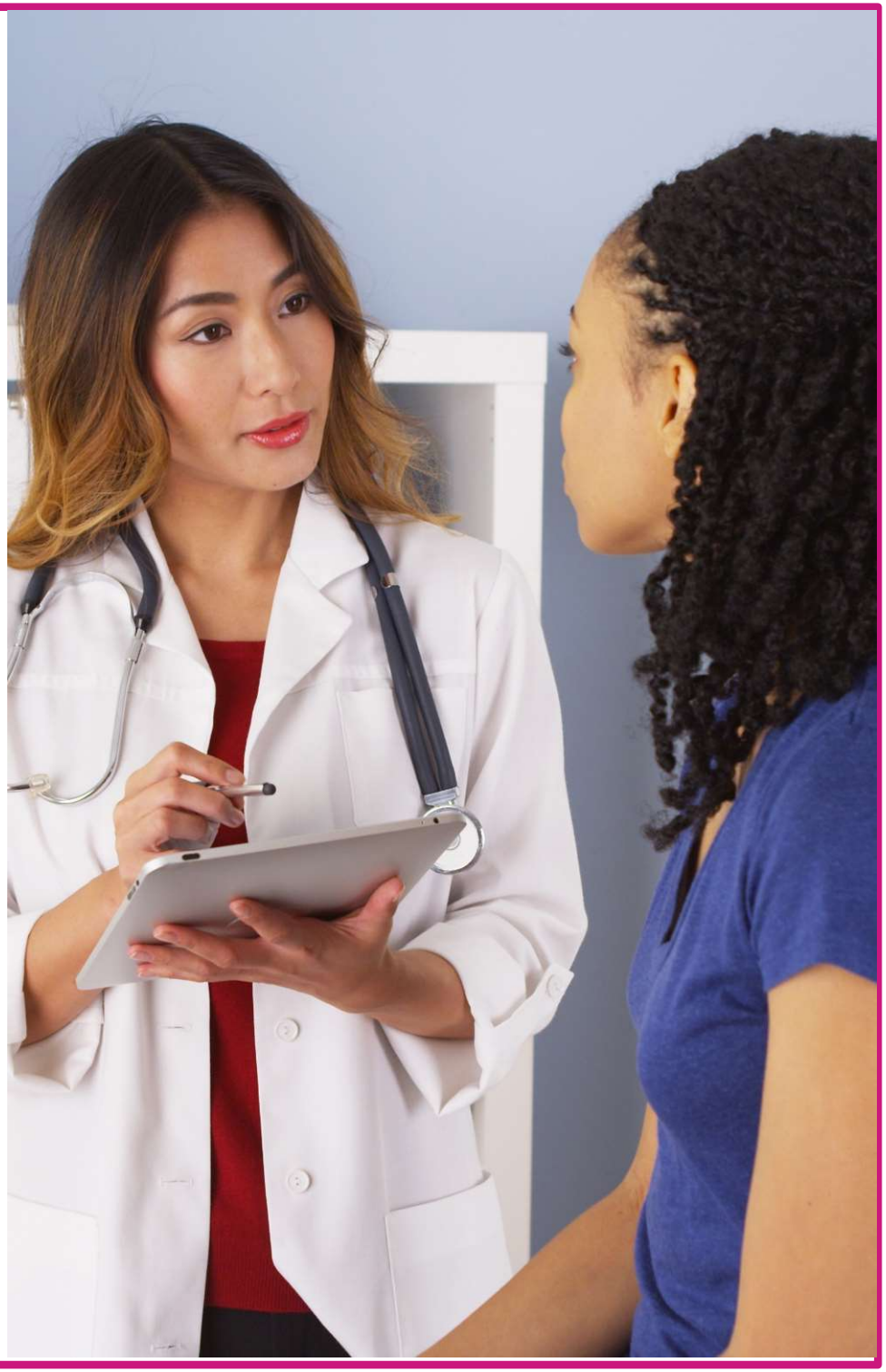
Welcome to MHS Health Wisconsin

Provider Name

Date



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Welcome Packet

- Secure Provider Portal Handouts
- MHS Health Wisconsin At-A-Glance
- Wellcare by Allwell At-A-Glance
- Electronic Funds Transfer - PaySpan Handout
- Interpreter Services Handout
- Tips for Communicating with People with Disabilities
- Provider Manual

All materials including authorization request forms are located on our website under Provider Resources – Manuals, Forms and Resources.

https://www.mhswi.com/providers/resources/forms-resources.html

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Who is MHS Health Wisconsin?

- 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, we serve our members through these programs:
  - BadgerCare Plus
  - Medicaid SSI
  - Medicare Advantage, Special Needs Plan (SNP)

Our purpose: To transform the health of the community, ***one person at a time.***

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Who is MHS Health Wisconsin?

Our brand identities

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BadgerCare Plus and Medicaid SSI

wellcare By allwell.™

Wellcare by Allwell Dual Medicare (HMO D-SNP)

Who is MHS Health Wisconsin?

- **MHS Health Wisconsin relationship with Network Health (NHP)**
  MHS Health Wisconsin administers the benefits for Network Health's BadgerCare Plus and Medicaid SSI members under Network Health's contract with the State of Wisconsin Department of Health Services (DHS).
  - All HMO covered services for these members are offered through MHS Health Wisconsin.
  - Contact MHS Health for Network Health BadgerCare Plus and Medicaid SSI prior authorization and claim processing. Call our Provider Inquiry Line at 1-800-222-9831 or visit our secure provider portal at https://provider.mhswi.com.

network health

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Who is MHS Health Wisconsin?

- **Local Service Backed by National Resources**
  - A comprehensive team located in Wisconsin with offices in West Allis, Appleton and Eau Claire
  - Wholly-owned subsidiary of Centene Corporation, St Louis, MO
    - Centene is a Fortune© 24 company and the largest Medicaid managed care organization in the U.S. with 26+ million members in all 50 states and 3 international markets; 75,900 employees
  - Ensures access to high-quality and culturally sensitive healthcare services
- **Care Coordination/Service Delivery**
  - Our care coordination model is comprehensive and member-focused
  - Promotes a medical home for each member
  - Partner with trusted providers
- **Continuous Quality Improvement**
  - Focuses on member safety, health and satisfaction
  - Emphasis on improved health outcomes for members

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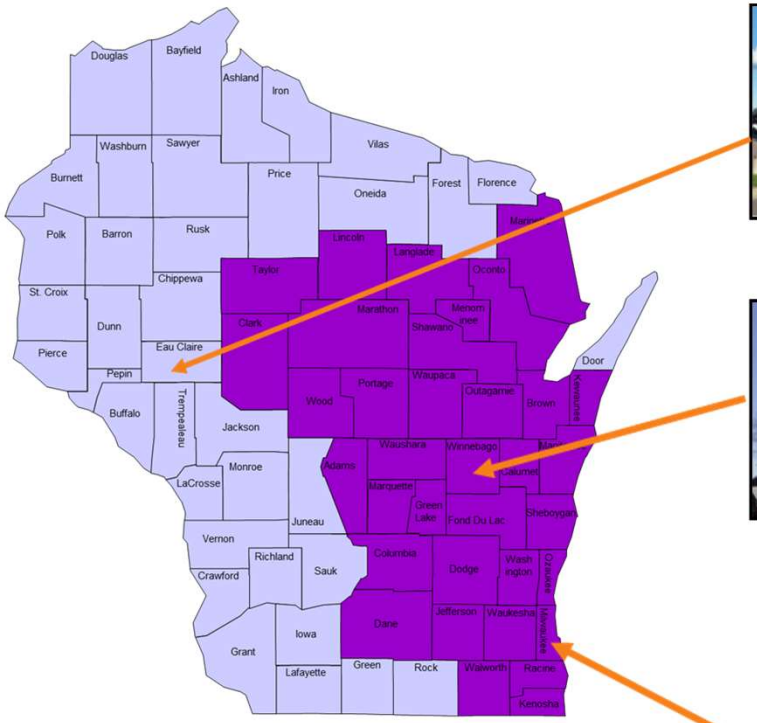
Who is MHS Health Wisconsin?

Statewide presence with local solutions



Medicaid (BC+ and SSI)
D-SNP and Medicaid

Eau Claire Office

Appleton Office

West Allis Office (main)

- Three Locations:
  - West Allis – Main
  - Appleton
  - Eau Claire
- Statewide Medicaid Footprint:
  - All 72 counties
  - Team of > 200 people in Wisconsin
  - Access to high-quality and culturally sensitive healthcare services in all counties
  - Care Coordination with integrated programs supported through local staff
  - Membership YTD: >120,000
  - 126+ Hospitals
  - 26,600+ physicians
- 34 County Medicare Footprint

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Member Eligibility

Wellcare by Allwell

Medicare Advantage Provider Inquiry Line supports our Medicare providers at 1-877-935-8024.

- The simplest way to verify eligibility is through our secure provider portal at *https://provider.mhswi.com*.

MHS Health Wisconsin/Network Health

BadgerCare Plus and SSI Medicaid

- The simplest way to verify eligibility is through our secure provider portal at *https://provider.mhswi.com*.
- Call our Provider Inquiry Line: 1-800-222-9831
- BadgerCare Plus and SSI Medicaid can also be verified through the Forward*Health* portal at *www.forwardhealth.wi.gov*.

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Supplemental Benefits

- **Envolve** – Centene Specialty Company

  - **Nurse Advice Line**: 24/7/365 Multilingual nurse advice provided
  - **Digital Health**: Extensive suite of digital services and health management
  - **Health & Life Coaching**: Multidisciplinary coaching and remote monitoring, blending traditional clinical disease management with behavioral and life assistance
  - **Vision**:
    - Medicaid/BadgerCare: Exam, lenses, and frames, plus an option to upgrade
    - Medicare: $0 copay for routine eye exam; $300 allowance for eyewear every calendar year
  - **Dental**: BadgerCare Plus and SSI Medicaid only in 6 southeastern counties
  - **Medicare Pharmacy** (Wellcare By Allwell)
    - Mail-order Pharmacy provided by Homescripts℠ and CVS Health
    - OTC provided by CVS Health

- **Delta Dental**

  - (Medicare) Wellcare By Allwell: $0 copay per visit for preventive and comprehensive dental services, max allowance of $2,400 every calendar year

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Credentialing

- MHS Health utilizes CAQH for credentialing. Please ensure that your CAQH application is current, fully completed, and includes a copy of your current certificate of insurance.
- Once MHS/NHP receives a **complete** application we can begin processing your request.
- MHS Health will make 3 outreach attempts for missing or expired information before your request is closed.
- Please allow up to 30 days for processing.
- Credentialing staff will notify applicants via email within 10 days of the Credentialing Committee decision.
- Providers can contact our Credentialing team at WI_Cred@mhswi.com.
- Credentialing Reference guide can be found on the MHS website.

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Practice and Practitioner Updates

- **Adding New Practitioners -** Go to "Become a Provider" section on our website, choose Medical or Behavioral Health (BH) and complete all required document(s).
  - Make sure your CAQH application is current, and you have allowed MHS Health Wisconsin access to your application
  - Re-credentialing is completed every 36 months. All MHS providers will be sent a re-credentialing application 90 days in advance of their last re-credentialing date.
- **Provider Changes**: Providers are responsible for notifying MHS Health Wisconsin of all changes to address, license, name or practice. Medical provider should complete and submit the Medical Practice Information Change Form and Behavioral Health providers should complete and submit the BH Provider Demographic Updates Form.
- **Delegated Provider Contracts**: Emailing roster updates at least monthly and full network rosters quarterly to MHS-WIPDM@mhswi.com will ensure accurate data for our directory and claims payment.
- **Methadone Providers**: Required to submit weekly rosters per WI DHS requirements by emailing roster to MHS-WIPDM@mhswi.com.

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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.
- Visit our website https://www.mhswi.com/providers/resources.html for Cultural Competency training resources.

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Cultural Considerations

Interpreter Services

- Interpreters are a covered benefit for our members
- Our policy is that providers use professional interpreters rather than a family member
- Interpreters submit claims directly to MHS Health Wisconsin. There is no additional paperwork or claims to be filed by the provider
- A member or provider may choose an available interpreter service and MHS Health Wisconsin will reimburse the interpreter.

*See **Interpreter List***

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Transportation Services

Non-emergency medical transportation (NEMT) is available through the WI DHS NEMT manager. The NEMT manager arranges and pays for rides to covered services for members who have no way to receive a ride. Non-emergency medical transportation can include rides using:

- Public Transportation, such as a city bus
- Non-emergency ambulances
- Specialized medical vehicles
- Other types of vehicles, depending on a member's medical and transportation needs

Rides must be scheduled by the member at least two business days before scheduled appointments; urgent appointments arrangements can be provided in three hours or less.

Call NEMT MANAGER 1-866-907-1493 OR (TTY 1-800-855-2880)

Monday through Friday 7 a.m. until 6 p.m.

MHS Health Member Services can provider further assistance at 888-713-6180.

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Community Health Services

MHS Health Wisconsin's outreach program is designed to provide member education on how to access healthcare and develop healthy lifestyles in a setting where they feel most comfortable.

Components of the Community Health Services Program:

- Community Connections:
  Connects Members to community resources)
- Home Connections: Connects members who are homebound to other resources)
- Connections Plus®: Provides free pre-programmed cellphones to members who are in case management programs)

Providers can request MHS Health Wisconsin conduct a home visit to help with non-compliance (missed appointments) or other serious concerns. Call 1-800-547-1647.

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Population Health Management

Program Goals

- Improve the quality of life for individuals with chronic conditions and disabilities
- Ensure care in the most appropriate setting
- Increase PCP visits and reduce unnecessary ER visits
- Foster member compliance with Early and Periodic Screening, Diagnostic and Treatment (EPSDT) and scheduling HealthCheck appointments
- Prenatal/postpartum care and other preventive health screenings

Services Include

- Utilization Management (prior authorizations)
- Care Management (to improve the health outcomes of the members we serve)
- Quality Review (clinical outcome review)

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Maternal & Infant Care Management

Start Smart for Your Baby®

- Focuses on high-risk pregnant women and families
- Facts about pregnancy and newborn care
- Provides education and support on community resources and services such as WIC, food, cribs, housing and clothing
- Breastfeeding support and help
- RN and Social Worker staff available to collaborate with providers
- Behavioral health support and resources/education
- Support in helping members quit smoking, alcohol or drugs
- Help choosing a doctor and hospital for their delivery
- Assistance/reminders in keeping up with prenatal and post partum appointments

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Notification of Pregnancy (NOP)

- Allows early entry into prenatal “Start Smart For Your Baby” case management, which improves outcomes for pregnant women and their babies
- A form can be printed from our website - completed forms are faxed to 1-866-671-3668
- You can enter the information directly online via the Secure Provider portal at mhswi.com/providers

Enhanced provider incentives for completion of the NOP form

$75 incentive for submission of each NOP in the **1st trimester**

$50 incentive for submission of each NOP in the **2nd trimester**

$25 incentive for submission of each NOP in the **3rd trimester**

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Utilization Management

- MHS Health utilizes InterQual® Criteria and State of Wisconsin Division of Health Services (DHS) authorization guidelines
- MHS Health uses SAMHSA criteria for Alcohol and Substance Use Services
- Decisions for non-urgent services will be made within 14 calendar days of the receipt of the prior authorization request
- Urgent/expedited authorization requests will be turned around within 72 hours
- Written or electronic notification of the authorization decision will be sent to the provider
- Be sure to request authorizations using the NPI number that will be billed on the claim
- Including all necessary clinical information with the authorization will ensure timely decision making

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Transition of Care Team (TOC)

MHS Health has built out a team that is dedicated solely to engaging/following members through the 30-day period after a discharge from hospital admission

- 100% of our Behavioral Health (BH) admissions are followed for at least 30 days
  - Team of licensed behavioral health clinicians
- Physical health admissions are prioritized by the team to address those at highest risk for readmission, those who have a history of readmissions, those with chronic conditions such a Diabetes or COPD, and those referred by the utilization management team
  - Team of RN's and social workers
- TOC team members ensure follow-up appointments are made and kept, address barriers to follow-up, conduct medication reconciliation, and ensure understanding of discharge instructions
- Following the 30 day transition period, members are referred to longitudinal care management as appropriate

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Quality and Accreditation

Wellcare by Allwell's Star Medicare Rating is 4.5

- CMS provides quality-related information to members to help them choose the highest quality plans available in their area.
- Each contracted plan receives an overall rating that summarizes data into a single star rating (1-5 with 5 representing a superior score).

MHS Health holds NCQA Accreditation

- MHS Health was awarded NCQA accreditation becoming the first NCQA accredited Medicaid managed care organization in the State of Wisconsin.
- We have maintained our accreditation each year since.

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Quality Program

- MHS Health ensures quality & safety of member care.
- MHS Health uses HEDIS ® and CMS quality specifications to measure quality of care. These results are collected by CMS (for Medicare), the State of Wisconsin (for Medicaid), and NCQA (for all lines of business).
- MHS Health has a CMS-approved Medicare Model of Care for its special needs population.
  - Reducing Hospital Admissions
  - Reducing Cardiovascular Risk

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Quality Measures

- Breast Cancer Screening
- Immunizations
- Diabetic Management
- Controlling High Blood Pressure
- Medication Management
- Hospital Readmission Rates
- Asthma/COPD
- Colorectal Screening
- Glaucoma Screening
- Care for Older Adults
- Behavioral Health: FUH & IET

We work hand-in-hand with our network providers to close member care gaps

See HEDIS Quick Reference Guide

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Quality Records

MHS Health strives to ensure our members are getting the care they need. In order to determine if the programs we implement are making a difference, we request medical records throughout the year. Some ways you can help with this are:

- Partnering with WISHIN – Submitting records through WISHIN allows us to review without you having to supply the records to us as well
- Electronic Medical Record (EMR) – Allow MHS Health select staff to log into your EMR system to review member medical records for specific quality outcome measures (BMI, pregnancy, well child visits, etc.)
- Supplemental Data Feeds – Partner with MHS Health to set up a feed where the records can be sent electronically which doesn't cause a lot of administrative work

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HealthCheck Screenings

- Wisconsin Department of Health Services (DHS) requires health plans to assure that 80% of their Medicaid members under the age of 21 have an age-specific number of HealthCheck screenings each year.
- Early & Periodic Screening, Diagnosis & Treatment visits are required for all members under the age of 21. This must be billed as a comprehensive preventive exam (not problem-focused).
- This includes Medicaid SSI members who are under 21 years of age.
- *You will receive higher reimbursement for services billed as a HealthCheck than as routine office visit*.

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My Health Pays Rewards Program

We are dedicated to working with you to help your patients achieve better health outcomes when they take advantage of their preventive care benefits.

- Members earn rewards when they get certain eligible screenings or preventive care.
- Rewards are automatically credited to a prepaid card after each eligible service.
- Members can use their prepaid cards to pay for a variety of eligible products and services.
- Details can be found on the member portion of our website.

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Provider Responsibilities

Access Standards

- Access to culturally sensitive healthcare services
- Insurance neutral appointment scheduling
- Appointment availability
- PCP and Behavioral Health Providers after-hours access
- Provider audits conducted to ensure compliance

See our provider manual on our website www.mhswi.com
for detailed appointment access standards.

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Behavioral Health & Specialty

Practitioner Responsibilities

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

- Coordinate the patient's care with the PCP
- Provide the PCP with consult reports and other appropriate records within five (5) business days

Behavioral Health Providers, while following the HIPAA policies, must stay in contact with members' PCP on treatment plans

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Behavioral Health Screening

Expectations for Pediatrics

SUPPORT Act, Bright Futures

- Per the SUPPORT Act, behavioral health services, including mental health treatment, substance use disorder treatment, and interventions for developmental delays are to be made available to Children's Health Insurance Program (CHIP) populations, which are included in Wisconsin's BadgerCare Plus program.
- MHS Health and Network Health Plan requires its primary care providers to follow the Bright Futures periodicity schedule that was developed and created by the American Academy of Pediatrics.
- HMOs have the responsibility to ensure the use of age-appropriate validated behavioral health screening and assessment tools for individuals aged 0-18 in primary care settings.
- The health plan completes random audits throughout the year that evaluate the provider's adherence to the Bright Futures periodicity table
- More details in Medicaid Provider Manual

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Mental Health Experience of Care & *Health Outcomes (ECHO) Survey*

Our members are surveyed as part of the Consumer Assessment of Healthcare Providers & Systems (CAHPS) program, and we appreciate that our contracted behavioral health providers provide quality services resulting in positive survey responses. Below is a list of areas of opportunity highlighted from our most recent survey.

- **Service Options** – Ensuring members have timely access and multiple avenues to behavioral health (BH) services to reduce the need for ED and crisis center services can have a significant impact in meeting member needs when care is needed "right away." This could include increased awareness of: community BH resources, self-help/support group services, telehealth, or BH crisis and helpline services. Providers can impact appointment wait times and in-office appointment delays through improving scheduling efficiencies.

- **Provider-Member Relationship** – To improve the quality of BH provider-member interactions, providers should focus on what is most important to the member, including regularly providing information and resources, offering alternate treatment options in routine conversation, and respecting the members' right-to-refuse.

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Mental Health Experience of Care &

Health Outcomes (ECHO) Survey

- **Condition Education and Resources** – The majority of respondents sought care for a child with ADHD, family, emotional, or mental health concerns. Ensuring that members have access to educational information, as well as how to find help for these conditions, is a key component to empowering and supporting members to develop self-management and self-symptom-management.
- **Key Areas Of Opportunity** – Primary areas of opportunity identified for improvement are most impacted by BH providers through communication, timeliness of care, patient choice and participation, and in the amount and quality of time spent with patients.

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Social Determinants of Health

CDC defines Social Determinants of Health (SDOH) as conditions in the places where people live, learn, work, and play that affect a wide range of health and quality-of life-risks and outcomes.

Healthy People 2030, U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. Retrieved 12/06/2021, from https://health.gov/healthypeople/objectives-and-data/social-determinants-health

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SDoH Common Screening Tools

SDOH Wheel in Epic

PRAPARE

Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences

PRAPARE Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences

AHC HRSN Screening Tool

Accountable Health Communities Health-Related Social Needs

AAFP

AMERICAN ACADEMY OF FAMILY PHYSICIANS

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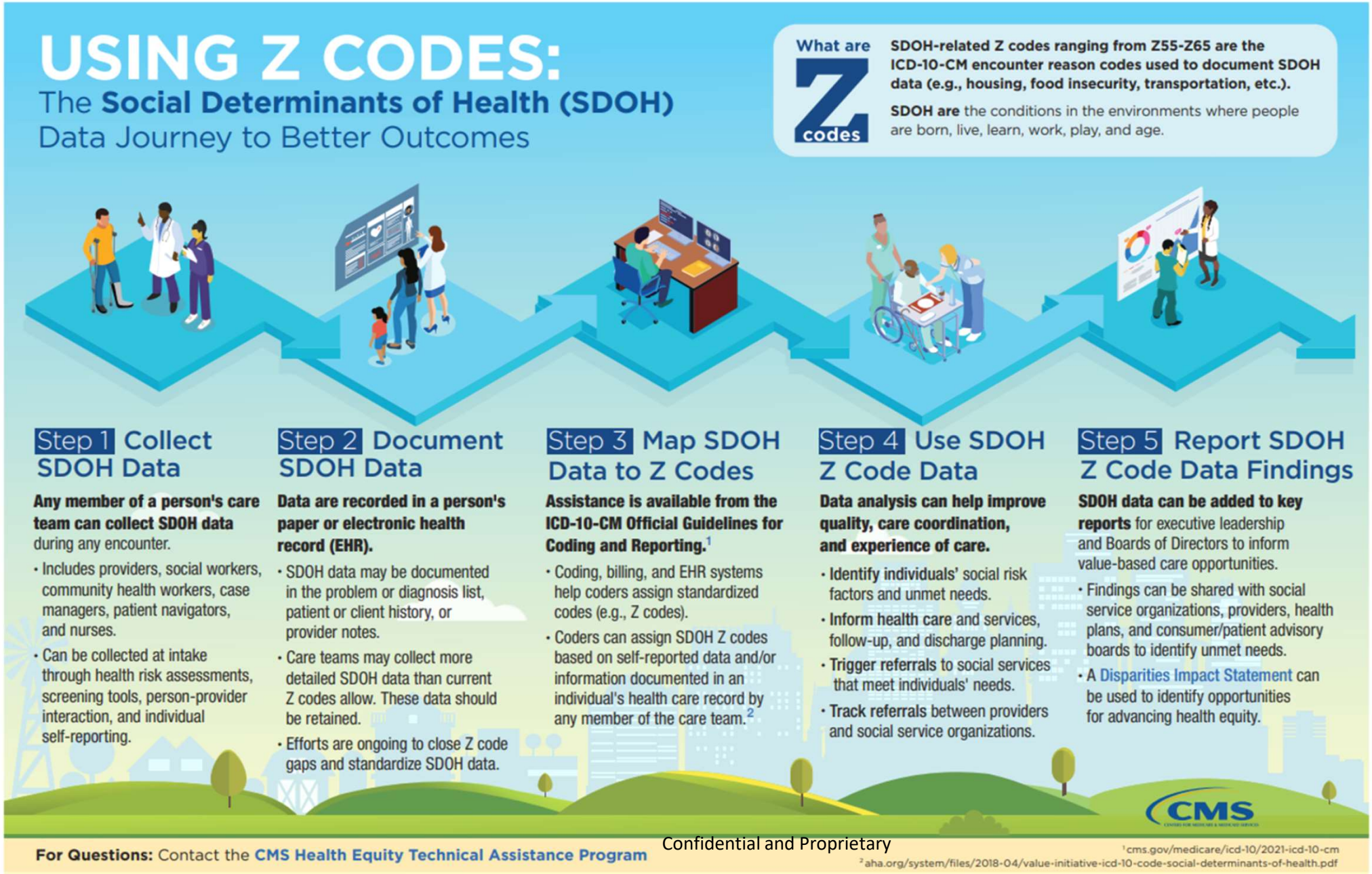
SDOH CMS Resources

Link to CMS info



Provider Trainings &

Education Resources

- Medicare Advantage Model of Care (MOC) training is required for all Medicare eligible providers within 90 days of contracting and annually thereafter**.** Visit the Provider Resources section on our website to complete the training and submit the attestation form at the end of the presentation.
- Jimmo vs Sebelius class action lawsuit settlement addresses the delivery of skilled nursing services to Medicare beneficiaries. All Medicare providers are required to review this training. Visit the Provider Resources section on our website to view the training.
- Behavioral Health Clinical Education - MHS Health offers online clinical education through Relias Learning. Visit the Behavioral Health Clinical Education section on our website.

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Provider Resources

Visit our website where you can:

- Access Secure Provider Portal
- Access Pre-Auth Check Tool
- View the Provider Manual
- View Clinical Practice Guidelines & Payment Policies
- Access our Quick Reference Guides and other resource materials
- Review MHS Health Wisconsin Provider Newsletters
- Get the latest news about MHS Health Wisconsin

Product	Website
BadgerCare Plus/Medicaid SSI	www.mhswi.com
Medicare Advantage SNP	www.wellcare.mhswi.com

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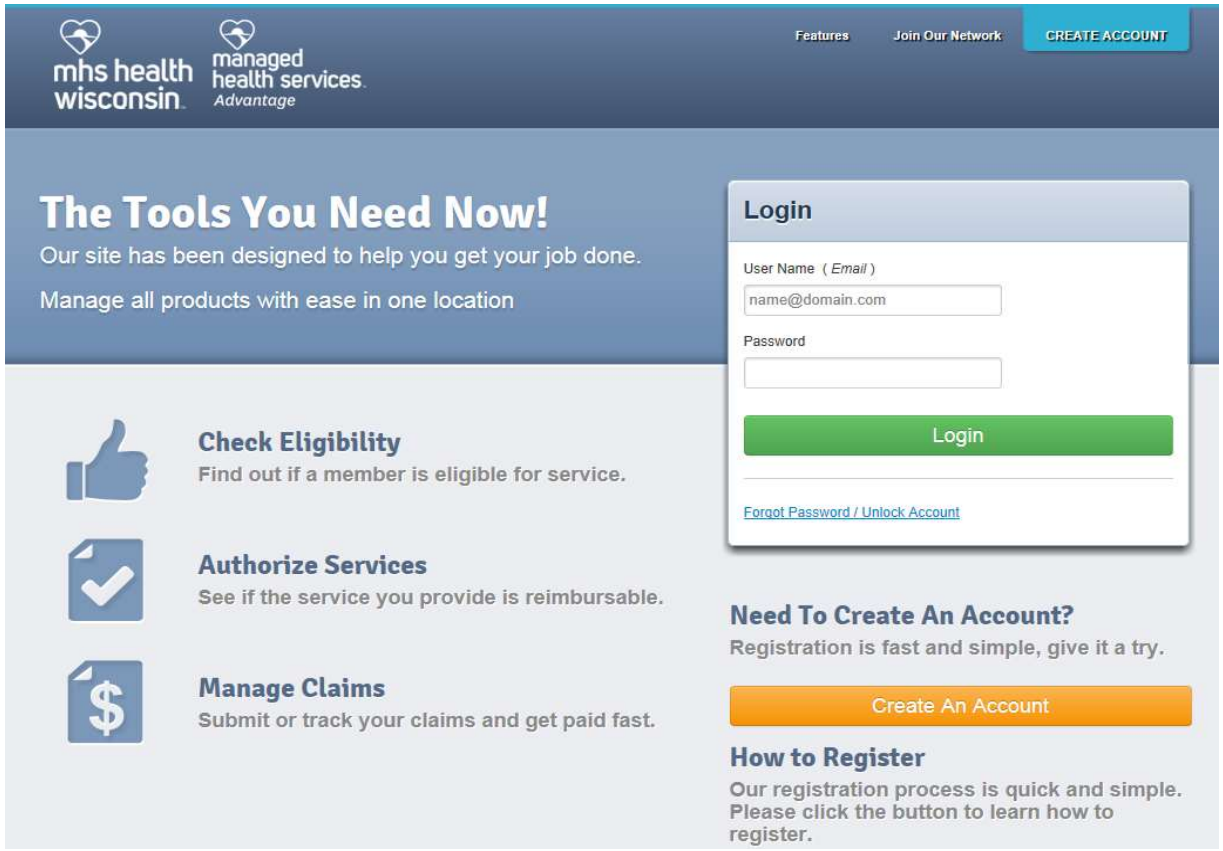
Secure Provider Portal



Registration is free and easy

provider.mhswi.com

Instructions for registering are available on that page

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Secure Provider Portal Highlights

- Member eligibility history and primary insurance information
- Claim information
  - Verify claim status and payment history with download option
  - Online claim submission, adjustment, and reconsideration
- Authorization submission and status
- Patient list access (for PCPs)
- Assessment submission
- Integrated care plan viewing
- Refer members for Care Management/Care Coordination
- Upload documentation for care gap closure

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Secure Provider Portal Tips

CONFIDENTIAL

Keeping the Provider Portal *Secure*

We count on ***you*** to help protect the confidential information of our members

- Each TIN needs at least one Account Manager to regularly monitor the access of its users (verify new accounts, disable those who leave the company, etc.)
- Account Manager access can be set up by your MHS Health Provider Relations rep

Key tips for portal use

- Each user can manage multiple Tax Identification Numbers (TINs) within one account
- Portal accounts will expire after 90 days of inactivity, requiring a password reset by the Account Manager
- An instruction manual for the portal is available at the bottom of each portal page

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Authorization Requirements

To quickly verify whether a service requires prior authorization, use the Pre-Auth Check tool on our website Copies of paper authorization request forms are also available on the site.

Providers may submit authorization requests to MHS Health Wisconsin in a variety of ways:

BadgerCare Plus and Medicaid SSI Authorization Requests

- Fax: (866) 467-1316
- Secure provider portal on our website
- Phone (800) 222-9831
- 24-hour nurse advice line (800) 280-2348 (after-hours, weekend or holiday authorizations)

Wellcare by Allwell Authorization Requests

- Fax: (877) 687-1183
- Secure provider portal on our website
- Phone: (877) 935-8024
- 24-hour nurse advice line (800) 280-2348 (after-hours, weekend or holiday authorizations)

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Authorization Requirements

DME/DMS – Medicaid & Medicare

- Must use in-network MHS Health Wisconsin providers.
- Bill up to purchase price only
- No reimbursement beyond purchase price
- Same guidelines for criteria & quantity limit as Medicaid Fee-For-Service
- DMS items over the Medicaid quantity & Medicare cap limits would need authorization; documentation of medical necessity and an RX is required.

All out-of-network provider services require authorization excluding emergency room services.

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Authorization Requirements

Behavioral Health Authorization Requests

- Secure provider portal on our website
- BadgerCare Plus/Medicaid SSI Outpatient Treatment Fax: (866) 694-3649
- Medicare Outpatient Treatment Fax: (877) 725-7751
- Inpatient psych and detox auth requests call (800) 589-3186 to complete live reviews
- Behavioral Health Authorization Appeals Fax: (866) 714-7991
- BadgerCare Plus/Medicaid SSI Phone: (800) 589-3186
- Medicare Phone: (877) 935-8024
- 24-hour nurse advice line (800) 280-2348 (after-hours, weekend or holiday authorizations)

Behavioral Health Services Requiring Pre-Authorization

- Inpatient Hospitalization & Detoxification
- 23-Hour Observation
- ECT
- IOP/Day Treatment
- Psychological Testing
- All Services by Out-of-Network Providers

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Claim Submission

- Secure Provider Portal
- EDI Submission
  - **Medicaid Claim Payer IDs: Medical - 68069, Behavioral Health – 68068**
  - **Wellcare Claim Payer ID: 68069**
  - Companion guides for EDI billing requirements plus loop segments can be found on our website:
  - If you have additional EDI questions, contact the Centene EDI Department by phone: (800) 225-2573 ext 25525 or by e-mail: EDIBA@centene.com
- Paper Claims
  - View the Provider Manual to find the appropriate mailing addresses and paper claim submission requirements.
- Timely Filing
  - Medicaid first time claims must be received within 90 days of the date of service or as defined by your MHS Health contract.
  - Wellcare first time claims within 120 days of the date of service.

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Medicaid Claims

Inquiry, Dispute & Appeal - Medicaid

MHS Health Wisconsin offers 3 procedures to request evaluation and/or determination of claim payments:

- Informal claims payment dispute resolution via phone or Secure Web Portal
- Administrative claims appeals
- Medical necessity appeals

NOTE: Most incorrect payments can be handled by calling provider services at (800) 222-9831. Behavioral health providers should call (877) 730-2117.

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).

See Provider Manual on our website for more details.

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Claims Filing Timelines

Medicare

- Medicare Advantage Claims are to be mailed to the following billing address:

  Wellcare by Allwell
  Attn: Claims
  P.O. Box 3060
  Farmington, MO 63640-3822

- Participating providers have 120 days from the date of service to submit a timely claim.

- All requests for reconsideration or claim disputes must be received within 90 days from the original date of explanation of payment or denial.

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Medicare Claims

Request for Reconsideration (Level I)

Reconsiderations may be submitted in the following ways:

- Form - Providers may utilize the Request for Reconsideration and Claim Dispute Form found on our website (preferred method) located in the Resources section under Medicare - Manuals, Forms and Resources
- Phone call to Provider Services - This method may be utilized for requests for reconsideration that do not require submission of supporting or additional information. (e.g., When a provider believes a particular service should be reimbursed at a particular rate, but the payment amount did not reflect that particular rate.
- Written Letter - Providers may send a written letter that includes a detailed description of the reason for the request. In order to ensure timely processing, the letter must include sufficient identifying information along with the claim & Explanation of Payment (EOP).

See Wellcare Provider Manual on our website for more details

Medicare Claims

Claim Dispute Level II

- Should be used only when a provider has received an unsatisfactory response to a request for reconsideration.
- Must be submitted on a Request for Reconsideration and Claim Dispute Form found on our website (preferred method) located in the Resources section under Medicare - Manuals, Forms and Resources. This form must be completed in its entirety.
- If the corrected claim, the request for reconsideration, or the claim dispute results in an adjusted claim, the provider will receive a revised Explanation of Payment (EOP). If the original decision is upheld, the provider will receive a revised EOP or letter detailing the decision and steps for escalated reconsideration.
- Wellcare by Allwell will process, and finalize all corrected claims, requests for reconsideration, and disputed claims to a paid or denied status in accordance with law and regulation.

See Wellcare Provider Manual on our website for more details

Billing Members

- **Providers may not bill a plan member for:**
  - A service which was denied payment as a result of the provider's failure to follow MHS Health Wisconsin processes (e.g., failure to obtain prior authorization, untimely (late) filing of claims, etc.)
  - The difference between the billed charges and the contracted reimbursement rate paid by MHS Health Wisconsin.
  - No Show for appointment.
- **Providers must not:**
  - Collect Medicare Part A and Medicare Part B deductibles, coinsurance, or copayments from members enrolled in the Qualified Medicare Beneficiaries (QMB) program, a Medicare-Medicaid dual eligible program which exempts individuals from Medicare cost-sharing liability.
- **Balance billing prohibitions may likewise apply to other dual eligible beneficiaries in Medicare Advantage plans if the State Medicaid Program holds these individuals harmless for Part A and Part B cost sharing.**

See Provider Manual on our website for more details

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Electronic Funds Transfer

- MHS Health Wisconsin partners with PaySpan Health, a FREE solution that helps providers transition into electronic payments and automatic reconciliation.
  - Improves cash flow by getting payments faster
  - Multiple practices and accounts are supported
  - Settle claims electronically
  - Match payments to remittance advices quickly

– Visit **PaySpanHealth.com** and click register.

– ***Visit*** *Electronic Transactions – Payspan EFT/ERA*

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Fraud, Waste, and Abuse

MHS Health follows the four parallel strategies of the Medicare and Medicaid programs to prevent, detect, report, and correct fraud, waste, and abuse:

- Preventing fraud through effective enrollment and education of physicians, providers, suppliers, and beneficiaries.
- Detection through data analytics and medical records review.
- Reporting any identified or investigated violations to the appropriate partners, including contractors, the NBI-MEDIC and federal and state law enforcement agencies, such as the Office of Inspector General (OIG), Federal Bureau of Investigation (FBI), Department of Justice (DOJ) and Medicaid Fraud Control Unit (MFCU).
- Correcting fraud, waste or abuse by applying fair and firm enforcement policies, such as pre-payment review, retrospective review, and corrective action plan.

Fraud, Waste, and Abuse

MHS Health performs front and back-end audits to ensure compliance with billing regulations. Most common errors include:

- Use of Incorrect billing code
- Not following the service authorization
- Procedure code not being consistent with provided service
- Excessive use of units not authorized by the case manager
- Lending of insurance card

Benefits of stopping fraud, waste, and abuse:

- Improves patient care
- Helps save dollars and identify recoupments
- Decreases wasteful medical expenses

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Fraud, Waste, and Abuse

MHS Health expects all its providers, contractors, and subcontractors to comply with applicable laws and regulations, including, but not limited to the following:

- Federal and State False Claims Act
- Qui Tam Provision (Whistleblower)
- Anti-Kickback Statute
- Physician Self-Referral Law (Stark Law)
- Health Insurance Portability and Accountability Act (HIPAA)
- Social Security Act (SSI)
- US Criminal Codes

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Compliance with the State Policy

- Providers may educate and inform their patients about the Health Plan's with which they contract.
- Providers are allowed to assist potentially eligible individuals with enrollment in the Medicaid managed care program by helping them:
  - Apply online at the Access website: www.access.wisconsin.gov
  - Complete the online form
  - Call or go to their county Income Maintenance (IM) agency or tribal agency to complete an application. Visit this site for a map of the different IM and Tribal Agencies per county.
- Providers are allowed to assist potentially eligible individuals with the BadgerCare Plus express enrollment process, as described on the ForwardHealth Portal, if they qualify.
- Providers are allowed to refer patients with questions about the BadgerCare Plus and/or Medicaid SSI programs to an HMO Enrollment Specialist at 1-800-291-2002.

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Compliance with the State Policy

- Providers are prohibited from recommending one HMO over another HMO, offering patients incentives to select one HMO over another HMO, or assisting the patient in deciding to select a specific HMO.
- Providers may inform their patients of the benefits, services, and specialty care services offered through the Health Plan in which they participate.
- Providers may give a member contact information for a particular Health Plan, but only at the member's request.
- Providers participating in D-SNP plans must remain neutral when assisting members with enrollment decisions to ensure that providers do not appear to be a D-SNP plan agent.
- D-SNP plans are allowed to have agreements with providers in connection with plan marketing activities as long as the activity is consistent with Medicare regulations. D-SNP plans may use providers/and or facilities to distribute plan marketing materials as long as the provider and/or the facility distributes marketing materials for all plans with which the provider participates.

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Medicare/Medicaid Reporting

Potential fraud, waste, or abuse reporting may be called to our anonymous and confidential hotline at 1-866-685-8664, or by calling:

- MHS Health Wisconsin at 1-800-547-1647. Ask for the Compliance Officer.
- Or, the Wisconsin Department of Health Services at 1-877-865-3432. Online at www.reportfraud.wisconsin.gov

To report suspected fraud, waste, or abuse in the Medicare program, please use one of the following avenues:

- Office of Inspector General (HHS-OIG): 1-800-447-8477/ TTY: 1-800-377-4950
- Fax: 1-800-223-8164
- NBI MEDIC: 1-877-7SafeRx (1-877-772-3379)
- Email: www.OIG.HHS.gov/fraud or HHSTips@oig.hhs.gov

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Attestation

To verify Orientation was completed:

- ✓ Click on the link below to access the form.
- ✓ Complete the form.
- ✓ Click submit after completion.

CLICK HERE FOR: Orientation Completion Form

Thank you for your time!

MHS Health Wisconsin Provider Relations Team

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