Important Information for Out of Network Providers

Key Contacts

The following chart includes several important telephone and fax numbers available to your office. When calling Home State, please have the following information available:

- NPI (National Provider Identifier) number
- Tax ID Number ("TIN") number
- Member's ID number or MO HealthNet ID number

Health Plan Information		
	Home State 11720 Borman Drive St. Louis, MO 63146 www.HomeStateHealth.com	
Department	**Telephone Number**	**Fax Number**
Provider Services	1-855-694-HOME (4663) TDD/TYY: 711	1-866-390-4429
Member Services	1-855-694-HOME (4663) TDD/TYY: 711	1-866-390-4429
Authorization Request Concurrent Review Case Management	1-855-694-HOME (4663)	1-855-286-1811 1-866-390-3139 1-877-276-8960
Envolve (24/7 Availability)	1-855-694-HOME (4663)	
Missouri Department of Social Services	1-573-751-3425 (MO HealthNet) Text Telephone 1-800-735-2966	1-573-751-6564
Medical Claims	**Reimbursement Rate Dispute**	**Medical Necessity Appeal**
Home State Attn: Claims PO Box 4050 Farmington, MO 63640-3829 **Home State Behavioral Health** PO Box 7400 Farmington, MO 63640-3827	Home State Attn: Claim Disputes PO Box 4050 Farmington, MO 63640-3829	**Home State** Attn: Medical Necessity 11720 Borman Drive St. Louis, MO 63146 **Centene Behavioral Health** Appeals Department 13620 Ranch Road 620 N. Bldg. 300C, Austin, TX 78717-1116
Electronic Claims Submission		

Home State c/o Centene EDI Department 1-800-225-2573, ext. 25525 or by e-mail to: EDIBA@centene.com

Verifying Eligibility

Member Eligibility Verification

To verify member eligibility, please use one of the following methods:

1. **Log on to the secure provider portal at** www.HomeStateHealth.com. Using our secure provider website, you can check member eligibility. You can search by date of service and either of the following: member name and date of birth, or member MO HealthNet ID and date of birth.

2. **Call our automated member eligibility IVR system**. Call 1-855-694-HOME (4663) from any touch tone phone and follow the appropriate menu options to reach our automated member eligibility-verification system 24-hours a day. The automated system will prompt you to enter the member MO HealthNet ID and the month of service to check eligibility.

3. **Call Home State's Provider Services.** If you cannot confirm a member's eligibility using the methods above, call our toll-free number at 1-855-694-HOME (4663). Follow the menu prompts to speak to a Provider Services Representative to verify eligibility before rendering services. Provider Services will need the member name or member MO HealthNet ID to verify eligibility.

Through Home State's secure provider web portal, PCPs are able to access a list of eligible members who have selected their services or were assigned to them. The Patient list is reflective of all changes made within the last 24 hours. The list also provides other important information including date of birth and indicators for patients whose claims data show a gap in care, such as a missed Early Periodic Screening, Diagnosis and Treatment (EPSDT) exam. In order to view this list, log on to www.HomeStateHealth.com. **Since eligibility changes can occur throughout the month and the member list does not prove eligibility for benefits or guarantee coverage, please use one of the above methods to verify member eligibility on date of service.**

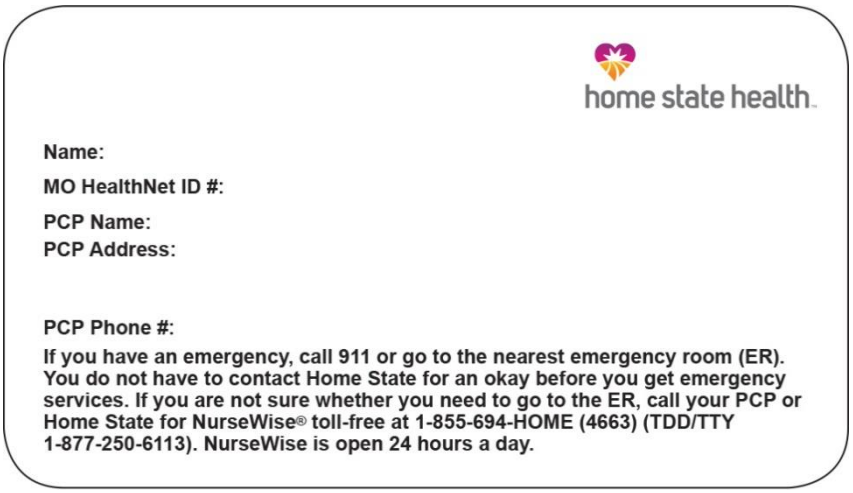
All new Home State members receive a Home State member ID card. A new card is issued only when the information on the card changes, if a member loses a card, or if a member requests an additional card. **Since member ID cards are not a guarantee of eligibility,** providers must verify members' eligibility on each date of service**.**

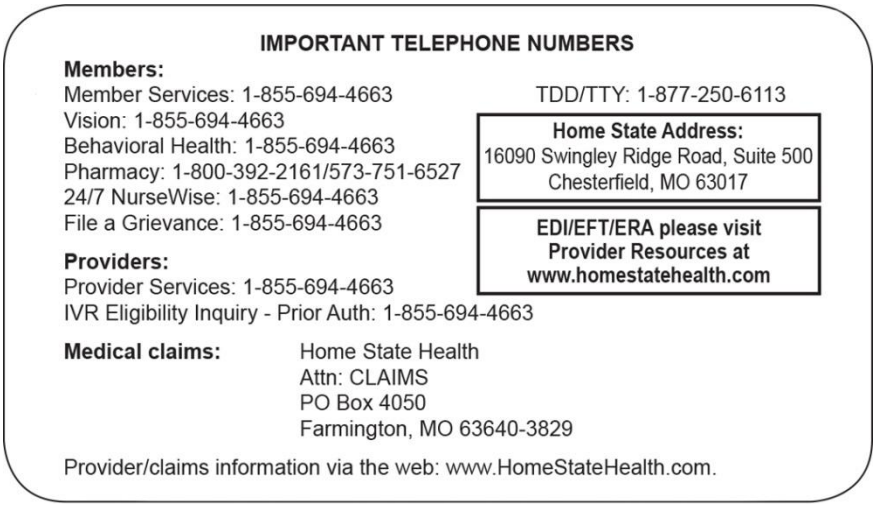
Providers must have a policy in place regarding the provision of non-emergency services to an adult MO HealthNet Managed Care member, including requesting and inspecting the adult member's MO HealthNet identification card (or other documentation provided by the state agency demonstrating MO HealthNet eligibility) and health plan membership card. If the adult member does not produce their health plan membership card, and the provider verifies eligibility and health plan enrollment, the provider may provide service if they have notified the health plan that the member has no health plan identification card. The provider must document this verification in the member's medical record

Member Identification Card

Providers are required to implement a policy of requesting and inspecting an adult member's MO HealthNet identification card (or other documentation provided by the state agency demonstrating MO HealthNet eligibility) and health plan membership card, prior to providing non-emergency services.

If you suspect fraud, please contact Provider Services at 1-855-694-HOME (4663) immediately. Members must keep the state-issued MO HealthNet ID card in order to receive benefits not covered by Home State, such as Pharmacy services. Members are directed to present both identification cards when seeking non-emergency services.





Self-Referrals

The following services do not require prior authorization or referral:

- Emergency services including emergency ambulance transportation
- OB/GYN services with a participating provider
- Women's health services provided by a Federally Qualified Health Center (FQHC) or Certified Nurse Practitioner (CNP)
- Family planning services and supplies from a qualified MO HealthNet family planning provider
- Testing and treatment of communicable disease
- General optometric services (preventative eye care) with a participating provider

Note: Except for emergency services, family planning services, and treatment of communicable disease, the above services must be obtained through Home State network providers.

Prior Authorization and Notifications

Prior authorization is a request to the Home State Utilization Management (UM) department for approval of services on the prior authorization list before the service is delivered.

Authorization must be obtained prior to the delivery of certain elective and scheduled services. Prior authorization should be requested at least five (5) calendar days before the scheduled service delivery date or as soon as need for service is identified.

Emergency room and post stabilization services never require prior authorization. Providers should notify Home State of post stabilization services such as but not limited to the weekend or holiday provision of home health, durable medical equipment, or urgent outpatient surgery, within one business day of the service initiation. Providers should **notify Home State of emergent inpatient admissions (including observation) within one business day** of the admission for ongoing concurrent review and discharge planning. Maternity admissions require notification and information on the delivery outcome. Clinical information is required for ongoing care authorization of the service.

Failure to obtain authorization may result in administrative claim denials. Home State providers are contractually prohibited from holding any Home State member financially liable for any service administratively denied by Home State for the failure of the provider to obtain timely authorization.

Authorization Determination Timelines

Authorization Determination Timelines Home State decisions are made as expeditiously as the member's health condition requires. For standard service authorizations, the decision will be made within thirty-six (36) hours, which shall include one (1) working day, of obtaining all necessary information for routine services. The health plan shall notify the requesting provider within thirty-six (36) hours, which shall include one (1) working day, following the receipt of the request of service regarding any additional information necessary to make a determination. The health plan shall not exceed fourteen (14) calendar days following the receipt of the request of service to provide approval or denial with the possible extension of up to fourteen (14) additional calendar days if the enrollee or the provider requests extension or if the health plan justifies a need (to the state agency, upon request) for additional information and shows how the extension is in the enrollee's best interest. "Necessary information" includes the results of any face-to-face clinical evaluation

(including diagnostic testing) or second opinion that may be required. Failure to submit necessary clinical information can result in an administrative denial of the requested service. For urgent/expedited requests, a decision and notification is made within 24-hours of the receipt of the request. Approval or denial of non-emergency services, when determined as such by emergency room staff, shall be provided within thirty (30) minutes of request. Involuntary detentions (ninety-six (96) hour detentions or court ordered detentions) or commitments shall not 37 Provider Services Department 1-855-694-HOME (4663) · TDD/TTY 711 be prior authorized for any inpatient days while the order of detention or commitment is in effect. For concurrent review of ongoing inpatient admission, decisions are made within one (1) working day of receipt of necessary information. Written or electronic notification includes the number of days of service approved, and the next review date.

Second and Third Opinions

Members or a healthcare professional with the member's consent may request and receive a second opinion from a qualified professional within the Home State network. If there is not an appropriate provider to render the second opinion within the network, the member may obtain the second opinion from an out-of-network provider at no cost to the member. Members have a right to a third surgical opinion when the recommendation of the second surgical opinion fails to confirm the primary recommendation and there is a medical need for a specific treatment, and if the member desires the third opinion. Out-of-network and in- network providers require prior authorization by Home State when performing second and third opinions.

Clinical Information

Authorization requests may be submitted by fax, phone or secure web portal. Authorization determinations may be communicated to the provider fax, phone, secure email, or secure web portal. Adverse determinations will be followed up in writing. When calling our prior authorization department, a referral specialist will enter demographic information and then transfer the call to a Home State nurse for the completion of medical necessity screening. During heavy call volumes, a nurse may answer the telephone and complete the medical necessity screening during the call. For all services on the prior authorization list, documentation supporting medical necessity will be required.

Home State clinical staff request clinical information minimally necessary for clinical decision making. All clinical information is collected according to federal and state regulations regarding the confidentiality of medical information. Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Home State is entitled to request and receive protected health information (PHI) for purposes of treatment, payment and healthcare operations, with the authorization of the member.

Information necessary for authorization of covered services may include but is not limited to:

- Member's name, Member ID number
- Provider's name and telephone number
- Facility name, if the request is for an inpatient admission or outpatient facility services
- Provider location if the request is for an ambulatory or office procedure
- Reason for the authorization request (e.g. primary and secondary diagnosis, planned surgical procedures, surgery date)
- Relevant clinical information (e.g. past/proposed treatment plan, surgical procedure, and diagnostic procedures to support the appropriateness and level of service proposed)
- Admission date or proposed surgery date if the request is for a surgical procedure

- Discharge plans
- For obstetrical admissions, the date and method of delivery, estimated date of confinement, and information related to the newborn or neonate.

If additional clinical information is required, a nurse or medical service representative will notify the caller of the specific information needed to complete the authorization process.

Reimbursement

All Out of Network services require prior authorization.

Facility

Home State Health shall reimburse non-participating hospitals 90% of the MO HealthNet Fee-for-Service Fee Schedule rate effective on the date the service was provided. This reimbursement rate does apply to hospitals providing behavioral health services.

This reimbursement does not apply to the following or any other non-participating reimbursement rates required under law or in the contract, including but not limited to:

a. Provider of outpatient hospital durable medical equipment,
b. Emergency services provided by out of network providers.

Physician

Home State Health shall reimburse non-participating providers, other than hospitals, one hundred percent (100%) of the MO HealthNet Fee-for-Service fee schedule rate effective on the date the service was provided.

This reimbursement rate does not apply to any other non-participating provider reimbursement rates required under law or in the Plan's MO HealthNet Contract, including but not limited to:

a. The reimbursement for non-participating hospitals in the paragraph above,
b. The reimbursement for emergency services provided by out-of-network hospitals,

Billing and Claims Submission

Overview

We are pleased to provide a comprehensive set of instructions for submitting and processing claims with us. You will find detailed information in this section of the manual for initiating transactions, addressing rejections and denials, and processing payments. For questions regarding billing requirements not addressed in this manual, or for any other questions, contact a Home State Health Provider Services Representative at 1-855-694-HOME (4663). In general, Home State Health follows the CMS (Centers for Medicare & Medicaid Services) billing requirements for paper, electronic data interchange (EDI), and web-submitted claims. Home State Health is required by State and Federal regulations to capture specific data regarding services rendered to its members. The provider must adhere to all billing requirements in order to ensure timely processing of claims and to avoid unnecessary rejections and/or denials. **Claims will be rejected or denied if not submitted correctly.**

***Please Note**: Any previous arrangements between a member and provider for private payment will become null and void once a claim for the service is submitted to Home State Health.*

Accurate Billing Information

Home State processes its claims in accordance with applicable State prompt pay requirements. Physicians, other licensed health professionals, facilities, and ancillary provider's contract directly with Home State Health for payment of covered services. It is important that providers ensure Home State Health has accurate billing information on file. Please confirm with your Provider Relations department that the following information is current in our files: • Provider name (as noted on current W-9 form) • National Provider Identifier (NPI)

Note: *Providers can apply for an NPI via the web or by mail.*

To Register Online: To register for an NPI using the web-based process, please visit the following website www.nppes.cms.hhs.gov/NPPES. Click on the link that says, "If you are a healthcare provider, the NPI is your unique identifier." Then click on the link that says, "Apply online for an NPI." This should be the first link. Follow the instructions on the web page to complete the process.

To Register by Mail:

- To obtain an NPI paper application, please call (800) 465-3203 (NPI Toll-Free)
- Tax Identification Number (TIN)
- Taxonomy code
- Physical location address (as noted on current W-9 form)
- Billing name and address

Home State Health requires notification **30 days in advance of changes pertaining to billing information.** Please submit this information on a W-9 form (required for TIN/legal entity name changes) or on business letterhead (accepted for all other billing changes –including billing address) to CHHS_PROVIDER_ROSTER@CENTENE.COM. Changes to a provider's TIN and/or address are not acceptable when conveyed via a claim form.

When required data elements are missing or are invalid, claims will be rejected or denied by Home State Health for correction and re-submission.

- For EDI claims, rejections happen through one of our EDI clearinghouses if the appropriate information is not contained on the claim.
- For paper claims, rejections happen prior to the claims being received in the claims adjudication system and will be sent to the provider with a letter detailing the reason(s) for the rejection.
- Denials happen once the claim has been received into the claims adjudication system and will be sent to the provider via an Explanation of Payment (EOP) or Electronic Remittance Advice (ERA).

Claims for billable services provided to Home State Health members must be submitted by the provider who performed the services or by the provider's authorized billing vendor.

Claims eligible for payment must meet the following requirements:

- The member is effective on the date of service,
- The service provided is a covered benefit under the member's contract on the date of service
- Referral and prior authorization processes were followed, if applicable, and
- Claim is submitted correctly (clean claim) and within the timely filing guidelines (see below)

Payment for service is contingent upon compliance with referral and prior authorization policies and procedures, as well as the guidelines outlined in this handbook.

Verification Procedures

All claims filed with Home State Health are subject to verification procedures. **These include but are not limited to verification of the following:**

- All claims will be subject to 5010 validation procedures based on CMS and MO HealthNet requirements.
- All required fields are to be completed on the current industry standard paper CMS 1500 Claim Form (HCFA), CMS 1450 (UB-04) Claim Form, EDI electronic claim format, or claims submitted individually or in a batch on our Secure Provider Portal.
- All Diagnosis, Procedure, Modifier, Location (Place of Service), Revenue, Type of Admission, and Source of Admission Codes are valid for: – The date of service – Provider type/specialty billing – Bill type – Age of the patient
- All Diagnosis Codes are billed to the greatest specificity
- The Principal Diagnosis billed reflects an allowed Principal Diagnosis as defined in the current published volume of the ICD (International Classification of Diseases) for the date of service billed.
    - For a CMS 1500 claim form, this criteria looks at all procedure codes billed and the diagnosis they are pointing to. If a procedure points to the diagnosis as primary and that code is not valid as a primary diagnosis, that service line will deny.
    - MO HealthNet requires the Present on Admission (POA) indicator for all diagnosis codes submitted on inpatient hospital claims in accordance with state regulation 13 CSR 70-15.200. The POA indicator will be required for discharges beginning on or after March 1, 2011. If the POA indicator is not present, claim reimbursement could be affected. The POA indicator must be present for the “Principal” and “Other” diagnosis codes reported on claim forms UB-04 and 837 Institutional.
- The Member identification number is located in Box 1A of the paper CMS 1500 claim form and Loop ID 2010 BA Segment NM109 of the 837p.
- A member is eligible for services under Home State Health during the time period in which services were provided.
- Appropriate authorizations must be obtained for the services performed if required. Providers can determine authorization requirements by using the Prior Authorization Prescreen Tool on the Home State Health website: https://www.homestatehealth.com/providers/pre-auth-needed.html
- Third party coverage has been clearly identified and appropriate COB (Coordination of Benefits) information has been included with the claim submission.

Clean Claim Definition

A clean claim is defined as a claim received by Home State Health for adjudication which has been completed and submitted in the nationally accepted format without apparent defect in its form completion, or content. In addition, a clean claim is in compliance with all standard coding guidelines and contains no defect, impropriety, and contains all required substantiating documentation. A clean claim contains no particular circumstance requiring uncommon treatment which would otherwise delay or prevent timely payment of the claim. The following exceptions apply to this definition: (a) a claim for which fraud is detected or suspected; and (b) a claim for which a Third-Party Resource should be responsible.

Non-Clean Claim Definition

A non-clean claim is defined as a submitted claim that requires further investigation or development beyond the information contained in the claim. The errors or omissions in the claim may result in; a)

a request for additional information from the provider or other external sources to resolve or correct data omitted from the claim; b) the need for review of additional medical records; or c) the need for other information necessary to resolve discrepancies. In addition, non-clean claims may involve issues regarding medical necessity and include claims not submitted within the filing deadlines.

Claims Filing Deadlines

Original claims (first time claims) must be submitted to Home State Health within 180 calendar days from the date services were rendered or reimbursable items were provided. Corrected claims must be submitted 180 days from the date of the original Explanation of Payment (EOP) or remit date. When Home State Health is the secondary payer, claims must be received within 365 calendar days from date of the final determination of the primary payer. Claims received outside of these time frames will deny for untimely submission. All requests for reconsideration or claim appeals must be received within 180 calendar days from the original date of notification of payment or denial. Prior processing (payment amount or service denial) will be upheld for provider claim requests for claim reconsideration, or claim appeals received outside of this time frame, unless a qualifying circumstance is offered and appropriate documentation is provided to support the qualifying circumstance. **Qualifying circumstances include:**

• Catastrophic event that substantially interferes with normal business operations of the provider or damage or destruction of the provider's business office or records by a natural disaster.

• Mechanical or administrative delays or errors by Home State Health, MO HealthNet, or the Missouri Department of Health and Human Services.

• The member was eligible however the provider was unaware that the member was eligible for services at the time services were rendered. Consideration is granted in this situation only if all of the following conditions are met:

– The provider's records document that the member refused or was physically unable to provide their ID card or information.

– The provider can substantiate that he continually pursued reimbursement from the patient until eligibility was discovered.

– The provider can substantiate that a claim was filed within 180 days of discovering plan eligibility.

– The provider has not filed a claim for this member prior to the filing of the claim under review.

Electronic Claims Submission

Network providers are encouraged to participate in Home State electronic claims/encounter filing program. The plan has the capability to receive an ANSI X12N 837 professional, institutional or encounter transaction. In addition, it has the ability to generate an ANSI X12N 835 electronic remittance advice known as an Explanation of Payment (EOP).

For more information on electronic filing and what clearinghouses Home State has partnered with, contact:

Home State
C/o Centene EDI Department
1-800-225-2573, extension 25525 or by e-mail at:
EDIBA@centene.com

Providers that bill electronically are responsible for filing claims within the same filing deadlines as providers filing paper claims. Providers that bill electronically must monitor their error reports and evidence of payments to ensure all submitted claims and encounters appear on the reports. Providers are responsible for correcting any errors and resubmitting the affiliated claims and encounters.

Home State Payer ID is 68069 and we work with the following clearinghouses:

- Emdeon

- SSI
- Trizetto Provider Solutions
- Availity

Paper Claims Submission

Paper Claim Form Requirements Home State Health only accepts the CMS 1500 (02/12 version) and CMS UB-04 paper claim forms. Other claim form types will be rejected.

Professional providers and medical suppliers complete the CMS 1500 (02/12) form, and institutional providers complete the CMS UB-04 claim form. Home State Health does not supply claim forms to providers. Providers should purchase these from a supplier of their choice. All paper claim forms must be typed or printed, and in the original red and white version to ensure clean acceptance and processing. **No black and white or handwritten information will be accepted on the claim form.** If you have questions regarding what type of form to complete, contact Home State Health Provider Services at 1-855-694-HOME (4663). 58 Provider Services Department 1-855-694-HOME (4663) · TDD/TTY 711

Submit claims to Home State Health at the following address:

First Time Claims and Corrected Claims:

Home State Health
Claim Processing Department
P. O. Box 4050
Farmington, MO 63640- 3829

Home State Health Behavioral Health
Attn: Claims
PO Box 7400
Farmington, MO 63640-3827

Claim Reconsiderations:

Home State Health Plan
Attn: Claim Reconsideration
P. O. Box 4050
Farmington, MO 63640- 3829

Claim Appeals:

Home State Health Plan
Attn: Claim Appeal
P. O. Box 4050
Farmington, MO 63640-3829

Authorization Appeals:

Home State Health
Attn: Authorization Appeal
11720 Borman Dr.
St. Louis, MO 63146

Centene Behavioral Health
Appeals Department

13620 Ranch Road 620 N, Bldg. 300C,
Austin, TX 78717-1116

Home State Health encourages all providers to submit claims electronically. Our Companion Guides for electronic billing are available on our website at www.homestatehealth.com Paper submissions are subject to the same edits as electronic and web submissions.

Additional Claims Considerations

• It is plan policy to implement benefit and contract updates, including fee schedule updates, within 60 days of release from the applicable state agency or signature date of a provider contract. The health plan does not reprocess claims when configuration is completed within this timeliness standard, even if the effective date of the change was prior to the final date of implementation.

• Submission of claims (whether electronically, via paper or through the secure portal) is considered provider verification that all data is true, accurate and complete.

• By accepting payment (via check or ACH) providers indicate they understand that payment is from Federal and State funds, and that any falsification, or concealment of a material fact, may be prosecuted under Federal and State laws.

• All provider national provider identification numbers (NPIs) on a claim - rendering, site, servicing and group - must be enrolled in the MO HealthNet program in order for the health plan to process payments for service
• Providers may only participate under one contractual arrangement.

Electronic Funds Transfers (EFT) and Electronic Remittance Advices (ERA)

Home State provides an innovative web-based solution for Electronic Funds Transfers (EFT's) and Electronic Remittance Advices (ERA's). Through this service, providers can take advantage of EFTs and ERAs to settle claims electronically. As a Provider, you can gain the following benefits from using EFT and ERA:

- Reduce accounting expenses – Electronic remittance advices can be imported directly into practice management or patient accounting systems, eliminating the need for manual re-keying
- Improve cash flow – Electronic payments mean faster payments, leading to improvements
  in cash flow
- Maintain control over bank accounts – You keep TOTAL control over the destination of claim payment funds and multiple practices and accounts are supported
- Match payments to advices quickly – You can associate electronic payments with electronic remittance advices quickly and easily

For more information, please visit our provider home page on our website at www.HomeStateHealth.com.

If further assistance is needed, please contact Provider Services 1-855-694-HOME (4663).

Third Party Liability

Third party liability refers to any other health insurance plan or carrier (e.g., individual, group, employer-related, self-insured or self-funded, or commercial carrier, automobile insurance and worker's compensation) or program that is or may be liable to pay all or part of the healthcare expenses of the member.

Home State is always the payer of last resort. Home State providers shall make reasonable efforts to determine the legal liability of third parties to pay for services furnished to Home State members. If the provider is unsuccessful in obtaining necessary cooperation from a member to identify potential third party resources, the provider shall inform Home State that efforts have been unsuccessful. Home State will make every effort to work with the provider to determine liability coverage.

If third party liability coverage is determined after services are rendered, Home State will coordinate with the provider to pay any claims that may have been denied for payment due to third party liability.

Authorization Appeals

Pre- or Post- service Authorization Appeals, including Medical Necessity Appeals, may be filed by a provider with knowledge of a Member's medical condition. A provider may also file an appeal on behalf of a member with the member's written consent. Authorization Appeals will be accepted within 60 calendar days from Home State Health's notice of an adverse benefit determination.

Payment Policies

Home State continually reviews and updates our payment and utilization policies to ensure that they are designed to comply with industry standards while delivering the best patient experience to our members.

Home State applies these as medical claims reimbursement edits within our claims adjudication system. These policies should be familiar, as they follow CMS/National Correct Coding Initiative (NCCI) guidelines, American College of Obstetricians and Gynecologists (ACOG) and have already been put in place by other payers. They are developed based on medical literature and research, industry standards and guidelines as published and defined by the American Medical Association's Current Procedural Terminology and most will impact only a small segment of providers who may be coding outside of standard practice.

Our current payment policies are located on our public website at www.homestatehealth.com.

Claim Requests for Reconsideration, Claim Disputes and Corrected Claims

Corrected claims must be submitted within 180 days from the date of service. All claim requests for reconsiderations and claim disputes must be received within 180 days from the date of original notification
of payment or denial was issued.

If a provider has a question or is not satisfied with the information s/he has received related to a claim, there are five effective ways in which the provider can contact Home State.

1. **Review the claim in question on the secure Provider Portal:**

   – Participating providers, who have registered for access to the secure provider portal, can access claims to obtain claim status, submit claim reconsiderations, and submit a first time or corrected claims. Supporting documentation can also be uploaded via the secure provider portal when filing claims reconsiderations.

All submissions sent through the portal allow for real-time tracking of Claim Status.

The Provider Portal allows Providers to obtain up-to-date information (24/7) without having to make a phone call. It's simple and secure way to:

– Verify eligibility and benefits

– View assigned membership

– View Care Plans

– View and submit authorizations

– Submit and check status of claims

– Review payment history

– Submit Provider Demographic Updates

– Secure Contact Us

– View Care Gaps/P4P Incentive Program

– Risk Adjustment IMPACT Incentive Program

– Submit and track claim reconsiderations

Visit https://www.homestatehealth.com/login.html to sign up for access to the Provider Portal

2. **Submit an Adjusted or Corrected Claim to Home State Health via the Provider Portal:**

Corrected claims must clearly indicate they are corrected in one of the following ways:

- Submit corrected claim via the secure Provider Portal
    - Within the Claim Details screen, select the "Correct Claim" option in the upper left
- Follow the instructions on the Provider Portal for submitting correction:
    - Submit corrected claim electronically via Clearinghouse
    - Institutional Claims (UB): Field CLM05-3 = 7 and REF*F8 = Original Claim Number
    - Professional Claims (HCFA): Field CLM05-3 = 6 and REF*F8 = Original Claim Number
- Resubmissions should be indicated by populating field 22 on the HCFA claim form, and populating field 64 in addition to a corrected type of bill on a UB.
- Please note hand written claims will be rejected.

If you do not have access to the Provider Portal, please mail corrected claims to:

Home State Health

Attn: Corrected Claim

PO Box 4050

Farmington, MO 63640-3829

Home State Health Behavioral Health

Attn: Corrected Claim

PO Box 7400 Farmington, MO 63640-3827

– Paper claims must clearly be typewritten or stamped as "RE-SUBMISSION" or

"CORRECTED CLAIM" and must include the original claim number; or the original EOP must be included with the resubmission.

– Failure to type or stamp the claim as a resubmission and include the original claim number (or include the EOP) may result in the claim being denied as a duplicate, a delay in the reprocessing, or denial for exceeding the timely filing limit. – The Claim Adjustment Form can be located on the provider website at HomeStateHealth.com

3. **Submit a "Claim Reconsideration" to Home State Health via the Provider Portal:**

– A claim reconsideration is an informal request from a provider (via phone, meeting, or email) for a claim review and potential adjustment OR a written reprocessing request submitted using the Plan's secure portal or P.O. Box of a Properly Denied or Reduced claim with supporting information that justifies additional payment.

– The request must include sufficient identifying information which includes, at a minimum, the patient name, patient ID number, date of service, total charges and provider name.

– The documentation must also include a detailed description of the reason for the request.

If you do not have access to the Provider Portal, please mail Claim Reconsiderations to:

Home State Health

Attn: Claim Reconsideration

PO Box 4050 Farmington, MO 63640-3829

Home State Health Behavioral Health

Attn: Claim Reconsideration

PO Box 7400

Farmington, MO 63640-3827

4. **Submit a "Provider Reconsideration and Appeal Request Form" to Home State Health:**

– An Authorization Appeal is a formal written request to reconsider an authorization denial (pre- or post-service), generally within 60 days of denial or reduction for Medicaid.

– A Claim Appeal is a formal written request for additional payment of a previously adjudicated electronically submitted Clean Claim. Providers must submit Claim Appeals in accordance with the process and timelines as outlined in the provider manual (generally 180 days from date of the transaction) or provider contract, if different.

– The Claim or Authorization Appeal Form can be located on the Home State Health provider website at HomeStateHealth.com.

– To expedite processing of your Claim or Authorization Appeal, please include all supporting documentation.

– For Claim Appeals, mail your "Provider Reconsideration and Appeal Request Form" and all related documentation (A copy of the EOP(s) with the claim numbers to be adjudicated clearly circled, and the response to your original Claim Reconsideration. **Do not attach original claim form**) to:

Home State Health

Attn: Claim Appeal

PO Box 4050

Farmington, MO 63640-5000

Home State Health Behavioral Health

Attn: Claim Appeal

PO Box 6000

Farmington, MO 63640-3827

– For Authorization Appeals, mail your "Provider Reconsideration and Appeal Request Form" and all related documentation (A letter outlining the reason for your request and applicable medical records supporting your request) to:

Home State Health

Attn: Authorization Appeal

11720 Borman Dr.

St. Louis, MO 63146

Centene Behavioral Health

Appeals Department

13620 Ranch Road 620 N, Bldg. 300C,

Austin, TX 78717-1116

5. **Contact a Home State Health Provider Service Representative at 1-855-694-HOME (4663)**

Providers may inquire about claim status, payment amounts or denial reasons. A provider may also make a request for reconsideration by clearly explaining the reason the claim is not adjudicated correctly. Please keep record of your call reference number, time and date of the call, name of the representative, and any take-away actions discussed during the call.

If the Provider Service discussion, the corrected claim, the request for reconsideration, or the claim appeal 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.

Home State Health shall process, and finalize all corrected claims, claim reconsiderations and claim appeals to a paid or denied status in accordance with State law and regulations.

GRIEVANCES AND APPEALS PROCESS

Member Grievances

A member grievance is defined as any member expression of dissatisfaction about any matter other than an "adverse action."

The grievance process allows the member, (or the member's authorized representative (family member, etc.) acting on behalf of the member or provider acting on the member's behalf with the member's written consent), to file a grievance either orally or in writing. Home State Health will acknowledge receipt of each grievance in the manner in which it is received. Any individuals who make a decision on grievances will not be involved in any previous level of review or decision making. In any case where the reason for the grievance involves clinical issues or relates to denial of expedited resolution of an appeal, Home State Health shall ensure that the decision makers are health care professionals with the appropriate clinical expertise in treating the member's condition or disease. [42 CFR § 438.406] Home State Health values its providers and will not take punitive action, including and up to termination of a provider agreement or other contractual arrangements, for providers who file a grievance on a member's behalf. Home State Health will provide assistance to both members and providers with filing a grievance by contacting our Member/Provider Services Department at 1-855-694-HOME (4663) for Home State Health/ 1-877-236-1020 for Show Me Healthy Kids managed by Home State Health. Acknowledgement Staff receiving grievances orally will acknowledge the grievance and attempt to resolve them immediately. Staff will document the substance of the grievance. For informal grievances, defined as those received orally and resolved immediately to the satisfaction of the member, representative or provider, the staff will document the resolution details. The Complaint and Grievance Coordinator (CGC) will date stamp written grievances upon initial receipt and send an acknowledgment letter, which includes a description of the grievance procedures and resolution time frames, within ten (10) calendar days of receipt.

Acknowledgement

Staff receiving grievances orally will acknowledge the grievance and attempt to resolve them immediately. Staff will document the substance of the grievance. For informal grievances, defined as those received orally and resolved immediately to the satisfaction of the member, representative or provider, the staff will document the resolution details. The Complaint and Grievance Coordinator (CGC) will date stamp written grievances upon initial receipt and send an acknowledgment letter, which includes a description of the grievance procedures and resolution time frames, within ten (10) calendar days of receipt.

Grievance Resolution Time Frame

Grievance Resolution will occur as expeditiously as the member's health condition requires, not to exceed 30 calendar days from the date of the initial receipt of the grievance. Grievances will be resolved by the CGC, in coordination with other Home State Health staff as needed. In our experience, most grievances are resolved at the staff level to the satisfaction of the member, representative or provider filing the grievance. Expedited grievance reviews will be available for members in situations deemed urgent and will be resolved within 72 hours. Home State Health may extend the timeframe for disposition of a grievance for up to 14 calendar days if the member requests the extension or the health plan demonstrates (to the satisfaction of the state agency, upon its request) that there is need for additional information and how the delay is in the member's best interest. If Home State Health extends the timeframe, it shall, for any extension not requested by the member, give the member written notice of the reason for the delay

Notice of Resolution

The CGC will provide written resolution to the member, representative or provider within the timeframes noted above. The letter will include the resolution and MO HealthNet requirements.

The grievance response shall include, but not be limited to, the decision reached by Home State Health, the reason(s) for the decision, the policies or procedures which provide the basis for the decision, and a clear explanation of any further rights available to the member in accordance with MO HealthNet policies. A copy of verbal complaint logs and records of disposition or written grievances shall be retained for seven years.

Grievances may be submitted by written notification to:

Home State Health Plan

Complaint and Grievances Coordinator (CGC) Home State Health

11720 Borman Drive

St. Louis, MO 63146

1-855-694-4663

Member Medical Necessity Authorization Appeals

A medical necessity authorization appeal is a formal written or verbal request to reconsider an authorization denial. An appeal is the request for review of an adverse benefit determination. An adverse benefit determination is the denial or limited authorization of a requested service, including the type or level of service, requirements for medical necessity, appropriateness, setting or effectiveness of a covered benefit; the reduction, suspension, or termination of a previously authorized service; the denial, in whole or part, of clean claims for a service; failure to provide services in a timely manner as defined in the appointment standards described herein and state requirements specified at 20 CSR 400-7.095; the failure to act within the time frames regarding the standard resolution of grievances ; the denial of a member's request to exercise his/her right under 42 CFR 438.52(b)(2)(ii) to obtain services outside the Home State Health network; and the denial of a member's request to dispute financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance and other member financial liabilities.

An appeal may be requested in writing or orally. Members may request that Home State review the adverse benefit determination to verify if the right decision has been made. A provider or an authorized representative may request an appeal on behalf of a member with the member's written consent, with the exception that providers cannot request continuation of benefits as specified in 42 CFR 438.420(b)(5). Appeals must be made within 60 calendar days from the date on Home State Health's notice of adverse benefit determination. Home State Health shall acknowledge receipt of each appeal in writing within 10 calendar days after receiving an appeal. Home State Health shall resolve each appeal and provide written notice of the appeal resolution, as expeditiously as the member's health condition requires, but shall not exceed 30 calendar days from the date Home State Health receives the appeal. Home State Health may extend the timeframe for resolution of the appeal up to 14 calendar days if the member requests the extension or Home State Health demonstrates (to the satisfaction of the state agency, upon its request) that there is need for additional information and how the delay is in the member's best interest. For any extension not requested by the member, Home State Health shall provide written notice to the member of the reason for the delay.

Expedited Appeals

Expedited appeals may be filed when either Home State Health or the member's provider determines that the time expended in a standard resolution could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function. No punitive action will be taken against a provider that requests an expedited resolution or supports a member's appeal. In instances where the member's request for an expedited appeal is denied, the appeal must be transferred to the timeframe for standard resolution of appeals.

Decisions for expedited appeals are issued as expeditiously as the member's health condition requires, not exceeding 72 hours from the initial receipt of the appeal. Home State Health may extend this timeframe by up to an additional 14 calendar days if the member requests the extension or if Home State Health provides evidence satisfactory to the MHD that a delay in rendering the decision is in the member's interest. For any extension not requested by the member, Home State Health shall provide written notice to the member of the reason for the delay. Home State Health shall make reasonable efforts to provide the member with prompt verbal notice of any decisions that are not resolved wholly in favor of the member followed by a written notice of action within the timeframes as noted above.

Notice of Resolution

Written notice shall include the following information:

- **a.** The decision reached by Home State Health
- **b.** The date of decision
- **c.** For appeals not resolved wholly in favor of the member the right to request a State fair hearing and information as to how to do so and
- **d.** The right to request to receive benefits while the hearing is pending and how to make the request, explaining that the member may be held liable for the cost of those services if the hearing decision upholds the Home State Health decision

Call, Fax or mail all appeals to:

Home State Health
Appeal Coordinator
11720 Borman Drive
St. Louis, MO 63146
1-855-694-HOME (4663)
Fax 1-877-309-6762

Show Me Healthy Kids managed by Home State Health
Appeal Coordinator
11720 Borman Drive
St. Louis, MO 63146
1-877-236-1020
Fax 1-877-309-6762

State Fair Hearing Process

Home State Health will include information in the Member Handbook, online and via the appeals process to members right for a State Fair Hearing directly to MHD. The member has the right to request a State Fair Hearing at any time during the appeal process not to exceed 120 calendar days from the date of the notice of resolution of the appeal.

Any adverse benefit determination or appeal that is not resolved wholly in favor of the member by Home State Health may be appealed by the member or the member's authorized representative to the MHD for a state fair hearing conducted in accordance with 42 CFR 431 Subpart E Adverse actions include reductions in service, suspensions, terminations, and denials. Home State Health's denial of payment for MO HealthNet covered services and failure to act on a request for services within required timeframes may also be appealed. State Fair Hearings must be requested orally or in writing by the member or the member's representative within 120 days of the health plan's notice of resolution of the appeal unless an acceptable reason for delay exists.

For member appeals, Home State Health is responsible for providing to the MHD and to the member an appeal summary describing the basis for the denial. For standard appeals, the appeal summary must be submitted to the MHD and the member at least 10 calendar days prior to the date of the hearing. For Standard resolution, the state will reach its decision within ninety (90) calendar days from the state agency's receipt of a state fair hearing request. Expedited resolution within three (3) business days from the state agency's receipt of a State fair hearing request for a denial of a service that:

i. Meets the criteria for an expedited appeal process but was not resolved using the health plan's expedited appeal timeframes, or

ii. Was resolved wholly or partially adversely to the member using the health plan's expedited appeal timeframes. Home State Health shall comply with the MHD's fair hearing decision. The MHD's decision in these matters shall be final and shall not be subject to appeal by Home State Health.

Continuation of Benefits

Members have the right to request continuation of benefits during an appeal or State fair hearing filing. If Home State Health Plan's actions are upheld in a hearing, the member may be liable for the cost of any continued benefits.

Reversed Appeal Resolution

In accordance with 42 CFR §438.424, if the Home State Health or the state fair hearing decision reverses a decision to deny, limit, or delay services, where such services were not furnished while

the appeal was pending, Home State Health will authorize the appealed services promptly and as expeditiously as the member's health condition requires. Additionally, in the event that services were continued while the appeal was pending, Home State Health will provide reimbursement for those services in accordance with the terms of the final decision rendered by the MHD and applicable regulations.

To File A MO HealthNet State Hearing:

MO HealthNet Division
PO Box 6500
Jefferson City, MO 65102-6500

Provider Complaints and Authorization Appeals

A **Complaint** is a verbal or written expression by a provider that indicates dissatisfaction or disagreement with Home State Health's policy, procedure, claims (including untimely payment of claims submitted for reimbursement), or any aspect of Home State Health's functions. Providers may express complaint if they are aggrieved by any rule or regulation, policy or procedure, contractual agreement, or decision by
the health plan. Home State Health logs and tracks all complaints whether received verbally or in writing.
A provider has 30 days from the date of the incident, such as the original remit date, to file a complaint. After the complete review of the complaint, Home State Health shall provide a written notice to the provider within 30 calendar days from the received date of the Plan's decision.

A **Provider Dispute**, including Claim Dispute, is a formal contractual right (may be different across providers) to express a grievance, which can be utilized once a provider has exhausted all other Plan Complaint, Authorization and Claim Reconsideration, and Appeals processes.

A Provider **Appeal** is the mechanism that allows providers the right to appeal actions of Home State Health such as a claim denial, in whole or in part, of payment for a service, claim for reimbursement not acted upon with reasonable promptness, or when a provider or if the provider is aggrieved by any rule, policy, procedure, contractual agreement, or decision by the health plan. Claim and Authorization Appeals are further defined below. A provider has 60 calendar days from Home State Health's adverse determination
or actions. Home State Health shall resolve each appeal and provide written notice of the appeal resolution, as expeditiously as the member's health condition requires, but shall not exceed 30 calendar days from the date Home State Health receives the appeal. Home State Health may extend the timeframe for resolution
of the appeal up to 14 calendar days if the member requests the extension or Home State Health demonstrates (to the satisfaction of the state agency, upon its request) that there is need for additional information and how the delay is in the member's best interest. For any extension not requested by the member, Home State Health shall provide written notice to the member of the reason for the delay.

Home State Health has dedicated staff for providers to contact to ask questions, file a provider complaint, appeal or State provider appeal, and resolve problems.

All disputes between HSH and in-network and out-of-network providers shall be between such providers and the health plan. In such cases, MO HealthNet Division shall operate solely as an Independent Appeal Committee to which providers and HSH shall be subject. In the case of any disputes regarding payment for covered services between HSH and providers, the member shall not be charged for any of the disputed costs except as allowed with a private pay agreement. If a state provider appeal is filed, per Section 2.17
of the MO HealthNet Managed Care contract, HSH shall cooperate with MO HealthNet until a State Provider Appeal Decision is issued.

A provider may request a State provider appeal in writing, no later than 120 calendar days, from the date
a provider appeal resolution is upheld through the health plans internal appeal process, and not resolved wholly in favor of the provider. If the health plan fails to adhere to the acknowledgement and

timing requirements, the provider is deemed to have exhausted the health plan's internal level of appeal and may submit a State provider appeal request.

A written State provider appeal decision will be sent to the provider and health plan within 90 calendar days of receipt of all necessary documentation. The health plan shall comply with decision reached as a result of the State provider appeal process within ten (10) calendar days from receipt of the decision. Upon receipt
of the State provider appeal decision, a provider or health plan may file a petition for review with the Administrative Hearing Commission per RSMo 208.156.8.

HSH shall reprocess a claim to deny or to pay consistent with a court order, the results of a State Fair Hearing decision, a State provider appeal decision, an Administrative Hearing Commission decision, corrective action, or at the single-state agency discretion, even if it is beyond health plan's timely filing policy.

A **Claim Appeal** is a formal written request for additional payment of a previously adjudicated electronically submitted Clean Claim. For Claim Appeals, mail your "Provider Reconsideration and Appeal Request Form" and all related documentation (A copy of the EOP(s) with the claim numbers to be adjudicated clearly circled, and the response to your original Claim Reconsideration. **Do not attach original claim form**) to:

Home State Health Plan
Attn: Claim Appeal
PO Box 4050
Farmington, MO 63640-5000

An **Authorization Appeal** is a formal written request to reconsider an authorization denial, pre- or post-service. For Authorization Appeals, mail your "Provider Reconsideration and Appeal Request Form" and all related documentation (A letter outlining the reason for your request and applicable medical records supporting your request) to:

Home State Health Plan
Attn: Authorization Appeal
11720 Borman Dr.
St. Louis, MO 63146
Fax 1-877-309-6267

Show Me Healthy Kids managed by Home State Health
Attn: Authorization Appeal
11720 Borman Dr.
St. Louis, MO 63146
Fax 1-877-309-6267

Centene Behavioral Health Appeals Department
13620 Ranch Road 620 N, Bldg. 300C
Austin, TX 78717-1116

Expedited Appeals may be filed when either Home State or the member's provider determines that the time expended in a standard resolution could seriously jeopardize the member's life or health or ability
to attain, maintain, or regain maximum function. No punitive action will be taken against a provider that requests an expedited resolution or supports a member's appeal. In instances where the member's request for an expedited appeal is denied, the appeal must be transferred to the timeframe for standard resolution of appeals.

Decisions for expedited appeals are issued as expeditiously as the member's health condition requires, not exceeding 72hours from the initial receipt of the appeal. Home State may extend this timeframe by up to an additional 14 calendar days if the member requests the extension or if Home State provides evidence satisfactory to the MHD that a delay in rendering the decision is in the member's interest.

Protected Health Information (PHI)

PHI may be shared only for Treatment, Payment, or Operations (TPO). Treatment – the provision, coordination, or management of health care and related services by a healthcare provider(s), to include 3rd party healthcare providers and health plans for treatment alternatives and health-related benefits. Example: A PCP discloses identifying information to Home State Health when obtaining authorization for services. Payment - activities to determine eligibility benefits and to ensure payment for the provision of healthcare services. Example: Provider submitting a claim with PHI to Home State Health for the purpose of payment for services. Health Care Operations – activities that manage, monitor, and evaluate the performance of a health care provider or health plan. Example: CMS conducting an internal audit. Provider agrees that all health information, including that related to patient conditions, medical utilization and pharmacy utilization, available through the portal or any other means, will be used exclusively for patient care and other related purposes as permitted by the HIPAA Privacy Rule.

Language Assistance The initial message on our Member Services Call Center is recorded in English and Spanish, and callers can choose a separate line to hear the full recording in their preferred language. After hours and for calls that become clinical in nature, NurseWise, our after-hours nurse advice line, provides Spanish-speaking Customer Service Representatives and Registered Nurses. For calls during or after business hours in languages for which bilingual staff are not available, NurseWise staff has access to Language Services Associates, which provides interpretation for 250 languages. Home State provides support services for hearing impaired members through Telecommunications Device for the Deaf (TDD). This is achieved primarily through the use of Telecommunication Relay Services via three-way calling. Pertinent information regarding the member's needs is exchanged between Home State, the member and the Telecommunication Relay Service Representative. Provider Services Department 1-855-694-HOME (4663), TDD/TTY 711.

In-Person Services Home State provides oral interpreter and American Sign Language services free of charge to members seeking health care-related services in a provider's service location, 24/7, and as necessary to ensure effective communication on treatment, medical history, health education, and any Contract-related matter. Members are educated about these support services, and how to obtain them, through the New Member Welcome Packet and our Member Newsletter. We maintain a list of certified interpreters who provide services on an as-needed basis, including for urgent and emergency care, when members request services. Home State responds to member requests for telephonic interpreters immediately, and within five business days for requests for services at provider offices. Network Development and Maintenance Home State will ensure the provision of covered services as specified by the State of Missouri