

MHS Breakfast Learning Session 2018



Agenda

-  MHS Overview
-  Prior Authorization Process
-  Web Portal Functionality
-  Public Website
-  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.

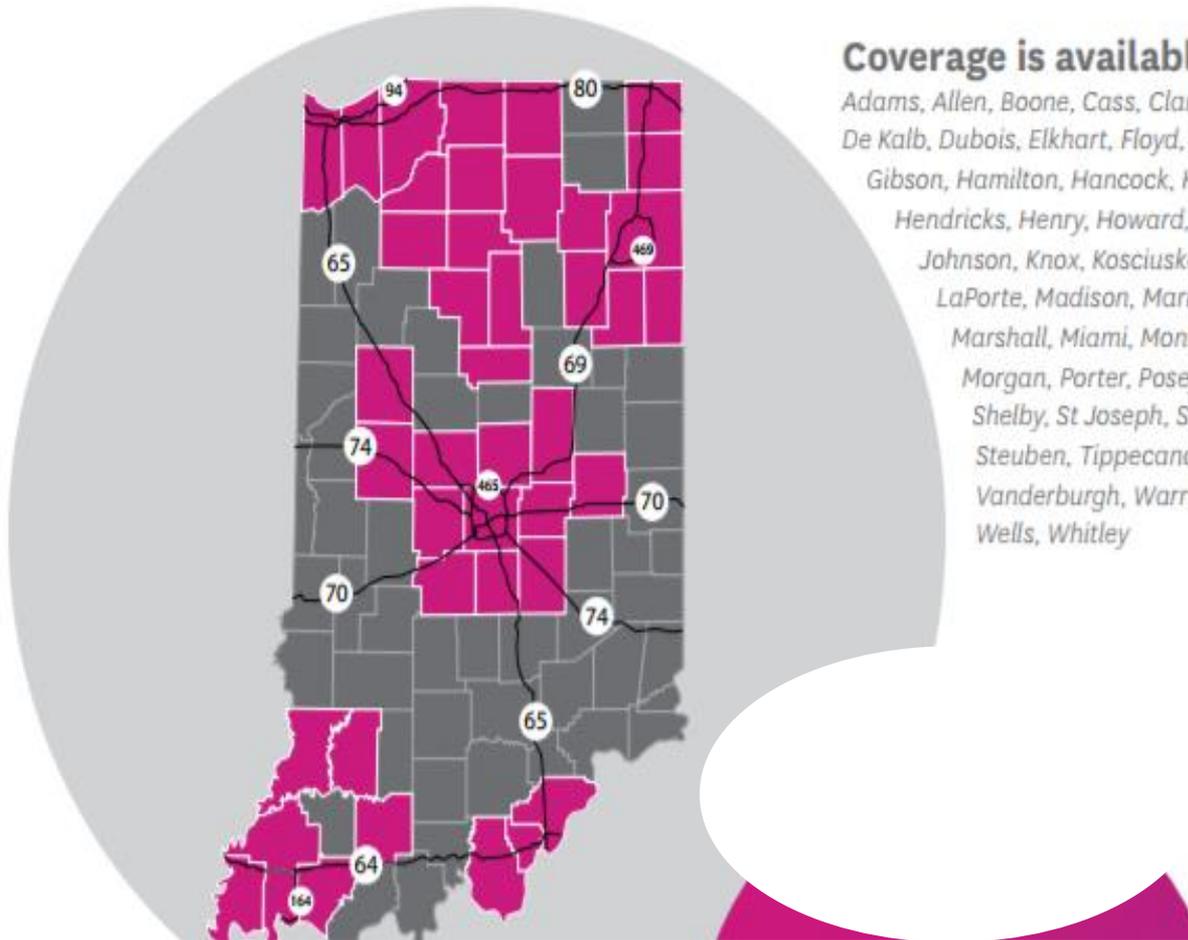
MHS also offers **Ambetter from MHS** in the Indiana health insurance marketplace, and **Allwell from MHS**, a Medicare Advantage plan. All of our plans include quality, comprehensive coverage with a provider network you can trust.

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



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](https://www.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 "XRAMES 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.

0318.PR.P.FL 1/18

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

C
Conditional

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.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	

*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 Authorization

-  Providers can submit **Prior Authorizations** online via the MHS Secure Provider Portal at mhsindiana.com/login
 - 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**



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



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 Training Documents



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.

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

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

Registration Complete!
Your Progress: [Progress Bar]

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.
🟡	08/19/2017	(4
🟡	08/19/2017	T	3
🟡	08/19/2017	E	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!



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**



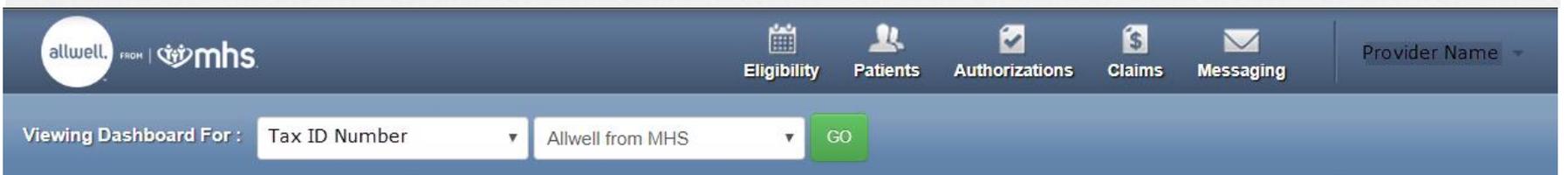
Viewing Dashboard For : Tax ID Number Medicaid GO

Eligibility Patients Authorizations Claims Messaging Help Provider Name



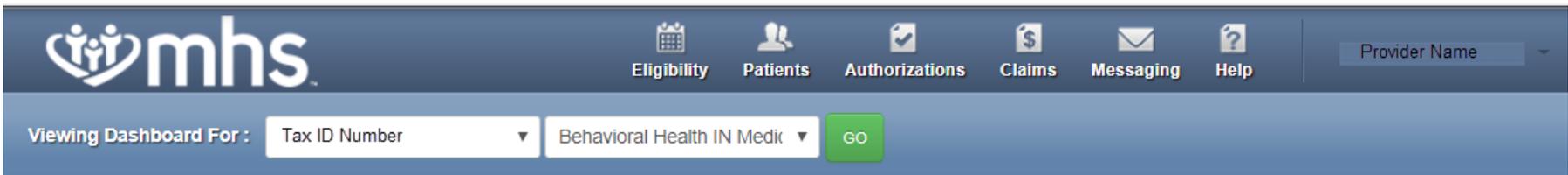
Viewing Dashboard For : Tax ID Number Ambetter from MHS GO

Eligibility Patients Authorizations Claims Messaging Help 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

Eligibility Patients Authorizations Claims Messaging Help Provider Name

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]
	06/29/2018	S [redacted]	[redacted]
	06/29/2018	I [redacted]	[redacted]
	06/29/2018	S [redacted]	[redacted]
	06/29/2018	J [redacted]	[redacted]

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

Homepage –Ambetter from MHS

The screenshot shows the Ambetter from MHS homepage. At the top, there 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, a 'Viewing Dashboard For:' section includes a 'Tax ID Number' dropdown, a 'Ambetter from MHS' dropdown, and a 'GO' button. A red-bordered 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 'Check Eligibility' button. To the right of the note is a 'Welcome' sidebar with a list of quick links: 'Add a TIN to My ACCOUNT', 'Manage Accounts', 'Patient Analytics', and 'Provider Analytics'. Below the quick links is a 'Recent Activity' section with columns for 'Date' and 'Activity'. At the bottom of the sidebar is a 'Go Paperless' section with the text '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.' and a 'PaySpan Site' button. The main content area below the note is titled 'Recent Claims' and contains a table with columns for STATUS, RECEIVED DATE, MEMBER NAME, and CLAIM NO. The table lists five claims, all with a received date of 06/29/2018.

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

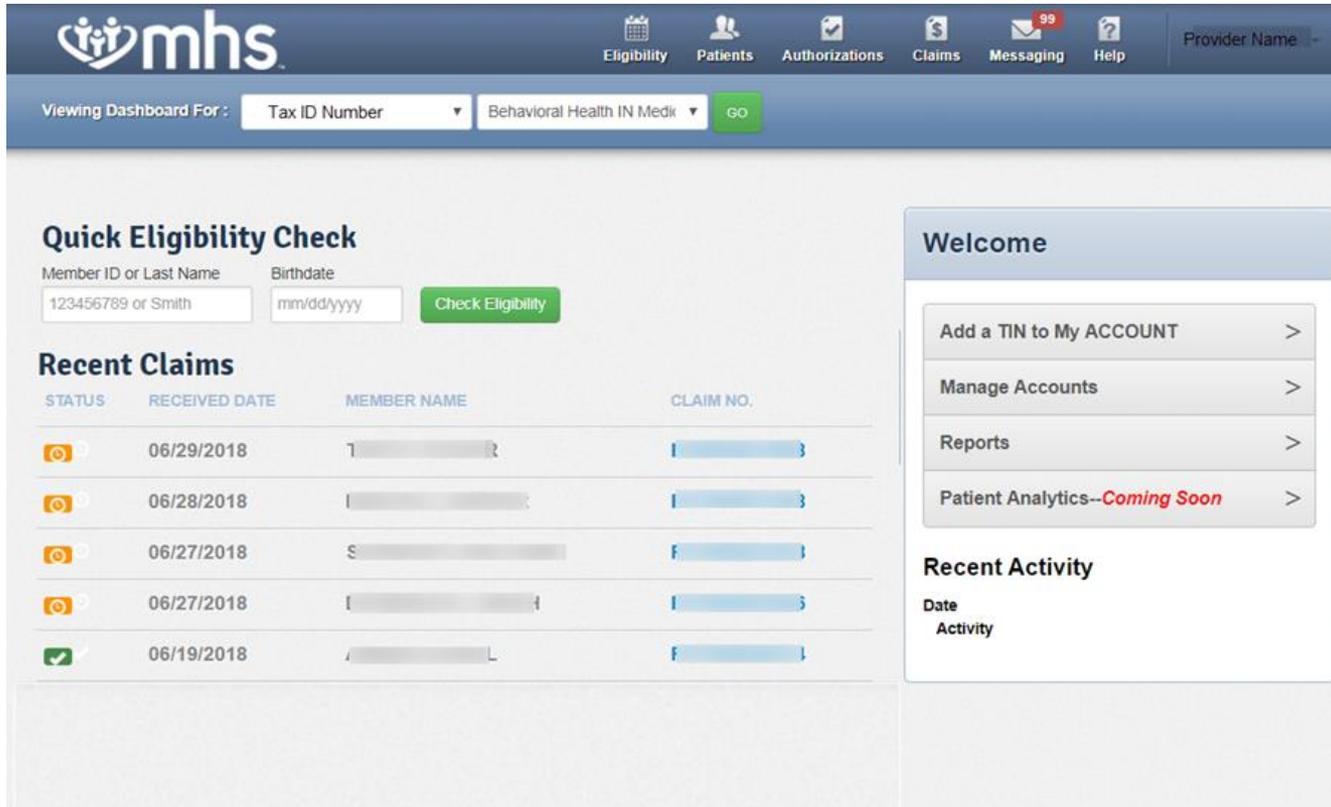
STATUS	RECEIVED DATE	MEMBER NAME	CLAIM NO.
	06/29/2018	L [redacted]	[redacted]
	06/29/2018	II [redacted]	[redacted]
	06/29/2018	E [redacted]	[redacted]
	06/29/2018	C [redacted]	[redacted]
	06/29/2018	H [redacted]	[redacted]

Quick Links:

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

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

Homepage –Behavioral Health IN Medicaid



The screenshot shows the MHS Behavioral Health IN Medicaid homepage. At the top, there is a navigation bar with icons for Eligibility, Patients, Authorizations, Claims, Messaging (with a notification badge of 99), and Help. A 'Provider Name' dropdown is also present. Below the navigation bar, there is a 'Viewing Dashboard For:' section with a 'Tax ID Number' dropdown, a 'Behavioral Health IN Medi' dropdown, and a 'GO' button. The main content area is divided into two columns. The left column features 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' table with columns for STATUS, RECEIVED DATE, MEMBER NAME, and CLAIM NO. The right column features a 'Welcome' section with a list of quick links: 'Add a TIN to My ACCOUNT', 'Manage Accounts', 'Reports', and 'Patient Analytics--Coming Soon'. Below the quick links is a 'Recent Activity' section with columns for Date and Activity.

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]

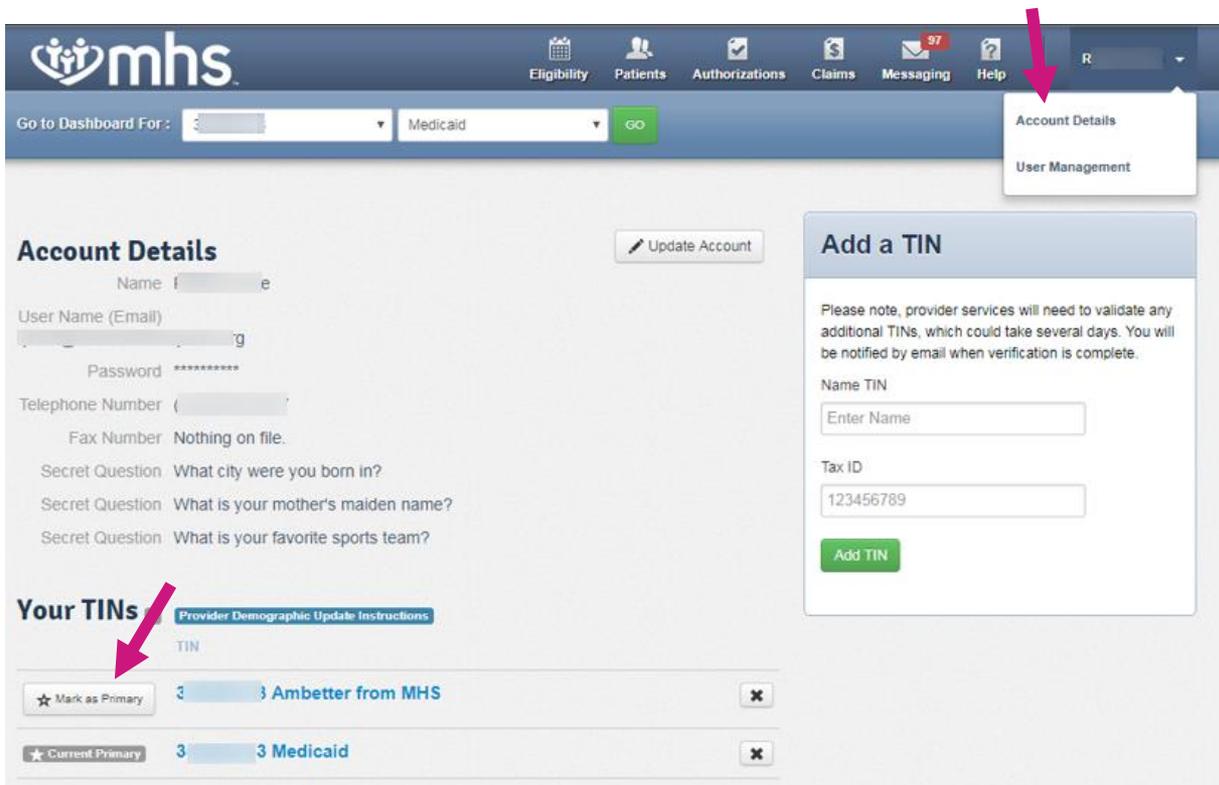
-  **Quick Links:**
- Eligibility Check
 - Add a TIN
 - Account Manager

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 displays the mhs user interface. At the top, there is a navigation bar with icons for Eligibility, Patients, Authorizations, Claims, Messaging, and Help. A dropdown menu is open next to the user name 'R', showing 'Account Details' and 'User Management'. Below the navigation bar, there is a 'Go to Dashboard For:' section with a dropdown menu set to 'Medicaid' and a 'GO' button. The main content area is divided into two sections: 'Account Details' and 'Add a TIN'. The 'Account Details' section includes an 'Update Account' button and fields for Name, User Name (Email), Password, Telephone Number, and Fax Number. The 'Add a TIN' section includes a note about validation, a 'Name TIN' field, a 'Tax ID' field, and an 'Add TIN' button. The 'Your TINs' section shows a list of TINs with a 'Mark as Primary' button and a 'Current Primary' button. A red arrow points to the 'Mark as Primary' button for the Medicaid TIN. Another red arrow points to the 'Account Details' option in the dropdown menu.

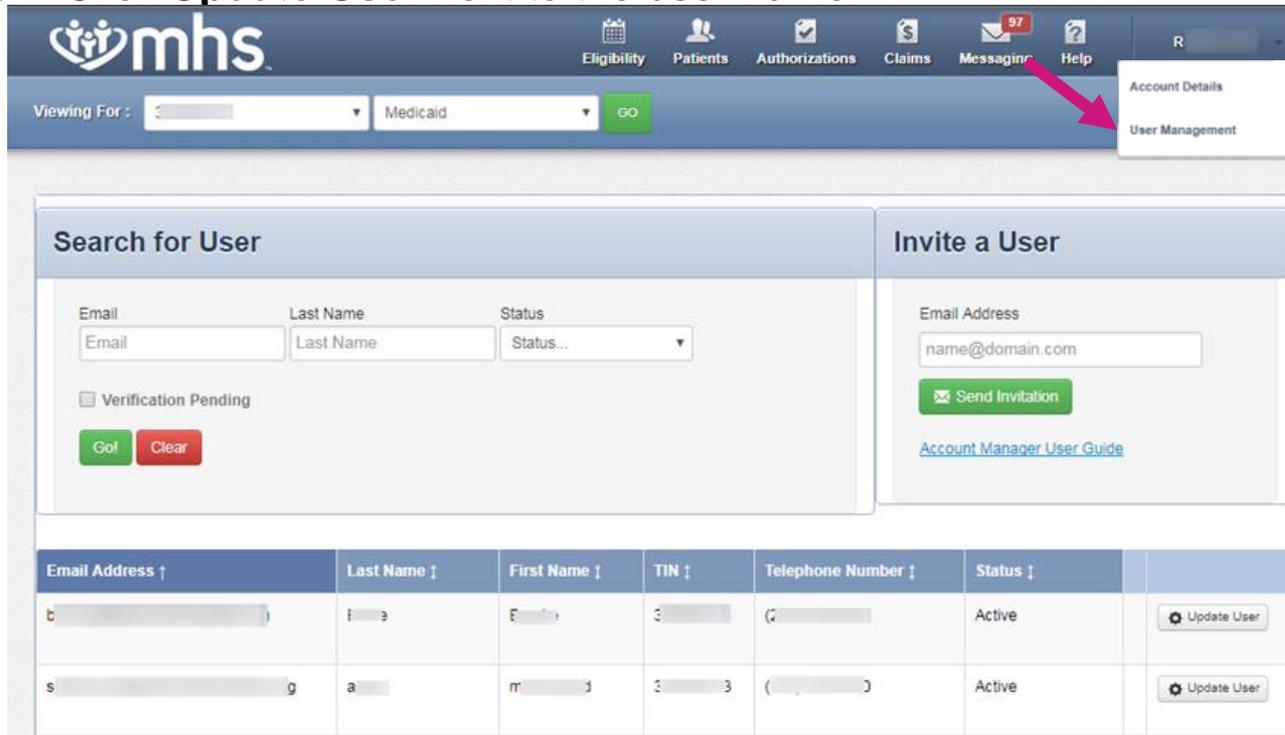
Account Manager

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 is a navigation bar with icons for Eligibility, Patients, Authorizations, Claims, Messaging (with a notification badge of 97), and Help. A dropdown menu is open next to the user's name 'R', showing options for 'Account Details' and 'User Management'. A red arrow points to the 'User Management' option. Below the navigation bar, there is a 'Viewing For' section with a dropdown menu set to 'Medicaid' and a 'GO' button. 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, along with a 'Verification Pending' checkbox and 'Go' and 'Clear' buttons. The 'Invite a User' panel has an 'Email Address' input field with the value 'name@domain.com' and a 'Send Invitation' button. Below these panels is a table of users with columns for Email Address, Last Name, First Name, TIN, Telephone Number, Status, and an 'Update User' button for each row.

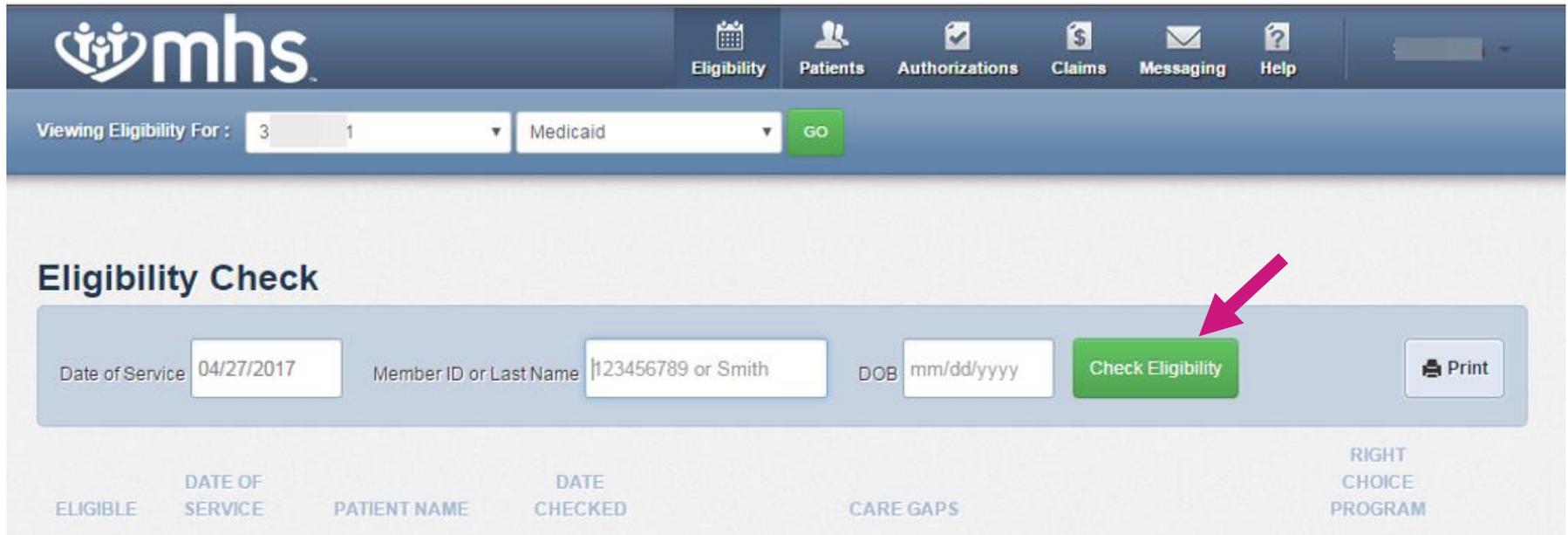
Email Address ↑	Last Name ↓	First Name ↓	TIN ↓	Telephone Number ↓	Status ↓	
b	i	E	3	(Active	 Update User
s	a	m	3	(Active	 Update User

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**



Viewing Eligibility For : 3 1 Medicaid GO

Eligibility Check

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

ELIGIBLE	DATE OF SERVICE	PATIENT NAME	DATE CHECKED	CARE GAPS	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: 08/28/2017 Member ID or Last Name: 123456789 or Smith DOB: mm/dd/yyyy **Check Eligibility** **Print**

ELIGIBLE	DATE OF SERVICE	PATIENT NAME	DATE CHECKED	CARE GAPS	RIGHT CHOICE PROGRAM
Ineligible	08/28/2017	F [redacted] N	08/28/2017		
	08/28/2017	T [redacted] S	08/28/2017	Risk Category Alerts: COPD/Asthma	
	08/28/2017	T [redacted] P [redacted] S	08/28/2017	Risk Category Alerts: COPD/Asthma Member has had 3 or more emergency room visits in past 90 days.	Yes

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 [Check Eligibility](#) [Print](#)

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	 Emergency Room Visit? 

Add Emergency Room Visit [X]

Reason For Visit*

Facility*

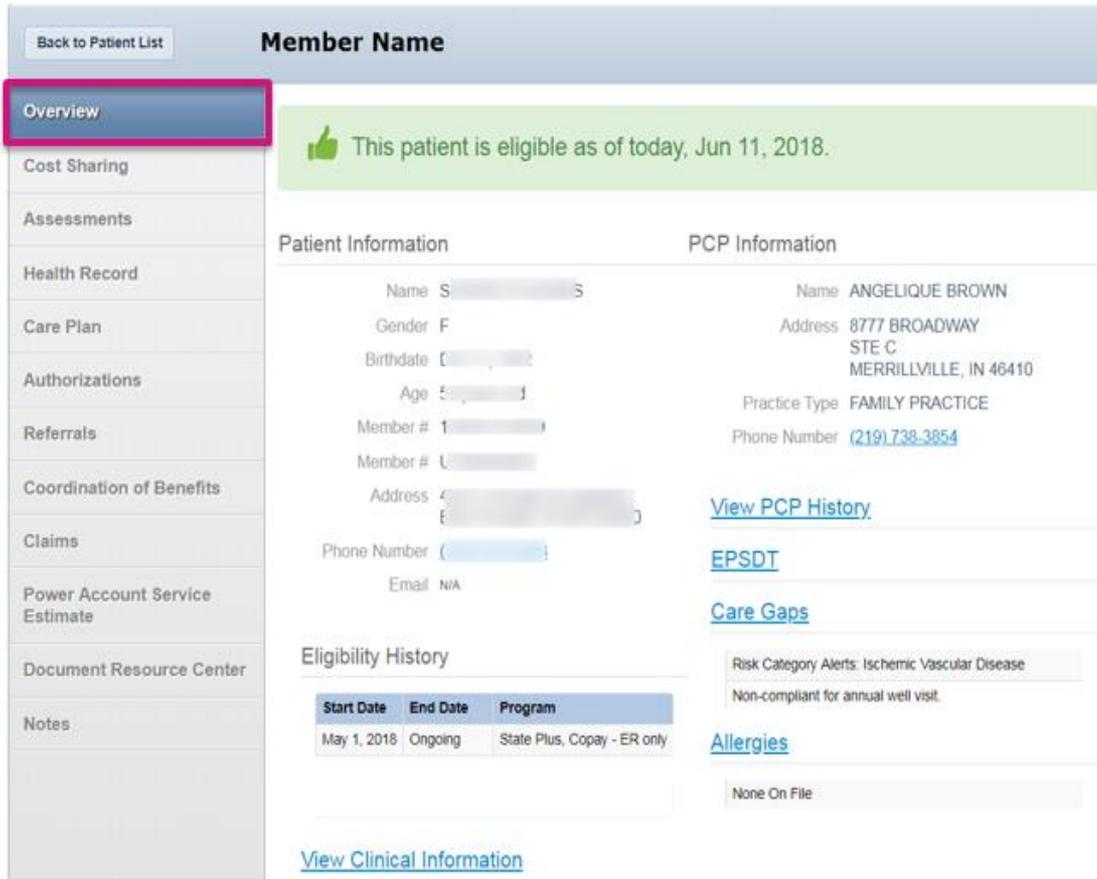
[Cancel](#) [Ok](#)

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 [redacted] S
 Gender F
 Birthdate [redacted]
 Age 5 [redacted]
 Member # [redacted]
 Member # U [redacted]
 Address [redacted]
 Phone Number [redacted]
 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](tel: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
MAJ 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

Back to Patient List
Member Name

Overview	HIP BASIC MEMBER COST SHARING GRID	
Cost Sharing	Type of Service	Co-Pay Amount
	Preventive Care	No co-pay
	Family Planning Services	No co-pay
Assessments	Outpatient Services	\$4.00
	Inpatient Services	\$75.00
Health Record	Preferred Drugs	\$4.00
	Non-Preferred Drugs	\$8.00
Care Plan	*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.	
Authorizations	NON-EMERGENCY USE OF AN EMERGENCY ROOM CO-PAYS	
	# of Non-Emergency Emergency Room Visits	Co-Pay Amount
Referrals	Each Visit	\$8.00
Coordination of Benefits	*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).	
Claims		
Power Account Service Estimate		
Document Resource Center		
Notes		

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	<p>HIP Preventative Services Assessment The HIP Preventive Services Attestation must be completed within 30 days of receipt.</p> <p style="text-align: right;">Fill Out Now!</p>	<p>Previous Assessments</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 70%;">Assessment Name</th> <th style="width: 30%;">Submit Date</th> </tr> </thead> <tbody> <tr> <td style="padding: 2px;">IN Member Health Risk Screen V3</td> <td style="padding: 2px;">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						
Document Resource Center						
Notes						

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**.

Back to Patient List Member Name

- Overview
- Cost Sharing
- Assessments
- Health Record
- Care Plan
- Authorizations
- Referrals
- Coordination of Benefits
- Claims
- Document Resource Center

Visits

Medications

Immunizations

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

Back to Eligibility Check
Member Name

- Overview
- Cost Sharing
- Assessments
- Health Record
- Care Plan
- Authorizations
- Referrals
- Coordination of Benefits
- Claims
- Power Account Service Estimate
- Document Resource Center
- Notes

Visits
Medications
Immunizations
Labs
Allergies

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**

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

Visits
Medications
Immunizations
Labs
Allergies

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

- Overview
- Cost Sharing
- Assessments
- Health Record
- Care Plan

Visits
Medications
Immunizations
Labs
Allergies

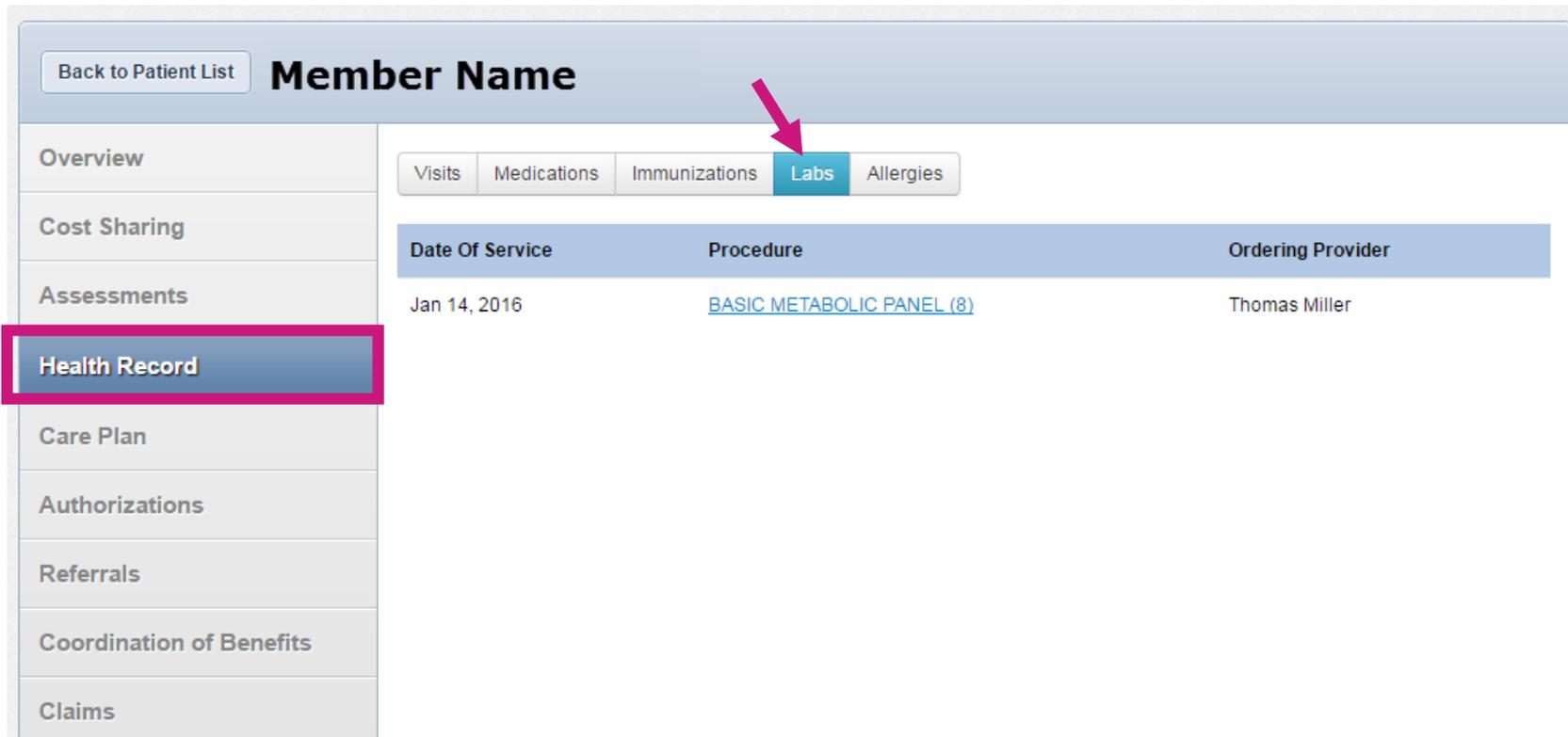
Immunizations
Schedule

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**



The screenshot shows a web interface for a member's health record. On the left is a vertical navigation menu with options: Overview, Cost Sharing, Assessments, Health Record (highlighted with a red box), Care Plan, Authorizations, Referrals, Coordination of Benefits, and Claims. The main content area has a header with a 'Back to Patient List' button and the member's name. Below the header is a tabbed interface with tabs for Visits, Medications, Immunizations, Labs (highlighted with a red arrow), and Allergies. A table below the tabs displays lab results with columns for Date Of Service, Procedure, and Ordering Provider. One entry is visible: Jan 14, 2016, BASIC METABOLIC PANEL (8), and Thomas Miller.

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

Health Record -Allergies

Member list of Allergies

Back to Eligibility Check
Member Name

- Overview
- Cost Sharing
- Assessments
- Health Record**
- Care Plan
- Authorizations
- Referrals
- Coordination of Benefits
- Claims

Visits
Medications
Immunizations
Labs
Allergies

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**.

Back to Patient List
Member Name

Overview	This member's care plan to treat:	Case Worker
Cost Sharing	Care Coordination	Ashley White
Assessments	04/06/2017 - OPEN	
Health Record		
Care Plan		
Authorizations		
Referrals		
Coordination of Benefits		
Claims		
Document Resource Center		
Notes		

Member states that she would like to quit smoking.

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

Member has tried quitting smoking several times. may be a barrier to success

What we're doing:

- 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 cigarettes 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.

Authorizations

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

Back to Patient List
Member Name

Overview

Cost Sharing

Assessments

Health Record

Care Plan

Authorizations

Referrals

Coordination of Benefits

Claims

Document Resource Center

Notes

Authorizations

STATUS	AUTH NBR	FROM DATE	TO DATE	DIAGNOSIS	AUTH TYPE	SERVICE
APPROVE	C [redacted]	02/06/2018	05/06/2018	M51.36	OUTPATIENT	Office Visit
APPROVE	C [redacted] 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 [redacted]

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**

- Overview
- Cost Sharing
- Assessments
- Health Record
- Care Plan
- Authorizations
- Referrals**
- Coordination of Benefits
- Claims

*Source

*Date

Last Name, First Name

Phone Number, Extension

Additional Comments

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

Overview

Cost Sharing

Assessments

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Care Plan

Authorizations

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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
--	--

LINE	DOS	PROC	DX	MODIFIERS	PLACE OF SERVICE	CHARGED	PAYMENT AMOUNT	PAYMENT DATE	CHECK NO.	STATUS	STATUS DESCRIPTION
1	07/24/2017	99213	K5904		11	\$75.00	\$51.99	08/03/2017	09004 24563	PAID	PAID IN FULL

Document Resource Center

Medical Necessity or Quality Management Document Upload

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

Overview	<div>Document Upload Document Review</div> <ol style="list-style-type: none">Document Category: <input type="text" value="Please Select a Category"/> <input type="text" value="Please Select a Category"/> <input type="text" value="Medical Necessity"/> <input type="text" value="Quality Management"/>Document Type: <input type="text"/>Upload File: <input type="button" value="Choose File"/> No file chosen<input type="button" value="Submit"/>
Cost Sharing	
Assessments	
Health Record	
Care Plan	
Authorizations	
Referrals	
Coordination of Benefits	
Claims	
Document Resource Center	

Notes

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

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

Notes

Create a New Note

General Note [Write Note](#)

Previous Notes **Date**

D [dropdown] has no submitted Notes at this time.

- Overview
- Cost Sharing
- Assessments
- Health Record
- Care Plan
- Authorizations
- Referrals
- Coordination of Benefits
- Claims
- Document Resource Center
- Notes**

Authorizations

Authorizations

View, create and filter group Authorizations

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

Viewing Authorizations For : Tax ID Number Medicaid GO Create Authorization

Authorizations Processed Errors Disclaimer Filter

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

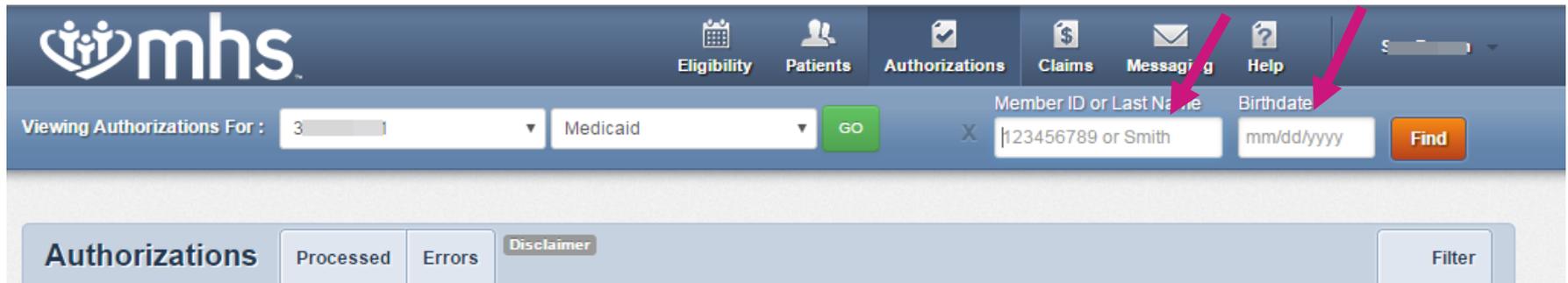
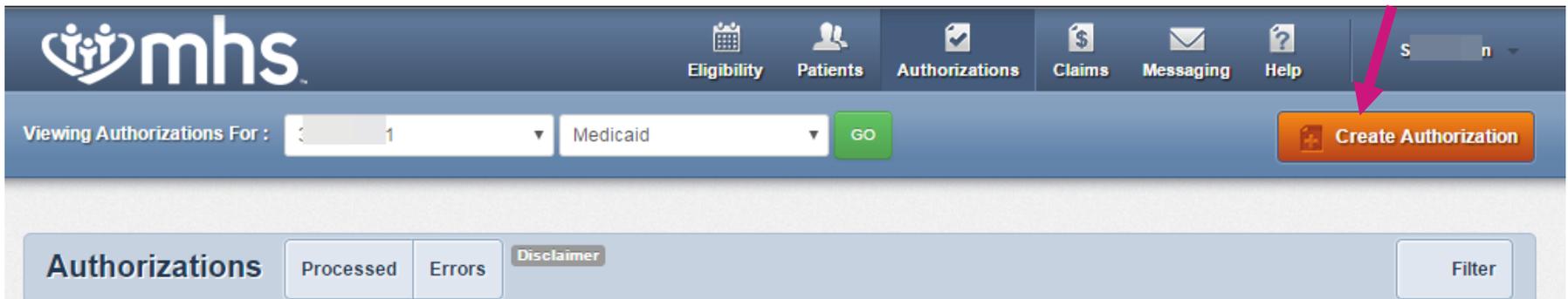
Please call the health plan for questions regarding voided authorization submissions. The authorization page is updated every 24 hours. To search, enter one or more of the following criteria, the date range is limited to three-month span. Only the last 18 months of authorizations data is available on-line.

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

Create a New Authorization

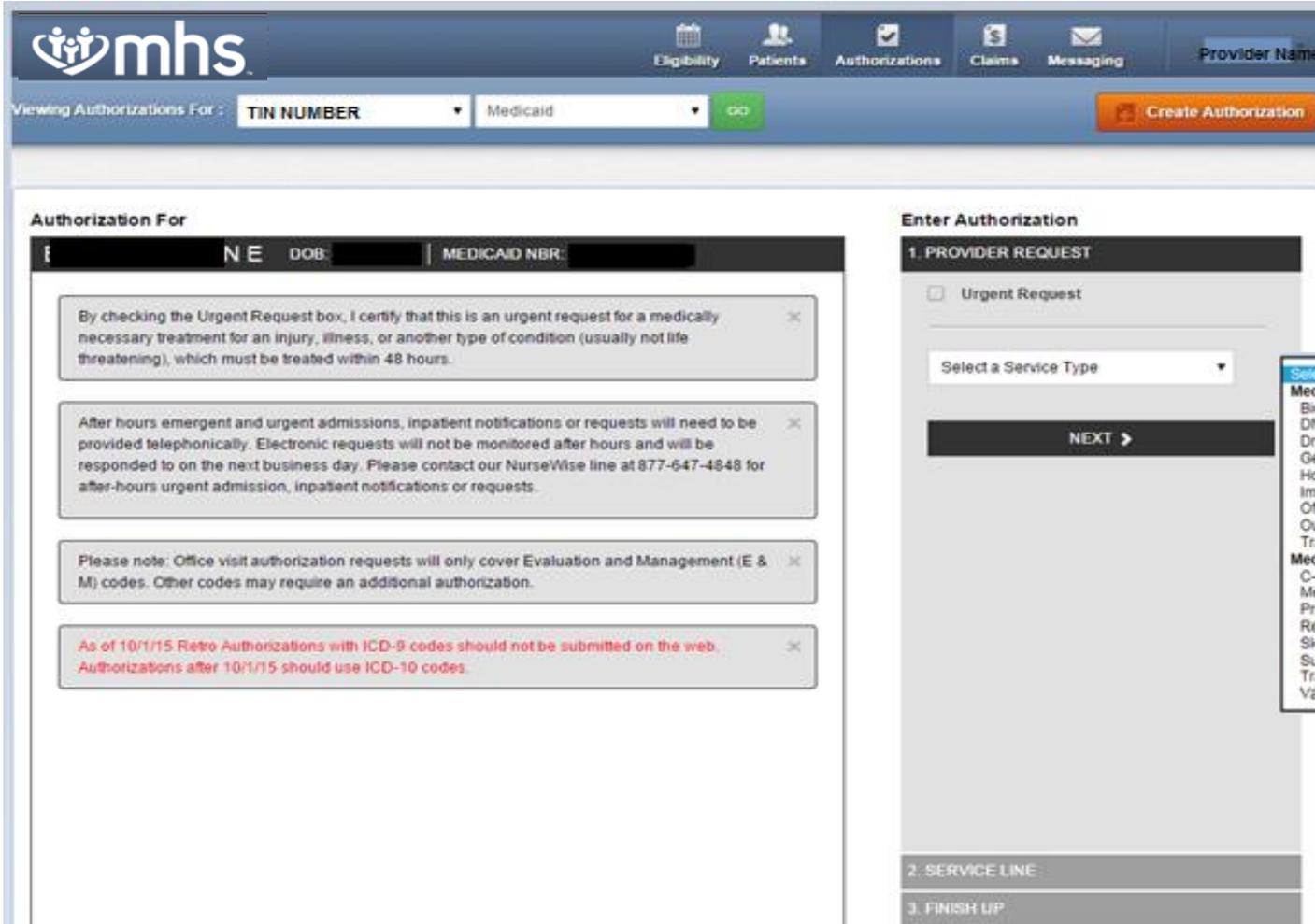
New Authorization

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



Creating a New Authorization

Select a Service Type



The screenshot shows the MHS web application interface for creating a new authorization. The top navigation bar includes icons for Eligibility, Patients, Authorizations, Claims, and Messaging, along with a 'Provider Name' field. Below the navigation bar, there is a search area for 'Viewing Authorizations For' with a dropdown menu set to 'TIN NUMBER' and a 'Medicaid' filter, followed by a 'GO' button and a 'Create Authorization' button.

The main content area is divided into two columns. The left column, titled 'Authorization For', contains a form with fields for 'NE', 'DOB', and 'MEDICAID NBR'. Below these fields are four informational boxes with close buttons (X):

- 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.

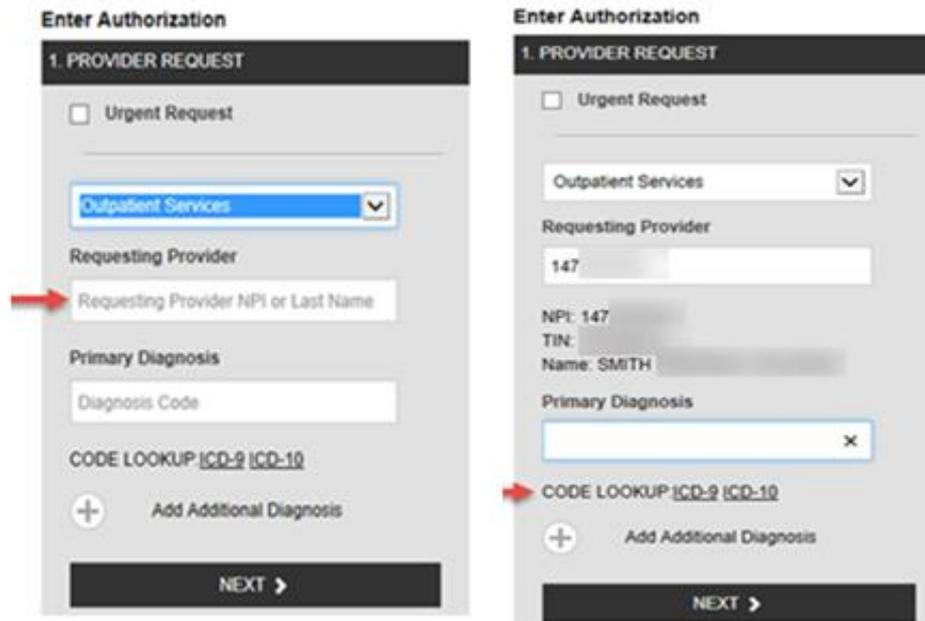
The right column, titled 'Enter Authorization', shows the '1. PROVIDER REQUEST' step. It includes an 'Urgent Request' checkbox and a 'Select a Service Type' dropdown menu. A 'NEXT >' button is located below the dropdown. A dropdown menu is open, showing a list of service types categorized into 'Medical Outpatient' and 'Medical Inpatient':

- 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

Below the '1. PROVIDER REQUEST' section, there are sections for '2. SERVICE LINE' and '3. FINISH UP'.

Creating a New Authorization

Select Provider NPI Add Primary Diagnosis



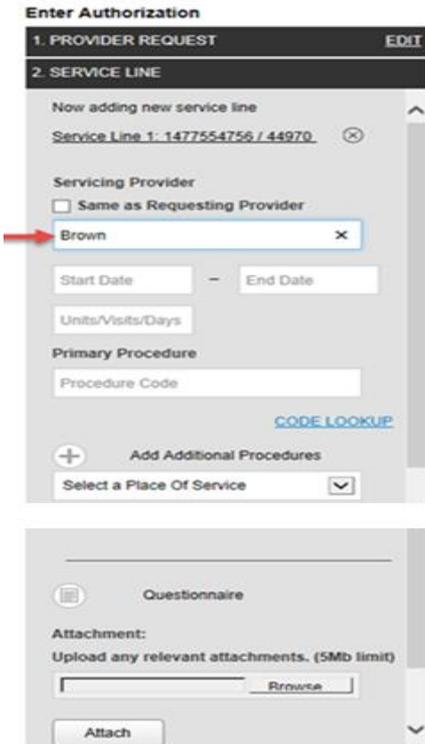
The image displays two side-by-side screenshots of the 'Enter Authorization' form, illustrating the steps to complete the '1. PROVIDER REQUEST' section.

Left Screenshot (Step 1): The form is titled 'Enter Authorization' and '1. PROVIDER REQUEST'. It includes an 'Urgent Request' checkbox, a service dropdown menu (set to 'Outpatient Services'), a 'Requesting Provider' section with a text input for 'Requesting Provider NPI or Last Name' (indicated by a red arrow), and a 'Primary Diagnosis' section with a 'Diagnosis Code' input field. At the bottom, there is a 'CODE LOOKUP ICD-9 ICD-10' section with an 'Add Additional Diagnosis' button and a 'NEXT >' button.

Right Screenshot (Step 2): This screenshot shows the form after the provider information has been entered. The 'Requesting Provider' field now contains '147', and the 'NPI: 147', 'TIN:', and 'Name: SMITH' fields are populated. The 'Primary Diagnosis' section now has a search box with an 'x' icon (indicated by a red arrow). The 'CODE LOOKUP ICD-9 ICD-10' section and 'Add Additional Diagnosis' button remain at the bottom, along with the 'NEXT >' button.

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

Servicing Provider

Same as Requesting Provider

Brown

Start Date - End Date

Units/Visits/Days

Primary Procedure

Procedure Code

[CODE LOOKUP](#)

+ Add Additional Procedures

Select a Place Of Service

Questionnaire

Attachment:
Upload any relevant attachments. (5Mb limit)

Browse

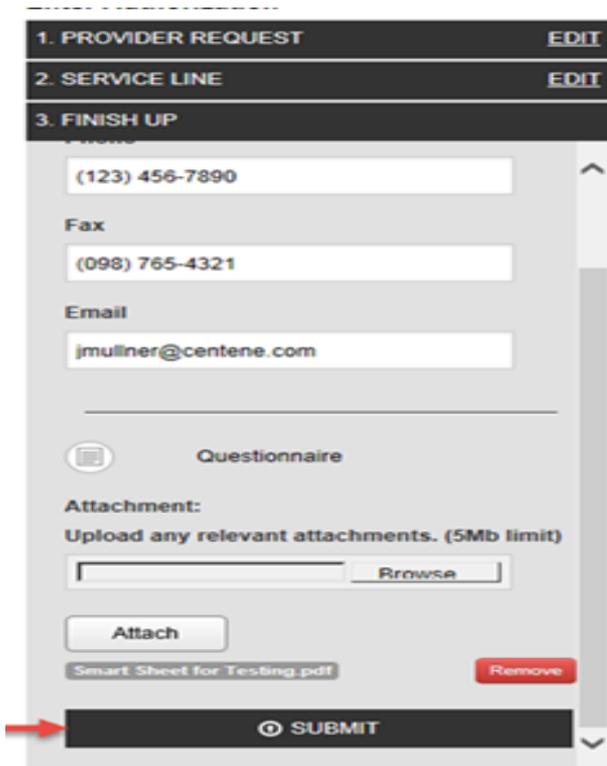
Attach

- 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



1. PROVIDER REQUEST EDIT

2. SERVICE LINE EDIT

3. FINISH UP

(123) 456-7890

Fax

(098) 765-4321

Email

jmuliner@centene.com

Questionnaire

Attachment:

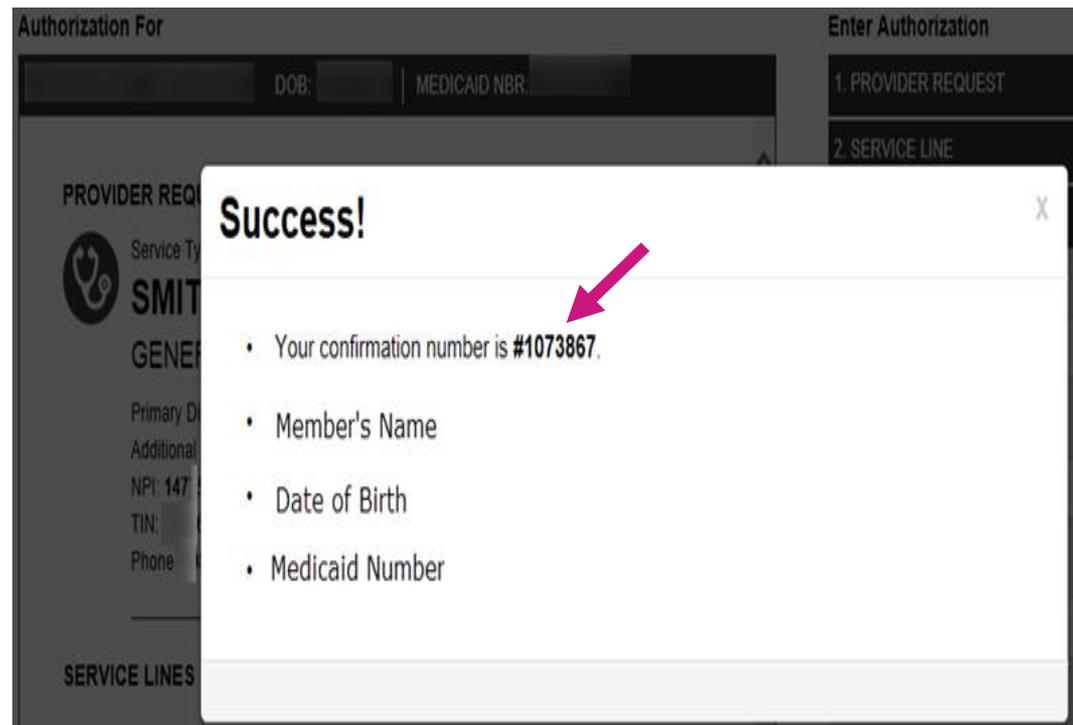
Upload any relevant attachments. (5Mb limit)

Browse

Attach

Smart Sheet for Testing.pdf Remove

SUBMIT



Authorization For

DOB: | MEDICAID NBR:

Enter Authorization

1. PROVIDER REQUEST

2. SERVICE LINE

PROVIDER REQUEST

Service Type

SMITH

GENERAL

Primary Doctor

Additional

NPI: 147

TIN:

Phone

SERVICE LINES

Success!

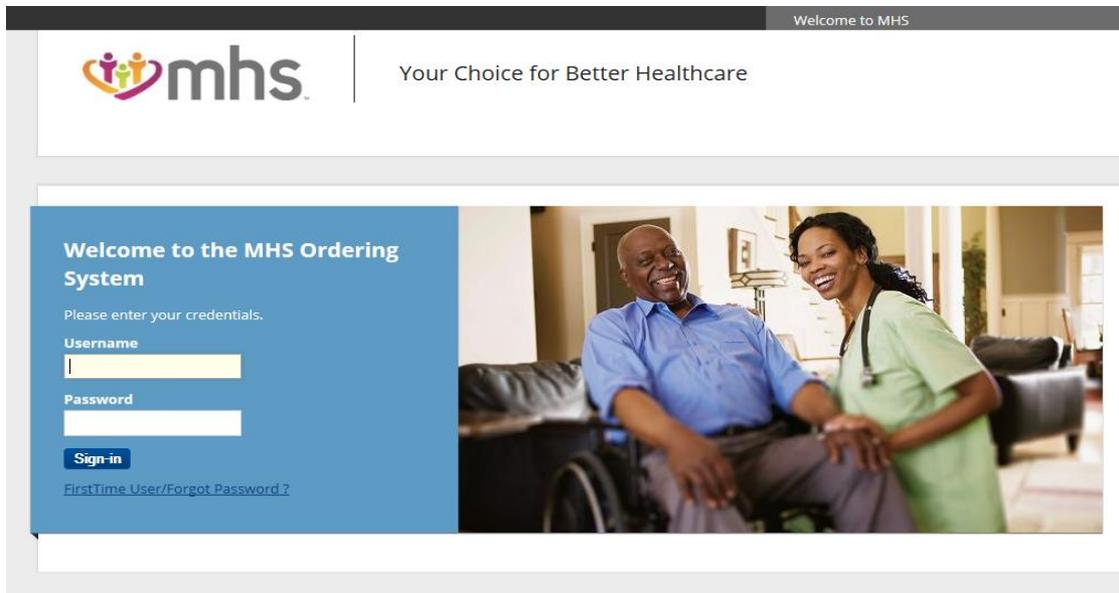
- Your confirmation number is #1073867.
- Member's Name
- Date of Birth
- Medicaid Number

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.



Welcome to MHS

mhs. | Your Choice for Better Healthcare

Welcome to the MHS Ordering System

Please enter your credentials.

Username

Password

Sign-in

[FirstTime User/Forgot Password?](#)



Claims

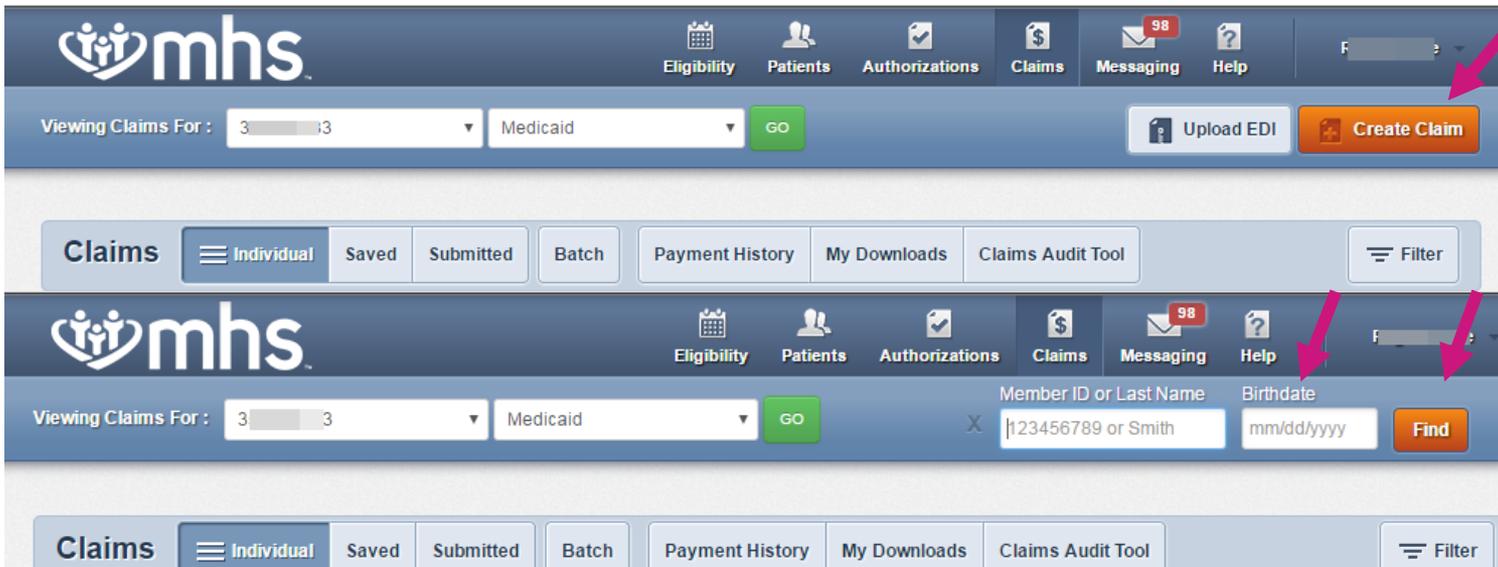
Claims

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**

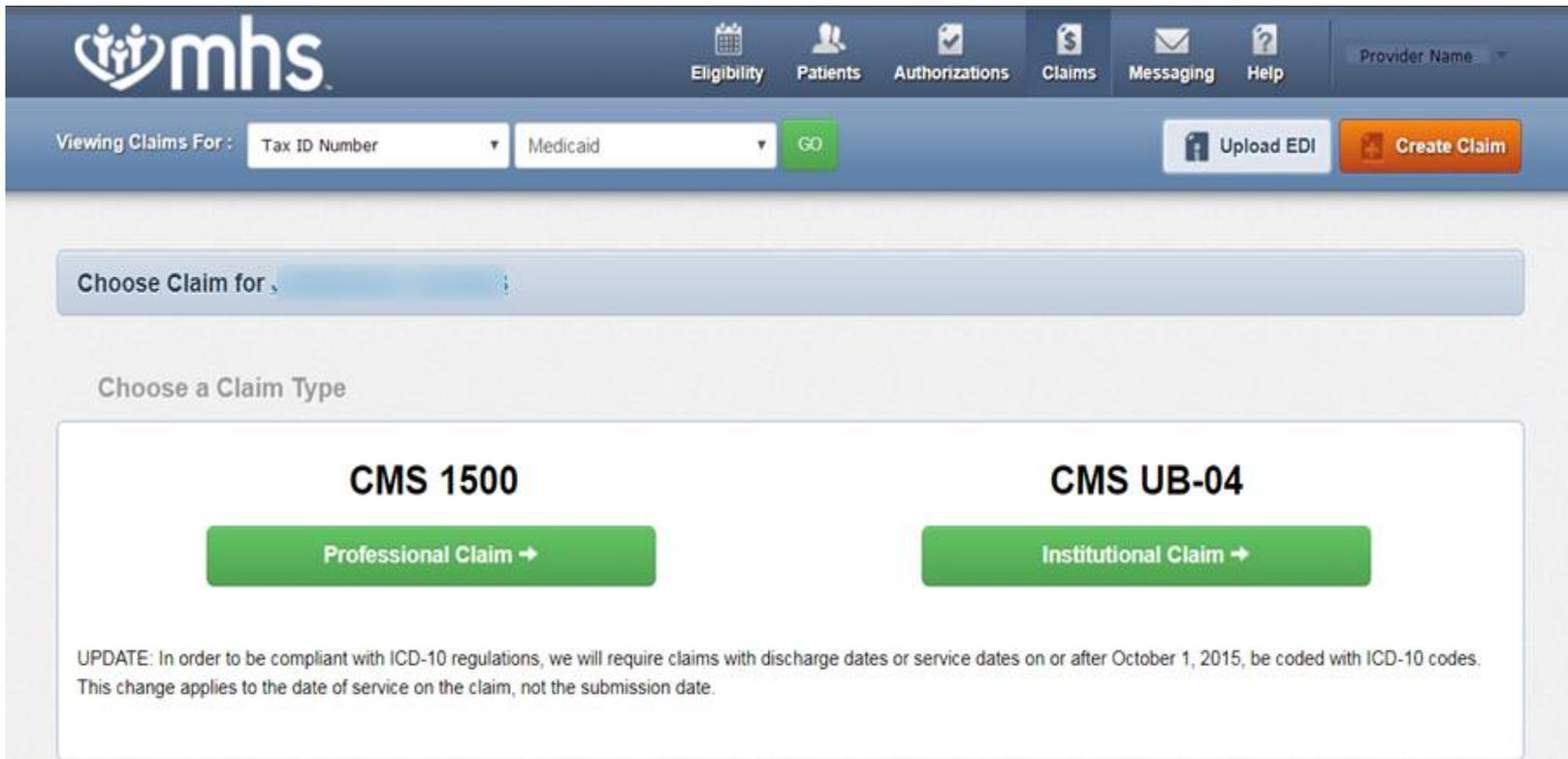


The screenshot displays the MHS web portal interface. At the top, there is a navigation bar with icons for Eligibility, Patients, Authorizations, Claims, Messaging (with a notification badge of 98), and Help. Below this is a search bar with a dropdown menu and a 'GO' button. The main content area features a 'Claims' section with tabs for Individual, Saved, Submitted, Batch, Payment History, My Downloads, and Claims Audit Tool. A 'Filter' button is also present. Below the navigation bar, there is a search form with fields for 'Member ID or Last Name' (containing '|123456789 or Smith') and 'Birthdate' (containing 'mm/dd/yyyy'). A 'Find' button is located to the right of these fields. A red arrow points to the 'Create Claim' button in the top right corner, and two red arrows point to the 'Member ID or Last Name' and 'Birthdate' input fields respectively.

Claim Submission

Choose the Claim Type

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



The screenshot shows the MHS Claims Submission interface. At the top, there is a navigation bar with the MHS logo and several menu items: Eligibility, Patients, Authorizations, Claims, Messaging, and Help. A dropdown menu for 'Provider Name' is also visible. Below the navigation bar, there is a section for 'Viewing Claims For:' with two dropdown menus: 'Tax ID Number' and 'Medicaid', followed by a green 'GO' button. To the right of this section are two buttons: 'Upload EDI' and 'Create Claim'. Below this is a large light blue box with the text 'Choose Claim for ,'. Underneath, there is a section titled 'Choose a Claim Type' which contains two columns. The left column is for 'CMS 1500' and has a green button labeled 'Professional Claim →'. The right column is for 'CMS UB-04' and has a green button labeled 'Institutional Claim →'. At the bottom of the form, there is an 'UPDATE' notice: '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.



* Required field

Patient's Account Number*	XXXXXXXXXX	26
Date of current Illness, Injury, Pregnancy (LMP)	Select Type... MM/DD/YYYY	14.
Other Date	Select Type... MM/DD/YYYY	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 [L](#) [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* [v](#)

Policy Number* [X](#)

[← Back](#) [Next →](#)

Professional Claim Submission: Step 3

Add Service Lines

Professional Claim for [ID] Your Progress >>>>>

Service Lines
Enter maximum of 50 service lines.

Back Next >

Total: \$500.00 * Required field Delete Save / Update

Now Viewing Line 1: 99213 / \$500.00

Procedure / Charges
1: 99213 / \$500.00

Dates of Service: From: 02/01/2018 To: 02/01/2018 243
 Place of Service: 11 - PROVIDER'S OFFICE 243
 Procedure Code: 99213 243
 Modifiers: XX Add Please enter the modifier and click the Add button.
 Diagnosis Code(s): M37 - PERS OUTSD INDUSTRY VEH INJNT ACC 243
 Charge: 500.00 247
 Units / Minutes / Days: 1 Type: UN - U 249
 Family Planning: Yes No EPOOT: Select... 249
 NDC: NDC NDC
 Supplemental Information: Supplemental Information

Primary Insurance
Note: 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: XXXXXX

Copy: XXXXXX

Co-Insurance: XXXXXX

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... 243

Denied Amount: XXXXXX

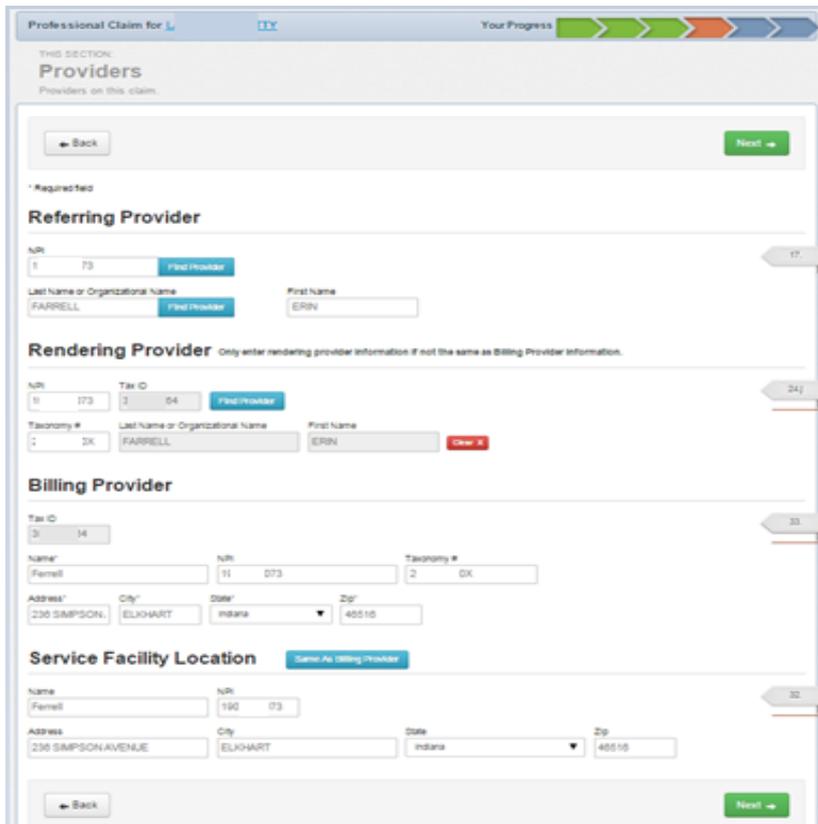
Add Denied Reason

Delete Save / Update

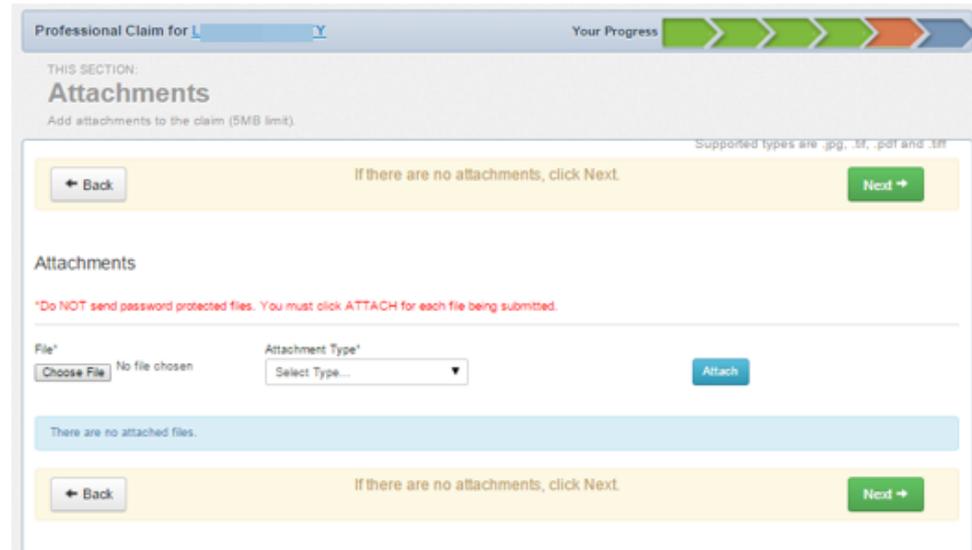
Back Next >

Professional Claim Submission: Step 4 - 5

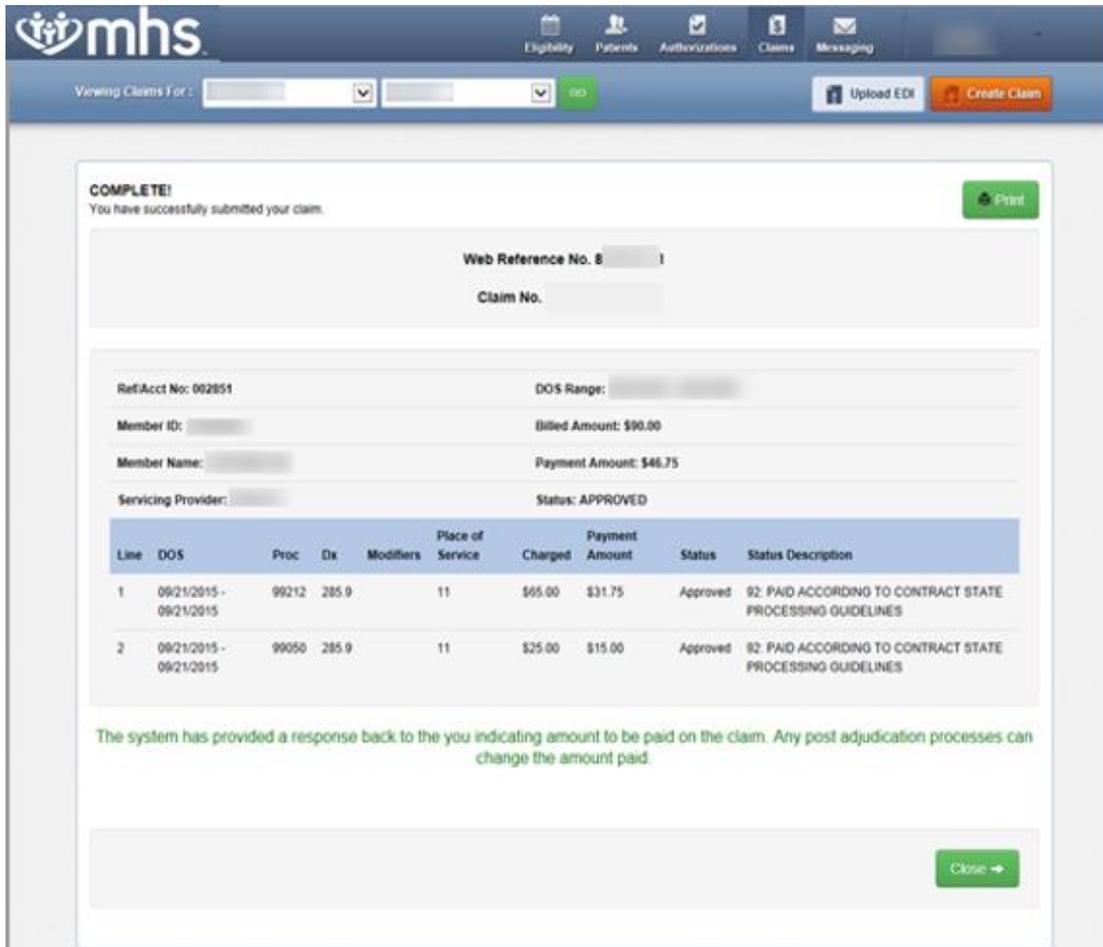
 Enter **Referring** and **Billing provider** information. Enter **Service Facility Location**. Click **Next**.



 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**.



RTEP Claim Pricing View



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

Web Reference No. 8
Claim No.

RefAcct 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.)

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

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

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

The screenshot shows the MHS Claims portal interface. At the top, there is a navigation bar with icons for Eligibility, Patients, Authorizations, Claims, Messaging, and Help. Below this is a search bar with the text "Viewing Claims For:" and a dropdown menu set to "Medicaid". There are buttons for "Upload EDI" and "Create Claim".

The main content area features a "Claims" section with a sub-tab "Individual" highlighted in a red box. Other tabs include "Saved", "Submitted", "Batch", "Payment History", "My Downloads", and "Claims Audit Tool". A "Filter" button is also present.

CLAIM NO. ↓	CLAIM TYPE ↓	MEMBER NAME ↓	SERVICE DATE(S) ↓	BILLED/ PAID ↓	CLAIM STATUS ↓
0000000005	CMS-1500	K [REDACTED] R	07/24/2017 - 07/24/2017	\$65.00 / \$41.38	👍
0000000031	CMS-1500	JE [REDACTED] EN	07/24/2017 - 07/24/2017	\$171.00 / \$106.34	👍
0000000036	CMS-1500	E [REDACTED] R	07/24/2017 - 07/24/2017	\$253.00 / \$101.04	👍
0000000011	CMS-1500	EI [REDACTED] R	07/24/2017 - 07/24/2017	\$2,783.00 / \$118.86	👍
0000000022	CMS-1500	E [REDACTED] R	07/24/2017 - 07/24/2017	\$2,783.00 / \$0.00	👎

A red box highlights the "Individual" tab and a legend box on the right side of the table. The legend box contains the following text:

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

Viewing Claims For : 3 Medicaid GO Upload EDI Create Claim

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

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

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

Back to Claims Correct Claim Copy Claim Claim No.: Q180INE01235

Ref/Acct No.: P10007521700 Member ID: 1() 9 Member Name: [] Y Member DOB: 1() ? 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 X

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 ██████████ E
 Control Number: C ██████████ 7
 Service Provider: IWUAGWU, ANTHONY

Group: T ██████████ \$,
 ID: 1 ██████████
 Account: F ██████████
 NPI: 1699844886

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

Group: T ██████████ \$,
 ID: F ██████████
 Account: F ██████████
 NPI: 1699844886

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

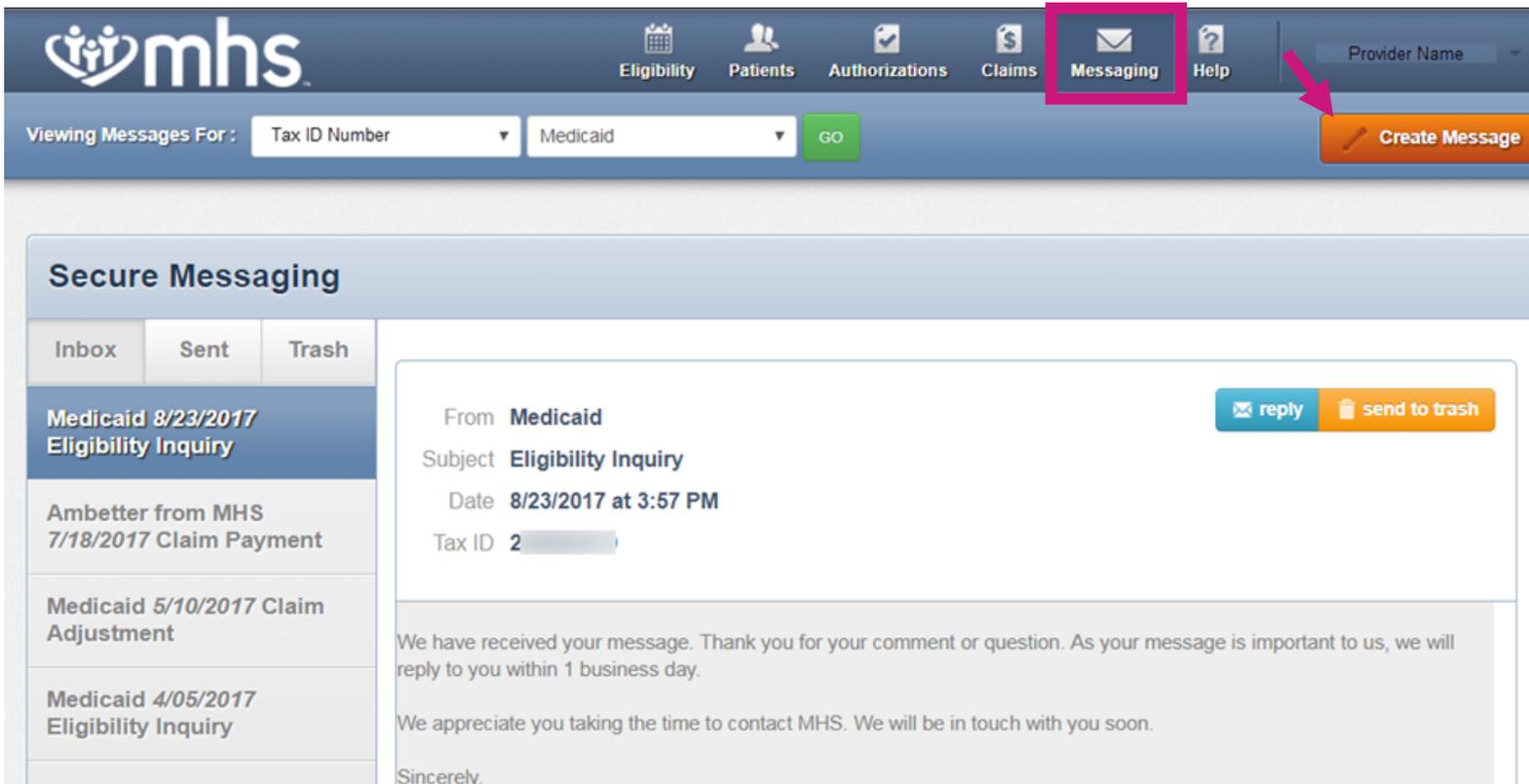
The Clear Claim Connection screen appears, allowing you to enter the Procedure Code, Quantity, Modifiers, Date and Place of Service, and Diagnosis for a claim proactively before you submit or retroactively after you submit.

Secure Messaging

Secure Messaging

Create a New Secure Message

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



The screenshot shows the MHS dashboard with the 'Messaging' tab highlighted in a pink box. A pink arrow points to the 'Create Message' button. Below the navigation bar, there are filters for 'Viewing Messages For:' with 'Tax ID Number' and 'Medicaid' selected, and a 'GO' button. The main content area is titled 'Secure Messaging' and shows a list of messages on the left and a detailed view of a message on the right. The message details include: From: Medicaid, Subject: Eligibility Inquiry, Date: 8/23/2017 at 3:57 PM, and Tax ID: 2. The message body contains a response from MHS: '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 Public Website (mhsindiana.com)

Provider Enrollment



FOR MEMBERS

FOR PROVIDERS

GET INSURED

FOR PROVIDERS

Login

Become a Provider

Prior Authorization +

Dental Providers

Pharmacy +

Provider Resources +

QI Program +

Provider News

Become a Provider

Become A Contracted Provider

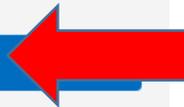
[Click Here](#)

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 Provider

[Click Here](#)

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.



Provider Enrollment

Non-Contracted Provider

Click Here

If you are not contracted with MHS, please complete the online non-contracted enrollment form. All submissions must include a completed W9. Set-up may take 45 – 60 days after we receive your submission.

To begin set-up with MHS, you must be enrolled with Indiana Medicaid and have an Indiana Medicaid provider number. You can enroll online at indianamedicaid.com.

Existing Behavioral Health Provider

Click Here

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.



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 **

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

- 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
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:
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 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

Medical Claim Processing

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

Summary

Provider Network Territories

Physical Health

PROVIDER NETWORK TERRITORIES

Indiana

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

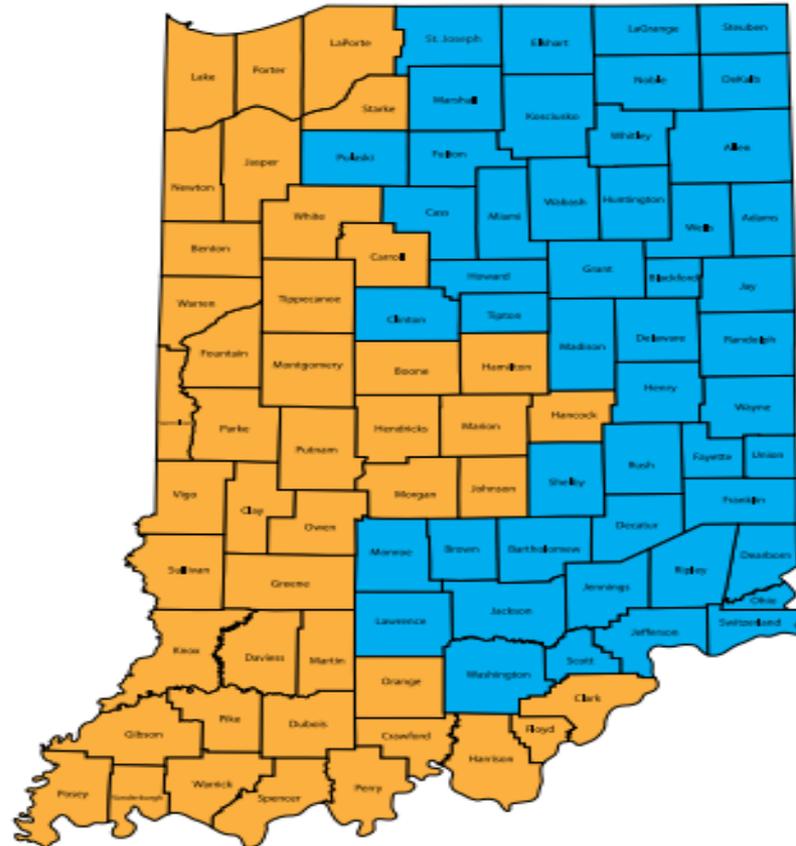
WEST TERRITORY

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

Indiana



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	kaqibson@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 **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**
- **Engolve Dental**
- **MHS contacts**

Questions?

Thank you for being our partner in care.