# Provider Reference Manual

home state health™

Provider Services Department:
1-855-694-HOME (4663)

TDD/TTY 1-877-250-6113

**2021**

HomeStateHealth.com

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# INTRODUCTION

## Welcome

Welcome to Home State Health Plan (Home State). We thank you for being part of Home State's network of participating physicians, hospitals, and other healthcare professionals. Our number one priority is the promotion of healthy lifestyles through preventive healthcare. Home State works to accomplish this goal by partnering with the providers who oversee the healthcare of Home State's members.

## About Us

Home State is a Managed Care Organization (MCO) contracted with the Missouri Department of Social Services to serve Missouri members through the Medicaid managed care program, MO HealthNet. Home State has the expertise to work with Missouri members to improve their health status and quality of life. Home State's management company, Centene Corporation ("Centene"), has been providing comprehensive managed care services to individuals receiving benefits under Medicaid and other government- sponsored healthcare programs for more than 27 years. Centene operates local health plans and offers a wide range of health insurance solutions to individuals and to the rising number of uninsured Americans. It also contracts with other healthcare and commercial organizations to provide specialty services. Home State is a physician-driven organization that is committed to building collaborative partnerships with providers. Home State will serve our Missouri members consistent with our core philosophy that quality healthcare is best delivered locally.

## Mission

Home State strives to provide improved health status, successful outcomes, and member and provider satisfaction in a coordinated care environment. Home State has been designed to achieve the following goals:

- Ensure access to primary and preventive care services
- Ensure care is delivered in the best setting to achieve an optimal outcome
- Improve access to all necessary healthcare services
- Encourage quality, continuity, and appropriateness of medical care
- Provide medical coverage in a cost-effective manner

All of our programs, policies and procedures are designed with these goals in mind. We hope that you will assist Home State in reaching these goals and look forward to your active participation.

## How to Use This Reference Manual

Home State is committed to working with our provider community and members to provide a high level of satisfaction in delivering quality healthcare benefits. We are committed to provide comprehensive information through this Provider Reference Manual as it relates to Home State's operations, benefits, and policies and procedures to providers. This Provider Reference Manual will be posted on Home State's website where providers can review and print it free of charge. Providers will be notified via Bulletins and notices posted on the provider website and in its weekly Explanation of Payment notices, of material changes to this Manual. For hard copies of this Provider Reference Manual **please contact** the Provider Services department at 1-855-694-HOME (4663) or if you need further explanation on any topics discussed in the manual.

# 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 Health**<br>11720 Borman Drive<br>St. Louis, MO 63146<br>HomeStateHealth.com | |
| **Department** | **Telephone Number** | **Fax Number** |
| Provider Services | 1-855-694-HOME (4663)<br>TDD/TTY: 711 | 1-866-390-4429 |
| Member Services | 1-855-694-HOME (4663)<br>TDD/TTY: 711 | 1-866-390-4429 |
| Authorization Request<br>Concurrent Review<br>Case Management | 1-855-694-HOME (4663) | 1-855-286-1811<br>1-866-390-3139<br>1-877-276-8960 |
| Envolve (24/7 Availability) | 1-855-694-HOME (4663) | |
| Missouri Department of Social Services | 1-573-751-3425 (MO HealthNet)<br>Text Telephone 1-800-735-2966 | 1-573-751-6564 |
| **Medical Claims** | **Reimbursement Rate Dispute** | **Medical Necessity Appeal** |
| **Home State**<br>Attn: Claims PO Box 4050<br>Farmington, MO 63640-3829 | **Home State**<br>Attn: Claim Disputes PO Box 4050<br>Farmington, MO 63640-3829 | **Home State**<br>Attn: Medical Necessity<br>11720 Borman Drive<br>St. Louis, MO 63146 |
| **Electronic Claims Submission** | | |
| **Home State**<br>c/o Centene EDI Department 1-800-225-2573, ext. 25525<br>or by e-mail to: EDIBA@centene.com | | |

# PRODUCT SUMMARY

MO HealthNet Managed Care population is comprised of beneficiaries whom are in a category of eligibility listed below:

## Eligible Populations

- Eligibility of Parents/Caretakers, Children, Pregnant Women, and Refugees:
  - Parents/Caretakers and Children eligible under MO HealthNet for Families, and Transitional MO HealthNet Assistance
  - Children eligible under MO HealthNet for Poverty Level Children
  - Women eligible under MO HealthNet for Pregnant Women and 60 days post-partum
  - Individuals eligible under Participants of Refugee MO HealthNet
  - Individuals who are eligible under the above groups and are Autism or Developmental Disabilities (DD) waiver participants
- Eligibility of Other MO HealthNet Children in the Care and Custody of the State and Receiving Adoption Subsidy Assistance:
  - All children in the care and custody of the Department of Social Services
  - All children placed in a not-for-profit residential group home by a juvenile court
  - All children receiving adoption subsidy assistance
  - All children receiving non-medical assistance (i.e., living expenses) that are in the legal custody of the Department of Social Services shall remain the responsibility of the Department of Social Services
- State Child Health Plan: Missouri has an approved combination State Child Health Plan under Title XXI of the Social Security Act (the Act) for the Children's Health Insurance Program (CHIP).

## Voluntary Populations

**MO HealthNet Managed Care eligibles in the above specified eligibility groups may voluntarily disenroll from the Managed Care Program or choose not to enroll in the Managed Care Program if they:**

- Are eligible for Supplemental Security Income (SSI) under Title XVI of the Act
- Are described in Section 501(a)(1)(D) of the Act
- Are described in Section 1902 (e)(3) of the Act
- Are receiving foster care or adoption assistance under part E of Title IV of the Act
- Are in foster care or otherwise in out-of-home placement
- Meet the SSI disability definition as determined by the Department of Social Services

# ENROLLMENT

The Missouri Department of Social Services, the Family Support Division (FSD) is responsible for eligibility determinations. The state agency will conduct enrollment activities for MO HealthNet Managed Care eligibles. Please visit dss.mo.gov/MHD/ for more information on the MO HealthNet enrollment process.

## Provider Restrictions

**Providers shall not conduct or participate in health plan enrollment, disenrollment, and transfer or opt out activities or attempt to influence a member's enrollment. Prohibited activities include:**

- Requiring or encouraging the member to apply for an assistance category not included in MO HealthNet Managed Care
- Requiring or encouraging the member and/or guardian to use the opt out as an option in lieu of delivering health plan benefits
- Mailing or faxing MO HealthNet Managed Care enrollment forms
- Aiding the member in filling out health plan enrollment forms
- Aiding the member in completing on-line health plan enrollment
- Photocopying blank health plan enrollment forms for potential members
- Distributing blank health plan enrollment forms
- Participating in three-way calls to the MO HealthNet Managed Care enrollment helpline
- Suggesting a member transfer to another health plan
- Other activities in which a provider attempts to enroll a member in a particular health plan or in any way assisting a member to enroll in a health plan

## Provider Marketing Guidelines

Home State and its participating providers may conduct marketing activities to MO HealthNet Managed Care members subject to MO HealthNet guidelines.

Providers must submit all member marketing materials to Home State prior to distributing. Home State will submit marketing and educational materials on behalf of the provider to MO HealthNet for written approval.

**Providers may advise MO HealthNet Managed Care members of the plans in which they participate through the following communications:**

- Equally display a list of all plans in which they participate
- Equally display all participating health plan logos
- Provide all participating health plan phone numbers
- Equally display all contracted health plan provided marketing and health education materials
- A letter to previous fee-for-service recipients who may be eligible for MO HealthNet Managed Care, informing them of all health plans with which they participate

# 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** 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 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.

home state health

**Name:**
**MO HealthNet ID #:**
**PCP Name:**
**PCP Address :**

**PCP Phone #:**

If you have an emergency, call 911 or go to the nearest emergency room (ER). You do not have to contact Home State for an okay before you get emergency services. If you are not sure whether you need to go to the ER, call your PCP or Nurse Advice Line at 1-855-694-4663 (TDD/TTY 1-877-250-6113). Relay 711.

**IMPORTANT TELEPHONE NUMBERS**

**Members:**
Member Services: 1-855-694-4663
Dental: 1-855-694-4663
Vision: 1-855-694-4663
Behavioral Health: 1-855-694-4663
Pharmacy: 1-800-392-2161/573-751-6527
24/7 Nurse Advice Line: 1-855-694-4663
File a Grievance: 1-855-694-4663
**Providers:**
Provider Services: 1-855-694-4663
IVR Eligibility Inquiry - Prior Auth: 1-855-694-4663
**Medical claims:** Home State Health Plan
Attn: CLAIMS
PO Box 4050
Farmington, MO 63640-3829

TDD/TTY: 1-877-250-6113

**Home State Address:**
11720 Borman Drive
St. Louis, MO 63146

**EDI/EFT/ERA please visit Provider Resources at www.homestatehealth.com**

Provider/claims information via the web: www.HomeStateHealth.com.

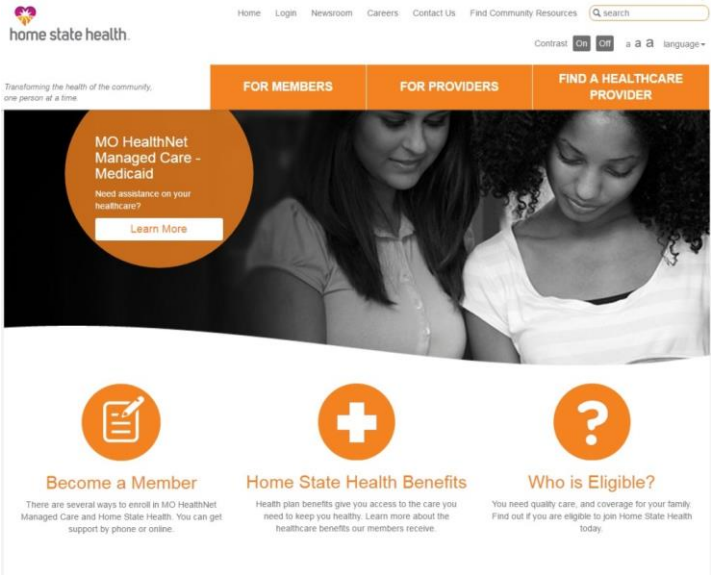
# HOME STATE WEBSITE

## Home State Website

The Home State website can significantly reduce the number of telephone calls providers need to make to the health plan. Utilizing the website allows immediate access to current provider and member information 24 hours, seven days a week. Please contact your Provider Relations Representative or our Provider Services department at 1-855-694-HOME (4663) with any questions or concerns regarding the website.

Home State's website is located at HomeStateHealth.com. Physicians can find the following information on the website:

- Provider Reference Manual
- Prior Authorization List
- Forms
- Home State News
- Clinical Guidelines
- Provider Bulletins
- Check to See if an authorization is required



## Secure Website

Home State website allows providers to obtain information at your convenience (24/7) without having to make a phone call. Home State's contracted providers and their office staff has the opportunity to register for our secure provider website. Here, we offer tools which make obtaining and sharing information easy! It's simple and secure! Go to HomeStateHealth.com to register. On the home page, select the Login link on the top right to start the registration process.

**Through the secure site you can:**

- View the PCP panel (patient list)
- Check member eligibility
- View Members' health record
- View member gaps in care
- Provider/Patient Analytics (quality scorecard including loyalty and risk scores)
- View and submit claims and adjustments
- View payment history
- View and submit prior authorizations (required)
- View and submit Notification of Pregnancy (required)
- Submit demographic changes
- Contact us securely and confidentially

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.

We are continually updating our website with the latest news and information, so save to your Internet "Favorites" list and check our site often. Please contact a Provider Relations Representative for a tutorial on the secure site.

# PRIMARY CARE PROVIDERS (PCP)

The primary care provider (PCP) is the cornerstone of Home State's service delivery model. The PCP serves as the "medical home" for the member. The "medical home" concept assists in establishing a member-provider relationship, supports continuity of care, patient safety, leads to elimination of redundant services and ultimately more cost-effective care and better health outcomes. Home State offers a robust network of PCPs to ensure every member has access to a medical home within the required travel distance standards (30 miles in the rural regions, 20 miles in basic county and 10 miles in the urban regions). Home State requests that PCP's inform our member services department when a Home State member misses an appointment so we may monitor that in our system and provide outreach to the member on the importance of keeping appointments. This will assist our providers in reducing their missed appointments and reduce the inappropriate use of Emergency Room services.

## Provider Types That May Serve as PCPs

Physicians who may serve as PCPs include Internists, Pediatricians, Obstetrician/Gynecologists, Physician Assistants (PA), Family and General Practitioners and Nurse Practitioners. The PCP may practice in a solo or group setting or at a FQHC, RHC or outpatient clinic. Home State may allow some specialists to serve as a member's PCP for members with multiple disabilities or with chronic conditions as long as the specialists agrees, in writing, and is willing to perform the responsibilities of a PCP as stipulated in this handbook.

## Member Panel Capacity

All PCPs shall state the number of members they are willing to accept into their panel. When the PCP has reached 85 percent capacity, the PCP must notify Home State. Home State **DOES NOT** guarantee that any provider will receive a certain number of members.

**Suggested panel sizes are as follows:**

- Physicians 1: up to 4,000
- Nurse Practitioner 1: up to 1,000
- Physician with physician extenders (Nurse Practitioner/Physician Assistant; and Certified Nurse Midwife for OB/GYNs only) may increase basic physician ratio of 1: up to 4,000 by 1,000 per extender

A PCP shall not refuse to treat members as long as the physician has not reached their stated panel size.

Providers shall notify Home State in writing at least forty-five (45) days in advance of his or her inability to accept additional MO HealthNet covered persons under Home State agreements. In no event shall any established patient who becomes a Covered Person be considered a new patient. Home State prohibits all providers from intentionally segregating members from fair treatment and covered services provided to other non-MO HealthNet members.

## Assignment of Medical Home

Home State offers a robust network of primary care providers to ensure every member has access to a "medical home" within the required travel distance standards (10 miles in the urban areas, 20 miles in basic county, and 30 miles in the rural areas).

For those members who have not selected a PCP during enrollment, Home State will use a PCP auto-assignment algorithm to assign an initial PCP. The algorithm assigns members to a

**PCP according to the following criteria and in the sequence presented below:**

1. **Member history with a PCP.** The algorithm will first look to see if the member is a returning member and attempt to match them to previous PCP. If the member is new to Home State, claim history provided by the state will be used to match a member to a PCP that the member had previous relationship where possible.

2. **Family history with a PCP.** If the member has no previous relationship with a PCP, the algorithm will look for a PCP that someone in the member's family, such as a sibling, is or has been assigned to.

3. **Geographic proximity of PCP to member residence**. The auto-assignment logic will ensure members travel no more than 30) miles in the rural regions, 20 miles in basic county, and 10 miles in the urban regions.

4. **Appropriate PCP type.** The algorithm will use age, gender, and language (to the extent they are known) and other criteria to ensure an appropriate match, such as children assigned to pediatricians and pregnant moms assigned to OB/GYNs.

Pregnant women should choose a pediatrician, or other appropriate PCP, for the care of their newborn baby before the beginning of the last trimester. In the event that the pregnant member does not select a pediatrician, or other appropriate PCP, Home State will assign one for her newborn.

## Medical Home Model

Home State is committed to promoting a medical home model of care that will provide better healthcare quality, improve self-management by members of their own care and reduce avoidable costs over time. Home State will actively partner with our providers, with community organizations, and groups representing our members to achieve this goal through the meaningful use of health information technology (HIT).

From an information technology perspective, we will be offering several HIT applications for our network providers. Our secure **Provider Portal** offers tools that will help support providers in the medical home model of care. These tools include:

- Online Care Gap Notification
- Member Panel Roster including member detail information
- Trucare Service Plan
- Health Record
- Provider Overview Report

## Primary Care Provider (PCP) Responsibilities

Primary Care Providers (PCP) shall serve as the member's initial and most important contact. PCP's responsibilities include, but are not limited, to the following:

- Establish and maintain hospital admitting privileges sufficient to meet the needs of all linked members, or entering into an arrangement for management of inpatient hospital admissions of members;
- Manage the medical and healthcare needs of members to assure that all medically necessary services are made available in a culturally competent and timely manner while ensuring patient safety at all times including members with special needs and chronic conditions;
- Educate members on how to maintain healthy lifestyles and prevent serious illness;
- Provide screening, well care and referrals to community health departments and other agencies in accordance with MO HealthNet provider requirements and public health initiatives;
- Conduct a behavioral health screen to determine whether the member needs behavioral health services;
- Maintain continuity of each member's healthcare by serving as the member's medical home;
- Offer hours of operation that are no less than the hours of operating hours offered to commercial members or comparable to commercial health plans if the PCP does not provide health services to commercial members;
- Provide referrals for specialty and subspecialty care and other medically necessary services which the PCP does not provide;
- Ensure follow-up and documentation of all referrals including services available under the State's fee for service program;
- Collaborate with Home State's case management program as appropriate to include, but not limited to, performing member screening and assessment, development of plan of care to address risks and medical needs, linking the member to other providers, medical services, residential, social, community and to other support services as needed;
- Maintain a current and complete medical record for the member in a confidential manner, including documentation of all services and referrals provided to the member, including but not limited to, services provided by the PCP, specialists, and providers of ancillary services;

- Adhere to the EPSDT periodicity schedule for members under age 21;
- Follow established procedures for coordination of in-network and out-of-network services for members, including obtaining authorizations for selected inpatient and selected outpatient services as listed on the current prior authorization list, except for emergency services up to the point of stabilization; as well as coordinating services the member is receiving from another health plan during transition of care;
- Share the results of identification and assessment for any member with special health care needs with another health plan to which a member may be transitioning or has transitioned so that those services are not duplicated; and
- Actively participate in and cooperate with all Home State's quality initiatives and programs.

PCPs may have a formalized relationship with other primary care providers to see their members when needed. However, PCPs shall be ultimately responsible for the above listed activities for the members assigned to them.

## Referrals

As promoted by the Medical Home concept, PCPs should coordinate the healthcare services for Home State members. PCPs can refer a member to a specialist when care is needed that is beyond the scope of the PCP's training or practice parameters. To better coordinate a members' healthcare, Home State Health encourages specialists to communicate to the PCP the results of the consultant and subsequent treatment plans.

In accordance with State Law, providers are prohibited from making referrals to healthcare entities with which the provider or a member of the providers' family has a financial relationship.

## Vaccines for Children (VFC) Program

Federally provided vaccines are available at no charge to public and private providers for eligible children ages newborn through 18 years through the VFC program. MO HealthNet requires providers who administer immunizations to qualified MO HealthNet eligible children to enroll in the VFC program. The Missouri Department of Health and Senior Services (DHSS) administers the VFC program. Providers should contact the DHSS at:

**Missouri Department of Health and Senior Services-Section**
**of Vaccine Preventable and Tuberculosis Disease Elimination**
Box 570
Jefferson City, Missouri 65102
(800) 219-3224 or fax (573) 526-5220

Home State participating providers who administer vaccines must enroll in the VFC program through the DHSS. Participating providers must utilize the VFC program for Home State members.

Home State will reimburse an administration fee per dose to providers who administer the free vaccine to eligible members **except** to those providers enrolled as rural health clinics (RHCs) or Federally Qualified Health Centers (FQHCs). Please refer to the Home State Provider Billing Manual for instructions on how to submit claims.

## Specialist Responsibilities

Specialists are required to report to Home State limitations on the number of referrals accepted. The Specialist must notify Home State when the Specialist reaches 85 percent capacity.

Home State encourages specialists to communicate to the PCP the need for a referral to another specialist, rather than making such a referral themselves. This allows the PCP to better coordinate the members' care and ensure the referred specialty physician is a participating provider within the Home State network and

that the PCP is aware of the additional service request. The specialty physician may order diagnostic tests without PCP involvement by following Home State's referral guidelines.

**Emergency admissions will require notification to Home State's Medical Management Department within one (1) business day, following the date of admission to conduct medical necessity review. This includes observation stays. All non-emergency inpatient admissions require prior authorization from Home State.**

**The specialist provider must:**

- Maintain contact with the PCP
- Obtain authorization from Home State's Medical Management Department ("Medical Management") if needed before providing services
- Coordinate the member's care with the PCP
- Provide the PCP with consult reports and other appropriate records within five business days
- Be available for or provide on-call coverage through another source 24-hours a day for management of member care
- Maintain the confidentiality of medical information
- Actively participate in and cooperate with all Home State's quality initiatives and programs.

As a participating Specialist in the Home State Health Network, it is important you understand the requirements for the Prior Authorization process to ensure your patients do not experience any disruption in care, and claims are paid in a timely and accurate manner.

Home State providers should refer to their contract for complete information regarding providers' obligations and mode of reimbursement or contact their Provider Partnership Associate with any questions or concerns.

## 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.

## Mainstreaming

Home State considers mainstreaming of its members an important component of the delivery of care and expects its participating providers to treat members without regard to race, color, creed, sex, religion, age, national origin ancestry, marital status, sexual preference, health status, income status, program membership or physical or behavioral disabilities except where medically indicated. Examples of prohibited practices include:

- Denying a member a covered services or availability of a facility

- Providing a Home State member a covered service that is different or in a different manner, or at a different time or at a different location than to other "public" or private pay members (examples: different waiting rooms or appointment times or days)
- Subjecting a member to segregation or separate treatment in any manner related to covered services

## Appointment Accessibility Standards

Home State follows the accessibility requirements set forth by applicable regulatory and accrediting agencies. Home State monitors compliance with these standards on an annual basis and will use the results of appointment standards monitoring to first, ensure adequate appointment availability and second, reduce unnecessary emergency room utilization.

| Type of Appointment | Scheduling Time Frame |
|---|---|
| **Physical and Behavioral Health Providers** | |
| Routine care without physical or behavioral symptoms (e.g. well child exams, routine physicals) | Within thirty (30) calendar days |
| Routine care with physical or behavioral symptoms (e.g. persistent rash, recurring high grade temperature) | Within one (1) week or five (5) business days, whichever is earlier |
| Urgent Care appointments for physical or behavioral illness injuries which require care immediately but do not constitute emergencies (e.g. high temperature, persistent vomiting or diarrhea, symptoms which are of sudden or severe onset, but which do not require emergency room services) | Within 24-hours |
| Aftercare appointments (physical or behavioral) | Within seven (7) calendar days after |
| Behavioral Health and Substance Abuse Emergent | Immediately (non-life threatening within 6 hours or direct to crisis center or ED) |
| **Pregnant Women** | |
| First trimester appointments | Within seven (7) calendar days of first |
| Second trimester appointments | Within seven calendar days of first request |
| Third trimester appointments | Within three days of first request |
| High risk pregnancies | Within three calendar days of identification of high risk, or immediately if an emergency exists |
| In-office waiting time for scheduled Physical, Behavioral Health, and OB appointments (defined as time spent both in the lobby and in the exam room) | Not to exceed one hour from the scheduled appointment time. |

## Covering Providers

PCPs and specialty physicians must arrange for coverage with another Home State network provider during scheduled or unscheduled time off. In the event of unscheduled time off, please notify Provider

Relations of coverage arrangements as soon as possible. The covering physician is compensated in accordance with the fee schedule in their agreement.

## Telephone Arrangements

**PCPs and Specialists must:**

- Answer the member's telephone inquiries on a timely basis
- Prioritize appointments
- Schedule a series of appointments and follow-up appointments as needed by a member
- Identify and, when possible, reschedule broken and no-show appointments
- Identify special member needs while scheduling an appointment (e.g., wheelchair and interpretive linguistic needs, non-compliant individuals, or those people with cognitive impairments)
- Adhere to the following response time for telephone call-back waiting times:
  - After hours telephone care for non-emergent, symptomatic issues within 30 minutes
  - Same day for non-symptomatic concerns
- Schedule continuous availability and accessibility of professional, allied, and supportive personnel to provide covered services within normal working hours. Protocols shall be in place to provide coverage in the event of a provider's absence
- After-hour calls should be documented in a written format in either an after-hour call log or some other method, and then transferred to the member's medical record

*Note: If after-hour urgent care or emergent care is needed, the PCP or his/her designee should contact the urgent care center or emergency department in order to notify the facility. Notification is not required prior to member receiving urgent or emergent care.*

Home State will monitor appointment and after-hours availability on an on-going basis through its Quality Improvement Program ("QIP").

## 24-Hour Access

Home State's PCPs, behavioral health providers, and specialty physicians are required to maintain sufficient access to covered physician services and shall ensure that such services are accessible to members as needed 24-hours a day, seven days a week.

- A provider's office phone must be answered during normal business hours,
- During after-hours, a provider must have arrangements for:
  - Access to a covering physician,
  - An answering service,
  - Triage service, or
  - A voice message that provides a second phone number that is answered. Any recorded message must be provided in English and Spanish, if the provider's practice includes a high population of Spanish speaking members.

**Examples of Unacceptable After-Hours Coverage include, but are not limited to:**

- The provider's office telephone number is only answered during office hours;
- The provider's office telephone is answered after-hours by a recording that tells patients to leave a message;

- The provider's office telephone is answered after-hours by a recording that directs patients to go to an Emergency Room for any services needed; and
- Returning after-hours calls outside thirty minutes.

The selected method of 24-hour coverage chosen by the member must connect the caller to someone who can render a clinical decision or reach the PCP, behavioral health provider, or specialist for a clinical decision. Whenever possible, PCP, behavioral health provider, specialty physician, or covering medical/behavioral professional must return the call within thirty (30) minutes of the initial contact. After-hours coverage must be accessible using the medical office's daytime telephone number.

Home State will monitor providers' offices through after-hours calls conducted by Home State's Provider Relations staff.

## Provider Directory Demographic Changes

To ensure accurate information is provided to our members, MO HealthNet Division and Home State require advanced notice of any demographic changes, such as location, office hours, hospital privileges, and phone and fax number. Please provide this information to Home State at least thirty (30) days prior to the effective date of the change. Demographic changes can be submitted via Home State's secure provider portal at HomeStateHealth.com.

## Hospital Responsibilities

Home State utilizes a network of hospitals to provide services to Home State members. Hospital services providers must be qualified to provide services under the MO HealthNet program. All services must be provided in accordance with applicable state and federal laws and regulations and adhere to the requirements set forth in the RFP.

**Hospitals must:**

- Notify the PCP immediately or no later than the close of the next business day after the member's emergency room visit.
- Obtain prior authorizations for all inpatient and selected outpatient services as listed on the current prior authorization list, except for emergency stabilization services.
- Notify Home State's Medical Management department by sending an electronic file of the ER admission by the next business day. The electronic file should include the member's name, MO HealthNet ID, presenting symptoms/diagnosis, DOS, and member's phone number.
- Notify Home State's Medical Management department of all admission within one (1) business day.
- Notify Home State's Medical Management department of all newborn deliveries within one (1) business day of the delivery.

Home State hospitals should refer to their contract for complete information regarding the hospitals' obligations and reimbursement.

## Advance Directives

Home State is committed to ensure that its members are aware of and are able to avail themselves of their rights to execute advance directives. Home State is equally committed to ensuring that its providers and staff are aware of and comply with their responsibilities under federal and state law regarding advance directives.

PCPs and providers delivering care to Home State members must ensure adult members 18 years of age and older receive information on advance directives and are informed of their right to execute advance directives. Providers must document such information in the permanent medical record.

**Home State recommends to its PCPs and providers that:**

- The first point of contact for the member in the PCP's or provider's office should ask if the member has executed an advance directive and the member's response should be documented in the medical record.
- If the member has executed an advance directive, the first point of contact should ask the member to bring a copy of the advance directive to the PCP's or provider's office and document this request in the member's medical record.
- An advance directive should be included as a part of the member's medical record and include mental health directives.

If an advance directive exists, the physician should discuss potential medical emergencies with the member and/or designated family member/significant other (if named in the advance directive and if available) and with the referring physician, if applicable. Any such discussion should be documented in the medical record.

## Voluntarily Leaving the Network

Providers must give Home State notice of voluntary termination following the terms of their participating agreement with our health plan. In order for a termination to be considered valid, providers are required to send termination notices via certified mail (return receipt requested) or overnight courier. In addition, providers must supply copies of medical records to the member's new provider upon request and facilitate the member's transfer of care at no charge to Home State or the member.

Home State will notify affected members in writing of a provider's termination, within 30 calendar days prior to the effective date of termination and no more than 15 calendar days of the receipt of the termination notice from the provider, provided that such notice from the provider was timely. If the terminating provider is a PCP, Home State Health will assign the member to a new PCP and notify the member their rights to change their PCP.

Providers must continue to render covered services to members who are existing patients at the time of termination until the later of 60 days, the anniversary date of the member's coverage, or until Home State can arrange for appropriate healthcare for the member with a participating provider.

Upon request from a member undergoing active treatment related to a chronic or acute medical condition, Home State will reimburse the provider for the provision of covered services for up to 90 days from the termination date. In addition, Home State will reimburse providers for the provision of covered services to members who are in the second or third trimester of pregnancy extending through the completion of postpartum care relating to the delivery.

**Exceptions may include:**

- Members requiring only routine monitoring
- Providers unwilling to continue to treat the member or accept payment from Home State Health

Home State Health will also provide written notice to a member within 30 days, prior to the effective date of termination and no more than 15 calendar days of receipt of the termination notice from the provider, who has been receiving a prior authorized course of treatment, when the treating provider becomes unavailable.

# CULTURAL COMPETENCY

Cultural competency within Home State is defined as "the willingness and ability of a system to value the importance of culture in the delivery of services to all segments of the population. It is the use of a systems perspective that values differences and is responsive to diversity at all levels in an organization. Cultural Competency is developmental, community focused and family oriented. In particular, it is the promotion of quality services to understand, racial/ethnic groups through the valuing of differences and integration of cultural attitudes, beliefs and practices into diagnostic and treatment methods and throughout the system to support the delivery of culturally relevant and competent care. It is also the development and continued promotion of skills and practices important in clinical practice, cross-cultural interactions and systems practices among providers and staff to ensure that services are delivered in a culturally competent manner."

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

Home State as part of its credentialing will evaluate the cultural competency level of its network providers and provide access to training and tool kits to assist provider's in developing culturally competent and culturally proficient practices.

**Network providers must ensure that:**

- Members understand that they have access to medical interpreters, signers, and TDD/TTY services to facilitate communication without cost to them
- Medical care is provided with consideration of the members' race/ethnicity and language and its impact/influence on the members' health or illness
- Office staff that routinely interact with members have access to and participate in cultural competency training and development
- Office staff that is responsible for data collection makes reasonable attempts to collect race and language specific member information. Staff will also explain race/ethnicity categories to a member so that the member is able to identify the race/ethnicity of themselves and their children
- Treatment plans are developed with consideration of the members race, country of origin, native language, social class, religion, mental or physical abilities, heritage, acculturation, age, gender, sexual orientation, and other characteristics that may influence the member's perspective on healthcare
- Office sites have posted and printed materials in English and Spanish, and if required by Missouri Department of Social Services, any other required non-English language

# BENEFIT EXPLANATION AND LIMITATIONS

## Home State Benefits

Home State network providers supply a variety of medical benefits and services, some of which are itemized on the following pages. For specific information not covered in this Provider Reference Manual, please contact Provider Services at1-855-694-HOME (4663) From 8:00 a.m. to 5:00 p.m. (CST) Monday through Friday. A Provider Services Representative will assist you in understanding the benefits.

Home State covers, at a minimum, those core benefits and services specified in our Agreement with MO HealthNet and are defined in the Missouri Medical State Plan, Administrative rules, and Department policies and procedure handbook. **Home State Health members may not be charged or balance billed for covered services.**

The following list is not intended to be an all-inclusive list of covered services. All services are subject to benefit coverage, limitations, and exclusions as described in applicable plan coverage guidelines. In addition, some services may require prior authorization. To check for prior authorization requirements please utilize our online prior authorization tool at HomeStateHealth.com.

| Service | Coverage | Benefit Limitation | Comments |
|---|---|---|---|
| **Allergy Services** | Covered | No limits or age restrictions | |
| **Ambulatory Surgery Center** | Covered | | |
| **Anesthesia Services** | Covered | | |
| **Behavioral Health Services** | Covered | Includes Community Based, Inpatient and Outpatient Services. | |
| **Circumcisions (Routine/Elective)** | Covered (added benefit) | all Newborn infants less than 28 days old | |
| **Dental Services** | Covered | Limited to children under 21 and certain pregnant women.<br>1 Cleaning every 6 months<br>• Extractions and fillings<br>• 1 set of x-rays per 24-month period<br>• Other dental services are available<br>• Orthodontic braces are only covered if medically necessary<br>Adult coverage is limited to treatment of trauma to the mouth, jaw, teeth, or other contiguous sites as a result of injury, and dental services when the absence of dental treatment would adversely affect a pre-existing medical condition. | |
| **Dialysis** | Covered | | |
| **Durable Medical Equipment (DME)** | Covered | | |
| **Early Periodic Screening Diagnosis and Treatment** | Covered | For members less than 21 years old | |

| Service | Coverage | Benefit Limitation | Comments |
|---|---|---|---|
| **Emergency Room Services** | Covered | | |
| **Enteral & Parenteral Nutrition for Home Use** | Covered | | |
| **Environmental Lead Assessment** | Covered | Limited to children under 21<br>Limited to 1 initial assessment per year | |
| **Family Planning** | Covered | | |
| **FQHC & RHC Services** | Covered | | |
| **Hearing Aids and Related Services** | Covered | Limited to children under 21. | |
| **Home Health Care Services** | Covered | Children under age 21 and adult pregnant women with ME codes 18, 43, 44, 45, and 61.<br>Children are limited to two evaluation visits per year. | For additional information on OT, PT, and ST, please see the Specialty Therapy and Rehab Services section of this manual |
| **Hospice Care** | Covered | Hospice services for children (ages 0-20) may be concurrent with the care related to curative treatment of the condition for which a diagnosis of a terminal illness has been made. | |
| **Hospital Services: Inpatient** | Covered | | |
| **Hospital Services: Outpatient** | Covered | | |
| **Hysterectomy** | Covered | Not covered if performed for the following reasons:<br>The hysterectomy was performed solely for the purpose of rendering an individual permanently incapable of reproducing; or if there was more than one purpose to the procedure, it would *not* have been performed except for the purpose of rendering the individual permanently incapable of reproducing | *Consent Form Required* |
| **Laboratory Services** | Covered | | Only stat labs may be performed in a physician's office. All other labs should be referred to an independent, contracted lab provider. For a sample listing of stat lab codes go to the Home State Health Payment Policy Manual at HomeStateHealth.com. |

| Service | Coverage | Benefit Limitation | Comments |
|---|---|---|---|
| **Maternity Care Services** | Covered | Includes:<br>• Nurse mid-wife services<br>• Pregnancy related services<br>• Services for conditions that might complicate pregnancy | |
| **Orthotics & Prosthetics (O&P)** | Covered | | |
| **Physician, and Nurse Practitioner Services** | Covered | | |
| **Podiatrist Services** | Covered | 21 and Older<br>Excludes: trimming of nondystrophic nails, any number; debridement of nail(s) by any method(s), one (1) to five (5); debridement of nail(s) by any method(s), six (6) or more; excision of nail and nail matrix, partial or complete; and strapping of ankle and/or foot | |
| **Radiology and x-rays** | Covered | | |
| **Sterilization Procedures** | Covered | | Consent Form Required |
| **Therapy (OT, PT, ST) Services (Outpatient) and comprehensive day rehabilitation** | Covered | **Limited to children under 21 and adult pregnant women with ME codes 18, 43, 44, 45, and 61.**<br>**Services for pregnant women are limited to the following:**<br>ST/PT/OT services are covered through the **home health** benefit when the adult pregnant member is medically homebound. PT/OT services provided by a **rehabilitation center** or **independent provider** are limited to adaptive training for a prosthetic, orthotic device, or if ST for adaptive training for an artificial larynx. **Outpatient hospital** providers can provide medically necessary PT services without limitation, OT if it is for adaptive training for a prosthetic, orthotic device, or if ST for adaptive training for an artificial larynx. | For additional information on OT, PT, and ST, please see the Specialty Therapy and Rehab Services section of this manual |
| **Chiropractic Services**<br>*** Separate Benefit from Alternative Therapy | Covered | 20 chiropractic service visits<br>Limited to chiropractic services (Examinations, diagnoses, adjustments, manipulations, and treatments of malpositioned articulations and structures of the body) | These services must be from a eligible provider, which is defined as a network provider that is licensed to provide chiropractic services<br>**See bulletin:** https://dss.mo.gov/mhd/providers/pdf/bulletin42-24.pdf |

| Service | Coverage | Benefit Limitation | Comments |
|---|---|---|---|
| **Alternative Therapy and Chronic Pain Management**<br><br>***** Separate Benefit from Chiropractic Services** | Covered | 30 chiropractic visits<br>Member must be 21 years old or older<br>Member must have one of the following conditions:<br>• Chronic, non-cancer neck and/or back pain, or<br>• Chronic pain post traumatic injury<br>Member must have a qualifying chronic pain diagnosis | These services must be provided by a chiropractor who obtained specific state approval to provide chiropractic services or a state approved acupuncturist |
| **Transplant Service** | Covered | Pre and Post-Transplant Services Only | |
| **Routine Vision Services and Eyewear** | Covered | **Under 21:**<br>1 eye exam per year<br>1 pair of eyeglasses every 2 (two) years<br>**21 and Over:**<br>1 eye exam every 2 (two) years<br>1 pair of glasses every 2 (two) years<br>Some benefit and eligibility restrictions may apply.<br>For specific questions regarding medical conditions or diseases of the eye, please contact Home State Health at 1-855-694-HOME (4663) | |
| **Additional Benefits** | | | |
| **Start Smart for Your Baby 17-P program** | | | |
| **Start Smart Birthdays Program** | | | |
| **Circumcision** | | Non-medically necessary for infants up to 30 days after birth | |
| **Transportation** | | Enhanced transportation services to all WIC appointments and on a case to case exception basis, related pharmacy and other treatment facilities. | |
| **Transportation** | Covered per MoHealthNet eligibility guidelines | | |

## Non-Contracted and Non-Covered Services

| Service | Comment |
|---|---|
| **Abortion** | MO HealthNet Fee for Service–See section 13.33G in MO HealthNet Provider Manual |
| **Home Births** | MO HealthNet Fee for Service |
| **Prescription Drugs** | MO HealthNet Fee for Service |

## Non-Emergent Medical Transportation

Home State will provide non-emergent transportation for covered services requested by the member or someone on behalf of the member. At the time of transport, the member must be eligible with Home State through a medical eligibility code that includes this benefit. ME codes 08, 52, 57, 64, 73, 74, 75 are excluded from this benefit. Home State requests its participating providers including its transportation vendor to inform our Member Services department when a member misses a transportation appointment so that it can monitor and educate the member on the importance of keeping medical appointments.

## 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. Our approach to developing and managing the provider network begins with a thorough analysis and evaluation of the MO HealthNet network adequacy requirements for the Managed Care Organization networks. Home State will develop and maintain a network of qualified providers in sufficient numbers and locations that is adequate and reasonable in number, in specialty type, and in geographic distribution to meet the medical needs of its members, both adults and children, without excessive travel requirements, and that is in compliance with MO HealthNet's access and availability requirements.

Home State offers a network of primary care providers to ensure every member has access to a medical home within the required travel distance standards (30 miles in the rural regions, 20 miles in basic county, and 10 miles in the urban regions). Physicians who may serve as PCPs include Internists, Pediatricians, Obstetrician/Gynecologists, Family and General Practitioners and Nurse Practitioners. (More information on Primary Care Physicians and their responsibilities can be found in this manual). In addition, Home State will have available, at a minimum, the following specialists for members on at least a referral basis:

| | |
|---|---|
| Allergy | Gastroenterology |
| Dermatology | Hematology/Oncology |
| Family Medicine | Infectious Disease |
| General Practice | Nephrology |
| Internal Medicine | Pulmonary Disease |
| Cardiology | Rheumatology |

| | |
|---|---|
| Endocrinology | Neurology |
| Obstetrics | Podiatry |
| Ophthalmology | Psychiatrist-Adult/General |
| Optometry | Psychiatrist-Child/Adolescent |
| Orthopedics | Psychologist/Other Therapies |
| Otolaryngology | Surgery/General |
| Pediatric (General) | Urology |
| Pediatric (Subspecialties) | Vision Care/Primary Eye care |
| Physical Medicine and rehab | |

In the event Home State's network is unable to provide medically necessary services required under the contract, Home State shall ensure timely and adequate coverage of these services through an out of network provider until a network provider is contracted and will ensure coordination with respect to authorization and payment issues in these circumstances. For assistance in making a referral to a specialist or subspecialties for a Home State member, please contact our Medical Management team at 1-855-694-HOME (4663) and we will identify a provider to make the necessary referral.

### Tertiary Care

Home State offers a network of tertiary care inclusive of level one and level two trauma centers, burn centers, Neonatal intensive care units, perinatology services, rehabilitation facilities, comprehensive cancer services, comprehensive cardiac services and medical sub specialists available 24-hours per day in the geographical service area. In the event Home State network is unable to provide the necessary tertiary care services required, Home State shall ensure timely and adequate coverage of these services through an out of network provider until a network provider is contracted and will ensure coordination with respect to authorization and payment issues in these circumstances.

## MEDICAL MANAGEMENT

### Overview

Home State's Medical Management department hours of operation are Monday through Friday from 8:00 a.m. to 5:00 p.m., CST (excluding holidays). After normal business hours, Envolve staff is available to answer questions about prior authorization. Medical Management services include the areas of utilization management, case management, disease management, and quality review. The department clinical services are overseen by the Home State medical director ("Medical Director"). The VP of Medical Management has responsibility for direct supervision and operation of the department.
To reach the Medical Director or VP of Medical Management contact:

**Medical Management**
1-855-694-HOME (4663)
Fax 1-855-286-1811
HomeStateHealth.com

### Utilization Management

The Home State Utilization Management Program (UMP) is designed to ensure members of Home State receive access to the right care at the right place and right time. Our program is comprehensive and applies to all eligible members across all product types, age categories, and range of diagnoses.

The UMP incorporates all care settings including preventive care, emergency care, primary care, specialty care, acute care, short-term care, and ancillary care services.

Home State's UMP seeks to optimize a member's health status, sense of well-being, productivity, and access to quality health care, while at the same time actively managing cost trends. The UMP aims to provide services that are a covered benefit, medically necessary, appropriate to the patient's condition, rendered in the appropriate setting and meet professionally recognized standards of care.

**Our program goals include:**

- Monitoring utilization patterns to guard against over- or under-utilization
- Development and distribution of clinical practice guidelines to providers to promote improved clinical outcomes and satisfaction
- Identification and provision of case and/or disease management for members at risk for significant health expenses or ongoing care
- Development of an infrastructure to ensure that all Home State members establish relationships with their PCPs to obtain preventive care
- Implementation of programs that encourage preventive services and chronic condition self-management
- Creation of partnerships with members/providers to enhance cooperation and support for UMP goals

See the section on Specialty Therapy and Rehabilitation Services for information about authorization of outpatient and home health occupational, physical and speech therapy services.

**Referrals** - PCP's should coordinate the healthcare services for Home State members. PCPs can refer a member to a specialist when care is needed that is beyond the scope of the PCP's training or practice parameters. To better coordinate a members' healthcare, Home State encourages specialists to communicate to the PCP the results of the consultant and subsequent treatment plans.

**Notifications -** A provider is required to promptly notify Home State when prenatal care is rendered. Early notification of pregnancy allows the health plan to assist the member with prenatal care coordination of services.

**Prior Authorizations** - Some services require prior authorization from Home State in order for reimbursement to be issued to the provider. All out-of-network services require prior authorization. To verify whether a prior authorization is necessary please visit Home State Health's website at HomeStateHealth.com and utilize the Prior Authorization tool to determine if prior authorization is required. The requesting provider should submit prior authorization request via Home State Health's secure provider web portal with supporting clinical information.

**Home State**
**Medical Management/Prior Authorization Department**
Telephone 1-855-694-HOME (4663)
HomeStateHealth.com

## 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 (Notification of Pregnancy is required)
- 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. Services that require authorization by Home State are noted in the table below. The requesting provider should submit prior authorization request via Home State Health's secure provider web portal with supporting clinical information. All out-of-network services require prior authorization. Below is a Table reflecting those services that require prior authorization. **The below list is not all inclusive. Please visit Home State Health's web site at HomeStateHealth.com and utilize the Prior Authorization Tool to determine if prior authorization is required.**

## Medicaid Pre-Auth

**DISCLAIMER:** All attempts are made to provide the most current information on the Pre-Auth Needed Tool. However, this does NOT guarantee payment. Payment of claims is dependent on eligibility, covered benefits, provider contracts, correct coding and billing practices. For specific details, please refer to the provider manual. If you are uncertain that prior authorization is needed, please submit a request for an accurate response.

**ATTENTION**: Effective January 1, 2021 Prior Authorization Requests should be submitted via our secure provider web portal. To submit a prior authorization Login Here. Copies of all supporting clinical information are required for prior authorizations. Lack of clinical information may result in delayed determination or an adverse determination.

Are Services being performed in the Emergency Department or Urgent Care Center, Public Health or Public Welfare Agency, or Family Planning services billed with a contraceptive management diagnosis?

☐ Yes ☐ No

| Types of Services | YES | NO |
|---|---|---|
| Is the member being admitted to an inpatient facility? | ○ | ○ |
| Is the member having observation services? | ○ | ○ |
| Are anesthesia services being rendered for pain management? | ○ | ○ |
| Are services for a facility billing with Dental Diagnosis? | ○ | ○ |
| Are oral surgery services being provided in the office? | ○ | ○ |
| Are services, other than DME, orthotics, prosthetics, and supplies, being rendered in the home? | ○ | ○ |

| Procedures/Services | Inpatient Authorization | Ancillary Services |
|---|---|---|
| All procedures and services performed by out of network providers (except ER, urgent care, family planning, and treatment of communicable disease) | All elective/scheduled admissions at least 5 business days prior to the scheduled date of admit (including deliveries)<br><br>*Note: Normal newborns do not require an authorization unless the level of care changes or the length of stay is greater than normal newborn* | Air Ambulance Transport (non-emergent fixed wing airplane) |
| **Potentially Cosmetic including but not limited to:**<br>• bariatric surgery, blepharoplasty, mammoplasty, otoplasty, rhinoplasty, septoplasty, varicose vein procedures | All services performed in out- of network facility | DME purchases costing $500 or more or rental of $250 or more |
| **Experimental or investigational** | Hospice care | Home healthcare services including home hospice, home infusion, skilled nursing, personal care services, and therapy |
| **High Tech Imaging (i.e. CT, MRI, PET)** | Rehabilitation facilities | Orthotics/Prosthetics billed with an “L” code costing $500 or more or rental of $250 or more |

| Procedures/Services | Inpatient Authorization | Ancillary Services |
|---|---|---|
| **PT/ST/OT** | Skilled nursing facility | Hearing Aid devices including cochlear implants |
| **Hysterectomy** | Transplant related support services including pre-surgery assessment and post-transplant follow up care | Genetic Testing |
| **Oral Surgery** | Notification for all Urgent/Emergent Admissions:<br>Within one (1) business day following date of Admission Newborn Deliveries must include birth outcomes | |
| **Pain Management** | | |

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

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 be prior authorized for any inpatient days while the order of detention or commitment is in effect. For concurrent review of ongoing inpatient admission and other services such as outpatient rehabilitation, home care or ongoing specialty care, 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 via Home State Health's secure provider 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.

## Clinical Decisions

Home State affirms that utilization management decision making is based on appropriateness of care and service and the existence of coverage. Home State does not reward practitioners or other individuals for issuing denials of service or care.

Delegated providers must ensure that compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any member.

The treating physician, in conjunction with the member, is responsible for making all clinical decisions regarding the care and treatment of the member. The PCP, in consultation with the Home State Medical Director, is responsible for making utilization management (UM) decisions in accordance with the member's plan of covered benefits and established medical necessity criteria. Failure to obtain authorization for services that require plan approval may result in payment denials.

## Peer to Peer Discussions

In the event of an adverse determination, including a denial, reduction, or termination of coverage, the provider may request a peer-to-peer discussion with the medical director. At the time of notification of denial, the provider will be notified of this right, and has two (2) business days to initiate a peer-to-peer discussion.

## Medical Necessity

Medical necessity is defined for Home State members as healthcare services, supplies or equipment provided by a licensed healthcare professional that are:

- Appropriate and consistent with the diagnosis or treatment of the patient's condition, illness, or injury
- In accordance with the standards of good medical practice consistent with evidence based and clinical practice guidelines
- Not primarily for the personal comfort or convenience of the member, family, or provider
- The most appropriate services, supplies, equipment, or level of care that can be safely and efficiently provided to the member
- Furnished in a setting appropriate to the patient's medical need and condition and, when supplied to the care of an inpatient, further mean that the member's medical symptoms or conditions require that the services cannot be safely provided to the member as an outpatient service
- Not experimental or investigational or for research or education

## Review Criteria

Home State uses a hierarchy of utilization review criteria based on federal, state, and Centene corporate policies to determine medical necessity for healthcare services. In addition, when applicable, Home State Health utilizes review criteria developed by McKesson InterQual® products to determine medical necessity for healthcare services. InterQual appropriateness criteria are developed by specialists representing a national panel from community-based and academic practice. InterQual criteria cover medical and surgical admissions, outpatient procedures, referrals to specialists, and ancillary services. Criteria are established and periodically evaluated and updated with appropriate involvement from physicians. InterQual is utilized as a screening guide and is not intended to be a substitute for practitioner judgment. The Medical Director, or other healthcare professional that has appropriate clinical expertise in treating the member's condition or disease, reviews all potential adverse determination and will make a decision in accordance with currently accepted medical or healthcare practices, taking into account special circumstances of each case that may require deviation from the norm in the screening criteria.

Providers may obtain the criteria used to make a specific adverse determination by contacting the Medical Management department at1-855-694-HOME (4663). Practitioners also have the opportunity to discuss any adverse decisions with a physician or other appropriate reviewer at the time of notification to the requesting practitioner/facility of an adverse determination. The Medical Director may be contacted by calling the Home State Health main toll-free phone number and asking for the Medical Director. A case manager may also coordinate communication between the Medical Director and requesting practitioner.

Members or healthcare professionals with the member's written consent may request an authorization appeal related to a medical necessity decision made during the authorization or concurrent review process orally or in writing to:

**Home State Health Plan**
Appeal Coordinator
11720 Borman Drive
St. Louis, MO 63146
1- 855-694-HOME (4663)
Fax Numbers:
Medical Necessity Authorization Appeals-1-877-309-6762
Member Grievances-1-866-390-4429 Concurrent Clinical Review Fax 1-866-390-3139
Prior Authorization Clinical Fax 1-855-286-1811

## New Technology

Home State Health evaluates the inclusion of new technology and the new application of existing technology for coverage determination. This may include medical procedures, drugs and/or devices. The Medical Director and/or Medical Management staff may identify relevant topics for review pertinent to the Home State Health population. The Clinical Policy Committee (CPC) reviews all requests for coverage and makes a determination regarding any benefit changes that are indicated.

If you need a new technology benefit determination or have an individual case review for new technology, please contact the Medical Management department at 1-855-694-HOME (4663).

Notification of Pregnancy: Members that become pregnant while covered by Home State Health may remain a Home State Health member during their pregnancy. The managing or identifying physician should notify the Home State Health prenatal team by completing the Notification of Pregnancy (NOP) form within five days of the first prenatal visit or confirmation of pregnancy. Providers are expected to identify the estimated date of confinement and delivery facility. See the Case Management section for information related to our Start Smart for Your Baby® program and our 17-P program for women with a history of early delivery.

*NOTE: A Notice of Pregnancy (NOP) is required in order for claims to reimburse. NOPs MUST be submitted via the secure portal. You can register for portal access at* HomeStateHealth.com/login*. All pregnancy related claims will deny if NOP is not submitted via the secure portal.*

# CONCURRENT REVIEW AND DISCHARGE PLANNING

Concurrent review nurses perform ongoing concurrent review for inpatient admissions through onsite or telephonic methods through contact with the hospital's Utilization and Discharge Planning departments and when necessary, with the member's attending physician. The Case Manager will review the member's current status, treatment plan and any results of diagnostic testing or procedures to determine ongoing medical necessity and appropriate level of care. Concurrent review decisions will be made within one (1) working day of receipt of necessary information, and notification within one (1) business day after the decision is made. Written or electronic notification includes the number of days of service approved, and the next review date.

Routine, uncomplicated vaginal or C-section delivery does not require concurrent review, however; the hospital must notify Home State Health within one business day of delivery with complete information regarding the delivery status and condition of the newborn.

## Retrospective Review

Retrospective review is an initial review of services provided to a member, but for which authorization and/or timely notification to Home State Health was not obtained due to extenuating circumstances (i.e. member was unconscious at presentation, member did not have their Home State Health Plan card or otherwise indicated MO HealthNet coverage, services authorized by another payer who subsequently determined member was not eligible at the time of service). Requests for retrospective review must be submitted

promptly. A decision will be made within 30 calendar days following receipt of the request, not to exceed 180 calendar days from the date of service.

## SPECIALTY THERAPY AND REHABILITATION SERVICES

Home State Health offers our members access to all covered, medically necessary outpatient physical, occupational and speech therapy services. Home State Health has partnered with National Imaging Associates, Inc. (NIA) to ensure that the physical medicine services (physical, occupational, and speech therapy) provided to Home State Health members are consistent with nationally recognized clinical guidelines.

Home State Health requires prior authorization of outpatient physical, occupational, and speech therapy services. This prior authorization program is managed by National Imaging Associates (NIA). As the nation's leading specialty health care management company, NIA delivers comprehensive and innovative solutions to improve quality outcomes and optimize cost of care. Under terms of the agreement between Home State Health and NIA, Home State Health will oversee the NIA Prior Authorization program and continue to be responsible for claims adjudication.

Providers may obtain prior authorization via Home State Health's secure provider web portal or NIA's website at RadMD.com.

Please keep in mind you will need to ensure that the member's benefit has not been exhausted prior to providing services, even if an "Approved Authorization" has been obtained. The purpose of NIA is to verify medical necessity of physical, occupational, and speech therapy services, and not to manage the member's benefits.

Prior authorization for home health occupational, physical or speech therapy services, as well as comprehensive day rehabilitation, should be submitted to Home State Health using the Outpatient Prior Authorization form located at HomeStateHealth.com.

**Home State Health Home Health Therapies Prior Authorization**
Fax number: 1-855-286-1811

## HIGH TECH RADIOLOGY SERVICES

As part of a continued commitment to further improve the quality of advanced imaging care delivered to our members, Home State Health utilizes National Imaging Associates (NIA) to provide prior authorization services and utilization. NIA focuses on radiation awareness designed to assist providers in managing imaging services in the safest and most effective way possible. Prior authorization is required for the following outpatient radiology procedures:

- CT /CTA
- MRI/MRA
- PET Scan
- Myocardial Perfusion Imaging – Nuclear Cardiology
- MUGA Scan
- Transthoracic Echocardiology
- Transesophageal Echocardiology
- Stress Echocardiography

If a convenient, cost-effective, in-network imaging facility is not selected at intake for MR and CTs, NIA will assign one that is closest to the member's zip code. Exceptions will be made in situations where there is a clinical reason why the test must take place at a specific, higher cost facility. The finalized authorization will reflect the imaging facility selected. In addition, the imaging provider selected or assigned pursuant to this

process will become the **provider of record for claims payment**. Any claim billed with an imaging provider's Tax ID that differs from the imaging provider's Tax ID selected or assigned during this process will be denied. Claim denial reasons are:

- EXNo-DENY Procedure code and Provider does not match auth
- EXNq-DENY Provider and DOS does not match auth
- EXNs-Deny Did not use authorized provider in network
- EXy1- Deny: Services Rendered by Non-Authorized Non Plan Provider

**Please communicate to your patient which facility is on the authorization and the importance of them having the imaging study conducted there to ensure proper payment of the claim.**

### Key Provisions:

- Emergency room, observation and inpatient imaging procedures do not require authorization.
- It is the responsibility of the ordering physician to obtain authorization.
- Providers rendering the above services should verify that the necessary authorization has been obtained. Failure to do so may result in claim non-payment.

Providers may obtain prior authorization via Home State Health's secure provider web portal or NIAs website at RadMD.com or call our Provider Services department at 1-855-694-HOME (4663). To reach NIA for urgent requests or other questions, please call 1-855-694-HOME (4663) and follow the prompt for high tech imaging authorizations.

## EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT

The Healthy Children and Youth (HCY)/Early and Periodic Screening, Diagnostic and Treatment (EPSDT) service is MO HealthNet's comprehensive and preventive child health program for individuals under the age of 21, provision of which is mandated by state and federal law. HCY/EPSDT services include periodic screening, vision dental and hearing services. In addition, the need for corrective treatment disclosed by such child health screenings must be arranged (directly or through referral) even if the service is not available under the State's Medicaid plan to the rest of the MO HealthNet population.

Home State Health and its providers will provide the full range of HCY/EPSDT services as defined in, and in accordance with, Missouri state regulations and Missouri Department of Social Services' policies and procedures for HCY/EPSDT services. Such services shall include, without limitation, periodic health screenings and appropriate up to date immunization using the Advisory Committee on Immunization Practices (ACIP) recommended immunization schedule and the American Academy of Pediatrics periodicity schedule for pediatric preventative care. This includes provision of all medically necessary services whether specified in the core benefits and services or not, except those services (carved out/excluded/prohibited services) that have been identified herein. The following minimum elements are to be included in the periodic health screening assessment:

a) Comprehensive health and development history (including assessment of both physical and mental development)

b) Comprehensive unclothed physical examination

c) Immunizations appropriate to age and health history

d) Assessment of nutritional status

e) Laboratory tests

f) Annual verbal lead assessment beginning at age six months and continuing through age 72 months

g) Blood testing is mandatory at 12 and 24 months or annually if residing in a high-risk area as defined by the Department of Health and Senior Services regulation

h) Developmental assessment

i) Vision screening and services, including at a minimum, diagnosis and treatment for defects in vision, including eyeglasses

j) Dental screening (oral exam by primary care provider as part of comprehensive exam). Recommend that preventive dental services begin at age six through 12 months and be repeated every six months

k) Hearing screening and services, including at a minimum, diagnosis and treatment for defects in hearing, including hearing aids; and

l) Health education and anticipatory guidance

Provision of all components of the HCY/EPSDT service must be clearly documented in the PCP's medical record for each member.

Home State requires that providers cooperate to the maximum extent possible with efforts to improve the health status of Missouri citizens, and to actively participate in the increase of percentage of eligible members obtaining HCY/EPSDT services in accordance with the adopted periodicity schedules. Home State Health will cooperate and assist providers to identify and immunize all members whose medical records do not indicate up-to-date immunizations.

For HCY/EPSDT and immunization billing guidelines please visit our Website at HomeStateHealth.com for Home State Health's Provider Billing Manual.

# EMERGENCY CARE SERVICES

Home State Health defines an emergency medical condition as a medical, behavioral health, or substance use-related condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (1) placing the physical or behavioral health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (2) serious impairments of bodily functions; (3) serious dysfunction of any bodily organ or part; Serious harm to self or others due to an alcohol or drug abuse emergency; (5) injury to self or bodily harm to others; or (6) with respect to a pregnant woman having contractions: that there is inadequate time to effect a safe transfer to another hospital before delivery, or (b) that transfer may pose a threat to the health or safety of the woman or the unborn.

Members may access emergency services at any time without prior authorization or prior contact with Home State Health. If members are unsure as to the urgency or emergency of the situation, they are encouraged to contact their Primary Care Provider (PCP) and/or Home State Health's 24-hour Nurse Triage Line (Envolve) for assistance; however, this is not a requirement to access emergency services. Home State Health contracts with emergency services providers as well as non-emergency providers who can address the member's non- emergency care issues occurring after regular business hours or on weekends.

Emergency services are covered by Home State Health when furnished by a qualified provider, including non-network providers, and will be covered until the member is stabilized. Any screening examination services conducted to determine whether an emergency medical condition exists will also be covered by Home State Health. Emergency services are covered and reimbursed regardless of whether the provider is in Home State Health's provider network as long as the provider is located within the United States. Emergency services obtained outside the United States are not covered by the State or Home State Health Plan. Payment will not be denied for treatment obtained within the United States under either of the following circumstances:

1. A member had an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in the definition of Emergency Medical Condition; or

2. A representative from the Plan instructs the member to seek emergency services.

Once the member's emergency medical condition is stabilized, Home State Health requires Notification for hospital admission or Prior Authorization for follow-up care as noted elsewhere in this handbook.

# 24-HOUR NURSE ADVICE LINE

envolve PeopleCare

Our members have many questions about their health, their primary care provider, and/or access to emergency care. Our health plan offers a nurse line service to help members proactively manage their health needs, decide on the most appropriate care, and encourage members to talk with their physician about preventive care.

Envolve is our 24-hour, nurse advice line for members. Registered nurses provide basic health education, nurse triage, and answer questions about urgent or emergency access through the Envolve service. Our staff often answers basic health questions but is also available to triage more complex health issues using nationally recognized protocols. Members with chronic problems, like asthma or diabetes, are referred to case management for education and encouragement to improve their health.

Members may use Envolve to request information about providers and services available in the community after hours, when the Home State Health Member Services department ("Member Services") is closed. The Envolve staff is available in both English and Spanish and can provide additional translation services if necessary.

We provide this service to support your practice and offer our members access to a registered nurse at any time – day or night. If you have any additional questions, please call Provider Services or Envolve at 1-855-694-HOME (4663).

# WOMEN'S HEALTHCARE

Home State Health will provide direct access to a health specialist in network for core benefits and services necessary to provide women routine and preventive health care services in addition to the member's PCP if the provider is not a women's health specialist. Members are allowed to utilize their own PCP or any family planning service provider for family planning services without the need for a referral or a prior authorization. In addition, members will have the freedom to receive family planning services and related supplies from an out of network provider without any restrictions. Family planning services include examinations, assessments, traditional contraceptive services, preconception and interconception care services. Home State Health will make every effort to contract with all local family planning clinic and providers and will ensure reimbursement whether the provider is in or out of network.

# PUBLIC HEALTH PROGRAMS

## Women, Infants and Children (WIC) Program

Women, Infants and Children (WIC) is a special supplemental nutrition program which provides services to pregnant women, new mothers, infants and children up to their 5th birthday based on nutritional risk and income eligibility. The primary services provided are health screening, risk assessment, nutrition education

and counseling, breastfeeding promotion and referrals to health care. Supplemental food is provided at no cost to participants.

## Eligibility

Eligibility is based on three things, category, income and nutritional risk.

**Categories include:**

- Women – pregnant women, postpartum breastfeeding women up to one year after delivery while nursing, and postpartum non-breastfeeding women up to six months after delivery or termination of the pregnancy.
- Infants – from birth up to one year of age.
- Children – from one year of age up to their 5th birthday.

## Income

Calculated on the family income at 185% or less of federal poverty level.

Home State Health requires providers to provide and document the referral of pregnant, breast-feeding, or postpartum women, or a parent/guardian of a child under the age of five, as indicated, to the WIC Program as part of the initial assessment of members, and as a part of the initial evaluation of newly pregnant women.

## Parents as Teachers (PAT)

PAT is a home-school-community partnership which supports parents in their role as their child's first and most influential teachers. Every family who is expecting a child or has a child under the age of kindergarten entry is eligible for PAT. PAT services include personal visits from certified parent educators, group meetings, developmental screenings, and connections with other community resources.

PAT programs collaborate with other agencies and programs to meet families' needs, including Head Start, First Steps, the Women Infants and Children Program (nutrition services), local health departments, the Family Support Division, etc. Independent evaluations of PAT show that children served by this program are significantly more advanced in language development, problem solving, and social development at age three than comparison children, ninety-nine point five percent (99.5%) of participating families are free of abuse or neglect, and early gains are maintained in elementary school, based on standardized tests.

The PAT program is administered at the local level by the public school districts in the State of Missouri. Families interested in PAT may contact their local district directly. PAT also accepts referrals from other sources including medical providers. Home State Health encourages providers to refer members to their local PAT program.

# CLINICAL PRACTICE GUIDELINES

Home State Health clinical and quality programs are based on evidence based preventive and clinical practice guidelines. Whenever possible, Home State Health adopts guidelines that are published by nationally recognized organizations or government institutions as well as state-wide collaborative and/or a consensus of healthcare professionals in the applicable field. Home State Health providers are expected to follow these guidelines and adherence to the guidelines will be evaluated at least annually as part of the Quality Improvement Program. Following is a sample of the clinical practice guidelines adopted by Home State Health.

- American Academy of Pediatrics: Recommendations for Preventive Pediatric Health Care
- American Diabetes Association: Standards of Medical Care in Diabetes
- Center for Disease Control and Prevention (CDC): Adult and Child Immunization Schedules

- National Heart, Lung, and Blood Institute: Guidelines for the Diagnosis and Management of Asthma and Guidelines for Management of Sickle Cell
- U.S. Preventive Services Task Force Recommendations for Adult Preventive Health

For links to the most current version of the guidelines adopted by Home State Health, visit our website at HomeStateHealth.com.

# CASE MANAGEMENT PROGRAM

Home State Health case management model is designed to help your Home State Health members obtain needed services, whether they are covered within the Home State Health array of covered services, from community resources, or from other non-covered venues. Our model will support our provider network whether you work in an individual practice or large multi-specialty group setting.

The program is based upon a coordinated care model that uses a multi-disciplinary case management team in recognition that a holistic approach yields better outcomes. The goal of our program is to help members achieve the highest possible levels of wellness, functioning, and quality of life, while decreasing the need for disruption at the PCP or specialist office with administrative work.

The program includes a systematic approach for early identification of eligible members, needs assessment, and development and implementation of an individualized care plan that includes member/family education and actively links the member to providers and support services as well as outcome monitoring and reporting back to the PCP. Our case management team will integrate covered and non-covered services and provide a holistic approach to a member's medical, as well as function, social and other needs. We will coordinate access to services such as behavioral health, dental and pharmacy services. Our program incorporates clinical determinations of need, functional status, and barriers to care such as lack of caregiver supports, impaired cognitive abilities and transportation needs.

A case management team is available to help all providers manage their Home State Health members. Listed below are programs and components of services that are available and can be accessed through the case management team. We look forward to hearing from you about any Home State Health members that you think can benefit from the addition of a Home State Health case management team member.

**To contact a case manager call:**

**Home State Health**
Case Management Department
1-855-694-HOME (4663)

## High Risk Pregnancy Program

The OB CM Team will implement our Start Smart for Your Baby® Program (Start Smart), which incorporates case management, care coordination, and disease management with the aim of decreasing preterm delivery and improving the health of moms and their babies. Start Smart is a unique perinatal program that follows women for up to one year after delivery and includes neonates and qualified children up to one year of age. The program goals are improving maternal and child health outcomes by providing pregnancy and parenting education to all pregnant members and providing case management to high and moderate risk members through the postpartum period and infants through the first year of life. A case manager with obstetrical nursing experience will serve as lead case manager for members at high risk of early delivery or who experience complications from pregnancy.

An experienced neonatal nurse will be the lead CM for newborns being discharged from the NICU unit and will follow them through the first year of life when they remain members. The OB/Neonate team has physician oversight advising the team on overcoming obstacles, helping identify high risk members, and recommending interventions. These physicians will provide input to Home State Health Medical Director on obstetrical care standards and use of newer preventive treatments such as 17 alpha-hydroxyprogesterone caproate (17-P).

Home State Health offers a premature delivery prevention program by supporting the use of 17-P. When a physician determines that a member is a candidate for 17-P, which use has shown a substantial reduction in the rate of preterm delivery, he/she will write a prescription for 17-P. This prescription is sent to the Home State Health case manager who will check for eligibility. The case manager can coordinate the ordering and delivery of the 17-P directly to the physician's office or coordinate home care for administration, if needed. A prenatal case manager will contact the member and do an assessment regarding compliance. The nurse will remain in contact with the member and the prescribing physician during the entire treatment period. Contact the Home State Health high risk pregnancy department for enrollment in the 17-P program.

## Complex Teams

These teams will be led by clinical licensed nurses with either adult or pediatric expertise as applicable. For both adult and pediatric teams, staff will be familiar with evidence-based resources and best practice standards and experience with the population, the barriers and obstacles they face, and socioeconomic impacts on their ability to access services. The Home State Health complex teams will manage care for members whose needs are primarily functional as well as those with such complex conditions as hemophilia, breast/cervical cancer, trauma, organ transplants, and renal dialysis. Foster care members and children with special health care needs are at special risk and are also eligible for enrollment in case management. Home State Health will use a holistic approach by integrating referral and access to community resources, transportation, follow-up care, medication review, specialty care, and education to assist members in making better health care choices.

A Transplant Coordinator will provide support and coordination of pre-surgery and post follow up care for members who need organ transplants. All members considered as potential transplant candidates should be immediately referred to the Home State Health case management department for assessment and case management services. Each candidate is evaluated for coverage requirements. Home State Health will coordinate coverage for transplant services with the state agency.

## Care Management in the Community Program

**Care Management in the Community** is Home State Health's outreach program designed to provide education to our members on how to access healthcare and develop healthy lifestyles in a setting where they feel most comfortable. The program components are integrated as a part of our case management program in order to link Home State Health and the community served. The program recruits staff from the local community being served to establish a grassroots support and awareness of Home State Health within the community. The program has various components that can be provided depending on the need of the member.

Members can be referred to the Care Management in the Community Program through numerous sources. Members who phone Home State Health to talk with Home State Health Member Services department may be referred for more personalized discussion on the topic they are inquiring about. Case managers may identify members who would benefit from one of the many Care Management in the Community components and complete a referral request. Providers may request Care Management in the Community referrals directly through their assigned case manager. Community groups may request that Care Management in the Community come to their facility to present to groups they have established or at special events or gatherings. Various components of the program are described below.

Community: Care Management in the Community Representatives are available to present in a group setting during events initiated by state entities, community groups, clinics, or any other approved setting. This form of community connection is extremely useful in rural areas where home visits may be the only mode of communication. Presentations may typically include what Mo HealthNet coordinated care is all about, overview of services offered by Home State Health, how to use the health plan and access services, the importance of obtaining primary preventive care, and other valuable information related to obtaining services from providers and Home State Health.

Home: Care Management in the Community Representatives are available on a full-time basis whenever a need or request from a member or provider arises. All home visits are pre-scheduled with the member unless the visit is a result of being unable to locate a member. Topics covered during a home visit include overview of covered benefits, how to schedule an appointment with the PCP, the importance of preventive

health care, appropriate use of preventive, urgent and emergency care services, obtaining medically necessary transportation, and how to contact the health plan for assistance.

Phone: Care Management in the Community Representatives may contact new members or members in need of more personalized information to review the health plan material over the telephone. All the previous topics may be covered, and any additional questions answered.

**To contact the Care Management in the Community Team call:**

**Home State Case Management**
1-855-694-HOME (4663)

## Chronic Care/Disease Management Programs

As a part of Home State Health services, Disease Management Programs (DM) are offered to members. Disease Management is the concept of reducing healthcare costs and improving quality of life for individuals with a chronic condition, through integrated care. Chronic care management supports the physician or practitioner/patient relationship and plan of care; emphasizes prevention of exacerbations and complications using evidence-based practice guidelines and patient empowerment strategies, and evaluates clinical, humanistic and economic outcomes on an ongoing basis with the goal of improving overall health.

Home State Health's Disease Management programs promote a coordinated, proactive, disease-specific approach to management that will improve members' self-management of their condition; improve clinical outcomes; and control high costs associated with chronic medical conditions. Home State Health's programs include but are not limited to: asthma, diabetes and depression.

All members identified as having a targeted diagnosis such as, but not limited to the following: major depression, asthma, and diabetes will be offered the opportunity to enroll in a Disease Management program. Members with selected disease states will be stratified into risk groups that will determine need and level of intervention. High-risk members with co- morbid or complex conditions will be referred for case management program evaluation.

**To refer a member for disease or care management call: Home State Health Case Management 1-855-694-HOME (4663).**

## Member Lock-In for Medical Services Program

Home State Health has implemented a Member Lock-In Program for medical services in accordance with the Missouri Code of State Regulations, 13 CSR 65-3.010. Home State Health will evaluate utilization patterns to identify members for lock-in. Members are notified of their locked-in status within 30 days and given their rights to grieve the lock-in.

Once the member selects their physician for lock in, Home State Health shall notify the physician in writing of the selection prior to the effective date of the member's enrollment into the Member Lock-In Program. The physician will have the option to decline participation as the selected provider.

When a member is placed in lock-in, a written referral from the lock-in physician may be required before another provider can be reimbursed for services rendered. The written referral must be submitted to Home State Health for review and approval retained by the referred provider, and furnished upon request. The referral must be dated and is only valid for the time period indicated on the referral.

It is necessary for the lock-in physician to contact Home State Health for each professional physician who is authorized to perform services or prescribe medication. **Referrals are not required for:**

1. Non-ambulance medical transportation
2. Home and community based services
3. Community mental health (services only)
4. Durable medical equipment 5. Vision services (routine eye exams only)
6. Radiology and most laboratory services

7. IP Hospital
8. ER or ER Physician (when emergently medically necessary)
9. Mental Health and Substance Use Treatment (services only)
10. Family Planning 11. OB provider (services only) 12. Dialysis

Referrals may be called in at 1-855-694-4663 or faxed in at 1-855-286-1811.

MO HealthNet will be including information in eMOMED to identify Home State Health members who are locked-in to a specific provider. A communication from MO HealthNet or Home State Health will be sent once this is available. Services obtained from a provider other than the locked- in provider without a referral will be denied.

**Denial codes are:**

**EX A1- DENY:** NO AUTHORIZATION ON FILE THAT MATCHES SERVICE(S) BILLED

**EX LZ -** DENIED REFERRING PROVIDER MUST BE MEMBERS PCP TO RECEIVE PAYMENT

*Note: Home State Health is not responsible for a lock-in program for pharmacy services; this is the responsibility of MO HealthNet.*

# PROVIDER PARTNERSHIP MANAGEMENT

## Provider Orientation

Home State Health's Provider Partnership Management department is designed around the concept of making your experience a positive one by being your advocate within Home State Health. Upon credentialing approval by Home State Health, each provider/practitioner is assigned a dedicated provider partnership associate. Within 30 days of the provider's effective date, the provider partnership associate will contact the provider to schedule an orientation.

## Responsibilities

**The Provider Partnership Management Department is responsible for providing the services listed below which include but are not limited to:**

**Provider Network Specialist**

- Conduct in person provider visits
- Physician and office staff orientation
- Hospital and ancillary staff orientation
- Ongoing provider education
- Joint Operating Committee Meetings

**Provider Performance Specialist**

- Conducting quarterly provider performance meetings
- Network performance profiling
- Individual physician performance profiling
- Ongoing provider education regarding provider performance

The goal of the department is to furnish you and your staff with the necessary tools to provide the highest quality of healthcare to Home State Health enrolled membership.

To contact the provider network specialist or provider performance specialist for your area, contact our Provider Services toll-free help line at 1-855-694-HOME (4663). Provider Services Representatives work with Provider Partnership Management to serve as your advocates to ensure that you receive necessary assistance and maintain satisfaction with Home State Health.

## Top Reasons to Contact Provider Partnership Management

**Provider Network Specialist**

- To schedule an in-service training for new staff
- To conduct ongoing education for existing staff
- To schedule monthly or quarterly joint operating committee meetings
- Questions regarding credentialing

**Provider Performance Specialist**

- To assist with quality performance scores
- To receive training on use of the online provider analytics tool
- To schedule monthly or quarterly provider performance meetings
- Questions regarding HEDIS specifications

Training and education on the Incentive Model for continuity of Care (CoC) incentive Plan

# 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)
- 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.

## Procedures for Electronic Submission

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

**The benefits of billing electronically include:**

- Reduction of overhead and administrative costs:
  - Eliminates the need for paper claim submission
  - Reduces claim re-work (adjustments)
- Receipt of clearinghouse reports as proof of claim receipt
- Faster transaction time for claims submitted electronically
- Validation of data elements on the claim format

Just as with paper claim submission, any electronic claims not submitted correctly or not containing the required field data will be rejected or denied.

The Home State Health Companion Guides for electronic billing are available on our website www.homestatehealth.com. See the Electronic Transactions section for more details.

**Important Steps to a Successful Submission of EDI Claims**

1. Select a clearinghouse to utilize or submit via the Home State Health's website or Provider Portal.
2. Contact the clearinghouse to inform them you wish to submit electronic claims to Home State Health. Home State Health's Payor ID is **68069**.
3. Inquire with the clearinghouse what data records are required.
4. Prior to submitting EDI claims, the provider should verify that notification of the provider's effective date has been received from Home State Health and the provider is set up in the Home State Health system.
5. You will receive two reports from the clearinghouse. *Always* review these reports daily. The first report will be a report showing the claims that were accepted by the clearinghouse, and are being transmitted to Home State Health, as well as those claims not meeting the clearinghouse requirements.

   *NOTE: A claim rejected at the clearinghouse level is not submitted to Home State Health. The second report will be a claim status report showing claims accepted and rejected by Home State Health. Always review the acceptance and claim status reports for rejected claims. If rejections are noted, correct the error(s) and resubmit.*
6. Most importantly, all claims must be submitted with provider identifying numbers. See the companion guide on the Home State Health website (www.homestatehealth.com.) for claim form instructions and claim forms for details.

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

*NOTE: Claims will be rejected by EDI for revenue codes missing a leading 0 in the 4-digit format and billing with a 3-digit revenue code*

## Electronic Claims Submission

Network providers are encouraged to participate in Home State Health 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 Health has partnered with, contact:**

**Home State Health**
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.

## Electronic Secondary Claims

Home State Health has the ability to receive coordination of benefit (COB or Secondary) claims electronically. The field requirements for successful electronic COB submission are below (5010 Format):

**Specific Data Record Requirements**

| COB Field Name<br>*The below should come from the primary payer 's Explanation of Payment* | 837I - Institutional<br>EDI Segment and Loop | 837P - Professional<br>EDI Segment and Loop |
|---|---|---|
| COB Paid Amount | If 2320/AMT01=**D**, MAP AMT02 or 2430/SVD02 | If 2320/AMT01=**D**, MAP AMT02 or 2430/SVD02 |
| COB Total Non-Covered Amount | If 2320/AMT01=**A8**, map AMT02 | If 2320/AMT01=**A8**, map AMT02 |
| COB Remaining Patient Liability | If 2300/CAS01 = PR, map CAS03<br>*Note: Segment can have 6 occurrences.*<br>Loop2320/AMT01=**EAF**, map AMT02 which is the sum of all of CAS03 with CAS01 segments presented with a PR | If 2320/AMT01=**EAF**, map AMT02 |
| COB Patient Paid Amount | | If 2320/AMT01 = **F5**, map AMT02 |
| COB Patient Paid Amount Estimated | If 2300/AMT01=**F3**, map AMT02 | |
| Total Claim Before Taxes Amount | If 2400/AMT01 = **N8**, map AMT02 | If 2320/AMT01 = **T**, map AMT02 |
| COB Claim Adjudication Date | IF 2330B/DTP01 = 573, map DTP03 | IF 2330B/DTP01 = 573, map DTP03 |

| COB Field Name<br>*The below should come from the primary payer 's Explanation of Payment* | 837I - Institutional<br>EDI Segment and Loop | 837P - Professional<br>EDI Segment and Loop |
|---|---|---|
| COB Claim Adjustment Indicator | IF 2330B/REF01 = T4,<br>map REF02 | IF 2330B/REF01 = T4, map REF02<br>with a Y |

Claims transmitted electronically must contain all the same data elements identified within the Claim Filing section of this manual. Please contact the clearinghouse you intend to use and ask if they require additional data record requirements. The Companion Guide for this process is located on Home State Health's website at www.homestatehealth.com.

**Electronic Claim Flow Description & Important General Information**

In order to send claims electronically to Home State Health, all EDI claims must first be forwarded to one of Home State Health's clearinghouses. This can be completed via a direct submission to a clearinghouse or through another EDI clearinghouse.

Once the clearinghouse receives the transmitted claims, they are validated against their proprietary specifications and Plan specific requirements. Claims not meeting the requirements are rejected and returned to the sender via a clearinghouse error report. The name of this report can vary based upon the provider's contract with their intermediate EDI clearinghouse. Accepted claims are transmitted to Home State Health, and the clearinghouse returns an acceptance report to the sender immediately.

Claims forwarded to Home State Health by a clearinghouse are validated against provider and member eligibility records. Claims that do not meet provider and/or member eligibility requirements are rejected and returned on a daily basis to the clearinghouse. The clearinghouse in-turn forwards the rejection back to its trading partner (the intermediate EDI clearinghouse or provider).

The report shows rejected claims, which must be reviewed and corrected timely. Claims passing eligibility requirements are then passed to the claim processing queues.

*Note: Providers are responsible for verification of EDI claims receipts. Acknowledgements for accepted or rejected claims received from the clearinghouse must be reviewed and validated against transmittal records daily.*

Since the clearinghouse returns acceptance reports directly to the sender, submitted claims not accepted by the clearinghouse are not transmitted to Home State Health.

If assistance is needed to resolve submission issues reflected on either the acceptance or claim status reports, please contact your clearinghouse or vendor customer service department.

Rejected electronic claims may be resubmitted electronically once the error has been corrected. Be sure to clearly indicate a corrected claim per the instructions above.

**Invalid Electronic Claim Record Rejections/Denials**

All claim records sent to Home State Health must first pass the clearinghouse proprietary edits and Plan-specific edits prior to acceptance. Claim records that do not pass these edits are invalid, and will be rejected without being recognized as received by Home State Health. In these cases, the claim must be corrected and re-submitted within the required filing deadline. It is important that you review the acceptance, or claim status reports, received from the clearinghouse in order to identify and re-submit these claims accurately.

Questions regarding electronically submitted claims should be directed to our EDI BA Support at 1-800-225-2573 Ext. 25525 or via e-mail at EDIBA@centene.com. If you are prompted to leave a voice mail, you will receive a return call within 24 business hours.

**Exclusions**

**There are certain transactions excluded from EDI submissions, outlined below:**

| Excluded Claim Categories |
|---|
| - Excluded from EDI Submission Options<br>- Must be Filed Paper |
| Claim records requiring supportive documentation or attachments (i.e., consent forms)<br>*Note: COB claims can be filed electronically, but if they are not, the primary payer EOB must be submitted with the paper claim.* |
| Medical records to support billing miscellaneous codes |
| Claim for services that are reimbursed based on purchase/rental price (e.g. DME, prosthetics) Provider is required to submit the invoice with the claim. |
| Claim for services requiring clinical review (e.g. complicated or unusual procedure) Provider is required to submit medical records with the claim. |
| Claim for services requiring documentation and a Certificate of Medical Necessity (e.g. Oxygen, Motorized Wheelchairs) |

## Electronic Billing Inquiries

**Please direct inquiries as follows:**

| Action | Contact |
|---|---|
| Clearinghouses Submitting Directly to Home State Health | Emdeon<br>SSI<br>Trizetto Provider Solutions<br>Availity |
| Home State Health Payer ID | 68069 |
| General EDI Questions: | Contact EDI Support at 1-800-225-2573 Ext. 25525 or (314) 505-6525 or via e-mail at EDIBA@centene.com. |
| Claims Transmission Report Questions: | Contact your clearinghouse technical support area. |
| Claim Transmission Questions (Has my claim been received or rejected?): | Contact EDI Support at 1-800-225-2573 Ext. 25525 or via e-mail at EDIBA@centene.com. |
| Remittance Advice Questions: | Contact Home State Health Provider Services at 866-769-3085 or the secure Provider Portal at *https://www.homestatehealth.com/login.html* |

| Action | Contact |
|---|---|
| Provider Payee, NPI, Tax ID, Payment Address Changes: | **Notify Provider Services in writing at:**<br>**Home State Health Plan**<br>11720 Borman Drive<br>St. Louis, MO 63146 or<br>CHHS_PROVIDER_ROSTER@CENTENE.COM |

## Procedures for Online Claim Submission

For providers who have internet access, and choose not to submit claims via EDI or paper, Home State Health has made it easy and convenient to submit claims via our secure provider portal.

To register, please go directly to https://www.homestatehealth.com/login.html, register for a user name and password, then select the "Claims Role Access" module. If you have technical support questions, please contact Provider Services at 1-855-694-HOME (4663).

Once you have access to the secure portal***** you may file first-time claims individually, or submit first time batch claims. You will also have the capability to find, view, and correct any previously processed claims. Supporting documentation can also be uploaded via the secure provider portal.

*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

## 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).

**Submit claims to Home State Health at the following address:**

**First Time Claims and Corrected Claims:**

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

**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 Plan**
Attn: Authorization Appeal
11720 Borman Dr.
St. Louis, MO 63146

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.

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

Home State Health partners with PaySpan to provide 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 on our EFT and ERA services, please visit our provider home page on our website at HomeStateHealth.com.

If further assistance is needed, please contact Provider Services 1-855-694-HOME (4663) or directly contact PaySpan at 1-877-331-7154.

## Coding of Claims/Billing Codes

Home State Health requires claims to be submitted using codes from the current published volume of the ICD, ASA, DRG, CPT4, and HCPCS Level II for the date the service was rendered. These requirements may be amended to comply with federal and state regulations as necessary. Below are some code related reasons a claim may reject or deny:

- Code billed is missing, invalid, or deleted at the time of service
- Code inappropriate for the age of the member
- Diagnosis Code is not extended to the highest specificity to the 7th character, if required.
- Procedure code is pointing to a diagnosis that is not appropriate to be billed as primary
- Code billed is inappropriate for the location or specialty billed
- Code billed is a part of a more comprehensive code billed on same date of service
- Code billed does not comply with current Home State Health Payment or Clinical policies, current policies can be found on the Home State Health Website at https://www.homestatehealth.com/providers/tools-resources/clinical-payment-policies.html

## Documentation Required with Claims

### Invoices

- Refer to the HealthNet Current Provider Manual(s) to determine if an Invoice of Cost (IOC) is required with claim submission. This will be indicated "IOC" within Reimbursement Guidelines.
- Claims with billing codes which are indicated as "IOC" and submitted without the required invoice will be denied.
- These services will be manually priced, per State Guidelines, using the information on the included invoice.
- Please be sure that the billing codes are identified on the invoice. Failure to properly identify which service(s) listed on the invoice apply to the service(s) billed may result in administrative delays.
- An electronic invoice of cost attachment is available to providers through the billing website at www.emomed.com.

### Consent Forms

When required, consent forms must be included with the claim during the time of submission, to avoid any delay in claim process.

**Consent forms are located on the Missouri Medicaid website at:**

- Sterilization Consent Form-

  http://manuals.momed.com/forms/(Sterilization)Consent_Form(MO-8812).pdf

- Acknowledgement of Receipt of Hysterectomy (Consent) Form -

  http://manuals.momed.com/forms/Acknowledgement_of_Receipt_of_Hysterectomy.pdf

- Certificate of Medical Necessity for Abortion-

  http://manuals.momed.com/forms/Certificate_of_Medical_Necessity_for_Abortion.pdf

## Code Auditing and Editing

Home State Health uses code-auditing software to assist in improving accuracy and efficiency in claims processing, payment and reporting, as well as meeting HIPAA compliance regulations. The software will detect, correct, and document coding errors on provider claims prior to payment. This is done by analyzing CPT, HCPCS, modifier, and place of service codes. Claims billed in a manner that does not adhere to the standards of the code editing software will be denied.

The code editing software contains a comprehensive set of rules addressing coding inaccuracies, such as unbundling, fragmentation, up-coding, duplication, invalid codes, and mutually exclusive procedures. The software offers a wide variety of edits that are based on:

- American Medical Association (AMA) – the software utilizes the CPT Manuals, CPT Assistant, CPT Insider's View, the AMA web site, and other sources.
- Centers for Medicare & Medicaid Services' (CMS) National Correct Coding Initiative (NCCI) which includes column 1/column 2, mutually exclusive and outpatient code editor (OCE0 edits). In addition to using the AMA's CPT manual, the NCCI coding policies are based on national and local policies and edits, coding guidelines developed by national societies, analysis of standard medical and surgical practices, and a review of current coding practices.
- Public-domain specialty society guidance (i.e., American College of Surgeons, American College of Radiology, American Academy of Orthopedic Surgeons).
- Clinical consultants who research, document, and provide edit recommendations based on the most common clinical scenario.
- In addition to nationally-recognized coding guidelines, the software has added flexibility to its rule engine to allow business rules that are unique to the needs of individual product lines.

**The following provides examples where the software will make a change on submitted codes:**

## Unbundling of Services

Identifies Services that have been unbundled, such as lab panels. If component lab codes are billed on a claim along with a more comprehensive lab panel code that more accurately represents the service performed, the software will bundle the component codes into the more comprehensive panel code. The software will also deny multiple claim lines and replace those lines with a single, more comprehensive panel code when the panel code is not already present on the claim:

**Examples:** Unbundling of Services

| Code | Description | Status |
|---|---|---|
| 80053 | Comprehensive Metabolic Panel | Disallow |
| 85025 | Complete CBC, automated and automated & automated differential WBC count | Disallow |
| 84443 | Thyroid Stimulating Hormone | Disallow |
| 80050 | General Health Panel | Allow |

**Explanation:** 80053, 85025 and 84443 are included in the lab panel code 80050 and therefore are not separately reimbursable. Those claim lines containing the component codes are denied and only the comprehensive lab panel code is reimbursed.

| Code | Description | Status |
|---|---|---|
| 80053 | Comprehensive Metabolic Panel | Disallow |
| 85025 | Complete CBC, automated and automated & automated differential WBC count | Disallow |
| 84443 | Thyroid Stimulating Hormone | Disallow |
| 80050 | General Health Panel | Add |

**Explanation:** 80053, 85025 and 84443 are included in the lab panel code 80050 and therefore are not separately reimbursable. Those claim lines containing the component codes are denied and CPT code 80050 is added to a new service line and recommended for reimbursement.

## Bilateral Surgery

Identical Procedures Performed on Bilateral Anatomical Sites during the Same Operative Session:

**Example:** Bilateral Surgery

| Code | Description | Status |
|---|---|---|
| 69436<br>DOS=01/01/10 | Tympanostomy | Disallow |
| 69436 50<br>DOS=01/01/10 | Tympanostomy billed with modifier 50 (bilateral procedure) | Allow |

**Explanation:** identifies the same code being billed twice, when reimbursement guidelines require the procedure to be billed once with a bilateral modifier. These should be billed on one line along with modifier 50 (bilateral procedure). *Note: Modifiers RT (right), or LT (left) should not be billed for bilateral procedures.*

## Duplicate Services

Submission of same procedure more than once on same date of service that cannot be or are normally not performed more than once on same day:

**Example:** Excluding a Duplicate CPT

| Code | Description | Status |
|---|---|---|
| 72010 | Radiologic exam, spine, entire, survey study, anteroposterior & lateral | Allow |
| 72010 | Radiologic exam, spine, entire, survey study, anteroposterior & lateral | Disallow |

**Explanation:**

- Procedure 72010 includes radiologic examination of the lateral and anteroposterior views of the entire spine that allow views of the upper cervical vertebrae, the lower cervical vertebrae, the thoracic vertebrae, the lumbar vertebrae, the sacrum, and the coccyx.
- It is clinically unlikely that this procedure would be performed twice on the same date of service.
- Anatomical modifiers may be required.

- Repeat procedures should be billed on the same claim form and indicated as a repeat procedure by using modifier 76.

## Evaluation and Management Services (E/M)

Submission of E/M service either within a global surgery period or on the same date of service as another E/M service:

**Global Surgery**

Procedures that are assigned a 30-day global surgery period are designated as *major* surgical procedures.

**Example:** Global Surgery Period

| Code | Description | Status |
|---|---|---|
| 27447<br><br>DOS=05/20/09 | Arthroplasty, knee, condoyle and plateau; medial and lateral compartments with or without patella resurfacing (total knee arthroplasty). | Allow |
| 99213<br><br>DOS=06/02/09 | Office or other outpatient visit for the evaluation and management of an EST patient, which requires at least two of these three key components: an expanded problem focused history; an expanded problem focused examination; medical decision making of low complexity. Counseling & coordination of care w/other providers or agencies are provided consistent w/nature of problem(s) & patient's &/or family's needs.<br><br>Problem(s) are low/moderate severity.<br><br>Physicians spend 15 minutes face-to-face w/patient &/or family. | Disallow |

**Explanation:**

- Procedure code 27447 has a global surgery period of 30 days.
- Procedure code 99213 is submitted with a date of service that is within the 30-day global period.
- When a substantial diagnostic or therapeutic procedure is performed, the evaluation and management service is included in the global surgical period.

**Example:** E/M with Minor Surgical Procedures

| Code | Description | Status |
|---|---|---|
| 11000<br><br>DOS=01/23/10 | Debridement of extensive eczematous or infected skin; up to 10% of body surface. | Allow |
| 99213<br><br>DOS=01/23/10 | Office or other outpatient visit for the evaluation and management of an EST patient, which requires at least two of these three key components: an expanded problem focused history; an expanded problem focused examination; medical decision making of low complexity. Counseling and coordination of care with other providers or agencies are provided consistent w/ nature of problem(s) and patient's and/or family's needs. | Disallow |

| Code | Description | Status |
|---|---|---|
| | Problem(s) are low/moderate severity.<br>Physicians spend 15 minutes face-to-face with patient and/or family. | |

**Explanation:**

- Procedure 11000 (0-day global surgery period) is identified as a minor procedure.
- Procedure 99213 is submitted with the same date of service.
- When a minor procedure is performed, the evaluation and management service is considered part of the global service.

**Same Date of Service**

One evaluation and management service is recommended for reporting on a single date of service.

**Example:** Same date of service

| Code | Description | Status |
|---|---|---|
| 99215 | Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a comprehensive history; a comprehensive examination; medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent w/ nature of problem(s) and patient's and/or family's needs. Usually, problem(s) are moderate/high severity. Physicians spend 40 minutes face-to-face with patient and/or family. | Allow |

**Explanation:**

- Procedure 99215 is used to report an evaluation and management service provided to an established patient during a visit.
- Procedure 99242 is used to report an office consultation for a new or established patient.
- Separate reporting of an evaluation and management service with an office consultation by a single provider indicates a duplicate submission of services. Interventions, provided during an evaluation and management service, typically include the components of an office consultation

**Note:**

**Modifier - 24** is used to report an unrelated evaluation and management service by the same physician during a post-operative period.

**Modifier - 25** is used to report a significant, separately identifiable evaluation and management service by the same physician on the same day of a procedure.

**Modifier - 79** is used to report an unrelated procedure or service by the same physician during the post-operative period.

**When modifiers - 24 and -25** are submitted with an evaluation and management service on the same date of service or during the post-operative period by the same physician, the evaluation and management service is questioned and a review of additional information is recommended.

**When modifier - 79** is submitted with an evaluation and management service on the same date of service or during the post-operative period by the same physician, separate reporting of the evaluation and management service is recommended.

## Modifiers

Codes added to the main procedure code to indicate the service has been altered by a specific circumstance.

**Modifier - 26 (professional component)**

**Definition: Modifier - 26** identifies the professional component of a test or study.

- If modifier - 26 is not valid for the submitted procedure code, the procedure code is not recommended for separate reporting.
- When a claim line is submitted without the modifier -26 in a facility setting (for example, POS 21, 22, 23, 24), the rule will replace the service line with a new line with the same procedure code and the modifier -26 appended.

**Example:**

| Code | Description | Status |
|---|---|---|
| 78278<br><br>POS=Inpatient | Acute gastrointestinal blood loss imaging | Disallow |
| 78278-26<br>POS=Inpatient | Acute gastrointestinal blood loss imaging | Allow |

**Explanation:**

- Procedure code 78278 is valid with modifier -26.
- Modifier - 26 will be added to procedure code 78278 when submitted without modifier -26.

**Modifier - 80 (Assistant Surgeon)**

**Definition:** This edit identifies claim lines containing procedure codes billed with an assistant surgeon modifier that typically do not require an assistant surgeon.

Many surgical procedures require aid in prepping and draping the patient, monitoring visualization, keeping the wound clear of blood, holding and positioning the patient, and assisting with wound closure and/or casting (if required). This assistance does not require the expertise of a surgeon. A qualified nurse, orthopedic technician, or resident physician can provide the necessary assistance.

**Example:**

| Code | Description | Status |
|---|---|---|
| 42820-80 | Tonsillectomy and adenoidectomy; under age 12 | Disallow |

**Explanation:**

- Procedure code 42820 is not recommended for Assistant Surgeon reporting because a skilled nurse or surgical technician can function as the assistant in the performance this procedure.

**CPT® Category II Codes**

CPT Category II Codes are supplemental tracking codes developed to assist in the collection and reporting of information regarding performance measurement, including HEDIS. Submission of CPT Category II Codes allows data to be captured at the time of service and may reduce the need for retrospective medical record review.

Uses of these codes are optional and are not required for correct coding. They may not be used as a substitute for Category I codes. However, as noted above, submission of these codes can minimize the administrative burden on providers and health plans.

## Code Editing Assistant

A web-based code auditing reference tool designed to "mirror" how Home State Health code auditing product(s) evaluate code combinations during the auditing of claims is available for participating providers via the secure provider portal (*https://www.homestatehealth.com/login.html)* This allows Home State Health to share with our contracted providers the claim auditing rules and clinical rationale we use to pay claims. You can access the tool in the "Claims Module" by clicking "Claim Auditing Tool".

**This tool offers many benefits:**

- *Prospectively* access the appropriate coding and supporting clinical edit clarifications for services *before* claims are submitted.
- *Proactively* determine the appropriate code/code combination representing the service for accurate billing purposes.

The tool will review what was entered and will determine if the code or code combinations are correct based on the age, location, modifier (if applicable), or other code(s) entered.

The Code Editing Assistant is intended for use as a 'what if' or hypothetical reference tool. It is meant to apply coding logic only**.** The tool *does not* take into consideration historical claims information which may have been used to determine an edit. The tool assumes all CPT codes are billed on a single claim.

The tool will not take into consideration individual fee schedule reimbursement, authorization requirements or other coverage considerations.

## 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.

## 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. Authorization Appeals will be accepted within 60 calendar days from Home State Health's notice of action (denial or claim reduction).

## Rejections Vs. Denials

All paper claims sent to the claims department must first pass specific edits prior to acceptance. Claim records that do not pass these edits are invalid and will be rejected or denied.

**Rejection:** A rejection is defined as an unclean claim that contains invalid, or missing data elements, which are required for acceptance of the claim into the claim processing system. These data elements are identified in the Companion Guide located on the website at www.homestatehealth.com. A list of common upfront rejections can be found listed below, and a more comprehensive list with explanations can be located in Appendix 1. Rejections will not enter our claims adjudication system, so there will be no Explanation of Payment (EOP) generated for these claims. The provider will receive a letter or a rejection report if the claim was submitted electronically.

**Denial:** If all edits pass, and the claim is accepted, it will then be entered into the system for processing. A denial is defined as a claim that has passed edits, and is entered into the system; however has been billed with invalid or inappropriate information causing the claim to deny. An EOP will be sent that includes the denial reason.

## Common Causes of Upfront Rejections

- Unreadable Information - The ink is faded, too light, or too bold (bleeding into other characters or beyond the box), or the font is too small**.**
- All hand written forms are rejected
- Black and white forms are rejected.
- Member Date of Birth is missing
- Member Name or Identification Number is missing
- Provider Name, Taxpayer Identification Number (TIN), or National Practitioner Identification (NPI) Number is missing
- Attending Provider information missing from Loop 2310A on Institutional claims when CLM05-1 (Bill Type) is 11, 12, 21, 22 or 72 or missing from box 48 on the paper UB claim form
- Date of Service is not prior to the received date of the claim (future date of service)

- Date of Service or Date Span is missing from required fields
- Type of Bill is invalid
- Diagnosis Code is missing, invalid, or incomplete
- Service Line Detail is missing
- Date of Service is prior to member's effective date
- Admission Type is missing (Inpatient Facility Claims – UB-04, field 14)
- Patient Status is missing (Inpatient Facility Claims – UB-04, field 17)
- Occurrence Code/Date is missing or invalid
- Revenue Code is missing or invalid
- CPT/Procedure Code is missing or invalid

## Common Causes of Claims Processing Delays and Denials

- Invalid or incorrect coding
- Explanation of Benefits (EOB) from the primary insurer is missing or incomplete
- Third Party Liability (TPL) information is missing or incomplete
- Member ID is invalid
- Provider TIN and NPI do not match
- Dates of Service span do not match the listed days/units
- Tax Identification Number (TIN) is invalid
- NPI and Tax ID combination not registered with Missouri Medicaid Audit & Compliance (MMAC) Provider Enrollment Unit.
- Incorrect Form Type used

## Common EOP Denial Codes and Descriptions

See the bottom of your paper EOP for the updated, and complete description of all explanation codes associated with your claims. Electronic Explanations of Payment will use standard HIPAA denial codes.

*Note: The following is not an all-inclusive list.*

| EX CODE | DESCRIPTION |
|---|---|
| 7 | DENY: THE PROCEDURE CODE IS INCONSISTENT WITH THE PATIENT S SEX |
| 9 | DENY: THE DIAGNOSIS IS INCONSISTENT WITH THE PATIENT S AGE |
| 10 | DENY: THE DIAGNOSIS IS INCONSISTENT WITH THE PATIENT S SEX |
| 18 | DENY: DUPLICATE CLAIM SERVICE |
| 1K | DENY: CPT OR DX CODE IS NOT VALID FOR AGE OF PATIENT |
| 28 | DENY: COVERAGE NOT IN EFFECT WHEN SERVICE PROVIDED |
| 29 | DENY: THE TIME LIMIT FOR FILING HAS EXPIRED |
| 35 | DENY: BENEFIT MAXIMUM HAS BEEN REACHED |
| 3D | DENY: NON-SPECIFIC DIAGNOSIS- REQUIRES 4TH DIGIT PLEASE RESUBMIT |
| 46 | DENY: THIS SERVICE IS NOT COVERED |

| EX CODE | DESCRIPTION |
|---|---|
| 4D | DENY: NON-SPECIFIC DIAGNOSIS- REQUIRES 5TH DIGIT PLEASE RESUBMIT |
| 50 | DENY: NOT A MCO COVERED BENEFIT |
| 86 | DENY: THIS IS NOT A VALID MODIFIER FOR THIS CODE |
| 99 | DENY: MISC UNLISTED CODES CAN NOT BE PROCESSED W O DESCRIPTION REPORT |
| 9M | DENY:THIS CPT CODE IS INVALID WHEN BILLED WITH THIS DIAGNOSIS |
| A1 | DENY: AUTHORIZATION NOT ON FILE |
| BG | DENY: TYPE OF BILL MISSING OR INCORRECT ON CLAIM, PLEASE RE-SUBMIT |
| BI | DENY: CLAIM CANNOT BE PROCESSED WITHOUT AN ITEMIZED BILL |
| Dr | DENY: CLAIM DOES NOT MEET EARLY ELECTIVE DELIVERY |
| DS | DENY: DUPLICATE SUBMISSION-ORIGINAL CLAIM STILL IN PEND STATUS |
| DW | DENY: INAPPROPRIATE DIAGNOSIS BILLED, CORRECT AND RESUBMIT |
| DX | DIAGNOSIS BILLED IS INVALID, PLEASE RESUBMIT WITH CORRECT CODE |
| EC | DIAGNOSIS CANNOT BE USED AS PRIMARY DIAGNOSIS, PLEASE RESUBMIT |
| F1 | DENY: FIELD 19 DOES NOT CONTAIN VALUE 20-44 |
| F2 | DENY: FIELD 19 DOES NOT CONTAIN LV,LC, IV, IC, CN, CS |
| F3 | DENY: MISSING DELIVERY CODE IN FIELD 19 |
| GE | DENY: GLOBAL CODE IS INVALID PER GUIDELINES |
| HQ | DENY: EDI CLAIM MUST BE SUBMITTED IN HARD COPY W CONSENT FORM ATTACHED |
| IM | DENY: RESUBMIT WITH CORRECT MODIFIER |
| L6 | DENY: BILL PRIMARY INSURER 1ST RESUBMIT WITH EOB |
| LO | DENY: CPT & LOCATION ARE NOT COMPATIBLE, PLEASE RESUBMIT |
| LZ | DENY: REFERRING PROVIDER MUST BE MEMBERS PCP TO RECEIVE PAYMENT |
| MG | DENY: SIGNATURE MISSING FROM BOX 31, PLEASE RESUBMIT |
| MO | MODIFIER BILLED IS NOT VALID, PLEASE RESUBMIT WITH CORRECT CODE |
| MQ | DENY: MEMBER NAME NUMBER DATE OF BIRTH DO NOT MATCH,PLEASE RESUBMIT |
| NT | DENY:PROVIDER NOT CONTRACTED FOR THIS SERVICE-DO NOT BILL PATIENT |
| NV | DENY: CONSENT FORM NOT VALID MISSING INFORMATION |
| U1 | CLAIM CANNOT BE PROCESSED WITHOUT MEDICAL RECORDS |
| UZ | DENY: SERVICES BILLED ON INCORRECT FORM, PLEASE REBILL ON A UB92 |
| V1 | DENY: SERVICE IS INCLUDED IN THE DELIVERY PAYMENT |
| Y6 | DENY: INSUFFICIENT INFO FOR PROCESSING,RESUBMIT W PRIME S ORIGINAL EOB |
| ZC | DENY: PROCEDURE IS INAPPROPRIATE FOR PROVIDER SPECIALTY |
| ZW | AFTER REVIEW, PREV DECISION UPHELD, SEE PROV HANDBOOK FOR APPEAL PROCESS |

Denial codes beginning with a lowercase letter typically indicate the denial is linked to a Plan Policy. In most cases, medical records are needed for review.

*Note: The following is not an all-inclusive list.*

| EX CODE | DESCRIPTION |
|---|---|
| er | PAY: LEVEL 2 ER PAID-PLEASE SUBMIT MED REC FOR HIGHER LEVEL PAYMENT |
| x4 | PAY: PAYMENT INCLUDES PAY FOR PERFORMANCE |
| x3 | PROCEDURE CODE UNBUNDLED FROM GLOBAL PROCEDURE CODE |
| yv | OUTPATIENT SERVICES INCLUDEED IN INPATIENT ADMIT PER CMS/PLAN GUIDELINES |
| yw | NOT COVERED OR ELIGIBLE SERVICE PER CMS OR PLAN GUIDELINES |
| yx | INCLUDED IN GLOBAL SURGICAL OR MATERNITY PACKAGE PER CMS OR ACOG |
| yy | REIMBURSEMENT REDUCTION BASED ON CPT AND/ OR CMS GUIDELINES |
| yz | INCORRECT USE OF MODIFIER -26 OR –TC BASED ON CMS |

## Common HIPAA Complaint EDI Rejection Codes

These codes are the standard national rejection codes for EDI submissions. All errors indicated for the code must be corrected before the claim is resubmitted.

Please see Home State Health's list of common EDI rejections, below, to determine specific actions you may need to take to correct your claims submission.

| Code | DESCRIPTION |
|---|---|
| 01 | Invalid Mbr DOB |
| 02 | Invalid Mbr |
| 06 | Invalid Prv |
| 07 | Invalid Mbr DOB & Prv |
| 08 | Invalid Mbr & Prv |
| 09 | Mbr not valid at DOS |
| 10 | Invalid Mbr DOB; Mbr not valid at DOS |
| 17 | Invalid Diag |
| 18 | Invalid Mbr DOB; Invalid Diag |
| 19 | Invalid Mbr; Invalid Diag |
| 23 | Invalid Prv; Invalid Diag |
| 34 | Invalid Proc |
| 35 | Invalid Mbr DOB; Invalid Proc |
| 36 | Invalid Mbr; Invalid Proc |
| 38 | Mbr not valid at DOS; Prv not valid at DOS; Invalid Diag |
| 39 | Invalid Mbr DOB; Mbr not valid at DOS; Prv not valid at DOS; Invalid Diag |
| 40 | Invalid Prv; Invalid Proc |
| 41 | Invalid Mbr DOB, Invalid Prv; Invalid Proc |

| Code | DESCRIPTION |
|---|---|
| 42 | Invalid Mbr; Invalid Prv; Invalid Proc |
| 43 | Mbr not valid at DOS; Invalid Proc |
| 44 | Invalid Mbr DOB; Mbr not valid at DOS; Invalid Proc |
| 46 | Prv not valid at DOS; Invalid Proc |
| 48 | Invalid Mbr; Prv not valid at DOS; Invalid Proc |
| 49 | Mbr not valid at DOS; Invalid Prv; Invalid Proc |
| 51 | Invalid Diag; Invalid Proc |
| 74 | Services performed prior to Contract Effective Date |
| 75 | Invalid units of service |

## Instructions for Supplemental Information

**CMS-1500 (02/12 version) Form, Shaded Field 24A-G**

The following types of supplemental information are accepted in a shaded claim line of the CMS 1500 (02/12 version) form field 24A-G:

- Anesthesia duration
- Narrative description of unspecified/miscellaneous/unlisted codes
- Vendor Product Number–Health Industry Business Communications Council (HIBCC)
- Product Number Health Care Uniform Code Council–Global Trade Item Number (GTIN), formerly Universal Product Code (UPC) for products

**The following qualifiers are to be used when reporting these services:**

**7** Anesthesia information

**ZZ** Narrative description of unspecified/miscellaneous/unlisted codes

**OZ** Product Number Health Care Uniform Code Council – Global Trade Item Number (GTIN)

**VP** Vendor Product Number- Health Industry Business Communications Council (HIBCC) Labeling Standard

To enter supplemental information, begin at 24A by entering the qualifier and then the information.

- Do not enter a space between the qualifier and the supplemental information.
- When reporting a service that does not have a qualifier, enter two blank spaces before entering the information.
- More than one supplemental item can be reported in a single shaded claim line if the information is related to the un-shaded claim line item it is entered on.
- When entering more than one supplemental item, enter the first qualifier at the start of 24A followed by the number, code, or other information.
- Do not enter a space between the qualifier and the supplemental information.

- Do not enter hyphens or spaces within the HIBCC, or GTIN number/code. After the entry of the first supplemental item, enter three blank spaces and then the next qualifier and number, code, or other information.
- Do not enter a space between the qualifier and the supplemental information.
- Do not enter hyphens or spaces within the HIBCC, or GTIN number/code.

**Examples:**

**Anesthesia**

| 24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY | B. PLACE OF SERVICE | C. EMG | D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER | E. DIAGNOSIS POINTER | F. $ CHARGES | G. DAYS OR UNITS | H. EPSDT Family Plan | I. ID. QUAL. | J. RENDERING PROVIDER ID. # |
|---|---|---|---|---|---|---|---|---|---|
| 7Begin 1315 End 1445 Time 90 minutes | | | | | | | | NPI | |

**Unlisted, Non-specific, or Miscellaneous CPT or HCPC Code**

| 24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY | B. PLACE OF SERVICE | C. EMG | D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER | E. DIAGNOSIS POINTER | F. $ CHARGES | G. DAYS OR UNITS | H. EPSDT Family Plan | I. ID. QUAL. | J. RENDERING PROVIDER ID. # |
|---|---|---|---|---|---|---|---|---|---|
| ZZLaparoscopic Ventral Hernia Repair Op Note Attached | | | | | | | | NPI | |

**Vendor Product Number- HIBCC**

| 24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY | B. PLACE OF SERVICE | C. EMG | D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER | E. DIAGNOSIS POINTER | F. $ CHARGES | G. DAYS OR UNITS | H. EPSDT Family Plan | I. ID. QUAL. | J. RENDERING PROVIDER ID. # |
|---|---|---|---|---|---|---|---|---|---|
| VPA123ABC7D9E1F | | | | | | | | NPI | |

**Product Number Health Care Uniform Code Council – GTIN**

| 24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY | B. PLACE OF SERVICE | C. EMG | D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER | E. DIAGNOSIS POINTER | F. $ CHARGES | G. DAYS OR UNITS | H. EPSDT Family Plan | I. ID. QUAL. | J. RENDERING PROVIDER ID. # |
|---|---|---|---|---|---|---|---|---|---|
| OZ01234567891112 | | | | | | | | NPI | |

## Claim Payment

**Clean claims will be adjudicated (finalized as paid or denied) at the following levels:**

- 95 percent within 30 business days of the receipt
- 99 percent within 90 calendar days of the receipt

## 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 Health is always the payer of last resort. Home State Health providers shall make reasonable efforts to determine the legal liability of third parties to pay for services furnished to Home State Health 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 Health that efforts have been unsuccessful. Home State Health 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 Health will coordinate with the provider to pay any claims that may have been denied for payment due to third party liability.

## Payment Policies

Home State Health 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 Health 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 homestatehealth.com.

## Claim Requests for Reconsideration, Claim Appeals, Corrected Claims, and Refunds

Corrected claims must be submitted within 180 days from the date of service. All claim requests for reconsiderations and claim appeals must be received within 180 days from the original date of the EOP (Explanation of Payment) or denial.

If a provider has a question or is not satisfied with the information they have received related to a claim, there are five effective ways in which the provider can address the claim.

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 (pg.28) on the HCFA claim form, and populating field 64 (pg.40) 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 Plan**
Attn: Corrected Claim
PO Box 4050
Farmington, MO 63640-3829

- 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 Plan**
Attn: Claim Reconsideration
PO Box 4050
Farmington, MO 63640-3829

**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 Plan**
Attn: Claim Appeal
PO Box 4050
Farmington, MO 63640-5000

- 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

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.

## Refunds

To report an overpayment please utilize Home State Health's Provider Refund Form found under Provider Resources/Forms on the Provider Page at HomeStateHealth.com. Please specify the reason for the overpayment, and return the overpayment to Home State Health within 60 calendar days after the date on which the overpayment was identified. Installment payments of the refund may be requested; such request shall be agreed to between Home State Health and the provider. Overpayments identified by a provider and not self-reported within the 60-calendar day timeframe may be considered false claims and may be subject to referrals as credible allegations of fraud and subject to payment suspension in accordance with 42 CFR 455.23.

**Submit Refund Forms and Refunds to:**

**Home State Health**
Attn: Refunds PO Box 95270
St. Louis, MO 63195-2790

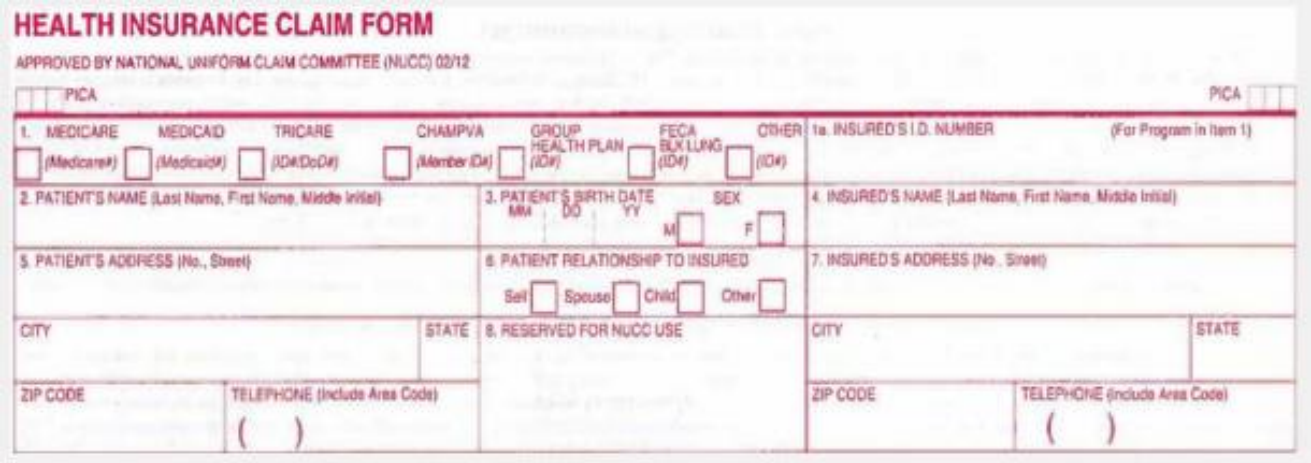
# CLAIMS FORM INSTRUCTIONS

Below is a Billing Guide for forms CMS-1500 and CMS UB-04.

Required (R) fields must be completed on all claims. Conditional (C) fields must be completed if the information applies to the situation or the service provided. Please reference the "Required or Conditional" column within the guides below.

*Note: Claims with missing or invalid Required (R) field information will be rejected or denied.*

## Completing a CMS 1500 Form


HEALTH INSURANCE CLAIM FORM
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12
PICA
1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)
1a. INSURED'S I.D. NUMBER (For Program in Item 1)
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)
3. PATIENT'S BIRTH DATE MM DD YY SEX M F
4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street)
6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other
7. INSURED'S ADDRESS (No., Street)
CITY STATE
8. RESERVED FOR NUCC USE
CITY STATE
ZIP CODE TELEPHONE (Include Area Code) ( )
ZIP CODE TELEPHONE (Include Area Code) ( )

| Field # | Field Description | Instruction or Comments | Required (R) or Conditional (C) |
|---|---|---|---|
| 1 | INSURANCE PROGRAM IDENTIFICATION | Check only the type of health coverage applicable to the claim. This field indicates the payer to whom the claim is being filed. Enter "X" in the box noted Medicaid (Medicaid #). | R |
| 1a | INSURED I.D. NUMBER | The 8-digit Medicaid identification number on the member's Home State Health I.D. card. | R |
| 2 | PATIENT'S NAME (Last Name, First Name, Middle Initial) | Enter the patient's name as it appears on the member's Home State Health I.D. card. Do not use nicknames. | R |
| 3 | PATIENT'S BIRTH DATE / SEX | Enter the patient's 8-digit date of (MM/DD/YYYY) and mark the appropriate box to indicate the patient's sex/gender. | R |
| 4 | INSURED'S NAME | Enter the patient's name as it appears on the member's Home State Health I.D. card. | C |

| Field # | Field Description | Instruction or Comments | Required (R) or Conditional (C) |
|---|---|---|---|
| 5 | PATIENT'S ADDRESS (Number, Street, City, State, Zip code) Telephone (include area code) | Enter the patient's complete address and telephone number including area code on the appropriate line.<br>First line – Enter the street address. Do not use commas, periods, or other punctuation in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101).<br>Second line – In the designated block, enter the city and state.<br>Third line – Enter the zip code and phone number. When entering a 9-digit zip code (zip+4 code), include the hyphen. Do not use a hyphen or space as a separator within the telephone number (i.e. (803)5551414).<br>*Note: Patient's Telephone does not exist in the electronic 837 Professional 4010A1.* | C |
| 6 | PATIENT'S RELATION TO INSURED | Always mark to indicate self. | C |
| 7 | INSURED'S ADDRESS (Number, Street, City, State, Zip code) Telephone (include area code) | Enter the patient's complete address and telephone number including area code on the appropriate line.<br>First line – Enter the street address. Do not use commas, periods, or other punctuation in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101).<br>Second line – In the designated block, enter the city and state.<br>Third line – Enter the zip code and phone number. When entering a 9-digit zip code (zip+4 code), include the hyphen. Do not use a hyphen or space as a separator within the telephone number (i.e. (803)5551414).<br>*Note: Patient's Telephone does not exist in the electronic 837 Professional 4010A1.* | Not Required |
| 8 | PATIENT STATUS | | Not Required |


9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)
a. OTHER INSURED'S POLICY OR GROUP NUMBER
b. RESERVED FOR NUCC USE
c. RESERVED FOR NUCC USE
d. INSURANCE PLAN NAME OR PROGRAM NAME
10. IS PATIENT'S CONDITION RELATED TO:
a. EMPLOYMENT? (Current or Previous) YES NO
b. AUTO ACCIDENT? PLACE (State) YES NO
c. OTHER ACCIDENT? YES NO
10d. CLAIM CODES (Designated by NUCC)
11. INSURED'S POLICY GROUP OR FECA NUMBER
a. INSURED'S DATE OF BIRTH MM DD YY SEX M F
b. OTHER CLAIM ID (Designated by NUCC)
c. INSURANCE PLAN NAME OR PROGRAM NAME
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a, and 9d.
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED DATE
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED

| Field # | Field Description | Instruction or Comments | Required (R) or Conditional (C) |
|---|---|---|---|
| 9 | OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) | Refers to someone other than the patient. REQUIRED if patient is covered by another insurance plan. Enter the complete name of the insured. | C |
| 9a | *OTHER INSURED'S POLICY OR GROUP NUMBER | REQUIRED if # 9 is completed. Enter the policy of group number of the other insurance plan. | C |
| 9b | OTHER INSURED'S BIRTH DATE / SEX | REQUIRED if # 9 is completed. Enter the 8-digit date of birth (MM/DD/YYYY) and mark the appropriate box to indicate sex/gender. M = male F = female for the person listed in box 9. | C |
| 9c | EMPLOYER'S NAME OR SCHOOL NAME | Enter the name of employer or school for the person listed in box 9. *Note: Employer's Name or School Name does not exist in the electronic 837 Professional 4010A1.* | C |
| 9d | INSURANCE PLAN NAME OR PROGRAM NAME | REQUIRED if # 9 is completed. Enter the other insured's (name of person listed in box 9) insurance plan or program name. | C |
| 10a, b,c | IS PATIENT'S CONDITION RELATED TO: | Enter a Yes or No for each category/line (a, b, and c). Do not enter a Yes and No in the same category/line. | R |
| 10d | RESERVED FOR LOCAL USE | | Not Required |
| 11 | INSURED'S POLICY OR FECA NUMBER | REQUIRED when other insurance is available. Enter the policy, group, or FECA number of the other insurance. | C |
| 11a | INSURED'S DATE OF BIRTH / SEX | Same as field 3. | C |

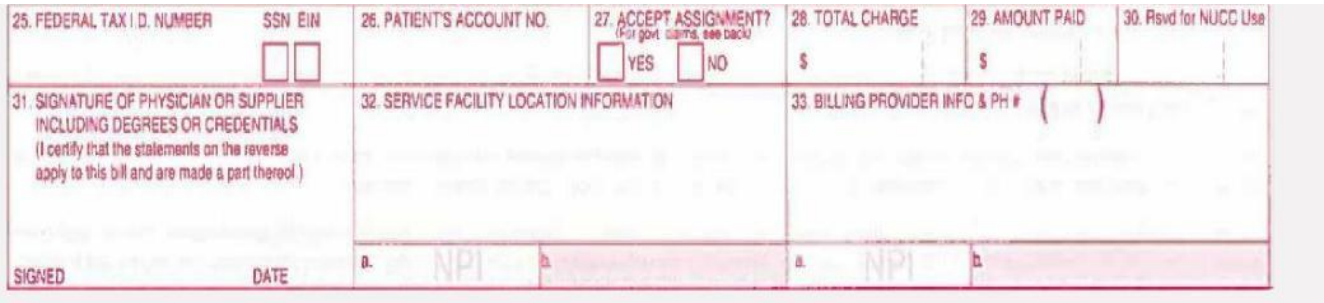
| Field # | Field Description | Instruction or Comments | Required (R) or Conditional (C) |
|---|---|---|---|
| 11b | EMPLOYER'S NAME OR SCHOOL NAME | REQUIRED if Employment is marked Yes in box 10a. | C |
| 11c | INSURANCE PLAN NAME OR PROGRAM NUMBER | Enter name of the insurance Health Plan or program. | C |
| 11d | IS THERE ANOTHER HEALTH BENEFIT PLAN | Mark Yes or No. If Yes, complete # 9a-d and #11c. | R |
| 12 | PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE | Enter "Signature on File", "SOF", or the actual legal signature. The provider must have the member's or legal guardian's signature on file or obtain their legal signature in this box for the release of information necessary to process and/or adjudicate the claim. | C |
| 13 | PATIENT'S OR AUTHORIZED PERSONS SIGNATURE | Obtain signature if appropriate. | Not Required |
| 14 | DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR Pregnancy (LMP) | Enter the 6-digit (MM/DD/YY) or 8-digit (MM/DD/YYYY) date reflecting the first date of onset for the: Present illness Injury LMP (last menstrual period) if pregnant | C |
| 15 | IF PATIENT HAS SAME OR SIMILAR ILLNESS. GIVE FIRST DATE | | Not Required |
| 16 | DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION | | Not Required |
| 17 | NAME OF REFERRING PHYSICIAN OR OTHER SOURCE | Enter the name of the referring physician or professional (First name, middle initial, last name, and credentials). | Not Required |
| 17a | ID NUMBER OF | Required if 17 is completed. Use ZZ qualifier for Taxonomy code. | C |
| 17b | NPI NUMBER OF REFERRING PHYSICIAN | Required if 17 is completed. If unable to obtain referring NPI, servicing NPI may be used. | C |
| 18 | HOSPITALIZATION DATES RELATED TO CURRENT SERVICES | | Not Required |
| 19 | RESERVED FOR LOCAL USE | | Not Required |
| 20 | OUTSIDE LAB / CHARGES | | Not Required |

| Field # | Field Description | Instruction or Comments | Required (R) or Conditional (C) |
|---|---|---|---|
| 21 | DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS A-L TO ITEM 24E BY LINE) | Enter the diagnosis or condition of the patient using the appropriate release/update of ICD-9/ICD-10 CM Volume 1 for the date of service. Diagnosis codes submitted must be valid ICD-9/ICD-10 codes for the date of service. "E" codes are NOT acceptable as a primary diagnosis. Note: Claims missing or with invalid diagnosis codes will be denied for payment. | R |
| 22 | MEDICAID RESUBMISSION CODE / ORIGINAL REF.NO. | For corrected claims, re-submissions or adjustments, enter the DCN (Document Control Number) of the original claim. A resubmitted claim MUST be indicated using one of the following resubmission codes: 6-Corrected Claim Replacement of prior claim 8-void/cancel prior claim | C |
| 23 | PRIOR AUTHORIZATION NUMBER | Enter the Home State Health (HSHP) authorization or referral number. Refer to the HSHP Provider Manual for information on services requiring referral and/or prior authorization. | Not Required |

| Field # | Field Description | Instruction or Comments | Required (R) or Conditional (C) |
|---|---|---|---|
| 24a-j General Information | Box 24 contains 6 claim lines. Each claim line is split horizontally into shaded and un-shaded areas. Within each un-shaded area of a claim line there are 10 individual fields labeled A-J. Within each shaded area of a claim line there are 4 individual fields labeled 24A-24G, 24H, 24J and 24Jb. Fields 24A through 24G are a continuous field for the entry of supplemental information. Instructions are provided for shaded and un-shaded fields.<br>The shaded area for a claim line is to accommodate the submission of supplemental information, EPSDT qualifier, and Provider Medicaid Number.<br>Shaded boxes a-g is for line item supplemental information and is a continuous line that accepts up to 61 characters. Refer to the instructions listed below for information on how to complete.<br>The un-shaded area of a claim line is for the entry of claim line item detail. | | |
| 24a-g Shaded | SUPPLEMENTAL INFORMATION | The shaded top portion of each service claim line is used to report supplemental information for:<br>NDC<br>Anesthesia Start/Stop time & duration<br>Unspecified, miscellaneous, or unlisted CPT and HCPC code descriptions.<br>HIBCC or GTIN number/code. | C |
| 24a Un-Shaded | DATE(S) OF SERVICE | Enter the date the service listed in 24D was performed (MM/DD/YYYY). If there is only one date, enter that date<br>in the “From” field. The “To” field may be left blank or populated with the “From” date. If identical services (identical CPT/HCPC code(s)) were performed each date must be entered on a separate line. | R |
| 24b Un-Shaded | PLACE OF SERVICE | Enter the appropriate 2-digit CMS standard place of service (POS) code. A list of current POS codes may be shaded found on the CMS website. | R |
| 24c Un-Shaded | EMG | Enter Y (Yes) or N (No) to indicate if the service was an emergency. | Not Required |

| Field # | Field Description | Instruction or Comments | Required (R) or Conditional (C) |
|---|---|---|---|
| 24d<br>Un-Shaded | PROCEDURES, SERVICES OR SUPPLIES CPT/HCPCS MODIFIER | Enter the 5-digit CPT or HCPC code and 2-character modifier– - if applicable. Only one CPT or HCPC and up to 4 modifiers may be entered per claim line. Codes entered must be valid for date of service. Missing or invalid codes will be denied for payment.<br>Only the first modifier entered is used for pricing the claim. Failure to use modifiers in the correct position or combination with the procedure code, or invalid use of modifiers, will result in a rejected, denied, or incorrectly paid claim. | R |
| 24e<br>Un- shaded | DIAGNOSIS CODE | Enter the alpha character diagnosis pointer ( A-L) from field 21. List the primary diagnosis for the service provided or performed first followed by any additional or related diagnosis listed in field 21 (using the alpha character diagnosis pointer, not the diagnosis code.) Do not use commas between the diagnosis pointer numbers. Diagnosis codes must be valid ICD-9/10 codes for the date of service or the claim will be rejected/denied. | R |
| 24f<br>Un- shaded | CHARGES | Enter the charge amount for the claim line item service billed. Dollar amounts to the left of the vertical line should be right justified. Up to 8 characters are allowed (i.e. 199,999.99). Do not enter a dollar sign ($). If the dollar amount is a whole number (i.e. 10.00), enter 00 in the area to the right of the vertical line. | R |
| 24g<br>Un- shaded | DAYS OR UNITS | Enter quantity (days, visits, units). If only one service provided, enter a numeric value of 1. | R |
| 24h Shaded | EPSDT<br>(Family Planning) | Leave blank or enter “Y” if the services were performed as a result of an EPSDT referral. | C |
| 24h<br>Un- shaded | EPSDT<br>(Family Planning) | Enter the appropriate qualifier for EPSDT visit | C |
| 24i Shaded | ID QUALIFIER | Use ZZ qualifier for Taxonomy<br>Use 1D qualifier for Medicaid ID, if an Atypical Provider | C |
| 24j Shaded | NON-NPI PROVIDER ID# | Enter as designated below the Medicaid ID number or taxonomy code.<br>Typical Providers:<br>Enter the Provider taxonomy code that corresponds to the qualifier entered in 24I shaded. Use ZZ qualifier for taxonomy code.<br>Atypical Providers:<br>Enter the Medicaid Provider ID number. | R |

| Field # | Field Description | Instruction or Comments | Required (R) or Conditional (C) |
|---|---|---|---|
| 24j Un-shaded | NPI PROVIDER ID | Typical Providers ONLY: Enter the 10-character NPI ID of the provider who rendered services. If the provider is billing as a member of a group, the rendering individual provider's 10-character NPI ID may be entered. . Enter the billing NPI if services are not provided by an individual (e.g. DME, Independent Lab, Home Health, RHC/FQHC general Medical Exam, etc.) | R |


25. FEDERAL TAX I.D. NUMBER SSN EIN
26. PATIENT'S ACCOUNT NO.
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO
28. TOTAL CHARGE $
29. AMOUNT PAID $
30. Rsvd for NUCC Use
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
32. SERVICE FACILITY LOCATION INFORMATION
33. BILLING PROVIDER INFO & PH # ( )
SIGNED DATE
a. NPI b.
a. NPI b.

| Field # | Field Description | Instruction or Comments | Required (R) or Conditional (C) |
|---|---|---|---|
| 25 | FEDERAL TAX I.D. NUMBER SSN/EIN | Enter the provider or supplier 9-digit Federal Tax ID number and mark the box labeled EIN. | R |
| 26 | PATIENT'S ACCOUNT NO. | Enter the provider's billing account number. | Not Required |
| 27 | ACCEPT ASSIGNMENT? | Enter an X in the YES box. Submission of a claim for reimbursement of services provided to a Medicaid recipient using Medicaid funds indicates the provider accepts Medicaid assignment. Refer to the back of the CMS 1500 (12-90) form for the section pertaining to Medicaid Payments. | R |
| 28 | TOTAL CHARGES | Enter the total charges for all claim line items billed – claim lines 24F. Dollar amounts to the left of the vertical line should be right justified. Up to 8 characters are allowed (i.e. 199,999.99). Do not enter a dollar sign ($). If the dollar amount is a whole number (i.e. 10.00), enter 00 in the area to the right of the vertical line. | R |

| Field # | Field Description | Instruction or Comments | Required (R) or Conditional (C) |
|---|---|---|---|
| 29 | AMOUNT PAID | REQUIRED when another carrier is the primary payer. Enter the payment received from the primary payer prior to invoicing Home State Health. Medicaid programs are always the payers of last resort.<br><br>Dollar amounts to the left of the vertical line should be right justified. Up to 8 characters are allowed (i.e. 199,999.99). Do not enter a dollar sign ($). If the dollar amount is a whole number (i.e. 10.00), enter 00 in the area to the right of the vertical line. | C |
| 30 | BALANCE DUE | REQUIRED when #29 is completed.<br><br>Enter the balance due (total charges minus the amount of payment received from the primary payer).<br><br>Dollar amounts to the left of the vertical line should be right justified. Up to 8 characters are allowed (i.e. 199,999.99). Do not enter a dollar sign ($). If the dollar amount is a whole number (i.e. 10.00), enter 00 in the area to the right of the vertical line. | C |
| 31 | SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS | If there is a signature waiver on file, you may stamp, print, or computer-generate the signature; otherwise, the practitioner or practitioner's authorized representative MUST sign the form. If signature is missing or invalid the claim will be returned unprocessed.<br><br>*Note: Does not exist in the electronic 837P.* | R |
| 32 | SERVICE FACILITY LOCATION INFORMATION | REQUIRED if the location where services were rendered is different from the billing address listed in field 33.<br><br>Enter the name and physical location. (P.O. Box #'s are not acceptable here.) First line – Enter the business/facility/practice name.<br><br>Second line– Enter the street address. Do not use commas, periods, or other punctuation in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101).<br><br>Third line – In the designated block, enter the city and state.<br><br>Fourth line – Enter the zip code and phone number. When entering a 9-digit zip code (zip+4 code), include the hyphen. | C |

| Field # | Field Description | Instruction or Comments | Required (R) or Conditional (C) |
|---|---|---|---|
| 32a | NPI – SERVICES RENDERED | **Typical Providers ONLY:** REQUIRED if the location where services were rendered is different from the billing address listed in field 33.<br>Enter the 10-character NPI ID of the facility where services were rendered. | C |
| 32b | OTHER PROVIDER ID | REQUIRED if the location where services were rendered<br>is different from the billing address listed in field 33.<br>**Typical Providers**<br>Enter the 2-character qualifier ZZ followed by the taxonomy code (no spaces).<br>**Atypical Providers**<br>Enter the 2-character qualifier 1D (no spaces). | C |
| 33 | BILLING PROVIDER INFO & PH # | Enter the billing provider's complete name, address (include the zip + 4 code), and phone number.<br>First line – Enter the business/facility/practice name.<br>Second line– Enter the street address. Do not use commas, periods, or other punctuation in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101).<br>Third line – In the designated block, enter the city and state.<br>Fourth line – Enter the zip code and phone number. When entering a 9-digit zip code (zip+ 4 code), include the hyphen. Do not use a hyphen or space as a separator within the telephone number (i.e. (803)551414). *NOTE: The 9 digit zip code (zip + 4 code) is a requirement for paper and EDI claim submission* | R |
| 33a | GROUP BILLING NPI | Typical Providers ONLY: REQUIRED if the location where services were rendered is different from the billing address listed in field 33.<br>Enter the 10-character NPI ID. | R |
| 33b | GROUP BILLING OTHER ID | Enter as designated below the Billing Group taxonomy code.<br>**Typical Providers:**<br>Enter the Provider taxonomy code. Use ZZ qualifier.<br>**Atypical Providers:**<br>Enter the Medicaid Provider ID number. | C |

## Completing a UB-04 Claim Form

A UB-04 form is the only acceptable claim form for submitting inpatient or outpatient Hospital claims charges for reimbursement by Home State Health. In addition, a UB-04 is required for Comprehensive Outpatient Rehabilitation facilities (CORF), Home Health Agencies, nursing home admissions, inpatient hospice services, independent and provider based rural health clinics, and dialysis services.

**Incomplete or inaccurate information will result in the claim/encounter being rejected for:**

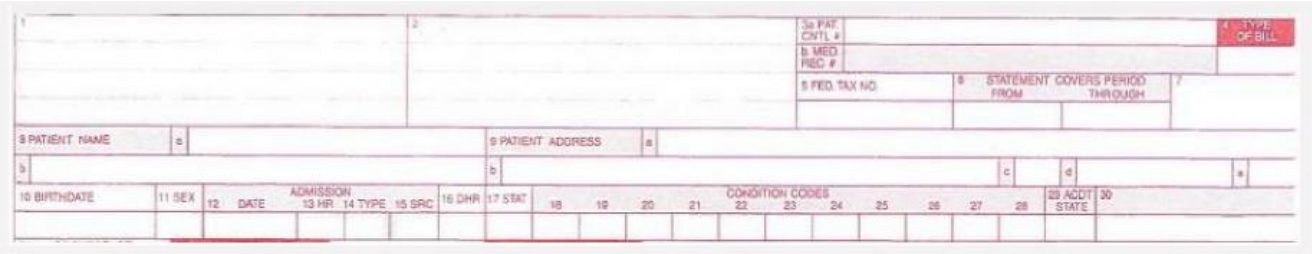
**UB-04 Hospital Outpatient Claims/Ambulatory Surgery**

**The following information applies to outpatient and ambulatory surgery claims:**

- Professional fees must be billed on a CMS 1500-claim form
- Include the appropriate CPT code next to each revenue code corrections.

**Exceptions**

Please refer to your provider contract with Home State Health or to the MO HealthNet Hospitals Provider Manual for Revenue Codes that do not require a CPT 4 code.



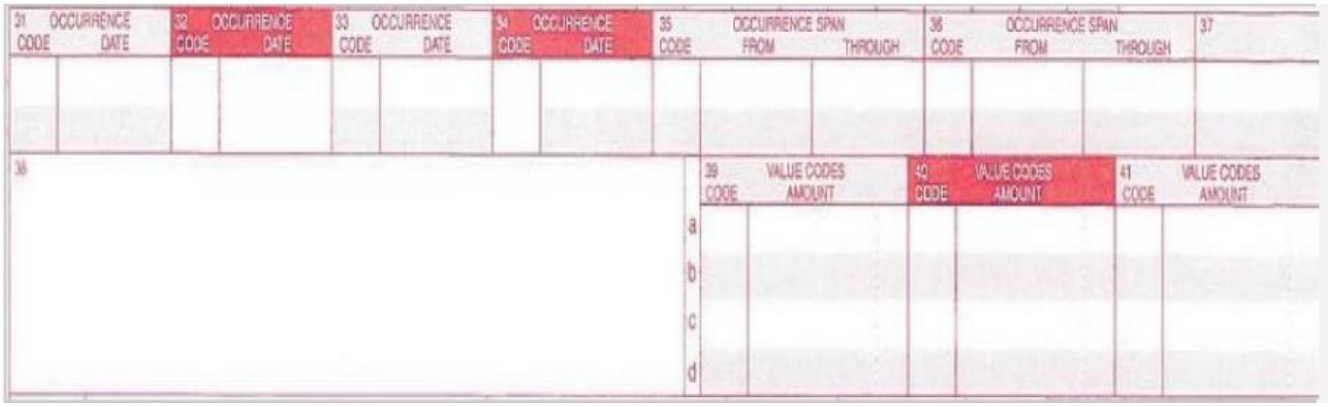
| Field # | Field Description | Instruction or Comments | Required (R) or Conditional (C) |
|---|---|---|---|
| 1 | (UNLABELED FIELD) | Line 1: Enter the complete provider name.<br>Line 2: Enter the complete mailing address.<br>Line 3: Enter the City, State, and zip+4 code (include hyphen).<br>NOTE: the 9- digit zip (zip + 4 code) is a requirement for paper and EDI claims.<br>Line 4: Enter the area code and phone number. | R |
| 2 | (UNLABELED FIELD) | Enter the Pay-To Name and Address. | Not Required |
| 3a | PATIENT CONTROL NO. | Enter the facility patient account/control number | Not Required |
| 3b | MEDICAL RECORD NUMBER | Enter the facility patient medical or health record number. | R |
| 4 | TYPE OF BILL | Enter the appropriate 3-digit type of bill (TOB) code as specified by the NUBC UB-04 Uniform Billing Manual minus the leading “0” (zero). A leading “0” is not needed.<br>Digits should be reflected as follows:<br>1st digit - Indicating the type of facility.<br>2nd digit - Indicating the type of care<br>3rd digit – Indicating the billing sequence | R |
| 5 | FED. TAX NO. | Enter the 9-digit number assigned by the federal government for tax reporting purposes. | R |
| 6 | STATEMENT COVERS PERIOD FROM/THROUGH | Enter begin and end or admission and discharge dates for the services billed. Inpatient and outpatient observation stays must be billed using the admission date and discharge date. Outpatient therapy, chemotherapy, laboratory, pathology, radiology and dialysis may be billed using a date span. All other outpatient services must be billed using the actual date of service. (MM/DD/YY) | R |
| 7 | (UNLABELED FIELD) | Not Used | Not Required |
| 8a | PATIENT NAME | 8a – Enter the patient’s 8-digit Medicaid identification number on the member’s Home State Health I.D. card. | Not Required |
| 8b | | 8b – Enter the patient’s last name, first name, and middle initial as it appears on the Home State Health Plan ID card. Use a comma or space to separate the last and first names. | Not Required |

| Field # | Field Description | Instruction or Comments | Required (R) or Conditional (C) |
|---|---|---|---|
| 8 a,b | PATIENT NAME | Titles (Mr., Mrs., etc.) should not be reported in this field.<br>Prefix: No space should be left after the prefix of a name e.g. McKendrick. H<br>Hyphenated names: Both names should be capitalized and separated by a hyphen (no space).<br>Suffix: A space should separate a last name and suffix. | R |
| 9 a-e | PATIENT ADDRESS | Enter the patient's complete mailing address of the patient.<br>Line a: Street address<br>Line b: City<br>Line c: State<br>Line d: ZIP code<br>Line e: Country Code (NOT REQUIRED) | R<br>(except line 9e) |
| 10 | BIRTHDATE | Enter the patient's date of birth (MMDDYYYY) | R |
| 11 | SEX | Enter the patient's sex. Only M or F is accepted. | R |
| 12 | ADMISSION DATE | Enter the date of admission for inpatient claims and date of service for outpatient claims. | C |
| 13 | ADMISSION HOUR | Enter the time using 2-digit military time (00-23) for the time of inpatient admission or time of treatment for outpatient services.<br>00 - 12:00 midnight to 12:59<br>1 - 01:00 to 01:59<br>2 - 02:00 to 02:59<br>3 - 03:00 to 03:39<br>4 - 04:00 to 04:59<br>5 - 05:00 to 05:59<br>6 - 06:00 to 06:59<br>7 - 07:00 to 07:59<br>8 - 08:00 to 08:59<br>9 - 09:00 to 09:59<br>10 - 10:00 to 10:59<br>11 - 11:00 to 11:59<br>12 - 12:00 noon to 12:59<br>13 - 01:00 to 01:59<br>14 - 02:00 to 02:59<br>15 - 03:00 to 03:59<br>16 - 04:00 to 04:59<br>17 - 05:00 to 05:59<br>18 - 06:00 to 06:59<br>19 - 07:00 to 07:59<br>20 - 08:00 to 08:59<br>21 - 09:00 to 09:59<br>22 - 10:00 to 10:59<br>23 - 11:00 to 11:59 | R |

| Field # | Field Description | Instruction or Comments | Required (R) or Conditional (C) |
|---|---|---|---|
| 14 | ADMISSION TYPE | Required for inpatient admissions (TOB 11X, 118X, 21X, 41X, 52X). Enter the 1-digit code indicating the priority of the admission using one of the following codes:<br>1 Emergency<br>2 Urgent<br>3 Elective<br>4 Newborn | C |
| 15 | ADMISSION SOURCE | **Enter the 1-digit code indicating the source of the admission or outpatient service using one of the following codes:**<br>**For Type of admission 1,2,3 or 5:**<br>1 Physician Referral<br>2 Clinic Referral<br>3 Health Maintenance Referral (HMO)<br>4 Transfer from a hospital<br>5 Transfer from Skilled Nursing Facility (SNF)<br>6 Transfer from another health care facility<br>7 Emergency Room<br>8 Court/Law enforcement<br>9 Information not available<br>**For type of admission 4 (newborn):**<br>1 Normal Delivery<br>2 Premature Delivery<br>3 Sick Baby<br>4 Extramural Birth<br>5 Born Inside the Hospital<br>6 Born Outside of This Hospital<br>7 - 9 Reserved for national assignment | |
| 16 | DISCHARGE HOUR | Enter the time using 2-digit military time (00-23) for the time of inpatient or outpatient discharge.<br>00- 12:00 midnight to 12:59<br>1 - 01:00 to 01:59<br>2 - 02:00 to 02:59<br>3 - 03:00 to 03:39<br>4 - 04:00 to 04:59<br>5 - 05:00 to 05:59<br>6 - 06:00 to 06:59<br>12 - 12:00 noon to 12:59<br>13 - 01:00 to 01:59<br>14 - 02:00 to 02:59<br>15 - 03:00 to 03:59<br>16 - 04:00 to 04:59<br>17 - 05:00 to 05:59<br>18 - 06:00 to 06:59 | C |

| Field # | Field Description | Instruction or Comments | | Required (R) or Conditional (C) |
|---|---|---|---|---|
| 16<br>(cont.) | | 7 - 07:00 to 07:59<br>8 - 08:00 to 08:59<br>9 - 09:00 to 09:59<br>10 - 10:00 to 10:59<br>11 - 11:00 to 11:59 | 19 - 07:00 to 07:59<br>20 - 08:00 to 08:59<br>21 - 09:00 to 09:59<br>22 - 10:00 to 10:59<br>23 - 11:00 to 11:59 | |
| 17 | PATIENT STATUS | REQUIRED for inpatient claims. Enter the 2-digit disposition of the patient as of the "through" date for the billing period listed in field 6 using one of the following codes:<br>01 Routine Discharge<br>02 Discharged to another short-term general hospital<br>03 Discharged to SNF<br>04 Discharged to ICF<br>05 Discharged to another type of institution<br>06 Discharged to care of home health service organization<br>07 Left against medical advice<br>08 Discharged/transferred to home under care of a Home IV provider<br>09 Admitted as an inpatient to this hospital (only for use on Medicare outpatient hospital claims)<br>20 Expired or did not recover<br>30 Still patient (To be used only when the client has been in the facility for 30 consecutive days if payment is based on DRG)<br>40 Expired at home (hospice use only)<br>41 Expired in a medical facility (hospice use only)<br>42 Expired—place unknown (hospice use only)<br>43 Discharged/Transferred to a federal hospital (such as a Veteran's Administration [VA] hospital)<br>50 Hospice—Home<br>51 Hospice—Medical Facility<br>61 Discharged/ Transferred within this institution to a hospital-based Medicare approved swing bed<br>62 Discharged/ Transferred to an Inpatient rehabilitation facility (IRF), including rehabilitation distinct part units of a hospital<br>63 Discharged/ Transferred to a Medicare certified long-term care hospital (LTCH) | | C |

| Field # | Field Description | Instruction or Comments | Required (R) or Conditional (C) |
|---|---|---|---|
| 17<br>(cont.) | | 64 Discharged/ Transferred to a nursing facility certified under Medicaid but not certified under Medicare<br>65 Discharged/ Transferred to a Psychiatric hospital or psychiatric distinct part unit of a hospital<br>66 Discharged/transferred to a critical access hospital (CAH) | |
| 18-28 | CONDITION CODES | REQUIRED when applicable. Condition codes are used to identify conditions relating to the bill that may affect payer processing.<br>Each field (18-24) allows entry of a 2-character code. Codes should be entered in alphanumeric sequence (numbered codes precede alphanumeric codes).<br>For a list of codes and additional instructions refer to the NUBC UB-04 Uniform Billing Manual. | C |
| 29 | ACCIDENT STATE | | Not Required |
| 30 | (UNLABELED FIELD) | Not Used | Not Required |



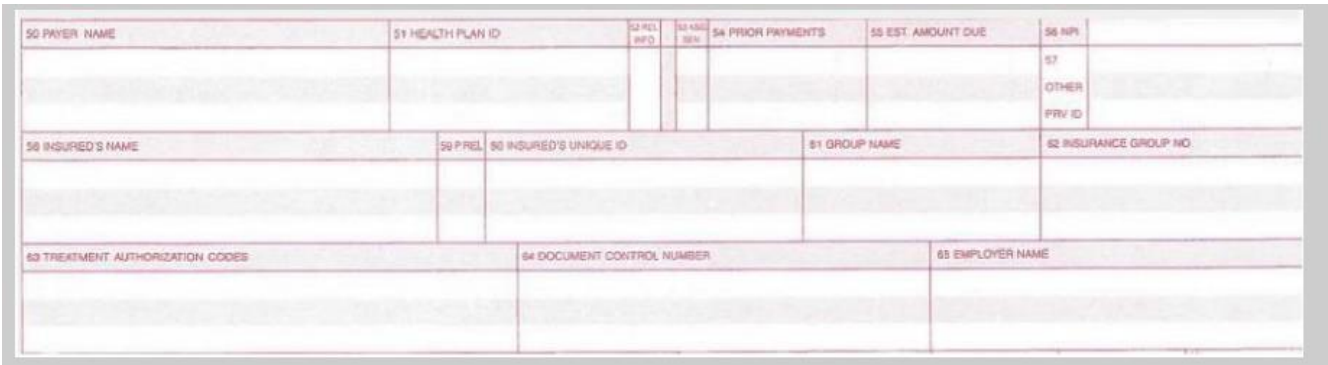
| Field # | Field Description | Instruction or Comments | Required (R) or Conditional (C) |
|---|---|---|---|
| 31-34 a-b | OCCURRENCE CODE and OCCURENCE DATE | **Occurrence Code:** REQUIRED when applicable. Occurrence codes are used to identify events relating to the bill that may affect payer processing.<br>Each field (31-34a) allows entry of a 2-character code. Codes should be entered in alphanumeric sequence (numbered codes precede alphanumeric codes).<br>For a list of codes and additional instructions refer to the NUBC UB-04 Uniform Billing Manual.<br>**Occurrence Date:** REQUIRED when applicable or when a corresponding Occurrence Code is present on the same line (31a-34a). Enter the date for the associated occurrence code in MMDDYYYY format. | C |
| 35-36 a-b | OCCURRENCE SPAN CODE and OCCURRENCE DATE | **Occurrence Span Code: REQUIRED** when applicable. Occurrence codes are used to identify events relating to the bill that may affect payer processing.<br>Each field (31-34a) allows entry of a 2-character code. Codes should be entered in alphanumeric sequence (numbered codes precede alphanumeric codes)<br>For a list of codes and additional instructions refer to the NUBC UB-<br>04 Uniform Billing Manual.<br>**Occurrence Span Date: REQUIRED** when applicable or when a corresponding Occurrence Span code is present on the same line<br>(35a-36a). Enter the date for the associated occurrence code in MMDDYYYY format. | |
| 37 | (UNLABELED FIELD) | Leave Blank | Not Required |
| 38 | RESPONSIBLE PARTY | NAME AND ADDRESS | Not Required |
| 39-41 a-d | VALUE CODES, CODES and AMOUNTS | **Code:**<br>**REQUIRED** when applicable. Value codes are used to identify events relating to the bill that may affect payer processing.<br>Each field (39-41) allows entry of a 2-character code. Codes should be entered in | C |

| Field # | Field Description | Instruction or Comments | Required (R) or Conditional (C) |
|---|---|---|---|
| 39-41 a-d (cont.) | | alphanumeric sequence (numbered codes precede alphanumeric codes).<br><br>Up to 12 codes can be entered. All “a” fields must be completed before using “b” fields, all “b” fields before using “c” fields, and all “c” fields before using “d” fields.<br><br>For a list of codes and additional instructions refer to the NUBC UB-C<br><br>04 Uniform Billing Manual.<br><br>**Amount:**<br>REQUIRED when applicable or when a Value Code is entered.<br><br>Enter the dollar amount for the associated value code.<br><br>Dollar amounts to the left of the vertical line should be right justified.<br><br>Up to 8 characters are allowed (i.e. 199,999.99). Do not enter a dollar sign ($) or a decimal. A decimal is implied. If the dollar amount is a whole number (i.e. 10.00), enter 00 in the area to the right of the vertical line. | |

| 42 REV CD | 43 DESCRIPTION | 44 HCPCS / RATE / HIPPS CODE | 45 SERV DATE | 46 SERV UNITS | 47 TOTAL CHARGES | 48 NON-COVERED CHARGES | 49 |
|---|---|---|---|---|---|---|---|
| | | | | | | | |

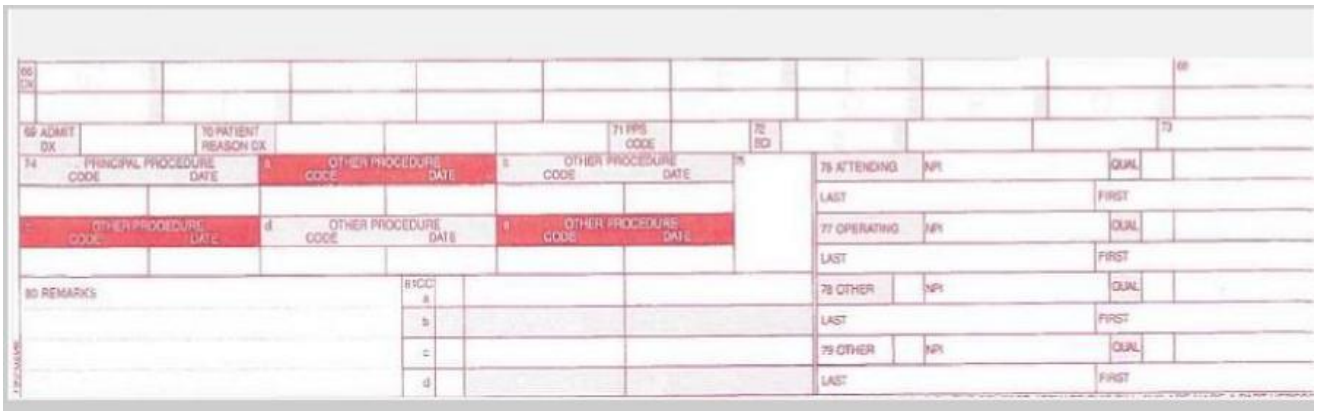
| Field # | Field Description | Instruction or Comments | Required (R) or Conditional (C) |
|---|---|---|---|
| General Information Fields<br><br>42-47 | SERVICE LINE DETAIL | The following UB-04 fields – 42-47:<br><br>Have a total of 22 service lines for claim detail information. Fields 42, 43, 45, 47, 48 include separate instructions for the completion of lines 1-22 and line 23. | C |
| 42<br><br>Line 1-22 | REV CD | Enter the appropriate revenue codes itemizing accommodations, services, and items furnished to the patient. Refer to the NUBC UB-04 Uniform Billing Manual for a complete listing of revenue codes and instructions. | R |

| Field # | Field Description | Instruction or Comments | Required (R) or Conditional (C) |
|---|---|---|---|
| 42<br>Line 23 | Rev CD | Enter 0001 for total charges. | R |
| 43<br>Line 1-22 | DESCRIPTION | Enter a brief description that corresponds to the revenue code entered in the service line of field 42. | R |
| 43<br>Line 23 | PAGE ___ OF ___ | Enter the number of pages. Indicate the page sequence in the "PAGE" field and the total number of pages in the "OF" field. If only one claim form is submitted enter a "1" in both fields (i.e. PAGE "1" OF "1"). | R |
| 44 | HCPCS/RATES | REQUIRED for outpatient claims when an appropriate CPT/HCPCS code exists for the service line revenue code billed. The field allows up to 9 characters. Only one CPT/HCPC and up to two modifiers are accepted. When entering a CPT/HCPCS with a modifier(s) do not use a spaces, commas, dashes or the like between the CPT/HCPC and modifier(s)<br>Refer to the NUBC UB-04 Uniform Billing Manual for a complete listing of revenue codes and instructions.<br>Please refer to your current provider contract with HSHP or the MO HealthNet Provider Manual. | C |
| 45<br>Line 1-22 | SERVICE DATE | REQUIRED on all outpatient claims. Enter the date of service for each service line billed. (MMDDYY) Multiple dates of service may not be combined for outpatient claims | C |
| 45<br>Line 23 | CREATION DATE | Enter the date the bill was created or prepared for submission on all pages submitted. (MMDDYY) | R |
| 46 | SERVICE UNITS | Enter the number of units, days, or visits for the service. A value of at least "1" must be entered. For inpatient room charges, enter the number of days for each accommodation listed. | R |
| 47 | TOTAL CHARGES | Enter the total charge for each service line. | R |
| 47 | TOTALS | Enter the total charges for all service lines. | R |
| 48 | TOTALS | Enter the total non-covered charges for all service | C |
| 49 | (UNLABELED FIELD) | Not Used | Not Required |




| Field # | Field Description | Instruction or Comments | Required (R) or Conditional (C) |
|---|---|---|---|
| 50<br>A-C | PAYER | Enter the name for each Payer from which reimbursement is being sought in the order of the Payer liability. Line A refers to the primary payer; B, secondary; and C, tertiary. | R |
| 51<br>A-C | HEALTH PLAN IDENTIFICATION NUMBER | | Not Required |
| 52<br>A-C | REL. INFO | REQUIRED for each line (A, B, C) completed in field 50. Release of Information Certification Indicator. Enter “Y” (yes) or “N” (no).<br>Providers are expected to have necessary release information on file. It is expected that all released invoices contain 'Y”. | R |
| 53 | ASG. BEN. | Enter “Y' (yes) or 'N' (no) to indicate a signed form is on file authorizing payment by the payer directly to the provider for services. | R |
| 54 | PRIOR PAYMENTS | Enter the amount received from the primary payer on the appropriate line when Medicaid/Home State Health Plan is listed as secondary or tertiary. | C |
| 55 | EST. AMOUNT DUE | | Not Required |
| 56 | NATIONAL PROVIDER IDENTIFIER or PROVIDER | Required: Enter provider’s 10-character NPI ID. | |
| 57 | OTHER PROVIDER ID | a. Enter the numeric provider Medicaid identification number assigned by the Medicaid program.<br>Enter the TPI number (non -NPI number) of the billing provider | R |
| 58 | INSURED'S NAME | For each line (A, B, C) completed in field 50, enter the name of the person who carries the insurance for the | R |

| Field # | Field Description | Instruction or Comments | Required (R) or Conditional (C) |
|---|---|---|---|
| | | patient. In most cases this will be the patient's name. Enter the name as last name, first name, middle initial. | |
| 59 | PATIENT RELATIONSHIP | | Not Required |
| 60 | INSURED'S UNIQUE ID | REQUIRED: Enter the patient's Insurance/Medicaid ID exactly as it appears on the patient's ID card. Enter the Insurance /Medicaid ID in the order of liability listed in field 50. | R |
| 61 | GROUP NAME | | Not Required |
| 62 | INSURANCE GROUP NO. | | Not Required |
| 63 | TREATMENT AUTHORIZATION CODES | Enter the Prior Authorization or referral when services require pre-certification. | C |
| 64 | DOCUMENT CONTROL NUMBER | Enter the 12-character Document Control Number (DCN) of the paid HEALTH claim when submitting a replacement or void on the corresponding A, B, C line reflecting Home State Health from field 50.<br>Applies to claim submitted with a Type of Bill (field 4) Frequency of "7" (Replacement of Prior Claim) or Type of Bill Frequency of "8" (Void/Cancel of Prior Claim).<br>* Please refer to reconsideration/corrected claims section | C |
| 65 | EMPLOYER NAME | | Not Required |
| 66 | DX VERSION QUALIFIER | | Required |



| Field # | Field Description | Instruction or Comments | Required (R) or Conditional (C) |
|---|---|---|---|
| 67 | PRINCIPAL DIAGNOSIS CODE | Enter the principal/primary diagnosis or condition using the appropriate release/update of ICD-9/10-CM Volume 1& 3 for the date of service.<br>Diagnosis code submitted must be a valid ICD-9/10 code for the date of service and carried out to its highest level of specificity– .up to 7 characters. 'E' and most "V/Z" codes are not acceptable as a primary diagnosis. | R |
| 67 A-Q | OTHER DIAGNOSIS CODE | Enter additional diagnosis or conditions that coexist at the time of admission or that develop subsequent to the admission and have an effect on the treatment or care received using the appropriate release/update of ICD-9/10-CM Volume 1& 3 for the date of service.<br>Diagnosis codes submitted must be a valid ICD-9/10CM codes for the date of service and carried out to its highest level of specificity –up to 7 characters. 'E' and most "V/Z" codes are not acceptable as a primary diagnosis.<br>*Note: Claims with incomplete or invalid diagnosis codes will be denied.* | C |
| 68 | (UNLABELED) | Not Used | Not Required |
| 69 | ADMITTING DIAGNOSIS CODE | Enter the diagnosis or condition provided at the time of admission as stated by the physician using the appropriate release/update of ICD-9/10-CM Volume 1& 3 for the date of service.<br>Diagnosis codes submitted must be a valid ICD-9/10CM codes for the date of service and carried out to its highest level of specificity – up to the 7 characters. 'E/Z' codes and most "V" are not acceptable as a primary diagnosis.<br>*Note: Claims with missing or invalid diagnosis codes will be denied.* | C |
| 70 a,b,c | PATIENT REASON CODE | Enter the ICD-9/10-CM code that reflects the patient's reason for visit at the time of outpatient registration. 70a requires entry, 70b-70c are conditional. | R |
| 71 | PPS / DRG CODE | | Not Required |
| 72 a,b,c | EXTERNAL CAUSE CODE | | Not Required |
| 73 | (UNLABELE D) | | Not Required |

| Field # | Field Description | Instruction or Comments | Required (R) or Conditional (C) |
|---|---|---|---|
| 74 | PRINCIPAL PROCEDURE CODE / DATE | **REQUIRED** on inpatient claims when a procedure is performed during the date span of the bill.<br>**CODE:** Enter the ICD-9/10 procedure code that identifies the principal/primary procedure performed. Do not enter the decimal between the 2nd or 3rd digits of code. It is implied.<br>**DATE:** Enter the date the principal procedure was performed (MMDDYY). REQUIRED for EDI Submissions. | C |
| 74 a-e | OTHER PROCEDUR E CODE DATE | **REQUIRED** on inpatient claims when a procedure is performed during the date span of the bill.<br>**CODE:** Enter the ICD-9/ICD-10 (October 2015) procedure code(s) that identify significant a procedure(s) performed other than the principal/primary procedure. Up to 5 ICD-9/ICD-10 (October 2015) procedure codes may be entered. Do not enter the decimal between the 2nd or 3rd digits of code. It is implied.<br>**DATE:** Enter the date the principal procedure was performed (MMDDYY). | C |
| 75 | (UNLABELED) | | Not Required |
| 76 | ATTENDING PHYSICIAN | Enter the NPI and Name of the physician in charge of the patient care:<br>**NPI:** Enter the attending physician 10-character NPI ID.<br>Taxonomy Code: Enter valid taxonomy code<br>**QUAL:** Enter one of the following qualifier and ID number<br>0B – State License #<br>1G – Provider UPIN<br>G2 – Provider Commercial #<br>ZZ – Taxonomy Code<br>LAST: Enter the attending physician's last name<br>FIRST: Enter the attending physician's first name. | R |
| | | | |

| Field # | Field Description | Instruction or Comments | Required (R) or Conditional (C) |
|---|---|---|---|
| 77 | OPERATING PHYSICIAN | **REQUIRED** when a surgical procedure is performed:<br>**NPI:** Enter the operating physician 10-character NPI ID.<br>Taxonomy Code: Enter valid taxonomy code<br>**QUAL:** Enter one of the following qualifier and ID number<br>0B – State License #<br>1G – Provider UPIN<br>G2 – Provider Commercial #<br>ZZ – Taxonomy Code<br>LAST: Enter the operating physician's last name<br>FIRST: Enter the operating physician's first name. | C |
| 78 & 79 | OTHER PHYSICIAN | Enter the Provider Type qualifier, NPI, and Name of the physician in charge of the patient care:<br>(Blank Field): Enter one of the following Provider Type Qualifiers:<br>DN – Referring Provider<br>ZZ – Other Operating MD<br>82 – Rendering Provider<br>NPI: Enter the other physician 10-character NPI ID.<br>QUAL: Enter one of the following qualifier and ID number<br>0B – State License # | C |
| 80 | REMARKS | | Not Required |
| 81 | CC | A: Taxonomy of billing provider. Use ZZ qualifier | |

# BILLING TIPS AND REMINDERS

## Ambulance

- Must be billed on a CMS 1500
- Air ambulance must be billed in place of service 21, 23, 26 or 51
- Transportation services billed for an HCY (Healthy Children and Youths) member can bill in locations 03, 04, 11, 12, 13, 14, 20, 21, 22, 23, 24, 25, 26, 31, 32, 33, 34, 49, 50, 51, 52, 53, 54, 55, 56, 57, 61, 62, 65, 71, 72, 81 or 99
- Location 41 (land) and 42 (water) are *not* accepted
- All other transportation should be billed in 21, 23, 26, 51, 55, 56, or 61
- Acceptable modifiers for transportation are GM, EP (HCY), HH, and HD
- Acceptable modifier for medical necessary service or supply is SC
- Treat No Transport (A0998), it is recommended to bill with location 12 (home). Providers should bill a location code that accurately reflects the place of service with exception of the following;
  - 21 Inpatient Hospital
  - 23 Emergency Room—Hospital
  - 26 Military Treatment Facility
  - 51 Inpatient Psychiatric Facility
  - 55 Residential Substance Abuse Treatment Facility
  - 56 Psychiatric Residential Treatment Center
  - 61 Comprehensive Inpatient Rehabilitation Hospital

## Ambulatory Surgery Center (ASC)

- Ambulatory surgery centers must submit charges using the CMS 1500 claim form
- Must be billed in place of service 24
- Must be billed with modifier SG
- An invoice must be billed with Corneal Transplant procedures
- Most surgical extractions are billable only under the ASC

## Anesthesia

- Services for which anesthesia is billed must be a covered service.
- Bill total number of minutes in Block 24G of the CMS 1500 Claim Form
- Failure to bill total number of minutes may result in incorrect reimbursement or claim denial
- Anesthesiologist must bill modifiers listed below for all ASA codes:
  - AA- Anesthesia service performed personally by anesthesiologist ; or
  - QX - CRNA/AA service with medical direction by a physician
  - QK - Medical direction of two, three or four concurrent anesthesia procedures involving qualified individuals.

- CRNAs must bill with modifiers listed below for all ASA codes:
  - QZ-CRNA service without medical direction by a physician
  - Qualifying Circumstances are billed in addition to ASA services
  - Only billable with a count of 1
  - There are no acceptable modifiers billable for these services
- Injections of anesthetic substance *must* be billed using the appropriate CPT procedure code.
  - Only billable with a count of 1
  - Spinal anesthesia is not covered with modifiers AA, QK, QX and QZ.

## Behavioral Health

- F32.9 (Depression); utilize the PHQ-9, a 9-question instrument given to patients in a primary care setting to screen for the presence and severity of depression.
- Claims billed for depression without severity noted will be denied.

| PHQ- 9 Score | Depression Severity (label the illness with these descriptions) | ICD-10-CM |
|---|---|---|
| 0-4 | None –Minimal | Not previously diagnosed depression = No ICD-10<br>Previously diagnosed depression= see “In Remission” codes below |
| 5-9 | Mild | F32.0<br>F33.0 |
| 10-14 | Moderate | F32.1<br>F33.1 |
| 15-19 | Moderately Severe | F32.1 (Moderate)<br>F33.1 (Moderate)<br>F32.2 (Severe)<br>F33.2 (Severe) |
| 20-27 | Severe | F32.2 (w/out psychotic features)<br>F33.2 (w/out psychotic features)<br>F32.3 (with psychotic features)<br>F33.3 (with psychotic features) |
| In Partial Remission | N/A – severity regardless | F32.4<br>F33.41 |
| In Full Remission | N/A – severity regardless | F32.5<br>F33.42 |

- F31.9 (Bipolar); utilize the Mood Disorder Questionnaire (MDQ) is a screening instrument for bipolar disorder that can easily be utilized in primary care settings. The MDQ includes 13 questions plus items assessing clusters of symptoms and functional impairment

- *Note: the MDQ is best at screening Bipolar I (depression and mania – at least one manic episode) disorder and not as sensitive to Bipolar II (depression and hypomania – no manic episodes, only hypomanic) or Bipolar not otherwise specified (NOS) disorder.*
- Depression is considered inclusive of Bipolar disorder. Report the bipolar, only, to the highest specificity.

## Chronic Condition Coding

- The following Chronic Conditions require the use of additional codes that identify any associated medical conditions and intellectual disabilities, such as IQ.
  - F84.0 Autistic Disorder
  - F84.2 Rett's Syndrome
  - F84.3 Other Childhood Disintegrative Disorder
  - F84.5 Asperger's Syndrome
  - F84.8 Other Pervasive Developmental Disorders
  - F84.9 Pervasive Developmental Disorder, unspecified
- Use an additional code to identify any associated medical conditions (i.e. sleep problems, seizures, poor condition of muscles) and intellectual disabilities such as IQ;
  - F70 Mild (IQ 50-69)
  - F71 Moderate (IQ 35-49)
  - F72 Severe (IQ 20-34)
  - F73 Profound (IQ under 20)
  - F78 Other intellectual disabilities
  - F79 Unspecified intellectual disabilities
  - R41.83 Borderline intellectual functioning (IQ above 70-84)
  - Must include documentation regarding IQ ID: “Patient has_____ID” or “With ID”
- Z03.89 (member has no intellectual disability)
  - Must include documentation regarding IQ ID: “No ID” or “Without ID”
- Z03.89 (IQ test not assessed/not able to be assessed)
  - Must include documentation regarding IQ ID: “ID not assessed” or “ID not able to be assessed”.
- Avoid terms such as “history of” if patient is still being monitored for this condition.

## Comprehensive Day Rehab

- Must be billed on a CMS 1500
- Must be billed in location 99 - Other Unlisted Facility Other service facilities.
- Must be prior authorized by the MO HealthNet Division.

## Coordination of Benefits (COB)

- COB claims must be received within three hundred and sixty-five (365) days from the member's primary carrier remittance advice date.
- Claims submitted for members with primary insurance on file must have the primary Explanation of Payment or remittance attached to the paper claim. *NOTE: Home State Health is always the payer of last resort. See section Third Party Liability of this manual for more information.*
- See section *Electronic Claim Submission* of this manual for instructions how to file electronic secondary claims.
- Secondary claims can also be filed electronically via our secure web portal which can be found at our website homestatehealth.com.
- Home State Health will reimburse COB claims up to our allowable but no greater than member responsibility when considering both the primary and secondary insurance. If the primary payment is greater than the Home State Health payment, no additional payment is due. If the primary payment is less than the Home State Health payment, the difference between Home State Health's allowable and primary carrier's payment will be issued. If the primary payment paid zero and applied to the member responsibility, Home State Health will pay the provider's rate with Home State Health**.** Non- participating providers are reimbursed up to 100% of the MO HealthNet fee schedule.

## Coding Tips

- Our coding tips are intended to support coding and documentation education.
  You can access our coding tips by visiting Home State Health's website at
  https://www.homestatehealth.com/providers/tools-resources/coding-page.html

## DME/Supplies/Prosthetics and Orthotics

- Must be billed with appropriate modifier; please refer to the MO HealthNet Durable Medical Equipment Manual, Section 19 for appropriate billing of modifiers.
  http://manuals.momed.com/collections/collection_dme/print.pdf
- Purchase only services must be billed with modifier NU.
- Submit invoice for all DME codes that require invoice with claim submission.
- DME reimbursements will not pro-rate, monthly rates will apply.

## Supplemental Oxygen

- Z99.81 (dependence on supplemental oxygen) is allowable for any patient using long-term supplemental oxygen, regardless of the duration of use each day.
  - unacceptable as a principal diagnosis for inpatient admission
  - cannot be used as diagnosis as present on admission (POA)
  - Do not bill in conjunction with cardiac pacemaker status (Z95.0)
- Z99.11 (dependence on respirator) is only used for life support.
  - cannot be used as diagnosis as present on admission (POA)
  - Do not bill in conjunction with cardiac pacemaker status (Z95.0)
  - When placed on hospital claim together with any of the following primary diagnosis codes, it can only be used as NON-CC/NON MCC: J95.850, Z99.0, Z99.12, Z99.81 & Z99.89.2

## EPSDT/HCY

- Must be billed with modifier EP & must be billed with full or partial EPSDT 5-digit screening code.
- Must be billed in place of service locations 03, 11, 12, 19, 21, 22, 25, 71, 72, or 99
- Populate 24h with appropriate indicator "E" if the service is an EPSDT/HCY screening, "F" if the service is family planning related, "B" if the service is both EPSDT/HCY and Family Planning related.
- Patients must be identified as new patient (99385) or established patient (99395).
- MHD requires the use of age appropriate routine child examination diagnosis codes (Z00.110 – Z00.111) or (Z00.121 – Z00.129) when using the EP Modifier.
  - Must be listed in the primary diagnosis position (first listed code).
- MO HealthNet does not accept claims when adult routine examination diagnosis codes (Z00.00 - Z00.01) are billed with the EP Modifier for patients between ages 18-20 years of age.
  - EP modifier for ages 18-20 years can only be used with diagnosis codes Z00.121 or Z00.129.
- Should code additional diagnoses if addressed and documented during visit.

**Routine Child Examination with EP Modifier**

| Age of Patient (at time of service) | Routine Child Examination CPT code New Patient | Routine Child Examination CPT code Established Patient | Routine Child Examination ICD-10 CM Diagnosis codes |
|---|---|---|---|
| 0 – 8 days | 99381EP | 99391EP | Z00.110-Newborn under 8 days old |
| 9 days- 28 days | 99381EP | 99391EP | Z00.111- Newborn 8 to 28 days old |
| 29 – 364 days | 99381EP | 99391EP | Z00.121 –Routine child health exam with abnormal findings.<br>Z00.129 – Routine child health exam without abnormal findings.<br>** DX above apply to all routine examination visits from 29 days to 20 years of age |
| 1-4 years | 99382EP | 99392EP | |
| 5-11 years | 99383EP | 99393EP | |
| 12-17 years | 99384EP | 99394EP | |
| 18-20 years | 99385EP | 99395EP | |

**Routine Child Examination without EP Modifier – Should NOT bill diagnosis codes listed below**

| Age of Patient (at time of service) | Routine Child Examination CPT code New Patient | Routine Child Examination CPT code Established Patient | ICD-10 CM Diagnosis codes that should not be billed when exam is billed without EP modifier. |
|---|---|---|---|
| 0 – 17 years | 99381-99384 | 99391-99394 | Z00.6-Encounter for examination for normal comparison and control in clinical research program<br>Z00.8-Encounter for other general examination<br>Z02.1-Encounter for pre-employment examination |

| Age of Patient (at time of service) | Routine Child Examination CPT code New Patient | Routine Child Examination CPT code Established Patient | ICD-10 CM Diagnosis codes that should not be billed when exam is billed without EP modifier. |
|---|---|---|---|
| | | | Z02.3-Encounter for examination for recruitment to armed forces<br>Z02.4-Encounter for examination for driving license<br>Z02.81- Encounter for paternity testing<br>Z02.83-Encounter for blood-alcohol and blood-drug test |

**RHC's bill HCPCS code T1015 along with appropriate preventative procedure code in field 44 of UB-04**

| Age of Patient (at time of service) | Routine Child Examination CPT code New Patient | Routine Child Examination CPT code Established Patient | HCPCS Code |
|---|---|---|---|
| Preventive visit,<br>0 – 20 years | 99381-99385 EP<br>Charge $.01 | 99391-99395 EP<br>Charge $.01 | T1015<br>Charge $ Usual/Customary Rate |

**Applicable Modifiers**

| 52 | 25 | UC |
|---|---|---|
| Submit with modifier EP when a partial screening is performed. Ex.99393 52 EP. All components have not been met, but at least the first 5 or more components were completed according to HCY/EPSDT requirements. | Defined as a significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service. Please note that modifier 25 should not be appended on the preventive codes if encounter was for wellness check. Such identifiable services should be billed using appropriate office or outpatient codes such as - (99201-99215). | Submitted when a referral is made for further care. |

*Note: Modifier 59 should be used when only components related to developmental and mental health are screened.*

## Early Elective Deliveries (EED)

- Appropriate EED code must be submitted in field 19 of a HCFA/CMS 1500 or Loop 2300, or 2400, NTE, 02 of the 837P
- Gestational age falls between 20-42 weeks.
- Acceptable delivery indicators are:
  - LV – Labor non-induced followed by vaginal delivery
  - LC – Labor non-induced followed by caesarean delivery
  - IV – induced labor followed by vaginal delivery
  - IC – induced labor followed by caesarean delivery
  - CN – caesarean delivery without labor, non-scheduled (i.e. add-ons)

- CS – caesarean delivery, scheduled
  The EED codes must be submitted in a 4-character format with **no spaces** between the gestational age and delivery indicator. The gestational age must be billed leading the delivery indicator.
  - Correct Format Example: 39LV; 32CS; 39LC; 28CN
  - Incorrect Format Example: 39 LV; LV39; 34CN; 40,IV; 137LV; 38/LV; 39 Weeks IV PG0295815; 37LC CORRECTED CLAIM; 35LC TWIN DELIVERY; [blank field]
  - If the gestational age/delivery indicator contains IV, IC, CN, or CS, and the gestational age is less than 39, the claim will be subject to editing for early elective delivery. If one of the diagnoses on the claim indicates that there is a medical indication for an early delivery, the claim will be exempt and continue to process.
  - Claims that have the IV, IC, CN, or CS indicator with a gestational age less than 39 weeks and no qualifying diagnosis for early induction of labor and delivery will be denied.

  Inpatient hospital claims (institutional and all physicians) related to denied delivering physician/provider claim will also deny or be recouped if already paid.

## Emergency Room Services

- The patient's primary discharge diagnosis should be billed in the first diagnosis position on the emergency room claim form.
- Both hospitals and physicians are required to include Evaluation and Management CPT/HCPCS codes 99281 -99285 when billing a claim for all emergency room services.

## Hearing Aids

- Must be billed with the modifier LT or RT

## Home Health

- Must be billed on a UB 04
- Bill type must be 3XX
- Must be billed in location 12
- Acceptable modifiers: TD, SC and EP (HCY)

## Imaging Services

- The Imaging Provider selected by either the ordering Provider or NIA (National Imaging Associates, Inc.) will become the Provider of record for claims payment of the related claim.
- The claim must reflect the Provider of Record. If a non-hospital provider (free-standing or in-office provider) is selected or assigned, the Place of Service (POS) code on the claim is expected to be 11.
- If the claim reflects a hospital code (e.g. POS 22 or 19), the claim will be denied.

## Laboratory-Clinical Laboratory Improvement Amendments Act (CLIA) 1988

- All Laboratory sites, including independent laboratories, hospitals, physician offices, nursing homes, etc. as defined at 42 CFR 493.2, must have either a CLIA Certificate or Waiver or Certificate of Registration to legally perform clinical laboratory testing anywhere in the United States; or be exempt by virtue of the fact that the lab is licensed by an approved state program.
- The CLIA number is a ten digit number.

- A valid CLIA number must be submitted in field 23 of a CMS-1500
- For EDI claims, if a single claim is submitted for those laboratory services for which CLIA certification or waiver is required, report the CLIA certification or waiver number in: X12N 837 (HIPAA version) loop 2300, REF02. REF01 = X4. If a claim is submitted with both laboratory services for which CLIA certification or waiver is required and non-CLIA covered laboratory test, report in the 2400 loop for the appropriate line report the CLIA certification or waiver number in: X12N 837. (HIPAA version) loop 2400, REF02. REF01 = X4.
- Providers must have the appropriate CLIA certification on their MO HealthNet provider file to allow accurate claims processing.
- If the CLIA code is missing or invalid, the claims will be denied asking for correction.

## Modifiers – General

****Not an all-inclusive list****

**25 Modifier**

- 25 Modifier should be used when a significant and separately identifiable E&M service is performed by the same physician on the same day of another procedure e.g. 99381 and 99211-25 Well-Child and sick visit performed on the same day by the same physician **Note***: 25 modifier is not appended to non E&M procedure codes, e.g. lab*
- Please review current HSHP Payment Policy regarding Modifier 25, here: https://www.homestatehealth.com/providers/tools-resources/clinical-payment-policies.html

**26 Modifier**

- Should never be appended to an office visit CPT code
- Use 26 modifier to indicate that the professional component of a test or study is performed using the 70000 (radiology) or 80000 (pathology) series of CPT codes
- Inappropriate use may result in a claim denial/rejection

**50 Modifier**

- Indicates a procedure performed on a bilateral anatomical site
- Procedure must be billed on a single claim line with the 50 modifier and quantity of one (1)
- RT and LT modifiers or quantities greater than one should not be billed when using modifier 50
- Please review current HSHP Payment Policy regarding Modifier 50, here: https://www.homestatehealth.com/providers/tools-resources/clinical-payment-policies.html

**59 Modifier**

- Please review current HSHP Payment Policy regarding Modifier 59, here: https://www.homestatehealth.com/providers/tools-resources/clinical-payment-policies.html

**TC Modifier**

- Used to indicate the technical component of a test or study is performed

**Therapy Modifiers**

- GN - speech therapy
- GO - occupational therapy
- GP - physical therapy
- HK - for use with specific evidence-based practices (dialectical behavior therapy, trauma-focused CBT, EMDR) for services provided to children who have experienced severe trauma.

**Specific Modifiers for Distinct Procedural Services**

- XE- Separate encounter: A service that is distinct because it occurred during a separate encounter
- XS- Separate structure: A service that is distinct because it was performed on a separate organ/structure
- XP- Separate practitioner: A service that is distinct because it was performed by a different practitioner
- XU- Unusual non-overlapping service: The use of a service that is distinct because it does not overlap usual components of the main service

## Multi page claims

- The page leading up to the last page of a multi-page claim should contain the word “continued” or “cont.”
- Totaling each page will result in separate claims that may incorrectly reimburse

## Nurse Midwife

- Must be billed on a CMS 1500
- Must be billed in location 11, 12, 21, 22, or 25
- Acceptable modifiers EP (HCY)

## Medical Supplies

- Physicians may bill for supplies and materials in addition to an office visit if these supplies are over and above those usually included with the office visit.

  Supplies such as gowns, drapes, gloves, specula, pelvic supplies, urine cups, swabs, jelly, etc., are included in the office visit and may *not* be billed separately. Providers may *not* bill for any reusable supplies.

## Newborn Delivery Services

- Use appropriate value codes as well as birth weight when billing for newborn delivery services.

## Notification of Pregnancy

- A Notification of Pregnancy (NOP) must be submitted and on file prior to reimbursement of obstetrical prenatal claims
- This includes claims billed for E&M codes with or without a TH modifier and/or an obstetrical diagnosis code.

- Failure to submit NOP will result in claim denial, reflected on the remittance advice as "EXnn Deny-No Notice of Pregnancy on File." Claims will not be reprocessed, even if NOP is submitted post claim submission. It must be received prior to services billed.
- NOPs will no longer be accepted via fax. All NOPs must be submitted via the secure portal NOP at the first prenatal visit for your pregnant patient via the Home State Health portal at http://www.HomeStateHealth.com.
- The NOP form cannot be submitted as an attachment to a claim through the secure portal. The form will not be recognized and therefore the claim will deny.

## Prenatal/Postpartum Billing and Bonus Program

- All prenatal, delivery, and postpartum claims are required to be submitted as fee for service (FFS). Claims submitted with global codes will be denied. For more information, see the "Prenatal and Postpartum Bonus Program and Changes in Obstetrical Billing Guideline" available on our website www.homestatehealth.com under News and Announcements.
- Prenatal, delivery, and postpartum claims are required to be submitted as fee for service (FFS).
  - Claims submitted with global codes will be denied.
  - In this situation, our Maternity Billing Payment policy applies.
- EXCEPTIONS where Global billing is accepted are limited to:
  - Show Me Healthy Babies Moms
  - HSH as secondary coverage (when billed with primary carrier EOP processed as global payment)
  - In this situation, our Global Maternity Payment policy applies
- OB Bonus Program for FFS maternity services as outlined above
  - Prenatal: $200 bonus for the seventh outpatient/office visit to the same practice (defined by TIN/GNPI)
  - EM codes without –TH modifier will be reimbursed normally but will not be eligible for bonus
  - Postpartum: $100 bonus for visits performed seven (7) to 84 days from delivery
  - The Plan automatically applies bonus payments to qualifying claims

| **Prenatal Care – global codes will be denied.** |
| --- |
| Use appropriate E&M code with TH modifier for all prenatal visits.<br><br>*$200 bonus for 7 visits within the same group practice.*<br>*E&M codes without –TH modifier will be reimbursed normally but will not be eligible for bonus*<br>*Global codes will be denied.* |

| Delivery – global codes will be denied. |
| --- |
| 59409 Vaginal Delivery Only<br>59514 Cesarean Delivery Only<br>59612 VBAC – Vaginal Delivery after Previous Cesarean<br>59620 Cesarean Delivery Only after attempted VBAC |

| Postpartum Care | |
| --- | --- |
| 59430-TH | Postpartum Care, performed 7 to 84 days from delivery<br><br>Use appropriate E&M code or 59430 without TH modifier for postpartum care performed less than 7 or more than 84 days from delivery |
| *$100 bonus for one postpartum visit within 7-84 days from delivery*<br>*59430 without the modifier or E&M codes for postpartum care will be reimbursed normally but will not be eligible for bonus.*<br>*Global codes will be denied.* | |

## Outpatient Observation

- All medications administered in an outpatient observation setting should be submitted to MO HealthNet Pharmacy Program. Providers must bill with a valid HCPS and NDC code for each medication administered. The MO HealthNet Division (MHD) will reimburse all pharmacy services on a fee-for-service basis.
- The observation stay itself should be submitted to Home State Health.
- Medications given during an inpatient stay should continue to be submitted on the hospital claim to Home State Health.

## Revenue Codes – General

- To align with CMS guidance and best practices, Health Plan providers should bill claims using the 4-digit revenue code format.
- Claims will be rejected if billed with a 3-digit revenue code (do not drop a leading 0 in the 4-digit format of the full revenue code.)

## Rural Health Clinics

### Independent RHC

- Claims must be submitted on a UB-04
- Revenue code in field #42 must be 0521
- Type of Bill in field #4 must be 71X

### Provider Based Rural Health Clinics

- Claims must be submitted on a UB-04

- Type of Bill in field #4 must be 71X
- Non-RHC services must be billed on a CMS-1500 using the RHC's non-RHC NPI.

### Surgical Procedure Codes

- Include a procedure code when billing one of the surgical revenue codes listed here: 360, 361, 362, 367, 369, 370, 371, 372, 374, 379, 490, 499, 720, 721, 722, 723, 724, 729, 750, 759
- Bill the charge amount on the same line as the surgical procedure code
- Include National Correct Coding Initiative (NCCI) modifiers with these surgical procedure codes when applicable.
- These surgical procedure codes are limited to one per provider per date of service.
- Providers will need to continue billing all other surgical procedure codes as normal.
- If a provider bills both a surgical procedure code from the fee schedule and a surgical procedure code that is not listed on the fee schedule, reimbursement is limited to the rate for the procedure that is listed on the fee schedule.

### Vaccines/VFC Program

- Vaccines associated with the Vaccine for Children Program (VFC) must be billed with the vaccine code and modifier SL indicating the administration.

## CLAIMS INTEGRITY TEAM

Home State Health's Claims Integrity team consists of Provider Support Liaisons and Provider Reimbursement Specialists who are dedicated to quick and accurate resolution of claim discrepancies.

**Provider Support Liaisons** are your first source of contact. The liaisons receive extensive claims training in order to provide claims support for providers and provide first call resolution.

**Provider Reimbursement Specialists** investigate to identify root cause for systemic issues as well as identify and report any trends.

You can reach the Claims Integrity Team by calling 1-855-694-HOME (4663). Follow the prompts for Provider Services/Claims.

## ENCOUNTERS

### What is an Encounter Versus a Claim?

An encounter is a claim which is paid at zero dollars as a result of the provider being pre- paid or capitated for the services, he/she provided our members. For example; if you are the PCP for a Home State Health member and receive a monthly capitation amount for services, you must file an encounter (also referred to as a "proxy claim") on a CMS 1500 for each service provided. Since you will have received a pre-payment in the form of capitation, the encounter or "proxy claim" is paid at zero-dollar amounts.

It is mandatory that your office submits encounter data. Home State Health utilizes the encounter reporting to evaluate all aspects of quality and utilization management, and it is required by MO HealthNet and by the Centers for Medicare and Medicaid Services (CMS). Encounters do not generate an Explanation of Payment (EOP).

A claim is a request for reimbursement either electronically or by paper for any medical service. A claim must be filed on the proper form, such as CMS 1500 or UB 04. A claim will be paid or denied with an explanation for the denial. For each claim processed, an EOP will be mailed to the provider who submitted the original claim. Claims will generate an EOP.

You are required to submit either an encounter or a claim for each service that you render to a Home State member.

## Procedures for Filing a Claim/Encounter Data

Home State Health encourages all providers to file claims/encounters electronically. See the Electronic Claims Submission section and the Provider Billing Manual for more information on how to initiate electronic claims/encounters.

## Billing the Member

Home State Health reimburses only services that are medically necessary and covered through MO HealthNet's MCO. Members cannot be charged or balance billed for covered services.

## Member Acknowledgement Statement

When services are not in the comprehensive benefit package or in the Additional Health Benefits section of the contract, and prior to providing the services, the provider must inform the member that the services are not covered and have the member acknowledge the information. *If the member still requests the service*, the provider shall obtain such acknowledgement in writing (private pay agreement) prior to rendering the service. Regardless of any understanding worked out between the provider and the member about private payment, *once the provider bills the health plan for the service that has been provided, the prior arrangement with the member becomes null and void.*

For more detailed information on Home State Health billing requirements, please refer to the Billing Manual available on the website HomeStateHealth.com

# CREDENTIALING AND RECREDENTIALING

The credentialing and re-credentialing process exists to ensure that participating providers meet the criteria established by the Home State Health, as well as government regulations and standards of accrediting bodies.

*Note: In order to maintain a current provider profile, providers are required to notify Home State Health if any relevant changes to their credentialing information in a timely manner.*

**Providers must submit at a minimum the following information when applying for participation with Home State Health:**

- Complete signed and dated Missouri Standardized Credentialing application or authorize Home State Health access to the CAQH (Council for Affordable Quality Health Care).
- Signed attestation of the correctness and completeness of the application, history of loss of license and/or clinical privileges, disciplinary actions, and/or felony convictions; lack of current illegal substance registration and/or alcohol abuse; mental and physical competence, and ability to perform the essential functions of the position, with or without accommodation
- Copy of current malpractice insurance policy face sheet that includes expiration dates, amounts of coverage and provider's name, or evidence of compliance with Missouri regulations regarding malpractice coverage or alternate coverage.
- Copy of current Missouri Controlled Substance registration certificate (if applicable)
- Copy of current Drug Enforcement Administration (DEA) registration Certificate
- Copy of W-9
- Copy of Educational Commission for Foreign Medical Graduates (ECFMG) certificate, if applicable
- Copy of current unrestricted medical license to practice in the state in which they practice.

- Current copy of specialty/board certification certificate, if applicable
- Curriculum vitae listing, at minimum, a five-year work history (not required if work history is completed on the application)
- Signed and dated release of information form not older than 120 days
- Proof of highest level of education – copy of certificate or letter certifying formal post-graduate training
- Copy of Clinical Laboratory Improvement Amendments (CLIA), if applicable
- Signed Advanced Directive Attestation as applicable
- Completed and signed Disclosure of Ownership (DOO) Form

*Note: As of January 1, 2018, according to federal regulation 42 CFR 438.602, states must screen and enroll, and periodically revalidate, all network providers of managed care organizations (MCOs). This requirement applies to ordering, prescribing, and referring "OPR" providers in the managed care setting, as well.*

**This requirement does not cause managed care network providers to see Fee-For-Service (FFS) Medicaid clients.** Providers who are already enrolled with MO HealthNet as an FFS or OPR provider do not need to submit another application as a MCO Network Provider.

Missouri Medicaid Audit & Compliance has created two enrollment application forms for MCO network providers to **enroll with MO HealthNet as a non-participating provider.** Both the individual practitioner and organizational provider forms can be found at https://mmac.mo.gov/enrollment-managed-care-network-providers-2/.

**Home State Health will verify the following information submitted for Credentialing and/or Re-credentialing:**

- Missouri license through appropriate licensing agency
- Board certification, or residency training, or medical education
- National Practitioner Data Bank (NPDB) for malpractice claims and license agency actions
- Hospital privileges in good standing or alternate admitting arrangements
- Review five-year work history
- Review federal sanction activity including Medicare/Medicaid services (OIG-Office of Inspector General)

Once the application is completed, the Home State Health Credentialing Committee ("Credentialing Committee") will render a final decision on acceptance following its next regularly scheduled meeting.

Providers must be credentialed prior to accepting or treating members. PCPs cannot accept member assignments until they are fully credentialed.

## Credentialing Committee

The Credentialing Committee has the responsibility to establish and adopt as necessary, criteria for provider participation, termination, and direction of the credentialing procedures, including provider participation, denial, and termination.

Committee meetings are held at least quarterly and more often as deemed necessary.

*Note: Failure of an applicant to adequately respond to a request for missing or expired information may result in termination of the application process prior to committee decision.*

Site visits are performed at practitioner offices within 60 days of identification of two or more member complaints related to physical accessibility, physical appearance, and adequacy of waiting and examining room space. If the practitioner's site visit score is less than 80 percent, the practitioner may be subject to termination and/or continued review until compliance is achieved. A site review evaluates appearance, accessibility, record-keeping practices and safety procedures.

## Re-Credentialing

To comply with accreditation standards, Home State Health conducts the re-credentialing process for providers at least every thirty- six months from the date of the initial credentialing decision. The purpose of this process is to identify any changes in the practitioner's licensure, sanctions, certification, competence, or health status that may affect the ability to perform services the provider is under contract to provide. This process includes all practitioners, primary care providers, specialists, and ancillary providers/facilities previously credentialed to practice within the Home State Health network. As part of the re-credentialing process, Home State Health will review records of primary care providers, hospitals, home health agencies, personal care providers, and hospices to determine if the provider is adhering to Home State Health's advance directive policy as stated in this manual.

In between credentialing cycles, Home State Health conducts ongoing sanction monitoring activities on all network providers. This includes an inquiry to the appropriate Missouri State Licensing Agency for a review of newly disciplined providers and providers with a negative change in their current licensure status. This monthly inquiry ensures that providers are maintaining a current, active, unrestricted license to practice in between credentialing cycles. Additionally, Home State Health reviews monthly reports released by the Office of Inspector General to review for any network providers who have been newly sanctioned or excluded from participation in Medicare/Medicaid.

A provider's agreement may be terminated if at any time it is determined by the Home State Health Credentialing Committee that credentialing requirements are no longer being met.

Home State Health Plan will promptly notify the State agency of any denial of provider credentialing or re-credentialing. This is in addition to reporting provider terminations on a quarterly fraud and abuse report. The state agency shall, pursuant to 42 CFR 100.3 (b), promptly notify HHS-OIG of the denial of credentialing or re-credentialing where that denial is based on a determination that the provider has been excluded from participation in Medicare, Medicaid, CHIP, or any other Federal health care program; has failed to renew its license or certification registration, or has a revoked professional license or certification; has been terminated by the state agency; or has been excluded by OIG under 42 CFR 1001.1001 or 1001.1051.

## Right to Review and Correct Information

All providers participating within the Home State Health network have the right to review information obtained by Home State Health to evaluate their credentialing and/or re-credentialing application. This includes information obtained from any outside primary source such as the National Practitioner Data Bank-Healthcare Integrity and Protection Data Bank, malpractice insurance carriers and state licensing agencies. This does not allow a provider to review references, personal recommendations, or other information that is peer review protected.

Should a provider believe any of the information used in the credentialing/re-credentialing process to be erroneous, or should any information gathered as part of the primary source verification process differ from that submitted by a practitioner, they have the right to correct any erroneous information submitted by another party. To request release of such information, a written request must be submitted to the Home State Health credentialing department. Upon receipt of this information, the provider will have 30 days to provide a written explanation detailing the error or the difference in information to the Home State Health Credentialing Committee. The Home State Health Credentialing Committee will then include this information as part of the credentialing/re-credentialing process.

## Right to Be Informed of Application Status

All providers who have submitted an application to join Home State Health have the right to be informed of the status of their application upon request. To obtain status, contact the Home State Health Provider Relations department at 1-855-694-HOME (4663).

## Right to Appeal Adverse Credentialing Determinations

Existing provider applicants who are declined for continued participation for reasons such as quality of care or liability claims issues have the right to request a reconsideration of the decision in writing within 30 days of formal notice of denial. All written requests should include additional supporting documentation in favor of the applicant's reconsideration for participation in the Home State Health network. Reconsiderations will be reviewed by the Credentialing Committee at the next regularly scheduled meeting, but in no case later than 30 days from the receipt of the additional documentation. The applicant will be sent a written response to his/her request within two weeks of the final decision.

# RIGHTS AND RESPONSIBILITIES

## Member Rights

**Home State Health members have the following rights:**

- Be treated with respect and dignity
- Receive needed medical services
- Privacy and confidentiality (including minors) subject to state and federal laws.
- Select your own PCP.
- Refuse treatment.
- Receive information about your health care and treatment options.
- Participate in decision-making about your health care.
- Have access to your medical records and to request changes, if necessary.
- Have someone act on your behalf if you are unable to do so.
- Get information on our Physician Incentive Plan, if any, by calling 1-855-694-HOME (4663).
- Be free of restraint or seclusion from a provider who wants to:
  - Make you do something you should not do;
  - Punish you;
  - Get back at you; or
  - Make things easier for him or her.
- Be free to exercise these rights without retaliation.
- Receive one copy of your medical records once a year at no cost to you

## Additional Rights

- Receive information about Home State Health, its services, its practitioners and providers and member rights and responsibilities.
- A candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.

- To voice grievances or appeals about Home State Health or the care it provides.
- To make recommendations regarding the Home State Health's member rights and responsibilities policy.
- Protection of oral, written and electronic information across the organization.
- Receive care from Indian Health Care Providers (IHCP) if you are an American Indian/Alaskan Native.

## Member Responsibilities

**Home State Health members have the responsibility to:**

- Call Home State Health to order a member ID card if yours is lost
- Carry your Home State Health member ID card AND your MO HealthNet card at all times
- Contact your PCP first when needing medical care
- Only use the emergency room in an emergency
- Follow all instructions given by your health care provider
- Follow appointment scheduling rules
- Make and keep PCP appointments or call ahead to cancel
- Make sure your child sees his/her PCP for regular check-ups and shots
- Supply information (to the extent possible) that the organization and its providers need in order to provide care
- Follow plans and instructions for care that you have agreed to with your providers
- Understand your health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible

## Provider Rights

**Home State Health providers have the right to:**

- Be treated by their patients and other healthcare workers with dignity and respect
- Receive accurate and complete information and medical histories for members' care
- Have their patients act in a way that supports the care given to other patients and that helps keep the provider's office, hospital, or other offices running smoothly
- Expect other network providers to act as partners in members' treatment plans
- Expect members to follow their directions, such as taking the right amount of medication at the right times
- Make a complaint or file an appeal against Home State Health and/or a member
- File a grievance with Home State Health on behalf of a member, with the member's consent
- Have access to information about Home State Health quality improvement programs, including program goals, processes, and outcomes that relate to member care and services
- Contact Home State Health Provider Services with any questions, comments, or problems,
- Collaborate with other healthcare professionals who are involved in the care of members

## Provider Responsibilities

**Home State Health providers have the responsibility to:**

- Help members or advocate for members to make decisions within their scope of practice about their relevant and/or medically necessary care and treatment, including the right to:
  - Recommend new or experimental treatments
  - Provide information regarding the nature of treatment options
  - Provide information about the availability of alternative treatment options,
  - therapies, consultations, and/or tests, including those that may self-administered
  - Be informed of the risks and consequences associated with each treatment option or choosing to forego treatment as well as the benefits of such treatment options
- Treat members with fairness, dignity, and respect
- Not discriminate against members on the basis of race, color, national origin, disability, age, religion, mental or physical disability, or limited English proficiency
- Maintain the confidentiality of members' personal health information, including medical records and histories, and adhere to state and federal laws and regulations regarding confidentiality
- Give members a notice that clearly explains their privacy rights and responsibilities as it relates to the provider's practice/office/facility
- Provide members with an accounting of the use and disclosure of their personal health information in accordance with HIPAA
- Allow members to request restriction on the use and disclosure of their personal health information
- Provide members, upon request, access to inspect and receive a copy of their personal health information, including medical records
- Provide clear and complete information to members, in a language they can understand, about their health condition and treatment, regardless of cost or benefit coverage, and allow the member to participate in the decision-making process
- Tell a member if the proposed medical care or treatment is part of a research experiment and give the member the right to refuse experimental treatment
- Tell a member, prior to the medical care or treatment, that the service(s) being rendered are not a covered benefit. Inform the member of the non-covered service and have the member acknowledge the information. If the member still requests the service, obtain the acknowledgement in writing (private pay agreement) prior to rendering the service. Regardless of any understanding worked out between the provider and the member about private payment, that agreement becomes null and void if a claim is submitted to the health plan.
- Allow a member who refuses or requests to stop treatment the right to do so, as long as the member understands that by refusing or stopping treatment the condition may worsen or be fatal
- Respect members' advance directives and include these documents in the members' medical record
- Allow members to appoint a parent, guardian, family member, or other representative if they can't fully participate in their treatment decisions
- Allow members to obtain a second and third opinion, and answer members' questions about how to access healthcare services appropriately

- Follow all state and federal laws and regulations related to patient care and patient rights
- Participate in Home State Health data collection initiatives, such as HEDIS and other contractual or regulatory programs, and allow use of performance data for QI activities
- Review clinical practice guidelines distributed by Home State Health
- Comply with Home State Health Medical Management program as outlined in this Reference Manual.
- Disclose overpayments or improper payments to Home State Health
- Provide members, upon request, with information regarding the provider's professional qualifications, such as specialty, education, residency, and board certification status
- Obtain and report to Home State Health information regarding other insurance coverage
- Notify Home State Health in writing if the provider is leaving or closing a practice
- Contact Home State Health to verify member eligibility or coverage for services, if appropriate
- Invite member participation, to the extent possible, in understanding any medical or behavioral health problems that the member may have and to develop mutually agreed upon treatment goals, to the extent possible
- Provide members, upon request, with information regarding office location, hours of operation, accessibility, and languages, including the ability to communicate with American Sign Language
- Not be excluded, penalized, or terminated from participating with Home State Health for having developed or accumulated a substantial number of patients in the Home State Health with high cost medical conditions
- Coordinate and cooperate with other service providers who serve MO HealthNet members such as Head Start Programs, Healthy Start Programs, Nurse Family Partnerships and school-based programs as appropriate
- Object to providing relevant or medically necessary services on the basis of the provider's moral or religious beliefs or other similar grounds
- Disclose to Home State Health, on an annual basis, any physician incentive plan (PIP) or risk arrangements the provider or provider group may have with physicians either within its group practice or other physicians not associated with the group practice even if there is no substantial financial risk between Home State Health and the physician or physician group

# 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).

## 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 action. An adverse action is the denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension, or termination of a previously authorized service; the denial, in whole or part of payment for a service excluding technical reasons; the failure to render a decision within the required timeframes; or 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. The review may be requested in writing or orally. Members may request that Home State review the adverse action to verify if the right decision has been made. Appeals must be made within 60 calendar days from the date on Home State Health's notice of action. 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 or mail all appeals to:**

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

## State Fair Hearing Process

Home State Health will include information in the Member Handbook, online and via the appeals process to members of their right to appeal directly to the 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 action 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 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. Appeals 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.

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.

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

**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.

# WASTE, ABUSE, AND FRAUD

## Waste Abuse and Fraud (WAF) System

Home State Health takes the detection, investigation, and prosecution of fraud and abuse very seriously, and has a waste, abuse and fraud (WAF) program that complies with Missouri and federal laws. Home State Health, in conjunction with its management company, Centene, successfully operates a waste, abuse and fraud unit. Home State Health performs front and back end audits to ensure compliance with billing regulations. Our sophisticated code editing software performs systematic audits during the claim's payment process. To better understand this system; please review the Billing and Claims section of this handbook. The Special Investigation Unit (SIU) performs retrospective audits that, in some cases, may result in taking

actions against those providers, individually or as a practice, commit waste, abuse, and/or fraud. **These actions include but are not limited to:**

- Remedial education and/or training to prevent the billing irregularity
- More stringent utilization review
- Recoupment of previously paid monies
- Termination of provider agreement or other contractual arrangement
- Civil and/or criminal prosecution
- Any other remedies available to rectify

**Some of the most common WAF practices include:**

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

If you suspect or witness a provider inappropriately billing or a member receiving inappropriate services, please call OIG's Hotline at 1-800-HHS-TIPS (1-800-447-8477), directly to a MO HealthNet Fraud Control Unit (MFCU), or our anonymous and confidential WAF hotline at 1-866-685-8664. Home State Health and Centene take all reports of potential waste, abuse or fraud very seriously and investigate all reported issues.

*Please Note: Due to the evolving nature of wasteful, abusive and fraudulent billing, Home State Health and Centene may enhance the WAF program at any time. These enhancements may include but is not limited to creating, customizing or modifying claim edits, upgrading software, modifying forensic analysis techniques, or adding new subcontractors to help in the detection of adherent billing patterns.*

## Authority and Responsibility

The Home State Health Director of Regulatory Affairs & Compliance has overall responsibility and authority for carrying out the provisions of the compliance program. Home State Health is committed to identifying, investigating, sanctioning and prosecuting suspected fraud and abuse.

The Home State Health provider network will cooperate fully in making personnel and/or subcontractor personnel available in person for interviews, consultation, grand jury proceedings, pre-trial conferences, hearings, trials and in any other process, including investigations.

# QUALITY IMPROVEMENT

Home State Health culture, systems and processes are structured around its mission to improve the health of all enrolled members. The Quality Assessment and Performance Improvement (QAPI) Program utilizes a systematic approach to quality using reliable and valid methods of monitoring, analysis, evaluation and improvement in the delivery of healthcare provided to all members, including those with special needs. This system provides a continuous cycle for assessing the quality of care and service among plan initiatives including preventive health, acute and chronic care, behavioral health, over- and under-utilization, continuity and coordination of care, patient safety, and administrative and network services.

This includes the implementation of appropriate interventions and designation of adequate resources to support the interventions.

Home State Health recognizes its legal and ethical obligation to provide members with a level of care that meets recognized professional standards and is delivered in the safest, most appropriate settings. To that end, Home State Health will provide for the delivery of quality care with the primary goal of improving the health status of its members. Where the member's condition is not amenable to improvement, Home State Health will implement measures to prevent any further decline in condition or deterioration of health status or provide for comfort measures as appropriate and requested by the member. This will include the identification of members at risk of developing conditions, the implementation of appropriate interventions and designation of adequate resources to support the interventions. Whenever possible, the Home State Health QAPI Program supports these processes and activities that are designed to achieve demonstrable and sustainable improvement in the health status of its members.

## Program Structure

The Home State Health Board of Directors (BOD) has the ultimate authority and accountability for the oversight of the quality of care and service provided to members. The BOD oversees the QI Program and has established various committees and ad-hoc committees to monitor and support the QI Program.

The Quality Improvement Committee (QIC) is a senior management committee with physician representation that is directly accountable to the BOD. The purpose of the QIC is to provide oversight and direction in assessing the appropriateness and to continuously enhance and improve the quality of care and services provided to members. This is accomplished through a comprehensive, plan-wide system of ongoing, objective, and systematic monitoring; the identification, evaluation, and resolution of process problems, the identification of opportunities to improve member outcomes, and the education of members, providers and staff regarding the QI, UM, and Credentialing programs. Home State Health maintains policies and procedures for quality assessment, utilization management, and continuous quality improvement. These policies and procedures are evaluated periodically to determine impact and effectiveness.

**The following sub-committees report directly to the Quality Committee:**

- Population Health and Clinical Outcomes Committee
- Peer Review Committee
- Credentialing Committee
- Performance Improvement Committee

**The following sub-committees and workgroups report directly to the Performance Improvement Committee:**

- Member and Provider Satisfaction Workgroup
- Quality Outcomes Workgroup
- CLAS Workgroup
- Provider Advisory Committee
- Practice Manager Advisory Committee
- Member Advisory Committee
- Joint Operations Committee

## Practitioner Involvement

Home State Health recognizes the integral role practitioner involvement plays in the success of its QAPI Program. Practitioner involvement in various levels of the process is highly encouraged through provider representation. Home State Health encourages PCP, behavioral health, specialty, and OB/GYN representation on key quality committees such as but not limited to, the QIC, Credentialing Committee and select ad-hoc committees.

## Quality Assessment and Performance Improvement Program Scope and Goals

The scope of the QAPI Program is comprehensive and addresses both the quality of clinical care and the quality of service provided to the Home State Health members. Home State Health QAPI Program incorporates all demographic groups, lines of business, benefit packages, care settings, providers and services in quality improvement activities, including preventive care, primary care, specialty care, acute care, short-term care, long-term care (depending upon the product), and ancillary services, and operations.

Home State Health primary QAPI Program goal is to improve members' health status through a variety of meaningful quality improvement activities implemented across all care settings and aimed at improving quality of care and services delivered.

**To that end, the Home State Health QAPI Program monitors the following:**

- Acute and chronic care management
- Behavioral health care
- Compliance with member confidentiality laws and regulations
- Compliance with preventive health guidelines and practice guidelines
- Continuity and coordination of care
- Data collection, analysis, and reporting
- Delegated entity oversight
- Department performance and service
- Employee and provider cultural competency
- Fraud and abuse detection and prevention
- Information management
- Marketing practices
- Member enrollment and disenrollment
- Member Grievance System
- Member satisfaction
- Member Services
- Network Performance
- Organizational structure
- Patient safety
- Primary Care Provider changes
- Pharmacy
- Provider and Plan accessibility

- Provider availability
- Provider Complaint System
- Provider network adequacy and capacity
- Provider satisfaction
- Provider Services
- Quality management
- Records management

- Selection and retention of providers (credentialing and recredentialing)
- Utilization Management, including under and over utilization

## Patient Safety and Quality of Care

Patient Safety is a key focus of Home State Health QAPI Program. Monitoring and promoting patient safety is integrated throughout many activities across the plan but primarily through identification of potential and/or actual quality of care events. A potential quality of care issue is any alleged act or behavior that may be detrimental to the quality or safety of patient care, is not compliant with evidence-based standard practices of care or that signals a potential sentinel event, up to and including death of a member. Home State Health employees (including medical management staff, member services staff, provider services, complaint coordinators, etc.), panel practitioners, facilities or ancillary providers, members or member representatives, Medical Directors or the BOD may advise the Quality Improvement (QI) Department of potential quality of care issues. Adverse events may also be identified through claims-based reporting. Potential quality of care issues requires investigation of the factors surrounding the event in order to make a determination of their severity and need for corrective action up to and including review by the Peer Review Committee as indicated. Potential quality of care issues received in the QI department are tracked and monitored for trends in occurrence, regardless of their outcome or severity level.

## Performance Improvement Process

Home State Health QIC reviews and adopts an annual QI Program and Work Plan based on managed care Medicaid appropriate industry standards. The QIC adopts traditional quality/risk/utilization management approaches to problem identification with the objective of identifying improvement opportunities. Most often, initiatives are selected based on data that indicates the need for improvement in a particular clinical or non-clinical area and includes targeted interventions that have the greatest potential for improving health outcomes or the service.

Performance improvement projects, focused studies and other QI initiatives are designed and implemented in accordance with principles of sound research design and appropriate statistical analysis. Results of these studies are used to evaluate the appropriateness and quality of care and services delivered against established standards and guidelines for the provision of that care or service. Each QI initiative is also designed to allow Home State Health to monitor improvement over time.

Annually, Home State Health develops a QI Work Plan for the upcoming year. The QI Work Plan serves as a working document to guide quality improvement efforts on a continuous basis. The work plan integrates QIC activities, reporting and studies from all areas of the organization (clinical and service) and includes timelines for completion and reporting to the QIC as well as requirements for external reporting. Results, conclusions, recommendations, and implemented system changes are reported to the QIC quarterly..., Studies and other performance measurement activities and issues to be tracked over time are scheduled in the QI Work Plan.

Home State Health communicates activities and outcomes of its QI Program to both members and providers through avenues such as the member newsletter, provider newsletter and the Home State Health web portal at HomeStateHealth.com.

At any time, Home State Health providers may request additional information on the health plan programs including a description of the QI Program and a report on Home State Health progress in meeting the QI Program goals by contacting the Quality Improvement department.

## Healthcare Effectiveness Data and Information Set (HEDIS)

HEDIS is a set of standardized performance measures developed by the National Committee for Quality Assurance (NCQA) which allows comparison across health plans. HEDIS gives purchasers and consumers the ability to distinguish between health plans based on comparative quality instead of simply cost differences. HEDIS reporting is a required part of NCQA Health Plan Accreditation and the Missouri State Medicaid contract.

As both the Missouri and Federal governments move toward a healthcare industry that is driven by quality, HEDIS rates are becoming more and more important, not only to the health plan, but to the individual provider as well. Missouri purchasers of healthcare use the aggregated HEDIS rates to evaluate the effectiveness of a Health Insurance Company's ability to demonstrate an improvement in preventive health outreach to its members. Physician specific scores are being used as evidence of preventive care from primary care office practices. The rates then serve as a basis for physician incentive programs such as 'pay for performance' and 'quality bonus funds'. These programs pay providers an increased premium based on scoring of quality indicators such as HEDIS.

## How are HEDIS rates calculated?

HEDIS rates can be calculated in two ways: administrative data or hybrid data. Administrative data consists of claim and encounter data submitted to the health plan. Measures typically calculated using only administrative data include annual mammogram, annual chlamydia screening, appropriate treatment of asthma, cholesterol management, antidepressant medication management, access to PCP services, and utilization of acute and mental health services.

Hybrid data consists of both administrative data and a sample of medical record data. Hybrid data requires review of a random sample of member medical records to abstract data for services rendered but that were not reported to the health plan through claims/encounter data. Accurate and timely claim/encounter data and submission of appropriate CPT II codes can reduce the necessity of medical record reviews (see Home State Health website and HEDIS brochure for more information on reducing HEDIS medical record reviews). Measures typically requiring medical record review include: childhood immunizations, well child visits, diabetic HbA1c, LDL, eye exam and nephropathy, controlling high-blood pressure, cervical cancer screening, and prenatal care and postpartum care.

**Who will be conducting the Medical Record Reviews (MRR) for HEDIS?**

Home State Health will contract with a national MRR vendor, to conduct the HEDIS MRR on its behalf. Medical record review audits for HEDIS are usually conducted March through May each year. At that time, you may receive a call from a medical record review representative if any of your patients are selected in the HEDIS samples. Your prompt cooperation with the representative is greatly needed and appreciated.

As a reminder, protected health information (PHI) that is used or disclosed for purposes of treatment, payment or healthcare operations is permitted by HIPAA Privacy Rules (45 CFR 164.506) and does not require consent or authorization from the member/patient. The MRR vendor will sign a HIPAA compliant Business Associate Agreement with Home State Health which allows them to collect PHI on our behalf.

**What can be done to improve my HEDIS scores?**

- Understand the specifications established for each HEDIS measure.

- Submit claim/encounter data for each and every service rendered. All providers must bill (or report by encounter submission) for services delivered, regardless of contract status. Claim/encounter data is the most clean and efficient way to report HEDIS. If services are not billed or not billed accurately, they are not included in the calculation. Accurate and timely submission of claim/encounter data will positively reduce the number of medical record reviews required for HEDIS rate calculation.
- Ensure chart documentation reflects all services provided.
- Bill CPT II codes related to HEDIS measures such as diabetes, eye exam and blood pressure.

If you have any questions, comments, or concerns related to the annual HEDIS project or the medical record reviews, please contact the Quality Improvement department at 1-855-694-HOME (4663).

## Provider Satisfaction Survey

Home State Health conducts an annual provider satisfaction survey that includes questions to evaluate provider satisfaction with our services such as claims, communications, utilization management, and provider services. The survey is conducted by an external vendor. Participants are randomly selected by the vendor, meeting specific requirements outlined by Home State Health, and the participants are kept anonymous. We encourage you to respond timely to the survey as the results of the survey are analyzed and used as a basis for forming provider related quality improvement initiatives.

## Consumer Assessment of Healthcare Provider Systems (CAHPS) Survey

The CAHPS survey is a member satisfaction survey that is included as a part of HEDIS and NCQA accreditation. It is a standardized survey administered annually to members by an NCQA certified survey vendor. The survey provides information on the experiences of members with health plan and practitioner services and gives a general indication of how well we are meeting the members' expectations. Member responses to the CAHPS survey are used in various aspects of the quality program including monitoring of practitioner access and availability.

## Provider Profiling and Incentive Programs

Over the past several years, it has been nationally recognized that pay-for-performance (P4P) programs, which include provider profiling, have emerged as a promising strategy to improve the quality and cost-effectiveness of care. Home State Health currently uses a pay-for-performance program that includes physician profiling to improve care and services provided to Home State Health members.

The P4P program promotes efforts that are consistent with the Institute of Medicine's aims for advancing quality (safe, beneficial, timely, patient-centered, efficient and equitable) as well as recommendations from other national agencies such as the CMS-AMA Physician Consortium, NCQA and NQF. Additionally, Home State Health will provide an opportunity for financial reward to PCPs and specialists using an incentive payment that encourages accurate and timely submission of preventive health and disease monitoring services in accordance with evidence-based clinical practice guidelines.

**The goals of Home State Health P4P program are:**

- Increase provider awareness of his/her performance in key areas
- Motivate providers to establish measurable performance improvement processes relevant to Home State Health member populations in their practices
- Use peer performance data and/or other established benchmarks to identify outlier provider practices that reflect best practices or less than optimal performance
- Increase opportunities for Home State Health to partner with providers to achieve measurable improvement in health outcomes by developing, implementing, and monitoring practice-based performance improvement initiatives

**Home State Health will accomplish these goals by:**

- Producing and distributing provider-specific reports containing meaningful, reliable, and valid data for evaluation by Home State Health and the provider.
- Creating incentives for provider implementation of practice-based performance improvement initiatives that are pertinent to Home State Health member populations linked with adopted evidence-based clinical practice guidelines and that yield measurable outcomes.
- Establishing and maintaining an open dialogue with profiled providers related to performance improvement.

PCPs who meet or exceed established performance goals and who demonstrate continued excellence or significant improvement over time may be recognized by Home State Health in publications such as newsletters, bulletins, press releases, and recognition in our provider directories as well as being eligible for applicable financial incentive programs. More information on our incentive programs can be found on the provider web portal or by contacting Home State Health Contracting and/or Provider Partnership departments.

# MEDICAL RECORDS REVIEW

## Medical Records

Home State Health providers must keep accurate and complete medical records. Such records will enable providers to render the highest quality healthcare service to members. They will also enable Home State Health to review the quality and appropriateness of the services rendered. To ensure the member's privacy, medical records should be kept in a secure location. Home State Health requires providers to maintain all records for members for at least seven (7) years. See the Member Rights section of this handbook for policies on member access to medical records.

## Required Information

Medical records means the complete, comprehensive member records including, but not limited to, x-rays, laboratory tests, results, examinations and notes, accessible at the site of the member's participating primary care physician or provider, that document all medical services received by the member, including inpatient, ambulatory, ancillary, and emergency care, prepared in accordance with all applicable state rules and regulations, and signed by the medical professional rendering the services.

**Providers must maintain complete medical records for members in accordance with the following standards:**

- Member's name, and/or medical record number on all chart pages.
- Personal/biographical data is present (i.e., employer, home telephone number, spouse, next of kin, legal guardianship, primary language, etc.).
- Prominent notation of any spoken language translation or communication assistance
- All entries must be legible and maintained in detail.
- All entries must be dated and signed or dictated by the provider rendering the care.
- Significant illnesses and/or medical conditions are documented on the problem list and all past and current diagnoses.
- Medication, allergies, and adverse reactions are prominently documented in a uniform location in the medical record; if no known allergies, NKA or NKDA are documented.
- An up-to-date immunization record is established for pediatric members or an appropriate history is made in chart for adults.

- Evidence that preventive screening and services are offered in accordance with Home State Health's practice guidelines.
- Appropriate subjective and objective information pertinent to the member's presenting complaints is documented in the history and physical.
- Past medical history (for members seen three or more times) is easily identified and includes any serious accidents, operations and/or illnesses, discharge summaries, and
- ER encounters; for children and adolescents (18 years and younger) past medical history relating to prenatal care, birth, any operations and/or childhood illnesses.
- Working diagnosis is consistent with findings.
- Treatment plan is appropriate for diagnosis.
- Documented treatment prescribed, therapy prescribed, and drug administered or dispensed including instructions to the member.
- Documentation of prenatal risk assessment for pregnant women or infant risk assessment for newborns.
- Signed and dated required consent forms.
- Unresolved problems from previous visits are addressed in subsequent visits.
- Laboratory and other studies ordered as appropriate.
- Abnormal lab and imaging study results have explicit notations in the record for follow up plans; all entries should be initialed by the primary care provider (PCP) to signify review.
- Referrals to specialists and ancillary providers are documented including follow up of outcomes and summaries of treatment rendered elsewhere including family planning services, preventive services and services for the treatment of sexually transmitted diseases.
- Health teaching and/or counseling is documented.
- For members 10 years and over, appropriate notations concerning use of tobacco, alcohol and substance use (for members seen three or more times substance abuse history should be queried).
- Documentation of failure to keep an appointment.
- Encounter forms or notes have a notation, when indicated, regarding follow-up care calls or visits. The specific time of return should be noted as weeks, months or as needed.
- Evidence that the member is not placed at inappropriate risk by a diagnostic or therapeutic problem.
- Confidentiality of member information and records protected.
- Evidence that an advance directive has been offered to adults 18 years of age and older.
- Any corrections, additions, or change in any medical record made more than 48 hours after the final entry is entered in the record and signed by the physician shall be clearly marked and identified as such, and the date, time, and name of the person making the correction, addition, or change shall be included, as well as the reason for the correction, addition, or change.

Home State Health will provide written notice prior to conducting a medical record review.

### Medical Records Release

All member medical records shall be confidential and shall not be released without the written authorization of the covered person or a responsible covered person's legal guardian. When the release of medical records is appropriate, the extent of that release should be based upon medical necessity or on a need to know basis.

*NOTE: When members enroll in MO HealthNet, they sign a waiver to release medical records and other requested participant protected health information to the State of Missouri and to agents of the State, such as Home State Health.*

### Medical Records Transfer for New Members

When a member changes primary care providers, upon request, his or her medical records or copies of medical records must be forwarded to the new primary care provider within ten (10) business days from receipt of request or prior to the next scheduled appointment to the new primary care provider whichever is earlier.

All PCPs are required to document in the member's medical record attempts to obtain historical medical records for all newly assigned Home State Health members. If the member or member's guardian is unable to remember where they obtained medical care, or they are unable to provide addresses of the previous providers then this should also be noted in the medical record.

## ACCESS TO RECORDS AND AUDITS

Home State Health will conduct random medical record audits as part of its QAPI Program to monitor compliance with the medical record documentation standards noted above. The coordination of care and services provided to members, including over/under utilization of specialists, as well as the outcome of such services also may be assessed during a medical record audit. Subject only to applicable State and federal confidentiality or privacy laws, Provider shall permit Home State Health or its designated representative access to Provider's Records, at Provider's place of business in this State during normal business hours, or remote access of such Records, in order to audit, inspect, review, perform chart reviews, and duplicate such Records. If performed on site, access to Records for the purpose of an audit shall be scheduled at mutually agreed upon times, upon at least thirty (30) business days prior written notice by Home State Health or its designated representative, but not more than sixty (60) days following such written notice.

## EMR ACCESS

Provider will grant Home State Health access to Provider's Electronic Medical Record (EMR) system in order to effectively case manage Members and capture medical record data for risk adjustment and quality reporting. There will be no other fees charged to Home State Health for this access.