

MHS UB 04 2018

Tips and Billing Guidelines



Agenda

Claim Process

- Claim Process
- Common Claim Rejections
- Common Claim Denials
- Claim Adjustments
- Claims Dispute Resolution
- Prior Authorization
- Claim Submission
- Reviewing Payments
- Home Health Billing
- Ambetter Claims Process
- Allwell Billing Overview

MHS Website/Portal

- Provider Portal

Claim Process

Claim Process

Electronic submission through EDI vendor

- Payer ID 68069
- MHS accepts TPL information via EDI
- 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 at: mhsindiana.com/login

- Provides immediate confirmation of received claims and acceptance
- Professional and Facility claims accepted
- Attachments accepted via MHS Secure Portal
- Claim Adjustments and TPL accepted

Claim Process

Paper Claims

- Managed Health Services
PO Box 3002
Farmington, MO 63640-3802

Claim Inquiries

- Check status online with the MHS Secure Provider Portal:
- mhsindiana.com/login.
- Call Provider Services at:
 - 1-877-647-4848
 - IVR

Claim Process – Billing with Ease

CONTRACTED PROVIDERS – Claims must be received within 90 calendar days of the date of service.

- Exceptions:
 - Newborns (30 days of life or less) – Claims must be received within 365 days from the date of service. Claim must be filed with the newborn's RID number
 - Third party Liability (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

Claim Process

Claim Rejection

- A rejection is an unclean claim that contains invalid or missing data elements required for acceptance of the claim in the claim process system. The provider will receive a letter or a rejection report from their EDI vendor if the claim was submitted electronically

Claim Denial

- A denial is a claim that has passed edits and is entered into the system but has been billed with invalid or inappropriate information causing the claim to deny. An EOP will be sent that includes the denial reason

Claim Rejections

Claim Rejections

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

- Paper to electronic mapping is available on mhsindiana.com/provider-guides

Claim Rejection Tips

Member Information

- Member's information needs to match what is on file with Indiana Medicaid
- Newborn's RID number is required for payment
- Verify Members eligibility via web portal

TPL or Secondary Claims

- Accepted electronically from vendors or via the MHS Secure Provider Portal
- COB verification can be requested via portal message option

Claim Rejections (Paper)

 **The provider identification and the tax identification numbers are missing or not on file with the health plan.**

- Verify that the provider's NPI is entered on the claim in box 56
- Verify that the address located in box 1 is the provider's service location address with the complete zip code
- Verify that the group taxonomy is in box 81CC with the B3 qualifier

Claim Denials

Common Claim Denials

Time Limit For Filing Has Expired (EX 29)

- Claims must be received within 90 calendar days of the date of service (contracted providers)
 - Exceptions
 - Newborn and Third Party Liability

Bill Primary Insurer 1st (EX L6)

- Verify other insurance (TPL). Medicaid is the payer of last resort

Common Claim Denials

NDC information missing or invalid



Services requiring NDC numbers must be billed with valid NDC numbers in the correct format:

- Enter the NDC qualifier of N4
- Enter the NDC 11 digit numeric code
- Enter the drug description
- Enter the NCD unit qualifier of F2 for international unit, GR for gram, ML for Milliliter and UN units
- Enter the NDC quantity (administered/billed amount) in the formation of 9999.99

Common Claim Denials

Coverage Not In Effect When Service Provided (EX 28)

- Check eligibility at each visit prior to submitting claims to ensure you are billing the correct carrier

Please Resubmit To Cenpatco For Consideration (EX 54)

- Behavioral Health Services for MHS members are covered by Cenpatco

Missing or Invalid POA (EX VV)

- Required for inpatient admissions unless exempt diagnosis

Common Claim Denials

Authorization Not On File (EX A1)

- Prior authorization should occur at least two (2) business days prior to the date of service
- All urgent and emergent services must be called in to MHS within two (2) business days after service/admit

Claim and Auth Service Provider Not Matching (EX HP)


- Provider of service does not match service billed on authorization


Denied By Medical Services (EX HL)

- Claim and authorization locations do not match

Claim Adjustments

Claim Adjustments

 Claim adjustments requests must be submitted within 67 days of the date of the MHS EOP. *Claims will not be reconsidered after day 67*




 Adjustments can also be processed via paper submissions. The MHS claim adjustment form

- Attach an MHS claim adjustment form along with documentation, including EOP (if available) explaining reason for resubmission. Please indicate original claim number
Example: (N123INE00987)




Dispute Resolution (2 STEP PROCESS)

Dispute Resolution

Level One Appeal

-  Should be made in writing by using the MHS 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 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

Level Two Appeal (Administrative)

 Submit the Informal Claims Dispute/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

Prior Authorization

Prior Authorization

Is Prior Authorization Needed?

 MHS website mhsindiana.com

- PA tool

 Quick reference guide

Prior Authorization

 **Some Services that require prior authorization regardless of contract status (not inclusive) are:**

- All elective hospital admissions
- All urgent and emergent hospital admissions (including NICU) require notice to MHS following the admission
- Transition to hospice
- Newborn deliveries (following delivery)
- Rehabilitation facility admissions
- Skilled nursing facility admissions
- Transition of care
- Transplants, including evaluations

 **Reference QRG for a more detailed listing**

Authorization Considerations

Need to know what requires Authorization?

- Reference QRG
- Pre-Auth Tool










How to obtain Authorization?

- Online (excluding Home Health and Hospice requests)
- Phone
- Fax

Authorizations are not a guarantee of payment

Prior Authorization

Information Needed to Complete All PAs:

-  Member's Name, RID, and Date of Birth
-  Type of service needed (e.g. office visit, outpatient surgery, DME, inpatient admission, testing, physical therapy, occupational therapy, speech therapy etc.)
-  Date(s) of service
-  Ordering Physician with NPI number
-  Servicing Physician with NPI number
-  HCPCS/CPT codes requested for approval
-  Diagnosis code
-  Contact person, including phone and fax numbers
-  Clinical information to support medical necessity
 - Including current (within three months) clinical that is pertinent to the requested service, history of symptoms, previous treatment and results, physician rationale for ordering treatments and/or testing (MD exam notes)

Providers must request updates to prior authorizations within 30 days from the original date of service before claim submission

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](#)

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

Is the member being admitted to an inpatient facility?

☐

☐

Are services, other than DME, orthotics, prosthetics, and supplies, being rendered in the home?

☐

☐

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:

N
No

99394 - PREV VISIT EST AGE 12-17
No Pre-authorization required for all providers.

Therapy Services - (Speech, Occupational, Physical Therapy)

 10/1/17 authorization is no longer required

 Benefit limitations are applicable

 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 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 800-424-5391

Outpatient Radiology PA Requests


 MHS partners with NIA for outpatient Radiology PA Process

 PA requests can be submitted

- NIA Web site at RadMD.com
- 1-866-904-5096
- Not applicable for ER and Observation requests

Claim Submission

Claim Submission

 Providers are able to use the portal to review claims on file for a patient, submit new claims, correct claims, and view payment history.

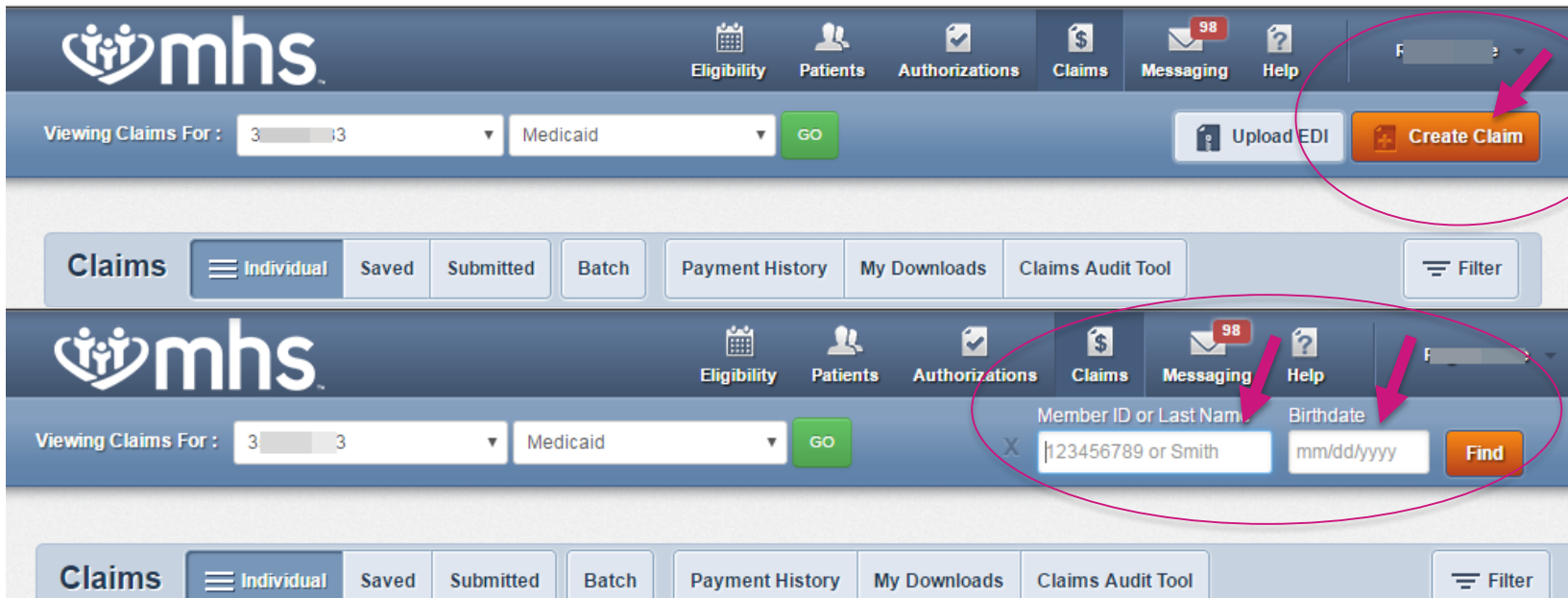
 Claims Submission

 Correct a Claim

 Payment History

 Review Claims on File for a patient

 **Submit a New Claim**

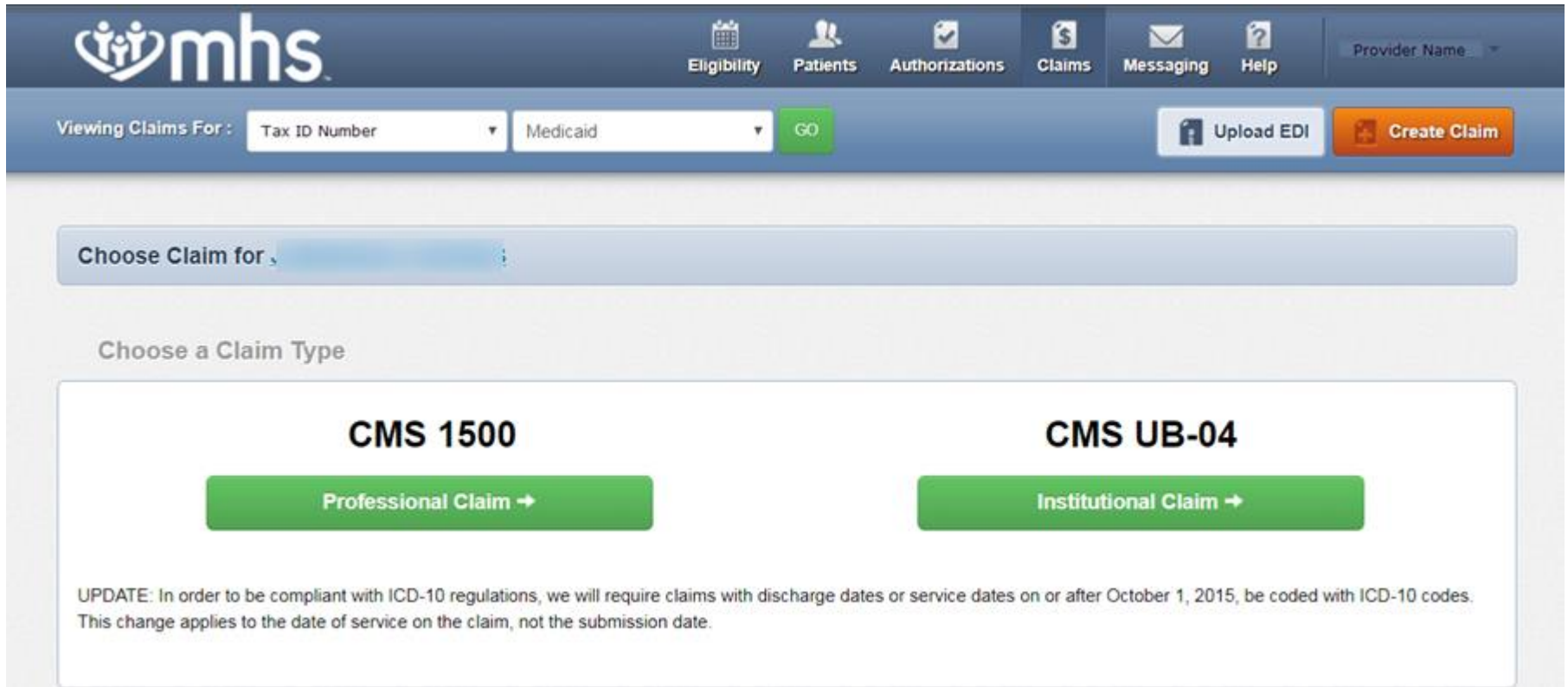


The screenshot displays the MHS portal interface. The top navigation bar includes the MHS logo and icons for Eligibility, Patients, Authorizations, Claims, Messaging (with a 98 notification), and Help. Below this, a section for 'Viewing Claims For' shows a dropdown menu with '3' and '3' selected, a 'Medicaid' dropdown, and a 'GO' button. To the right, there is an 'Upload EDI' button and a red 'Create Claim' button, which is circled in red with a red arrow pointing to it. Below this, a 'Claims' section has tabs for 'Individual', 'Saved', 'Submitted', 'Batch', 'Payment History', 'My Downloads', and 'Claims Audit Tool', along with a 'Filter' button. The bottom section shows the same navigation bar and 'Viewing Claims For' section. To the right, there is a search form with fields for 'Member ID or Last Name' (containing '123456789 or Smith') and 'Birthdate' (containing 'mm/dd/yyyy'), and a 'Find' button. This search form is also circled in red with red arrows pointing to the 'Messaging' and 'Help' icons in the navigation bar above it.

Claim Submission

 Choose the **Claim Type**

- **Professional or Institutional** claim submission



The screenshot shows the MHS web application interface for claim submission. At the top is a navigation bar with the MHS logo and links for Eligibility, Patients, Authorizations, Claims, Messaging, and Help. Below this is a search bar with 'Tax ID Number' and 'Medicaid' selected, and a 'GO' button. To the right are 'Upload EDI' and 'Create Claim' buttons. The main content area has a 'Choose Claim for' dropdown and a 'Choose a Claim Type' section. Under 'Choose a Claim Type', there are two options: 'CMS 1500' with a 'Professional Claim →' button, and 'CMS UB-04' with an 'Institutional Claim →' button. At the bottom, an update notice states: '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.'

Viewing Claims For : Tax ID Number Medicaid GO

Upload EDI Create Claim


Choose Claim for ,

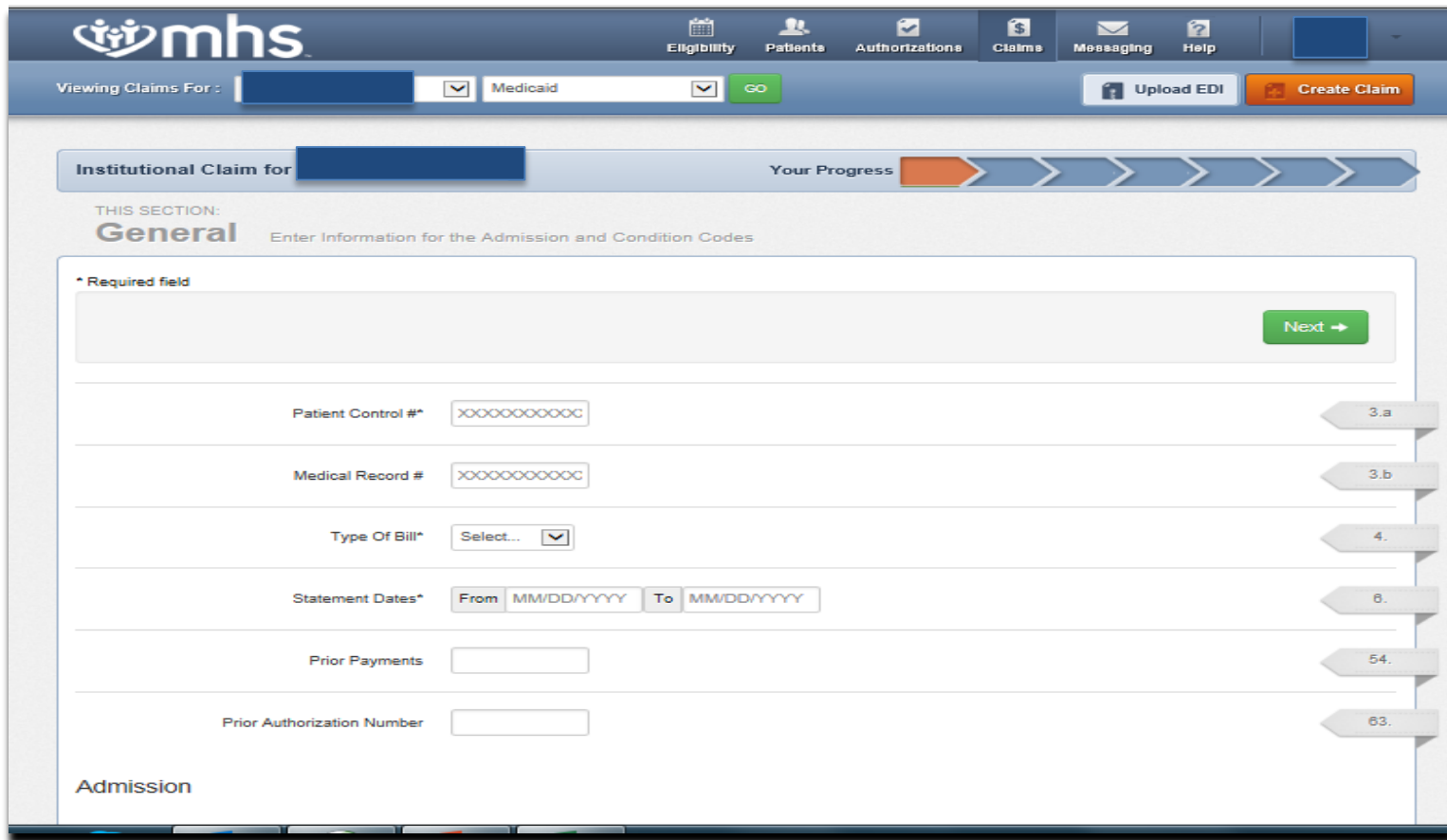
Choose a Claim Type

CMS 1500
Professional Claim →

CMS UB-04
Institutional Claim →

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

 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**.



The screenshot shows the mhs Institutional Claim form. At the top, there is a navigation bar with links for Eligibility, Patients, Authorizations, Claims, Messaging, and Help. Below this, a header section displays 'Viewing Claims For:' followed by a dropdown menu set to 'Medicaid' and a 'GO' button. To the right of this header are buttons for 'Upload EDI' and 'Create Claim'.


The main content area is titled 'Institutional Claim for' followed by a redacted patient name. A progress bar labeled 'Your Progress' shows the current step as 'General'. Below this, the section is titled 'THIS SECTION: General' with the instruction 'Enter Information for the Admission and Condition Codes'.

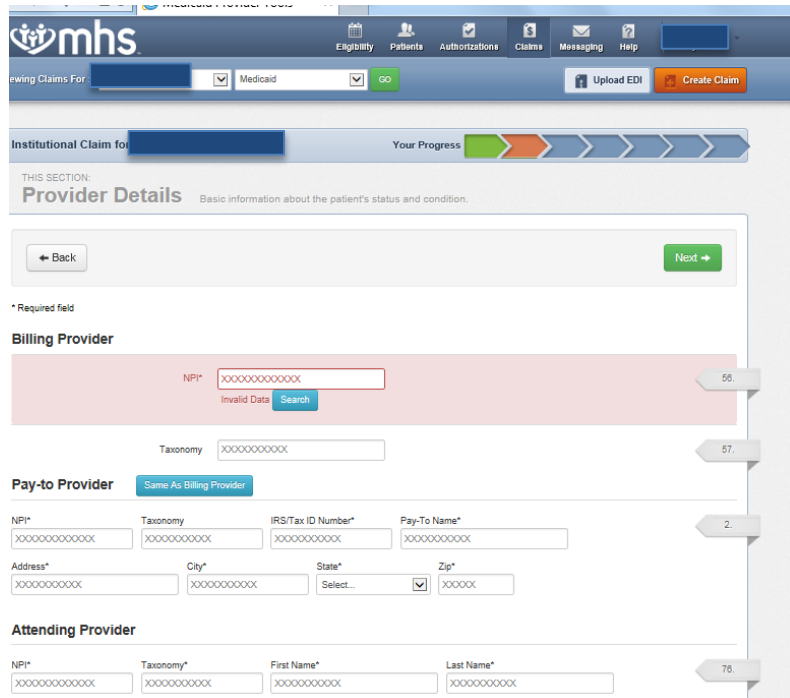
The form contains several required fields, indicated by an asterisk (*):

- Patient Control #***: A text field containing 'XXXXXXXXXX'.
- Medical Record #**: A text field containing 'XXXXXXXXXX'.
- Type Of Bill***: A dropdown menu with 'Select...' as the current selection.
- Statement Dates***: Two date fields labeled 'From' and 'To', both containing 'MM/DD/YYYY'.
- Prior Payments**: A text field.
- Prior Authorization Number**: A text field.


On the right side of the form, there are numbered tabs for navigation: 3.a, 3.b, 4., 6., 54., and 63. A green 'Next' button with a right arrow is located at the top right of the form area.

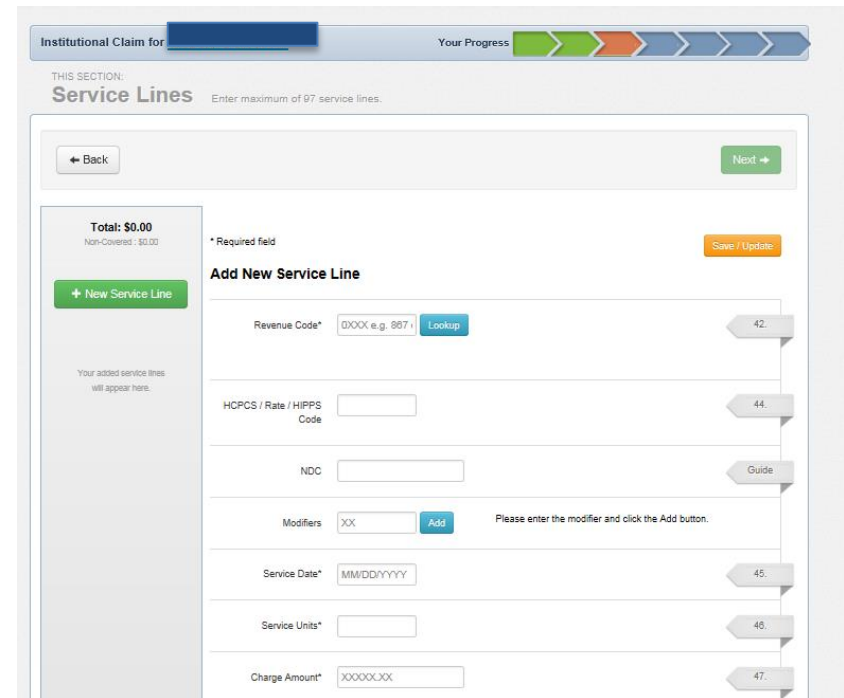
At the bottom left of the form, the word 'Admission' is displayed.

 Add the **provider information**. Click save and continue to go to next section.




The screenshot shows the 'Provider Details' section of the 'Institutional Claim for [redacted]' form. The progress bar indicates the current step. The section includes fields for Billing Provider (NPI, Taxonomy, Address, City, State, Zip), Pay-to Provider (NPI, Taxonomy, IRS/Tax ID Number, Pay-To Name, Address, City, State, Zip), and Attending Provider (NPI, Taxonomy, First Name, Last Name). A 'Back' button is on the left and a 'Next' button is on the right. A red box highlights the NPI field with the message 'Invalid Data' and a 'Search' button.

 Click **Add new service line** and enter the service lines information.



The screenshot shows the 'Service Lines' section of the 'Institutional Claim for [redacted]' form. The progress bar indicates the current step. The section includes a 'Back' button and a 'Next' button. A 'Total: \$0.00' is displayed. A 'New Service Line' button is available. The 'Add New Service Line' form includes fields for Revenue Code, HCPCS / Rate / HIPPS Code, NDC, Modifiers, Service Date, Service Units, and Charge Amount. A 'Save / Update' button is on the right. A red box highlights the 'Add' button next to the Modifiers field.

Enter additional insurance (if applicable)



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

[Virginia Ryan](#)

Viewing Claims For :

Institutional Claim for [KRYSTAL L MULLEN](#)

Your Progress

THIS SECTION:

Additional Insurance

 Enter additional insurance details.

You may skip this section if there is no additional insurance.

Primary Insurance

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

Carrier Type

Policy Number


Amount Allowed

Deductible

Copay

Co-Insurance

Enter diagnosis codes



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

Viewing Claims For:

Institutional Claim for:
 Your Progress:

THIS SECTION:

Diagnosis Codes

 Enter all relevant diagnosis codes.

* Required field

ICD Version Indicator* ☒ ICD 10

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

Principal Diagnosis Code* XXXX e.g. V87: POA Indicator Select...

67.

Admitting Diagnosis Code* XXXX e.g. V87:

69.

Diagnosis Codes (87A-Q) XXXX e.g. 140: POA Indicator Select...

67.a-q

Patient Reason for Visit XXXX e.g. V87:

70.

External Cause of Injury Code (ECI) XXXX e.g. V87:

72.

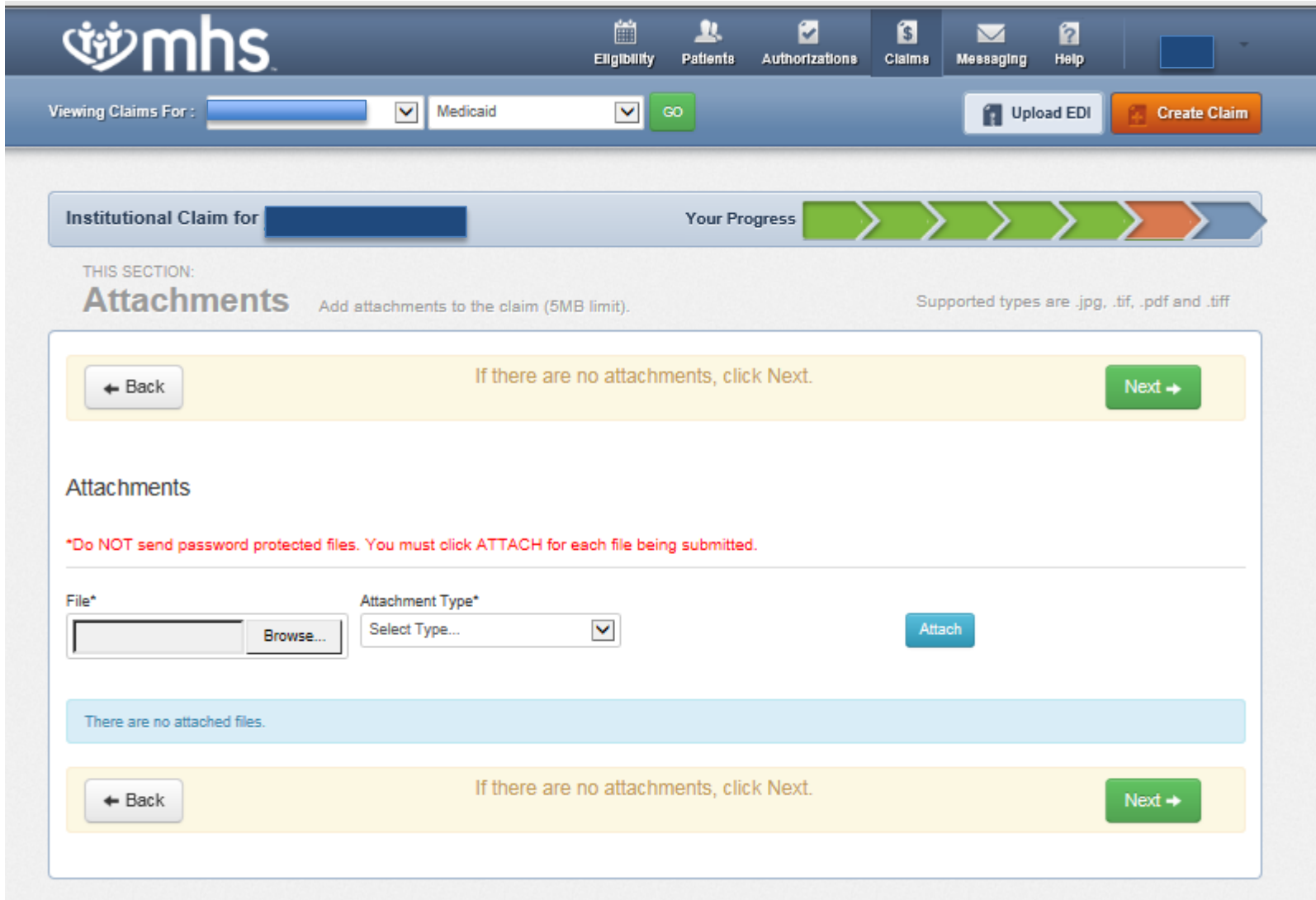
Prospective Payment Code

71.

Condition Codes XX e.g. 01:

18-98

Add attachments (if applicable)



The screenshot shows the MHS web interface for filing an Institutional Claim. The top navigation bar includes links for Eligibility, Patients, Authorizations, Claims, Messaging, and Help. Below this, a 'Viewing Claims For' section shows 'Medicaid' selected. A progress bar indicates the current step is 'Attachments'. The main section is titled 'Attachments' with a note: 'Add attachments to the claim (5MB limit). Supported types are .jpg, .tif, .pdf and .tiff'. A yellow banner at the top of the section contains 'Back' and 'Next' buttons with the instruction 'If there are no attachments, click Next.' Below this, the 'Attachments' section has a red warning: '*Do NOT send password protected files. You must click ATTACH for each file being submitted.' The form includes a 'File*' input with a 'Browse...' button, an 'Attachment Type*' dropdown menu, and an 'Attach' button. A light blue message box states 'There are no attached files.' At the bottom, another yellow banner with 'Back' and 'Next' buttons and the instruction 'If there are no attachments, click Next.' is present.

Institutional Claim for [Redacted] **Your Progress** [Progress Bar]

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

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

Attachments


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

File* [Text Box] Browse... Attachment Type* [Dropdown Menu] Attach

There are no attached files.


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

Review claim and submit



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

Viewing Claims For:

Institutional Claim for
 Your Progress 

THIS SECTION:
Review and Submit Please review your claim before submitting.

Almost done!

You can go back to review your claim or submit now.

Claim ID:

General Info [Edit](#)







Patient Control #: 111111111
 Medical Record #: 111111111
 Type Of Bill: 110
 Statement From Date: 09/01/2017
 Statement To Date: 09/05/2017
 Prior Payments:
 Prior Authorization Number:
 Admission Date: 09/01/2017
 Admission Hour: 10
 Admission Type: 9
 Admission Source: 7
 Discharge Status: 01
 Discharge Hour: 09

Provider Details [Edit](#)

Provider Type	NPI	Taxonomy	Name	Tax ID	Address (1)	Address (2)	City	State	Zip
Billing Provider	<input type="text"/>								
PayTo Provider	<input type="text"/>								

Provider Type	NPI	Taxonomy	First Name	Last Name	IRS/Tax ID Num	Organization
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Tips to Remember

-  Clicking on items (claim numbers, check numbers, dates) that are highlighted will reveal additional information.
-  When filtering to find a claim or payment, only a 90 day date range can be used.
-  Click on the Submitted Claims tab to view claims that have been submitted. The Filter tab can be utilized to see older dates.
-  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.
-  If you manage multiple tax id numbers you can choose another tax id and view the dashboard associated with that TIN from any screen.

Reviewing Payments

EFTs and ERAs

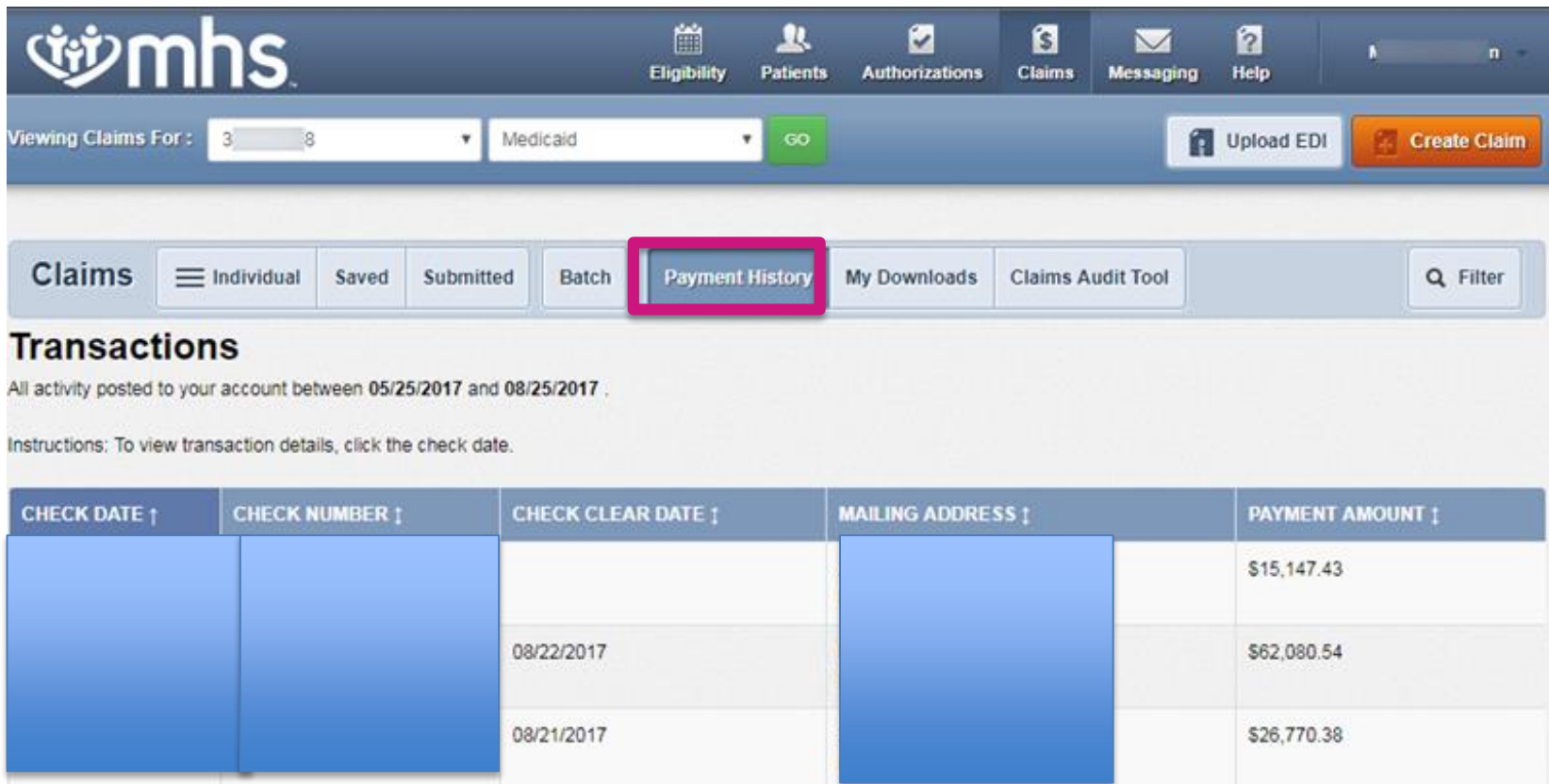
PaySpan Health

- Web based solution for Electronic Funds Transfers (EFTs) and Electronic Remittance Advices (ERAs)
- One year retrieval of remittance advice
- Provided at no cost to providers and allows online enrollment
- Register at payspanhealth.com
 - For questions call 1-877-331-7154 or email providersupport@payspanhealth.com

Payment History

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

- Click on **Check Date** to view Explanation of Payment

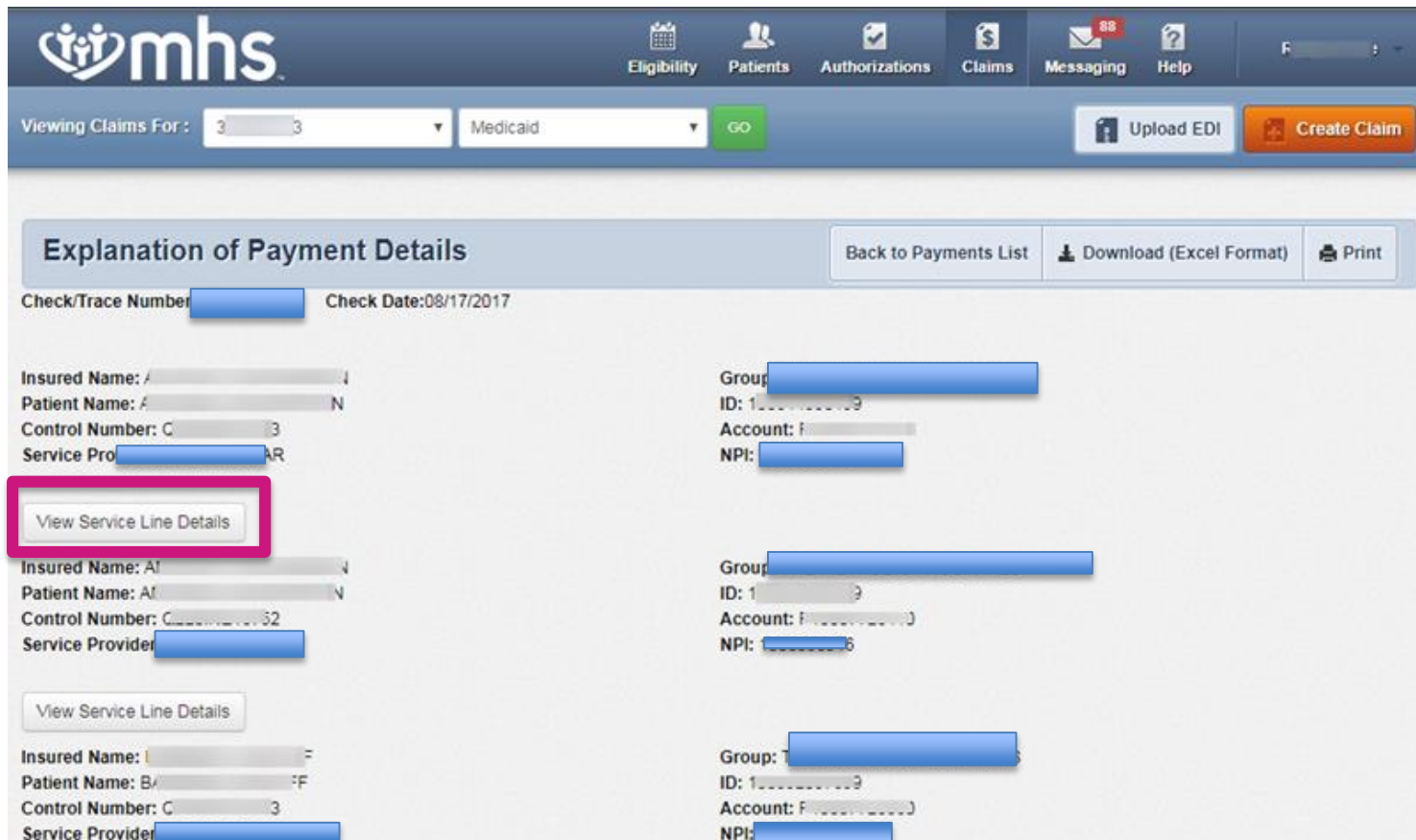


The screenshot shows the MHS web application interface. At the top, there is a navigation bar with icons for Eligibility, Patients, Authorizations, Claims, Messaging, and Help. Below this, a section for 'Viewing Claims For:' includes a dropdown menu set to '3' and a 'Medicaid' filter, with a green 'GO' button. To the right are buttons for 'Upload EDI' and 'Create Claim'. A central navigation bar contains tabs for 'Claims', 'Individual', 'Saved', 'Submitted', 'Batch', 'Payment History' (highlighted with a red box), 'My Downloads', and 'Claims Audit Tool'. Below this is a 'Transactions' section with a date range of '05/25/2017 and 08/25/2017'. Instructions state: 'To view transaction details, click the check date.' A table displays transaction data with columns for Check Date, Check Number, Check Clear Date, Mailing Address, and Payment Amount. The table contains three rows of data, with the first two rows partially obscured by blue rectangular overlays.

CHECK DATE ↑	CHECK NUMBER ↑	CHECK CLEAR DATE ↓	MAILING ADDRESS ↓	PAYMENT AMOUNT ↓
				\$15,147.43
		08/22/2017		\$62,080.54
		08/21/2017		\$26,770.38

Payment History

Click on **View Service Line Details**



The screenshot displays the MHS web application interface for viewing payment history. At the top, the MHS logo is on the left, and navigation links for Eligibility, Patients, Authorizations, Claims, Messaging (with a red notification badge), and Help are on the right. Below the navigation bar, a header section contains a dropdown for 'Viewing Claims For:' set to '3', a dropdown for 'Medicaid', a green 'GO' button, an 'Upload EDI' button, and a red 'Create Claim' button. The main content area is titled 'Explanation of Payment Details' and includes links for 'Back to Payments List', 'Download (Excel Format)', and 'Print'. Below this, there are three rows of claim details. Each row shows a 'Check/Trace Number' (redacted), a 'Check Date' (08/17/2017), and various fields for Insured Name, Patient Name, Control Number, Service Provider, Group, ID, Account, and NPI. The first row's 'View Service Line Details' button is highlighted with a red rectangular box.

Explanation of Payment Details [Back to Payments List](#) [Download \(Excel Format\)](#) [Print](#)

Check/Trace Number: [Redacted] Check Date: 08/17/2017

Insured Name: [Redacted]
Patient Name: [Redacted] N
Control Number: C [Redacted] 3
Service Provider: [Redacted] AR

View Service Line Details

Insured Name: Al [Redacted]
Patient Name: Al [Redacted] N
Control Number: C [Redacted] 52
Service Provider: [Redacted]

View Service Line Details

Insured Name: [Redacted] F
Patient Name: BA [Redacted] F
Control Number: C [Redacted] 3
Service Provider: [Redacted]

Group: [Redacted]
ID: 1 [Redacted] 9
Account: F [Redacted] 0
NPI: [Redacted]

Group: [Redacted]
ID: 1 [Redacted] 9
Account: F [Redacted] 0
NPI: [Redacted]

Group: [Redacted]
ID: 1 [Redacted] 9
Account: F [Redacted] 0
NPI: [Redacted]

Payment History

View Service Line Details

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

Explanation of Payment Details

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

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

Check/Trace Number: [REDACTED]
Check Date: 08/17/2017

Insured Name: [REDACTED]
Patient Name: [REDACTED]
Control Number: [REDACTED]
Service Provider: [REDACTED]

Group: T [REDACTED]
ID: [REDACTED]
Account: F [REDACTED]
NPI: [REDACTED]

[View Service Line Details](#)

Insured Name: [REDACTED]
Patient Name: [REDACTED]
Control Number: [REDACTED]
Service Provider: [REDACTED]

Group: T [REDACTED]
ID: [REDACTED]
Account: F [REDACTED]
NPI: [REDACTED]

[View Service Line Details](#)

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

Remit Code Descriptions
on
REDUCED PAYMENT FOR OUT OF NETWORK PROVIDER

Home Health Billing

Home Health Billing

Revenue and Healthcare Common Procedure Coding System (HCPCS) codes

42X

- G0151 – Physical therapy in home health setting
- 97001 – Physical Therapy Evaluations

43X

- G0152 – Occupational therapy in home health setting
- 97003 – Occupational Therapy Evaluations

44X

- G0153 – Speech therapy in home health setting
- 92521–92524 – Speech Evaluations

552 – 99600

- Skilled nursing home health visit (modifier TD for RN and TE for LPN or licensed vocational nurse (LVN))


572 - 99600

- Home health aide home health visit

 (modifier TD for RN and TE for LPN or licensed vocational nurse (LVN))

Home Health Billing

Overhead:

 Home health providers receive an overhead rate for administrative costs for each visit to the members home.

 Providers can only receive one overhead rate per member per date of service.

 Overhead can be billed as a span date if the dates of service are consecutive.

Home Health Billing

Overhead:

There are two occurrence codes that can be used to submit the overhead



Occurrence code 61



used for individual days as well as span dates.



Occurrence code 50



Used only within 30 days of hospital discharge.

Ambetter Claims Process

Claims

Clean Claim

- A claim that is received for adjudication in a nationally accepted format in compliance with standard coding guidelines and does not have any defect, impropriety, lack of any required documentation or particular circumstance requiring special treatment that prevents timely payment

Exceptions

- A claim for which fraud is suspected
- A claim for which a third party resource should be responsible

Claim Submission

The timely filing deadline for initial claims is 180 days from the date of service or date of primary payment when Ambetter is secondary.

Claims may be submitted in 3 ways:

1. The secure web portal located at ambetter.mhsindiana.com
2. **Electronic Clearinghouse**
 - Payor ID 68069
 - Clearinghouses currently utilized by ambetter.mhsindiana.com will continue to be utilized
 - For a listing our the Clearinghouses, please visit our website at ambetter.mhsindiana.com
3. **Paper claims may be submitted to PO Box 5010 Farmington, MO 64640-5010**

Claim Submission

Claim Reconsiderations

- A written request from a provider about a disagreement in the manner in which a claim was processed. No specific form is required.
- Must be submitted within 180 days of the Explanation of Payment.
- Claim Reconsiderations may be mailed to PO Box 5010 – Farmington, MO 63640-5010

Claim Disputes

- Must be submitted within 180 days of the Explanation of Payment
- A Claim Dispute form can be found on our website at ambetter.mhsindiana.com
- The completed Claim Dispute form may be mailed to PO Box 5000 – Farmington, MO 63640-5000

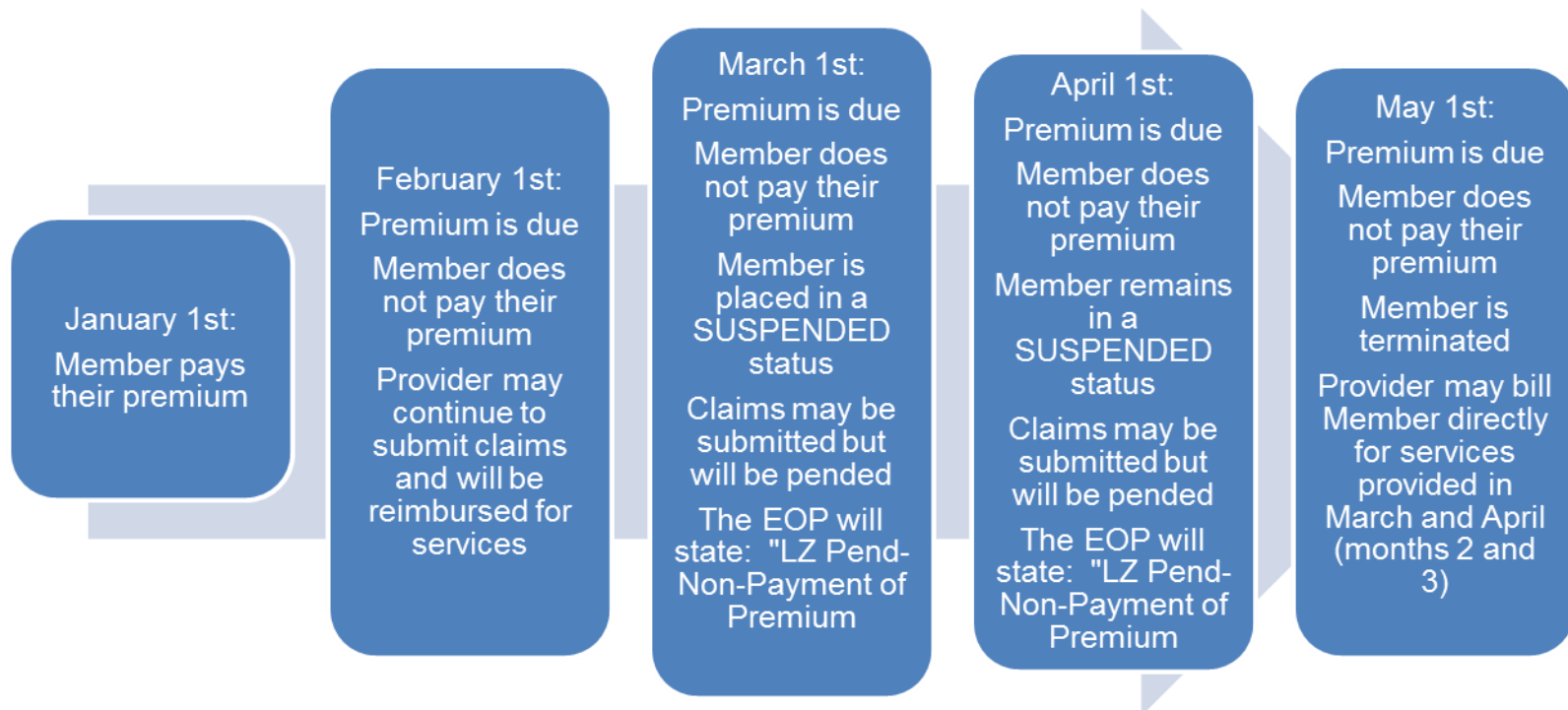
Claim Submission

Member in Suspended Status

- A provision of the ACA allows members who are receiving Advanced Premium Tax Credits (APTCs) a 3 month grace period for paying claims.
- After the first 30 days, the member is placed in a suspended status. The Explanation of Payment will indicate LZ Pend: Non-Payment of Premium.
- While the member is in a suspended status, claims will be pended.
- When the premium is paid by the member, the claims will be released and adjudicated.
- If the member does not pay the premium, the claims will be released and the provider may bill the member directly for services.

Claim Submission

Member in Suspended Status



Claims for members in a suspended status are not considered “clean claims”.

** Note: When checking Eligibility, the Secure Portal will indicate that the member is in a suspended status.*

Claim Submission

Other helpful information:

Rendering Taxonomy Code

- Claims must be submitted with the rendering provider's taxonomy code
- The claim will deny if the taxonomy code is not present
- This is necessary in order to accurately adjudicate the claim

CLIA Number

- If the claim contains CLIA certified or CLIA waived services, the CLIA number must be entered in Box 23 of a paper claim form or in the appropriate loop for EDI claims
- Claims will be rejected if the CLIA number is not on the claim

Claim Payment

PaySpan

- Ambetter partners with PaySpan for Electronic Remittance Advice (ERA) and Electronic Funds Transfer
- If you currently utilize PaySpan, you will auto-enrolled in PaySpan for the Ambetter product
- **If you do not currently utilize PaySpan: To register call 1-877-331-7154 or visit payspanhealth.com**

Allwell Billing Overview

Electronic Claims Transmission

 **Six clearinghouses for Electronic Data Interchange (EDI) submission**

 **Faster processing turn around time than paper submission**

- Emdeon – Payer ID 68069
- Gateway
- Availity/THIN
- SSI
- Medavant
- Smart Data Solution

EDI Support

Companion guides for EDI billing requirements plus loop segments can be found on the following website:

mhsindiana.com/providers/resources/electronic-transactions

For more information, contact:

Allwell from MHS c/o Centene EDI Department

1-800-225-2573, extension 25525

e-mail: EDIBA@centene.com

Claims Filing Timelines






 **Medicare Advantage Claims are to be mailed to the following billing address:**

Allwell from MHS
P.O. Box 3060
Farmington, MO 63640-3822


 **Participating providers have **180 days** from the date of service to submit a timely claim**

 **All requests for reconsideration or claim disputes must be received within **180 days** from the original date of notification of payment or denial**

Claims Payment

-  A clean claim is received in a nationally accepted format in compliance with standard coding guidelines, and requires no further information, adjustment, or alteration for payment
-  A claim will be paid or denied with an Explanation of Payment (EOP) mailed to the provider who submitted the original claim
-  Providers may NOT bill members for services when the provider fails to obtain authorization and the claim is denied
-  Dual-eligible members are protected by law from balance billing for Medicare Parts A and B services. This includes deductibles, coinsurance, and copayments
-  Providers may not balance bill members for any differential

Coding Auditing & Editing

 **Allwell from MHS** uses code editing software based on a variety of edits:

- American Medical Association (AMA)
- Specialty society guidance
- Clinical consultants
- Centers for Medicare & Medicaid Services (CMS)
- National Correct Coding Initiative (NCCI)

 **Software audits for coding inaccuracies such as:**

- Unbundling
- Upcoding
- Invalid codes

Claims Reconsideration & Disputes

 A claim dispute is to be used only when a provider has received an unsatisfactory response to a request for reconsideration

 Submit reconsiderations or disputes to:
Allwell from MHS

Attn: Reconsiderations

P. O. Box 4000

Farmington, MO 63640-4000

Provider Portal

Secure Portal Registration or Login



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

Contrast ☒ On ☐ Off [a](#) [a](#) [a](#) language▼

FOR MEMBERS

FOR PROVIDERS

GET INSURED

FOR PROVIDERS

Login

Become a Provider

Prior Authorization +

Dental Providers

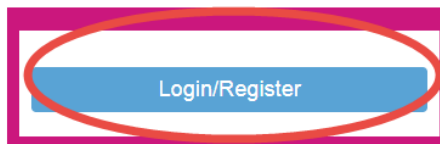
Pharmacy +

Provider Resources +

QI Program +

Provider News

Portal Login



[Click here for more information](#) on the Provider Portal functions and training documents.

Behavioral Health Secure Portal

[Click here for the Cenpatico behavioral health portal.](#)

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 button. A new window will open. You can login or register.

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.

Registration

Registration Complete!

Your Progress 

Thank you for completing your registration! A Superior HealthPlan provider services specialist will be sending you an email when your profile has been activated. Please allow up to 2 business days for processing.

If you do not receive an email within 2 business days, please log in and contact us using secure messaging or call 866-895-8443 for additional assistance.

[Login](#)



The Tools You Need Now!

Our site has been designed to help you get your job done.

For registration or secure website questions call (866) 912-0327.

Manage all products with ease in one location



Check Eligibility

Find out if a member is eligible for service.



Authorize Services

See if the service you provide is reimbursable.



Manage Claims

Submit or track your claims and get paid fast.

Login

User Name (Email)

name@domain.com

Password

Login

[Forgot Password / Unlock Account](#)

Need To Create An Account?

Registration is fast and simple, give it a try.

Create An Account

How to Register

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

Provider Registration Video

Provider Registration PDF



Eligibility



Patients



Authorizations



Claims



Messaging



Help

Provider Name

Viewing Dashboard For :

Tax ID Number

Medicaid

GO

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	C	1
	08/19/2017	F	8

Welcome

Add a TIN to My ACCOUNT >

Manage Accounts >

Reports >

Patient Analytics >

Provider Analytics--Coming Soon >

Recent Activity

Date

Activity


Quick Links


[Provider Resources](#)







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

Please allow 24-48 hours for your account to be verified. An email will be sent once access to the portal tools have been granted to the respective account.

Dashboard Change


 Provider has the ability to change between **Tax IDs** along with **Medicaid** and **Ambetter** and **Allwell** at anytime.









 Eligibility  Patients  Authorizations  Claims  Messaging  Help

Viewing Dashboard For :

Quick Eligibility Check Welcome



 Eligibility  Patients  Authorizations  Claims  Messaging  Help

Viewing Dashboard For :

Quick Eligibility Check Welcome



MHS Provider Relations Team

Candace Ervin	Envolve Dental Indiana Provider Relations	1-877-647-4848 ext. 20187	Candace.Ervin@envolvehealth.com
Chad Pratt	Provider Relations Specialist – Northeast Region	1-877-647-4848 ext. 20454	ripratt@mhsindiana.com
Tawanna Danzie	Provider Relations Specialist – Northwest Region	1-877-647-4848 ext. 20022	tdanzie@mhsindiana.com
Jennifer Garner	Provider Relations Specialist – Southeast Region	1-877-647-4848 ext. 20149	jgarner@mhsindiana.com
Taneya Wagaman	Provider Relations Specialist – Central Region	1-877-647-4848 ext. 20202	twagaman@mhsindiana.com
Katherine Gibson	Provider Relations Specialist – North Central Region	1-877-647-4848 ext. 20959	kagibson@mhsindiana.com
Esther Cervantes	Provider Relations Specialist – South West Region	1-877-647-4848 ext. 20947	Estherling.A.PimentelCervantes@mhsindiana.com
Mary Schermer	Behavioral Health Provider Relations Specialist - West Region	1-877-647-4848 ext. 20269	mary.schermer@mhsindiana.com
LaKisha Browder	Behavioral Health Provider Relations Specialist - East Region	1-877-647-4848 ext. 20224	lakisha.browder@mhsindiana.com

Provider Network Territories

Physical Health

PROVIDER NETWORK TERRITORIES

TAWANNA DANZIE

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

CHAD PRATT

Provider Performance Associate
1-877-647-4848 ext. 20454
rpratt@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

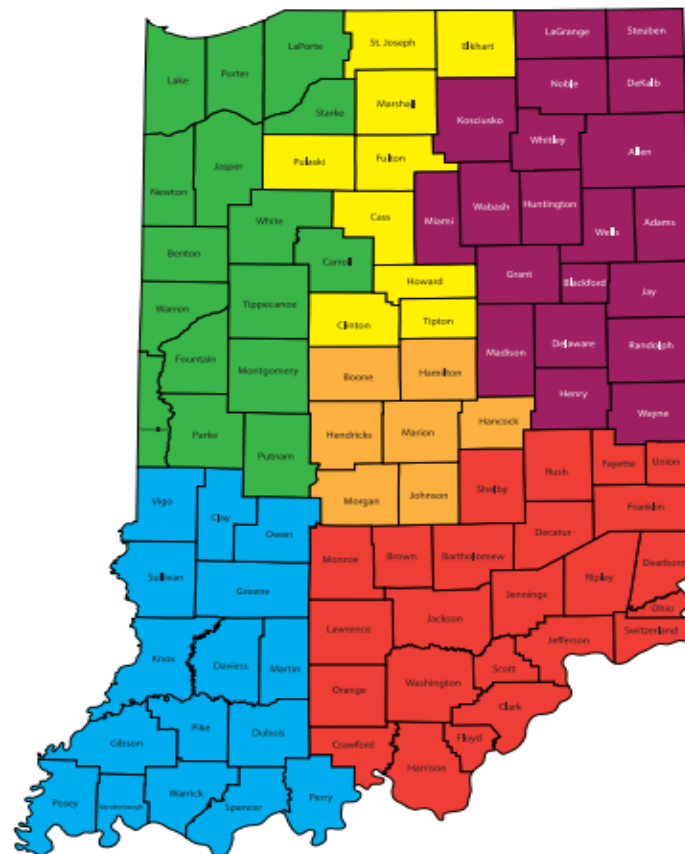
ESTHER CERVANTES

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

JENNIFER GARNER

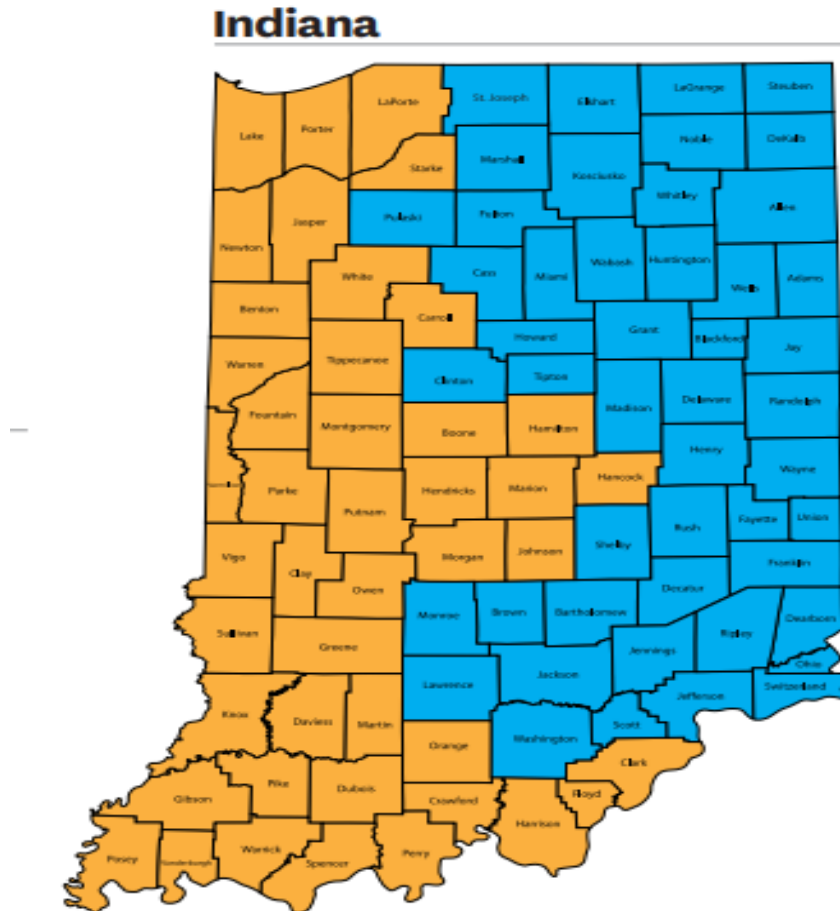
Provider Performance Associate
1-877-647-4848 ext. 20149
jgarner@mhsindiana.com
Exception to map: IU Health, Eskenazi Health

Indiana









mschermer@mhsindiana.com

lbrowder@mhsindiana.com



What You Learned Today

-  The difference between a claim rejection and claim denials
-  Common denials and resolution process
-  How to submit and correct claims via the Web Portal
-  How to contact your Provider Network representative
-  Ambetter Claim Process
-  How to bill claims for Allwell

Questions?