Show Me Healthy Kids

MANAGED BY HOME STATE HEALTH

home state health

Show Me Healthy Kids Claim Support and Portal Training

How Do I Submit Claims?

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Portal Submission – Used When Credentialing is *Completed*

Submit Claims Electronically through your Preferred Clearinghouse:

- Emdeon
- SSI
- Trizetto Provider Solutions
- Availity

Behavioral and Medical Claims are Processed through Home State Health, but on Separate Platforms with Different Payer ID's:
Home State's *Medical Payer ID* is 68069
Home State's *BH Medical Payer ID* is 68068

For more information please visit:
Electronic Transactions | Home State Health

Provider Portal

- **Group NPI must be registered with MMAC before gaining access to the secure portal.**
- To register, please go directly to https://www.homestatehealth.com/login.html, register for a username and password, then select the "Claims Role Access" module.

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

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

PaySpan® Payment and Remittance Advice

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- Home State and **PaySpan** Health have partnered to provide **Electronic Fund Transfer (EFT)** and **Electronic Remittance Advice (ERA)** services
- This service is FREE
- **ERA's** can be imported directly into Practice Management systems
- Once contracted, **PaySpan** will issue a registration code and the online enrollment process takes 5 to 10 minutes to complete.
- To obtain a unique registration code contact PaySpan Provider Services at: **877-331-7154 (Option 1)**
- Contact Provider Services for more information or visit www.PaySpan.com

CMS 1500 Form

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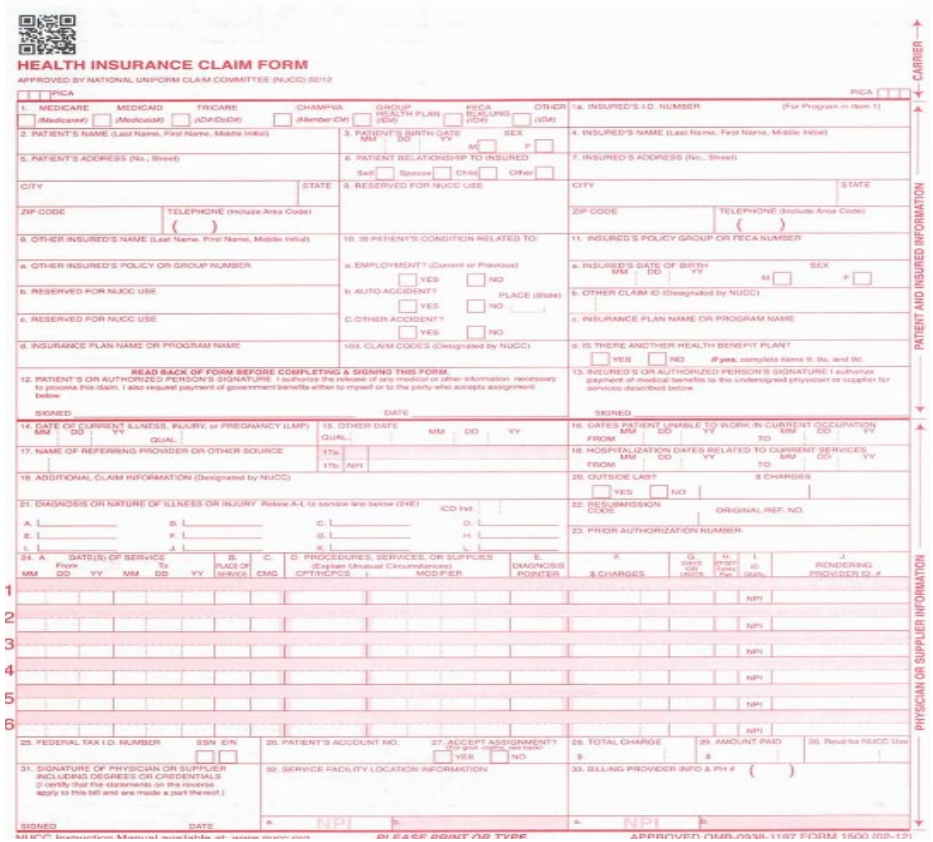
While waiting for group NPI registration with MMAC, you may submit paper claims on a CMS 1500. CMS 1500 form contains unique medical codes detailing the care administered during the member's visit.



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (SSN) FECA BLKLUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE MM DD YY QUAL.

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D. E. F. G. H. I. J.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

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

1 NPI

2 NPI

3 NPI

4 NPI

5 NPI

6 NPI

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

What Information Does A Claim Contain?

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Claim Header:

- National Provider Identifier (NPI) for the attending physician and the service facility
- Primary diagnosis code
- Inpatient procedure, if applicable
- Diagnosis-related group (DRG)
- Name of the patient's insurance company, and
- Overall charge for the claim

Claim Detail:

- Date of service
- Procedure code
- Corresponding diagnosis code
- National Drug Code (NDC), if applicable
- Attending physician's NPI number, and
- Charge for the service

For additional details on claim submission please see Provider Manual Billing and Claims Submission section here: https://www.homestatehealth.com/content/dam/centene/home-state-health/pdfs/HSH_SMHK%20Provider%20Manual%20508%20Compliant%2012272022.pdf

Completing a CMS 1500 Claim Form

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Home State Health has a step-by-step billing guide located in the Provider Manual starting on page 81 on the pdf link below.

Provider Manual Link

- Required (R) fields must be completed on all claims.
  - ➢ Any required fields that are missing – claims will be rejected.
- Conditional (C) fields must be completed if the information applies to the situation, or the service provided.

Please see the example from Provider Manual:

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

Note: Therapy and Professional services are billed on the 1500 claim form.

Primary Diagnosis

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What is a Primary Diagnosis?

The primary diagnosis refers to the patient condition that demands the most provider resources during the patient's stay. There is often confusion surrounding primary and principal diagnoses and, consequently, the terms are commonly used interchangeably. While these can be (and frequently are) the same diagnosis in practice, their definitions are distinct. While a principal diagnosis is the underlying cause of patient symptoms, the primary diagnosis is used for healthcare billing purposes.

Why are Primary Diagnoses Important in Healthcare?

Primary diagnoses play an important function in how providers are reimbursed for healthcare services. Whether it is diagnosis-related grouping (DRG) or ICD-10 coding, the primary diagnosis is used to inform the payer how much the provider is owed after a medical claim is submitted.

What Is An ICD-10 Code

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The ICD-10 is a code system that contains codes for diseases, signs and symptoms, abnormal findings, circumstances and external causes of diseases or injury.

Mental, Behavioral and Neurodevelopmental Disorders F01-F99

What does an ICD-10 code looks like?

- ICD-10-CM Diagnoses Codes are 3–7-character codes
  - Character 1 is alphabetic
  - Character 2 is numeric
  - Characters 3–7 are alphabetic or numeric, with a decimal after 3rd digit
    - Example: Generalized anxiety disorder- F41.1

Basic Intro to ICD-10 Code:
Training Link ICD -10 Codes

Note: Have you signed up for MO Healthnet News?
https://dss.mo.gov/mhd/providers/index.htm#GD-snippet-form
Provider Bulletins can assist with Coding and Fee Schedules
https://dss.mo.gov/mhd/providers/pages/bulletins.htm

What Is A HCPCS Code?

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HCPCS: Healthcare Common Procedure Coding System

- A HCPCS code (pronounced hicks-picks) is a five-digit code containing 1 letter and 4 numeric characters. (example: K0108, E0630)
- There are 2 levels of HCPCS
  - Level I codes are based on CPT codes. They're used for services and procedures offered by healthcare providers.
  - Level II codes cover health care services and procedures that aren't performed by healthcare providers. Examples of items billed with level II codes are medical equipment, supplies, and ambulance services.

HCPCS level II code lists can be found on the **CMS website**. Level I codes, however, are copyrighted by the AMA just like CPTs. **(CPT Codes: Format, Categories, and Uses verywellhealth.com))**

What Is A CPT Code

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CPT code is a code billed to insurer to indicate the services rendered to a patient.

CPT: Current Procedural Terminology

- A CPT code is a five-digit numeric code (example: 99214, 99306)

Matching CPT Codes to Services rendered:

- Complete a CPT code search on the **American Medical Association website.** You will have to register (for free). You are limited to five searches per day. You can search by a CPT code or use a keyword to see what the code for a service might be. **(CPT Codes: Format, Categories, and Uses (verywellhealth.com))**
- Please use our Prior Authorization tool located on our website under Provider Resources to validate if that is a covered benefit or if prior authorization is required. **https://www.homestatehealth.com/providers/pre-auth-needed/medicaid-pre-auth.html**

Covered Services 7/1

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Psychiatric Residential Treatment Facility (PRTF)

- As of July 1, 2022, MHD managed care plans began covering **PRTF** services for their members.
- Providers must bill HCPCS code H2013
- Please see for reference: **https://dss.mo.gov/mhd/providers/pdf/bulletin44-32.pdf**
- Providers must submit claims for other behavioral health services (e.g., **individual, family, and group psychotherapy**) to Home State Health for SMHK members rather than to MHD. In order to ensure continuity of care, Home State Health will cover out of network providers who are already serving this population for a period of six months.
- The vast majority of COA 4 participants will be covered by SMHK/Home State Health, but children and youth who have opted out of managed care will be covered through fee-for-service.

Residential CCS Services

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Providers must bill HCPCS code H0019 and the appropriate modifier for facility type and treatment level

Qualified Residential Treatment Program

Facility Type	Level 2	Level 3	Level 4
QRTP	H0019 HK	H0019 HK TF	H0019 HK TG
Non-QRTP	H0019 HA	H0019 HA TF	H0019 HA TG

Procedure Code	HCPCS Standard Description
H0019	Behavioral health; long-term residential (non-medical, non-acute care in a residential treatment program where stay is typically longer than 30 days), without room and board, per diem

PRTF Bulletin Billing draft (mo.gov)
SMHK Residential Codes and Rates Bulletin Final (mo.gov)
PRTF Bulletin Billing (mo.gov)

Covered Services 10/1/2022

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PHASED IMPLEMENTATION SMHK went live on July 1, 2022

- In order to allow adequate time for provider training, credentialing, and system changes, coverage of residential and treatment foster care (TFC) services by the specialty plan will not be implemented until October 1, 2022.

- The services below are covered only for participants with the following medical eligibility codes: (Children's Division: 07, 08, 37, 38, 66, 0F; Adoption/Guardianship Subsidy: 36, 56, 57, 5A). **CD will continue to pay room and board to residential facilities for individuals receiving services through MHD fee-for service and for individuals receiving services through SMHK/Home State Health.**

Treatment Foster Care & Transition Treatment Foster Care

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- Providers must bill for TFC with HCPCS codes H2020. Modifiers are not required for this service.
- Providers must bill for Transition TFC with HCPCS code H2022 and modifier HE.

Provider	Service	Proc code / Mod	HCPCS Description
TFC	TFC	H2020	Therapeutic behavioral health services, per diem
TFC	Transition TFC	H2022 HE	Community based wrap-around services, per diem

PRTF Bulletin Billing draft (mo.gov)
SMHK Residential Codes and Rates Bulletin Final (mo.gov)
PRTF Bulletin Billing (mo.gov)

Residential Aftercare

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Providers must bill for aftercare services with HCPCS code H2022 and the appropriate modifier for facility type

Facility Type	Procedure code / modifier
QRTP	H2022 HK
Non-QRTP	H2022 HA

Procedure Code	HCPCS Standard Description
H2022	Community based wrap-around services, per diem

PRTF Bulletin Billing draft (mo.gov)
SMHK Residential Codes and Rates Bulletin Final (mo.gov)
PRTF Bulletin Billing (mo.gov)

What Happens When Claim is Submitted

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When claim submitted on paper

- Once received a clean claim processes within 30 - 45 days.
- There are 180 days to submit a claim for timely filing.
- Validate claim status by contacting Provider Services at 1-877-236-1020.
- Rejected claims will be followed up with a letter of notification.

When submitted electronic

- Once received a clean claim processes within 30 - 45 days.
- There are 180 days to submit a claim for timely filing.
- Pending, paid, and denied status with reason codes appear on provider portal once clean claim is received in system.
- Rejected claims will not enter our pre-adjudication process. Please work with your clearinghouse to identify and resubmit claim for processing.

Avoid Claim Denials

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Most common claim denials:

- Incorrect Diagnosis Code Used
- Incorrect Claim Form (CMS 1500 must be used)
- Member Ineligible for Home State Health Services
  - *Always check MO HealthNet* ***www.emomed.com***
  - *Call Provider Services at 1-877-236-1020*
- Incorrect Payer ID Used (Behavioral vs. Medical)
- Form was Signed!
- Black/White Form Submitted
- Handwritten Forms Submitted

Claims Support

Show Me Healthy Kids
MANAGED BY HOME STATE HEALTH

Contact Home State Health's **Provider Services** Team, Monday through Friday from 8AM – 5PM, 1-877-236-1020

Submission	Address
First Time Claims and Corrected Claims:	Home State Health Plan Claim Processing Department P. O. Box 4050 Farmington, MO 63640- 3829 Home State Health Behavioral Health Attn: Claims PO Box 7400 Farmington, MO 63640-3827
Claim Reconsiderations:	Home State Health Plan Attn: Claim Reconsideration P. O. Box 4050 Farmington, MO 63640- 3829
Claim Appeals:	Home State Health Plan Attn: Claim Appeal P. O. Box 4050 Farmington, MO 63640-3829

Note: You must obtain a Provider Services Reference Number First Before Escalating Issues To a Provider Network Specialist

Claims Escalation Process

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- Call Provider Services per Applicable Line of Business (number on the back of ID card) to Inquire About Claim. (Obtain Representative's Name and Reference Number)

- Submit Claim Reconsideration
  - ➢Provider Portal https://www.homestatehealth.com/login.html
    (Obtain Reference Number)
  - ➢Mail Paper Reconsideration if Portal isn't Functioning Properly or Claim Number can't be Located. (Forms are Located on Website per Line of Business).

- If you have called Provider Services and/or sent in a Claim Reconsideration, and there are more than 10 claims, please complete Claim Escalation Excel Spreadsheet and email to our Claims Integrity Department, MO_Claims_Integrity@homestatehealth.com.
  (Ensure Original Provider Services Reference Number is Noted on Spreadsheet)

- Submit Claim Appeal. (Forms are Located on Website per Line of Business).

Provider Services

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Provider Representative Specialists Assist with:

- Appeal and claim reconsideration guidance
- Member benefits and eligibility
- Our Find a Provider online directory
- Authorization requirements
- Claim submission requirements
- Evidence of payment (EOP)/remittance advice support
- PaySpan (EFT/ERA) assistance
- Provider data review
- Payment and clinical policy questions
- Website/portal questions, including password reset

Provider Engagement Administrator

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Provider Engagement Administrators Assist with:

- Product education
- Sharing provider resources/tools
- Policy and procedure protocols
- Use of the secure provider portal
- Core business functions
- Access and availability oversight
- Quality and credentialing site visits

Helpful Links:

Show Me Healthy Kids
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Home State Health Provider Resources	Missouri Provider Resources | Home State Health
Basic Intro to ICD-10 Codes	ICD-10 Codes Link
American Medical Association	American Medical Association Link
Home State Health Show Me Healthy Kids	Show Me Healthy Kids (homestatehealth.com)
PaySpan (Electronic Funds Transfer)	Payspan | Login Page (payspanhealth.com)
Home State Secured Provider Portal	Log In (entrykeyid.com)

Portal Overview

Secure Provider Portal Introduction

The Provider Portal allows providers to:

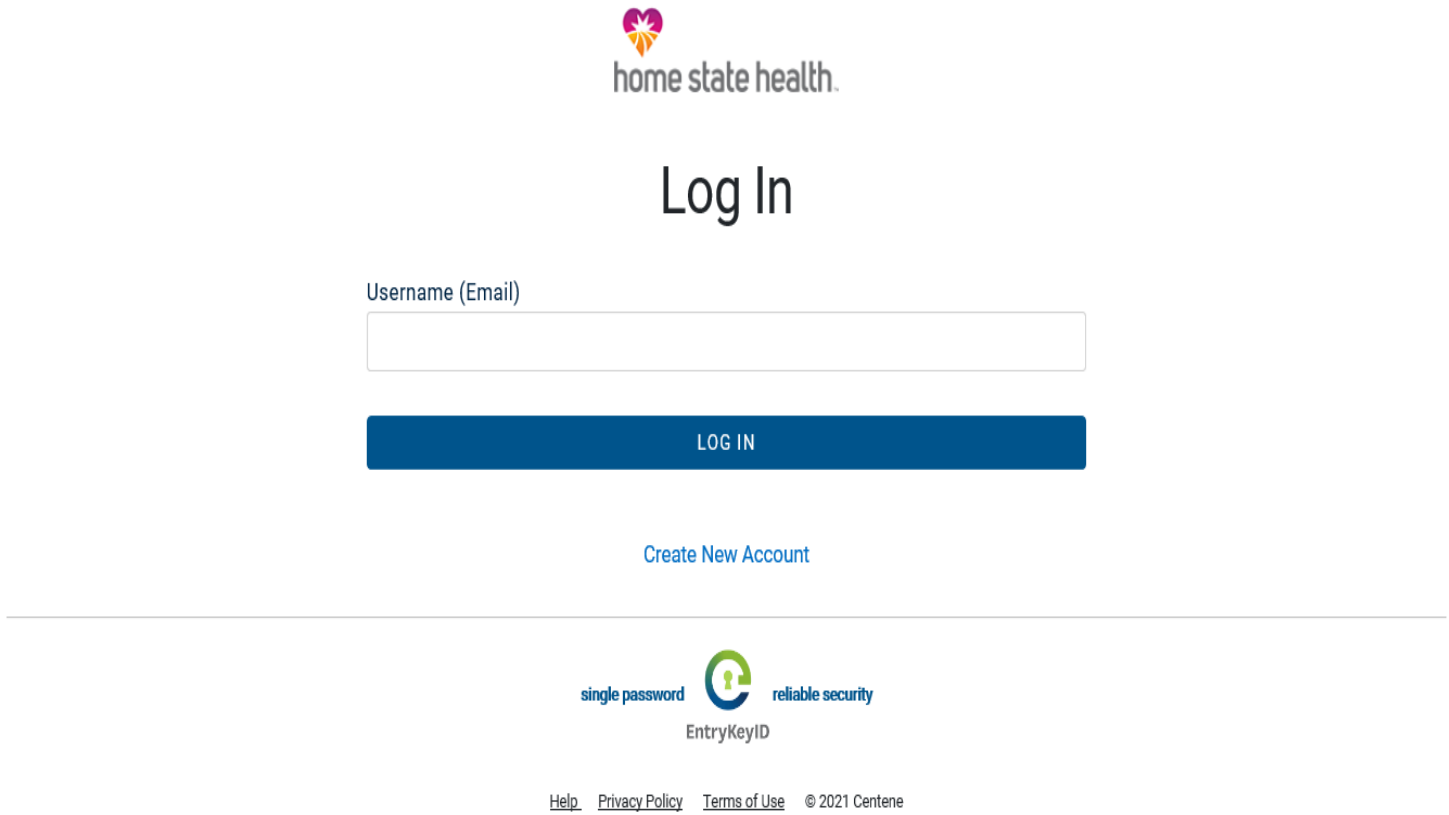
- Check eligibility
- Submit, correct, and check claim status
- Submit and view prior authorizations
- View patient care gaps
- And much more

Home State Health's secure portal : https://www.homestatehealth.com/login.html

All at no charge….*FREE!*

Portal Registration and Login

Tip: When a tax identification number operates in more than one state, the portal user can register for each health plan's portal with the same username (e-mail) and password.

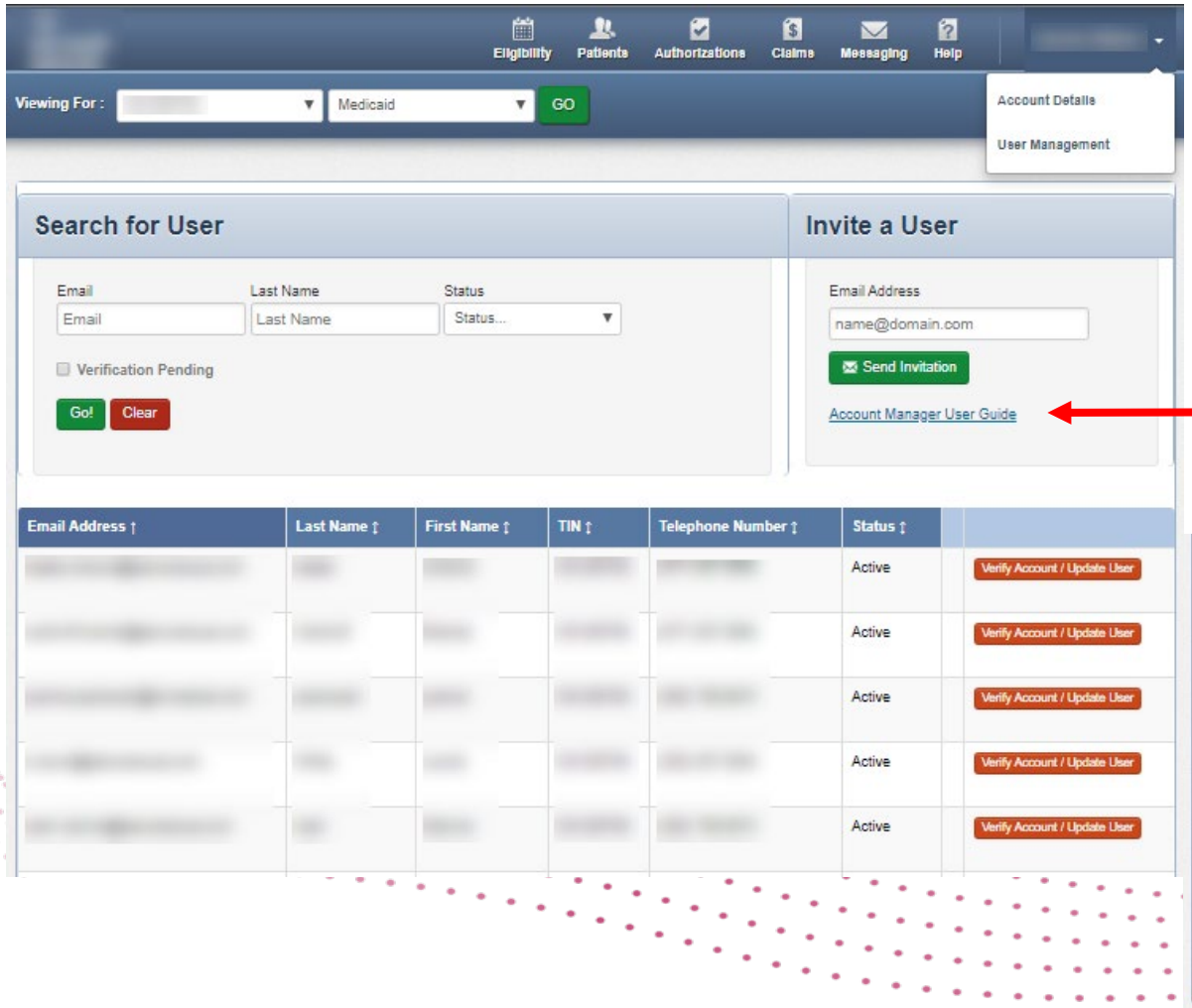


Account Manager

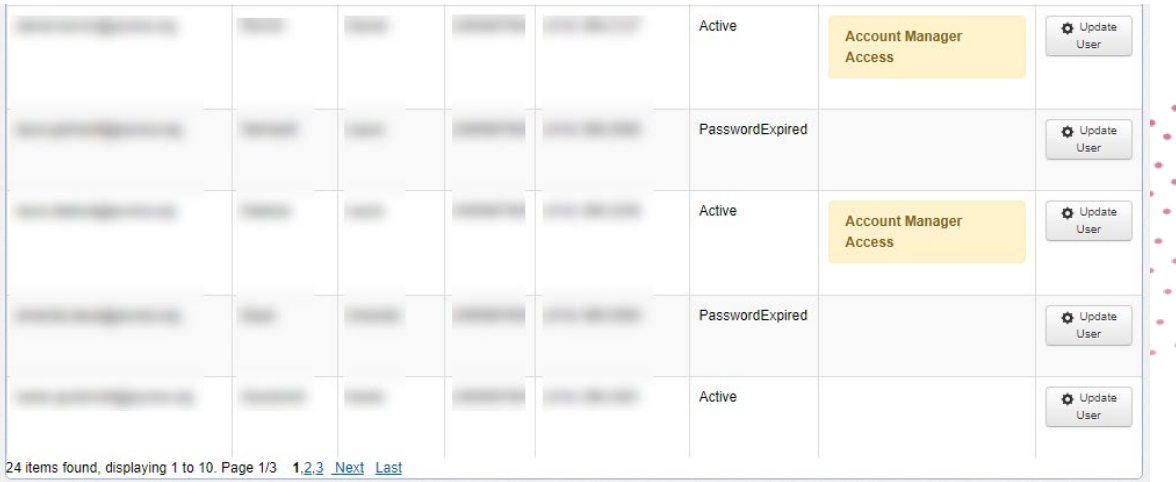
- A Portal Account Manager is a role assigned to a primary contact within a provider organization

- The Account Manager is responsible for the day-to-day support of all Secure Provider Portal user accounts that are registered under the same tax identification number. Some account manager tasks include:
  - Approving access for new secure portal users
  - Assigning permissions for users based on job responsibilities
  - Regularly adjusting permissions when roles change
  - Terminating users who no longer work at the practice.

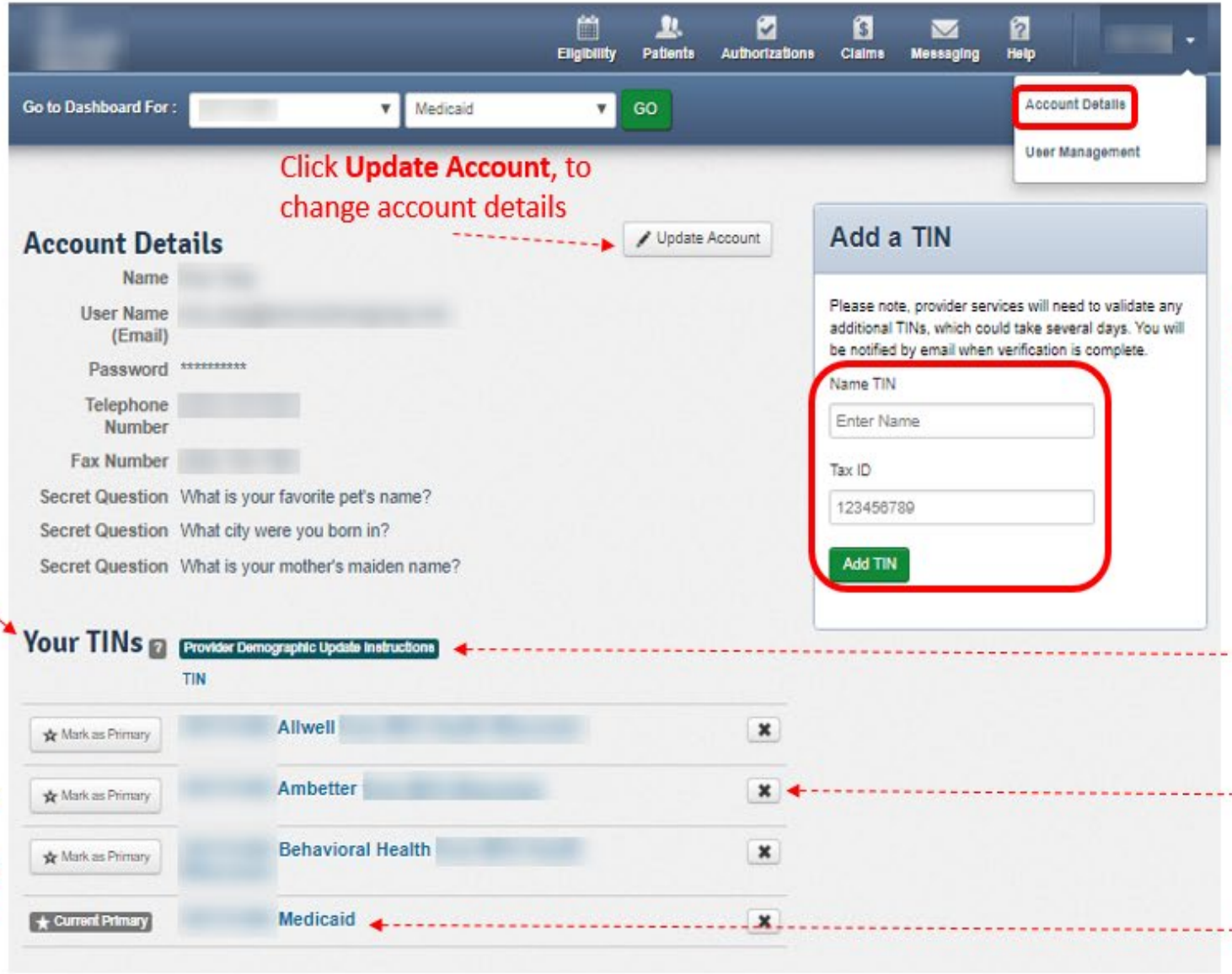
Account Management User



Portal Account Managers, can click here to access the **Account Manager User Guide**



Portal Account Details



Who is Eligible?

Show Me Healthy Kids (SMHK)

- Children in the care and custody of the Missouri Department of Social Services
- Children or youth in alternative care
- Children receiving adoption or legal guardianship subsidy
- Former foster care youth under the age of 26, who were in foster care on their 18th birthday and covered by Medicaid from another state, and who are not currently eligible for Medicaid coverage under another program
- Former foster care youth under the age of 26, who were in foster care on their 18th birthday and covered by MO HealthNet (Missouri Medicaid), and who meet other eligibility criteria

Home State Health

- Women aged 18-55 with no health insurance
- Children under age 19
- Adult age 19-64
- Senior 65 and older
- Parents or Caretakers of children
- Pregnant women and Unborn child

Medical Eligibility (ME) Codes SMHK

Verify ME Codes for Show Me Healthy Kids via eMOMED at www.emomed.com

ME Code	ME Code Description
DSS Division of Family Services	
07	Foster Care – IV – E
37	Title XIX-FFP/HDN
38	Independent Foster Care Children – Ages 18 to age 26
08	CWS-FC
66	Child Welfare – HIF
0F	Subset of participants currently under ME 07 and ME 38. ME 0F will model ME 08 eligibility, claims processing, and financial coding.
Adoption Subsidy	
56	Adoption Subsidy – IV – E Eligible - 5A
36	Adoption Subsidy– FFP
57	Adoption Subsidy – CWS
5A	Subset of participants currently under ME 56. ME 5A will model ME 57 eligibility, claims processing, and financial coding.
DSS Division of Youth Services	
29	Division of Youth Services – FYS-FC
52	DYS – GR
50	DYS – Poverty
68	DYS - HIF

Checking Eligibility

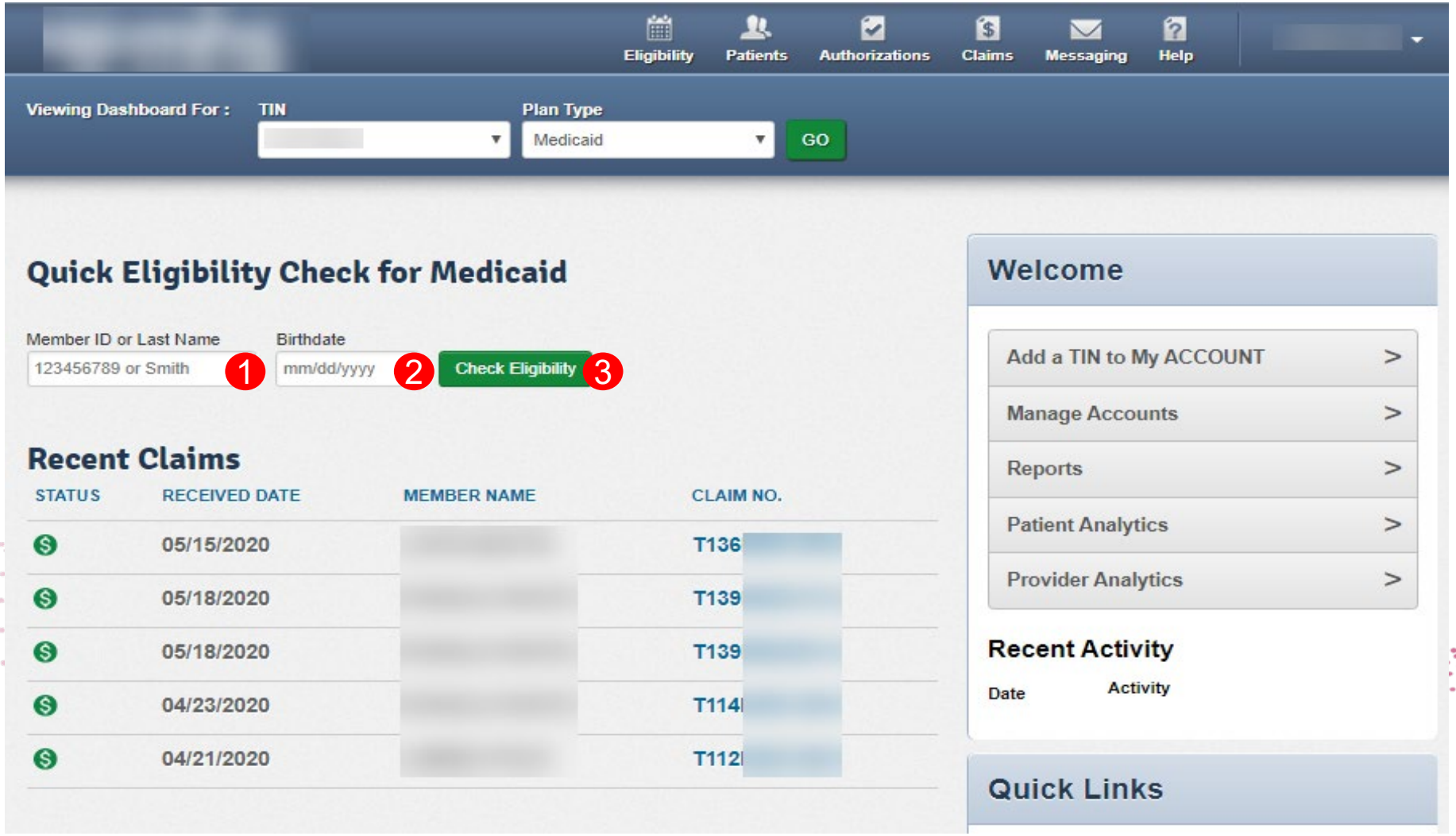
Why is it important to check eligibility?

Once the provider determines the participant may have or has MO HealthNet eligibility, it is the provider's responsibility to check the participant's eligibility. **This must be done before every visit. Eligibility is updated daily. The participant must be eligible on the date of service or claims will deny.**

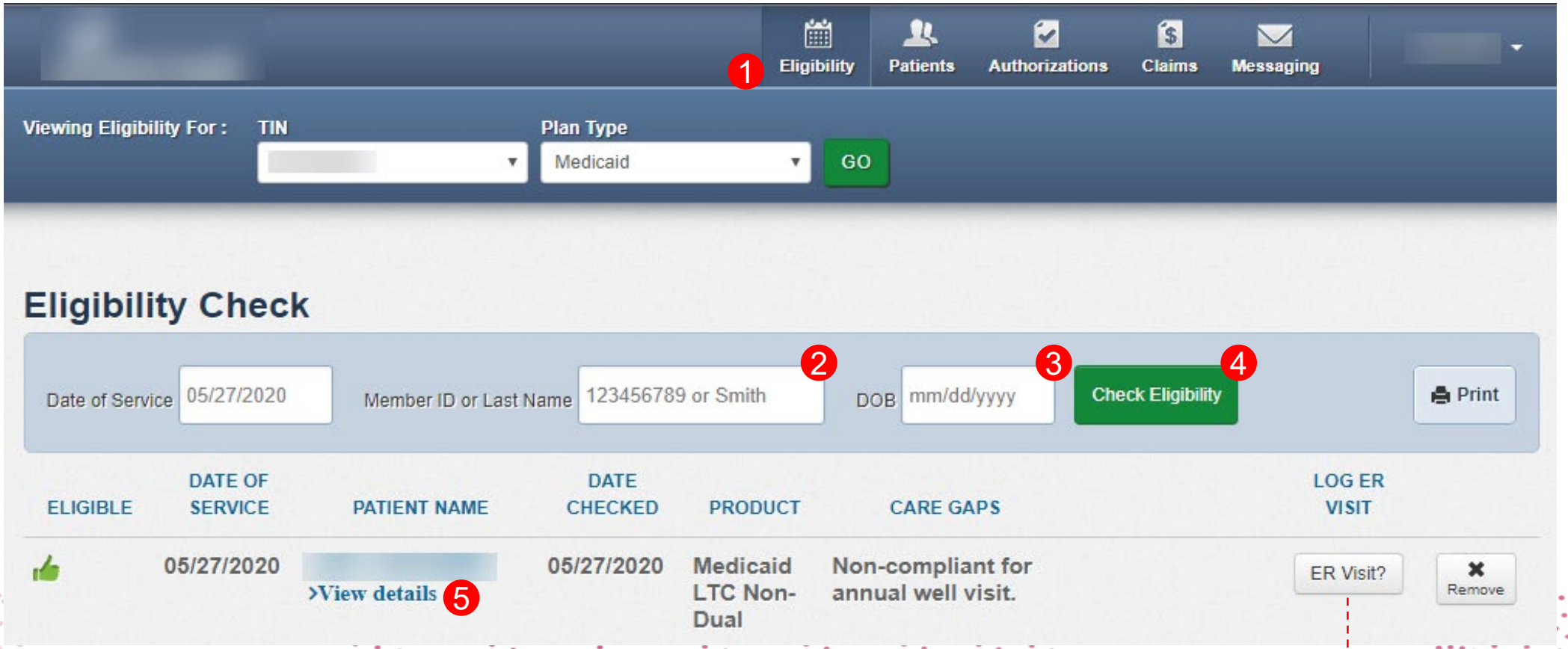
Eligibility Tips:

- When checking eligibility, if the member does not pull up, verify data entered
- If Member ID + DOB does not pull up the member, try Member Last Name + DOB
- Check for other insurance-Coordination of Benefits (COB) **MO HealthNet is the payer of last resort. Providers must bill all other payers as primary.**
- As best practice, always check member eligibility prior to and the day of appointment

Eligibility Check, option 1

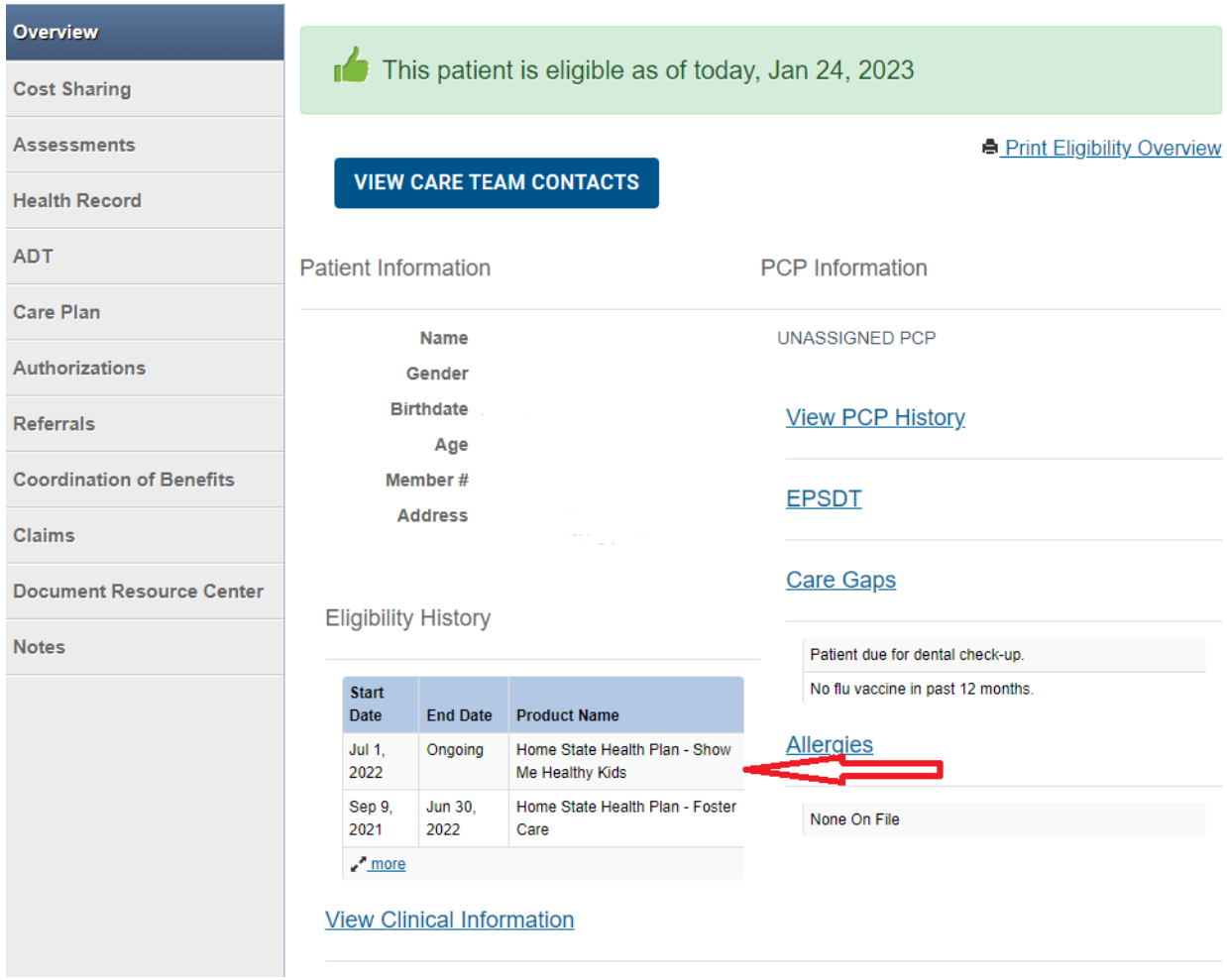


Eligibility Check, option 2

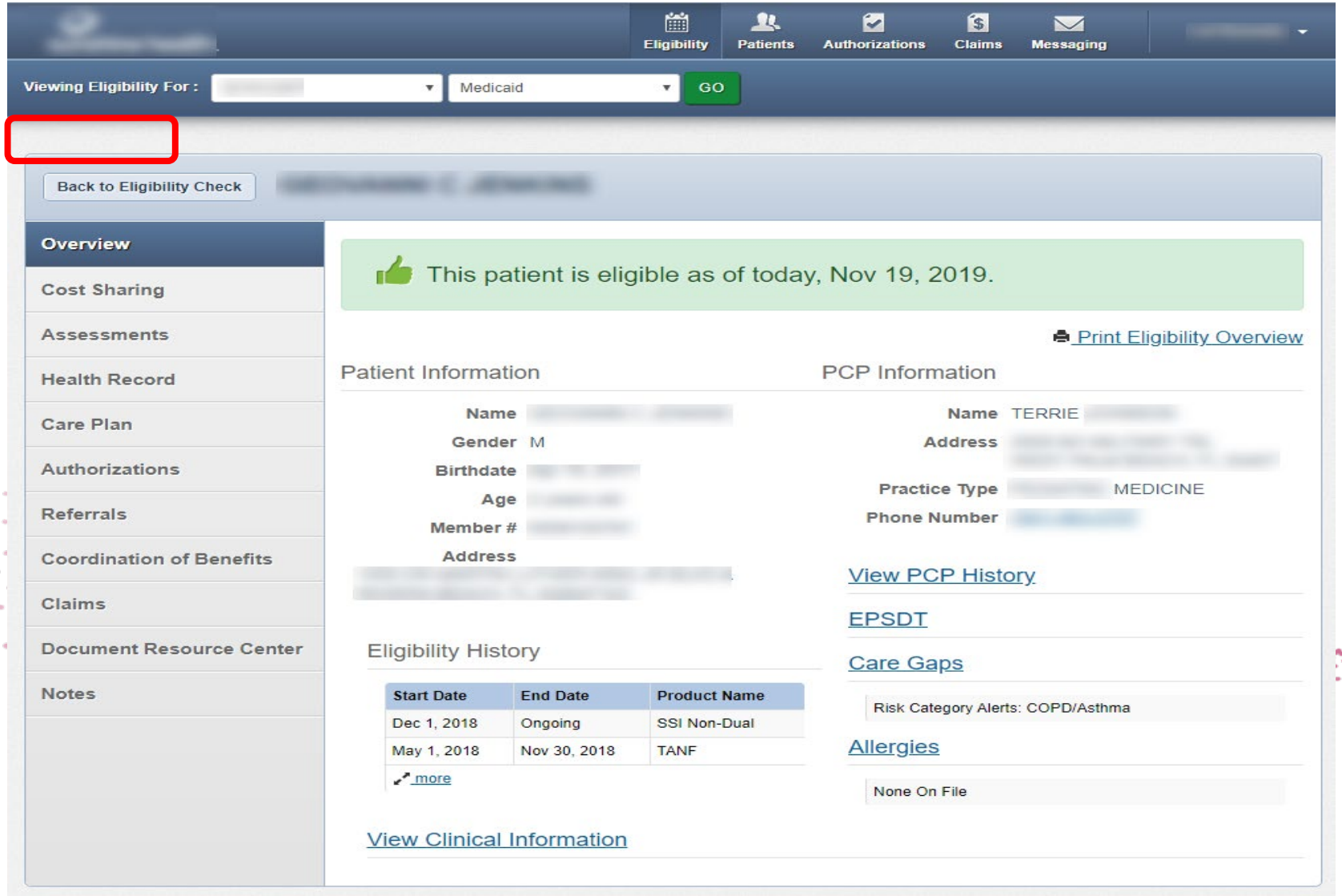


If Eligibility Check is for an ER visit, click **ER Visit?**

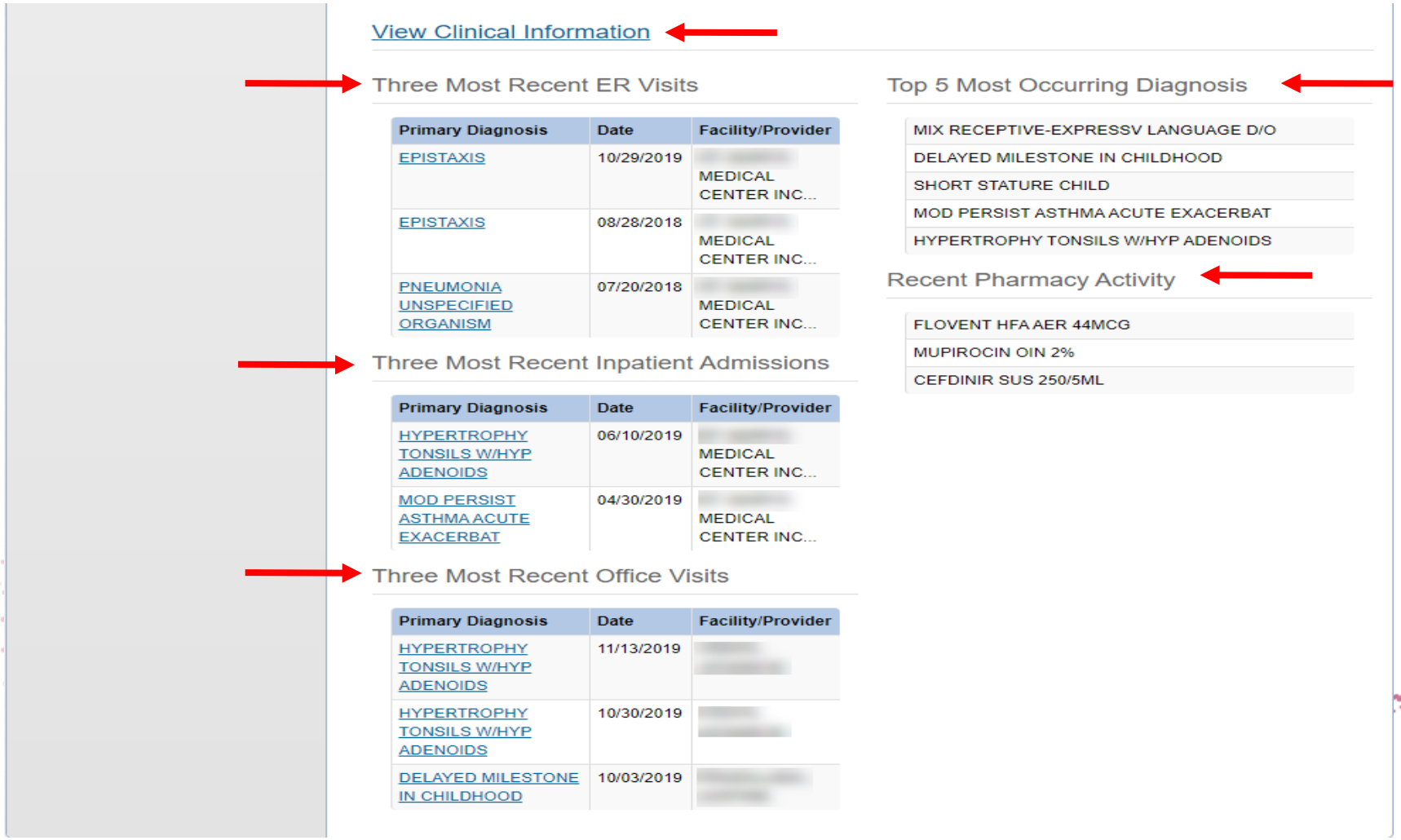
Patient Overview



Patient Overview



Patient Overview continued



View Clinical Information

Three Most Recent ER Visits

Primary Diagnosis	Date	Facility/Provider
EPISTAXIS	10/29/2019	[redacted] MEDICAL CENTER INC...
EPISTAXIS	08/28/2018	[redacted] MEDICAL CENTER INC...
PNEUMONIA UNSPECIFIED ORGANISM	07/20/2018	[redacted] MEDICAL CENTER INC...

Three Most Recent Inpatient Admissions

Primary Diagnosis	Date	Facility/Provider
HYPERTROPHY TONSILS W/HYP ADENOIDS	06/10/2019	[redacted] MEDICAL CENTER INC...
MOD PERSIST ASTHMA ACUTE EXACERBAT	04/30/2019	[redacted] MEDICAL CENTER INC...

Three Most Recent Office Visits

Primary Diagnosis	Date	Facility/Provider
HYPERTROPHY TONSILS W/HYP ADENOIDS	11/13/2019	[redacted]
HYPERTROPHY TONSILS W/HYP ADENOIDS	10/30/2019	[redacted]
DELAYED MILESTONE IN CHILDHOOD	10/03/2019	[redacted]

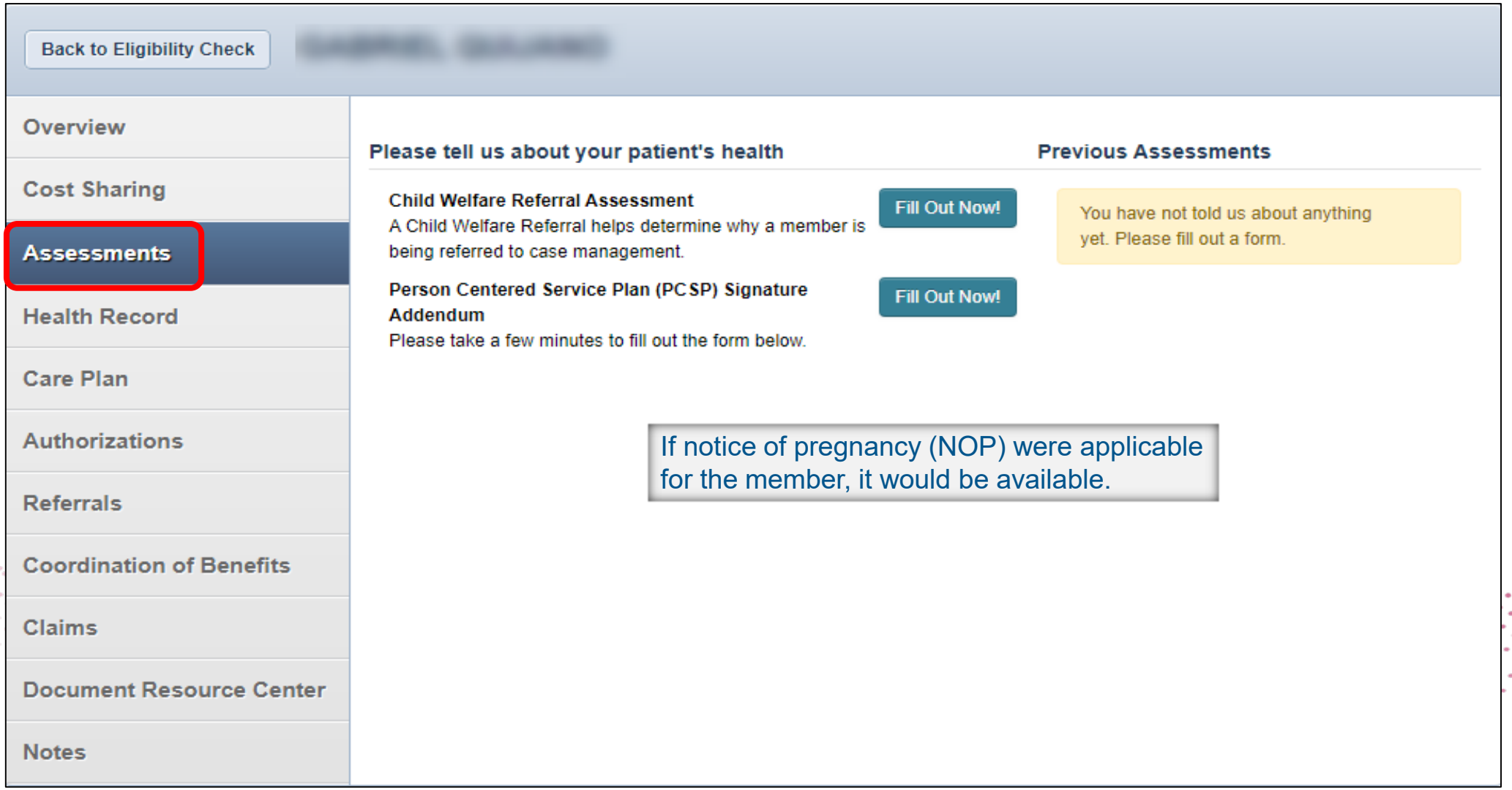
Top 5 Most Occurring Diagnosis

MIX RECEPTIVE-EXPRESSV LANGUAGE D/O
DELAYED MILESTONE IN CHILDHOOD
SHORT STATURE CHILD
MOD PERSIST ASTHMA ACUTE EXACERBAT
HYPERTROPHY TONSILS W/HYP ADENOIDS

Recent Pharmacy Activity

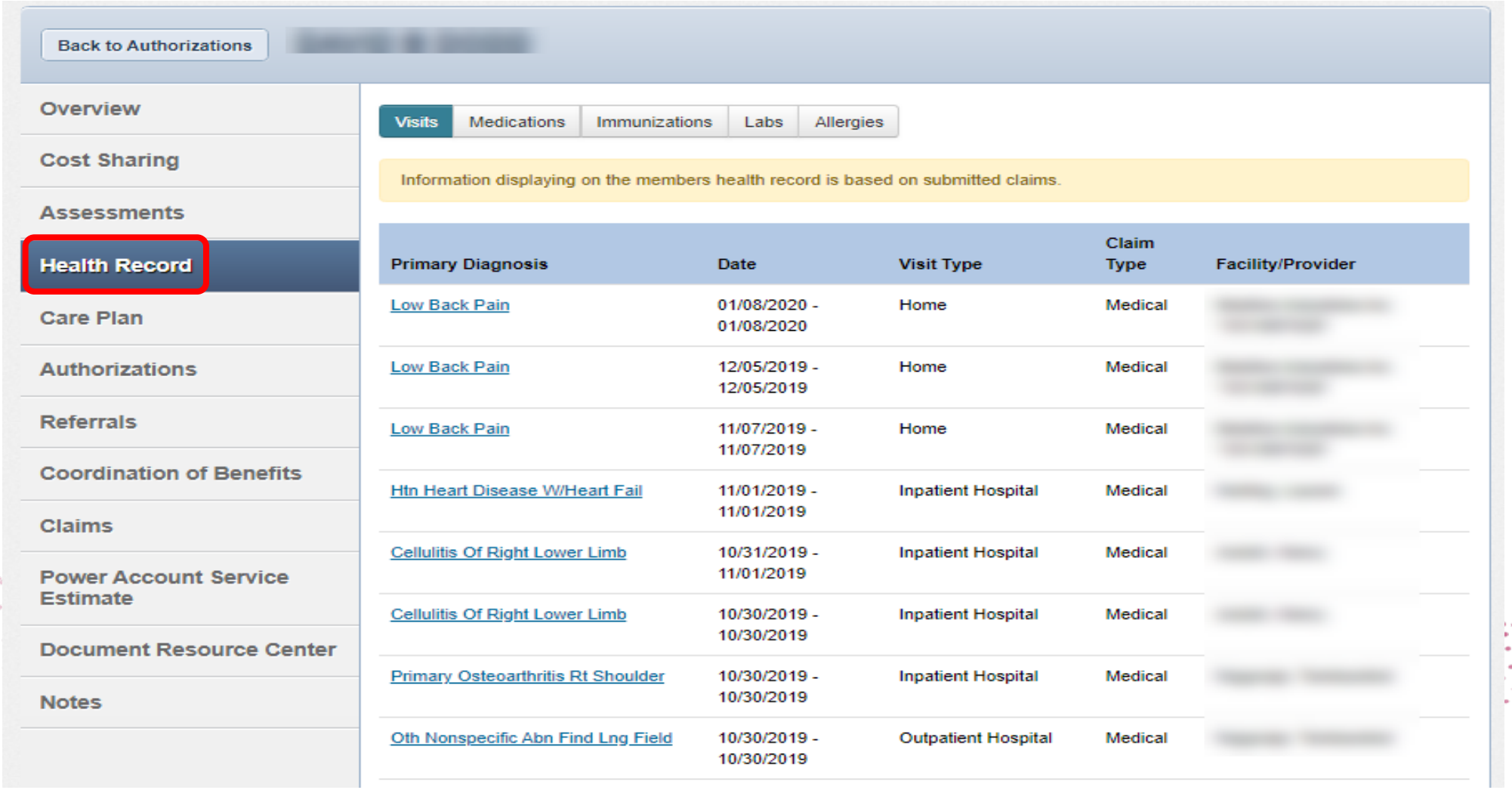
FLOVENT HFA AER 44MCG
MUPIROCIN OIN 2%
CEFDINIR SUS 250/5ML

Patient Overview - Assessments



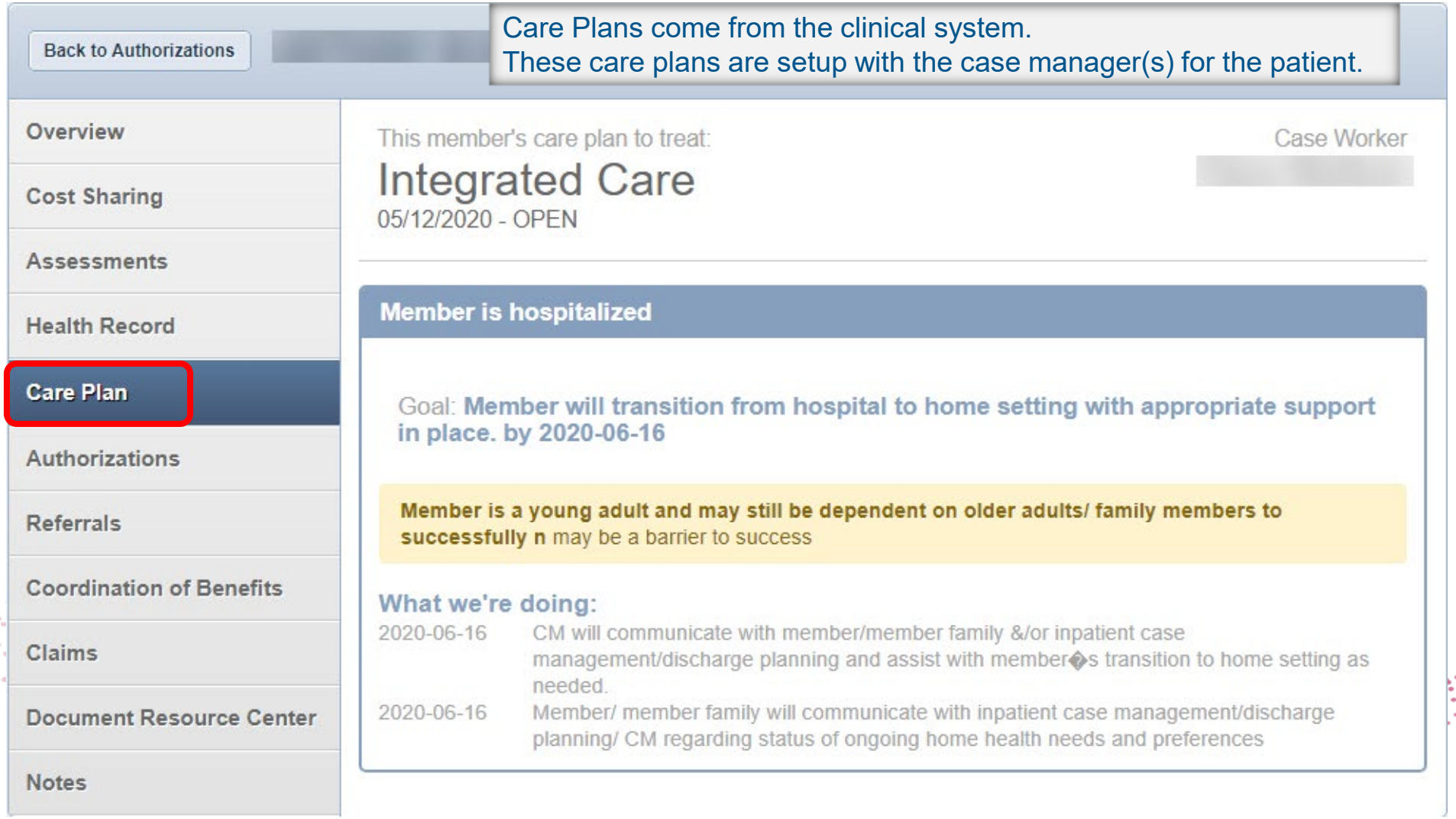
If notice of pregnancy (NOP) were applicable for the member, it would be available.

Patient Overview- Health Record

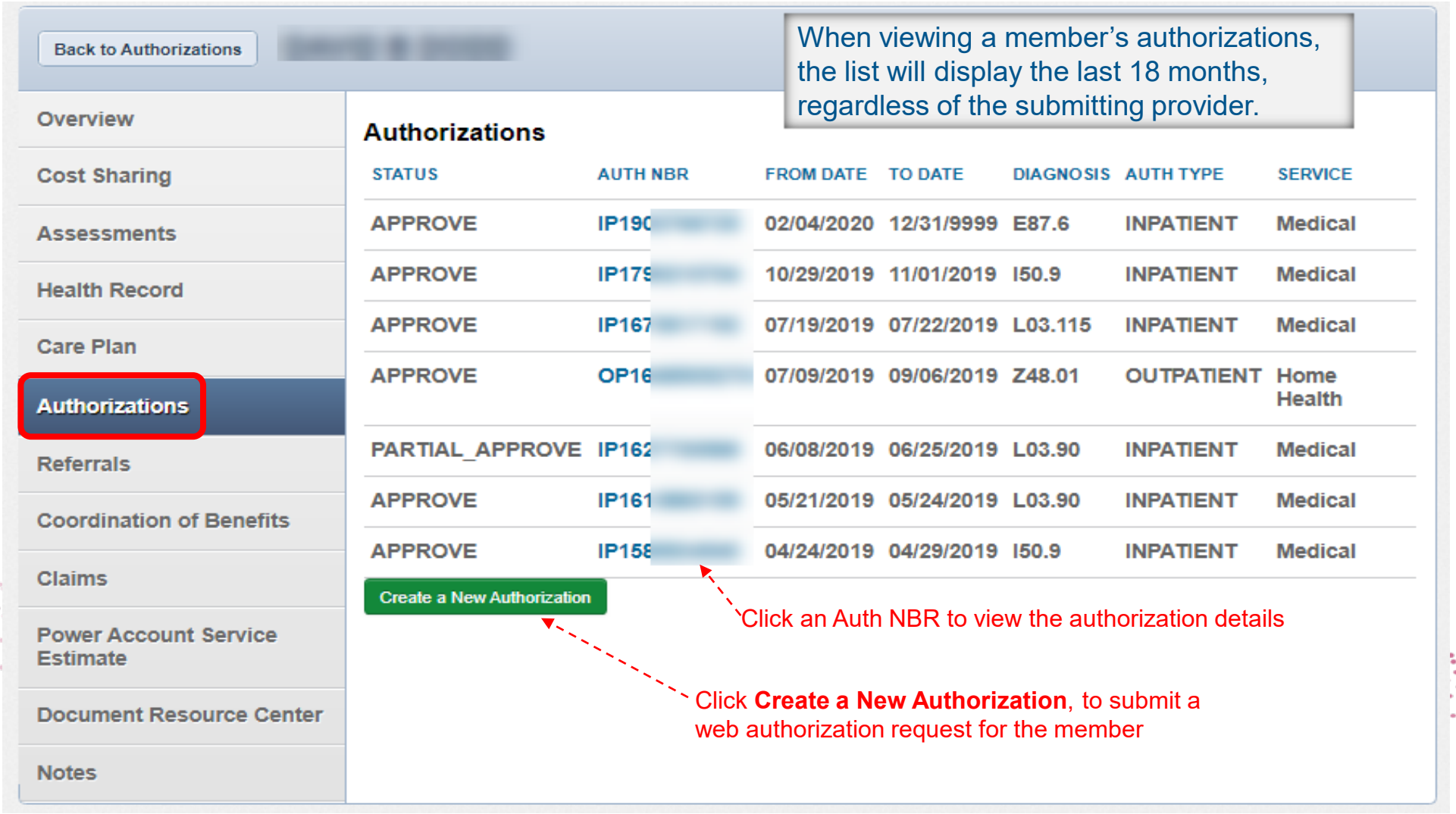


Patient Overview – Care Plan

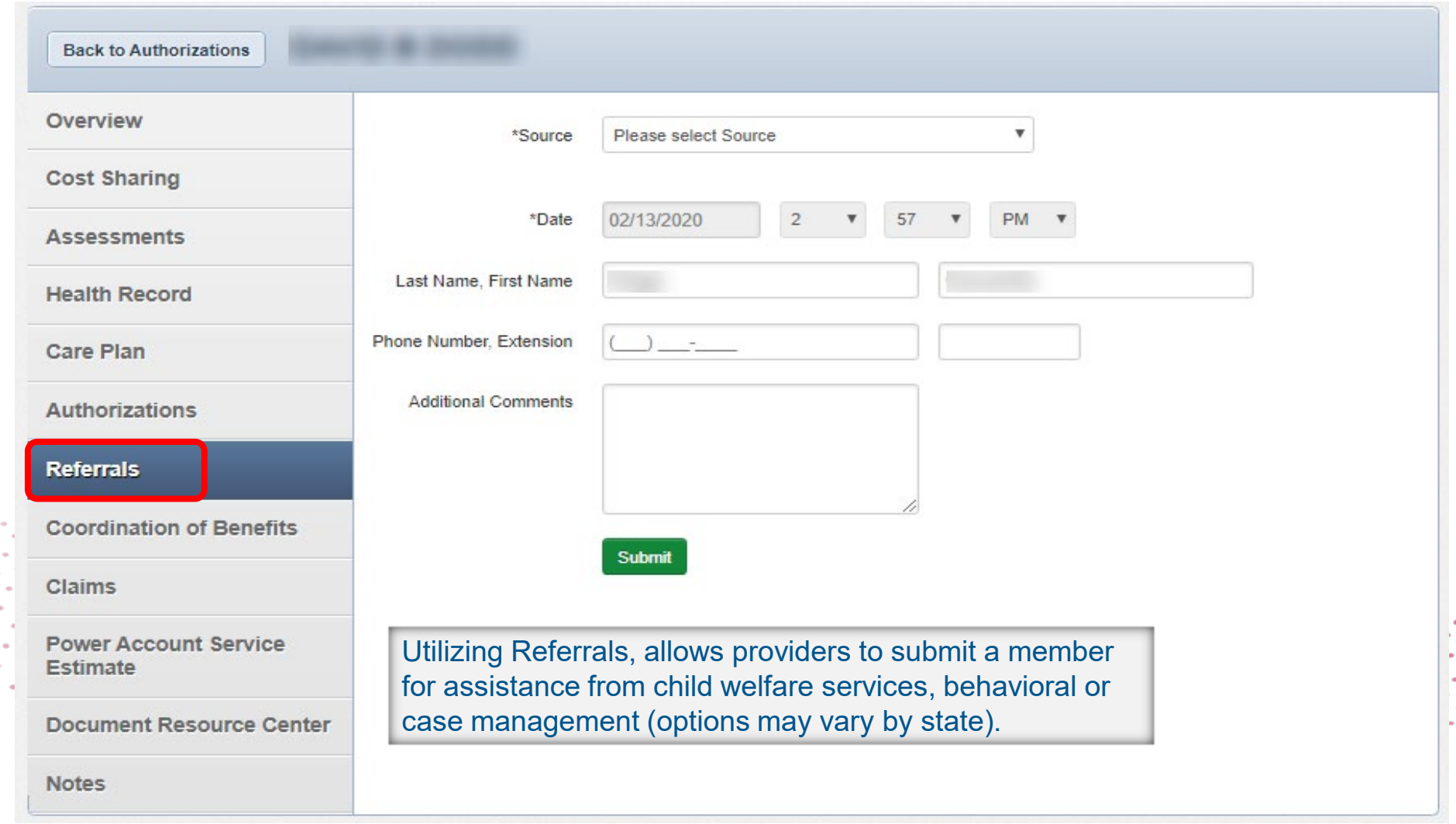
Care Plans come from the clinical system.
These care plans are setup with the case manager(s) for the patient.



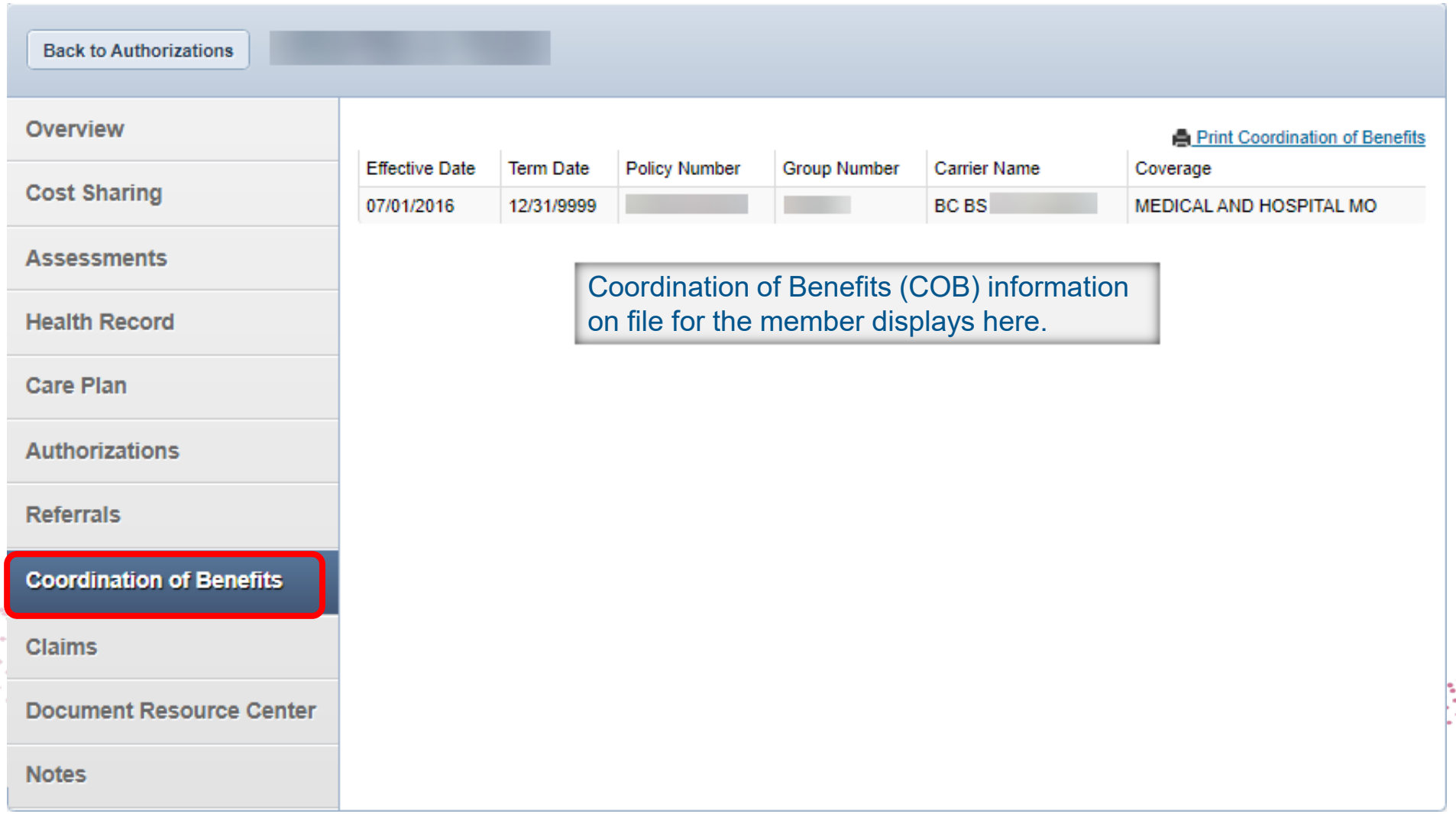
Patient Overview - Authorizations



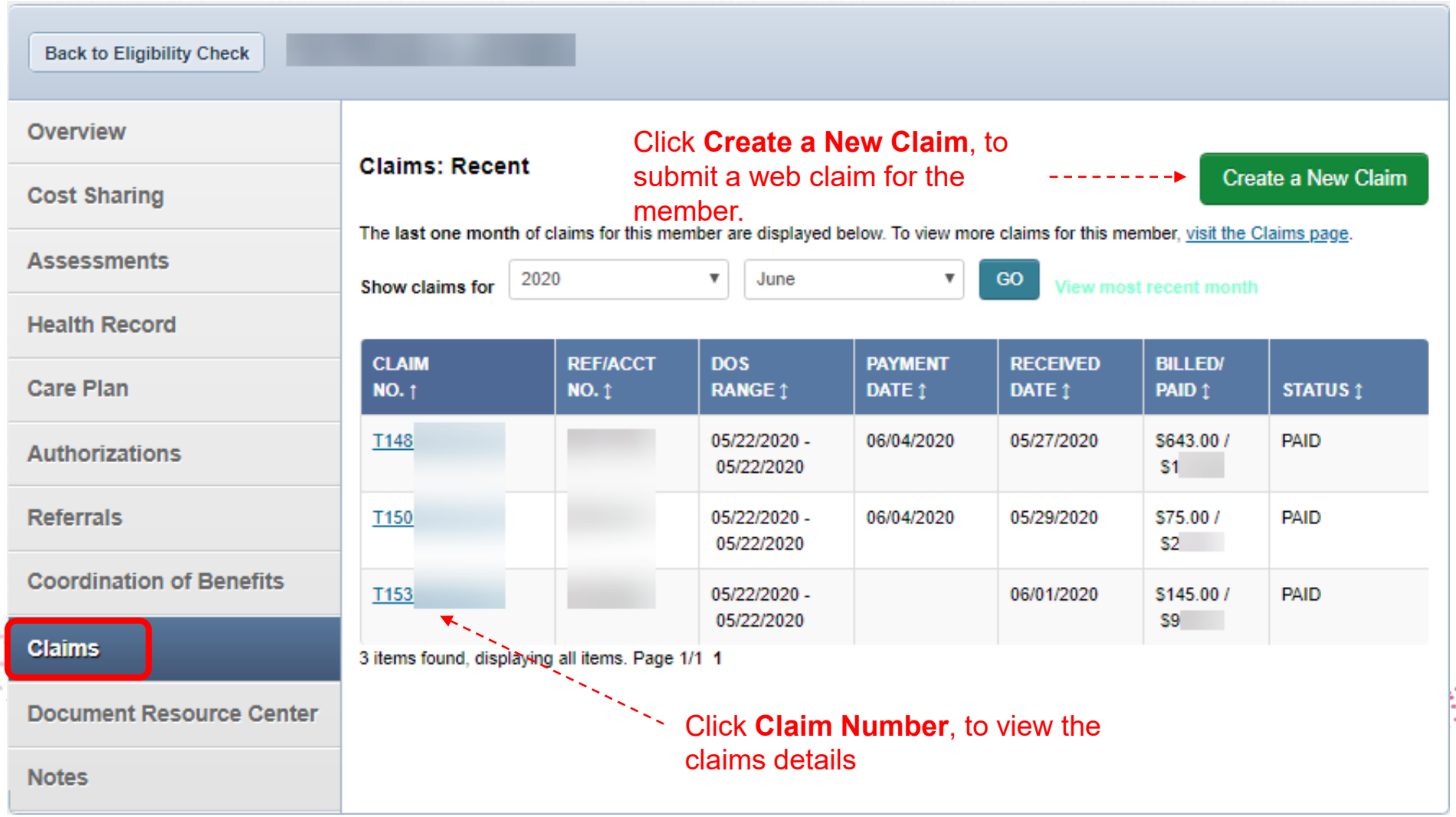
Patient Overview - Referrals



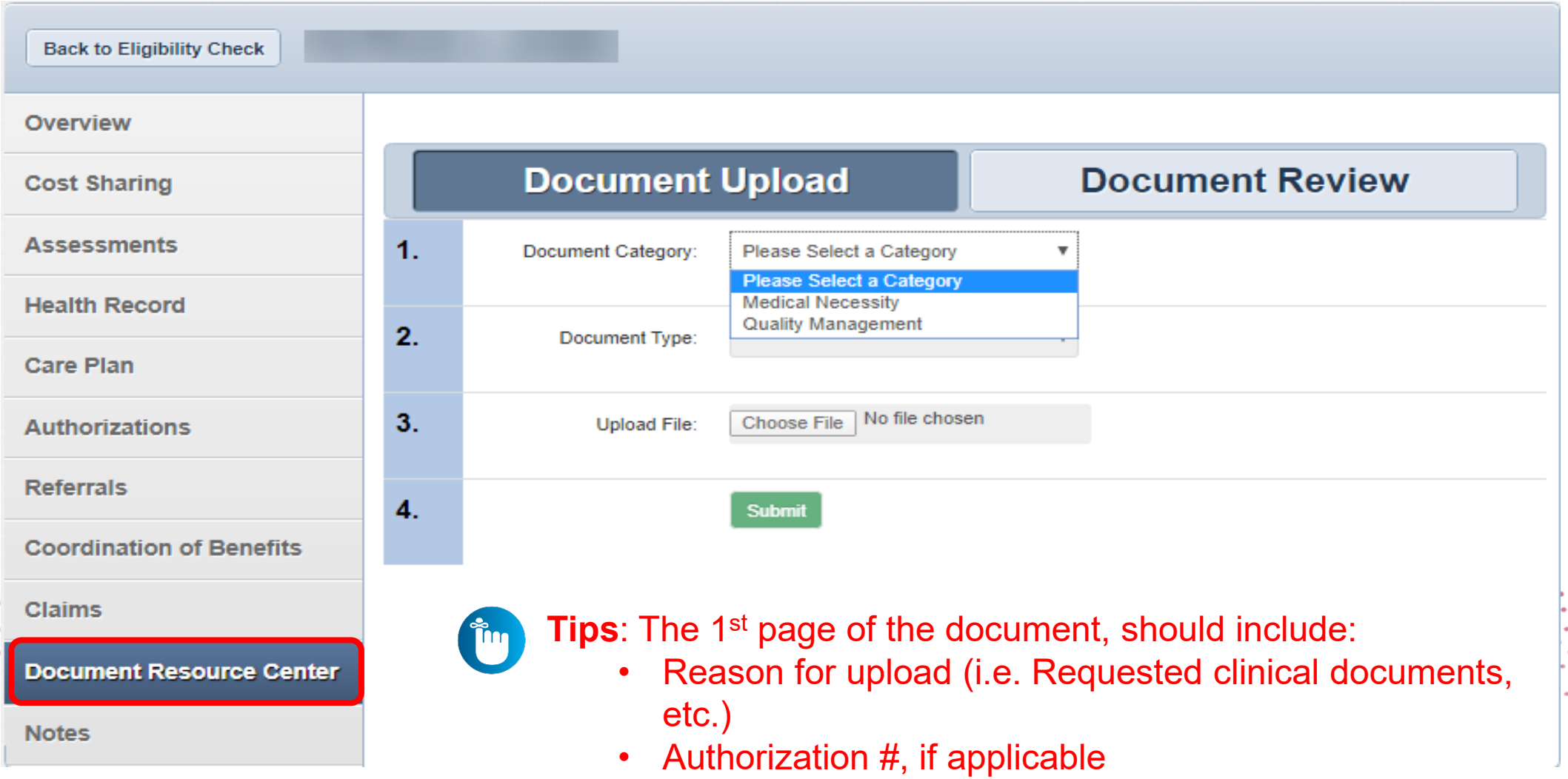
Patient Overview – Coordination of Benefits



Patient Overview - Claims



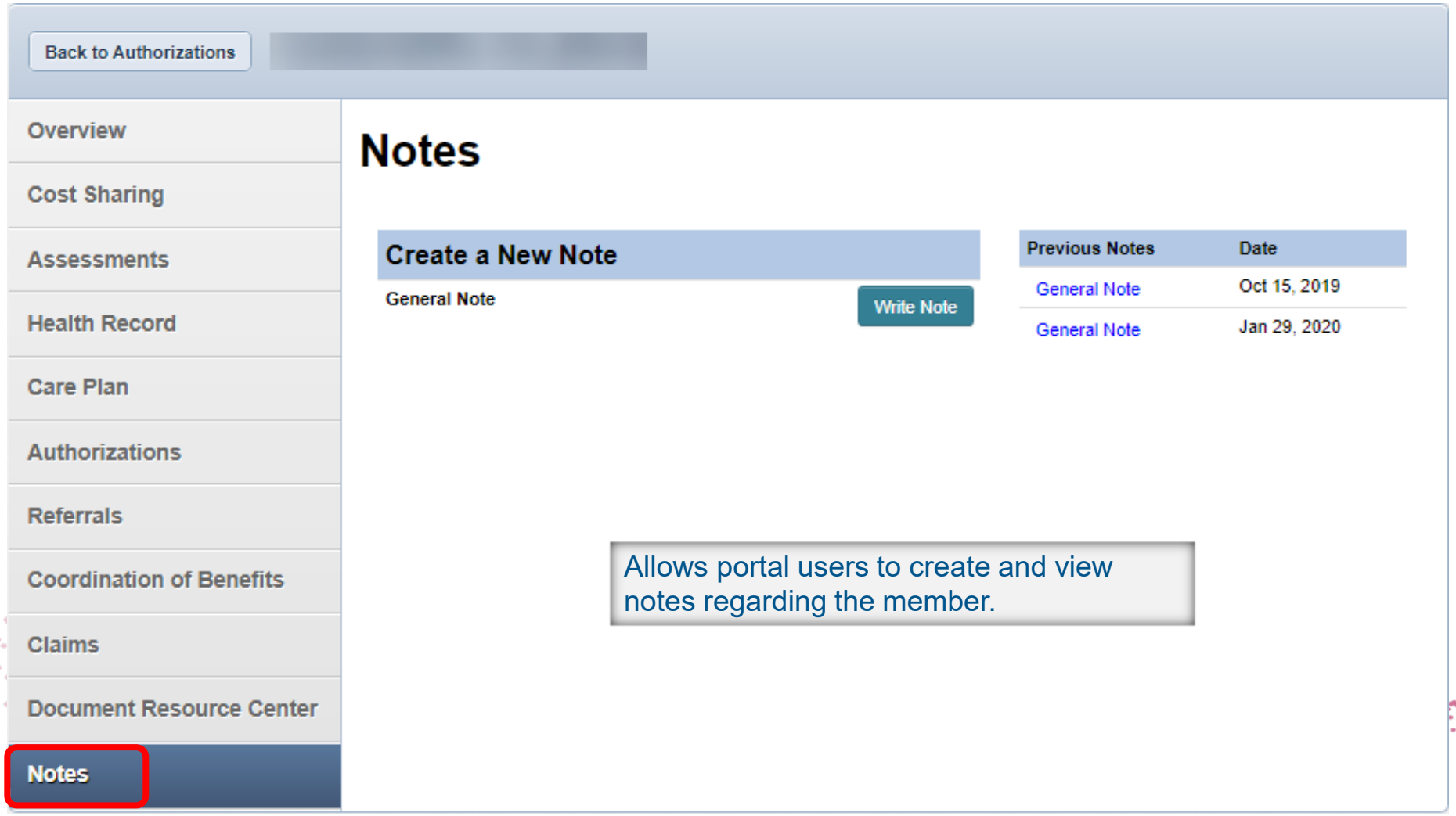
Patient Overview – Document Resource Center



Tips: The 1st page of the document, should include:

- Reason for upload (i.e. Requested clinical documents, etc.)
- Authorization #, if applicable

Patient Overview – Notes

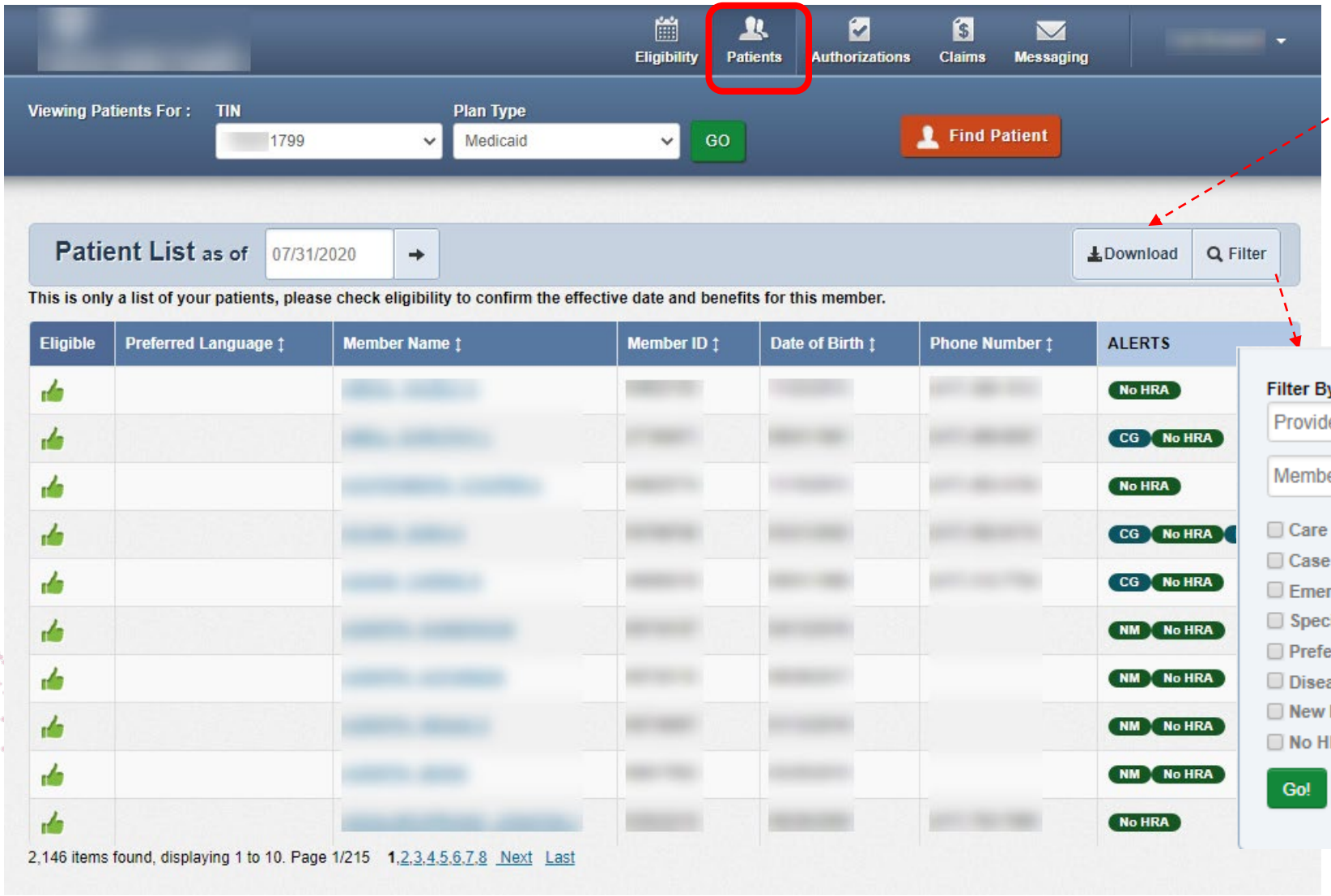


Patient Lists

Primary Care Providers can view and download a list of their assigned members.
The Patient List displays:

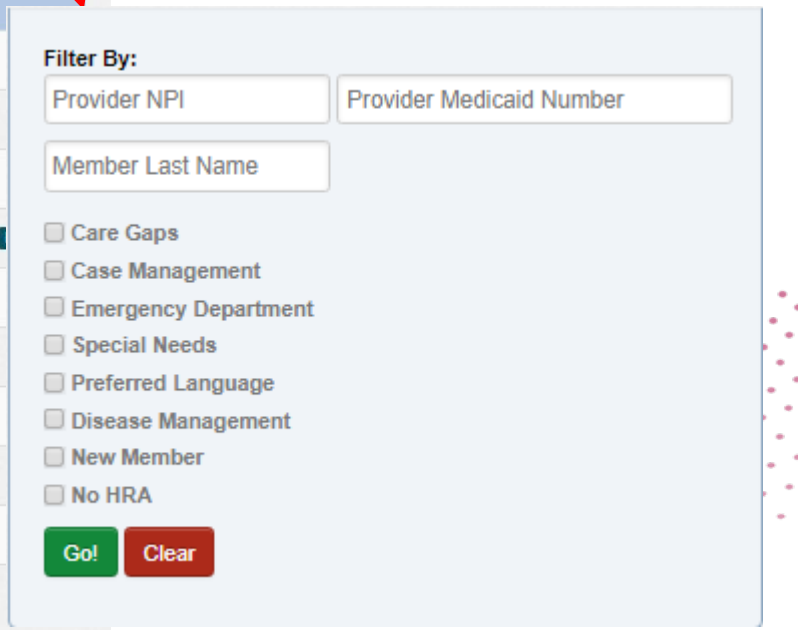
- Member Name
- Member ID #
- DOB
- Preferred language
- Eligibility status
- Phone number
- Alerts

Patient Lists



Click **Download** to export the Patient List into Excel.

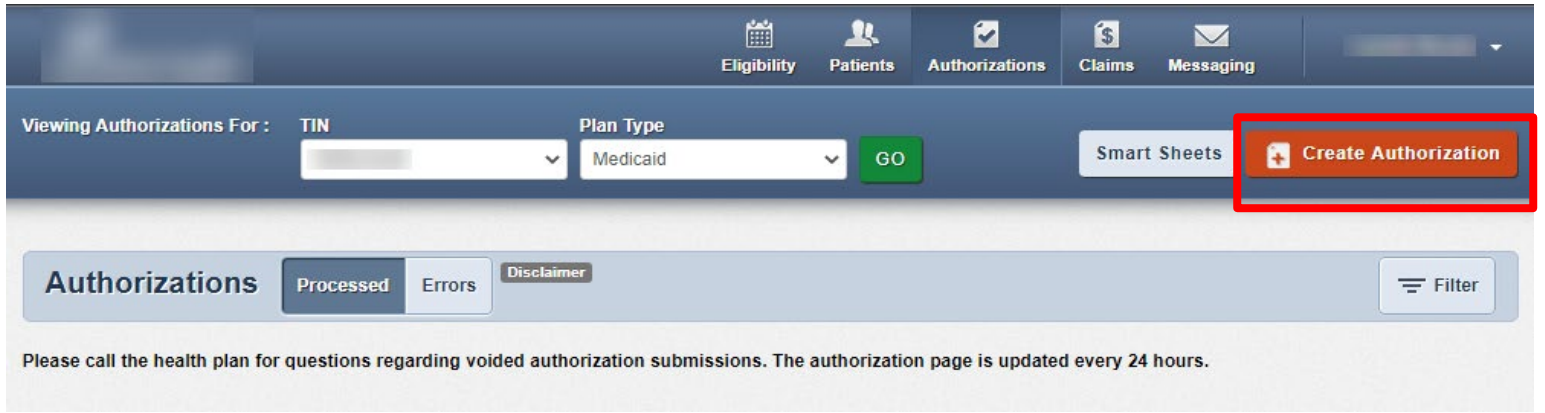
Click **Filter** to access filter options.

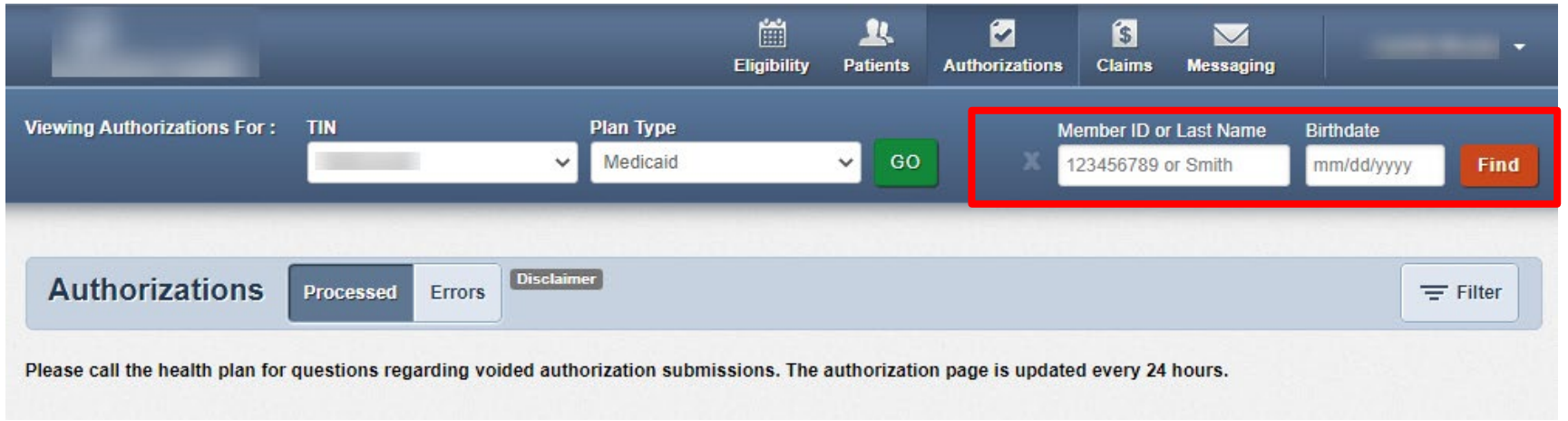


Create Authorization (Web Authorization Request)

To begin a web authorization request:

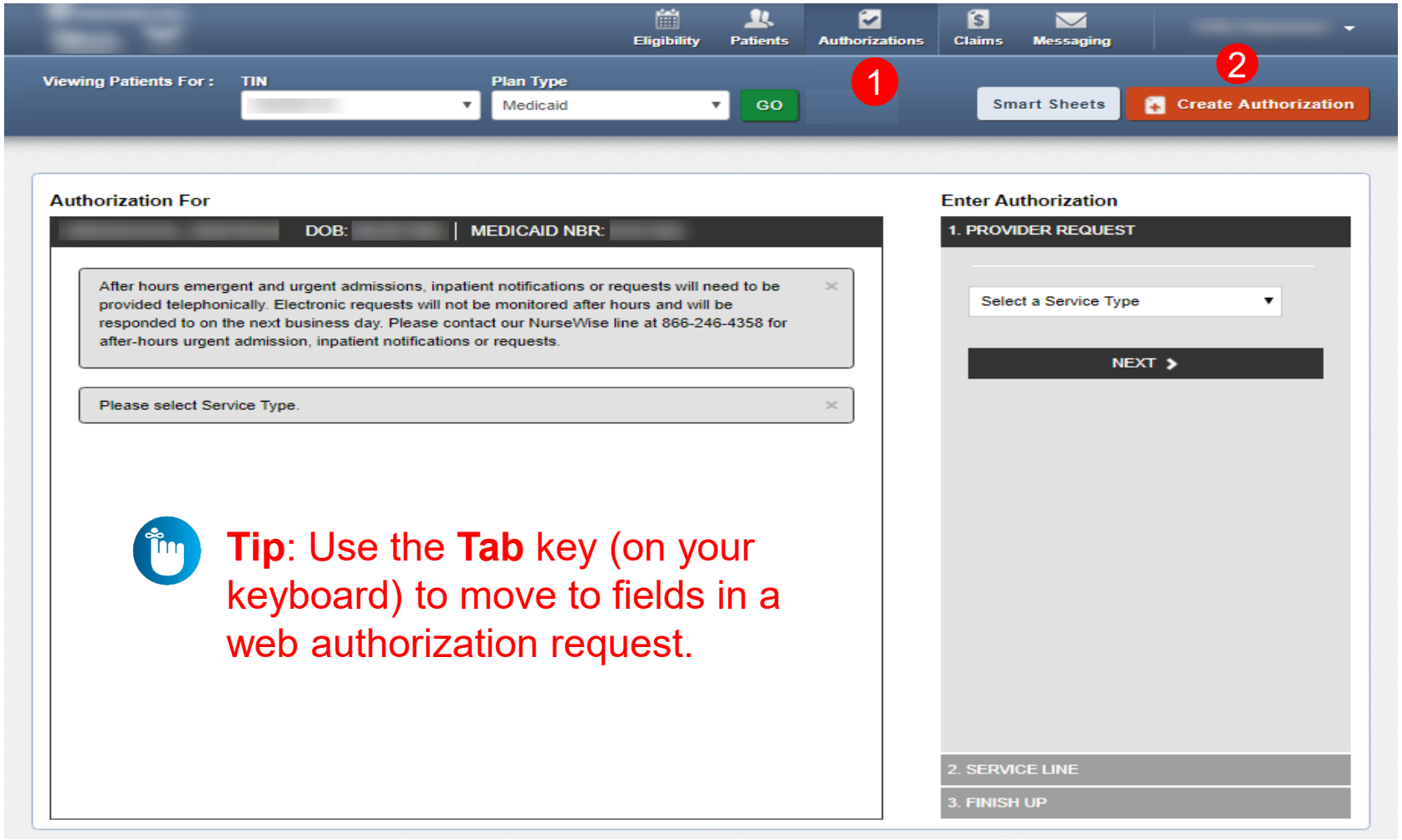
1. Click **Create Authorization**
2. Enter **Member ID or Last Name**
3. Enter Member's **Birthdate**
4. Click **Find**





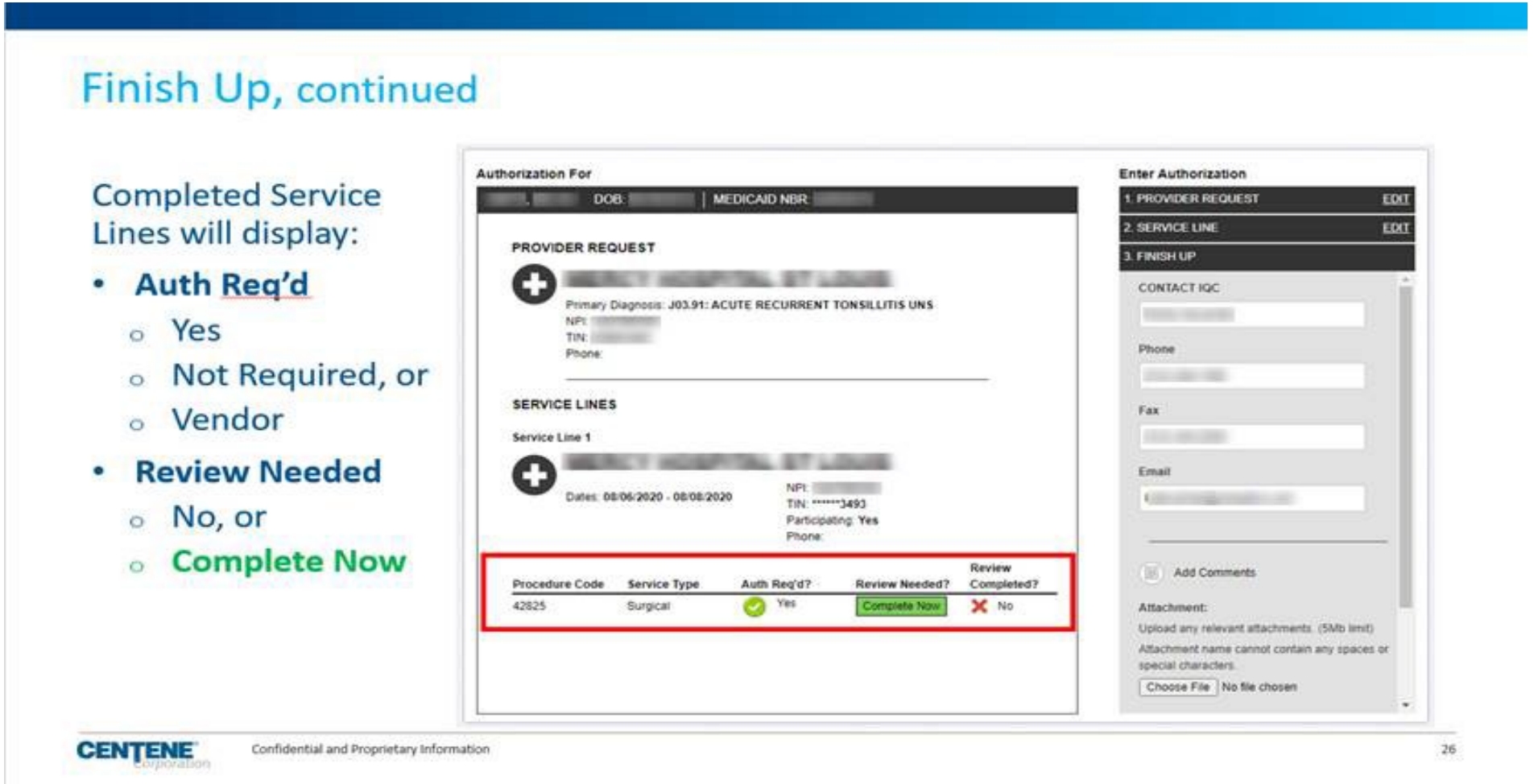
Tip: You cannot create a web authorization on an ineligible member.

Create Authorization (Web Authorization Request)



Tip: Use the **Tab** key (on your keyboard) to move to fields in a web authorization request.

Criteria



Residential Prior Authorization https://www.homestatehealth.com/content/dam/centene/home-state-health/pdfs/HSH-MO-SMHK-Resi-PA-Proces.pdf

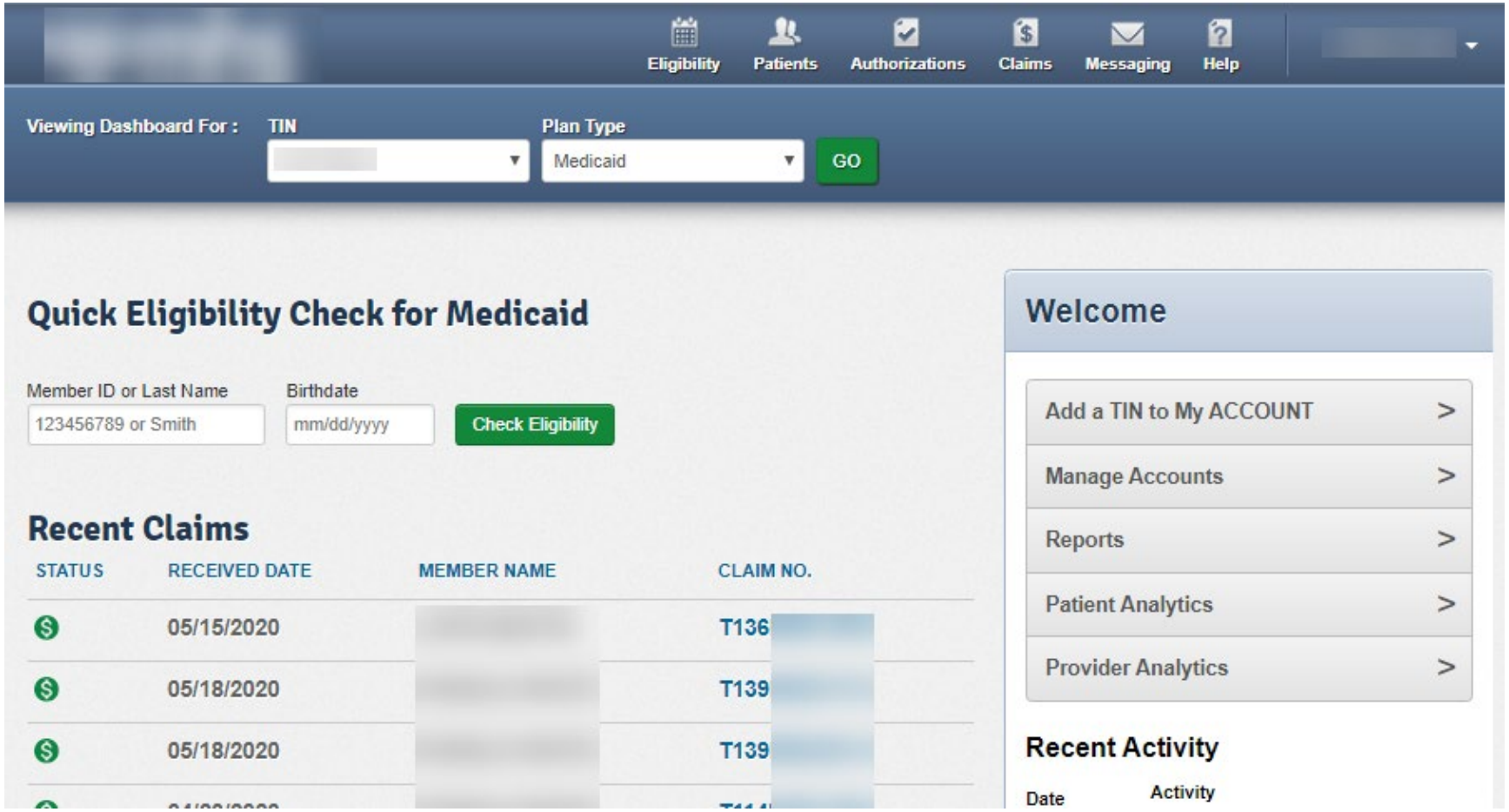
Residential Criteria- https://www.homestatehealth.com/content/dam/centene/home-state-health/pdfs/HSH-MO-SMHK-Critria-CHKLST.pdf

Accessing Authorizations

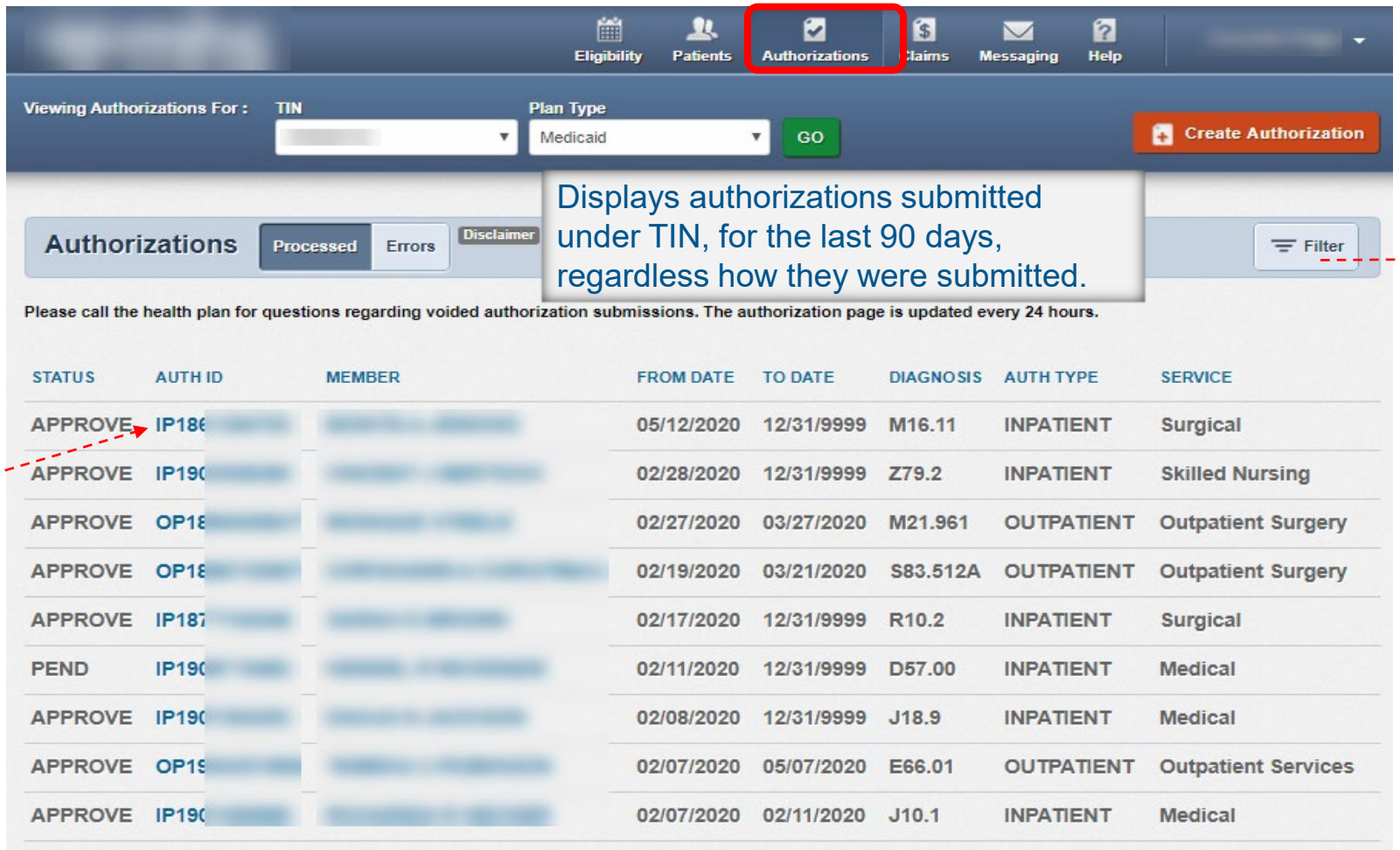
To access, create, or submit a web authorization request, click **Authorizations**.

Providers can use the portal to submit web authorization requests and view 18 months of authorization history.

Tip: The member drives your Plan Type selection. For example, an Ambetter member will not pull up under Medicaid.



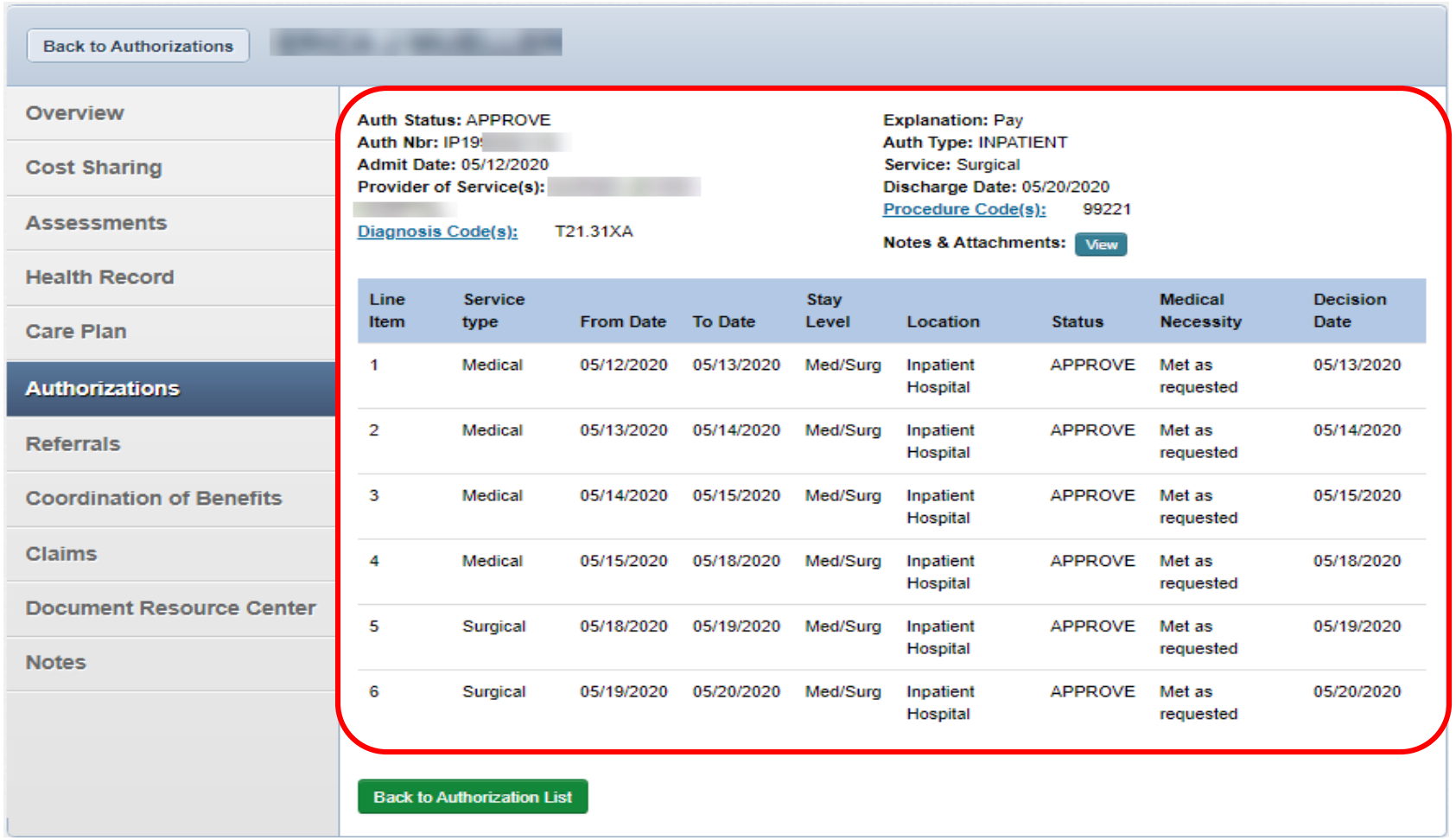
Authorization Summary



Click an **Auth ID** to view authorization details

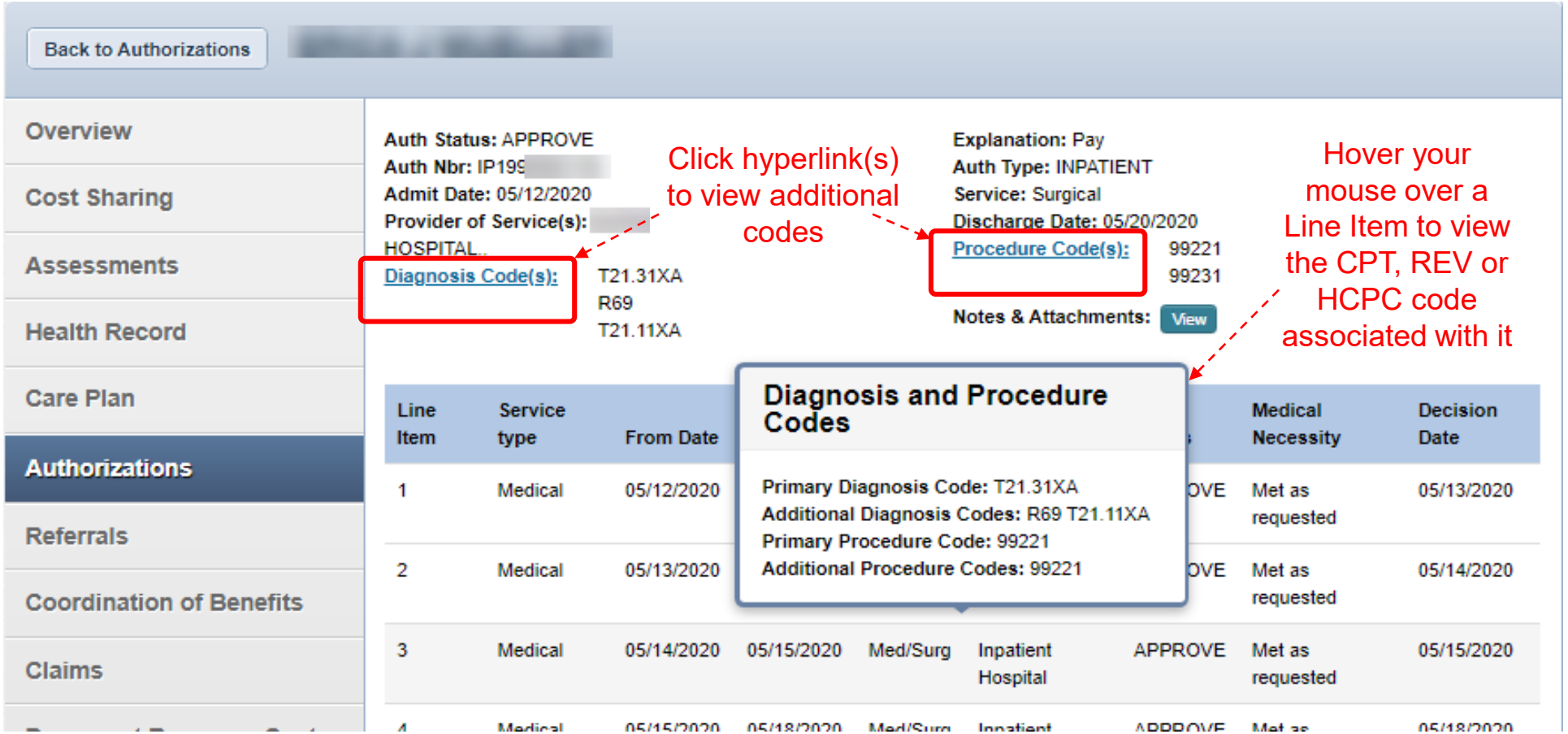
Click **Filter** to access filter options

Authorization Details



Line Item	Service type	From Date	To Date	Stay Level	Location	Status	Medical Necessity	Decision Date
1	Medical	05/12/2020	05/13/2020	Med/Surg	Inpatient Hospital	APPROVE	Met as requested	05/13/2020
2	Medical	05/13/2020	05/14/2020	Med/Surg	Inpatient Hospital	APPROVE	Met as requested	05/14/2020
3	Medical	05/14/2020	05/15/2020	Med/Surg	Inpatient Hospital	APPROVE	Met as requested	05/15/2020
4	Medical	05/15/2020	05/18/2020	Med/Surg	Inpatient Hospital	APPROVE	Met as requested	05/18/2020
5	Surgical	05/18/2020	05/19/2020	Med/Surg	Inpatient Hospital	APPROVE	Met as requested	05/19/2020
6	Surgical	05/19/2020	05/20/2020	Med/Surg	Inpatient Hospital	APPROVE	Met as requested	05/20/2020

Authorization Details Links and Pop-Up



Authorization Tips

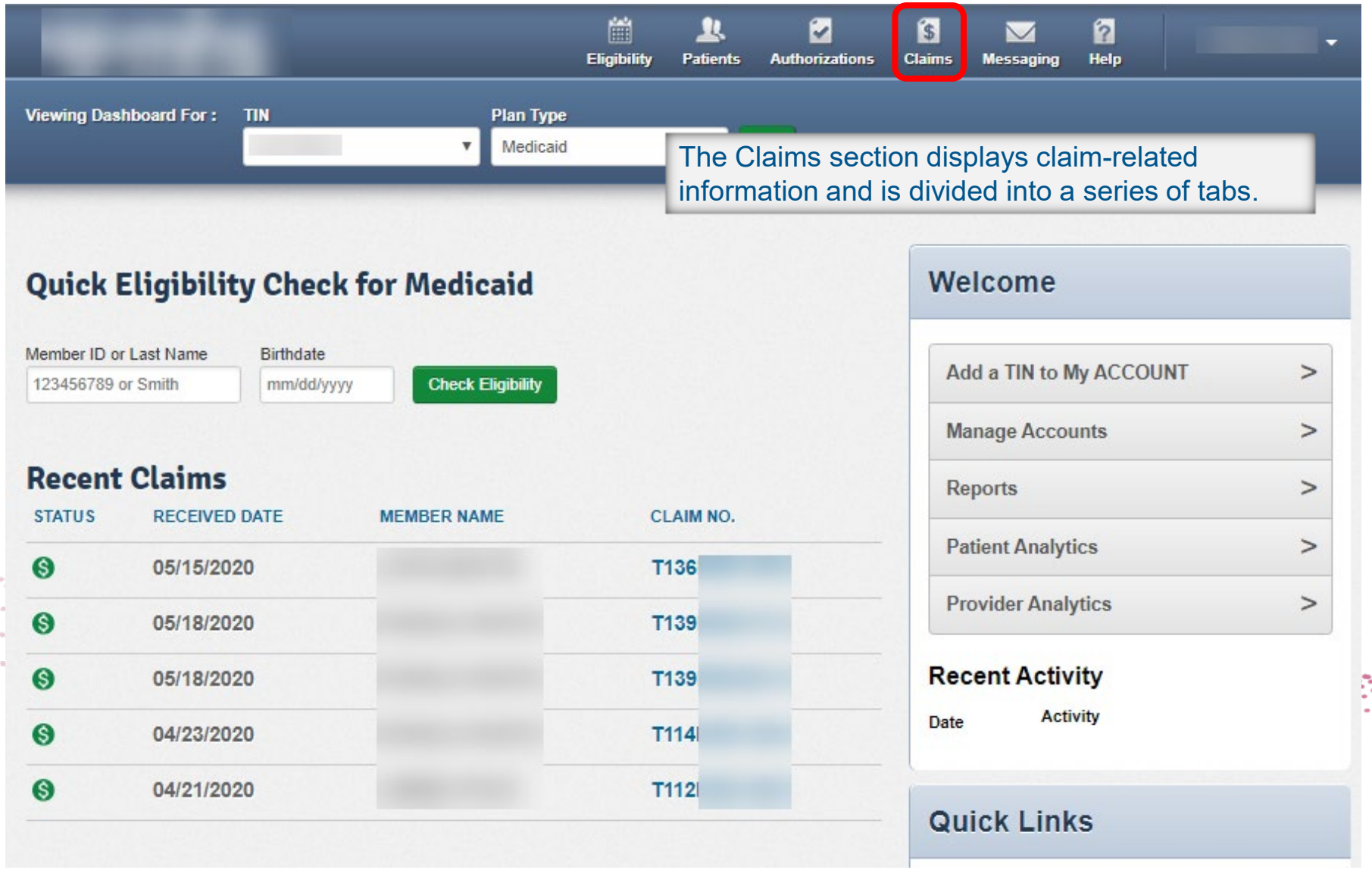
- Always check the member's eligibility before submitting an authorization request
  - A web authorization **cannot** be submitted on an ineligible member

- Web authorizations generally load in processing queue within seconds of submission
- Up to five (5) separate documents can be attached to a web authorization request
- Always use the confirmation number to check the status of the request

If an error is encountered the web authorization request will not load, and thereby will not be processed

Authorization submissions are required through the portal as of January/2021

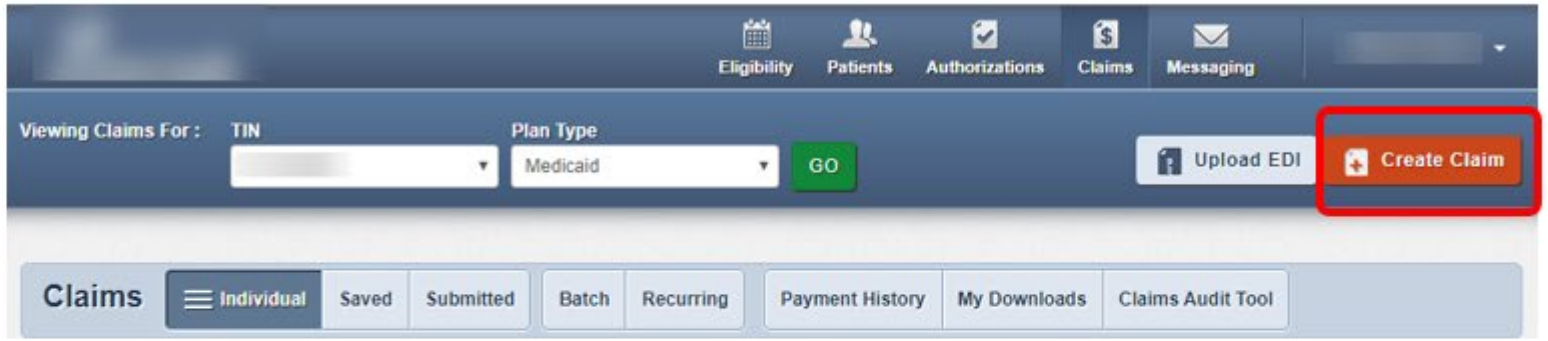
Claims

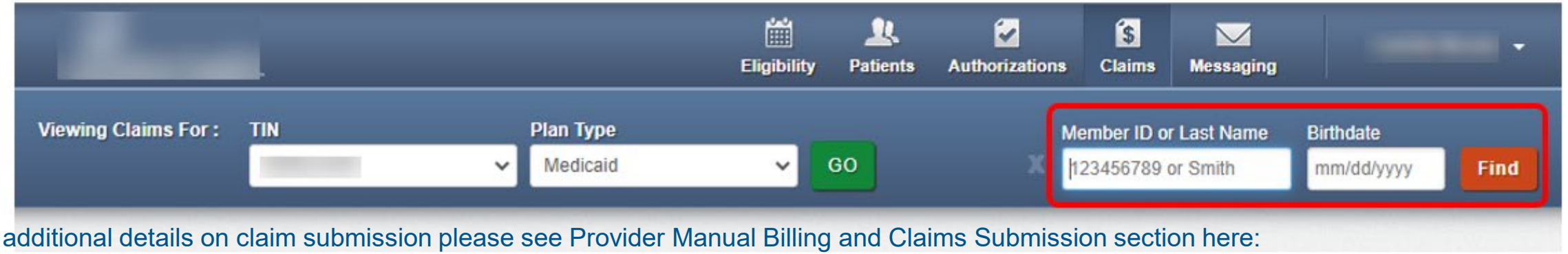

Eligibility
Patients
Authorizations
Claims
Messaging
Help
Viewing Dashboard For :
TIN
Plan Type
Medicaid
The Claims section displays claim-related information and is divided into a series of tabs.
Quick Eligibility Check for Medicaid
Member ID or Last Name
123456789 or Smith
Birthdate
mm/dd/yyyy
Check Eligibility
Recent Claims
STATUS
RECEIVED DATE
MEMBER NAME
CLAIM NO.
05/15/2020
T136
05/18/2020
T139
05/18/2020
T139
04/23/2020
T114
04/21/2020
T112
Welcome
Add a TIN to My ACCOUNT
Manage Accounts
Reports
Patient Analytics
Provider Analytics
Recent Activity
Date
Activity
Quick Links

Claim Submission – Create a new Claim (Individual Web Claim)

To begin an individual web claim:

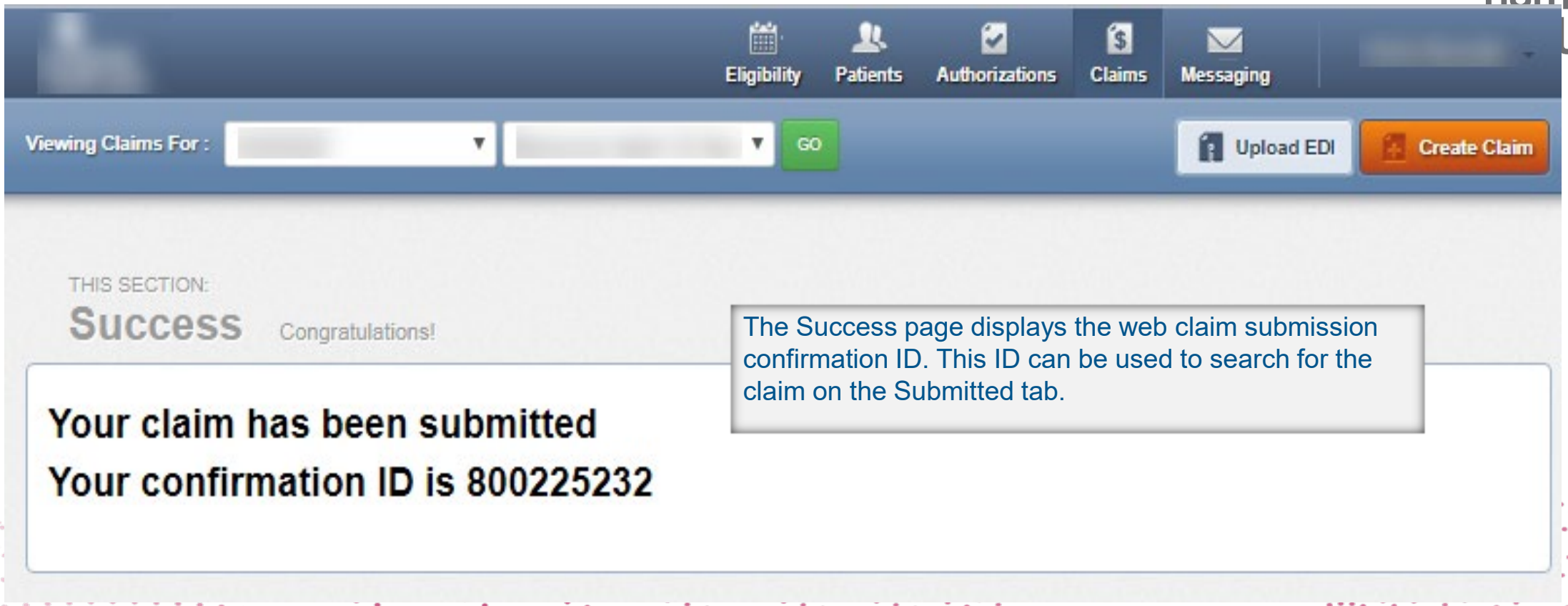
1. Click **Create Claim**
2. Enter **Member ID or Last Name**
3. Enter Member's **Birthdate**
4. Click **Find**





For additional details on claim submission please see Provider Manual Billing and Claims Submission section here: https://www.homestatehealth.com/content/dam/centene/home-state-health/pdfs/HSH_SMHK%20Provider%20Manual%20508%20Compliant%2012272022.pdf

Create new Claim – Submission Confirmation

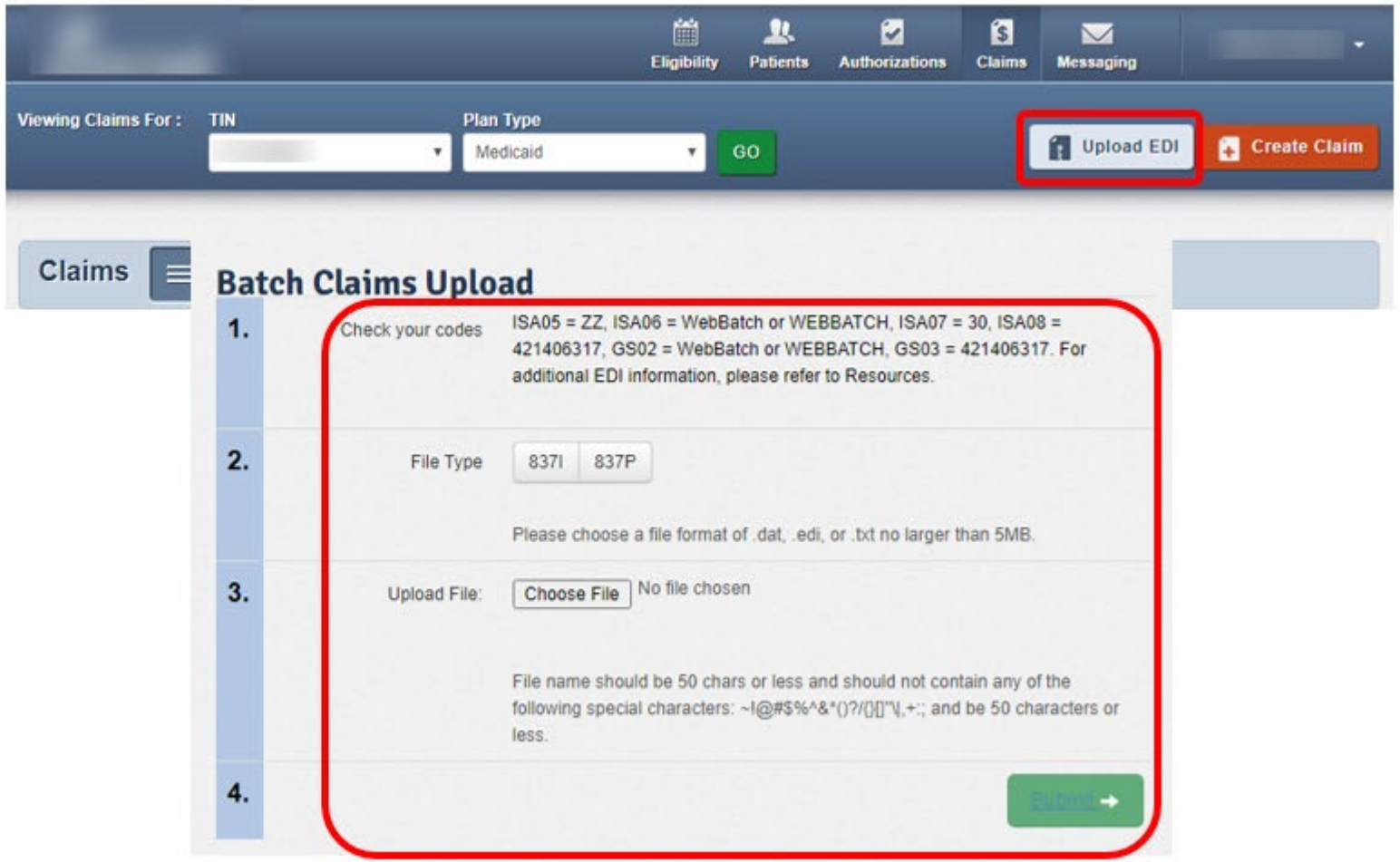


The Success page displays the web claim submission confirmation ID. This ID can be used to search for the claim on the Submitted tab.

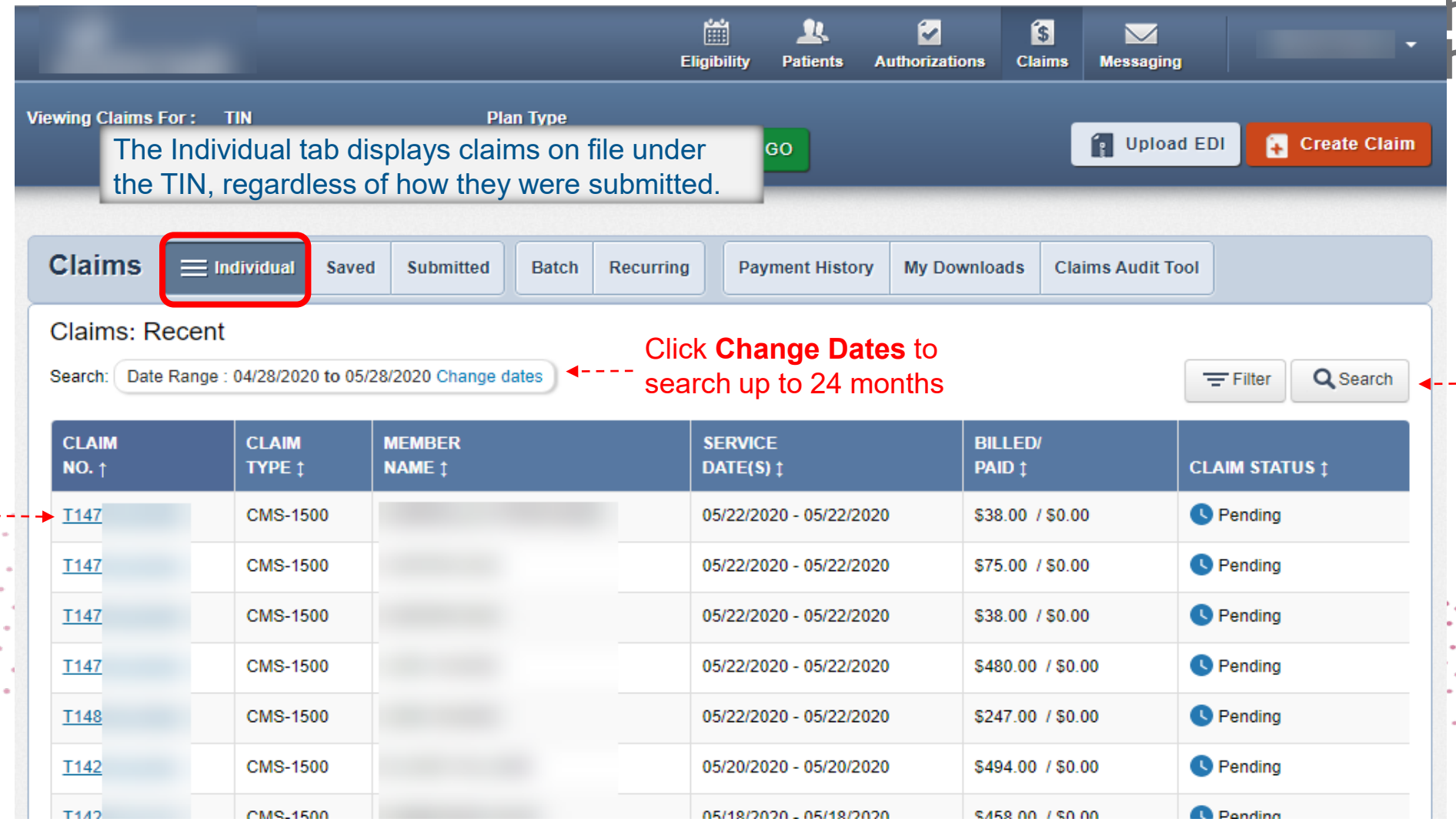
Claim Submission – Upload Electronic Data Interchange (EDI)

Click **Upload EDI** to upload an EDI Batch (837I / 837P).

1. Check the codes in your file.
   - Ensure file name is less than 50 characters and does not contain special characters
2. Select **File Type**.
3. Click **Choose File**. A separate window will display.
4. Select file from your computer directory.
5. Click **Open**.
6. Click **Submit**.



Viewing Claims



Click **Change Dates** to search up to 24 months

Click **Filter** and/or **Search** for additional options

Click Claim Number to view claim details

Benefits of Portal Utilization

home state health

- Portal available 24/7
- Cost savings, portal free to submit claims and authorizations
- Better management of patient's care, i.e., care gaps
- Efficiency of electronic authorizations and claim submissions
- Ability to view patient eligibility
- Ability to view both patient and provider history/data
- Ability to correct claims

Questions?

Show Me Healthy Kids

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