Missouri Care Provider Orientation
History
Missouri Care has been a MO HealthNet managed care health plan since 1998. We currently serve 54 counties in the Eastern, Central and Western Regions of Missouri. Our mission is to provide access to quality health care for the members we serve. In 2013, WellCare purchased Missouri Care Health Plan.

Led by Lou Gianquinto, Missouri Care President, Missouri Care earned the top score and was one of the three health plans awarded the new contract award by the State of Missouri to provide managed care services to MO HealthNet participants statewide effective May 1, 2017.

🌟 Missouri Care has three Regional Offices. These are located in:
- St. Louis
- Columbia
- Springfield

🌟 In addition, Missouri Care will be opening two Welcome Centers in Cape Girardeau and St. Joseph.
WELLCARE FAST FACTS

- Led by Ken Burdick, CEO.
- Is a FORTUNE 500 and Barron’s 500 company, NYSE: WCG.
- Serves 3.8 million members nationwide.
- Provides access to 381,000 contracted health care providers and 68,000 contracted pharmacies.
- Employs 7,200 associates nationwide
Missouri Medicaid (Fee for Service)

The following individuals who are Medicaid recipients will remain with the Medicaid program and not enrolled in a Managed Care health plan.

- Seniors
- People who are Blind or Visually Impaired
- People with Disabilities
- Participants in the AIDS Waiver program
- Participants with Medicare Coverage
- Women with breast or cervical cancer
- Participants in the Women's Health Services program

Who is Covered Under Managed Care (Missouri Care)?

- MO HealthNet for Pregnant Women and Newborns
- MO HealthNet for Families
- MO HealthNet for Children
- Individuals receiving Refugee Assistance
- Children’s Health Insurance Program (CHIP)
- Children in Care and Custody of the State or receiving Adoption Subsidy
The first ID Card example is the red **Missouri Medicaid ID** card issued to eligible Missouri Medicaid recipients.

This second ID Card example is the **MO HealthNet card** issued to eligible Missouri Medicaid recipients who are eligible for MO HealthNet Managed Care.
Statewide Managed Care Medicaid Expansion
As of 5/1/2017 Missouri Care will begin serving MO HealthNet Managed Care participants statewide. We are proud to serve all Missourians eligible for MO HealthNet services in partnership with the State, our providers and the communities we graciously serve.

A total of three plans were awarded statewide with Missouri Care being one of the three health plans. The contract is renewable annually for up to a total duration of five years.

Market Share
- In order to further right-size the market share across the awarded plans, no plan will hold more than 55% of the market share.
- There will be no change in the current minimum market share of 20%.
- The managed care contracts awarded also includes a provision allowing for Medicaid eligibility expansion, should the General Assembly pass legislation authorization such expansion.
What Has Changed?
While the Managed Care program is based on the MO HealthNet fee-for-service program, the two programs have differences. Please contact each Managed Care health plan for specific information.
• Prior authorization
• Timely filing rules
• Rates of reimbursement may differ from the fee-for-service program
• Enhanced member benefits

Contact Information for MO HealthNet regarding Statewide Managed Care Expansion
If you have any questions or need additional information regarding statewide Managed Care, please contact Jessica Emmerich at 573-526-4274 or the MO HealthNet Provider Communications Hotline at 573-751-2896.

MO HealthNet Provider Bulletins and Newsletters
Provider Bulletins are available on the MO HealthNet Division (MHD) (Formerly the Division of Medical Services) website at http://dss.mo.gov/mhd/providers/pages/bulletins.htm Bulletins will remain on the Provider Bulletins page only until incorporated into the provider manuals as appropriate, then moved to the Archived Bulletin page.

MO HealthNet News: Providers and other interested parties are urged to go to the MHD website at http://dss.mo.gov/mhd/ to subscribe to the electronic mailing list to receive automatic notifications of provider bulletins, provider manual updates, and other official MO HealthNet communications via email.
Managed Care Medicaid Expansion

Statewide MO HealthNet Managed Care Expansion Regions
Effective 5/1/2017

[Map showing regions of Missouri with different colors indicating various regions and expansions effective as of 5/1/2017]
Missouri Care contracts with providers statewide. Below is a copy of the PR Territory Map.

Provider Relations Territory Map

Border State Assignments
- Iowa (Stephanie Thompson)
- Kansas (Mika Fue)
- Nebraska (Chelle Haynes)
- Illinois (Ronnie Caradine)
- Arkansas and (Abigail Shivers)
- Oklahoma
- Kentucky and Tennessee (TBD)

(Counties with ** are being covered Interim)

- Barb Wheeler | Phone: 573-355-4033 | Email: Barb.Wheeler@wellcare.com
- Ronald Caradine | Phone: 618-207-9152 | Email: Ronald.Caradine@wellcare.com
- Chelle Haynes | Phone: 573-441-2119 | Email: Chelle.Haynes@wellcare.com
- Stephanie Thompson | Phone: 573-303-4805 | Email: Stephanie.Thompson@wellcare.com
- Mika Fue | Phone: 573-876-1505 | Email: Tamika.Fue@wellcare.com
- Abigail Shivers | Phone: 417-572-7803 | Email: Abigail.Shivers@wellcare.com

www.missouricare.com
1-800-322-6027
Map Effective Date: 3/27/2017
Missouri Care contracts with Behavioral Health providers statewide. Below is a copy of the BH PR Territory Map.

Missouri Care Provider Relations Territories Behavioral Health

Barb Wheeler
Phone: 573-355-4033
Barbara.Wheeler@wellcare.com

Kristin Boyd
Phone: 314-365-1008
Kristin.Boyd@wellcare.com
The State of Missouri requires us to ensure our provider network’s appointment wait times do not exceed the standards outlined in the provider contract and handbook. In order to assess appointment timeliness, Missouri Care conducts quarterly phone audits. We make these calls to assess your compliance level to the following requirements:

<table>
<thead>
<tr>
<th>Service</th>
<th>Timeframe Requirement for the Appointment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical – Urgent Care</td>
<td>Within 24 hours</td>
</tr>
<tr>
<td>Medical – Routine Care with Symptoms</td>
<td>Within 1 week or 5 business days, whichever is earlier</td>
</tr>
<tr>
<td>Medical – Routine Care</td>
<td>Within 30 calendar days</td>
</tr>
<tr>
<td>Medical – Follow-up to Hospital Discharge</td>
<td>Within 7 calendar days from the discharge date</td>
</tr>
<tr>
<td>Behavioral Health – Routine Care</td>
<td>Within 10 business days</td>
</tr>
<tr>
<td>Behavioral Health – Routine Care with Symptoms</td>
<td>Within 1 week or 5 business days, whichever is earlier</td>
</tr>
<tr>
<td>Behavioral Health – Urgent Care</td>
<td>Within 24 hours</td>
</tr>
<tr>
<td>Behavioral Health – Non-life-threatening Emergency Care</td>
<td>Within 6 hours</td>
</tr>
<tr>
<td>Behavioral Health – Follow-up to Hospital Discharge</td>
<td>Within 7 calendar days from the discharge date</td>
</tr>
<tr>
<td>Maternity Care – 1st Trimester Initial Visit</td>
<td>Within 7 calendar days</td>
</tr>
<tr>
<td>Maternity Care – 2nd Trimester Initial Visit</td>
<td>Within 7 calendar days</td>
</tr>
<tr>
<td>Maternity Care – 3rd Trimester Initial Visit</td>
<td>Within 3 calendar days</td>
</tr>
<tr>
<td>Maternity Care – High-Risk Pregnancy Initial Visit</td>
<td>Within 3 calendar days or immediately if emergency exists</td>
</tr>
</tbody>
</table>
Appointment Availability

After Hours Availability

Primary Care Providers must provide or arrange for coverage of services, consultation or approval for referrals 24 hours per day, 7 days per week.

To ensure accessibility and availability, PCPs must provide one of the following:

• Answering service or system that will page physician
• Advice Nurse with access to physician
• Answering system with option to page physician
• Answering service that will page the provider after a message is left
• Answering service or system that provides number to access physician

If a Requirement isn’t Met

If the requirement is not met during the survey call, the provider will receive a letter advising of the requirement(s) not met. It is up to the provider’s office to educate their staff and ensure that the requirements are being met. A copy of the letter is on the following page.

A future follow-up call will be made to determine if the provider’s office will meet all requirements.
If a Requirement isn’t Met
If the requirement is not met during the survey call, the provider will receive a letter advising of the requirement(s) not met. It is up to the provider’s office to educate their staff and ensure that the requirements are being met.

A future follow-up call will be made to determine if the provider’s office will meet all requirements.
Healthcare providers have the **responsibility** to **Ask** members, age 18 and older, if they have an Advance Directive or Living Will, **Explain** what each are and **Document** in the member’s medical record that this information was provided to the member.

The following handout provides information regarding Advance Directives and the documentation that is required in the member’s record.
Missouri Care pays for commercial language services required for our members, including services rendered in a provider’s office or facility, as long as the translator is not on the staff of the facility.

If language interpretation services are needed, please complete and send the Interpreter Request Form so arrangements for an interpreter may be set up for the member’s appointment.

Electronic Media for the Hearing Impaired
Members have access to the TTY/TDD line for hearing impaired services. WellCare’s Customer Service department is responsible for any necessary follow-up calls to the member. The toll-free TTY/TDD number can be found on the member’s identification card.
Missouri Care relies on the Provider network to advise us of demographic changes in order to keep the Provider information current. To ensure our members and Care Management staff have up-to-date information, please give us 30 days prior written notice of the following changes:

- Group Name or Affiliation
- Panel status
- Physical or Billing address
- Telephone or fax number
- Tax Identification Number
- Billing Address
- Fax Number
- Age Limitation
- New NPI number
- Terminations

Please submit your change request in writing to Missouri Care as far in advance of the change as possible. We require 90 days’ prior written notice of Provider terminations.

You may submit the advance notice of these changes via any of these methods:

Email: MissouriProviderRelations@wellcare.com
Fax: 1-866-946-1105
Mail: Missouri Care
Attn: Provider Operations
4205 Philips Farm Road, Suite 100
Columbia, MO 65201
Enrolling a New Provider

If your office has a new provider who is interested in joining our provider network, below is the information we need:

- A letter on the provider’s office letterhead requesting to add the provider, the provider’s Tax ID Number and the provider’s name, NPI Number and Title/Degree
- The provider’s CAQH needs to be updated and attested to where we can download their CAQH application and all supporting documents uploaded to CAQH
- The completed Provider Profile Sheet
- The completed Collaborative Supervising Physician form if the provider is a mid-level practitioner
- The provider’s Certificate of Insurance needs to be current on CAQH and it needs to be active for at least the next 45 days otherwise we will need a copy emailed to us so we have a current copy.

The provider’s office address that matches the Tax ID Number needs to be on CAQH. Please email this information to our Provider Operations Coordinator Team. Their email address is MissouriProviderRelations@wellcare.com

After the provider is entered into our system, you will receive a Welcome Letter email advising of the provider’s effective date and their Missouri Care/WellCare Provider ID Number, etc.

Please note: The new provider needs a Prior Authorization Number for each member and each Date of Service until the new provider is participating. The Prior Authorization Number needs to also be on the claim. Our Prior Authorization Department is available by phone at our toll-free number of 1-800-322-6027.
Enrollment is managed by the state and updated daily. Once determined eligible to participate in the MO HealthNet program, members may choose Missouri Care as their health care plan.

Once enrolled, MO HealthNet Managed Care-eligible members must choose a PCP or one is assigned by their designated health plan. Members have two identification numbers. They have a DCN number which is assigned by MO HealthNet, and they have a Subscriber ID number which is assigned by Missouri Care. Both of these numbers are listed on the member’s ID card.
Eligibility Verification

Eligibility can be verified by calling MO HealthNet’s Interactive Voice Response (IVR) Unit at (573) 635-8908 or through MO HealthNet’s online system, eMOMed available at the web at www.emomed.com

As a contracted Missouri Care Provider, you can see any Missouri Care member, even if you are not the PCP of record. Missouri Care will accept claims billed with either the Member ID Number or the MO HealthNet DCN.

Please note: A member’s eligibility status can change at any time. Therefore, providers are encouraged to check eligibility on the Date of Service and request and copy a member’s ID card, along with additional proof of ID, such as photo identification, and file these in the patient’s medical record.

Providers should access Missouri Care’s Secure Provider Portal at www.missouricare.com/provider to obtain the member’s current assigned PCP.
Below is a screen print of a member’s eligibility information on eMOMed. Insurance Type MC indicates the member is enrolled in a Managed Care plan. The “Lockin Information” indicates which Managed Care Health Plan the member is enrolled in. Eligibility may change daily. As a result, it is important to check eligibility on the Date of Service.

<table>
<thead>
<tr>
<th>Eligibility / Benefit Information 1 of 6</th>
<th>Eligibility / Benefit Code</th>
<th>Service Type</th>
<th>Plan Code</th>
<th>Time Period Qualifier</th>
<th>Monetary Amt</th>
<th>Insurance Type</th>
<th>Medicare Nbr</th>
<th>Date Qualifier</th>
<th>From Date</th>
<th>Thru Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Co-Payment</td>
<td>30 - Health Benefit Plan Coverage</td>
<td>60</td>
<td>7 - Day</td>
<td>$0.00</td>
<td>MC - MO HealthNet</td>
<td>291</td>
<td>08/01/2016</td>
<td>12/31/2016</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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<thead>
<tr>
<th>Eligibility / Benefit Information 2 of 6</th>
<th>Eligibility / Benefit Code</th>
<th>Service Type</th>
<th>Plan Code</th>
<th>Time Period Qualifier</th>
<th>Monetary Amt</th>
<th>Insurance Type</th>
<th>Medicare Nbr</th>
<th>Date Qualifier</th>
<th>From Date</th>
<th>Thru Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Active Coverage</td>
<td>30 - Health Benefit Plan Coverage</td>
<td>60</td>
<td>7 - Day</td>
<td>$0.00</td>
<td>MC - MO HealthNet</td>
<td>291</td>
<td>08/01/2016</td>
<td>12/31/2016</td>
<td></td>
<td></td>
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<tr>
<th>Eligibility / Benefit Information 3 of 6</th>
<th>Eligibility / Benefit Code</th>
<th>Service Type</th>
<th>Plan Code</th>
<th>Time Period Qualifier</th>
<th>Monetary Amt</th>
<th>Insurance Type</th>
<th>Medicare Nbr</th>
<th>Date Qualifier</th>
<th>From Date</th>
<th>Thru Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Active Coverage</td>
<td>1 - Medical Care</td>
<td>60</td>
<td>7 - Day</td>
<td>$0.00</td>
<td>MC - MO HealthNet</td>
<td>291</td>
<td>08/01/2016</td>
<td>12/31/2016</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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<tr>
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<th>Eligibility / Benefit Code</th>
<th>Service Type</th>
<th>Plan Code</th>
<th>Time Period Qualifier</th>
<th>Monetary Amt</th>
<th>Insurance Type</th>
<th>Medicare Nbr</th>
<th>Date Qualifier</th>
<th>From Date</th>
<th>Thru Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-Covered</td>
<td>33 - Chiropractic</td>
<td>60</td>
<td>7 - Day</td>
<td>$0.00</td>
<td>MC - MO HealthNet</td>
<td>291</td>
<td>08/01/2016</td>
<td>12/31/2016</td>
<td></td>
<td></td>
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</tbody>
</table>

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<thead>
<tr>
<th>Eligibility / Benefit Information 5 of 6</th>
<th>Eligibility / Benefit Code</th>
<th>Service Type</th>
<th>Plan Code</th>
<th>Time Period Qualifier</th>
<th>Monetary Amt</th>
<th>Insurance Type</th>
<th>Medicare Nbr</th>
<th>Date Qualifier</th>
<th>From Date</th>
<th>Thru Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other or Additional Payor</td>
<td>HM - Health Maintenance Organization (HMO)</td>
<td>60</td>
<td>7 - Day</td>
<td>$0.00</td>
<td>MC - MO HealthNet</td>
<td>291</td>
<td>08/01/2016</td>
<td>12/31/2016</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Lockin Information**
- Name: MISSOURI CARE HEALTH PLAN
- Office Phone: (800)322-6037
Children’s Mercy Pediatric Network (CMPCN) is an integrated pediatric network operated by the Children’s Mercy Hospital System.

CMPCN provides delegated medical management services including: case management, utilization management and disease management for select Missouri Care members in the following counties: Bates, Cass, Cedar, Clay, Henry, Jackson, Johnson, Lafayette, Platte, Polk, Ray, St. Clair and Vernon. Missouri Care members who are part of this network can be identified by the CMPCN logo on their ID card.
The difference with members enrolled through the CMPCN network is CMPCN manages and issues Prior Authorization Requests for these members. The authorization approvals are shared by CMPCN with Missouri Care. Missouri Care will process the claims for these members.

A Missouri Care member is still free to choose any contracted provider to receive services. If an authorization is necessary, or you have a referral for case management, you will contact CMPCN instead of Missouri Care.

All Behavioral Health management services will continue to be managed by Missouri Care.

<table>
<thead>
<tr>
<th>Who to Contact for:</th>
<th>Missouri Care or CMPCN?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prior Authorization Request for Missouri Care Members</td>
<td>Contact CMPCN</td>
</tr>
<tr>
<td>BH Case Management and Utilization Management</td>
<td>Missouri Care</td>
</tr>
<tr>
<td>Who to File Claims to</td>
<td>Missouri Care</td>
</tr>
<tr>
<td>Eligibility Verification</td>
<td>eMOMed (MO HealthNet)</td>
</tr>
<tr>
<td>Who to File an Appeal or Grievance to:</td>
<td>Missouri Care</td>
</tr>
</tbody>
</table>
CMPCN provides delegated medical management services for Missouri Care members who are part of the CMPCN network.

Preauthorization Requests
Please check the CMPCN website at [http://www.cmpcn.org](http://www.cmpcn.org) to determine if a service requires authorization and for related preauthorization forms and the prior authorization quick guide.

Preauthorization requests for Missouri Care/CMPCN members should be directed to CMPCN at the Phone and Fax Numbers as follows:

- The Prior Authorization Phone Number is 1-877-347-9367
- The Prior Authorization Fax Number is 1-888-670-7260
- The Clinical Services Phone Number is 1-888-670-7262

Claims Submission
Claims for CMPCN members are submitted to Missouri Care for processing.
Missouri Care has partnered with PaySpan Health to provide EFTs and ERAs.

Missouri Care does not mail Explanation of Payment Remits to providers. Providers can view, save and print Remits via PaySpan’s website.

Registration and use of PaySpan’s services are free to both participating and non-participating providers.

To register with PaySpan, please visit their website at [www.payspanhealth.com](http://www.payspanhealth.com) or by calling PaySpan at 1-877-331-7154.

1. Enter your registration code and click Submit or Enter your practice information and follow the prompts through the remaining steps.
2. You will need:
   - Your vendor/provider identification number and TIN
   - A valid email address
   - Bank routing number and account number
<table>
<thead>
<tr>
<th>Service</th>
<th>Phone Number</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Missouri Care Prior Authorization</td>
<td>1-800-322-6027 and follow phone prompts</td>
<td></td>
</tr>
<tr>
<td>Member Services</td>
<td>1-800-322-6027 and follow phone prompts</td>
<td></td>
</tr>
<tr>
<td>Provider Relations</td>
<td>1-800-322-6027 and follow phone prompts</td>
<td></td>
</tr>
<tr>
<td>MTM Transportation Services</td>
<td>1-800-695-5791 (Contact Number for Members)</td>
<td></td>
</tr>
<tr>
<td>24 Hour Nurse Line for Member’s Questions</td>
<td>1-800-556-1555 (Contact Number for Members)</td>
<td></td>
</tr>
<tr>
<td>DentaQuest</td>
<td>1-800-341-8478 (Contact Number for Providers)</td>
<td></td>
</tr>
<tr>
<td>DentaQuest</td>
<td>1-888-696-9533 (Contact Number for Members)</td>
<td></td>
</tr>
<tr>
<td>MARCH Vision</td>
<td>1-888-493-4070 (Option 2 for Members, Option 3 for Providers)</td>
<td></td>
</tr>
<tr>
<td>MO HealthNet Eligibility Verification</td>
<td>573-635-8908 (Option 1) or <a href="http://www.eMOMed.com">www.eMOMed.com</a></td>
<td></td>
</tr>
</tbody>
</table>
Missouri Care has a secure Provider Portal available that provides access to the following:

- Account Management
- Submit Primary Claims Online (Professional and Institutional Claims)
- Member Eligibility Information
- Submit Prior Authorizations Online
- Clinical Coverage and Practice Guidelines
- Training Materials
- Reports for the following: Member Panels, Care Gaps, Authorization Status, Claim Status, and Eligibility Status
Log on to www.wellcare.com
1. Select your State “(Missouri)”
2. Select “Provider”
3. Select “Missouri”
4. Select “MO HealthNet”
5. Click on “Go to Logon”

It is important to manage the members assigned to your providers. New members will select a PCP or have a PCP assigned to them.

As a result, it is important to review your Member Panel Reports regularly and schedule needed appointments for the members assigned to your providers in order to manage their care effectively.
Use your previously set up Username and Password.

If you do not yet have a Username and Password, the Administrator for your office will need to create one for you prior to using the secure Web Portal.

If you are the Administrator for your office and have not previously registered, please click on the “Register Now” link to register your office and create a User Name and Password for yourself. As the Administrator, you may also create additional user accounts.
Once you are logged in, click on the “Reports” tab.
Member Panel Reports

**Active Members**
- A quick method of reviewing current member assignment.

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**Authorization Status**
- Allows you to review all the referrals and authorizations that have been submitted and provides detail to ensure accuracy.

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**Claim Status**
- To find the status of one or more claims submitted, you have several options. If you provide service for a variety of health plans, all can be combined in one report. You can narrow your search by specifying a date range, claim type, provider or facility. You can further narrow your search by providing member IDs and person numbers.

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**Eligibility Status**
- To verify a member's eligibility, select the appropriate health plan (s) and enter the member's ID. This feature will accommodate multiple member IDs in a single inquiry.

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**Inpatient Log**
- Up-to-date information on members that have been registered or admitted as an inpatient to a medical facility.

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**Pharmacy Utilization Report**
- Offers you an opportunity to review the prescriptions provided to members.

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Click on “Active Members”
1. Type in Provider ID that you wish to see the member listing for.
2. Click on the “Save” icon and it will ask you what format you would like to save the report in.
3. Once the document is saved it will go directly to your Web Portal inbox on your Secure Provider Portal home page.

As a reminder, if you are set up as a large group and not an individual provider you will need to use the Group ID.
Click on the report that was sent and you will then be able to view the report in the format you selected.
All request are stored in the “Your Inbox” section until you delete them.
Member EPSDT and 120-Day Non-Compliant Reports and Notifications

120 Day Non-Compliance Report
Each month Missouri Care will provide each PCP a list of members who are not in compliance with the periodicity schedule. This includes EPSDT-eligible children who have not had a screen within 120 days of enrolling in Missouri Care.

PCPs are required to make all reasonable efforts to establish satisfactory physician-patient relationships with their assigned members. We provide member contact information as part of the monthly HCY/EPSDT 120 Day and Non-Compliance report.

Notifications to Members
Missouri Care sends written notification to the families with eligible children when appropriate well-child visits are due. In addition, Missouri Care will follow-up with families that have failed to access well-child visits after 120 calendar days of when the well-child visit was due.
Moving Members to a Different PCP

If you’re unsuccessful in reaching a member to schedule an appointment and would like the member moved to a different PCP you may request this from your PR Rep. A member can only be changed to a different PCP if a member has seen another PCP in the past 12 months.

To Initiate this request, please send the list of members (including the Member’s Name and ID Number) to your PR Rep. You may also put a star next to the Report indicating the member isn’t yours. Your PR Rep will request a report detailing if the member has seen another PCP in the past 12 months. If the member has, the PR Rep can move the member to that PCP.

If the Member has not seen another PCP in the past 12 months the member will need to remain assigned to the PCP until the member or another PCP’s office requests the member to be assigned to them.
Member PCP Change Requests

Missouri Care has a PCP Change Request Form for members who are currently assigned to a different PCP and would like to change their PCP.

Please complete the PCP Change Form and have the member sign the form and you may fax the form to the fax number specified.

The member’s PCP will be changed and a new ID card with the new PCP’s name will be mailed to the member.
Missouri Care Provider Orientation

Health Services
Inappropriate Emergency Room utilization is costly and inefficient. Missouri Care encourages providers to help reduce avoidable ER Utilization by educating their patients on when it is appropriate to go to the ER.

Consider the following

- During New Patient Consultations talk to your new patients about when to use the emergency room.
- Give them your 24-hour phone number and make sure they know where the nearest Urgent Care Center is located.
- Offer same day appointments and walk-ins, if possible.
- Provide clear instructions on your website for patients who need care outside of office hours. Be sure to list your after-hours phone number as well as nearby Urgent Care Centers that may provide services, if needed.
- Offer extended hours – before or after regular work hours, or weekend hours, to keep working patients and/or parents out of the Emergency Room.
  - CPT Code: 99050 (Services provided in the office at time other than regularly scheduled office hours, or days when the office is closed (e.g., holidays, Saturday or Sunday) in addition to your E&M code for additional reimbursement.)
- Follow up with your patients that visit the ER for non-emergent conditions to reinforce appropriate use of the ER.
- If you have a patient who is a frequent ER user, please make a referral to our Case Management team.
Prior Authorization

Missouri Care requires prior authorization for elective or non-emergency services. A decision will be provided within 36 hours to include 1 business day. If the standard timeframe could seriously jeopardize the Member’s life or health, Missouri Care will make an expedited authorization determination and provide notice within **24 hours** of the request.

- An extension may be granted for an additional 10 calendar at the Member or the Provider’s request or if there is a need for additional information and the extension is in the Member’s best interest.
- Missouri Care will fax an authorization response to the Provider’s fax number(s) included on the authorization request form.
- All out-of-network services require PA. All new providers must get authorization for every service until they are given an effective date.

Online Prior Authorization Lookup Tool

There is also a searchable Authorization Lookup Tool available on our website at [www.wellcare.com/Missouri/Providers/Authorization-Lookup](http://www.wellcare.com/Missouri/Providers/Authorization-Lookup) that can be used to look up CPT/HCPCS codes to determine if an authorization is required.

- Prior authorizations may be requested through one of the following methods: online via the secure Provider Portal
- Fax
- Phone for urgent requests.
eviCore (formerly known as CareCore National) is our in-network vendor and manages the authorizations for the following services. Please contact eviCore for authorization requests for the following services:

- Advanced Radiology
- Cardiology
- Molecular and genetic laboratory testing
- Pain management
- Physical and Occupational Therapy
- Radiation Therapy Management
- Sleep Diagnostics

For Urgent Authorizations and Provider Services, please call eviCore directly at 1-888-333-8641

To Fax Authorization Request Submissions, please use Fax Number 1-866-896-2152

Web submissions may be submitted via the eviCore Provider Web Portal. A searchable Authorization Lookup and Eligibility Tool is also available online.

Please Note: If the member is a CMPCN member, please contact CMPCN for authorization requests.
Concurrent Review/Discharge Planning
Planning is initiated as soon as Missouri Care is notified of a member’s admission to a hospital, skilled nursing facility or acute rehabilitation facility.

Progeny Health
Progeny Health specializes in NeoNatal Care Coordination services. Their Neonatologists, Pediatricians and partner with the Missouri Care clinical team to provide telephonic care coordination for NICU stays.

Discharge Planning begins upon admission and is designed to identify the member’s post-hospital needs.
• The attending physician, hospital discharge planner, PCP, ancillary providers and/or community resources are required to coordinate care and post-discharge services to ensure that the member receives the appropriate level of care. Care Managers will be consulted for complex discharges and can assist with ensuring a smooth transition.
After enrolling in the Missouri Care Health Plan, all members will receive a Welcome Call that includes a Health Risk Assessment (HRA) Screening.

Members with identified needs will be outreached by a member of the Care Management team to offer Care Management services.

- The member will be matched with a Care Manager whose skill sets match the member’s needs.
- The Care Manager will then schedule a meeting with the member to complete additional assessments that will allow for increased understanding about their health history and needs.

Field-Based, In-Person Care Management
We provide field-based, in-person care management that meets people in their homes or where most convenient and supplement with telephonic outreach and education.

Integrated Care Management
Our care management approach integrates clinical, behavioral, social services, and pharmacy into our 360° view of the member and provides specialized support for members with complex physical, behavioral and social needs.
Members may qualify for Care Management Services for the following reasons:

- Complex illnesses that require the coordination of many services
- Had or are going to have a transplant
- High Risk Pregnancy
- Children in Foster Care
- Experienced Domestic Abuse
- High-Risk Behavioral Health Needs
- Major Depression
- Asthma
- Multiple chronic illnesses
- Children with special healthcare needs

How to Make a Referral

Providers are encouraged to make case management referrals. Referrals may be made through the following methods:

- Call 1-800-322-6027 and follow the phone prompts for Case Management
- Fax a referral to 1-866-946-1104 (the referral form is on the Missouri Care website)
- Contact Kelley Peters RN, Case Management Manager directly at 573-441-2174 or by email at Kelley.Peters@wellcare.com

Disease Management

Our disease management program provides members educational materials to assist them in managing conditions such as Asthma, Coronary Artery Disease, Congestive Heart Failure, Diabetes, Hypertension, Smoking Cessation, Weight Management and Depression.

Our Disease Management team can be reached at: 1-877-393-3090 (TTY 1-877-247-6272).
NCQA awarded Missouri Care an accreditation status of “Accredited” for Service and Clinical Quality that meets or exceeds NCQA’s rigorous requirements for consumer protection and quality improvement.

**NCQA Accredits Health Plans Based On:**

- NCQA Standards / Supporting Documents (50% of score)
- HEDIS and CAHPS Results (50% of score)

**HEDIS (Healthcare Effectiveness Data and Information Set)**

- HEDIS - Ensures Health Plans are Offering Quality Preventive Care and Services
- HEDIS - Allows Consumers to Compare Performance of Health Plans
- **What Can You Do?** – Encourage Members to Close HEDIS Care Gaps

**CAHPS (Consumer Assessment of Healthcare Providers and Systems)**

- **Member Satisfaction Survey** evaluates members’ experiences with health care
- **What Can You Do?** – Promote Customer Satisfaction and Timely Care of Services
HEDIS Can Also Help You

• Identify Non-Compliant members to ensure they receive preventative screenings
• Understand how you compare with other Missouri Care providers as well as with the national average

Strategies to Improve HEDIS

• **Partnerships** - Collaboration with Community and Health Fairs to Improve HEDIS
• **Quality Practice Advisors** - Nurses with HEDIS Expertise Visit Provider Offices
• **Provider Summits** - Share Opportunities to Improve Quality Efforts Around HEDIS
• **Provider Incentives** - PCP/BH Providers with High Volume Members who Close Care Gaps
• **Provider Education** - HEDIS Toolkits and Care Gap Reports
• **Electronic Medical Record (Flat File Transfer)** - Collects HEDIS Data from EMR
• **Member Outreach** - Members Receive HEDIS Services Due Reminders
• **Member Incentives** - Members Rewarded for Completing HEDIS Services
• **Telephonic Outreach** - Call Members in Need of HEDIS Services - schedules appointments
• **Providers** - Capitalize on Member’s Visit by closing Gaps in Care
HCY/EPSDT SCREENING FORM (WELL CHILD VISIT)
Use the State agency’s age-specific HCY Screening and HCY Lead Risk Assessment Guide forms on the internet: http://manuals.momed.com/manuals/presentation/forms.jsp
• Screener must sign and date the form and retain it in the patient’s medical record
• Provider can also document the screenings in an electronic medical record

HCY/EPSDT SCREENING
A full screen must include all of the components listed below. If all of the components are not included, a provider cannot bill for a full screen and is to bill for a partial screen, which includes the first five components below:

- Interval History
- Unclothed Physical Examination
- Anticipatory Guidance
- Lab/Immunizations (Lab and administration of immunizations is reimbursed separately)
- Lead Assessment (Provider must use the HCY Lead Risk Assessment form)

- Development Personal-Social and Language
- Fine Motor/Gross Motor Skills
- Hearing Screening
- Vision Screening
- Dental Screening
What Can You Do To Impact Quality Care

Capitalize on the Member’s Visit

• Close All Care Gaps – Contact Members to schedule appointments for care needed.

• Turn a “Sick Visit” into “HCY/EPSDT Screening” (Well Child Visit)
  Example: The Member comes in for Sick Visit. If the child is due for a well-child visit, treat the sick child and conduct a HCY/EPSDT Screening during the same visit.
  • Review your visit criteria to determine appropriate billing:
    • HCY/EPSDT Screening only (if Sick Visit is minor), or
    • Both HCY/EPSDT Screening and Sick Visit (if major)

• Turn a “Sports Physical” into “HCY/EPSDT Screening”
  Example: Member comes in for Sports Physical. If the child is due for a well-child visit, conduct Sports Physical and HCY/EPSDT Screening.
  • Bill for HCY/EPSDT Screening only
  • Reimbursement for HCY/EPSDT Screening is higher than Sports Physical

• Missouri Care allows one School Physical per year in addition to a Well Child Visit (separate visits).

• Members 3 years or older can receive 1 well-child visit per calendar year (at any time during the year).
**Please note, the above MO HealthNet CPT Codes and rates screen print is subject to change and is for example purposes only. Please refer to the MO HealthNet Fee Schedule available at [https://dssapp3.dss.mo.gov/FeeSchedules/maindisclaimer.shtml](https://dssapp3.dss.mo.gov/FeeSchedules/maindisclaimer.shtml) for the most updated information.**
Medical records should be accurate, comprehensive, and reflect all aspects of care for each member.

**Annual Medical Record Review** assesses the compliance of a random sample of providers with:

- Documented Standards
- Preventative Health Guidelines
- EPSDT Visit Components

Examples a complete medical record should contain:

- Identification of the member: Name, Date of Birth, and Demographics
- The current status of the member, including reason for the visit
- Assessment and clinical impression for diagnosis
- Plan for care and treatment
- Reports and notes from consultations, referrals and specialists
- Appropriate follow-up after hospital admissions and ER visits
- Patient education: verbal, written or by telephone

Results will be shared with providers and a Corrective Action Plan will be required if the score is lower than 80 percent overall. A re-audit will be conducted the following year for providers who score less than 80%.
Missouri Care Provider Orientation

Claims Overview

5/3/2017
Timely Filing and Coordination of Benefits Information

Missouri Care as the Primary Payer
• First submission time filing is defined by your contract

Missouri Care as the Secondary Payer
• Within 365 days from DOS for first submission or resubmission
• Within 90 days from the date of the primary EOB if that is longer than 365 days from date of service

Corrected Claims
• Within 365 days from the Date of Service

Coordination of Benefits (COB)
Missouri Care is always the final payer. If our member has primary insurance, please file the claim with the primary insurance carrier first then submit a claim with the primary carrier’s Remittance Advance to Missouri Care for processing. We will coordinate benefits from the primary insurance carrier’s EOB.

Missouri Care will reimburse the difference between what the primary insurance pays and the allowable if there is a remaining balance.

The member cannot be balance billed for the difference or the contractual write-off amounts.
If you believe the primary insurance has terminated and our system still shows the primary insurance was active, you may email our COB Team and they will contact the primary insurance to verify the coverage dates and update our system if the primary insurance has terminated.

- To contact our COB Team, please send an email to the COB Team at COBValidations@wellcare.com
- Include the member’s First and Last Name and Missouri Care ID Number or MO HealthNet DCN
- If you would like a reply back, please state you’d like a response back after the verification is complete with the outcome of the verification.
Claims Submission Information

Via EDI/Clearinghouse

- McKesson/RelayHealth CPIDs—1844 (Professional) or 8551 (Institutional)
- For Non-McKesson/RelayHealth—14163 (Professional or Institutional)

By Paper
To submit claims by paper, please use the following claims mailing address:

Missouri Care Claims
P.O. Box 31224
Tampa, FL 33631-3224

- The provider’s NPI is required on the claim.
- If a preauthorization number was obtained this must be listed in Box 23 on a 1500 claim form or in Box 63 on a UB-04 claim form.
- Paper claims must be submitted on the red and white claim forms in a typed format. Handwritten claims are not accepted.
Submitting Claims to Missouri Care Electronically

Below are free options available to providers to submit primary and/or secondary claims to Missouri Care.

**MissouriCare.com Secure Provider Portal (allows Primary Claim Submission Only)**
The Missouri Care Provider Portal is only available to participating contracted providers and allows only primary claims to be submitted through the Provider Portal. The Provider Portal does not currently allow secondary claims to be submitted online.

**Relay Health McKesson**
If you have EDI capability and need a free clearinghouse solution to submit EDI claims (secondary payer (COB) claims do not require the physical EOB attachment) and the prior payment information is included in the 837 data, Relay Health McKesson is a free solution clearinghouse available to providers. Relay Health McKesson has the capability to upload EDI claims both 837P and 837I. for WellCare destination payer claims.

To get started – please contact Relay Health McKesson’s subsidiary company, MD-Online by calling 1-888-499-5465 and selecting Option 1 into the main menu and then please select option 2 for Enrollment.

To submit Primary and Secondary claims electronically, you may use the following two options:

**AdminiStep (allows Primary and Secondary Claim Submission)**
Administep allows providers to submit claims to WellCare and offers the ability to submit secondary claims to Missouri Care with the ability to enter the COB payment. This is available for the CMS 1500 and UB04 claim forms. Please visit [www.administep.com](http://www.administep.com) for more information.

**MD-Online (allows Primary and Secondary Claim Submission)**
MD-Online is a Relay Health subsidiary company has Lync 1500 (CMS 1500) entry capability and provides COB submission information. Please visit [www.mdon-line.com](http://www.mdon-line.com) for more information.
Rejected and Denied Claim Information

A **Rejected Claim** is a claim that was not able to be accepted and is not processed. These claims are not in our claims processing system and will not appear on a Remit.

If a claim rejects, you will receive a **Claim Rejection Letter** providing the claim information and a reason explaining why the claim could not be accepted. Common reasons for rejected claims include if the member cannot be found in our system or if information is missing or incomplete on your claim form.

A **Denied Claim** is a claim that was accepted and processed in our claims processing system and assigned a Claim Number. The services that deny will have a Denial Reason Code on the Remit to explain why that service was not able to be paid.
### Common Front End Rejection Reasons

The most common Front End Rejection Reasons include the following:

<table>
<thead>
<tr>
<th>Rejection Description</th>
<th>Grand Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Billing Provider Address contains a PO Box Address. Please verify the information and resubmit a claim with the appropriate Billing Provider Address.</td>
<td>1,672</td>
</tr>
<tr>
<td>Admission Date/Hour may be used on Inpatient Claims only</td>
<td>1,141</td>
</tr>
<tr>
<td>Admitting Diagnosis may be used only when claim involves inpatient admission</td>
<td>974</td>
</tr>
<tr>
<td>Discharge Hour may be used on final inpatient claim only</td>
<td>947</td>
</tr>
<tr>
<td>Date Accident is Required when Condition Being Reported is Accident Related</td>
<td>623</td>
</tr>
<tr>
<td>The Insurance ID of the patient may have recently changed and is not eligible for benefits under this plan on the Date of Service.</td>
<td>22,740</td>
</tr>
<tr>
<td>The patient was not eligible for benefits under this plan on the date(s) of service using the patient information submitted (ID Number, DOB, Name, Address).</td>
<td>10,228</td>
</tr>
<tr>
<td>We are unable to identify the patient on this claim as our member using the patient information submitted (ID, DOB, Name, Address).</td>
<td>8,424</td>
</tr>
<tr>
<td>Some or all of the Billing or Rendering Provider Information (Tax ID Number, Provider Name, Provider Address) on this claim is either missing, invalid or ineligible.</td>
<td>1,473</td>
</tr>
<tr>
<td>A National Provider ID (NPI) is required in the Rendering Provider field (2310B NM 109 for EDI 837P or 24J on a CMS 1500 claim form).</td>
<td>1,110</td>
</tr>
</tbody>
</table>
Corrected Claims and Voided Claims Information

Differences Between Corrected Claims and Voided Claims

A Corrected Claim is a claim that has already been processed, whether paid or denied, and is resubmitted with additional charges, different procedure or diagnosis codes or any information that would change the way the claim originally processed.

A Voided Claim is for a claim that you have submitted a claim in error.

<table>
<thead>
<tr>
<th>When to Submit a Corrected Claim</th>
</tr>
</thead>
<tbody>
<tr>
<td>The original claim was filed with an incorrect Procedure Code or Diagnosis Code, etc.</td>
</tr>
<tr>
<td>The original claim was filed with an incorrect billed charge amount</td>
</tr>
<tr>
<td>Original claim filed with incorrect units</td>
</tr>
<tr>
<td>Original claim filed with the incorrect primary insurance payment information</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>When to Submit a Voided Claim</th>
</tr>
</thead>
<tbody>
<tr>
<td>The original claim was filed in error</td>
</tr>
<tr>
<td>The original claim was filed under an incorrect patient</td>
</tr>
<tr>
<td>A duplicate claim was billed in error for the same services</td>
</tr>
<tr>
<td>Original claim filed as primary instead of secondary</td>
</tr>
</tbody>
</table>
How to Submit a Professional 1500 Claim via EDI and on a Paper Claim Form

How to Send a Corrected Claim via EDI

• Loop 2300 Segment CLM composite element CLM05-3 should be “7” to indicate you are submitting a Corrected Claim or “8” to indicate you are voiding the claim.
• Loop 2300 Segment REF element REF01 should be “F8” indicating the following number is the control number assigned to the original bill (original claim reference number).
• Loop 2300 Segment REF element REF02 should be ‘the original Claim Number’ - the control number assigned to the original bill (original claim reference number for the claim you are intended to replace.)

How to Send a Corrected Claim via a paper CMS 1500 Claim Form

For Professional Claims
The provider must include the original WellCare Claim Number and Bill Frequency Code per industry standards. When submitting a Corrected or Voided claim, enter the appropriate Bill Frequency Code left justified in the left-hand side of Box 22 and the WellCare Claim Number in the right-hand side of Box 22.

In the “Medicaid Resubmission Code” field, list “7” to indicate you are submitting a Corrected Claim or list “8” to indicate you are voiding the claim. **Note, if a Claim Number is not listed for a voided claim, all claims for the same member, Date of Service and provider will be voided.

In the “Original Ref. No” field, please list the WellCare Claim Number for the claim you are correcting.
How to Submit a UB-04 Corrected Claim

The provider must include the original Missouri Care Claim Number and Bill Frequency Code per industry standards.

In Box 4 – Type of Bill: The third character represents the “Frequency Code”.

In Box 64 list the Missouri Care Claim Number of the claim you are correcting. The Claim Number is listed on the Remittance Advice.
How to Submit a Corrected Claim via the Secure Provider Portal

To edit a claim, the Missouri Care Secure Provider Portal immediately prompts in red asking the provider to enter required information. If this information is entered incorrectly, the claim will reject immediately and the claim will not be submitted. The following information is required:

- Billing Provider NPI
- Rendering Provider NPI
- Claim Frequency Type Code (please choose option “7” for a corrected/replacement claim)

Any field with an * is required.

For Corrected Claims, the provider must list the Claim Number of the claim being corrected in the “Previously Submitted Claim ID” field.
Prompt Pay
Missouri Care adheres to the Missouri Prompt Pay statutes. The current prevailing Missouri interest rate and penalties will be applied for electronically submitted clean claims paid more than 45 days after receipt.

Individual participating provider agreements may contain provider-specific prompt pay and interest agreements that differ from state or federal requirements.

- In First Quarter 2017, Missouri Care processed 87% of claims in 10 calendar days, 93% in 20 days, and 99% in 30 days.

- For Calendar year 2016 Missouri Care processed 85% of claims in 10 days, 95% in 20 days, and 99% in 30 days.

Coding Software
Missouri Care uses a commercial software package which relies upon Government Programs and other industry standards in the development of its guidelines.

We also update internal payment systems in response to additions, deletions, and changes to Government Sponsor, CMS, and other industry standards.
The MO HealthNet Fee Schedule is available at the following link
https://dssapp3.dss.mo.gov/FeeSchedules/maindisclaimer.shtml

Click on the link for the appropriate category for the CPT Code or Modifier you are wanting to view the allowed amount or modifier information for.

Next, click the radio button next to the “Proc Code” or “Modifier” and type in what Procedure Code or Modifier.

The search will show you if the CPT Code and/or modifier combination are payable.

**Please note, the above MO HealthNet fee schedule information screen print information is subject to change and is for example purposes only. Please refer to the MO HealthNet Fee Schedule available at the above website address for the most updated information.**
Generally, Missouri Care expects the modifiers to be billed in the same order as they appear on the MO HealthNet Fee Schedule. Informational modifiers should be billed after the MO HealthNet required modifiers.

For example, for ‘Other Service’ billed with code H2025, the modifiers HX and HQ should be billed as H2025 HX HQ.

**Specific Exceptions**

- Consistent with MHD’s Physician’s provider manual (Section 9.6), for partial EPSDT screenings, the modifiers indicating a partial screen should be billed first (e.g., 99381 52 EP).

- For Durable Medical Equipment (DME) services, the modifiers indicating whether an item is new (NU) rental (RR) or repair (RB) should be billed in the first field; if other modifiers are appropriate, those modifiers should be billed in the order on the MO HealthNet Physicians Fee Schedule.

- For surgery services, the modifiers related to ‘Postoperative Services’ (modifier 55), ‘Without Postoperative Services’ (modifier 54), and ‘Assistant Surgery’ (modifier 80) should be billed in the first field; if other modifiers are appropriate, those modifiers should be billed in the order listed on the MO HealthNet Physicians Fee Schedule.
Missouri Care utilizes the MO HealthNet list of acceptable modifiers. Please refer this list available on MO HealthNet’s website to determine if a modifier will be accepted. [https://dssapp3.dss.mo.gov/FeeSchedules/modifiers.aspx](https://dssapp3.dss.mo.gov/FeeSchedules/modifiers.aspx)

**Please note, the above MO HealthNet Modifier List screen print is subject to change and is for example purposes only. Please refer to the MO HealthNet Acceptable Modifier List available at the above website address for the most updated information.**
The MO HealthNet Billing Manuals are available at the following website address:
http://manuals.momed.com/manuals/
If there is a third party payer indicated on the eligibility file for the member, Missouri Care will cost avoid the claim and require that the provider to file the claim first with the primary insurance carrier.

If there is not a third party payer indicated on the eligibility file for the member, Missouri Care will pay the claim.

If, after paying a claim, Missouri Care determines there is a third party payer, we will seek to recover payment from the primary insurance carrier.
EPSDT Screening Billing

We follow the MO HealthNet Billing Manual regarding EPSDT Screening services.

• The EPSDT visit must be billed with ICD-10 codes Z00.110, Z00.111, Z00.121 or Z00.129 and **must** be shown as the primary diagnosis.

• The Complete EPSDT visit must be billed with modifier EP.

• The EPSDT visit can be billed with an Office Visit and the Office Visit must be billed with an illness ICD diagnosis code and modifiers EP 25.

• School Physicals should be billed as an EPSDT visit with modifiers 52 EP to indicate a partial screening.

• There isn’t a 365 day rule. Missouri Care allows only **one** EPSDT visit per calendar year.
Early Elective Delivery Billing

Missouri Care follows the MO HealthNet policy and does not reimburse for Early Elective Deliveries, or deliveries prior to 39 weeks gestational age that are not medically indicated. Early Elective Delivery is defined as a delivery by induction of labor without medical necessity followed by a delivery or a delivery by C-Section before 39 weeks gestation without medical necessity. A delivery following non-induced labor is not considered an Early Elective Delivery regardless of gestational weeks.

To identify an early elective delivery service, the gestational age/delivery is required on the CMS 1500 claim form. Field 19 of a paper claim must have the below information provided or for electronic 827P claims, Loop 2300, or 2400, NTE, 02.

When billing claims, only the four alphanumeric characters will be accepted. Do not put any additional information in the field otherwise the claim will deny. Do not add a space in between the characters (i.e 40LV).

The first two digits indicate the gestational age based on the best obstetrical estimate. They must be numeric characters and values from 20 through 42.

The third and fourth digits represent the method of delivery. They must be one of the following alpha characters:

- 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

If the indicator contains an IV, IC, CN, or CS and the gestational age is less than 39 and there is a medical indication for an early delivery, the claim will be exempt from the editing.

The ACOG lists the conditions that may be indications for early induction of labor and delivery to determine diagnosis codes that are appropriate to justify an early delivery. Claims without a qualifying diagnosis will be denied.
Billing Members

Missouri Care members should not be billed, or reported to a collection agency for any **covered services** your office provides.

Missouri Code of State Regulations Title 13 CSR 70-4.030 states in part, “When an enrolled Medicaid provider provides an item or service to a Medicaid recipient eligible for the item or service on the date provided, there shall be a presumption that the provider accepts the recipient’s Medicaid benefits and seeks reimbursement from the Medicaid agency in accordance with all the applicable Medicaid rules.”

If a member receives a bill and contacts our office, a Missouri Care staff member may contact your office as well to confirm the member will no longer be charged for the service.

The provider’s office can file a Claims Dispute or an Appeal if the service was paid incorrectly or denied. The provider must submit the Claims Dispute or Appeal within the appropriate timeframes.
Missouri Care has contracted with the following laboratories for in-network laboratory services for our members. Please utilize lab services from one of these providers below.

<table>
<thead>
<tr>
<th>Contracted In-Network Lab</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Aegis Sciences Corporation</td>
<td>Calloway Laboratories</td>
</tr>
<tr>
<td>Myriad Genetic Laboratories</td>
<td>Quest Diagnostics</td>
</tr>
<tr>
<td>AIM Laboratories</td>
<td>Diatherix Laboratories</td>
</tr>
<tr>
<td>Neuroquest</td>
<td>Renaissance Rx</td>
</tr>
<tr>
<td>American Toxicology Institute</td>
<td>Dominion Diagnostics</td>
</tr>
<tr>
<td>Pathgroup Labs</td>
<td>Saint Lukes Health System Laboratories</td>
</tr>
<tr>
<td>Ameritox</td>
<td>Interlab</td>
</tr>
<tr>
<td>Medical Diagnostic Laboratories</td>
<td>Saint Lukes Regional Laboratories</td>
</tr>
<tr>
<td>Ascendant MDX</td>
<td>Laboratory Services Cooperative</td>
</tr>
<tr>
<td>Medtox Laboratories</td>
<td>Signature Genomic Laboratories</td>
</tr>
<tr>
<td>Associated Clinic Labs</td>
<td>Lifewatch Services</td>
</tr>
<tr>
<td>Millennium Health</td>
<td>Tamarac Medical</td>
</tr>
<tr>
<td>Associated Pathologists</td>
<td>Litton Pathology Associates</td>
</tr>
<tr>
<td>Lab Test, LLC</td>
<td>Therapath</td>
</tr>
<tr>
<td>Bio-Reference Laboratories</td>
<td>MAWD Pathology</td>
</tr>
<tr>
<td>LabCorp of America</td>
<td>Toxic Diagnostic Services</td>
</tr>
<tr>
<td>Boyce and Bynum Pathology Laboratories</td>
<td>My Blooming Health Mobile</td>
</tr>
<tr>
<td>Physicians Reference Laboratory</td>
<td></td>
</tr>
</tbody>
</table>
All pharmacy charges on an outpatient basis should be billed to MO HealthNet.

Example: For an IUD insertion, the charge for the IUD itself (a pharmaceutical) should be billed to MO HealthNet. The office visit and related charges should be billed to Missouri Care.

Pharmacy services provided during inpatient and observation stays should be billed to Missouri Care.
A **Complaint** is a written expression by a provider, which indicates dissatisfaction or dispute with health plan policy, procedure, claims processing time, etc. or any aspect of health plan functions. These are filed to our Appeals Department with documentation supporting why you are requesting the policy change.

A **Dispute** and an **Appeal** are written expressions by a provider in which a provider disagrees with the processing of a claim. Filing a Dispute is the first step. If the Claims Dispute Team agrees the claim was processed incorrectly, the claim will be adjusted. If the Claims Dispute Team upholds the processing, a letter will be mailed to the pay-to address. If you disagree with the Claims Dispute outcome, you may file an appeal.

**Dispute**

Providers must first file a Dispute within **365** days from the date of the Explanation of Payment.

Disputes may be submitted through the following methods:
- The “Claim Inquiry” option on the Secure Provider Portal
- By fax at 1-877-277-1808, Attn: Claims Dispute Team.
- Through Customer Service

**Appeal**

Appeals may be submitted within **90 days** from an adverse determination through the following methods:
- By Fax: 1-877-851-2043, Attn: Appeals Department
- By Mail:
  - Missouri Care
  - Attn: Appeals Department
  - 4205 Philips Farm Road, Suite 100
  - Columbia, Missouri 65201

After 45 days, to check the status of an appeal, please send a fax to our Appeals Department with the claim information for the appeal you filed.
Claim Overpayments

If you identify an overpayment, please submit the Refund Request Form.

Provider Refund Request and Refund Submission Form

Request Date: __________________________

Fill out the form completely and keep a copy for your records. Your refund request and refund will be reviewed and processed once all necessary documentation is received. Please allow 20 days for a response or posting of refund. If all necessary documentation is not received, a response may surpass the 20 day timeframe.

☐ Skilled Nursing Facility  ☐ Physician/Allied Health Practitioners
☐ Hospital  ☐ Other Health Care Providers (Lab, DME, etc.)
☐ Home and Community Based Providers (Foster Home, Home Care, etc.)

Provider Information

Name: __________________________
Provider #: __________________________
Tax ID #: __________________________
Telephone: __________________________
Check #: __________________________
Contact Person: __________________________

Patient Information

Name: __________________________
Member Id #: __________________________
Date of Birth: __________________________

Service Provided Information

Date(s) of Service: __________________________
Place of Service: __________________________

Claim(s) Number: __________________________
Claim(s) Number: __________________________

Reason for Request or Refund:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

By signing this form, you agree to these terms and will not bill the member, except for applicable copays.

Signature: __________________________  Date: __________________________

Payment Mailing Address: P.O. Box 31584 | Tampa, FL 33631-3684
Correspondence Mailing Address: P.O. Box 31588 | Tampa, FL 33631-3684
Telephone: 1-877-385-0457 | Fax: 813-205-6284
Missouri Care has additional billing guides available for the below specialties:
• Ambulatory Surgery Center
• DME
• Home Health
• Hospital/Facility
• Pregnancy and OB Billing
• Rural Health
• Therapy Services

If you’re interested in receiving this additional information, please contact your Provider Relations Representative.
Missouri Care Provider Orientation

Member Resources
Missouri Care continues to look for new ways to improve the health of our members. “Why” a member selects our Plan is very important for us to understand.

Missouri Care’s Community Relations Team and Community Advocates participate in hundreds of events each year impacting thousands of members, collaborate on health initiatives, host New Member Orientation Meetings and volunteer in the communities we serve.

**Partnerships**

We are proud to have partnerships with the following organizations:

- MO Community Partnership
- Maternal Child & Family
- WIC/Health Department
- FQHCs and RHCs
- St. Louis Regional Health Commission
- City of Life Church
- Parents as Teachers
- Big Brothers Big Sisters
- LINC
- AARP
- Parks and Recreation
- Mid America Regional Council
- Immunization Task Force
- Maternal and Child Coalition
- Black Health Care Coalition
Missouri Care offers the following additional benefits in addition to the MO HealthNet benefits.

**WEIGHT WATCHERS®**
- Gives you access to traditional Weight Watchers meetings and online subscriptions; members can attend 26 meetings a year
- **What’s Covered**
  - Membership fees
- **Who’s Eligible**
  - All qualified Missouri Care members age 13 and up

**CURVES® COMPLETE**
- A 3-month membership for qualified members; the program’s goal is to support healthy lifestyles and improve health outcomes
- **What’s Covered**
  - Membership fees
- **Who’s Eligible**
  - All qualified Missouri Care members age 12 and up

**PEAK FLOW METERS**
- A peak flow meter is used to measure how well air moves out of your lungs. Measuring peak flow is an important part of managing asthma. This can help you prevent an asthma attack.
- **What’s Covered**
  - Peak flow meter
- **Who’s Eligible**
  - Members with asthma

**ENHANCED TRANSPORTATION**
- Trips to:
  - A pharmacy right after a medical appointment
  - WIC appointments
  - Child birthing, breastfeeding or similar classes
  - Hospital for parents visiting a child
  - Methadone clinic
  - Behavioral health inpatient
  - Residential facility for parents to take part in family therapy
- **Who’s Eligible**
  - All Missouri Care members (some exclusions may apply)

**MATERNITY SUPPORT HOSE & SUPPORT BELTS**
- These items are provided at no cost; no prior authorization is needed
- **What’s Covered**
  - Maternity support hose and support belts
- **Who’s Eligible**
  - Pregnant members

**BOY SCOUTS**
- Children can receive no-cost membership to the Boy Scouts. (summer camp not offered)
- **What’s Covered**
  - Annual membership
- **Who’s Eligible**
  - Missouri Care members*

**BOYS & GIRLS CLUBS**
- Children can receive no-cost membership to the Boys & Girls Clubs. (does not include summer and program fees)
- **What’s Covered**
  - Annual membership
- **Who’s Eligible**
  - Missouri Care members*

**GIRL SCOUTS**
- Children can receive no-cost membership to the Girl Scouts. (summer camp not offered)
- **What’s Covered**
  - Annual membership
- **Who’s Eligible**
  - Missouri Care members*

**4-H CLUB**
- Children can receive no-cost membership to the 4-H Club. (summer camp not offered)
- **What’s Covered**
  - Annual membership
- **Who’s Eligible**
  - Missouri Care members*
Missouri Care offers a CommUnity Assistance Line. It is available to anyone at no cost and provides access to assistance for services that include help paying for utilities and rent, access to healthy food, reduced-cost or no-cost child care and more. The number is **1-866-775-2192** and the video relay number is **1-855-628-7552**. The hours of operation are from 8 a.m. to 5 p.m. Central Time.
Healthy Behaviors Rewards Program

Members Receive Rewards for Completing the following:

• **New Members** - Health Risk Assessment
• **Children’s Health** - Well Child Visits
• **Adult Health** - Annual Adult Screening
• **Well-Woman Screening** - Annual Well-Woman Screening
• **Prenatal Care** - 1 Prenatal Visit within 1st Trimester (or 42 days of enrollment)
• **Postpartum Care** - 1 Postpartum Visit within 21-56 days after Delivery
• **Diabetes** - Retinal/Dilated Eye Exam This Year, or Negative Retinal/Dilated Eye Exam Last Year
• **Diabetes** - Complete HbA1C Lab Test
• **Behavioral Health (BH)** - See BH Provider within 7 days after BH Hospitalization

How the Healthy Rewards Program Works

• Providers complete the form on Healthy Rewards Brochure and mail to Missouri Care
• Members receive a reloadable debit card from $10 - $20 for each service
• The debit card is redeemable at designated retailers
Missouri Care is proud to offer COBALT.

COBALT provides free online courses for members and their caregivers for a variety of topics including:

- Restore – For Difficulty Sleeping
- Shade – For Alcohol or Substance Abuse
- Fearfighter – For Anxiety, panic and phobias
- Moodcalmer – For mild to moderate depression

To access the service, members can register at [wellcare.cobaltcbt.com](http://wellcare.cobaltcbt.com) then click “Create Account Now.”
Advocates for Family Health can help members with the following:

- If a member needs help understanding their rights and benefits under MO HealthNet Managed Care
- The member feels their rights to health care are being denied
- The member is not able to solve the problem by talking to a PCP, a nurse or their MO HealthNet Managed Care health plan.
- The member wants help when filing a grievance
- The member needs help when appealing a decision by their MO HealthNet Managed Care health plan
- The member needs help getting a State Fair Hearing

Our members may receive legal help at no cost to them by contacting the Legal Aid office for their county.

Additional information is available in our Member Handbook available at https://www.wellcare.com/Missouri/Members/Medicaid-Plans/Missouri-Care
Thank you for participating in our Provider Orientation!