



# Claims CMS-1500

2023 Annual IHCP Works Seminar

Presenter: Natalie Smith, Provider Engagement  
Administrator

# Agenda

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

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# MHS Overview

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# 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



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# Claim Submission Process

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# Medical Claims 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/login.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 Claims 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/login.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  
P.O. Box 6800  
Farmington, MO 63640-3818



# Claims Billing with Ease

- **NPI, Tax ID, Zip +4**
- This information is necessary for the system to make a one-to-one match based on the information provided on the claim and the information on file with Indiana Medicaid.
  - Member Information
  - Newborn's 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 Member ID (MID).
  - 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.

# Paper Claim Corrections

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

# Paper Claim Corrections

- If you must submit via paper – never handwrite “corrected claim” on the claim form.
- Complete box 22 (Resubmission Code) to include a 7 (the "Replace" billing code) to notify us of a corrected or replacement claim.

The form is a standard paper claim form with the following sections and fields:

- 14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP):** MM DD YY, QUAL.
- 15. OTHER DATE:** QUAL, MM DD YY.
- 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION:** FROM MM DD YY TO MM DD YY.
- 17. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES:** FROM MM DD YY TO MM DD YY.
- 18. OUTSIDE LAB? \$ CHARGES:** YES  NO
- 19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC):**
- 20. RESUBMISSION CODE:** Contains the number '7'. An orange arrow points to this field with the text "Resubmission code is '7'".
- 21. PRIOR AUTHORIZATION NUMBER:**
- 22. ORIGINAL REF. NO.:** A blue arrow points to this field.
- 23. ORIGINAL CLAIM NUMBER:** An orange arrow points to this field with the text "Original claim number".
- 24. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY:** A-I, ICD Inc. 0.
- 25. PROCEDURE(S) OF SERVICE:** From MM DD YY To MM DD YY, PLACE OF SERVICE, EMG, CPT/NCPCS, MODIFIER.
- 26. DIAGNOSIS POINTER:**
- 27. \$ CHARGES:** Contains the number '1'.
- 28. DAYS OF LEAVES:**
- 29. NPS:**
- 30. RENDERING PROVIDER ID #:**
- 31. FEDERAL TAX I.D. NUMBER:** SSN, EIN.
- 32. PATIENT'S ACCOUNT NO.:**
- 33. ACCEPT ASSIGNMENT?:**
- 34. TOTAL CHARGE:**
- 35. AMOUNT PAID:**
- 36. SIGNATURE OF PHYSICIAN OR SUPPLIER:** Including degrees or credentials. A blue arrow points to this section.
- 37. DATE:**
- 38. SIGNATURE OF PHYSICIAN OR SUPPLIER:**
- 39. DATE:**

# Laboratory Billing

- All providers that bill laboratory services on a *CMS-1500* form must have Clinical Laboratory Improvement Amendments (CLIA) certification or a CLIA waiver certification equal to the procedure code being billed and included on the *CMS-1500*.
- **EXc1 DENIED: INVALID CLIA NUMBER:**  
This denial code will appear on the providers EOP.  
This verification will ensure that MHS is compliant with the CMS guidelines. Providers will have to submit a corrected claim timely with proper CLIA certificate number entered on their claim submission.

# Laboratory Billing

- **Physician's Office Lab Testing (POLT)**

MHS Policy CC.PP.055: To ensure laboratory tests are performed in the correct setting, the health plan will limit the performance of in-office laboratory testing to the CPT® and HCPCS codes listed in the Short Turnaround Time (STAT) laboratory (lab) code list included in this policy.

# Laboratory Billing

- These are tests that are needed immediately, in order to manage medical emergencies or urgent conditions. To this end, specific clinical laboratory tests have been designated as appropriate to be performed in the office setting.
- The health plan's automated claims adjudication system will deny in-office (location 11) laboratory procedures that are not included on the STAT lab list found on the MHS Indiana website.
- Policy can be found at:

<https://www.mhsindiana.com/content/dam/centene/mhsindiana/policies/payment-policies/CC.PP.055.pdf>

# Transportation Claims

- 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
  - Call Provider Services at 1-877-647-4848

# Claim Rejections

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

# Claim Rejections

## Medical

- **07** Invalid Subscriber/Member ID
- **02** Invalid Provider ID-Rendering Physician (Provider State Crosswalk File)
- **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
- **90** Invalid or Missing Modifier
- **40** Diagnosis code is missing
- **B5** Missing/incomplete/Invalid CLIA

## Behavioral Health

- **02** Invalid Provider ID-Rendering Physician (Provider State Crosswalk File)
- **09** Member Invalid on Date of Service
- **07** Invalid Subscriber/Member ID
- **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
- **31** Invalid Service Procedure code

# Claim Rejections

- EDI rejections require the provider to contact their clearinghouse and obtain a payer rejection report.
- Paper to electronic mapping is available on:  
<https://www.mhsindiana.com/providers/resources/guides-and-manuals.html>
- MHS website tools:
  - Reject code listing
  - Refer to Top 10 Rejection Code Help Aid Document  
<https://www.mhsindiana.com/content/dam/centene/mhsindiana/medicaid/pdfs/508-Top-10-Rejections-Edu-Doc.pdf>.

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# MHS Provider Claims Issue Resolution Process

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# 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>

DO NOT USE THIS FORM FOR MEDICAL NECESSITY APPEALS.

## Medical Claim Dispute/Appeal Form

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

\_\_\_\_ 1<sup>st</sup> Level (Informal Dispute/Reconsideration)  
\_\_\_\_ 2<sup>nd</sup> Level (Appeal) – if you are not satisfied with resolution of informal dispute

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

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

### \* Required fields

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

### Reason for the appeal:

- Claim was denied for no authorization, but authorization number \_\_\_\_\_ was obtained.
- Claim was denied for no authorization, but no authorization is required for this service.
- Claim was denied for no authorization, however authorization was not obtained due to member's eligibility or medical condition.
- Claim 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).
  - o *Note: if the past timely filing deadline denies falls on a weekend or a holiday, the provider may request a reconsideration ( see Reconsideration Request Form)*
- Claim was paid the incorrect amount (include calculation of expected payment and supporting information).
- Claim denied based on Managed Health Services Payment policy (attach medical records to support services provided).
  - o *Note: Payment policies can be found at <https://www.mhsindiana.com/providers/resources/clinical-payment-policies.html>*
- Other. Please explain (and provide supporting documentation): \_\_\_\_\_

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

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

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

<b>Medical Claims:</b> Managed Health Services PO Box 3000 Farmington, MO 63640-3800
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<b>Behavioral Health Claims:</b> Managed Health Services BH Appeals PO Box 6000 Farmington, MO 63640-3809
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1-877-647-4548 | TTY: 1-800-743-3333 | mhsindiana.com  
 Allwell from MHS | Ambetter from MHS | Healthy Indiana Plan (HIP) | Hoosier Care Connect | Hoosier Healthwise

1220.06.P.LT 1/21



# Informal Claims Dispute or Objection Form

## Level 1:

- Submit all documentation supporting your objection.
  - Copies of original MHS EOP showing how the claims in question were processed.
  - Copies of any subsequent MHS EOPs or other determinations on the claim(s) in question.
  - Documentation of any previous attempt you have made to resolve the issue with MHS.
  - Other documentation that supports your request for reprocessing or reconsideration of the claim(s).
- 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 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 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 and 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 and Web Inquiries

- 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 Claims 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 \(mhsindiana.com\)](https://www.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-2023.pdf>

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# Additional Claim Assistance

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# 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/Wellcare by Allwell)
  - Claim Number(s)
  - DOS or DOS Range if multiple denials
  - Related Prior Authorization Numbers (this is key if issue involves claims denied for no authorization)
  - Provider reason for dispute

# Provider Relations Regional Mailboxes

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

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# Portal Functionality

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# Secure Web Portal Login or Registration

The screenshot displays the MHS website's 'Portal Login' page for providers. At the top, the MHS logo is on the left, and navigation links (Home, Find a Provider, Portal Login, Events, Careers, Contact Us) and a search bar are on the right. A contrast toggle and language selector are also present. Below the navigation is a purple bar with three tabs: 'FOR MEMBERS', 'FOR PROVIDERS' (selected), and 'GET INSURED'. The main content area is divided into a left sidebar and a main panel. The sidebar, under 'FOR PROVIDERS', lists various services with expandable icons: Enrollment and Updates, Prior Authorization, Dental Providers, Pharmacy, Opioid Resources, Behavioral Health Providers, Provider Resources, QI Program, Provider News, Email Sign Up, and Coronavirus Information. The main panel features a 'Portal Login' heading and a call to action: 'Create your own online account today!'. It explains that MHS offers convenient tools for logging in or registering. A prominent blue button labeled 'Login/Register' is highlighted with a red box. Below this, a 'Provider Email Sign Up' section contains a blue 'Sign Up' button. A section titled 'PORTAL TRAINING GUIDES' lists several PDF resources: Account Manager User Guide, Provider Secure Portal Brochure, Submit a Claim CMS 1500, Submit a Claim CMS UB-04, Update Portal Account Details, and Utilize Member Management Forms. A note states that Clear Claim Connection does not provide an all-inclusive listing of claim edits. A 'Registration Help' section provides instructions for new users, including a link to the 'Become a Provider' page and a phone number (1-877-647-4848). At the bottom, there are links for 'Vision Provider Portal Login' and 'Dental Provider Portal Login', followed by a list of benefits: 'Verify member eligibility' and 'View member benefits'.

Home Find a Provider Portal Login Events Careers Contact Us

Contrast  On  Off 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** -

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

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

### Registration Help

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

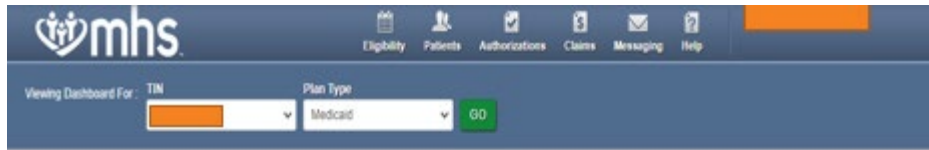
### Vision and Dental Providers

[Vision Provider Portal Login](#)

[Dental Provider Portal Login](#)

- Verify member eligibility
- View member benefits

# Homepage-MHS (Medicaid)



Eligibility Patients Authorizations Claims Messaging Help

Viewing Dashboard For: TIN [dropdown] Plan Type [Medicaid] [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, Kimberly!

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    
MM/DD/YYYY

Select Action Type \*

[SUBMIT](#)

## 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.

# Claims Audit Tool

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

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

CLAIM NO. ↑	CLAIM TYPE ↑	MEMBER NAME ↑	SERVICE DATE(S) ↓	BILLED/ PAID ↓	CLAIM STATUS ↓
1	CMS-1500	3	08/22/2017 - 08/22/2017	\$73.00 / \$0.00	⌚

**McKesson** Empowering Healthcare **Clear Claim Connection™**

**Claim Entry**

Gender:  Male  Female

Date of Birth:  /  /  (mm/dd/yyyy)

ICD Code Set:

Click grid to enter information.  
 \* For quick entry, use your Down Arrow key after you enter a Procedure Code. Date of Service will default to today's date, and Place of Service will default to 11 (Office). Tabbing through Date of Service and Place of Service will give you the same defaults.

Line	Procedure	Mod 1	Mod 2	Mod 3	Mod 4	Qty.	Date of Service	Place of Service	Line Diag. 1	Line Diag. 2	Line Diag. 3	Line Diag. 4
1	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	-- select --	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
2	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	-- select --	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
3	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	-- select --	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
4	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	-- select --	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
5	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	-- select --	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Add More Procedures >>

Review Claim Audit Results Clear

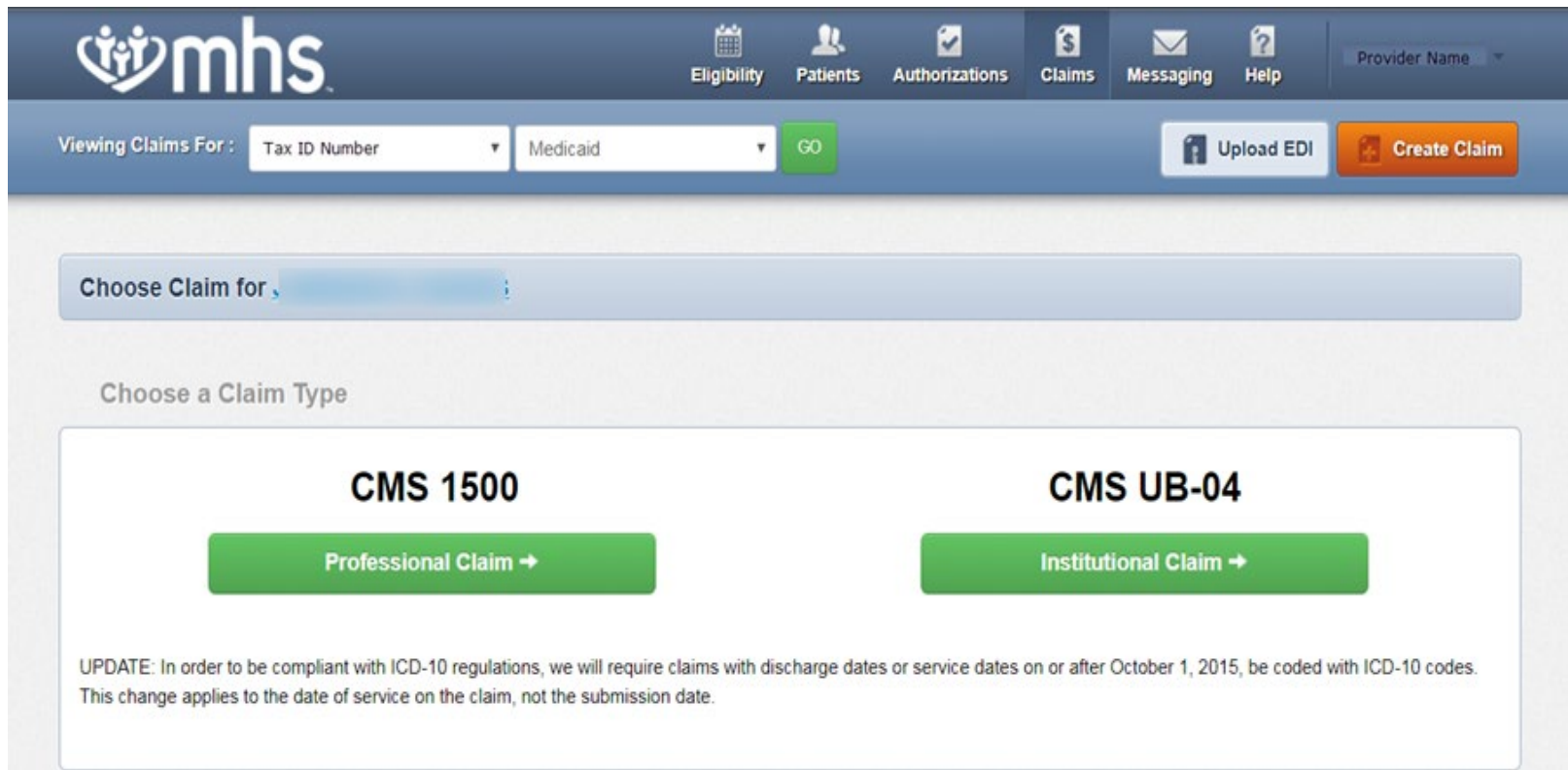
# Claims

- **Web Portal Claims Functionalities:**
  - **Submit** new claim.
  - **Review** claims information on file for a patient.
  - **Correct** claims.
  - **View payment history.**
- **Submit a New Claim:**
  - Click **Create Claim** and enter **Member ID** and **Birthdate**

The screenshot displays the mhs web portal interface for submitting a new claim. The top navigation bar includes icons for Eligibility, Patients, Authorizations, Claims, Messaging (with a notification badge of 98), and Help. Below the navigation bar, there is a search area for 'Viewing Claims For' with a dropdown menu set to '3' and 'Medicaid', and a 'GO' button. To the right of this search area are 'Upload EDI' and 'Create Claim' buttons. A secondary navigation bar contains 'Claims', 'Individual', 'Saved', 'Submitted', 'Batch', 'Payment History', 'My Downloads', 'Claims Audit Tool', and 'Filter'. The bottom section shows a search form for 'Member ID or Last Name' (with '123456789 or Smith' entered) and 'Birthdate' (with 'mm/dd/yyyy' entered), and a 'Find' button.

# Claims Submission

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



Viewing Claims For: Tax ID Number Medicaid GO Upload EDI Create Claim

Choose Claim for

Choose a Claim Type

**CMS 1500**  
Professional Claim →

**CMS UB-04**  
Institutional Claim →

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



---

# Professional Billing

---

# Professional Claims Submission:

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

Professional Claim for C. [REDACTED] EL Your Progress

THIS SECTION:  
**General Info** Information about the dates of the claim.

Next →

\* Required field

Patient's Account Number*	<input type="text" value="XXXXXXXXXX"/>	26
Date of current Illness, Injury, Pregnancy (LMP)	Select Type... <input type="text" value="MM/DD/YYYY"/>	14.
Other Date	Select Type... <input type="text" value="MM/DD/YYYY"/>	15.

# Professional Claims Submission

- Add the **Diagnosis Codes** for the patient in Box 21.
- Click the **Add** button to save.

- Click **Add Coordination of Benefits** to include any payments made by another insurance carrier (if applicable).

Professional Claim for LY Your Progress

THIS SECTION:  
**Diagnosis Codes**  
Diagnosis Code and Additional Insurance information.

← Back Next →

\* Required field

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

Diagnosis Codes\* XXXX e.g. V87: Add (Enter diagnosis code and click on Add button) 21.

V837 -- PERS OUTSD INDUST VEH INJ NT ACC Remove X

Add Coordination of Benefits

← Back Next →

Primary Insurance Remove X

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

Carrier Type\* C50M -- Commercial

Policy Number\* 1154451344 X

← Back Next →

# Professional Claims Submission

- Add **Service Lines**.

The screenshot displays the 'Professional Claims Submission' interface. At the top, it shows 'Professional Claim for [ID]' and 'Your Progress' with a progress indicator. The main section is titled 'Service Lines' with the instruction 'Enter maximum of 50 service lines.' Below this, there are 'Back' and 'Next' buttons. A sidebar on the left shows a 'Total: \$500.00' and a '+ New Service Line' button, which is highlighted by a pink arrow. The main form area shows 'Now Viewing Line 1: 99213 / \$500.00' with fields for 'Dates of Service' (From: 02/01/2016, To: 02/01/2016), 'Place of Service' (11 - PROVIDER'S OFFICE), 'Procedure Code' (99213), 'Modifiers' (XX), 'Diagnosis Code(s)' (V837 - PERS OUTDO INDUST VEH INJ NT ACC), 'Charge' (500.00), 'Units / Minutes / Days' (1), 'Type' (U/N - UI), 'Family Planning' (Yes/No/EPGOT), 'NDC' (NDC), and 'Supplemental Information'. A pink arrow points to the 'Next' button at the bottom right. To the right of the main form is a 'Primary Insurance' section with fields for 'Amount Allowed' (500.00), 'Deductible' (XXXXXX), 'Copay' (XXXXXX), 'Co-Insurance' (XXXXXX), and 'Amount Paid' (500.00). Below this is a 'Service Line Denial Reasons' section with a 'Denied Category' dropdown, a 'Denied Amount' field (XXXXXX), and an 'Add Denied Reason' button. At the bottom right of the entire form, there are 'Delete', 'Save / Update', 'Back', and 'Next' buttons, with a pink arrow pointing to the 'Next' button.

# Professional Claims Submission

- Enter **Referring** and **Billing Provider** information. Enter **Service Facility Location**.
- Click **Next**.

Professional Claim for L Y Your Progress

THIS SECTION: **Providers**  
Providers on this claim.

← Back Next →

\*Required

**Referring Provider**

NPI: 1 73 Find Provider  
Last Name or Organizational Name: FARRELL First Name: ERN Find Provider

**Rendering Provider** Only enter rendering provider information if not the same as Billing Provider information.

NPI: 1 073 Tax ID: 2 04 Find Provider  
Taxonomy #: 1 2K Last Name or Organizational Name: FARRELL First Name: ERN Save X

**Billing Provider**

Tax ID: 3 14  
Name: Farrell NPI: 11 073 Taxonomy #: 2 0K  
Address: 230 SIMPSON, ELKHART, Indiana Zip: 46510

**Service Facility Location** Same as Billing Provider

Name: Farrell NPI: 190 073  
Address: 230 SIMPSON AVENUE, ELKHART, Indiana Zip: 46510

← Back Next →

- In the Attachments section you can **Browse** and **Attach** any documents to the claim as desired. (Note: If you have no attachments, skip this section.)
- Click **Next**.

Professional Claim for L Y Your Progress

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

← Back If there are no attachments, click Next. Next →

**Attachments**

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

File\* No file chosen Attachment Type\* Select Type... Attach

There are no attached files.

← Back If there are no attachments, click Next. Next →

# Professional Claims Submission

Professional Claim for **L** Your Progress

THIS SECTION:  
**Review**  
Please review your claim and submit.

[← Back](#) This claim is eligible for Real Time Editing and Pricing.  
Please click on the Validate button to proceed to the next step. [Validate →](#)

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

**Claim Id:** 8

Member Record Number: 2 0  
Member Claim Amount Paid: 0  
Patient's Account Number: M 0

**General Info** [Edit](#)  
Statement From Date: 03/16/2017  
Statement To Date: 03/16/2017  
Date of current illness, injury, pregnancy (LMP):  
Other Date:  
Hospitalized From:  
Hospitalized To:  
Additional Claim Information:  
Outside Lab?: No  
Outside Lab Amount:  
Prior Authorization Number:  
CLIA Number:

**Diagnosis Codes and Primary Insurance** [Edit](#)

Diagnosis Codes  
R011 – CARDIAC MURMUR UNSPECIFIED

**Service Lines** [Edit](#)

Line	From	To	Place	Proc	Diagnosis	Amount	Units/Minutes/Days	Family Plan	EPSDT	NDC	Supplemental Info
1	03/16/2017	03/16/2017	22	93010	R011	\$55.00	1.0	No			

**Providers** [Edit](#)

Provider Type	Name	Tax ID	NPI	Taxonomy	Address
Referring Provider	CARBUNARU, GOLDY		1366473456		
Rendering Provider					
Billing Provider	MOHAMMED S GHAZA,	200734793	1275540361	246W00000X	5107 N BEND DR, FORT WAYNE, IN, 468041753
Service Facility Location	LUTHERAN CHILDRENS HOSPITAL				7950 W JEFFERSON BLVD, FORT WAYNE, IN, 468049998

**Attachments**

[← Back](#) This claim is eligible for Real Time Editing and Pricing.  
Please click on the Validate button to proceed to the next step. [Validate →](#)

- In the **Review** section, you can see if the claim is eligible for Real Time Editing and Pricing (RTEP).
- Click **Validate** for RTEP claims and click **Submit** for regular processed claims.

# RTEP Claim Pricing View

**COMPLETE!**  
You have successfully submitted your claim. [Print](#)

Web Reference No. 8  
Claim No.

RefAcct No: 002851      DOS Range:   
Member ID:      Billed Amount: \$90.00  
Member Name:      Payment Amount: \$48.75  
Servicing Provider:      Status: APPROVED

Line	DOS	Proc	Dx	Modifiers	Place of Service	Charged	Payment Amount	Status	Status Description
1	09/21/2015 - 09/21/2015	99212	285.9		11	\$65.00	\$31.75	Approved	92: PAID ACCORDING TO CONTRACT STATE PROCESSING GUIDELINES
2	09/21/2015 - 09/21/2015	99050	285.9		11	\$25.00	\$15.00	Approved	92: PAID ACCORDING TO CONTRACT STATE PROCESSING GUIDELINES

The system has provided a response back to the you indicating amount to be paid on the claim. Any post adjudication processes can change the amount paid.

[Close](#)

## RTEP Overview:

- On the final screen, each procedure code will receive a reimbursement estimate, pending claim explanation or denial reason.
- Claims with a reimbursement estimate or pending explanation may be impacted by final adjudication, including a change to the reimbursement amount or a denial.
- Adjudication status may be affected by Code Editing or other payment rules.

---

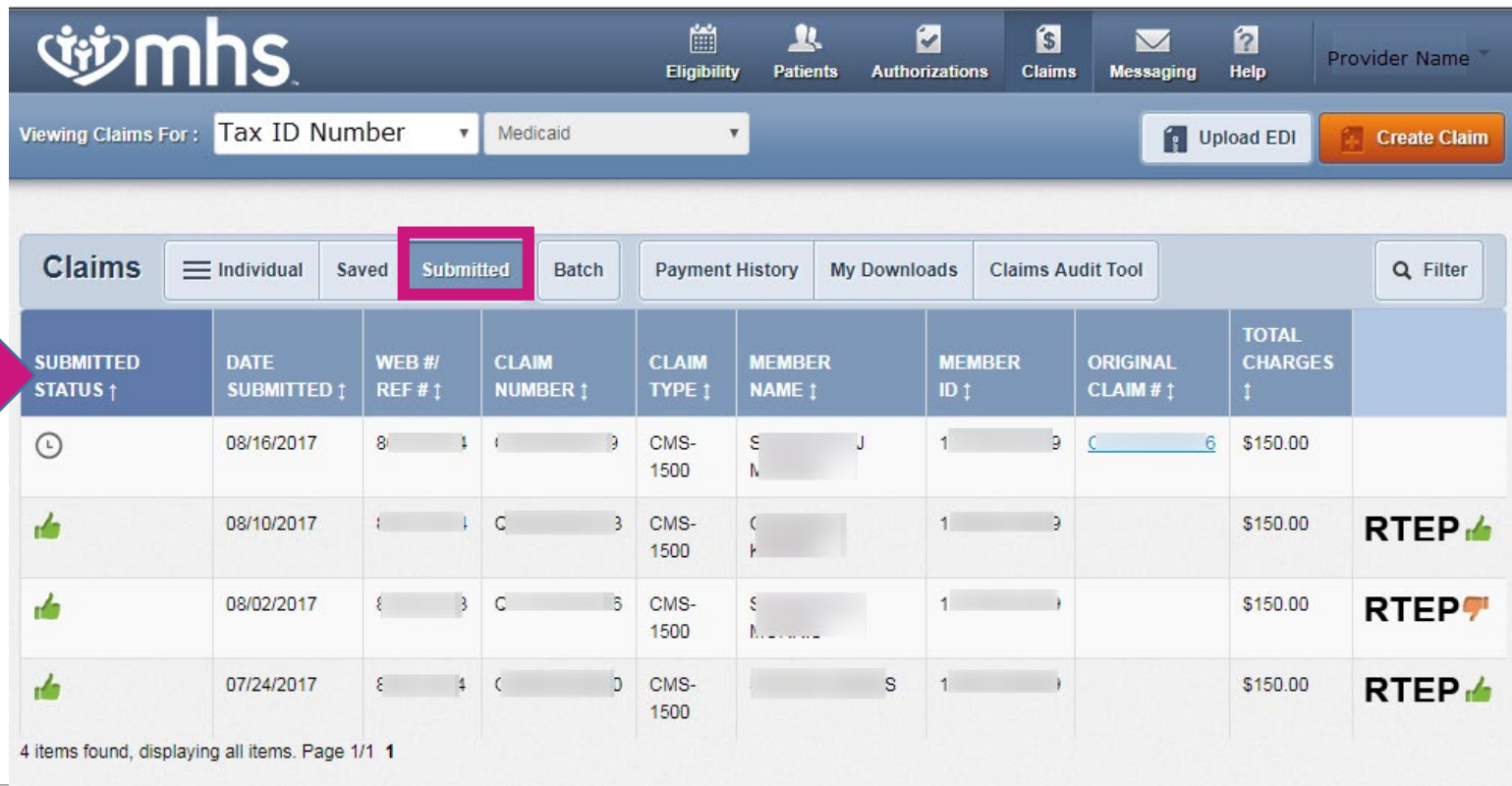
# Web Portal Claim and Payment Review

---



# Submitted Claims

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



Viewing Claims For : Tax ID Number Medicaid Upload EDI Create Claim

Claims Individual Saved Submitted Batch Payment History My Downloads Claims Audit Tool Filter

SUBMITTED STATUS ↑	DATE SUBMITTED ↓	WEB #/ REF # ↓	CLAIM NUMBER ↓	CLAIM TYPE ↓	MEMBER NAME ↓	MEMBER ID ↓	ORIGINAL CLAIM # ↓	TOTAL CHARGES ↓	
🕒	08/16/2017	8/...	(...)	CMS-1500	S... J M...	1...	C... 6	\$150.00	
👍	08/10/2017	{...}	C... 3	CMS-1500	C... K...	1...		\$150.00	RTEP 👍
👍	08/02/2017	{...}	C... 6	CMS-1500	S... M...	1...		\$150.00	RTEP 🗑️
👍	07/24/2017	{...}	C... 0	CMS-1500	... S	1...		\$150.00	RTEP 👍

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

# Individual Claims

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

CLAIM NO. ↑	CLAIM TYPE ↓	MEMBER NAME ↓	SERVICE DATE(S) ↓	BILLED/ PAID ↓	CLAIM STATUS ↓
Q 5	CMS-1500	K R	07/24/2017 - 07/24/2017	\$65.00 / \$41.38	👍
C 1	CMS-1500	JE EN	07/24/2017 - 07/24/2017	\$171.00 / \$106.34	👍
C 86	CMS-1500	E R	07/24/2017 - 07/24/2017	\$253.00 / \$101.04	👍
C 1	CMS-1500	EI R	07/24/2017 - 07/24/2017	\$2,783.00 / \$118.86	👍
C 2	CMS-1500	E R	07/24/2017 - 07/24/2017	\$2,783.00 / \$0.00	👎

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

The screenshot shows the mhs Claims management interface. At the top, there is a navigation bar with icons for Eligibility, Patients, Authorizations, Claims, Messaging (with 88 notifications), and Help. Below this is a search bar for 'Viewing Claims For' with a dropdown menu set to '3' and a 'Medicaid' filter. A large pink arrow points to the 'Saved' tab in the 'Claims' section, which is highlighted with a pink box. The 'Submitted' tab has a red notification badge with the number '11'. Below the tabs, there is a table of claims with columns for DATE CREATED, CLAIM TYPE, CLAIM ID, MEMBER NAME, MEMBER ID, ORIGINAL CLAIM #, and TOTAL CHARGES. Each row includes 'Edit' and 'Delete' links.

DATE CREATED ↑	CLAIM TYPE ↓	CLAIM ID ↓	MEMBER NAME ↓	MEMBER ID ↓	ORIGINAL CLAIM # ↓	TOTAL CHARGES ↓		
08/10/2017	Institutional	8[REDACTED]0	R[REDACTED]	1[REDACTED]9	<a href="#">Q[REDACTED]3</a>	\$54,159.07	<a href="#">Edit</a>	<a href="#">Delete</a>
08/07/2017	Institutional	8[REDACTED]5	P[REDACTED]S	1[REDACTED]9	<a href="#">Q[REDACTED]1</a>	\$461.75	<a href="#">Edit</a>	<a href="#">Delete</a>
08/02/2017	CMS-1500	8[REDACTED]0	AI[REDACTED]N	1[REDACTED]9	<a href="#">Q[REDACTED]4</a>	\$292.00	<a href="#">Edit</a>	<a href="#">Delete</a>
08/01/2017	Institutional	8[REDACTED]7	J[REDACTED]E	1[REDACTED]9	<a href="#">Q[REDACTED]6</a>	\$461.75	<a href="#">Edit</a>	<a href="#">Delete</a>
08/01/2017	Institutional	8[REDACTED]1	F[REDACTED]	1[REDACTED]9	<a href="#">Q[REDACTED]1</a>	\$461.75	<a href="#">Edit</a>	<a href="#">Delete</a>
07/17/2017	Institutional	8[REDACTED]3	[REDACTED]N	1[REDACTED]9		\$507.00	<a href="#">Edit</a>	<a href="#">Delete</a>

# Payment History

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

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

Claims [ ] Individual [ ] Saved [ ] Submitted [ ] Batch [ ] Recurring [ ] **Payment History** [ ] Claims Audit Tool [ ] Filter [ ]

### Transactions

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

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

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

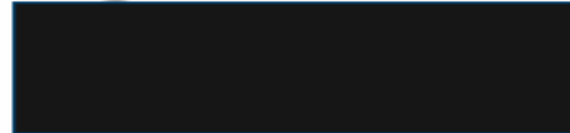
# Provider EOP

STANDARD

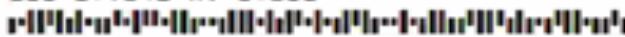


Electronic Service Requested

34000706113



b06 D.7648 AV D.366 S-DIGIT 30374




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

### STATEMENT TOTAL

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

### Remittance Advice and Explanation of Payment


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

Serv	Dates	Procedure	Modifiers	Days Ct/Qty	Charged	Allowed	Deduct / Copay	Coinsur/ Discount	Interest	Med Allow/ Med Paid	TPP	Denied	Payment Codes	Payment
0100	[REDACTED]	[REDACTED]	G5	1.00	6388.16	263.75	.00	.00	.00	.00	.00	.00	A0 SR 30	258.47
								5.28						
0200	[REDACTED]	[REDACTED]	G5	1.00	6388.16	263.75	.00	.00	.00	.00	.00	.00	A0 SR 30	258.47
								5.28						
0300	[REDACTED]	[REDACTED]	G5	1.00	6388.16	263.75	.00	.00	.00	.00	.00	.00	A0 SR 30	258.47
								5.28						
0400	[REDACTED]	[REDACTED]	G5	1.00	6388.16	263.75	.00	.00	.00	.00	.00	.00	A0 SR 30	258.47
								5.28						
0500	[REDACTED]	[REDACTED]	G5	1.00	6388.16	263.75	.00	.00	.00	.00	.00	.00	A0 SR 30	258.47
								5.28						
0600	[REDACTED]	[REDACTED]	G5	1.00	6388.16	263.75	.00	.00	.00	.00	.00	.00	A0 SR 30	258.47
								5.28						
0700	[REDACTED]	[REDACTED]	G5	1.00	6388.16	263.75	.00	.00	.00	.00	.00	.00	A0 SR 30	258.47
								5.28						

# 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** 

**FOLLOW THESE INSTRUCTIONS TO GET STARTED WITH PAYSAN® 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**.

Personal Provider Identifier (PIN)  Day Code

Provider Federal Tax Identification Number (TIN)  Minimum 9 characters and may include letters (a-z), numbers (0-9), dashes (-), underscores (\_), apostrophes ('), and periods (.)

OR

Employer Identification Number (EIN)

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

Provider Contact Name  **Organization**

Organization Full Name  Minimum 8 characters and may include letters (a-z), numbers (0-9), dashes (-), underscores (\_), apostrophes ('), and periods (.)

Head Address

Head Address will be used to bill bills.

Confirm Email Address

Telephone Number

Please call us the 800-331-7154 format.

Pin  **Challenge Question**

Other Message

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

Account Name

This is the account that will be used to debit this recurring account through the PaySpan system.

Financial Institution Routing Number

Provider's Account Number with Financial Institution

Confirm Provider's Account Number with Financial Institution

Type of Account at Financial Institution

Enable Electronic Payments

Request Paper Remittance  
The Paper does not allow paper remittance.

Assign new or additional Papers to this recurring account

- 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](mailto:providersupport@payspanhealth.com)

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0221.PR.P.FL 2/21

# Tips to Remember

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

---

# Online Claim Reconsiderations on the MHS Secure Provider Portal

---



# Summary of Online Reconsiderations

- **Skip the phone call.**
  - Providers can make their case directly on the portal.
- **Make the case.**
  - Providers can submit informal dispute/reconsideration comments using expanded text fields.
- **Add context.**
  - Providers can easily attach supporting documentation when filing an informal dispute/reconsideration.
- **Stay current.**
  - Providers may opt in/out for informal dispute/reconsideration status change emails.
  - Providers may also view status online.

# Online Reconsiderations

Providers are able to:

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

# Online Reconsiderations


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

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

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

## Claim #T1234P1235: Denied

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



Claim Accepted      In Process      Denied

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

### Service Lines

Label	Label	Label	Label	Label	Label	Label	Label
-------	-------	-------	-------	-------	-------	-------	-------

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

The screenshot displays the 'Secure Provider Portal' interface. At the top, a dark blue navigation bar contains icons and labels for 'Eligibility', 'Patients', 'Authorizations', 'Claims', and 'Messaging', along with a 'User Name' dropdown. Below this, a light blue header bar shows a 'Back to Claims' button and a search field containing a redacted ID, followed by the text ': Claim #T1234P1235'. The main content area is white and features three distinct options, each with a blue 'SELECT' button on the left. 'Option 1: Correct the claim' includes a brief description. 'Option 2: Informally dispute the claim' includes a description and a bulleted list of details. 'Option 3: Appeal the claim' includes a description and a bulleted list of details.

Back to Claims [Redacted] : Claim #T1234P1235

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

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

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

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

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

# Claim Reconsideration

- Enter your explanation for reconsideration and check email updates.

### Reconsider Claim

Claim No:

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

**Reconsideration Type**  
Denied for Untimely Filing

**Notes**  
*Brief Explanation*

500 Character Limit

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

**Uploaded Files**


**Email Updates**  
 Check here to receive email status updates for this reconsideration.  
Please upload files less than 10MB each. Supported file formats are PDF, TIFF, TIF, JPEG, and JPG.

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


Back to Claims
**Claim Details**

## Claim #T1234P1235: Denied


COPY
DISPUTE




Claim Accepted



Claim Denied



Dispute Submitted



Claim Denied  
(Decision Upheld)

Dispute

U026IA1234566

### Dispute/Appeal Details

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

<b>Member</b>	<b>Provider</b>	<b>Claim</b>	<b>Most Recent Payment</b>
Participant Name <div style="background-color: #0056b3; height: 15px; width: 100%;"></div>	Ref./Acct No. <b>1234567890</b>	DOS Range <b>08/12/2020 - 08/15/2020</b>	Payment Date ---
Member ID <b>ID123459</b>	Servicing Provider <div style="background-color: #0056b3; height: 15px; width: 100%;"></div>	Received Date <b>09/12/2020</b>	Check/EFT No. ---
Member DOB <div style="background-color: #0056b3; height: 15px; width: 100%;"></div>	Servicing NPI <b>1234567890</b>	Billed Amount <b>\$6,1234.12</b>	Check Dated ---
			Paid Claim Amount <b>\$0.00</b>
			Total Check Amount ---

### Service Lines

Label	Label	Label	Label	Label	Label	Label
-------	-------	-------	-------	-------	-------	-------

# Coordination of Benefits

- This screen shows if a member has other insurance.

[Back to Patient List](#) **Member Name**

Overview	Effective Date	Term Date	Policy Number	Group Number	Carrier Name	Coverage
Cost Sharing	06/01/2008	12/21/2013	██████████		AETNA	MEDICAL AND HOSPITAL
Assessments						
Health Record						
Care Plan						
Authorizations						
<b>Coordination of Benefits</b>						
Claims						



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# Prior Authorization

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# 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



**FOR MEMBERS**    **FOR PROVIDERS**    **GET INSURED**

**FOR PROVIDERS**

- Login
- Enrollment and Updates +
- Prior Authorization -
  - Medicaid Pre-Auth
  - Ambetter Pre-Auth
  - Medicare Pre-Auth
- Dental Providers
- Pharmacy +
- Opioid Resources
- Behavioral Health Providers +
- Provider Resources +
- QI Program +
- Provider News
- Email Sign Up
- Coronavirus Information +

## Medicaid Pre-Auth

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

Vision services need to be verified by [Envolve Vision](#).  
 Dental services need to be verified by [Envolve Dental](#).  
 Ambulance and Transportation services need to be verified by [LCP Transportation](#).  
 Musculoskeletal services need to be verified by [TurningPoint](#).  
 Complex imaging, MRA, MRI, PET, CT scans, PT, ST, and OT need to be verified by [NIA](#).

Non-participating providers must submit Prior Authorization for all services.  
 For non-participating providers, [join our network](#).

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

Yes  No

Types of Services	YES	NO
Is the member being admitted to an inpatient facility?	<input type="radio"/>	<input checked="" type="radio"/>
Are services other than lab, radiology, domiciliary visits DME, Orthotics, or Prosthetics 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"/>

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

**Y** **58270** - VAG HYST UTRUS 250 GM<-;REP ENTROCL  
 Pre-authorization required for all providers.

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

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# MHS Team

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# MHS Team

## MHS Provider Network Territories

### Indiana

#### NORTHEAST REGION

For claims issues, email:  
[MHS\\_ProviderRelations\\_NE@mhsindiana.com](mailto:MHS_ProviderRelations_NE@mhsindiana.com)  
 Chad Pratt, Provider Partnership Associate II  
 1-877-647-4848, ext. 20454

#### NORTHWEST REGION

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 1-877-647-4848, ext. 20080

#### SOUTH CENTRAL REGION

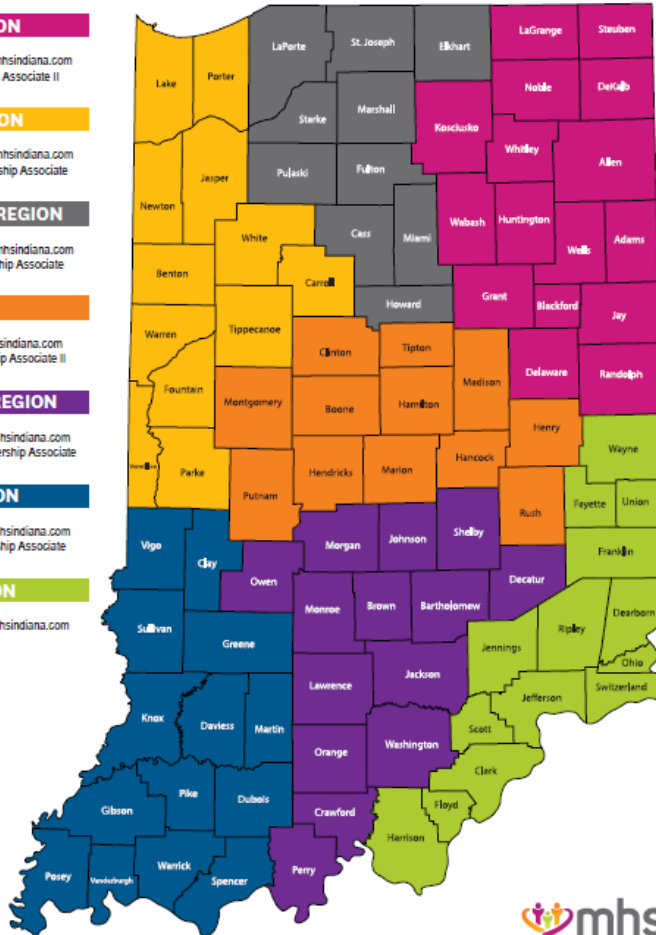
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 Allwell from MHS - Ambetter from MHS - Healthy Indiana Plan (HIP) - Hoosier Care Connect - Hoosier Healthwise

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# MHS Team

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### NETWORK LEADERSHIP

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### ENVOLVE DENTAL, INC.

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### PROVIDER GROUPS

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Ascension Complete  
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Lutheran Medical Group  
Parkview Health System  
Beacon Medical Group  
Heart City Health Center



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AllWell from MHS - Ambetter from MHS - Healthy Indiana Plan (HIP) - Hoosier Care Connect - Hoosier Healthwise

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Questions?  
Thank you for being our  
partner in care.

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