












MHS Lunch Learning Session 2018




Agenda

-  MHS Overview
-  Provider Analytics-P4P
-  Prior Authorization Process
-  Web Portal Functionality
-  Public Website / Provider Enrollment Functions
-  Behavioral Health Updates
-  Medical Claims Processing
-  Engolve Dental
-  Summary
-  Questions

Who is MHS?

 **Managed Health Services** (MHS) is a managed care entity that has been proudly serving the state of Indiana for more than twenty years through the Hoosier Healthwise and Hoosier Care Connect Medicaid programs; and the Healthy Indiana Plan (HIP) Medicaid alternative program.

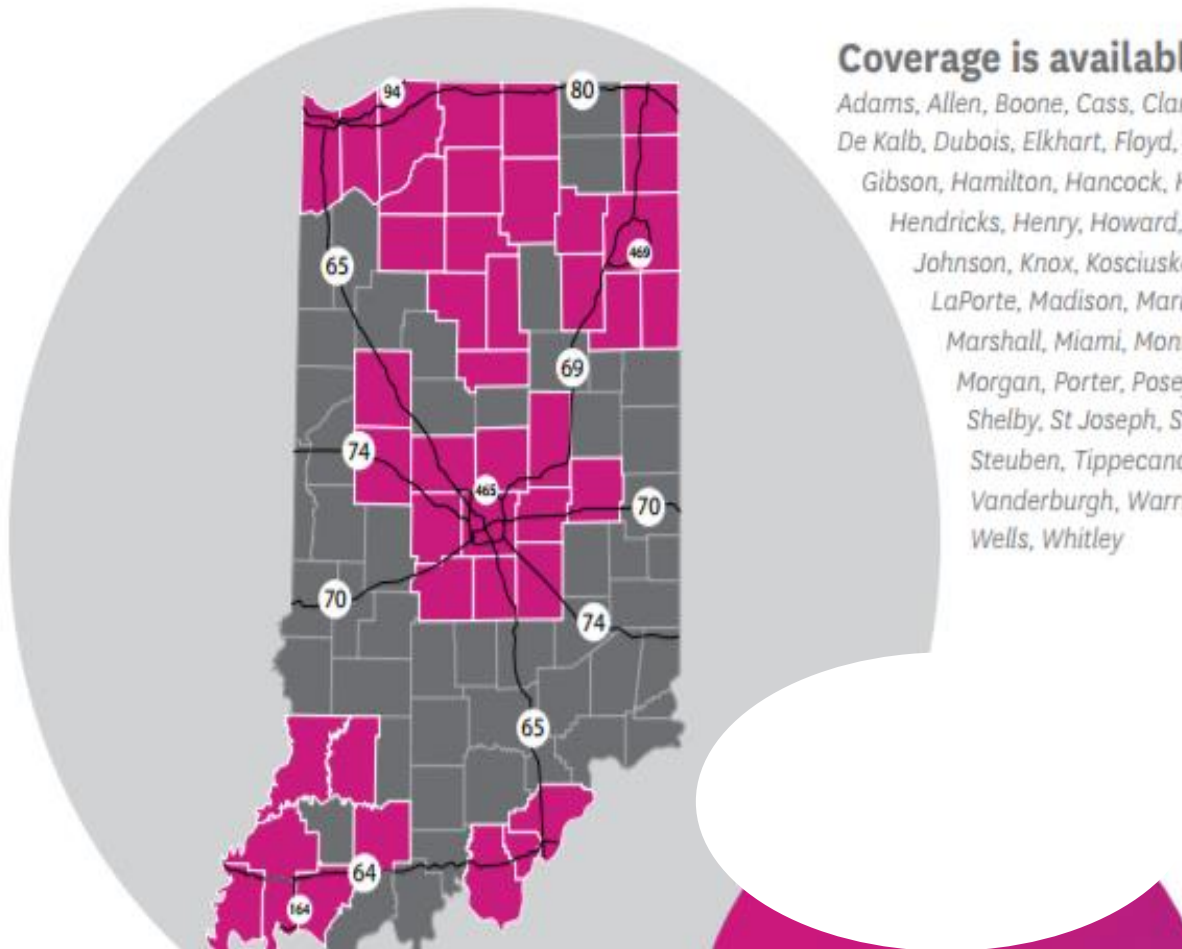
 MHS also offers **Ambetter from MHS** in the Indiana health insurance marketplace, and **Allwell from MHS**, a Medicare Advantage plan. All of our plans include quality, comprehensive coverage with a provider network you can trust.

 MHS is your choice for better healthcare.

MHS Products



Ambetter 2018



Coverage is available in:





Adams, Allen, Boone, Cass, Clark, Daviess,
De Kalb, Dubois, Elkhart, Floyd, Fulton,
Gibson, Hamilton, Hancock, Harrison,
Hendricks, Henry, Howard, Huntington,
Johnson, Knox, Kosciusko, Lake,
LaPorte, Madison, Marion,
Marshall, Miami, Montgomery,
Morgan, Porter, Posey, Pulaski,
Shelby, St Joseph, Starke,
Steuben, Tippecanoe,
Vanderburgh, Warrick,
Wells, Whitley

Allwell 2018



Provider Analytics- P4P

2018 Pay for Performance (P4P)

-  Bonus **Pay for Performance** (P4P) fund written into Primary Medical Provider contracts
-  Measures are different for each product line
-  Measures aligned with HEDIS® and NCQA
-  Annual payout



2018 HHW P4P

Schedule A-2 A-1 for Hoosier Healthwise

Please send information to **MHS** Attn: P4P Program, 550 N. Meridian Suite 101 Indianapolis, IN 46204 or email to P4P@mhsindiana.com

Pay-For-Performance Measures		Goal Rate	Minimum Number of Covered Persons	Points
Children's Care (Quality)				42 points
Childhood Immunization Status (CIS)COMBO 10	% of 2 year old Covered Persons who had the following immunizations by their second birthday: 4 DTaP, 3 IPV, 1 MMR, 3 Hib, 3 Hep B, 1 VZV, 4 PCV, 1 Hep A, 2 or 3 RV (depending on dose schedule), 2 Flu	HEDIS 75 th percentile	10	7 points
Follow-Up Care for Children Prescribed ADHD Medication – Initiation Phase	% of members 6–12 years of age as of the IPSD with an ambulatory prescription dispensed for ADHD medication, who had one follow-up visit with practitioner with prescribing authority during the 30-day Initiation Phase	HEDIS 75 th percentile	5	7 points
Follow-Up Care for Children Prescribed ADHD Medication – continuation phase	% of members 6–12 years of age as of the IPSD with an ambulatory prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended	HEDIS 75 th percentile	5	7 points
Well-Child Visits in the First 15 Months of Life (W15)	% of Covered Persons turning 15 mos within the current year who had 6 or more visits with PMP before turning 15 mos old	HEDIS 75 th percentile	10	7 points
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)	% of Covered Persons who turned 3-6 years old within the year who had 1 or more well child visits within the current year	HEDIS 75 th percentile	10	7 points
Adolescent Well-Care Visits (AWC)	% of Covered Persons 12-21 years old who had at least 1 comprehensive well care visit with PMP or OB within the current year	HEDIS 75 th percentile	10	7 points

2018 HHW P4P

Maternal Care (Quality)					20 points
Prenatal and Postpartum Care (PPC)	Timeliness of Prenatal Care - % of deliveries that received a prenatal care visit in the first trimester or within 42 days of enrollment	HEDIS 75th percentile	5		7 points
Prenatal and Postpartum Care (PPC)	Postpartum Care - % of deliveries that had a postpartum visit on or between 21 and 56 days after delivery	HEDIS 75th percentile	5		7 points
Women's Care (Quality)					7 points
Chlamydia Screening in Women (CHL)	% of female Covered Persons age 16-24 years identified as sexually active who had at least one Chlamydia test in the current year	HEDIS 75th percentile	5		7 points
Respiratory Care					14 points
MED Management for People With Asthma (Med 75% rate)	% of members 5-64 years of age during the measurement year who were identified as having persistent asthma and were dispensed appropriate medications and remained on an asthma controller medication for at least 75% of their treatment period	HEDIS 75th percentile	5		7 points
Asthma Medication Ratio (AMR) - total	% of members 5-64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year	HEDIS 75th percentile	5		7 points

2018 HHW P4P

Ambulatory Measures					7 points
Ambulatory Care (AMB) – ER utilization	utilization of ambulatory care in the ED - # visits per 1,000 member months	HEDIS 10th percentile	10		7 points
Provider Outreach (Administrative) Credit given for use of any 3 of the following 5:					10 points*
Provider-Initiated Preventive Health Outreach	Selected outreach condition must be applicable to at least 20% of total panel, i.e. telephonic campaign, Covered Person mailing campaign, special well-child health check day at your office. Report of Outreach must be received by MHS by December 31 of the measurement year. At a minimum, the outreach must be described and a list of Covered Persons who received the outreach must be included.				
Panel Size Increase	Increase panel size by 10%				
Training Attendance or Use of Bright Futures	Physician or Office Manager attendance in one MHS training/orientation sessions during the calendar year or documented use of the AAP Bright Futures program				
Use of Patient Satisfaction Survey	Use of a practice-level patient satisfaction survey, such as the American Academy of Family Physicians model questionnaire				
Use of EMR or MHS Well Visit Form	Use of Electronic Medical Record or the MHS Child or Adult Health Maintenance Form for well-visits				

*Use of 1 = 3 points

Use of 2 = 6 points

Use of 3 or more = 10 points

2018 HHW P4P Measures



Child and adolescent well-care

- Childhood immunization status (CIS)
- Well-child visits 0-15 months (W15)
- Well-child visits 3-6 years (W34)
- Well-adolescent visits 12-21 years (AWC)
- Follow-up care for children prescribed ADHD medication – Acute and Continuation phases (ADD)



Maternal Care

- Timeliness/initiation of prenatal care (PPC)
- Postpartum care (PPC)

2018 HHW P4P Measures



Women's care

- Chlamydia screening (CHL)



Respiratory care

- MED Management for Asthmatics (MMA)
- Asthma Medication Ratio (AMR) - total



Ambulatory Measures

- Ambulatory Care (AMB) – ER utilization



2018 HIP P4P

Schedule A-2B-1 for HIP

Please send information to **MHS** Attn: P4P Program, 550 N. Meridian Suite 101 Indianapolis, IN 46204 or email to P4P@mhsindiana.com

Pay-For-Performance Measures			Goal Rate	Minimum Number of Covered Persons	Points
Women's Care (Quality)					21 points
	Chlamydia Screening in Women (CHL)	% of female Covered Persons age 16-24 years identified as sexually active who had at least one Chlamydia test in the current year	HEDIS 75th percentile	5	7 points
	Cervical Cancer Screening (CCS)	% of female Covered Persons age 24-64 years who received 1 or more Pap tests to screen for cervical cancer in the current year	HEDIS 75th percentile	5	7 points
	Breast Cancer Screening (BCS)	% of women 50-74 years of age who had a mammogram to screen for breast cancer	HEDIS 75th percentile	5	7 points
Maternal Care (Quality)					20 points
	Prenatal and Postpartum Care (PPC)	Timeliness of Prenatal Care - % of deliveries that received a prenatal care visit in the first trimester or within 42 days of enrollment	HEDIS 75th percentile	5	7 points
	Prenatal and Postpartum Care (PPC)	Postpartum Care - % of deliveries that had a postpartum visit on or between 21 and 56 days after delivery	HEDIS 75th percentile	5	7 points

2018 HIP P4P

Ambulatory Measures					14 points
Ambulatory Care (AMB) – ER utilization	utilization of ambulatory care in the ED - # visits per 1,000 member months	HEDIS 10th percentile	10	7 points	
Adults' Access to Preventive/Ambulatory Health Services (AAP)	% of members 20 years and older who had an ambulatory or preventive care visit	HEDIS 75th percentile	10	7 points	
Provider Outreach (Administrative) Credit given for use of any 3 of the following 5:					10 points*
Provider-Initiated Preventive Health Outreach	Selected outreach condition must be applicable to at least 20% of total panel, i.e. telephonic campaign, Covered Person mailing campaign, special well-child health check day at your office. Report of Outreach must be received by MHS by December 31 of the measurement year. At a minimum, the outreach must be described and a list of Covered Persons who received the outreach must be included.				
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Use of Patient Satisfaction Survey	Use of a practice-level patient satisfaction survey, such as the American Academy of Family Physicians model questionnaire				
Use of EMR or MHS Well Visit Form	Use of Electronic Medical Record or the MHS Adolescent or Adult Health Maintenance Form for well-visits				
P4P Scoring Key for Provider Outreach					
<ul style="list-style-type: none">Complete one activity above to earn 3 Points. (30% payment for this section)Complete two activities above to earn 6 Points. (60% payment for this section)Complete three or more activities above and earn 100% payment for this section.					

2018 HIP P4P Measures

Maternal care

- Timeliness/initiation of prenatal care (PPC)
- Postpartum care (PPC)

Women's Care

- Chlamydia Screening (CHL)
- Cervical Cancer Screening (CCS)
- Breast Cancer Screening (BCS)

2018 HIP P4P Measures

Respiratory care

- MED Management for Asthmatics (MMA)
- Pharmacotherapy Management of COPD Exacerbation (PCE) - systemic corticosteroid

Behavior Health Care

- Antidepressant Med Management (AMM) – Acute Phase

2018 HIP P4P Measures



Diabetes Care (CDC)

- Diabetes Care - Eye exam (retinal) performed
- Diabetes Care - Medical attention for nephropathy



Ambulatory Measures

- Ambulatory Care (AMB) – ER utilization
- Adults' Access to Preventive/Ambulatory Health Services (AAP)

2018 HCC P4P

Schedule 2C-1A for Hoosier Care Connect

Please send information to MHS Attn: P4P Program, 550 N. Meridian Suite 101 Indianapolis, IN 46204 or email to P4P@mhsindiana.com

Pay-For-Performance Measures			Goal Rate	Minimum Number of Covered Persons	Points
Children's Care (Quality)					28 points
Childhood Immunization Status (CIS) COMBO 10	% of 2 year old Covered Persons who had the following immunizations by their second birthday: 4 DTaP, 3 IPV, 1 MMR, 3 Hib, 3 Hep B, 1 VZV, 4 PCV, 1 Hep A, 2 or 3 RV (depending on dose schedule), 2 Flu		HEDIS 75 th percentile	10	7 points
Well-Child Visits in the First 15 Months of Life (W15)	% of Covered Persons turning 15 months within the current year who had 6 or more visits with PMP before turning 15 months old		HEDIS 75 th percentile	10	7 points
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)	% of Covered Persons who turned 3-6 years old within the year who had 1 or more well child visits within the current year		HEDIS 75 th percentile	10	7 points
Adolescent Well-Care Visits (AWC)	% of Covered Persons 12-21 years old who had at least 1 comprehensive well care visit with PMP or OB within the current year		HEDIS 75 th percentile	10	7 points
Respiratory Care					27 points
MED Management for People With Asthma (Med 75% rate)	% of members 5-64 years of age during the measurement year who were identified as having persistent asthma and were dispensed appropriate medications and remained on an asthma controller medication for at least 75% of their treatment period		HEDIS 75 th percentile	5	7 points
Asthma Medication Ratio (AMR) - total	% of members 5-64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year		HEDIS 75 th percentile	5	7 points

2018 HCC P4P

Pharmacotherapy Management of COPD Exacerbation (PCE) - systemic corticosteroid	% of COPD exacerbations for members 40 years of age and older who had an acute inpatient discharge or ED visit on or between January 1– November 30 of the measurement year and who were dispensed a systemic corticosteroid (or there was evidence of an active prescription) within 14 days of the event	HEDIS 75th percentile	5	7 points
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	% of adults 18– 64 years of age with a diagnosis of acute bronchitis who were not dispensed an antibiotic prescription on or within three days after the diagnosis. [Members with chronic respiratory disorders such as COPD and Cystic Fibrosis are excluded from this measure.]	HEDIS 75th percentile	5	6 points
Diabetes Care				14 points
Diabetes Care - Eye exam (retinal) performed	% of members 18–75 years of age with diabetes (type 1 and type 2) who had an eye exam (retinal) performed	HEDIS 75th percentile	5	7 points
Diabetes Care - Medical attention for nephropathy	% of members 18–75 years of age with diabetes (type 1 and type 2) who had medical attention for nephropathy	HEDIS 75th percentile	5	7 points
Ambulatory Measures				14 points
Ambulatory Care (AMB) – ER utilization	utilization of ambulatory care in the ED - # visits per 1,000 member months	HEDIS 10th percentile	10	7 points
Adults' Access to Preventive/Ambulatory Health Services (AAP)	% of members 20 years and older who had an ambulatory or preventive care visit	HEDIS 75th percentile	10	7 points
Behavioral Health Care				7 points
Antidepressant Medication Management (AMM) – Acute Phase	% of members who remained on an antidepressant medication for at least 84 days (12 weeks)	HEDIS 75th percentile	5	7 points

2018 HCC P4P

Provider Outreach (Administrative) Credit given for use of any 3 of the following 5:		10 points*
Provider-Initiated Preventive Health Outreach	Selected outreach condition must be applicable to at least 20% of total panel, i.e. telephonic campaign, Covered Person mailing campaign, special well-child health check day at your office. Report of Outreach must be received by MHS by December 31 of the measurement year. At a minimum, the outreach must be described and a list of Covered Persons who received the outreach must be included.	
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P4P Scoring Key for Provider Outreach <ul style="list-style-type: none"> • Complete one activity above to earn 3 Points. (30% payment for this section) • Complete two activities above to earn 6 Points. (60% payment for this section) • Complete three or more activities above and earn 100% payment for this section. 		

2018 HCC P4P Measures



Child and Adolescent Well-Care


- Childhood immunization status (CIS)
- Well-child visits 0-15 months (W15)
- Well-child visits 3-6 years (W34)
- Well-adolescent visits 12-21 years (AWC)




Behavior Health Care

- Antidepressant Medication Management (AMM) –
Acute Phase

2018 HCC P4P Measures

- 
- The logo for MHS, featuring a stylized heart shape composed of three human figures in blue, green, and orange, followed by the lowercase letters "mhs" in a bold, sans-serif font.
- Diabetes Care (CDC)**
 - Diabetes Care - Eye exam (retinal) performed
 - Diabetes Care - Medical attention for nephropathy

- 
- The logo for MHS, featuring a stylized heart shape composed of three human figures in blue, green, and orange, followed by the lowercase letters "mhs" in a bold, sans-serif font.
- Ambulatory Measures**
 - Ambulatory Care (AMB) – ER utilization
 - Adults' Access to Preventive/Ambulatory Health Services (AAP)

2018 HCC P4P Measures

Respiratory Care

- MED Management for People With Asthma (MMA)
- Asthma Medication Ratio (AMR) – total
- Pharmacotherapy Management of COPD Exacerbation (PCE) - systemic corticosteroid
- Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB)

Administrative Measures

 Credit given for use of any 3 of the following 5 Measures:

1. Provider-Initiated Preventive Health Outreach
2. Panel Size Increase by 10%
3. Physician or Office Manager attendance at one MHS training/orientation session during the calendar year or documented use of the AAP Bright Futures program
4. Use of Patient Satisfaction Survey
5. Use of EMR or MHS Well Visit Form

Secure Web Portal Reporting

P4P Scorecards

Reports updated monthly on **MHS Secure Portal**

- Group scorecards
- Individual scorecards
- Members in Need of Services lists

Updated measurement rates on **Scorecards** include:

- Claims data (pharmacy, encounter/medical)
- CHIRP / Lab results
- Medical record documentation
- Collected annually

* Send email to P4P@mhsindiana.com to sign up to receive email alerts when documents are posted!

MHS Secure Portal

 Click For Providers then Login/Register



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

Contrast ☐ On ☒ Off language ▾

FOR MEMBERS

FOR PROVIDERS

GET INSURED

FOR PROVIDERS

Login

Enrollment and Updates

Prior Authorization



Dental Providers

Pharmacy



Behavioral Health



Provider Resources



QI Program



Provider News



Portal Login

If you are a contracted MHS provider, you can log in or register now. If you are a non-contracted provider, you will be able to register after you submit your first claim.

Login/Register

Join Our Network

Thank you for your interest in becoming a Managed Health Services (MHS) network provider. We look forward to working with you to improve the health of the community.

Join Our Network

Provider Quick Links



PRE-AUTH CHECK

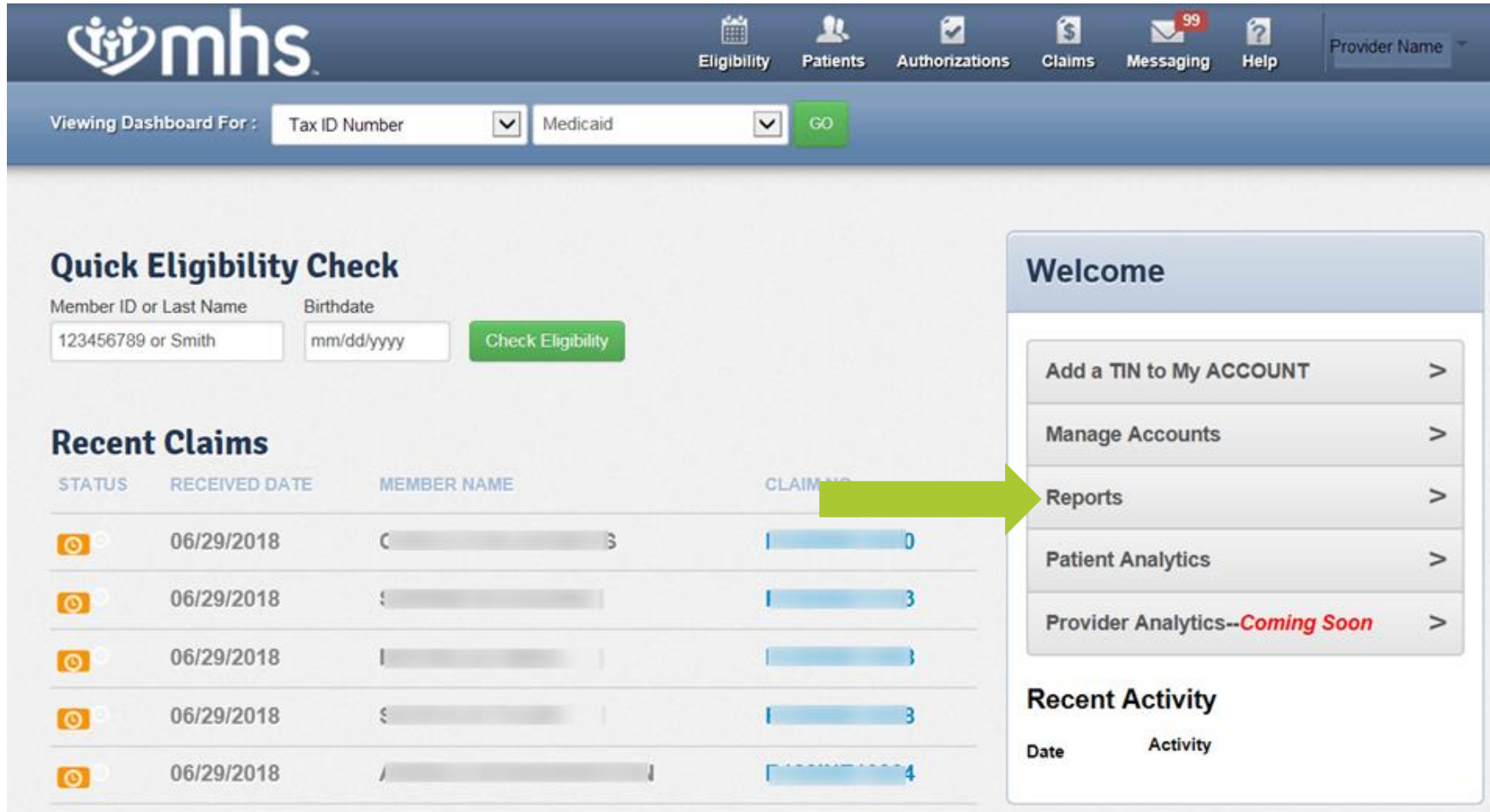


SUBMIT CLAIM/CHECK
CLAIM STATUS



PHARMACY

MHS Secure Portal



The screenshot shows the MHS Secure Portal dashboard. At the top is a navigation bar with the MHS logo and icons for Eligibility, Patients, Authorizations, Claims, Messaging (with a 99 notification), and Help. A dropdown menu for 'Provider Name' is on the right. Below the navigation bar is a section for 'Viewing Dashboard For:' with dropdowns for 'Tax ID Number' and 'Medicaid', and a 'GO' button. The main content area is divided into two columns. The left column contains a 'Quick Eligibility Check' section with input fields for 'Member ID or Last Name' (containing '123456789 or Smith') and 'Birthdate' (containing 'mm/dd/yyyy'), and a 'Check Eligibility' button. Below this is a 'Recent Claims' section with a table. The right column contains a 'Welcome' section with a list of links: 'Add a TIN to My ACCOUNT', 'Manage Accounts', 'Reports', 'Patient Analytics', and 'Provider Analytics--Coming Soon'. Below this is a 'Recent Activity' section with columns for 'Date' and 'Activity'. A green arrow points from the 'Reports' link in the 'Welcome' section to the 'CLAIMS' column header in the 'Recent Claims' table.

Quick Eligibility Check

Member ID or Last Name: 123456789 or Smith
 Birthdate: mm/dd/yyyy
 Check Eligibility

Recent Claims

STATUS	RECEIVED DATE	MEMBER NAME	CLAIMS
	06/29/2018	C [redacted]	0
	06/29/2018	S [redacted]	3
	06/29/2018	I [redacted]	3
	06/29/2018	S [redacted]	3
	06/29/2018	/ [redacted]	4

Welcome

- Add a TIN to My ACCOUNT >
- Manage Accounts >
- Reports >
- Patient Analytics >
- Provider Analytics--*Coming Soon* >

Recent Activity

Date	Activity
------	----------

Group Scorecard Example

Group name: 1

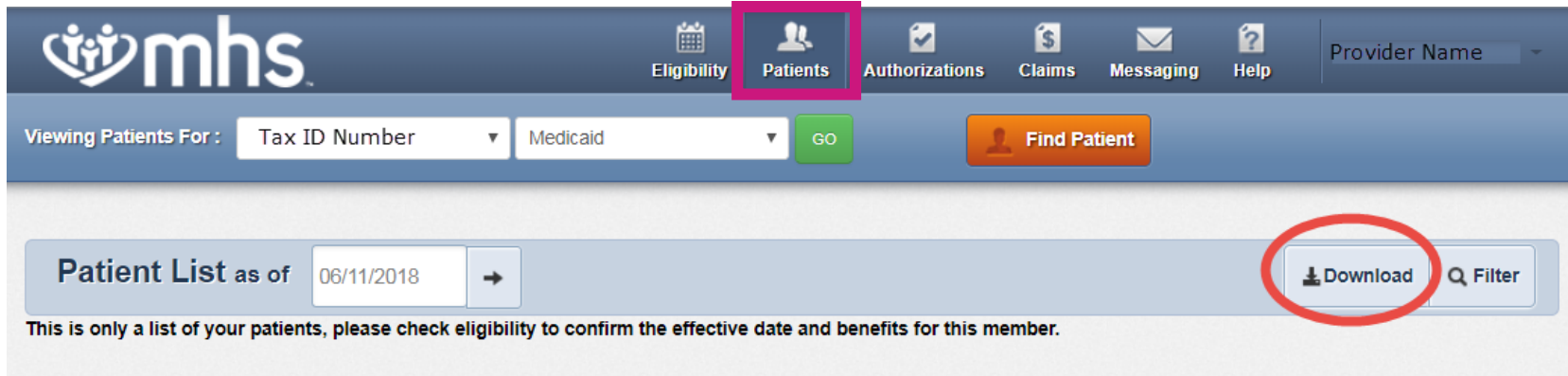
Time period covered by this report: YTD 1/1/2018 thru 4/30/2018



Group Performance Metrics

Prod	Measure	Minimun applicable members needed for measurement	Number of applicable Members in your practice	Number of Members who comply with the applicable criteria	Group average percentage of members who comply with the criteria	NCQA 75th percentile of members who comply with the criteria (MHS GOAL)	Members needed to reach MHS GOAL
HCC	Adolescent Well Care	10	55	10	18.18%	59.72%	23
HCC	Adults' Access to Preventiv	10	385	263	68.31%	85.97%	68
HCC	Antidepressant Medication	5	17	5	29.41%	56.94%	5
HCC	Asthma Medication Ratio (A	5	9	3	33.33%	67.45%	4
HCC	Avoidance of Antibiotic Trea	5	7	2	28.57%	33.74%	1
HCC	Diabetes Care - Eye exam (r	5	83	29	34.94%	63.33%	24
HCC	Diabetes Care - Medical atte	5	76	60	78.95%	91.67%	10
HCC	MED Management for Peopl	5	4	1	25.00%	40.09%	1
HCC	Pharmacotherapy Managem	5	13	11	84.62%	73.11%	0
HCC	Well Child 15 Months - 6+ vi	10	1	1	100.00%	68.66%	0
HCC	Well Child 3-6 Years	10	10	3	30.00%	78.51%	5

Member Gap List Example



Viewing Patients For : Tax ID Number Medicaid GO Find Patient

Patient List as of 06/11/2018 → Download Filter


This is only a list of your patients, please check eligibility to confirm the effective date and benefits for this member.

Excel file

- Sortable
- Filterable

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S
1	4/27/2017																		
2																			
3																			
4																			
5																			
6																			
7	Care Gaps do not reflect claims processed after most current data refresh. Non-Compliant Pay for Performance lists do not reflect claims processed after the report run date and also excludes members who have lost HEDIS eligibility.																		
8																			
9	Member Last Name	Member First Name	Preferred Language	Member ID	Effective Date	Term Date	Program (Category)	Gender	Date of Birth	Phone Number	Address 1	City	State	Zip	Care Gaps	Right Choice Program	Disease Management	Emergency Department	Case Management
10	AMMAY	H	E	1000000000	11/1/2016	12/31/9999	Hoosier Care Connect	F	8/2/2000	2000000006	100 Main St	Fort	IN	46000					
11	AMMAY	M	L	1000000009	11/1/2016	12/31/9999	Hoosier Healthwise	F	8/2/2000	2000000006	100 Main St	Fort	IN	46000			Risk Category Alerts: COPD/Asthma		Medium: Mental Health Monthly Contact
12	AMMAY	M	L	1000000009	2/2/2017	12/31/9999	State Plus, Copay - ER only	F	5/2/2001	2000000004	31 Main St	Angola	IN	46700	No chlamydia test in				
13	AMMAY	S	N	1000000000	11/1/2016	12/31/9999	HIP Plus, Copay - ER only	M	2/2/2000	2000000000	1500 Main St	Kokomo	IN	46900					
14	AMMAY	L	M	1000000009	11/1/2016	4/30/2017	Hoosier Healthwise	M	4/1/2001	2000000001	200 Main St	Fort	IN	46000			Risk Category Alerts: Ischemic Vascular	Member has had 3 or more emergency room	

P4P Payout Calculations

 Payout calculations based on final **HEDIS** admin rates and paid at group level.



 Factors include –

- Panel size – must have at least 150 members
- Required number of members qualified per measure
- Funds from measures without enough members get rolled into other qualifying measures



P4P Program

Ambetter P4P Program

-  Funded at a rate of **\$4.00 per member per month (PMPM)**
-  Three conditions must be met in order to receive the incentive payment:
 - Obtain a minimum of **30 qualifying events** between all measures
 - Score a minimum of **50% in total** for compliant events
 - Meet the minimum target threshold score on **at least 30%** of the measures

Ambetter P4P Program (cont.)

Measure Code	Measure	Description	Target
MPM	Annual Monitoring of Persistent Medications- ACE/ARBS	Annual monitoring for members on angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARB). Requires members having either a lab panel test or serum potassium AND serum creatinine	See Combined Rate below
MPM	Annual Monitoring of Persistent Medications – Digoxin	Annual monitoring for members on digoxin. Requires members having either a lab panel test and serum digoxin test or serum digoxin test AND serum potassium AND serum creatinine	See Combined Rate below
MPM	Annual Monitoring of Persistent Medications – Diuretics	Annual monitoring for members on diuretics. Requires members having either a lab panel test or serum potassium AND serum creatinine	See Combined Rate below
MPM	Annual Monitoring of Persistent Medications – Combined rate	Total rate (the sum of the three numerators divided by the sum of the three denominators)	86.0%
AMM EAPT	Antidepressant Medication Management – Acute Phase	The percentage of members 18 years of age and older who had a diagnosis of major depression, and were treated with antidepressant medication and remained on an antidepressant medication treatment for at least 84 days (12 weeks)	70.0%
AMM ECPT	Antidepressant Medication Management Effective Continuation Phase Treatment	The percentage of members 18 years of age and older who had a diagnosis of major depression, and were treated with antidepressant medication and remained on an antidepressant medication treatment for at least 180 days (6 months).	54%

Ambetter P4P Program (cont.)

Measure Code	Measure	Description	Target
CCS	Cervical Cancer Screening	The percentage of female members 21-64 years of age who were screened for cervical cancer using either of the following criteria: <ul style="list-style-type: none"> Female members age 21-64 who had cervical cytology performed every 3 years Female members age 30-64 who had cervical cytology/HPV co-testing performed every 5 years 	65.0%
CHL	Chlamydia Screening in Women	The percentage of female members 16-24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year	50.0%
CDC-A1C	Comprehensive Diabetes Care – HbA1c Test	The percentage of members 18-75 years of age with diabetes (type 1 and type 2) who had Hemoglobin A1c (HbA1c) testing	94.0%
CDC Nephropathy	Comprehensive Diabetes Care – Nephropathy Monitoring	A nephropathy screening test or evidence of nephropathy, as documented through administrative data. This includes diabetics who had one of the following during the measurement year: <ul style="list-style-type: none"> A nephropathy screening test A positive urine <u>macroalbumin</u> test 	86.0%
AAB	Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	The percentage of members 18-64 years of age with a diagnosis of acute bronchitis who were not dispensed an antibiotic prescription.	27.0%
PDC	Proportion of Days Covered -RAS Antagonists	The percentage of members 18 years and older who met the proportion of days covered of 80% during the measurement period.	78.0%
PDC	Proportion of Days Covered - Statins	The percentage of members 18 years and older who met the proportion of days covered of 80% during the measurement period	73.0%
PDC	Diabetes All Class	The percentage of members 18 years and older who met the proportion of days covered of 80% during the measurement period	72.0%
LBP	Use of Imaging Studies for Low Back Pain	The percentage of members with a primary diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, <u>CT</u> scan) within 28 days of the diagnosis.	79%

Ambetter P4P Program (cont.)

Measure Code	Measure	Description	Target
BCS	Breast Cancer Screening – Total	Measure evaluates the percentage of women ages 50–74 who had a mammogram at least once in the past two years. Women who have had a bilateral mastectomy are exempt from this measure.	76%
COL	Colorectal Cancer Screening	Measure evaluates the percentage of members ages 50-75 who had at least one appropriate screening for Colorectal Cancer in the past year.	67%

Ambetter P4P Program (cont.)



How to access the Ambetter from MHS

Secure Portal:

- Visit Ambetter.mhsindiana.com to sign up or log in to the Secure Portal
- Click on the **Patients Tab**
- The **Patient List/Member Roster** will be displayed
- Those Patients with a “**CG**” indicate that there are **Care Gaps**. When you hover over this button, it will display the specific Care Gaps
- By clicking on the **Download** button, the **Patient List/Member Roster** may be downloaded into an **Excel** format

Ambetter P4P Program (cont.)

Steps to Download Patient List/Member Roster



- Visit Ambetter.mhsindiana.com to sign up or log in to the Ambetter from MHS Secure Portal
- Click on the **Patients** Tab located on the homepage

Ambetter P4P Program (cont.)

- **Patient List/Member Roster** will be displayed
- Patients with a “**CG**” indicate that there are Care Gaps. When you hover over this button, it will display the specific Care Gaps

Patient List as of 08/29/2018 →						Download	Filter
This is only a list of your patients, please check eligibility to confirm the effective date and benefits for this member.							
Eligible	Preferred Language ↑	Member Name ↑	Member ID ↑	Program Name	Date of Birth ↑	ALERTS	
👍		E [text box]	L [text box] 1	Ambetter	01/02/1967	CG	
👍		E [text box]	L [text box] 3	Ambetter	11/18/1998	CG	
👍		[text box]	L [text box]	Ambetter	08/29/1961	CG	
👍		A [text box]	L [text box] 1	Ambetter	05/05/1960	CG	




Ambetter P4P Program (cont.)

- Click on the **“Download”** button to download the Patient List/Member Roster in Excel format

Patient List as of 08/29/2018 →

Download Filter

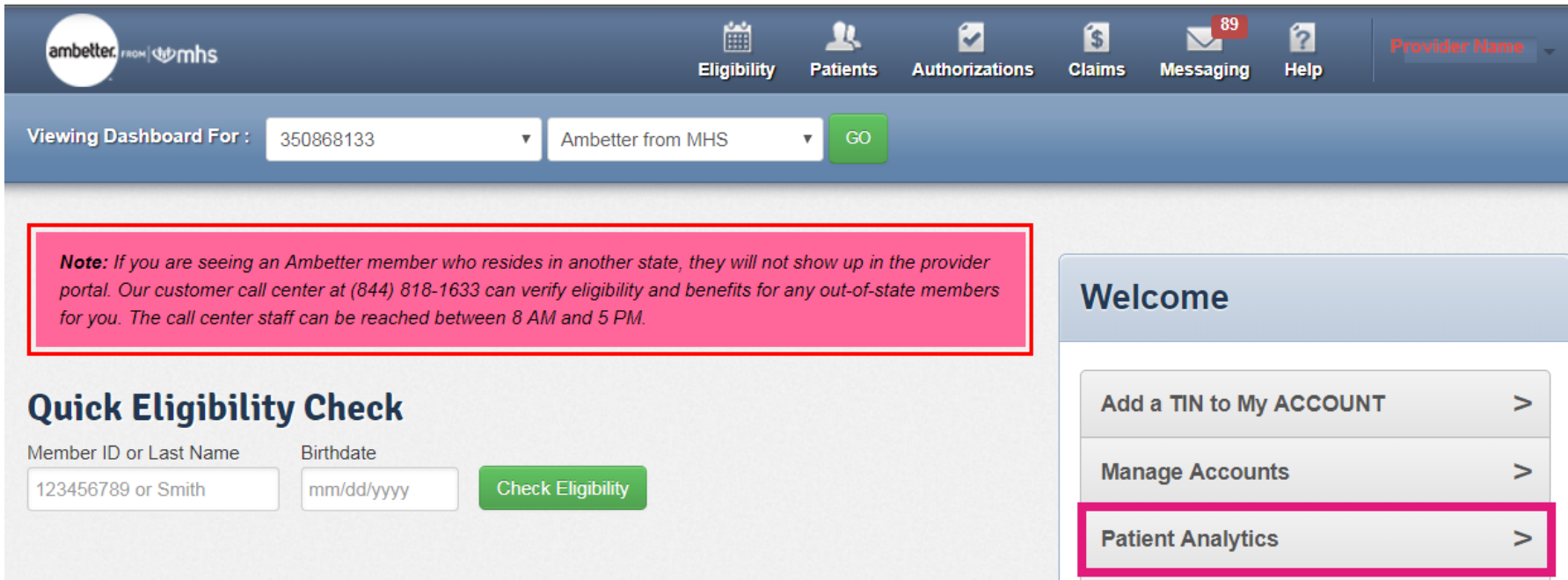
This is only a list of your patients, please check eligibility to confirm the effective date and benefits for this member.

Eligible	Preferred Language ↑	Member Name ↑	Member ID ↑	Program Name	Date of Birth ↑	ALERTS
		E	1	Ambetter	01/02/1967	 CG
		E	3	Ambetter	11/18/1998	CG

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P
1	8/29/2018															
2																
3																
4																
5																
6																
7																
8																
9	Member Last Name	Member First Name	Preferred Language	Member ID	Effective Date	Term Date	Gender	Date of Birth	Phone Number	Address 1	City	State	Zip	Care Gaps	Disease Management	No HRA
10	A	S		1	5/1/2018	12/31/2018	M				Merrillville	IN	464104517	No colorectal cancer		N
11	A	C		3	5/6/2018	12/31/2018	F				Merrillville	IN	464104517	Non-compliant for		N
12	A	M		4	1/2/2018	12/31/2018	F				Valparaiso	IN	463857701	No colorectal cancer		N
13	A	N S		1	8/1/2018	12/31/2018	F				Gary	IN	464084402	No colorectal cancer		N
14	A	N E		1	4/6/2018	12/31/2018	M				Merrillville	IN	464104515	DM - No retinal eye	Risk Category Alerts: Diabetes	N
15	A	T		1	1/1/2018	12/31/2018	F				Crown Point	IN	46307	Hyperlipidemia - Non-	Risk Category Alerts: Diabetes	N
16	A	N L		1	2/1/2018	12/31/2018	F				Gary	IN	464081107	No PAP in past 36		N
17	E	Q E		1	2/20/2018	12/31/2018	F				Crown Point	IN	463077306	No PAP in past 36		N
18	E	F		1	1/2/2018	12/31/2018	F				Gary	IN	464072413	No colorectal cancer		N
19	E	F		1	4/11/2018	12/31/2018	F				Gary	IN	464071813	No PAP in past 36		N

Reports – Patient Analytics

 Click on **Patient Analytics** from Homepage



The screenshot shows the Ambetter from MHS provider portal homepage. At the top is a navigation bar with icons for Eligibility, Patients, Authorizations, Claims, Messaging (with 89 notifications), and Help. A dropdown menu for 'Provider Name' is on the right. Below the navigation bar is a 'Viewing Dashboard For' section with a dropdown menu showing '350868133', another dropdown showing 'Ambetter from MHS', and a green 'GO' button. A pink note box contains the following text: *Note: If you are seeing an Ambetter member who resides in another state, they will not show up in the provider portal. Our customer call center at (844) 818-1633 can verify eligibility and benefits for any out-of-state members for you. The call center staff can be reached between 8 AM and 5 PM.* Below the note is a 'Quick Eligibility Check' section with input fields for 'Member ID or Last Name' (containing '123456789 or Smith') and 'Birthdate' (containing 'mm/dd/yyyy'), and a green 'Check Eligibility' button. On the right side, there is a 'Welcome' section with a list of links: 'Add a TIN to My ACCOUNT', 'Manage Accounts', and 'Patient Analytics'. The 'Patient Analytics' link is highlighted with a pink border.

ambetter FROM **mhs**

Eligibility Patients Authorizations Claims Messaging 89 Help

Provider Name

Viewing Dashboard For : 350868133 Ambetter from MHS GO

Note: If you are seeing an Ambetter member who resides in another state, they will not show up in the provider portal. Our customer call center at (844) 818-1633 can verify eligibility and benefits for any out-of-state members for you. The call center staff can be reached between 8 AM and 5 PM.

Quick Eligibility Check

Member ID or Last Name Birthdate

123456789 or Smith mm/dd/yyyy Check Eligibility

Welcome

Add a TIN to My ACCOUNT >

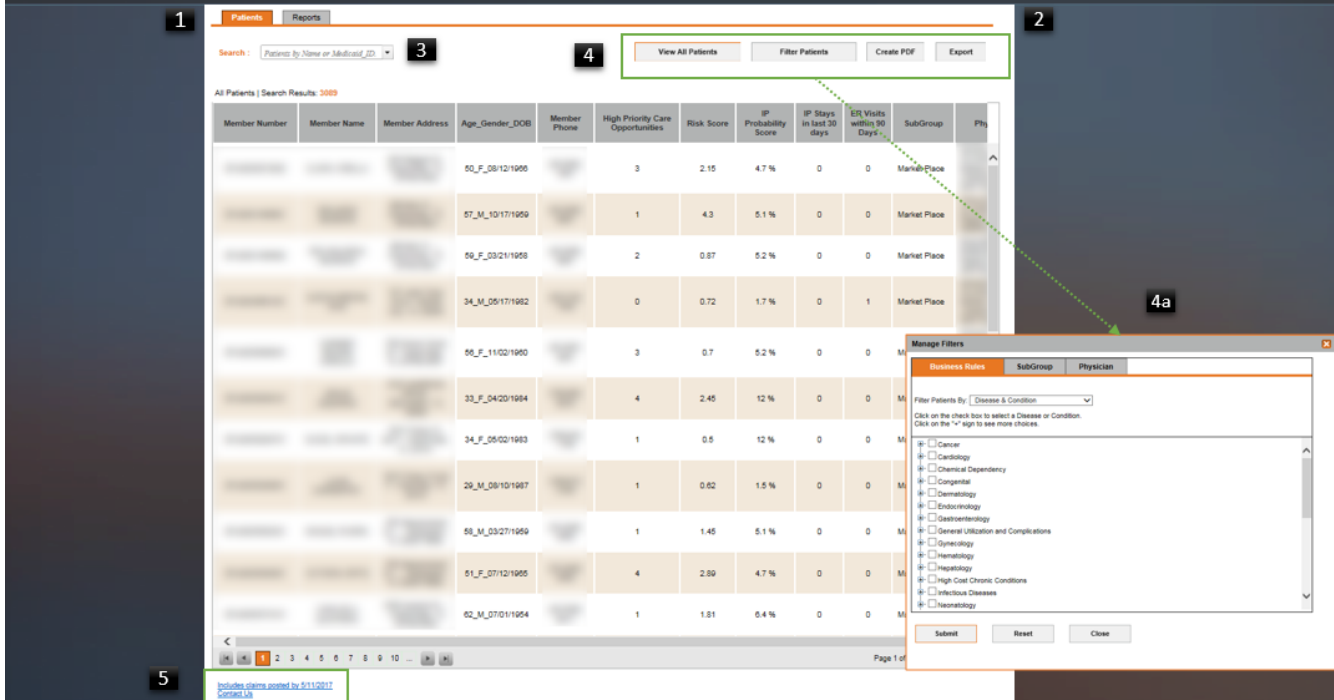
Manage Accounts >

Patient Analytics >

Reports – Patient Analytics

Functionalities of the Patient Tab

Patient Analytics



The screenshot shows the Patient Analytics interface. At the top, there are tabs for 'Patients' (1) and 'Reports' (2). Below the tabs is a search bar (3) with a dropdown menu. To the right of the search bar are buttons for 'View All Patients', 'Filter Patients', 'Create PDF', and 'Export' (4). Below these buttons is a table of patient data. The table has columns for Member Number, Member Name, Member Address, Age_Gender_DOB, Member Phone, High Priority Care Opportunities, Risk Score, IP Probability Score, IP Stays in last 30 days, ERT Visits within 90 Days, SubGroup, and Phy. The table shows several rows of patient data. A 'Manage Filters' dialog box (4a) is open, showing options to filter patients by Business Rules, SubGroup, or Physician. The dialog box has a search bar and a list of filters. At the bottom of the dialog box are buttons for 'Submit', 'Reset', and 'Close'. At the bottom of the table, there are pagination controls (5) showing 'Page 1 of 1' and a link to 'includes claims posted by 5/11/2017'.

Patients Tab

- 1. Tabs:** Allows the providers to choose between the Patients information and Reports.
- 2. Logout Button:** For security purposes, logout to protect patient information. Not shown, in upper right hand corner.
- 3. Search:** Allows providers to search by the patient's name, Medicaid, Medicare or Marketplace ID number.

- 4. Filters and Export Features:** Allows users to view all patients or filter by multiple criteria. The users will also have the ability to create a PDF document or export a detailed patient profile.

4a. Manage Filters: Filter the patient list by business rules, subgroups, and physicians.

- 5. Timeframe:** Provides the date when claims have been posted, followed by a link to contact for questions or concerns. ³

Reports – Patient Analytics

 Each member has a detailed Patient Profile

Patient Analytics

Currently logged into: Logged in as: [User] | Log Out

Patients | Reports

Search: [Patients by Name or Medicaid ID] [Back To Patient List](#)

1 Member Number: [1] Member Name: [J. S.] Member Address: []
 Age/Gender/DOB: [5 / Female / 1/1/1980] Member Phone: [] Preventative/Visit Care Opps: 1
 Diabetic Care Opportunities: 4 Women's Health Care Opportunities: 1 IP Stays in last 30 days: 0
 ER Visits within 90 Days: 0

2 All Care Opportunities **3** Diagnosis **4** Procedures **5** Medications **6** Lab/Observational **7** Care Team

[Create PDF](#)

* = Prospective Measures

Conditions	All Patient Care Opportunities	Quality Measure	Compliance
Breast Cancer	* Breast Cancer-EBM - Pt(s) age 52 - 74 yrs should have a screening mammogram every 27 mos (HEDIS). NS-H	★	No
Diabetes	* Diabetes-EBM - Adult(s) w/ diabetes should have an LDL cholesterol w/in prospective rpt period. CP-I	★	No
Diabetes	* Diabetes-EBM - Pt(s) should have ambulatory care for diabetes w/in prospective rpt period. CP-I	★	No
Diabetes	* Diabetes-EBM - Pt(s) 18 - 75 yrs of age w/ diabetes who should have an annual HbA1c test (HEDIS). NS-H	★	No
Diabetes	* Diabetes-EBM - Pt(s) 18-75 yrs of age w/evidence of poor diabetic control (> 9.0%) should have an HbA1c test <9.0% (HEDIS). NSHA	★	No
Diabetes	* Diabetes-ECC EBM - Pt(s) 18 - 75 yrs of age w/ diabetes who should have an annual screening for nephropathy or evidence of nephropathy. CP-N	★	No

Includes claims posted by 3/13/2017
Contact Us

Patient Profile

- 1. Member Demographics:** Displays information about the member.
- 2. All Care Opportunities:** The default landing page for patient details. Displays care opportunities or measures that indicate if a patient has or has not received treatment for a health condition.
- 3. Diagnosis:** Shows primary and secondary diagnoses from claims data.

- 4. Procedures:** Shows patient procedures associated with primary and secondary diagnoses.
- 5. Medications:** Displays a list of medications prescribed to the patient.
- 6. Lab/Observational:** Shows lab values, interpretations, and trends.
- 7. Care Team:** Allows users to view the patient's providers. Providers are labeled as Managing Doctor or Other Doctor.

5

Reports – Patient Analytics

Quality Measure Report by selected groups and filters

Patient Analytics

Currently logged in as: [User] | [Log Out](#)

Quality Measure Report

View a report by clicking on image below

Monitor Quality Measures

This report displays all Quality Measures for your patients. It includes the compliance status of each measure and the ability to access the specific patient data and details.

Management Reports

Patient Management Reports

This report displays all Patient Reports for your patients. It includes the number of patients for each report and the ability to access the specific patient data and details.

Additional Reports

Saved Reports

This section displays all of your saved reports.

[\[Download/Print/Share\]](#)

Currently logged in as: F | [Log Out](#)

Monitor Quality Measures

[Submit](#) [Reset](#) [Create PDF](#) [Export](#) [Save](#)

Summary of Quality Measure Results Total | 1220 Compliant | 337 Non-Compliant | 883 Rate | 27.6%

Group by: 1 Group by Options selected

Refine your results with multiple-selection filters and click **Submit**

Filter by: [Compliant & Non-Compliant](#)

Filter by: [Select one or more Lines of Business](#)

Filter by: [Select one or more Quality Measures](#)

Table Grouped by: [Quality Measure](#) Total Number of Rows | 52

Quality Measure Description	Total	Compliant	Non-Compliant	Compliance Rate (%)
ADHD-EBM - Pt(s) w/outpt, intensive outpt or partial hosp should have a follow-up visit w/prescrib provider during the 30 days after the initial ADHD Rx (HEDIS, HP) NS-H	1	0	1	0%
Alcohol / Tobacco / Substance Abuse-EBM - Current tobacco users should rec'v medical assistance for tobacco use cessation w/in the prospective rpt period. R-1	26	3	23	11.5%
Asthma-EBM - Adult(s) w/ presumed persistent asthma not using an inhaled corticosteroid or acceptable alternative. R-1	4	3	1	75%
Asthma-EBM - Ped pt(s) w/ presumed persistent asthma w/o inhaled corticosteroid or acceptable alternative. R-1	2	2	1	98.9%
Asthma-EBM - Pt(s) w/o ambulatory care for asthma in last 6 rpt mos. CP-I	22	12	10	44.4%
Body Mass Index-EBM - Pt(s) 3-17 yrs of age should have an outpt visit w/PCP or OB/GYN & have evidence of BMI % documented annually (HEDIS) NS-H	26	0	26	0%
Body Mass Index-EBM - Pt(s) 3-17 yrs of age should have an outpt visit w/PCP or OB/GYN & have nutrition counseling annually (HEDIS) NS-H	26	0	26	0%

[Includes claims posted by 3/15/2017](#)
[Contact Us](#)

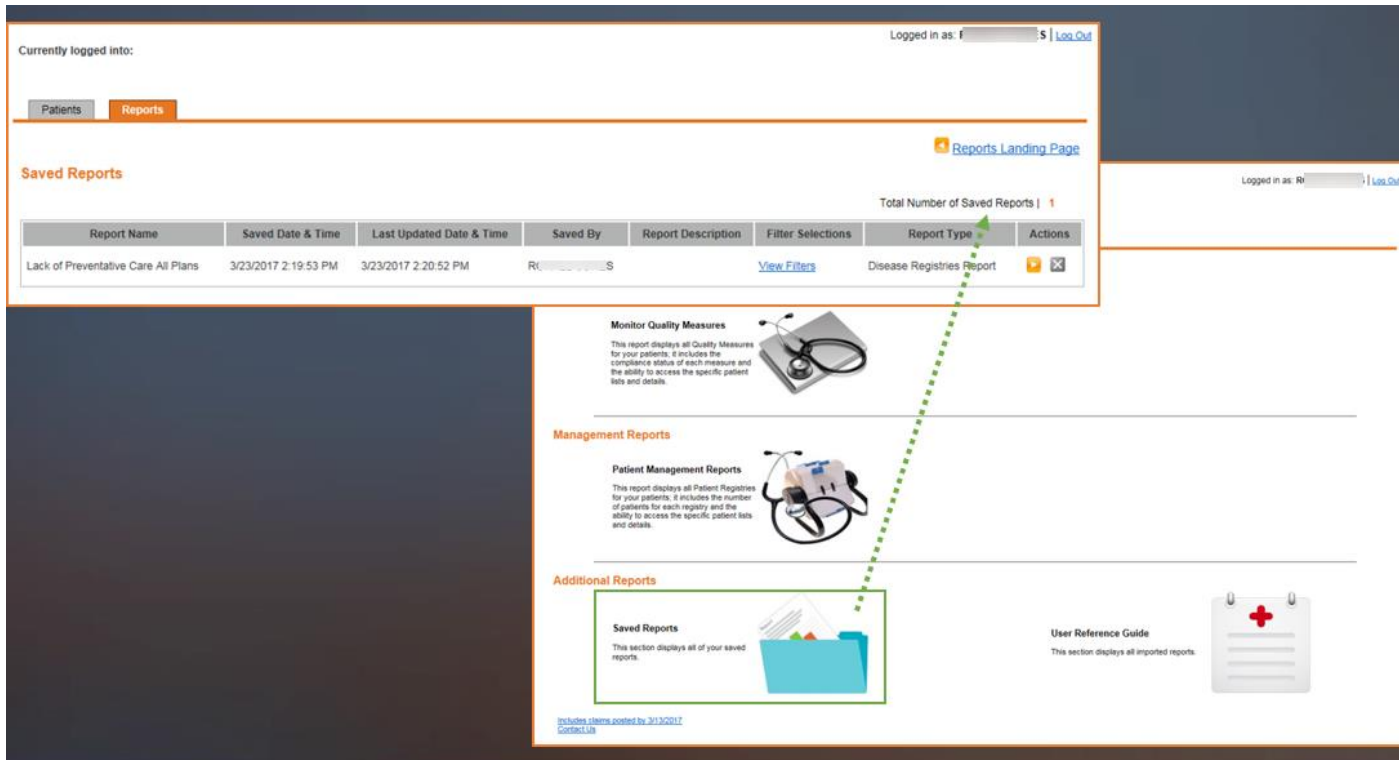
Quality Measure Report:

Monitor Quality Measures Report

- Users are able to view reports by selected grouping and filtering options.

Reports – Patient Analytics

Creating Saved Reports for frequent use





Currently logged into: Logged in as: f S | [Log Out](#)

[Patients](#) [Reports](#)

[Reports Landing Page](#)

Saved Reports

Total Number of Saved Reports | 1

Report Name	Saved Date & Time	Last Updated Date & Time	Saved By	Report Description	Filter Selections	Report Type	Actions
Lack of Preventative Care All Plans	3/23/2017 2:19:53 PM	3/23/2017 2:20:52 PM	R...		View Filters	Disease Registries Report	 

Monitor Quality Measures
This report displays all Quality Measures for your patients. It includes the compliance status of each measure and the ability to access the specific patient lists and details.

Management Reports

Patient Management Reports
This report displays all Patient Registries for your patients. It includes the number of patients for each registry and the ability to access the specific patient lists and details.

Additional Reports

Saved Reports
This section displays all of your saved reports.

User Reference Guide
This section displays all imported reports.

Includes items posted by 3/13/2017 Contact Us

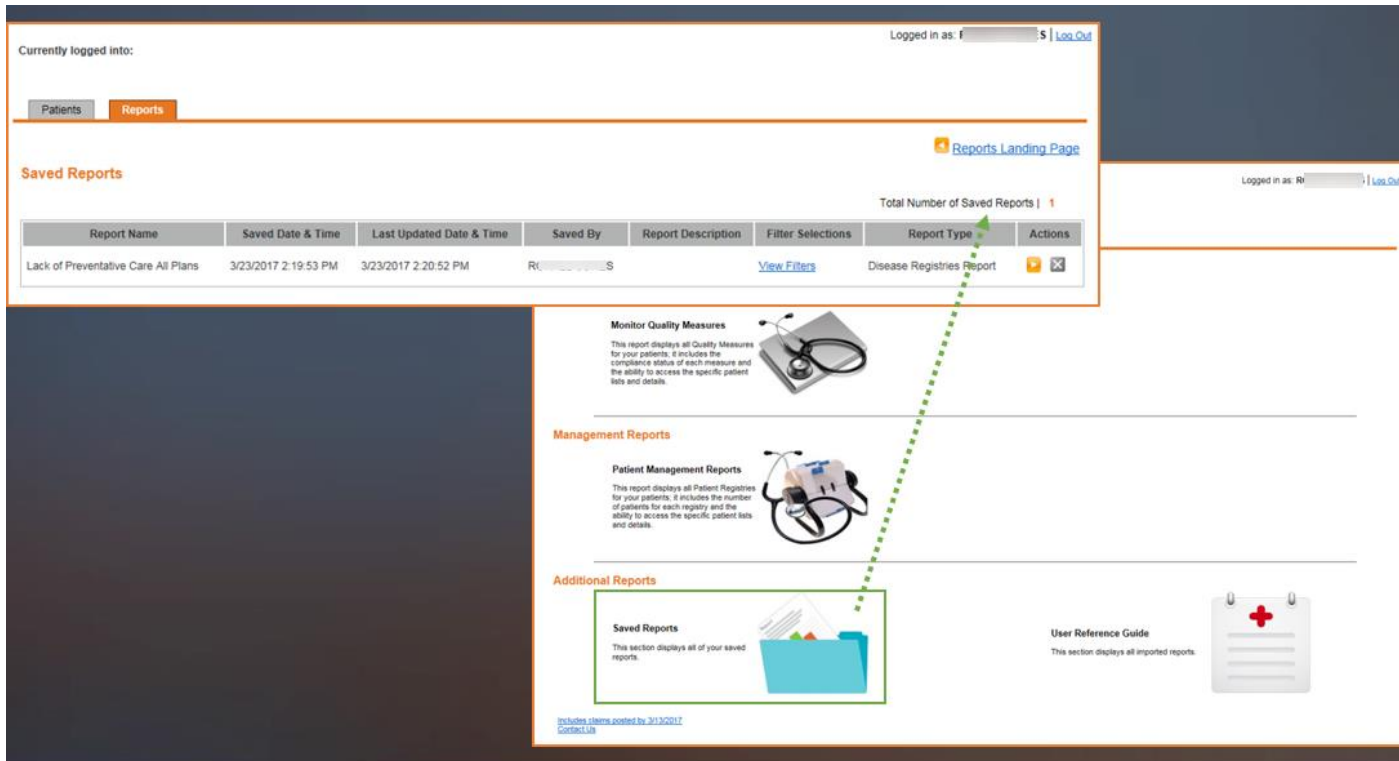
Additional Reports

Saved Reports:

- Shows reports saved by current user.

Reports – Patient Analytics

Creating Saved Reports for frequent use





Currently logged into: Logged in as: f S | [Log Out](#)

[Patients](#) [Reports](#)

[Reports Landing Page](#)

Saved Reports

Total Number of Saved Reports | 1

Report Name	Saved Date & Time	Last Updated Date & Time	Saved By	Report Description	Filter Selections	Report Type	Actions
Lack of Preventative Care All Plans	3/23/2017 2:19:53 PM	3/23/2017 2:20:52 PM	R...		View Filters	Disease Registries Report	 

Monitor Quality Measures
This report displays all Quality Measures for your patients. It includes the compliance status of each measure and the ability to access the specific patient lists and details.

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Additional Reports

Saved Reports:

- Shows reports saved by current user.

10

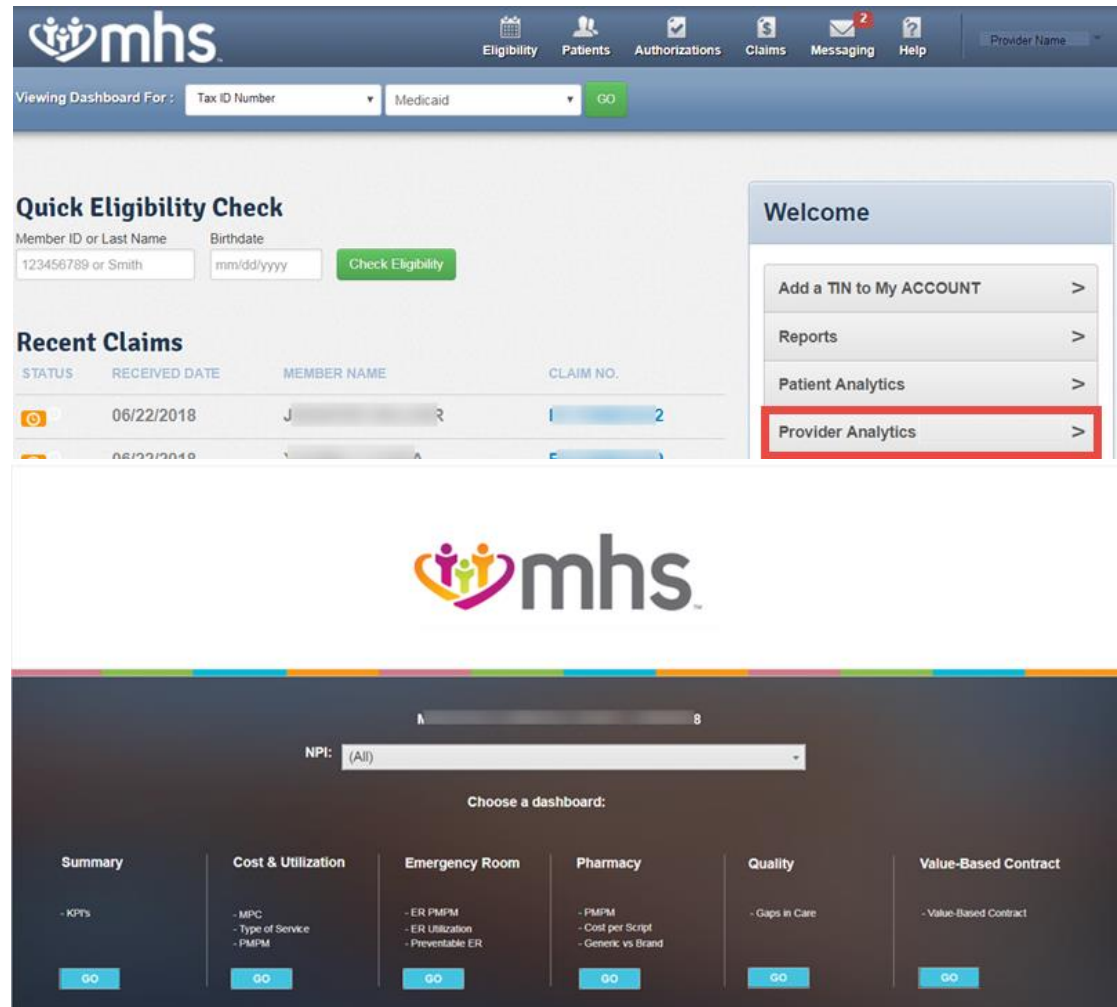
Reports – Provider Analytics



The tool designed to support patient care and help improve performance in value-based programs.



Provider Analytics has multiple tabs, including a Quality tab which provides care gap information, and the Value-based Contracting tab.



The screenshot shows the mhs Provider Analytics dashboard. At the top, there's a navigation bar with icons for Eligibility, Patients, Authorizations, Claims, Messaging, and Help. Below this, a header section allows viewing the dashboard for a specific Tax ID Number and Medicaid status. The main content area is divided into several sections:






- Quick Eligibility Check:** A form to check eligibility by Member ID or Last Name and Birthdate.
- Recent Claims:** A table showing recent claims with columns for Status, Received Date, Member Name, and Claim No.
- Welcome Panel:** A sidebar on the right with links to Add a TIN to My ACCOUNT, Reports, Patient Analytics, and **Provider Analytics** (highlighted with a red box).
- Dashboard Selection:** A section below the main content area with a dropdown for NPI (set to (All)) and a "Choose a dashboard:" label. Below this are six dashboard options: Summary, Cost & Utilization, Emergency Room, Pharmacy, Quality, and Value-Based Contract. Each option has a list of metrics and a "GO" button.

Prior Authorization

Prior Authorization



Prior Authorization (Medical Services)

Prior Authorization is an approval from MHS to provide services designated as needing authorization before treatment and/or payment

-  Inpatient authorizations = IP + 10 digits
-  Outpatient authorizations = OP + 10 digits
-  Emergent ER Symptoms suggesting imminent, life-threatening condition no PA required, but notification requested within **two business days**
-  Urgent concurrent = Emergent inpatient admission. Determination timeline within **24 hours** of receipt of request.
-  Pre-service non urgent = Elective scheduled procedures. Determination within **15 calendar days**. Benefit limitations apply (dependent on product).





Prior Authorization

MHS Medical Management will review state guidelines and all available clinical documentation and seek Medical Director input, as needed

-  PA for observation level of care (**up to 72 hours for Medicaid or 48 hours for Ambetter and Allwell**), diagnostic services do not require an authorization for contracted facilities. Non-contracted facilities do not require prior authorization.
-  If the provider requests an inpatient level of care for a covered/eligible condition, or procedure and documentation supports an outpatient/observation level of care, MHS will send the case for Medical Director review

Prior Authorization



Outpatient Services

-  All elective procedures that require prior authorization must have request to MHS at least **two business days** prior to the date of service
-  All urgent and emergent services do not require prior authorization, but admissions must be called in to MHS within **two business days** following the admit
-  Prior Authorizations are **not** a guarantee of payment
-  Members **must** be Medicaid Eligible on the date of service

****Failure to obtain prior authorization for non urgent and emergent services will result in a denial for related claims***

Prior Authorization

Transfers

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

Self-Referral Services

Exceptions to prior authorization requirements













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

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

****Benefit limitations apply***

Prior Authorization

Services that require prior authorization regardless of contract status:

-  Injectable drugs (see the [Guides and Manual](#) page for up-to-date list of codes)
-  Nutritional counseling (unless diabetic)
-  Pain management programs, including epidural, facet and trigger point injections
-  PET, MRI, MRA and Nuclear Cardiology/SPECT scans
-  Cardiac rehabilitation
-  Hearing aids and devices
-  Home and Institutional hospice (coverage varies by product)
-  In-home infusion therapy
-  Orthopedic footwear
-  Respiratory therapy services
-  Pulmonary rehabilitation
-  Home care (except after an IP admission with benefit limitations)

Prior Authorization



Is Prior Authorization Needed?

- MHS website: mhsindiana.com
- Quick reference guide
- Non-contracted provider services now align with PA requirements for contracted providers



PROVIDER Quick Reference Guide

Effective June 1, 2018

Applies to all Hoosier Healthwise (HHW), Healthy Indiana Plan (HIP) and Hoosier Care Connect (HCC) packages.
For an Ambetter Provider Quick Reference Guide, please visit ambetter.mhsindiana.com. Coverage is subject to specific benefit package of member.



1-877-647-4848

TTY/TDD: 1-800-743-3333

mhsindiana.com

GENERAL OFFICE HOURS:

8 a.m. to 5 p.m., EST, closed holidays

MEMBER SERVICES AND PROVIDER SERVICES:

8 a.m. to 8 p.m.

REFERRALS AND AUTHORIZATIONS:

8 a.m. to 5 p.m., closed 12 p.m. to 1 p.m.

AFTER-HOURS:

MHS' 24/7 Nurse Advice Line for members is available to answer calls for emergent authorization needs. Or, you may leave a message on our after-hours recording system. Messages are returned within one business day.

MANAGED HEALTH SERVICES (MHS)

ELECTRONIC PAYER ID:

68069

BEHAVIORAL HEALTH PAYER ID:

68068

MEDICAL CLAIMS ADDRESS:

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

Claims sent to MHS' Indianapolis address will be returned to the provider.

MEDICAL NECESSITY APPEALS ONLY ADDRESS:

ATTN: APPEALS
P.O. Box 441567
Indianapolis, IN 46244

MEDICAL CLAIMS APPEALS ADDRESS:

Managed Health Services
P.O. Box 3000
Farmington, MO 63640-3802

Providers have 67 calendar days from the date of the Explanation of Payment to file an adjustment, resubmit, or appeal a decision.

Failure to do so within the specified timeframe will waive the right for reconsideration.

MEDICAL CLAIMS REFUNDS:

To refund claims overpayment, please send check and documentation to:

Coordinated Care Corporation
75 Remittance Dr., Suite 6446
Chicago, IL 60675-6446

MHS FAX NUMBERS

NETWORK MANAGEMENT: 1-866-912-4244

Ex. Provider enrollment, office or billing address change

MEDICAL APPEALS: 1-866-714-7993

CASE MANAGEMENT: 1-866-694-3653

Ex. Member Referrals to CM/DM

REFERRALS AND AUTHORIZATIONS: 1-866-912-4245

MHS WEBSITE: MHSINDIANA.COM

mhsindiana.com/providers Latest MHS provider updates and news, as well as forms, manuals, guides, online PA tool and tutorials. (Please visit mhsindiana.com/forms to get the latest forms for submission to MHS.)

mhsindiana.com/health MHS' Health Library. Click on "XRAYES Health Library" for free print-on-demand patient health fact sheets on over 4,000 topics, available in English and Spanish.

mhsindiana.com/login MHS' Secure Provider Portal lets you submit prior authorization, claims, claim adjustments, and view your panel's medical records and care gaps.

mhsindiana.com/transactions Information for electronic processing and payment of claims with MHS.

OTHER RESOURCES

payspanhealth.com MHS is pleased to partner with PaySpan to provide an innovative web based solution for Electronic Funds Transfers (EFTs) and Electronic Remittance Advices (ERAs). This service is provided at no cost to providers and allows online enrollment at payspanhealth.com.

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

0518.PR.P.FL 7/18

Prior Authorization

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](#)

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

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

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

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

☐ Yes ☐ No

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

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

Prior Authorization

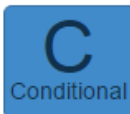
Are Services being performed in the Emergency Department or Urgent Care Center or are these family planning services billed with a contraceptive management diagnosis?

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

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

Check




99394 - PREV VISIT EST AGE 12-17

Pre-authorization is required if service is rendered at home except for Primary Care Providers or Health Department. In all other locations, Pre-authorization is required for non-participating providers.




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

Prior Authorization (PA) Request







-  Providers can update previously approved PAs within 30 days of the original date of service prior to claim denial for changes in:
- Dates of service
 - CPT/HCPCS codes
 - Physician

**Providers may make corrections to the existing PA as long as the claim has not been submitted*

Therapy Services - (Speech, Occupational, Physical Therapy)

-  10/1/17 authorization is no longer required
-  Must follow billing guidelines (GP, GN, GO modifiers)
-  National Imaging Associates, Inc. (NIA) will conduct retrospective review to evaluate medical necessity
 - If requested, medical records can be uploaded to RadMD.com or faxed to NIA at 1-800-784-6864
 - Medical necessity appeals will be conducted by NIA
 - Follow steps outlined in denial notification
 - NIA Customer Care Associates are available to assist providers at 1-800-424-5391

Durable & Home Medical Equipment

-  Members and referring providers do not need to search for a DME provider or provider of medical supplies to service their needs
-  Order is submitted directly to MHS, through the Medline portal, unless PA is required, and delivered to the member
-  Availability via Medline's web portal to submit orders and track delivery
-  Prior authorization required by the **ordering physician** for all non-participating DME providers.
-  Does not apply to items provided by and billed by physician office
-  Exclusions applicable to specific hospital based DME/HME vendors

Durable & Home Medical Equipment


 DME Requests should be initiated via **MHS secure portal**

- **Steps to enter DME Requests via Web Portal**

- Go to mhsindiana.com, log into the provider portal, and click on “**Create Authorization.**”
- Choose DME and you will be directed to the **Medline** portal for order entry.

Outpatient Radiology PA Requests

 MHS partners with NIA for outpatient Radiology PA Process

-  PA requests can be submitted via:
- NIA Web site at **RadMD.com**
 - 1-866-904-5096
 - Not applicable for ER and Observation requests

Pharmacy Requests

Engage Pharmacy Solutions

 Preferred Drug Lists and authorization forms are available at **mhsindiana.com/provider/pharmacy**

- PA requests
 - Phone 1-866-399-0928
 - Fax non specialty drugs 1-866-399-0929
 - Specialty drugs 1-866-678-6976
 - **pharmacy.engagehealth.com**

 Formulary integrated into many EHR solutions


 Online PA submission available through CoverMyMeds

- **covermymeds.com**




 Online PA forms for Specialty Drugs at **mhsindiana.com**

Additional Information Needed




Bariatric Surgery

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





Pain Management

-  Must have documentation of at least six weeks of therapy on area receiving treatment
-  Include previous procedures/surgeries, medications, description of pain, any contra-indications or imaging studies
-  Include prior injection test results for injection series

Home Health

-  Physician's orders and signed plan of care, including most recent MD notes about the issue at hand
-  Home care plan, including home exercise program
-  Progress notes for medical necessity determination

Telephone Authorization

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

Fax Authorization

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

Patient Information					
Medicaid ID/RID#:					
DOB:					
Patient Name:					
Address:					
City/State/Zip:					
Patient/Guardian Phone:					
PMP Name:					
PMP NPI:					
PMP Phone:					
Medical Diagnosis (Use of ICD-9 Diagnostic Code is Required)					
Dx1		Dx2		Dx3	

*Member RID, name, and
DOB **required***





*Diagnosis code(s)
required*

Please check the requested assignment category below:

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

Check service category

Web Portal Authorization

-  Providers can submit Prior Authorizations online via the [MHS Secure Provider Portal](#)
-  When using the portal, providers can upload supporting documentation directly
-  **Exceptions**: Must submit hospice, home health and biopharmacy PA requests via **fax**
-  Providers also can check authorization status on the portal

PA Denial and Appeal Process



If MHS denies the requested service:

- And the member is still receiving services, the provider has the right to an expedited appeal. The attending physician must request this.
- And the member already has been discharged, the attending physician must submit an appeal in writing within **33 days** of the denial



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

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



Prior authorization appeals are also known as medical necessity appeals

PA Denial and Appeal Process



Send Prior Authorization/Medical Necessity Appeals to:

Managed Health Services

Attn: Appeals Coordinator

PO Box 441567

Indianapolis, IN 46204



Providers must initiate appeals within **33 calendar days** of the receipt of the denial letter for MHS to consider



We will communicate determination to the provider within **20 business days** of receipt





A prior authorization appeal is different than a claim appeal request



Applicable to members and non-contracted providers

Prior Authorization (PA) Request

 MHS strives to return a decision on **all** PA requests within **two business days** of request


 Reasons for a delayed decision may include:

- Lack of information or incomplete request
- Illegible faxed copies of PA forms – e.g. handwriting is illegible or fax is otherwise not readable
- Request requiring Medical Director review

 MHS has up to **seven days** to render PA decisions

Prior Authorization (PA) Request



 PA approval requires the need for medical necessity

 If your claim is denied, please contact Provider Services at 1-877-647-4848 to determine the cause of the denial

 Medical Management **does not** verify eligibility or benefit limitations

- Provider is responsible for eligibility and benefit verification

Continuity of Care PA Request

-  MHS will honor **pre-existing authorizations** from any other Medicaid program during the first **30 days** of enrollment or up to the expiration date of the previous authorization, whichever occurs first, and upon notification to MHS. Include the approval from the prior MCE with the request.
-  Reference: MHS Provider Manual Chapter 6

MHS Portal

Secure Web Portal Login or Registration

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



Home Find a Provider Portal Login Events Contact Us

Contrast ☐ On ☒ Off a a a language▼

FOR MEMBERS

FOR PROVIDERS

GET INSURED

FOR PROVIDERS

Login

Enrollment and Updates

Prior Authorization +

Dental Providers

Pharmacy +

Behavioral Health +

Provider Resources +

QI Program +

Provider News

Portal Login

Login/Register

Portal Resources

[Click here for additional information and step by step guides.](#)

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 our Secure Provider Portal Help Line at 1-866-912-0327.

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

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.

Web Portal Resources



Home Find a Provider Portal Login Events Contact Us

Contrast ☐ On ☐ Off a a language

FOR MEMBERS

FOR PROVIDERS

GET INSURED

FOR PROVIDERS

- Login
- Become a Provider
- Prior Authorization
- Dental Providers
- Pharmacy
- Behavioral Health
- Provider Resources
- QI Program
- Provider News

Web Portal

We encourage our providers to take advantage of our easy-to-use secure Provider Portal instead of making a phone call. On our secure portal, you can:

- Manage multiple practices under one account
- Check member eligibility
- View medical history and gaps in care
- Submit and manage claims
- Submit prior authorizations
- Securely contact a plan representative

We also have the following enhanced features below:

- Update demographic information
- Assist your patients in completing their Health Risk Assessment forms
- See patient Care Gaps (indicates if your patient is due for a preventive exam or service)
- Check the status of Prior Authorization requests
- Utilize the Member Management Forms

Follow the [registration guide \(PDF\)](#) or if you have any questions, please call the Web Portal helpdesk line at 1-866-912-0327.

There's no waiting, no on-hold music, no time limits. Registration is free and easy.

MHS Secure Provider Portal Training Documents

Guides:

- [Provider Secure Portal Guide \(PDF\)](#)
- [Provider Secure Portal Flyer \(PDF\)](#)
- [Account Details QRG \(PDF\)](#)
- [Account Manager User Guide \(PDF\)](#)
- [Member Management Forms Guide \(PDF\)](#)

How To:

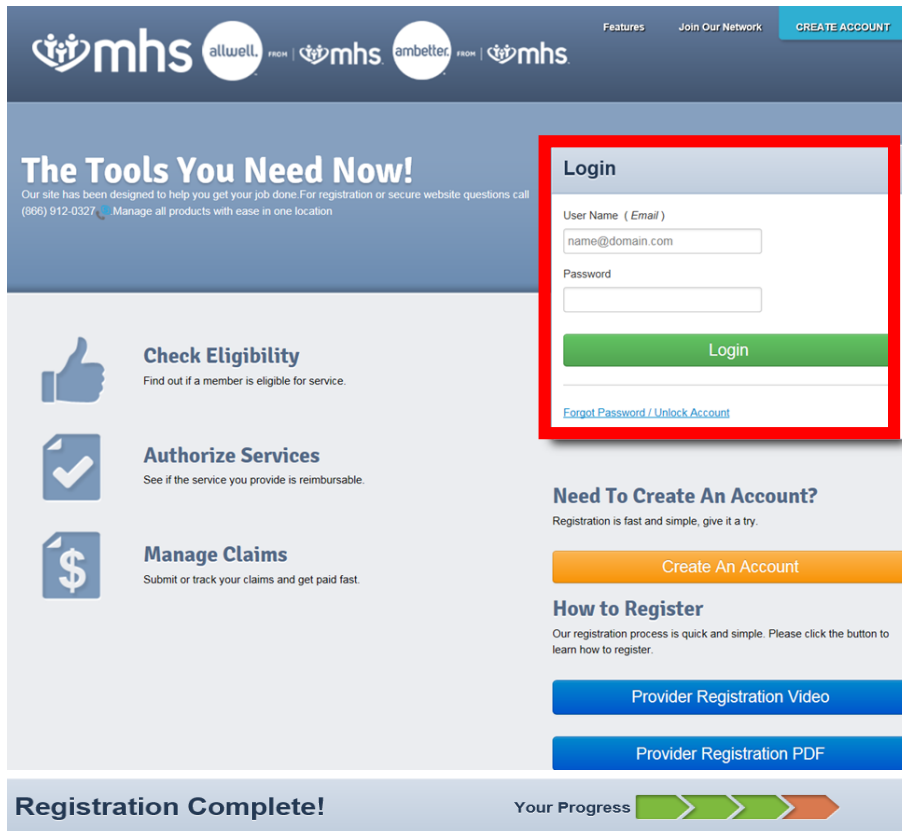
- [Submit a Claim CMS 1500 \(PDF\)](#)
- [Submit a Claim CMS UB-04 \(PDF\)](#)
- [Submit a Corrected Claim \(PDF\)](#)
- [View Claim Status \(PDF\)](#)
- [View Payment History \(PDF\)](#)



Documents Include:

- Registration Guide
- MHS Web Portal Functionality Guides
- How To Complete Specific Tasks on the MHS Web Portal

Complete Registration or Login



The Tools You Need Now!
Our site has been designed to help you get your job done. For registration or secure website questions call (866) 912-0327. Manage all products with ease in one location.

Check Eligibility
Find out if a member is eligible for service.

Authorize Services
See if the service you provide is reimbursable.

Manage Claims
Submit or track your claims and get paid fast.

Login

User Name (Email)
name@domain.com

Password

[Forgot Password / Unlock Account](#)

[Login](#)

Need To Create An Account?
Registration is fast and simple, give it a try.


[Create An Account](#)

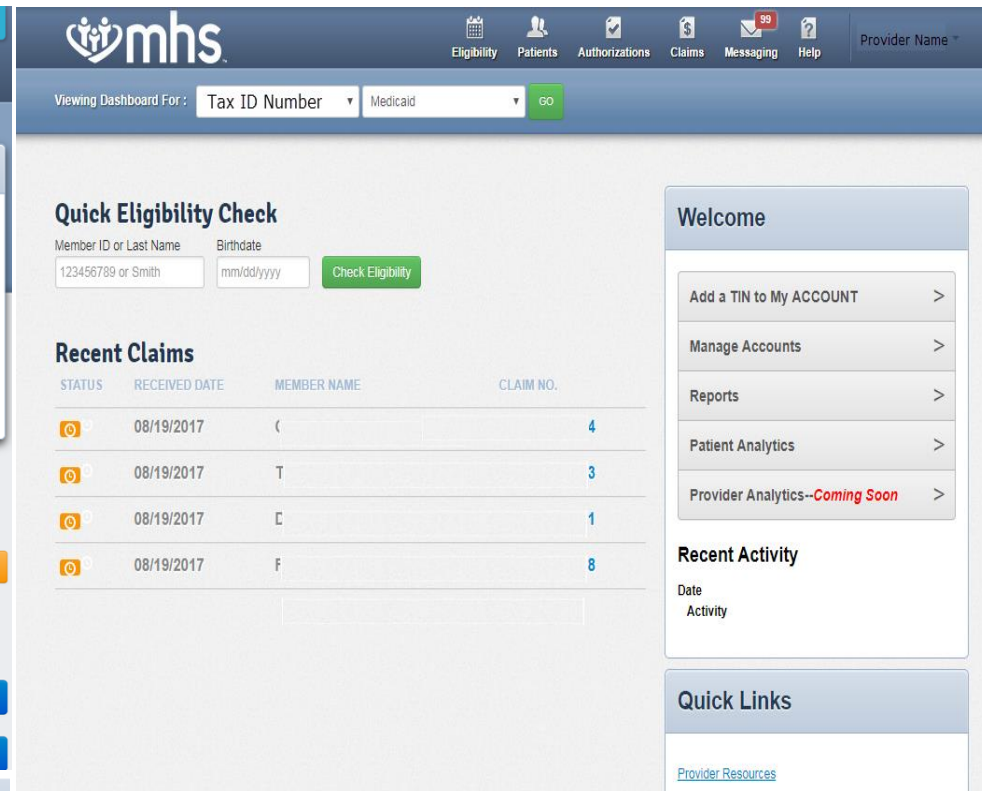
How to Register
Our registration process is quick and simple. Please click the button to learn how to register.

[Provider Registration Video](#)

[Provider Registration PDF](#)

Registration Complete!





Your Progress 



Quick Eligibility Check

Member ID or Last Name Birthdate
123456789 or Smith mm/dd/yyyy [Check Eligibility](#)

Recent Claims

STATUS	RECEIVED DATE	MEMBER NAME	CLAIM NO.
	08/19/2017	C	4
	08/19/2017	T	3
	08/19/2017	C	1
	08/19/2017	F	8

Welcome

[Add a TIN to My ACCOUNT](#)

[Manage Accounts](#)

[Reports](#)

[Patient Analytics](#)

[Provider Analytics--Coming Soon](#)

Recent Activity

Date
Activity

Quick Links

[Provider Resources](#)


The Registration is complete and the Secure Portal homepage will be visible!







[Login](#) 

An email will be sent to the provider when they have access to specific tools.

Dashboard Change

 User has the ability to change between **Tax IDs** added along with choices for: **Medicaid**, **Ambetter from MHS**, **Allwell from MHS** and **Behavioral Health IN Medicaid**



 Eligibility
  Patients
  Authorizations
  Claims
  Messaging
  Help

Provider Name ▾

Viewing Dashboard For :

Tax ID Number ▾

Medicaid ▾

GO



 Eligibility
  Patients
  Authorizations
  Claims
  Messaging
  Help

Provider Name ▾

 Viewing Dashboard For :

Tax ID Number ▾

Ambetter from MHS ▾

GO



 Eligibility
  Patients
  Authorizations
  Claims
  Messaging

Provider Name ▾

 Viewing Dashboard For :

Tax ID Number ▾

Allwell from MHS ▾

GO



 Eligibility
  Patients
  Authorizations
  Claims
  Messaging
  Help

Provider Name ▾


 Viewing Dashboard For :

Tax ID Number ▾

Behavioral Health IN Medic ▾

GO

Homepage –MHS (Medicaid)



[Eligibility](#)
[Patients](#)
[Authorizations](#)
[Claims](#)
[Messaging ⁹⁹](#)
[Help](#)

Viewing Dashboard For :

Quick Eligibility Check

Member ID or Last Name

Birthdate

Recent Claims

STATUS	RECEIVED DATE	MEMBER NAME	CLAIM NO.
	06/29/2018	C [redacted]	[redacted] 0
	06/29/2018	S [redacted]	[redacted] 3
	06/29/2018	I [redacted]	[redacted] 3
	06/29/2018	S [redacted]	[redacted] 3
	06/29/2018	/ [redacted]	[redacted] 4

Welcome

Add a TIN to My ACCOUNT >

Manage Accounts >

Reports >

Patient Analytics >

Provider Analytics--*Coming Soon* >

Recent Activity

Date	Activity
------	----------

Quick Links

[Provider Resources](#)

[Member Management Forms](#)

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

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

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

Please note: Claims information is updated every 24 hours.

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

Go Paperless

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

MHS Welcome and Quick Links

Welcome

Add a TIN to My ACCOUNT >

Manage Accounts >

Reports >

Patient Analytics >

Provider Analytics--Coming Soon >

Recent Activity

Date

Activity

Quick Links

[Provider Resources](#)

[Member Management Forms](#)

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

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

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

Please note: Claims information is updated every 24 hours.

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

Go Paperless

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

PaySpan Site

Welcome

- **Multiple TINs** can be managed from a single account.
- **Account Managers** can oversee the secure portal accounts of their staff/office. User can be added, disabled, and have their permissions changed.
- **Reports** are available here
- **Patient and Provider Analytics**

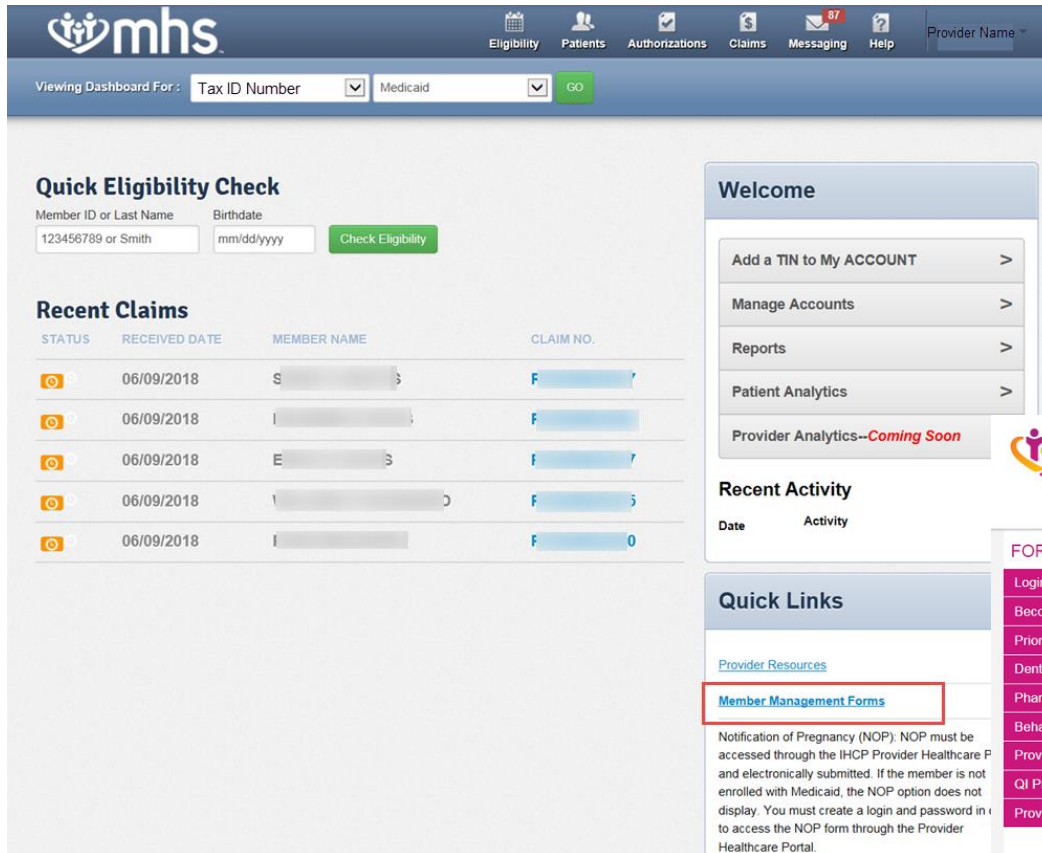
Quick Links

- Public link to **Provider Resources**
 - ☐ Demographic Update Tool
 - ☐ Preferred Drug Lists
 - ☐ Provider Education
- **Member Management Forms**
- **IHCP Provider Healthcare Portal link**
- **Pharmacy Information**

Go Paperless

MHS Member Management Forms

 Click on **Member Management Forms** under **Quick Links**



The screenshot shows the MHS Member Management dashboard. At the top, there's a navigation bar with icons for Eligibility, Patients, Authorizations, Claims, Messaging, and Help. Below this is a search bar with 'Tax ID Number' selected and 'Medicaid' as the filter. The main content area is divided into several sections:

- Quick Eligibility Check:** A form with fields for 'Member ID or Last Name' (123456789 or Smith) and 'Birthdate' (mm/dd/yyyy), with a 'Check Eligibility' button.
- Recent Claims:** A table with columns: STATUS, RECEIVED DATE, MEMBER NAME, and CLAIM NO. It lists five recent claims from 06/09/2018.
- Welcome:** A sidebar with links: 'Add a TIN to My ACCOUNT', 'Manage Accounts', 'Reports', 'Patient Analytics', and 'Provider Analytics--Coming Soon'.
- Recent Activity:** A table with columns: Date and Activity.
- Quick Links:** A section with a link to 'Member Management Forms' highlighted by a red box. Below it is a notification about the Notification of Pregnancy (NOP) form.

 **Choose between:**

- Member Disenrollment Form
- Panel Management Form



FOR PROVIDERS

- Login
- Become a Provider
- Prior Authorization
- Dental Providers
- Pharmacy
- Behavioral Health
- Provider Resources
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Home Find a Provider Portal Login Events Contact Us

Contrast On Off a a language

FOR MEMBERS

FOR PROVIDERS

GET INSURED

Member Management Forms

All PMP's have the right to state the number of members they are willing to accept into their practice. The panel size for members is based on the panel size requested on the Provider Enrollment form. Member assignment is based on the member's choice and the IHCP auto-assignment process; therefore, MHS does not guarantee any PMP will receive a set number of members.

PMP's shall not refuse to treat MHS members on his or her panel as long as the panel limit has not been met. MHS must be notified 45 calendar days in advance of a PMP's inability to accept additional covered enrollees under MHS agreements. To make a change to your panel size, please contact your Provider Partnership Associate.

Member Disenrollment

[Click Here](#)

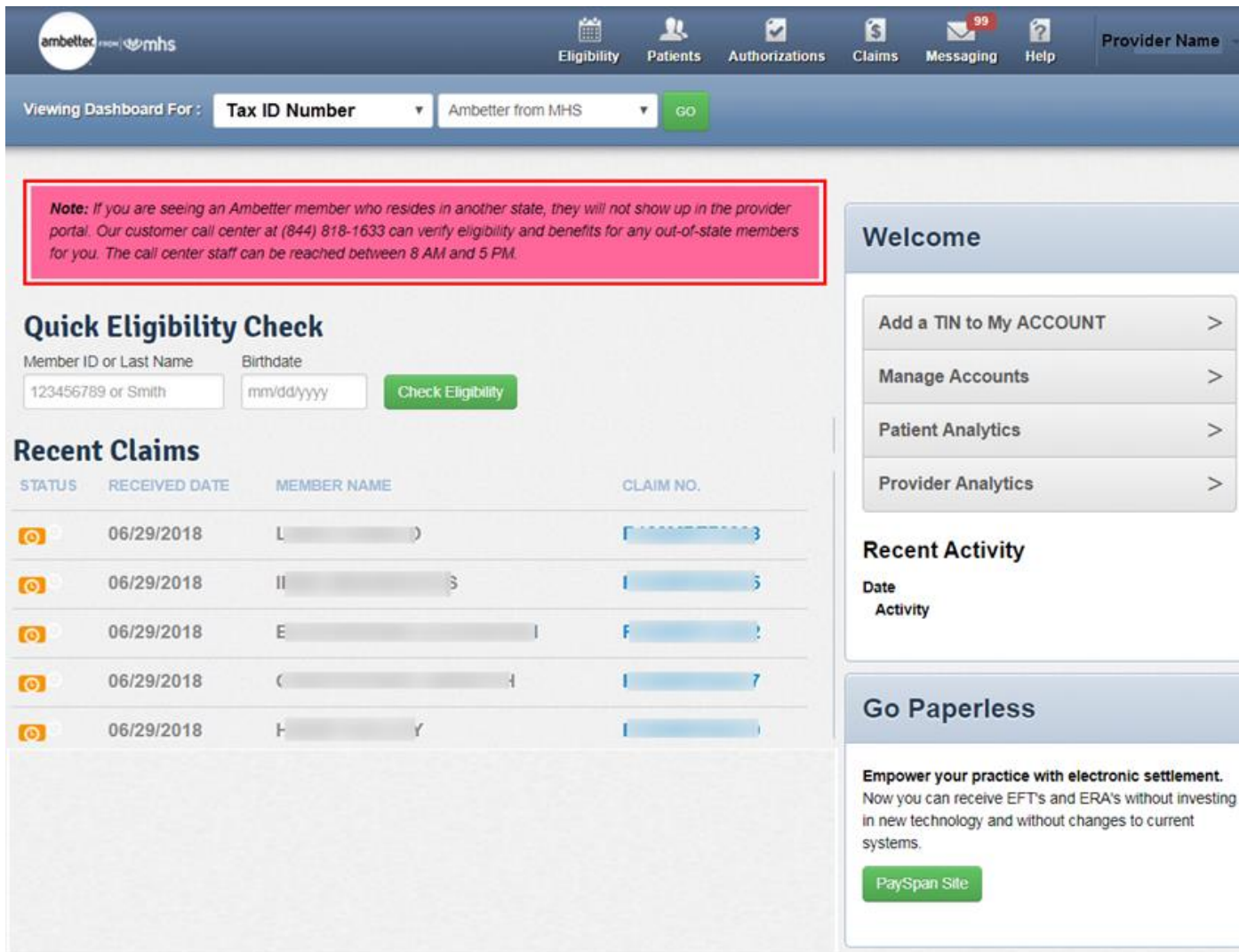
Panel Management Form

[Click Here](#)

MHS follows a state-defined process which requires MHS approval before a member can be dismissed from a PMP's panel. Please complete the Member Disenrollment form below in its entirety to request a member be removed from your panel. It can take 30 - 45 days for this removal to occur. For a list of valid reasons for a request for member disenrollment and other important information, please review the [Provider Manual](#).

If your panel is full or has been placed on hold and you would like to add a member, please use the Panel Management Form below. There is no limit on the number or frequency of additions. For additional information about when a member can change their PMP selection and other important information, please review the [Provider Manual](#).

Homepage –Ambetter from MHS



The screenshot shows the Ambetter from MHS homepage. At the top is a navigation bar with icons for Eligibility, Patients, Authorizations, Claims, Messaging (with a 99 notification), and Help. A 'Provider Name' dropdown is on the right. Below the navigation bar is a 'Viewing Dashboard For:' section with a 'Tax ID Number' dropdown, a text input for 'Ambetter from MHS', and a 'GO' button. A red-bordered note box contains a message about out-of-state members. The main content area is divided into three sections: 'Quick Eligibility Check' with input fields for 'Member ID or Last Name' (123456789 or Smith) and 'Birthdate' (mm/dd/yyyy), and a 'Check Eligibility' button; 'Recent Claims' with a table of claims; and 'Welcome' with links to 'Add a TIN to My ACCOUNT', 'Manage Accounts', 'Patient Analytics', and 'Provider Analytics'. Below these are 'Recent Activity' and 'Go Paperless' sections. The 'Go Paperless' section includes a message about electronic settlement and a 'PaySpan Site' button.

Note: If you are seeing an Ambetter member who resides in another state, they will not show up in the provider portal. Our customer call center at (844) 818-1633 can verify eligibility and benefits for any out-of-state members for you. The call center staff can be reached between 8 AM and 5 PM.

Quick Eligibility Check

Member ID or Last Name: 123456789 or Smith Birthdate: mm/dd/yyyy [Check Eligibility](#)

Recent Claims

STATUS	RECEIVED DATE	MEMBER NAME	CLAIM NO.
	06/29/2018	L [redacted]	[redacted]
	06/29/2018	II [redacted]	[redacted]
	06/29/2018	E [redacted]	[redacted]
	06/29/2018	C [redacted]	[redacted]
	06/29/2018	H [redacted]	[redacted]

Welcome

- [Add a TIN to My ACCOUNT](#)
- [Manage Accounts](#)
- [Patient Analytics](#)
- [Provider Analytics](#)


Recent Activity

Date
Activity

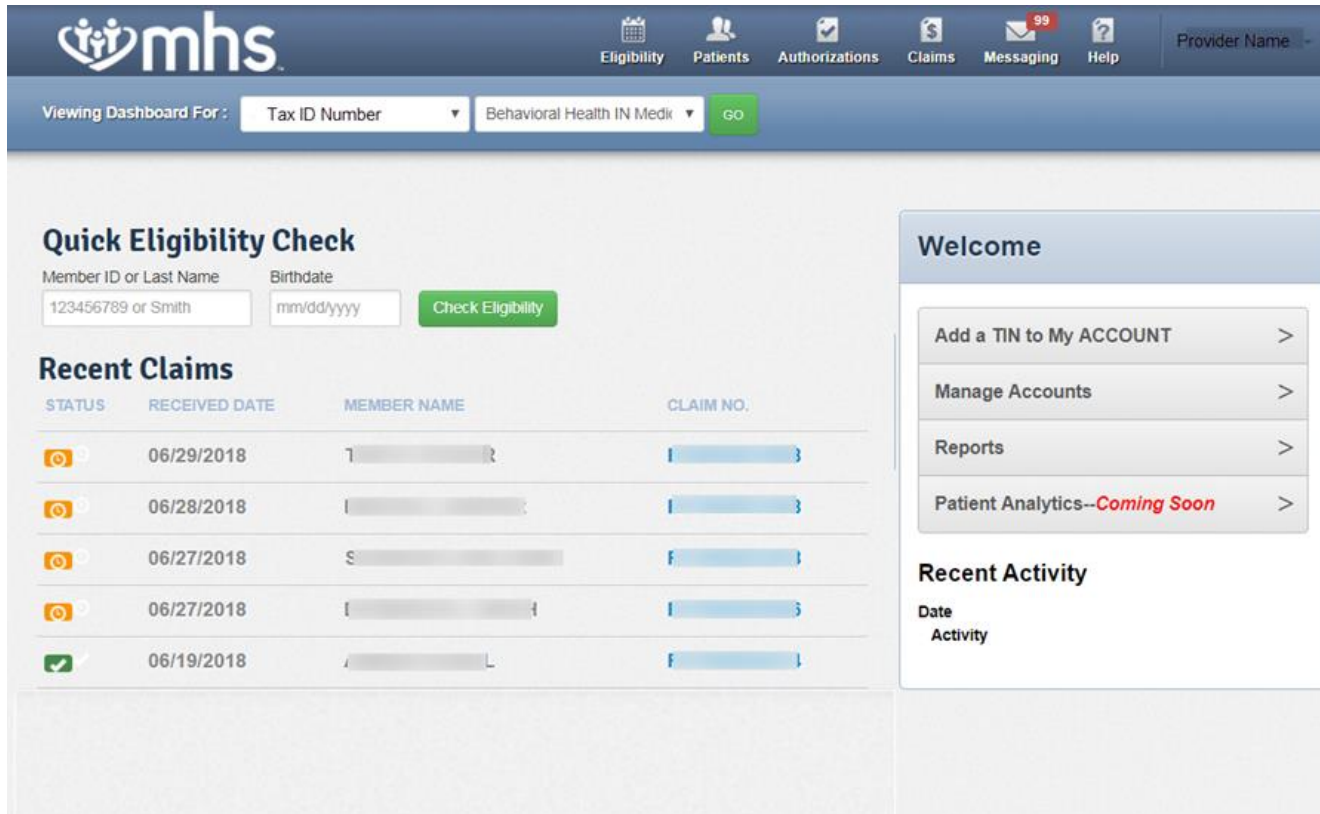
Go Paperless

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

[PaySpan Site](#)

-  **Quick Links:**
- Eligibility Check
 - Add a TIN
 - Account Manager
 - Analytics
 - Secure Messaging

Homepage –Behavioral Health IN Medicaid



Quick Eligibility Check

Member ID or Last Name: 123456789 or Smith Birthdate: mm/dd/yyyy [Check Eligibility](#)

Recent Claims


STATUS	RECEIVED DATE	MEMBER NAME	CLAIM NO.
	06/29/2018	[REDACTED]	[REDACTED]
	06/28/2018	[REDACTED]	[REDACTED]
	06/27/2018	[REDACTED]	[REDACTED]
	06/27/2018	[REDACTED]	[REDACTED]
	06/19/2018	[REDACTED]	[REDACTED]

Welcome

- [Add a TIN to My ACCOUNT](#)
- [Manage Accounts](#)
- [Reports](#)
- [Patient Analytics--Coming Soon](#)

Recent Activity

Date	Activity

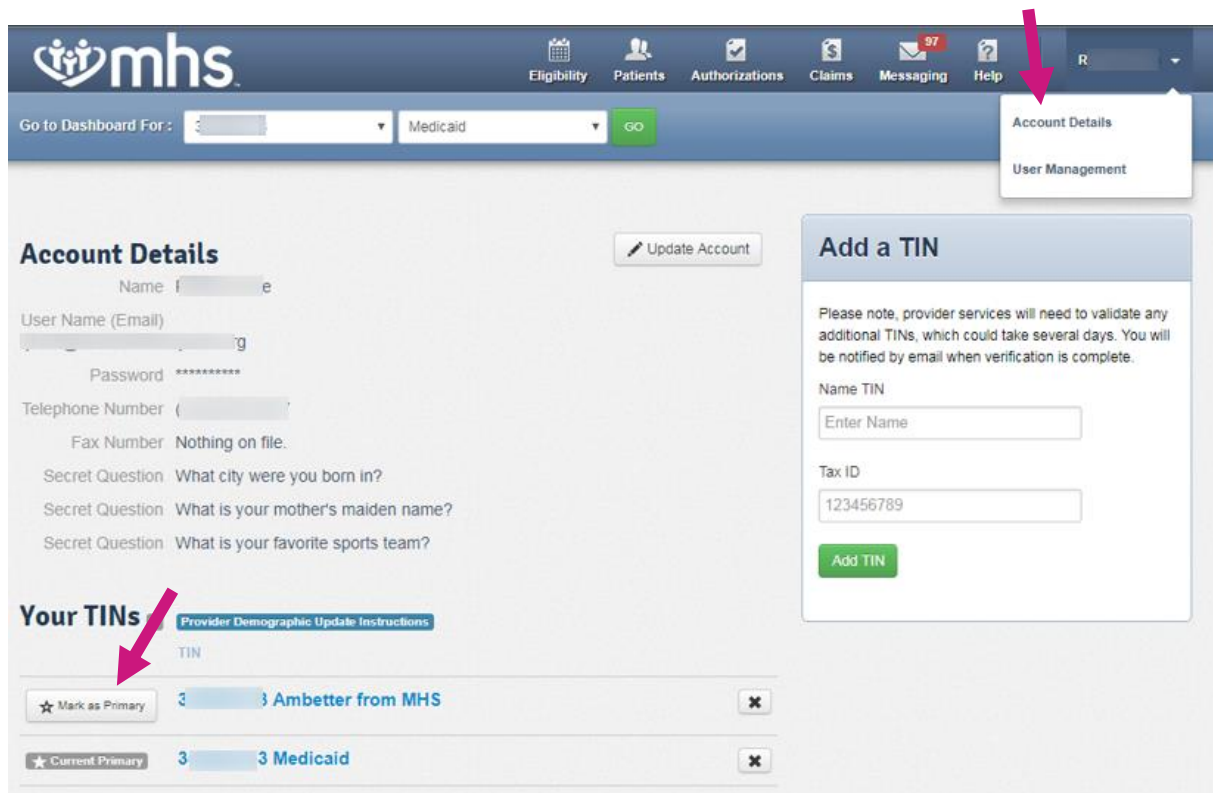
-  **Quick Links:**
- Eligibility Check
 - Add a TIN
 - Account Manager

Account Details

To view your Account Details:

1. Select the **drop-down arrow** next to user name in the upper right corner on the dashboard
2. Click **Account Details**

Note: Under Your TINs you see the Current **Primary** Default TIN for the account, and can select another TIN to **Mark As Default** or **Remove** a TIN.



The screenshot shows the mhs dashboard with a navigation bar containing links for Eligibility, Patients, Authorizations, Claims, Messaging (97), and Help. A dropdown menu is open next to the user name 'R', showing 'Account Details' and 'User Management'. The 'Account Details' section includes fields for Name, User Name (Email), Password, Telephone Number, Fax Number (Nothing on file), and Secret Questions. The 'Add a TIN' section includes a text box for Name TIN, a text box for Tax ID (123456789), and an 'Add TIN' button. The 'Your TINs' section shows a list of TINs with a 'Mark as Primary' button next to the 'Ambetter from MHS' TIN.

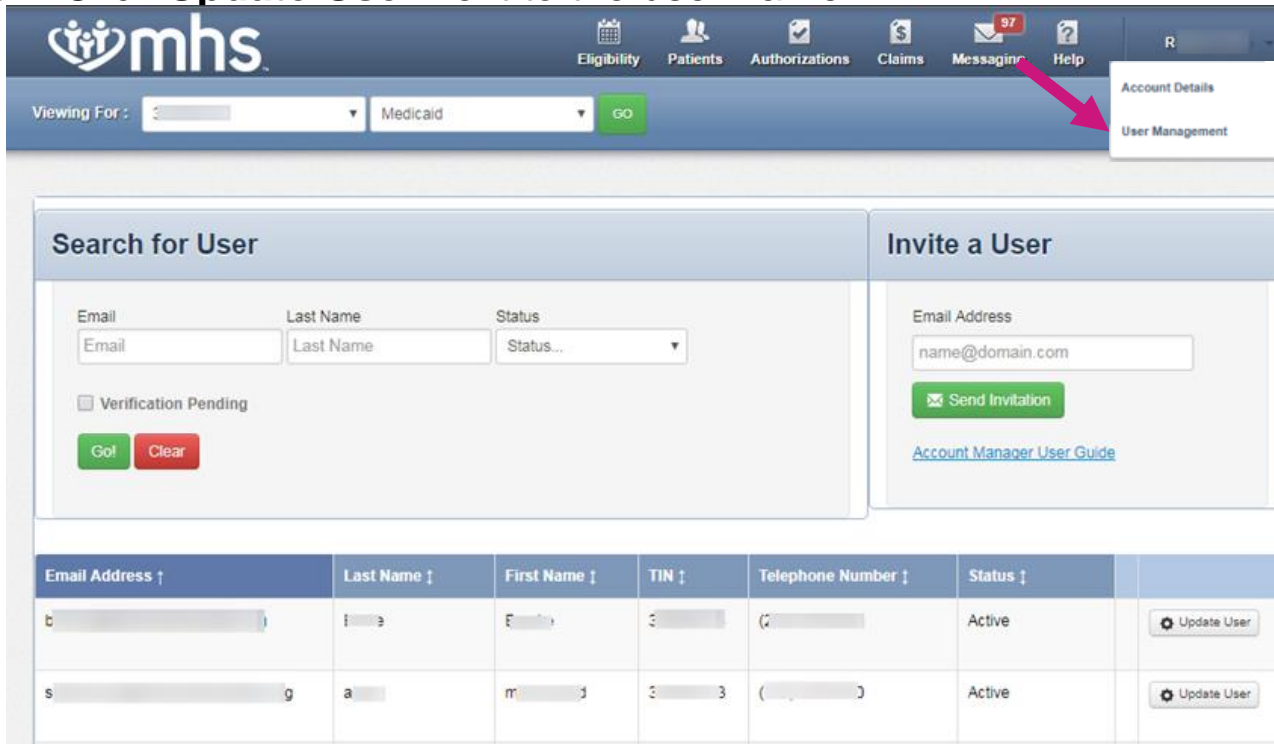
Account Manager

User Management



For **Account Managers** to manage their office staff/users associated to their practice:

When using this feature you can disable/enable users, and manage permissions for your account.

1. Select the drop-down arrow next to your name in the upper right corner.
2. Select **User Management**.
3. Click **Update User** next to the user name.



The screenshot shows the MHS Account Manager interface. At the top, there's a navigation bar with icons for Eligibility, Patients, Authorizations, Claims, Messaging (with a red notification badge), and Help. Below this is a 'Viewing For' section with a dropdown menu set to 'Medicaid' and a 'GO' button. On the right, a dropdown menu is open, showing 'Account Details' and 'User Management' (highlighted with a red arrow). The main content area is divided into two panels: 'Search for User' and 'Invite a User'. The 'Search for User' panel has input fields for Email, Last Name, and Status, a 'Verification Pending' checkbox, and 'Go' and 'Clear' buttons. The 'Invite a User' panel has an 'Email Address' input field, a 'Send Invitation' button, and a link to the 'Account Manager User Guide'. Below these panels is a table listing users with columns for Email Address, Last Name, First Name, TIN, Telephone Number, Status, and an 'Update User' button for each row.

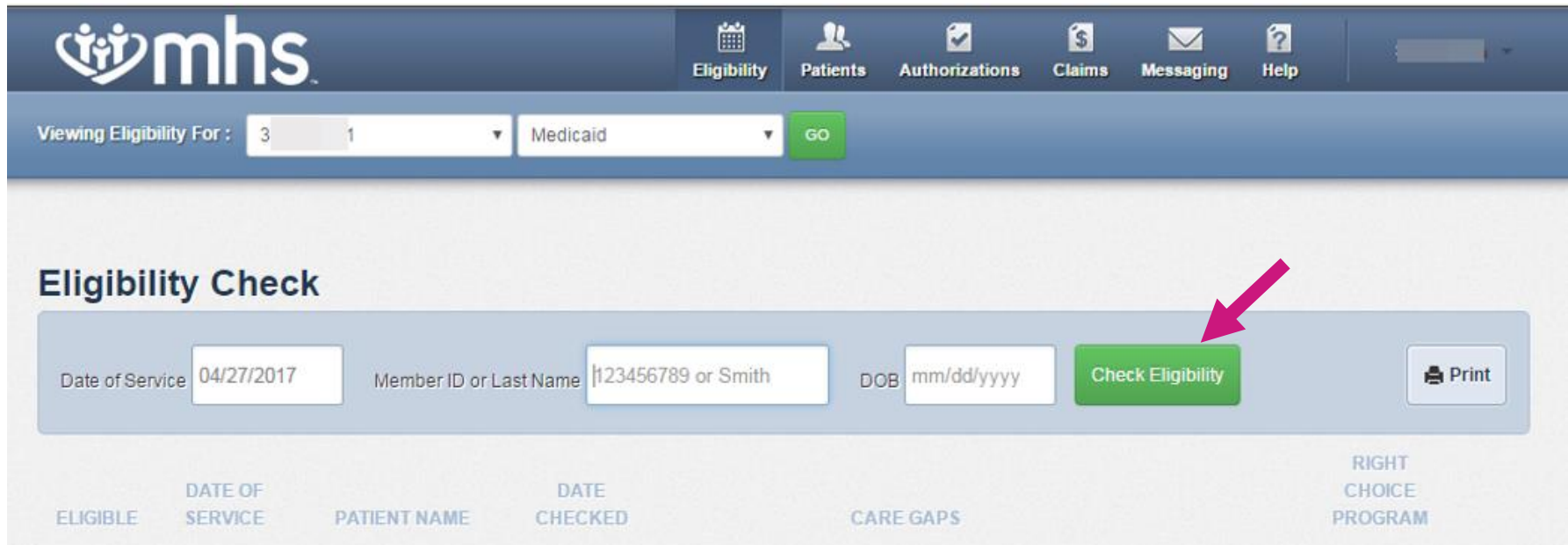
Email Address ↑	Last Name ↑	First Name ↑	TIN ↑	Telephone Number ↑	Status ↑	
b	i	E	3	(2)	Active	 Update User
s	a	m	3	()	Active	 Update User

Eligibility

Check Eligibility

 The **Eligibility** tab offers an **Eligibility Check** tool designed to quickly check the status of any member.

- Update the **Date of Service**, if necessary
- Enter the **Member ID** or **Last Name** and **DOB (Date of Birth)**
- Click **Check Eligibility**






The screenshot shows the MHS web application interface. At the top is a navigation bar with the MHS logo and several tabs: Eligibility, Patients, Authorizations, Claims, Messaging, and Help. Below the navigation bar is a section for 'Viewing Eligibility For :'. It contains two dropdown menus: the first is set to '3' and the second is set to 'Medicaid'. To the right of these is a green 'GO' button. Below this is the 'Eligibility Check' section. It contains three input fields: 'Date of Service' with the value '04/27/2017', 'Member ID or Last Name' with the value '123456789 or Smith', and 'DOB' with the placeholder 'mm/dd/yyyy'. To the right of these fields is a green 'Check Eligibility' button, which is highlighted by a red arrow. To the right of the 'Check Eligibility' button is a 'Print' button. Below the input fields is a table with the following headers: ELIGIBLE, DATE OF SERVICE, PATIENT NAME, DATE CHECKED, CARE GAPS, and RIGHT CHOICE PROGRAM.

Check Eligibility

 Eligibility status is indicated by a **Green** Thumbs-Up for **Eligible** and an **Orange** Thumbs-Down for **Ineligible**.

Eligibility Check

Date of Service
Member ID or Last Name
DOB

ELIGIBLE	DATE OF SERVICE	PATIENT NAME	DATE CHECKED	CARE GAPS	RIGHT CHOICE PROGRAM
 Ineligible	08/28/2017	F [redacted] N	08/28/2017		<input type="button" value="X Remove"/>
	08/28/2017	T [redacted] S	08/28/2017	Risk Category Alerts: COPD/Asthma	<input type="button" value="+ Emergency Room Visit?"/> <input type="button" value="X Remove"/>
	08/28/2017	T [redacted] S P [redacted]	08/28/2017	Risk Category Alerts: COPD/Asthma Member has had 3 or more emergency room visits in past 90 days.	<input type="button" value="+ Emergency Room Visit?"/> Yes <input type="button" value="X Remove"/>

Details for any member can be viewed by clicking on the **Member's Name**.

Care Gaps can also be seen within the search results.

By clicking **Emergency Room Visit?**, an ER visit will be indicated.


Right Choice Program indicator labeled **Yes**

Add Emergency Room Visit

 Update with specific details regarding the **Reason for Visit** and **Facility**

Eligibility Check

Date of Service: 04/27/2017
Member ID or Last Name: 123456789 or Smith
DOB: mm/dd/yyyy

ELIGIBLE	DATE OF SERVICE	PATIENT NAME	DATE CHECKED	CARE GAPS	RIGHT CHOICE PROGRAM
	04/27/2017	F [REDACTED] Z	04/27/2017	Risk Category Alerts: COPD/Asthma	<input type="button" value="+ Emergency Room Visit?"/> <input type="button" value="X Remove"/>














Add Emergency Room Visit

Reason For Visit*

Facility*

Member Record

Member Record Details

-  Member Overview
-  Cost Sharing
-  Assessments
-  Health Record
-  Visits, Medications, Immunizations, Labs, and Allergies
-  Care Plan
-  Authorizations
-  Referrals
-  Coordination of Benefits
-  Claims
-  Power Account Service Estimate *only HIP Members
-  Document Resource Center
-  Notes

Member Overview

[Back to Patient List](#)

Member Name

Overview

Cost Sharing

Assessments

Health Record

Care Plan

Authorizations

Referrals


Coordination of Benefits

Claims

Power Account Service Estimate

Document Resource Center

Notes

 This patient is eligible as of today, Jun 11, 2018.

Patient Information

Name S S

Gender F

Birthdate

Age 5

Member # 1

Member # U

Address

Phone Number

Email N/A

PCP Information

Name ANGELIQUE BROWN

Address 8777 BROADWAY STE C MERRILLVILLE, IN 46410

Practice Type FAMILY PRACTICE

Phone Number (219) 738-3854

View PCP History

EPSDT

Care Gaps

Eligibility History

Start Date	End Date	Program
May 1, 2018	Ongoing	State Plus, Copay - ER only

View Clinical Information

Risk Category Alerts: Ischemic Vascular Disease

Non-compliant for annual well visit.

Allergies

None On File

Overview Tab

1. Patient Information
2. Eligibility History
3. PMP Information and PMP History
4. EPSDT
5. Care Gaps
6. Allergies

View Clinical Information

[View Clinical Information](#)

Three Most Recent ER Visits

Primary Diagnosis	Date	Facility/Provider
ANXIETY DISORDER UNSPECIFIED	05/05/2017	ST JOSEPH HEALTH SYSTEM
CONTUSION LEFT FOREARM INITIAL ENC	04/27/2017	ST JOSEPH HEALTH SYSTEM
DIZZINESS AND GIDDINESS	04/08/2017	ST JOSEPH HEALTH SYSTEM

Three Most Recent Inpatient Admissions

Primary Diagnosis	Date	Facility/Provider
MAJOR DEPRESS RECURR SEV W/PSYCH SX	04/02/2017	ST JOSEPH HOSPITAL
MAJOR DEPRESSIVE D/O RECURRENT UNS	12/08/2016	PARKVIEW HOSPITAL
BIPOLAR CURR DEPRESS SEV W/PSYCH	08/16/2016	NORTHEASTERN CENTER

Three Most Recent Office Visits

Primary Diagnosis	Date	Facility/Provider
UNSPECIFIED MOOD AFFECTIVE DISORDER	04/27/2017	SRIRAM SURAKAN, KISHORE
MIXED HYPERLIPIDEMIA	04/18/2017	MILLER, THOMAS
IMPACTED CERUMEN BILATERAL	03/14/2017	MILLER, THOMAS

Top 5 Most Occurring Diagnosis

BIPOLAR CURR DEPRESS SEV W/PSYCH
SUICIDAL IDEATIONS
UNSPECIFIED ACUTE APPENDICITIS
UNSPECIFIED ABDOMINAL PAIN
MAJOR DEPRESSIVE D/O RECURRENT UNS

Recent Pharmacy Activity

DIVALPROEX TAB 500MG DR
HALOPERIDOL TAB 2MG
HYDROXYZ PAM CAP 25MG



Clinical Information

- Three Most Recent ER Visits
- Three Most Recent Inpatient Admissions
- Three Most Recent Office Visits
- Top 5 Most Occurring Diagnosis
- Recent Pharmacy Activity

Cost Sharing

 **Cost Sharing** shows if a member has any co-payments

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HIP BASIC MEMBER COST SHARING GRID	
Type of Service	Co-Pay Amount
Preventive Care	No co-pay
Family Planning Services	No co-pay
Outpatient Services	\$4.00
Inpatient Services	\$75.00
Preferred Drugs	\$4.00
Non-Preferred Drugs	\$8.00
*MHS will not collect POWER Account contributions or impose any other cost-sharing, including co-pays for non-urgent care use of hospital emergency departments, on members who are pregnant or Native American Indian.	
NON-EMERGENCY USE OF AN EMERGENCY ROOM CO-PAYS	
# of Non-Emergency Emergency Room Visits	Co-Pay Amount
Each Visit	\$8.00
*Co-pays for non-emergency use of an emergency room will be collected by all eligible HIP member EXCEPT for those exempt from cost-sharing (pregnancy or Native American Indian).	

Assessments

Types of Assessments


1. Link to **Notification of Pregnancy**
2. **HIP Preventative Services Assessment** submission
3. View completion of **Previous Assessments**

[Back to Eligibility Check](#)

Member Name

Overview	Please click here to complete NOP via IHCP Provider Healthcare Portal.					
Cost Sharing	Please tell us about your patient's health					
Assessments	<div> HIP Preventative Services Assessment The HIP Preventive Services Attestation must be completed within 30 days of receipt. Fill Out Now! </div>	Previous Assessments <table> <thead> <tr> <th>Assessment Name</th> <th>Submit Date</th> </tr> </thead> <tbody> <tr> <td>IN Member Health Risk Screen V3</td> <td>06/02/2018</td> </tr> </tbody> </table>	Assessment Name	Submit Date	IN Member Health Risk Screen V3	06/02/2018
Assessment Name	Submit Date					
IN Member Health Risk Screen V3	06/02/2018					
Health Record						
Care Plan						
Authorizations						
Referrals						
Coordination of Benefits						
Claims						
Power Account Service Estimate						
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Health Record -Visits

 **Visits** shows a listing of the member's Primary Diagnosis, Date, Visit Type, Claim Type and Facility/Provider. Including **Medical, Dental, Vision** and **Behavioral**.

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Visits
Medications
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Labs
Allergies

Primary Diagnosis	Date	Visit Type	Claim Type	Facility/Provider
Paranoid Schizophrenia	08/11/2017 - 08/11/2017	Outpatient Hospital	Behavioral	Regional Mental Health Center
Paranoid Schizophrenia	08/11/2017 - 08/11/2017	Outpatient Hospital	Behavioral	Douglas, Kobie Italo
Acute Sinusitis Unspecified	08/01/2017 - 08/01/2017	Emergency Room - Hospital	Medical	St Mary Mdcl Ctr.
Unspecified Injury Face Initial Enc	08/01/2017 - 08/01/2017	Emergency Room - Hospital	Medical	Spackey, Justin
Acute Sinusitis Unspecified	08/01/2017 - 08/01/2017	Emergency Room - Hospital	Medical	Dmitruk, Irene
Type 2 Dm Without Complications	07/28/2017 - 08/11/2017	Home	Medical	Admiral Medical Supply, Inc
Paranoid Schizophrenia	07/24/2017 - 07/24/2017	Outpatient Hospital	Behavioral	Regional Mental Health Center
Paranoid Schizophrenia	07/24/2017 - 07/24/2017	Outpatient Hospital	Behavioral	Dobransky, Paul
Oth Long Term Current Drug Therapy	06/12/2017 - 06/12/2017	Independent Laboratory	Medical	Professional Clinical Laboratories L

Health Record -Medications

Member's most recent Pharmacy Claims

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Fill Date	Drug Name	Dose	Quantity	Dispensing Pharmacy
05/20/2018	HYDROXYCHLOR TAB 200MG	200 MG	60	CVS PHARMACY
05/19/2018	LEFLUNOMIDE TAB 20MG	20 MG	30	CVS PHARMACY
05/04/2018	CITALOPRAM TAB 20MG	20 MG	30	CVS PHARMACY
05/04/2018	VYVANSE CAP 40MG	40 MG	30	CVS PHARMACY
05/01/2018	PREDNISONE TAB 5MG	5 MG	60	CVS PHARMACY
05/01/2018	TIZANIDINE TAB 4MG	4 MG	30	CVS PHARMACY
04/25/2018	HYDROXYCHLOR TAB 200MG	200 MG	60	CVS PHARMACY
04/23/2018	DICLOFENAC TAB 75MG DR	75 MG	60	CVS PHARMACY
04/23/2018	LEFLUNOMIDE TAB 20MG	20 MG	30	CVS PHARMACY
04/23/2018	MONTELUKAST TAB 10MG	10 MG	90	CVS PHARMACY
04/23/2018	TIZANIDINE TAB 4MG	4 MG	8	CVS PHARMACY

Health Record -Immunizations

 Member's most recent **Immunizations** and **Schedule**

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[Visits](#)
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[Immunizations](#)
[Schedule](#)

VACCINE	DATE ADMINISTERED	ADMIN AGE
IMMUNIZ ADMIN; 1/COMBO VACCINE/TOXOID	02/17/2016	29Y 8M
IMMUNIZ ADMIN; 1/COMBO VACCINE/TOXOID	02/17/2016	29Y 8M
IMMUNIZ ADMIN; 1/COMBO VACCINE/TOXOID	02/17/2016	29Y 8M

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

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[Visits](#)
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[Immunizations](#)
[Schedule](#)

[View Child Immunization Schedule](#)
[View Adolescent Immunization Schedule](#)
[View Adult Immunization Schedule](#)

[View Catch-up Immunization Schedule](#)

Health Record -Labs

 Member's most recent **Labs**

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Date Of Service	Procedure	Ordering Provider
Jan 14, 2016	BASIC METABOLIC PANEL (8)	Thomas Miller

Health Record -Allergies

Member list of Allergies

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Substance	Reaction	Severity	Source	Allergy Details	Active	Date Identified
Other (AMOXICILLIN)	Hives	Severe	Member/Self-Reported	ALSO NAUSEA	Yes	Sep 16, 2016
Other (HYDROCODONE)	Hives	Severe	Member/Self-Reported	ALSO NV	Yes	Sep 16, 2016
Penicillin	Hives	Severe	Member/Self-Reported	ALSO NAUSEA	Yes	Sep 16, 2016
Sulfa Drugs	Hives	Severe	Member/Self-Reported	ALSO NV	Yes	Sep 16, 2016

Care Plan

 Displays if a member has a **Care Plan**.

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Member Name

Overview	This member's care plan to treat: Care Coordination 04/06/2017 - OPEN	Case Worker Ashley White
Cost Sharing		
Assessments		
Health Record		
Care Plan		
Authorizations	Member states that she would like to quit smoking.	
Referrals	Goal: Member states that she would like to decrease smoking one pack of ciagrettes to a 1/2 pack within the next 60 days. by 2018-07-16	
Coordination of Benefits	Member has tried quitting smoking several times. may be a barrier to success	
Claims	What we're doing:	
Document Resource Center	2017-10-10 CC will outreach in 60 days to monitor progress on smoking cessation/address care opp. 2017-06-05 Member agrees CC will send out education on smoking cessation and care opp. on this date. 2017-05-29 CC will follow up with member in 60 days regarding goal of decreasing smoking from one pack of ciagrettes to a 1/2 pack. 2017-08-22 CC will send member educational information on quitting smoking. 2018-03-26 CC will outreach in 60 days to monitor progress on smoking cessation/address care opp. 2018-01-29 CC offered semi-annual case conference 2017-04-06 CC will send member edu info on quitting smoking 2018-07-16 CC will outreach in 60 days to monitor progress on smoking cessation/address care opp. 2018-01-29 CC will outreach in 60 days to monitor progress on smoking cessation/address care opp. 2017-08-22 Member agrees CC will outreach in 60 days to monitor progress on smoking cessation/address care opp. 2018-05-21 CC will outreach in 60 days to monitor progress on smoking cessation/address care opp. 2018-07-16 Member agrees to cut down from 6 cigarettres to 3/4 daily within the next 60 days. 2017-08-04 Member states that she would like to decrease smoking one pack of ciagrettes to a 1/2 pack within the next 60 days. 2018-02-12 CC sent semi-annual case conference letter to provider. CC will follow up in 2 weeks to determine appropriate action. 2017-12-04 CC will outreach in 60 days to monitor progress on smoking cessation/address care opp.	
Notes		

Authorizations

 View previously submitted or create a **New Authorization**

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Member Name

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Authorizations

STATUS	AUTH NBR	FROM DATE	TO DATE	DIAGNOSIS	AUTH TYPE	SERVICE
APPROVE	C 1	02/06/2018	05/06/2018	M51.36	OUTPATIENT	Office Visit
APPROVE	C 6	03/14/2017	01/05/2018	G89.4	OUTPATIENT	Office Visit

Create a New Authorization

Click on **AUTH NBR** above

Auth Status: APPROVE
Auth Nbr: C 1
Service: Office Visit
Provider of Service(s): GREGORY MASIMORE
Diagnosis Code(s): M51.36

Explanation: Pay
Auth Type: OUTPATIENT
From Date: 02/06/2018
To Date: 05/06/2018
Procedure Code(s): 99214
Notes & Attachments: [View](#)

Line Item	Service type	Start Date	End Date	Units Req.	Units Apprd	Servicing Provider	Location	Status	Medical Necessity	Decision Date
1	Office Visit	02/06/2018	05/06/2018	3	3	GREGORY MASIMORE	Office	APPROVE	Met as requested	01/31/2018

Referrals

 Refer a member to **Case Management** or **Behavioral Health**

[Back to Eligibility Check](#)

Member Record

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Authorizations

Referrals

Coordination of Benefits

Claims

*Source

Please select Source

Please select Source
Case Management
Behavioral Health Referral to Health Plan

*Date

03/25/2017

10

31

AM

Last Name, First Name

Phone Number, Extension

Additional Comments

Submit


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	W16453617501		AETNA	MEDICAL AND HOSPITAL
Assessments						
Health Record						
Care Plan						
Authorizations						
Coordination of Benefits						
Claims						

Claims

 **Claims** screen shows the members most recent claims and create a new claim

- Clicking on the **Claim No.** shows additional details

[Back to Patient List](#)

Member Name

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Coordination of Benefits

Claims

Document Resource Center

CLAIM NO. ↑	REF/ACCT NO. ↑	DOS RANGE ↑	PAYMENT DATE ↑	RECEIVED DATE ↑	SERVICING PROVIDER ↑	BILLED/ PAID ↑	STATUS ↑
C 0	C77000G7	07/24/2017 - 07/24/2017	08/03/2017	07/25/2017	MILLER, THOMAS	\$75.00 / \$51.99	PAID

One item found. Page 1/1 1

Create a New Claim

[Back to Claims](#)
[Correct Claim](#)
[Copy Claim](#)

Claim No.: C 0

Ref/Acct No.: C 7

Member ID: 1 99

Member Name: 3

Member DOB: 0

Servicing Provider: MILLER, THOMAS

Servicing NPI: 1326048802

DOS Range: 07/24/2017 - 07/24/2017

Received Date: 07/25/2017

Billed Amount: \$75.00

Payment Amount: \$51.99

Payment Date: 08/03/2017

Status: PAID

Document Resource Center

Medical Necessity or Quality Management Document Upload

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Member Name

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Document Upload

Document Review

1.

Document Category:

Please Select a Category

Please Select a Category

Medical Necessity

Quality Management

2.

Document Type:

Please Select a Category

Medical Necessity

Quality Management

3.

Upload File:

Choose File

No file chosen

4.

Submit

Notes

 Create new **Note** and see previous **Notes**

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Document Resource Center

Notes

Notes

Create a New Note

General Note

Write Note

Previous Notes

Date

D

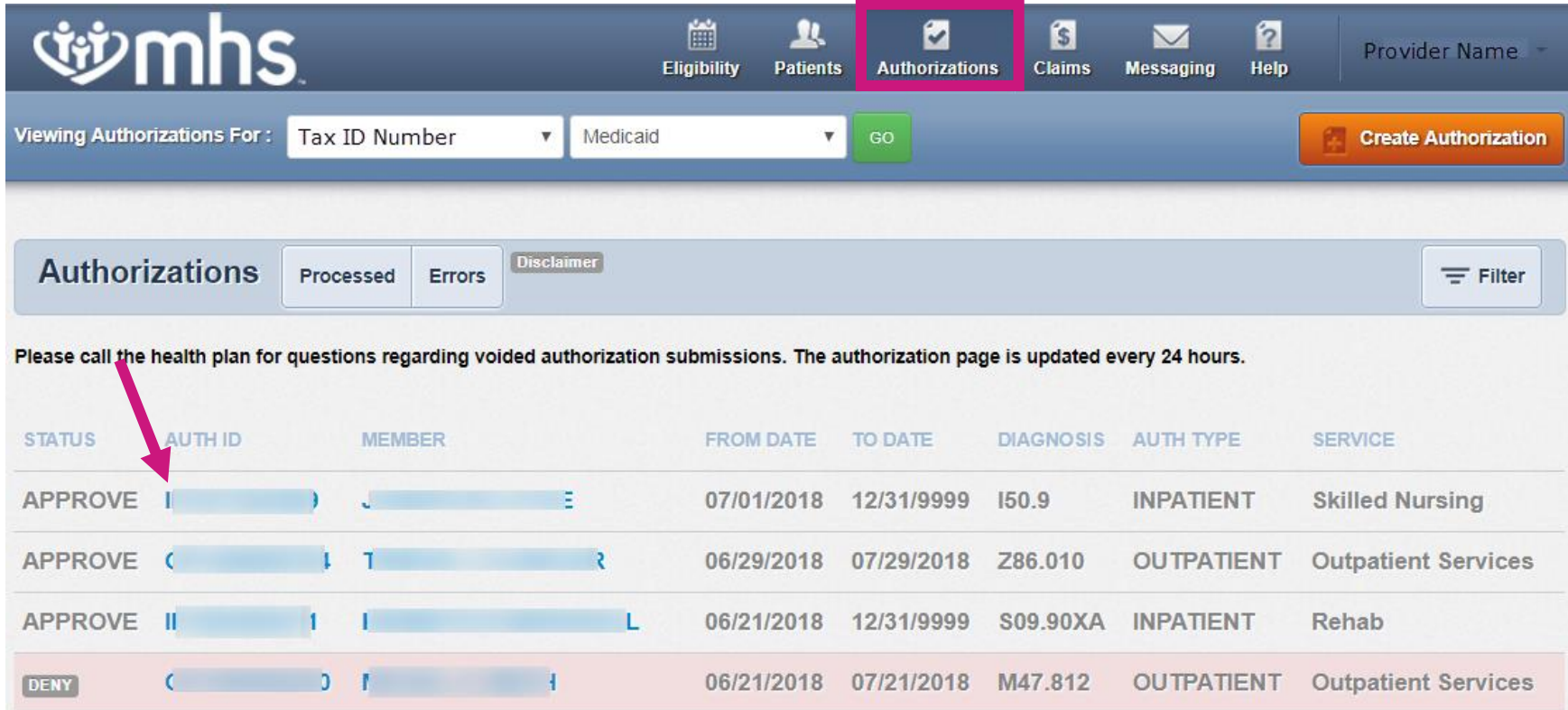
has no submitted Notes at this time.

Authorizations

Authorizations

 View, create and filter group Authorizations

- Click on the **AUTH ID** to see additional information

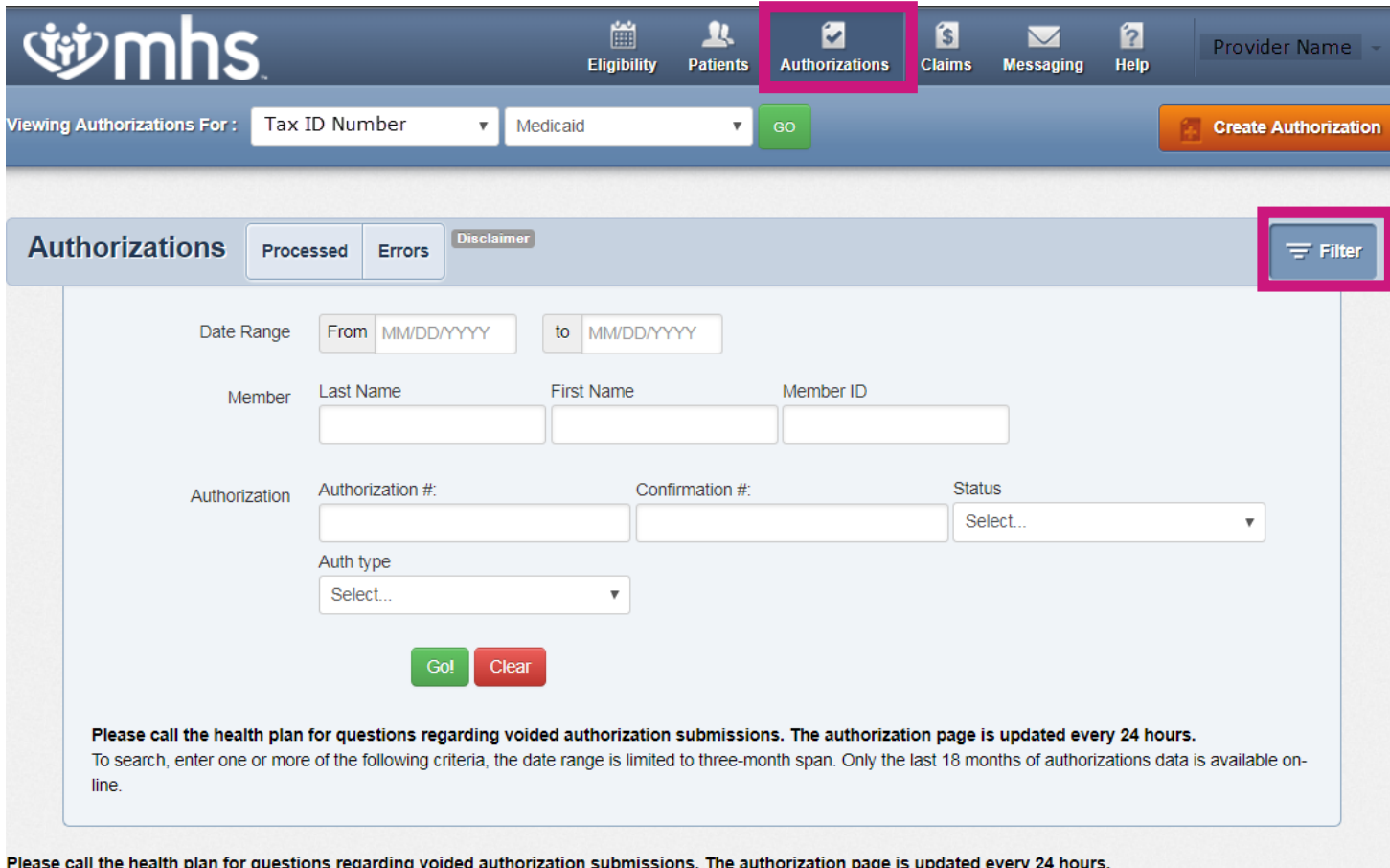


The screenshot shows the MHS Authorizations interface. At the top, there is a navigation bar with icons for Eligibility, Patients, Authorizations (highlighted with a red box), Claims, Messaging, and Help. Below the navigation bar, there is a section for viewing authorizations, including dropdown menus for 'Tax ID Number' and 'Medicaid', a 'GO' button, and a 'Create Authorization' button. The main content area displays a table of authorizations with columns: STATUS, AUTH ID, MEMBER, FROM DATE, TO DATE, DIAGNOSIS, AUTH TYPE, and SERVICE. A red arrow points to the 'AUTH ID' column header. The table contains four rows of data, with the first three rows having a status of 'APPROVE' and the last row having a status of 'DENY'. A 'Filter' button is located in the top right corner of the table area. A disclaimer message is displayed above the table: 'Please call the health plan for questions regarding voided authorization submissions. The authorization page is updated every 24 hours.'

STATUS	AUTH ID	MEMBER	FROM DATE	TO DATE	DIAGNOSIS	AUTH TYPE	SERVICE
APPROVE	[REDACTED]	[REDACTED]	07/01/2018	12/31/9999	I50.9	INPATIENT	Skilled Nursing
APPROVE	[REDACTED]	[REDACTED]	06/29/2018	07/29/2018	Z86.010	OUTPATIENT	Outpatient Services
APPROVE	[REDACTED]	[REDACTED]	06/21/2018	12/31/9999	S09.90XA	INPATIENT	Rehab
DENY	[REDACTED]	[REDACTED]	06/21/2018	07/21/2018	M47.812	OUTPATIENT	Outpatient Services

Authorizations

 **Filter** Authorizations by **Date Range**, **Member**, **Authorization#**, **Confirmation#**, **Status** or **Auth Type**



Authorizations | Processed | Errors | Disclaimer

Filter

Date Range: From MM/DD/YYYY to MM/DD/YYYY

Member: Last Name, First Name, Member ID

Authorization: Authorization #, Confirmation #, Status (Select...)

Auth type: Select...

Go! **Clear**

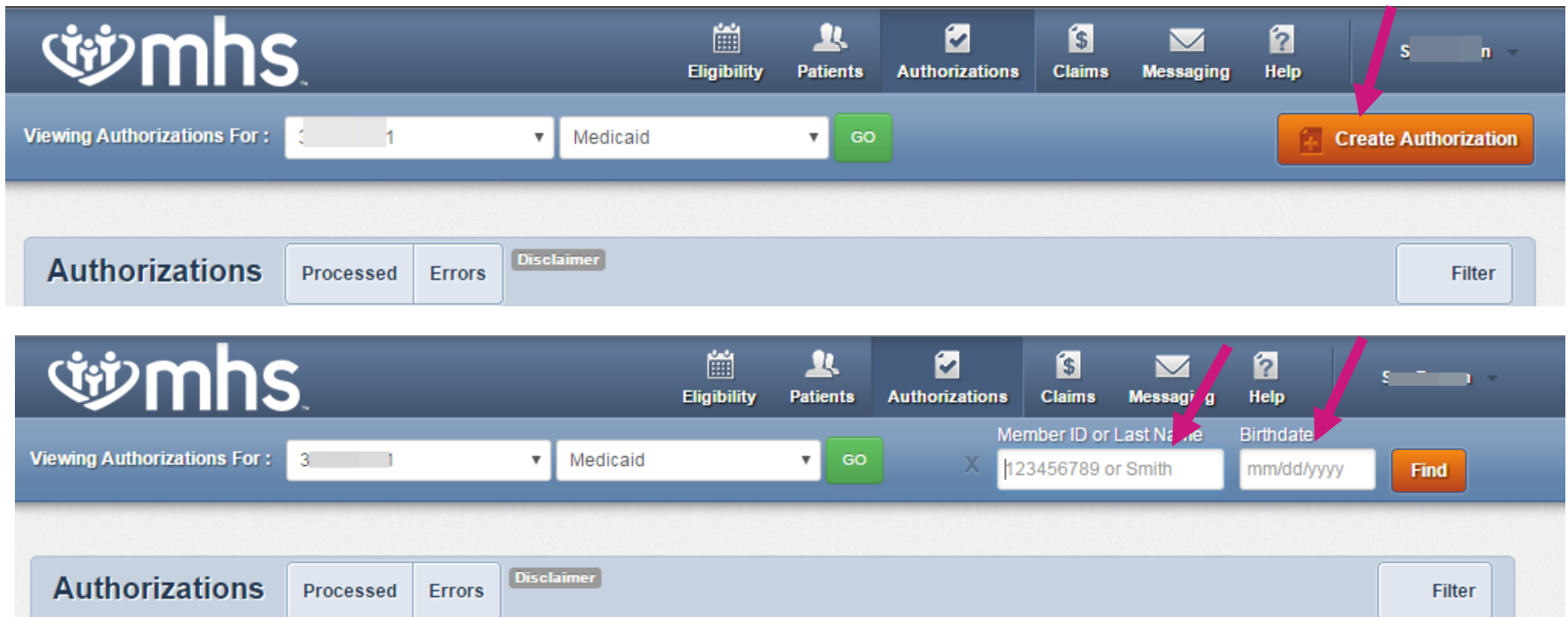
Please call the health plan for questions regarding voided authorization submissions. The authorization page is updated every 24 hours. To search, enter one or more of the following criteria, the date range is limited to three-month span. Only the last 18 months of authorizations data is available on-line.

Please call the health plan for questions regarding voided authorization submissions. The authorization page is updated every 24 hours.

Create a New Authorization

New Authorization

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



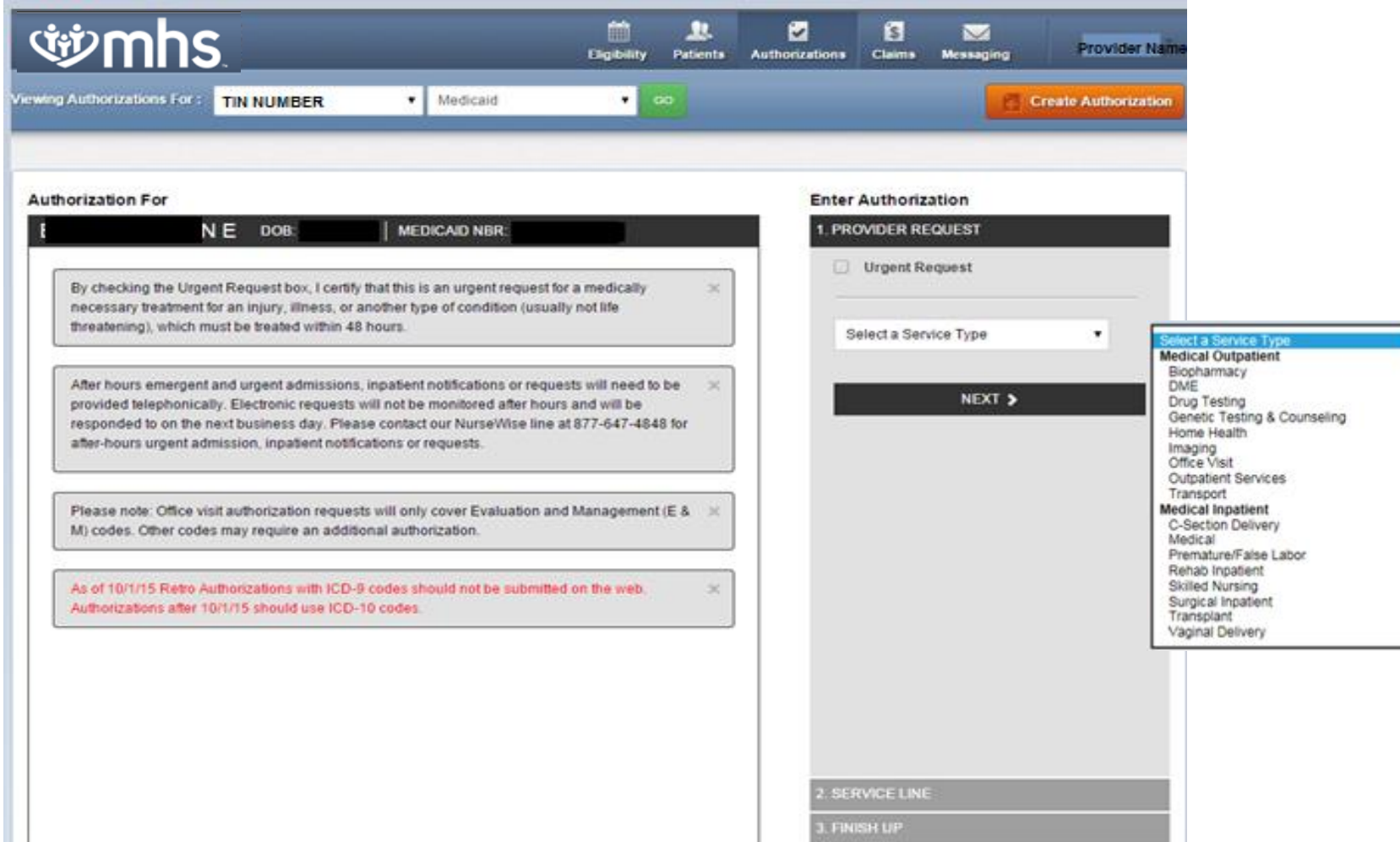
The image displays two screenshots of the MHS (My Health Solutions) web application interface, specifically the 'Authorizations' section.

Top Screenshot: The 'Create Authorization' button is highlighted with a red arrow. The interface shows the 'mhs' logo, navigation tabs (Eligibility, Patients, Authorizations, Claims, Messaging, Help), and a search bar. Below the navigation, there are dropdown menus for 'Viewing Authorizations For' (set to '1') and 'Medicaid', a 'GO' button, and the 'Create Authorization' button.

Bottom Screenshot: The search fields for 'Member ID or Last Name' and 'Birthdate' are highlighted with red arrows. The interface shows the 'mhs' logo, navigation tabs, and a search bar. Below the navigation, there are dropdown menus for 'Viewing Authorizations For' (set to '3') and 'Medicaid', a 'GO' button, and a search area with fields for 'Member ID or Last Name' (containing '23456789 or Smith') and 'Birthdate' (containing 'mm/dd/yyyy'), a 'Find' button, and a 'Filter' button.

Creating a New Authorization

Select a Service Type



The screenshot displays the MHS Authorization System interface. At the top, there is a navigation bar with icons for Eligibility, Patients, Authorizations, Claims, and Messaging, along with a 'Provider Name' field. Below this, a search bar shows 'Viewing Authorizations For : TIN NUMBER Medicaid' with a 'GO' button and a 'Create Authorization' button.

The main content area is divided into two sections:

- Authorization For:** This section includes fields for 'NE', 'DOB', and 'MEDICAID NBR'. Below these fields are four informational boxes:
 - By checking the Urgent Request box, I certify that this is an urgent request for a medically necessary treatment for an injury, illness, or another type of condition (usually not life threatening), which must be treated within 48 hours.
 - After hours emergent and urgent admissions, inpatient notifications or requests will need to be provided telephonically. Electronic requests will not be monitored after hours and will be responded to on the next business day. Please contact our NurseWise line at 877-647-4648 for after-hours urgent admission, inpatient notifications or requests.
 - Please note: Office visit authorization requests will only cover Evaluation and Management (E & M) codes. Other codes may require an additional authorization.
 - As of 10/1/15 Retro Authorizations with ICD-9 codes should not be submitted on the web. Authorizations after 10/1/15 should use ICD-10 codes.
- Enter Authorization:** This section is titled '1. PROVIDER REQUEST' and includes an 'Urgent Request' checkbox. Below this is a 'Select a Service Type' dropdown menu, which is currently open, showing a list of service types:
 - Medical Outpatient:** Biopharmacy, DME, Drug Testing, Genetic Testing & Counseling, Home Health, Imaging, Office Visit, Outpatient Services, Transport.
 - Medical Inpatient:** C-Section Delivery, Medical, Premature/False Labor, Rehab Inpatient, Skilled Nursing, Surgical Inpatient, Transplant, Vaginal Delivery.

At the bottom of the 'Enter Authorization' section, there are buttons for 'NEXT >' and '2. SERVICE LINE', and a section for '3. FINISH UP'.

Creating a New Authorization

Select Provider NPI Add Primary Diagnosis

Enter Authorization

1. PROVIDER REQUEST

☐ Urgent Request

Outpatient Services

Requesting Provider

Requesting Provider NPI or Last Name

Primary Diagnosis

Diagnosis Code

CODE LOOKUP [ICD-9](#) [ICD-10](#)

+

 Add Additional Diagnosis

NEXT >

Enter Authorization

1. PROVIDER REQUEST

☐ Urgent Request

Outpatient Services

Requesting Provider

147

NPI: 147

TIN:

Name: SMITH

Primary Diagnosis

CODE LOOKUP [ICD-9](#) [ICD-10](#)

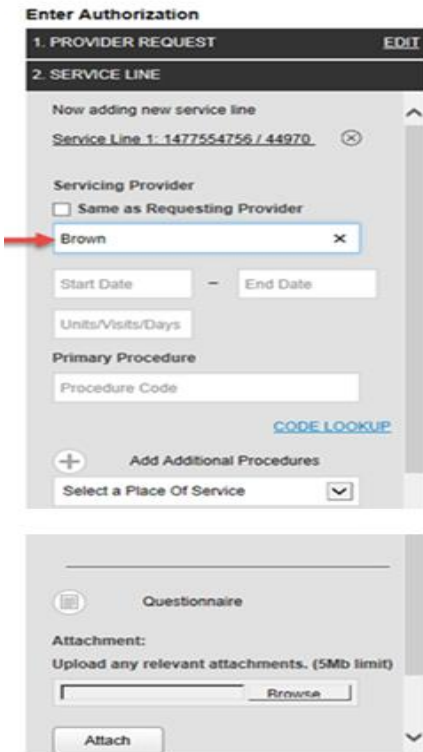
+

 Add Additional Diagnosis

NEXT >

Creating a New Authorization

Service Line Details



Enter Authorization

1. PROVIDER REQUEST [EDIT](#)

2. SERVICE LINE

Now adding new service line

Service Line 1: 1477554756 / 44970 [X](#)

Servicing Provider

☐ Same as Requesting Provider

[Brown](#) [X](#)

Start Date - End Date

Units/Visits/Days

Primary Procedure

Procedure Code [CODE LOOKUP](#)

[+](#) Add Additional Procedures

Select a Place Of Service [v](#)

Questionnaire

Attachment:

Upload any relevant attachments. (5Mb limit)

[Browse](#)

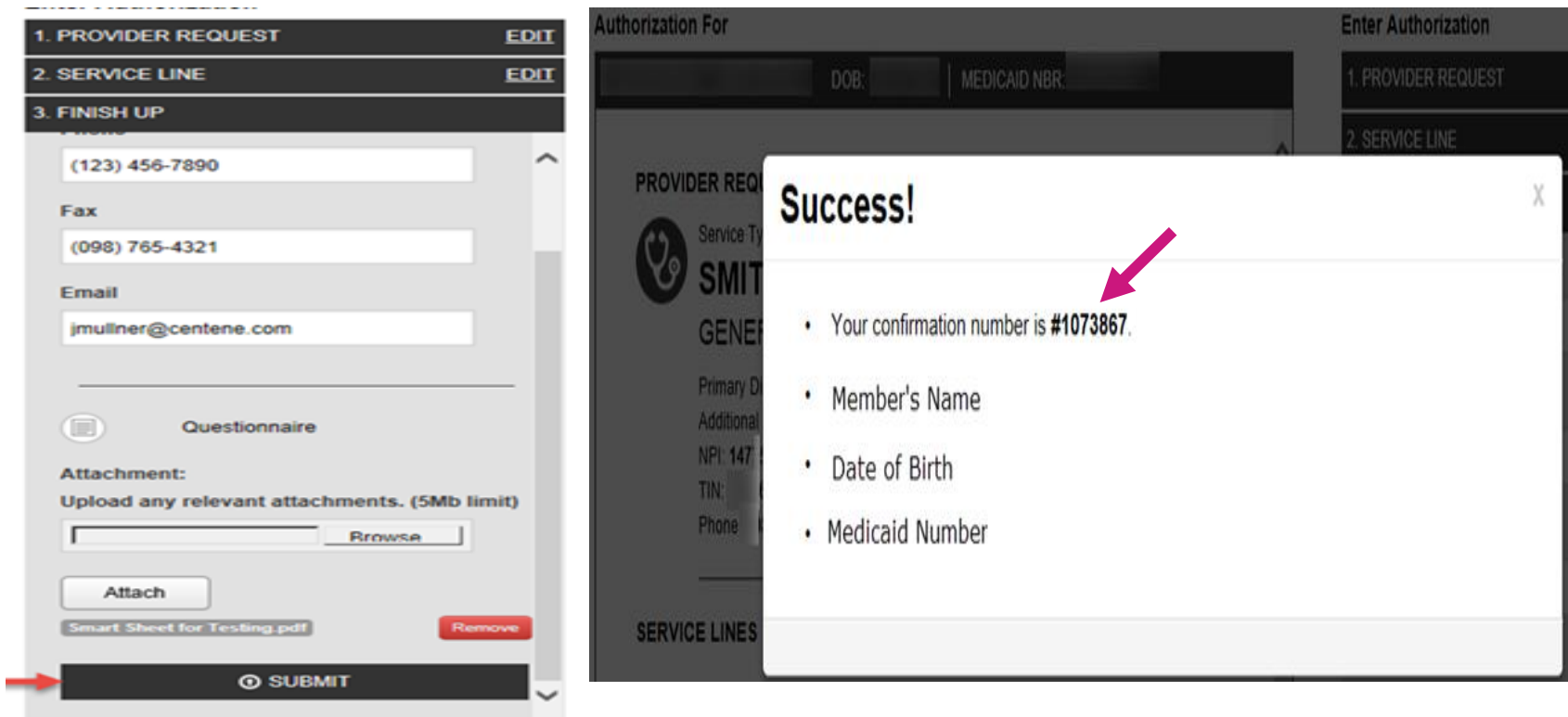
[Attach](#)

- Provider Request will appear on the left side of the screen
- Update Servicing Provider
 - Check box if same as Requesting Provider
 - Update Servicing Provider information if not the same
- Update Start Date and End Date
- Update Total Units/Visits/Days
- Update Primary Procedure
 - Code lookup provided
- Add any additional procedures
- Add additional Service Line if applicable
 - All service lines added will appear on the left side of the screen

Creating a New Authorization

 Submit a new **Authorization**

- **Confirmation Number**



The image shows two screenshots from the MHS authorization system. The left screenshot displays the '1. PROVIDER REQUEST' step of the authorization process. It includes fields for Phone (with a dropdown for area code), Fax, Email, and a Questionnaire section. An attachment section allows users to upload files (5Mb limit) with a 'Browse' button and an 'Attach' button. A 'SUBMIT' button is at the bottom, highlighted with a red arrow. The right screenshot shows a 'Success!' modal dialog box with a pink arrow pointing to the confirmation number. The modal lists the following information:

- Your confirmation number is **#1073867**.
- Member's Name
- Date of Birth
- Medicaid Number

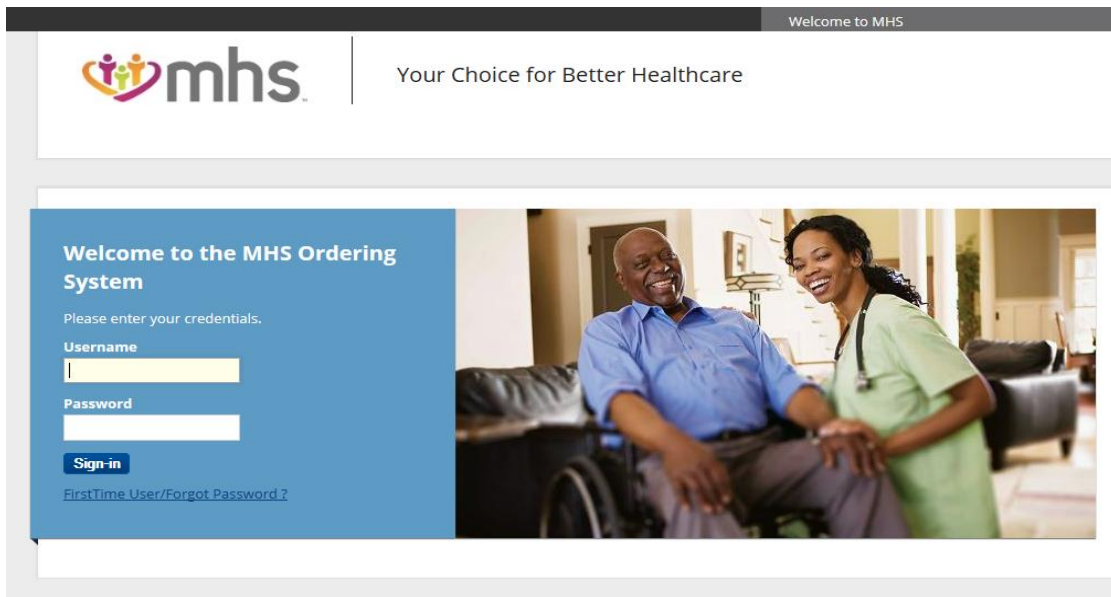
The background of the right screenshot shows the 'Authorization For' section with fields for DOB and MEDICAID NBR, and the 'Enter Authorization' section with steps 1. PROVIDER REQUEST and 2. SERVICE LINE.

Authorization for Durable & Home Medical Equipment



Requests should be initiated via **MHS Secure portal**





1. Select **Authorizations** tab and click on **Create Authorization**.
2. Enter **Member ID** or **Last Name** and **Date of Birth**
3. Choose **DME** and you will be directed to the Medline portal for order entry.

A screenshot of the MHS Ordering System login page. The page has a dark grey header with 'Welcome to MHS' on the right. Below the header is a white banner with the MHS logo on the left and the tagline 'Your Choice for Better Healthcare' on the right. The main content area is divided into two sections. The left section is a blue box with the text 'Welcome to the MHS Ordering System' and 'Please enter your credentials.' Below this are input fields for 'Username' and 'Password', a 'Sign-in' button, and a link for 'FirstTime User/Forgot Password?'. The right section is a photograph of a smiling Black man in a blue shirt sitting in a wheelchair, with a smiling Black woman in green scrubs standing next to him, holding his hand.

Claims

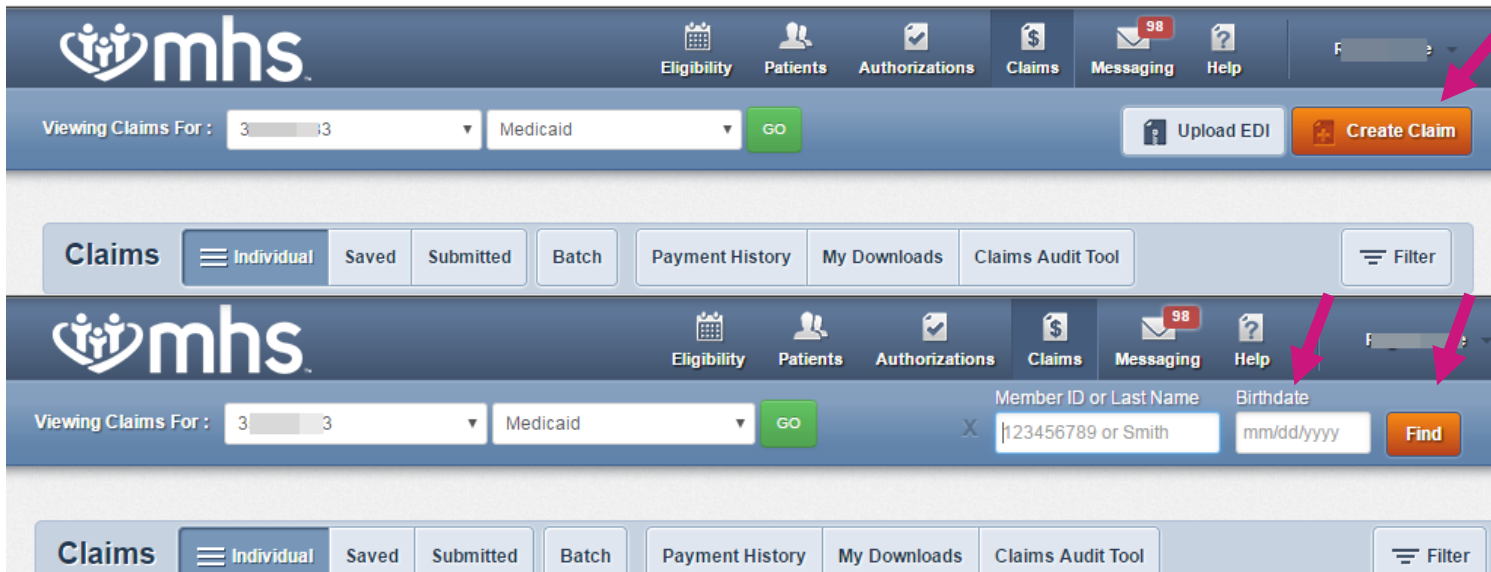
Claims

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**

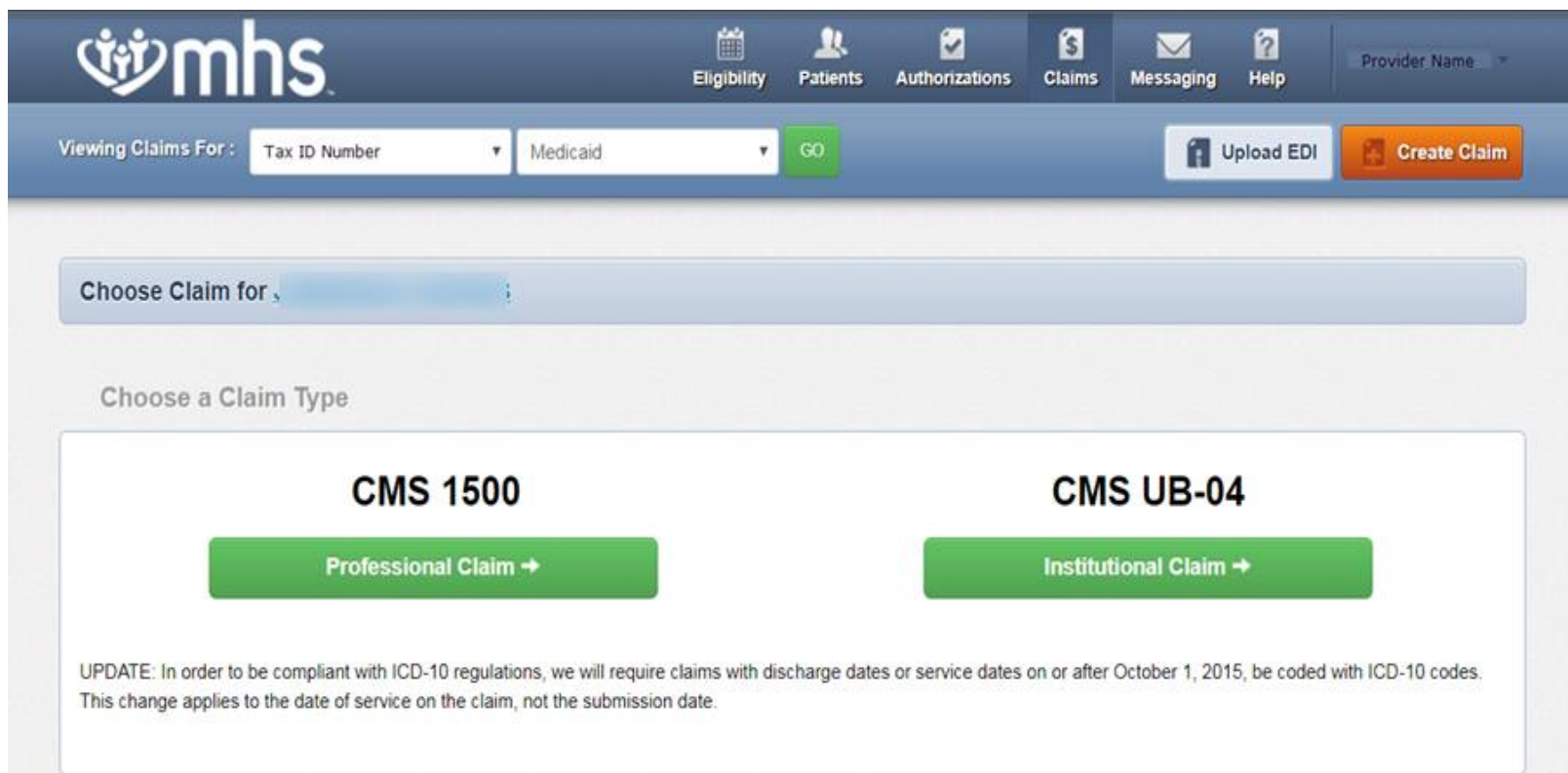


The screenshot shows the MHS web portal interface. At the top, there is a navigation bar with icons for Eligibility, Patients, Authorizations, Claims, Messaging, and Help. Below this is a section for 'Viewing Claims For' with a dropdown menu set to '3' and a 'Medicaid' filter, followed by a 'GO' button. To the right of this section is an 'Upload EDI' button and a prominent orange 'Create Claim' button, which is highlighted with a red arrow. Below the 'Viewing Claims For' section is a 'Claims' tab with sub-tabs for Individual, Saved, Submitted, Batch, Payment History, My Downloads, and Claims Audit Tool. At the bottom, there is a search section with fields for 'Member ID or Last Name' (containing '123456789 or Smith') and 'Birthdate' (with a placeholder 'mm/dd/yyyy'), and a 'Find' button. Red arrows point to the 'Create Claim' button and the search fields.

Web Portal Claim Submission

Choose the Claim Type

- **Professional** or **Institutional** claim submission



The screenshot shows the MHS Web Portal Claim Submission interface. At the top is the MHS logo. Below it is a navigation bar with icons and labels for Eligibility, Patients, Authorizations, Claims, Messaging, and Help. To the right of the navigation bar is a dropdown menu for Provider Name. Below the navigation bar is a section for Viewing Claims For, with dropdown menus for Tax ID Number and Medicaid, and a GO button. To the right of this section are buttons for Upload EDI and Create Claim. Below this is a section for Choose Claim for, with a dropdown menu. Below that is a section for Choose a Claim Type, with two options: CMS 1500 Professional Claim and CMS UB-04 Institutional Claim. At the bottom is an update notice regarding ICD-10 regulations.

mhs

Eligibility Patients Authorizations Claims Messaging Help

Provider Name

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 Claim Submission: Step 1

 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*
XXXXXXXXXX

Date of current Illness, Injury, Pregnancy (LMP)

Select Type...
MM/DD/YYYY

Other Date


Select Type...
MM/DD/YYYY


26


14.

15.

Professional Claim Submission: Step 2

 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 [LJ](#) TY 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* [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 [x Remove](#)

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

Carrier Type* 

Policy Number* 

[← Back](#) [Next →](#)

Professional Claim Submission: Step 3

Add Service Lines

Professional Claim for J.

TY

Your Progress

THE SECTION

Service Lines

Enter maximum of 50 service lines.

Back

Next

Total: \$500.00

New Service Line

PROCEDURE / CHARGES

1: 99213 / \$500.00

Required field

Delete Save / Update

Now Viewing Line 1: 99213 / \$500.00

Dates of Service*
From: 02/01/2016 To: 02/01/2016
DLA

Place of Service*
11 - PROVIDER'S OFFICE
DLB

Procedure Code*
99213
DLB

Modifiers
XX Add Please enter the modifier and click the Add button.
DLB

Diagnosis Code(s)*
J637 - PERS OUTSD INDOUST VEH/ALNT ACC
DLB

Charge*
500.00
DLT

Units / Minutes / Days*
1 Type*
LN - LR
DLG

Family Planning
Yes No EPODT: Select...
DLH

NDC
NDC
NDC

Supplemental Information
Supplemental Information

Primary Insurance

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

Amount Allowed*
500.00

Deductible
XXXX.XX

Copay
XXXX.XX

Co-Insurance
XXXX.XX

Amount Paid
500.00

Service Line Denial Reasons

Select denied category, enter amount and click "Add Denied Reason" to add a denied amount to your claim.

Denied Category
Select...

Denied Amount
XXXX.XX


Add Denied Reason

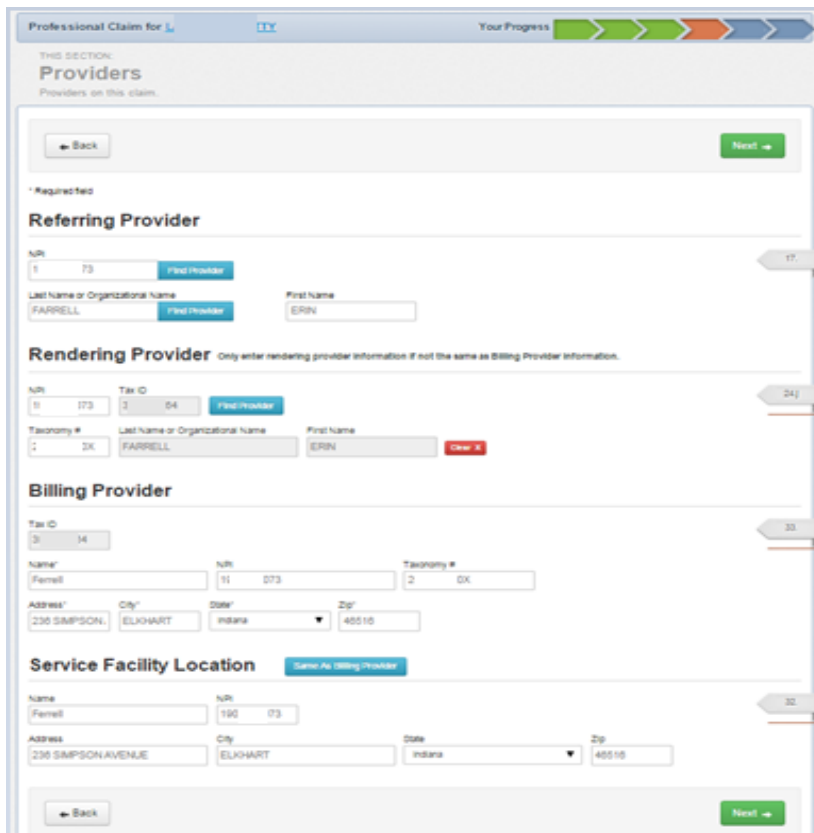
Delete Save / Update

Back

Next

Professional Claim Submission: Step 4 - 5

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



Professional Claim for **L** **Y** Your Progress **1** **2** **3** **4** **5**

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

Referring Provider

NPI: **11 73** **First Provider**

Last Name or Organizational Name: **FARRELL** **First Name**: **ERIN**

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

NPI: **11 173** Tax ID: **3 04** **First Provider**

Taxonomy #: **2 0X** Last Name or Organizational Name: **FARRELL** **First Name**: **ERIN** **Clear X**

Billing Provider

Tax ID: **3 14**

Name: **Farell** NPI: **11 073** Taxonomy #: **2 0X**


Address: **236 SIMPSON** City: **ELKHART** State: **Indiana** Zip: **46516**

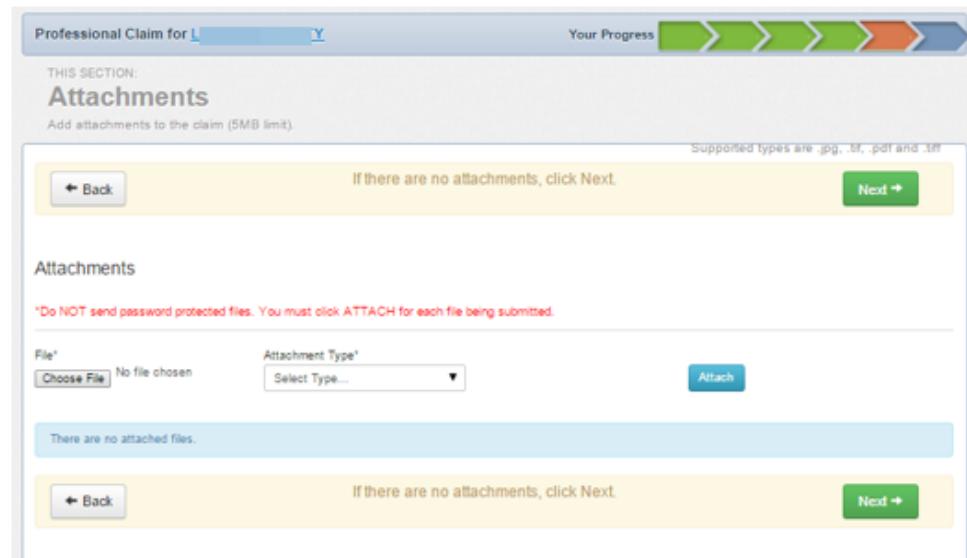
Service Facility Location **Same As Billing Provider**

Name: **Farell** NPI: **190 073**

Address: **236 SIMPSON AVENUE** City: **ELKHART** State: **Indiana** Zip: **46516**

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 **1** **2** **3** **4** **5**

THIS SECTION: **Attachments**
Add attachments to the claim (5MB limit).

Supported types are .jpg, .tif, .pdf and .xml

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 Claim Submission: Step 6

 In the **Review** section, you can see if the claim is eligible for Real Time Editing and Pricing.





 Click **Validate** for RTEP Claims and Click **Submit** for regular processed claims.

Professional Claim for **L** **S** 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 
 Member Claim Amount Paid: 
 Patient's Account Number: 

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			

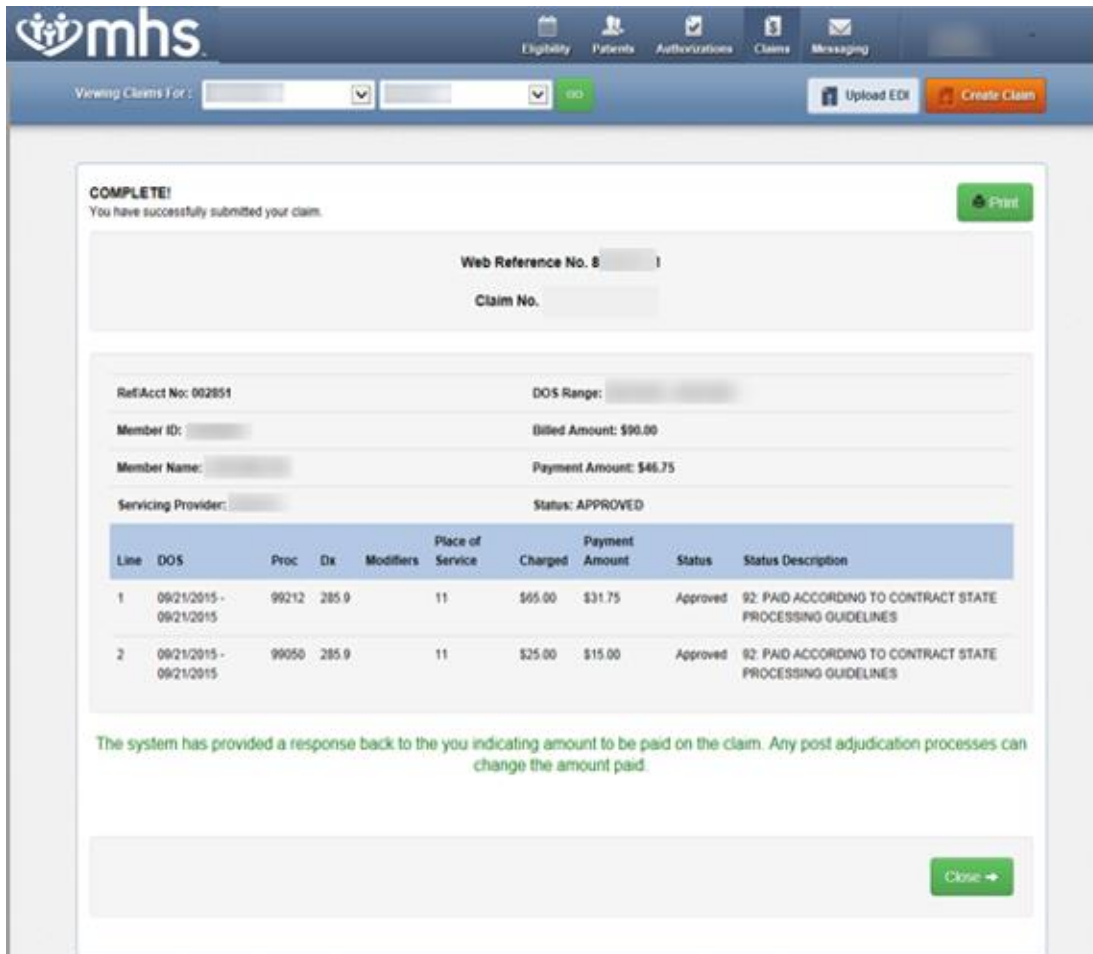
Providers [Edit](#)

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 →](#)

RTEP Claim Pricing View



COMPLETE!
You have successfully submitted your claim.

Web Reference No. 8
Claim No.

Ref/Acct No: 092851 DOS Range:
Member ID: Billed Amount: \$90.00
Member Name: Payment Amount: \$46.75
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

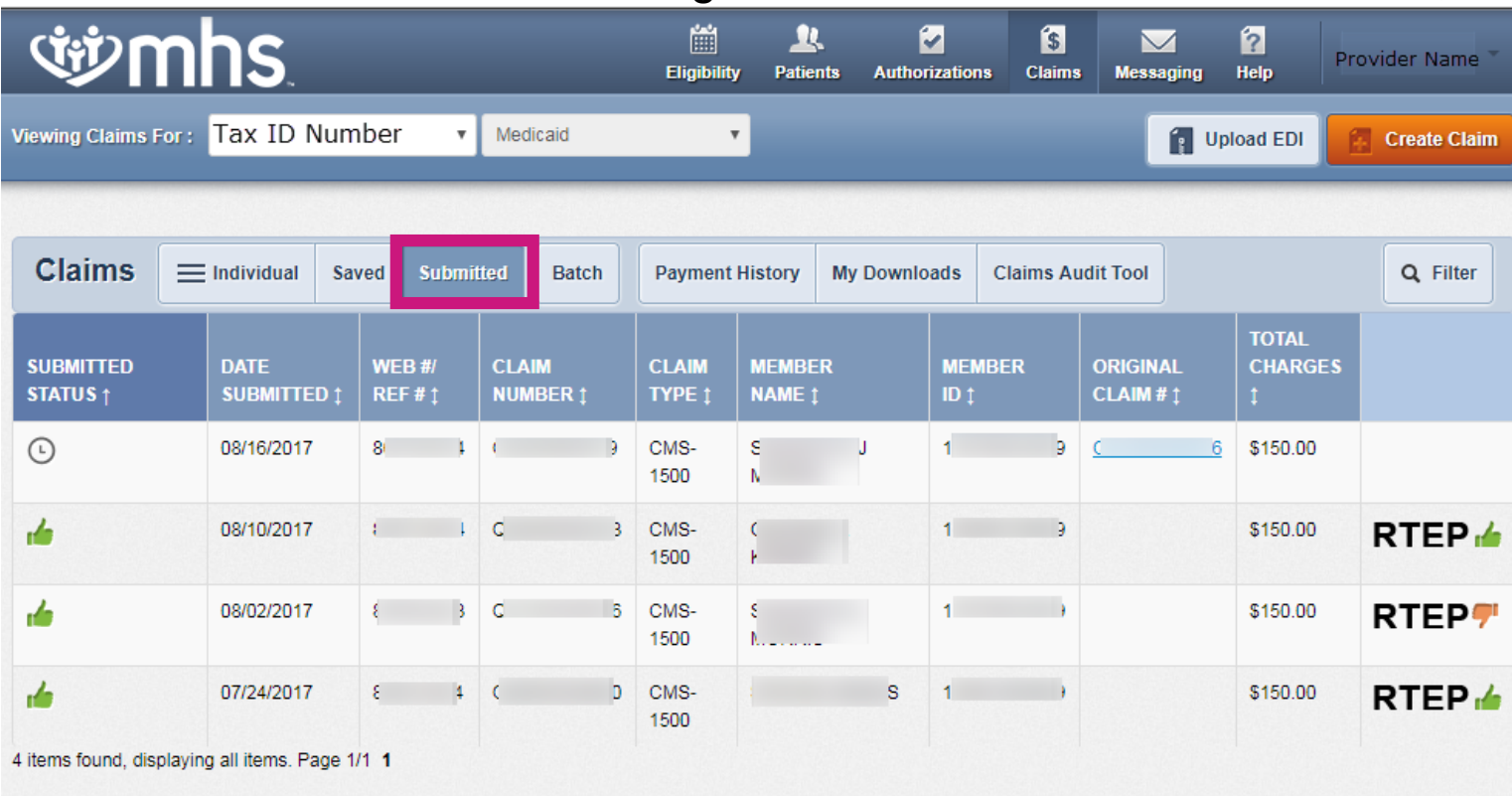
- On the final screen each procedure code will receive a reimbursement estimate, pended claim explanation or denial reason.
- Claims with a reimbursement estimate or pend explanation, may be impacted by final adjudication including a change to the reimbursement amount or a denial
- Adjudication status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

Submitted Claims

 The **Submitted** tab will show only claims created via the MHS portal.








- **Paid** is a green thumbs up,
- **Denied** is a orange thumbs down
- **Pending** is a clock

 **RTEP** claims also show if eligible. (i.e. line 2 was submitted. But was not eligible for RTEP.)



The screenshot shows the MHS portal interface. At the top is the MHS logo and navigation tabs: Eligibility, Patients, Authorizations, Claims, Messaging, and Help. Below the navigation is a header bar with "Viewing Claims For:" followed by dropdowns for "Tax ID Number" and "Medicaid". To the right are buttons for "Upload EDI" and "Create Claim".







The main content area shows the "Claims" tab selected, with sub-tabs for Individual, Saved, Submitted (highlighted with a red box), and Batch. There are also links for Payment History, My Downloads, and Claims Audit Tool, along with a Filter button.

SUBMITTED STATUS ↑	DATE SUBMITTED ↑	WEB #/ REF # ↑	CLAIM NUMBER ↑	CLAIM TYPE ↑	MEMBER NAME ↑	MEMBER ID ↑	ORIGINAL CLAIM # ↑	TOTAL CHARGES ↑	
	08/16/2017	8 [redacted]	[redacted]	CMS-1500	S [redacted] J [redacted]	1 [redacted]	C [redacted] 6	\$150.00	
	08/10/2017	[redacted]	C [redacted]	CMS-1500	C [redacted]	1 [redacted]		\$150.00	RTEP 
	08/02/2017	[redacted]	C [redacted]	CMS-1500	S [redacted]	1 [redacted]		\$150.00	RTEP 
	07/24/2017	[redacted]	C [redacted]	CMS-1500	[redacted] S [redacted]	1 [redacted]		\$150.00	RTEP 

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

Reviewing Claims

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, only a **1 month** span 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.
-  When managing multiple tax id numbers, a new tax id and view the dashboard associated with that TIN from any screen.
-  When filtering **Payment History** the span is limited to 1 month.

Individual Claims



On the **Individual** tab, submitted using paper, portal or clearing house.

- View the Claim Number, Claim Type, Member Name, Service Dates, Billed/Paid, and Claim Status

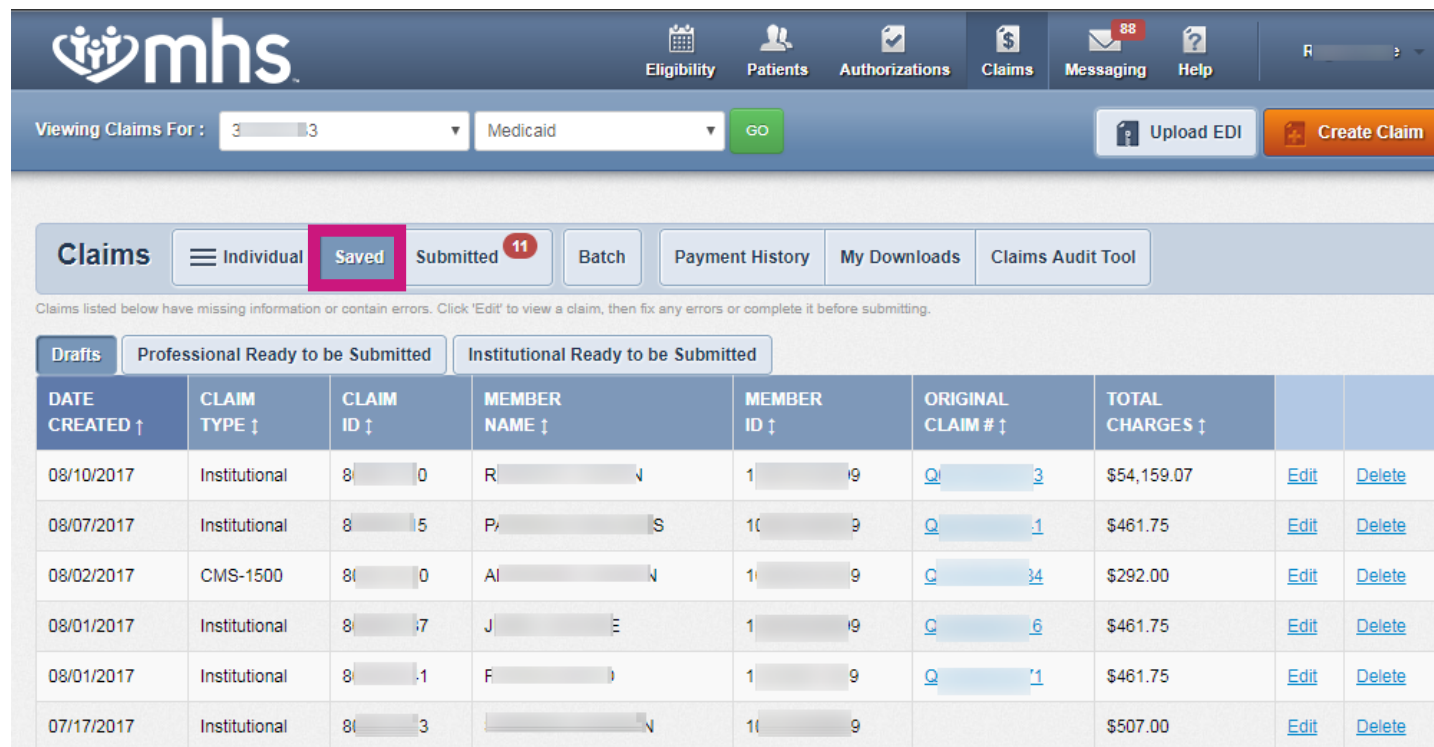
mhs					
Eligibility		Patients	Authorizations	Claims	Messaging Help
Viewing Claims For :		3	Medicaid	GO	Upload EDI Create Claim
Claims	Individual	Saved	Submitted	Batch	Payment History My Downloads Claims Audit Tool Filter
CLAIM NO. ↑	CLAIM TYPE ↑	MEMBER NAME ↑	SERVICE DATE(S) ↑	BILLED/ PAID ↑	CLAIM STATUS ↑
0	CMS-1500	K	07/24/2017 - 07/24/2017	\$65.00 / \$41.38	👍
31	CMS-1500	JE	07/24/2017 - 07/24/2017	\$171.00 / \$106.34	👍
36	CMS-1500	E	07/24/2017 - 07/24/2017	\$253.00 / \$101.04	👍
1	CMS-1500	EI	07/24/2017 - 07/24/2017	\$2,783.00 / \$118.86	👍
2	CMS-1500	E	07/24/2017 - 07/24/2017	\$2,783.00 / \$0.00	👎

Paid is a green thumbs up,
Denied is a 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's a navigation bar with icons for Eligibility, Patients, Authorizations, Claims, Messaging (with 88 notifications), and Help. Below this is a header section with 'Viewing Claims For:' followed by a dropdown menu set to '3', a 'Medicaid' dropdown, and a 'GO' button. To the right are 'Upload EDI' and 'Create Claim' buttons.

The main section is titled 'Claims' and has several tabs: 'Individual', 'Saved' (highlighted with a red box), 'Submitted' (with a red badge showing '11'), 'Batch', 'Payment History', 'My Downloads', and 'Claims Audit Tool'.

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

There are three sub-tabs: 'Drafts', 'Professional Ready to be Submitted', and 'Institutional Ready to be Submitted'. The 'Drafts' tab is active, showing a table of claims.

DATE CREATED ↑	CLAIM TYPE ↑	CLAIM ID ↑	MEMBER NAME ↑	MEMBER ID ↑	ORIGINAL CLAIM # ↑	TOTAL CHARGES ↑		
08/10/2017	Institutional	8100	R...	109	Q...3	\$54,159.07	Edit	Delete
08/07/2017	Institutional	8105	P...	109	Q...1	\$461.75	Edit	Delete
08/02/2017	CMS-1500	8100	A...	109	Q...34	\$292.00	Edit	Delete
08/01/2017	Institutional	8107	J...	109	Q...6	\$461.75	Edit	Delete
08/01/2017	Institutional	8101	F...	109	Q...1	\$461.75	Edit	Delete
07/17/2017	Institutional	8103	...	109		\$507.00	Edit	Delete

Correcting Claims

 After clicking on a **Claim #** link


1. Click **Correct Claim**
2. Proceed through the claims screens correcting the information that you may have omitted when the claim was originally submitted.
3. Continue clicking **Next** to move through the screens required to resubmit.
4. Review the claim information
5. Click **Submit**.

[Back to Claims](#)
[Correct Claim](#)
[Copy Claim](#)
Claim No.: Q180INE01235

Ref/Acct No.: P10007521700
 Member ID: 1000000009
 Member Name: [REDACTED]
 Member DOB: 10/01/1980
 Servicing Provider: SHAH, VINEET
 Servicing NPI: 1699868455
 DOS Range: 05/25/2017 - 05/25/2017

Received Date: 06/29/2017
 Billed Amount: \$99.00
 Payment Amount: \$0.00
 Payment Date: 07/10/2017
 Status: DENIED

LINE	DOS	PROC	DX	MODIFIERS	PLACE OF SERVICE	CHARGED	PAYMENT AMOUNT	PAYMENT DATE	CHECK NO.	STATUS	STATUS DESCRIPTION
1	05/25/2017	73110	S62101 A	TC, RT	11	\$99.00	\$0.00	07/10/2017	09004 13973	DENY	DUPLICATE CLAIMS OR MULTIPLE PROVIDERS BILLING SAME/SIMILAR CODE(S)

 Only claims with a status of **PAID** or **DENIED** can be corrected online.

Payment History

View Service Line Details

- The explanation of payment details displays the date and check number
- This view shows each patient payment by service line detail made on the check

Explanation of Payment Details

[Back to Payments List](#)
[Download \(Excel Format\)](#)
[Print](#)

Your request has been received
Go to Claims>My Downloads to retrieve your file or check the status of your download request.

Check/Trace Number:0900428203 Check Date:08/17/2017

Insured Name: E
Patient Name: A
Control Number: 7
Service Provider: IWUAGWU, ANTHONY

Group: T
ID: 1
Account: F
NPI: 1699844886

View Service Line Details

Insured Name: E
Patient Name: A
Control Number: 7
Service Provider: IWUAGWU, ANTHONY


Group: T
ID: 1
Account: F
NPI: 1699844886

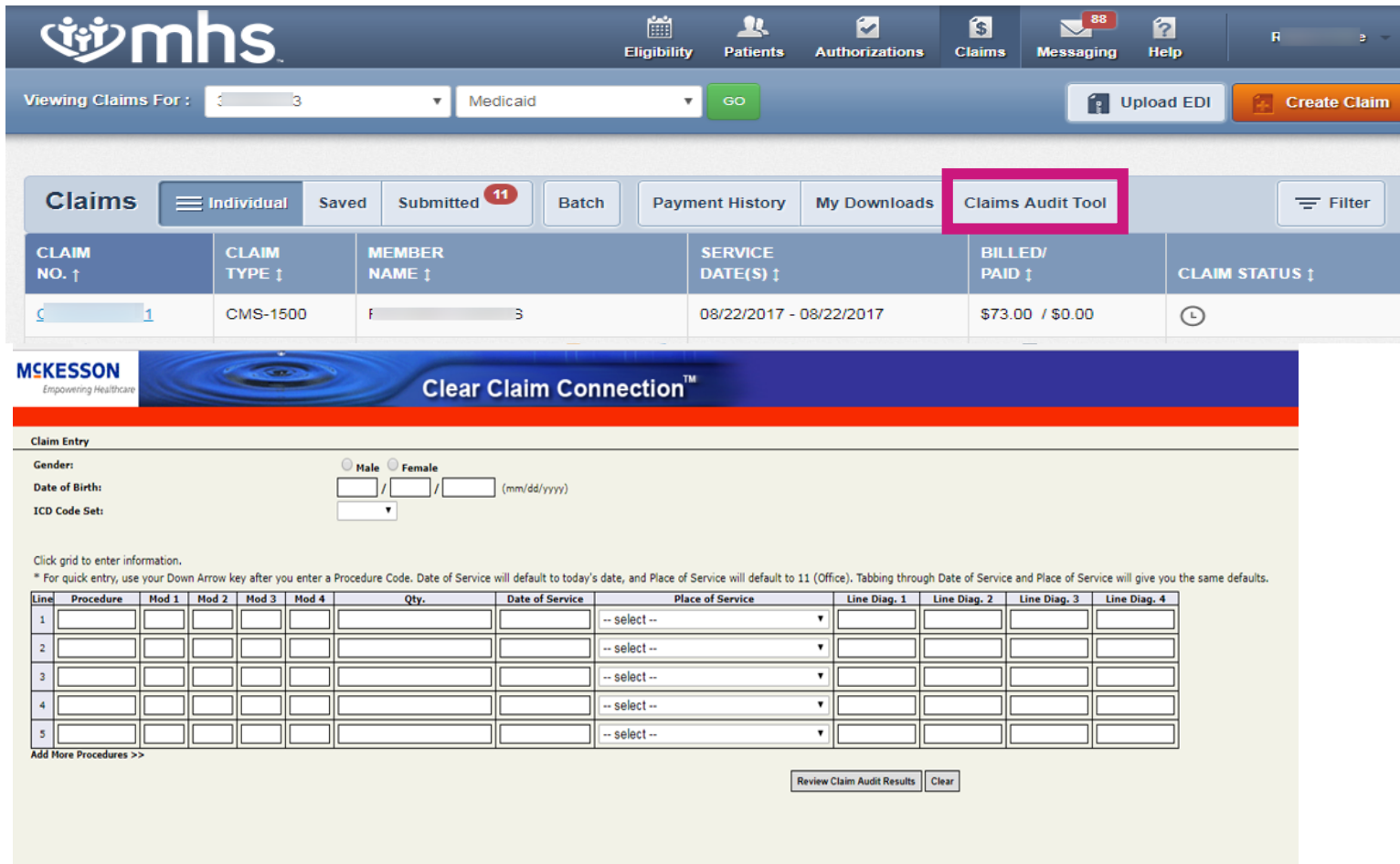
View Service Line Details

Serv	Date	Proc#/ Proc2	Mod	Days/ Cnt Qty	Charged	Allowed	Deduct/ Copay	Coinsur	Discount/ Interest	Med Allow/ Med Paid	TPP	Denied	Remit Codes	Payment
10	06/03/2017	99235		0/1	305.00	160.37	0.00/0.00	0.00	0.00/0.00	0.00/0.00	0.00	0.00	on	160.37
Sub Total:					\$305.00	\$160.37	\$0.00/\$0.00	\$0.00	\$0.00/\$0.00	\$0.00/\$0.00	\$0.00	\$0.00		\$160.37

Remit Code Descriptions
on
REDUCED PAYMENT FOR OUT OF NETWORK PROVIDER

Claims Audit Tool

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



The screenshot shows the MHS Claims Audit Tool interface. At the top, there's a navigation bar with icons for Eligibility, Patients, Authorizations, Claims, Messaging (with 88 notifications), and Help. Below this is a header section with 'Viewing Claims For:' dropdowns set to '3' and 'Medicaid', a 'GO' button, and 'Upload EDI' and 'Create Claim' buttons. The main section has tabs for 'Claims', 'Individual', 'Saved', 'Submitted' (with 11 notifications), 'Batch', 'Payment History', 'My Downloads', and 'Claims Audit Tool' (highlighted with a pink box). Below the tabs is a table with columns: CLAIM NO. ↑, CLAIM TYPE ↑, MEMBER NAME ↑, SERVICE DATE(S) ↑, BILLED/PAID ↑, and CLAIM STATUS ↑. The first row shows claim number 1, CMS-1500 type, member name 3, service dates 08/22/2017 - 08/22/2017, billed/paid \$73.00 / \$0.00, and a clock icon for status. Below the table is a 'Clear Claim Connection' section with a 'Claim Entry' form. The form includes fields for Gender (Male/Female), Date of Birth (mm/dd/yyyy), and ICD Code Set. A note states: '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.' Below the note is a grid with columns: Line, Procedure, Mod 1, Mod 2, Mod 3, Mod 4, Qty., Date of Service, Place of Service, Line Diag. 1, Line Diag. 2, Line Diag. 3, and Line Diag. 4. The grid has 5 rows. At the bottom of the grid is a link 'Add More Procedures >>'. Below the grid are two buttons: 'Review Claim Audit Results' and 'Clear'.

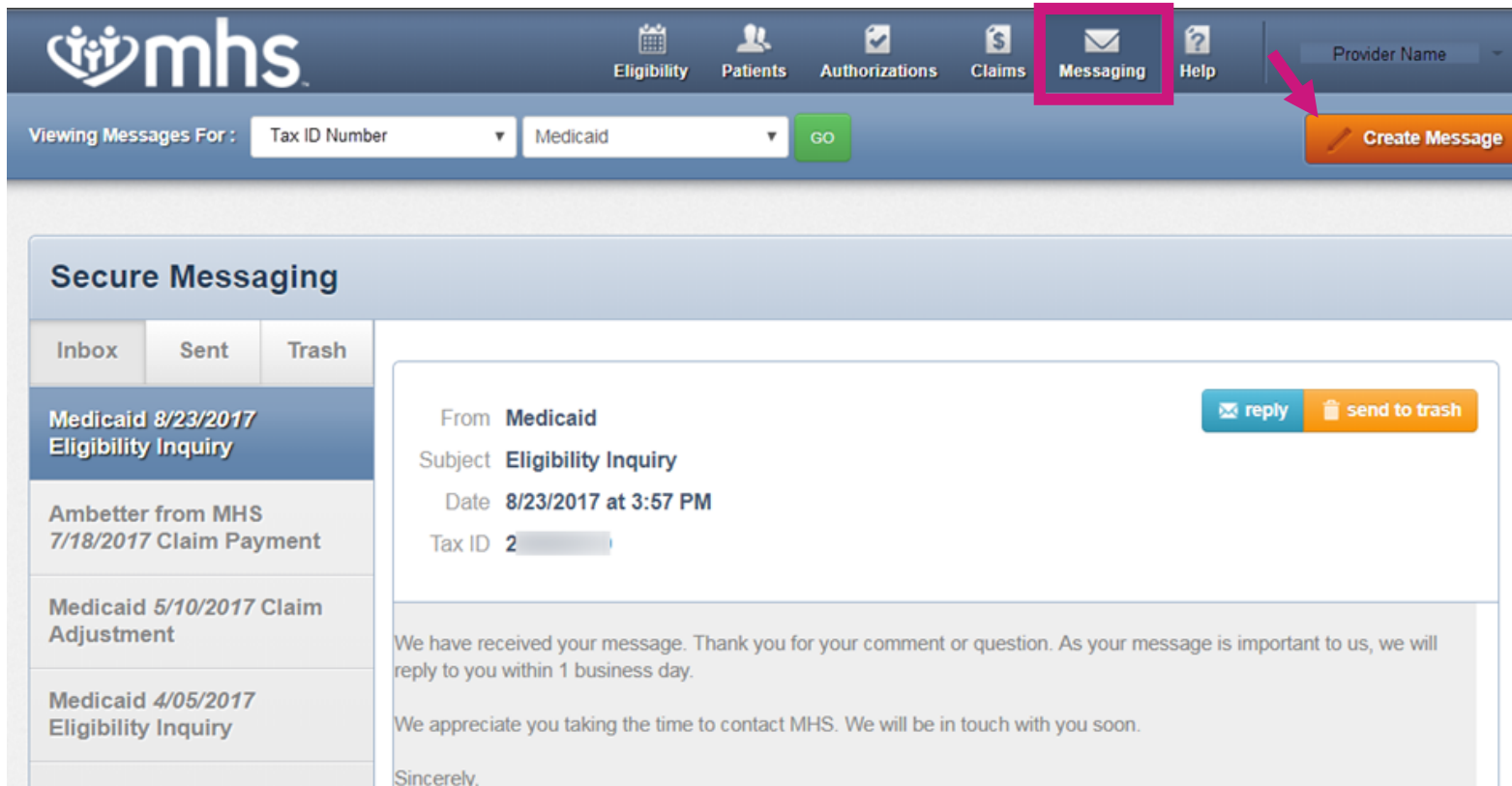
Secure Messaging

Secure Messaging



Create a New Secure Message

- Click **Messaging** tab from the Dashboard.
- Click **Create Message**



mhs

Eligibility Patients Authorizations Claims **Messaging** Help

Provider Name

Viewing Messages For : Tax ID Number Medicaid GO

Create Message

Secure Messaging

Inbox	Sent	Trash
Medicaid 8/23/2017 Eligibility Inquiry		
Ambetter from MHS 7/18/2017 Claim Payment		
Medicaid 5/10/2017 Claim Adjustment		
Medicaid 4/05/2017 Eligibility Inquiry		

From **Medicaid** **reply** **send to trash**

Subject **Eligibility Inquiry**

Date **8/23/2017 at 3:57 PM**

Tax ID **2**

We have received your message. Thank you for your comment or question. As your message is important to us, we will reply to you within 1 business day.

We appreciate you taking the time to contact MHS. We will be in touch with you soon.

Sincerely,

Secure Messaging

Contents of a Secure Message

- Select **Subject** and if applicable **Member ID** and **Date of Birth** along with your message then click **Send**
- A confirmation message appears that your message successfully sent.

New Message

If your message is about a specific member, please include their ID and Date of Birth below.

To	<input type="text" value="Medicaid"/>	Member ID	<input type="text" value="123456789"/>
Subject	<input type="text" value="Select a subject"/>	Date of Birth	<input type="text" value="mm/dd/yyyy"/>

Your Message

MHS Website

Provider Enrollment



Home Find a Provider Portal Login Events Contact Us

Contrast ☐ On ☒ Off a a a language ▾

FOR MEMBERS

FOR PROVIDERS

GET INSURED

FOR PROVIDERS

Login

Enrollment and Updates

Prior Authorization +

Dental Providers

Pharmacy +

Behavioral Health +

Provider Resources +

QI Program +

Provider News

Enrollment and Updates

New Contract

[Request a New Contract](#)

We appreciate your interest in MHS and are excited to set up your office as a participating provider. If you would like more information, please fill out the online information request form. An MHS representative will reach out to you shortly to discuss contracting options for your office.

Existing Contracted Medical Provider

[Enroll Provider](#)

If you are a provider who is part of an existing contracted entity, use this online contracted enrollment form to enroll a new provider. All submissions must include a completed IHCP application.

Existing Contracted Behavioral Health Provider

[Enroll Behavioral Health Provider](#)

If you are a provider who is part of an existing contracted behavioral health entity, use this online contracted enrollment form to enroll a new provider.

Non-Contracted Provider

[Set Up Non-Contracted Provider](#)

If you are not contracted with MHS, complete the non-contracted enrollment form. All submissions must include a completed W9. Set-up may take 45 – 60 days after we receive your submission. You must be enrolled with Indiana Medicaid and have an Indiana Medicaid provider number. You can enroll online at indianamedicaid.com.

Demographic Updates

[Demographic Update Tool](#)

If you are already a contracted provider with MHS and would like to update existing information, please use our online provider update forms.

Provider Enrollment

Existing Contracted Medical Provider

Enroll Provider

If you are a provider who is part of an existing contracted entity, use this online contracted enrollment form to enroll a new provider. All submissions must include a completed IHCP application.

Existing Contracted Behavioral Health Provider

Enroll Behavioral Health Provider

If you are a provider who is part of an existing contracted behavioral health entity, use this online contracted enrollment form to enroll a new provider.



Non-Contracted Provider

Set Up Non-Contracted Provider

If you are not contracted with MHS, complete the non-contracted enrollment form. All submissions must include a completed W9. Set-up may take 45 – 60 days after we receive your submission. You must be enrolled with Indiana Medicaid and have an Indiana Medicaid provider number. You can enroll online at indianamedicaid.com.

Provider Enrollment

When referring patients to the hospital, do you utilize hospitalists?

☐ Yes

☐ No

Group NPI

Group Medicaid Number *

Alpha Suffix

TIN *

Please attach a copy of your completed IHCP enrollment form. Required for Medicaid (HIP, HHW or HCC).

No file chosen

If a midlevel practitioner, please attach a copy of your collaboration agreement.

No file chosen

Comments

Provider Enrollment

Enrollment Requested By:

*First Name **

*Last Name **

*Date **

*Contact Email **

*Contact Phone **



Submit

MHS Behavioral Health Provider Enrollment

*Please attach a copy of your completed IHCP enrollment form. **

Choose File No file chosen

*Please attach a copy of your Health Service Provider of Psychology (HSPP) Attestation. **

Choose File No file chosen

*Please attach a copy of your Behavioral Health Specialty Profile. **

Choose File No file chosen

Demographic Updates







Provider Demographic Updates

Provider Resources

MHS provides the tools and support you need to deliver the best quality of care. Please view the listing on the left, or below, that covers forms, guidelines, helpful links, and training.

- [Demographic Update Tool](#)
- [Guides and Manuals](#)
- [Electronic Transactions](#)
- [Preferred Drug Lists](#)
- [Provider Education](#)
- [Newsletters](#)
- [Helpful Links](#)



-  Providers can utilize the Demographic Update Tool to update below information.
-  Address Changes
-  Demographic Changes
-  Update Member Assignment Limitations
-  Term an Existing Provider
-  Make a Change to an IRS Number or NPI Number

Provider Demographic Updates

Demographic Update Tool

MHS is committed to providing our providers with the best tools possible to support their administrative needs. We have created an easy way for you to request updates to your information and ensure we receive what we need to complete your request in a timely manner.

Need to review your existing information or have a question? If you are a contracted provider you can visit our [Provider Directory](#) to review your information. Please note that hospital-based and midlevel providers will not show in the directory. If you are a non-contracted provider, please call Provider Services at 1-877-647-4848. Our [Contact Us](#) page is always available for general questions as well.

Ambetter only provider? Visit our [Ambetter website](#).

What would you like to do?

MAKE AN ADDRESS CHANGE? 

MAKE A DEMOGRAPHIC CHANGE? 

UPDATE MEMBER ASSIGNMENT LIMITATIONS? 

TERM AN EXISTING PROVIDER? 

MAKE A CHANGE TO AN IRS NUMBER OR NPI NUMBER? 

Behavioral Health

Behavioral Health Claim Process



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 submission through the MHS Secure Provider Portal

- Verify Member Eligibility
- Submit and manage both Professional and Facility claims, including 937 batch files
- To create an account, go to: **provider.mhsindiana.com**



Paper Claims





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



Claim Inquiries




- Check status online
- Call Provider Services at 1-877-647-4848

Behavioral Health Claim Process



-  MHS contracted providers have 90 calendar days from date of service to file a claim
-  Non-contracted providers have 365 calendar days from date of service to file a claim
-  Cenpatco Secure Provider Portal – check claim status or file corrected claims
-  EDI transactions accepted through the following vendors:

Trading Partner	Payor ID	Contact Number
Emdeon	68068	(800) 845-6592
Capario	68068	(800) 792-5256, x812
Availity	68068	(800) 282-4548

Behavioral Health Dispute Resolution

-  Must be made in writing by using the MHS Behavioral Health Informal Claim Dispute or objection form, available at mhsindiana.com/provider-forms.
-  Submit all documentation supporting your objection.
-  Send to MHS within **67 calendar days** of receipt of the MHS on Explanation of Payment (EOP). *Please reference the original claim number.* Requests received after day 67 will not be considered.

**Behavioral Health Services
Attn: Appeals Department
P.O. Box 6000
Farmington, MO 63640-3809**

-  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 67 calendar days from date on EOP to initiate a formal claim appeal.

Behavioral Health Prior Authorization



Prior Authorization





- Please call Care Management for inpatient and partial hospitalization authorizations at 1-877-647-4848. Follow prompts to Behavioral Health.
- Authorization forms may be obtained on our website
 - Outpatient Treatment Request (OTR) Form/Tip-Sheet/Training
 - Intensive Outpatient/Day Treatment Form Mental Health/Chemical Dependency
 - Applied Behavioral Analysis Treatment (OTR)
 - Psychological Testing Authorization Request Form (Outpatient & Inpatient)










Medical Necessity Appeals

- Submit to:
Cenpatco, Attn: Appeals Coordinator
12515-8 Research Blvd., Suite 400
Austin, TX 78707
- Fax to: 1-866-714-7991

Behavioral Health Services Requiring Authorization Facility Services

-  Inpatient Admissions
-  Intensive Outpatient Program (IOP)
-  Partial Hospitalization
-  SUD Residential Treatment

Behavioral Health Services Requiring Authorization Professional Services

-  Psychiatric Diagnostic Evaluation (Limited to 1 per member per 12 month Rolling year without authorization)
-  Electroconvulsive Therapy
-  Psychological Testing (Unless for Autism: then no auth is required)
-  Developmental Testing, with interpretation and report (non-Early Periodic Screening, Diagnosis Treatment (EPSDT))
-  Neurobehavioral status exam, with interpretation and report
-  Neuropsych Testing per hour (face to face) (Unless for Autism: then no auth is required). (Non-Participating Providers only)
-  Applied Behavioral Analysis (ABA) Services

Claim Submission

Claim Submission



EDI Submission

- Preferred method of claims submission
- Faster and less expensive than paper submission
- MHS Electronic Payor ID 68089



Online through the MHS Secure Provider Portal at

mhsindiana.com

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



Paper Claims

Managed Health Services

PO Box 3002

Farmington, MO 63640-3802

Claim Submission

 **Claims must be received within 90 calendar days of the date of service**

 ***Exceptions (rejections do not substantiate filing limit requirements)***

- 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 RID #
- TPL – Claims with primary insurance must be received within 365 days of the date of service with a copy of the primary EOB. If primary EOB is received after the 365 days, providers have 60 days from date of primary EOB 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 patients primary

Dispute Resolution/Appeals



Must be made in writing by using the MHS informal claim dispute/objection form, available at mhsindiana.com/provider-forms.



Submit all documentation supporting your objection.



Send to MHS within **67 calendar days** of receipt of the MHS EOP. *Please reference the original claim number.* Requests received after day 67 will not be considered.

Managed Health Services
Attn: Appeals
P.O. Box 3000
Farmington, MO 63640-3800



MHS will acknowledge your appeal within 5 business days.






Provider will receive notice of determination within 45 calendar days of the receipt of the appeal.

A call to MHS Provider Services does not reserve appeal rights

Dispute Resolution/Appeals


Level One Appeal

-  Must be made in writing by using the MHS informal claim dispute/objection form.
-  Submit all documentation supporting your objection.
-  Send to MHS within **67 calendar days** of receipt of the MHS EOP.



A call to MHS Provider Services does not reserve appeal rights

Dispute Resolution/Appeals

Level Two Appeal (Administrative)

-  Submit the informal claims dispute or objection form with all supporting documentation to the MHS appeals address:

Managed Health Services
Attn: Appeals
P.O. Box 3000
Farmington, MO 63640-3800

-  MHS will acknowledge your appeal within 5 business days.
-  Provider will receive notice of determination within 45 calendar days of the receipt of the appeal.

Engolve Dental

Engolve Dental






All dental paper claims should be billed to:
Engolve Dental Claims: IN
P.O. Box 20847
Tampa FL 33622-0847

For questions please contact:

 Engolve Dental Provider Services at
1-855-609-5157

 **Candy Ervin**, Engolve Dental Indiana
Provider Relations Specialist Market
Manager, at
Candace.Ervin@engagehealth.com

Engolve Dental

-  **Engolve Dental clearinghouse payer ID – 46278**
-  **Web address:** envolvedental.com
-  **Provider Web Portal Address:** <https://pwp.envolvedental.com>
-  **Contracting Paperless** - Go to our secure website at <https://providers.envolvedental.com>
-  **Credentialing Paperless –**
dentalcredentialing@envolvehealth.com
 - Entire process typically is completed within 45 days

Behavioral Health Provider Network Territories

WEST TERRITORY

Mary Schermer

Provider Relations Specialist

1-877-647-4848 ext. 20268

mschermer@mhsindiana.com

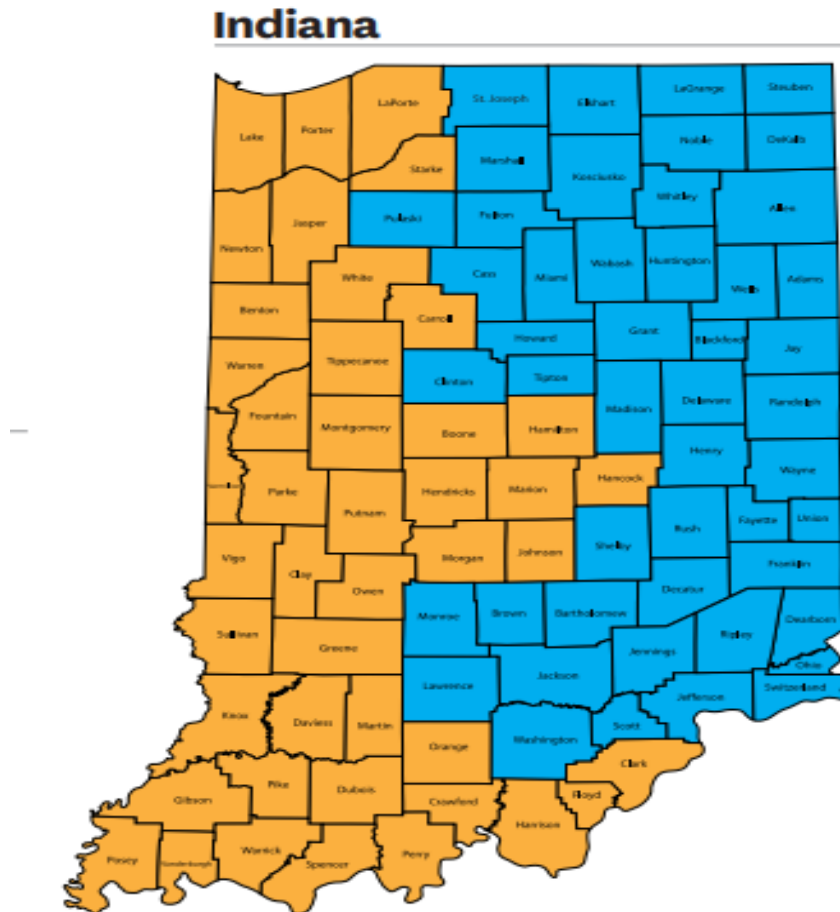
EAST TERRITORY

LaKisha Browder, MBA

Provider Relations Specialist

1-877-647-4848 ext. 20224

lbrowder@mhsindiana.com



MHS Provider Relations Team

Candace Ervin	Involve Dental Indiana Provider Relations	1-877-647-4848 ext. 20187	Candace.Ervin@envolvehealth.com
Chad Pratt	Provider Relations Specialist – Northeast Region	1-877-647-4848 ext. 20454	ripratt@mhsindiana.com
Tawanna Danzie	Provider Relations Specialist – Northwest Region	1-877-647-4848 ext. 20022	tdanzie@mhsindiana.com
Jennifer Garner	Provider Relations Specialist – Southeast Region	1-877-647-4848 ext. 20149	jgarner@mhsindiana.com
Taneya Wagaman	Provider Relations Specialist – Central Region	1-877-647-4848 ext. 20202	twagaman@mhsindiana.com
Katherine Gibson	Provider Relations Specialist – North Central Region	1-877-647-4848 ext. 20959	kagibson@mhsindiana.com
Esther Cervantes	Provider Relations Specialist – South West Region	1-877-647-4848 ext. 20947	Estherling.A.PimentelCervantes@mhsindiana.com
LaKisha Browder	Behavioral Health Provider Relations Specialist - East Region	1-877-647-4848 ext. 20224	lakisha.j.browder@mhsindiana.com

Review

 We hope you learned more about the following topics:

- What **products** are offered by MHS
- Additional details regarding the **Pay for Performance** quality program
- Additional details regarding the MHS **PA process and timelines**
- **MHS portal** functionality
- Online **provider enrollment** and **demographic change** applications
- **Behavioral Health** claims submission and appeals
- MHS Medical **claims submission and appeals**
- **Engage Dental**
- **MHS contacts**

Questions?

Thank you for being our partner in care.