Claims Issues & Disputes 2022

Agenda

- MHS Overview
- Claim Submission Process
- Portal Functionality
- Online Claim Reconsiderations on the MHS Secure Provider Portal
- MHS Provider Claims Issue Resolution Process
- Additional Claims Assistance
- MHS Team
- Summary
- Questions

MHS Overview

Who is MHS?

- Managed Health Services (MHS) is a health insurance provider that has been proudly serving Indiana residents for more than twenty-five years through Hoosier Healthwise, the Healthy Indiana Plan (HIP) and Hoosier Care Connect.

- **MHS is your choice for better healthcare.**

MHS Products

Claim Submission Process

Medical Claim Submission

- **Electronic Data Interchange Submission:**
  - Preferred method of claims submission
  - Faster and less expensive than paper submission
  - MHS Electronic Payor ID **68069**
- Online through the **MHS Secure Provider Portal** at mhsindiana.com/providers.html
- Provides immediate confirmation of received claims and acceptance
  - Institutional and Professional
  - Batch claims
  - Claim adjustments/corrections
  - Claim review/adjustments request
- **Paper Claims:**

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

Behavioral Health Claim Submission

- **Electronic Submission:**
  - Payer ID **68068**
  - MHS accepts Third Party Liability (TPL) information via Electronic Data Interchange
  - It is the responsibility of the provider to review the error reports received from the clearinghouse (Payer Reject Report)
- Online Submission through the **MHS Secure Provider Portal:**
  - Verify member eligibility
  - Submit and manage both Professional and Facility Claims, including 937 batch files
  - To create an account, go to: mhsindiana.com
- **Paper Claims:**
  - MHS Behavioral Health
    PO Box 6800
    Farmington, MO 63640-3818
- **Claim Inquiries:**
  - Check status online
  - Call Provider Services at 1-877-647-4848

Claim Billing with Ease

- **NPI, Tax ID, Zip +4**
- This information is necessary for the system to make a one-to-one match based off the information provided on the claim and the information on file with Indiana Medicaid.
  - Member Information
  - Newborn's Medicaid Identification number is required for payment
- **Attachment Forms:**
  - Required forms need to accompany the claim form
- **Secondary Claims (TPL):**
  - Accepted electronically from vendors or via the MHS Secure Provider Portal

Claim Submission

- Contracted or In-Network providers: 90 calendar days from the date of service or discharge date.
- Exceptions:
  - Newborns (30 days of life or less) – Claims must be received within 365 days from the date of service. Claim must be filed with the newborn's Medicaid Identification number.
  - TPL – Claims with primary insurance must be received within 365 days of the date of service with a copy of the primary Explanation of Benefits (EOB). If primary EOB is received after the 365 days, providers have *60 days* from date of primary EOB to file claim to MHS. If the third party does not respond within 90 days, claims may be submitted to MHS for consideration. Claims submitted must be accompanied by proof of filing with the patient's primary.

Claim Submission

Claim Acceptance & Adjudication

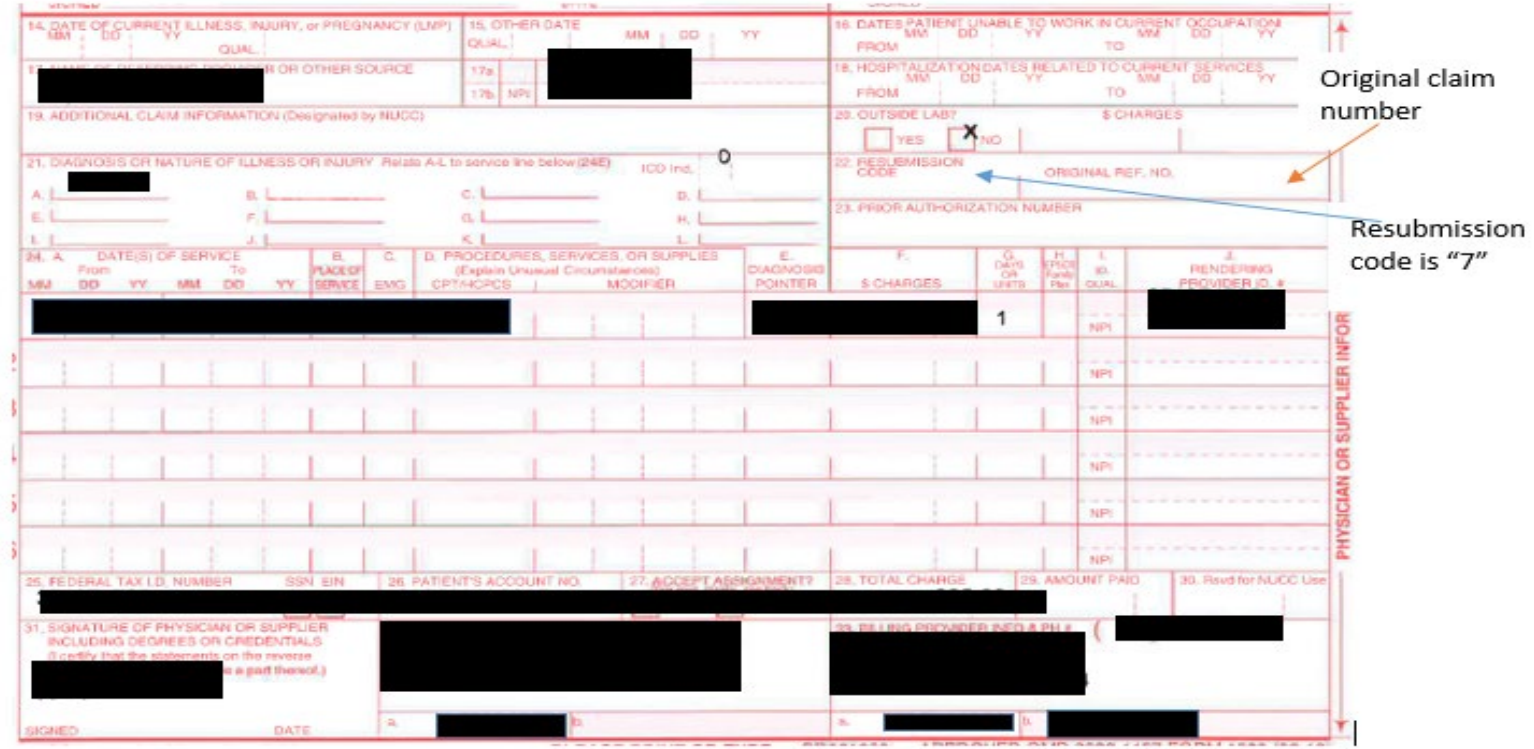
- System reviews claim for errors and critical fields (i.e. dates of service, billing/rendering provider, etc.) prior to acceptance.
- Regulatory requirements (federal and state) mandate certain information to be present in order to accept and pay a claim.
- National Provider Identifier (NPI) common rejection/denial; provider information on claim **must** match record at IHCP enrollment – a State requirement.

Paper Claim Corrections

- A corrected claim can be submitted following IHCP claim adjustment processes.
- A claim adjustment code is required on all claims, based on the type of claim submitted.
  - Example: Frequency 7 entered in Box 22 of the CMS-1500 form.
  - Example: Frequency 7 used as the last digit for the bill type on a UB-04 form (i.e. 1x7).
- The original claim number must also be listed on the corrected claim.
  - Box 22 on the CMS-1500 and box 64 on the UB-04
  - Remember a rejection, must be submitted as first-time claim, not as a corrected claim.
- Handwriting or stamping on a claim will not be accepted as submission of a corrected claim, and will be rejected with code RE.

Paper Claim Corrections

- If you must submit via paper – never handwrite “corrected claim” on the claim form.
- Complete box 22 (Resubmission Code) to include a 7 (the "Replace" billing code) to notify us of a corrected or replacement claim.



Claim Rejections

- EDI rejections require the provider to contact their clearinghouse and obtain a payer rejection report.
- Paper to electronic mapping is available on: mhsindiana.com/providers/resources/guides-and-manuals.html
- MHS website tools :
  - Reject code listing
  - Refer to top 10 rejection code help aid document mhsindiana.com/content/dam/centene/mhsindiana/medicaid/pdfs/0117-OS-P-WM-Top-10-Rejections-Education-Document-for-Portal-1-26-2018.pdf

Claim Rejections

Claim Rejection

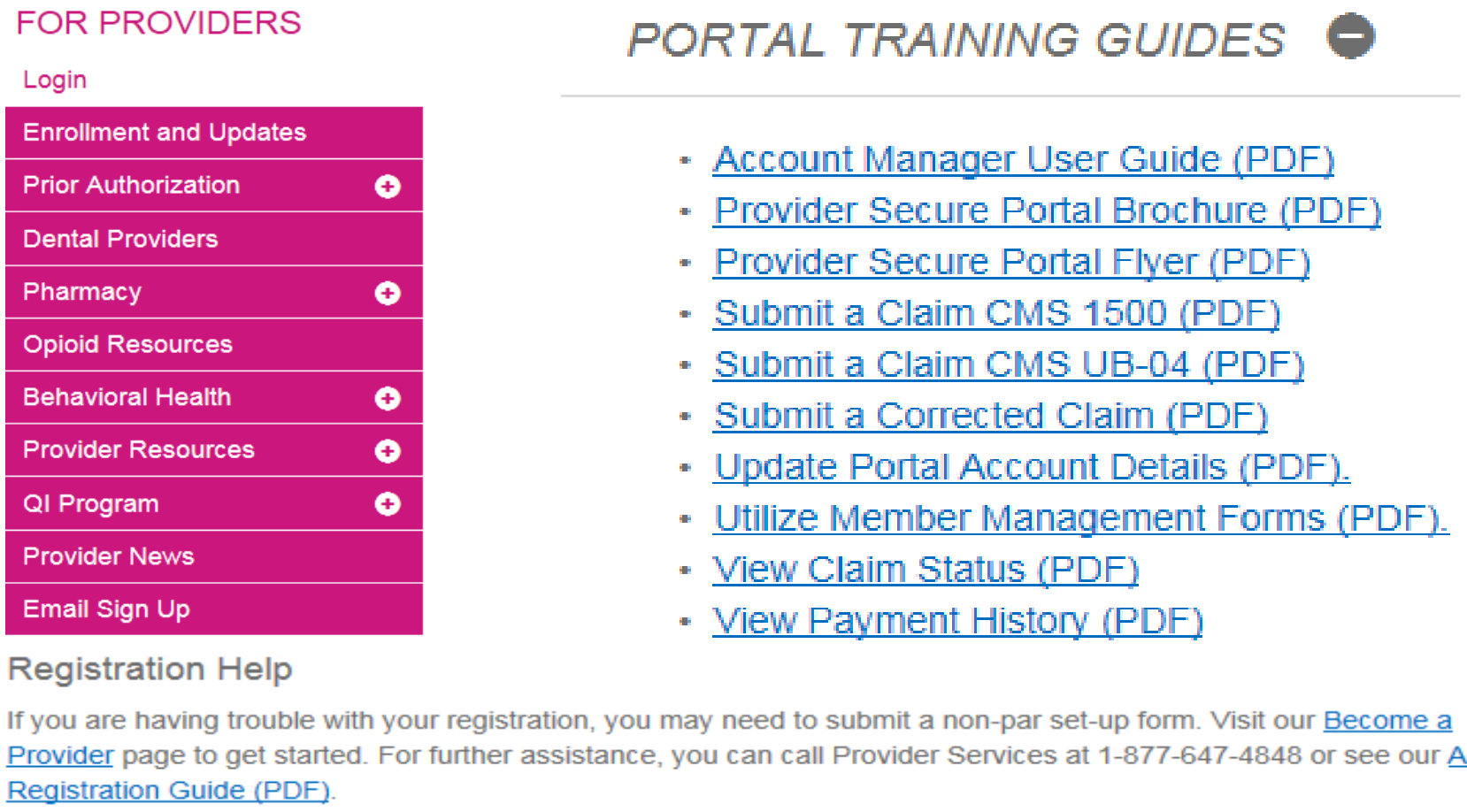
- A rejection is an unclean claim that contains invalid or missing data elements required for acceptance of the claim in the claim process system.
- Timely filing is not substantiated.
- Rejected claims need corrected and submitted as a new claim.
- Examples of rejected claims:
    - Provider/practitioner not enrolled in IHCP
    - Invalid member RID number
    - Incorrect type of bill for the service or location
    - Missing or invalid modifier

Portal Functionality

Web Portal Training Documents

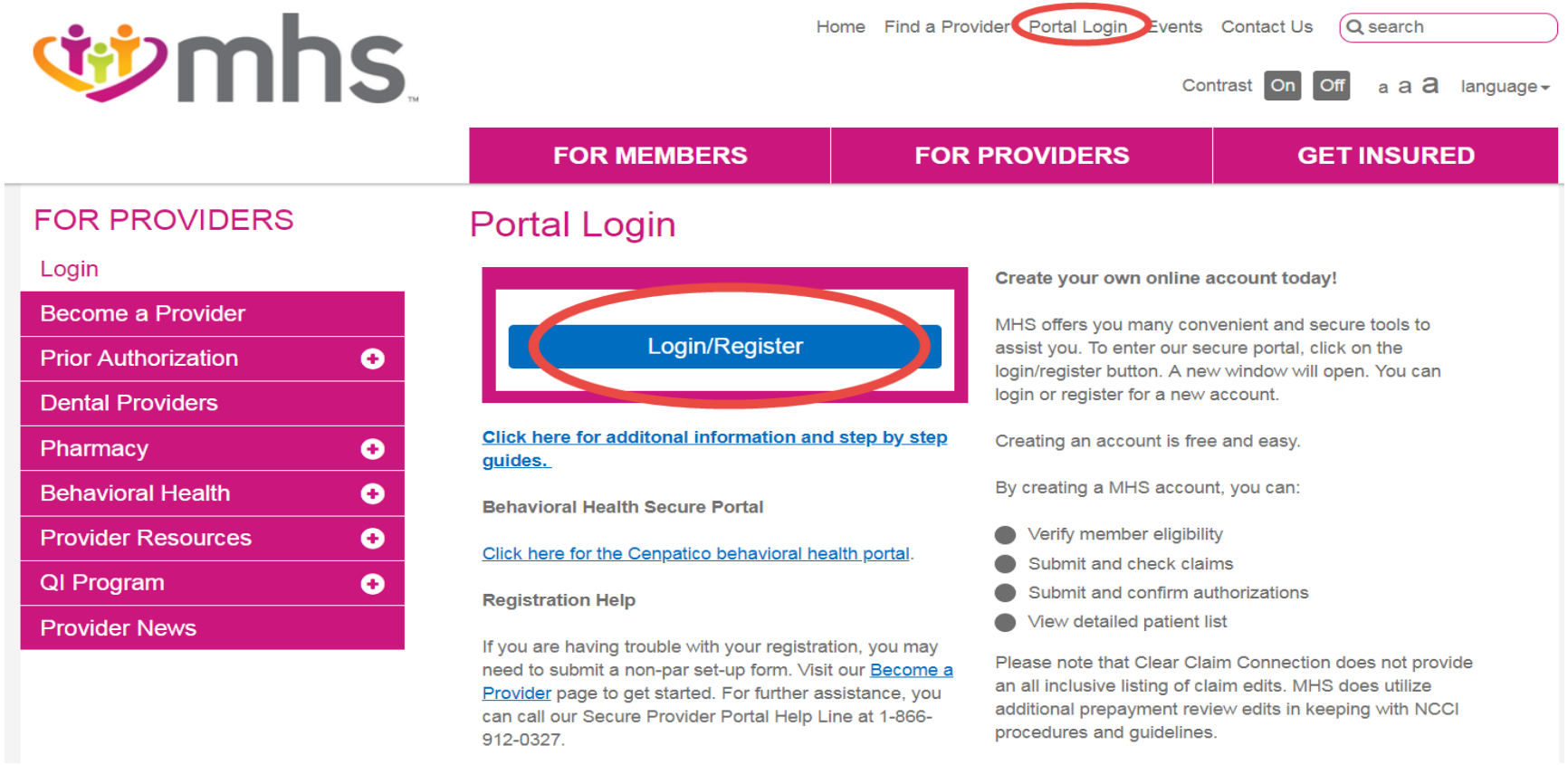
Documents Include:

- Registration Guide
- MHS Web Portal User Guides
- How To Complete Specific Tasks on the MHS Web Portal

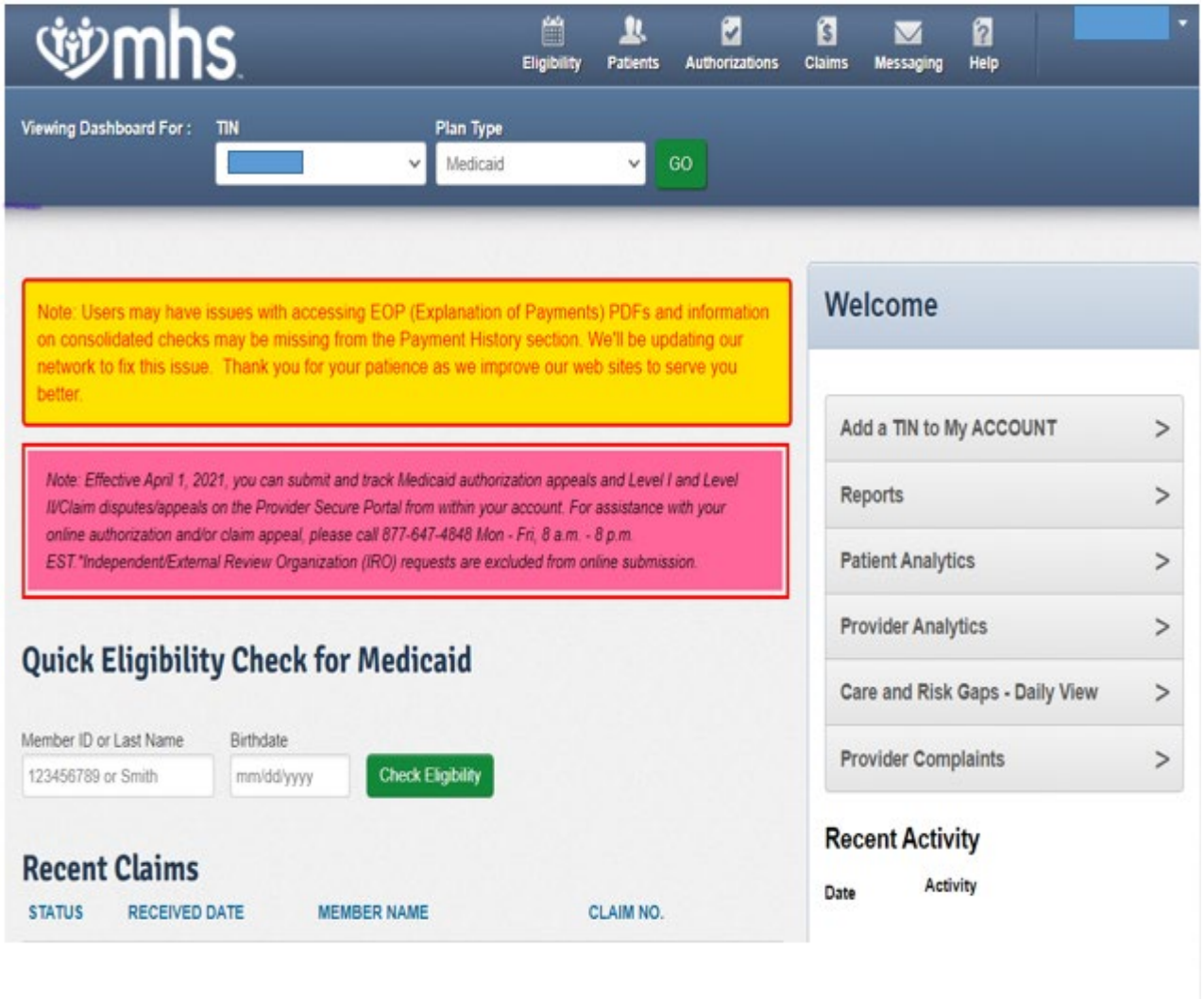


Secure Web Portal Login or Registration

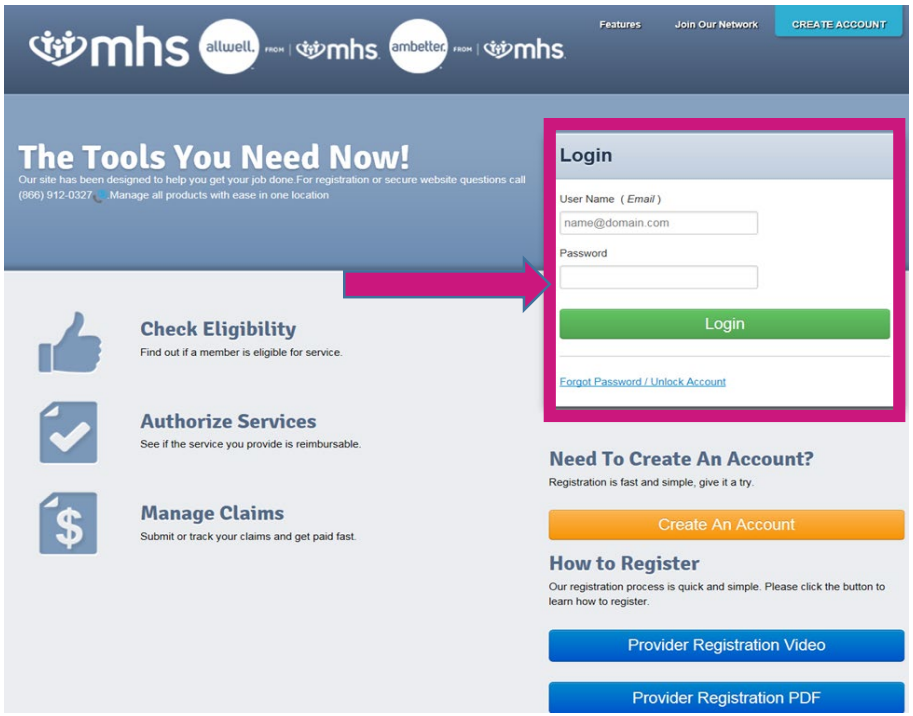
- Login/Register is the same for **MHS**, **Ambetter from MHS, Wellcare by Allwell from MHS** and **Behavioral Health** Providers.

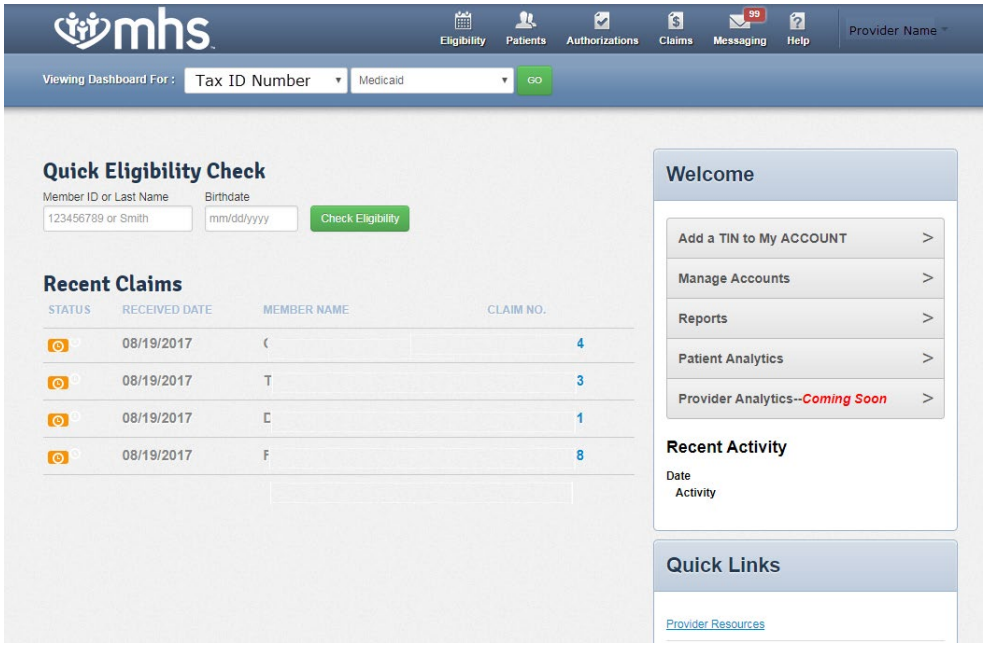


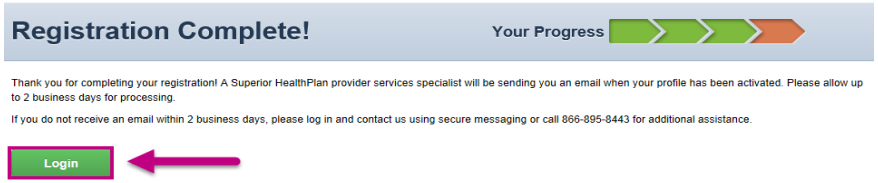
Homepage – MHS (Medicaid)



Complete Registration or Login







- The Registration is complete and the Secure Portal homepage will be visible!

- An email will be sent to the provider when they have access to specific tools.

Online Claim Reconsideration on the MHS Secure Provider Portal

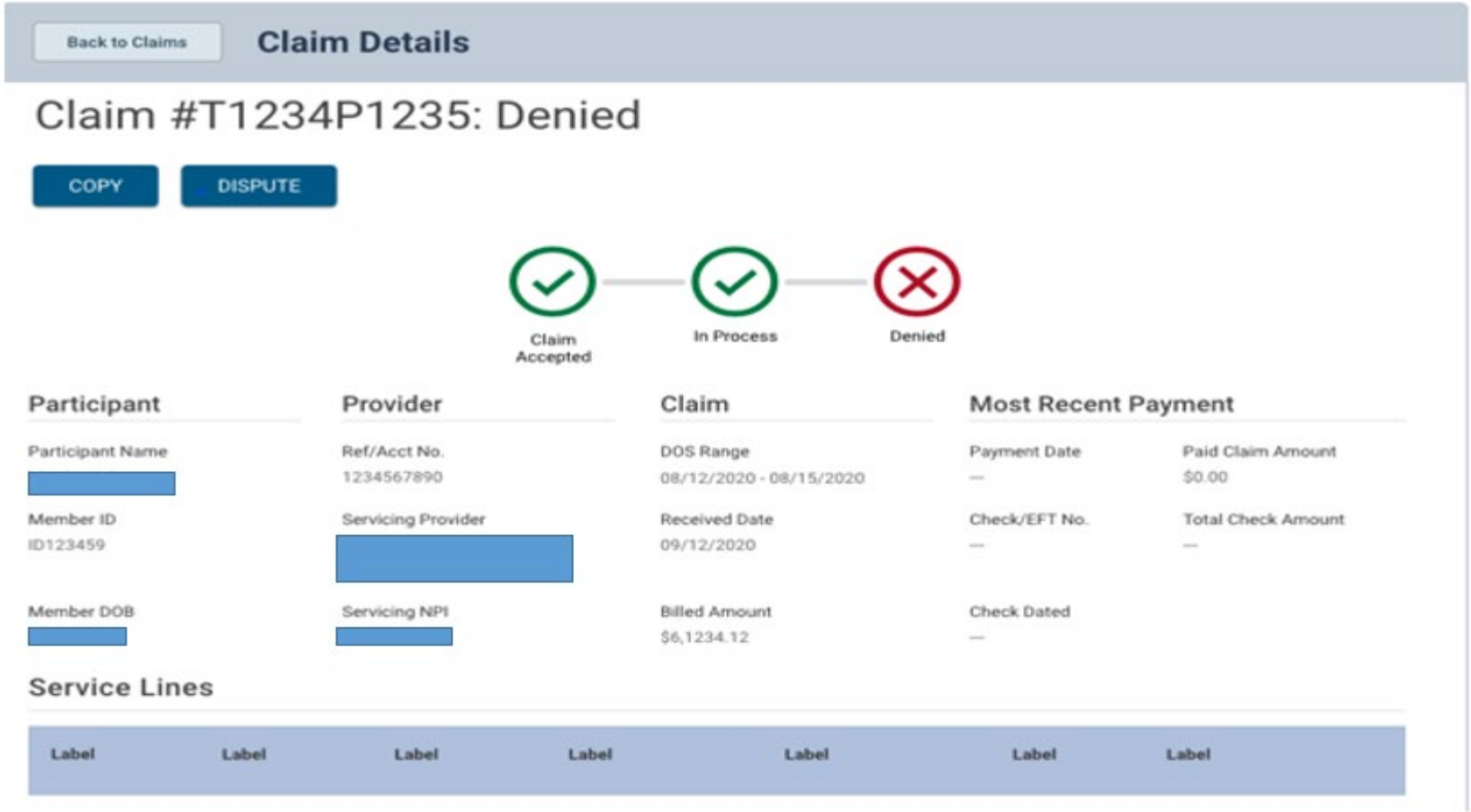
Online Reconsiderations

- Providers may now view denial code information.
- Providers will be able to:
  - Submit informal disputes/reconsiderations on the secure portal
  - Upload/view supporting documents
  - View acknowledgement letters
  - Track real-time updates

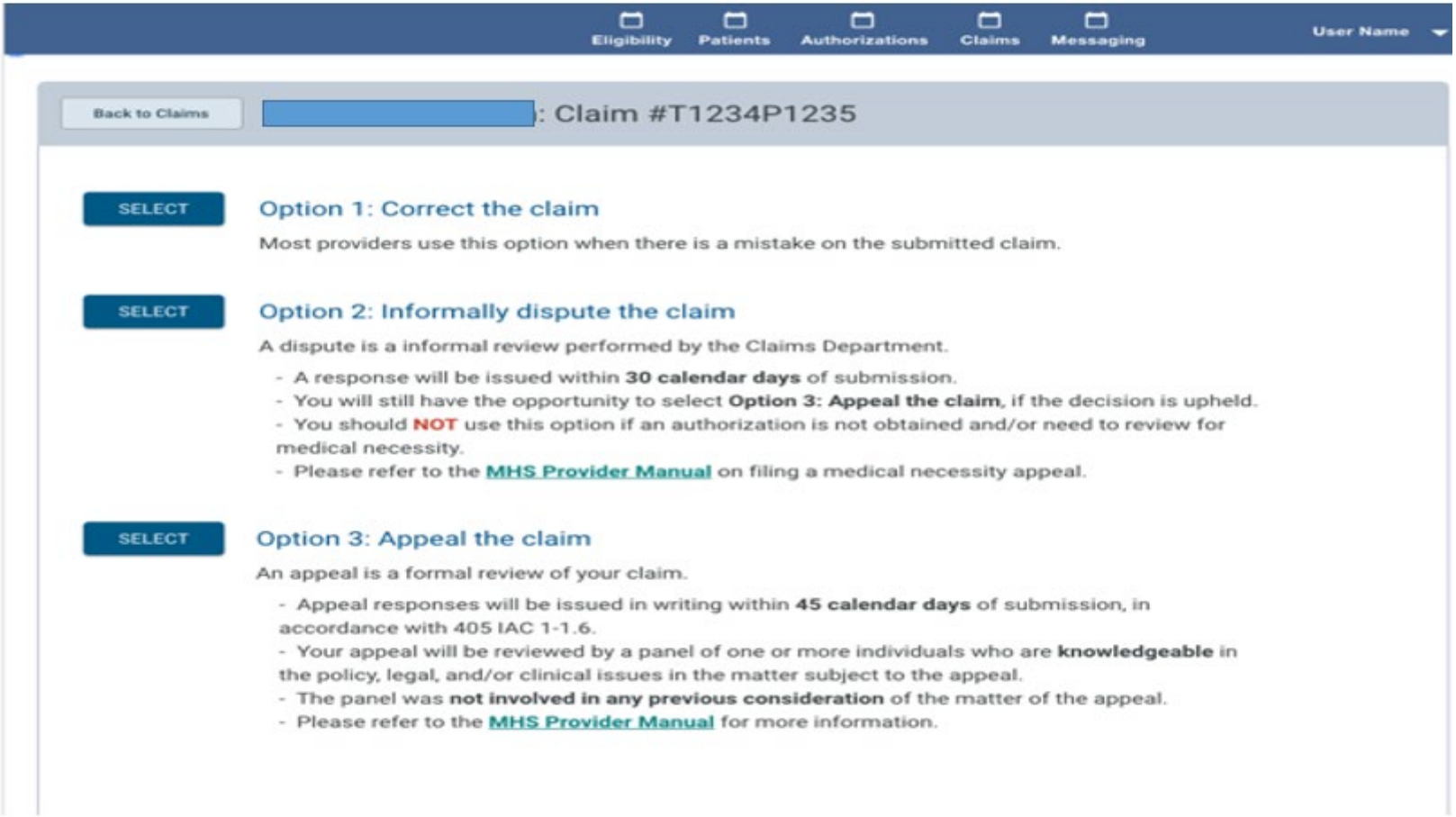
Online Reconsiderations

- It is important to note that all requests submitted via the online Portal for Level 1 will be considered an **informal dispute.** (Secure messages are not considered reconsiderations/appeals.)
- Calling Provider Services **will not** pause the time frame for timely submissions for informal disputes.
- Providers **do not** need to call prior to submitting an online claim reconsideration/information dispute.
- Providers may include a dispute form, but it is not required, as they may include comments directly into the portal.

Level 1 Informal Claim Dispute and Level 2 Claim Appeals on the Secure Provider Portal

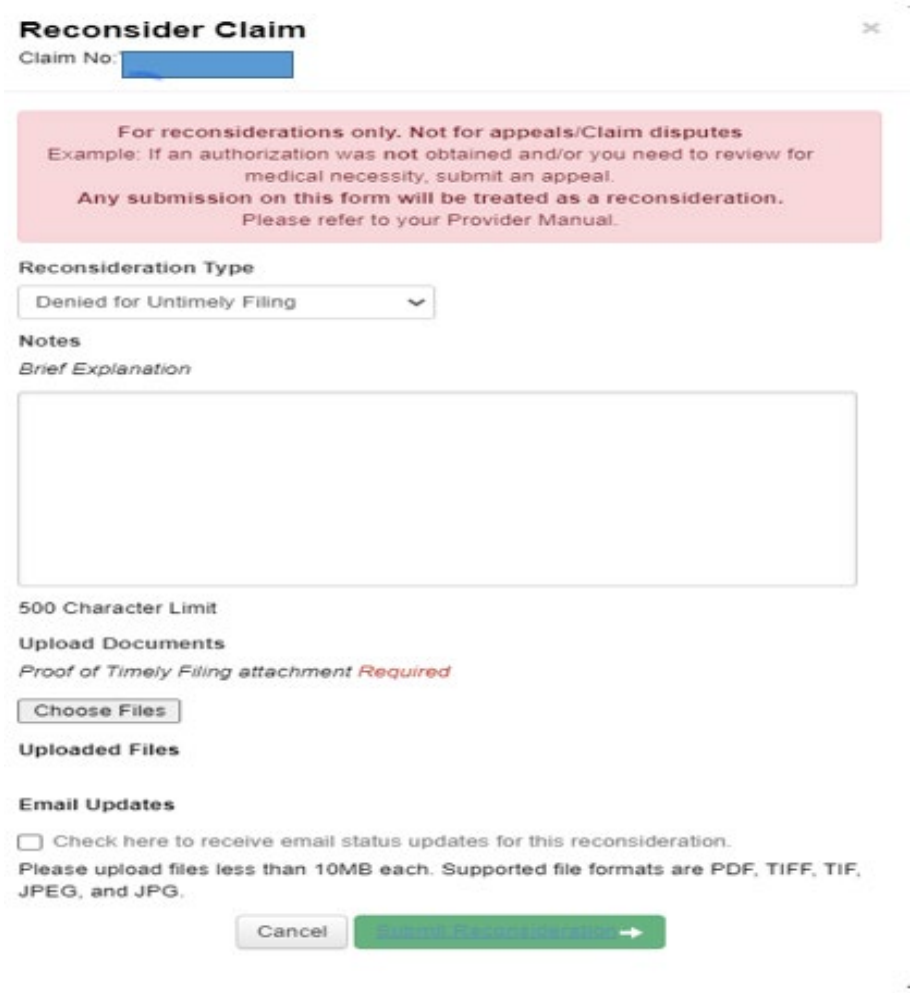


Level 1 Informal Claim Dispute and Level 2 Claim Appeals on the Secure Provider Portal

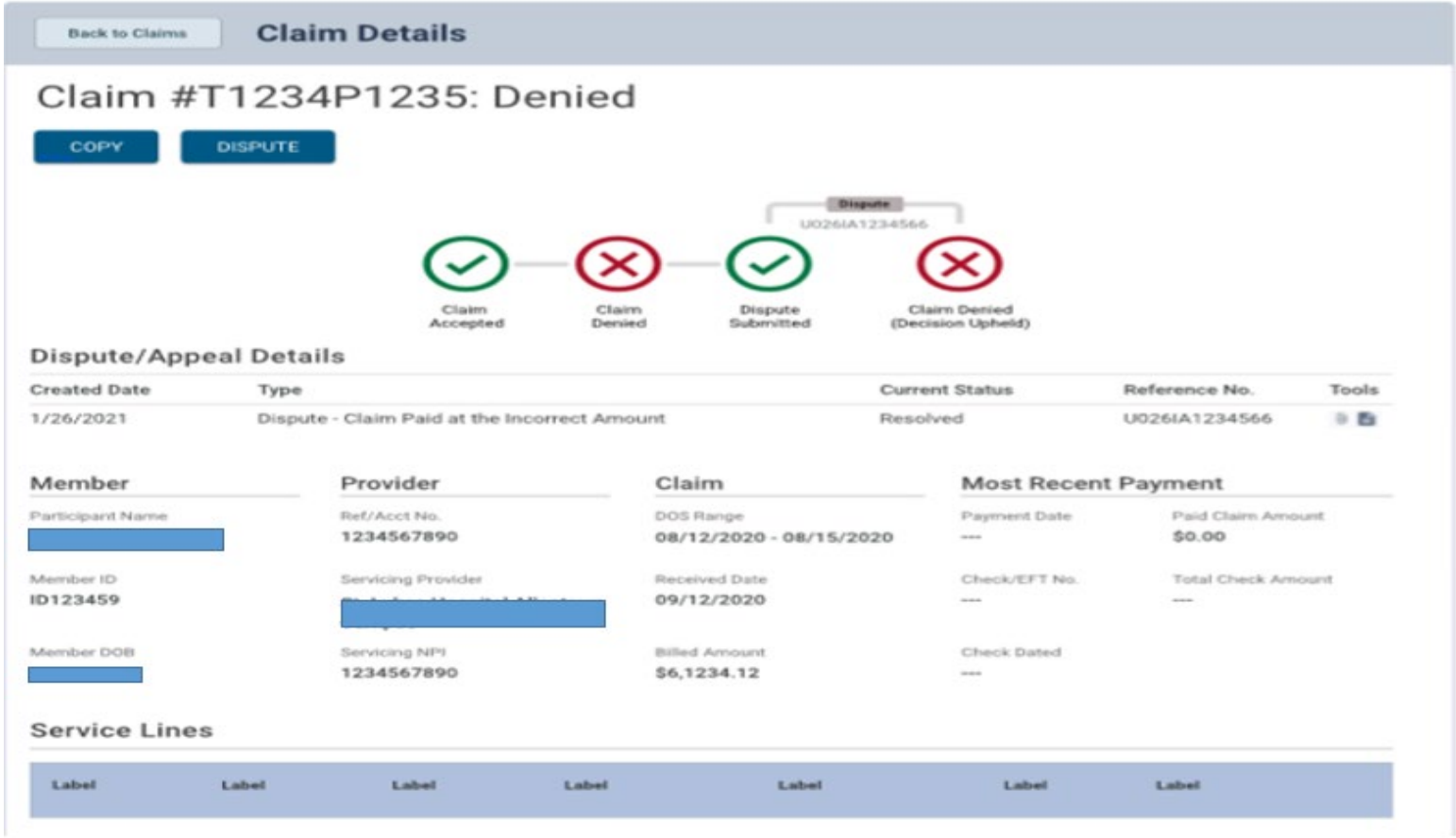


Claim Reconsiderations

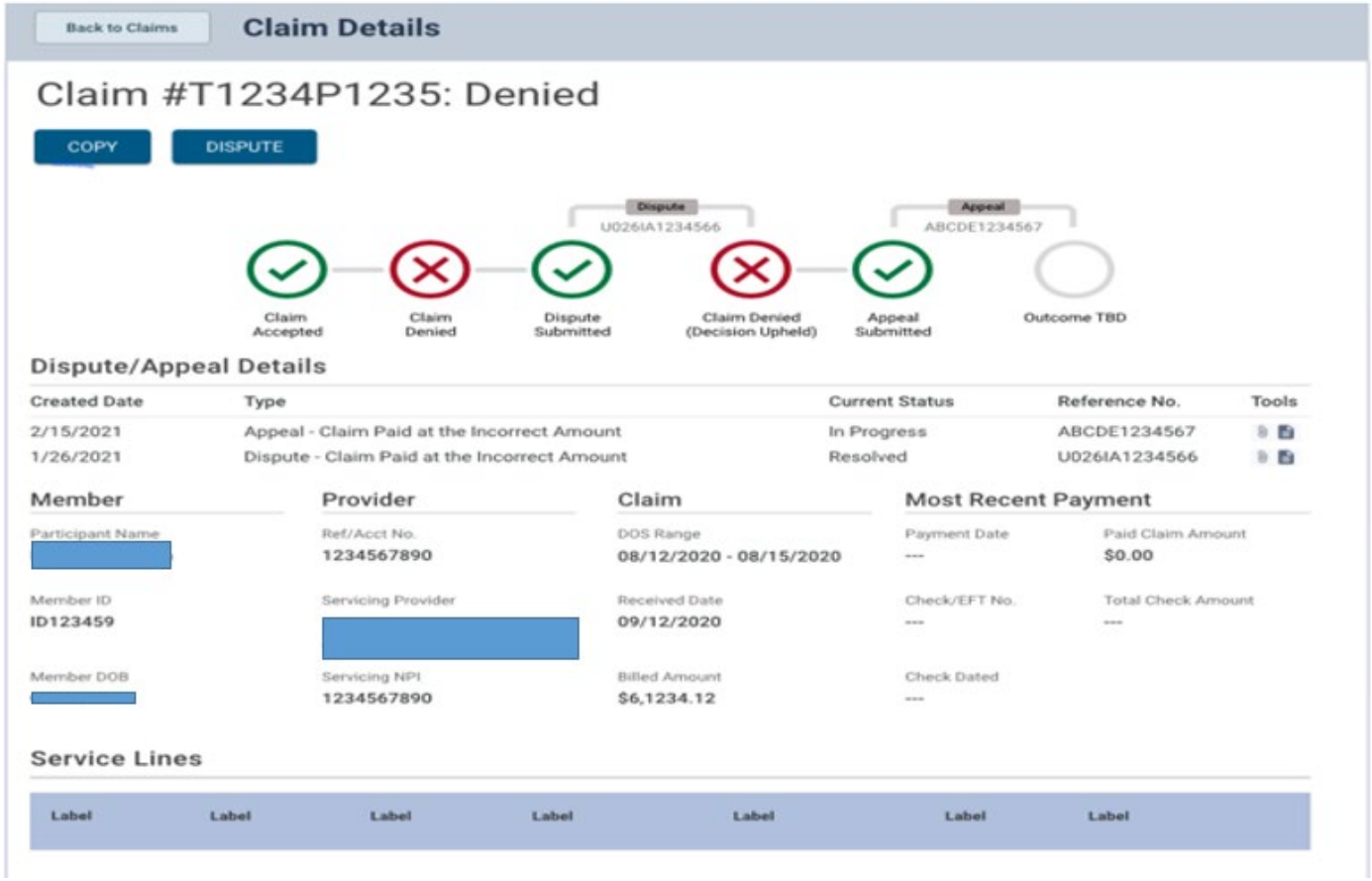
Enter your explanation for reconsideration and check email updates.



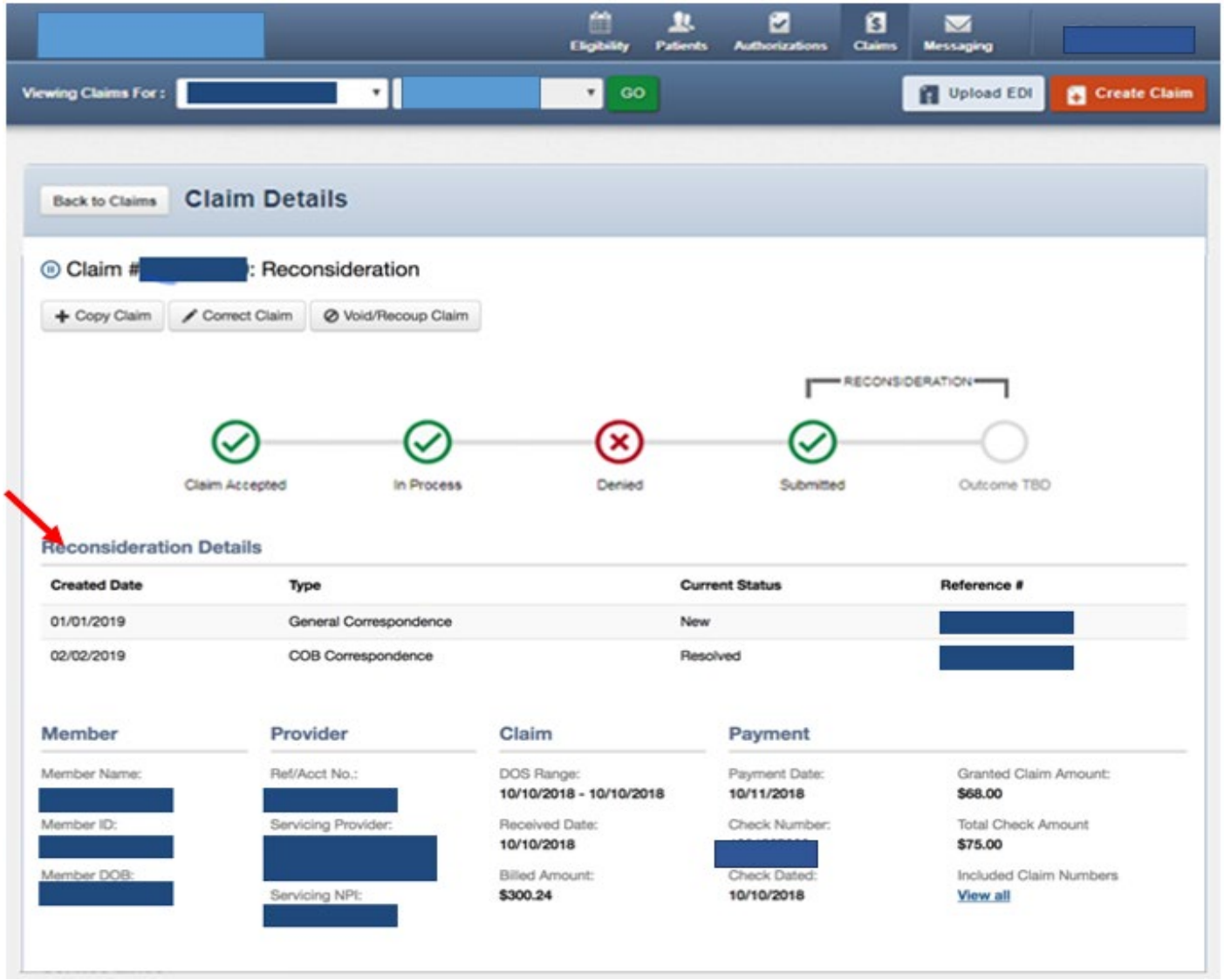
Level 1 Informal Claim Dispute and Level 2 Claim Appeals on the Secure Provider Portal



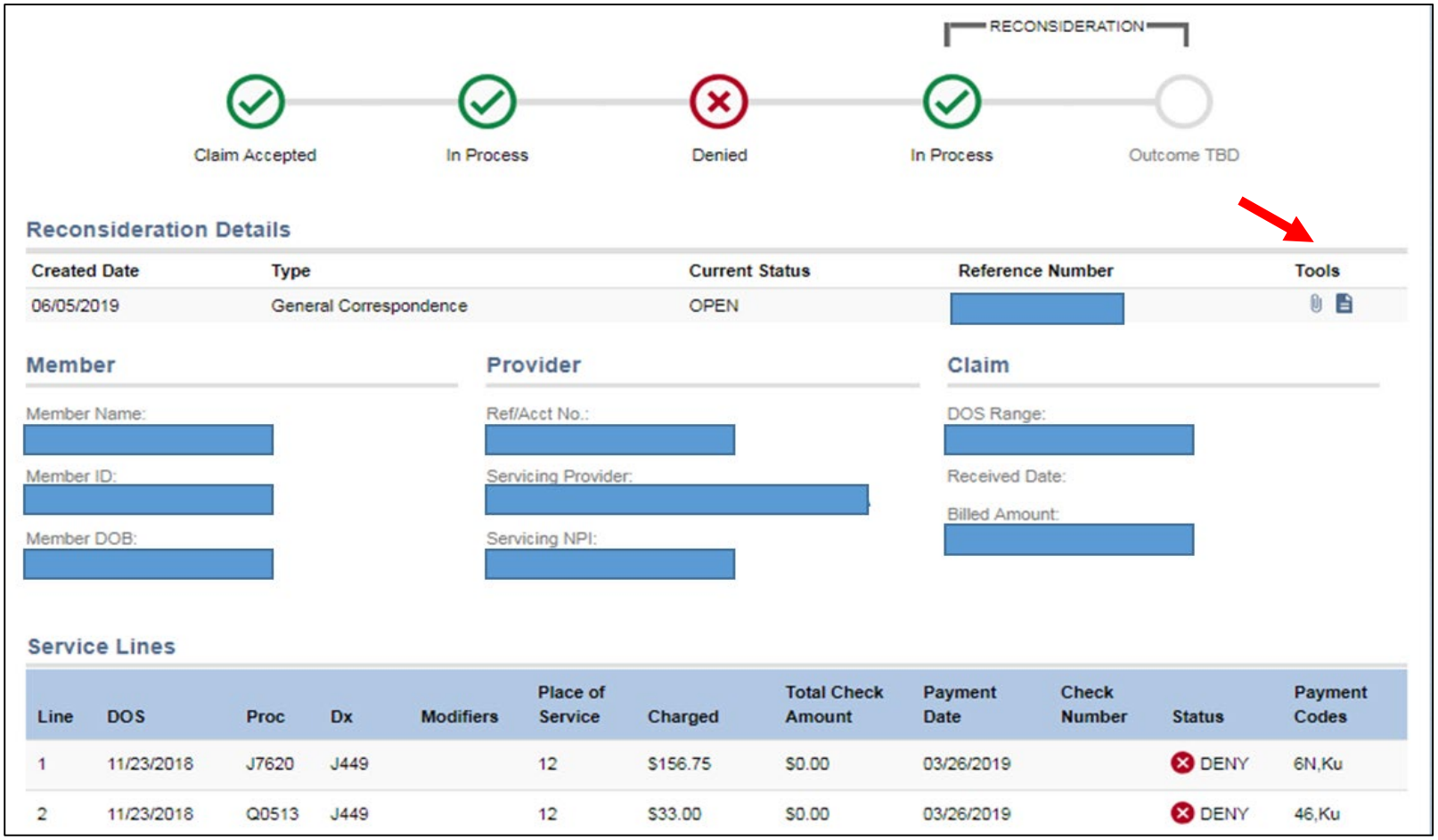
Level 1 Informal Claim Dispute and Level 2 Claim Appeals on the Secure Provider Portal



Online Reconsiderations

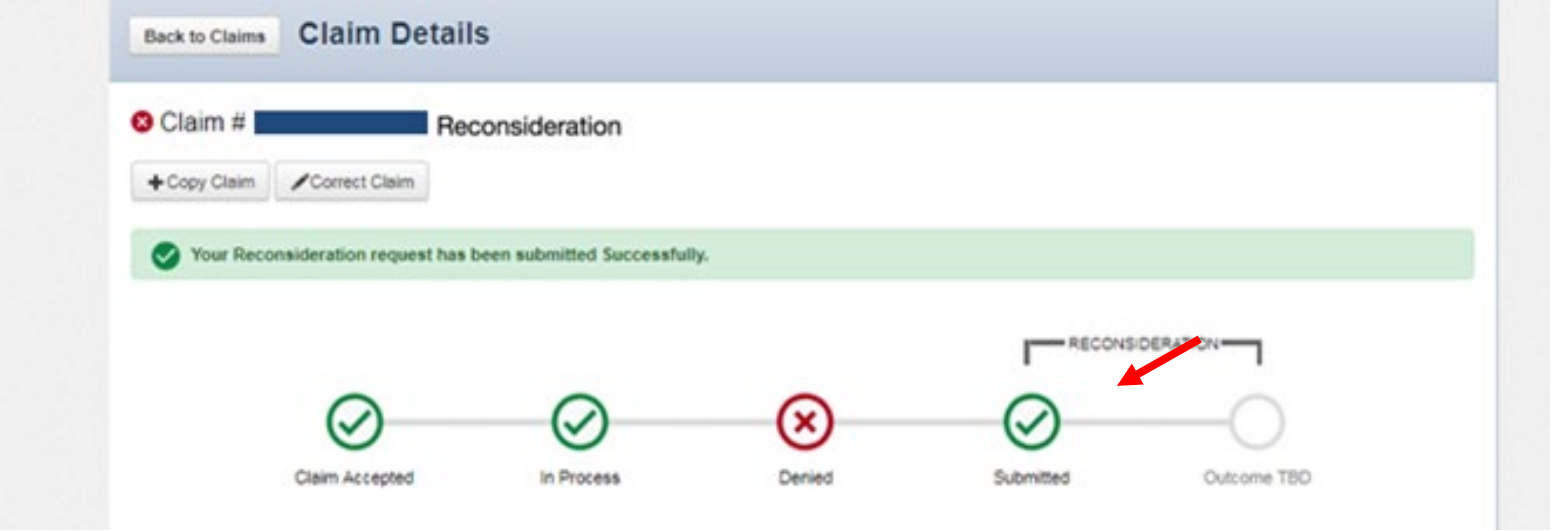


Online Reconsiderations Additional Attachments



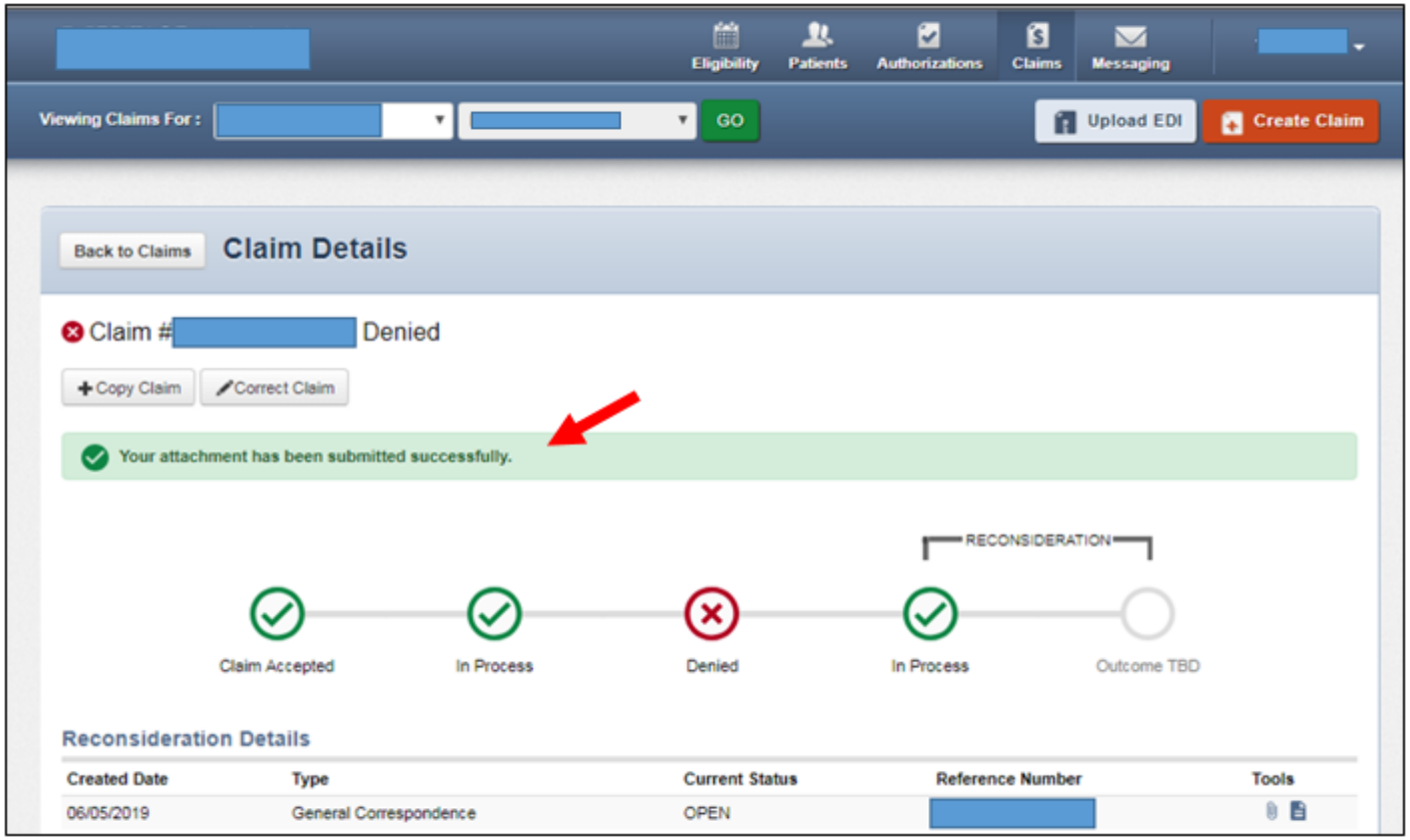
Online Reconsiderations

- The tracker graphic will be updated to reflect that a reconsideration is in progress.



Additional Attachments – Success Banner

- Upon successful upload of files, a success banner is displayed.



Summary Of Online Reconsiderations

- **Skip the phone call.** Providers can make their case directly on the portal.
- **Make the case.** Providers can submit informal dispute/reconsideration comments using expanded text fields.
- **Add context.** Providers can easily attach supporting documentation when filing an informal dispute/reconsideration.
- **Stay current.** Providers may opt in/out for informal dispute/reconsideration status change emails. Providers may also view status online.

MHS Provider Claims Issue Resolution Process

Provider Claims Issue Resolution

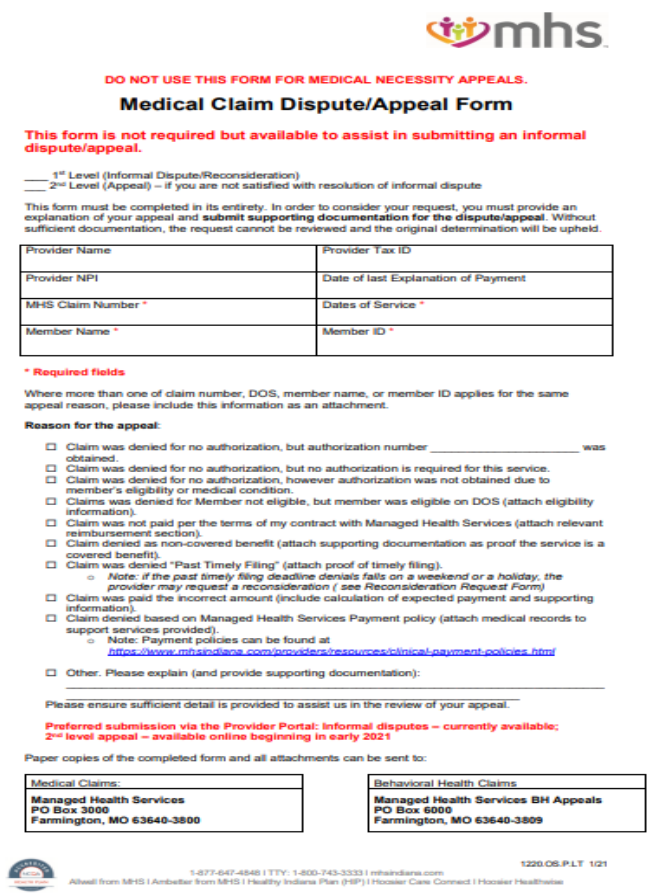
PROCESS

- Level 1: Informal Claims Dispute Online or with Medical Claim Dispute/Appeal form
- Level 2: Formal Claim Dispute –Administrative Claim Appeal Online or with Medical Claim Dispute/Appeal form
- Level 3: Arbitration
- Please note, this is different than an Authorization appeal. A claim appeal cannot change a denied authorization status. To change authorization status, you must appeal the denied authorization.

Claim Dispute/Appeal Form – Medical and Behavioral Health

- **Medical Claims Address:**
  Managed Health Services
  PO Box 3000
  Attn: Appeals Department
  Farmington, MO 63640-3800

- **Behavioral Health Claims Address:**
  Managed Health Services BH
  Appeals
  PO Box 6000
  Attn: Appeals Department
  Farmington, MO 63640-3809



DO NOT USE THIS FORM FOR MEDICAL NECESSITY APPEALS.

Medical Claim Dispute/Appeal Form

This form is not required but available to assist in submitting an informal dispute/appeal.

___1st Level (Informal Dispute/Reconsideration)
___2nd Level (Appeal) – if you are not satisfied with resolution of informal dispute

This form must be completed in its entirety. In order to consider your request, you must provide an explanation of your appeal and **submit supporting documentation for the dispute/appeal**. Without sufficient documentation, the request cannot be reviewed and the original determination will be upheld.

Provider Name	Provider Tax ID
Provider NPI	Date of last Explanation of Payment
MHS Claim Number *	Dates of Service *
Member Name *	Member ID *

* Required fields

Where more than one of claim number, DOS, member name, or member ID applies for the same appeal reason, please include this information as an attachment.

Reason for the appeal:

- ☐ Claim was denied for no authorization, but authorization number _____ was obtained.
- ☐ Claim was denied for no authorization, but no authorization is required for this service.
- ☐ Claim was denied for no authorization, however authorization was not obtained due to member's eligibility or medical condition.
- ☐ Claims was denied for Member not eligible, but member was eligible on DOS (attach eligibility information).
- ☐ Claim was not paid per the terms of my contract with Managed Health Services (attach relevant reimbursement section).
- ☐ Claim denied as non-covered benefit (attach supporting documentation as proof the service is a covered benefit).
- ☐ Claim was denied "Past Timely Filing" (attach proof of timely filing).
  - *Note: if the past timely filing deadline denials falls on a weekend or a holiday, the provider may request a reconsideration (see Reconsideration Request Form)*
- ☐ Claim was paid the incorrect amount (include calculation of expected payment and supporting information).
- ☐ Claim denied based on Managed Health Services Payment policy (attach medical records to support services provided).
  - Note: Payment policies can be found at https://www.mhsindiana.com/providers/resources/clinical-payment-policies.html
- ☐ Other. Please explain (and provide supporting documentation):

Please ensure sufficient detail is provided to assist us in the review of your appeal.

Preferred submission via the Provider Portal: Informal disputes – currently available; 2nd level appeal – available online beginning in early 2021

Paper copies of the completed form and all attachments can be sent to:

Medical Claims:	Behavioral Health Claims
Managed Health Services **PO Box 3000** **Farmington, MO 63640-3800**	**Managed Health Services BH Appeals** **PO Box 6000** **Farmington, MO 63640-3809**

1220.OS.P.LT 1/21

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

mhsindiana.com/content/dam/centene/mhsindiana/medicaid/pdfs/MHS-Dispute-Appeal-form.pdf

Informal Claims Dispute or Objection Form

Level 1:

- Submit all documentation supporting your objection.

- Must be submitted via the Secure Web Portal or in writing within 60 calendar days of receipt of the MHS Explanation of Payment (EOP) by using the Medical Claim Dispute/Appeal form.
  - Requests received after day 60 will not be considered.
  - Copies of original MHS EOP showing how the claims in question were processed required.
  - Copies of any subsequent MHS EOPs or other determinations on the claim(s) in question required.
  - Documentation of any previous attempt you have made to resolve the issue with MHS required.
  - Other documentation that supports your request for reprocessing or reconsideration of the claim(s) required.

Informal Claims Dispute or Objection Form

Level 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 60 calendar days from date of dispute response to initiate a formal claim appeal (Level 2).

Informal Claims Dispute or Objection Form

Level 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 EOP/remit
      - Brief description of 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

Level 2:

- Level 2 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 60 calendar days from receipt of the informal dispute resolution notice.

- An administrative claim appeal must be submitted via the Secure Portal or in writing by using the Medical Claim Dispute/Appeal form with an explanation, including any specific details which may justify reconsideration of the disputed claim. The appeal should be clearly marked on the form as Level 2.

- See the MHS Provider Manual Chapter 5 Claims Administrative Reviews and Appeals for more information. mhsindiana.com/content/dam/centene/mhsindiana/medicaid/pdfs/508-Provider-Manual-2021.pdf

Arbitration

Level 3:

- Level 3 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 (Level 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.
- See the MHS Provider Manual Chapter 5 Claims Administrative Reviews and Appeals for more information. mhsindiana.com/content/dam/centene/mhsindiana/medicaid/pdfs/508-Provider-Manual-2021.pdf

Provider Services Phone Requests & Web Portal Inquiries

- After the informal claims dispute (Level 1) has been submitted, for assistance or questions the provider can access the Provider Service Phone line, or Web Portal.

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. - 8 p.m.**
- **Provider Web Portal:** **https://www.mhsindiana.com/providers/login.html**
  - Use the Messaging Tool.

Provider Services Phone Requests & Web Portal Inquiries

Helpful Tips:

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

Additional Claim Assistance

Provider Relations Regional Mailboxes

- This is not considered a formal notification of provider dispute.
- If all claim denials are upheld after following the dispute processes and the provider has not received resolution by calling Provider Services or utilizing the secure messaging on the portal, please contact MHS Provider Relations through the claims issues mailbox assigned to your region.
- Issues will be logged by the internal Provider Relations team and providers will receive a response email with next steps and any assigned reference numbers. Response to incoming email can take 2-4 weeks depending on workload.
- Please do not email your Provider Partnership Associate directly as this may delay the time in getting a response due to their travel.

Provider Relations Regional Mailboxes

Helpful Tips:

- Please submit the following information to the provider relations regional mailbox (attach spreadsheet if multiple claims, but below fields must be included).
  - Issue Reference Number(s)
  - TIN
  - Group/Facility Name
  - Practitioner Name & NPI
  - Member Name and RID Number
  - Product (Medicaid/Ambetter/Wellcare By Allwell)
  - Claim Number(s)
  - DOS or DOS Range, if multiple denials
  - Related Prior Authorization Numbers (this is key if issue involves claims denied for no authorization)
  - Provider reason for dispute

Provider Relations

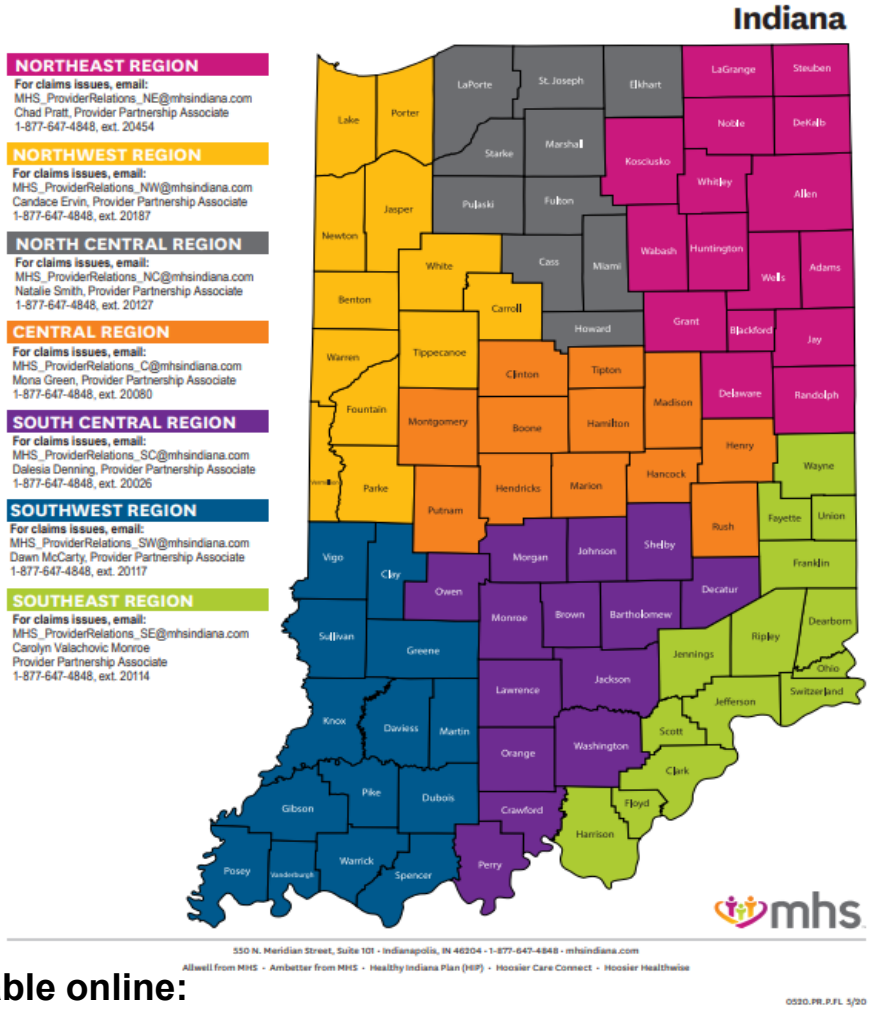
Regional Mailboxes

Regional Mailboxes

- **Northeast Region:** MHS_ProviderRelations_NE@mhsindiana.com
- **North Central Region:** MHS_ProviderRelations_NC@mhsindiana.com
- **Central Region:** MHS_ProviderRelations_C@mhsindiana.com
- **Northwest Region:** MHS_ProviderRelations_NW@mhsindiana.com
- **Southwest Region:** MHS_ProviderRelations_SW@mhsindiana.com
- **Southeast Region:** MHS_ProviderRelations_SE@mhsindiana.com
- **South Central Region:** MHS_ProviderRelations_SC@mhsindiana.com
- **Tier 1 Providers:** IndyProvRelations@mhsindiana.com

MHS Team

MHS Provider Network Territories



Available online:
mhsindiana.com/content/dam/centene/mhsindiana/medicaid/pdfs/ProviderTerritory_map_2021.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. 20080

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
Program Manager,
Provider Engagement
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

ENVOLVE DENTAL, INC.
ANTWAN PEREZ-ALVAREZ
Antwan.Perez-Alvarez@EnvolveHealth.com
Tyneshia James
Tyneshia.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

Network Leadership

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
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Questions?

Thank you for being our partner in care.