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
- Envolve Dental
- Summary
- Questions

Who is MHS?

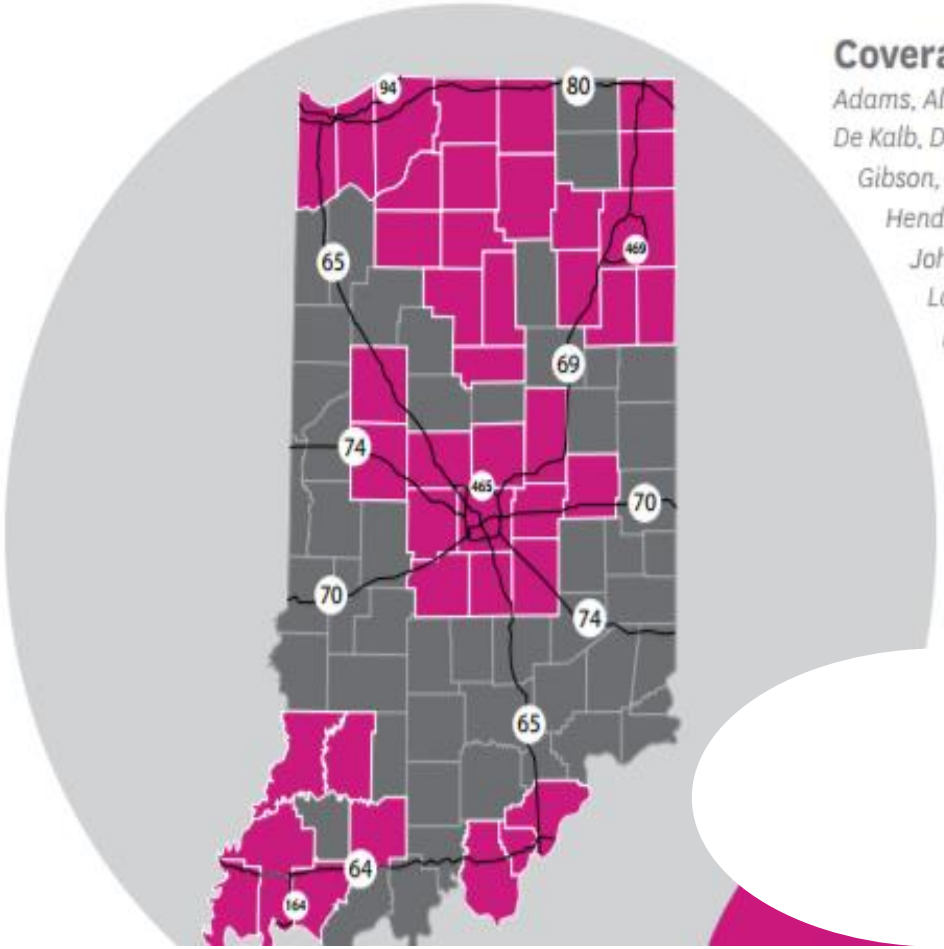
- **Managed Health Services** (MHS) is a managed care entity that has been proudly serving the state of Indiana for more than twenty years through the Hoosier Healthwise and Hoosier Care Connect Medicaid programs; and the Healthy Indiana Plan (HIP) Medicaid alternative program.

- 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 75th 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 75th 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 75th 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 75th 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 75th 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 75th 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.			
	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 session 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 Adolescent or Adult Health Maintenance Form for well-visits			
	P4P Scoring Key for Provider Outreach • 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 75th 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 75th 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 75th 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 75th 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 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 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.
	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 session 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
	P4P Scoring Key for Provider Outreach • 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

- **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 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

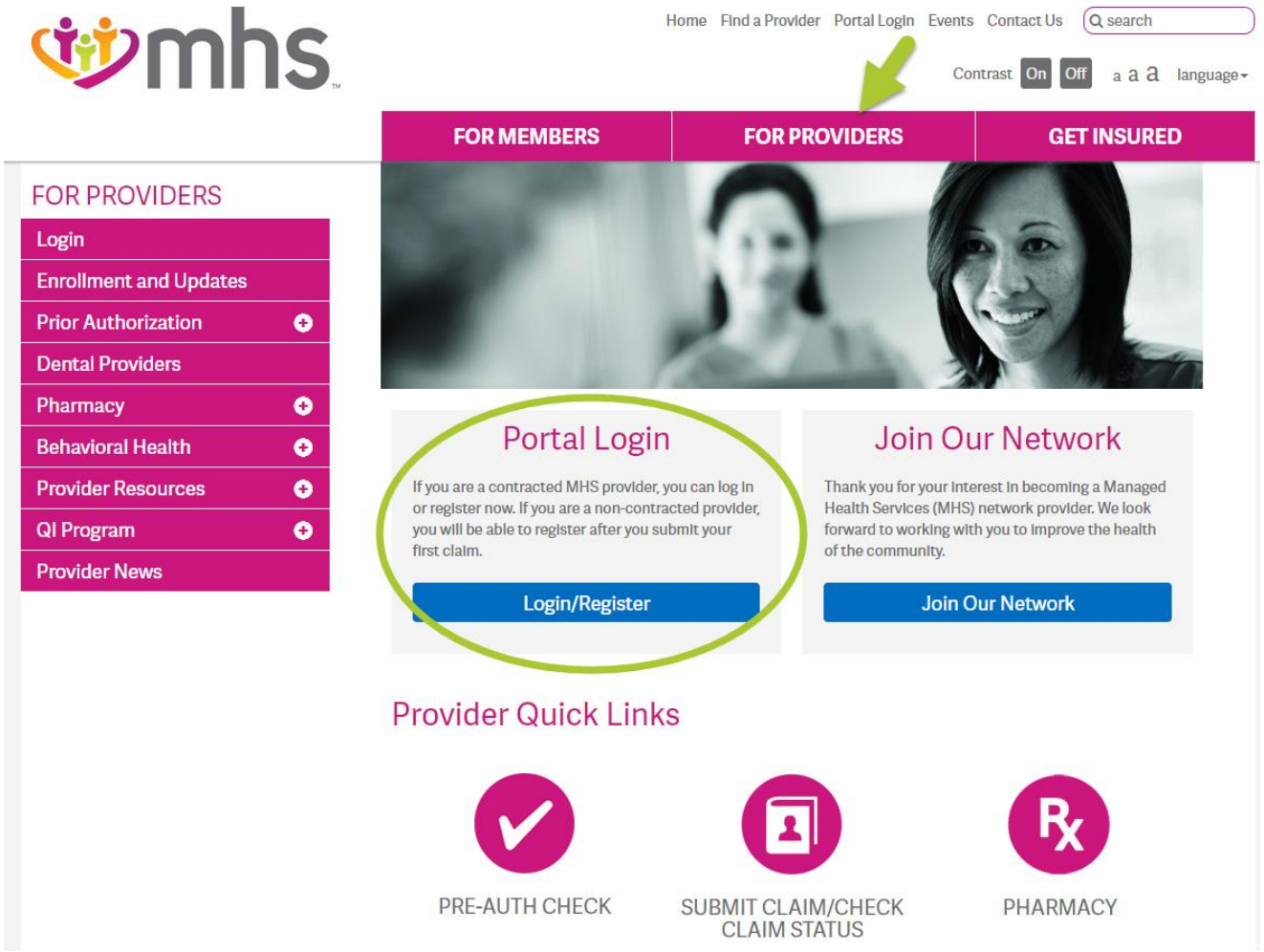
P4P Scorecards

- 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

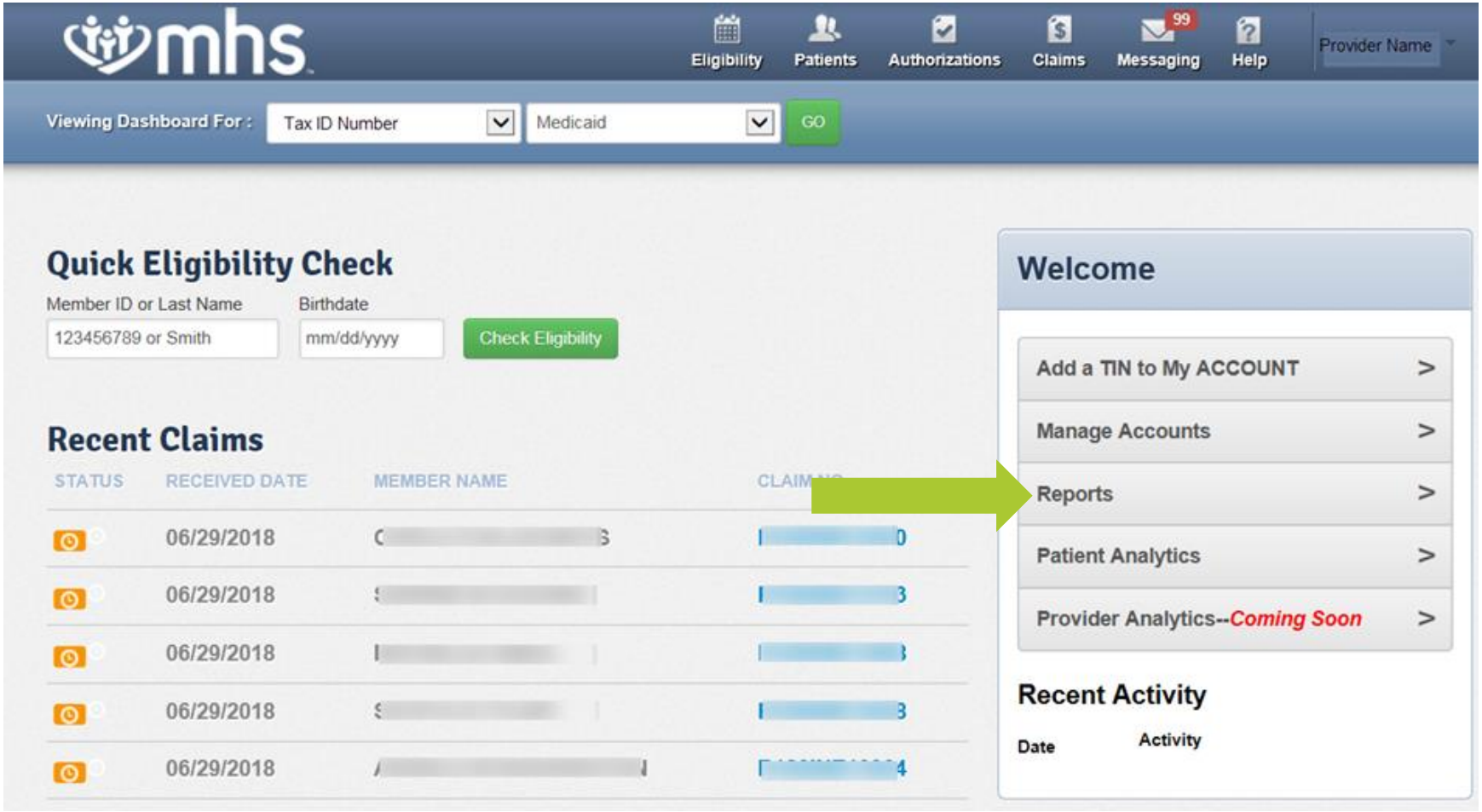
* Send email to P4P@mhsindiana.com to sign up to receive email alerts when documents are posted!

MHS Secure Portal

Click **For Providers** then **Login/Register**



MHS Secure Portal



Group Scorecard Example

Group name: T[redacted]c

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

Group Performance Metrics

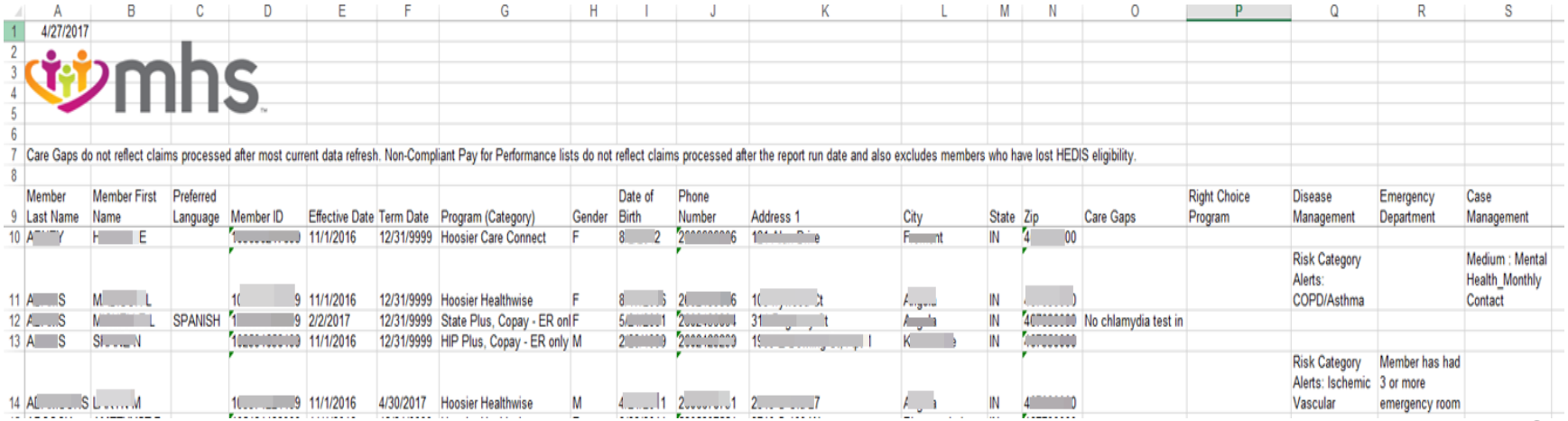
Prod	Measure	Minimun applicable members needed for measurement	Number of applicable Members in your practice	Number of Members who comply with the applicable criteria	Group average percentage of members who comply with the criteria	NCQA 75th percentile of members who comply with the criteria (MHS GOAL)	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

Page 1 of 3

Member Gap List Example

Excel file

- Sortable
- Filterable



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: • 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: • A nephropathy screening test • A positive urine macroalbumin 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, CT 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**

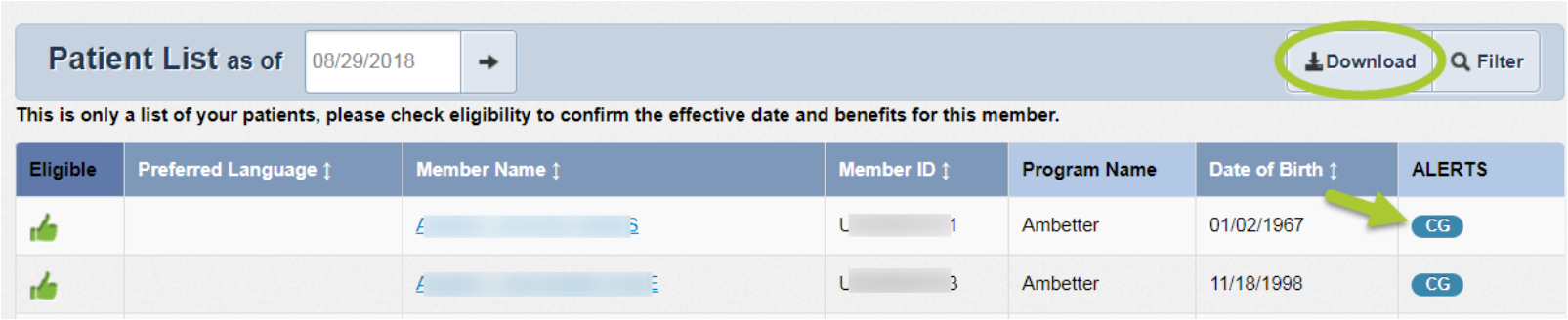
- Visit Ambetter.mhsindiana.com to sign up or log in to the Ambetter from MHS Secure Portal
- Click on the **Patients** Tab located on the homepage

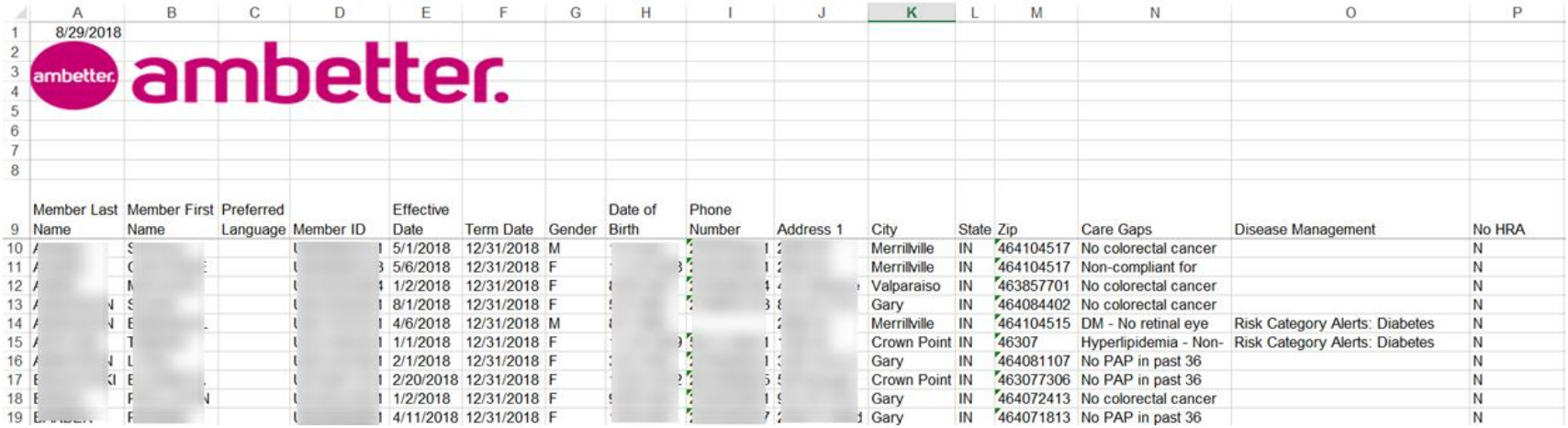
Ambetter P4P Program (cont.)

- **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

Ambetter P4P Program (cont.)

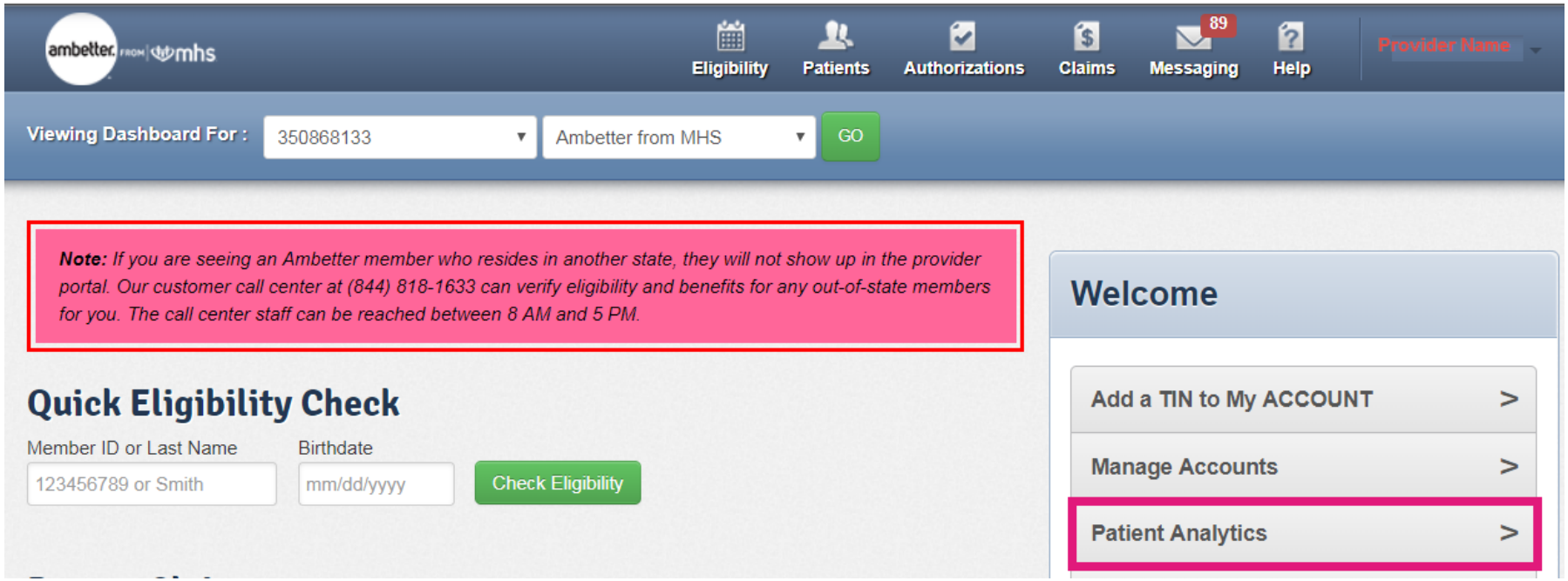
- Click on the "**Download**" button to download the Patient List/Member Roster in Excel format





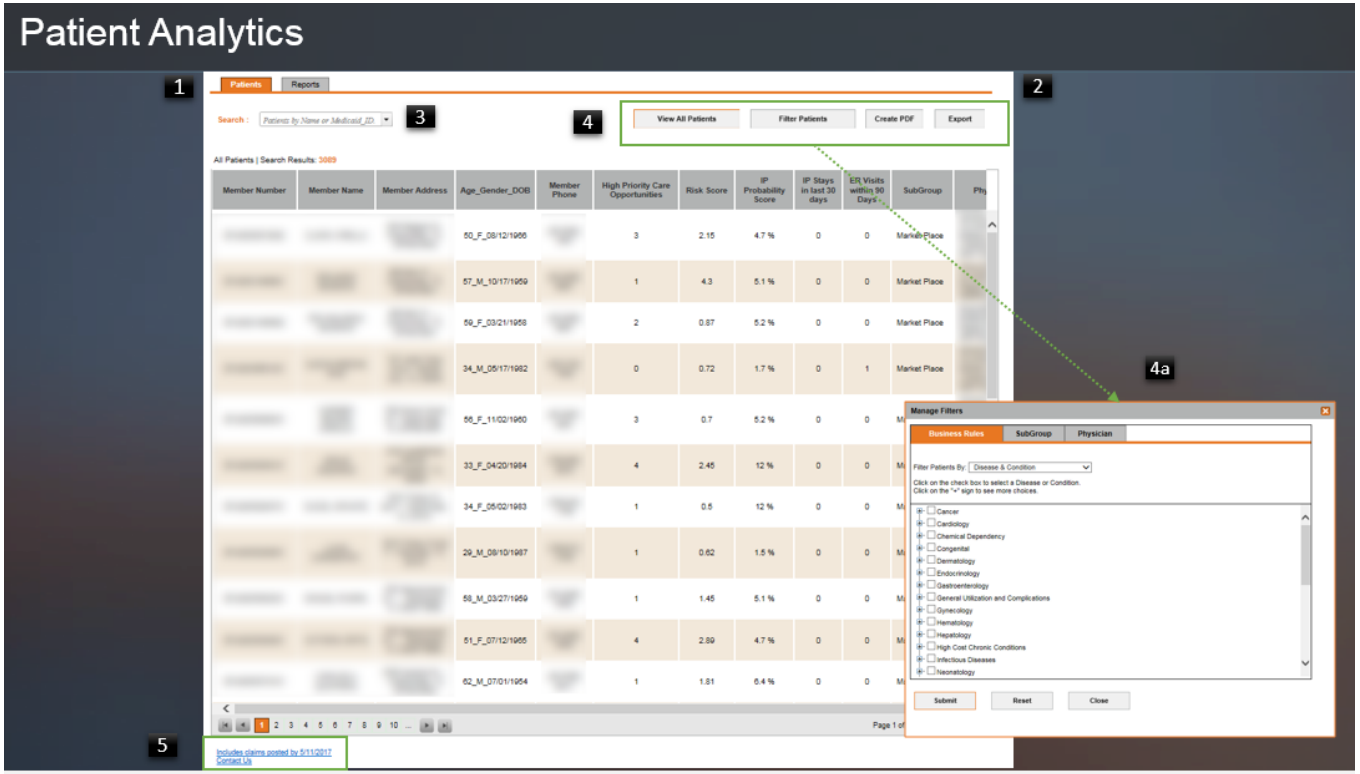
Reports – Patient Analytics

Click on **Patient Analytics** from Homepage



Reports – Patient Analytics

Functionalities of the **Patient Tab**



Patients Tab

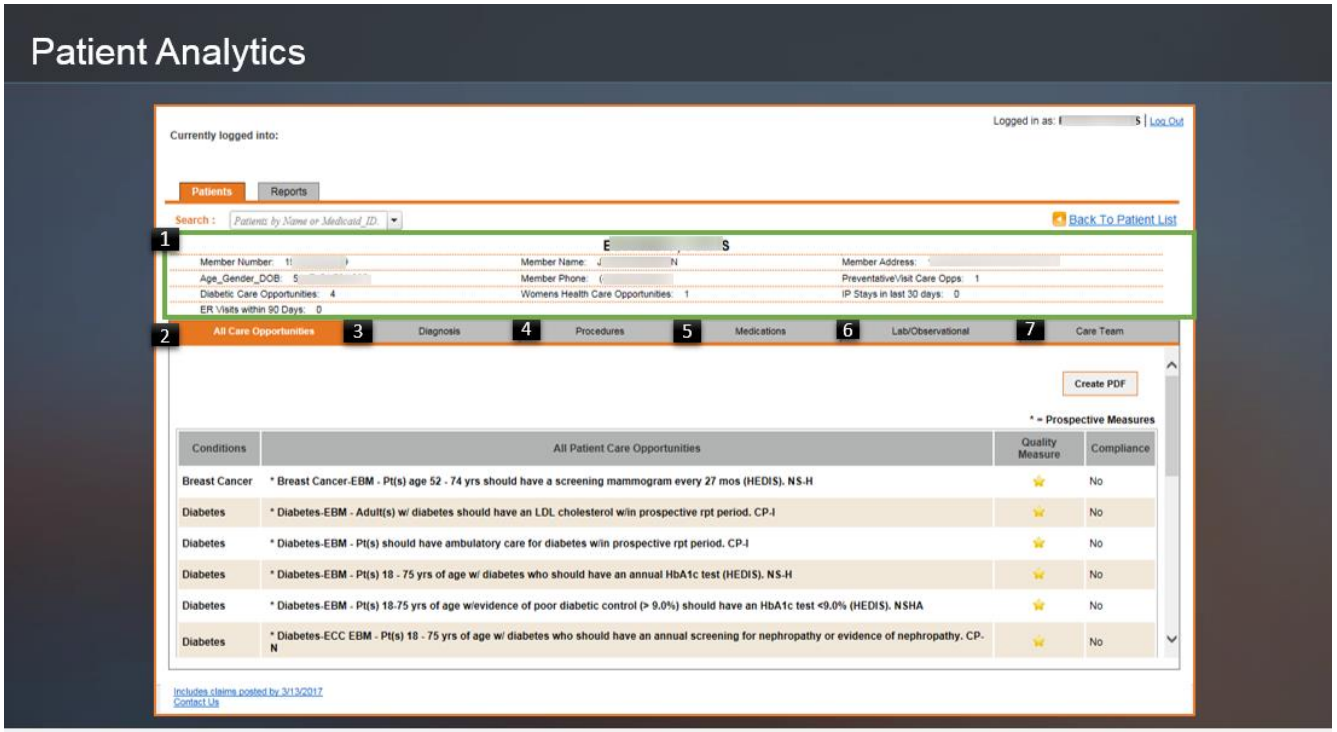
1. **Tabs:** Allows the providers to choose between the Patients information and Reports.
2. **Logout Button:** For security purposes, logout to protect patient information. Not shown, in upper right hand corner.
3. **Search:** Allows providers to search by the patient's name, Medicaid, Medicare or Marketplace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



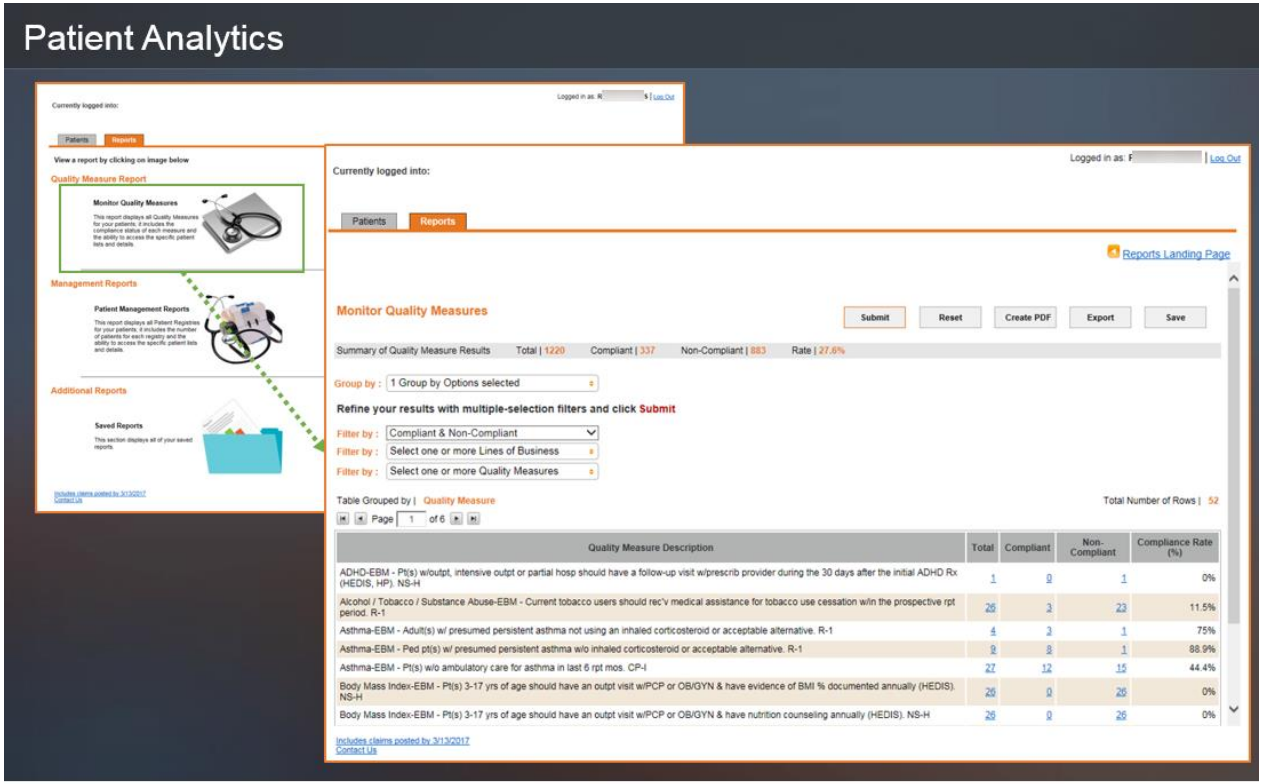
Patient Profile

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



Quality Measure Report:

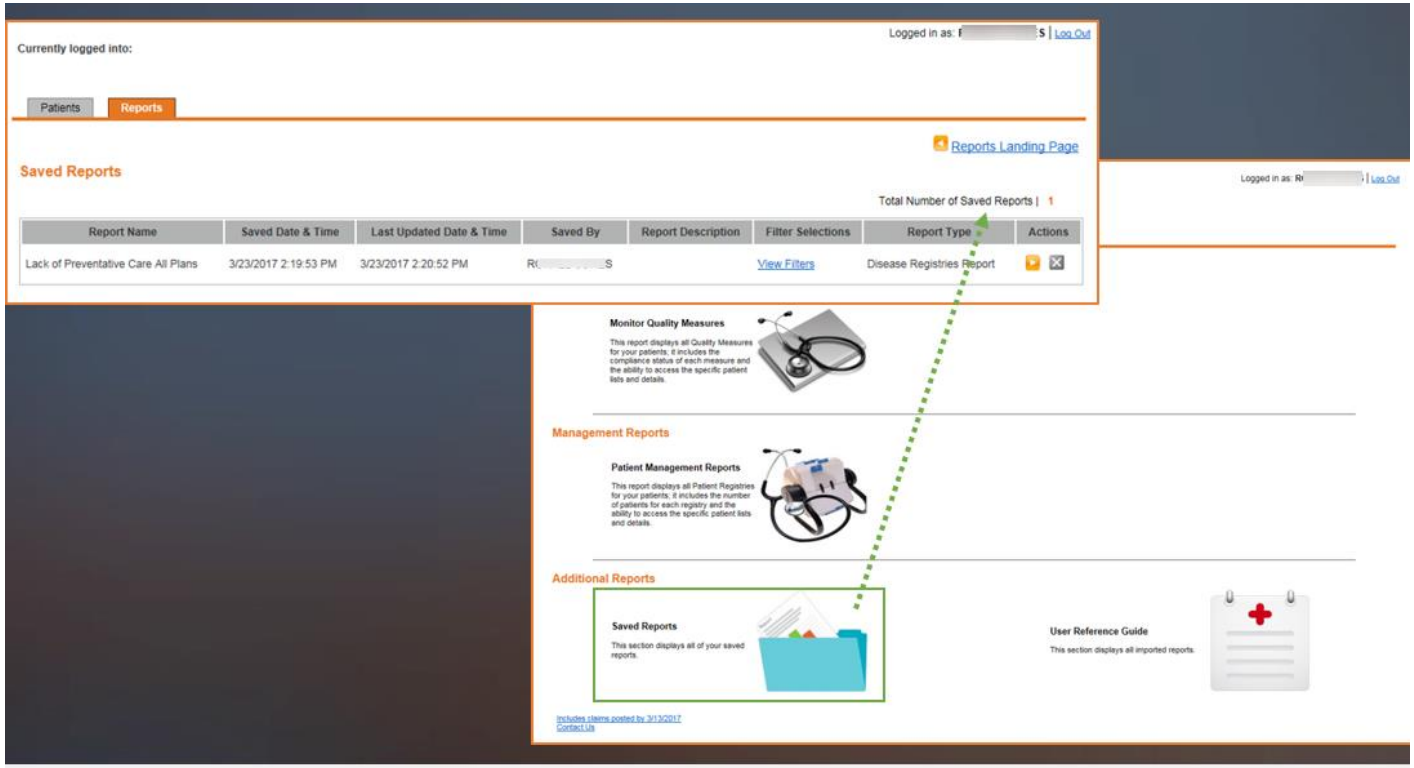
Monitor Quality Measures Report

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

7

Reports – Patient Analytics

- Creating **Saved Reports** for frequent use



Additional Reports

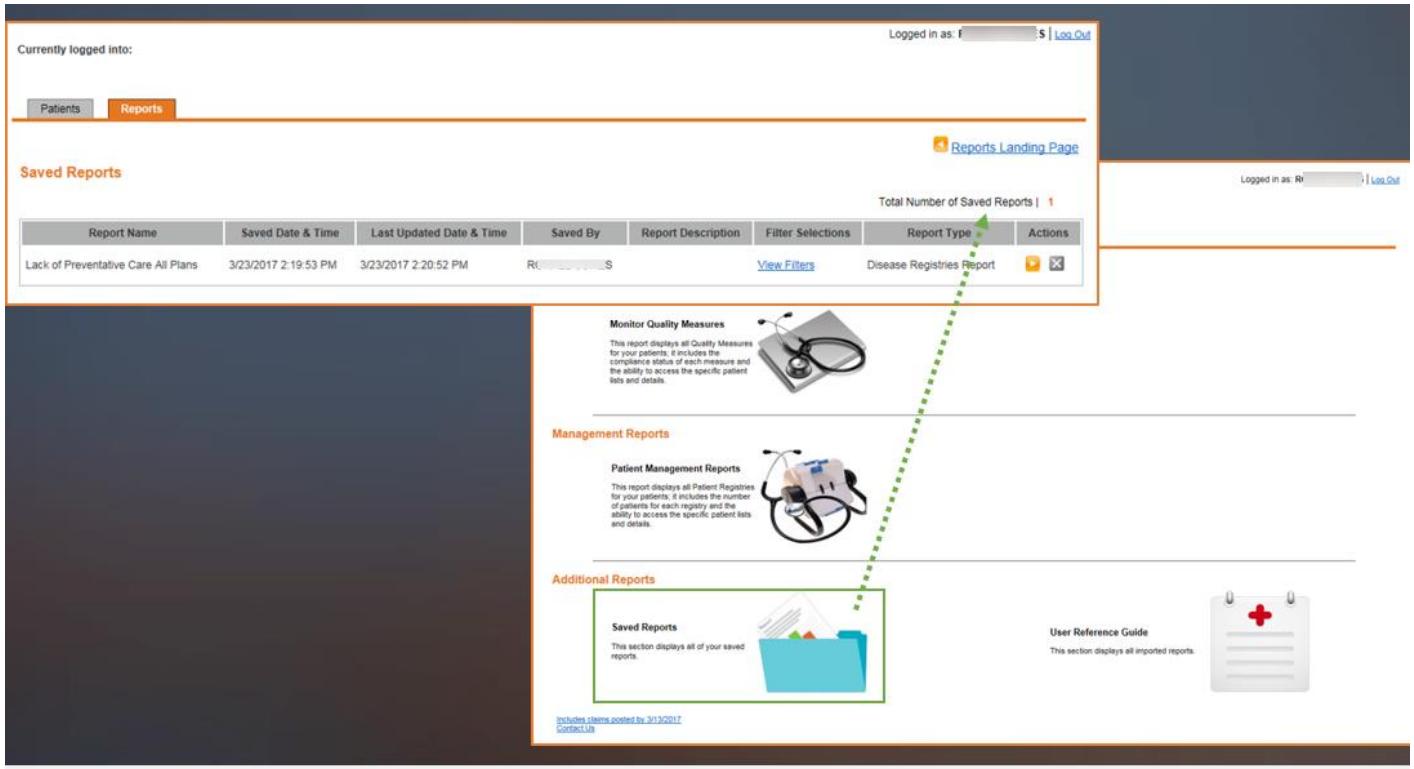
Saved Reports:

- Shows reports saved by current user.

10

Reports – Patient Analytics

Creating **Saved Reports** for frequent use



Additional Reports

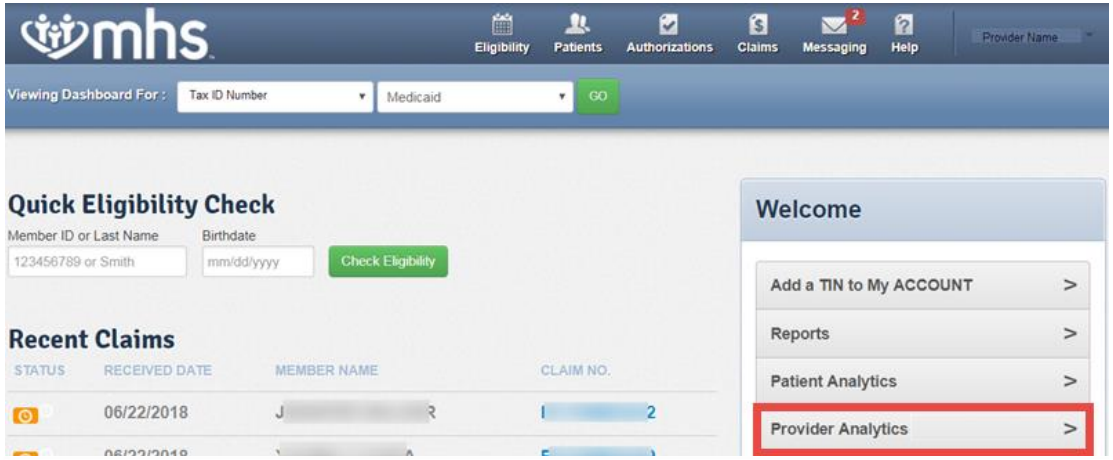
Saved Reports:

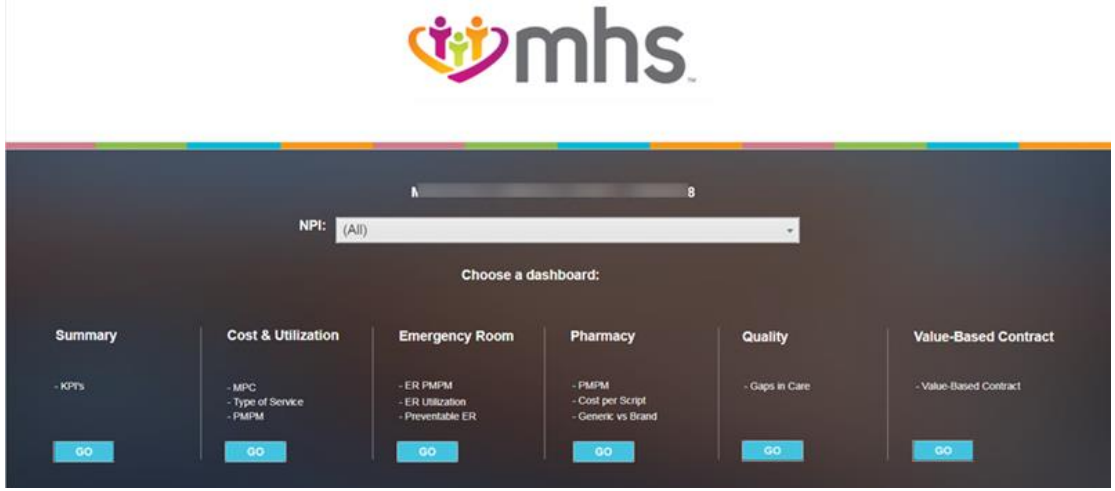
- Shows reports saved by current user.

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.





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

mhs

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.

HHW · HIP · Hoosier CARE CONNECT

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 "KRAMES Health Library" for free print-on-demand patient health fact sheets on over 4,000 topics, available in English and Spanish.
mhsindiana.com/login	MHS' Secure Provider Portal lets you submit prior authorization, 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.

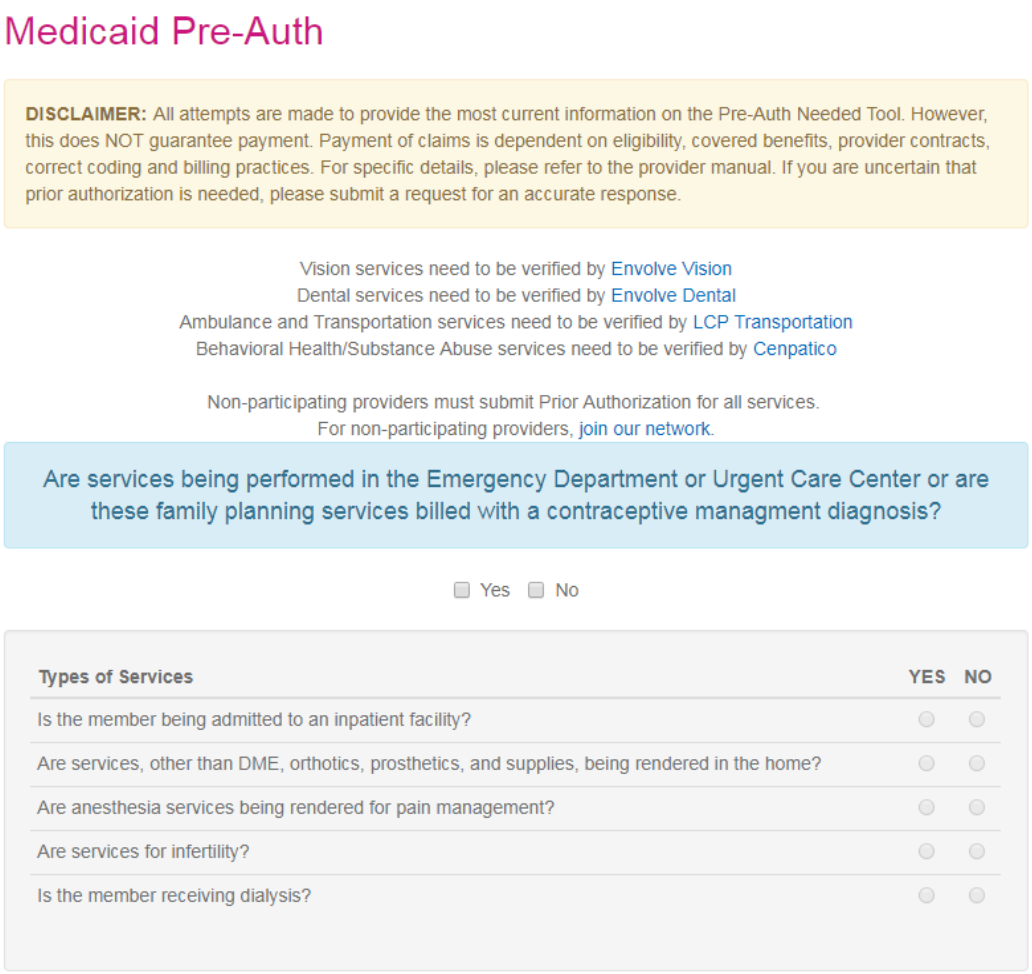
OTHER RESOURCES

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.

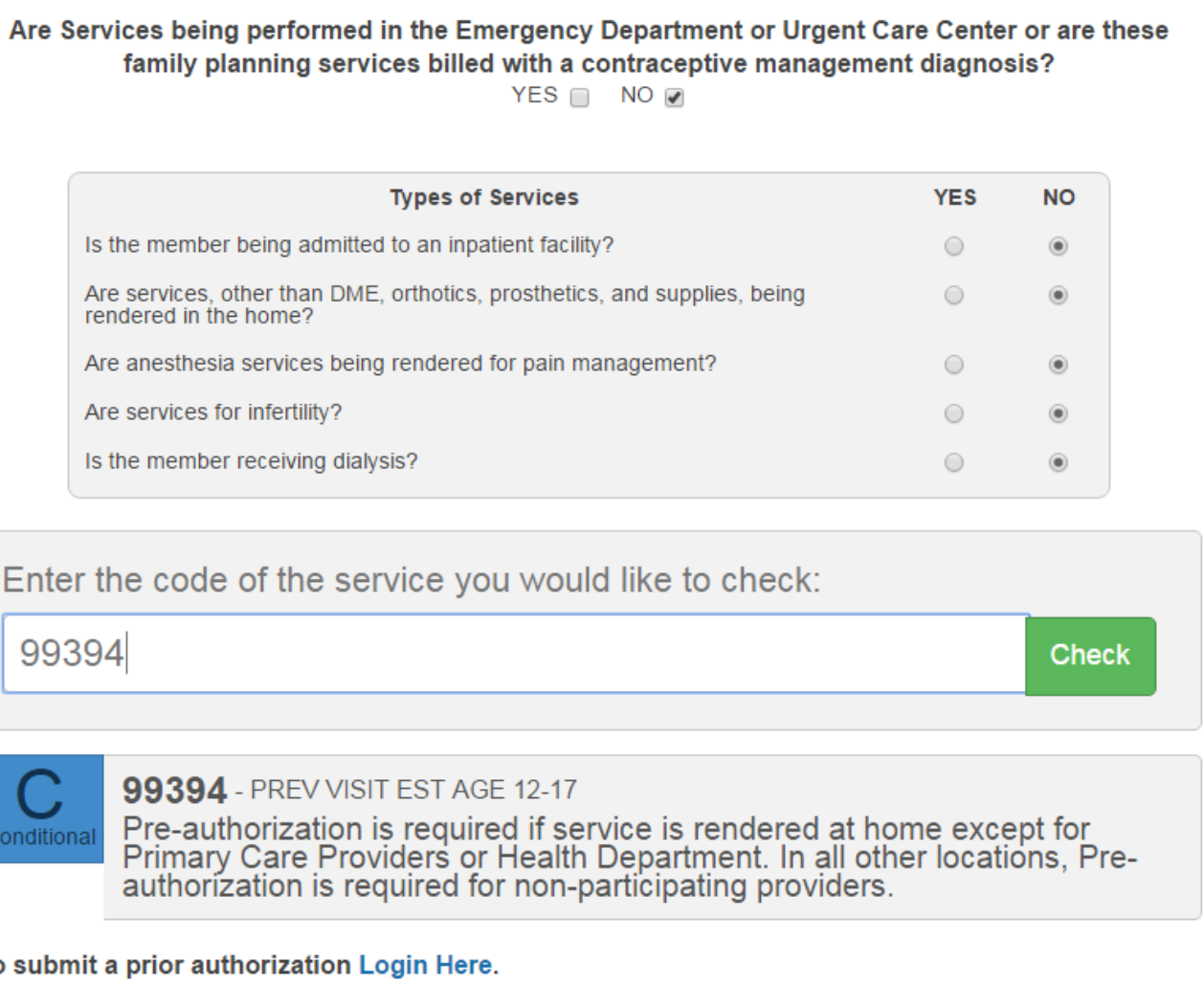
Are services being performed in the Emergency Department or Urgent Care Center or are these family planning services billed with a contraceptive managment diagnosis?

☐ Yes ☐ No

Types of Services	YES	NO
Is the member being admitted to an inpatient facility?	○	○
Are services, other than DME, orthotics, prosthetics, and supplies, being rendered in the home?	○	○
Are anesthesia services being rendered for pain management?	○	○
Are services for infertility?	○	○
Is the member receiving dialysis?	○	○

To submit a prior authorization Login Here.

Prior Authorization



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

Envolve 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.envolvehealth.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	

Please check the requested assignment category below:

☐DME	☐Inpatient	☐Physical Therapy
☐*Purchased*	☐Observation	☐Speech Therapy
☐*Rented*	☐Office Visit	☐Transportation
☐Home Health	☐Occupational Therapy	☐Other
☐Hospice	☐Outpatient	

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

*Diagnosis code(s) **required***

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

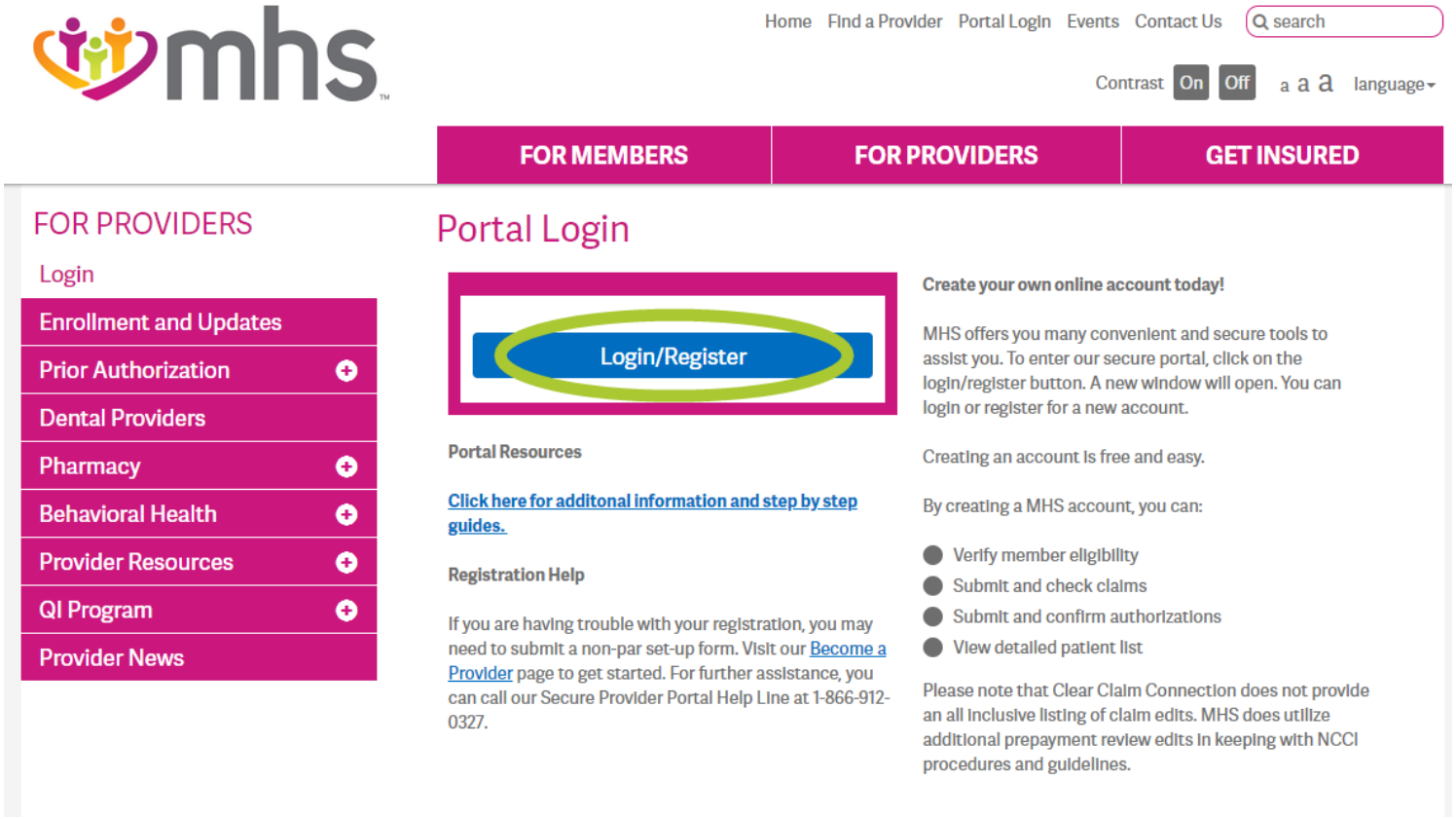
- MHS will honor **pre-existing authorizations** from any other Medicaid program during the first **30 days** of enrollment or up to the expiration date of the previous authorization, whichever occurs first, and upon notification to MHS. Include the approval from the prior MCE with the request.

- Reference: MHS Provider Manual Chapter 6

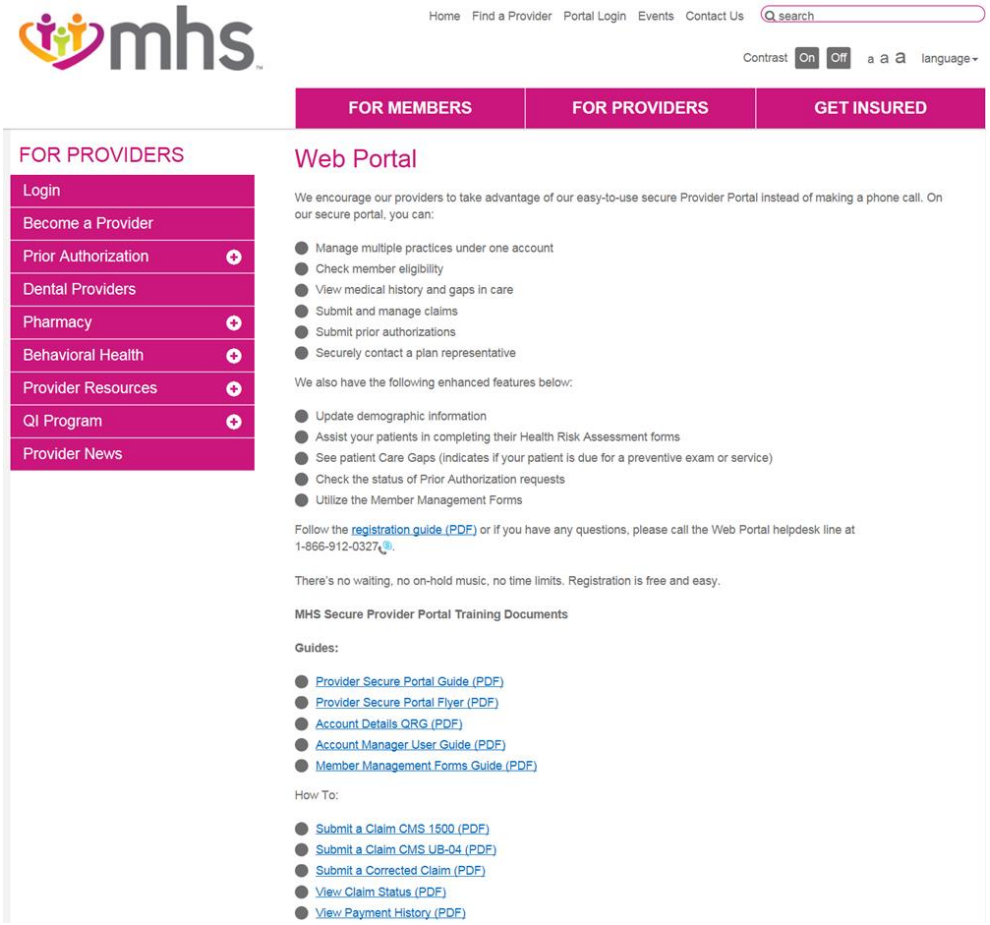
MHS Portal

Secure Web Portal Login or Registration

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



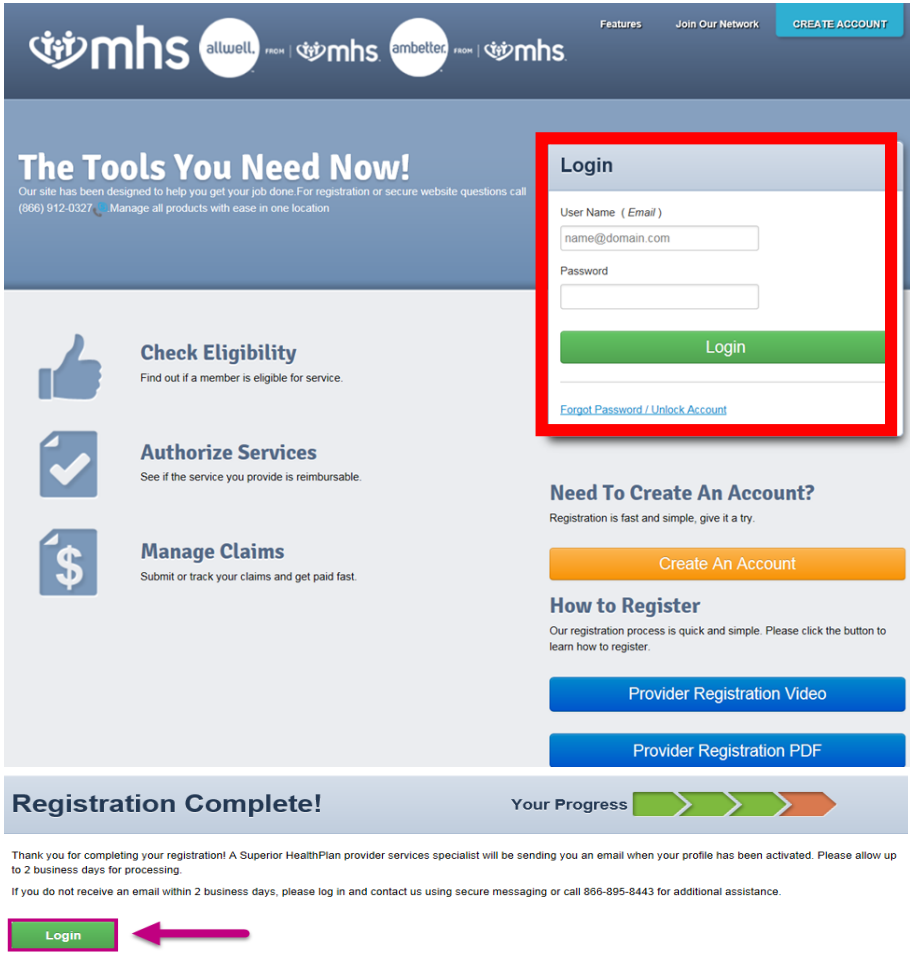
Web Portal Resources



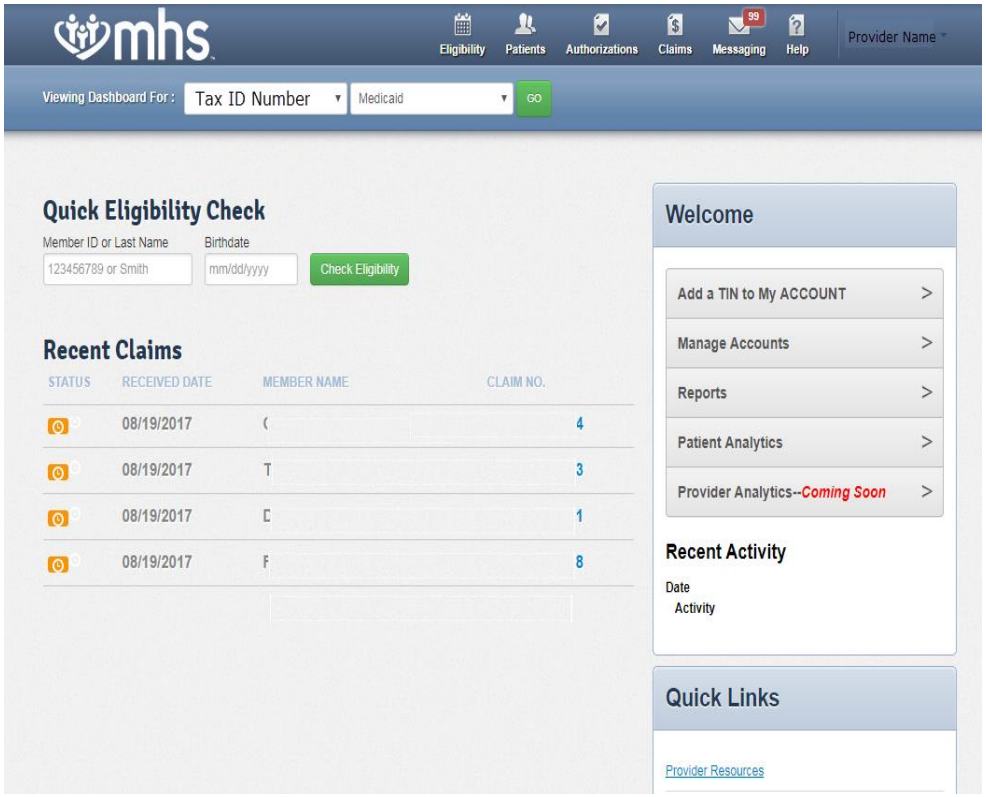
Documents Include:

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

Complete Registration or Login



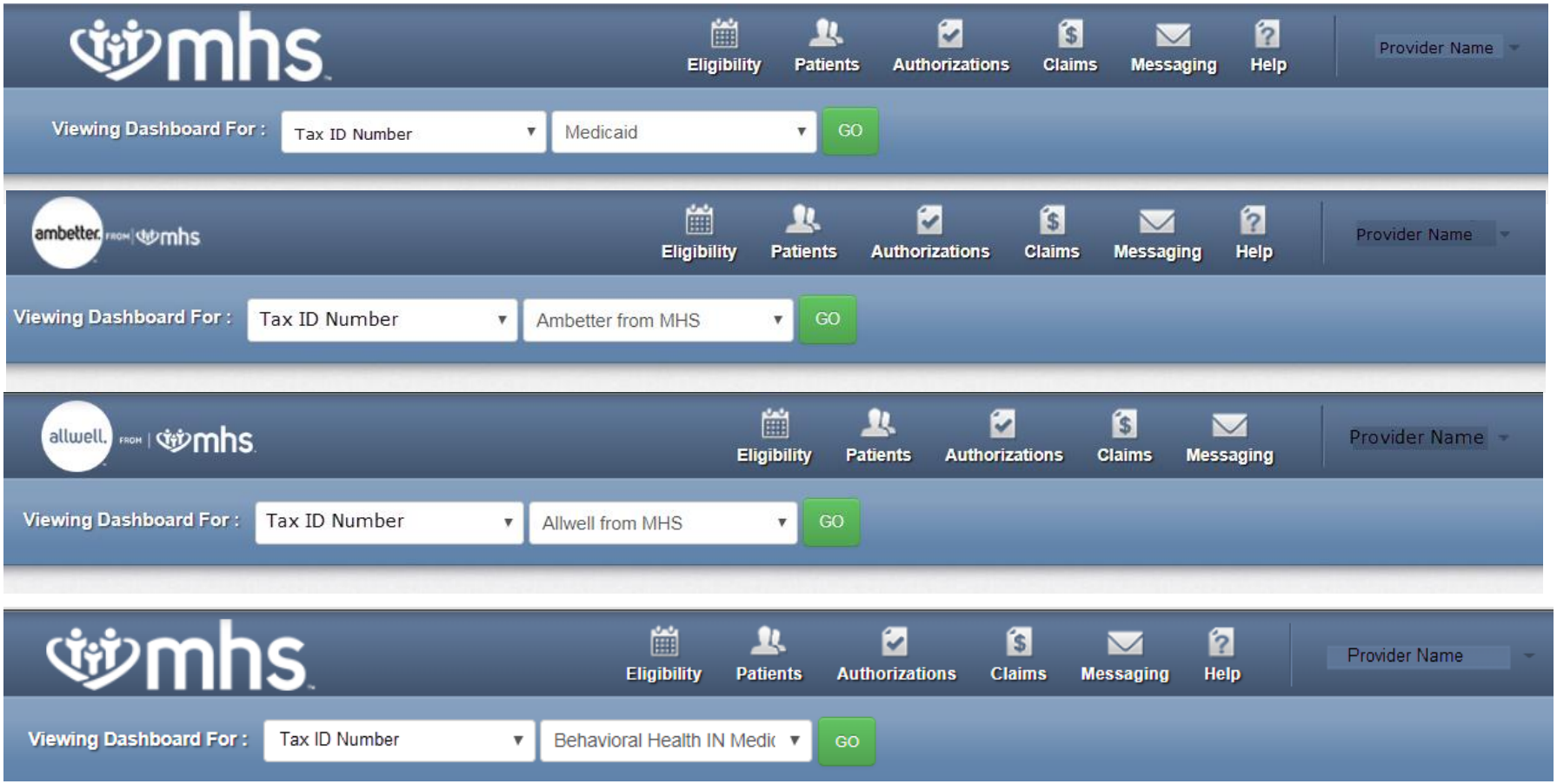
An email will be sent to the provider when they have access to specific tools.



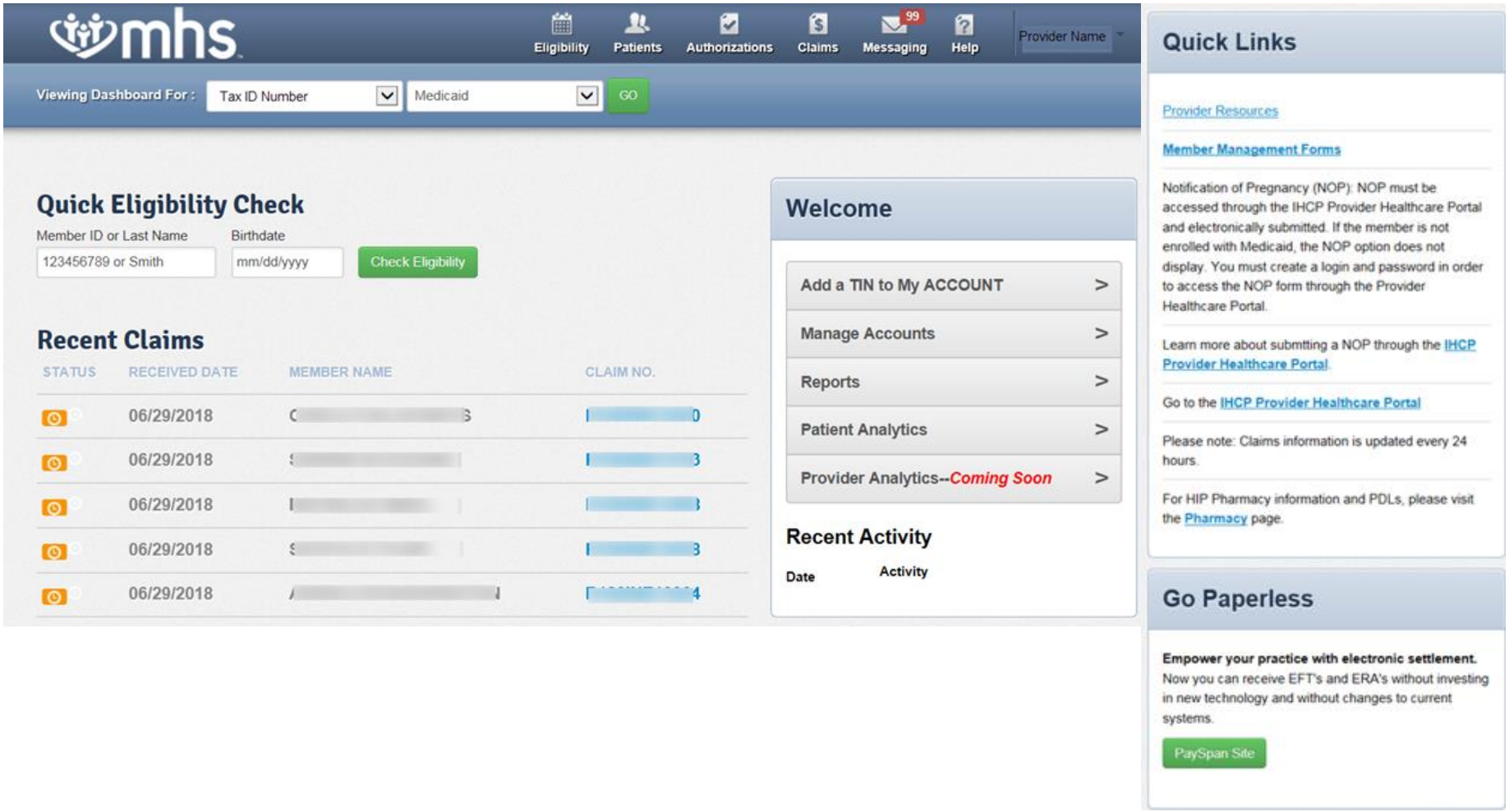
The Registration is complete and the Secure Portal homepage will be visible!

Dashboard Change

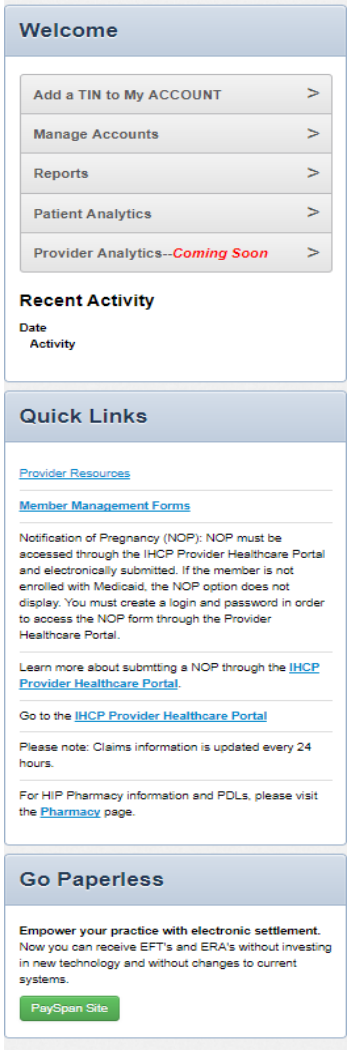
- User has the ability to change between **Tax IDs** added along with choices for: **Medicaid**, **Ambetter from MHS, Allwell from MHS** and **Behavioral Health IN Medicaid**



Homepage –MHS (Medicaid)



MHS Welcome and Quick Links



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**

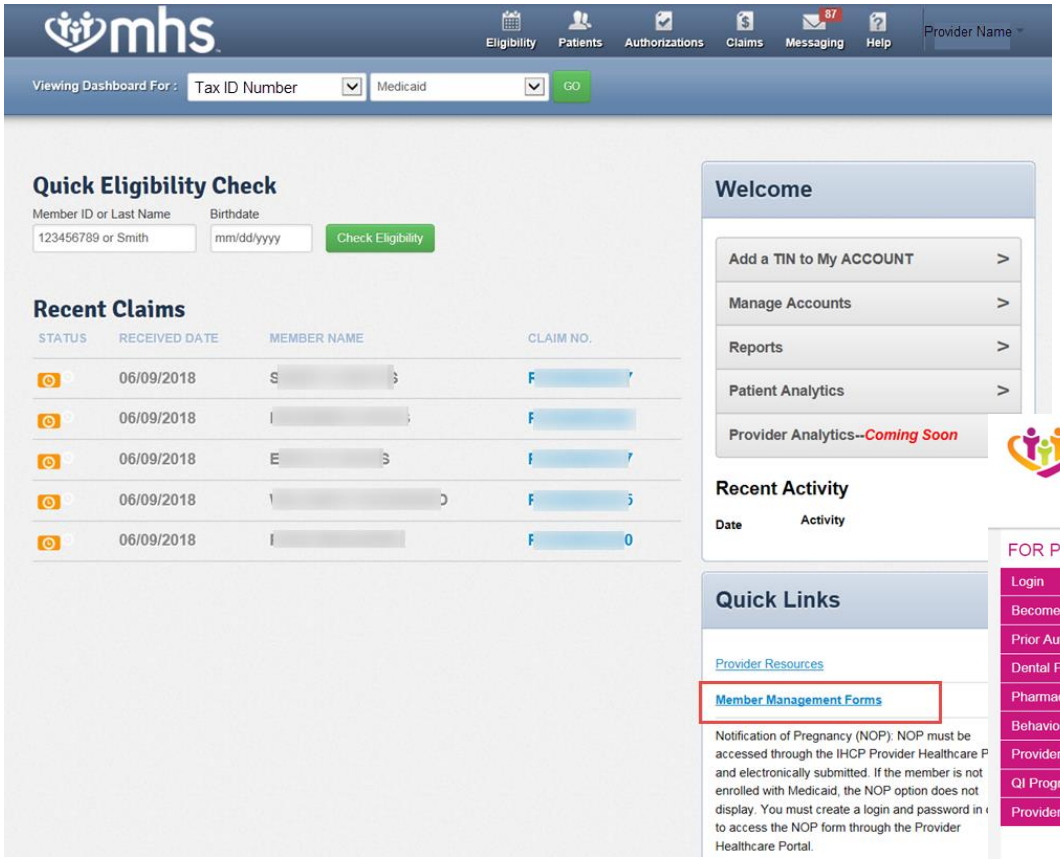
Quick Links

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

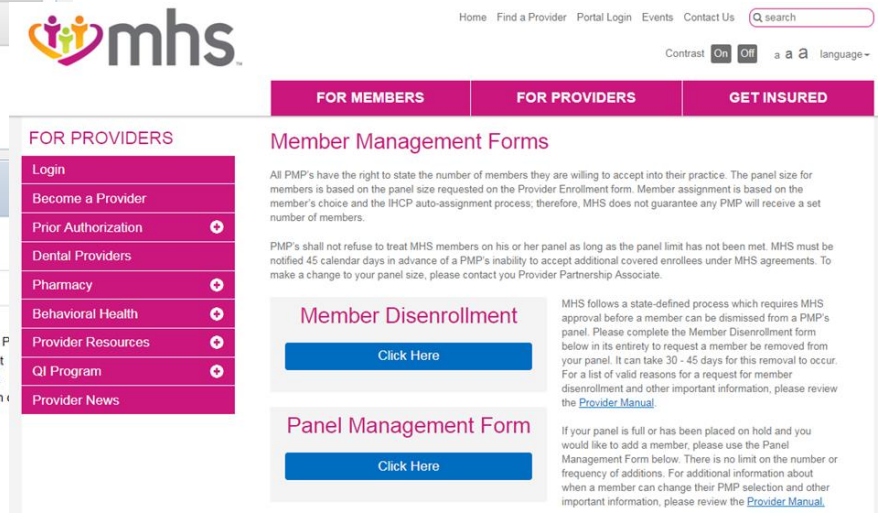
Go Paperless

MHS Member Management Forms

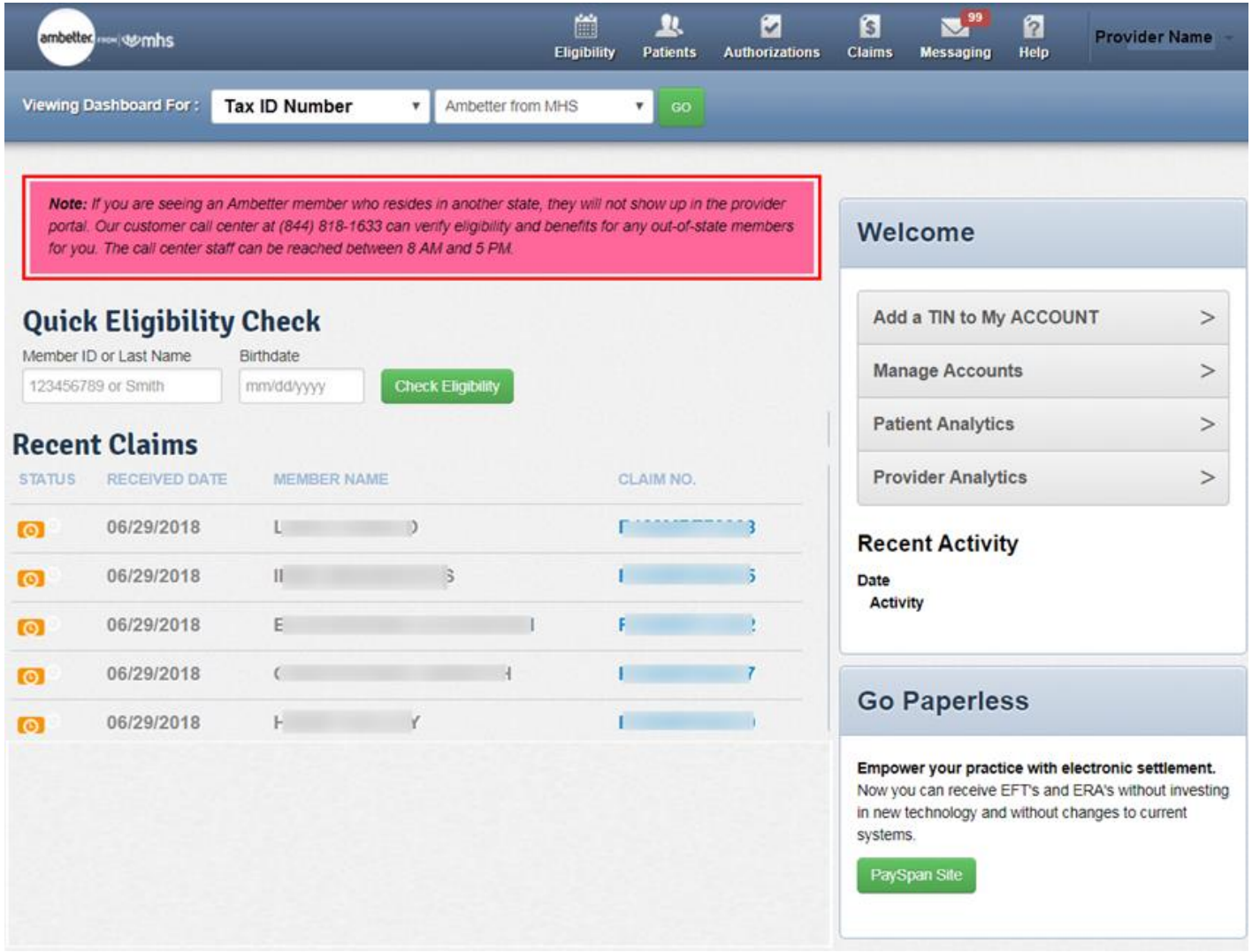
Click on **Member Management Forms** under **Quick Links**



- **Choose between**:
- Member Disenrollment Form
- Panel Management Form



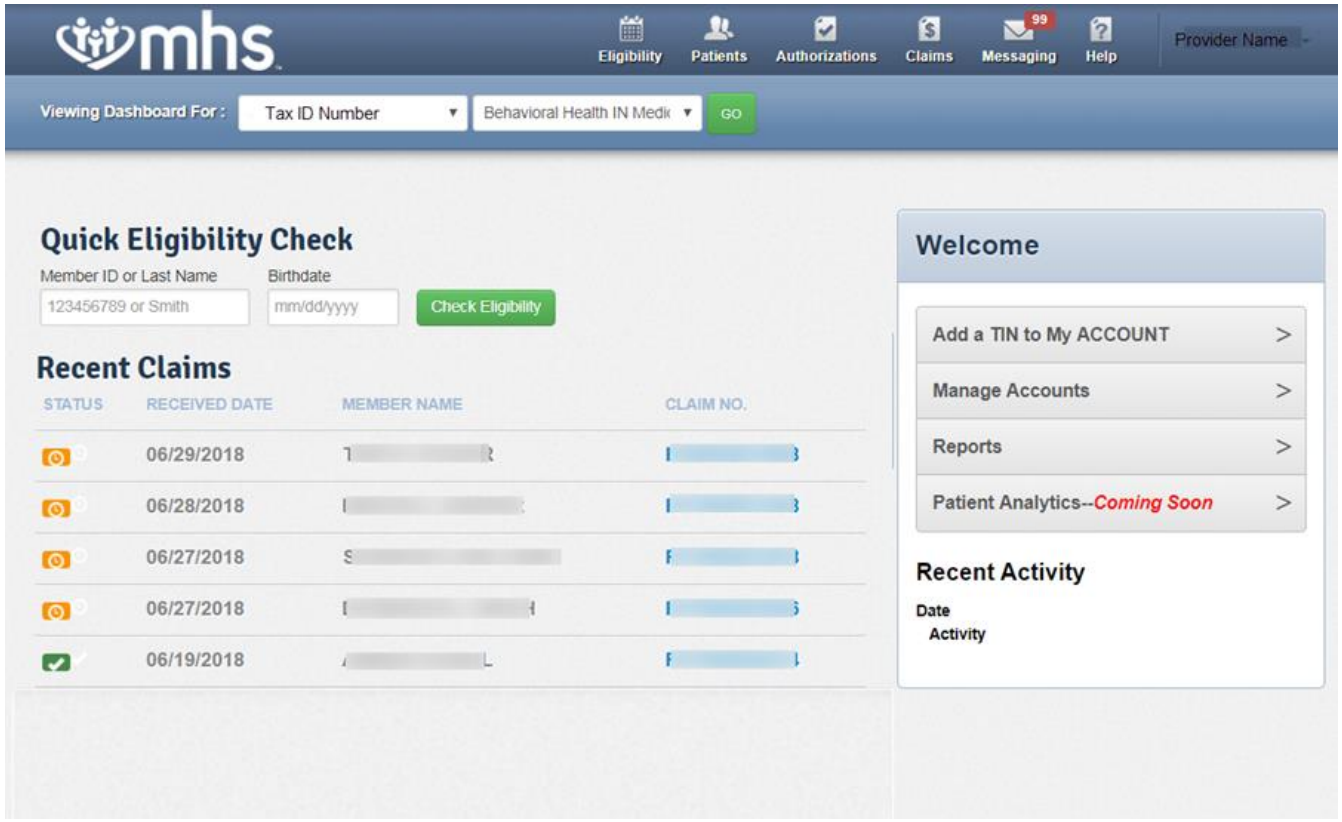
Homepage –Ambetter from MHS



Quick Links:

- Eligibility Check
- Add a TIN
- Account Manager
- Analytics
- Secure Messaging

Homepage –Behavioral Health IN Medicaid



Quick Links:

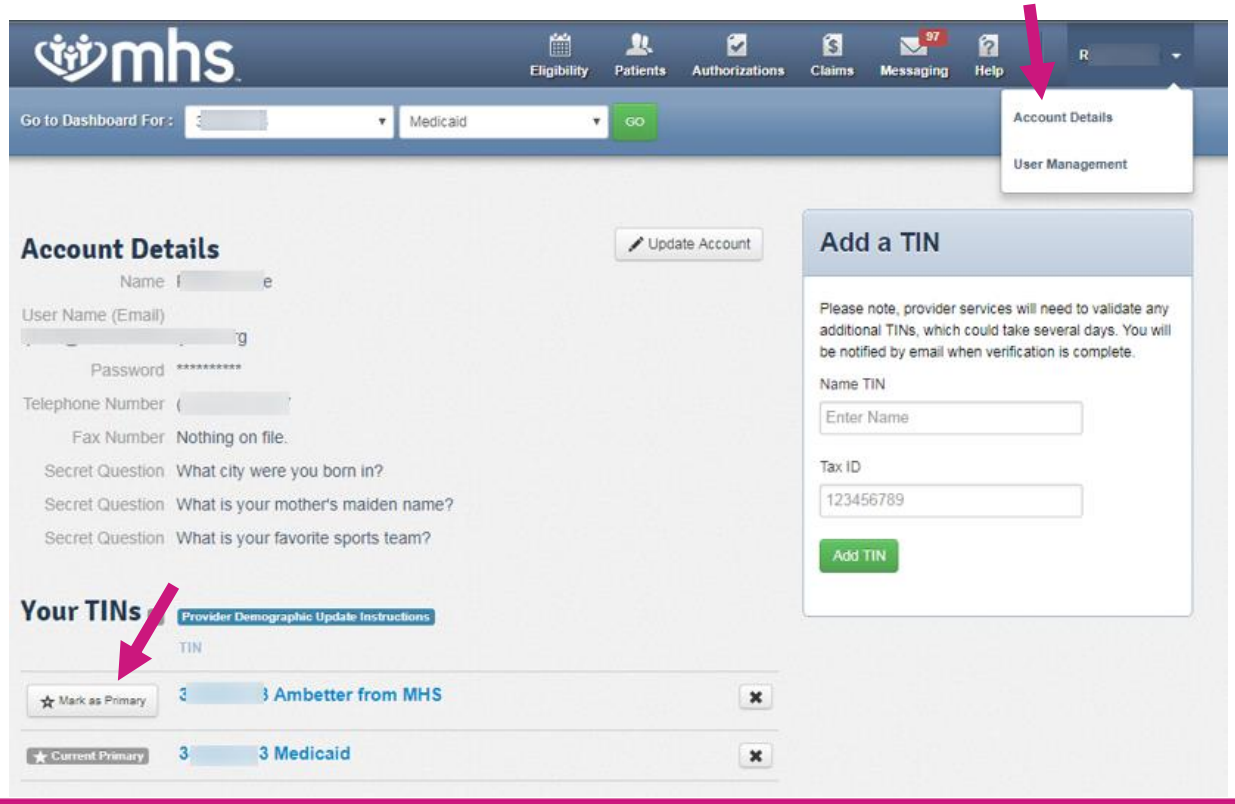
- Eligibility Check
- Add a TIN
- Account Manager

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.



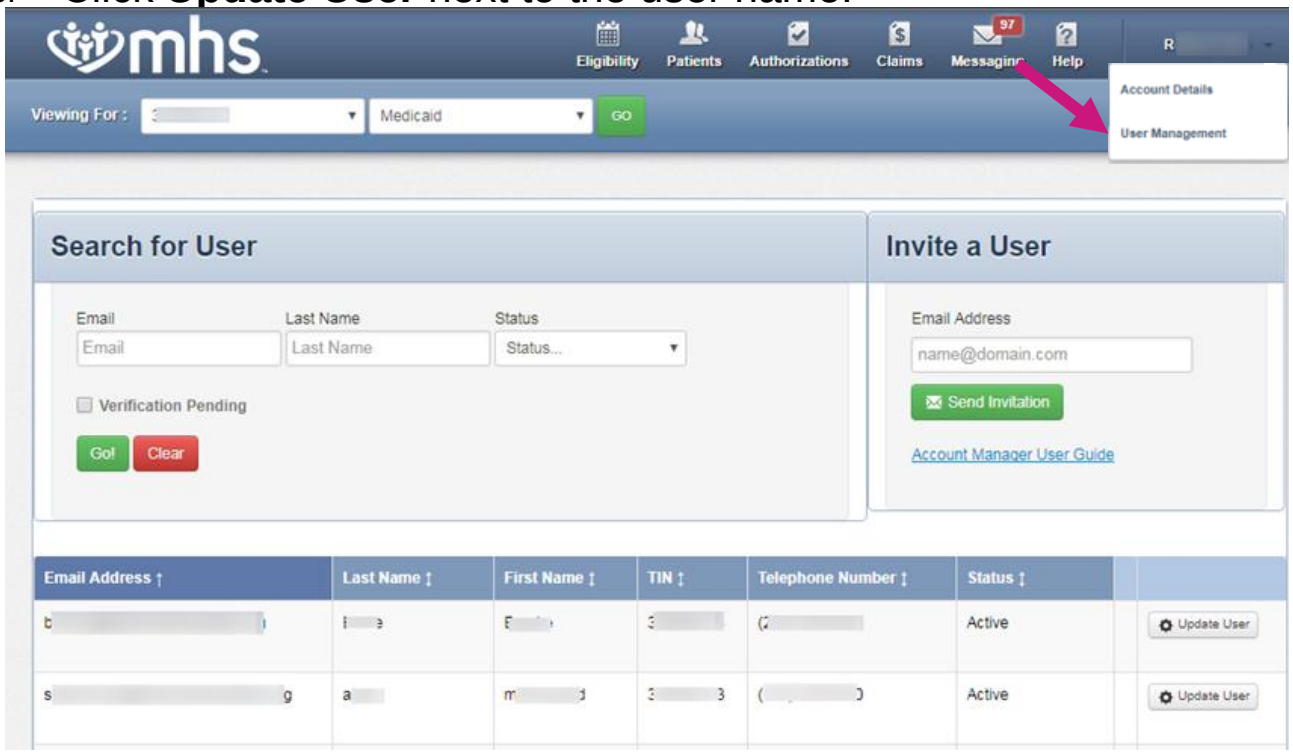
Account Manager

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.

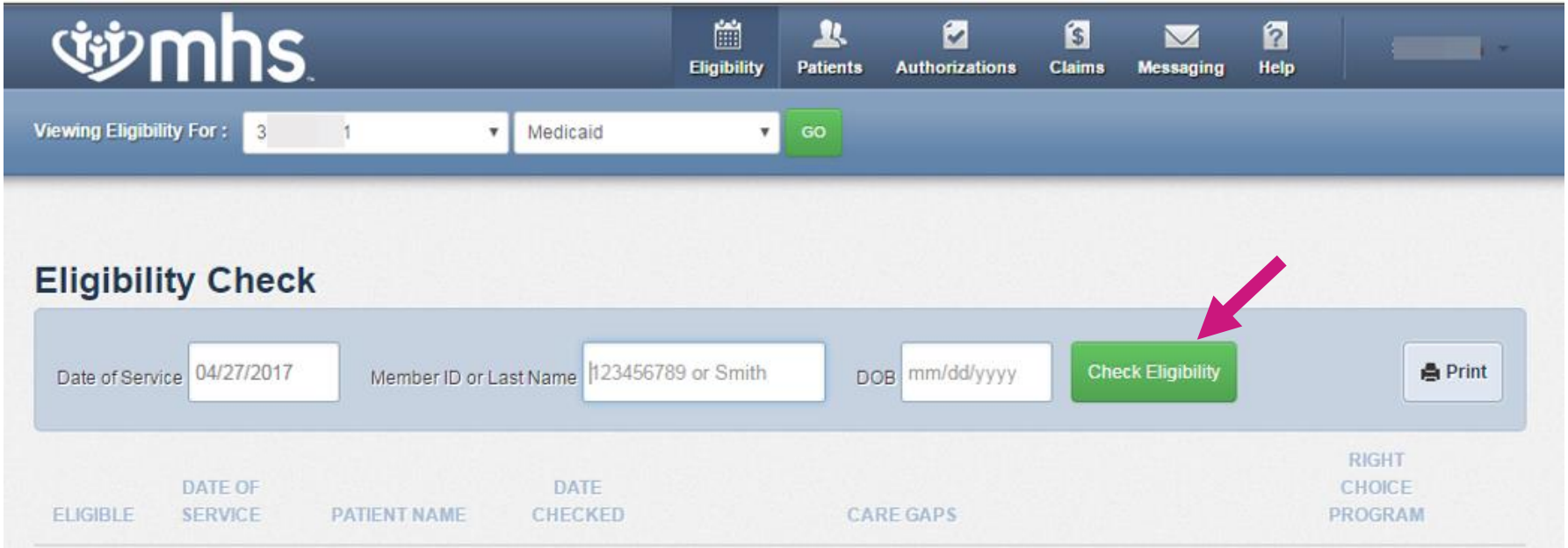
1. Select the drop-down arrow next to your name in the upper right corner.
2. Select **User Management**.
3. Click **Update User** next to the user name.



Eligibility

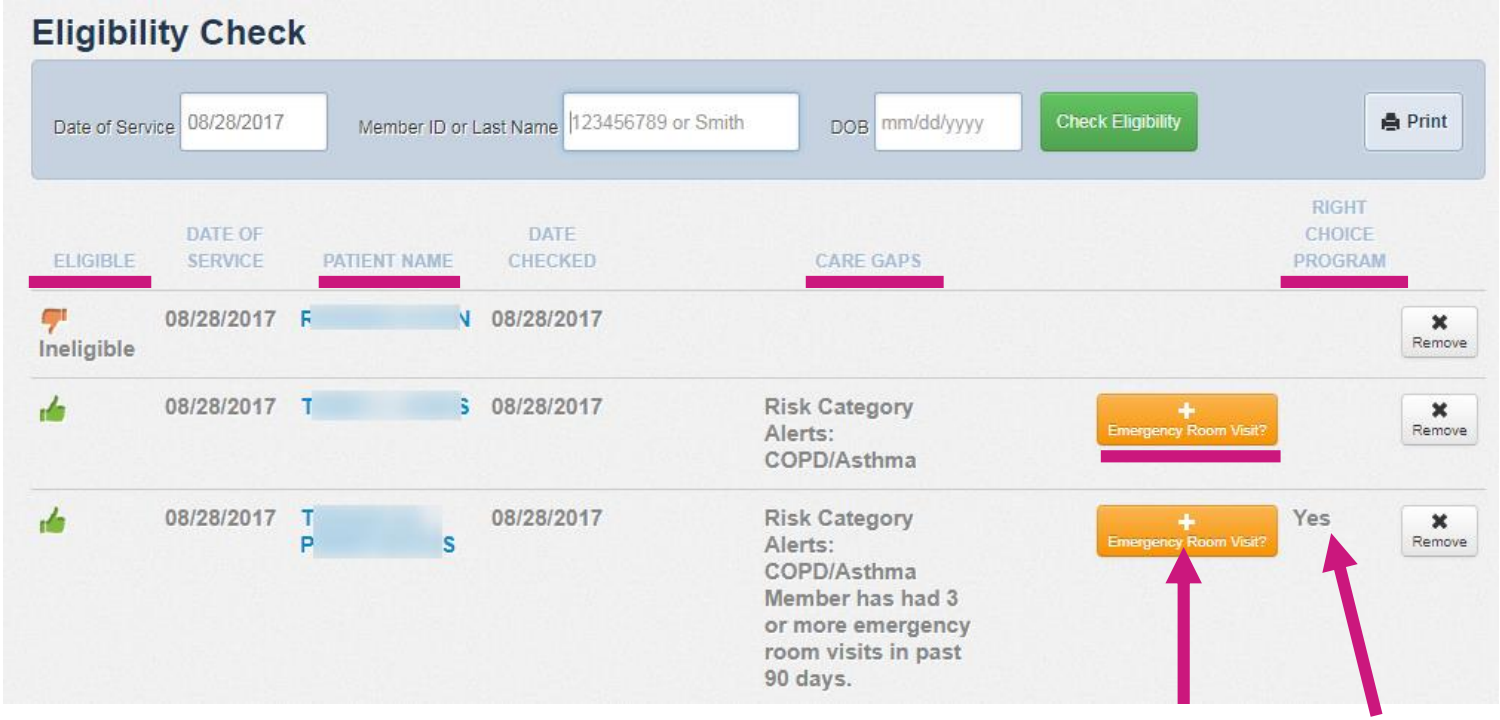
Check Eligibility

- 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**



Check Eligibility

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



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

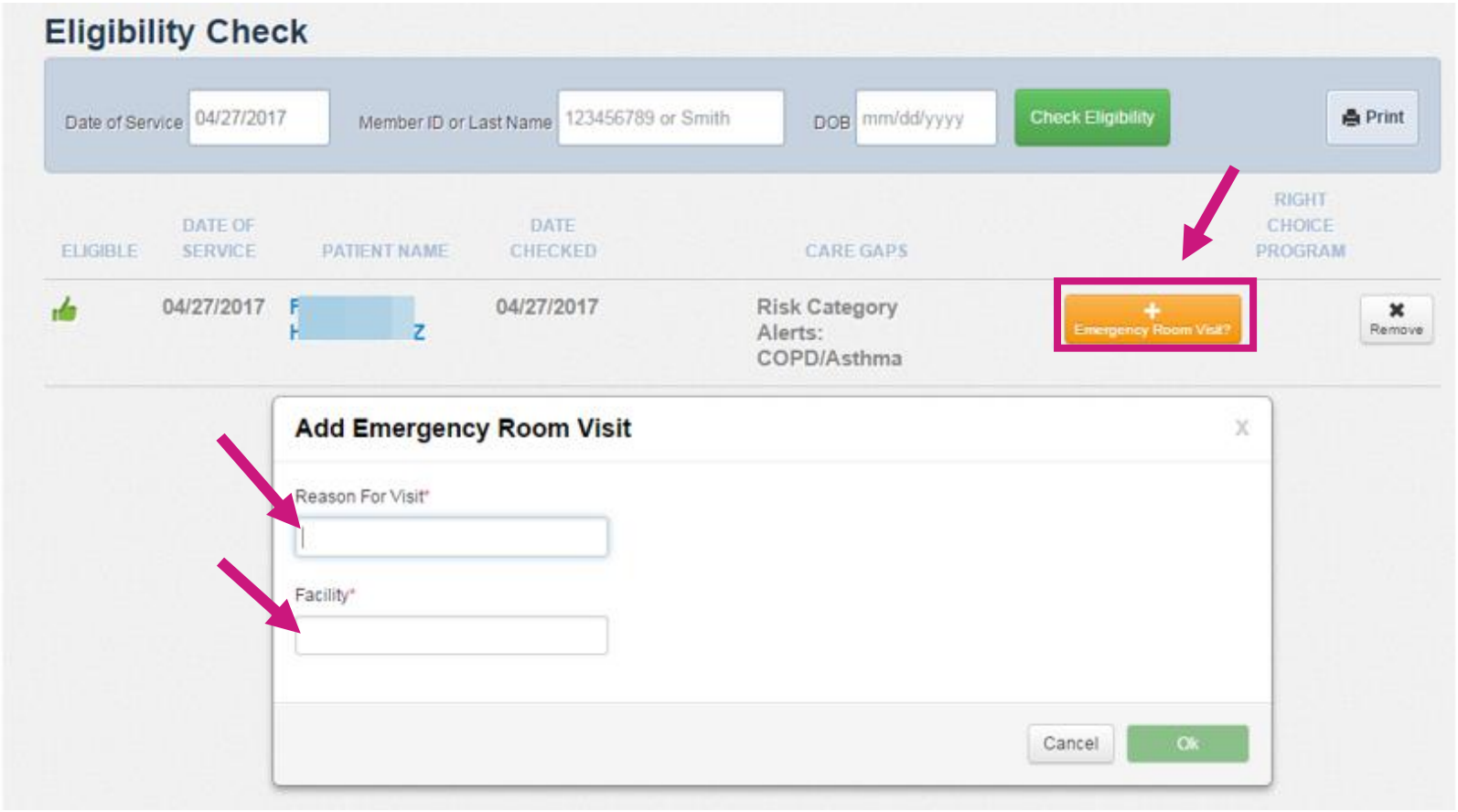
Care Gaps can also be seen within the search results.

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**

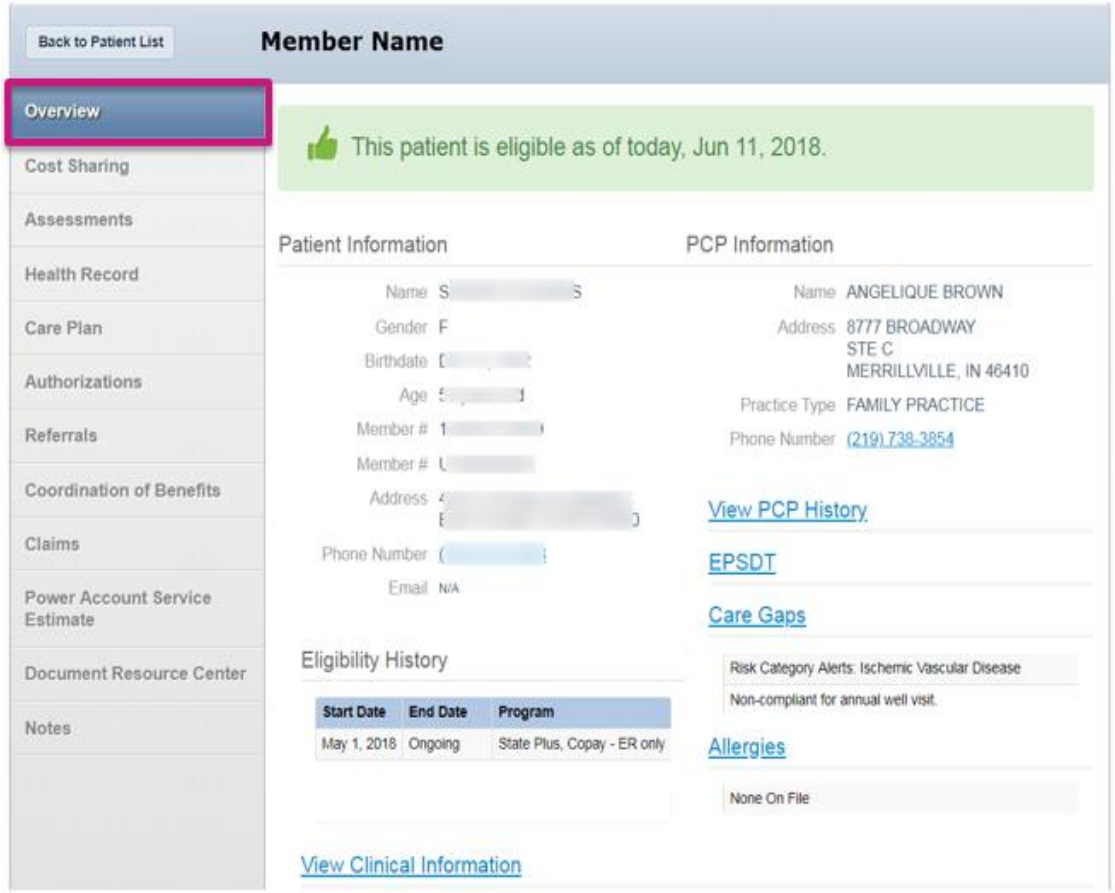


Member Record

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

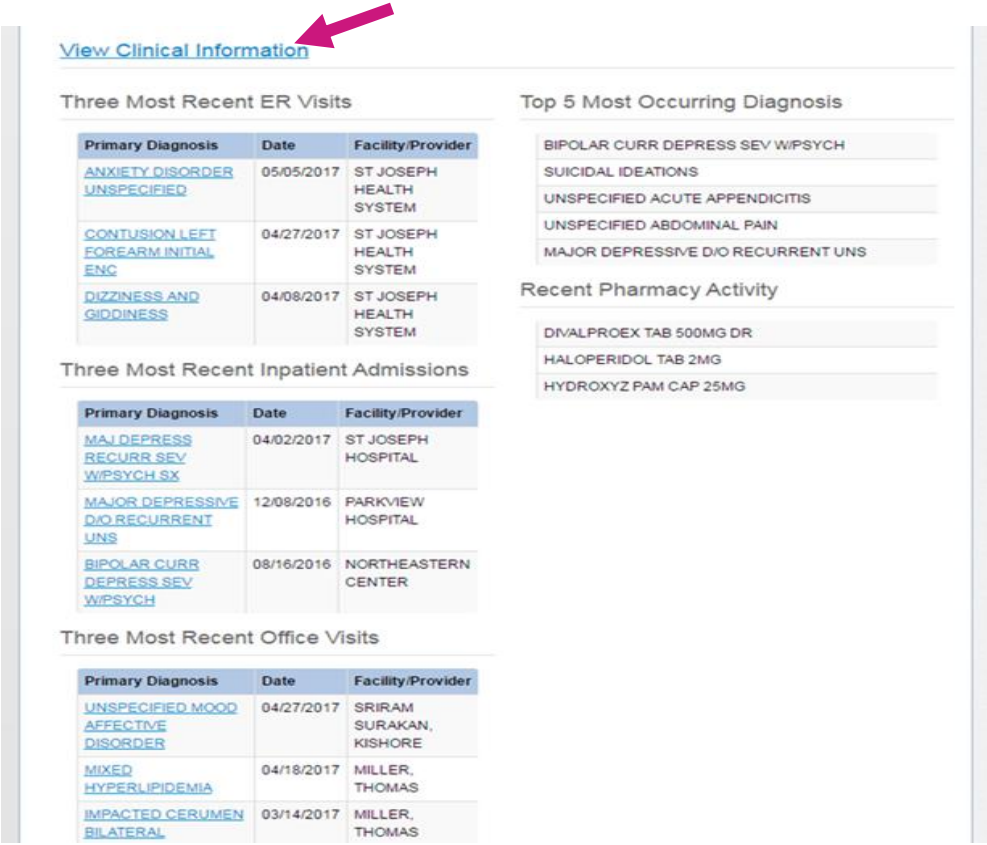
Member Overview



Overview Tab

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

View Clinical Information

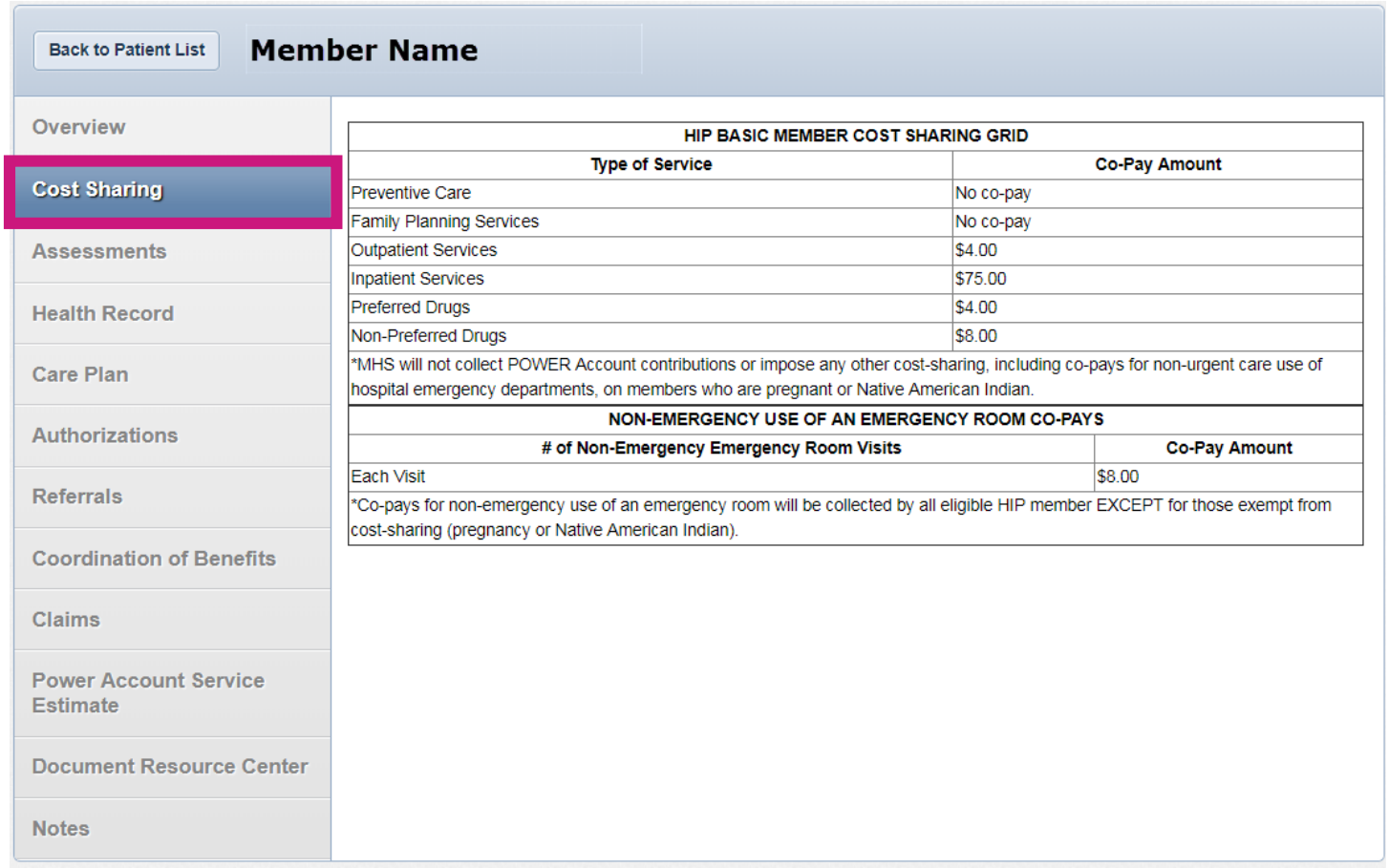


Clinical Information

- 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



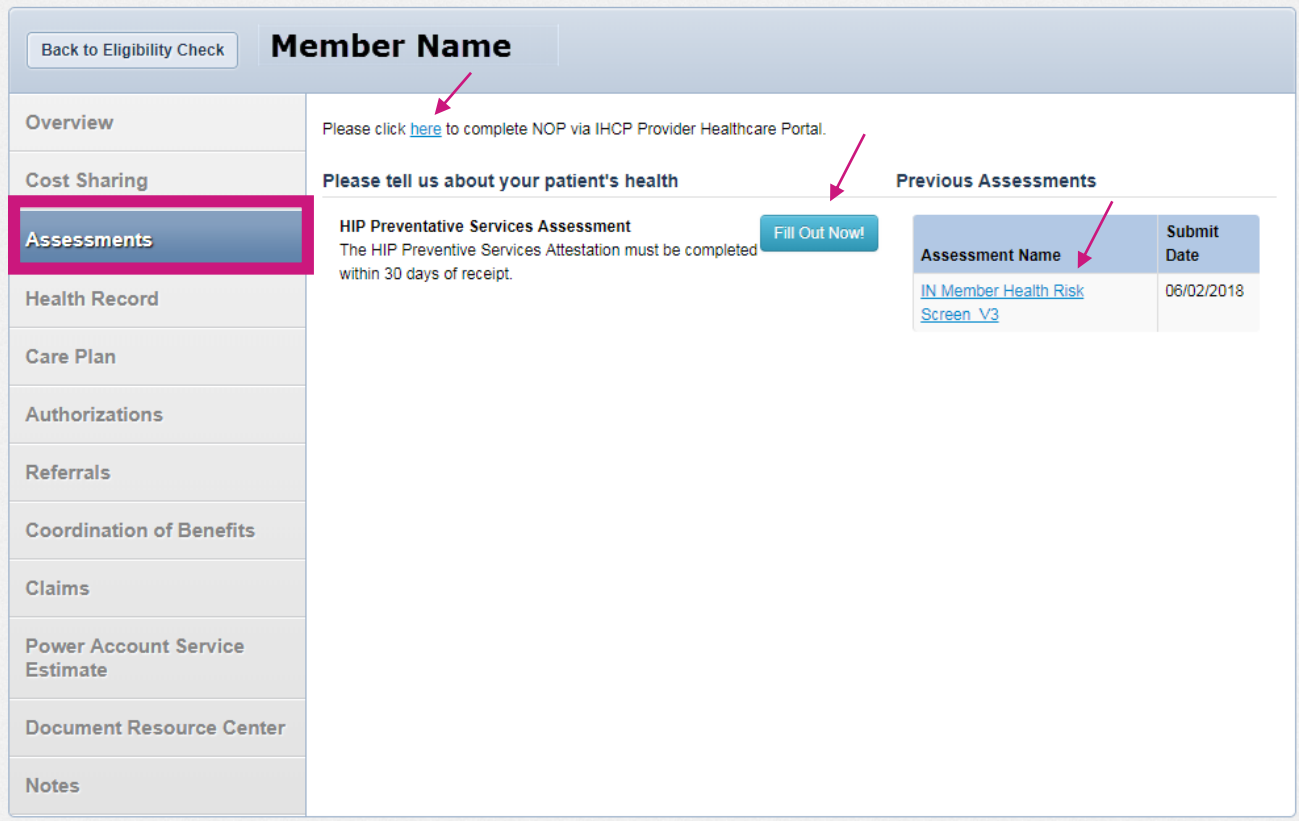
HIP BASIC MEMBER COST SHARING GRID	
Type of Service	**Co-Pay Amount**
Preventive Care	No co-pay
Family Planning Services	No co-pay
Outpatient Services	$4.00
Inpatient Services	$75.00
Preferred Drugs	$4.00
Non-Preferred Drugs	$8.00
*MHS will not collect POWER Account contributions or impose any other 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

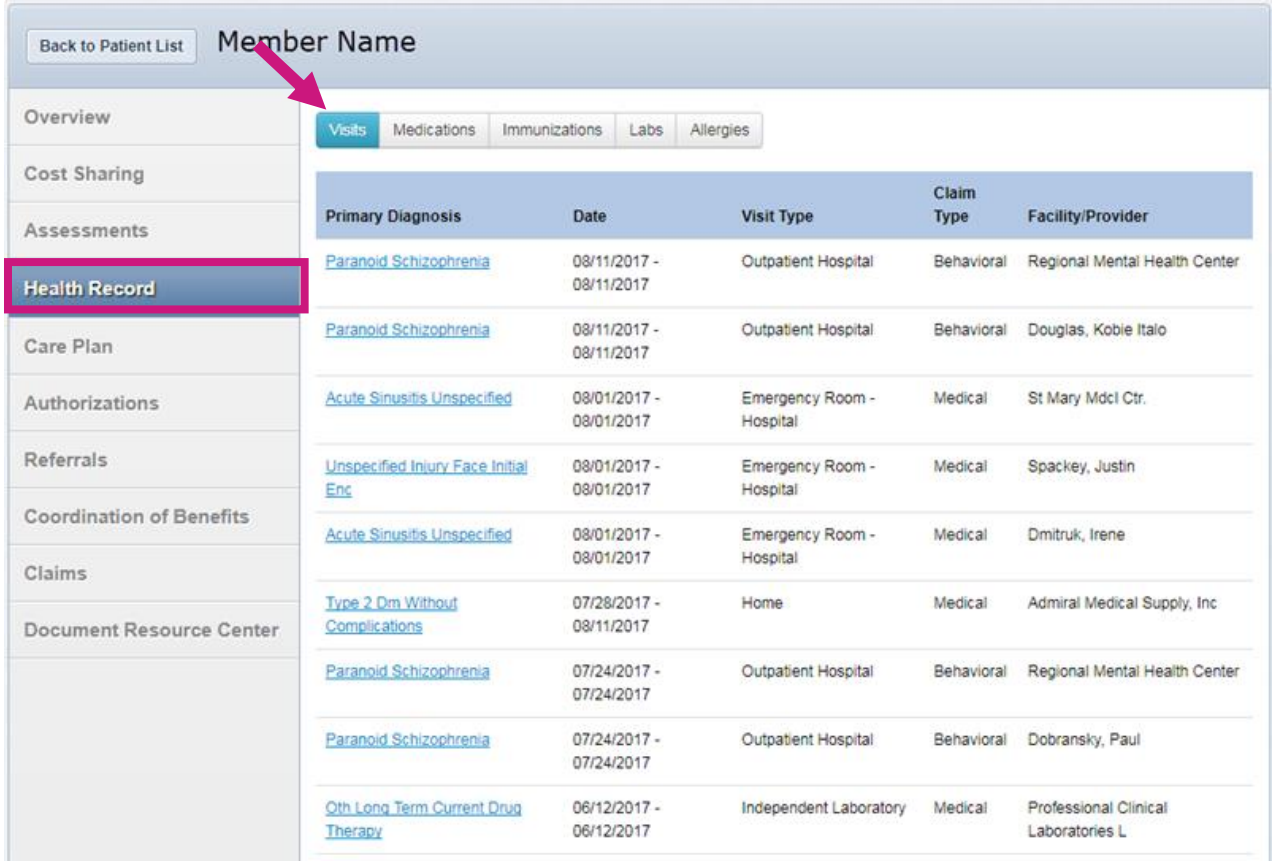
Types of **Assessments**

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



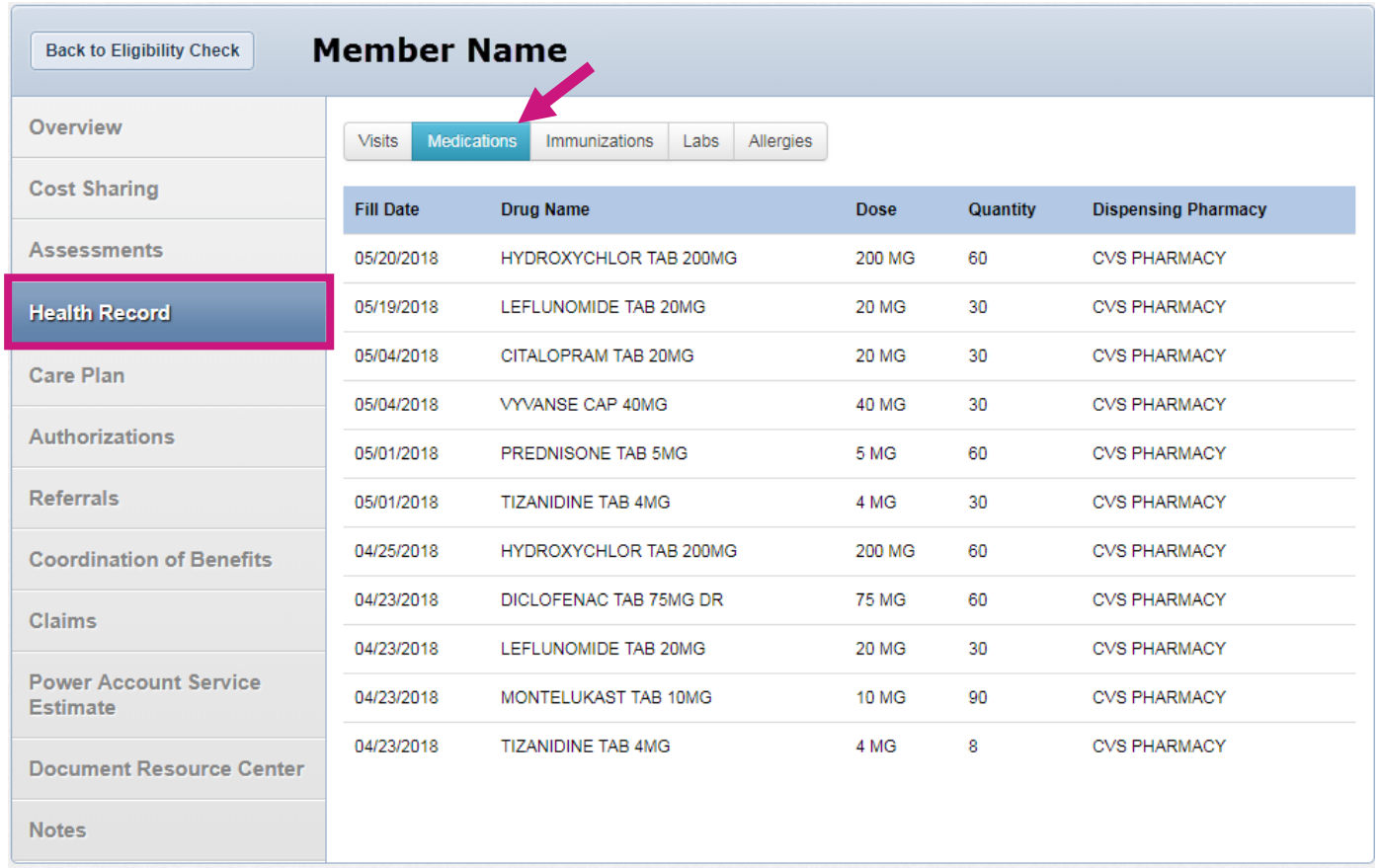
Health Record -Visits

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



Health Record -Medications

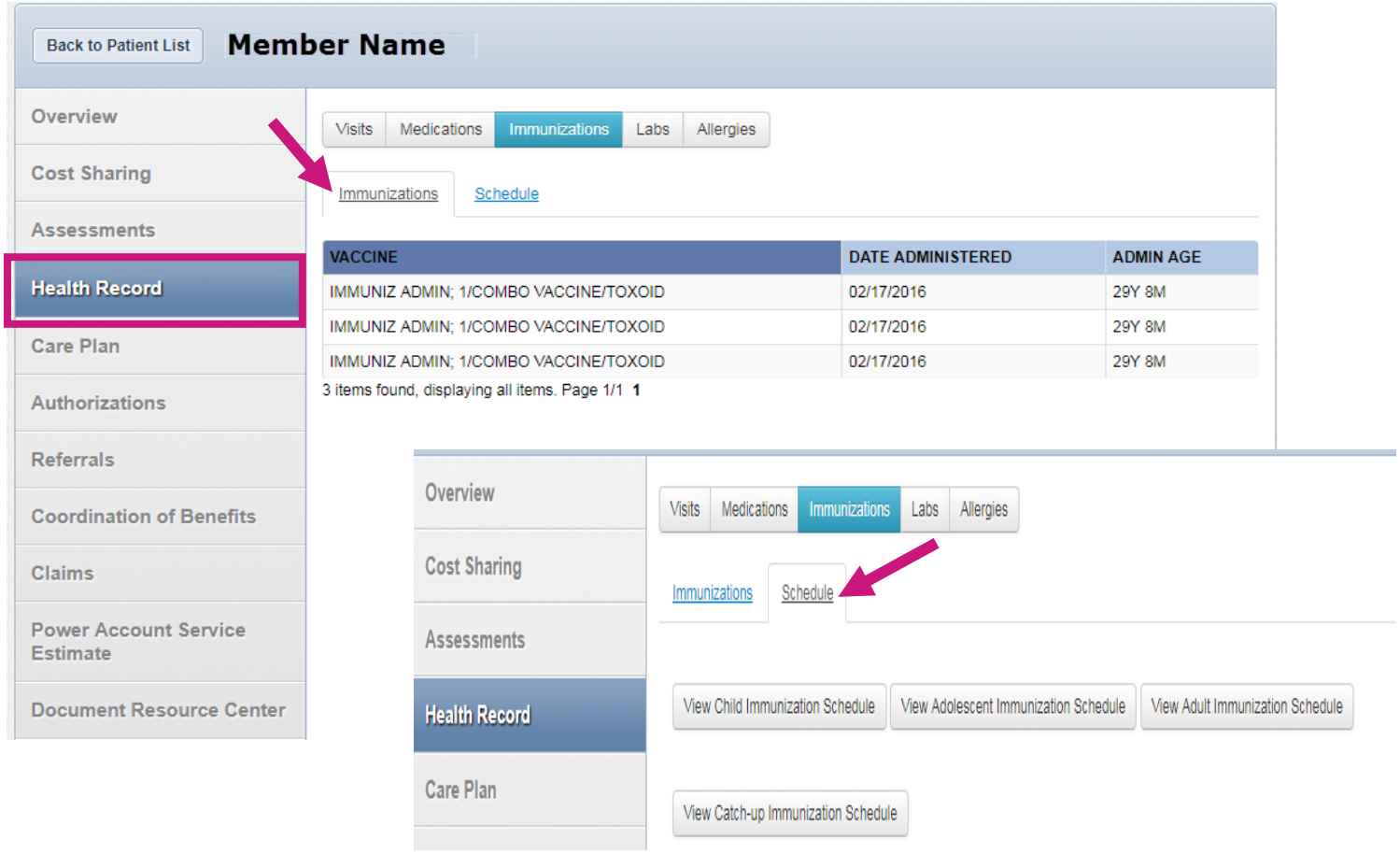
- Member's most recent **Pharmacy Claims**



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

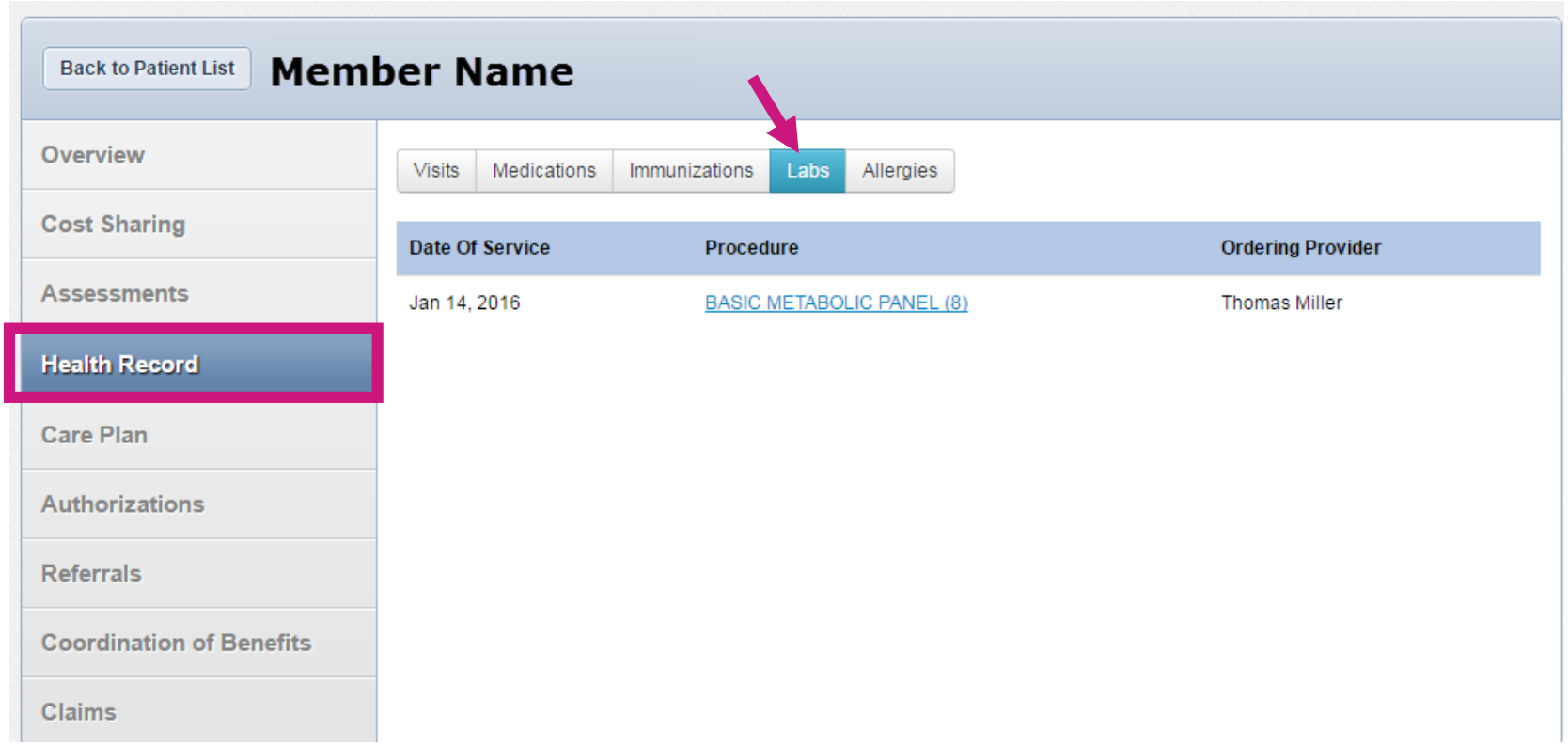
Health Record -Immunizations

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



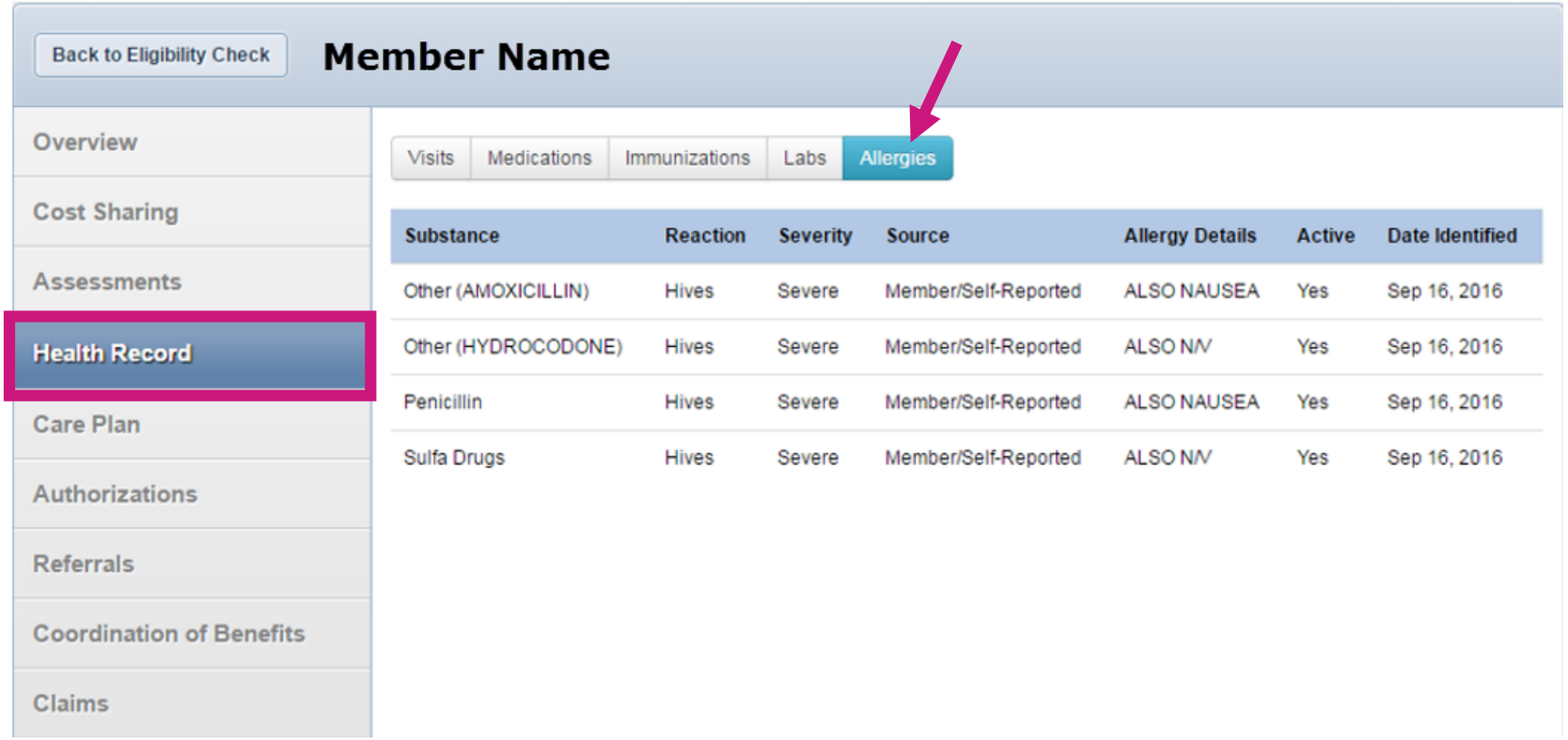
Health Record -Labs

- Member's most recent **Labs**



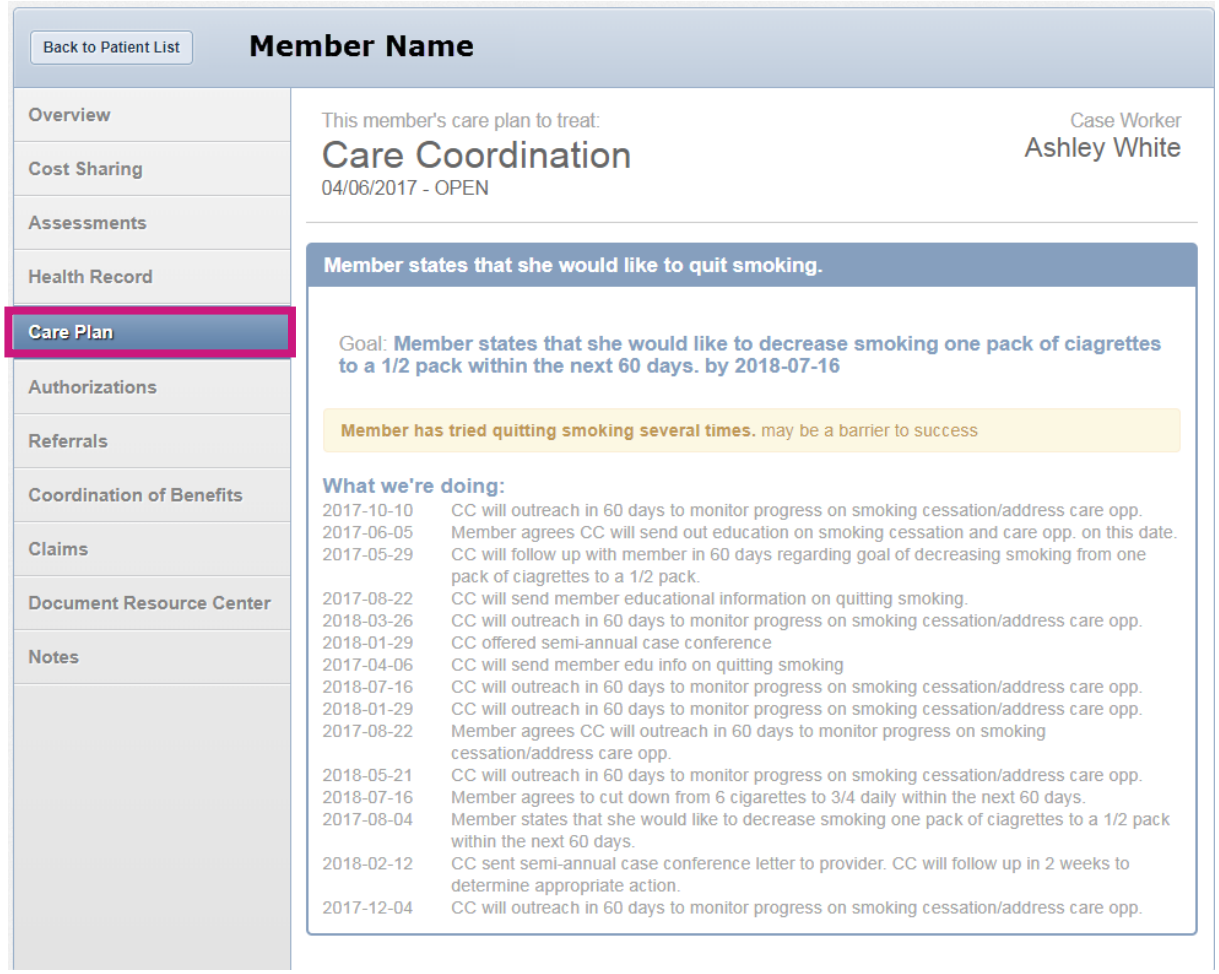
Health Record -Allergies

- Member list of **Allergies**



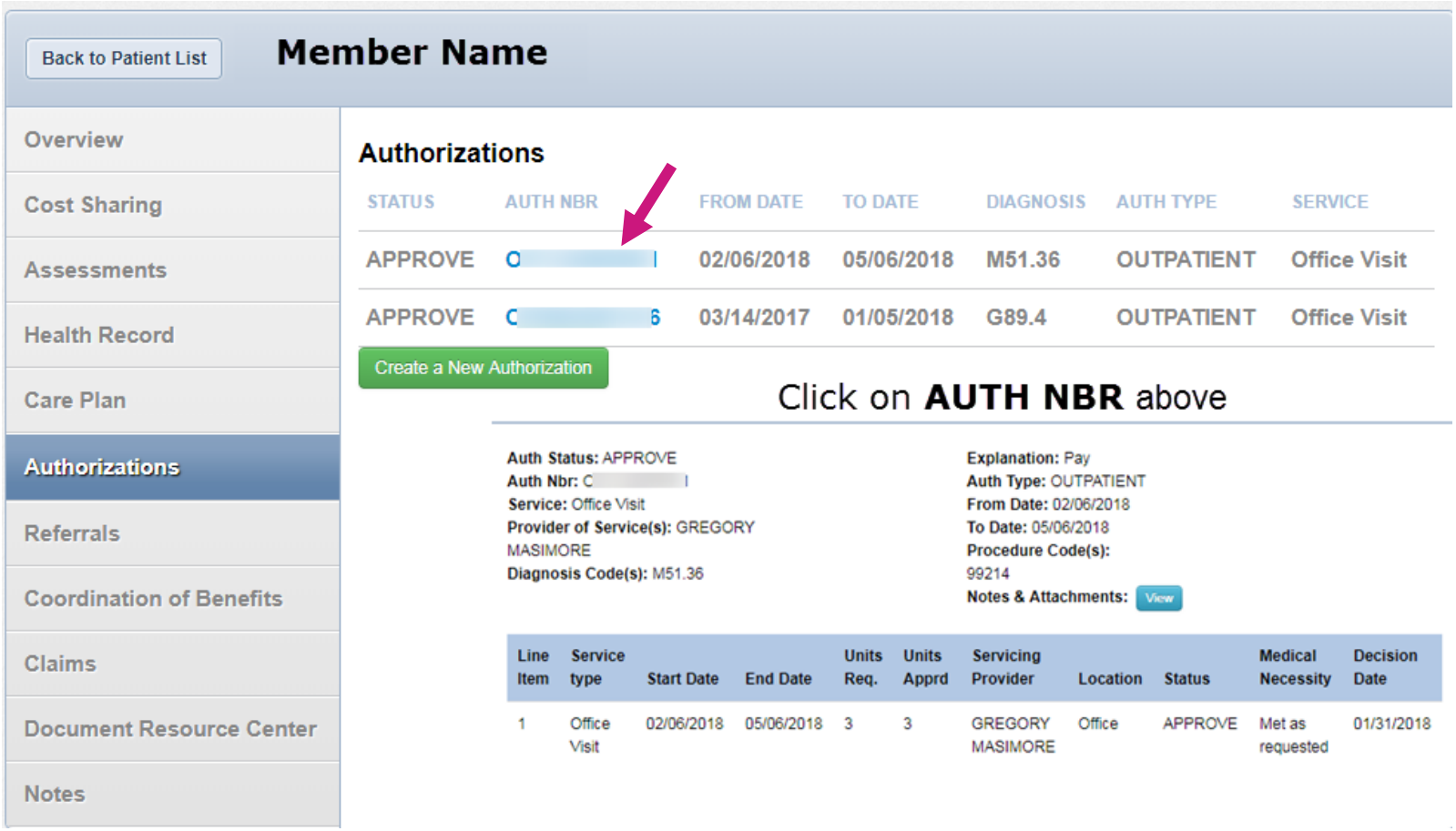
Care Plan

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



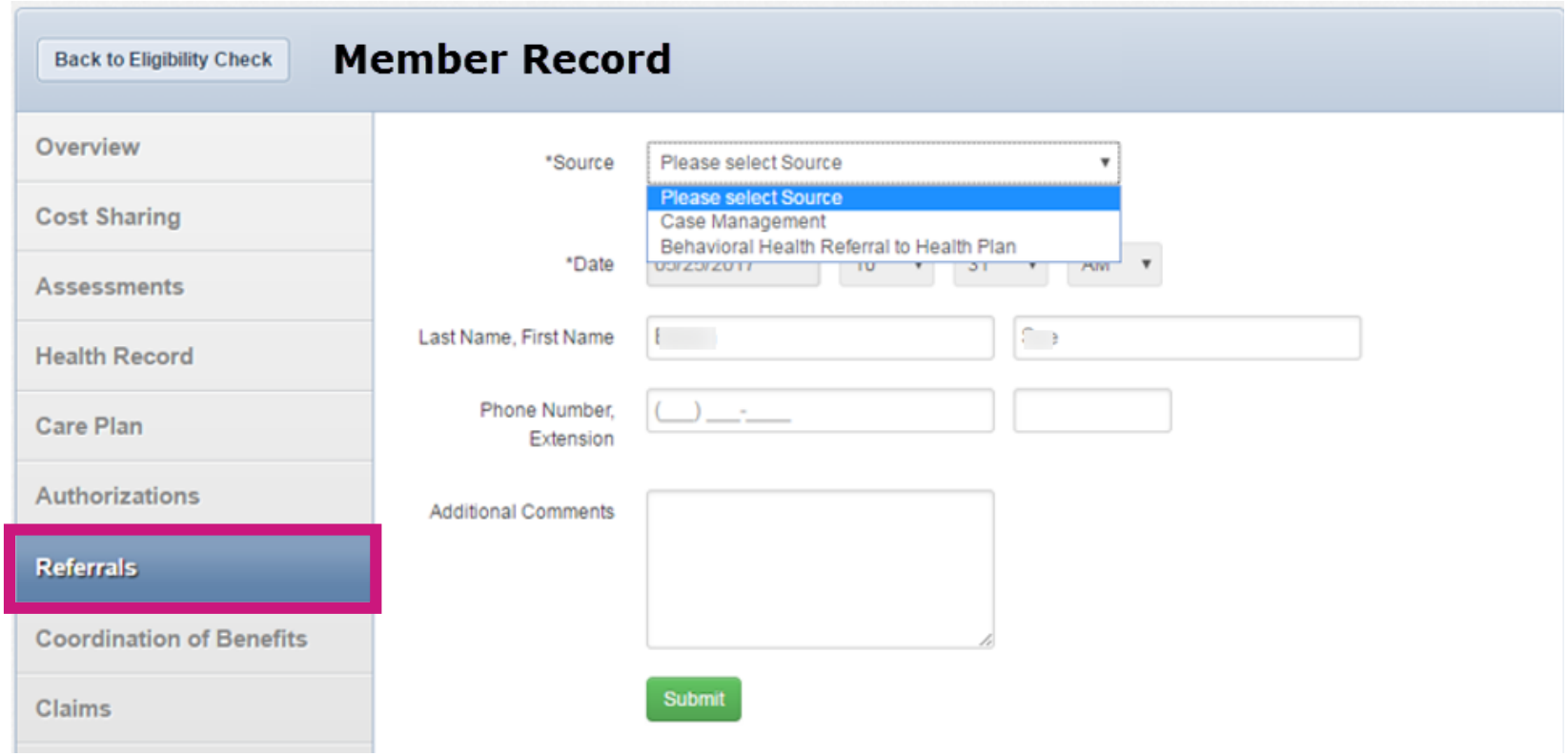
Authorizations

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



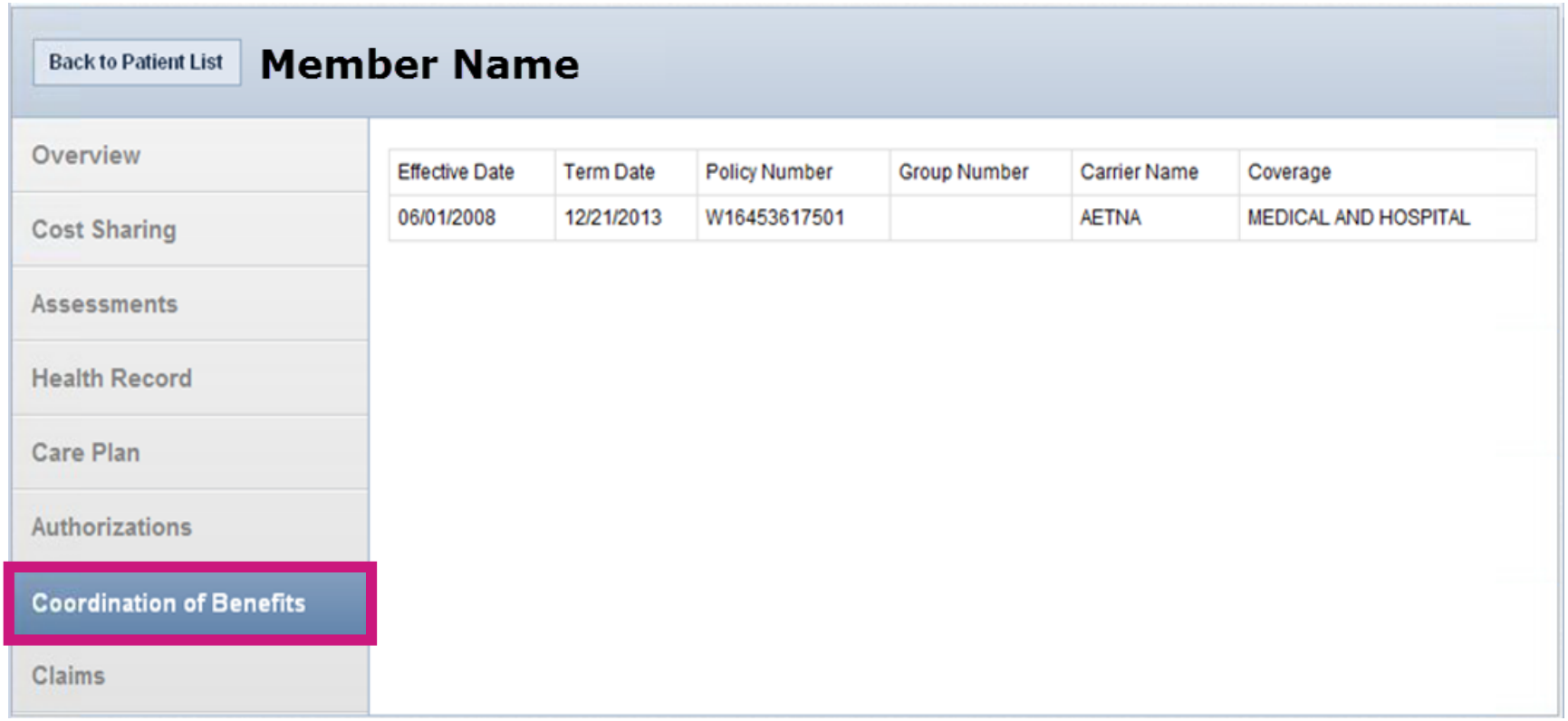
Referrals

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



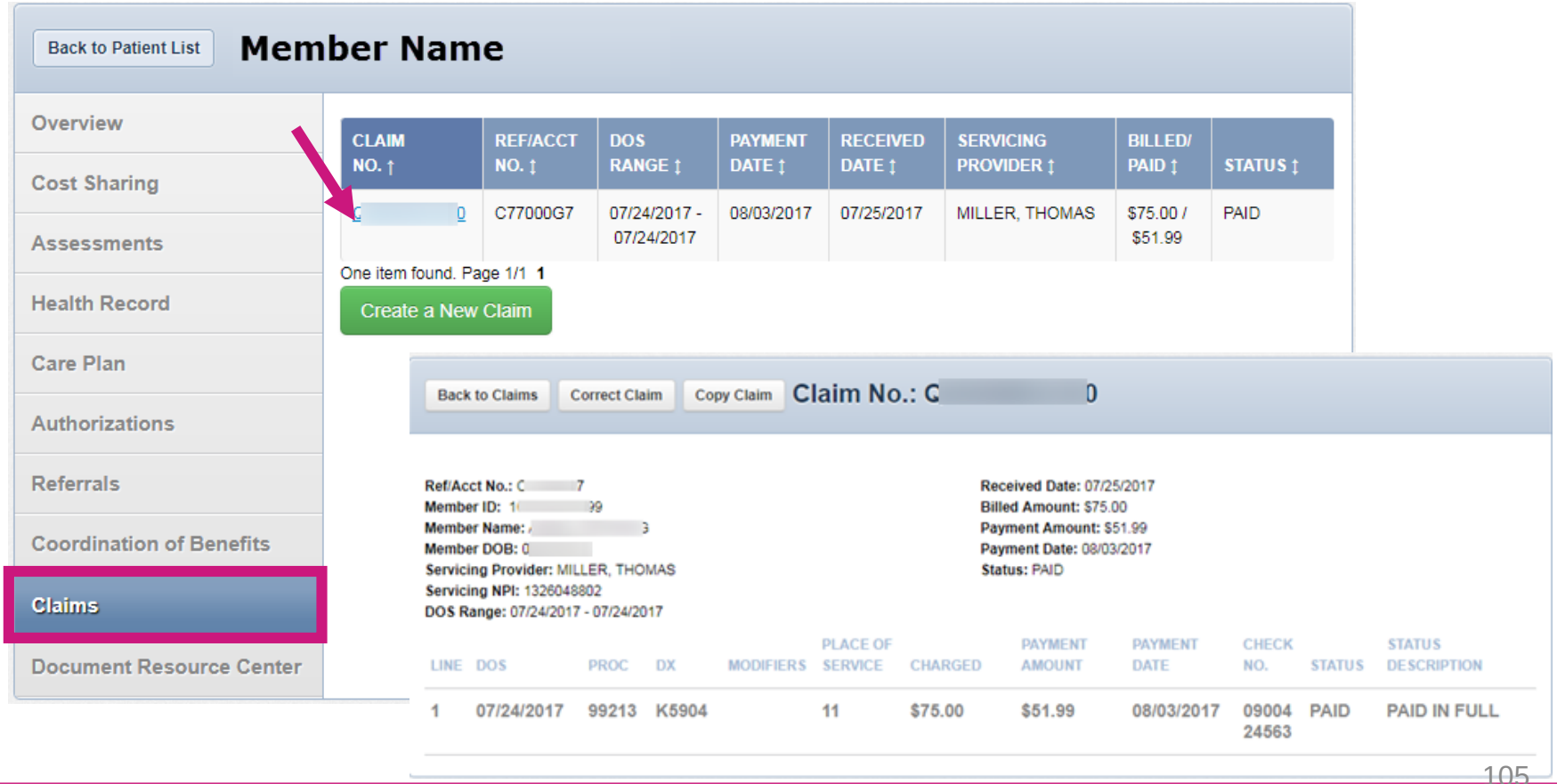
Coordination of Benefits

- This screen shows if a member has other insurance.



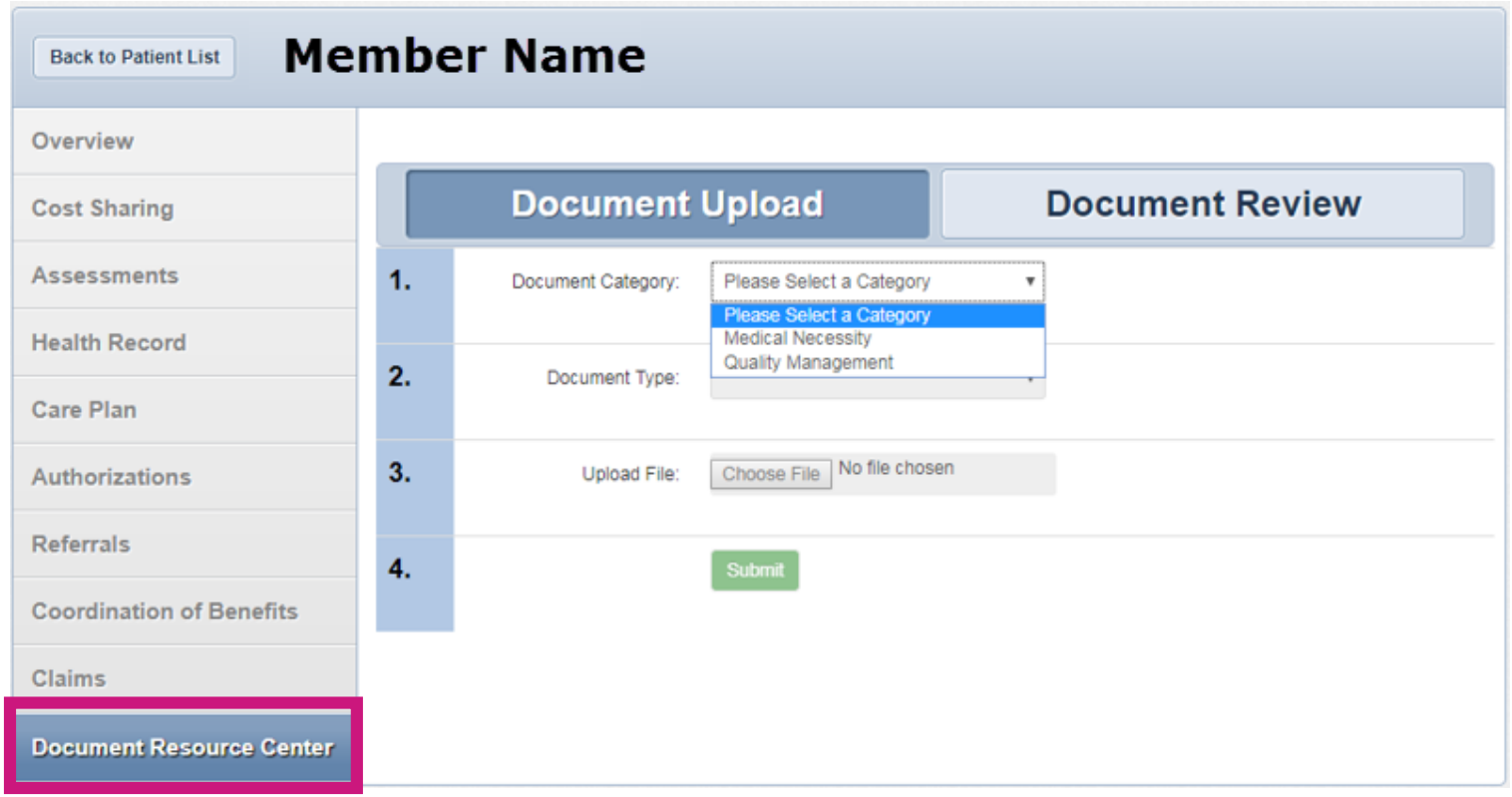
Claims

- **Claims** screen shows the members most recent claims and create a new claim
  - Clicking on the **Claim No.** shows additional details



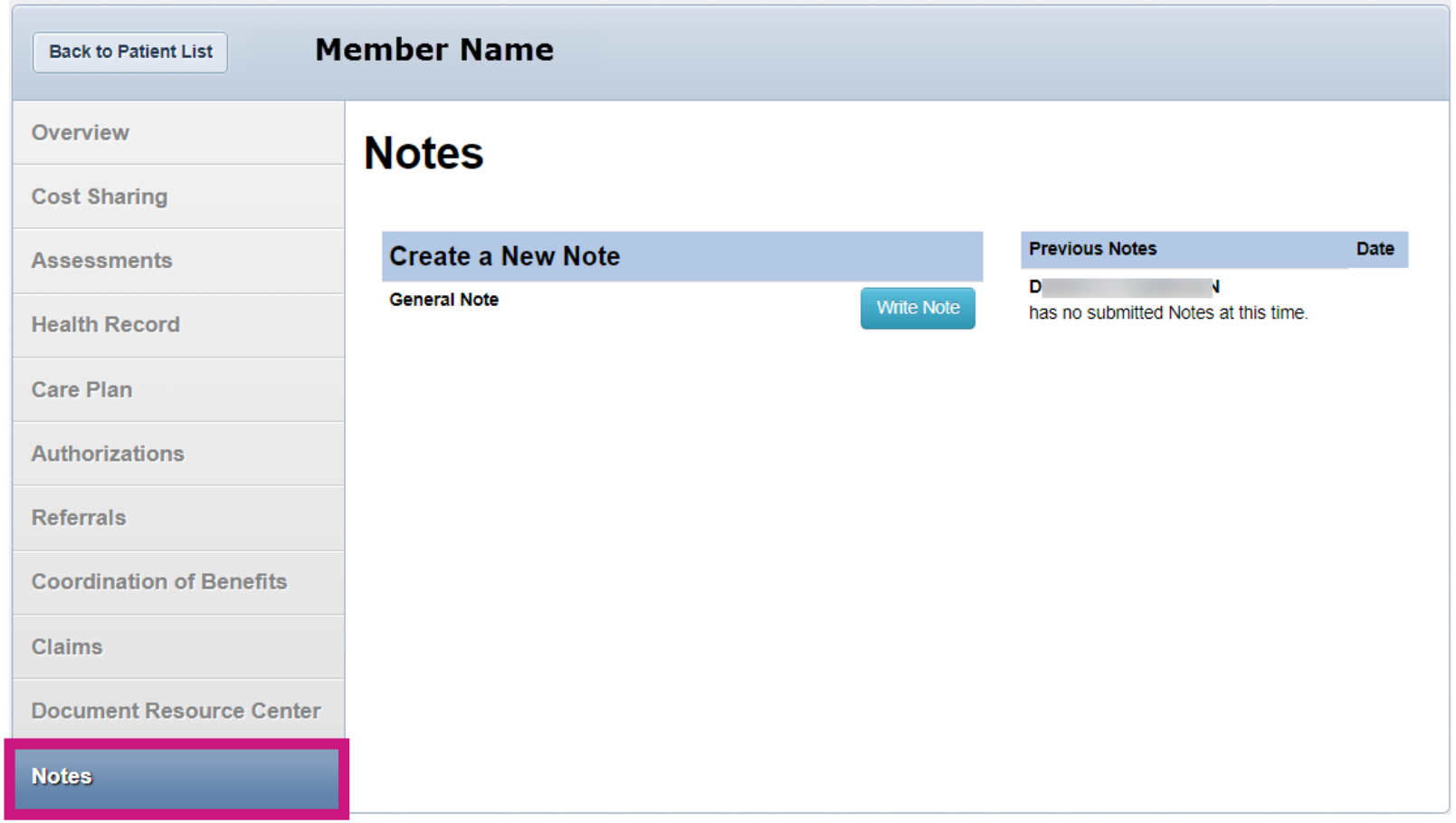
Document Resource Center

Medical Necessity or **Quality Management** Document Upload



Notes

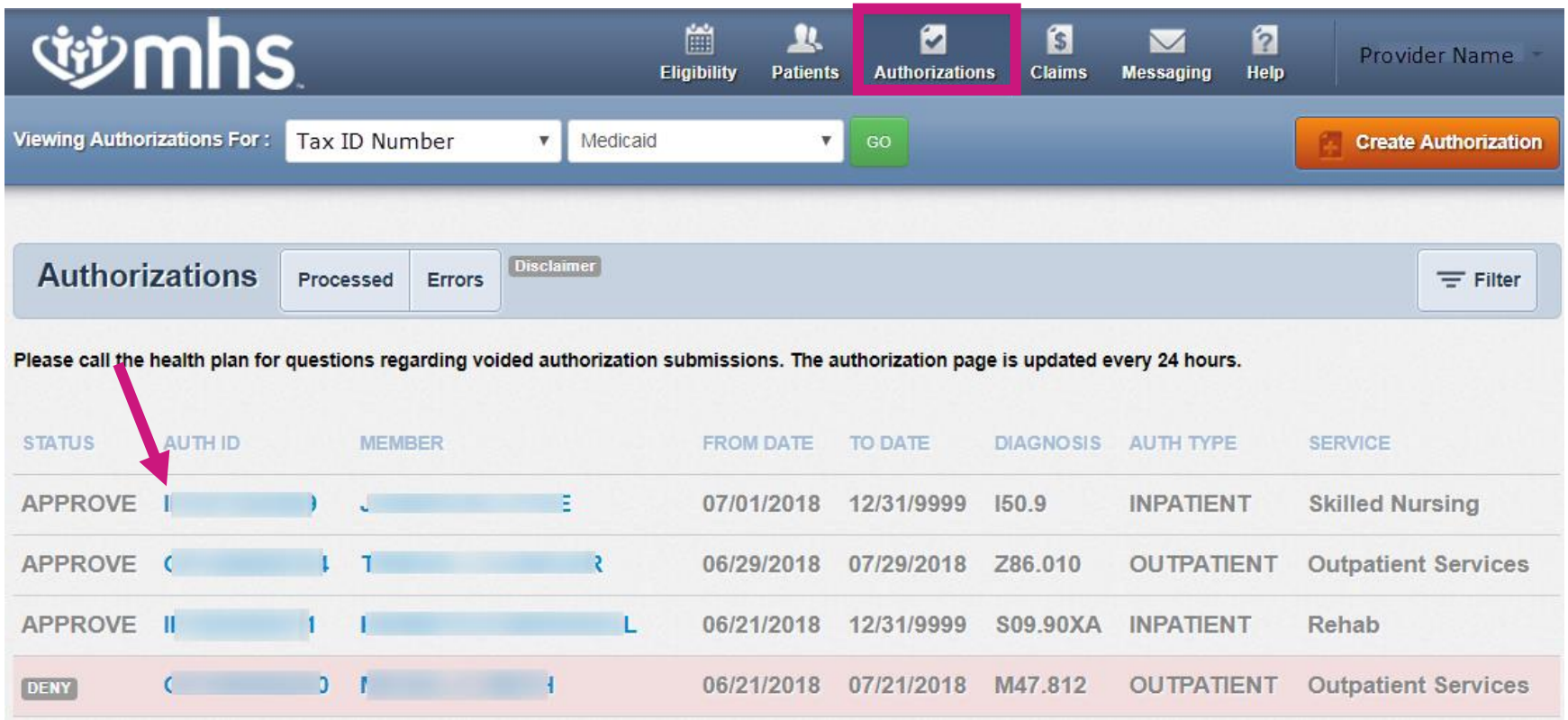
- Create new **Note** and see previous **Notes**



Authorizations

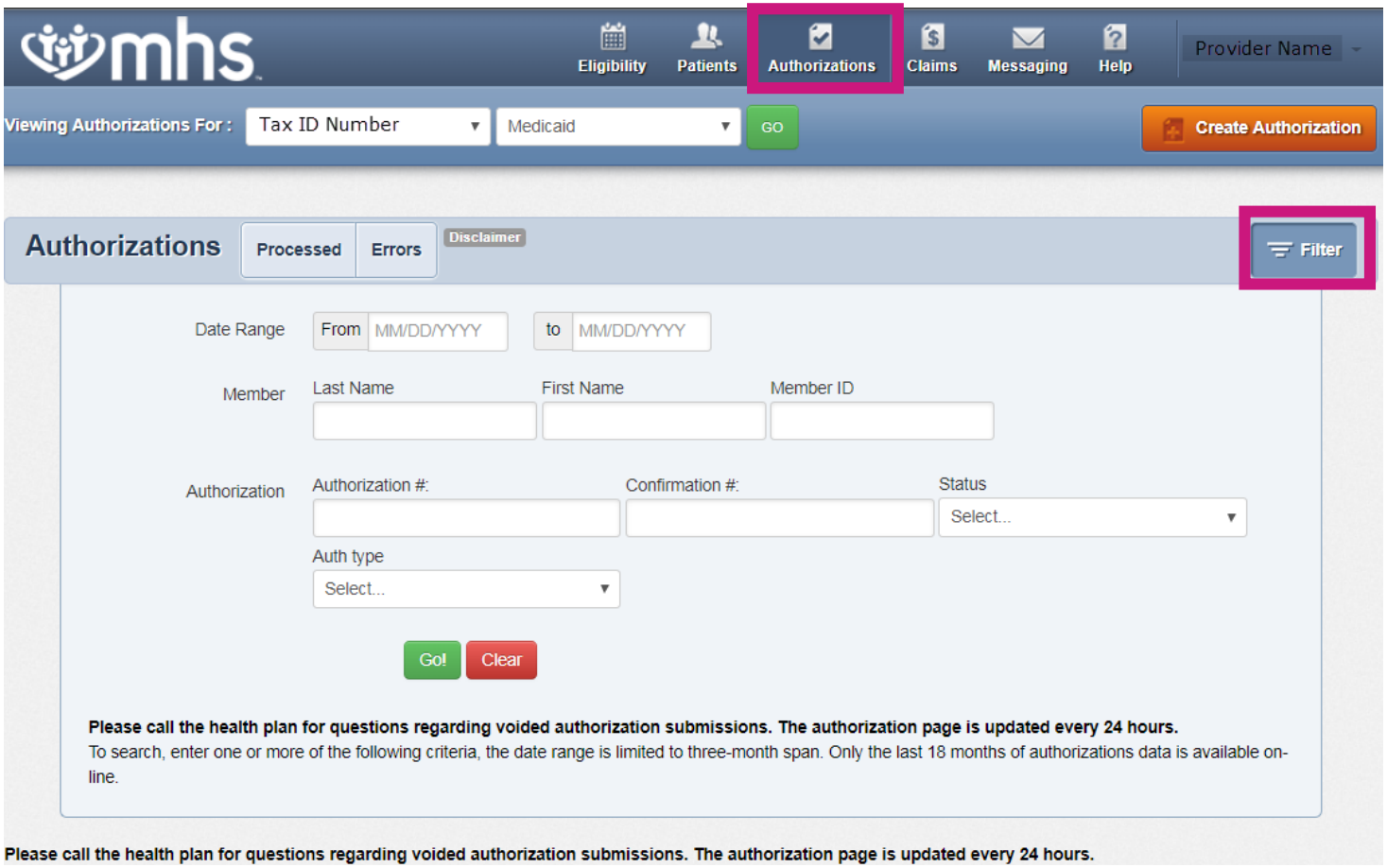
Authorizations

- View, create and filter group Authorizations
  - Click on the **AUTH ID** to see additional information



Authorizations

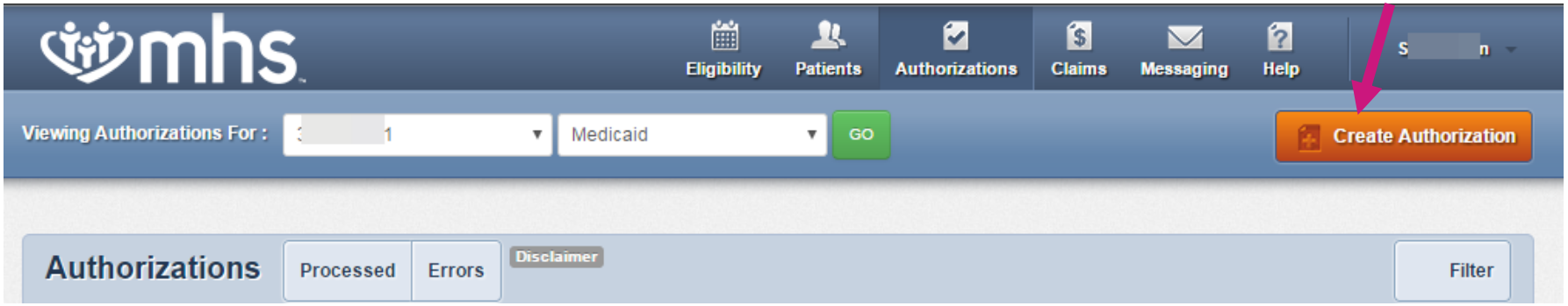
- **Filter** Authorizations by **Date Range**, **Member**, **Authorization#**, **Confirmation#**, **Status** or **Auth Type**

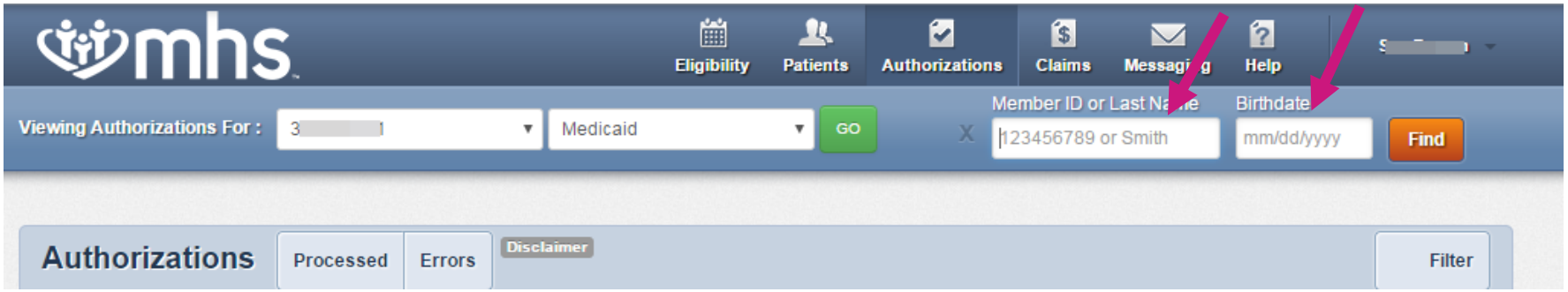


Create a New Authorization

New Authorization

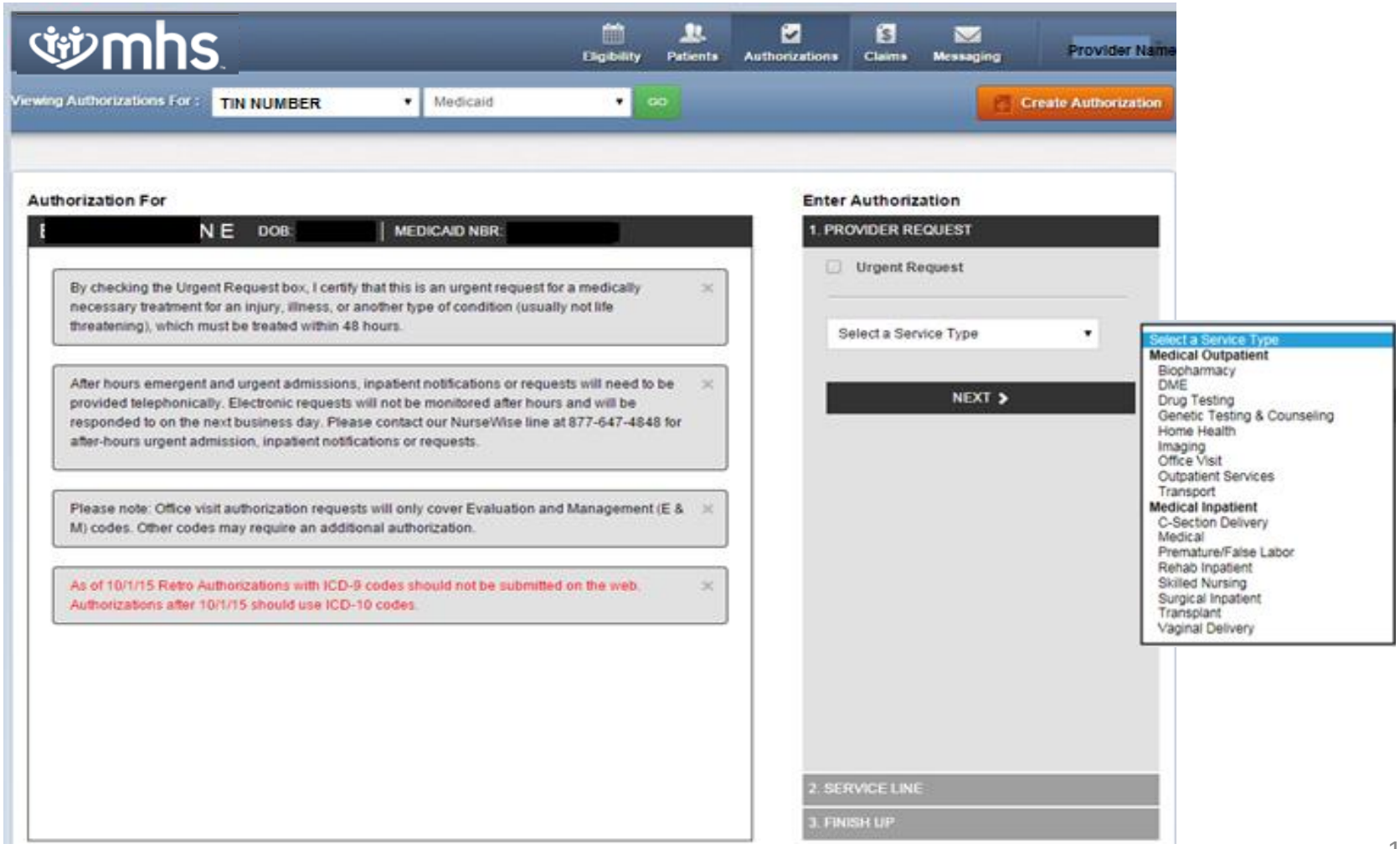
- Click **Create Authorization**
- Enter **Member ID** or **Last Name** and **Birthdate**





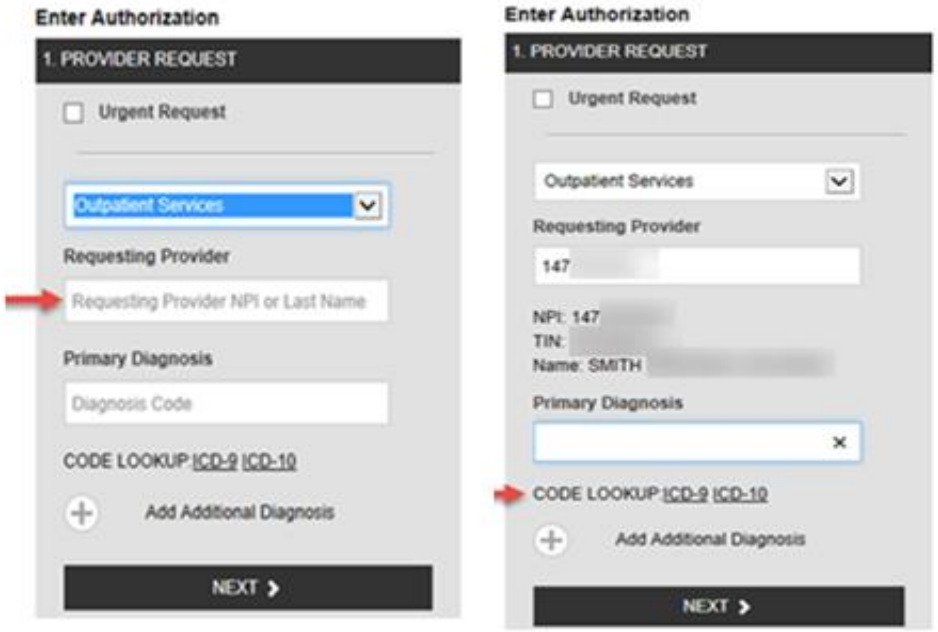
Creating a New Authorization

- Select a **Service Type**



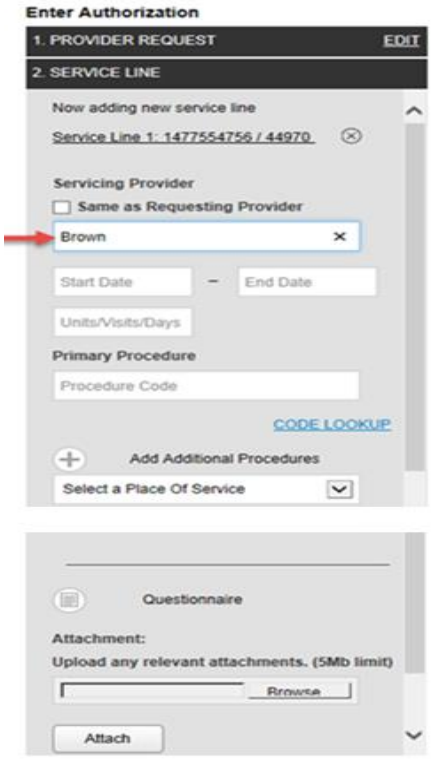
Creating a New Authorization

Select Provider NPI Add Primary Diagnosis



Creating a New Authorization

Service Line Details

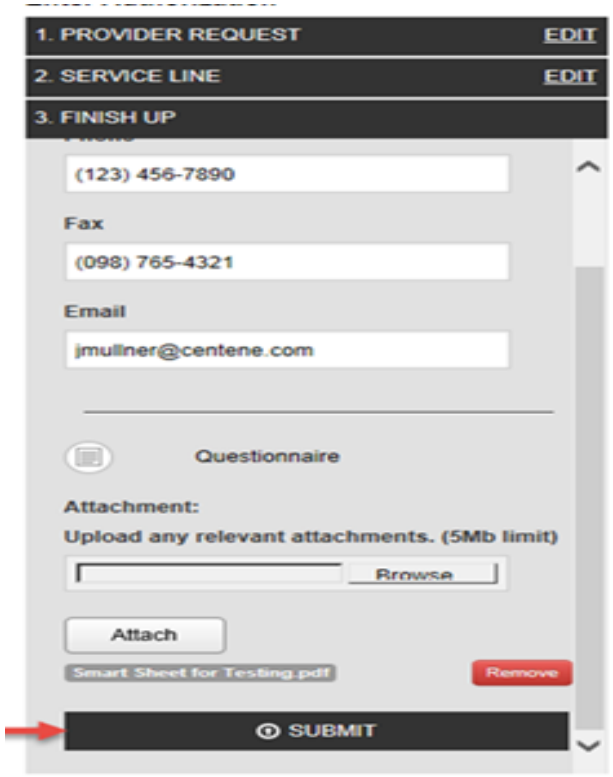


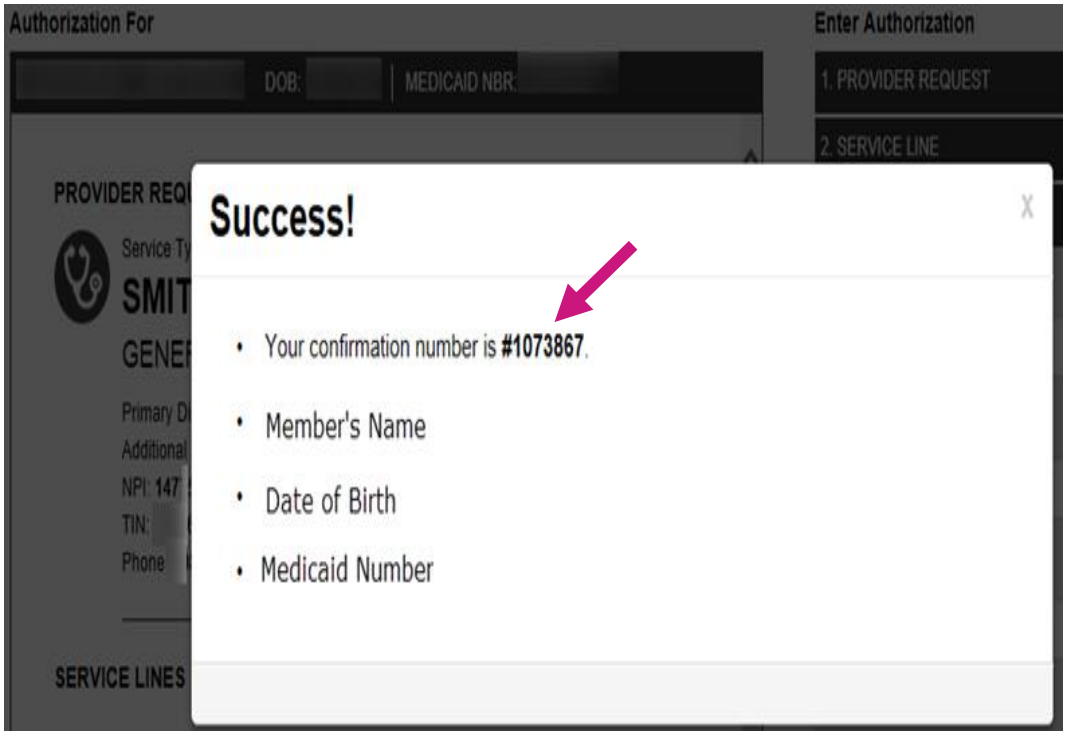
- Provider Request will appear on the left side of the screen
- Update Servicing Provider
  - Check box if same as Requesting Provider
  - Update Servicing Provider information if not the same
- Update Start Date and End Date
- Update Total Units/Visits/Days
- Update Primary Procedure
  - Code lookup 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**

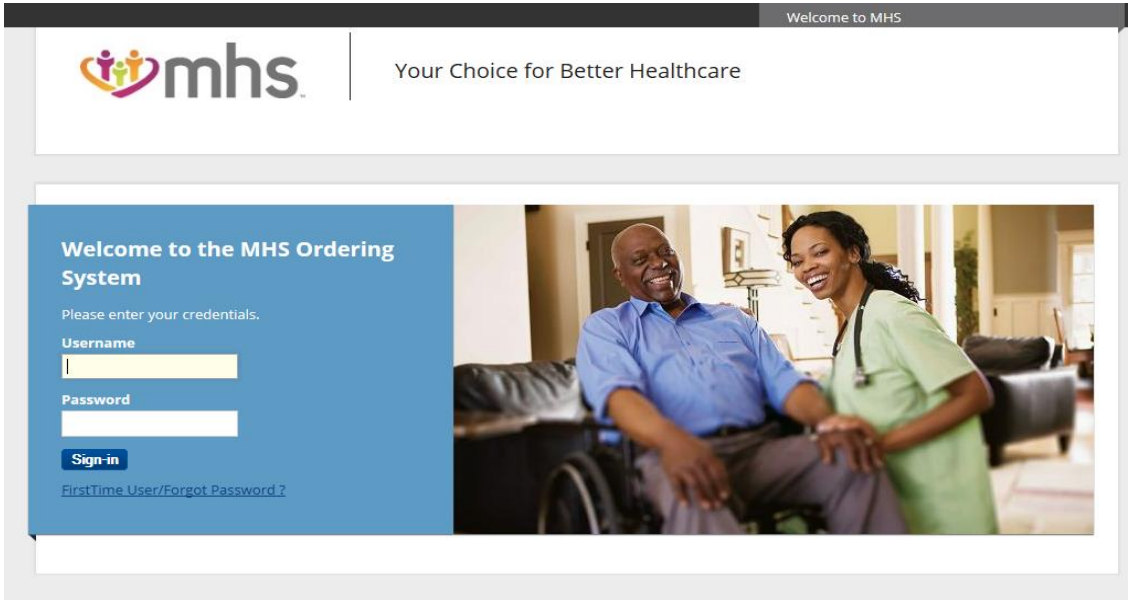
- **Confirmation Number**





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.



Claims

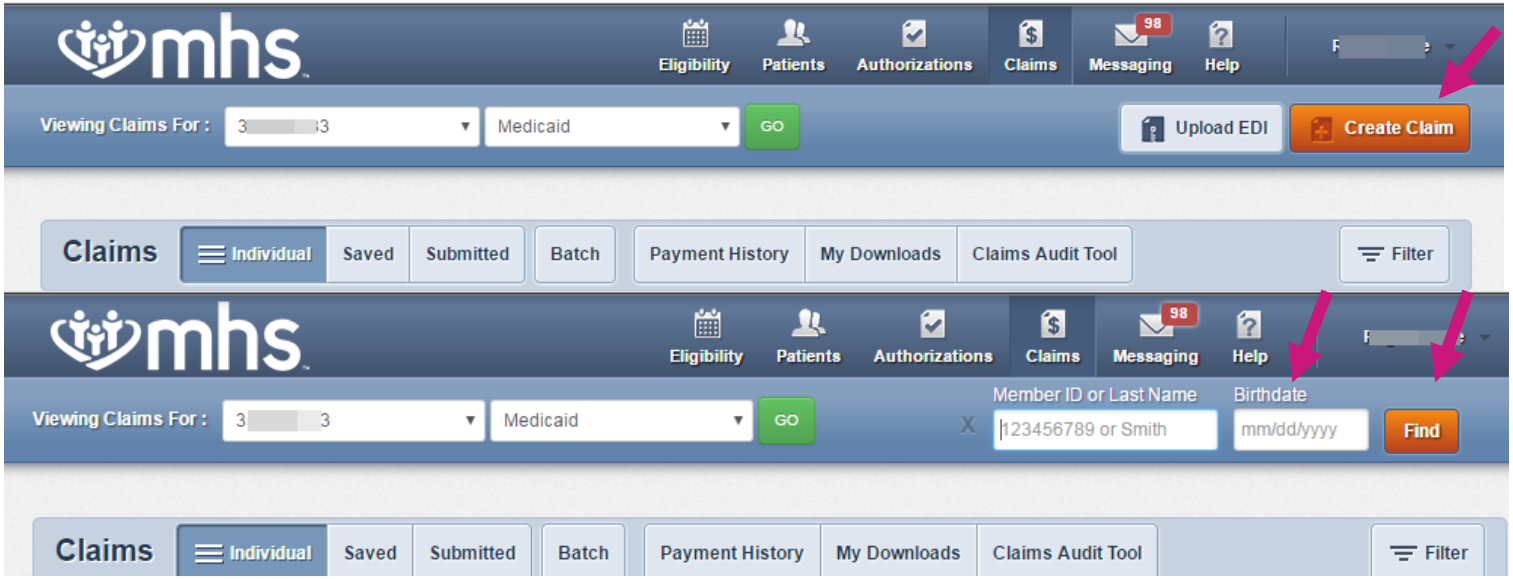
Claims

Web Portal Claims Functionalities

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

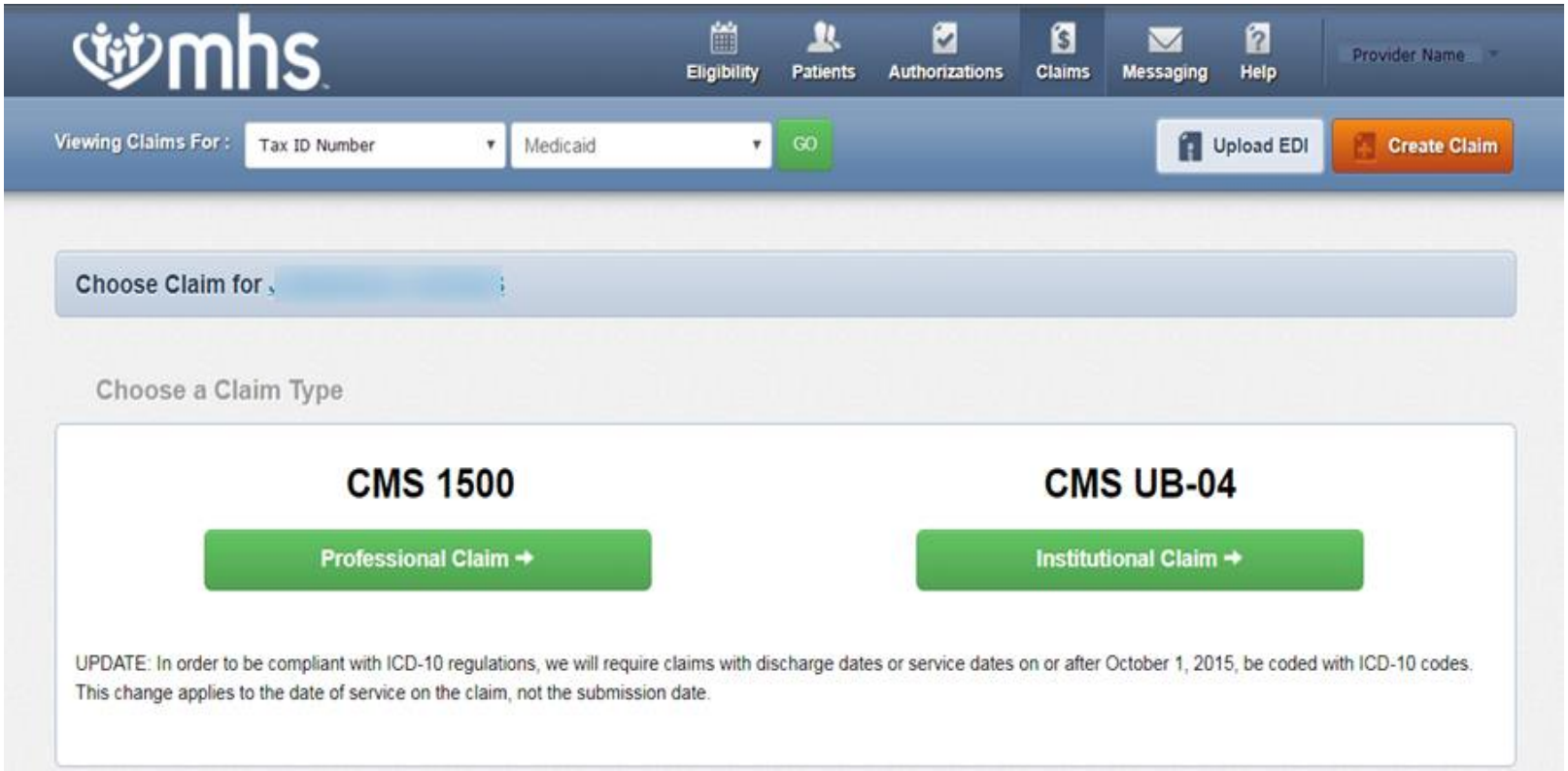
Submit a New Claim

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



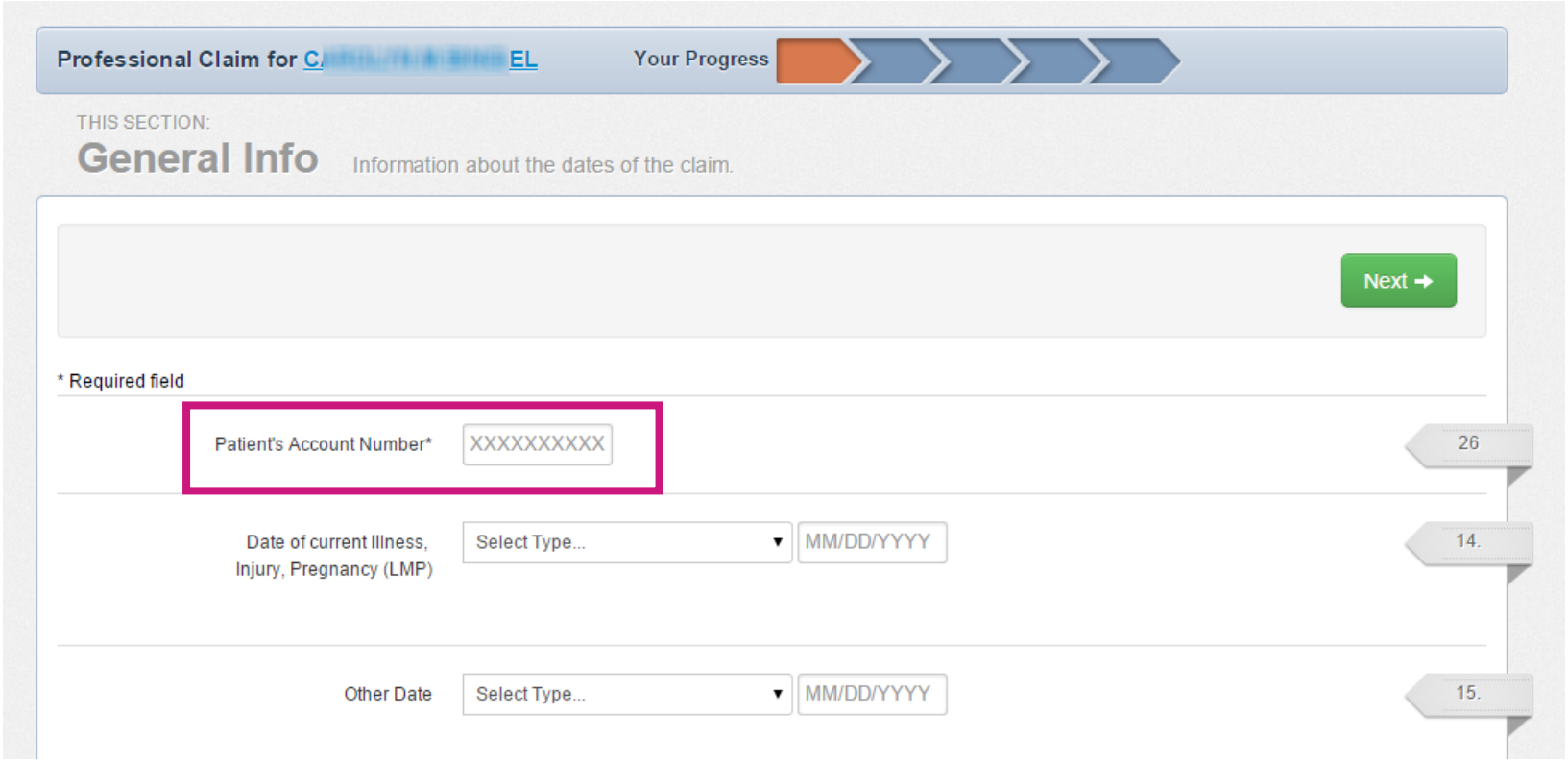
Web Portal Claim Submission

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



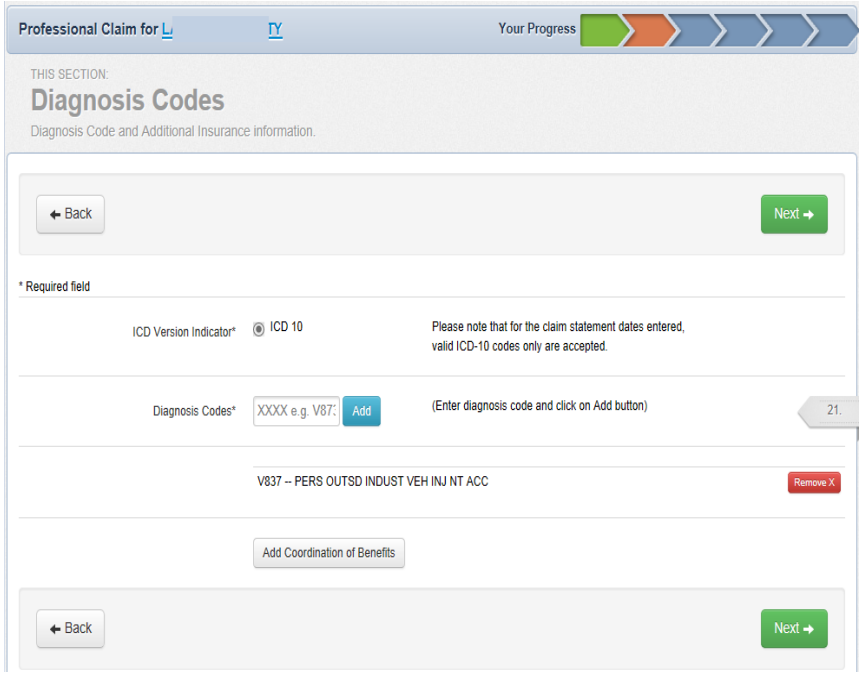
Professional Claim Submission: Step 1

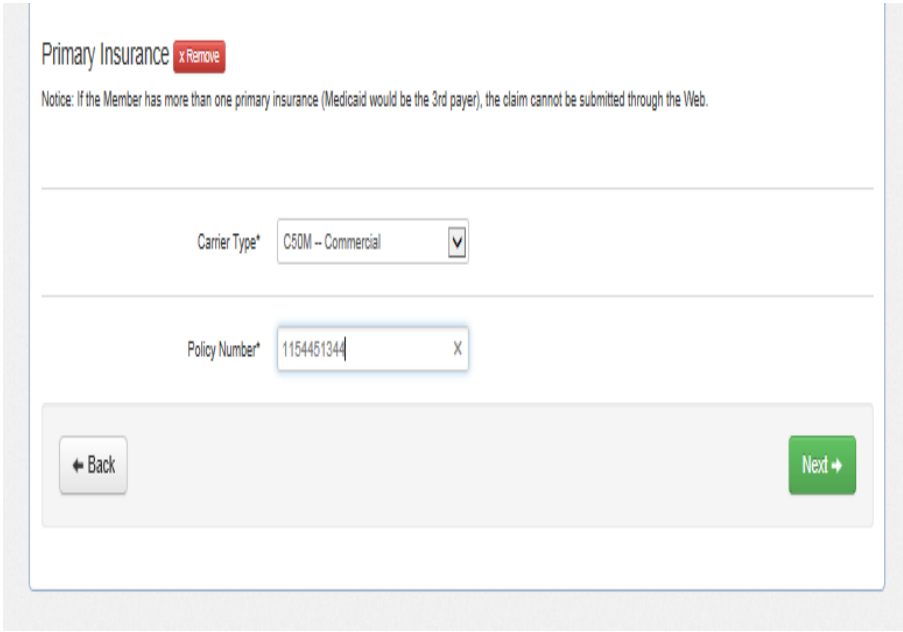
- In the **General Info** section, populate the **Patient's Account Number** and other information related to the patient's condition by typing into the appropriate fields. Click **Next**.



Professional Claim Submission: Step 2

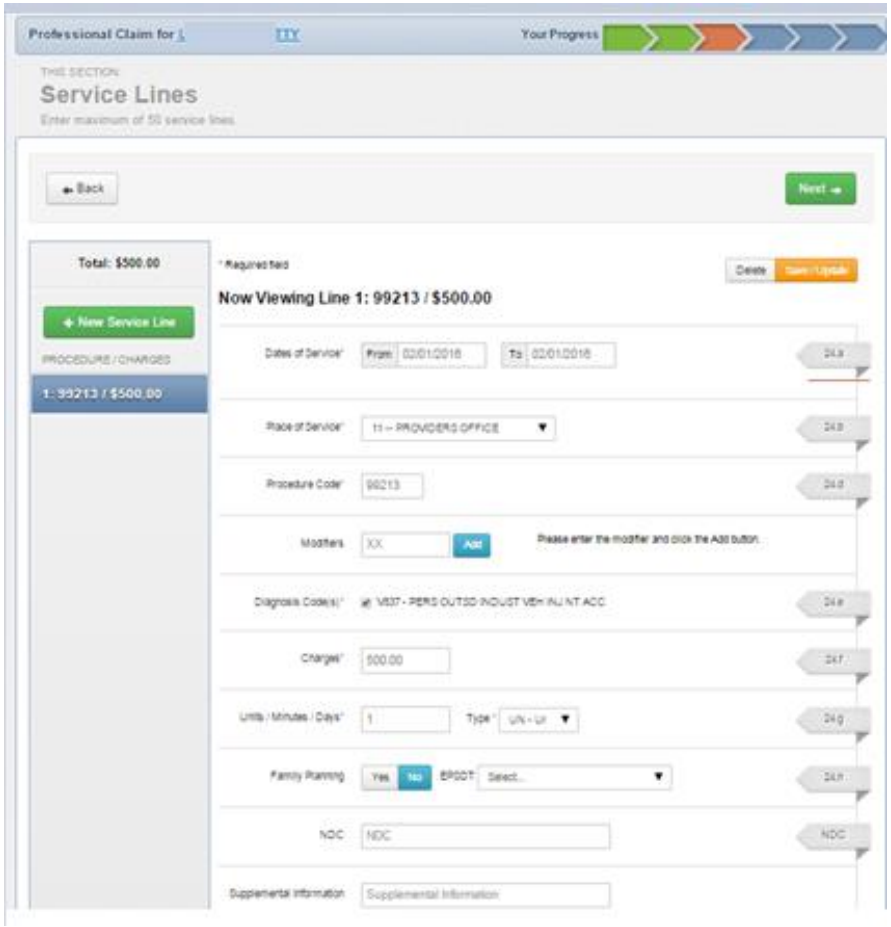
- Add the **Diagnosis Codes** for the patient in Box 21. Click the **Add** button to save.
- Click **Add Coordination of Benefits** to include any payments made by another insurance carrier (if applicable).

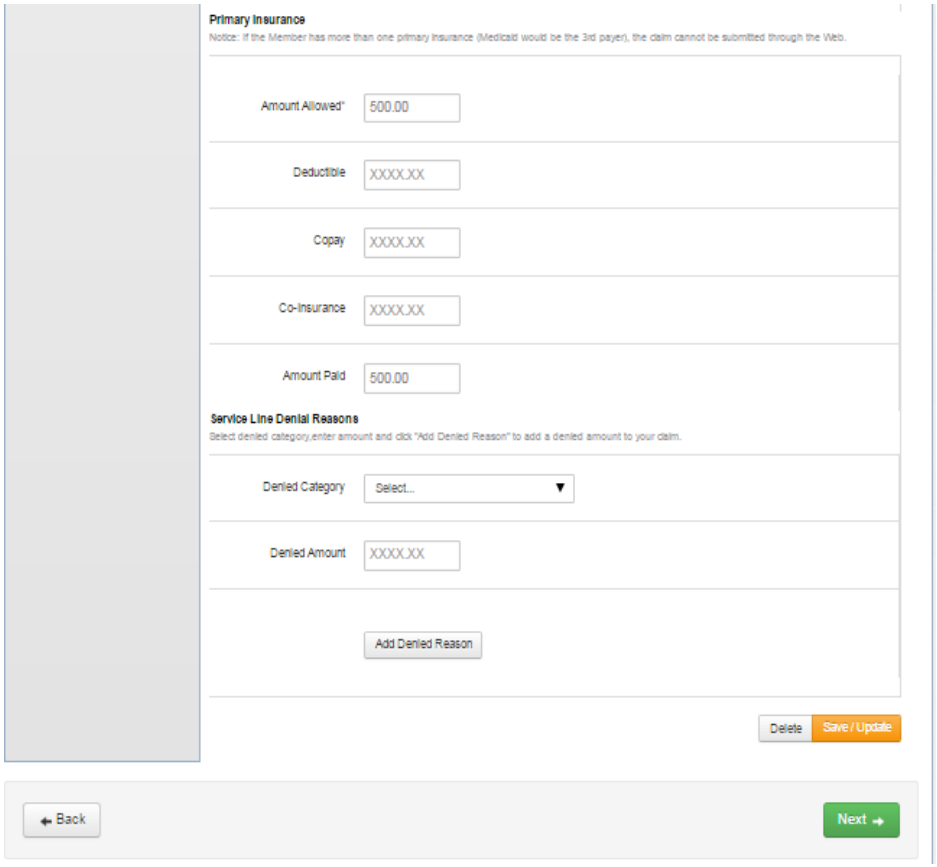




Professional Claim Submission: Step 3

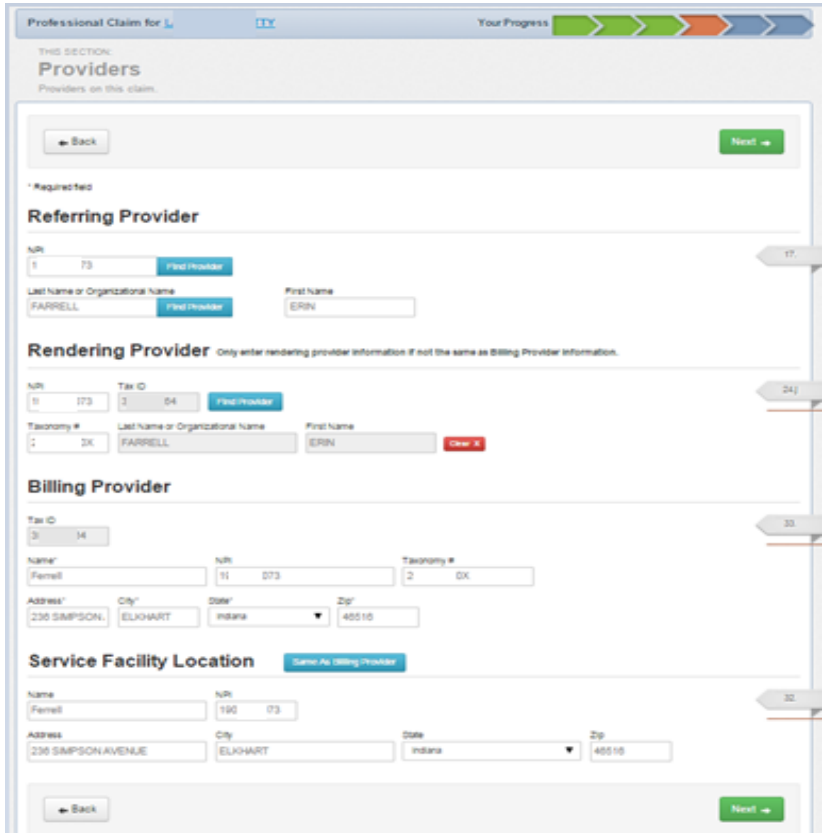
Add **Service Lines**



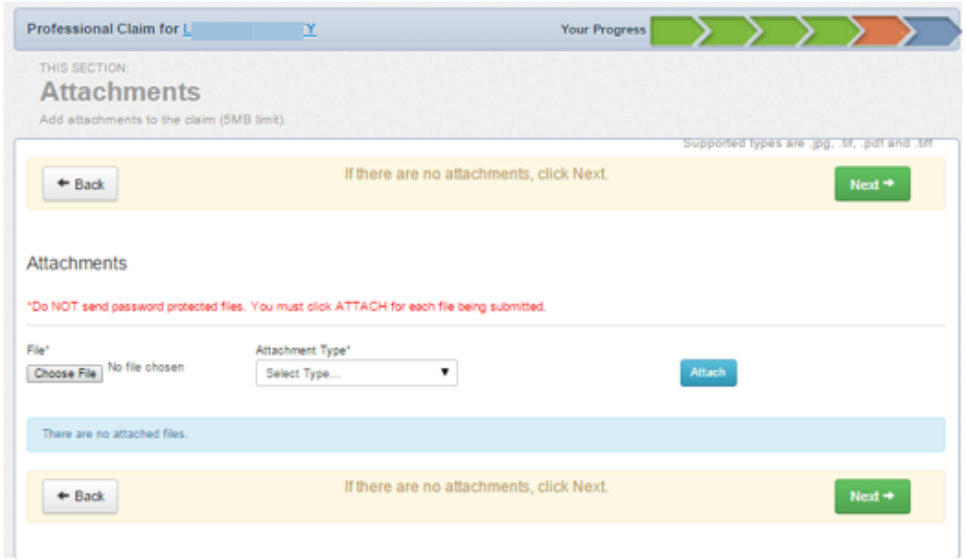


Professional Claim Submission: Step 4 - 5

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

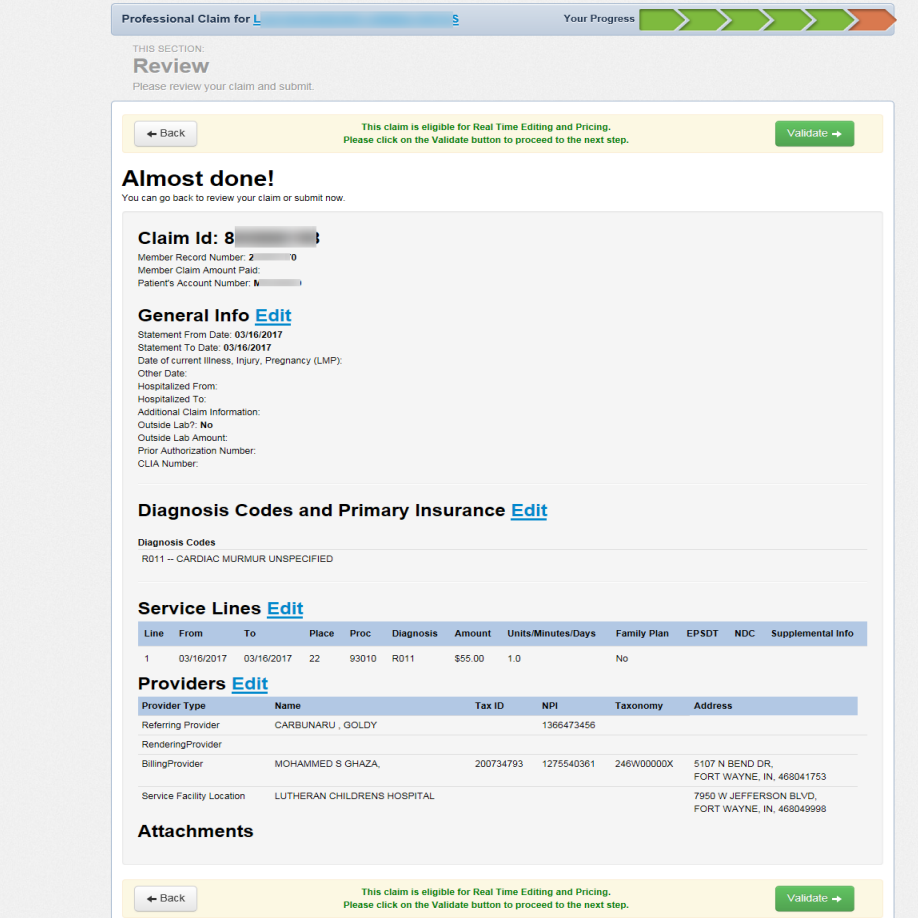


- In the Attachments section you can **Browse** and **Attach** any documents to the claim as desired. (Note: If you have no attachments, skip this section.) Click **Next**.



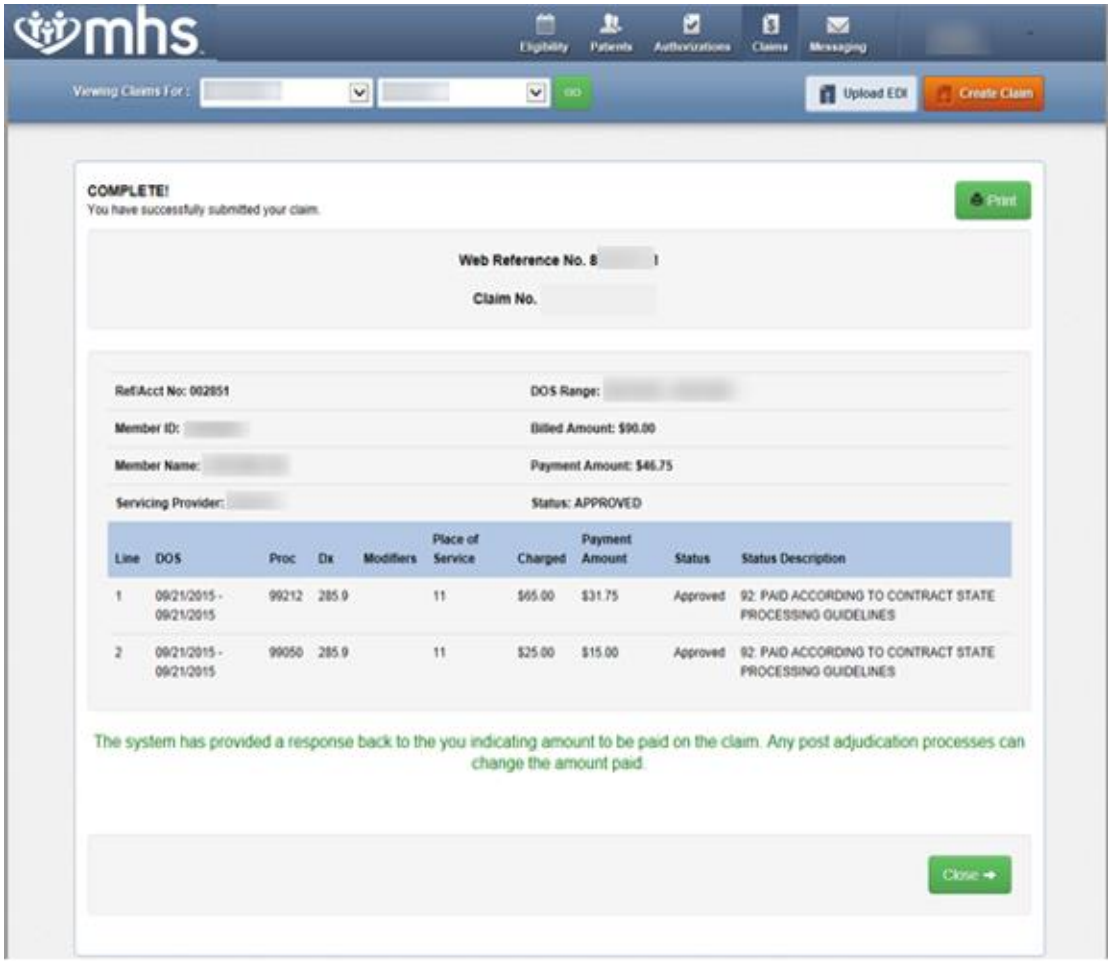
Professional Claim Submission: Step 6

- 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.

RTEP Claim Pricing View

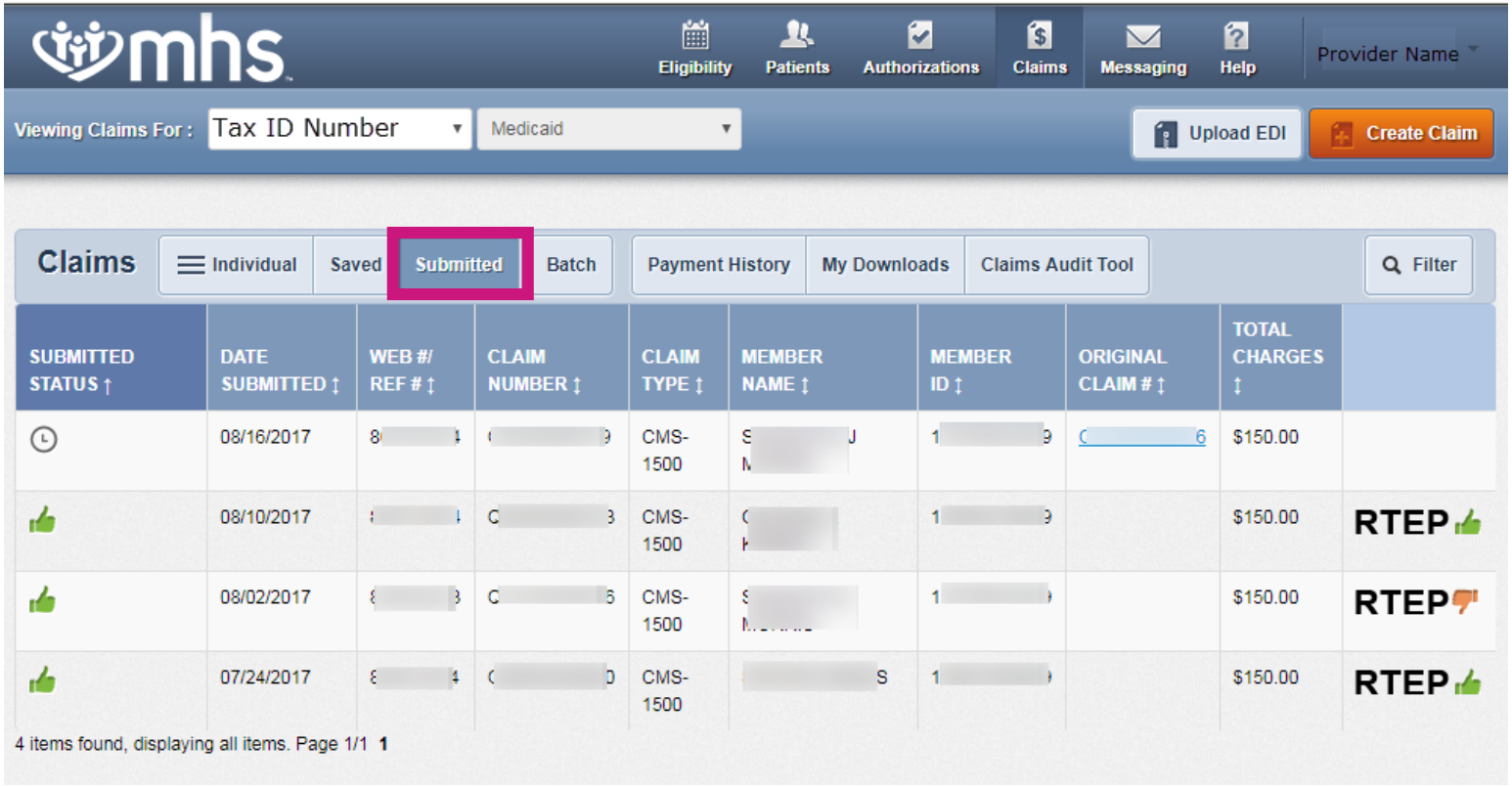


RTEP Overview

- 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.)



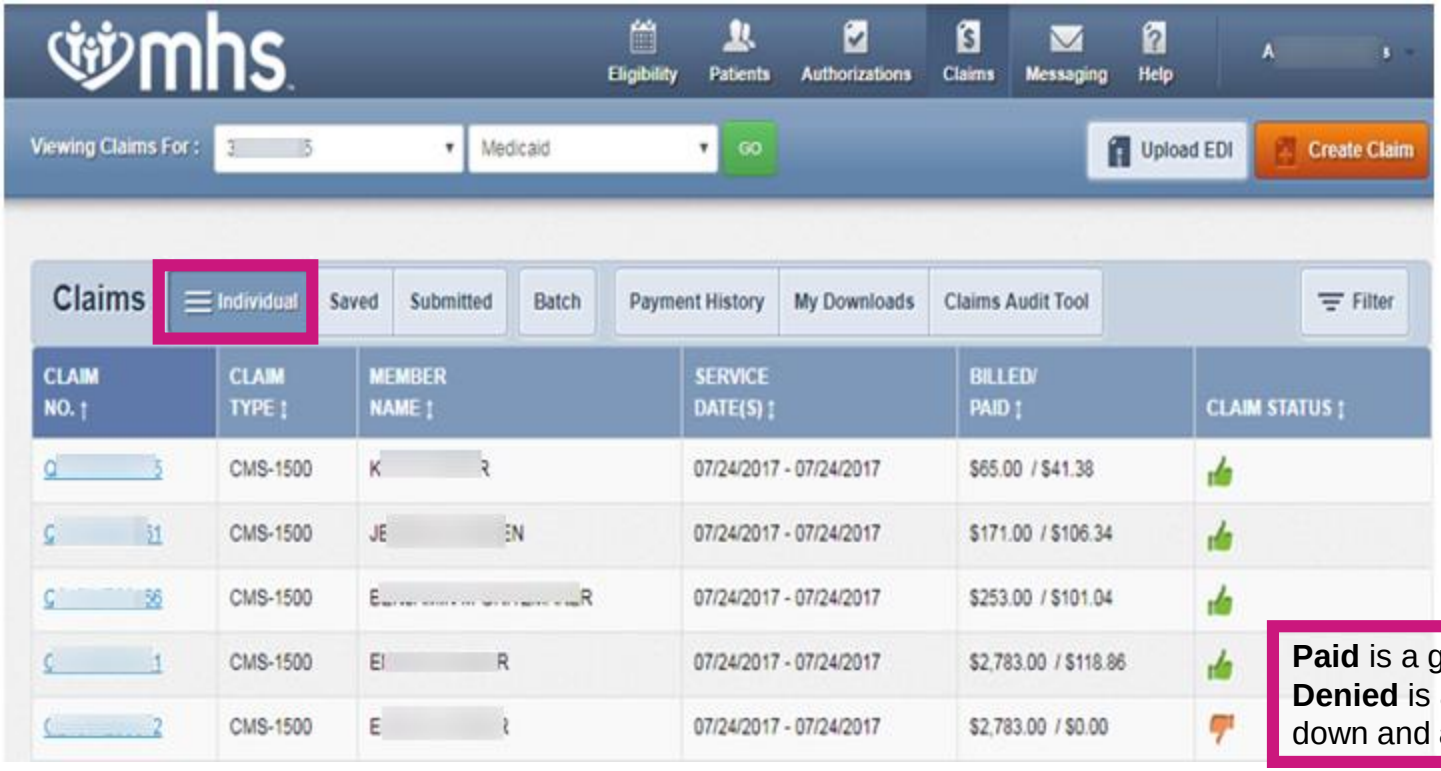
Reviewing Claims

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



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

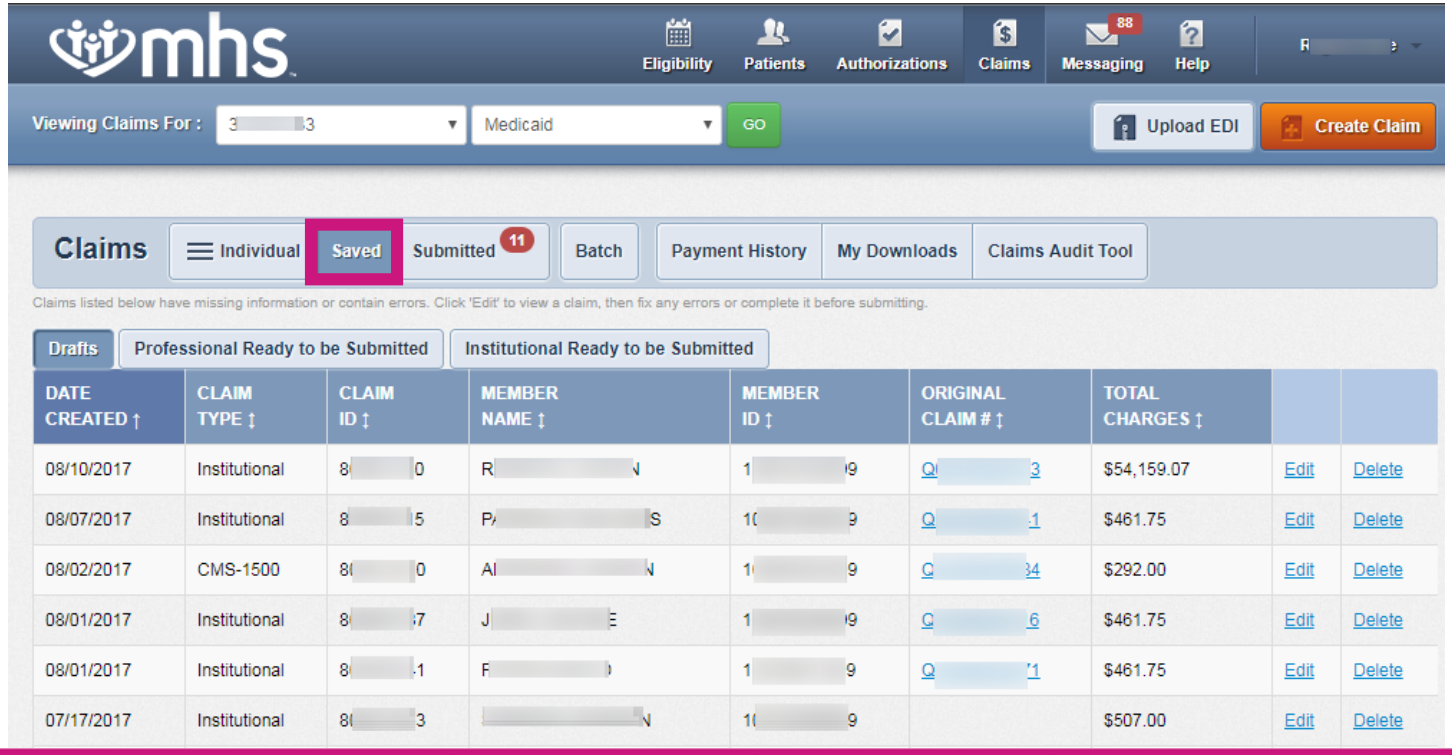
Saved Claims

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



DATE CREATED	CLAIM TYPE	CLAIM ID	MEMBER NAME	MEMBER ID	ORIGINAL CLAIM #	TOTAL CHARGES		
08/10/2017	Institutional	8 0	R N	1 9	Q 3	$54,159.07	Edit	Delete
08/07/2017	Institutional	8 5	P S	1 9	Q 1	$461.75	Edit	Delete
08/02/2017	CMS-1500	8 0	A N	1 9	Q 4	$292.00	Edit	Delete
08/01/2017	Institutional	8 7	J E	1 9	Q 6	$461.75	Edit	Delete
08/01/2017	Institutional	8 1	F	1 9	Q 1	$461.75	Edit	Delete
07/17/2017	Institutional	8 3	N	1 9		$507.00	Edit	Delete

Correcting Claims

- After clicking on a **Claim #** link

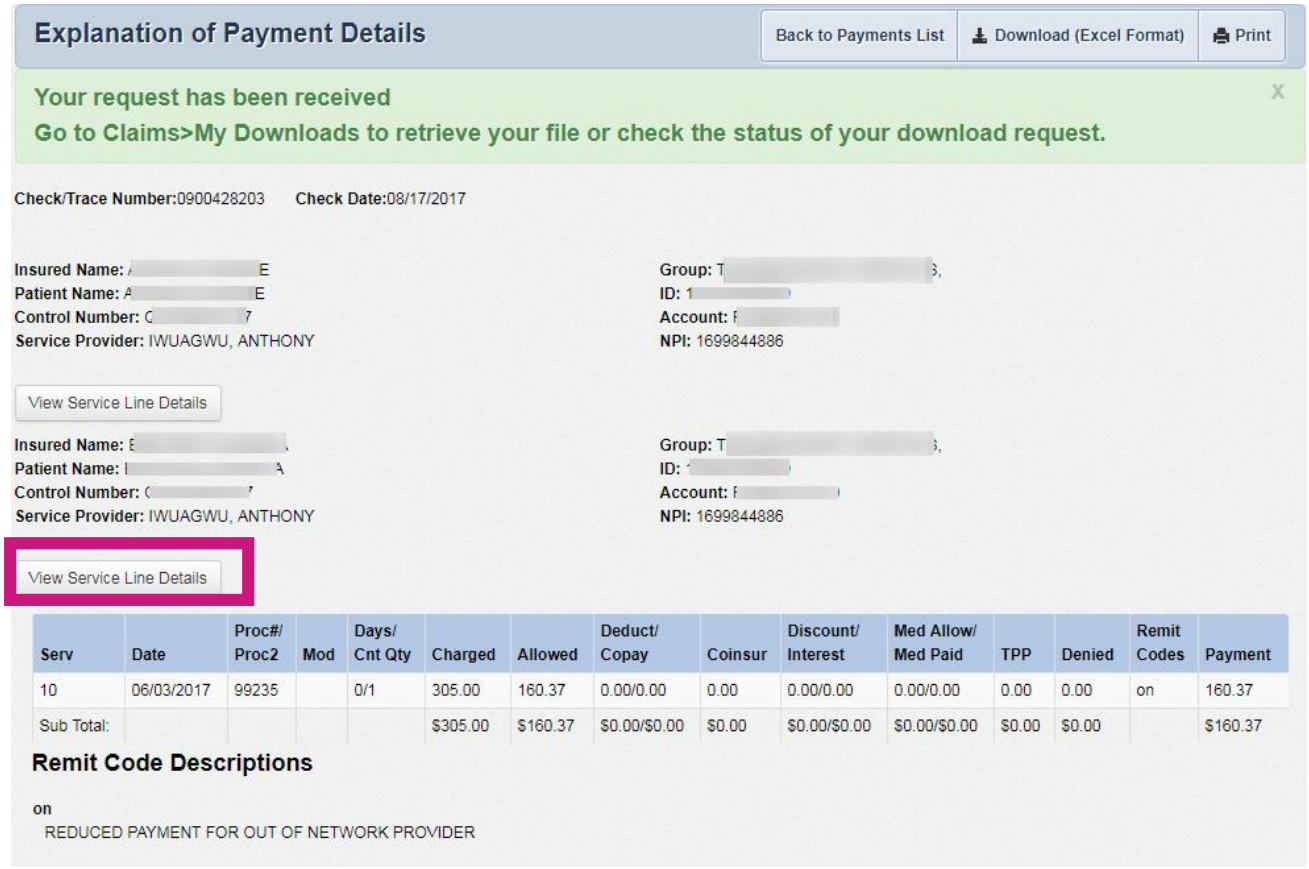
1. Click **Correct Claim**
2. Proceed through the claims screens correcting the information that you may have omitted when the claim was originally submitted.
3. Continue clicking **Next** to move through the screens required to resubmit.
4. Review the claim information
5. Click **Submit**.

- 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: [redacted]E
Patient Name: [redacted]E
Control Number: [redacted]7
Service Provider: IWUAGWU, ANTHONY

Group: T[redacted]S,
ID: 1[redacted]
Account: F[redacted]
NPI: 1699844886

View Service Line Details

Insured Name: E[redacted].
Patient Name: I[redacted]A
Control Number: C[redacted]7
Service Provider: IWUAGWU, ANTHONY

Group: T[redacted]S,
ID: [redacted]
Account: F[redacted]
NPI: 1699844886

View Service Line Details

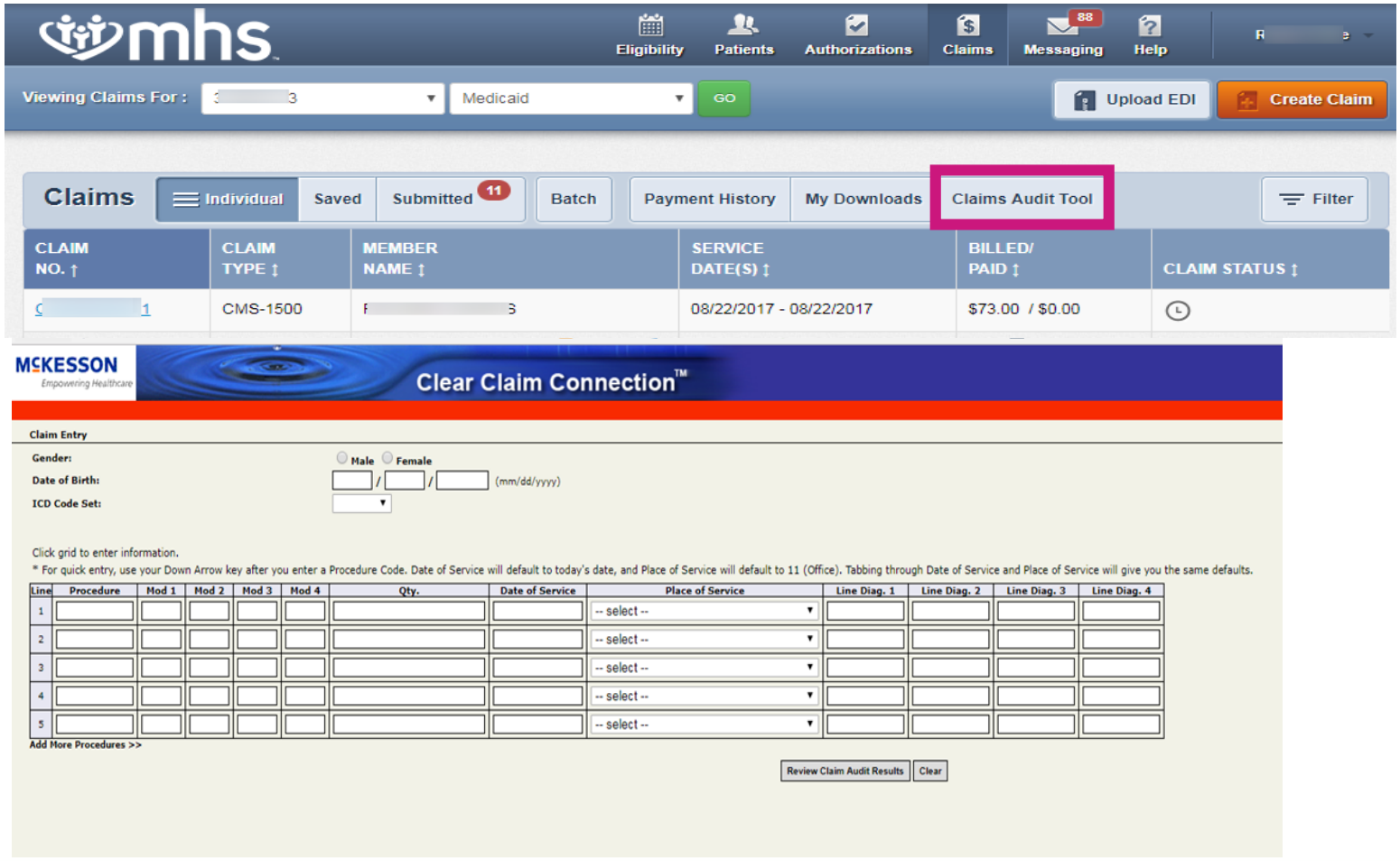
Serv	Date	Proc#/ Proc2	Mod	Days/ Cnt Qty	Charged	Allowed	Deduct/ Copay	Coinsur	Discount/ Interest	Med Allow/ Med Paid	TPP	Denied	Remit Codes	Payment
10	06/03/2017	99235		0/1	305.00	160.37	0.00/0.00	0.00	0.00/0.00	0.00/0.00	0.00	0.00	on	160.37
Sub Total:					$305.00	$160.37	$0.00/$0.00	$0.00	$0.00/$0.00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

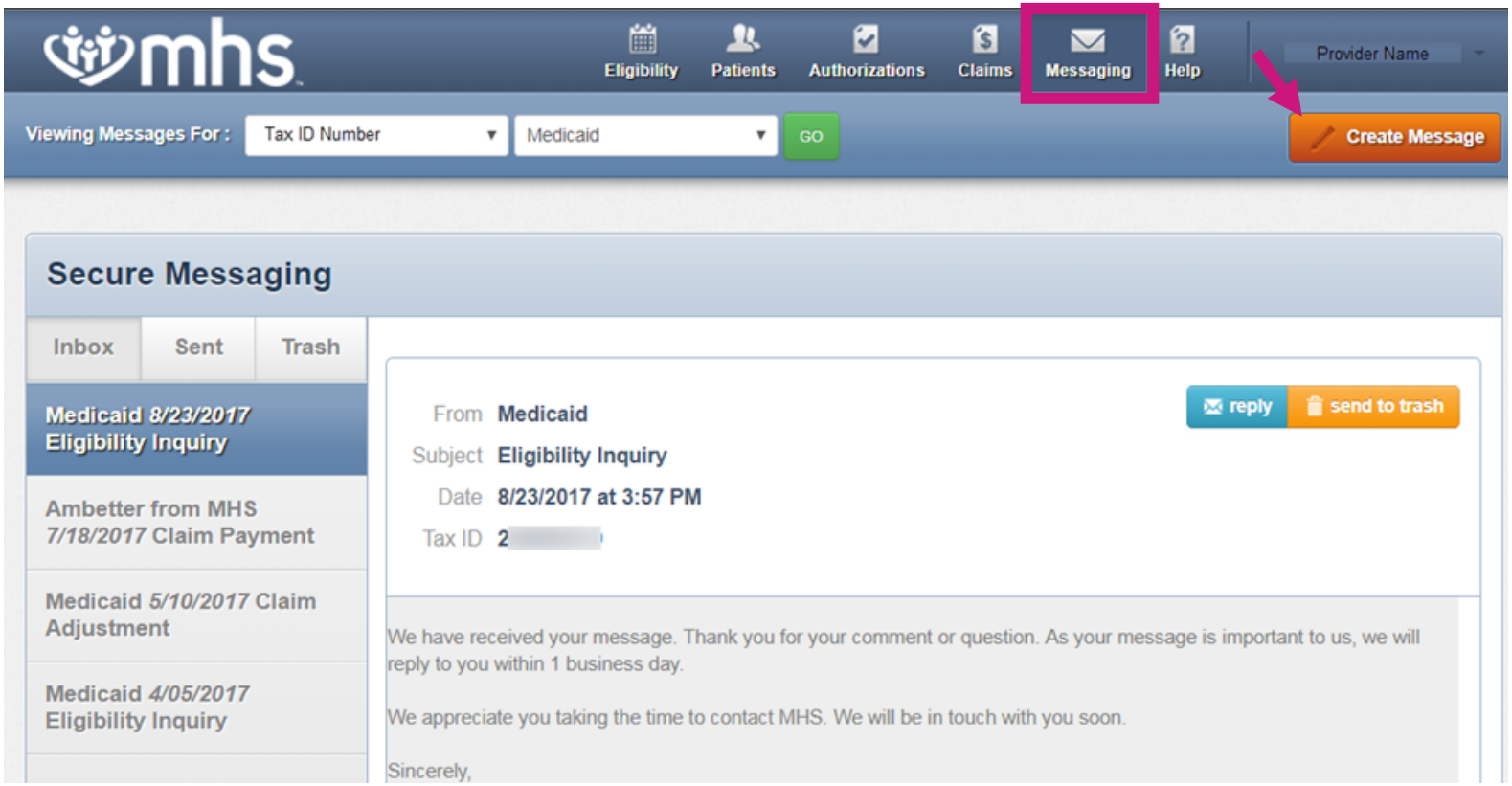


Secure Messaging

Secure Messaging

Create a New Secure Message

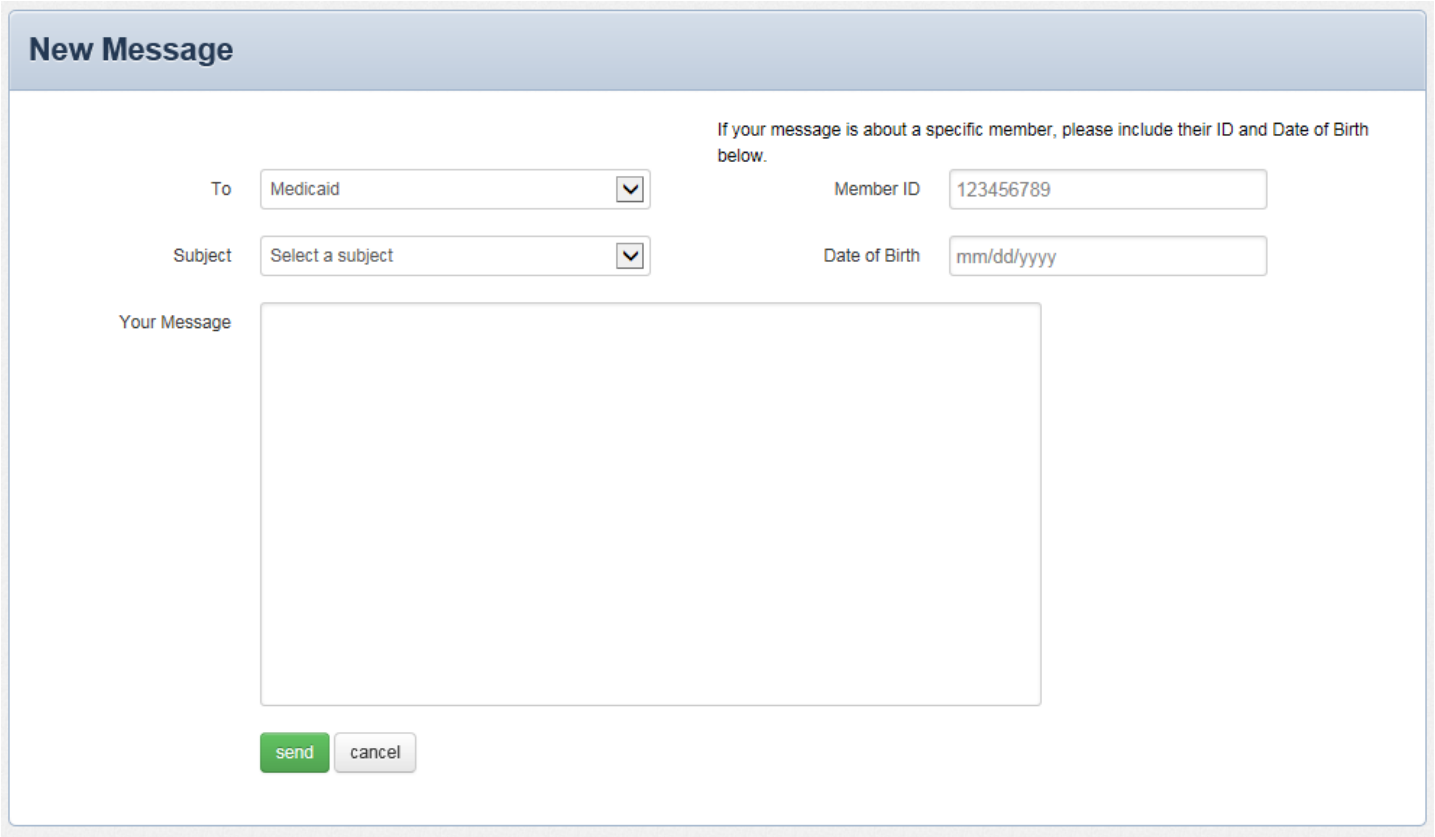
- Click **Messaging** tab from the Dashboard.
- Click **Create Message**



Secure Messaging

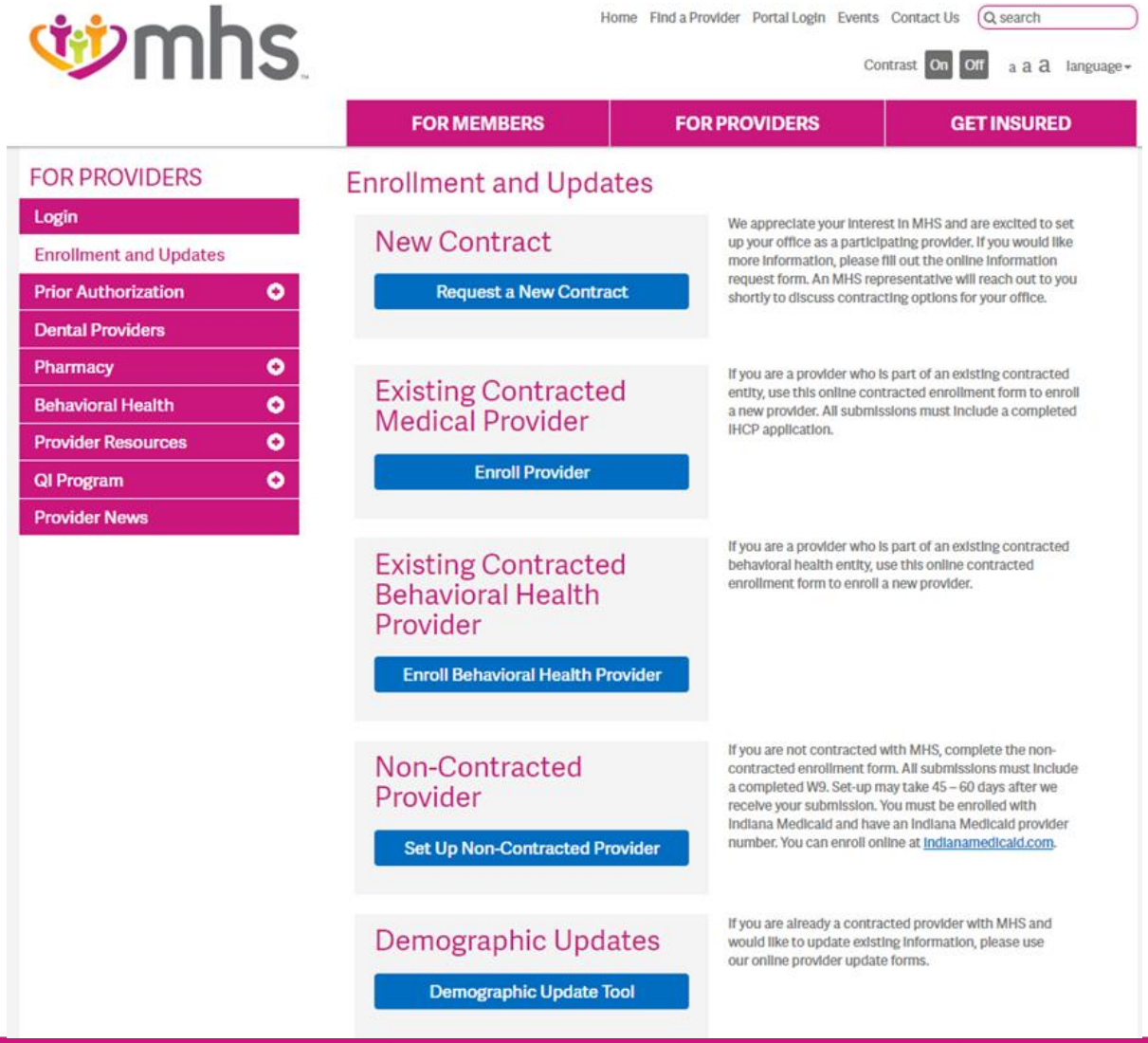
Contents of a Secure Message

- 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.



MHS Website

Provider Enrollment



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).

Choose File No file chosen

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

Choose File No file chosen

Comments

Provider Enrollment

Enrollment Requested By:

*First Name **

*Last Name **

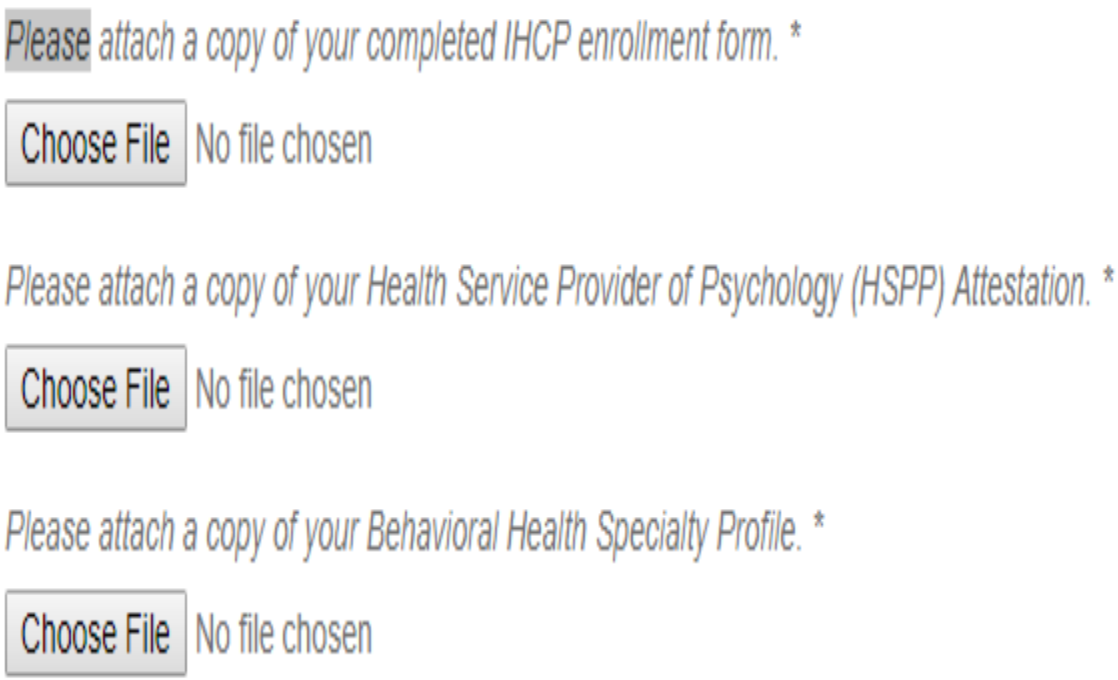
*Date **

*Contact Email **

*Contact Phone **

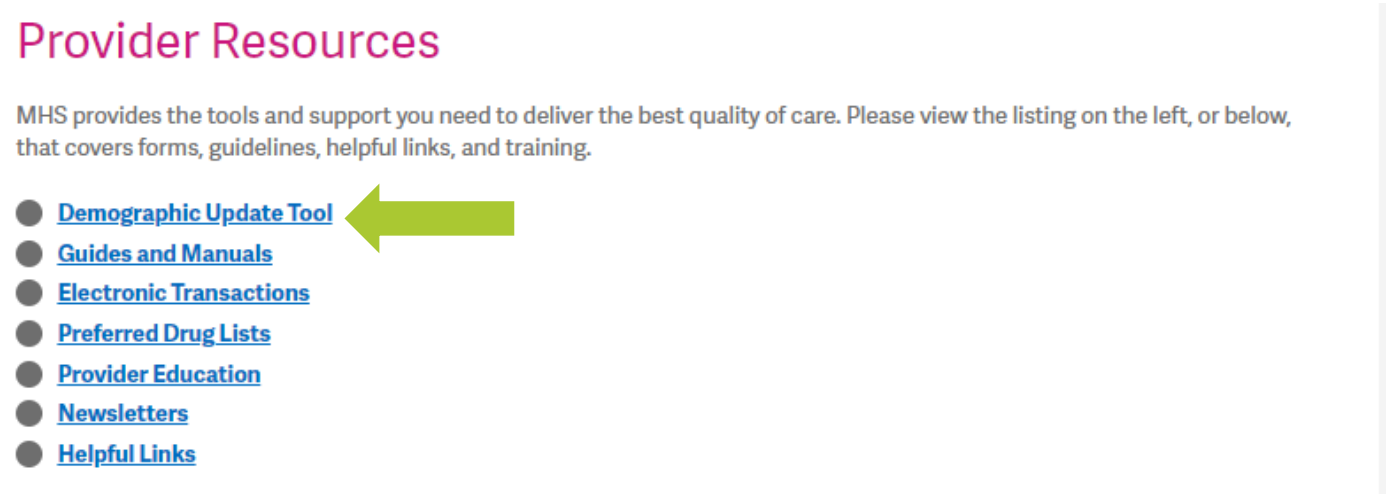
Submit

MHS Behavioral Health Provider Enrollment



Demographic Updates

Provider Demographic Updates



- 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**
  - Cenpatico 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
- Cenpatico 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
Caparo	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:
  Cenpatico, 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 authorizaton)
- 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 primar

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.

Envolve Dental

Envolve Dental

All dental paper claims should be billed to:

Envolve Dental Claims: IN
P.O. Box 20847
Tampa FL 33622-0847

For questions please contact:

- Envolve Dental Provider Services at **1-855-609-5157**
- **Candy Ervin**, Envolve Dental Indiana Provider Relations Specialist Market Manager, at Candace.Ervin@envolvehealth.com

Envolve Dental

- **Envolve 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

Provider Network Territories

Physical Health

PROVIDER NETWORK TERRITORIES

TAWANNA DANZIE
Provider Performance Associate
1-877-647-4848 ext. 20022
tdanzie@mhsindiana.com
Exception to map: Franciscan Alliance

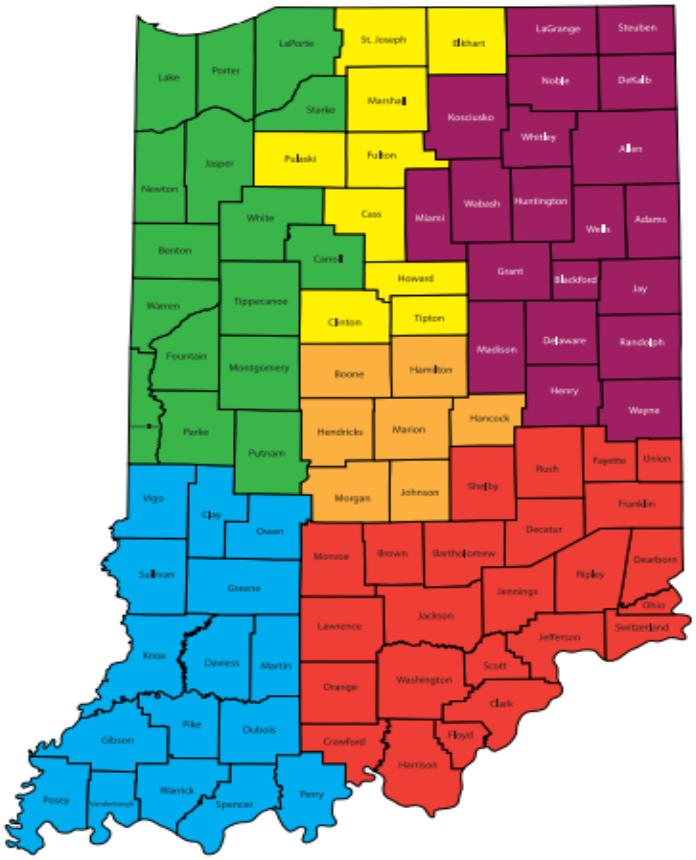
CHAD PRATT
Provider Performance Associate
1-877-647-4848 ext. 20454
ripratt@mhsindiana.com

TANEYA WAGAMAN
Provider Performance Associate
1-877-647-4848 ext. 20202
twagaman@mhsindiana.com

KAT GIBSON
Provider Performance Associate
1-877-647-4848 ext. 20959
kagibson@mhsindiana.com

ESTHER CERVANTES
Provider Performance Associate
1-877-647-4848 ext. 20947
escervantes@mhsindiana.com

JENNIFER GARNER
Provider Performance Associate
1-877-647-4848 ext. 20149
jgarner@mhsindiana.com
Exception to map: IU Health, Eskenazi Health



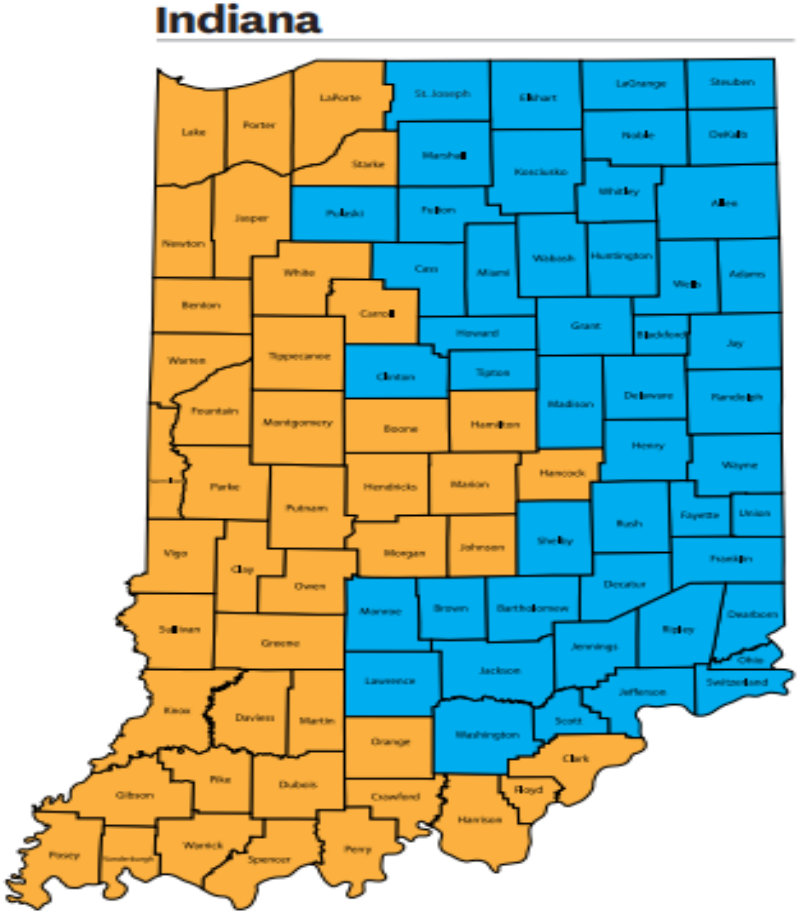
Behavioral Health Provider Network Territories

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	Envolve 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**
- **Envolve Dental**
- **MHS contacts**

Questions?

Thank you for being our partner in care.