









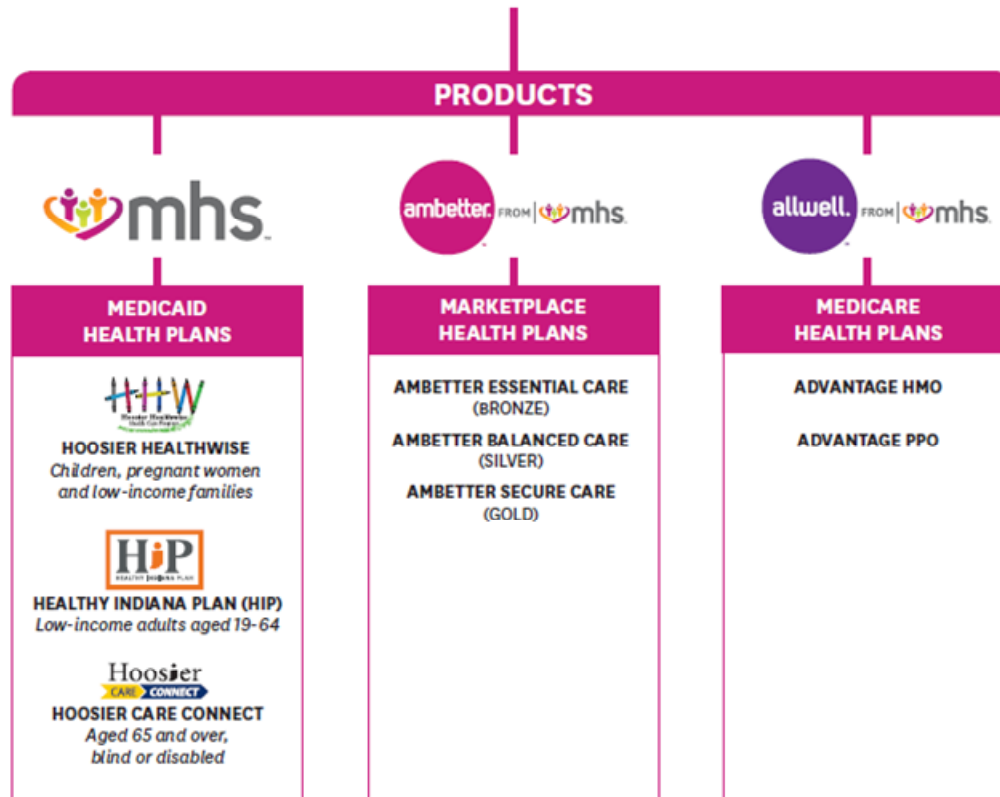
How to Make Prior Authorizations Work for You



Agenda

-  Prior Authorization (PA)
-  Need to Know
-  Web Portal
-  Telephonic Requests
-  Fax Requests
-  Appeals Process
-  MHS Team
-  Questions and Answers






MHS Products



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.

-  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.
-  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:


-  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.
-  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.
-  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.

Ambetter Timeframes for PA Requests and Notifications

Service Type	Timeframe
Scheduled admissions	Prior Authorization required five business days prior to the scheduled admission date
Elective outpatient services	Prior Authorization required five business days prior to the elective outpatient service date
Emergent inpatient admissions	Notification within one business day
Observation – 48 hours or less	Notification within one business day for non-participating providers
Observation – greater than 48 hours	Requires inpatient prior authorization within one business day
Maternity admissions	Notification within one business day
Newborn admissions	Notification within one business day
Neonatal Intensive Care Unit (NICU) admissions	Notification within one business day
Outpatient Dialysis	Notification within one business day
Organ transplant initial evaluation	Prior Authorization required at least 30 days prior to the initial evaluation for organ transplant services.
Clinical trials services	Prior Authorization required at least 30 days prior to receiving clinical trial services.

Ambetter Utilization Determination Timelines

Type	Timeframe
Prospective/Urgent	72 hours (three calendar days)
Prospective/Non-Urgent	15 calendar days
Concurrent/Urgent	24 hours (one calendar day)
Concurrent/Non-Urgent	15 calendar days
Retrospective	30 calendar days

Allwell Timeframes for PA Requests and Notifications

Service Type	Timeframe
Elective/scheduled admissions	Required five (5) business days prior to the scheduled admission date
Emergent inpatient admissions	Notification required within one (1) business day
Emergency room and post stabilization, urgent care and crisis intervention	Notification requested within one (1) business day



Allwell Utilization Determination Timelines

Level of Urgency

Type	Timeframe
Standard	Expediently as the member's health condition required, but no later than 14 calendar days after receipt of request
Standard Extension	Up to 14 additional calendar days (not to exceed 28 calendar days from receipt of original request)
Expedited	Expediently as the member's health condition requires, but no later than 72 hours after receipt of request
Expedited Extension	Up to 14 additional calendar days (not to exceed 17 calendar days after receipt of original request)
Concurrent	As soon as medically indicated; usually within 1 business day of request depending on the plan's policy













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.

Prior Authorization/Medicaid

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)

Prior Authorization

Is Prior Authorization Needed?

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

PROVIDER Quick Reference Guide

Effective June 1, 2019

Applies to all Hoosier Healthwise (HHW), Healthy Indiana Plan (HIP) and Hoosier Care Connect (HCC) packages.
 For an Ambetter Provider Quick Reference Guide, please visit ambetter.mhsindiana.com. Coverage is subject to specific benefit package of member.

1-877-647-4848
TTY/TDD: 1-800-743-3333

mhsindiana.com

GENERAL OFFICE HOURS:
8 a.m. to 5 p.m., EST, closed holidays

MEMBER SERVICES AND PROVIDER SERVICES:
8 a.m. to 8 p.m.

REFERRALS AND AUTHORIZATIONS:
8 a.m. to 5 p.m., closed 12 p.m. to 1 p.m.

AFTER-HOURS:
MHS' 24/7 Nurse Advice Line for members is available to answer calls for emergent authorization needs. Or, you may leave a message on our after-hours recording system. Messages are returned within one business day.

MANAGED HEALTH SERVICES (MHS)

<p>ELECTRONIC PAYER ID: 68069</p> <p>BEHAVIORAL HEALTH PAYER ID: 68068</p> <p>MEDICAL CLAIMS ADDRESS: Managed Health Services P.O. Box 3002 Farmington, MO 63640-3802</p> <p>Claims sent to MHS' Indianapolis address will be returned to the provider.</p> <p>MEDICAL NECESSITY APPEALS ONLY ADDRESS: ATTN: APPEALS P.O. Box 441567 Indianapolis, IN 46244</p>	<p>MEDICAL CLAIMS APPEALS ADDRESS: Managed Health Services P.O. Box 3000 Farmington, MO 63640-3800</p> <p>Providers have 67 calendar days from the date of the Explanation of Payment to file an adjustment, resubmit, or appeal a decision.</p> <p>Failure to do so within the specified timeframe will waive the right for reconsideration.</p> <p>MEDICAL CLAIMS REFUNDS: To refund claims overpayment, please send check and documentation to: Coordinated Care Corporation 75 Remittance Dr., Suite 6446 Chicago, IL 60675-6446</p>
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MHS FAX NUMBERS

NETWORK MANAGEMENT: 1-866-912-4244
Ex. Provider enrollment, office or billing address change

MEDICAL APPEALS: 1-866-714-7993

CASE MANAGEMENT: 1-866-694-3653
Ex. Member Referrals to CM/DM

REFERRALS AND AUTHORIZATIONS: 1-866-912-4245

MHS WEBSITE: MHSINDIANA.COM

mhsindiana.com/providers Latest MHS provider updates and news, as well as forms, manuals, guides, online PA tool and tutorials. (Please visit mhsindiana.com/forms to get the latest forms for submission to MHS.)

mhsindiana.com/health MHS' Health Library. Click on "KRAMES Health Library" for free print-on-demand patient health fact sheets on over 4,000 topics, available in English and Spanish.

mhsindiana.com/login MHS' Secure Provider Portal lets you submit prior authorization, claims, claim adjustments, and view your panel's medical records and care gaps.

mhsindiana.com/transactions Information for electronic processing and payment of claims with MHS.

OTHER RESOURCES
payspanhealth.com MHS is pleased to partner with PaySpan to provide an innovative web based solution for Electronic Funds Transfers (EFTs) and Electronic Remittance Advices (ERAs). This service is provided at no cost to providers and allows online enrollment at payspanhealth.com.

You can find out more about the information in this Guide in the MHS Provider Manual, online at mhsindiana.com/providers/resources, or by contacting MHS at 1-877-647-4848.

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Prior Authorization

Medicaid Pre-Auth Needed?

Become a Provider

CLAS Standards

MHS Provider Webinars

Partnered Member Events

Pharmacy Benefits Information for Providers

Prior Authorization

Transactions

PaySpan Health

POWER Account Resource Center

Provider Information Resource Center

Provider Guides

Dental Providers

Presumptive Eligibility

Quality Improvement

HEDIS®

Practice Guidelines

Immunization Information

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?

YES NO

Types of Services	YES	NO
Is the member being admitted to an inpatient facility?	<input type="radio"/>	<input type="radio"/>
Are services, other than DME, orthotics, prosthetics, and supplies, being rendered in the home?	<input type="radio"/>	<input type="radio"/>
Are anesthesia services being rendered for pain management?	<input type="radio"/>	<input type="radio"/>
Are services for infertility?	<input type="radio"/>	<input type="radio"/>
Is the member receiving dialysis?	<input type="radio"/>	<input type="radio"/>

Prior Authorization

Types of Services	YES	NO
Is the member being admitted to an inpatient facility?	<input type="radio"/>	<input checked="" type="radio"/>
Are services, other than DME, orthotics, prosthetics, and supplies, being rendered in the home?	<input type="radio"/>	<input checked="" type="radio"/>
Are anesthesia services being rendered for pain management?	<input type="radio"/>	<input checked="" type="radio"/>
Are services for infertility?	<input type="radio"/>	<input checked="" type="radio"/>
Is the member receiving dialysis?	<input type="radio"/>	<input checked="" type="radio"/>

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










Check

N
No

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

Fast Track/Retro Eligibility Effective 4/1/19




-  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.

Retro Eligibility/Newborns

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.

Self-Referral Services/ Medicaid



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](https://www.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

-  MHS strives to return a decision on **all** PA requests within **seven (7) business days** of request.
-  Reasons for a delayed decision may include:
 - Lack of information or incomplete request
 - Illegible faxed copies of PA forms – i.e handwriting is illegible or fax is otherwise not readable
 - Request requiring Medical Director review
-  MHS has up to **seven (7) days** to render PA decisions.

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:

 Preferred Drug Lists and authorization forms are available at mhsindiana.com/provider/pharmacy:

- PA requests
- Phone 1-866-399-0928
- Fax non specialty drugs 1-866-399-0929
- Specialty drugs 1-866-678-6976
- pharmacy.envolvehealth.com

 Formulary integrated into many Electronic Health Records (EHR) solutions




 Online PA submission available through CoverMyMeds:

- covermymeds.com

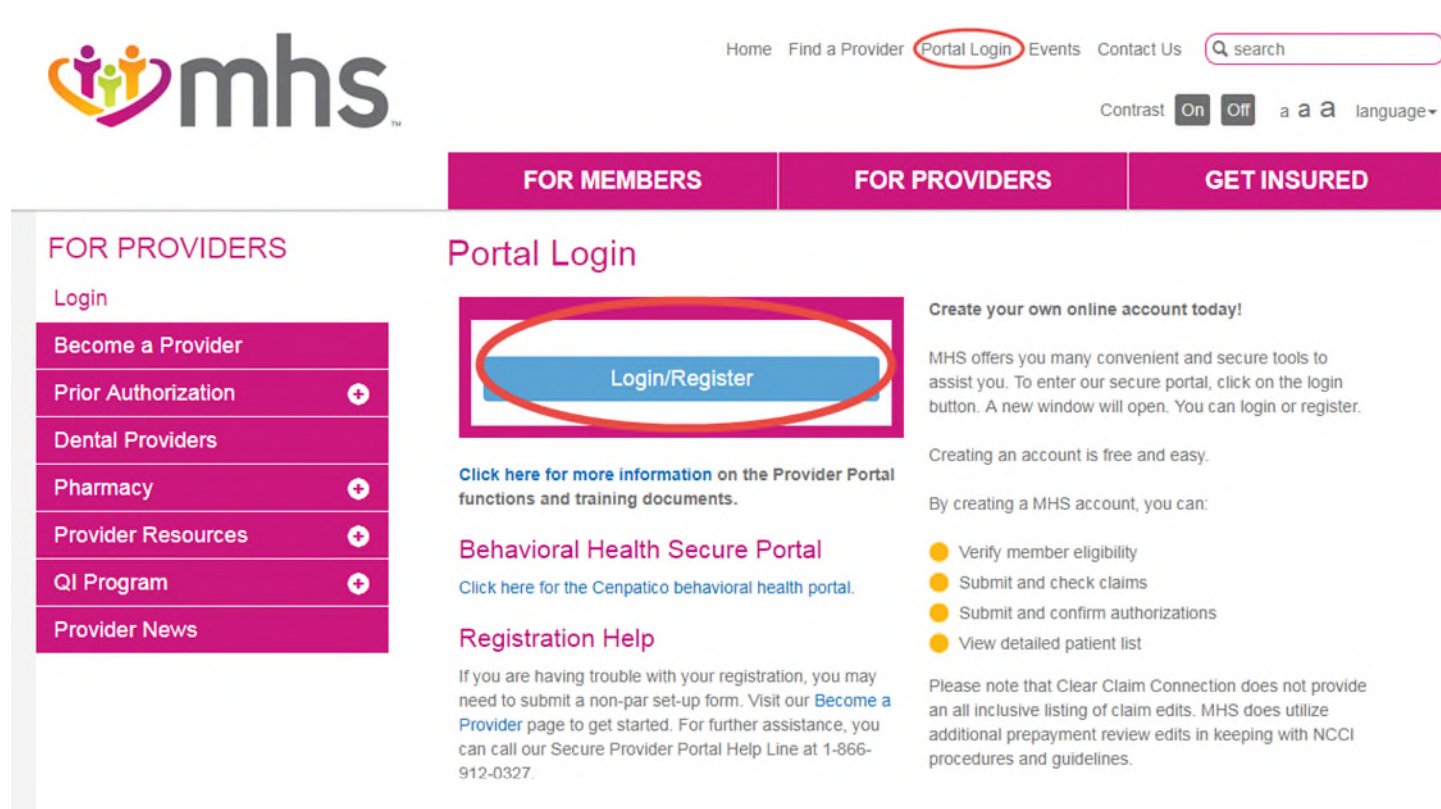
 Online PA forms for Specialty Drugs on mhsindiana.com

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



The screenshot shows the MHS website interface. At the top, there is a navigation bar with links for Home, Find a Provider, Portal Login (circled in red), Events, and Contact Us. A search bar is located to the right of these links. Below the navigation bar, there are three main sections: FOR MEMBERS, FOR PROVIDERS, and GET INSURED. The FOR PROVIDERS section is expanded, showing a sidebar with links like Become a Provider, Prior Authorization, Dental Providers, Pharmacy, Provider Resources, QI Program, and Provider News. The main content area for FOR PROVIDERS is titled "Portal Login" and features a "Login/Register" button (circled in red). Below this button, there are sections for "Behavioral Health Secure Portal" and "Registration Help". To the right of the "Login/Register" button, there is a section titled "Create your own online account today!" which provides instructions on how to create an account and lists benefits of having an MHS account.

Home Find a Provider **Portal Login** Events Contact Us

Contrast On Off a a a language

FOR MEMBERS **FOR PROVIDERS** **GET INSURED**

FOR PROVIDERS

Login

- Become a Provider
- Prior Authorization +
- Dental Providers
- Pharmacy +
- Provider Resources +
- QI Program +
- Provider News

Portal Login

Login/Register

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

Behavioral Health Secure Portal

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

Registration Help

If you are having trouble with your registration, you may need to submit a non-par set-up form. Visit our [Become a Provider](#) page to get started. For further assistance, you can call our Secure Provider Portal Help Line at 1-866-912-0327.

Create your own online account today!

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

Creating an account is free and easy.

By creating a MHS account, you can:

- Verify member eligibility
- Submit and check claims
- Submit and confirm authorizations
- View detailed patient list

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

Registration

Registration Complete!

Your Progress

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

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

Login



Features Join Our Network CREATE ACCOUNT

The Tools You Need Now!

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

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

Manage all products with ease in one location



Check Eligibility

Find out if a member is eligible for service.



Authorize Services

See if the service you provide is reimbursable.



Manage Claims

Submit or track your claims and get paid fast.

Login

User Name (Email)

name@domain.com

Password

Login

[Forgot Password / Unlock Account](#)

Need To Create An Account?

Registration is fast and simple, give it a try.

Create An Account

How to Register

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

Provider Registration Video

Provider Registration PDF



Eligibility Patients Authorizations Claims Messaging Help

Provider Name

Viewing Dashboard For: Tax ID Number Medicaid GO

Quick Eligibility Check

Member ID or Last Name Birthdate
 123456789 or Smith mm/dd/yyyy Check Eligibility

Recent Claims

STATUS	RECEIVED DATE	MEMBER NAME	CLAIM NO.
	08/19/2017	(4
	08/19/2017	T	3
	08/19/2017	E	1
	08/19/2017	F	8

Welcome

- Add a TIN to My ACCOUNT >
- Manage Accounts >
- Reports >
- Patient Analytics >
- Provider Analytics--Coming Soon >

Recent Activity

Date
Activity

Quick Links

[Provider Resources](#)

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

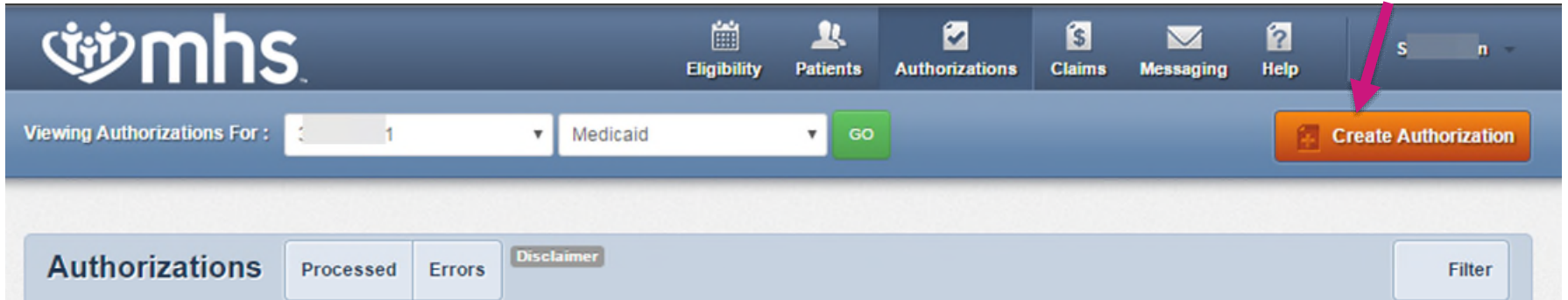
The screenshot shows the MHS Authorizations interface. At the top is a navigation bar with the MHS logo and icons for Eligibility, Patients, Authorizations, Claims, Messaging, and Help. A search bar on the right is labeled "Provider Name". Below the navigation bar is a filter section with "Viewing Authorizations For:" followed by two dropdown menus: "Tax ID Number" and "Medicaid", and a green "GO" button. To the right of the filter section is an orange "Create Authorization" button. Below the filter section is a header for "Authorizations" with tabs for "Processed", "Errors", and "Disclaimer", and a "Filter" button. A message states: "Please call the health plan for questions regarding voided authorization submissions. The authorization page is updated every 24 hours." Below the message is a table with the following columns: STATUS, AUTH ID, MEMBER, FROM DATE, TO DATE, DIAGNOSIS, AUTH TYPE, and SERVICE.

STATUS	AUTH ID	MEMBER	FROM DATE	TO DATE	DIAGNOSIS	AUTH TYPE	SERVICE
APPROVE	0 [REDACTED] 1	AI [REDACTED] H	07/24/2017	10/24/2017	E11.9	OUTPATIENT	DME
PARTIAL_APPROVE	C [REDACTED] 9	[REDACTED] V	06/14/2017	09/19/2017	B07.9	OUTPATIENT	Office Visit

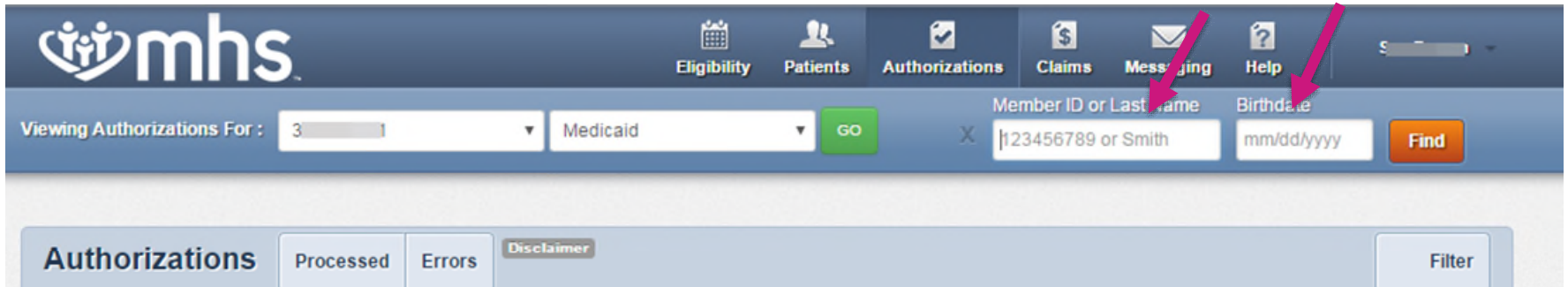
Creating a New Authorization

 Click **Create Authorization**.

 Enter **Member ID** or **Last Name** and **Birthdate**.



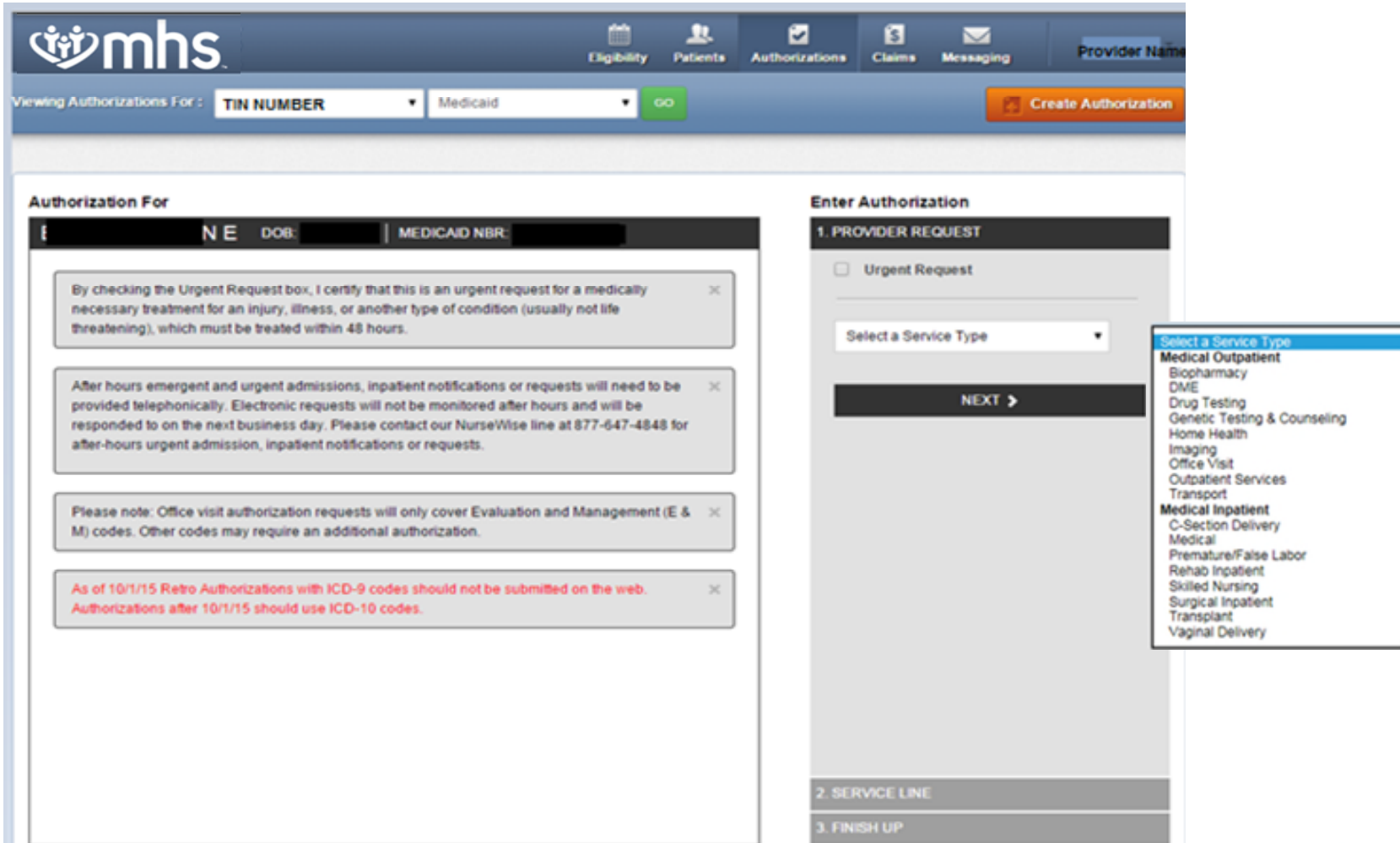
The screenshot shows the mhs interface with a navigation bar containing 'Eligibility', 'Patients', 'Authorizations', 'Claims', 'Messaging', and 'Help'. Below the navigation bar, there are two dropdown menus for 'Viewing Authorizations For' (set to '1') and 'Medicaid', with a green 'GO' button. A red arrow points to an orange 'Create Authorization' button on the right side of the interface.



The screenshot shows the mhs interface with a navigation bar containing 'Eligibility', 'Patients', 'Authorizations', 'Claims', 'Messaging', and 'Help'. Below the navigation bar, there are two dropdown menus for 'Viewing Authorizations For' (set to '3') and 'Medicaid', with a green 'GO' button. To the right, there are two input fields: 'Member ID or Last Name' (containing '123456789 or Smith') and 'Birthdate' (containing 'mm/dd/yyyy'). A red arrow points to the 'Member ID or Last Name' field, and another red arrow points to the 'Birthdate' field. A red 'Find' button is located to the right of the input fields.

Creating a New Authorization

Select a Service Type



The screenshot shows the MHS web application interface for creating a new authorization. The top navigation bar includes icons for Eligibility, Patients, Authorizations, Claims, and Messaging, along with a 'Provider Name' field. Below the navigation bar, there is a search area for 'Viewing Authorizations For' with a dropdown menu set to 'TIN NUMBER' and another dropdown set to 'Medicaid'. A 'Create Authorization' button is visible on the right.

The main content area is divided into two columns. The left column, titled 'Authorization For', contains a form with fields for 'NE', 'DOB', and 'MEDICAID NBR'. Below these fields are four informational boxes with 'X' icons in the top right corner:

- 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.

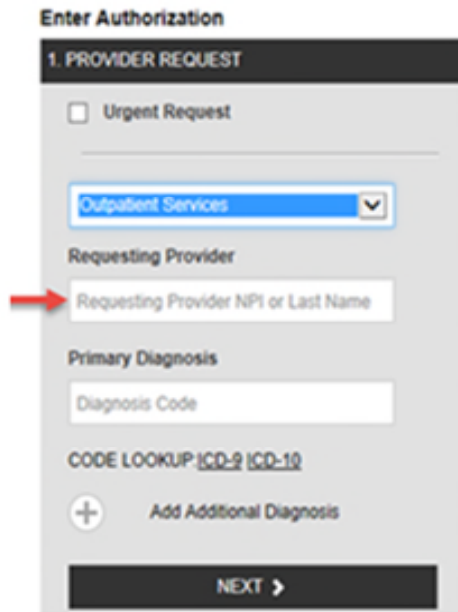
The right column, titled 'Enter Authorization', shows a '1. PROVIDER REQUEST' section. It includes an 'Urgent Request' checkbox and a 'Select a Service Type' dropdown menu. A 'NEXT >' button is located below the dropdown. A dropdown menu is open, showing a list of service types:

- 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

Below the '1. PROVIDER REQUEST' section, the '2. SERVICE LINE' and '3. FINISH UP' sections are partially visible.

Creating a New Authorization

Select Provider NPI Add Primary Diagnosis



Enter Authorization
1. PROVIDER REQUEST

Urgent Request

Outpatient Services

Requesting Provider

Requesting Provider NPI or Last Name

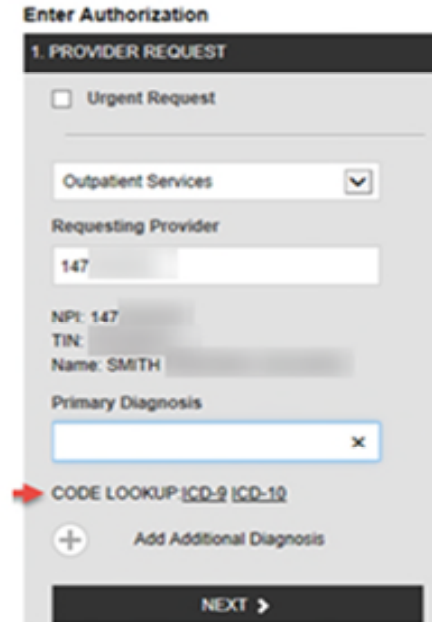
Primary Diagnosis

Diagnosis Code

CODE LOOKUP [ICD-9](#) [ICD-10](#)

+ Add Additional Diagnosis

NEXT >



Enter Authorization
1. PROVIDER REQUEST

Urgent Request

Outpatient Services

Requesting Provider

147

NPI: 147
TIN:
Name: SMITH

Primary Diagnosis

CODE LOOKUP [ICD-9](#) [ICD-10](#)

+ Add Additional Diagnosis

NEXT >


Creating a New Authorization

 If required Add Additional Procedures

Authorization For

DOB: [REDACTED] | MEDICAID NBR: [REDACTED]

PROVIDER REQUEST

 Service Type: Outpatient Outpatient Services
SMITH [REDACTED]
GENERAL SURGERY
Primary Diagnosis: 5430: HYPERPLASIA OF APPENDIX
Additional Diagnosis: 5379: UNSPEC DISORDER STOMACH&DUODENUM
NPI: 147 [REDACTED]
TIN: [REDACTED]
Phone: [REDACTED]

Enter Authorization

1. PROVIDER REQUEST [EDIT](#)

2. SERVICE LINE

TIN: [REDACTED]
Name: SMITH [REDACTED]
07/14/2015 - 07/24/2015
1
Primary Procedure
44970
LAPAROSCOPY RUSGICAL
APPENEDECTOMY
[CODE LOOKUP](#)

+ Add Additional Procedures

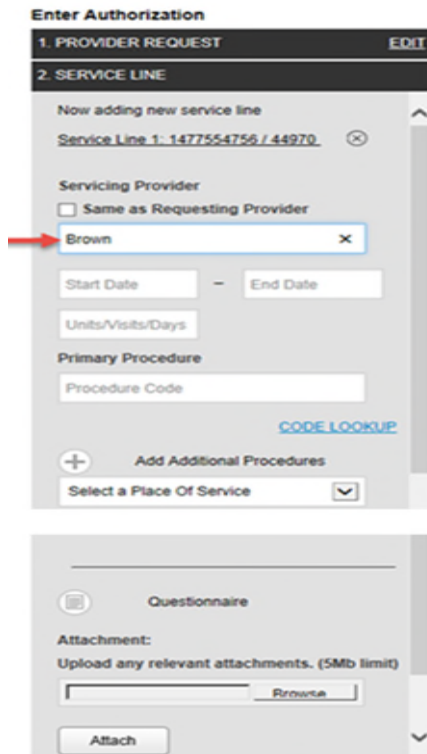
Select a Place Of Service
Ambulatory Surgical Center
Outpatient Hospital
Unspecified

+ Add New Service Line

NEXT >

Creating a New Authorization

Service Line Details:



Enter Authorization

1. PROVIDER REQUEST EDIT

2. SERVICE LINE

Now adding new service line

Service Line 1: 1477554756 / 44970 ✕

Servicing Provider

Same as Requesting Provider

→ Brown ✕

Start Date - End Date

Units/Visits/Days

Primary Procedure

Procedure Code

[CODE LOOKUP](#)

+ Add Additional Procedures

Select a Place Of Service ▼

Questionnaire

Attachment:

Upload any relevant attachments. (5Mb limit)

→

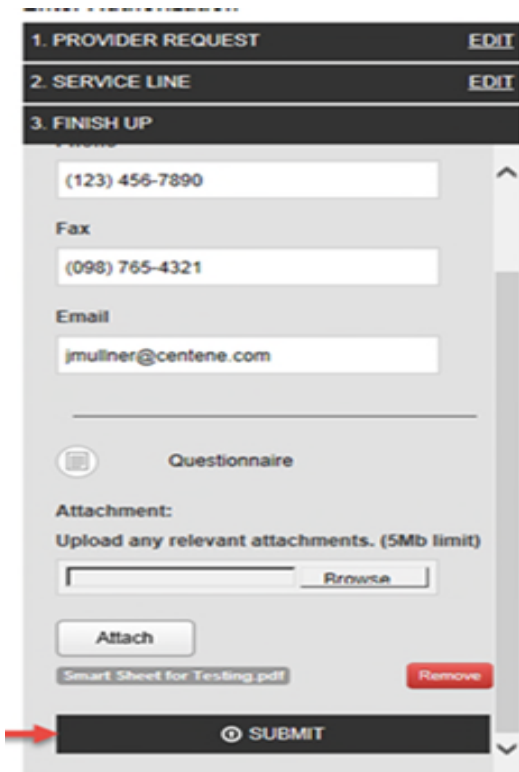
Attach

- 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.

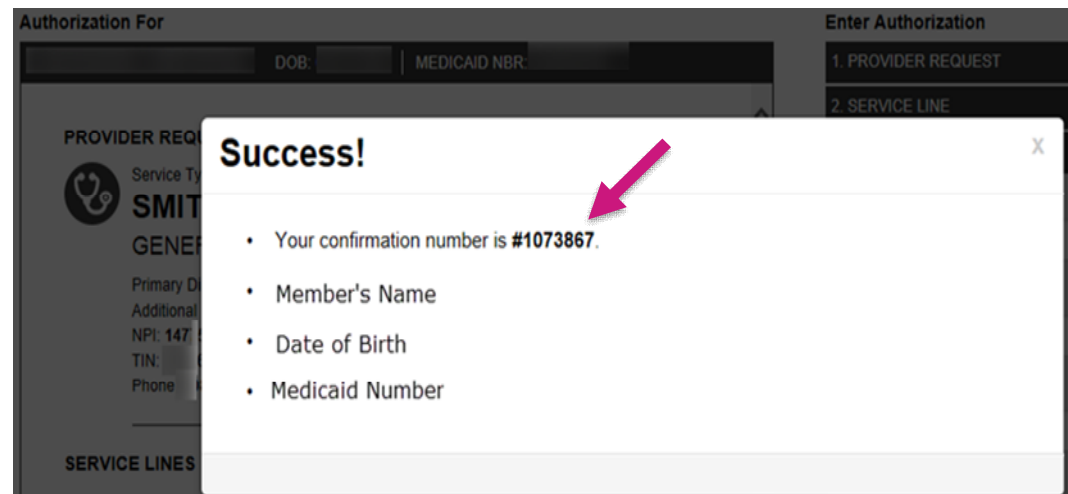
Creating a New Authorization

 Submit a new Authorization:

- **Confirmation number.**



The screenshot shows a multi-step form for creating an authorization. The steps are: 1. PROVIDER REQUEST (EDIT), 2. SERVICE LINE (EDIT), and 3. FINISH UP. Under 'FINISH UP', there are input fields for phone number (123) 456-7890, fax (098) 765-4321, and email jmulner@centene.com. There is a 'Questionnaire' section with a plus icon, an 'Attachment:' section with a 'Browse' button and an attached file 'Smart Sheet for Testing.pdf', and a 'SUBMIT' button at the bottom. A red arrow points to the 'SUBMIT' button.







The screenshot shows the 'Success!' message overlay on the authorization form. The message contains the following information:

- Your confirmation number is #1073867.
- Member's Name
- Date of Birth
- Medicaid Number

A pink arrow points to the confirmation number in the message.

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:

Patient Information					
IHCP Member ID (RID):					
Date of Birth:					
Patient Name:					
Address:					
City/State/ZIP Code:					
Patient/Guardian Phone:					
PMP Name:					
PMP NPI:					
PMP Phone:					
Ordering, Prescribing, or Referring (OPR) Provider Information					
OPR Physician NPI:					
Medical Diagnosis (Use of ICD Diagnostic Code Is Required)					
Dx1		Dx2		Dx3	



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



Medical Diagnosis
code(s) **required**



Check service category

- Please check the requested assignment category below:
- | | | |
|--------------------------------------|---|---|
| <input type="checkbox"/> DME | <input type="checkbox"/> Inpatient | <input type="checkbox"/> Physical Therapy |
| <input type="checkbox"/> Purchased | <input type="checkbox"/> Observation | <input type="checkbox"/> Speech Therapy |
| <input type="checkbox"/> Rented | <input type="checkbox"/> Office Visit | <input type="checkbox"/> Transportation |
| <input type="checkbox"/> Home Health | <input type="checkbox"/> Occupational Therapy | <input type="checkbox"/> Other |
| <input type="checkbox"/> Hospice | <input type="checkbox"/> Outpatient | |

Fax Authorization

Requesting Provider Information:	
NPI#:	
Tax ID#:	
Service Location Code:	
Provider Name:	
Rendering Provider Information	
Ordering Physician NPI#:	
Tax ID#:	
Name	
Address:	
City/State/Zip:	
Phone:	
Fax:	

← Enter the **Requesting** provider's information

← Enter the **Rendering** provider's individual NPI#



Fax Authorization

Dates of Service		Procedure/ Service Codes	Modifier(s)		Requested Service	Taxonomy	POS	Units	Dollars
Start	Stop								



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

-  Send 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:

Kara Wilson	Engolve Dental Indiana Provider Relations	1-855-609-5157	Kara.Wilson@engagehealth.com
Chad Pratt	Provider Partnership Associate – Northeast Region	1-877-647-4848 ext. 20454	mhs_providerrelations_NE@mhsindiana.com
Candace Ervin	Provider Partnership Associate – Northwest Region	1-877-647-4848 ext. 20187	mhs_providerrelations_NW@mhsindiana.com
Dawn McCarty	Provider Partnership Associate – Southwest Region	1-877-647-4848 ext. 20117	mhs_providerrelations_SW@mhsindiana.com
Esther Cervantes	Provider Partnership Associate – Central Region	1-877-647-4848 ext. 20947	mhs_providerrelations_C@mhsindiana.com
Open	Provider Partnership Associate – Southeast Region	1-877-647-4848	mhs_providerrelations_SE@mhsindiana.com
Lakisha Browder	Internal Provider Network Specialist	1-877-647-4848 ext. 20224	lbrowder@mhsindiana.com
Jennifer Dean	Internal Provider Network Specialist	1-877-647-4848 ext. 20221	jedean@mhsindiana.com



Provider Partnership Associate II Groups

TAWANNA DANZIE

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





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

Provider Partnership Associate II
1-877-647-4848 ext. 20149
jgarner@mhsindiana.com

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

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.