# Claims
# UB-04

# 2022 Annual IHCP Works Seminar

# Agenda

- MHS Overview
- Claim Submission Process
- MHS Provider Claims Issue Resolution Process
- Additional Claims Assistance
- Portal Functionality
- Facility Billing
- Web Portal Claim Payment and Review
- Online Claim Reconsiderations on the MHS Secure Provider Portal
- Prior Authorization
- MHS Team
- Summary
- Questions

# MHS Overview

# Who is MHS?

- Managed Health Services (MHS) is a health insurance provider that has been proudly serving Indiana residents for more than twenty-five years through Hoosier Healthwise, the Healthy Indiana Plan (HIP) and Hoosier Care Connect.

- **MHS is your choice for better healthcare.**

# MHS Products



# Claim Submission Process

# Medical Claim Submission

- **Electronic Data Interchange Submission:**
  - Preferred method of claims submission
  - Faster and less expensive than paper submission
  - MHS Electronic Payor ID **68069**

- Online through the **MHS Secure Provider Portal** at https://www.mhsindiana.com/providers.html

- Provides immediate confirmation of received claims and acceptance
  - Institutional and Professional
  - Batch Claims
  - Claim Adjustments/Corrections
  - Claim review/Adjustments request

- **Paper Claims:**
  Managed Health Services
  PO Box 3002
  Farmington, MO 63640-3802

# Behavioral Health Claim Submission

**Electronic Submission:**

- Payer ID **68068**
- MHS accepts Third Party Liability (TPL) information via Electronic Data Interchange
- It is the responsibility of the provider to review the error reports received from the Clearinghouse (Payer Reject Report)

Online through the **MHS Secure Provider Portal** at https://www.mhsindiana.com/providers.html

Provides immediate confirmation of received claims and acceptance

- Institutional and Professional
- Batch Claims
- Claim Adjustments/Corrections
- Claim review/Adjustments request

**Paper Claims:**

- MHS Behavioral Health
  PO Box 6800
  Farmington, MO 63640-3818

# Claim Billing with Ease

- **NPI, Tax ID, Zip +4**

- This information is necessary for the system to make a one-to-one match based on the information provided on the claim and the information on file with Indiana Medicaid.
  - Member Information
  - Newborn's Medicaid Identification number is required for payment

- **Attachment Forms:**
  - Required forms need to accompany the claim form

- **Secondary Claims (TPL):**
  - Accepted electronically from vendors or via the MHS Secure Provider Portal

# Claim Submission

- Contracted or In-Network providers: 90 calendar days from the date of service or discharge date.

- Exceptions:
  - Newborns (30 days of life or less) – Claims must be received within 365 days from the date of service. Claim must be filed with the newborn's Medicaid Identification number.
  - TPL – Claims with primary insurance must be received within 365 days of the date of service with a copy of the primary Explanation of Benefits. If primary EOP is received after the 365 days, providers have *60 days* from date of primary EOP to file claim to MHS. If the third party does not respond within 90 days, claims may be submitted to MHS for consideration. Claims submitted must be accompanied by proof of filing with the patient's primary.

# Claim Submission

## Claim Acceptance & Adjudication

- System reviews claim for errors and critical fields (i.e. dates of service, billing/rendering provider, etc.) prior to acceptance.
- Regulatory requirements (federal and state) mandate certain information to be present in order to accept and pay a claim.
- National Provider Identifier (NPI) common rejection/denial; provider information on claim **must** match record at IHCP enrollment – a State requirement.

# Paper Claim Corrections

- A corrected claim can be submitted following IHCP claim adjustment processes.

- A claim adjustment code is required on all claims, based on the type of claim submitted.
  - Example: Frequency 7 entered in Box 22 of the CMS-1500 form.

- The original claim number must also be listed on the corrected claim.
  - Box 22 on the CMS-1500
  - Remember a rejection, must be submitted as 1st time claim, not as a corrected claim.
- Handwriting or stamping on a claim will not be accepted as submission of a corrected claim, and will be rejected with code RE.

# Transportation Claims

- Managed Health Services (MHS) will process all Medicaid emergent and non-emergent ambulance claims, including air ambulance, which would have previously been processed by LCP Transportation.

- Claims for the following services should be sent to MHS:
  - 911 Transports
  - Medically necessary non-emergent hospital transports requiring an ambulance with advanced life support (ALS) or basic life support (BLS).
  - Air ambulance

- Only providers enrolled with the Indiana Health Coverage Programs (IHCP) are eligible for reimbursement. Claims must be filed within 180 days of the Date of Service (DOS) for non-contracted providers and within 90 days of DOS for contracted providers.

- Claims should be submitted to MHS via a CMS-1500 professional claim form. Claims may be submitted via EDI (preferred), MHS web portal or paper.

# Transportation Claims

- MHS will follow IHCP billing guidelines for coding and reimbursement.

  For more information on Medicaid ambulance billing guidelines, please visit:
  transportation-services.pdf (in.gov)

- **Claim Inquiries**:
  - Check status online
  - Call Provider Services at 1-877-647-4848

# Claim Rejections

- A rejection is an unclean claim that contains invalid or missing data elements required for acceptance of the claim in the claim process system.
- Timely filing is not substantiated.
- Rejected claims need corrected and submitted as a new claim.

# Claim Rejections

- EDI rejections require the provider to contact their clearinghouse and obtain a payer rejection report.
- Paper to electronic mapping is available on: https://www.mhsindiana.com/providers/resources/guides-and-manuals.html
- MHS website tools :
  - Reject code listing
  - Refer to Top 10 Rejection Code Help Aid Document

  https://www.mhsindiana.com/content/dam/centene/mhsindiana/medicaid/pdfs/508-Top-10-Rejections-Edu-Doc.pdf.

# Claim Rejections

## Medical

- **07** Invalid Subscriber/Member ID
- **09** Member Invalid on Date of Service
- **01** Invalid Provider ID Billing Physician (Provider State Crosswalk File)
- **08** Invalid Member Date of Birth
- **76** Original claim number required
- **40** Diagnosis code is missing
- **90** Invalid or Missing Modifier
- **B5** Missing/incomplete/Invalid CLIA
- **77** Invalid Claim Type
- **A3** Claim exceeded the maximum 97 service line limit

## Behavioral Health

- **09** Member Invalid on Date of Service
- **07** Invalid Subscriber/Member ID
- **08** Invalid Member Date of Birth
- **01** Invalid Provider ID Billing Physician (Provider State Crosswalk File)
- **76** Original claim number required
- **40** Diagnosis code is missing
- **31** Invalid Service Procedure code
- **A3** Claim exceeded the maximum 97 service line limit

# MHS Provider Claims Issue Resolution Process

# Provider Claims Issue Resolution

**PROCESS**

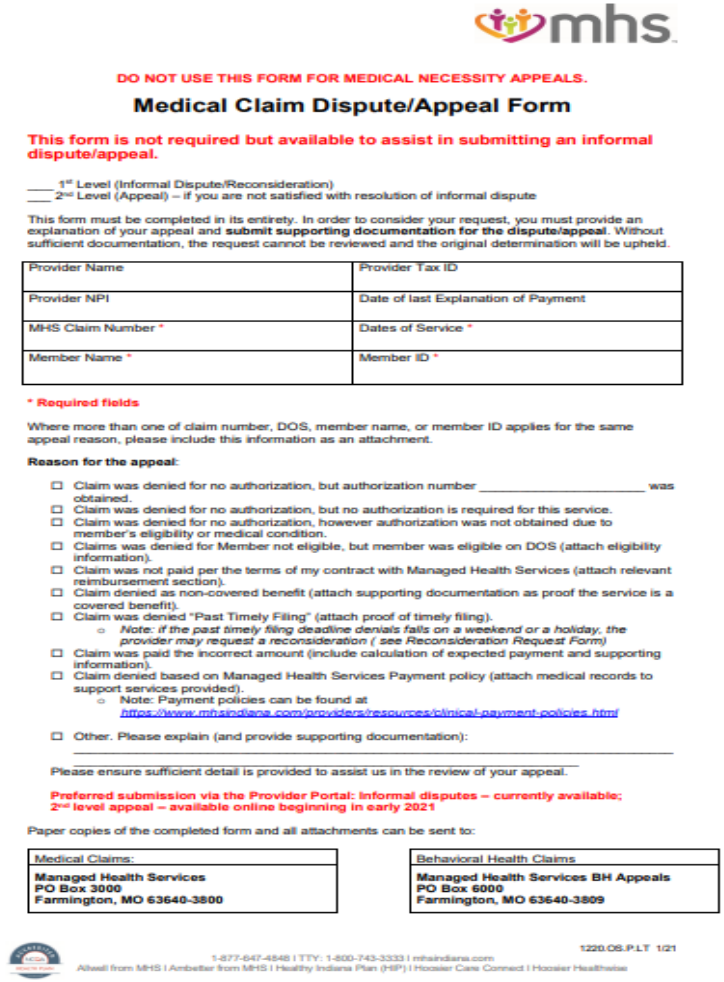
- Level 1: Informal Claims Dispute Online or with Medical Claim Dispute/Appeal form
- Level 2: Formal Claim Dispute –Administrative Claim Appeal Online or with Medical Claim Dispute/Appeal form
- Level 3: Arbitration
- Please note, this is different than an Authorization appeal. A claim appeal cannot change a denied authorization status. To change authorization status, you must appeal the denied authorization.

# Claim Dispute/Appeal Form – Medical and Behavioral Health

- Medical Claims Address:
  Managed Health Services
  PO Box 3000
  Attn: Appeals Department
  Farmington, MO 63640-3800

- Behavioral Health Claims Address:
  Managed Health Services BH Appeals
  PO Box 6000
  Attn: Appeals Department
  Farmington, MO 63640-3809

[https://www.mhsindiana.com/content/dam/centene/mhsindiana/medicaid/pdfs/508-MHS-Dispute-Appeal-form.pdf](https://www.mhsindiana.com/content/dam/centene/mhsindiana/medicaid/pdfs/508-MHS-Dispute-Appeal-form.pdf)



DO NOT USE THIS FORM FOR MEDICAL NECESSITY APPEALS.

**Medical Claim Dispute/Appeal Form**

**This form is not required but available to assist in submitting an informal dispute/appeal.**

___ 1st Level (Informal Dispute/Reconsideration)
___ 2nd Level (Appeal) – if you are not satisfied with resolution of informal dispute

This form must be completed in its entirety. In order to consider your request, you must provide an explanation of your appeal and **submit supporting documentation for the dispute/appeal**. Without sufficient documentation, the request cannot be reviewed and the original determination will be upheld.

| | |
|---|---|
| Provider Name | Provider Tax ID |
| Provider NPI | Date of last Explanation of Payment |
| MHS Claim Number * | Dates of Service * |
| Member Name * | Member ID * |

*** Required fields**

Where more than one of claim number, DOS, member name, or member ID applies for the same appeal reason, please include this information as an attachment.

**Reason for the appeal:**

- ☐ Claim was denied for no authorization, but authorization number _____ was obtained.
- ☐ Claim was denied for no authorization, but no authorization is required for this service.
- ☐ Claim was denied for no authorization, however authorization was not obtained due to member's eligibility or medical condition.
- ☐ Claims was denied for Member not eligible, but member was eligible on DOS (attach eligibility information).
- ☐ Claim was not paid per the terms of my contract with Managed Health Services (attach relevant reimbursement section).
- ☐ Claim denied as non-covered benefit (attach supporting documentation as proof the service is a covered benefit).
- ☐ Claim was denied "Past Timely Filing" (attach proof of timely filing).
  - *Note: if the past timely filing deadline denials falls on a weekend or a holiday, the provider may request a reconsideration ( see Reconsideration Request Form)*
- ☐ Claim was paid the incorrect amount (include calculation of expected payment and supporting information).
- ☐ Claim denied based on Managed Health Services Payment policy (attach medical records to support services provided).
  - Note: Payment policies can be found at https://www.mhsindiana.com/providers/resources/clinical-payment-policies.html
- ☐ Other. Please explain (and provide supporting documentation):
  _____

Please ensure sufficient detail is provided to assist us in the review of your appeal.

**Preferred submission via the Provider Portal: Informal disputes – currently available; 2nd level appeal – available online beginning in early 2021**

Paper copies of the completed form and all attachments can be sent to:

| Medical Claims: | Behavioral Health Claims |
|---|---|
| **Managed Health Services**<br>**PO Box 3000**<br>**Farmington, MO 63640-3800** | **Managed Health Services BH Appeals**<br>**PO Box 6000**<br>**Farmington, MO 63640-3809** |

1-877-647-4848 | TTY: 1-800-743-3333 | mhsindiana.com
Allwell from MHS | Ambetter from MHS | Healthy Indiana Plan (HIP) | Hoosier Care Connect | Hoosier Healthwise

1220.OS.P.LT 1/21

# Informal Claims Dispute or Objection Form

## Level 1:

- Submit all documentation supporting your objection.

- Must be submitted via the Secure Web Portal or in writing within 60 calendar days of receipt of the MHS Explanation of Payment (EOP) by using the Medical Claim Dispute/Appeal form.
  - Requests received after day 60 will not be considered.
  - Copies of original MHS EOP showing how the claims in question were processed.
  - Copies of any subsequent MHS EOPs or other determinations on the claim(s) in question.
  - Documentation of any previous attempt you have made to resolve the issue with MHS.
  - Other documentation that supports your request for reprocessing or reconsideration of the claim(s).

# Informal Claims Dispute or Objection Form

## Level 1:

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

- At that time (or upon receipt of our response if sooner), you will have up to 60 calendar days from date of dispute response to initiate a formal claim appeal (Level 2).

# Informal Claims Dispute or Objection Form

**Level 1:**

- Helpful Tips:
  - Disputing multiple claim denials:
    - Submit separate 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 informal claims dispute forms.

# Provider Services Phone Requests & Web Portal Inquiries

- After the informal claims dispute (Level 1) has been submitted, for assistance or questions the provider can access the Provider Service Phone line, or Web Portal.

# Provider Services Phone Requests & Web Portal Inquiries

- After the informal claims dispute (Level 1) has been submitted, for assistance or questions, the provider can access the Provider Service Phone line or Web Portal. The inquiries will be logged and assigned a ticket number. Please keep this ticket number for your reference.

- 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.

# Provider Services Phone Requests & Web Portal Inquiries

- Helpful Tips:
  - Disputing multiple claim denials:
    - Provide the provider services rep or web portal team member with one claim number as an example of the specific denial.
    - **Communication is Key**!
      - Inform the rep you have a “claims research request” to review all claims for the specific denial reason.
      - State if this denial is happening for one or multiple practitioners within your group or clinic; (if multiple, provide your TIN)
      - Provide the MHS denial code and description found on the EOP.
      - Briefly describe why you are disputing this denial or seeking research.

# Formal Claim Dispute - Administrative Claim Appeal

## Level 2

- Level 2 is a Formal Claim Dispute, Administrative Claim Appeal.

- In the event the provider is not satisfied with the informal claim dispute/objection resolution, the provider may file an administrative claim appeal. The appeal must be filed within 60 calendar days from receipt of the informal dispute resolution notice.

- An administrative claim appeal must be submitted via the Secure Portal or in writing by using the Medical Claim Dispute/Appeal form with an explanation including any specific details which may justify reconsideration of the disputed claim. The appeal clearly marked on the form as Level 2.

- See the MHS Provider Manual Chapter 5 Claims Administrative Reviews and Appeals for more information. https://www.mhsindiana.com/content/dam/centene/mhsindiana/medicaid/pdfs/508-Provider-Manual-2021.pdf

# Arbitration

**Level 3:**

- Level 3 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 (Level 2), the provider may request arbitration. Claims with similar issues from the same provider may be grouped together for the purpose of requesting arbitration.

- To initiate arbitration, the provider should submit a written request to MHS on company letterhead. The request must be postmarked no later than 60 calendar days after the date the provider received MHS' decision on the administrative claim appeal.

- Arbitration Requests need to be mailed to,

  MHS Arbitration
  550 N. Meridian Street, Suite 101
  Indianapolis, IN 46204

- See the MHS Provider Manual Chapter 5 Claims Administrative Reviews and Appeals for more information.
  https://www.mhsindiana.com/content/dam/centene/mhsindiana/medicaid/pdfs/508-Provider-Manual-2021.pdf

# Additional Claim Assistance

# Provider Relations Regional Mailboxes

- If all claim denials are upheld after following the dispute processes and the Provider has not received resolution by calling Provider Services or utilizing the secure messaging on the portal, please contact the Provider Relations team through the claim 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.

- Please do not email your Provider Partnership Associate directly as this may delay the time in getting a response due to their travel.

# Provider Relations Regional Mailboxes

Helpful Tips:

- Please 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

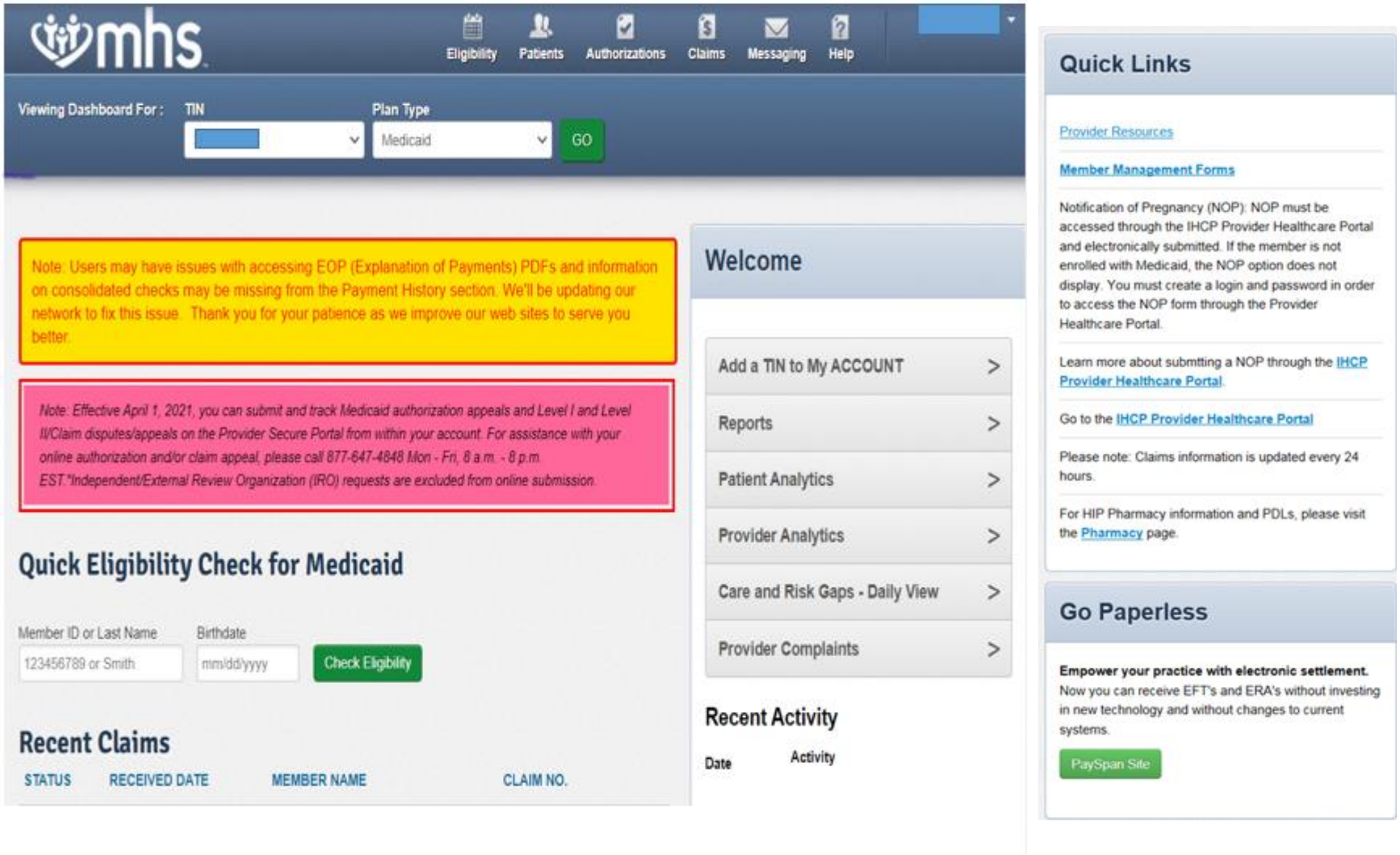
# Provider Relations Regional Mailboxes

- Regional Mailboxes
  - Northeast Region: MHS_ProviderRelations_NE@mhsindiana.com
  - North Central Region: MHS_ProviderRelations_NC@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
  - South Central Region: MHS_ProviderRelations_SC@mhsindiana.com
  - Tier 1 Providers: IndyProvRelations@mhsindiana.com

# Portal Functionality

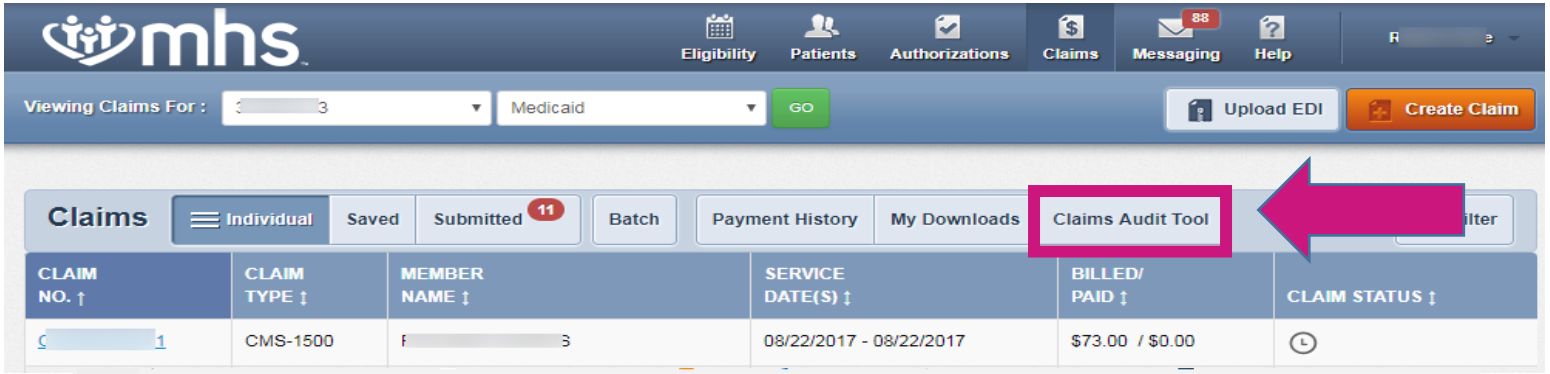
# Secure Web Portal Login or Registration

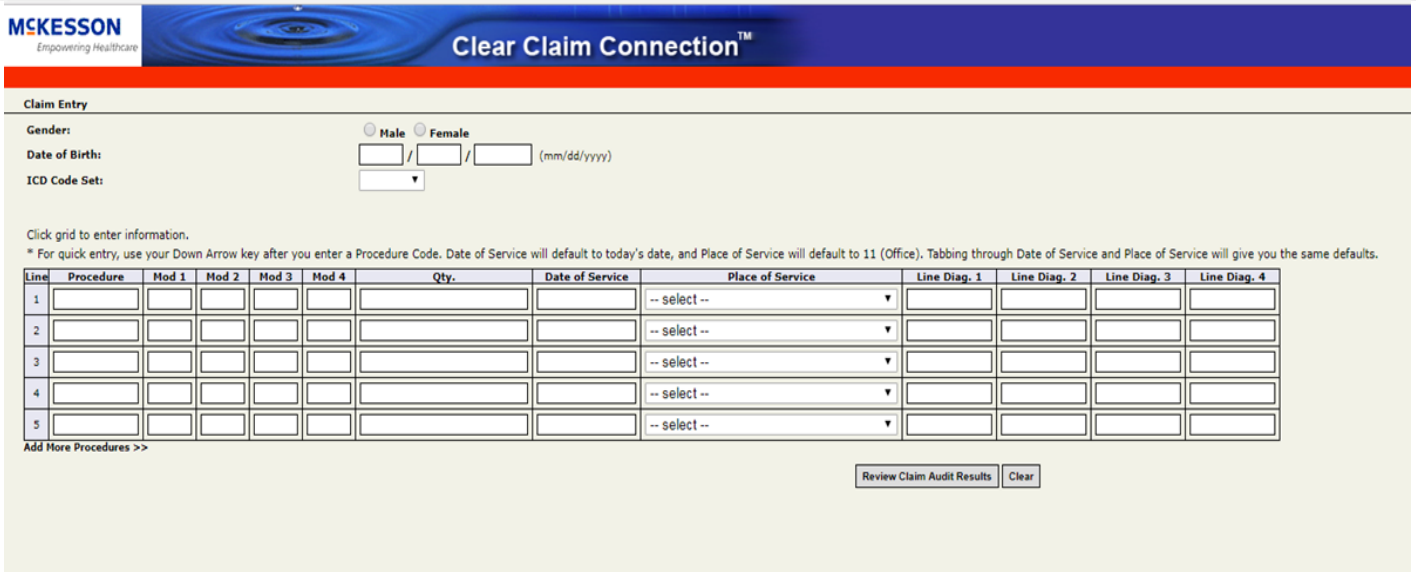
# Homepage – MHS (Medicaid)



# Claims Audit Tool

- The Clear Claim Connection screen appears, allowing you to enter the Procedure Code, Quantity, Modifiers, Date and Place of Service, and Diagnosis for a claim proactively before you submit or retroactively after you submit.



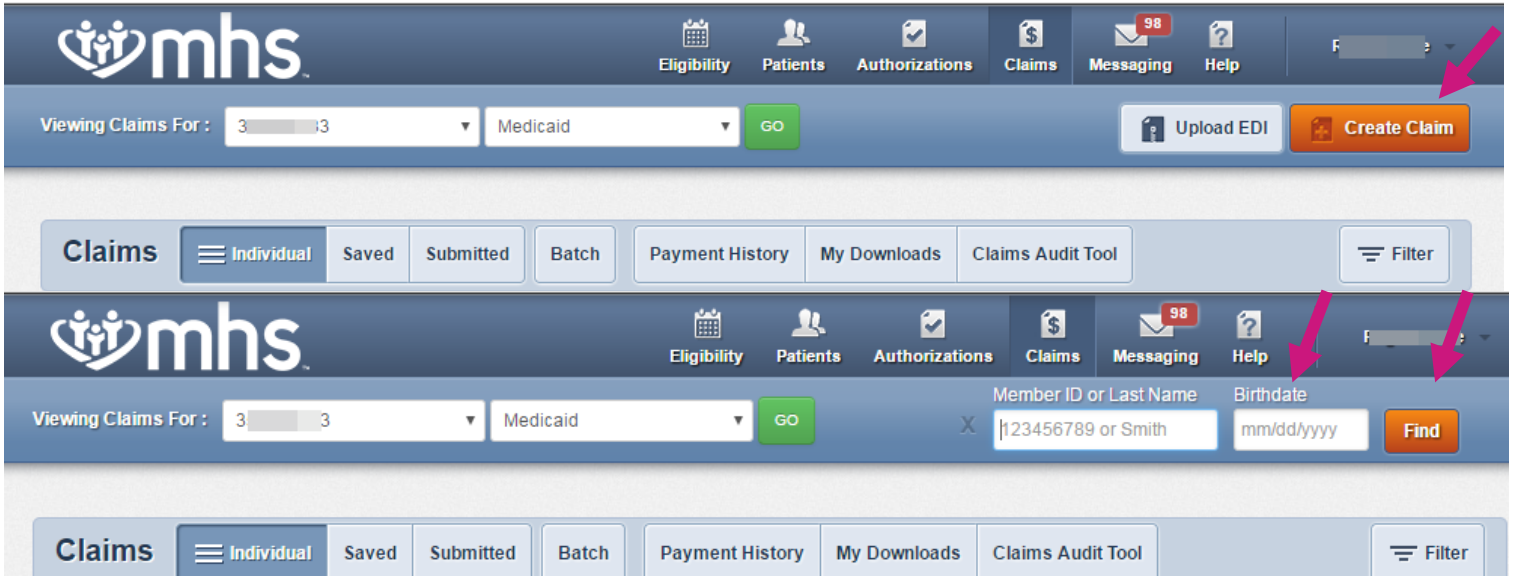
# Claims

## Web Portal Claims Functionalities:

- **Submit** new claim.
- **Review claims** information on file for a patient.
- **Correct** claims.
- **View payment history.**

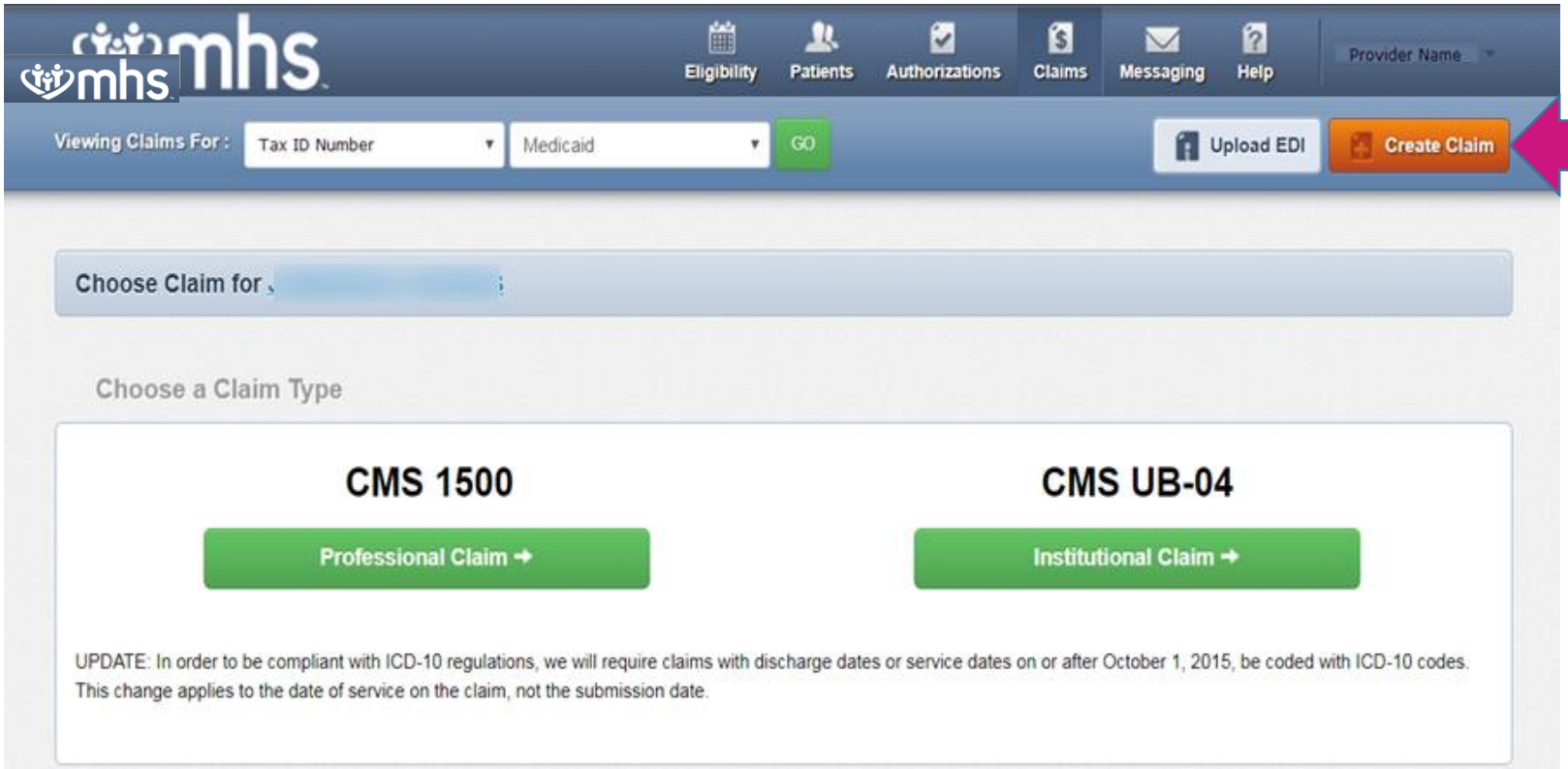
## Submit a New Claim:

- Click **Create Claim** and enter **Member ID** and **Birthdate**



# Claim Submission

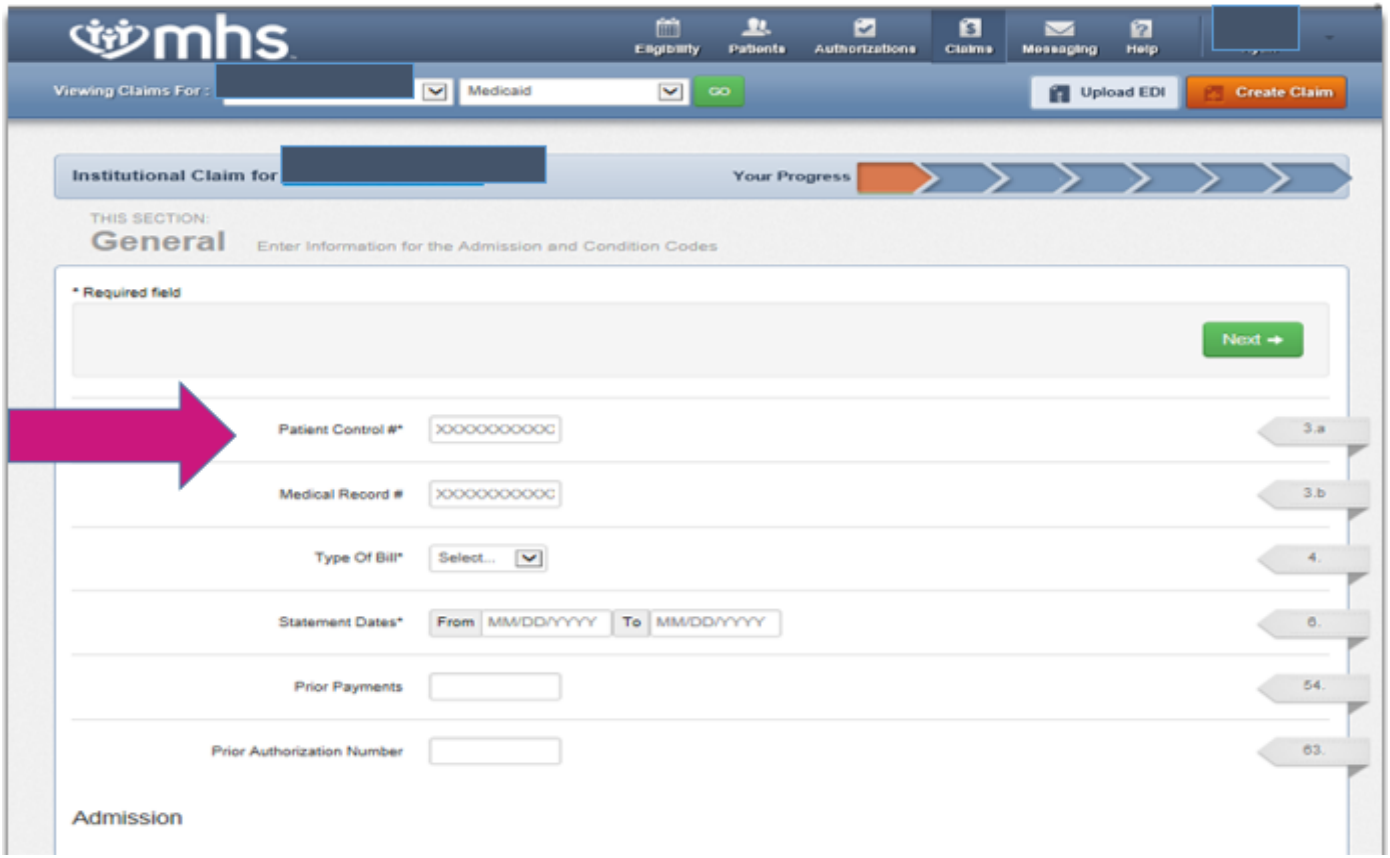
- Choose the **Claim Type**
  - **Professional** or **Institutional** claim submission



# Facility Billing

# UB-04 Billing

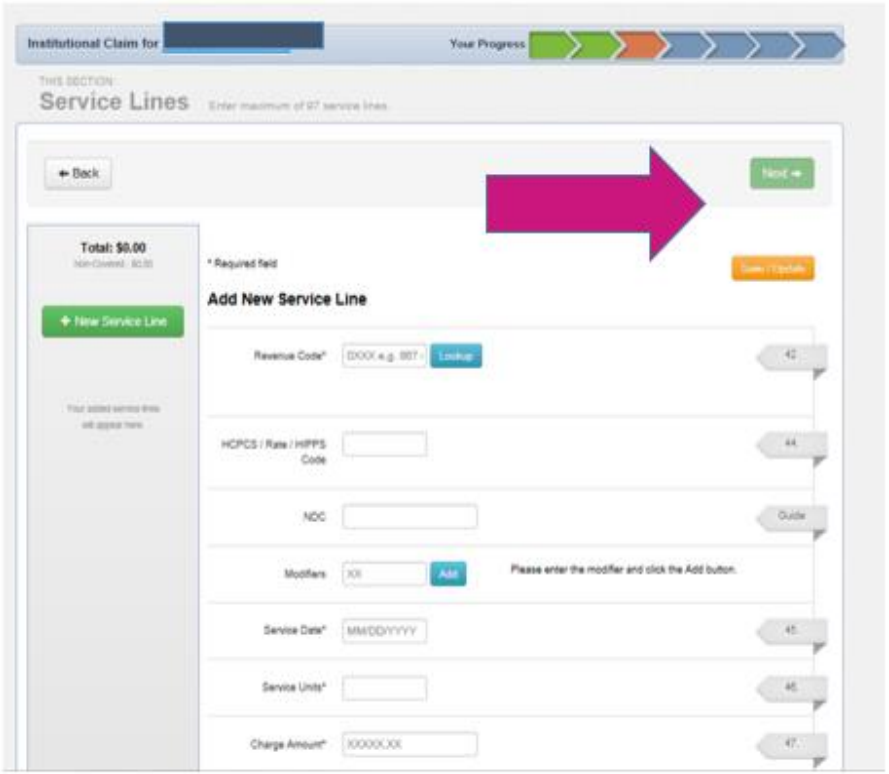
- In the **General Info** section, populate the **Patient's Control Number** and other information related to the patient's condition by typing into the appropriate fields.
- Click **Next**.



# UB-04 Billing

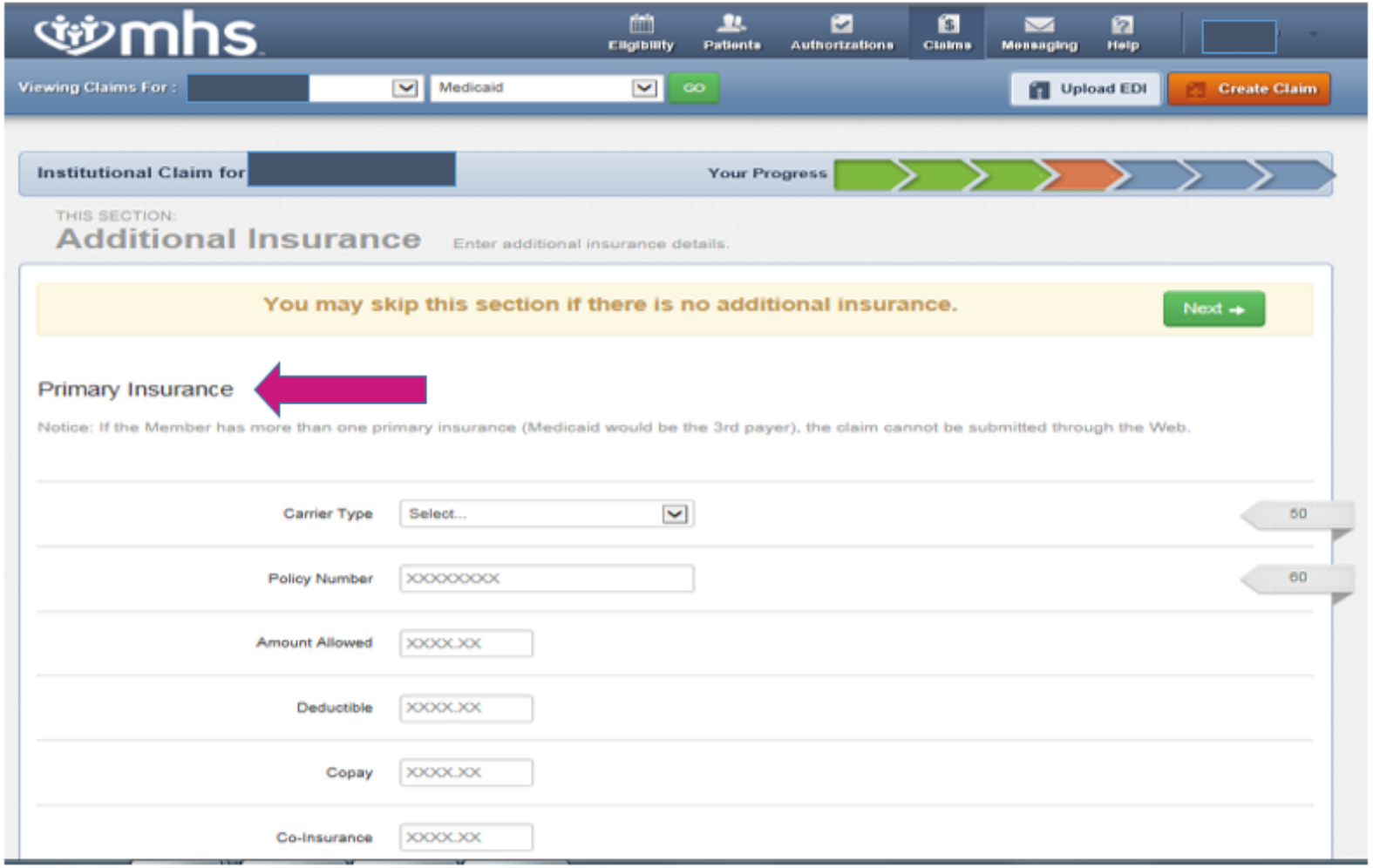
- Add the **provider information.**
- Click **save** and click **next** to proceed


- Click **Add New Service Line** and enter the service lines information.

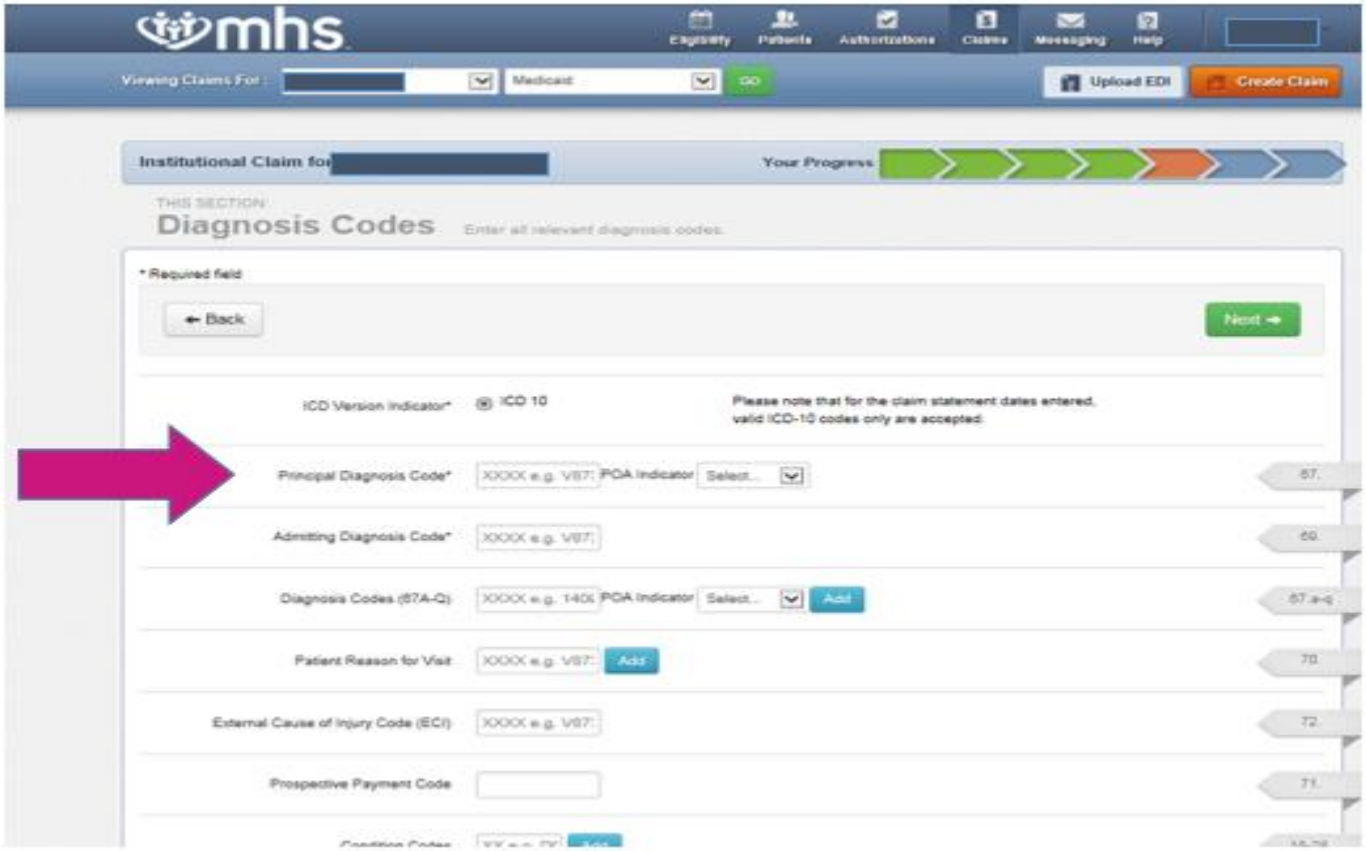


# UB-04 Billing

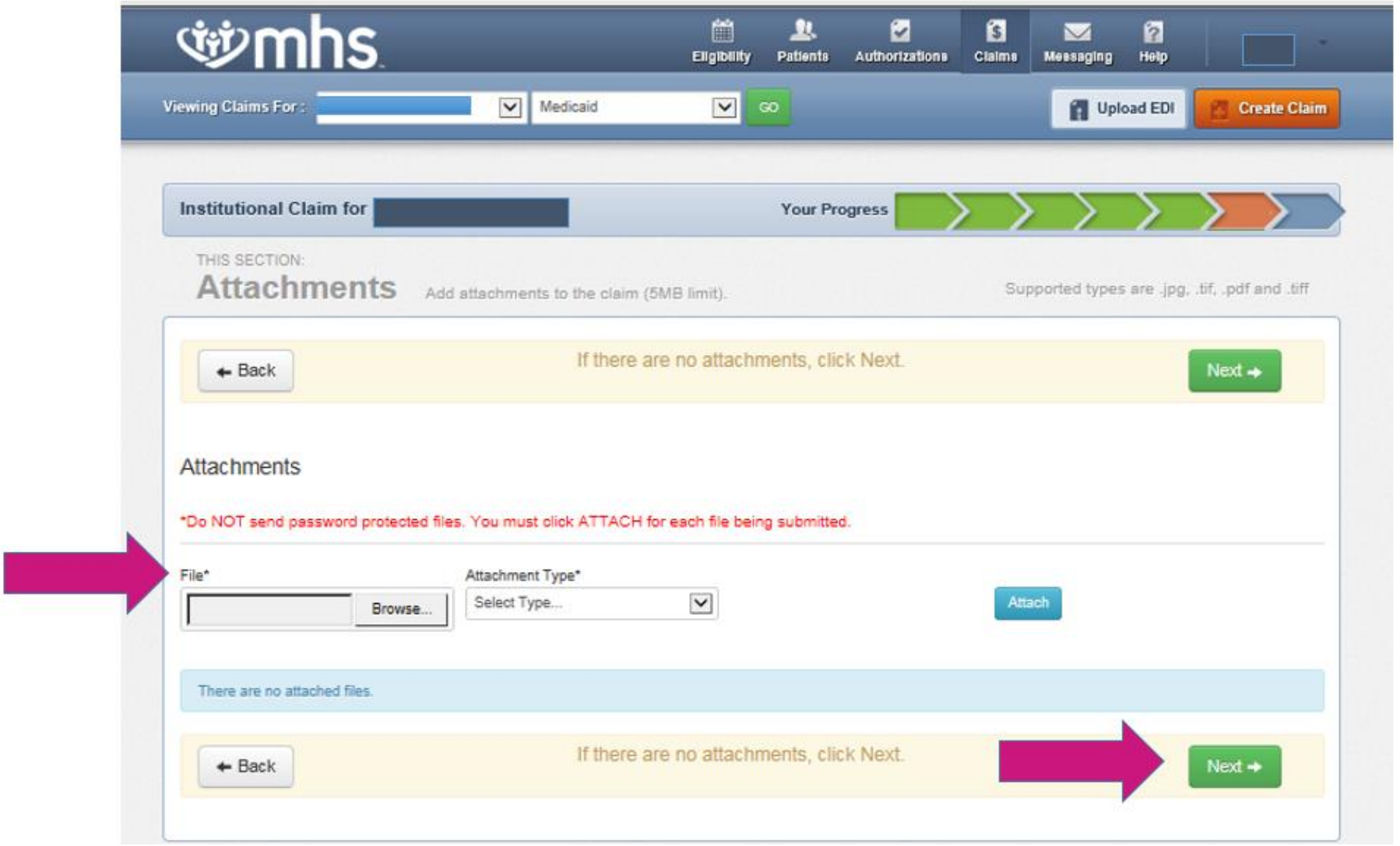
## Enter Additional Insurance (if applicable)



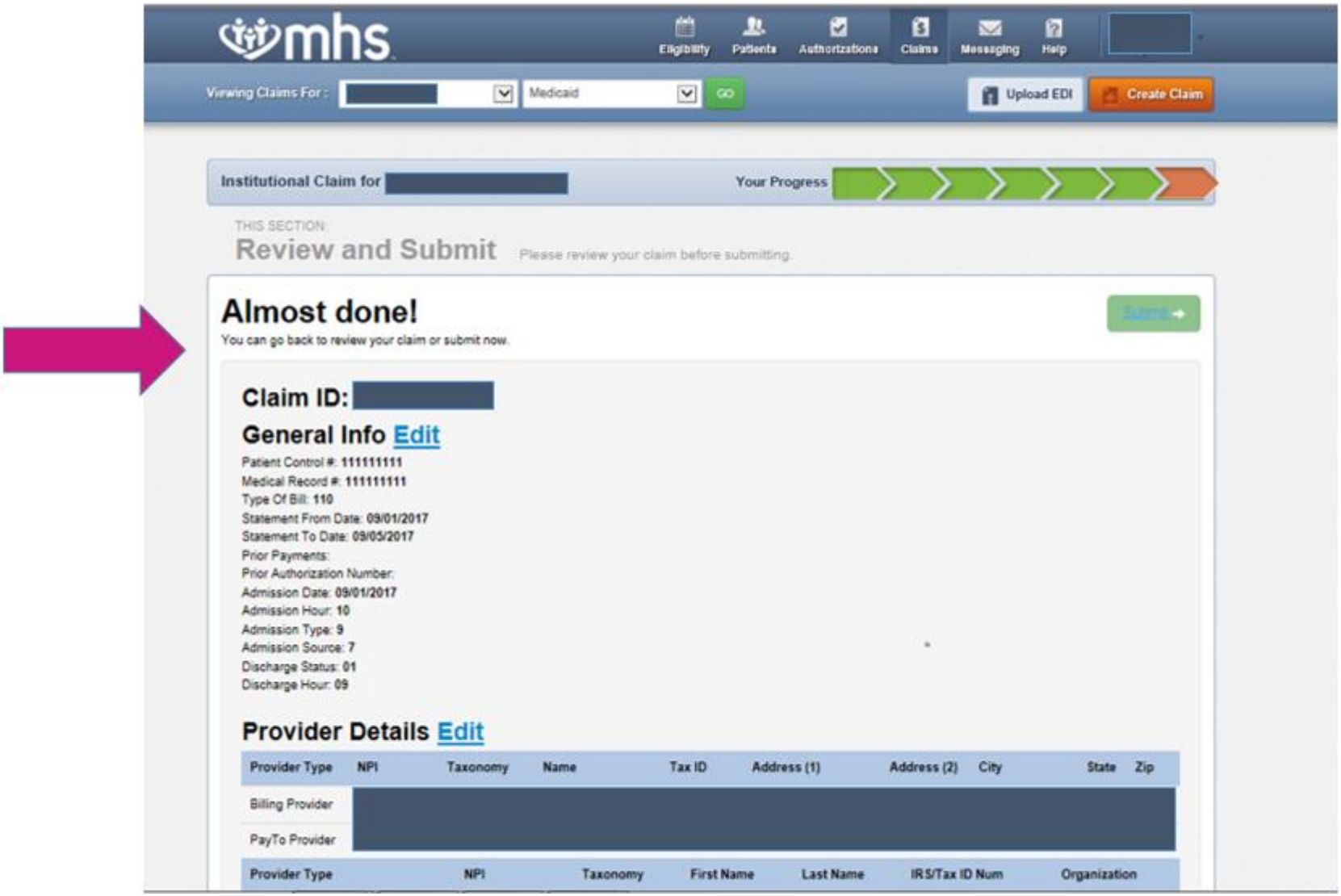
# Enter Diagnosis Codes (use Add button)



# Add Attachments (if applicable)



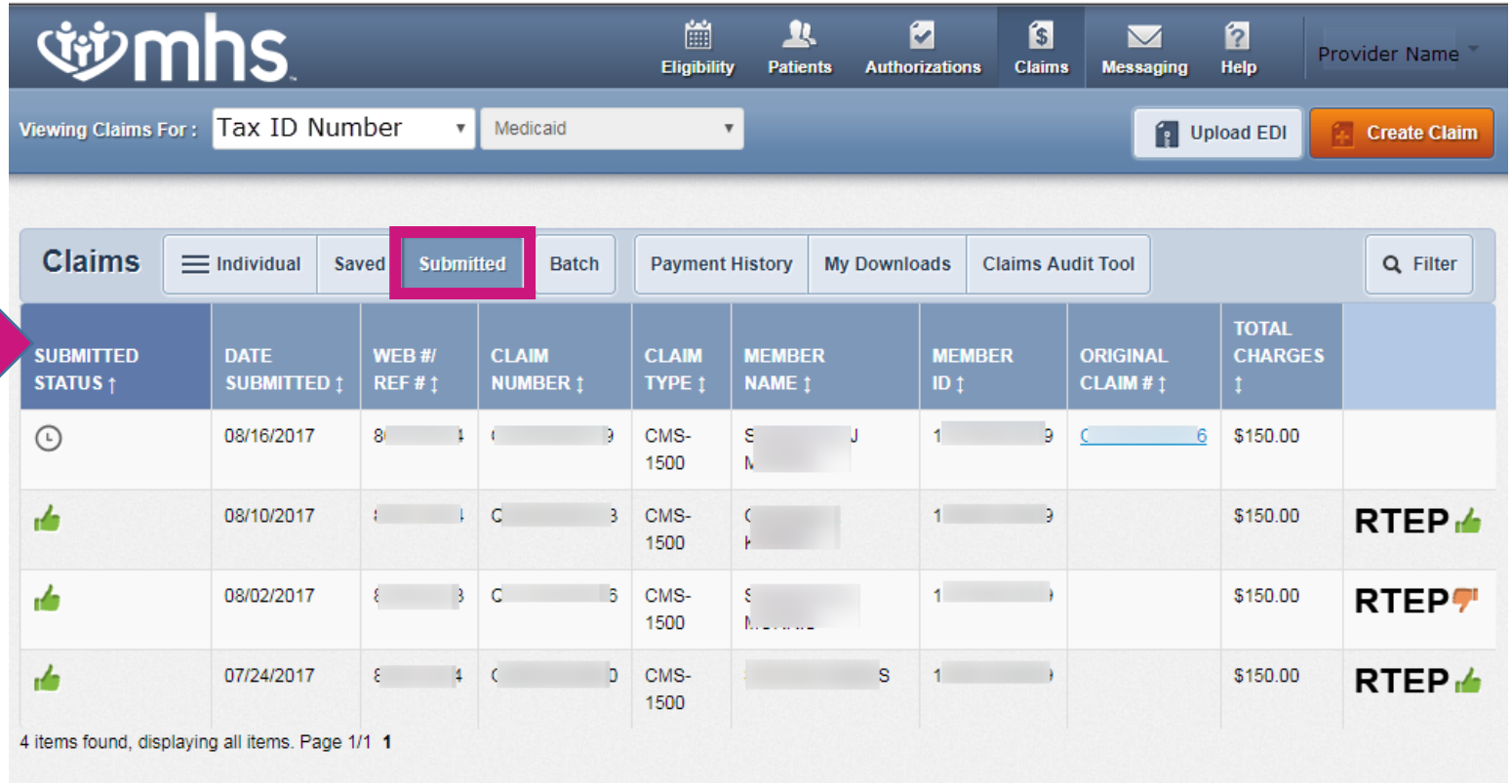
# Review Claim and Submit



# Web Portal Claim and Payment Review

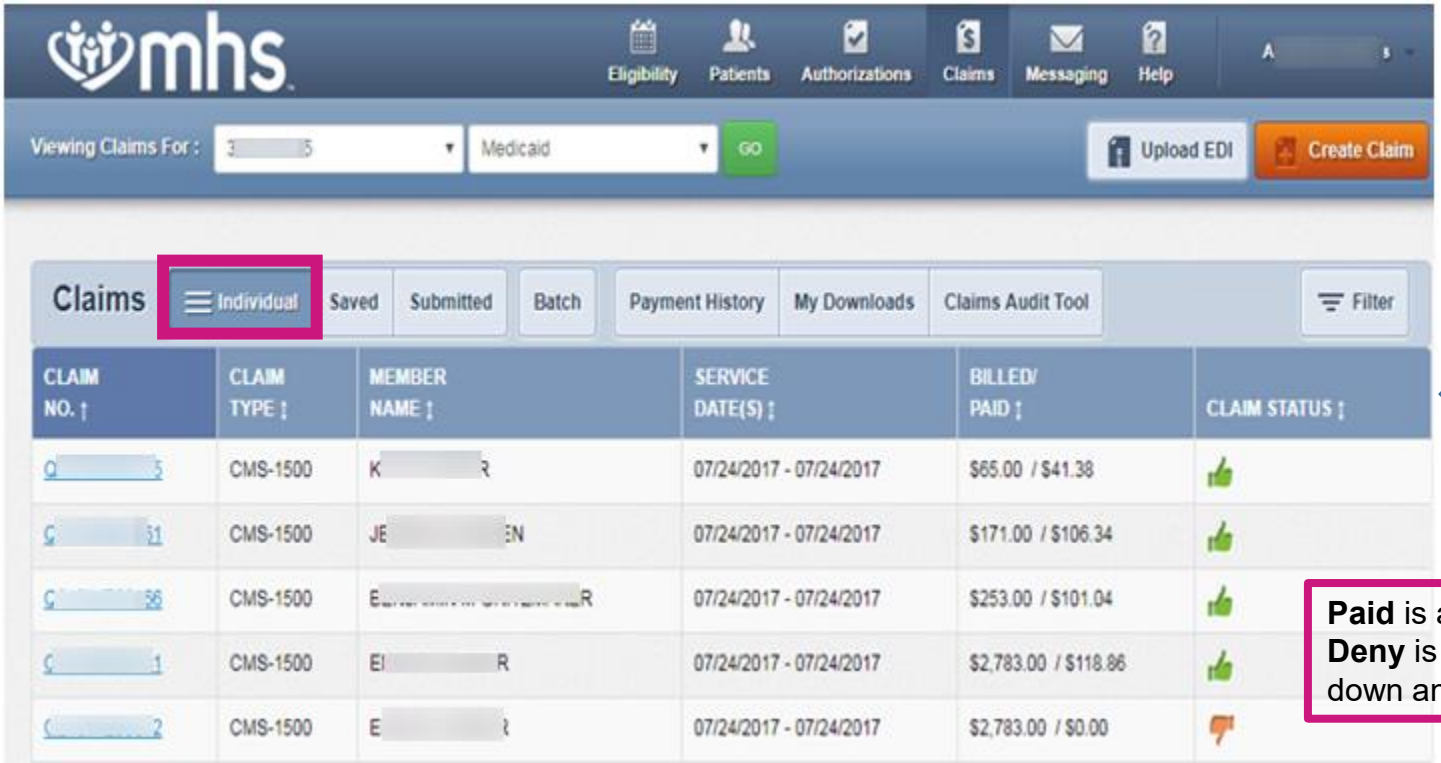
# Submitted Claims

- The **Submitted** tab will only display claims created via the MHS portal:
  - **Paid** is a green thumbs up.
  - **Denied** is an orange thumbs down.
  - **Pending** is a clock.
- **RTEP** claims also show if eligible (i.e. line 3 was submitted, but was not eligible for RTEP).



# Individual Claims

- On the **Individual** tab, submitted using paper, portal or clearing house:
  - View the Claim No, Claim Type, Member Name, Service Date(s), Billed/Paid, and Claim Status




**Paid** is a green thumbs up, **Deny** is an orange thumbs down and a clock is **Pending.**

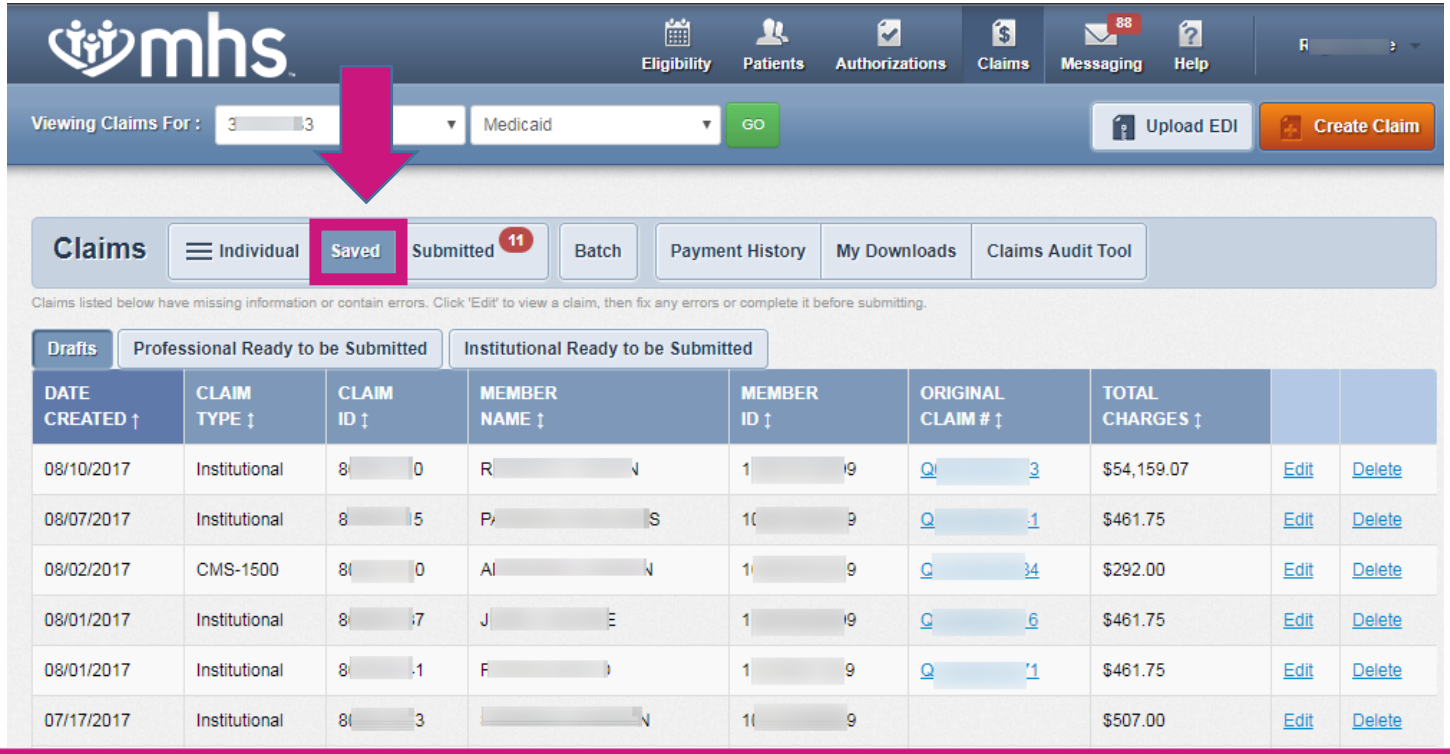
# Saved Claims

To view **Saved** claims: Drafts, Professional, or Institutional

1. Select **Saved.**
2. Click **Edit** to view a claim.
3. Fix any errors or complete before submitting.

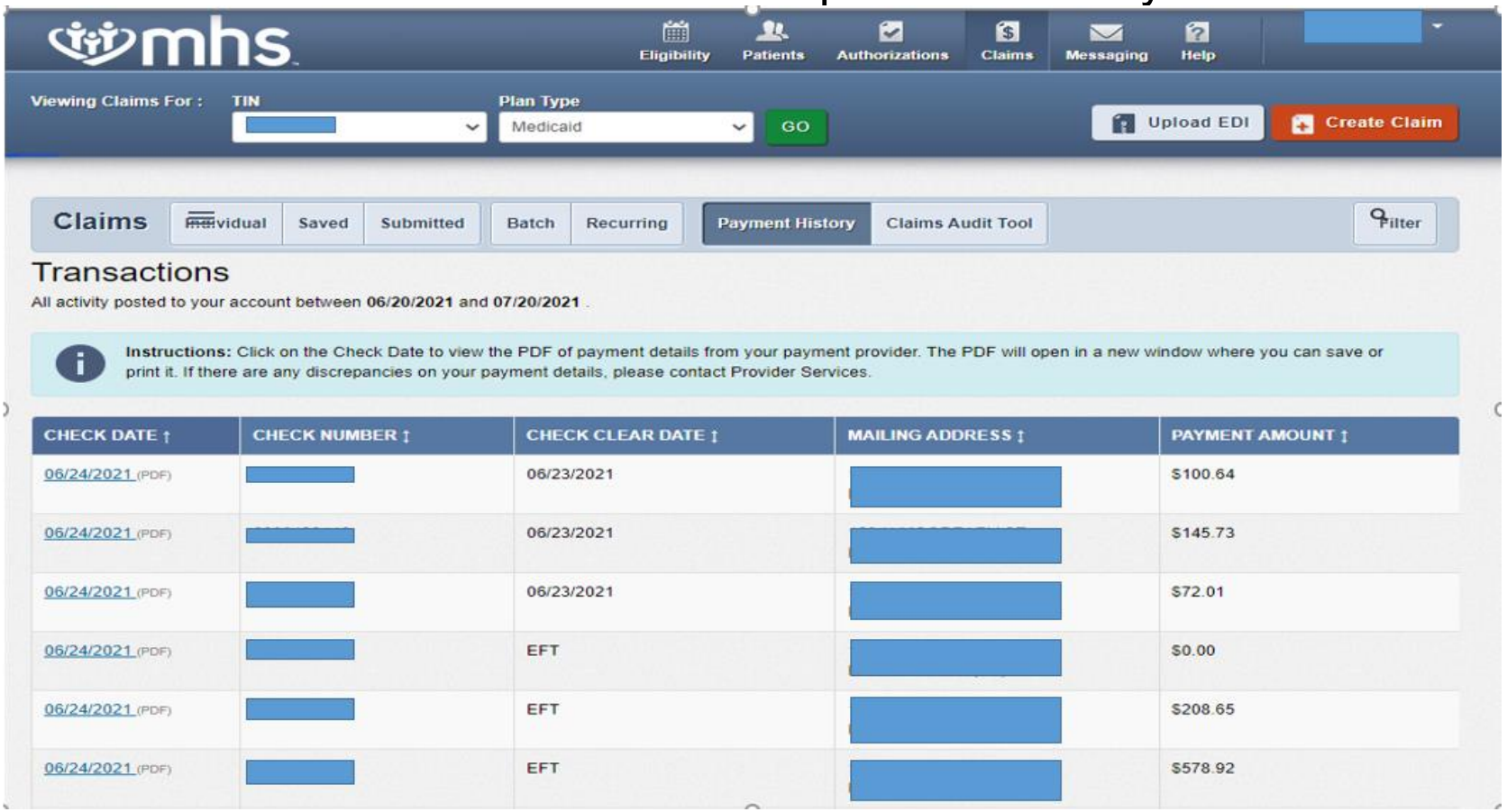
Or

4. Click **Delete** to delete saved claim that is no longer necessary.
5. Click **OK** to confirm the deletion.



# Payment History

- Click on **Payment History** to view Check Date, Check Number, Check Clear Date, Mailing Address and Payment Amount
  - Click on **Check Date** to view Explanation of Payment



# Provider EOP

[redacted]

Electronic Service Requested

5-DIGIT 30374

bOb 0.7648 AV 0.386

[redacted]

[redacted]

RUN DATE: 07/09/20
CHECK #: [redacted]
PAYEE ID: [redacted]
IRS#: [redacted]

STATEMENT TOTAL

Beginning Negative Services Balance: .00
Beginning Prepayment Balance: .00
Total Beginning Balance: .00
Claims Paid This Run: [redacted]
Check Amount: [redacted]

Remittance Advice and Explanation of Payment

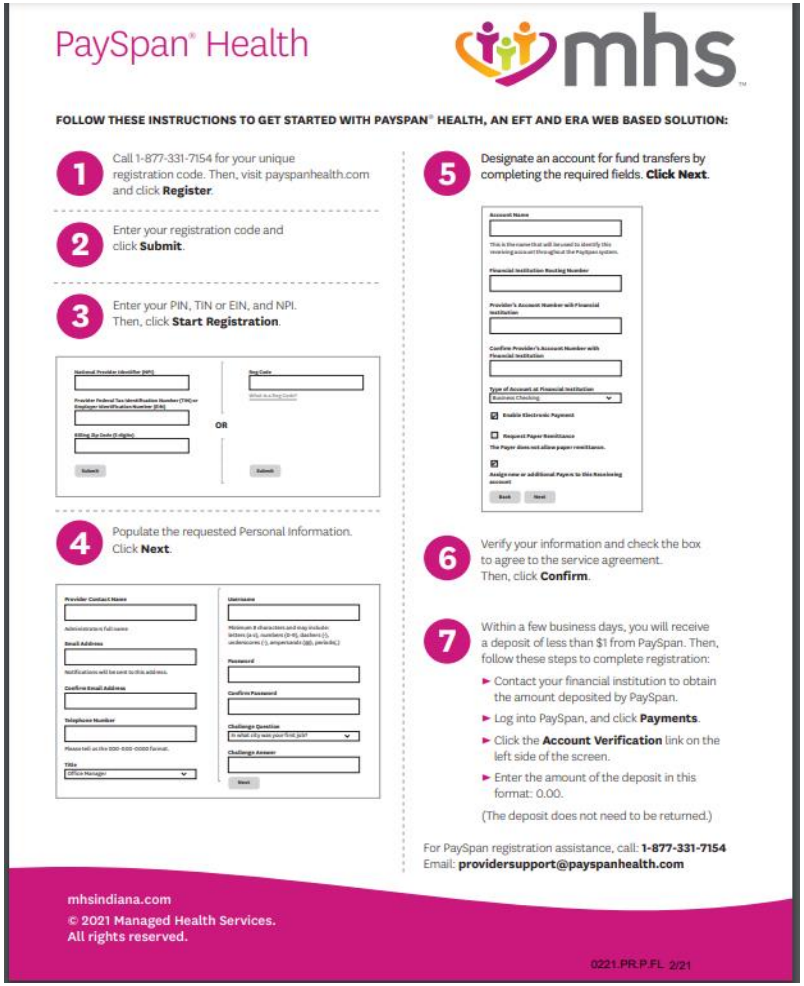
Insured Name: [redacted] Member ID: [redacted] Claim No: [redacted]
Patient Name: [redacted] PCN: [redacted] Carrier: DE Provider ID: [redacted]
Service Provider: [redacted] LNPI: [redacted] Group: [redacted]

| Serv | Dates | Procedure | Modifiers | Days Ct/Qty | Charged | Allowed | Deduct / Copay | Coinsur/ Discount | Interest | Med Allow/ Med Paid | TPP | Denied | Payment Codes | Payment |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 0100 | [redacted] | [redacted] | G5 | 1.00 | 6388.16 | 263.75 | .00 | .00 5.28 | .00 | .00 | .00 | .00 | A0 SR 3O | 258.47 |
| 0200 | [redacted] | [redacted] | G5 | 1.00 | 6388.16 | 263.75 | .00 | .00 5.28 | .00 | .00 | .00 | .00 | A0 SR 3O | 258.47 |
| 0300 | [redacted] | [redacted] | G5 | 1.00 | 6388.16 | 263.75 | .00 | .00 5.28 | .00 | .00 | .00 | .00 | A0 SR 3O | 258.47 |
| 0400 | [redacted] | [redacted] | G5 | 1.00 | 6388.16 | 263.75 | .00 | .00 5.28 | .00 | .00 | .00 | .00 | A0 SR 3O | 258.47 |
| 0500 | [redacted] | [redacted] | G5 | 1.00 | 6388.16 | 263.75 | .00 | .00 5.28 | .00 | .00 | .00 | .00 | A0 SR 3O | 258.47 |
| 0600 | [redacted] | [redacted] | G5 | 1.00 | 6388.16 | 263.75 | .00 | .00 5.28 | .00 | .00 | .00 | .00 | A0 SR 3O | 258.47 |
| 0700 | [redacted] | [redacted] | G5 | 1.00 | 6388.16 | 263.75 | .00 | .00 | .00 | .00 | .00 | .00 | A0 SR 3O | 258.47 |

# EFTs and ERAs

## PaySpan Health

- Web based solution for:
  - Electronic Funds
  - Transfers (EFTs) and Electronic Remittance Advices (ERAs)
- One year retrieval of remittance advice.
- Provided at no cost to providers and allows online enrollment.
- Register at [Payspan | Healthcare Payment Reimbursement Solutions]
- For questions call 1-877-331-7154.



PaySpan® Health

mhs

FOLLOW THESE INSTRUCTIONS TO GET STARTED WITH PAYSPAN® HEALTH, AN EFT AND ERA WEB BASED SOLUTION:

1. Call 1-877-331-7154 for your unique registration code. Then, visit payspanhealth.com and click **Register**.
2. Enter your registration code and click **Submit**.
3. Enter your PIN, TIN or EIN, and NPI. Then, click **Start Registration**.
4. Populate the requested Personal Information. Click **Next**.
5. Designate an account for fund transfers by completing the required fields. **Click Next**.
6. Verify your information and check the box to agree to the service agreement. Then, click **Confirm**.
7. Within a few business days, you will receive a deposit of less than $1 from PaySpan. Then, follow these steps to complete registration:
   - Contact your financial institution to obtain the amount deposited by PaySpan.
   - Log into PaySpan, and click **Payments**.
   - Click the **Account Verification** link on the left side of the screen.
   - Enter the amount of the deposit in this format: 0.00.

   (The deposit does not need to be returned.)

For PaySpan registration assistance, call: **1-877-331-7154**
Email: **providersupport@payspanhealth.com**

mhsindiana.com



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# Tips to Remember

- Clicking on items (claim numbers, check numbers, dates) that are highlighted blue will reveal additional information.
- When **filtering** to find a claim or payment history, only a **30-day** span within the same month can be used.
- Click on the **Saved Claims** tab to view claims that have been created but not Submitted. Claims in this queue can be edited for submission or deleted from this tab.
- In order to utilize the **Correct Claim** feature, the claim needs to be in a **Paid** or **Denied** status.

# Online Claim Reconsiderations on the MHS Secure Provider Portal

# Summary Of Online Reconsiderations

## Skip the phone call.

- Providers can make their case directly on the portal.

## Make the case.

- Providers can submit informal dispute/reconsideration comments using expanded text fields.

## Add context.

- Providers can easily attach supporting documentation when filing an informal dispute/reconsideration.

## Stay current.

- Providers may opt in/out for informal dispute/reconsideration status change emails.
- Providers may also view status online.

# Online Reconsiderations

- Providers are able to:
  - Submit informal disputes/reconsiderations on the secure portal
  - Upload/view supporting documents
  - View acknowledgement letters
  - Track real time updates
  - View denial code information.

# Online Reconsiderations

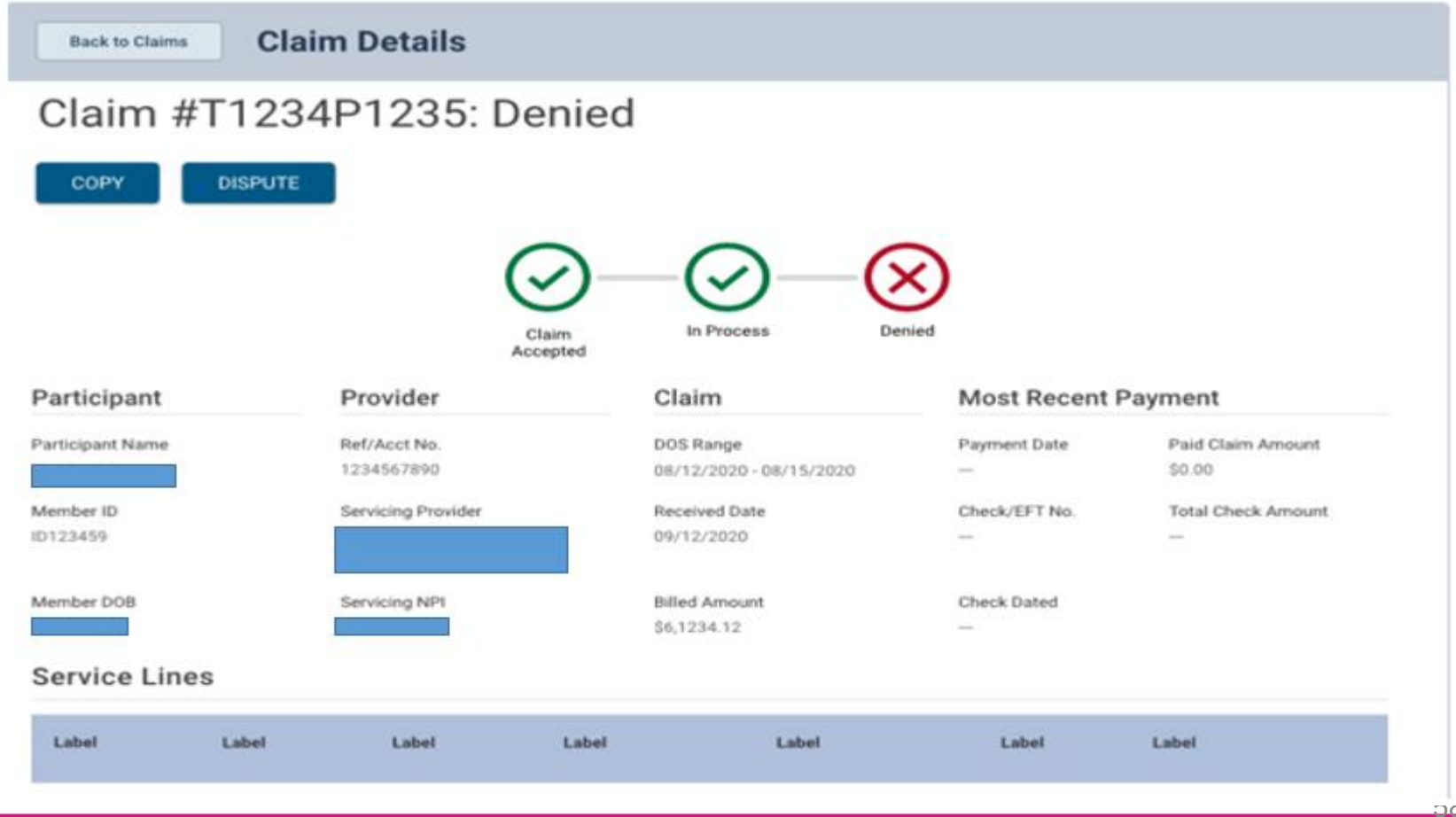
- It is important to note that all requests submitted via the online Portal for Level 1 will be considered an **informal dispute.** Secure messages are not considered reconsiderations/appeals.

- Calling Provider Services **will not** pause the time frame for timely submissions for informal disputes.

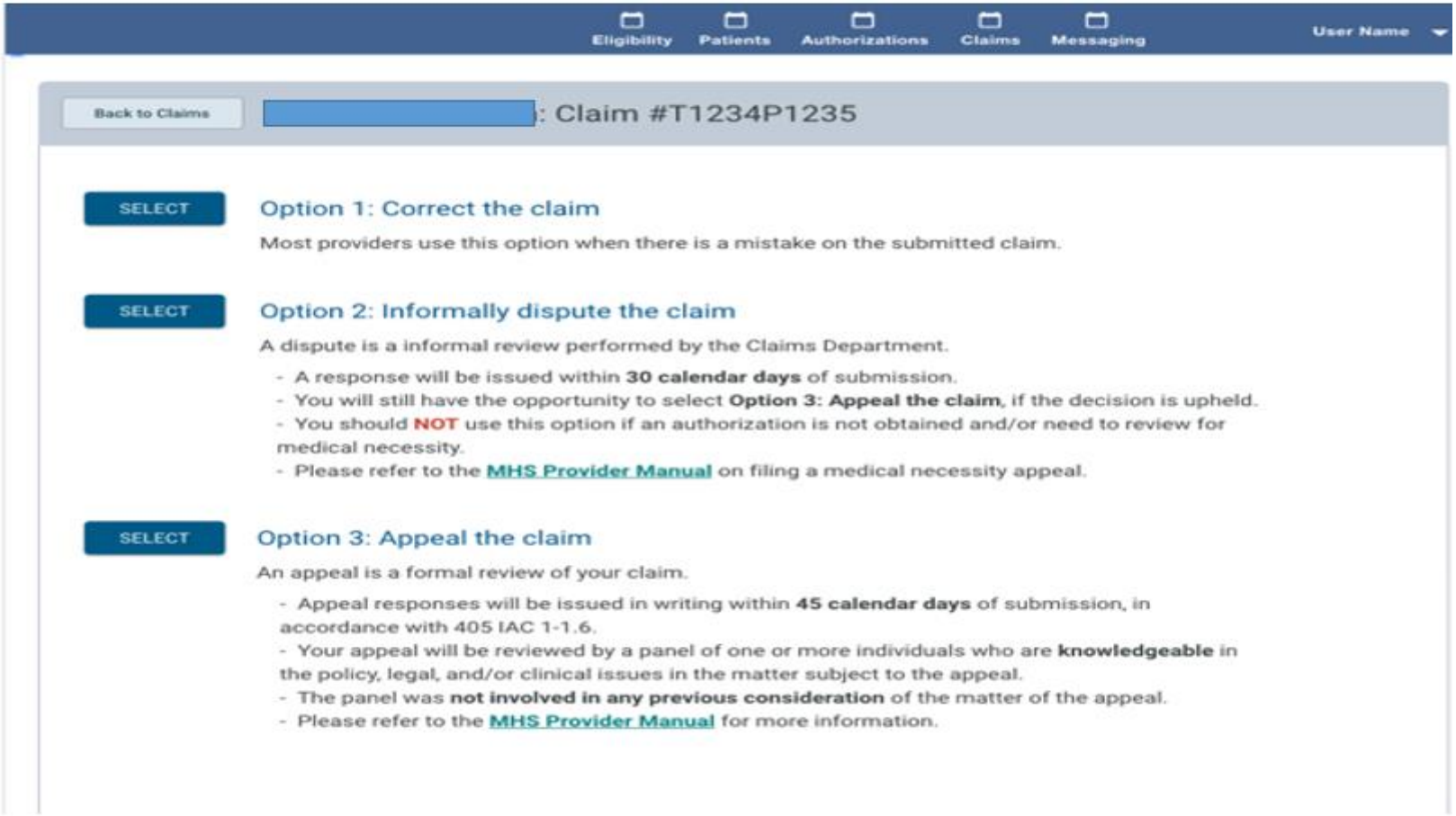
- Providers **do not** need to call prior to submitting an online claim reconsideration/information dispute.

- Providers may include a dispute form, but it is not required, as they may include comments directly into the portal.

# Level 1 Informal Claim Dispute and Level 2 Claim Appeals on the Secure Provider Portal

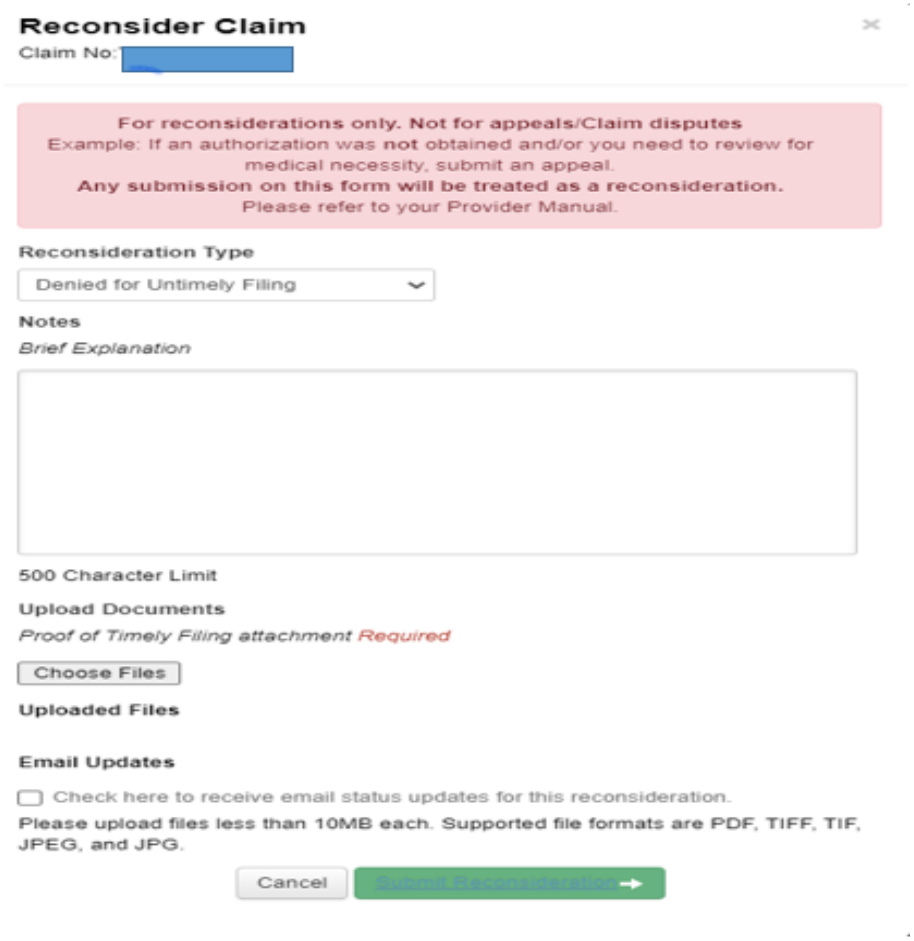


# Level 1 Informal Claim Dispute and Level 2 Claim Appeals on the Secure Provider Portal

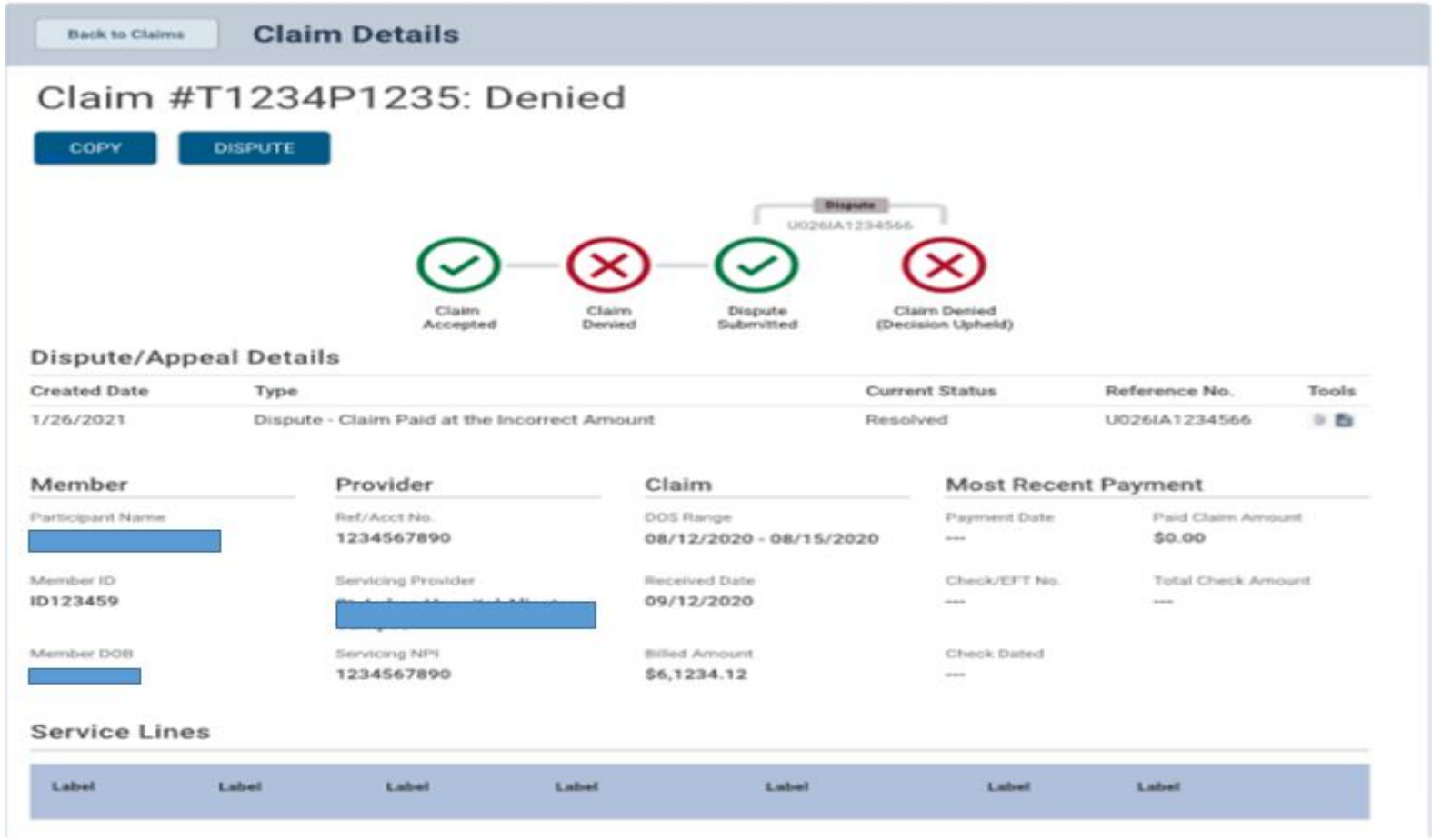


# Claim Reconsiderations

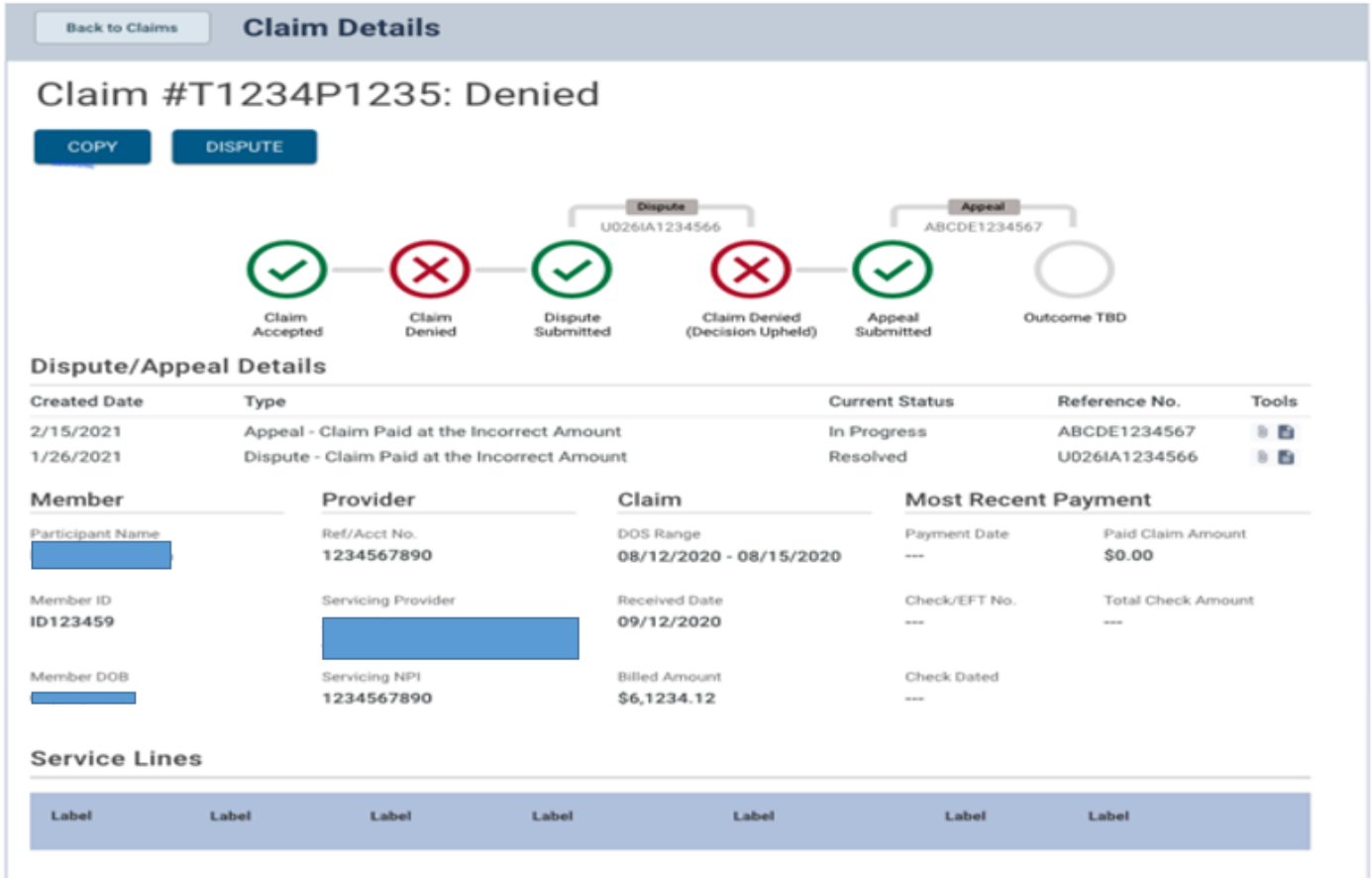
Enter your explanation for reconsideration and check email updates.



# Level 1 Informal Claim Dispute and Level 2 Claim Appeals on the Secure Provider Portal

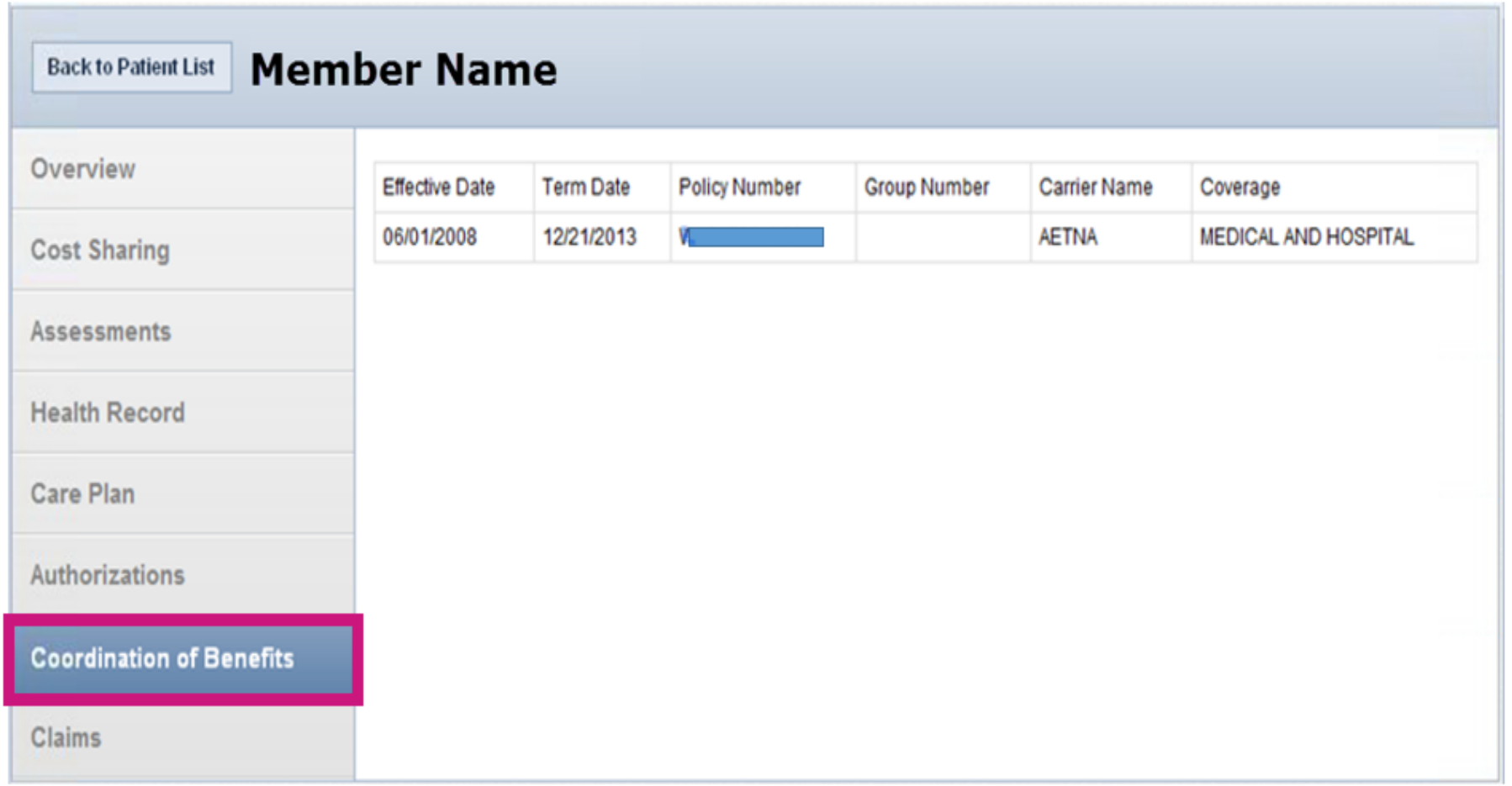


# Level 1 Informal Claim Dispute and Level 2 Claim Appeals on the Secure Provider Portal



# Coordination of Benefits

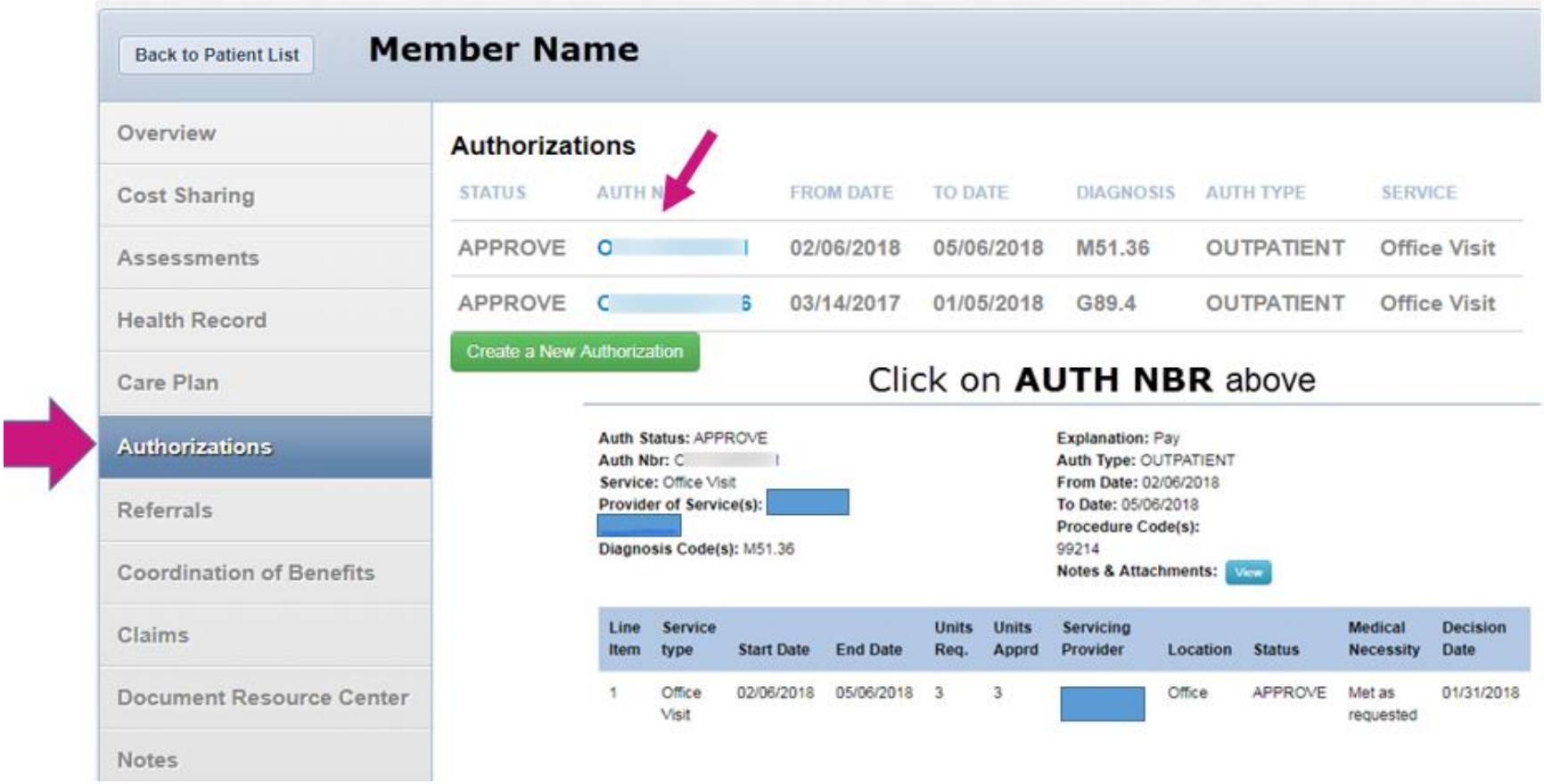
- This screen shows if a member has other insurance.



# Prior Authorization

# Authorizations

- View previously submitted or **Create a New Authorization.**



# Authorization Considerations

- **Need to know what requires Authorization:**
  - Quick Reference Guides (QRG)
  - Pre-Authorization tool
- **How to obtain Authorization:**
  - Online
  - Phone
  - Fax
- **Authorizations do not guarantee payment**

# Prior Authorization

## Is Prior Authorization Needed?

- Provider Quick Reference Guide https://www.mhsindiana.com/content/dam/centene/mhsindiana/medicaid/pdfs/508-Provider-QRG-2021.pdf

- Pre-AuthTool https://www.mhsindiana.com/providers/prior-authorization.html

mhs PROVIDER Quick Reference Guide

Effective June 2021

Applies to all Hoosier Healthwise (HHW), Healthy Indiana Plan (HIP) and Hoosier Care Connect (HCC) packages.

For an Ambetter Provider Quick Reference Guide, please visit ambetter.mhsindiana.com. Coverage is subject to specific benefit package of member.

Hoosier Healthwise | HIP | Hoosier CARE CONNECT

**1-877-647-4848**
TTY/TDD: 1-800-743-3333
**mhsindiana.com**

GENERAL OFFICE HOURS:
8 a.m. to 5 p.m., EST, closed holidays

MEMBER SERVICES AND PROVIDER SERVICES:
8 a.m. to 8 p.m.

REFERRALS AND AUTHORIZATIONS:
8 a.m. to 5 p.m., closed 12 p.m. to 1 p.m.

CASE MANAGEMENT:
8 a.m. to 5 p.m.

AFTER-HOURS:
MHS' 24/7 Nurse Advice Line for members is available to answer calls for emergent authorization needs. Or, you may leave a message on our after-hours recording system. Messages are returned within one business day.

MANAGED HEALTH SERVICES (MHS)

ELECTRONIC PAYER ID:
68069

BEHAVIORAL HEALTH PAYER ID:
68068

MEDICAL CLAIMS ADDRESS:
Managed Health Services
P.O. Box 3002
Farmington, MO 63640-3802

Claims sent to MHS' Indianapolis address will be returned to the provider.

MEDICAL NECESSITY APPEALS ONLY ADDRESS:
ATTN: APPEALS
P.O. Box 441567
Indianapolis, IN 46244

MEDICAL CLAIMS APPEALS ADDRESS:
Managed Health Services
P.O. Box 3000
Farmington, MO 63640-3800

Providers have 60 calendar days from the date of the Explanation of Payment to file an adjustment, resubmit, or appeal a decision.

Failure to do so within the specified timeframe will waive the right for reconsideration.

MEDICAL CLAIMS REFUNDS:
To refund claims overpayment, please send check and documentation to:

Coordinated Care Corporation
75 Remittance Dr., Suite 6446
Chicago, IL 60675-6446

MHS FAX NUMBERS

MEDICAL APPEALS: 1-866-714-7393

CASE MANAGEMENT: 1-866-694-3653
*Ex. Member Referrals to CM/DM*

REFERRALS AND AUTHORIZATIONS: 1-866-912-4245

MHS WEBSITE: MHSINDIANA.COM

mhsindiana.com/providers ..... Latest MHS provider updates and news, as well as online provider enrollment, office and billing address change forms, quality and care gap tools, forms, manuals, guides, online PA tool and tutorials.

mhsindiana.com/health ..... MHS' Health Library. Click on "KRAMES Health Library" for free print-on-demand patient health fact sheets on over 4,000 topics, available in English and Spanish.

mhsindiana.com/login ..... MHS' Secure Provider Portal lets you submit prior authorization appeals, level I and level II claim disputes and appeals, claims, claim adjustments, and view your panel's medical records and care gaps.

mhsindiana.com/transactions ..... Information for electronic processing and payment of claims with MHS.

OTHER RESOURCES
payspanhealth.com ..... MHS is pleased to partner with PaySpan to provide an innovative web based solution for Electronic Funds Transfers (EFTs) and Electronic Remittance Advices (ERAs). This service is provided at no cost to providers and allows online enrollment at payspanhealth.com.

You can find out more about the information in this Guide in the MHS Provider Manual, online at mhsindiana.com/providers/resources, or by contacting MHS at 1-877-647-4848.

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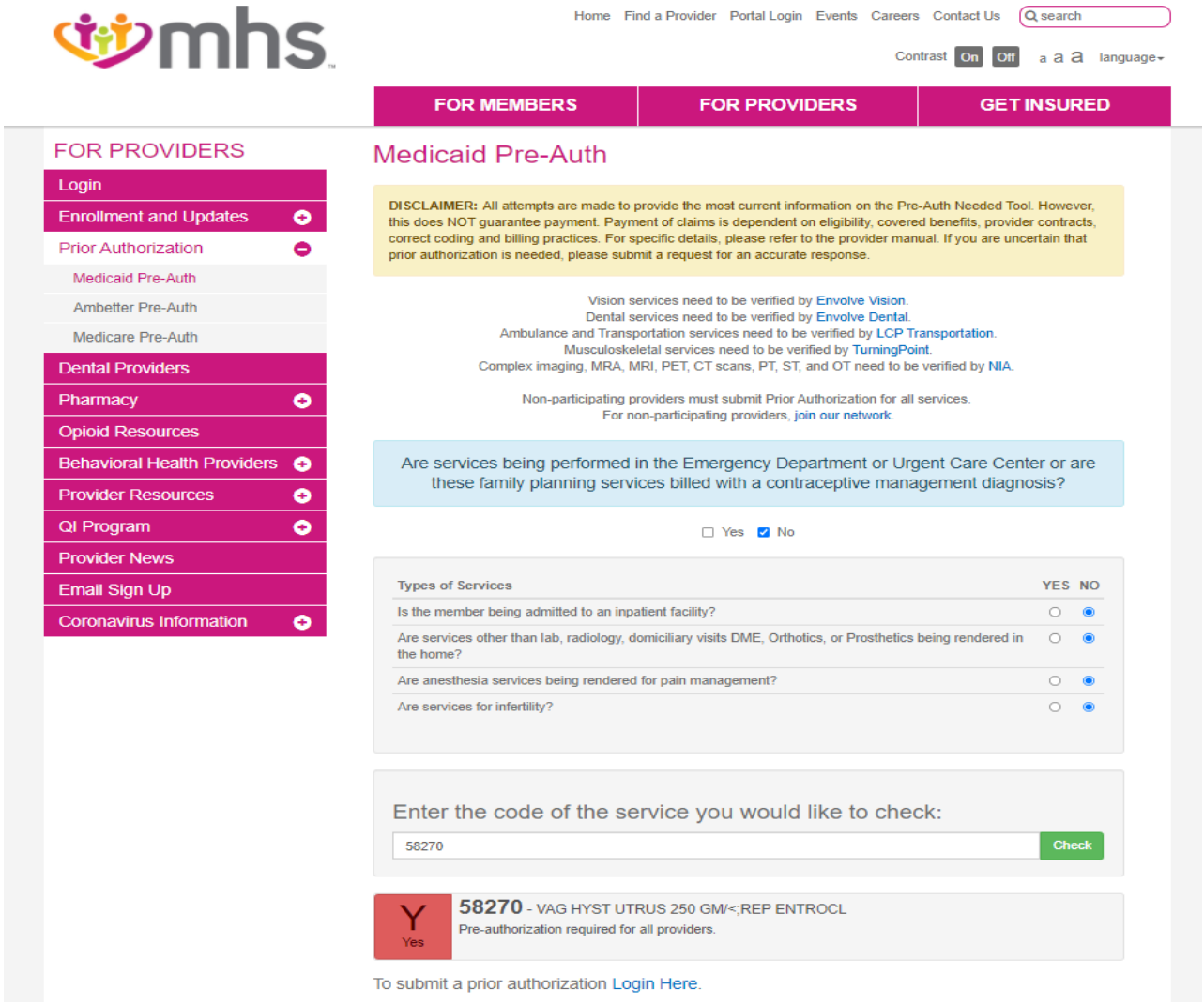
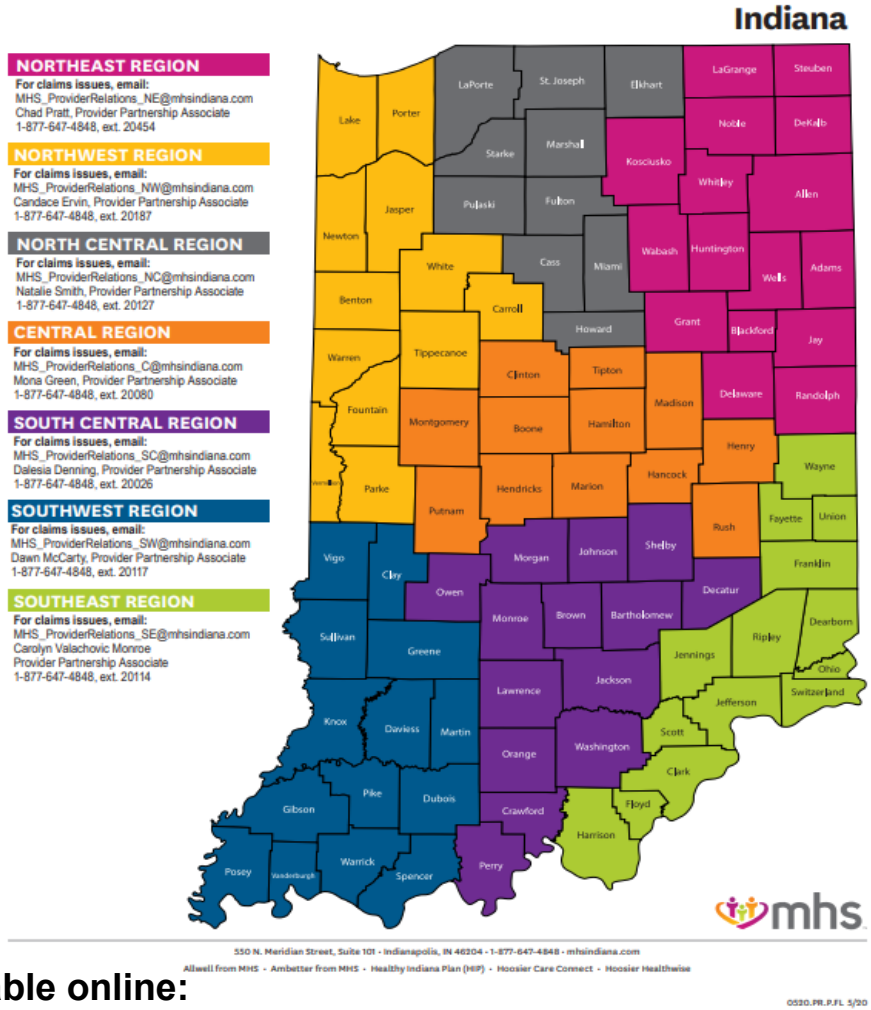
# Prior Authorization



# MHS Team

# MHS Provider Network Territories




**Available online:**
https://www.mhsindiana.com/content/dam/centene/mhsindiana/medicaid/pdfs/ProviderTerritory_map_2021.pdf

## NORTHEAST REGION

**For claims issues, email:**
MHS_ProviderRelations_NE@mhsindiana.com
Chad Pratt, Provider Partnership Associate
1-877-647-4848, ext. 20454

## NORTHWEST REGION

**For claims issues, email:**
MHS_ProviderRelations_NW@mhsindiana.com
Candace Ervin, Provider Partnership Associate
1-877-647-4848, ext. 20187

## NORTH CENTRAL REGION

**For claims issues, email:**
MHS_ProviderRelations_NC@mhsindiana.com
Natalie Smith, Provider Partnership Associate
1-877-647-4848, ext. 20127

## CENTRAL REGION

**For claims issues, email:**
MHS_ProviderRelations_C@mhsindiana.com
Mona Green, Provider Partnership Associate
1-877-647-4848, ext. 20080

## SOUTH CENTRAL REGION

**For claims issues, email:**
MHS_ProviderRelations_SC@mhsindiana.com
Dalesia Denning, Provider Partnership Associate
1-877-647-4848, ext. 20026

## SOUTHWEST REGION

**For claims issues, email:**
MHS_ProviderRelations_SW@mhsindiana.com
Dawn McCarty, Provider Partnership Associate
1-877-647-4848, ext. 20117

## SOUTHEAST REGION

**For claims issues, email:**
MHS_ProviderRelations_SE@mhsindiana.com
Carolyn Valachovic Monroe
Provider Partnership Associate
1-877-647-4848, ext. 20114

# MHS Provider Network Territories


**TAWANNA DANZIE**
Provider Partnership Associate II
1-877-647-4848 ext. 20022
tdanzie@mhsindiana.com


**PROVIDER GROUPS**

- Beacon Medical Group
- Franciscan Alliance
- HealthLinc
- Heart City Health Center
- Indiana Health Centers
- Lutheran Medical Group
- Parkview Health System
- South Bend Clinic


**JENNIFER GARNER**
Program Manager,
Provider Engagement
1-877-647-4848 ext. 20149
jgarner@mhsindiana.com


**PROVIDER GROUPS**

- American Health Network of Indiana
- Columbus Regional Health
- Community Physicians of Indiana
- HealthNet
- Health & Hospital Corporation of Marion County
- Indiana University Health
- St. Vincent Medical Group

**ENVOLVE DENTAL, INC.**


**THOMAS "TONY" SMITH**
Thomas.Smith@EnvolveHealth.com
Dental Provider Services: 1-855-609-5157
Questions: ProviderRelations@EnvolveHealth.com


**ENVOLVE VISION, INC.**


**CHANTEL MCKINNEY**
Chantel.McKinney@EnvolveHealth.com
Vision Provider Services: 1-844-820-6523
Questions: Envolve_AdvancedCaseUnit@EnvolveHealth.com

# Network Leadership

## NETWORK LEADERSHIP

**JILL CLAYPOOL**
Vice President, Network Development & Contracting
1-877-647-4848 ext. 20855
jill.e.claypool@mhsindiana.com

**NANCY ROBINSON**
Senior Director, Provider Network
1-877-647-4848 ext. 20180
nrobinson@mhsindiana.com

**MARK VONDERHEIT**
Director, Provider Network
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## NEW PROVIDER CONTRACTING

**TIM BALKO**
Director, Network Development & Contracting
1-877-647-4848 ext. 20120
tbalko@mhsindiana.com

**MICHAEL FUNK**
Manager, Network Development & Contracting
1-877-647-4848 ext. 20017
michael.j.funk@mhsindiana.com

## NETWORK OPERATIONS

**KELVIN ORR**
Director, Network Operations
1-877-647-4848 ext. 20049
kelvin.d.orr@mhsindiana.com

# Questions?

# Thank you for being our partner in care.