Agenda

- Behavioral Health Provider Types
- Covered Services
- Substance Use Disorder (SUD) Residential Treatment Service
- IOT, Crisis Intervention & Peer Recovery Services_BT201929
- Provider Enrollment
- Demographic Updates
- Prior Authorization
- Claims Process
- Behavioral Health Claims Issue Resolution
- MHS Portal
- Provider Relations Resources
- Questions
Behavioral Health Provider Types
MHS Behavioral Health Network

Provider Types
- Hospitals
- Community Mental Health Centers (CMHC)
- BH Practitioners within FQHC/RHC setting
- Behavioral Health Agency
- Prescribers
  - Psychiatrist –(MD/DO)
  - Psych Nurses (RN, APRN, ARNP, LPN)
- Psychologist (PHD, PSYD, HSPP)
- Master Level Clinicians (LCSW, LMFT, Non-Licensed & Substance Abuse Providers)
- Please note that professional covered services can only be billed and reimbursed to IHCP enrolled:
  - Psychiatrists
  - Psychologists (HSPP Only)
  - Nurse Practitioners
    - Independently Practicing
    - Enrolled with IHCP & employed by a physician or group
Covered Services
Behavioral Health Covered Services

- Inpatient & Outpatient Facility Services:
  - Inpatient Admission for Mental Health or Substance Abuse
  - Inpatient Eating Disorders
  - Observation (limited to 72-hour stay)
  - Telehealth Services
  - Intensive Outpatient Treatment (IOT) for Mental Health or Substance Abuse_BT201929
  - Partial Hospitalization
  - Psychiatric Clinic
  - Psychiatric Outpatient Hospital Services
  - SUD Services Residential Treatment_BT201801

*Listing is not all-inclusive and subject to change
Behavioral Health Covered Services

- Professional Services
- Psychiatric Diagnostic Evaluation
- Individual/Family/Group Psychotherapy
- Crisis Psychotherapy
- Psychoanalysis
- Psychological Testing
- Neuropsych Testing
- Applied Behavioral Analysis (ABA) Services
- Evaluation and Management
- Observation Care Discharge Services
- Initial Observation Care
- Initial Hospital Care
- Office Consultations
- Inpatient Consultations
- Smoking Cessation
- Alcohol and/or Substance Abuse structured screening and brief intervention
- Opioid Treatment Program (OTP)

* Listing is not all-inclusive and subject to change
Substance Use Disorder (SUD) Residential Treatment
Residential SUD Treatment Provider Enrollment

Effective March 1, 2018, IHCP established a new provider specialty for SUD residential addiction treatment facilities.

- Provider type 35 – Addiction Services; and
- Provider specialty 836 – SUD Residential Addiction Treatment Facility

To enroll, a facility must meet the following requirements and submit proof of both:

- DMHA certification as a residential (sub-acute stabilization) facility or Department of Child Services (DCS) licensing as a child care institution or private secure care institution; and

- DMHA designation indicating approval to offer ASAM Level 3.1; or Level 3.5 residential services
SUD Residential Treatment Services

Residential SUD Treatment Claims Submission:

- SUD Billing:
  - H2034 U1 or U2 – Low-Intensity Residential Treatment
  - H0010 U1 or U2 – High-Intensity Residential Treatment

- Reimbursement is limited to one unit per member per provider per day;

- Facilities should bill using a CMS-1500:
  - Claims MUST be submitted at the facility level with the facility NPI as rendering (box 24J) on the CMS-1500 claim form;

*(Practitioners may not bill or be listed as the rendering)*,
SUD Residential Treatment Services

Residential SUD Treatment Claims Submission:

Providers will be reimbursed for residential stays for substance use treatment on a *per diem* basis;

The following services are included within the *per diem*:

- H2034 U1 or U2 – Low-Intensity Residential Treatment:
  - Individual Therapy
  - Group Therapy
  - Medication Training and Support
  - Case Management
  - Drug Testing
  - Peer Recovery Supports

- H0010 U1 or U2 – High-Intensity Residential Treatment
  - Individual Therapy
  - Group Therapy
  - Medication Training and Support
  - Case Management
  - Drug Testing
  - Peer Recovery Supports
  - Skills Training and Development
SUD Residential Treatment Services

Residential SUD Treatment Claims Submission:

- SUD residential addiction treatment facilities rendering services other than those included in the *per diem* must bill for those additional services using another, appropriate IHCP enrolled provider type and specialty:

- Services that are reimbursable outside the daily per diem rate include Physician Visits and Physician-administered medications;

- Services included in the per diem payment will not be reimbursed separately for a member for the same DOS as the per diem payment is reimbursed;

- Refer to IHCP Bulletin 201801 for further policy and reimbursement related details;
SUD Residential Treatment Services

Residential SUD Treatment Prior Authorization:

- SUD residential treatment services require prior authorization;

- Please visit the MHS website at the following location for PA forms specific to SUD services: [https://www.mhsindiana.com/providers/behavioral-health/bh-provider-forms.html](https://www.mhsindiana.com/providers/behavioral-health/bh-provider-forms.html);

- PA Forms specific to SUD services include:
  - Initial Assessment Form for Substance Use Disorder Treatment Admission;
  - Residential/Inpatient Substance Use Disorder Treatment Prior Authorization Request Form;
  - Reassessment Form for Continued Substance Use Disorder Treatment;
IOT, Crisis Intervention & Peer Recovery Services_BT201929
Effective July 1, 2019, the Indiana Health Coverage Programs (IHCP) has modified the coverage of crisis intervention, intensive outpatient treatment (IOT), and peer recovery services;

For dates of service (DOS) on or after July 1, 2019, IOT, Crisis Intervention and peer recovery services will no longer be restricted to members eligible for the Medicaid Rehabilitation Option (MRO) benefit plan; in addition, all three services will no longer be carved out of managed care;

BT201929 provides a description of providers that can perform these services, including description of services, and billing information;

For IOT services, BT201929 billing guidance supersedes the instructions in prior BT201739 for managed care billing of IOP (Intensive Outpatient Program) services.
IOT, Crisis Intervention & Peer Recovery Services

Description of Providers for Mental Health Services

- Licensed Professionals;
- Qualified Behavioral Health Professional (QBHP);
- Licensed Independent Practice School Psychologist;
- Authorized Health Care Professional (AHCP);
- Other Behavioral Health Professional (OBHP);

Please review the details outlined in BT201929.
IOT, Crisis Intervention & Peer Recovery Services

Description of Services/Provider Qualifications/Billing

Crisis Intervention

- Crisis Intervention Services (HCPCS code H2011): Crisis intervention is available to all members. Crisis intervention is a short-term emergency behavioral health service, available 24 hours a day, 7 days a week.

- Crisis intervention does not require prior authorization;

- Crisis Intervention Service (Provider Qualifications): The following providers may deliver crisis intervention:
  - Licensed professional
  - QBHP
  - OBHP
IOT, Crisis Intervention & Peer Recovery Services

Description of Services/Provider Qualifications/Billing

Crisis Intervention (cont.)

◗ Crisis Intervention Service (Billing)
  ◗ Must be billed using HCPCS code H2011;

◗ CMS 1500 Billing is allowed but must contain the rendering practitioner information within box 24J of the claim form. As a reminder (BR201930), midlevel practitioners must bill using the supervising MD or HSPP’s NPI including applicable modifiers;

◗ Facility charges may be billed on a UB-04 claim form, Provider Healthcare Portal institutional claim, or 837I electronic transaction), using national coding guidelines;

◗ Crisis Intervention Service (Program Standards, Rates & Limitations): Please review the details outlined in BT201929;
IOT, Crisis Intervention & Peer Recovery Services

Description of Services/Provider Qualifications/Billing

Intensive Outpatient Treatment

Intensive Outpatient Treatment: a treatment program that operates at least 3 hours per day, at least 3 days per week; for rehabilitation of alcohol and other drug abuse or dependence in a group setting;

IOT includes individual and family therapy, group therapy, skills training, medication training and support, peer recovery services, care coordination, and counseling. IHCP requires the provision of at least 120 minutes of therapeutic intervention per 3 hour session;

IOT Services require Prior Authorization;

Intensive Outpatient Treatment (Provider Qualifications): The following providers are authorized to deliver IOT:
- Licensed professionals;
- QBHPs;
- OBHPs
IOT, Crisis Intervention & Peer Recovery Services

Description of Services/Provider Qualifications/Billing

Intensive Outpatient Treatment

Intensive Outpatient Treatment (Billing)

- Facility Billing: Must be billed on a UB-04 claim form with Revenue Codes 905 (IOT Psychiatric) or 906 (IOT Chemical Dependency) as stand-alone codes;

- Professional Billing: May be billed on a CMS-1500 claim form with either HCPCS codes:
  - H0015: Alcohol and/or drug services;
  - S9480: Intensive outpatient psychiatric services, per diem;

Intensive Outpatient Treatment (Program Standards, Rates, Limitations & Exclusions): Please review the details outlined in BT201929;
IOT, Crisis Intervention & Peer Recovery Services

Description of Services/Provider Qualifications/Billing

Peer Recovery Services

Peer Recovery Services: are individual, face-to-face services that provide structured, scheduled activities that promote socialization, recovery, self-advocacy, development of natural supports, and maintenance of community living skills.

Peer recovery services are available without prior authorization up to 365 hours (1,460 units) per rolling calendar year;

Peer recovery services must be delivered by individuals certified in peer recovery services per the Department of Mental Health and Addiction (DMHA) training and competency standards for a certified recovery specialist (CRS).
Peer Recovery Services (Provider Qualifications): Individuals providing peer recovery services must be under the supervision of a licensed professional, including:

- Licensed physician (including licensed psychiatrist);
- Licensed psychologist or a psychologist endorsed as an HSPP;
- LCSW;
- LMHC;
- LMFT;
- LCAC, as defined under IC 25-23.6-10.5;
- QBHP;
- Opioid Treatment Program (OTP) enrolled as provider specialty 835;
IOT, Crisis Intervention & Peer Recovery Services

Description of Services/Provider Qualifications/Billing

Peer Recovery Services

Peer Recovery Services (Billing):
- Must be billed using HCPCS code H0038;
- Facility charges may be billed on a UB-04 claim form;
- Professional Services may be billed on a CMS-1500 claim form;

Peer Recovery Services (Program Standards & Rates): Please review the details outlined in BT201929;
Provider Enrollment
Provider Enrollment

 современная, вводная, и демографическая информация обновлений
просьбы инициируются через сайт MHS по следующему адресу:
https://www.mhsindiana.com/providers/become-a-provider.html

Provider can call Customer Service (877) 647-4848 to obtain the status of their requests;
Provider Enrollment
Demographic Updates
Demographic Updates

Providers can utilize the Demographic Update Tool to update information, such as:

- Address Changes
- Demographic Changes
- Term an Existing Provider
- Make a Change to an IRS Number or NPI Number

Provider Resources

MHS provides the tools and support you need to deliver the best quality of care. Please view the listing on the left, or below, that covers forms, guidelines, helpful links, and training.

- Demographic Update Tool
- Guides and Manuals
- Electronic Transactions
- Preferred Drug Lists
- Provider Education
- Newsletters
- Helpful Links
Demographic Updates

Demographic Update Tool

MHS is committed to providing our providers with the best tools possible to support their administrative needs. We have created an easy way for you to request updates to your information and ensure we receive what we need to complete your request in a timely manner.

Need to review your existing information or have a question? If you are a contracted provider you can visit our Provider Directory to review your information. Please note that hospital-based and midlevel providers will not show in the directory. If you are a non-contracted provider, please call Provider Services at 1-877-647-4848. Our Contact Us page is always available for general questions as well.

Ambetter only provider? Visit our Ambetter website.

What would you like to do?

- **MAKE AN ADDRESS CHANGE?**
- **MAKE A DEMOGRAPHIC CHANGE?**
- **UPDATE MEMBER ASSIGNMENT LIMITATIONS?**
- **TERM AN EXISTING PROVIDER?**
- **MAKE A CHANGE TO AN IRS NUMBER OR NPI NUMBER?**
Prior Authorization
Prior Authorization:

- Please call MHS Care Management for inpatient and partial hospitalization authorizations at 1-877-647-4848. Follow prompts to Behavioral Health;

- Authorization forms may be obtained on our website:
  - Outpatient Treatment Request (OTR) Form/Tip-Sheet/Training
  - Intensive Outpatient/Day Treatment Form Mental Health/Chemical Dependency
  - Applied Behavioral Analysis Treatment (OTR)
  - Psychological Testing Authorization Request Form (Outpatient & Inpatient)
  - SUD Residential Treatment Services Prior Auth Form(s)
Prior Authorization

Facility Services:
- Inpatient Admissions
- Intensive Outpatient Treatment (IOT)
- Partial Hospitalization
- SUD Residential Treatment
Prior Authorization

Professional Services:

☑ Psychiatric Diagnostic Evaluation (Limited to 1 per member per 12 month rolling year without authorization)

☑ Electroconvulsive Therapy

☑ Psychological Testing
  ☑ Unless for Autism: then no auth is required

☑ Developmental Testing, with interpretation and report (non-EPSDT)

☑ Neurobehavioral status exam, with interpretation and report

☑ Neuropsych Testing per hour, face to face
  ☑ Unless for Autism: then no auth is required
  ☑ Non-Participating Providers only

☑ ABA Services
**Prior Authorization**

**Limitations on Outpatient Mental Health Services:**

📅 Effective 12/15/2018 MHS has implemented The Indiana Health Coverage Programs Mental Health and Addiction limitation policy for the following CPT codes that, in combination, are limited 20 units per member, per provider, per rolling 12-month period:

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<th>Description</th>
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<tr>
<td>90832 - 90834</td>
<td>Individual Psychotherapy</td>
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<tr>
<td>90837 - 90840</td>
<td>Psychotherapy, with patient and/or family member &amp; Crisis</td>
</tr>
<tr>
<td></td>
<td>Psychotherapy</td>
</tr>
<tr>
<td>90845 - 90853</td>
<td>Psychoanalysis &amp; Family/Group Psychotherapy with or without patient</td>
</tr>
</tbody>
</table>

Please Note: CPT codes 90833, 90836, and 90838 for psychotherapy with medical evaluation and management are medical services. Therefore, the IHCP does not reimburse clinical social workers, clinical psychologists, or any mid-level practitioners (excluding nurse practitioners and clinical nurse specialists) for these codes.
Prior Authorization

Limitations on Outpatient Mental Health Services (Cont.):

有效的2018年12月15日，Managed Health Services (MHS) 已开始对日期为2018年12月15日或之后的服务申请单（DOS）上的索赔进行限制。超过限制的索赔将被拒绝。

如果成员需要超出20个单位的额外服务，提供者可以请求预先授权更多单位。审批将根据医疗记录的审查来确定服务的必要性。

提供者需要确定他们在2018年12月15日至12个月滚动期间提供了20个单位的服务给成员来确定是否需要预先授权请求。DOS 之前为2018年12月15日的日期不计入到20个单位的限制。

“Per Provider”由MHS定义为每个单独的提供者NPI在CMS-1500申报表（Box 24J）上被记账。

此变更仅适用于在CMS 1500申报表上被记账的专业服务。
Prior Authorization

Limitations on Outpatient Mental Health Services (cont.):

- For submission of prior authorization:
  - BH prior authorization outpatient treatment request (OTR) forms located: https://www.mhsindiana.com/providers/behavioral-health/bh-provider-forms.html;
  - Fax number for submission at the top: 1-866-694-3649;
  - It is best to include all service codes, duration/units/frequency requests on one OTR form per member;
  - MHS typical approved authorization date span is 3-6 months depending on medical necessity determination;
  - MHS internal turn-around time on OTR request is 7 days, while our contractual turnaround time is 14 days;
  - Decision letters, referred to either as a Notice of Coverage or Denial Letter is sent as a response to every request;
Prior Authorization

Limitations on Outpatient Mental Health Services (Cont.):

For submission of prior authorization (cont.):

If MHS determines that additional information is needed, MHS will call the provider, using the contact information provided on the OTR form, and providers are typically given 23-48 hours to call us back. If a denial is issued, providers have 30 days to appeal that decision and provide additional documentation.

Medical Necessity appeals must be received by MHS within 60 calendar days of the date listed on the denial determination letter. The monitoring of the appeal timeline will begin the day MHS receives and receipt-stamps the appeal. Medical necessity behavioral health appeals should be mailed or faxed to:

MHS Behavioral Health
ATTN: Appeals Coordinator
12515 Research Blvd, Suite 400
Austin, TX 78701
FAX: 1-866-714-7991
Claim Process

Electronic submission:
• Payer ID 68068
• MHS accepts Third Party Liability (TPL) information via EDI
• It is the responsibility of the provider to review the error reports received from the Clearinghouse (Payer Reject Report).

Online submission through the MHS Secure Provider Portal:
• Verify member eligibility.
• Submit and manage both Professional and Facility claims, including 937 batch files.
• To create an account, go to: mhsindiana.com/providers/login.

Paper Claims:
• MHS Behavioral Health
  PO Box 6800
  Farmington, MO 63640-3818

Claim Inquiries:
• Check status online with the MHS Secure Provider Portal.
• Call Provider Services at 1-877-647-4848.
Claim Process

Filing Limits:

❖ For contracted providers, all claims must be submitted within 90 calendar days of the date of service.

❖ Claims with primary insurance must be received within 365 days of the date of service with primary EOB information. If primary EOB is received after the 365 days, providers have 60 days from date of primary EOB to file claim to MHS.

❖ Claims for non-contracted providers must be submitted within 180 calendar days of the date of service.
Claim Process

Corrected claims should be resubmitted electronically or on our portal within 60 calendar days of the date claim originally processed.

MHS Secure Provider Portal – check claim status or file corrected claims.

EDI transactions accepted through the following vendors:

<table>
<thead>
<tr>
<th>Trading Partner</th>
<th>Payor ID</th>
<th>Contact Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emdeon</td>
<td>68068</td>
<td>(800) 845-6592</td>
</tr>
<tr>
<td>Capario</td>
<td>68068</td>
<td>(800) 792-5256, x812</td>
</tr>
<tr>
<td>Availity</td>
<td>68068</td>
<td>(800) 282-4548</td>
</tr>
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Behavioral Health Claims Issue Resolution
Behavioral Health Claims Issue Resolution

- **Step 1:** BH Informal Claims Dispute Form
- **Step 2:** Provider Services Phone Requests & Web Portal Inquiries
- **Step 3:** Provider Relations Regional Mailboxes
- **Step 4:** Formal Claim Dispute - Administrative Claim Appeal
- **Step 5:** Arbitration

**Please Note:** Steps 1, 4 & 5 are considered MHS’s formal provider claims dispute and appeal process. These steps are strongly recommended to substantiate official proof of provider submission of dispute.
BH Informal Claims Dispute Form

Step 1:

🎉 Must be submitted in writing by using the MHS Behavioral Health Informal Claim Dispute form, available at mhsindiana.com/provider-forms.

🎉 Submit all documentation supporting your objection.

🎉 Send to MHS within 67 calendar days of receipt of the MHS Explanation of Payment (EOP). Please reference the original claim number. Requests received after day 67 will not be considered:

MHS Behavioral Health Services
Attn: Appeals Department
P.O. Box 6000
Farmington, MO 63640-3809

🎉 MHS will make all reasonable efforts to review your documentation and respond to you within 30 calendar days.

🎉 If you do not receive a response within 30 calendar days, consider the original decision to have been upheld.

🎉 At that time (or upon receipt of our response if sooner), you will have up to 67 calendar days from date on EOP to initiate a formal claim appeal (Step 4).
BH Informal Claims Dispute Form

Step 1:

Helpful Tips:

- Serves as official notice to MHS of a dispute or appeal on a claim. Skipping this step could jeopardize consideration to review your request through other listed steps;

- The provider must include sufficient information for MHS to identify the claim(s) in question and the reason the provider is disputing or objecting to MHS' processing of the claim(s);

- Disputing multiple claim denials:
  - Submit separate BH Informal Claims Dispute Forms for each member/patient experiencing the denial;
  - Provide additional information such as:
    - The MHS denial code and description found on the EOP remit;
    - Briefly describe why you are disputing this denial;
    - For multiple claims please either list all claim numbers or in the “Reason for Dispute” section state that “member is experiencing denial reason ___ for all claims DOS____ to ______; Please review all associated claims”;

- Save copies of all submitted BH informal claims dispute forms;
Provider Services Phone Requests & Web Portal Inquiries

Step 2:

Step 2 is a companion avenue of resolution but is not considered a formal notification of provider dispute; it is required that providers complete Step 2 prior to contacting Provider Relations.

Claim issues presented by providers to the Provider Services phone line & Web Portal Inquiries will be logged and assigned a ticket number; Please keep this ticket number for your reference, as well as to use later in case you choose to utilize Step 3.

The provider must include sufficient information to identify the claim(s) in question and the reason the provider is disputing or objecting to MHS’ processing of the claim(s).

Phone: 1-877-647-4848; Provider Services 8 a.m. to 8 p.m.
Provider Web Portal: https://www.mhsindiana.com/providers/login.html
Use the Messaging Tool
Customer/Provider Services Phone Requests & Web Portal Inquiries

Step 2:

 Helpful Tips:

 🌷 Disputing multiple claim denials:
 🌷 Provide the provider services rep or web portal team member with 1 claim number as an example of the specific denial.

 🌷 Communication is Key!:
 🌷 Tell the rep you have a “claims research request” to review all claims for the specific denial reason;
 🌷 State if this denial is happening for 1 or multiple practitioners within your group or clinic; (if multiple, provide your TIN)
 🌷 Provide the MHS denial code and description found on the EOP remit;
 🌷 Briefly describe why you are disputing this denial or seeking research.
Customer/Provider Services Phone Requests & Web Portal Inquiries

Step 2:

🎉 Helpful Tips:

🎉 Communication is Key! (cont.):

🎉 Do not include multiple claim denial reasons within the same research request. Submit separate research requests for each individual denial reason.

🎉 Please refrain submitting research requests for vague reasons or if you can clearly determine the denial is valid; For example:

🎉 Valid timely filing denials;

🎉 Services that require prior authorization but PA wasn’t obtained;

🎉 Retain all reference numbers provided by the Provider Services and Web-Portal teams.

🎉 Research can take up to 30-45 days; At any time you can follow up with the Provider Services or Web Portal team with a status update request (make sure to provide the original reference number).
Customer/Provider Services Phone Requests & Web Portal Inquiries

Step 2:

Communications Example:

Helpful Tips:

“Hello, I am calling from XYZ Provider group and we are experiencing multiple claim denials for denial code EX__. We would like to have a claims research ticket created to research this issue. Claim Number______ is an example. This denial is occurring for multiple patients being treated by our practitioner Dr. Smith and her NPI is ________. This denial has occurred on a total of # claims DOS ____ to ____. We believe this is an invalid denial because______.”
Provider Relations Regional Mailboxes

Step 3:

っていました Step 3 is a companion avenue of resolution but is not considered a formal notification of provider dispute; Step 3 should only be used after provider has exhausted Steps 1 and 2.

If Step 1 results in an upheld denial and Step 2 is not resolved to within 45 calendar days, please contact the Provider Relations team through the claims issues mailbox assigned to your region.

Issues will be logged by the internal Provider Relations team and providers will receive a response email with next steps and any assigned reference numbers. Response to incoming email can take 2-4 weeks depending on workload.
Provider Relations Regional Mailboxes

Step 3:

 Helpful Tips:

 After Step 2 has been performed, but no resolution or issue upheld; submit the following information to the provider relations regional mailbox (attach spreadsheet if multiple claims but below fields must be included)

- Issue Reference Number(s);
- TIN
- Group/Facility Name
- Practitioner Name & NPI
- Member Name and Rid Number
- Product (Medicaid/Ambetter/Allwell)
- Claim Number(s)
- DOS or DOS Range if multiple denials
- Related Prior Authorization Numbers (this is key if issue involves claims denied for no authorization)
- Provider reason for dispute
Provider Relations Regional Mailboxes

Step 3:

- Regional Mailboxes
  - Northeast Region: MHS_ProviderRelations_NE@mhsindiana.com
  - Central Region: MHS_ProviderRelations_C@mhsindiana.com
  - Northwest Region: MHS_ProviderRelations_NW@mhsindiana.com
  - Southwest Region: MHS_ProviderRelations_SW@mhsindiana.com
  - Southeast Region: MHS_ProviderRelations_SE@mhsindiana.com
Formal Claim Dispute - Administrative Claim Appeal

Step 4:

🌟 Step 4 is a continuation of Step 1 and is a Formal Claim Dispute, Administrative Claim Appeal;

🌟 Administrative claim appeals are reviewed by a panel of one or more MHS employees or consultants who are trained in the operations of the MHS claims system as well as state and federal Medicaid laws, regulations and provider payments and coding practices;

🌟 See the MHS Provider Manual Chapter 5 Claims Administrative Reviews and Appeals for more instructions;
Arbitration

Step 5:

🎉 Step 5 is a continuation of Steps 1 & 4 and is a part of the formal MHS Provider Claims dispute process;

🎉 In the event a provider is not satisfied with the outcome of the administrative claim appeal process (Step 4), the provider may request arbitration. Claims with similar issues from the same provider may be grouped together for the purpose of requesting arbitration.

🎉 See the MHS Provider Manual Chapter 5 Claims Administrative Reviews and Appeals for more instructions;
Provider News

🎉 To ensure that your practice is up to date on all MHS related news announcements, please sign up to receive provider email updates here:
https://www.mhsindiana.com/providers/email-sign-up.html
MHS Portal
MHS Web Portal

Please visit our website at the following location for enrollment and user guides related to our provider web portal tool:
https://www.mhsindiana.com/providers/login.html

By creating a MHS account, you can:
- Verify member eligibility
- Submit and check claims
- Submit and confirm authorizations
- View detailed patient list
- Message the web-portal team regarding claim denials

Review the Portal Training Guides located at the above site location;
Provider Relations Team
# MHS Provider Network Territories

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Tawanna Danzie</strong></td>
<td>Provider Partnership Associate II</td>
<td>1-877-647-4848 ext. 20029, <a href="mailto:tdanzie@mhsindiana.com">tdanzie@mhsindiana.com</a></td>
</tr>
<tr>
<td><strong>Provider Groups</strong></td>
<td></td>
<td>Beacon Medical Group, Community Care Network, Franciscan Alliance, Goshen Health System, HealthInc, Heart City Health Center, Indiana Health Centers, Lutheran Medical Group, Northshore Health Centers, Parkview Health System, South Bend Clinic</td>
</tr>
<tr>
<td><strong>Jennifer Garner</strong></td>
<td>Provider Partnership Associate II</td>
<td>1-877-647-4848 ext. 21049, <a href="mailto:jgarner@mhsindiana.com">jgarner@mhsindiana.com</a></td>
</tr>
<tr>
<td><strong>Provider Groups</strong></td>
<td></td>
<td>American Health Network of Indiana, Columbus Regional Health, Community Physicians of Indiana, Good Samaritan Hospital Physician Services, HealthNet, Health &amp; Hospital Corporation of Marion County, Indiana University Health, Little Company of Mary Hospital of Indiana, Riverview Hospital, St. Vincent Medical Group</td>
</tr>
<tr>
<td><strong>Internal Representatives</strong></td>
<td></td>
<td><strong>Jennifer Dean</strong> Provider Network Specialist, 1-877-647-4848 ext. 20028, <a href="mailto:jdean@mhsindiana.com">jdean@mhsindiana.com</a></td>
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<tr>
<td><strong>Provider Groups</strong></td>
<td></td>
<td><strong>Lakisha Browder</strong> Provider Relations Specialist, 1-877-647-4848 ext. 20029, <a href="mailto:lbrowder@mhsindiana.com">lbrowder@mhsindiana.com</a></td>
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<td><strong>Envolve Dental, Inc.</strong></td>
<td></td>
<td><strong>Michael J. Williams</strong> Provider Relations Specialist, 1-727-437-1832, Dental Provider Services: 1-855-600-5157, <a href="mailto:Michael.Williams@envolverhealth.com">Michael.Williams@envolverhealth.com</a></td>
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Hoosier Healthwise | Healthy Indiana Plan | Hoosier Care Connect
## MHS Provider Relations Team

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<th>Position</th>
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<tbody>
<tr>
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Questions?

Thank you for being our partner in care.
Session Survey

• Please use the QR code or the weblink below to complete a survey about the session you just attended. Each session has a unique survey so be sure to complete the appropriate one for each session you attend. We will be taking your feedback from this survey to improve future IHCP events.

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