MHS Health Wisconsin

Medicaid Provider Manual



mhs health wisconsin™

February, 2016

Introductory Information - MHS Health at-a-Glance

MHS Health Wisconsin and Network Health Plan
More than 10,000 clinicians and 90 hospitals service MHS Health and Network Health Plan (NHP) members through BadgerCare Plus, Medicaid SSI, and Medicare Advantage - Special Needs Plan (SNP), and our Ambetter from MHS Health Wisconsin commercial plans.

Location
MHS Health Wisconsin
10700 W. Research Dr., Suite 300, Milwaukee, WI 53226

MHS Provider Inquiry Line
Using Interactive Voice Recognition (IVR), check the following:

- Eligibility
- Claims information
- Benefits
- Authorization status
- Authorization requests

Provider Inquiry Line
1-800-222-9831

Please have your NPI or Tax Identification Number or the member's Medicaid ID number.

Medical Services FAX lines:
Prior authorization requests:
866-467-1316
Notification of Pregnancy Form: 866-681-5125

NurseWise® 24-hour Nurse Advice Line
800-280-2348

Behavioral Health - Cenpatico 800-589-3186

Pharmacy Benefit for Medicaid only
For Medicaid, please bill the following as fee-for-service to the State: Prescription drugs, radiopharmaceuticals, injectable biopharmaceuticals and other injectables administered in a home health facility, an MD office, a skilled nursing facility, and most outpatient environments.

Visit the website at www.mhswi.com to:
- Obtain a list of MHS Health and NHP patients and their benefit and eligibility details, including other insurance, member care gaps, PCP and eligibility history.
- Search for network Providers (updated weekly)
- Submit and view authorizations
- Use code-auditing software
- Submit claims including other insurance payment
- Export, download and check claim status, payment history, payment amounts & dates which are updated every 24 hours

Electronic Claim Submission
Clearinghouses and payor IDs: For all MHS Health and NHP claims for the below payors - 68069

Availity	Allscripts/Payorpath	Capario
Claim Remedi	Claimsource	CPSI
DeKalb	First Health Care	GatewayEDI
GHNonline	IGI	McKesson
MDonLine	Physicians CC	Practice Insight
Smarta Data	SSI	Viatrack
RelayHealth (NDC/per Se)		

Emdeon WebMD Envoy
MHS/NHP..... 39187
Managed Health Services Advantage ...68056
Networks MHS/NHP/Advantage..... 96822

Paper Claim Submission and Correction
MHS Health Wisconsin
Attn: Claims Department
P.O. Box 3001
Farmington, MO 63640-3801

Refund Overpayment (on Provider check stock)
MHS Health Wisconsin
6417 Paysphere Circle
Chicago, IL 60674-6417

Return checks
MHS Health Wisconsin
Attn: Returned Checks
PO Box 3001
Farmington, MO 63640-3801

To request a review of a "medical code denial"
MHS Health Wisconsin
Attn: Medical Review Unit
PO Box 3001
Farmington, MO 63640-3800

Administrative Claim Appeal
MHS Health Wisconsin
Attn: Appeals Department
PO Box 3000
Farmington, MO 63640-3800

Medical Necessity Claim Appeal
MHS Health Wisconsin
Attn: Medical Necessity Appeals
10700 W. Research Dr., Suite 300
Milwaukee, WI 53226

Member Services- 888-713-6180

MHS Health and NHP refers to the BadgerCare Plus, Medicaid SSI members of MHS Health Wisconsin and Network Health Plan

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 10,000 clinicians and 94 hospitals. We serve our members through these programs:

- BadgerCare Plus
- BadgerCare Plus Childless Adults Program
- Medicaid SSI
- Medicare Advantage, Special Needs Plan (SNP)
- Ambetter Marketplace Plan

MHS Health Wisconsin is a wholly-owned subsidiary of Centene Corporation, St. Louis, MO.
Centene Corporation, a Fortune 500 company, is a diversified, multi-national healthcare enterprise that provides a portfolio of services to government-sponsored healthcare programs, focusing on under-insured 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 behavioral health management, care management software, correctional healthcare services, dental benefits management, in-home health services, life and health management, managed vision, pharmacy benefits management, specialty pharmacy and tele health 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 service 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 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 in regard to a current member. This is considered part of treatment, payment, and health care operations and is allowable under HIPAA. It is the policy of MHS Health Wisconsin 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 compliance officer at:
1-800-222-9831.

MHS Health and Betty Brinn
MHS Health Wisconsin and the market have changed in many ways since 1984. Yet, we are essentially the same organization that Maxicare Health Insurance and Family Hospital created 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 is certified to enroll members in 51 counties* listed below

Ashland
Bayfield
Brown
Calumet
Chippewa
Columbia
Clark
Dodge
Door
Douglas
Eau Claire
Florence Fond
Du Lac Forest
Green Lake
Iron
Jefferson
Kenosha
Kewaunee
Langlade
Lincoln
Manitowoc
Marathon
Marinette
Marquette
Menominee
Milwaukee
Oconto
Oneida
Outagamie
Ozaukee
Polk
Portage
Price
Racine
Rock
Rusk
Sawyer
Shawano
Sheboygan
Taylor
Vilas
Walworth
Washburn
Washington
Waukesha
Waupaca
Waushara
Winnebago
Wood

*For the most current list of counties in which we are certified, please contact our Provider Inquiry Line at 800-222-9831.

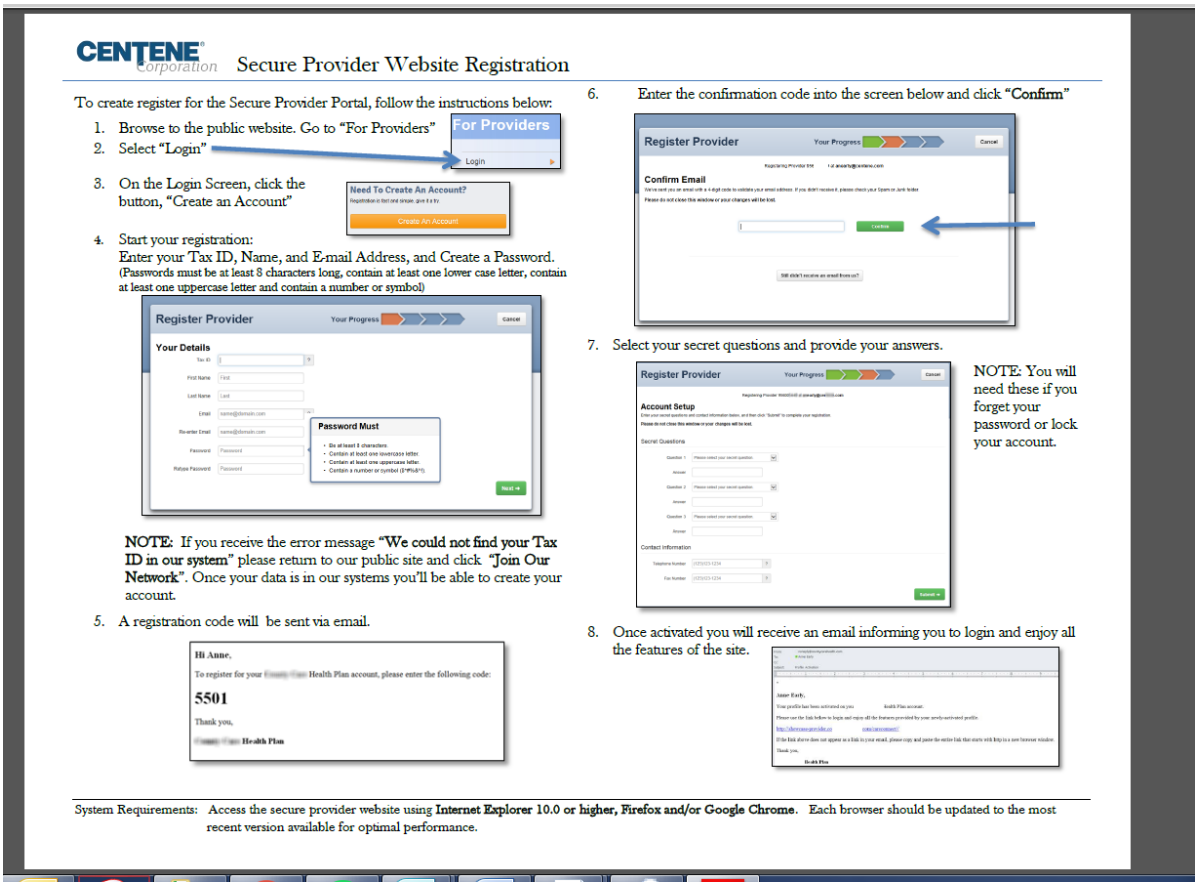
Provider friendly & easy to use

Section 1 Secure Provider Portal

The MHS secure portal can be accessed at www.mhswi.com and via the link below:
https://cnet.centene.com/sites/MemberNProviderSolutions/WebPortalServices/SitePages/Home.aspx?RootFolder=%2Fsites%2FMemberNProviderSolutions%2FWebPortalServices%2FShared%20Documents%2FSecure%20Member%20Site&FolderCTID=0x01200066E67056D905F6429D45FF8CC3D7B4C0&View=%7B8FE684B1%2D23AE%2D4A76%2DA21E%2DF9A25FAB39DF%7D

This 100 page resource is updated frequently so detailed information is not contained in this Provider Manual. Providers are encouraged to always access this link for the most current information.

Registration
Begin by completing the online registration process which can be started at the sign-in page. There is also a video link that may be helpful, located on the bottom right hand side of the page.



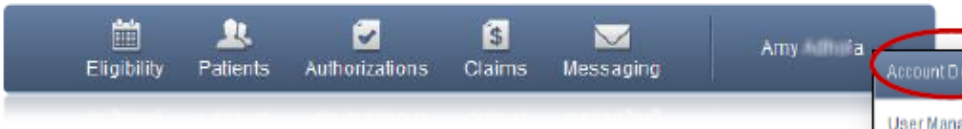
After completing online registration, users can enter the secure site to:

- Check eligibility and eligibility history including other insurance
- Identify potential gaps in care while checking eligibility
- Get a list of your MHS/NHP patients
- Search for network Providers (updated weekly)
- Submit and view authorizations
- Use code-auditing tool
- Submit claims to MHS, including COB claims
- Check claim status, payment history, payment amounts/dates, export, download, and obtain copies of EOPs

Updating Provider information on the secure portal

Most information can be easily updated by Providers by following these simple steps.

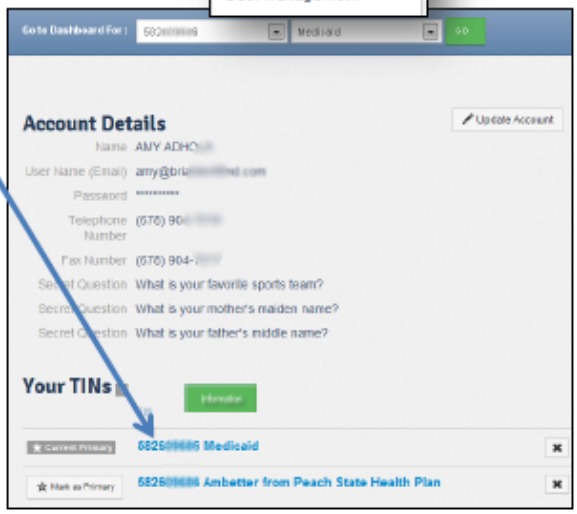
1. From the Main Tool Bar - select **Account Details** under the Users Name.



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 8:00 a.m. to 7:00 p.m., Monday – Friday. Call us and select from the following options when prompted by saying:

- Check eligibility (member eligibility)
- Claims information (billing/claim questions/Provider Relations staff)
- Benefit information
- Check authorizations status
- Authorization request

Provider Inquiry Line
1-800-222-9831

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 and Network Health Plan members to call Member Services at 1-888-713-6180.

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, NurseWise® at 1-800-280-2348.

Behavioral Health: Call Cenpatico at 1-800-589-3186.

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

Claims
Provider Services phone center representatives take your calls on the MHS Provider Inquiry Line. They research your claims questions. You may present up to four claim status inquiries per call.

We make office calls!
Provider Network Specialists visit the offices of all independent clinicians new to the MHS Health Wisconsin network and any clinicians requesting training of office billing staff. Group orientation workshops are held to review MHS Health policies, claims, and medical management information. Clinicians and office staff are invited.

Tools are available
For your convenience, the tools described in this manual are available via the *MHS Health Wisconsin Provider Inquiry Line (please call to request; we'll fax or mail what you need) or* the *MHS Health Wisconsin website* at www.mhswi.com

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. Additional copies available upon request.
- **MHS Health Wisconsin Provider Quick Reference Guide**
  A single-page reference to procedures and services requiring MHS Health Wisconsin prior authorization.
- **Directory of in-plan Providers**
  A printed directory of network primary care Providers, specialists, and ancillary Providers. The most current listing (updated weekly) is available on our website.
- **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 more timely 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.

Medical practice change notifications

Medical practice notifications can be provided to MHS Health via the secure portal. Instructions are included in the previous section. Change notifications must be submitted on the Medical Practice Information Change Form. If the change involves your practice's corporate name or your tax ID number (TIN), you must also submit a W-9 form. MHS will not accept changes to a Provider's address or TIN number when conveyed via a claim form.

You may also contact MHS Health Wisconsin by fax to have your information changed. Please see our website under Provider Resources, Administrative Billing Tools and Forms. Complete the Medical Practice Information Change form and fax it to MHS Health Wisconsin at 1-800-789-3843.

Quick Reference Guide

The Provider Quick Reference Guide can be found on the following two pages. It is also on our website in the section titled "For Providers".

Quick Reference Guide – part I

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MHS Health Wisconsin (MHS Health) - Network Health Plan (NHP) Prior Authorization Requirements

www.mhswi.com or (800) 222-9831

Important Numbers

Provider Inquiry Line
(800) 222-9831
- ✓ Eligibility
- ✓ Authorizations
- ✓ Claim status

Member Services
(888) 713-6180

Important Fax Numbers

Outpatient Authorization
(866) 467-1316

Inpatient Hospital Face/Census Sheets
(800) 354-6136

Concurrent Authorization
(866) 700-0988

Notification of Pregnancy
(866) 681-5125

After hours, weekends & holidays call MHS Health's 24-hour nurse advice line at (800) 280-2348

April 2014

PROCEDURES/SERVICES
- Procedures & services performed by out-of-plan providers
- Procedures that are cosmetic
- Abortions (must include required consent & special criteria)
- Bariatric surgery
- Blepharoplasty
- Botox injection
- Capsule endoscopy
- Cardiac imaging – MRI/CT/PET scans
- Cochlear implants
- Court-ordered services
- Experimental or Investigational procedures
- General Anesthesia for Dental Procedure age 5 years and older
- Hospitalizations – All planned admissions, newborn deliveries (by next business day), hospice, rehab, skilled nursing, transplants, including transplant evaluations.
- Hysterosalpingography
- Implantable devices
- Mammoplasty
- Neuropsychological testing
- Obstetrical ultrasound

(2 allowed in a 9-month period, any additional will require authorization, with the exception of those ordered by perinatologists).

PROCEDURES/SERVICES CONTINUED
- Oral surgery – TMJ surgeries
- Otoplasty
- Pain management: all invasive measures
- Reconstructive/plastic surgery (excluding breast reconstruction after mastectomy)
- Rhinoplasty and/or septoplasty
- Scar revision/keloids/excisions
- Spine surgery - including disc replacement
- Synagis injections
- Ultraviolet (UV) therapy
- Varicose vein procedures

Other Services
- Genetic Testing
- Notification of Pregnancy
- Quantitative Drug Testing (for Drugs of Abuse and Molecular diagnostic testing)

ANCILLARY SERVICES
- Air ambulance transport (non-emergent, fixed wing)
- DME - See www.mhswi.com for details
- Enteral nutrition
- Orthotics/prosthetics sale items See www.mhswi.com for details (physician office locations excluded)
- Podiatry – After 3 visits
- Therapy – ongoing services
- Occupational/physical therapy – per member benefit - required after 1st 6 visits within a rolling 12 month period or if visit exceeds 6 units per day.
- Speech therapy – required after evaluation
- Home care services – which include skilled nursing visits, infusion therapy, hospice, personal care worker, wound care, physical therapy, occupational therapy and speech therapy
- Transportation – non-emergent ambulance transportation must be handled through Medical Transportation Management, Inc.

Use our Prior Authorization Tool for quick confirmation - available on our website!

Our website is available 24 hours a day, seven days a week, including holidays!

Quick Reference Guide – part II

MHS Health/NHP Provider Network Quick Reference Guide
Prior Authorization (PA) Requirements - (800) 222-9831

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❖ **BEHAVIORAL HEALTH/SUBSTANCE ABUSE**
Must use Cenpatico Behavioral Health network.
Call (800) 589-3186

❖ **CHIROPRACTIC (covered by Medicaid FFS)**
Members may use any Medicaid-certified chiropractor. Claims are billed to the state fee for service.

❖ **CLAIMS SUBMISSION**
Claims must be submitted within 90 days , (or as specified in the contract), of the date of service. Failure to do so will result in denial of claim.

❖ **ELECTRONIC SUBMISSIONS:**
Can be done via web portal or utilizing a variety of clearinghouses. Please check www.mhswi.com for details on electronic submissions.

PAPER SUBMISSIONS
MHS Health Wisconsin
P.O. Box 3001
Farmington, MO 63640-3801

❖ **DENTAL – DentaQuest (800) 504-9660**
Preventive treatment, routine exams & diagnostic X-rays are covered for MHS Health/NHP members living in Milwaukee, Kenosha, Racine , Ozaukee, & Waukesha counties. Members outside of these counties covered under FFS , call DentaQuest for further info.

❖ **DURABLE MEDICAL EQUIPMENT/SUPPLIES (DME)/(DMS)**
Must use MHS Health provider. (Physician office locations excluded). Bill up to the purchase price. DME/DMS items over the Medicaid quantity limit would need PA & supporting medical documentation , including RX from the physician. We follow the same guidelines for criteria & quantity limit as Medicaid.

❖ **EMERGENCY ADMISSIONS**
No PA required for emergency admits from physician offices. Hospitals **MUST** notify MHS Health of the admission.

www.mhswi.com **(800) 222-9831**

❖ **Hearing Aids**
Valid codes: **V5030, V5040, V5100, V5180, V5220, V5256, V5260, V5261, V5257**
Valid Modifiers: **LT-Left side, RR-Rental, RT-Right side.**
Provider must purchase hearing aids from manufacturers with contract w/ Division of Health Care Access & Accountability. Attach copy of the invoice w/claim, including hearing aid manufacturer, model billed , & contract purchase price.

❖ **ORTHOTICS/PROSTHETICS**
Must use MHS Health provider, who must obtain prior auth for ALL orthopedic footwear, shoe modifications and any billing utilizing an "L" code > $500. Must submit with documentation to support medical necessity. (Physician office locations excluded).

❖ **PAIN MANAGEMENT**
PA required for injections related to pain management. All invasive measures require auth. Documentation required for PA of initial injection includes history of: condition, treatment attempted prior to injection , & imaging reports. PA requests for additional injections require office notes documenting progress since previous injection, and any other additional info. to support medical necessity .

❖ **PERSONAL CARE WORKER**
For initial/renewal or increase in unit requests all of the following is required:
- MD order & office notes/plan of care
- Personal care screening tool
- PCW notes for ALL renewal requests;
- PT/OT Personal Needs Assessment may be required upon initial or renewal requests.
- MapQuest (or similar tool) indicating travel time

❖ **PHARMACY BENEFIT (covered by Medicaid FFS)**
Prescription drugs, radiopharmaceuticals, injectable biopharmaceuticals & other injectables administered in home health, MD office, skilled nursing & most outpatient settings should be billed to FFS.

❖ **PODIATRY**
No PA is required for the first 3 visits per calendar year. Routine foot care is NOT a covered benefit.

❖ **TRANSPORTATION**
ALL non-emergent medical transportation needs are handled by Medical Transportation Management, Inc.
(866) 907-1493

❖ **SMOKING CESSATION**
MHS offers coverage for office visits & counseling sessions related to smoking cessation. The services are covered when billed with ICD-9 diagnosis code **305.1** in positions 1-4 or diagnosis code **V15.82** in positions 2-4. For smoking cessation counseling, use the following codes:
99406- smoking & tobacco use cessation counseling visit; intermediate, > than 3 minutes, up to 10 minutes.
99407 – smoking & tobacco use cessation counseling visit; intensive, > than 10 minutes. Remember to screen every pregnant woman for tobacco use during initial prenatal visit & each follow-up , document in the medical record.

❖ **STERILIZATION**
The Federal Sterilization Informed Consent form must be submitted with claims for any sterilization procedures including: tubal ligation, vasectomies & hysterectomies. Failure to comply with any of the requirements will result in denial of all claims associated with the procedure. Further guidelines are outlined in the Wisconsin Medical Assistance Provider Manual.

❖ **THERAPIES**
PA not required for initial evaluation by an in-plan , physical, occupational or speech therapist. PA is not required for the first 6 visits of physical /occupational therapy within rolling 12 month period (per member , NOT provider). If visit exceeds 6 units per day, PA is required (1 unit =15 min). Speech therapy requires PA after the initial evaluation. To continue services, treating clinician must request PA & provide documentation of medical necessity.

❖ **VISION – OptiCare (866) 458-2134**
Must use a network provider. Members should call OptiCare to find a provider. Routine vision services are covered annually. Referral to ophthalmologists for medical conditions must be to an in-plan provider.

Section 3 Guidelines for Providers

Physician feedback

We welcome your opinion. You are encouraged to contact MHS Health Wisconsin 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 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, and Pediatrics. OB/GYNs may elect to be considered a primary care Provider or a specialist in the MHS Health network. To see a list of assigned members please visit our secure Provider portal on our website www.mhswi.com.

MHS Health Wisconsin expects that PCPs:

- Have a 24-hour answering service or a telephone recording instructing members 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 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.
- Ensure that patients over the age of 18 years 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/Health Check	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

MHS Health Wisconsin mails new members (and individuals who have been members for 12 continuous months) a handbook which includes a Provider directory. The handbook encourages members to select a PCP and to inform MHS Health Wisconsin of their selection by:

- Completing and mailing a form located in the handbook packet, or
- Calling MHS Health Member Services.

If a new member does not make a selection within 30 days, MHS Health Wisconsin will assign that member to a Provider.

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

Changing a PCP

Plan members may change their PCP on request. When members call Member Services to change their PCP, they are told that the change will be effective on the first day of the following month, or upon 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 primary care Provider (PCP). The family planning Provider need not be contracted with MHS Health Wisconsin.

- 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 primary care Provider 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 Wisconsin or the Provider is out-of-plan.

Reassigning care of a member

A Provider may become unwilling to continue to serve as a primary care Provider for a member who repeatedly breaks appointments or repeatedly fails to arrive at appointments, is abusive (physically or verbally) to the Provider or the 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 Member Services for help selecting a new Provider.
6. A copy of the letter should be sent to MHS.
7. A copy of the letter should be kept in the patient chart.

Advance directives

Wisconsin law allows persons 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/healthcare 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 Wisconsin requires contracted Providers to document in medical records whether or not their patients who are MHS/NHP 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 contact documents that on an Advance Directive Label or Declaration Sheet and includes in the member's medical record.
- MHS Member Services 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 downloading at www.mhswi.com.

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

MHS Health Wisconsin Providers should refer to his/her MHS Health 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 Wisconsin 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 situation. 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 (5) 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 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

Hospital responsibilities

Inpatient facilities are required to notify MHS Health Wisconsin 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.

Notification timelines are*:	
Emergent and urgent admissions	within two business days following the 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 Wisconsin Medical Services *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 8:00 a.m. to 7:00 p.m., Monday – Friday. For Medical Services on the MHS Health Wisconsin Provider Inquiry Line call the number at right and when prompted say "authorization request" and then "inpatient admissions".

Provider Inquiry Line
1-800-222-9831

After hours, weekends and holidays

After hours, callers are given the option to call the MHS 24-hour nurse advice line: NurseWise®, 1-800-280-2348

Cooperation with Quality Improvement (QI) Program

MHS Health Wisconsin requires Providers and Practitioners to cooperate with all QI activities. Contracted Providers and Practitioners are required to participate in an after-hours care survey that is conducted annually to ensure members receive appropriate after-hours care from our primary care Practitioner network. MHS Health Wisconsin partners with Providers and Practitioners to gather performance data to ensure the success of the QI Program. This program is outlined in *Section 3 Quality Improvement Program* in more detail.

Billing members

Wisconsin Medicaid prohibits MHS Health Wisconsin, its clinicians, and subcontractors from billing a member for medically necessary services covered under the Wisconsin Medical Assistance and SSI programs and 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 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
    - the amount for which the member will be responsible

The standard Consent for Treatment release form 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 competency

Cultural Competency within the MHS Health Wisconsin 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 Wisconsin 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 Wisconsin provides access to training and tool kits to assist our network Providers in developing culturally competent and culturally proficient practices.

Resources

Please see our Provider website (www.mhswi.com) 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 Wisconsin will pay for the services. (Instruct interpreters to bill MHS Health Wisconsin). A list of professional interpreter service Providers is available on our website. Family members and friends are not the same as a professional interpreter; they are more likely to modify what the patient has actually said in their effort to be helpful. Therefore, we recommend 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 1-608-266-5817 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 the age of 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 or to the 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 Wisconsin Member Services 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 Member Services at 1-888-713-6180 for a listing of the domestic abuse agencies in your area.

Medicaid fraud and abuse
MHS Health Wisconsin 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.

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

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 payor 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 as 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 Wisconsin Compliance Officer at 1-800-222-9831.

Section 4 Quality Improvement Program

The MHS Health Wisconsin Quality Improvement (QI) Program is a comprehensive effort to protect, maintain and improve the quality of care provided to our BadgerCare Plus, Medicaid SSI, Medicare Advantage and Ambetter commercial 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 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 quality improvement director, and the MHS Health Quality Improvement Committee (QIC). A 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, Pap test rates, Health Check rates)
- Utilization management
- Compliance with preventive health and practice guidelines
- Compliance with all applicable regulatory and accreditation agency rules, regulations and standards, as well as State and federal laws.
- HEDIS data reporting

Clinician participation in quality initiatives
Clinician participation is an important component of the MHS Health QI Program. 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 Services Department. Call the MHS Health Provider Inquiry Line at 1-800-222-9831 and when prompted say “something else”. This will connect you to the Provider Services Department.

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 MHS Health/Network Health Plan members. The committee reviews, evaluates, and approves the QI Program and recommends interventions and improvements.

Meetings are scheduled five times annually. Membership includes health plan management, network clinicians 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 clinicians 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 clinicians 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 the Wisconsin Department of Health Services (DHS) guidelines. The SIU Committee includes representation from both MHS 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 Wisconsin 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 the 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
Data analysts identify diabetic members considered to be at high risk for the onset of complications. RN coordinators mail the members reminders to have a retinal eye exam and to have their HbA1c levels checked and their kidney function monitored.
A link to national web-based clinical practice guidelines is on the MHS website.

Health Check
Through Health Check, 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. Health Checks promote a comprehensive child health program of prevention and treatment.

- MHS Health mails reminders and/or calls members in need of a Health Check and informs them of the benefits of prevention and the health services and assistance available.

You may obtain a copy of Health Check age-specific forms by accessing the MHS Health website or by calling the MHS Health Provider Inquiry Line. See *Section 8 Health Check Section* for more information.

Immunization reminder program
The MHS Health immunization program was developed in an effort 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 approaching nine and 21 months of age are sent a reminder mailing and/or an outreach call to make an appointment with their doctor for any needed immunizations.

- Yearly, primary care physicians receive the current immunization and catch-up schedules and information on the Wisconsin Immunization Registry. 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 StartSmart® For Your Baby program.
- Articles related to immunizations for older children appear in both member and Provider newsletters. 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 MHS Health website.

Pregnancy and depression program
MHS Health partners with our behavioral health vendor, Cenpatico, to improve members' 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 packet that includes a brochure about pregnancy and depression. The information includes the Cenpatico 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 Cenpatico behavioral health care 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 Cenpatico if they feel they need help.
- Members receive a postpartum depression brochure and the Edinburgh screening survey after delivery.

See MHS Health Clinical Practice Guidelines, Management of Pregnancy, Preconception and Prenatal Care, on the MHS Health website.

Pregnant women and tobacco use
MHS Health Wisconsin 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.

Smoking cessation program
MHS Health identifies members who are smokers and provides outreach to those who have indicated a desire to quit smoking via the following efforts:

- New members receive a mailing packet outlining the MHS Health Smoking Cessation Program, listing resources and providing direction for a quit attempt.
- Pregnant and postpartum smokers are directed to the First Breath Program.
- Articles in member and Provider newsletters.

- Members are encouraged to contact the Wisconsin Tobacco QUIT LINE
  - 1-800 QUIT NOW or 1-800-784-8669
  - Spanish – 1-877-2NO-FUME or 1-877-266-3863
  - TTY for hearing impaired 1-877-77-6534
  - www.ctri.wisc.edu/quitline.html
- Resources for members and Providers are offered on the MHS Health website: www.mhswi.com
- MHS Health offers coverage for office visits and counseling sessions related to smoking cessation. There is enhanced reimbursement for coding smoking and tobacco cessation counseling. These services are covered when billed with diagnosis code 305.1 (tobacco use disorder) as a primary, secondary, third, or fourth diagnosis and a valid CPT code:
  - 99406 smoking and tobacco cessation counseling visit; intermediate, greater than three minutes up to 10 minutes.
  - 99407 smoking and tobacco cessation counseling visit; intensive, greater than 10 minutes.

Childhood obesity

MHS Health has a program to increase both Practitioners' and members' awareness of the problem of childhood obesity and the need to be screened annually.

- Practitioners should screen children annually for childhood obesity and document the BMI percentile in the medical record.
- Prior to 10/1/2015, BMI screening should be billed using ICD-9 code V85.51 - V85.54 as a secondary diagnosis. CPT code 3008F should be used to indicate the screening has been done and again V85.51–V85.54 should be used as a secondary diagnosis. Screening is reimbursable when billed correctly. After 10/1/2015 the State designated ICD-10 codes should be used to indicate the BMI screening.
- Health education sheets on healthy eating are available on the MHS Health website under Patient Health Education, (H) Health.

Other mailed reminder topics:

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

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.

Ambulatory medical records requirements

General standards
The following commonly accepted standards for medical record documentation are adopted from the National Committee for Quality Assurance (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.

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

- Treatment
- Payment (claims)
- MHS Health operations

Medical records transfer for new patients
Physicians 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.

Medical records audits
As part of the re-credentialing process, MHS Health audits the medical records of PCPs with more than 100 assigned plan members. The Provider agrees to allow representatives of MHS Health timely access to office sites and/or provide copies of medical records, in accordance with the BadgerCare Plus and Medicaid SSI MCO contract.

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.

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 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 will be reported to a MHS Quality Improvement Committee 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/Performance Improvement Programs as required in the BadgerCare Plus and Medicaid SSI MCO contract.

Please visit the Provider section of our website at www.mhswi.com 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.

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, Medicaid SSI and Core recipients receive a **Forward Health** 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
- Commercial eligibility verification vendors (accessed through software, magnetic stripe card readers, and the Internet)
- 270/271 Health Care 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 and Network Health Plan enrollment

- Visit the MHS Health website at www.MHSwi.com. This is a secure password-protected site.
- Call the MHS Health Provider Inquiry Line: 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, the MHS Health's parent organization. For more information on conducting these transactions electronically, call the MHS Health Provider Inquiry Line.

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 the 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.

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

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 right away.

Wisconsin Medicaid 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.

NurseWise®
When MHS Health and Network Health Plan members have healthcare questions and cannot reach their PCP, they can call our NurseWise® nurse advice line at 1-800-280-2348. TDD/TTY for the hearing impaired: 1-888-780-7155. NurseWise® is a 24-hour nurse information line available to your patients who are MHS Health/Network Health Plan members. MHS Health provides NurseWise® to support your practice and to offer plan members access to a nurse every day (24/7). If you have questions, please call the MHS Health Provider Inquiry Line or NurseWise®.

NurseWise® 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
NurseWise® 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.

Transportation
Additional details regarding transportation services can be found in *Section 15 Transportation*. Members enrolled in the State of Wisconsin's Medicaid program will be required to contact Medical Transportation Management, Inc. (MTM, Inc.) for transportation rides throughout the State.

- MTM, Inc. Reservation Line 1-866-907-1493 (voice) or 1-866-288-3133 (TTY)
- "Where's My Ride" 1-866-907-1494
- "We Care" For complaints 1-866-436-0457
- MTM Inc. Web site *www.mtm-inc.net/wisconsin/

*Use this website 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.

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

Emergency transportation

- 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 and NHP Medicaid SSI and BadgerCare Plus members have the following benefits:

Services	Standard & SSI Plan	MHS / NHP Co pay
*Medication	State drug list	*$.50 - $3
Physician visits	Full coverage	MHS/NHP covers
Inpatient hospital	Full coverage	MHS/NHP covers
Outpatient hospital	Full coverage	MHS/NHP covers
Emergency room	Full coverage	MHS/NHP covers
Nursing home	Full coverage	MHS/NHP covers
Physical therapy	Full coverage	MHS/NHP covers
Home health	Full coverage	MHS/NHP covers
Medical equipment	Full coverage	MHS/NHP covers
Medical supplies	Full coverage	MHS/NHP covers
*Transportation	Routine to & from covered services	Full coverage
Ambulance	Full Coverage	MHS/NHP covers
*Dental	Preventive, restorative, palliative	*$1 -3
Vision	One exam & glasses per year	MHS/NHP covers
added vision	$100 allowance for better frames or $ 80 toward contact lenses	MHS/NHP covers
Hearing	Full coverage	MHS/NHP covers
Hospice	Full coverage	No copay
Family planning	Full coverage	No copay
*Chiropractor	Full coverage	*$3
Podiatrist	Full coverage	MHS/NHP covers
Mental health	Outpatient – full coverage. Inpatient stays for age 22-64 in institutional settings are not covered.	MHS/NHP covers
Health education	MHS added benefit	Asthma, diabetes, hypertension

*Depending on the member's county of residence, the dental benefit may be provided by MHS Health, NHP or by the State. 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.

Medically necessary covered services

- Provider services, including those of physician, nurse, advanced nurse Practitioners, physician assistants and nurse midwives
- Inpatient and outpatient hospital services
- Family planning services and supplies
- Health Checks 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. The following counties are included: 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 member services 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 please 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 this is a "dental emergency."

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

- Call our Member Services (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 NurseWise®, our 24-hour nurse advice line at (800) 280-2348 or for TDD/TTY at (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.

Behavioral health
MHS provides plan members with treatment for mental health and substance abuse (alcohol and other drugs). A referral is not required; members must call Cenpatico at 1-800-589-3186 for an appointment at a clinic in their area. (TDD/TTY for the hearing impaired at 1-866-739-3424).

Vision services
MHS Health provides MHS Health/Network Health Plan 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 Doctor Search/Provider Directory page of the MHS Health website. For help selecting a Provider, members may call OptiCare Managed 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:

- 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 Health Check

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 Health Check.

The State requires health plans to assure that 80 percent of their Medicaid members under age 21 have an age-specific number of Health Check screenings each year.

What is a Health Check?
Health Checks promote a comprehensive child health program of prevention and treatment. Health plans like MHS Health seek out 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 Health Check 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 Health Check, 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.

Health Check Screening Guidelines (periodicity table) are found on page 30 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 Health Checks
Through Health Check, 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 Health Check 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 Health Checks

- Physician assistants and nurse Practitioners who perform Health Check 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.
- Health Check examinations must be billed using the appropriate CPT code for the age of the child.
- Bill for immunizations given during Health Check or routine office visits (they're not included as part of the Health Check reimbursement).
- Use the appropriate CPT code for the specific vaccine given
- Be advised vaccine administration is not reimbursed

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

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 Health Check 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 Health Check screen does not result in a referral for further evaluation or treatment, Providers should only indicate the appropriate procedure code, not the modifier.

Health Check screening guidelines (periodicity table)

m = Month y = Year

	Infancy							Early Childhood						Late Childhood						Adolescence			
	Birth	1m	2m	4m	6m	9m	12m	15m	18m	24m	30m	2y	3y	4y	5y	6-7y	8-9y	10-11y	12-13y	14-15y	16-17y	18-19y	20-21y
1. Health, Nutritional and Developmental Assessment																							
A. History	■		■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
B. Develop/ Behavioral Assessment	■		■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
C. Health Ed/ Anticipatory Guidance	■		■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
2. Physical Assessment																							
A. Measurements																							
Height/ Weight	■		■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
Head Circum	■		■	■	■	■	■	■	■	■	■												
Blood Pressure													■	■	■	■	■	■	■	■	■	■	■
B. Unclothed Phys Exam	■		■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
C. Sensory																							
Vision	■		■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
Hearing	■		■	■	■	■	■	■	■	■	■	■	■	■	■	■			■		■		
D. Dental												■	■	■	■	■	■	■	■	■	■	■	■
3. Immunizations (based on 2015 CDC schedule)																							
	Infancy							Early Childhood						Late Childhood						Adolescence			
	Birth	1m	2m	4m	6m	9m	12m	15m	18m	24m	30m	2y	3y	4y	5y	6-7y	8-9y	10-11y	12-13y	14-15y	16-17y	18-19y	20-21y
HepB	1st Dose	2nd Dose			3rd Dose																		
Rotavirus (2 or 3* Dose series)			1st Dose	2nd Dose	3rd Dose																		
DTaP			1st Dose	2nd Dose	3rd Dose			4th Dose						5th Dose									
Tdap																		Tdap					
Hib			1st Dose	2nd Dose																			
Pneumo-coccal			1st Dose	2nd Dose	3rd Dose		4th Dose																
IPV			1st Dose	2nd Dose	3rd Dose									4th Dose									
Influenza (2 doses for some)			Annual Vaccination (1 or 2 doses)							Annual Vaccination (1 or 2 doses)							Annual Vaccination (1 dose only)						
MMR							1st Dose							2nd Dose									
Varicella							1st Dose							2nd Dose									
HepA							1st Dose (initiate 12-23 months)					2nd Dose (6-18 months after the first dose)											
HPV2 (female)																			3 dose series				
HPV4 (male)																							
Meningo-coccal																			1st Dose		Booster 16 Y		
4. Procedures																							
Blood Level Test							1st Test			2nd Test													
HIV	As indicated																						
Tuberculin	As indicated																						
Urinalysis	As indicated																						

Section 10 Medical Management

MHS Health Wisconsin's Medical Management Department hours of operation are Monday through Friday (excluding holidays) from 8:00 a.m. to 5:00 p.m.

Provider Inquiry Line
1-800-222-9831

Medical 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.
- Something else (Network Development and Contracting).

"We make office calls"

- Staff is available at least eight hours a day during normal business hours for inbound collect or toll-free calls regarding UM issues.
- Staff can receive inbound communication regarding UM issues after normal business hours.
- 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
Pregnancy Notification	1-866-681-5125 681-3668

After hours, weekends and holidays

After hours you will have the option of contacting the MHS Health 24-hour nurse advice line; NurseWise® 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 NurseWise® 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 Plan (NHP) members to call Member Services at 1-888-713-6180.

Behavioral Health Call Cenpatico at 1-800-589-3186

Pharmacy benefit

This benefit is generally covered by the State of Wisconsin under the Medicaid fee-for-service program. Prescription drugs, radiopharmaceuticals, injectable biopharmaceuticals and other injectables administered in a home health, MD office, skilled nursing, and most outpatient settings should be billed to Medicaid fee-for-service. For assistance in determining the State's responsibility versus MHS, please call the MHS Health Provider Inquiry Line (shown above), and when prompted, say "benefits."

Referring MHS Health and NHP members

The primary care physician (PCP) should coordinate healthcare services for MHS Health /NHP members. PCPs should refer members 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, 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 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 prior to 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.

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 and telephone 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.

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 will 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 Wisconsin Department of Health Services (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 in making adverse medical necessity determinations by contacting the MHS Health Provider Inquiry Line.

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 seventy-two (72) hours of receipt of request.

Authorization requirements
Network Providers receive an MHS Health Quick Reference Guide listing service authorization requirements. This list is subject to periodic updates. Providers will be notified in writing of any changes.

Providers should reference our website or call MHS Health if they're unclear whether a service requires prior authorization. Prior authorization is not required for emergency care, family planning services, preventive services or basic prenatal care.

Services requiring prior authorization
Call Medical Services on the MHS Health Provider Inquiry Line and when prompted say, “authorization request.”

•	Procedures and services performed by out- of-plan Providers	•	Obstetrical Ultrasound (two allowed in 9-month period, any additional will require authorization, with exception of those ordered by perinatologists)
•	Abortions (must include required consent and special criteria)		
•	Bariatric surgery		
•	Blepharoplasty		
•	Botox injection	•	Oral surgery—TMJ surgeries
•	Capsule endoscopy	•	Otoplasty
•	Cardiac imaging-MRI/CT/PET scans	•	Pain management: all invasive measures
•	Cochlear implants	•	Reconstructive/plastic surgery (except breast reconstruction after mastectomy)
•	Court-ordered services		
•	Experimental or Investigational	•	Rhinoplasty / septoplasty
•	General anesthesia for dental procedures age 5 years and older	•	Scar revisions / keloid / excisions
•	Hysterosalpingography	•	Spine surgery, including disc replacement
•	Infertility procedures	•	Ultraviolet (UV) therapy
•	Implantable devices	•	Varicose vein procedures
•	Mammoplasty		
•	Neuropsychological testing	•	Viscosupplementation

Inpatient authorization
- All planned/emergency hospital admissions – in plan and out of plan
- All services performed in out of plan facilities
- Hospice
- Newborn deliveries (by the next business day)
- Rehabilitation facility admissions
- Skilled nursing facility admissions
- Transplants, including evaluations

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)
    - Occupational –required after initial six visits
    - Physical—required after initial six visits
    - Speech—after initial evaluation
- Podiatry (after three visits)
- Home care services including
    - Skilled nursing visits
    - Infusion therapy
    - Hospice
    - 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 co morbid 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 which have 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 1-608-266-8276.

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 years, nine months a child must be referred to his or her local public school system for evaluation.

- At age three, 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 visits for PT and OT by an in-plan therapist. No auth is needed for an initial ST evaluation by an in-plan therapist. In-plan MHS 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 and over (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 /NHP 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 or NHP 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 or NHP 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.*

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 Health Checks 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.

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 on-line 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. 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 1-800-222-9831. When prompted say "authorization request" and when asked which services you are calling about, say "inpatient admissions."

Notification timelines are*:	
Emergent and urgent admissions	within two business days following the 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.

Concurrent review
MHS Health Medical Management will concurrently review the treatment and status of all members who are inpatient through on-site 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.

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 State of Wisconsin Division of Health Services (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.

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 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 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.

Medical case management

Medical 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 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.

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 policies and standards regarding its ethical framework for case management, are available to:

- Staff
- MHS Health /NHP 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 treatment plan.
6. Evaluation of community resources and available benefits needed to meet the member's health care 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 health care 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.

Providers may refer MHS Health /NHP members for case management services by contacting MHS Health Medical Management or by using the MHS Health Care 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 1-800-222-9831, when prompted say, "authorization request" and the next prompt say, "case manager."

Maternal and infant case management programs
Please refer to the MHS Health Pregnancy Notification Form on the MHS website under Provider Medical Forms. Providers may also submit notifications on-line 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 CentAccount 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 /NHP members to case management, please call the MHS Health Maternal/Infant Program at (800) 496-5803. Members may also self-refer.

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.

Healthy Solutions for Life is a disease management program that targets MHS Health members with these conditions. The programs provide an assessment of the member's knowledge of their condition, educational materials, and consultation with the member's physician, telephonic outreach and support services, and home visits, as indicated, for high-risk members.

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.

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.

Call 1-800-905-6989 to refer MHS Health and NHP members to *Healthy Solutions for Life*. This program is part of MHS Health Wisconsin's disease management program. Disease management 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. 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

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

- Telephone outreach
    - Connections representatives call members who are in need of Health Checks, immunizations, screenings, mammograms, and other preventative appointments. Representatives provide reminders, help find physicians, and assist in scheduling.
- Home visits
    - Connections representatives conduct home visits to complete health risk assessments, explain benefits, and to establish contact with members who have no telephone access.
- Events
    - Connections representatives attend community events to educate members about good health practices. Representatives also host events exclusively for MHS Health members such as health fairs and educational events for pregnant women and new mothers.

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 health risks who do not have access to a phone.

To request a home visit call MHS Health MemberConnections at (888) 713-6180. When prompted say, "something else" and when transferred, ask for "MemberConnections."

New technology
Though 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.

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

Provider Inquiry Line
1-800-222-9831

Section 11 Pharmacy Benefit

The pharmacy benefit for BadgerCare Plus and Medicaid SSI members eligible with MHS Health Wisconsin (MHS) and Network Health Plan (NHP) is managed directly by the Wisconsin Department of Health Services (DHS). All prior authorizations for pharmacy benefits should be directed to the state. The state has developed a Preferred Drug List (PDL). It and current updates can be viewed on their website at http://dhfs.wisconsin.gov/medicaid/pharmacy/pdl/index.htm

Providers with questions can call:

- DHS Provider Services at 1-800-947-9627
- DHS Recipient Call Center at 1-800-362-3002.
- STAT-PA — 1-800-947-1197 (for prior authorizations)
- STAT-PA Help Desk — 1-800-947-1197, press "0"

For billing of oral and injectable therapy, injectable medication administered in MD offices and dialysis clinics please refer to Forward Health Update #2014-79, or any updates that follow on the ForwardHealth website.

Pharmacy appeals and grievances

State-administered benefit

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. An emergency supply can help to bridge the gap between prescription and authorization.

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. Most medications fall under DHS Pharmacy benefits.

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 Wisconsin (MHS Health) for the provision of covered medical services to BadgerCare Plus and SSI members of MHS Health and Network Health Plan (MHS/NHP).

Claims (invoices) submitted to MHS Health are processed in Farmington, Missouri. Payment is issued from Centene Corporation, St. Louis, Missouri. MHS 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 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 the State and Centers for Medicare and Medicaid Services (CMS) guidelines for the appropriate list of current valid codes.

Definitions

Clean claims are claims submitted for payment:

- within an identified time limit,
- in the required format, and
- Do not require MHS Health to investigate, develop or acquire additional information from the Provider or other external sources.

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

Claim submission

Accurate billing information is important
Provide MHS Health with accurate billing information to assure the timely processing of your claims including but not limited to:

- Provider name (as listed on Provider's current W-9 form)
- Provider's NPI number
- Provider's physical location address
- Billing name and address, if different
- Provider's tax identification number (TIN)
- Taxonomy

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

Change notifications must be in writing. A copy of the MHS Health's Medical Practice Information Change Form is in the appendix pack in this manual. You can also obtain a copy by accessing the MHS Health Provider website or by calling the MHS Health Provider Inquiry Line.

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

The 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.
- Providers must submit a claim for every plan patient visit.
- Claims must be submitted on standard red and white forms, CMS-1500 HCFA 02/12 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 no accepted.
- Providers cannot bill plan members for covered services.
- 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:
  (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 (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 60 days of the date on the EOP.

When payment cannot be made

- The patient was not an MHS Health /NHP 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.
- 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 9-digit zip code of the service location.
- Use POA indicators consistent with State of Wisconsin guidelines.
- Bill partial claims prior to discharge for intervals of no less than 60 days.

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.
- Don't use red ink.
- 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.

Where to submit a paper claim

Medicaid - Submit all paper claims, except those for services listed as "carve outs" (e.g., routine dental services, routine vision exams, 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:

Dental Health & Wellness
PO Box 46
Milwaukee, WI 53201

Vision - Submit claims to:

OptiCare
MHS Health Wisconsin or Network Health Plan
PO Box 7548
Rocky Mount, NC 27804

Behavioral health - submit claims to:

Cenpatico Wisconsin Claims
PO Box 6123
Farmington, MO 63640

Claim rejection vs. denial

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

Claim records that do not pass these "up front" 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

Submitting claims electronically (EDI)

Electronic Data Interchange (EDI) allows faster, more efficient and cost-effective claim submission for Providers. Performed in accordance with nationally recognized standards, EDI supports the health care 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 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/Centene.
- The Provider must confirm with their vendor the accurate location of the MHS Provider ID number.

Direct questions about submitting claims electronically to: MHS/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/Centene receives all EDI claims through a clearinghouse.
- The clearinghouse validates received claims against their proprietary specifications and MHS/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/Centene.
    - Accepted claims are transmitted to MHS/Centene, and the clearinghouse sends an acceptance report to the sender immediately.
- Claims sent to MHS/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 acknowledgements 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/Centene edits are invalid and will be rejected without being recognized as received by MHS/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 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 to check status of the claim.

Vendor issues

Since the clearinghouse returns acceptance/rejection reports directly to the sender, MHS/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: The NPI number should be submitted in the ANSI X12, 005010X223, 837I in loops:

2010AA	Billing Provider
2010AB	Pay-to-provider
2310A	Attending Physician
2310B	Operating Physician
2310C	Other provider
2310F	Referring provider
2310E	Service Facility Name
2420D	Referring Provider
2420A	Attending Physician
2420B	Operating Physician

If any of the above loops are used, the following segments are required in each loop:

- NM108/09, NM108 (qualifier) XX, NM109 = Provider NPI number

- REF segment with REF01= EI, REF02 = Tax ID
- 2000A in element PRV02 = PXC (qualifier) and in element PRV03 = Provider Taxonomy Code

The Billing Provider's 9-digit zip code is required in the 2010AA loop.

837 Professional: The NPI number should be submitted in the ANSI X12, 004010X098A1, 837P in loops

2010AA	Billing Provider
2010AB	Pay-to-provider
2310A	Referring Provider
2310B	Rendering Provider
2310C	Service Facility Location
2310D	Supervising Provider
2420C	Service Facility Location
2420D	Supervising Provider
2420F	Referring Provider
2420A	Rendering Provider
2420B	Purchased Service Provider
2420E	Ordering Provider

- M108/09, NM108 (qualifier) XX, NM109 = Provider NPI number
- REF segment with REF01= EI, REF02 = Tax ID
- PRV02 = PXC (qualifier) and PRV03 = Provider Taxonomy Code
- The Billing Provider's 9-digit zip code is required in the 2010AA loop

Please note, usage of the PRV segment (Taxonomy Code) does not apply to loops 2310C, 2310DC, 2310E, 2420B, 2420C, 2420D, 2420E

Atypical Providers – are not required to have an NPI number. However, if an atypical Provider has been assigned a NPI number and attested that number to the state, they need to follow the same requirements as typical Providers. Atypical Providers need to only send the following segment in each loop listed in the 837 Professional sections.

- NM108/09, NM108 (qualifier) 24, NM109 = Provider Tax ID
- REF 1D = Medicaid number or Health Plan Identifier

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/Centene

Invalid electronic claim records, common plan rejections (EDI edits within the claim system) and a listing of all EDI denial codes is 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 Audit Reports	Contact MHS/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 Provider Inquiry Line at 1-800-222-9831, when prompted say, “Claims information”.
To update or verify Provider information (e.g. payee, UPIN, or tax ID numbers or payment address information)	Call the MHS 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.
3. Inquiry with the clearinghouse what data records are required.
4. Verify with Provider Relations at MHS that the Provider is set up in the MHS 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 and those claims not meeting the clearinghouse requirements. The second report will be a claim status report showing claims accepted and rejected by MHS. 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.

Excluded Claim Categories

- Claims requiring supportive documentation or attachments such as COB claims with a primary insurer’s EOB
- Claims billing with miscellaneous codes
- Claims for medical, administrative or claim appeals
- Claims requiring documentation of the receipt of an informed consent form
- Claims for services that are reimbursed based on purchase price (e.g. custom DME, prosthetics)
- Claims for services requiring clinical review (e.g. complicated or unusual procedure)
- Claims for services needing documentation and requiring Certificate of Medical Necessity (e.g. oxygen, motorized wheelchairs)

Please 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.

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 Wisconsin 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 offers Providers the option of submitting first time and COB claims via our Provider portal. To access this function, 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 payor 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 /NHP members who have other insurance, Providers must attach a copy of the payment/denial/rejection letter or the EOP (which includes the explanation code) from the other (primary) insurance carrier. Claims submitted without this information will be denied by MHS Health.

The information must be received by MHS Health within 90 days of the date on the primary carrier's EOP or letter or as defined in your MHS Health contract.

Claims with Managed Health Services Advantage and MHS Health 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 payor, the secondary payor, generally, is responsible for payment of coinsurance and deductible amounts up to the primary payor's allowable, but not to exceed the secondary payor's allowable. If primary payor paid 100 percent of their allowed amount, no additional payment will be due from MHS Health.

When MHS Health is the secondary payor and the Provider has followed the above process, MHS Health will pay the difference between the actual amount paid by the primary payor 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 payor. This includes instances where Medicare is the primary payor source.

1. Amount charged by Provider $2000			
Amount allowed by primary payor, based on contractual obligation with Provider	$1,000	Amount allowed by secondary payor, 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 payor	$550		
Amount paid to Provider by primary payor (allowable less deductible)	$450	Amount paid to Provider by secondary payor	$0
Adjudication. The secondary payor, MHS, pays $0. The amount paid by the primary payor ($450) is greater than the MHS allowable amount ($400). The member cannot be billed.			
2. Amount charged by Provider $2,000			
Amount allowed by primary payor, based on contractual obligation with Provider	$1,000	Amount allowed by secondary payor, 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 payor	$550		
Amount paid to Provider by primary payor	$450	Amount paid to Provider by secondary payor	$350
Adjudication. The secondary payor, MHS Health, pays $350, the difference between the amount the primary payor 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 payor, based on contractual obligation with Provider	$1,000	Amount allowed by secondary payor, 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 payor	$550		

Amount paid to Provider by primary payor	$450	Amount paid to Provider by secondary payor	$550
Adjudication The secondary payor, MHS Health, pays $550, the difference between what the primary payor 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

    PO 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.

Claim payment
All clean paper claims will be adjudicated (finalized as paid or denied) within 30 days of the receipt of the claim. All clean electronically transmitted claims (EDI) will be adjudicated within 21 days of receipt of the electronic claim. Please note that there may be an additional fee for processing paper claims which is consistent with the State of Wisconsin.

Each claim payment check will be accompanied by an Explanation of Payment (EOP). An EOP itemizes charges for that reimbursement and the amount of the check from MHS Health.

Unsatisfactory claim payment
Please see *Section 12 Provider Complaints, Grievances and Appeals Section* for more information.
Provider Services representatives are available to discuss claims payment, denial, or status of a claim. Providers can contact us on the MHS Health Provider Inquiry Line at 1-800-222-9831, when prompted say, "claim information", and your call will be transferred to a Provider services representative.

Providers may also submit a written request for consideration of additional reimbursement. The request must include the Explanation of Payment (EOP) and all other necessary documentation within 90 days of the date of the EOP or as defined in your MHS Health contract.

When submitting corrected claims, claims should be free of handwritten verbiage and submitted on a standard red and white UB-04 or HCFA 1500 claim form along with the original EOP. Any UB-04 or HCFA 1500 forms received that do not meet the CMS printing requirements, will be rejected back to the Provider or facility upon receipt.

In addition to submitting corrected claims on a standard red and white form, the previous claim number should be referenced in field 64 of the UB-04 and 22 of the HCFA 1500 as outlined in the NUCC guidelines. The appropriate frequency code/resubmission code should also be billed in field 4 of the UB-04 and 22 of the HCFA 1500. 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.

All disputed claims will be processed in compliance with the claims payment resolution procedure as described in *Provider Complaints, Grievances and Appeals Section* of this manual.

Any response to approved adjustments will be provided by way of check with accompanying EOP.

Completing a CMS 1500 claim form

HEALTH INSURANCE CLAIM FORM

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

PICA

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.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

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

Completing a CMS 1500 claim form
Claims for all professional services must be submitted on a CMS 1500 red claim form.

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
The following describes the information fields of a CMS 1500 form:

- Capitalized and bold font will indicate the information requested in the field is required.
- An asterisk (*) next to capitalized and bold type indicates the information requested in the field is required if applicable.

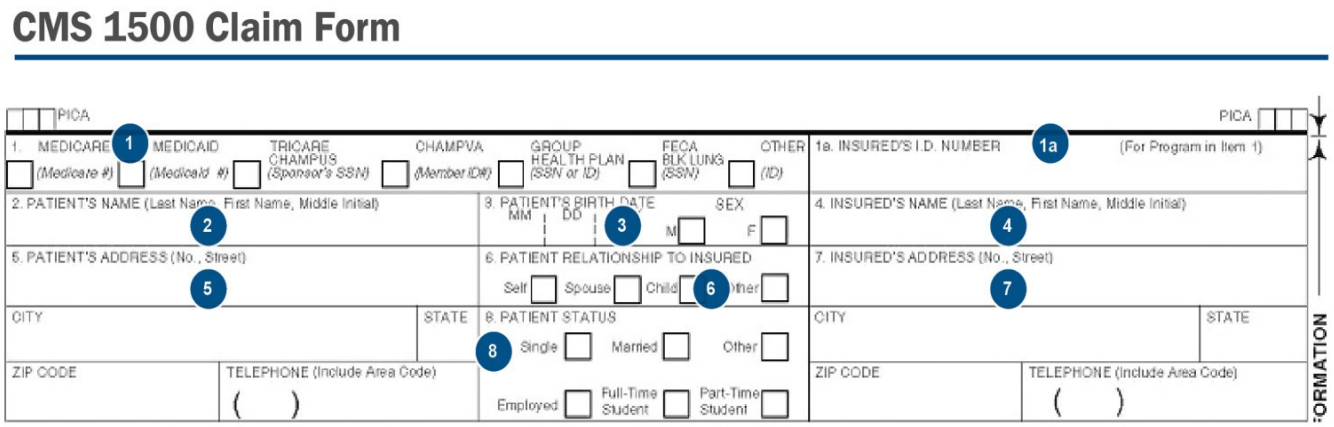
Failure to complete required fields may result in delayed or denied payment.

Claim form field requirements
The following charts describe the required fields that must be completed for the standard CMS 1500 or UB-04 red claim forms. If the field is required without exception, an “R” (Require) is noted in the “Required or Conditional” box. If completing the field is dependent upon certain circumstances, the requirement is listed as “C” (Conditional) and the relevant conditions are explained in the “Instructions and Comments” box.

The CMS 1500 claim form must be completed for all professional medical services, and the UB-04 claim form must be completed for all facility claims. All claims must be submitted within the required filing deadline of one year from the date of service.

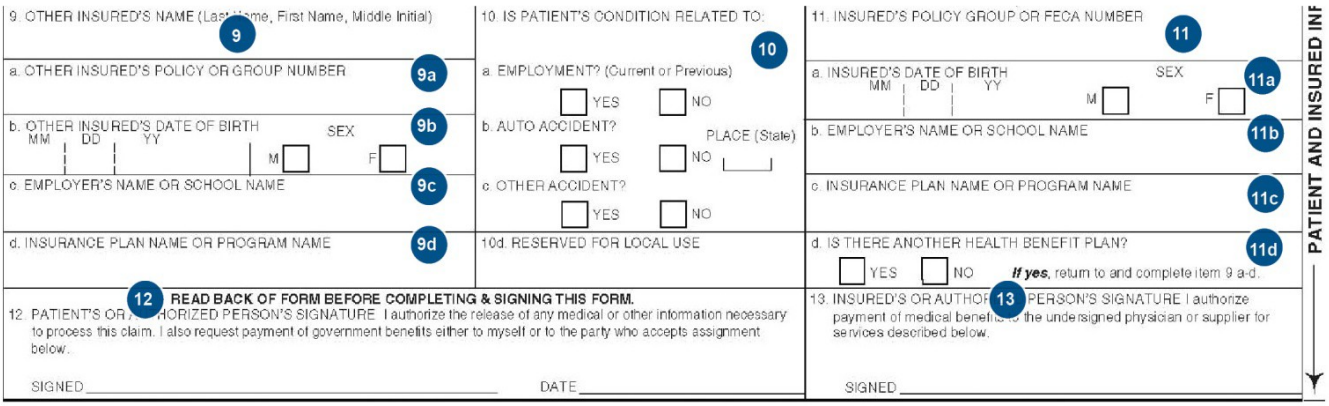
Although the following examples of claim filing requirements refer to paper claim forms, claim data requirements apply to all claim submissions, regardless of the method of submission (electronic or paper).

CMS 1500 (2/12) red claim form instructions
Please note: Claims with missing or invalid required (R) field information will be rejected or denied.



FIELD #	FIELD DESCRIPTION	INSTRUCTION OR COMMENTS	REQUIRED OR CONDITIONAL
1	Insurance Program Identification	Check only the type of health coverage applicable to the claim. This field indicates the payor to whom the claim is being filed. Select "D", other.	Not Required
1a	INSURED I.D. NUMBER	The 10-digit Medicaid identification number on the member's ID card.	R
2	PATIENT'S NAME (Last, First, Middle)	Enter the patient's name as it appears on the member's ID card. Do not use nicknames.	R
3	PATIENT'S BIRTH DATE / SEX	Enter the patient's 8-digit date of birth (MM|DD|YYYY) and mark the appropriate box to indicate the patient's sex/gender.	R
4	INSURED'S NAME	Enter the patient's name as it appears on the members ID card.	R
5	PATIENT'S ADDRESS (number, street, city, state, ZIP code) Telephone (include area code)	Enter the patient's complete address and telephone number including area code on the appropriate line. First line – Enter the street address. Do not use commas, periods, or other punctuation in the address (e.g., 123 N in Street 101 instead of 123 N. Main Street, #101) Second line – In the designated block, enter the city and state. Third line – Enter the ZIP code and phone number. When entering a 9-digit ZIP code (ZIP +4 code), include the hyphen. Do not use a hyphen or space as a separator (803)5551414. Note: Patient's Telephone does not exist in the electronic 837 Professional 4010A1.	R
6	PATIENT'S RELATION TO INSURED	Always mark to indicate self.	C
7	INSURED'S ADDRESS (number, street, city, state, ZIP code) Telephone (include area code)	Enter the patient's complete address and telephone number including area code on the appropriate line. First line – Enter the street address. Do not use commas, periods, or other punctuation in the address (e.g., 123 N in Street 101 instead of 123 N. Main Street, #101) Second line – In the designated block, enter the city and state. Third line – Enter the ZIP code and phone number. When entering a 9-digit ZIP code (ZIP {+4 code), include the hyphen. Do not use a hyphen or space as a separator (803)5551414. Note: Patient's Telephone does not exist in the electronic 837 Professional 4010A1.	Not Required
8	PATIENT STATUS		Not Required

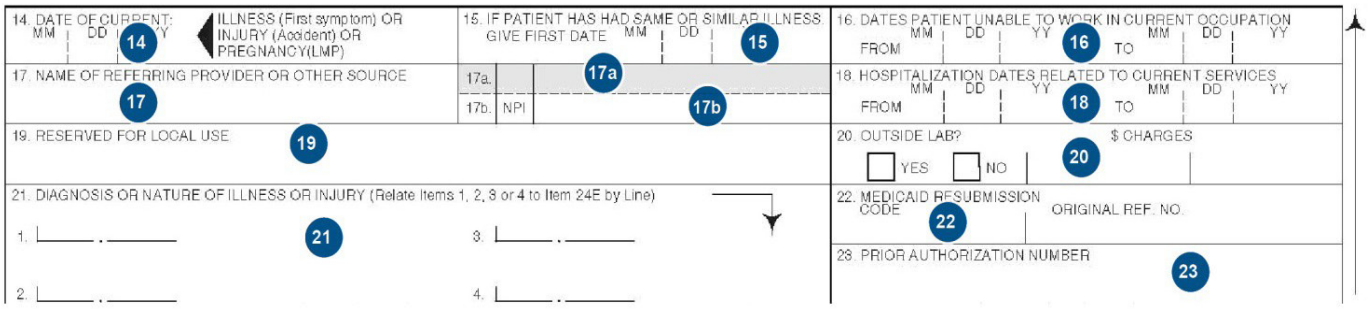
CMS 1500 Claim Form



FIELD #	FIELD DESCRIPTION	INSTRUCTION OR COMMENTS	REQUIRED OR CONDITIONAL
9	OTHER INSURED'S NAME (last, first, middle)	Refers to someone other than the patient. Required if patient is covered by another insurance plan. Enter the complete name of the insured. NOTE: COB claims that require attached EOBs must be submitted on paper.	C
9a	*OTHER INSURED'S POLICY OR GROUP NUMBER	Required if # 9 is completed. Enter the policy of group number of the other insurance plan.	C
9b	OTHER INSURED'S BIRTH DATE / SEX	Required if # 9 is completed. Enter the 8-digit date of birth (MM|DD|YYYY) and mark the appropriate box to indicate sex/gender. M = male F = female for the person listed in box 9.	C
9c	EMPLOYER'S NAME OR SCHOOL NAME	Enter the name of employer or school for the person listed in box 9. Note: Employer's name or school name does not exist in the electronic 837 Professional 4010A1.	C
9d	INSURANCE PLAN NAME OR PROGRAM NAME	Required if # 9 is completed. Enter the other insured's (name of person listed in box 9) insurance plan or program name.	C
10 a,b,c	IS PATIENT'S CONDITION RELATED TO:	Enter a Yes or No for each category/line (a, b, and c). Do not enter a Yes and No in the same category/line.	C
10d	RESERVED FOR LOCAL USE		Not Required
11	INSURED'S POLICY GROUP OR FECA NUMBER	Required when other insurance is available. Enter the policy, group, or FECA number of the other insurance.	C
11a	INSURED'S DATE OF BIRTH / SEX	Same as field 3.	C

FIELD #	FIELD DESCRIPTION	INSTRUCTION OR COMMENTS	REQUIRE OR CONDITIONAL
11b	EMPLOYER'S NAME OR SCHOOL NAME	Required if Employment is marked Yes in box 10a.	C
11c	INSURANCE PLAN NAME OR PROGRAM NAME	Enter name of the insurance health plan or program name.	C
11d	IS THERE ANOTHER HEALTH BENEFIT PLAN	Mark Yes or No. If Yes, complete # 9a-d and #11c.	R
12	PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE	Enter "Signature on File", "SOF", or the actual legal signature. The Provider must have the member's or legal guardian's signature on file or obtain their legal signature in this box for the release of information necessary to process and/or adjudicate the claim.	Not Required
13	PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE		Not Required

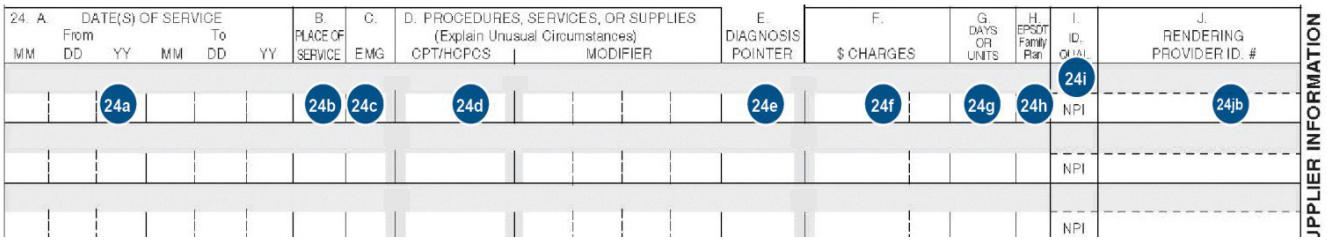
CMS 1500 Claim Form



FIELD #	FIELD DESCRIPTION	INSTRUCTION OR COMMENTS	REQUIRED OR CONDITIONAL
14	DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)	Enter the 6-digit (MM|DD|YY) or 8-digit (MM|DD|YYYY) date reflecting the first date of onset for the: Present illness Injury LMP (last menstrual period) if pregnant	C
15	IF PATIENT HAS SAME OR SIMILAR ILLNESS. GIVE FIRST DATE		Not Required

FIELD #	FIELD DESCRIPTION	INSTRUCTION OR COMMENTS	REQUIRED OR CONDITIONAL
16	DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION		Not Required
17	NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	Enter the name of the referring physician or professional (first name, middle initial, last name, and credentials).	Not Required
17a	ID NUMBER OF REFERRING PHYSICIAN	Required if 17 is completed. Use ZZ qualifier for taxonomy code.	C
17b	NPI NUMBER OF REFERRING PHYSICIAN	Required if 17 is completed. If unable to obtain Referring NPI, servicing NPI may be used.	C
18	HOSPITALIZATIO N DATES RELATED TO CURRENT SERVICES		Not Required
19	RESERVED FOR LOCAL USE		Not Required
20	OUTSIDE LAB / CHARGES		Not Required
21	DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3, OR 4 TO ITEM 24E BY LINE)	Enter the diagnosis or condition of the patient using the appropriate release/update of ICD-9-CM Volume 1 for the date of service. Diagnosis codes submitted must be a valid ICD-9 code or ICD-10 code when applicable for the date of service for the date of service and carried out to its highest digit – 4th or“5”. "E" codes are NOT acceptable as a primary diagnosis. NOTE: Claims missing or with invalid diagnosis codes will be denied for payment.	R
22	MEDICAID RESUBMISSION CODE / ORIGINAL REF.NO.	For re-submissions or adjustments, enter the 12-character DCN (document control number) of the original claim. A resubmitted claim MUST be marked using large bold print within the body of the claim form with “RESUBMISSION” to avoid denials for duplicate submission. NOTE: Re-submissions may NOT currently be submitted via EDI.	C
23	PRIOR AUTHORIZATION NUMBER	Enter the health plan authorization or referral number. Refer to the health plan Provider Manual for information on services requiring referral and/or prior authorization.	Not Required

CMS 1500 Claim Form

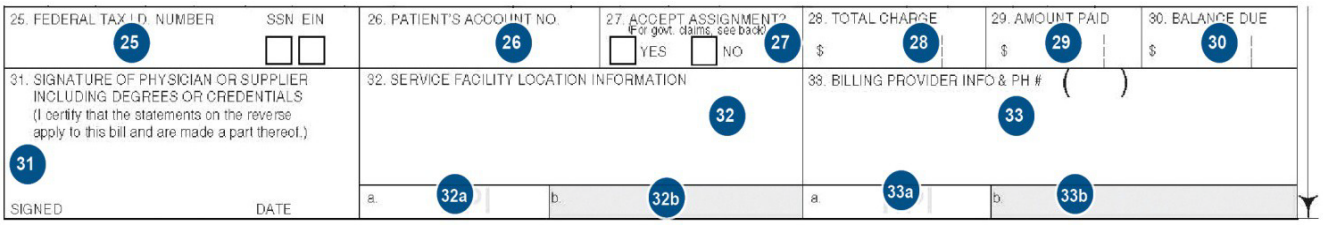


FIELD #	FIELD DESCRIPTION	INSTRUCTION OR COMMENTS	REQUIREDOR CONDITIONAL
24A-J General Information	Box 24 contains 6 claim lines. Each claim line is split horizontally into shaded and unshaded areas. Within each unshaded area of a claim line there are 10 individual fields labeled A-J. Within each shaded area of a claim line there are four individual fields labeled 24A-24G, 24H, 24J and 24J. Fields 24A through 24G are a continuous field for the entry of supplemental information. Instructions are provided for shaded and unshaded fields.		
	The shaded area for a claim line is to accommodate the submission of supplemental information, EPSDT qualifier, Provider NPI, and Provider Medicaid Number.		
	Shaded boxes a-g is for line item supplemental information and is a continuous line that accepts up to 61 characters. Refer to the instructions listed below and in Appendix 4 for information on how to complete.		
	The un-shaded area of a claim line is for the entry of claim line item detail.		
24A-G Shaded	SUPPLEMENTAL INFORMATION	The shaded top portion of each service claim line is used to report supplemental information for: • NDC • Anesthesia start/stop time & duration • Unspecified, miscellaneous, or unlisted CPT and HCPC code descriptions. • HIBCC or GTIN number/code. For detailed instructions and qualifiers refer to Appendix 4 of this manual.	C
24A Shaded	DATE(S) OF SERVICE	Enter the date the service listed in 24D was performed (MM|DD|YY). If there is only one date enter that date in the “From” field. The “To” field may be left blank or populated with the “From” date. If identical services (identical CPT/HCPC code(s)) were performed within a date span, enter the date span in the “From” and “To” fields. The count listed in field 24G for the service must correspond with the date span entered.	R
24B Unshaded	PLACE OF SERVICE	Enter the appropriate 2-digit CMS standard place of service (POS) code. A list of current POS codes may be found on the CMS website or the following link: http://www.cms.hhs.gov/PlaceofServiceCodes/Downloads/placeofservice.pdf	R

<table>
<tr><th>FIELD #</th><th>FIELD DESCRIPTION</th><th>INSTRUCTION OR COMMENTS</th><th>REQUIRED OR CONDITIONAL</th></tr>
<tr><td>24C
Unshaded</td><td>EMG</td><td>Enter Y (Yes) or N (No) to indicate if the service was an emergency.</td><td>R</td></tr>
<tr><td rowspan="4">24D
Unshaded</td><td rowspan="4">PROCEDURES, SERVICES OR SUPPLIES
CPT/HCPCS
MODIFIER</td><td>Enter the 5-digit CPT or HCPC code and 2-character modifier– - if applicable. Only one CPT or HCPC and up to 4 modifiers may be entered per claim line. Codes entered must be valid for date of service. Missing or invalid codes will be denied for payment.</td><td rowspan="4">R</td></tr>
<tr><td>Only the first modifier entered is used for pricing the claim. Failure to use modifiers in the correct position or combination with the procedure code, or invalid use of modifiers, will result in a rejected, denied, or incorrectly paid claim.</td></tr>
<tr><td>The following national modifiers are recognized as modifiers that will impact the pricing of your claim.</td></tr>
<tr><td><table>
<tr><td>24</td><td>26</td><td>50</td><td>51</td><td>52</td></tr>
<tr><td>53</td><td>54</td><td>55</td><td>62</td><td>66</td></tr>
<tr><td>76</td><td>78</td><td>79</td><td>80</td><td>81</td></tr>
<tr><td>82</td><td>99</td><td>AA</td><td>AD</td><td>FP</td></tr>
<tr><td>LL</td><td>LT</td><td>NU</td><td>QK</td><td>QS</td></tr>
<tr><td>QX</td><td>QY</td><td>QZ</td><td>RR</td><td>RT</td></tr>
<tr><td>SB</td><td>TC</td><td>UE</td><td></td><td></td></tr>
</table></td></tr>
<tr><td>24E
Unshaded</td><td>DIAGNOSIS CODE</td><td>Enter the numeric single digit diagnosis pointer (1, 2, 3, and 4) from field 21. List the primary diagnosis for the service provided or performed first followed by any additional or related diagnosis listed in field 21 (using the single digit diagnosis pointer, not the diagnosis code.) Do not use commas between the diagnosis pointer numbers. Diagnosis codes must be valid ICD-9 codes or ICD-10 code when applicable for the date of service or the claim will be rejected and denied.</td><td>R</td></tr>
<tr><td>24F
Unshaded</td><td>CHARGES</td><td>Enter the charge amount for the claim line item service billed. Dollar amounts to the left of the vertical line should be right justified. Up to 8 characters are allowed (i.e. 199,999.99). Do not enter a dollar sign ($). If the dollar amount is a whole number (i.e. 10.00), enter 00 in the area to the right of the vertical line.</td><td>R</td></tr>
<tr><td>24G
Unshaded</td><td>DAYS OR UNITS</td><td>Enter quantity (days, visits, units). If only one service provided, enter a numeric value of 1.</td><td>R</td></tr>
<tr><td>24H
Shaded</td><td>EPSDT (CHCUP)
Family Planning</td><td>Leave blank</td><td>Not Required</td></tr>
<tr><td>24H
Unshaded</td><td>EPSDT (CHCUP)
Family Planning</td><td>Enter the appropriate qualifier for EPSDT visit</td><td>C</td></tr>
</table>

FIELD #	FIELD DESCRIPTION	INSTRUCTION OR COMMENTS	REQUIRED OR CONDITIONAL
24I Shaded	ID QUALIFIER	Use ZZ qualifier for taxonomy	C
24J Shaded	Non-NPI PROVIDER ID#	Enter as designated below the Medicaid ID number or taxonomy code. Typical Providers: Enter the Provider taxonomy code or Medicaid Provider ID number that corresponds to the qualifier entered in 24I shaded. Use ZZ qualifier for taxonomy code. Atypical Providers: Enter the 6-digit Medicaid Provider ID number or health plan identification number along with G2 qualifier	R
24J Unshaded	NPI PROVIDER ID	Typical Providers only, enter the 10-character NPI ID of the Provider who rendered services. If the Provider is billing as a member of a group, the rendering individual Provider's 10-character NPI ID may be entered.	R

CMS 1500 Claim Form



FIELD #	FIELD DESCRIPTION	INSTRUCTION OR COMMENTS	REQUIRED OR CONDITIONAL
25	FEDERAL TAX I.D. NUMBER SSN/EIN	Enter the Provider or supplier 9-digit federal Tax ID number and mark the box labeled EIN.	R
26	PATIENT'S ACCOUNT NO.	Enter the Provider's billing account number.	Not Required
27	ACCEPT ASSIGNMENT?	Enter an X in the YES box. Submission of a claim for reimbursement of services provided to a Medicaid recipient using Medicaid funds indicates the Provider accepts Medicaid assignment. Refer to the back of the CMS 1500 (12-90) form for the section pertaining to Medicaid payments.	R

28	TOTAL CHARGES	Enter the total charges for all claim line items billed – claim lines 24F. Dollar amounts to the left of the vertical line should be right justified. Up to 8 characters are allowed (i.e. 199,999.99). Do not enter a dollar sign ($). If the dollar amount is a whole number (i.e. 10.00), enter 00 in the area to the right of the vertical line.	R

FIELD #	FIELD DESCRIPTION	INSTRUCTION OR COMMENTS	REQUIRED OR CONDITIONAL
29	AMOUNT PAID	This is required when another carrier is the primary payor. Enter the payment received from the primary payor prior to invoicing to the health plan. Medicaid programs are always the payors of last resort. Dollar amounts to the left of the vertical line should be right justified. Up to 8 characters are allowed (i.e. 199,999.99). Do not enter a dollar sign ($). If the dollar amount is a whole number (i.e. 10.00), enter 00 in the area to the right of the vertical line.	C
30	BALANCE DUE	This is required when #29 is completed. Enter the balance due (total charges minus the amount of payment received from the primary payor). Dollar amounts to the left of the vertical line should be right justified. Up to 8 characters are allowed (i.e. 199,999.99). Do not enter a dollar sign ($). If the dollar amount is a whole number (i.e. 10.00), enter 00 in the area to the right of the vertical line.	C
31	SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS	If there is a signature waiver on file, you may stamp, print, or computer-generate the signature. Note: does not exist in the electronic 837P.	R
32	SERVICE FACILITY LOCATION INFORMATION	This is Require if the location where services were rendered is different from the billing address listed in field 33. Enter the name and physical location. (P.O. Box #'s are not acceptable here.)	C
		First line – Enter the business/facility/practice name.	
		Second line– Enter the street address. Do not use commas, periods, or other punctuation in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101).	
		Third line – In the designated block, enter the city and state.	
		Fourth line – Enter the ZIP code and phone number. When entering a 9-digit ZIP code. (Zip + 4 code), include the hyphen.	

32a	NPI – SERVICES RENDERED	Typical Providers only: This is required if the location where services were rendered is different from the billing address listed in field 33. Enter the 10-character NPI ID of the facility where services were rendered.	C

FIELD #	FIELD DESCRIPTION	INSTRUCTION OR COMMENTS	REQUIRED OR CONDITIONAL
32b	OTHER PROVIDER ID	This is required if the location where services were rendered is different from the billing address listed in field 33.	C
		Typical Providers Enter the 2-character qualifier ZZ followed by the taxonomy code (no spaces).	
		Atypical Providers Enter the 2-character qualifier 1D followed by the 6-character Medicaid Provider ID number (no spaces) along with G2 qualifier.	
33	BILLING PROVIDER INFO & PHONE NUMBER	Enter the billing Provider's complete name ,address (include the ZIP + 4 code), and phone number.	R
		First line – Enter the business/facility/practice name.	
		Second line– Enter the street address. Do not use commas, periods, or other punctuation in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101).	
		Third line – In the designated block, enter the city and state.	
		Fourth line – Enter the ZIP code and phone number. When entering a 9-digit ZIP code (ZIP+4 code), include the hyphen. Do not use a hyphen or space as a separator within the telephone number (i.e. (803)5551414).	
33a	GROUP BILLING NPI	Typical Providers only: This is required if the location where services were rendered is different from the billing address listed in field 33. Enter the 10-character NPI ID.	R
33b	GROUP BILLING OTHER ID	Enter as designated below the billing group Medicaid ID number or taxonomy code.	R
		Typical Providers: Enter the Provider taxonomy code. Use ZZ qualifier.	
		Atypical Providers: Enter the 6-digit Medicaid Provider ID number.	

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 (typed or written) 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. *See page 11–75.*
- In the following situations, claims for services provided to MHS Health /NHP members must be submitted on paper (not electronically), because additional attachments must be included:
  - The member also has other insurance. (A copy of the Explanation of Payment [EOP] or denial letter from the "other insurance" must be included).
  - The claim is for a sterilization procedure. (A signed state consent form must be included).

It is the Provider's responsibility to appeal or dispute any adverse claims processing outcomes within 90 days of the date on the EOP, unless timely filing is defined otherwise in your contract.

NPI for billing

Providers must include an NPI for billing, performing, attending, ordering, facility and referring Providers when submitting Provider information. Atypical Providers only may continue to report their Medicaid ID in Field 24ja.

All electronic and paper claims submitted must include an NPI billing Provider, taxonomy code tax identification number, and 9-digit ZIP code of the service location, as outlined below.

Paper claim submission of CMS 1500 claim form

- Field 17a: Qualifier = ZZ, plus taxonomy code of referring Provider.
- Field 17b: NPI of referring Provider.
  Note: Fields 17a and 17b are situational and only required when service(s) or supply(s) on claim was referred or ordered by another Provider.
- Field 24i : Qualifier = ZZ.
- Field 24ja (shaded): Servicing Provider primary taxonomy code on file with the State. Legacy ID if an atypical Provider.
- Field 24jb (unshaded): NPI of servicing Provider.
- Field 25 : Tax identification number.
- Field 32: Entire address, including the 9-digit ZIP code of the service facility location.
- Field 33: Entire address, including 9-digit ZIP code of the billing Provider's service location.
- Field 33a: NPI of billing Provider.
- Field 33b: Qualifier = ZZ, plus taxonomy code of the billing Provider.

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

Billing Health Checks

For details on billing see *Section 8 Health Checks*.

Health Professional Shortage Area (HPSA)

A list of HPSA-eligible ZIP and procedure codes (June 2006) is on the MHS Health website.
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

Eligible procedure codes
Wisconsin Medicaid's list of current procedural terminology (CPT) codes that are eligible for the HPSA-enhanced reimbursement rate reflects current CPT codes for primary care and emergency medicine procedures.

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

Ante partum care visits
Providers are required to use modifier "TH" (Obstetrical treatment/services, prenatal or postpartum) with procedure codes 99204 or 99213 only when those codes are used to indicate the first three ante partum care visits. Providers are required to use both the "TH" modifier and HPSA modifier when these prenatal services are HPSA-eligible for appropriate reimbursement.

Pediatric services
Providers should not submit claims with both HPSA modifier "AQ" and the "TJ" modifier (program group, child and/or adolescent) for procedure codes 99201-99215 and 99281-99285. Providers should use only a HPSA modifier, when applicable. Wisconsin Medicaid will determine the recipient's age and determine the proper HPSA reimbursement for these procedure codes.

Health Check services
Health Check services are not eligible for HPSA incentive payment. Procedure codes 99381-99385 are not eligible for HPSA bonuses, regardless of the billing or performing Provider or recipient's location. That's because reimbursement for these procedure codes includes the enhanced reimbursement for Health Check services.

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).
Follow these guidelines to bill the preparation and handling fee:

- CPT code 99000 if a single specimen is being sent for the member.
- CPT code 99001 if multiple specimens are being sent for the member.
- Reimbursement will be at one (1) unit for either 99000 or 99001 per visit.
- Be sure to indicate the correct two-digit location of service code to represent the location where the specimen was obtained.

Handling fees will not be reimbursed if:

- The laboratory is located within your office or clinic
- The physician is reimbursed for the professional and/or technical component of the laboratory test.

Remember that routine venipuncture; CPT 36415 is not a billable 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 surgical service provided must be a Medicaid-covered procedure.
- The procedure may also require prior authorization by MHS Health. Please see *Section 9 Medical Management Section* or *the MHS* Health *Network Provider's Quick Reference Guide.*
- Appropriate surgical codes must be used on a CMS 1500 claim form.
- Documentation of medical necessity, e.g., the operative report, must be attached to the claims of both the surgeon and co-surgeon(s).

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

On the claim, the covered surgery with the greatest allowed amount is reimbursed as the primary surgical procedure, the next highest as secondary, etc. Multiple surgical procedures performed by the same Provider during the same surgical session should be billed on the same claim:

- Bill the primary procedure first.
- Bill additional procedures with the appropriate CPT code (followed by the appropriate modifier).

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).

- Documentation of medical necessity, such as the operative report, must be attached to the claims of both the surgeon and the co-surgeon(s).
- Claims of co-surgeons are subject to the multiple surgery and bilateral surgery rate structure outlined above.
- Reimbursement is based on determinations made during medical review in accordance with NCCI. The allowed amount depends on the procedures performed.

Assistant surgeons
Services are reimbursed at 20% of the maximum amount allowed for the surgical procedure. Submit claims using the appropriate surgical CPT code (followed by the appropriate modifier).

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

Physician Assistants and Mid-Levels

- Physician assistants who assist in surgery are reimbursed at 90% of the amount allowed for a clinician (MD/DO) who assists at surgery (18% of the allowed amount for the surgical procedure).
- 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 for the procedure. Report total anesthesia time units in minutes.

Certified registered nurse anesthetists
Submit claims with the appropriate ASA code for the procedure followed by the CRNA modifier. Report total anesthesia time units in minutes.

Place of service (POS)
The following CMS 1500 standard Place of Service codes must be used:

04	Homeless shelter
05	Indian health service free-standing facility
06	Indian health service Provider facility
07	Tribal 638 free-standing facilities
08	Tribal 638 Provider based facility
11	Office
12	Home
13	Assisted living facility
14	Group home
15	Mobile unit
17	Walk-in retail health clinic
20	Urgent care facility
21	Inpatient hospital
22	Outpatient hospital
23	Emergency Room
24	Ambulatory surgical center
25	Birthing center
26	Military treatment facility
31	Skilled nursing facility
32	Nursing facility
33	Custodial care facility
34	Hospice
41	Ambulance – land
42	Ambulance – air or water
49	Independent clinic
50	Federally qualified health center
51	Inpatient psychiatric facility
52	Psychiatric facility – partial hospitalization
53	Community mental health center
54	Intermediate care facility/mentally retarded
55	Residential substance abuse treatment facility
56	Psychiatric residential treatment center
57	Non-residential substance abuse treatment facility
60	Mass immunization center
61	Comprehensive inpatient rehabilitation facility
62	Comprehensive outpatient rehabilitation facility
65	End-stage renal disease treatment facility
71	State or local public health clinic
72	Rural health clinic
81	Independent laboratory

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) 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 contract. Claims received outside of the contractually agreed time frame will be denied payment.
- Provide all information requested on the UB-04 claim form.
- Incomplete or inaccurate information may result in delayed or denied payment
- An additional fee may apply for processing paper claims, consistent with the State of Wisconsin.

Present on admission (POA) requirements for inpatient hospital claims

Hospital Providers that are reimbursed on a DRG basis will be required to include present on admission (POA) indicator information for all primary and secondary diagnoses. Claims will be denied if the required POA indicator is not present. Additionally, reimbursement may be affected by the POA indicator.

MHS Health adopted the conditions and diagnosis codes implemented by Wisconsin Medicaid and BadgerCare Plus and established by Centers for Medicare and Medicaid Services (CMS) and included in the MS-DRG grouper that incorporates POA and hospital acquired conditions (HAC).

UB-04 claim form instructions

The following describes the information fields of a UB-04 claim form:

- Capitalized and bold type indicates the information requested in the field is required.
- An asterisk (*) next to capitalized, bold type indicates the information requested in the field is required if applicable.

Required (R) fields must be completed on all claims. Conditional (C) fields must be completed if the information applies to the situation or the service provided.

UB-04 Claim Form

Field #	Field Description	Instructions and Comments	Required or Conditional
1	(UNLABELED FIELD)	Line 1: Enter the complete Provider name. Line 2: Enter the complete mailing address. Line 3: Enter the city, state, and ZIP+4 code (include hyphen) Line 4: Enter the area code and phone number.	R
2	(UNLABELED FIELD)	Enter the pay-to name and address.	Not Required
3a	PATIENT CONTROL NO.	Enter the facility patient account/control number.	Not Required
3b	MEDICAL RECORD NUMBER	Enter the facility patient medical or health record number.	R
4	TYPE OF BILL	Enter the appropriate 3-digit type of bill (TOB) code as specified by the NUBC UB-04 Uniform Billing Manual minus the leading "0" (zero). A leading "0" is not needed. Digits should be reflected as follows: • 1st digit - Indicating the type of facility. • 2nd digit - Indicating the type of care. • 3rd digit - Indicating the billing sequence. Bill type 112 must be for a minimum of 60 days. Bill type 113 and 114 can be submitted after a minimum of 90 days or discharge and must include all charges from date of admission. Additional bill type 113 must be in increments of 30 days and include all charges from date of admission.	R
5	FEDERAL TAX NUMBER	Enter the 9-digit number assigned by the federal government for tax reporting purposes.	R
6	STATEMENT COVERS PERIOD FROM & THROUGH	Enter the date services began and the date services ended for the services billed. The date services began may not be the admission date if the patient was treated as an outpatient prior to admission as an inpatient. Services provided 72 hours prior to inpatient admission should be included on the inpatient bill rather than billed separately. Outpatient therapy, chemotherapy, laboratory, pathology, radiology and dialysis may be billed using a date span. All other outpatient services must be billed using the actual date of service. (MMDDYY)	R

7	(UNLABELED FIELD)	Not Used	Not Required
8a-b	PATIENT NAME	8a – Enter the patient's 10-digit Medicaid identification number on the member's health plan card.	Not Required
		8b – Enter the patient's last name, first name, and middle initial as it appears on the health plan card. Use a comma or space to separate the last and first names. • Titles (Mr., Mrs., etc.) should not be reported in this field. • Prefix: No space should be left after the prefix of a name e.g. McKendrick • Hyphenated names: Both names should be capitalized and separated by a hyphen (no space). • Suffix: A space should separate a last name	R
9a-e	PATIENT ADDRESS	Enter the patient's complete mailing address of the patient. Line a: Street address Line b: City Line c: State Line d: ZIP code Line e: Country code (not required)	R (except line 9e)
10	BIRTHDATE	Enter the patient's date of birth (MMDDYYYY)	R
11	SEX	Enter the patient's sex. Only M or F is accepted.	R
12	ADMISSION DATE	Enter the date of admission for inpatient claims and date of service for outpatient claims.	R
13	ADMISSION HOUR	Enter the time using 2-digit military time (00-23) for the time of inpatient admission or time of treatment for outpatient services. 00-12:00 midnight to 12:59 12- 12:00 noon to 12:59 01- 01:00 to 01:59 13- 01:00 to 01:59 02- 02:00 to 02:59 14- 02:00 to 02:59 03- 03:00 to 03:39 15- 03:00 to 03:59 04- 04:00 to 04:59 16- 04:00 to 04:59 05- 05:00 to 05:59 17- 05:00 to 05:59 06- 06:00 to 06:59 18- 06:00 to 06:59 07- 07:00 to 07:59 19- 07:00 to 07:59 08- 08:00 to 08:59 20- 08:00 to 08:59 09- 09:00 to 09:59 21- 09:00 to 09:59 10- 10:00 to 10:59 22- 10:00 to 10:59 11- 11:00 to 11:59 23- 11:00 to 11:59	R
14	ADMISSION TYPE	Required for inpatient admissions (TOB 11X, 118X, 21X, 41X). Enter the 1-digit code indicating the priority of the admission using one of the following codes: 1 Emergency 2 Urgent 3 Elective 4 Newborn	C

<table>
<tr><td>15</td><td>ADMISSION SOURCE</td><td>Enter the 1-digit code indicating the source of the admission
or outpatient service using one of the following codes:
1 Physician referral
2 Clinic referral
4 Transfer from a hospital
6 Transfer from another health care facility
7 Emergency room
8 Court/law enforcement
9 Information not available</td><td>R</td></tr>
<tr><td>16</td><td>DISCHARGE HOUR</td><td>Enter the time using 2-digit military time (00-23) for the time of inpatient or outpatient discharge.

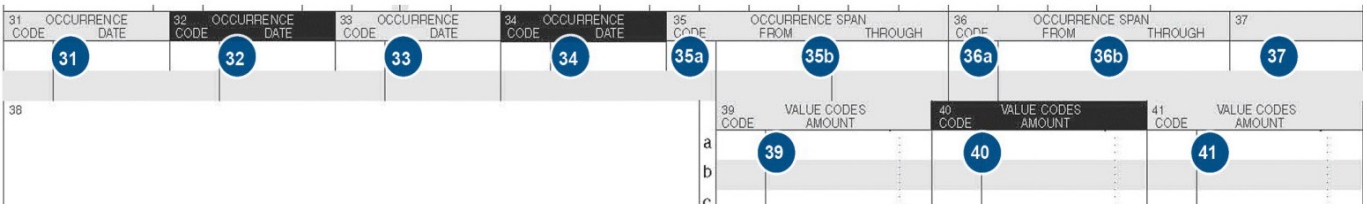
00-12:00 midnight to 12:59 12- 12:00 noon to 12:59
01- 01:00 to 01:59 13- 01:00 to 01:59
02- 02:00 to 02:59 14- 02:00 to 02:59
03- 03:00 to 03:39 15- 03:00 to 03:59
04- 04:00 to 04:59 16- 04:00 to 04:59
05- 05:00 to 05:59 17- 05:00 to 05:59
06- 06:00 to 06:59 18- 06:00 to 06:59
07- 07:00 to 07:59 19- 07:00 to 07:59
08- 08:00 to 08:59 20- 08:00 to 08:59
09- 09:00 to 09:59 21- 09:00 to 09:59
10- 10:00 to 10:59 22- 10:00 to 10:59
11- 11:00 to 11:59 23- 11:00 to 11:59</td><td>R</td></tr>
<tr><td>64

17</td><td>PATIENT STATUS</td><td>This is required for inpatient claims. Enter the 2-digit disposition of the patient as of the “through” date for the billing period listed in field 6. Listed below is a sampling of codes. Refer NUBC for a complete listing.

<table>
<tr><td>Status</td><td>Description</td></tr>
<tr><td>01</td><td>Discharged to home or self-care.</td></tr>
<tr><td>02</td><td>Transferred to another short-term general Hospital.</td></tr>
<tr><td>03</td><td>Transferred to a SNF.</td></tr>
<tr><td>04</td><td>Transferred to a facility that provides custodial or supportive care.</td></tr>
<tr><td>05</td><td>Transferred to cancer or children’s facility.</td></tr>
<tr><td>06</td><td>Discharged home to care of home health.</td></tr>
<tr><td>07</td><td>Left against medical advice.</td></tr>
<tr><td>20</td><td>Expired.</td></tr>
<tr><td>21</td><td>Discharged/transferred to court/law enforcement</td></tr>
<tr><td>30</td><td>Still patient.</td></tr>
<tr><td>43</td><td>Discharged/transferred to a federal healthcare facility.</td></tr>
<tr><td>50</td><td>Discharged to hospice-home.</td></tr>
<tr><td>51</td><td>Discharge to hospice-medical facility (certified) providing hospice level of care.</td></tr>
<tr><td>31</td><td></td></tr>
<tr><td>32</td><td></td></tr>
</table></td><td></td></tr>
</table>

		61	Discharged/transferred to a hospital-based Medicare-Approved Swing Bed with a Planned Acute Care Hospital Inpatient Readmission	
		62	Discharged/Transferred to an IRF, distinct rehabilitation unit of a hospital	
		63	Discharged/Transferred to a Medicare certified long-term care hospital (LTCH) with a planned acute care hospital inpatient readmission.	
		64	Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare with a planned acute care hospital inpatient readmission.	
		65	Discharged/transferred to a psychiatric hospital or distinct psychiatric unit of a hospital.	
		66	Discharged/transferred To a critical access hospital (CAR) with a planned acute care hospital inpatient readmission	
		69	Discharged/transferred to a designated disaster alternative care site	
		70	Discharged/transferred to another type of healthcare institution not defined elsewhere in this code list with a planned acute care hospital inpatient readmission.	
		93	Discharged or transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital with a planned acute care hospital inpatient readmission.	
		94	Discharged/transferred to a critical access hospital with a planned acute care hospital inpatient readmission.	
		95	Discharged/transferred to another type of healthcare institution not defined elsewhere in this code list with a planned acute care hospital inpatient readmission.	
18-28	CONDITION CODES	This is required when applicable. Condition codes are used to identify conditions relating to the bill that may affect payor processing. Each field (18-24) allows entry of a 2-character code. Codes should be entered in alphanumeric sequence (numbered codes precede alphanumeric codes). For a list of codes and additional instructions refer to the NUBC UB-04 Uniform Billing Manual.		C
29	ACCIDENT STATE			C
30	(UNLABELED FIELD)	Not Used		C

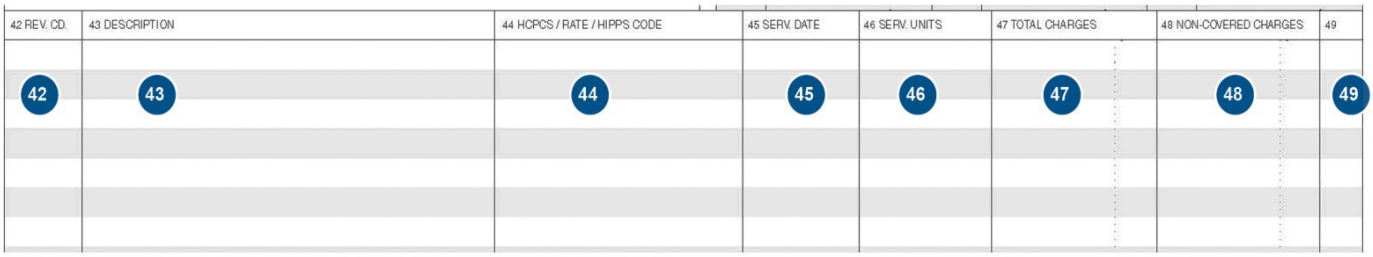
UB-04 Claim Form



31-34 a-b	OCCURRENCE CODE & OCCURENCE DATE	Occurrence Code: Required when applicable. Occurrence codes are used to identify events relating to the bill that may affect payor processing. Each field (31-34a) allows entry of a 2-character code. Codes should be entered in alphanumeric sequence (numbered codes precede alphanumeric codes). For a list of codes and additional instructions refer to the NUBC UB-04 Uniform Billing Manual. Occurrence Date: Required when applicable or when a corresponding Occurrence Code is present on the same line (31a-34a). Enter the date for the associated occurrence code in MMDDYYYY format.	C
35-36 a-b	OCCURRENCE SPAN CODE & OCCURRENCE DATE	Occurrence Span Code: Required when applicable. Occurrence codes are used to identify events relating to the bill that may affect payor processing. Each field (31-34a) allows entry of a 2-character code. Codes should be entered in alphanumeric sequence (numbered codes precede alphanumeric codes). For a list of codes and additional instructions refer to the NUBC UB-04 Uniform Billing Manual. Occurrence Span Date: Required when applicable or when a corresponding Occurrence Span code is present on the same line (35a-36a). Enter the date for the associated occurrence code in MMDDYYYY format.	C
37	(UNLABELED FIELD)	Required for re-submissions or adjustments. Enter the 12-character DCN (Document Control Number) of the original claim. A resubmitted claim must be marked using large bold print within the body of the claim form with “RESUBMISSION” to avoid denials for duplicate submission. NOTE: Re-submissions may NOT currently be submitted via EDI.	C
38	RESPONSIBLE PARTY NAME AND ADDRESS		Not Required

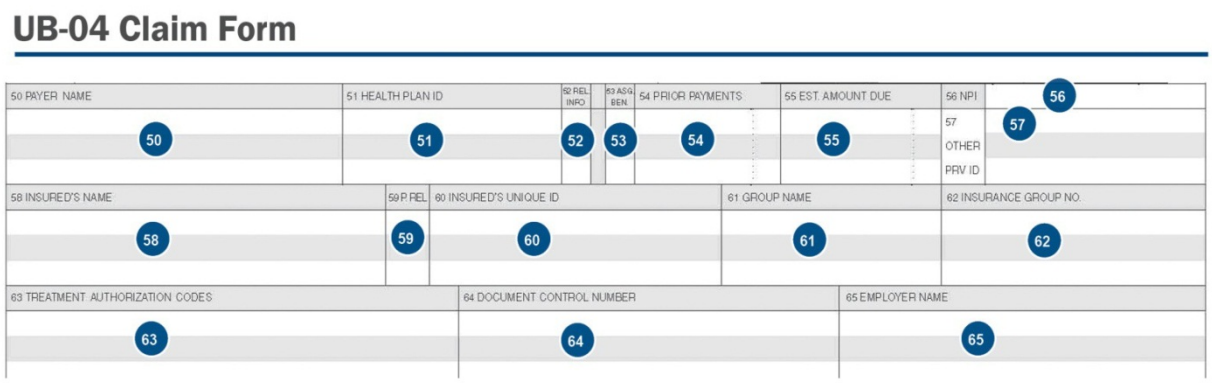
39-41 a-d	VALUE CODES & AMOUNTS	Code: Required when applicable. Value codes are used to identify events relating to the bill that may affect payor processing. Each field (39-41) allows entry of a 2-character code. Codes should be entered in alphanumeric sequence (numbered codes precede alphanumeric codes). Up to 12 codes can be entered. All “a” fields must be completed before using “b” fields, all “b” fields before using “c” fields, and all “c” fields before using “d” fields. For a list of codes and additional instructions refer to the NUBC UB-04 Uniform Billing Manual. Amount: Required when applicable or when a Value Code is entered. Enter the dollar amount for the associated value code. Dollar amounts to the left of the vertical line should be right justified. Up to 8 characters are allowed (i.e. 199,999.99). Do not enter a dollar sign ($) or a decimal. A decimal is implied. If the dollar amount is a whole number (i.e. 10.00), enter 00 in the area to the right of the vertical line.	C

UB-04 Claim Form



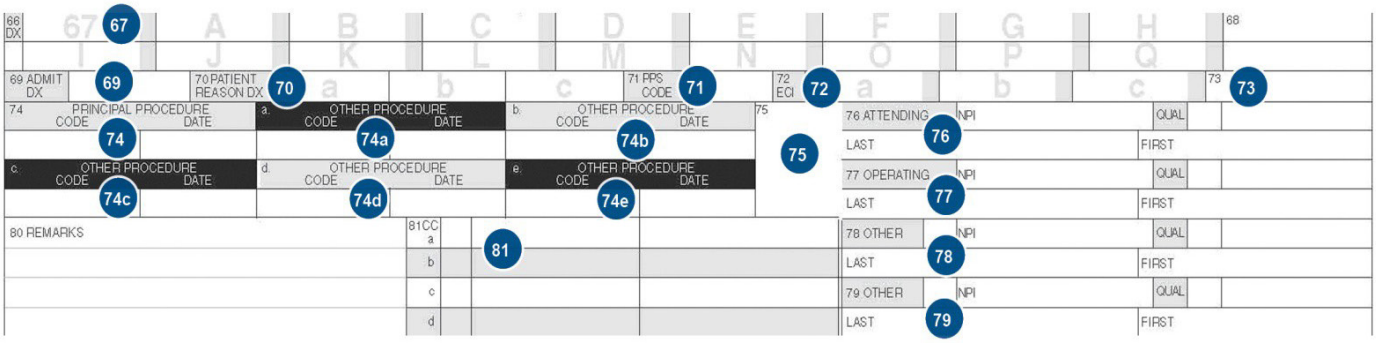
General Information Fields 42-47	SERVICE LINE DETAIL	These UB-04 fields have a total of 22 service lines for claim detail information. Fields 42, 43, 45, 47, 48 include separate instructions for the completion of lines 1-22 and line 23.	
42 Line 1-22	REV CD	Enter the appropriate 4-digit revenue codes itemizing accommodations, services, and items furnished to the patient. Refer to the NUBC UB-04 Uniform Billing Manual for a complete listing of revenue codes and instructions. Enter accommodation revenue codes first followed by ancillary revenue codes. Enter codes in ascending numerical value.	R
42 Line 23	Rev CD	Enter 0001 for total charges.	R
43 Line 1-22	DESCRIPTION	Enter a brief description that corresponds to the revenue code entered in the service line of field 42.	R
43 Line 23	PAGE _OF _	Enter the number of pages. Indicate the page sequence in the “PAGE” field and the total number of pages in the “OF” field. If only one claim form is submitted enter a “1” in both fields (i.e. PAGE “1” OF “1”).	R
44	HCPCS/RATES	Required for outpatient and SNF claims when an appropriate CPT/HCPCS code exists for the service line revenue code billed. The field allows up to nine characters. Only one CPT/HCPC and up to two modifiers are accepted. When entering a CPT/HCPCS with a modifier(s) do not use a spaces, commas, dashes or the like between the CPT/HCPC and modifier(s). Refer to the NUBC UB-04 Uniform Billing Manual for a complete listing of revenue codes and instructions. The following revenue codes/revenue code ranges must always have an accompanying CPT/HCPC. 300-302 329-330 360-361 610-612 304-307 333 363-366 615-616 309-312 340-342 368-369 618-619 314 349-352 400-404 634-636 319-324 359 490-499 923	C

45 Line 1-22	SERVICE DATE	Required on all outpatient claims. Enter the date of service for each service line billed. (MMDDYY)	C
45 Line 23	CREATION DATE	Enter the date the bill was created or prepared for submission on all pages submitted. (MMDDYY)	R
46	SERVICE UNITS	Enter the number of units, days, or visits for the service. A value of at least “1” must be entered.	R
47 Line 1-22	TOTAL CHARGES	Enter the total charge for each service line.	R
47 Line 23	TOTALS	Enter the total charges for all service lines.	R
48 Line 1-22	NON-COVERED CHARGES	Enter the non-covered charges included in field 47 for the revenue code listed in field 42 of the service line. Do not list negative amounts.	C
48 Line 23	TOTALS	Enter the total non-covered charges for all service lines.	C
49	(UNLABELED FIELD)	Not Used	Not Required



50 A-C	PAYOR	Enter the name for each Payor reimbursement is being sought in the order of the Payor liability. Line A refers to the primary payor; B, secondary; and C, tertiary.	R
51 A-C	HEALTH PLAN ID NUMBER		Not Required
52 A-C	REL. INFO	Required for each line (A, B, C) completed in field 50. Release of Information Certification Indicator. Enter “Y” (yes) or “N” (no). Providers are expected to have necessary release information on file. It is expected that all released invoices contain "Y”.	R
53	ASG. BEN.	Enter “Y" (yes) or "N" (no) to indicate a signed form is on file authorizing payment by the payor directly to the Provider for services.	R
54	PRIOR PAYMENTS	Enter the amount received from the primary payor on the appropriate line when Medicaid/ Health Plan is listed as secondary or tertiary.	C
55	EST. AMOUNT DUE		Not Required
56	NATIONAL PROVIDER IDENTIFIER or PROVIDER ID	Required: Enter Provider’s 10-character NPI ID.	R
57	OTHER PROVIDER ID	Enter the qualifier “1D” followed by your 6-digit Medicaid Provider ID number.	Not Required
58	INSURED'S NAME	For each line (A, B, C) completed in field 50, enter the name of the person who carries the insurance for the patient. In most cases this will be the patient’s name. Enter the name as last name, first name, middle initial.	R
59	PATIENT RELATIONSHIP		Not Required
60	INSURED’S UNIQUE ID	Required: Enter the patient's Insurance/Medicaid ID exactly as it appears on the patient's ID card. Enter the Insurance /Medicaid ID in the order of liability listed in field 50.	R
61	GROUP NAME		Not Required
62	INSURANCE GROUP NO.		Not Required
63	TREATMENT AUTHORIZATION CODES		Not Required
64	DOCUMENT CONTROL NUMBER	Enter the 12-character Document Control Number (DCN) of the paid Health Plan claim when submitting a replacement or void on the corresponding A, B, C line reflecting Health Plan from field 50. Applies to claim submitted with a Type of Bill (field 4) Frequency of “7” (Replacement of Prior Claim) or Type of Bill Frequency of “8” (Void/cancel of prior Claim).	C
65	EMPLOYER NAME		Not Required
66	DX		Not Required

UB-04 Claim Form



67	PRINCIPAL DIAGNOSIS CODE	Enter the principal/primary diagnosis or condition (the condition established after study that is chiefly responsible for causing the visit) using the appropriate release/update of ICD-9-CM Volume 1& 3 for the date of service (ICD-10 when applicable). Diagnosis codes submitted must be a valid ICD-9 code for the date of service and carried out to its highest digit – 4th or“5”. "E" and most “V” codes are NOT acceptable as a primary diagnosis. (ICD-10 when applicable). Please note: Claims missing or with invalid diagnosis codes or incomplete or invalid POA indicator will be denied.	R
67 A-Q	OTHER DIAGNOSIS CODE	Enter additional diagnosis or conditions that coexist at the time of admission or that develop subsequent to the admission and have an effect on the treatment or care received using the appropriate release/update of ICD-9-CM Volume 1& 3 or ICD-10 when applicable for the date of service. Diagnosis codes submitted must be a valid ICD-9 codes or ICD-10 code when applicable and carried out to its highest digit – 4th or“5”. "E" and most “V” codes are NOT acceptable as a primary diagnosis. Please note: Claims with incomplete or invalid diagnosis codes or incomplete or invalid POA indicators will be denied for payment.	C
68	(UNLABELED)	Not used	Not Required

69	ADMITTING DIAGNOSIS CODE	Enter the diagnosis or condition provided at the time of admission as stated by the physician using the appropriate release/update of ICD-9-CM Volume 1& 3 for the date of service, or ICD-10 when applicable. Diagnosis codes submitted must be a valid ICD-9 codes or ICD-10 when applicable and carried out to its highest digit – 4th or“5”. "E" codes and most “V” are not acceptable as a primary diagnosis. Please note: Claims missing or with invalid diagnosis codes will be denied for payment.	R
70 a,b,c	PATIENT REASON CODE	Enter the ICD-9-CM or ICD-10 code that reflects the patient’s reason for visit at the time of outpatient registration. 70a requires entry, 70b-70c are conditional. Diagnosis codes submitted must be a valid ICD-9 codes or ICD-10 code when applicable and carried out to its highest digit – 4th or“5.” "E" codes and most “V” are not acceptable as a primary diagnosis. Please note: Claims missing or with invalid diagnosis codes will be denied for payment.	R
71	PPS / DRG CODE		Not Required
72 a,b,c	EXTERNAL CAUSE CODE		Not Required
73	(UNLABELED)		Not Required
74	PRINCIPAL PROCEDURE CODE / DATE	Required on inpatient claims when a procedure is performed during the date span of the bill. CODE: Enter the ICD-9 or ICD-10-PCS procedure code that identifies the principal/primary procedure performed. Do not enter the decimal between the 2nd or 3rd digits of code. It is implied. DATE: Enter the date the principal procedure was performed (MMDDYY). Required for EDI Submissions.	C
74 a-e	OTHER PROCEDURE CODE DATE	Required on inpatient claims when a procedure is performed during the date span of the bill. CODE: Enter the ICD-9/ICD-10-PCS procedure code(s) that identify significant a procedure(s) performed other than the principal/primary procedure. Up to five procedure codes may be entered. Do not enter the decimal between the 2nd or 3rd digits of code. It is implied. DATE: Enter the date the principal procedure was performed (MMDDYY).	C
75	(UNLABELED)		Not Required

76	ATTENDING PHYSICIAN	Enter the NPI and name of the physician in charge of the patient care: NPI: Enter the attending physician 10-character NPI ID. Taxonomy Code: Enter valid taxonomy code QUAL: Enter one of the following qualifier and ID number 0B – State license # 1G – Provider UPIN G2 – Provider commercial # ZZ – Taxonomy code LAST: Enter the attending physician's last name FIRST: Enter the attending physician's first name.	R
77	OPERATING PHYSICIAN	Required when a surgical procedure is performed: NPI: Enter the operating physician 10-character NPI ID. Taxonomy Code: Enter valid taxonomy code QUAL: Enter one of the following qualifier and ID number 0B – State license # G2 – Provider commercial # ZZ – Taxonomy code LAST: Enter the attending physician's last name FIRST: Enter the attending physician's first name.	C
78 & 79	OTHER PHYSICIAN	Enter the Provider type qualifier, NPI, and name of the physician in charge of the patient care: (Blank Field): Enter one of the following Provider type qualifiers: DN – Referring Provider ZZ – Other operating MD 82 – Rendering Provider NPI: Enter the other physician 10-character NPI ID. QUAL: Enter one of the following qualifier and ID number 0B – State license # 1G – Provider UPIN G2 – Provider commercial # LAST: Enter the attending physician's last name FIRST: Enter the attending physician's first name.	C
80	REMARKS		Not Required

81	CC	**A:** Taxonomy of billing Provider. Use ZZ qualifier.	R

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.
- Claims without POA indicator for all inpatient hospital stays will be denied. Exempt codes should be submitted with the POA indicator blank. Inpatient mental health and rehabilitation facilities are exempt from this requirement.
- UB04 claims for a patient admitted and discharged on the same calendar date will be processed as outpatient claims.
- Transfers within the same facility are to be billed as one admission.
- Box 51 – The Medical Assistance number (MA) of the servicing Provider must appear here.
- In the following situations, claims for services provided to plan members must be submitted on paper (not electronically), because additional attachments must be included:
    - The member also has other insurance. A copy of the Explanation of Payment (EOP) or denial letter from the "other insurance" must be included.
    - The claim is for a sterilization procedure. A signed state consent form must be included.

It is the Provider's responsibility to appeal/dispute any adverse claims processing outcomes within 90 days of the date on the EOP or as defined in your MHS Health contract. See *Section 12 Provider Complaints, Grievances and Appeals* for more information.

NPI

Providers must include an NPI for billing, performing, attending, ordering, facility and referring Providers when submitting Provider information. All electronic and paper claims submitted must include an NPI billing Provider, taxonomy code tax identification number, and 9-digit ZIP code of the service location, as outlined below.

Paper Claim Submission for UB-04 Claim Forms

- Form Locator Field 1: The billing Provider service location name, address and **9-digit ZIP code.**
- Form Locator Field 5: Tax Identification number of billing Provider.
- Form Locator Field 56: NPI number of billing Provider.
- Form Locator Field 76: NPI of attending physician.
- Form Locator Field 76: Qualifier = ZZ, plus taxonomy code of attending physician.
  Please note, Field 76 is situational and only required on inpatient services.
- Form Locator Field 77: NPI of operating physician.
  Please note, Field 77 is situational and only required when a surgical procedure is performed.
- Form Locator Field 81CCa: Qualifier = ZZ, plus taxonomy of billing Provider.
  Please note, there may be an additional fee for processing paper claims, consistent with the State of Wisconsin.

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, the hospital inpatient claim received with an admit date equal to the discharge date will be reimbursed at the hospital outpatient rate. Exceptions to this rule are:

- 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 both of the following occur:

- The member is eventually admitted as an inpatient.
- 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." MHS Health Wisconsin, as well as Wisconsin Medicaid, pays hospitals one 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 as shown below. Contractual rates are based on the DRG base rate.

BASIC DRG CALCULATION

Basic DRG Calculation	
1. Hospital Base Rate	*$5309.00*
2. Medicaid DRG Weight	*2.096*
3. Base DRG Amount	*$11,127.66*
4. Add-on Percentage per applicable Provider contract	*1.0%*
5. DRG Payment with applicable add-on percentage	*$11,238.94*
Outlier Calculation	
6. Allowable Claim Charges	*$90,000.00*
7. Cost to Charge Ratio	*0.4949*
*8. Allowable Claim Costs (line6*line7)*	*$44,541.00*
9. DRG Payment	*$11,238.94*
10. Claim Cost Exceeding DRG Payment	*$33,302.06*
11. Hospital Trim Point	*$32,337.00*
12. Claim Costs Exceeding DRG Payment and Trim Point	*$965.06*

13. Variable Cost Factor	*0.7700*
14. Outlier Amount	*$743.10*
15. Allowed Amount for Claim (line 5+Line 14)	*$11.967.04*

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.

DRG & charge validation
The DRG is based on the billed diagnoses and procedure codes and the applicable State DRG Grouper Version. Claims are routinely reviewed for verification of charges and DRG validation. 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 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 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 payors may approve coverage on the basis of an ICD-9 code or ICD-10 when applicable, and payors may set reasonable claim payment deadlines (taking into account delays resulting from missing documents from the initial claim).
>
> Note that payors may not deny coverage solely on the basis of ICD-9 codes or ICD-10 code when applicable. Payors 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 payor (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.

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-9 diagnosis code auditing and review
ICD-9 codes are reviewed and may be moved to different diagnosis categories based on actual adjudication experience. For example, if it is discovered that claims with an ICD-9 diagnosis code that is designated as a non-obvious emergency is being paid 90 percent of the time that ICD-9 diagnosis code may be moved to a more appropriate classification.

MHS Health will consider any requests for reclassifying specific ICD-9 diagnosis codes if the hospital believes MHS has misclassified the diagnosis code. If after review, it is determined that an ICD-9 diagnosis code qualifies for reclassification, the reclassification will apply to all hospitals.

Claims may also be reviewed for validation of the DRG or the billed charges. This process may require copies of medical records or itemized bills. Required documents will be requested by letter or through the remittance advice.

ICD-10 diagnosis code auditing and review
ICD-10 is the next code set for diagnosis and inpatient procedure coding. The switch from ICD-9 to ICD-10 is mandated for October 1, 2015. The transition to ICD-10 is occurring because ICD-9 produces limited data about patients' medical conditions and hospital inpatient procedures. The new codes will impact many parts of the health care process, from patient referrals to billing and payment.
ICD-10-CM/PCS (International Classification of Diseases, 10th Edition, Clinical Modification/ Procedure Coding System) consists of two parts.

ICD-10-CM is for use in all U.S. health care settings. Diagnosis coding under ICD-10-CM uses 3 to 7 digits instead of the 3 to 5 digits used with ICD-9-CM, but the format of the code sets is similar.

ICD-10-PCS is for use in U.S. inpatient hospital settings only. ICD-10-PCS uses 7 alphanumeric digits instead of the 3 or 4 numeric digits used under ICD-9- CM procedure coding. Coding under ICD-10-PCS is much more specific and substantially different from ICD-9-CM procedure coding.
MHS will consider any requests for reclassifying specific ICD-10 diagnosis codes if the hospital believes MHS 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 DRG or the billed charges. 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. These “status” conditions are generally reported with V-codes. While it is true that in some cases it is inappropriate to use a V-code as a primary diagnosis based on the Official ICD-10-CM Guidelines for Coding and Reporting, when correct and complete coding requires the use of V-codes, they should be reported on the claim. 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 Wisconsin network and providing excellent care to our members.

Section 13 Provider Complaints, Grievances and Appeals

MHS Health Wisconsin 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.

Appealing UM decisions
In the event of an adverse determination of medical 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 will 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.

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 or NHP member or Provider acting on behalf of a member may appeal any utilization (medical) 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.

Mail to:
MHS Health Wisconsin
Attn: Grievance and Appeals
10700 W. Research Dr., Suite 300
Milwaukee, WI 53226

This process is explained in the Member Handbook and member newsletters. 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 MHS Health Appeals Committee meeting held weekly. 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.

Inquiry, dispute and appeal of claim payment

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

1. Informal claim payment dispute resolution – A request for a change that is the result of an error in processing such as typographical errors, configuration issues, fee schedules or supported timely filing reconsiderations.
2. Administrative claim appeal (formal appeal) – A request for reconsideration or exception to a plan policy or contract requirement such as benefit limitations, eligibility, failure to obtain authorization or unsupported timely filing.
3. Medical necessity appeal – A request for a review of an adverse decision made by the MHS Health Medical Management Department.

Procedures

Informal claim payment dispute resolution procedure

An informal claim resolution procedure precedes the formal claim resolution procedure. MHS Health procedures for requests for adjustment and reconciliation and resubmission are as follows.

- Allow Provider to make verbal or written inquiries to resolve claims payment issues.
- Must be made 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.
- Must be a verbal inquiry for claim adjustment, correction or overpayment.
- Code Review Denial should be submitted with medical records for review.

Verbal inquiry

To check the status of previously submitted claim(s), call the MHS 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 adjustment

A Provider may request an adjustment when the payment received for a claim is less than the payment expected. The request must be made within 90 days of the date of the EOP 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 Provider Services 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

A Provider may correct and resubmit a claim that was denied because of incorrect or insufficient information. Corrected claims must be resubmitted within 90 days of the date of the EOP or as defined in your MHS Health contract.

- 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. 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. 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.

Paper claims should be mailed to: MHS Health Wisconsin
Attn: Claims Department
PO Box 3001
Farmington, MO 63640-3801

Claim overpayment

A Provider may receive more payment for a claim than is expected. MHS Health will recoup the amount of the overpayment. 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 Centene checks to:
MHS Health Wisconsin
Attn: Returned Checks
PO 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
6417 Paysphere Circle
Chicago, IL 60674-417

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	57	58				

Providers must:

- Submit a request in writing, within 90 days of the adverse finding.
- 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

Administrative claim appeal (formal appeal)

Please reference the *Claim Appeal Form* on the MHS Health website for more information. 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, within 90 days of the adverse finding 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 reconsideration, if applicable.
  Mail to:

MHS Health Wisconsin
Attn: Appeals Department
PO Box 3000
Farmington, MO 63640-3800

An acknowledgement letter will be sent within five business days of receipt of the appeal. A final determination of the review will be communicated within 30 days of receipt of the appeal. After taking these steps, if a Provider has not heard from MHS Health or feels that further appeal is necessary, an appeal may be made to the Wisconsin Department of Health Services.

This appeal must be made within 60 days of receipt of the response from MHS Health.

Mail to:
Medicaid Fiscal Agent
Managed Care Unit
PO Box 6470
Madison, WI 53716-0470

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

Mail to:
MHS Health Wisconsin
Attn: Appeals Department
PO Box 3000
Farmington, MO 63640-3800

Medical necessity appeals are reviewed and decided by a different MHS Health medical director than the medical director who made the original adverse decision. If a member and/or Provider acting on behalf of a member feel further appeal is necessary, an appeal may be made to the Department of Health Services (DHS).

Mail to:
Bureau of Managed Healthcare Programs
Attn: Appeals Contract Specialist
PO Box 309
Madison, WI 53701-0309

Section 14 Member Services

MHS Health Member Services Department is available at 1-888-713-6180 during normal hours of operation Monday through Friday (excluding holidays) from 8 a.m. to 5 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 5 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 NurseWise® nurse advice line for immediate care.

Please ask your patients who are MHS Health or Network Health Plan (NHP) members to direct their questions to MHS Health Member Services at 1-888-713-6180. Member Services 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 representative cannot resolve an inquiry to a member's satisfaction, the call is documented as a complaint. 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 helps members

Selecting a PCP

New members receive a Member Handbook and Provider Directory by mail. The handbook encourages members to select a PCP within 30 days of joining our health plan. If they do 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 Member Services.
- Contacting MHS 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 are able to select both a primary care physician as well as an OB/GYN for all of their primary healthcare needs.

Changing a PCP
Members may change their PCP upon request. Members are allowed to 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, and, as requested, additional languages and formats (e.g., Braille, large font and audiotapes). Materials include:

- Quarterly newsletters.
- Targeted disease management brochures.
- Provider Directory.
- NurseWise® 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.

Provider Inquiry Line
1-800-222-9831

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.

Member rights and responsibilities listed below are included in the Member Handbook mailed to each new member and published annually in member and Provider newsletters.

Member rights and responsibilities
- Have the right to ask for an interpreter and have one provided during any BadgerCare Plus, and Medicaid SSI appointment
- Have the right to an interpreter during any complaint or appeal process.

- Have the right to receive the information provided in a member handbook in another language or another format.
- Have the right to receive healthcare services as provided for in Federal and State law. All covered services must be available and accessible. When medically appropriate, services must be available 24 hours a day, seven days a week.
- Have the right to receive information about this organization, its services, Practitioners, and Providers. To get this information, call Member Services toll-free at 1-888-713-6180.
- Have the right to receive information about this organization's member rights and responsibilities policy.
- Have the right to make recommendations regarding this policy.
- Have the right to receive information about appropriate or medically necessary treatment options for your condition including medication treatment options, regardless of cost or benefit coverage. This includes the right to request a second opinion in a manner appropriate to your condition and ability to understand.
- Have the right to make decisions about your healthcare. This includes the right to refuse treatment.
- Have the right to be treated with respect and with care for your dignity and privacy.
- Have the right to be free from any form of restraint or seclusion used as a means of force, control, ease of reprisal, or retaliation.
- Have the right to request and receive a copy of your medical records and to request that they be amended or corrected as specified in 45 CFR Part 164.
- Have the right to choose a primary care Provider (PCP) for yourself and each member of your family who is eligible under this plan.
- Have the responsibility to yourself to participate in your own healthcare. This includes making and keeping appointments.
- Have the responsibility to understand your health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.
- If you are not able to keep an appointment, you must inform your doctor as soon as possible.
- Members must present ForwardHealth ID card when getting care or prescriptions.
- Have the responsibility to tell your doctor what he or she needs to know to treat you.
- Have the responsibility to follow the treatment plan agreed upon by you and your doctor.
- Have responsibility to keep your information up to date. Please tell the caseworker about changes in income or address.
- Advise the Provider of other insurance and follow the guidelines of the other insurance.

Civil rights

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

All medically necessary covered services are available to all members.

All services are provided in the same manner to all members.

All persons or organizations connected with MHS Health who 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 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 Member Services toll-free at 1-888-713-6180.

Physician incentive plan

Members are entitled to ask if MHS has special financial arrangements with physicians that can affect the use of referrals and other services needed. To obtain this information, call Member Services 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 at:

MHS Health Wisconsin
10700 W. Research Dr. Suite 300
Milwaukee, WI 53226

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 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. An appeal must be made no later than 45 days after the date of the action being appealed. To appeal to MHS Health, call the MHS Health member advocate at 1-888-713-6180 or write to:

MHS Member Advocate
10700 W. Research Dr., Suite 300
Milwaukee, WI 53226

To appeal to the State, call the HMO Ombuds at 1-800-760-0001, or write to:

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

Members may also wish to 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 made no later than 45 days after the date of action being appealed. 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 1-608-266-3096 or TDD/TTY for the hearing impaired,1-608-264-9853.

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 Member Services to initiate a complaint. Member Services can be reached by calling 1-888-713-6180. When an MHS Health Member Services 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 acknowledges receiving the member's complaint by sending a letter to the member (or Provider on behalf of a member) within five business days of the initial complaint.

- Complaints of an emergent nature are resolved immediately.
- Complaints of an urgent nature will be resolved within 48 (forty-eight) hours.
- All other member complaints will be 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 mail, telephone (1-888-713-6180) or in person via the contact information below.

MHS Health Wisconsin
MHS Health Member Advocate
10700 W. Research Dr. Suite 300
Milwaukee, WI 53226

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.

State appeal

A member (or Provider on behalf of a member) may appeal to the State if he or she believes their Medicaid benefits have been unfairly denied, limited, reduced, delayed or stopped by MHS Health. An appeal must be made within 45 days of the date of the action the member is appealing. To appeal, a member must call or write:

EDS, HMO Ombuds
PO Box 6470
Madison, WI 53716

Medicaid Fair Hearing - Phone 1-800-760-0001

A member (or Provider on behalf of a member) may also have the right to appeal to the State of Wisconsin Division of Hearings and Appeals (DHA) for a Fair Hearing if he or she believes their Medicaid benefits have been unfairly denied, limited, reduced, delayed or stopped by MHS. The member will be notified in writing of their right to a Medicaid Fair Hearing.

An appeal must be made within 45 days of the date of the action the member is appealing.
If the action is appealed before its effective date, the service may continue. If the hearing decision is not in favor of the member, the member may need to pay for the cost of the service.

The hearing is held in the member's county. Members may be accompanied by a friend or be represented. To request a Fair Hearing, the member (or Provider on behalf of a member) must write to:

Department of Administration
Division of Hearings and Appeals
PO Box 7875
Madison, WI 53707-7875

Section 15 Provider Credentialing

All network Practitioners must successfully complete the MHS Health credentialing and contracting process.

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 adheres to corporate standards and the guidelines of the National Committee for Quality Assurance (NCQA).

All Practitioners participating with MHS 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. Please contact us at 1-800-547-1647.

MHS Health credentials Providers in the following categories:

- Physician (MD and DO).
- Physician assistants.
- Advanced practice nurse prescribers.
- Certified nurse midwives.

Credentialing Committee
The chief medical officer and/or a peer review committee are responsible for the credentialing and re-credentialing of health plan Practitioners 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 414-773-4002 or call 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 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/NHP 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

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 90 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 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 and freestanding urgent care facilities.

Accrediting bodies recognized by MHS

- 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.

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 Practitioner/Provider has been suspended or terminated by MHS Health Wisconsin, he/she 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 Practitioner and Provider should send a written reconsideration request to:

MHS Health Wisconsin
Attn: Credentialing Department
10700 W. Research Drive
Milwaukee, WI 53226

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, 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 Managed Health Services 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.

Section 16 Transportation

The State of Wisconsin provides transportation benefits. Members enrolled in the State of Wisconsin's Medicaid program will be required to contact Medical Transportation Management, Inc. (MTM, Inc.) for transportation rides throughout the state.

- MTM, Inc. Reservation Line — 1-866-907-1493 (voice) or 1-866-288-3133 (TTY)
- "Where's My Ride" — 1-866-907-1494
- "We Care" For complaints — 1-866-436-0457
- MTM Inc. website — www.mtm-inc.net/wisconsin/

Use this website 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.

Remember, members will still need to call at least two business days before a routine appointment to schedule a ride. If they do not call two business days before an appointment, MTM, Inc. may not be able to provide them with a ride and may have to reschedule their appointment. Members may call up to a month ahead of their scheduled appointment. Urgent calls can be made 24 hours per day 7 days a week.

Name	Contact Information	Purpose
Facility Line	1-866 907-1497	This number is reserved exclusively for healthcare Providers to call and make routine, standing order or urgent reservations for a member.
Transportation Provider Help Desk	1-877 892-3997	This number serves as a primary point of contact for transportation Providers and MTM Inc. for all issues, including, but not limited to, member no-shows, claims, complaints, and operational issues.
Reservation line for routine and urgent rides	1-866 907-1493	This is a reservation number that members and their families and caregivers call to schedule rides. Routine rides can be scheduled Monday-Friday 7:00 a.m. to 6:00 p.m. and must be scheduled at least two business days in advance. Urgent rides can be scheduled 24 hours a day, seven days a week.
Reservation line for deaf and hearing impaired (TTY)	1-800-855-2880	This is a reservation number that members, their families, caregivers, and healthcare Providers call if they are deaf or hearing impaired.
"Where's My Ride"	1-866-907-1494	This number is reserved for members, family members and caregivers, or Providers calling regarding transportation service issues. For example, if transportation is more than 15 minutes late dropping off or picking up a member.
"We Care"	1-866-436-0457	This number is reserved for members, family members and caregivers, or Providers to call regarding a complaint.

Medical Transportation Management	1-866-686-7618 Fax number	The fax number is for case managers, social workers, or healthcare Providers to fax a routine or standing order request.
Medical Transportation Management Website	www.mtm-inc.net/wisconsin/	The website to schedule and cancel routine and standing order rides, file complaints, and obtain forms.
Operations Center	1-866-831-4130	This is the main telephone number for the operations center located in Madison, Wisconsin.

10700 W. Research Dr., Suite 300
Milwaukee, WI 53226

1-888-713-6180

mhs health wisconsin™