Billing for Hospice

0920.PR.P.PP.3 10/20

Agenda

- Hospice for Members
  - Who is Responsible?
  - Billing Guidelines
  - Hospice Benefits
  - Hospice Rates
  - Service Intensity Add-on (SIA)
  - Claims Appeals
  - Rejections
  - Ambetter Hospice Billing
  - Allwell Hospice Billing
  - Contacts

Who is Responsible?

- All covered hospice benefits for members enrolled in Hoosier Care Connect and the Healthy Indiana Plan (HIP) is the responsibility of the enrolling health plan, **effective January 1, 2020**.
- Members will remain enrolled with their Managed Care Entity (MCE) for the duration of the hospice period whether the member receives in-home hospice care or institutional hospice care.

Who is Responsible?

- The hospice provider is responsible for coordinating all hospice services with the member's MCE.
  - Obtaining prior authorization (PA).
  - Ensuring the member has an institutional hospice level of care (LOC), as appropriate.
- For additional information about PA, claim submission, and other requirements related to hospice services for Hoosier Care Connect members, contact MHS Provider Services at **1-877-647-4848.**
- Members enrolled in Hoosier Healthwise, including the Children's Health Insurance Program (CHIP), will continue to be transitioned out of managed care when electing hospice.

Hospice Coverage

- For an individual to receive Medicaid-covered hospice services, a physician must certify in writing that the individual is terminally ill and expected to die within 6 months, if the terminal illness runs its normal course.
- Services provided in hospice care must be reasonable and medically necessary for the management of the terminal illness.

Hospice Covered Services

- **Services covered in the Hospice per diem:**
  - Hospice nursing care
  - Hospice medical social services
  - Hospice physician services
  - Hospice counseling services
  - Short-term inpatient care
  - Medical appliances and supplies
  - Home Health services provided by hospice aide or home health aide
  - Homemaker services
  - Physical therapy, occupational therapy, and speech-language pathology provided for purposes of symptom control
  - Inpatient hospice respite care
  - Room and board for hospice members residing in a nursing facility
  - Any other item or service specified in the hospice plan of care, of the item or service is a Medicare-covered service

Prior Authorization

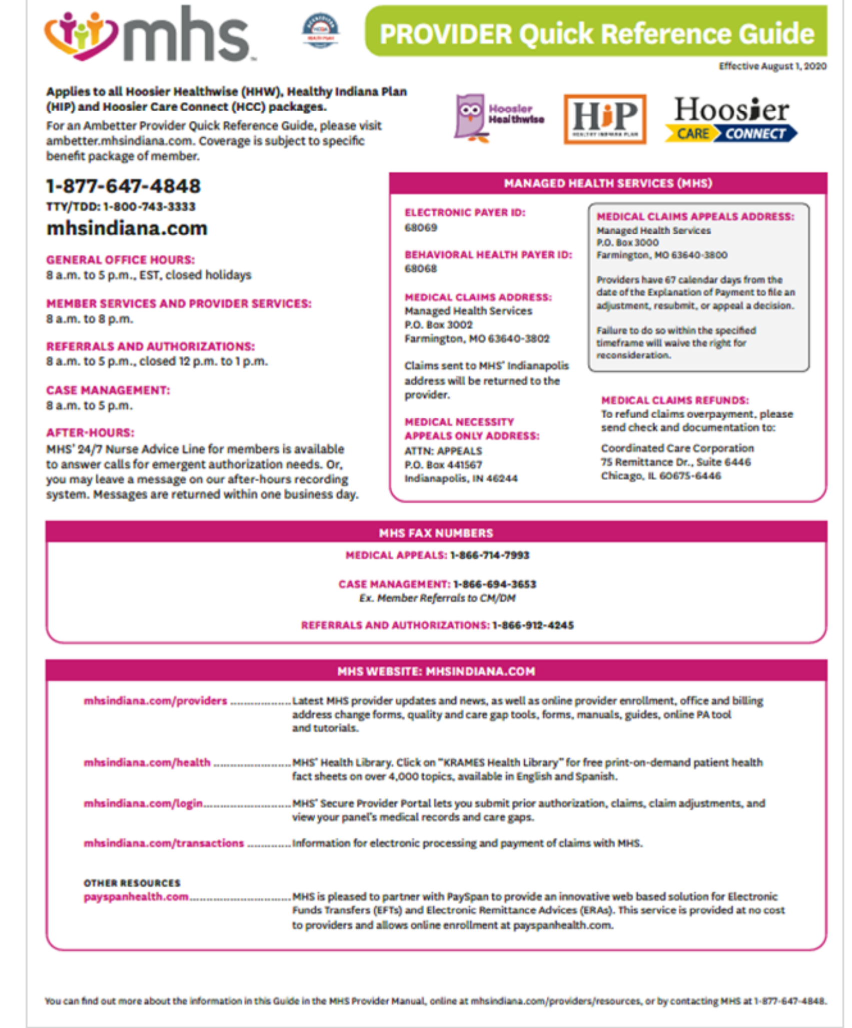
- Eligibility should be checked prior to requesting Prior Authorization or providing services.
- Authorizations request for Medicaid hospice members should be submitted to the appropriate Managed Care Entity (MCE) or its designated PA contractor.
- PA is required for any IHCP-covered service not related to the hospice member's terminal condition.

Authorization Considerations

- **Need to know what requires authorization:**
  - Reference QRG
  - Pre-Authorization tool
- **How to obtain authorization:**
  - Online
  - Phone
  - Fax
- **Authorizations do not guarantee payment.**

Prior Authorization

- **Is Prior Authorization Needed?**
  - MHS website: mhsindiana.com
  - Quick reference guide
  - Non-contracted provider services now align with PA requirements for contracted providers.



mhs

PROVIDER Quick Reference Guide

Effective August 1, 2020

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

Hoosier Healthwise | HIP | Hoosier CARE CONNECT

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

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

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

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

CASE MANAGEMENT:
8 a.m. to 5 p.m.

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

MANAGED HEALTH SERVICES (MHS)

ELECTRONIC PAYER ID:
68069

BEHAVIORAL HEALTH PAYER ID:
68068

MEDICAL CLAIMS ADDRESS:
Managed Health Services
P.O. Box 3002
Farmington, MO 63640-3802

Claims sent to MHS' Indianapolis address will be returned to the provider.

MEDICAL NECESSITY APPEALS ONLY ADDRESS:
ATTN: APPEALS
P.O. Box 441567
Indianapolis, IN 46244

MEDICAL CLAIMS APPEALS ADDRESS:
Managed Health Services
P.O. Box 3000
Farmington, MO 63640-3800

Providers have 67 calendar days from the date of the Explanation of Payment to file an adjustment, resubmit, or appeal a decision.

Failure to do so within the specified timeframe will waive the right for reconsideration.

MEDICAL CLAIMS REFUNDS:
To refund claims overpayment, please send check and documentation to:

Coordinated Care Corporation
75 Remittance Dr., Suite 6446
Chicago, IL 60675-6446

MHS FAX NUMBERS

MEDICAL APPEALS: 1-866-714-7993

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

REFERRALS AND AUTHORIZATIONS: 1-866-912-4245

MHS WEBSITE: MHSINDIANA.COM

mhsindiana.com/providers .... Latest MHS provider updates and news, as well as online provider enrollment, office and billing address change forms, quality and care gap tools, forms, manuals, guides, online PA tool and tutorials.

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

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

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

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

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

Hospice Benefits

- The contract between the hospice provider and the facility covers all costs related to the terminal illness.
- The hospice provider will submit claims directly to the MCE for reimbursement.
- The hospice provider will be paid at the rate appropriate to the level of care provided to the hospice member; general inpatient (GIP) hospice level of care will be reimbursed at the GIP rate and inpatient respite hospice level of care will be reimbursed at the respite rate.

Hospice Levels of Care

- **Routine home hospice care** in the member's home (residential setting other than a nursing facility) - IHCP hospice per diem only.
- **Continuous home hospice care** in a nursing facility- IHCP hospice per diem plus room and board per diem.
- **Inpatient respite hospice care** for members who reside in a private home – IHCP hospice per diem only. (Note: There is no additional room and board per diem for this service.)
- **General inpatient hospice care** regardless of the member's place of residence – IHCP hospice per diem only. (Note: There is no additional room and board per diem for this service.)

Hospice Revenue Codes

- 551 - RN service intensity add-on payment
- 561 - Social worker service intensity add-on payment
- 650 - Routine home hospice care delivered in a nursing facility
- 651 - Routine home hospice care delivered in the home
- 652 - Continuous home hospice care delivered in the home

Hospice Revenue Codes

- 655 - Inpatient respite hospice care
- 656 - General inpatient hospice care
- 657 - Hospice direct care physician services
- 658 - Continuous home hospice care delivered in a nursing facility
- 659 - Medicare/Medicaid dully eligible nursing facility members only

Revenue Codes for Bed-Hold Days

- 180 - Nursing facility bed-hold nonpaid revenue code
- 183 - Nursing facility bed-hold hospice therapeutic leave days
- 185 - Nursing facility bed-hold for hospitalization for services unrelated to the terminal illness of the hospice member

Hospice Rates

- The Centers for Medicare & Medicaid Services (CMS) release new federal hospice rates annually in September. New rates are forthcoming.
- These rates are the basis for payments to Medicaid-enrolled hospice providers.
- Reimbursement for IHCP hospice benefits is based on the methodology established by the CMS for the administration of the federal Medicare program.

Hospice Rates

- Reimbursement for the IHCP hospice benefits is based on CMS administration of the federal Medicare program.
- The total per diem amounts reimbursed to IHCP-enrolled providers are calculated according to the IHCP hospice member's level of care (LOC) and location of services.

Reference: BT201950, Dated September 17, 2019

Hospice Rates

- Federal per diem rates for routine home care, continuous home care, inpatient respite care, and general inpatient care, effective October 1, 2020, through September 30, 2021

Level of service	Daily rate	Component subject to wage index	Unweighted component
Routine home care (days 1-60)	$199.51	$137.08	$62.43
Routine home care (days 61+)	$157.69	$108.35	$49.34
Continuous home care	$1,432.97	$984.59	$448.38
Inpatient respite care	$485.36	$262.72	$222.64
General inpatient care	$1,045.66	$669.33	$376.33

Hospice Rates

- Federal rates for service intensity add-on payments made in conjunction with routine home care, effective October 1, 2020, through September 30, 2021

Level of service	Daily rate	Component subject to wage index	Unweighted component
Service intensity add-on	$59.71	$41.02	$18.69

Hospice Per Diem

- The hospice per diem rates for both routine and continuous home hospice LOC in the private home, as well as the Service Intensity Add on(SIA) in the private home, are adjusted using the wage index for the city or county where the member resides.
- The hospice per diem rates for both routine and continuous hospice LOC in the nursing facility, as well as the SIA in the nursing facility, are adjusted using the wage index of the city or county where the hospice facility is located.

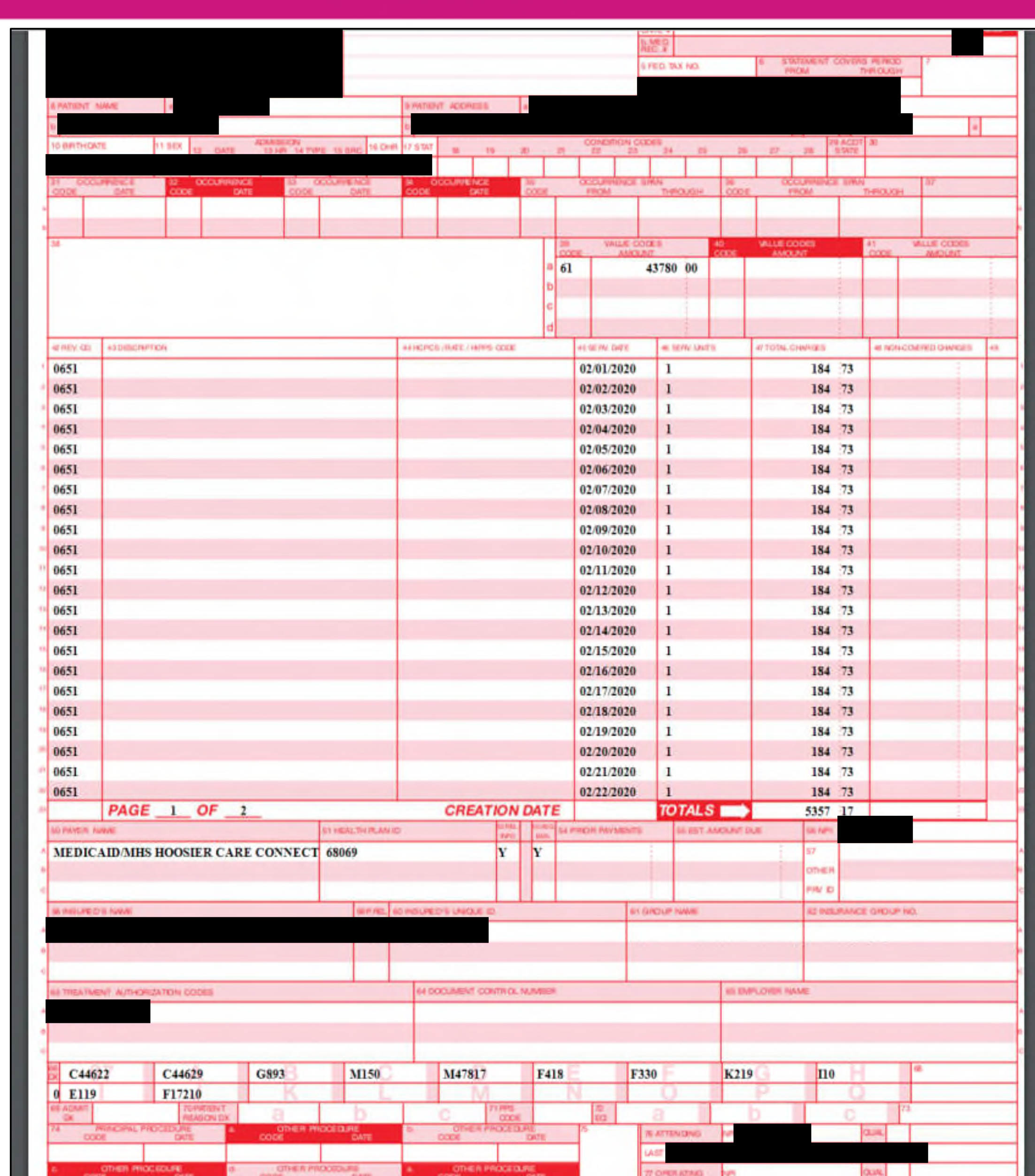
Service Intensity Add-on (SIA)

- The SIA payment is in addition to the routine home care per diem rate in both the private home and in the nursing facility.
- The SIA payment is limited to 16 units or 4 hours per day and is applied only to routine home hospice care level of care (LOC).
- The SIA payment is also adjusted for regional wage differences.
- The billing guidance for SIA payments for DOS on or after January 1, 2019 is unchanged from current practice as follows:
  - The following revenue codes must be billed for the SIA payment, as appropriate:
    - 551 – RN SIA payment
    - 561 – social worker SIA payment

Service Intensity Add-on (SIA)

- The SIA revenue codes must be billed as detail line items on the claim in conjunction with billing for routine home care hospice services for the same DOS.
- Routine home care hospice services must be billed with revenue codes 650 or 651 for DOS on or after January 1, 2019.
- A procedure code is not required in conjunction with revenue code 551 or 561.
- Claims with revenue code 551 or 561 must include occurrence code 55 and the date of death in the first open occurrence code field.
- The claim must include a patient discharge status code of 20, 40, 41, or 42 (field 17 of the UB-04 claim form).

Clean Claim



39 Value Code	Amount
61	43780 00

42 Rev. Cd.	45 Serv. Date	46 Serv. Units	47 Total Charges
0651	02/01/2020	1	184 73
0651	02/02/2020	1	184 73
0651	02/03/2020	1	184 73
0651	02/04/2020	1	184 73
0651	02/05/2020	1	184 73
0651	02/06/2020	1	184 73
0651	02/07/2020	1	184 73
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0651	02/19/2020	1	184 73
0651	02/20/2020	1	184 73
0651	02/21/2020	1	184 73
0651	02/22/2020	1	184 73

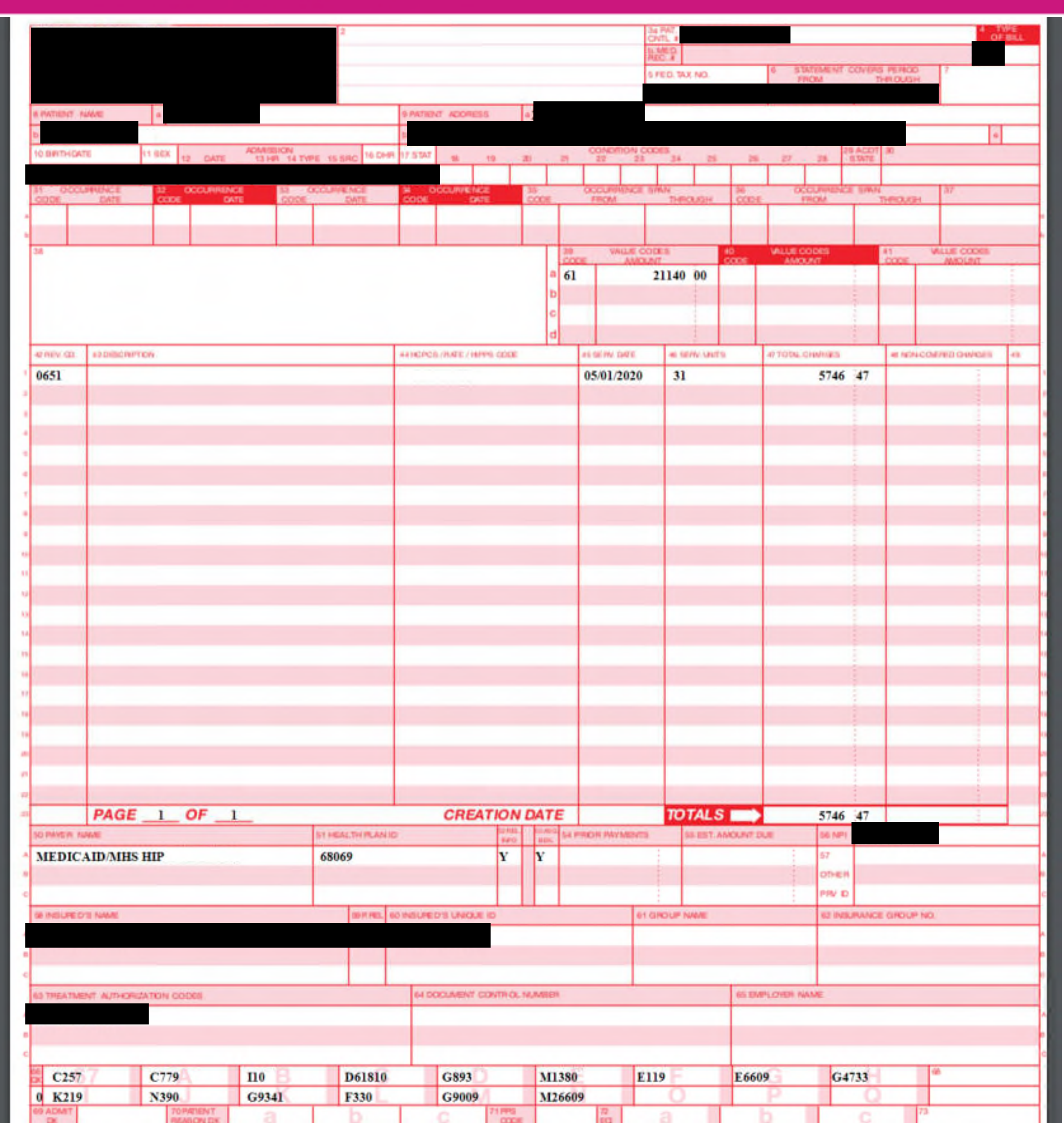
PAGE 1 OF 2 CREATION DATE TOTALS 5357 17

50 Payer Name	51 Health Plan ID	52 Rel. Info	53 Asg. Ben.
MEDICAID/MHS HOOSIER CARE CONNECT	68069	Y	Y

C44622 C44629 G893 M150 M47817 F418 F330 K219 I10

E119 F17210

Incorrect Billing



Value Code	Amount
61	21140 00

Rev. Cd.	Description	HCPCS / Rate / HIPPS Code	Serv. Date	Serv. Units	Total Charges	Non-Covered Charges
0651			05/01/2020	31	5746 47	

PAGE 1 OF 1 CREATION DATE TOTALS 5746 47

Payer Name	Health Plan ID	Rel. Info	Asg. Ben.
MEDICAID/MHS HIP	68069	Y	Y

C257 C779 I10 D61810 G893 M1380 E119 E6609 G4733

K219 N390 G9341 F330 G9009 M26609

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 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.
- By using the MHS Web Portal Reconsideration process.
- Calling Provider Services at **Phone: 1-877-647-4848; Provider Services hours 8 a.m. to 8 p.m.**
- 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.

0517.PR.P.FO 5/17

1-877-647-4848 I TTY/TDD: 1-800-743-3333 I mhsindiana.com

Allwell from MHS I Ambetter from MHS I Healthy Indiana Plan (HIP) I Hoosier Care Connect I Hoosier Healthwise

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 mad 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

Step 1:

- 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).

Informal Claims Dispute or Objection Form

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.

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_2020.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_2020.pdf

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: https://www.mhsindiana.com/providers/login.html**
  - Use the Messaging Tool.

Ambetter Hospice Billing

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:

IN NETWORK COVERAGE ONLY

Subscriber: [Jane Doe]
Member: [John Doe]
Policy #: [XXXXXXXXX]
Member ID #: [XXXXXXXXXXXXX]
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

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.

AMB20-IN-C-00051

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**** Possession of an ID card is not a guarantee of eligibility and benefits.***

Prior Authorization

Submit Prior Authorization

If a service requires authorization, submit via one of the following ways:

SECURE WEB PORTAL
Provider.mhsindiana.com
This is the preferred and fastest method.

PHONE
1-877-687-1182
After normal business hours and on holidays, calls are directed to the plan's 24-hour nurse advice line. Notification of authorization will be returned by phone, fax or web.

FAX
Medical and Behavioral Health
1-855-702-7337

See below for a list of services that require prior authorization.

Please note:

1. Emergency services DO NOT require prior authorization.
2. All out-of-network services and providers DO require prior authorization.
3. Failure to complete the required authorization or notification may result in a denied claim.
4. Using non-contracted specialists and facilities can result in balanced billing for members

Prior Authorization

- Home Health Care Services including, home infusion, skilled nursing, and therapy
- Home Health Services
- Private Duty Nursing
- Adult Medical Day Care
- Hospice
- Furnished Medical Supplies & DME

Prior Authorization Request

Providers can **update** previously approved PAs **within 30 days** of the original date of service prior to claim denial for changes in:

- Dates of service
- CPT/HCPCS codes
- Physician

Providers may make corrections to the existing PA as long as the claim has not been submitted.

Claims

Clean Claim

- A claim that is received for adjudication in a nationally accepted format in compliance with standard coding guidelines and does not have any defect, impropriety, lack of any required documentation or particular circumstance requiring special treatment that prevents timely payment.

Exceptions

- A claim for which fraud is suspected.
- A claim for which a third party resource should be responsible.

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 web 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 our the Clearinghouses, please visit out website at ambetter.mhsindiana.com
3. Paper claims may be submitted to PO Box 5010 Farmington, MO 64640-5010

2020 Ambetter Provider and Billing Manual

- https://ambetter.mhsindiana.com/content/dam/centene/mhsindiana/Ambetter/PDFs/IN-2020AmbetterPrvdrManual2.pdf

Ambetter from MHS Payment Policy Manual

- You can also find the Ambetter Payment Policies on our website by following the link below.
- https://ambetter.mhsindiana.com/provider-resources/clinical-payment-policies.html

Complaints/Grievances/Appeals

Claims

- A provider must exhaust the Claims Reconsideration and Claims Dispute process before filing a Complaint/Grievance.

Corrected Claims, Requests for Reconsideration or Claim Disputes

- All claim requests for corrected claims, reconsiderations or claim disputes must be received within 180 days from the date of the original notification of payment or denial. Prior processing will be upheld for corrected claims or provider claim requests for reconsideration or disputes received outside of the 180 day timeframe, unless a qualifying circumstance is offered and appropriate documentation is provided to support the qualifying circumstance.

Complaints/Grievances/Appeals

Appeals

- For Claims, the Claims Reconsideration, Claims Dispute and Complaint/Grievances process must be exhausted prior to filing an appeal.

Medical Necessity

- Must be filed within 30 calendar days from the Notice of Action.
- Ambetter shall acknowledge receipt within 10 business days of receiving the appeal.
- Ambetter shall resolve each appeal and provide written notice as expeditiously as the member's health condition requires but not to exceed 30 calendar days.
- Expedited appeals may be filed if the time expended in a standard appeal could seriously jeopardize the member's life or health. The timeframe for a decision for an expedited appeal will not exceed 72 hours.

Complaints/Grievances/Appeals

Reconsiderations

- A request for reconsideration is a written communication (i.e. a letter) from the provider about a disagreement with the manner in which a claim was processed, but does not require a claim to be corrected and does not require medical records.
- The documentation must also include a description of the reason for the request.
- Indicate "Reconsideration of (original claim number)."
- Include a copy of the original Explanation of Payment.
- Unclear or non-descriptive requests could result in no change in the processing, a delay in the research, or delay in the reprocessing of the claim.
- The "Request for Reconsideration" should be sent to:

Ambetter from MHS
Attn: Reconsideration
PO Box 5010
Farmington, MO 63640-5010

Complaints/Grievances/Appeals

Claim Dispute

- A claim dispute should be used only when a provider has received an unsatisfactory response to a request for reconsideration.
- Providers wishing to dispute a claim must complete the Claim Dispute Form located at ambetter.mhsindiana.com.
- To expedite processing of the dispute, please include the original request for reconsideration letter and the response.
- The Claim Dispute form and supporting documentation should be sent to:

Ambetter from MHS Indiana
Attn: Claim Dispute
PO Box 5000
Farmington, MO 63640-5000

Prior Authorization

Prior Authorization will be granted at the CPT code level

- If a claim is submitted containing CPT codes that were not authorized, the services will be denied.
- If additional procedures are performed during the procedure, the provider must contact the health plan to update the authorization in order to avoid a claim denial.
- It is recommended that this be done within 72 hours of the procedure; however, it must be done prior to claim submission or the claim will deny.
- Ambetter will update authorizations but will not retro-authorize services.
  - The claim will deny for lack of authorization.
  - If there are extenuating circumstances that led to the lack of authorization, the claim may be appealed.

Provider Services

- **Ambetter from MHS** Member/Provider Services department includes trained Provider Relations staff who are available to respond quickly and efficiently to all provider inquiries or requests including, but not limited to:
  - Credentialing/Network Status
  - Claims
  - Request for adding/deleting physicians to an existing group
- By calling **Ambetter from MHS** Member/Provider Services number at 1-877-687-1182, providers will be able to access real time assistance for all their service needs.

Contact Information

Ambetter from MHS

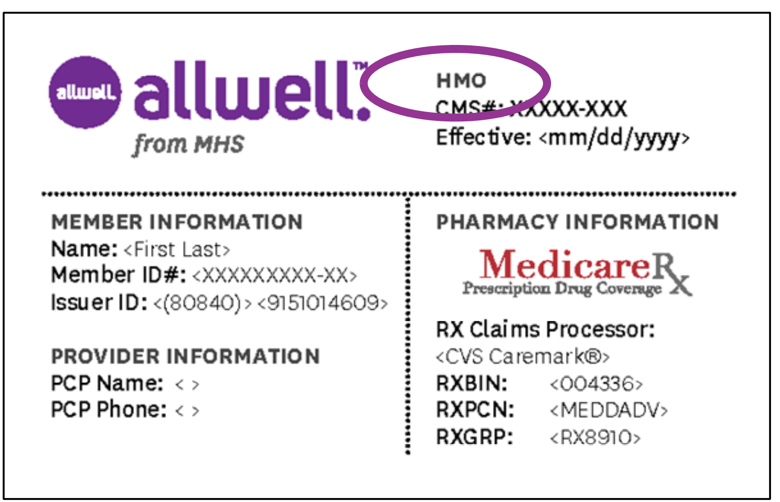
Phone: 1-877-687-1182

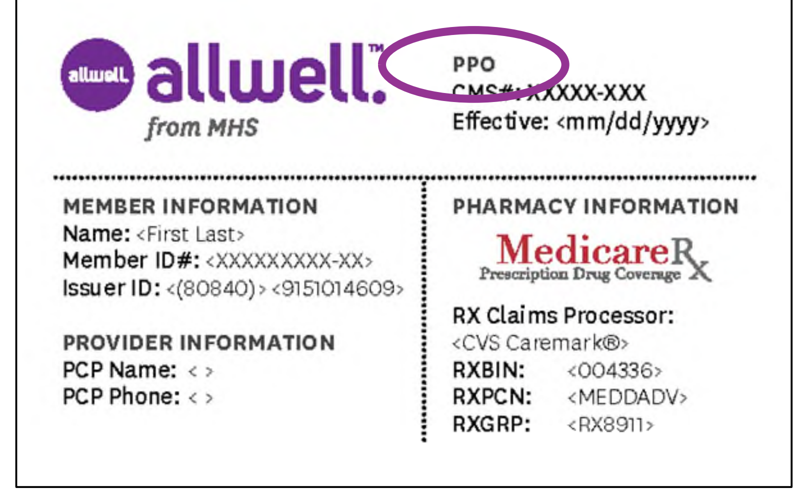
TTY/TDD: 1-800-743-3333

ambetter.mhsindiana.com

Allwell Hospice Billing

Member ID Cards





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

Coding Auditing & Editing

- Allwell uses code editing software based on a variety of edits:
  - American Medical Association (AMA)
  - Specialty society guidance
  - Clinical consultants
  - Centers for Medicare & Medicaid Services (CMS)
  - National Correct Coding Initiative (NCCI)
- Software audits for coding inaccuracies such as:
  - Unbundling
  - Upcoding
  - Invalid codes

Provider Website

- Through the website, providers can access:
  - Billing Manuals
  - Forms
  - HEDIS Quick Reference Guides
  - Provider News
  - Pre-Auth Needed Tool
  - Provider Resources

Provider Website

On our health plan website providers can access:

- Authorizations
- Claims
  - Download Payments History
  - Processing Status
  - Submission / Adjustments
  - Clear Claim Connection – Claim Auditing Software
- Health Records
  - Care Gaps*
- Monthly PCP Cost Reports*
- Patient Listings* & Member Eligibility

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 Web Portal at: https://www.mhsindiana.com/providers/prior-authorization/medicare-pre-auth.html.

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 https://www.mhsindiana.com/providers/prior-authorization/medicare-pre-auth.html to check all services

Paper Claim Submission

- Hospice claims are to be billed on an Institutional Claim (UB-04).
- The mailing address for first time claims, corrected claims and requests for reconsideration:

Allwell
Attn: Claims
P.O. Box 3060
Farmington, MO 63640-3822

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

EDI Support

- Companion guides for EDI billing requirements plus loop segments can be found on the following website: mhsindiana.com/providers/resources/electronic-transactions
- For more information, contact:
  Allwell from MHS c/o Centene EDI Department
  1-800-225-2573, extension 25525
  e-mail: EDIBA@centene.com

Corrected Claims, Request for Reconsideration or Claim Dispute

- All requests for corrected claims, reconsiderations or claim disputes must be received within 180 days from the date of explanation of payment or denial is issued.
  - **Corrected claim** – A provider is submitting a correction to the original claim.
  - **Request for Reconsideration** – Provider disagrees with the original claim outcome (payment amount, denial reason, etc.)
  - **Claim Dispute** – Provider disagrees with the outcome of the Request for Reconsideration.

Allwell Corrected Claims

- The original claim number must be in type in field 64(UB-04) with the corresponding frequency code (7=replacement or corrected; 8= voided or cancelled) in field 4 of the UB-04 claim.
- Corrected claims must be submitted on standard red and white forms. Handwritten corrected claims will be upfront rejected.

Allwell Claim Reconsideration

- 1. Form – Found on website.
- 2. Phone call to Provider services May be used if no submission of supporting or additional information is needed.
- 3. Written letter with detailed description.
- Request for reconsideration or any applicable attachments must be mailed to:

Allwell
Attn: Request for Reconsideration
PO BOX 3060
Farmington, MO 63640-3822

Claim Dispute

- A claim dispute should only be used when a provider has received unsatisfactory response to a request for reconsideration.
- Claim dispute form found on our website; the form must be entirely completed.

Allwell
Attn: Claim Dispute
PO Box 4000
Farmington, MO 63640-4400

Timely Filing

- Participating providers must submit first time claims within 180 calendar days of the date of service.
- Claims received outside of this timeframe will be denied for untimely submission.

Examples of Common Causes for Upfront Claim Rejections

- Unreadable Information - The ink is faded, too light, or too bold (bleeding into other characters or beyond the box), or the font is too small.
- Member Date of Birth is missing.
- Member Name or Identification Number is missing.
- Provider Name, Taxpayer Identification Number (TIN), or National Practitioner Identification (NPI) Number is missing.
- Attending Provider information missing from Loop 2310A on Institutional claims when CLM05-1 (Bill Type) is 11, 12, 21, 22, or 72 or missing from box 48 on the paper UB claim form.
- Date of Service is not prior to the received date of the claim (future date of service).
- Date of Service or Date Span is missing from required fields. Example: "Statement From" or “Service From" dates.
- Type of Bill is invalid.
- Diagnosis Code is missing.

Top Rejection Codes

- 080 - Invalid member DOB
- 09 - Member invalid on DOS
- 90 - One or more of the modifiers are invalid or missing
- A4 - At least one service line detail must be submitted
- A6 - Total charges billed does not equal total of service lines billed
- 92 - Invalid or missing NPI

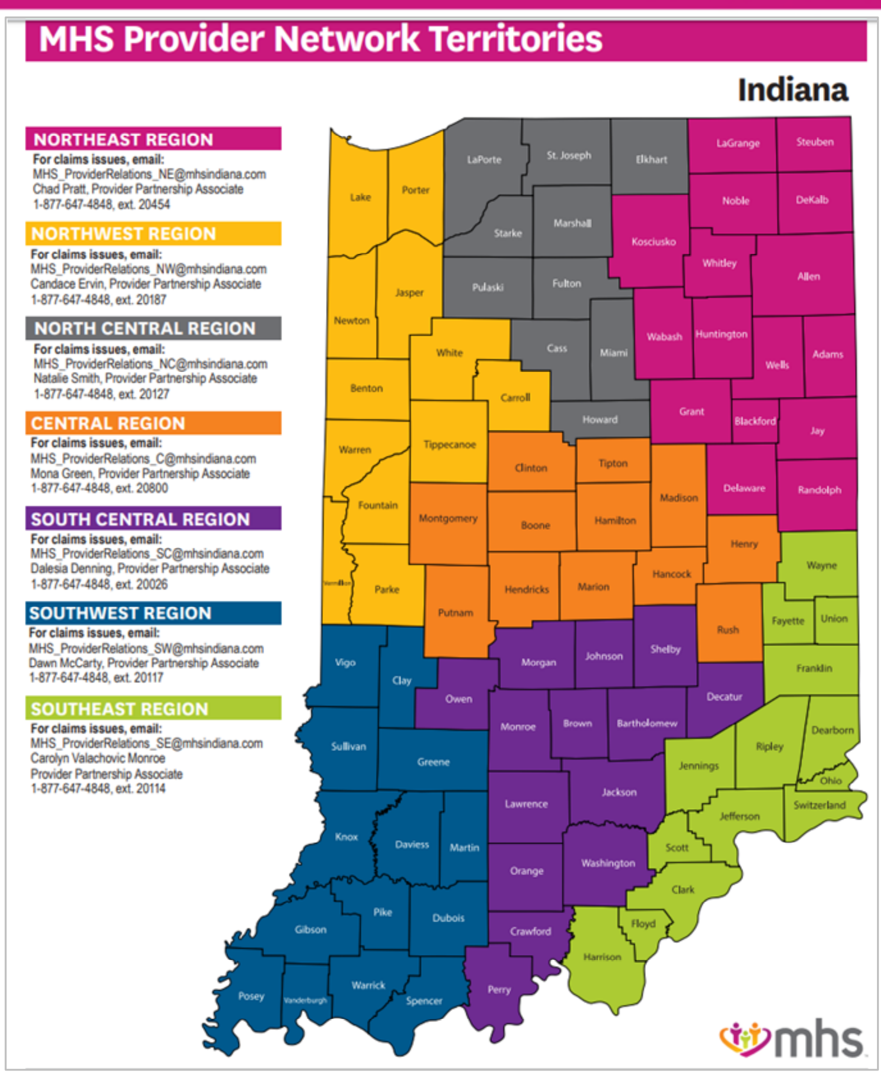
Allwell Key Contacts and Important Phone Numbers

- The following table includes several important telephone and fax numbers available to providers and their office staff. When calling, it is helpful to have the following information available:
  - The provider's NPI number
  - The practice Tax ID Number
  - The member's ID number

Allwell from MHS	Address: Allwell 550 N Meridian St Suite 101 Indianapolis, IN 46204 Website: allwell.mhsindiana.com
Provider Services	Phone: 1-855-766-1541 (TTY: 711) Office Hours: October 1 - February 14, 7 days a week, 8 a.m. to 8 p.m.; February 15 - September 30, Monday - Friday, 8 a.m. to 8 p.m.
Member Services	Phone: 1-855-766-1541 (TTY: 711) DSNP Office Hours: October 1 - February 14, 7 days a week, 8 a.m. to 8 p.m.; April 1 - September 30, Monday - Friday, 8 a.m. to 8 p.m.
Medical Management Inpatient and Outpatient Prior Authorization	Fax: 1-877-808-9362
Concurrent Review/Clinical Information	
Admission/Census Reports/Face Sheets	
Care Management	Fax: 1-844-208-4156
Behavioral Health Outpatient Prior Authorization	Fax: 1-877-725-7751
24/7 Nurse Advice Line	1-855-766-1541 (TTY: 711)
Interpreter Services	1-855-766-1541
Pharmacy Services	1-844-202-6824

Allwell Key Contacts and Important Phone Numbers (con't)

National Imaging Associates (NIA)	1-877-807-2363 Website: www.RadMD.com
Envolve Vision	Email: visionbenefits.envolvehealth.com
Envolve Dental	Email: https://dental.envolvehealth.com/
Fraud Waste and Abuse (FWA)	To report suspected fraud, waste and abuse call, 1-866-685-8664.
EDI Claims Assistance	For EDI Claim Assistance inquires, call 1-800-225-2573, ext. 6075525 Email: ediba@centene.com
Payspan	Phone: 1-877-331-7154 Email: providersupport@payspanhealth.com



Available online:
[https://www.mhsindiana.com/content/dam/centene/mhs indiana/medicaid/pdfs/ProviderTerritory_map_2020.pdf](https://www.mhsindiana.com/content/dam/centene/mhsindiana/medicaid/pdfs/ProviderTerritory_map_2020.pdf)

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

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
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

NETWORK LEADERSHIP

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

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

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

NEW PROVIDER CONTRACTING

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

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

NETWORK OPERATIONS

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

ENVOLVE DENTAL, INC.

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

Back of Map

Available online:
https://www.mhsindiana.com/content/dam/centene/mhsindiana/medicaid/pdfs/ProviderTerritory_map_2020.pdf

Questions?

Thank you for being our partner in care.