



















# Welcome to Managed Health Services (MHS)



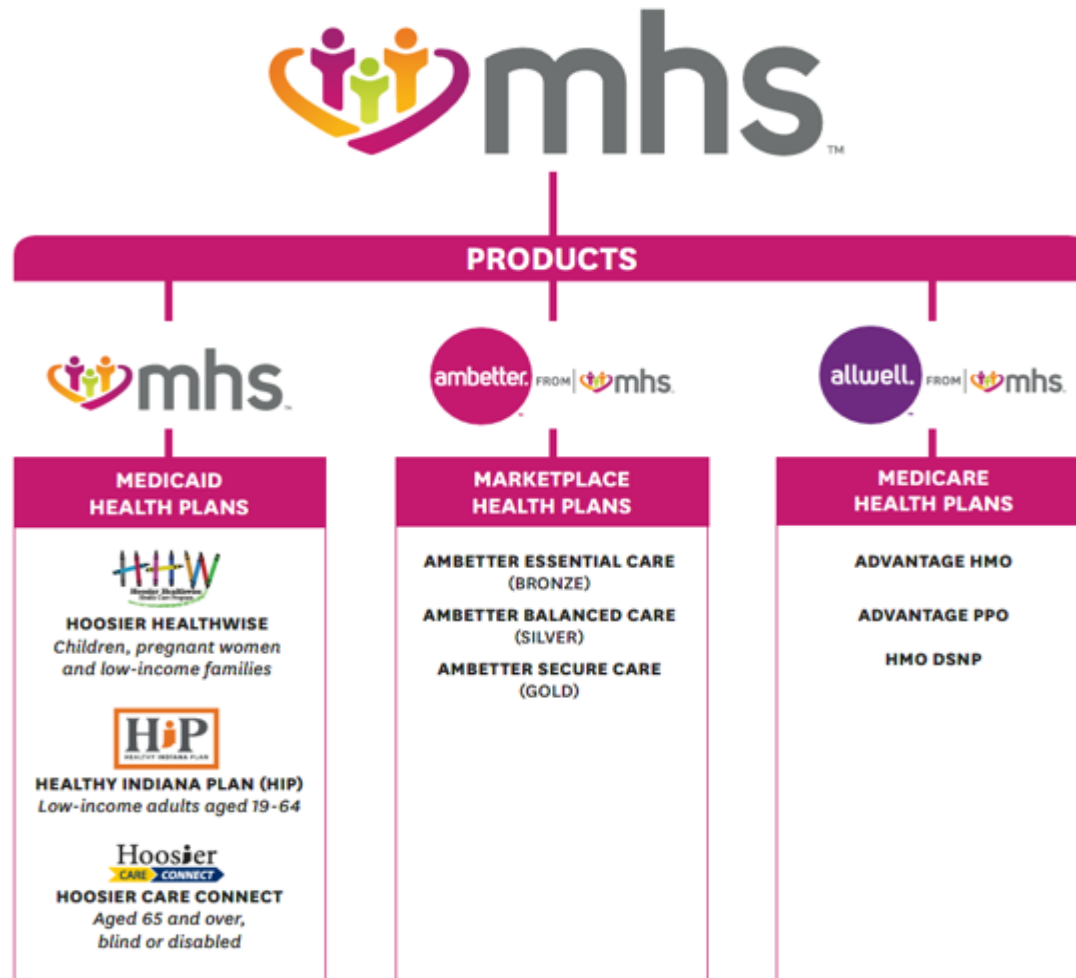
# Agenda

-  MHS Overview
-  Health Programs
-  Claim Process
-  Vaccines for Children
-  Notification of Pregnancy
-  Prior Authorization Process
-  HEDIS
-  Culturally and Linguistic Appropriate Services (CLAS)
-  Coordinated Care Programs
-  MHS Partnership
-  Ambetter
-  Allwell
-  MHS Website
-  COVID-19 updates
-  Questions

# Who is MHS?

-  Managed Health Services (MHS) is a health insurance provider that has been proudly serving Indiana residents for 25 years through Hoosier Healthwise, the Healthy Indiana Plan (HIP) and Hoosier Care Connect.
-  MHS also offers a qualified health plan through the Health Insurance Marketplace called Ambetter from MHS and a Medicare Advantage product called Allwell from MHS. All of our plans include quality, comprehensive coverage with a provider network you can trust.
-  **MHS is your partner in care.**

# MHS Products



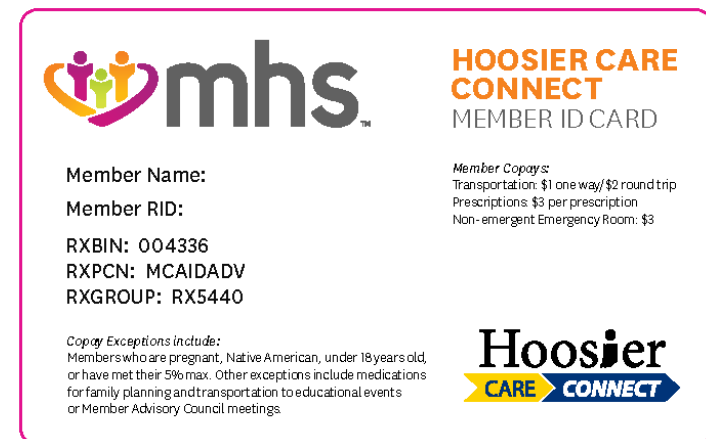
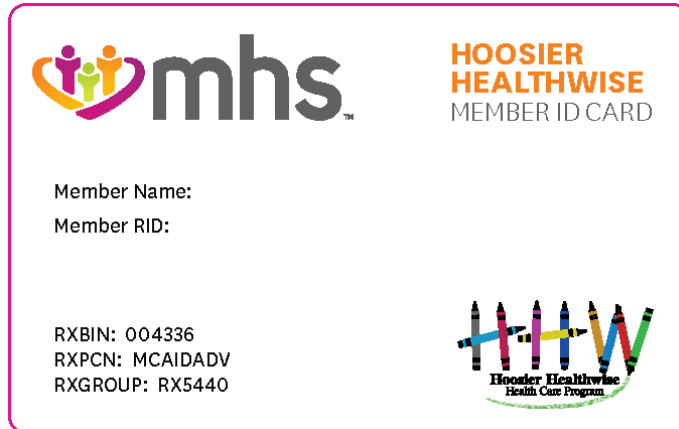


# Medicaid

# MHS Medicaid ID Cards















\*Used for both HIP and HIP Maternity



# Member & Provider Services

**1-877-647-4848**

-  Dedicated staff available Monday - Friday from 8 a.m. - 8 p.m.
-  Hoosier Healthwise, HIP and Hoosier Care Connect customer service
-  Eligibility verification if needed
-  Claims status and assistance
-  Translation and transportation coordination
-  Health needs screening
-  New IVR option-telephonic, self service verification of claims and eligibility
-  Spanish speaking representatives (additional languages available upon request)
-  Facilitates member disenrollment requests
-  Panel full/hold requests
-  New member tool kits
-  Member QRG




# Healthy Indiana Plan





# Who is Eligible for the Healthy Indiana Plan (HIP)?

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

-  Members will select a managed care entity (MCE) responsible for coordinating care in partnership with their medical provider(s).
-  Care coordination services will be individualized based on a member's assessed level of need determined through a health screening.
-  HIP provides coverage for qualified low-income Hoosiers ages 19 to 64, who are not receiving Medicare and are interested in participating in a low-cost, consumer-driven health care program. HIP uses a proven, consumer-driven approach that was pioneered in Indiana.

# POWER Up to HIP Plus

## Encourage HIP members to join HIP Plus

### Enhanced benefit package

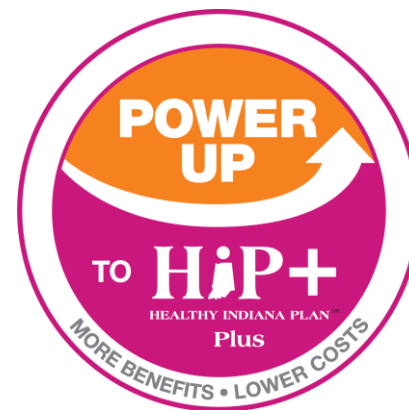
- No copays! Only pay a monthly contribution
- Dental coverage
- Vision coverage
- Additional therapy services
- Rx mail order option
- Chiropractic care

### When can members POWER Up?

- Open enrollment
- Redetermination/Potential Plus Loop

### Contact MHS Customer Service to POWER Up to HIP Plus

- 1-877-647-4848



# HIP Basic Plan – Copay

When members with income less than or equal to 100% FPL do not pay their HIP Plus monthly contribution, they are moved to HIP Basic. HIP Basic Members are responsible for the copayments below for health and pharmacy services.

*\*Copayments may not be more than the cost of services received.*

Service	HIP Basic Co-Pay Amounts ≤100% FPL
Outpatient Services	\$4
Inpatient Services	\$75
Preferred Drugs	\$4
Non-preferred drugs	\$8
Non-emergency ER visit	\$8




# Hoosier Care Connect

(Aged, Blind & Disabled)



# Who is Eligible for Hoosier Care Connect?

Hoosier Care Connect is a coordinated care program for Indiana Health Coverage Programs (IHCP) members age 65 and over, or with blindness or a disability who are residing in the community and are not eligible for Medicare.

-  Members will select a managed care entity (MCE) responsible for coordinating care in partnership with their medical provider(s).
-  Hoosier Care Connect members will receive all Medicaid-covered benefits in addition to care coordination services.
-  Care coordination services will be individualized based on a member's assessed level of need determined through a health screening.

# Hoosier Healthwise

(CHIP)



# Who is Eligible for Hoosier Healthwise?

Hoosier Healthwise covers the following members:

 Children up to age 19

 The Children's Health Insurance Plan (CHIP)

- This option is available for individuals up to age 19 who may earn too much money to qualify for the standard Hoosier Healthwise coverage.

# **Claim Process**



# Claim Process



## EDI Submission

- Preferred method of claims submission
- Faster and less expensive than paper submission
- MHS Electronic Payor ID: 68089



## Online through the MHS Secure Provider Portal:

[mhsindiana.com](https://mhsindiana.com)

- Provides immediate confirmation of received claims and acceptance
- Institutional and Professional
- Batch Claims
- Claim Adjustments/Corrections



## Paper Claims

- Managed Health Services  
PO Box 3002  
Farmington, MO 63640-3802

# Claim Process





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

## *Exceptions*

- Newborns (30 days of life or less) – Claims must be received within 365 days from the date of service. Claim must be filed with the newborns RID #.
- Claims with primary insurance must be received within 365 days of the date of service with a copy of the primary EOB. If primary EOB is received after the 365 days, providers have *60 days* from date of primary EOB to file claim to MHS.






# Claim Process

## Resubmissions

-  Paper copy or web submission
-  **Electronic adjustments through the Secure Provider Portal**
-  Hard copy resubmissions:
  - Adjustment option on the MHS website
  - Must attach EOP, documentation, and explanation of the resubmission reason
  - May use the Provider Claims Adjustment Request Form
-  Providers have **67 calendar days** from the date of EOP to file a resubmission. *Please note, claims will not be reconsidered after this timeline.*



# Provider Claims Issue Resolution

## PROCESS

-  Step 1: Informal Claims Dispute or Objection Form
-  Step 2: Formal Claim Dispute - Administrative Claim Appeal
-  Step 3: Arbitration
-  For assistance or questions after completing step one:
  - Provider Services Phone Requests & Web Portal Inquiries
-  If additional assistance is needed anytime after Step 1 and after calling Provider Services or completing Web Portal inquiry:
  - Provider Relations Regional Mailboxes

# Informal Claims Dispute or Objection Form

## Step 1:

-  Must be submitted in writing within **67 calendar days** of receipt of the MHS Explanation of Payment (EOP) by using the MHS Informal Claim Dispute or Objection form, available at [mhsindiana.com/providers/resources/forms](https://mhsindiana.com/providers/resources/forms); there is a general form for medical and a separate form for Behavioral Health claims. The address for submission is listed on each of the forms.
-  Requests received after day 67 will not be considered.

# Informal Claims Dispute or Objection Form - Medical



Address:  
Managed Health Services  
Post Office Box 3000  
Attn: Appeals Department  
Farmington, MO 63640-3800

<https://www.mhsindiana.com/content/dam/centene/mhsindiana/medicaid/pdfs/0517.PR.P.FO%20Informal-Claim-Dispute-Objection-Form-EN-May2017.pdf>



## Informal Claim Dispute / Objection Form (Level I Administrative and Claims Appeals)

### Applicability:

Use this form or your letterhead to file a written request to begin the Managed Health Services (MHS) informal claim dispute / objection resolution process, in accordance with the MHS provider manual and Indiana regulations (405 IAC 1-1.6-1 through 1-1.6-6). This is Step 1 of the administrative or claim payment appeal process. You must pursue an informal dispute / objection before you may file a formal appeal.

### Time Limits/ When to File:

The claim(s) in question must have originally been submitted to MHS in a timely manner:

- MHS contracted providers have 90 calendar days from date of service to file a claim
- Non-contracted providers have 365 calendar days from date of service to file a claim

The timely filing requirement in the case of claims for members with retroactive coverage, such as presumptively eligible pregnant women and newborns, is waived.

All providers have 67 calendar days from receipt of the MHS Explanation of Payment (EOP) to file an informal dispute, objection, or appeal with MHS.

### What-to-file check list:

- ☐ This form or written request for informal claims dispute / objection resolution on your letterhead.
- ☐ Copies of original MHS EOP showing how the claim(s) in question were processed.
- ☐ Copies of any subsequent MHS EOPs or other determinations on the claim(s) in question.
- ☐ Documentation of any previous attempt you have made to resolve the issue with MHS.
- ☐ Other documentation that supports your request for reprocessing or reconsideration of the claim(s), such as:
  - Records or documentation previously requested by MHS to resolve the claim.
  - Proof of timely filing or documentation to support reasonableness of filing date. Rejections are not proof of timely submission.
  - Documentation to support request for exception to MHS plan policy, benefit limitations and/or authorization requirements.
  - Documentation to support paying claims otherwise denied by coding or other audits.

All fields are required:

Provider Name:	Member Name:
Provider Tax ID#:	Member (RID) Number:
Requestor Name:	Requestor Title:
Date of this Request:	Requestor Phone Number:
Claim Number(s):	Date(s) of Service:
Reason for Informal Claims Dispute / Objection, including why you think MHS should pay the claim(s), adjust or reconsider them and how the attached documentation supports your request. Attach additional sheets as needed.	

### Where to File:

Send form or written Informal Dispute/Objection letter with relevant attachments by first class, priority or express U.S. mail to: Managed Health Services, Post Office Box 3000, Attn: Appeals Department, Farmington, MO 63640-3800

MHS will make all reasonable efforts to review your documentation and respond to you within 30 calendar days. If you do not receive a response within 30 calendar days, consider the original decision to have been upheld. At that time (or upon receipt of our response if sooner), you will have up to 67 calendar days from date on Explanation of Payment (EOP) to initiate a formal claim appeal.



1-877-647-4648 | TTY/TDD: 1-800-743-3333 | mhsindiana.com  
Allwell from MHS | Ambetter from MHS | Healthy Indiana Plan (HIP) | Hoosier Care Connect | Hoosier Healthwise

0517.PR.P.FO 5/17

# Informal Claims Dispute or Objection Form – Behavioral Health



Address:

- Behavioral Health Services  
Post Office Box 6000  
Attn: Appeals Department  
Farmington, MO 63640-3809

<https://www.mhsindiana.com/content/dam/centene/mhsindiana/medicaid/pdfs/Behavioral-Health-Informal-Claim-Dispute-Objection-Form.pdf>

## Behavioral Health Informal Claim Dispute / Objection Form (Level I Administrative and Claims Appeals)

### Applicability:

Use this form or your letterhead to file a written request to begin the Managed Health Services (MHS) informal claim dispute / objection resolution process, in accordance with the MHS provider manual and Indiana regulations (405 IAC 1-1.6-1 through 1-1.6-6). This is Step 1 of the administrative or claim payment appeal process. You must pursue an informal dispute / objection before you may file a formal appeal.

### Time Limits/When to File:

The claim(s) in question must have originally been submitted to MHS in a timely manner:

- MHS contracted providers have 90 calendar days from date of service to file a claim
- Non-contracted providers have 365 calendar days from date of service to file a claim

The timely filing requirement in the case of claims for members with retroactive coverage, such as presumptively eligible pregnant women and newborns, is waived.

All providers have 67 calendar days from receipt of the MHS Explanation of Payment (EOP) to file an informal dispute, objection, or appeal with MHS.

### What-to-file check list:

- ☐ This form or written request for informal claims dispute / objection resolution on your letterhead.
- ☐ Copies of original MHS EOP showing how the claim(s) in question were processed.
- ☐ Copies of any subsequent MHS EOPs or other determinations on the claim(s) in question.
- ☐ Documentation of any previous attempt you have made to resolve the issue with MHS.
- ☐ Other documentation that supports your request for reprocessing or reconsideration of the claim(s), such as:
  - Records or documentation previously requested by MHS to resolve the claim.
  - Proof of timely filing or documentation to support reasonableness of filing date. Rejections are not proof of timely submission.
  - Documentation to support request for exception to MHS plan policy, benefit limitations and/or authorization requirements.
  - Documentation to support paying claims otherwise denied by coding or other audits.

All fields are required:

Provider Name:	Member Name:
Provider Tax ID#:	Member (RID) Number:
Requestor Name:	Requestor Title:
Date of this Request:	Requestor Phone Number:
Claim Number(s):	Date(s) of Service:
Reason for Informal Claims Dispute / Objection, including why you think MHS should pay the claim(s), adjust or reconsider them and how the attached documentation supports your request. Attach additional sheets as needed:	

### Where to File:

Send form or written Informal Dispute/Objection letter with relevant attachments by first class, priority or express U.S. mail to: Behavioral Health Services, Post Office Box 6000, Attn: Appeals Department, Farmington, MO 63640-3809

MHS will make all reasonable efforts to review your documentation and respond to you within 30 calendar days. If you do not receive a response within 30 calendar days, consider the original decision to have been upheld. At that time (or upon receipt of our response if sooner), you will have up to 67 calendar days from date on Explanation of Payment (EOP) to initiate a formal claim appeal.




1-877-647-4848 | TTY/TDD: 1-800-743-3333 | mhsindiana.com  
Allwell from MHS | Ambetter from MHS | Healthy Indiana Plan (HIP) | Hoosier Care Connect | Hoosier Healthwise

0517.PR.P.FO 5/17




# Informal Claims Dispute or Objection Form

## Step 1:

- 
- A small icon of the MHS logo, featuring three stylized human figures in blue, green, and orange forming a heart shape.
- Submit all documentation supporting your objection.
  - Copies of original MHS EOP showing how the claims in question were processed.
  - Copies of any subsequent MHS EOPs or other determinations on the claim(s) in question.
  - Documentation of any previous attempt you have made to resolve the issue with MHS.
  - Other documentation that supports your request for reprocessing or reconsideration of the claim(s).



# Informal Claims Dispute or Objection Form

-  MHS will make all reasonable efforts to review your documentation and respond to you within 30 calendar days.
-  If you do not receive a response within 30 calendar days, consider the original decision to have been upheld.
-  At that time (or upon receipt of our response if sooner), you will have up to 67 calendar days from date of Dispute response to initiate a formal claim appeal (Step 2).

# Customer/Provider Services Phone Requests & Web Portal Inquiries

## Step 1:





 Helpful Tips:

 Disputing multiple claim denials:

- Submit separate Informal Claims Dispute Forms for each member/patient experiencing the denial;
- Provide additional information such as:
  - The MHS denial code and description found on the EOPP/remit;
  - Briefly describe why you are disputing this denial;
  - For multiple claims please either list all claim numbers or in the “Reason for Dispute” section state that “**member is experiencing denial reason \_\_\_\_ for all claims DOS \_\_\_\_ to \_\_\_\_; Please review all associated claims**”;

 Save copies of all submitted informal claims dispute forms.

# Provider Services Phone Requests & Web Portal Inquiries

-  This is not considered a formal notification of provider dispute.
-  Claim issues presented by providers to the Provider Services phone line & Web Portal Inquiries for review will be logged and assigned a ticket number; Please keep this ticket number for your reference.
-  **Phone: 1-877-647-4848; Provider Services 8 a.m. to 8 p.m.**
-  **Provider Web Portal:** [mhsindiana.com/providers/login](https://mhsindiana.com/providers/login)
  - Use the Messaging Tool.

# Customer/Provider Services Phone Requests & Web Portal Inquiries



## Helpful Tips:



### Disputing multiple claim denials:

- Provide the provider services rep or web portal team member with one claim number as an example of the specific denial.
- **Communication is Key!**
  - Tell the rep you have a “claims research request” to review all claims for the specific denial reason.
  - State if this denial is happening for one or multiple practitioners within your group or clinic (if multiple, provide your TIN).
  - Provide the MHS denial code and description found on the EOP.
  - Briefly describe why you are disputing this denial or seeking research.

# Customer/Provider Services Phone Requests & Web Portal Inquiries



## Helpful Tips:








### **Communication is Key!** (cont.):

- Do not include multiple claim denial reasons within the same research request. Submit separate research requests for each individual denial reason.
- Please refrain submitting research requests for vague reasons or if you can clearly determine the denial is valid; For example:
  - Valid timely filing denials;
  - Services that require prior authorization but PA wasn't obtained
- Retain all reference numbers provided by the Provider Services and Web-Portal teams.

Research can take up to 30-45 days; at any time you can follow up with the Provider Services or Web Portal team with a status update request (make sure to provide the original reference number).






# Formal Claim Dispute - Administrative Claim Appeal

## Step 2

-  Step 2 is a continuation of Step 1 and is a Formal Claim Dispute, Administrative Claim Appeal.
-  In the event the provider is not satisfied with the informal claim dispute/objection resolution, the provider may file an administrative claim appeal. The appeal must be filed within 67 calendar days from receipt of the informal dispute resolution notice.
-  An administrative claim appeal must be submitted in writing on company letterhead with an explanation including any specific details which may justify reconsideration of the disputed claim. The word “appeal” must be clearly marked on the letter.
-  Administrative claim appeals need to be submitted to: Managed Health Services, P.O. Box 3000, Farmington, MO 63640
-  See the MHS Provider Manual Chapter 5 Claims Administrative Reviews and Appeals for more information.  
[https://www.mhsindiana.com/content/dam/centene/mhsindiana/medicaid/pdfs/Provider\\_Manual\\_2019.pdf](https://www.mhsindiana.com/content/dam/centene/mhsindiana/medicaid/pdfs/Provider_Manual_2019.pdf)

# Arbitration

## Step 3:

-  Step 3 is a continuation of Steps 1 & 2 and is a part of the formal MHS Provider Claims dispute process.
-  In the event a provider is not satisfied with the outcome of the administrative claim appeal process (Step 2), the provider may request arbitration. Claims with similar issues from the same provider may be grouped together for the purpose of requesting arbitration.
-  To initiate arbitration, the provider should submit a written request to MHS on company letterhead. The request must be postmarked no later than 60 calendar days after the date the provider received MHS' decision on the administrative claim appeal.
-  Arbitration Requests need to be mailed to, MHS Arbitration, 550 N. Meridian Street, Suite 101, Indianapolis, IN 46204, unless otherwise directed in the letter.
-  See the MHS Provider Manual Chapter 5 Claims Administrative Reviews and Appeals for more information.  
[https://www.mhsindiana.com/content/dam/centene/mhsindiana/medicaid/pdfs/Provider\\_Manual\\_2019.pdf](https://www.mhsindiana.com/content/dam/centene/mhsindiana/medicaid/pdfs/Provider_Manual_2019.pdf)

# Need to Know – EFTs and ERAs




## Payspan Health

-  Web based solution for Electronic Funds Transfers (EFTs) and Electronic Remittance Advices (ERAs)
-  One year retrieval of remittance advice
-  Provided at no cost to providers and allows online enrollment
-  Register at [payspanhealth.com](https://payspanhealth.com)
  - For questions call 1-877-331-7154 or email [providersupport@payspanhealth.com](mailto:providersupport@payspanhealth.com)



# **VFC and Notice of Pregnancy Updates**

# Vaccines for Children (VFC)

-  All members under the age of 19 are eligible for vaccines distributed via the Vaccine for Children (VFC) program.
-  Since VFC vaccine is at no cost to the provider, reimbursement is allowed for the vaccine administration.
-  Effective January 1, 2020, the IHCP rate for administration is \$15 and is reimbursable at the lesser of billed charges or the IHCP fee.



# Vaccines for Children (VFC)









Providers must bill in the following manner

- Appropriate diagnosis code of Z00.121 or Z00.129.
- Procedure code with specific vaccine administered, preferably with a billed amount of \$0.00.
- Regardless of amount billed, the service line will be reimbursed at \$0.
- Appropriate vaccine administration CPT® code 90471 - 90474 with the SL modifier.
- Claims billed for VFC vaccine administration codes without the SL modifier will be denied **EXs9**.

# Vaccines for Children (VFC)


-  Providers will no longer be reimbursed for vaccines available through the VFC but provided out of private stock.
-  Provider may bill for vaccines that are not available through the VFC program.

# Notification of Pregnancy (NOP)

-  NOP was developed to help identify pregnancy earlier with the goal of increasing positive birth outcomes.
-  The program requests the IHCP's NOP form be completed and submitted through the IHCP Provider Healthcare Portal for each pregnancy.
-  Providers completing the online NOP form in a timely manner will receive an incentive of \$60 per notification.
-  The process consists of 4 questions to be completed online with first OB visit once member is effective with Medicaid.
-  Reimbursement is obtained by billing CPTR 99354 TH on claim form.
-  The form must be valid - meaning it is a non-duplicative form, the pregnancy is less than 30 weeks gestation, and a valid RID number is included.





# **Prior Authorization Process**

# Prior Authorization

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

**Prior Authorizations are not a guarantee of payment.**

# Utilization Management

-  Prior Authorization (PA) can be initiated through the MHS referral line at 1-877-647-4848.
  - The PA process begins at MHS by speaking with the MHS non-clinical referral staff.
-  Prior Authorizations can be completed via fax.
-  Prior Authorizations can also be submitted online via the Secure Provider Portal at [mhsindiana.com/login](https://mhsindiana.com/login).
-  When using the portal, supporting documentation can be uploaded directly.
  - Authorization status can also be checked on the portal.



## FOR MEMBERS

## FOR PROVIDERS

## GET INSURED

## FOR PROVIDERS

[Login](#)
[Enrollment and Updates](#)
[Prior Authorization](#) −
[Medicaid Pre-Auth](#)
[Ambetter Pre-Auth](#)
[Medicare Pre-Auth](#)
[Dental Providers](#)
[Pharmacy](#) +
[Opioid Resources](#)
[Behavioral Health](#) +
[Provider Resources](#) +
[QI Program](#) +
[Provider News](#)
[Email Sign Up](#)

## Medicaid Pre-Auth

**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](#).

Dental services need to be verified by [Envolve Dental](#).

Ambulance and Transportation services need to be verified by [LCP Transportation](#).

Musculoskeletal services need to be verified by [TurningPoint](#).

Non-participating providers must submit Prior Authorization for all services.

For non-participating providers, [join our network](#).

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

☐ 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?

☐ ☐

### Types of Services

YES NO

Is the member being admitted to an inpatient facility?

☐ YES ☒ NO

Are services, other than DME, orthotics, prosthetics, and supplies, being rendered in the home?

☐ YES ☒ NO

Are anesthesia services being rendered for pain management?

☐ YES ☒ NO

Are services for infertility?

☐ YES ☒ NO

Is the member receiving dialysis?

☐ YES ☒ NO

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

99394


Check

**N**  
No

**99394** - PREV VISIT EST AGE 12-17  
No Pre-authorization required for all providers.


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


# Musculoskeletal Safety & Quality Program

 MHS has entered into an agreement with Turning Point Healthcare Solutions, LLC to implement a Musculoskeletal Safety and Quality Program. This program includes prior authorization for medical necessity and appropriate length of stay (when applicable) for both inpatient and outpatient settings.

 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](https://myturningpoint-healthcare.com)







Telephone Intake:

- 1-574-784-1005 | 1-855-415-7482








Fax Intake: 1-463-207-5864

# NIA – PT, OT and ST


-  Utilization management of these services is managed by NIA.
-  Prior authorization for PT, OT, and ST services is required to determine whether services are medically necessary and appropriate; determination is made by MHS not NIA.
-  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.
-  **Chiropractors rendering therapy services are exempt from the NIA program.**

# Durable & Home Medical Equipment (DME)

-  Prior authorization required by the **ordering physician** for all non-participating DME providers.
-  Members and referring providers will no longer need to search for a DME provider or provider of medical supplies to service their needs.
-  Order is submitted directly to MHS, coordinated by Medline and delivered to the member.
-  Availability via Medline's web portal to submit orders and track delivery.
-  Does not apply to items provided by and billed by physician office.

# 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 Secure Provider Portal, and click on “Create Authorization.” Choose 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

# Inpatient Prior Authorization


 To ensure timely and accurate medical necessity review of a Medicaid 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, using the IHCP universal prior authorization form or via the MHS Secure Provider Portal.**

 Please submit timely notification and clinical information to support an inpatient admission via fax to 1-866-912-4245 or upload via the MHS Secure Provider Portal.



# Behavioral Health






## Limitations on Outpatient Mental Health Services:

 Effective 12/15/2018 MHS has implemented The Indiana Health Coverage Programs Mental Health and Addiction limitation policy for the following CPT codes that, in combination, are limited 20 units per member, per provider, per rolling 12-month period:






<u>Code</u>	<u>Description</u>
90832 - 90834	Individual Psychotherapy
90837 - 90840	Psychotherapy, with patient and/or family member & Crisis Psychotherapy
90845 and 90853	Psychoanalysis & Family/Group Psychotherapy with or without patient

# Behavioral Health

## Limitations on Outpatient Mental Health Services (Cont.):

-  Effective 12/15/18, Managed Health Services (MHS) has begun applying this limitation for claims with dates of service (DOS) on or after 12/15/18. Claims exceeding the limit will deny EX Mb: Maximum Benefit Reached.
-  If the member requires additional services beyond the 20 unit limitation, providers may request prior authorization for additional units. Approval will be given based on the necessity of the services as determined by the review of medical records.
-  Providers will need to determine if they have provided 20 units to the member in the past rolling 12 months (starting with DOS 12/15/18) to determine if a prior authorization request is needed.
-  “Per Provider” is defined by MHS as per individual rendering practitioner NPI being billed on the CMS-1500 claim form (Box 24J).
-  This change is related to professional services being billed on CMS 1500.

# Utilization Management



-  All elective inpatient/outpatient services must be prior authorized with MHS at least 2 business days prior to the date of service.
-  MHS will only accept notification of an inpatient admission and any clinical information submitted for medical necessity review via fax or MHS web portal, using the IHCP universal prior authorization form.
-  Please submit timely notification and clinical information to support an inpatient admission via fax to 1-866-912-4245.
-  All urgent and emergent services must be called to MHS within 2 business days after the admit.
-  Previously approved prior authorizations can be updated for changes in dates of service or CPT/HCPSC codes within 30 days of the original date of service.

**Failure to obtain prior authorization for services may result in claim denials!**

# Utilization Management

## MEDICAL NECESSITY GRIEVANCE AND APPEALS

**Managed Health Services  
Attn: Appeals Coordinator  
PO BOX 441567 Indianapolis, IN 46240**

-  Determination will be communicated to the provider within 20 business days of receipt.
-  Remember: Appeals must be initiated **within 60 days** of the denial to be considered. Please note, this is different than a claim appeal request.

# **HEDIS/Pay for Performance (P4P)**




# Why Should Providers Care About HEDIS?



HEDIS rates are used to:

- Guide Pay For Performance Measures
- Levy bonuses
- Support increased quality outcomes for members
- Encourage preventive care services

# P4P Overview

-  Bonus Pay for Performance (P4P) fund written into PMP contracts and dependent on product line.
-  Measures aligned with HEDIS and NCQA.
-  Annual payout.

# P4P Scorecards



## Reports updated regularly on Secure Provider Portal

- Group scorecards
- Individual scorecards
- Members in Need of Services lists





The screenshot shows the Secure Provider Portal dashboard. At the top, there is a navigation bar with links for Eligibility, Patients, Authorizations, Claims, and Messaging. Below this is a "Quick Eligibility Check" section with input fields for "Member ID or Last Name" (containing "123456789 or Smith") and "Birthdate" (containing "mm/dd/yyyy"), and a "Check Eligibility" button. To the right is a "Welcome" sidebar with a list of links: "Add a TIN to My ACCOUNT", "Reports", "Patient Analytics", and "Provider Analytics" (which is highlighted with a red box). Below the sidebar is a "Recent Activity" section with a table showing "Date" and "Activity". The main content area also features a "Recent Claims" table with columns for "STATUS", "RECEIVED DATE", "MEMBER NAME", and "CLAIM NO.", displaying several rows of data.






# **Coordinated Care Programs**




# Case Management Programs

-  MHS Case Management is made up of nurses and social workers
-  **Case Managers will:**
- Help members, doctors, and other providers, including behavioral health providers.
  - Help members obtain services covered by their Medicaid benefit package.
  - Help explain and inform members about their condition.
  - Work with provider's healthcare plan for the member.
  - Inform members about community resources.

# Right Choices Program

-  Members identified as high utilizers in need of specialized intervention are enrolled into the Right Choices Program (RCP).
-  The member is “locked-in” to their primary physician and delivery of care for specialty services is coordinated through that provider’s office.
-  RCP participants are assigned to
  - One primary medical provider (PMP)
  - One pharmacy
  - One hospital

# First Year of Life

-  This Care Management program is designed to encourage education and compliance with immunizations and well visits for babies.
-  The First Year of Life program matches a member with a Nurse Care Manager who is there to answer questions and provide helpful information sheets to let the member know what to expect as the baby grows.
-  The Nurse Care Manager will also call the member and send reminders to schedule upcoming immunizations and well-child visits with the baby's doctor as needed.

*\*By participating in the program, members will be eligible to earn more My Health Pays rewards.*

# Smoking Cessation



## The Indiana Tobacco Quitline

- 1-800-QUIT-NOW (1-800-784-8669)
- Free phone-based counseling service that helps Indiana smokers quit.
- One on one coaching for tobacco users trying to quit.
- Resources available for both providers and patients.




Counseling can be billed to MHS using CPT code 99407- U6.



Counseling must be at least 10 minutes.


# **MHS Partnership**

# Transportation



 All MHS Hoosier Healthwise (except for Package C) , Hoosier Care Connect, and Healthy Indiana Plan (HIP) members qualify for **unlimited free transportation** services provided by LCP.

 Rides will take members to and from:

- Doctor visits
- Medicaid enrollment visits
- Pharmacy visits (following a doctor's visit)
- Medicaid reenrollment visits






 Members need to call MHS Member Services at 1-877-647-4848 to schedule their ride at least three business days before their appointment.

# Transportation



-  **Managed Health Services (MHS) will process all Medicaid emergent and non-emergent ambulance claims, including air ambulance.**
-  Claims for the following services should be sent to MHS:
  - 911 transports
  - Medically necessary non-emergent hospital transports requiring an ambulance with advanced life support (ALS) or basic life support (BLS).
  - Providers have 10 business days to submit prior authorization for services.





# Translation Services

-  Available to MHS members/providers at no cost.
-  Can accommodate most languages and locations.
-  Interpretation services available in person or telephonically.
-  Please contact MHS Member Services at 1-877-647-4848 for specific information on accessing these services.
-  Spanish speaking representatives available to speak with members if needed (additional languages are available upon request).

# Culturally and Linguistic Appropriate Services (CLAS)

-  CLAS refers to healthcare services that are respectful of and responsive to the cultural and linguistic needs of patients.
-  Visit [mhsindiana.com](https://mhsindiana.com) provider guides page for a brochure about CLAS standards.




# **MHS 24/7 Nurse Advice Line**

-  The MHS Nurse Advice Line is available 24 hours a day, seven days a week to answer members' health questions.
-  The Nurse Advice line staff is bilingual in English and Spanish. Additional languages are available.



# Earn Rewards w/ Preventive Care

## MHS My Health Pays® Healthy Rewards Program

-  MHS will reward members' healthy choices through our My Health Pays® Rewards program. Members can earn dollar rewards by staying up to date on preventive care.
-  These rewards will be added to a My Health Pays® Prepaid Visa® Card.
-  Use your My Health Pays® rewards to help pay for everyday items at Walmart\*, utilities, transportation, telecommunications (cell phone bill), childcare services, education and rent.



*\*This card may not be used to buy alcohol, tobacco or firearms products. This card is issued by The Bancorp Bank pursuant to a license from Visa U.S.A. Inc. The Bancorp Bank; Member FDIC. Card cannot be used everywhere Visa debit cards are accepted. See Cardholder Agreement for complete usage restrictions. Funds expire 90 days after termination of insurance coverage or 365 days after date reward was earned, whichever comes first.*

# Ambetter from MHS

(Health Insurance Marketplace)



# Ambetter from MHS

 Statewide Coverage in 2020

 Member Open Enrollment was 11/1/19 to 12/15/19

# The Affordable Care Act




## Key Objectives of the Affordable Care Act (ACA):

- Increase access to quality health insurance
- Improve affordability

## Additional Parameters:

- Dependent coverage to age 26
- Pre-existing condition insurance plan (high risk pools)
- No lifetime maximum benefits
- Preventative care covered at 100%
- Insurer minimum loss ratio (80% for individual coverage)


# Ambetter from MHS is an HMO Benefit Plan

-  Members enrolled in Ambetter must utilize in-network participating providers except in the case of emergency services.
-  Participating providers can be identified by visiting our website and clicking on Find a Provider.
-  If an out of network provider is utilized, (except in the case of emergency services), the member will be 100% responsible for all charges.



# ID Cards

## Member ID Card:

		<b>IN NETWORK COVERAGE ONLY</b>	
<b>Subscriber:</b>	[Jane Doe]	<b>Effective Date of Coverage:</b>	[XX/XX/XX]
<b>Member:</b>	[John Doe]	<b>RXBIN:</b>	004336
<b>Policy #:</b>	[XXXXXXXXXX]	<b>RXPCN:</b>	ADV
<b>Member ID #:</b>	[XXXXXXXXXXXXXX]	<b>RXGROUP:</b>	RX5453
<b>Plan:</b>	[Ambetter Balanced Care 1]		

---

<b>COPAYS</b>	<b>PCP:</b> \$10 coin. after ded.	<b>Deductible (Med/Rx):</b>	[\$250/\$500]
	<b>Specialist:</b> \$25 coin. after ded.	<b>Coinsurance (Med/Rx):</b>	[50%/30%]
	<b>Rx (Generic/Brand):</b> \$5/\$25 after Rx ded.		
	<b>Urgent Care:</b> 20% coin. after ded.		
	<b>ER:</b> \$250 copay after ded.		

### Ambetter.mhsindiana.com

#### Member/Provider Services:

1-877-687-1182

TTY/TDD: 1-800-743-3333

24/7 Nurse Line: 1-877-687-1182

#### Numbers below for providers:

Pharmacy Help Desk: 1-866-270-3922

EDI Payor ID: 68069

EDI Help Desk: Ambetter.mhsindiana.com

#### Medical Claims:

Managed Health Services

Attn: CLAIMS

PO Box 5010

Farmington, MO

63640-5010

Additional information can be found in your Evidence of Coverage. If you have an Emergency, call 911 or go to the nearest Emergency Room (ER). Emergency services given by a provider not in the plan's network will be covered without prior authorization. Receiving non-emergent care through the ER or with a non-participating provider may result in a change to member responsibility. For updated coverage information, visit Ambetter.mhsindiana.com.

AMBT7-IN-C-00036

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**\* Possession of an ID Card is not a guarantee of eligibility and benefits**



# Verification of Eligibility, Benefits and Cost Share

You may see the names **Celtic Insurance Company** or **Coordinated Care** in relation to your Ambetter patients, or our parent company, *Centene Corporation*. You can always confirm patient eligibility through the Secure Provider Portal at [provider.mhsindiana.com](http://provider.mhsindiana.com).

## Member ID Card:



### IN NETWORK COVERAGE ONLY

**Subscriber:** [Jane Doe]  
**Member:** [John Doe]  
**Policy #:** [XXXXXXXXXX]  
**Member ID #:** [XXXXXXXXXXXXXX]  
**Plan:** [Ambetter Balanced Care 1]

**Effective Date of Coverage:** [XX/XX/XX]  
**RXBIN:** 004336  
**RXPCN:** ADV  
**RXGROUP:** RX5453

**COPAYS** **PCP:** \$10 coin. after ded.  
**Specialist:** \$25 coin. after ded.  
**Rx (Generic/Brand):** \$5/\$25 after Rx ded.  
**Urgent Care:** 20% coin. after ded.  
**ER:** \$250 copay after ded.

**Deductible (Med/Rx):**  
[\$250/\$500]  
**Coinsurance (Med/Rx):**  
[50%/30%]

### Ambetter.mhsindiana.com

#### Member/Provider Services:

1-877-687-1182

TTY/TDD: 1-800-743-3333

24/7 Nurse Line: 1-877-687-1182

#### Numbers below for providers:

Pharmacy Help Desk: 1-866-270-3922

EDI Payor ID: 68069

EDI Help Desk: [Ambetter.mhsindiana.com](http://Ambetter.mhsindiana.com)

#### Medical Claims:

Managed Health Services

Attn: CLAIMS

PO Box 5010

Farmington, MO

63640-5010

Additional information can be found in your Evidence of Coverage. If you have an Emergency, call 911 or go to the nearest Emergency Room (ER). Emergency services given by a provider not in the plan's network will be covered without prior authorization. Receiving non-emergent care through the ER or with a non-participating provider may result in a change to member responsibility. For updated coverage information, visit [Ambetter.mhsindiana.com](http://Ambetter.mhsindiana.com).

AMB17-IN-C-00036

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**\* Possession of an ID Card is not a guarantee of eligibility and benefits**

# Verification of Eligibility, Benefits and Cost Share



## Providers should always verify member eligibility:

- Every time a member schedules an appointment.
- When the member arrives for the appointment.



## Eligibility, Benefits and Cost Shares can be verified in 3 ways:

- **The Ambetter Secure Provider Portal found at: [ambetter.mhsindiana.com](https://ambetter.mhsindiana.com)**
  - If you are already a registered user of the MHS secure portal, you do NOT need a separate registration.
- **24/7 Interactive Voice Response system**
  - Enter the Member ID Number and the month of service to check eligibility.
- **Contact Provider Services at: 1-877-687-1182**



## Panel Status






- PCPs should confirm that a member is assigned to their patient panel.
- This can be done via our Secure Provider Portal.
- PCPs can still administer services if the member is not assigned and may wish to have member assigned to them for future care.

# My Health Pays<sup>®</sup> Program

Members can earn up to **\$125** that will be loaded onto their My Health Pays Visa<sup>®</sup> and can be used for eligible expenses.



## Here's how it works:

-  Complete the Wellbeing Survey (**\$50**)
-  Get an annual wellness exam (**\$50**)
-  Get an annual flu shot in the fall (**\$25**)
-  Card must be activated online and benefits are effectuated with the plan effective date.
-  Cards are mailed to the member automatically when the first reward is earned.

# Utilization Management

# Prior Authorization

**Prior Authorization can be requested in 3 ways:**

- 1. The Ambetter Secure Provider Portal found at [ambetter.mhsindiana.com](https://ambetter.mhsindiana.com)**
  - If you are already a registered user of the MHS portal, you do NOT need a separate registration!
- 2. Fax Requests to: 1-855-702-7337**
  - The Fax authorization forms are located on our website at [ambetter.mhsindiana.com](https://ambetter.mhsindiana.com)
- 3. Call for Prior Authorization at 1-877-687-1182**

# Prior Authorization

## Procedures / Services

- Potentially Cosmetic
- Experimental or Investigational
- High Tech Imaging (i.e., CT, MRI, PET)
- Infertility
- Obstetrical Ultrasound
  - One allowed in 9 month period, any additional will require prior authorization except those rendered by perinatologists.
  - For urgent/emergent ultrasounds, treat using best clinical judgment and this will be reviewed retrospectively.
- Pain Management

# Prior Authorization

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 admission date
Emergent inpatient admissions	Notification within one business day
Observation – 23 hours or less	Notification within one business day for non-participating providers
Observation – greater than 23 hours	Requires inpatient prior authorization within one business day
Emergency room and post stabilization, urgent care and crisis intervention	Notification 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

***\* This is not meant to be an all-inclusive list***



# Utilization Determination Timeframes

Type	Timeframe
Prospective/Urgent	One (1) Business day
Prospective/Non-Urgent	Two (2) Business days
Emergency services	60 minutes
Concurrent/Urgent	Twenty-four (24) hours (1 calendar day)
Retrospective	Thirty (30) calendar days

***\* This is not meant to be an all-inclusive list***

# Claims

# Claim Submission

The timely filing deadline for initial claims is 180 days from the date of service or date of primary payment when Ambetter is secondary.

## Claims may be submitted in 3 ways:

1. The Secure provider Portal located at [ambetter.mhsindiana.com](https://ambetter.mhsindiana.com)
2. Electronic Clearinghouse
  - Payor ID 68069
  - Clearinghouses currently utilized by [ambetter.mhsindiana.com](https://ambetter.mhsindiana.com) will continue to be utilized
  - For a listing of the Clearinghouses, please visit our website at [ambetter.mhsindiana.com](https://ambetter.mhsindiana.com)
3. Paper claims may be submitted to PO Box 5010 Farmington, MO 64640-5010

# Claim Submission

## Claim Reconsiderations






- A written request from a provider about a disagreement in the manner in which a claim was processed. No specific form is required.
- Must be submitted within 180 days of the Explanation of Payment
- Claim Reconsiderations may be mailed to PO Box 5010, Farmington, MO 63640-5010.

## Claim Disputes

- Must be submitted within 180 days of the Explanation of Payment.
- A Claim Dispute form can be found on our website at [ambetter.mhsindiana.com](http://ambetter.mhsindiana.com).
- The completed Claim Dispute form may be mailed to PO Box 5000, Farmington, MO 63640-5000.

# Claim Submission

## Member in Suspended Status

-  A provision of the ACA allows members who are receiving Advanced Premium Tax Credits (APTCs) a 3 month grace period for paying claims.
-  After the first 30 days, the member is placed in a suspended status. The Explanation of Payment will indicate LZ Pend: Non-Payment of Premium.
-  While the member is in a suspended status, claims will be pended.
-  When the premium is paid by the member, the claims will be released and adjudicated.
-  If the member does not pay the premium, the claims will be released and the provider may bill the member directly for services.

# Claim Submission

## Rendering Taxonomy Code

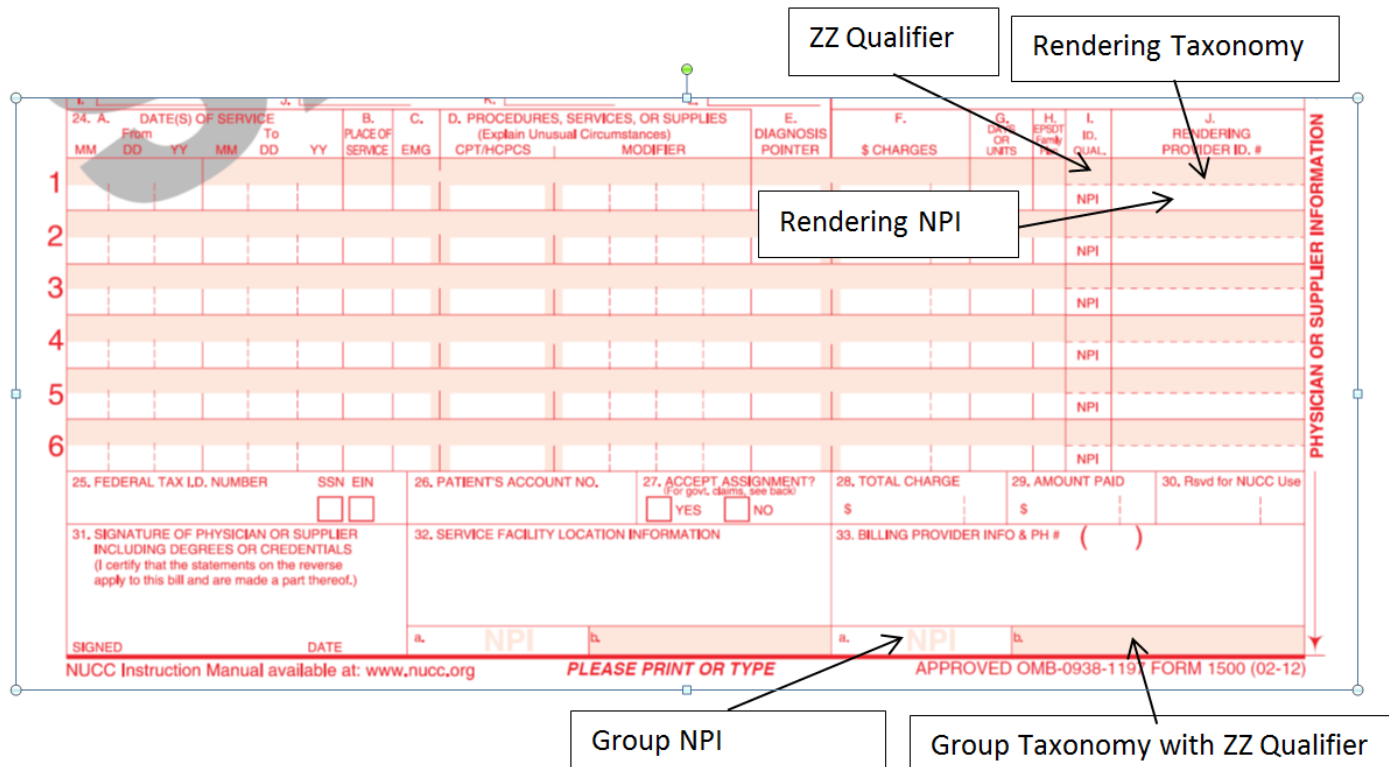
- Claims must be submitted with the rendering provider's taxonomy code.
- The claim will deny if the taxonomy code is not present.
- This is necessary in order to accurately adjudicate the claim.

## CLIA Number

- If the claim contains CLIA certified or CLIA waived services, the CLIA number must be entered in Box 23 of a paper claim form or in the appropriate loop for EDI claims.
- Claims will be rejected if the CLIA number is not on the claim.

# Taxonomy Code

## Example of Taxonomy Code – CMS 1500



The diagram illustrates the CMS 1500 form with annotations for Taxonomy Code and NPI. The form is divided into several sections:

- Physician or Supplier Information:** This section includes fields for the provider's name, address, and contact information. It also includes a field for the provider's NPI (National Provider Identifier).
- Rendering Taxonomy:** This field is located in the top right corner of the form, next to the provider's name. It is used to specify the taxonomy code for the service provided.
- ZZ Qualifier:** This is a specific annotation pointing to the 'Rendering Taxonomy' field, indicating that the code is a 'ZZ' qualifier.
- Rendering NPI:** This annotation points to the 'NPI' field in the 'Physician or Supplier Information' section, indicating that the NPI is the 'Rendering NPI'.
- Group NPI:** This annotation points to the 'NPI' field in the 'Billing Provider Info & PH #' section, indicating that the NPI is the 'Group NPI'.
- Group Taxonomy with ZZ Qualifier:** This annotation points to the 'Rendering Taxonomy' field, indicating that the code is a 'ZZ' qualifier.

The form includes the following fields and sections:

- 24. A. DATE(S) OF SERVICE:** Fields for From (MM, DD, YY) and To (MM, DD, YY).
- B. PLACE OF SERVICE:** Field for the place of service.
- C. EMG:** Field for emergency services.
- D. PROCEDURES, SERVICES, OR SUPPLIES:** Fields for CPT/HCPCS and MODIFIER.
- E. DIAGNOSIS POINTER:** Field for the diagnosis pointer.
- F. \$ CHARGES:** Field for the total charge.
- G. OR UNITS:** Field for the number of units.
- H. EPSDT:** Field for EPSDT status.
- I. ID. QUAL.:** Field for the provider's ID number.
- J. RENDERING PROVIDER ID. #:** Field for the rendering provider's ID number.
- 25. FEDERAL TAX ID. NUMBER:** Fields for SSN and EIN.
- 26. PATIENT'S ACCOUNT NO.:** Field for the patient's account number.
- 27. ACCEPT ASSIGNMENT?** Fields for YES and NO.
- 28. TOTAL CHARGE:** Field for the total charge.
- 29. AMOUNT PAID:** Field for the amount paid.
- 30. Rsvd for NUCC Use:** Field reserved for NUCC use.
- 31. SIGNATURE OF PHYSICIAN OR SUPPLIER:** Field for the provider's signature.
- 32. SERVICE FACILITY LOCATION INFORMATION:** Field for the service facility location.
- 33. BILLING PROVIDER INFO & PH #:** Field for the billing provider's information.

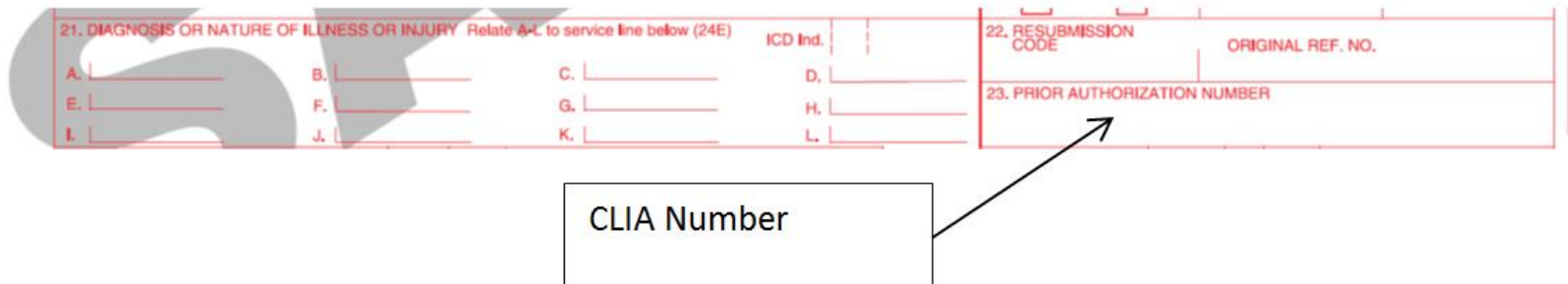
The form also includes the following text:

- NUCC Instruction Manual available at: [www.nucc.org](http://www.nucc.org)
- PLEASE PRINT OR TYPE
- APPROVED OMB-0938-1191 FORM 1500 (02-12)

# CLIA Number

 CLIA Number is required on CMS 1500 Submissions in Box 23.

 CLIA Number is not required on UB04 Submissions.



The diagram shows a portion of a CMS 1500 form. Box 21, 'DIAGNOSIS OR NATURE OF ILLNESS OR INJURY', is divided into four columns (A, B, C, D) and four rows (A, E, I, J). Box 22, 'RESUBMISSION CODE', and Box 23, 'PRIOR AUTHORIZATION NUMBER', are located to the right of Box 21. An arrow points from a box labeled 'CLIA Number' to Box 23.

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)				ICD Ind.	22. RESUBMISSION CODE	ORIGINAL REF. NO.
A. _____	B. _____	C. _____	D. _____			
E. _____	F. _____	G. _____	H. _____			
I. _____	J. _____	K. _____	L. _____			
					23. PRIOR AUTHORIZATION NUMBER	



# Claim Submission

## Billing the Member

- Copays, coinsurance and any unpaid portion of the deductible may be collected at the time of service.
- The Secure Provider Portal will indicate the amount of the deductible that has been met.
- If the amount collected from the member is higher than the actual amount owed upon claim adjudication, the provider must reimburse the member within 45 days.

# Allwell from MHS

(Medicare Advantage)



# Allwell from MHS (Medicare Advantage)



Coverage in 2020



Member Open Enrollment  
was 10/15/19 to 12/7/19




FROM |  mhs.

2020 Coverage Map

2020 Counties




# Overview: Medicare Advantage Plans

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

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



 Approach to care management facilitates the integration of:



- Community resources
- Health education
- Disease management

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

- RNs
- Social Workers
- Pharmacy Technicians
- Behavioral Health Case Managers



# Member ID Cards

	
<div style="border: 1px solid orange; border-radius: 50%; padding: 2px; display: inline-block;">HMO</div>	
CMS#: XXXXX-XXX Effective: <mm/dd/yyyy>	
<b>MEMBER INFORMATION</b> Name: <First Last> Member ID#: <XXXXXXXXXX-XX> Issuer ID: <(80840)> <9151014609>	<b>PHARMACY INFORMATION</b> 
<b>PROVIDER INFORMATION</b> PCP Name: < > PCP Phone: < >	<b>RX Claims Processor:</b> <CVS Caremark®> RXBIN: <004336> RXPCN: <MEDDADV> RXGRP: <RX8910>

	
<div style="border: 1px solid orange; border-radius: 50%; padding: 2px; display: inline-block;">PPO</div>	
CMS#: XXXXX-XXX Effective: <mm/dd/yyyy>	
<b>MEMBER INFORMATION</b> Name: <First Last> Member ID#: <XXXXXXXXXX-XX> Issuer ID: <(80840)> <9151014609>	<b>PHARMACY INFORMATION</b> 
<b>PROVIDER INFORMATION</b> PCP Name: < > PCP Phone: < >	<b>RX Claims Processor:</b> <CVS Caremark®> RXBIN: <004336> RXPCN: <MEDDADV> RXGRP: <RX8911>

# **Prior Authorization**

# Utilization Management

-  Authorization must be obtained prior to the delivery of certain elective and scheduled services.
-  The preferred method for submitting authorization requests is through the Secure Provider Portal at: [provider.mhsindiana.com](https://provider.mhsindiana.com).

Service Type	Time Frame
Elective/scheduled admissions	Required five business days prior to the scheduled admit date
Emergent inpatient admissions	Notification required within one business day
Emergency room and post stabilization	Notification requested within one business day

# Prior Authorizations


 Prior authorization is required for services such as:

- Inpatient admissions, including observation
- Home health services
- Ancillary services
- Radiology – MRI, MRA, PET, CT
- Pain management programs
- Outpatient therapy and rehab (OT/PT/ST)
- Transplants
- Surgeries
- Durable Medical Equipment (DME)
- Part B drugs

 Use the Pre-Auth Needed Tool at [allwell.mhsindiana.com](https://allwell.mhsindiana.com) to check all services.








# Out-of-Network Coverage

 Plan authorization is required for out-of-network services, except:



- Emergency care
- Urgently needed care when the network provider is not available (usually due to out-of-area)
- Kidney dialysis at Medicare-certified dialysis center when temporarily out of the service area

# Medical Necessity Determination

-  When medical necessity cannot be established, a peer to peer conversation is offered.
-  Denial letters will be sent to the member and provider.
-  The clinical basis for the denial will be indicated.
-  Medical Necessity Appeals must be initiated within 30 days of the denial to be considered. Please note, this is different than a claim appeal request.
-  Member appeal rights will be fully explained.

# Billing Overview

# Electronic Claims Transmission

-  Six clearinghouses for Electronic Data Interchange (EDI) submission.
-  Faster processing turn around time than paper submission.
  - Emdeon – Payer ID 68069
  - Gateway
  - Availity/THIN
  - SSI
  - Medavant
  - Smart Data Solution


# Claims Filing Timelines

 Medicare Advantage Claims are to be mailed to the following billing address:

**Allwell from MHS**



P.O. Box 3060

Farmington, MO 63640-3822

 Participating providers have **180 days** from the date of service to submit a timely claim.

 All requests for reconsideration or claim disputes must be received within **180 days** from the original date of notification of payment or denial.

# Claims Reconsideration & Disputes

-  A claim dispute is to be used only when a provider has received an unsatisfactory response to a request for reconsideration.
-  Submit reconsiderations or disputes to:  
**Allwell from MHS**  
Attn: Reconsiderations  
P. O. Box 4000  
Farmington, MO 63640-4000

# MHS Website

# MHS Website



[mhsindiana.com](https://mhsindiana.com)



Provides access to Medicaid, Ambetter and Allwell



Provider directory search functionality



Pre-Auth Needed tool



Payspan / EFT information

- Convenient payments
- One year retrieval of remittance information
- No cost to providers



Printable current forms, guides and manuals

- Update billing information form
- Denial and Rejection code listings
- QRG-Quick Reference Guide



Patient education material


















- KRAMES online services – MHS members have 24 hour a day access to info sheets about more than 4,000 topics relating to health and medication via MHS website. Most information is available in multiple languages including both English and Spanish: [mhsindiana.kramesonline.com](https://mhsindiana.kramesonline.com)



Contact Us feature



# MHS Secure Provider Portal Features

-  Access for Medicaid, Ambetter and Allwell
-  Online registration – multiple users
-  Manage multiple practices and line of business under one account
-  Check member eligibility
-  View panels and membership information
-  View members RX and medical history
-  Access Gaps in Care
-  Access Quality Reports including Pay For Performance
-  Direct claim submission
-  Enhanced claim detail
-  COB processing with or without attachments
-  Claim adjustment
-  Claim auditing tool
-  Eligibility and COB verification
-  Prior authorization
-  Online Health Record Vault for “your” patients (includes specialty care)
-  Care Management Plan

# Secure Web Portal Login or Registration

 Login/Register is the same for **MHS**, **Ambetter from MHS**, **Allwell from MHS** and **Behavioral Health Providers**.



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 +

Behavioral Health +

Provider Resources +

QI Program +

Provider News

## Portal Login

Login/Register

[Click here for additional information and step by step guides.](#)

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/register button. A new window will open. You can login or register for a new account.

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.

# **COVID-19 Updates**

## **(Applicable during “Health Emergency” )**












# Timely Filing Update

 Reference BT 202036

 Extended timely filing limit on Medicaid claims to **180 calendar days**

 Effective for DOS on or after March 1, 2020, and through the duration of the public health emergency for COVID-19

# COVID-19

-  Testing: MHS will accept the new HCPCS codes below beginning 4/1/2020 for dates of service 2/4/20 onward.
-  HCPCS code (U0001) Providers using the Centers for Disease Control and Prevention (CDC) 2019 Novel Coronavirus Real Time RT-PCR Diagnostic Test Panel
-  HCPCS code (U0002) allows laboratories to bill for non-CDC laboratory tests for SARS-CoV-2/2019-nCoV (COVID-19).
-  Screening: CDC has provided guidance that providers should use the following ICD- 10 codes until the COVID-19 specific ICD-10 is available after 10/1/2020
  -  B97.29 – Confirmed Cases: Other coronavirus as the cause of diseases classified elsewhere
  -  B34.2 – Coronavirus infection, unspecified
  -  Z20.828 – Contact with and (suspected) exposure to other viral communicable diseases
  -  Z03.818 – Exposure to COVID-19 and the virus is ruled out after imminent, life-threatening condition
-  Rate Adjustment Projects will occur once rates are loaded for dates of service 2/4/20 and onward
-  Ambetter and Ambetter will honor \$0 cost share for COVID-19 Testing and Screening
-  MHS will ensure there are no authorizations for these services to ensure our members receive the care needed

# Telehealth


 Medicaid-please reference BT202022


 <http://provider.indianamedicaid.com/ihcp/Bulletins/BT202034.pdf>

 Ambetter





 Continuation of zero member liability (copays, cost sharing, etc.) for care delivered via telehealth

 Any services that can be delivered virtually will be eligible for telehealth coverage

 All prior authorization requirements for telehealth services will be lifted for dates of service from March 17, 2020 through June 30, 2020

 Telehealth services may be delivered by providers with any connection technology to ensure patient access to care

# Sub Acute/Acute Authorization updates

-  Medicaid Acute Inpatient Authorizations-please reference [BT202030](#)
-  Sub Acute Update-MHS specific Medicaid products only
  -  SNF/subacute admissions will be “notification only”.
  -  MHS will be approving 7 days without need for review (providers will need to submit the notification).







# DME/HME Prior Authorization

 Effective 4/1/20 Respirator Services waiving PA

 Medicaid see reference [BT202031](#)




# Online Claim Reconsiderations


-  4/3/20 Providers can submit online claim reconsiderations for all MHS products using the MHS online Provider Portal
-  MHS online Portal Enhancements include;
  -  Payment Code Description
  -  Filter Functionality
  -  Submit Reconsiderations
  -  Claims payment detail

# Peer to Peer/Medical Necessity

 Providers are encouraged to submit requests via electronic modes






 Auth request via web portal or fax

 Peer to Peer requests can be submitted via email: [Indy\\_Peer\\_to\\_Peer@mhsindiana.com](mailto:Indy_Peer_to_Peer@mhsindiana.com) (there are underscores after Indy\_Peer\_to\_Peer).

 Medical Necessity Appeals should be sent via email to [appeals@mhsindiana.com](mailto:appeals@mhsindiana.com) vs mail



# Allwell COVID-19 Updates

## 7/1/20

-  \$0 Member Liability Extension (specific details apply)
-  Extended Meal Benefits (additional 14 meals for qualifying members)
-  Increased Annual Wellness Visit Incentives
-  Additional Over-The-Counter (OTC) Benefits
-  Access to WellCare's Community Connections Help Line 1-866-775-2192

# **MHS Network Team**

# Provider Relations

-  Each provider will have an **MHS Provider Partnership Associate** assigned to them.
-  This team serves as the primary liaison between the Plan and our provider network and is responsible for:
  - Provider Education
  - HEDIS/Care Gap Reviews
  - Assist Providers with EHR Utilization
  - Initiate credentialing of a new practitioner
  - Facilitate inquiries related to administrative policies, procedures, and operational issues
  - Monitor performance patterns
  - Contract clarification
  - Membership/Provider roster
  - Assist in Secure Provider Portal registration and Payspan

## MHS Provider Network Territories

### Indiana

#### NORTHEAST REGION

**For claims issues, email:**  
MHS\_ProviderRelations\_NE@mhsindiana.com  
Chad Pratt, Provider Partnership Associate  
1-877-647-4848, ext. 20454

#### NORTHWEST REGION

**For claims issues, email:**  
MHS\_ProviderRelations\_NW@mhsindiana.com  
Candace Ervin, Provider Partnership Associate  
1-877-647-4848, ext. 20187

#### NORTH CENTRAL REGION

**For claims issues, email:**  
MHS\_ProviderRelations\_NC@mhsindiana.com  
Natalie Smith, Provider Partnership Associate  
1-877-647-4848, ext. 20127

#### CENTRAL REGION

**For claims issues, email:**  
MHS\_ProviderRelations\_C@mhsindiana.com  
Mona Green, Provider Partnership Associate  
1-877-647-4848, ext. 20800

#### SOUTH CENTRAL REGION

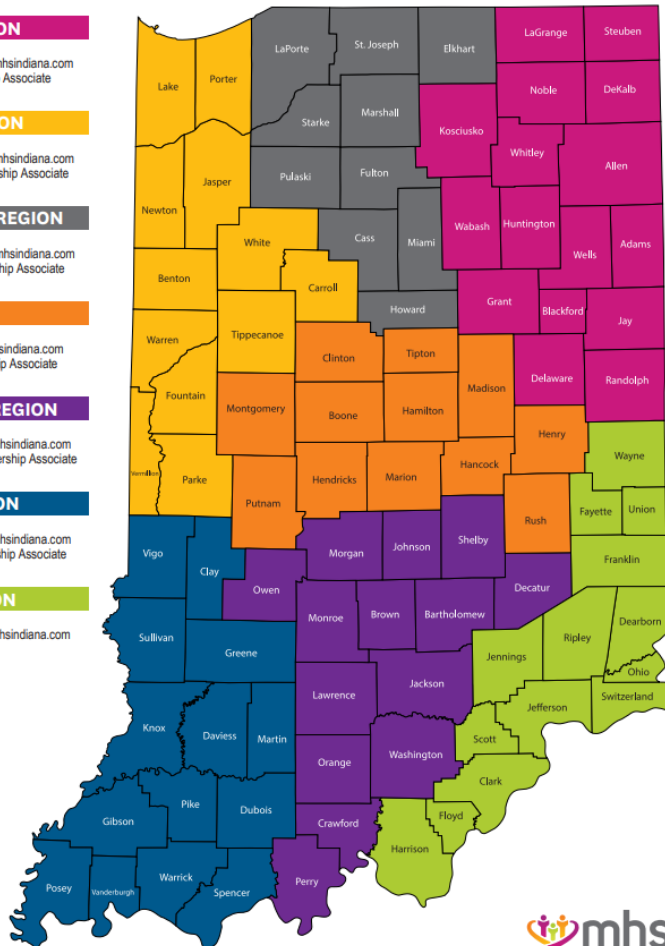
**For claims issues, email:**  
MHS\_ProviderRelations\_SC@mhsindiana.com  
Dalesia Denning, Provider Partnership Associate  
1-877-647-4848, ext. 20026

#### SOUTHWEST REGION

**For claims issues, email:**  
MHS\_ProviderRelations\_SW@mhsindiana.com  
Dawn McCarty, Provider Partnership Associate  
1-877-647-4848, ext. 20117

#### SOUTHEAST REGION

**For claims issues, email:**  
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1-877-647-4848, ext. 20114



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**Available online:**

[https://www.mhsindiana.com/content/dam/centene/mhsindiana/medicaid/pdfs/ProviderTerritory\\_map\\_2020.pdf](https://www.mhsindiana.com/content/dam/centene/mhsindiana/medicaid/pdfs/ProviderTerritory_map_2020.pdf)

## MHS Provider Network Territories

### TAWANNA DANZIE

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

### PROVIDER GROUPS

Beacon Medical Group  
Franciscan Alliance  
HealthLinc  
Heart City Health Center  
Indiana Health Centers  
Lutheran Medical Group  
Parkview Health System  
South Bend Clinic

### JENNIFER GARNER

Provider Partnership Associate II  
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jgarner@mhsindiana.com

### PROVIDER GROUPS

American Health Network of Indiana  
Columbus Regional Health  
Community Physicians of Indiana  
HealthNet  
Health & Hospital Corporation of  
Marion County  
Indiana University Health  
St. Vincent Medical Group

### NETWORK LEADERSHIP

#### JILL CLAYPOOL

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#### MARK VONDERHEIT

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### NEW PROVIDER CONTRACTING

#### TIM BALKO

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#### MICHAEL FUNK

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### NETWORK OPERATIONS

#### KELVIN ORR

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### ENVOLVE DENTAL, INC.

#### MICHAEL J. WILLIAMS

Provider Relations Specialist  
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Michael.Williams@EnvolveHealth.com

## Back of Map

### Available online:

[https://www.mhsindiana.com/content/dam/centene/mhsindiana/medical/pdfs/ProviderTerritory\\_map\\_2020.pdf](https://www.mhsindiana.com/content/dam/centene/mhsindiana/medical/pdfs/ProviderTerritory_map_2020.pdf)

# **Questions and Answers**