








Prior Authorizations 101

2022 Annual IHCP Works Seminar





Agenda

-  Prior Authorization (PA)
-  What You Need to Know
-  MHS Secure Provider Portal
-  Telephonic and Fax Authorizations
-  Appeals Process
-  MHS Team
-  Questions

Prior Authorization



Prior Authorization

MHS Medical Management will review state guidelines and clinical documentation, Medical Director input will be available, if needed.

-  PAs for observation level of care (**up to 72 hours for Medicaid**), and diagnostic services do not require an authorization for contracted facilities.
-  If the provider requests an inpatient level of care for a covered/eligible condition, but procedure and documentation supports an outpatient/observation level of care, MHS will send the case for Medical Director review.





Prior Authorization

Inpatient Services:

-  MHS only accepts notification of an inpatient admission via fax, using the IHCP Universal Prior Authorization Form, or via the MHS Secure Provider Portal.
-  Please submit timely notification and clinical information to support an inpatient admission via fax to 1-866-912-4245 or upload via the MHS Secure Provider Portal.

Prior Authorization



Outpatient Services:

-  All elective procedures that require prior authorization must have request to MHS at least **two business days** prior to the date of service.
-  All ER services do not require prior authorization, however if it results in an emergent inpatient admission, the PA request must be called into MHS Prior Authorization Department within **two business days** following the admit.
-  Members **must** be Medicaid Eligible on the date of service.
-  Prior Authorizations are not a guarantee of payment.

Failure to obtain prior authorization for services requiring authorization will result in a denial for related claims.













Prior Authorization

Transfers:

-  MHS requires **notification and approval** for all transfers from one facility to another at least two business days in advance.
-  MHS requires **notification** within two business days following all emergent transfers. Transfers include, but are not limited to:
 - Facility to facility
 - It is the responsibility of the transferring facility to obtain prior authorization for higher level of care changes.

Prior Authorization

Services that require prior authorization regardless of contract status:

-  Injectable drugs
-  Nutritional counseling (unless diabetic)
-  Pain management programs, including epidural, facet and trigger point injections
-  PET, MRI, MRA and Nuclear Cardiology/SPECT scans
-  Cardiac rehabilitation
-  Hearing aids and devices
-  Home and Institutional hospice (coverage varies by product)
-  In-home infusion therapy
-  Orthopedic footwear
-  Respiratory therapy services
-  Home care (except after an IP admission with benefit limitations)
-  Physical Therapy, Occupational, and Speech Therapy

Prior Authorization

Is Prior Authorization Needed?

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

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.

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	MEDICAL CLAIMS APPEALS ADDRESS: Managed Health Services P.O. Box 3002 Farmington, MO 63640-3800
BEHAVIORAL HEALTH PAYER ID: 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.
MEDICAL CLAIMS ADDRESS: Managed Health Services P.O. Box 3002 Farmington, MO 63640-3802	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
Claims sent to MHS' Indianapolis address will be returned to the provider.	
MEDICAL NECESSITY APPEALS ONLY ADDRESS: ATTN: APPEALS P.O. Box 44187 Indianapolis, IN 46244	

MHS FAX NUMBERS

MEDICAL APPEALS: 1-866-714-7993

CASE MANAGEMENT: 1-866-694-3853
Ex. Member Referrals to CCM

REFERRALS AND AUTHORIZATIONS: 1-866-912-4345

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 1 and level 2 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.

0720.PB.PSL 5.11/20

Online Prior Authorization Tool

Medicaid Pre-Auth Needed?

Become a Provider

CLAS Standards

MHS Provider Webinars

Partnered Member Events

Pharmacy Benefits Information for Providers

Prior Authorization

Transactions

PaySpan Health

POWER Account Resource Center

Provider Information Resource Center

Provider Guides

Dental Providers

Presumptive Eligibility

Quality Improvement

HEDIS®

Practice Guidelines

Immunization Information

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](#)

Complex Imaging, MRA, MRI, PET and CT scans need to be verified by [NIA](#)

Hoosier Healthwise dental services need to be verified by [State](#)

Healthy Indiana Plan (HIP) and Hoosier Care Connect dental services need to be verified by [Envolve Dental](#)

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

Behavioral Health/Substance Abuse need to be verified by [Cenpatico](#)

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?	<input type="radio"/>	<input type="radio"/>
Are services, other than DME, orthotics, prosthetics, and supplies, being rendered in the home?	<input type="radio"/>	<input type="radio"/>
Are anesthesia services being rendered for pain management?	<input type="radio"/>	<input type="radio"/>
Are services for infertility?	<input type="radio"/>	<input type="radio"/>
Is the member receiving dialysis?	<input type="radio"/>	<input type="radio"/>

Online Prior Authorization Tool

Types of Services	YES	NO
Is the member being admitted to an inpatient facility?	<input type="radio"/>	<input checked="" type="radio"/>
Are services, other than DME, orthotics, prosthetics, and supplies, being rendered in the home?	<input type="radio"/>	<input checked="" type="radio"/>
Are anesthesia services being rendered for pain management?	<input type="radio"/>	<input checked="" type="radio"/>
Are services for infertility?	<input type="radio"/>	<input checked="" type="radio"/>
Is the member receiving dialysis?	<input type="radio"/>	<input checked="" type="radio"/>

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

Check

N
No

99394 - PREV VISIT EST AGE 12-17
No Pre-authorization required for all providers.

What You Need to Know

Self-Referral Services

 **Exceptions** to prior authorization requirements.




Members can see these specialists and get these services without a direct referral from their PMP:

- Podiatrist
- Chiropractor
- Family planning
- Immunizations
- Routine vision care
- Routine dental care
- Behavioral health by type and specialty
- HIV/AIDS case management
- Diabetes self-management

Benefit limitations apply.

National Imaging Associates (NIA)

Physical, Occupational and Speech Therapy

-  Utilization management of these services is managed by NIA.
-  Prior authorization for PT, OT, and ST services is required to determine whether services are medically necessary and appropriate.
-  All MHS approved training/education materials are posted on the NIA website, [RadMD.com](https://www.radmd.com). For new users to access these web-based documents, a RadMD account ID and password must be created.

NIA

Outpatient Radiology PA Requests

 MHS partners with NIA for **outpatient** radiology PA process.

 Authorization is required for:

- PET Scan
- MRI/MRA
- CT/CTA/CCTA

 PA requests must be submitted via:

- NIA website at [RADMD | RADMD-HOME](#)
- 1-866-904-5096

****Not applicable for ER and Observation requests.***






Durable & Home Medical Equipment

 MHS utilizes a tiered provider network for Durable Medical Equipment.

 All DME requests should be faxed directly to MHS at 1-866-912-4245.

Turning Point

Musculoskeletal Safety & Quality Program

-  MHS has entered into an agreement with Turning Point Healthcare Solutions, LLC to implement a Musculoskeletal Safety and Quality Program.
-  This program includes prior authorization for medical necessity and appropriate length of stay (when applicable) for both inpatient and outpatient settings.
-  Emergency Related Procedures do not require authorization.
-  Clinical Policies are available by contacting Turning Point at 1-574-784-1005 for access to digital copies.
-  **TRAINING:** Informational webinars are available! Please register at:
<https://register.gotowebinar.com/rt/7079530369468972290>

Turning Point

Cardiovascular Authorizations

 Managed Health Services has delegated its utilization management function to TurningPoint for cardiac services.

 **Services that require prior authorization:**

- Cardiac Surgical Procedures:
 - Automated Implantable Cardioverter Defibrillator
 - Leadless Pacemaker
 - Pacemaker
 - Revision or Replacement of Implanted Cardiac Device

 **Emergent surgeries do not require a prior authorization.**

Web Portal Intake: <https://myturningpoint-healthcare.com>


Telephone Intake: 1-574-784-1005 | 1-855-415-7482

PA Documentation Needed

Bariatric Surgery:

 Must include cardiac workup, pulmonary workup, diet and exercise logs, current lab reports, and psychologist report.

Pain Management:

 Must have documentation of at least six weeks of therapy on area receiving treatment.

 Include previous procedures/surgeries, medications, description of pain, any contra-indications or imaging studies.

 Include prior injection test results for injection series.

Home Health:

 Physician's orders and signed plan of care, including most recent MD notes about the issue at hand.

 Home care plan, including home exercise program.

 Progress notes for medical necessity determination.



Sub-Acute Care

MHS conducts clinical review for ongoing authorization and coordination of discharge needs for our members in sub-acute facilities at least every 3-5 days. It is important that you provide a complete current clinical update on our member's status at each review.






 The review should include current information (within one day) on:

- Member's condition
- Level of functioning (prior to admission)
- Medications
- Therapies provided
- Participation in therapies
- Progress toward goals
- New or amended goals
- Updates from care conferences
- Updates to our member's plan of care
- Discharge plans and needs identified (home health/DME, etc.)
- Anticipated discharge date

Sub-Acute Care cont.



-  Indiana Administrative Code requires that individuals requesting a nursing facility admission to a Medicaid-certified NF meet a nursing facility level of care (*405 IAC 1-3-1* and *405 IAC 1-3-2.*). A PASRR is required before admission and must be submitted with the admission request and when updated according to IAC requirements.
-  Please submit this information as requested by MHS nurse reviewer every 3-5 days.

Prior Authorization (PA) Request

-  MHS strives to return a decision on **all** PA requests within **two business days** of request.
-  Providers can **update** previously approved PAs **within 30 days** of the original date of service prior to claim denial for changes to:
 - Dates of Service
 - CPT/HCPCS codes
 - MHS has up to **seven days** to render PA decisions.
-  PA approval requires the need for medical necessity.
-  As of September 1, 2022, MHS implemented InterQual for authorization medical necessity review criteria.
-  Medical Management **does not** verify eligibility or benefit limitations; Provider is responsible for eligibility and benefit verification.

***Denied Authorizations must follow the authorization appeal process, not the claims appeal process; claims appeals can not change the status of a denied authorization.**

Continuity of Care PA Request





-  MHS will honor pre-existing authorizations from any other Medicaid program during the first 30 days of enrollment or up to the expiration date of the previous authorization, whichever occurs first, and upon notification to MHS.
-  Include the approval from the prior MCE with the request.

***Reference: MHS Provider Manual Chapter 7**

Pharmacy Requests

MHS Pharmacy Benefit Manager is Envolve.

Envolve Pharmacy Solutions:

-  Preferred Drug Lists and authorization forms are available at <https://www.mhsindiana.com/providers/pharmacy.html>
 - PA Requests
 - Phone 1-866-399-0928
 - Fax non specialty drugs 1-866-399-0929
 - Specialty drugs 1-866-678-6976
 - <https://pharmacy.envolvehealth.com>
-  Formulary integrated into many Electronic Health Records (EHR) solutions.
-  Online PA submission available through CoverMyMeds:
<https://covermy meds.com>
-  Online PA forms for Specialty Drugs on <https://mhsindiana.com>

Behavioral Health Prior Authorization








Facility Services Requiring Prior Auth:

 Inpatient Admissions








 Intensive Outpatient Treatment (IOT)

 Partial Hospitalization SUD Residential Treatment

Behavioral Health Prior Authorization



-  Psychiatric Diagnostic Evaluation (Limited to 1 per member per calendar year without authorization.)
-  Behavioral Health Outpatient Therapy “BHOP Therapy” (Limited to 20 visits per member, per practitioner, per calendar year).
-  Electroconvulsive Therapy
-  Psychological Testing (unless for Autism-no auth required)
-  Developmental Testing, with interpretation and report (non-EPSDT) Neurobehavioral status exam, with interpretation and report.
-  Neuropsych Testing per hour, face to face. (unless for Autism-no auth required)
-  ABA Services (Psychological testing for Autism does not require PA)

Behavioral Health Prior Authorization

-  Please call MHS Care Management for inpatient and partial hospitalization authorizations at 1-877-647-4848.
-  MHS Authorization forms may be obtained on our website:
<https://www.mhsindiana.com/providers/behavioral-health/bh-provider-forms.html>
-  Outpatient Treatment Request (OTR) Form - Fax: 1-866-694-3649
-  Intensive Outpatient/Day Treatment Form Mental Health/Chemical Dependency - Fax: 1-866-694-3649
-  Applied Behavioral Analysis Treatment (OTR) - Fax: 1-866-694-3649
-  Psychological & Neuropsych Testing Authorization Request Form - Fax: 1-866- 694-3649
-  Residential/Inpatient Substance Use Disorder Treatment Prior Authorization Form
 - Fax Inpatient: 1-844-288-2591; Fax Outpatient: 1-866-694-3649

Behavioral Health Prior Authorization

Limitations on Outpatient Mental Health Services

-  MHS follows the Indiana Health Coverage Programs Mental Health and Addiction limitation policy for the following CPT codes that, in combination, are limited to 20 units per provider, per calendar year.
-  Package C Hoosier Healthwise members are eligible for 30 units per provider, per calendar year.

<u>Code</u>	<u>Description</u>
90832 - 90834	Individual Psychotherapy
90837 - 90840	Psychotherapy, with patient and/or family member & Crisis Psychotherapy
90845, 90846, 90847, 90849, 90853	Psychoanalysis & Family/Group Psychotherapy with or without patient

MHS Secure Provider Portal

Web Portal Authorizations


 Providers can submit Prior Authorizations online via the MHS Secure Provider Portal at <https://mhsindiana.com/login>


- When using the portal, providers can upload supporting documentation directly.

 Providers can check the authorization status on the portal.


***Exceptions:** Must submit Inpatient, hospice, home health and bio pharmacy PA requests via **fax 1-866-912-4245.**

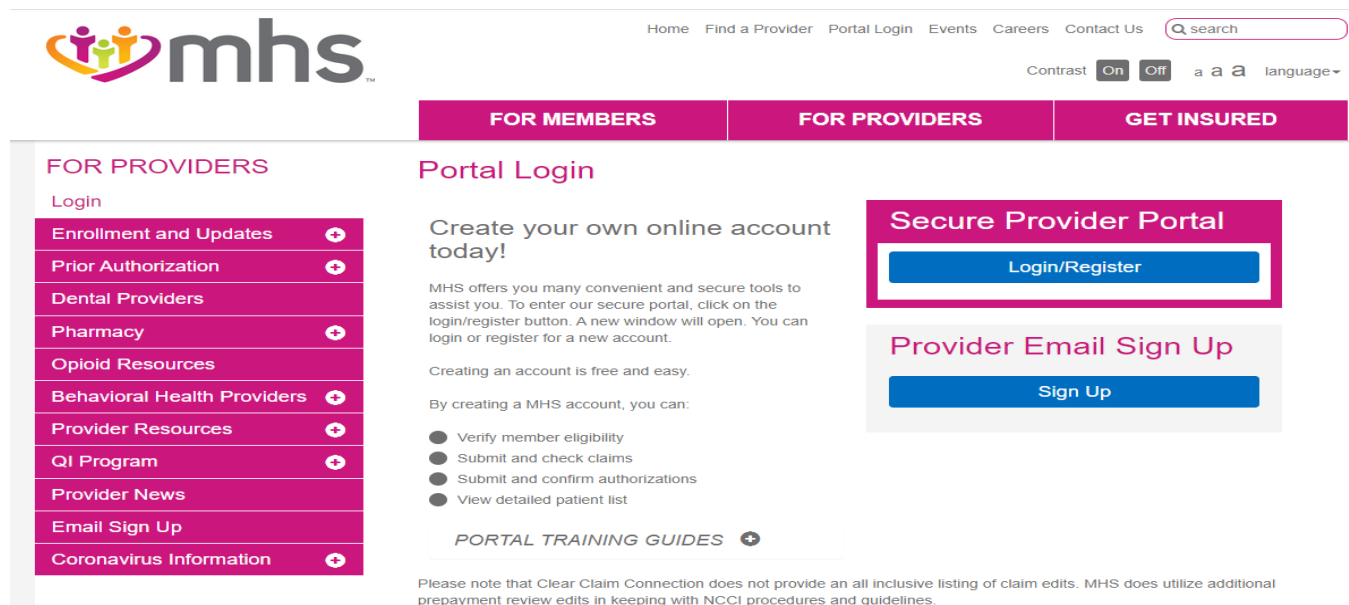
Secure Web Portal Login or Registration

 Login/Register is the same for **MHS**, **Ambetter from MHS**, **Allwell from MHS** and **Behavioral Health Providers**

FOR MEMBERS	FOR PROVIDERS	GET INSURED
 A photograph of two women smiling. The woman on the right is in the foreground, looking towards the camera, while the woman on the left is slightly out of focus in the background.		
<h3>Portal Login</h3> <p>If you are a contracted MHS provider, you can log in or register now. If you are a non-contracted provider, you will be able to register after you submit your first claim.</p> <p>Login/Register</p>	<h3>Join Our Network</h3> <p>Thank you for your interest in becoming a Managed Health Services (MHS) network provider. We look forward to working with you to improve the health of the community.</p> <p>Join Our Network</p>	

Web Portal Training Documents

 Login/Register is the same for **MHS, Ambetter from MHS, Allwell from MHS** and Behavioral Health Providers



The screenshot shows the MHS web portal interface. At the top, there is a navigation bar with links for Home, Find a Provider, Portal Login, Events, Careers, and Contact Us, along with a search bar. Below the navigation bar are three main sections: FOR MEMBERS, FOR PROVIDERS, and GET INSURED. The FOR PROVIDERS section is expanded, showing a list of links on the left and a 'Portal Login' guide on the right. The 'Portal Login' guide includes a 'Secure Provider Portal' section with a 'Login/Register' button and a 'Provider Email Sign Up' section with a 'Sign Up' button. Below the guide, there are 'PORTAL TRAINING GUIDES' and a note about Clear Claim Connection.

Home Find a Provider Portal Login Events Careers Contact Us

Contrast On Off a a a 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

Secure Provider Portal

Login/Register

Provider Email Sign Up

Sign Up

PORTAL TRAINING GUIDES +

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.

Complete Registration or Login



Log In

Username (Email)

LOG IN

[Create New Account](#)

single password



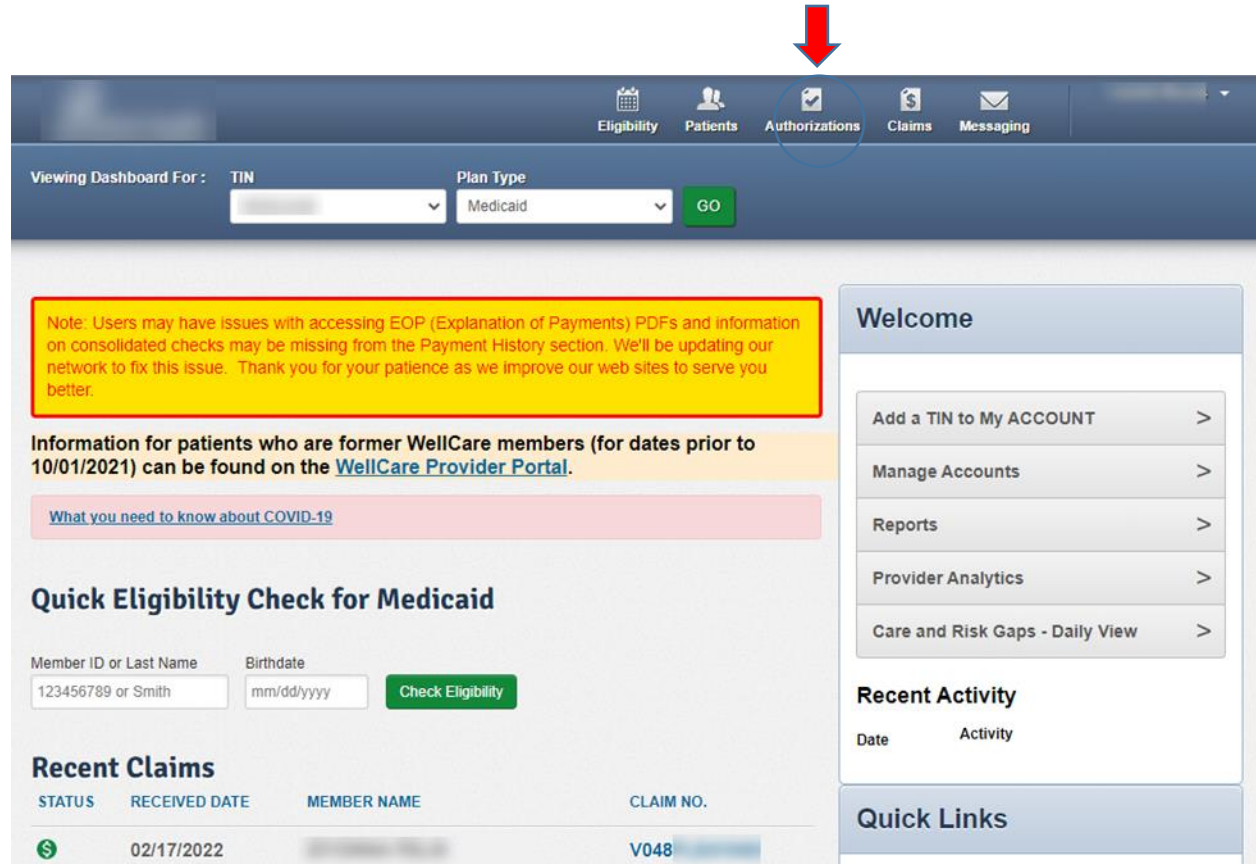
reliable security

EntryKeyID

[Help](#) [Privacy Policy](#) [Terms of Use](#) © 2022 Centene

Authorizations

To access authorization information or create and submit a web authorization request, click **Authorizations**. The Authorizations Summary displays.



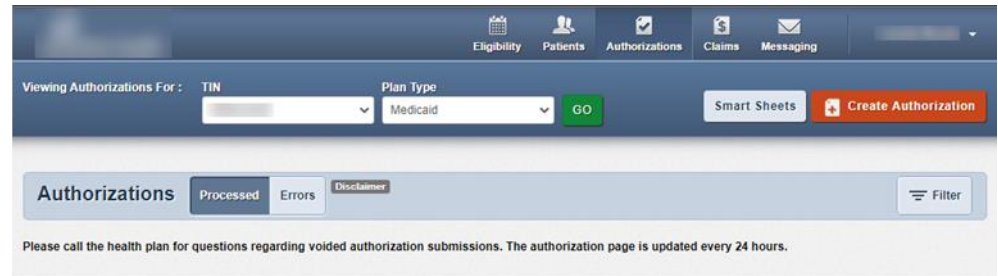
***Tip: The member drives your Plan Type selection. For example, an Ambetter member will not pull up under Medicaid. To find an Ambetter member, the Plan Type must be 'Ambetter'.**

Authorizations:

Create authorizations

To begin a web authorization request:

- Click Create Authorization.
- Enter Member ID or Last Name
- Enter Member's Birthdate.
- Click Find



The screenshot shows the top navigation bar with 'Eligibility', 'Patients', 'Authorizations', 'Claims', and 'Messaging'. Below the navigation bar, there are two dropdown menus for 'TIN' and 'Plan Type' (set to 'Medicaid'), a 'GO' button, a 'Smart Sheets' button, and a red 'Create Authorization' button. Below this is a section for 'Authorizations' with tabs for 'Processed', 'Errors', and 'Disclaimer', and a 'Filter' button. A disclaimer text at the bottom reads: 'Please call the health plan for questions regarding voided authorization submissions. The authorization page is updated every 24 hours.'



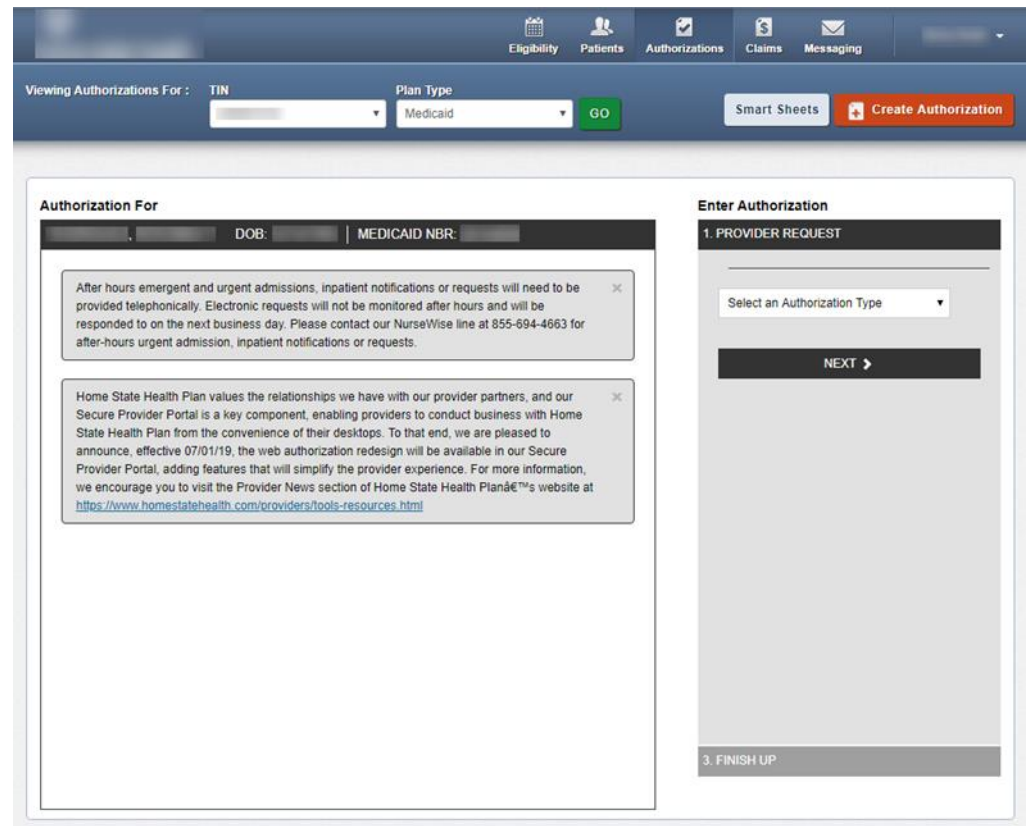
This screenshot is similar to the one above but includes additional search fields. It shows 'Member ID or Last Name' with the value '123456789 or Smith' and 'Birthdate' with the format 'mm/dd/yyyy'. There is a 'Find' button next to these fields. The rest of the interface, including the navigation bar and 'Authorizations' section, is identical to the previous screenshot.

***Tip: You cannot create a web authorization on an ineligible member.**

Creating a New Authorization

Web Authorization request has three sections:

1. Provider Request
2. Service Line
3. Finish Up



The screenshot shows the MHS web authorization interface. At the top, there are navigation tabs for Eligibility, Patients, Authorizations, Claims, and Messaging. Below the navigation, there is a header area with the text "Viewing Authorizations For:" followed by a TIN dropdown menu, a Plan Type dropdown menu (set to Medicaid), and a GO button. To the right of the header are buttons for "Smart Sheets" and "Create Authorization".

The main content area is divided into two columns. The left column is titled "Authorization For" and contains two text boxes with expandable/collapsible icons (X). The first text box contains the following text: "After hours emergent and urgent admissions, inpatient notifications or requests will need to be provided telephonically. Electronic requests will not be monitored after hours and will be responded to on the next business day. Please contact our NurseWise line at 855-694-4663 for after-hours urgent admission, inpatient notifications or requests." The second text box contains the following text: "Home State Health Plan values the relationships we have with our provider partners, and our Secure Provider Portal is a key component, enabling providers to conduct business with Home State Health Plan from the convenience of their desktops. To that end, we are pleased to announce, effective 07/01/19, the web authorization redesign will be available in our Secure Provider Portal, adding features that will simplify the provider experience. For more information, we encourage you to visit the Provider News section of Home State Health Plan's website at <https://www.homesstatehealth.com/providers/tools-resources.html>".

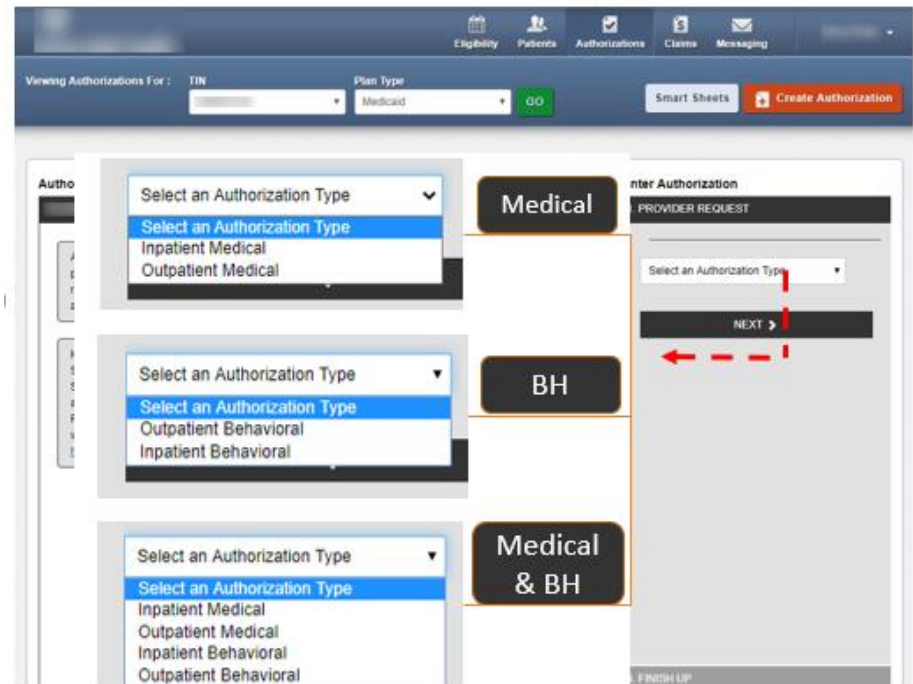
The right column is titled "Enter Authorization" and contains a section labeled "1. PROVIDER REQUEST". This section includes a dropdown menu labeled "Select an Authorization Type" and a "NEXT" button with a right-pointing arrow. At the bottom of the right column, there is a section labeled "3. FINISH UP".

Initiating a Web Authorization

Select an Authorization Type

Web Authorization type options, may vary by product type:

- Medicaid
- Behavioral Health (BH) Medicaid
- Wellcare by Allwell
- Ambetter



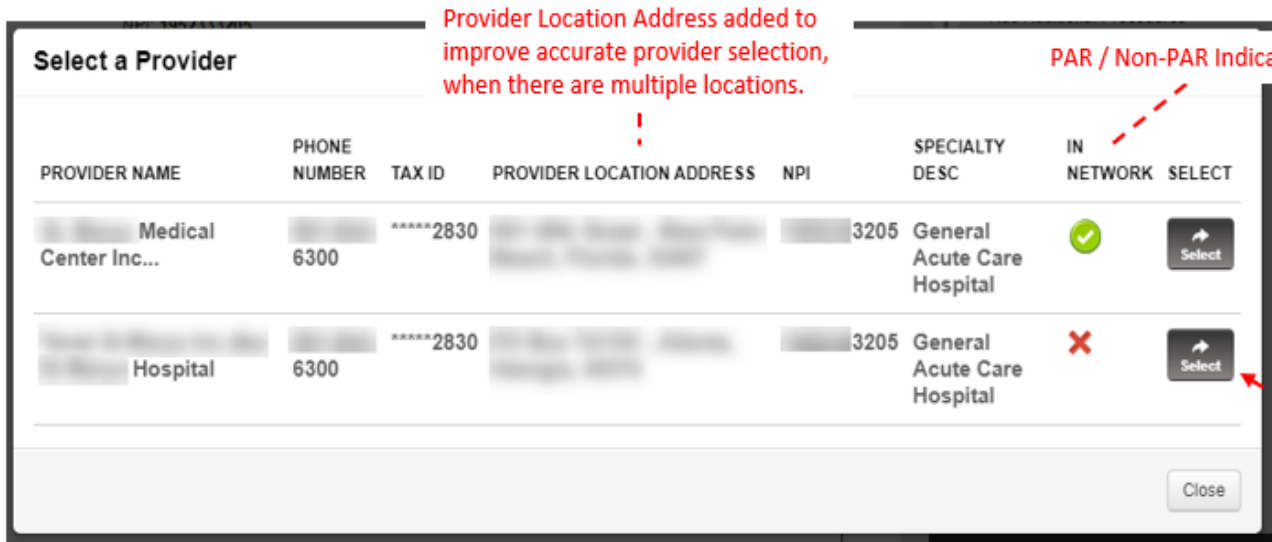
The screenshot displays the MHS web authorization interface. At the top, there are navigation tabs for Eligibility, Patients, Authorizations, Claims, and Messaging. Below this, a header section shows 'Viewing Authorizations For: TIN' and 'Plan Type: Medicaid' with a 'GO' button and a 'Create Authorization' button. The main content area is divided into three columns. The left column contains three dropdown menus, each labeled 'Select an Authorization Type'. The middle column has three buttons: 'Medical', 'BH', and 'Medical & BH'. The right column is titled 'Enter Authorization' and contains a 'PROVIDER REQUEST' section with another 'Select an Authorization Type' dropdown and a 'NEXT >' button. A red dashed arrow points from the 'NEXT >' button back to the dropdown menu. At the bottom right, there is a 'FINISH UP' button.

Web Authorization

Select a Provider Pop- up

👤 When Provider information is entered in a web authorization Provider / Facility field, the **Select a Provider** pop-up displays.

👤 If the NPI or name is not loaded in our system, the “**No providers found**” pop-up displays.



Provider Location Address added to improve accurate provider selection, when there are multiple locations.

PAR / Non-PAR Indicator

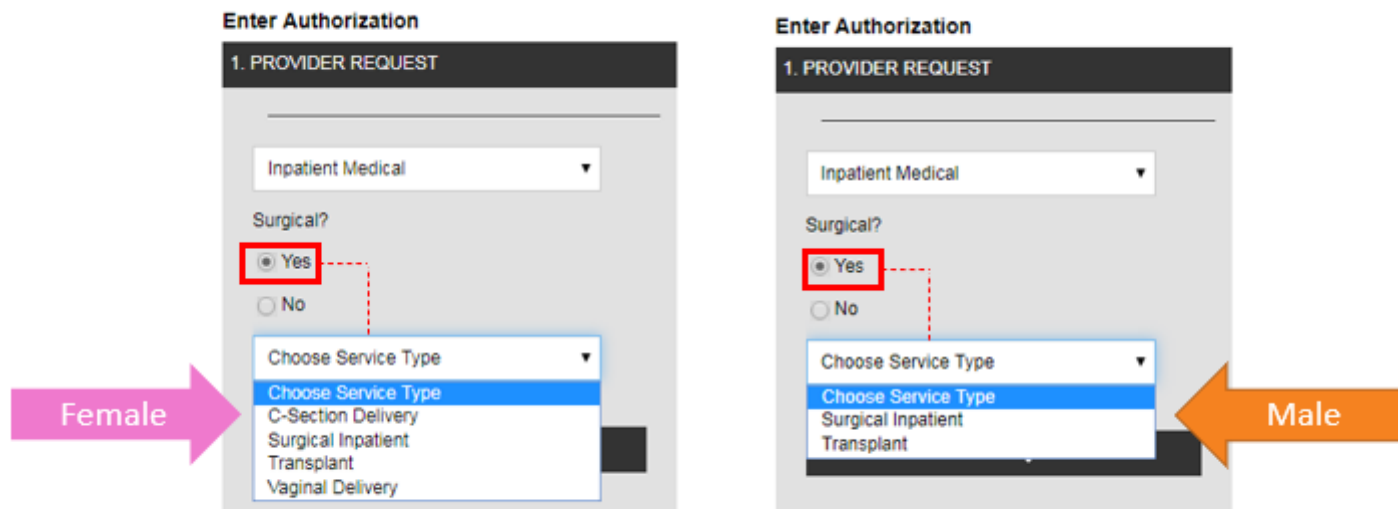
PROVIDER NAME	PHONE NUMBER	TAX ID	PROVIDER LOCATION ADDRESS	NPI	SPECIALTY DESC	IN NETWORK	SELECT
Medical Center Inc...	6300	*****2830		3205	General Acute Care Hospital	✓	Select
Hospital	6300	*****2830		3205	General Acute Care Hospital	✗	Select

Click Select, to choose Provider / Facility.

Close

Inpatient Medical-Service Type Options (Surgical)

When Inpatient Medical and Surgical is selected, the age (female only) and gender of the Member drives the options in the Service Type drop-down.



The image displays two side-by-side screenshots of the 'Enter Authorization' form, specifically the '1. PROVIDER REQUEST' section. Both screenshots show the 'Inpatient Medical' service type selected in a dropdown menu. Below this, the 'Surgical?' question is answered with 'Yes', which is highlighted with a red box. A red dashed line connects the 'Yes' selection to the 'Choose Service Type' dropdown menu.

Female (Left Screenshot): A pink arrow points to the 'Choose Service Type' dropdown menu, which is open and shows the following options: 'Choose Service Type', 'C-Section Delivery', 'Surgical Inpatient', 'Transplant', and 'Vaginal Delivery'. The 'Choose Service Type' option is highlighted in blue.

Male (Right Screenshot): An orange arrow points to the 'Choose Service Type' dropdown menu, which is open and shows the following options: 'Choose Service Type', 'Surgical Inpatient', and 'Transplant'. The 'Choose Service Type' option is highlighted in blue.

Provider Request-Inpatient Medical (Surgical)

C-Section Delivery, or
Vaginal Delivery

Enter Authorization

1. PROVIDER REQUEST

Inpatient Medical

Surgical?
 Yes
 No

C-Section Delivery

Requesting Provider

NPI: [REDACTED]
TIN: [REDACTED]
Name: [REDACTED]

Primary Diagnosis
O82

ENCOUNTER FOR CD WITHOUT INDICATION

CODE LOOKUP: [ICD-10](#)

NEXT >

3. FINISH UP

When completed, click Next.

Surgical Inpatient, or
Transplant

Enter Authorization

1. PROVIDER REQUEST

Inpatient Medical

Surgical?
 Yes
 No

Surgical Inpatient

Procedure Code
42821

TONSILLECTOMY & ADENOIDECTOMY, AGE 12/OVER

Requesting Provider

NPI: [REDACTED]
TIN: [REDACTED]
Name: [REDACTED]

Primary Diagnosis
J03.01

ACUTE RECUR STREP TONSILLITIS

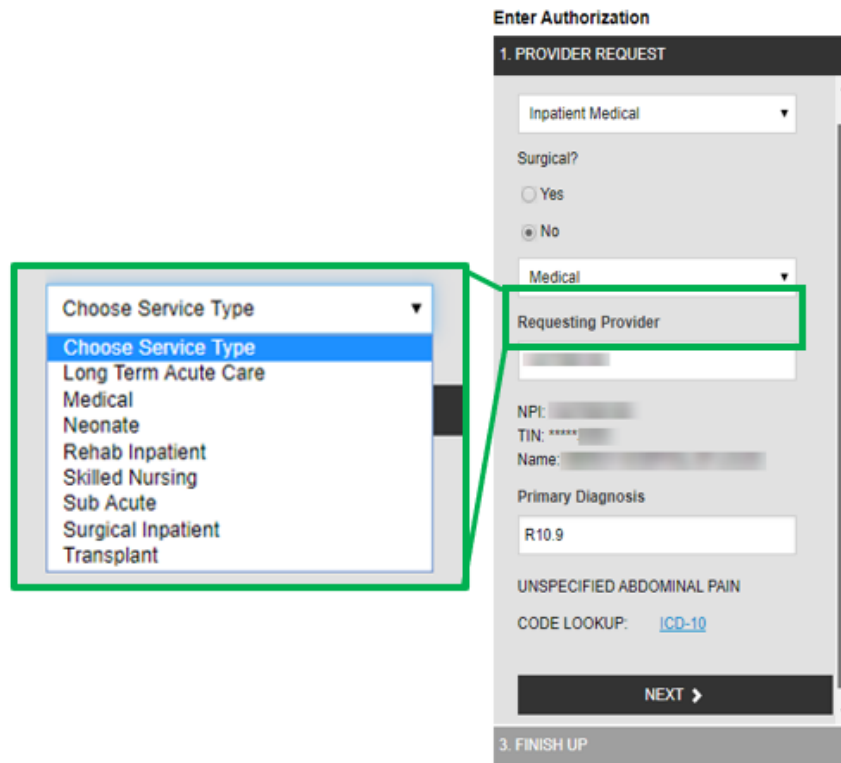
CODE LOOKUP: [ICD-10](#)

NEXT >

3. FINISH UP

A Procedure Code is required on Surgical Inpatient and Transplant requests

Provider Request-Inpatient Medical (Surgical)



Enter Authorization

1. PROVIDER REQUEST

Inpatient Medical

Surgical?

Yes

No

Medical

Requesting Provider

NPI: [REDACTED]

TIN: *****

Name: [REDACTED]

Primary Diagnosis

R10.9

UNSPECIFIED ABDOMINAL PAIN

CODE LOOKUP: [ICD-10](#)

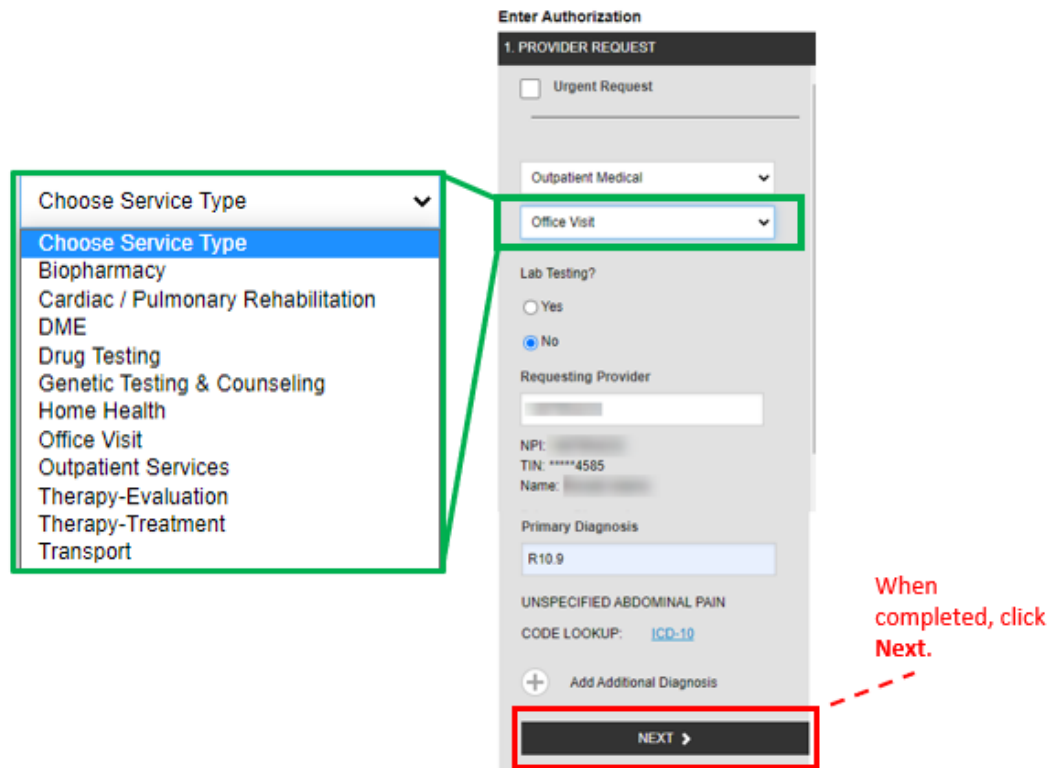
NEXT >

3. FINISH UP

Choose Service Type

- Choose Service Type
- Long Term Acute Care
- Medical
- Neonate
- Rehab Inpatient
- Skilled Nursing
- Sub Acute
- Surgical Inpatient
- Transplant

Provider Request- Outpatient Medical



Enter Authorization

1. PROVIDER REQUEST

Urgent Request

Outpatient Medical

Office Visit

Lab Testing?

Yes

No

Requesting Provider

NPI: _____

TIN: *****4585

Name: _____

Primary Diagnosis

R10.9

UNSPECIFIED ABDOMINAL PAIN

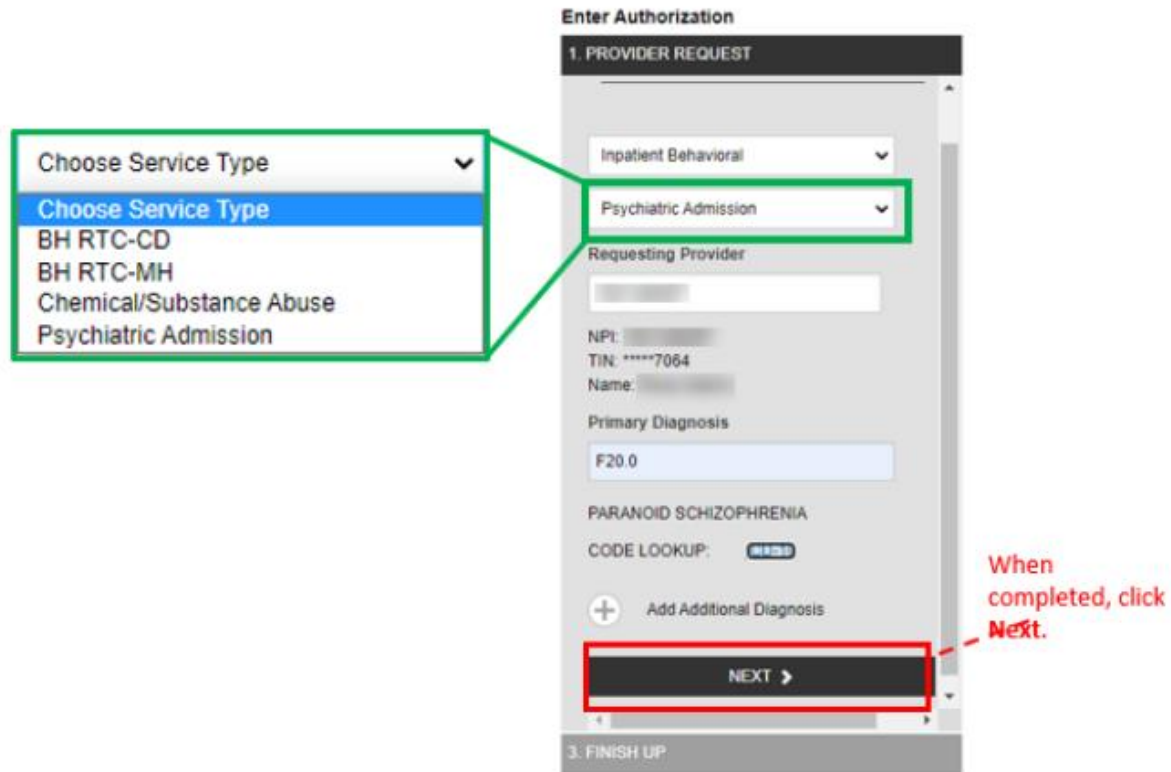
CODE LOOKUP: [ICD-10](#)

+ Add Additional Diagnosis

NEXT >

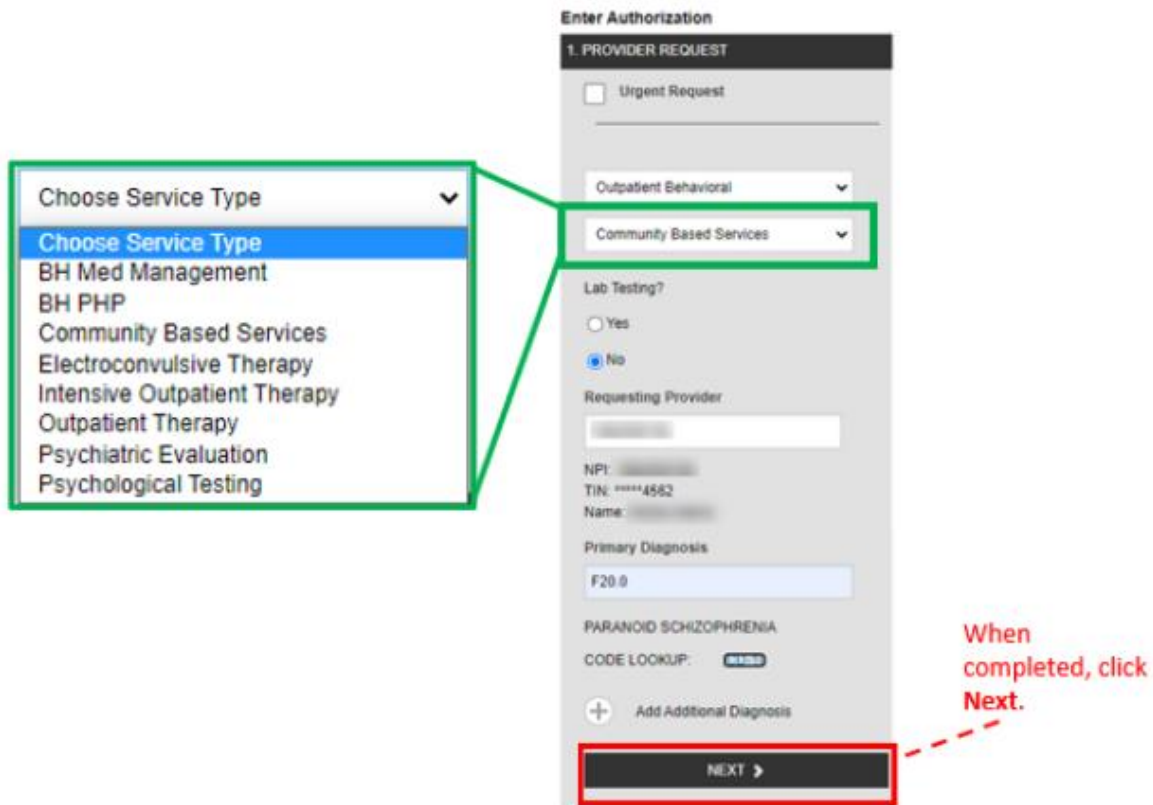
When completed, click **Next.**

Provider Request-Inpatient Behavioral



The screenshot shows a mobile application interface for entering authorization. The main form is titled "Enter Authorization" and "1. PROVIDER REQUEST". It contains several fields: "Inpatient Behavioral" (dropdown), "Psychiatric Admission" (dropdown), "Requesting Provider" (text input), "NPI:" (text input), "TIN: ****7064" (text input), "Name:" (text input), "Primary Diagnosis" (text input with "F20.0" entered), "PARANOID SCHIZOPHRENIA" (text), "CODE LOOKUP:" (button), and "Add Additional Diagnosis" (button with a plus icon). A "NEXT >" button is at the bottom. A callout box on the left shows a dropdown menu for "Choose Service Type" with options: "Choose Service Type", "BH RTC-CD", "BH RTC-MH", "Chemical/Substance Abuse", and "Psychiatric Admission". A red callout points to the "NEXT >" button with the text "When completed, click Next."

Provider Request- Outpatient Behavioral



Enter Authorization

1. PROVIDER REQUEST

Urgent Request

Outpatient Behavioral

Community Based Services

Lab Testing?

Yes

No

Requesting Provider

NPI: [REDACTED]

TIN: *****4582

Name: [REDACTED]

Primary Diagnosis

F20.0

PARANOID SCHIZOPHRENIA


CODE LOOKUP: MADE


+ Add Additional Diagnosis

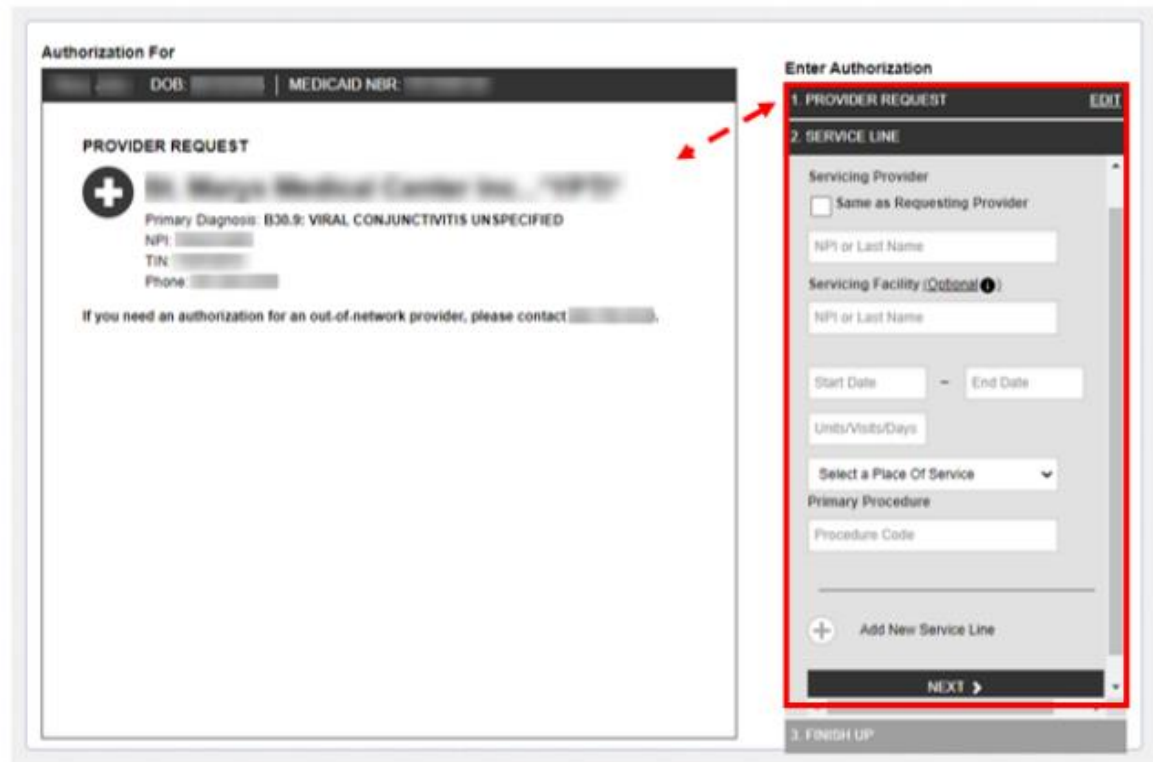
NEXT >

When completed, click **Next.**

Entering Service Line Detail


 The left pane displays the information entered in the Provider Request section, for review.


 Complete the Service Line information in the right pane.

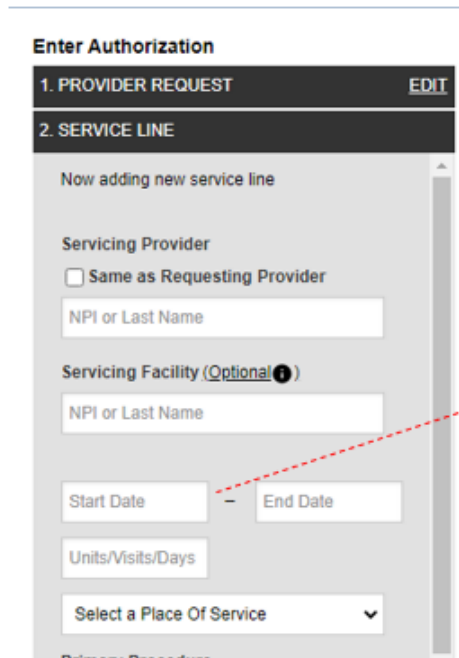


The screenshot displays a web-based authorization form. The left pane, titled 'Authorization For', shows a 'PROVIDER REQUEST' section with a plus icon, a blurred provider name, and fields for 'Primary Diagnosis: B30.9: VIRAL CONJUNCTIVITIS UNSPECIFIED', 'NPI', 'TIN', and 'Phone'. A note below states: 'If you need an authorization for an out-of-network provider, please contact [blurred]'. The right pane, titled 'Enter Authorization', is highlighted with a red border and contains two main sections: '1. PROVIDER REQUEST' (with an 'EDIT' button) and '2. SERVICE LINE'. The '2. SERVICE LINE' section includes a 'Servicing Provider' section with a checkbox for 'Same as Requesting Provider', an 'NPI or Last Name' field, a 'Servicing Facility (Optional)' section with an 'NPI or Last Name' field, 'Start Date' and 'End Date' fields, a 'Units/Visits/Days' field, a 'Select a Place Of Service' dropdown menu, a 'Primary Procedure' section with a 'Procedure Code' field, and an 'Add New Service Line' button with a plus icon. A 'NEXT >' button is located at the bottom of the right pane. A third section, '3. FINISH UP', is partially visible at the very bottom.

Entering Service Line Detail- Start Date

 Excluding lab testing, the Start Date is limited to the previous business day.

 The 3-day allowance, is only applicable for web authorizations entered on Monday, but the Start Date was the previous business day, which would be Friday.



Enter Authorization

1. PROVIDER REQUEST EDIT


2. SERVICE LINE

Now adding new service line

Servicing Provider

Same as Requesting Provider

NPI or Last Name

Servicing Facility (Optional )

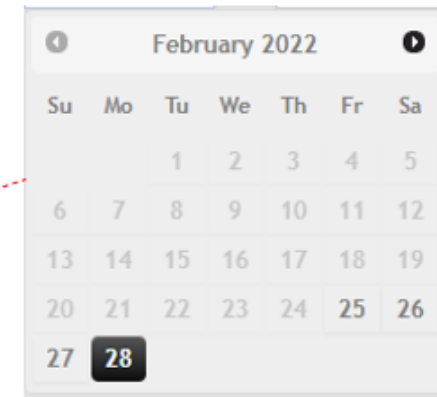
NPI or Last Name

Start Date - End Date

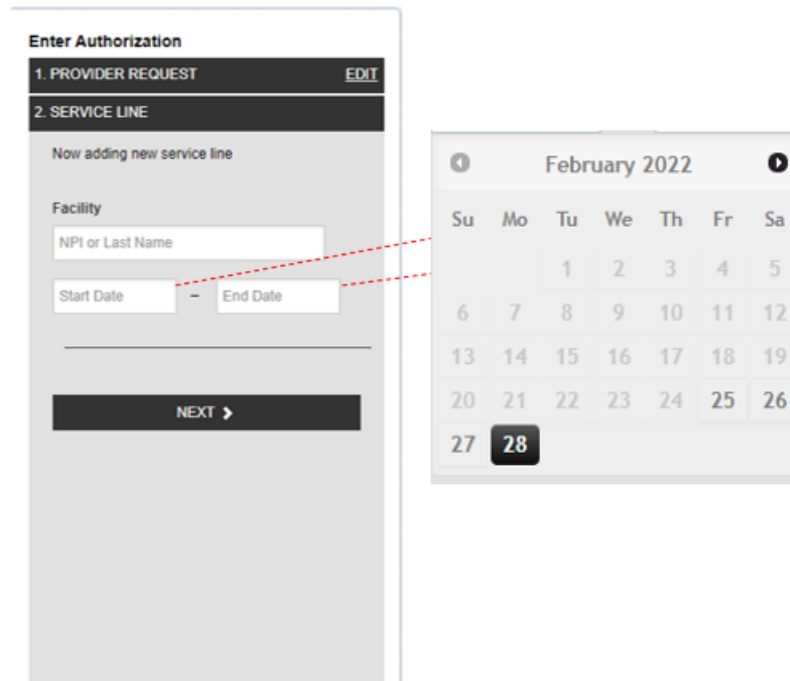
Units/Visits/Days

Select a Place Of Service

Primary Procedure



Entering Service Line Detail- Inpatient Medical (Surgical)



The screenshot displays a mobile application interface for entering authorization details. The main form is titled "Enter Authorization" and is divided into two sections: "1. PROVIDER REQUEST" and "2. SERVICE LINE". The "2. SERVICE LINE" section is currently active, showing the text "Now adding new service line". Below this, there is a "Facility" field with a sub-label "NPI or Last Name". A date range is specified with "Start Date" and "End Date" fields, separated by a hyphen. A "NEXT >" button is located at the bottom of the form. A calendar overlay is positioned to the right of the form, showing the month of February 2022. The calendar grid includes days of the week (Su, Mo, Tu, We, Th, Fr, Sa) and dates from 1 to 28. The date 28 is highlighted in a dark grey box, and a red dashed line connects this date to the "End Date" field in the form.

February 2022						
Su	Mo	Tu	We	Th	Fr	Sa
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28					

Entering Service Line Detail- Inpatient Medical Non-Surgical

Inpatient Medical → LTAC

1. PROVIDER REQUEST EDIT

2. SERVICE LINE

Now adding new service line

Facility

NPI or Last Name

Start Date - End Date

Select a Place Of Service

Primary Procedure

Procedure Code

NEXT >

Select a Place Of Service

- Inpatient Hospital
- Nursing Facility
- Skilled Nursing Facility

Inpatient Medical → Rehab Inpatient

1. PROVIDER REQUEST EDIT

2. SERVICE LINE

Now adding new service line

Facility

NPI or Last Name

Start Date - End Date

Select a Place Of Service

NEXT >

Select a Place Of Service

- Comprehensive Inpatient Rehabilitation Facility
- Inpatient Hospital

Inpatient Medical → Sub Acute

1. PROVIDER REQUEST EDIT

2. SERVICE LINE

Now adding new service line

Facility

NPI or Last Name

Start Date - End Date

Select a Place Of Service

NEXT >

Select a Place Of Service

- Custodial Care Facility
- Nursing Facility

Entering Service Line Detail – Outpatient Medical

Click the checkbox, if the Requesting and Servicing Provider is the same

1. PROVIDER REQUEST [EDIT](#)

2. SERVICE LINE

Now adding new service line

Servicing Provider

Same as Requesting Provider

NPI or Last Name

Servicing Facility (Optional ⓘ)

NPI or Last Name

Start Date – End Date

Units/Visits/Days

NOTE: For outpatient authorization requests it may be necessary to check the servicing facility as well as the servicing provider to determine if an authorization is required for the requested procedures. Failure to check for both the servicing provider and servicing facility may result in denied claims due to missing authorizations

Select a Place Of Service

Primary Procedure

Procedure Code

[CODE LOOKUP](#)

+ Add New Service Line

NEXT >

3. FINISH UP

- Select a Place Of Service
- Ambulatory Surgical Center
- Assisted Living Facility
- Birthing Center
- Custodial Care Facility
- End-Stage Renal Disease Treatment Facility
- Group Home
- HOMELESS SHELTER
- Home
- Independent Clinic
- Independent Lab
- Inpatient Hospital
- Mobile Unit
- Off Campus - Outpatient Hospital Office
- Outpatient Hospital
- Public Health Clinic
- Rural Health Clinic
- Temporary Lodging
- Urgent Care Facility

Entering Service Line Detail – Outpatient Behavioral

Enter Authorization

1. PROVIDER REQUEST [EDIT](#)

2. SERVICE LINE

Now adding new service line

Servicing Provider

NPI or Last Name

Start Date – End Date

Units/Visits/Days


Primary Procedure


Procedure Code

[CODE LOOKUP](#)

Add New Service Line

Entering Service Line Detail – Outpatient Medical/Behavioral: Add New Service Line

 The **Add New Service Line**, capability enables Provider portal users to submit web authorization requests with multiple procedure codes.

 If you add Service Line(s), the addition must align with the options selected in Provider Request:

- Outpatient Medical / Service Type
- Lab Testing? Yes or No


- Outpatient Behavioral / Service Type
- Lab Testing? Yes or No

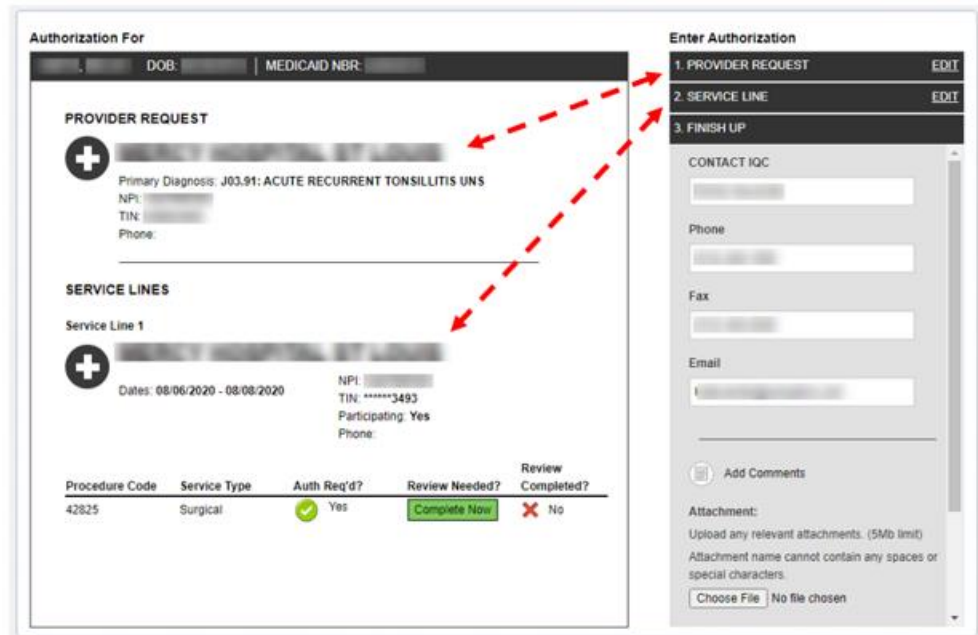
Click plus icon to add Service Line(s)



Final Steps-Medicaid

 Completed Provider Request and Service Line(s) displays in the left pane.

 The Contact information will auto-populate the user's information.



Authorization For

DOB: [REDACTED] MEDICAID NBR: [REDACTED]

PROVIDER REQUEST

+ [REDACTED]

Primary Diagnosis: J03.91: ACUTE RECURRENT TONSILLITIS UNS
 NPI: [REDACTED]
 TIN: [REDACTED]
 Phone: [REDACTED]

SERVICE LINES

Service Line 1

+ [REDACTED]

Dates: 08/06/2020 - 08/08/2020 NPI: [REDACTED]
 TIN: *****3493
 Participating: Yes
 Phone: [REDACTED]

Procedure Code	Service Type	Auth Req'd?	Review Needed?	Review Completed?
42825	Surgical	<input checked="" type="checkbox"/> Yes	<input type="button" value="Complete Now"/>	<input checked="" type="checkbox"/> No

Enter Authorization

1. PROVIDER REQUEST
2. SERVICE LINE
3. FINISH UP

CONTACT IQC

[REDACTED]

Phone: [REDACTED]

Fax: [REDACTED]

Email: [REDACTED]

Attachment:
 Upload any relevant attachments. (5Mb limit)
 Attachment name cannot contain any spaces or special characters.
 No file chosen


Final steps – InterQual Connect (IQC)

Before submitting the request, you will see this screen stating that auth is required and review needed. By clicking on Complete Now this will take you to IQC to complete the integrated medical review.

Authorization For

DOB: [REDACTED] | MEDICAID NBR: [REDACTED]


PROVIDER REQUEST

 [REDACTED]

Primary Diagnosis: J03.91: ACUTE RECURRENT TONSILLITIS UNS
 NPI: [REDACTED]
 TIN: [REDACTED]
 Phone: [REDACTED]

SERVICE LINES

Service Line 1

 [REDACTED]

Dates: 08/06/2020 - 08/08/2020 NPI: [REDACTED]
 TIN: *****3493
 Participating: Yes
 Phone: [REDACTED]

Procedure Code	Service Type	Auth Req'd?	Review Needed?	Review Completed?
42825	Surgical	✔ Yes	Complete Now	✘ No

Enter Authorization

1. PROVIDER REQUEST [EDIT](#)
2. SERVICE LINE [EDIT](#)
3. FINISH UP


CONTACT IQC

[REDACTED]

Phone: [REDACTED]

Fax: [REDACTED]

Email: [REDACTED]

 Add Comments

Attachment:
 Upload any relevant attachments. (5Mb limit)
 Attachment name cannot contain any spaces or special characters.

No file chosen

Web Authorization Submission




After completing the IQC review you can now upload your medical necessity documents and click Submit.

Authorization For

DOB: [REDACTED] | MEDICAID NBR: [REDACTED]


PROVIDER REQUEST

 [REDACTED]

Primary Diagnosis: J03.91: ACUTE RECURRENT TONSILLITIS UNS
 NPI: [REDACTED]
 TIN: [REDACTED]
 Phone: [REDACTED]

SERVICE LINES

Service Line 1

 [REDACTED]

Dates: 08/27/2020 - 08/29/2020 NPI: [REDACTED]
 TIN: *****3493
 Participating: Yes
 Phone: [REDACTED]

Enter Authorization


1. PROVIDER REQUEST [EDIT](#)

2. SERVICE LINE [EDIT](#)

3. FINISH UP




CONTACT IQC

Email

 Add Comments

Attachment:
 Upload any relevant attachments. (5Mb limit)
 Attachment name cannot contain any spaces or special characters.
 No file chosen

Jane_Doe_Clinical.pdf

Procedure Code	Service Type	Auth Req'd?	Review Needed?	Review Completed?
42825	Surgical	 Yes	 Attached	 Yes

Telephone and Fax Authorizations

Telephone Authorization

- 👤 Providers can initiate Prior Authorization via the MHS referral line by calling 1-877-647-4848:
 - Monday - Friday 8 a.m. to 5 p.m. (Closed for lunch from noon to 1 p.m.)
 - After hours, MHS 24-hour nurse line available to take emergent requests.
- 👤 The PA process begins at MHS by speaking with the MHS non-clinical referral staff.
- 👤 For procedures requiring additional review, we will transfer providers to a live nurse line to facilitate the PA process.
- 👤 Please have all clinical information ready at time of call.

Fax Authorization

MHS Medical Management Department at 1-866-912-4245

Patient Information					
IHCP Member ID (RID):					
Date of Birth:					
Patient Name:					
Address:					
City/State/ZIP Code:					
Patient/Guardian Phone:					
PMP Name:					
PMP NPI:					
PMP Phone:					
Ordering, Prescribing, or Referring (OPR) Provider Information					
OPR Physician NPI:					
Medical Diagnosis (Use of ICD Diagnostic Code Is Required)					
Dx1		Dx2		Dx3	



Member ID/RID,
DOB Patient name,
required



Medical Diagnosis
code(s) **required**



Check service
category

Please check the requested assignment category below:

- | | | |
|--------------------------------------|---|---|
| <input type="checkbox"/> DME | <input type="checkbox"/> Inpatient | <input type="checkbox"/> Physical Therapy |
| <input type="checkbox"/> Purchased | <input type="checkbox"/> Observation | <input type="checkbox"/> Speech Therapy |
| <input type="checkbox"/> Rented | <input type="checkbox"/> Office Visit | <input type="checkbox"/> Transportation |
| <input type="checkbox"/> Home Health | <input type="checkbox"/> Occupational Therapy | <input type="checkbox"/> Other |
| <input type="checkbox"/> Hospice | <input type="checkbox"/> Outpatient | |

Fax Authorization

Requesting Provider Information:	
NPI#:	
Tax ID#:	
Service Location Code:	
Provider Name:	
Rendering Provider Information	
Ordering Physician NPI#:	
Tax ID#:	
Name	
Address:	
City/State/Zip:	
Phone:	
Fax:	

← Enter the **Requesting** provider's information

← Enter the **Rendering** provider's individual NPI#

Fax Authorization

Dates of Service		Procedure/ Service Codes	Modifier(s)		Requested Service	Taxonomy	POS	Units	Dollars
Start	Stop								

Prior Authorization Denial and Appeal Process

Medical PA Denial and Appeal Process




If MHS denies the requested service:

- And the member is still receiving services, the provider has the right to an expedited appeal. The attending physician must request the expedited appeal.
- And the member already has been discharged, the attending physician must submit an appeal in writing within **60 days** of the denial.

The attending physician has the right to a peer-to-peer discussion with an MHS physician:


- Providers initiate peer-to-peer discussions and expedited appeals by calling an MHS Appeals Coordinator at 1-877-647-4848.
- They must request peer-to-peer within **10 days** of the adverse determination.

Medical PA Denial and Appeal Process

-  Send Prior Authorization/Medical Necessity Appeals to:
Managed Health Services
Attn: Appeals Coordinator
PO Box 441567
Indianapolis, IN 46244
-  Providers must initiate appeals within **60 days** of the receipt of the denial letter for MHS to consider.
-  We will communicate determination to the provider within **30 calendar days** of receipt.

****A prior authorization appeal is different than a claim appeal request.***

PA/Medical Necessity Appeals on the Provider Secure Portal

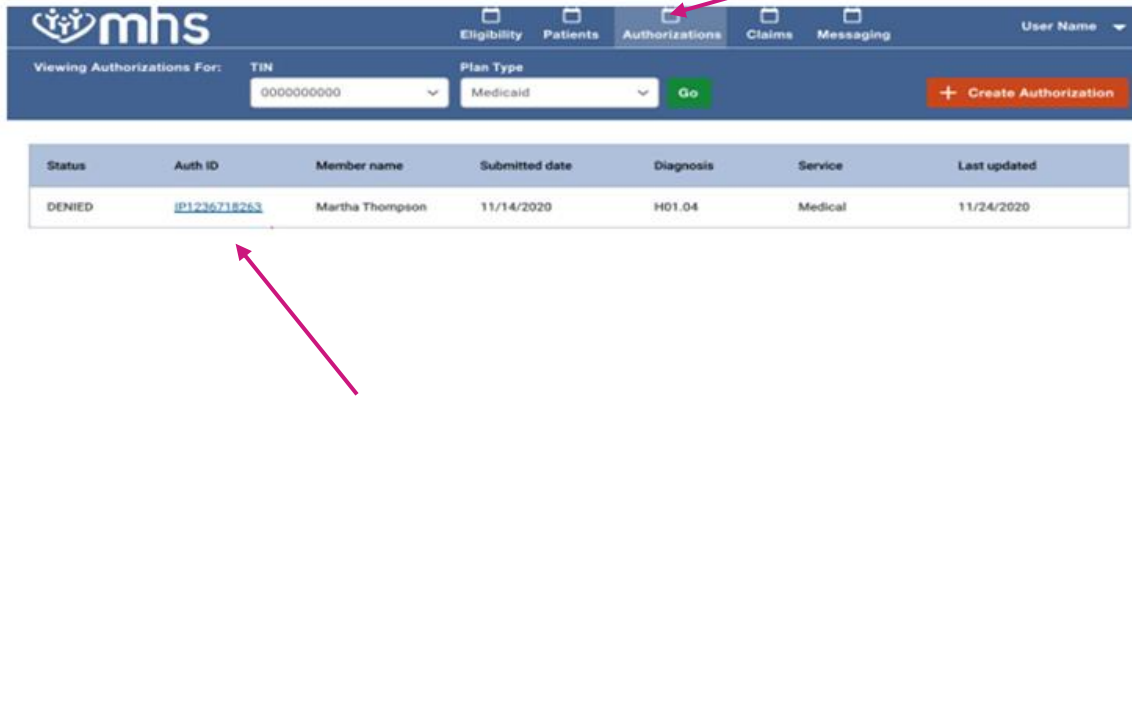
-  Medicaid prior authorization/medical necessity denial appeals can be submitted to Managed Health Services (MHS) and will allow tracking of the appeal from submission through decision on the Secure Provider Portal.

PA/Medical Necessity Appeals on the Provider Secure Portal

The screenshot shows the MHS Provider Secure Portal dashboard. At the top, there are navigation tabs for Eligibility, Patients, Authorizations, Claims, and Messaging. A search bar is present with fields for TIN (000000000) and Plan Type (Medicaid), and a 'Go' button. A red box highlights the 'Select "Authorizations"' option in the navigation menu. Below the search bar, a pink note states: "Note: Effective April 1, 2021, you can submit and track Medicaid authorization appeals and Level I and Level II/Claim disputes/appeals on the Provider Secure Portal from within your account. For assistance with your online authorization and/or claim appeal, please call 877-647-4848 Mon - Fri, 8 a.m. - 8 p.m. EST. *Independent/External Review Organization (IRO) requests are excluded from online submission." Below the note is a "Quick Eligibility Check for Medicaid" section with input fields for Member ID or Last Name (47362539 or Smith) and Birthdate (mm/dd/yyyy), and a "Check Eligibility" button. To the right, there is a "Welcome" section with a list of menu items: Add a TIN to My ACCOUNT, Reports, Patient Analytics, Provider Analytics, and Provider Complaints. Below that is a "Recent Activity" section showing a claim on 10/10/2020. At the bottom right is a "Quick Links" section with items: Provider Resources, Member Management Forms, IHCP Provider Health Portal, Peer to Peer Contact Form, and Pharmacy. The "Recent Claims" section features a table with the following data:

Status	Received Date	Member Name	Claim Number
●	10/09/2020	Ringo Starr	Y6435729HJ87
●	10/10/2020	Paul McCartney	Y6435729HJ87
●	10/12/2020	George Harrison	Y6435729HJ87
●	10/09/2020	John Lennon	Y6435729HJ87
●	10/10/2020	Penny Lane	Y6435729HJ87
●	10/12/2020	Jude Smith	Y6435729HJ87

PA/Medical Necessity Appeals on the Provider Secure Portal

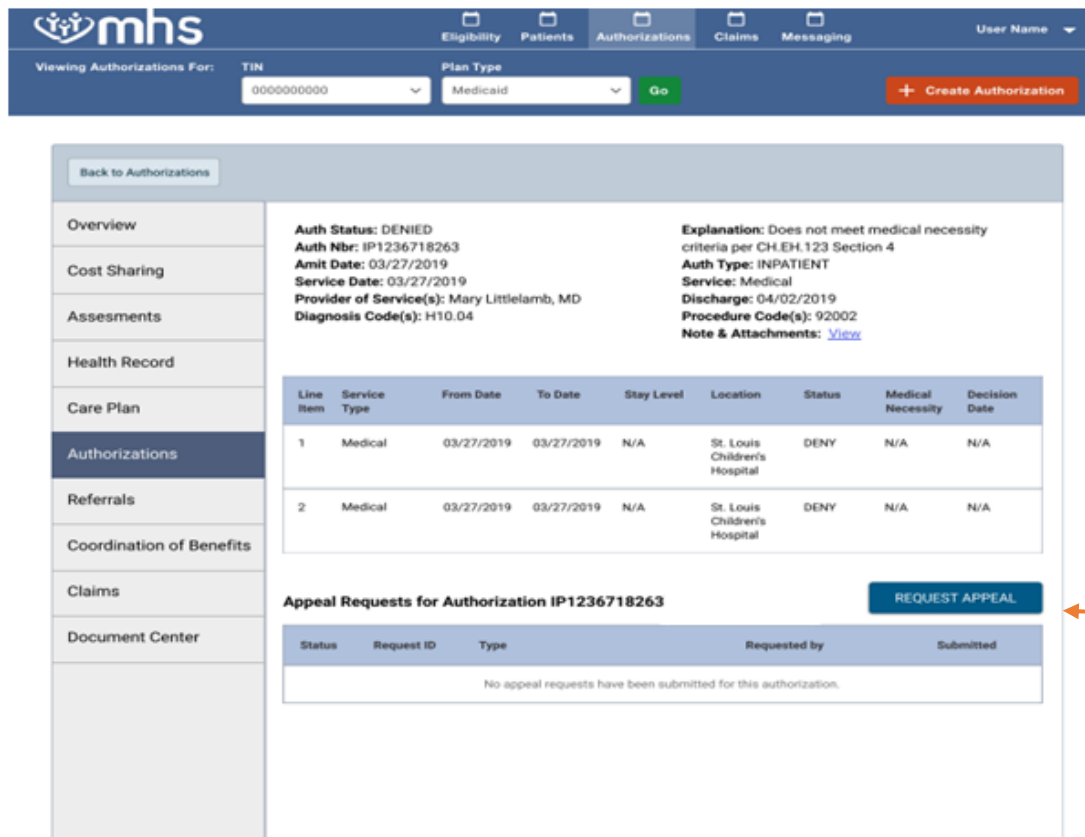


The screenshot displays the mhs Provider Secure Portal interface. The top navigation bar includes tabs for Eligibility, Patients, Authorizations, Claims, and Messaging. The Authorizations tab is selected, and a pink arrow points to it. Below the navigation bar, there are input fields for TIN (000000000) and Plan Type (Medicaid), along with a Go button and a + Create Authorization button. A table below shows a list of authorizations with the following data:

Status	Auth ID	Member name	Submitted date	Diagnosis	Service	Last updated
DENIED	IP1236718263	Martha Thompson	11/14/2020	H01.04	Medical	11/24/2020

A pink arrow points to the Auth ID link in the table.

PA/Medical Necessity Appeals on the Provider Secure Portal



The screenshot shows the MHS Provider Secure Portal interface. At the top, there are navigation tabs for Eligibility, Patients, Authorizations, Claims, and Messaging. Below these, there are search filters for TIN (0000000000) and Plan Type (Medicaid), along with a 'Go' button and a '+ Create Authorization' button. The main content area is divided into a left sidebar with navigation options (Overview, Cost Sharing, Assessments, Health Record, Care Plan, Authorizations, Referrals, Coordination of Benefits, Claims, Document Center) and a main panel. The main panel displays the details for a denied authorization (Auth Nbr: IP1236718263) with an explanation: 'Does not meet medical necessity criteria per CH.EH.123 Section 4'. Below this, there is a table of authorization lines (2 lines, both Medical, DENY status). At the bottom of the main panel, there is a section for 'Appeal Requests for Authorization IP1236718263' with a 'REQUEST APPEAL' button highlighted by an orange arrow. Below this button is a table for tracking appeal requests, which currently shows 'No appeal requests have been submitted for this authorization.'

PA/Medical Necessity Appeals on the Provider Secure Portal

Authorization Details

Authorization Number
██████████

Patient Full Name
██████████

Admittance Date
08/30/2021

Service Date
08/30/2021

Discharge Date
09/30/2021

Provider of Service
██████████

Authorization type
OUTPATIENT

Service
Outpatient Services

Diagnosis Code(s)
M47.817

Procedure Code(s)
64493, 64493, 64494, 64494

Appeal Request Form

Appeal request for authorization **IP1236718234**

Appeal type*
Please select one or more appeal types.

Administrative
 Medical Necessity

Provider Submitting the Appeal* Office Contact Name* Phone*

██████████ Betty Blue (555) 555-5555

Enter last name or NPI

Rationale*
Provide a detailed explanation with new information for this appeal.

Lorem Ipsum is simply dummy text of the printing and typesetting industry. Lorem Ipsum has been the industry's standard dummy text ever since the 1500s when an unknown printer took a gallery of type and scrambled it to make a type specimen book.

2000 Characters remaining

Evidence Materials & Attachments
Submit new evidence that will help support your appeal.

.../Folder 1/Folder 2/Folder 3/File.pdf [UPLOAD FILE](#)

File	Type	Size
MarthaThompson12345_xray_010119.png	PNG	230kb

[SAVE & REVIEW](#)

PA/Medical Necessity Appeals on the Provider Secure Portal

Back
Submit Appeal Request

Authorization Detail

Authorization Number
IP1236718263

Patient Full Name
Martha Thompson

Patient DOB
06/20/1981

Admittance Date
03/27/2019

Service Date
03/27/2019

Discharge Date
04/02/2019

Provider of Service
Mary Littlelamb, MD

Authorization Type
Inpatient

Service
Medical

Diagnosis Code(s)
H01.04

Procedure Code(s)
92002

Appeal Request Form

Appeal Request for Authorization IP1236718263

Appeal type*
Please select one or more appeal types.

Administrative
 Medical Necessity

DENIED

Explanation
Does not meet medical necessity criteria per CH.EH.123 Section 4.

[View Notes & Attachments](#)

Are you sure you want to go back?

By leaving this form, you will lose all of this information.

Lorem Ipsum is simply dummy text of the printing and typesetting industry. Lorem Ipsum has been the industry's standard dummy text ever since the 1500s, when an unknown printer took a galley of type and scrambled it to make a type specimen book.

2000 characters remaining

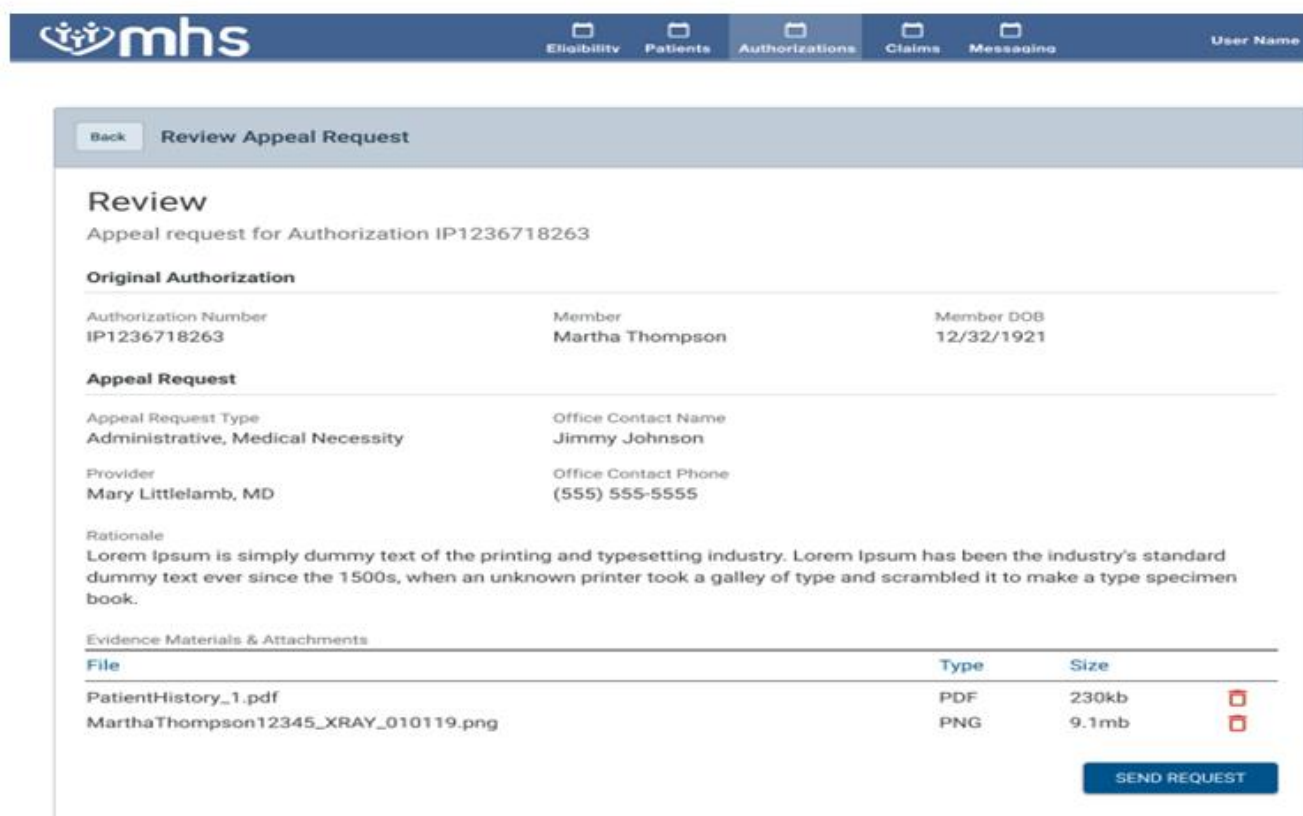
Evidence Materials & Attachments*
Submit new evidence that will help support your appeal.

.../Folder 1/Folder 2/Folder 3/File.pdf
UPLOAD FILE

2000 characters remaining

File	Type	Size	
PatientHistory_1.pdf	PNG	230kb	🗑️
MarthaThompson12345_XRAY_010119.png	PNG	9.1mb	🗑️

PA/Medical Necessity Appeals on the Provider Secure Portal



Review
Appeal request for Authorization IP1236718263

Original Authorization



Authorization Number IP1236718263	Member Martha Thompson	Member DOB 12/32/1921
--------------------------------------	---------------------------	--------------------------

Appeal Request

Appeal Request Type Administrative, Medical Necessity	Office Contact Name Jimmy Johnson
Provider Mary Littlelamb, MD	Office Contact Phone (555) 555-5555

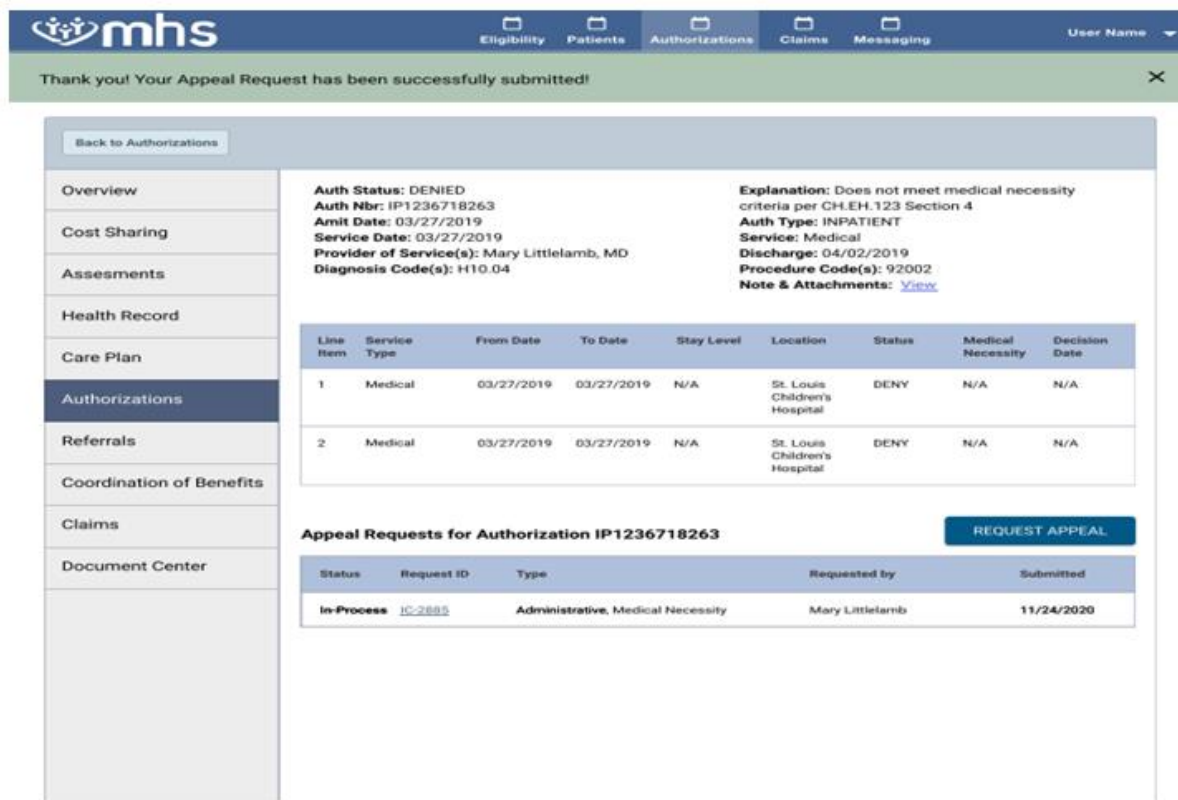
Rationale
Lorem Ipsum is simply dummy text of the printing and typesetting industry. Lorem Ipsum has been the industry's standard dummy text ever since the 1500s, when an unknown printer took a galley of type and scrambled it to make a type specimen book.

Evidence Materials & Attachments

File	Type	Size	
PatientHistory_1.pdf	PDF	230kb	
MarthaThompson12345_XRAY_010119.png	PNG	9.1mb	

[SEND REQUEST](#)

PA/Medical Necessity Appeals on the Provider Secure Portal



Thank you! Your Appeal Request has been successfully submitted!

[Back to Authorizations](#)

Overview

Auth Status: DENIED
Auth Nbr: IP1236718263
Amit Date: 03/27/2019
Service Date: 03/27/2019
Provider of Service(s): Mary Littlelamb, MD
Diagnosis Code(s): H10.04

Explanation: Does not meet medical necessity criteria per CHEH.123 Section 4
Auth Type: INPATIENT
Service: Medical
Discharge: 04/02/2019
Procedure Code(s): 92002
Note & Attachments: [View](#)

Line Item	Service Type	From Date	To Date	Stay Level	Location	Status	Medical Necessity	Decision Date
1	Medical	03/27/2019	03/27/2019	N/A	St. Louis Children's Hospital	DENY	N/A	N/A
2	Medical	03/27/2019	03/27/2019	N/A	St. Louis Children's Hospital	DENY	N/A	N/A

Appeal Requests for Authorization IP1236718263 [REQUEST APPEAL](#)

Status	Request ID	Type	Requested by	Submitted
In-Process	IC-2885	Administrative, Medical Necessity	Mary Littlelamb	11/24/2020

PA/Medical Necessity Appeals on the Provider Secure Portal

[Eligibility](#)
[Patients](#)
[Authorizations](#)
[Claims](#)
[Messaging](#)
User Name

Back
Review Appeal Request

Appeal request for Authorization IP1236718263
 Current status: **In-Process**

Original Authorization

Authorization Number IP1236718263	Member Martha Thompson	Member DOB 12/32/1921
--------------------------------------	---------------------------	--------------------------

Appeal Request

Appeal Request Type Administrative, Medical Necessity	Office Contact Name Jimmy Johnson
Provider Mary Littlelamb, MD	Office Contact Phone (555) 555-5555

Rationale
 Lorem Ipsum is simply dummy text of the printing and typesetting industry. Lorem Ipsum has been the industry's standard dummy text ever since the 1500s, when an unknown printer took a galley of type and scrambled it to make a type specimen book.

Evidence Materials & Attachments


File	Type	Size	
PatientHistory_1.pdf	PDF	230kb	
MarthaThompson12345_XRAY_010119.png	PNG	9.1mb	

SEND REQUEST

Appeal Summary

Appeal ID	Status					
ABCD1234	Assigned					
EFGH1234	In-Process					

Behavioral Health PA Denial and Appeal Process

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

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

MHS Team

MHS Provider Network Territories

Indiana

NORTHEAST REGION

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SOUTH CENTRAL REGION

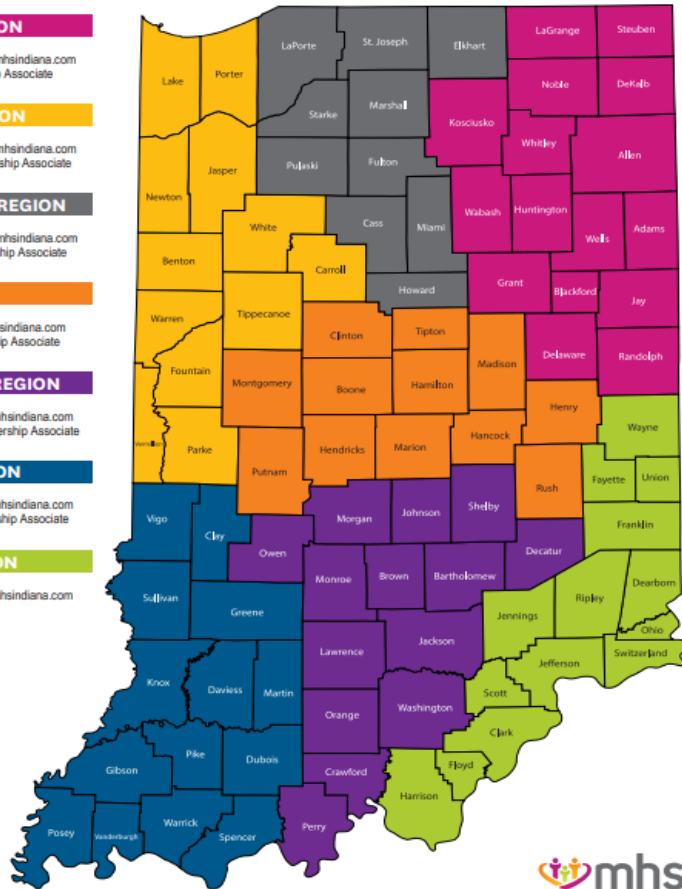
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SOUTHWEST REGION

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Available online:

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

MHS Provider Network Territories

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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

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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

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Questions: ProviderRelations@EnvolveHealth.com

ENVOLVE VISION, INC.

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Network Leadership

NETWORK LEADERSHIP

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Questions?

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