How to Make Prior Authorizations Work for You
Agenda

<header list-style-type: bullet>
  - Prior Authorization (PA)
  - Need to Know
  - Web Portal
  - Telephonic Requests
  - Fax Requests
  - Appeals Process
  - MHS Team
  - Questions and Answers
</header>
MHS Products

- **MEDICAID HEALTH PLANS**
  - Hoosier Healthwise
  - Healthy Indiana Plan (HIP)
  - Hoosier Care Connect

- **MARKETPLACE HEALTH PLANS**
  - Ambetter Essential Care (Bronze)
  - Ambetter Balanced Care (Silver)
  - Ambetter Secure Care (Gold)

- **MEDICARE HEALTH PLANS**
  - Advantage HMO
  - Advantage PPO
Prior Authorization

Prior Authorization (Medical Services):

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

- **Inpatient (IP) authorizations = IP + 10 digits**
- **Outpatient (OP) authorizations = OP + 10 digits**
- **Emergent ER Symptoms** suggesting imminent, life-threatening condition no PA required, but notification requested within **two (2) business days**.
- **Urgent concurrent = Emergent inpatient admission.** Determination timeline within **24 hours** of receipt of request.
- **Pre-service non urgent = Elective scheduled procedures.** Determination within **15 calendar days.** Benefit limitations apply (dependent on product).
Prior Authorization

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

 окру sweet and Ambetter and Allwell), diagnostic services do not require an authorization for contracted facilities.

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.
MHS Medicaid Prior Authorization

Outpatient Services:

督 All elective procedures that require prior authorization must have submitted request to MHS at least two (2) business days prior to the date of service.
督 All urgent and emergent services do not require prior authorization, but admissions must be called in to MHS within two (2) business days following the admit.
督 Members must be Medicaid Eligible on the date of service.

* Prior Authorizations are not a guarantee of payment.

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

Members who are enrolled in Ambetter HMO and EPO plans must utilize in-network participating providers. Members and Providers can identify participating providers by using the Find a Provider tool located on mhsindiana.com

When an out-of-network provider is utilized, except in the case of emergency services, the member will be 100% responsible for all charges.

Note: All out of network services require prior authorization, excluding emergency room services.
<table>
<thead>
<tr>
<th>Service Type</th>
<th>Timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scheduled admissions</td>
<td>Prior Authorization required five business days prior to the scheduled admission date</td>
</tr>
<tr>
<td>Elective outpatient services</td>
<td>Prior Authorization required five business days prior to the elective outpatient service date</td>
</tr>
<tr>
<td>Emergent inpatient admissions</td>
<td>Notification within one business day</td>
</tr>
<tr>
<td>Observation – 48 hours or less</td>
<td>Notification within one business day for non-participating providers</td>
</tr>
<tr>
<td>Observation – greater than 48 hours</td>
<td>Requires inpatient prior authorization within one business day</td>
</tr>
<tr>
<td>Maternity admissions</td>
<td>Notification within one business day</td>
</tr>
<tr>
<td>Newborn admissions</td>
<td>Notification within one business day</td>
</tr>
<tr>
<td>Neonatal Intensive Care Unit (NICU) admissions</td>
<td>Notification within one business day</td>
</tr>
<tr>
<td>Outpatient Dialysis</td>
<td>Notification within one business day</td>
</tr>
<tr>
<td>Organ transplant initial evaluation</td>
<td>Prior Authorization required at least 30 days prior to the initial evaluation for organ transplant services.</td>
</tr>
<tr>
<td>Clinical trials services</td>
<td>Prior Authorization required at least 30 days prior to receiving clinical trial services.</td>
</tr>
</tbody>
</table>
# Ambetter Utilization Determination Timelines

<table>
<thead>
<tr>
<th>Type</th>
<th>Timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prospective/Urgent</td>
<td>72 hours (three calendar days)</td>
</tr>
<tr>
<td>Prospective/Non-Urgent</td>
<td>15 calendar days</td>
</tr>
<tr>
<td>Concurrent/Urgent</td>
<td>24 hours (one calendar day)</td>
</tr>
<tr>
<td>Concurrent/Non-Urgent</td>
<td>15 calendar days</td>
</tr>
<tr>
<td>Retrospective</td>
<td>30 calendar days</td>
</tr>
</tbody>
</table>
# Allwell Timeframes for PA Requests and Notifications

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elective/scheduled admissions</td>
<td>Required five (5) business days prior to the scheduled admission date</td>
</tr>
<tr>
<td>Emergent inpatient admissions</td>
<td>Notification required within one (1) business day</td>
</tr>
<tr>
<td>Emergency room and post stabilization, urgent care and crisis intervention</td>
<td>Notification requested within one (1) business day</td>
</tr>
</tbody>
</table>
# Allwell Utilization Determination Timelines

<table>
<thead>
<tr>
<th>Level of Urgency</th>
<th>Type</th>
<th>Timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standard</td>
<td>Expeditiously as the member’s health condition required, but no later than 14 calendar days after receipt of request</td>
<td></td>
</tr>
<tr>
<td>Standard Extension</td>
<td>Up to 14 additional calendar days (not to exceed 28 calendar days from receipt of original request)</td>
<td></td>
</tr>
<tr>
<td>Expedited</td>
<td>Expeditiously as the member’s health condition requires, but no later than 72 hours after receipt of request</td>
<td></td>
</tr>
<tr>
<td>Expedited Extension</td>
<td>Up to 14 additional calendar days (not to exceed 17 calendar days after receipt of original request)</td>
<td></td>
</tr>
<tr>
<td>Concurrent</td>
<td>As soon as medically indicated; usually within 1 business day of request depending on the plan’s policy</td>
<td></td>
</tr>
</tbody>
</table>
Prior Authorization

Transfers:

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

🎉 MHS requires **notification** within two (2) 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.
Services that require prior authorization regardless of contract status:

- Injectable drugs (see mhsindiana.com/provider-guides for up-to-date list of codes)
- Nutritional counseling (unless diabetic)
- Pain management programs, including epidural, facet and trigger point injections
- PET, MRI, MRA and Nuclear Cardiology/SPECT scans
- Cardiac rehabilitation
- Hearing aids and devices
- Home and Institutional hospice (coverage varies by product)
- In-home infusion therapy
- Orthopedic footwear
- Respiratory therapy services
- Pulmonary rehabilitation
- Home care (except after an IP admission with benefit limitations)
Is Prior Authorization Needed?

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

Medicaid Pre-Auth Needed?

DISCLAIMER: All attempts are made to provide the most current information on the Pre-Auth Needed Tool. However, this does NOT guarantee payment. Payment of claims is dependent on eligibility, covered benefits, provider contracts, correct coding and billing practices. For specific details, please refer to the provider manual. If you are uncertain that prior authorization is needed, please submit a request for an accurate response.

Vision services need to be verified by **Envolve Vision**
Complex Imaging, MRA, MRI, PET and CT scans need to be verified by **NIA**
Hoosier Healthwise dental services need to be verified by **State**
Healthy Indiana Plan (HIP) and Hoosier Care Connect dental services need to be verified by **Envolve Dental**
Ambulance and Transportation services need to be verified by **LCP Transportation**
Behavioral Health/Substance Abuse need to be verified by **Cenpatico**
Non-participating providers must submit Prior Authorization for all services
For non-participating providers, **Join Our Network**

Are Services being performed in the Emergency Department or Urgent Care Center or 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>
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<tr>
<td>Are anesthesia services being rendered for pain management?</td>
<td></td>
<td></td>
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<tr>
<td>Are services for infertility?</td>
<td></td>
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</tr>
<tr>
<td>Is the member receiving dialysis?</td>
<td></td>
<td></td>
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</tbody>
</table>
Prior Authorization

Types of Services

<table>
<thead>
<tr>
<th>Question</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>
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</tr>
<tr>
<td>Is the member receiving dialysis?</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.
Prior Authorization

Information Needed to Complete All PAs:

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

*Providers must request updates to prior authorizations within 30 days from the original date of service before claim submission.*
Need to Know
BT201913 – IHCP provides prior authorization process for individuals on Fast Track Prepayment.

Providers must use the following process for inpatient stays to ensure that they can properly submit a retroactive PA request for individuals utilizing a Fast Track prepayment:

• The provider must assist an individual in completing an application for health coverage.
• As part of the application process, the provider will assist the individual with submitting a Fast Track prepayment.
• After assisting with the application for health coverage, the provider must complete a Fast Track Notification Form (available on the Forms page at in.gov/medicaid/providers) and fax the form to the managed care entity (MCE) selected on the application. **This process must be completed within 5 days of the date of admission.** To locate the fax number for the applicable MCE, see the IHCP Quick Reference Guide at in.gov/medicaid/providers.
• After eligibility has been established, the MCE will return a Full Eligibility Notification Form (available on the Forms page at in.gov/medicaid/providers) to the provider via fax. This form will contain the member’s MCE assignment and Member ID (also known as RID). The notification will occur within 7 days following eligibility discovery.
• The provider will then be able to submit a PA request for the service rendered since the first day of the month of the Fast Track prepayment. **Providers must submit the PA request within 60 days of receiving the Full Eligibility Notification Form.** Providers must verify eligibility, using the IHCP Provider Healthcare Portal, prior to submitting the PA request.
Non Fast Track Retro Eligibility/Adults

If an adult, 19 years or older, presents for services without insurance and the facility does not help the member apply for HPE or complete the HIP application, the facility must notify MHS of the admission within 60 days of becoming aware of the member’s date of Medicaid eligibility.

Please submit the IHCP PA form and the MHS Late Notification of Services Submission form with clinical information supporting the medical necessity for the admission.
Retro Eligibility/Newborns

Mother Covered by Indiana Medicaid MCE

The facility must notify MHS of an admission of an infant who remains hospitalized after the mother is discharged within two (2) business days.

The facility is responsible for determining the mother’s coverage.

The facility should assume that the member will be assigned to the mother’s MCE.
Mother Not Covered by Indiana Medicaid MCE

—if the infant’s mother is not covered by an MCE at the time of delivery, the facility must notify MHS of the admission within 60 days of becoming aware of the member’s eligibility using the IHCP PA form and the MHS Late Notification of Services Submission form with clinical information supporting the medical necessity for the admission.

—it is presumed that the facility would become aware of the member’s eligibility within one week of visibility on the State Portal.
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)

must follow billing guidelines (GP, GN, GO modifiers).

National Imaging Associates, Inc. (NIA) conducts retrospective review to evaluate medical necessity:

- If requested, medical records can be uploaded to RadMD.com or faxed to NIA at 1-800-784-6864.
- Medical necessity appeals will be conducted by NIA:
  - Follow steps outlined in denial notification
  - NIA Customer Care Associates are available to assist providers at 1-800-424-5391.
Durable & Home Medical Equipment

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

👩‍⚕️ Medline’s web portal is used to submit orders and track delivery.

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

👩‍⚕️ Exclusions applicable to specific hospital based DME/HME vendors.
Durable & Home Medical Equipment

_requests should be initiated via **MHS secure portal:**

- **Web Portal:** Simply go to mhsindiana.com, log into the provider portal, and click on “Create Authorization.” Click DME and you will be directed to the Medline portal for order entry.
- **Fax Number:** 1-866-346-0911
- **Phone Number:** 1-844-218-4932
Outpatient Radiology PA Requests

MHS partners with NIA for outpatient Radiology PA Process
PA requests must be submitted via:
  • NIA Web site at RadMD.com
  • 1-866-904-5096
  *Not applicable for ER and Observation requests
Additional Information Needed

**Bariatric Surgery:**
- Must include cardiac workup, pulmonary workup, diet and exercise logs, current lab reports, and psychologist report.

**Pain Management:**
- Must have documentation of at least six (6) weeks of therapy on area receiving treatment.
- Include previous procedures/surgeries, medications, description of pain, any contra-indications or imaging studies.
- Include prior injection test results for injection series.

**Home Health:**
- Physician’s orders and signed plan of care, including most recent MD notes about the issue at hand.
- Home care plan, including home exercise program.
- Progress notes for medical necessity determination.
Prior Authorization (PA) Request

Providers can **update** previously approved PAs **within 30 days** of the original date of service prior to claim denial for changes to:

- Dates of service
- CPT/HCPCS codes
- Provider

*Providers may make corrections to the existing PA as long as the claim has not been submitted.*
Prior Authorization (PA) Request

วางแผน MHS ที่จะกลับมาตัดสินใจเกี่ยวกับการขออนุญาตล่วงหน้า (PA) ภายในห้า (5) วันที่ทำการของร้านของคุณ.

เหตุผลที่มีการสิ้นเปลืองเวลาในการตัดสินใจอาจรวมถึง:
• ขาดสาระหรือการขอที่ไม่สมบูรณ์
• กระดาษที่ถูกสแกนไม่สามารถอ่านได้ หรือ ข้อความที่ไม่ชัดเจน
• การต้องการตรวจจากแพทย์ประจำเวที

แผน MHS มีสิทธิ์ใช้เวลาขึ้นไปสูงสุดห้า (5) วันที่ทำการในการตัดสินใจ PA.
Prior Authorization (PA) Request

🌟 PA approval requires the need for medical necessity.
🌟 If your claim is denied, please contact Provider Services at 1-877-647-4848 to determine the cause of the denial.
🌟 Medical Management does not verify eligibility or benefit limitations:
  • Provider is responsible for eligibility and benefit verification
Continuity of Care PA Request

🎉 MHS will honor pre-existing authorizations from any other Medicaid program during the first 30 days of enrollment or up to the expiration date of the previous authorization, whichever occurs first, and upon notification to MHS. Include the approval from the prior MCE with the request.

*Reference: MHS Provider Manual Chapter 6
Pharmacy Requests

MHS Pharmacy Benefit Manager is Envolve Pharmacy Solutions:

 предпочитительные списки препаратов и бланки разрешений доступны на mhsindiana.com/provider/pharmacy:

- Заявки на разрешение (PA requests)
- Телефон: 1-866-399-0928
- Факс для неспецифических препаратов: 1-866-399-0929
- Специфические препараты: 1-866-678-6976
- pharmacy.envolvehealth.com

Формуляр интегрирован в множество электронных систем здравоохранения (EHR) решений

Онлайн-заявки на разрешение доступны через CoverMyMeds:

- covermymeds.com

Онлайн-бланки заявок на специфические препараты доступны на mhsindiana.com
Web Portal
Web Authorization

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

- When using the portal, providers can upload supporting documentation directly.

  **Exceptions:** Must submit hospice, home health and biopharmacy PA requests via fax 1-866-912-4245

Providers can check the authorization status on the portal.
Secure Portal Registration or Login

FOR PROVIDERS
- Login
- Become a Provider
- Prior Authorization
- Dental Providers
- Pharmacy
- Provider Resources
- QI Program
- Provider News

FOR MEMBERS
Portal Login

Create your own online account today!
MHS offers you many convenient and secure tools to assist you. To enter our secure portal, click on the login button. A new window will open. You can login or register.

Creating an account is free and easy.
By creating a MHS account, you can:
- Verify member eligibility
- Submit and check claims
- Submit and confirm authorizations
- View detailed patient list

Please note that Clear Claim Connection does not provide an all inclusive listing of claim edits. MHS does utilize additional prepayment review edits in keeping with NCCI procedures and guidelines.

Click here for more information on the Provider Portal functions and training documents.

Behavioral Health Secure Portal
Click here for the Compatico behavioral health portal.

Registration Help
If you are having trouble with your registration, you may need to submit a non-par set-up form. Visit our Become a Provider page to get started. For further assistance, you can call our Secure Provider Portal Help Line at 1-866-912-0337.
Please allow 24-48 hours for your account to be verified. An email will be sent once access to the portal tools have been granted to the respective account.
## Authorizations:

View, create and filter group authorizations

### Authorizations

<table>
<thead>
<tr>
<th>STATUS</th>
<th>AUTH ID</th>
<th>MEMBER</th>
<th>FROM DATE</th>
<th>TO DATE</th>
<th>DIAGNOSIS</th>
<th>AUTH TYPE</th>
<th>SERVICE</th>
</tr>
</thead>
<tbody>
<tr>
<td>APPROVE</td>
<td>C_1</td>
<td>All</td>
<td>07/24/2017</td>
<td>10/24/2017</td>
<td>E11.9</td>
<td>OUTPATIENT</td>
<td>DME</td>
</tr>
<tr>
<td>PARTIAL_APPROVE</td>
<td>C_9</td>
<td>All</td>
<td>06/14/2017</td>
<td>09/19/2017</td>
<td>B07.9</td>
<td>OUTPATIENT</td>
<td>Office Visit</td>
</tr>
</tbody>
</table>

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

- Click **Create Authorization**.
- Enter **Member ID** or **Last Name** and **Birthdate**.
Creating a New Authorization

Select a Service Type

- Medical Outpatient
- Biopharmacy
- DME
- Drug Testing
- Genetic Testing & Counseling
- Home Health
- Imaging
- Office Visit
- Outpatient Services
- Transport
- Medical Inpatient
- C-Section Delivery
- Medical
- Premature/False Labor
- Rehab Inpatient
- Skilled Nursing
- Surgical Inpatient
- Transplant
- Vaginal Delivery

By checking the Urgent Request box, I certify that this is an urgent request for a medically necessary treatment for an injury, illness, or another type of condition (usually not life threatening), which must be treated within 48 hours.

After hours emergent and urgent admissions, inpatient notifications or requests will need to be provided telephonically. Electronic requests will not be monitored after hours and will be responded to on the next business day. Please contact our NurseWise line at 877-647-4848 for after-hours urgent admission, inpatient notifications or requests.

Please note: Office visit authorization requests will only cover Evaluation and Management (E & M) codes. Other codes may require an additional authorization.

As of 10/1/15 Retro Authorizations with ICD-9 codes should not be submitted on the web. Authorizations after 10/1/15 should use ICD-10 codes.
Creating a New Authorization

Select Provider NPI  Add Primary Diagnosis
Creating a New Authorization

If required Add Additional Procedures
Creating a New Authorization

Service Line Details:

- Provider Request will appear on the left side of the screen.
- Update Servicing Provider:
  - Check box if same as Requesting Provider.
  - Update Servicing Provider information if not the same
- Update Start Date and End Date.
- Update Total Units/Visits/Days.
- Update Primary Procedure:
  - Code lookup provided.
- Add any additional procedures.
- Add additional Service Line if applicable:
  - All service lines added will appear on the left side of the screen.
Creating a New Authorization

Submit a new Authorization:
- Confirmation number.
Telephonic
Telephone Authorization

Providers can initiate Prior Authorization via 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
Fax Authorization

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

- Member ID/RID, DOB
- Patient name, required

Medical Diagnosis code(s) required

Check service category
## Fax Authorization

<table>
<thead>
<tr>
<th>Requesting Provider Information:</th>
</tr>
</thead>
<tbody>
<tr>
<td>NPI#:</td>
</tr>
<tr>
<td>Tax ID#:</td>
</tr>
<tr>
<td>Service Location Code:</td>
</tr>
<tr>
<td>Provider Name:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rendering Provider Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ordering Physician NPI#:</td>
</tr>
<tr>
<td>Tax ID#:</td>
</tr>
<tr>
<td>Name</td>
</tr>
<tr>
<td>Address:</td>
</tr>
<tr>
<td>City/State/Zip:</td>
</tr>
<tr>
<td>Phone:</td>
</tr>
<tr>
<td>Fax:</td>
</tr>
</tbody>
</table>

- Enter the **Requesting** provider’s information
- Enter the **Rendering** provider’s individual NPI#
# Fax Authorization

<table>
<thead>
<tr>
<th>Dates of Service</th>
<th>Procedure/Service Codes</th>
<th>Modifier(s)</th>
<th>Requested Service</th>
<th>Taxonomy</th>
<th>POS</th>
<th>Units</th>
<th>Dollars</th>
</tr>
</thead>
<tbody>
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Prior Authorization
Denial and Appeal Process
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 the expedited appeal.

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.*
PA Denial and Appeal Process

 pena Prior Authorization/Medical Necessity Appeals to:
* Managed Health Services
* Attn: Appeals Coordinator
* PO Box 441567
* Indianapolis, IN 46244

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.*

*This process is applicable to members and non-contracted providers.*
MHS Team
## MHS Provider Relations Team:

<table>
<thead>
<tr>
<th>Name</th>
<th>Role</th>
<th>Contact Details</th>
<th>Email</th>
</tr>
</thead>
<tbody>
<tr>
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</tr>
</tbody>
</table>
## Provider Partnership Associate II Groups

| TAWANNA DANZIE | Beacon Medical Group  
|                | Community Care Network  
|                | Franciscan Alliance  
|                | Goshen Health System  
|                | HealthLinc  
|                | Heart City Health Center  
|                | Indiana Health Centers  
|                | Lutheran Medical Group  
|                | Northshore Health Centers  
|                | Parkview Health System  
|                | South Bend Clinic  
| JENNIFER GARNER | 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  

Provider Partnership Associate II  
1-877-647-4848 ext. 20022  
tdanzie@mhsindiana.com  

Provider Partnership Associate II  
1-877-647-4848 ext. 20149  
jgarner@mhsindiana.com
What You Learned Today:

- PA process and timelines
- DME/HME and Therapy PA requirements
- PA submission options
- Appeals Process
Questions?

Thank you for being our partner in care.