










The Ins and Outs of CMS 1500 Billing



AGENDA

-  Claim Process
-  Creating Claim on MHS Web Portal
-  Reviewing Claims
-  Claim Denial
-  Claim Adjustment
-  Dispute Resolution
-  Taxonomy
-  Allwell Information
-  Ambetter Information

CLAIM PROCESS

Claim Process

Electronic submission through Electronic Data Interchange vendor

- MHS
- Payor ID 68069
- MHS accepts 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 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

- Must be **Red** & White
- Lettering must be in black
Managed Health Services
PO Box 3002
Farmington, MO 63640-3802

Claim Inquiries

- Check status online with the MHS Secure Provider Portal
- mhsindiana.com

Call Provider Services at:

- 1-877-647-4848
- Interactive Voice Response (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 EOP. If primary EOP is received after the 365 days, providers have 60 days from date of primary EOP to file claim to MHS

Claim Process – Billing with Ease

NPI, Tax ID, Zip +4, and Taxonomy

- This information is required for the system to make a one to one match based off of the information provided on the claim and the information on file with IHCP
- Member Information
- Newborn's RID number is required for payment

Attachment Forms

- Need to be accompanied with the claim form when submitted for claim processing

Secondary Claims (TPL)

- Accepted electronically from vendors or via the MHS Secure Provider Portal

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


Creating a Claim on MHS Provider Portal


Create a New Claim





 Eligibility

 Patients

 Authorizations


 Claims


 Messaging

 Help

Name ▾

Viewing Claims For : ▾ ▾

 Upload EDI

 Create Claim



 Eligibility

 Patients

 Authorizations

 Claims

 Messaging

 Help

Name ▾

Viewing Claims For : ▾ ▾

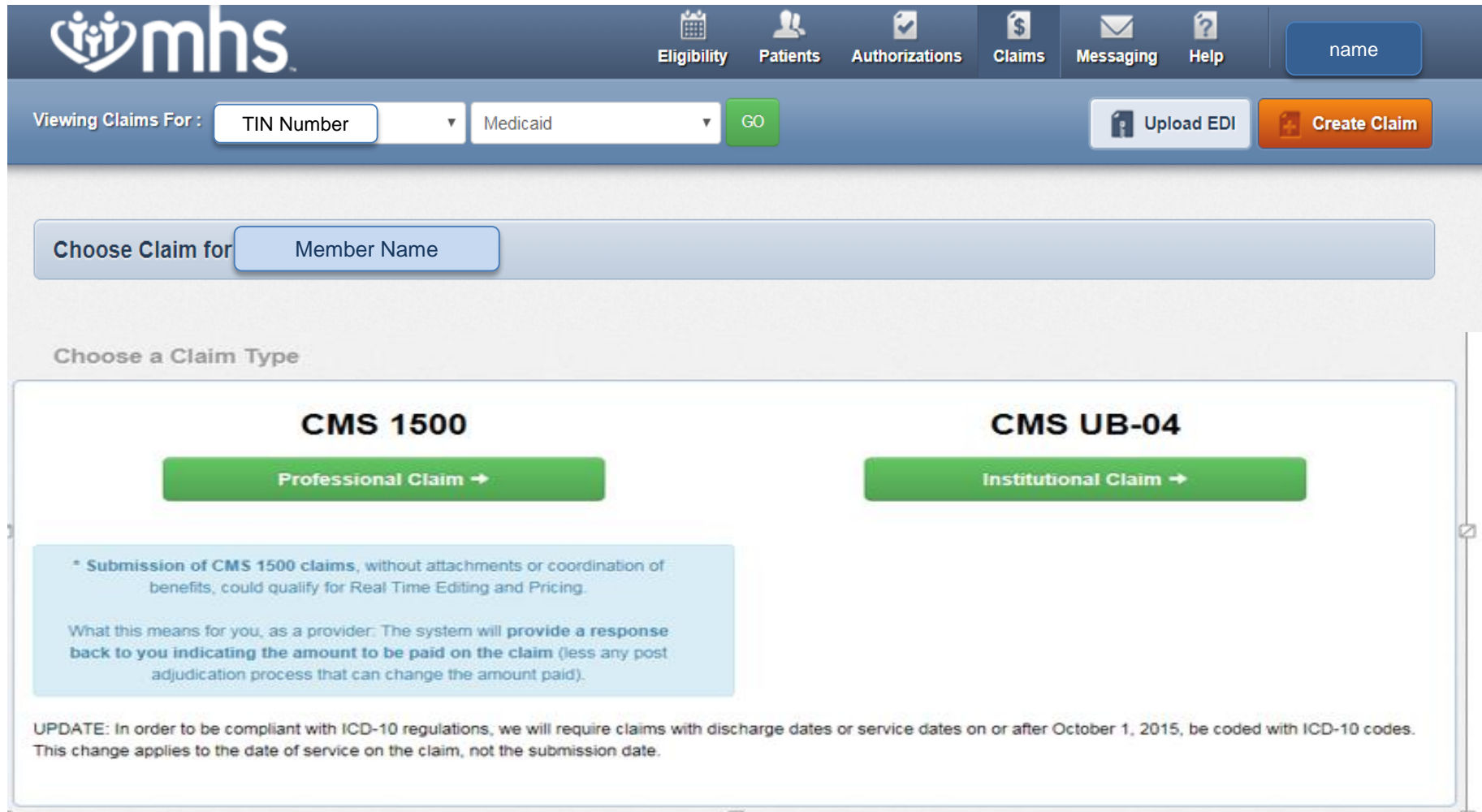
X

Member ID or Last Name

Birthdate

Enter the Member's Last Name or Member ID (RID) along with their Date of Birth.

Click on Type of Claim



The screenshot shows the MHS Claims portal interface. At the top is the MHS logo. Below it is a navigation bar with links for Eligibility, Patients, Authorizations, Claims, Messaging, and Help. A search bar labeled 'name' is on the right. Below the navigation bar is a section for 'Viewing Claims For :'. It includes two dropdown menus: 'TIN Number' and 'Medicaid', followed by a green 'GO' button. To the right of these are two buttons: 'Upload EDI' and 'Create Claim'. Below this is a section for 'Choose Claim for' with a dropdown menu showing 'Member Name'. Below that is a section for 'Choose a Claim Type'. It contains two large green buttons: 'Professional Claim →' under 'CMS 1500' and 'Institutional Claim →' under 'CMS UB-04'. Below these buttons is a light blue box containing text about CMS 1500 claims and a response back to providers. At the bottom is an 'UPDATE' section regarding ICD-10 regulations.

Viewing Claims For : TIN Number Medicaid GO Upload EDI Create Claim

Choose Claim for Member Name

Choose a Claim Type

CMS 1500
Professional Claim →

CMS UB-04
Institutional Claim →

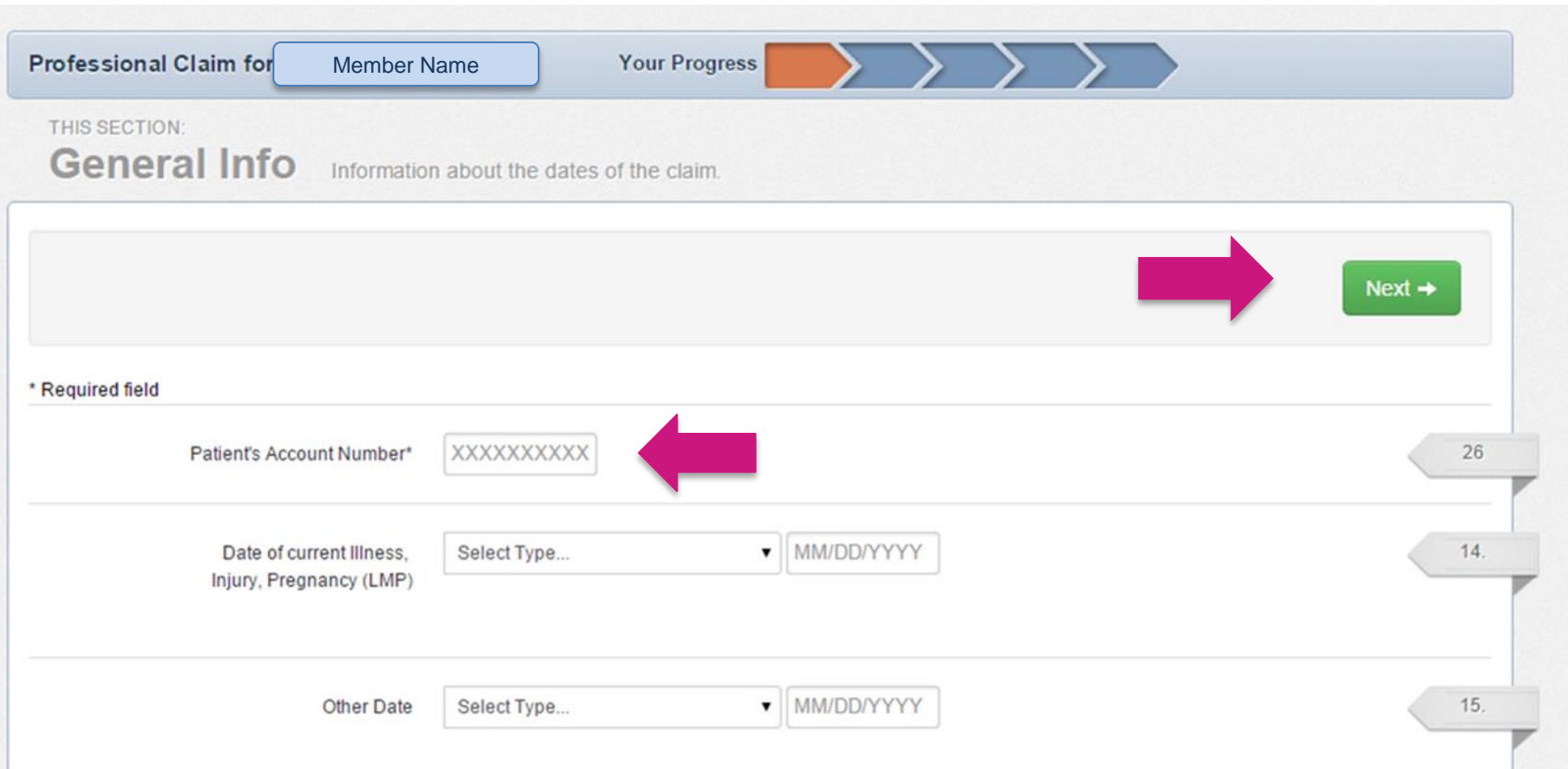
* Submission of CMS 1500 claims, without attachments or coordination of benefits, could qualify for Real Time Editing and Pricing.

What this means for you, as a provider: The system will provide a response back to you indicating the amount to be paid on the claim (less any post adjudication process that can change the amount paid).

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** (member information) and other information related to the patient's condition by typing into the appropriate fields. Click **Next**.



Professional Claim for Member Name Your Progress

THIS SECTION:
General Info Information about the dates of the claim.

*** Required field**

Patient's Account Number* XXXXXXXXXXXX

Date of current Illness, Injury, Pregnancy (LMP) Select Type... MM/DD/YYYY

Other Date Select Type... MM/DD/YYYY

Next →

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 LY 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)

V837 ~ PERS OUTSD INDUST VEH INJ NT ACC [Remove It](#)

[Add Coordination of Benefits](#)

[← Back](#) [Next →](#)

Primary Insurance [x Remove](#)

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

Carrier Type*

Policy Number*

[← Back](#) [Next →](#)

Claim Submission: Step 3

add procedure codes and date of service

Professional Claim for **TTY** Your Progress

THIS SECTION:
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

[+ New Service Line](#)

PROCEDURE / CHARGES
1: 99213 / \$500.00

Dates of Service* From: 02/01/2016 To: 02/01/2016 [24.a](#)

Place of Service* 11 - PROVIDER'S OFFICE [24.b](#)

Procedure Code* 99213 [24.c](#)

Modifiers XX [Add](#) Please enter the modifier and click the Add button.

Diagnosis Code(s)* 01 - V837 - PERS OUTSD INDUST MCH INJ NT ACC [24.e](#)

Charges* 500.00 [24.f](#)

Units / Minutes / Days* 1 Type* UN - UN [24.g](#)

Family Planning Yes No EP50T Select... [24.h](#)

NDC NDC [NDC](#)

Supplemental Information Supplemental Information

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

Amount Allowed* 500.00

Deductible XXXX.XX

Copy XXXX.XX

Co-Insurance XXXX.XX

Amount Paid 500.00

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

Denied Category Select... [▼](#)

Denied Amount XXXX.XX

[Add Denied Reason](#)

[Delete](#) [Save / Update](#)

[Back](#) [Next](#)

Claim Submission: Steps 4 – 5

Provider Information

Enter referring and billing provider information. Enter Service Facility Location. Click **Next**

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

Professional Claim for [Redacted] Your Progress [Progress Bar]

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

[Back](#) [Next](#)

* Required

Referring Provider

NPI: [1] [73] [Find Provider](#)

Last Name or Organizational Name: [1] [Find Provider](#) First Name: [ERIN]

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

NPI: [1] [73] Tax ID: [2] [54] [Find Provider](#)

Taxonomy: [2] [DK] Last Name or Organizational Name: [FARRELL] First Name: [ERIN] [Clear X](#)

Billing Provider

Tax ID: [2] [54]

Name: [Farrell] NPI: [1] [73] Taxonomy: [2] [DK]

Address: [2] [DK] City: [ELKHART] State: [Indiana] Zip: [45515]

Service Facility Location [Same As Billing Provider](#)

Name: [Farrell] NPI: [1] [73]

Address: [1] [ON AVENUE] City: [ELKHART] State: [Indiana] Zip: [45515]

[Back](#) [Next](#)

Professional 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: [Choose File] No file chosen Attachment Type: [Select Type...] [Attach](#)

There are no attached files.

[Back](#) If there are no attachments, click Next. [Next](#)

Claim Submission: Step 6

In the Review section, you can review the claim once again. Click **Submit**

Professional Claim for [redacted] Your Progress [progress bar]

THIS SECTION: **Review**
Please review your claim and submit.

← Back Submit →

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

Claim Id: 8132
Member Record Number: 132
Member Claim Amount Paid:
Patient's Account Number: 221520

General Info [Edit](#)
Statement From Date: 02/01/2016
Statement To Date: 02/01/2016
Date of current illness, injury, Pregnancy (UMP):
Other Date:
Hospitalized From:
Hospitalized To:
Outside Lab: No
Outside Lab Amount:
Prior Authorization Number:
CUIA Number:

Diagnosis Codes and Primary Insurance [Edit](#)
Diagnosis Codes
V537 -- PERS OUTSD INDUST VEH INJ NT ACC

Service Lines [Edit](#)

Line	From	To	Place	Proc	Diagnosis	Amount	Units/Minutes/Days	Family Plan	EPST	NDC	Supplemental Info
1	02/01/2016	02/01/2016	11	99213	V537	\$1,000.00	1	No			

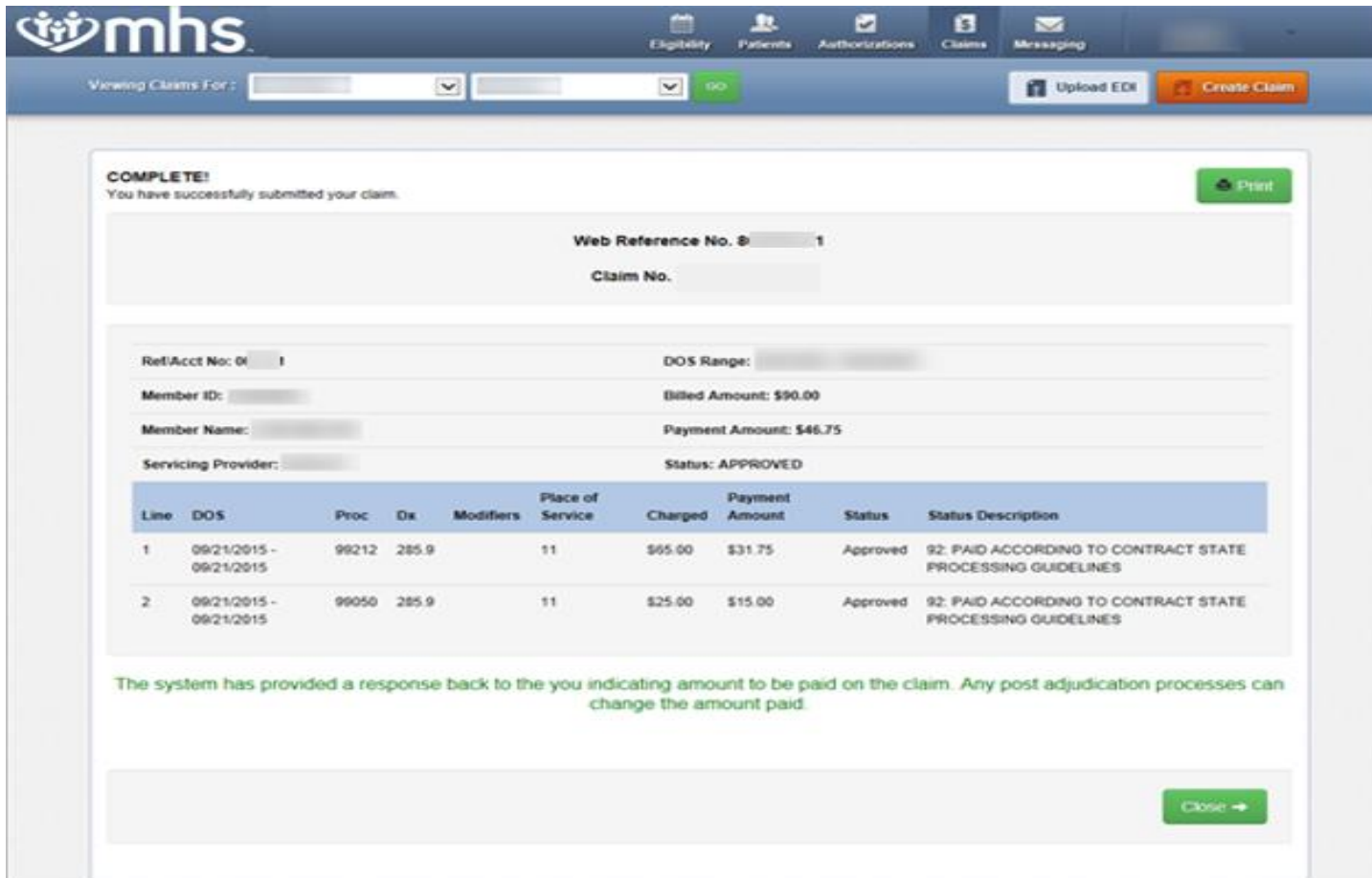
Providers [Edit](#)

Provider Type	Name	Tax ID	NP	Taxonomy	Address
Referring Provider	[redacted]	1	73		
Rendering Provider	[redacted]	2	14	2	X
Billing Provider	[redacted]	3	14	1	3
				26	X
Service Facility Location			1	3	
					236
					236
					236

Attachments

← Back Submit →

Once a claim is submitted it will go through RTEP. This screen will show you a possible payment. The amount is before the claim has gone through any audits or edits.



COMPLETE!
You have successfully submitted your claim.

Web Reference No. 8 1
Claim No.

Ref/Acct No: 01 1
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 →

Reviewing Claims

Submitted Claims

The following screen will show those claims created via the portal only.

mhs

Eligibility

Patients

Authorizations

Claims

Messaging

Provider Name

Viewing Claims For :

TIN 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	
	03/09/2016	80 10	PI 64	CMS-1500	JET AN	101 99	P0 11	\$254.24	
	03/09/2016	80 35	PI 140	CMS-1500	JET AN	101 99	P0 172	\$1,589.00	
	03/09/2016	80 06	PI 338	CMS-1500	JET AN	10 99	P0 71	\$254.24	
	03/07/2016	80 12	P0 25	CMS-1500	M/ ES	10 99		\$88.00	Fix
	03/07/2016	80 15	P0 21	CMS-1500	M/ S	10 99		\$20.00	Fix
	03/07/2016	80 14	P 189	CMS-1500	ST LL	10 99		\$109.00	

Individual Claims

To view the details of the individual claim, click the blue **Claim Number** to open the claim

Eligibility

Patients

Authorizations

Claims

Messaging

Provider Name

Viewing Claims For :

TIN NUMBER

Medicaid

Upload EDI

Create Claim

Claims

Individual

Saved

Submitted

Batch

Payment History

My Downloads

Claims Audit Tool

Filter


CLAIM NO. ↑	CLAIM TYPE ↑	MEMBER NAME ↑	SERVICE DATE(S) ↑	BILLED/ PAID ↑	CLAIM STATUS ↑
68	CMS-1500	KI ERS	02/25/2016 - 02/25/2016	\$241.00 / \$132.14	
73	CMS-1500	MA ON	02/25/2016 - 02/25/2016	\$146.00 / \$102.81	
74	CMS-1500	GI IS	02/25/2016 - 02/25/2016	\$117.00 / \$87.00	
75	CMS-1500	RI IN	02/25/2016 - 02/25/2016	\$146.00 / \$102.81	
76	CMS-1500	MI JO	02/25/2016 - 02/25/2016	\$60.00 / \$34.28	
78	CMS-1500	WE ON	02/25/2016 - 02/25/2016	\$153.00 / \$62.16	
79	CMS-1500	R IS	02/25/2016 - 02/25/2016	\$134.00 / \$68.31	
80	CMS-1500	G IS	02/25/2016 - 02/25/2016	\$177.96 / \$111.00	
87	CMS-1500	AI Y	02/25/2016 - 02/25/2016	\$299.00 / \$0.00	
88	CMS-1500	LI N	02/25/2016 - 02/25/2016	\$99.00 / \$69.63	

4,488 items found, displaying 551 to 560. Page 56/549

[Prev](#)
[52](#)
[53](#)
[54](#)
[55](#)
[56](#)
[57](#)
[58](#)
[59](#)
[Next](#)

5,488 items found, displaying 551 to 560. Page 56/549 < Prev 52.53.54.55.56.57.58.59 Next >

View Claim Information



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

Viewing Claims For :

TIN NUMBER

Medicaid

Upload EDI

Create Claim

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

Claim No.: O106GAE09634

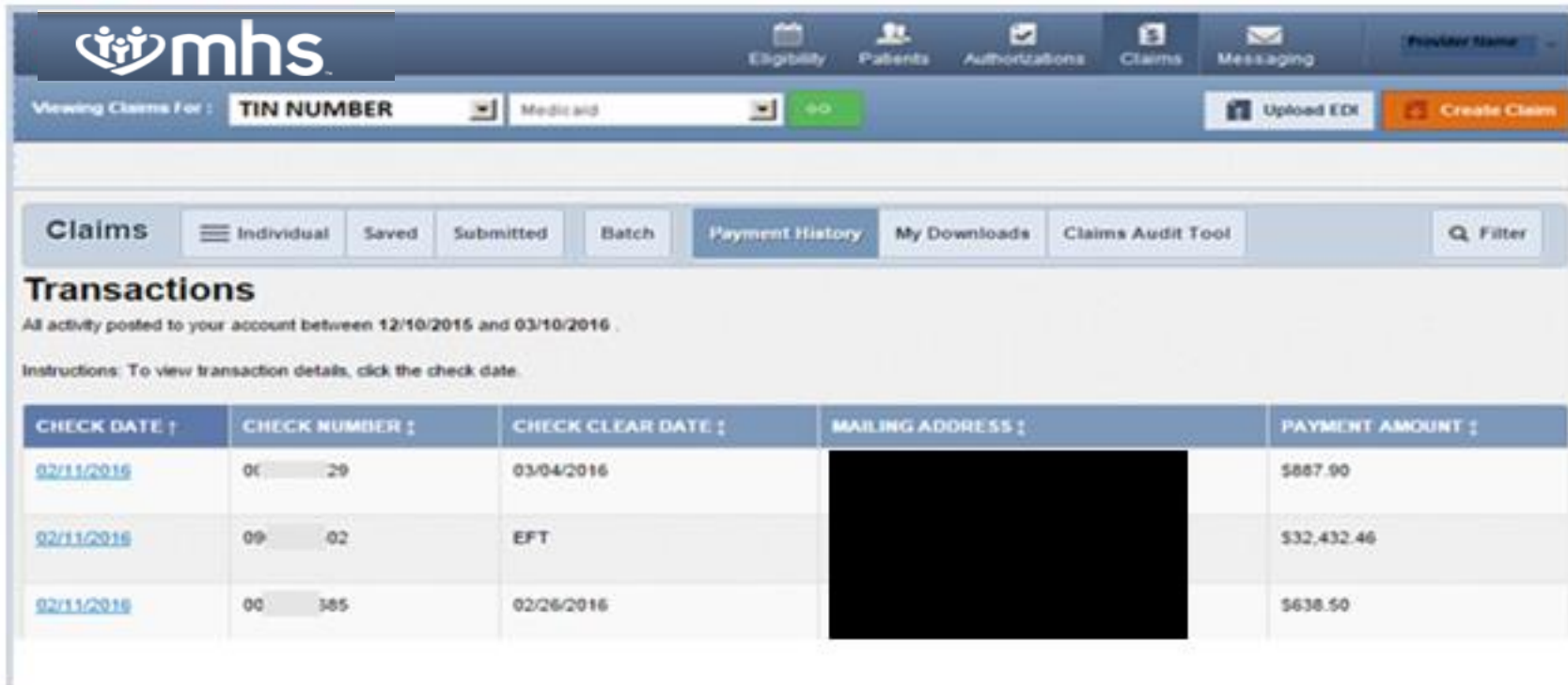
Ref/Acct No.: 721
Member ID: 2221
Member Name: A
Member DOB: 01
Serving Provider: EMS
DOS Range: 04/0

Received Date: 04/16/2015
Billed Amount: \$1,244.84
Payment Amount: \$352.87
Payment Date: 04/20/2015
Status: PAID

[Terms & Conditions](#)
[Privacy Policy](#)
[Copyright © 2015, Centene Corporation](#)

Payment History

To view the **Explanation of Payment** details, click the **Check Date**.




The screenshot shows the MHS Claims Payment History interface. At the top, there's a navigation bar with icons for Eligibility, Patients, Authorizations, Claims, and Messaging. Below this, a search bar shows 'Viewing Claims For : TIN NUMBER' and 'Medicaid'. A 'Filter' button is on the right. The main section is titled 'Claims' and includes tabs for Individual, Saved, Submitted, Batch, Payment History (selected), My Downloads, and Claims Audit Tool. Below the tabs, the 'Transactions' section displays a table of payment history for the period 12/10/2015 to 03/10/2016. The table has columns for Check Date, Check Number, Check Clear Date, Mailing Address, and Payment Amount. Three transactions are listed, all with a check date of 02/11/2016. The mailing address column is redacted with a black box.

CHECK DATE :	CHECK NUMBER :	CHECK CLEAR DATE :	MAILING ADDRESS :	PAYMENT AMOUNT :
02/11/2016	00 29	03/04/2016	[REDACTED]	\$887.90
02/11/2016	09 02	EFT	[REDACTED]	\$32,432.46
02/11/2016	00 385	02/26/2016	[REDACTED]	\$638.50

Fee Schedule Information

 We follow the IHCP Fee Schedule

- provider.indianamedicaid.com/ihcp/Publications/MaxFee/fee_home.asp

 HIP fee schedule follows Medicare fee schedule, **however** in the absence of a Medicare code we will pay at 130% of Medicaid fee schedule

- Link for Medicare: cms.gov/Medicare/Medicare.html

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, Third Party Liability, and Non Participating Providers
- Claims must be corrected within **67 days** of the EOP date.



Bill Primary Insurer 1st (EX L6)

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

Common Claim Denials



Coverage Not In Effect When Service Provided (EX 28)

- Check eligibility at each visit prior to submitting claims to ensure that member is eligible and you are billing correct health plan.



Please Resubmit To Envolve For Consideration (EX 54)

- Behavioral Health Services for MHS members are covered by Envolve

Common Claim Denials

Not an MCE Covered Benefit (EX 50)

- Service must be covered by IHCP
- Carved out services not paid by MHS

Member Name/Number/Date Of Birth Do Not Match (EX MQ)

- Member information on claim must match what is on file with Indiana Medicaid

Modifier Missing or Invalid (EX IM)

- Certain CPT codes require modifiers in order to be processed.
 - i.e. deliveries must be billed with either modifier UA, UB or UC

Common Claim Denials

Authorization Not On File (EX A1)

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

Qualifier, NDC Number, Unit Of Measure Required (EX N5)

- As of January 1, 2012, providers must submit the product NDC, the NDC unit of measure (UOM), and NDC quantity of units, along with the procedure code, when submitting claims to IHCP MCEs for certain procedure-coded drugs
- A list of the procedure codes that require NDCs is located on indianamedicaid.com (this list is updated quarterly)

Authorization Not on File (A1)

Prior Authorization numbers go in box 23

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (UMPI) MM DD YY										15. OTHER DATE QUAL. MM DD YY										16. DATES PATIENT USABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY									
17. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY										18. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO										19. CHARGES									
20. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										21. SUBMISSION CODE										22. ORIGINAL REF. NO.									
23. PRIOR AUTHORIZATION NUMBER										24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY										25. B. PLACE OF SERVICE SVC									
26. C. PROCEDURE, SERVICE, OR SUPPLY (Specify unusual circumstances) CPT/ICD-9-CM MOONIER										27. E. DIAGNOSIS NUMBER										28. F. CHARGES									
29. G. DAYS OF UNK										30. H. OTHER FEE										31. I. QUAL									
32. J. RENDERING PROVIDER ID #										33. K. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE OR CREDENTIALS (If unable, the statement on the reverse is a good one.)										34. L. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE OR CREDENTIALS (If unable, the statement on the reverse is a good one.)									
35. M. DATE										36. N. DATE										37. O. DATE									

Prior Authorization
number

Common Claim Denials



Claim and Auth Service Provider Not Matching (EX HP)

- Authorization on file does not match date of service billed



Claim and Auth Provider Specialty Not Matching (EX HS)

- Authorization on file does not match provider billing service

Common Claim Denials

Denied After Review of Patients Claim History (EX ya)

- National Correct Coding Initiative (NCCI)
 - Developed by the Centers for Medicare and Medicaid
 - Policies were developed using AMA's CPT guidelines, national professional association's recommendations, and common coding practices
- MHS utilizes HealthCare Insight (HCI) for NCCI reviews.
 - Denials are issued by a clinician
- Guidance and resources are available on [cms.gov](https://www.cms.gov)

CLAIM ADJUSTMENTS

Claim Adjustments

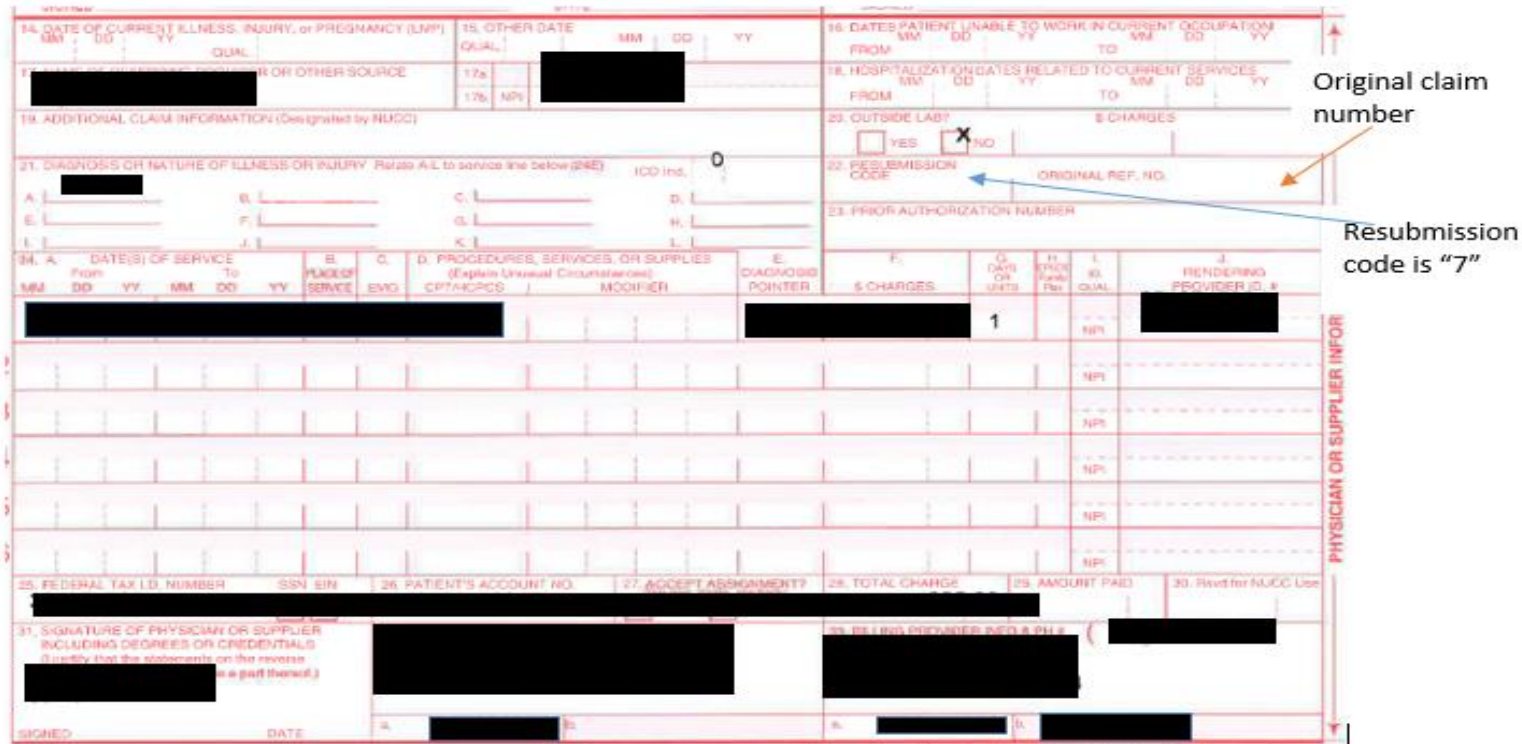
 Claim adjustment requests must be submitted within **67** days of the date of the MHS EOP. **Please note**, claims **will not** be reconsidered after day 67.

 Adjustments can be processed via online submission. The MHS claim adjustment form is available at:
mhsindiana.com/provider/provider-forms

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

Claim Adjustments

- If you must submit via paper – never handwrite “corrected claim” on the claim form.
- Complete box 22 (Resubmission Code) to include a 7 (the "Replace" billing code) to notify us of a corrected or replacement claim.



The form is a standard medical claim form with various sections. Key fields include:

- 14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (NPI):** MM DD YY
- 15. OTHER DATE:** MM DD YY
- 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION:** FROM MM DD YY TO MM DD YY
- 17. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES:** FROM MM DD YY TO MM DD YY
- 18. OUTSIDE LAB?** YES ☐ NO ☒ \$ CHARGES
- 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY:** ICD-10 code: 0
- 22. RESUBMISSION CODE:** 1
- 23. PRIOR AUTHORIZATION NUMBER:** ORIGINAL REF. NO.
- 24. A. DATE(S) OF SERVICE:** From MM DD YY To MM DD YY
- 24. B. PLACE OF SERVICE:** 1
- 24. C. PROCEDURE, SERVICE, OR SUPPLY:** CPT/HCPCS MODIFIER
- 24. D. CHARGE:** \$ CHARGES
- 24. E. DAYS OR UNITS:** 1
- 24. F. PROVIDER:** NPI
- 25. FEDERAL TAX ID NUMBER:** SSN EIN
- 26. PATIENT'S ACCOUNT NO.:**
- 27. ACCEPT ASSIGNMENT?**
- 28. TOTAL CHARGE:**
- 29. AMOUNT PAID:**
- 30. Used for NUCC Use:**
- 31. SIGNATURE OF PHYSICIAN OR SUPPLIER:**
- 32. BILLING PROVIDER NPI & PH #:**




Annotations on the form:

- Original claim number (points to box 23)
- Resubmission code is "7" (points to box 22)




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: Claim 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 30 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 or objection form with all supporting documentation to the MHS appeals address:


Managed Health Services
Attn: Claim 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.

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**

Taxonomy

Taxonomy Codes

 In accordance with bulletin **BT201745**

 Providers who bill with a NPI must include the full nine-digit ZIP Code and an appropriate **taxonomy code** for the specific provider

 This billing **does not** apply to atypical providers, such as waiver providers and most transportation providers

Taxonomy Codes

Example of CMS – 1500 Form



The image shows a CMS-1500 form with several fields highlighted and annotated. The form is divided into several sections, including patient information, diagnosis, procedure, and provider information.

Annotations:

- Taxonomy:** Points to the "Taxonomy" field in the "PHYSICIAN OR SUPPLIER INFORMATION" section (Field 10).
- NPI:** Points to the "NPI" field in the "PHYSICIAN OR SUPPLIER INFORMATION" section (Field 10).
- Group taxonomy:** Points to the "Group taxonomy" field in the "PHYSICIAN OR SUPPLIER INFORMATION" section (Field 10).

Form Fields:

- 14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP):** MM DD YY
- 15. OTHER DATE:** QUAL, MM DD YY
- 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION:** FROM MM DD YY TO MM DD YY
- 17. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES:** FROM MM DD YY TO MM DD YY
- 18. OUTSIDE LAB?** YES ☐ NO ☒ **19. CHARGES:**
- 20. SUBMISSION CODE:** ORIGINAL REF. NO.
- 21. PRIOR AUTHORIZATION NUMBER:**
- 22. A. DATES OF SERVICE:** From MM DD YY To MM DD YY
- 22. B. PROCEDURE, SERVICE, OR SUPPLY:** (Explain Unusual Circumstances) CPT/HCPCD MODIFIER
- 22. C. DIAGNOSIS:** ICD-9-CM
- 22. D. CHARGES:** \$ CHARGES
- 22. E. DAYS OF WEEK:** 1
- 22. F. NPI:** NPI
- 22. G. RENDERING PROVIDER ID:** NPI
- 23. FEDERAL TAX ID NUMBER:** SSN EIN
- 24. PATIENT'S ACCOUNT NO.:**
- 25. ACCEPT ASSIGNMENT:**
- 26. TOTAL CHARGE:**
- 27. AMOUNT PAID:**
- 28. SIGNATURE OF PHYSICIAN OR SUPPLIER:** INCLUDING DEGREE OR CREDENTIALS (Indicate that the statement on the reverse is a part thereof.)
- 29. BILLING INFORMATION:** BILL TO: () BILL FROM: () BILL TO: () BILL FROM: ()

Reminders

 **CLIA**

 **Therapy Services**

Clinical Laboratory Improvement Amendments (CLIA)

All providers that bill laboratory services on a **CMS1500** form must have CLIA certification or a CLIA waiver certification equal to the procedure code being billed. Effective on or after October 1, 2017, if a provider bills for a procedure without appropriate CLIA certification or CLIA waiver certification, reimbursement will be denied for that claim line:

EXc1 DENIED: INVALID CLIA NUMBER

This verification will ensure that MHS is compliant with the CMS guidelines.


Therapy Services

Speech, Occupational, Physical Therapy

 10/1/17 authorization is no longer required

- **Benefit limitation applies**

 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](https://www.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


Allwell Claims Information

Claims Filing Timelines—Allwell






 The timely filing deadline for initial claims is **180** days from the date service

 Claims may be submitted in 3 ways:

- **The secure web portal located at Allwell.mhsindiana.com**
- **Electronic Clearinghouse**
 - **Payor ID 68069**
 - Clearinghouses currently utilized by Allwell.mhsindiana.com will continue to be utilized
 - For a listing of our Clearinghouses, please visit our website at Allwell.mhsindiana.com

 Paper claims may be submitted to
Allwell Claims
PO Box 3060
Farmington, MO 63640-3822


Claims Payment – Allwell

-  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

Fee Schedule

-  We use the Medicare Fee Schedule for Allwell
- cms.gov/Medicare/Medicare.html

Coding Auditing & Editing—Allwell

 **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 – Allwell

 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

Ambetter Claim Information

Claims Submission –Ambetter

 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:

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

Claim Submission – Ambetter

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 – Ambetter

Member in Suspended Status


-  After the first premium is paid, a grace period of 3 months from the premium due date is given for the payment of the premium.
-  Coverage will remain in force during the grace period.
-  If payment of premium is not received within the grace period, coverage will be terminated as of the last day of the first month during the grace period.
-  During months two and three of the grace period, claims will be pended. The EX code on the Explanation of Payment will state: “LZ – Pend: Non-Payment of Premium. During the first month, claims may be submitted and paid.

Fee Schedule


-  We use the Medicare Fee Schedule for Ambetter
- cms.gov/Medicare/Medicare.html

Complaints/Grievances/Appeals

Claims







-  A provider must exhaust the Claims Reconsideration and Claims Dispute process before filing a Complaint/Grievance

Corrected Claims, Requests for Reconsideration or Claim Disputes

-  All claim requests for corrected claims, reconsiderations or claim disputes must be received within 180 days from the date of the original notification of payment or denial. Prior processing will be upheld for corrected claims or provider claim requests for reconsideration or disputes received outside of the 180 day timeframe, unless a qualifying circumstance is offered and appropriate documentation is provided to support the qualifying circumstance.





Complaints/Grievances/Appeals

Reconsiderations

-  A request for reconsideration is a written communication (i.e. a letter) from the provider about a disagreement with the manner in which a claim was processed, but does not require a claim to be corrected and does not require medical records.
-  The documentation must also include a description of the reason for the request.
-  Indicate “Reconsideration of (original claim number)”
-  Include a copy of the original Explanation of Payment
-  Unclear or non-descriptive requests could result in no change in the processing, a delay in the research, or delay in the reprocessing of the claim.
-  The “Request for Reconsideration” should be sent to:
 - Ambetter from MHS Indiana
 - Attn: Reconsideration
 - PO Box 5010
 - Farmington, MO 63640-5010



Complaints/Grievances/Appeals

Claim Dispute


-  A claim dispute should be used only when a provider has received an unsatisfactory response to a request for reconsideration.
-  Providers wishing to dispute a claim must complete the Claim Dispute Form located at Ambetter.mhsindiana.com
-  To expedite processing of the dispute, please include the original request for reconsideration letter and the response.
-  The Claim Dispute form and supporting documentation should be sent to:
Ambetter from MHS Indiana
Attn: Claim Dispute
PO Box 5000
Farmington, MO 63640-5000

Complaints/Grievances/Appeals





Complaint/Grievance

-  Must be filed within 30 calendar days of the Notice of Action
-  Upon receipt of complete information to evaluate the request, Ambetter will provide a written response within 30 calendar days





Appeals

-  Claims are not appealable. Please follow the Claim Reconsideration, Claim Dispute and Complaint/Grievance process.

Medical Necessity

-  Must be filed within 30 calendar days from the Notice of Action
-  Ambetter shall acknowledge receipt within 10 business days of receiving the appeal
-  Ambetter shall resolve each appeal and provide written notice as expeditiously as the member's health condition requires but not to exceed 30 calendar days.
-  Expedited appeals may be filed if the time expended in a standard appeal could seriously jeopardize the member's life or health. The timeframe for a decision for an expedited appeal will not exceed 72 hours.

Complaints/Grievances/Appeals

-  Members may designate Providers to act as their Representative for filing appeals related to Medical Necessity.
 -  Ambetter requires that this designation by the Member be made in writing and provided to Ambetter
-  No punitive action will be taken against a provider by Ambetter for acting as a Member's Representative.
-  Full Details of the Claim Reconsideration, Claim Dispute, Complaints/Grievances and Appeals processes can be found in our Provider Manual at: [Ambetter.mhsindiana.com](https://www.ambetter.mhsindiana.com)



MHS Provider Relations Team

Candace Ervin	Involve Dental Indiana Provider Relations	1-877-647-4848 ext. 20187	Candace.Ervin@involvehealth.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
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

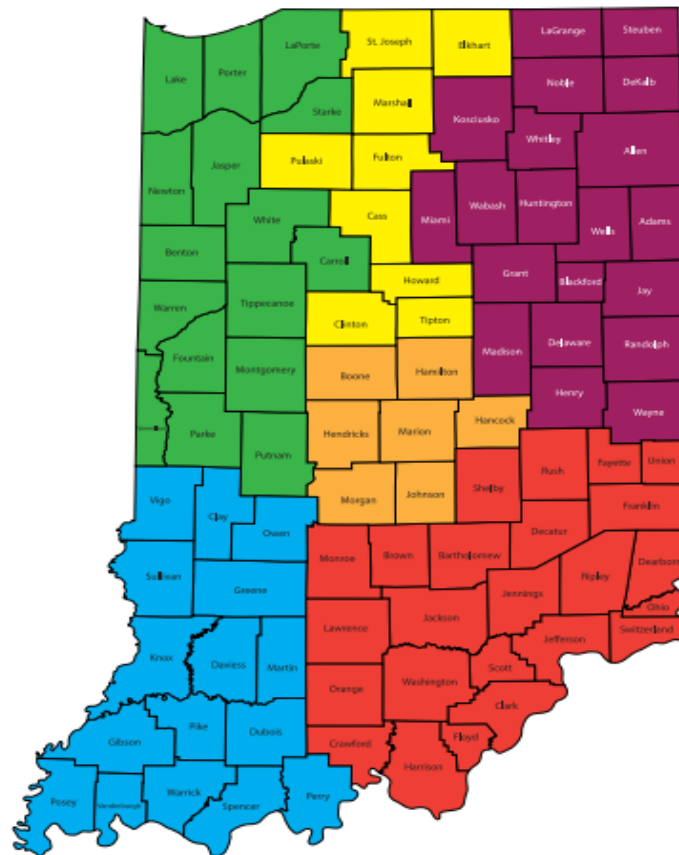
ESTHER CERVANTES

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

JENNIFER GARNER

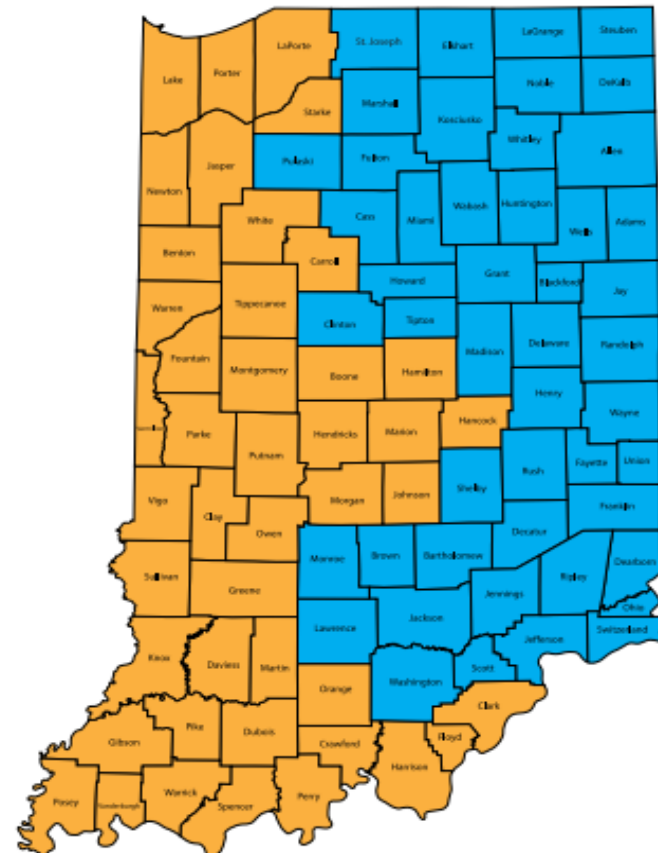
Provider Performance Associate
1-877-647-4848 ext. 20149
jgarner@mhsindiana.com
Exception to map: IU Health, Eskenazi Health

Indiana










Mary Schermer
Provider Relations Specialist
1-877-647-4848 ext. 20268
mschermer@mhsindiana.com

LaKisha Browder, MBA
Provider Relations Specialist
1-877-647-4848 ext. 20224
lbrowder@mhsindiana.com



What we learned today

-  Claims **timely filing limits** for MHS, Allwell and Ambetter
-  **Rejections** do not make it into the MHS system – these claims will need to be corrected and **resubmitted**
-  How to troubleshoot Common **Claim Denials**
-  How to **Dispute Claims** for MHS, Allwell and Ambetter
-  New updates related to **CLIA, Taxonomy codes** and **Therapy**
-  Allwell information
-  Ambetter information

Questions

Thank you for being our partner in care.