitations to the member's coverage.

ID Cards
BadgerCare Plus and Medicaid SSI recipients receive a **ForwardHealth** ID card when they initially become eligible. Possession of a ForwardHealth or Forward ID card does not guarantee eligibility since recipients who lose eligibility are instructed to keep their ID cards in case they again become eligible for BadgerCare Plus and Medicaid SSI benefits.

Verify BadgerCare Plus and Medicaid SSI eligibility using the state Eligibility Verification System (EVS)

- ForwardHealth Portal at www.forwardhealth.wi.gov/ (must establish a provider account)
- WiCall – Automated Voice Response (AVR) system: 1-800-947-3544
- Eligibility verification vendors (accessed through software, magnetic stripe card readers, and the Internet)
- 270/271 Healthcare Eligibility/Benefit Inquiry and Response (270/271) transactions
- State Provider Services at 1-800-947-9627 from 7 a.m. to 6 p.m., Monday-Friday

All EVS methods provide the most current information, including:

- Managed care enrollment status
- Eligibility status for the date(s) of service requested
- Other health insurance and/or Medicare coverage

How to Verify MHS Health or Network Health Plan Enrollment

- Visit the MHS Health website at mhswi.com to register for the secure Provider Portal. This is a password-protected site. Directions are provided at mhswi.com.
- Call the MHS Health Provider Inquiry Line at 1-800-222-9831. When prompted, say "Eligibility."
- You will have the option to speak with a live representative or to verify eligibility through the Integrated Voice Response System (IVR) for faster service.
- MHS has the capability to receive an ANSI X12N 270 health plan eligibility inquiry and generate an ANSI X12N 271 health plan eligibility response transaction through Centene (MHS Health parent organization). For more information on conducting these transactions electronically, call the MHS Health Provider Inquiry Line 1-800-222-9831.

Section 7 Routine, Urgent, and Emergent Services

Definitions

Routine care is designed to prevent disease altogether, to detect and treat it early, or to manage its course most effectively. Examples of routine care include immunizations and regular screenings such as Pap tests or cholesterol checks.

Urgent care is a situation requiring treatment of a health condition, including a behavioral health situation, which is not an emergency, but is severe or painful enough to cause a prudent layperson, possessing an average knowledge of medicine, to believe that his or her condition requires medical evaluation or treatment within 24 hours to prevent serious deterioration of the member's condition or health.

Emergency care is a situation when an acute medical condition shows symptoms of sufficient severity (including severe pain) that a prudent layperson, possessing an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Placing the physical or mental health of the individual (or the health of an unborn child) in serious jeopardy.
- Serious impairment of bodily functions.
- Serious dysfunction of any bodily organ or part.

Or, with respect to a pregnant woman in active labor:

- There is inadequate time for a safe transfer to another hospital before delivery.
- The transfer may pose a threat to the health and safety of the woman or the unborn child.

Additional emergency situations defined by the Department of Health Services contract include:

- A psychiatric emergency involving a significant risk of serious harm to oneself or others.
- A substance abuse (alcohol and other drug abuse) emergency exists if there is a significant risk of serious harm to an enrollee or others, or there is a likelihood of return to drug abuse without immediate treatment.
- Emergency dental care is defined as an immediate service needed to relieve the patient from pain, an acute infection, swelling, trismus, fever, or trauma.

Provider must document the nature of the emergency in the recipient's medical record for all emergency situations.

The following are not considered emergencies:

- Routine follow-up care
- Removal of sutures
- Well-child checkups/adult checkups
- Immunizations, including TB

Members are encouraged to contact their PCP prior to seeking urgent or emergent care, except in a life- threatening emergency or permanent injury if not treated immediately.

Wisconsin Medicaid, and therefore MHS Health, must promptly provide or pay for medically necessary, Medicaid-covered emergency services based on the medical signs and symptoms present when the enrollee first arrived for treatment. The PCP plays a major role in educating plan members about appropriate and inappropriate use of hospital emergency rooms.

24/7 Nurse Advice Line
When members have healthcare questions and cannot reach their PCP, they can call our 24-hour Nurse Advice Line at 1-800-280-2348. TDD/TTY for the hearing impaired: 1-888-780-7155. MHS Health provides the advice line at no charge to support your practice and offer plan members access to a nurse 24 hours a day, 7 days a week. If you have questions, please call the MHS Health Provider Inquiry Line at 1-800-222-9831 or the Nurse Advice Line.

Advice line nurses provide:

- Health information in English and Spanish (interpreter services for other languages are also available).
- Nurse triage and answers to questions about urgent or emergency access.
- Answers to questions about pregnancy and newborn care.
- Answers to questions about how much medicine to give children.
- Referral to case management for education and encouragement to members with chronic health problems, like asthma and diabetes.
- Information about network providers and local services that are available after MHS Health is closed.
- Member eligibility verification for providers, any time of the day.

Protocols
Advice line nurses document calls and consult McKesson's Care Enhancement Call Center system. Clinical Guidelines are nationally recognized guidelines developed by Barton Schmitt, M.D. and David A. Thompson, M.D. These protocols are widely used in nurse call centers and have been reviewed and approved by physicians around the country.

Non-emergency Medical Transportation
Additional details regarding transportation services can be found in *Section 17 Transportation*. Members enrolled in the State of Wisconsin's Medicaid program will be required to contact Veyo

Veyo Reservation Line	1-866-907-1493 (voice) or TTY 711
Veyo Information	https://wi.ridewithveyo.com/
Book a Ride Online	https://member.veyo.com/

*Use the websites above to schedule and cancel routine and recurring rides, file complaints, and obtain forms. To schedule rides online, you will need to have already scheduled at least one ride for the member by calling the reservation phone number and have a valid email address. Should you have an urgent (not emergent) need for transportation and Veyo is not accommodating, please contact MHS Health Customer Services at 1-888-713-6180.

Ambulance and Emergency Transportation
Our members' coverage includes ambulance service for emergency care.

- Emergency Basic Life Support (BLS) transportation does not require prior authorization.
- All high-mode transportation and out-of-state transports require prior authorization. The MHS Health Medical Services fax line for authorizations is 1-866-467-1316.

Section 8 Covered Services

MHS Health/Network Health Plan members have the following benefits. Services must be medically necessary.

Services	Standard & SSI Plan	Co pay
*Pharmacy	State preferred drug list	*$0.50 - $3
Medication given during a provider visit	Full Coverage	MHS covers
Physician visits	Full coverage	MHS covers
Inpatient hospital	Full coverage	MHS covers
Outpatient hospital	Full coverage	MHS covers
Emergency room	Full coverage	MHS covers
Nursing home	Full coverage	MHS covers
Physical therapy	Full coverage	MHS covers
Home health	Full coverage	MHS covers
Medical equipment	Full coverage	MHS covers
Medical supplies	Full coverage	MHS covers
*Transportation	Routine to & from covered services	Full coverage
Ambulance	Full Coverage	MHS covers
*Dental	Preventive, restorative, palliative	*$1 - $3
Vision	One exam & glasses per year	MHS covers
added vision	$100 allowance for better frames or $ 80 toward contact lenses	MHS covers
Hearing	Full coverage	MHS covers
Hospice	Full coverage	No copay
Family planning	Full coverage	No copay
*Chiropractor	Full coverage	*$3
Podiatrist	Full coverage	MHS covers
Mental health and Substance Use Disorder (SUD) outpatient	Full coverage	MHS covers
Mental health and Substance Use Disorder (SUD) inpatient	Full coverage for ages 0-21 (Stays for age 22-64 in institutional settings are not covered)	MHS covers
*SUD Residential treatment	Covered by FFS	*No co-pay
Health education	MHS added benefit	Asthma, diabetes, hypertension

*Pharmacy and chiropractic services are provided by the State in all areas. Members may access this care from any provider that will accept the ForwardHealth Card. Routine transport is provided by the State through a separate company. Depending on the member's county of residence, the dental benefit may be provided by MHS Health or by the State.

Medically Necessary Covered Services

- Provider services: physicians, nurses, advanced nurse practitioners, physician assistants, nurse midwives
- Inpatient and outpatient hospital services
- Family planning services and supplies
- HealthChecks for members under age 21, including referrals for medically necessary services
- Preventive health screenings for adults
- Smoking cessation counseling by a PCP
- Laboratory and X-ray services
- Mental health treatment

Dental Services (for specified counties)
MHS Health provides covered dental services for members residing in the following counties: Milwaukee, Kenosha, Racine, Waukesha, Washington, and Ozaukee. Members residing in these counties must use in-plan dentists. See our Provider Directory at www.mhswi.com or call Customer Service at 888-713-6180 for a list of in-plan dental providers.

Dental Emergency for Members Living in the Specified Counties
A dental emergency is defined as an immediate dental service needed to treat dental pain, swelling, fever, infection, or injury to the teeth.

Members who are already established with an in-plan dentist should be directed to follow these steps during a dental emergency:

- Call the dentist's office.
- Identify themselves as having a dental emergency.
- Tell the dentist what the dental problem is (toothache, swollen face, etc.).
- Make sure the office understands that it is a "dental emergency."

Members who do not currently have an in-plan dentist should be directed to follow these steps:

- Call our Customer Service (888) 713-6180.
- Inform us that they are having a dental emergency.
- We will facilitate an appointment for the member.

For help with a dental emergency, call our 24-hour Nurse Advice Line at 1-800-280-2348 (TDD/TTY at 1-888-780-7155).

Dental Services (for non-specified counties)
Members who reside outside of the specified counties must access dental services from any dentist who will accept their ForwardHealth card. These dental services are provided by Medicaid fee-for-service, not MHS Health.

Behavioral Health
MHS Health provides plan members with treatment for mental health and substance use disorder (alcohol and other drugs) issues. A referral is not required for most counseling services when seeing participating providers. Members can call1-888-713-6180 for a listing of behavioral health providers in their area or go to the provider directory on our website. (Wisconsin Relay Service at 1-800-947-3529).

Vision Services
MHS Health provides members with vision services. A referral is not required for annual routine vision exams. Members must receive services from network providers. To schedule appointments, members may select a provider listed in the Member Handbook and call the number listed for an appointment. Network vision care providers are also listed on the provider directory page on our website. For help selecting a provider, members may call Envolve Vision Customer Service at 1-866-458-2134. Members with medical conditions must be referred to an ophthalmologist in the MHS Health network. When members need new eyewear or eyewear repairs, they need only present their ForwardHealth ID card at a network location. No appointment is needed.

Podiatrists
No authorization is required for the first three visits per calendar year to a podiatrist. Generally, routine foot care is not a covered benefit. The care of "flat feet" is not a covered benefit.

Palliative Foot Care
Palliative podiatric care is the cutting, cleaning, and trimming of toenails, corns, calluses, and bunions. When covered, palliative care is covered at one fee for each service on multiple digits for one or both feet. Palliative services are covered only if the member is under the active care of a physician for one of the following conditions (see next page):

- Diabetes mellitus
- Arteriosclerosis obliterans evidenced by claudication
- Peripheral neuropathies involving the feet and associated with:
  - Malnutrition or vitamin deficiency
  - Diabetes mellitus
  - Drugs and toxins
  - Multiple sclerosis
  - Uremia
  - Cerebral Palsy
  - Multiple sclerosis
  - Spinal cord injuries
  - Blindness
  - Parkinson's Disease
  - Cerebrovascular accident
  - Scleroderma

Family Planning and Confidentiality
Federal guidelines require that members have the option of selecting a provider for family planning who is not their primary care provider (PCP). The family planning provider need not be contracted with MHS Health. The clinician selected for family planning services does not replace the PCP chosen by or assigned to the enrollee for all other medical services.

MHS Health must allow adolescents to have their own PCP or to seek family planning services from a certified family planning agency. If a member selects a non-MHS Health network provider for family planning services, the State will cover the cost on a fee-for-service basis.

Chiropractic Services
MHS Health does not cover chiropractic services. Members may receive chiropractic services from any Medicaid chiropractic provider on a fee-for-service basis.

Organ transplants
MHS Health covers kidney and cornea transplants only. In general, all other transplants (including dual transplants) are covered by the State of Wisconsin. All transplant evaluations by a transplant surgeon and facility are the responsibility of MHS Health and require prior authorization by MHS Health. A pre-approved referral is required before scheduling a member for a transplant evaluation. Plan members access transplant services through the MHS Health "Centers of Excellence" network.

Section 9 HealthCheck, Developmental, and Behavioral Health Screenings

Developmental and Behavioral Health (BH) Screenings (Bright Futures)
Per the SUPPORT Act, behavioral health services, including mental health treatment, substance use disorder treatment, and interventions for developmental delays are to be made available to members ages 0-18 enrolled into Wisconsin's BadgerCare Plus programs. MHS Health and Network Health Plan have the responsibility to ensure the use of age-appropriate, evidence based validated behavioral health screening and assessment tools for individuals aged 0-18 in primary care settings, according to a periodicity schedule that supports early identification of conditions that affect children's early and long-term development. MHS Health and Network Health Plan requires its primary care providers to follow the Bright Futures periodicity schedule that was developed and created by the American Academy of Pediatrics.

Bright Futures Medical Record Review Audits
To ensure that the Bright Futures Periodicity Table is followed by primary care providers, the health plan completes random audits throughout the year that evaluate the provider's adherence to the Bright Futures periodicity table as well as validates that appropriate actions were taken with the member and/or member's guardian for any positive findings per the assessment's criteria. In order to effectively complete the random audits of developmental and behavioral health assessments, the Quality Improvement Department designee identifies a random sample of members that would meet the timeframe for an assessment to be completed per the periodicity table. The designee submits medical records requests from the providers. Upon receipt of the records, the designee reviews the medical records for evidence that an evidence-based assessment was completed timely and scored appropriately. Using the nationally recognized Bright Futures guidelines, the designee validates that the practitioner made the appropriate referral and/or recommendations for any positive findings. If the practitioner did not take the appropriate steps per the tool's technical specification, the Provider Relations designee completes follow-up education and/or develops a corrective action plan with the practitioner.

CPT Code	Description
96110	Developmental screening (e.g., developmental milestone survey, speech, and language delay screen), with scoring and documentation, per standardized instrument
96112	Developmental test administration (including assessment of fine and/or gross motor, language, cognitive level, social, memory and/or executive functions by standardized developmental instruments when performed), by physician or other qualified health care professional, with interpretation and report; first hour
96127	Brief emotional/behavioral assessment (e.g., depression inventory, attention-deficit/hyperactivity disorder [ADHD] scale), with scoring and documentation, per standardized instrument

The Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)
This service is Medicaid's comprehensive and preventive child health program for individuals under age 21. The EPSDT service has been a part of the federal Medicaid program since its beginning in the late 1960s. In Wisconsin, the EPSDT program is called HealthCheck.

The State requires health plans to ensure that 80% of their Medicaid members under age 21 have an age-specific number of HealthCheck screenings each year.

What is a HealthCheck?
A HealthCheck promotes a comprehensive child health program of prevention and treatment. Health plans like MHS Health identify members and inform them of the benefits of prevention and the health services and assistance available. Health plans also help members and their families use health resources, including their own talents and knowledge, effectively and efficiently.

A HealthCheck screening includes the following:

- A review of the patient's health history
- An assessment of growth and development
- Identification of potential physical or developmental problems
- Preventive health education
- Referral assistance to providers

Under HealthCheck, Wisconsin Medicaid covers necessary healthcare, diagnostic services, treatment, and other measures to correct or ameliorate defects, physical and mental illnesses, and conditions discovered during the screening services.

HealthCheck Screening Guidelines (periodicity table) can be found here and appropriate age-specific forms are on the MHS Health website.

Note: Lead screening is required at a 12-month and 24-month visit. Please include results on that age-specific form.

Performing HealthCheck
Through HealthCheck, the child's health needs are assessed during initial and periodic examinations and evaluations, assuring that the health problems found are diagnosed and treated early, before they become more complex and their treatment more costly.

All HealthCheck examinations must include the following components as appropriate to the age of the child:

- Comprehensive health, nutritional, and developmental history, including health education and anticipatory guidance
- Comprehensive unclothed physical examination
- Vision screen
- Hearing screen
- Oral assessment/evaluation
- Immunizations
- Laboratory tests

Billing HealthChecks

- Physician assistants and nurse practitioners who perform HealthCheck exams, immunizations, and select diagnostic procedures and bill lab handling fees are reimbursed at 100% of the maximum allowed amount for the clinician (MD/DO) who would have performed the same service.
- HealthCheck examinations must be billed using the appropriate CPT code for the age of the child.
- Bill for immunizations given during HealthCheck or routine office visits (they're not included as part of the HealthCheck reimbursement).
- Use the appropriate CPT code for the specific vaccine given.
- Be advised vaccine administration is not reimbursed.

CPT Code	
99460 or 99463	History and exam of newborn in hospital
99461	Normal newborn care including physical examination in setting other than hospital or
99381 or 99391	HealthCheck exam of infant – to 1 year old
99382 or 99392	HealthCheck exam of child 1-4 years of age
99383 or 99393	HealthCheck exam of child 5-11 years of age
99384 or 99394	HealthCheck exam of adolescent 12-17 years of age
99385 or 99395	HealthCheck exam of young adults 18- 20 years of age

National Place of Service (Location) Codes are Required

The State of Wisconsin recognizes the following place of service codes:

05 – Indian health service free-standing facility

06 – Indian health service provider-based facility

07 – Tribal 638 free-standing facility

08 – Tribal 638 provider-based facility

11 – Office

12 – Home

22 – Outpatient hospital

50 – Federally Qualified Health Center (FQHC)

60 – Mass Immunization Center

71 – State or local public health clinic

72 – Rural health clinic

99 – Other place of service

National Modifier

The only modifier that applies to HealthCheck services provided by physicians, physician clinics, physician assistants, and nurse practitioners (CPT codes 99381-99385, 99391-99395) is:

- UA – Providers should also indicate modifier "UA" with the appropriate procedure code if a comprehensive screen results in a referral for further evaluation and treatment. If a comprehensive HealthCheck screen does not result in a referral for further evaluation or treatment, providers should only indicate the appropriate procedure code, not the modifier.

HealthCheck screening guidelines (periodicity table)

HealthCheck Screening Guidelines (periodicity table) can be found at the American Academy of Pediatrics web page:

Specific vaccination schedules can be found at the Centers for Disease Control website

Section 10 Medical Management

MHS Health's Medical Management Department hours of operation are Monday through Friday (excluding holidays) from 8 a.m. to 5 p.m.

Provider Inquiry Line
1-800-222-9831

Services available on the provider Inquiry Line

- Check eligibility (member eligibility)
- Claims, I-9 information, billing and claim questions, Provider Relations staff
- Benefit information
- Check authorization status
- Authorization request
- Staff is available during normal business hours for inbound collect or toll-free calls regarding UM issues
- Staff can receive inbound communication regarding urgent UM issues after normal business hours via the after-hours Nurse Advice line on demand
- Staff is identified by name, title and organization name when initiating or returning calls regarding UM issues
- TDD/TTY services for members who need them
- Language assistance for members to discuss UM issues

Medical Services Fax Lines

Authorization	1-866-467-1316 or 1-866-883-1708 for Medicaid In/Out Patient Services 1-877-687-1183 for Medicare In/Out Patient Services 1-800-354-6136 for Admissions
Pregnancy Notification	1-866-681-5125 or 1-866-681-3668
Behavioral Health Authorization	1-866-694-3649

After hours, you will have the option of contacting the MHS Health 24-hour Nurse Advice line at 1-800-280-2348.

After hours, emergent and urgent admissions, inpatient notifications or requests will need to be provided by telephone. Faxes will not be monitored after hours and will be responded to on the next business day. Please contact the 24/7 Nurse Advice line at 1-800-280-2348 for after hours, urgent admissions, inpatient notifications, or requests.

Please note the MHS Health Provider Inquiry Line is for use by providers and their staff only. Please advise your patients who are MHS Health or Network Health members to call Customer Service at 1-888-713-6180.

Pharmacy Benefit

This benefit is covered by the State of Wisconsin under the Medicaid fee-for-service program. Prescription medications, radiopharmaceuticals, biopharmaceuticals and other injectables administered in a home health setting, provider's office, skilled nursing facility, and most outpatient settings should be billed to Medicaid fee-for-service. For assistance in determining the State's responsibility versus MHS Health, please call the MHS Health Provider Inquiry Line at 1-800-222-9831, and when prompted, say "benefits."

Follow the current prior authorization process for inpatient and outpatient services for in office provider administered medications.

Referring MHS Health and Network Health Members
The PCP should coordinate healthcare services for MHS Health/Network Health members. PCPs should refer members to other providers when medically necessary services are beyond their scope of practice. Services that require authorization by MHS Health are listed in this section and on the MHS Health Provider Quick Reference Guide.

Members may self-refer only for certain specific services, such as family planning, behavioral health, dental and vision, as stated in this manual.

MHS Health encourages specialists to communicate to the PCP the need for a referral to another specialist, rather than making such a referral themselves. This allows the PCP to better coordinate their patient's care and to make sure the specialist to whom the member being referred is a participating provider with MHS Health.

The network provider must call MHS Health for prior authorization of any service from a non-network provider or facility.

Prior Authorization Requests
Prior authorization is required for certain medical and behavioral health services, procedures, and diagnostic tests that are frequently over- or underutilized, that are costly, or which indicate a need for case management.

Failure to notify MHS Health before providing services requiring prior authorization can result in denial of payment for lack of pre-authorization.

A staff member will enter the information received and transfer the request to a nurse for the medical necessity screening.

Medical Necessity
Medically necessary services are generally accepted medical practices provided in light of conditions present at the time of the treatment. These services are:

- Appropriate and consistent with the diagnosis of the treating provider and the omission of which could adversely affect the eligible member's medical condition
- Compatible with the standards of acceptable medical practice in the community
- Provided in a safe, appropriate and cost-effective setting given the nature of the diagnosis and severity of the symptoms
- Not provided solely for the convenience of the member or the convenience of the healthcare provider or hospital
- Not primarily custodial care unless custodial care is a covered service or benefit under the member's evidence of coverage
- Certain provider-administered medications
- Step Therapy: In some cases, our plan requires a member to try a certain medication to treat his/her medical condition before we will cover another medication for that condition.

There must be no other effective and more conservative or substantially less costly treatment, service, and setting available.

Experimental, investigational, or cosmetic procedures are not a covered benefit.

Information Necessary for Authorization
Information necessary may include, but is not limited to:

- Member's name, address, telephone number, date of birth, sex, and Medicaid number.
- Physician's name, credentials, addresses, and telephone number
- Hospital/facility name, address, telephone number, Tax ID Number and NPI Number if the request is for an inpatient admission or outpatient service
- Reason for admission/service – primary and secondary diagnoses, surgical procedure and surgery date
- Relevant clinical information – past/proposed treatment plan, surgical procedures and diagnostic procedures to support the appropriateness and level of service proposed.
- Admission date or proposed date of surgery
- Requested length of stay, if the request is for an inpatient admission
- Discharge plans, if the request is for an inpatient admission
- For obstetrical admissions, the method of delivery and information related to the newborn or neonate.
- For behavioral health inpatient admissions, alternative provided or considered, treatment goals, estimated length, family and social support and current mental status

When more information is required to complete the medical necessity screening, the nurse will notify the provider requesting the additional information needed. If the information is not received in the timeframe designated, an administrative denial may be issued.

Professionals Review
At MHS Health, qualified healthcare professionals review your requests for services using clinical guidelines and criteria developed by InterQual and/or the DHS.

All adverse medical necessity determinations are made only by a licensed physician. The provider may request a copy of the criteria/guidelines used by MHS Health in making adverse medical necessity determinations by contacting the MHS Health Provider Inquiry Line at 1-800-222-9831.

Affirmative Statement for Utilization Management (UM)
All individuals involved in UM decision-making at MHS Health sign an affirmative statement about incentives and acknowledge that MHS Health makes UM decisions based on appropriateness of care and existence of coverage**.** MHS Health does not reward practitioners or other individuals for issuing denials of coverage or service care, and financial incentives for UM decision makers do not encourage decisions that result in underutilization. Staff receive this statement upon hire and annually thereafter. This statement is distributed upon initial contracting with practitioners and providers via the Provider Manual and annually thereafter to all network providers via our provider newsletter.

Non-urgent Service Authorization
Prior authorization decisions for non-urgent services shall be made within 14 calendar days of the receipt of the request for services. An extension may be granted for an additional 14 calendar days if the member or the provider requests an extension or if MHS Health needs additional information to complete the authorization or if the extension is in the member's best interest.

Urgent Service Authorization
In the event the provider indicates or MHS Health determines that following the non-urgent services timeframes could seriously jeopardize the member's health or life, MHS Health will make an expedited authorization determination and provide notice to the provider within 72 hours of receipt of request.

Authorization Requirements
Providers should reference our website Prior Auth Check Tool or call MHS Health if they are unclear whether a service requires prior authorization. Prior authorization is not required for emergency care, family planning services,

preventive services or basic prenatal care. For a listing of behavioral health authorization requirements, call 1-800-222-9831. Non-urgent prior authorizations that are sent after business hours are processed the next business day.

Services Requiring Prior Authorization
Call Medical Services on Provider Inquiry Line at 1-800-222-9831, when prompted say, "authorization request."

Procedures and services performed by out-of-plan providers	
Abortions (must include required consent and special criteria)	Intensive Behavioral Health Outpatient Services (hospital-based) IOP
Bariatric surgery	Mammoplasty
Blepharoplasty	Neuropsychological testing
Botox injection	Psychological Testing
Capsule endoscopy	Observation
Child/Adolescent and Substance Abuse programs	Oral surgery—TMJ surgeries
Cochlear implants	Otoplasty
Court-ordered services	Pain management: all invasive measures
Day Treatment- Adult Mental Health and Substance Use Disorder	Reconstructive/plastic surgery (except breast reconstruction after mastectomy)
ECT- Electro-Convulsive Therapy	Rhinoplasty / septoplasty
Experimental or Investigational	Scar revisions / keloid / excisions
General anesthesia for dental procedures age 5 years and older	Spine surgery, including disc replacement
Hysterosalpingography	Ultraviolet (UV) therapy
Infertility procedures	Varicose vein procedures
Implantable devices	Viscosupplementation

Inpatient Authorization
- All planned/emergency hospital admissions – in network and out of network
- All services performed in out-of-network facilities
- Hospice
- Newborn deliveries (by the next business day)
- Rehabilitation facility admissions
- Skilled nursing facility admissions
- Transplants, including evaluations
- Psychiatric and substance-use related admissions
- Electro-convulsive Therapy (ECT)

Ancillary Services
- Air transport (non-emergent, fixed wing)
- DME purchases costing $500 and over (physician office locations excluded)
- Orthotics/prosthetics billed with an "L" code costing $500 and over (physician office locations excluded)

- Therapy (ongoing services – Initial six visits are valid for in-plan providers only)
- Occupational – required after initial six visits
  - Physical – required after initial six visits
  - Speech – after initial evaluation

Day Treatment Services

- Intensive Outpatient Services (hospital-based)
- Electro-convulsive Therapy
- Podiatry (after three visits)
- Home care services including
  - Skilled nursing visits
  - Infusion therapy
  - Hospice (CTI &EOB)
  - Personal care worker
  - Wound care
  - PT/OT/ST

Other Services

- Genetic counseling
- Notification of pregnancy

Avoid Delays

When requesting prior authorization, follow these tips:

- Document all relevant information on the request form.
- Be specific about what is being requested and why services are needed.
- Fax all relevant information with faxed requests.
- Fax prior authorization requests for non-emergency surgeries at least two weeks in advance.
- Include date of surgery with prior authorization request.
- Provide contact name and phone number.

Procedures Requiring Specific Information

When requesting prior authorization for the following procedures, please include the specific information listed below.

Gastric Bypass Surgery

- Psychiatric evaluations
- Diet information including start/end dates
- Amount of weight lost
- Whether or not weight stayed off
- Documentation showing at least one high-risk, life-limiting comorbid medical condition capable of producing a significant decrease in health status that is demonstrated to be unresponsive to appropriate treatment.

Plastic Surgery

- Photos

Septoplasty

- Percentage of space lost due to deviation of the septum
- Whether or not an obstruction is present

Services with Specific Prior Authorization Requirements

Chronic Pain Management

- No prior authorization is required for evaluation by an in-plan physical medicine specialist.
- In-plan MHS Health Providers specializing in pain management must provide the service.
- To continue services, the treating pain management clinician must request authorization and submit supportive documentation.

Birth-to-3 Program

For county contacts, call the State program at 608-266-8276.

This early intervention program for infants and toddlers with a 25% or more developmental delay is provided in each county. Birth-to-3 clinicians provide speech, occupational, and physical therapy services.

- No prior authorization is required for evaluation by in-plan Birth-to-3 providers.
- To continue services, Birth-to-3 clinicians must request authorization and submit the child's evaluation report and progress notes.
- Authorization is provided in three-month periods until the child's third birthday.
- At age two (2) years, nine (9) months, a child must be referred to his or her local public school system for evaluation.
- At age three (3), the public school system takes responsibility for providing therapies.

Physical, Occupational and Speech Therapies (PT, OT, and ST)

No prior authorization is required for the initial six (6) visits for PT and OT by an in-plan therapist. No authorization is needed for an initial ST evaluation by an in-plan therapist. In-plan MHS Health providers must provide the service. Network providers are listed on the MHS Health website and in the MHS Health *Professional Services Directory*.

Continuing Services after Initial ST Evaluation

Providers must request prior authorization and submit the following information:

- Start of care date
- Diagnosis
- Number of visits requested
- Authorization is provided for
  - a specified number of visits
  - valid "from" and "to" dates

If additional services are needed for PT, OT, or ST, providers must request prior authorization and submit the following information:

- therapist notes indicating treatment to date
- therapy goals and whether they have been met or unmet
- number of additional visits requested

Durable Medical Equipment (DME), Orthotics, and Prosthetics

No prior authorization is required for ordering or prescribing DME, orthotics, and prosthetics but the following applies:

- Must use MHS Health provider who must obtain MHS Health authorization (Network providers are listed on the MHS Health website and in the MHS Health Professional Services Directory).
- The in-plan provider must obtain authorization for:
  - Purchases with retail cost of $500 or greater
  - All orthopedic footwear, shoe modification and additions billed with an "L" code costing $500
  - or more (physician office locations excluded)
- The PCP can write a prescription for services or the PCP can order services by calling the vendor directly.
- The following DME services and supplies are covered by MHS Health:
  - Durable medical equipment
  - Medical supplies
  - Respiratory care supplies

Home Care Services

- Authorization is required.
- Prior authorization may be required for obstetrical home care requests. Please contact MHS Health Medical Services.
- In-plan MHS Health home healthcare agencies must provide the service. (Contracted agencies are listed on the MHS Health website and in the MHS Health Professional Services Directory).
  - The agency requests MHS Health authorization.
  - Authorization is based on medical necessity.
- Custodial care is not covered.
- The following home healthcare services are covered by MHS Health:
  - Skilled nursing
  - Therapy
  - Home health aide
  - Personal care worker

Skilled Nursing and Sub-acute Facilities

When a member requires this level of care, MHS Health case managers work with the patient's PCP and the hospital's discharge planners and utilization review staff to locate and facilitate a transfer.

Abortions

MHS Health follows authorization requirements and provides coverage for abortions as outlined in the *Wisconsin Medicaid Provider Handbook.*

All abortions require prior authorization from the MHS Health medical director. Abortions must meet current federal and state criteria to be covered.

Coverage is limited to the following situations:

- Abortion is medically necessary to save the life of the woman
  - Prior to the abortion, the performing clinician must attest in a signed statement that the abortion meets this condition.
  - Abortions performed solely for the purpose of preserving the mother's mental health do not meet the criteria for medical necessity.
- Sexual assault or incest
  - Prior to the abortion, the performing clinician must attest in a signed statement that, to his/her belief:
    - sexual assault or incest has occurred, and
    - the crime has been reported to law enforcement authorities.
- Due to a medical condition existing prior to the abortion, abortion is directly and medically necessary to prevent

grave, long-lasting physical health damage to the woman.
    - Prior to the abortion, the performing clinician must attest in a signed statement that the abortion meets this condition.

When an abortion meets federal and state requirements and has been prior authorized by MHS Health, MHS Health covers office visits and all medically necessary related services.

- Services incidental to a non-covered abortion (e.g., lab tests, ultrasounds, recovery room services, routine follow-up office services) are not covered by MHS Health.
- Prenatal visits prior to the abortion are covered whether or not the abortion is covered.
- Treatment of complications resulting from an abortion is covered whether or not the abortion is covered.

Sterilization

Please refer to the Sterilization Consent Form and Instructions in the following links:

- Consent form for sterilization https://www.dhs.wisconsin.gov/forms/f0/f01164.pdf
- Consent for sterilization instructions https://www.dhs.wisconsin.gov/forms/f0/f01164a.pdf
- Consent form for sterilization in Spanish https://www.dhs.wisconsin.gov/forms/f0/f01164s.pdf

MHS Health must follow authorization requirements and provide coverage for sterilization procedures as outlined in the *Wisconsin Medicaid Provider Handbook*.

Sterilization procedures are defined as:

- Any surgical procedure performed for the primary purpose of rendering a male or female permanently incapable of reproducing.
    - This policy does not pertain to procedures that result in sterility but are medically necessary (e.g., removal of a cancerous uterus, testicular tumor, etc.)

Sterilization Procedures Must Meet Current Federal and State Criteria to be Covered

Requirements are:

- The provider obtains voluntary, informed, written consent from the MHS Health/Network Health member. The form and content of the consent comply with all state requirements.
- The individual is not institutionalized.
- The individual is at least 21 years old on the date the informed consent is signed.
- The individual is not mentally incompetent. (Defined by Wisconsin Medicaid as a person declared mentally incompetent by a federal, state, or local court for any purposes unless said person has been declared competent for the purpose of consenting to sterilization).
- At least 30 days, but not more than 180 days, (not counting the dates of consent and surgery) have elapsed between the date of written informed consent and the sterilization date.
    - Exception: In cases of premature delivery, sterilization may be performed at the time of the premature delivery, if:
        - the voluntary, informed, written consent of the MHS Health/Network Health member was obtained:
            - at least 30 days before the expected due date (not counting the consent and surgery dates), *and*
            - 72 hours before the premature delivery.
    - Exception: In cases of emergency abdominal surgery, sterilization may be performed at the time of the emergency surgery, if:
        - voluntary, informed, written consent of the MHS Health/Network Health member was obtained at least 72 hours before the emergency surgery.

The servicing provider has ultimate responsibility for obtaining the required written informed consent. The informed consent must be submitted to MHS Health at the time of the authorization request.

Organ Transplants
MHS Health covers kidney and cornea transplants only. In general, all other transplants (including dual transplants) are covered by the State of Wisconsin. All transplant evaluations by a transplant surgeon and facility are the responsibility of MHS Health. Referrals for transplant evaluations and actual transplants must be pre-approved by MHS Health. *Failure to obtain pre-approval when required may result in payment denial to the providers.*

Behavioral Health Services
- Psychological testing
- Neuropsychological testing
- ECT
- Intensive Outpatient Program (IOP) hospital based
- Day treatment – child/adolescent, adult mental health, adult substance abuse
- Inpatient hospitalization
- Observation
- Services provided by a non-contracted provider

Services That Do Not Require Prior Authorization

Emergency and Urgent Care
- Emergency transportation services.
- Urgent or emergent care services rendered in emergency rooms and urgent care centers.

Laboratory
- Routine laboratory tests consistent with guidelines

Maternity and OB
- Annual wellness exam, including pap-smear
- Labor checks
- Normal deliveries (notification required)
- OB ultrasounds, up to two for routine pregnancies within a 9-month period. If additional ultrasounds needed, prior authorization is required.

Primary Care
- Primary care provider office visits and minor procedures, including HealthChecks or Early and Periodic Screening Diagnostics Treatment (EPSDT).

Specialists
- Certain diagnostic tests and procedures that are considered by the health plan to be routinely part of an office visit.

Mental Health
- Mental health therapy and substance use counseling, including individual, family and group therapy
- Medication assisted treatments, including Methadone and Suboxone treatments

Pregnancy Notification
Please refer to the MHS Health Pregnancy Notification form on the MHS Health website under Provider Medical Forms. Providers may also submit notifications online through our provider portal. Providers will receive an enhanced incentive for each qualifying Pregnancy Notification. Call the plan at 1-800-222-9831 for details.

Please submit an MHS Health Pregnancy Notification form for pregnant members as soon as possible. Early

identification of pregnant members allows us to offer case management to high-risk members. We also offer incentives for members to complete their provider visits.

Inpatient Notification

Inpatient facilities are required to notify MHS Health of admissions to enable care coordination and discharge planning, ensure timely claim payment, and track inpatient utilization. If it is determined that an inpatient admission is not medically necessary and services could be provided in another appropriate setting, the medical director may authorize approval for an alternative level of care. To provide notification, please contact Medical Services on the MHS Health Provider Inquiry Line at 1-800-222-9831. When prompted say "authorization request," and when asked which services you are calling about, say "inpatient admissions." For psychiatric admissions, call 1-800-589-3186.

Notification timelines are*:	
Emergent and urgent admissions	Within two (2) business days following the admission
Psychiatric admissions	Within 24 hours
Maternity admissions	At admission
All other admissions	By the close of the next business day

*Failure to notify within this timeframe may result in denial of payment for lack of timely notification.

Concurrent Review

MHS Health Medical Management will concurrently review the treatment and status of all members who are inpatient through onsite review or contact with the hospital's Utilization Review/Discharge Planning Departments, and when necessary, the member's attending physician. An inpatient stay will be reviewed as indicated by the member's diagnosis and response to treatment. The review will include medical necessity for admission, the evaluation of the member's current status, proposed plan of care, discharge plans and any subsequent diagnostic testing or procedures. Medical Management staff may contact the member's admitting physician prior to discharge to clarify the member's progress, identify discharge needs, and to assist in coordination of medically necessary follow-up services if indicated.

Discharge Planning

Discharge planning is expected to be initiated upon admission. MHS Health Medical Management staff will coordinate with the appropriate hospital department, the member's family and member to provide the medically necessary discharge service needed to support the member and prevent complications and readmissions. The attending physician may also be contacted to ensure that the member receives appropriate post-hospital care.

Follow-up treatment after a psychiatric hospitalization is one of the most important markers monitored by MHS Health in an effort to help members remain stable and to maintain treatment compliance after discharge. Follow-up after discharge is monitored closely by NCQA, which has developed and maintains the HEDIS®. Even more importantly, increased compliance with this measure has been proven to decrease readmissions and helps minimize no-shows in outpatient treatment.

While a member is in an inpatient facility receiving acute psychiatric services, MHS Health's Utilization and Case Managers work with the facility's treatment team to make arrangements for continued care with outpatient network practitioners. Every effort is made to collaborate with the outpatient providers to assist with transition back to the community and a less restrictive environment as soon as the member is stable. Discharge planning should be initiated upon admission.

Prior to discharge from an inpatient setting, an ambulatory follow-up appointment must be scheduled within 24 hours after discharge. MHS Health's Care Coordination/Case Management staff follow-up with the member prior to this appointment to remind him/her of the appointment. If a member does not keep his/her outpatient appointment after discharge, MHS Health asks that network practitioners please inform MHS Health as soon as possible. Upon

notification of a no-show, MHS Health's Care Coordination staff will follow-up with the member and assist with rescheduling the appointment and provide resources as needed to ensure appointment compliance.

Retrospective Review
MHS Health may agree to provide retrospective review in extenuating circumstances where there was no opportunity for notification or concurrent review. A decision is made within 30 calendar days once all the necessary information has been received to determine medical necessity.

Utilization Management Criteria
MHS Health applies McKesson's InterQual utilization review criteria and DHS authorization guidelines. InterQual criteria are developed by specialists representing a national panel from community-based and academic practice. The InterQual criteria cover Pediatric Acute, Adult Acute, Long-Term Acute Care, Sub acute/SNF, Durable Medical Equipment, and Adult and Pediatric Procedures. InterQual is used as a screening guide and is not intended to be a substitute for practitioner judgment. In addition, MHS Health utilizes the American Society of Addiction Medicine Patient Placement Criteria (ASAM) for substance abuse medical necessity criteria. ASAM and the McKesson InterQual criteria sets are proprietary and cannot be distributed in full; however, a copy of the specific criteria relevant to any individual need for authorization is available upon request.

Utilization review decisions are made in accordance with currently accepted medical or healthcare practices, local delivery system, and take into account special circumstances and individual needs of each case that may require deviation from the norm stated in the screening criteria. Criteria are used to determine medical necessity but not for the denial of services. The medical director reviews all potential adverse determinations for medical necessity. The criteria are reviewed and approved on an annual basis by MHS Health /Centene physicians and the MHS Health Quality Improvement Committee.

Criteria Available on Request
Providers may obtain the criteria used to make a specific decision by contacting MHS Health. The provider, on behalf of the member, may appeal medical necessity and administrative denials. *See Provider Complaints, Grievances and Appeals Section.*

MHS Health provides practitioners with the opportunity to discuss determinations with the medical director. To contact the medical director, please call Medical Services on the MHS Health Provider Inquiry Line 1-800-222-9831, dial 0, and ask for the medical director.

Practitioners will be notified of denials verbally and in writing and will be advised if the medical director is available to discuss the decision Denial letters will explain the appeal process, including the right to submit written comments, documents, or other information relevant to the appeal.

Assistant Surgeon
Reimbursement is provided to assistant surgeons when medically necessary. MHS Health utilizes guidelines for assistant surgeons as set forth by the American College of Surgeons, American Medical Association, CMS, and others.

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

Continuity of Care
In some instances, MHS Health will authorize payment for an out-of-network provider when services have been provided prior to the member's enrollment. Services will be authorized until the member is discharged from care or the treating physician determines it is safe to transition the member's care to an in-network provider.

MHS Health will ensure appropriate post-discharge care when a member transitions from a State institution, and will ensure appropriate screening, assessment, and crisis intervention services are available in support of members who are in the care and custody of the State.

Medical or Behavioral Health Case Management
Medical and Behavioral Health case management is a collaborative process to assess, plan, implement, coordinate, monitor, and evaluate the options and services to meet an individual's health needs. The process includes using communication and available resources to promote quality, cost-effective outcomes. Case management is a member-centered, goal-oriented, culturally relevant, and logically managed process to help ensure that a member receives needed services in a supportive, effective, efficient, timely, and cost- effective manner.

The case manager supports the physician by tracking compliance with the case management plan and facilitating communication between the PCP, member, family, specialists, and the MHS Health team. The case manager will share the member's care plan with their PCP. Providers are also encouraged to view care plans in WISHIN. The case manager also facilitates referrals and links to community resources and providers. The managing physician maintains responsibility for the patient's ongoing care needs. The case manager will notify the PCP and/or managing physician if the member is not following the plan of care or requires additional services.

MHS Health will provide individual case management services for members who have high-risk, high cost, complex, or catastrophic conditions. The case manager will work with all involved providers to coordinate care.

Complex case management is considered an opt-out program such that all eligible members have the right to participate or to decline to participate.

MHS Health provides case management services in an ethical manner, based on CCMC and CMSA's *Statement on Ethics* and *Standards of Practice.* Upon your request, information on MHS Health policies and standards regarding its ethical framework for case management, are available to:

- Staff
- MHS Health/Network Health members
- Consumers
- Contractors
- Clients

Case Management Process
The MHS Health case management process includes the following steps:

1. Obtain member's agreement to participate in case management.
2. Assessment of member's past medical history, current health status, functional evaluation, and safety.
3. Documentation of clinical and socio/economic history.
4. Assessment of cultural and linguistic needs.
5. Identification of the medical/behavioral treatment plan.
6. Evaluation of community resources and available benefits needed to meet the member's healthcare needs.
7. Evaluation of the member's educational needs related to their health status and treatment plan.
8. Evaluation of the member/family decision-making skills, including healthcare advanced directives.
9. Development of a case management plan including problems, prioritized goals, and interventions.
10. Identification of barriers in meeting the case management plan.
11. Identification of schedule for follow-up with the member.

12. Development and communication of a self-management plan for the member.
13. Assessment of progress against the case management plan.
14. The care plan will be shared with the member's PCP.

Providers may refer MHS Health/Network Health members for case management services by contacting MHS Health Medical Management or by using the MHS Healthcare Coordination Services Referral Request Form. You can obtain a copy by accessing the MHS Health website or by calling the provider Inquiry Line.

To refer a member for case management services, please contact Medical Services on the MHS Health Provider Inquiry Line at 1-800-222-9831: Press 2 for member services, and then press 4 for case management. Please let the care management that answers know that you would like to make a referral, and they will process the request.

Maternal and Infant Case Management Programs
Please refer to the MHS Health Pregnancy Notification Form on the MHS Health website under Provider Medical Forms. Providers may also submit notifications online through our provider portal.
Providers will receive an enhanced incentive for each qualifying Pregnancy Notification. Call the plan for details.

Please submit an MHS Health Pregnancy Notification form for pregnant members as soon as possible. Once notified, MHS Health staff attempts to contact each new mother. Our goal is to improve healthy birth outcomes by providing additional resources for pregnant women and offering case management services. Women will receive a My Health Pays Card with incentives added to the card to be used at participating stores if they participate in the case management program.

To refer pregnant MHS Health/Network Health members to case management, please contact Medical Services on the MHS Health Provider Inquiry Line at 1-800-222-9831, Press 2 for member services, and then press 4 for case management. Please let the care management that answers know that you would like to make a referral, and they will process the request.

Disease Management Programs and Goals
MHS Health provides members with disease management programs for the following conditions: asthma, COPD, diabetes, and heart failure. MHS Health will notify providers with program information and the referral process as additional programs are implemented.

Call 1-800-905-6989 to refer members to *Healthy Solutions for Life*. This program is part of MHS Health's Disease Management Program, which is designed to support, encourage, and inspire people with chronic conditions to take stock of their health, change their lives for the better, and become active self-managers of their health.

- Asthma and COPD – The goals of this programs include, but are not limited to, promoting member adherence to asthma treatment guidelines, preventing acute COPD exacerbations and optimize functional status.
- Diabetes – The program goals include optimization of blood glucose, blood pressure, and lipid control to minimize the development and/or progression of diabetic complications.
- Heart Failure – This program promotes member adherence to heart disease treatment guidelines, preventing subsequent cardiac events and optimize functional status.

Program highlights include:

- Telephonic coaching by licensed professionals with medical director oversight
- Addresses life barriers
- Compliance with suggested screenings, physician care plan & office visits
- Medication education, side effect management and adherence
- Promotion of healthy eating habits and regular physical activity
- Specialty consults for co-morbid conditions

The programs increase positive clinical outcomes for the member by improving the member's ability to control the disease therefore improving their quality of life.

MemberConnections®

The MemberConnections Department provides member outreach and education to plan members. MemberConnections reaches out to members through:

- Telephone outreach
  - MemberConnections representatives call members who are in need of need of assistance navigating benefits or assistance with locating community resources and can provide non-clinical health coaching.
- Home visits
  - MemberConnections representatives conduct home visits to complete health risk assessments, establish contact with members who have no telephone access, and provide in-person non-clinical health coaching.
- Events
  - MemberConnections representatives attend community events to educate members about good health practices.

Providers can request that MHS Health conduct a home visit to help with non-compliance (missed appointments) or other serious concerns.

The ConnectionsPlus Phone program provides a limited-use cell phone to members with acute health risks who do not have access to a phone.

To request a home visit, call MHS Health MemberConnections at 1-888-713-6180, ext 23346.

New Technology

Through a corporate Clinical Policy Committee, MHS Health evaluates new technology and new applications of existing technology for possible inclusion as covered services based on their pertinence to the MHS Health membership. The medical director and Medical Management staff may identify relevant medical procedures, drugs and/or devices for review. Should a request be made for coverage of new technology that has not yet been reviewed by the Clinical Policy Committee, the MHS Health Medical Director will review all information and make a one-time determination. The new technology will be reviewed at the next regular meeting of the Clinical Policy Committee.

Provider Inquiry Line
1-800-222-9831

If you need a benefit determination or have an individual case for review, please contact Medical Services on the MHS Health Provider Inquiry Line.

Section 11 Pharmacy Benefit

The pharmacy benefit for MHS Health/Network Health BadgerCare Plus and Medicaid SSI members is managed by the Wisconsin Department of Health Services (DHS) under the Medicaid fee-for-service program. All prior authorizations (PA) for pharmacy benefits should be directed to the DHS. DHS has developed a Preferred Drug List (PDL). Please refer to the Wisconsin ForwardHealth website for the PDL and other pertinent pharmacy information including prior authorization instructions and forms.

Providers with questions can call:

- Forward*Health* Provider Service Call Center at 1-800-947-9627
- STAT-PA at 1-800-947-1197 (for stat prior authorizations)
- STAT-PA Help Desk at 1-800-947-9627

For billing of oral and injectable therapy, injectable medication administered in provider offices, and dialysis clinics please refer to the Forward*Health* website.

Dispensing Emergency Supply

If a pharmacist cannot fill a prescription because the required authorization has not yet been obtained, the pharmacist may provide up to a 14-day emergency supply if deemed medically necessary. An emergency supply bridges the gap between prescribing and authorization.

Pharmacy Appeals and Grievances

In the event a clinician or member disagrees with a decision regarding coverage of a medication, the clinician may request reconsideration by submitting additional information to the responsible paying agency.

Plan Level Medication Monitoring – Psychotropic Medications

MHS Health will monitor psychotropic medication usage to identify any medications for physical conditions prescribed by psychiatric providers as well as to review psychotropic medications prescribed by primary care physicians (PCP).

A comprehensive evaluation to include a thorough health history, psychosocial assessment, mental status exam, and physical exam should be performed before beginning treatment for a mental or behavioral disorder.

The role of non-pharmacological interventions should be considered before beginning a psychotropic medication, except in urgent situations such as suicidal ideation, psychosis, self-injurious behavior, physical aggression that is acutely dangerous to others, or severe impulsivity endangering the member or others; or when there is marked disturbance of psycho-physiological functioning (such as profound sleep disturbance), marked anxiety, isolation, or withdrawal.

Section 12 Billing Information and Guidelines

This guide is intended for physicians and other licensed health professionals, facilities and ancillary providers contracted directly with MHS Health for the provision of covered medical services to MHS Health/Network Health BadgerCare Plus and SSI members.

Claims (invoices) submitted to MHS Health are processed in Farmington, Missouri. Payment is issued from Centene Corporation, St. Louis, Missouri. MHS Health is a wholly owned subsidiary of Centene.

Claims submission instructions contained in this manual are effective on the date of initial printing and distribution. All covered providers are required to submit claims according to the HIPAA ASC X12 Version 5010 and NCPDP Version D.0 and the 5010 requirements will supersede instructions printed in this manual.

Every code submitted on a CMS-1500 claim form or a UB-04, even if the code is entered in a non-required field, is required to be a valid code, whether it is from a national code set or from an implementation guide code set. Claims with an invalid code will be denied. Refer to ForwardHealth and Centers for Medicare and Medicaid Services (CMS) guidelines in addition to the National Uniform Billing Committee (NUBC), coding manuals for CPT, HCPCS ICD-10, and UB04 Manual for the appropriate list of current valid codes.

The following is a list of useful definitions.

Clean claims are claims submitted for payment:

- within an identified time limit,
- on the correct form and in the required format,
- Do not require MHS Health to investigate, develop or acquire additional information from the provider or other external sources, and
- Must be consistent with state and national billing and coding guidelines for the CMS-1500 claims form and UB-04 claim form.

Non-clean claims are claims submitted for payment containing errors or omissions requiring further investigation. When a claim is determined to be non-clean, MHS Health will:

- Ask the billing provider to submit the necessary additional information, or
- Return the claim to the provider.

Explanation of Payment (EOP)
MHS Health mails payment vouchers (EOPs) to providers. An EOP includes:

- An explanation of each paid amount or denial
- A last-page summary
- A listing of explanation codes used on the remit

Reconsideration of a Claim is an informal request to review a claim or a portion of a claim that a provider feels was incorrectly paid or denied because of processing errors.

Resubmission or Adjustment of a Claim is a claim or a portion of a claim that was denied and is resubmitted through the claims process with changed or added information.

Claim Submission
Accurate billing information is important. Provide MHS Health with accurate billing information to assure the timely processing of your claims by including all the billing information as required by ForwardHealth.

When billing information submitted on claims does not match that which is currently in our files, MHS Health will return claims, creating payment delays.

Provider change notifications must be in writing. Obtain a copy of the MHS Health's Medical Practice Information Change Form on the website at mhswi.com or by calling the MHS Health Provider Inquiry Line at 1-800-222-9831.

If the change involves your practice's corporate name or your tax ID number (TIN), you must also submit a W-9 form. MHS Health will not accept changes to a provider's address or TIN when it is conveyed via a claim form.

Basics of Submitting a Claim – via paper and EDI
Providers may submit claims electronically or via paper – the same data is required for both.
Please remember the following when submitting your claim:

- All documentation must be accurate and legible.
- Claims must be submitted on standard red and white forms, CMS-1500 or UB-04 form (or their successors) or electronically in an approved format.
- Handwritten and/or black and white submissions of claims are not acceptable.
- Corrected claim stickers are not accepted; handwritten corrections are not accepted.
- For corrected claims, see Forward*Health* for instructions.
- Providers cannot bill Medicaid members for any services unless a waiver is signed. Please see Section 3- Guidelines for Providers – Billing Members – page 17 of this manual.
- Providers who submit claims electronically through a third-party vendor, such as a clearinghouse, must access from your vendor an audit report ("error" report) that is generated each time you submit claims. The audit report:
  - Verifies that MHS Health has accepted your electronically submitted "clean" claims, and
  - Lists rejected claims.
- Providers must correct errors on rejected claims and resubmit.

NOTE: There may be an additional fee for processing paper claims, consistent with the State of Wisconsin.
For EDI Support contact:
1-800-225-2573, ext. 25525
ediba@centene.com

Timelines for Submitting Claims
Claims submitted by in-plan providers and facilities must be received by MHS Health within 90 days of the date of service or as defined in your MHS Health contract.

Requests for reconsideration or adjustment of processed claims must be received by MHS Health within 90 days of the date on the EOP or as defined in your MHS Health contract.

Providers submitting claims for services provided to plan members who have other insurance must attach to each claim a copy of the EOP in either paper or electronic form (which includes the explanation of the denial) or rejection letter from the other (primary) insurance carrier. The information must be received by MHS Health within 365 days of the date on the EOP or letter or as defined in your MHS Health contract.

Claims submitted by out-of-plan providers must be received by MHS Health within 365 days of the date of service. Requests for reconsideration or adjustment to processed claims must be received within 90 days of the date on the EOP.

Payment Cannot Be Made When (but not limited to):

- The patient was not an MHS Health/Network Health member on the date of service.
- The service provided was not a covered benefit on the date of service.
- MHS Health referral and prior authorization processes were not followed.

Common Billing Errors

To avoid claims being rejected, be sure to:

- Use SPECIFIC CPT-4 or HCPCs codes. Avoid the use of non-specific or "catch-all" codes (e.g., 99070).
- Use the most current CPT-4 and HCPCs codes; out-of-date codes will be denied.
- Use the fourth or fifth digit when required for all ICD-9 codes or ICD-10 code when applicable for the date of service
- All claims/encounters must be submitted with the proper provider NPI number, taxonomy code, and zip code plus 4.
- Include the complete member Medicaid number on all claims/encounters.
- Verify other insurance information entered on claim.
- Submit claims within the filing limit deadline.
- Include the NPI for billing, performing, attending, ordering, facility and referring providers.
- Include NPI billing provider, taxonomy code, tax identification number, and nine-digit zip code of the service location.
- Use POA indicators consistent with Forward*Health* guidelines.
- Bill partial claims prior to discharge for intervals of no less than 60 days.

Submitting Claims Electronically (EDI)

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

Claims transmitted electronically must contain all the same data elements as required in claims submitted on paper.

Benefits of Billing Electronically

- Reduction of overhead and administrative costs. EDI eliminates the need for paper claim submission. It has also been proven to reduce claim re-work (adjustments).
- Receipt of clearinghouse reports as proof of claim receipt. This makes it easier to track the status of claims.
- Faster transaction time. An EDI claim averages about 24 to 48 hours from the time it is sent to the time it is received. This enables providers to easily track their claims.
- Validation of data elements on the claim form. By the time a claim is successfully received electronically, information needed for processing is present. This reduces the chance of data entry errors that occur when completing paper claim forms.
- Quicker claim completion. Claims that do not need additional investigation are processed quicker. More than 90 percent of electronically submitted claims pass through the MHS Health system on a "first submission" basis and are processed quickly.

How to Start

- The provider office must have the capability of sending EDI claims (1) through direct submission to a clearinghouse or (2) indirectly through another vendor/clearinghouse.
- If filing indirectly, the provider must confirm with their vendor that the vendor will transmit the claims to one of the clearinghouses used by MHS Health/Centene.
- The provider must confirm with their vendor the accurate location of the MHS Health Provider ID number.

Direct questions about submitting claims electronically to: MHS Health/Centene 1-800-225-2573, ext. 25525. If you are asked to leave a voice message, your call will be returned within 24 business hours.

Submission Flow

- MHS Health/Centene receives all EDI claims through a clearinghouse.
- The clearinghouse validates received claims against their proprietary specifications and MHS Health/Centene **specific requirements.**
  - Claims not meeting the requirements are immediately rejected and sent back to the sender along with a clearinghouse error report.
    - The provider must review the error report daily to identify any claims that were not successfully transmitted to MHS Health/Centene.
  - Accepted claims are transmitted to MHS Health/Centene, and the clearinghouse sends an acceptance report to the sender immediately.
- Claims sent to MHS Health/Centene by the clearinghouses are validated against provider and member eligibility records.
  - Claims not meeting the requirements are rejected and sent back to the clearinghouse daily, which forwards the rejection to its trading partner (the intermediate EDI vendor or provider).
    - The provider must review the report daily to identify, correct, and resubmit rejected claims timely.
  - Claims passing eligibility requirements are entered in the claim processing system.

Work Error Reports

Providers are responsible for verifying that their electronically submitted claims are accepted by their clearinghouse or other vendor. You can do that by, each day, reviewing and reconciling the electronic acknowledgments you receive of accepted and rejected claims against your office's transmittal records.

Correct and Re-Submit Timely

Electronically submitted claims that do not pass the clearinghouse proprietary and MHS Health/Centene edits are invalid and will be rejected without being recognized as received by MHS Health/Centene.

- The provider must correct and re-submit these claims within the required filing deadline of 90 calendar days from the date of service or as defined in your MHS Health contract.
- Proof of timely filing must be a document that indicates the date the claim was submitted, to whom it was submitted and, at least one additional date (within 90 days of the DOS) that the provider either filed another claim copy or called MHS Health to check status of the claim.

Vendor Issues

Since the clearinghouse returns acceptance/rejection reports directly to the sender, MHS Health/Centene is not aware of your claims that are rejected by the clearinghouse. Please contact the customer service department of your clearinghouse or vendor for assistance in resolving submission issues.

Submitting EDI Claims

837 Institutional and Professional Claims: MHS Health follows the same guidelines as Medicaid FFS for submitting claims electronically. Click here for information on claim submission requirements.

Common Reasons for Rejection of Claims Submitted to Clearinghouses

- Missing or invalid required fields
- Member Name or ID number missing
- Provider Name, TIN, taxonomy or NPI number missing

Common Reasons for Upfront Rejection of Claims Submitted to MHS Health/Centene

Invalid electronic claim records, common plan rejections (EDI edits within the claim system) and a listing of all EDI denial codes are in the Appendix Pack in this manual.

- Invalid provider numbers – ensure the TIN and NPI are correct.
- Invalid member numbers – ensure the number and date of birth was input correctly on file.

Electronic Billing Questions

Action	Contact
To transmit claims electronically	Contact a clearinghouse.
General questions about EDI Questions about your MHS Health Audit Reports	Contact MHS Health/Centene EDI Support at 1-800-225-2573 Ext. 25525.
Questions about specific claims transmissions or acceptance	Contact your clearinghouse technical support
Questions about claims reported on the Remittance Advice (EOP)	Contact MHS Health Provider Inquiry Line at 1-800-222-9831, when prompted say, "Claims information" For Behavioral Health Claims call 877-730-2117
To update or verify provider information (e.g. payee, UPIN, or tax ID numbers or payment address information)	Call the MHS Health Provider Inquiry Line 1-800-222-9831, when prompted say, "Something else" and your call will be transferred to Provider Services.

Important Steps to Successful Submission of EDI Claims:

1. Select clearinghouse
2. Contact the clearinghouse to inform them you wish to submit electronic claims to MHS Health.
3. Inquiry with the clearinghouse what data records are required.
4. Verify with Provider Relations at MHS Health that the provider is set up in the MHS Health system before submitting EDI claims.
5. You will receive two reports from the clearinghouse. Always review these reports daily. The first report will be a report showing the claims that were accepted by the clearinghouse and are being transmitted to MHS Health and those claims not meeting the clearinghouse requirements. The second report will be a claim status report showing claims accepted and rejected by MHS Health. Always review the acceptance and claim status reports for rejected claims. If rejections are noted, correct and resubmit.

Exclusions from Electronic Billing

Certain claims are excluded from electronic billing and must be submitted on paper. These exclusions apply to inpatient and outpatient claim types. Fees for processing paper claims will not apply if a paper claim is required by MHS Health.

Excluded Claim Categories

- Claims for medical, administrative or claim appeals
- Claims requiring documentation of the receipt of a sterilization consent form

- Claims for services that are reimbursed based on purchase price and require the invoice (e.g., custom DME, prosthetics)
- Claims for hearing aids require the invoice from the company providing the device
- Claims for services requiring clinical review (e.g., complicated or unusual procedure)

NOTE: Provider identification number validation is not performed at the clearinghouse level. The clearinghouse will reject claims for provider information only if the provider number fields are empty.

Submitting Paper Claims and Imaging Requirements

MHS Health converts paper claims to electronic images for our automated adjudication process.

Following these guidelines when preparing paper claims for submission will help assure our accurate and timely processing of your claims.

- Submit claims on a standard red and white UB-04 or HCFA 1500 claim form.
- Printed in Flint OCR Red, J6983, (or exact match) ink.
- Type all fields completely and correctly.
- Use the correct PO Box number.
- Submit claims in an envelope size 9" x 12" or larger.
- Don't submit handwritten claim forms.
- No black and white forms are accepted.
- Don't circle data.
- Don't add extraneous information to any field.
- Don't use highlighter or stickers.
- Don't submit photocopied or downloaded claim forms.
- Don't submit carbon copied claim forms.
- Don't submit claim forms via fax.
- Claims submitted to the wrong address indicated for submitting claims will be returned to the provider.

Where to Submit a Paper Claim

Medicaid - Submit all paper claims, except those for services listed as below (e.g., routine dental services, routine vision exams, and behavioral health services) to:	MHS Health Wisconsin ATTN: Claims Department P.O. Box 3001 Farmington, MO 63640-3801
Dental - Submit claims for members in Milwaukee, Waukesha, Racine, and Kenosha, Washington and Ozaukee counties to:	Envolve Dental P.O. Box 46 Milwaukee, WI 53201
Vision – Submit claims to:	Envolve Vision MHS Health Wisconsin P.O. Box 7548 Rocky Mount, NC 27804
Behavioral Health – Submit claims to:	MHS Health Wisconsin ATTN: Behavioral Health Claims P.O. Box 6123 Farmington, MO 63640

Claim Rejection vs. Denial

All paper claims sent to the MHS Health must pass specific edits prior to acceptance.

Claim records that do not pass these "upfront" edits are invalid and will be rejected. Please keep in mind that rejected claims do not have appeal rights and untimely filing guidelines will still apply.

In the claim processing system, a rejected claim is defined as an "unclean claim," one that contains invalid or missing data elements (e.g., provider tax identification number is missing or not identifiable). The most common causes of up-front rejections are listed below. If a claim passes all up-front edits, the claim is accepted and entered into the claim processing system. During processing, when a claim is found to have been billed with invalid or inappropriate information, the claim denies. The submitting provider is sent an EOP detailing the denial reason.

Common Reasons for Up-front Rejection of Paper Claims

- Unreadable information.
- Incorrect form type.
- Member DOB missing.
- Member name or ID number missing.
- Provider name, TIN, or NPI number missing.
- DOS on claim is not prior to receipt of claim (future date of service).
- Diagnosis code missing or invalid.
- No detail service line submitted.
- DOS falls outside of member's eligibility dates.
- Admission type missing (when inpatient).
- Patient status missing (when inpatient).
- Occurrence code/date missing or invalid.
- REV code missing or invalid.
- CPT/procedure code missing or invalid.
- POA indicator missing or invalid.
- Partial bill for less than 60 days and prior to discharge.
- Other; insurance fields missing appropriate data when submitted with an EOB.

Common Reasons for Claim Processing Delays and Denials

- Billed charges missing or incomplete.
- Claims not submitted on "red" dropout OCR forms.
- Diagnosis code missing 4th or 5th digit.
- Procedure or modifier codes invalid or missing.
- DRG codes missing or invalid.
- EOBs (Explanation of Benefits) from primary insurers missing or incomplete.
- EPSDT Information missing or incomplete.
- Member ID invalid.
- Newborn claim information invalid.
- Place of service code invalid
- Provider TIN and NPI/Medicaid do not match
- Revenue code invalid
- Spanning dates of service do not match the listed days/units
- Signature missing
- Tax Identification Number (TIN) invalid
- Third Party Liability (TPL) information missing or incomplete
- Untimely claims submission

835 Electronic Remittance Advice (ERA)

MHS Health offers providers the option of receiving an 835 electronic remittance advice transaction. The ERA will be received from the clearinghouse the provider utilizes for 837 files.

During set-up, providers must supply the following information:

- EDI/vendor and submitter ID
- Group/facility name
- Contact name, phone number, and email address
- Address
- Tax ID
- Payee ID

To participate, providers must complete an MHS Health /Centene EFT agreement. The agreement form includes registration to receive ERA.

A copy of the MHS Health /Centene EFT agreement is in the appendix pack. You can also obtain a copy by accessing the MHS Health Provider website or by calling the MHS Health Provider Inquiry Line.

Electronic Fund Transfer (EFT)

MHS Health offers providers the option of receiving payment by electronic fund transfer (EFTs) instead of a mailed paper check. MHS Health has partnered with PaySpan Health to offer you expanded claim payment services. By signing up with PaySpan Health, a web-based application, you will receive convenient electronic claim payments and online remittance advices (ERAs/EOPs). These services assist practices in receiving claims payments faster. Call PaySpan Health at 877-331-7154 or register at payspanhealth.com.

Web Portal Claims Submission

MHS Health offers providers the option of submitting first-time and COB claims via our provider portal, as well as claims for reconsideration. To access these functions, among others, provider representatives must become a registered user at www.mhswi.com.

Other Insurance – Coordination of Benefits (COB)

COB is the coordination of benefits for members with two or more types of insurance coverage. The insurance carrier identified as primary pays its full benefits first. Federal and State law require that Medicaid is the payer of last resort; Medicaid may be billed only after all other pay sources are exhausted.

After a provider has submitted a claim to a member's primary insurance carrier and received payment/denial/rejection, the provider may submit the claim to MHS Health. When submitting a claim for services provided to MHS Health /Network Health members who have other insurance, providers must submit with the COB information from the primary. Claims submitted without this information will be denied by MHS Health.

The information must be received by MHS Health within 365 days of the date on the primary carrier's EOP or letter or as defined in your MHS Health contract.

Claims with Allwell from MHS Health Wisconsin and MHS Health/Network Health BadgerCare Plus or SSI Medicaid will process automatically under both plans.

- Providers will receive an EOP for claims paid under Medicare with EX code 30 ("Medicare crossover claim forwarded to Medicaid for secondary payment".)
- Providers will not need to submit the Medicare EOP for coordination of benefits. The system will cross the claim over into Medicaid after the claim is finalized in Medicare Advantage.

Administrative Denials by Primary

When adjudicating claims during the COB process, MHS Health will apply the same administrative rules as the primary carrier. For example, if a claim was denied by the primary carrier because it was submitted outside of the allowable timeframe, MHS Health will also deny the claim for untimely submission.

Payment Protocol
When the services provided are payable by the secondary payer, the secondary payer, generally, is responsible for payment of coinsurance and deductible amounts up to the primary payer's allowable, but not to exceed the secondary payer's allowable. If primary payer paid 100% of the allowed amount, no additional payment will be due from MHS Health.

When MHS Health is the secondary payer and the provider has followed the above process, MHS Health will pay the difference between the actual amount paid by the primary payer and the MHS Health -allowed amount, not to exceed the member's liability.

The following three scenarios illustrate the MHS Health COB adjudication policy for all situations in which MHS Health in not the primary payer. This includes instances where Medicare is the primary payer source.

1. Amount charged by provider	**$2000**		
Amount allowed by primary payer, based on contractual obligation with provider	$1,000	Amount allowed by secondary payer, based on the contracted rate for network providers or the State rate for out-of- network providers	$400
Amount allocated to deductible/coinsurance by primary payer	$550		
Amount paid to provider by primary payer(allowable less deductible)	$450	Amount paid to provider by secondary payer	$0
Adjudication. The secondary payer, MHS, pays $0. The amount paid by the primary payer ($450) is greater than the MHS Health allowable amount ($400). The member cannot be billed.			
2. Amount charged by provider	**$2,000**		
Amount allowed by primary payer, based on contractual obligation with provider	$1,000	Amount allowed by secondary payer, based on the contracted rate for network providers or the State rate for out-of- network providers	$800
Amount allocated to deductible/coinsurance by primary payer	$550		
Amount paid to provider by primary payer	$450	Amount paid to provider by secondary payer	$350
Adjudication. The secondary payer, MHS Health, pays $350, the difference between the amount the primary payer actually paid the provider ($450) and the MHS Health allowable amount ($800), which is less than the member's liability.			
3. Amount charged by provider	**$1,000**		
Amount allowed by primary payer, based on contractual obligation with provider	$1,000	Amount allowed by secondary payer, based on the contracted rate for network providers or the State rate for out-of- network providers	$1,200
Amount allocated to deductible/coinsurance by primary payer	$550		
Amount paid to provider by primary payer	$450	Amount paid to provider by secondary payer	$550
Adjudication The secondary payer, MHS Health, pays $550, the difference between what the primary payer actually paid the provider ($450) and the MHS Health allowable amount ($1,200), but not to exceed the member's liability of $550.			

"Other Insurance – Yes" (OI-Y)
When a member has failed to respond to efforts by the provider to clarify the member's primary insurance situation, the provider's claims will be considered by MHS Health for payment if the provider has complied in full with the following MHS Health "OI-Y" Policy.

1. Two (2) times to request that the member respond to their primary carrier.

a. One of those attempts must have been by letter.
b. One of those attempts must have been by phone.

2. Documentation of the attempts must accompany the claims the provider sends to MHS Health.
    a. Acceptable documentation of the contact/attempt by letter is a copy of the letter attached to the submitted claims.
    b. Acceptable documentation of the contact/attempt by phone is the provider's notes regarding the call, including the date and time of day.

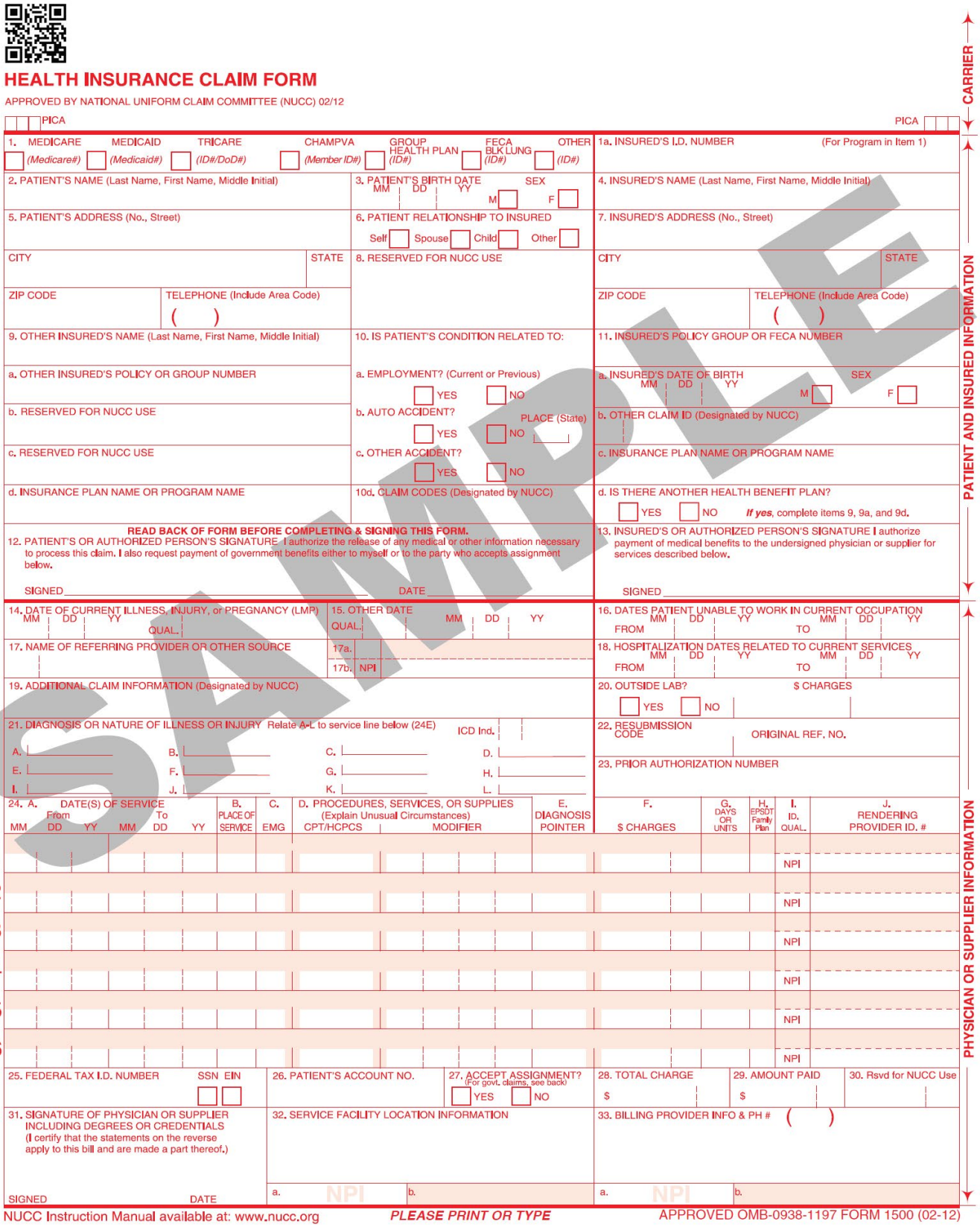
    Submit these claims to:

    MHS Health Wisconsin
    ATTN: COB Unit – OI-Y
    P.O. Box 3001
    Farmington, MO 63640-3801

MHS Health uses many sources of information to keep a current and accurate record of a recipient's other coverage, including the State of Wisconsin, providers, and plan members. However, the information may be incomplete or incorrect if we received inaccurate information from the insurer or the agency responsible for determining the member's eligibility.

Subrogation and Workers' Compensation
MHS Health or its designee will pursue any subrogation and Workers' Compensation recoveries. It is expected that providers comply with any such recovery efforts.

Completing a CMS 1500 claim form



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1										NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SAMPLE

Completing a CMS 1500 Claim Form
Claims for all professional services must be submitted on a CMS 1500 red claim form. See sample on previous page.

Ensuring Claims are Eligible for Payment

- Assure that all claims – electronic and paper – are received by MHS Health within 90 days of the date of service or as defined in your MHS Health contract.
- Claims received outside of 90 days, or the contractually agreed time frame will be denied payment.
- Provide all information requested on the CMS 1500 form.
- Insufficient or inaccurate information may result in delayed or denied payment.

How to Complete a CMS 1500 Claim Form
MHS follows the NUCC guidelines for CMS 1500 form submission. Click here for information on claims submission requirements please use the following link:

Things to Remember When Using a CMS 1500 Claim Form

- Newborns – Providers may no longer use the mother's Medicaid identification number on claims for services provided to a newborn 10 days of age or less on the date of service.
- Box 31 – The name of the servicing provider must appear in Box 31.
- Box 25 – Federal tax ID number of the provider of service must appear in Box 25.
- Box 24G, day/unit billing – All units listed in Box 24G on a HCFA (CMS) claim form must be rounded to whole numbers; decimal points cannot be used. Anesthesia must be billed in minutes.
- Place of Service (POS) – Correct codes must be used. Claims received with incorrect codes will be rejected.

It is the provider's responsibility to appeal or dispute any adverse claims processing outcomes. All requests for corrected claims, reconsiderations, or claim disputes must be received within 90 days from the date of explanation of payment or denial is issued, unless timely filing is defined otherwise in your contract.

NOTE: There may be a fee for processing paper claims, consistent with the State of Wisconsin.

Billing HealthChecks
For details on billing, see *Section 8 HealthChecks*.

Electronic Visit Verification – EVV The Federal 21st Century Cures Act requires all States to implement Electronic Visit Verification (EVV) for Medicaid-covered personal care services by January 1, 2021, and home health services by January 1, 2023. The Centers for Medicare & Medicaid Services will penalize State programs if they do not implement EVV.

Effective November 2, 2020, EVV was implemented for Medicaid-covered personal care and supportive home care services. Workers are required to use EVV. 100% EVV compliance is expected from agencies providing personal care services during the soft launch period. Claim payments non-compliant with EVV requirements will be denied after the forthcoming date to be announced by the DHS (Wisconsin Department of Health Services) in calendar year 2022. As of the publishing of this manual, no hard launch date has been set by the State.

Specifically, impacted services are those billed under the following Healthcare Common Procedure Coding System (HCPCS) procedure codes:

- Personal care services:
    - T1019 (Personal care services, per 15 minutes, not for an inpatient or resident of a hospital, nursing facility, ICF/MR1 or IMD, part of the individualized plan of treatment)
    - T1020 (Personal care services, per diem, not for an inpatient or resident of a hospital, nursing facility, ICF/MR or IMD, part of the individualized plan of treatment)

- Supportive home care services:
    - S5125 (Attendant care services; per 15 minutes)
    - S5126 (Attendant care services; per diem)

MHS Health requires EVV usage for all workers including those identified as Live-In Workers.

Failure to comply with this requirement may result in a denial of payment to the Provider or Contracted Provider.

Health Professional Shortage Area (HPSA)
Wisconsin Medicaid provides enhanced reimbursement to Medicaid-certified PCPs, emergency medicine and urgent care providers, neonatologists, and certified nurse midwives for selected services when one or both of the following apply:

- The performing or billing provider is located in a HPSA-eligible ZIP code.
- The recipient has a residential address (according to Medicaid's eligibility records) within a HPSA-eligible ZIP code.

Primary care and emergency medicine providers include:

- physicians, physician assistants, nurse practitioners, and nurse midwives
- with specialties in general practice, OB-GYN, family practice, internal medicine, pediatrics or emergency medicine

HPSA Eligible procedure codes – Wisconsin Medicaid maintains the list of current procedural terminology (CPT) codes that are eligible for the HPSA- enhanced reimbursement rate.

HPSA modifier – To obtain HPSA-enhanced reimbursement for services, providers must use the "AQ" modifier for physician services provided in a HPSA.

Eligible Procedure Codes
MHS Health will only reimburse for current procedural terminology (CPT) codes that are listed as covered on the max fee schedule for the provider type, provider specialty, and location codes for the rendering provider

Billing Lab Handling Fees
When a physician sends a specimen to an outside laboratory (not located within your office or clinic), the physician will be reimbursed a handling fee. The handling fee covers the collection, preparation, forwarding and handling of obtained specimen(s).

Remember that routine venipuncture; CPT 36415 is not a separately reimbursable service as collection of the specimen is included in the reimbursement for the test, per the State of Wisconsin.

Billing and Reimbursement of Professional Surgical Services
For a claim to be considered for payment by MHS Health:

- The procedure may also require prior authorization by MHS Health. Please see Section 9 Medical Management Section.
- Appropriate surgical codes must be used on a CMS 1500 claim form.
- Documentation of medical necessity, e.g., may be requested for both the surgeon and co-surgeon. Medical records submitted with first time claims will not be reviewed.

Multiple Surgical Procedures
Multiple surgical procedures performed by the same provider for the same patient during the same surgery session are paid at the following rates:

- Primary procedure – 100% of the maximum allowable fee

- Secondary procedure – 50% of the maximum allowable fee
- Tertiary procedure – 25% of the maximum allowable fee
- All additional procedures – 13% of the maximum allowable fee

Claims for multiple surgical procedures are reviewed in accordance with National Correct Coding Initiatives (NCCI), and where applicable, adjustments may be made to the allowed amounts.

Bilateral Surgical Procedures
Bilateral surgical procedures are identical procedures performed bilaterally during a single operative session. They are paid at the following rate:

- 150% of the maximum allowed fee for the single service.

Claims submitted for bilateral surgical procedures must include:

- The appropriate CPT code (followed by the appropriate modifier).
- Submitted as a one-line claim.
- A quantity of one in box 24G.

Claims for bilateral surgical procedures are reviewed in accordance with NCCI, and where applicable, adjustments are made to the allowed amounts.

Co-Surgeons
Please submit claims using the appropriate surgical CPT code followed by the appropriate modifier. Claims of co-surgeons are subject to the multiple surgery and bilateral surgery rate structure outlined above.

Assistant Surgeons
Submit claims using the appropriate surgical CPT code followed by the appropriate modifier for assistant surgeons.

Claims for surgical assistance are subject to the multiple surgery and bilateral surgery rate structure and are reviewed in accordance with NCCI.

- Physician Assistants Claims of physician assistants who provide surgical assistance are subject to the multiple surgery and bilateral surgery rate structure outlined above.
- Claims of physician assistants who provide surgical assistance are reviewed by HPR code review and where applicable, payments are made.

Billing Anesthesia Services
Claims must be submitted on a CMS 1500 claim form. Use the appropriate ASA code and modifiers for the procedure. Report total anesthesia time units in minutes.

Completing a UB-04 Red Claim Form
A UB-04 claim form is the only acceptable claim form for submitting inpatient or outpatient facility charges, nursing home services, certain home health bills with revenue and occurrence codes, inpatient hospice services, ambulatory surgery centers (ASC), personal care worker services, private duty nurse and dialysis services.

Ensuring Claims Eligibility for Payment

- Ensure all claims, both electronic and paper, are received by MHS Health within 90 days of the date of service or as defined in your MHS Health contract. Claims received outside of the contractually agreed time frame will be denied payment.
- Provide all information requested on the UB-04 claim form.

Present on Admission (POA) Requirements for Inpatient Hospital Claims
Hospital providers that are reimbursed on an APR-DRG basis will be required to include present on admission (POA)

indicator information for all primary and secondary diagnoses. Additionally, reimbursement may be affected by the POA indicator.

NOTE: Inpatient mental health and rehabilitation facilities are exempt from this requirement.

UB-04 Claim Form Instructions
MHS Health follows the NUBC guidelines for UB-04 claims submission. Click here for information on claims submission requirements please use the following link:

Things to Remember When Completing a UB-04 Claim Form

- Newborns – Providers may not use the mother's Medicaid identification number on claims for services provided to a newborn 10 days of age or less on the date of service.
- Hospitals may submit initial claims for interim payments for long lengths of stays after 60 days.
- Subsequent claims must be for at least 30 additional days and all accumulated charges since admission should be included on the claim, if the patient has not been discharged. If a patient has been discharged, the final bill should be accumulative of all charges since admission. Partial days for less than 60 days will be denied.
- UB04 claims for a patient admitted and discharged on the same calendar date will be denied to resubmit as outpatient claims unless they meet state criteria for inpatient stay.
- Transfers within the same facility are to be billed as one admission. If billed as two separate claims they will be denied to submit as one claim; this includes transfers to the rehab unit.

Claims for sterilization services provided to plan members must be submitted on paper (not electronically).
A signed state consent form must be included.

It is the provider's responsibility to appeal/dispute any adverse claims processing outcomes. All requests for corrected claims, reconsiderations, or claim disputes must be received within 90 days from the date of explanation of payment or denial is issued, or as defined in your MHS Health contract. See *Section 12 Provider Complaints, Grievances and Appeals* for more information.

Special Conditions – One Day Inpatient Stays
A member is considered an inpatient when the member is admitted to the hospital as an inpatient and is counted in the midnight census. Therefore, claims with an admit date equal to the discharge date must be submitted as an outpatient hospital service except for the following circumstances:

- If a member is admitted and dies before the midnight census.
- If a member is admitted and transferred before the midnight census.
- A maternity stay. A hospital stay is considered an inpatient stay when a member is admitted to a hospital and delivers a baby, even when the mother and baby are discharged on the date of admission. This also applies when the mother and/or baby are transferred to another hospital.

Continuous Stay for Hospital Services That Span More Than One Date of Service
MHS Health considers all hospital services to be part of a single, continuous inpatient stay when the following occur:

- The member is eventually admitted as an inpatient, and
- The stay takes place over two or more dates of service.

Providers are required to include on an inpatient claim all services provided during an outpatient visit that span through midnight and which eventually continue to admission of the member for an inpatient stay. That is, outpatient services provided on the date directly prior to the date on which the member is counted in the midnight census are charged in the inpatient claim.

Transfers Between Units Within a Hospital
Patients who are transferred from one hospital unit to another within the same hospital are not considered discharged until the entire hospital stay has ended. A discharge occurs when the patient leaves the hospital for any reason other

than a "leave of absence." Hospitals are reimbursed one APR DRG per stay and does not recognize specialty rehabilitation or psychiatric units for separate reimbursement purposes

Outlier Calculations
Some claims may qualify for an outlier payment. The outlier calculation is based on the State formula for APR DRG methodology. Please refer to the state web portal for details on the Wisconsin Medicaid DRG Pricing Calculator.

Interim Billing
Interim bills may be submitted when a claim has a length of stay equal to or greater than 60 days. Additional interim bills can be submitted in increments of 30 additional days or discharge. All interim bills must include all charges from the date of admission.

Observation
Claims that indicate more than 48 hours of observation will be denied; however, providers may resubmit the claim and applicable medical documentation supporting the extended length of observation for reconsideration.

APR DRG & Charge Validation
The DRG is based on the billed diagnoses and procedure codes and the applicable State APR DRG Grouper Version. Claims are routinely reviewed for verification of compliance with national coding and billing guidelines. This review process may require copies of medical records and/or itemized bills. The required documents may be requested by letter or through the remittance advice. If the review results in recommended coding changes, the provider will be notified and provided the opportunity to respond to the recommended coding changes.

Emergency Department Hospital Claims Adjudication Process

Purpose
This process describes the methodology by MHS Health for managing the emergency services benefit in compliance with directives from Centers for Medicare and Medicaid Services (CMS) and the applicable State agencies having jurisdiction over the health plan.

MHS Health works with physicians and hospitals to decrease the need for emergency services through proactive strategies that address chronic conditions such as asthma and to redirect members to more appropriate settings for non-emergent care e.g., the office of the member's PCP.

In addition, MHS Health provides Emergency Department (ED) post-discharge follow up and continuity of care services.

MHS Health is dedicated to providing its members with high quality healthcare. This includes immediate access to emergency services when required. At the same time, MHS Health recognizes that it is not in the member's best interest to receive routine (non-emergent) episodic care in the ED and those members are best served by receiving such care from their PCPs.

Background
The federal Balanced Budget Act (BBA) of 1997 and the Medicaid statute have established the definition of "emergency medical condition" as follows:

A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;

- Serious impairment of bodily functions; or
- Serious dysfunction of any body organ or part.

CMS has issued specific guidelines to state Medicaid directors regarding that agency's expectations of how the Medicaid emergency services benefit is to be administered utilizing the Prudent Layperson (PLP) Standard as defined above. These guidelines are contained in letters to State Medicaid directors dated February 20, 1998, April 5, 2000, and April 18, 2000. The following statements from the April 18, 2000, letter have a direct bearing on the Hospital Claims Adjudication Process:

> *"The BBA requires that a Medicaid beneficiary be permitted to obtain emergency services immediately at the nearest provider when the need arises. When the prudent layperson standard is met, no restriction may be placed on access to emergency care. Limits on the number of visits are not allowed.*
>
> *The determination of whether the prudent layperson standard is met must be made on a case-by-case basis. The only exceptions to this general rule are that payers may approve coverage on the basis of an ICD-9 code or ICD-10 when applicable, and payers may set reasonable claim payment deadlines (taking into account delays resulting from missing documents from the initial claim).*
>
> *Note that payers may not deny coverage solely on the basis of ICD-9 codes or ICD-10 code when applicable. Payers are also barred from denying coverage on the basis of ICD-9 codes or ICD-10 code when applicable and then requiring resubmission of the claim as part of an appeal process. This bar applies even if the process is not labeled as an appeal. Whenever a payer (whether an MCO or a state) denies coverage or modifies a claim for payment, the determination of whether the prudent layperson standard has been met must be based on all pertinent documentation, must be focused on the presenting symptoms (and not on the final diagnosis), and must take into account that the decision to seek emergency services was made by a prudent layperson (rather than a medical professional)."*

It is clear that ED claims with certain diagnoses (e.g., status asthmaticus or fractured femur) represent true medical emergencies and should be reimbursed as such. There are a group of diagnoses (e.g., upper respiratory infection) where it is not clear whether or not the criteria for PLP emergency have been met. In these instances, the only means of making a determination as to the appropriate level of reimbursement is to review the ED record in order to establish and assess the member's presenting symptoms.

Hospital Claims Processing
MHS Health classifies claims for services rendered in a hospital's emergency department. Claims are initially classified by principal final diagnosis as representing either obvious emergencies or situations that are not obvious emergencies.

MHS Health has two different processes for adjudicating ED claims: one for hospitals that agree to an automated process for adjudicating ED claims and a non-automated process for hospitals that do not agree to the automated process.

Medicaid Members from Other States
MHS Health does not pay for services provided to members enrolled in other state Medicaid programs. Providers are advised to contact other state Medicaid programs to determine whether the service sought is a covered service under that state's Medicaid program.

Members Traveling Out of State
When a member travels out of state but is within the United States (including its territories), Canada, or Mexico, MHS Health cover medical services in any of the following circumstances:

- An emergency illness or accident

- When the member's health would be endangered if treatment were postponed
- When the member's health would be endangered if travel to Wisconsin were undertaken

NOTE: Some providers located in a state that borders Wisconsin may be Wisconsin Medicaid enrolled as a border-status provider if the provider notifies Forward*Health* in writing that it is common practice for members in a particular area of Wisconsin to seek their medical services. Border-status providers follow the same policies as Wisconsin providers. Financial institution receiving payment must be located within the United States.

Automated Process for Contracted Hospitals

- ED claims will be categorized by the ICD-9 or ICD-10 code when applicable diagnosis code located in the primary diagnosis code location as billed on the UB-04 form.
- If the code falls in the list of diagnoses that are considered obvious emergencies, it is paid in full at the rate negotiated with the hospital for such emergencies. In addition, claims for facility charges for medically necessary ancillary services provided while the member was in the ED will be reimbursed according to the contract, which may provide for a global fee covering all ED services.
- Codes falling in the list of diagnoses that are categorized as not obvious emergencies will be paid at the rate negotiated with the hospital for evaluation of non-emergent conditions in the ED. In addition, claims for facility charges for medically necessary ancillary services provided while the member was in the ED will be reimbursed according to the contract, which may provide for a global fee covering all ED services.
- ED charges for members who are admitted for inpatient care are subsumed into the inpatient claim. In addition, all other claim payment hierarchy rules apply.

ICD-10 Diagnosis Code Auditing and Review

MHS Health will consider any requests for reclassifying specific ICD-10 diagnosis codes if the hospital believes MHS Health has misclassified the diagnosis code. If after review, it is determined that an ICD-10 diagnosis code qualifies for reclassification, the reclassification will apply to all hospitals.

Claims may also be reviewed for validation of the national coding and billing guidelines. This process may require copies of medical records or itemized bills. Required documents will be requested by letter or through the remittance advice.

Complete Coding and Maximizing Your Billing

There are initiatives used by the Centers for Medicare and Medicaid Services (CMS) and by State Medicaid agencies to account for expected differences in cost of treatment of members who have varying health status. These programs rely on complete and accurate diagnosis coding and reporting according to the ICD-10-CM coding guidelines.

In order to better assess the health acuity of our members and ensure the accuracy of our reporting, we ask our provider partners to correctly and completely report the conditions affecting our members every time they are addressed or affect the patient's care by documenting these in the medical record and reporting the appropriate diagnosis code on the claim. The Official ICD-10-CM Guidelines for Coding and Reporting, Section IV.K, indicates for outpatient services providers should "code all documented conditions that coexist at the time of the encounter/visit, and require or affect patient care treatment or management."

All conditions, even status conditions such as a patient requiring intermittent renal dialysis or a patient who has previously undergone amputation of a limb, often play into the medical decision making during an office encounter. Diagnosis codes which are not appropriate to report as a primary diagnosis may be appropriate to report as a secondary or tertiary diagnosis.

Performing, documenting and coding a head-to-toe exam on every patient at least once every year can be another strategy to both improve patient health and make sure all relevant conditions are being reported. In some cases, historical conditions (history of myocardial infarction, previous below knee amputation), are important to the current and future health of our patients. Receiving correct and complete diagnosis information on claims provides better

insight into the health issues facing our members, so we can better serve their needs. Our goals are mutual - to help our patients achieve and maintain better health.

We appreciate your commitment to thorough documentation of each and every encounter to reflect the conditions present and services provided, and to following all official documentation and coding guidelines provided by the CMS and other regulatory agencies. Thank you for being part of the MHS Health network and providing excellent care to our members.

Section 13 Provider Complaints, Grievances, and Appeals

MHS Health encourages open clinician-patient communication regarding appropriate treatment alternatives and does not penalize clinicians for discussing medically necessary or appropriate care with the patient. The plan provides an explanation of the grievance process and the right to an independent review of adverse determination to newly enrolled members upon enrollment and annually thereafter, according to the requirements of the State. This process is also explained in the member handbook, member newsletters, and member educational flyers.

The following is a list of useful definitions.

Authorized Representative: An individual appointed by the member, including a power of attorney or estate representative, who may serve as an authorized representative with documented consent of the member. The role of the authorized representative with documented consent of the member. The role of the authorized representative primarily includes filing a grievance or appeal, and approving the member's care plan.

Member Appeals: A review by MHS Health of an adverse benefit determination pre-service.

Resubmission or Adjustment of a Claim: A claim or a portion of a claim that was denied is resubmitted through the claims process with changed or added information. This is not a formal appeal.

Reconsideration of a Claim: An informal request to review a claim or a portion of a claim that a provider feels was incorrectly paid or denied because of processing errors. This is not a formal appeal.

Provider Appeals: An application or proceeding for review when a provider does not agree with the claim reconsideration decision. For example: A claim is denied by MHS Health for untimely claim filing. The Provider must appeal the denial action to MHS Health; an internal review by MHS Health will be completed.

Member Appeals

Complaints & Grievances
MHS Health provides an explanation of the grievance process and notice of the right to an independent review of adverse determination, according to the requirements of the state, to newly enrolled members at enrollment and annually thereafter.

An MHS Health/Network Health member or an *Authorized Representative* may appeal any *pre-service* utilization management determination resulting in a denial, termination or other limitation of covered healthcare services. Should a member initiate an appeal without the pertinent medical information, MHS Health will assist the member by requesting medical records or medical documentation.

This process is explained in the Member Handbook, member newsletters, and the State of Wisconsin Department of Health Services Member Grievances and Appeals Guide. The DHS guide can be found here. MHS Health produces all vital materials in English, Hmong, Russian and Spanish, and, as requested, additional languages and formats (for example, Braille, large font and audio tapes). Upon conclusion of each stage in the appeal process, members and/or providers acting on behalf of the member are provided with a written explanation of the appeal process. All appeals are reviewed at the weekly MHS Health Appeals Committee meeting. The committee is comprised of healthcare professionals, advocacy staff, and representatives of all MHS Health departments. Nothing in the MHS Health policies, procedures or provider agreements prohibits a member and/or provider from discussing or exercising the right to appeal.

Appealing UM Decisions (*pre-service*)
In the event of an adverse determination of services denied by a MHS Health medical director in accordance with UM policies and procedures, written notification is sent to the provider and the member. It includes the following information:

- The principal reasons and clinical basis for the adverse determination
- A description or the source of the screening criteria that were utilized as guidelines in making the determination

The communication also informs the member of:

- The right to, the method for obtaining, and the rules that govern representation at the state fair hearing.
- The right to file grievances and appeals.
- The requirements and timeframes for filing a grievance and appeal.
- The availability of assistance in the filing process.
- The toll-free numbers that the member can use to file a grievance or an appeal by phone.
- The fact that benefits may be requested to continue if the member files an appeal or a request for a fair hearing within the timeframes specified for the filing and the fact that the member may be required to pay the cost of the services furnished while the appeal is pending, if the final decision is adverse to the member.
- The right to obtain any/all documents.
- The right to obtain criteria.
- The right to have a member representative.

Member Appeals and Complaints & Grievances should be mailed to:

MHS Health Wisconsin
ATTN: Grievance and Appeals
801 S. 60th St, Suite 200
West Allis, WI 53214

Provider Reconsiderations and Appeals

Inquiry, dispute and appeal of claim payment

MHS Health offers providers three options to request payment evaluation and/or determination:

1. **Informal claim resolution or reconsideration**

   A request for a change that is the result of an error in processing such as keying errors, configuration issues, fee schedules or supported timely filing reconsiderations. Filing a claim reconsideration is not the same as filing a formal appeal.

   An informal claim resolution procedure precedes the formal appeal. MHS Health procedures for requests for reconsideration and resubmission are as follows:

   - Allow provider to make verbal or written inquiries to resolve claims payment issues.
   - Must be received within 90 days of the date of the Explanation of Payment (EOP) or as defined in your MHS Health contract.
   - Original claim must have also met timely filing criteria.

   Verbal Inquiry

   To check the status of previously submitted claim(s), call the MHS Health Provider Inquiry Line at 1- 800-222-9831. When prompted say, “Claim Information.” The MHS Health Provider Inquiry Line is staffed by MHS Health Provider Services representatives from 8 a.m. to 5 p.m., Monday through Friday.

   Be sure to have the following information at hand:

   - Servicing provider’s name.
   - Member's MA number.
   - Member’s name.
   - Member’s date of birth.
   - Date of service.
   - Claim number, if applicable.

Claim Reconsideration

A provider may request a reconsideration when the payment received for a claim is less than the payment expected. The request must be received within 90 days of the date of the EOP or denial, or as defined in your MHS Health contract. Call the MHS Health Provider Inquiry Line at 1-800-222-9831. When prompted say, "Claim Information." A MHS Health representative will evaluate the payment and, if appropriate, will:

- Request reprocessing of the claim, or
- Indicate that you need to resubmit the claim as a "Corrected Claim"

Claim Correction or Adjustment

A provider may correct or adjust and resubmit a claim that was denied because of incorrect or insufficient information. Corrected claims must be received within 90 days of the date of the EOP or as defined in your MHS Health contract. A claim correction or adjustment is not considered an appeal.

- CMS-1500 should be submitted with the appropriate resubmission code (value of 7) in field 22 of the paper claim with the original claim number of the corrected claim. For the EDI 837P, the data should be sent in the 2300 Loop, segment CLM05 (with value of 7) along with an addition loop in the 2300 loop, segment REF*F8* with the original claim number for which the corrected claim is being submitted.
- UB-04 should be submitted with the appropriate resubmission code in the 3rd digit of the bill type (for corrected claim this will be 7) and the original claim number in field 64 of the paper claim. For the EDI 837I, the data should be sent in the 2300 Loop, segment CLM05 (with value of 7) along with an addition loop in the 2300 loop, segment REF*F8* with the original claim number for which the corrected claim is being submitted.

Omission of these data elements may cause inappropriate denials, delays in processing and payment or may result in the claim being denied as a duplicate, or for exceeding the filing limit deadline.

Corrected or adjusted claims submission can be submitted via our provider portal:

To access this function, provider representatives must become a registered user at www.mhswi.com.

Corrected or adjusted paper claims can be mailed to:

MHS Health Wisconsin
ATTN: Claims Department
P.O. Box 3001
Farmington, MO 63640-3801

For Behavioral Health corrected or adjusted paper claims mail to:

MHS Health Wisconsin
ATTN: BH WI Claims Appeals
P.O. Box 6000
Farmington MO 63640

Claim overpayment
A provider may receive more payment for a claim than is expected. Providers are required to report and return any overpayments received within 60 days of the Provider's discovery of the overpayment and must notify MHS Health in writing of the reason for the overpayment. MHS Health will recoup the amount of the overpayment as outlined below. If the claim involves COB, a copy of other insurance EOP must be sent to the MHS Health Claims Department to recoup along with the description of processing codes.

Return uncashed Centene checks to:
MHS Health Wisconsin
ATTN: Returned Checks
P.O. Box 3001
Farmington, MO 63640-3801

If you prefer to refund the overpayment by check (on your check stock), include a copy of the EOP and send to:
MHS Health Wisconsin
P.O. Box 3657
Carol Stream, IL 60132-3657

For behavioral health claims, send to:
BH WI Claims
P.O. BOX 3656
Carol Stream, IL 601323656

Code review denial
MHS Health utilizes a claims adjudication software package, for automated claims coding verification and to ensure that MHS Health is processing claims in compliance with general industry standards.

A provider may request re-evaluation of claims denied by code auditing software. The most common codes are listed below but are not all-inclusive.

EX Code List (not all-inclusive)

x1	x2	x3	x4	x5	x6	x7	x8	x9	xa
Xb	xc	xd	xe	xf	xg	xh	xo	xp	xq
Xr	xy	ya	yd	ye	yq	ys	yu	57	58

Providers must:
- Submit a request in writing, within 90 days of the EOP or as defined in your MHS Health contract.
- Include a copy of the EOP that indicates how and when the claim was processed.
- Include the patient's medical record, chart notes and/or other pertinent information to support the request for reconsideration.

Mail to:
MHS Health Wisconsin
ATTN: Medical Review Unit
PO Box 3001
Farmington, MO 63640-800

2. **Administrative Claim Appeal (Formal Appeal)**
A request for re-evaluation or exception to a plan policy or contract requirement such as benefit limitations, eligibility, failure to obtain authorization or unsupported timely filing.

Prior to submitting a Formal Appeal, a provider must:

1. Submit an informal claim payment dispute resolution request.
2. Submit a claim reconsideration.

NOTE: All medical records must be submitted with formal appeals.

Please complete the *Claim Appeal Form* on the MHS Health website. A provider may request that a specific issue be re-evaluated by MHS Health. To do so, follow these guidelines:

- Submit a request in writing, which must be received within 90 days of the EOP or denial or as defined in your MHS Health contract.
- Clearly mark "Appeal" on the request letter.
- Note reason the claim or issue merits reconsideration. Please be specific.
- Include a copy of the claim in question and a copy of the EOP that indicates how and when the claim was processed.
- Include medical records, chart notes and other pertinent information to support the request for the appeal, if applicable.

Formal claim appeals must be mailed to the addresses below.

NOTE: Any formal appeals sent to addresses other than what is listed below will not be accepted and returned to sender. Further, the use of USB flash drives, CDs, etc. are restricted from company-authorized devices, and will not be accepted for review of medical records and will also be returned to sender.

MHS Health Wisconsin
ATTN: Appeals Department
P.O. Box 3000
Farmington, MO 63640-3800

Behavioral Health Claims mail to:
BH WI Appeals
P.O. Box 6000
Farmington MO 63640

A final determination of the review will be communicated within 45 days of receipt of the appeal.

After taking these steps, if a provider has not heard from MHS Health after 45 days or has heard from MHS Health and feels that further appeal is necessary, an appeal may be made to the Wisconsin Department of Health Services within 60 days of receipt of the response from MHS Health.
Mail to:

Medicaid Fiscal Agent Managed Care Unit
P.O. Box 6470
Madison, WI 53716-0470

3. Medical Necessity Appeal *(post service)*

A request for a review of an adverse decision made by the MHS Health Medical Management Department.

Claims denied for medical necessity should be mailed to the Appeals Department. Medical necessity appeals require pertinent medical information that supports the reason for the appeal.

NOTE: Any formal appeals sent to a different address other than what is stated below will be returned to sender.

Mail Medical Necessity Appeals to:
MHS Health Wisconsin
ATTN: Medical Necessity Appeals
P.O. Box 3000
Farmington, MO 63640-3800

Mail BH Medical Necessity Appeals to:
Behavioral Health Appeals-MHS WI
12515-8 Research Blvd #400
Austin TX 78758

Medical necessity appeals are reviewed and decided by a different MHS Health medical director than the medical director who made the original adverse decision.

Second Level Appeal to DHS

Providers that have exhausted payment dispute resolution with MHS Health may choose to pursue resolution directly with the Wisconsin Department of Health Service and have 60 calendar days from MHS Health's final appeal decision to submit all required information to the Wisconsin Department of Health Services. DHS' form can be found here.

Providers are required to submit to DHS copies of all of the following documentation. Failure to submit the required documentation or submitting incomplete/insufficient/illegible documentation may lead to DHS upholding of the original denial. The decision to overturn MHS' denial should be clearly supported by the documentation submitted for review:

a. A copy of the original claim submitted to the HMO. If applicable, include a copy of all corrected claims submitted to the HMO.
b. A copy of all of the HMO's payment denial remittance(s) showing the date(s) of denial and reason code with a description of the exact reason(s) for the claim denial.
c. A copy of the provider's written appeal to the HMO.
d. A copy of the HMO response to the appeal.
e. A copy of the medical record for appeals regarding coding issues, or emergency determination. Providers should only send relevant medical documentation that supports the appeal. Large records submitted with no indication of where supporting information is found, will not be reviewed. Large documents should be submitted on a CD.
f. A copy of any contract language that supports the appeal. If contract language is submitted, indicate the exact language that supports overturning the payment denial. Contract language submitted with no indication will not be reviewed and the appeal denial upheld. Contract language will be used to determine compliance.
g. Any other documentation that supports the appeal (e.g., commercial insurance Explanation of Benefits/Explanation of Payment to support Wisconsin Medicaid as the payer of last resort). Appeals to the Department can be faxed or mailed to:

BadgerCare Plus and Medicaid SSI Managed Care Unit – Provider Appeal
P.O. Box 6470
Madison, WI 53716-0470
Fax Number: 608-224-6318

Providers should notify Forward*Health* if the HMO subsequently overturns their original denial and reprocesses and pays the claim for which an appeal has been submitted. Notification should be faxed to Forward*Health* at 608-224-6318. This documentation will be added to the original appeal documentation to complete the record and the appeal withdrawn. Providers can also call Managed Care Unit at 1-800-760-0001, option 1, to check on the status of a submitted appeal.

Mail to:
Bureau of Managed Healthcare Programs
ATTN: Appeals Contract Specialist
P.O. Box 309
Madison, WI 53701-0309

Section 14 Customer Service

MHS Health Customer Service Department is available at 1-888-713-6180 during normal hours of operation Monday through Friday (excluding holidays) from 8 a.m. to 6 p.m. For all non- emergency and emergency calls after normal business hours, MHS Health maintains an automated system available for call center access between the hours of 7 p.m.-8 a.m. Central Time Monday through Friday and at all hours on weekends and holidays. This automated system provides the members with a direct prompt to access our nurse advice line for immediate care.

Please ask your patients who are MHS Health/Network Health members to direct their questions to MHS Health Customer Service at 1-888-713-6180. Customer Service representatives respond to members who call or write MHS Health with questions or inquiries, about:

- Eligibility
- Plan benefits
- Provider participation
- Selecting a PCP
- Changing PCPs
- Related health services (pharmacy, vision, behavioral health, treatment for alcohol and other drug abuse, durable medical equipment, and dental, where applicable)
- Transportation to a health-related appointment vendor is MTM for all counties
- (Reservations call 1-866-907-1493 to check the status of a ride or complaints 1-866-907-1494)
- Interpreter services
- Medical bills
- Co-pays
- Adult and children's required state initiatives

Representatives document every inquiry and track it through to resolution. Most issues are resolved at the time of the initial call. Staff is trained in customer relations, issue resolution, complaint protocol and member rights.

If a member expresses dissatisfaction with the health plan or any of our providers, the call is documented as a complaint. Phone representatives will attempt to resolve complaints, but if they cannot, the complaint is then investigated by the responsible MHS Health department(s). For more information, please see *Section 12 Provider Complaints, Grievance and Appeals.*

How MHS Health Helps Members

Selecting a PCP

New members receive a Member Handbook by mail. The handbook encourages members to select a PCP within 30 days of joining our health plan. A Provider Directory can be accessed by visiting the MHS website or by calling Customer Service. If the member does not select a PCP, the member is assigned to a PCP by MHS Health. The member can inform the plan of their selection by:

- Completing and mailing a cardstock form located in the welcome packet.
- Calling MHS Health Customer Service.
- Contacting MHS Health via the website: www.mhswi.com.
- Registering for the secure member portal via the website: www.mhswi.com.

MHS Health considers PCPs to be the "medical home" of plan members. The "medical home" concept helps establish patient-provider relationships and contributes to healthier outcomes.

Selecting an OB/GYN and PCP

MHS Health members can select both a primary care physician and an OB/GYN for all of their primary healthcare needs.

Changing a PCP
Members may change their PCP upon request and seek care from the new PCP immediately. The member can also inform the plan about the change by contacting us via the website: www.mhswi.com.

Selecting a Family Planning Provider
Federal guidelines require that members have the option of selecting a provider for family planning who is not their PCP. The clinician selected for family planning services does not replace the PCP chosen by or assigned to the enrollee for all other medical services.

The family planning provider need not be contracted with MHS Health. If a member selects a non-MHS Health network provider for family planning services, the cost will be covered by Medicaid on a fee-for-service basis.

MHS Health must allow adolescents to have their own primary care clinician or to seek family planning services from a certified family planning agency.

Member materials
Plan members receive printed information from MHS Health through mailings and during face-to-face contacts. MHS Health produces all vital materials in English, Hmong, Russian and Spanish, Lao, Mandarin Chinese and, as requested, additional languages and formats (e.g., Braille, large font and audiotapes). Materials include:

- Quarterly newsletters
- Targeted disease management brochures
- Provider Directory
- Nurse advice line
- Information about emergency room use
- Member Handbook (available in English, Spanish, Hmong and Russian) which includes information such as:
  - Pregnancy Notification Forms
  - Health Risk Assessment Forms (HRA)
  - PCP Provider directory
  - PCP selection form
  - Adult and child preventive health guidelines
  - Benefit information
  - Member rights and responsibilities

Providers interested in receiving any of these materials may contact the MHS Health Provider Inquiry Line. When prompted, say "Something else" and the call will be transferred to Provider Services.

Provider Inquiry Line
1-800-222-9831

Member Rights and Responsibilities on the following page are included in the Member Handbook mailed to each new member and published annually in member and provider newsletters.

Member Rights and Responsibilities Statement

Member Rights

- You have the right to have an interpreter with you during any BadgerCare Plus or Medicaid SSI covered service.
- You have the right to get the information provided in this member handbook in another language or format.
- You have the right to get health care services as provided for in federal and state law. All covered services must be available and accessible to you. When medically appropriate, services must be available 24 hours a day, seven days a week.
- You have a right to a candid discussion of appropriate or medically necessary treatment options for your conditions, regardless of cost or benefit coverage.
- You have the right to participate with practitioners in making decisions about your health care.
- You have the right to be treated with respect and recognition of your dignity and right to privacy.
- You have the right to be free from any form of restraint or seclusion used as a means of force, control, ease, or reprisal.
- You have the right to be free to exercise your rights without adverse treatment by the HMO and its network providers.
- You may switch HMOs without cause during the first 90 days of enrollment.
- You have the right to switch HMOs, without cause, if the State imposes sanctions or temporary management on this health plan.
- You have the right to receive information from this health plan regarding any significant changes with Network Health at least 30 days before the effective date of the change.
- You have a right to receive information about this health plan, its services, its practitioners and providers and member rights and responsibilities.
- You have a right to voice complaints or appeals about the organization or the care it provides.
- You have a right to make recommendations regarding the organization's member rights and responsibilities policy.

Member Responsibilities

- You have a responsibility to supply information (to the extent possible) that the organization and its practitioners and providers need in order to provide care.
- You have a responsibility to follow plans and instructions for care that they have agreed to with their practitioners.
- You have a responsibility to understand their health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.

Members Have the Right to Disenroll from the HMO if:

- You move out of the HMO/PIHP's service area
- Your HMO/PIHP does not, for moral or religious objections, cover a service you want
- You need a related service performed at the same time, not all related services are available within the provider network, and your PCP or another provider determines that receiving the services separately could put you at unnecessary risk
- Other reasons, including poor quality of care, lack of access to services covered under the contract, or lack of access to providers experienced in dealing with your care needs.

Civil Rights
MHS Health provides covered services to all eligible members regardless of: age, race, religion, color, disability, ethnicity, sex, gender identify, sexual orientation, national origin, marital status, arrest or conviction record and military participation.

All medically necessary covered services are available and will be provided in the same manner to all members. All persons or organizations connected with MHS Health that refer or recommend members for services shall do so in the same manner for all members. Translation or interpreting services are available for those who need them. This service is free.

Medical Records
Members may ask for copies of medical records from providers. MHS Health can assist in obtaining copies of these records. Please call toll-free at 1-888-713-6180 for assistance

Provider Credentials
Members have the right to information about providers including the provider's education, board certification, and re-certification. To obtain this information, call Customer Service toll-free at 1-888-713-6180.

Physician Incentive Plan
Members are entitled to ask if MHS Health has special financial arrangements with physicians that can affect the use of referrals and other services needed. To obtain this information, call Customer Service toll-free at 1-888-713-6180.

Complaints
MHS would like to know if members have complaints about care. Please call your MHS Health member advocate at 1-888-713-6180 with complaints or write MHS Health at:

MHS Health Wisconsin
801 S. 60 St. Suite 200
West Allis, WI 53214

To speak with someone outside of MHS Health about a problem, call the HMO enrollment specialist at 1-800-291-2002. The enrollment specialist may be able to help solve the problem. They can also assist in writing a formal complaint to MHS Health or to the State HMO Program. The address of the State HMO Program is:

EDS, HMO Ombuds
P.O. Box 6470
Madison, WI 53716

MHS Health cannot treat you differently from other members because you filed a complaint and healthcare benefits will not be affected.

Benefits Denied
You may appeal if you believe your benefits are unfairly denied, limited, reduced, delayed, or stopped by MHS Health. Members have 60 calendar days from the date on the adverse benefit determination notice to file a request for an appeal.

To appeal to MHS Health, call the MHS Health member advocate at 1-888-713-6180 or write to:
MHS Member Advocate
801 S 60th St., Suite 200
West Allis, WI 532214

Members must exhaust all appeal rights through the health plan first. If upheld or the health plan does not adhere to timeliness guidelines, members may appeal to the State of Wisconsin Division of Hearing and Appeals for a Fair Hearing if

they believe benefits are unfairly denied, limited, reduced, delayed, or stopped by MHS Health. An appeal must be requested no later than 90 days calendar days from the date of the Health Plan's notice of resolution. For a fair hearing, send a written request to:

Department of Administration Division of Hearings and Appeals
P.O. Box 7875
Madison, WI 53707-7875

The hearing will be held in the county where the member lives. If special arrangements are needed for a disability or for English translation, please call 608-266-3096 or TDD/TTY for the hearing impaired,608-264-9853.

MHS cannot treat you differently from other members because you requested a fair hearing and healthcare benefits will not be affected. If assistance is needed writing a complaint or appeal, please call EDS Ombuds, 1-800-760-0001, or HMO Enrollment specialist, 1-800-291-2002.

Member Complaint and Grievance Resolution

MHS Health provides members (or providers on behalf of members) access to a complaint and grievance resolution process.

MHS Health responds to member complaints in a timely manner and attempts to resolve all members' complaints to the member's satisfaction. If a member is dissatisfied with a complaint resolution, MHS Health provides a grievance process for further appeal.

Complaint Resolution

If a Member Service representative cannot resolve a member's inquiry to the member's satisfaction, the call is handled as a complaint including investigation. Any MHS Health representative can accept a member complaint. A member complaint may be verbal or written. A member (or provider on behalf of a member) has unlimited access to MHS Health Customer Service to initiate a complaint. Customer Service can be reached by calling 1-888-713-6180. When an MHS Health Customer Service representative receives a member complaint via the telephone, they attempt to resolve the complaint at that time, according to MHS Health policies and procedures. If a complaint cannot be resolved within 24 hours of receipt, MHS Health acknowledges receiving the member's complaint by sending a letter to the member (or provider on behalf of a member) within ten business days of the initial complaint.

- Complaints of an emergent nature are resolved immediately.
- Complaints of an urgent nature will be resolved within 48 hours.
- All other member complaints will be acknowledged within 10 days and resolved and responded to within 30 days of the time of receipt.
- A member will not be penalized for filing a complaint.
- If the member is not satisfied with the complaint resolution, he or she can write a grievance letter.

Filing A Grievance

A plan member (or provider on behalf of a member) can file a grievance by telephone (1-888-713-6180) or by mail via the contact information below.

MHS Health Wisconsin
MHS Health Member Advocate
801 S. 60 St. Suite 200
West Allis, WI 53214

Any supporting documentation should accompany the grievance. All member grievances remain confidential. A member will not be penalized for filing a grievance. At no time will MHS Health cease care pending a grievance investigation.

Section 15 Provider Credentialing

Credentialing Requirements
All network practitioners must successfully complete the MHS Health credentialing and contracting process.

Providers must adhere to the following requirements:

- In order to continue participation with MHS Health all providers must adhere to MHS Health's Clinical Practice Guidelines and Medical Necessity Criteria which are located in this Manual.
- Providers must consistently meet our credentialing standards, and guidelines on PCP notification.
- Failure to adhere to guidelines and standards at any time can lead to termination from the network.
- Notification is required immediately upon receipt of revocation or suspension of a provider's State license by the Department of Regulation and Licensing or Bureau of Quality Assurance.
- In order to be credentialed, all providers must be licensed to practice independently in the State the practice is located.
- For MDs and DOs, proof of their medical school graduation, completion of residency and other postgraduate training. Evidence of board certification shall suffice in lieu of proof of medical school graduation, residency and other postgraduate training, as applicable.
- License must be current, active, in good standing, and without limitations.
- MDs and DOs that have hospital privileges must keep them current. MD's and DOs that choose to relinquish their privileges should notify MHS Health.
- Graduate degrees must be from an accredited institution.
- All providers are subject to the completion of primary source verification.
- The provider further agrees to provide all documentation in a timely manner required for credentialing and/or re-credentialing.
- The provider agrees to maintain adequate professional liability insurance as set forth in the provider Agreement.
- All credentialing applications are subject to consideration and review by the Credentialing Committee, which meets monthly.
- Providers must be active and current on CAQH before applying to join the network.
- Providers request to join the network on line at www.mhsiwi.com.

Council for Affordable Quality HealthCare (CAQH)
CAQH is utilized to streamline the credentialing/re-credentialing process. If you are not registered, please complete the registration process online at www.caqh.org, or call the help desk at 888-599-1771. There is no cost for providers to submit their credentialing applications with CAQH.

Once registered, providers will need to grant MHS Health /Centene access to their CAQH information. Provider information, such as supporting documents, will need to be updated every 120 days on CAQH. The following information is verified during credentialing and re-credentialing:

- Wisconsin license through appropriate licensing agency
- Board certification, residency training, and medical education
- National Practitioner Data Bank (NPDB) and HIPDB claims
- Review five (5) year work history
- Review federal sanction activity including Medicare/Medicaid services Office of Inspector General (OIG) and Excluded Parties Listing System (EPLS)

It is the provider's responsibility to notify MHS Health of any of the following within ten (10) days of the occurrence:

- Any lawsuits related to professional role
- Licensing board actions
- Malpractice claims or arbitration
- Disciplinary actions before a State agency and Medicaid/Medicare sanctions
- Cancellation or material modification of professional liability insurance
- Member complaints against provider
- Any situation that would impact a provider's ability to carry out the provisions of their Provider Participation Agreement, including the inability to meet member accessibility standards
- Changes or revocation with DEA certifications, hospital staff changes or NPDB or Medicare sanctions.

NOTE: Providers may also require a site visit conducted by a MHS Health representative as part of the credentialing or re-credentialing process. Failure to pass the site visit may result in a Corrective Action Plan (CAP) that must be satisfied before being considered for admission to the network.

Please immediately notify MHS Health of any updates to your Tax Identification Number, service site address, telephone/fax number, and ability to accept new referrals in a timely manner so that our systems are current and accurately reflect your practice. In addition, we ask that you please respond to any questionnaires or surveys submitted regarding your referral demographics, as these may be requested from time to time.

Re-Credentialing Requirements

Network Providers will be re-credentialed every three (3) years as required by the State of Wisconsin. Providers will receive notice that they are due to be recredentialed well in advance of their credentialing expiration date and, as such, must have a CAQH registration on file. Failure to attest and/or update your information on CAQH in a timely manner can result in termination from the network.

Quality indicators including but not limited to, complaints, appointment availability, critical incidents, and compliance with discharge appointment reporting, will be taken into consideration during the re-credentialing process.

Credentialing Policies and Procedures

Credentialing and re-credentialing policies and procedures shall be in writing and include the following:

- Formal delegation and approvals of the credentialing process;
- A designated credentialing committee;
- Identification of Network Providers who fall under its scope of authority;
- A process which provides for the verification of the credentialing and recredentialing criteria;
- Approval of new Network Providers and imposition of sanctions, termination, suspension and restrictions on existing Network Providers;
- Identification of quality deficiencies which result in MHS's restriction, suspension, termination or sanctioning of a Network Provider; and
- A process to implement an appeal procedure for Network Providers whom MHS Health has terminated.

Right to Review, Correct Information, and Obtain Credentialing/Recredentialing Application Status All providers participating with the MHS Health behavioral health network have the right to review information obtained by MHS Health to evaluate their credentialing and/or re-credentialing application. This includes information obtained from any outside primary source such as the National Practitioner Data Bank-Healthcare Integrity and Protection Data Bank, malpractice insurance carriers and the Composite State Board of Medical Examiners and other State board agencies. This does not allow a provider to review references, personal recommendations, or other information that is peer review protected.

Should a provider believe any of the information used in the credentialing/re-credentialing process to be erroneous, or

should any information gathered as part of the primary source verification process differ from that submitted by a provider, they have the right to correct any erroneous information submitted by another party. To request release of such information, a written request must be submitted to MHS Health credentialing department. Upon receipt of this information, the provider will have fourteen (14) days to provide a written explanation detailing the error or the difference in information to MHS Health. The MHS Health Behavioral Health Credentialing Committee will then include this information as part of the credentialing/re-credentialing process. In addition, practitioners/providers have the right to request the status of the provider's credentialing and or recredentialing application by calling the Credentialing Department or submitting via email or fax.

Primary Source Verification

The MHS Health practitioner application process focuses on primary source verification of each applicant's license, DEA, education and training, work history gaps, malpractice history, and any sanction activity via the National Practitioner Data Bank, the Health Integrity Provider Data Bank (NPDB/HIPDB,) and the Office of the Inspector General (OIG). MHS Health adheres to corporate standards and the guidelines of the National Committee for Quality Assurance (NCQA).

All practitioners participating with MHS Health have the right to review information obtained by MHS Health to evaluate their credentialing and/or re-credentialing application. This includes information obtained from any outside primary source such as the National Practitioner Data Bank-Healthcare Integrity and Protection Data Bank, malpractice insurance carriers, and the Department of Regulation and Licensing Medical Examining Board. Notification of these rights may occur via individual correspondence, in the provider Manual, or on the MHS Health website. If the process identifies a substantial discrepancy in information gathered as part of the primary source verification process from that which was provided by the applicant, MHS Health will notify the applicant and allow him/her to review and correct any and all erroneous information submitted by another party. Practitioners are not, however, allowed to review references, personal recommendations, or other information that is peer review protected.

Status of an Application

Providers have the right to contact us at any time to request an update on the status of your credentialing or re-credentialing application. Contact us at 1-800-222-9831, ask for "Credentialing" or email WI-CRED@mhswi.com.

Credentialing Committee

The chief medical officer and/or a peer review committee are responsible for the credentialing and re-credentialing of health plan providers and facilities. The committee is comprised of participating plan clinicians who meet bi-monthly.

A Quick Reference Guide to Credentialing

The following guide identifies the criteria required for network participation, as specified in the MHS Health Credentialing Program Description and policies and procedures. The criteria are based on MHS Health, corporate, URAC, and NCQA guidelines.

To qualify to participate in the MHS Health Wisconsin Provider Network, a provider must:

- Have an effective Wisconsin Medicaid number.
- Have a current unlimited/unrestricted medical license in the state where the practice is located.
- Have an effective Wisconsin NPI number.
- Have a current DEA certificate.
- Have a current certificate of malpractice insurance with the appropriate limits of liability as set by the State of Wisconsin for the practice where practitioner is employed.
- Demonstrate appropriate experience, background and relevant training for the specialty they will practice as an MHS Health in-plan provider, if application is approved.
- Have a professional office in one or more counties within the MHS Health certified service area.
- Provider must list all current hospital affiliations or state if they use hospitalists or if they are clinic-based only.

Contact your MHS Health credentialing specialist at 1-800-222-9831 and ask for "Credentialing" to request a credentialing packet be sent to you when the above qualifications have been met. The credentialing staff sends out packets on a weekly basis. You can call the above numbers to check on the status of your application at any time. Any application submitted to MHS Health that does not meet the above requirements will be returned to the applicant who must begin the credentialing process again.

Primary Source Verification (PSV) will start once a "clean" application has been received by the credentialing staff. The applicant has the right to review information submitted to support their credentialing application. If, during the PSV process, MHS Health identifies a discrepancy in information provided by the applicant, the MHS Health credentialing staff will notify the applicant via certified mail. The applicant has the right to correct any erroneous information gathered from outside sources as part of the verification process, however, this does not allow any peer review protected information, such as references, personal recommendations, or other information as stated by Federal law. If the applicant fails to meet the 14-day correction timeframe, the credentialing process will be terminated, and the applicant must begin the credentialing process again.

The PSV process requires at least 30 days for completion. The **entire** credentialing process, which also includes an on-site visit, if needed, and review by the MHS Health Credentialing Committee (CC), is usually completed in 60-90 days. MHS Health credentialing staff will notify all applicants in writing within 10 days of the CC's decision of the approval/denial of their application.

Applications are not considered approved until they have completed the credentialing & contracting process and you are notified that you may begin to see MHS Health /Network Health members. MHS Health cannot grant any exceptions for applicants who have not completed the credentialing in its entirety.

MHS Health credentials the following providers

- Physicians (MD and DO) with the exception of:
  - Urgent care and ER physicians, hospitalists, radiologists, pathologists and anesthesiologists. However, you must notify our Credentialing Department or visit our website at www.mhswi.com and choose Provider Resources to complete a new provider setup form so that we can load these providers into our system for payment.
- Pain management (must have the appropriate education/training and will be considered on an individual basis)
- Physician assistants (PA)
- Advance practice nurse prescribers (APNP)
- Certified nurse midwives (CNM)
- Locum tenens
- All behavioral health practitioners

MHS Health does not credential the following providers:

- Physical, occupational or speech therapists, unless they hold an independent contract, and audiologists. However, you must notify our Provider Services Department and complete a New Provider Setup Form so that we can load these providers into our system for payment.

Re-credentialing

Every 36 Months, all MHS Health providers will be sent a re-credentialing application at least 60 days in advance of their last re-credentialing date. To be re-credentialed, all providers must meet the criteria listed above; in addition, a medical record review by MHS Health Quality Improvement staff may be required. MHS Health re-credentials HDOs every three years to assure the organization remains in good standing with State and Federal regulatory bodies, has been reviewed and approved by an accrediting body (as applicable), and continues to meet MHS Health's participation and quality improvement requirements.

Quality Improvement staff performs random medical record reviews of all primary care and OB/GYN practitioners who have 50 or more plan members as patients. For more information, please see *Section Four Medical Records.*

Credentialing of Health Delivery Organizations (HDOs)
Prior to contracting with a health delivery organization (HDOs), MHS Health verifies that the organization has been approved by a recognized accrediting body or meets MHS Health standards for participation and is in good standing with State and Federal agencies.

HDOs are hospitals, home health and hospice facilities, skilled nursing facilities, free standing surgi-centers, free standing urgent care facilities and methadone clinics.

Accrediting Bodies Recognized by MHS Health

- American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF)
- Accreditation Association for Ambulatory Healthcare (AAAHC)
- American Board for Certification of Prosthetics and Orthotics (ABCPO)
- American Osteopathic Association (AOA)
- College of American Pathologists (CAP)
- Commission on Accreditation of Rehabilitation Facilities (CARF)
- Community Health Accreditation Program (CHAPS)
- Continuing Care Accreditation Commission (CCAC)
- Clinical Laboratory Improvement Amendment certification (CLIA). (Please note: certification is required; not just CLIA license)
- Commission on Office Laboratory Accreditation (COLA)
- Joint Commission on Accreditation of Healthcare Organizations (JCAHO)
- National Committee for Quality Assurance (NCQA)
- Utilization Review Accreditation Commission (URAC)

When an organization is not accredited, MHS Health will accept a CMS or State quality review in lieu of a scheduled on-site evaluation with the exception that the CMS or State review is no greater than three years old. If the above does not apply then MHS Health will schedule an on-site evaluation to review the scope of services available at the facility, and its physical accessibility and safety, and quality improvement program. MHS Health will obtain a copy of the current state on-site evaluation to determine if the facility is in compliance with MHS Health standards.

NOTE: The above is subject to change at any time per MHS Health and State Guidelines.

Network Practitioner/Provider Appeal of Suspension or Termination of Contract Privileges
If a network provider has been suspended or terminated by MHS Health, they may contact the MHS Health Provider Relations department at 1-800-222-9831 to request further information or discuss how to appeal the decision.

For a formal appeal of the suspension or termination of contract privileges, the network provider should send a written reconsideration request to:

MHS Health Wisconsin
ATTN: Provider Relations
801 S. 60 St. Suite 200
West Allis, WI 53214

Please note that the written request should describe the reason(s) for requesting reconsideration and include any supporting documents. This reconsideration request must be postmarked within thirty (30) days from the receipt of the suspension or termination letter to comply with the appeal process.

Providers are given the opportunity for two levels of appeal hearing. The first level consists of an Appeals Committee, which is a panel of three peers that will review the credentialing committee's determination. Peers are defined as a provider with the same licensure, and at least one participating provider (in network), not necessarily of the same specialty as the requesting provider and were not involved in the initial credentialing determination. The hearing will be scheduled as soon as possible, no later than 6 months from the request. The Appeals Committee's determination will be communicated to the provider in writing detailing the rationale for the decision, and further appeal rights that includes the procedure for requesting a second-level appeals hearing, if applicable.

At the conclusion of the first-level appeal hearing the provider will be given the right to request a second-level appeal hearing. The second-level appeal hearing is conducted by MHS Health Board of Directors. The Board of Directors consists of at least three individuals that were not involved in the first-level panel. The Board of Directors shall review the recommendation of the Appeals Committee and provide a final determination. The determination will be communicated to the provider in writing detailing the rationale for the decision.

Network Provider Demographic/Information Updates

Providers should advise MHS Health with as much advance notice as possible of demographic information updates. Provider information such as address, telephone and office hours are used in our Provider Directory and it is important that we have the most current information. MHS Health wants the Provider Directory on the web site to accurately reflect the Wisconsin provider network. Changes/updates should be forwarded to MHS Health via one of the following.

Mail to:
MHS Health
ATTN: PDM Unit - Wisconsin
801 S. 60th St, Suite 200
West Allis, WI 53214

Fax to: 866-671-3669

Email to: MHS-WIPDM@mhswi.com

Section 16 Pay for Performance

Alternative Payment Models (APM):
MHS Health will engage in APM's with providers through quality care and value-based arrangements including but not limited to one-time and/or recurring bonus payments upon MHS Health's direction. These arrangements are based on HEDIS® measures that are aligned with State Medicaid/DHS Pay-for-Performance (P4P) Program initiatives that support DMS quality priorities. Please contact the MHS Health Provider Relations Department at 1-800-222-9831 for more information regarding APMs.

Provider Incentives
MHS Health offers additional provider financial incentives, through add-on payments and enhanced fee schedule payments, for the completion of certain quality-based services. Examples may include:

- Pregnancy Notifications
- Body Mass Index (BMI)

Please contact the MHS Health Provider Relations Department at 1-800-222-9831 for more information regarding current provider incentives.

Section 17 Transportation

The State of Wisconsin provides transportation benefits to and from Medicaid covered services. Members enrolled in the State of Wisconsin's Medicaid program will be required to contact the state's transportation vendor for transportation rides throughout the state.

Veyo Reservation Line	1-866-907-1493 (voice) or TTY 711
Veyo Information	https://wi.ridewithveyo.com/
Book a Ride Online	https://member.veyo.com/

*Use the websites above to schedule and cancel routine and recurring rides, file complaints, and obtain forms. To schedule rides online, you will need to have already scheduled at least one ride for the member by calling the reservation phone number and have a valid email address. Should you have an urgent (not emergent) need for transportation and Veyo is not accommodating, please contact MHS Health Customer Services at 1-888-713-6180.

To schedule a ride to routine services, members must call Veyo at 866-907-1493 at least two business days before their appointment. If you call with less notice and the trip is not urgent, they may be asked to reschedule their appointment. Two business days' notice includes the day of the call but not the day of the appointment.

MHS Health Wisconsin
801 S 60th Street
Suite 200
West Allis, WI 53214

www.mhswi.com

1-800-222-9831

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