










# How to Make Prior Authorizations Work for You



# Agenda

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

# Prior Authorization


## Prior Authorization (Medical Services):


Prior Authorization (PA) is an approval from MHS to provide services designated as needing authorization before treatment and/or payment.

 Inpatient (IP) authorizations = IP + 10 digits

 Outpatient (OP) authorizations = OP + 10 digits



 ER Visits suggesting imminent, life-threatening condition no PA required, but notification requested within **two business days**.

 Urgent concurrent = Emergent inpatient admission. Determination timeline within **24 hours** of receipt of request.

 Pre-service non urgent = Elective scheduled procedures. Determination within **7 calendar days**. Benefit limitations apply (dependent on product).






# Prior Authorization

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

-  PA for observation level of care (**up to 72 hours for Medicaid**), diagnostic services do not require an authorization for contracted facilities.
-  If the provider requests an inpatient level of care for a covered/eligible condition, but procedure and documentation supports an outpatient/observation level of care, MHS will send the case for Medical Director review.



# Prior Authorization

## Outpatient Services:

-  All elective procedures that require prior authorization must have submitted request to MHS at least **two business days** prior to the date of service.
-  All ER services do not require prior authorization, but admission must be called into MHS Prior Authorization Dept within **two business days** following the admit.
-  Members **must** be Medicaid Eligible on the date of service.
-  Prior Authorizations are not a guarantee of payment.
-  ***Failure to obtain prior authorization for non urgent and emergent services will result in a denial for related claims.***
















# Prior Authorization

## Transfers:

-  MHS requires **notification and approval** for all transfers from one facility to another at least two business days in advance.
-  MHS requires **notification** within two business days following all emergent transfers. Transfers include, but are not limited to:
  - Facility to facility
  - Higher level of care changes require PA and it is the responsibility of the transferring facility to obtain.

# Prior Authorization

## Services that require prior authorization regardless of contract status:

-  Injectable drugs (see [mhsindiana.com/provider-guides](https://mhsindiana.com/provider-guides) for up-to-date list of codes)
-  Nutritional counseling (unless diabetic)
-  Pain management programs, including epidural, facet and trigger point injections
-  PET, MRI, MRA and Nuclear Cardiology/SPECT scans
-  Cardiac rehabilitation
-  Hearing aids and devices
-  Home and Institutional hospice (coverage varies by product)
-  In-home infusion therapy
-  Orthopedic footwear
-  Respiratory therapy services
-  Pulmonary rehabilitation
-  Home care (except after an IP admission with benefit limitations)
-  Physical Therapy, Occupational, and Speech Therapy
-  Non-emergent ambulance services
-  Orthopedic and spinal surgical procedures



# Prior Authorization

## Is Prior Authorization Needed?

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






### 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](https://ambetter.mhsindiana.com). Coverage is subject to specific benefit package of member.

**1-877-647-4848**  
TTY/TDD: 1-800-743-3333  
[mhsindiana.com](https://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 (effective March 1, 2021, 60 days).

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

[mhsindiana.com/login](https://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](https://mhsindiana.com/transactions) ..... Information for electronic processing and payment of claims with MHS.

**OTHER RESOURCES**

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

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

0700.PR.PFL 3L 10/20



# Prior Authorization

## Medicaid Pre-Auth Needed?

[Become a Provider](#)

[CLAS Standards](#)

[MHS Provider Webinars](#)

[Partnered Member Events](#)

[Pharmacy Benefits Information for Providers](#)

[Prior Authorization](#)

[Transactions](#)

[PaySpan Health](#)

[POWER Account Resource Center](#)

[Provider Information Resource Center](#)

[Provider Guides](#)

[Dental Providers](#)

[Presumptive Eligibility](#)

[Quality Improvement](#)

[HEDIS®](#)

[Practice Guidelines](#)

[Immunization Information](#)

**DISCLAIMER:** All attempts are made to provide the most current information on the Pre-Auth Needed Tool. However, this does NOT guarantee payment. Payment of claims is dependent on eligibility, covered benefits, provider contracts, correct coding and billing practices. For specific details, please refer to the [provider manual](#). If you are uncertain that prior authorization is needed, please submit a request for an accurate response.

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

Complex Imaging, MRA, MRI, PET and CT scans need to be verified by [NIA](#)

Hoosier Healthwise dental services need to be verified by [State](#)

Healthy Indiana Plan (HIP) and Hoosier Care Connect dental services need to be verified by [Envolve Dental](#)

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

Behavioral Health/Substance Abuse need to be verified by [Cenpatico](#)

Non-participating providers must submit Prior Authorization for all services  
For non-participating providers, [Join Our Network](#).

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

YES ☐ NO ☐

Types of Services	YES	NO
Is the member being admitted to an inpatient facility?	<input type="radio"/>	<input type="radio"/>
Are services, other than DME, orthotics, prosthetics, and supplies, being rendered in the home?	<input type="radio"/>	<input type="radio"/>
Are anesthesia services being rendered for pain management?	<input type="radio"/>	<input type="radio"/>
Are services for infertility?	<input type="radio"/>	<input type="radio"/>
Is the member receiving dialysis?	<input type="radio"/>	<input type="radio"/>

# Prior Authorization

Types of Services	YES	NO
Is the member being admitted to an inpatient facility?	<input type="radio"/>	<input checked="" type="radio"/>
Are services, other than DME, orthotics, prosthetics, and supplies, being rendered in the home?	<input type="radio"/>	<input checked="" type="radio"/>
Are anesthesia services being rendered for pain management?	<input type="radio"/>	<input checked="" type="radio"/>
Are services for infertility?	<input type="radio"/>	<input checked="" type="radio"/>
Is the member receiving dialysis?	<input type="radio"/>	<input checked="" type="radio"/>

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










Check

**N**  
No

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

# Prior Authorization

## Information Needed to Complete All PAs:

-  Member's Name, RID, and Date of Birth
-  Type of service needed (e.g. office visit, outpatient surgery, DME, inpatient admission, testing, physical therapy, occupational therapy, speech therapy etc.)
-  Date(s) of service
-  Ordering Physician with NPI number
-  Servicing/Rendering Physician with Rendering NPI number
-  HCPCS/CPT codes requested for approval
-  Diagnosis code
-  Contact person, including phone and fax numbers
-  Clinical information to support medical necessity (home care requires a signed Plan of Care POC)
  - Including current (within three months) clinical that is pertinent to the requested service, history of symptoms, previous treatment and results, physician rationale for ordering treatments and/or testing (MD exam notes).

**\*Providers must request updates to prior authorizations within 30 days from the original date of service before claim submission.**

# **Need to Know**

# Self-Referral Services


## Exceptions to prior authorization requirements.

Members can see these specialists and get these services without a direct referral from their PMP:


- Podiatrist
- Chiropractor
- Family planning
- Immunizations
- Routine vision care
- Routine dental care
- Behavioral health by type and specialty
- HIV/AIDS case management
- Diabetes self management


*\*Benefit limitations apply*

# Therapy Services (Speech, Occupational, Physical Therapy)


 Effective 01-01-2021, Ambetter providers will need to submit authorization request for therapies to NIA.

 Must follow billing guidelines (GP, GN, GO modifiers)







 Effective July 1, 2019, physical, occupational and speech therapy (PT, OT, and ST) services will no longer be managed through a post-service review process for MHS. We remain committed to ensuring that these services provided to our members are consistent with nationally recognized clinical guidelines. Therefore, beginning July 1, 2019, prior authorization for PT, OT, and ST services will be required to determine whether services are medically necessary and appropriate.

 Chiropractic care –No prior authorization is needed. Coverage available for covered services provided by a licensed chiropractor when rendered within the scope of the practice of chiropractic.

 The utilization management of these services will continue to be managed by NIA.





 To get started, simply go to [www.RadMD.com](http://www.RadMD.com), click the New User button and submit a “Physical Medicine Practitioner” Application for New Account. Once the application has been processed and a password link delivered by NIA via e-mail, you will then be invited to create a new password.

# Therapy Services (Speech, Occupational, Physical Therapy)

-  Links to the approved training/education documents are found on the My Practice page for those providers logged in as a Physical Medicine Practitioner.
-  All Health Plan approved training/education materials are posted on the NIA website, [www.RadMD.com](http://www.RadMD.com). For new users to access these web-based documents, a RadMD account ID and password must be created.
-  Fax number to NIA at 1-800-784-6864
-  Medical necessity appeals will be conducted by NIA
  -  Follow steps outlined in denial notification
  -  NIA Customer Care Associates are available to assist providers at 1-800-424-5391.



# Durable & Home Medical Equipment (DME)

-  Members and referring providers do not need to search for a DME provider or provider of medical supplies to service their needs.
-  Medline's web portal is used to submit orders and track delivery.
-  Does not apply to items provided by and billed by physician office.
-  Exclusions applicable to specific hospital based DME/HME vendors.

# Durable & Home Medical Equipment



Requests should be initiated via **MHS secure portal:**

- **Web Portal:** Simply go to [mhsindiana.com](https://mhsindiana.com), log into the provider portal, and click on “Create Authorization.” Click DME and you will be directed to the Medline portal for order entry.
- **Fax Number:** 1-866-346-0911
- **Phone Number:** 1-844-218-4932

# Outpatient Radiology PA Requests

 MHS partners with NIA for outpatient Radiology PA Process

 PA requests must be submitted via:

- NIA Web site at [RadMD.com](http://RadMD.com)
- 1-866-904-5096




***\*Not applicable for ER and Observation requests***

# Additional Information Needed




## Bariatric Surgery:

-  Must include cardiac workup, pulmonary workup, diet and exercise logs, current lab reports, and psychologist report.

## Pain Management:




-  Must have documentation of at least six weeks of therapy on area receiving treatment.
-  Include previous procedures/surgeries, medications, description of pain, any contra-indications or imaging studies.
-  Include prior injection test results for injection series.

## Home Health:

-  Physician's orders and signed plan of care, including most recent MD notes about the issue at hand.
-  Home care plan, including home exercise program.
-  Progress notes for medical necessity determination.

# Ambulance Coverage

May 1, 2019, MHS began handling Emergent and Non-Emergent Ambulance claims to include:

-  911 transports
-  Medically necessary non-emergent transports requiring an ambulance with advanced life support (ALS) or basic life support (BLS)
-  Air ambulance

## Clarification of Authorization Requirements

Prior authorization is required to ensure medical necessity for the following non-emergent ambulance services:

### Ambulance:




- A0426 - Ambulance service, adv. life support, non-emergency transport, level 1
- A0428 - Ambulance service, basic life support, non-emergent transport.
- A0999 - Unlisted ambulance service
- T2003 - Non-emergency transportation encounter/trip
- T2004 - Non-emergency transportation commercial carrier

### Air Transport:

- A0140 - Non-emergency transportation and air travel
- A0430 - Air Ambulance, conventional air services, one way (fixed wing)
- A0999 - Unlisted Ambulance service

# Ambulance Coverage

## Mileage

-  Providers are reminded to use procedure code A0425 along with the appropriate U modifier to ensure mileage is reimbursed at the appropriate level.
-  MHS requests that U1 or U2 be reported in the primary modifier field.
-  Claims that are submitted with the U modifier not in the primary field may only reimburse at the base rate.

## Clinical Documentation Needed for Approval of Non Emergent Transport

-  MHS requires both the Ambulance Run Report and the Physician Certificate of Service form when submitting the authorization request for approval.

# Ambulance Coverage

## Run Reports



MHS does not require an Ambulance Run Report when submitting claims, however ambulance providers are required to maintain as supporting documents for post payment review.

For more information on Medicaid ambulance billing guidelines, please visit

<https://www.in.gov/medicaid/files/transportation%20services.pdf>.



# Orthopedic and Spinal Surgical Procedures

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

# Orthopedic and Spinal Surgical Procedures

## Orthopedic Surgical Procedures

- Knee Arthroplasty
- Unicompartmental/Bicompartmental Knee Replacement
- Hip Arthroplasty
- Shoulder Arthroplasty
- Elbow Arthroplasty
- Ankle Arthroplasty
- Wrist Arthroplasty
- Acromioplasty and Rotator Cuff Repair
- Anterior Cruciate Ligament Repair
- Knee Arthroscopy
- Hip Resurfacing
- Meniscal Repair
- Hip Arthroscopy
- Femoroacetabular Arthroscopy
- Ankle Fusion
- Shoulder Fusion
- Wrist Fusion
- Osteochondral Defect Repair








# Orthopedic and Spinal Surgical Procedures

## Spinal Surgical Procedures


- Spinal Fusion Surgeries
  - Cervical
  - Lumbar
  - Thoracic
  - Sacral
  - Scoliosis
- Disc Replacement
- Laminectomy/Discectomy
- Kyphoplasty/Vertebroplasty
- Sacroiliac Joint Fusion
- Implantable Pain Pumps
- Spinal Cord Neurostimulator
- Spinal Decompression

# Turning Point Cardiac Update

Turning Point began authorization functions Cardiac Services effective 5/1/20 for Dates of Service 5/18/20

-  Automated Implantable Cardioverter Defibrillator
-  Leadless Pacemaker
-  Pacemaker
-  Revision or Replacement of Implanted Cardiac Device
-  Coronary Artery Bypass Grafting (Non-Emergent)
-  Coronary Angioplasty and Stenting
-  Non-Coronary Angioplasty and Stenting

 Web Portal Intake: <http://www.myturningpoint-healthcare.com>





 Telephonic Intake: 1-574-784-1005 | 1-855-415-7482

 Facsimile Intake: 1-463-207-5864

 Informational webinars are available! Please register at:  
<https://attendee.gotowebinar.com/rt/6895616165794853901>

 Refer to notice for specific provisions

# Turning Point

-  Emergency Related Procedures do not require authorization.
-  It is the responsibility of the ordering physician to obtain authorization.
-  Providers rendering musculoskeletal services, must verify that the necessary authorization has been obtained; failure to do so may result in non-payment of your claims.
-  Clinical Policies are available by contacting TurningPoint at 574-784-1005 for access to digital copies.

- **TRAINING:**

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

# Sub Acute Care

MHS conducts clinical review for ongoing authorization and coordination of discharge needs for our members in subacute facilities at least every 3-5 days. It is important that you provide a complete current clinical update on our member's status at each review.

 The review should include current information (within one day) on:

 Member's condition

 Level of functioning (prior to admission)


 Medications

 Therapies provided

 Participation in therapies


 Progress toward goals


 New or amended goals

 Updates from care conferences

 Updates to our member's plan of care

 Discharge plans and needs identified (home health/DME, etc.)

 Anticipated discharge date

 Indiana Code requires that individuals requesting a nursing facility admission to a Medicaid-certified NF meet a nursing facility level of care (405 IAC 1-3-1 and 405 IAC 1-3-2.). A PASRR is required before admission and must be submitted with the admission request and when updated according to IAC requirements.

 Please submit this information as requested by MHS nurse reviewer every 3-5 days.

# Prior Authorization (PA) Request

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

- Dates of service
- CPT/HCPCS codes
- Provider

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




# Prior Authorization (PA) Request

 MHS strives to return a decision on **all** PA requests within **two business days** of request.

 Reasons for a delayed decision may include:

- Lack of information or incomplete request
- Illegible faxed copies of PA forms – i.e handwriting is illegible or fax is otherwise not readable
- Request requiring Medical Director review

 MHS has up to **seven days** to render PA decisions.

 ***Denied Authorizations*** must follow the authorization appeal process, not the claims appeal process, claims appeals can not change the status of a denied authorization.


# Prior Authorization (PA) Request

 PA approval requires the need for medical necessity.

 Medical Management **does not** verify eligibility or benefit limitations:

- Provider is responsible for eligibility and benefit verification.

# Continuity of Care PA Request

 MHS will honor pre-existing authorizations from any other Medicaid program during the first 30 days of enrollment or up to the expiration date of the previous authorization, whichever occurs first, and upon notification to MHS. Include the approval from the prior MCE with the request.

***\*Reference: MHS Provider Manual Chapter 6***


# Pharmacy Requests


MHS Pharmacy Benefit Manager is Envolve.

Envolve Pharmacy Solutions:

 Preferred Drug Lists and authorization forms are available at [mhsindiana.com/provider/pharmacy](https://mhsindiana.com/provider/pharmacy):

- PA requests
- Phone 1-866-399-0928
- Fax non specialty drugs 1-866-399-0929
- Specialty drugs 1-866-678-6976
- [pharmacy.envolvehealth.com](https://pharmacy.envolvehealth.com)





 Formulary integrated into many Electronic Health Records (EHR) solutions.

 Online PA submission available through CoverMyMeds:

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

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

# Inpatient Prior Authorization

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

# **Web Portal**

# Web Authorization

 Providers can submit Prior Authorizations online via the MHS Secure Provider Portal at [mhsindiana.com/login](https://mhsindiana.com/login):

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

 **Exceptions**: Must submit hospice, home health and biopharmacy PA requests via **fax 1-866-912-4245**.

 Providers can check the authorization status on the portal.



# Secure Portal Registration or Login



[Home](#) [Find a Provider](#) [Portal Login](#) [Events](#) [Contact Us](#)

Contrast ☒ On ☐ Off [a](#) [a](#) [a](#) [language](#)

FOR MEMBERS

FOR PROVIDERS

GET INSURED

## FOR PROVIDERS

Login

[Become a Provider](#)

[Prior Authorization](#) [+](#)

[Dental Providers](#)

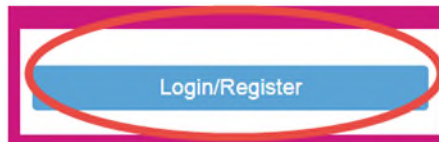
[Pharmacy](#) [+](#)

[Provider Resources](#) [+](#)

[QI Program](#) [+](#)

[Provider News](#)

## Portal Login



[Click here for more information](#) on the Provider Portal functions and training documents.

### Behavioral Health Secure Portal

[Click here for the Cenpatco behavioral health portal.](#)

### Registration Help

If you are having trouble with your registration, you may need to submit a non-par set-up form. Visit our [Become a Provider](#) page to get started. For further assistance, you can call our Secure Provider Portal Help Line at 1-866-912-0327.

### Create your own online account today!

MHS offers you many convenient and secure tools to assist you. To enter our secure portal, click on the login button. A new window will open. You can login or register.

Creating an account is free and easy.

By creating a MHS account, you can:

- Verify member eligibility
- Submit and check claims
- Submit and confirm authorizations
- View detailed patient list

Please note that Clear Claim Connection does not provide an all inclusive listing of claim edits. MHS does utilize additional prepayment review edits in keeping with NCCI procedures and guidelines.

# Registration

## Registration Complete!

Your Progress 

Thank you for completing your registration! A Superior HealthPlan provider services specialist will be sending you an email when your profile has been activated. Please allow up to 2 business days for processing.

If you do not receive an email within 2 business days, please log in and contact us using secure messaging or call 866-895-8443 for additional assistance.

Login



Features Join Our Network CREATE ACCOUNT

## The Tools You Need Now!

Our site has been designed to help you get your job done.

For registration or secure website questions call (866) 912-0327.

Manage all products with ease in one location



### Check Eligibility

Find out if a member is eligible for service.



### Authorize Services

See if the service you provide is reimbursable.



### Manage Claims

Submit or track your claims and get paid fast.

### Login

User Name ( Email )

name@domain.com

Password

Login

[Forgot Password / Unlock Account](#)

### Need To Create An Account?

Registration is fast and simple, give it a try.

Create An Account

### How to Register

Our registration process is quick and simple. Please click the button to learn how to register.

Provider Registration Video

Provider Registration PDF



Eligibility Patients Authorizations Claims Messaging Help

Provider Name

Viewing Dashboard For: Tax ID Number

Medicaid

GO

## Quick Eligibility Check

Member ID or Last Name




Birthdate

123456789 or Smith

mm/dd/yyyy

Check Eligibility

## Recent Claims

STATUS	RECEIVED DATE	MEMBER NAME	CLAIM NO.
	08/19/2017	C	4
	08/19/2017	T	3
	08/19/2017	C	1
	08/19/2017	F	8

## Welcome

Add a TIN to My ACCOUNT >

Manage Accounts >

Reports >

Patient Analytics >

Provider Analytics--Coming Soon >

## Recent Activity

Date

Activity


## Quick Links







[Provider Resources](#)

Please allow 24-48 hours for your account to be verified. An email will be sent once access to the portal tools have been granted to the respective account.

# Authorizations:


 View, create and filter group authorizations



 Eligibility
  Patients
  Authorizations
  Claims
  Messaging
  Help

Viewing Authorizations For :

**Authorizations**

 Filter

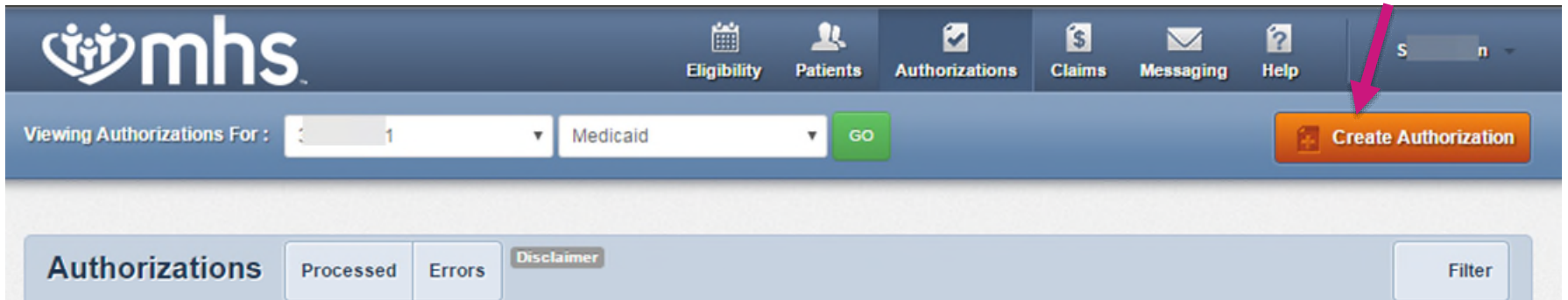
Please call the health plan for questions regarding voided authorization submissions. The authorization page is updated every 24 hours.

STATUS	AUTH ID	MEMBER	FROM DATE	TO DATE	DIAGNOSIS	AUTH TYPE	SERVICE
APPROVE	O [REDACTED] 1	AI [REDACTED] H	07/24/2017	10/24/2017	E11.9	OUTPATIENT	DME
<b>PARTIAL_APPROVE</b>	C [REDACTED] 9	[REDACTED] V	06/14/2017	09/19/2017	B07.9	OUTPATIENT	Office Visit

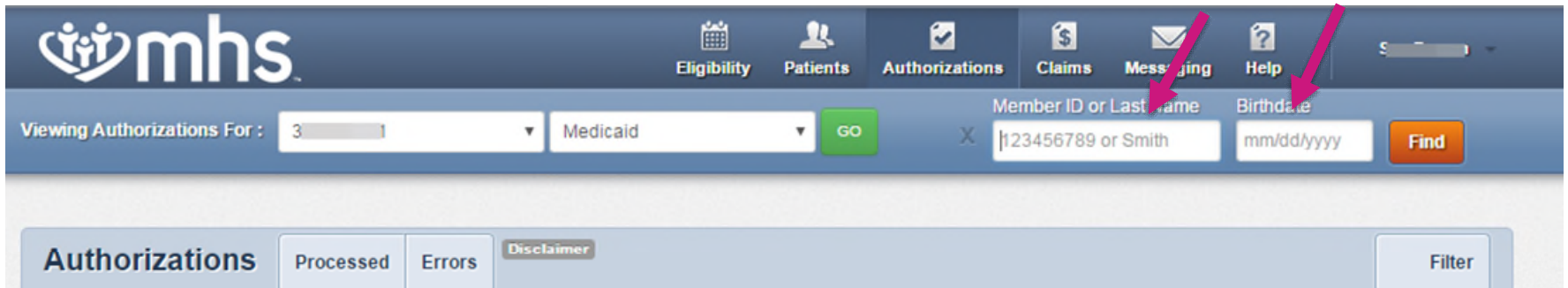
# Creating a New Authorization

 Click **Create Authorization**.

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



The screenshot shows the mhs portal interface. At the top, there is a navigation bar with icons for Eligibility, Patients, Authorizations, Claims, Messaging, and Help. Below this, there is a section for 'Viewing Authorizations For:' with a dropdown menu set to '1' and a 'Medicaid' filter. A green 'GO' button is next to it. On the right side of this section, there is an orange button labeled 'Create Authorization' with a red arrow pointing to it. Below the 'Viewing Authorizations For:' section, there is a table with columns for 'Authorizations', 'Processed', 'Errors', and 'Disclaimer'. A 'Filter' button is also present.

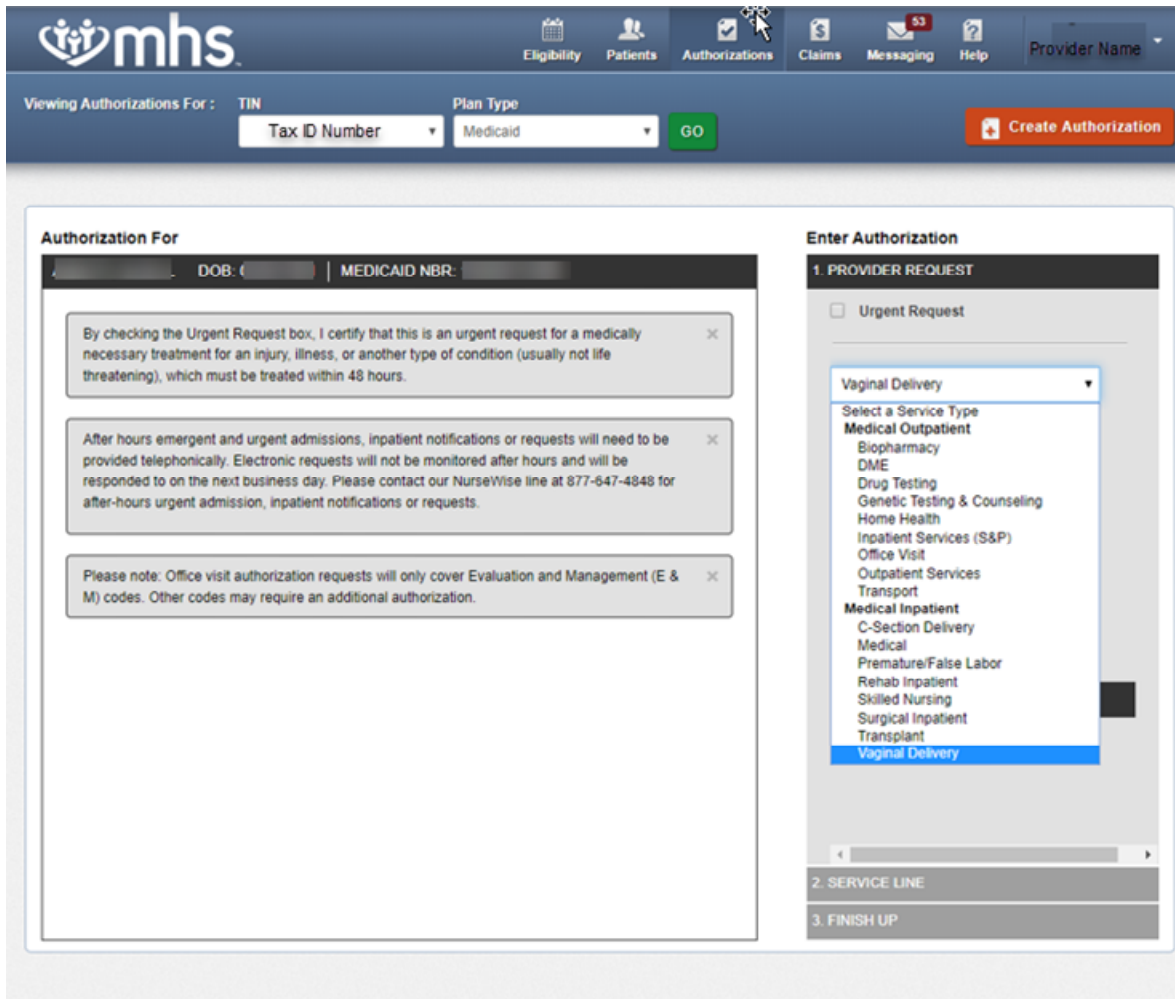


The screenshot shows the mhs portal interface. At the top, there is a navigation bar with icons for Eligibility, Patients, Authorizations, Claims, Messaging, and Help. Below this, there is a section for 'Viewing Authorizations For:' with a dropdown menu set to '3' and a 'Medicaid' filter. A green 'GO' button is next to it. To the right of the 'GO' button, there are two input fields: 'Member ID or Last Name' and 'Birthdate'. The 'Member ID or Last Name' field contains the text '123456789 or Smith' and the 'Birthdate' field contains the text 'mm/dd/yyyy'. A red 'X' icon is to the left of the 'Member ID or Last Name' field. A red arrow points to the 'Member ID or Last Name' field, and another red arrow points to the 'Birthdate' field. Below the input fields, there is an orange 'Find' button. Below the 'Viewing Authorizations For:' section, there is a table with columns for 'Authorizations', 'Processed', 'Errors', and 'Disclaimer'. A 'Filter' button is also present.



# Creating a New Authorization

## Select a Service Type



The screenshot shows the MHS Authorization System interface. At the top, there is a navigation bar with icons for Eligibility, Patients, Authorizations, Claims, Messaging, and Help. A dropdown menu for 'Provider Name' is also present. Below the navigation bar, there is a section for 'Viewing Authorizations For:' with fields for 'TIN' (Tax ID Number) and 'Plan Type' (Medicaid), a 'GO' button, and a 'Create Authorization' button.

The main content area is divided into two columns. The left column, titled 'Authorization For', contains fields for 'DOB' and 'MEDICAID NBR'. Below these fields are three informational boxes:

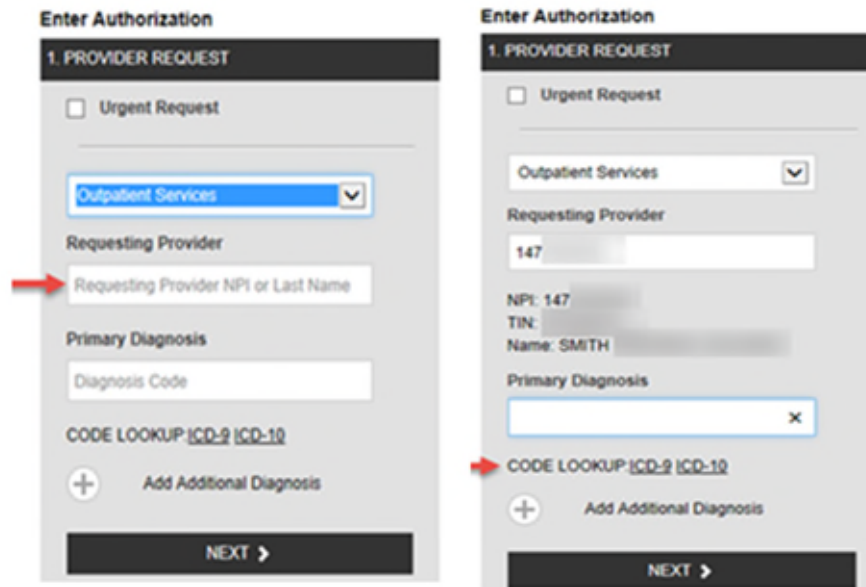
- By checking the Urgent Request box, I certify that this is an urgent request for a medically necessary treatment for an injury, illness, or another type of condition (usually not life threatening), which must be treated within 48 hours.
- After hours emergent and urgent admissions, inpatient notifications or requests will need to be provided telephonically. Electronic requests will not be monitored after hours and will be responded to on the next business day. Please contact our NurseWise line at 877-647-4848 for after-hours urgent admission, inpatient notifications or requests.
- Please note: Office visit authorization requests will only cover Evaluation and Management (E & M) codes. Other codes may require an additional authorization.

The right column, titled 'Enter Authorization', contains a section for '1. PROVIDER REQUEST'. It includes a checkbox for 'Urgent Request' and a dropdown menu for 'Select a Service Type'. The dropdown menu is currently open, showing a list of service types categorized under 'Medical Outpatient' and 'Medical Inpatient'. 'Vaginal Delivery' is selected and highlighted in blue.

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

# Creating a New Authorization

Select Provider NPI    Add Primary Diagnosis

The image displays two side-by-side screenshots of a web form titled "Enter Authorization". Both screenshots show the "1. PROVIDER REQUEST" section. The left screenshot has a red arrow pointing to the "Requesting Provider NPI or Last Name" input field. The right screenshot has a red arrow pointing to the "Primary Diagnosis" input field, which is currently empty and has a close button (X) in its top right corner. The form includes a "Urgent Request" checkbox, a "Service" dropdown menu (set to "Outpatient Services"), a "Requesting Provider" field (containing "147"), and fields for "NPI: 147", "TIN:", and "Name: SMITH". Below the "Primary Diagnosis" field is a "CODE LOOKUP: ICD-9 ICD-10" link and an "Add Additional Diagnosis" button with a plus icon. A "NEXT >" button is at the bottom of each form.


# Creating a New Authorization

 If required Add Additional Procedures

Authorization For

DOB:  MEDICAID NBR:

**PROVIDER REQUEST**

 Service Type: Outpatient Outpatient Services  
**SMITH**  
**GENERAL SURGERY**  
 Primary Diagnosis: 5430: HYPERPLASIA OF APPENDIX  
 Additional Diagnosis: 5379: UNSPEC DISORDER STOMACH&DUODENUM  
 NPI: 147  
 TIN:  
 Phone:

**Enter Authorization**

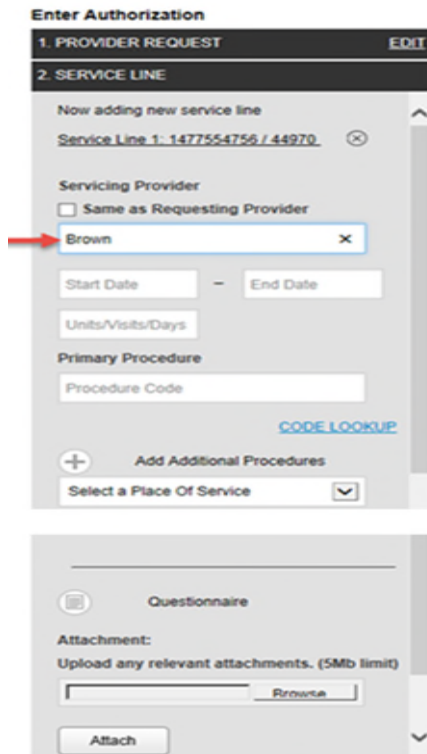
**1. PROVIDER REQUEST** [EDIT](#)

**2. SERVICE LINE**

TIN:  
 Name: SMITH  
 07/14/2015 - 07/24/2015  
 1  
 Primary Procedure  
 44970  
 LAPAROSCOPY RUSGICAL  
 APPENEDECTOMY  
[CODE LOOKUP](#)  
 + Add Additional Procedures  
 Select a Place Of Service  
 Ambulatory Surgical Center  
 Outpatient Hospital  
 Unspecified  
 + Add New Service Line  
 NEXT >

# Creating a New Authorization

## Service Line Details:



**Enter Authorization**

**1. PROVIDER REQUEST** EDIT

**2. SERVICE LINE**

Now adding new service line

Service Line 1: 1477554756 / 44970

Servicing Provider

☐ Same as Requesting Provider

Brown

Start Date - End Date

Units/Visits/Days

Primary Procedure

Procedure Code

[CODE LOOKUP](#)

+ Add Additional Procedures

Select a Place Of Service

Questionnaire

Attachment:

Upload any relevant attachments. (5Mb limit)

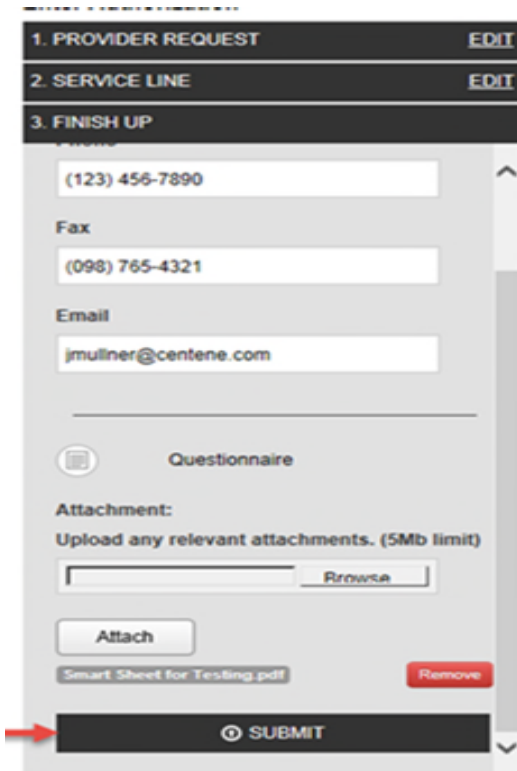
Attach

- Provider Request will appear on the left side of the screen.
- Update Servicing Provider:
  - Check box if same as Requesting Provider.
  - Update Servicing Provider information if not the same
- Update Start Date and End Date.
- Update Total Units/Visits/Days.
- Update Primary Procedure:
  - Code lookup provided.
- Add any additional procedures.
- Add additional Service Line if applicable:
  - All service lines added will appear on the left side of the screen.



# Creating a New Authorization

-  Submit a new Authorization:
- **Confirmation number.**



1. PROVIDER REQUEST [EDIT](#)

2. SERVICE LINE [EDIT](#)

3. FINISH UP

Phone  
(123) 456-7890

Fax  
(098) 765-4321

Email  
jmuliner@centene.com

Questionnaire

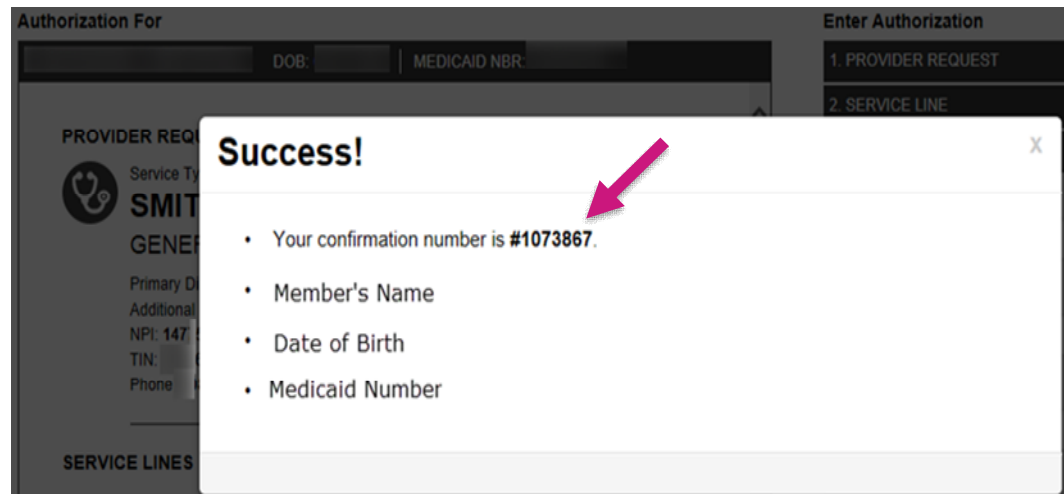
Attachment:  
Upload any relevant attachments. (5Mb limit)

[Browse](#)

[Attach](#)

Smart Sheet for Testing.pdf [Remove](#)

[SUBMIT](#)



Authorization For

DOB: | MEDICAID NBR: |

Enter Authorization

1. PROVIDER REQUEST

2. SERVICE LINE

PROVIDER REQUEST

Service Type  
**SMIT**

GENERAL

Primary Doctor  
Additional  
NPI: 147  
TIN:  
Phone:





SERVICE LINES

**Success!**

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

# Telephone Authorizations

# Telephone Authorization

-  Providers can initiate Prior Authorization via the MHS referral line by calling 1-877-647-4848:
  - Monday - Friday 8 a.m. to 5 p.m. (Closed for lunch from noon to 1 p.m.)
  - After hours, MHS 24-hour nurse line available to take emergent requests.
-  The PA process begins at MHS by speaking with the MHS non-clinical referral staff.
-  For procedures requiring additional review, we will transfer providers to a “live” nurse line to facilitate the PA process.
-  Please have all clinical information ready at time of call.

# **Fax Authorization**

# Fax Authorization

**MHS Medical Management Department at 1-866-912-4245:**

Patient Information					
IHCP Member ID (RID):					
Date of Birth:					
Patient Name:					
Address:					
City/State/ZIP Code:					
Patient/Guardian Phone:					
PMP Name:					
PMP NPI:					
PMP Phone:					
Ordering, Prescribing, or Referring (OPR) Provider Information					
OPR Physician NPI:					
Medical Diagnosis (Use of ICD Diagnostic Code Is Required)					
Dx1		Dx2		Dx3	

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

← Medical Diagnosis  
code(s) **required**

← Check service category

Please check the requested assignment category below:

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> DME              | <input type="checkbox"/> Inpatient            | <input type="checkbox"/> Physical Therapy |
| <input type="checkbox"/> <i>Purchased</i> | <input type="checkbox"/> Observation          | <input type="checkbox"/> Speech Therapy   |
| <input type="checkbox"/> <i>Rented</i>    | <input type="checkbox"/> Office Visit         | <input type="checkbox"/> Transportation   |
| <input type="checkbox"/> Home Health      | <input type="checkbox"/> Occupational Therapy | <input type="checkbox"/> Other            |
| <input type="checkbox"/> Hospice          | <input type="checkbox"/> Outpatient           |   |

# Fax Authorization

Requesting Provider Information:
NPI#:
Tax ID#:
Service Location Code:
Provider Name:
Rendering Provider Information
Ordering Physician NPI#:
Tax ID#:
Name
Address:
City/State/Zip:
Phone:
Fax:

← Enter the **Requesting** provider's information

← Enter the **Rendering** provider's individual NPI#

# Fax Authorization

Dates of Service Start                  Stop		Procedure/ Service Codes	Modifier(s)		Requested Service	Taxonomy	POS	Units	Dollars

# **Prior Authorization Denial and Appeal Process**



# PA Denial and Appeal Process

## If MHS denies the requested service:






- And the member is still receiving services, the provider has the right to an expedited appeal. The attending physician must request the expedited appeal.
- And the member already has been discharged, the attending physician must submit an appeal in writing within **60 days** of the denial.

The attending physician has the right to a peer-to-peer discussion with an MHS physician:

- Providers initiate peer-to-peer discussions and expedited appeals by calling an MHS appeals coordinator at 1-877-647-4848.
- They must request peer-to-peer within **10 days** of the adverse determination.

***\*Prior authorization appeals are also known as medical necessity appeals.***

# PA Denial and Appeal Process

-  Send Prior Authorization/Medical Necessity Appeals to:  
**Managed Health Services**  
**Attn: Appeals Coordinator**  
**PO Box 441567**  
**Indianapolis, IN 46244**
-  Providers must initiate appeals within **60 days** of the receipt of the denial letter for MHS to consider.
-  We will communicate determination to the provider within **20 business days** of receipt.
-  ***A prior authorization appeal is different than a claim appeal request.***
-  ***This process is applicable to members and non-contracted providers.***

# **Behavioral Health Prior Authorization**

# Prior Authorization

## Prior Authorization:

- Please call MHS Care Management for inpatient and partial hospitalization authorizations at 1-877-647-4848.
- Follow prompts to Behavioral Health
  - Inpatient and Partial Hospitalization requires facilities to **fax** in the clinical information to 1-844-288-2591
- MHS accepts the IHCP Universal Prior Authorization form for BH services.
- Providers also have the option of using the MHS template BH PA forms available on our website.

# Prior Authorization

## Prior Authorization (cont.):

- MHS Authorization forms may be obtained on our website:  
<https://www.mhsindiana.com/providers/behavioral-health/bh-provider-forms.html>
  - Outpatient Treatment Request (OTR) Form; Fax: 1-866-694-3649
  - Intensive Outpatient/Day Treatment Form Mental Health/Chemical Dependency; Fax: 1-866-694-3649
  - Applied Behavioral Analysis Treatment (OTR); Fax: 1-866-694-3649
  - Psychological & Neuropsych Testing Authorization Request Form Fax: 1-866-694-3649
  - Residential/Inpatient Substance Use Disorder Treatment Prior Auth Form:
    - Fax Inpatient: 1-844-288-2591; Fax: Outpatient: 1-866-694-3649
    - Initial Assessment and Re-Assessment Forms
- If using the IHCP Universal form, please fax to the numbers listed above to reduce fax transfers.

# Prior Authorization

## **Prior Authorization (cont.):**

- If MHS determines that additional information is needed, MHS will call the provider, using the contact information provided on the OTR form, and providers are typically given 23-48 hours to call us back.
- Medical Necessity appeals must be received by MHS within 60 calendar days of the date listed on the denial determination letter. The monitoring of the appeal timeline will begin the day MHS receives and receipt-stamps the appeal. Medical necessity behavioral health appeals should be mailed or faxed to:

MHS Behavioral Health

ATTN: Appeals Coordinator

12515 Research Blvd, Suite 400

Austin, TX 78701

FAX: 1-866-714-7991

# Prior Authorization

## Services Requiring Prior Auth:

### Facility Services:

- Inpatient Admissions
- Intensive Outpatient Treatment (IOT)
- Partial Hospitalization
- SUD Residential Treatment

# Prior Authorization

## Services Requiring Prior Auth (Cont.)


### Professional Services:

- Psychiatric Diagnostic Evaluation (Limited to 1 per member per 12 month rolling year without authorization)
- Behavioral Health Outpatient Therapy “**BHOP Therapy**” (Limited to 20 visits per member, per practitioner, per 12 month Rolling period)
- Electroconvulsive Therapy
- Psychological Testing
  - Unless for Autism: then no auth is required
- Developmental Testing, with interpretation and report (non-EPSDT)
- Neurobehavioral status exam, with interpretation and report
- Neuropsych Testing per hour, face to face
  - Unless for Autism: then no auth is required
  - Non-Participating Providers only
- ABA Services



# Prior Authorization

## Limitations on BHOP Therapy:

 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 practitioner, 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 – 90847, 90849, 90853	Psychoanalysis & Family/Group Psychotherapy with or without patient

Please Note: CPT codes 90833, 90836, and 90838 for psychotherapy with medical evaluation and management are medical services. Therefore, the IHCP does not reimburse clinical social workers, clinical psychologists, or any mid-level practitioners (excluding nurse practitioners and clinical nurse specialists) for these codes.

\*Codes 90841, 90850, 90851 and 90852 are inactive for 2020 per CMS.


# Prior Authorization

## Limitations on BHOP Therapy (Cont.):





-  Effective 12/15/18, Managed Health Services (MHS) began applying this limitation for claims with dates of service (DOS) on or after 12/15/18. As of January 2020, claims exceeding the limit will deny EXTh: “Services exceeding 20 visits require Prior Authorization.”
-  If the member requires additional services beyond the 20 unit limitation, practitioners 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.
  - Please do not submit for BHOP Prior Auth until the 20 allowed visits have been fully exhausted. Requesting Prior authorization pre-maturely will result in the loss of a portion or all 20 allowed visits as the PA will take precedent over the 20 allowed visits.
-  Providers will need to determine if they have provided 20 visits to the member in the past rolling 12 months to determine if a prior authorization request is needed. DOS prior to 12/15/18 are not counted towards the 20 unit limitation.
-  “Per Practitioner” 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 claims only.

# Prior Authorization

## Limitations on BHOP Therapy (cont.):




-  For submission of prior authorization:
- BH prior authorization outpatient treatment request (OTR) forms located: <https://www.mhsindiana.com/providers/behavioral-health/bh-provider-forms.html>
  - Fax number for submission at the top: 1-866-694-3649.
  - It is best to include all service codes, duration/units/frequency requests on one OTR form per member.
  - MHS typical approved authorization date span is 3-6 months depending on medical necessity determination.
  - MHS internal turn-around time on OTR request is 7 days, while our contractual turnaround time is 14 days.
  - Decision letters, referred to either as a Notice of Coverage or Denial Letter is sent as a response to every request.

# Prior Authorization Form Submission (Helpful Tips)

-  The following section provides helpful tips when submitting BH and Substance Abuse prior authorizations. This information focuses on what information needs to be included within Provider Information sections of the PA forms. There are known frequent issues where provider incorrect entry is causing provider claim denials.
-  This information is being provided to reduce authorization submission errors which we anticipate will result in a decrease in provider claim denials.
-  Please Note: Previously approved PA's can be updated, within 30 days of the original request submission, for changes to:
  - Practitioner, and/or;
  - Dates of Service;
    - Unless the DOS overlaps a previous adverse determination (denial or partial approval), OR;
    - The DOS includes retro days (dates more than 1 business day prior to the initial request)
-  Updates/Corrections to Prior Authorizations must be requested prior to related claim denials.

# Prior Authorization Form Submission (Helpful Tips)





## Outpatient Treatment Request (OTR) Form:

-  Submit for professional BH services that require prior authorization including BHOP Therapy services; (Exception of ABA services which has its own separate Auth Form).
-  Form found at the following link: <https://www.mhsindiana.com/providers/behavioral-health/bh-provider-forms.html>
-  The NPI# entered on the OTR form, needs to match the NPI of the billing supervising MD, psychologist HSPP or Advanced Practice Registered Nurse (independently practicing).

PROVIDER INFORMATION	
Provider Name	
Provider Credential	MD <input type="checkbox"/> PHD <input type="checkbox"/> OTHER <input type="checkbox"/>
Group / Agency Name	
Physical Address	
Telephone Number	Facsimile Number
Medicaid / TPI / NPI #	Tax ID #
Please indicate to whom the authorization should be made	Individual Provider (Y/N) <input type="checkbox"/> Group / Facility (Y/N) <input type="checkbox"/>

# Prior Authorization Form Submission (Helpful Tips)






## Outpatient Treatment Request (OTR) Form (cont.):

-  Provider Information Section: Complete this field for the “rendering practitioner” billing for the service in box 24J of the CMS 1500 form.
-  Provider Name: Enter the name of the billing practitioner.
-  Medicaid/TPI/NPI #:
  - Mid-Level practitioner NPI **should not** be entered here.
  - **Do not enter your Group NPI** in this field! You must enter the rendering practitioner NPI that will be billed, (i.e. supervising MD, psychologist HSPP or Advanced Practice Registered Nurse (independently practicing), in box 24J of the CMS-1500 claim form.
-  Circle “**Yes**” under the “**Individual Provider**” option for whom the auth should be made to:

PROVIDER INFORMATION	
Provider Name	
Provider Credential	MD <input type="checkbox"/> PHD <input type="checkbox"/> OTHER <input type="checkbox"/>
Group / Agency Name	
Physical Address	
Telephone Number	Facsimile Number
Medicaid / TPI / NPI #	Tax ID #
Please indicate to whom the authorization should be made	Individual Provider (Y/N) <input type="checkbox"/> Group / Facility (Y/N) <input type="checkbox"/>

# Prior Authorization Form Submission (Helpful Tips)

## INTENSIVE OUTPATIENT/DAY TREATMENT FORM MENTAL HEALTH/CHEMICAL DEPENDENCY:

-  Submit for prior authorization of IOT services with this form found here:  
<https://www.mhsindiana.com/providers/behavioral-health/bh-provider-forms.html>
-  IOT services can either be billed on a UB-04 form (for facility billing) or CMS-1500 form.
-  Prior Authorization submission must match the combination in which the Provider intends to bill:
  -  Facility Billing: Must submit the IOT auth form under the Facility NPI, and checking the applicable REV Code.
  -  Professional Billing: Must submit the IOT Auth form under the billing practitioner (Psych MD; Psychology HSPP or APRN) that will be billed within box 24J of the CMS 1500 form; Select the applicable HCPCS code for billing.

PROVIDER INFORMATION	
Check agency or provider to indicate how to authorize.	
<input type="checkbox"/> Agency/Group Name	
<input type="checkbox"/> Provider Name	
Professional Credentials	
Address/City/State	
Phone	Fax
NPI (required)	Tax ID (required)

Please check only one box.
<input type="checkbox"/> REV 905 ( Mental Health IOP)
<input type="checkbox"/> REV 906 ( CD IOP)
<input type="checkbox"/> REV 907 ( Day Treatment)
<input type="checkbox"/> HCPCS H0015 (Alcohol and/or drug services intensive outpatient treatment)
<input type="checkbox"/> HCPCS S9480 (Intensive outpatient psychiatric services per diem)
<input type="checkbox"/> HCPCS H0038



# Prior Authorization Form Submission (Helpful Tips)

## APPLIED BEHAVIORAL ANALYSIS (ABA) AUTHORIZATION FORM:



Submit for prior authorization of ABA services with this form found here:

[https://www.mhsindiana.com/content/dam/centene/mhsindiana/medicaid/pdfs/BH\\_IN\\_Medicaid\\_ABA\\_OTR.pdf](https://www.mhsindiana.com/content/dam/centene/mhsindiana/medicaid/pdfs/BH_IN_Medicaid_ABA_OTR.pdf)



BT201774 stated, “Effective March 1, 2018, reimbursement of ABA services will be made only to **enrolled ABA therapists** and enrolled school corporations.

- Enroll as a mental health provider with an ABA therapist specialty (provider type 11/provider specialty 615) to obtain an IHCP Provider ID for billing purposes.
- Providers already enrolled as a licensed HSPP (provider type 11/provider specialty 114) must add the new ABA specialty to their enrollment profile. This update must be made before March 1, 2018, to be reimbursed for DOS beginning March 1, 2018.



# Prior Authorization Form Submission (Helpful Tips)

## APPLIED BEHAVIORAL ANALYSIS (ABA) AUTHORIZATION FORM:



Please enter the information for your (IHCP/MHS) enrolled ABA therapist (BCBA-D, BCBA, HSPP), (provider type 11/provider specialty 615) into the Provider Name and Provider NPI# fields. **Do not enter a group NPI in the NPI# field!**

### BILLING PROVIDER INFORMATION

Provider Name:

Provider NPI#:

Tax ID#:

Provider Phone:

Group/Facility Name:




Group/Facility Address:

Phone Number:

Fax Number:

# Prior Authorization Form Submission (Helpful Tips)

## Residential/Inpatient Substance Use Disorder (SUD) Treatment Prior Authorization Request Form:

-  BT201801 indicates that SUD services are facility based services reimbursed to IHCP enrolled SUD residential addiction treatment facilities.
  - Provider type 35 – *Addiction Services*; and
  - Provider specialty 836 – *SUD Residential Addiction Treatment Facility*
-  BT201801 also states “Providers should bill using a professional claim.”
-  Rendering Practitioners are not allowed to be tied to Provider type 35/Specialty 836 (facilities only!)

# Prior Authorization Form Submission (Helpful Tips)

## Residential/Inpatient Substance Use Disorder (SUD) Treatment Prior Authorization Request Form:



Under the “Rendering Provider Information” fields of the auth form, please enter the IHCP/MHS enrolled SUD **facility NPI** under the Rendering Provider NPI field.

- Please Note: When billing SUD services on the professional claim form (CMS-1500) box 24J **cannot contain the NPI of a practitioner.** You must input the facility NPI in box 24J or leave blank.

Rendering Provider Information	
Rendering Provider NPI:	
Tax ID:	
Name:	
Address:	
City/State/ZIP Code:	
Phone:	
Fax:	

# **Provider Relations Team**

## 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

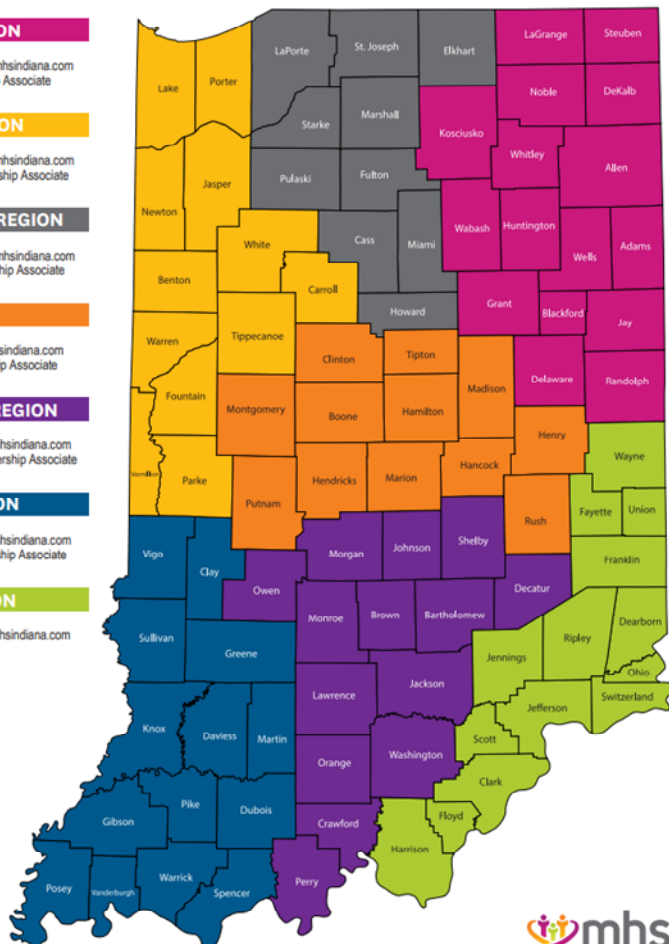
For claims issues, email:  
MHS\_ProviderRelations\_SC@mhsindiana.com  
Dalesia Denning, Provider Partnership Associate  
1-877-647-4848, ext. 20026

#### 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:  
MHS\_ProviderRelations\_SE@mhsindiana.com  
Carolyn Valachovic Monroe  
Provider Partnership Associate  
1-877-647-4848, ext. 20114



#### 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

Available online:

[https://www.mhsindiana.com/content/dam/centene/mhsindiana/medicaid/pdfs/ProviderTerritory\\_map\\_2021.pdf](https://www.mhsindiana.com/content/dam/centene/mhsindiana/medicaid/pdfs/ProviderTerritory_map_2021.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  
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  
jille.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.

#### CHERIE MCCARTER

Cherie.McCarter@EnvolveHealth.com  
Tynesha.James  
Tynesha.James@EnvolveHealth.com  
Dental Provider Services: 1-855-609-5157  
Questions: ProviderRelations@EnvolveHealth.com

### ENVOLVE VISION, INC.

#### CHANTEL MCKINNEY

Chantel.McKinney@EnvolveHealth.com  
Yojani Benitez  
Yojani.Benitez@EnvolveHealth.com  
Vision Provider Services: 1-844-820-6523  
Questions: Envolve\_AdvancedCaseUnit@EnvolveHealth.com

## Back of Map

Available online:

[https://www.mhsindiana.com/content/dam/centene/mhsindiana/medical/pdfs/ProviderTerritory\\_map\\_2021.pdf](https://www.mhsindiana.com/content/dam/centene/mhsindiana/medical/pdfs/ProviderTerritory_map_2021.pdf)

# **Questions?**

**Thank you for being our partner in care.**