
















MHS 101 (2020)



Agenda

-  MHS Overview
-  Health Programs
-  Claim Process
-  Prior Authorization Process
-  HEDIS & P4Q
-  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



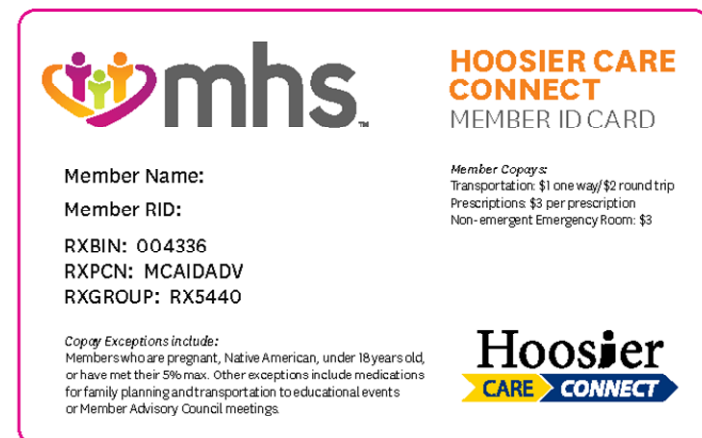
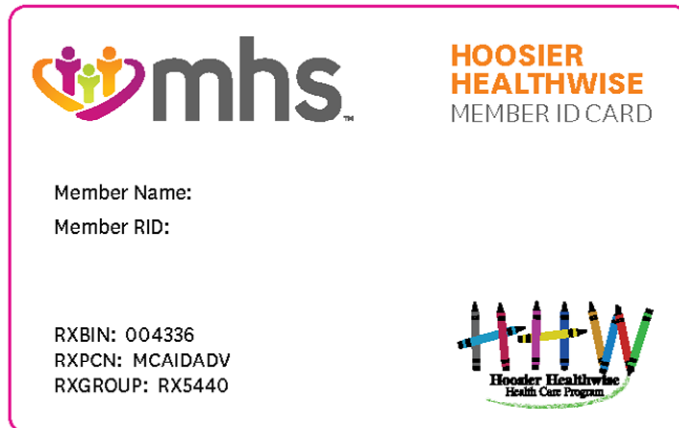


Medicaid

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

Provider Relations

-  Each provider will have an **MHS Provider Partnership Associate** assigned to them.
-  This team serves as the primary liaison between the Plan and our provider network and is responsible for:
 - Provider Education
 - HEDIS/Care Gap Reviews
 - Assist Providers with EHR Utilization
 - Initiate credentialing of a new practitioner
 - Facilitate inquiries related to administrative policies, procedures, and operational issues
 - Monitor performance patterns
 - Contract clarification
 - Membership/Provider roster
 - Assist in Secure Provider Portal registration and Payspan

MHS Provider Network Territories

Indiana

NORTHEAST REGION

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

NORTHWEST REGION

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

NORTH CENTRAL REGION

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

CENTRAL REGION

For claims issues, email:
 MHS_ProviderRelations_C@mhsindiana.com
 Mona Green, Provider Partnership Associate
 1-877-647-4848, ext. 20800

SOUTH CENTRAL REGION

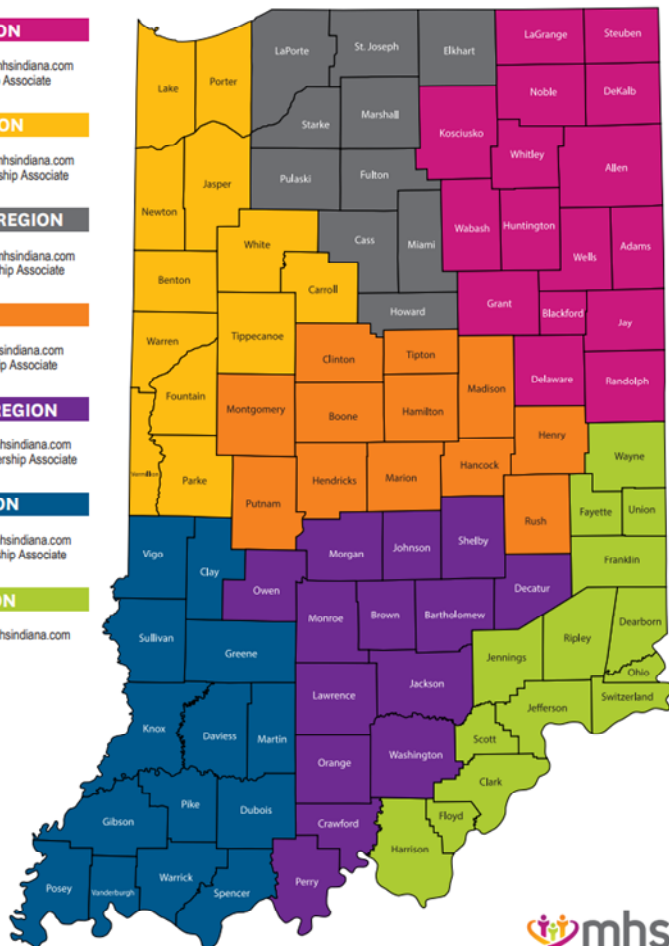
For claims issues, email:
 MHS_ProviderRelations_SC@mhsindiana.com
 Dalesia Denning, Provider Partnership Associate
 1-877-647-4848, ext. 20026

SOUTHWEST REGION

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

SOUTHEAST REGION

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



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SOUTHEAST REGION

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 Carolyn Valachovic Monroe
 Provider Partnership Associate
 1-877-647-4848, ext. 20114

Available online:

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

MHS Provider Network Territories

TAWANNA DANZIE

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

PROVIDER GROUPS

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

JENNIFER GARNER

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/medical/pdfs/ProviderTerritory_map_2020.pdf

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.




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: 68089
- Behavioral Health Payor ID: 68068

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.

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 **67 calendar days** from the date of EOP to file a resubmission. *Please note, claims will not be reconsidered after this timeline.*

Provider Claims Issue Resolution

Dispute Resolution/Claim Appeals

3 Levels of Disputes:

- **First Level-** Reconsideration/Informal Dispute
 - Can be done on the secure portal or by mail
 - Informal Dispute Form found [here](#).
 - Send hard copy to **P.O. Box 3000, Farmington, MO 63640-3800**
- **Second Level-** Formal Dispute
 - Must be sent in by mail to **P.O. Box 3000, Farmington, MO 63640-3800**
- **Third Level-** Arbitration- Must be sent in by mail
 - Must be sent by mail to **MHS Arbitration, 550 N. Meridian Street, Suite 101, Indianapolis, IN 46204**



Informal Claims Dispute or Objection Forms

Medical

Address:

Managed Health Services
Post Office Box 3000
Attn: Appeals Department
Farmington, MO 63640-380

Behavioral

Address:

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



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.



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

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



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.

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: 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.







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

0517.PR.PF.0 5/17

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

Need to Know – 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

Prior Authorization Process

Prior Authorization

 MHS does not require referrals for services.





 Some services require prior authorization.

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


- Provider can check to see if a service (CPT or HCPCS code) requires authorization by going to the MHS Website. [Found Here](#)


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.

Turning Point

-  MHS has entered into an agreement with Turning Point Healthcare Solutions, LLC to implement two programs:
 - Musculoskeletal Safety and Quality Program
 - Cardiac Surgical Quality and Safety Management Program


 This program includes the prior authorization function for medical services under both programs.

 Web Portal Intake:

- myturningpoint-healthcare.com

 Telephone Intake:





- 1-574-784-1005 | 1-855-415-7482

 Fax Intake: 1-463-207-5864






 **TRAINING:**

- Informational webinars are available! Please register at: <https://register.gotowebinar.com/rt/7079530369468972290>.
- Informational webinars are available! Please register at: <https://attendee.gotowebinar.com/rt/6895616165794853901>

National Imaging Associates (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

-  To ensure timely and accurate medical necessity review of a Medicaid inpatient admission, **effective November 1, 2019, MHS will only accept notification of an inpatient admission and any clinical information submitted for medical necessity review via fax, 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.

Utilization Management



-  All elective inpatient/outpatient services must be prior authorized with MHS at least 2 business days prior to the date of service.
-  MHS will only accept notification of an inpatient admission and any clinical information submitted for medical necessity review via fax or MHS web portal, using the IHCP universal prior authorization form.
-  Please submit timely notification and clinical information to support an inpatient admission via fax to 1-866-912-4245.
-  All urgent and emergent services must be called 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!

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.

HEDIS/Pay for Performance (P4P) & Partnership for Quality (P4Q)

Why Should Providers Care About HEDIS?



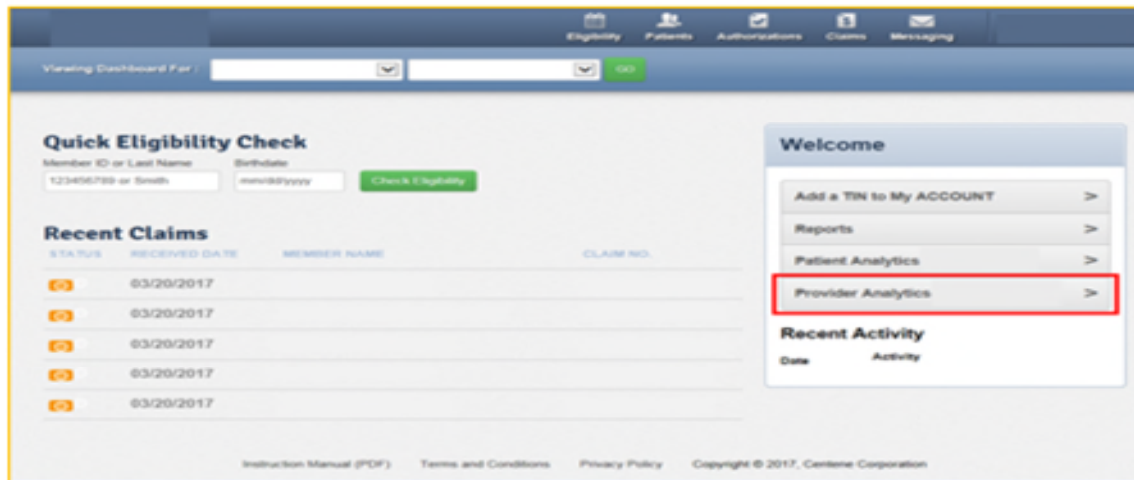
HEDIS rates are used to:

- Guide Pay For Performance Measures
- Levy bonuses
- Support increased quality outcomes for members
- Encourage preventive care services

P4P Scorecards

Reports updated regularly on Secure Provider Portal

- Group scorecards
- Individual scorecards
- Members in Need of Services lists



The screenshot shows the Secure Provider Portal dashboard. At the top, there are navigation tabs for Eligibility, Patients, Authorizations, Claims, and Messaging. Below this is a search bar for viewing a dashboard for a specific member. The main content area is divided into two columns. The left column features a 'Quick Eligibility Check' section with input fields for Member ID or Last Name and Birthdate, and a 'Check Eligibility' button. Below this is a 'Recent Claims' table with columns for Status, Received Date, Member Name, and Claim No. The right column contains a 'Welcome' section with a list of menu items: 'Add a TIN to My ACCOUNT', 'Reports', 'Patient Analytics', and 'Provider Analytics' (which is highlighted with a red box). Below the menu is a 'Recent Activity' section with columns for Date and Activity. At the bottom of the page, there are links for the Instruction Manual (PDF), Terms and Conditions, Privacy Policy, and Copyright information for 2017, Centene Corporation.

STATUS	RECEIVED DATE	MEMBER NAME	CLAIM NO.
CS	03/20/2017		
CS	03/20/2017		
CS	03/20/2017		
CS	03/20/2017		
CS	03/20/2017		

P4Q

- Partnership for Quality (P4Q) is a Risk Adjustment bonus program for our Providers
- Risk Adjustment pays Bonuses for completed and verified Provider Appointment Agendas and/or submission of Comprehensive Physical Exam medical records. This is a claims based program – members need to be assessed during the program year by their PCP along with a claim submitted to support the provider’s assessment.
- Appointment Agendas serve as a valuable tool that provides offices with both insight into historical diagnosis data for providers to use to assist in assessing their members to ensure all member conditions are assessed at least once per year.
- Providers earn Bonus payments for proactively coordinating preventive medicine and thoroughly assessing all of their patients current conditions in an effort to improve health and provide appropriate clinical quality of care

Provider Incentive

% of Appointment Agendas Completed/Paid	Bonus Amt per Paid Appointment Agenda
<50%	\$100
>50 to <80%	\$200
>80%	\$300

- 100% of the risk adjustment gaps are assessed;
 - Checking Active Diagnosis and Documented
 - Resolved / Not Present box in the P4Q dashboard
 - **or** on the printed Appointment Agenda **AND**
 - Provider has submitted a paid claim
- Providers will be paid quarterly after the third quarter has been completed.

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.

Care Management Programs Includes....

Right Choices Program

- Members identified as high utilizers in need of specialized intervention are enrolled into the Right Choices Program (RCP).

First Year of Life


- This Care Management program is designed to encourage education and compliance with immunizations and well visits for babies.

Smoking Cessation

- The Indiana Tobacco Quitline
 - 1-800-QUIT-NOW (1-800-784-8669)


MHS Partnership

Transportation



 All MHS Hoosier Healthwise (except for Package C) , Hoosier Care Connect, and Healthy Indiana Plan (HIP) members qualify for **unlimited free transportation** services provided by LCP.

 Rides will take members to and from:






- Doctor visits
- Medicaid enrollment visits
- Pharmacy visits (following a doctor's visit)
- Medicaid reenrollment visits

 Members need to call MHS Member Services at 1-877-647-4848 to schedule their ride at least three business days before their appointment.



Transportation

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

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).

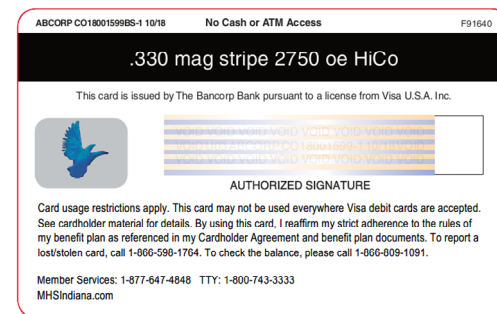
MHS 24/7 Nurse Advice Line

-  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.
-  Members can use the 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

-  Statewide Coverage in 2020.
-  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.

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:



**IN NETWORK
COVERAGE ONLY**

Subscriber: [Jane Doe]	Effective Date of Coverage: [XX/XX/XX]
Member: [John Doe]	RXBIN: 004336
Policy #: [XXXXXXXXXX]	RXPCN: ADV
Member ID #: [XXXXXXXXXXXXXXXXXX]	RXGROUP: RX5453
Plan: [Ambetter Balanced Care 1]	

<p>COPAYS</p> <p>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.</p>	<p>Deductible (Med/Rx): [\$250/\$500]</p> <p>Coinsurance (Med/Rx): [50%/30%]</p>
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Ambetter.mhsindiana.com

<p>Member/Provider Services: 1-877-687-1182 TTY/TDD: 1-800-743-3333 24/7 Nurse Line: 1-877-687-1182</p> <p>Numbers below for providers: Pharmacy Help Desk: 1-866-270-3922 EDI Payor ID: 68069 EDI Help Desk: Ambetter.mhsindiana.com</p>	<p>Medical Claims: Managed Health Services Attn: CLAIMS PO Box 5010 Farmington, MO 63640-5010</p>
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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.

AMB17-IN-C-00036
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** 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**

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

- Can be done on the secure portal or by mail
- 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

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)




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

Allwell from MHS (Medicare Advantage)

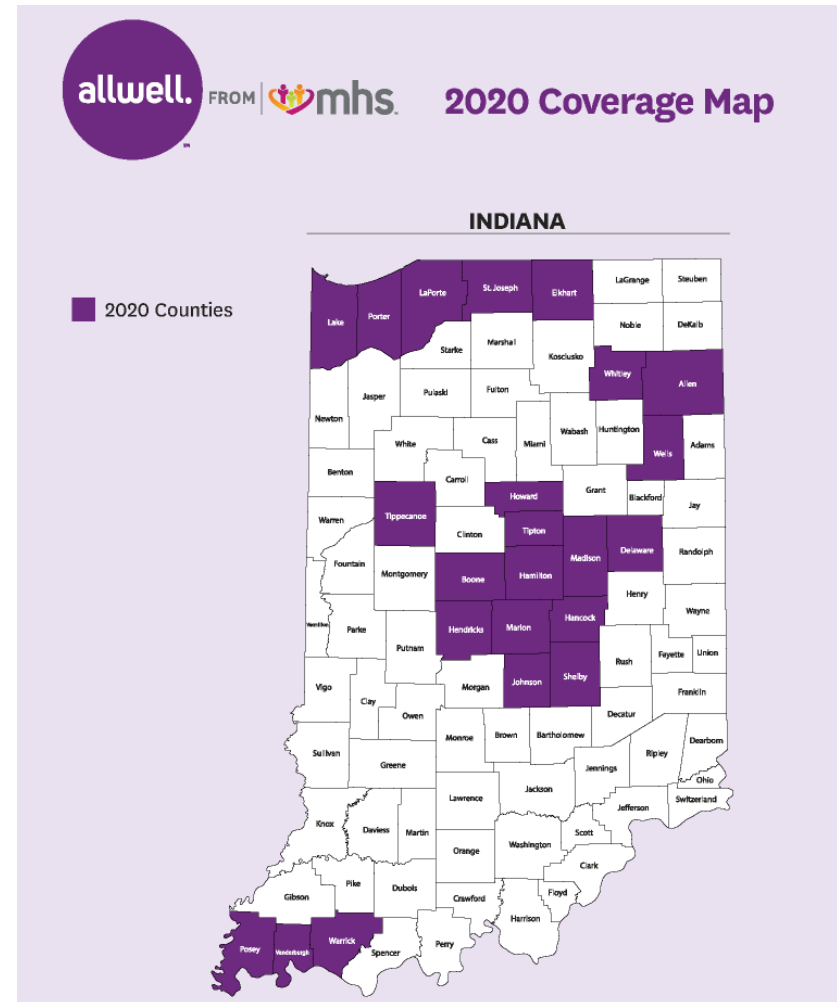


Coverage in 2020

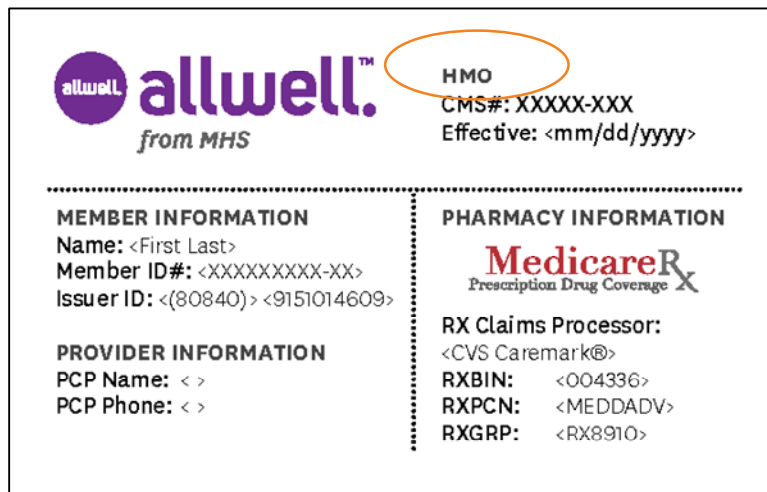


Plan authorization is required for out-of-network services, except:

- 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



Member ID Cards



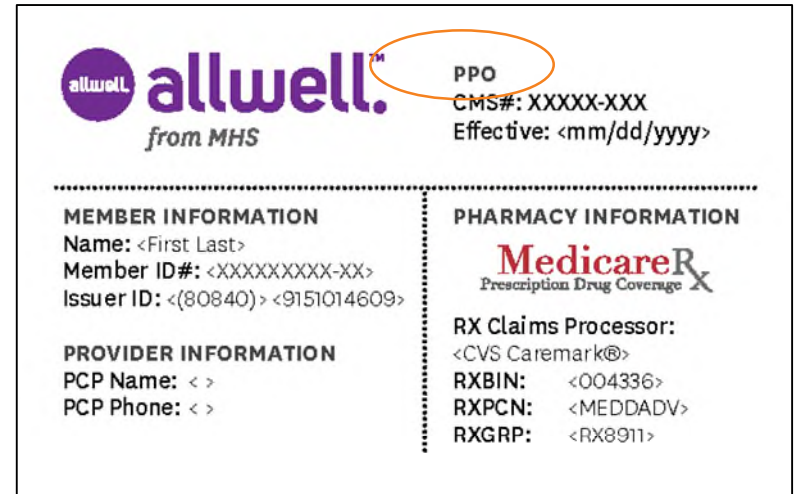
allwell.TM **HMO**
from MHS
CMS#: XXXXX-XXX
Effective: <mm/dd/yyyy>

MEMBER INFORMATION
Name: <First Last>
Member ID#: <XXXXXXXXXX-XX>
Issuer ID: <(80840)> <9151014609>

PROVIDER INFORMATION
PCP Name: < >
PCP Phone: < >

PHARMACY INFORMATION
MedicareRx
Prescription Drug Coverage

RX Claims Processor:
<CVS Caremark®>
RXBIN: <004336>
RXPCN: <MEDDADV>
RXGRP: <RX8910>



allwell.TM **PPO**
from MHS
CMS#: XXXXX-XXX
Effective: <mm/dd/yyyy>

MEMBER INFORMATION
Name: <First Last>
Member ID#: <XXXXXXXXXX-XX>
Issuer ID: <(80840)> <9151014609>




PROVIDER INFORMATION
PCP Name: < >
PCP Phone: < >

PHARMACY INFORMATION
MedicareRx
Prescription Drug Coverage

RX Claims Processor:
<CVS Caremark®>
RXBIN: <004336>
RXPCN: <MEDDADV>
RXGRP: <RX8911>






Prior Authorization

Utilization Management

-  Authorization must be obtained prior to the delivery of certain elective and scheduled services.
-  Use the Pre-Auth Needed Tool at allwell.mhsindiana.com to check all 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

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.
-  Can be done on the secure portal or by mail
-  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**.



FOR MEMBERS

FOR PROVIDERS

GET INSURED

FOR PROVIDERS

Login

Become a Provider

Prior Authorization

Dental Providers

Pharmacy

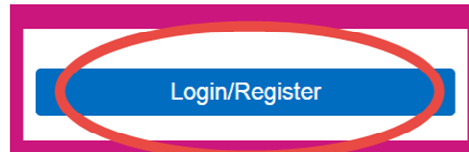
Behavioral Health

Provider Resources

QI Program

Provider News

Portal Login



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

Behavioral Health Secure Portal

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

Registration Help

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

Create your own online account today!

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

Creating an account is free and easy.












By creating a MHS account, you can:

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






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

COVID – 19 Updates

COVID-19

-  **Testing:** MHS will accept the new HCPCS codes below beginning 4/1/2020 for dates of service 2/4/20 onward.
 -  HCPCS code (U0001) Providers using the Centers for Disease Control and Prevention (CDC) 2019 Novel Coronavirus Real Time RT-PCR Diagnostic Test Panel
 -  HCPCS code (U0002) allows laboratories to bill for non-CDC laboratory tests for SARS-CoV-2/2019-nCoV (COVID-19).
-  **Screening:** CDC has provided guidance that providers should use the following ICD-10 codes until the COVID-19 specific ICD-10 is available after 10/1/2020.
 -  B97.29 – Confirmed Cases: Other coronavirus as the cause of diseases classified elsewhere
 -  B34.2 – Coronavirus infection, unspecified
 -  Z20.828 – Contact with and (suspected) exposure to other viral communicable diseases
 -  Z03.818 – Exposure to COVID-19 and the virus is ruled out after imminent, life-threatening condition
-  **Rate Adjustment Projects** will occur once rates are loaded for dates of service 2/4/20 and onward.
-  **Ambetter and Allwell** will honor \$0 cost share for COVID-19 Testing and Screening.
-  **MHS** will ensure there are no authorizations for these services to ensure our members receive the care needed.

Allwell COVID-19 Updates 7/1/20

-  \$0 Member Liability Extension (specific details apply)
-  Extended Meal Benefits (additional 14 meals for qualifying members)
-  Increased Annual Wellness Visit Incentives
-  Additional Over-The-Counter (OTC) Benefits
-  Access to WellCare's Community Connections Help Line 1-866-775-2192

Questions and Answers