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 HEALTH PLANS

HOOSIER HEALTHWISE
Children, pregnant women and low-income families

HEALTHY INDIANA PLAN (HIP)
Low-income adults aged 19-64

MEDICARE HEALTH PLANS

AMBETTER ESSENTIAL CARE (BRONZE)
AMBETTER BALANCED CARE (SILVER)
AMBETTER SECURE CARE (GOLD)

MARKETPLACE HEALTH PLANS

ADVANTAGE HMO
ADVANTAGE PPO
HMO DSNP
Medicaid
MHS Medicaid ID Cards

*Used for both HIP and HIP Maternity

Member Name:
Member RID:
RXBIN: 004336
RXPCN: MCAIDADV
RXGROUP: RX5440

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MHS Healthwise

Member Name:
Member RID:
RXBIN: 004336
RXPCN: MCAIDADV
RXGROUP: RX5440

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Hoosier Care Connect

Member Name:
Member RID:
RXBIN: 004336
RXPCN: MCAIDADV
RXGROUP: RX5440

*Member Copays:
Transportation: $1 one-way/$2 round trip
Prescriptions: $0 per prescription
Non-emergent Emergency Room: $3

Copy Exceptions include:
Members who are pregnant, Native American, under 18 years old, or have met their lifetime. Other exceptions include medications for family planning and transportation to educational events or Member Advisory Council meetings.
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
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.*

<table>
<thead>
<tr>
<th>Service</th>
<th>HIP Basic Co-Pay Amounts &lt;=100% FPL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient Services</td>
<td>$4</td>
</tr>
<tr>
<td>Inpatient Services</td>
<td>$75</td>
</tr>
<tr>
<td>Preferred Drugs</td>
<td>$4</td>
</tr>
<tr>
<td>Non-preferred drugs</td>
<td>$8</td>
</tr>
<tr>
<td>Non-emergency ER visit</td>
<td>$8</td>
</tr>
</tbody>
</table>
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](http://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; 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

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
Informal Claims Dispute or Objection Form

Step 1:

🎉 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).
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
  • Use the Messaging Tool.
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.
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:
  o Valid timely filing denials;
  o 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.

Arbitration

Step 3:

 água Step 3 is a continuation of Steps 1 & 2 and is a part of the formal MHS Provider Claims dispute process.

 água 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.

 água 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.

 água Arbitration Requests need to be mailed to, MHS Arbitration, 550 N. Meridian Street, Suite 101, Indianapolis, IN 46204, unless otherwise directed in the letter.

Need to Know – EFTs and ERAs

Payspan Health

 предлагает веб-решение для электронных переводов средств (EFTs) и электронных уведомлений об оплате (ERAs). Один год хранения уведомлений об оплате.

Еще одним преимуществом является то, что данная услуга предоставляется без дополнительной платы для поставщиков и позволяет проводить онлайн-регистрацию.

Зарегистрируйтесь на payspanhealth.com

Для вопросов обращайтесь по телефону 1-877-331-7154 или по электронной почте providersupport@payspanhealth.com.
VFC and Notice of Pregnancy Updates
Vaccines for Children (VFC)

授權所有年齡未滿19歲的成員可享用VFC計畫分發的疫苗。

- 自VFC疫苗對提供者而言是無費用，因此允許對疫苗注射進行報酬。
- 有效日期為2020年1月1日，IHCP的注射費為15美元，並可於最低承擔費用或IHCP費用中選擇報酬。
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.
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.
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.

When using the portal, supporting documentation can be uploaded directly.

- Authorization status can also be checked on the portal.
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 Enolve Vision.
Dental services need to be verified by Enolve 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

<table>
<thead>
<tr>
<th>Types of Services</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is the member being admitted to an inpatient facility?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are services, other than DME, orthotics, prosthetics, and supplies, being rendered in the home?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are anesthesia services being rendered for pain management?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are services for infertility?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Types of Services

<table>
<thead>
<tr>
<th>Service Description</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
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<td></td>
</tr>
<tr>
<td>Are services for infertility?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is the member receiving dialysis?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

99394

**99394 - PREV VISIT EST AGE 12-17**

No Pre-authorization required for all providers.

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

👩‍⚕️ 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. 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, 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:

有效的12/15/2018 MHS已经实施了印第安纳州健康保险计划的心理健康和成瘾症限制政策，对以下CPT代码进行限制，结合在一起，每个成员，每个提供者，每个递归12个月期限制20单位：

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>90832 - 90834</td>
<td>Individual Psychotherapy</td>
</tr>
<tr>
<td>90837 - 90840</td>
<td>Psychotherapy, with patient and/or family member &amp; Crisis Psychotherapy</td>
</tr>
<tr>
<td>90845 and 90853</td>
<td>Psychoanalysis &amp; Family/Group Psychotherapy with or without patient</td>
</tr>
</tbody>
</table>
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/HCPCS 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
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

Report updated regularly on Secure Provider Portal

- Group scorecards
- Individual scorecards
- Members in Need of Services lists
Coordinated Care Programs
**Case Management Programs**

ホールド 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.
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

挂号

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 provider guides page for a brochure about CLAS standards.
MHS 24/7 Nurse Advice Line

HDR The MHS Nurse Advice Line is available 24 hours a day, seven days a week to answer members’ health questions.

HDR 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

 предлагает вознаграждение за здоровые выборы через свою программу My Health Pays® Rewards. Члены могут заработать долларовые вознаграждения, оставаясь в курсе профилактической медицинской помощи.

Эти вознаграждения будут добавлены к My Health Pays® Prepaid Visa® Card.

Используйте свои My Health Pays® rewards, чтобы помочь платить за повседневные товары в Walmart*, услуги, транспортировку, связь (например, счет за мобильную связь), услуги дошкольного образования, образование и аренду.

*Этот карт à ne peut pas être utilisé pour acheter alcool, tabac ou produits d’armes à feu. Cette carte est émise par The Bancorp Bank sous licence de 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:

Subscriber: [Jane Doe]
Member: [John Doe]
Policy #: [XXXXXXXX]
Member ID #: [XXXXXXXXXXXXX]
Plan: [Ambetter Balanced Care 1]

IN NETWORK
COVERAGE ONLY

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

COPAY:
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%]

* 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.

**Member ID Card:**

*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
  - 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® Program

Members can earn up to $125 that will be loaded onto their My Health Pays Visa® 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
   • 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

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

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scheduled admissions</td>
<td>Prior Authorization required five business days prior to the scheduled admission date</td>
</tr>
<tr>
<td>Elective outpatient services</td>
<td>Prior Authorization required five business days prior to the elective outpatient admission date</td>
</tr>
<tr>
<td>Emergent inpatient admissions</td>
<td>Notification within one business day</td>
</tr>
<tr>
<td>Observation – 23 hours or less</td>
<td>Notification within one business day for non-participating providers</td>
</tr>
<tr>
<td>Observation – greater than 23 hours</td>
<td>Requires inpatient prior authorization within one business day</td>
</tr>
<tr>
<td>Emergency room and post stabilization, urgent care and crisis intervention</td>
<td>Notification within one business day</td>
</tr>
<tr>
<td>Maternity admissions</td>
<td>Notification within one business day</td>
</tr>
<tr>
<td>Newborn admissions</td>
<td>Notification within one business day</td>
</tr>
<tr>
<td>Neonatal Intensive Care Unit (NICU) admissions</td>
<td>Notification within one business day</td>
</tr>
<tr>
<td>Outpatient Dialysis</td>
<td>Notification within one business day</td>
</tr>
</tbody>
</table>

*This is not meant to be an all-inclusive list*
# Utilization Determination Timeframes

<table>
<thead>
<tr>
<th>Type</th>
<th>Timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prospective/Urgent</td>
<td>One (1) Business day</td>
</tr>
<tr>
<td>Prospective/Non-Urgent</td>
<td>Two (2) Business days</td>
</tr>
<tr>
<td>Emergency services</td>
<td>60 minutes</td>
</tr>
<tr>
<td>Concurrent/Urgent</td>
<td>Twenty-four (24) hours (1 calendar day)</td>
</tr>
<tr>
<td>Retrospective</td>
<td>Thirty (30) calendar days</td>
</tr>
</tbody>
</table>

*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
2. Electronic Clearinghouse
   • Payor ID 68069
   • Clearinghouses currently utilized by ambetter.mhsindiana.com will continue to be utilized
   • For a listing of the Clearinghouses, please visit our website at 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.
- The completed Claim Dispute form may be mailed to PO Box 5000, Farmington, MO 63640-5000.
Claim Submission

Member in Suspended Status

[](https://example.com) 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

- ZZ Qualifier
- Rendering Taxonomy
- Rendering NPI
- Group NPI
- Group Taxonomy with ZZ Qualifier
**CLIA Number**

- CLIA Number is required on CMS 1500 Submissions in Box 23.
- CLIA Number is not required on UB04 Submissions.
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
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

**HMO**
- CMS#: XXXXX-XX
- Effective: <mm/dd/yyyy>
- Member ID#: <XXXXX-XX>
- Issuer ID: <(808-40)> <9151014603>

**Pharmacy Information**
- Rx Claims Processor: <CVS Caremark®>
- RXBIN: <004336>
- RXPCN: <MEDDADV>
- RXGRP: <RX81910>

**Provider Information**
- PCP Name: < >
- PCP Phone: < >

**PPO**
- CMS#: XXXXX-XX
- Effective: <mm/dd/yyyy>
- Member ID#: <XXXXX-XX>
- Issuer ID: <(808-40)> <9151014603>

**Pharmacy Information**
- Rx Claims Processor: <CVS Caremark®>
- RXBIN: <004336>
- RXPCN: <MEDDADV>
- RXGRP: <RX81910>

**Provider Information**
- PCP Name: < >
- PCP Phone: < >
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.

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Time Frame</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elective/scheduled admissions</td>
<td>Required five business days prior to the scheduled admit date</td>
</tr>
<tr>
<td>Emergent inpatient admissions</td>
<td>Notification required within one business day</td>
</tr>
<tr>
<td>Emergency room and post stabilization</td>
<td>Notification requested within one business day</td>
</tr>
</tbody>
</table>
Prior Authorizations

 גרוע 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

גרוע Use the Pre-Auth Needed Tool at 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

 الدراسي 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

- 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
- 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.
COVID-19 Updates
(Applicable during “Health Emergency” )
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

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
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 (there are underscores after Indy_Peer_to_Peer).
- Medical Necessity Appeals should be sent via email to appeals@mhsindiana.com vs mail
$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

Available online:
https://www.mhsindiana.com/content/dam/centene/mhsindiana/medicaid/pdfs/ProviderTerritory_map_2020.pdf
## MHS Provider Network Territories

### PROVIDER GROUPS

**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  
1-877-647-4848 ext. 20149  
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

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### NETWORK LEADERSHIP

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

**NANCY ROBINSON**  
Senior Director, Provider Network  
1-877-647-4848 ext. 20180  
nrobinson@mhsindiana.com

**MARK VONDERHEIT**  
Director, Provider Network  
1-877-647-4848 Ext. 20240  
mvonderheitt@mhsindiana.com

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### NEW PROVIDER CONTRACTING

**TIM BALKO**  
Director, Network Development & Contracting  
1-877-647-4848 ext. 20106  
tbalko@mhsindiana.com

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

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### NETWORK OPERATIONS

**KELVIN ORR**  
Director, Network Operations  
1-877-647-4848 ext. 20043  
kelvin.d.orr@mhsindiana.com

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### ENVOLVE DENTAL, INC.

**MICHAEL J. WILLIAMS**  
Provider Relations Specialist  
1-727-437-1932  
Dental Provider Services: 1-855-609-5157  
Michael.Williams@EnvolveHealth.com

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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)
Questions and Answers