Reimbursement

Out of Network providers require prior authorization. Out of Network Hospital providers will be reimbursed at 90% of per diem and fee for service. Please note that LPH, DME, and Lab services are not part of the 90% reimbursement for physician claims.

Key Contacts

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

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

Health Plan Information		
	Home State 11720 Borman Drive St. Louis, MO 63146 www.HomeStateHealth.com	
Department	**Telephone Number**	**Fax Number**
Provider Services	1-855-694-HOME (4663) TDD/TYY: 1-877-250-6113	1-866-390-4429
Member Services	1-855-694-HOME (4663) TDD/TYY: 1-877-250-6113	1-866-390-4429
Authorization Request Concurrent Review Case Management	1-855-694-HOME (4663)	1-855-286-1811 1-866-390-3139 1-877-276-8960
Envolve (24/7 Availability)	1-855-694-HOME (4663)	
Missouri Department of Social Services	1-573-751-3425 (MO HealthNet) Text Telephone 1-800-735-2966	1-573-751-6564
Medical Claims	**Reimbursement Rate Dispute**	**Medical Necessity Appeal**
Home State Attn: Claims PO Box 4050 Farmington, MO 63640-3829	Home State Attn: Claim Disputes PO Box 4050 Farmington, MO 63640-3829	Home State Attn: Medical Necessity 11720 Borman Drive St. Louis, MO 63146
Electronic Claims Submission		

Home State

c/o Centene EDI Department 1-800-225-2573, ext. 25525

or by e-mail to: EDIBA@centene.com

Verifying Eligibility

Member Eligibility Verification

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

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

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

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

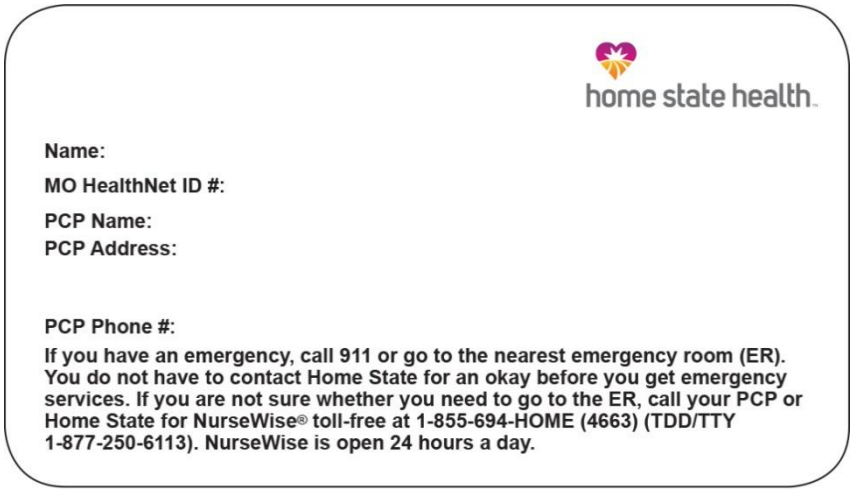
Through Home State's secure provider web portal, PCPs are able to access a list of eligible members who have selected their services or were assigned to them. The Patient list is reflective of all changes made within the last 24 hours. The list also provides other important information including date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

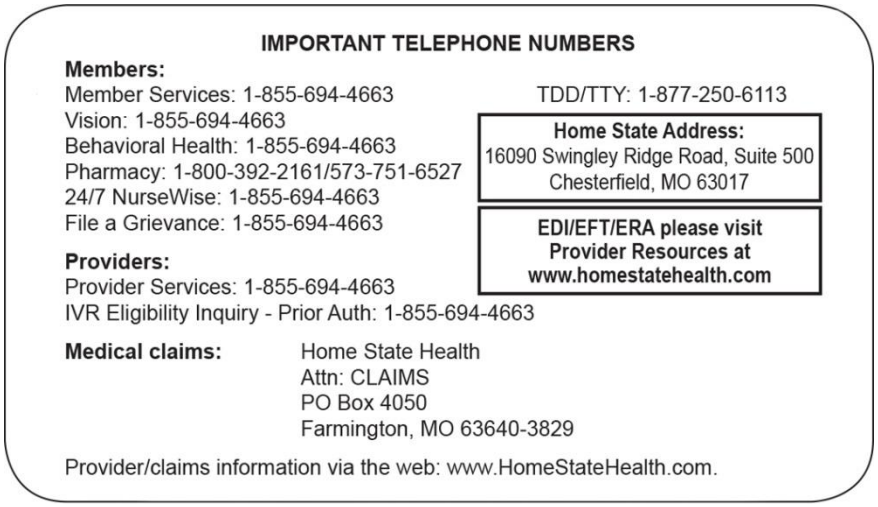
All new Home State members receive a Home State member ID card. A new card is issued only when the information on the card changes, if a member loses a card, or if a member requests an additional card. **Since member ID cards are not a guarantee of eligibility,** providers must verify members' eligibility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

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

Member Identification Card

Providers are required to implement a policy of requesting and inspecting an adult member's MO HealthNet identification card (or other documentation provided by the state agency demonstrating MO HealthNet eligibility) and health plan membership card, prior to providing non-emergency services. If you suspect fraud, please contact Provider Services at 1-855-694-HOME (4663) immediately. Members must keep the state-issued MO HealthNet ID card in order to receive benefits not covered by Home State, such as Pharmacy services. Members are directed to present both identification cards when seeking non-emergency services.





Self-Referrals

The following services do not require prior authorization or referral:

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

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

Prior Authorization and Notifications

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

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

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

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

Authorization Determination Timelines

Home State decisions are made as expeditiously as the member's health condition requires. For standard service authorizations, the decision will be made within two (2) business days from receipt of necessary medical information and notification within one (1) business day after the decision is made (not to exceed a total 14 calendar days from receipt of the request unless an extension is requested). "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 24-hours 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.

Second and Third Opinions

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

Clinical Information

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

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

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

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

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

Billing and Claims Submission

General Guidelines

This Provider Reference Manual describes general billing and claim submission guidelines. Please visit our Website at www.HomeStateHealth.com for Home State's complete Provider Billing Manual.

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 for payment of covered services. It is important that providers ensure Home State 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

We recommend that providers notify Home State as soon as possible, but no later than 30 days in advance of changes pertaining to billing information. Please submit this information on a W-9 form. Changes to a Provider's TIN and/or address are NOT acceptable when conveyed via a claim form.

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 and the provider billing manual located at www.HomeStateHealth.com.

Billing Tips

- Prenatal/Postpartum Billing and Bonus Program
  - All prenatal, delivery, and postpartum claims are required tobe submitted as fee for service (FFS). Claims submitted with global codes will be denied.

Prenatal Care – global codes will be denied.
Use appropriate E&M code with TH modifier for all prenatal visits. *$200 bonus for 7 visits to the same practitioner.* *E&M codes without –TH modifier will be reimbursed normally but will not be eligible for bonus* *Global codes will be denied.*

Delivery – global codes will be denied.
59409 Vaginal Delivery Only
59514 Cesarean Delivery Only
59612 VBAC – Vaginal Delivery after Previous Cesarean
59620 Cesarean Delivery Only after attempted VBAC

Postpartum Care	
59430-TH	Postpartum Care, performed 21 to 56 days from delivery Use appropriate E&M code or 59430 without TH modifier for postpartum care performed less than 21 or more than 56 days from delivery
$100 bonus for one postpartum visit within 21-56 days from delivery *59430 without the modifier or E&M codes for postpartum care will be reimbursed normally but will not be eligible for bonus.* *Global codes will be denied.*	

- Newborn Delivery Services
  - Use appropriate value codes as well as birth weight when billing for newborn delivery services.
- Early Elective Deliveries (EED)
  - Appropriate EED code must be submitted in field 19 of a HCFA
  - Gestational age falls between 20-44 weeks.
  - Acceptable delivery indicators are: LV, LC, IV, IC, CN, CS
  - 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
    - Incorrect Format Example: 39 LV or LV39
- 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
        - HCPC procedure code T1015 must be submitted in field #44
        - HCPC/CPT code(s) for other services provided must be submitted in field 44 in addition to code T1015
        - EPSDT/HCY Exam-EP modifier should ONLY be billed with a full or partial EPSDT Screening code.
        - HCPC procedure code T1015EP must be submitted in field #44 when submitting The 5-digit EPSDT/HCY screening code must be shown in Field #44 as well.
        - One of the following codes must be shown as the primary diagnosis in Field #67: Z00.110, Z00.111, Z00.121, Z00.129, Z00.00 or Z00.01
    - 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.
- Coordination of Benefits (COB)
    - COB claims must be received within one hundred and eighty (180) days from the member's primary carrier remittance advice date. A copy of the primary carrier remittance advice must accompany the claim. NOTE: Home State Health is always the payer of last resort. See section Third Party Liability in the Home State Provider Manual for more information.
    - Secondary claims can also be filed electronically via our secure web portal which can be found at our website www.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'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 reimbursedup to 100% of the MO HealthNet fee schedule.

Please visit our Website at www.HomeStateHealth.com for Home State's complete Provider Billing Manual.

Clean Claim Definition

A clean claim is defined as a claim received by Home State 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.

Timely Filing

Providers must submit all original claims (first time claims) and encounters to Home State within 180 calendar days of the date of service.

All corrected claims, requests for reconsideration or claim disputes must be received within 180 calendar days from the date of notification of payment or denial is issued.

Electronic Claims Submission

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

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

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

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

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

- Emdeon
- SSI
- Trizetto Provider Solutions
- Availity

Paper Claims Submission

All claims and encounters should be submitted to:

INITIAL CLAIMS, CORRECTED CLAIMS and REQUESTS FOR RECONSIDERATION:

Home State
ATTN: CLAIMS DEPARTMENT
P.O. BOX 4050
Farmington, MO 63640-3829

CLAIM DISPUTES:
NOTE: Please use the Claim Dispute Form located at www.HomeStateHealth.com

Home State
ATTN: CLAIMS DEPARTMENT
P.O. BOX 4050
Farmington, MO 63640-3829

Home State Health does not accept black and white or handwritten claim forms.

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

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

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

For more information, please visit our provider home page on our website at www.HomeStateHealth.com.
If further assistance is needed, please contact Provider Services 1-855-694-HOME (4663).

Claim Payment

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

- 90 percent within 15 business days of the receipt
- 99 percent within 30 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 is always the payer of last resort. Home State providers shall make reasonable efforts to determine the legal liability of third parties to pay for services furnished to Home State members. If the provider is unsuccessful in obtaining necessary cooperation from a member to identify potential third party resources, the provider shall inform Home State that efforts have been unsuccessful. Home State will make every effort to work with the provider to determine liability coverage.

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

Payment Policies

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

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

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

Claim Requests for Reconsideration, Claim Disputes and Corrected Claims

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

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

1. Review the claim in question on the secure Provider Portal:
    - Participating providers, who have registered for access to the secure provider portal, can access claims to obtain claim status, submit claims or submit a corrected claim.
2. Contact a Home State 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 simple request for reconsideration by clearly explaining the reason why the claim is not adjudicated correctly.
3. Submit an Adjusted or Corrected Claim to Home State:
    - Corrected claims must clearly indicate they are corrected in one of the following ways:
        - Submit corrected claim via the secure Provider Portal
            - Follow the instructions on the portal for submitting a 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
        - **Mail corrected claims to**:

Home State
Attn: Corrected Claim PO Box 4050
Farmington, MO 63640-3829

- All paper claim forms *must* be typed or printed, and in the original red and white version to ensure clean acceptance and processing. No handwritten information will be accepted on the claim form.
- 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 www.HomeStateHealth.com

4. **Submit a "Request for Reconsideration" to Home State:**

- A request for reconsideration is a written communication (i.e. a letter) from the provider about
  a disagreement in the way a claim was processed but does not require a claim to be corrected and does not require medical records.
- 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.
- **Mail Requests for Reconsideration to:**

Home State
Attn: Reconsideration PO Box 4050
Farmington, MO 63640-3829

Submit a "Claim Dispute Form" to Home State:

- A claim dispute is to be used only when a provider has received an unsatisfactory response to a request for reconsideration.
- The Claim Dispute Form can be located on the provider website at www.HomeStateHealth.com.
- To expedite processing of your dispute, please include the original Request for Reconsideration letter and the response.
- Mail your "Claim Dispute Form" and all other attachments to:

Home State Health
Attn: Claim Dispute PO Box 4050
Farmington, MO 63640-3829

If the Provider Service contact, the corrected claim, the request for reconsideration or the claim dispute results in an adjusted claim, the provider will receive a revised Explanation of Payment (EOP). If the

original decision is upheld, the provider will receive a revised EOP or letter detailing the decision and steps for escalated reconsideration.

Home State shall process, and finalize all corrected claims, requests for reconsideration and disputed claims to a paid or denied in accordance with State law and regulations.

Grievances and Appeals Process

Member Grievances

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

The grievance process allows the member, (or the member's authorized representative (family member, etc.) acting on behalf of the member or provider acting on the member's behalf with the member's written consent), to file a grievance either orally or in writing. Home State 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 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 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 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) business 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 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 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 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, 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
Complaint and Grievances Coordinator (CGC) Home State
11720 Borman Drive
St. Louis, MO 63146
1-855-694-4663

Appeals

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 network. The review may be requested in writing or orally, however oral requests must be followed up in writing unless an expedited resolution is requested. Members may request that Home State review the adverse action to verify if the right decision has been made. Appeals must be made within 90 calendar days from the date on Home State's notice of action. Home State shall acknowledge receipt of each appeal in writing within 10 business days after receiving an appeal. Home State 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 receives the appeal. Home State may extend the timeframe for resolution of the appeal up to 14 calendar days if the member requests the extension or Home State 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 shall provide written notice to the member of the reason for the delay.

Expedited Appeals

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 72 hours 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. For any extension not requested by the member, Home State shall provide written notice to the member of
the reason for the delay. Home State 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;

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 decision.

Call or mail all appeals to:

Home State
Complaint and Grievances Coordinator (CGC)
11720 Borman Drive
St. Louis, MO 63146
1-855-694-HOME (4663)

State Fair Hearing Process

Home State 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 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'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 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 of the state agency's receipt of a state fair hearing request. For expedited appeals, (that meet the criteria set forth in 42 CFR 438.410), the state shall reach its decision within three (3) working days from the state agency's receipt of a hearing request for a denial of a service that meets the criteria for an expedited appeal process but was not resolved using the health plan's expedited appeal timeframes, or was resolved wholly or partially adversely to the member using the health plan's expedited appeal timeframes.

Home State 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.

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 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 will authorize the disputed 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 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 Appeals

A **Complaint** is a verbal or written expression by a provider that indicates dissatisfaction or dispute with Home State's policy, procedure, claims, or any aspect of Home State's functions. Home State 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 shall provide a written notice to the provider within 30 calendar days from the received date of the Plan's decision. An **Appeal** is the mechanism that allows providers the right to appeal actions of Home State such as a claim denial, prior authorization denial, or if the provider is aggrieved by any rule, policy or procedure or decision made by Home State. A provider has 30 calendar days from Home State's notice of action. Home State shall acknowledge receipt of each appeal within 10 business days after receiving an appeal. Home State 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 receives the appeal. Home State may extend the timeframe for resolution of the appeal up to 14 calendar days if the member requests the extension or Home State 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 shall provide written notice to the member of the reason for the delay.

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 72 hours from the initial receipt of the appeal. Home State may extend this timeframe by up to an additional 14 calendar days if the member requests the extension or if Home State provides evidence satisfactory to the MHD that a delay in rendering the decision is in the member's interest.

Protected Health Information (PHI) 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 HSHP 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 HSHP 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.

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 have 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.

In-Person Services Home State provides oral interpreter and 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.