Welcome to Managed Health Services (MHS)

mhs™

Hoosier Healthwise | Healthy Indiana Plan | Hoosier Care Connect

Agenda

- MHS Overview
- Health Programs
- Claim Process
- Prior Authorization Process
- HEDIS
- Coordinated Care Programs
- MHS Partnership
- Ambetter
- Questions

Who is MHS?

Managed Health Services (MHS) is a health insurance provider that has been proudly serving Indiana residents for two decades through Hoosier Healthwise, the Healthy Indiana Plan (HIP) and Hoosier Care Connect.

MHS also offers a qualified health plan through the Health Insurance Marketplace called Ambetter from MHS. All of our plans include quality, comprehensive coverage, with a provider network you can trust.

MHS is your choice for better healthcare.

Provider Relations

Each provider will have an **MHS Provider Network Specialist** assigned to them. This team serves as the primary liaison between the Plan and our provider network and is responsible for:

- Provider Education
- HEDIS/Care Gap Reviews
- Financial Analysis
- Assisting Providers with EHR Utilization
- Demographic Information Updates
- Initiate credentialing of a new practitioner
- Facilitate inquiries related to administrative policies, procedures, and operational issues
- Monitor performance patterns
- Contract clarification
- Membership/Provider roster
- Assist in Provider Portal registration and Payspan

MHS Provider Relations Team

Nancy Robinson	Senior Director, Provider Relations	1-877-647-4848 ext. 20180	nrobinson@mhsindiana.com
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Healthy Indiana Plan

Who is eligible for the Healthy Indiana Plan (HIP)?

The Healthy Indiana Plan (HIP) is an affordable health insurance program from the State of Indiana for uninsured adult Hoosiers.

- Members will select a managed care entity (MCE) responsible for coordinating care in partnership with their medical provider(s)
- Care coordination services will be individualized based on a member's assessed level of need determined through a health screening
- HIP provides coverage for qualified low-income Hoosiers ages 19 to 64, not receiving Medicare who are interested in participating in a low-cost, consumer-driven health care program

HIP uses a proven, consumer-driven approach that was pioneered in Indiana.

POWER Up to HIP Plus

Encourage HIP members to join HIP Plus

- Enhanced benefit package
  - No copays! Only pay a monthly contribution
  - Dental coverage
  - Vision coverage
  - Additional therapy services
  - Rx mail order option
  - Chiropractic care
- When can members POWER Up?
  - » Open enrollment
  - » Redetermination/Potential Plus Loop
- Contact MHS Customer Service to POWER Up to HIP Plus
  - 1-877-647-4848

HIP Basics

- Personal Wellness and Responsibility (POWER) Account - combination of member and state contributions covers first $2,500 of health care services received each year.
  - Members pay a portion, as low as $1 per month
- Members who don't pay monthly contributions face penalties:
  - If income is over 100% FPL ($1,005/mo. for an individual)
    - Member is subject to a 6 month lockout period in which they may not receive HIP benefits
  - If income is under 100% of FPL
    - Member receives reduced benefits and must make copayments each time they receive a health service (HIP Basic)

Failure to pay the monthly contribution may make receiving health care more expensive for the member!

HIP Basic Plan – Copay

When members with income less than or equal to 100% FPL do not pay their HIP Plus monthly contribution, they are moved to HIP Basic. HIP Basic Members are responsible for making the below copayments for health and pharmacy services.

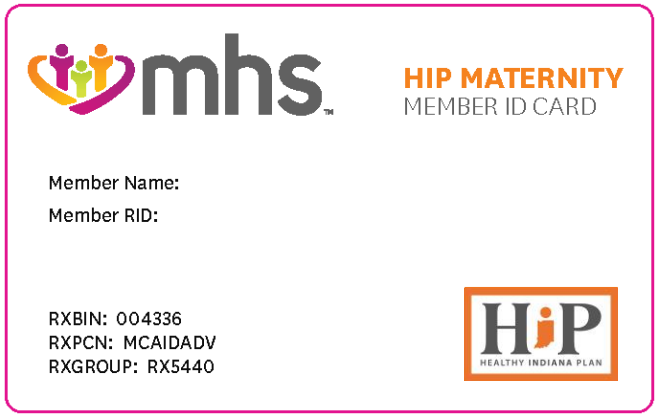
**Copayments may not be more than the cost of services received.*

Service	HIP Basic Co-Pay Amounts <=100% FPL
Outpatient Services	$4
Inpatient Services	$75
Preferred Drugs	$4
Non-preferred drugs	$8
Non-emergency ER visit	Up to $25

HIP Member ID Cards

HIP POWER Account

HIP Maternity ID Card



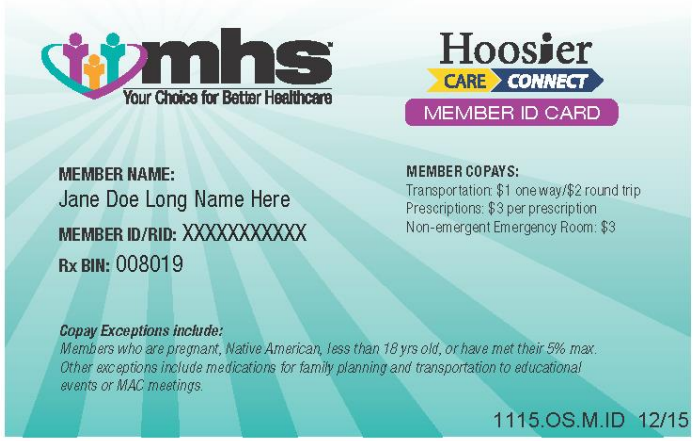
Hoosier Care Connect

Who is Eligible for Hoosier Care Connect?

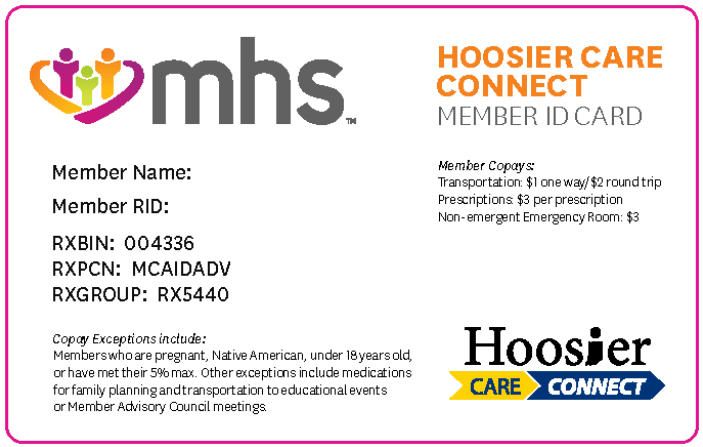
Hoosier Care Connect is a coordinated care program for Indiana Health Coverage Programs (IHCP) members age 65 and over, or with blindness or a disability who are residing in the community and are not eligible for Medicare

- Members will select a managed care entity (MCE) responsible for coordinating care in partnership with their medical provider(s)
- Hoosier Care Connect members will receive all Medicaid-covered benefits in addition to care coordination services
- Care coordination services will be individualized based on a member's assessed level of need determined through a health screening

Hoosier Care Connect Member ID Card



Old Branding



New Branding

Hoosier Healthwise

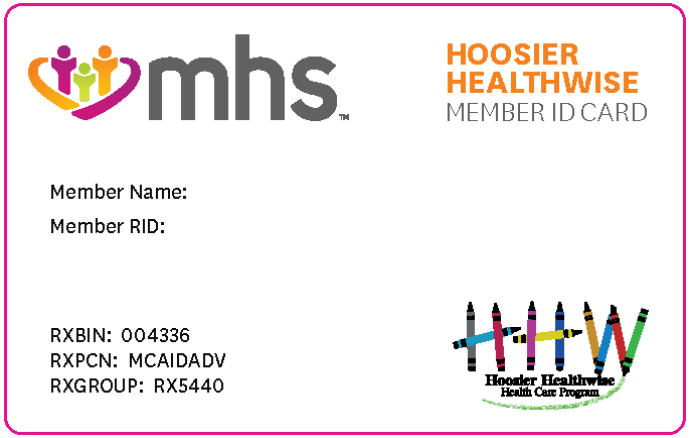
Who is Eligible for Hoosier Healthwise?

Hoosier Healthwise covers the following members:

- Children up to age 19
- Pregnant women
- The Children's Health Insurance Plan (CHIP)
  - This option is available for individuals up to age 19 who may earn too much money to qualify for the standard Hoosier Healthwise coverage

Hoosier Healthwise Member ID Card

Old Branding



New Branding

MHS Website

MHS Website

- mhsindiana.com
- Provider directory search functionality
- Payspan / EFT information
  - Convenient payments
  - One year retrieval of remittance information
  - No cost to providers
- Printable current forms, guides and manuals
  - Update billing information form
  - Denial and Rejection code listings
  - QRG-Quick Reference Guide
- Patient education material
  - KRAMES online services – MHS members have 24 hour a day access to info sheets about more than 4,000 topics relating to health and medication via MHS website. Most information is available in multiple languages including both English and Spanish: mhsindiana.kramesonline.com
- Contact Us feature

MHS Secure Portal Features

- Access for both contracted/non-contracted groups
- Online registration – multiple users
- **Patient Eligibility Listing**
- **Pay For Performance Reporting**
- **Enhanced claim detail**
- **Direct claim submission**
- COB processing with or without attachments
- Claim adjustment
- Claim auditing tool
- Eligibility and COB verification
- Prior authorization
- Gaps in Care
- Online Health Record Vault for “your” patients (includes specialty care)
- Care Management Plan

CLAIM PROCESS

Claim Process

- **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: 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 Process

- 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 newborns RID #.

  - 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

Resubmissions

- Hard copy or web submission
- **Electronic adjustments through the web portal**
- Hard copy resubmissions:
  - Adjustment option on the MHS website.
  - Must attach EOP, documentation, and explanation of the resubmission reason.
  - May use the Provider Claims Adjustment Request Form.

- Providers have **67 calendar days** from the date of EOP to file a resubmission. *Please note, claims will not be reconsidered after this timeline.*

Claim Process

Dispute Resolution

- Should be made in writing by using the Dispute/Objection form.
- 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 the timeline 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 Provider Inquiry does not reserve appeal rights!

Need to Know – 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

Prior Authorization Process

Prior Authorization

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

Prior Authorizations are not a guarantee of payment.

Utilization Management

- Prior Authorization (PA) can be initiated through the MHS referral line at 1-877-647-4848
  - The PA process begins at MHS by speaking with the MHS non-clinical referral staff.

- Prior Authorizations can be completed via fax

- Prior Authorizations can also be submitted online via the MHS Secure Provider Portal at mhsindiana.com/login. When using the portal, supporting documentation can be uploaded directly.
  - Authorization status can also be checked on the portal.

Medicaid Pre-Auth Needed?

- Become a Provider
- Pre-Auth Needed?
  - Medicaid Pre-Auth Needed?
- Transactions
- Provider Forms
- Provider Guides
- Provider Newsletters
- Practice Guidelines
- ICD-10
- Provider Links
- Quality Improvement
- HEDIS®
- Medical Record Documentation Standards
- PaySpan Health
- Charging a POWER Account

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 Opticare
Dental Services need to be verified by State
Ambulance and Transportation Services need to be verified by LCP Transportation
Behavioral Health/Substance Abuse 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 Family Planning services billed with a V25 to V25.9 diagnosis?

YES ☐ NO ☐

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

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

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

99394 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.

This service requires prior authorization.
Login Here to submit authorization

To submit a prior authorization Login Here.

Durable & Home Medical Equipment (DME)

- Members and referring providers will no longer need to search for a DME provider or provider of medical supplies to service their needs
- Order is submitted directly to MHS, coordinated by Medline 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

Durable & Home Medical Equipment

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

- **Web Portal**: Simply 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.
- **Fax Number**: 1-866-346-0911
- **Phone Number:** 1-844-218-4932

Utilization Management

- All elective inpatient/outpatient services must be prior authorized with MHS at least 2 business days prior to the date of service.
- All urgent and emergent services must be called to MHS within 2 business days after the admit.
- Previously approved prior authorizations can be updated for changes in dates of service or CPT/HCPCS codes within 30 days of the original date of service.

Failure to obtain prior authorization for services may result in claim denials!

Utilization Management

MEDICAL NECESSITY GRIEVANCE AND APPEALS

Managed Health Services
Attn: Appeals Coordinator
550 N. Meridian Street, Suite 101
Indianapolis, IN 46204

- Determination will be communicated to the provider within 20 business days of receipt
- Remember: Appeals must be initiated within **33 days** of the denial to be considered. Please note, this is different than a claim appeal request

HEDIS

Why should Providers care about HEDIS?

- HEDIS rates are used to:
  - Guide Pay For Performance Measures
  - Levy bonuses
  - Support increased quality outcomes for Members
  - Encourage preventive care services

P4P Overview

- Bonus Pay for Performance (P4P) fund written into PMP contracts and dependent on product line
- Measures aligned with HEDIS and NCQA
- Annual payout

P4P Scorecards

- **Reports updated regularly on secure portal**
  - Group scorecards
  - Individual scorecards
  - Members in Need of Services lists

Group Scorecard Example

Group name:

Time period covered by this report: YTD 2015 - 1/1/2015 thru 11/30/2015

Group Performance Metrics

Prod	Measure	Minimun applicable members needed for measurement	Number of applicable Members in your practice	Number of Members who comply with the applicable criteria	Group average percentage of members who comply with the criteria	NCQA 75th percentile of members who comply with the criteria (MHS GOAL)	Members needed to reach MHS GOAL
HHW	Adolescent Well Care	10	32	10	31.25%	59.98%	10
HHW	Cervical Cancer	8	1	0	0.00%	67.88%	1
HHW	Childhood Imm - Combo 2	10	1	0	0.00%	79.40%	1
HHW	Chlamydia Screening - Total	10	1	0	0.00%	61.98%	1
HHW	Lead Screening	10	1	0	0.00%	79.67%	1
HHW	Well Child 3-6 Years	10	11	4	36.36%	78.46%	5
HIP	CDC All - Eye Exam	0	3	2	66.67%	62.30%	0
HIP	CDC All - LDL Test	0	3	3	100.00%	79.52%	0
HIP	Cervical Cancer	0	25	9	36.00%	72.99%	10
HIP	Chlamydia Screening - Total	0	1	0	0.00%	61.81%	1
HIP	Colorectal Cancer	0	1	1	100.00%	61.90%	0

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Provider Scorecard Example

Physician name
Group name
Address

Time period covered by this report: YTD 2015 - 1/1/2015 thru 11/30/2015

Physician Performance Metrics

Product	Measure	Number of applicable Members assigned to you	Number of Members who comply with the applicable criteria	Your average percentage of members who comply with the criteria	NCQA 75th percentile of members who comply with the criteria MHS GOAL	Members Needed to reach MHS Goal
HHW	Adolescent Well Care	119	45	37.82%	59.98%	27
HHW	CDC All - LDL Test	1	1	100.00%	80.18%	0
HHW	Cervical Cancer	3	1	33.33%	67.88%	2
HHW	Childhood Imm - Combo 2	8	2	25.00%	79.40%	5
HHW	Chlamydia Screening - Tot	17	13	76.47%	61.98%	0
HHW	Lead Screening	8	2	25.00%	79.67%	5
HHW	Use App Meds Asthma	4	3	75.00%	87.50%	1
HHW	Well Child 15 Months - 6 vi	13	6	46.15%	66.24%	3
HHW	Well Child 3-6 Years	91	54	59.34%	78.46%	18
HIP	CDC All - Eye Exam	14	7	50.00%	62.30%	2
HIP	CDC All - LDL Test	14	12	85.71%	79.52%	0
HIP	Cervical Cancer	84	41	48.81%	72.99%	21
HIP	Chlamydia Screening - Tot	11	6	54.55%	61.81%	1
HIP	Colorectal Cancer	13	6	46.15%	61.90%	3

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Coordinated Care Programs

Case Management Programs

- **MHS case management is made up of nurses and social workers**

- **Case Managers will:**
  - Help members, doctors, and other providers, including behavioral health providers
  - Help members obtain services covered by their Medicaid benefit package
  - Help explain and inform members about their condition
  - Work with provider's healthcare plan for the member
  - Inform members about community resources

First Year of Life

This Care Management program is designed to encourage education and compliance with immunizations and well visits for babies.

The First Year of Life program matches a member with a Nurse Care Manager who is there to answer questions and provide helpful information sheets to let the member know what to expect as the baby grows.

We will also call the member and send reminders to schedule upcoming immunizations and well-child visits with the baby's doctor as needed.

**By participating in the program, members will be eligible to earn more CentAccount rewards*

Right Choices Program

- Members identified as high utilizers in need of specialized intervention are enrolled into the Right Choices Program (RCP)
- The member is “locked-in” to their primary physician and delivery of care for specialty services is coordinated through that provider’s office
- RCP participants are assigned to
  - one primary medical provider (PMP)
  - one pharmacy
  - one hospital

Claim Process

Smoking Cessation

- The Indiana Tobacco Quitline
  - 1-800-QUIT-NOW / (800) 784-8669
  - Free phone-based counseling service that helps Indiana smokers quit.
  - One on one coaching for tobacco users trying to quit.
  - Resources available for both providers and patients.
- Counseling can be billed to MHS using CPT code 99407-U6 Counseling must be at least 10 minutes

Transportation

- Effective January 1, 2017 all MHS members including Hoosier Healthwise, Hosier Care Connect, and Healthy Indiana Plan (HIP) Members will qualify for transportation services provided by LCP

- Rides will take members to and from:
  - Doctor visits
  - Medicaid enrollment visits
  - Pharmacy visits
  - Medicaid reenrollment visits

- Members need to call MHS Member Services at 1-877-647-4848 to schedule their ride at least three days before their appointment

MHS Partnership

Member & Provider Services

1-877-647-4848

- Dedicated staff available Monday - Friday from 8 a.m. - 8 p.m.
- Hoosier Healthwise, HIP and Hoosier Care Connect customer service
- Eligibility verification if needed
- Claims status and assistance
- Translation and transportation coordination
- Health needs screening
- New IVR option-telephonic, self service verification of claims and eligibility
- Spanish speaking representatives (additional languages available upon request)
- Facilitates member disenrollment requests
- Panel full/hold requests
- New member tool kits
- Member QRG

Translation Services

- Available to MHS members/providers at no cost
- Can accommodate most languages and locations
- Interpretation services available in person or telephonically
- Please contact MHS Member Services at 1-877-647-4848 for specific information on accessing these services.
- Spanish speaking representatives available to speak with members if needed. (additional languages are available upon request)

MHS 24/7 Nurse Advice Line

- The MHS Nurse Advise Line is available 24 hours a day, seven days a week to answer members' health questions.

- The Nurse Advice line staff is bilingual in English and Spanish.

Earn Rewards with Preventive Care

MHS CentAccount® Healthy Rewards Program

- MHS will reward members' healthy choices through our CentAccount Healthy Rewards program. Members can earn dollar rewards by staying up to date on preventive care.

- These rewards will be added to a CentAccount card that can be used to buy things like healthy groceries, baby items and clothing as well as over-the-counter drugs (allergy, cold meds, etc.).

- Members can use their CentAccount card at a select number of retailers including Meijer, RiteAid, Dollar General and Family Dollar.

Ambetter from MHS

The Affordable Care Act

Key Objectives of the Affordable Care Act (ACA):

- Increase access to quality health insurance
- Improve affordability

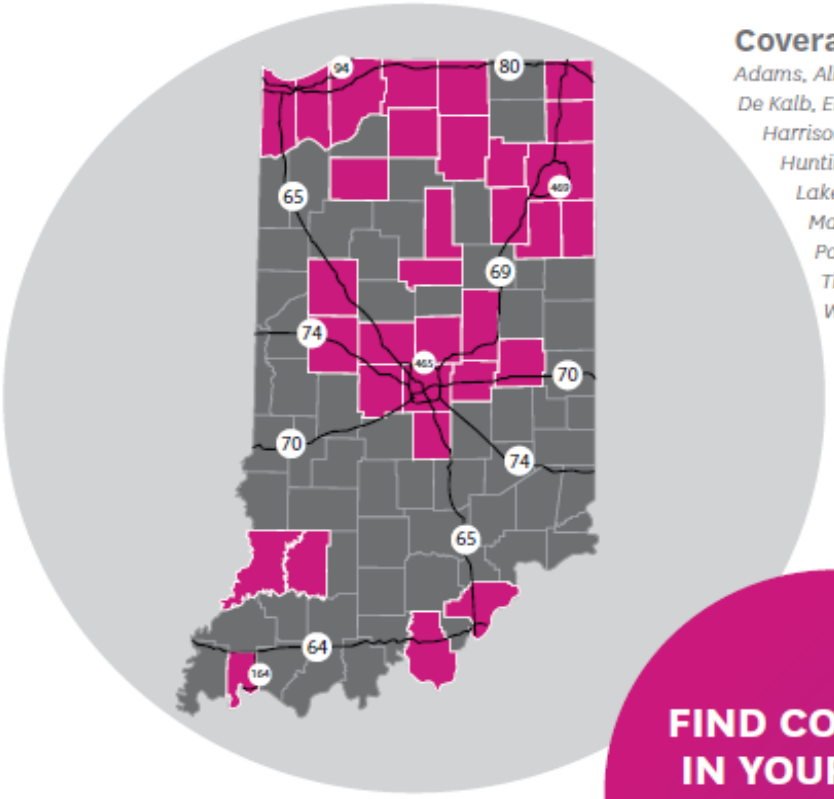
Additional Parameters:

- Dependent coverage to age 26
- Pre-existing condition insurance plan (high risk pools)
- No lifetime maximum benefits
- Preventative care covered at 100%
- Insurer minimum loss ratio (80% for individual coverage)

Ambetter from MHS is an HMO Benefit Plan

- Members enrolled in Ambetter must utilize in-network participating providers except in the case of emergency services.
- Participating providers can be identified by visiting our website and clicking on Find a Provider.
- If an out of network provider is utilized, (except in the case of emergency services), the member will be 100% responsible for all charges.

Coverage Area



Coverage is available in:

Adams, Allen, Boone, Clark, Daviess, De Kalb, Elkhart, Hamilton, Hancock, Harrison, Hendricks, Henry, Howard, Huntington, Johnson, Knox, Kosciusko, Lake, LaPorte, Madison, Marion, Marshall,Miami, Montgomery, Porter, Pulaski, St Joseph, Steuben, Tippecanoe, Vanderburgh, Wells, Whitley.

FIND COVERAGE IN YOUR AREA.

CALL US TODAY

1-844-205-2224

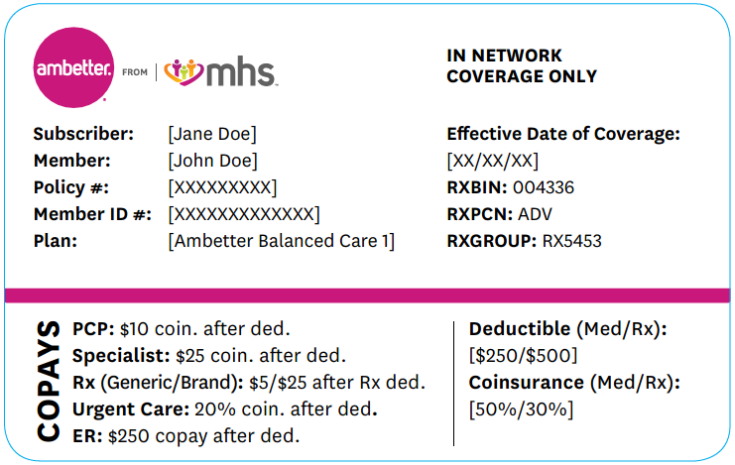
(TTY/TDD 1-800-743-3333)

Ambetter.mhsindiana.com

Verification of Eligibility, Benefits and Cost Share

Member ID Card:

Old Branding



New Branding

**** Possession of an ID Card is not a guarantee eligibility and benefits***

Verification of Eligibility, Benefits and Cost Share

- **Providers should always verify member eligibility:**
  - Every time a member schedules an appointment
  - When the member arrives for the appointment
- **Eligibility verification can be done via:**
  - Secure Provider Portal, ambetter.mhsindiana.com
  - Calling Provider Services, **1-877-687-1182**
- **Panel Status**
  - PCPs should confirm that a member is assigned to their patient panel
  - This can be done via our Secure Provider Portal
  - PCPs can still administer service if the member is not and may wish to have member assigned to them for future care

Verification of Eligibility, Benefits and Cost Share

Eligibility, Benefits and Cost Shares can be verified in 3 ways:

1. **The Ambetter secure portal found at:**
   ambetter.mhsindiana.com
   - If you are already a registered user of the MHS secure portal, you do NOT need a separate registration!

2. **24/7 Interactive Voice Response system**
   - Enter the Member ID Number and the month of service to check eligibility

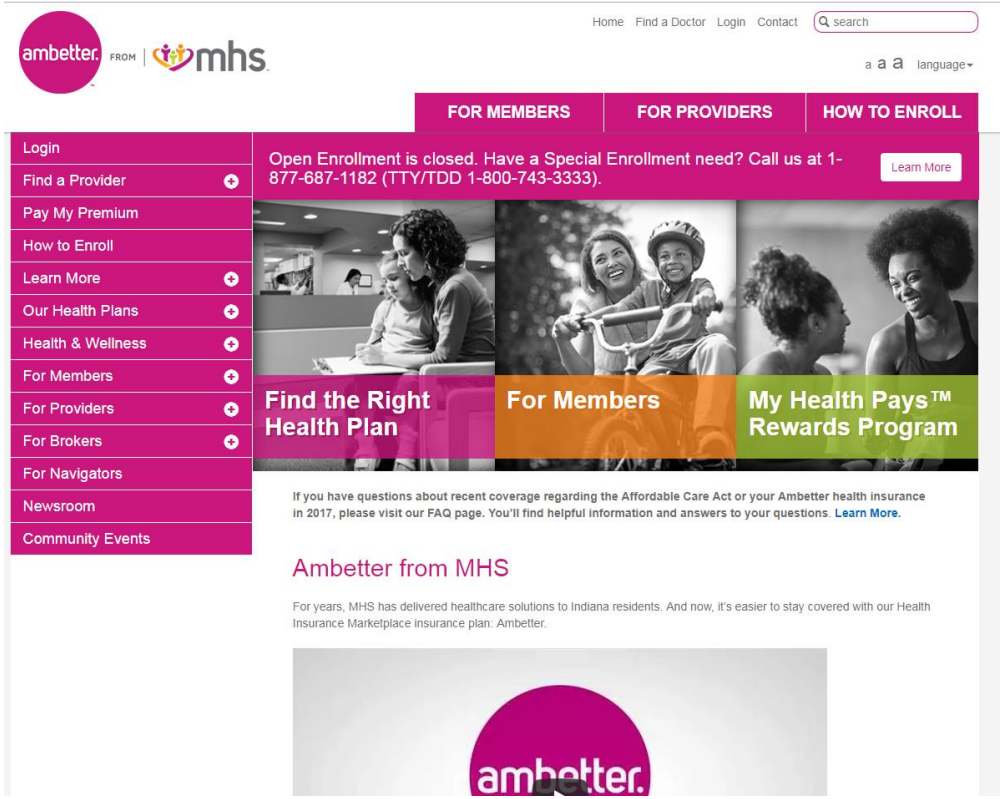
3. **Contact Provider Service at: 1-877-687-1182**

Ambetter Website

Ambetter Website

You may access the Public Website for Ambetter two ways:

1. Go to mhsindiana.com and click on Ambetter
2. Go to ambetter.mhsindiana.com



Ambetter Website

Information contained on our Website

- The Provider and Billing Manual
- Quick Reference Guides
- Forms (Notification of Pregnancy, Prior Authorization Fax forms, etc.)
- The Pre-Auth Needed Tool
- The Pharmacy Preferred Drug Listing
- And much more…

Secure Provider Portal

Information contained on our Secure Provider Portal

- Member Eligibility & Patient Listings
- Health Records & Care Gaps
- Authorizations
- Claims Submissions & Status
- Corrected Claims & Adjustments
- Payments History
- Monthly PCP Cost Reports

Secure Provider Portal

PCP Reports

- PCP reports available on **Ambetter from MHS** secure provider web portal are generated on a monthly basis and can be exported into a PDF or Excel format.

PCP Reports Include

- Patient List with HEDIS Care Gaps
- Emergency Room Utilization
- Rx Claims Report
- High Cost Claims

My Health Pays Program

Members can earn up to **$125** that will be loaded onto their Health Pays Visa® and can be used for eligible expenses.

Here's how it works:

- Complete the Welcome Survey **($50)**
- Get an annual wellness exam **($50)**
- Get an annual flu shot in the fall **($25)**
- Card must be activated online and benefits are effectuated with the plan effective date
- Cards are mailed to the member automatically when the first reward is earned

Utilization Management

Prior Authorization

Prior Authorization can be requested in 3 ways:

1. **The Ambetter secure portal found at ambetter.mhsindiana.com**
   - If you are already a registered user of the MHS portal, you do NOT need a separate registration!

2. **Fax Requests to: 1-855-702-7337**
   The Fax authorization forms are located on our website at ambetter.mhsindiana.com

3. **Call for Prior Authorization at 1-877-687-1182**

Prior Authorization

Procedures / Services

- Potentially Cosmetic
- Experimental or Investigational
- High Tech Imaging (i.e., CT, MRI, PET)
- Infertility
- Obstetrical Ultrasound
  - One allowed in 9 month period, any additional will require prior authorization except those rendered by perinatologists.
  - For urgent/emergent ultrasounds, treat using best clinical judgment and this will be reviewed retrospectively.
- Pain Management

Prior Authorization

Service Type	Timeframe
Scheduled admissions	Prior Authorization required five business days prior to the scheduled admission date
Elective outpatient services	Prior Authorization required five business days prior to the elective outpatient admission date
Emergent inpatient admissions	Notification within one business day
Observation – 23 hours or less	Notification within one business day for non-participating providers
Observation – greater than 23 hours	Requires inpatient prior authorization within one business day
Emergency room and post stabilization, urgent care and crisis intervention	Notification within one business day
Maternity admissions	Notification within one business day
Newborn admissions	Notification within one business day
Neonatal Intensive Care Unit (NICU) admissions	Notification within one business day
Outpatient Dialysis	Notification within one business day

**** This is not meant to be an all-inclusive list***

Utilization Determination Timeframes

Type	Timeframe
Prospective/Urgent	One (1) Business day
Prospective/Non-Urgent	Two (2) Business days
Emergency services	60 minutes
Concurrent/Urgent	Twenty-four (24) hours (1 calendar day)
Retrospective	Thirty (30) calendar days

**** This is not meant to be an all-inclusive list***

Claims

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 out 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.

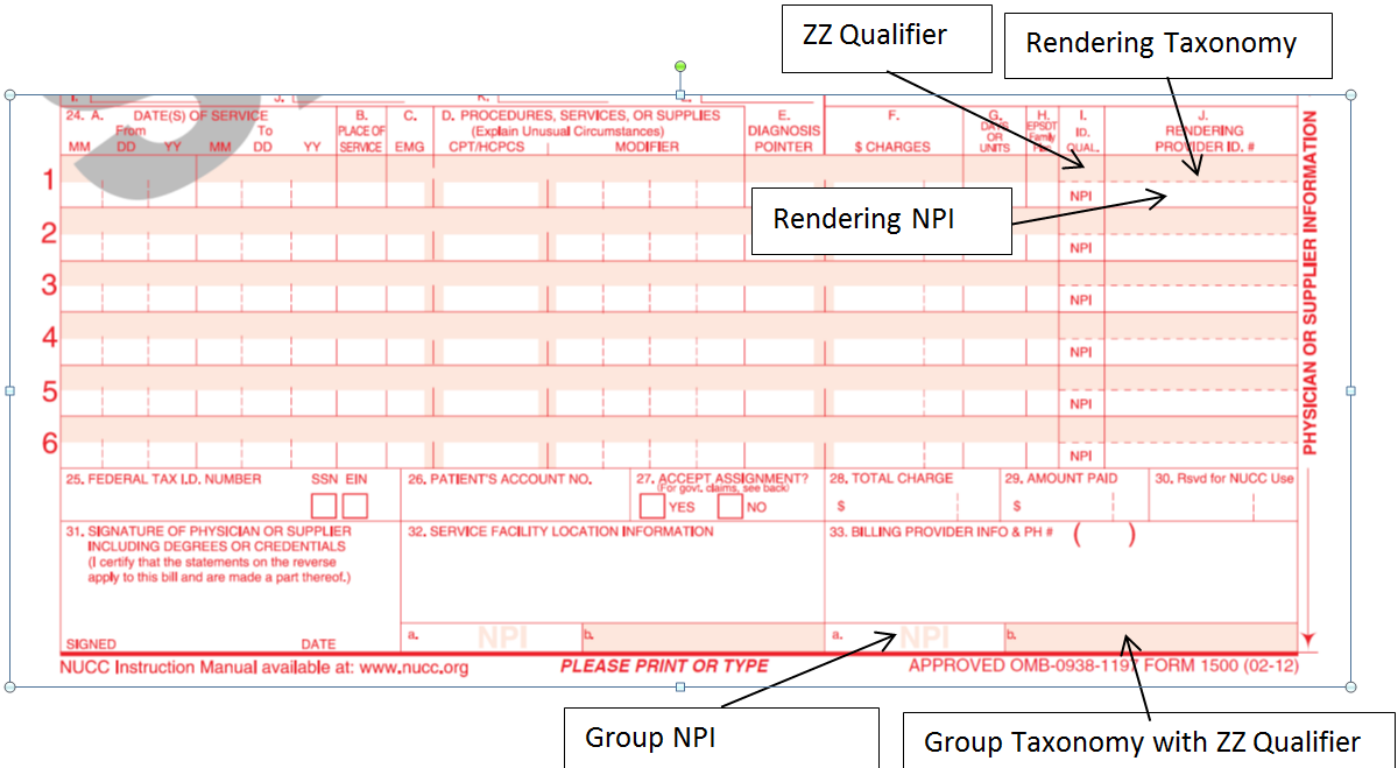
Claim Submission

- **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

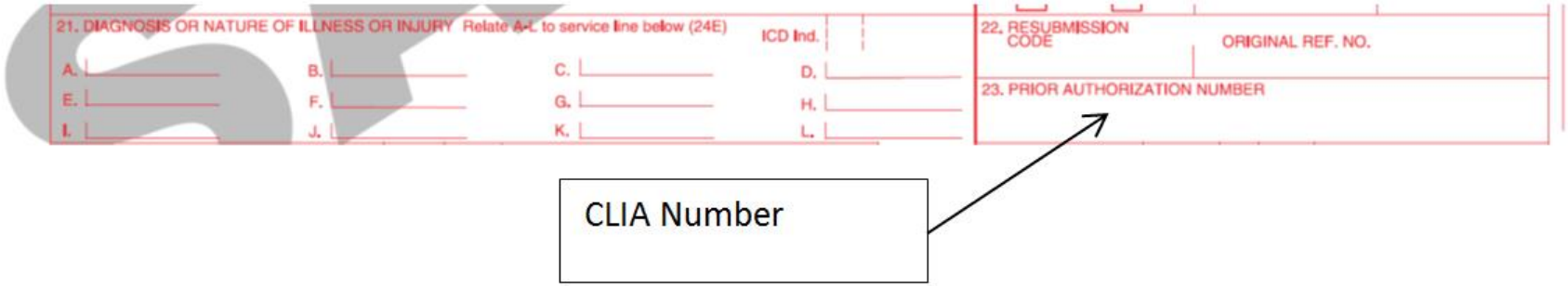
Taxonomy Code

Example of Taxonomy Code – CMS 1500



CLIA Number

- CLIA Number is required on CMS 1500 Submissions in Box 23
- CLIA Number is not required on UB04 Submissions



Claim Submission

Billing the Member:

- Copays, Coinsurance and any unpaid portion of the Deductible may be collected at the time of service.
- The Secure Web Portal will indicate the amount of the deductible that has been met.
- If the amount collected from the member is higher than the actual amount owed upon claim adjudication, the provider must reimburse the member within 45 days.

Questions and Answers