

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 16090 Swingley Ridge Road, Suite 500 Chesterfield, MO 63017 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 Authorization Requests for PT, OT, and ST	1-855-694-HOME (4663)	1-855-286-1811 1-866-390-3139 1-877-276-8960 1-855-254-1798
NurseWise (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 16090 Swingley Ridge Road Suite 500 Chesterfield, MO 63017
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.**

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.



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 Home State for NurseWise® toll-free at 1-855-694-HOME (4663) (TDD/TTY 1-877-250-6113). NurseWise is open 24 hours a day.

IMPORTANT TELEPHONE NUMBERS

Members:

Member Services: 1-855-694-4663 TDD/TTY: 1-877-250-6113
Vision: 1-855-694-4663
Behavioral Health: 1-855-694-4663
Pharmacy: 1-800-392-2161/573-751-6527
24/7 NurseWise: 1-855-694-4663
File a Grievance: 1-855-694-4663

Home State Address:
16090 Swingley Ridge Road, Suite 500
Chesterfield, MO 63017

Providers:

Provider Services: 1-855-694-4663
IVR Eligibility Inquiry - Prior Auth: 1-855-694-4663

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

Medical claims: Home State Health
Attn: CLAIMS
PO Box 4050
Farmington, MO 63640-3829

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

Referrals – Paper referrals are not required; however 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.

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 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 or to obtain a prior authorization, call:

Home State
Medical Management/Prior Authorization Department
Telephone 1-855-694-HOME (4663)
Fax 1-855-286-1811
www.HomeStateHealth.com

Prior Authorization requests may be done electronically following the ANSI X 12N 278 transaction code specifications. For more information on conducting these transactions

electronically contact:

Home State
C/o Centene EDI
Department
1-800-225-2573, extension 25525

Or by e-mail at:

EDIBA@centene.com

Prior Authorization and Notifications

Prior authorization is a request to the Home State Utilization Management (UM) department for approval of services.

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. All out-of-network services require prior authorization.**

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.

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.

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.

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, and
- Referral and prior authorization processes were followed, if applicable.

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.

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
- Gateway

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

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.

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
 - Paper claims must clearly be marked 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 mark 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.

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

5. 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
 - 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

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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 Plan
Complaint and Grievances Coordinator (CGC)
Home State
16090 Swingley Ridge Rd., Suite 500
Chesterfield, MO 63017
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

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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 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)
16090 Swingley Ridge Rd., Suite 500
Chesterfield, MO 63017
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 90 calendar days from the date of the notice of action.

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

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or in writing by the member or the member's representative within 90 days of the member's receipt of notice of adverse action 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 date the member filed the appeal with the health plan if the member filed initially with the health plan (excluding the days the member took to subsequently file for a State fair hearing) or the date the member filed for direct access to a State fair hearing. For expedited appeals, (that meet the criteria set forth in 42 CFR 438.410), if the appeal was heard first through the health plan appeal process the state shall reach its decision within three 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. If the appeal was made directly to the State fair hearing process without accessing the health plan appeal process the state shall reach its decision within three 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.

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 which 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 which 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.

