

Provider Orientation:














Allwell from MHS (Medicare Advantage)



FROM



Agenda

-  Plan Overview
-  Membership, Benefits, and Additional Services
-  Providers and Authorizations
-  Preventive Care and Screenings
-  Model of Care (For DSNP only)
-  Medicare STAR Ratings
-  Web Based Tools
-  Network Partners
-  Billing Overview
-  Electronic Funds Transfer & Electronic Medical Records
-  Advance Directives
-  Regulatory Matters
-  Fraud, Waste, and Abuse
-  CMS Mandatory Trainings



Plan Overview




Overview: Medicare Advantage Plans

 **Allwell from MHS** provides complete continuity of care to members including:

- Integrated coordination of care
- Care management
- Co-location of behavioral health expertise
- Integration of pharmaceutical services with the PBM
- Additional services specific to the beneficiary needs

 Approach to care management facilitates the integration of:

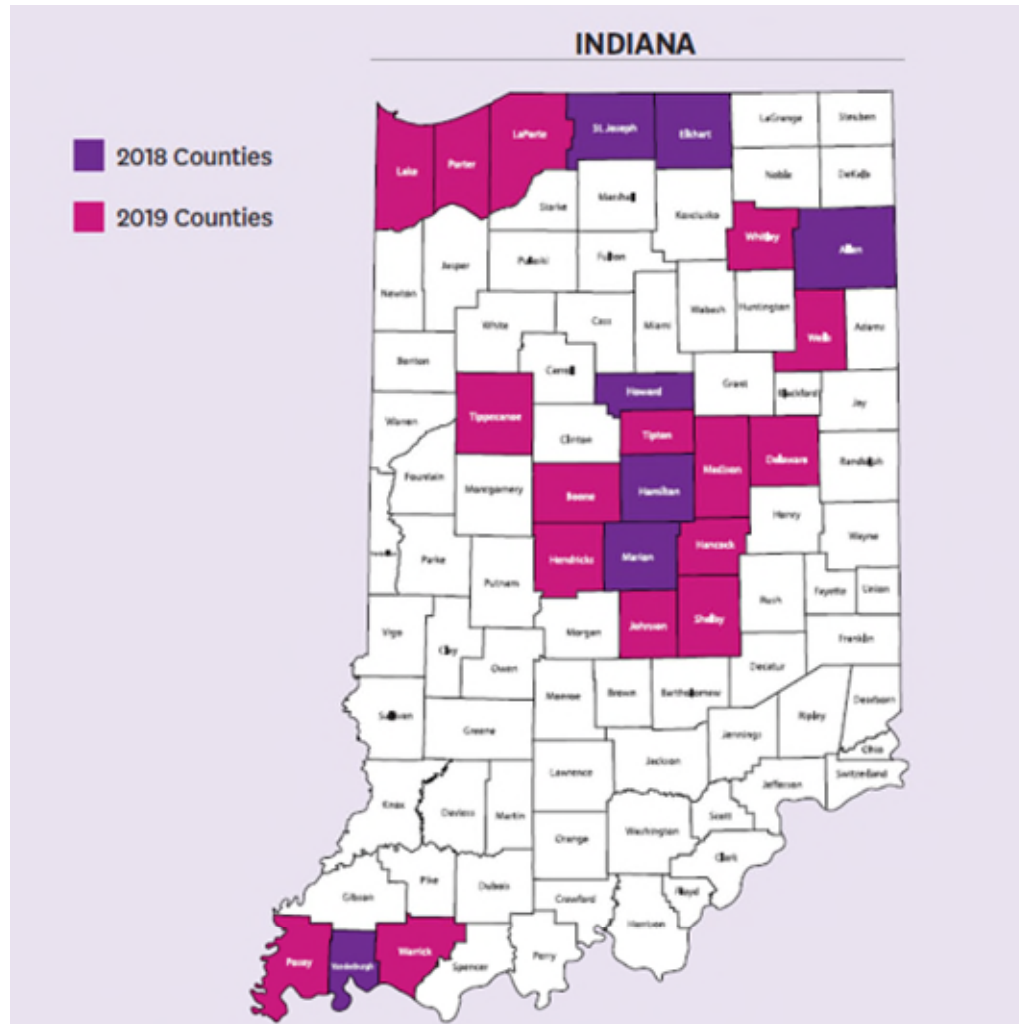
- Community resources
- Health education
- Disease management

 Promotes access to care as beneficiaries are served through a single, locally-based multidisciplinary team including:

- RNs
- Social Workers
- Pharmacy Technicians
- Behavioral Health Case Managers







2019 Counties



Membership, Benefits, and Additional Services



Membership

-  Medicare beneficiaries have the option to stay in the original fee-for-service Medicare Plan or choose a Medicare Advantage Health Plan
-  Advantage members may change PCPs at any time
-  Changes take effect on the first day of the month
-  Providers should verify eligibility before every visit by using one of the below options:
 - Website: allwell.mhsindiana.com
 - 24/7 Interactive Voice Response Line: 1-855-766-1541
 - Provider Services: 1-855-766-1541
 - TTY: 711



Member ID Cards


 <p>HMO CMS#: <XXXX-XXXX> Effective: <MM/DD/YYYY></p>		<p>FOR MEMBERS Member Services: <1-855-766-1541> (TTY: 711) 24-hr Nurse Advice: <1-855-766-1541> (TTY: 711) https://allwell.mhsindiana.com</p>	<p>FOR EMERGENCIES Dial 911 or go to the nearest Emergency Room (ER).</p>
<p>MEMBER INFORMATION Name: <First MI Last> Member ID#: <XXXXXXXX-XX> Issuer ID: <(80840)> <9151014609></p>	<p>PHARMACY INFORMATION  Prescription Drug Coverage Rx Claims Processor: <CVS Caremark> RXBIN: <004336> RXPCN: <MEDDADV> RXGRP: <RX8910></p>	<p>FOR PROVIDERS For eligibility: <1-855-766-1541> Prior authorization or case management referrals: <1-855-766-1541> Pharmacy prior auth: <1-800-867-6564> For help: (PHARMACY USE ONLY) <1-888-865-6567></p>	<p>Submit Part D Drug Claims to: <Allwell> <Attn: Pharmacy Claims> <P.O. Box 419069> <Rancho Cordova, CA> <95741-9069></p>
<p>PROVIDER INFORMATION PCP Name: <> PCP Phone: <></p>		<p>MEDICAL CLAIMS EDI Payor ID: <68069> <Allwell From MHS> <Attn: Claims> <P.O. Box 3060 Farmington, MO 63640-3822></p>	

 <p>HMO SNP CMS#: <XXXX-XXXX> Effective: <MM/DD/YYYY></p>		<p>FOR MEMBERS Member Services: <1-833-202-4704> (TTY: 711) 24-hr Nurse Advice: <1-855-766-1541> (TTY: 711) https://allwell.mhsindiana.com</p>	<p>FOR EMERGENCIES Dial 911 or go to the nearest Emergency Room (ER).</p>
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 <p>PPO CMS#: <XXXX-XXXX> Effective: <MM/DD/YYYY></p>		<p>FOR MEMBERS Member Services: <1-855-766-1541> (TTY: 711) 24-hr Nurse Advice: <1-855-766-1541> (TTY: 711) https://allwell.mhsindiana.com</p>	<p>FOR EMERGENCIES Dial 911 or go to the nearest Emergency Room (ER).</p>
<p>MEMBER INFORMATION Name: <First MI Last> Member ID#: <XXXXXXXX-XX> Issuer ID: <(80840)> <9151014609></p>	<p>PHARMACY INFORMATION  Prescription Drug Coverage Rx Claims Processor: <CVS Caremark> RXBIN: <004336> RXPCN: <MEDDADV> RXGRP: <RX8911></p>	<p>FOR PROVIDERS For eligibility: <1-855-766-1541> Prior authorization or case management referrals: <1-855-766-1541> Pharmacy prior auth: <1-800-867-6564> For help: (PHARMACY USE ONLY) <1-888-865-6567></p>	<p>Submit Part D Drug Claims to: <Allwell> <Attn: Pharmacy Claims> <P.O. Box 419069> <Rancho Cordova, CA> <95741-9069></p>
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Allwell Plan Coverage

 We offer HMO, PPO, and HMO DSNP plans

 \$0 for Premiums*

 \$0/\$5 PCP copay (HMO v. PPO)


 \$0 & \$5 generics

 Great Value-Add Benefits

- \$65 quarterly OTC benefit, \$85 quarterly OTC benefit for DSNP
- Hearing aid benefit
- \$150 eyeglasses benefit for HMO and PPO, \$200 benefit for DSNP
- Silver & Fit
- Preventive dental

 All Part A and Part B benefits by Medicare





 Part B drugs – such as chemotherapy drugs

 Part D drugs – no deductible at network retail pharmacies or mail order, will have copay or coinsurance for some tiers

*\$0 premiums apply to all of the HMO products; and, the PPO product in Allen, Elkhart, St. Joseph, Wells, and Whitley Counties.























Pharmacy Formulary

-  The Allwell formulary is available at:
allwell.mhsindiana.com
 - Please note that the PPO/HMO and the DSNP formulary are different.
-  Please refer to the formulary for specific types of exceptions
-  When requesting a formulary exception, a [Request For Medicare Prescription Drug Coverage Determination](#) form must be submitted
-  The completed form can be faxed to Envolve Pharmacy Solutions at: 1-800-977-8226



Covered Services

-  Hospital Inpatient
-  Hospital Outpatient
-  Physician Services
-  Prescribed Medicines
-  Lab and X-Ray
-  Emergent Transportation
-  Home Health Services
-  Screening Services
-  Preventive Dental
-  Vision Services
-  Hearing Services
-  Behavioral Health
-  Medical Equipment & Supplies
-  Appropriate Cancer Screening Exams
-  Appropriate Clinical Screening Exams
-  Initial Preventative Physical Exam – Welcome to Medicare
-  Annual Wellness Visit
-  Therapy Services
-  Chiropractic Services
-  Podiatric Services

Additional Benefits

Hearing Services

- \$0 co-pay for one routine hearing test every year
- \$0 co-pay for one hearing aid fitting evaluation
- Various levels of hearing aids available at copays between \$0 and \$995, with a 60 day evaluation period

Preventive Dental Services

- Two Oral exams per year with no co-pay
- Two Cleanings per year with no co-pay
- One Dental X-Ray per year with no co-pays

Additional Benefits

Vision Services

- One routine eye exam every year
- One pair of glasses or contacts lenses every year
- \$150 eyewear allowance each year (\$200 for DSNP)

Over-The-Counter Items

- Commonly used over-the-counter items – listing available at: allwell.mhsindiana.com
- Conveniently shipped to member's home within 5 – 12 business days
- Call Member Services at 1-855-766-1541 (TTY: 711) to order items up to \$65 per calendar quarter (\$85/quarter for DSNP)



Additional Benefits

Nurse Advice Line


- Free nurse advice line staffed with registered nurses 24/7 to answer health questions

Certified fitness program at specified Silver & Fit gyms at no extra cost or an in-home fitness kit






Additional Services

Multi-language Interpreter Services

 Free interpreter services to answer questions about the medical or drug plan. To get an interpreter, call us at 1-855-766-1541.

Non-Emergency Transportation (DSNP only)

-  Provides 36 one-way trips per year, to approved locations
-  Schedule trips 48 hours in advance using the plan's contracted providers
-  Contact us at 1-855-766-1541 to schedule non-emergency transportation



Providers and Authorization



Primary Care Physicians (PCP)


PCPs serve as a “medical home” and provide the following:

 Sufficient facilities and personnel

 Covered services as needed

- 24-hours a day, 365 days a year



 Coordination of medical services and specialist referrals

 Members with after-hours accessibility using one of the following methods:

- Answering service
- Call center system connecting to a live person
- Recording directing member to a covering practitioner
- Live individual who will contact a PCP



Utilization Management

-  Authorization must be obtained prior to the delivery of certain elective and scheduled services
-  The preferred method for submitting authorization requests is through the Secure Web Portal at: provider.mhsindiana.com

Service Type	Time Frame
Elective/scheduled admissions	Required five business days prior to the scheduled admit date
Emergent inpatient admissions	Notification required within one business day
Emergency room and post stabilization	Notification requested within one business day

Prior Authorizations

 Prior authorization is required for services such as:

- Inpatient admissions, including observation
- Home health services
- Ancillary services
- Radiology – MRI, MRA, PET, CT
- Pain management programs
- Outpatient therapy and rehab (OT/PT/ST)
- Transplants
- Surgeries
- Durable Medical Equipment (DME)
- Part B drugs

 Use the “Pre-Auth Needed Tool” at allwell.mhsindiana.com to check all services






Out-of-Network Coverage

 Plan authorization is required for out-of-network services, except:

- Emergency care
- Urgently needed care when the network provider is not available (usually due to out-of-area)
- Kidney dialysis at Medicare-certified dialysis center when temporarily out of the service area
- ***Please note that the Allwell PPO plan DOES include out-of-network benefits at a higher cost share to the member.***



Medical Necessity Determination

-  When medical necessity cannot be established, a peer to peer conversation is offered
-  Denial letters will be sent to the member and provider
-  The clinical basis for the denial will be indicated
-  Medical Necessity Appeals must be initiated within 30 days of the denial to be considered. Please note, this is different than a claim appeal request.
-  Member appeal rights will be fully explained

Preventive Care & Screening Tests



Preventive Care

 No copay for all preventive services covered under original Medicare at zero cost-sharing

 Initial Preventative Physical Exam - Welcome to Medicare

- Measurement of height, weight, body mass index, blood pressure, visual acuity screen, and other routine measurements
- Also includes an electrocardiogram, education, and counseling
- Does not include lab tests
- Limited to one per lifetime

 Annual Wellness Visit

- Available to members after the member has the one-time initial preventative physical exam (Welcome to Medicare Physical)



Preventive Care


Abdominal Aortic Aneurysm Screening	Cervical and Vaginal Cancer Screenings	Medical Nutrition Therapy Services
Alcohol Misuse Counseling	Colonoscopy	Medication Review
Blood Pressure Screening	Colorectal Cancer Screenings	Obesity Screening and Counseling
BMI, Functional Status	Depression Screening	Pain Assessment
Bone mass measurement	Diabetes Screenings	Prostate Cancer Screenings (PSA)
Breast Cancer Screening (mammogram)	Fecal Occult Blood Test	Sexually Transmitted Infections Screening and Counseling
Cardiovascular Disease (behavioral therapy)	Flexible Sigmoidoscopy	Tobacco Use Cessation Counseling (counseling for people with no sign of tobacco-related disease)
Cardiovascular Screenings	HIV screening	Vaccines, Including Flu Shots, Hepatitis B Shots, Pneumococcal Shots

Model of Care

(DSNP Only)



Model of Care (DSNP Only)

 The Model of Care is Allwell's plan for delivering our integrated care management program for members with special needs





 The goals of Model of Care are:

- Improve access to medical, mental health, and social services
- Improve access to affordable care
- Improve coordination of care through an identified point of contact
- Improve transitions of care across healthcare settings and providers
- Improve access to preventive health services
- Assure appropriate utilization of services
- Assure cost-effective service delivery
- Improve beneficiary health outcomes






Model of Care (DSNP Only)

Model of Care elements are:



-  Description of the SNP Population
-  Care Coordination and Care Transitions Protocol
-  Provider Network
-  Quality Measurement

Model of Care Process (DSNP Only)

-  Every dual member is evaluated with a comprehensive Health Risk Assessment (HRA) within 90 days of enrollment, and at minimum annually, or more frequently with any significant change in condition or transition of care
-  The HRA collects information about the member's medical, psychosocial, cognitive and functional needs, and medical and behavioral health history
-  Members are then triaged to the appropriate Allwell Case Management Program for follow up



Model of Care Process (DSNP Only)




-  Allwell values our partnership with our physicians and providers
-  The Model of Care requires all of us to work together to benefit our members by:
 - Enhanced communication between members, physicians, providers, and Allwell
 - Interdisciplinary approach to the member's special needs
 - Comprehensive coordination with all care partners
 - Support for the member's preferences in the Model of Care
 - Reinforcement of the member's connection with their medical home



Medicare STAR Ratings

Medicare Star Ratings

What Are CMS Star Ratings?

-  The Centers for Medicare & Medicaid Services (CMS) uses a five-star quality rating system to measure Medicare beneficiaries' experience with their health plans and the health care system
-  The ratings are posted on the CMS consumer website, [medicare.gov](https://www.medicare.gov), to give beneficiaries help in choosing an MA and MA-PD plan offered in their area
-  The Star Rating program is designed to promote improvement in quality and recognize primary care providers for demonstrating an increase in performance measures over a defined period of time

Medicare Star Ratings

CMS's Star Rating Program is based on measures in 9 Different domains:






Part C

1. Staying healthy: screenings, tests and vaccines
2. Managing chronic (long-term) conditions
3. Member experience with the health plan
4. Member complaints, problems getting services and improvement in the health plan's performance
5. Health plan customer service






Part D

1. Drug Plan Customer Service
2. Member Complaints and Changes in the Drug Plan's Performance
3. Member Experience with the Drug Plan
4. Drug Safety and Accuracy of Drug Pricing

How Can Providers Impact & Improve Star Ratings?

-  Continue to encourage patients to obtain preventive screenings annually or as recommended
-  Manage chronic conditions such as hypertension and diabetes including medication adherence
-  Continue to talk to your patients and document interventions regarding topics such as fall prevention, bladder control, and the importance of physical activity and emotional health and wellbeing
-  Create office practices to identify non-compliant patients at the time of their appointment
-  Follow-up with patients regarding their test results

How Can Providers Impact & Improve Star Ratings?

-  Submit complete and correct encounters/claims with appropriate codes and properly document medical chart for all members, including availability of medical records for chart abstractions
-  Review the gap in care files listing members with open gaps, which is available on our secure portal
-  Review medication and follow up with members within 14 days post hospitalization
-  Identify opportunities for you or your office to have an impact on your patient's health and well-being
-  Make appointments available to patients and reduce wait times



Web-Based Tools

Provider Website

 Through the website, providers can access:

- Billing Manuals
- Forms
- HEDIS Quick Reference Guides
- Provider News
- Pre-Auth Needed Tool
- Provider Resources

Provider Website

On our health plan website providers can access:

 Authorizations


 Claims

- Download Payments History
- Processing Status
- Submission / Adjustments
- Clear Claim Connection – Claim Auditing Software

 Health Records




- Care Gaps*

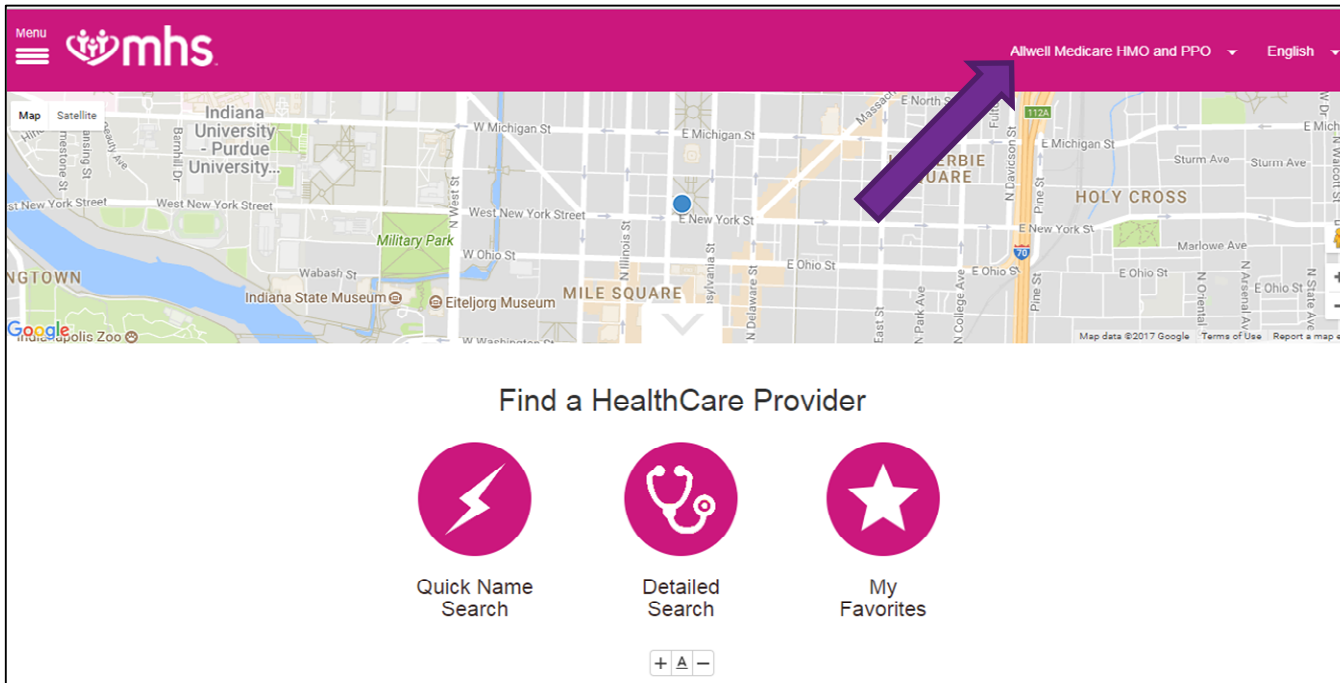
 Monthly PCP Cost Reports*

 Patient Listings* & Member Eligibility

*Available for PCP's only

Online Search Tools

-  Determine whether a provider is in network
-  Conduct Formulary look-up
-  Find Summary of Benefits and EOC



The screenshot shows the mhs website interface. At the top, there is a pink header with the mhs logo, a menu icon, and navigation links for "Allwell Medicare HMO and PPO" and "English". Below the header is a map of Indianapolis, Indiana, with labels for "Indiana University - Purdue University...", "Military Park", "Indiana State Museum", "Eiteljorg Museum", "MILE SQUARE", "HOLY CROSS", and "NGTOWN". A purple arrow points from the "Allwell Medicare HMO and PPO" link to the map. Below the map, the text "Find a HealthCare Provider" is displayed. Underneath this text are three circular icons: a lightning bolt for "Quick Name Search", a stethoscope for "Detailed Search", and a star for "My Favorites". At the bottom of the search options, there are small icons for "+", "A", and "-".

Secure Provider Portal

On the secure provider portal you can access:

 Authorizations

 Claims

- Download Payment History
- Processing Status
- Submission / Adjustments
- Clear Claim Connection – Claim Auditing Software

 Health Records

- Care Gaps*




 Monthly PCP Cost Reports*











 Patient Listings* & Member Eligibility

*Available for PCP's only




Primary Care Provider Reports

-  **Patient List** – located on the secure portal at provider.mhsindiana.com
-  Includes member's name, ID number, date of birth, and telephone number.
-  Available to download to Excel or PDF formats and includes additional information such as member's effective date, termination date, product, gender, and address.

Patient List as of 10/08/2014		Download	Filter	Cost Reports
ELIGIBLE	MEMBER NAME	MEMBER #	DATE OF BIRTH	PHONE NUMBER
	MEMBER, MEMBER	MEMBER#1	MM/DD/YYYY	
	MEMBER, MEMBER	MEMBER#2	MM/DD/YYYY	
	MEMBER, MEMBER	MEMBER#3	MM/DD/YYYY	
	MEMBER, JR. WILLARD	MEMBER#4	MM/DD/YYYY	(773) 555-1234
	MEMBER, JACOBSON	MEMBER#5	MM/DD/YYYY	(773) 555-1234
	MEMBER, JR. JORDAN	MEMBER#6	MM/DD/YYYY	(773) 555-1234
	MEMBER, JR. JORDAN	MEMBER#7	MM/DD/YYYY	(773) 555-1234
	MEMBER, JR. JORDAN	MEMBER#8	MM/DD/YYYY	(773) 555-1234
	MEMBER, JORDAN	MEMBER#9	MM/DD/YYYY	(773) 555-1234
	MEMBER, JORDAN	MEMBER#10	MM/DD/YYYY	(773) 555-1234

Updating Your Data

 Providers can improve Member access to care by ensuring that their data is current in our provider directory

 To update your provider data:


- Login to the secure Provider Portal
- From the main tool bar select “Account Details”
- Select the provider whose data you want to update
- Choose the appropriate service location
- Make appropriate edits and Save

Patient Analytics




Patient Analytics


What is Patient Analytics?


 Patient Analytics is a web-based patient care platform that uses claims data to create a detailed patient- and population-level reporting.


What Does Patient Analytics Do?


 Within Patient Analytics, each patient has a detailed clinical profile. Patients with the most care gaps are identified allowing providers to take a proactive approach to managed care.

Key Benefits

 **Population Health:** Providers are able to manage member's information using patient registries. The information can easily be accessed online and many elements can be printed.

 **Medical History** – Patient Analytics contains up to 24 months of medical, pharmacy, and lab claims.

 **Increased Visibility** – Primary Care Physicians (PCPs) will have access to claims history submitted by other providers.

 **Improved Outcomes:** Patient Analytics helps providers improve patient care, performance, outcomes and adherence to quality measures.



Patients Tab

- Tabs:** Allows the providers to choose between the Patients information and Reports.
- Logout Button:** For security purposes, logout to protect patient information. Not shown, in upper right hand corner.
- Search:** Allows providers to search by the patient's name, Medicaid, Medicare or Marketplace ID number.
- Filters and Export Features:** Allows users to view all patients or filter by multiple criteria. The users will also have the ability to create a PDF document or export a detailed patient profile.

The screenshot displays the 'Patients' tab interface. At the top, there are tabs for 'Patients' and 'Reports'. Below them is a search bar with the placeholder text 'Patients by Name or Medicaid ID'. To the right of the search bar are buttons for 'View All Patients', 'Filter Patients', 'Create PDF', and 'Export'.

The main area shows a table of patients with the following columns: Member Number, Member Name, Member Address, Age_Gender_DOB, Member Phone, High Priority Care Opportunities, Risk Score, IP Probability Score, IP Stays in last 30 days, ER Visits within 90 Days, SubGroup, and Phy. The table lists several patients, including those with IDs 50, 57, 59, 34, 56, 33, 34, 29, 58, 51, and 62.








A 'Manage Filters' dialog box is open in the bottom right corner. It has tabs for 'Business Rules', 'SubGroup', and 'Physician'. The 'Business Rules' tab is selected, showing a 'Filter Patients By' dropdown set to 'Disease & Condition'. Below this, there is a list of medical conditions with checkboxes: Cancer, Cardiology, Chemical Dependency, Congenital, Dermatology, Endocrinology, Gastroenterology, General Utilization and Complications, Gynecology, Hematology, Hepatology, High Cost Chronic Conditions, Infectious Diseases, and Neonatology. At the bottom of the dialog are 'Submit', 'Reset', and 'Close' buttons.

Search Results

Patient Demographics

All Patients | Search Results: 3089

Member Number	Member Name	Member Address	Age_Gender_DOB	Member Phone	High Priority Care Opportunities	Risk Score	IP Probability Score	IP Stays in last 30 days	ER Visits within 90 Days	SubGroup	Physician
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-  **High Priority Care Opportunities:** Displays a count of care opportunities deemed to be of the highest importance.
-  **Risk Score:** Identifies the likelihood that the patient will incur cost and services in the next 12 months when compared to an average patient. An average patient has a health of 1.0. Higher values indicate the patient is more likely to need services in the future.
-  **IP Probability:** A percentage indicating the likelihood that a patient will have one or more inpatient confinements in the next 12 months.
-  **Inpatient Stays in the Last 30 Days:** A metric that captures the number of distinct inpatient hospitalizations in the last 30 days based on processed claims.
-  **Emergency Room Visits within 90 Days:** A metric that shows the number of distinct emergency room visits within 90 days based on processed claims.
-  **Subgroup:** Medicaid, Medicare, or Marketplace.
-  **Physician:** Displays the provider's name and credentials.

Patient Profile

1. **Member Demographics:** Displays information about the member.
2. **All Care Opportunities:** The default landing page for patient details. Displays care opportunities or measures that indicate if a patient has or has not received treatment for a health condition.
3. **Diagnosis:** Shows primary and secondary diagnoses from claims data.
4. **Procedures:** Shows patient procedures associated with primary and secondary diagnoses.
5. **Medications:** Displays a list of medications prescribed to the patient.
6. **Lab/Observational:** Shows lab values, interpretations, and trends.
7. **Care Team:** Allows users to view the patient's providers. Providers are labeled as Managing Doctor or Other Doctor.

The screenshot displays the mhs Patient Profile interface. At the top, the mhs logo is visible, along with the text 'Currently logged into:' and 'Logged in as: \$1 | Log Out'. Below the logo, there are tabs for 'Patients' and 'Reports'. A search bar is present with the text 'Search: Patients by Name or Medicaid ID'. The member information section includes fields for Member Number, Member Name, Member Address, Age, Gender, DOB, Member Phone, High Priority Care Opportunities, Risk Score, IP Probability Score, and ER Visits within 90 Days. Below this, there are tabs for 'All Care Opportunities', 'Diagnosis', 'Procedures', 'Medications', 'Lab/Observational', and 'Care Team'. The 'All Care Opportunities' tab is selected, showing a table of conditions and care opportunities. The table has columns for 'Conditions', 'All Patient Care Opportunities', 'High Priority', and 'Compliance'. The conditions listed are Diabetes, Diabetes, Well Care, Diabetes, and Diabetes. The care opportunities are described in the 'All Patient Care Opportunities' column. The 'High Priority' column shows a yellow star icon for all conditions. The 'Compliance' column shows 'Yes' for all conditions. A 'Create PDF' button is located in the top right corner of the table. Below the table, there is a note: 'Includes claims posted by 7/26/2017'. At the bottom, there is a disclaimer: 'Provider agrees that all health information, including that related to patient conditions, medical utilization and pharmacy utilization, available through the portal or any other means, will be used exclusively for patient care and other related purposes as permitted by the HIPAA Privacy Rule. Contact Us'.

Conditions	All Patient Care Opportunities	High Priority	Compliance
Diabetes	* EBM - Adult(s) w/ diabetes should have an LDL cholesterol w/in prospective rpt period. CP-I	★	Yes
Diabetes	* EBM - Pt(s) should have ambulatory care for diabetes w/in prospective rpt period. CP-I	★	Yes
Well Care	* EBM - Pt(s) >= 20 yrs of age should have a preventive or ambulatory care visit every 3 yrs (HP). NS-H	★	Yes
Diabetes	* EBM - Pt(s) 18 - 75 yrs of age w/ diabetes who should have an annual HbA1c test. NS-H	★	Yes
Diabetes	* EBM - Pt(s) 18-75 yrs of age w/evidence of poor diabetic control (> 9.0%) should have an HbA1c test <9.0%. NSHA	★	Yes

Reports

Currently logged into:  Logged in as: t. [redacted] | [Log Out](#)

[Patients](#)

[Reports](#)

View a report by clicking on image below

Quality Measure Report

Monitor Quality Measures

This report displays all Quality Measures for your patients; it includes the compliance status of each measure and the ability to access the specific patient lists and details.



Management Reports

Patient Management Reports

This report displays all Patient Registries for your patients; it includes the number of patients for each registry and the ability to access the specific patient lists and details.



Additional Reports

Saved Reports

This section displays all of your saved reports.



User Reference Guide

This section displays all imported reports.



[Includes claims posted by 7/26/2017](#)

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[Contact Us](#)

Quality Measures Report

Monitor Quality Measures Report

👤 Users are able to view reports by selected grouping and filtering options

Currently logged into:

mhs

Patients Reports

View a report by clicking on image below

Quality Measure Report

Monitor Quality Measures

This report displays all Quality Measures for your patients. It includes the compliance status of each measure and the ability to access the specific patient lists and details.

Management Reports

Patient Management Reports

This report displays all Patient Registries for your patients. It includes the number of patients for each registry and the ability to access the specific patient lists and details.

Additional Reports

Saved Reports

This section displays all of your saved reports.

User Reference Guide

This section displays all imported n

[Includes claims posted by 7/26/2017](#)

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[Contact Us](#)

Currently logged into:

mhs

Patients Reports

[Reports Landing Page](#)

Monitor Quality Measures

Submit Reset Print Export Save

Summary of Quality Measure Results Total | 10960 Compliant | 4419 Non-Compliant | 6541 Rate | 40.3%

Group by: 1 Group by Options selected

Refine your results with multiple-selection filters and click **Submit**

Filter by: Compliant & Non-Compliant

Filter by: Select one or more Lines of Business

Filter by: Select one or more Quality Measures

Table Grouped by: Quality Measure Total Number of Rows | 68

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Quality Measure Description	Total	Compliant	Non-Compliant	Compliance Rate (%)
EBM - Adult(s) w/ diabetes should have an LDL cholesterol w/in prospective rpt period. CP-1	124	112	12	90.3%
EBM - Adult(s) w/ presumed persistent asthma not using an inhaled corticosteroid or acceptable alternative. R-1	83	63	20	75.9%
EBM - Ped pt(s) w/ presumed persistent asthma who inhaled corticosteroid or acceptable alternative. R-1	19	17	2	89.5%
EBM - Pt(s) should have ambulatory care for diabetes w/in prospective rpt period. CP-1	152	144	8	94.7%
EBM - Pt(s) >= 20 yrs of age should have a preventive or ambulatory care visit every 3 yrs (HP). NS-H	1800	1338	462	74.3%
EBM - Pt(s) >= 40 yrs of age w/ COPD exacerbation who haven't received a bronchodilator w/in 30 days of the hosp or ED dischg (HEDIS). NS-H	21	16	5	76.2%
EBM - Pt(s) 12 - 24 mos of age should have a PCP visit w/in prospective rpt period. NS-H	68	58	10	85.3%
EBM - Pt(s) 12-19 yrs of age should have a PCP visit w/in the prospective rpt period. NS-H	330	216	114	65.5%
EBM - Pt(s) 13 yrs old at the end of the rpt period should have 3 HPV vaccines between their 9th & 13th birthdays. NS-H	18	0	18	0%

[Includes claims posted by 7/26/2017](#)

Provider agrees that all health information, including that related to patient conditions, medical utilization and pharmacy utilization, available through the portal or any other means, will be used exclusively for patient care and other related purposes as permitted by the HIPAA Privacy Rule.

[Contact Us](#)

PCP Cost Reports

-  **Rx Claims Report:** This report includes members with pharmacy claims on a monthly basis. The report is available in Excel and PDF formats, provides detailed member information, provider information, detailed prescription information (such as pharmacy, units, days refill, etc.), and cost.
-  **Members with Frequent ER visits:** This report includes members who frequently visit the ER on a monthly basis. The report is available in Excel and PDF formats, and provides member information, paid (ER) provider information, claim number, procedure information, diagnosis, and cost.
-  **High Cost Claims:** This report includes members with high cost claims. The report is available in Excel and PDF formats, and provides detailed member information, provider information, claim number, procedure information, diagnosis, and cost.



Network Partners



Partners and Vendors

Envolve Pharmacy Solutions: Pharmacy Benefit Manager

- 1-844-202-6824 Phone
- 1-800-977-8226 (Fax) PA Requests

Envolve Vision Benefits: Routine Eye Care Benefit & Ophthalmology Specialty Care

- 1-800-334-3937
- envolvevision.com

Envolve Dental: Dental Services


- 1-855-609-5157
- dental.envolvehealth.com

National Imaging Associates (NIA): Non-Emergent, Outpatient High-Tech Imaging

- 1-800-424-4821
- RadMD.com





AcariaHealth - Specialty Pharmacy

 AcariaHealth is a national comprehensive specialty pharmacy providing services in all specialty disease states including:

- Cystic Fibrosis
- Hemophilia
- Hepatitis C
- Multiple Sclerosis
- Oncology
- Rheumatoid Arthritis

 Most biopharmaceuticals and injectables require prior authorization at: customercare@acariahealth.com

Preferred Pharmacies

-  CVS
-  Walmart
-  University Retail
-  Hometown Pharm
-  Neighborcare
-  Nephew
-  Sam's Club
-  Kroger
-  Kroger Savon
-  Riley Retail
-  COSTCO
-  Schnuck's
-  Deaconess Family




Billing Overview



Electronic Claims Transmission

- 👤 Six clearinghouses for Electronic Data Interchange (EDI) submission
- 👤 Faster processing turn around time than paper submission
 - Emdeon – Payer ID 68069
 - Gateway
 - Availity/THIN
 - SSI
 - Medavant
 - Smart Data Solution

EDI Support

 Companion guides for EDI billing requirements plus loop segments can be found on the following website:
mhsindiana.com/providers/resources/electronic-transactions

 For more information, contact:
Allwell from MHS c/o Centene EDI Department
1-800-225-2573, extension 25525
e-mail: EDIBA@centene.com


Claims Filing Timelines

 Medicare Advantage Claims are to be mailed to the following billing address:

Allwell from MHS

P.O. Box 3060






Farmington, MO 63640-3822

 Participating providers have **180 days** from the date of service to submit a timely claim

 All requests for reconsideration or claim disputes must be received within **180 days** from the original date of notification of payment or denial



Claims Payment

-  A clean claim is received in a nationally accepted format in compliance with standard coding guidelines, and requires no further information, adjustment, or alteration for payment
-  A claim will be paid or denied with an Explanation of Payment (EOP) mailed to the provider who submitted the original claim
-  Providers may NOT bill members for services when the provider fails to obtain authorization and the claim is denied
-  Dual-eligible members are protected by law from balance billing for Medicare Parts A and B services. This includes deductibles, coinsurance, and copayments.
-  Providers may not balance bill members for any differential

Coding Auditing & Editing

 Allwell uses code editing software based on a variety of edits:


- American Medical Association (AMA)
- Specialty society guidance
- Clinical consultants
- Centers for Medicare & Medicaid Services (CMS)
- National Correct Coding Initiative (NCCI)

 Software audits for coding inaccuracies such as:

- Unbundling
- Upcoding
- Invalid codes



Claims Reconsideration & Disputes

 A claim dispute is to be used only when a provider has received an unsatisfactory response to a request for reconsideration

 Submit reconsiderations or disputes to:

Allwell from MHS

Attn: Reconsiderations

P. O. Box 4000

Farmington, MO 63640-4000








Electronic Funds Transfer (EFT) Electronic Remittance Advice (ERA)



EFT/ERA




-  Electronic payments can mean faster payments, leading to improvements in cash flow.
-  Eliminate re-keying of remittance data.
-  Match payments to statements quickly.
-  Providers can quickly connect with any payers that are using PaySpan Health to settle claims.
-  Free service for network providers - payspanhealth.com




Meaningful Use – Electronic Medical Records



Meaningful Use


 EHR/EMR allows healthcare professionals to provide patient information electronically instead of using paper records.

 Electronic Health Records/Electronic Medical Records (EHR/EMR) can provide many benefits, including:


- Complete and accurate information
- Better access to information
- Patient empowerment


Advance Directives

Advance Medical Directives

 An advance directive will assist the Primary Care Provider to understand the member's wishes about their health care in the event they become unable to make decisions on their own behalf. Examples include:

- Living Will
- Health Care Power of Attorney
- “Do Not Resuscitate” Orders

 Member's medical records must be documented to indicate whether an advance directive has been executed

 Providers must also educate staff on issues concerning advance directives and must maintain written policies that address the rights of members to make decisions about medical care

Regulatory Matters



Medicare Outpatient Observation Notice (MOON)

- Contracted hospitals and critical access hospitals must deliver the Medicare Outpatient Observation Notice (MOON) to any Member who receives observation services as an outpatient for more than 24 hours.
- The MOON is a standardized notice to a Member informing that the Member is an outpatient receiving observation services and not an inpatient of the hospital or critical access hospital and the implications of such status. The MOON must be delivered no later than 36 hours after observation services are initiated, or if sooner upon release.
- The OMB approved Medicare Outpatient Observation Notice and accompanying form instructions can be found at www.cms.gov/Medicare/Medicare-General-Information/BNl/index.html







Fraud, Waste, and Abuse




Fraud, Waste, and Abuse

Allwell follows the four parallel strategies of the Medicare and Medicaid programs to prevent, detect, report, and correct fraud, waste, and abuse:

-  Preventing fraud through effective enrollment and education of physicians, providers, suppliers, and beneficiaries
-  Detection through data analytics and medical records review
-  Reporting any identified or investigated violations to the appropriate partners, including contractors, the NBI-MEDIC and federal and state law enforcement agencies, such as the Office of Inspector General (OIG), Federal Bureau of Investigation (FBI), Department of Justice (DOJ) and Medicaid Fraud Control Unit (MFCU)
-  Correcting fraud, waste or abuse by applying fair and firm enforcement policies, such as pre-payment review, retrospective review, and corrective action plan



Fraud, Waste, and Abuse

 Allwell performs front and back end audits to ensure compliance with billing regulations

 Most common errors include:


- Use of Incorrect billing code
- Not following the service authorization
- Procedure code not being consistent with provided service
- Excessive use of units not authorized by the case manager
- Lending of insurance card

 Benefits of stopping fraud, waste, and abuse:

- Improves patient care
- Helps save dollars and identify recoupments
- Decreases wasteful medical expenses



Fraud, Waste, and Abuse





 Allwell expects all its providers, contractors, and subcontractors to comply with applicable laws and regulations, including, but not limited to the following:

- Federal and State False Claims Act
- Qui Tam Provision (Whistleblower)
- Anti-Kickback Statute
- Physician Self-Referral Law (Stark Law)
- Health Insurance Portability and Accountability Act (HIPAA)
- Social Security Act (SSI)
- US Criminal Codes




Fraud, Waste, and Abuse


Effective January 1, 2016:

-  First-Tier, Downstream, and Related Entities (FDR), as well as delegated entities, will be required to complete training via the Medicare Learning Network (MLN) website
-  The trainings must be completed by each individual provider/practitioner within the group rather than one person representing the group collectively
-  The updated regulation requires all applicable entities (providers, practitioners, administrators) to complete the training within 90 days of contracting or becoming a delegated entity and annually thereafter
-  Once training is complete, each applicable entity will need to complete the certificate(s) of completion or attestation through the CMS MLN and provide a copy to the health plan



Medicare Reporting

 Potential fraud, waste, or abuse reporting may be called to our anonymous and confidential hotline at 1-866-685-8664 or by contacting the Compliance Officer at 1-866-796-0530 or by email to ComplianceIN@centene.com

 To report suspected fraud, waste, or abuse in the Medicare program, please use one of the following avenues:

- Office of Inspector General (HHS-OIG): 1-800-447-8477/ TTY: 1-800-377-4950
- Fax: 1-800-223-8164
- NBI MEDIC: 1-877-7SafeRx (1-877-772-3379)
- Email: [OIG.HHS.gov/fraud](https://oig.hhs.gov/fraud) or HHSTips@oig.hhs.gov
- Medicare's Fraud Hotline: 1-866-685-8664



CMS Mandatory Trainings


CMS Mandatory Trainings


 All contracted providers, contractors, and subcontractors are required to complete three required trainings:


- Model of Care (MOC): Within 30 days of joining Allwell and annually thereafter (DSNP only)
- General Compliance (Compliance): Within 90 days of joining Allwell and annually thereafter
- Fraud, Waste, and Abuse (FWA): Within 90 days of joining Allwell and annually thereafter



Model of Care Training Requirements*

 Model of Care training is a CMS requirement for newly contracted Medicare Providers within 30 days of execution of contract.

 Model of Care training must be completed annually by each participating Provider.

 The Model of Care training and attestation information is available on:
Allwell.mhsindiana.com





Sunshine Health > For Providers > Provider Resources

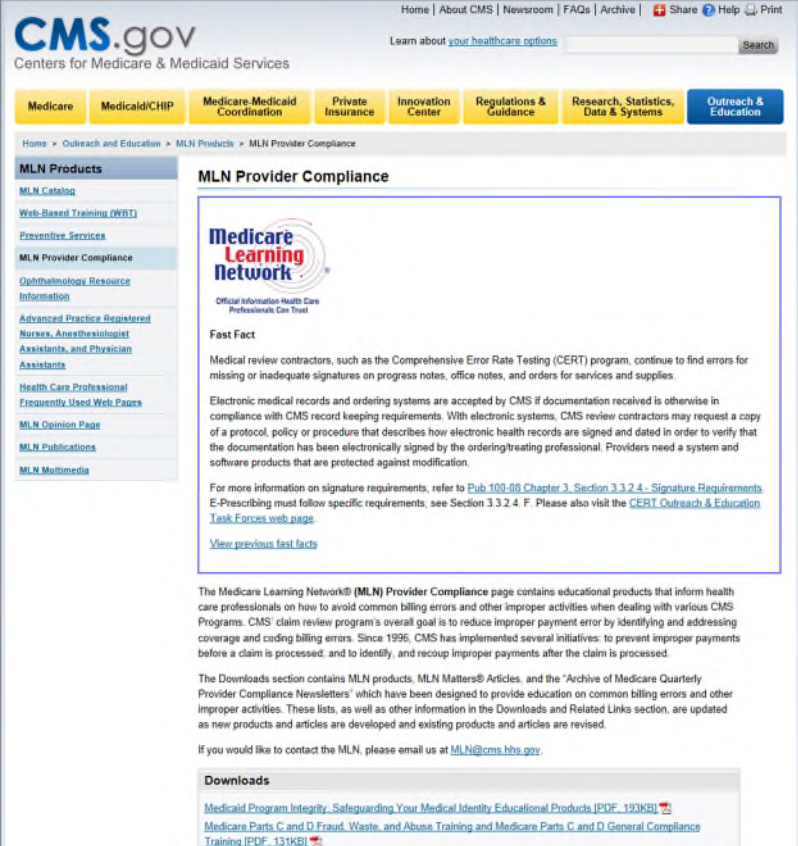
Provider Resources

Become a Provider	Provider Manuals <ul style="list-style-type: none">• Provider Manual [PDF]• Provider Manual – Healthy Kids• Provider Manual – Medicare Advantage• Provider Manual – LTC• NEW! Provider Billing Manual
Electronic Transactions	Claims Related Forms <ul style="list-style-type: none">• Claims adjustment form [PDF]• w-9 (PDF)• Provider Information Update Form [PDF]
Login	General Provider Forms <ul style="list-style-type: none">• Inpatient Prior Authorization Fax Form [PDF]• Outpatient Prior Authorization Fax Form [PDF]• MMA – Provider Quick Reference Guide [PDF]• Provider Quick Reference Guide• Pediatric Anticipatory Guidance [PDF]• Notification of Pregnancy Form [PDF]• Connections Referral Form [PDF]• Prenatal Vitamin Form [PDF]• Prior Authorization List 2012 [PDF]• MMA – Prior Authorization List effective May 1, 2014• Treating Tobacco Use and Dependence – QRG [PDF]• Provider Education – Marketing
National Imaging Associates (NIA)	Advantage Model of Care Training <ul style="list-style-type: none">• Medicare Advantage Model of Care Training
Pharmacy	
Pre-Auth Needed?	
Provider Resources	
FAQs	
Helpful Links	
ICD-10 Overview	
Immunization Information	
Provider Newsletter	
Reporting Fraud, Waste and Abuse	
Providers	
QAPI Program	

*DSNP only

General Compliance & Medicare Fraud, Waste, and Abuse Training

-  Providers are required to complete training via the Medicare Learning Network (MLN) website
-  Must be completed by each individual provider/practitioner within the group rather than one person representing the group collectively
-  Training must be completed within 90 days of contracting and annually thereafter
-  Complete the certificate(s) of completion or attestation through the CMS MLN and provide a copy to Allwell



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Medicare Medicaid/CHIP Medicare Medicaid Coordination Private Insurance Innovation Center Regulations & Guidance Research, Statistics, Data & Systems Outreach & Education

Home > Outreach and Education > MLN Products > MLN Provider Compliance

MLN Products

- MLN Catalog
- Web-Based Training (WBT)
- Preventive Services
- MLN Provider Compliance
- Ophthalmology Resource Information
- Advanced Practice Registered Nurses, Anesthesiologist Assistants, and Physician Assistants
- Health Care Professional Frequently Used Web Pages
- MLN Opinion Page
- MLN Publications
- MLN Multimedia

MLN Provider Compliance

Medicare Learning Network
Official Information Health Care Professionals Can Trust

Fast Fact

Medical review contractors, such as the Comprehensive Error Rate Testing (CERT) program, continue to find errors for missing or inadequate signatures on progress notes, office notes, and orders for services and supplies.

Electronic medical records and ordering systems are accepted by CMS if documentation received is otherwise in compliance with CMS record keeping requirements. With electronic systems, CMS review contractors may request a copy of a protocol, policy or procedure that describes how electronic health records are signed and dated in order to verify that the documentation has been electronically signed by the ordering/treating professional. Providers need a system and software products that are protected against modification.

For more information on signature requirements, refer to [Pub 100-06 Chapter 3, Section 3.3.2.4 - Signature Requirements](#). E-Prescribing must follow specific requirements; see Section 3.3.2.4. F. Please also visit the [CERT Outreach & Education Task Forces web page](#).

[View previous fast facts](#)

The Medicare Learning Network® (MLN) Provider Compliance page contains educational products that inform health care professionals on how to avoid common billing errors and other improper activities when dealing with various CMS Programs. CMS' claim review program's overall goal is to reduce improper payment error by identifying and addressing coverage and coding billing errors. Since 1996, CMS has implemented several initiatives: to prevent improper payments before a claim is processed; and to identify, and recoup improper payments after the claim is processed.

The Downloads section contains MLN products, MLN Matters® Articles, and the "Archive of Medicare Quarterly Provider Compliance Newsletters" which have been designed to provide education on common billing errors and other improper activities. These lists, as well as other information in the Downloads and Related Links section, are updated as new products and articles are developed and existing products and articles are revised.

If you would like to contact the MLN, please email us at MLN@cms.hhs.gov.

Downloads

- [Medicaid Program Integrity, Safeguarding Your Medical Identity Educational Products \[PDF, 133KB\]](#)
- [Medicare Parts C and D Fraud, Waste, and Abuse Training and Medicare Parts C and D General Compliance Training \[PDF, 131KB\]](#)

MHS Provider Relations Team

MHS Provider Network Territories

NORTHEAST REGION

Claims Issues: MHS_ProviderRelations_NE@mhsindiana.com
Chad Pratt, Provider Partnership Associate
1-877-647-4848 ext. 20454
cpratt@mhsindiana.com

CENTRAL REGION

Claims Issues: MHS_ProviderRelations_C@mhsindiana.com
Open
1-877-647-4848

NORTHWEST REGION

Claims Issues: MHS_ProviderRelations_NW@mhsindiana.com
Candace Ervin, Provider Partnership Associate
1-877-647-4848 ext. 20187
Candace.V.Ervin@mhsindiana.com

SOUTHWEST REGION

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Dawn McCarty, Provider Partnership Associate
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Dawnalee.A.McCarty@mhsindiana.com

SOUTHEAST REGION

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Mark Vonderheit
Director, Provider Network
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mvonderheit@mhsindiana.com

NEW PROVIDER CONTRACTING

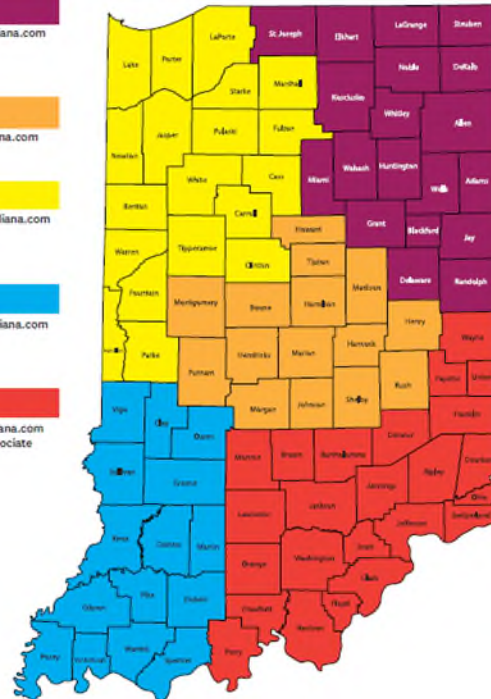
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Indiana



MHS Provider Relations Team

MHS Provider Network Territories

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PROVIDER GROUPS

Beacon Medical Group
Community Care Network
Franciscan Alliance
Goshen Health System
HealthLinc
Heart City Health Center
Indiana Health Centers
Lutheran Medical Group
Northshore Health Centers
Parkview Health System
South Bend Clinic

JENNIFER GARNER

Provider Partnership Associate II
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PROVIDER GROUPS

American Health Network of Indiana
Columbus Regional Health
Community Physicians of Indiana
Good Samaritan Hospital Physician Services
HealthNet
Health & Hospital Corporation of Marion County
Indiana University Health
Little Company of Mary Hospital of Indiana
Riverview Hospital
St. Vincent Medical Group

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Questions?