Managed Health Services (MHS) 101

mhs™

ambetter.

Hoosier Healthwise

HIP HEALTHY INDIANA PLAN

Hoosier CARE CONNECT

allwell.

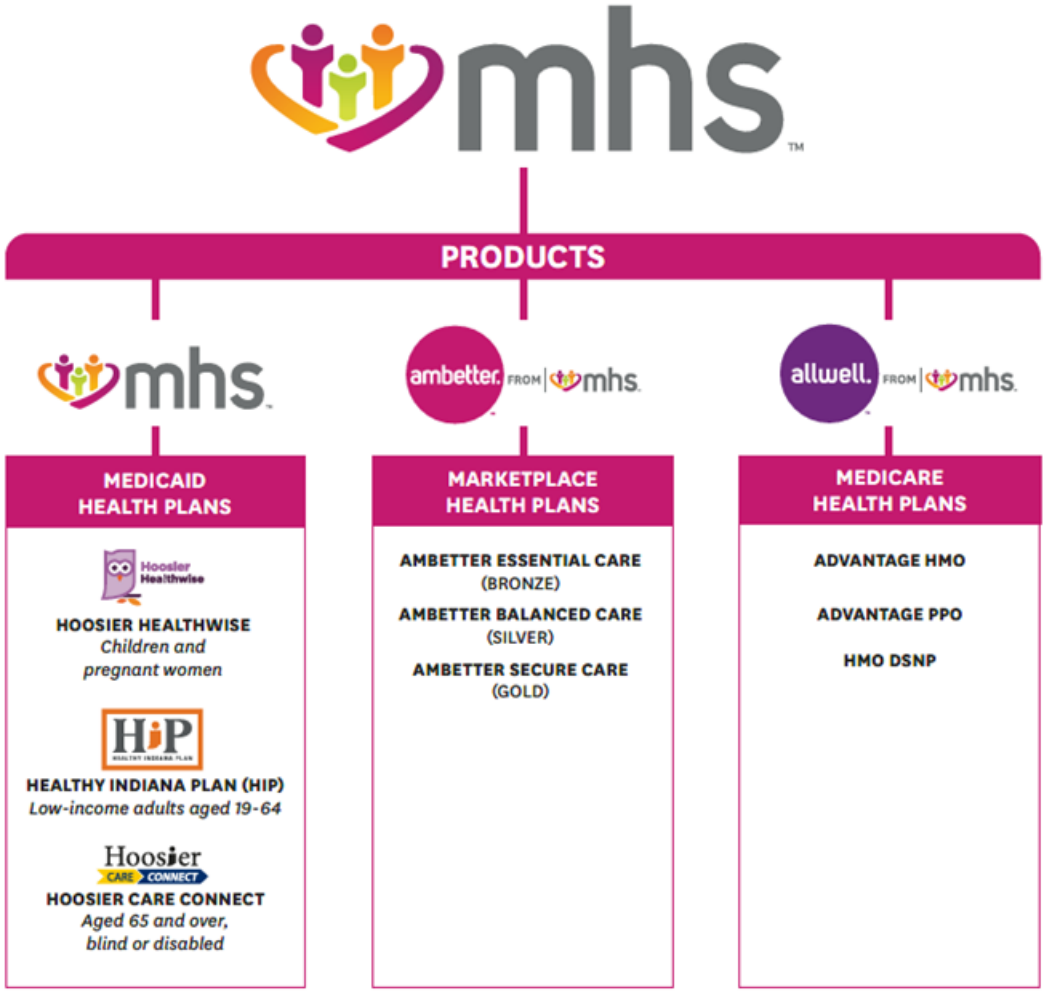
Agenda

- MHS Overview
- Health Programs
- Claim Process
- Provider Claims Issue Resolution
- Vaccines for Children
- Notification of Pregnancy
- Prior Authorization Process
- Integrated Care
- Self Referral Services
- Coordinated Care Programs
- Culturally and Linguistic Appropriate Services (CLAS)
- MHS Partnership
- Ambetter
- Allwell
- MHS Website
- Provider Analytics
- Questions

Who is MHS?

- Managed Health Services (MHS) is a health insurance provider that has been proudly serving Indiana residents for over 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.**

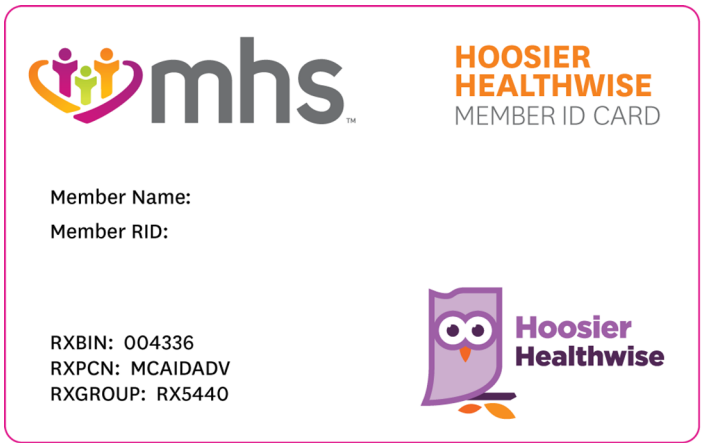
MHS Products

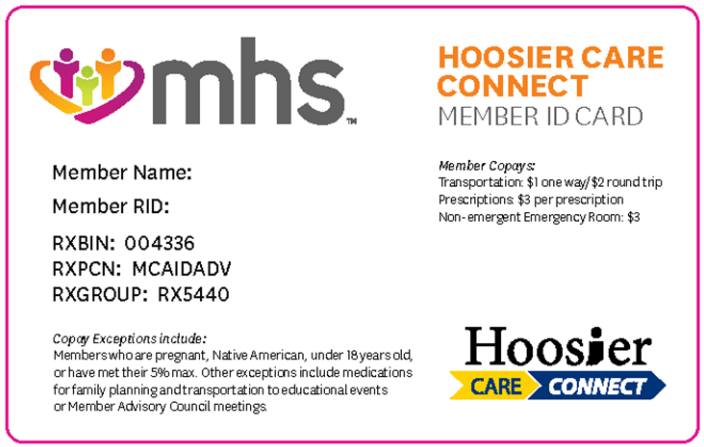


Medicaid

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 Copay 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

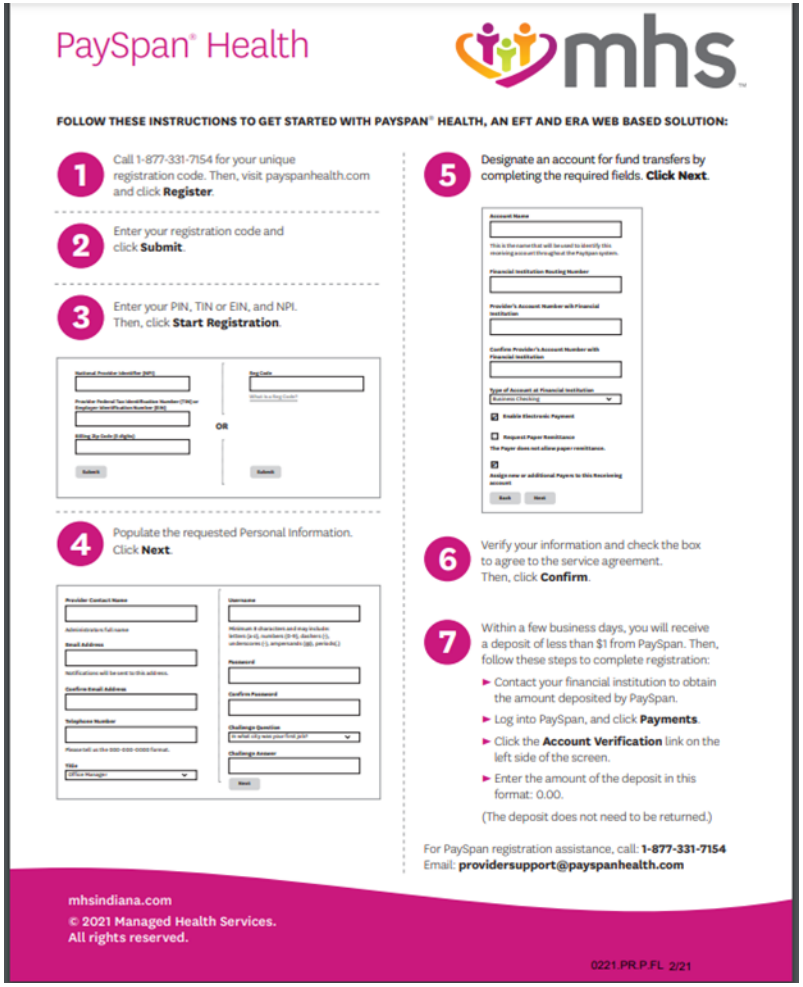
- **Electronic adjustments through the Secure Provider Portal:**
  - Adjustment option on the MHS website.
  - Must attach EOP, documentation, and explanation of the resubmission reason.
  - May use the Provider Claims Adjustment Request Form
- Paper copy resubmissions:

  Managed Health Services
  PO Box 3002
  Farmington, MO 63640-3802
- 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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MHS Provider Claims Issue Resolution Process

Provider Claims Issue Resolution

PROCESS

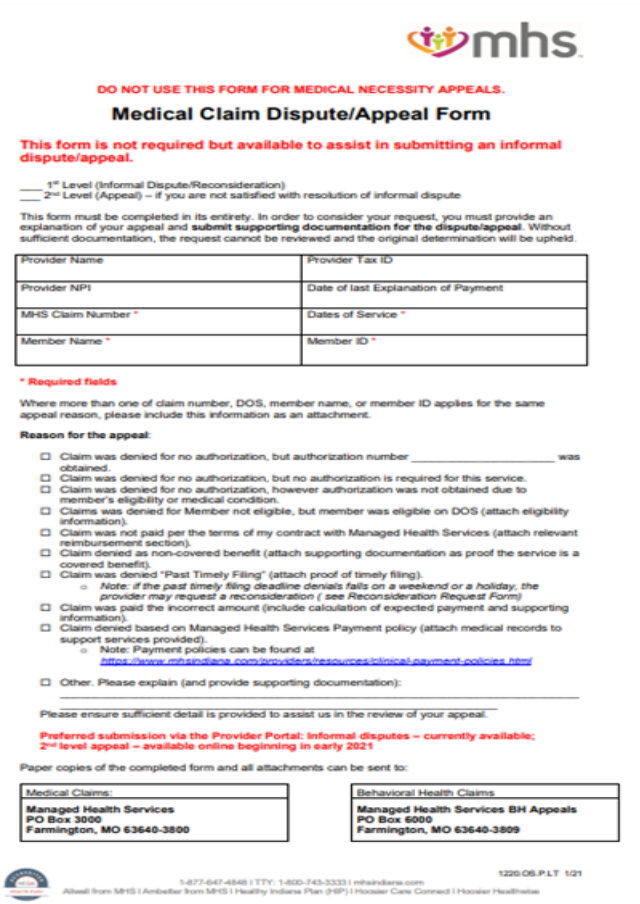
- Level 1: Informal Claims Dispute or Objection Form
- Level 2: Formal Claim Dispute - Administrative Claim Appeal
- Level 3: Arbitration
- For assistance or questions after completing step one:
  - Provider Services Phone Requests & Web Portal Inquiries
- If additional assistance is needed anytime after Level 1 and after calling Provider Services or completing Web Portal inquiry:
  - Provider Relations Regional Mailboxes
- Please note, this is different than an Authorization appeal. A claim appeal cannot change denied authorization status. To change authorization status, you must appeal the denied authorization.

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**

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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

Informal Claims Dispute or Objection Form

Level 1:

- Submit all documentation supporting your objection.

  - Must be submitted in writing within 60 calendar days of receipt of the MHS Explanation of Payment (EOP) by using the MHS Informal Claim Dispute or Objection form.
  - Requests received after day 60 will not be considered.
  - Copies of original MHS EOP showing how the claims in question were processed.
  - Copies of any subsequent MHS EOPs or other determinations on the claim(s) in question.
  - Documentation of any previous attempt you have mad to resolve the issue with MHS.
  - Other documentation that supports your request for reprocessing or reconsideration of the claim(s).

Informal Claims Dispute or Objection Form

Level 1:

- MHS will make all reasonable efforts to review your documentation and respond to you within 30 calendar days.
- If you do not receive a response within 30 calendar days, consider the original decision to have been upheld.
- At that time (or upon receipt of our response if sooner), you will have up to 60 calendar days from date of Dispute response to initiate a formal claim appeal (Step 2).

Informal Claims Dispute or Objection Form

Level 1:

- Helpful Tips:
  - Disputing multiple claim denials:
    - Submit separate Informal Claims Dispute Forms for each member/patient experiencing the denial;
    - Provide additional information such as:
      - The MHS denial code and description found on the EOPP/remit;
      - Briefly describe why you are disputing this denial;
      - For multiple claims please either list all claim numbers or in the "Reason for Dispute" section state that "member is experiencing denial reason ___ for all claims DOS____ to _____; Please review all associated claims";
  - Save copies of all submitted informal claims dispute forms.

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

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

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

Arbitration

Level 3:

- Level 3 is a continuation of Levels 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. https://www.mhsindiana.com/content/dam/centene/mhsindiana/medicaid/pdfs/Provider_Manual_2019.pdf

Provider Services Phone and Portal Requests

- This is **not** considered a formal notification of provider dispute.
- Claim issues presented by providers to the Provider Services phone line & Web Portal Inquiries for review will be logged and assigned a ticket number; Please keep this ticket number for your reference
- **Phone: 1-877-647-4848; Provider Services 8 a.m. to 8 p.m.**
- **Provider Web Portal:** mhsindiana.com/providers/login
  - Use the Messaging Tool.

Provider Service Phone and Portal Requests

- Helpful Tips:
  - Disputing multiple claim denials:
    - Provide the provider services rep or web portal team member with one claim number as an example of the specific denial.
    - **Communication is Key**!
      - Tell the rep you have a “claims research request” to review all claims for the specific denial reason.
      - State if this denial is happening for one or multiple practitioners within your group or clinic; (if multiple, provide your TIN)
      - Provide the MHS denial code and description found on the EOP.
      - Briefly describe why you are disputing this denial or seeking research.

Provider Services Phone and Portal Requests

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

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

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.
- Providers 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.

Prior Authorization

Prior Authorization (Medical Services):

Prior Authorization (PA) is an approval from MHS to provide services designated as needing authorization before treatment and/or payment.

- Inpatient (IP) authorizations = IP + 10 digits
- Outpatient (OP) authorizations = OP + 10 digits
- ER Visits suggesting imminent, life-threatening condition no PA required, but notification requested within **two business days.**
- Urgent concurrent = Emergent inpatient admission. Determination timeline within **24 hours** of receipt of request.
- Pre-service non urgent = Elective scheduled procedures. Determination within **7 calendar days.** Benefit limitations apply (dependent on product).

Prior Authorization

MHS Medical Management will review state guidelines and clinical documentation. Medical Director input will be available if needed.

- PA for observation level of care (**up to 72 hours for Medicaid**), diagnostic services do not require an authorization for contracted facilities.
- If the provider requests an inpatient level of care for a covered/eligible condition, but procedure and documentation supports an outpatient/observation level of care, MHS will send the case for Medical Director review.

Prior Authorization

Outpatient Services:

- All elective procedures that require prior authorization must have submitted request to MHS at least **two business days** prior to the date of service.
- All ER services do not require prior authorization, but admission must be called into MHS Prior Authorization Dept. within **two business days** following the admit.
- Members **must** be Medicaid Eligible on the date of service.
- Prior Authorizations are not a guarantee of payment.
- ***Failure to obtain prior authorization for non urgent and emergent services will result in a denial for related claims.***

Prior Authorization

Transfers:

- MHS requires **notification and approval** for all transfers from one facility to another at least two business days in advance.
- MHS requires **notification** within two business days following all emergent transfers. Transfers include, but are not limited to:
  - Facility to facility
  - Higher level of care changes require PA and it is the responsibility of the transferring facility to obtain.

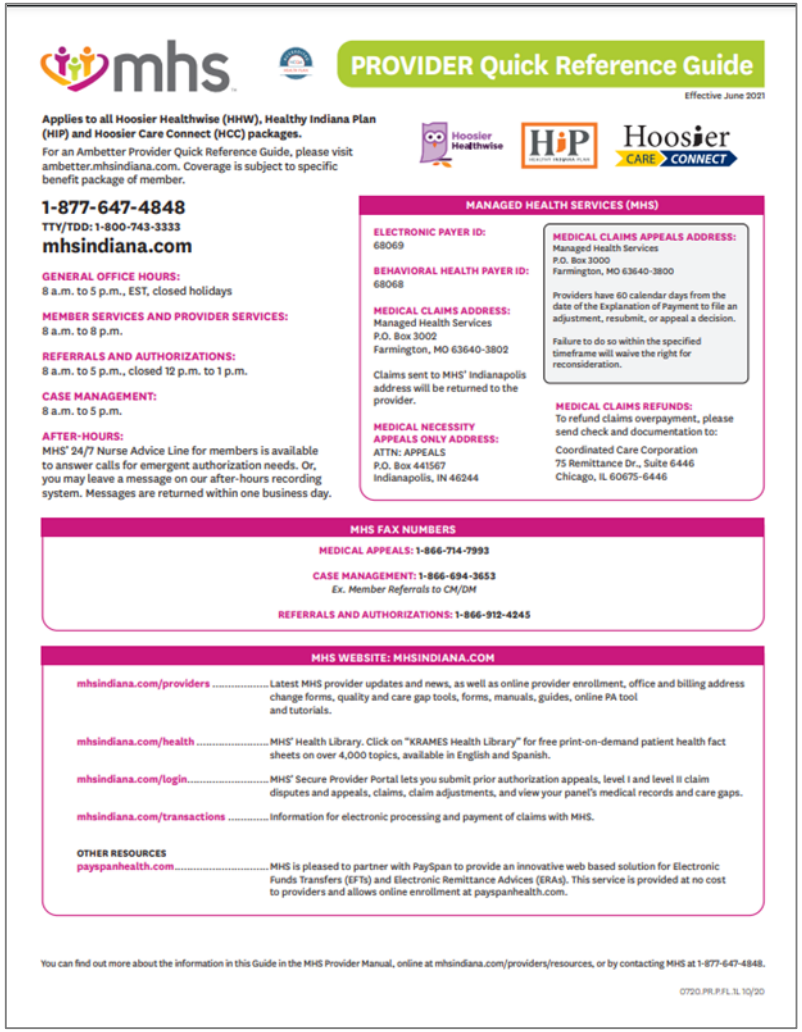
Prior Authorization

Services that require prior authorization regardless of contract status:

- Injectable drugs (see mhsindiana.com/provider-guides for up-to-date list of codes)
- Nutritional counseling (unless diabetic)
- Pain management programs, including epidural, facet and trigger point injections
- PET, MRI, MRA and Nuclear Cardiology/SPECT scans
- Cardiac rehabilitation
- Hearing aids and devices
- Home and Institutional hospice (coverage varies by product)
- In-home infusion therapy
- Orthopedic footwear
- Respiratory therapy services
- Pulmonary rehabilitation
- Home care (except after an IP admission with benefit limitations)
- Physical Therapy, Occupational, and Speech Therapy
- Non-emergent ambulance services
- Orthopedic and spinal surgical procedures

Prior Authorization

- **Is Prior Authorization Needed?**
  - MHS website: mhsindiana.com
  - Quick reference guide
  - Non-contracted provider services now align with PA requirements for contracted providers



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PROVIDER Quick Reference Guide

Effective June 2021

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

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

Hoosier Healthwise | HIP | Hoosier CARE CONNECT

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

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

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

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

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

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

MANAGED HEALTH SERVICES (MHS)

ELECTRONIC PAYER ID:
68069

BEHAVIORAL HEALTH PAYER ID:
68068

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

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

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

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

Providers have 60 calendar days from the date of the Explanation of Payment to file an adjustment, resubmit, or appeal a decision.

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

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

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

MHS FAX NUMBERS

MEDICAL APPEALS: 1-866-714-7993

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

REFERRALS AND AUTHORIZATIONS: 1-866-912-4245

MHS WEBSITE: MHSINDIANA.COM

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

OTHER RESOURCES

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

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

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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?	○	○

Prior Authorization

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.

Prior Authorization

Information Needed to Complete All PAs:

- Member's Name, RID, and Date of Birth
- Type of service needed (e.g. office visit, outpatient surgery, DME, inpatient admission, testing, physical therapy, occupational therapy, speech therapy etc.)
- Date(s) of service
- Ordering Physician with NPI number
- Servicing/Rendering Physician with Rendering NPI number
- HCPCS/CPT codes requested for approval
- Diagnosis code
- Contact person, including phone and fax numbers
- Clinical information to support medical necessity (home care requires a signed Plan of Care POC)
  - Including current (within three months) clinical that is pertinent to the requested service, history of symptoms, previous treatment and results, physician rationale for ordering treatments and/or testing (MD exam notes).

***Providers must request updates to prior authorizations within 30 days from the original date of service before claim submission.**

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 Turning Point 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, 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

Behavioral Health

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 Outpatient Mental Health Services (BHOP)

- 6/1/2021: Package C Hoosier Healthwise members became eligible for increased benefits.
  - Eligible for 30 outpatient therapy codes, in combination, per member, per provider, 12 months rolling period.
  - All other Medicaid categories, 20 unit criteria is still applicable.
  - See MHS Newsroom at mhsindiana.com for complete details.

Behavioral Health Prior Authorizations

Limitations on Outpatient Mental Health Services (Cont.):

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

Behavioral Health Prior Authorizations

Limitations on Outpatient Mental Health Services (Cont.):

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

Prior Authorization/Medical Necessity Appeals on the Provider Secure Portal

- Medicaid prior authorization/medical necessity denial appeals can be submitted to 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 46244

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

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

Integrated Care

Behavioral Health Integration

HOW DOES THIS AFFECT ME AS A PMP?

- PMPs can assist in coordinating care for members with known or suspected behavioral health needs by helping them access an MHS Behavioral Health Provider.
- You have access to complete claim history via the online MHS Secure Provider Portal that includes detail regarding Behavioral Health services received by your members.
- Members may also self-refer for outpatient Behavioral Health services by scheduling an appointment directly with an MHS provider; these services **DO NOT** require a referral from the PMP.

Behavioral Health Integration

- Training is available to assist in the identification of members in need of behavioral health services to ensure coordination of physical and behavioral healthcare among all providers.
- MHS are encourage the use of the Behavioral/Physical Health Coordination Form (mhsindiana.com) so that providers can easily, efficiently, and legally exchange Information.

Behavioral Health Trainings

- MHS also offers a variety of live training opportunities.
- Attendees will need to log into the GoToTraining room and will also need to call into the conference number.
- For a list of upcoming trainings and to register, go to the GoToTraining page.

Behavioral Health Training Examples

- Substance Related and Addictive Disorders, Module 1
- Behavioral Health 101 Series: Anxiety
- DSM 5, Module 1
- Motivational Interviewing: Level 1, Part 1
- Behavioral Health 101 Series: Bipolar Disorder

Person Centered Thinking Training

- MHS has developed training via Podcast for our contracted providers. Please contact your Provider Partnership Associate to register.
- The core concept training for anything Person Centered. Teaches staff how to better discover what is important to the person and what is important for the person and to find balance between the two.

Person Centered Thinking Training

- Lesson 1 – Person Centered Thinking – Overview
- Lesson 2 – Person Centered Thinking – Core Concepts
- Lesson 3 – Person Centered Thinking – Promoting Positive Control
- Lesson 4 – Person Centered Thinking – Moving to Support

Self-Referral Services

Self-Referral Services

- Birth control (family planning)
- Behavioral healthcare/psychiatric services
- Chiropractic care
- MHS case management
- Emergency room
- Shots (immunizations)
- Sexually-transmitted infection and treatment
- Treatment for alcohol/drug abuse
- Women's care
- Eye/vision checkups, glasses/contacts
- Dental care
- Podiatric services
- Diabetes self-management services

Please refer to the Provider Portal for detail.

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.

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 Partnership

Transportation

- All MHS Hoosier Healthwise (except for Package C) , Hoosier Care Connect, and Healthy Indiana Plan (HIP) members qualify for 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

- **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).

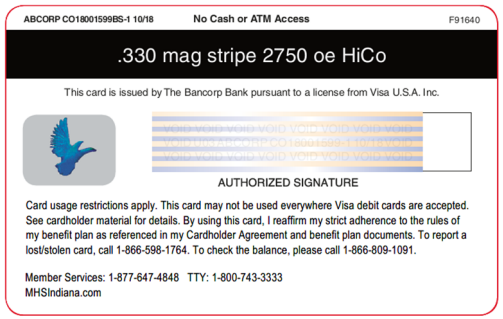
MHS 24/7 Nurse Advice Line

- 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).

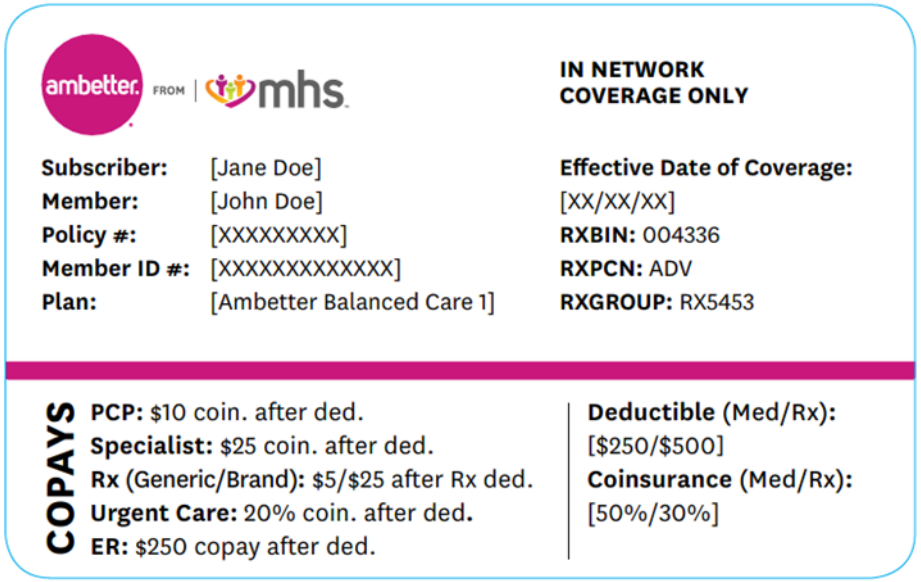
Ambetter from MHS is an HMO Benefit Plan

- 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.

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

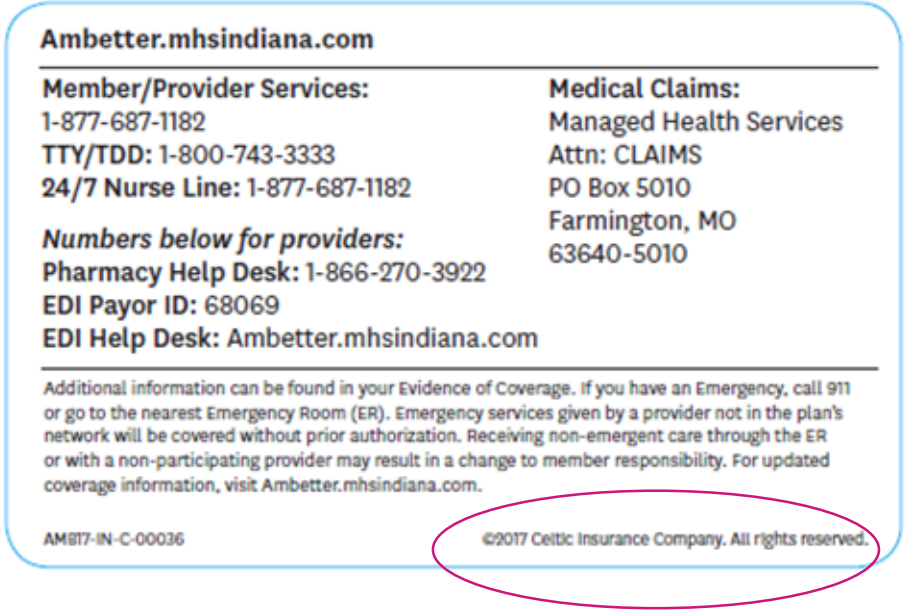
IN NETWORK COVERAGE ONLY

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

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

- **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 1/1/2021
- Outpatient physical, occupations and speech therapy
- 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

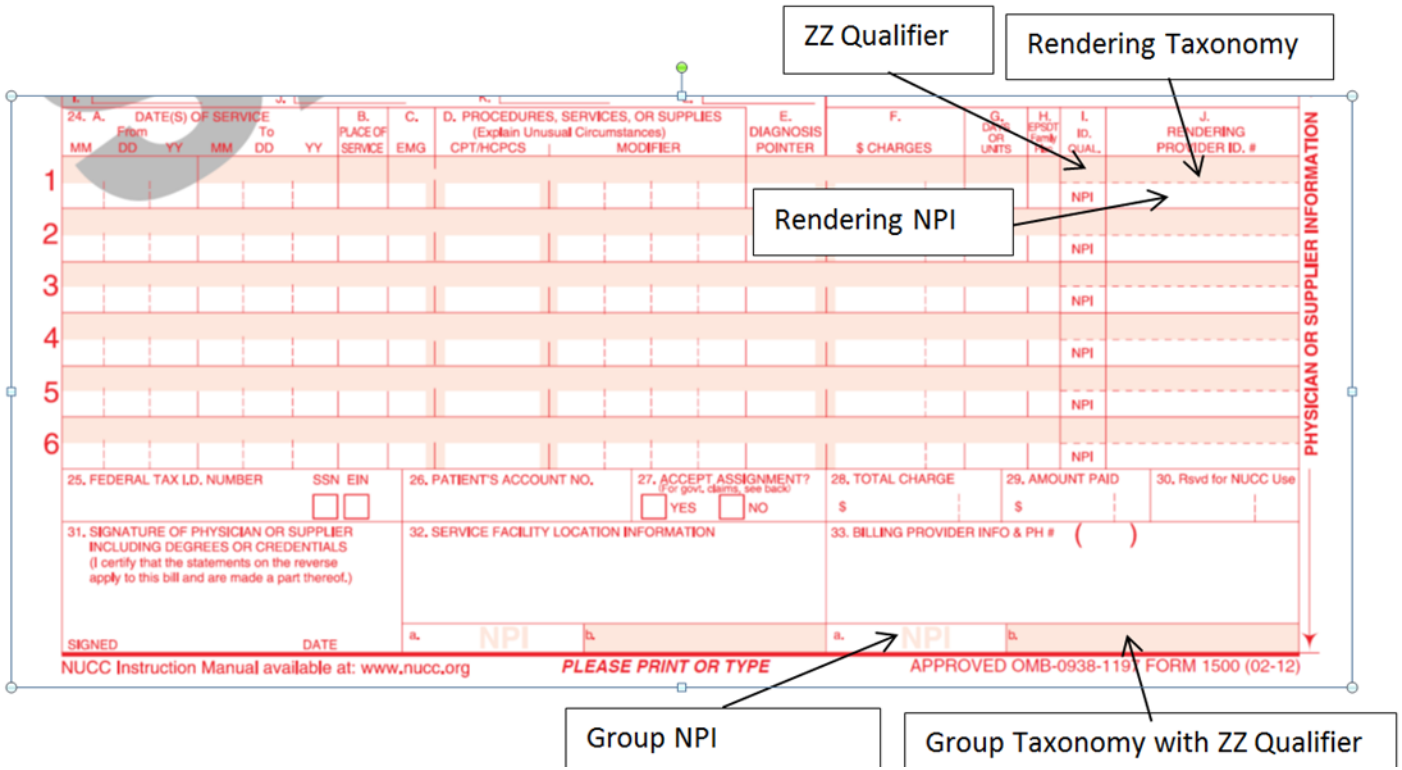
- A provision of the ACA allows members who are receiving Advanced Premium Tax Credits (APTCs) a 3 month grace period for paying claims.
- After the first 30 days, the member is placed in a suspended status. The Explanation of Payment will indicate LZ Pend: Non-Payment of Premium.
- While the member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

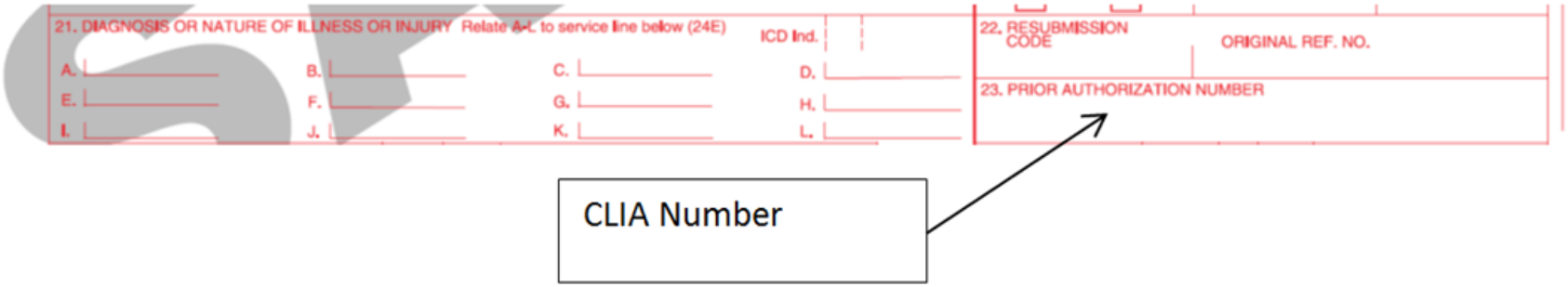
Taxonomy Code

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

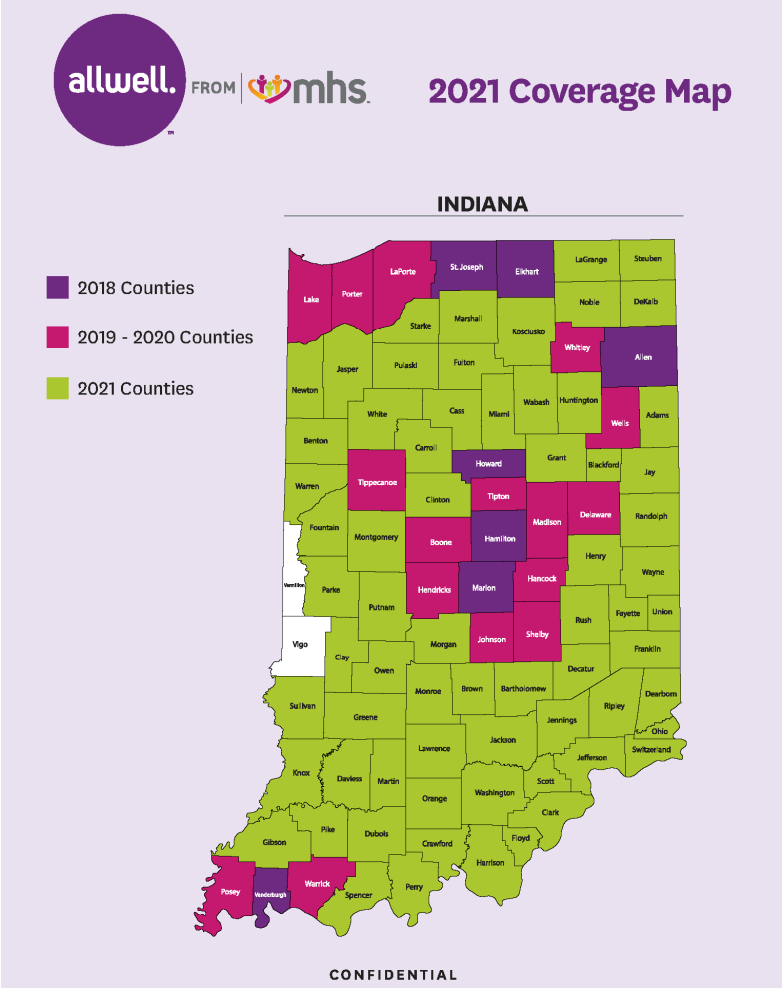
- Copays, coinsurance and any unpaid portion of the deductible may be collected at the time of service.
- The Secure Provider Portal will indicate the amount of the deductible that has been met.
- If the amount collected from the member is higher than the actual amount owed upon claim adjudication, the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

Allwell from MHS

(Medicare Advantage)

Allwell from MHS (Medicare Advantage)

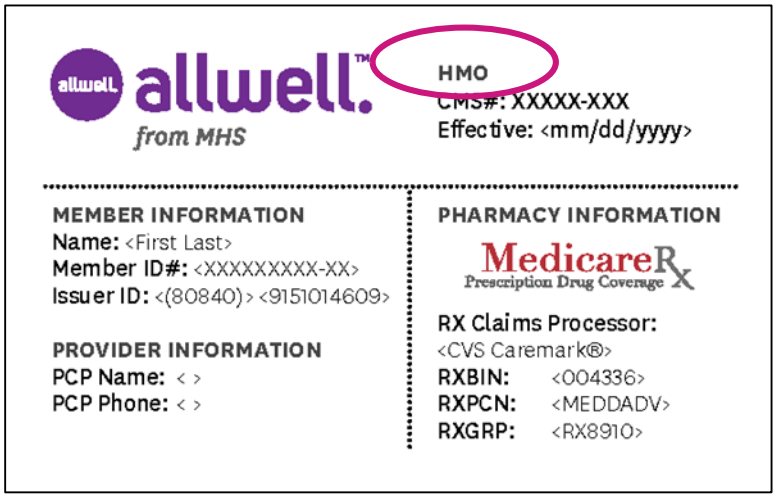
- Coverage in 2021

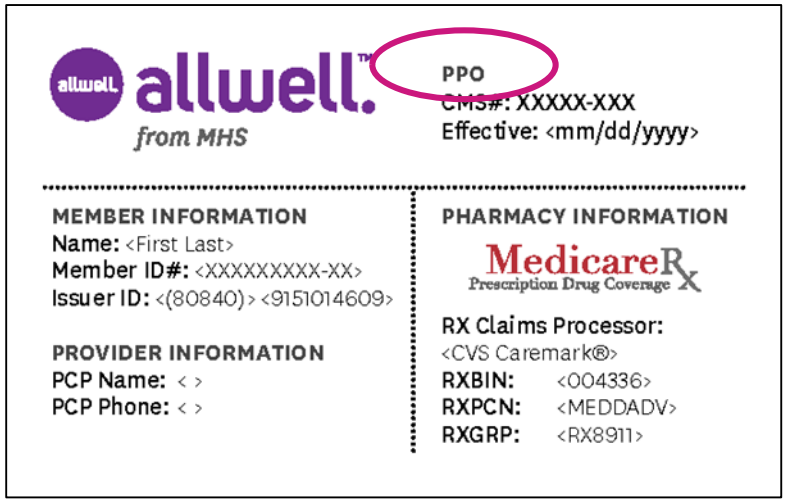


Overview: Medicare Advantage Plans

- **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

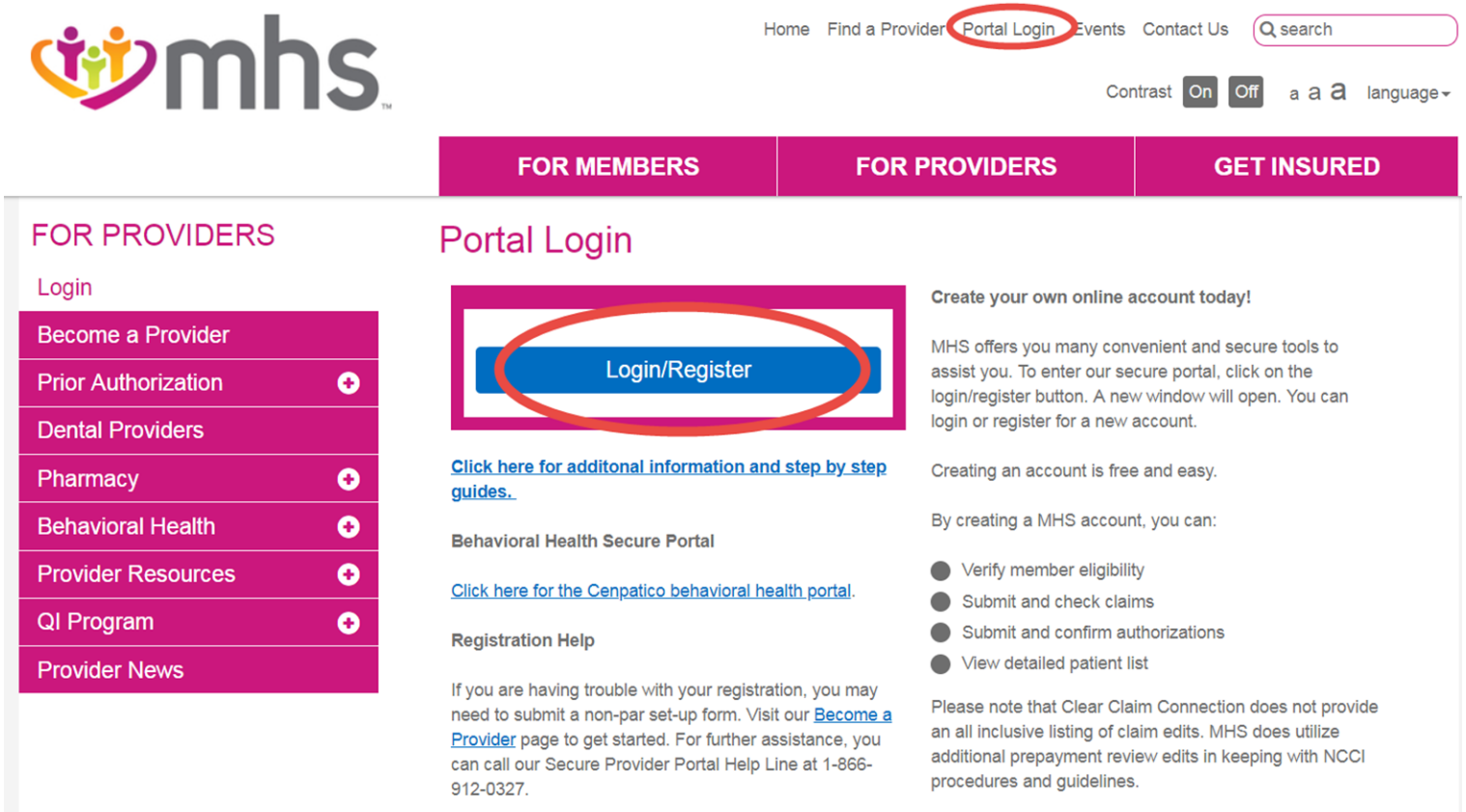
- mhsindiana.com
- Provides access to Medicaid, Ambetter and Allwell
- Provider directory search functionality
- Pre-Auth Needed tool
- Payspan / EFT information
  - Convenient payments
  - One year retrieval of remittance information
  - No cost to providers
- Printable current forms, guides and manuals
  - 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.

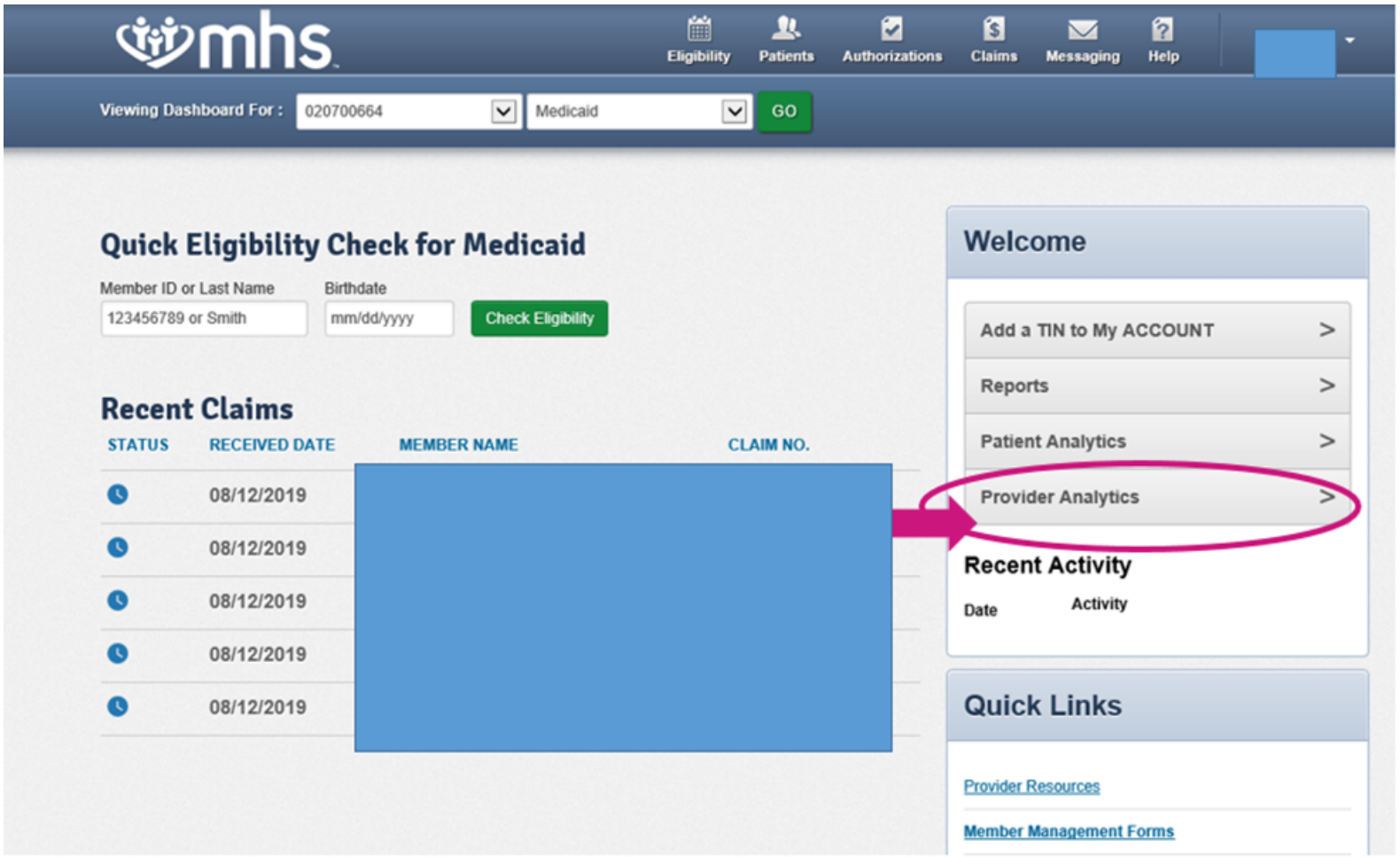


Provider Portal Enhancements

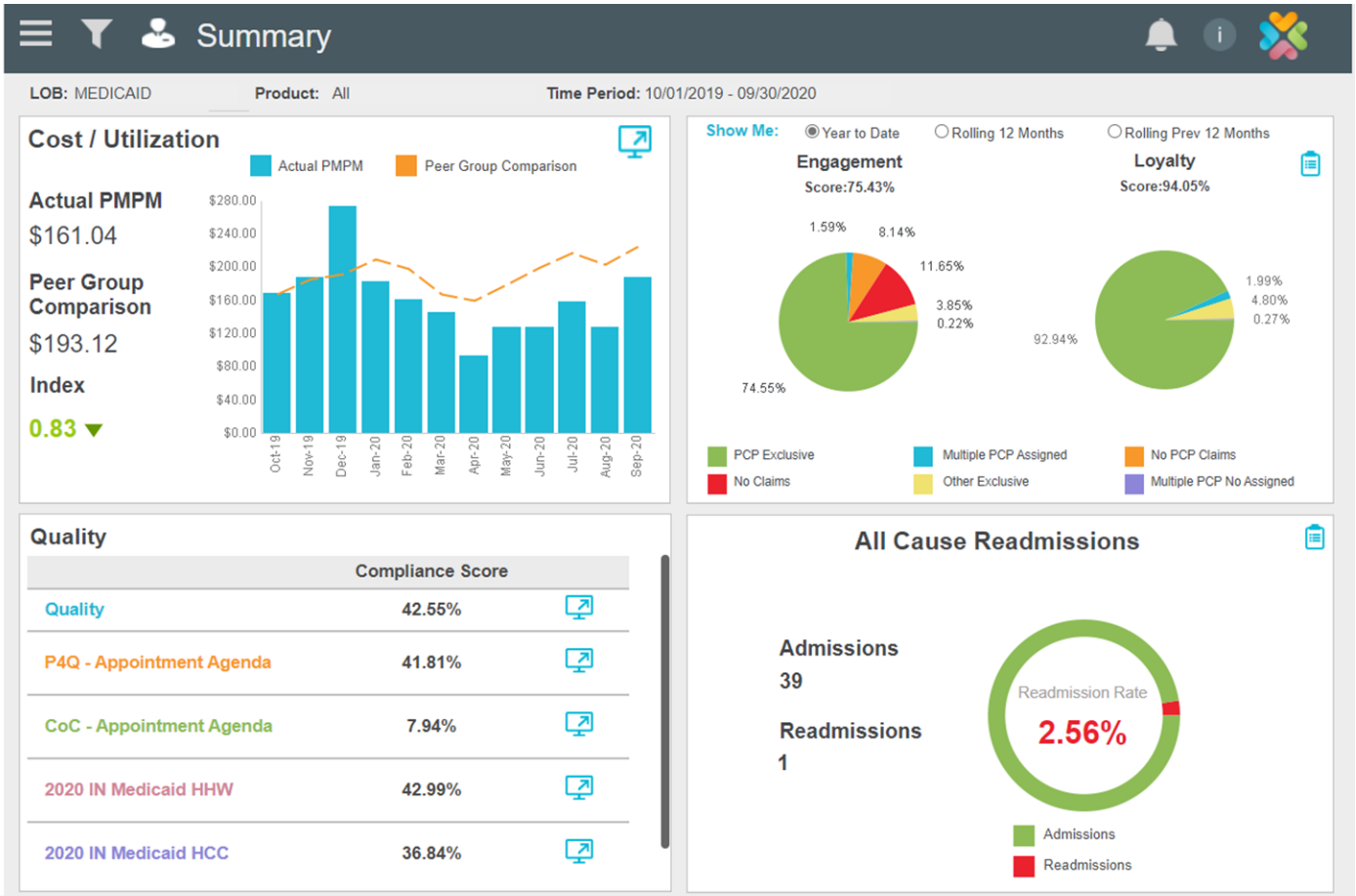
- An enhanced MHS claim wizard is available for select DME, supplies and Skilled Nursing Facility claims via the Secure MHS Provider Portal.
- The claims wizard allows billers to create claims for multiple members and/or dates of service in one form.
- Services that may be billed through the claim wizard include the following:
  - Incontinence Supplies
  - Enteral Supplies
  - DME Rental
    - Oxygen Concentrator
    - Portable Gas
    - Airway Pressure Device
    - Humidifier
  - SNF – Skilled Nursing Facility Inpatient Room and Board only
- Via the claims wizard, providers may create a list of members that are provided reoccurring services, which will allow the provider to quickly create claims for those members and services without having to re-enter the information each time the service is billed.
- Additionally, the wizard can create claims for multiple members at the same.
- A tutorial on how to utilize the claims wizard can be found at Claim Wizard Guide (PDF).

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

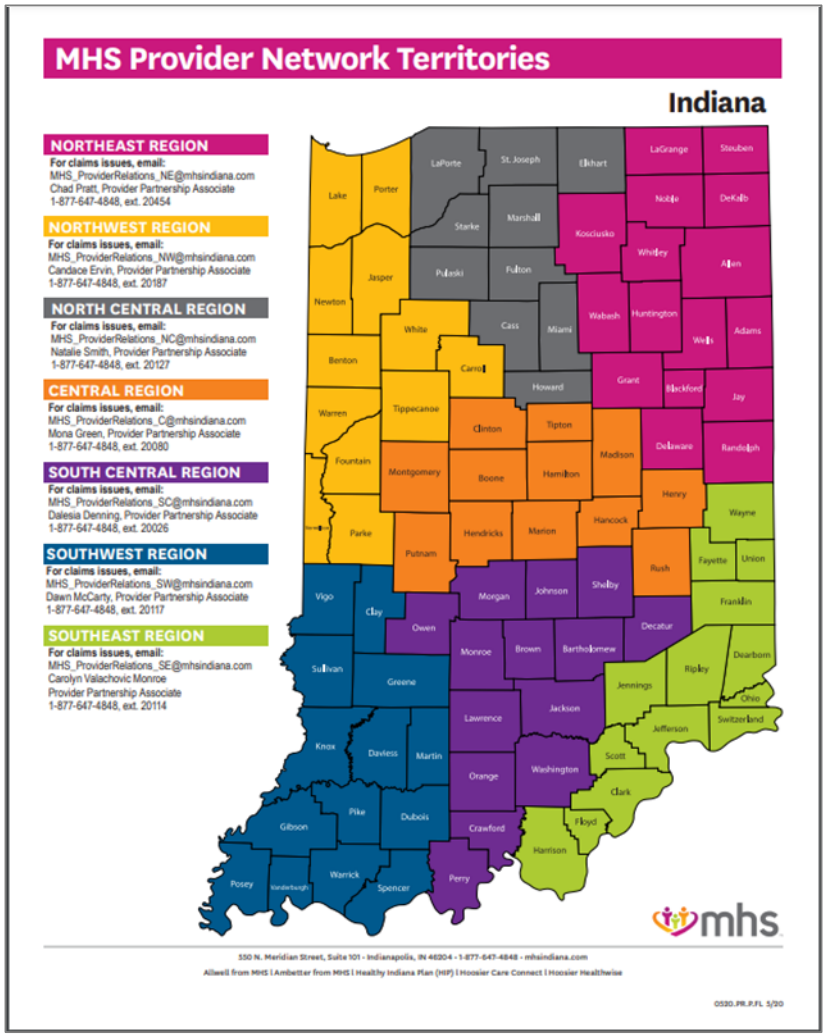
What is the Continuity of Care (CoC) Program?

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_2021.pdf

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MHS Provider Network Territories

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

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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

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Questions and Answers