










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 **seven 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 PA must have submitted a request to MHS at least **two business days** prior to the Date of Service.

 All ER services do not require PA, but admission must be called into MHS Prior Authorization within **two business days** following the admit.



 Members **must** be Medicaid eligible on the Date of Service.

 PAs are not a guarantee of payment.

 ***Failure to obtain PA 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 PA regardless of contract status:

-  Injectable Drugs (see 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, Occupational, and Speech Therapy
-  Non-emergent ambulance services
-  Orthopedic and spinal surgical procedures

Prior Authorization

Is PA Needed?

- MHS website:
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. Coverage is subject to specific benefit package of member.

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

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

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

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

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

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

MANAGED HEALTH SERVICES (MHS)

ELECTRONIC PAYER ID:
 68069

BEHAVIORAL HEALTH PAYER ID:
 68068

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

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

MEDICAL NECESSITY APPEALS ONLY ADDRESS:
 ATTN: APPEALS
 P.O. Box 441067
 Indianapolis, IN 46244

MEDICAL CLAIMS APPEALS ADDRESS:
 Managed Health Services
 P.O. Box 3002
 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/DH

REFERRALS AND AUTHORIZATIONS: 1-866-912-4245

MHS WEBSITE: MHSINDIANA.COM

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

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

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

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

OTHER RESOURCES

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

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

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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:

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 PAs within 30 days from the original Date of Service before claim submission.**

Need to Know

Self-Referral Services






Exceptions to PA 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 January 1, 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, PA for PT, OT and ST services will be required to determine whether services are medically necessary and appropriate.
 - Chiropractic care – No PA 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 [RadMD.com](https://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, [RadMD.com](https://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, 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 website at [RadMD.com](https://www.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 contraindications 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 be reimbursed 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 supporting documents for postpayment review.

For more information on Medicaid ambulance billing guidelines, please visit [in.gov/medicaid/files/transportation%20services.pdf](https://www.in.gov/medicaid/files/transportation%20services.pdf).

Orthopedic and Spinal Surgical Procedures

-  TurningPoint Healthcare Solutions manages PA for medical necessity and appropriate length of stay (when applicable) for services listed below through MHS' existing contractual relationships.
-  PA 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

TurningPoint Cardiac Update

TurningPoint began authorization functions for Cardiac Services effective May, 1, 2020 for Dates of Service, May 18, 2020.

- 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: 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:
attendee.gotowebinar.com/rt/6895616165794853901

 Refer to notice for specific provisions.

Turning Point

-  Emergency-Related Procedures do not require PA.
-  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: register.gotowebinar.com/rt/7079530369468972290

Subacute Care

MHS conducts clinical review for ongoing authorization and coordination of discharge needs for our members in subacute facilities at least every three – five 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 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 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 cannot change the status of a denied authorization.***


Prior Authorization 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/providers/pharmacy/preferred-drug-lists.html

- PA requests
- Phone: 1-866-399-0928
- Fax non-specialty drugs: 1-866-399-0929
- Specialty drugs: 1-866-678-6976
- pharmacy.envolvehealth.com





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

 Online PA submission available through CoverMyMeds:

- covermy meds.com

 Online PA forms for Specialty Drugs on 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 PA 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 (HCC) 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 PAs online via the MHS Secure Provider Portal at 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

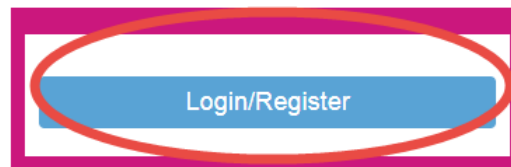
Pharmacy +

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](#) 

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)

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](#)





mhs  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 :

Tax ID Number
 Medicaid
 GO

Create Authorization

Authorizations
 Processed
 Errors
 Disclaimer

Filter

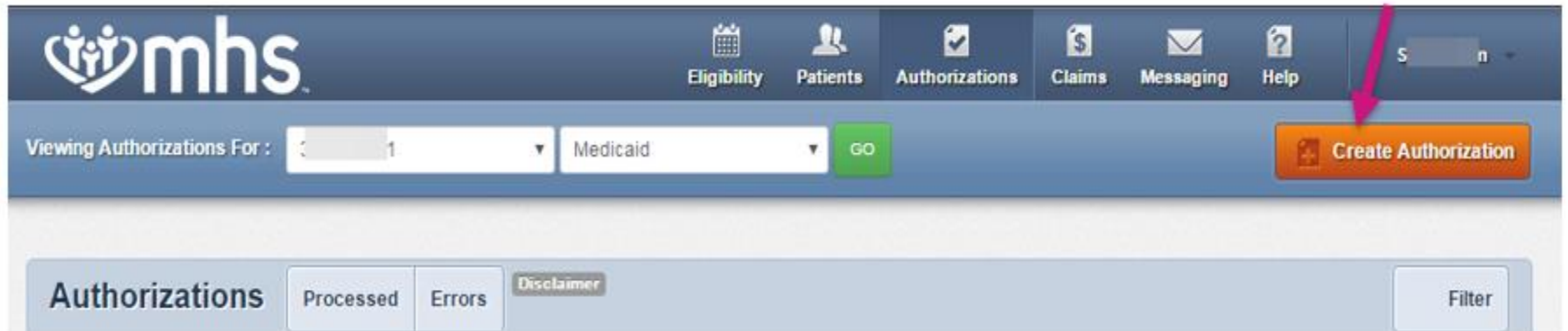
Please call the health plan for questions regarding voided authorization submissions. The authorization page is updated every 24 hours.

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

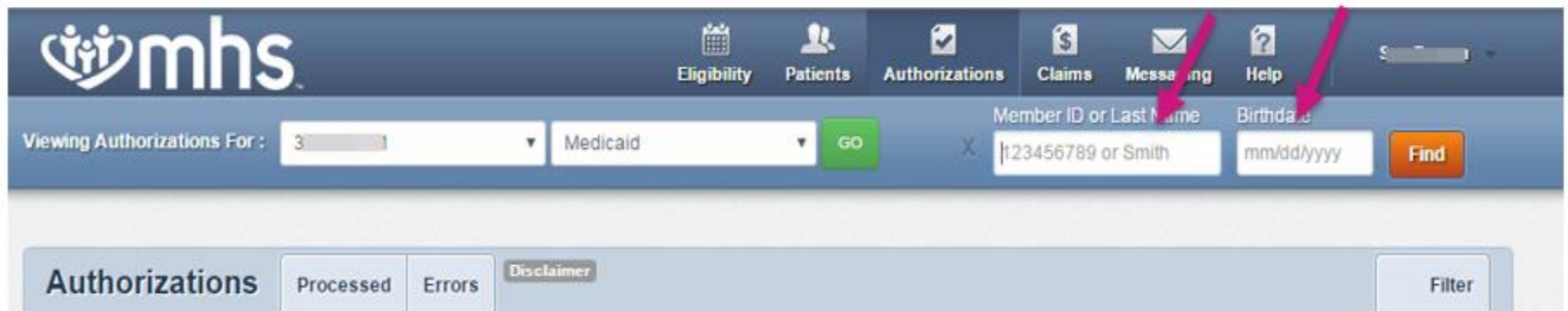
Creating a New Authorization

 Click **Create Authorization**.

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



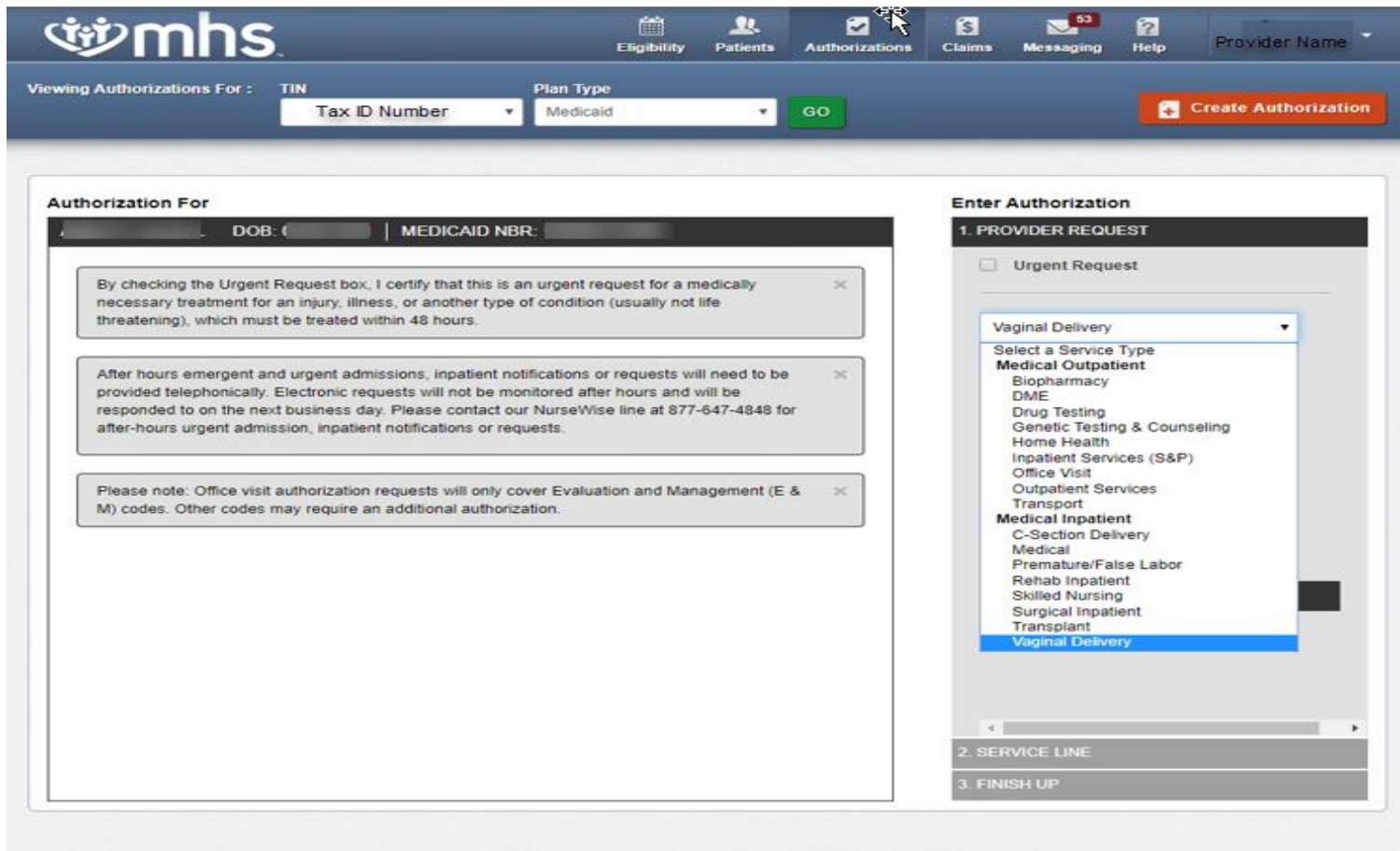
The screenshot shows the MHS web application interface. At the top, there is a navigation bar with the MHS logo and several menu items: Eligibility, Patients, Authorizations, Claims, Messaging, and Help. Below the navigation bar, there is a section for 'Viewing Authorizations For :'. This section includes a dropdown menu with the number '1' selected, a 'Medicaid' dropdown, and a green 'GO' button. To the right of this section, there is a red arrow pointing to an orange button labeled 'Create Authorization'.



The screenshot shows the MHS web application interface. At the top, there is a navigation bar with the MHS logo and several menu items: Eligibility, Patients, Authorizations, Claims, Messaging, and Help. Below the navigation bar, there is a section for 'Viewing Authorizations For :'. This section includes a dropdown menu with the number '3' selected, a 'Medicaid' dropdown, and a green 'GO' button. To the right of this section, 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 'Find' button is located to the right of these fields. Two red arrows point to the 'Member ID or Last Name' and 'Birthdate' fields respectively.

Creating a New Authorization

 Select a Service Type.



The screenshot shows the MHS Authorizations web application interface. At the top, there is a navigation bar with the MHS logo and several menu items: Eligibility, Patients, Authorizations (highlighted with a mouse cursor), Claims, Messaging, Help, and a dropdown for Provider Name. Below the navigation bar, there is a section for viewing authorizations, with fields for TIN, Tax ID Number, Plan Type (set to Medicaid), and a GO button. A red button labeled 'Create Authorization' is also present.

The main content area is divided into two columns. The left column, titled 'Authorization For', contains three informational boxes with expand/collapse icons (X). The first box states: '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.' The second box states: '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.' The third box states: '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 an 'Urgent Request' checkbox and a dropdown menu for 'Vaginal Delivery'. The dropdown menu is open, showing a list of service types categorized under 'Medical Outpatient' and 'Medical Inpatient'. The 'Vaginal Delivery' option is 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

Enter Authorization

1. PROVIDER REQUEST

☐ Urgent Request

Outpatient Services

Requesting Provider

Requesting Provider NPI or Last Name

Primary Diagnosis

Diagnosis Code

CODE LOOKUP: ICD-9 ICD-10

+ Add Additional Diagnosis

NEXT >

Enter Authorization

1. PROVIDER REQUEST

☐ Urgent Request

Outpatient Services

Requesting Provider

147

NPI: 147

TIN:

Name: SMITH

Primary Diagnosis

CODE LOOKUP: ICD-9 ICD-10

+ Add Additional Diagnosis

NEXT >


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

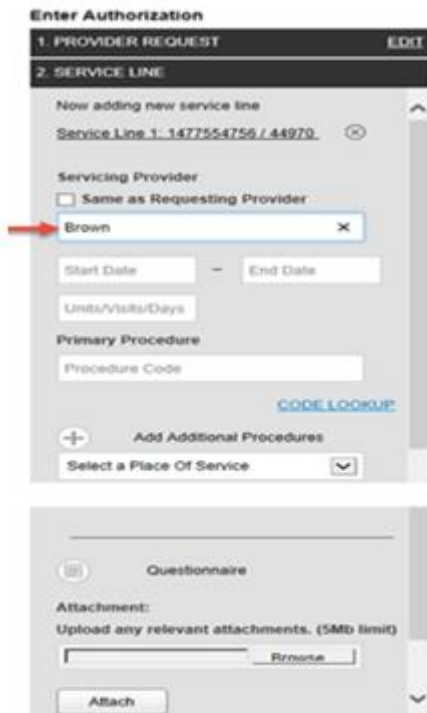
1. PROVIDER REQUEST [EDIT](#)

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

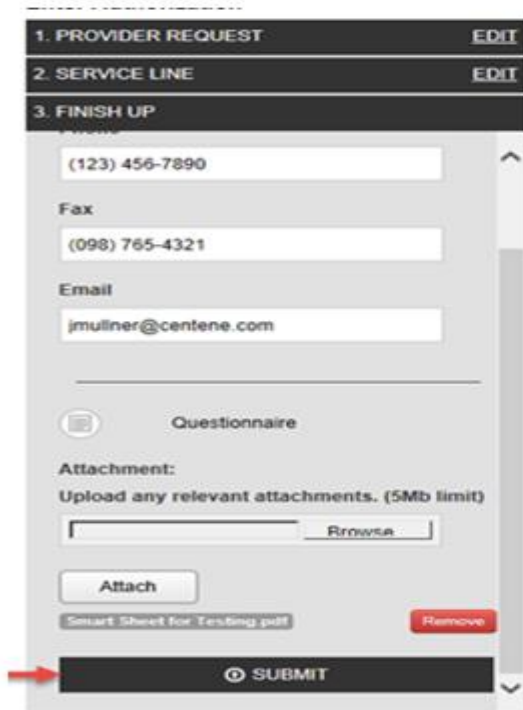
Attachment:

Upload any relevant attachments. (5MB limit)

-  Provider request will appear on the left side of the screen.
-  Update Servicing Provider:
 - Check box if same as Requesting Provider.
 - Update Servicing Provider 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

(123) 456-7890

Fax

(098) 765-4321

Email

jmuliner@centene.com

Questionnaire

Attachment:

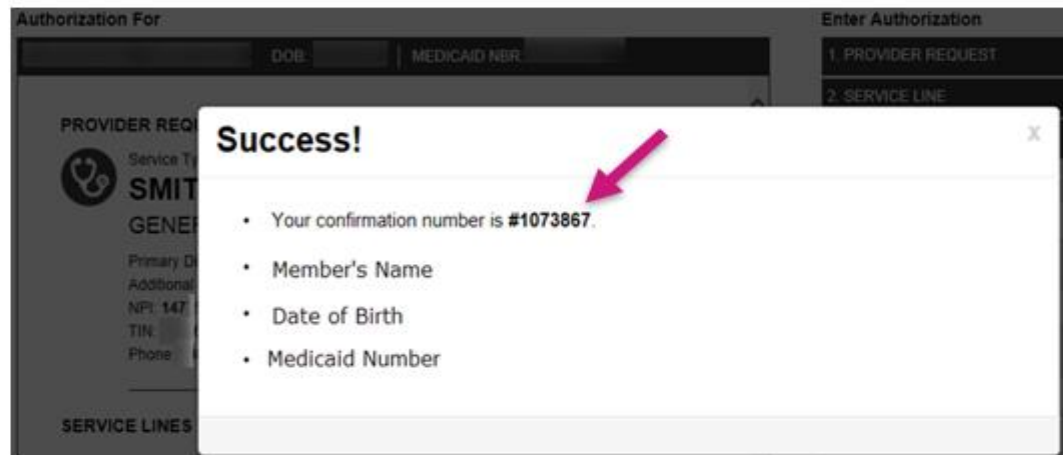
Upload any relevant attachments. (5Mb limit)

Browse

Attach

Smart Sheet for Testing.pdf **Remove**

SUBMIT



Authorization For

DOB: MEDICAID NBR:

Enter Authorization

1. PROVIDER REQUEST

2. SERVICE LINE

Success!

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

PROVIDER REQUEST

Service Type

SMITH

GENERAL

Primary Doctor

Additional

NPI: 147


TIN

Phone


SERVICE LINES


Telephone Authorizations

Telephone Authorization

 Providers can initiate PA 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 advice 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 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	
Please check the requested assignment category below:					
<input type="checkbox"/> DME	<input type="checkbox"/> Inpatient	<input type="checkbox"/> Physical Therapy			
<input type="checkbox"/> Purchased	<input type="checkbox"/> Observation	<input type="checkbox"/> Speech Therapy			
<input type="checkbox"/> Rented	<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				

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

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

← Check service category

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/Medical Necessity Appeals

Prior Authorization/Medical Necessity Appeals

-  Members, their authorized representatives, or legal representatives of a deceased member's estate, may appeal adverse determinations regarding their care. A health care practitioner or provider with knowledge of the member's medical condition may also act as the authorized representative. A provider, acting on behalf of the member and with the member's written consent, may file the appeal.
-  Appeals must be initiated **within 60 days** of the denial to be considered.
-  Members may continue to receive benefits while the appeal is pending but may be liable for the costs if the decision is unfavorable.
-  Determination will be communicated to the provider within 30 calendar days of receipt. Decisions regarding expedited appeals are made no later than 48 calendar hours after receipt.

Prior Authorization/Medical Necessity Appeals



Member & Provider Appeals may be submitted to MHS in the following ways:

- Web: Secure Provider Portal
- Call: Medicaid: 1-877-647-4848
- Email: appeals@mhsindiana.com
- Fax: Medicaid: 1-866-714-7993

- Mail: MHS Grievance & Appeals
PO Box 441567
Indianapolis, IN 46244

Members may also file a PA/Medical Necessity Appeal in person:

MHS
550 N. Meridian Street, Suite 101
Indianapolis, IN 46204

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.

****PA 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, Partial Hospitalization, and SUD RTC requires facilities to **fax** in the clinical information to 1-844-288-2591.
- MHS accepts the IHCP Universal PA 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:
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 PA 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 PA:

Facility Services:

- Inpatient Admissions (Approved per diem)
- Intensive Outpatient Treatment (IOT)
 - Outpatient (may be different timeframes depending on codes billed)
- Partial Hospitalization (Approved per diem)
- SUD Residential Treatment
- ABA Services (Approved by units)

Prior Authorization

Services Requiring PA (Cont.)




Professional Services:

- Psychiatric Diagnostic Evaluation
- Behavioral Health Outpatient Therapy “**BHOP Therapy**” (Limited to 20 visits per member, per practitioner, units per member, per provider, per year.)
- Electroconvulsive Therapy
- Psychological Testing
 - Unless for Autism: then no authorization 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 authorization is required
 - Non-Participating Providers only
- ABA Services – are approved by units

Behavioral Health





Limitations on Outpatient Mental Health Services:

 MHS follows the Indiana Health Coverage Programs Mental Health and Addiction limitation policy for the following CPT codes that, in combination, are limited to 20 units per member, per provider, per year.

<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


Behavioral Health

Limitations on Outpatient Mental Health Services (Cont.):

-  Effective December 15, 2018 MHS began applying this limitation for claims with Dates of Service on or after December 15, 2018. Claims exceeding the limit will deny EX Mb: Maximum Benefit Reached.
-  If the member requires additional services beyond the 20-unit limitation, providers may request PA for additional units. Approval will be given based on the necessity of the services as determined by the review of medical records.
-  “Per Provider” is defined by MHS as per individual rendering practitioner NPI being billed on the CMS-1500 claim form (Box 24J).
-  This change is related to professional services being billed on CMS-1500.

Prior Authorization

Limitations on BHOP Therapy (cont.):

-  For submission of PA:
- BH prior authorization outpatient treatment request (OTR) forms located: 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 three - six months, depending on medical necessity determination.
 - MHS turnaround time on OTR request is seven days.
 - Decision letters, referred to either as a Notice of Coverage or Denial Letter, are 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 PAs. 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 PAs 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 one business day prior to the initial request).



Updates/Corrections to PAs 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 PA, including BHOP Therapy Services; (exception of ABA services, which has its own separate Authorization Form).
- Form found at the following link: 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 authorization should be made to:

PROVIDER INFORMATION	
Provider Name	<input type="text"/>
Provider Credential	MD <input type="checkbox"/> PHD <input type="checkbox"/> OTHER <input type="checkbox"/>
Group / Agency Name	<input type="text"/>
Physical Address	<input type="text"/>
Telephone Number	Facsimile Number <input type="text"/>
Medicaid / TPI / NPI #	Tax ID # <input type="text"/>
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 PA of IOT services with this form found here: 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.
-  PA submission must match the combination in which the provider intends to bill:
 - Facility Billing: Must submit the IOT Authorization Form under the Facility NPI and check the applicable REV Code.
 - Professional Billing: Must submit the IOT Authorization 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 PA of ABA services with this form found here:
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:	<input type="text"/>
Provider NPI#:	<input type="text"/>
Tax ID#:	<input type="text"/>
Provider Phone:	<input type="text"/>
Group/Facility Name:	<input type="text"/>
Group/Facility Address:	<input type="text"/>
Phone Number:	<input type="text"/>
Fax Number:	<input type="text"/>


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 authorization 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:	

MHS Provider Relations

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

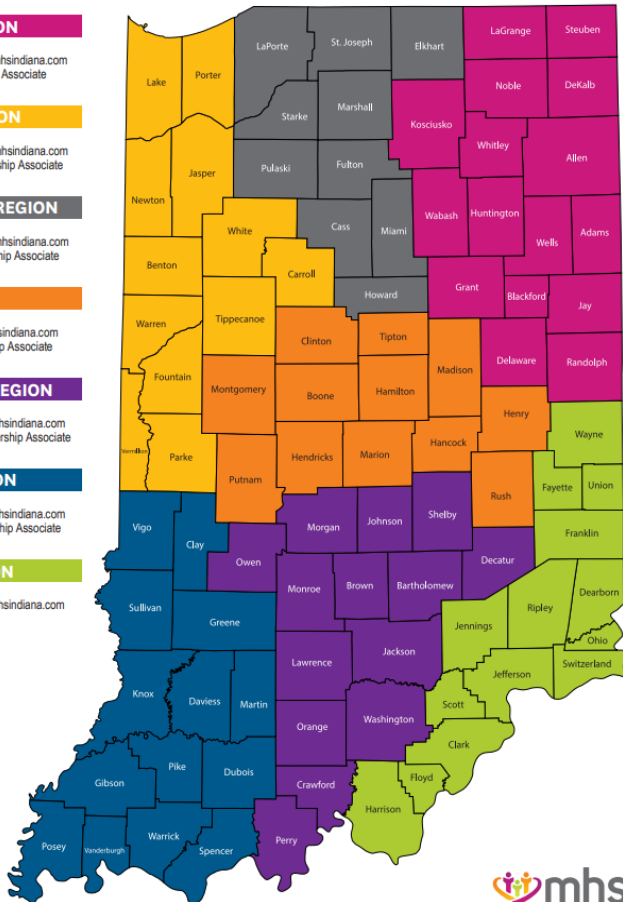
For claims issues, email:
MHS_ProviderRelations_SC@mhsindiana.com
Dalesia Denning, Provider Partnership Associate
1-877-647-4848, ext. 20026

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:

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

Questions?

Thank you for being our partner in care.