









# 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

# 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](https://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](http://mhsindiana.com)
- Quick reference guide
- Non-contracted provider services now align with PA requirements for contracted providers

**PROVIDER Quick Reference Guide**  
Effective June 1, 2018

Applies to all provider services (primary, specialty, infusion, hospice, palliative care, etc.) and Hoosier Care Connect (HCC) packages. For additional provider quick reference guides, please visit [www.mhsindiana.com](http://www.mhsindiana.com). Our website is subject to specific benefit package or member.

**1-877-647-4848**  
TTY: 708-1-800-743-8338  
[mhsindiana.com](http://mhsindiana.com)

**GENERAL OFFICE HOURS:**  
8:30 a.m. to 5 p.m., M-F, excluding holidays

**MEMBER SERVICES AND PROVIDER SERVICE:**  
8:30 a.m. to 5 p.m.

**REFERRALS AND AUTHORIZATIONS:**  
8:30 a.m. to 5 p.m., Monday to Friday, 9:00 a.m. to 4:00 p.m.

**AFTER-HOURS:**  
After 5:00 p.m. Hoosier Care Connect Live! for members is available to provide care for emergent authorized care needs. Call our My Care Message on our other care receiving system, messages are returned within one business day.

INDIANIAN HEALTH CARE SERVICES DIVISION	
<b>ELECTRONIC PAPER DE:</b> 90000	<b>PHYSICIAN CLAIMS APPEALS DIVISION:</b> Managed Health Services P.O. Box 3020 Terre Haute, IN 47063-0320
<b>REGIONAL HEALTH PAPER DE:</b> 90000	Providers have 60 calendar days from the date of the determination of the appeal to file an appeal, requests, or requests for review.
<b>MEDICAL CLAIMS DIVISION:</b> MEDICAL FIRST SERVICE P.O. Box 3020 Terre Haute, IN 47063-0320	Failure to file an appeal or request for review within the specified timeframe will be subject to denial.
<b>CUSTOMER SERVICE/REGISTRATION:</b> CUSTOMER SERVICE/REGISTRATION P.O. Box 3020 Terre Haute, IN 47063-0320	<b>MEDICAL CLAIMS RESPONSE:</b> To request a copy of your appeal, please contact the Customer Service/Registration at: Customer Service/Registration P.O. Box 3020 Terre Haute, IN 47063-0320
<b>MEDICAL SECURITY:</b> APPEALS ONLY ADDRESS ATTN: APPEALS P.O. Box 3020 Terre Haute, IN 47063-0320	

**HOOSIER CARE CONNECT**

**NETWORK MANAGEMENT:** 1-800-484-4848  
In: In-state or out-of-state, after or before business hours

**MEDICAL APPEALS:** 1-800-743-8338  
In: Hoosier Care Connect (HCC)

**CARE MANAGEMENT:** 1-800-484-4848  
In: Hoosier Care Connect (HCC)

**RESPONSIBLE AREA STAFFING TALK:** 1-800-484-4848

**HOOSIER WEBSITE: [mhsindiana.com](http://mhsindiana.com)**

**[mhsindiana.com/providers](http://mhsindiana.com/providers)** ..... Latest MHS provider updates and news, as well as forms, manuals, guides, online Web tool and Submittals. (Please visit [mhsindiana.com/forms](http://mhsindiana.com/forms) to get the latest forms for submission to MHS.)

**[mhsindiana.com/learn](http://mhsindiana.com/learn)** ..... MHS Health Library. Click on "HOOSIER CARE CONNECT" for the most up-to-date patient health fact sheets on over 1,000 topics. Available in English and Spanish.

**[mhsindiana.com/sign](http://mhsindiana.com/sign)** ..... MHS Secure Provider Portal lets you submit prior authorization requests, claim adjustments, and see your profile's medical records and messages.

**[mhsindiana.com/connections](http://mhsindiana.com/connections)** ..... Information for electronic processing and payment of claims with MHS.

**OTHER RESOURCES:**  
**[payapartners.com](http://payapartners.com)** ..... MHS is pleased to partner with Paycom for your HR and compensation needs and solutions for Hoosier Healthwise (HWH) and CareConnect (CareConnect). This service is provided at no cost to providers and allows online enrollment at [payapartners.com](http://payapartners.com).

The user should review the information in this Guide to the MHS Provider Manual, online and offline, and other resources, or by contacting MHS at 1-877-647-4848.



# 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/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](http://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](http://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](https://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](http://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
- ✓ Unicompartamental/Bicompartamental 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](http://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](https://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](https://pharmacy.envolvehealth.com)

 Formulary integrated into many Electronic Health Records (EHR) solutions

 Online PA submission available through CoverMyMeds:

- [covermymeds.com](https://covermymeds.com)

 Online PA forms for Specialty Drugs on [mhsindiana.com](https://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](https://mhsindiana.com/login):

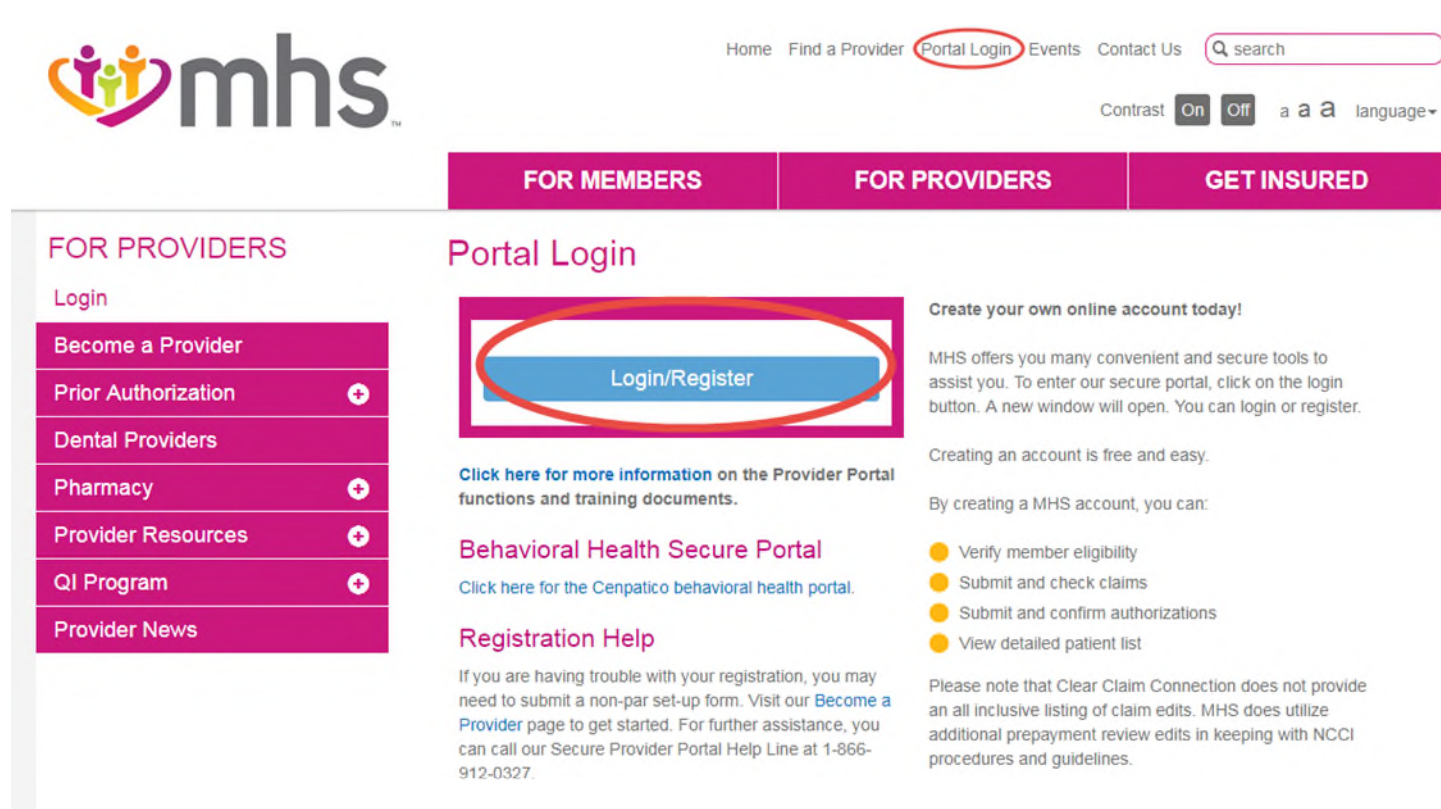
- When using the portal, providers can upload supporting documentation directly.

 **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



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) within a blue box. Below this button, there are links for more information on the Provider Portal functions and training documents, a link to the Behavioral Health Secure Portal, and a link to Registration Help. To the right of the "Login/Register" button, there is a section titled "Create your own online account today!" which explains that MHS offers convenient and secure tools to assist users. It states that creating an account is free and easy, and lists benefits such as verifying member eligibility, submitting and checking claims, submitting and confirming authorizations, and viewing detailed patient lists. A note at the bottom of this section states that Clear Claim Connection does not provide an all-inclusive listing of claim edits, and 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



 Eligibility
 Patients
 Authorizations
 Claims
 Messaging
 Help
Provider Name ▾

 Viewing Authorizations For : Tax ID Number ▾ Medicaid ▾ GO

 Create Authorization
 

Authorizations

Processed
Errors
Disclaimer

Filter

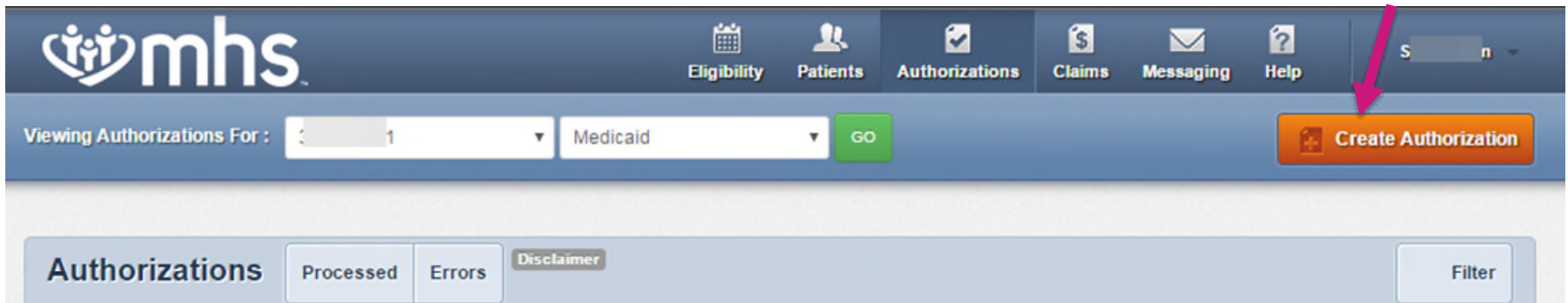
Please call the health plan for questions regarding voided authorization submissions. The authorization page is updated every 24 hours.

STATUS	AUTH ID	MEMBER	FROM DATE	TO DATE	DIAGNOSIS	AUTH TYPE	SERVICE
APPROVE	<span style="background-color: #add8e6; padding: 2px;">O</span> <span style="background-color: #add8e6; padding: 2px;">1</span>	<span style="background-color: #add8e6; padding: 2px;">A</span> <span style="background-color: #add8e6; padding: 2px;">H</span>	07/24/2017	10/24/2017	E11.9	OUTPATIENT	DME
<span style="background-color: #d9d2e9; padding: 2px 5px; font-size: 0.8em;">PARTIAL_APPROVE</span>	<span style="background-color: #add8e6; padding: 2px;">C</span> <span style="background-color: #add8e6; padding: 2px;">9</span>	<span style="background-color: #add8e6; padding: 2px;">V</span>	06/14/2017	09/19/2017	B07.9	OUTPATIENT	Office Visit

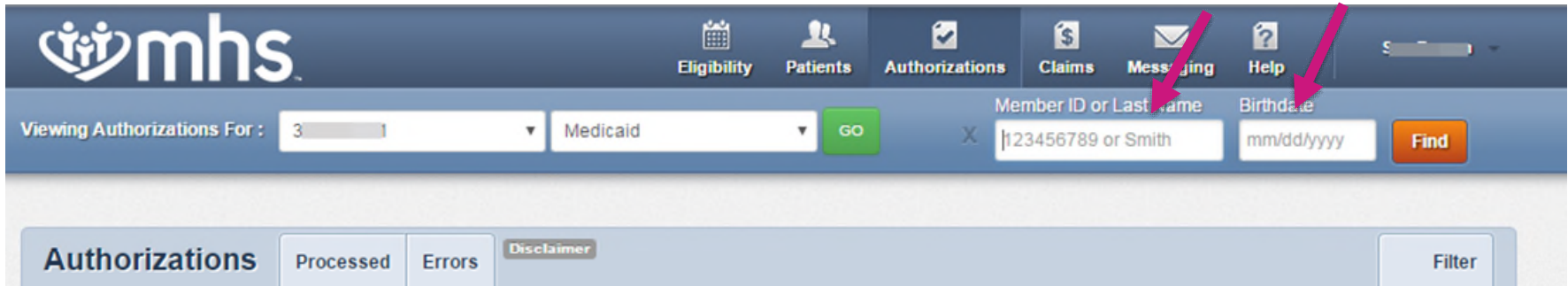
# Creating a New Authorization

 Click **Create Authorization**.

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



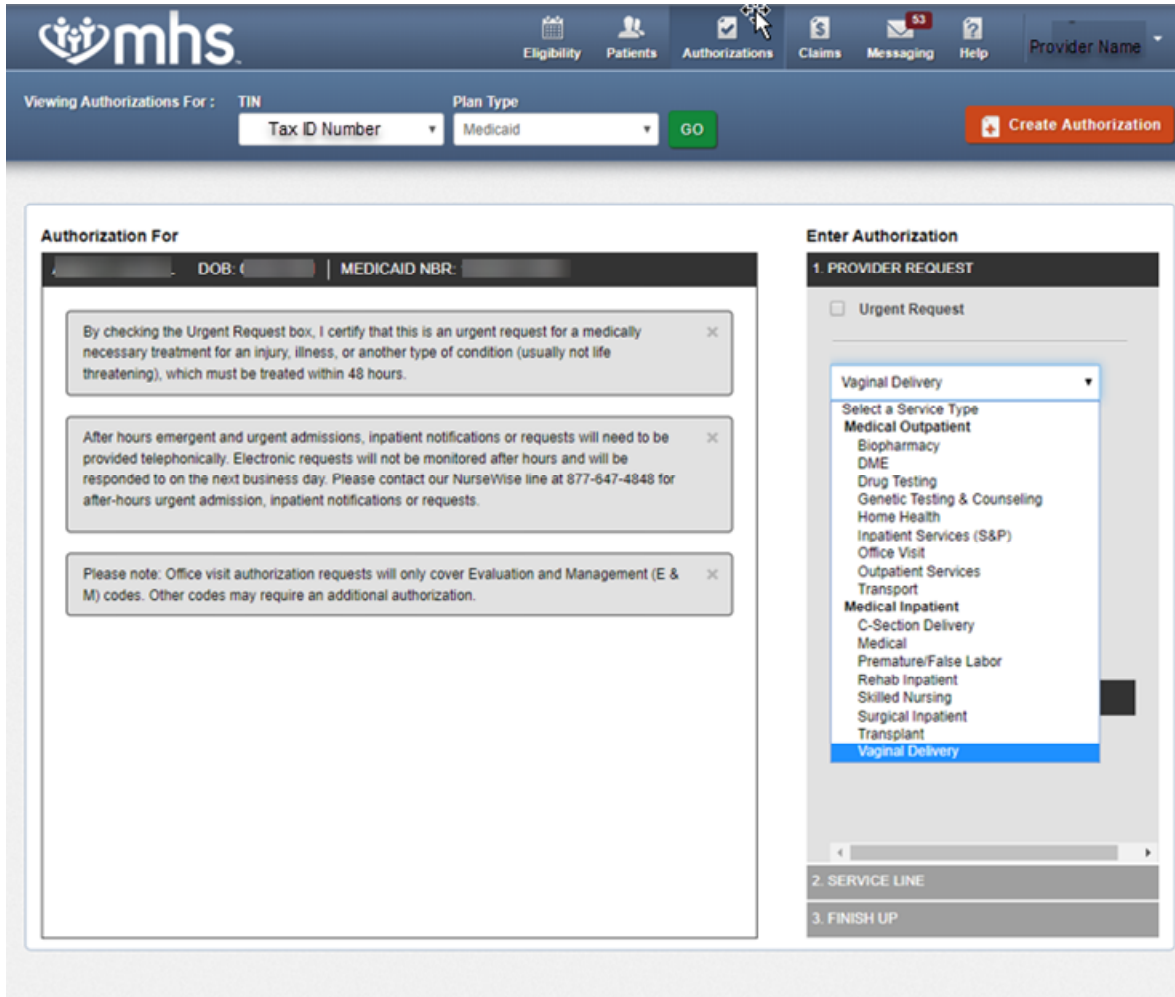
The screenshot shows the mhs navigation bar with icons for Eligibility, Patients, Authorizations, Claims, Messaging, and Help. Below the navigation bar, there are dropdown menus for 'Viewing Authorizations For' (set to 1) and 'Medicaid', with a green 'GO' button. A red arrow points to an orange 'Create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



The screenshot shows the mhs navigation bar with icons for Eligibility, Patients, Authorizations, Claims, Messaging, and Help. Below the navigation bar, there are 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 birthdate field.

# Creating a New Authorization

## Select a Service Type



The screenshot displays the MHS authorization system interface. At the top, there is a navigation bar with icons for Eligibility, Patients, Authorizations, Claims, Messaging, and Help, along with a 'Provider Name' dropdown. Below this, a search bar allows filtering by TIN (Tax ID Number) and Plan Type (Medicaid), with a 'GO' button and a 'Create Authorization' button.

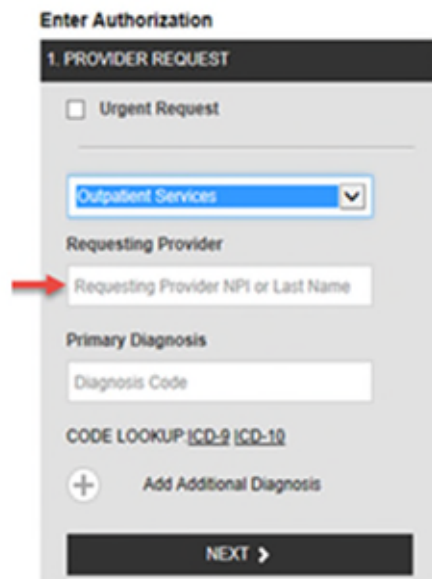
The main content area is divided into two sections:

- Authorization For:** This section includes fields for Patient ID, DOB, and MEDICAID NBR. It contains three informational boxes:
  - 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:** This section is titled '1. PROVIDER REQUEST' and includes an 'Urgent Request' checkbox. A dropdown menu is open, showing a list of service types:
  - 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

Below the dropdown menu, there are sections for '2. SERVICE LINE' and '3. FINISH UP'.

# 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

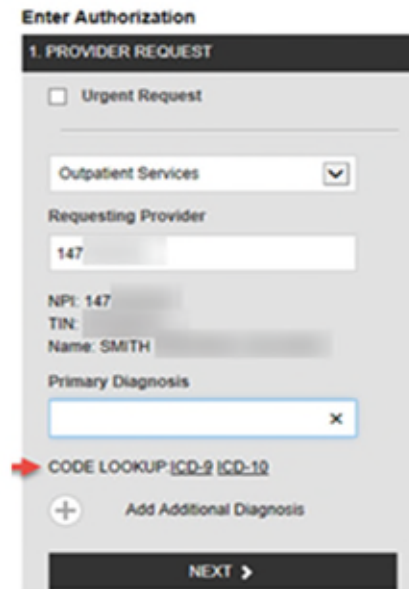
Primary Diagnosis

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

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

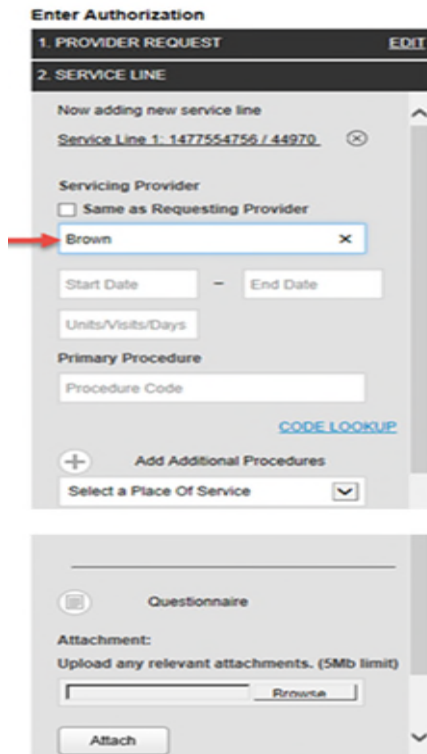
+ Add New Service Line

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

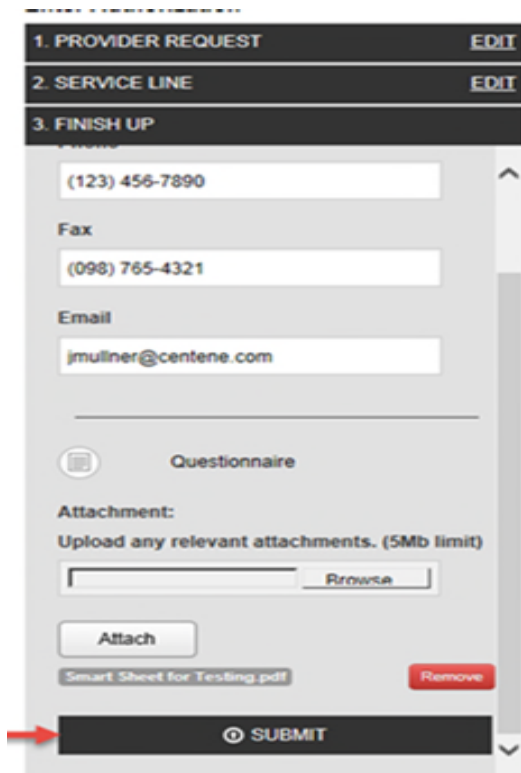
- Provider Request will appear on the left side of the screen.
- Update Servicing Provider:
  - Check box if same as Requesting Provider.
  - Update Servicing Provider information if not the same
- Update Start Date and End Date.
- Update Total Units/Visits/Days.
- Update Primary Procedure:
  - Code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



1. PROVIDER REQUEST **EDIT**

2. SERVICE LINE **EDIT**

3. FINISH UP

(123) 456-7890

Fax  
(098) 765-4321

Email  
jmulner@centene.com

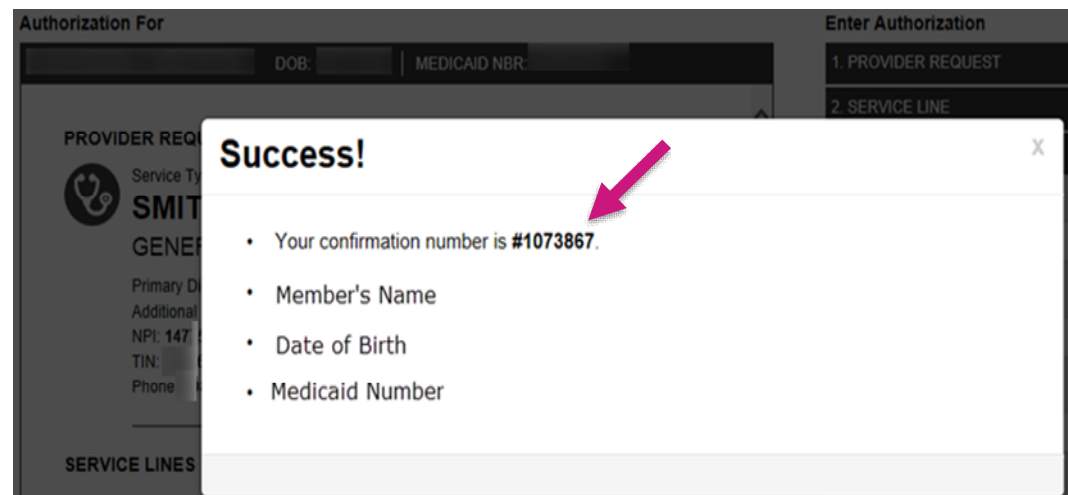
Questionnaire

Attachment:  
Upload any relevant attachments. (5Mb limit)

Attach

Smart Sheet for Testing.pdf **Remove**

**SUBMIT**



Authorization For

DOB: | MEDICAID NBR: |

Enter Authorization

1. PROVIDER REQUEST

2. SERVICE LINE

**Success!**

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



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"/> <i>Purchased</i> | <input type="checkbox"/> Observation          | <input type="checkbox"/> Speech Therapy   |
| <input type="checkbox"/> <i>Rented</i>    | <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.***

# **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

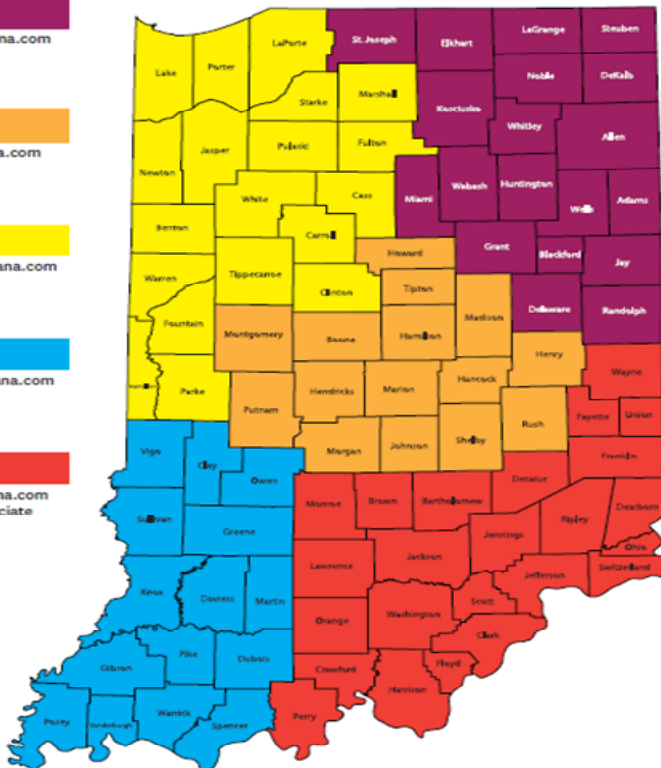
## NETWORK LEADERSHIP

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

**Nancy Robinson**  
 Senior Director, Provider Network  
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 nrobinson@mhsindiana.com

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

## Indiana



## 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

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### 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

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### 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

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### 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





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### 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>