Welcome to Managed Health Services (MHS)

0221.PR.P.PP.2

Agenda

- MHS Overview
- Health Programs
- Claim Process
- Vaccines for Children
- Notification of Pregnancy
- Prior Authorization Process
- Provider Analytics
- Culturally and Linguistic Appropriate Services (CLAS)
- Coordinated Care Programs
- MHS Partnership
- Ambetter
- Allwell
- MHS Website
- COVID-19 updates
- 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.

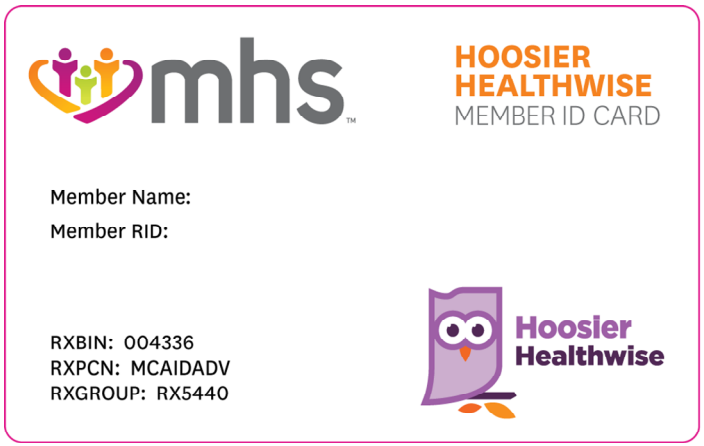
- **MHS is your partner in care.**

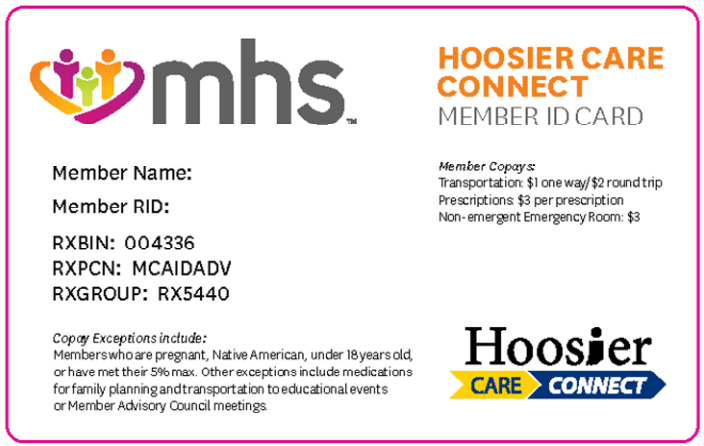
MHS Products

Medicaid

MHS Medicaid ID Cards

*Used for both HIP and HIP Maternity





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

Healthy Indiana Plan

Who is Eligible for the Healthy Indiana Plan (HIP)?

The Healthy Indiana Plan (HIP) is an affordable health insurance program from the State of Indiana for uninsured adult Hoosiers.

- Members will select a managed care entity (MCE) responsible for coordinating care in partnership with their medical provider(s).
- Care coordination services will be individualized based on a member's assessed level of need determined through a health screening.
- HIP provides coverage for qualified low-income Hoosiers ages 19 to 64, who are not receiving Medicare and are interested in participating in a low-cost, consumer-driven health care program. HIP uses a proven, consumer-driven approach that was pioneered in Indiana.

POWER Up to HIP Plus

Encourage HIP members to join HIP Plus

- Enhanced benefit package
  - No copays! Only pay a monthly contribution
  - Dental coverage
  - Vision coverage
  - Additional therapy services
  - Rx mail order option
  - Chiropractic care
- When can members POWER Up?
  - Open enrollment
  - Redetermination/Potential Plus Loop
- Contact MHS Customer Service to POWER Up to HIP Plus
  - 1-877-647-4848

HIP Basic Plan – Copay

When members with income less than or equal to 100% FPL do not pay their HIP Plus monthly contribution, they are moved to HIP Basic. HIP Basic Members are responsible for the copayments below for health and pharmacy services.

**Copayments may not be more than the cost of services received.*

Service	HIP Basic Co-Pay Amounts <=100% FPL
Outpatient Services	$4
Inpatient Services	$75
Preferred Drugs	$4
Non-preferred drugs	$8
Non-emergency ER visit	$8

Hoosier Care Connect

(Aged, Blind & Disabled)

Who is Eligible for Hoosier Care Connect?

Hoosier Care Connect is a coordinated care program for Indiana Health Coverage Programs (IHCP) members age 65 and over, or with blindness or a disability who are residing in the community and are not eligible for Medicare.

- Members will select a managed care entity (MCE) responsible for coordinating care in partnership with their medical provider(s).
- Hoosier Care Connect members will receive all Medicaid-covered benefits in addition to care coordination services.
- Care coordination services will be individualized based on a member's assessed level of need determined through a health screening.

Hoosier Healthwise

(CHIP)

Who is Eligible for Hoosier Healthwise?

Hoosier Healthwise covers the following members:

- Children up to age 19.
- The Children's Health Insurance Plan (CHIP)
  - This option is available for individuals up to age 19 who may earn too much money to qualify for the standard Hoosier Healthwise coverage.

Claim Process

Claim Process

- **EDI Submission**
  - Preferred method of claims submission.
  - Faster and less expensive than paper submission.
  - MHS Electronic Payor ID: 68069
- **Online through the MHS Secure Provider Portal:** mhsindiana.com
  - Provides immediate confirmation of received claims and acceptance.
  - Institutional and Professional
  - Batch Claims
  - Claim Adjustments/Corrections
- **Paper Claims**
  - Managed Health Services
    PO Box 3002
    Farmington, MO 63640-3802

Claim Process

- Claims must be received within **90 calendar days** of the date of service.
- *Exceptions*
  - Newborns (30 days of life or less) – Claims must be received within 365 days from the date of service. Claim must be filed with the newborns RID #.
  - Claims with primary insurance must be received within 365 days of the date of service with a copy of the primary EOB. If primary EOB is received after the 365 days, providers have *60 days* from date of primary EOB to file claim to MHS.
  - Retro eligibility - Provider must submit claims within 90 days of retro eligibility assignment being established through IHCP.

Claim Process

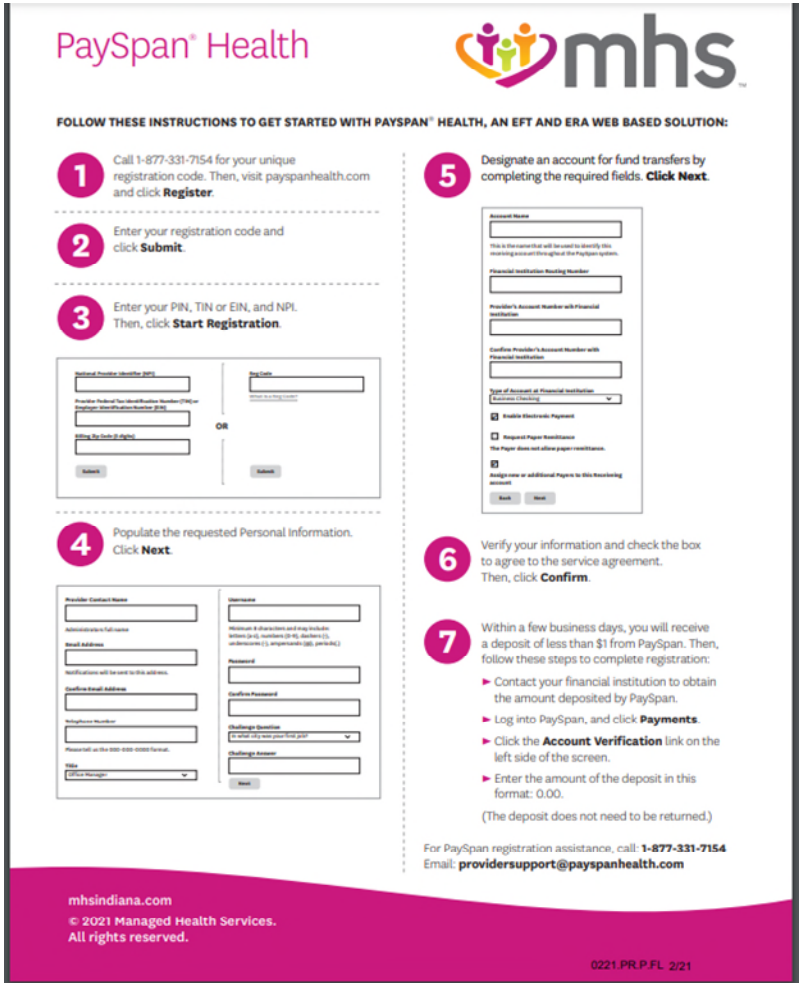
Resubmissions

- Paper copy or web submission.
- **Electronic adjustments through the Secure Provider Portal.**
- Hard copy resubmissions:
  - Adjustment option on the MHS website.
  - Must attach EOP, documentation, and explanation of the resubmission reason.
  - May use the Provider Claims Adjustment Request Form.
- Providers have **60 calendar days** from the date of EOP to file a resubmission. *Please note, claims will not be reconsidered after this timeline.*

EFTs and ERAs

PaySpan Health

- Web based solution for:
  - Electronic Funds
  - Transfers (EFTs) and Electronic Remittance Advices (ERAs)
- One year retrieval of remittance advice.
- Provided at no cost to providers and allows online enrollment.
- Register at payspanhealth.com
- For questions call 1-877-331-7154 or email providersupport@payspanhealth.com



PaySpan® Health

mhs

FOLLOW THESE INSTRUCTIONS TO GET STARTED WITH PAYSPAN® HEALTH, AN EFT AND ERA WEB BASED SOLUTION:

1. Call 1-877-331-7154 for your unique registration code. Then, visit payspanhealth.com and click **Register**.
2. Enter your registration code and click **Submit**.
3. Enter your PIN, TIN or EIN, and NPI. Then, click **Start Registration**.
4. Populate the requested Personal Information. Click **Next**.
5. Designate an account for fund transfers by completing the required fields. **Click Next**.
6. Verify your information and check the box to agree to the service agreement. Then, click **Confirm**.
7. Within a few business days, you will receive a deposit of less than $1 from PaySpan. Then, follow these steps to complete registration:
   - Contact your financial institution to obtain the amount deposited by PaySpan.
   - Log into PaySpan, and click **Payments**.
   - Click the **Account Verification** link on the left side of the screen.
   - Enter the amount of the deposit in this format: 0.00.

   (The deposit does not need to be returned.)

For PaySpan registration assistance, call: **1-877-331-7154**
Email: **providersupport@payspanhealth.com**

mhsindiana.com

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Provider Claims Issue Resolution

PROCESS

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

Informal Claims Dispute or Objection Form

Level 1:

- Must be submitted within 60 calendar days of receipt of the MHS Explanation of Payment (EOP) either utilizing our online dispute tool via the MHS Secure Provider Portal or in writing by using the MHS Claim Dispute/Appeal Form, available at mhsindiana.com/providers/resources/forms.

- The form has now been updated and can be used for either Medical or Behavioral Health claims. The address for submission is listed on the form for both Medical and BH.

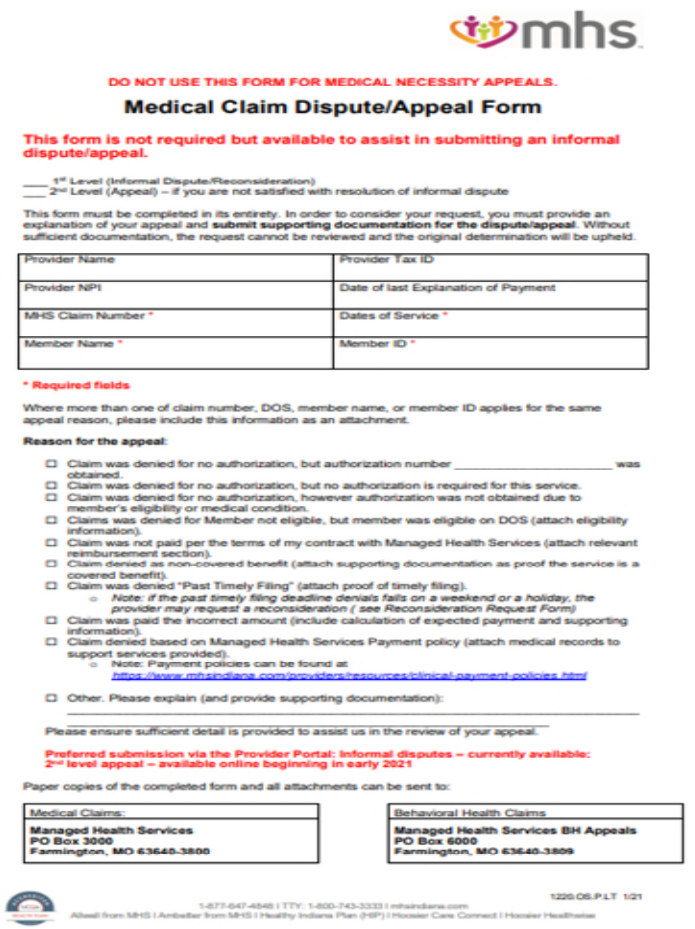
- Requests received after day 60 will not be considered.

Claim Dispute/Appeal Form – Medical and Behavioral Health

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

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

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



DO NOT USE THIS FORM FOR MEDICAL NECESSITY APPEALS.

Medical Claim Dispute/Appeal Form

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

___ 1st Level (Informal Dispute/Reconsideration)
___ 2nd Level (Appeal) – if you are not satisfied with resolution of informal dispute

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

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

* Required fields

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

Reason for the appeal:

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

_____

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

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

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

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

1-877-647-4648 | TTY: 1-800-743-3333 | mhsindiana.com
Allwell from MHS | Ambetter from MHS | Healthy Indiana Plan (HIP) | Hoosier Care Connect | Hoosier Healthwise

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Informal Claims Dispute or Objection Form

Level 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 made 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

- MHS will make all reasonable efforts to review your documentation and respond to you within 30 calendar days.

- Upon receipt of our response, you will have 60 calendar days from date of Dispute response to initiate a formal claim appeal (Level 2).

Provider Services Phone Requests & Web Portal Inquiries

- Contacting Provider Services via phone or Web Portal 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:** mhsindiana.com/providers/login
  - Use the Messaging Tool

Provider Relations Regional Mailboxes

- Provider Relations Regional Mailboxes are not considered a formal notification of provider dispute.
- If Level 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:

- 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

Formal Claim Dispute - Administrative Claim Appeal

Level 2

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

- An administrative claim appeal must be submitted either in writing using the claim dispute and appeal form with an explanation including any specific details which may justify reconsideration of the disputed claim or by utilizing our online 2nd Level appeal process on the secure provider portal.

- 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.

Arbitration

Level 3:

- Level 3 is a continuation of Level 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 (Level 2), the provider may request arbitration. Claims with similar issues from the same provider may be grouped together for the purpose of requesting arbitration.
- To initiate arbitration, the provider should submit a written request to MHS on company letterhead. The request must be postmarked no later than 60 calendar days after the date the provider received MHS' decision on the administrative claim appeal.
- Arbitration Requests need to be mailed to, MHS Arbitration, 550 N. Meridian Street, Suite 101, Indianapolis, IN 46204, unless otherwise directed in the letter.
- See the MHS Provider Manual Chapter 5 Claims Administrative Reviews and Appeals for more information.

VFC and Notification of Pregnancy Updates

Vaccines for Children (VFC)

- All members under the age of 19 are eligible for vaccines distributed via the Vaccine for Children (VFC) program.
- Since VFC vaccine is at no cost to the provider, reimbursement is allowed for the vaccine administration.
- The IHCP rate for administration is $15 and is reimbursable at the lesser of billed charges or the IHCP fee.

Vaccines for Children (VFC)

- Providers must bill in the following manner
  - Appropriate diagnosis code of Z00.121 or Z00.129.
  - Procedure code with specific vaccine administered, preferably with a billed amount of $0.00.
  - Regardless of amount billed, the service line will be reimbursed at $0.
  - Appropriate vaccine administration CPT® code 90471 - 90474 with the SL modifier.
  - Claims billed for VFC vaccine administration codes without the SL modifier will be denied **EXs9.**

Vaccines for Children (VFC)

- Providers will no longer be reimbursed for vaccines available through the VFC but provided out of private stock.
- Provider may bill for vaccines that are not available through the VFC program.

Notification of Pregnancy (NOP)

- NOP was developed to help identify pregnancy earlier with the goal of increasing positive birth outcomes.
- The program requests the IHCP's NOP form be completed and submitted through the IHCP Provider Healthcare Portal for each pregnancy.
- Providers completing the online NOP form in a timely manner will receive an incentive of $60 per notification.
- The process consists of 4 questions to be completed online with first OB visit once member is effective with Medicaid.
- Reimbursement is obtained by billing CPTR 99354 TH on claim form.
- The form must be valid - meaning it is a non-duplicative form, the pregnancy is less than 30 weeks gestation, and a valid RID number is included.

Prior Authorization Process

Prior Authorization

- Prior Authorization is an approval from MHS to provide services designated as needing approval prior to treatment and/or payment.

Prior Authorizations are not a guarantee of payment.

Utilization Management

- Prior Authorization (PA) can be initiated through the MHS referral line at 1-877-647-4848.
  - The PA process begins at MHS by speaking with the MHS non-clinical referral staff.
- Prior Authorizations can be completed via fax.
- Prior Authorizations can also be submitted online via the Secure Provider Portal at mhsindiana.com/login.
- When using the portal, supporting documentation can be uploaded directly.
  - Authorization status can also be checked on the portal.

FOR PROVIDERS

- Login
- Enrollment and Updates
- Prior Authorization
  - Medicaid Pre-Auth
  - Ambetter Pre-Auth
  - Medicare Pre-Auth
- Dental Providers
- Pharmacy
- Opioid Resources
- Behavioral Health
- Provider Resources
- QI Program
- Provider News
- Email Sign Up

Medicaid Pre-Auth

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.
Dental services need to be verified by Envolve Dental.
Ambulance and Transportation services need to be verified by LCP Transportation.
Musculoskeletal services need to be verified by TurningPoint.

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?	○	○
Are services, other than DME, orthotics, prosthetics, and supplies, being rendered in the home?	○	○
Are anesthesia services being rendered for pain management?	○	○
Are services for infertility?	○	○

Types of Services	YES	NO
Is the member being admitted to an inpatient facility?	○	◉
Are services, other than DME, orthotics, prosthetics, and supplies, being rendered in the home?	○	◉
Are anesthesia services being rendered for pain management?	○	◉
Are services for infertility?	○	◉
Is the member receiving dialysis?	○	◉

Enter the code of the service you would like to check:

99394 Check

N
No

99394 - PREV VISIT EST AGE 12-17
No Pre-authorization required for all providers.

To submit a prior authorization Login Here.

Cardiac Services

Turning Point Healthcare Solutions manages prior authorizations for the Cardiac Services below:

- 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

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 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.**

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

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

Inpatient Prior Authorization

- MHS no longer accepts phone calls and only accepts notification of an inpatient admission via fax at 1-866-912-4245, using the IHCP universal prior authorization form, or via the MHS Secure Provider Portal. mhsindiana.com/login

Utilization Management

- All elective inpatient/outpatient services must be prior authorized with MHS at least 2 business days prior to the date of service.
- All urgent and emergent services must be faxed in or submitted via the MHS Secure Provider Portal to MHS within 2 business days after the admit.
- Previously approved prior authorizations can be updated for changes in dates of service or CPT/HCPCS codes within 30 days of the original date of service.

Failure to obtain prior authorization for services may result in claim denials!

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 rolling 12-month period.

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

Behavioral Health

Limitations on Outpatient Mental Health Services (Cont.):

- Effective 12/15/18, Managed Health Services (MHS) has begun applying this limitation for claims with dates of service (DOS) on or after 12/15/18. 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 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 (starting with DOS 12/15/18) to determine if a prior authorization request is needed.
- “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/Medical Necessity Appeals on the Provider Secure Portal

- **Effective April 1, 2021**, Medicaid prior authorization/medical necessity denial appeals can be submitted to Managed Health Services (MHS) and will allow tracking of the appeal from submission through decision on the Secure Provider Portal.

Utilization Management

MEDICAL NECESSITY GRIEVANCE AND APPEALS

Managed Health Services
Attn: Appeals Coordinator
PO BOX 441567 Indianapolis, IN 46240

- 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.

Behavioral Health Utilization Management

- Behavioral Health 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

Coordinated Care Programs

Case Management Programs

- MHS Case Management is made up of nurses and social workers.
- **Case Managers will:**
  - Help members, doctors, and other providers, including behavioral health providers.
  - Help members obtain services covered by their Medicaid benefit package.
  - Help explain and inform members about their condition.
  - Work with provider's healthcare plan for the member.
  - Inform members about community resources.

Right Choices Program

- Members identified as high utilizers in need of specialized intervention are enrolled into the Right Choices Program (RCP).
- The member is “locked-in” to their primary physician and delivery of care for specialty services is coordinated through that provider’s office.
- RCP participants are assigned to:
  - One primary medical provider (PMP)
  - One pharmacy

First Year of Life

- This Care Management program is designed to encourage education and compliance with immunizations and well visits for babies.
- The First Year of Life program matches a member with a Nurse Care Manager who is there to answer questions and provide helpful information sheets to let the member know what to expect as the baby grows.
- The Nurse Care Manager will also call the member and send reminders to schedule upcoming immunizations and well-child visits with the baby's doctor as needed.

**By participating in the program, members will be eligible to earn more My Health Pays rewards.*

Smoking Cessation

- All counseling can be billed to MHS using CPT code 99407- U6.
- Counseling must be at least 10 minutes.
- **$50 “pay above” incentive for initial counseling visit for Hoosier Care Connect Members.**
- The Indiana Tobacco Quitline
  - 1-800-QUIT-NOW (1-800-784-8669)
  - Free phone-based counseling service that helps Indiana smokers quit.
  - One on one coaching for tobacco users trying to quit.
  - Resources available for both providers and patients.

MHS Partnership

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 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 do have ten (10) business days from the date of transport to obtain prior authorization.

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).

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.

MHS 24/7 Nurse Advice Line

- The MHS Nurse Advice Line is available 24 hours a day, seven days a week to answer members' health questions.
- The Nurse Advice line staff is bilingual in English and Spanish. Additional languages are available.

Earn Rewards w/ Preventive Care

MHS My Health Pays® Healthy Rewards Program

- MHS will reward members' healthy choices through our My Health Pays® Rewards program. Members can earn dollar rewards by staying up to date on preventive care.
- These rewards will be added to a My Health Pays® Prepaid Visa® Card.
- Use your My Health Pays® rewards to help pay for everyday items at Walmart*, utilities, transportation, telecommunications (cell phone bill), childcare services, education and rent.

**This card may not be used to buy alcohol, tobacco or firearms products. This card is issued by The Bancorp Bank pursuant to a license from Visa U.S.A. Inc. The Bancorp Bank; Member FDIC. Card cannot be used everywhere Visa debit cards are accepted. See Cardholder Agreement for complete usage restrictions. Funds expire 90 days after termination of insurance coverage or 365 days after date reward was earned, whichever comes first.*

Ambetter from MHS

(Health Insurance Marketplace)

The Affordable Care Act

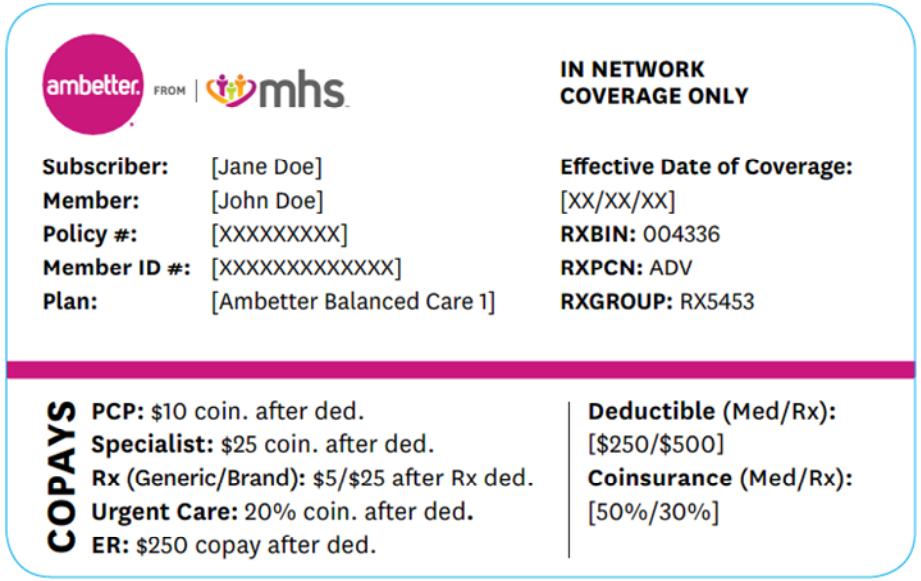
- **Key Objectives of the Affordable Care Act (ACA):**
  - Increase access to quality health insurance.
  - Improve affordability.
- **Additional Parameters:**
  - Dependent coverage to age 26.
  - Pre-existing condition insurance plan (high risk pools).
  - No lifetime maximum benefits.
  - Preventative care covered at 100%.
  - Insurer minimum loss ratio (80% for individual coverage).

Ambetter from MHS is an HMO Benefit Plan

- Members enrolled in Ambetter must utilize in-network participating providers except in the case of emergency services.
- Participating providers can be identified by visiting our website and clicking on Find a Provider.
- If an out of network provider is utilized, (except in the case of emergency services), the member will be 100% responsible for all charges.
- Statewide Coverage as of 2020.

ID Cards

Member ID Card:


ambetter. FROM | mhs

IN NETWORK COVERAGE ONLY

Subscriber: [Jane Doe]
Member: [John Doe]
Policy #: [XXXXXXXXX]
Member ID #: [XXXXXXXXXXXXX]
Plan: [Ambetter Balanced Care 1]

Effective Date of Coverage: [XX/XX/XX]
RXBIN: 004336
RXPCN: ADV
RXGROUP: RX5453

COPAYS
PCP: $10 coin. after ded.
Specialist: $25 coin. after ded.
Rx (Generic/Brand): $5/$25 after Rx ded.
Urgent Care: 20% coin. after ded.
ER: $250 copay after ded.

Deductible (Med/Rx): [$250/$500]
Coinsurance (Med/Rx): [50%/30%]


Ambetter.mhsindiana.com

Member/Provider Services:
1-877-687-1182
TTY/TDD: 1-800-743-3333
24/7 Nurse Line: 1-877-687-1182

Numbers below for providers:
Pharmacy Help Desk: 1-866-270-3922
EDI Payor ID: 68069
EDI Help Desk: Ambetter.mhsindiana.com

Medical Claims:
Managed Health Services
Attn: CLAIMS
PO Box 5010
Farmington, MO
63640-5010

Additional information can be found in your Evidence of Coverage. If you have an Emergency, call 911 or go to the nearest Emergency Room (ER). Emergency services given by a provider not in the plan's network will be covered without prior authorization. Receiving non-emergent care through the ER or with a non-participating provider may result in a change to member responsibility. For updated coverage information, visit Ambetter.mhsindiana.com.

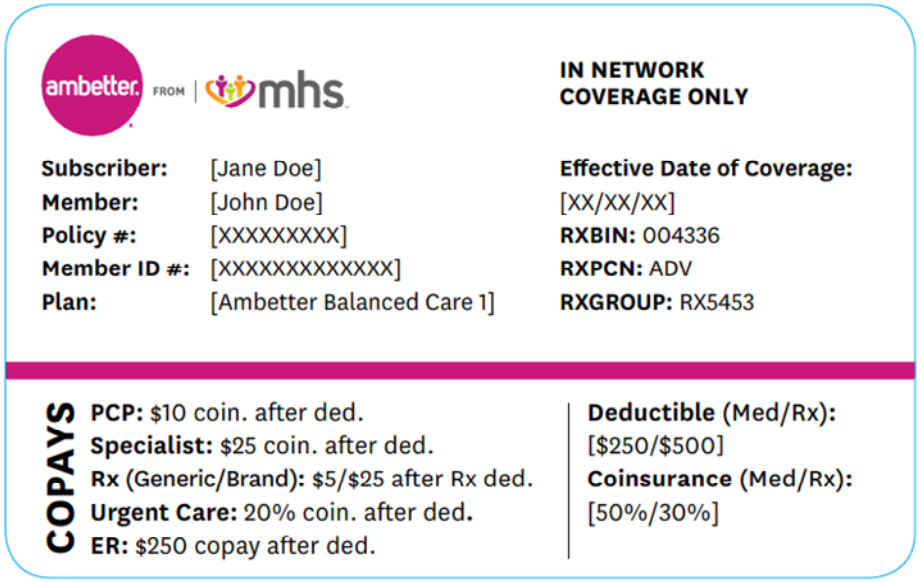
AM817-IN-C-00036

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

Verification of Eligibility, Benefits and Cost Share

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:



ambetter. FROM mhs

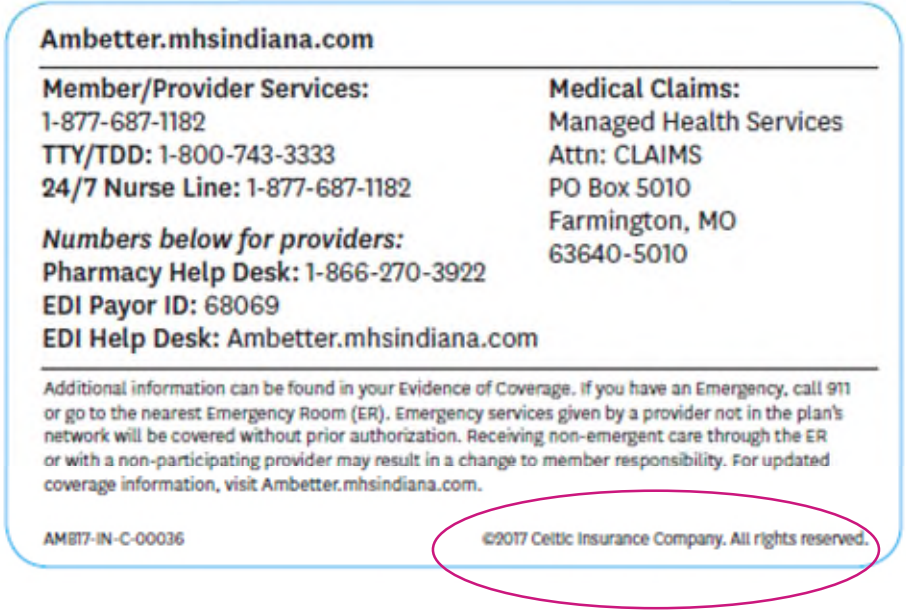
IN NETWORK COVERAGE ONLY

Subscriber: [Jane Doe]
Member: [John Doe]
Policy #: [XXXXXXXXX]
Member ID #: [XXXXXXXXXXXXX]
Plan: [Ambetter Balanced Care 1]

Effective Date of Coverage: [XX/XX/XX]
RXBIN: 004336
RXPCN: ADV
RXGROUP: RX5453

COPAYS
PCP: $10 coin. after ded.
Specialist: $25 coin. after ded.
Rx (Generic/Brand): $5/$25 after Rx ded.
Urgent Care: 20% coin. after ded.
ER: $250 copay after ded.

Deductible (Med/Rx): [$250/$500]
Coinsurance (Med/Rx): [50%/30%]



Ambetter.mhsindiana.com

Member/Provider Services:
1-877-687-1182
TTY/TDD: 1-800-743-3333
24/7 Nurse Line: 1-877-687-1182

Numbers below for providers:
Pharmacy Help Desk: 1-866-270-3922
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Medical Claims:
Managed Health Services
Attn: CLAIMS
PO Box 5010
Farmington, MO
63640-5010

Additional information can be found in your Evidence of Coverage. If you have an Emergency, call 911 or go to the nearest Emergency Room (ER). Emergency services given by a provider not in the plan's network will be covered without prior authorization. Receiving non-emergent care through the ER or with a non-participating provider may result in a change to member responsibility. For updated coverage information, visit Ambetter.mhsindiana.com.

AM817-IN-C-00036

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

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 services if the member is not assigned and may wish to have member assigned to them for future care.

My Health Pays® Program

Members can earn up to **$125** that will be loaded onto their My Health Pays Visa® and can be used for eligible expenses.

Here's how it works:

- Complete the Wellbeing Survey **($50)**
- Get an annual wellness exam **($50)**
- Get an annual flu shot in the fall **($25)**
- Card must be activated online and benefits are effectuated with the plan effective date.
- Cards are mailed to the member automatically when the first reward is earned.

Utilization Management

Prior 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**

Prior Authorization

Procedures / Services

- Potentially Cosmetic
- Experimental or Investigational
- High Tech Imaging (i.e., CT, MRI, PET)
- Infertility
- Obstetrical Ultrasound
    - One allowed in 9 month period, any additional will require prior authorization except those rendered by perinatologists.
    - For urgent/emergent ultrasounds, treat using best clinical judgment and this will be reviewed retrospectively.
- Pain Management

National Imaging Associates (NIA)

- Reminder: NIA began facilitating Ambetter authorizations for MHS 1/1/21
- Outpatient physical, occupations and speech therapy
- www.RadMD.com

Prior Authorization

Service Type	Timeframe
Scheduled admissions	Prior Authorization required five business days prior to the scheduled admission date
Elective outpatient services	Prior Authorization required five business days prior to the elective outpatient admission date
Emergent inpatient admissions	Notification within one business day
Observation – 23 hours or less	Notification within one business day for non-participating providers
Observation – greater than 23 hours	Requires inpatient prior authorization within one business day
Emergency room and post stabilization, urgent care and crisis intervention	Notification within one business day
Maternity admissions	Notification within one business day
Newborn admissions	Notification within one business day
Neonatal Intensive Care Unit (NICU) admissions	Notification within one business day
Outpatient Dialysis	Notification within one business day

**** This is not meant to be an all-inclusive list.***

Utilization Determination Timeframes

Type	Timeframe
Prospective/Urgent	One (1) Business day
Prospective/Non-Urgent	Two (2) Business days
Emergency services	60 minutes
Concurrent/Urgent	Twenty-four (24) hours (1 calendar day)
Retrospective	Thirty (30) calendar days

**** This is not meant to be an all-inclusive list***

Claims

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 our website at ambetter.mhsindiana.com.
3. **Paper claims may be submitted to PO Box 5010 Farmington, MO 64640-5010.**

Claim Submission

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.

Claim Disputes

- Must be submitted within 180 days of the Explanation of Payment.
- A Claim Dispute form can be found on our website at ambetter.mhsindiana.com.
- The completed Claim Dispute form may be mailed to PO Box 5000, Farmington, MO 63640-5000.

Claim Submission

Member in Suspended Status

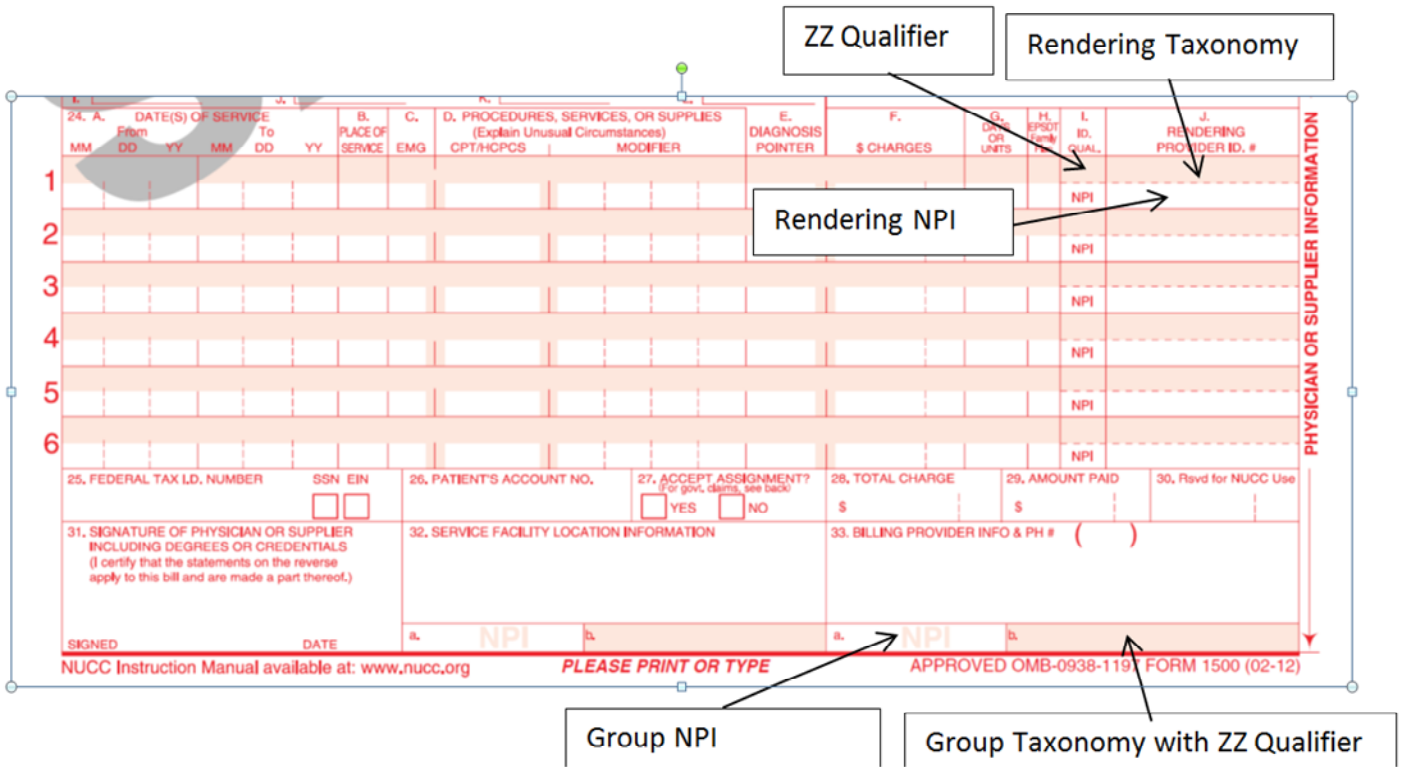
- A provision of the ACA allows members who are receiving Advanced Premium Tax Credits (APTCs) a 3 month grace period for paying claims.
- After the first 30 days, the member is placed in a suspended status. The Explanation of Payment will indicate LZ Pend: Non-Payment of Premium.
- While the member 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.

Claim Submission

- **Rendering Taxonomy Code**
  - Claims must be submitted with the rendering provider's taxonomy code.
  - The claim will deny if the taxonomy code is not present.
  - This is necessary in order to accurately adjudicate the claim.
- **CLIA Number**
  - If the claim contains CLIA certified or CLIA waived services, the CLIA number must be entered in Box 23 of a paper claim form or in the appropriate loop for EDI claims.
  - Claims will be rejected if the CLIA number is not on the claim.

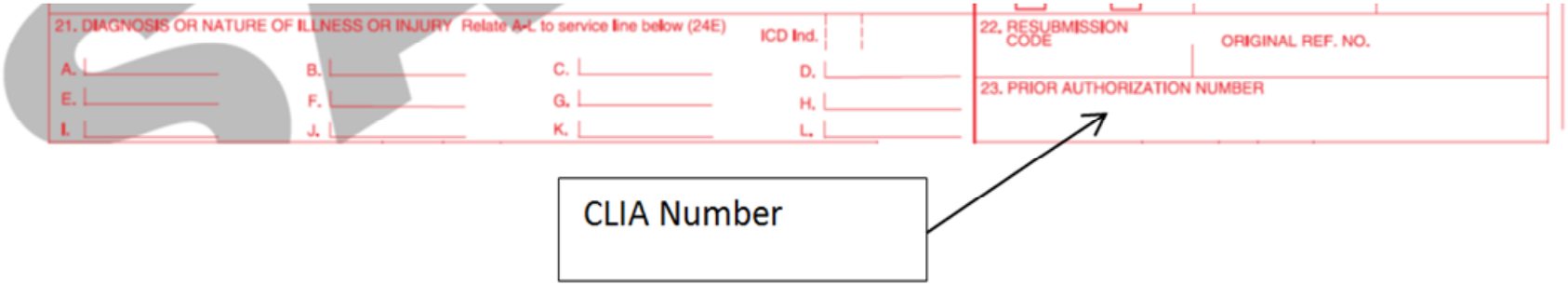
Taxonomy Code

Example of Taxonomy Code – CMS 1500



CLIA Number

- CLIA Number is required on CMS 1500 Submissions in Box 23.
- CLIA Number is not required on UB04 Submissions.



Claim Submission

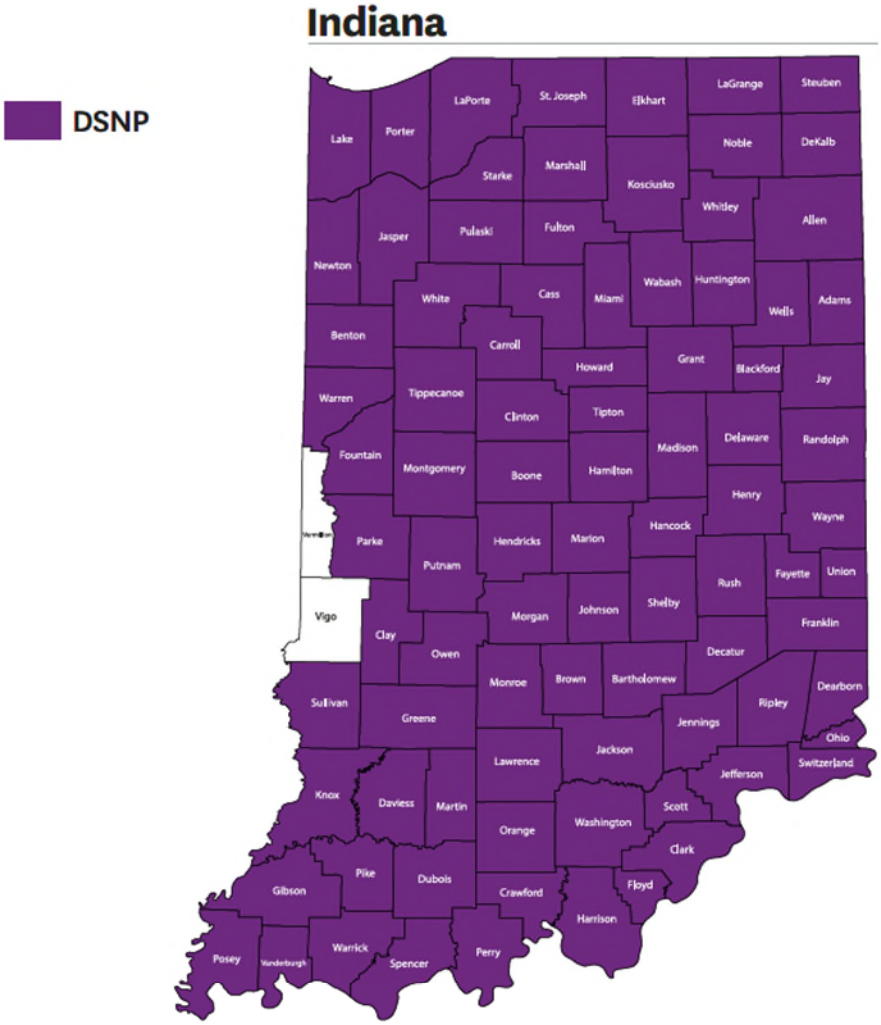
Billing the Member

- 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 from MHS

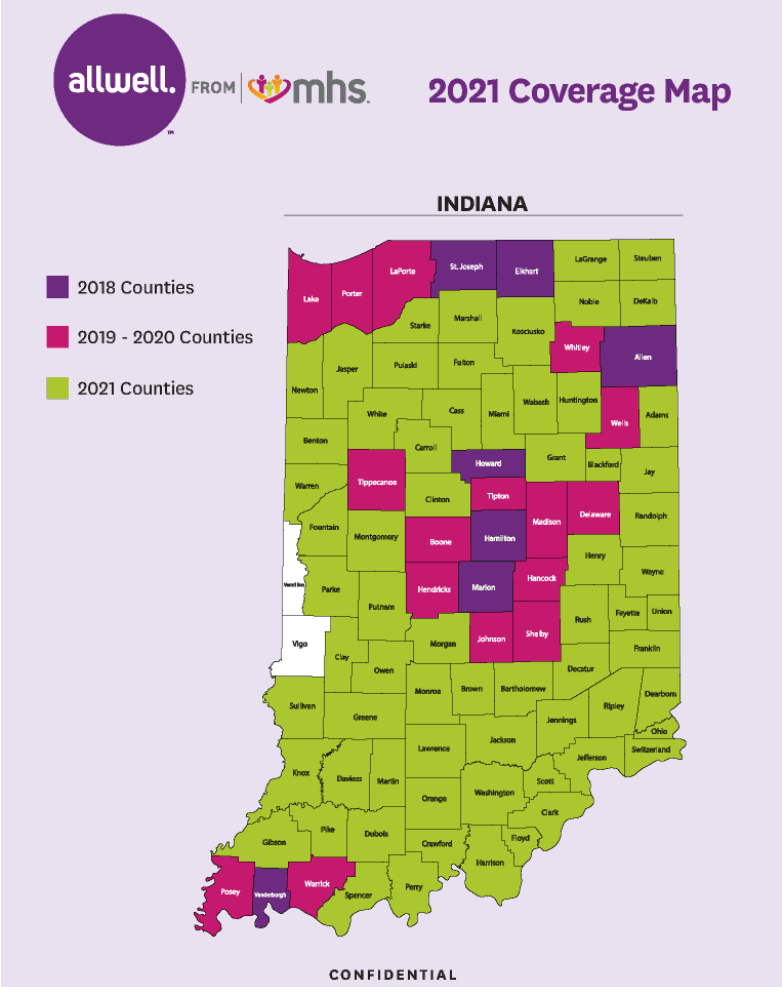
(Medicare Advantage)

2021 County Coverage - DSNP



Allwell from MHS (Medicare Advantage)

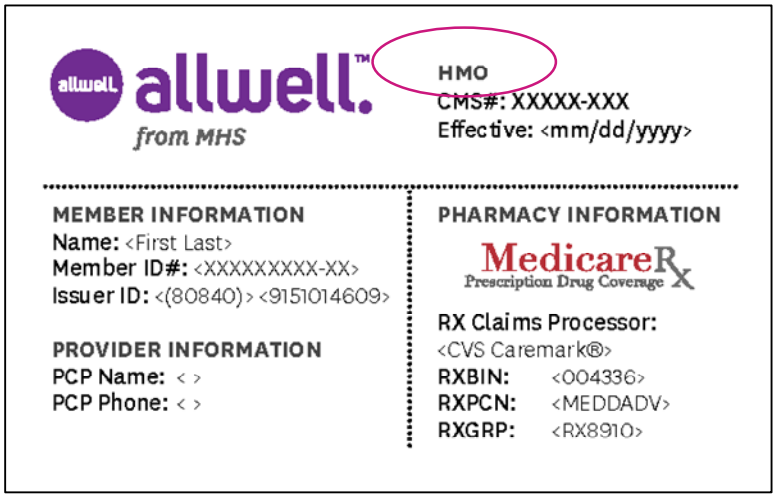
- Coverage in 2021

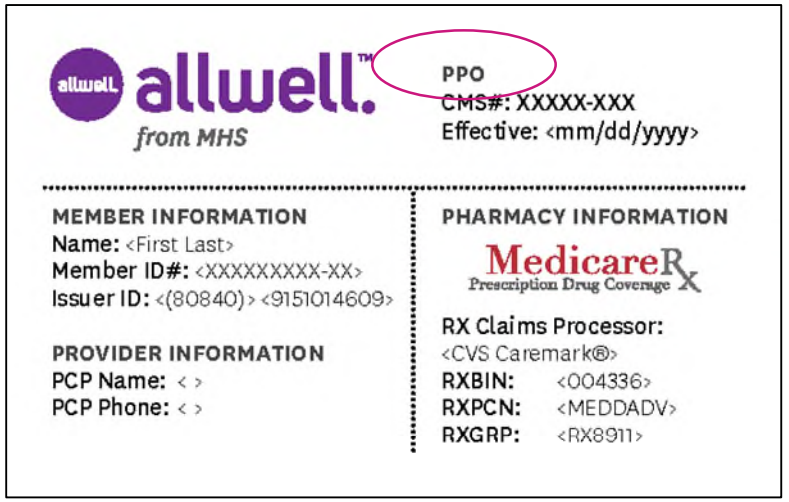


Overview: Medicare Advantage Plans

- **Allwell from MHS** provides complete continuity of care to members including:
  - Integrated coordination care
  - Care management
  - Co-location of behavioral health expertise
  - Integration of pharmaceutical services with the PBM
  - Additional services specific to the beneficiary needs
- Approach to care management facilitates the integration of:
  - Community resources
  - Health education
  - Disease management
- Promotes access to care as beneficiaries are served through a single, locally-based multidisciplinary team including:
  - RNs
  - Social Workers
  - Pharmacy Technicians
  - Behavioral Health Case Managers

Member ID Cards





Prior Authorization

Utilization Management

- 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

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.

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.

Medical Necessity Determination

- When medical necessity cannot be established, a peer to peer conversation is offered.
- Denial letters will be sent to the member and provider.
- The clinical basis for the denial will be indicated.
- Medical Necessity Appeals must be initiated within 30 days of the denial to be considered. Please note, this is different than a claim appeal request.
- Member appeal rights will be fully explained.

Billing Overview

Electronic Claims Transmission

- Six clearinghouses for Electronic Data Interchange (EDI) submission.
- Faster processing turn around time than paper submission.
  - Emdeon – Payer ID 68069
  - Gateway
  - Availity/THIN
  - SSI
  - Medavant
  - Smart Data Solution

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.

Claims Reconsideration & Disputes

- A claim dispute is to be used only when a provider has received an unsatisfactory response to a request for reconsideration.
- Submit reconsiderations or disputes to:

  Allwell from MHS
  Attn: Reconsiderations
  P. O. Box 4000
  Farmington, MO 63640-4000

MHS Website

MHS Website

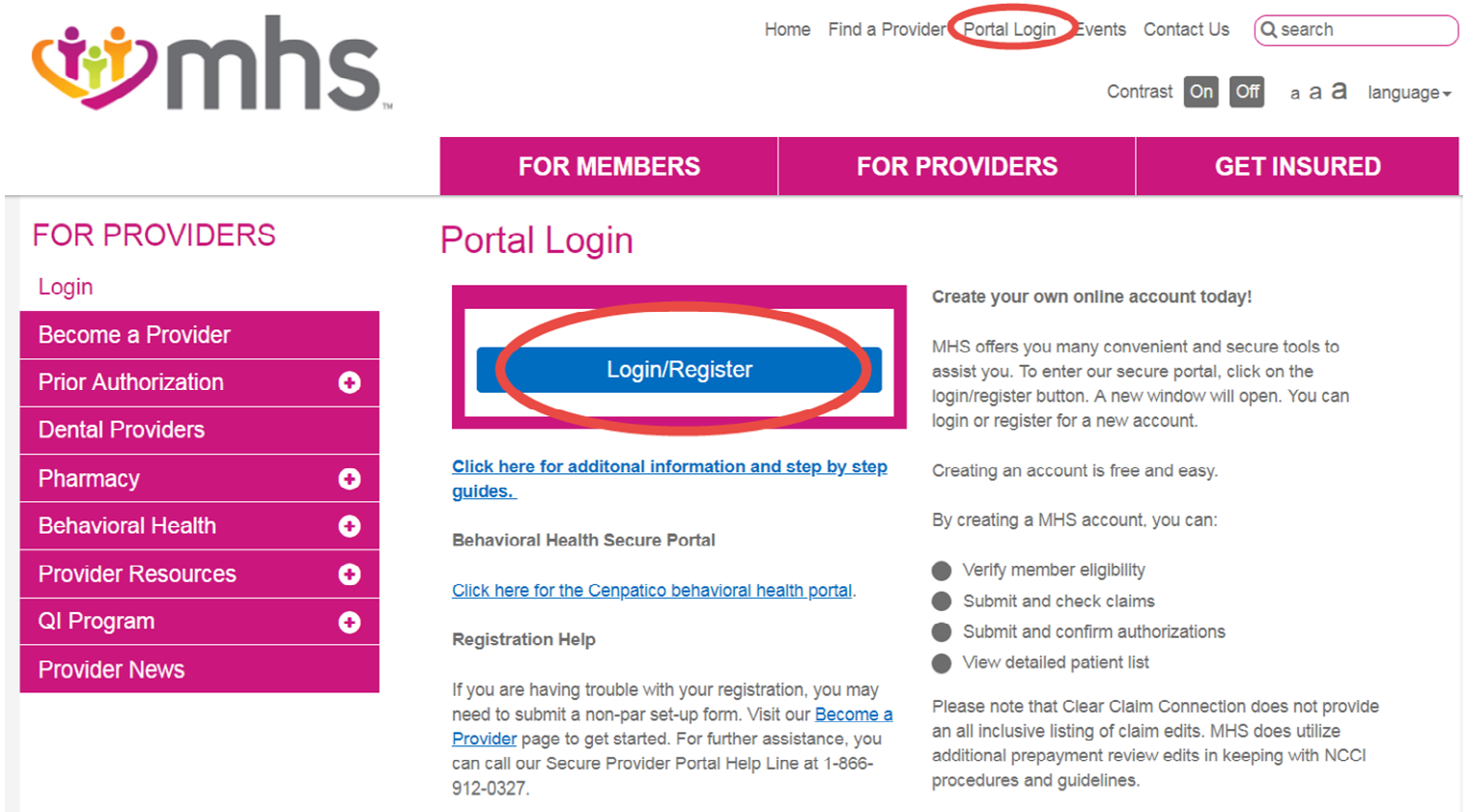
- mhsindiana.com
- Provides access to Medicaid, Ambetter and Allwell
- Provider directory search functionality
- Pre-Auth Needed tool
- Payspan / EFT information
  - Convenient payments
  - One year retrieval of remittance information
  - No cost to providers
- Printable current forms, guides and manuals
  - Update billing information form
  - Denial and Rejection code listings
  - QRG-Quick Reference Guide
- Patient education material
  - KRAMES online services – MHS members have 24 hour a day access to info sheets about more than 4,000 topics relating to health and medication via MHS website. Most information is available in multiple languages including both English and Spanish: mhsindiana.kramesonline.com
- Contact Us feature

MHS Secure Provider Portal Features

- Access for Medicaid, Ambetter and Allwell
- Online registration – multiple users
- Manage multiple practices and line of business under one account
- Check member eligibility
- View panels and membership information
- View members RX and medical history
- Access Gaps in Care
- Access Quality Reports including Pay For Performance
- Direct claim submission
- Enhanced claim detail
- COB processing with or without attachments
- Claim adjustment
- Claim auditing tool
- Eligibility and COB verification
- Prior authorization
- Online Health Record Vault for “your” patients (includes specialty care)
- Care Management Plan

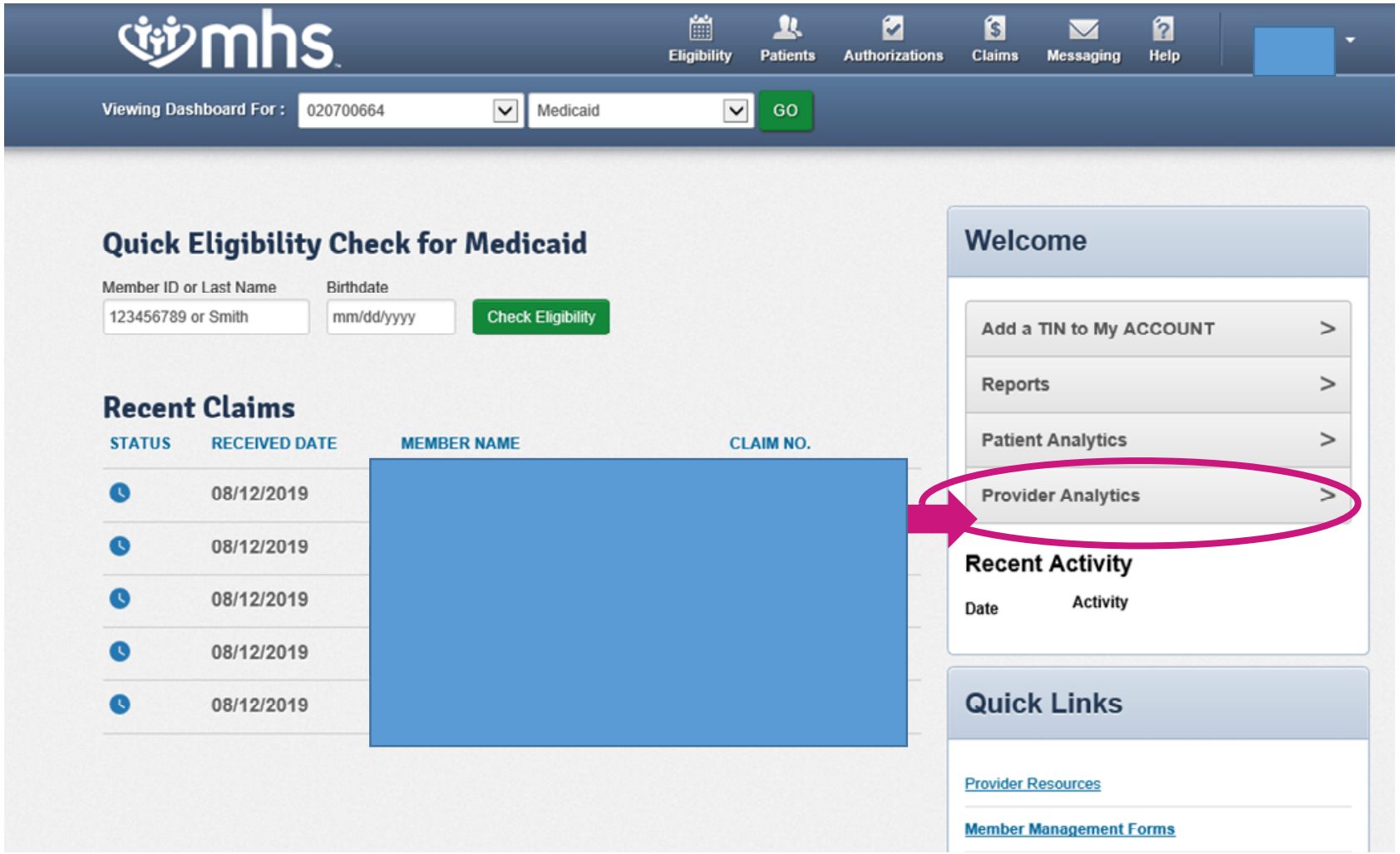
Secure Web Portal Login or Registration

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

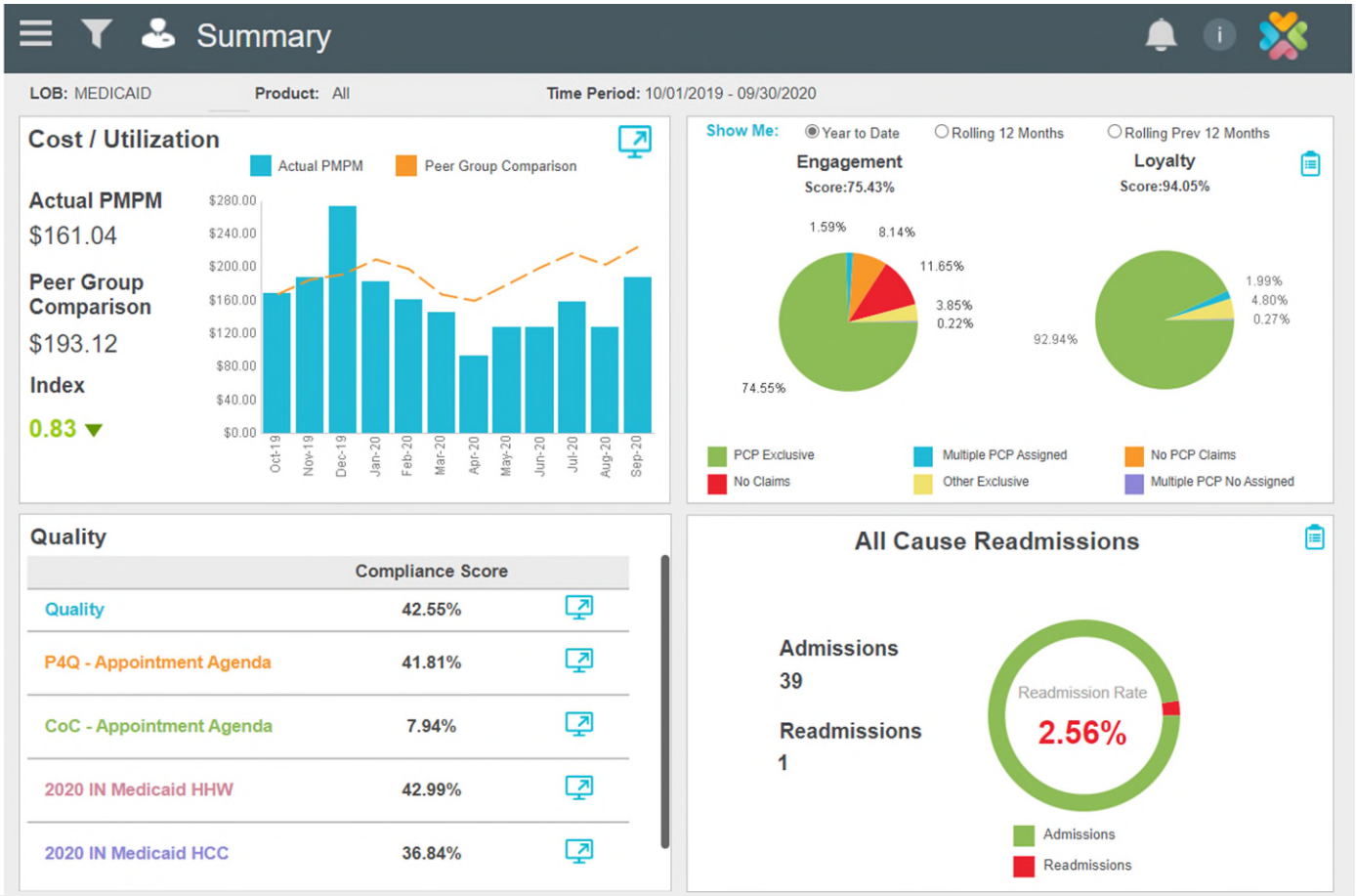


Provider Analytics

MHS Secure Portal



Provider Analytics Landing Page



P4P Overview

- Bonus Pay for Performance (P4P) fund written into PMP contracts and dependent on product line.
- Measures aligned with HEDIS and NCQA.
- Annual payout.

Continuity of Care (CoC) Program

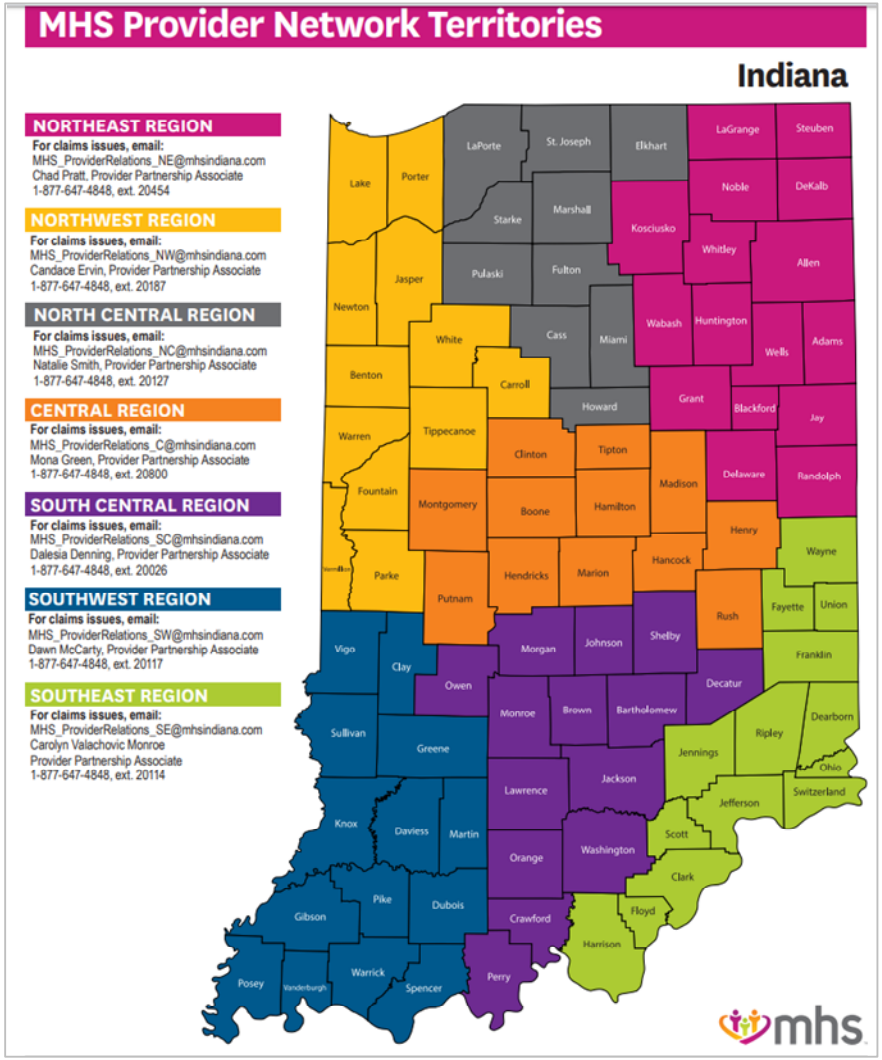
What is the Continuity of Care (CoC) Program?

CoC is a Risk Adjustment bonus program for you, our Provider Partner, aimed at increasing visibility into members' existing, as well as suspected conditions, which leads to enhanced quality of care for chronic condition management and prevention.

CoC Program Overview

- Continuity of Care (CoC) - Risk Adjustment bonus program for our Providers.
- Bonuses paid for completed and verified appointment agendas and/or submission of a Comprehensive Physical Exam (CPE) medical record.
- Providers receive bonus payments based on annual assessments of patient's chronic conditions.
- The intent of the CoC Program is to promote proactive management of chronic conditions and preventative services.
- Appointment Agendas - provide historical diagnosis data for providers to ensure annual assessment of chronic conditions.
- Claims based program – patient's annual assessment performed by PCP and claim is submitted.
- Improved health and quality care for members.

MHS Network Team



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.

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 and Answers