










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.

The image shows a paper claim form with several fields filled out or annotated. Key annotations include:





- An orange arrow pointing to box 18 (Original claim number) with the text "Original claim number".
- A blue arrow pointing to box 22 (Resubmission code) with the text "Resubmission code is '7'".
- Box 22 contains the value "7".
- Box 23 (Prior authorization number) contains the value "1".
- Box 24 (Date(s) of service) shows a range from MM/DD/YY to MM/DD/YY.
- Box 25 (Federal tax ID number) contains a redacted number.
- Box 26 (Patient's account number) contains a redacted number.
- Box 27 (Accept assignment?) is checked.
- Box 28 (Total charge) contains a redacted amount.
- Box 29 (Amount paid) contains a redacted amount.
- Box 30 (Red for NUCC Use) is checked.
- Box 31 (Signature of physician or supplier) contains a redacted signature.
- Box 32 (Billing provider NPI & PI #) contains a redacted NPI and PI #.

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

FOR PROVIDERS

Login

Enrollment and Updates
Prior Authorization 
Dental Providers
Pharmacy 
Opioid Resources
Behavioral Health 
Provider Resources 
QI Program 
Provider News
Email Sign Up

PORTAL TRAINING GUIDES

- [Account Manager User Guide \(PDF\)](#)
- [Provider Secure Portal Brochure \(PDF\)](#)
- [Provider Secure Portal Flyer \(PDF\)](#)
- [Submit a Claim CMS 1500 \(PDF\)](#)
- [Submit a Claim CMS UB-04 \(PDF\)](#)
- [Submit a Corrected Claim \(PDF\)](#)
- [Update Portal Account Details \(PDF\)](#)
- [Utilize Member Management Forms \(PDF\)](#)
- [View Claim Status \(PDF\)](#)
- [View Payment History \(PDF\)](#)

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 Provider Services at 1-877-647-4848 or see our [Account Registration Guide \(PDF\)](#).

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**.



FOR MEMBERS

FOR PROVIDERS

GET INSURED

FOR PROVIDERS

Login

Become a Provider

Prior Authorization

Dental Providers

Pharmacy

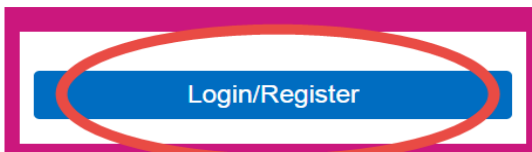
Behavioral Health

Provider Resources

QI Program

Provider News

Portal Login



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

Behavioral Health Secure Portal

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

Registration Help

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

Create your own online account today!

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

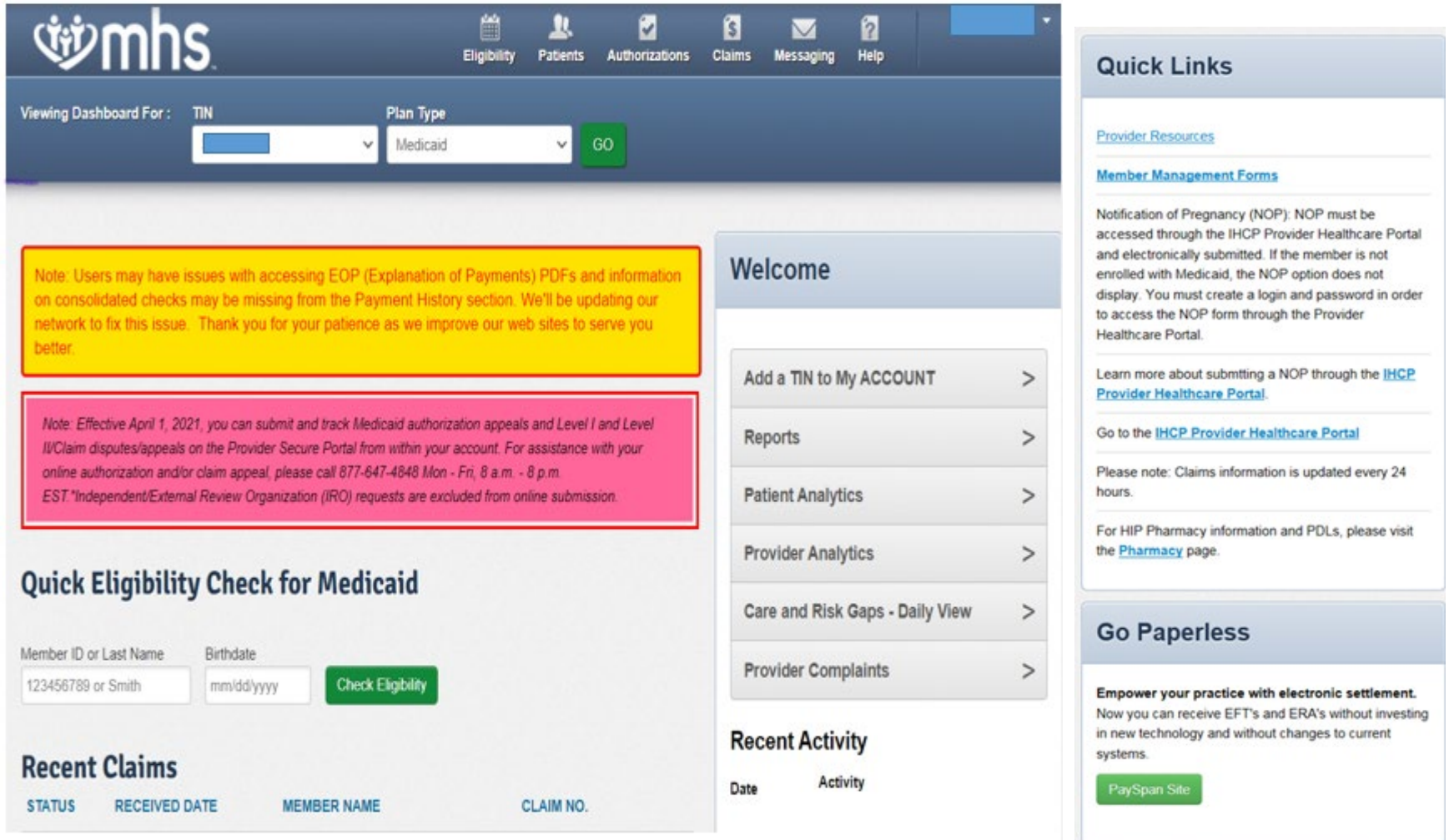
Creating an account is free and easy.

By creating a MHS account, you can:

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

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

Homepage – MHS (Medicaid)



The screenshot shows the MHS Medicaid homepage. At the top, there is a navigation bar with icons for Eligibility, Patients, Authorizations, Claims, Messaging, and Help. Below this is a header section with a dropdown for TIN and a dropdown for Plan Type (set to Medicaid), with a GO button. The main content area includes a yellow note about EOP PDFs, a pink note about Medicaid authorization appeals, a 'Quick Eligibility Check for Medicaid' section with input fields for Member ID or Last Name and Birthdate, and a 'Recent Claims' table. On the right, there is a 'Quick Links' section with links to Provider Resources and Member Management Forms, a 'Welcome' section with a list of menu items (Add a TIN to My ACCOUNT, Reports, Patient Analytics, Provider Analytics, Care and Risk Gaps - Daily View, Provider Complaints), and a 'Go Paperless' section with a PlaySpan Site button.

Quick Links

- [Provider Resources](#)
- [Member Management Forms](#)

Notification of Pregnancy (NOP): NOP must be accessed through the IHCP Provider Healthcare Portal and electronically submitted. If the member is not enrolled with Medicaid, the NOP option does not display. You must create a login and password in order to access the NOP form through the Provider Healthcare Portal.

Learn more about submitting a NOP through the [IHCP Provider Healthcare Portal](#).

Go to the [IHCP Provider Healthcare Portal](#)

Please note: Claims information is updated every 24 hours.

For HIP Pharmacy information and PDLs, please visit the [Pharmacy](#) page.

Go Paperless

Empower your practice with electronic settlement. Now you can receive EFT's and ERA's without investing in new technology and without changes to current systems.

[PlaySpan Site](#)

Quick Eligibility Check for Medicaid

Member ID or Last Name: Birthdate: [Check Eligibility](#)

Recent Claims

STATUS	RECEIVED DATE	MEMBER NAME	CLAIM NO.
--------	---------------	-------------	-----------

Welcome

- [Add a TIN to My ACCOUNT](#)
- [Reports](#)
- [Patient Analytics](#)
- [Provider Analytics](#)
- [Care and Risk Gaps - Daily View](#)
- [Provider Complaints](#)

Recent Activity

Date	Activity
------	----------

Note: Users may have issues with accessing EOP (Explanation of Payments) PDFs and information on consolidated checks may be missing from the Payment History section. We'll be updating our network to fix this issue. Thank you for your patience as we improve our web sites to serve you better.

Note: Effective April 1, 2021, you can submit and track Medicaid authorization appeals and Level I and Level II/Claim disputes/appeals on the Provider Secure Portal from within your account. For assistance with your online authorization and/or claim appeal, please call 877-647-4648 Mon - Fri, 8 a.m. - 8 p.m. EST. *Independent/External Review Organization (IRO) requests are excluded from online submission.

Complete Registration or Login

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

[Forgot Password / Unlock Account](#)

[Login](#)

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](#)

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](#)

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

Quick Eligibility Check

Member ID or Last Name: 123456789 or Smith Birthdate: 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	E	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](#)





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

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

Back to Claims
Claim Details

Claim #T1234P1235: Denied

COPY
DISPUTE

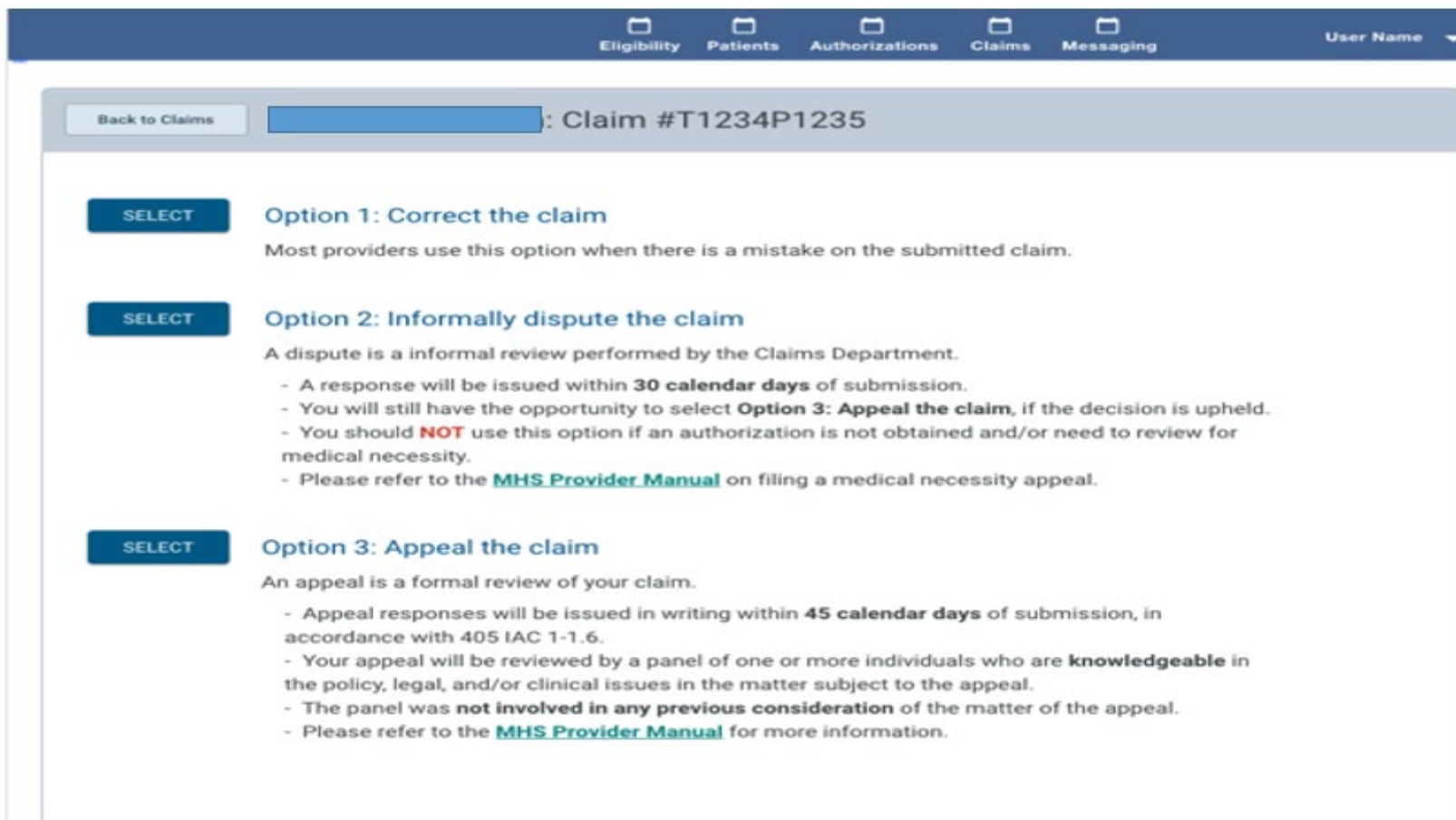
Claim Accepted In Process Denied

Participant	Provider	Claim	Most Recent Payment	
Participant Name [Redacted]	Ref./Acct No. 1234567890	DOS Range 08/12/2020 - 08/15/2020	Payment Date --	Paid Claim Amount \$0.00
Member ID ID123459	Servicing Provider [Redacted]	Received Date 09/12/2020	Check/EFT No. --	Total Check Amount --
Member DOB [Redacted]	Servicing NPI [Redacted]	Billed Amount \$6,1234.12	Check Dated --	

Service Lines

Label	Label	Label	Label	Label	Label	Label

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



The screenshot displays the 'Claims' section of the Secure Provider Portal. At the top, a navigation bar includes links for Eligibility, Patients, Authorizations, Claims, and Messaging, along with a 'User Name' dropdown. Below this, a breadcrumb trail shows 'Back to Claims' and a search bar containing 'Claim #T1234P1235'. The main content area lists three options for handling a claim:

- Option 1: Correct the claim**
Most providers use this option when there is a mistake on the submitted claim.
- Option 2: Informally dispute the claim**
A dispute is a informal review performed by the Claims Department.
 - A response will be issued within **30 calendar days** of submission.
 - You will still have the opportunity to select **Option 3: Appeal the claim**, if the decision is upheld.
 - You should **NOT** use this option if an authorization is not obtained and/or need to review for medical necessity.
 - Please refer to the [MHS Provider Manual](#) on filing a medical necessity appeal.
- Option 3: Appeal the claim**
An appeal is a formal review of your claim.
 - Appeal responses will be issued in writing within **45 calendar days** of submission, in accordance with 405 IAC 1-1.6.
 - Your appeal will be reviewed by a panel of one or more individuals who are **knowledgeable** in the policy, legal, and/or clinical issues in the matter subject to the appeal.
 - The panel was **not involved in any previous consideration** of the matter of the appeal.
 - Please refer to the [MHS Provider Manual](#) for more information.

Claim Reconsiderations

Enter your explanation for reconsideration and check email updates.

Reconsider Claim

Claim No: [REDACTED]

For reconsiderations only. Not for appeals/Claim disputes
Example: If an authorization was not obtained and/or you need to review for medical necessity, submit an appeal.
Any submission on this form will be treated as a reconsideration.
Please refer to your Provider Manual.

Reconsideration Type

Denied for Untimely Filing ▼

Notes

Brief Explanation

500 Character Limit

Upload Documents

*Proof of Timely Filing attachment **Required***

Choose Files

Uploaded Files

Email Updates

Check here to receive email status updates for this reconsideration.

Please upload files less than 10MB each. Supported file formats are PDF, TIFF, TIF, JPEG, and JPG.


Cancel ➔

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

Back to Claims
Claim Details

Claim #T1234P1235: Denied

COPY
DISPUTE



U026IA1234566

Dispute/Appeal Details

Created Date	Type	Current Status	Reference No.	Tools
1/26/2021	Dispute - Claim Paid at the Incorrect Amount	Resolved	U026IA1234566	

Member

Participant Name
[REDACTED]

Member ID
ID123459

Member DOB
[REDACTED]

Provider

Ref/Acct No.
1234567890

Servicing Provider
[REDACTED]

Servicing NPI
1234567890

Claim

DOS Range
08/12/2020 - 08/15/2020

Received Date
09/12/2020

Billed Amount
\$6,1234.12

Most Recent Payment

Payment Date	Paid Claims Amount
---	\$0.00
Check/EFT No.	Total Check Amount
---	---
Check Dated	

Service Lines

Label	Label	Label	Label	Label	Label	Label

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

Back to Claims
Claim Details

Claim #T1234P1235: Denied

COPY
DISPUTE

Dispute
Appeal
U026IA1234566
ABCDE1234567

Dispute/Appeal Details

Created Date	Type	Current Status	Reference No.	Tools
2/15/2021	Appeal - Claim Paid at the incorrect Amount	In Progress	ABCDE1234567	
1/26/2021	Dispute - Claim Paid at the incorrect Amount	Resolved	U026IA1234566	

Member

Participant Name
[REDACTED]

Member ID
ID123459

Member DOB
[REDACTED]

Provider

Ref/Acct No.
1234567890

Servicing Provider
[REDACTED]

Servicing NPI
1234567890

Claim

DOS Range
08/12/2020 - 08/15/2020

Received Date
09/12/2020

Billed Amount
\$6,1234.12

Most Recent Payment

Payment Date

Check/EFT No.

Check Dated

Paid Claim Amount
\$0.00

Total Check Amount

Service Lines

Label	Label	Label	Label	Label	Label	Label

Online Reconsiderations

Viewing Claims For: [dropdown] [dropdown] **GO** [Upload EDI](#) [Create Claim](#)

[Back to Claims](#) **Claim Details**

Claim # [redacted]: Reconsideration

[+ Copy Claim](#) [Correct Claim](#) [Void/Recoup Claim](#)

RECONSIDERATION

Claim Accepted (✓) — In Process (✓) — Denied (✗) — Submitted (✓) — Outcome TBD (○)

Reconsideration Details

Created Date	Type	Current Status	Reference #
01/01/2019	General Correspondence	New	[redacted]
02/02/2019	COB Correspondence	Resolved	[redacted]

Member **Provider** **Claim** **Payment**

Member Name: [redacted]	Ref/Acct No.: [redacted]	DOS Range: 10/10/2018 - 10/10/2018	Payment Date: 10/11/2018	Granted Claim Amount: \$68.00
Member ID: [redacted]	Servicing Provider: [redacted]	Received Date: 10/10/2018	Check Number: [redacted]	Total Check Amount: \$75.00
Member DOB: [redacted]	Servicing NPI: [redacted]	Billed Amount: \$300.24	Check Dated: 10/10/2018	Included Claim Numbers View all

Online Reconsiderations Additional Attachments

RECONSIDERATION

Claim Accepted (green check) → In Process (green check) → Denied (red X) → In Process (green check) → Outcome TBD (grey circle)

Reconsideration Details

Created Date	Type	Current Status	Reference Number	Tools
06/05/2019	General Correspondence	OPEN	[Redacted]	

Member

Member Name: [Redacted]

Member ID: [Redacted]

Member DOB: [Redacted]

Provider

Ref/Acct No.: [Redacted]

Servicing Provider: [Redacted]

Servicing NPI: [Redacted]

Claim

DOS Range: [Redacted]

Received Date: [Redacted]

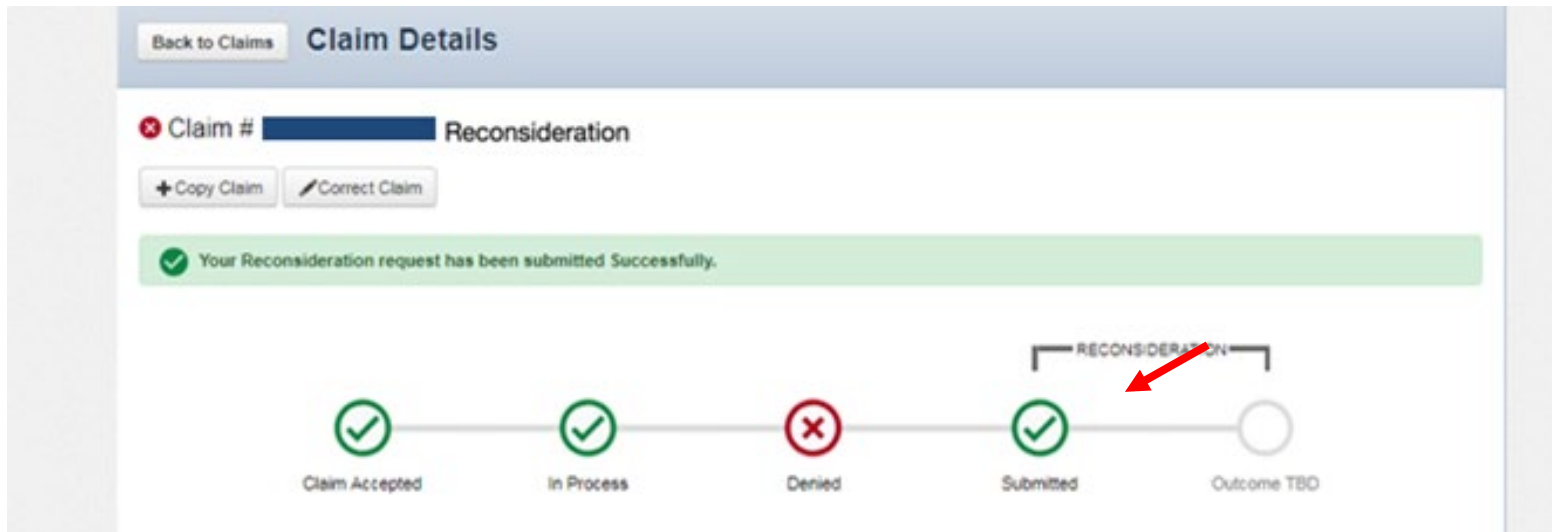
Billed Amount: [Redacted]

Service Lines

Line	DOS	Proc	Dx	Modifiers	Place of Service	Charged	Total Check Amount	Payment Date	Check Number	Status	Payment Codes
1	11/23/2018	J7620	J449		12	\$156.75	\$0.00	03/26/2019		DENY	6N,Ku
2	11/23/2018	Q0513	J449		12	\$33.00	\$0.00	03/26/2019		DENY	46,Ku

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.

The screenshot shows the MHS Claims portal interface. At the top, there are navigation tabs for Eligibility, Patients, Authorizations, Claims, and Messaging. Below these, there are filters for 'Viewing Claims For' and buttons for 'Upload EDI' and 'Create Claim'. The main content area is titled 'Claim Details' and shows a claim status of 'Denied'. A green success banner with a checkmark icon and the text 'Your attachment has been submitted successfully.' is displayed below the claim status, with a red arrow pointing to it. Below the banner is a progress bar with five stages: 'Claim Accepted' (green checkmark), 'In Process' (green checkmark), 'Denied' (red X), 'In Process' (green checkmark), and 'Outcome TBD' (grey circle). A bracket labeled 'RECONSIDERATION' spans the 'In Process' and 'Outcome TBD' stages. At the bottom, there is a 'Reconsideration Details' table.

Created Date	Type	Current Status	Reference Number	Tools
06/05/2019	General Correspondence	OPEN	[Redacted]	[Icons]





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

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



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).
 - o 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).
 - o 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:
 Managed Health Services
 PO Box 3000
 Farmington, MO 63640-3800


Behavioral Health Claims
 Managed Health Services BH Appeals
 PO Box 6000
 Farmington, MO 63640-3809



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

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. 20080

SOUTH CENTRAL REGION

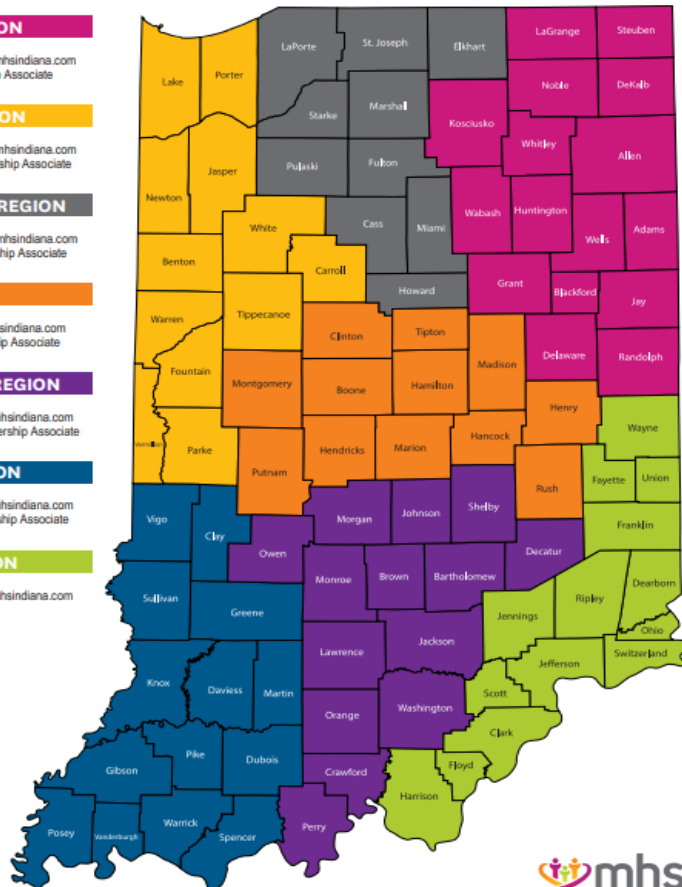
For claims issues, email:
 MHS_ProviderRelations_SC@mhsindiana.com
 Dalesia Denning, Provider Partnership Associate
 1-877-647-4848, ext. 20026

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



550 N. Meridian Street, Suite 101 • Indianapolis, IN 46204 • 1-877-647-4848 • mhsindiana.com
 Allwell from MHS • Ambetter from MHS • Healthy Indiana Plan (HIP) • Hoosier Care Connect • Hoosier Healthwise

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Available online:

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

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
michael.j.funk@mhsindiana.com

NETWORK OPERATIONS

KELVIN ORR

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

Questions?

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