

# 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 1<sup>st</sup> 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>



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.

1<sup>st</sup> Level (Informal Dispute/Reconsideration)

2<sup>nd</sup> 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 documentation).
- 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).
  - o Note: if the past timely filing deadline 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).
  - o 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;  
 2<sup>nd</sup> level appeal – available online beginning in early 2021

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

Medical Claims:
Managed Health Services PO Box 3000 Farmington, MO 63640-3800

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



Allwell from MHS | Ambetter from MHS | Healthy Indiana Plan (HIP) | Hoosier Care Connect | Wellcare by Allwell

1220.OS.PLT 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/08-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](mailto:MHS_ProviderRelations_NE@mhsindiana.com)
- North Central Region: [MHS\\_ProviderRelations\\_NC@mhsindiana.com](mailto:MHS_ProviderRelations_NC@mhsindiana.com)
- Central Region: [MHS\\_ProviderRelations\\_C@mhsindiana.com](mailto:MHS_ProviderRelations_C@mhsindiana.com)
- Northwest Region: [MHS\\_ProviderRelations\\_NW@mhsindiana.com](mailto:MHS_ProviderRelations_NW@mhsindiana.com)
- Southwest Region: [MHS\\_ProviderRelations\\_SW@mhsindiana.com](mailto:MHS_ProviderRelations_SW@mhsindiana.com)
- Southeast Region: [MHS\\_ProviderRelations\\_SE@mhsindiana.com](mailto:MHS_ProviderRelations_SE@mhsindiana.com)
- South Central Region: [MHS\\_ProviderRelations\\_SC@mhsindiana.com](mailto:MHS_ProviderRelations_SC@mhsindiana.com)
- Tier 1 Providers: [IndyProvRelations@mhsindiana.com](mailto:IndyProvRelations@mhsindiana.com)



# **Portal Functionality**

# Secure Web Portal Login or Registration



Home Find a Provider Portal Login Events Careers Contact Us



search

Contrast     language+

FOR MEMBERS

FOR PROVIDERS

GET INSURED

## FOR PROVIDERS

Login

[Enrollment and Updates](#) 

[Prior Authorization](#) 

[Dental Providers](#)

[Pharmacy](#) 

[Opioid Resources](#)

[Behavioral Health Providers](#) 

[Provider Resources](#) 

[QI Program](#) 

[Provider News](#)

[Email Sign Up](#)

[Coronavirus Information](#) 

## Portal Login

Create your own online account today!

MHS offers you many convenient and secure tools to assist you. To enter our secure portal, click on the login/register button. A new window will open. You can login or register for a new account.

Creating an account is free and easy.

By creating a MHS account, you can:

- Verify member eligibility
- Submit and check claims
- Submit and confirm authorizations
- View detailed patient list

## PORTAL TRAINING GUIDES

- [Account Manager User Guide \(PDF\)](#)
- [Provider Secure Portal Brochure \(PDF\)](#)
- [Submit a Claim CMS 1500 \(PDF\)](#)
- [Submit a Claim CMS UB-04 \(PDF\)](#)
- [Update Portal Account Details \(PDF\)](#)
- [Utilize Member Management Forms \(PDF\)](#)

Please note that Clear Claim Connection does not provide an all inclusive listing of claim edits. MHS does utilize additional prepayment review edits in keeping with NCCI procedures and guidelines.

## Registration Help

If you are having trouble with your registration, you may need to submit a non-par set-up form. Visit our [Become a Provider](#) page to get started. For further assistance, you can call Provider Services at 1-877-647-4848 or see our [Account Registration Guide \(PDF\)](#).

## Vision and Dental Providers

[Vision Provider Portal Login](#)

[Dental Provider Portal Login](#)

- Verify member eligibility
- View member benefits

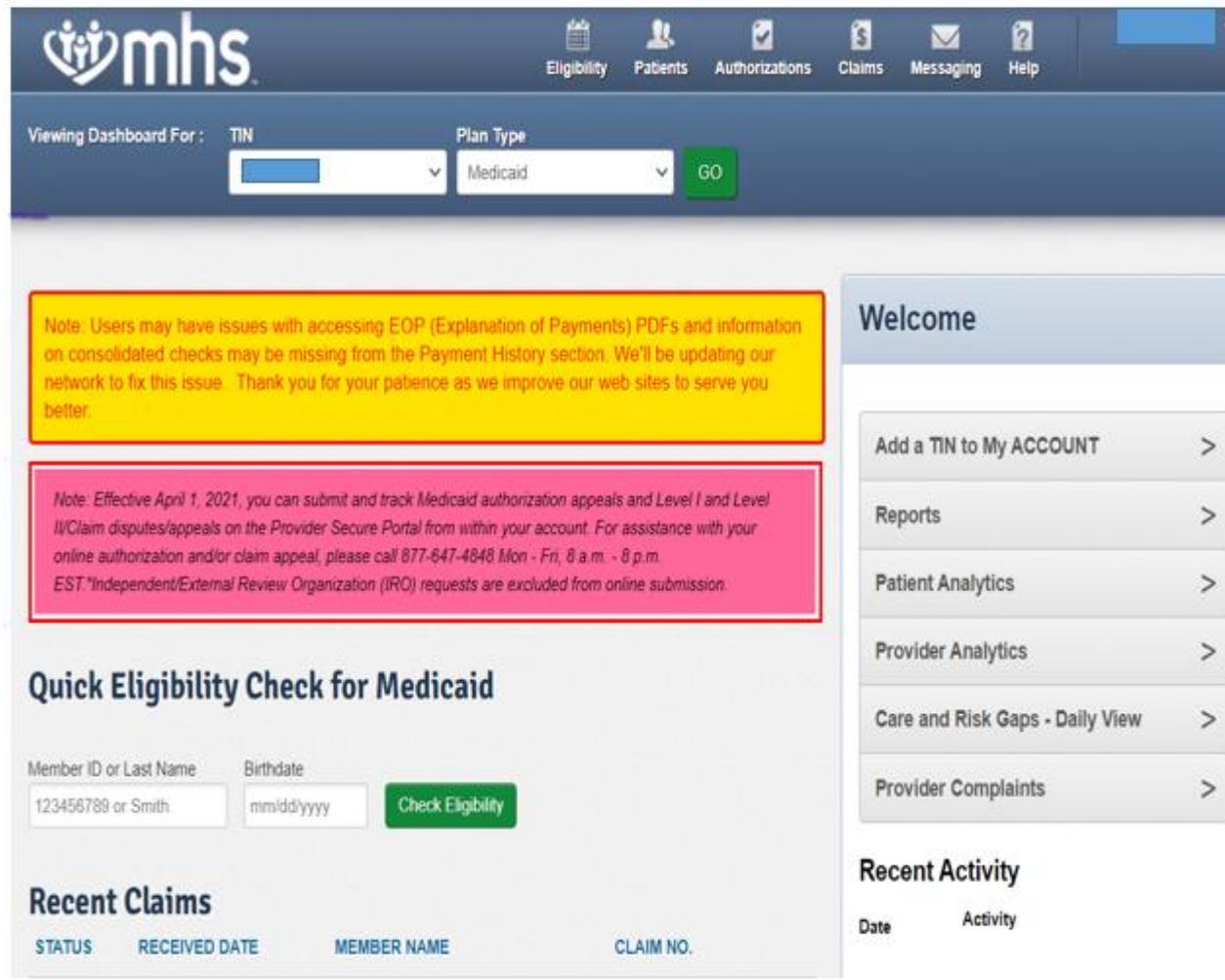
## Secure Provider Portal

[Login/Register](#)

## Provider Email Sign Up

[Sign Up](#)

# Homepage – MHS (Medicaid)



**Quick Links**

[Provider Resources](#)

[Member Management Forms](#)

Notification of Pregnancy (NOP): NOP must be accessed through the IHCP Provider Healthcare Portal and electronically submitted. If the member is not enrolled with Medicaid, the NOP option does not display. You must create a login and password in order to access the NOP form through the Provider Healthcare Portal.

Learn more about submitting a NOP through the [IHCP Provider Healthcare Portal](#).

Go to the [IHCP Provider Healthcare Portal](#)

Please note: Claims information is updated every 24 hours.

For HIP Pharmacy information and PDLs, please visit the [Pharmacy](#) page.

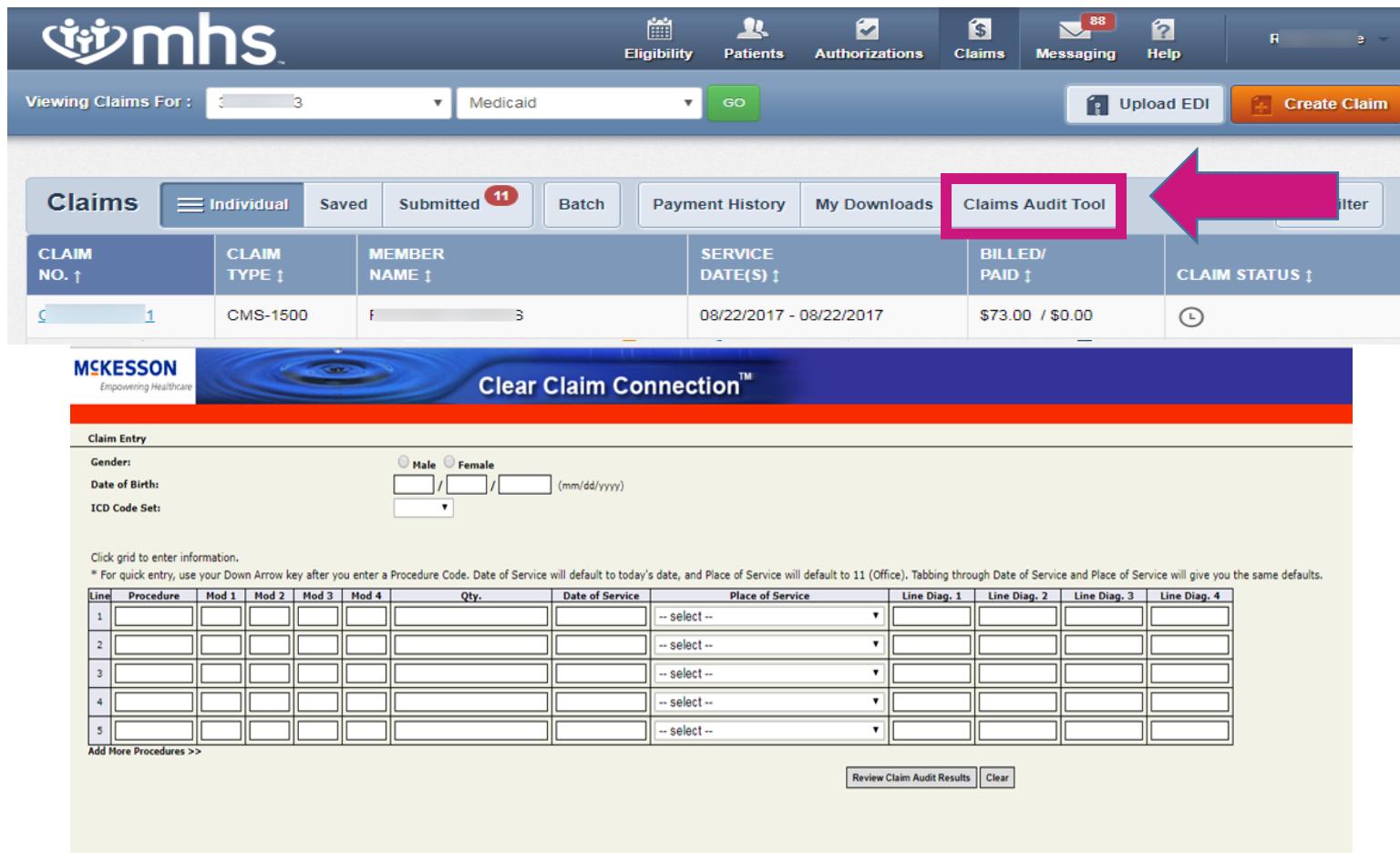
**Go Paperless**

Empower your practice with electronic settlement. Now you can receive EFT's and ERA's without investing in new technology and without changes to current systems.

[PaySpan Site](#)

# 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.



The screenshot shows the 'Claims Audit Tool' interface. At the top, there is a navigation bar with icons for Eligibility, Patients, Authorizations, Claims (highlighted with a pink box), Messaging, and Help. Below the navigation bar, there is a search bar for 'Viewing Claims For' and a dropdown for 'Medicaid'. There are also buttons for 'Upload EDI' and 'Create Claim'.

The main area is a table with columns for CLAIM NO. ↑, CLAIM TYPE ↑, MEMBER NAME ↑, SERVICE DATE(S) ↑, BILLED/PAID ↑, and CLAIM STATUS ↑. A single row is visible with values: CLAIM NO. 1, CLAIM TYPE CMS-1500, MEMBER NAME F B, SERVICE DATE(S) 08/22/2017 - 08/22/2017, BILLED/PAID \$73.00 / \$0.00, and CLAIM STATUS L.

Below the table, there is a 'Clear Claim Connection' header with the 'MCKESSON Empowering Healthcare' logo. The 'Claim Entry' section contains fields for Gender (Male, Female), Date of Birth (mm/dd/yyyy), and ICD Code Set. A note says 'Click grid to enter information.' and 'For quick entry, use your Down Arrow key after you enter a Procedure Code. Date of Service will default to today's date, and Place of Service will default to 11 (Office). Tabbing through Date of Service and Place of Service will give you the same defaults.'

The main data entry area is a grid with columns for Line, Procedure, Mod 1, Mod 2, Mod 3, Mod 4, Qty., Date of Service, Place of Service, Line Diag. 1, Line Diag. 2, Line Diag. 3, and Line Diag. 4. Each row has a dropdown menu next to the 'Place of Service' field. At the bottom of the grid, there is a link 'Add More Procedures >>' and buttons for 'Review Claim Audit Results' and 'Clear'.

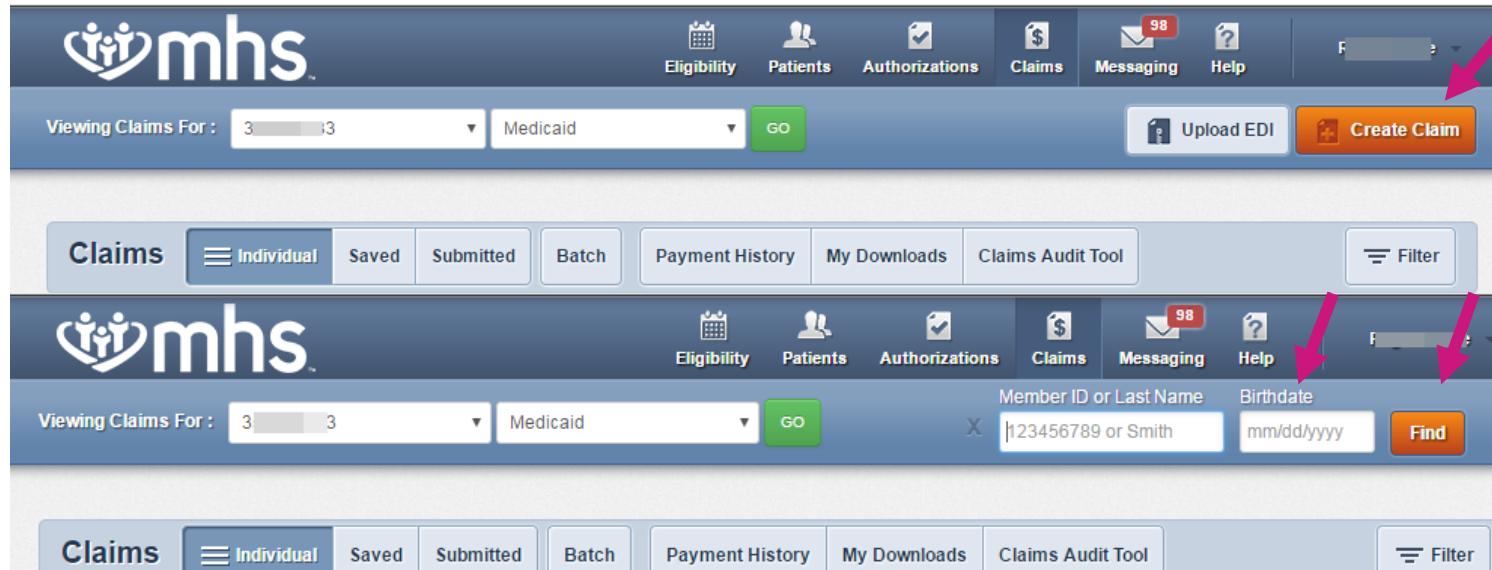
# Claims

## 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**



The image shows a screenshot of the mhs Web Portal interface. The top navigation bar includes links for Eligibility, Patients, Authorizations, Claims, Messaging, and Help. A red arrow points to the 'Create Claim' button in the top right corner of the header. The main content area has tabs for Claims, Individual, Saved, Submitted, Batch, Payment History, My Downloads, and Claims Audit Tool. Below this is a secondary header with links for Eligibility, Patients, Authorizations, Claims, Messaging, Help, and a search bar. A red arrow points to the 'Birthdate' field in the search bar. The search bar also contains fields for 'Member ID or Last Name' (with the value '123456789 or Smith') and a 'Find' button. The bottom of the interface features a navigation bar with the same set of tabs and a 'Filter' button.

# Claim Submission

## Choose the Claim Type

- Professional or Institutional claim submission

Viewing Claims For: Tax ID Number: Medicaid GO

Eligibility Patients Authorizations Claims Messaging Help Provider Name

Choose Claim for:

Choose a Claim Type

**CMS 1500**

Professional Claim →

**CMS UB-04**

Institutional Claim →

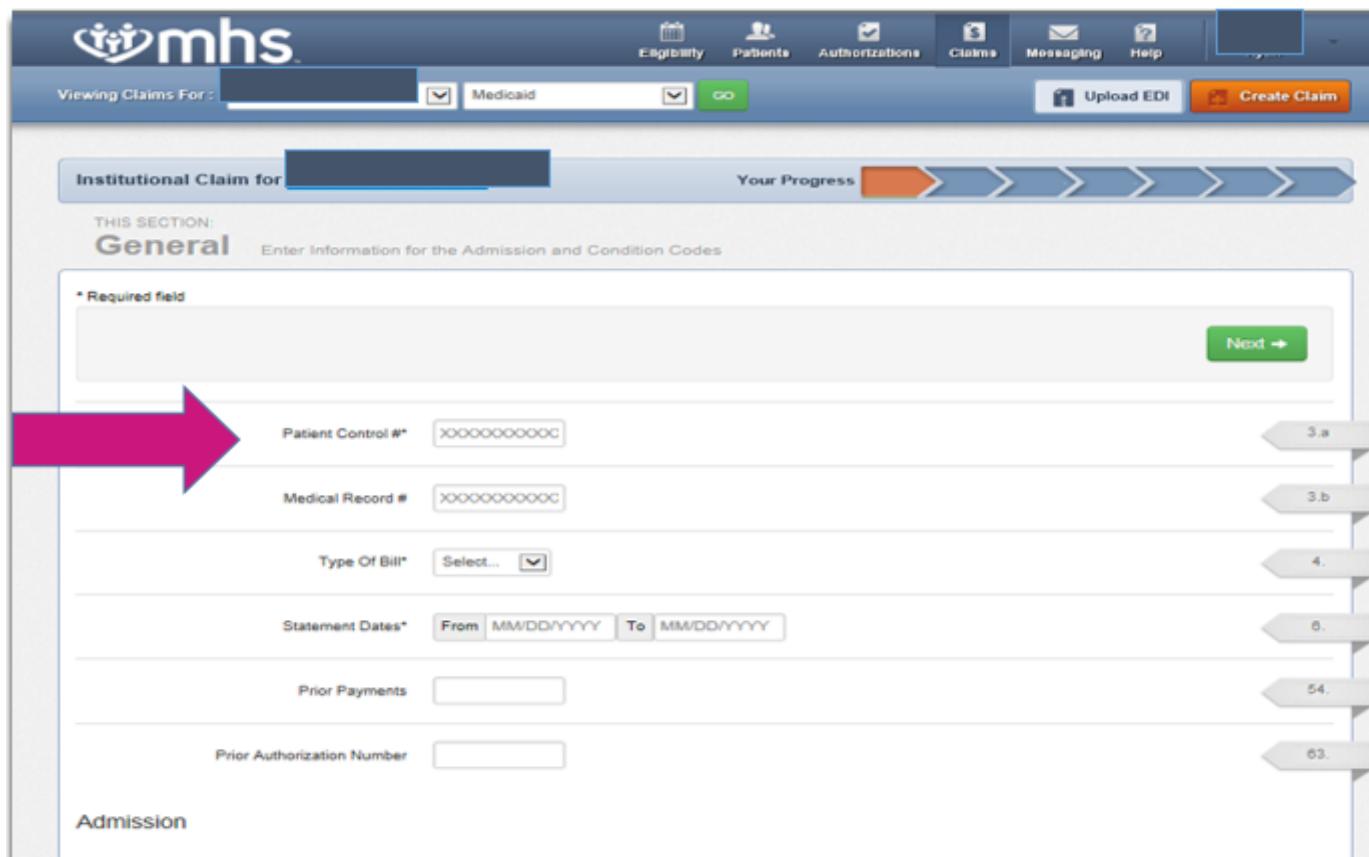
UPDATE: In order to be compliant with ICD-10 regulations, we will require claims with discharge dates or service dates on or after October 1, 2015, be coded with ICD-10 codes. This change applies to the date of service on the claim, not the submission date.



# 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**.



Viewing Claims For:  Medicaid

Institutional Claim for:  Your Progress: 

THIS SECTION: **General** Enter Information for the Admission and Condition Codes

\* Required field

Patient Control #  3.a

Medical Record #  3.b

Type Of Bill\*  4

Statement Dates\*  MM/DD/YYYY  MM/DD/YYYY 6

Prior Payments

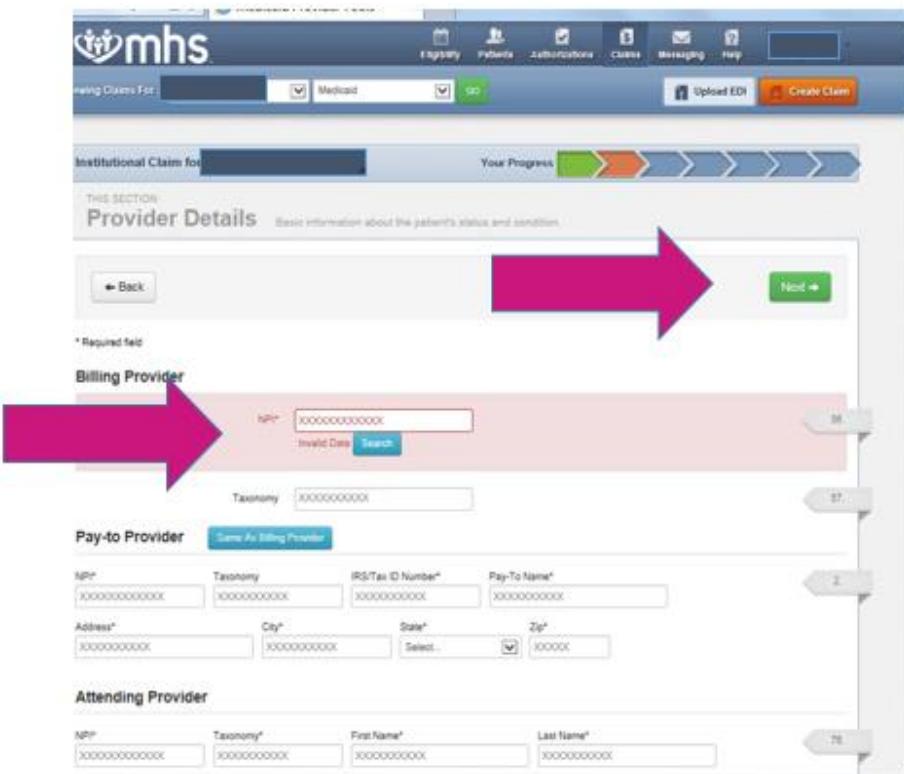
Prior Authorization Number  54

Admission 63

# UB-04 Billing

>Add the provider information.

Click **save** and click **next** to proceed



Institutional Claim for [REDACTED] Your Progress

**THIS SECTION**  
**Provider Details** Basic information about the patient's status and condition.

**Billing Provider**

NPI\*:  Invalid Date  Taxonomy:

**Pay-to Provider**

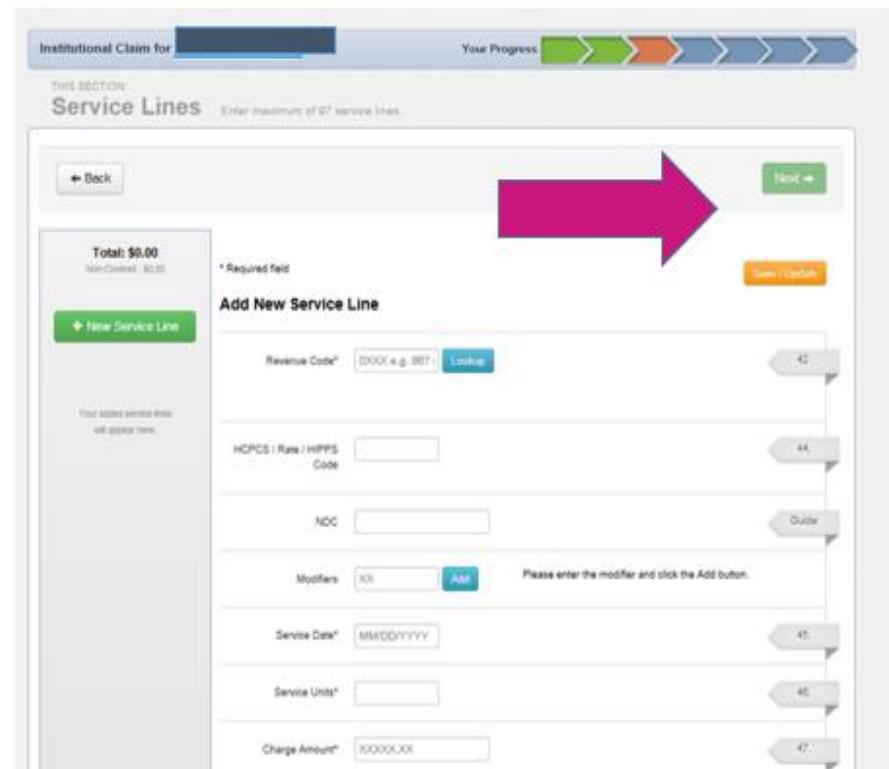
NPI\*:  Taxonomy:  IRS/Tax ID Number\*:  Pay-To Name\*:

**Address\***  **City\***  **State\***  **Zip\***

**Attending Provider**

NPI\*:  Taxonomy\*:  First Name\*:  Last Name\*:

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



Institutional Claim for [REDACTED] Your Progress

**THIS SECTION**  
**Service Lines** Enter maximum of 97 service lines.

**Add New Service Line**

Total: \$0.00 Non-Current - (0:0)

**Revenue Code\***   42

**HCPCS / Rate / HCPCS Code** 44

**NDC**  45

**Modifiers**   Please enter the modifier and click the Add button. 46

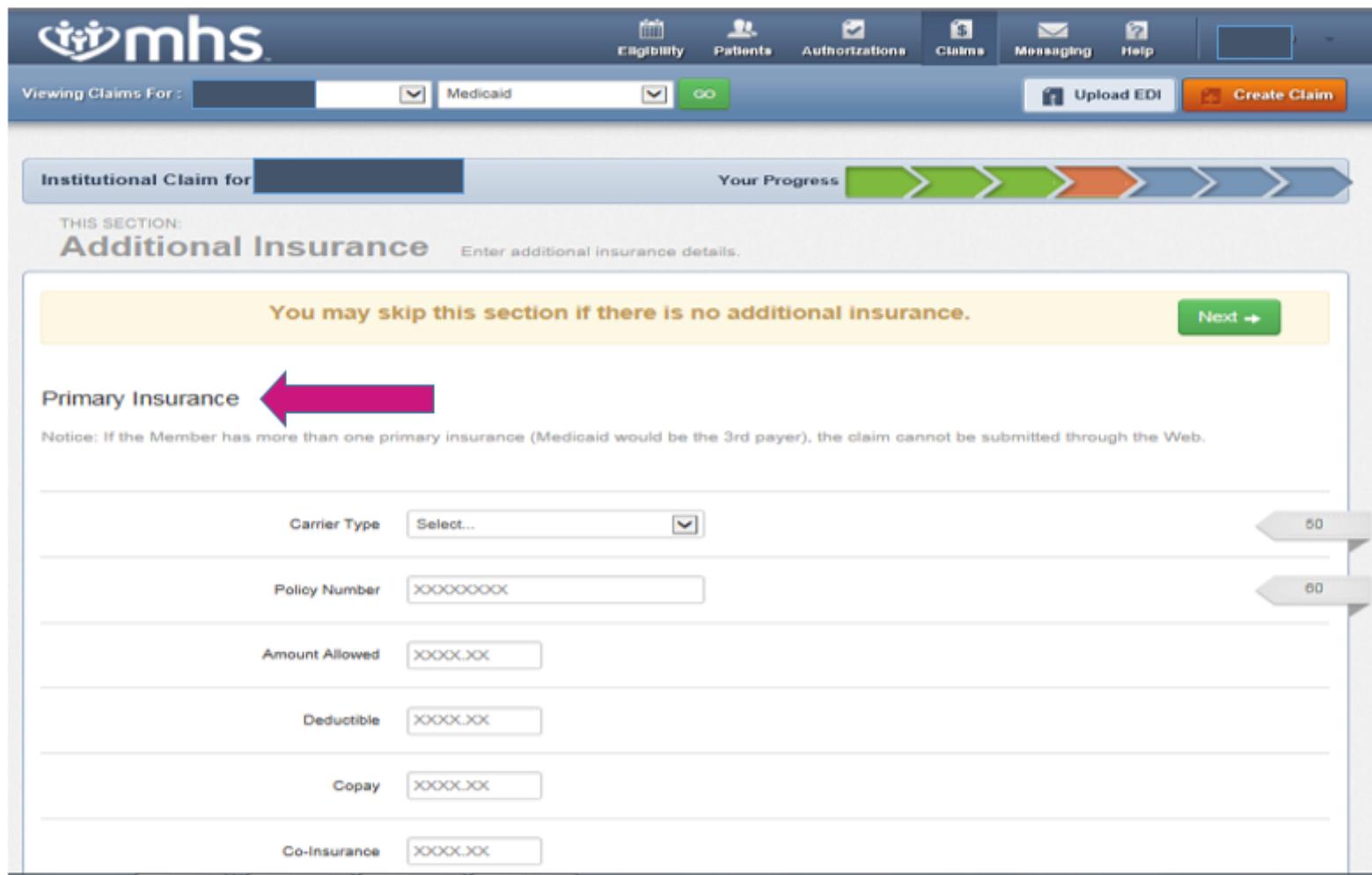
**Service Date\***  47

**Service Units\***  48

**Charge Amount\***  49

# UB-04 Billing

## Enter Additional Insurance (if applicable)



Viewing Claims For:   Medicaid

Eligibility Patients Authorizations Claims Messaging Help

Upload EDI Create Claim

Institutional Claim for  Your Progress > > > > > >

THIS SECTION:  
**Additional Insurance** Enter additional insurance details.

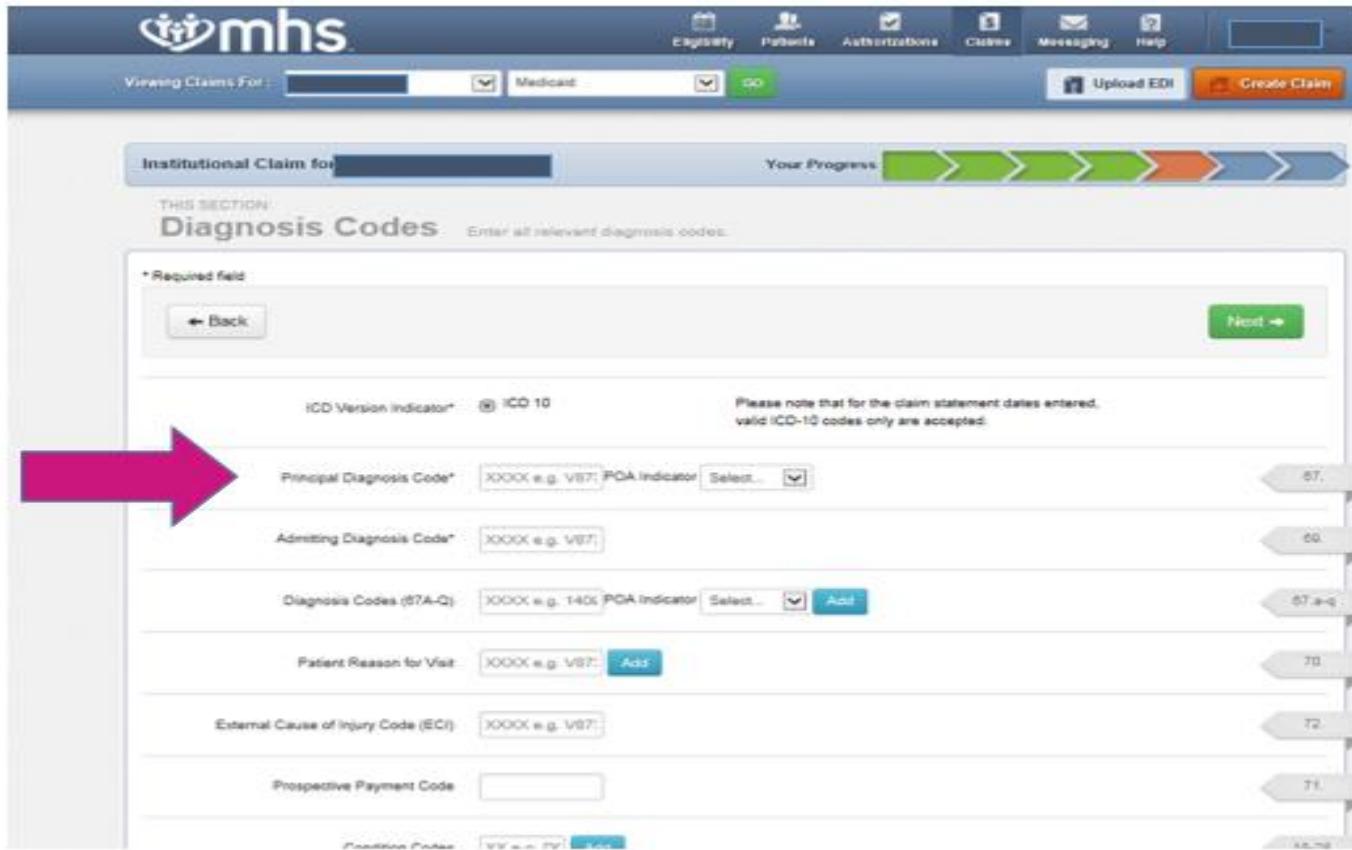
You may skip this section if there is no additional insurance.

**Primary Insurance** ←

Notice: If the Member has more than one primary insurance (Medicaid would be the 3rd payer), the claim cannot be submitted through the Web.

Carrier Type	<input type="text" value="Select..."/>	50
Policy Number	<input type="text" value="XXXXXX"/>	60
Amount Allowed	<input type="text" value="XXXX.XX"/>	
Deductible	<input type="text" value="XXXX.XX"/>	
Copay	<input type="text" value="XXXX.XX"/>	
Co-Insurance	<input type="text" value="XXXX.XX"/>	

# Enter Diagnosis Codes (use Add button)



Viewing Claims For:  Medicaid

Institutional Claim for:  Your Progress: 

THIS SECTION: **Diagnosis Codes** Enter all relevant diagnosis codes.

\* Required field

ICD Version Indicator:  ICD 10 Please note that for the claim statement dates entered, valid ICD-10 codes only are accepted.

Principal Diagnosis Code\*  POA Indicator

Admitting Diagnosis Code\*  

Diagnosis Codes (57a-Q)  POA Indicator   

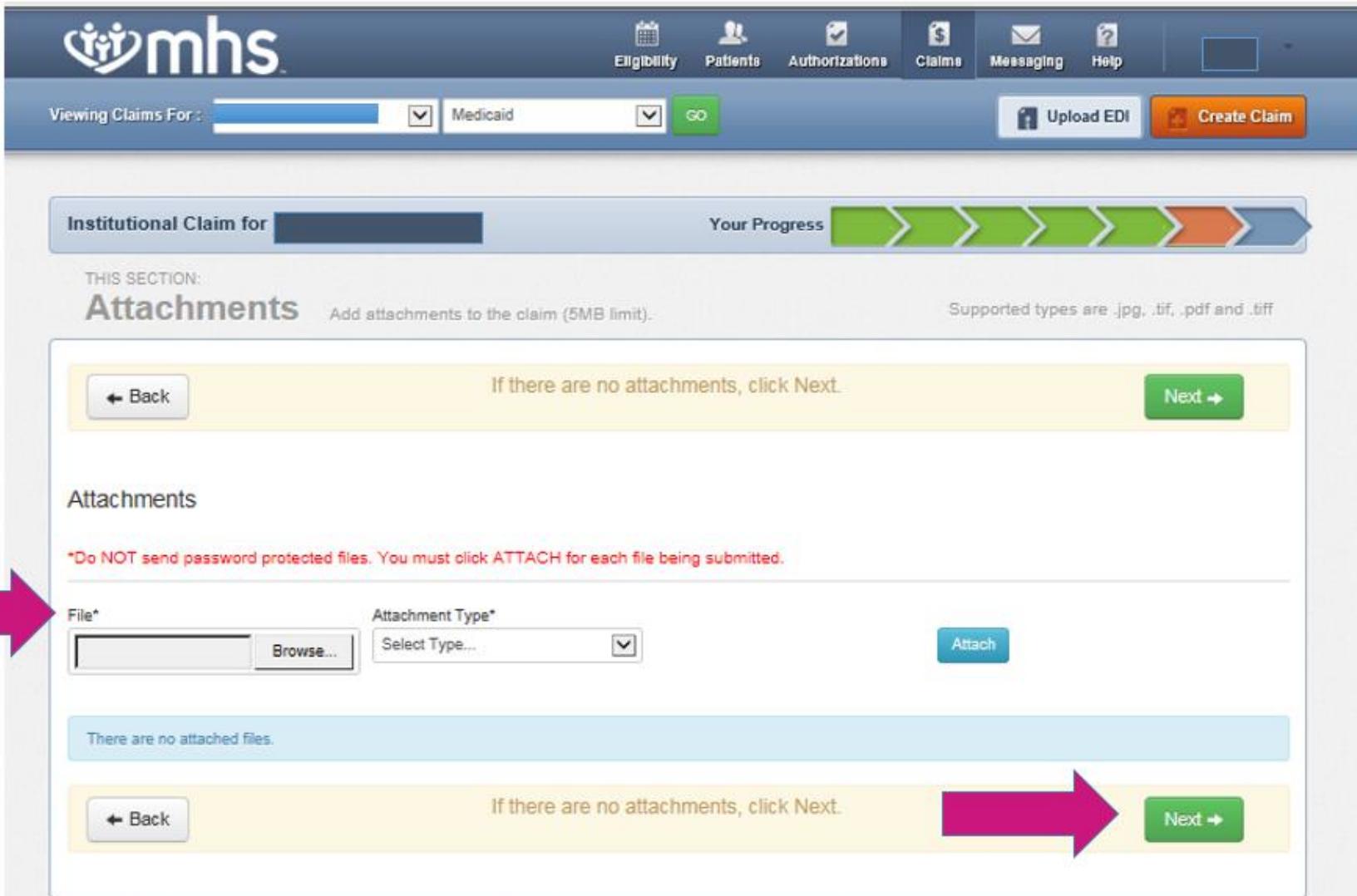
Patient Reason for Visit:   

External Cause of Injury Code (ECI):  

Prospective Payment Code:  

Position Codes:   

# Add Attachments (if applicable)



Viewing Claims For:  Medicaid  GO  Upload EDI  Create Claim

Institutional Claim for [REDACTED] Your Progress

THIS SECTION: **Attachments** Add attachments to the claim (5MB limit). Supported types are .jpg, .tif, .pdf and .tiff

If there are no attachments, click Next.

Back Next →

Attachments

\*Do NOT send password protected files. You must click ATTACH for each file being submitted.

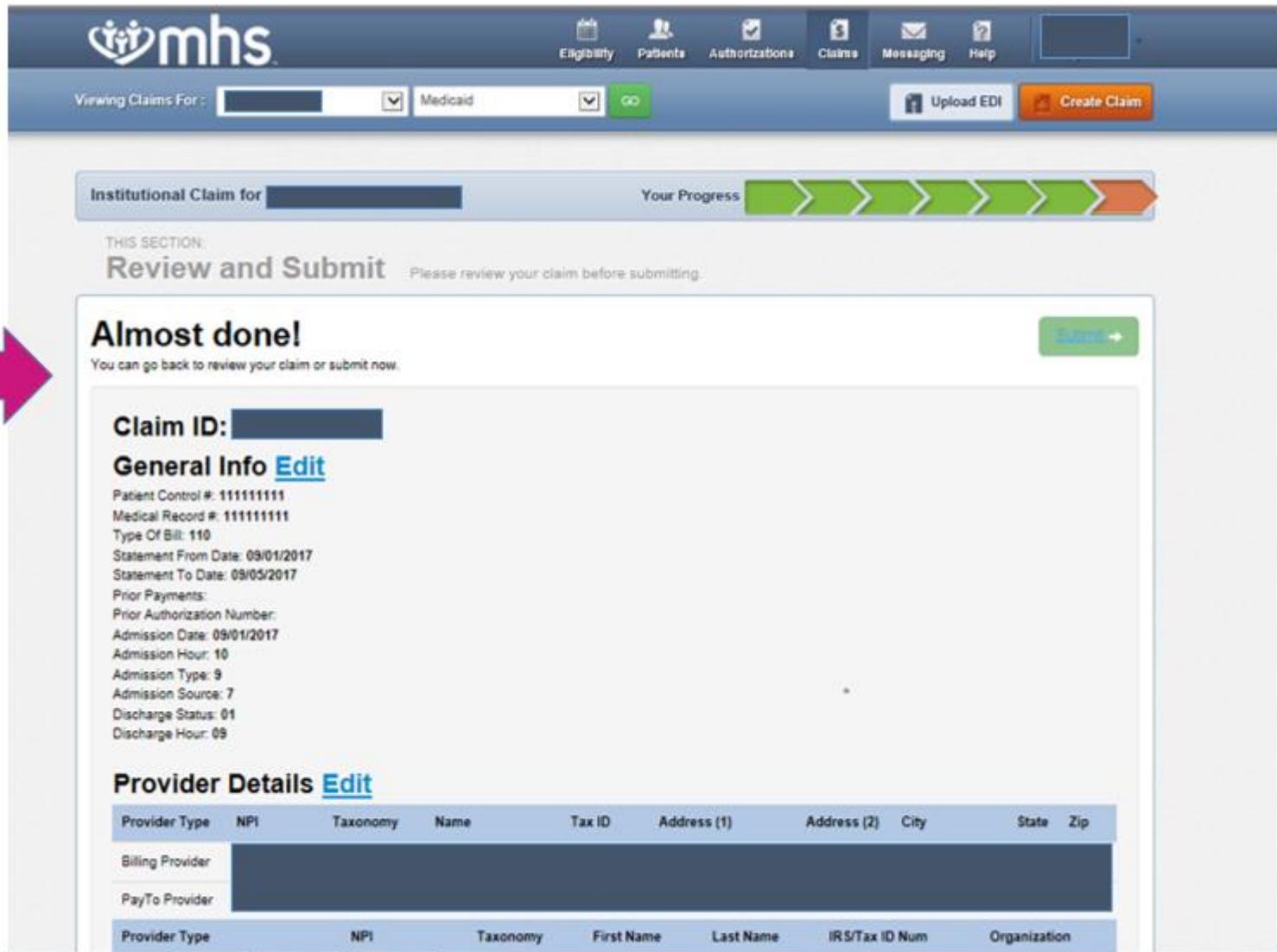
File\*  Attachment Type\*

There are no attached files.

If there are no attachments, click Next.

Back Next →

# Review Claim and Submit



Viewing Claims For: [REDACTED] Medicaid

Institutional Claim for: [REDACTED] Your Progress: [REDACTED]

THIS SECTION: **Review and Submit** Please review your claim before submitting.

**Almost done!**  
You can go back to review your claim or submit now.

**Claim ID:** [REDACTED]

**General Info** [Edit](#)

Patient Control #: 1111111111  
Medical Record #: 1111111111  
Type Of Bill: 110  
Statement From Date: 09/01/2017  
Statement To Date: 09/05/2017  
Prior Payments:  
Prior Authorization Number:  
Admission Date: 09/01/2017  
Admission Hour: 10  
Admission Type: 9  
Admission Source: 7  
Discharge Status: 01  
Discharge Hour: 09

**Provider Details** [Edit](#)

Provider Type	NPI	Taxonomy	Name	Tax ID	Address (1)	Address (2)	City	State	Zip
Billing Provider	[REDACTED]								
PayTo Provider	[REDACTED]								
Provider Type	NPI	Taxonomy	First Name	Last Name	IRS/Tax ID Num	Organization			

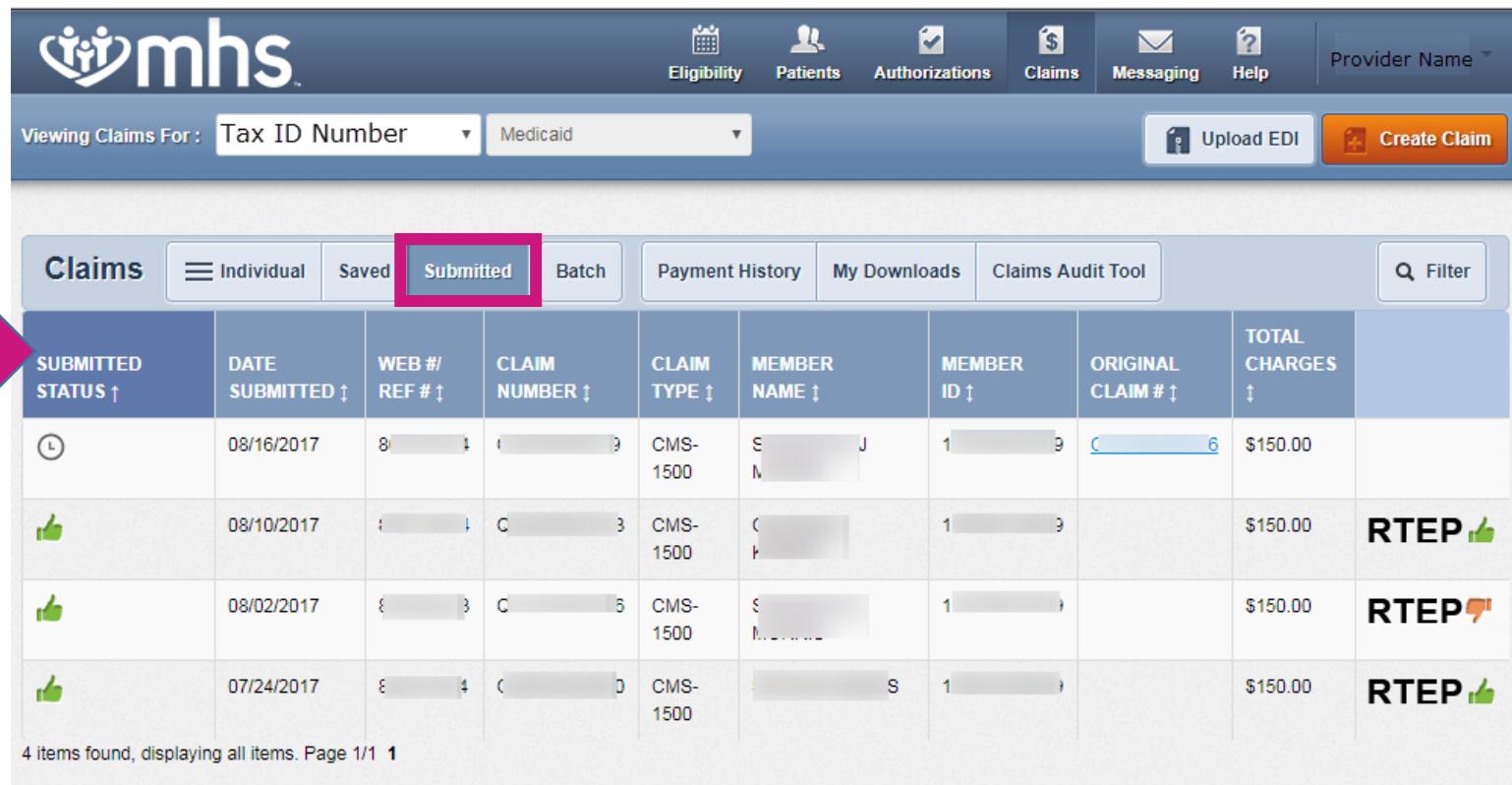
# **Web Portal Claim and Payment Review**

# 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).



Viewing Claims For: Tax ID Number ▾ Medicaid ▾

Upload EDI Create Claim

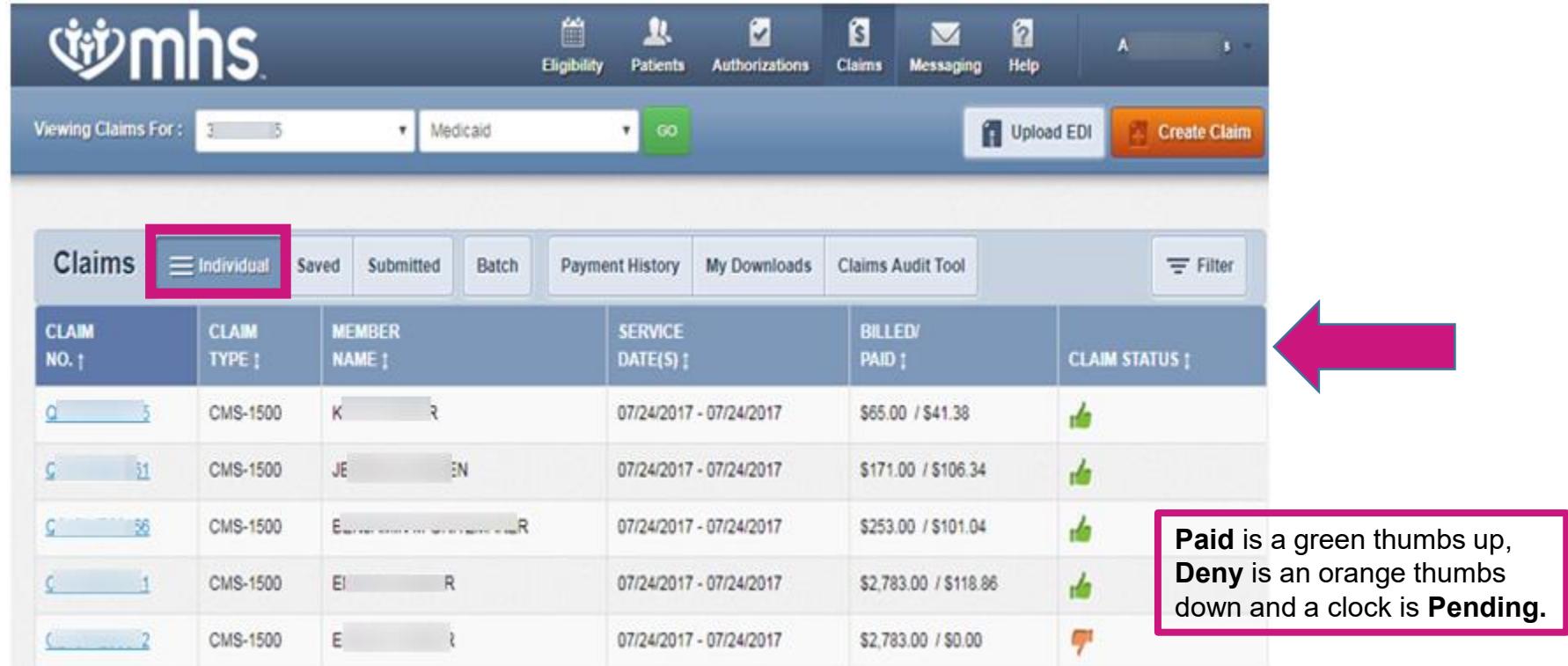
Claims										Filter	
Submitted	Individual	Saved	Submitted	Batch	Payment History	My Downloads	Claims Audit Tool				
Submitted Status ↑	Date Submitted ↑	Web #/Ref # ↑	Claim Number ↑	Claim Type ↑	Member Name ↑	Member ID ↑	Original Claim # ↑	Total Charges ↑			
🕒	08/16/2017	8 1 4	0 0 0	CMS-1500	S J	1 9	C 6	\$150.00			
👍	08/10/2017	8 1 4	C 3	CMS-1500	C H	1 9		\$150.00	RTEP		👍
👍	08/02/2017	8 1 3	C 5	CMS-1500	S M	1 9		\$150.00	RTEP		👎
👍	07/24/2017	8 1 4	C 0	CMS-1500	S S	1 9		\$150.00	RTEP		👍

4 items found, displaying all items. Page 1/1 1

# 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



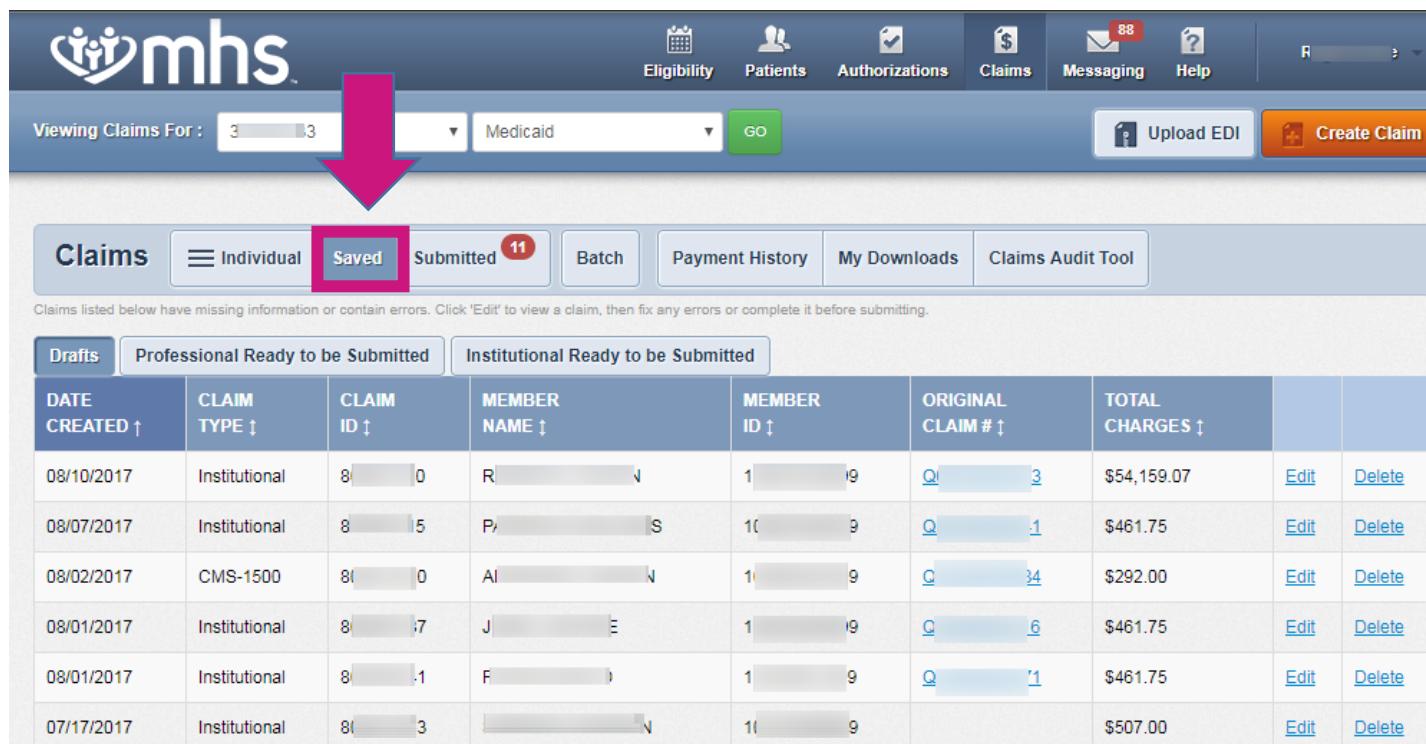
Claims	Individual	Saved	Submitted	Batch	Payment History	My Downloads	Claims Audit Tool	Filter
CLAIM NO.:	CLAIM TYPE:	MEMBER NAME:	SERVICE DATE(S):	BILLED PAID:	CLAIM STATUS:			
95	CMS-1500	K R	07/24/2017 - 07/24/2017	\$65.00 / \$41.38				
911	CMS-1500	JE EN	07/24/2017 - 07/24/2017	\$171.00 / \$106.34				
956	CMS-1500	E R	07/24/2017 - 07/24/2017	\$253.00 / \$101.04				
91	CMS-1500	EI R	07/24/2017 - 07/24/2017	\$2,783.00 / \$118.86				
92	CMS-1500	E R	07/24/2017 - 07/24/2017	\$2,783.00 / \$0.00				

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.



Viewing Claims For : 3 - 13 ▼ Medicaid ▼ GO

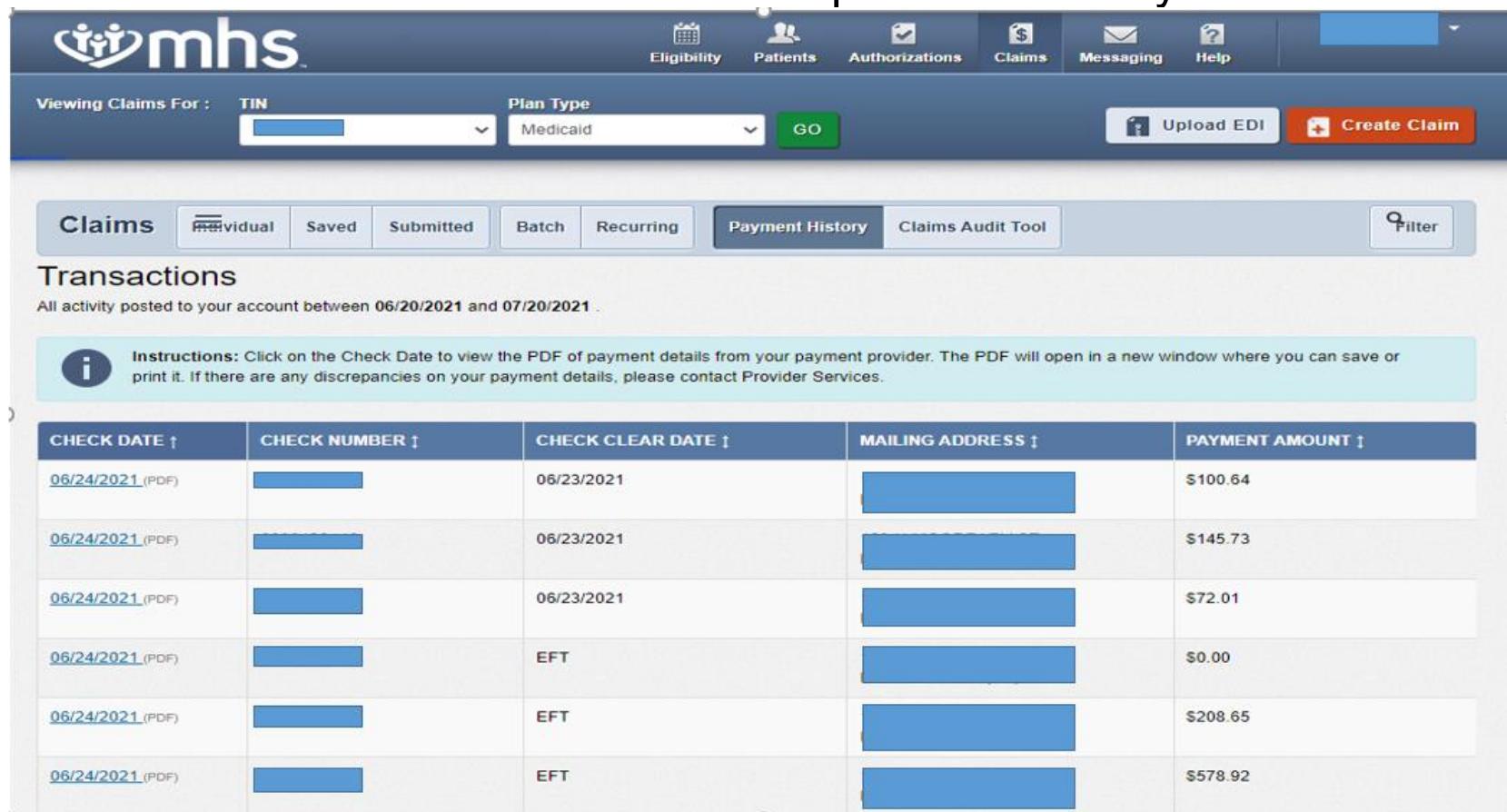
Claims Individual **Saved** Submitted 11 Batch Payment History My Downloads Claims Audit Tool

Claims listed below have missing information or contain errors. Click 'Edit' to view a claim, then fix any errors or complete it before submitting.

Drafts	Professional Ready to be Submitted	Institutional Ready to be Submitted						
DATE CREATED ↑	CLAIM TYPE ↓	CLAIM ID ↓	MEMBER NAME ↑	MEMBER ID ↓	ORIGINAL CLAIM # ↓	TOTAL CHARGES ↑		
08/10/2017	Institutional	81 0	R 1 9	1 9	Q 3	\$54,159.07	<a href="#">Edit</a>	<a href="#">Delete</a>
08/07/2017	Institutional	81 5	P 1 S	1 9	Q 1	\$461.75	<a href="#">Edit</a>	<a href="#">Delete</a>
08/02/2017	CMS-1500	81 0	A 1 9	1 9	Q 34	\$292.00	<a href="#">Edit</a>	<a href="#">Delete</a>
08/01/2017	Institutional	81 7	J 1 E	1 9	Q 6	\$461.75	<a href="#">Edit</a>	<a href="#">Delete</a>
08/01/2017	Institutional	81 1	F 1 0	1 9	Q 1	\$461.75	<a href="#">Edit</a>	<a href="#">Delete</a>
07/17/2017	Institutional	81 3	1 N	1 9		\$507.00	<a href="#">Edit</a>	<a href="#">Delete</a>

# 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



Viewing Claims For : TIN Plan Type: Medicaid GO Upload EDI Create Claim

Claims Individual Saved Submitted Batch Recurring Payment History Claims Audit Tool Filter

### Transactions

All activity posted to your account between 06/20/2021 and 07/20/2021.

**Instructions:** Click on the Check Date to view the PDF of payment details from your payment provider. The PDF will open in a new window where you can save or print it. If there are any discrepancies on your payment details, please contact Provider Services.

CHECK DATE ↑	CHECK NUMBER ↑	CHECK CLEAR DATE ↑	MAILING ADDRESS ↑	PAYMENT AMOUNT ↑
<a href="#">06/24/2021 (PDF)</a>	[REDACTED]	06/23/2021	[REDACTED]	\$100.64
<a href="#">06/24/2021 (PDF)</a>	[REDACTED]	06/23/2021	[REDACTED]	\$145.73
<a href="#">06/24/2021 (PDF)</a>	[REDACTED]	06/23/2021	[REDACTED]	\$72.01
<a href="#">06/24/2021 (PDF)</a>	[REDACTED]	EFT	[REDACTED]	\$0.00
<a href="#">06/24/2021 (PDF)</a>	[REDACTED]	EFT	[REDACTED]	\$208.65
<a href="#">06/24/2021 (PDF)</a>	[REDACTED]	EFT	[REDACTED]	\$578.92

# Provider EOP

• 100 •

Page 10

**Electronic Service Requested**

卷一第167頁 30374

## ANSWER

Digitized by srujanika@gmail.com

Page 1 of 1

2020 RELEASE UNDER E.O. 14176

1000

07/09/20

**RUN DATE:**  
**CHECK #:**  
**PAYEE ID:**  
**IRS#:**

Beginning Negative Services Balance: 00  
Beginning Prepayment Balance: 00  
Total Beginning Balance: 00  
Claims Paid This Run:

Check Amount:

## Remittance Advice and Explanation of Payment

Insured Name: [REDACTED] Member ID: [REDACTED] Claim No: [REDACTED]  
Patient Name: [REDACTED] PCN: [REDACTED] Provider ID: [REDACTED]  
Service Provider: [REDACTED] L-NPI: [REDACTED] Group: [REDACTED]  
Carrier: DE

Serv	Dates	Procedure	Modifiers	Days Cr/Qty	Charged	Allowed	Deduct / CoPay	Consisnt/ Discount	Interest	Med Allow/ Med Paid	TPP	Denied	Payment Codes	Payment
0100	■■■	■■■	G5	1.00	6388.16	263.75	.00	.00	.00	.00	.00	00	A0 SR 30	258.4
0200	■■■	■■■	G5	1.00	6388.16	263.75	.00	.00	.00	.00	.00	00	A0 SR 30	258.4
0300	■■■	■■■	G5	1.00	6388.16	263.75	.00	.00	.00	.00	.00	00	A0 SR 30	258.4
0400	■■■	■■■	G5	1.00	6388.16	263.75	.00	.00	.00	.00	.00	00	A0 SR 30	258.4
0500	■■■	■■■	G5	1.00	6388.16	263.75	.00	.00	.00	.00	.00	00	A0 SR 30	258.4
0600	■■■	■■■	G5	1.00	6388.16	263.75	.00	.00	.00	.00	.00	00	A0 SR 30	258.4
0700	■■■	■■■	G5	1.00	6388.16	263.75	.00	.00	.00	.00	.00	00	A0 SR 30	258.4

# 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](http://Payspan | Healthcare Payment Reimbursement Solutions)
-  For questions call 1-877-331-7154.

### PaySpan® Health

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](http://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**.

National Provider Identifier (NPI)  
 Provider Federal Tax Identification Number (TIN) or  
 Organization Identification Number (EIN)  
 Billing Zip Code (5 digits)

Due Date  
 When is Due Date?

OR

Billing Zip Code (5 digits)

Submit

- 4** Populate the requested Personal Information. Click **Next**.

Provider Contact Name  
 Administration Full Name  
 Email Address  
 Notifications will be sent to this email.  
 Confirm Email Address

Username  
 Minimum 8 characters and may include letters (a-z), numbers (0-9), underscores (\_), and periods (.)  
 Password  
 Confirm Password  
 Challenge Question  
 In what city was your first job?  
 Challenge Answer

- 5** Designate an account for fund transfers by completing the required fields. Click **Next**.

Account Name  
This is the name that will be used to identify this banking account throughout the PaySpan system.

Financial Institution Routing Number  
Provider's Account Number with Financial Institution

Confirm Provider's Account Number with Financial Institution  
Confirms Provider's Account Number with Financial Institution

Type of Account at Financial Institution  
Business Checking

Enable Electronic Payment  
 Request Paper Remittance  
The Paper does not allow paper remittance.

Assign one or additional Paper to this banking account

Next

Back

- 6** Verify your information and check the box to agree to the service agreement. Then, click **Confirm**.

Provider Contact Name  
 Administration Full Name  
 Email Address  
 Notifications will be sent to this email.  
 Confirm Email Address

Username  
 Minimum 8 characters and may include letters (a-z), numbers (0-9), underscores (\_), and periods (.)  
 Password  
 Confirm Password  
 Challenge Question  
 In what city was your first job?  
 Challenge Answer

I agree to the service agreement.

Next

- 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](mailto:providersupport@payspanhealth.com)

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0221.PR.P.FL 2/21

# 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

Back to Claims **Claim Details**

Claim #T1234P1235: Denied

**COPY** **DISPUTE**

Claim Accepted      In Process      Denied

Participant	Provider	Claim	Most Recent Payment	
Participant Name [REDACTED]	Ref/Acct No. 1234567890	DOS Range 08/12/2020 - 08/15/2020	Payment Date —	Paid Claim Amount \$0.00
Member ID ID123459	Servicing Provider [REDACTED]	Received Date 09/12/2020	Check/EFT No. —	Total Check Amount —
Member DOB [REDACTED]	Servicing NPI [REDACTED]	Billed Amount \$6,1234.12	Check Dated —	

**Service Lines**

| Label |
-------	-------	-------	-------	-------	-------	-------

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

Eligibility Patients Authorizations Claims Messaging User Name ▾

[Back to Claims](#) : Claim #T1234P1235

**SELECT** **Option 1: Correct the claim**  
Most providers use this option when there is a mistake on the submitted claim.

**SELECT** **Option 2: Informally dispute the claim**  
A dispute is an informal review performed by the Claims Department.

- A response will be issued within **30 calendar days** of submission.
- You will still have the opportunity to select **Option 3: Appeal the claim**, if the decision is upheld.
- You should **NOT** use this option if an authorization is not obtained and/or need to review for medical necessity.
- Please refer to the [MHS Provider Manual](#) on filing a medical necessity appeal.

**SELECT** **Option 3: Appeal the claim**  
An appeal is a formal review of your claim.

- Appeal responses will be issued in writing within **45 calendar days** of submission, in accordance with 405 IAC 1-1.6.
- Your appeal will be reviewed by a panel of one or more individuals who are **knowledgeable** in the policy, legal, and/or clinical issues in the matter subject to the appeal.
- The panel was **not involved in any previous consideration** of the matter of the appeal.
- Please refer to the [MHS Provider Manual](#) for more information.

# Claim Reconsiderations

Enter your explanation for reconsideration and check email updates.

**Reconsider Claim** ✖

Claim No: [REDACTED]

**For reconsiderations only. Not for appeals/Claim disputes**  
Example: If an authorization was not obtained and/or you need to review for medical necessity, submit an appeal.  
**Any submission on this form will be treated as a reconsideration.**  
Please refer to your Provider Manual.

**Reconsideration Type**  
Denied for Untimely Filing

**Notes**  
*Brief Explanation*

500 Character Limit

**Upload Documents**  
*Proof of Timely Filing attachment Required*

Choose Files

**Uploaded Files**

**Email Updates**

Check here to receive email status updates for this reconsideration.

Please upload files less than 10MB each. Supported file formats are PDF, TIFF, TIF, JPEG, and JPG.

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

[Back to Claims](#) **Claim Details**

Claim #T1234P1235: Denied

[COPY](#) [DISPUTE](#)



**Dispute/Appeal Details**

Created Date	Type	Current Status	Reference No.	Tools
1/26/2021	Dispute - Claim Paid at the Incorrect Amount	Resolved	U026IA1234566	

**Member**

Participant Name	Ref/Acct No.	Claim	Most Recent Payment
	1234567890	DOS Range 08/12/2020 - 08/15/2020	Payment Date ---
Member ID ID123459	Servicing Provider	Received Date 09/12/2020	Check/EFT No. ---
Member DOB	Servicing NPI	Billed Amount \$6,1234.12	Total Check Amount ---

**Provider**

**Claim**

**Most Recent Payment**

**Service Lines**

| Label |
|-------|-------|-------|-------|-------|-------|-------|
|       |       |       |       |       |       |       |

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

[Back to Claims](#) **Claim Details**

Claim #T1234P1235: Denied

[COPY](#) [DISPUTE](#)



**Dispute/Appeal Details**

Created Date	Type	Current Status	Reference No.	Tools
2/15/2021	Appeal - Claim Paid at the Incorrect Amount	In Progress	ABCDE1234567	<a href="#">B</a> <a href="#">E</a>
1/26/2021	Dispute - Claim Paid at the Incorrect Amount	Resolved	U026IA1234566	<a href="#">B</a> <a href="#">E</a>

Member	Provider	Claim	Most Recent Payment	
Participant Name [REDACTED]	Ref/Acct No. 1234567890	DOS Range 08/12/2020 - 08/15/2020	Payment Date ---	Paid Claim Amount \$0.00
Member ID ID123459	Servicing Provider [REDACTED]	Received Date 09/12/2020	Check/EFT No. ---	Total Check Amount ---
Member DOB [REDACTED]	Servicing NPI 1234567890	Billed Amount \$6,1234.12	Check Dated ---	

**Service Lines**

| Label |
-------	-------	-------	-------	-------	-------	-------

# Coordination of Benefits

 This screen shows if a member has other insurance.

Back to Patient List **Member Name**

Effective Date	Term Date	Policy Number	Group Number	Carrier Name	Coverage
06/01/2008	12/21/2013	W_____		AETNA	MEDICAL AND HOSPITAL

Overview

Cost Sharing

Assessments

Health Record

Care Plan

Authorizations

**Coordination of Benefits**

Claims



# Prior Authorization

# Authorizations

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

↗

[Back to Patient List](#)
Member Name

Overview	Authorizations																												
Cost Sharing	STATUS	AUTH NBR	FROM DATE	TO DATE	DIAGNOSIS	AUTH TYPE	SERVICE																						
Assessments	APPROVE	C 1	02/06/2018	05/06/2018	M51.36	OUTPATIENT	Office Visit																						
Health Record	APPROVE	C 5	03/14/2017	01/05/2018	G89.4	OUTPATIENT	Office Visit																						
Care Plan	<a href="#">Create a New Authorization</a>																												
Authorizations	<b>Click on AUTH NBR above</b>																												
Referrals	Auth Status: APPROVE Auth Nbr: C 1 Service: Office Visit Provider of Service(s): <span style="background-color: #4f81bd; color: white; padding: 2px;"> </span>				Explanation: Pay Auth Type: OUTPATIENT From Date: 02/06/2018 To Date: 05/06/2018 Procedure Code(s): 99214 <a href="#">Notes &amp; Attachments: View</a>																								
Coordination of Benefits	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 10%;">Line Item</th> <th style="width: 10%;">Service type</th> <th style="width: 10%;">Start Date</th> <th style="width: 10%;">End Date</th> <th style="width: 10%;">Units Req.</th> <th style="width: 10%;">Units Apprd</th> <th style="width: 10%;">Servicing Provider</th> <th style="width: 10%;">Location</th> <th style="width: 10%;">Status</th> <th style="width: 10%;">Medical Necessity</th> <th style="width: 10%;">Decision Date</th> </tr> </thead> <tbody> <tr> <td>1</td> <td>Office Visit</td> <td>02/06/2018</td> <td>05/06/2018</td> <td>3</td> <td>3</td> <td><span style="background-color: #4f81bd; color: white; padding: 2px;"> </span></td> <td>Office</td> <td>APPROVE</td> <td>Met as requested</td> <td>01/31/2018</td> </tr> </tbody> </table>							Line Item	Service type	Start Date	End Date	Units Req.	Units Apprd	Servicing Provider	Location	Status	Medical Necessity	Decision Date	1	Office Visit	02/06/2018	05/06/2018	3	3	<span style="background-color: #4f81bd; color: white; padding: 2px;"> </span>	Office	APPROVE	Met as requested	01/31/2018
Line Item	Service type	Start Date	End Date	Units Req.	Units Apprd	Servicing Provider	Location	Status	Medical Necessity	Decision Date																			
1	Office Visit	02/06/2018	05/06/2018	3	3	<span style="background-color: #4f81bd; color: white; padding: 2px;"> </span>	Office	APPROVE	Met as requested	01/31/2018																			
Claims																													
Document Resource Center																													
Notes																													

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# 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/medi/caid/pdfs/508-Provider-QRG-2021.pdf>

- Pre-AuthTool

<https://www.mhsindiana.com/providers/prior-authorization.html>



**PROVIDER Quick Reference Guide**

Effective June 2021





**MANAGED HEALTH SERVICES (MHS)**

<b>ELECTRONIC PAYER ID:</b> 68069	<b>MEDICAL CLAIMS APPEALS ADDRESS:</b> Managed Health Services P.O. Box 3000 Farmington, MO 63640-3800
<b>BEHAVIORAL HEALTH PAYER ID:</b> 68068	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.
<b>MEDICAL CLAIMS ADDRESS:</b> Managed Health Services P.O. Box 3002 Farmington, MO 63640-3802	<b>MEDICAL CLAIMS REFUNDS:</b> To refund claims overpayment, please send check and documentation to: Coordinated Care Corporation 75 Remittance Dr., Suite 6446 Chicago, IL 60675-6446
<b>REFERRALS AND AUTHORIZATIONS:</b> 8 a.m. to 5 p.m., closed 12 p.m. to 1 p.m.	<b>CASE MANAGEMENT:</b> 8 a.m. to 5 p.m.
<b>AFTER-HOURS:</b> 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.	<b>MEDICAL NECESSITY APPEALS ONLY ADDRESS:</b> ATTN: APPEALS P.O. Box 441567 Indianapolis, IN 46244

**MHS FAX NUMBERS**

<b>MEDICAL APPEALS:</b> 1-866-714-7993	<b>CASE MANAGEMENT:</b> 1-866-694-3633
Ex. Member Referrals to CM/DM	
<b>REFERRALS AND AUTHORIZATIONS:</b> 1-866-912-4245	

**MHS WEBSITE: MHSINDIANA.COM**

<b>mhsindiana.com/providers</b>	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.
<b>mhsindiana.com/health</b>	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.
<b>mhsindiana.com/login</b>	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.
<b>mhsindiana.com/transactions</b>	Information for electronic processing and payment of claims with MHS.
<b>OTHER RESOURCES</b> <a href="https://www.payspanhealth.com">payspanhealth.com</a>	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 <a href="https://www.payspanhealth.com">payspanhealth.com</a> .

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

0720.PR.PGL.5.10/20

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# Prior Authorization



[Home](#) [Find a Provider](#) [Portal Login](#) [Events](#) [Careers](#) [Contact Us](#) [search](#)

Contrast [On](#) [Off](#) [a](#) [a](#) [language](#)

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[FOR PROVIDERS](#)

[GET INSURED](#)

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[Enrollment and Updates](#)



[Prior Authorization](#)



[Medicaid Pre-Auth](#)

[Ambetter Pre-Auth](#)

[Medicare Pre-Auth](#)

## Dental Providers

[Pharmacy](#)



## Opioid Resources

[Behavioral Health Providers](#)



[Provider Resources](#)



[QI Program](#)



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[Email Sign Up](#)

[Coronavirus Information](#)



## Medicaid Pre-Auth

**DISCLAIMER:** All attempts are made to provide the most current information on the Pre-Auth Needed Tool. However, this does NOT guarantee payment. Payment of claims is dependent on eligibility, covered benefits, provider contracts, correct coding and billing practices. For specific details, please refer to the provider manual. If you are uncertain that prior authorization is needed, please submit a request for an accurate response.

Vision services need to be verified by [Envolve Vision](#).

Dental services need to be verified by [Envolve Dental](#).

Ambulance and Transportation services need to be verified by [LCP Transportation](#).

Musculoskeletal services need to be verified by [TurningPoint](#).

Complex imaging, MRA, MRI, PET, CT scans, PT, ST, and OT need to be verified by [NIA](#).

Non-participating providers must submit Prior Authorization for all services.

For non-participating providers, [join our network](#).

Are services being performed in the Emergency Department or Urgent Care Center or are these family planning services billed with a contraceptive management diagnosis?

Yes  No

### Types of Services

YES NO

Is the member being admitted to an inpatient facility?

Are services other than lab, radiology, domiciliary visits DME, Orthotics, or Prosthetics being rendered in the home?

Are anesthesia services being rendered for pain management?

Are services for infertility?

Enter the code of the service you would like to check:

58270

[Check](#)



**58270** - VAG HYST UTRUS 250 GM/;<REP ENTRCL

Pre-authorization required for all providers.

To submit a prior authorization [Login Here](#).

Ambetter from MHS | Hoosier Healthwise | Healthy Indiana Plan | Hoosier Care Connect | Wellcare by Allwell

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# **MHS Team**

## MHS Provider Network Territories

### 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

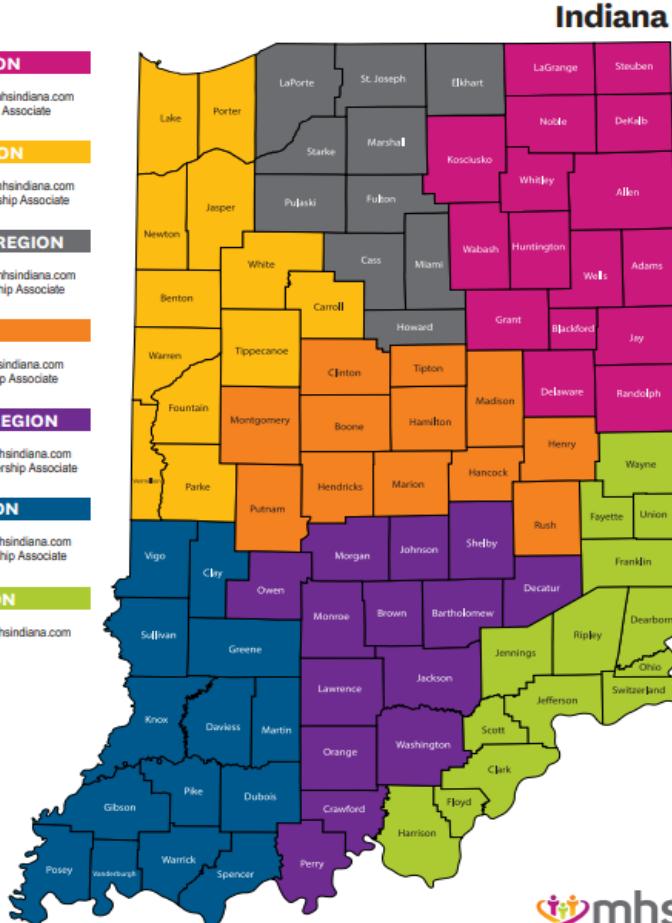
For claims issues, email:  
**MHS\_ProviderRelations\_SC@mhsindiana.com**  
 Dalesia Denning, Provider Partnership Associate  
 1-877-647-4848, ext. 20026

### 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:  
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 Carolyn Valachovic Monroe  
 Provider Partnership Associate  
 1-877-647-4848, ext. 20114



## Available online:

[https://www.mhsindiana.com/content/dam/centene/mhsindiana/medicaid/pdfs/ProviderTerritory\\_map\\_2021.pdf](https://www.mhsindiana.com/content/dam/centene/mhsindiana/medicaid/pdfs/ProviderTerritory_map_2021.pdf)

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# MHS Provider Network Territories

## TAWANNA DANZIE

Provider Partnership Associate II  
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## 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

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Provider Engagement  
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## 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.

### CHANEL MCKINNEY

Chantel.McKinney@EnvolveHealth.com  
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Questions: Envolve\_AdvancedCaseUnit@EnvolveHealth.com

# Network Leadership

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## NETWORK LEADERSHIP

### **JILL CLAYPOOL**

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### **MARK VONDERHEIT**

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## NEW PROVIDER CONTRACTING

### **TIM BALKO**

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### **MICHAEL FUNK**

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## NETWORK OPERATIONS

### **KELVIN ORR**

Director, Network Operations  
1-877-647-4848 ext. 20049  
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## Questions?

**Thank you for being our  
partner in care.**