Welcome to MHS Health Wisconsin

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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 in Milwaukee by Elizabeth "Betty" Brinn to manage the healthcare of the Medicaid population.
- Today, we serve the members in the following programs:
  - BadgerCare Plus
  - Medicaid SSI
  - Medicare Advantage, Dual Special Needs Plan (D-SNP)

Our Mission | Transform the health of the community, one person at a time.

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Who is MHS Health Wisconsin?

Our brand identities

mhs health wisconsin — BadgerCare Plus and Medicaid SSI

wellcare By allwell — Medicare Dual Eligible Special Needs (HMO D-SNP)

Who is MHS Health Wisconsin?

MHS Health Wisconsin relationship with Network Health

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.

Who is MHS Health Wisconsin?

- **Local Service Backed by National Resources**
  - Team dedicated to MHS Health Wisconsin
  - Wholly-owned subsidiary of Centene Corporation, St Louis, MO.
    - — Fortune© 500 (#22 in 2024)
    - — Largest Medicaid managed care organization in the U.S.
    - — #1 carrier in the nation on the Health Insurance Marketplace (Ambetter)
    - — Nearly 28 million members in all 50 states
    - — 60,500+ employees
  - Focused on 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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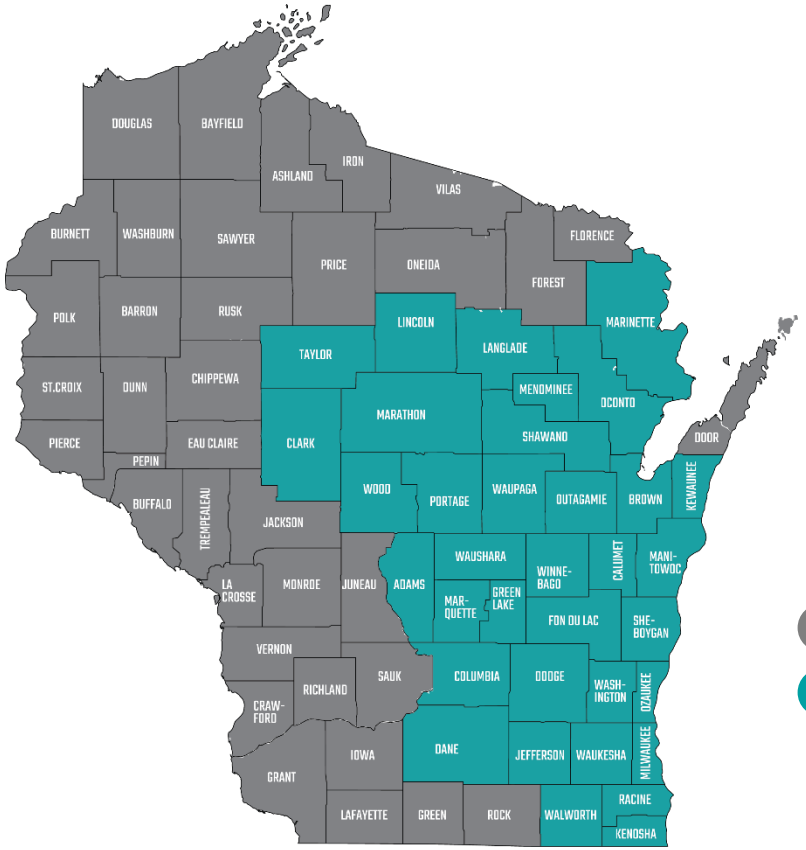
Who is MHS Health Wisconsin?

Statewide presence with local solutions



- West Allis Office
- 150+ MHS Health employees

Medicaid: All 72 counties

Medicare: 35 counties

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Member Eligibility

MHS Health Wisconsin/Network Health

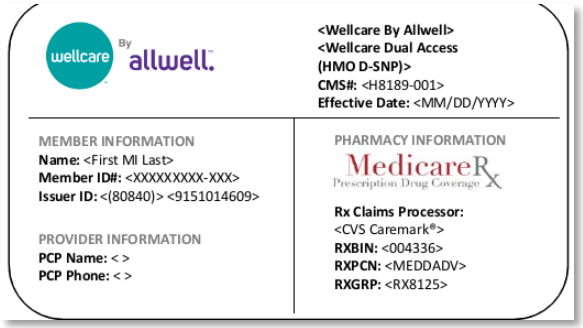
BadgerCare Plus and Medicaid SSI

- 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 Medicaid SSI can also be verified through the ForwardHealth portal at www.forwardhealth.wi.gov.

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



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Supplemental Benefits

- **Envolve** – Centene Specialty Company

  - **Nurse Advice Line**: 24/7 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 Medicaid SSI (only in 6 southeastern counties)
  - **Medicare Pharmacy** (Wellcare By Allwell)
    - Mail-order Pharmacy provided by Homescripts™ and CVS Health
    - OTC provided by CVS Health

- **DentaQuest**

  - (Medicare) Wellcare By Allwell: $0 copay per visit for preventive and comprehensive dental services.

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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 Health 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 QRG can be found on the website under “Join Our Network.”

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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).
  - Re-credentialing is completed every 36 months. All MHS Health 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. Provider's can also update demographic information via the Manage Practice tab on the portal. This new functionality is only available to users that have administrative user access (Account Manager).
- **Notification of Termination:** Providers should notify MHS Health in writing regarding any terminated group or practitioner(s). Please send an email to WI_Provider_Relations@mhswi.com with the provider's name, TIN, NPI, and date of termination.
- **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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Patient Reassignment

- If you have patients who need to be reassigned to another Provider or Practitioner, please use the PCP reassignment template located on our website under Provider Resources.

- By using this template, we can make the reassignment process accurate and timely.

- If you have questions on this process, please reach out to your provider relations representative at 1-800-222-9831 or the Provider Relations mailbox at wi_provider_relations@mhswi.com.

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Cultural Competency

Cultural Competency at MHS Health 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/provider-training/Cultural-Competency.html for Cultural Competency training resources.

THINK CULTURAL HEALTH

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Cultural Considerations

Interpretation and Translation Services

- Interpreters, including American Sign Language, are a covered member benefit at no cost to the member
- Providers can use a third-party vendor or an In-House Interpreter. (FH Update 2023-28)
- 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.
- Upon request, all member written materials will be translated into the member's preferred language or alternative format at no cost to the member. This includes large print, Braille, audio format, electronic file, etc.

See Interpreter vendor list at mhswi.com

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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.

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

Monday through Friday 7 a.m. — 6 p.m.

MHS Health Member Services can also help. Call 1-888-713-6180, M-F, 8-5.

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Community Health Services

MHS Health Wisconsin's Community Health Services team provides member education on how to access healthcare, tools to develop healthy lifestyles, and connections to local community resources to meet members needs.

Components of the Community Health Services Program:

- Community Connections:
  Connects Members to community resources to meet driver of health needs
- Housing Connections: Housing Specialists connect members to resources to obtain safe, affordable, and stable housing
- Health Connections: Asthma and diabetes in-home coaching programs
- Connections Plus®: Provides free pre-programmed cellphones to members who are in case management programs

Providers can request MHS Health Wisconsin attempt to connect with a member to help with non-compliance (missed appointments) or other serious concerns. Call 1-888-713-6180 and ask to speak to a member of the Community Health Services team.

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Pregnancy & Newborn Care

Start Smart for Your Baby®

- Focus on pregnancy and post-partum support
- 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
- Member dollar rewards for member's timely completion of Notice of Pregnancy and Post-Partum Check-Up

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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 ASAM (American Society of Addiction Medicine) 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 and member.
- 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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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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Quality and Accreditation

Wellcare by Allwell's Star Medicare Rating = 4.0

- 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 star rating (1-5 with 5 representing a superior score).

MHS Health Medicaid NCQA Star rating = 4.0

- MHS Health is the first NCQA-accredited Medicaid managed care organization in Wisconsin.

Network Health Medicaid NCQA Star rating = 4.0

MHS Health Medicaid and Network Health Medicaid are accredited for both Health Plan and Health Equity Accreditation by NCQA.

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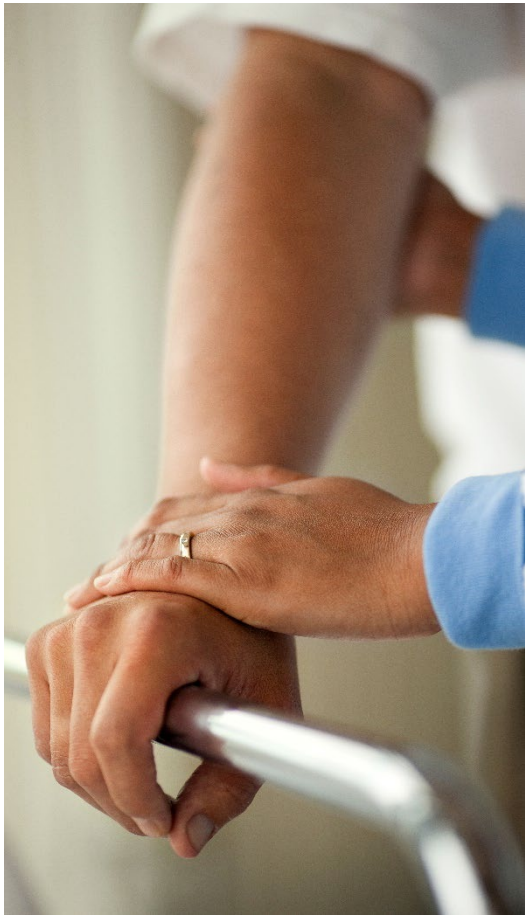
Quality Program

- 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.



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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
- Diabetic Retinal Screening
- Care for Older Adults
- Behavioral Health

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

See HEDIS Quick Reference Guide

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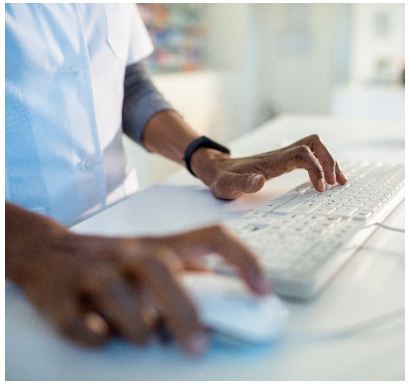
Quality Records



MHS Health strives to ensure our members are getting the care they need. To determine if the programs we implement are making a difference, we request medical records throughout the year.

Ways you can help:

- 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) encourages health plans to assure that 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).

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 visa 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.

my health pays REWARDS

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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.
- Bright Futures Attestation Form is located on our website.
- 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

Outpatient Mental Health 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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Outpatient Mental Health 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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Drivers of Health

CDC defines Drivers of Health (DOH) 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.

Supporting members' total health requires addressing drivers of health (DoH) and understanding the structural barriers in social, economic and political systems that contribute to the inequities. The graphic on the right illustrates the DoH framework with MHS Health membership and the community in the center, as they are at the core of all efforts.

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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 Centene Provider Training.

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Provider Resources

Visit our website where you can:

- Access Secure Provider Portal
- Access Availity
- Access Pre-Auth Check Tool
- View the Provider Manual
- View Clinical and Payment Policies
- View Preventive and Clinical Practice Guidelines
- 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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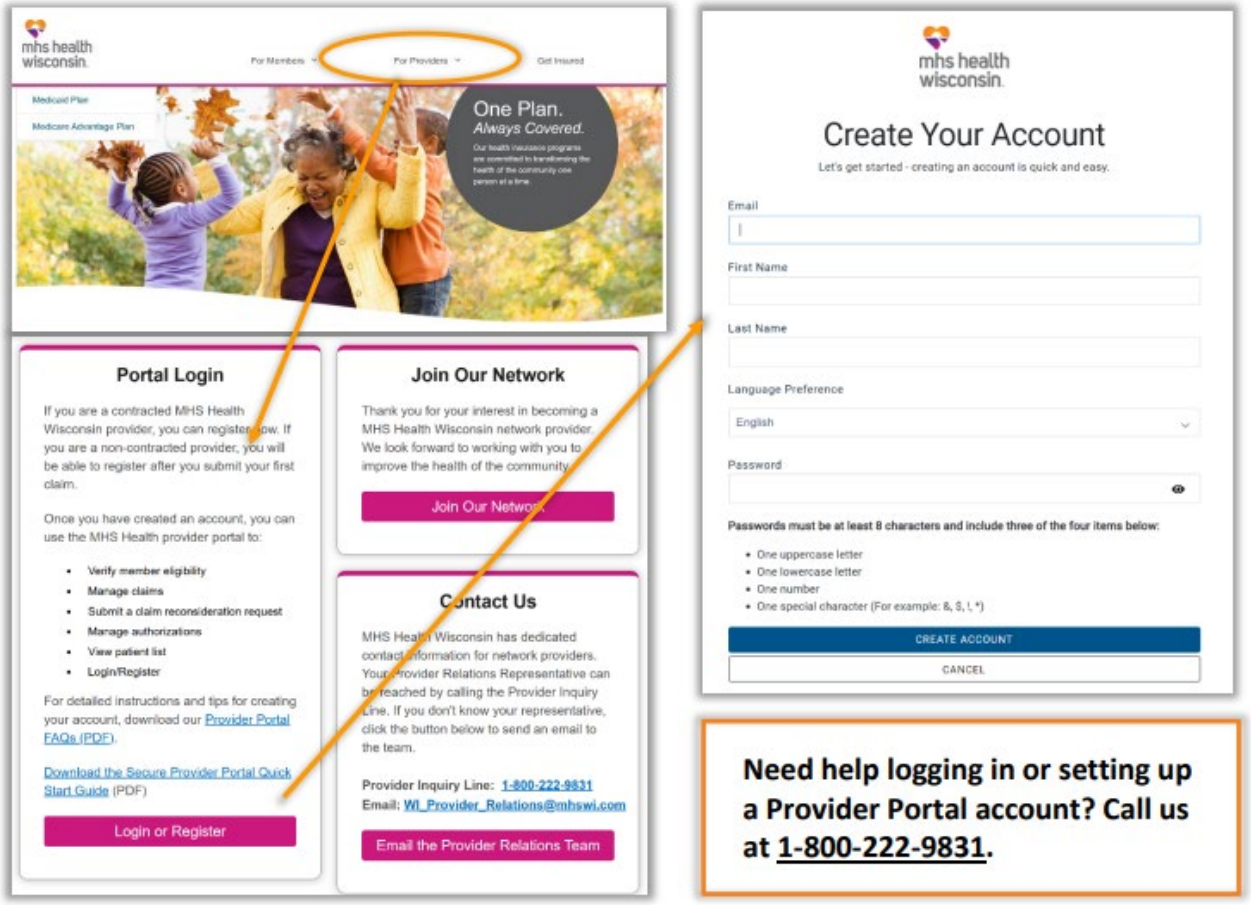
Secure Provider Portal



Registration:
To access the Provider Portal, begin by completing the online registration process that can be found on the login page.

Secure Provider Portal Highlights

After completing online registration, users can enter the Provider Portal to:

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

Updating Provider Information on the Secure Provider Portal:

Most information can be easily updated within the Provider Portal.

Need more help? Access the Secure Provider Portal Quick Start Guide

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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

*As of October 21 ,2024, you can now validate eligibility and benefits, submit claims, check claim status, submit authorizations, and access MHS Health Wisconsin payer resources via **Availity Essentials**. To register for an Essentials account, visit **Register and Get Started with Availity Essentials**. For help with registration, providers can reach out to Availity Client Services at 1-800-AVAILITY (1-800-282-4548). Assistance is available Monday through Friday between 8 a.m. – 8 p.m. ET.

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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

- Medical Services 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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Behavioral Health Authorization Requirements

MHS Health WI - BadgerCare Plus/Medicaid SSI

- BH Provider Customer Service- 877-730-2117
- Outpatient Treatment Fax: 833-522-2807
- Inpatient Treatment Fax: 833-522-2806
- Inpatient psych and detox auth requests call (800) 589-3186 to complete live reviews

Wellcare By Allwell:

- BH Provider Customer Service Phone: (877) 935-8024
- Outpatient Treatment Fax: 833-325-1832
- Inpatient Treatment Fax: 833-325-1831

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 Submissions

- 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
- Timely Filing
  - First time claims must be received within 120 days of the date of service or as defined by your MHS Health contract.
  - All requests for reconsideration or claim disputes must be received within 90 days from the original date of explanation of payment or denial.

Medicaid Claims Dispute & Appeals

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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Medicare Claim Reconsiderations

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. To ensure timely processing, the letter must include sufficient identifying information along with the claim & Explanation of Payment (EOP).

Claim Dispute Level II

- Should be used only when a provider has received an unsatisfactory response to a request for reconsideration.

See Wellcare Provider Manual on our website for more details

Billing Members

- **Providers <u>may not bill</u> 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.

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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