Agenda

- MHS Overview
- P4P Quality
- Prior Authorization Process
- Web Portal Functionality
- Public Website
- Behavioral Health Updates
- Medical Claims processing
- Partners and Vendors
- Summary
- 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 and a Medicare Advantage product called Allwell from MHS. All of our plans include quality, comprehensive coverage, with a provider network you can trust.

MHS is your choice for better healthcare.
MHS Products

[Logos for Allwell, Ambetter, and MHS]
Allwell Overview: Medicare Advantage Plans

**Allwell from MHS** provides complete continuity of care to members including:

- Integrated coordination of care
- Care management
- Co-location of behavioral health expertise
- Integration of pharmaceutical services with the PBM
- Additional services specific to the beneficiary needs

**Approach to care management** facilitates the integration of:

- Community resources
- Health education
- Disease management

**Promotes access to care as beneficiaries are served through a single, locally-based multidisciplinary team including:**

- RNs
- Social Workers
- Pharmacy Technicians
- Behavioral Health Case Managers
We offer HMO, PPO, and HMO DSNP plans

$0 for Premiums*

$0/$5 PCP copay (HMO v. PPO)

$0 & $5 generics

Great Value-Add Benefits

- $65 quarterly OTC benefit, $85 quarterly OTC benefit for DSNP
- Hearing aid benefit
- $150 eyeglasses benefit for HMO and PPO, $200 benefit for DSNP
- Silver & Fit
- Preventive dental

All Part A and Part B benefits by Medicare

Part B drugs – such as chemotherapy drugs

Part D drugs – no deductible at network retail pharmacies or mail order, will have copay or coinsurance for some tiers

*$0 premiums apply to all of the HMO products; and, the PPO product in Allen, Elkhart, St. Joseph, Wells, and Whitley Counties.
2019 Counties
Providers should verify eligibility before every visit by using one of the below options:

- Website: allwell.mhsindiana.com
- 24/7 Interactive Voice Response Line: 1-855-766-1541
- Provider Services: 1-855-766-1541
- TTY: 711
Ambetter from MHS is an Exclusive Provider Network Benefit Plan

- Members enrolled in Ambetter must utilize in-network participating providers and practitioners except in the case of emergency services.
- When referring a member to another provider or practitioner, please make sure that the referral is contracted with Ambetter.
- If a non-contracted provider or practitioner is utilized, except in the case of emergency services, the member will be responsible for charges that exceed the allowed amount. This could mean hundreds of dollars in out-of-pocket expenses for the member.
- Contracted providers and practitioners can be identified by visiting our website at ambetter.mhsindiana.com and clicking on Find a Provider.

Thank you for protecting our members from unnecessary out-of-pocket expenses!
2019 Ambetter
State-wide Coverage

2019 Coverage Map - Indiana
Verification of Eligibility, Benefits and Cost Share

Member ID Card:

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

Used for both HIP and HIP Maternity

Member Name: 
Member RID:

RXBIN: 004336
RXPCN: MCAIDADV
RXGROUP: RX5440

Member Name: 
Member RID:

RXBIN: 004336
RXPCN: MCAIDADV
RXGROUP: RX5440

Copy exceptions includes:
Members who are pregnant, Native American, under 18 years old, or have met their 24K max. Other exceptions include medications
for family planning and transportation to educational events or Member Advisory Council meetings.

Allwell from MHS | Ambetter from MHS | Hoosier Healthwise | Healthy Indiana Plan | Hoosier Care Connect
Healthy Indiana Plan (HIP)

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

メンバー 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.
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.*

<table>
<thead>
<tr>
<th>Service</th>
<th>HIP Basic Co-Pay Amounts &lt;=100% FPL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient Services</td>
<td>$4</td>
</tr>
<tr>
<td>Inpatient Services</td>
<td>$75</td>
</tr>
<tr>
<td>Preferred Drugs</td>
<td>$4</td>
</tr>
<tr>
<td>Non-preferred drugs</td>
<td>$8</td>
</tr>
<tr>
<td>Non-emergency ER visit</td>
<td>$8</td>
</tr>
</tbody>
</table>
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
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 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.
HEDIS/Pay for Performance (P4P)
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
2019 P4P

- Bonus Pay for Performance (P4P) fund written into Primary Medical Provider contracts
- Measures are different for each product line
- Measures aligned with HEDIS® and NCQA
- Annual payout
## 2019 HHW P4P

### P4P SCHEDULE A-2A-1
**Hoosier Healthwise**

Please send information to Managed Health Services (MHS), Attn: P4P Program, 550 N. Meridian Street, Suite 101, Indianapolis, IN 46204.

<table>
<thead>
<tr>
<th>Pay-For-Performance Measures</th>
<th>Goal Rate</th>
<th>Minimum Number of Covered Persons</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Children’s Care (Quality)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Childhood Immunization Status (CIS) COMBO 10</td>
<td>% of 2 year old Covered Persons who had the following immunizations by their second birthday: DTP/DTA, HEP B, IPV, 1 MMR, 1 Hib, 3 Hib, 1 Hep A, 2 or 3 Hep A, PEP (depending on date of birth), 2 Pnu</td>
<td>HEDIS 75th percentile</td>
<td>10</td>
</tr>
<tr>
<td>Lead Screening in Children</td>
<td>% of children 2 years of age who had one or more capillary or venous lead blood test for lead poisoning by their second birthday.</td>
<td>HEDIS 75th percentile</td>
<td>10</td>
</tr>
<tr>
<td>Follow-Up Care for Children Prescribed ADHD Medication – Initiation Phase</td>
<td>% of members 6-12 years of age at the IPSD with an ambulatory prescription dispensed for ADHD medication, who had one follow-up visit with a practitioner with prescribing authority during the 30-day initiation Phase</td>
<td>HEDIS 75th percentile</td>
<td>5</td>
</tr>
<tr>
<td>Follow-Up Care for Children Prescribed ADHD Medication – continuation phase</td>
<td>% of members 6-12 years of age at the IPSD with an ambulatory prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the initiation Phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the initiation Phase ended</td>
<td>HEDIS 75th percentile</td>
<td>5</td>
</tr>
<tr>
<td>Well-Child Visits in the First 16 Months of Life (WCV)</td>
<td>% of Covered Persons turning 15 mos within the current year who had 6 or more visits with PMP before turning 15 mos old</td>
<td>HEDIS 75th percentile</td>
<td>10</td>
</tr>
<tr>
<td>Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (WCV)</td>
<td>% of Covered Persons who turned 3-6 years old within the current year who had 1 or more well child visits within the current year</td>
<td>HEDIS 75th percentile</td>
<td>10</td>
</tr>
<tr>
<td>Adolescent Well-Care Visits (AWCV)</td>
<td>% of Covered Persons 12-23 years old who had at least 1 comprehensive well care visit with PMP or OB within the current year</td>
<td>HEDIS 75th percentile</td>
<td>10</td>
</tr>
</tbody>
</table>

### Maternal Care (Quality)

<table>
<thead>
<tr>
<th>Maternal Care (Quality)</th>
<th>Postpartum Care</th>
<th>Timelessness of Ongoing Prenatal Care (PPC)</th>
<th>HEDIS 75th percentile</th>
<th>5</th>
<th>6 points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prenatal and Postpartum Care (PPC)</td>
<td>% of deliveries that had a postpartum visit or between 21 and 56 days after delivery</td>
<td>HEDIS measure (HEEDIS PPC) using hybrid data</td>
<td>5</td>
<td>0 points</td>
<td></td>
</tr>
<tr>
<td>Ambulatory Care (AMC)</td>
<td>Utilization of ambulatory care in the ED - # visits per 1,000 member months</td>
<td>HEDIS 12th percentile</td>
<td>10</td>
<td>10 points</td>
<td></td>
</tr>
<tr>
<td>Respiratory Care</td>
<td>% of members 5-64 years of age during the measurement year who were identified as having persistent asthma and were dispensed appropriate medications and remained on an asthma controller medication for at least 75% of their treatment period</td>
<td>HEDIS 75th percentile</td>
<td>5</td>
<td>10 points</td>
<td></td>
</tr>
</tbody>
</table>

### Provider Outreach (Administrative) Credit Given to Providers in Good Standing:

- A Provider is determined to be in “Good Standing” if they comply and complete the following:
  1. Host, or participate in, a Preventive Health Outreach program or activity.
  2. Do not have a closed Provider Panel, and are able to accept new members.
  3. Attendance in one MHS training/education sessions during the calendar year.

- OR
  1. Enrolls in My Health Direct before the end of the 1st quarter of the new calendar year and remains enrolled through the end of the calendar year.

---

Allwell from MHS | Ambetter from MHS | Hoosier Healthwise | Healthy Indiana Plan | Hoosier Care Connect
# 2019 HIP P4P

## P4P SCHEDULE A-2B-1
Healthy Indiana Plan (HIP)

Please send information to Managed Health Services (MHS), Attn: P4P Program, 550 N. Meridian Street, Suite 101, Indianapolis, IN 46204.

<table>
<thead>
<tr>
<th>Pay-For-Performance Measures</th>
<th>Goal Rate</th>
<th>Minimum Number of Covered Persons</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Women’s Care (Quality)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chlamydia Screening in Women (CHL)</td>
<td></td>
<td>% of female Covered Persons age 15-24 years identified as sexually active who had at least one Chlamydia test in the current year</td>
<td>HEDIS 75th percentile</td>
</tr>
<tr>
<td>Cervical Cancer Screening (CCS)</td>
<td></td>
<td>% of female Covered Persons age 24-64 years who received 1 or more Pap tests to screen for cervical cancer in the current year</td>
<td>HEDIS 75th percentile</td>
</tr>
<tr>
<td>Breast Cancer Screening (BCS)</td>
<td></td>
<td>% of women 50–74 years of age who had a mammogram to screen for breast cancer</td>
<td>HEDIS 75th percentile</td>
</tr>
<tr>
<td><strong>Maternal Care (Quality)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prenatal and Postpartum Care (PPC)</td>
<td></td>
<td>% of deliveries that had a postpartum visit on or between 21 and 55 days after delivery</td>
<td>HEDIS 75th percentile</td>
</tr>
<tr>
<td>Timeliness of Ongoing Prenatal Care (PPC)</td>
<td></td>
<td>% of deliveries that received a prenatal care visit as a member of the organization in the first trimester, on the enrollment start date or within 42 days of enrollment in the organization, HEDIS measure (HEUS PPC) using hybrid data</td>
<td>HEDIS 75th percentile</td>
</tr>
<tr>
<td><strong>Respiratory Care</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MED Management for People With Asthma (Med 75% rate)</td>
<td></td>
<td>% of members 5–64 years of age during the measurement year who were identified as having persistent asthma and were dispensed appropriate medications and remained on an asthma controller medication for at least 75% of their treatment period</td>
<td>HEDIS 75th percentile</td>
</tr>
<tr>
<td><strong>Ambulatory Measures</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Behavior Health Care

<table>
<thead>
<tr>
<th></th>
<th>% of members who remained on an antidepressant medication for at least 64 days (12 weeks)</th>
<th>HEDIS 75th percentile</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antidepressant Medication Management (AHM) – Acute Phase</td>
<td></td>
<td>5</td>
<td>6 points</td>
</tr>
</tbody>
</table>

## Diabetes Care

<table>
<thead>
<tr>
<th></th>
<th>% of members 18–75 years of age with diabetes (type 1 and type 2) who had an eye exam (retinal) performed</th>
<th>HEDIS 75th percentile</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes Care – Eye exam (retinal) performed</td>
<td></td>
<td>5</td>
<td>6 points</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>% of members 18–75 years of age with diabetes (type 1 and type 2) who had medical attention for nephropathy</th>
<th>HEDIS 75th percentile</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes Care – Medical attention for nephropathy</td>
<td></td>
<td>5</td>
<td>6 points</td>
</tr>
</tbody>
</table>

## Adult Care

<table>
<thead>
<tr>
<th></th>
<th>% of members 19 years or older who had a preventive care visit.</th>
<th>HEDIS 75th percentile</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Preventive Care</td>
<td></td>
<td>13</td>
<td>20 points</td>
</tr>
</tbody>
</table>

## Provider Outreach (Administrative) Credit Given to Providers in Good Standing:

10 points

A Provider is determined to be in "Good Standing" if they comply and complete the following:
1. Host, or participate in, a Preventive Health Outreach program or activity,
2. Do not have a closed Provider Panel, and are able to accept new members,
3. Attendance in one MHS training/education session during the calendar year.

OR
1. Enrolls in the Health Direct before the end of the 1st quarter of the new calendar year and remains enrolled through the end of the calendar year.
# 2019 HCC P4P

## P4P SCHEDULE 2C-1A
### Hoosier Care Connect

Please send information to Managed Health Services (MHS), Attn: P4P Program, 550 N. Meridian Street, Suite 101, Indianapolis, IN 46204.

<table>
<thead>
<tr>
<th>Pay-For-Performance Measures</th>
<th>Goal Rate</th>
<th>Minimum Number of Covered Persons</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Children’s Care (Quality)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Childhood Immunization Status (CIB) COMBO 10</td>
<td>% of 2 year old Covered Persons who had the following immunizations by their second birthday: 4 DTaP, 3 RV, 1 MMR, 3 Hib, 3 Hep B, 1 PCV, 1 Hep A, 2 or 3 RV (depending on dose schedule), 2 Flu</td>
<td>HEDIS 75th percentile</td>
<td>10</td>
</tr>
<tr>
<td>Well-Child Visits in the First 15 Months of Life (W15s)</td>
<td>% of Covered Persons turning 12 months within the current year who had 6 or more visits with P4P before turning 15 months old</td>
<td>HEDIS 75th percentile</td>
<td>10</td>
</tr>
<tr>
<td>Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)</td>
<td>% of Covered Persons who turned 3-6 years old within the year who had 1 or more well child visits within the current year</td>
<td>HEDIS 75th percentile</td>
<td>10</td>
</tr>
<tr>
<td>Adolescent/Well-Care Visits (AWC)</td>
<td>% of Covered Persons 13-21 years old who had at least 1 comprehensive well care visit with P4P or CB within the current year</td>
<td>HEDIS 75th percentile</td>
<td>10</td>
</tr>
<tr>
<td><strong>Respiratory Care</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MEd Management for People With Asthma (Med 75% rate)</td>
<td>% of members 5–84 years of age during the measurement year who were identified as having persistent asthma and were dispensed appropriate medications and remained on an asthma controller medication for at least 75% of their treatment period</td>
<td>HEDIS 75th percentile</td>
<td>5</td>
</tr>
<tr>
<td>Pharmacotherapy Management of COPD Exacerbation (PCEx) - systemic corticosteroids</td>
<td>% of COPD exacerbations for members 40 years of age and older who had an acute inpatient discharge or ED visit on or between January 1–November 30 of the measurement year and who were discharged a systemic corticosteroid (or there was evidence of an active prescription) within 14 days of the event</td>
<td>HEDIS 75th percentile</td>
<td>5</td>
</tr>
</tbody>
</table>

## P4P SCHEDULE 3A-1
### Hoosier Care Connect

### Diabetes Care
- % of members 18–75 years of age with diabetes (type 1 and type 2) who had an eye exam (retinal) performed: HEDIS 75th percentile<br>5 | 6 points
- % of members 18–75 years of age with diabetes (type 1 and type 2) who had medical attention for nephropathy: HEDIS 75th percentile<br>5 | 6 points

### Behavioral Health Care
- Antidepressant Medication Management (AMM) - Acute Phase<br>% of members who remained on an antidepressant medication for at least 84 days (12 weeks): HEDIS 75th percentile<br>5 | 6 points

### Adult Care
- Adult Preventive Care<br>% of members 19 years or older who had a preventive care visit: HEDIS 75th percentile<br>10 | 15 points

### Ambulatory Measures
- Ambulatory Care (AMB) - ER Utilization<br>Utilization of ambulatory care in the ED - # visits per 1,000 member months: HEDIS 75th percentile<br>5 | 12 points

### Provider Outreach (Administrative) Credit Given to Providers in Good Standing: 10 points

A Provider is determined to be in “Good Standing” if they comply and complete the following:
1. Host, or participate in, a Preventive Health Outreach program or activity;
2. Do not have a closed Provider Panel, and are able to accept new members;
3. Attendance in one MHS training/orientation sessions during the calendar year.

OR
1. Enrolls in My Health Direct before the end of the 1st quarter of the new calendar year and remains enrolled through the end of the calendar year.
Administrative Measures

A provider is determined in “Good Standing” if they comply and complete the following:

- Host or participate in a Preventative Health Outreach or activity.
- Do not have a closed Provider Panel, and are able to accept new members.
- Attendance of one MHS training/orientation sessions during the calendar year.

OR

- Enroll in My Health Direct before the end of the 1st quarter of the new calendar year and remains enrolled through the end of the year.
Provider analytics

Provider Analytics link is located on the landing page of the Provider Portal.
On the Summary dashboard, providers will click on the Navigation Bars located in the upper left hand corner to make their selection.
Prior Authorization
Prior Authorization

Prior Authorization (Medical Services)

Prior Authorization is an approval from MHS to provide services designated as needing authorization before treatment and/or payment.

- Inpatient authorizations = IP + 10 digits
- Outpatient authorizations = OP + 10 digits
- Emergent ER Symptoms suggesting imminent, life-threatening condition no PA required, but notification requested within **two business days**
- Urgent concurrent = Emergent inpatient admission. Determination timeline within **24 hours** of receipt of request.
- Pre-service non urgent = Elective scheduled procedures. Determination within **15 calendar days**. Benefit limitations apply (dependent on product).
Prior Authorization

違反 Prior Authorization Needed?

- MHS website: mhsindiana.com
- Quick reference guide
- Non-contracted provider services now align with PA requirements for contracted providers
Prior Authorization

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 Evolve Vision.
Dental services need to be verified by Evolve Dental.
Ambulance and Transportation services need to be verified by LCP Transportation.
Musculoskeletal services need to be verified by TurningPoint.

Non-participating providers must submit Prior Authorization for all services. For non-participating providers, join our network.

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

<table>
<thead>
<tr>
<th>Types of Services</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is the member being admitted to an inpatient facility?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Are services, other than DME, orthotics, prosthetics, and supplies, being rendered in the home?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Are anesthesia services being rendered for pain management?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Are services for infertility?</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

To submit a prior authorization Login Here.
Prior Authorization

<table>
<thead>
<tr>
<th>Prior Authorization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid Pre-Auth</td>
</tr>
<tr>
<td>Ambetter Pre-Auth</td>
</tr>
<tr>
<td>Medicare Pre-Auth</td>
</tr>
</tbody>
</table>

**Dental Providers**

**Pharmacy**

**Opioid Resources**

**Behavioral Health**

**Provider Resources**

**QI Program**

**Provider News**

**Email Sign Up**

---

**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 anesthesia services being rendered for pain management?
- Are services for infertility?

<table>
<thead>
<tr>
<th>Types of Services</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Facility</td>
<td>☐</td>
<td>☒</td>
</tr>
<tr>
<td>Home Services</td>
<td>☒</td>
<td>☐</td>
</tr>
<tr>
<td>Pain Management</td>
<td>☐</td>
<td>☒</td>
</tr>
<tr>
<td>Infertility</td>
<td>☐</td>
<td>☒</td>
</tr>
</tbody>
</table>

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

99394

**99394 – PREV VISIT EST AGE 12-17**

No Pre-authorization required for all providers.

To submit a prior authorization [Login Here](#).
Web Authorization

✅ Providers can submit Prior Authorizations online via the MHS Secure Provider Portal at mhsindiana.com/login
  • When using the portal, providers can upload supporting documentation directly

例外：必须通过传真提交临终关怀、家庭医疗和生物药房PA请求。

✅ Exceptions: Must submit hospice, home health and biopharmacy PA requests via fax

✅ Providers also can check authorization status on the portal
✅ Failure to obtain PA will result in claims payment denials for late notifications.
Providers can initiate Prior Authorization through the MHS referral line by calling 1-877-647-4848
• Monday - Friday 8 a.m. to 5 p.m. (Closed for lunch from noon to 1 p.m.)
• After hours, MHS 24 hour nurse line available to take emergent requests.
The PA process begins at MHS by speaking with the MHS non-clinical referral staff
For procedures requiring additional review, we will transfer providers to a “live” nurse line to facilitate the PA process
Please have all clinical information ready at time of call
# Fax Authorization

**1-866-912-4245: MHS Medical Management Department**

<table>
<thead>
<tr>
<th>Patient Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid ID/RID#:</td>
</tr>
<tr>
<td>DOB:</td>
</tr>
<tr>
<td>Patient Name:</td>
</tr>
<tr>
<td>Address:</td>
</tr>
<tr>
<td>City/State/Zip:</td>
</tr>
<tr>
<td>Patient/Guardian Phone:</td>
</tr>
<tr>
<td>PMP Name:</td>
</tr>
<tr>
<td>PMP NPI:</td>
</tr>
<tr>
<td>PMP Phone:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medical Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Use of ICD-9 Diagnostic Code is Required)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Dx1</th>
<th>Dx2</th>
<th>Dx3</th>
</tr>
</thead>
</table>

Please check the requested assignment category below:

- [ ] DME
  - [ ] Purchased
  - [ ] Rented
- [ ] Home Health
- [ ] Hospice
- [ ] Inpatient
- [ ] Observation
- [ ] Office Visit
- [ ] Occupational Therapy
- [ ] Physical Therapy
- [ ] Speech Therapy
- [ ] Transportation
- [ ] Outpatient
- [ ] Other

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

**Diagnosis code(s) required**

**Check service category**
Prior Authorization (PA) Request

Providers must **update** previously approved PAs **within 30 days** of the original date of service prior to claim denial for changes in:
- Dates of service
- CPT/HCPCS codes
- Physician

Providers must initiate appeals within 60 days of the receipt of the denial letter for MHS to consider.

Additional Information found in the [MHS Provider Manual](#)

*Providers may make corrections within 30 days to the existing PA as long as the claim has not been submitted*
Prior Authorization

MHS Medical Management will review state guidelines and all available clinical documentation and seek Medical Director input as needed.

♀ PA for observation level of care (up to 72 hours for Medicaid or 48 hours for Ambetter and Allwell), diagnostic services do not require an authorization for contracted facilities. Non-contracted facilities do not require prior authorization.
♀ If the provider requests an inpatient level of care for a covered/eligible condition, or procedure and documentation supports an outpatient/observation level of care, MHS will send the case for Medical Director review.
Prior Authorization

Outpatient Services

🎉 All elective procedures that require prior authorization must send request to MHS at least **two business days** prior to the date of service.
🎉 All urgent and emergent services do not require prior authorization, but admissions must be called in to MHS within **two business days** following the admit.
🎉 Prior Authorizations are **not** a guarantee of payment.
🎉 Failure to obtain PA will result in claims payment denials for late notifications. Claim denials may result when a claim is denied due to a failure to obtain PA for services where PA is required.
🎉 Members **must** be Medicaid Eligible on the date of service.

*Failure to obtain prior authorization for non urgent and emergent services will result in a denial for related claims*
Prior Authorization

Transfers

 Harm MHS requires **notification and approval** for all transfers from one facility to another at least two business days in advance

 Harm MHS requires **notification** within two business days following all emergent transfers Transfers include, but are not limited to:
  - Facility to facility
  - Higher level of care changes require PA and it is the responsibility of the transferring facility to obtain

 Failure to obtain PA will result in claims payment denials for late notification
Self-Referral Services

 Exceptions to prior authorization requirements

 Members can see these specialists and get these services without a direct referral from their PMP:

 - Podiatrist
 - Chiropractor
 - Family planning
 - Immunizations
 - Routine vision care
 - Routine dental care
 - Behavioral health by type and specialty
 - HIV/AIDS case management
 - Diabetes self management

 *Benefit limitations apply*
Therapy Services - (Speech, Occupational, Physical Therapy)

Effective July 1, 2019, physical, occupational and speech therapy (PT, OT, and ST) services will no longer be managed through a post-service review process for MHS.

Prior authorization for PT, OT, and ST services will be required to determine whether services are medically necessary and appropriate.

The utilization management of these services will continue to be managed by NIA.
Effective 6/1/2019 Turning Point manages all prior authorizations for medical necessity and appropriate length of stay (when applicable) for musculoskeletal surgical procedures:

**MUSCULOSKELETAL**

**Orthopedic Surgical Procedures**
- Knee Arthroplasty
- Unicompartmental/Bicompartmental Knee Replacement
- Hip Arthroplasty
- Shoulder Arthroplasty
- Elbow Arthroplasty
- Ankle Arthroplasty
- Wrist Arthroplasty
- Acromioplasty and Rotator Cuff Repair
- Anterior Cruciate Ligament Repair
- Knee Arthroscopy
- Hip Resurfacing
- Meniscal Repair
- Hip Arthroscopy
- Femoroacetabular Arthroscopy
- Ankle Fusion
- Shoulder Fusion
- Wrist Fusion
- Osteochondral Defect Repair

**Spinal Surgical Procedures**
- Spinal Fusion Surgeries
  - Cervical
  - Lumbar
  - Thoracic
  - Sacral
  - Scoliosis
- Disc Replacement
- Laminectomy/Discectomy
- Kyphoplasty/Vertebroplasty
- Sacroiliac Joint Fusion
- Implantable Pain Pumps
- Spinal Cord Neurostimulator
- Spinal Decompression
Emergency Related Procedures do not require authorization.

It is the responsibility of the ordering physician to obtain authorization.

Providers rendering musculoskeletal services, must verify that the necessary authorization has been obtained; failure to do so may result in non-payment of your claims.

Clinical Policies are available by contacting TurningPoint at 1-574-784-1005 for access to digital copies.

**TRAINING:**
- Informational webinars are available! Please register at: [https://register.gotowebinar.com/rt/7079530369468972290](https://register.gotowebinar.com/rt/7079530369468972290)
Turning Point’s Utilization Management

🎉 Web Portal Intake:
  • myturningpoint-healthcare.com

🎉 Telephonic Intake:
  • 574-784-1005 | 855-415-7482

🎉 Facsimile Intake: 463-207-5864
Durable & Home Medical Equipment

- Members and referring providers do not need to search for a DME provider or provider of medical supplies to service their needs.

- Order is submitted directly to MHS, through the Medline portal, unless PA is required, and delivered to the member.

- **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.

- Availability via Medline’s web portal to submit orders and track delivery.

- Prior authorization required by the **ordering physician** for all non-participating DME providers.

- Does not apply to items provided by and billed by physician office.

- Exclusions applicable to specific hospital based DME/HME vendors.
IMAGING PRIOR AUTHORIZATION REQUESTS- NIA

National Imaging Associates (NIA) manages non-emergent, advanced, outpatient imaging services to include prior authorization for MHS members.

The ordering physician is responsible for obtaining authorization.

To obtain authorization, go to the NIA website RadMD.com or through the NIA dedicated toll-free phone number, 1-866-904-5096.

Failure to obtain PA may result in nonpayment of claim.

Emergency room, observation and inpatient imaging procedures do not require authorization.
PA Denial and Appeal Process

If MHS denies the requested service:
- And the member is still receiving services, the provider has the right to an expedited appeal. The attending physician must request this.
- And the member already has been discharged, the attending physician must submit an appeal in writing within 60 days of the denial.

The attending physician has the right to a peer-to-peer discussion with an MHS physician:
- Providers initiate peer-to-peer discussions and expedited appeals by calling an MHS appeals coordinator at 1-877-647-4848.
- They must request peer-to-peer within 10 days of the adverse determination.

Prior authorization appeals are also known as medical necessity appeals.
Send Prior Authorization/Medical Necessity Appeals to:
Managed Health Services
Attn: Appeals Coordinator
550 North Meridian Street, Suite 101
Indianapolis, IN 46204

Providers must initiate appeals within **60 days** of the receipt of the denial letter for MHS to consider.

We will communicate determination to the provider within **20 business days** of receipt.

*A prior authorization appeal is different than a claim appeal request.*

Applicable to members and non-contracted providers.
Prior Authorization (PA) Request

MHS strives to return a decision on all PA requests within two business days of request.

Reasons for a delayed decision may include:
- Lack of information or incomplete request
- Illegible faxed copies of PA forms – e.g. handwriting is illegible or fax is otherwise not readable
- Request requiring Medical Director review

MHS has up to seven days to render PA decisions.

PA approval requires the need for medical necessity.

If your claim is denied, please contact Provider Services at 1-877-647-4848 to determine the cause of the denial.

Medical Management does not verify eligibility or benefit limitations.
- Provider is responsible for eligibility and benefit verification.
MHS will honor pre-existing authorizations from any other Medicaid program during the first 30 days of enrollment or up to the expiration date of the previous authorization, whichever occurs first, and upon notification to MHS. Include the approval from the prior MCE with the request.

Reference: MHS Provider Manual Chapter 6
MHS Portal
Providers may register at mhsindiana.com to access MHS’ Secure portal to:

- Check member eligibility
- Manage multiple practices and line of business under one account
- View panels and membership information
- View member’s RX and medical history
- Submit/check claims and authorizations
- Access explanation of payments
- Access quality reports
- Access gaps in care
Secure Web Portal Login or Registration

Login/Register is the same for MHS, Ambetter from MHS, Allwell from MHS and Behavioral Health Providers.
### Web Portal Training Documents

**Documents Include:**
- Registration Guide
- MHS Web Portal Functionality Guides
- How To Complete Specific Tasks on the MHS Web Portal

---

<table>
<thead>
<tr>
<th>FOR MEMBERS</th>
<th>FOR PROVIDERS</th>
<th>GET INSURED</th>
</tr>
</thead>
</table>

**Web Portal**

We encourage our providers to take advantage of our easy-to-use secure Provider Portal instead of making a phone call. On our secure portal, you can:

1. Manage multiple practices under one account
2. Check member eligibility
3. View medical history and gaps in care
4. Submit and manage claims
5. Submit prior authorizations
6. Securely contact a plan representative.

We also have the following enhanced features below:

- Update demographic information
- Assist your patients in completing their Health Risk Assessment forms
- View patient Care Gaps (indicates if your patient is due for a preventive exam or service)
- View the status or prior Authorization requests
- Utilize the Member Management Forms

Follow the [registration guide](#) or if you have any questions, please call the Web Portal helpdesk line at 1-866-613-0327.

There’s no waiting, no on-hold music, no time limits. Registration is free and easy.

**MHS Secure Provider Portal Training Documents**

- [Provider Secure Portal Guide](#)
- [Provider Secure Portal User (PDF)](#)
- [Account Details ORG (PDF)](#)
- [Account Manager: User Guide (PDF)](#)
- [Member Management Forms Guide (PDF)](#)

**How To:**

- Submit a Claim CMS 1500 (PDF)
- Submit a Claim CMS UB-04 (PDF)
- Submit a Corrected Claim (PDF)
- View Claim Status (PDF)
- View Payment History (PDF)
Complete Registration or Login

The Tools You Need Now!
Our site has been designed to help you get your job done. For registration or secure website questions call (866) 912-0327.

Check Eligibility
Find out if a member is eligible for service.

Authorize Services
See if the service you provide is reimbursable.

Manage Claims
Submit or track your claims and get paid fast.

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

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

Provider Registration Video
Provider Registration PDF
Welcome

- **Multiple TINs** can be managed from a single account.
- **Account Managers** can oversee the secure portal accounts of their staff/office. User can be added, disabled, and have their permissions changed.
- **Reports** are available here

Patient and **Provider Analytics**

Quick Links

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

Go Paperless
MHS Member Management Forms

Click on Member Management Forms under Quick Links

Choose between:
- Member Disenrollment Form
- Panel Management Form
Account Details

To view your Account Details:

1. Select the drop-down arrow next to user name in the upper right corner on the dashboard.
2. Click Account Details.

Note: Under Your TINs you see the Current Primary Default TIN for the account, and can select another TIN to Mark As Default or Remove a TIN.
Account Manager

 начинается с информации, что для менеджеров по счетам (Account Managers) разработана функция управления пользователями (User Management), с помощью которой можно禁能/включать пользователей и управлять разрешениями для своей учетной записи.

1. Выберите выпадающее меню рядом с вашим именем в верхнем правом углу.
2. Выберите User Management.
3. Нажмите на Update User рядом с именем пользователя.
Member Record
Member Record Details

- Member Overview
- Cost Sharing
- Assessments
- Health Record
- Visits, Medications, Immunizations, Labs, and Allergies
- Care Plan
- Authorizations
- Referrals
- Coordination of Benefits
- Claims
- Power Account Service Estimate *only HIP Members
- Document Resource Center
- Notes
Authorizations

- View, create and filter group Authorizations
- Click on the **AUTH ID** to see additional information
- **Filter** Authorizations by Date Range, Member, Authorization#, Confirmation#, Status or Auth Type
Authorization for Durable & Home Medical Equipment

Requests should be initiated via MHS Secure portal

1. Select **Authorizations** tab and click on **Create Authorization**.
2. Enter **Member ID** or **Last Name** and **Date of Birth**
3. Choose **DME** and you will be directed to the Medline portal for order entry.
Claims
Claims

Web Portal Claims Functionalities

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

Submit a New Claim

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

Choose the Claim Type

- Professional or Institutional claim submission
Submitted Claims

The **Submitted** tab will show only claims created via the MHS portal.
- **Paid** is a green thumbs up,
- **Denied** is an orange thumbs down
- **Pending** is a clock

**RTEP** claims also show if eligible. (i.e. line 2 was submitted. But was not eligible for RTEP.)
Individual Claims

On the Individual tab, submitted using paper, portal or clearing house.

- View the Claim Number, Claim Type, Member Name, Service Dates, Billed/Paid, and Claim Status

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

To view Saved claims: Drafts, Professional or Institutional

1. Select Saved
2. Click Edit to view a claim
3. Fix any errors or complete before submitting
   Or
4. Click Delete to delete saved claim that is no longer necessary
5. Click OK to confirm the deletion
Correcting Claims

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

Only claims with a status of PAID or DENIED can be corrected online.
Payment History

View Service Line Details

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

Explanation of Payment Details

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: 0000428203    Check Date: 08/17/2017

Insured Name: [Redacted]
Patient Name: [Redacted]
Control Number: [Redacted]
Service Provider: INUAGWU, ANTHONY

View Service Line Details

<table>
<thead>
<tr>
<th>Serv</th>
<th>Date</th>
<th>Proc#/Proc#2</th>
<th>Mod</th>
<th>Days/Cnt Qty</th>
<th>Charged</th>
<th>Allowed</th>
<th>Deduct/Copay</th>
<th>Coinsur</th>
<th>Discount/Interest</th>
<th>Med Allow/Med Paid</th>
<th>TPP</th>
<th>Denied</th>
<th>Remit Codes</th>
<th>Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>06/03/2017</td>
<td>99235</td>
<td>0/1</td>
<td></td>
<td>305.00</td>
<td>160.37</td>
<td>0.00/0.00</td>
<td>0.00</td>
<td>0.00/0.00</td>
<td>0.00/0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>160.37</td>
<td>$160.37</td>
</tr>
</tbody>
</table>

Sub Total: 305.00 $160.37 $0.00/0.00 $0.00 $0.00/0.00 $0.00/0.00 $0.00/0.00 $0.00/0.00 0.00 0.00 on 160.37

Remit Code Descriptions

on REDUCED PAYMENT FOR OUT OF NETWORK PROVIDER
Clicking on items (claim numbers, check numbers, dates) that are highlighted blue will reveal additional information.

When filtering to find a claim or payment, only a 1 month span can be used.

Click on the Saved Claims tab to view claims that have been created but not Submitted. Claims in this queue can be edited for submission or deleted from this tab.

In order to utilize the Correct Claim feature, the claim needs to be in a Paid or Denied status.

When filtering Payment History the span is limited to 1 month.
Secure Messaging
Secure Messaging

Create a New Secure Message

• Click **Messaging** tab from the Dashboard.
• Click **Create Message**
MHS Public Website
(mhsindiana.com)
MHS Website

- mhsindiana.com
- Provides access to Medicaid, Ambetter and Allwell
- Provider directory search functionality
- Pre-Auth Needed tool
- 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
Provider Enrollment
Provider Enrollment

Become a Provider

Become A Contracted Provider

Click Here

Existing Contracted Provider

Click Here

We appreciate your interest in MHS and are excited to set up your office as a participating provider. If you would like more information, please fill out the online information request form. An MHS representative will reach out to you shortly to discuss contracting options for your office.

If you are a provider who is part of an existing contracted entity, use this online contracted enrollment form to enroll a new provider. All submissions must include a completed IHCP application.
Provider Enrollment

**Non-Contracted Provider**
Click Here

If you are not contracted with MHS, please complete the online non-contracted enrollment form. All submissions must include a completed W-9. Set-up may take 45 – 60 days after we receive your submission.

To begin set-up with MHS, you must be enrolled with Indiana Medicaid and have an Indiana Medicaid provider number. You can enroll online at [indianamedicaid.com](http://indianamedicaid.com).

**Existing Behavioral Health Provider**
Click Here

If you are a provider who is part of an existing contracted behavioral health entity, use this online contracted enrollment form to enroll a new provider.
Provider Enrollment

When referring patients to the hospital, do you utilize hospitalists?

- Yes
- No

Group NPI

Group Medicaid Number *

Alpha Suffix

TIN *

Please attach a copy of your completed IHCP enrollment form. Required for Medicaid (HIP, HHW or HCC).

Choose File

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

Choose File

Comments
Provider Enrollment

Enrollment Requested By:

First Name *

Last Name *

Date *

Contact Email *

Contact Phone *

Submit
MHS Behavioral Health Provider Enrollment

*Please attach a copy of your completed IHCP enrollment form.*
Choose File: No file chosen

*Please attach a copy of your Health Service Provider of Psychology (HSPP) Attestation.*
Choose File: No file chosen

*Please attach a copy of your Behavioral Health Specialty Profile.*
Choose File: No file chosen
Demographic Updates
Providers can utilize the Demographic Update Tool to update below information.

- Address Changes
- Demographic Changes
- Update Member Assignment Limitations
- Term an Existing Provider
- Make a Change to an IRS Number or NPI Number
Provider Demographic Updates

Demographic Update Tool

MHS is committed to providing our providers with the best tools possible to support their administrative needs. We have created an easy way for you to request updates to your information and ensure we receive what we need to complete your request in a timely manner.

Need to review your existing information or have a question? If you are a contracted provider you can visit our Provider Directory to review your information. Please note that hospital-based and midlevel providers will not show in the directory. If you are a non-contracted provider, please call Provider Services at 1-877-647-4848. Our Contact Us page is always available for general questions as well.

Ambetter only provider? Visit our Ambetter website.

What would you like to do?

MAKE AN ADDRESS CHANGE?

MAKE A DEMOGRAPHIC CHANGE?

UPDATE MEMBER ASSIGNMENT LIMITATIONS?

TERM AN EXISTING PROVIDER?

MAKE A CHANGE TO AN IRS NUMBER OR NPI NUMBER?
Behavioral Health
Behavioral Health Claim Process

**Electronic submission**
- Payer ID 68068
- MHS accepts Third Party Liability (TPL) information via Electronic Data Interchange
- It is the responsibility of the provider to review the error reports received from the Clearinghouse (Payer Reject Report)

**Online submission through the MHS Secure Provider Portal**

**Paper Claims**
- MHS Behavioral Health
- ATTN: Claims Department
- P.O. Box 6800
- Farmington, MO 63640-3817

**Claim Inquiries**
- Check status online
- Call Provider Services at 1-877-647-4848
Behavioral Health Dispute Resolution

Must be made in writing by using the MHS Behavioral Health Informal Claim Dispute or objection form, available at mhsindiana.com/provider-forms.

Submit all documentation supporting your objection.

Send to MHS within 67 calendar days of receipt of the MHS on Explanation of Payment (EOP). Please reference the original claim number. Requests received after day 67 will not be considered.

Behavioral Health Services
Attn: Appeals Department
P.O. Box 6000
Farmington, MO 63640-3809

MHS will make all reasonable efforts to review your documentation and respond to you within 30 calendar days.

At that time (or upon receipt of our response if sooner), you will have up to 67 calendar days from date on EOP to initiate a formal claim appeal.
Behavioral Health Prior Authorization

PRIOR AUTHORIZATION

- Please call Care Management for inpatient and partial hospitalization authorizations at 1-877-647-4848. Follow prompts to Behavioral Health.
- Authorization forms may be obtained on our website
  - Outpatient Treatment Request (OTR) Form/Tip-Sheet/Training
  - Intensive Outpatient/Day Treatment Form Mental Health/Chemical Dependency
  - Applied Behavioral Analysis Treatment (OTR)
  - Psychological Testing Authorization Request Form (Outpatient & Inpatient)

Medical Necessity Appeals

- Submit to:
  MHS Behavioral Health
  ATTN: Appeals Coordinator
  12515-8 Research Blvd, Suite 400
  Austin, TX 78759
Behavioral Health Services Requiring Authorization

Professional Services

Psychiatric Diagnostic Evaluation (Limited to 1 per member per 12 month Rolling year without authorization)

Electroconvulsive Therapy

Psychological Testing (Unless for Autism: then no auth is required)

Developmental Testing, with interpretation and report (non-Early Periodic Screening, Diagnosis Treatment EPSDT)

Neurobehavioral status exam, with interpretation and report

Neuropsych Testing per hour (face to face) (Unless for Autism: then no auth is required). (Non-Participating Providers only)

Applied Behavioral Analysis (ABA) Services
Medical Claim Processing
Claim Submission

EDI Submission
• Preferred method of claims submission
• Faster and less expensive than paper submission
• MHS Medical Electronic Payor ID: 68069
• MHS BH Electronic Payor ID: 68068

Online through the MHS Secure Provider Portal at mhsindiana.com
• Provides immediate confirmation of received claims and acceptance
• Institutional and Professional
• Batch Claims
• Claim Adjustments/Corrections

Paper Claims
Managed Health Services
PO Box 3002
Farmington, MO 63640-3802
Claim Submission

Claims must be received within 90 calendar days of the date of service

Exceptions (rejections do not substantiate filing limit requirements)

- Newborns (30 days of life or less) – Claims must be received within 365 days from the date of service. Claim must be filed with the newborn’s RID #
- TPL – Claims with primary insurance must be received within 365 days of the date of service with a copy of the primary EOB. If primary EOB is received after the 365 days, providers have 60 days from date of primary EOB to file claim to MHS. If the third party does not respond within 90 days, claims may be submitted to MHS for consideration. Claims submitted must be accompanied by proof of filing with the patients primary
Dispute Resolution/Appeals

Must be made in writing by using the MHS informal claim dispute/objection form, available at mhsindiana.com/provider-forms.

Submit all documentation supporting your objection.

Send to MHS within 67 calendar days of receipt of the MHS EOP. Please reference the original claim number. Requests received after day 67 will not be considered*.

Medical Claims:
MHS Medical Appeals
Attn: Appeals
P.O. Box 3000
Farmington, MO 63640-3800

Behavioral Claims:
MHS BH Appeals
Attn: Appeals Department
P.O. Box 6000
Farmington, MO 63640-3809

MHS will acknowledge your appeal within 5 business days.

Provider will receive notice of determination within 45 calendar days of the receipt of the appeal.

*A call to MHS Provider Services does not reserve appeal rights
Dispute Resolution/Appeals

Level One Appeal- Claim Objection

必须要以书面形式使用MHS非正式索赔争端/异议表来提出。

- 提交所有支持您异议的所有文件。
- 须在收到原始MHS EOP后67日历天内发送到MHS。
- 提出二级上诉，如果索赔在初始异议提交后30天内未被推翻。

A call to MHS Provider Services does not reserve appeal rights
Dispute Resolution/Appeals

Level Two Appeal (Administrative)

Submit the informal claims dispute or objection form with all supporting documentation to the MHS appeals address:

Managed Health Services
Attn: Appeals
P.O. Box 3000
Farmington, MO 63640-3800

MHS will acknowledge your appeal within 5 business days.

Provider will receive notice of determination within 45 calendar days of the receipt of the appeal for a formal appeal.
MHS Partners
Partners and Vendors

茭 Envolve Pharmacy Solutions: Pharmacy Benefit Manager
  • 1-844-202-6824 Phone
  • 1-800-977-8226 (Fax) PA Requests
茭 Envolve Vision Benefits: Routine Eye Care Benefit & Ophthalmology Specialty Care
  • 1-800-334-3937
  • envolvevision.com
茭 Envolve Dental: Dental Services
  • 1-855-609-5157
  • dental.envolvehealth.com
茭 National Imaging Associates (NIA): Non-Emergent, Outpatient High-Tech Imaging
  • 1-800-424-4821
  • RadMD.com
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
MHS Provider Network Territories

NORTHEAST REGION
Claims Issues: MHS_ProviderRelations_Ni@mhsindiana.com
Chad Pratt, Provider Partnership Associate
1-877-647-4848 ext. 20454
rigratt@mhsindiana.com

CENTRAL REGION
Claims Issues: MHS_ProviderRelations_C@mhsindiana.com
Esther Cervantes, Provider Partnership Associate
1-877-647-4848 ext. 20547
Estherling.A.Cervantes@mhsindiana.com

NORTHWEST REGION
Claims Issues: MHS_ProviderRelations_NW@mhsindiana.com
Candace Ervin, Provider Partnership Associate
1-877-647-4848 ext. 20887
Candace.Ervin@mhsindiana.com

SOUTHWEST REGION
Claims Issues: MHS_ProviderRelations_SW@mhsindiana.com
Dawn McCarty, Provider Partnership Associate
1-877-647-4848 ext. 30197
Dawnmare.Ad-McCarty@mhsindiana.com

SOUTHEAST REGION
Claims Issues: MHS_ProviderRelations_SE@mhsindiana.com
1-877-647-4848

NETWORK LEADERSHIP
Jill Claypool
Vice President, Network
Development & Contracting
1-877-647-4848 ext. 20355
jill.e.claypool@mhsindiana.com

Nancy Robinson
Senior Director, Provider Network
1-877-647-4848 ext. 20180
nrobinson@mhsindiana.com

Mark Vonderheik
Director, Provider Network
1-877-647-4848 Ext. 50340
mvonderheik@mhsindiana.com

NEW PROVIDER CONTRACTING
Tim Balko
Director, Network Development & Contracting
1-877-647-4848 ext. 30933
thalko@mhsindiana.com

Michael Funk
Manager, Network Development & Contracting
1-877-647-4848 ext. 30099
michael.f.funk@mhsindiana.com

NETWORK OPERATIONS
Kelvin Orr
Director, Network Operations
1-877-647-4848 ext. 30049
kelvin.d.orr@mhsindiana.com
# MHS Provider Network Territories

## TAWANNA DANZIE
Provider Partnership Associate II
1-877-547-4848 ext. 20522
tdanzie@mhsindiana.com

**PROVIDER GROUPS**
- Beacon Medical Group
- Community Care Network
- Franciscan Alliance
- Goshen Health System
- Healthline
- Heart City Health Center
- Indiana Health Centers
- Lutheran Medical Group
- Northside Health Centers
- Parkview Health System
- South Bend Clinic

## JENNIFER GARNER
Provider Partnership Associate II
1-877-547-4848 ext. 20149
jgarner@mhsindiana.com

**PROVIDER GROUPS**
- American Health Network of Indiana
- Columbus Regional Health
- Community Physicians of Indiana
- Good Samaritan Hospital Physician Services
- HealthNet
- Health & Hospital Corporation of Marion County
- Indiana University Health
- Little Company of Mary Hospital of Indiana
- Riverview Hospital
- St. Vincent Medical Group

## INTERNAL REPRESENTATIVES

### JENNIFER DEAN
Provider Network Specialist
1-877-547-4848 ext. 20320
jdean@mhsindiana.com

### LAKISHA BROWDER
Provider Relations Specialist
1-877-547-4848 ext. 20524
lbrowder@mhsindiana.com

## ENVOLVE DENTAL, INC.

### MICHAEL J. WILLIAMS
Provider Relations Specialist
1-727-437-1032
Dental Provider Services: 1-932-503-5137
Michael.Williams@EnvolveHealth.com
Review

We hope you learned more about the following topics:

- What products are offered by MHS
- Additional details regarding the MHS PA process and timelines
- MHS portal functionality
- Online provider enrollment and demographic change applications
- Behavioral Health claims submission and appeals
- MHS Medical claims submission and appeals
- MHS Vendors
- Quality measures and P4P information
Questions?

Thank you for being our partner in care.