Claims UB-04

2023 Annual IHCP Works Seminar

Presenter: Dalesia Denning, Provider Engagement Advisor

Agenda

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

MHS Overview

Who is MHS?

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

- MHS is your choice for better healthcare.

MHS Products

Claim Submission Process

Medical Claim Submission

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

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

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

- **Paper Claims:**

  Managed Health Services
  P.O. Box 3002
  Farmington, MO 63640-3802

Behavioral Health Claim Submission

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

- Online through the **MHS Secure Provider Portal** at https://www.mhsindiana.com/providers.html
- Provides immediate confirmation of received claims and acceptance
  - Institutional and Professional
  - Batch Claims
  - Claim Adjustments/Corrections
  - Claim review/Adjustments request

- **Paper Claims:**

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

Claim Billing with Ease

- The NPI, Tax ID, Zip +4 is necessary for the system to make a one-to-one match based on the information provided on the claim and the information on file with Indiana Medicaid.
- Member Information:
  - Newborn's Member ID (MID) is required for payment
- Attachment Forms:
  - Required forms need to accompany the claim form
- Secondary Claims (TPL):
  - Accepted electronically from vendors or via the MHS Secure Provider Portal

Claim Submission

- In-Network providers: 90 calendar days from the date of service or discharge date. Out-of-Network providers: 180 calendar days from the date of service or discharge date.

Exceptions:

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

Claim Submission

Claim Acceptance and Adjudication

- System reviews claim for errors and critical fields (i.e., dates of service, billing/rendering provider, etc.) prior to acceptance.

- Regulatory requirements (federal and state) mandate certain information to be present in order to accept and pay a claim.

- National Provider Identifier (NPI) common rejection/denial; provider information on claim must match record at IHCP enrollment – a State requirement.

Paper Claim Correction

- A corrected claim can be submitted following IHCP claim adjustment processes.
- A claim adjustment code is required on all claims, based on the type of claim submitted.
  - Example: Frequency 7 entered in Box 22 of the CMS-1500 form.
- The original claim number must also be listed on the corrected claim.
  - Box 22 on the CMS-1500
- A rejection, must be submitted as 1st time claim, not as a corrected claim.
- Handwriting or stamping on a claim will not be accepted as submission of a corrected claim, and will be rejected with code RE.

Transportation Claims

- Managed Health Services (MHS) will process all Medicaid emergent and non-emergent ambulance claims, including air ambulance, which would have previously been processed by LCP Transportation.
- Claims for the following services should be sent to MHS:
  - 911 Transports
  - Medically necessary non-emergent hospital transports requiring an ambulance with advanced life support (ALS) or basic life support (BLS)
  - Air ambulance
- Only providers enrolled with the Indiana Health Coverage Programs (IHCP) are eligible for reimbursement. Claims must be filed within 180 days of the Date of Service (DOS) for non-contracted providers and within 90 days of DOS for contracted providers.
- Claims should be submitted to MHS via a CMS-1500 professional claim form. Claims may be submitted via EDI (preferred), MHS web portal or paper.

Transportation Claims

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

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

- **Claim Inquiries**:
  - Check status online via the MHS Secure Web Portal
  - Call Provider Services at 1-877-647-4848

Claim Rejections

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

Claims Rejections

- EDI rejections require the provider to contact their clearinghouse and obtain a payer rejection report.

- Paper to electronic mapping is available on: https://www.mhsindiana.com/providers/resources/guides-and-manuals.html

- MHS website tools :
  - Reject code listing
  - Refer to Top 10 Rejection Code Help Aid Document https://www.mhsindiana.com/content/dam/centene/mhsindiana/medicaid/pdfs/508-Top-10-Rejections-Edu-Doc.pdf

Reason for Claim Rejections

Medical

07 Invalid Subscriber/Member ID

09 Member Invalid on Date of Service

01 Invalid Provider ID Billing Physician (Provider State Crosswalk File)

08 Invalid Member Date of Birth

76 Original claim number required

40 Diagnosis code is missing

90 Invalid or Missing Modifier

B5 Missing/incomplete/Invalid CLIA

77 Invalid Claim Type

A3 Claim exceeded the maximum 97 service line limit

Behavioral Health

09 Member Invalid on Date of Service

07 Invalid Subscriber/Member ID

08 Invalid Member Date of Birth

01 Invalid Provider ID Billing Physician (Provider State Crosswalk File)

76 Original claim number required

40 Diagnosis code is missing

31 Invalid Service Procedure code

A3 Claim exceeded the maximum 97 service line limit

MHS Provider Claims Issue Resolution Process

Provider Claims Issue Resolution

PROCESS

- Level 1: Informal Claims Dispute Online or with Medical Claim Dispute/Appeal form
- Level 2: Formal Claim Dispute –Administrative Claim Appeal Online or with Medical Claim Dispute/Appeal form
- Level 3: Arbitration

Please note, this is different than an Authorization appeal. A claim appeal cannot change a denied authorization status. To change authorization status, you must appeal the denied authorization.

Claim Dispute/Appeal Form – Medical and Behavioral Health

Medical Claims Address:

Managed Health Services

PO Box 3000

Attn: Appeals Department

Farmington, MO 63640-3800

Behavioral Health Claims Address:

Managed Health Services BH

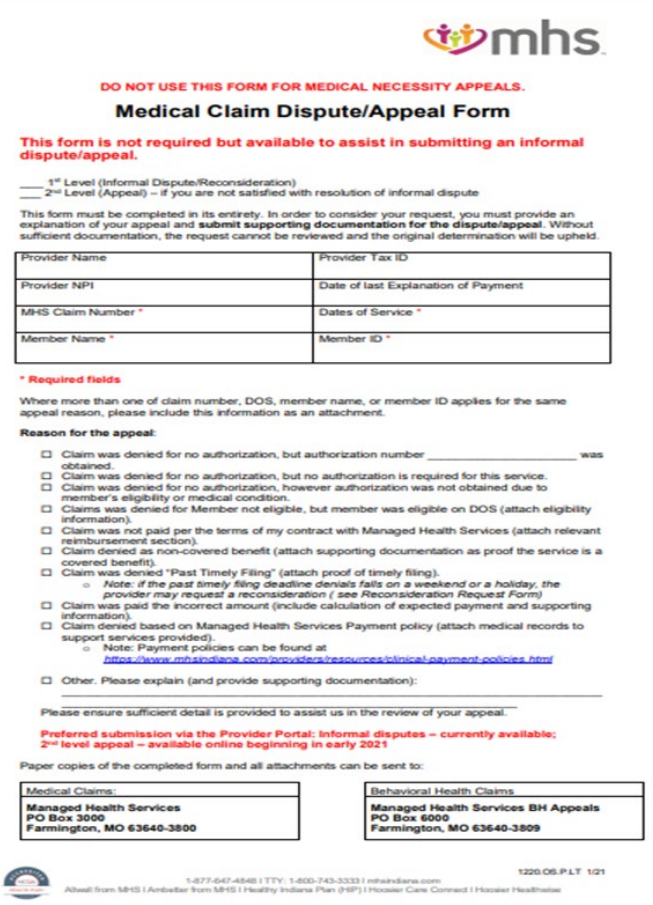
Appeals

P.O. Box 6000

Attn: Appeals Department

Farmington, MO 63640-3809

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



mhs

DO NOT USE THIS FORM FOR MEDICAL NECESSITY APPEALS.

Medical Claim Dispute/Appeal Form

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

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

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

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

* **Required fields**

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

Reason for the appeal:

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

_____

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

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

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

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

1220.05.P.LT 1/21

1-877-647-4648 | TTY: 1-800-743-3333 | mhsindiana.com
Allwell from MHS | Ambetter from MHS | Healthy Indiana Plan (HIP) | Hoosier Care Connect | Hoosier Healthwise

Informal Claims Dispute or Objection Form

Level 1:

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

Informal Claims Dispute or Objection Form

Level 1:

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

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

Informal Claims Dispute or Objection Form

Level 1: Helpful Tips

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

Provider Services Phone Requests & Web Portal Inquiries

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

- Phone: 1-877-647-4848; Provider Services 8 a.m. to 8 p.m.

- Provider Web Portal: https://www.mhsindiana.com/providers/login.html
- Use the Messaging Tool.

Provider Services Phone Requests & Web Portal Inquiries

Helpful Tips:

Disputing multiple claim denials:

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

Formal Claim Dispute - Administrative Claim Appeal

Level 2:

- Level 2 is a Formal Claim Dispute, Administrative Claim Appeal.
- In the event the provider is not satisfied with the informal claim dispute/objection resolution, the provider may file an administrative claim appeal. The appeal must be filed within 60 calendar days from receipt of the informal dispute resolution notice.
- An administrative claim appeal must be submitted via the Secure Portal or in writing by using the Medical Claim Dispute/Appeal form with an explanation including any specific details which may justify reconsideration of the disputed claim. The appeal clearly marked on the form as Level 2.
- See the MHS Provider Manual Chapter 5 Claims Administrative Reviews and Appeals for more information.
- MHS - Provider Manual 2023 (mhsindiana.com)

Arbitration

Level 3:

- Level 3 is a part of the formal MHS Provider Claims dispute process.
- In the event a provider is not satisfied with the outcome of the administrative claim appeal process (Level 2), the provider may request arbitration. Claims with similar issues from the same provider may be grouped together for the purpose of requesting arbitration.
- To initiate arbitration, the provider should submit a written request to MHS on company letterhead. The request must be postmarked no later than 60 calendar days after the date the provider received MHS' decision on the administrative claim appeal.

  Arbitration Requests need to be mailed to:

  MHS Arbitration

  550 N. Meridian Street, Suite 101

  Indianapolis, IN 46204

- See the MHS Provider Manual Chapter 5 Claims Administrative Reviews and Appeals for more information.

https://www.mhsindiana.com/content/dam/centene/mhsindiana/medicaid/pdfs/508-Provider-Manual-2021.pdf

Additional Claim Assistance

Provider Relations Regional Mailboxes

- If all claim denials are upheld after following the dispute processes and the provider has not received resolution by calling Provider Services or utilizing the secure messaging on the portal, please contact the Provider Relations team through the claim issues mailbox assigned to your region.
- Issues will be logged by the internal Provider Relations team and providers will receive a response email with next steps and any assigned reference numbers.
- Please do not email your Provider Partnership Associate directly as this may delay the time in getting a response due to their travel.

Provider Relations Regional Mailboxes

Helpful Tips:

Please submit the following information to the provider relations regional mailbox (attach spreadsheet if multiple claims but below fields must be included)

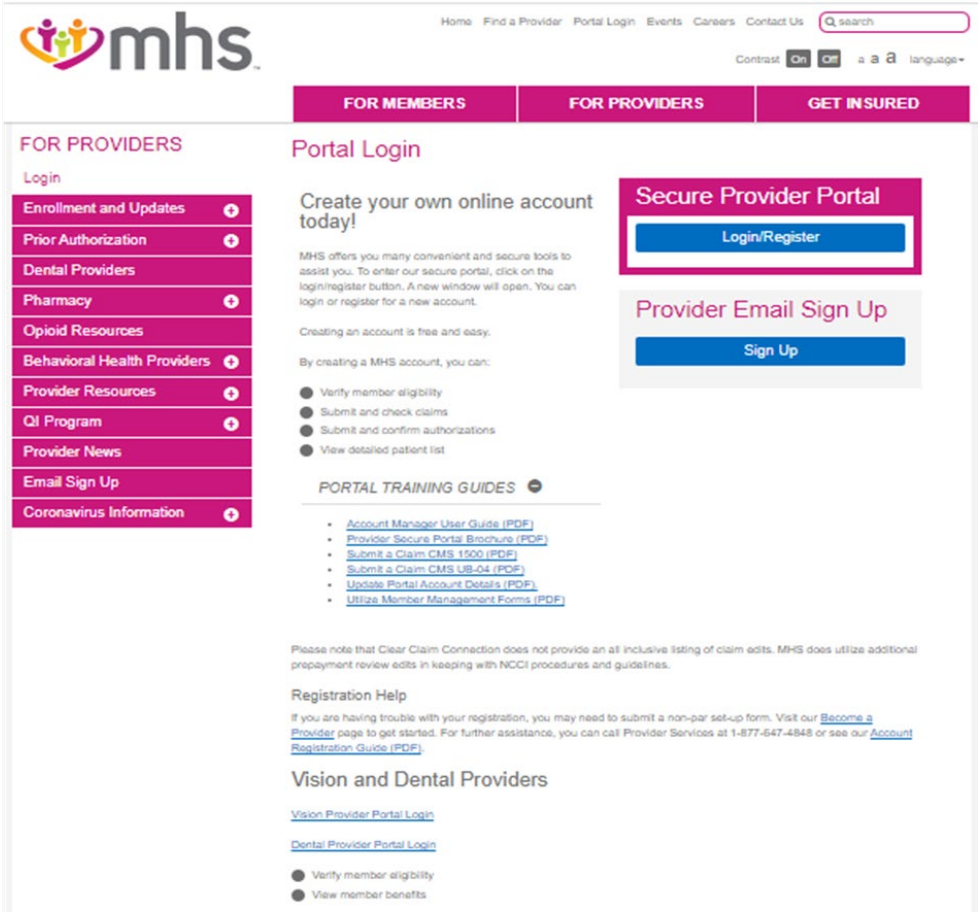
- Issue Reference Number(s)
- TIN
- Group/Facility Name
- Practitioner Name and NPI
- Member Name and MID Number
- Product (Medicaid/Ambetter/Allwell)
- Claim Number(s)
- DOS or DOS Range if multiple denials
- Related Prior Authorization Numbers (this is key if issue involves claims denied for no authorization)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

Provider Relations Regional Mailboxes

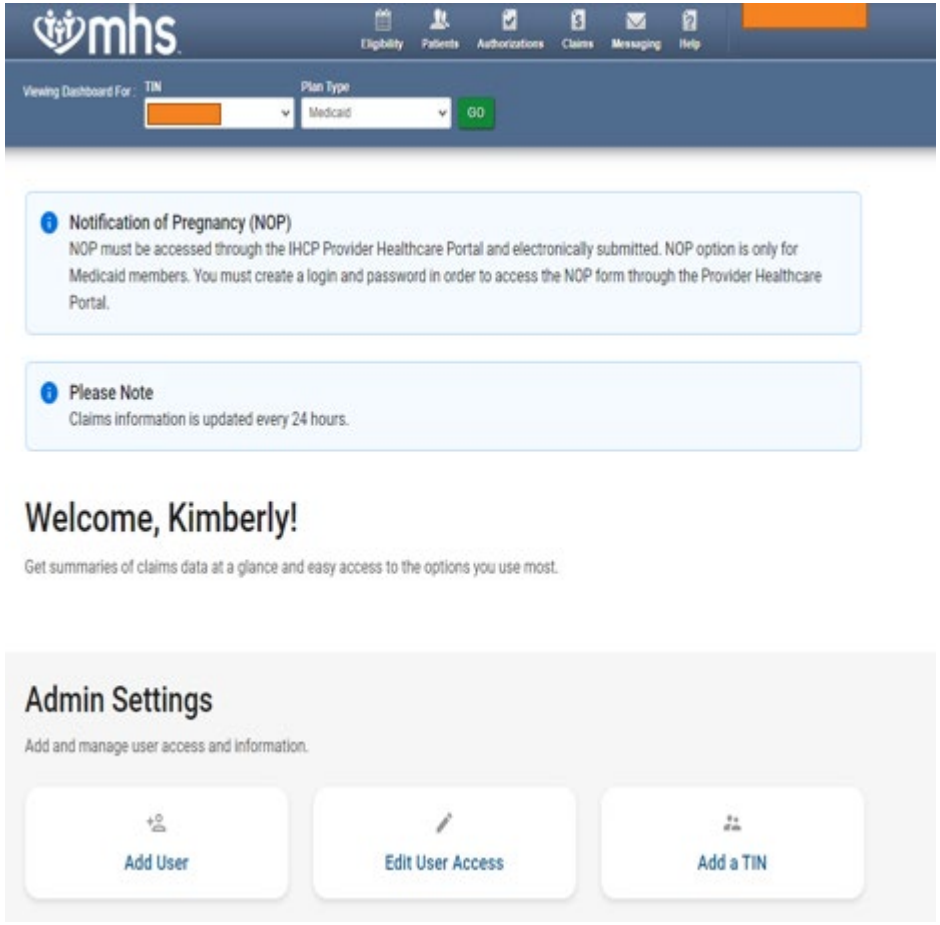
- Regional Mailboxes
  - Northeast Region: MHS_ProviderRelations_NE@mhsindiana.com
  - North Central Region: MHS_ProviderRelations_NC@mhsindiana.com
  - Central Region: MHS_ProviderRelations_C@mhsindiana.com
  - Northwest Region: MHS_ProviderRelations_NW@mhsindiana.com
  - Southwest Region: MHS_ProviderRelations_SW@mhsindiana.com
  - Southeast Region: MHS_ProviderRelations_SE@mhsindiana.com
  - South Central Region: MHS_ProviderRelations_SC@mhsindiana.com
  - Tier 1 Providers: IndyProvRelations@mhsindiana.com

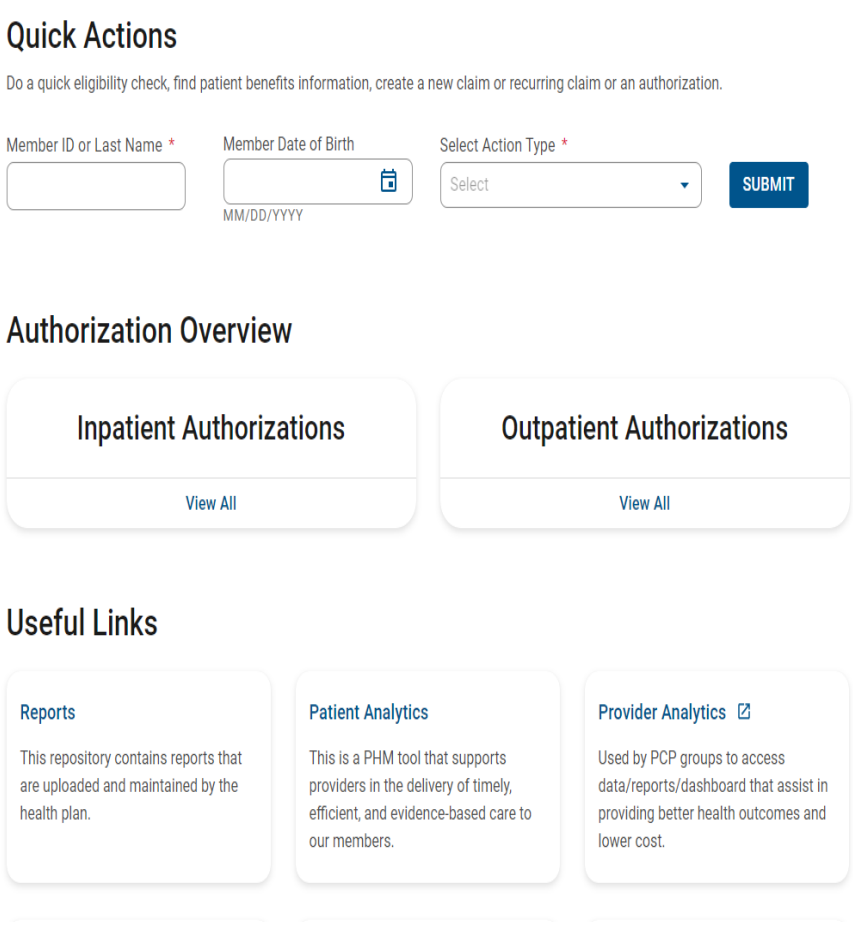
Portal Functionality

Secure Web Portal Login or Registration



Homepage-MHS (Medicaid)





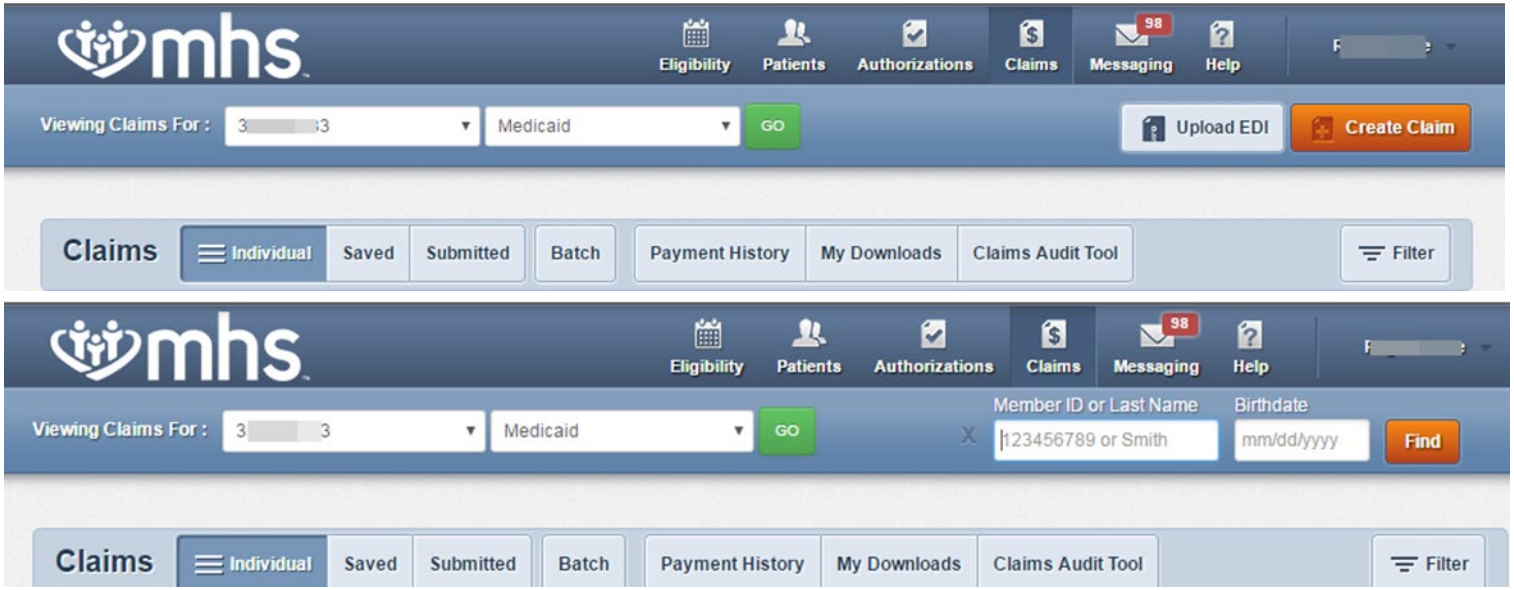
Claims

Web Portal Claims Functionalities:

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

Submit a New Claim:

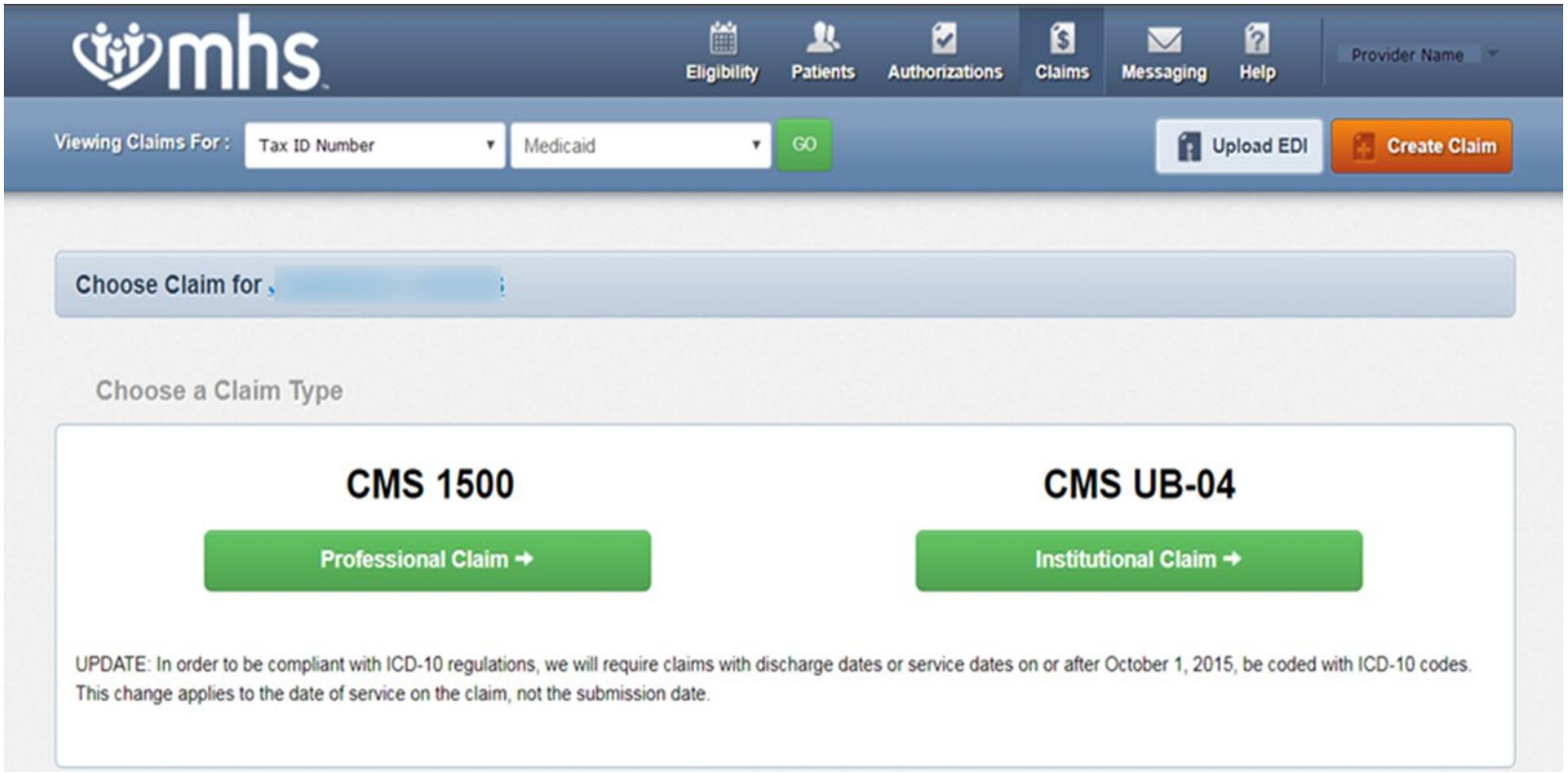
- Click **Create Claim** and enter **Member ID** and **Birthdate**



Claim Submission

Choose the Claim Type

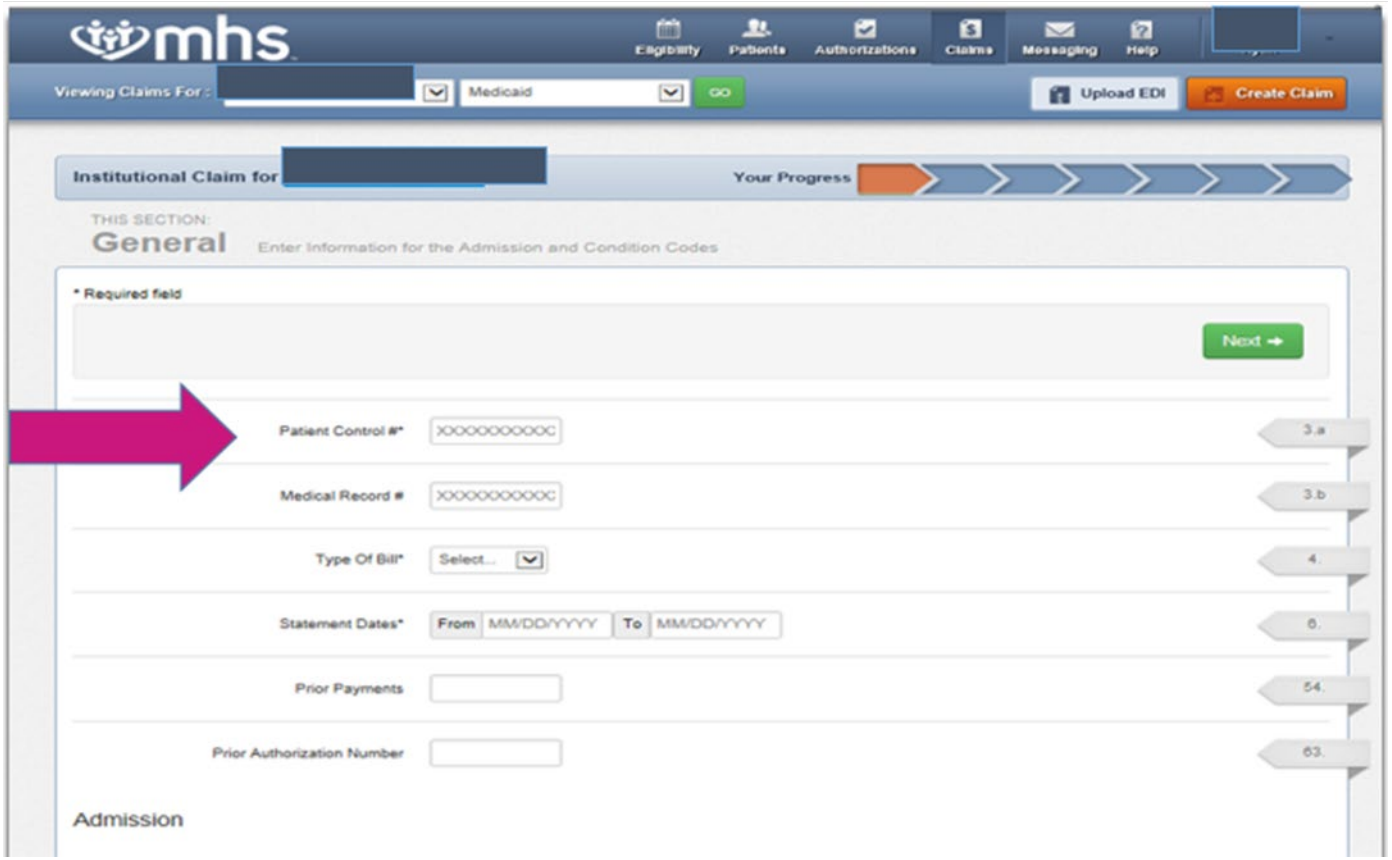
- Professional or Institutional claim submission



Facility Billing

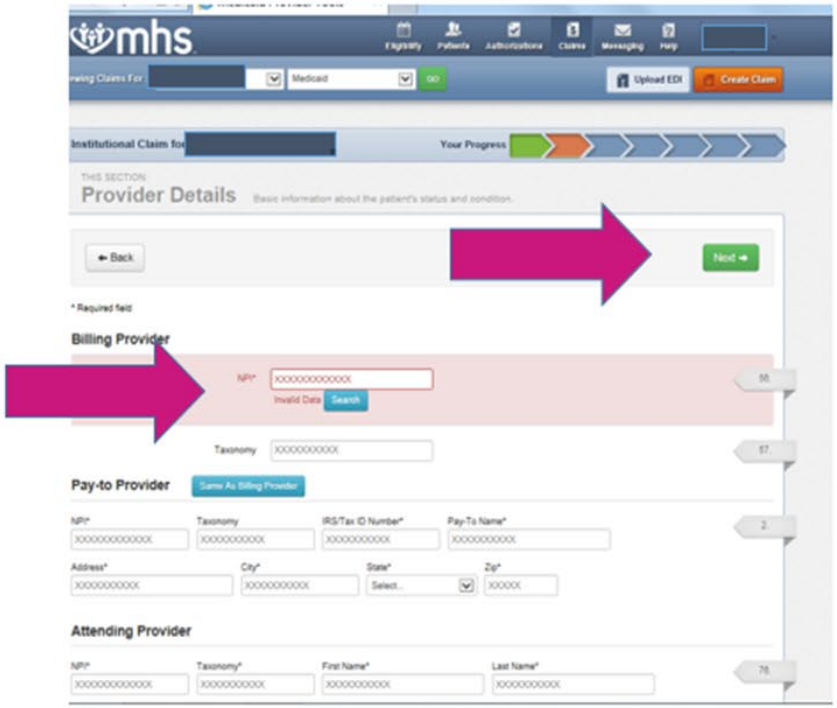
UB-04 Billing

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

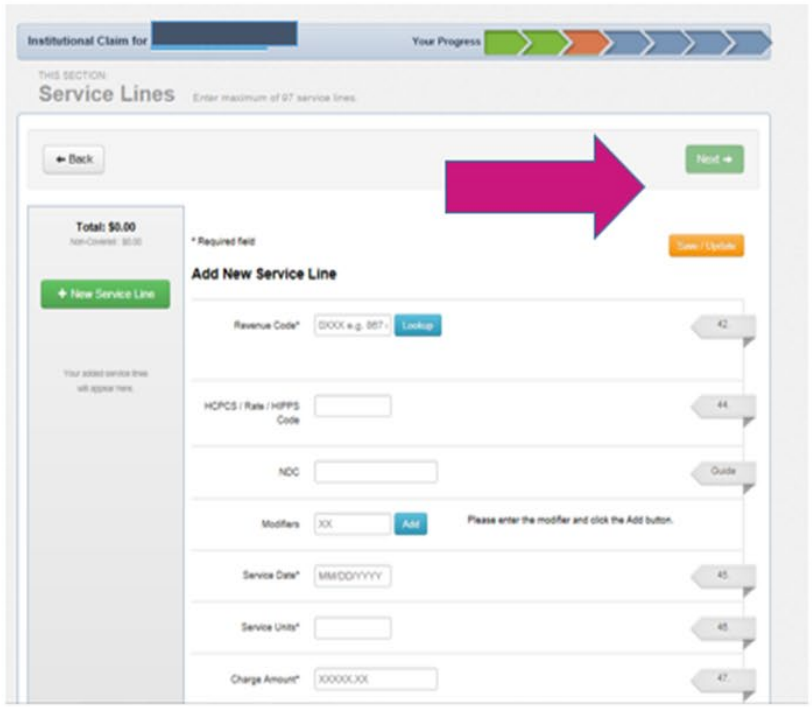


UB-04 Billing

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

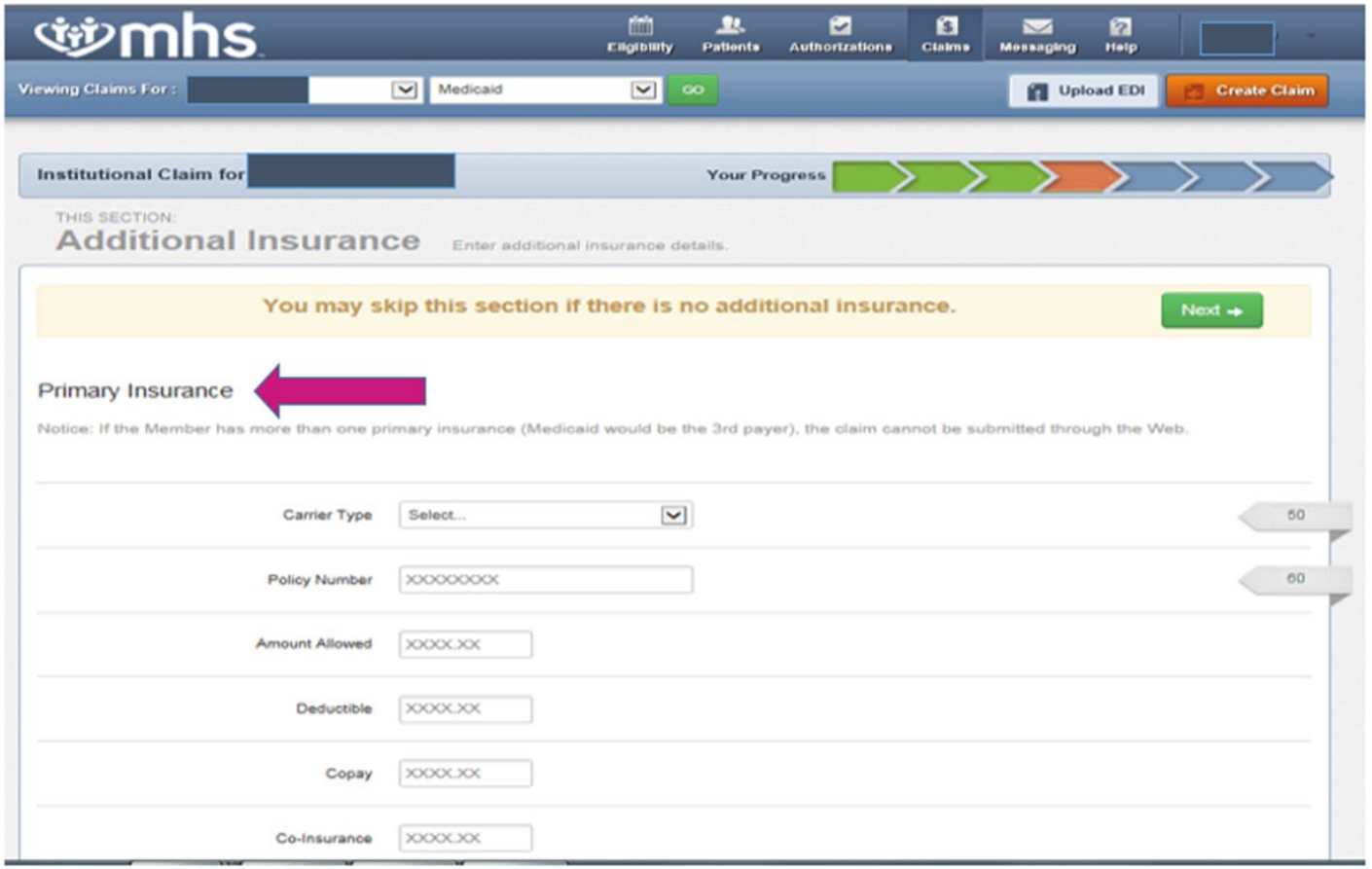


Click **Add New Service Line** and enter the service lines information.

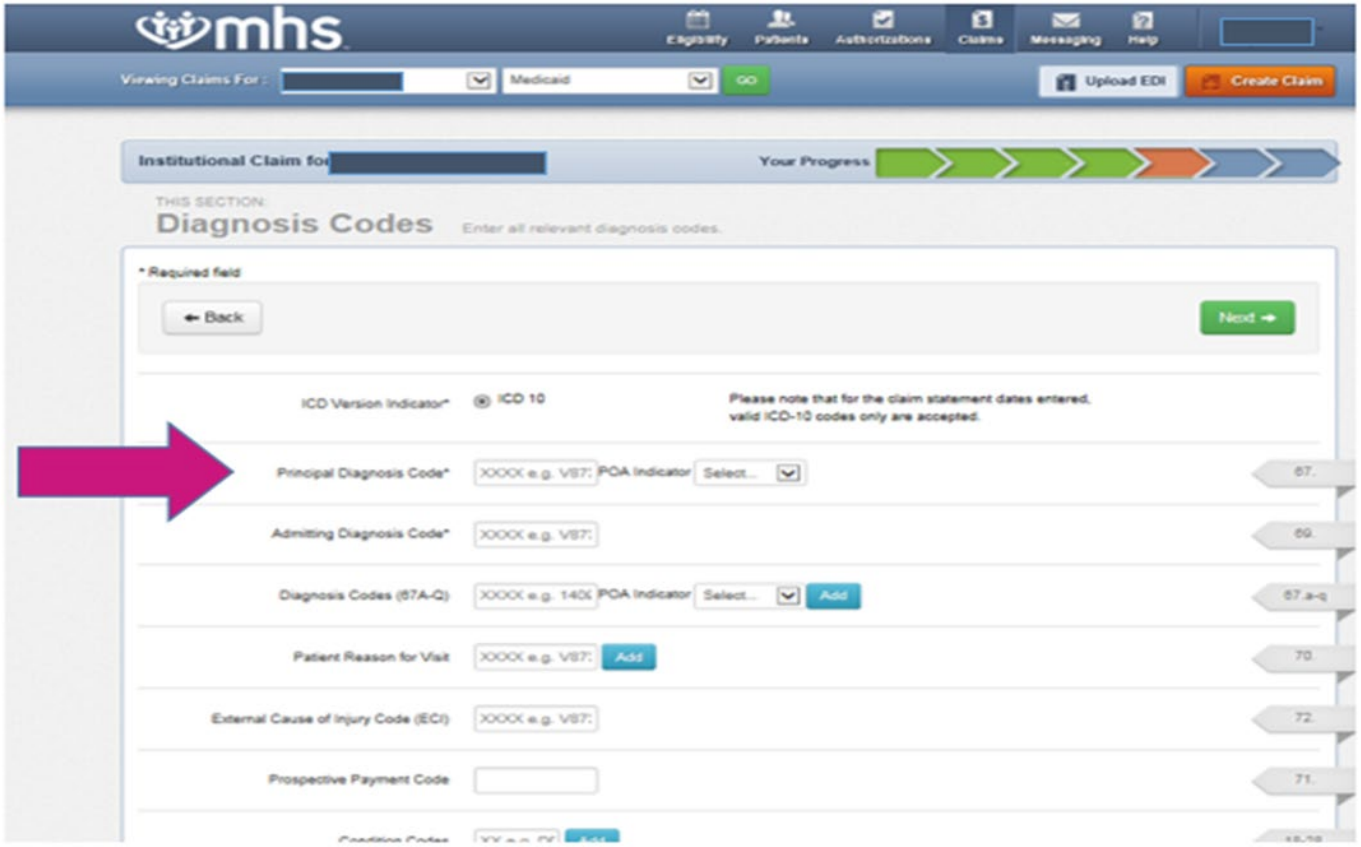


UB-04 Billing

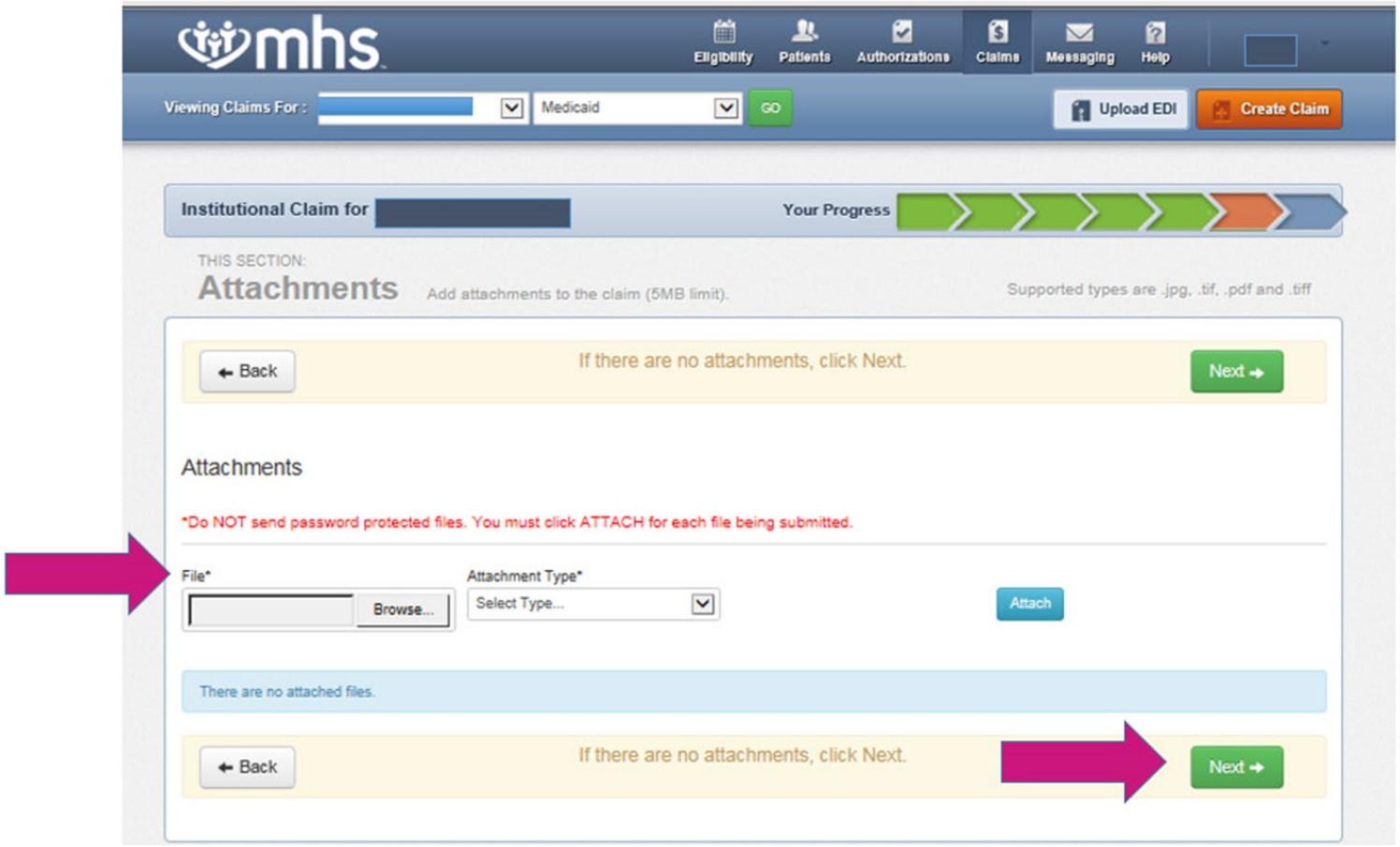
- Enter Additional Insurance (if applicable)



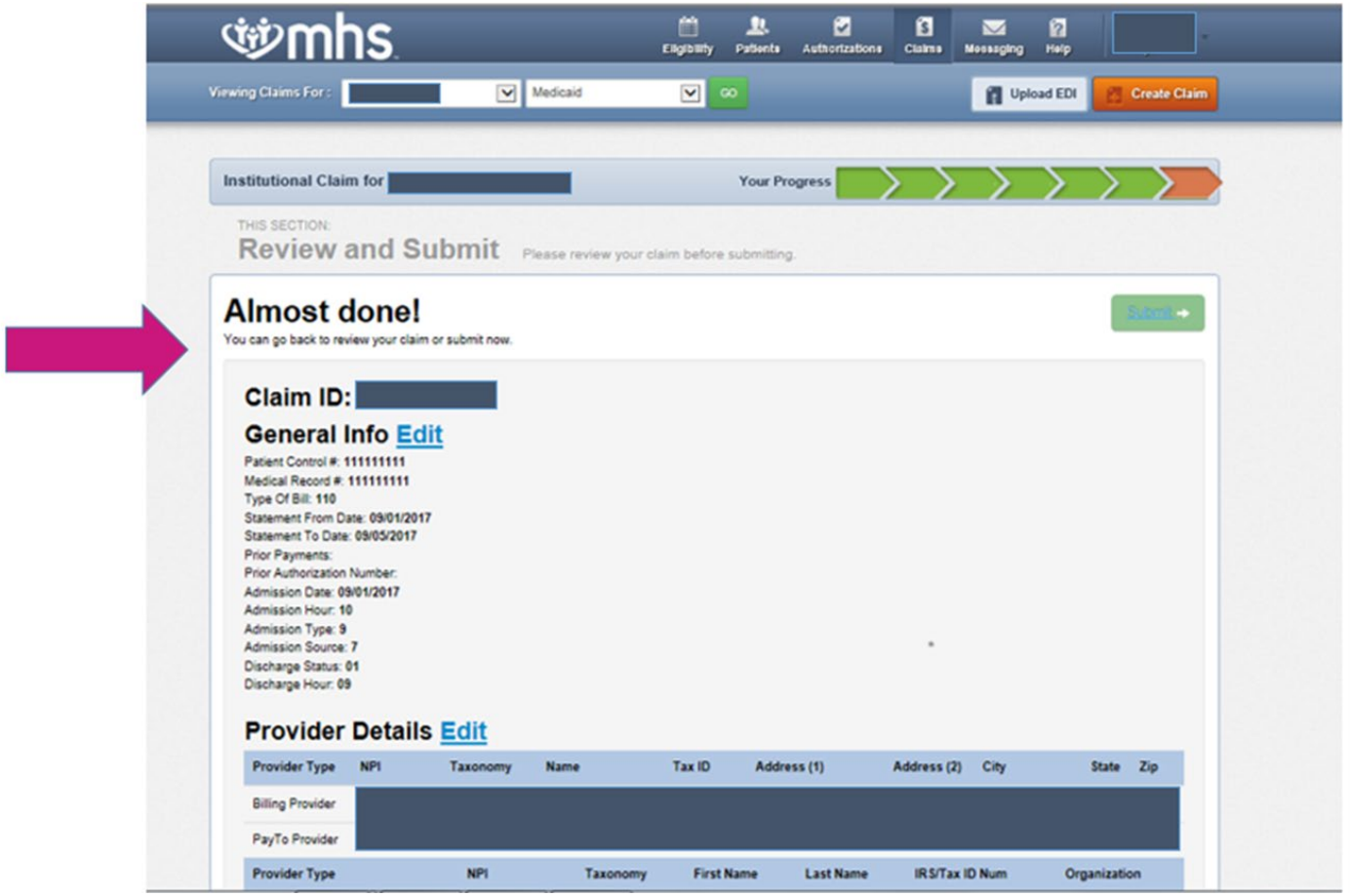
Enter Diagnosis Codes (use Add button)



Add Attachment(if applicable)



Review Claim and Submit

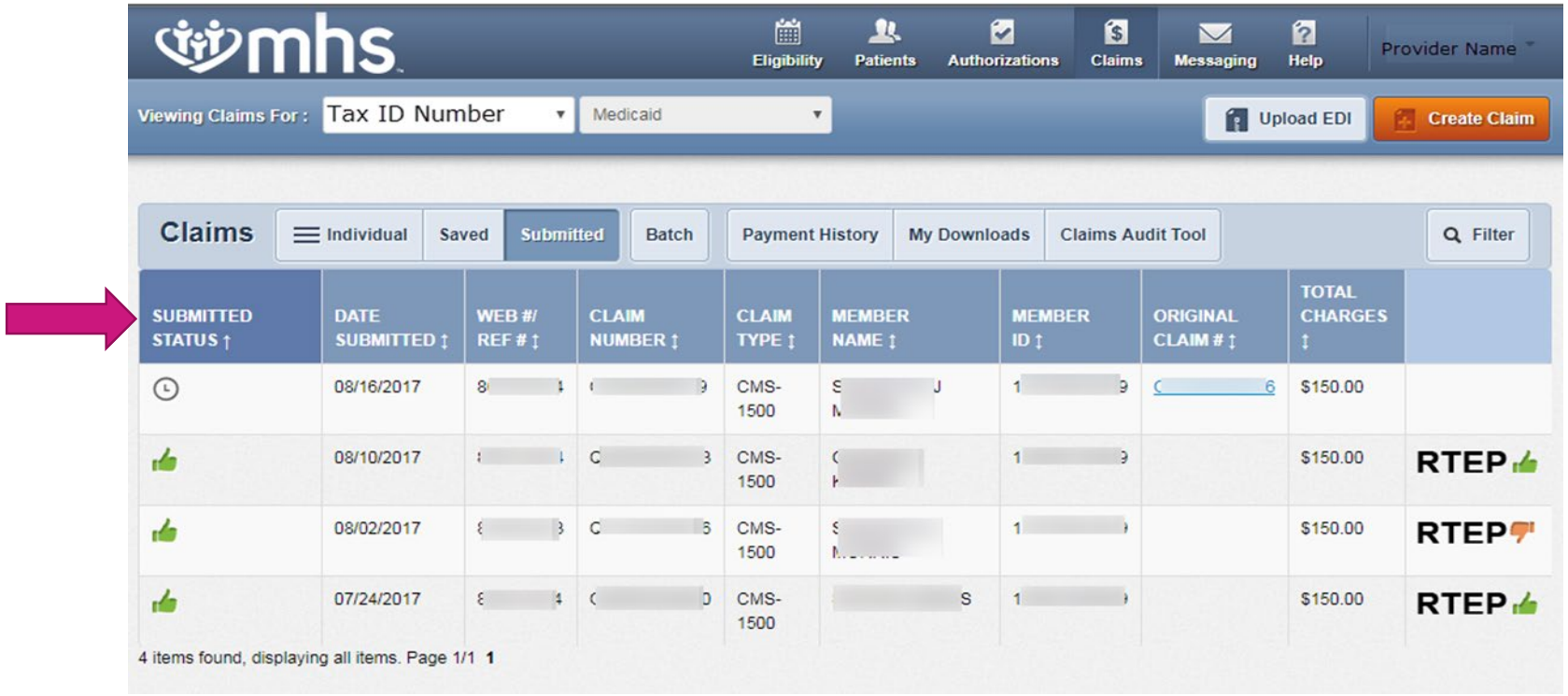


Web Portal Claim and Payment Review

Submitted Claims

The Submitted tab will only display claims created via the MHS portal:

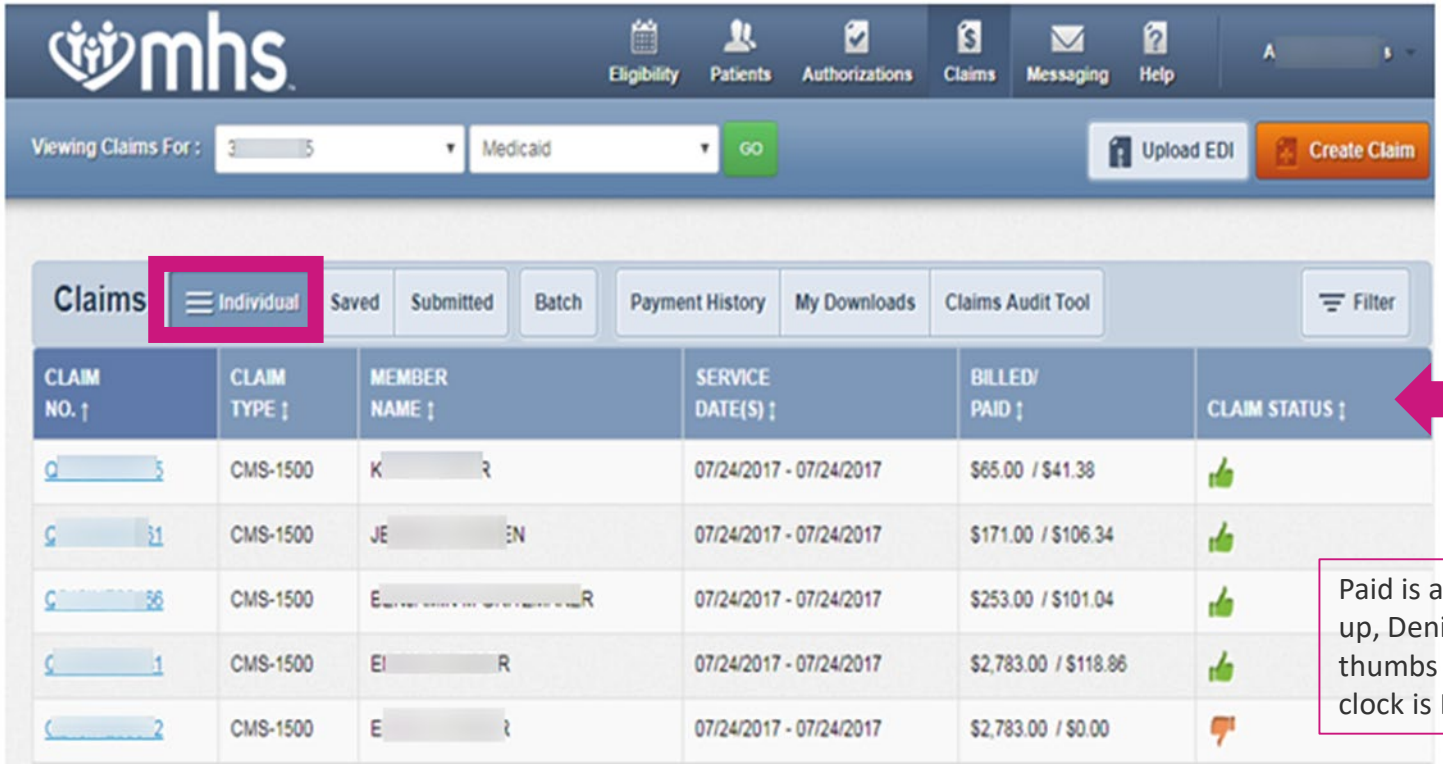
- Paid is a green thumbs up.
- Denied is an orange thumbs down.
- Pending is a clock.
- RTEP claims also show if eligible (i.e., line 3 was submitted, but was not eligible for RTEP).



Individual Claims

On the Individual tab, submitted using paper, portal or clearinghouse:

- View the Claim Number, Claim Type, Member Name, Service Date(s), Billed/Paid, and Claim Status



Paid is a green thumbs up, Denied is an orange thumbs down and a clock is Pending

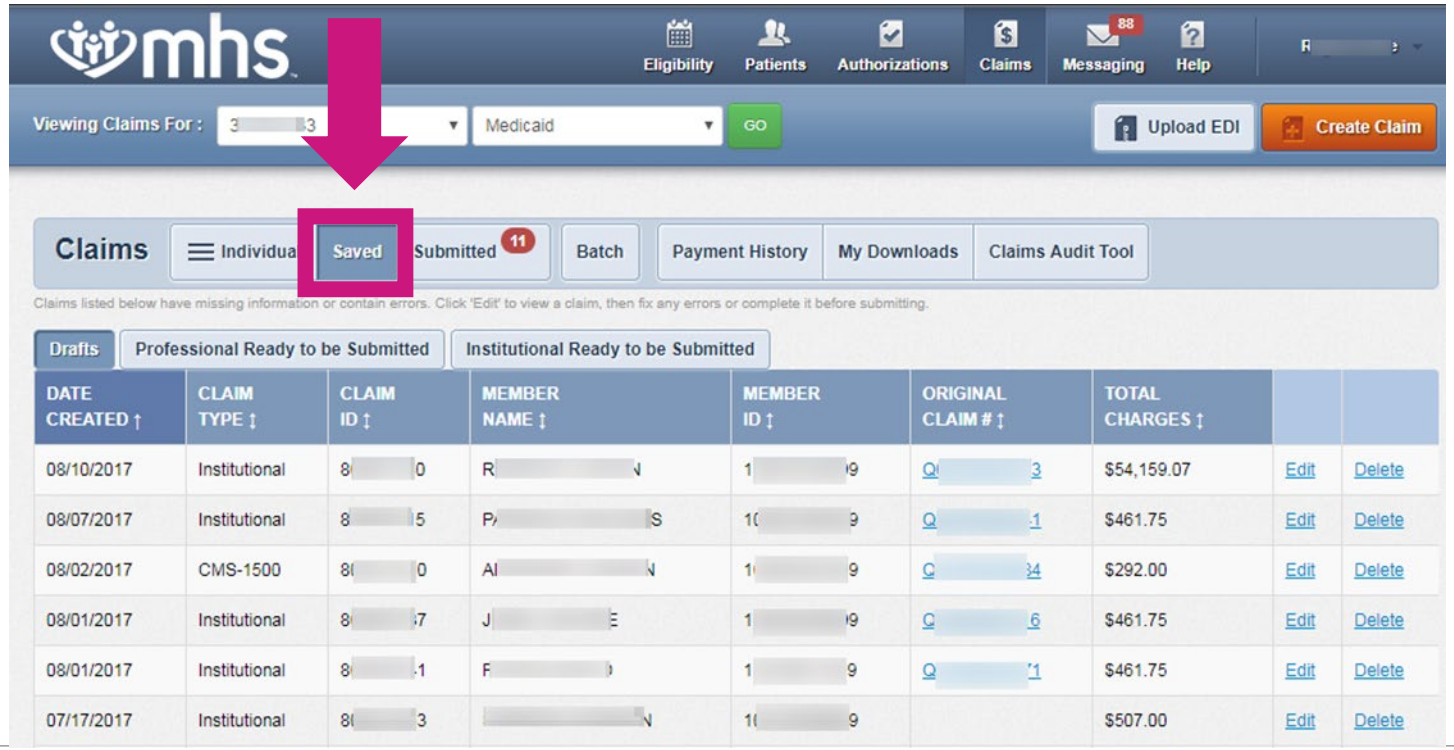
Saved Claims

To view Saved claims: Drafts, Professional, or Institutional

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

Or

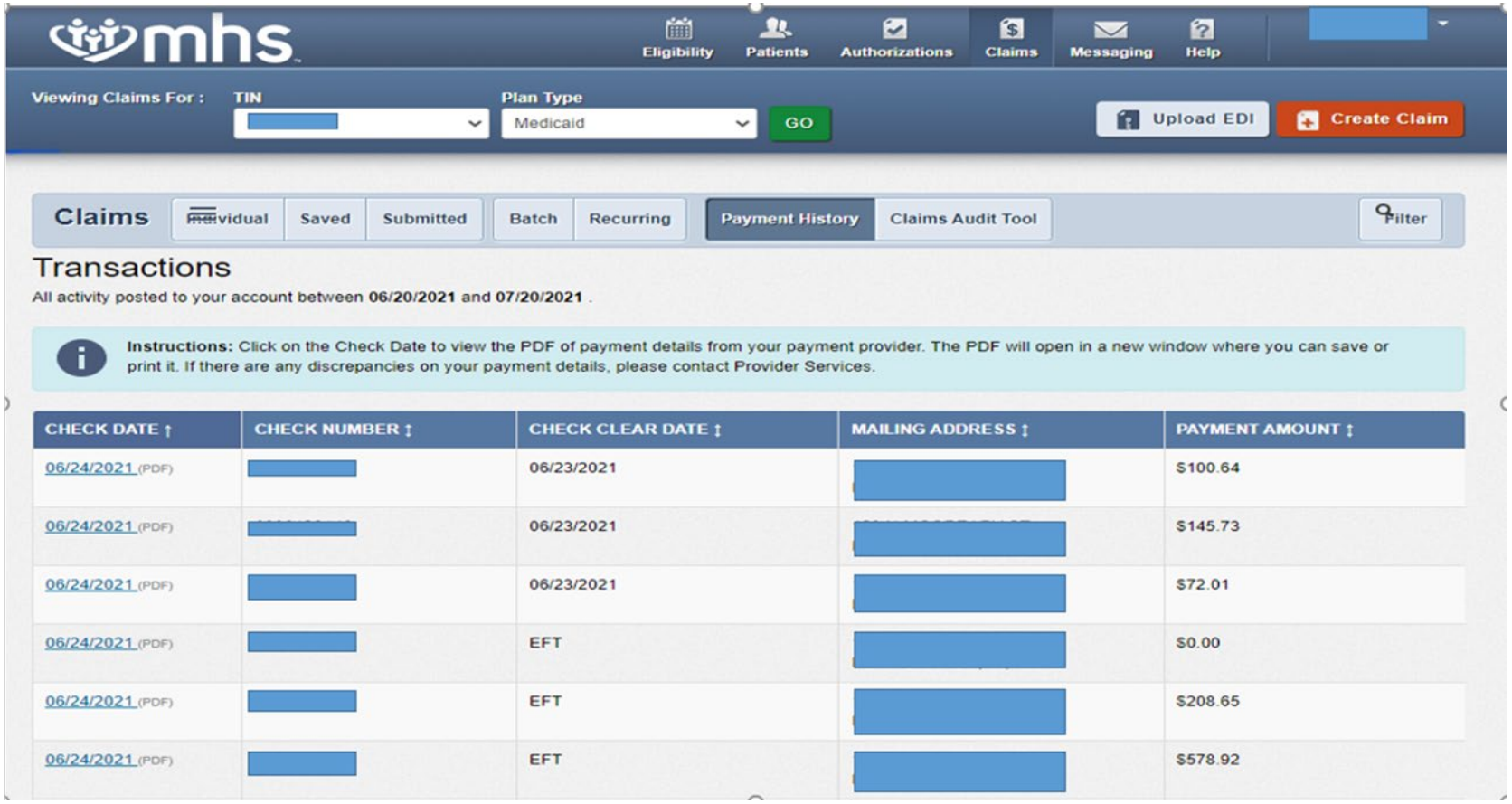
1. Click Delete to delete saved claim that is no longer necessary.
2. Click OK to confirm the deletion.



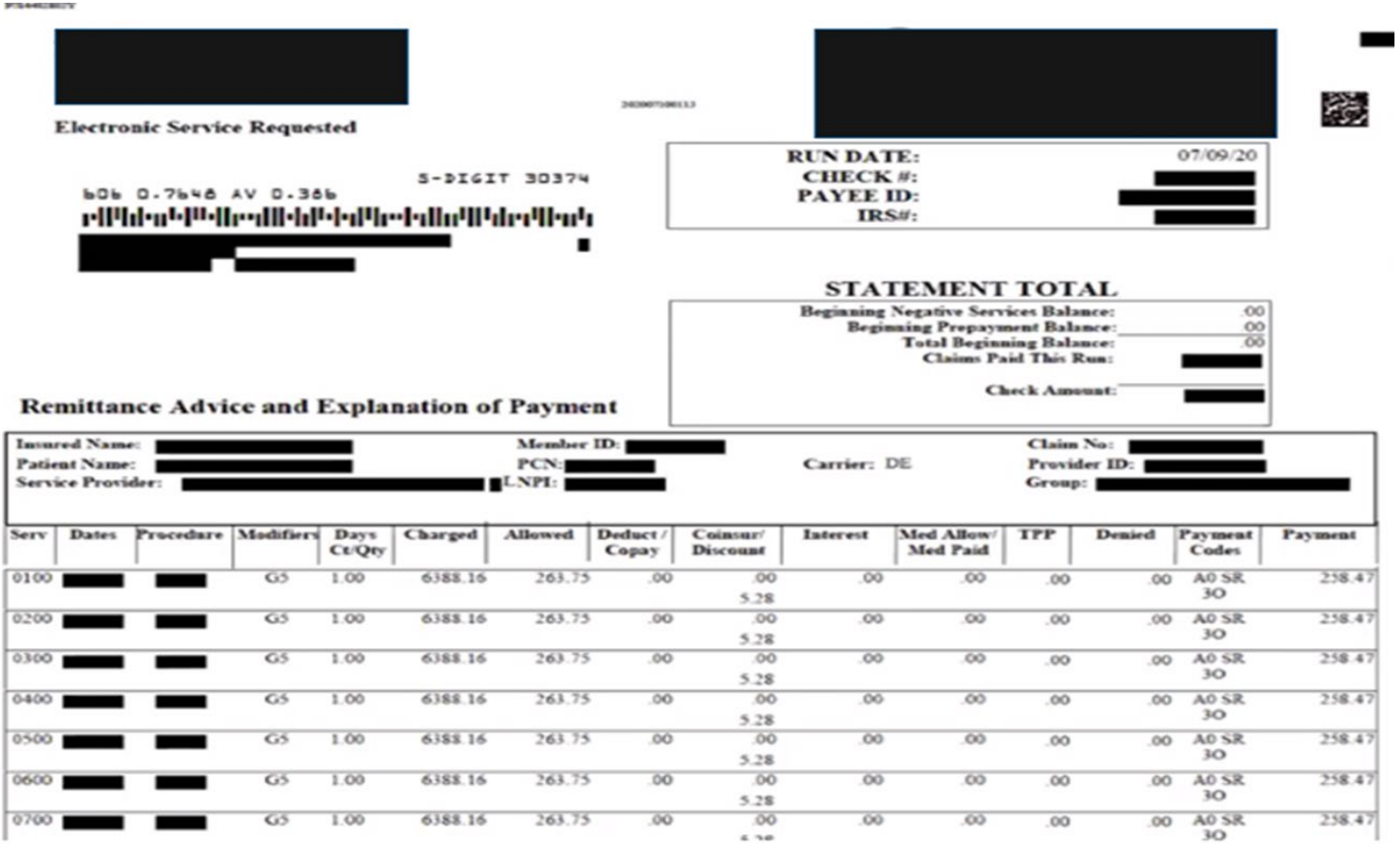
Payment History

Click on Payment History to view Check Date, Check Number, Check Clear Date, Mailing Address and Payment Amount.

- Click on Check Date to view Explanation of Payment



Provider EOP



[redacted]

Electronic Service Requested

5-DIGIT 30374

b0b 0.7b48 AV 0.38b

[redacted]

[redacted]

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

STATEMENT TOTAL

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

Remittance Advice and Explanation of Payment

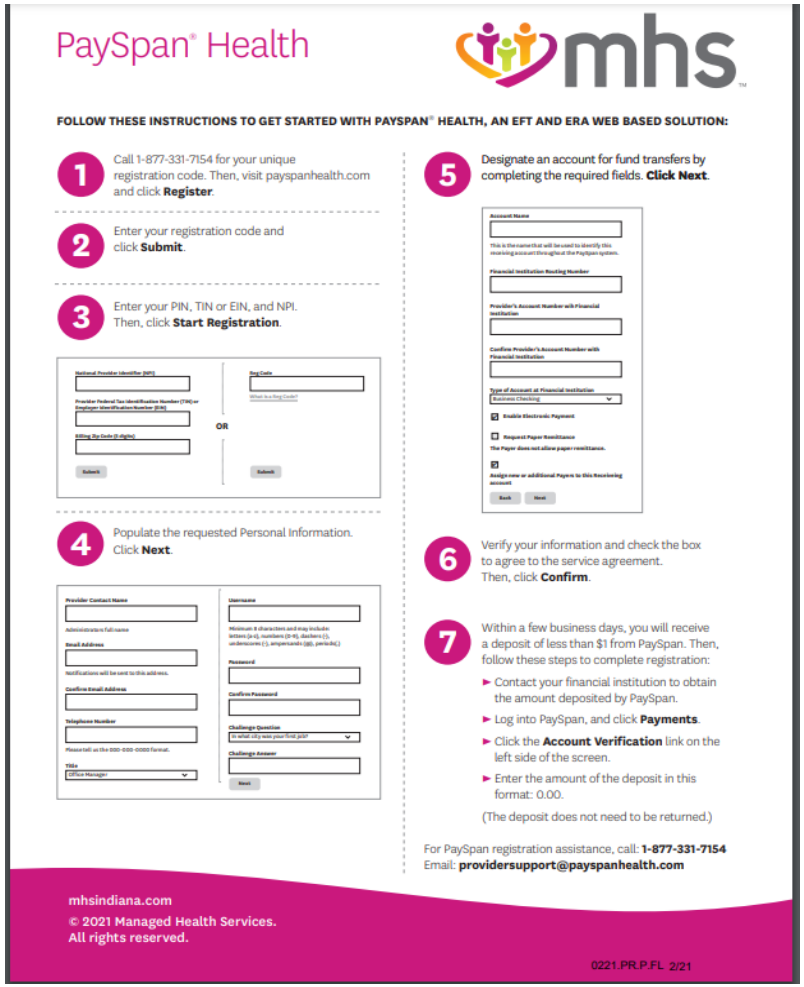
Insured Name: [redacted]
Patient Name: [redacted]
Service Provider: [redacted]
Member ID: [redacted]
PCN: [redacted]
NPI: [redacted]
Carrier: DE
Claim No: [redacted]
Provider ID: [redacted]
Group: [redacted]

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

EFT and ERAs

PaySpan Health

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



PaySpan® Health

mhs

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

1. Call 1-877-331-7154 for your unique registration code. Then, visit payspanhealth.com and click **Register**.
2. Enter your registration code and click **Submit**.
3. Enter your PIN, TIN or EIN, and NPI. Then, click **Start Registration**.

OR

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

   (The deposit does not need to be returned.)

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

mhsindiana.com

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Tips to Remember

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

Online Claims Reconsiderations on the MHS Secure Provider Portal

Summary Of Online Reconsiderations

Skip the phone call.

- Providers can make their case directly on the portal.

Make the case.

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

Add context.

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

Stay current.

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

Online Reconsiderations

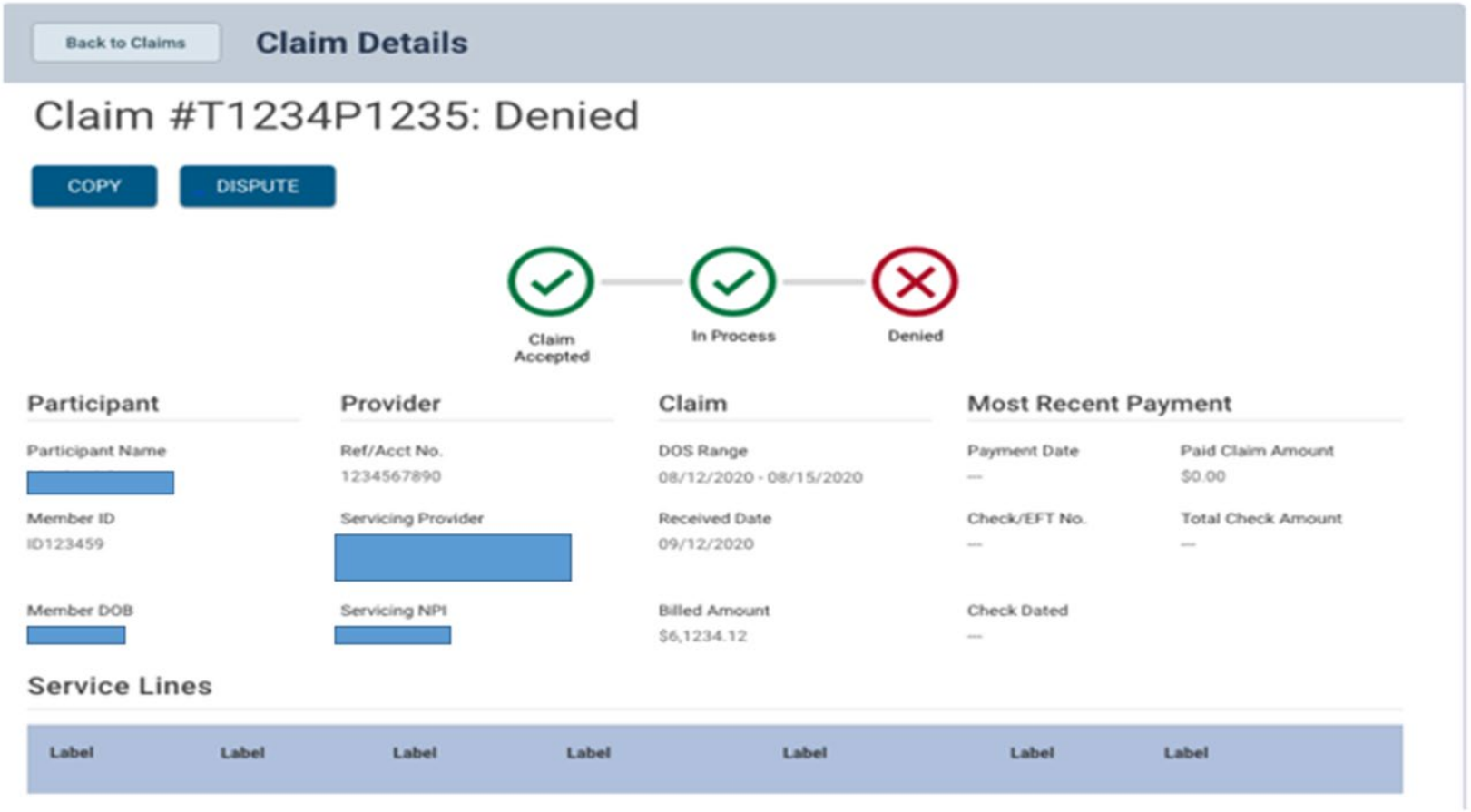
Providers are able to:

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

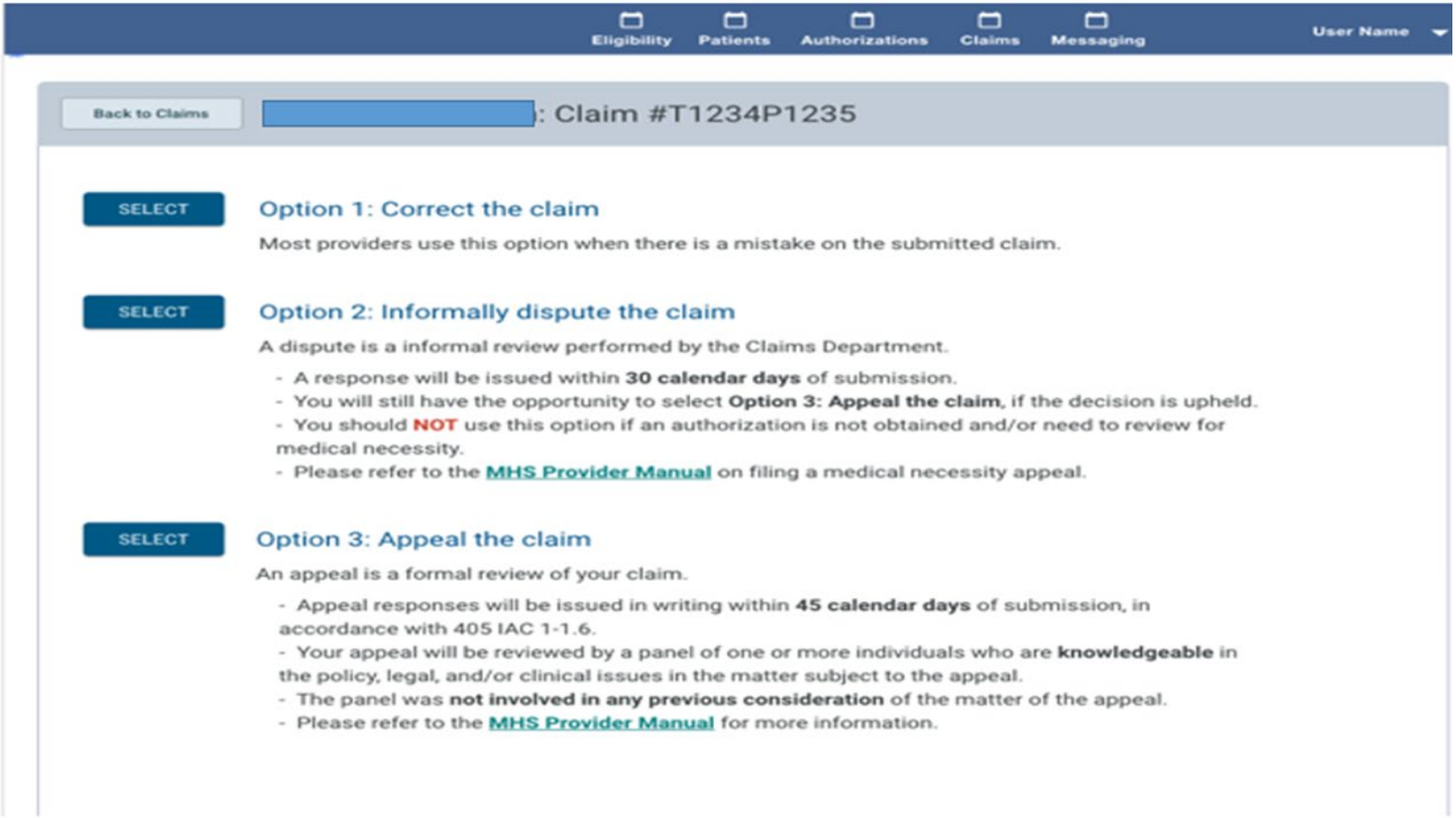
Online Reconsiderations

- It is important to note that all requests submitted via the online Portal for Level 1 will be considered an informal dispute. Secure messages are not considered reconsiderations/appeals.
- Calling Provider Services will not pause the time frame for timely submissions for informal disputes.
- Providers do not need to call prior to submitting an online claim reconsideration/information dispute.
- Providers may include a dispute form, but it is not required, as they may include comments directly into the portal.

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

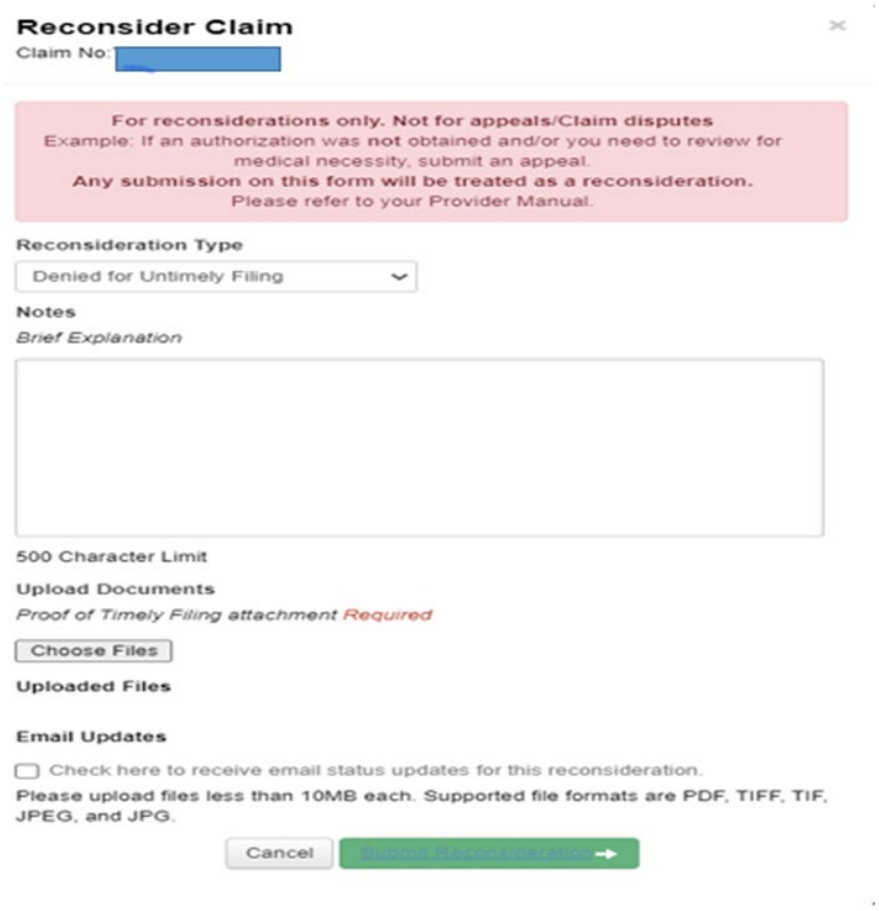


Level 1 Informal Claim Dispute and Level 2 Claim Appeals on the Secure Provider Portal



Claim Reconsiderations

Enter your explanation for reconsideration and check email updates.



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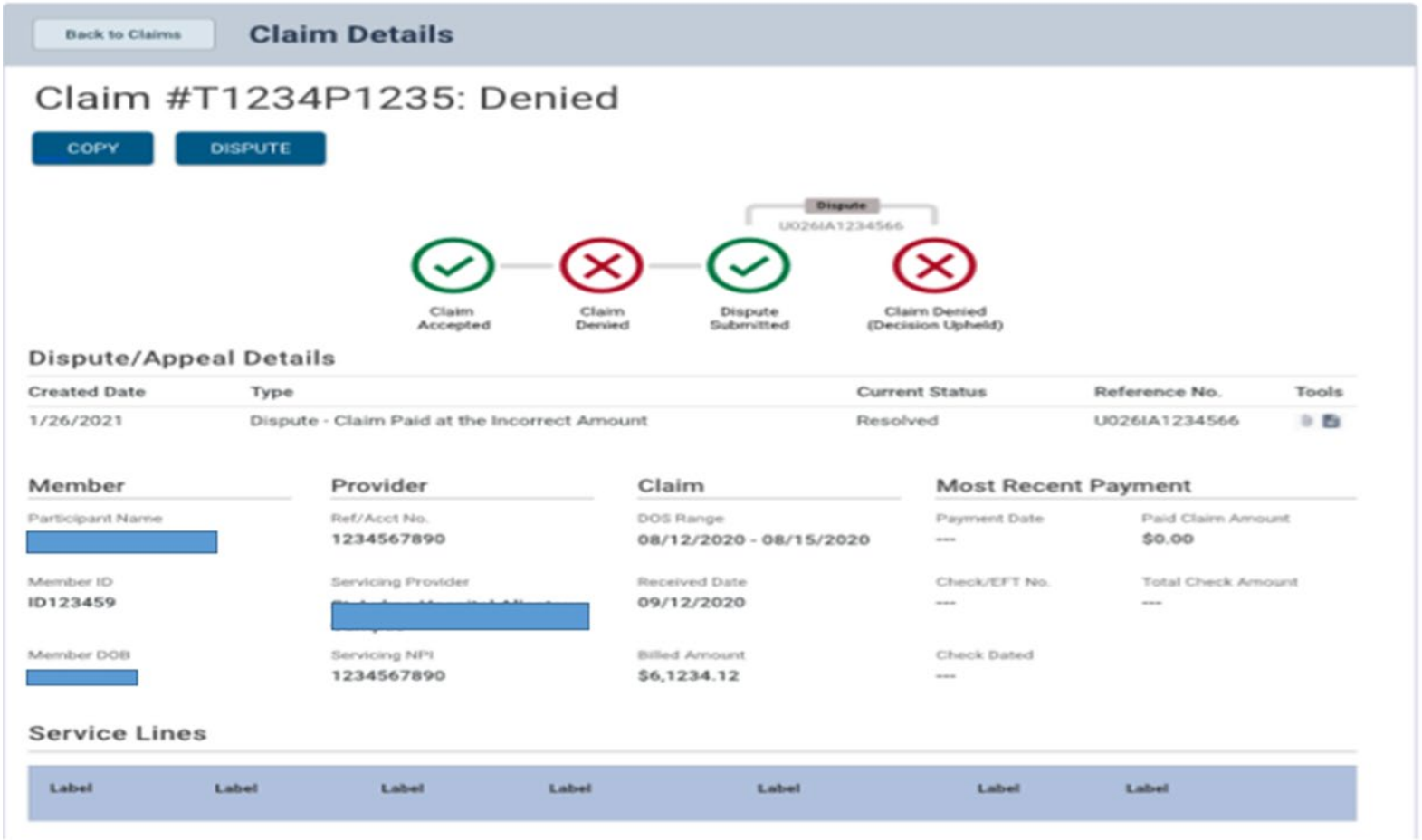

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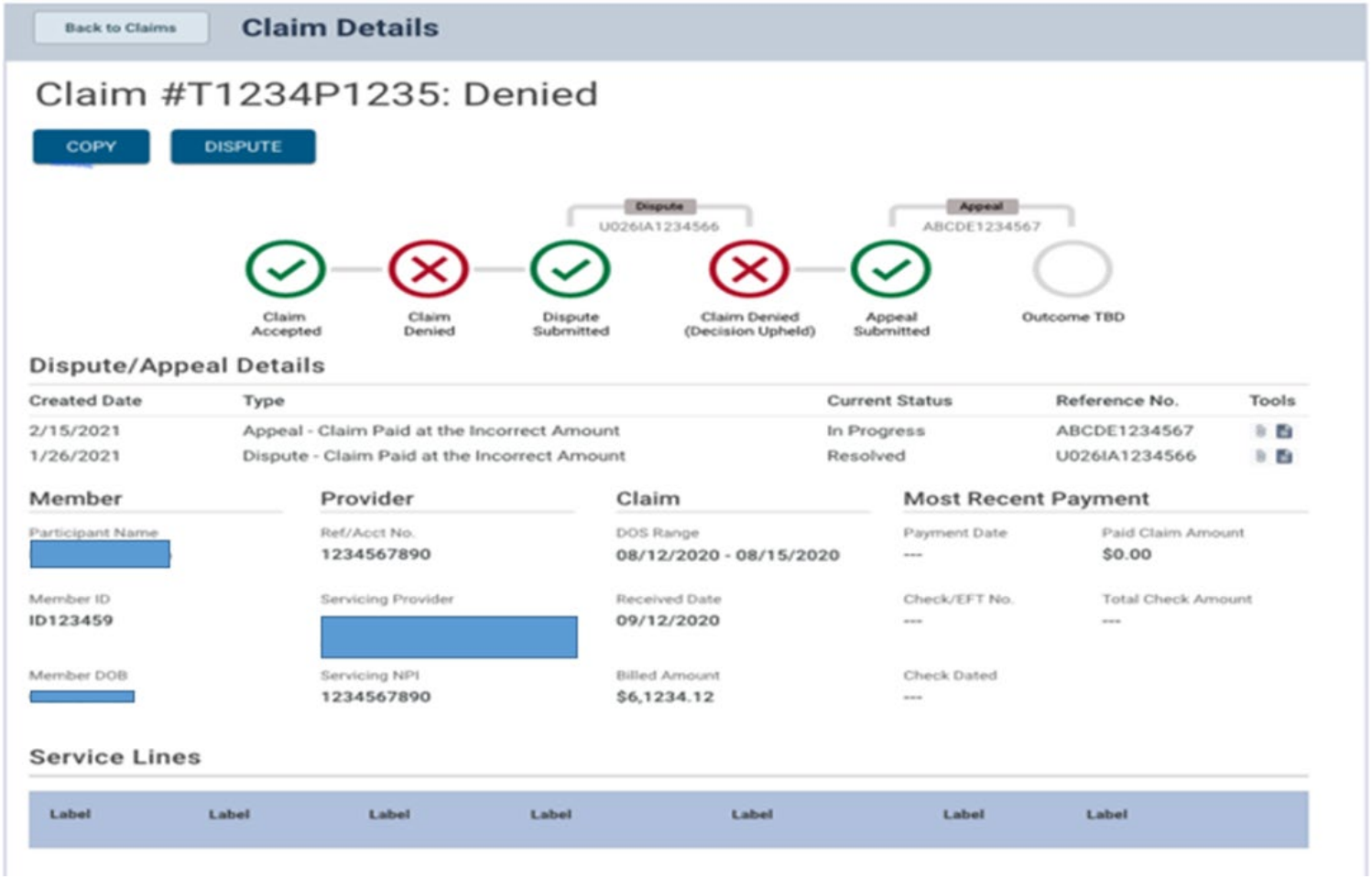
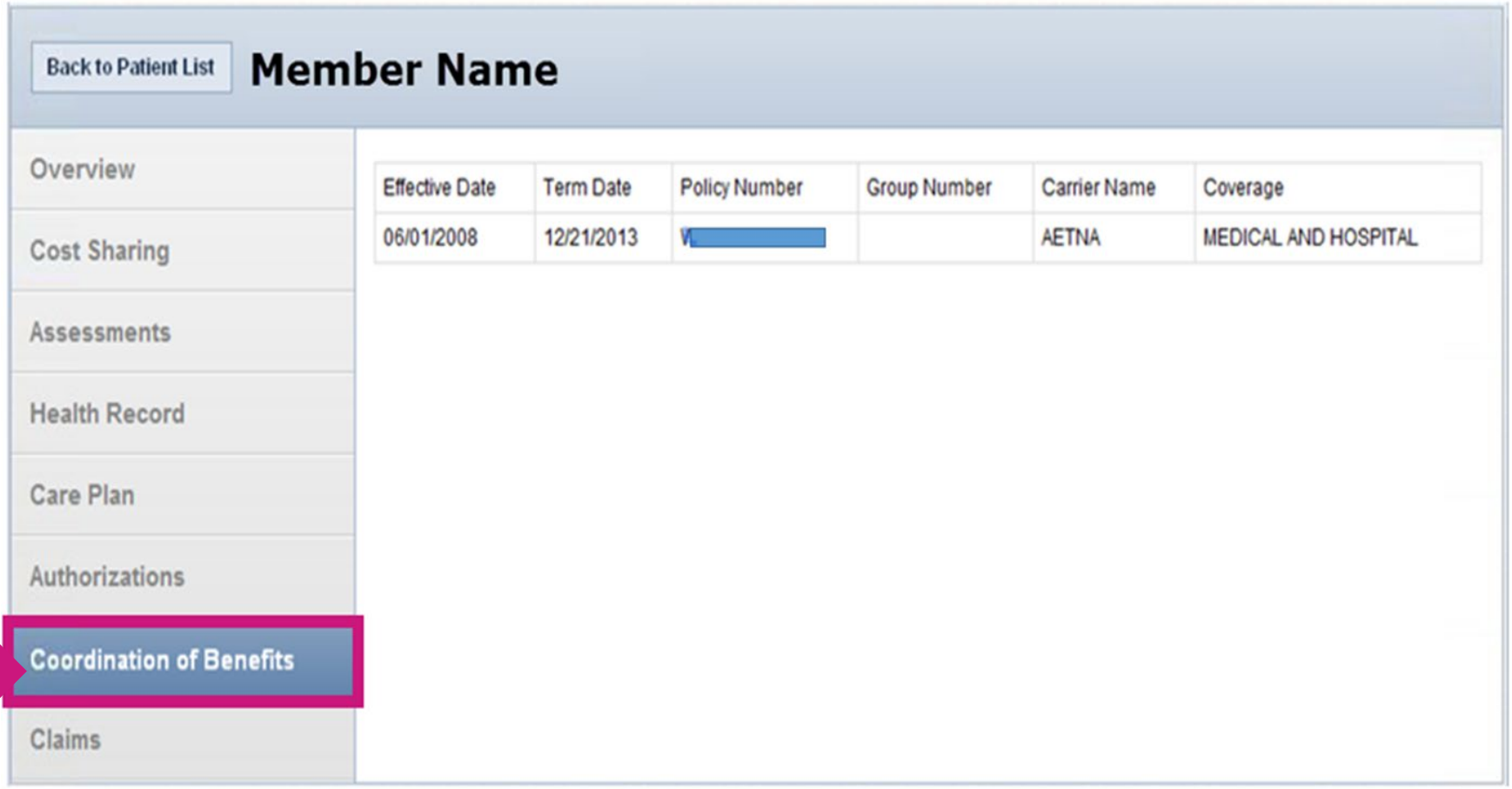


Coordination of Benefits

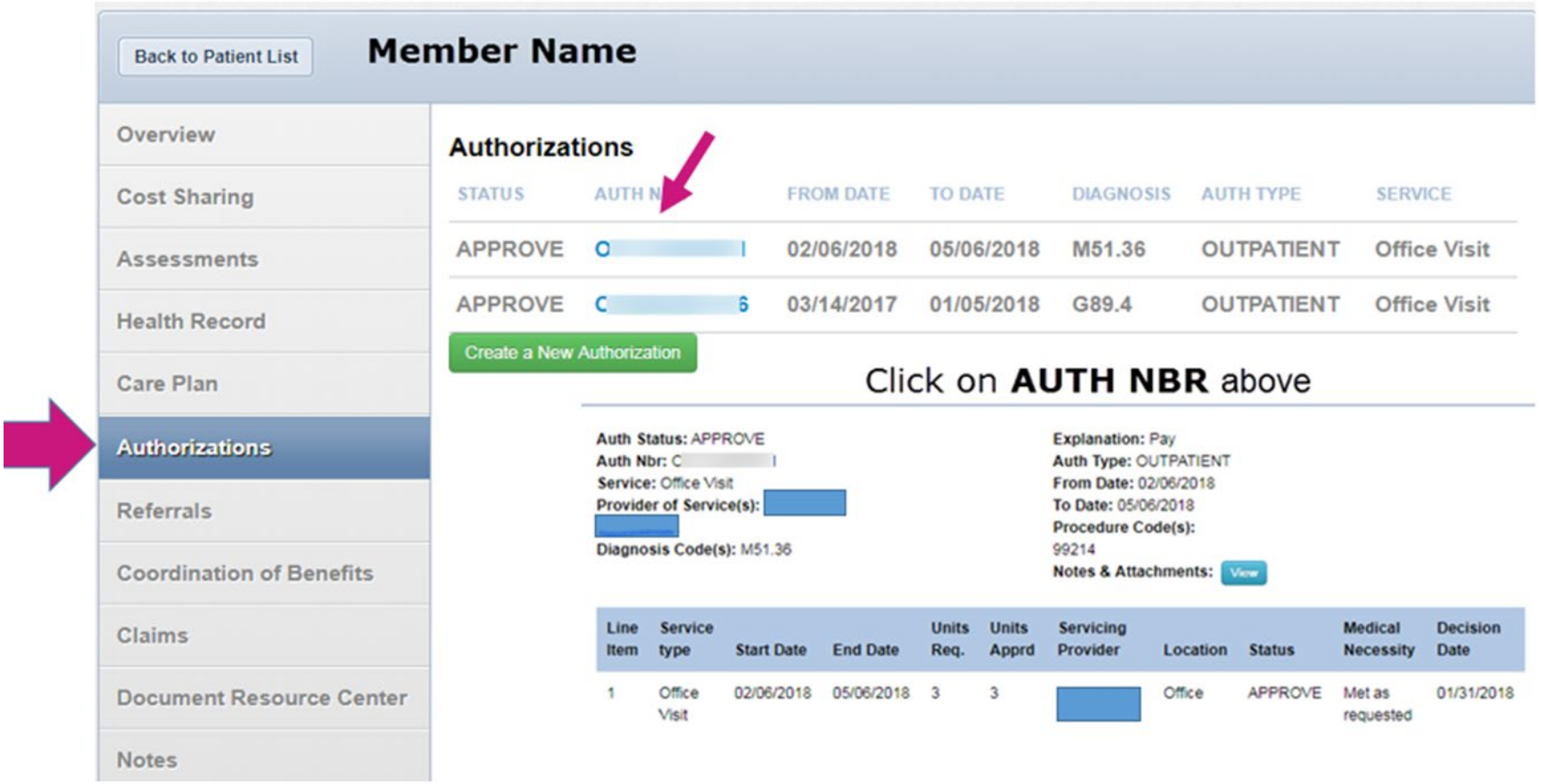
This screen shows if a member has other insurance.



Prior Authorization

Authorizations

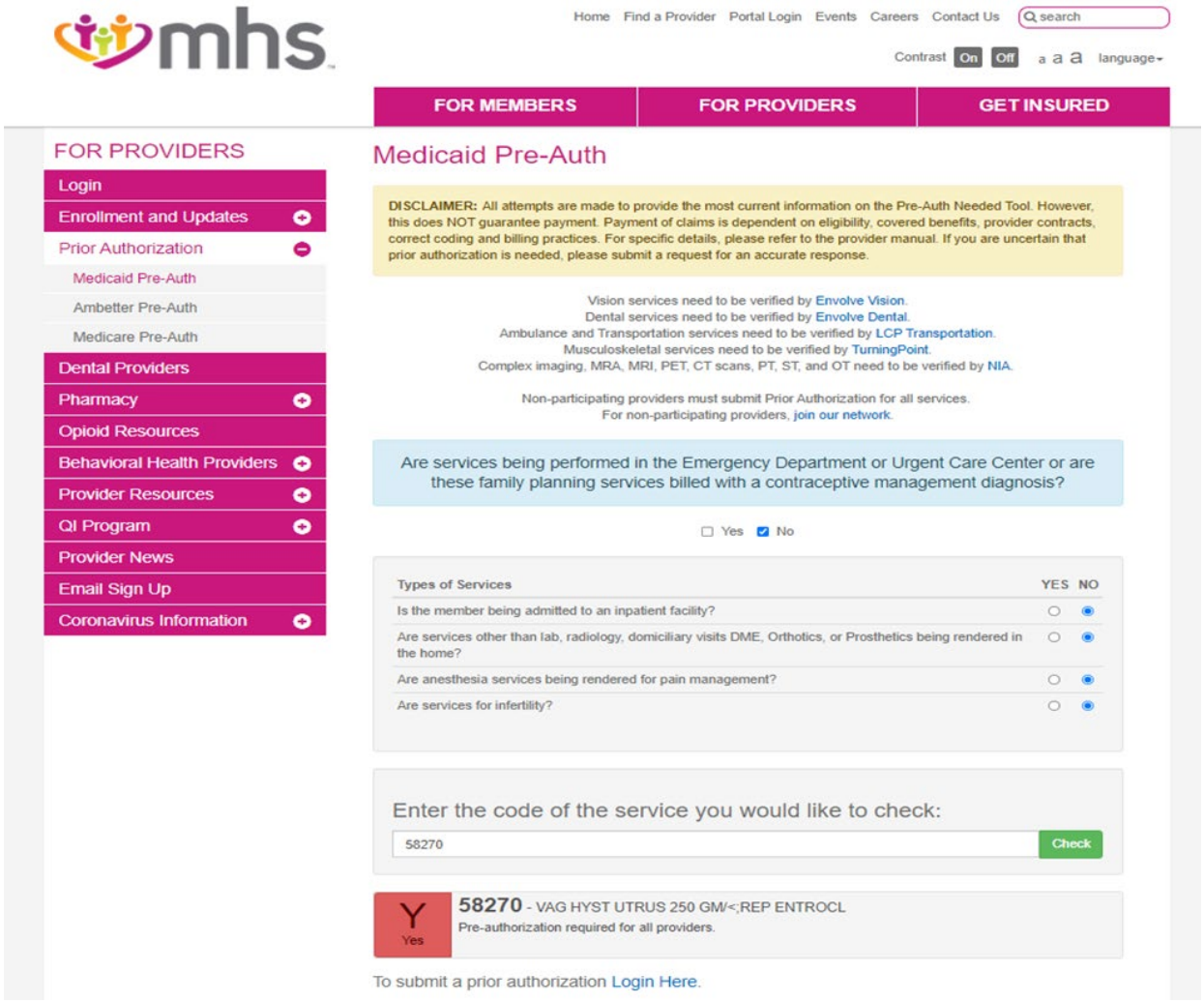
View previously submitted or Create a New Authorization.



Authorization Considerations

- **Need to know what requires Authorization:**
  - Pre-Authorization tool https://www.mhsindiana.com/providers/prior-authorization/medicaid-pre-auth.html
- **How to obtain Authorization:**
  - Online: https://www.mhsindiana.com/providers/prior-authorization.html
  - Phone: 1-877-647-4848
  - Fax: 1-866-912-4245
- **Authorizations do not guarantee payment.**

Prior Authorization



MHS Team

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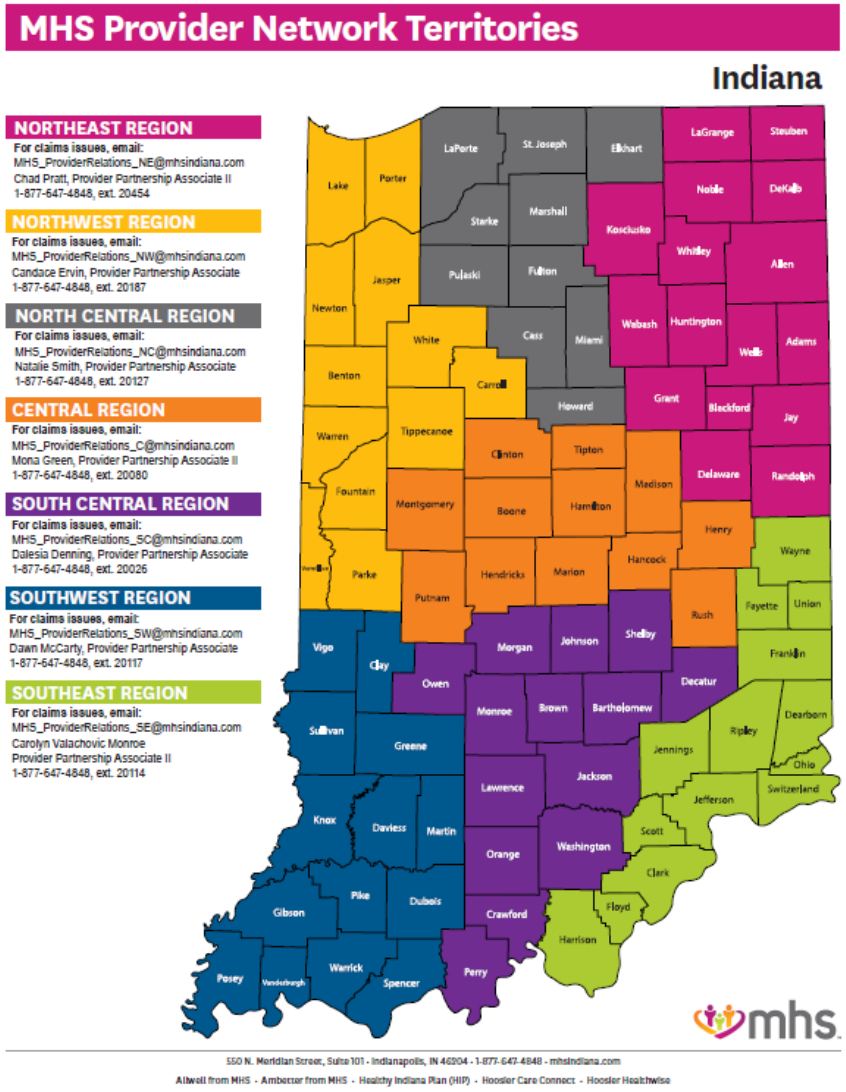
MHS Provider Network Territories



NORTHEAST REGION

For claims issues, email:
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MHS Team

MHS Provider Network Territories

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Aliwell from MHS - Amberter from MHS - Healthy Indiana Plan (HIP) - Hoosier Care Connect - Hoosier Healthwise

Thank you for being our partner in care.

Questions?