



Prior Authorization: Simplifying Prior Authorization for Better Patient Care

2025 Indiana Health Coverage Programs
(IHCP) Annual Works Seminar

Agenda

- Medical Prior Authorization (PA)
- Need to Know
- Web Portal
- Fax Authorizations
- Prior Authorization and Medical Necessity Appeals
- Prior Authorization Denials and Appeal Process
- Behavioral Health (BH) PA Updates
- Fax Request
- Pertinent Information
- BH Prior Authorizations Denials
- BH Prior Authorizations and Appeals
- MHS Network Team
- Questions and Answers

Medical Prior Authorization (PA)

Medical Prior Authorization

Medical PA is an approval from MHS to provide services designated as needing authorization before treatment and/or payment.

- Emergency Room (ER) services do not require PA.
 - Admission must be called into the MHS Prior Authorization Department within two business days. Please contact 1-877-647-4848
- Urgent concurrent = Emergent inpatient admission. Determination timeline within 24 hours of receipt of request.

PA Guidelines for Medical and Behavioral Health

MHS adheres to the following timelines for PA decisions:

- Up to 48 hours for standard PA decisions.
- Within 24 hours for urgent PA decisions.
- Concurrent review request within 48 hours.

Possible Reasons for Delayed Decisions:

- Incomplete or insufficient information submitted with the request.
- Requests requiring review by the Medical Director.
- If the provider requests an inpatient level of care for a covered/eligible condition, but the procedure and documentation support an outpatient/observation level of care, the case will be sent for Medical Director review.

Important Note: The Medical Management team does not verify member eligibility or benefit limitations. It is the provider's responsibility to confirm eligibility and verify benefit coverage is assigned to MHS.

Medical Prior Authorization

MHS Medical Management will review State guidelines and clinical documentation.

- If the provider requests an inpatient level of care for a covered or eligible condition, but procedure and documentation supports an outpatient or observation level of care, MHS will send the case for Medical Director review.
- Elective procedures that require PA must be submitted to MHS at least two business days prior to the date of service.

***Authorizations do not guarantee payment.**

Transfer Prior Authorization Requests

- 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.

***Higher level of care changes require PA, and it is the responsibility of the new transferring facility to obtain.**

Ways to Obtain a Prior Authorization

- Check to see if a Medicaid Pre-Authorization is necessary by using our online tool. If an authorization is needed, you can access our [MHS Provider Portal](#) to submit a request online.
- The [Prior Authorization](#) link will take you to the Medicaid Pre-Auth page.
- For imaging, outpatient surgeries and testing, requests for services may be obtained via:

Phone: 1-877-647-4848

Fax: 1-866-912-4245

Online: [MHS Provider Portal](#)

How to Obtain a Prior Authorization

For Providers

Login

Behavioral Health Providers

Clinical & Payment Policies

Dental Providers

Email Sign Up

Enrollment and Updates

Pharmacy

Prior Authorization

Medicaid Pre-Auth

Ambetter Pre-Auth

Medicare Pre-Auth

Provider Education & Training

Provider Resources

QI Program

Provider News

Opioid Resources

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

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 anesthesia services being rendered for pain management?	<input type="radio"/>	<input type="radio"/>
Are services for infertility?	<input type="radio"/>	<input type="radio"/>

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

[2023 30 Most Frequently Submitted CPT Codes \(PDF\)](#)

Prior Authorization Web Tool – No

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 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"/>

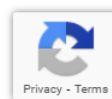
Enter the code of the service you would like to check:

99394

CHECK FOR PRE-AUTH

N
No

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

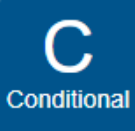


Prior Authorization Web Tool - Conditional

Types of Services	YES	NO
Is the member being admitted to an inpatient facility?	<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"/>

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

90834

**90834** - PSYTX W PT 45 MINUTES
Prior authorization is required after 20 units in calendar year.

Log into the [MHS Provider Portal](#) to submit a Prior Authorization

Prior Authorization Web Tool - Yes

Types of Services	YES	NO
Is the member being admitted to an inpatient facility?	<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"/>

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

75563

CHECK FOR PRE-AUTH

Y
Yes

75563 - CARD MRI W/STRESS IMG & DYE
Authorization required through NIA for these services.

Log into the [MHS Provider Portal](#) to submit a Prior Authorization

Information Needed For Prior Authorization

Information Needed to Complete All Prior Authorization Request:

- Member's Name, Medicaid ID, and Date of Birth
- Type of service needed
- Date(s) of service
- Ordering Physician with National Provider Identifier (NPI) number
- Servicing/Rendering Physician with Rendering NPI number
- Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) codes requested for approval
- Diagnosis code
- Contact person, including phone and fax numbers
- Clinical information to support medical necessity
- Home care requires a signed Plan of Care (POC)

Prior Authorization Update Requests

- Providers can update previously approved PA within 90 calendar days of the original date of service prior to claim denial for changes to:
 - Dates of service
 - CPT/HCPCS codes
 - Provider demographic changes

***Providers are encouraged to make corrections to the existing PA prior to submitting the claim.**

Continuity of Care Prior Authorization Requests

- MHS will honor pre-existing authorizations from any other Indiana Medicaid payor following the below mentioned guidelines:
 - During the first 90 calendar days during member enrollment, or up to the expiration date of the previous authorization, whichever occurs first, and upon notification of transition to MHS.
 - Providers must include the approval from the prior payor and Fee-for Service (FFS), once the member transfers to MHS.

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

Sub-Acute Care Prior Authorization Requests

- MHS conducts clinical review for ongoing authorization and coordination of discharge needs for our members in Sub-acute facilities at least every three to five calendar days.
- One-day sub-acute care request turnaround time.
- Indiana Administrative Code (IAC) requires that individuals requesting a nursing facility (NF) admission to a Medicaid-certified meet a NF level of care [Indiana Administrative Code](#)
- A Preadmission Screening and Resident Review (PASRR) is required before admission and must be submitted with the admission request and when updated according to IAC requirements.

Sub-Acute Care

The PASRR is submitted to MHS with the admission request and should include complete current information regarding:

- 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 the member's plan of care
- Discharge plans and needs identified (Home Health/Durable Medical Equipment (DME), etc.)
- Anticipated discharge date

Inpatient Prior Authorization Requests

- Notification of an inpatient admission and any clinical information may be submitted for medical necessity review via:
 - [MHS Provider Portal](#), using the [IHCP Universal PA Form](#)
 - Via fax 1-866-912-4245
- Phone notifications of admission and submission of clinical information for members enrolled in Hoosier Healthwise, the Healthy Indiana Plan (HIP), or Hoosier Care Connect will not be accepted.

Need to Know

Outpatient Radiology Prior Authorization Request

- MHS partners with Evolent for outpatient radiology PA process
- PA requests must be submitted via:
 - Evolent Website: [RadMD.com](https://www.radmd.com)
 - Evolent phone number: 1-866-904-5096

**Not applicable for ER, Observation, or Inpatient.*

Evolut

Physical, Occupational and Speech Therapy

- Utilization management of these services is managed by Evolut for Medicaid.
- All Health Plan approved training/education materials are posted on the Evolut website, [RadMD](#), under the Resources tab. For new users to access these web-based documents, a RadMD account ID and password must be created.
- Chiropractors rendering therapy services are exempt from the Evolut program.

Evolut – Cardiac Services

Cardiac Services

Evolut manages prior authorizations for the cardiac services below:

- Automated Implantable Cardioverter Defibrillator
- Leadless Pacemaker
- Pacemaker
- Revision or Replacement of Implanted Cardiac Device
- Coronary Artery Bypass Grafting (Non-Emergent)
- Coronary Angioplasty and Stenting
- Non-Coronary Angioplasty and Stenting

Telephonic Intake: Direct:1-574-784-1005 | Toll Free:1-855-415-7482

Facsimile Intake: 1-463-207-5864

***This is not an all-inclusive list.**

Durable & Home Medical Equipment (DME/HME)

- Non-Participating DME providers require prior authorization on all services. Prior Authorization requests must be submitted by the ordering physician. All requests should be faxed directly to MHS
- Orders are sent directly to and coordinated by MHS and delivered to the member.
- Does not apply to items provided by and billed by physician office.
- To initiate a prior authorization:
Log into the [MHS Provider Portal](#) click on “Create Authorization.” Choose DME and you will be directed to the DME portal for order entry.
- **Fax Number:** 1-866-912-4245 **Phone Number:** 1-844-218-4932.

Ambulance Coverage

Prior authorization is required to ensure medical necessity for the following non-emergent ambulance services:

Ambulance:

A0426 - Ambulance service, adv. life support, non-emergency transport, level 1

A0428 - Ambulance service, basic life support, non-emergent transport.

A0999 - Unlisted ambulance service

T2003 - Non-emergency transportation encounter/trip

T2004 - Non-emergency transportation commercial carrier

Air Transport:

A0140 - Non-emergency transportation and air travel

A0430 - Air Ambulance, conventional air services, one way (fixed wing)

A0999 - Unlisted Ambulance service

Please contact for our transportation vendor for prior authorization request

Pharmacy Requests

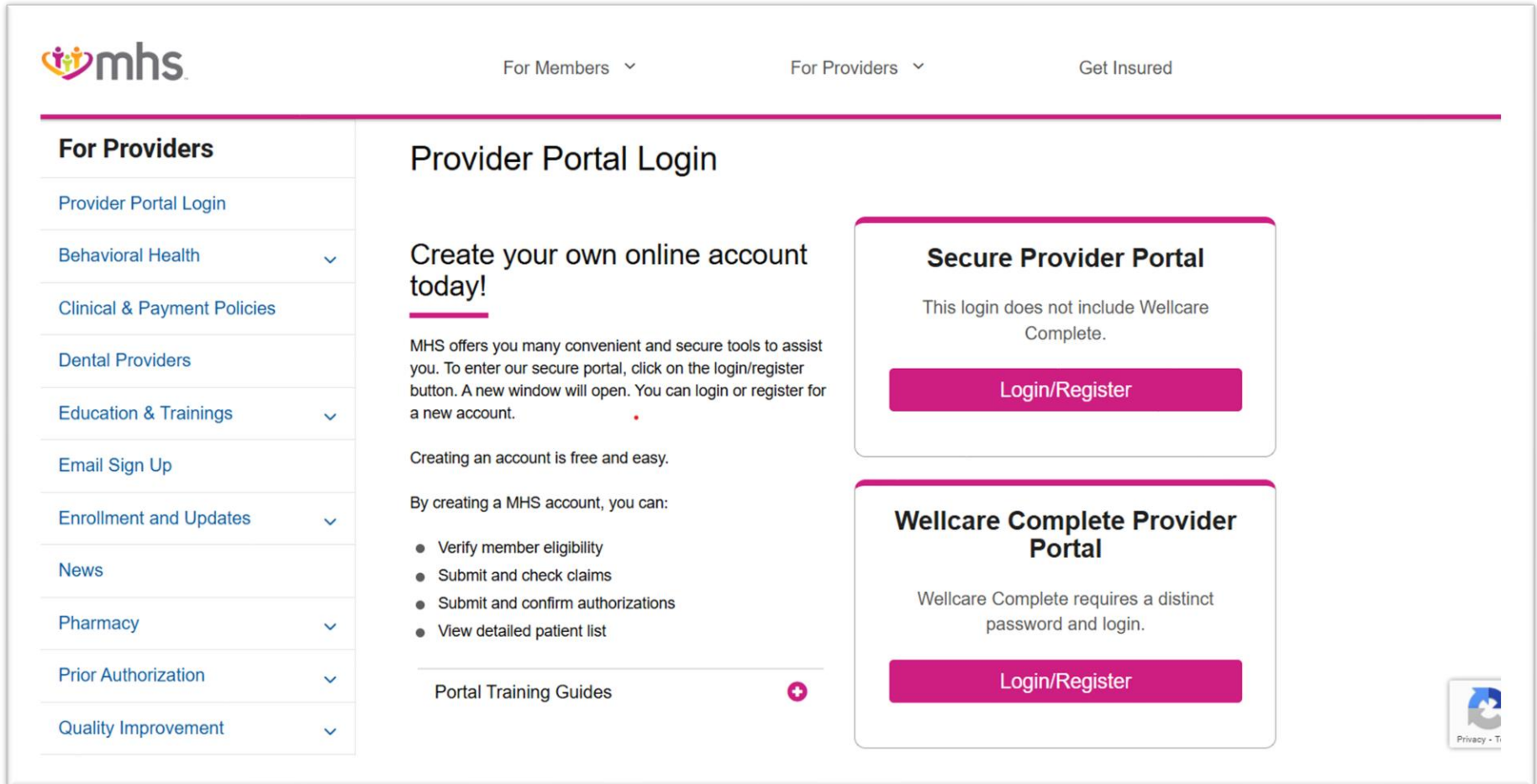
MHS Pharmacy Benefit Manager is Express Scripts, Inc. (ESI)

- Preferred Drug Lists and authorization forms are available on our [MHS website](#).
- PA requests:
 - Phone: 1-866-399-0928
 - Fax non-specialty drugs: 1-866-399-0929
 - Fax specialty drugs: 1-833-645-2742
- Formulary integrated into many Electronic Health Records (EHR) solutions.
- Online PA submission available through CoverMyMeds:
 - covermymeds.com/main/
- Specialty Drugs
 - AcariaHealth General Customer Care
 - Phone: 1-800-511-5144 Fax: 1-877-541-1503

Web Portal

Secure Portal Registration or Login

Sign up or log into the [MHS Provider Portal](#)



The screenshot displays the MHS website's navigation and provider portal options. The top navigation bar includes the MHS logo, links for 'For Members', 'For Providers', and 'Get Insured'. A left sidebar lists various provider resources, with 'Provider Portal Login' at the top. The main content area is titled 'Provider Portal Login' and features a call to action to create an account, a description of the portal's benefits, and a list of capabilities. Two prominent buttons, 'Login/Register', are provided for both the 'Secure Provider Portal' and the 'Wellcare Complete Provider Portal'. A 'Portal Training Guides' link is also present at the bottom of the main content area.

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For Members ▾ For Providers ▾ Get Insured

For Providers

- Provider Portal Login
- Behavioral Health ▾
- Clinical & Payment Policies
- Dental Providers
- Education & Trainings ▾
- Email Sign Up
- Enrollment and Updates ▾
- News
- Pharmacy ▾
- Prior Authorization ▾
- Quality Improvement ▾

Provider 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 +

Secure Provider Portal

This login does not include Wellcare Complete.

Login/Register

Wellcare Complete Provider Portal

Wellcare Complete requires a distinct password and login.

Login/Register

Privacy - T

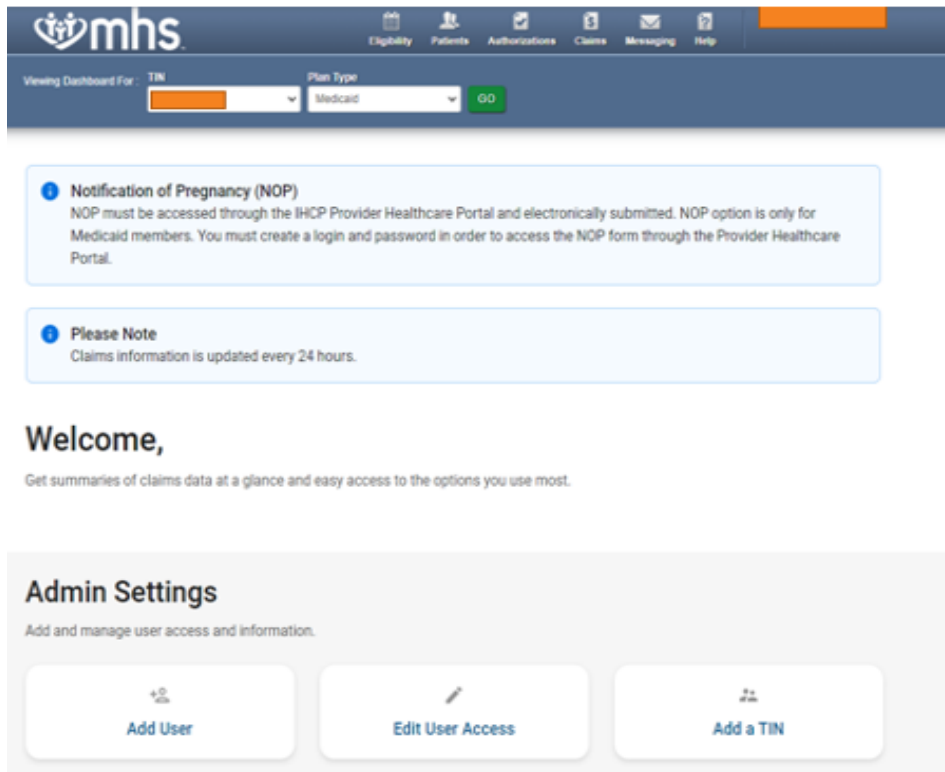
Web Authorization

- Providers can submit PAs online via the MHS Secure Provider Portal.
- When using the portal, providers can upload supporting documentation directly.
- Providers can check the authorization status on the portal.
- Same steps for Behavioral Health (BH) and Medical using appropriate links.

Exceptions: Must submit Hospice, Home Health, and biopharmaceuticals PA requests via fax at 1-866-912-4245.

Homepage - MHS (Medicaid)

After logging into the [MHS Provider Portal](#) this homepage will appear that allows providers to access information



The screenshot shows the MHS Provider Portal homepage. At the top is a navigation bar with the MHS logo and icons for Eligibility, Patients, Authorizations, Claims, Messaging, and Help. Below the navigation bar is a section for 'Viewing Dashboard For' with a dropdown for 'TIN' and a dropdown for 'Plan Type' set to 'Medicaid', with a 'GO' button. Below this are two informational boxes: 'Notification of Pregnancy (NOP)' and 'Please Note'. The 'Welcome,' section follows, with a subtitle 'Get summaries of claims data at a glance and easy access to the options you use most.' At the bottom is the 'Admin Settings' section, which includes the text 'Add and manage user access and information.' and three buttons: 'Add User', 'Edit User Access', and 'Add a TIN'.

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Eligibility Patients Authorizations Claims Messaging Help

Viewing Dashboard For: TIN [dropdown] Plan Type: Medicaid [dropdown] **GO**

Notification of Pregnancy (NOP)
NOP must be accessed through the IHCP Provider Healthcare Portal and electronically submitted. NOP option is only for Medicaid members. You must create a login and password in order to access the NOP form through the Provider Healthcare Portal.

Please Note
Claims information is updated every 24 hours.

Welcome,
Get summaries of claims data at a glance and easy access to the options you use most.

Admin Settings
Add and manage user access and information.

Add User **Edit User Access** **Add a TIN**

Quick Actions

Do a quick eligibility check, find patient benefits information, create a new claim or recurring claim or an authorization.

Member ID or Last Name * Member Date of Birth Select Action Type * **SUBMIT**

MM/DD/YYYY

Authorization Overview

Inpatient Authorizations

[View All](#)

Outpatient Authorizations

[View All](#)

Useful Links

Reports

This repository contains reports that are uploaded and maintained by the health plan.

Patient Analytics

This is a PHM tool that supports providers in the delivery of timely, efficient, and evidence-based care to our members.

Provider Analytics [🔗](#)

Used by PCP groups to access data/reports/dashboard that assist in providing better health outcomes and lower cost.

Creating a New Authorization

- Click **Create Authorization**.
- Enter **Member ID** or **Last Name** and **Birthdate**.

The image displays two screenshots of the mhs web application interface, illustrating the steps to create a new authorization.

Top Screenshot: The header shows the mhs logo and navigation tabs: Eligibility, Patients, Authorizations, Claims, Messaging, and Help. A dropdown menu is open on the right, showing a search bar and a "Create Authorization" button, which is highlighted with a red arrow. Below the header, the "Viewing Authorizations For:" section shows a dropdown menu set to "Medicaid" and a green "GO" button. The main content area has tabs for "Authorizations", "Processed", "Errors", and "Disclaimer", with a "Filter" button on the right.

Bottom Screenshot: This screenshot shows the same interface but with the "Create Authorization" button highlighted by a red arrow. Below the header, the "Viewing Authorizations For:" section shows a dropdown menu set to "Medicaid" and a green "GO" button. The main content area has tabs for "Authorizations", "Processed", "Errors", and "Disclaimer", with a "Filter" button on the right. The "Create Authorization" button is highlighted with a red arrow. Below the header, the "Viewing Authorizations For:" section shows a dropdown menu set to "Medicaid" and a green "GO" button. The main content area has tabs for "Authorizations", "Processed", "Errors", and "Disclaimer", with a "Filter" button on the right. The "Create Authorization" button is highlighted with a red arrow.

Creating a New Authorization

- Select a Service Type.

The screenshot shows a web application interface for creating a new authorization. At the top, there is a navigation bar with icons for 'Claims', 'Messaging' (with a red badge showing '53'), and 'Help'. To the right of these icons is a search bar labeled 'Provider Name'. Below the navigation bar is a prominent red button with a white plus icon and the text 'Create Authorization'.

The main content area is titled 'Enter Authorization' and contains three sections: '1. PROVIDER REQUEST', '2. SERVICE LINE', and '3. FINISH UP'. The '1. PROVIDER REQUEST' section is currently active and contains a checkbox for 'Urgent Request'. Below this is a dropdown menu that is open, showing a list of service types. The dropdown is titled 'Vaginal Delivery' and lists the following options: 'Select a Service Type', 'Medical Outpatient', 'Biopharmacy', 'DME', 'Drug Testing', 'Genetic Testing & Counseling', 'Home Health', 'Inpatient Services (S&P)', 'Office Visit', 'Outpatient Services', 'Transport', 'Medical Inpatient', 'C-Section Delivery', 'Medical', 'Premature/False Labor', 'Rehab Inpatient', 'Skilled Nursing', 'Surgical Inpatient', 'Transplant', and 'Vaginal Delivery' (which is highlighted at the bottom).

Adding Information for Authorization

Select Provider NPI.

Add Primary Diagnosis.

The image displays two side-by-side screenshots of a web form titled "Enter Authorization". Both screenshots show the "1. PROVIDER REQUEST" section.

Left Screenshot: This view shows the initial state of the form. A red arrow points to the "Requesting Provider NPI or Last Name" text input field. Other visible fields include "Outpatient Services" (a dropdown menu), "Requesting Provider" (a text input), "Primary Diagnosis" (a text input labeled "Diagnosis Code"), and a "CODE LOOKUP ICD-9 ICD-10" section with a plus icon and the text "Add Additional Diagnosis". A "NEXT >" button is at the bottom.

Right Screenshot: This view shows the form after some data has been entered. A red arrow points to the "CODE LOOKUP ICD-9 ICD-10" section. The "Outpatient Services" dropdown is now set to "Outpatient Services". The "Requesting Provider" field is filled. The "NPI:" field is filled, and the "TIN:" field is also filled. The "Name: SMITH" is displayed. The "Primary Diagnosis" field is now a dropdown menu with a close button (X). The "CODE LOOKUP ICD-9 ICD-10" section remains the same. The "NEXT >" button is at the bottom.


Adding Procedure

Add Additional Procedures (if applicable).

Authorization For

DOB: | MEDICAID NBR:

PROVIDER REQUEST

 Service Type: Outpatient Outpatient Services
SMITH
GENERAL SURGERY
Primary Diagnosis: 5430: HYPERPLASIA OF APPENDIX
Additional Diagnosis: 5379: UNSPEC DISORDER STOMACH&DUODENUM
NPI:
TIN:
Phon:

Enter Authorization

1. PROVIDER REQUEST [EDIT](#)

2. SERVICE LINE

TIN:
Name:
07/14/2015 - 07/24/2015
1
Primary Procedure
44970
LAPAROSCOPY RUSGICAL
APPENEDECTOMY
[CODE LOOKUP](#)
+ Add Additional Procedures
Select a Place Of Service
Ambulatory Surgical Center
Outpatient Hospital
Unspecified
+ Add New Service Line
NEXT >

Creating a New Authorization

Service Line Details:

Enter Authorization

1. PROVIDER REQUEST EDIT

2. SERVICE LINE

Now adding new service line

Service Line 1: 147755-4756 / 44970

Servicing Provider:

☐ Same as Requesting Provider

Brown

Start Date - End Date

Units/Visits/Days

Primary Procedure

Procedure Code

[CODE LOOKUP](#)

Add Additional Procedures

Select a Place Of Service

Attachment:

Upload any relevant attachments. (5Mb limit)

- Provider request will appear on the left side of the screen.
- Update Servicing Provider. Check box if same as Requesting Provider.
- Update Servicing Provider if not the same.
- Update Start Date and End Date.
- Update Total Units, Visits or Days.
- Update Primary Procedure.
- Add any additional procedures.
- Add additional Service Line if applicable: All Service Lines added will appear on the left side of the screen.

Creating a New Authorization

- Submit a new Authorization:
 - **Confirmation number**

The screenshot displays a web interface for creating a new authorization. On the left, a form titled '1. PROVIDER REQUEST' is visible, with sections for '2. SERVICE LINE' and '3. FINISH UP'. The 'FINISH UP' section includes fields for a phone number (123) 456-7890, a fax number (098) 765-4321, and an email address jmuliner@centene.com. Below these fields is a 'Questionnaire' section and an 'Attachment' section with a 'Browse' button and an 'Attach' button. A red 'Remove' button is also present. At the bottom of the form is a large black 'SUBMIT' button, which is highlighted by a pink arrow. On the right, a 'Success!' modal is displayed, listing the following information: 'Your confirmation number is', 'Member's Name', 'Date of Birth', and 'Medicaid Number'. A pink arrow points to the 'Your confirmation number is' field in the modal. The background of the modal shows a sidebar with 'PROVIDER REQUEST' and 'SERVICE LINES' sections, and a top bar with 'Authorization For' and 'Enter Authorization' tabs.

Fax Authorizations

Fax Authorizations

MHS Medical Management Department

Prior Authorization

Fax: 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	

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

← Member ID, DOB, Patient Name required.

← Medical Diagnosis code(s) required.

← Check Service category.

PA Forms can be found on the website

Fax Authorizations- Pertinent Information

Requesting Provider Information	
Requesting Provider NPI/Provider ID	
Taxonomy:	
Taxpayer Identification Number (TIN):	
Provider Name:	
Rendering Provider Information	
Rendering Provider NPI/Provider ID:	
TIN:	
Name:	
Address	
City/State/ZIP Code:	
Phone:	
Fax:	

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

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

Fax Authorization

Fax Authorizations – Procedures

Dates of Service Start Stop		Procedure/ Service Codes	Modifiers		Service Description	Taxonomy	Place of Service (POS)	Units	Dollars

Please complete all fields to ensure the PA request will be processed accurately.

Prior Authorization and Medical Necessity Appeals

Prior Authorization/Medical Necessity Appeals

- Appeals must be initiated within 48 hours of the denial to be considered.
- Members may continue to receive benefits while the appeal is pending but may be liable for the costs if the decision is unfavorable. Determination will be communicated to the provider within 48 hours of the receipt.
- Decisions regarding expedited appeals are made no later than 24 hours.
- Peer-to-Peer (P2P) requests must be within 48 hours of the adverse determination.

Prior Authorization Submission

- Prior Authorization/Medical Necessity Appeals may be submitted to MHS in the following ways:
 - Web: [Secure Provider Portal](#)
 - Call: Medicaid: 1-877-647-4848
Monday - Friday 8:00 a.m. to 5:00 p.m. EST.
 - Email: Appeals@mhsindiana.com
 - Fax: Medicaid: 1-866-714-7993
 - Mail: MHS Grievance & Appeals
P.O. Box 441567
Indianapolis, IN 46244

Prior Authorization Denial and Appeal Process

Prior Authorization Denial and Appeal Process

- **If MHS denies the requested service:**
 - And the member is still receiving services; you have the right to an expedited appeal. The attending physician **must request** the expedited appeal.
 - Or if the member already has been discharged, the attending physician must submit an appeal in writing within 60 calendar days of the denial.
 - The attending physician has the right to a P2P discussion with an MHS physician.
 - Providers initiate P2P discussions and expedited appeals by calling an MHS Appeals Coordinator at 1-877-647-4848.

***PA appeals are also known as medical necessity appeals.**

Peer to Peer

P2P Discussion

- The Indiana MHS Medicaid P2P Schedulers report to Dr. Erwin, Chief Medical Officer.
- You must request P2P within 48 hours of the adverse determination.

***A PA appeal is different than a claim appeal request.**

PA Denial and Appeal Process

- PA and appeals can be completed through our Secure Web Portal: [MHS Secure Portal](#)
- Appeals can also be mailed to:
Authorization/Medical Necessity
Managed Health Service
Attn: Appeals Coordinator
P.O. Box 441567
Indianapolis, IN 46244
- To check status of an Appeal or Grievance email:
Appeal status inquiries should be sent to MHS Indy Appeals: appeals@mhsindiana.com
Grievance status inquiries should be sent to MHS Indy Compliance Outreach:
compliance_outreach_in@centene.com

P2P phone line (855-696-2613), extension 87058 will transfer to the P2P Schedulers.

Behavioral Health PA Updates

Behavioral Health Authorization continued

Facility Services:

- Inpatient Admissions
- Intensive Outpatient Treatment (IOT)
- Outpatient (may be different timeframes depending on codes billed)
- Partial Hospitalization
- Substance Use Disorder (SUD) Residential Treatment

***Authorizations do not guarantee payment.**

Behavioral Health Authorization continued

Professional Services:

- Psychiatric Diagnostic Evaluation
- Behavioral Health Outpatient Therapy (BHOP Therapy)
- Electroconvulsive Therapy
- Psychological Testing (unless for autism, then no authorization is required)
- Developmental testing, with interpretation and report {(non-Early and Periodic Screening, Diagnosis, and Treatment (EPSDT))}
- Neurobehavioral status exam, with interpretation and report
- Neuropsychological testing per hour, face-to-face:
 - Unless for autism, then no authorization is required
- Applied Behavior Analysis (ABA) Services – are approved by units
- Non-participating providers only

Behavioral Health Authorization continued

- Please visit our [Behavioral Health Forms](#) page to access the complete list of forms required for prior authorization submissions:

BH Forms

Inpatient and Residential Treatment for Substance Use Disorder (SUD)

- [Discharge Consultation Documentation \(PDF\)](#)
- [Initial Assessment Form for Substance Use Disorder Treatment Admission](#) 
- [Reassessment Form for Continued Substance Use Disorder Treatment](#) 
- [Residential/Inpatient Substance Use Disorder Treatment Prior Authorization Request Form](#) 

Outpatient Treatment Request (OTR) Form

- [Applied Behavioral Analysis Treatment OTR \(PDF\)](#)
- [IN Medicaid ABA Provider Request Tip Sheet \(PDF\)](#)
- [Intensive Outpatient Day Treatment Form \(PDF\)](#)
- [HHW/HIP Outpatient Treatment Request \(OTR\) Form \(PDF\)](#)

- When submitting a prior authorization request for Behavioral Health Services, ensure all sections are filled out accurately, including service details, provider information, and member details.

Behavioral Health Authorization

When submitting a prior authorization request for Behavioral Health Services, please include the following documents as applicable:

Type of Document	Supporting Documents
Member Treatment Summary (Narrative)	A written summary detailing the member's treatment history and current care plan.
Assessment Findings	Results from clinical evaluations, diagnostic tests, or any behavioral health assessments.
Prescribed Medications	Include a list of current medications along with dosages and duration of use.
Psychotherapy Documentation	Specify prescribed therapy, goals, objectives, and the member's individualized care plan.
Diagnoses	Clearly document all relevant behavioral health and physical diagnoses.
Treatment Plan	Include measurable goals, timelines, and strategies to address the member's specific needs.
Supporting Medical Records	Relevant clinical notes, progress reports, or prior treatment outcomes.
Service Request Details	Provide details regarding requested services (e.g., frequency, duration, and intensity).
Additional Documentation	Any other pertinent information or supporting materials that may assist in the authorization process.

Fax Request

Fax Request

All **BH Forms** can be obtain for the following treatments:

- Outpatient Treatment Request (OTR)
- Intensive Outpatient/Day Treatment Form
- Mental Health Chemical Dependency
- Applied Behavioral Analysis Treatment Psychological & Neuropsych Testing Authorization Request Form

Outpatient Treatment Request (OTR) Form




- [Applied Behavioral Analysis Treatment OTR \(PDF\)](#)
 - [IN Medicaid ABA Provider Request Tip Sheet \(PDF\)](#)
 - [Intensive Outpatient Day Treatment Form \(PDF\)](#)
 - [HHW/HIP Outpatient Treatment Request \(OTR\) Form \(PDF\)](#)
- Fax completed forms to **1-866-694-3649**.

BH Forms

All **BH Forms** can be obtain for the following treatments:

- Residential/Inpatient Substance Use Disorder (SUD) Treatment Prior Authorization Form:

Inpatient and Residential Treatment for Substance Use Disorder (SUD)

- [Discharge Consultation Documentation \(PDF\)](#)
 - [Initial Assessment Form for Substance Use Disorder Treatment Admission](#) 
 - [Reassessment Form for Continued Substance Use Disorder Treatment](#) 
 - [Residential/Inpatient Substance Use Disorder Treatment Prior Authorization Request Form](#) 
-
- Fax Inpatient: **1-844-288-2591**
 - Fax Outpatient: **1-866-694-3649**

Pertinent Information

Pertinent Information (IOT)

When requesting Intensive Outpatient Treatment, please follow the chart below:

(IOT) Rendered In a Facility	(IOT) Rendered In Professional Setting
<p>Facility providers that bill institutional claims (<i>UB-04</i> claim form or the electronic equivalent) must submit PA with one of the following revenue codes based on the type of service rendered:</p> <ul style="list-style-type: none">✓ 905 – Psychiatric-Behavioral Health Treatments/Services-Intensive Outpatient Services✓ 906 – Chemical Dependency-Behavioral Health Treatments/Services-Intensive Outpatient Services✓ No procedure codes to be submitted with revenue codes	<p>Professional providers that bill claims (<i>CMS-1500</i> claim form or the electronic equivalent) must submit PA with one of the following procedure codes, based on the type of service rendered:</p> <ul style="list-style-type: none">✓ S9480 - Psychiatric IOT✓ H0015 - Drug & Alcohol IOT✓ No revenue codes to be submitted with procedure codes

Pertinent Information (SUD)

When completing the “Rendering Provider Information” section of the authorization form, ensure the following:

- ✓ Enter the IHCP/MHS-enrolled **SUD facility NPI** in the Requesting and Rendering Provider NPI field.

Requesting Provider Information	
Requesting Provider NPI/Provider ID:	
Taxonomy:	
Taxpayer Identification Number (TIN):	
Provider Name:	
Provider Address:	
Rendering Provider Information	
Rendering Provider NPI/Provider ID:	
TIN:	
Name:	
Address:	
City/State/ZIP Code:	
Phone:	
Fax:	

Pertinent Information Previously Approved PA

- Previously approved PA's can be updated within 30 calendar days of the original request submission to accommodate changes such as:
 - Practitioner Information
 - Dates of Service (DOS)
- **Exceptions:**
 - Updates are not permitted if the new DOS overlaps with a previous adverse determination, such as a denial or partial approval.
 - Updates cannot include retroactive days (i.e., dates more than one business day prior to the initial request submission).
- **Important:**
 - All updates or corrections to PAs must be requested before any related claims are denied. Timely submissions ensure continuity of care and accurate claims processing.

Pertinent Information Limitations on Outpatient Mental Health Services

MHS adheres to the, IHCP Mental Health and Addiction Limitation Policy which imposes the following restrictions:

- A maximum of 20 BHOP units per member, per practitioner, per calendar year applies to the specified CPT codes.
- This policy reflects a change from the previous rolling 12-month period.

Important Guidelines:

- Do not submit authorization requests that extend beyond December 31 of the current calendar year.
- HHW Package C members are allowed up to 30 BHOP units per calendar year under this policy.

Providers are encouraged to carefully monitor utilization to ensure compliance with these limitations.

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



This is not a concussive list

Benefit Limitations Denials

Claims exceeding the benefit limit will deny as:

- Maximum Benefit Reached, claim denial code EX Mb:

If the member requires additional services beyond the 20-unit limitation, providers may request prior authorization for additional units.

Approval will be given based on the necessity of the services as determined by the review of medical records.

Providers will need to determine if they have provided 20 units to the member in the calendar year to determine if a prior authorization request is needed.

“Per Provider” is defined by MHS as per individual rendering practitioner NPI being billed on the *CMS-1500* claim form (Box 24J).

BH Prior Authorization Denials

Prior Authorization Denials continued

Example denial letter with denial reason:

RE: Member Name:

DOB:

Medicaid ID #:

Attn: , MD c/c Hospital Inc., Fax

Dear ,

Managed Health Services (MHS) is your partner in health through Hoosier Healthwise, the Healthy Indiana Plan (HIP) or Hoosier Care Connect. Your doctor has asked MHS to approve Inpatient Psychiatric Hospitalization (twenty-four (24) hour help in a hospital) for dates of service through discharge requested on . After we reviewed the information that your doctor sent about your need for Inpatient Psychiatric Hospitalization, we have denied that request.

We reviewed the information received against InterQual 2024, Behavioral Health, Adult and Geriatric Psychiatry, Inpatient. The request was reviewed and denied because Medical necessity criteria is not met for the requested service dates because the information given to us shows that you no longer have problems that need twenty-four (24) hour hospital care. Your mood is better. You do not have thoughts or plans to harm yourself or others. You do not hear voices telling you to harm yourself or others. You are taking your medicine. You do not need emergency medication. You are taking better care of yourself. You can get support from family, friends, or your community. You can continue treatment outside the hospital. You do not need this level of care for safe and effective treatment. The last covered day is . Dates forward are denied. Outpatient (a place to get help in the community) services with case management (help to find services) or other increased supports, might be helpful.

This decision has been made by Adam Bowman, MD, our Medical Director, who is a licensed and actively practicing Board Certified Psychiatrist.

BH Prior Authorization Appeals

Prior Authorization Appeals Contact

- Prior Authorization/BH Appeals may be submitted to MHS in the following ways:

Web: [Secure Provider Portal](#)

Email: Appeals@mhsindiana.com

Call: Medicaid: 1-877-647-4848

Fax: Medicaid: 1-866-714-7991

Mail: MHS Appeals
 P.O. Box 10378
 Van Nuys, CA 914-10-0378

MHS Network Team



MHS Resources

- For additional information, please contact your MHS Provider Engagement Account Manager to schedule an appointment today
- Additional resources available at on the [MHS Website](#)
- Register online for additional [Monthly Web Sessions](#)

PEAM Contact Information

NORTHEAST REGION

For claims issues, email:
MHS_ProviderRelations_NE@mhsindiana.com
joy.k.diarra@mhsindiana.com
Joy Diarra, Provider Engagement Account Manager
1-317-864-2378

NORTHWEST REGION

For claims issues, email:
MHS_ProviderRelations_NW@mhsindiana.com
Candace.V.Ervin@mhsindiana.com
Candace Ervin, Provider Engagement Account Manager
1-317-364-7635

NORTH CENTRAL REGION

For claims issues, email:
MHS_ProviderRelations_NC@mhsindiana.com
Natalie.Smith@mhsindiana.com
Natalie Smith, Provider Engagement Account Manager
1-317-379-9035

CENTRAL REGION

For claims issues, email:
MHS_ProviderRelations_C@mhsindiana.com
ldavis@mhsindiana.com
Latisha Davis, Provider Engagement Account Manager
1-317-601-5999

SOUTH CENTRAL REGION

For claims issues, email:
MHS_ProviderRelations_SC@mhsindiana.com
DDENNING@mhsindiana.com
Dalesia Denning, Provider Engagement Account Manager
1-317-951-3800

SOUTHWEST REGION

For claims issues, email:
MHS_ProviderRelations_SW@mhsindiana.com
Dawnalee.A.McCarty@mhsindiana.com
Dawn McCarty, Provider Engagement Account Manager
1-317-556-6171

SOUTHEAST REGION

For claims issues, email:
MHS_ProviderRelations_SE@mhsindiana.com
tiffany.calloway@centene.com
Tiffany Calloway,
Provider Engagement Account Manager
1-812-697-8126

PEAM Manager Map Color Key



Large Provider Groups - Carolyn

CAROLYN VALACHOVIC MONROE

Provider Engagement Account Manager

1-317-443-8243

CMONROE@mhsindiana.com

PROVIDER GROUPS

Eskenazi/The Health and Hospital
Corp.

Baptist Health

Lifespring

Wellcare

Deaconess (including Little Company
of Mary)

Good Samaritan

Norton (including King's Daughters,
Clark & Scott Memorial)

Indiana University Health

Reid Hospital

St. Elizabeth Hospital

Community Health

Large Provider Groups – Mona

MONA GREEN

Provider Engagement Account Manager

1-812-614-1003

mona.green@mhsindiana.com

PROVIDER GROUPS

St. Vincent/Ascension

Wellcare Complete

Lutheran Medical Group

Parkview Health System

Beacon Medical Group

American Senior Care

CarDon & Associates

OrthoIndy

Heart City Health

ONE

Franciscan Health

Behavioral Health Provider Contact

ANGEL JOHNSON

Provider Engagement Account Manager

1-317-468-5184

angel.johnson3@centene.com

PROVIDER GROUPS

Park Center

Otis Bowen

Centerstone

Valley Oaks Health

Grant-Blackford

Four County

Hamilton Center

Community Mental Health
Center (Lawrenceburg)

Oaklawn

Northeastern Center

Edgewater Health

Regional Mental Health

Swanson Center

Porter-Starke Services

Southwestern Behavioral
Community Mental Health
Center (Vevay/Batesville)

Additional Contact Information

MHS Provider Network

NETWORK LEADERSHIP

JILL CLAYPOOL
Senior Vice President, Network Development & Contracting
1-877-647-4848
Jill.E.Claypool@mhsindiana.com

MARK VONDERHEIT
Senior Director, Provider Network
1-877-647-4848
MVONDERHEIT@mhsindiana.com

JENNIFER GARNER
Manager, Provider Relations
1-317-771-5537
jgarner@mhsindiana.com

NETWORK OPERATIONS

KELVIN ORR
Director, Network Operations
1-877-647-4848
Kelvin.D.Orr@mhsindiana.Com

NEW PROVIDER CONTRACTING

TIM BALKO
Director, Network Development & Contracting
1-877-647-4848
TBALKO@mhsindiana.com

MICHAEL FUNK
Manager, Network Development & Contracting
1-877-647-4848
Michael.L.Funk@mhsindiana.com

CENTENE VISION

SIERRA HICKS
sierra.hicks@centene.com
Vision Provider Services: 1-844-820-6523

CENTENE DENTAL

THOMAS "TONY" SMITH
thomas.smith3@centene.com
Dental Provider Services: 1-855-609-5157

Thank You for Attending!

By taking a few moments to complete the event and sessions evaluations, you'll help us understand your experience and shape the future of our programs.



Questions?

Thank you for being our partner in care.
