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Medicaid Care Management Business Process Training: Provider Questions and Answers

TOPICS

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DHHS

1. We are a small family practice whose panel has been closed to new patients for several years. We will certainly accept the new Medicaid insurance of our current patients, but do not have the capacity to accept new-to-the-practice patients. Please have each of the three companies explain how I should handle this.

A provider who has signed a contract with one or all of the 3 Health Plans must consult with Provider Relations at each Health Plan regarding closed panels. Providers should also check the terms of the contract they signed to determine how that Plan handles closed panels.

2. Referring to the slide where you showed the differences between the coverage start dates- Does the last example mean the patient will not have ANY coverage or would it mean that the client that enrolled after 4 PM would have their claims go to Xerox for the month of February?

The client who enrolled after the 4 PM close of business would be covered under Medicaid Fee-for-Service until their Health Plan coverage effective date of February 1st. Claims for that time period would be submitted to Xerox.

3. What date will the information be available through Xerox for us to check which plan our families have selected?

December 1st – NOTE that Xerox shows eligibility on the date the provider checked and does not project future eligibility.

4. Will the MCO or NH Medicaid be responsible for notifying Medicare of who is the responsible insurance payer for Medicare crossover assuming that the dually eligible client chooses to participate in the MCO?

Providers must submit a claim to Medicare and receive a denial before submitting the claim to the MCO, the same way claims for individuals with other third party coverage are handled. There are no 'cross-over' claims for MCOs.

5. Will the three MCOs require that a denial Explanation of Benefits (EOB) from the Third Party Liability (TPL) for each date of service be attached to any paper claim sent to them to collect payment for services as Xerox currently does?

This question should be sent to Provider Relations of each Health Plan to check on their process. Information should also be available in the Provider Manuals of each Health Plan.

6. Will all NH Medicaid members be enrolled in an MCO? Or can they opt to stay in the traditional FFS?

Most – but not all – Medicaid recipients will be enrolled in an MCO. Some recipients do have the option of opting out of MCM; still others are exempt. Participation status for all Medicaid recipients is available through this Resource Document below.

<http://www.dhhs.nh.gov/ombp/caremgmt/documents/recipient-participation-guide.pdf>

7. Some services are not covered by private insurance, for example Case Management. Can we bill the MCO directly or do we have to bill the private insurance for a denial?

Consult directly with the Health Plan(s) you have contracted with to get directions on how they want providers to handle this.

8. How are we to obtain prior authorization (PA) for services that may be provided at the beginning of the month if enrollment information is not provided before the first of the month?

When MCM Program starts – December 1st, 2013 – the Health Plans are contractually obligated to honor existing Prior Authorizations for up to 90 days. Providers delivering services on or after December 1st that have DHHS issued PAs should coordinate with the health plans to ensure that the PA is in place so that claims will be paid. Health Plans will use those first 90 days to review medical plans. NOTE: Health Plans may require authorization for different services than DHHS does.

9. Will authorizations approved by one MCO be honored by the other MCO's should the client switch MCO's?

That is to be determined by each Health Plan. Consult directly with the Health Plan(s) you have contracted with to get directions on how they will handle this situation.

10. What is considered long-term support services or waived?

NH Medicaid has 4 different waivers for long-term services and supports (LTSS): Acquired Brain Disorder, Developmentally Disabled, Choices for Independence and In Home Supports. These services are not included in Step 1 of MCM.

11. In the eligibility transactions (270/271) will the Managed Care plan name be provided if the client has one?

Yes.

12. How does it work when a long-term care (LTC) resident can opt out now, but then leaves to go to community living? What is their timeframe for switching from opting out to a plan? Also, what if they come from the community with a plan to a long-term care facility with a plan, how does that affect a long-term care facility or their services from outside providers?

It is the recipient's MCM participation status that determines what would happen in this case, not the fact that they live in a facility or in the community. A voluntary recipient can remain in opt out status if they leave the facility and can change at any time. A recipient who is enrolled with a Health Plan while living in the community can retain that Health Plan in a LTC facility. (See #14 for answer to what might happen if the recipient has a different Health Plan that the facility does.)

13. Does our Medicaid NH contract cover Meridian Health Plan?

NH Medicaid has contracted with 3 Health Plans: Meridian Health Plan, NH Healthy Families and Well Sense. Providers must also sign a contract with each Health Plan in addition to their NH Medicaid contract.

14. If we choose not to sign a contract with all three companies, we cannot treat these patients and bill Medicaid, correct? We would need to transfer them to another facility?

First, not every resident of a facility will be covered by one of the Health Plans for certain medical services. Those who are exempt or opted out of MCM will remain in Medicaid Fee-for-Service with service provision and reimbursement the same as it is today. Second, services included in a nursing home per diem will continue to be reimbursed Fee-for-Service. It is only those services outside of the per diem that MCM coverage applies. It is difficult to determine why a resident would have to be transferred to another facility.

15. Will the Primary Care Provider be provided in the 270/271 eligibility transaction? It currently is not, can it be added?

No. There are no plans to add the PCP to the information contained in the eligibility transaction. In many cases, this information will not be known by Xerox only by the Health Plan.

16. If a dual eligible client does opt in to an MCO plan but is eligible for the Choices for Independence (CFI) waiver are these services handled directly through Fee-for-Service(FFS) (traditional Medicaid)?

Yes, these services will be reimbursed through the Xerox FFS system as they are currently.

17. Did all recipients (duals included) receive the heads-up letter and follow-up letter? I have a dual eligible who states he did not receive any letters addressed to him – only to his dependent child.

All enrolled Medicaid recipients eligible for MCM were mailed the heads-up letter and Enrollment Packets (exempt recipients who were the sole member of their case did not receive a letter). It is best to call **Medicaid Client Services at 1-800-852-3345 (ext 4344) or 603-271-4344** regarding this client.

18. Will clients that are being covered by Medicaid in a long-term care nursing home be auto assigned a plan? Do they need to opt out?

Mandatory and voluntary Medicaid recipients who did not choose a Health Plan during the 60-day period (date indicated in their letter) or make an active choice (voluntary clients) to opt out will be auto assigned to a plan. Mandatory clients will have 90 days to switch plans. Voluntary clients can either switch plans or opt out at any time. Both types of MCM participants need to call the **Enrollment Call Center at 1-888-901-4999**. (NOTE: clients that are exempt from MCM do not need to do anything.)

Participation status for all Medicaid recipients is available through this Resource Document below.

<http://www.dhhs.nh.gov/ombp/caremgmt/documents/recipient-participation-guide.pdf>

19. When will clients in a LTC facility be affected by MCM?

Many clients in LTC facilities are affected at this time (Step 1). Voluntary clients, however, can choose to opt out in Step 1. Step 2 – when such clients would become mandatory – is projected to begin one year after Step 1 (Program Start Date of December 1, 2013).

20. How will the state let home visiting programs know the MCO selection of their clients?

Home visiting programs should contact their clients and ask them which Health Plan they chose. If the client is not sure, the provider can check eligibility and Health Plan enrollment the same way they do today:

- Online through the Xerox MMIS Health Enterprise Portal
- Electronic 270/271 enrollment transactions
- Automated voice response
- Contact Xerox NH Provider Relations at (603)223-4774 or (866) 291-1674.

21. Home Visiting NH providers have a Medicaid number but no NPI or TPN. How will this be handled in electronic claims submissions?

The *Quick Reference Guide* <http://www.dhhs.nh.gov/ombp/caremgmt/documents/provider-handbook-mbp.pdf> and the *MCO Provider Claims Submission Requirements* <http://www.dhhs.nh.gov/ombp/caremgmt/documents/mco-claims-submission.pdf> contain the information you need to know regarding claims submission. Questions not answered in these documents need to go to the individual Health Plans.

22. If each MCO and Medicaid manages their own process for the excess of psychotherapy service limits requests, does that mean a provider has to call each Health Plan a client has ever been enrolled in?

The provider should call the Health Plan that the client is currently enrolled with on the date of service. That Health Plan will determine how they will manage service limits for those clients who are newly enrolled, i.e., coming from Fee-for Service Medicaid or another Health Plan. The same holds true if a client has seen multiple providers – it is the *Health Plan* a client is enrolled with that should be contacted, not each provider that client has ever seen.

23. Will each company have the same number of allowed psychotherapy visits (18 for adults and 24 for those under age 21)?

The Health Plans are contractually required to deliver at least the same number of visits as Medicaid Fee-for-Service. They may, however, choose to offer additional services. That is up to each Health Plan. Providers need to check with each Health Plan.

24. Who manages the excess (requests to exceed) service limits for psychotherapy services – the Health Plans and Medicaid Fee-for-Service?

The Health Plan will manage these requests for their enrolled MCM members. NH Medicaid will manage those requests for recipients who remain in the Medicaid Fee-for-Service program.

25. Will providers have access to both the Health Plan that a client has and the ID# through the Medicaid (Xerox) portal we use today to check eligibility?

Two of the Health Plan's - NH Healthy Families and Meridian Health Plan – are using the client's Medicaid ID#, which is the same number available in the Xerox portal. Well Sense is using a different ID#, therefore, providers will need to either check their client's card for that number or contact Well Sense. Contact information for each of the Health Plans can be found in the Quick Reference Guide:

<http://www.dhhs.nh.gov/ombp/caremgmt/documents/provider-handbook-mbp.pdf>

MERIDIAN

1. Currently MMIS does not require behavioral health authorizations for Medicare clients who have Medicaid as a secondary. Will Meridian require authorization for Medicare/Medicaid behavioral health clients (non-facility)?

No. Meridian Health Plan will accept the authorization from the primary. For additional details, as well as the other services that do or do not require a Prior Authorization, please see the Authorization Overview grid on page 27 of the Meridian Health Plan Provider Manual located at: <http://www.mhplan.com/nh/providers/index.php?location=provider&page=manual>

2. If we are an outpatient community based pediatric therapy company that sometimes provides services in the home. Is this considered home care services and will it require a prior authorization?

Authorization. For additional details, as well as the other services that do or do not require a Prior Authorization, please see the Authorization Overview grid on page 27 of the Meridian Health Plan Provider Manual located at:

<http://www.mhplan.com/nh/providers/index.php?location=provider&page=manual>

Source: Taken from Provider Manual service authorization grid

Corporate Prior Authorization (may require clinical information)	
	<ul style="list-style-type: none">• High-Tech Imaging – CT Scan, MRI, MRA, PET, Nuclear Cardiology• Elective and emergent inpatient admissions• Home Health Care services including home infusion, skilled nursing and therapy<ul style="list-style-type: none">○ Home Health Services○ Private Duty Nursing○ Hospice○ Furnished medical supplies and DME

3. Our office is located in Maine but is linked to NH hospital. Many of our patients have Medicaid. Will there be anything different for our practice?

If the NH Hospital is contracted with Meridian Health plan, typically all the hospital owned practices are contracted with Meridian and in- or out-of-state would not be an issue. If, however, the Maine office is not contracted with Meridian, it is possible that Prior Authorization would be required for members to see out of state out of network providers. All providers must be NH Medicaid providers.

4. Can you please clarify that Meridian will be using the clients Medicaid ID # as their subscriber #?

Yes, Meridian Health Plan will use the current New Hampshire Medicaid ID as the Meridian Health Plan member ID. When a member joins Meridian, they will receive a member ID card sent by first class mail within five days. A separate card will be provided for each member of the family who is enrolled with Meridian. The Meridian ID Card will include the following:

- Member Name
- Member Date of Birth
- Medicaid ID Number
- PCP Phone Number
- Member Services Phone Number
- Other Special Instructions

Members must bring their Meridian ID card with them every time they need to access medical services within the Meridian provider network. Members are not to share cards with anyone else. If there are any questions, please call Member Services at 855-291-5221.

5. Can you also clarify if providers can submit an 837 file directly though the provider portal?

Providers may submit batch claims to Meridian Health Plan. Providers may call 1-866-968-1935 or email helpdesk@mhplan.com to request a copy of the Trading Partner form that will need to be completed to exchange files with Meridian Health Plan.

6. Does our Medicaid NH contract cover Meridian Plan?

No, providers must also sign a contract with Meridian Health Plan in addition to their NH Medicaid contract.

To become a participating provider with Meridian Health Plan contact the Provider Services department at 877-480-8250.

Building a comprehensive network for New Hampshire's Medicaid needs is a top priority. To join Meridian's network providers must first be enrolled in New Hampshire Medicaid. More information is available at nh.mmis.nh.gov or by calling 603-224-1747.

7. For mental health counseling, will Meridian authorize 24 sessions initially as NH Medicaid does?

Refer to the Behavioral Health Referral and Authorization Table on pages 46-49 of the Meridian Health Plan Provider Manual, located at <http://www.mhplan.com/nh/providers/index.php?location=provider&page=manual>, for details.

8. We are a community mental health center and many of our staff see clients in their homes or in the schools for individual or family therapy. Is this considered home care and need prior authorization?

Yes. Home Health Care services include therapy and require a corporate Prior Authorization. For additional details, as well as the other services that do or do not require a Prior Authorization, please see the Authorization Overview grid on page 27 of the Meridian Health Plan Provider Manual located at:

<http://www.mhplan.com/nh/providers/index.php?location=provider&page=manual>

Source: Taken from Provider Manual service auth grid

Corporate Prior Authorization (may require clinical information)	
<ul style="list-style-type: none">• High-Tech Imaging – CT Scan, MRI, MRA, PET, Nuclear Cardiology• Elective and emergent inpatient admissions• Home Health Care services including home infusion, skilled nursing and therapy<ul style="list-style-type: none">○ Home Health Services○ Private Duty Nursing○ Hospice○ Furnished medical supplies and DME	Find

9. Are ambulance providers required to be enrolled in your network to be reimbursed? And if so, do non-emergency transports require prior authorization?

Ambulance providers do not need to be in the Meridian network to be reimbursed NH Medicaid rates for emergency transport. Prior Authorization is not needed for emergency transport.

Non-emergent ambulance transportation does require Corporate Prior Authorization. For additional details, as well as the other services that do or do not require a Prior Authorization, please see the Authorization Overview grid on page 27 of the Meridian Health Plan Provider Manual located at:

<http://www.mhplan.com/nh/providers/index.php?location=provider&page=manual>

10. Do wheelchair van transports require prior authorization?

No, wheelchair van transports do not require prior authorization up to the service limit. For additional details, as well as the other services that do or do not require a Prior Authorization, please see the Authorization Overview grid on pages 27-29 of the Meridian Health Plan Provider Manual located at:

<http://www.mhplan.com/nh/providers/index.php?location=provider&page=manual>

11. Will Meridian be paying according to their own established fee schedule or paying based on the current NH Medicaid fee schedule?

Meridian Health Plan pays the current NH Medicaid fee schedule for most services.

12. We currently use MD Online as our clearing house; do you accept electronic claims from them?

Please check with MD Online or email helpdesk.com for the latest information on submitting claims.

13. For services not covered by the primary insurance can we bill Meridian directly without billing the primary (example service Case Management)?

It is important to remember that Meridian Health Plan is a Medicaid plan and is always the final payer. Meridian is responsible only for the difference between what the primary insurance pays and the allowable Medicaid fee screen. Please submit claims that have other insurance payers to Meridian with an attached EOB payment or rejection.

14. Does our current NH Medicaid contract cover the 3 new MCO plan. Or do we need to have new contracts with each MCO Plan?

No, providers must also sign a contract with Meridian Health Plan in addition to their NH Medicaid contract.

To become a participating provider with Meridian Health Plan contact the Provider Services department at 877-480-8250.

Building a comprehensive network for New Hampshire's Medicaid needs is a top priority. To join Meridian's network providers must first be enrolled in New Hampshire Medicaid. More information is available at  <http://www.dhhs.nh.gov> or by calling 603-224-1747.

Source: Provider home page language.

15. Will each company have their own fiscal year? If so, this poses issues for providers since on Health Plan might not require authorizations while another one does.

Meridian Health Plan's fiscal year is from July 1st to June 30th.

16. ID cards for the 3 MCOs – one will provide clients with a temporary card. Is it possible to get specific dates on when cards will be issued? Until cards are provided will providers need to call the MCOs with names/DOB so that we do not delay billing for a long period of time?

When a member joins Meridian, they will receive a member ID card sent by first class mail within five days. A separate card will be provided for each member of the family who is enrolled with Meridian. The Meridian ID Card will include the following:

- Member Name
- Member Date of Birth
- Medicaid ID Number
- PCP Phone Number

Member Services Phone Number
Other Special Instructions

Members must bring their Meridian ID card with them every time they need to access medical services within the Meridian provider network. Members are not to share cards with anyone else. If there are any questions, please call Member Services at 855-291-5221.

Member eligibility changes frequently, so it is important to verify eligibility prior to rendering services to a member.

To verify if a member is currently eligible to receive services through Meridian, the following steps must be followed:

1. Request that the member present his/her Meridian ID card at each encounter
2. Request that the member present his/her State of New Hampshire Medicaid ID card which is generated at the time of enrollment in the Medicaid program
3. Review your PCP monthly eligibility report or verify on-line utilizing the Meridian Provider Portal each time the member appears at the office for care or referrals
4. Call the Member Services department at 855-291-5221 for assistance with eligibility determinations

17. Does the Behavioral Health therapy clock restart on December 1st? Or will the MCO be receiving the mental health session counts provided to the member up to December 1st?

Please call Meridian Behavioral health for the latest information on this. 1-855-291-5218

18. What are the current podiatry modifiers used?

Meridian uses the same modifiers that are in the NH Medicaid claims manuals.

NH HEALTHY FAMILIES

1. We currently use MD Online as our clearing house; does NHHF accept electronic claims from them?

Yes, MD Online is one of many clearinghouses New Hampshire Healthy Families accepts.

2. There is currently a maximum limit of 12 week intervals that MMIS will cover for prior authorization requests...will this stay the same for NHHF or will there be a new maximum time frame that prior authorization requests will cover?

Prior Authorization time frames are based on medical necessity and individualized based on the member. There is not a set amount of time.

3. How can we get our email contact to NHHF to get the information on the web portal training occurring later on this month?

Providers have the opportunity to receive information about the New Hampshire Healthy Families web portal at our provider orientations. New Hampshire Healthy Families will offer a separate opportunity for web portal training. When these training opportunities are confirmed, providers can register at New Hampshire Healthy Families website at www.nhhealthyfamilies.com.

NHMF has established those dates and has made those webinar opportunities available on our website. The below link will bring the provider to our website where the provider can sign up for the webinars being offered throughout January: <http://www.nhhealthyfamilies.com/providers/provider-orientation/>

4. Please describe the requirements for ambulance providers. Are ambulance providers required to be enrolled in your network to be reimbursed? What about emergency transports?

For emergency transports in an ambulance, the ambulance provider is not required to be enrolled in the New Hampshire Healthy Families network. For non-emergent ambulance transportation, the ambulance provider needs to enroll with NHMF's transportation vendor.

5. Last week I spoke with Steve and we were unable to be recognized with our tax id because we are really not a provider until 12/1/13. Has this problem been corrected?

For a period of time prior to the program start date of December 1, 2013, providers were unable to access the Cenpatico portal. Cenpatico developed a workaround so the portal began to receive providers in advance of the program start date. Providers should not experience difficulties signing up for or accessing the portal moving forward. If a provider does encounter portal-related issues, they should contact Steve Stefanick directly at 603-716-4677 or [sstefanick@cenpatico.com](mailto:ss Stefanick@cenpatico.com).

6. Regarding ERAs, if we submit 837 claims through a clearinghouse, in our case, Capario, doesn't HIPAA require a carrier to return the 835/ERA via the same channel—and not necessarily via PaySpan?

All of our ERAs go through PaySpan at no cost to the provider. We are not aware of any such HIPAA requirement.

7. What about current clients? Do they get an additional 24 outpatient Mental Health visits without a PA?

For patients with current prior authorizations, these existing authorizations will be honored for up to 90 days. For a member who comes into a new treatment episode of care with a participating provider, he/she will receive services based on Covered Services and Authorization Guidelines. That means, seeking any required prior authorizations. Any care provided for a member by a non-participating provider will require a prior authorization. The authorization limits are based on medical necessity criteria and the member's needs.

8. For a new client, the first session does not require a PA however, after this initial session, a PA must be submitted to request more therapy sessions? With a treatment plan?

Services that require prior authorization are outlined on the Covered Services and Authorization Grid. For participating providers, certain services will require an authorization which can be requested via an Outpatient Treatment Request and submitted to Cenpatico for review. Any non-participating provider will need to request a prior authorization for all services

9. Is your fee rate the same as current NH Medicaid rates?

Our standard approach is to pay providers in alignment with NH Medicaid rates.

10. Will each company have their own fiscal year? If so, this poses issues for providers since on Health Plan might not require authorizations while another one does.

While we are not sure of other Managed Care Organizations fiscal calendars, New Hampshire Healthy Families runs January through December. However, the identification of a fiscal year does not have a direct bearing on the development of our authorization policy. We can say that each MCO will likely have some differences in their policy which is determined by a number of factors beyond fiscal year.

11. ID cards for the 3 MCOs – one will provide clients with a temporary card. Is it possible to get specific dates on when cards will be issued? Until cards are provided will providers need to call the MCOs with names/DOB so that we do not delay billing for a long period of time?

All enrollees with New Hampshire Healthy Families were sent an identification (ID) card (either permanent or temporary) to ensure home delivery prior to the first day of coverage, December 1, 2013. Members who selected a primary care provider (PCP) as part of their enrollment process have been sent a permanent ID card that includes the name of their selected PCP on the ID card. All members identified on our Department of Health and Human Services (DHHS) provided enrollment files without a PCP, were sent a temporary ID card to allow additional time to select a PCP. Providers should keep in mind that, just like current Medicaid, the presentation of an ID card is not a guarantee of enrollment in a health plan and provider should seek to validate enrollment. For New Hampshire Healthy Families members, providers can confirm enrollment by:

- (1) Calling our automated system;
- (2) Viewing eligibility online (once enrolled in our provider portal); or

Visit the DHHS Medicaid Management Information System online to validate the name of the patient's current health plan enrollment.

WELL SENSE HEALTH PLAN

1. If we are an outpatient community based pediatric therapy company that sometimes provides services in the home is this considered home care services and will it require a prior authorization through Well Sense?

Yes, the place of service (facility/practice site/member's home) does matter. Outpatient therapy requires prior authorization. Visit [Well Sense.org/provider](http://www.Well Sense.org/provider) and view Section 8 – Utilization Management and Prior Authorization of our Provider Manual for details on prior authorization and to obtain the prior authorization form. You may also view our Reimbursement Policies at [Payment Policies](#).

2. There is currently a maximum limit of 12 week intervals that MMIS will cover for prior authorization requests...will this stay the same for Well Sense or will there be a new maximum time frame that prior authorization requests will cover?

Prior authorization is determined based on the medical necessity. There are common time intervals for acute services and different time intervals for services expected to be more long term. For example, initial Home Care services for an acute medical issue is commonly up to 1 month, whereas Hospice services commonly have approvals for 3 months. Please visit www.Well Sense.org/provider and view Section 8 – Utilization Management and Prior Authorization of our Provider Manual for details on prior authorization.

3. Are ambulance providers required to be enrolled in your network (or CTS) to be reimbursed? What about emergency transports?

Ambulance providers should be enrolled in our network for emergent transport. For non-emergent transport please enroll with CTS.

4. Can you please clarify if providers can submit an 837 file directly through your provider portal?

Yes, Well Sense Health Plan accepts direct submittal. Please contact our EDI department at 617-748-6175.

5. Are prior authorizations by units or visits?

Prior authorization is based on service. Please visit www.Well Sense.org/provider and view Section 8 – Utilization Management and Prior Authorization of our Provider Manual for details on prior authorization

6. Are the DME claims sent directly to Northwood for processing? Or are they sent to Well Sense directly?

DME providers should submit claims directly to Northwood for processing.

7. In NH, NH Medicaid allows non-licensed Master's level clinicians to see and be reimbursed for psychotherapy in a Community Mental Health Center setting. Will Well Sense / Beacon be the same? If so, do you see this changing in the future?

Yes, Beacon Health Strategies is allowing the CMHC provider to bill under their own NPI as the rendering for the unlicensed clinicians.

8. Are speech, OT and PT considered combined services in allowing authorization for units or visits?

Yes, therapy visits are combined for outpatient visits.

9. We are from a long-term care facility; many residents require wheelchair transport to outside specialist offices, outpatient testing, etc. How do we handle their transportation?

Please contact our partner, Coordinated Transportation Solutions at 800-492-9923 for additional details.

10. For clients who are Medicare primary, there are many services that are not covered by Medicare, such as TCM's. Medicaid allows us to skip billing the primary for the denial as they are already aware of which services are "non-covered". Will we be able to do the same with Well Sense OR will we be required to bill the primary for the denial?

Providers should submit to Medicare first, obtain the denial and file the claim as COB with a copy of the Medicare remittance advice.

11. What is the notification process for urgent care centers and emergency rooms?

Notify the Plan no later than the next business day following emergency services at 866.-813-8607. Include member name, member ID number and reason for admission. Medically necessary urgent or emergent care does not require prior authorization.

12. Will Well Sense use the Medicaid ID or Well Sense number to look up patients?

Well Sense Health Plan will use a unique Well Sense ID number for members. To view eligibility, you can use member first, last name and DOB and/or the Well Sense unique ID number.

13. If we are not a Medicare provider will be able to submit a bill to you? Do we need to bill Medicare and get a denial/will there be any coverage through Medicaid?

Yes, you can submit claims to Well Sense Health Plan; however, you should submit a claim to Medicare if they are primary to obtain the denial and then submit to Well Sense as the payer of last resort.

14. Will Well Sense accept electronic claims from MD Online (our current clearinghouse)?

Yes, please visit WellSense.org/providers for additional information on EDI.

15. For Recipients who have a Medicare Part D plan – how are their pharmacy bills handled?

Enrollees with a Medicare Part D plan should bill the Part D plan as primary for prescription coverage. Well Sense is the secondary payer for Part D excluded drugs.

16. What is we do not choose to contract with Beacon and a patient chooses the Beacon plan, does Medicaid then cover them?

Medicaid is not paying for Behavioral Health visits if the enrolled health plan member does not obtain services through a Managed Care Organization, i.e., there is no option to opt out for behavioral health services. You may outreach to provider.relations@beaconhs.com to become a participating provider with us.

17. Will each company have their own fiscal year? If so, this poses issues for providers since on Health Plan might not require authorizations while another one does.

Well Sense will follow the same fiscal year as DHHS for eligibility.

18. ID cards for the 3 MCOs – one will provide clients with a temporary card. Is it possible to get specific dates on when cards will be issued? Until cards are provided, will providers need to call the MCOs with names/DOB so that we do not delay billing for a long period of time?

ID cards are currently being sent to Members. Well Sense Health Plan is NOT issuing temporary ID cards. To verify member eligibility, always verify at time of service:

- with DHHS via the MMIS system; or
- Well Sense Health Plan options:
 - Secure provider portal: Well Sense.org
 - Call the Provider Service Center at 877-957-1300 option 3.