Common Issues and Dispute Resolutions

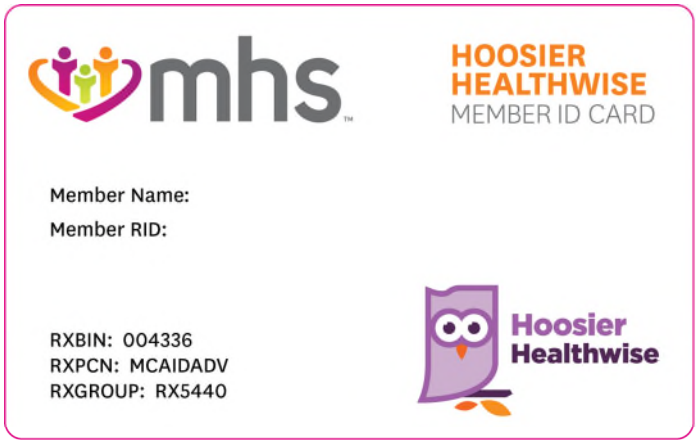
Agenda

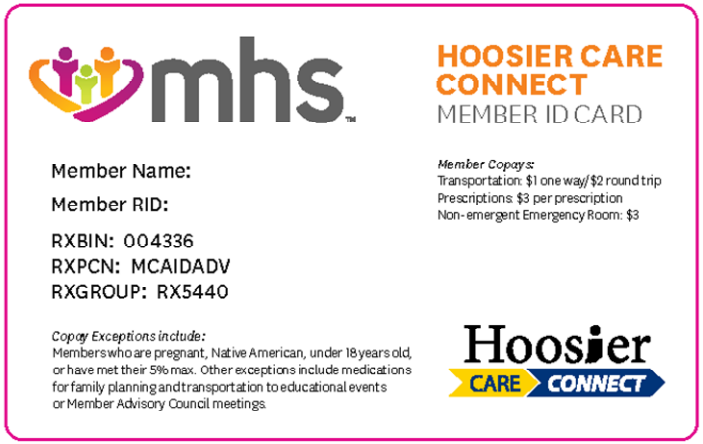
- Health Programs
- COVID-19 Updates
- Common Eligibility and Benefit Issues
- Common Prior Authorizations Issues
- Common Claims Issues
- Provider Claims Issue Resolution Process
- New Online Claim Reconsiderations
- Provider Relations Resources
- Provider Enrollment Issues
- MHS Secure Provider Website
- Questions

MHS Products

MHS Medicaid ID Cards

*Used for both HIP and HIP Maternity

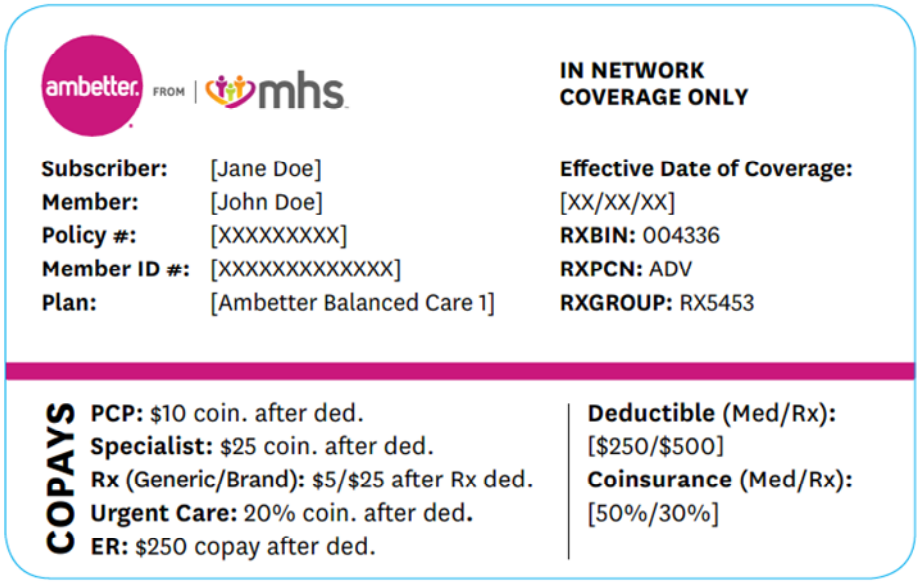


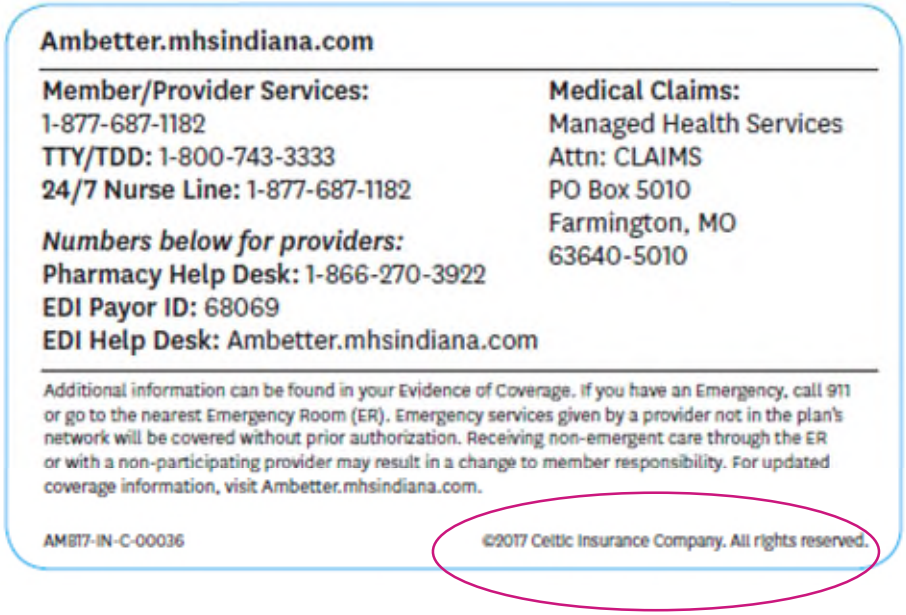


Ambetter Member ID Cards

You may see the names ***Celtic Insurance Company*** or ***Coordinated Care*** in relation to your Ambetter patients, or our parent company, *Centene Corporation*. You can always confirm patient eligibility through the Secure Provider Portal at provider.mhsindiana.com.

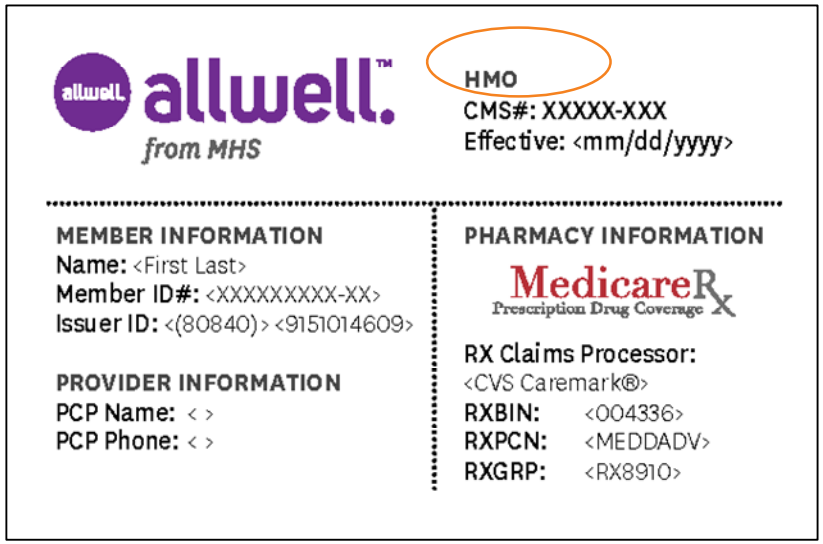
Member ID Card:

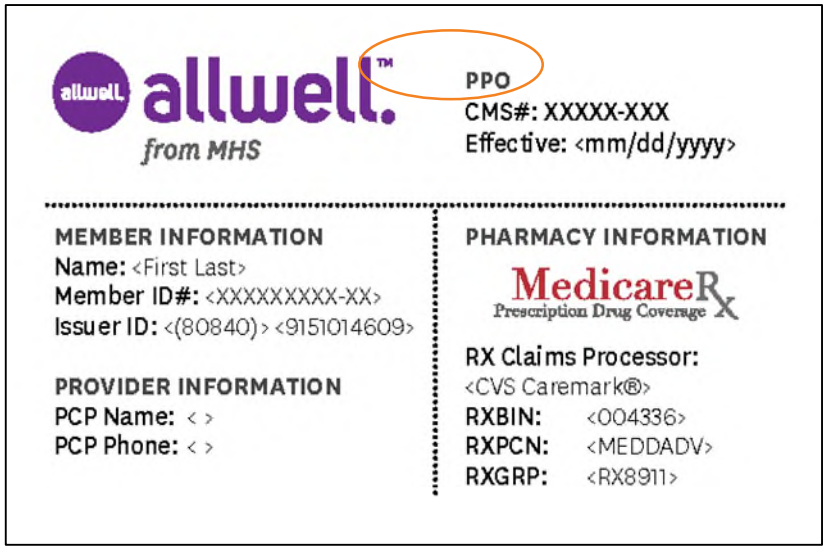




**** Possession of an ID Card is not a guarantee of eligibility and benefits.***

Allwell Member ID Cards





MHS COVID-19 Updates

COVID-19 Updates

Medicaid Filing Limit Updates

- Reference BT 202036.
- Extended timely filing limit on Medicaid claims to **180 calendar days.**
- Effective for DOS on or after March 1, 2020, and through the duration of the public health emergency for COVID-19.

COVID-19 Updates

Telehealth

- Medicaid - please reference BT202022
- Ambetter
  - Continuation of zero member liability (copays, cost sharing, etc.) for care delivered via telehealth.
  - Any services that can be delivered virtually will be eligible for telehealth coverage.
  - All prior authorization requirements for telehealth services will be lifted for dates of service from March 17, 2020 through June 30, 2020.
  - Telehealth services may be delivered by providers with any connection technology to ensure patient access to care.

COVID-19 Updates

Testing and Screening

- When medically necessary diagnostic testing or medical screening services are ordered and/or referred by a licensed health care provider, we will cover the cost of medically necessary COVID-19 tests and the associated physician's visit.
- Due to COVID-19, the State has removed all payments and copayments for Healthy Indiana Plan, Hoosier Healthwise, and Hoosier Care Connect members.

COVID-19 Updates

Prior Authorizations

- MHS will not require prior authorization, prior certification, prior notification and/or step therapy protocols for medically necessary COVID-19 diagnostic testing and medical screening services, when medically necessary services are ordered and/or referred by a licensed health care provider.

COVID-19 Updates

Sub Acute/Acute Authorization Updates

- Medicaid Acute Inpatient Authorizations - please reference *BT202030*
- Sub Acute Update - MHS specific Medicaid products only
  - SNF/subacute admissions will be “notification only.”
  - MHS will be approving 7 days without need for review (providers will need to submit the notification).

COVID-19 Updates

DME/HME Prior Authorization

- Effective 4/1/20 Respirator Services waiving PA
  - Medicaid - see reference *BT202031*

COVID-19 Updates

Enrollment

- During the COVID-19 emergency to address changes made by FSSA in BT202029 and BT202039.
- MHS will still require providers and practitioners to be enrolled with IHCP in order to bill for reimbursement for Hoosier Healthwise, Healthy Indiana Plan and Hoosier Care Connect.
- MHS will be relaxing the enrollment requirement that requires the NPI of the rendering practitioner to be linked to the Group Billing NPI on the IHCP enrollment file.

COVID-19 Updates

Enrollment

- Enrollment requests that do not meet the linkage requirement in place prior to the COVID-19 emergency will be flagged in the system and termed 90 days after the emergency is declared over, unless the provider notifies MHS that the linkage has been updated at IHCP.
- Requests for enrolling a PMP holding a panel must still have the group linkage established with IHCP, as MHS is required to register panel-holding PMPs with the state at a linked location.
- If a request is received that the linkage is not established at IHCP, MHS will reach out to the group to get clarification and direction on finalizing enrollment.

COVID-19 Updates

Enrollment

- Effective May 15, 2020, MHS will be removing the claim reject ***B2, Not enrolled with MHS with rendering NPI/TIN on DOS. Enroll with MHS and resubmit claim.*** This will allow claims to enter the MHS system even if the practitioner or provider is not yet enrolled with MHS. MHS will then enroll the practitioner as a non-contracted provider based on the information submitted on the claim unless the practitioner is not enrolled with IHCP at all. If a claim rejects B2 prior to May 15, 2020, please resubmit after the 15th.
- Effective, May 15, 2020, MHS will remove the claim reject ***B1 Rendering and Billing NPI are not tied on state file.*** If a claim rejects B1 prior to May 15, 2020 please resubmit after the 15th.

COVID-19 Updates

Credentialing

- During the COVID-19 emergency, credentialing applications that do not meet minimum standards, but do meet the criteria will be processed as provisional applications.
- If a provider is missing documentation for full credentialing and must be provisionally credentialed, a notice will be sent to the practitioner indicating the provisional status with instructions on what must be provided in the credentialing file to ensure full credentialing. Per NCQA guidelines for provisional credentialing during the COVID-19 emergency, provisional status can last no longer than 180 days.
- **Practitioners who do not complete full credentialing requirements within the 180 days will be automatically changed to a non-contracted status.**

Common Eligibility and Benefit Issues

Ambetter Verification of Eligibility, Benefits and Cost Share

- **Providers should always verify member eligibility:**
  - Every time a member schedules an appointment
  - When the member arrives for the appointment
- **Eligibility, Benefits and Cost Shares can be verified in 3 ways:**
  - **The Ambetter Secure Provider Portal found at:** ambetter.mhsindiana.com
    - If you are already a registered user of the MHS secure portal, you do NOT need a separate registration
  - **24/7 Interactive Voice Response system**
    - Enter the Member ID Number and the month of service to check eligibility
  - **Contact Provider Services at: 1-877-687-1182**
- **Panel Status**
  - PCPs should confirm that a member is assigned to their patient panel
  - This can be done via our Secure Provider Portal.
  - PCPs can still administer service if the member is not and may wish to have member assigned to them for future care.

Ambetter Verification of Eligibility, Benefits and Cost Share

Member in Suspended Status

- A provision of the ACA allows members who are receiving Advanced Premium Tax Credits (APTCs) a 3 month grace period for paying claims.
- After the first 30 days, the member is placed in a suspended status. The Explanation of Payment will indicate LZ Pend: Non-Payment of Premium.
- While the member is in a suspended status, claims will be pended
- When the premium is paid by the member, the claims will be released and adjudicated.
- If the member does not pay the premium, the claims will be released and the provider may bill the member directly for services.

Common Prior Authorization Issues

Common Prior Authorization Issues

- **Need to know what requires Authorization:**
  - MHS website: mhsindiana.com
  - Quick reference guide
  - Non-contracted provider services now align with PA requirements for contracted providers
- **How to obtain Authorization:**
  - Online (excluding Home Health and Hospice requests)
  - Phone
  - Fax
- **Inpatient Authorizations are only accepted via fax or the MHS Secure Web Portal.**

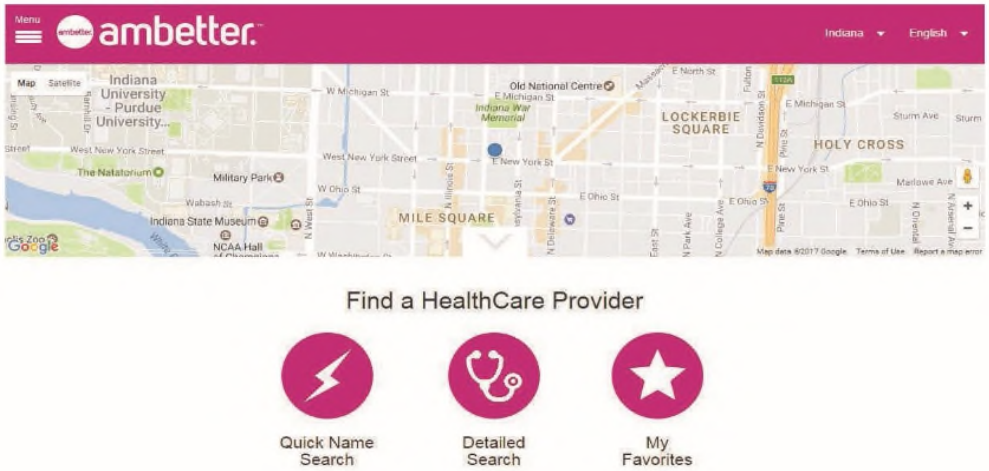
Prior Authorizations are not a guarantee of payment.
Failure to obtain prior authorization for services may result in claim denials!

Inpatient Prior Authorization

- MHS no longer accepts phone calls and only accepts notification of an inpatient admission via fax, using the IHCP universal prior authorization form, or via the MHS Secure Provider Portal.
- Please submit timely notification and clinical information to support an inpatient admission via fax to 1-866-912-4245 or upload via the MHS Secure Provider Portal.

Ambetter from MHS is an Exclusive Provider Network Benefit Plan

- Members enrolled in Ambetter must utilize in-network participating providers and practitioners except in the case of emergency services.
- When referring a member to another provider or practitioner, please make sure that the referral is contracted with Ambetter.
- If a non-contracted provider or practitioner is utilized, except in the case of emergency services, the member will be responsible for charges that exceed the allowed amount. ***This could mean hundreds of dollars in out-of-pocket expenses for the member.***
- Contracted providers and practitioners can be identified by visiting our website at **ambetter.mhsindiana.com** and clicking on Find a Provider.



Thank you for protecting our members from unnecessary out-of-pocket expenses!

Ambetter Prior Authorizations

- **Need to know what requires Authorization:**
- **Prior Authorization can be requested in 3 ways:**

1. **The Ambetter Secure Provider Portal found at** ambetter.mhsindiana.com
    - If you are already a registered user of the MHS portal, you do NOT need a separate registration!

2. **Fax Requests to: 1-855-702-7337**
    - The Fax authorization forms are located on our website at ambetter.mhsindiana.com

3. **Call for Prior Authorization at 1-877-687-1182**

Allwell Prior Authorizations

- Prior authorization is required for services such as:
  - Inpatient admissions, including observation
  - Home health services
  - Ancillary services
  - Radiology – MRI, MRA, PET, CT
  - Pain management programs
  - Outpatient therapy and rehab (OT/PT/ST)
  - Transplants
  - Surgeries
  - Durable Medical Equipment (DME)
  - Part B drugs
- Use the Pre-Auth Needed Tool at allwell.mhsindiana.com to check all services

Allwell Out-of-Network Prior Auth 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

- Use the Pre-Auth Needed Tool at allwell.mhsindiana.com to check all services

Common Allwell Prior Authorization Issues

- Authorization must be obtained prior to the delivery of certain elective and scheduled services
- The preferred method for submitting authorization requests is through the Secure Provider Portal at: provider.mhsindiana.com

Service Type	Time Frame
Elective/scheduled admissions	Required five business days prior to the scheduled admit date
Emergent inpatient admissions	Notification required within one business day
Emergency room and post stabilization	Notification requested within one business day

Behavioral Health Prior Authorizations

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 20 units per member, per provider, per rolling 12-month period which started on 12/15/2019 and will start over on 12/15/2020:

Code	Description
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

*Note: Codes 90850, 90851 and 90852 are inactive for 2020 per CMS.

Behavioral Health Prior Authorizations

Limitations on Outpatient Mental Health Services (Cont.):

- “Per Provider” is defined by MHS as per individual rendering practitioner NPI being billed on the CMS-1500 claim form (Box 24J).
- Claims exceeding the limit will deny EX Th: Services exceeding 20 require prior authorization.

Behavioral Health Prior Authorizations

Limitations on Outpatient Mental Health Services (Cont.):

- If the member requires additional services beyond the 20 unit limitation, providers may request prior authorization for additional units. Approval will be given based on the necessity of the services as determined by the review of medical records.
- Providers will need to determine if they have provided 20 units to the member in the past rolling 12 months to determine if a prior authorization request is needed.

Common Claim Issues

Common Claim Issues

- Claim Submission Rejections
- Common EDI Claim Rejections
- Top 5 Claim Denials
- Common Claim Denials

Claims Submission

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 may be corrected and resubmitted.
- 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

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/provider-guides.
- MHS website tools :
  - Reject code listing
  - Refer to top 10 rejection code help aid document
- A provider cannot appeal a rejected claim.

Top 5 Claim Denials for 2020

1. Time Limit For Filing Has Expired (EX29)
2. Bill Primary Insurer 1st (EXL6)
3. Authorization Not On File (EXA1)
4. Denied After Review of Patients Claim History (EXya)
5. Invalid or missing modifier (EXIM)

Additional Information for Denial Codes can be found using this link:

https://www.mhsindiana.com/content/dam/centene/mhsindiana/medicaid/pdfs/0917-OS-P-WM-EX-Code-Descriptions-MHS-Denial-Codes-11-17-2017.pdf

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 of the information provided on the claim and the information on file with Indiana Medicaid.
  - Member Information
  - Newborn's RID 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

Ambetter Claim Submission

The timely filing deadline for initial claims is 180 days from the date of service or date of primary payment when Ambetter is secondary.

Claims may be submitted in 3 ways:

1. **The Secure provider Portal located at** ambetter.mhsindiana.com
2. **Electronic Clearinghouse**
    - Payor ID 68069
    - Clearinghouses currently utilized by ambetter.mhsindiana.com will continue to be utilized
    - For a listing of the Clearinghouses, please visit out website at ambetter.mhsindiana.com
3. **Paper claims may be submitted to PO Box 5010 Farmington, MO 64640-5010**

Ambetter Claim Submission

Billing the Member

- Copays, coinsurance and any unpaid portion of the deductible may be collected at the time of service.
- The Secure Provider Portal will indicate the amount of the deductible that has been met.
- If the amount collected from the member is higher than the actual amount owed upon claim adjudication, the provider must reimburse the member within 45 days.

Allwell Common Claim Issues

- **Common Cause of Claims Processing Delays and Denials**
- Procedure or Modifier Codes entered are invalid or missing.
- This includes GN, GO, or GP modifier for therapy services.
- Diagnosis Code is missing the 4th or 5th digit.
- DRG code is missing or invalid.
- Explanation of Benefits (EOB) from the primary insurer is missing or incomplete.
- Third Party Liability (TPL) information is missing or incomplete.
- Member ID is invalid.
- Place of Service Code is invalid.
- Provider TIN and NPI do not match.
- Revenue Code is invalid.
- Dates of Service span do not match the listed days/units.
- Tax Identification Number (TIN) is invalid.

Allwell Claims Filing Timelines

- Medicare Advantage Claims are to be mailed to the following billing address:

Allwell from MHS
P.O. Box 3060
Farmington, MO 63640-3822

- Participating providers have **180 days** from the date of service to submit a timely claim.
- All requests for reconsideration or claim disputes must be received within **180 days** from the original date of notification of payment or denial.

Behavior Health Claim Billing with Ease

- **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

MHS Provider Claims Issue Resolution Process

Provider Claims Issue Resolution

PROCESS

- Step 1: Informal Claims Dispute or Objection Form
- Step 2: Formal Claim Dispute - Administrative Claim Appeal
- Step 3: Arbitration
- For assistance or questions after completing step one:
  - Provider Services Phone Requests & Web Portal Inquiries
- If additional assistance is needed anytime after Step 1 and after calling Provider Services or completing Web Portal inquiry:
  - Provider Relations Regional Mailboxes

Informal Claims Dispute or Objection Form

Step 1:

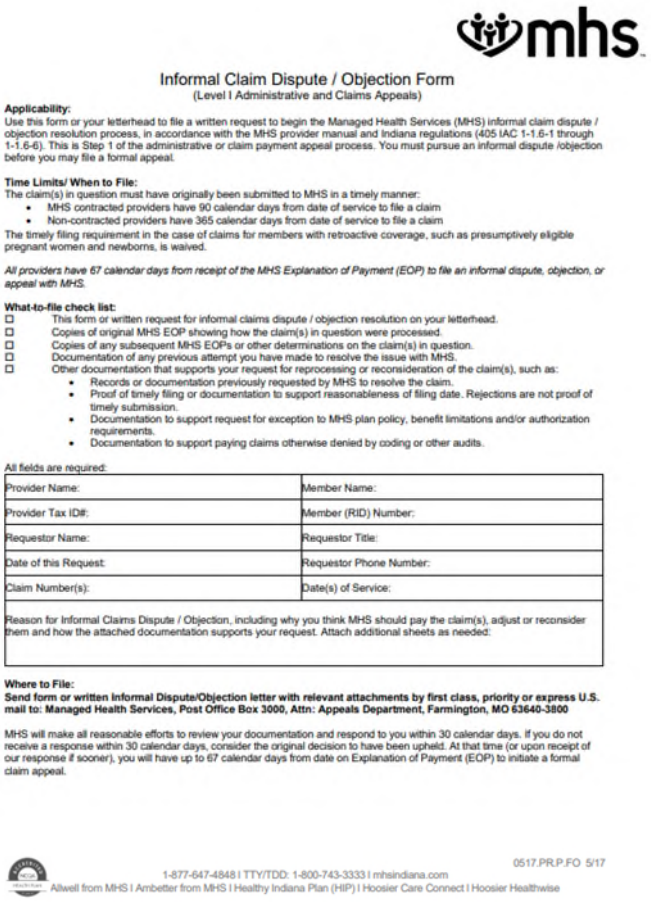
- Must be submitted in writing within 67 calendar days of receipt of the MHS Explanation of Payment (EOP) by using the MHS Informal Claim Dispute or Objection form, available at mhsindiana.com/providers/resources/forms; there is a general form for medical and a separate form for Behavioral Health claims. The address for submission is listed on each of the forms.

- Requests received after day 67 will not be considered.

Informal Claims Dispute or Objection Form - Medical

Address:
Managed Health Services
Post Office Box 3000
Attn: Appeals Department
Farmington, MO 63640-3800

https://www.mhsindiana.com/content/dam/centene/mhsindiana/medicaid/pdfs/0517.PR.P.FO%20Informal-Claim-Dispute-Objection-Form-EN-May2017.pdf



Informal Claim Dispute / Objection Form
(Level I Administrative and Claims Appeals)

Applicability:
Use this form or your letterhead to file a written request to begin the Managed Health Services (MHS) informal claim dispute / objection resolution process, in accordance with the MHS provider manual and Indiana regulations (405 IAC 1-1.6-1 through 1-1.6-6). This is Step 1 of the administrative or claim payment appeal process. You must pursue an informal dispute /objection before you may file a formal appeal.

Time Limits/ When to File:
The claim(s) in question must have originally been submitted to MHS in a timely manner:
- MHS contracted providers have 90 calendar days from date of service to file a claim
- Non-contracted providers have 365 calendar days from date of service to file a claim

The timely filing requirement in the case of claims for members with retroactive coverage, such as presumptively eligible pregnant women and newborns, is waived.

All providers have 67 calendar days from receipt of the MHS Explanation of Payment (EOP) to file an informal dispute, objection, or appeal with MHS.

What-to-file check list:
- ☐ This form or written request for informal claims dispute / objection resolution on your letterhead.
- ☐ Copies of original MHS EOP showing how the claim(s) in question were processed.
- ☐ Copies of any subsequent MHS EOPs or other determinations on the claim(s) in question.
- ☐ Documentation of any previous attempt you have made to resolve the issue with MHS.
- ☐ Other documentation that supports your request for reprocessing or reconsideration of the claim(s), such as:
  - Records or documentation previously requested by MHS to resolve the claim.
  - Proof of timely filing or documentation to support reasonableness of filing date. Rejections are not proof of timely submission.
  - Documentation to support request for exception to MHS plan policy, benefit limitations and/or authorization requirements.
  - Documentation to support paying claims otherwise denied by coding or other audits.

All fields are required:

Provider Name:	Member Name:
Provider Tax ID#:	Member (RID) Number:
Requestor Name:	Requestor Title:
Date of this Request:	Requestor Phone Number:
Claim Number(s):	Date(s) of Service:
Reason for Informal Claims Dispute / Objection, including why you think MHS should pay the claim(s), adjust or reconsider them and how the attached documentation supports your request. Attach additional sheets as needed:	

Where to File:
Send form or written Informal Dispute/Objection letter with relevant attachments by first class, priority or express U.S. mail to: Managed Health Services, Post Office Box 3000, Attn: Appeals Department, Farmington, MO 63640-3800

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 67 calendar days from date on Explanation of Payment (EOP) to initiate a formal claim appeal.

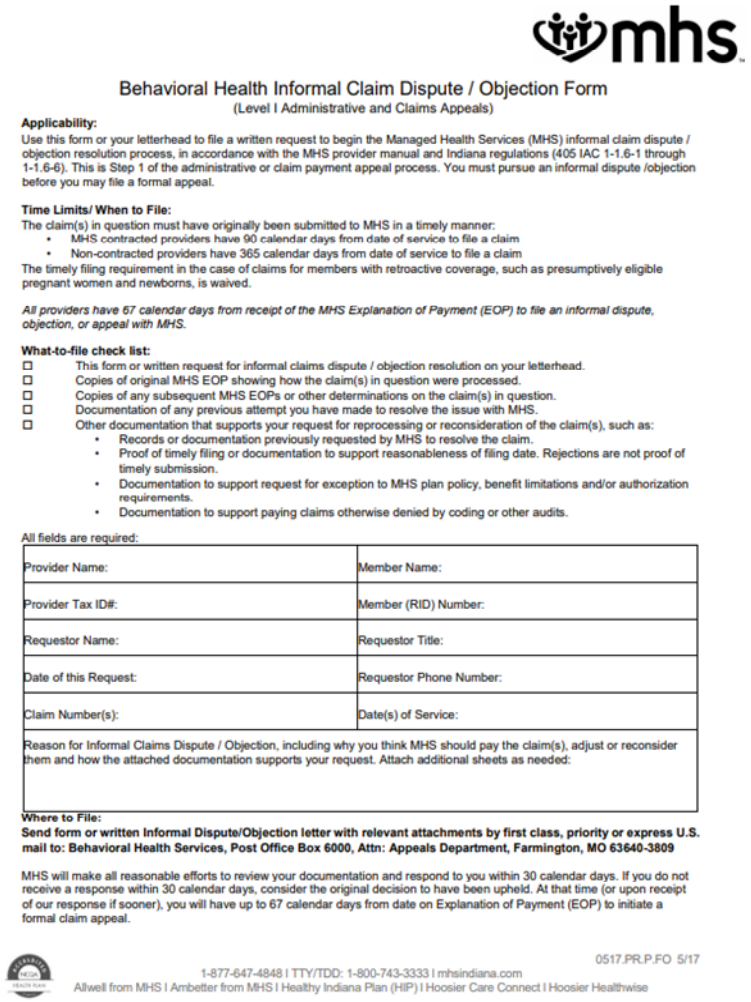
0517.PR.P.FO 5/17
1-877-647-4848 | TTY/TDD: 1-800-743-3333 | mhsindiana.com
Allwell from MHS | Ambetter from MHS | Healthy Indiana Plan (HIP) | Hoosier Care Connect | Hoosier Healthwise

Informal Claims Dispute or Objection Form – Behavioral Health

Address:

- Behavioral Health Services
  Post Office Box 6000
  Attn: Appeals Department
  Farmington, MO 63640-3809

https://www.mhsindiana.com/content/dam/centene/mhsindiana/medicaid/pdfs/Behavioral-Health-Informal-Claim-Dispute-Objection-Form.pdf



Behavioral Health Informal Claim Dispute / Objection Form

(Level I Administrative and Claims Appeals)

Applicability:

Use this form or your letterhead to file a written request to begin the Managed Health Services (MHS) informal claim dispute / objection resolution process, in accordance with the MHS provider manual and Indiana regulations (405 IAC 1-1.6-1 through 1-1.6-6). This is Step 1 of the administrative or claim payment appeal process. You must pursue an informal dispute /objection before you may file a formal appeal.

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- Non-contracted providers have 365 calendar days from date of service to file a claim

The timely filing requirement in the case of claims for members with retroactive coverage, such as presumptively eligible pregnant women and newborns, is waived.

All providers have 67 calendar days from receipt of the MHS Explanation of Payment (EOP) to file an informal dispute, objection, or appeal with MHS.

What-to-file check list:

- ☐ This form or written request for informal claims dispute / objection resolution on your letterhead.
- ☐ Copies of original MHS EOP showing how the claim(s) in question were processed.
- ☐ Copies of any subsequent MHS EOPs or other determinations on the claim(s) in question.
- ☐ Documentation of any previous attempt you have made to resolve the issue with MHS.
- ☐ Other documentation that supports your request for reprocessing or reconsideration of the claim(s), such as:
  - Records or documentation previously requested by MHS to resolve the claim.
  - Proof of timely filing or documentation to support reasonableness of filing date. Rejections are not proof of timely submission.
  - Documentation to support request for exception to MHS plan policy, benefit limitations and/or authorization requirements.
  - Documentation to support paying claims otherwise denied by coding or other audits.

All fields are required:

Provider Name:	Member Name:
Provider Tax ID#:	Member (RID) Number:
Requestor Name:	Requestor Title:
Date of this Request:	Requestor Phone Number:
Claim Number(s):	Date(s) of Service:
Reason for Informal Claims Dispute / Objection, including why you think MHS should pay the claim(s), adjust or reconsider them and how the attached documentation supports your request. Attach additional sheets as needed:	

Where to File:

Send form or written Informal Dispute/Objection letter with relevant attachments by first class, priority or express U.S. mail to: Behavioral Health Services, Post Office Box 6000, Attn: Appeals Department, Farmington, MO 63640-3809

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 67 calendar days from date on Explanation of Payment (EOP) to initiate a formal claim appeal.

0517.PR.P.FO 5/17

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

Allwell from MHS | Ambetter from MHS | Healthy Indiana Plan (HIP) | Hoosier Care Connect | Hoosier Healthwise

Informal Claims Dispute or Objection Form

Step 1:

- Submit all documentation supporting your objection.
  - Copies of original MHS EOP showing how the claims in question were processed.
  - Copies of any subsequent MHS EOPs or other determinations on the claim(s) in question.
  - Documentation of any previous attempt you have mad to resolve the issue with MHS.
  - Other documentation that supports your request for reprocessing or reconsideration of the claim(s).

Informal Claims Dispute or Objection Form

Step 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 67 calendar days from date of Dispute response to initiate a formal claim appeal (Step 2).

Informal Claims Dispute or Objection Form

Step 1:

- Helpful Tips:
  - Disputing multiple claim denials:
    - o Submit separate Informal Claims Dispute Forms for each member/patient experiencing the denial;
    - o Provide additional information such as:
      - o The MHS denial code and description found on the EOPP/remit;
      - o Briefly describe why you are disputing this denial;
      - o 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.

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

Customer/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.

Customer/Provider Services Phone Requests & Web Portal Inquiries

- Helpful Tips:
  - **Communication is Key!** (cont.):
    - Do not include multiple claim denial reasons within the same research request. Submit separate research requests for each individual denial reason.
    - Please refrain submitting research requests for vague reasons or if you can clearly determine the denial is valid; For example:
      - Valid timely filing denials;
      - Services that require prior authorization but PA wasn't obtained
    - Retain all reference numbers provided by the Provider Services and Web-Portal teams.

Research can take up to 30-45 days; at any time you can follow up with the Provider Services or Web Portal team with a status update request (make sure to provide the original reference number).

New

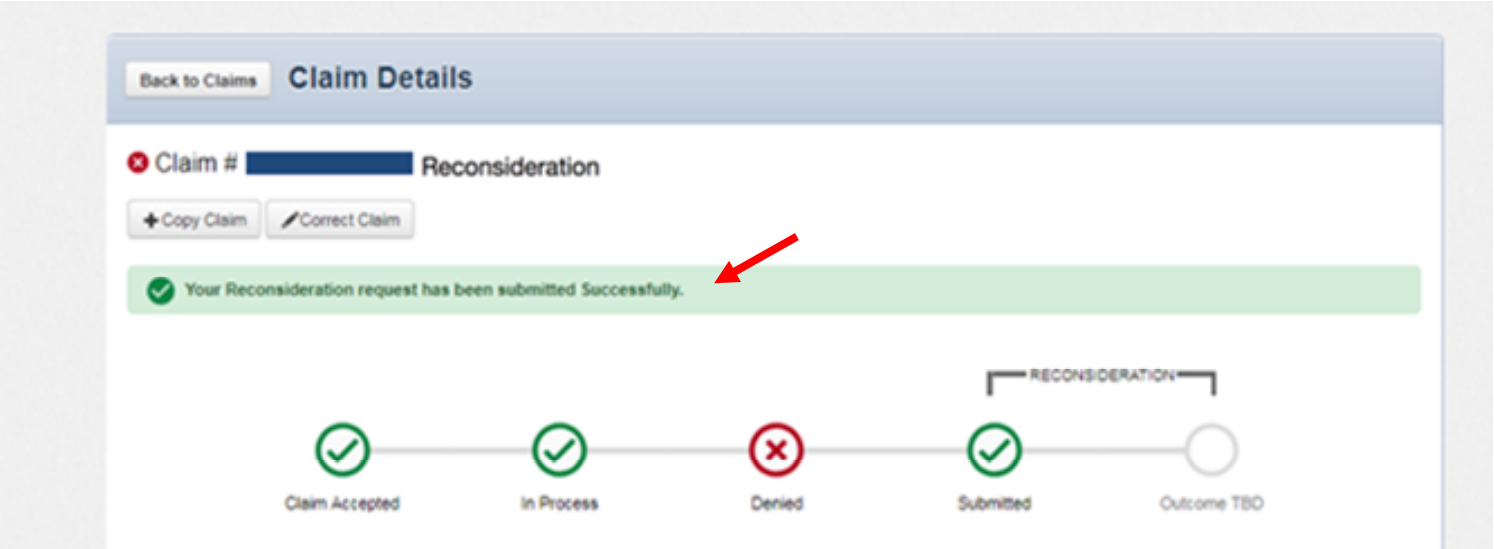
Online Claim Reconsiderations on the MHS Secure Provider Portal

What's New

- Providers may now view EX 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

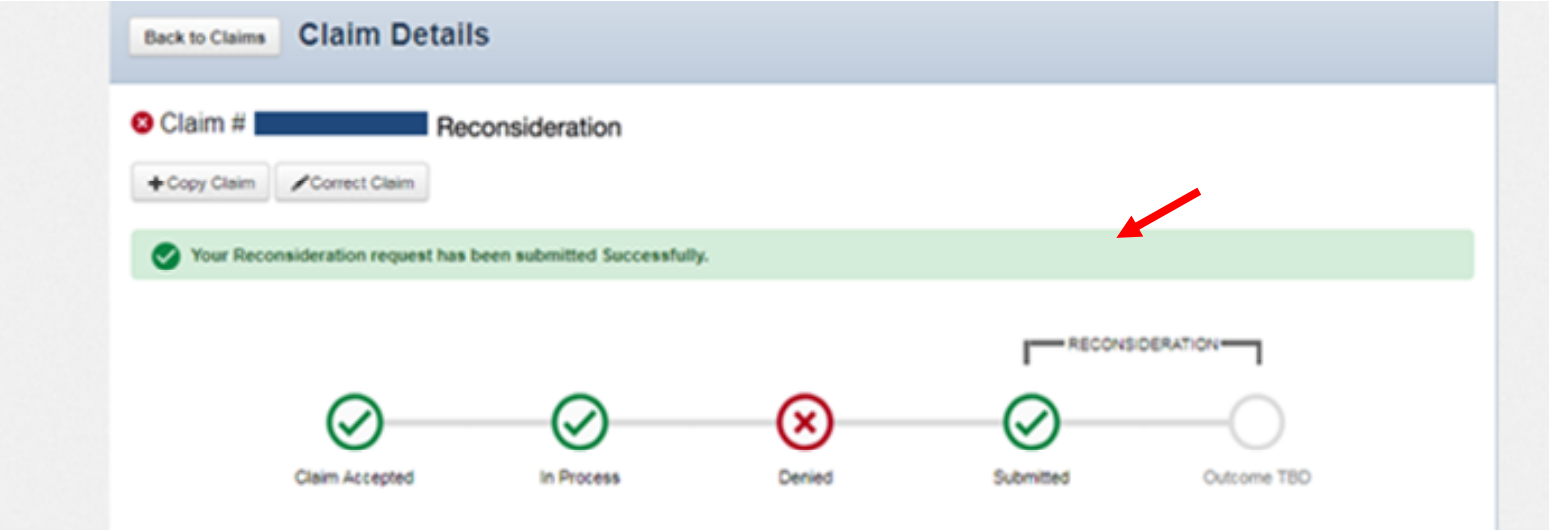
Submit Reconsideration – Updated Tracker

- Upon submission, a success banner will be displayed.



Submit Reconsideration – Updated Tracker

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



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.

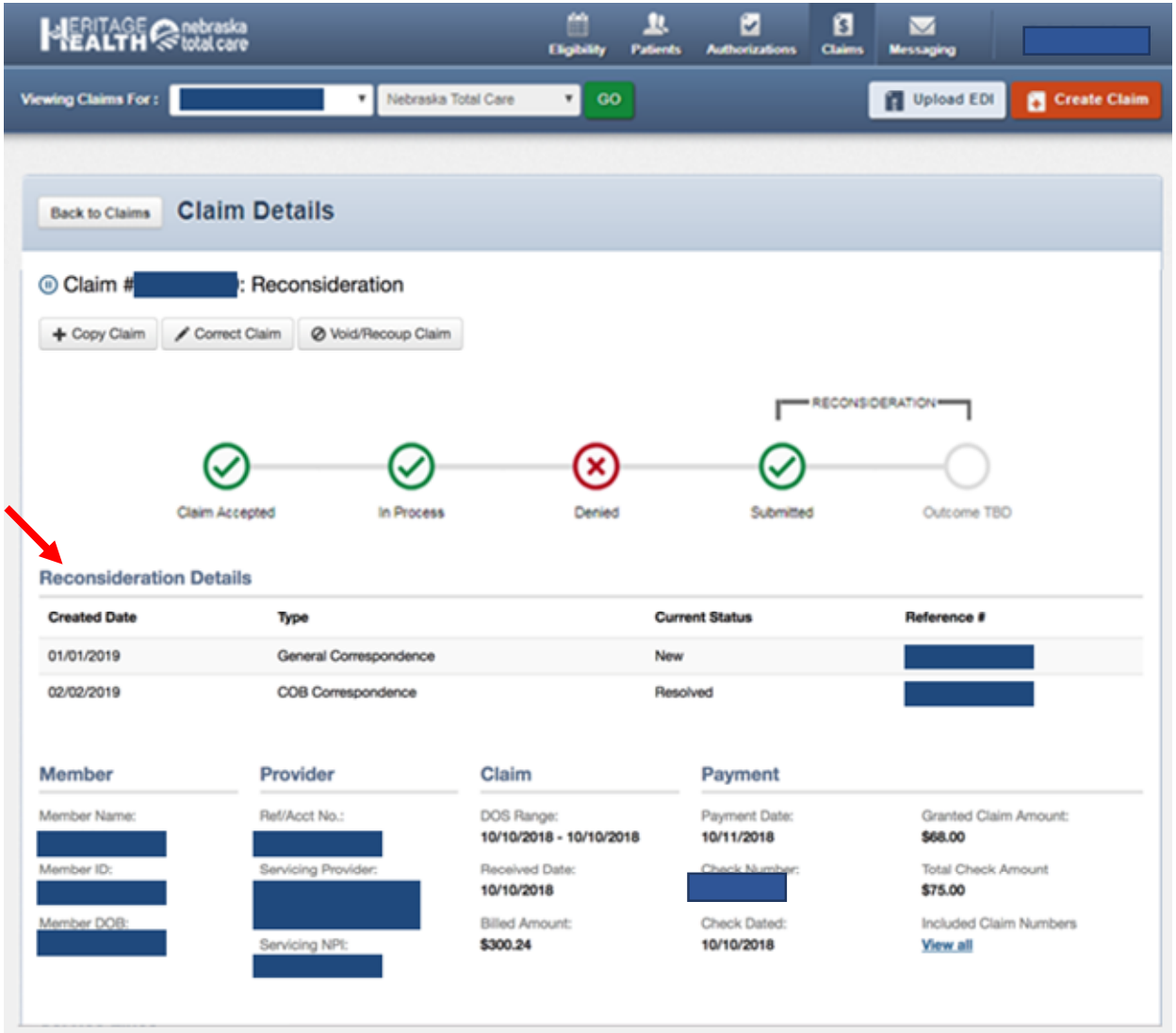
Add context.

Providers can easily attach supporting documentation when filing an informal dispute/reconsideration.

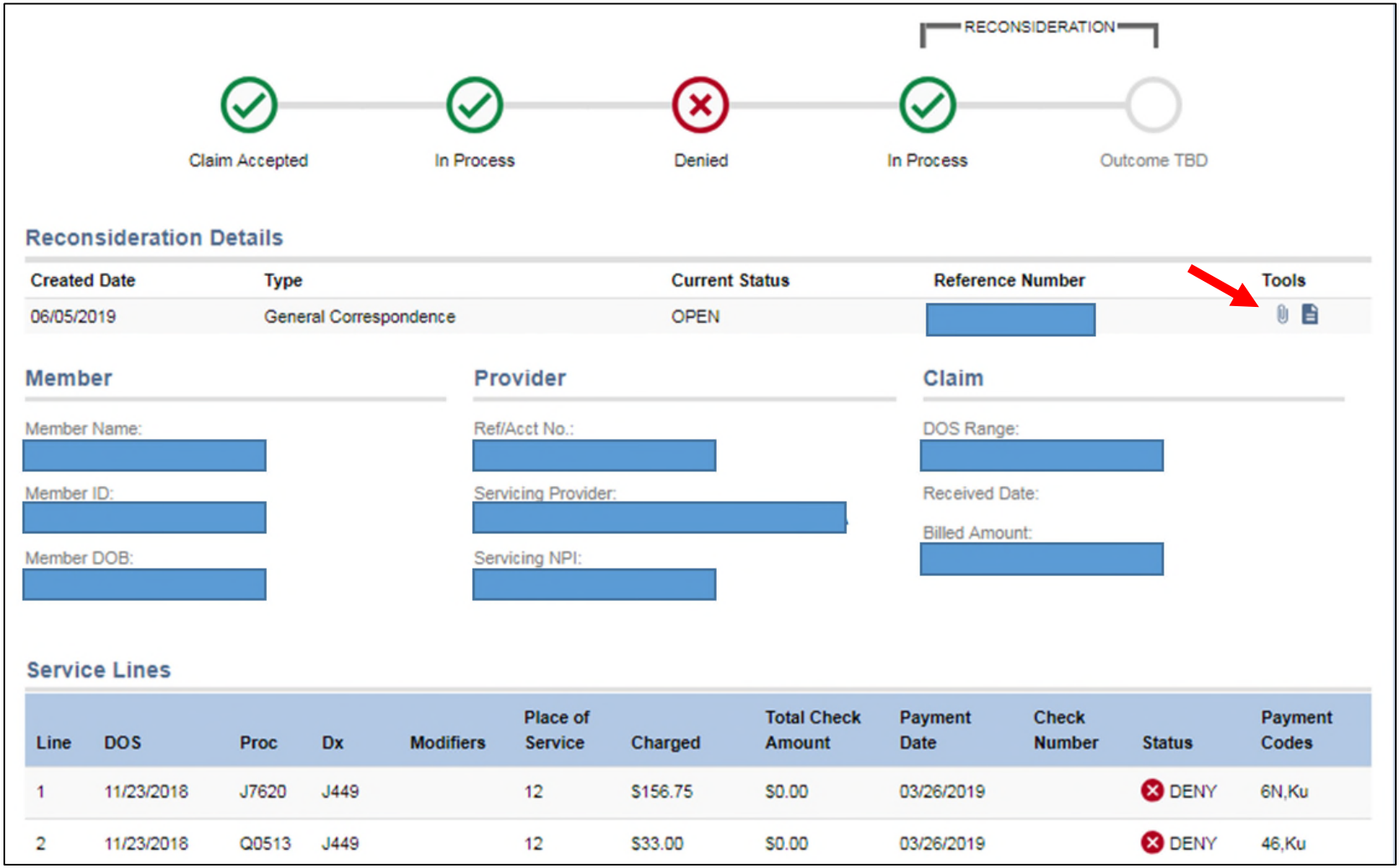
Stay current.

- Providers may opt in/out for informal dispute/reconsideration status change emails.
- Providers may also view status online.

Reconsideration Details

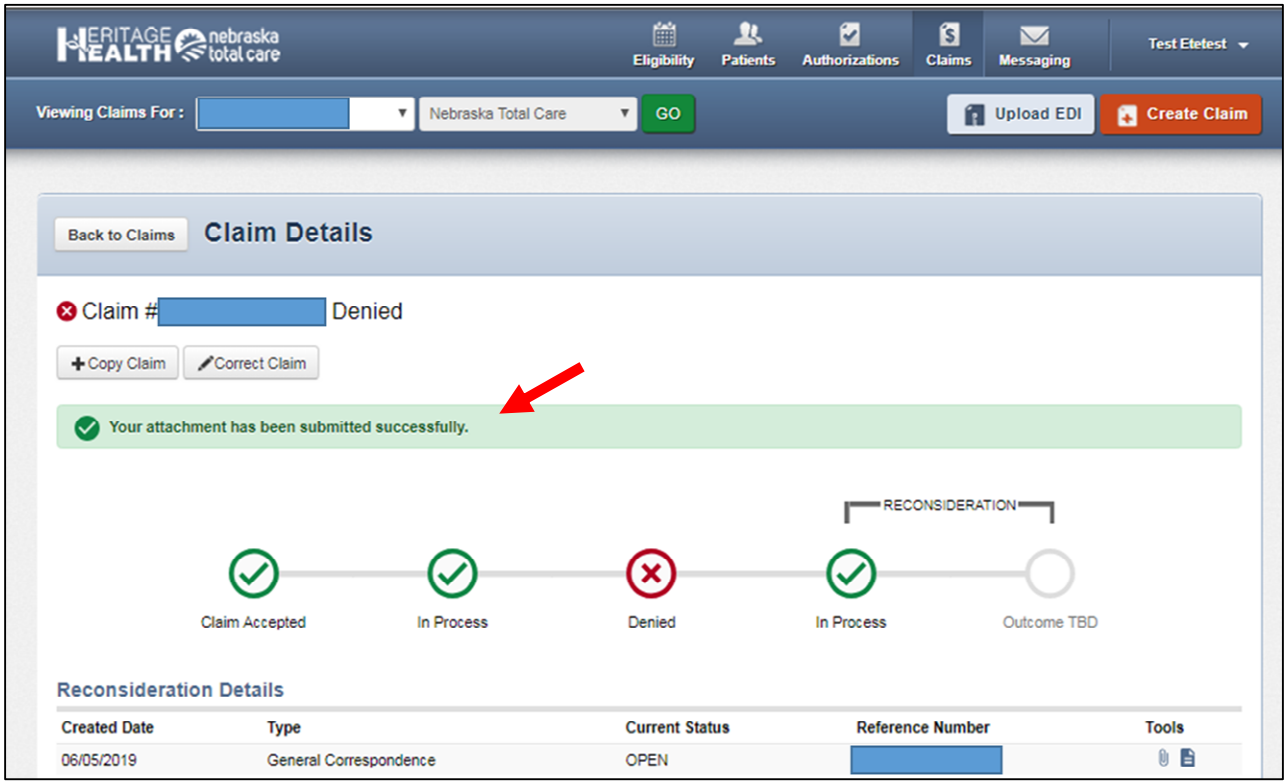


Additional Attachments



Additional Attachments – Success Banner

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



Online Reconsiderations

- It is important to note that all requests submitted via the reconsideration tool will be considered an **informal dispute.**
- 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.

Provider Relations Regional Mailboxes

- This is not considered a formal notification of provider dispute.
- If Step 1 results in an upheld denial and calling Provider Services or submitting inquiry through portal does not resolve the issue within 45 calendar days, please contact the Provider Relations team 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:

- After Step 1 has been performed and Provider Services/Portal inquiry does not result in resolution or issue is upheld; 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/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

Formal Claim Dispute - Administrative Claim Appeal

Step 2

- Step 2 is a continuation of Step 1 and 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 67 calendar days from receipt of the informal dispute resolution notice.

- An administrative claim appeal must be submitted in writing on company letterhead with an explanation including any specific details which may justify reconsideration of the disputed claim. The word “appeal” must be clearly marked on the letter.

- Administrative claim appeals need to be submitted to: Managed Health Services, P.O. Box 3000, Farmington, MO 63640

- See the MHS Provider Manual Chapter 5 Claims Administrative Reviews and Appeals for more information. https://www.mhsindiana.com/content/dam/centene/mhsindiana/medicaid/pdfs/Provider_Manual_2019.pdf

Arbitration

Step 3:

- Step 3 is a continuation of Steps 1 & 2 and 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 (Step 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, unless otherwise directed in the letter.

- See the MHS Provider Manual Chapter 5 Claims Administrative Reviews and Appeals for more information. https://www.mhsindiana.com/content/dam/centene/mhsindiana/medicaid/pdfs/Provider_Manual_2019.pdf

Utilization Management

MEDICAL NECESSITY GRIEVANCE AND APPEALS

Managed Health Services
Attn: Appeals Coordinator
PO BOX 441567
Indianapolis, IN 46244

- Determination will be communicated to the provider within 20 business days of receipt.
- Remember: Appeals must be initiated **within 60 days** of the denial to be considered. Please note, this is different than a claim appeal request.

Ambetter Claim Reconsiderations

- **Claim Reconsiderations**
  - A written request from a provider about a disagreement in the manner in which a claim was processed. No specific form is required.
  - Must be submitted within 180 days of the Explanation of Payment.
  - Claim Reconsiderations may be mailed to PO Box 5010, Farmington, MO 63640-5010.

Allwell Medicare Grievances and Authorization Appeals

- **Attn: Medicare Grievances and Authorization Appeals (Medicare Operations) 7700 Forsyth Blvd St. Louis, MO 63105**
- For process or status questions, members or their representatives can contact Member Services at 1-855-766-1541.

Provider Enrollment Issue Resolution

Common Contracting Issues

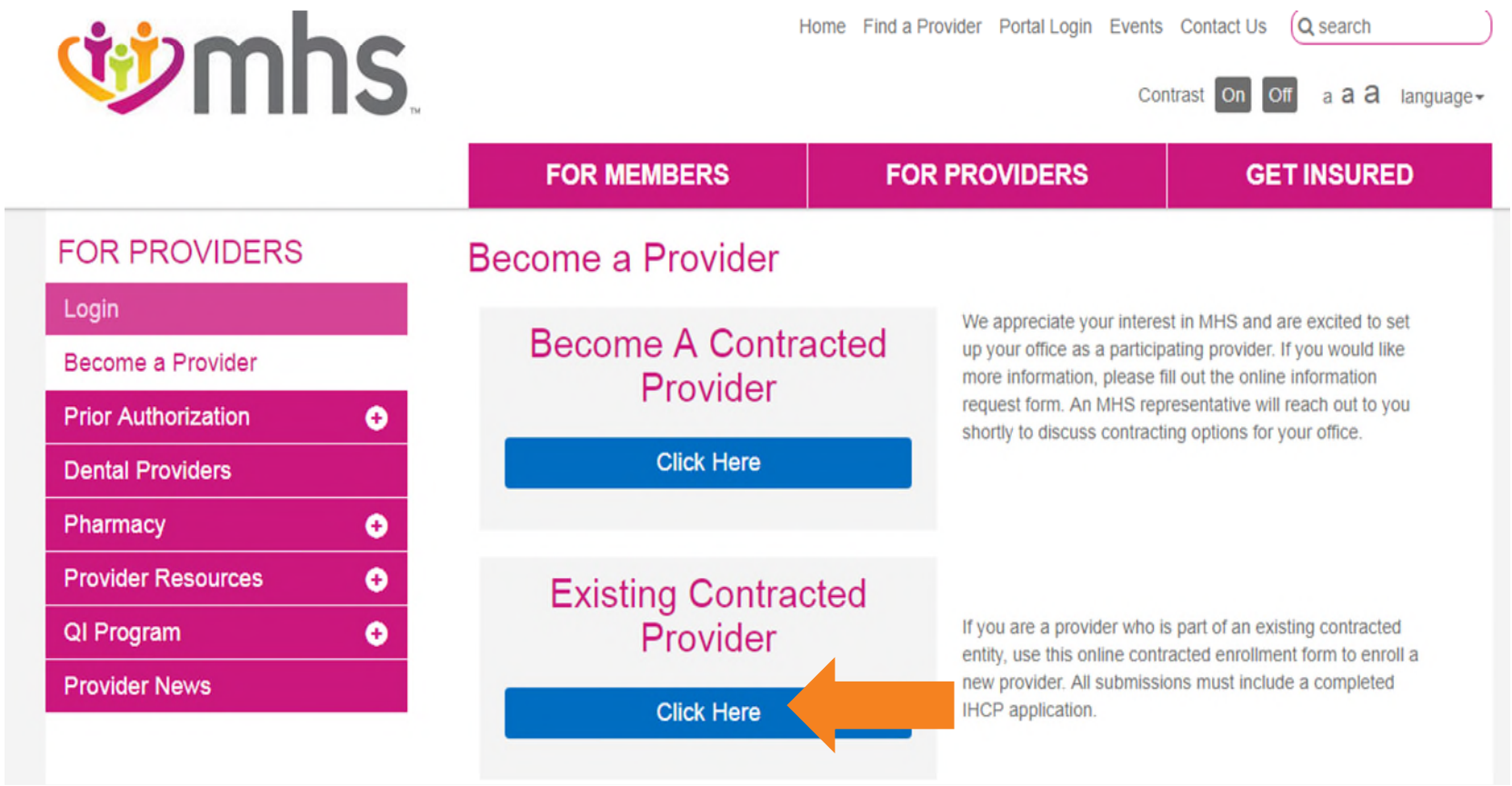
- Confirm the fully executed contract effective date prior to seeing members.
- A complete package of all requested documents for contracting must be received prior to becoming participating. After you are considered a MHS participating provider you will receive a copy of the fully executed agreement.
- Adding additional practitioners to an existing agreement must be done via website tool. You must complete the online form as well as uploading a fully completed enrollment form. For NPs, they must attach a Collaboration Agreement with the Enrollment form or enrollment will be rejected.
- Demographic updates must be completed online using the secured provider portal. Emails sent to the contracting department will not be not considered as demographic updates.
- Status updates can be completed by contacting the MHS Provider Services team 877-647-4848.

Common Credentialing Issues

- Prior to starting the credentialing process providers should update and verify any outdated provider information. i.e. (collaborate agreement, DEA, work history, etc.).
- Return all requested documents to MHS for processing.
- MHS notification will be sent when credentialing is complete.

Provider Enrollment

Provider Enrollment



Provider Enrollment

Non-Contracted Provider

Click Here

If you are not contracted with MHS, please complete the online non-contracted enrollment form. All submissions must include a completed W9. Set-up may take 45 – 60 days after we receive your submission.

To begin set-up with MHS, you must be enrolled with Indiana Medicaid and have an Indiana Medicaid provider number. You can enroll online at indianamedicaid.com.

Existing Behavioral Health Provider

Click Here

If you are a provider who is part of an existing contracted behavioral health entity, use this online contracted enrollment form to enroll a new provider.

Provider Enrollment

When referring patients to the hospital, do you utilize hospitalists?

- Yes
- No

Group NPI

*Group Medicaid Number **

Alpha Suffix

*TIN **

Please attach a copy of your completed IHCP enrollment form. Required for Medicaid (HIP, HHW or HCC).

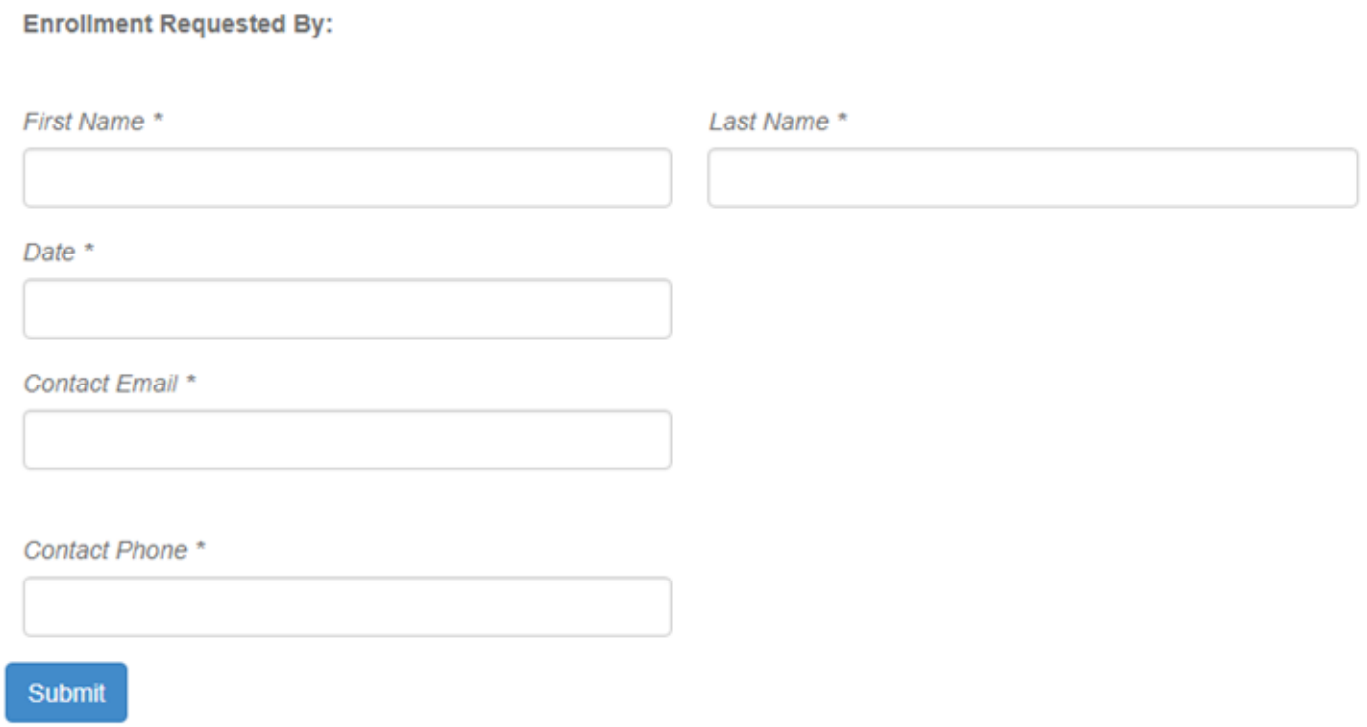
Choose File No file chosen

If a midlevel practitioner, please attach a copy of your collaboration agreement.

Choose File No file chosen

Comments

Provider Enrollment



MHS Behavioral Health Provider Enrollment

Please attach a copy of your completed IHCP enrollment form. *

Choose File No file chosen

Please attach a copy of your Health Service Provider of Psychology (HSPP) Attestation. *

Choose File No file chosen

Please attach a copy of your Behavioral Health Specialty Profile. *

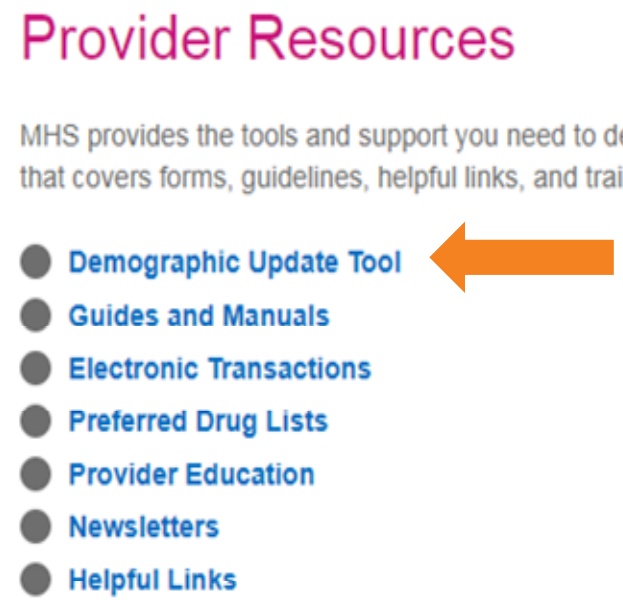
Choose File No file chosen

MHS Behavioral Health Provider Enrollment

- Upon attempt to enroll BH Practitioners, failure to include the MD/HSPP Attestation Collaboration Agreement form will cause the application to reject.

Demographic Updates

Provider Demographic Updates



- Providers can utilize the Demographic Update Tool on mhsindiana.com/providers to update below information.
  - Address Changes
  - Demographic Changes
  - Update Member Assignment Limitations
  - Term an Existing Provider
  - Make a Change to an IRS Number or NPI Number

Provider Demographic Updates

Demographic Update Tool

MHS is committed to providing our providers with the best tools possible to support their administrative needs. We have created an easy way for you to request updates to your information and ensure we receive what we need to complete your request in a timely manner.

Need to review your existing information or have a question? If you are a contracted provider you can visit our Provider Directory to review your information. Please note that hospital-based and midlevel providers will not show in the directory. If you are a non-contracted provider, please call Provider Services at 1-877-647-4848. Our Contact Us page is always available for general questions as well.

Ambetter only provider? Visit our Ambetter website.

What would you like to do?

- *MAKE AN ADDRESS CHANGE?*
- *MAKE A DEMOGRAPHIC CHANGE?*
- *UPDATE MEMBER ASSIGNMENT LIMITATIONS?*
- *TERM AN EXISTING PROVIDER?*
- *MAKE A CHANGE TO AN IRS NUMBER OR NPI NUMBER?*

MHS Secure Web Portal Enhancements

MHS Secure Web Portal Enhancements

The Online Tools You Need Just Got Even Better!

We've improved our secure provider portal to make doing business with us easier. New visual trackers and other enhancements will allow you to be more efficient, saving you time and hassle.

Manage claims more efficiently with easier online claims and tracking.

- **Visually track your claims.** See which have been approved or denied with the new color-coded tracker.
- **Easily view Denial Codes.** Denial Code descriptions are now on the Claims Details page—you no longer need to open each claim line.

The informal dispute/reconsideration process is now all online for ease of use:

- **Skip the phone call.** Make your case online.
- **Make your case.** Submit informal dispute/reconsideration comments using expanded text fields.
- **Add context.** Easily attach documentation when you file a informal dispute/reconsideration.
- **Stay current.** Opt in/out for informal dispute/reconsideration status change emails.

The call center is still available to verbally discuss any questions or concerns.

Quickly check member eligibility online with the new overview page.

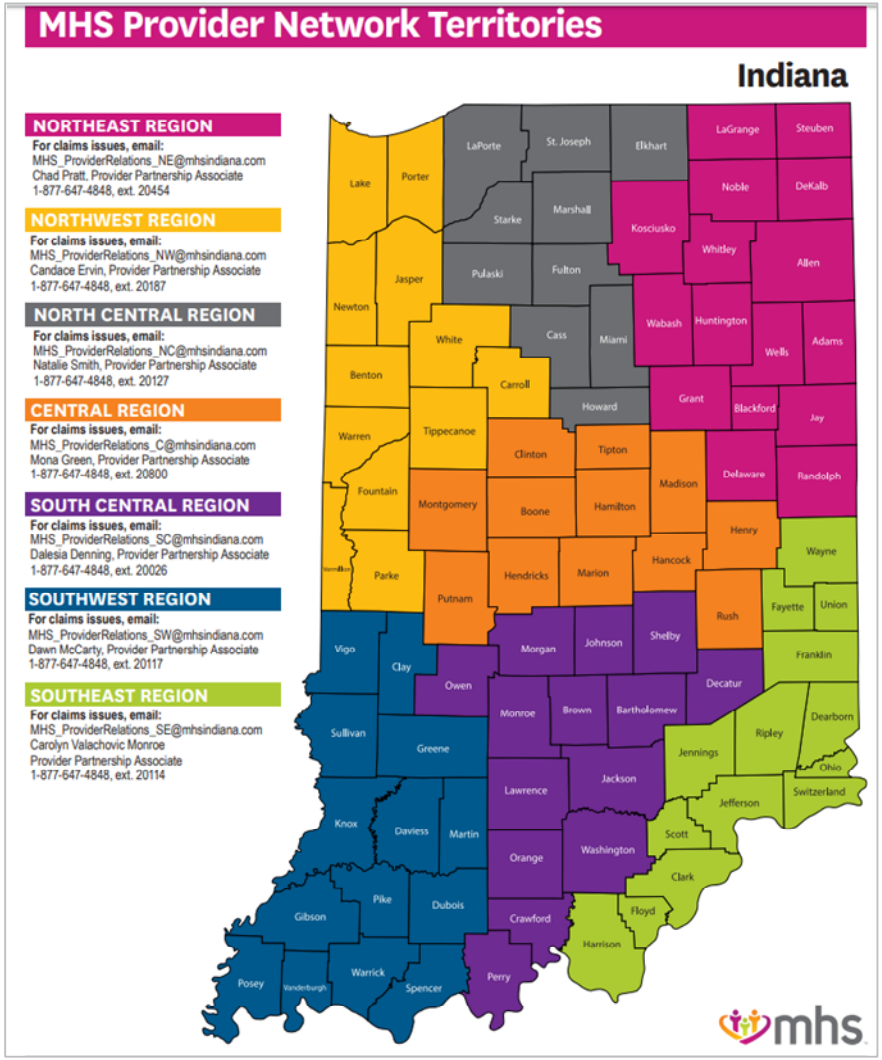
- Now you can **see all important member data** on one page.

Prior Authorization pop-up window makes the process more efficient.

- This helpful reminder prompts you to attach supporting documents to avoid delays.

MHS Secure Provider Portal Features

- Access for Medicaid, Ambetter and Allwell
- Access for both contracted/non-contracted groups
- Online registration – multiple users
- Patient Eligibility Listing
- Pay For Performance Reporting
- Online Claims Dispute
- Enhanced claim detail
- Direct claim submission
- COB processing with or without attachments
- Claim adjustment
- Claim auditing tool
- Eligibility and COB verification
- Prior authorization
- Gaps in Care
- Online Health Record Vault for “your” patients (includes specialty care)
- Care Management Plan



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. 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

MHS Provider Network Territories

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

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

JENNIFER GARNER
Provider Partnership Associate II
1-877-647-4848 ext. 20149
jgarner@mhsindiana.com

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

NETWORK LEADERSHIP

JILL CLAYPOOL
Vice President, Network Development & Contracting
1-877-647-4848 ext. 20855
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

ENVOLVE DENTAL, INC.

MICHAEL J. WILLIAMS
Provider Relations Specialist
1-727-437-1832
Dental Provider Services: 1-855-609-5157
Michael.Williams@EnvolveHealth.com

Back of Map

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

Questions?

Thank you for being our partner in care.