How to Make Prior Authorizations Work for You

0318.PR.P.PP 5/18

Agenda

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

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
- ER Visits 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 **7 calendar days.** Benefit limitations apply (dependent on product).

Prior Authorization

MHS Medical Management will review state guidelines and clinical documentation. Medical Director input will be available if needed.

- PA for observation level of care (**up to 72 hours for Medicaid)**, diagnostic services do not require an authorization for contracted facilities.

- If the provider requests an inpatient level of care for a covered/eligible condition, but 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 have submitted request to MHS at least **two business days** prior to the date of service.
- All ER services do not require prior authorization, but admission must be called into MHS Prior Authorization Dept within **two 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.***

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 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.

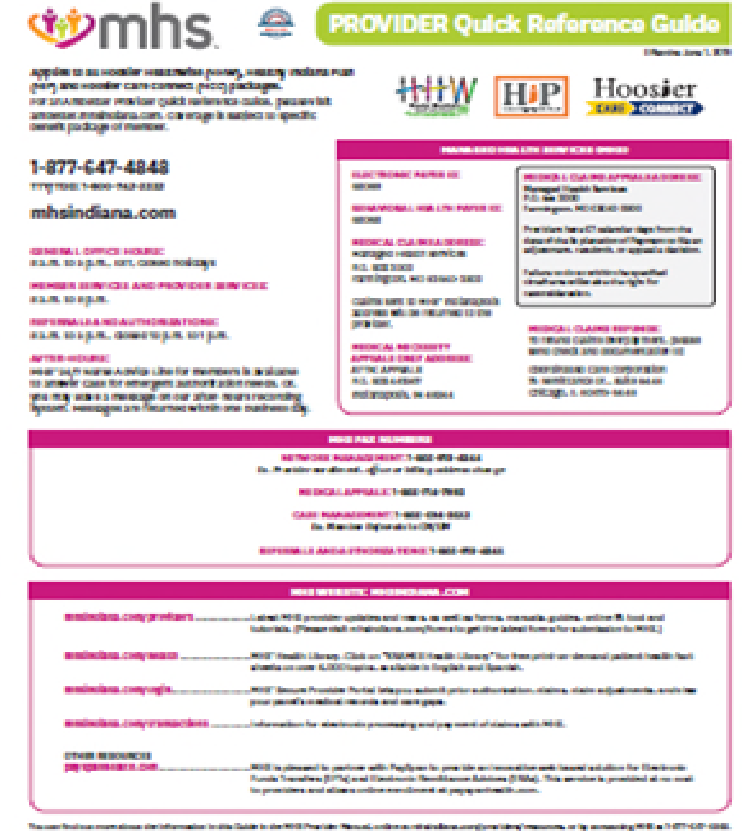
Prior Authorization

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)
- Physical Therapy, Occupational, and Speech Therapy

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



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

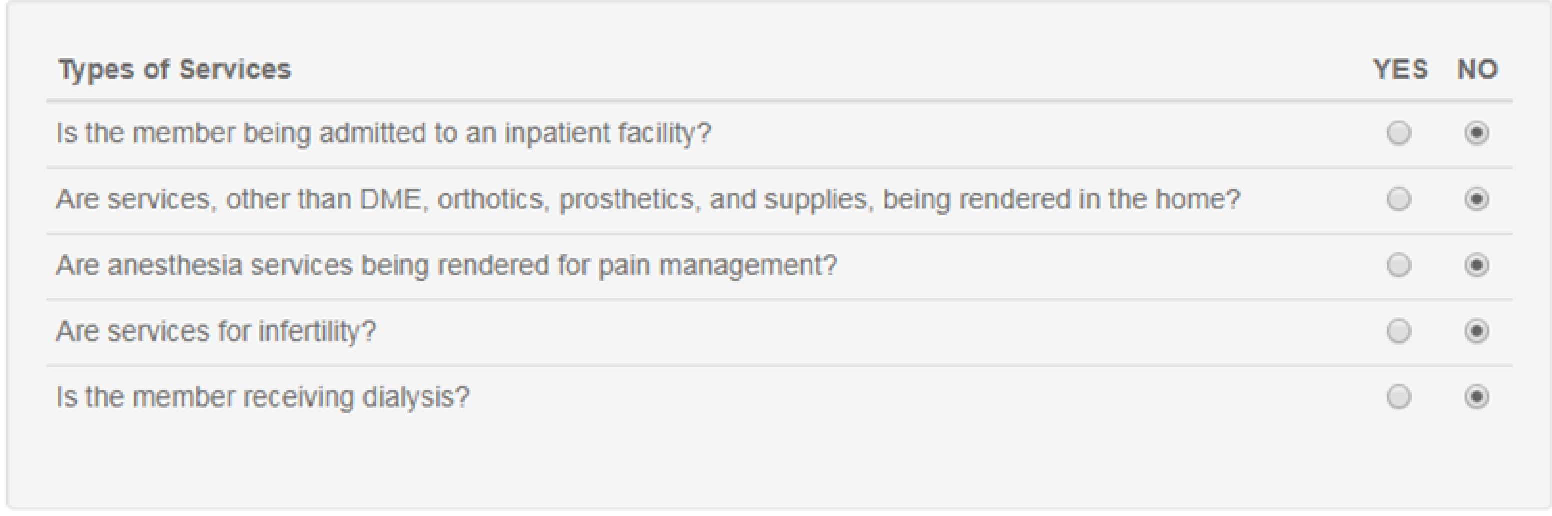
Non-participating providers must submit Prior Authorization for all services
For non-participating providers, Join Our Network.

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?	○	○
Are services, other than DME, orthotics, prosthetics, and supplies, being rendered in the home?	○	○
Are anesthesia services being rendered for pain management?	○	○
Are services for infertility?	○	○
Is the member receiving dialysis?	○	○

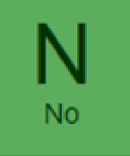
Prior Authorization



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

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

99394 | Check



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/Rendering Physician with Rendering 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

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)

- Must follow billing guidelines (GP, GN, GO modifiers)
- 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. We remain committed to ensuring that these services provided to our members are consistent with nationally recognized clinical guidelines. Therefore, beginning July 1, 2019, 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.
- To get started, simply go to www.RadMD.com, click the New User button and submit a "Physical Medicine Practitioner" Application for New Account. Once the application has been processed and a password link delivered by NIA via e-mail, you will then be invited to create a new password.

Therapy Services (Speech, Occupational, Physical Therapy)

- Links to the approved training/education documents are found on the My Practice page for those providers logged in as a Physical Medicine Practitioner.
- All Health Plan approved training/education materials are posted on the NIA website, www.RadMD.com. For new users to access these web-based documents, a RadMD account ID and password must be created.
- Fax number 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 (DME)

- 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 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.

Musculoskeletal Safety & Quality Program

Managed Health Services (MHS) provides health coverage for members enrolled in Hoosier Healthwise, the Healthy Indiana Plan (HIP), Hoosier Care Connect, Ambetter from MHS, and Allwell from MHS. In keeping with our commitment of promoting continuous quality improvement for services provided to our members, MHS has entered into an agreement with **TurningPoint Healthcare Solutions, LLC**, to implement a Musculoskeletal Surgical Quality and Safety management program. This program includes prior authorization for medical necessity and appropriate length of stay (when applicable) for both inpatient and outpatient settings. This decision is consistent with industry-wide efforts to ensure clinically appropriate quality of care and to manage the increasing utilization of these services.

Under terms of the agreement between MHS and **TurningPoint Healthcare Solutions**, MHS will oversee the **TurningPoint Healthcare Solutions** program and continue to be responsible for claims adjudication.

Based on a June 1, 2019, implementation, this correspondence serves as notice under your MHS Participating Provider Agreement of changes to the program.

TurningPoint Healthcare Solutions will manage prior authorization for medical necessity and appropriate length of stay (when applicable) for services listed below through MHS' existing contractual relationships. Prior authorization will be required for the following musculoskeletal surgical procedures:

MUSCULOSKELETAL

Orthopedic Surgical Procedures

Including all associated partial, total, and revision surgeries

- ✓ 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

Including all associated partial, total, and revision surgeries

- ✓ 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

Turning Point

- 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 574-784-1005 for access to digital copies

- **TRAINING:**
  - Informational webinars are available! Please register at: https://register.gotowebinar.com/rt/7079530369468972290

Turning Point's Utilization Management

- Web Portal Intake:
  - myturningpoint-healthcare.com

- Telephone Intake:
  - 574-784-1005 | 855-415-7482

- Fax Intake: 463-207-5864

Cardiovascular Authorizations

- Stay tuned, there are changes coming in Spring 2020.

Sub Acute Care

Managed Health Services (MHS) provides health coverage for members enrolled in Hoosier Healthwise, the Healthy Indiana Plan (HIP) and Hoosier Care Connect. MHS conducts clinical review for ongoing authorization and coordination of discharge needs for our members in subacute facilities at least every 3-5 days. It is important that you provide a complete current clinical update on our member's status at each review.

- The review should include current information (within one day) on:
- Member's condition
- Level of functioning (prior to admission)
- Medications
- Therapies provided
- Participation in therapies
- Progress toward goals
- New or amended goals
- Updates from care conferences
- Updates to our member's plan of care
- Discharge plans and needs identified (home health/DME, etc.)
- Anticipated discharge date
- Indiana Code requires that individuals requesting a nursing facility admission to a Medicaid-certified NF meet a nursing facility level of care (*405 IAC 1-3-1* and *405 IAC 1-3-2*.). A PASRR is required before admission and must be submitted with the admission request and when updated according to IAC requirements.
- Please submit this information as requested by MHS nurse reviewer every 3-5 days.

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 **two 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 days** to render PA decisions.
- ***Denied Authorizations*** *must follow the authorization appeal process, not the claims appeal process, claims appeals can not change the status of a denied authorization.*

Prior Authorization (PA) Request

- PA approval requires the need for medical necessity.
- 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
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

Inpatient Prior Authorization

- To ensure timely and accurate medical necessity review of a physical health inpatient admission, **effective November 1, 2019 MHS will only accept notification of an inpatient admission and any clinical information submitted for medical necessity review via fax or the MHS Provider web tool, using the IHCP universal prior authorization form.** Notification of admission and submission of clinical information via phone will not be accepted. This applies to members enrolled in Hoosier Healthwise, the Healthy Indiana Plan (HIP), Hoosier Care Connect and Ambetter.
- Please submit timely notification and clinical information to support an inpatient admission via fax to 1-866-912-4245.

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 Inpatient, 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

Home | Find a Provider | Portal Login | Events | Contact Us | search

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

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

mhs

Eligibility | Patients | Authorizations | Claims | Messaging | Help | Provider Name

Viewing Authorizations For : Tax ID Number | Medicaid | GO

Create Authorization

Authorizations

Processed | Errors | Disclaimer | Filter

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

STATUS	AUTH ID	MEMBER	FROM DATE	TO DATE	DIAGNOSIS	AUTH TYPE	SERVICE
APPROVE	O[illegible]1	Al[illegible]H	07/24/2017	10/24/2017	E11.9	OUTPATIENT	DME
PARTIAL_APPROVE	C[illegible]9	[illegible]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.**

Creating a New Authorization

Select a Service Type

mhs | Eligibility | Patients | Authorizations | Claims | Messaging 53 | Help | Provider Name

Viewing Authorizations For : TIN Tax ID Number Plan Type Medicaid GO

Create Authorization

Authorization For

DOB: | MEDICAID NBR:

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.

Enter Authorization

1. PROVIDER REQUEST

Urgent Request

Vaginal Delivery

Select a Service Type

Medical Outpatient
- Biopharmacy
- DME
- Drug Testing
- Genetic Testing & Counseling
- Home Health
- Inpatient Services (S&P)
- Office Visit
- Outpatient Services
- Transport

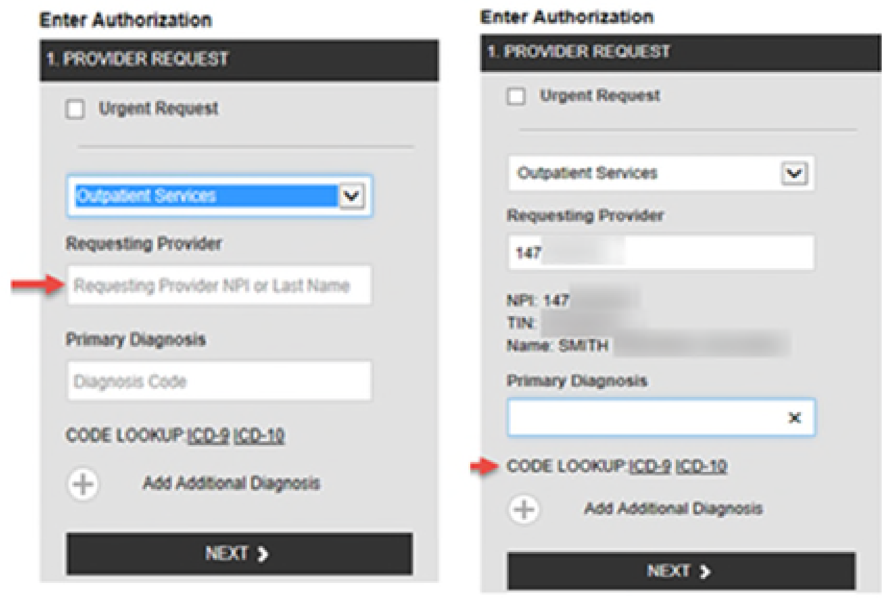
Medical Inpatient
- C-Section Delivery
- Medical
- Premature/False Labor
- Rehab Inpatient
- Skilled Nursing
- Surgical Inpatient
- Transplant
- Vaginal Delivery

2. SERVICE LINE

3. FINISH UP

Creating a New Authorization

Select Provider NPI   Add Primary Diagnosis



Creating a New Authorization

- If required **Add Additional Procedures**

Authorization For

DOB: | MEDICAID NBR:

PROVIDER REQUEST

Service Type: Outpatient Outpatient Services

SMITH

GENERAL SURGERY

Primary Diagnosis: 5430: HYPERPLASIA OF APPENDIX
Additional Diagnosis: 5379: UNSPEC DISORDER STOMACH&DUODENUM
NPI: 147
TIN:
Phone:

Enter Authorization

1. PROVIDER REQUEST EDIT

2. SERVICE LINE

TIN:
Name: SMITH

07/14/2015 – 07/24/2015

1

Primary Procedure

44970

LAPAROSCOPY RUSGICAL APPENEDECTOMY

CODE LOOKUP

Add Additional Procedures

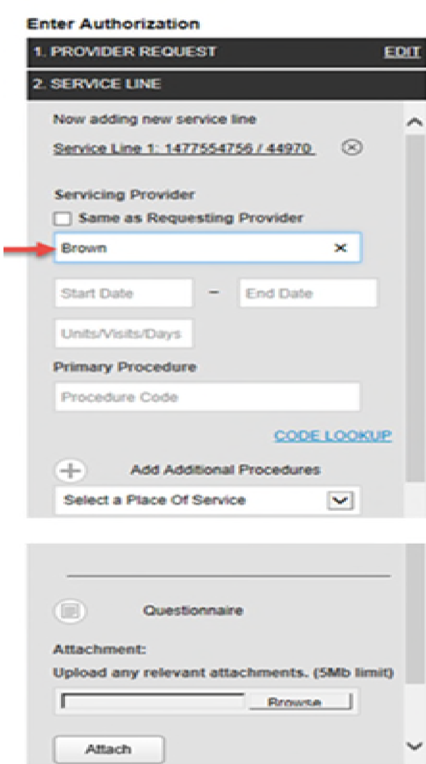
Select a Place Of Service
Ambulatory Surgical Center
Outpatient Hospital
Unspecified

Add New Service Line

NEXT

Creating a New Authorization

Service Line Details:

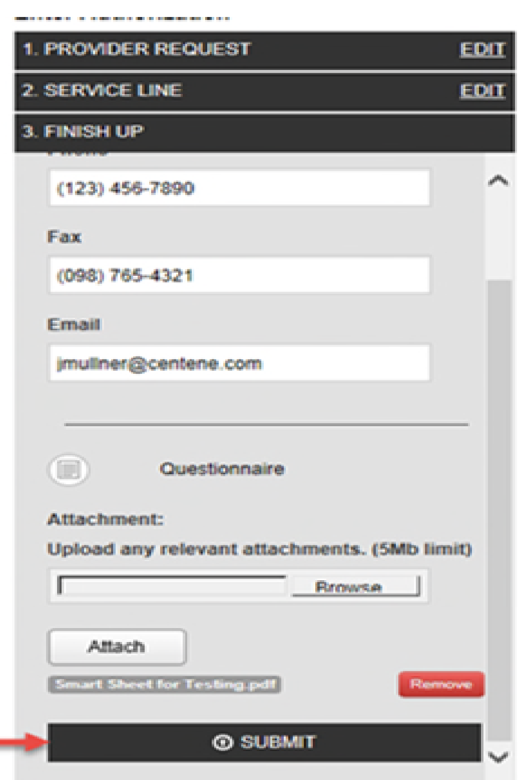


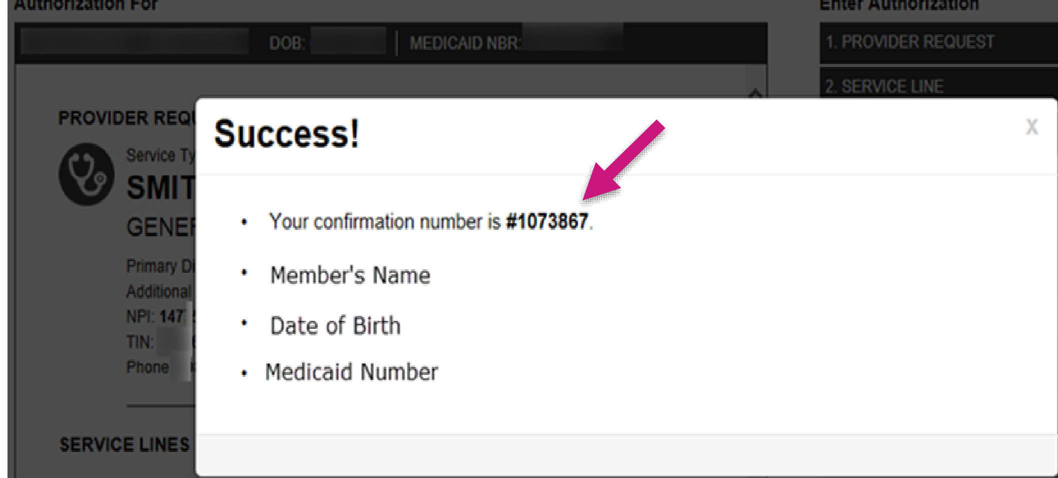
- Provider Request will appear on the left side of the screen.
- Update Servicing Provider:
  - Check box if same as Requesting Provider.
  - Update Servicing Provider information if not the same
- Update Start Date and End Date.
- Update Total Units/Visits/Days.
- Update Primary Procedure:
  - Code 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.**





Telephone Authorizations

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	

Please check the requested assignment category below:

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

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

Medical Diagnosis code(s) **required**

Check service category

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.***

Provider Relations Team

MHS Provider Network Territories

NORTHEAST REGION

Claims Issues: MHS_ProviderRelations_NE@mhsindiana.com
Chad Pratt, Provider Partnership Associate
1-877-647-4848 ext. 20454
ripratt@mhsindiana.com

CENTRAL REGION

Claims Issues: MHS_ProviderRelations_C@mhsindiana.com
Esther Cervantes, Provider Partnership Associate
1-877-647-4848 ext. 20947
Estherling.A.PimentelCervantes@mhsindiana.com

NORTHWEST REGION

Claims Issues: MHS_ProviderRelations_NW@mhsindiana.com
Candace Ervin, Provider Partnership Associate
1-877-647-4848 ext. 20187
Candace.V.Ervin@mhsindiana.com

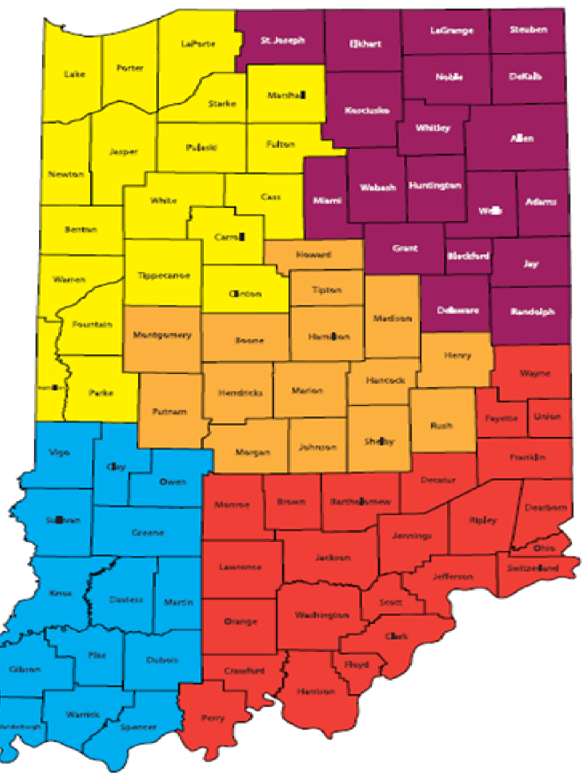
SOUTHWEST REGION

Claims Issues: MHS_ProviderRelations_SW@mhsindiana.com
Dawn McCarty, Provider Partnership Associate
1-877-647-4848 ext. 20117
Dawnalee.A.McCarty@mhsindiana.com

SOUTHEAST REGION

Claims Issues: MHS_ProviderRelations_SE@mhsindiana.com
Carolyn Valachovic Monroe, Provider Partnership Associate
1-877-647-4848 ext. 20114
cmonroe@mhsindiana.com

Indiana



NETWORK LEADERSHIP

Jill Claypool
Vice President, Network Development & Contracting
1-877-647-4848 ext. 20855
jill.e.claypool@mhsindiana.com

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

Mark Vonderheit
Director, Provider Network
1-877-647-4848 Ext. 20240
mvonderheit@mhsindiana.com

NEW PROVIDER CONTRACTING

Tim Balko
Director, Network Development & Contracting
1-877-647-4848 ext. 20120
tbalko@mhsindiana.com

Michael Funk
Manager, Network Development & Contracting
1-877-647-4848 ext. 20017
michael.j.funk@mhsindiana.com

NETWORK OPERATIONS

Kelvin Orr
Director, Network Operations
1-877-647-4848 ext. 20049
kelvin.d.orr@mhsindiana.com

MHS Provider Network Territories

TAWANNA DANZIE

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

PROVIDER GROUPS

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

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
1-877-647-4848 ext. 20221
jedean@mhsindiana.com

GRETCHEN SCHALLER

Provider Relations Specialist
1-877-647-4848 ext. 40235
gschaller@mhsindiana.com

ENVOLVE DENTAL, INC.

MICHAEL J. WILLIAMS

Provider Relations Specialist
1-727-437-1832
Dental Provider Services: 1-855-609-5157
Michael.Williams@EnvolveHealth.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.

Session Survey

- Please use the QR code or the weblink below to complete a survey about the session you just attended. Each session has a unique survey so be sure to complete the appropriate one for each session you attend. We will be taking your feedback from this survey to improve future IHCP events.

https://tinyurl.com/fssa1020