Ancillary Providers and MHS: Working Together

October 2021

Agenda

- MHS Overview
- Turning Point – Musculoskeletal Safety & Quality Program
- NIA – PT, OT, ST
- Ancillary –Transportation, Durable Medical Equipment(DME)
- Dental & Vision
- Home Health Services
- Hospice Services
- Culturally and Linguistic Appropriate Services (CLAS
- Prior Authorization
- Contact Information
- Questions

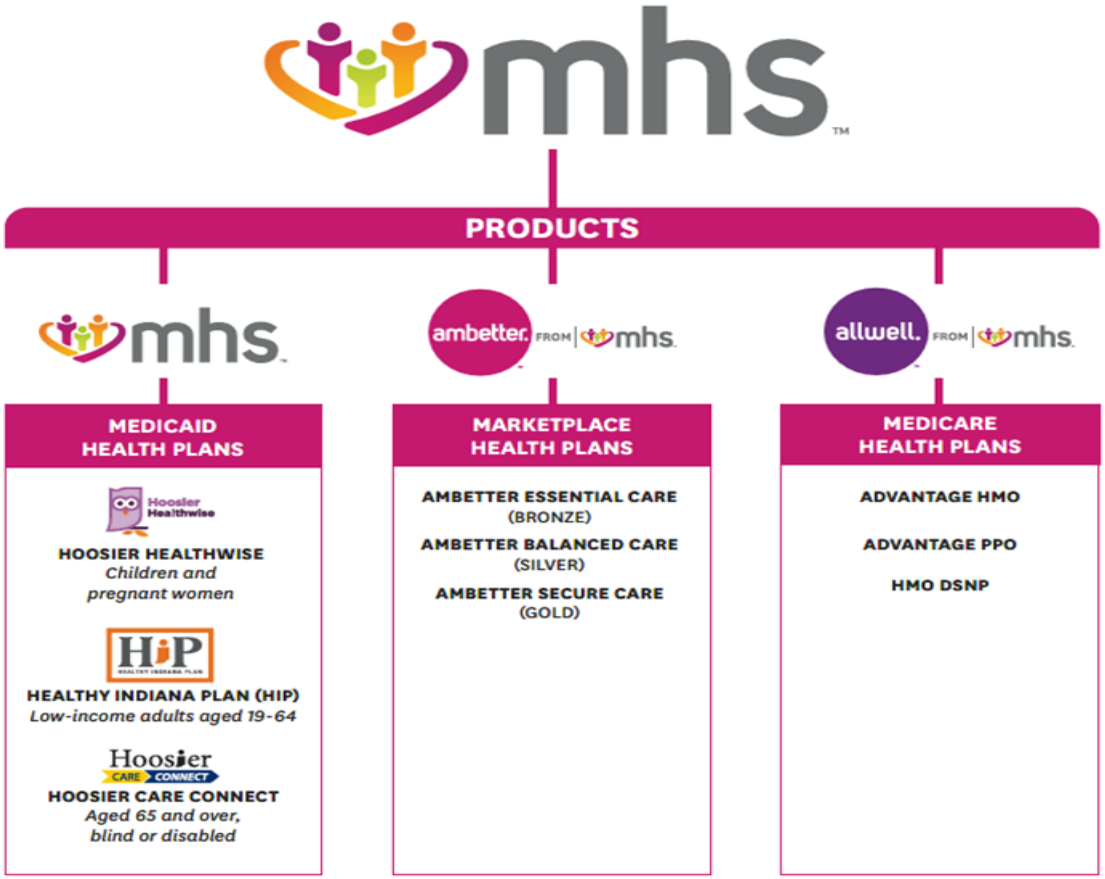
Who is MHS?

- Managed Health Services (MHS) is a health insurance provider that has been proudly serving Indiana residents for 25 years through Hoosier Healthwise, the Healthy Indiana Plan (HIP) and Hoosier Care Connect.

- MHS also offers a qualified health plan through the Health Insurance Marketplace called Ambetter from MHS and a Medicare Advantage product called Allwell from MHS. All of our plans include quality, comprehensive coverage with a provider network you can trust.

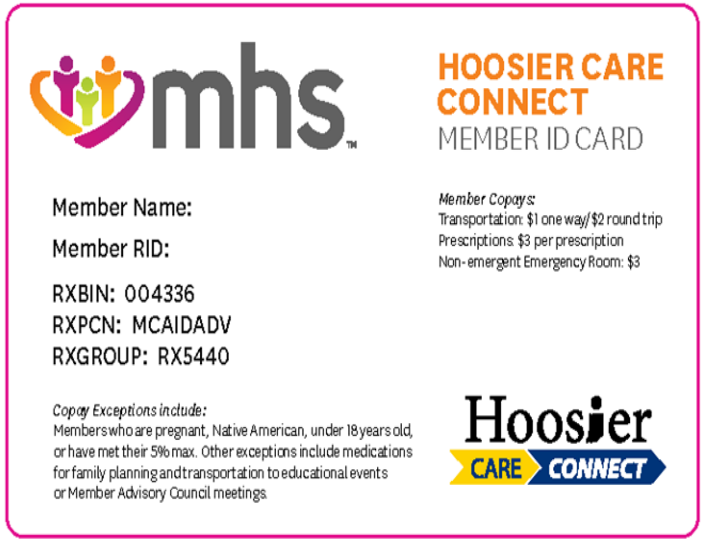
- **MHS is your partner in care.**

MHS Products



Medicaid

MHS Medicaid ID Cards



MHS Partnership

Turning Point

Musculoskeletal Safety & Quality Program

- MHS has entered into an agreement with Turning Point Healthcare Solutions, LLC to implement a Musculoskeletal Safety and Quality Program. This program includes prior authorization for medical necessity and appropriate length of stay (when applicable) for both inpatient and outpatient settings.
  - Emergency Related Procedures do not require authorization.
  - It is the responsibility of the ordering physician to obtain authorization.
  - Providers rendering musculoskeletal services, must verify that the necessary authorization has been obtained; failure to do so may result in non-payment of your claims.
  - Clinical Policies are available by contacting TurningPoint at 574-784-1005 for access to digital copies.

Turning Point's Utilization Management

- Web Portal Intake:
  - myturningpoint-healthcare.com
- Telephone Intake:
  - 1-574-784-1005 | 1-855-415-7482
- Fax Intake: 1-463-207-5864

NIA - PT, OT, ST

NIA – PT, OT and ST

- Utilization management of these services is managed by NIA.
- Prior authorization for PT, OT, and ST services is required to determine whether services are medically necessary and appropriate; determination is made by MHS not NIA.
- All Health Plan approved training/education materials are posted on the NIA website, www.RadMD.com. For new users to access these web-based documents, a RadMD account ID and password must be created.
- **Chiropractors rendering therapy services are exempt from the NIA program.**

Transportation

Transportation

- All MHS Hoosier Healthwise (except for Package C) , Hoosier Care Connect, and Healthy Indiana Plan (HIP) members qualify for unlimited transportation services provided by LCP.
- Rides will take members to and from:
  - Doctor and Dentist visits
  - Medicaid enrollment visits and reenrollment visits
  - Pharmacy visits (following a doctor's visit)
- Members need to call MHS Member Services at 1-877-647-4848 to schedule their ride at least three business days before their appointment.

Transportation

- **Managed Health Services (MHS) will process all Medicaid emergent and non-emergent ambulance claims, including air ambulance.**
- Claims for the following services should be sent to MHS:
  - 911 transports
  - Medically necessary non-emergent hospital transports requiring an ambulance with advanced life support (ALS) or basic life support (BLS).
- Providers have 10 business days to submit prior authorization for these services.

Durable Medical Equipment (DME) MEDLINE

Durable & Home Medical Equipment (DME)

- Prior authorization required by the **ordering physician** for all non-participating DME providers.
- Members and referring providers will no longer need to search for a DME provider or provider of medical supplies to service their needs.
- Order is submitted directly to MHS, coordinated by Medline and delivered to the member.
- Availability via Medline's web portal to submit orders and track delivery.
- Does not apply to items provided by and billed by physician office.

Durable & Home Medical Equipment (DME)

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

- **Web Portal**: Simply go to mhsindiana.com, log into the Secure Provider Portal, and click on “Create Authorization.” Choose 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

Envolve Dental

Dental Providers

Dental Providers

Envolve Dental administers MHS dental benefits for Healthy Indiana Plan, Hoosier Care Connect and Hoosier Healthwise members.

Download a copy of MHS' Start Smart for your Dental Health sheet and other dental health fact sheets as patient handout from our MHS Health Library.

For more infomation about your benefits, read our MHS Indiana Medicaid Dental Benefits (PDF).

PAPER CLAIMS SHOULD BE SUBMITTED TO:

PRIOR AUTHORIZATIONS SHOULD BE SUBMITTED TO:

ELECTRONIC CLAIMS SHOULD BE SUBMITTED VIA:

Contact Information

For information about claims submission, PA requests, and the credentialing and contracting process, providers should contact Envolve Dental Provider Services at 1-855-609-5157.

Dental claims submissions:

- **Envolve Dental**
  Claims: IN
  PO Box 20847
  Tampa, FL 33622-0847

Prior authorizations submissions:

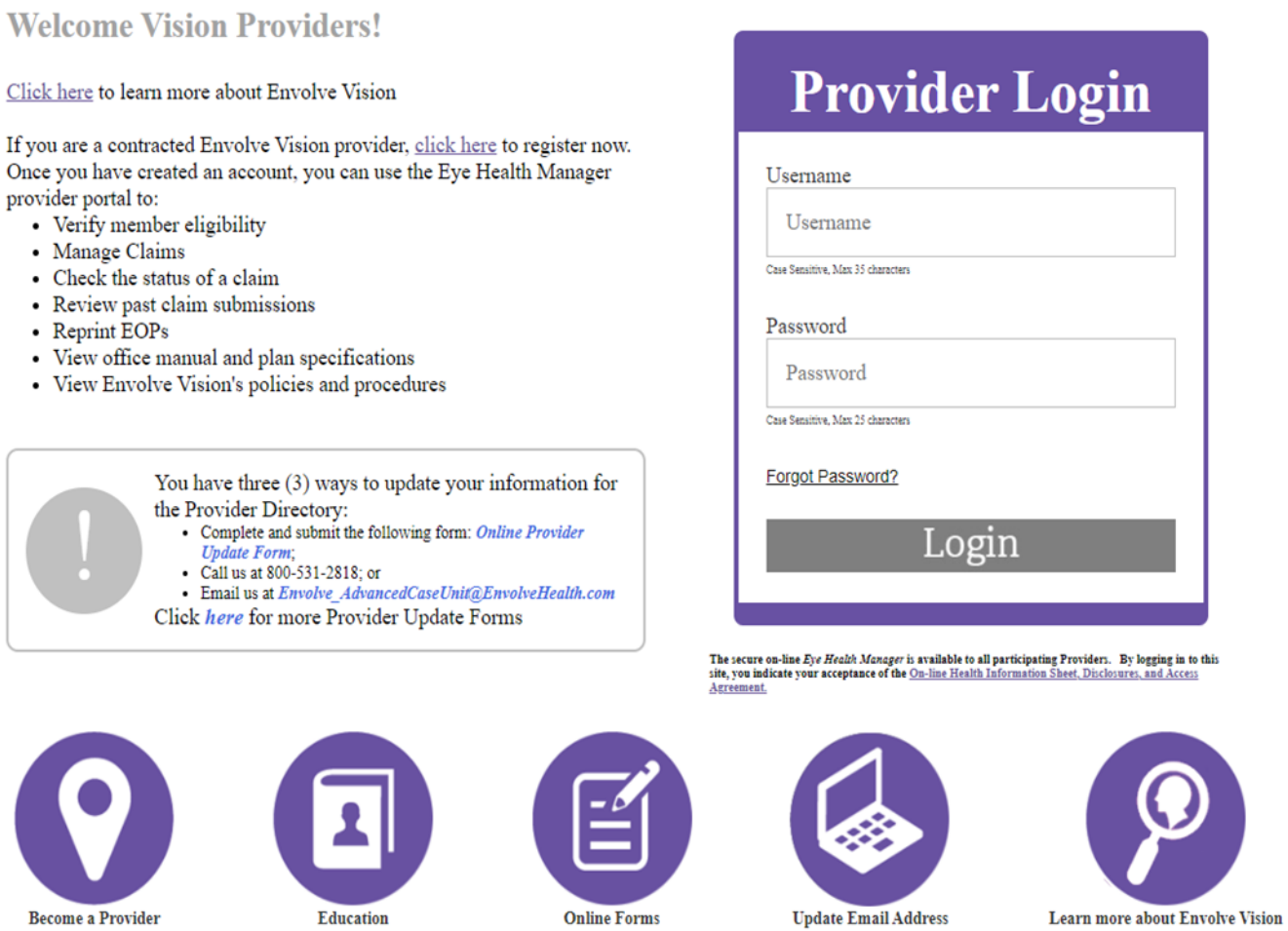
- **Envolve Dental**
  Authorizations: IN
  PO Box 20847
  Tampa, FL 33622-0847

Electronic claims submissions:

- **Envolve Dental**
  Payer ID: 46278

Envolve Vision

Envolve Vision



Home Health Services

Home Health Covered Services

- Skilled Nursing
- Home Health Aide Services
- Skilled Therapies
- Physical Therapy
- Occupational Therapy
- Speech-Language Pathology

Home Health

- Must be billed on a UB 04.
- Bill type must be 32X or 34X.
- Both Rev and CPT codes are required.
- Each visit must be billed individually on separate service line.
- Therapy services require a modifier.
- Nursing services require a modifier.

Revenue Code Crosswalk

Revenue Code	Procedure Code	Revenue Code	Procedure Code
420	G0151	439	G0152
421	G0151	440	G0153
422	G0151	441	G0153
423	G0151	442	G0153
424	97161-97163	443	G0153
429	G0151	444	92521-92524
430	G0152	449	G0153
431	G0152	552	99600 TD, 99600 TE
432	G0152	559	99601, 99602
433	G0152	572	99600
434	97165-97167		

Home Health Services

Code	Services Performed By	Billing Unit
Occurrence code 73	Overhead	One unit per provider per member per day
Procedure code modifier 99600 TD	Registered nurse	Hourly
Procedure code modifier 99600 TE	Licensed practical nurse	Hourly
Procedure code 99600	Home Health aide	Hourly
Procedure code G0151	Physical therapist	15-minute increments
Procedure code G0152	Occupational therapist	15-minute increments
Procedure code G0153	Speech-language pathologist	15-minute increments

Overhead Occurrence Code

- Home health providers receive an overhead rate for administrative costs for each visit to the members home.
- Providers must bill home health overhead with occurrence code 73.
- Providers can only receive one overhead rate per member per date of service.

Overhead Occurrence Codes

- On the *UB-04* claim form, for each nonconsecutive date of service billed, providers should enter the occurrence code and the corresponding date in the Occurrence Code and Date fields (31a–34b).
- On the Portal institutional claim, for each nonconsecutive date of service billed, in the *Occurrence Codes* panel, providers should enter the occurrence code and the corresponding date, using the same date in both the From Date and To Date fields for each entry.

Overhead Occurrence Codes

- If the dates of service billed **are consecutive**, and one encounter was provided every day:
- On the *UB-04* claim form, providers should enter the appropriate occurrence code and the first and last dates of service being billed in the Occurrence Span Code, From, and Through fields (35a–36b).
- On the Portal institutional claim, use the same occurrence code fields as are used for nonconsecutive dates, but use the From Date and To Date fields to indicate that the single code entry represents a span.

Home Health Authorizations

- Providers must submit hospice, home health and biopharmacy PA requests via **fax** to **1-866-912-4245.**
- Providers can check the authorization status on the portal.

PA Documentation Needed

- 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.

PA Exception for Hospital Discharge

- Physicians order in writing prior to discharge.
- RN, LPN and home aide services, not to exceed 120 units within 30 calendar days following the discharge.
- Any combination of therapy services, not to exceed 30 units in 30 calendar days following the discharge.

PA Exception for Hospital Discharge

- Hospital discharge is counted as day 1.
- Use occurrence code 42 with corresponding date of discharge in the occurrence code and occurrence date fields of the institutional claim(field 31a-34b claim form) to bypass PA requirements.
- PA is not required for emergency visits.

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

Medical PA Denial and Appeal Process

If MHS denies the requested service:

- And the member is still receiving services, the provider has the right to an expedited appeal. The attending physician must request the expedited appeal.
- And the member already has been discharged, the attending physician must submit an appeal in writing within **60 days** of the denial.
- **The attending physician has the right to a peer-to-peer discussion with an MHS physician**:
  - Providers initiate peer-to-peer discussions and expedited appeals by calling an MHS appeals coordinator at 1-877-647-4848.
  - They must request peer-to-peer within **10 days** of the adverse determination.

Prior authorization appeals are also known as medical necessity appeals.

Ambetter Home Health

Ambetter Home Health Billing

- Providers must use type of bill (TOB) 329.
- We only pay final claim for the 60 days. Do not bill RAP or interim claims.
- CBSA number must be listed in box 39.
- Treatment authorization code (TAC) must be listed in box 63.
- A prior authorization is required for all Home Health claims.
- Revenue code 023, with the appropriate HIPPS Code, must be billed along with any additional revenue codes that are appropriate.

Ambetter Home Health Top Denials

- EX28 – Denied; Coverage not in effect when services provided.
- EX35 – Benefit max has been reached.
- EXMQ – Member name and DOB do not match; Resubmit claim.
- EX29 – The timely filing has expired.
- EXHT – No Auth on file that matches service billed.
- EXI6 – Bill primary insurer 1st; Resubmit with EOB.

Ambetter Timely Filing

Initial Claims
Calendar Days

- Par
- 180

- Non-Par
- 90

Coordination of Benefits
Calendar Days

- Par
- 180 days from the primary payer EOP date to the date received.

- Non-Par
- 90 days from the primary payer EOP date to the date received.

Quick Reference Guide

Simplify Office Administrative Tasks

ambetter. FROM | mhs

Keep our Quick Reference Guide nearby to make pre-visit planning and post-visit tasks quick and easy.

Website: Ambetter.mhsindiana.com

- Patient care forms
- Pre-Auth Needed tool
- Ambetter from MHS news
- Provider Manual
- Preferred Drug List
- Member resources

Secure Provider Portal: Provider.mhsindiana.com

- Verify member eligibility
- Access patient health records
- View patient gaps
- Manage prior authorizations
- Submit and manage claims
- And more!

Member Eligibility

Check member eligibility via:

- Secure Web Portal
- 24/7 Toll-Free Interactive Voice Response (IVR) Line: 1-877-687-1182
- Provider Services: 1-877-687-1182

Patient Care Gaps

Find recommended services that a member has not completed.

1. Visit the Secure Provider Portal.
2. Review patient information for any gaps in care.
3. Plan to address care gaps during future appointment.

Prior Authorization

Use the Pre-Auth Needed tool on our website to determine if prior authorization is required.

Submit prior authorizations via:

- Secure Provider Portal
- Medical and Behavioral Fax: 1-855-702-7337
- Phone: 1-877-687-1182

Claims

Timely Filing guidelines: 180 days from date of service.

Claims can be submitted via:

- Secure Portal
- Clearinghouses: EDI Payor ID 68069
- Mail paper claims to: P.O. Box 5010 | Farmington, MO 63640-5010

Pre-Visit Planning Checklist

- ✓ Verify member eligibility.
- ✓ Check for patient care gaps and address them during upcoming office visit.
- ✓ Use Pre-Auth Needed tool to determine if prior authorization is needed before appointment.

Allwell Home Health

Allwell Home Health Billing

- Must be billed on a UB 04.
- Bill type must be 3XX.
- Must be billed in location 12.
- Both Rev and CPT codes are required.
- Each visit must be billed individually on separate service line.

Allwell Error Codes/Rejection Reasons

- Invalid Mbr DOB
- 02 Invalid Mbr
- 06 Invalid Provider
- 07 Invalid Mbr DOB & Provider
- 08 Invalid Mbr & Provider
- 09 Mbr not valid at DOS
- 10 Invalid Mbr DOB; Mbr not valid a DOS
- 12 Provider not valid on DOS

Allwell Timely Filing

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

Quick Reference Guide

Simplify Office Administrative Tasks

allwell. FROM | mhs

Keep our Quick Reference Guide nearby to make pre-visit planning and post-visit tasks quick and easy.

Website: Allwell.mhsindiana.com

- Patient care forms
- Pre-Auth Needed tool
- MHS news
- Provider Manual
- Preferred Drug List
- Member resources

Secure Provider Portal: Allwell.mhsindiana.com

- Verify member eligibility
- Access patient health records
- View patient gaps
- Manage prior authorizations
- Submit and manage claims
- And more!

Member Eligibility

Check member eligibility via:

- Secure Web Portal
- Provider Services: 1-855-766-1541
- TTY: 711

Patient Care Gaps

Find recommended services that a member has not completed.

1. Visit the Secure Provider Portal.
2. Review patient information for any gaps in care.
3. Plan to address care gaps during future appointment.

Pre-Visit Planning Checklist

- ✓ Verify member eligibility.
- ✓ Check for patient care gaps and address them during upcoming office visit.
- ✓ Use Pre-Auth Needed tool to determine if prior authorization is needed before appointment.

Hospice Services

Hospice – Who is Responsible?

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

Who is Responsible?

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

Hospice Coverage

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

Hospice Covered Services

Services covered in the Hospice per diem:

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

Hospice Benefits

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

Hospice Levels of Care

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

Hospice Revenue Codes

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

Hospice Revenue Codes

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

Revenue Codes for Bed-Hold Days

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

Hospice Rates

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

Hospice Rates

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

Reference: BT201950, Dated September 17, 2019

Hospice Rates

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

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

Hospice Rates

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

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

Hospice Per Diem

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

Service Intensity Add-on (SIA)

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

Culturally and Linguistic Appropriate Services (CLAS)

Culturally and Linguistic Appropriate Services (CLAS)

- CLAS refers to healthcare services that are respectful of and responsive to the cultural and linguistic needs of patients.
- Visit mhsindiana.com provider guides page for a brochure about CLAS standards.

Translation Services

- Available to MHS members/providers at no cost.
- Can accommodate most languages and locations.
- Interpretation services available in person or telephonically.
- Please contact MHS Member Services at 1-877-647-4848 for specific information on accessing these services.
- Spanish speaking representatives available to speak with members if needed (additional languages are available upon request).

Prior Authorization

Hospice Prior Authorization

- Authorizations request for Medicaid hospice members should be submitted to the appropriate Managed Care Entity (MCE) or its designated PA contractor.
- PA is required for any IHCP-covered service not related to the hospice member's terminal conditio

Prior Authorization

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

Prior Authorization (PA) Request

- MHS strives to return a decision on **all** PA requests within **two business days** of 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
- MHS has up to **seven days** to render PA decisions.
- 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
- ***Denied Authorizations*** *must follow the authorization appeal process, not the claims appeal process, claims appeals can not change the status of a denied authorization.*

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

Authorization Considerations

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

Out-of-Network Coverage

- Plan authorization is required for out-of-network services, except:
  - Emergency care
  - Urgently needed care when the network provider is not available (usually due to out-of-area).
  - Kidney dialysis at Medicare-certified dialysis center when temporarily out of the service area.

Prior Authorization

Is Prior Authorization Needed?

- MHS website: mhsindiana.com
- Quick reference guide
- Non-contracted provider services now align with PA requirements for contracted providers

mhs

PROVIDER Quick Reference Guide

Effective August 1, 2020

Applies to all Hoosier Healthwise (HHW), Healthy Indiana Plan (HIP) and Hoosier Care Connect (HCC) packages.

For an Ambetter Provider Quick Reference Guide, please visit ambetter.mhsindiana.com. Coverage is subject to specific benefit package of member.

Hoosier Healthwise | HIP | Hoosier CARE CONNECT

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

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

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

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

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

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

MANAGED HEALTH SERVICES (MHS)

ELECTRONIC PAYER ID:
68069

BEHAVIORAL HEALTH PAYER ID:
68068

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

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

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

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

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

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

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

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

MHS FAX NUMBERS

MEDICAL APPEALS: 1-866-714-7993

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

REFERRALS AND AUTHORIZATIONS: 1-866-912-4245

MHS WEBSITE: MHSINDIANA.COM

mhsindiana.com/providers	Latest MHS provider updates and news, as well as online provider enrollment, office and billing address change forms, quality and care gap tools, forms, manuals, guides, online PA tool and tutorials.
mhsindiana.com/health	MHS' Health Library. Click on "KRAMES Health Library" for free print-on-demand patient health fact sheets on over 4,000 topics, available in English and Spanish.
mhsindiana.com/login	MHS' Secure Provider Portal lets you submit prior authorization, claims, claim adjustments, and view your panel's medical records and care gaps.
mhsindiana.com/transactions	Information for electronic processing and payment of claims with MHS.

OTHER RESOURCES

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

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

0720.PR.P.FL.1

Resources

Resources

- Prior Authorization: https://www.mhsindiana.com/providers/prior-authorization.html
- Clinical & Payment Policies: https://www.mhsindiana.com/providers/resources/clinical-payment-policies.html
- Provider Manuals and Quick Reference Guides: https://www.mhsindiana.com/providers/resources/guides-and-manuals.html
- Newsletters: https://www.mhsindiana.com/providers/resources/newsletters.html

Resources

- Prior Authorization: https://www.mhsindiana.com/providers/prior-authorization.html
- Clinical & Payment Policies: https://www.mhsindiana.com/providers/resources/clinical-payment-policies.html
- Provider Manuals and Quick Reference Guides: https://www.mhsindiana.com/providers/resources/guides-and-manuals.html
- Newsletters: https://www.mhsindiana.com/providers/resources/newsletters.html

Member & Provider Services

1-877-647-4848

- Dedicated staff available Monday - Friday from 8 a.m. - 8 p.m.
- Hoosier Healthwise, HIP and Hoosier Care Connect customer service
- Eligibility verification if needed
- Claims status and assistance
- Translation and transportation coordination
- Health needs screening
- New IVR option-telephonic, self service verification of claims and eligibility
- Spanish speaking representatives (additional languages available upon request)
- Facilitates member disenrollment requests
- Panel full/hold requests
- New member tool kits
- Member QRG

MHS TEAM

Provider Relations Regional Mailboxes

Helpful Tips:

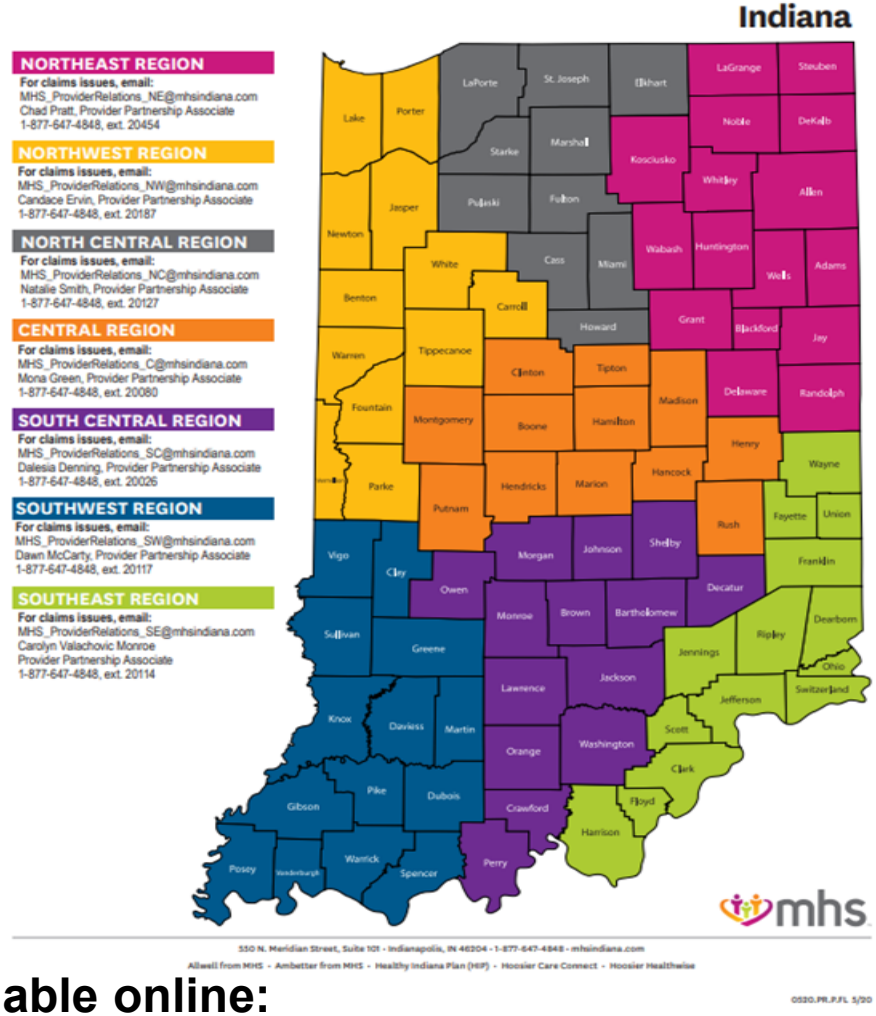
- Please submit the following information when sending an email for claims inquiry to the provider relations regional mailbox (attach spreadsheet if multiple claims but below fields must be included)
  - Issue Reference Number(s);
  - TIN
  - Group/Facility Name
  - Practitioner Name & NPI
  - Member Name and RID Number
  - Product (Medicaid/Ambetter/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
- 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
- Tier 1 Providers: Indy_Prov_Relations@mhsindiana.com

MHS Provider Network Territories



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

NORTHEAST REGION
For claims issues, email:
MHS_ProviderRelations_NE@mhsindiana.com
Chad Pratt, Provider Partnership Associate
1-877-647-4848, ext. 20454

NORTHWEST REGION
For claims issues, email:
MHS_ProviderRelations_NW@mhsindiana.com
Candace Ervin, Provider Partnership Associate
1-877-647-4848, ext. 20187

NORTH CENTRAL REGION
For claims issues, email:
MHS_ProviderRelations_NC@mhsindiana.com
Natalie Smith, Provider Partnership Associate
1-877-647-4848, ext. 20127

CENTRAL REGION
For claims issues, email:
MHS_ProviderRelations_C@mhsindiana.com
Mona Green, Provider Partnership Associate
1-877-647-4848, ext. 20080

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

SOUTHWEST REGION
For claims issues, email:
MHS_ProviderRelations_SW@mhsindiana.com
Dawn McCarty, Provider Partnership Associate
1-877-647-4848, ext. 20117

SOUTHEAST REGION
For claims issues, email:
MHS_ProviderRelations_SE@mhsindiana.com
Carolyn Valachovic Monroe
Provider Partnership Associate
1-877-647-4848, ext. 20114

MHS Provider Network Territories

TAWANNA DANZIE
Provider Partnership Associate II
1-877-647-4848 ext. 20022
tdanzie@mhsindiana.com

PROVIDER GROUPS
- Beacon Medical Group
- Franciscan Alliance
- HealthLinc
- Heart City Health Center
- Indiana Health Centers
- Lutheran Medical Group
- Parkview Health System
- South Bend Clinic

JENNIFER GARNER
Program Manager,
Provider Engagement
1-877-647-4848 ext. 20149
jgarner@mhsindiana.com

PROVIDER GROUPS
- American Health Network of Indiana
- Columbus Regional Health
- Community Physicians of Indiana
- HealthNet
- Health & Hospital Corporation of Marion County
- Indiana University Health
- St. Vincent Medical Group

ENVOLVE DENTAL, INC.
ANTWAN PEREZ-ALVAREZ
Antwan.Perez-Alvarez@EnvolveHealth.com
Tyneshia James
Tyneshia.James@EnvolveHealth.com
Dental Provider Services: 1-855-609-5157
Questions: ProviderRelations@EnvolveHealth.com

ENVOLVE VISION, INC.
CHANTEL MCKINNEY
Chantel.McKinney@EnvolveHealth.com
Yojani Benitez
Yojani.Benitez@EnvolveHealth.com
Vision Provider Services: 1-844-820-6523
Questions: Envolve_AdvancedCaseUnit@EnvolveHealth.com

Questions?

Thank you for being our partner in care.