Welcome to Managed Health Services (MHS)









Hoosier Care Connect







Agenda

- MHS Overview
- Claim Process
- Prior Authorization Process
- Coordinated Care Programs
- MHS Partnership
- Healthy Indiana Plan (HIP)
- Hoosier Care Connect
- Website Tools and Features
- Questions





About MHS

Managed Health Services (MHS) is a health insurance provider that has been proudly serving Indiana residents for two decades through Hoosier Healthwise (HHW), Healthy Indiana Plan (HIP) and Hoosier Care Connect. We provide coverage for doctor visits and immunizations, regular checkups, health screenings and other medical services. Our members include children, pregnant women and adults to age 64.

MHS also offers a qualified health plan through the health insurance marketplace call Ambetter from MHS. We provide healthcare that fits your needs, at a price that fits your budget. All of our plans include quality, comprehensive coverage with a provider network you can trust.

MHS is your choice for affordable health insurance.





MHS Provider Relations Team

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CLAIM PROCESS







Claim Process

- **EDI Submission**
 - Preferred method of claims submission
 - Faster and less expensive than paper submission
 - MHS Electronic Payor ID 68089
- 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 (rejections do not substantiate filing limit requirements)

- 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 newborn's RID #.
- TPL 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. If the third party does not respond within 90 days, claims may be submitted to MHS for consideration. Claims submitted must be accompanied by proof of filing with the patient's primary.





Claim Process – Billing with Ease

NPI, Tax ID, Zip +4, and Taxonomy

 This information is required for the system to make a one to one match based off of the information provided on the claim and the information loaded in the provider profile on Web interChange.

Member Information

Newborn's RID number is required for payment.

Consent Forms

 Need to be attached to the claim form when submitted for claim processing.

Secondary Claims

 Accepted electronically from vendors or via the MHS Secure Provider Portal.





Claim Process

Smoking Cessation

- 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.
- Counseling can be billed to MHS using CPT code 99407-U6.
 Counseling must be at least 10 minutes.





Claim Process

Claim Rejection

 A rejection is an unclean claim that contains invalid or missing data elements required for acceptance of the claim in the claim process system. The provider will receive a letter or a rejection report from their EDI vendor if the claim was submitted electronically.

Claim Denial

 A denial is a claim that has passed edits and is entered into the system but has been billed with invalid or inappropriate information causing the claim to deny. An EOP will be sent that includes the denial reason.





- UB-04 and CMS-1500 forms received that do not meet the CMS printing requirements will be rejected.
- Black and White CMS-1500 claim forms will reject.
- Handwritten claims will reject.

Dropping rejections to paper submissions may still result in claim rejections.





NDC information missing or invalid

- Services requiring NDC numbers must be billed with valid NDC numbers in the correct format in fields 24A to 24H.
 - Enter the NDC qualifier of N4
 - Enter the NDC 11 digit numeric code
 - Enter the drug description
 - Enter the NCD unit qualifier of F2 for international unit, GR for gram, ML for milliliter and UN units
 - Enter the NDC quantity (administered/billed amount) in the formation of 9999.99 (6 positions)
- CMS guidelines for billing NDC (nucc.org)
- A list of the procedure codes that require NDC is located on indianamedicaid.com. This list is updated quarterly.





- The provider identification and Tax ID numbers are missing or not on file with the health plan.
 - Verify that the rendering provider's NPI is entered on the claim in the lower half of box 24 J.
 - Verify that the provider's Tax ID number appears on the claim in box 25.
 - Verify the address located in box 33 is the provider's service location address with the complete 9 digit zip code.
 - Verify the group taxonomy is in box 33 B with the zz qualifier (required in some instances).
- EDI rejections require the provider to contact their clearinghouse and obtain a payer rejection report.
 - Paper to electronic mapping guide (EDI COB Mapping Guide) is available on mhsindiana.com/provider-guides.





Claim Submitted was Black and White or Handwritten

Corrected Claims

 CMS-1500 should be submitted with the appropriate resubmission code (value of 7) in field 22 of the paper claim with the original claim number of the corrected claim. EDI 837P, the data should be sent in the 2300 Loop, segment CLM05 (with value of 7) along with an addition loop in the 2300 loop, segment REF*F8* with the original claim number for which the corrected claim is being submitted.





Common Claim Denials

- Claim and Auth Service Provider Not Matching (EX HP)
 - Authorization on file does not match date of service billed.
- Claim and Auth Provider Specialty Not Matching (EX HS)
 - Authorization on file does not match provider billing service.





Common Claim Denials

- **Denied After Review of Patient's Claim History** (EX ya)
 - National Correct Coding Initiative (NCCI)
 - Developed by the Centers for Medicare and Medicaid.
 - Policies were developed using AMA's CPT guidelines, national professional association's recommendations, and common coding practices.
 - MHS utilizes HealthCare Insight (HCI) for NCCI reviews.
 - Denials are issued by a clinician.
 - Guidance and resources are available on cms.gov.





Claim Process – Billing with Ease

- **L6 Denials** Providers are required to submit claims to other insurance prior to billing MHS for members who have other insurance on file. In the event the other insurance fails to respond within 90 days of the billing date, the provider can submit the claim to MHS for payment consideration demonstrating the attempt to bill the other insurance. Previously, this documentation was required to be submitted as an attachment to the claim via the MHS web portal or via a paper claim.
- May submit claim via EDI. To complete the electronic submission simply complete the following steps:
 - Complete the COB loop on the 837P transaction as with any other electronic claim (see chapter 4 of the MHS Provider Manual for more information on the COB loop)
 - Indicate a paid amount of \$0.00 in the COB Paid Amount field
 - Document the phrase "No response after 90 days" in the claim note segment of the 837P





Claim Process

Resubmissions

- Hard copy or web submission
- Electronic adjustments through the web portal
- Hard copy resubmissions:
 - Clearly mark RESUBMISSION or CORRECTED CLAIM and original claim number at the top of the claim. 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.





Claim Process

Dispute Resolution

- Should be made in writing by using the Dispute/Objection form.
- Submit all documentation supporting your objection.
- Send to MHS within **67 calendar days** of receipt of the MHS EOP. Please reference the original claim number. Requests received after the timeline will not be considered.

Managed Health Services Attn: Appeals P.O. Box 3000 **Farmington, MO 63640-3800**

- MHS will acknowledge your appeal within 5 business days.
- Provider will receive notice of determination within 45 calendar days of the receipt of the Appeal.

A call to Provider Inquiry does not reserve appeal rights.





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 <u>payspanhealth.com</u>.
 - For questions call 1-877-331-7154 or email providersupport@payspanhealth.com.





PRIOR AUTHORIZATION PROCESS







REFERRAL

A referral is a request (verbal, written or telephonic communication) by a PMP for specialty care services.

PRIOR AUTHORIZATION

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

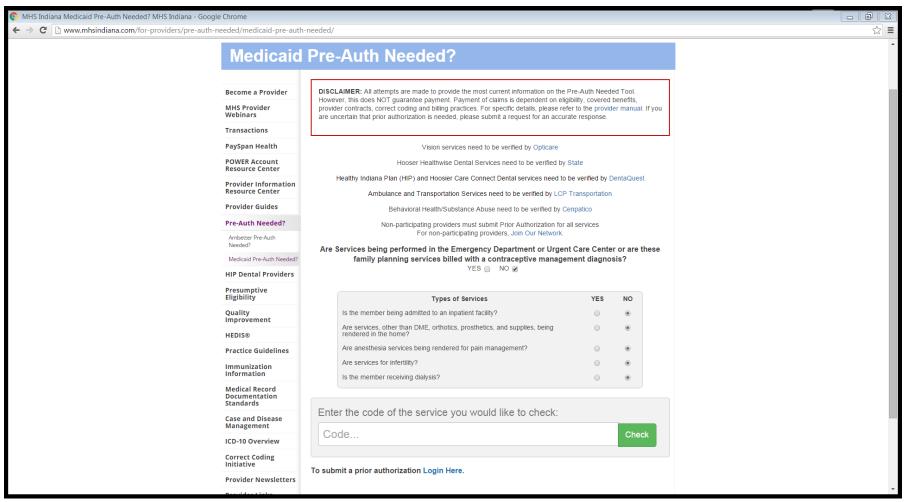




- Prior Authorization (PA) can be initiated through the MHS referral line at 1-877-647-4848.
 - The PA process begins at MHS by speaking with the MHS nonclinical referral staff.
- Prior Authorizations can be completed via fax.
- Prior Authorizations can also be submitted online via the MHS Secure Provider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











To initiate an authorization, referral staff will require the following information:

- Place of service: outpatient, observation or inpatient
- Service type: elective, emergent or transfer
- Service date
- Name of admitting physician
- CPT code for proposed services
- Primary and any secondary diagnosis
- Contact name and number to obtain clinical information





- All elective inpatient/outpatient services must be prior authorized with MHS at least 2 business days prior to the date of service.
- All urgent and emergent services must be 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.





Services that require a prior authorization regardless of contract status:

- Experimental or investigational treatment/services
- Cardiac rehabilitation
- Hearing aids and devices
- Home care services
- Implantable devices including cochlear implants
- In-home infusion therapy
- Cholecystectomies
- Hysteroscopy and Hysterectomy
- Genetic testing
- Quantitative drug screening
- Nutritional counseling (non-diabetics only)
- Pain Management Programs including epidural, facet and trigger point injections
- PET, MRI, MRA and Nuclear Cardiology/SPECT scans
- Scar revision/cosmetic or plastic surgery/Septoplasty/Rhinoplasty/spider and/or varicose vein treatment
- Therapies, excluding evaluations and members 21+ years of age
- Orthotics and prosthetics >\$250
- Certain DME services





- The MHS CM will review all available clinical documentation; apply Milliman Care Guidelines, and seek Medical Director input as needed.
- PA for Observation Level of Care (up to 72 hours) is not required in contracted facilities. That includes Ancillary services such as x-rays, scans and labs.
- If the provider requests an inpatient level of care for a covered/eligible condition/procedure and documentation supports an outpatient/observation level of care, the case will be sent for a Medical Director review.





Denial and Appeal Process

If MHS denies the requested service:

- MHS CM will notify the provider verbally within one business day of the denial, provide the clinical rationale, and explain appeal rights.
- A formal letter of denial further explaining rationale and appeals rights will be mailed within the next business day.
- If denial is based on Milliman Care Guidelines, provider has right to obtain a copy of the guidelines in which denial is based.
- If member is still receiving services, the provider has the right to an expedited appeal which must be requested by the attending physician.
- If the member is already discharged, an appeal must be submitted in writing from the attending physician within 33 days of the denial.
- The attending physician has the right to a Peer-to-Peer discussion.
- Peer-to-Peer discussions and Expedited Appeals are initiated by calling the MHS Appeal Coordinator at 1-877-647-4848.





MEDICAL NECESSITY GRIEVANCE AND APPEALS

Managed Health Services
Attn: Appeals Coordinator
1099 North Meridian Street, Suite 400
Indianapolis, IN 46204

- Determination will be communicated to the provider within 20 business days of receipt.
- Remember: Appeals must be initiated within 33 days of the denial to be considered. Please note, this is different than a claim appeal request.





COORDINATED CARE PROGRAMS







Specialized Health Programs

MHS has several programs designed to help improve the health of its members through education and personal assistance by our staff including:

- Pregnancy
- Diabetes
- Asthma
- **COPD**
- **Coronary Artery Disease**
- Chronic Kidney Disease
- Congestive Heart Failure
- Lead
- **Behavioral Health**
- Depression
- Hypertension
- **ADHD**
- Autism & Autism Spectrum Disorders
- Children with Special Needs Unit
- Special Healthcare Needs







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.





MHS Start Smart for Your Baby & **Special Deliveries**

MHS offers two educational care management programs for MHS members who are pregnant called Start Smart for Your Baby and MHS Special Deliveries. These programs are designed to match a pregnant member with an OB Nurse Care Manager, who can help the member receive proper care throughout her pregnancy as well as after she delivers.

MHS OB Nurses can:

- Help you understand what is happening to your body during the pregnancy.
- Talk about problems that may come up during your pregnancy.
- Talk about what to do if you have complications during your pregnancy.
- Help you make doctor appointments or schedule a free ride to the doctor's office.
- Help you get a free cell phone if you need one. You can use this phone to reach your doctor, family and other important people while you are pregnant.
- Help you guit smoking or using tobacco.
- Help you find more ways to earn CentAccount© rewards by going to your OB doctor visits.
- Answer any other questions about your health and the health of your baby.

^{*}By participating in either program, members will be eligible to earn more CentAccount rewards.





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.

We 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 CentAccount rewards.





Children with Special Needs Unit

Designed to support coordination of care for children with chronic conditions, children enrolled in the program receive care management services by a dedicated team of MHS doctors, nurses, social workers and care coordinators, specializing in the healthcare needs of children.

This includes conditions such as:

- Cerebral palsy
- Cystic fibrosis
- Developmental disabilities
- **Autism**
- Traumatic brain injuries
- Congenital syndromes with significant developmental delays
- Other special healthcare needs





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
 - one hospital





MHS PARTNERSHIP







Provider Administration

Adding a new provider

- Practitioner must have Indiana Medicaid ID linked to group before MHS credentialing and set up process can begin.
- The IHCP MCE Enrollment form is utilized.
- Contact Provider Relations at 1-877-647-4848 to obtain Participating Physician Attestation document which links practitioner to existing contract.
- Once set up is complete, a Welcome Letter is provided.
- Important: Prior to confirmation of contract status, obtain a Prior Authorization or bill "Incident To" for all services rendered to MHS members to ensure claim payment.





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 disensollment requests
- Panel full/hold requests
- New member tool kits
- Member QRG





Transportation

MHS HHW, Hoosier Care Connect*, HIP State Plan and Pregnant HIP Members can get UNLIMITED free rides to and from:

- **Doctor visits**
- Medicaid enrollment visits
- Pharmacy visits (after a doctor's visit)

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

^{*}Hoosier Care Connect members have unlimited transportation services, but may have a required copay of \$1 each way/\$2 round-trip.





Translation Services

- Available to MHS members and 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).





MemberConnections®

- Takes the health plan to the member and promotes preventive health
- Acts as link between member and care coordination programs
- Coordinates events for non-compliant members
- Conducts member education
- Provides community resource information
- Referral form is available on website
- Fax back correspondence to provider





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.







Culturally and Linguistically Appropriate Services (CLAS)

CLAS refers to healthcare services that are respectful of and responsive to the cultural and linguistic needs of patients.

Visit <u>mhsindiana.com</u> provider guides page for a brochure about CLAS standards.





Earn Rewards with Preventive Care MHS CentAccount® Healthy Rewards Program

MHS will reward members' healthy choices through our CentAccount Healthy Rewards program. Members can earn dollar rewards by staying up to date on preventive care.

These rewards will be added to a CentAccount card that can be used to buy things like healthy groceries, baby items and clothing as well as over-the-counter drugs (allergy, cold meds, etc.).

Members can use their CentAccount card at a select number of retailers including Walmart, Meijer, RiteAid, Dollar General and Family Dollar.





PHARMACY







Pharmacy Benefits (HIP/Hoosier Care Connect only)

Pharmacy - High-Level Overview

- Managed Health Services (MHS) has contracted with US Script to provide appropriate, high quality, and cost effective drug therapy to MHS HIP members.
 - US Script will handle call inquiries for provider and pharmacies: 1-855-772-7121 or usscript.com/contact
 - For prior authorization questions providers should contact 1-855-772-7125 or usscript.com/contact
 - Acaria will handle specialty pharmacy: 1-855-678-6976 (fax)
- MHS works with providers and pharmacists to ensure that medications used to treat a variety of conditions and diseases are covered. MHS covers prescription medications and certain over-the-counter medications when ordered by an MHS provider. The pharmacy program does not cover all medications. Some require Prior Authorization or have limitations on age, dosage, and maximum quantities.
- Reminder: Hoosier Health Rx Benefits are coordinated through Catamaran.





Preferred Drug List

- Preferred Drug Lists can be found on the MHS website at mhsindiana.com/for-providers
- Contact Pharmacy Benefit Manager (PBM) *US SCRIPT* for approval for drugs that require a PA
- PA forms can be found on website at mhsindiana.com
- Confirmation via fax
- Denials only made by PharmD



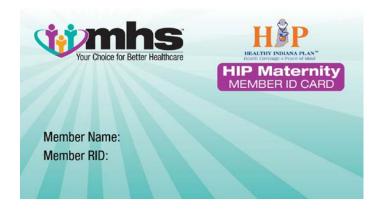


HEALTHY INDIANA PLAN (HIP)

HIP POWER Account



HIP Maternity ID Card







HIP 2.0: Plan Options



- •Initial plan selection for all members
- •Benefits: Comprehensive, including vision and dental
- Cost sharing:
- Must pay affordable monthly POWER account contribution: Approximately 2% of member income, ranging from \$1 to \$100 per month
- No copayment for services*

HIP Basic

- Fall-back option for members with household income less than or equal to100% FPL only
- •Benefits: Meet minimum coverage standards, no vision or dental coverage
- •Cost sharing:
- •May not pay one affordable monthly POWER account contribution
- •Must pay copayment for doctor visits, hospital stays, and prescriptions

HIP State Plan

- Individuals who qualify for additional benefits
- Benefits: Comprehensive, with some additional benefits including vision and dental
- Cost sharing:
 - •HIP Plus OR HIP Basic cost sharing

HIP Link

•To help member pay for employer-sponsored health insurance

*EXCEPTION: Using Emergency Room for routine medical care





HIP 2.0: Overview

- Personal Wellness and Responsibility (POWER) Account combination of member and state contributions covers first \$2,500 of health care services received each year.
 - Members pay a portion, as low as \$1 per month
- Members who don't pay monthly contributions face penalties
 - If income is over 100% FPL (up to \$1,378/mo. for an individual)
 - Member is subject to a 6 month lockout period in which they may not receive HIP benefits
 - If income is under 100% of FPL (up to \$973/mo. for an individual)
 - Member receives reduced benefits and must make copayments each time they receive a health service (HIP Basic)
 - Failure to pay the monthly contribution makes receiving health care more expensive for the member





HIP 2.0: State Plan

- Available for certain qualifying individuals
 - Low-income (<19% FPL) Parents and Caretakers
 - Low-income (<19% FPL) 19 & 20 year olds
 - Medically Frail
 - Transitional Medical Assistance (TMA)
- Benefits equivalent to current Medicaid benefits
 - All HIP Plus benefits covered with additional benefits, including transportation to doctor appointments
 - State Plan benefits replace HIP Basic or HIP Plus benefits
 - State Plan benefits are the same, regardless of HIP Basic or HIP Plus enrollment
- Keep HIP Basic or HIP Plus cost sharing requirements
 - HIP State Plan Plus: Monthly POWER account contribution
 - HIP State Plan Basic: Copayments on most services





HIP Plus Contributions Are Not Premiums

- Unlike premiums, members own their contributions
- If members leave the program early with an unused balance, the portion of the unused balance they are entitled to is returned to them.
 - Members reporting a change in eligibility and leaving the program (e.g. move out of state) will retain 100% of their unused portion
 - Members leaving for non-payment of the POWER account will retain 75% of their unused portion
- If members leave the program early but incurred expenses, they may receive a bill from their health plan for their remaining portion of the health expenses.
- Members remaining in the program may be eligible to receive a rollover of their remaining contributions.
 - Rollover is applied to the required contribution for the following year





HIP Basic: Copays

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 making the below copayments for health and pharmacy services.

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

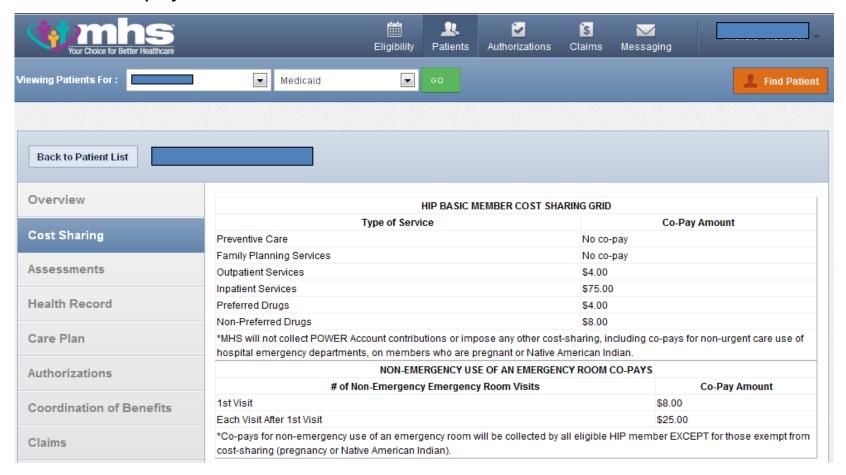
Service	HIP Basic Co-Pay Amounts <=100% FPL
Outpatient Services (including office visit)	\$4
Inpatient Services	\$75
Preferred Drugs	\$4
Non-preferred drugs	\$8
Non-emergency ER visit	Up to \$25





HIP Basic: Copays

Member copay information is available on the MHS Secure Provider Portal.







Pregnancy Benefits

Pregnant women receive benefits only available to pregnant women, regardless of selected HIP plan. (Members must notify the DFR or MHS when they become pregnant.)

- Exempt from cost sharing
- Additional benefits continue for a 2 month post-partum period

Additional Benefits Include:

Vision

Dental

Non-emergency transportation

Chiropractic





HIP Coverage for Pregnant Women

Woman becomes pregnant while enrolled in HIP

- HIP member becomes pregnant
- Additional pregnancy-only benefits begin
 - No cost sharing during pregnancy/post-partum period
 - OPTION: May request to move to HIP Maternity (MAGP)

Woman is pregnant at application or redetermination

- Woman eligible for HIP 2.0 and is pregnant at the time of application or at her annual redetermination will receive HIP Maternity (MAGP)
 - No cost sharing during pregnancy/post-partum period
 - May have coverage gap when reentering HIP after pregnancy if end of pregnancy not reported on time

RECOMMEND:

Report end of pregnancy promptly to guarantee continued HIP coverage without a gap.





POWER Account Card Overview

- Serves as the member ID card.
- Providers can use it like a debit card for real-time Point of Service payments.
- Members are instructed to present to provider at time of service.
- Mailed to member as soon as they become fully eligible for HIP.
- Maintains a \$0.00 balance until funded through POWER Account Funds Calculator.
- Contains the following info:
 - The member's RID, to allow the provider to check eligibility
 - RX BIN #, for the pharmacy to know how to charge for Rx
 - A statement indicating the card cannot be used for member copays
 - MHS contact information





POWER Account Card

Use the POWER Account card as you would any debit or credit card to collect real-time payment at Point of Service.







How the POWER Account Card Works

- The card is funded in real-time for the specific claim amount through the MHS POWER Account Funds Calculator tool.
- The amount loaded onto the card is the portion of the first \$2,500 of covered services for the HIP member.
- Once the card is loaded with the appropriate claim amount, the provider can swipe the card to pay for covered services in real-time.

*The POWER Account card cannot be used for member co-payments, preventive services or facilities services (services billed on a UB04 form).





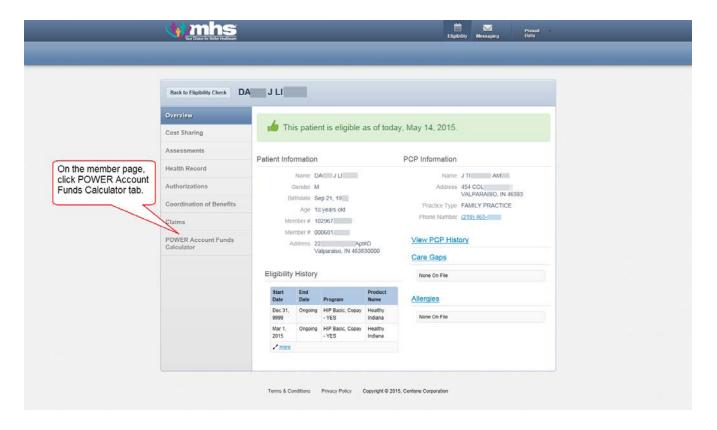
How the POWER Account Funds Calculator Tool Works

- Provider logs into the MHS Secure Provider Portal *Requires a provider portal registration account.
- Provider launches POWER Account Funds Calculator.
- Provider agrees to terms of use.
- Provider inputs required fields into the calculator.
- The calculator is programmed based on the HIP reimbursement manual.
- The calculator will only return lower of POWER Account balance or the lowest reimbursement amount for a specific code.
- Real-time funding will only occur when:
 - The provider agrees to terms of the transaction.
 - The provider confirms the 'fund card' button during the transaction.





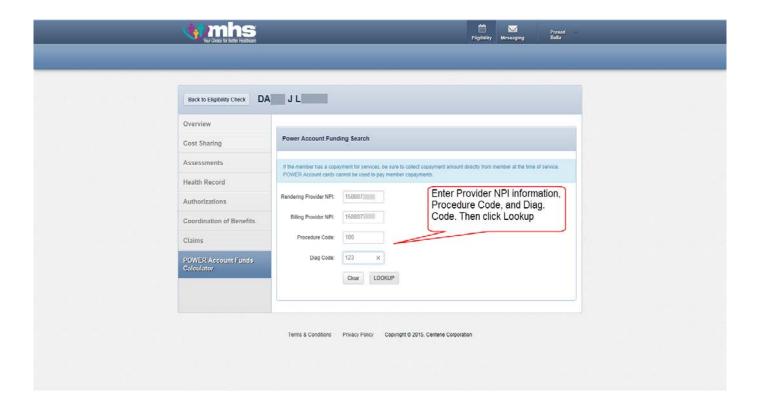
After Eligibility Confirmation, click on the 'POWER Account Funds Calculator' to begin transaction.







Enter the required fields and click "Lookup" to confirm the approved amount to fund the POWER Account card.







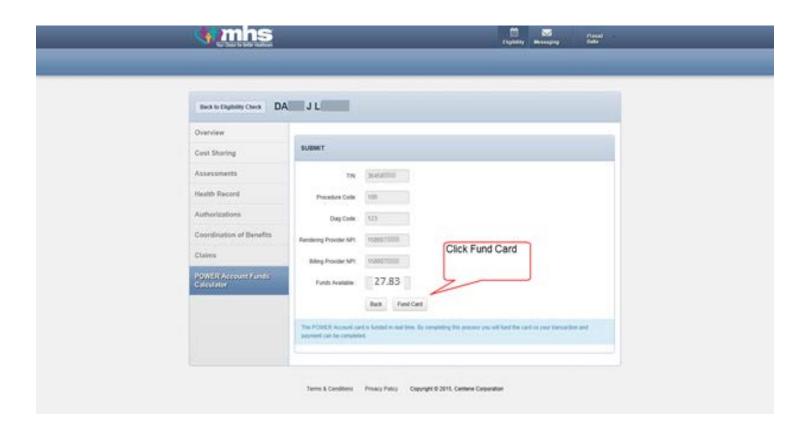
The approved amount to fund the card appears in the "Funds Available" field.

Eligibility Patients Authorizations Claims Messaging ✓ Medicaid Viewing Patients For: ~ Find Patient Back to Patient List Approved amount that will be applied Overview to the card in real SUBMIT Cost Sharing time. Assessments 351325628 Health Record Procedure Code: 76817 thorizations Diag Code: Coordination of Benefits Rendering Provider NPI Claims Billing Provider NPI: 555555555 POWER Account Funds Funds Available 27.83 Calculator Fund Card Back The POWER Account card is funded in real time. By completing this process you will fund the card so your transaction and payment can be completed.





Confirm Funding!







Important Notes

- This tool can only be used for office visit services.
- Providers are still required to submit a claim. MHS will recoup funds if a claim is not filed.
- MHS encourages Providers to submit claims within 45 days of date of service to avoid potential recoupment issues.
- *Provider must acknowledge in Box 29 of the CMS 1500 claim form that a portion of the claim has been paid (this could be the POWER Account Contribution or copayment or both). If the amount funded is not in box 29 your claim may be overpaid and will be subject to recoupment.
- This tool is only intended for HIP members and cannot be used for other Indiana Medicaid programs.
- The POWER Account card cannot be used for member co-payments, preventive services or facilities services (services billed on a UB04 form).

*If your clearing house or internal billing system will not allow you to input required information in Box 29, claims must be submitted through the MHS online secure portal.





Point of Service Payment Exceptions

Potential Error Codes & Messages:

- The Calculator will return a \$0.00 for ACA preventive services and for non-covered services.
 - Return message "Preventive Services Diag. Codes are not eligible"
- If the member's POWER Account has already exhausted the initial \$2500 amount, transaction will not process.
 - Return message "POWER Account Exhausted No Funds Available"
- If a provider has already billed for the requested claim against the member's initial \$2500 POWER Account funds the transaction will not process.
 - Return message "Funds Previously Requested No Additional Funds Available"
- If an incorrect claim code is entered, the transaction will not process.
 - Return message "Unable to Calculate Available Funds Given Info Provided"

Important note: MHS will recoup the funded payment from future claims when:

- the card is funded and a claim is not received to match the funded amount.
- the claim denies for payment.





HOOSIER CARE CONNECT







About Hoosier Care Connect

Who is covered?

- Aged (65+)
- Blind
- Disabled
- Individuals receiving Supplemental Security Income (SSI)
- M.E.D. Works enrollees





About Hoosier Care Connect

Included Benefits

State Medicaid Benefits including:

- Primary Care
- Acute Care
- Emergency Services

Carve-Outs

- Medicaid Rehabilitation Option Services (MRO)
- 1915(i) State Plan Home and Community Based Services
- First Steps
- Individualized Education Plans





Health Needs and Comprehensive Health Assessment

- Health Needs Assessment is used to assess members to identify their need for care coordination services.
 - Completed by MHS within 90 days of enrollment.
 - Online or via phone
 - Comprehensive Health Assessment
- Complete Health Assessment within 150 days of enrollment for members identified during Health Needs Screening.
 - Identifies the psychosocial, functional and financial needs of the member.
 - Incorporates family, caregiver and provider input to identify the member's strengths, needs and available resources.





MHS Care Coordinator

All MHS members enrolled in Hoosier Care Connect will be matched with an MHS Care Coordinator. This Care Coordinator will work with the member to identify potential barriers or issues related to their health care needs, as well as address goals, objectives and interventions to meet the needs of the individual.







MHS WEBSITE







MHS Website

- mhsindiana.com
- Provider directory search functionality
- 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







Login

Contact Us Newsroom Community Events Careers

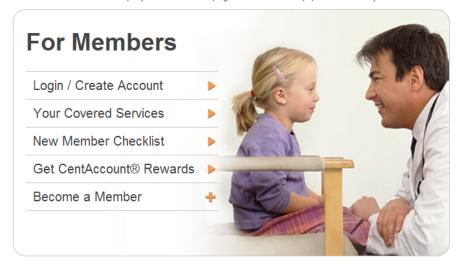
Find a Provider

Search [español]

For Members

For Providers

MHS is an insurance company that has been helping Indiana's Medicaid population for nearly two decades.



For Providers

Login

Join Our Network



from MHS

Make Ambetter Your Health Insurance Partner Today!

Learn More

Featured Items



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Ambetter

Introducing Ambetter from MHS Indiana.



Understanding the ACA

A guide to the Affordable Care



Get Emails from MHS

Member and Provider updates to your inbox.



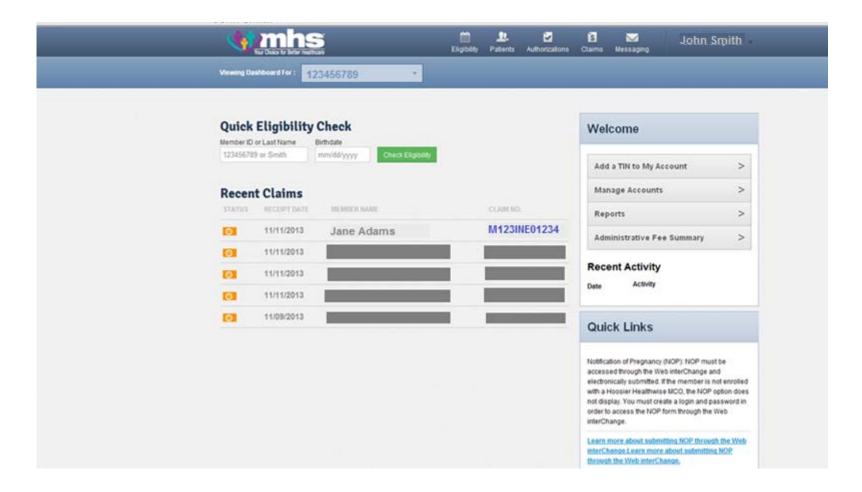
Health Library

Access more than 4.000 topics relating to health and me...





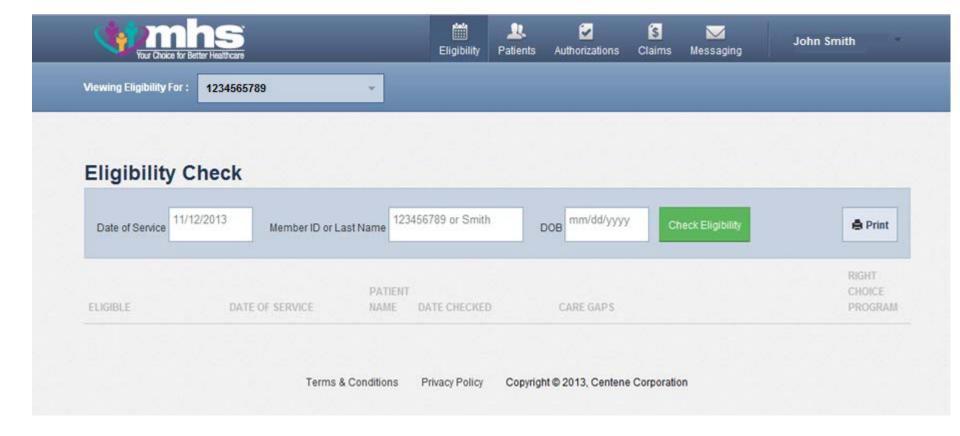
MHS Provider Portal Home Page







MHS Member Eligibility Check

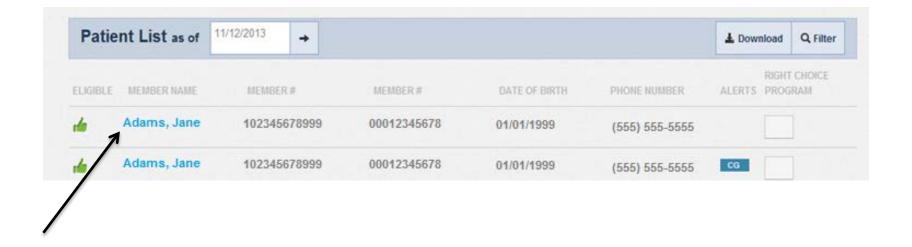






Individual Patient Overview

 In the patient list, you can click on a member's name to open the Individual Patient Overview.







MHS Secure Portal Features

- Access for both contracted and non-contracted groups
- Online registration multiple users
- Enhanced claim detail
- Direct claim submission
- COB processing with or without attachments
- Claim adjustment
- Claim auditing tool
- Direct claim submission
- Prior authorization
- Eligibility and COB verification
- Pay For Performance reporting
- Care Gaps
- Online Health Record Vault for "your" patients (includes specialty care)
- Care Management Plan





QUESTIONS AND ANSWERS

