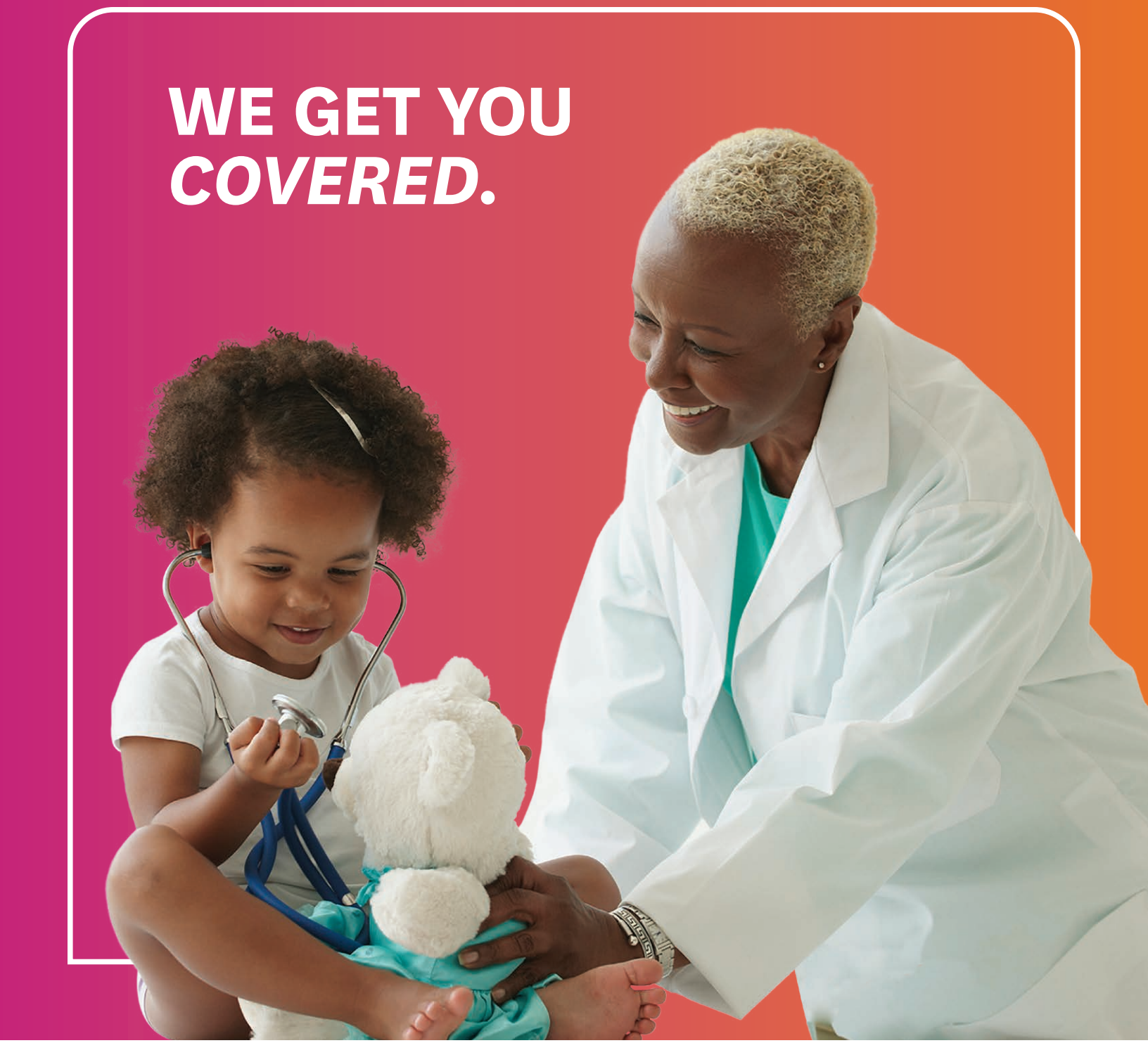

Provider Manual

2025

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Chapter 1: Managed Health Services (MHS)

Managed Health Services (MHS) is a managed care entity (MCE) that has contracted with the State of Indiana to serve Medicaid recipients enrolled in:

- **Healthy Indiana Plan (HIP)** – an affordable healthcare program created by the State of Indiana to cover adults ages 19 to 64 whose income is up to 138% of the Federal Poverty Level (FPL).
- **Hoosier Healthwise (HHW)** – the State of Indiana's Medicaid program for children and pregnant members in Package A and children under age 19 in Package C.
- **Hoosier Care Connect (HCC)** – the State's program for Indiana Medicaid enrollees who are aged, blind, or disabled and who are not Medicare eligible and do not have an institutional level of care. Members who are currently or formerly in foster care, receiving adoption assistance, or are Wards of the State may also opt in to receive Hoosier Care Connect coverage.

The State of Indiana's Family and Social Services Administration's (FSSA) department administers these State and Federal benefit plans through the Indiana Health Coverage Programs (IHCP).

The FSSA Office of Medicaid Policy and Planning (OMPP) efficiently and effectively administers Medicaid programs for the State of Indiana. OMPP's suite of programs, called the Indiana Health Coverage Programs, includes traditional Medicaid, risk-based managed care and a variety of waiver services tailored to the needs of specific populations. For questions and/or updates, please call the FSSA office at 800-403-0864 and the OMPP office at 317-233-4455 or write to 402 W. Washington St, Room W392, P.O. Box 7083, Indianapolis, IN 46204.

Our Goals

MHS' top priority is to promote healthy lifestyles through preventive healthcare. MHS works to accomplish this goal by partnering with Primary Medical Providers (PMPs) who oversee the healthcare of MHS members as the members' "medical home."

MHS programs are designed to achieve the following:

- Ensure access to primary and preventive care services
- Improve access to all necessary healthcare services
- Encourage quality, continuity and appropriateness of medical care
- Provide medical coverage in a cost-effective manner

Centene

MHS is a wholly-owned subsidiary of Centene Corporation, a Fortune 500 company and leading multi-line healthcare enterprise that provides programs and related services to individuals receiving benefits under Medicaid, including Supplemental Security Income (SSI) and the State Children's Health Insurance Program (SCHIP).

mhsindiana.com and the MHS Secure Provider Portal

The Provider Section of the MHS website offers many useful features and information on the latest developments regarding IHCP.

Providers may register online to access MHS' Secure Provider Portal, where you can:

- Manage multiple practices under one account
- Check member eligibility
- View member panels
- View medical history and gaps in care
- Submit/check authorizations
- Submit/check/adjust claims
- Submit claims in batch
- Access explanation of payments
- View HEDIS Pay for Performance Reports
- Communicate electronically with MHS
- Process, view claims and prior authorization appeals

Email

MHS will send you bi-weekly and quarterly newsletters from communications@mhsindiana.com, information on the latest developments regarding IHCP programs and other pertinent topics. You may request to opt out of any or all mass email communications from MHS at any time. You can reach us electronically by using the "Contact Us" form at mhsindiana.com/contact-us.

Contact Us

You can reach MHS toll-free at 1-877-647-4848. For assistance with speech or hearing disabilities, please call the Relay Indiana TDD/TTY phone number at 1-800-743-3333. Our Member Services & Provider Services phone line is open Monday - Friday from 8 a.m.-8 p.m. ET. You may also reach us through our Secure Provider Portal messaging feature. All inquiries will be responded to within one business day. Our address is 429 N. Pennsylvania St. Suite 109, 46204. Please note, we cannot accept claims at this address. Please refer to Chapter 4 for the correct mailing address.

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Chapter 2: Guidelines for Providers

All MHS providers are required to comply with the requirements of their contract agreement, as well as policies and guidelines outlined in this manual. Providers must act in such a manner that ensures members receive their member rights and are held to their responsibilities.

The Medical Home

The Primary Medical Provider (PMP) serves as the medical home for the member. The medical home concept assists in establishing a member-provider relationship and ultimately leads to better health outcomes. As such, specialists are required to coordinate the member's care with the PMP, including providing the PMP with consult reports and other appropriate records in a timely manner. MHS encourages specialists to work through a PMP rather than directly with another specialist. This allows the PMP to better coordinate a member's care and to ensure the referred specialist is in the MHS network.

Referrals and Prior Authorization

MHS does not track provider referrals, however, PMPs are encouraged to refer members to other practitioners when medically-necessary services are beyond their scope of practice. Guidelines for prior authorizations by MHS are outlined in Chapter 7.

Covered Services

Provider groups shall arrange for all participating physicians to provide members with covered services with the same care and attention provided to all patients. Each participating physician shall provide covered services in accordance with all generally accepted clinical, legal and ethical standards and in a manner consistent with physician licensure, qualifications, training and experience within the standards of practice for quality care generally recognized within the medical community in which the physician practices. The members' covered services are specific to their benefits for a specific program. For a list of member benefits by program, please refer to Chapter 15.

Provider Assistance with Public Health Services

MHS is required, through its contractual relationship with OMPP, to coordinate with public health entities regarding the provision of public health services. Providers must assist MHS in these efforts by:

- Complying with public health reporting requirements regarding communicable diseases and diseases which are preventable by immunization as defined by State law.
- Assisting with the notification of, or referral to the local public health entity, any communicable disease (as defined as State law) outbreaks involving members.
- Referring of persons with whom the member has come into contact to the local public health entity for tuberculosis contact investigation, evaluation and preventive treatment.
- Referring of persons with whom the member has come into contact to the local public health entity for sexually-transmitted infection (STI) and human immunodeficiency virus (HIV) contact investigation, evaluation and preventive treatment.
- Referring for Women, Infant and Children (WIC) services and information sharing as appropriate.
- Assisting in the coordination and follow up of suspected or confirmed cases of childhood lead exposure.

Early and Periodic Screening, Diagnostic and Treatment (EPSDT)

The Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program is Indiana's comprehensive preventive services program available to Medicaid members under 21 years of age. PMPs are expected to perform EPSDT health examinations and screenings in their entirety and recommended screenings at the required intervals as outlined in the Periodicity Schedule. All components of the exam must be documented and included in the medical record of each eligible member. In addition, EPSDT services include the provision of medically necessary services to members less than 21 years old in institutions of mental disease (IMDs).

More information about the EPSDT program can be found in Chapter 10. For complete guidelines, please refer to the EPSDT Provider Manual at in.gov/medicaid/providers/files/epsdt.pdf.

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. The online form simplifies the process of completing paperwork to document pregnancies, evaluating potential complications.

Providers completing the online NOP form in a timely manner will receive an incentive of $60 per notification. The process consists of four (4) questions to be completed online with first OB visit once member is effective with Medicaid. Reimbursement is obtained by billing G9997 with modifier TH:

- G9997 – Documentation of patient pregnancy anytime during the measurement period prior to and including the current encounter.
- TH – Obstetrical treatment/services, prenatal or postpartum on claim form: in.gov/medicaid/providers/clinical-services/notification-of-pregnancy-nop. Additionally, the form must be valid - meaning it is a non-duplicative form, the pregnancy is less than 30 weeks gestation, and a valid MID number is included.

Service Carve-outs

While MHS retains responsibility for the delivery and payment of most care for its members, certain services are the financial responsibility of the State and are reimbursed on a fee-for-service basis, commonly referred to as "carved-out" services.

- **Medicaid Rehabilitation Option (MRO) Services**
  MHS is not responsible for claims reimbursement for such services. However, MHS is responsible for ensuring care coordination with physical and other behavioral health services for individuals receiving MRO services. Associated services related to MRO services include, but are not limited to, transportation.
- **1915 (i) State Plan Home and Community-Based Services**
  The State has three State Plan Home and Community-Based services programs: Behavioral and Primary Healthcare Coordination (BPHC), Adult Mental Health and Habilitation (AMHH) and Children's Mental Health Wraparound (CMHW). These services are carved-out of MHS' financial responsibility. MHS coordinates with these services to prevent duplication and fragmentation of services.
- **1915 (c) State Plan Home and Community Based Waiver Services**
  The State has the following programs: Traumatic Brain Injury, Aged & Disabled, Community Integration and Habilitation and Family Supports. These services are carved-out of MHS' financial responsibility. MHS coordinates with these services to prevent duplication and fragmentation of services. Note: For HIP members, Behavioral and Primary Healthcare Coordination (BPHC) are carved-out. Individuals eligible to receive BPHC services who are otherwise eligible for a HIP eligibility category will remain enrolled with MHS but MHS shall not be financially responsible for reimbursement of the BPHC service. MHS coordinates with these services to prevent duplication and fragmentation of services.
- **Individualized Family Services Plan (IFSP) Services**
  IFSP services provided to HHW and HCC members under the FSSA First Steps program are carved-out from MHS' responsibility.
- **Individualized Education Plan (IEP) Services**
  IEP services provided to Hoosier Healthwise and Hoosier Care Connect members by a school are carved-out.
- **First Steps Services**
- **Comprehensive Environmental Lead Investigation**
  All comprehensive environmental lead investigation services are carved-out of managed care, which means these services will be reimbursed through the fee-for-service (FFS) delivery system.
- **Designated Physician-Administered Drugs**
  Listed in Physician-Administered Drugs Carved-Out of Managed Care and Reimbursable Outside the Inpatient Diagnosis-Related Group, accessible from the Code Sets page at in.gov/medicaid/providers.
- **Pharmaceutical drugs including**
  Hepatitis C drugs; Cystic fibrosis drugs Kalydeco, Orkambi, and Symdeko; Exondys 51; Spinraza

Pharmacy

MHS is committed to providing appropriate, high-quality, and cost-effective drug therapy to all MHS members. 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 (OTC) medications when ordered by an Indiana Medicaid enrolled MHS practitioner. The pharmacy program does not cover all medications. Some medications require prior authorization (PA) or have limitations on age, dosage, gender and maximum quantities. MHS encourages the use of electronic prescriptions or e-prescribing.

Excluded Benefits - Hoosier Care Connect

The following excluded benefits are available under traditional Medicaid:

- **Long-Term Institutional Care**: MHS may obtain services for its members in a nursing facility setting on a short term basis, defined as fewer than 30 calendar days. MHS is responsible for up to 60 days while the LOC determination is pending. This may occur if this setting is more cost-effective than other options and the member can obtain the care and services needed in the nursing facility. MHS may negotiate rates for reimbursing the nursing facilities for these short-term stays. If a member admitted to a nursing facility for a short term stay remains in the nursing facility for more than 30 days, MHS shall notify the State or its designee, in the timeframe and format required by FSSA. MHS may request disenrollment of a member in these cases, which shall be determined in FSSA's sole discretion.
- **Psychiatric Treatment in a State Hospital**: The state hospital system serves adults with mental illness (including adults who have co-occurring mental health and addiction issues, who are deaf or hearing impaired, and who have forensic involvement), and children and adolescents with serious emotional disturbances.
- **Psychiatric Residential Treatment Facility (PRTF) Services**: HCC members who are admitted to a PRTF will have their enrollment with MHS suspended. As part of the discharge planning process the PRTF will evaluate the member for transition to the Money Follows the Person (MFP) Grant. If MFP enrollment is not appropriate or accessible, the member will be re enrolled with MHS upon PRTF discharge. In these cases, MHS will work with the PRTF on discharge planning.
- **Intermediate Care Facilities for Individuals with Intellectual Disabilities**: HCC members who are admitted to an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) shall be disenrolled from the Contractor and enrolled in traditional Medicaid. Before the stay can be reimbursed by the IHCP, the level of care must be approved by the State. The Contractor must coordinate care for its members that are transitioning into an ICF/IID by working with the facility. The Contractor is responsible for payment for up to 60 calendar days for its members placed in an ICF/IID while the level of care determination is pending.
- **Home and Community Based Services (HCBS) Waiver**: Individuals who have been approved for these waivers will be disenrolled from managed care. MHS will coordinate care for its members that are transitioning into the waiver.
- **Hospice**: HHW members who are admitted to Hospice shall be disenrolled from managed care. MHS will coordinate care for its HHW members that are transitioning into hospice by providing to an IHCP hospice provider any information required to complete the hospice election form for the Contractor's terminally ill members desiring hospice, as described in the IHCP Hospice Provider Manual.

Availability and Accessibility

Each participating provider shall maintain sufficient facilities and personnel to provide covered services and shall ensure such services are available as needed 24 hours a day, 365 days a year. Each participating provider shall see MHS members during hours of operation that are no less than those offered to patients with commercial coverage. MHS will monitor appointment and after-hours availability on an annual basis through our Quality Improvement program.

Appointment Availability

The following are OMPP minimum standards for Medicaid member appointment availability and are required for MHS network providers:

APPOINTMENT TYPE	APPOINTMENT TIME FRAME
Urgent or emergent care	24 hours
Non-urgent symptomatic	72 hours
Routine physical exam	Three months
Initial appointment (non-pregnant adult)	Three months
Routine gynecological exam	Three months
New obstetrical patient	Within one month of attempting to schedule
Initial appointment well-child	Within one month of attempting to schedule
Children with special needs	One month
Average office wait time	Equal to or less than one hour
Specialist referral – Emergency	24 hours
Specialist referral – Urgent	48 hours
Non-life threatening behavioral health emergency	Six hours
Urgent behavioral health care	48 hours
Initial behavioral health appointment	10 business days

After-Hours Telephone Accessibility Arrangement

PMPs must have a mechanism in place to offer members direct contact with their PMP, or the PMP's qualified clinical staff person, through a toll-free telephone number 24 hours a day, seven days a week and generally meet all State requirements. PMPs must provide "live voice" coverage after normal business hours. Acceptable options are:

- Direct answer by PMP or qualified clinical staff designee
- Answering Service or Pager – all calls returned in 30 minutes
- Recorded Message – instructs member to call another number to reach PMP, on-call physician, or nurse helpline
- Phone transfer to another location that will have PMP or designee return a call within 30 minutes

To be considered compliant, PMPs must also provide instruction for life threatening situations in all of the situations above. The PMP must provide appropriate direction to the member to contact 911 or the nearest emergency department.

The following are considered unacceptable after-hours telephone arrangements:

- Office phone answered by a recording that asks patients to leave a message
- Office phone answered by a recording which only directs members to go to an emergency room for any services needed
- Returning calls more than 30 minutes following initial call

After-hours calls should always be documented and included in the member's medical record.

Out-of-Office Coverage

Participating providers shall arrange for out-of-office coverage with a covering physician who has executed a participating physician agreement with the participating provider, unless the covering physician is a partner or member of the same group practice.

Provider Disenrollment from IHCP

Termination from IHCP, whether voluntary or involuntary, results in the provider's immediate disenrollment from the HHW, HCC and HIP programs and the MHS network. Any time a provider voluntarily disenrolls from IHCP or terminates a group membership, the provider must notify the IHCP Provider Enrollment Unit and MHS in writing. MHS providers who wish to disenroll from only HHW, only HCC or only HIP must go to mhsindiana.com and submit the disenrollment form. Providers should refer to their MHS contract for specific information about terminating participation in the MHS network.

Interpreter/Translation Services

MHS is committed to providing staff and interpreters to help members who speak a language other than English. Not sure of your patient's language? You may also find out a patient's language by logging on to our provider portal and downloading your Patient List, or by contacting our MHS Member Services at the toll-free number located on the back of the member's ID card. You may also work with the interpreter service to identify the right language. MHS offers the following language assistance services. All interpreters are trained professionals.

Over-the-Phone Interpretation

Telephonic interpreter services are available 24/7 and in approximately 150 languages to assist providers and members in communicating with each other when there are no other interpreters available. Providers may call MHS Provider Services at 1-877-647-4848 for help with interpreter requests.

Video Remote Interpretation

Multiple languages are available for remote interpretation. Supported platforms include Zoom, Google Hangouts Meet, GoToMeeting, WebEx and any telehealth platform in which an interpreter can join as a guest or provider attendee. Please contact our Member Advocate team at language_services@mhsindiana.com to request an Interpreter Request Form to submit your request.

In-Person Interpretation

MHS offers face-to-face interpreters practicing in more than 150 languages including Spanish, Burmese and American Sign Language. Email requests to: language_services@mhsindiana.com. When possible, MHS requests a five-day prior notification for face-to-face services.

Advance Directives

Advance directives are defined in 42 CFR 489.100 as, "a written instruction, such as a living will or durable power of attorney for health care, recognized under state law (whether statutory or as recognized by the courts of the State), relating to the provision of health care when the individual is incapacitated." MHS is committed to ensuring its members know of and are able to avail themselves of their rights to execute advance directives. MHS is equally committed to ensuring its providers and staff are aware of and comply with their responsibilities under federal and state law regarding advance directives. Any provider delivering care to MHS members must ensure members receive written information on advance directives and are informed of their right to execute advance directives. Providers must document such information in the member's medical record. MHS will monitor compliance with this provision. Providers may be audited annually. If you have any questions regarding advance directives, please contact MHS Medical Management.

Provider-Member Communication

MHS providers are encouraged to communicate honestly with the members they serve. We will not interfere with member-provider communication as long as you are acting within the lawful scope of your practice. We will not restrict your free communication with members about their medical conditions or MHS policy. We will not restrict your right to inform members of the risks, benefits and consequences of treatment or non-treatment. MHS will not prohibit you from advising members of their right to participate in decisions regarding their health, including the right to refuse treatment and express preferences for future treatment methods. In addition, MHS will not take punitive action against any MHS provider who requests an expedited resolution or supports an MHS member's appeal. Providers may freely communicate with patients about their treatment regardless of benefit coverage limitations. Provider Discrimination: In accordance with 42 CFR §438.102, MHS will not discriminate as to the participation, reimbursement or indemnification of any provider who is acting within the scope of his or her license or certification under applicable state law solely on the basis of that license or certification. No provider may discriminate in the provision of Medicaid services with regard to age, race, creed, color, national origin, sex, sexual orientation or disability.

Member Panel Capacity

All PMPs reserve the right to state the number of members they are willing to accept into their practice. The panel size for members will be based on the panel size requested on the Provider Enrollment Form. Member assignment is based on the member's choice and the IHCP auto-assignment process; therefore, MHS does not guarantee any PMP will receive a set number of members. Physicians who are Primary Care Physicians may hold a maximum panel of 2,500 Covered Persons, unless a larger panel limitation is mutually agreed upon by both parties. The PMP shall not refuse to treat MHS members on his or her panel so long as the limit has not been met, and shall notify MHS at least 45 calendar days in advance of his or her inability to accept additional covered enrollees under MHS agreements. To make changes to panel size, please visit mhsindiana.com and use the demographic update tool.

Quality Improvement (QI) Activities

MHS requires providers and practitioners to cooperate with all QI activities, as well as allow the plan to use provider and/or practitioner performance data to ensure the success of the QI Program as outlined in Chapter 13. If you are interested in learning more about MHS QI Programs, please visit mhsindiana.com/providers/quality-improvement.html.

American Indian and Alaskan Native Health Care Providers

Permit any American Indian/ Alaska Native (AI/AN) member who is eligible to receive services from a participating Indian healthcare provider to choose to receive covered services from that Indian healthcare provider, and if that Indian healthcare provider participates in the network as a PMP, to choose that Indian healthcare provider as his or her PMP, as long as that Indian healthcare provider has the capacity to provide the services.

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Chapter 3: Compliance

Health Insurance Portability and Accountability Act (HIPAA)

The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 establish national standards for electronic healthcare transactions, code sets, operating rules and national identifiers for providers, health plans and health care clearinghouse. To learn more about Administrative Simplication, please visit the Centers for Medicare & Medicaid Services "HIPAA and Administrative Simplification."

Privacy Regulation

At MHS, we take the privacy, security and confidentiality of our members' health information seriously. We have processes, policies and procedures that comply with HIPAA and other applicable confidentiality/privacy laws. MHS has also implemented reasonable administrative, physical and technical safeguards to protect the health information of our members. A copy of MHS' Member Privacy Notice is included in the Member Handbook and available online at MHS Member Handbook. If you have any questions about MHS privacy or security practices, please contact the MHS Privacy Official at 1-877-647-4848.

Transactions and Code Sets Regulation

HIPAA mandates that many of the major healthcare electronic data exchanges such as electronic claims and eligibility be standardized into the same national format for all payers, providers and clearinghouses. All providers who submit governed data electronically to Centene Management Corporation (Centene), the MHS fiscal agent, must do so in the required HIPAA format.

HIPAA-Regulated Transactions

There are eight electronic transactions currently mandated by HIPAA legislation. If a provider conducts any of the transactions mandated by HIPAA, they must utilize the HIPAA standard transaction format. Emails and diskettes can no longer be utilized if the data content meets the definition of any of the HIPAA mandated transactions listed:

TRANSACTION NAME	HIPAA TRANSACTION NUMBER
Claims and Encounters	837
Enrollment and Disenrollment	834
Health Plan Eligibility Solicitation and Response	270/271
Payment and Remittance Advice	835
Premium Payment	820
Claim Status Solicitation and Response	276/277
Referral and Authorization	278

HIPAA Electronic Transactions

The following are the HIPAA electronic transaction capabilities supported through MHS via MHS' parent corporation, Centene:

- **Claims and Encounters - Transaction 837**
  Network providers are encouraged to participate in MHS' electronic claims filing program through Centene.
- **Health Plan Eligibility Solicitations and Response Transaction - 270 and 271**
  MHS has the capability to receive an ANSI X12N 270 health plan eligibility inquiry and generate a real-time ANSI X12N 271 health plan eligibility response transaction.
- **Payment and Remittance Advice Transaction – 835**
  Centene has the capability to generate an ANSI X12N 835 ERA.
- **Claim Status Solicitation and Response Transaction - 276 and 277**
  MHS has the capability to receive an ANSI X12N 276 health claims status inquiry and to generate a real-time ANSI X12N 277 health claims status response transaction.

For more information on conducting these transactions electronically, please contact the Centene EDI department by phone at 1-800-225-2573 or email at ediba@centene.com.

Chapter 3: Compliance (cont'd)

HIPAA Required Code Sets

The HIPAA code sets regulation requires codes used in both paper and electronic transactions be standardized. As a result of this requirement, "local" procedural codes utilized for the Medicaid product or plan-specific "homegrown" procedure codes can no longer be used for billing and/or authorizing services. Only national standard codes (i.e., CPT®-4 and HCPCS) can be used for claims and/or authorization of services. The implementation of standard procedure codes requires the use of modifiers and condition codes necessary for the level of code specificity. This level of specificity may not be achieved through the use of procedure codes alone.

Sending Protected Health Information Securely

There are times when you may need to communicate member information to MHS, Centene or OMPP. Please remember to provide member information via a secure method such as mail, fax, or phone or by using the MHS Secure Provider Portal. You should not send member information by email unless it is sent using an encrypted email service. If you have questions, contact your MHS Provider Engagement Administrator.

Federal, State and MCE Audits and Investigations

One responsibility of being an MHS Medicaid Provider is to cooperate with audits and investigations. Failure to cooperate with an audit or investigation can result in claims payment suspension, claim recoupment, and removal from the MHS network or even the Indiana Medicaid program. Medicaid payment rates include the cost for providing records. Reimbursement for medical records will not be provided by members, MHS, Centene or any state or federal government agencies. In the event MHS determines to recoup an overpayment at the conclusion of an audit, the provider has the right to appeal. Claim appeal procedures, including an informal and formal appeal process, will be utilized following the timelines described in Chapter 5. To ensure accurate audit appeal processing, please read all correspondence related to the audit findings and submit your response to the address included in notice of recoupment.

Report Fraud, Waste and Abuse

MHS is committed to maintaining the integrity of the Indiana Medicaid Programs. If you suspect that a plan member or provider is engaging in fraud, waste, or abuse, you have both the right and the responsibility to report it. CMS defines Fraud Waste and Abuse as: Fraud is when someone knowingly deceives, conceals, or misrepresents to obtain money or property from any health care benefit program. Medicare or Medicaid fraud is considered a criminal act. Waste is overusing services or other practices that directly or indirectly result in unnecessary costs to any health care benefit program. Abuse is when health care providers or suppliers perform actions that directly or indirectly result in unnecessary costs to any health care benefit program.

Examples of Fraud, Waste and Abuse may include: Conducting excessive office visits, prescribing more medications than necessary, and ordering excessive laboratory tests. Member Fraud or Abuse may include: Allowing someone not covered by the plan to use their member ID card, and attempting to obtain medications that are not medically necessary. Provider Fraud or Abuse may include: Billing for services that were not provided. Offering incentives to members in exchange for using their member ID number.

Our Commitment to Prevention and Accountability MHS has established procedures to detect, prevent, and respond to potential fraud, waste, and abuse. These processes are designed to protect the integrity of our programs and ensure that resources are used appropriately. Members, providers, staff, and others are encouraged to report any concerns. MHS also provides access to our Fraud and Abuse Policy, which applies to both members and providers. To request a copy of our Fraud, Waste and Abuse Prevention, Detection and Reporting Procedures, please contact MHS Compliance.

Fraud and Abuse

MHS takes the prevention, detection, and investigation of fraud waste and abuse very seriously. We have a robust program in place that complies with industry standards and state and federal law.

THE SPECIAL INVESTIGATIONS UNIT

Federal and state law requires that all managed care entities create and operate special investigations units (SIUs). The primary purpose of the SIU is to identify fraud, waste, and abuse, refer fraud findings to state authorities, and recover overpayments related to FWA (recoupments). The MHS SIU employs sophisticated code editing software (data analytics), which performs systematic audits during the claims payment process to identify billing aberrancies.

Chapter 3: Compliance (cont'd)

Those aberrancies provide unit personnel with investigative leads.

Common offenses that the SIU investigates include upcoding, billing for services not rendered, double billing, billing for unnecessary medical services, the overprescribing of controlled substances and billing for unauthorized services. The SIU also investigates member fraud such as program eligibility issues, "doctor shopping" and member benefit fraud.

MHS requires all contractors and subcontractors to report suspected FWA committed by its employees, associates and business partners.

TO REPORT SUSPECTED FRAUD: email mhsfraudreport@mhsindiana.com or call the Fraud Hotline at 1-866-685-8664.

PREPAYMENT REVIEW
Upon identifying a provider's billing anomalies, a provider may be placed on prepayment review. Providers who are placed on prepayment review will receive a letter notifying the provider of the prepayment review from the SIU informing them that their claims will not be paid until requested medical records are submitted. If records are not received, the submitted claims will be denied and the provider will continue on prepayment review status.

SIU AUDITS
The SIU conducts three types of provider audits: desk audits, announced onsite audits and unannounced audits. These audits are conducted consistent with IHCP policy and procedure and the terms of provider contracts.

RECOUPMENT OF FUNDS
If the SIU determines that a provider has been overpaid, the SIU will send a letter to the provider informing them that recoupment of funds is being sought. The letter details the investigative findings and requests reimbursement.

Your review may be subject to extrapolation. The SIU employs a statistician who uses a CMS approved procedure to pull a statistically valid random sample of claims before an actual claim overpayment is determined. Using the actual amount, the statistician performs a valid extrapolation of the claims and determines a more realistic overpayment amount based on the universe of claims that the provider submitted. Claims are usually reviewed for an 18-month to two year period.

If you receive a demand letter, please read all correspondence related to the audit findings and submit your response to the address included in demand letter. This will ensure timely and accurate processing.

NOTE: The SIU medical records submission process is different from the usual claims submission process. If you receive a request from the SIU to submit medical records, please use the process described in the letter.

SIU APPEALS
When the SIU identifies an overpayment and determines a recoupment is appropriate, the SIU will send the provider a demand letter. The demand letter details how the SIU determined the amount of overpayment and offers the provider repayment options. The SIU follows the appeals process set forth in 405 IAC 1-1.6-3. The appeal process is described in Chapter 5 of this manual.

MHS expects all its contractors and subcontractors to comply with applicable laws and regulations, including but not limited to the following:
- Federal and State False Claims Act
- Qui Tam Provisions (Whistleblower)
- Anti-Kickback Statute
- Physician Self-Referral Law (Stark Law)
- HIPAA violations
- All varieties of health care fraud

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Chapter 4: General Claims Information and Guidelines

MHS follows IHCP claims billing and payment guidelines as outlined in the IHCP Provider Modules for all HHW, HIP and HCC claims. For MHS members, all claims, with the exception of the following, should be submitted to MHS:
- All carve-outs should be billed to IHCP.
- All enhanced vision services should be billed to Centene Vision.
- All behavioral health Medicaid Rehabilitation Option services.
- Dental claims should be billed to Centene Dental Services.
- Pharmacy claims should be billed to Centene Pharmacy.

Payment for service is contingent upon compliance with referral and prior authorization policies and procedures, the billing guidelines outlined in this manual and IHCP requirements.

Reimbursement

HIP, HHW and HCC claims will be reimbursed in accordance with the IHCP Medicaid Fee Schedule and MHS Provider contracts. Claims are reimbursed in accordance with IHCP Medicaid Fee Schedule, if the service is provided by a facility that qualified for HAF payments. Be sure to confirm eligibility and program coverage at each visit. Members can change products within the HIP program at any time, which will impact your reimbursement. Use the IHCP Provider Healthcare Portal or equivalent or View Member Benefits for package coverage and copayment information. Pregnant members will present either a HIP ID card or a HHW ID card. The member MID will remain the same regardless of the card presented at the time of the encounter, and all pregnancy claims will be paid at Medicaid rates.

Emergency Service Claim Reimbursement

This section applies to contracted and non-contracted providers. Please follow the reimbursement guidelines below:
The State has created and maintains an ED auto-pay list that is comprised of diagnosis codes that should always be considered emergent. Utilize the State auto-pay list of diagnosis codes to determine whether a service is emergent or non-emergent.

MHS will review the diagnosis codes for their presence on the autopay list in the following claim fields (or equivalent fields on the corresponding electronic claim):
- On a UB-04 claim: – Field 67 and 67 A-Q – DX (primary and other diagnosis codes) – Field 69 – ADMIT DX (diagnosis code at time of admission, as stated by the physician) – Field 70 A-C – PATIENT REASON DX (diagnosis codes that reflect the patient's reason for visit) – Field 72 A-C – ECI (external cause of injury diagnosis codes, also known as E-codes)
- On a CMS-1500 claim: – Field 21 A-L – DIAGNOSIS OR NATURE OF ILLNESS (primary and other diagnosis codes

Observation stays shall not be subject to auto-pay lists for determining level of payment. The ED auto-pay list is public so providers and hospitals may decide if they need to submit records or not on the initial submission.

If the claim does not match the auto-pay list for emergent level of reimbursement, and records are not provided, the claim can be paid at a screening fee. For claims paid at the screening fee or a non-emergent case rate, MHS shall include on the remittance that the provider can submit records for PLP review within 120 days and where the records should be sent. Review PLP section for more information on State requirements. MHS will cover medical screening examination, as defined by the Emergency Medical Treatment and Active Labor Act (EMTALA) regulations at 42 CFR 489.24.

Provider Information on File

Inaccurate provider information can cause delays in claims processing, payment and rejections. It is important providers ensure MHS has accurate information on file, including:
- Practitioner or provider name
- Medicaid number
- National Practitioner Identification (NPI) number (group and/or individual)
- Physical location address
- Billing name and address (if different)
- Tax Identification Number (TIN)

If information needs to be updated, please utilize our online Demographic Update Tool at mhsindiana.com/provider-updates. In addition, MHS will annually and quarterly contact you via mail and email to validate your information, in compliance with CMS and NCQA requirements.

PLEASE NOTE *Throughout the manual this icon refers to the following statement:*
Healthy Indiana Plan (HIP) cost-sharing, which includes copayments and POWER Account contributions, will continue to be paused. For CHIP and MEDWorks, cost sharing resumed as of July 1, 2024.

Updating Billing information

Providers must notify MHS in advance of changes pertaining to billing information. Please submit updates to billing addresses via the Billing Update form, available at mhsindiana.com. If the address for the 1099 is being updated, MHS requires a copy of the W-9 with your update.

Changing Your Tax Identification Number (TIN)

Changes to a provider's TIN and/or address are not accepted when conveyed via a claim form. Providers must request a change to their TIN via the Provider Update forms on mhsindiana.com or in writing to MHS Contracting, 429 N. Pennsylvania St. Suite 109, 46204. Please include the old TIN as well as the new TIN, the group NPI, the IN Medicaid legacy provider number and the effective date of the TIN change.

Mismatched Member Information

If a member's name and/or date of birth differ in the provider's records as compared to the information MHS has on file, the member's information will be verified on the IHCP Provider Healthcare Portal. If the provider's information does not match the IHCP Provider Healthcare Portal, the provider or member must contact the Division of Family Resources to update the information with IHCP. Once the information is corrected, the provider may resubmit a corrected claim. If the provider's information matches the IHCP Provider Healthcare Portal, then MHS submits a system correction to our member eligibility information and will submit the claim for reprocessing.

Billing the Member (HHW, HIP and HCC)

In general, providers may not bill members. Providers:

- Cannot use standard waivers to hold members liable for a bill.
- Cannot balance-bill members for amounts exceeding Medicaid's allowable or what Medicaid does not cover.
- Cannot refuse to see a member due to an unpaid bill from a service rendered prior to when the member was covered by the HHW, HIP or HCC program.
- Cannot bill members for medical records.
- Cannot bill members for missed appointments.

In limited instances, a provider can charge IHCP members, including those in HHW, HIP or HCC, for services not covered by IHCP. HIP members may be billed directly for non-covered services and any copayments incurred including ER copayments. For information on billing HHW or HCC members, please refer to the Provider Enrollment Module of the IHCP Provider Reference Modules. The provider must receive and retain the member's signed statement accepting financial responsibility for the services. This statement must be specific about the services to be billed, must be signed by the member before receiving the services, and must be retained as documentation in the patient's medical record. A subsequent waiver must be executed prior to each time a non-covered service is rendered; for example, if a member has reached his maximum number of chiropractic adjustments for a year, at each subsequent adjustment the practitioner must obtain a waiver specific to that day's service.

Copayments were eliminated for HCC BT2023101.

In addition, the member copayment must be waived for any member who contacts MHS' 24-Hour Nurse Advice Line prior to utilizing a hospital emergency department to obtain advice on their medical conditions and the appropriate setting to receive care. If a member contacts MHS' Nurse Advice Line line prior to seeking emergency care, the member will not be subject to the prudent layperson (PLP) review to determine whether an emergency medical condition exists for purposes of applying the copayment.

If a member notifies MHS a provider has billed inappropriately, MHS will send the provider a letter regarding the member's rights. If a provider continues to bill a member inappropriately, a report will be filed with OMPP. OMPP can terminate providers from IHCP participation for inappropriate billing.

For information on billing HIP members, please refer to Chapter 16.

Third Party Liability (TPL)

A Third Party Liability (TPL) is a source of payment for medical services other than the IHCP benefit package and the member. Federal and state law requires IHCP be the payer of last resort. MHS makes every attempt to obtain TPL data and to process claims accordingly.

MHS' TPL data is more current than IHCP data and should be used when billing MHS. The information is loaded into our claims payment system and is then forwarded to the State for updates.

Providers can contact MHS or check MHS' Secure Provider Portal to receive any applicable TPL information. The provider is required to provide MHS with any TPL information it obtains from the member. To provide this information, please contact MHS Provider Services.

Claims Submission

MHS encourages all providers to participate in MHS' Electronic Claims/Encounter filing program through Centene. For more information on electronic filing, visit mhsindiana.com, or contact the EDI department at 1-800-225-2573, ext. 25525 or ediba@centene.com.

Providers who bill electronically are responsible for filing claims within the same filing deadlines as stated below. Providers who bill electronically must monitor their EDI Acceptance Report daily and confirm all submitted claims and encounters appear on the report. Providers are responsible for correcting any errors and resubmitting the claims and encounters.

Please remember the following when filing your claim:

- All claims data must be submitted on either form CMS-1500 or UB-04, or by electronic media in an approved format.
- Review and retain a copy of the error report received for claims that have been submitted electronically, and then fix any errors and resubmit with your next batch of claims.
- For EDI claims, utilize the MHS payer ID 68069 for medical (physical health) claims and payer ID 68068 for behavioral health claims.
- For contracted providers, all claims must be submitted within 90 calendar days of the date of service. The filing limit may be extended for newborn claims when the eligibility has been retroactively received by MHS, up to a maximum of 365 calendar days for services provided within the first 30 days of life.
- Claims with primary insurance must be received within 365 days of the date of service with primary EOB information. If primary EOB is received after the 365 days, providers have 60 days from date of primary EOB to file claim to MHS.
- Claims for non-contracted providers must be submitted within 180 calendar days of the date of service.
- In a workers' compensation case for which MHS is not financially responsible, the provider should directly bill the employer's workers' compensation carrier for payment.
- **Payment Integrity has specific markers that allow claims to pay when a gender mismatch appears present. Payment Integrity does not apply gender edits when: Claim line contains modifier KX and diagnosis codes F64.0, F64.1, F64.2, F64.8 or F64.9 or Claim contains condition code 45.**
- Provider is to submit claim for payment within 90 days of claim's recovery or recoupment notice from the previous payer.

Retro Member Eligibility

MHS recognizes that occasionally members will be assigned eligibility with IHCP and MHS retroactively. In the event of a retro eligibility assignment, MHS will work with the provider to ensure timely filing is waived. MHS request that providers submit claims within 90 days of retro eligibility assignments being established. If the provider is unable to submit the claim within 90 days of retro eligibility assignment and claims submitted deny for timely filing, MHS request the provider submit a claim reconsideration via the web portal with the retro eligibility information to have timely filing waived.

Avoid Common Errors

In order to avoid rejected claims or encounters, always remember to:

- Use the most current CPT®-4 and HCPCS codes (out-of-date codes will be denied).
- The ICD indicator must be completed. This is box 21 on CMS-1500 and box 66 on the UB-04.
- Use specific CPT® or HCPCS codes, and avoid the use of non-specific or "catch-all" codes (i.e., 99070).
- Use the correct ICD coding. All claims/encounters must be submitted with the complete member MID number, date of birth and member name.
- Verify other insurance information entered on claim.
- If a laboratory test is being billed, ensure the CLIA number is in box 23.
- The rendering provider's NPI must appear in Box 24J of the CMS-1500 or Box 56 of the UB-04.
- OPR is a required entry for select providers.
- The referring NPI number is entered in box 17b for the CMS-1500 and box 78 for the UB4. EDI billing for referring NPI is loop 2310-A.
- Ensure the NPI, TIN and ZIP+4 of the service location of the billing provider are submitted on the claims in the same manner it was reported to the State Fiscal Agent, IHCP.
- Include Present on Admission indicator on all inpatient hospital claims.

- Include NDC codes on all claims for injections/drugs as well as the unit qualifier and description.
- PT/OT/ST therapies require use of appropriate modifiers.

Claim Submissions Online at MHS Indiana Care Portal for Members| Login | MHS Indiana

Providers may opt to create and submit individual claims as well as submit batch claims via the MHS Secure Provider Portal . This feature is available for professional and facility claim submissions. For tutorials about how to submit via our portal, visit mhsindiana.com or call MHS Provider Services.

Paper Claim Submissions

Any UB-04 and CMS-1500 forms received by our Claims Processing Center that do not meet the CMS printing requirements will be rejected back to the provider or facility upon receipt.

The printing requirements are outlined by CMS regulations within the Medicare Claims Processing Manual Chapter 26, Completing and Processing Form CMS-1500 Data Set. This requirement includes first time and resubmitted claims. The only acceptable claim forms are those printed in Flint Optical Character Recognition (OCR) red ink. Copies of the form cannot be used for submission of claims, since your copy may not accurately replicate the scale and OCR color of the form.

Compliance with the CMS regulation will allow for timely processing of claims and allow OCR technology to perform optimally.

MHS uses an imaging process for paper claims retrieval. To ensure accurate and timely claims capture, please observe the following claims submission rules when submitting paper claims:

DO:

- Do use the correct P.O. Box number. Physical Health: P.O. Box 3002, Farmington, MO 63640-3802. Behavioral Health: P.O. Box 6800, Farmington, MO 63640-3817. Claims sent to MHS' Indianapolis address will be returned to the provider.
- Do submit all claims in a 9"x12" (or larger) envelope.
- Do type all fields completely and correctly.
- Do use black or blue printer ink only.
- Do complete claims forms in accordance with IHCP.
- Do submit on a proper form: CMS-1500 or UB-04.

DO NOT:

- Do not submit claim forms, including corrected claims/adjustment, with any handwriting.
- Do not use red ink on claim forms.
- Do not circle any data on claim forms.
- Do not add extraneous information to any claim form field.
- Do not use highlighter on any claim form field.

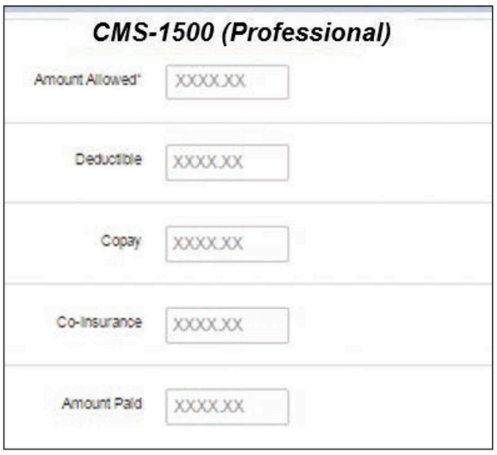
Chapter 4: General Claims Information and Guidelines (cont'd)

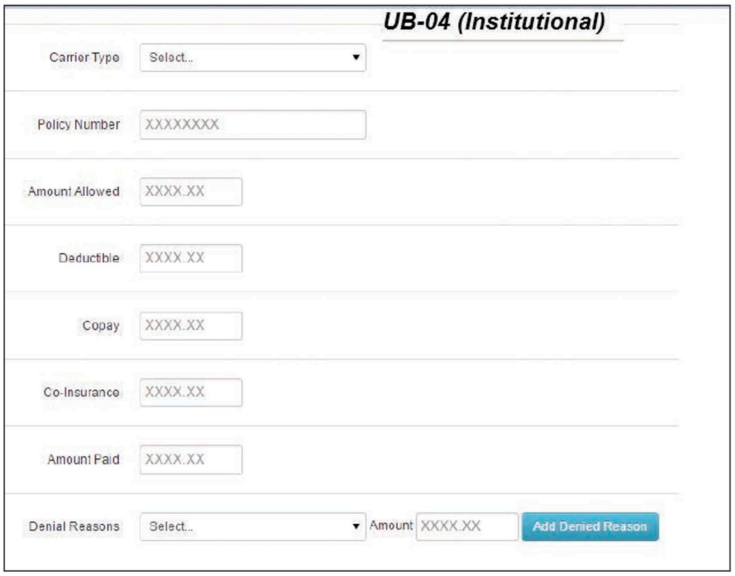
Coordination of Benefits (COB)

Did you know you can submit COB claims electronically? MHS does not require a copy of the Explanation of Payment (EOP) when COB claims are submitted electronically through your clearinghouse or via the MHS Secure Provider Portal.

MHS Secure Provider Portal Submission

When using the Secure Provider Portal, input your COB information directly in the data fields or attach the EOP to the claim. The data fields used to populate COB information are outlined below:





EDI – Clearinghouse

For clearinghouse 837 transactions, simply code the transaction to include the loop for COB as outlined below. For questions on setting up your 837, please contact your clearinghouse.

COB Field Name The below should come from the primary payer's Explanation of Payment.	**837I - Institutional EDI Segment and Loop**	**837P - Professional EDI Segment and Loop**
COB Paid Amount	If 2320/AMT01=D, MAP AMT02 or 2430/SVD02	If 2320/AMT01=D, MAP AMT02 or 2430/SVD02
COB Total Non-Covered Amount	If 2320/AMT01=A8, map AMT02	If 2320/AMT01=A8, map AMT02
COB Remaining Patient Liability	If 2300/CAS01 = PR, map CAS03 Note: Segment can have six occurrences. Loop2320/AMT01=EAF, map AMT02 which is the sum of all of CAS03 with CAS01 segments presented with a PR.	If 2320/AMT01=EAF, map AMT02
COB Patient Paid Amount	N/A	If 2320/AMT01 = F5, map AMT02
COB Patient Paid Amount Estimated	If 2300/AMT01=F3, map AMT02	N/A
Total Claim Before Taxes Amount	If 2400/AMT01 = N8, map AMT02	If 2320/AMT01 = T, map AMT02
COB Claim Adjudication Date	If 2330B/DTP01 = 573, map DTP03	If 2330B/DTP01 = 573, map DTP03
COB Claim Adjustment Indicator	If 2330B/REF01 = T4, map REF02	If 2330B/REF01 = T4, map REF02 with a Y

Notes:

- Calculations can be required depending on how the Primary Payer paid the services, i.e., either individual service lines or rolled up to a claim level.

  Example:
  The sum of all line level payment amounts (Loop ID-2430 SVD02) less any claim level adjustment amounts (LOOP ID-2320 CAS adjustments) must balance to the claim level payment amount (Loop ID-2320 AMT02). Expressed as a calculation for given payer: {Loop ID-2320 AMT02 payer payment} = {sum of Loop ID-2430 SVD02 payment amounts} minus {sum of Loop ID-2320 CAS adjustment amounts}.

- SBR01+S, then Loop 2320 is used to generate COB.

90-Day Provision for Coordination of Benefits Billing Available Electronically

Providers may file claims electronically when other insurance fails to respond within 90 days of billing.

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.

Providers may now submit claims 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.

Claims will be processed and considered for payment. In addition to payment EX codes, claims will also indicate and EX code of mN - 90-day provision, claim subject to repayment when primary insurance processes claim.

Claims with Attachments

All claim attachments can be submitted via the MHS Secure Provider Portal. Consent for sterilization forms can only be attached to sterilization claims submitted via the MHS Secure Provider Portal (preferred method) or via paper submission. Consent for sterilization forms cannot be submitted via clearinghouses. If you have questions on how to attach documents, please call MHS Provider Services at 1-877-647-4848.

Clean Claim and Non-Clean Claim Definitions

Clean claims are invoices properly submitted in a timely manner and in the required format that do not require MHS to investigate, develop or acquire additional information from the provider or other external sources. Such claims should have no defect or impropriety or particular circumstance requiring special treatment that prevents timely payments from being made, including any lack of required, substantiating documentation.

Non-clean claims are submitted claims that require further investigation or development beyond the information contained therein. These errors or omissions result in MHS requesting additional information from the provider or other external sources to resolve or correct data omitted from the bill, reviewing additional medical records, or accessing other information necessary to resolve discrepancies. In addition, claims with issues relating to payment including, but not limited to, issues regarding medical necessity or claims not submitted within the identified filing limits, are also defined as non-clean.

Post-Processing Claims Audit

A post-processing claims audit consists of a review of clinical documentation and claims submissions to determine whether the payment made was consistent with the services rendered. To start the audit, MHS auditors request medical records for a defined review period. Providers have 30 days to respond to the request; if no response is received, a second and final request for medical records is forwarded to the provider. If the provider fails to respond to the second and final request for medical records, or if services for which claims have been paid are not documented in the medical record, MHS will recover all amounts paid for the services in question.

MHS auditors review cases for common fraud, waste and abuse practices including:

- Unbundling of codes
- Up-coding services
- Add-on codes billed without primary CPT
- Diagnosis and/or procedure code not consistent with the member's age/gender
- Use of exclusion codes
- Excessive use of units
- Misuse of benefits
- Claims for services not rendered

MHS auditors consider state and federal laws and regulations, provider contracts, billing histories, and fee schedules in making determinations of claims payment appropriateness. If necessary, a clinician of like-specialty may also review specific cases to determine if billing is appropriate. Auditors issue an audit results letter to each provider upon completion of the audit, which includes a claims report identifying all records reviewed during the audit. If the auditor determines that clinical documentation does not support the claims payment in some or all circumstances, MHS will seek recovery of all overpayments. Depending on the number of services provided during the review period, MHS may calculate the overpayment using an extrapolation methodology. Extrapolation is the use of statistical sampling to calculate and project overpayment amounts. It is used by Medicare Program Safeguard Contractors, CMS Recovery Audit Contractors, and Medicaid Fraud Control Units in calculating overpayments, and is recommended by the OIG in its Provider Self-Disclosure Protocol (63 Fed. Reg. 58,399; Oct. 30, 1998).

Code Auditing and Editing (Code Review)

MHS utilizes code-auditing software for automated claims-coding verification and to ensure MHS is processing claims in compliance with general industry standards. This auditing software applies to facility and professional claims.

Denial codes beginning with a lower case x or y are generated by the code-auditing software. This software evaluates code combinations during auditing/processing of claims. The exact reason for denial will not show on the EOP (remittance). These denials cannot be reprocessed by MHS Provider Services. A claim appeal with supporting documentation must be completed if the provider does not agree with the denial decision or adjustment request.

The code-auditing software takes into consideration the conventions set forth in the healthcare insurance industry, such as CMS policies, current health insurance and specialty society guidelines, and the American Medical Association's "CPT® Assistant Newsletter."

Using a comprehensive set of rules, the code-auditing software provides consistent and objective claims review by:

- Accurately applying coding criteria for the clinical areas of medicine, surgery, laboratory, pathology, radiology and anesthesiology as outlined by the association's CPT®-4 manual
- Evaluating the CPT®-4 and HCPCS codes submitted by detecting, correcting and documenting coding inaccuracies including, but not limited to unbundling, up coding, fragmentation, duplicate coding, invalid codes and mutually-exclusive procedures
- Incorporating historical claims auditing functionality which links multiple claims found in a member's claims history to current claims to ensure consistent review across all dates of service

For detailed information on specific code-edit criteria, please access MHS' Secure Provider Portal. Code edits can be reviewed in the "Clear Claim Connection" link.

Billing for an obstetrical delivery for the initial inpatient hospital stay (also observation) and subsequent in-hospital professional charges including discharge services.

Providers may bill separately and be reimbursed separately for the following E/M charges if they were performed by delivering provider: 99221, 99222, 99223, 99231, 99232, 99233, 99238, 99234, 99235 and 99236.

Post-delivery charges should be billed within 60 days of delivery and may be reimbursed for up to two inpatient or outpatient postpartum visits using CPT® code 59430 (which is for postpartum care only).

As an additional resource to code auditing and editing, please visit our Clinical and Payment Policies page on our website.

Claims for Newborns

MHS' Newborn claims must be billed in the same manner as all members, with the Newborn's Medicaid State ID Number, Date of Birth, and Gender matching Indiana State file.

At times, MHS receives claims for a newborn before the State transmits the newborn member's eligibility information. We cannot process the claim using the MID for any member other than the newborn.

- When a claim is submitted, the member's eligibility is verified upfront by comparing the Member ID, Member Date of Birth and Gender billed on the claim to the MHS member database.
- Claims billed with an ID# other than the Newborn's Medicaid State ID will reject upfront.
- If the claim rejects, providers should verify with the State that the newborn is an MHS Member and that the claim is billed with Medicaid ID#, DOB and gender matching the State Eligibility file, then resubmit the claim.
- Newborn claims are allowed up to 365 days for Timely Filing, in consideration of late loads or updates within the State file, and late transmissions from the State to MHS.

Claims Payment

All clean paper claims will be adjudicated (finalized as paid or denied) within 30 calendar days of the receipt of the claim. All clean electronically-transmitted (EDI) claims will be adjudicated within 21 calendar days of receipt of the electronic claim. It is the provider's responsibility to check their EDI Acceptance Report to verify MHS has accepted their electronically-submitted claim.

Accompanying each claim payment check is a payment voucher - the Explanation of Payment (EOP) – which itemizes charges for that reimbursement and the amount of the check from MHS. Please remember there is a 60-calendar-day time frame from the date of the EOP in which to dispute any claims. It is the provider's responsibility to check EOPs in a timely manner.

MHS reserves the right to conduct pre- and/or post-payment claim reviews as appropriate. Additional information, such as cost invoices and/or itemized statements as well as medical records, may be requested as part of the review process.

Electronic Remittance Advice and Electronic Funds Transfer

MHS partners with Payspan Health to offer a solution for Electronic Funds Transfers (EFTs) and Electronic Remittance Advices (ERAs). Using this free service, providers can take advantage of EFTs and ERAs to settle claims electronically without making an investment in expensive EDI software. Following a fast online enrollment, you will be able to receive ERAs and import the information directly into your Practice Management or Patient Accounting System, eliminating the need to key remittance data off of paper advices.

Payspan Health Benefits to Providers

- **Free service** – Providers are not charged any fees to use the service.
- **Eliminate re-keying of remittance data** – Electronic remittance advices can be imported directly into Practice Management or Patient Accounting Systems, eliminating the need for manual keying off of paper advices.
- **Maintain control over bank accounts** – Providers keep control over the destination of claim payment funds. Multiple practices and accounts are supported.
- **Match payments to advices quickly** – Providers can associate electronic payments with electronic remittance advices quickly and easily.
- **Pursue secondary billings faster** – Accelerates the revenue life cycle.
- **Improve cash flow** – Electronic payments can mean faster payments, leading to improvements in cash flow.
- **Connect with multiple payers** – Providers can quickly connect with any payers using Payspan Health to settle claims.

With Payspan Health, you have a number of options for viewing and receiving remittance details. Payspan Health will match your preference for remittance information with the following options (potentially constrained by payers):

- EDI 835 ERA data file that can be downloaded directly to your Practice Management or Patient Accounting System
- Electronic remittance advice presented online and printed in your location

Get started today by enrolling online at payspanhealth.com or by contacting Payformance Corporation at 1-877-331-7154.

Recoupments

Recoupments are first shown on an EOP as a reprocessing of the affected claim with a claim code to explain the action taken. If the provider cannot match the recoupment to the claim on the current or previous EOPs, he or she should contact MHS Provider Services for assistance. Information is obtained from the provider regarding the recoupment, and a report will be run from the provider's TIN to find where the negative balance started. The provider will then be notified of the findings. Recoupments are initiated due to over- and under-payments. Other insurance recoupments are not made against the provider of service. Providers must return an overpayment within 60 calendar days after the date on which the overpayment was identified, and to notify MHS in writing of the reason for the overpayment per 42 CFR 438.608(d)(2). MHS will pursue primary carriers directly. To refund claims overpayment, please send check and documentation to: MHS Attention: Claims Recovery Team, Coordinated Care Corporation, Inc., P.O. Box 856420, Minneapolis, MN 55485-6420.

Claim Corrections and Resubmissions (Adjustments)

If a provider's claim has been denied or paid only in part due to an error on the original claim submission and the provider needs to make any corrections to a claim, the provider must correct that section of the claim and resubmit the "entire claim" within 60 days of original date on the EOP to ask for a correction/adjustment.

- 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 data should be sent in the Loop 2300, segment CLM05 (with value of 7) along with an addition loop in the Loop 2300, segment REF*F8* with the original claim number for which the corrected claim is being submitted.
- UB-04 should be submitted with the appropriate resubmission code in the 3rd digit of the bill type (for corrected claim this will be 7) and the original claim number in field 64 of the paper claim. EDI 837I, data should be sent in the Loop 2300, segment CLM05 (with value of 7) along with an addition loop in the Loop 2300, segment REF*F8* with the original claim number for which the corrected claim is being submitted.

If a corrected claim is submitted without this information, the claim will be processed as a first-time claim and will deny as a duplicate. Additionally, this process is only the process for correcting denied claims or claims that were submitted with incorrect information, not correcting rejected claims.

MHS encourages you to submit corrected claims via EDI with the information in the appropriate loop list above. However you may choose to also utilize our website. While it is not necessary to attach the original MHS EOP or a claim adjustment request form when submitting through the web, you may attach if you choose.

Corrected paper claims can be forwarded to the appropriate MHS Claims P.O. Box indicated within Chapter 4 "Paper Claim Submissions" of this manual. Corrected paper claims must be clearly marked in the appropriate box 22 on CMS-1500 or box 64 of a UB-04 with original claim number. Providers resubmitting claims may attach an adjustment request form to the claim along with documentation, including the EOP they originally received from MHS, explaining the reason for resubmission. All paper claim submissions must be on an original "red" CMS-1500 claim form version 02/12. Claim form copies or claims with handwritten information will be rejected as "non-clean" claims and returned for corrected submission.

It is important to understand pursuing a claim adjustment request does not stop the 60-calendar-day count from the date of your EOP to the deadline for initiating the claims appeal process (see Reconsideration/ Informal Dispute or Objection), nor does a claim adjustment request serve as notice of appeal to MHS.

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Billing

To ensure proper reimbursement for EPSDT services, please refer to the Provider Manual at https://www.in.gov/medicaid/providers/files/modules/epsdt.pdf

Immunizations Reimbursement

The policy of IHCP is to reimburse vaccines available through the Vaccines for Children (VFC) at $15 for their administration only. MHS will reimburse in a manner consistent with that policy. All claims for these vaccines given to members 18 and younger will be reimbursed at the lesser of $15 plus contract rate or the provider's billed charges. If you are not currently participating in the VFC program, you may contact your Provider Engagement Administrator for information, or you can visit the VFC website at in.gov/isdh/17203.htm.

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 $15. However, provider must bill in the following manner:

- Appropriate diagnosis code Z00.121 or Z00.129 in the primary position (and indicate the diagnosis pointer for the vaccine and the administration procedure codes).
- Procedure code with specific vaccine administered with a billed amount of $0.00. Regardless of amount billed, the service line will be reimbursed at $0.
- Appropriate vaccine administration code with the SL modifier. (90471 – 90474)

When a VFC vaccine is administered by a nurse practitioner employed by physicians in a physician-directed group or clinic, the administration procedure codes should be billed followed by the SA modifier (for example, 90471 SL SA) to identify the service is performed by a nurse practitioner.

Claims may be billed as a stand-alone service, with a preventive visit (CPT® 99381 – 99385 or 99391 – 99395), or as an evaluation and management (E/M) code if medically appropriate (CPT® 99211 – 99215). If a member is in the office for an E/M and in need of a vaccine, please remember that the E/M code must be billed with a 25 modifier.

Private Stock for Vaccines

Providers will no longer be reimbursed for vaccines available through the VFC but provided out of private stock. Claims billed for vaccines available through the VFC will be reimbursed at $0.

Providers may bill for vaccines that are not available through the VFC program. Providers may bill for both the vaccine and the administration code as follows:

- Vaccine procedure code with specific vaccine administered with usual and customary billed amount
- Administration using CPT® code 90471-90474 with usual and customary billed amount

If an E/M service code is billed on the same date of service (DOS) as the vaccine administration, the vaccine administration code will not be separately reimbursed, even if the E/M is billed with a modifier 25. For private stock vaccines, separate reimbursement for CPT® 90471-90474 is only allowed when the vaccine and the administration of the vaccine are the only services provided for the DOS.

Prudent Layperson (PLP) Review for Emergency Room (ER)

All contracted and non-contracted providers may request Prudent Layperson (PLP) review for Emergency Room (ER) claims billed with revenue code 450. This is applicable for all MHS plans, including Ambetter Health (Marketplace) and Wellcare by Allwell (Medicare).

A request for PLP review must be submitted with appropriate documentation either via the online dispute tool or by mail to MHS, P.O. Box 3002, Farmington, MO 63640-3800. If, after review, it is determined that it would be reasonable to assume that the ER visit would be considered emergent to a layperson, the payment will be adjusted to pay at the emergent rate. Request for PLP review must be made within 120 days of the initial reimbursement date. MHS must conduct the PLP review and reprocess the claim (if determined to be emergent) within 30 days of receiving medical records from the provider.

Please contact MHS Provider Services at 1-877-647-4848 with any questions.

Getting Help with a Claim

The fastest method of checking claims status is via the Secure Provider Portal at mhsindiana.com. There you can look up your claims and obtain a current status and confirm the basis for a payment or denial. Providers are able to submit an online request for reconsideration, whereby you can sign up for alerts notifying you of the status until resolved. This action bypasses the MHS Provider Services call center and is sent directly to the Claims Department for review.

If you need further assistance after reviewing your claims via the Secure Provider Portal, please call MHS Provider Services. A provider should have the member MID number, servicing provider's name, date of service and the amount originally billed. Other information that may be requested in order to identify the claim(s) in question includes member name, date of birth and the claim number, if applicable.

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Chapter 5: Claims Administrative Reviews and Appeals

MHS Provider Services can confirm the basis for a payment or denial, check authorizations and status of official appeals submitted. Upon identification of a claim that requires adjustment, the representatives will send the adjustment request to the claims department as appropriate.

If you call with a complicated claim issue, your call will be immediately routed to a trained representative equipped to thoroughly research your claim with no limits or time restrictions. Providers may call to inquire about their claims or submit an online reconsideration; however, calling MHS or submitting an online reconsideration will not serve as **official** notice to MHS of a dispute or appeal on a claim. It will not stop the 60-calendar-day count from the date of your EOP to file a written informal dispute or appeal.

MHS offers providers three official mechanisms to request claim information or payment evaluation and determination. These are listed in this chapter and an overview is provided, including how each process works, timelines and the responsibilities and rights of the provider and MHS at each step. Claim appeals do not include appeals for clinical decisions or medical necessity. For medical necessity appeals, refer to Chapter 8.

Claim inquiries, corrected claims, and adjustment requests do not constitute part of the official appeals process outlined in this chapter. For more about these topics, refer to Chapter 4.

Informal Claim Dispute

If the provider believes an improper payment of a claim for covered Medicaid services has occurred through either the omission of information or a claims system error, the provider may file an informal claim dispute by either:

- Submitting a request for informal dispute via the Secure Provider Portal
- Submitting a copy of the MHS EOP along with a completed informal dispute form via mail or
- Submitting a written request for an informal dispute on company letterhead.

Informal claim disputes/reconsiderations must be submitted either via the Secure Provider Portal or in writing within 60 calendar days from the date on the EOP. The provider must include sufficient information for MHS to identify the claim(s) in question and the reason the provider is disputing to MHS' processing of the claim(s). Informal claim disputes can be:

- Submitted via the Secure Web Portal
- Mailed to the following address:
  - Medical Claims: Managed Health Services, P.O. Box 3002, Farmington, MO 63640.
  - Behavioral Health Claims: Managed Health Services, P.O. Box 6800, Farmington, MO 63640-3809

Upon receipt of the informal claim dispute, MHS will review the claim and the additional information submitted and respond to the provider within 30 calendar days. If MHS notifies the provider it will uphold the original claim determination, the original decision or denial is upheld and the dispute process is concluded. If the provider disagrees with the outcome, the provider may file a formal claim dispute (or administrative claim appeal) as outlined in the next section. If the provider does not receive a response within 30 calendar days, they may call MHS Provider Services to check on the status of the dispute.

If an informal dispute is submitted via the Secure Web Portal reconsideration tool, status will be available as the claim is being reviewed. If the provider submits the informal dispute via mail, if a response is not received within 30 calendar days, then the provider may call Provider Services to check on the status of the dispute.

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 is not available to a provider who does not first submit an informal claim dispute/objection.

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 should be submitted to:

- Medical Claims - Managed Health Services, P.O. Box 3002, Farmington, MO 63640
- Behavioral Health Claims - Managed Health Services, P.O. Box 6800, Farmington, MO 63640-3809

MHS will return an acknowledgment letter within five business days of receipt of the administrative claim appeal.

Administrative Claim Appeal Review and Determination

Administrative claim appeals are reviewed by a panel of one or more MHS employees or consultants who are trained in the operations of the MHS claims system as well as state and federal Medicaid laws, regulations and provider payments and coding practices.

If the original determination is upheld, the provider will be notified within 45 calendar days of receipt of the appeal. The written determination will include, as applicable, a detailed explanation of the factual and legal basis of the panel's determination. The written determination will also include notice to the provider of the provider's right, within 60 calendar days after receipt of the MHS written determination, to submit to binding arbitration the matter that was the subject of the formal claim resolution procedure.

In the event MHS fails to deliver to the provider a written determination within 45 calendar days of the initial receipt of the administrative claim appeal, the initial decision will be overturned and the appeal ruled in favor of the provider. If the denial determination is overturned (ruled in favor of the provider), the provider is notified via a new EOP showing the claim(s) being reprocessed.

Arbitration

MHS follows the provider dispute process outlined in 405 Indiana Administrative Code 1-1.6-1 et. seq. (for reference: in.gov/legislative/iac/iac_title?iact=405) for both contracted and non-contracted providers. Therefore, in the event a provider is not satisfied with the outcome of the administrative claim appeal process, 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. The letter should explain arbitration is being requested, the reason the provider still believes the claims should be paid or adjusted, along with sufficient information to allow MHS to identify the claims and verify they have been considered at both the dispute/objection and the appeal stage prior to the arbitration request. Providers can choose to mail or fax their pre-arbitration review requests to the following address:

Mailing Address:
MHS Pre-Arbitration Review
429 N. Pennsylvania Street, Suite 109
Indianapolis, IN 46204
Or
New Fax Number:
MHS Pre-Arbitration Review
Fax Number: 1 (833) 364- 2498

Staff who has not previously been involved with making determination on claims will be assigned by MHS to research each case within 30 calendar days of receipt of the provider's arbitration request. MHS shall respond by:

- Contacting the provider to present additional information to the provider and discuss the case in detail, along with instructions on how to file an arbitration, if needed; or
- Contacting the provider to offer to settle the matter.

Binding arbitration must be conducted in accordance with the rules and regulations of the American Health Lawyers Association, pursuant to the Uniform Arbitration Act as adopted in the State of Indiana at Indiana Code 34-57-2-1 et.seq., unless the provider and MHS mutually agree to an alternative binding resolution process.

Claim Processing Following Determination

A claim appeal which has been presented with sufficient documentation to render a final determination shall be processed within 30 calendar days after the final determination. If a claim lacks sufficient supporting documentation, MHS will make a final determination of denial for lack of supporting documentation. The provider will be notified and will have 30 days to submit the requested documentation. If after 30 days the appeal still lacks sufficient documentation, the denial will be upheld and final.

Determining Correct Appeal Procedure for Inpatient Denials

Inpatient stays may be denied either for medical necessity or failure to obtain prior authorization. It is important appeals are sent to the appropriate department, dependent upon the type of denial.

If a request for an inpatient stay was denied for medical necessity, but a provider submits an inpatient claim because he or she disagrees with the decision, the claim may subsequently be denied for no prior authorization. If this occurs, an appeal would be considered a medical necessity appeal. Please follow the procedure outlined in Chapter 8 for medical necessity appeals.

If a claim for an inpatient stay has been denied for no prior authorization because it was not obtained in the manner described in this provider manual, an appeal would be considered a claim appeal. Please follow the procedure outlined in this chapter for submission of the appeal.

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Chapter 6: Transportation

Nonemergency Transportation Services (Excluding Ambulance)

Nonemergency transportation is a covered service for HHW, HIP and HCC members who are going to IHCP providers for medically necessary services.

MHS contracts with LCP Transportation Broker (LCP) to provide eligible MHS members with **unlimited** nonemergency transportation for medical needs. Members, and providers on behalf of the member, can arrange transportation by contacting MHS Member Services at 1-877-647-4848 and selecting the option for transportation.

Nonemergency transportation is provided by vehicle, bus and mileage reimbursement.

- Prior authorization (PA) is required for out-of-state trips.
- MHS also provides additional transportation benefits to:
  - Pharmacies
  - Women, Infants and Children (WIC)
  - Medicaid redetermination appointment
  - MHS special events
  - County Health Departments
  - Parent Visitation to Hospital (NICU visits)
  - FSSA
  - Bariatric Surgery/Counseling/Follow-up
  - Dietitian
  - Dentist
  - Orthodontist
  - Non-Medical COVID-19 Testing sites
  - Grocery store transportation (Lyft only unless curb-to-curb online orders, members cannot be dropped off)
- Members must schedule non-urgent single appointments and recurring appointments at least two business days in advance (requests less than three business days or same-day may be authorized for urgent care services). Reoccurring trips may be scheduled up to 90 days in advance for standing orders (i.e dialysis, chemotherapy, substance abuse treatment, ABA therapy) and 30 days in advance for regular medical appointments.
- Additional riders may be approved to ride with the member as needed.
- All credentialing and claims for nonemergency transportation providers are processed by LCP with the exception of nonemergency ambulance transportation providers that are processed directly by MHS. Please follow directions for ambulance claims processing in the sections that follow.
- If you are a transportation provider, please refer to your Vendor Agreement with LCP for NEMT claims processing information.
- All transportation will remain compliant with ADA standards providing accessibility to all members.
- Members should call 911 for all emergency transportation needs.

Nonemergency Transportation Claims

Claims processed by LCP:

- Nonemergency medical transportation (NEMT)/taxi
- Scheduled non-emergent stretcher van regardless of date of service

Claims may be sent to LCP, P.O. Box 531097, Indianapolis, IN 46253. Many services require authorization. The requests have to be made prior to the claims being submitted, but not prior to service being provided. If the claim is submitted prior to the authorization being loaded in the LCP system, the claim will deny as not authorized. The provider may call to have the authorization into the system. The provider's Medicaid MID number and NPI will be required when calling in the authorization. Once the authorization is loaded in the LCP system, the provider many resubmit the claims within 60 days.

Chapter 6: Transportation (cont'd)

Ambulance and Fixed Air Transportation

Emergency Transportation

MHS directly prior authorizes and reimburses for ambulance transports. Transportation by ambulance is reimbursable for all HHW, HIP and HCC members in emergent situations without a prior authorization. Prior authorization from MHS is required for all fixed wing transfer and non-emergent transfer by ambulance. If you refer a member to the ER, please notify MHS immediately through the Referral Services line at 1-877-647-4848, as this will affect the HIP member copayment process at the ER.

Prior Authorization for Non-Emergent Ambulance and Air Transport

Ambulance providers will require a prior authorization from MHS for the following services:

Ambulance:

- A0426 - Ambulance service, adv. life support, non-emergency transport, level 1
- A0428 - Ambulance service, basic life support, non-emergent transport.
- A0999 - Unlisted ambulance service
- T2003 - Nonemergency transportation encounter/trip
- T2004 - Nonemergency transportation commercial carrier

Air Transport:

- A0140 - Nonemergency transportation and air travel
- A0430 - Air Ambulance, conventional air services, one way (fixed wing)
- A0999 - Unlisted Ambulance service

PLEASE NOTE *Throughout the manual this icon refers to the following statement:*
Healthy Indiana Plan (HIP) cost-sharing, which includes copayments and POWER Account contributions, will continue to be paused. For CHIP and MEDWorks, cost sharing resumed as of July 1, 2024.

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Chapter 7: Medical Management

MHS Medical Management offers assistance to providers regarding member eligibility for particular services covered under IHCP benefit packages as well as obtaining prior authorizations. Sources for determining coverage eligibility include the Indiana Code, Indiana Administrative Code, OMPP IHCP MCE Policy and Procedure Manual, IHCP Modules, IHCP Bulletins and the OMPP-MCE contract.

Services provided or requested that are not eligible for coverage under IHCP benefit packages are deemed ineligible for coverage. Those services determined to be eligible for coverage are subject to medical necessity review including appropriateness of care and service. All managed care entities will follow the prior authorization and utilization management medical criteria hierarchy described below. MHS uses InterQual Clinical Guidelines for all prior authorization reviews with the exception on Evolent adopted the use of the MCG Guidelines® for Indiana Medicaid members. Prior authorization requests will be reviewed for medical necessity determination based on the following hierarchy and be reviewed in the order listed below.

The hierarchy is as follows:

- Federal Law - All review criteria must comply with federal law (if the Code of Federal Regulations has any Medicaid-specific requirements, the IHCP must comply).
- Non-Customized National Clinical Guidelines
- Indiana code - All review criteria must comply with Medicaid-specific provideions of the Indiana Code. MCE-derived Guidelines
- State Plan - Review criteria are subject to the t erms of the state plan (which is the IHCP agreement wit the Centers for Medicare & Medicaid Services (CMS) outlining the coverage and reimbursement of IHCP services).
- Professional Society Guidelines • Indiana Administrative Code - All review criteria must comply with Medicaid-specific provisions of the Indiana Administrative Code (which is given authority from the Indiana Code).
- Professional Reverences/SME
- IHCP Policy National Clinical guidelines (InterQual or MCGs), MCE-developed PA-UM policy and criteria, IHCP policy • Best Standards of Care The MCE may choose to use either InterQual or MCG and may also customize those criteria. MCE-derived PA-UM policy and criteria must be submitted to the state for preapproval. The MCE may use IHCP policy and criteria MCEs may still choose to use Medicare NCDs and LCDs, when clinically appropriate Professional society guidelines - guided by publishe peer-revieewed literature(can supersede national and MCE-developed PA-UM policy and criteria if specifically called out to be used in the Scope of Work, such as the American Society of Addiction Medicine Professional reference/Subject matter expert - guided by published peer-reviewed literrature Best standards of care-guided by published peer-reviewed literature.

Appropriately licensed, qualified professionals make all medical necessity decisions. The Indiana Department of Insurance, OMPP, and MHS providers are notified in writing prior to implementing any significant changes that affect provider processes or procedures. Utilization Management (UM) decision-making is based only on the appropriateness of care and services and existence of coverage. MHS does not provide any incentives to MHS staff or providers for issuing denials of coverage or care or for under-utilizing medically-necessary and appropriate care and services.

Contact MHS Medical Management

Contact MHS Medical Management for information about the Utilization Management process and authorization of care. Hours of operation for MHS Medical Management are Monday- Friday (excluding holidays), 8 a.m.-12 p.m. and 1-5 p.m. (EST). MHS representatives are available for members through the 24-Hour Nurse Advice Line, a multilingual triage nurse line. The free Nurse Advice Line is available 24/7, every day of the year, including holidays. MHS Medical Management provides an after-hours answering system which has instructions regarding service requests and inquiries as well as recorded messages. A nurse and physician are on-call after hours, on weekends and holidays to assist in urgent requests for services. All messages regarding non-urgent services are returned during business hours within two business days. All outbound calls from MHS Medical Management will be initiated by an MHS staff member who will identify him or herself by name, title and organization.

Referral and Prior Authorization (PA)

Referral

A referral is a request (web/provider portal, verbal, written or phone communication) by a PMP for specialty care services. It is the responsibility of the PMP and specialist to coordinate member appointments and treatment needs.

Prior Authorization (PA)

A PA is an authorization from MHS to provide services designated as requiring approval prior to treatment and/or payment. All procedures requiring authorization must be obtained by contacting MHS prior to rendering services. PA is required for certain services/procedures which are frequently over- and/or underutilized or services/procedures which are complex and may indicate a need for case management.

Information Needed to Request Prior Authorization or Referral

- Member information: name, MID number and date of birth
- Type of service (e.g., office visit, outpatient surgery, DME, inpatient admission, testing, therapy, etc.)
- Date(s) of service
- Ordering physician (NPI and Tax ID numbers required)
- Servicing physician (NPI and Tax ID numbers required)
- HCPCS/CPT® codes requested for approval
- Clinical information to support medical necessity, including the following:
  - History of symptoms
  - Previous treatment and results
  - Physician rationale for ordering treatments and/or testing

DME PA requests require the following additional information
- Certificate of medical necessity must be complete and have current (within three months) information and MD signature within the year
- Physician's orders
- Whether the request is for purchase or rental
- Power wheelchairs: must have home evaluation
- Enteral/Formula: current height/weight, growth charts, nutrition history, previous testing/imaging and clinical records within three months surgeries, current MD office visit notes related to the request

Home Healthcare Services also require the following information:
- Physician's orders
- Progress notes to assist in determining medical necessity
- Signed Plan of Care

Bariatric Surgery requests also require the following information:
The IHCP member must meet all the following criteria for bariatric surgery to be considered medically necessary:
- Member is morbidly obese as defined by either of the following:
  - BMI of at least 30 with a diagnosis of type 2 diabetes mellitus with inadequately controlled hyperglycemia despite optimal medical treatment (such as oral medication or insulin)
  - BMI of at least 35 with comorbidity or coexisting medical conditions, such as hypertension, cardiopulmonary conditions, sleep apnea or diabetes
  - BMI of at least 40 without comorbidity
- Failed weight-loss therapy; the scope and duration of failed weight-loss therapy must meet the one of the following:
  - Unsuccessful weight-loss therapy as shown with both of the following:
    - Morbid obesity has persisted for at least five years
    - Physician-supervised nonsurgical weight-loss program has been unsuccessful for at least six consecutive months
    - *Note: Successful weight-loss therapy is defined as the ability to reduce body weight by approximately 10% from baseline in a period of eight months.*
  - Unsuccessful weight-loss maintenance:
    - Member successfully achieved weight loss after participating in a physician-supervised nonsurgical weight-loss program but has been unsuccessful at maintaining weight loss for two years (greater than 3-kilogram [6.6-pound] weight gain)
    - *Note: Unsuccessful weight-loss maintenance is defined as a weight regain of more than 3 kilograms (6.6 pounds) in two years and the inability to maintain a sustained reduction in waist circumference of at least 4 centimeters.*

Pain Management requests also require the following information:
- Documentation of at least six weeks of therapy on area to be treated within the last six months, in addition to what has been tried and failed
- Previous procedures/surgeries, medications, description of pain, any contra-indications or imaging studies
- Prior injection test results for injection sites

Medical Infusion Requests:
- Progress notes to assist in determining medical necessity
- Note: some infusion or injectable medication will be limited to the pharmacy benefit. (see Chapter 9: Pharmacy)

Always check member eligibility for date of service, as requests may be delayed if the member is with another MCE or is otherwise not eligible.

How to Obtain a Referral or Prior Authorization from MHS:
For outpatient surgeries and testing, requests for services may be obtained via:
- Phone: 1-877-647-4848;
- Fax: 1-866-912-4245; or
- Online: Through the MHS Secure Provider Portal Login.

Authorization approval is for medical necessity only. If your claim subsequently denies, please contact MHS Provider Services at 1-877-647-4848 to determine the reason for the denial.

MHS will return a decision on all standard PA requests within 48 hours, or 24 hours for urgent requests (excluding all federal and state holidays). Reasons for a delayed decision include the following:
- Lack of information
- Illegible faxes

Referrals Requirements

Referrals to Specialists
Specialty physicians do not require an authorization number from MHS. Please communicate directly with the PMP's office for referrals. If a specialist determines there is a need for ongoing treatment after the initial visit, the PMP and specialist offices should communicate directly for any needed referrals.

MHS requires PMPs to refer to in-network/contracted specialists when possible.

A specialist may order diagnostic tests without PMP involvement by following MHS referral guidelines as outlined in this chapter. MHS does not allow specialty providers to refer to another specialist. This referral must be made by the PMP.

Self-Referral Services
Please refer to Chapter 15.

Prior Authorization (PA) Requirements

Contracted Providers

Contracted providers requesting authorization for elective/routine services that require a PA must obtain it at least 48 hours prior to the date of service to ensure an authorization determination occurs prior to rendering a service. MHS does allow requests for authorization from contracted providers up to 48 hours after the date of service, subject to the appropriate medical review.

Non-Contracted Providers

Non-contracted providers requesting authorization for elective/routine services that require a PA must obtain it 48 hours prior to the date of service. Retroactive authorizations will not be granted except in the event of an emergent situation. If a provider is unable to request a PA at least two business days in advance due to the emergent nature of the member's condition, a PA request must be initiated within two business days following the date of service/admission. MHS will make every effort to expedite the request. All inpatient admissions/services require authorization within two business days of the admission/service.

Failure to obtain PA as previously described may result in claims payment denials for late notifications. Claim denials may result when a claim is denied due to a failure to obtain PA for services where PA is required.

List of Services Requiring Prior Authorization

Services requiring PA, as listed in this section, are pertinent for all providers. The list may not be all-inclusive and is subject to periodic updates. Providers should check mhsindiana.com for updates via the blog, provider newsletters and the Provider Quick Reference Guide (QRG). Providers should also refer to the online tool for specific code requirements. You may also call MHS Medical Management if you are unclear whether a service requires PA. *Approved PAs do not guarantee claim payments*.

BEHAVIORAL HEALTH AND SUBSTANCE ABUSE SERVICES PRIOR AUTHORIZATION OR NOTIFICATION REQUIREMENTS

- Substance Abuse, Eating Disorders
- Intensive Outpatient Treatment Program IOT (Mental Health, Substance Abuse)
- Partial Hospitalization Program
- Substance Abuse Disorder (SUD) Services Residential Treatment Facility (Below a 30-day length of stay)
- BH Outpatient Therapy (Combined limit of 20 units per member, per practitioner per 12-month rolling year, 90832-90834, 90836-90840,90845-90853)
- Psychiatric diagnostic evaluation without medical services (Limited to one (1) per member per 12-month (Rolling year) without authorization)
- Electroconvulsive Therapy
- Psychological testing
- Transcranial Magnetic Stimulation (TMS)
- Neuropsych Testing
- Applied Behavioral Analysis (ABA) Services

CARDIAC AND ORTHOPEDIC SERVICES PRIOR AUTHORIZATION OR NOTIFICATION REQUIREMENTS

Turning point handles all initial requests for cardiac services. Initial requests can be faxed to 1-463-207-5864. Evolent handles all initial requests for orthopedic services. Initial requests can be submitted online through the Evolent provider portal at evolent.com/provider-portal. Evolent can be contacted at 1-866-904-5096.

Please note:
- TurningPoint authorization UPDATES are processed internally through MHS.
- Evolent authorization UPDATES are processed by Evolent.
- TurningPoint and Evolent appeals are handled internally through MHS Appeals.

Below is a Quick Reference Guide to assist:

AUTHORIZATION REQUEST TYPE	TURNINGPOINT	MHS	EVOLENT	MHS
Initial Requests	✓		✓	
Provider Changing/Adding Codes		✓	✓	
Provider Updating DOS		✓	✓	
Provider Changing Facility/ Provider		✓	✓	
Appeals		✓		✓
Peer-to-Peer	✓		✓	

If additional assistance is needed please request to be transferred to the MHS Medical Management Operations' TurningPoint line at 1-877-647-4848, ext. 604-7774.

CONTRACTED AND NON-CONTRACTED PROVIDERS PRIOR AUTHORIZATION OR NOTIFICATION REQUIREMENTS

PRIOR AUTHORIZATIONS (PA)
The services listed require PA for all providers. **This list is not all-inclusive and is subject to periodic updates.** Providers should refer to the online tool for specific code requirements.

NOTE: Ancillary services performed during an in-network observation stay (such as labs, X-rays and scans) do not require PA.

ANCILLARY SERVICES
- Cardiac rehabilitation
- Hearing aids and devices
- Home care services, home health, hospice, PT/OT/ST billed as location 12
- In-home infusion therapy
- Orthopedic footwear, shoe modifications and additions (non-diabetic only)
- Respiratory therapy service
- Pulmonary rehabilitation

INPATIENT AUTHORIZATION
- All elective hospital admissions
- All urgent and emergent hospital admissions (including NICU) require notice to MHS by the second business day after admission
- Newborn deliveries by second business day after delivery
- Rehabilitation facility admissions
- Skilled Nursing Facility admissions
- Transfer between facilities
- Transplants, including evaluations
- Hysterectomy

OUTPATIENT SERVICES AUTHORIZATION (NON-ELECTIVE ONLY)
- Assistant surgeon
- Blepharoplasty
- Dental surgery for members > 5 y/o and/or general anesthesia is requested
- Experimental or investigational treatment/services
- Genetic testing and counseling
- Hysteroscopy and hysterectomy
- Implantable devices including cochlear implants
- Infertility services
- Injectable Drugs (see mhsindiana.com/providers/prior-authorization.html for up to date list of codes requiring PA and if they should be billed through pharmacy or medical benefit)
- Mammoplasty
- MRI and MRA unless performed as part of an observation stay
- Nutritional counseling (non-diabetics only)
- Pain management programs (pain injections done the same day as approved surgery do not require PA)
- PET and nuclear cardiology/SPECT scans
- Quantitative drug screens
- Scar revisions/cosmetic or plastic surgery
- Septoplasty/rhinoplasty
- Spider/varicose veins
- Specialized radiation therapy

TUBAL LIGATION AND VASECTOMY
A PA is not required for these services, however, the completed consent form is required at the time of claims submission.

DME
All out of network DME services & the following DME, Orthotics and Prosthetics require prior authorization by the ordering physician.

- ***Incontinence Supplies***: Incontinence supplies do not require PA if provided by an in-network provider; however the monthly maximum benefit is $162.50 per month in allowable reimbursement.
- ***Speech Communication Devices:*** E2502-E2510, L8627-L8628, L8690-L8691, L8693
- ***Diabetic footwear and insulin pump supplies:*** A9274, A9277, A9278
- ***Decubitus Care, Hot-cold Application, Hospital Beds and Accessories, Traction:*** E0186, E0190, E0217, E0236, E0240, E0250-E0255, E0260-E0266, E0277, E0292E0304, E0316, E0328-E0329, E0371-E0373, A6501, A6507, A6511, A8003, E0193, , E0849, E0912, E0935, E0936,E0948, E1310, E2402
- ***Light Therapies:*** E0691-E0694
- ***Monitors and Medical supplies:*** A4210, E0615-E0619, E2100, E2120
- ***Neuromuscular Stimulators, Bone Growth Stimulators:*** E0740, E0745, E0747, E0748, E0760, E0770, E0785, K0606, L8680-L8684, L8686-L8689, Q0479-Q0484, Q0489-Q0491, Q0495-Q0496, Q0502-Q0506
- ***Nutrition, Enteral, Parenteral:*** B4100-B4216, B5000-B9999
- ***Orthotics and Prosthetics:*** L0112, L0170, L0190, L0200, L0456-L0464, L0468-L0470, L0480-L0492, L0631, L0635-L0640, L0648, L0650-L0859, L0999-L1005, L1200, L1230, L1300-L1499, L1640, L1680-L1755,L1832-L1834, L1840, L1844, L1846, L1860, L1904, L1907, L1932-L1971, L1990-L2034, L2036-L2038, L2050-L2060, L2090-L2180, L2280, L2330, L2340-L2350, L2510-L2526, L2540, L2570-L2580, L2627-L2628, L2999, L3230, L3330, L3671-L3674, L3720-L3766, L3900-L3905, L3915-L3916, L3960-L3981, L3999, L4000, L4010-L4030, L4130, L4205, L4631-L5617, L5626-L5628, L5630-L5631, L5638-L5653, L5661-L5665, L5671, L5673, L5677, L5679, L5681-L5683, L5700-L5707, L5711-L5859, L5920, L5930-L5968, L5973, L5975-L5976, L5979-L6590, L6621-L6628, L6638, L6646-L6648, L6686-L6690, L6692-L6698, L6704, L6707-L6722, L6880-L6885, L6895, L6900-L7259, L7364-L7366, L7368, L7404-L7499, L7900, L8030, L8035-L8047, L8499, L8600, L8609-L8612, L8614-L8615, L8619, L8627-L8628, L8631, L8659-L8693, L8699, Q4111, S1040, T1999, T2028-T2029, T5001, V2531, V2623, V2627, V2629, V5014, V5040-V5060, V5120-V5140, V5180, V5210-V5220, V5246-V5253, V5256-V5261, V5298-V5299
- ***Pumps, Compression Devices***: B4224, B9000-B9006, E0650-E0652, E0667-E0668, E0670, E0781-E0784, E0786, E0791, E2000
- ***Respiratory Equipment:*** E0445, E0455-E0483, E0500, E0550, E0565, E0466, E0574, E0575, E0601, E1390-E1391
- ***Wheelchairs, Patient Lifts, Accessories:*** E0147, E0625, E0628, E0640-E0642, E0630-E0638, E0958, E0983, E0984, E0986, E0988, E1002, E1004, E1008, E1010-E1012, , E1030-E1031, E1050-E1070, E1084, E1086-E1093, E1110-E1161, E1195, E1220, E1222-E1226, E1229, E1232-E1238, E1240-E1260, E1280-E1296, E2202-E2204, E2228, E2291-E2295, E2310-E2311, E2321, E2325, E2341, E2343, E2359, E2366, E2368, E2370, E2373-E2378, E2512-E2599, E2603-E2609, E2611-E2617, E2622, E2624, E2628, E8000-E8002, K0010, K0014, K0739, K0813, K0816, K0821-K0829, K0835, K0837-K0864, K0877, K0884-K0898
- ***Other DME codes:*** A6511, A9900, A9999, E0170-E0172, E1399, E1800-E1806, E1810-E1811, E1815-E1818, E1825-E1830, E1840-E1841, K0108, K0609, K0730, K0800-K0802, L2180, L2540, L3981, L6026, L7259, L7364, L7366, Q1003, Q4100, Q4111,Q4118, S1040, S5162, V5246, V5247, V5298

Indiana Medicaid may require purchase of equipment if rental cost exceeds purchase price. MHS follows this process. Therefore, payment of rental items may not be provided if rental price exceeds purchase price, even if an authorization is obtained. You will receive notification via your EOP should this occur and you should call MHS immediately.

THERAPY SERVICES *(applies to both contracted and non-contracted providers)*
Effective July 1, 2019, Physical, Occupation and Speech therapy services DO REQUIRE prior authorization. Evolent manages therapy prior authorization for MHS members. All therapy claims must contain the appropriate modifier when submitted to the health plan in order to ensure appropriate adjudication (GN, GO, GP).

To obtain therapy prior authorization, contact Evolent via:
- ***Web:*** RadMD.com
- ***Phone Number***: 1-866-904-5096

MUSCULOSKELETAL PROCEDURES
Specific musculoskeletal (orthopedic and spinal surgical) procedures require prior authorization by Evolent.

For a complete list of codes that require PA and to submit a PA request, contact Evolent via:
- ***Web***: www.RadMD.com
- ***Phone Number***: 1-800-327-0641

NON-AMBULANCE TRANSPORTATION *(applies to both contracted and non-contracted providers)* Prior authorization from MHS is required for fixed wing transfer and non-emergent transfer by ambulance.

Outpatient Facilities

Facilities should not render services without obtaining the PA number from the ordering physician. Failure to ensure the referring provider has obtained the PA may result in a claim denial. It is recommended the facility verify the CPT® code that was authorized as well as the date of service requested. If the anticipated CPT® billing code changes and a different procedure is done, the rendering provider has up to 30 calendar days following service to contact MHS to update the code that was approved on the PA.

Inpatient and Observation Services

MHS requires the following for inpatient and observation services:

- Emergent, urgent or unplanned inpatient hospital admissions - the hospital must notify MHS within two business days of the date of admission
- Elective/scheduled or planned hospital admissions - the PMP, admitting physician or hospital must notify MHS two business days prior to the requested admission date
- Inpatient neonate NICU level or special care nursery admissions - the hospital must notify MHS within two business days after the admission date
- Admissions to rehabilitation facilities, hospice and skilled nursing facilities - the facility must notify MHS at least two business days prior to a planned admission or no more than two days post-admission for an urgent or emergent admission
- Transplants admissions (including evaluations) - PMP, treating physician or the facility must notify MHS at least two business days prior to the admission

Observation Bed Guidelines

Emergent observation services do not require PA. Observation services are considered appropriate for members whose condition is expected to improve with treatment within 24-72 hours. Examples include diabetic ketoacidosis, asthma, bronchitis, uncomplicated pneumonia, and surgery that is not expected to be complicated from other health conditions. Observation is used to:

- Evaluate, diagnose and treat an acutely ill patient's condition
- Determine the need for a possible inpatient hospital admission
- Provide aggressive treatment for an acute condition

If the member's condition does not improve within 72 hours, the hospital should notify MHS for authorization for an inpatient admission. By State regulation, services performed in less than 24 hours cannot be billed as an inpatient stay.

In some instances, the hospitalization begins in an observation status, and later the patient is upgraded to an inpatient admission. In these instances, all incurred observation charges and services will be rolled into the acute reimbursement rate or as designated by the contracted arrangement with MHS. The observation should not be billed separately. The physician and/or hospital are responsible for notifying MHS of an acute admission.

All inpatient admissions less than 24 hours will be authorized at an observation level of care and should be billed as such. Providers are not expected to substitute outpatient observation services for medically-appropriate inpatient hospital admissions.

Inpatient stays may be denied for lack of medical necessity, a delay in care/services or failure to obtain PA. It is important that appeals are sent to the appropriate department, dependent upon the type of denial:

- If an inpatient claim has been denied for lack of medical necessity, the appeal would be considered a medical necessity appeal. Please follow the procedure outlined in this chapter for submission of the appeal.
- If an inpatient claim has been denied for no PA, the appeal would be considered a claim appeal. Please follow the procedure outlined in Chapter 5 for submission of the appeal.

Facility-to-Facility Transfers

MHS requires two business days advance notification for all non-emergent transfers as well as two business days notification following all emergent transfers. Transfers include, but are not limited to, facility-to-facility and transfers to a level-of-care. Prior authorization from MHS is required for fixed wing transfer and non-emergent transfer by ambulance.

Post-Stabilization

MHS covers post-stabilization services related to emergency medical conditions provided after a member is stabilized, to maintain the stabilized condition, or to improve or resolve the member's condition as described in 42 CFR 438.114. MHS is financially responsible for post-stabilization services obtained within or outside MHS' network when preapproved by a provider or other MHS representative. In addition, MHS is also financially responsible for post-stabilization care services obtained within or outside MHS' network which are not pre-approved by an MHS provider or other MHS representative and administered to maintain the member's stabilized condition if:

- MHS does not respond to a request from the treating provider for pre-approval within one hour of being called
- MHS cannot be contacted
- The MHS representative and the treating physician cannot reach an agreement concerning the member's care, and an in-network provider is unavailable for consultation. In this situation, MHS must allow the treating physician an opportunity to consult with a provider, and the treating physician may continue with care of the member until a provider is reached or one of the criteria of 42 CFR 422.113 (c)(3) is met.

Late Notification

MHS requires the below processes to be followed when a member is not covered by Indiana Medicaid upon presentation to the facility.

Mother Covered by Indiana Medicaid MCE

The facility must notify MHS of an admission of an infant who remains hospitalized after the mother is discharged within two business days. The facility is responsible for determining the mother's coverage and chosen/assigned MCE. The facility should assume that the member will be assigned to the mother's MCE.

Mother Not Covered by Indiana Medicaid MCE

If the infant's mother is not covered by an MCE at the time of delivery, the facility must notify MHS of the admission within 60 days of becoming aware of the member's eligibility using the IHCP PA form and the MHS Late Notification of Services Submission form with clinical information supporting the medical necessity for the admission. It is presumed that the facility would become aware of the member's eligibility within one week of visibility on the State Portal.

Fast Track

If an adult, 19 years or older, presents for services without insurance, and for a reason beyond the facility's control are unable to complete the HPE process, the facility may assist the member or the member may apply for HIP coverage using the standard application process or the Fast Track process, which includes a $10 payment via credit card. The Fast Track payment will provide for coverage the first of the month that payment was made, if the member is determined eligible. Providers must follow the process as outlined in BT201913 and use the following process for inpatient stays to ensure that they can properly submit a retroactive PA request for individuals utilizing a Fast Track prepayment:

- The provider must assist an individual in completing an application for health coverage.
- As part of the application process, the provider will assist the individual with submitting a Fast Track prepayment.
- After assisting with the application for health coverage, the provider must complete a Fast Track Notification Form (available on the Forms page at in.gov/medicaid/providers/files/Full-Eligibility-Notification-Form.pdf) and fax the form to the MCE selected on the application. This process must be completed within five days of the date of admission. To locate the fax number for the applicable MCE, see the IHCP Quick Reference Guide at in.gov/medicaid/providers/files/quick-reference.pdf
- After eligibility has been established, the MCE will return a Full Eligibility Notification Form (available on the Forms page at in.gov/medicaid/providers) to the provider via fax. This form will contain the member's MCE assignment and Member ID. The notification will occur within seven days following eligibility discovery.
- The provider will then be able to submit a PA request for the service rendered since the first day of the month of the Fast Track prepayment. Providers must submit the PA request within 60 days of receiving the Full Eligibility Notification Form. Providers must verify eligibility, using the IHCP Provider Healthcare Portal, prior to submitting the PA request.

No Fast Track
If an adult, 19 years or older, presents for services without insurance and the facility does not help the member apply for HPE or complete the HIP application, the facility must notify MHS of the admission within 60 days of becoming aware of the member's date of Medicaid eligibility using the IHCP PA form and the MHS Late Notification of Services Submission form with clinical information supporting the medical necessity for the admission. It is presumed that the facility would become aware of the member's eligibility within one week of visibility on the State Portal.

Assistant Surgeon

Coverage and subsequent reimbursement for assistant surgeon services are based on medical necessity at the time of the procedure.

Hospital medical staff bylaws requiring an assistant surgeon for a designated procedure are not grounds for reimbursement. Medical staff bylaws alone do not constitute medical necessity, nor is reimbursement guaranteed when the member or family requests an assistant surgeon be present for the surgery.

Continuity of Care

MHS is committed to providing continuity of care of medically-necessary healthcare for members as they transition between various IHCP programs. In some instances, MHS will authorize payment for a provider other than the PMP to coordinate the member's care as in the following examples:

- If an existing out-of-network provider has been treating a new member and MHS has been notified of the arrangement. The out-of-network provider must comply with the MHS Medical Management program and accept the IHCP fee schedule rates. The out-of-network provider must transfer the member's records to the MHS provider and will not be authorized for ongoing care for more than 90 days (or nine months in the case of a member who at the time of enrollment is diagnosed with a terminal illness).
- MHS will honor any pre-existing authorizations from any other Medicaid program for the time frame below or up to the expiration date of the previous authorization, whichever occurs first, and upon notification to MHS and submission of a copy of the authorization for the prior program.
  - HHW and HIP for the first 30 days of enrollment
  - HCC for the first 90 days of enrollment
- A provider, who is aware of a PA from a previous MCE, fee-for-service program, or another insurer, should inform MHS as soon as possible.

Dental Services

PMPs are encouraged to inform MHS members to visit an IHCP dental provider for routine dental exams; however, routine dental exams do not require a referral from the PMP. When dental exams require surgical treatment for members less than five years of age or treatment for any member requires a facility or anesthesia charge, the dentist must contact MHS for PA. All dental claims will be billed through Centene Dental. Please contact Centene at centenedental.com for all enrollment and billing guidelines.

Radiology, Diagnostic Imaging and Therapy

As part of a continued commitment to further improve the quality of advanced imaging and radiology services, MHS is using Evolent to provide prior authorization services and utilization. Evolent focuses on radiation awareness designed to assist providers in managing imaging services in the safest and most effective way possible.

Prior authorization is required for the following outpatient radiology procedures:

- CT/CTA
- CCTA
- MRI/MRA
- PET Scan
- Myocardial Perfusion Imaging
- MUGA Scan
- Stress Echocardiography
- Echocardiography

Key provisions:

- Emergency room, observation, and inpatient imaging procedures do not require authorization.
- Providers rendering the above services should verify that the necessary authorization has been obtained. Failure to do so may result in claim non-payment.
- It is the responsibility of the ordering physician to obtain authorization.

Therapy Services (applies to both contracted and non-contracted providers)

Physical, Occupation and Speech therapy services DO REQUIRE prior authorization. Evolent manages therapy prior authorization for MHS members. All therapy claims must contain the appropriate modifier when submitted to the health plan in order to ensure appropriate adjudication (GN, GO, GP).

Evolent provides an interactive website (RadMD.com), which should be used to obtain online authorizations.

To obtain authorization, the provider should go to RadMD.com, or through the Evolent dedicated toll-free phone number at 1-866-904-5096.

Interventional Pain Management

Evolent manages non-emergent outpatient prior authorizations for Interventional Pain Management (IPM) procedures. It is the responsibility of the ordering physician to obtain authorization for all IPM procedures outlined below. Outpatient IPM procedures requiring prior authorization include:

- Spinal Epidural Injections
- Paravertebral Facet Joint Injections or Blocks
- Paravertebral Facet Joint Denervation (Radiofrequency Neurolysis)
- Sacroiliac Joint Injections
- Spinal Cord Stimulators

Note: A separate prior authorization number is required for each procedure ordered. Prior authorization is not required through Evolent for services performed in the emergency department, on an inpatient basis or in conjunction with a surgery. Prior authorization and/or notification of admission is still required through New Hampshire Healthy Families. To obtain authorization through Evolent, visit RadMD.com or call 1-800-327-0641.

Musculoskeletal Care Management (MSK)

In keeping with our commitment of promoting continuous quality improvement for services provided to MHS members, MHS has partnered with Evolent to implement a Musculoskeletal Care Management (MSK) program. This program includes prior authorization for non-emergent MSK procedures for MHS members. This decision is consistent with industry-wide efforts to ensure clinically appropriate quality of care and to manage the increasing utilization of these services.

How the Program Works

MSK Surgeries: Prior authorization will be required for the following non-emergent inpatient and outpatient hip, knee, shoulder, lumbar and cervical surgeries:

Hip

- Revision/Conversion Hip Arthroplasty
- Total Hip Arthroplasty/Resurfacing
- Femoroacetabular Impingement (FAI) Hip Surgery (includes CAM/pincher & labral repair)
- Hip Surgery – Other (includes synovectomy, loose body removal, debridement, diagnostic hip arthroscopy, and extra-articular arthroscopy knee)

Knee

- Revision Knee Arthroplasty
- Total Knee Arthroplasty (TKA)
- Partial-Unicompartmental Knee Arthroplasty (UKA)
- Knee Manipulation under Anesthesia (MUA)
- Knee Ligament Reconstruction/Repair
- Knee Meniscectomy/Meniscal Repair/Meniscal Transplant
- Knee Surgery – Other (includes synovectomy, loose body removal, diagnostic knee arthroscopy, debridement with or without chondroplasty, lateral release/patellar realignment, articular cartilage restoration)

Shoulder
- Revision Shoulder Arthroplasty
- Total/Reverse Shoulder Arthroplasty or Resurfacing
- Partial Shoulder Arthroplasty/Hemiarthroplasty
- Shoulder Rotator Cuff Repair
- Shoulder Labral Repair
- Frozen Shoulder /Adhesive Capsulitis Repair
- Shoulder Surgery – Other (includes debridement, manipulation, decompression, tenotomy, tenodesis, synovectomy, claviculectomy, diagnostic shoulder arthroscopy)

Cervical
- Cervical Anterior Decompression with Fusion –Single & Multiple Levels
- Cervical Posterior Decompression with Fusion –Single & Multiple Levels
- Cervical Posterior Decompression (without fusion)
- Cervical Artificial Disc Replacement – Single & Two Levels
- Cervical Anterior Decompression (without fusion)

Lumbar
- Lumbar Microdiscectomy
- Lumbar Decompression (Laminotomy, Laminectomy, Facetectomy & Foraminotomy)
- Lumbar Spine Fusion (Arthrodesis) With or Without Decompression – Single & Multiple Levels
- Lumbar Artificial Disc – Single & Multiple Levels
- Sacroiliac
- Sacroiliac Joint Fusion

As a part of the Evolent clinical review process, actively practicing, orthopedic surgeon specialists (hip, knee, and shoulder) or neurosurgeons (spine) will conduct the medical necessity reviews and determinations of musculoskeletal surgery cases.

Please refer to the "Solutions" tab on the Evolent home page RadMD.com for additional information on the MSK program. Checklists and tip sheets are available there to help providers ensure surgical procedures are delivered according to national clinical guidelines. Should you have questions, please contact Evolent at 1-800-327-0641.

Rendering Prior Authorization Decisions

The National Committee for Quality Assurance (NCQA) and OMPP require health plansto provide a decision to requests for PA within specific time frames of the initial requests. For standard authorization requests, MHS is required to provide a decision to your PA request within 48 hours of the request, excluding weekends and state and federal holidays. For situations in which a provider indicates, or the MCE determines, that following the standard time frame could seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function, MHS is required to make an expedited decision to your authorization no later than 24 hours from receipt of the request, excluding weekends and state and federal holidays.

To ensure sound decisions are made during the PA review process, MHS is often in need of supporting clinical information. Clinical information includes the member's history of symptoms, previous treatments and outcomes, testing results, and the ordering physicians' rationale for service to be performed.

For a non-urgent or standard request that was submitted without full information needed for a decision, the health plan will request the information and allow an additional 14 calendar days for the submission of the additional information. The health care provider then has 24 hours to respond to the request. MHS will make a determination (decision) and notification of that determination within 24 hours from time of receipt of the additional supporting clinical information.

For a non-urgent request, the health plan may extend the time frame once, by up to 14 calendar days if a member requests the extension or the health plan needs additional information. The UM department must document that at least one attempt to obtain the necessary information was requested from the provider. Once the additional information is received a decision will be rendered within 48 hours, excluding weekends and state and federal holidays.

Utilization Management (UM) Review Guidelines

Prior authorization is a key component of the Utilization Management (UM) program, requiring providers to obtain approval before certain services are rendered. MHS also conducts concurrent reviews for ongoing services, particularly for inpatient stays, to assess progress and discharge planning. MHS primarily uses InterQual guidelines for UM reviews. An urgent condition is defined as a health condition (including an urgent behavioral health situation) which is not an emergency, but would cause a prudent layperson possessing the average knowledge of healthcare to believe the situation requires medical treatment or evaluation within 24 hours by the member's PMP or PMP designee to prevent serious deterioration of the individual.

An emergency medical condition is defined as a medical condition manifested by acute symptoms of sufficient severity (Including severe pain), such that a prudent layperson who possesses an average knowledge of healthcare could reasonably expect the absence of immediate medical care to result in death, serious health-related injury, permanent impairment of bodily functions, or serious dysfunction of any bodily organ or part, or a threat to the health or safety of a pregnant woman or an unborn child, with inadequate time or inability to ensure a safe transfer to another hospital. A member may select any IHCP provider or hospital for true emergency care.

InterQual and MHS-developed guidelines are utilized as a screening guide and are not intended to be a substitute for practitioner judgment. Review decisions are made in accordance with currently-accepted medical or healthcare practices, taking into account special circumstances of each case which may require deviation from the normal screening guidelines. Guidelines are used by UM nurses to determine medical necessity and approval of authorization request. If criteria is not met for approval, the UM nurse will refer the request and associated medical record information to an MHS Medical Director and/or Pharmacist. Medical Directors and/or Pharmacists are responsible for all medical necessity denial decisions.

Utilization management review guidelines can be obtained by contacting MHS Medical Management at 1-877-647-4848 or by mailing a request to 429 N. Pennsylvania St. Suite 109, 46204.

Peer-to-Peer Review

Practitioners who disagree with a determination based on medical necessity may request a peer-to-peer review within seven (7) business days after a service authorization notification letter is received. MHS will make every effort to provide the peer to peer no later than forty-eight (48) hours (excluding weekends and state and federal legal holidays) after MHS receives the request from the provider. When making the peer to peer request the provider must contact MHS Appeals and provide three available dates and times to schedule a personal discussion with the MHS Medical Director or Pharmacist reviewer who rendered the determination. Providers may contact MHS Appeals at 1-877-647-4848, extension 87058 to leave a voicemail with their availability.

Utilization Management Inpatient Authorization Review Process

Pre-admission Screening and Resident Review Process

The Pre-admission Screening and Resident Review (PASRR) remains a requirement in all IHCP programs for certified nursing facilities. Individuals, regardless of known diagnosis or method of payment, residing at an IHCP certified nursing facility are subject to PASRR. See the IHCP Provider Manual for additional information and instructions on the process and instructions related to level-of-care review. The discharging facility is responsible for contacting MHS Medical Management for authorization and status of nursing facility placement process for all MHS members.

Concurrent Review

MHS Medical Management will concurrently review the treatment and status of all members who are inpatient through contact with the member's attending physician and hospital utilization and discharge planning departments. An inpatient continued stay will be subject to medical review as indicated by the member's diagnosis and response to treatment. The review will include evaluation of the member's plan of care and any subsequent diagnostic testing or procedures. If a stay is longer than the authorized length, the facility must provide clinical information supporting an extended stay 48 hours prior to the expiration of the authorized period.

Discharge Planning

Discharge planning activities are expected to be initiated upon admission by the admitting facility. MHS Medical Management is available to assist in coordinating the discharge planning efforts with the member's attending physician, PMP and hospital discharge planning department in order to ensure appropriate post-hospitalization discharge care. MHS concurrent review nurses initiate discharge planning upon day of admission. CCR nurses provide admitting facilities with fax and phone numbers to communicate needs through. Additionally, those facilities that are connected to MHS through EMR have messaging capabilities for real-time communication.

The MHS Medical Management nurse case managers will coordinate follow-up care for members by working with the member, PMP, appropriate hospital personnel and specialty providers as appropriate. MHS Medical Management will maintain documentation of all coordinated care efforts on a case-by-case basis.

For information about discharge planning for behavioral health-related admissions, refer to Chapter 12.

Prior Authorization Turnaround Times

MHS TURNAROUND TIME EXPECTATIONS			
Level of Urgency	**Determination TAT***	**Notification TAT**	**Extensions/ Exceptions**
Concurrent	Within 48 hours from receipt of the request	Within 48 hours from receipt of the request	May extend the time frame once, by up to 14 calendar days, under the following conditions: • The member requests an extension, or • MHS needs additional information, provided it must be document that at least one attempt to obtain the necessary information.
Urgent Preservice	Within 24 hours from receipt of the request	Within 24 hours from receipt of the request	If an urgent pre-service request is incomplete and requires additional information MHS must request the additional information within **24 hours.** The providers then have **24 hours** to respond to the request.
Standard Preservice	Within 48 hours from receipt of the request	Within 48 hours from receipt of the request	For a non-urgent preservice request, MHS may extend the time frame once, by up to **14 calendar days** if a member requests the extension or MHS needs additional information, provided MHS must document that at least one attempt to obtain the necessary information.
Retro (Post Service)	Within 30 calendar days from receipt of the request	Within 30 calendar days from receipt of the request	None

*TAT= Turnaround Time (These turnaround times do not include weekends or Federal/State-approved holidays.)

Routine, Urgent and Emergency Care Services Defined

Members are encouraged to contact their PMP or our MHS 24-Hour Nurse Advice Line prior to seeking urgent or emergent care except in a true emergency. If a member is referred to the emergency room by his or her PMP/doctor or the MHS Nurse Advice Line, any copay will be waived. MHS cannot refuse to cover emergency services if the emergency room provider, hospital or fiscal agent does not notify the member's PMP or MHS of the member's screening and treatment within 10 calendar days of presentation for emergency services. If you send a member to the ER, please notify MHS at 1-877-647-4848. The following are the MHS definitions for routine, urgent and emergent care:

Routine care is designed to prevent illness, and manage disease complications and disease processes. Examples of routine care include immunizations and regular screenings such as PAP smears or cholesterol checks.

An urgent condition is defined as a health condition (including an urgent behavioral health situation) which is not an emergency, but would cause a prudent layperson possessing the average knowledge of healthcare to believe the situation requires medical treatment or evaluation within 24 hours by the member's PMP or PMP designee to prevent serious deterioration of the individual.

An emergency medical condition is defined as a medical condition manifested by acute symptoms of sufficient severity (including severe pain), such that a prudent layperson who possesses an average knowledge of healthcare could reasonably expect the absence of immediate medical care to result in death, serious health-related injury, permanent impairment of bodily functions, or serious dysfunction of any bodily organ or part, or a threat to the health or safety of a pregnant woman or an unborn child, with inadequate time or inability to ensure a safe transfer to another hospital. A member may select any IHCP provider or hospital for true emergency care.

Contracted providers may request Prudent Layperson (PLP) review for Emergency Room (ER) claims billed with revenue code 450. A request for PLP review must be submitted with appropriate documentation either via the online dispute tool or by mail to MHS, P.O. Box 3002, Farmington, MO 63640-3800. If, after review, it is determined that it would be reasonable to assume that the ER visit would be considered emergent to a layperson, the payment will be adjusted to pay at the emergent rate. Request for PLP review must be made within 120 days of the initial reimbursement date. MHS shall cover emergency services without the need for prior authorizations. MHS shall comply with policies and procedures set forth by the IHCP Provider Bulletin regarding Emergency Room Services.

8

Chapter 8: Medical Management Appeals

Essential to MHS' mission is providing quality medical care to our members professionally and cost-effectively. Achieving this mission may require a review of coverage for specific services, and these requests may be denied or modified by an MHS physician reviewer. As a provider of these services, you may disagree with that denial and request that MHS reverse the decision. The purposes of the medical management process are:

- To ensure appeals are appropriately addressed and resolved in a timely manner
- To continually improve the level of service provided to members by critically evaluating the appropriateness of medical necessity decisions and the manner in which they are made
- To improve processes by providing feedback to MHS departments regarding medical necessity decision

MHS has pledged to the State of Indiana, to members and to the provider community that MHS will take no action to discourage, retaliate or discriminate in any way against any provider who assists a member in filing an appeal under the MHS member appeal process, nor against any provider who pursues a medical management appeal under the process described here.

Appeal Review Guidelines

An MHS Medical Director who was not involved with the original decision will review and make a decision on medical necessity appeals. No reviewer in direct competition with the submitting provider, the member's managing physician, or who is involved directly in the member's care may be involved in reviewing and deciding the appeal.

MHS will engage a specialist consultant in the same specialty as the member's managing physician to review a medical necessity appeal if MHS does not have a medical director of the same or similar specialty. The specialist consultant may grant or deny the appeal.

Medical Necessity Appeal

A medical necessity appeal is the first and only level of appeal for the member and provider relating to medical necessity determinations. Medical necessity appeals may be filed by one of the following:

- The member
- The member's authorized representative
- The member's attorney
- The member's provider of record
- A healthcare practitioner with knowledge of the member's medical condition acting on the member's behalf

A provider may file an appeal on behalf of the member with the member's written consent; however, if an appeal is urgent or concurrent, such as for a hospital inpatient admission, written consent of the member is not necessary. The medical necessity appeal must be filed in writing by a physician (or hospital provider if a statement is included from the managing physician supporting the appeal).

Providers must file claim disputes/reconsiderations per the informal claim dispute process outlined in Chapter 5 to reduce delays in claims processing. Denied prior authorization and medical necessity appeals are to be filed according to MHS' medical necessity appeals process.

Written member or provider appeals can be delivered by email to appeals@mhsindiana.com, by fax to 1-866-714-7993, online via the Secure Provider Portal mhsindiana.com/providers/login.html, or by mail to MHS Appeals, PO Box 441567, Indianapolis, IN 46244. Behavioral health appeals can be delivered by mail to Centene, 13620 Ranch Road 620 N, Building 300C, Austin, TX 78717-1116.

All member or provider appeals of an MHS decision as to medical necessity must include a statement from the provider supporting the appeal and the need for the service.

Each medical necessity appeal will be reviewed by an MHS Medical Director or Pharmacist. The reviewer may reverse the original decision and grant the appeal in whole or in part, or will uphold the original denial.

Receipt and Review Timeline

If a provider needs to correct a typographical, clerical, or spelling error or accepts an alternative suggested by MHS in the adverse determination, then the provider must respond not later than forty-eight (48) hours after receiving the adverse determination. Upon receipt, MHS will respond within 48 hours with an authorization or adverse determination based on the new information provided in the provider's response. A member or provider on behalf of the member may request an appeal within 60 calendar days of the date listed on the denial determination letter. Monitoring the appeal timeline will begin the day MHS receives and receipt-stamps the appeal.

Within 48 hours of the receipt of the appeal, MHS will mail a written acknowledgment of receipt of the appeal to the submitting physician, the assigned PMP, and the member. If the appeal receipt is outside the allotted time frame, MHS will send a letter stating the appeal was received past the 60-calendar-day time frame, and the appeal will not be able to be considered.

Determination Timeline

MHS must make the final determination regarding member appeals within 30 calendar days of the date of receipt of the appeal request. If MHS needs additional time to review the appeal, MHS may request up to 14 additional calendar days in writing, on or before the end of the 30th calendar day, or the appeal will be approved. If the provider-initiated appeal is received within 48 hours, MHS will resolve the appeal within 48 hours.

The appealing party(ies) will receive written notification of the appeal resolution within 30 calendar days, signed by the MHS Physician Reviewer or their designee, and mailed within five business days of the appeal determination to:

- The attending or managing physician and/or the facility
- The member's PMP
- The member and/or the member's designated personal representative
- In the case of an adverse determination, the letter will include information on the availability of any additional level of appeal

Expedited Medical Necessity Appeals

The expedited appeal process is available in cases where, in the judgment of the member's managing physician, the time frame in the appeals process would result in a delay in the diagnosis and treatment of the member that would seriously jeopardize their life or seriously jeopardize their ability to reach and maintain maximum function. If the services have already been rendered, such as with post-service or claims appeals, the expedited appeals process is not available or appropriate.

An expedited appeal must be initiated by the member, member's authorized representative, member's attorney, member's provider of record or a healthcare practitioner with knowledge of the member's medical condition as soon as possible. Expedited appeals may be submitted verbally by calling MHS at 1-877-647-4848, electronically on the Provider Secure Portal, by fax to 1-866-714-7993, emailed to Appeals@mhsindiana.com or mailed to MHS Appeals, PO Box 441567, Indianapolis, IN, 46244. All member or provider appeals of an MHS medical necessity decision must include a statement from the provider supporting the appeal and the need for the service. Behavioral health appeals can be faxed to 1-866-714-7991 or delivered by mail to MHS Behavioral Health, 12515-8 Research Blvd., Suite 400, Austin, TX.

Receipt and Review Timeline

MHS will make a decision regarding an expedited appeal by 48 hours after the request is received. An MHS physician reviewer, different from the physician reviewer who made the initial medical necessity determination, will review the appeal request and all associated documentation. The review may also include contacting the member's managing physician to discuss the pertinent aspects of the case.

Determination Timeline

When a determination is made, MHS will notify the managing physician verbally within 48 hours of receiving the request. A written notification of the decision will be sent to the member, the member's managing provider, the facility (if applicable), and the member's PMP within three business days of providing or attempting to provide the verbal notification. This notification will contain information about the basis for the decision and what additional appeal may be available.

Written notification of the appeal resolution is sent within 48 hours excluding state and federal holidays of attempting to provide verbal notification. The written notification is signed by the MHS physician reviewer or his or her designee and is mailed to:

- The attending or managing physician and/or the facility
- The member's PMP
- The member and/or the member's designated personal representative

In the case the requestor does not agree with the determination, the letter will include information on the availability of any additional level of appeal.

Chapter 8: Medical Management Appeals (cont'd)

External Independent Review (EIR)

If a member or provider disagrees with the appeal decision, they may request an external independent review by an independent review organization. This option is available for any decision made by MHS Medical Management, a decision based on medical necessity, or a decision by MHS that the requested service is experimental or investigational. The member or provider may request an external independent review after exhausting MHS' internal first level of appeal. The member or provider may request concurrently an external independent review and a State Fair Hearing. MHS will send the complete case file to an external, independent reviewer registered with the Indiana Department of Insurance. For the provider to represent the member in the external independent review, the member must provide MHS with verbal and written consent.

Independent external reviews must be requested within 120 calendar days of the date of the appeal decision letter. The review may be requested in writing and may be submitted by email to appeals@mhsindiana.com, by fax to 1-866-714-7993, or by mail to MHS Appeals, PO Box 441567, Indianapolis, IN 46244.

You may also request an independent review by contacting MHS Appeals at 1-877-647-4848. The independent reviewer has medical staff review the case, who will then send their answer to both the submitting member and to MHS within 15 business days. MHS pays for this review.

State Fair Hearing (SFH)

A State Fair Hearing must be initiated by the member, member's authorized representative, member's provider of record, or a healthcare practitioner with knowledge of the member's medical condition. State Fair Hearing must be requested within 120 calendar days of the date of the appeal decision letter. A State Fair Hearing and an external independent review may occur simultaneously.

To request a State Fair Hearing, write to the:
Office of Administrative Law Proceedings
100 N. Senate Avenue, Room N802, Indianapolis, IN 46204
Email: fssa.appeals@oalp.in.gov
Phone: 317-234-3488 or 866-259-3573 (toll free)
Fax: 317-232-4412

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Chapter 9: Pharmacy

MHS assumes pharmacy benefit management for HIP, HHW and Hoosier Care Connect through Centene Pharmacy Solutions.

Pharmacy benefits for MHS members vary based on the member's individualized plan benefits. Information regarding individualized member's pharmacy coverage can be best found via our Secure Provider Portal.

Preferred Drug List

MHS Indiana utilizes the State Unified Preferred Drug List (SUPDL) for HHW, HIP and HCC.

This list can be found on the State site, here. The preferred drug list will also include:

- Quantity limits
- Age limit
- Step therapy
- Prior authorization criteria, if required.

The SUPDL is maintained by fee-for-service Medicaid.

Specialty medications may be requested through Acaria Specialty Solutions at acariahealth.com or 1-800-511-5144. A complete list of specialty medications can be found on the MHS website.

MHS uses a preferred network model. A complete list of network pharmacies can be found on the MHS Find A Provider tool. Please note Walgreens is not a network pharmacy.

Non-Covered Drugs

Review the PDL to see if your medication is covered or if there are any restrictions.

Chapter 9: Pharmacy (cont'd)

Mandatory Generic Substitution

Unless a medication is listed on the State Unified Preferred Drug List (SUPDL) as a brand, IN Medicaid requires that a generic be dispensed. Generic drugs have the same active ingredient, work the same as brand name drugs, and may have lower copayments. If the member or physician/clinician feels a brand name drug is medically necessary, the physician/clinician can ask for prior authorization. We will cover the brand name drug according to our clinical guidelines if there is a medical reason the member needs the particular brand name drug. If MHS does not grant authorization, we will notify the member and physician/clinician and provide information regarding the appeal process. The provision is waived for narrow therapeutic drugs due to their narrow therapeutic index (NTI) as recognized by current medical and pharmaceutical literature.

Prior Authorization

For pharmacy prior authorization call 1-855-772-7125 or fax a prior authorization form to 1-866-399-0929. In the event Centene Pharmacy is unavailable or while waiting for a prior authorization determination, the pharmacy may dispense a 72-hour supply of the prescribed drug. Prior authorization requests will be answered by Centene Pharmacy within 24 hours. Prior authorization forms can be found on the provider section of the MHS website.

Injectable drugs provided in a physician's office may require prior authorization and if those medications are listed on the SUPDL, you can follow the steps to obtain a PA. If a medication is not listed, you can find the PA requirements on our MHS website. Prior authorization requests will be answered within 24 hours. Urgent requests will be answered within 48 hours. Time frames for both urgent and standard do not include weekends and state and federal legal holidays.

Specialty Medications

Specialty medications for HIP, HHW and HCC members require prior authorization from Acaria Specialty Solutions, our specialty medication vendor. Acaria can receive prior authorization requests via web, fax at 1-855-678-6976 or by voice at 1-855-772-7121. The coverage determination voice line is 1-866-399-0928.

Contacts for Appeals

In the event a patient and/or physician disagrees with the decision regarding coverage of a medication, the physician may appeal the decision in writing to MHS Appeals.

- By email to appeals@mhsindiana.com
- By fax to 1-866-714-7993
- By mail to MHS Appeals, PO Box 441567, Indianapolis, IN 46244

A provider may file an appeal on behalf of the member with the member's written consent; however, if an appeal is urgent or concurrent, such as for a hospital inpatient admission, written consent of the member is not necessary. MHS will make a determination (decision) and notification within 24 hours from time of receipt from the requesting provider on concurrent reviews.

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Chapter 10: Preventive Healthcare Programs

MHS has instituted a variety of programs and activities to promote preventive health services for our members. Following is a list of some of our programs and activities.

Preventive Care Outreach

MHS conducts a variety of health promotion activities to encourage and facilitate preventive health visits, including but not limited to:

- Annual visit reminder postcards
- First Year of Life and Call to Action outreach calls
- Special mailings to promote Childhood Immunization, Adolescent Well-Care, Diabetes Care and Women's Health Services
- Seasonal Influenza Vaccination campaign
- Medical Home education

My Health Pays®

My Health Pays® is an incentive program that encourages members to make healthy choices. MHS members can earn rewards on a My Health Pays® Visa® Prepaid Card for getting regular checkups and exams. Members can use My Health Pays® rewards to help pay for everyday items at Walmart, utilities, transportation, telecommunications (cell phone bill), childcare services, education and rent. To learn more about the My Health Pays® program, visit mhsindiana.com/rewards.

MHS Healthy Celebrations

MHS Healthy Celebration events focus on getting members in need of service to the doctor's office to receive their needed preventive care. MHS partners with a PMP office to schedule a specific day and time (four-hour minimum) for MHS members within that panel and in need of service to visit the office and receive specialty visits and screenings for:

- Children's Health: EPSDT/well-child (lead screen age appropriate)
- Women's Health: Mammography & Chlamydia
- Adult annual well-visits

After the visit, the family can enjoy games, prizes, refreshments and more before they leave the doctor's office. Each member receives a goody bag full of MHS informational materials, giveaways and a healthy snack.

Early and Periodic Screening Diagnostic and Treatment (EPSDT)

Indiana's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program is a comprehensive preventive healthcare program designed to improve the overall health of infants, children and adolescents.
MHS PMPs are required to participate in the EPSDT program.

The required well-child exams and screenings must be performed in accordance with the EPSDT Periodicity and Screening Schedule that is based on American Academy of Pediatrics recommendations. Refer to the EPSDT Provider Manual for complete guidelines at https://in.gov/medicaid/providers/files/epsdt.pdf that MHS must conduct the PLP review and reprocess the claim (if determined to be emergent) within 30 days of receiving medical records from the provider. The Periodicity and Screening Schedule is in the EPSDT Provider Manual. MHS offers educational meetings by a QI Nurse to review EPSDT components and best practice strategies. If an issue is found during an EPSDT visit, further diagnosis and treatment is covered.

Every wellness visit is to include:

- Comprehensive unclothed physical examination
- Age-appropriate immunizations (see immunization schedule on next page)
- Assessment of nutritional status/measurements
- Age-appropriate vision and hearing tests, and screenings for acuity
- Oral health risk assessments and dental referrals
- Laboratory tests as indicated
- Screening for blood lead toxicity to include:
  - Blood lead test between nine and 15 months, or as close as reasonably possible to the patient's appointment. If the child is at high risk for lead exposure, the initial screening should occur at the six-month visit.

- Another blood lead test between 21 and 27 months, or as close as reasonably possible to the patient's appointment.
  - Any child between 28 and 72 months that does not have a record of any prior blood lead test must have a blood lead test performed as soon as possible.
  - If the provider can verify via the Children's Health and Immunization Registry Program (CHIRP), or the records from another provider, that blood lead testing has occurred at the required interval(s), they are not obligated to repeat the procedure.
  - If a parent or guardian refuses to allow their child to be tested, providers are encouraged to document the refusal in writing and have the parent or guardian sign an attestation of refusal. Providers are expected to keep a copy of the refusal, either digital or hard copy, with the patient record until the child reaches age seven. Providers are only required to keep a single refusal on file is a parent or guardian indicates they will not allow initial or follow-up testing.

- Developmental, behavioral, psychosocial and depression surveillance and screenings:
  - Developmental screenings (using standard questionnaire or other tool) at the nine-month, 18-month and 30-month visits and Developmental surveillance at every visit (other than the nine-month, 18 month, and the 30th month visit
  - Psychosocial/behavioral assessment (using standard questionnaire or other tool) should be family centered and may include an assessment of child's social-emotional health, caregiver depression and social determinants of health
  - Tobacco, Alcohol or Drug Use Assessment (verbal assessment) should be completed beginning at the 11-year visit
  - Depression Screening (using standard questionnaire or other tool) should be administered at each annual EPSDT visit, beginning at the 12-year visit
  - Maternal Depression Screening of the mother should be done at the child's 1-, 2-, 4- and 6- month EPSDT visit.

- Health Education, additional diagnoses, treatment and referrals to specialists as needed, and anticipatory guidance for both the child and caregiver

Bright Futures

Bright Futures is a comprehensive set of health supervision guidelines developed by a multidisciplinary health expert team. The guidelines are intended to establish a standard of care of health promotion, disease prevention and developmental surveillance. The FSSA has elected to make Bright Futures the standard for infant, child and adolescent health supervision. See the Bright Futures website at brightfutures.aap.org. To obtain a toolkit please visit the American Academy of Pediatrics website here.

MEDTOX

It is a federal requirement to test all Medicaid recipients for lead toxicity between nine and 15 months, and again between 21 and 27 months (or as close as reasonably possible to the patient's appointment), and again between 28 and 72 months if no prior blood lead testing was done, regardless of their risk factors.

MEDTOX filter paper lead testing is a simple, cost-effective and accurate service to collect lead screenings. Screenings can be performed with as little as two drops of blood during any office visit. Collection supplies are delivered directly to the practitioner's office, and MEDTOX handles the Medicaid filing. MEDTOX utilizes state-of-the-art technology to assure timely and accurate results. If you are interested in learning more or signing up for MEDTOX, please contact your Provider Engagement Administrator.

Immunizations

Infants, children and adolescents under the age of 19 should receive all recommended immunizations unless medically contraindicated or against parental religious beliefs. A complete immunization history must be documented in the medical record, even if the member has received immunizations at a facility other than your office (i.e. health department, previous PMP office). Visit the Centers for Disease Control for the recommended immunization schedule for children and adolescents.

Adults should receive all recommended immunizations unless medically contraindicated or against religious beliefs. A complete immunization history must be documented in the medical record even if the member has received immunizations at a facility other than your office (i.e. health department, previous PMP office). Visit the Centers for Disease Control for the recommended adult immunization schedule.

Vaccines for Children (VFC)

MHS PMPs may receive vaccines for immunizations free of charge through the IDOH. Information for enrolling in this program is available by contacting the IDOH Indiana Immunization Program at 1-800-701-0704. More information can be found at in.gov/health/immunization/vaccines-for-children/ and in the IHCP Provider Manual. The MHS policy on payment for immunizations is outlined in Chapter 4.

Children & Hoosiers Immunization Registry Program (CHIRP)/MyVaxIndiana

Medical providers in Indiana are required to submit complete vaccination records (for vaccines administered to individuals under 19 years of age) to the State CHIRP registry system within seven business days. CHIRP is a statewide, confidential, electronic system designed to keep track of immunization records through the online portal at CHIRP.in.gov. There is no charge to participate, and it is easy to enroll and use. Additional benefits include:

- Helping to reduce under- and over-immunization
- Improving immunization rates by providing an up-to-date immunization history
- Providing IDOH lead screening test results
- Simplifying vaccine management by tracking inventory and automatically creating the VFC reporting document
- Creating a reminder/recall notification for parents and members
- Easier printing of official immunization cards
- Reducing staff time spent searching and calling for immunization records

Additional information is available by calling the CHIRP Support Center at 1-888-227-4439 and online at CHIRP.in.gov.

Healthy Indiana Plan (HIP) Recommended Preventive Care/Incentive

Preventive care incentives are built into the HIP program by offering financial reimbursement of POWER Account funds through account "rollover" from one benefit year to the next when members receive required preventive care services. Please refer to Chapter 16.

Tobacco Cessation and the Indiana Tobacco Quitline (1-800-QUIT-NOW)

MHS reimburses providers for tobacco cessation counseling. MHS also covers prescription cessation aids. Providers may prescribe one or more modalities of treatment. Providers must include counseling in any combination of treatment.

MHS recommends providers ask all adolescents and adults about tobacco use and provide tobacco cessation counseling for those who use tobacco products. Pregnant women who use tobacco products should have counseling that includes information about the effects of tobacco use on the unborn child and how cessation can improve birth outcomes. To begin this process, MHS suggests asking two questions, "Do you smoke?" and "Can I help you quit?," of every member. Research has shown even brief counseling is effective in facilitating quit attempts.

MHS encourages utilization of the Indiana Tobacco Quitline which offers free one-on-one counseling services available in more than 170 languages and other resources to providers who want to assist their patients. The Quitline referral/consent form is located on the MHS website in the Provider Resources section under Forms – Care Management. To make referrals fill out the fax referral form along with your patient, have them sign for consent as required by HIPPA and fax to the number listed on the form. Once the referral is made, the Quitline will report whether or not the patient has been contacted, enrolled into services and plans to quit. Additional Quitline information can be obtained online at www.in.gov/health/tpc/cessation/indiana-tobacco-quitline/ or by calling 1-800-QUIT NOW.

MHS offers incentives to providers that help our HCC, HIP members and HHW members quit tobacco. As a reminder, MHS covers all tobacco cessation counseling when billed with the CPT code 99406 or 99407. MHS also reimburses an additional $50 for the initial counseling visit. Even brief counseling is effective in facilitating a patient's attempts to quit using tobacco. Get the conversation going with two questions: "Do you use tobacco?" and "Would you like to quit?"

Learn more about the tools available to you to help patients quit using tobacco with the MHS smoking cessation resource center. Thank you for being our partner in care.
mhsindiana.com/members/medicaid/benefits-services/smoking-cessation.html

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Chapter 11: Case Management Programs

MHS has a Case Management team consisting of nurses and social workers to work with members to manage acute episodes, multiple chronic conditions or events, provide education on new chronic conditions, and link them with health and community resources. The goals of the program are to:

- Identify members who could benefit from Case Management
- Help members obtain appropriate medical and social services
- Help the member understand the importance of adherence to the provider treatment programs and medication adherence
- Help the member better understand their medical condition and prevent exacerbation of the condition

Prenatal and Well-Baby Programs

Preconception planning and ongoing prenatal care is important to managing risk factors and minimizing potential complications during the gestation period, thereby reducing infant morbidity and mortality. Statistics show women who receive early and regular prenatal care are more likely to have healthier babies.

MHS provides Case Management services to our pregnant members with specific focus on high-risk members. Staff conducts phone outreach to all identified pregnant members in order to complete a prenatal assessment and stratification based on identified risk factors.

Start Smart for Your Baby®

MHS offers our award-winning Start Smart for Your Baby® program to all of our pregnant members. The program provides educational materials and guidance to encourage our members to obtain prenatal healthcare as well as information about how to stay healthy during pregnancy to improve health outcomes. Members identified with any risk factors are encouraged to enroll in our OB Case Management program. Our nurses contact members to encourage compliance with their treatment plans as well as to answer questions and provide assistance in preparation of delivery.

MHS Special Deliveries

Members at high risk for pregnancy complications are enrolled in Special Deliveries. These members are assigned to a nurse with high-risk OB experience who follows the members throughout their pregnancies to support their treatment plans and monitor members for potential signs of complication through home visits and over-the-phone communications. Our nurses provide status reports throughout the member's pregnancy and are available to assist the member at any time. MHS also offers several home-based programs to address complications related to pregnancy, such as gestational diabetes and hyperemesis gravidarum.

Start Smart for Your Baby® Postpartum Program

Members receive a Start Smart newborn mailing after they deliver, including information about caring for their newborn and a special preventive care incentive through the MHS My Health Pays® rewards program, earned when the baby receives his or her EPSDT visits.

First Year of Life Program

Our First Year of Life nursing team reaches out to mothers of newborns to encourage enrollment in the program. This innovative program is designed to encourage consistent well-child care, including appropriate receipt of immunizations; provide education on appropriate use of the ER as well as home and child safety; prevent injuries and shaken baby syndrome; and identify signs of postpartum depression. The staff continues support and education throughout the baby's first 15 months of life.

Chapter 11: Case Management Programs (cont'd)

Referral to Case Management

Any physician wishing to refer a member to the program should submit the Case Management Referral form, available in the Secure Provider Portal, or call MHS Medical Management at 1-877-647-4848.

Disease Management Programs

MHS Disease Management program provides disease management services to members diagnosed with asthma, diabetes, COPD, CKD, CHF and CKD. Disease Management provides over-the-phone education and outreach through personal health coaches. Respiratory therapists and certified diabetic educators provide home visits to members at highest risk for hospital admission and health-related complications. All members with the above diagnoses will receive educational materials and some level of intervention based on severity. The goals of the program are:

- Identifying members with the above diagnoses who are at risk for complications
- Assuring members have access to appropriate care, receive appropriate medications and understand the importance of compliance with medications
- Collaborating with providers to ensure each member has a home action plan to manage their disease and identify triggers

The program will identify at-risk and non-compliant members from sources including inpatient admission related to complications associated with their disease, emergency department reports, review of pharmacy claims, physician referrals and care gaps. All members who have been referred by their physician will be contacted for enrollment in the program. Participants are interviewed using specially-designed assessment tools to identify specific problems.

Any physician wishing to refer a member to the program should submit the Disease Management Referral form, available at provider form, or call MHS Medical Management at 1-877-647-4848.

Lead Disease Management

The MHS Lead Disease Management Program provides disease management services to its members, including Case and Care Management to ensure timely, effective services for members identified as having exposure to lead. MHS provides assistance with issues such as, but not limited to, coordination of and referral to services for lead testing, lead level monitoring, education, follow-up and identification of any gaps in care as well as providing providers lead level information regarding their members. MHS has adopted the State of Indiana Lead Guidelines.

MHS contracts with MEDTOX to provide MHS providers with free lead screening toolkits. Supplies, lab and reporting are all included for free as part of the toolkit. Please contact your MHS Provider Engagement Administrator for more information.

Frequent Emergency Room Utilizers Management Program

MHS Medical Management identifies members over-utilizing the ER and provides Case Management Services to decrease inappropriate utilization.

Chapter 11: Case Management Programs (cont'd)

Right Choices Program (RCP)

Members may receive specialized intervention due to medical or behavioral conditions that prevent them from establishing a medical home. They can receive these services from a Case Management team through RCP. Based on thresholds established by the State, members will be reviewed by a clinical team at MHS and enrolled in RCP as appropriate. RCP participants are assigned to one PMP and one pharmacy. RCP members will be reviewed by the clinical team, including the member's provider(s), every two years for possible "graduation" from the RCP. A member can appeal their RCP status through normal appeal channels. Members who see a provider outside of their assigned RCP provider list, claims will be denied. Please see Chapter 8 for more information.

An RCP member's PMP makes all referrals to specialists, including carved-out services if medications are prescribed. MHS will provide a Case Management Nurse or social worker - translation who will complete the member's "team of experts" and will be available to both the member and the providers as a resource. When a member is placed in RCP, letters will be mailed to the PMP and pharmacy alerting them of lock-in participation.

Children with Special Needs

The Children with Special Needs program (CWSN) was developed to improve member and family knowledge of various developmental disorders and to assist them in the establishment of an appropriate medical home. The program uses strategies that are implemented by the CWSN staff, focusing on the utilization of various evidence-based CPGs. The CWSN program utilizes providers as well as community partners for healthcare education and assistance. A multidisciplinary team from MHS will be able to assist the member and the member's family in obtaining the services they need to achieve optimal quality of life. The main goals of the unit are:

- To reduce/eliminate barriers to care, education and social activities
- To reduce/eliminate fragmentation of services and complications relating to comorbidity frequently seen in special needs children
- To increase a member's ability to perform activities of daily living
- Connect members and their families with community-based resources and support
- Improve members' quality of life

Identified and referred members are screened and assessed for inclusion in the program. Members who participate in the program may have the following, which include but are not limited to:

- Autism Spectrum disorders
- Congenital anomalies
- Pervasive developmental delays
- Neurological disorders

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Chapter 12: Behavioral Health Services

Behavioral Health Case Management

MHS offers Behavioral Health Case Management services provided by master's level licensed Behavioral Health Case Managers to assist members who are experiencing behavioral health and/or substance use disorders. MHS offers a variety of tools and interventions to assist members with maintaining compliance with treatment and tenure in the community. MHS helps connect members with providers to ensure a member receives medically necessary treatment in a timely manner. MHS also coordinates access to care for carved-out and excluded services at State Hospitals, Medicaid Rehabilitation Option services (MRO), 1915(i) services, State Plan Home and Community Based Services (HCBS) programs, Behavioral and Primary Healthcare Coordination (BPHC), Adult Mental Health and Habilitation (AMHH) and Children's Mental Health Wraparound (CMHW), and services provided at a Psychiatric Residential Treatment Facility (PRTF). MHS Behavioral Health Case Management staff collaborate with Medical Case Management staff to ensure collaboration and integration for members with dual behavioral and medical diagnoses.

All members who are hospitalized for inpatient mental health treatment are enrolled in Case Management for a minimum of 90 days. PMPs can also refer members for case management services who may benefit from coordination of activities or additional assistance in obtaining resources. Referrals can be made by calling MHS at 1-877-647-4848 or through the Secure Provider Portal.

Behavioral Health Disease Management

MHS offers Disease Management programs for the following diagnoses:

- Attention deficit/hyperactivity disorder
- Depression, including perinatal depression
- Anxiety
- Substance use disorders, including perinatal substance use disorder

Members enrolled in disease management receive educational mailings regarding their diagnosis and helpful tools to assist with managing and directing their care. Members identified as moderate or high-risk receive additional assistance and outreach from our Case Management staff. PMPs are encouraged to inform members of these services and to make referrals to MHS for members they identify with any of these conditions.

Behavioral/Physical Healthcare Coordination

Behavioral Health Providers are contractually required to notify MHS within five calendar days of the covered person's visit, and submit information about the treatment plan, the covered person's diagnosis, medications, and other pertinent information.

The provider will document and, upon request, share the following information for a member receiving behavioral health treatment with member's PMP:

- A written summary of each member's treatment session
- Primary and secondary diagnosis
- Findings from assessments
- Medication prescribed
- Psychotherapy prescribed
- Any other relevant information

Behavioral Health profiles are available to all PMPs via the Secure Provider Portal and located under the member's health record. Profiles are updated monthly and are intended to facilitate coordination between Behavioral Health and Physical Health Providers. The profile is a summary of behavioral health services provided, Behavioral Health Providers, psychiatric medications and behavioral health outpatient/inpatient services that each of our members accessed during the previous month. For any member who receives inpatient acute behavioral healthcare, MHS will forward information to the PMP and Outpatient Behavioral Health Provider immediately upon discharge. MHS Behavioral Health Case Managers are available for discharge planning and follow-up for discharged members.

MHS requires PMPs and Behavioral Health Providers to exchange information to ensure coordination of care as per State requirements.

Without the consent of the patient, the patient's mental health record may only be disclosed as follows:
(1) To individuals who meet the following conditions:
(A) Are employed by:
(i) the provider at the same facility or agency;
(ii) a managed care provider (as defined in IC 12-7-2-127); or
(iii) a health care provider or mental health care provider, if the mental health records are needed to provide health care or mental health services to the patient.
(B) Are involved in the planning, provision, and monitoring of services.
(2) To the extent necessary to obtain payment for services rendered or other benefits to which the patient may be entitled, as provided in IC 16-39-5-3 .
(3) To the patient's court appointed counsel and to the Indiana protection and advocacy services commission.
(4) For research conducted in accordance with IC 16-39-5-3 and the rules of the division of mental health and addiction, the rules of the division of disability and rehabilitative services, or the rules of the provider.
(5) To the division of mental health and addiction for the purpose of data collection, research, and monitoring managed care providers (as defined in IC 12-7-2-127) who are operating under a contract with the division of mental health and addiction.
(6) To the extent necessary to make reports or give testimony required by the statutes pertaining to admissions, transfers, discharges, and guardianship proceedings.
(7) To a law enforcement agency if any of the following conditions are met:
(A) A patient escapes from a facility to which the patient is committed under IC 12-26.
(B) The superintendent of the facility determines that failure to provide the information may result in bodily harm to the patient or another individual.
(C) A patient commits or threatens to commit a crime on facility premises or against facility personnel.
(D) A patient is in the custody of a law enforcement officer or agency for any reason and:
(i) the information to be released is limited to medications currently prescribed for the patient or to the patient's history of adverse medication reactions; and
(ii) the provider determines that the release of the medication information will assist in protecting the health, safety, or welfare of the patient.
Mental health records released under this clause must be maintained in confidence by the law enforcement agency receiving them.
(8) To a coroner or medical examiner, in the performance of the individual's duties.
(9) To a school in which the patient is enrolled if the superintendent of the facility determines that the information will assist the school in meeting educational needs of the patient.
(10) To the extent necessary to satisfy reporting requirements under the following statutes:
(A) IC 12-10-3-10
(B) IC 12-24-17-5
(C) IC 16-41-2-3
(D) IC 31-25-3-2
(E) IC 31-33-5-4
(F) IC 34-30-16-2
(G) IC 35-46-1-13
(11) To the extent necessary to satisfy release of information requirements under the following statutes:
(A) IC 12-24-11-2
(B) IC 12-24-12-3, IC 12-24-12-4, and IC 12-24-12-6
(C) IC 12-26-11
(12) To another health care provider in a health care emergency.
(13) For legitimate business purposes as described in IC 16-39-5-3 .
(14) Under a court order under IC 16-39-3.
(15) With respect to records from a mental health or developmental disability facility, to the United States Secret Service if the following conditions are met:
(A) The request does not apply to alcohol or drug abuse records described in 42 U.S.C. 290dd-2 unless authorized by a court order under 42 U.S.C. 290dd-2(b)(2)(c) .
(B) The request relates to the United States Secret Service's protective responsibility and investigative authority under 18 U.S.C. 3056 , 18 U.S.C. 871 , or 18 U.S.C. 879 .
(C) The request specifies an individual patient.
(D) The director or superintendent of the facility determines that disclosure of the mental health record may be necessary to protect a person under the protection of the United States Secret Service from serious bodily injury or death.
(E) The United States Secret Service agrees to only use the mental health record information for investigative purposes and not disclose the information publicly.

(F) The mental health record information disclosed to the United States Secret Service includes only:
(i) the patient's name, age, and address;
(ii) the date of the patient's admission to or discharge from the facility; and
(iii) any information that indicates whether or not the patient has a history of violence or presents a danger to the person under protection.
(16) To the statewide waiver ombudsman established under IC 12-11-13, in the performance of the ombudsman's duties.
(b) After information is disclosed under subsection (a)(15) and if the patient is evaluated to be dangerous, the records shall be interpreted in consultation with a licensed mental health professional on the staff of the United States Secret Service.
(c) A person who discloses information under subsection (a)(7) or (a)(15) in good faith is immune from civil and criminal liability.

Opioid Treatment Program (OTP)

MHS members can self-refer for OTP treatment and Prior Authorization (PA) isn't required; however, providers must maintain documentation demonstrating medical necessity reflecting the coverage criteria is met as well as the individual's length of treatment is in the member's record.

A daily opioid treatment program includes administration and coverage of methadone or buprenorphine, routine drug testing, group therapy, individual therapy, pharmacological management, HIV testing, Hepatitis A, B, and C testing, pregnancy tests, Tuberculosis testing, Syphilis testing, follow-up examinations, Case Management and one evaluation and management office visit every 90 days for the management of patient activities identified in the individualized treatment plan that assists in patient goal attainment, including referrals to other service providers and linking patients to recovery support groups.

Individuals aged 18 and older seeking OTP services must meet the following medical necessity criteria:

- Must be addicted to an opioid drug
- Must have been addicted for at least one year before admission to the OTP
- Must meet the criteria for the Opioid Treatment Services (OTS) level of care, according to all six dimensions of the American Society of Addiction Medicine (ASAM) Patient Placement Criteria

Individuals under the age of 18 seeking OTP services must meet the following medical necessity criteria:

- Must be addicted to an opioid drug
- Must have two documented unsuccessful attempts at short-term withdrawal management or drug-free addiction treatment within a 12-month period preceding admission
- Must meet the criteria for the Opioid Treatment Services (OTS) level of care, according to all six dimensions of the ASAM Patient Placement Criteria

The following individuals are exempt from the one year addiction requirement:

- Members released from a penal institution – If the individual seeks OTP services within six months of release
- Pregnant women
- Previously treated individuals – If the individual seeks OTP services within two years after treatment discharge

Provider Requirements for OTP

- Opioid treatment programs certified by the Indiana FSSA DMHA are required to enroll as IHCP providers. Practitioners billing for services exclusive to OTP must be attached to a provider (clinic) that is enrolled under provider type 11 – Behavioral Health Provider, specialty 835 – Opioid Treatment Program.
- OTP Clinics may also be enrolled at IHCP as another provider type such as a Mental Health Clinic or CMHC, but they must also have a IHCP number that is Addiction Medicine/Opioid Treatment enrollment AND the practitioners must be tied to the ICHP provider that is for OTP.
- Bundled services with HCPCS codes H0020 – Alcohol and/or drug services/methadone administration and/or service (provision of the drug be a licensed program). Practitioners may also be reimbursed for 90792 – Psychiatric diagnostic evaluation with medical services and 90832-90834 and 90836-90838- psychotherapy services.
- Billed by a practitioner, usually a medical doctor, as rendering NPI on a CM1500 (should not be billed by clinics as rendering).
- Claims billed for codes H0020 that are billed by practitioners that are not enrolled as confirmed OTP certified, will deny EX 46 (service not covered).

Billing for Behavioral Health Services

PMPs providing physical assessments including a behavioral health component may bill MHS directly for those services. The CPT® codes that can be billed are 96150-96155. Mid-level providers (LCSW, LMFT, LMHC) working with the PMP who bill these codes may bill MHS under the PMP's billing information. If more intensive therapeutic services are provided by the mid-level, such as individual therapy (e.g. 90804), those should be billed directly to MHS under a supervising physician (psychiatrist) or health service provider in psychology (HSPP), and the mid-level provider would need to be credentialed by MHS. For behavioral health claims, utilize the MHS payer ID 68068.

Substance Use Disorder (SUD) Residential Treatment

MHS will provide coverage for short-term low-intensity and high-intensity residential treatment for Opioid Use Disorder (OUD) and other Substance Use Disorder (SUD) treatment in settings of all sizes, including facilities that qualify as Institutions of Mental Disease (IMDs). Prior authorization (PA) is required for all residential SUD stays. Residential stays are allowed to be authorized with a statewide average length of 30 calendar days, based on medical necessity. If a facility determines that a member requires more time than was initially authorized, the facility should submit a PA update request showing that the member has made progress but can be expected to show more progress given more treatment time. An additional length of stay can be approved based on documentation of medical necessity.

When residential services are determined medically necessary for a member, MHS will approve a minimum of 14 days for residential treatment, unless the facility requests fewer than 14 days. If a facility determines that a member requires more time than the initial 14 days, the facility should submit a PA update request showing that the member has made progress but can be expected to show more progress given more treatment time. An additional length of stay can be approved based on documentation of medical necessity.

Admission criteria for residential stays for OUD or other SUD treatment will be based on the ASAM Patient Placement Criteria Level 3.1 (Clinically Managed Low-Intensity Residential Services) and Level 3.5 (Clinically Managed High-Intensity Residential Services). Providers are required to include all appropriate documentation demonstrating medical necessity for residential treatment with PA requests.

Facilities need to include all necessary documentation to demonstrate medical necessity for the SUD level of care being requested. Documentation should include diagnoses, clinical presentation, treatment history, treatment goals, prescriber contact following admission and weekly thereafter. Other relevant information should also include a complete picture of the member's individual needs. Providers should incorporate documentation supporting the ASAM six dimensions of the multidimensional assessment. When submitting an initial PA request, providers should include documentation of the psychosocial assessment.

Provider Requirements for Substance Use Disorder (SUD) Residential Treatment

- Providers designated as offering ASAM Level 3.5 services only can seek PA and reimbursement for stays at ASAM Level 3.5 only.
- Providers designated as offering ASAM Level 3.1 services only can seek PA and reimbursement for stays at ASAM Level 3.1 only.
- Providers that have separate units within the facility, distinctly designated for ASAM Level 3.1 services and ASAM Level 3.5 services, may seek PA and reimbursement for both levels, as appropriate. Residential stays for either level will only be approved with evidence of medical necessity.

Access & Availability Standards

Members shall be able to receive timely access to medically necessary behavioral health services. Providers are required to offer timely access to behavioral health screening, assessment, referral and treatment services, including outpatient services as well as inpatient psychiatric hospital services, inpatient drug and alcohol detoxification and inpatient drug and alcohol rehabilitation, with the exception of treatment rendered in a State Hospital.

All outpatient mental health services shall be delivered by licensed psychiatrists and health service providers in psychology (HSPP), or an advanced practice nurse or person holding a master's degree in social work, marital and family therapy or mental health counseling.

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Chapter 13: Quality Improvement

Overview

The MHS Quality Improvement (QI) Program seeks to ensure:

- The quality of clinical care and services as well as the safety of clinical care
- Member satisfaction with the experience of care
- Compliance with applicable state/federal regulations and NCQA standards

To that end, an extensive monitoring system has been put in place to assess topics which include, but are not limited to:

- Compliance with evidence-based care standards reflected in HEDIS measures related to preventive health and chronic condition management
- Member and provider satisfaction
- Adverse events
- Member complaints
- Compliance with NCQA and OMPP standards for:
  - Practitioner availability (including geographic distribution and member preferences related to culture/race/ethnicity/language)
  - Member access to appointments and after-hours clinical advice
- Continuity and Coordination of Care
- Effectiveness of Case Management and Disease Management services
- Care provided to members with special and complex health needs and the medically frail
- Pharmacy services
- Medical record documentation

The MHS QI strategy is developed with input from practitioners and members. Practitioners have an opportunity for input through the Clinical and Service QI Committee (CASQIC), UM Committee, Credentialing Committee, P&T Committee, Physician Advisory Committee and Provider Satisfaction Survey, as well as less formal feedback mechanisms. Members may provide input through the Member Advisory Council, focus groups and through analysis of their responses to satisfaction questionnaires.

The goals of the MHS QI program are to develop and maintain a system that does the following:

- Provides MHS members a healthcare delivery system that meets and exceeds generally accepted definitions of quality
- Promotes optimal physical and behavioral health outcomes
- Monitors and improves as needed:
  - Clinical Care Quality
  - Continuity and Coordination of Care
  - Services to Members with Special Needs
  - Quality of Service
  - Safety of Clinical Care
  - Satisfaction with the Care/Service Experience
- Actively involves providers in the improvement of the quality of patient care
- Seeks member input and incorporates it into quality improvement program activities
- Provides a definition of performance standards via Healthcare Effectiveness Data and Information Set (HEDIS®), a set of standardized performance measures designed to allow reliable comparison of performance of managed healthcare plans
- Monitors member satisfaction via the Consumer Assessment Healthcare Providers and Systems (CAHPS®), a set of standardized surveys that measure patient satisfaction with the experience of care
- Monitors practitioner satisfaction through standardized surveys about their experience with MHS
- Monitors member satisfaction with MHS Case Management

- Provides healthcare services in a manner consistent with:
  - Generally-accepted principles of professional practice and adherent to evidence-based guidelines
  - Cultural and linguistic needs/preferences of MHS members
- Promotes recovery from mental illness through excellent member Care Management
- Promotes member recovery and resiliency to support improved healthcare outcomes
- Achieves compliance with NCQA and State/Federal regulatory standards
- Analyzes the existence of significant healthcare disparities in clinical areas
- Obtains "Best in Class" standing in the State of Indiana
- Produces actionable, valid and reliable data to drive decision making, resulting in improved quality of services and member care

The following general objectives have been defined as a means of achieving the above-listed goals:

- Identify clinical priorities for members within each line of business
- Ensure that effective resources and programs are in place to address clinical priorities, via the following mechanisms:
  - Adoption and distribution of preventive health and clinical guidelines
  - Provider education
  - Member education
  - Care gap/appointment outreach calls
  - Population health approach via
    - Case Management
    - Complex Medical and OB Case Management
    - Disease Management
  - ER diversion/medical home promotion
  - Primary-Specialty Care Coordination
  - Medical-Behavioral Health (BH) Care Coordination
  - Health promotion incentive programs
  - Grievance and Appeals mechanisms
- Monitor trends related to service utilization and respond to identified issues
- Ensure provider network adequacy/geographic distribution via systematic monitoring
- Ensure appropriate appointment and after-hours access via annual monitoring of the PMP and Specialist networks
- Ensure the availability of culturally and linguistically appropriate services through systematic monitoring and improvement activities
- Ensure that the voice of the customer helps inform QI Program direction, through member and provider participation in QI committees
- Implement focused monitoring activities to ensure that needs of members with special needs and the medically frail are met
- Comply with State and NCQA standards
- Participate in clinical studies using HEDIS data and data from similar sources to regularly assess the quality and appropriateness of care provided to members, including members under 21 years of age taking into account EPSDT/HealthWatch requirements
- Include at least one Provider Relations Quality Improvement project annually
- Actively participate in any State-sponsored prenatal Care Coordination programs
- Participate in the Office of Medicaid Policy and Planning (OMPP) Quality Strategy Committee and relevant subcommittees
- Comply with future CMS national reporting measures and required topics for improvement projects
- Participate in External Quality Review Organization (EQRO) initiatives developed by the FSSA and include EQRO recommendations in QI Program planning
- Evaluate the QI program annually and modify it as necessary to achieve program effectiveness

Examples (which are not all-inclusive) of ongoing activities established to support MHS quality and safety goals are:

- The Provider Pay-for-Performance Program (P4P), based on achievement of priority HEDIS measure goals (more information about this program can be found on the MHS Secure Provider Portal)
- The My Health Pays® member incentive program involving rewards for Health Needs Screening and annual PMP well-visits
- Adoption of Clinical Practice and Preventive Health Guidelines
- Dissemination of best practice examples
- EPSDT/preventative health practice audits and education
- Practice support by Field QI Coordinators
- Preventive health outreach to members (through both verbal and written communications)
- Home lab testing options
- Member complaint and adverse event monitoring, with Quality of Care review of potential quality issues
- Comprehensive Case and Disease Management programs

Quality Improvement Oversight

The MHS Board of Directors approves the QI Program and monitors the program's effectiveness. The Board of Directors delegates the authority for the operational implementation and accountability for this program to the MHS CEO, the Chief Medical Director and the Clinical and Service Quality Improvement Committee (CASQIC), which is comprised of MHS network healthcare practitioners including PMPs, Specialists and Behavioral Health Practitioners along with Community Stakeholders.

The structure of the QI Program is designed to promote organizational accountability, responsibility and authority in the identification, evaluation and correction of Quality-of-Care problems and organizational areas needing improvement. This involves extensive participation of advisory committees, MHS staff and network practitioners.

The following is a list of the committees that participate in the implementation and evaluation of QI activities:

- **Senior Executive Quality Improvement Committee (SEQIC)** - Comprised of MHS' CEO and senior executive staff, this committee approves policies, procedures and process coordination of the QI Program.
- **Clinical and Service Quality Improvement Committee (CASQIC)** - Responsible for assessing the status and progress of all QI Program efforts, CASQIC recommends and/or monitors information and trends for conformance with standards and criteria for the delivery of care and service. CASQIC reviews outcome studies and recommends action based on results. It serves as the Peer Review Committee for Quality-related issues. In addition, CASQIC reviews HEDIS and CAHPS® rates and assists in identifying barriers, opportunities and practical interventions. CASQIC approves policies and procedures, reviews quality improvement activities, determines the need for the adoption of Clinical Practice and Preventive Care Guidelines and approves when guidelines are updated.
- **Utilization Management Committee (UMC)** - The Utilization Management Committee's primary purpose is to provide oversight of the UM program and associated activities to ensure UM activities are integrated into all functional areas and departments. The committee is responsible for analyzing UM data, identifying trends and addressing identified issues. Additional responsibilities include monitoring the appropriateness of care, including over- and/or under-utilization of services as well as review and approval of medical necessity criteria and CPGs.
- **Member Complaints and Appeals Advisory Analysis Workgroup** - This MHS staff-only committee is responsible for reviewing member and provider Quality-of-Care and Quality-of-Service complaints and appeals, developing reports, analyzing trends and providing recommendations to the CASQIC.
- **Credentialing Committee (CC)** – The Credentialing Committee is responsible for the review and assessment of provider applications to join MHS' network. The CC establishes that each network practitioner is qualified by training and experience and his/her clinical performance is consistent with the standards established by the MHS Credentials Policy. Learn more about the Credentialing Committee in Chapter 17.
- **Member Advisory Council (MAC)** - The MAC provides a forum for MHS to solicit member input into the QI program. The MAC includes members, parents/guardians of children who are MHS members, and MHS staff as appropriate.

Delegated Activities/Services

MHS may assign authority to other organizations to conduct functions and activities on MHS' behalf as defined within a formal agreement. This arrangement is called "delegation." MHS may delegate operational functions, such as claims processing, practitioner credentialing, UM, and fraud and abuse monitoring, to another entity. As described in the QI documents, the delegated entity must undergo a pre-delegation review to demonstrate its ability to provide the operational function to be delegated. MHS and the delegated entity execute a formal delegation agreement, and MHS monitors activities and functions regularly using a formal, systematic process to assess compliance to the terms of the delegation agreement.

Healthcare Effectiveness Data and Information Set (HEDIS) Annual Request for Information

MHS is required to perform HEDIS audits as outlined by National Committee for Quality Assurance (NCQA) and Centers for Medicare & Medicaid Services (CMS) for monitoring the performance of all managed care organizations. All managed care organizations that are NCQA accredited perform HEDIS reviews during the same time each year on randomly selected medical records. The medical records you provide during the HEDIS process help us validate the quality of care provided to our members. This audit is a retrospective review of services and performance of care.

Receiving all requested medical records helps ensure that our results are an accurate reflection of the care provided. Results are used to measure performance, identify quality initiatives and provide educational programs for providers and members.

Results are reported as part of Medicare Stars, NCQA health plan ratings and State and Marketplace report cards.

Your office plays a central role in promoting the health of our members. MHS relies on your office to facilitate the HEDIS process by:

- Providing the appropriate care within the designated time frames
- Documenting all care in the patient's medical record
- Accurately coding all claims. Providing accurate information on a claim may reduce the number of medical records requested
- **Responding to our requests for medical records within five - seven business days**

Aligning Provider Incentives

MHS provider incentives align with our members incentives to encourage Quality of Care, including appropriate delivery of EPSDT services, and efficiency in service delivery. MHS has listened to our providers who have expressed concerns with getting members into the office for preventive care. In response, MHS is adding an alternate provider incentive program for providers who continue to work to schedule a visit with their members for preventive care, even after the HEDIS measure technical specification time limitation has expired. Specifically, the program is referred to as the EPSDT Provider Incentive Program. This program rewards the PMP for closing a care gap for the CIS (Childhood Immunization Status; Combination 10), the W30 (Well-Child Visits in the First 30 Months of Life), and LSC (Lead Screening in Children) measures. MHS provides the PMP with a 90-days grace period following the HEDIS deadline for measure compliance. If the PMP closes a care gap for one or more of these measures in the 90-days grace period, then MHS will provide a $25 rewards for each such care gap closed. Contact your provider network and/ or quality liaison to learn more about this incentive program. The details are also posted on the MHS provider portal.

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Chapter 14: Member Eligibility, Enrollment and PMP Selection/Panel Assignment

Eligibility for Hoosier Healthwise (HHW) & Hoosier Care Connect (HCC)

The local county office of the DFR, a part of the Family and Social Services Administration (FSSA), is responsible for determining eligibility of persons applying for the HHW and HCC program. Persons interested in applying for HHW or HCC should be referred to the local county office of the DFR in the county in which they live. A link to the complete listing of DFR offices by county can be located in Chapter 1 of the IHCP Provider Manual.

Applicants select a health plan on their DFR benefit application. If the applicant is enrolled in HHW or HCC but did not select an MCE on the application, he or she has 14 days from the eligibility determination date to select an MCE. Individuals who do not make a voluntary health plan selection are assigned to a health plan via an automated assignment process that links the member with an appropriate health plan. The health plan assists the member with PMP selection.

Member eligibility in HHW and HCC is effective on the first or 15th calendar day of a month and may be confirmed by any of the eligibility verification systems described in this chapter or Chapter 3 of the IHCP Provider Manual.

HHW & Hoosier Care Connect Member Open Enrollment and Plan Changes

HHW and HCC Members are enrolled with a health plan for a one-year period so long as they remain eligible. Members will have the opportunity to change their MCE at the following intervals:

- Within 90 days of starting coverage
- Once per calendar year for any reason
- During the Medicare open enrollment window (mid-October-mid December) to be effective the following calendar year
- At any time using the just cause process (defined below)

If the member's doctor changes to another health plan and the member wishes to remain with that doctor, this can be a just cause reason to initiate a change. Members will not automatically follow the PMP.

Any Medicaid member may change their MCE for Just Cause. Determination as to whether a member has met one of these reasons is solely the determination of the Enrollment Broker and FSSA. The reasons include, but not limited to, the following:

- Receiving poor quality of care;
- Failure to provide covered services;
- Failure of the Contractor to comply with established standards of medical care administration;
- Lack of access to providers experienced in dealing with the member's health care needs;
- Significant language or cultural barriers;
- Corrective action levied against the Contractor by the office;
- Limited access to a primary care clinic or other health services within reasonable proximity to a member's residence;
- A determination that another MCE's formulary is more consistent with a new member's existing health care needs;
- Lack of access to medically necessary services covered under the Contractor's contract with the State;
- A service is not covered by the Contractor for moral or religious objections, as described in Section 6.3.2;
- Related services are required to be performed at the same time and not all related services are available within the Contractor's network, and the member's provider determines that receiving the services separately will subject the member to unnecessary risk;
- The member's primary healthcare provider disenrolls from the member's current MCE and reenrolls with another MCE. The enrollee would have to change their residential, institutional, or employment based on that provider's change in status from an in-network to an out-of-network provider and, as a result, would experience a disruption in their residence or employment; or
- Other circumstances determined by the office or its designee to constitute poor quality of health care coverage.

MHS tries to resolve all member concerns. If the issue cannot be resolved, the member will be referred to IHCP.

Chapter 14: Member Eligibility, Enrollment and PMP Selection/Panel Assignment (cont'd)

Eligibility for Healthy Indiana Plan (HIP)

HIP is a program created to provide health care coverage to low-income adults. Hoosiers between the ages of 19-64 whose family income is up to 138% of the federal poverty level are eligible for HIP. Eligibility is determined by the DFR, as it is with HHW and HCC.

As with HHW and HCC, applicants select a health plan on their DFR benefit application. Members must make a MCE selection before their first payment. The health plan assists the member with PMP selection.

HIP members have an annual period when they can change their MCE called "MCE Selection Period." The MCE Selection Period runs from November 1 – December 15. HIP members are locked into their MCE for one calendar year. If they leave Medicaid and return, they will return to the MCE they were assigned to when they left the program. Additionally they will not able to switch MCEs during their annual redetermination period.

The State determines member eligibility for HIP, which can be determined anytime within the month of the member paying their POWER Account contribution. Eligibility may be confirmed by any of the eligibility verification systems described in this chapter or Chapter 3 of the IHCP Provider Manual. Generally, with a few exceptions, HIP members are guaranteed eligible for a 12-month benefit period. Remember to use the IHCP Provider Healthcare Portal or View Member Benefits for package coverage and copayment information at each encounter.

There are several benefit packages in HIP, some of which require copays upon the rendering of services. Please see the table below for additional information. Information on copays is provided in Chapter 15. Use the IHCP Provider Healthcare Portal or View Member Benefits for package coverage and copayment information at each encounter.

PLEASE NOTE *Throughout the manual this icon refers to the following statement:*
Healthy Indiana Plan (HIP) cost-sharing, which includes copayments and POWER Account contributions, will continue to be paused. For CHIP and MEDWorks, cost sharing resumed as of July 1, 2024.

IHCP BENEFIT PACKAGE: DESCRIPTION	ZERO COST SHARE (YES OR NO)	COPAYS (YES OR NO)
HIP Maternity	Yes	No
Plus	No	Yes–ER Only
Basic	No	Yes
State Plan Plus	No	Yes–ER Only
State Plan Basic	No	Yes

HIP Member Open Enrollment and Plan Changes

HIP Members are enrolled with a health plan for a one-year period so long as they remain eligible for HIP. MHS HIP members can change health plans any time before the member pays his/her first POWER Account payment, during the annual MCE Selection Period, or when a member has a for cause reason to initiate a change (such as if the doctor changes to another health plan and the member wishes to remain with that doctor).

Chapter 14: Member Eligibility, Enrollment and PMP Selection/Panel Assignment (cont'd)

Pregnancy and HIP Members

HIP members who become pregnant are eligible to receive maternity benefits through their current HIP benefit plan. HIP members will receive maternity services through the HIP Maternity benefit package. Pregnant members are not subject to cost sharing such as copays. As a reminder, a Notification of Pregnancy risk assessment (NOP) should be completed for all pregnant members.

Verifying Member Eligibility

Providers are responsible for verifying eligibility every time a member schedules an appointment and when the member arrives for service. As some HIP members are responsible for copays, it is very important for providers to check the eligibility and packages of HIP members to determine if a copay is due at the time of service. Please see Chapter 15 for additional information regarding copays. Use the IHCP Provider Healthcare Portal or mhsindiana.com for package coverage and copayment information.

PMPs should also verify the member is assigned to his or her panel, as members may request a PMP change at any time. If you have a member in your office who is not currently assigned to your panel, you may accept the member as a new patient. Please see the PMP Selection/Panel Assignments section below for additional information.
It is important to note IHCP may only indicate MHS as the member's health plan and will not include specific PMP assignment until 30 days following enrollment with a health plan. After that initial 30-day period, this information will be available via the MHS Secure Provider Portal, the IHCP Provider Healthcare Portal and the IHCP AVR system.

Until the actual date of enrollment with MHS, MHS is not financially responsible for services the prospective member receives, nor is MHS financially responsible for members whose coverage has been terminated. MHS is responsible for the institutional charges for those individuals who are MHS members at the time of a hospital inpatient admission and who experience a change in health plans during that confinement, where the type of admission is paid under the DRG methodology.

Means for Verifying Eligibility

To verify eligibility and plan enrollment, providers may access the following resources:

- **GABBY** - GABBY is a verbal interactive virtual agent that has been added to the options on the IHCP Customer Assistance phone line. GABBY is designed to listen to the caller and respond accurately and completely. This interactive virtual agent will be able to provide information and assist with questions (for example: member eligibility verification, benefit limits, claim status, provider enrollment status, prior authorization and payment information) based on the users' inquiry without having to return to the main menu.

  GABBY utilizes conversational artificial intelligence (AI) including natural language processing/understanding (NLP/U) to perform tasks and deliver immediate and accurate answers to provider inquiries 24 hours a day, seven days a week. If GABBY determines that it is unable to assist a caller with their inquiry, it will be able to route the call to the next available agent in the Customer Assistance call center during regular business hours.

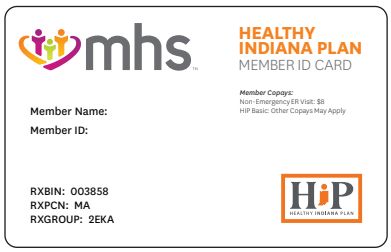
To reach this IVR, providers will continue to call the IHCP Customer Assistance line at 800-457-4584, option 2.

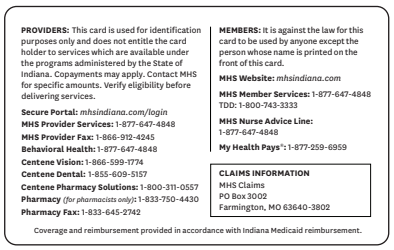
- **IHCP Provider Healthcare Portal** – The IHCP Provider Healthcare Portal (Portal) is a secure website that allows providers to perform multiple functions including obtaining eligibility information and filing FFS claims. The Portal is fast and easy to use, and online help is available through the eligibility verification process. For more information, see the Provider Healthcare Portal provider reference module.
- **The MHS Secure Provider Portal (Provider Login)** – MHS provides a Secure Portal for providers to check member eligibility, check and submit claims, check and submit authorizations, review cost sharing (copayment requirements for HIP members) and more (see more uses in Chapter 1). Providers needing assistance using the site may contact the MHS Portal Help Desk at 1-866-912-0327.

Chapter 14: Member Eligibility, Enrollment and PMP Selection/Panel Assignment (cont'd)

Member ID Cards

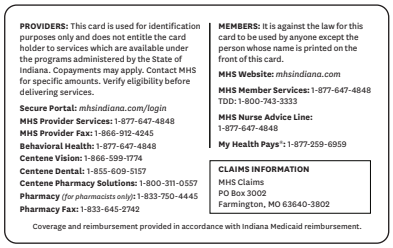
All MHS members will have one of the following ID cards that will contain their MID. Remember to use the IHCP Provider Healthcare Portal or mhsindiana.com for package coverage and copayment information at each encounter.





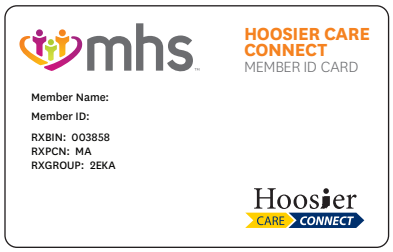
Healthy Indiana Plan ID Card

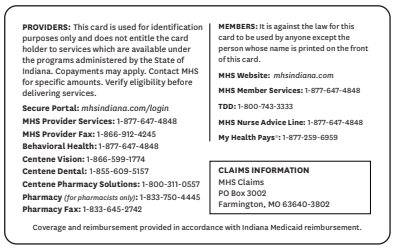
All HIP members receive a HIP ID card. This includes HIP Maternity members.



Hoosier Healthwise ID Card

All members enrolled in HHW will receive this ID card.





Hoosier Care Connect ID Card

All members enrolled in HCC will receive this ID card.

Member Redetermination

Member redetermination of HHW, HIP and Hoosier Care Connect eligibility is performed by the DFR and normally occurs every 12 months. The redetermined HHW or HCC member will be given an opportunity by the DFR to choose a health plan. Redetermination is generally a seamless process if there have been no gaps in coverage, but some members lose eligibility upon their redetermination due date, especially members in HIP Maternity, where eligibility is dependent on a member's pregnancy. All pregnant HIP members are responsible for alerting the DFR or MHS of their end of pregnancy to avoid gaps in coverage. It is also important to note federal guidelines require that members show proof of citizenship when going through the redetermination process.

You can help reinforce the importance of complying with reenrollment instructions to ensure the continued eligibility of your members. MHS periodically reminds members to renew their benefits as continued eligibility means better Continuity of Care.

Chapter 14: Member Eligibility, Enrollment and PMP Selection/Panel Assignment (cont'd)

Member Enrollment Guidelines for MHS Providers

MHS providers must adhere to member enrollment marketing guidelines as outlined by OMPP. Providers may not:

- Influence members to choose one health plan over another
- Influence members to make choices based upon reimbursement rates or methodology used by a particular health plan
- Enroll members in a plan unless the physician's office, clinic or site has been designated by the State as an enrollment center

Providers may:

- Distribute State-approved MHS educational materials to members
- Encourage members to renew in a timely manner so they do not get assigned to a different PMP
- Inform the member of care options, including hospital services, specialists or specialty care available from MHS
- Assist a member in contacting MHS to determine if a particular specialist or service is available
- Encourage pregnant MHS members to select a PMP for their baby before the baby is born

PMP Selection/Panel Assignments

Members select an MCE during their Medicaid enrollment period. Once the member selects MHS, staff works with the member to select a PMP within 30 days. If the member does not select a PMP within the 30 days, MHS will auto-assign the member to an MHS PMP based upon State-approved assignment logic.

Find A Provider (FAP) Tool

Our FAP tool is located on our website at mhsindiana.com/find-a-provider. This is where our MHS in-network doctors, specialists, hospitals and other facilities can be found using a quick and easy online search. This tool can be filtered down to a demographic and cultural analysis of each provider including: name, address, telephone number, professional qualifications, specialty and board certification status, gender, additional office languages, additional practitioner languages, gender limitations and accessibility features (parking access, exterior building access, interior building access, and programmatic access).

If you discover an update is needed on our FAP tool, please fill out the Demographic Update Tool at mhsindiana.com/providers/become-a-provider/demographic-update-tool.html. You can also call MHS Provider Services department to request a change to your information on the FAP tool.

Adding a New Member to Your Panel

If you have a member in your office who is not currently assigned to your panel, you may accept the member as a new patient. To add new members to your panel, please submit a request via the MHS Secure Provider Portal at Provider Login.

Full Panel Additions

The MHS PMP may request that a member who is currently assigned to MHS be added to his or her full panel at any time with no limitations on the number or frequency of additions. To add new members to a full panel, please submit a request via the MHS Secure Provider Portal at Provider Login.

Due to open enrollment, any request regarding a member not currently assigned to MHS must occur after the member's 90-day free change period for HHW members or after a HIP member makes his/her first payment. All non-member requests will be sent to the enrollment broker so the member can be assigned to the appropriate MCE. The MCE will assist with PMP selection once the member has been assigned to the MCE.

Panel Hold Requests and Additions

A PMP's panel may be placed on hold at the PMP's request through the Provider Secure Portal for a limited time. This process generally prevents new assignments other than assignments due to a previous PMP relationship being identified during the auto-assignment process or case assignments. In certain circumstances, a previous relationship may exist between a member or family and the PMP. If auto-assignment will not place the member with the PMP, the PMP may request the addition via the MHS Secure Provider Portal at Provider Login.

Chapter 14: Member Eligibility, Enrollment and PMP Selection/Panel Assignment (cont'd)

MHS will allow providers to add additional members to his/her panel at any time with no limitations on the number or frequency of additions. Providers who have a panel freeze or panel stop can only request a member be added upon receiving special approval from the Office of Medicaid Policy and Planning.

Pre-birth Selection

Providers are encouraged to advise pregnant members to contact MHS Member Services to select a PMP for their baby prior to the birth. A pre-birth selection can ensure the baby is assigned to your panel and simplify some coverage questions when the baby is born. Providers may also assist in the promotion of pre-birth selection by using the Pre-Birth PMP Selection Form available at Guides & Manuals. Send the completed form to MHS Member Services. Providers may also contact Member Services at 1-877-647-4848 to make a pre-birth selection on behalf of a member.

If the mother does not make a pre-birth PMP selection, the baby will be auto-assigned to a PMP within the MHS network. If the mother does not make a health plan change within the 90-day free change period, the baby will remain locked into the MHS plan for 12 months. If the child is auto-assigned and the mother wants to change to another MHS doctor, she may do so by calling MHS Member Services.

Physician Disenrollments and Continuity of Care

If a PMP leaves your practice or is leaving at a future date, please visit mhsindiana.com and use the Demographic Update Tool. You may work with MHS to have the members from his or her panel assigned to another PMP panel within your practice. If you do not have another PMP that will absorb the members, MHS will work with the member to find a new PMP for continued care.

MHS will notify members when a PMP or specialist is leaving the network. In the case of a specialist leaving the network, MHS will notify members who have been seen in the previous six months. In both cases, if the member is in the middle of active treatment for certain illnesses, the member may be able to continue care with that physician. Continued care must be coordinated through MHS Medical Management.

Member Disenrollment

MHS follows a State-defined process which requires MHS approval before a member can be dismissed from a PMP's panel. If the provider is part of a Physician Hospital Organization (PHO) or large group with multiple locations, a member dismissed from one practice is not an automatic dismissal from each provider in that PHO or large group.

All providers must follow the process outlined in this section in order to remove a member from his or her panel. All requests for member disenrollment must be submitted via the MHS provider portal at mhsindiana.com.

Please allow 30-45 calendar days for the member to be removed from your panel. If the request is denied, MHS will return a denial notification within five days of receipt of your request.

Chapter 14: Member Eligibility, Enrollment and PMP Selection/Panel Assignment (cont'd)

If a pregnant member is being disenrolled from your panel because they are no longer pregnant, the member's aid category must be changed by the State to indicate the member is no longer pregnant. Please allow 60- 90 calendar days to process this type of request.

Valid Reasons for a Request for Disenrollment

- Missed appointments (three missed appointments in a 12-month period). The member must be informed after the first missed appointment about the importance of keeping appointments and the possibility of being disenrolled from a PMP's panel should additional appointments be missed.
- Member fraud
- Misuse, under-utilization or over-utilization of services that risk the member's health/well-being and or exceed acceptable expectation and MHS guidelines
- Threatening, abusive or hostile behavior displayed by the member or family of member (include dates and a brief description of events)
- Medical needs better met by another provider
- Breakdown of the physician/member relationship
- Member accessing care from another provider
- Member was previously disenrolled from panel (include original approval letter)
- OB reassignment for members who are no longer pregnant (include delivery date)

The following are reasons that MHS may not approve your request:

- No supporting documentation with original request
- ER abuse - this is not a valid reason for disenrollment
- Member is assigned to your panel, but you have never seen him/her
- Member has not paid a previous bill

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Chapter 15: Member Benefits, Services and Copays

MHS is required to provide specific medically-necessary services to its members. MHS does not limit or exclude any covered service(s) on the basis of moral or religious objections or grounds. The following grid provides an overview of HHW, HCC, HHW Package C (CHIP), HIP Basic and HIP Plus benefits. Please refer to the MHS Member Handbooks and IHCP Bulletins and Banners for a more inclusive listing of limitations and exclusions.

	HHW & HCC	HHW Package C (CHIP)	HIP BASIC	HIP PLUS	HIP State Basic/ Plus
Maternity - Delivery	No	No	No	No	Covered
During and After Pregnancy Care Call MHS right away if you become pregnant.	Covered	Covered	Covered	Covered	Covered
Well-child checkups (Early periodic screening, diagnosis & treatments)	Covered	Covered	Covered under age 20	Covered under age 20	Covered under age 20
Orthotics - Braces for legs; orthopedic shoes; prosthetics	Covered	Covered	Covered	Covered	Covered
Cosmetic procedures	No	No	No	No	No
Diabetes strips, blood sugar monitoring	Covered	Covered	Covered	Covered	Covered
Tests to find if you have a health condition (diagnostics)	Covered	Covered	Covered	Covered	Covered
Developmental delay evaluation & treatment	Covered	Covered	No	No	No
Foot care	Covered	Covered	Covered with Restrictions	Covered with Restrictions	Covered with restrictions
Treatment for learning disability, problem solving or memory issues	No	No	No	No	No
Hearing aids (1 per member every 5 years)	Covered	Covered	Only for Ages 19 & 20	Only for Ages 19 & 20	Only for ages 19 & 20
Home healthcare	Covered	Covered	Covered	Covered	Covered
Hospital stays	Covered	Covered	Covered	Covered	Covered
Labs/X-rays	Covered	Covered	Covered	Covered	Covered
Medical supplies/equipment	Covered	Covered	Covered	Covered	Covered
New or experimental services or alternative therapies	No	No	No	No	No
Unlimited transportation to doctor visits, pharmacy (after a doctor's visit), emergency care and Medicaid re-enrollment	Covered	Covered	Covered	Covered	Covered
Surgeries (outpatient)	Covered	Covered	Covered	Covered	Covered
Continued care after hospital stays (post stabilization)	Covered	Covered	Covered	Covered	Covered
Prescriptions (copay may be required)	Covered	Covered	Covered – See website for PDL	Covered – See website for PDL	Covered – See website for PDL
Doctor visits (services from your PMP/family doctor)	Covered	Covered	Covered	Covered	Covered
Referrals to specialists	Covered	Covered	Covered	Covered	Covered
Authorized therapies – physical, speech, occupational, respiratory	Covered	Covered	Covered	Covered	Covered

Chapter 15: Member Benefits, Services and Copays (cont'd)

Healthy Indiana Plan (HIP) cost-sharing, which includes co-payments and POWER Account contributions, will continue to be paused. For CHIP and MEDWorks, cost sharing resumed as of July 1, 2024.

Hospice	Carve-Out - HHW Covered - HCC	Carve-Out	Covered	Covered	Covered
Ambulance	Covered	Covered	Covered	Covered	Covered
The following are Self-Referral Services. HHW, HCC, and HHW Package C (CHIP) members can get these services listed from any provider that accepts Indiana Medicaid. Healthy Indiana Plan members must get the services listed from in-plan providers, except for birth control and emergency room visits.					
	HHW	HCC	HIP BASIC	HIP PLUS	HIP State Basic/ Plus
Birth control (family planning)	Covered	Covered	Covered	Covered	Covered
Behavioral healthcare/psychiatric services	Covered	Covered	Covered	Covered	Covered
Chiropractic care	Covered	Covered	No	Covered with Restrictions*	Covered with Restrictions*
MHS case management	Covered	Covered	Covered	Covered	Covered
Emergency room	Covered	Covered	Covered	Covered	Covered
Shots (immunizations)	Covered	Covered	Covered	Covered	Covered
Sexually-transmitted infection (STI) treatment (ongoing)	Covered	Covered	Covered	Covered	Covered
Treatment for alcohol/drug abuse	Covered	Covered	Covered	Covered	Covered
Women's care (pap test, chlamydia test, mammogram)	Covered	Covered	Covered	Covered	Covered
Eye/vision checkups, glasses/contacts	Covered	Covered	Pregnant Members and Members Ages 19 & 20	Covered	Covered
Dental care	Covered	Covered	Pregnant Members and Members Ages 19 & 20	Covered	Covered
Podiatric services	Covered	Covered	Covered with Restrictions**	Covered with Restrictions**	Covered with Restrictions**
Diabetes self-management services	Covered	Covered	Covered	Covered	Covered
*Annual limit of six (6) spinal manipulation visits per covered person per benefit year. Self-referral - provider referral is not required. No prior authorization is needed. Coverage available for covered services provided by a licensed chiropractor when rendered within the scope of the practice of chiropractic. **Covered when medically necessary for the treatment of diabetes and lower extremity circulatory diseases.					

HHW, HCC and HIP programs exclude some benefits from coverage under Managed Care. Please see the IHCP website for more information.

HIP Medical Copays (HIP Basic, HIP State Plan Basic only)

Please see Chapter 16: Health Indiana Plan (HIP)/POWER Account for details regarding HIP member copays.

Important Notes on Copays for Medical Services

- Pursuant to federal law, copays may not be collected from members who are pregnant, Native American Indian or Alaska Native. The State will identify all members who are determined eligible for the cost-exemption as a Native American Indian or Alaska Native. This will be identified in the benefit package. Please review the section on Verifying Member Eligibility in Chapter 14 to identify members required to make copays.
- In instances where MHS pays for services provided to a HIP Basic member, MHS will exclude the amount of the required HIP Basic copay from the rates paid to the provider.

HIP Cost Sharing and Copayments

Cost Sharing is defined as the costs a member is responsible for paying for health services when covered by health insurance. Members enrolled in HIP have cost sharing in the form of copayments and monthly POWER Account Contributions (PAC).

Member cost sharing may not exceed five percent of a family's income divided by family size quarterly. Once this contribution has been met, the member will not have cost sharing obligations (copayments or PAC payments) until the beginning of the next quarter.

Payment of copayments:
- Copayments are based on the type of service provided and plan the member is on.
- Copayments are collected by the rendering provider at the point of service.
- There is no copayment required for preventive care, maternity or family planning services.
- Failure to pay copayments will not affect Medicaid eligibility, but the provider may refuse to provide services.

HIP Basic and HIP State Basic Copayment Amounts:
- Outpatient Services – Including Doctor's Office Visits: $4
- Inpatient Services – Including Hospital Stays: $75
- Preferred Drugs: $4
- Non-Preferred Drugs: $8
- Non-Emergency ER visit: $8

*All Medicaid members are subject to copayments for Non-Emergent Emergency Room Visits. Members in "zero cost share" benefit plans are exempt from the Non-Emergent Emergency Room Visit copayment.

HIP Emergency Copay

HIP members may be responsible for an emergency room copay. Copays will apply to non-emergent visits to the emergency room. Any time a member is referred to the emergency room by his or her PMP/doctor or the MHS Nurse Advice Line, a copay will not be required. Members will be charged $8 for non-emergent ER visit. If the member pays an emergency room copay but is admitted to the hospital on the same day as the emergency room visit, the copay is refunded to the member. Providers can refer to the Secure Provider Portal for member-specific ER utilization history.

Providers will collect the copay from members. POWER Account funds cannot be used by the member to pay the copay.

Prior to assessing the copayment, the member must be screened to ensure they do not have an emergency health condition. The requirements for a medical screening examination and stabilizing treatment when an individual presents at the emergency room remain in place regardless of the member's ability to pay. Members that do not have an emergency health condition must be informed of other options for treatment of their non-emergency condition and of the cost sharing associated with seeking treatment in the ER. Per federal requirements, the ER provider may require payment of the copayment before the non-emergency service is provided, however the provider must also:

- Provide the name and location of an alternate non-emergency services provider that is available and accessible;
- Verify that an alternate provider can provide the services without the imposition of the copayment; and
- Provide a referral to coordinate scheduling of this treatment.

Additionally, if copay is collected and later waived it must be refunded to the member.

Non-Emergency Use of Emergency Room Copays	
# of Non-Emergency Room Visits	Copay Amount
All visits	$8
*Copays for non-emergency room visits will be collected from all eligible HIP members EXCEPT for those exempt from cost-sharing (Pregnancy, Native American Indian or Alaska Native).	

If you refer a member to the Emergency Room, please notify MHS immediately at 1-877-647-4848, as this will affect the HIP member copayment process at the ER.

PLEASE NOTE *Throughout the manual this icon refers to the following statement:*
Healthy Indiana Plan (HIP) cost-sharing, which includes copayments and POWER Account contributions, will continue to be paused. For CHIP and MEDWorks, cost sharing resumed as of July 1, 2024.

HHW Package C (CHIP) Prescription Copays

Type of Perscription	HHW Package C (CHIP) Copay
Generic prescriptions	$3 per drug
Brand-name prescriptions	$10 per drug

HIP Prescription Copays

HIP members enrolled in HIP Basic or HIP State Plan Basic are required to pay the following copays for prescriptions. HIP Plus members do not pay a pharmacy copay.

Type of Prescription	Copay Amount
Preferred Drugs	$4 per drug
Non-Preferred Drugs	$8 per drug

Interpreter/Translation Services

MHS is committed to providing staff and interpreters to help members who speak a language other than English. Not sure of your patient's language? You may also find out a patient's language by logging on to our Provider Portal and downloading your Patient List, or by contacting MHS Member Services at the toll-free number located on the back of the member's ID card. You may also work with the interpreter service to identify the right language.

MHS offers the following language assistance services. All interpreters are trained professionals.

Over-the-Phone Interpretation
Telephonic interpreter services are available 24/7 and in approximately 150 languages to assist providers and members in communicating with each other when there are no other interpreters available. Providers may call MHS Provider Services at 1-877-647-4848 for help with interpreter requests.

Video Remote Interpretation
Multiple languages are available for remote interpretation. Supported platforms include Zoom, Skype for Business, Google Hangouts Meet, GoToMeeting, WebEx and any telehealth platform in which an interpreter can join as a guest or provider attendee. Please contact our Member Advocate team at language_services@mhsindiana.com to request an Interpreter Request Form to submit your request.

In-Person Interpretation
MHS offers face-to-face interpreters practicing in more than 150 languages including Spanish, Burmese and American Sign Language. Email requests to: language_services@mhsindiana.com.
When possible, MHS requests a five day prior notification for face-to-face services.

Free 24-Hour MHS Nurse Advice Line

The MHS Nurse Advice Line is available 24 hours a day, seven days a week, including weekends and holidays. Callers can talk to experienced nurses when they call. The main goal of the Nurse Advice Line is to direct members to the appropriate level of care. Any time a member is referred to the emergency room by the Nurse Advice Line, a copay will not be required. Nurse Advice Line staff use state-of-the-art advice protocols and plan methodologies. All calls taken by Nurse Advice Line staff are logged and tracked. Providers will receive a notification on the Provider Portal when one of their patients outreaches to the Nurse Advice Line.

Ombudsman Program

The MHS Ombudsman Program is a partnership between MHS and Mental Health America of Indiana (MHAI) that is designed to assist MHS members in finding effective ways to resolve concerns about benefits and services provided under their MHS coverage. MHS wants members to feel comfortable contacting a trusted community-based organization with any complaints they may have about the health plan or the services they have received.

New Member Welcome

Upon enrollment, members receive a New Member Packet which includes detailed information about their covered services and appropriate access to care, including:

- Adult and child health prevention guidelines
- Services and benefits
- Member rights and responsibilities
- Grievance and appeal instructions

New members will also receive a call to welcome them to the plan. A Care Engagement Specialist will assist with:

- Health Needs Screening completion
- Alternative material formatting needs
- Social assistance resources
- Selection and assignment of a doctor
- Assistance with scheduling doctor appointments
- Program/benefit questions and rewards program education
- An in-person health engagement opportunity

Member Materials

MHS has developed targeted programs to address the needs of its members. Members may receive specific preventive care reminders, disease management bulletins and treatment updates, and invitations to community and member-specific events. These materials are available in English and Spanish and can include:

- Quarterly newsletters
- Targeted disease management information
- MHS Nurse Advice Line information
- Emergency room Information
- Tobacco cessation information

Providers interested in receiving any of these materials for use at their offices may contact MHS.

MHS Community Relations

Community Relations is an outreach team of MHS staff who can help members one-on-one with understanding their health coverage and other community resources. The team can provide educational services at a member's home or over the phone. They will help members build a relationship with their doctor, and help members understand their health benefits and get care quickly. MHS Community Relations can help with transportation, food, shelter or other health programs.

Community Relations can also work specifically with MHS providers to plan educational events, including Baby Showers and Healthy Celebrations for MHS members.

Connections Plus®

MHS provides cell phones to members enrolled in Care Management who do not have access to a landline telephone. It is important for members to reach their doctors, Care Managers and FSSA. Qualifying members receive 500 free monthly minutes as well as unlimited texting. To refer a member (who lacks telephone access) to the Connections Plus® Program or for additional information on the program, contact MHS Community Relations.

MHS Baby Showers

MHS Baby Showers are generally two to three-hour events hosted at a provider office or local community center that can be tailored to the specific needs of a provider. The goal of the event is to educate members on the importance of prenatal and postpartum care as well as immunizations for their baby. The event consists of food, drinks, games, prizes, health education and safety tips. We provide an educational overview of MHS programs including OB and Behavioral Health Case Management and also partner with various community organizations to talk about services that relate specifically to pregnant women and new moms. During the event, we give away items like teethers, rattles and health kits as game prizes, and every member that attends gets a gift bag that includes various goodies and a pack of diapers.

MHS Healthy Celebrations

MHS Healthy Celebration events focus on non-compliant members. MHS partners with a PMP office to schedule a specific day and time (four-hour minimum) for non-compliant MHS members on the PMP's panel to visit the office and receive specialty visits and screenings, such as Children's Health: EPSDT/well-child (lead screen age appropriate) or Women's Health: Mammography & Chlamydia.

After the doctor visit, screening or immunizations have occurred, MHS will provide a member benefit overview. Each member will also receive a goody bag full of MHS and educational materials and health related giveaways. Then the family can enjoy games, prizes and healthy snacks before they leave the doctor's office.

Partnership for Home Visits

MHS partners with companies like Harmony Care Medical Group, Signify and Inovalon to perform in-home assessments, and close HEDIS and risk gaps at the time of assessment.

Online Mental Health Resources

MHS offers online, consumer-directed mental health resources at no charge to our members through MyStrength.com, a website that offers a range of resources to improve mental health and overall well-being. MyStrength is not a provider location but a consumer-directed resource accessible through the Internet and also through a member's smart phone. The website offers members the ability to take responsibility for their health care and learn more about their diagnoses, track their symptoms, and receive motivational ideas and information.

We also encourage family caregivers of our members with behavioral health issues to enroll and use MyStrength for support and to better understand their family member's behavioral health condition and needs. Members can participate in MyStrength to increase awareness of mental health needs and engage in personalized e-Learning programs to help overcome depression and anxiety supported by tools, weekly exercises and daily inspiration in a safe and confidential environment.

Member Advisory Council (MAC)

MAC is a face-to-face forum that allows members to learn about the programs and services MHS has to offer them. Members can share their feedback and offer any suggestions they may have. Community organizations are also invited to come to present information to the members as well. The information that is gathered is shared internally with the departments that it impacts, to implement potential change to enhance programs and services.

Other Benefits

- Behavioral/Physical Healthcare coordination services - refer to Chapter 12
- My Health Pays® preventive care incentive program - refer to Chapter 10
- Disease management and extensive disease management - refer to Chapter 11
- Tobacco cessation - refer to Chapter 10
- Telemonitoring for high-risk members
- Annual diabetes home test kits
- Annual diabetic eye examinations
- Enhanced vision services
- School-based health services
- "Call to Action" program
- Health Library
- Care Grant Initiative

Member Rights and Responsibilities

MHS members have the right to:

- Receive information about MHS as well as MHS services, practitioners, providers and your rights and responsibilities. We will send you a member handbook when you become eligible and a member newsletter four times a year. In addition, detailed information on MHS is located on our website at mhsindiana.com. You may also call Member Services at 1-877-647-4848.
- Be treated with respect and with due consideration for your dignity and privacy.
- Receive information on available treatment options and alternatives, presented in a manner appropriate to your condition and ability to understand.
- A candid discussion of appropriate or medically-necessary treatment options, regardless of cost or benefit coverage.
- Participate with practitioners in decisions regarding your healthcare, including the right to refuse treatment.
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in federal regulations on the use of restraints and seclusion.
- Request and receive a copy of your medical records, and request they be amended or corrected as allowed in federal healthcare privacy regulations.
- Voice complaints, grievances or appeals about the organization or the care it provides
- Make recommendations about our Member Rights and Responsibilities policy.
- An ongoing source of primary care appropriate to your needs and a person formally designated as primarily responsible for coordinating your healthcare services
- Personalized help from MHS staff so you can ensure you are getting the care needed, especially in cases where you or your child have special healthcare needs such as dealing with a long-term disease or severe medical condition. We make sure you get easy access to all the care that is needed and will help coordinate care with multiple doctors and get case managers involved to make things easier for you. If you have been determined to have a special healthcare need by an assessment under 42 CFR 438.208(c)(2) that requires a course of treatment or regular care monitoring, we will work with you to provide direct access to a specialist as appropriate for your condition and needs.
- Have timely access to covered services.
- Have services available 24 hours a day, seven days a week when such availability is medically necessary.
- Get a second opinion from a qualified healthcare professional.
- Direct access to women's health specialists for routine and preventative care, including family planning, annual women's tests and OB service, without approval by MHS or your MHS doctor. This includes birth control, HPV tests, chlamydia tests and annual pap smears.
- Receive written notice of a decision to deny a service authorization request or to authorize a service in an amount, duration or scope that is less than requested. You will receive this information as quickly as needed so your medical needs are met and treatment is not delayed. We will not jeopardize your medical condition waiting for approval of services. Authorizations are reviewed based on your medical needs and made in compliance with State time frames.
- Request this information in other languages or formats, including Spanish, large print or Braille. Please contact MHS at 1-877-647-4848 if you need this information in another format.

MHS members have the responsibility to:

- Provide information (to the extent possible) needed by MHS, its practitioners and other healthcare providers so they can properly care for you.
- Follow plans and instructions for care which you have agreed to with your MHS doctors.
- Understand your health problems and participate in developing mutually-agreed-upon treatment goals to the degree possible.

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Chapter 16: Healthy Indiana Plan (HIP)/Power Account

The HIP program is designed to promote healthy behaviors and appropriate use of healthcare services with financial incentive to adopt healthy behaviors through the annual rollover of unused funds.

POWER Account

HIP members are responsible for making a financial contribution to their health care coverage, either through regular POWER (Personal Wellness and Responsibility Account) Account contributions or HIP Basic copayments for services. Required contributions for HIP Plus or HIP State Plan Plus are based on a tiered scale as shown below. HIP Plus can be cheaper than HIP Basic because there are no other costs or copayments for doctor visit, prescriptions or hospital visits. Non-emergency visits to the emergency room may have an $8 copay.

Tier	Monthly PAC Single Individual	Monthly PAC Spouses	PAC with Tobacco Surcharge	Spouse PAC when one has tobacco surcharge	Spouse PAC when both have tobacco surcharge (each)
1	$1	$1	$1.50	$1 & $1.50	$1.50
2	$5	$2.50	$7.50	$2.50 & $3.75	$3.75
3	$10	$5	$15	$5 & $7.50	$7.50
4	$15	$7.50	$22.50	$7.50 & $11.25	$11.25
5	$20	$10	$30	$10 & $15	$15

Members enrolled in HIP Basic or HIP State Plan Basic are not required to make monthly contributions to their POWER Account, but are required to pay the following copayments at the time services are rendered:

Service	Copay
Preventative Services	$0
Outpatient Services	$4
Inpatient Services	$75
Preferred Drugs	$4
Non-Preferred Drugs	$8
Non-Urgent ER	$8

All HIP members are subject to non-urgent emergency room copays listed above unless, pursuant to federal law, they are an exempt population.

Pursuant to federal law, members who are pregnant, Native American Indian or Alaska Native are except from contributions and copays. The State will identify all members who are determined eligible for cost-exemption as a Native American Indian or Alaska Native.

The POWER Account may be comprised of the monthly contribution amount from the member plus a State contribution serving as a health savings account. The member's contribution funds the POWER Account as the monthly contribution is received. The member is responsible for the entire yearly POWER Account contribution, although they are allowed to make monthly payments for the amount owed. The State's portion of the POWER Account is funded upon the member's enrollment in the HIP program. The POWER Account is used to cover the member's initial eligible medical expenses. If funds received from the member are not sufficient to cover initial medical expenses taken against the POWER Account, MHS loans member funds to the POWER Account, and the member must repay those expenses by continuing to remit payment to MHS until their entire yearly POWER Account contribution amount is paid.

Providers can make the monthly contribution on behalf of the member, with the permission of the member. Any provider that wishes to make the monthly contribution should inform their provider representative. MHS will then provide a Third Party Payer form to the provider. The provider will return the completed form with a list of the member(s) they wish to make contributions for and the amount(s).

The maximum POWER Account balance per eligible benefit year is $2,500 (Example: member contribution total is $300, State subsidy is $2,200). The member's contribution is based on a percentage of their gross family income with consideration of family size.

Chapter 16: Healthy Indiana Plan (HIP)/Power Account (cont'd)

While the POWER Account funds are used to pay the first $2,500 of eligible medical expenses to participating providers, they are not used for the first $500 of preventive care services covered under the Affordable Care Act (ACA). Unused portions of the POWER Account are eligible for rollover to the next 12-month benefit period when the member receives an appropriate age and gender preventive healthcare service, including:

Preventive Care Services**	Male 19-35	Female 19-35	Male 35-50	Female 35-50	Male 50-64	Female 50-64
Annual Physical	Covered	Covered	Covered	Covered	Covered	Covered
Mammogram	N/A	N/A	N/A	N/A	N/A	Covered
Pap Smear	N/A	21+	N/A	Covered	N/A	Covered
Cholesterol Testing *	N/A	N/A	Covered	45+	Covered	Covered
Blood Glucose Screen *	Covered	Covered	Covered	Covered	Covered	Covered
Tetanus-Diphtheria Screen	Covered	Covered	Covered	Covered	Covered	Covered
Flu Shot *	Covered	Covered	Covered	Covered	Covered	Covered

**Annual or as required by your disease/history specific condition*
***Measures listed in the chart were current on the date of publication. Preventive services for obtaining rollover are subject to change at the discretion of the State. Changes to the chart and associated policies will be communicated through MHS Provider Relations and at mhsindiana.com.*

POWER Account funds must only be used to pay for covered services until that member's $2,500 deductible is met. Copays are non-covered services for this purpose. MHS will maintain up-to-date member POWER Account balance information.

If the member is renewed through the redetermination process and there is a balance remaining in the member's POWER Account at the end of the coverage term, some or all of the balance will be rolled over to reduce the member's new POWER Account contribution for the following coverage term. The amount available for rollover will depend on whether the member received OMPP-recommended preventive care services in the previous coverage term. Rollover amounts will offset the contribution requirement during the following 12-month benefit period. The State's portion of the contribution will not rollover if the member fails to receive appropriate preventive services. If recommended preventive healthcare services are not received, only the member's unused funds will rollover to the following benefit year.

HIP Basic and HIP State Plan Basic members not contributing to their POWER Account will not have the ability to rollover funds since they did not participate in funding the POWER Account. HIP Basic and HIP State Plan Basic members will still maintain the incentive to manage the POWER Account and receive recommended preventive services, however, as these members may be eligible for a HIP Plus discount directly related to the percentage of the POWER Account balance remaining at the end of the plan year.

Members who are terminated from HIP Plus or are transferred to HIP Basic before their POWER Account is fully funded may incur debt. Debt is incurred through missed POWER Account payments as well as utilizing the pre-funded POWER Account prior to the member fully funding their portion. If the monthly contribution amount is insufficient and cannot cover initial medical expenses, the member must repay those expenses by remitting payment to MHS. This applies under the following circumstances:

- The POWER Account is not fully funded at the time a member's HIP eligibility terminates
- Insurer attempts to collect the debt
- Insurer reports non-payment of the debt to the State

PLEASE NOTE *Throughout the manual this icon refers to the following statement:*
Healthy Indiana Plan (HIP) cost-sharing, which includes copayments and POWER Account contributions, will continue to be paused. For CHIP and MEDWorks, cost sharing resumed as of July 1, 2024.

Chapter 16: Healthy Indiana Plan (HIP)/Power Account (cont'd)

Billing HIP Members

Members may be billed directly for non-covered services and any copayments incurred including ER copayments. Please see Chapter 4 - General Claims Information and Guidelines for more information.

Benefits Information

A list of HIP covered services is available in Chapter 15. HIP coverage limitations include:

- Preventive services covered under the Affordable Care Act (ACA) are not applied to the $2,500 POWER Account balance.

Pregnancy Services

HIP members who become pregnant are eligible to receive maternity benefits through their current HIP benefit plan. Pregnant members are not subject to cost-sharing such as copays. As a reminder, a Notification of Pregnancy risk assessment (NOP) should be completed for all pregnant members.

ER Copayments

Members will be charged $8 for all non-emergent visits. Copayments will be waived or returned to the member if he or she is admitted to the hospital on the same day as the emergency room visit. If the attending emergency physician deems the visit to be a true medical emergency, or if the member's PMP/doctor or the MHS 24-Hour Nurse Advice Line sends the member to the ER.

A member must receive an appropriate medical screening examination under Section 1867 of the Emergency Medical Treatment and Active Labor Act. The emergency department must inquire about the member's access to an alternative non-emergency services provider and must not charge a copayment if the member does not have access to such an alternative provider. Once it is established that the member has an available and accessible alternate non-emergency services provider and a determination has been made the individual does not have an emergency medical condition, the hospital must inform the member before providing non-emergency services that:

- The hospital may require payment of the copayment before the service can be provided
- The hospital will provide the name and location of an alternate non-emergency services provider that is available and accessible
- An alternate provider can provide the services without the imposition of the copayment
- The hospital provides a referral to coordinate scheduling of this treatment

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Chapter 17: Credentialing

Credentialing Requirements

The purpose of the credentialing and re-credentialing process is to ensure all practitioners and organizational providers initially meet and continue to meet the established criteria for participation in the MHS provider network. In order to participate in the MHS network, all licensed physicians, healthcare professionals and facilities must meet minimum requirements as set forth by MHS. Additionally, practitioners and organizational providers are required to notify MHS of any relevant changes to their credentialing information in a timely manner. At all times, information surrounding credentialing activities will remain confidential.

Credentialing Committee (CC)

The MHS CC consists of MHS staff physicians and other physicians in the MHS network. The Committee is supported by MHS Credentialing, Provider Relations, Compliance and QI staff. This committee reports regularly to the MHS Senior Executive Quality Improvement Committee. It has the responsibility to establish and adopt, as necessary, criteria for physician participation and termination, and to direct the credentialing procedures, including physician participation, denial and termination. Committee meetings are held once a month or as deemed necessary.

MHS encourages practitioners to enroll with the Council for Affordable Quality Healthcare (CAQH). CAQH is a practitioner database website where practitioners can register their credentialing information for any and all organizations to which they want to apply. It is free to practitioners and is convenient because you only have to submit information to one place, one time (and, of course, as it gets updated) rather than to each MCE, hospital or network you wish to join. It is also secure, as only authorized credentialing organizations may access your information with your permission. Please visit their website at caqh.org.

Criteria for MHS Network Practitioner Participation

The following are minimum requirements for participation in the MHS network:

- A current unrestricted, non-probationary Indiana Medical License or unrestricted, non-probationary license in the state in which the practitioner is seeing MHS members.
- Attestation of DEA Coverage Plan with name of covering physician OR covering practice name.
- If applicable, a current Indiana Controlled Substances Certificate of Registration or, if practicing outside of Indiana, a controlled substance certificate issued by that State (if applicable).
- A current malpractice insurance face sheet for each carrier that includes insured dates and amounts of coverage.
- Evidence of current malpractice/professional liability insurance in the amounts of $500,000/$1.5 million or as required under Indiana law or the laws of the applicable state in which the practitioner is seeing members.
- Clinical privileges in the practitioner's specialty at a minimum of one licensed hospital in the State of Indiana. In the absence of hospital privileges, a practitioner may provide evidence of a formalized inpatient coverage arrangement through other practitioners who have been credentialed through MHS or have arrangements with a facility that utilizes hospitalists for inpatient admissions.
- A National Practitioner Data Bank (NPDB) query which is reviewed by and found acceptable to the Credentialing Committee
- A professional malpractice liability claims history which is reviewed by and found acceptable to the Credentialing Committee. When reviewing this history, the Committee will consider, among other factors, frequency of cases, severity of cases, outcome of cases, involvement of other practitioners and the practitioner's explanation where provided.
- A copy of the Indiana Professional Licensing Agency report documenting any history of State sanctions.
- Good standing on the HHS-OIG (Office of Inspector General) and the System for Award Management (SAM) with no sanctions by Medicare or Medicaid.
- No match listed on the Social Security Death Master File (SSDMF) which is reviewed and found acceptable to the Credentialing Committee.
- If the practitioner has previous sanctions of any type, twice the length of the sanction must have passed prior to participation in the MHS network.
- Completed site audit with a passing score set by MHS when applicable.
- An agreement to abide by the applicable Participating Provider Agreement, which includes all the clauses and terms required by MHS as well as by the State of Indiana Medicaid contracting authority; a participating provider's service agreement may be terminated if it is determined by MHS' Board of Directors or the Credentialing Committee that participation requirements are not being met.
- A completed malpractice questionnaire for each malpractice claim or judgment, if applicable.
- A current copy of specialty/board certification certificate, if applicable.

- Satisfactory review of a five-year work history via the Practitioner Application or curriculum vitae with no unexplained gaps of employment over six-months for initial applicants.
- A current release of information signed and dated.
- A current IHCP provider enrollment number.
- An NPI number.

Criteria for MHS Network Organizational Provider Participation

The following are minimum requirements for participation in the MHS network:

- A valid Indiana license or a valid license in the state where MHS members will be provided services
- Insurance that meets the requirements of the state where the organizational provider is located
- A letter of accreditation (if applicable)
- A current site survey demonstrated by one of the following:
  - A certificate of accreditation,
  - A current CMS certificate, or
  - A copy of the site survey conducted by the applicable State licensing agency, which indicates the facility passed the inspection
- A current IHCP provider enrollment number
- An NPI number
- Clinical Laboratory Improvement Amendments (CLIA) certificate (if applicable)
- Drug Enforcement Agency (DEA)# (if applicable)
- W-9 Form

MHS Credentialing will ensure the provider has met all Federal and State regulatory requirements by reviewing the above information as well as ensuring the organization has no sanctions from the OIG, SAM or applicable State agencies.

MHS will process all credentialing applications within 30 calendar days of receipt of a complete application. MHS will also ensure that all credentialed providers are loaded into our provider files and claims system within 15 calendar days of receipt from the delegated entity.

PMPs must submit to an onsite survey of their office and treatment areas and be credentialed prior to accepting MHS membership. PMPs cannot accept member assignments until they are fully credentialed. Specialists must be credentialed prior to becoming an in-network provider. OB/GYN specialists must submit to an onsite survey as well.

Recredentialing

MHS conducts the re-credentialing process for practitioners and providers no more than three years from the date of the initial credentialing decision. The purpose of this process is to identify any changes in the practitioner's facility, license, sanctions, certification, competence or other related information that may affect their ability to perform the services for which the practitioner or provider is contracted to provide. This process includes all practitioners (PMPs and specialists), ancillary providers and hospitals previously credentialed to practice within the MHS network.

Right to Review and Correct Information

All practitioners participating with MHS have the right to review information obtained by the plan to evaluate their credentialing and/or re-credentialing application. This includes information obtained from any outside primary source such as the National Practitioner Data Bank (NPDB), malpractice insurance carriers and the Department of Regulation and Licensing Medical Examining Board. This does not allow a practitioner to review references, personal recommendations or other information that is peer-review protected.

Should the practitioner believe any of the information used in the credentialing/re-credentialing process to be erroneous, or should any information gathered as part of the primary source verification process differ from that submitted the practitioner, he or she will have the right to correct that information and to submit comments and explanations for any other factual information. To request release of such information, the practitioner submits a written request to MHS Credentialing. Upon receipt of notice to the practitioner from MHS of the presence of apparently adverse information about him or her, the practitioner will have 14 calendar days to provide a written explanation detailing the error or the difference in information to MHS. MHS' Credentialing Committee will then include this information to be considered as part of the credentialing/re-credentialing process. At any time during the credentialing process, the practitioner has the right to request the status of their credentialing application by contacting MHS Credentialing at 1-877-647-4848 or by using the MHS website.

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Chapter 18: Provider Enrollment

MHS offers the ability for most providers to enroll through our website here: mhsindiana.com/providers/become-a-provider.html.
This includes:

- Request for a new contract
- Adding a new line of business to an existing contract
- Enrolling a practitioner to an existing contract
- Demographic updates, including address changes, panel updates, terminations, etc.
- Non-contracted enrollments
- Status updates

MHS is required to send notification of an incomplete network participation request to the requesting provider within five (5) business days after receipt of the initial request.

- MHS will provide a description of the deficiency back to the original requester via email.
- If the error was on the credentialing application, MHS will state the reason why the application was determined to be an unclean and will include direction on how to resolve.
- MHS may deny an incomplete network participation request if it is not responded to within five business days of the notice for corrections. This could result in resubmitting the request to enroll.

If a decision on a clean credentialing application is not complete within 15 calendar days of receipt of the complete credentialing application (and the provider is applying to participate for the first time with MHS), the provider will be considered provisionally credentialed (assuming the provider meets the NCQA standards for provisional credentialing).

- MHS will provide a letter notifying the requesting provider of the decision to provisionally credential the provider.
- The provisional credentialing requirement does not apply to providers contracted through a delegated agreement or providers that are recredentialing with MHS.

For new contract requests, an MHS representee will be assigned to the request to join the network. The MHS representee will work with you on your agreement. Once the agreement is signed by both parties, MHS will submit the agreement, along with the enrollment information to be credentialed and loaded into our system. MHS will assign an effective date and a welcome letter will be sent within 30 days of a clean enrollment

Directory Display

MHS follows NCQA guidelines, displaying only those practitioner types that have been credentialed and offer scheduled appointments in their office. Practitioners who provide services as the result of seeing a patient in a facility setting and midlevel's who do not hold a panel are not credentialed and not displayed on the directory. Practitioners specialties include but are not limited to:

- Emergency Medicine
- Radiology
- Anesthesiology (excluding Pain Management)
- Pathology
- Midlevels not acting as a PCP holding a panel
- Practitioners who practice exclusively in a facility setting
- CRNA
- Midwives
- Occupational Therapist

Address Limitations

MHS request that only addresses where practitioners actively accept patients for appointments be submitted for enrollment. MHS will limit addresses for directory display to no more than five (5) addresses per practitioner, but must have at least one address for each group NPI which the practitioner bill under.

For practitioners listed above that do not display on MHS will only enroll the practitioner at the primary address submitted. It is not necessary to submit additional address for non-directory display practitioners, unless there is an additional group NPI.

Updating Provider Information

MHS provides an easy to use demographic update tool to allow providers and practitioners to easily update demographic information. Please let MHS know when there are changes to any information regarding individual practitioners or your group to ensure that members can easily access services with you organization.

MHS would also like to remind providers and practitioners that any updates submitted to MHS should also be reported to the Indiana Health Coverage Programs.

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Chapter 19: Medical Record Keeping & Documentation Standards

A complete medical record must be maintained on each member for whom the practitioner has rendered healthcare services and in accordance with accepted professional practice standards, State and Federal requirements. Records must include documentation of all services provided directly by the practitioner who provides primary care services and be retained and kept confidential by the practitioner for at least seven (7) years.

Medical records and information must be protected from public access, and any information released must comply with HIPAA guidelines. Upon request, all participating practitioner medical records must be available for utilization review and QI studies, including HEDIS, as well as regulatory agency requests and member relations inquiries as stated in the provider agreement. Medical records must be available at the practice site for other practitioners who provide care and services to the member. MHS practitioners must provide a copy of a member's medical record upon reasonable request by the member at no charge, and the practitioner must facilitate the transfer of the member's medical record to another practitioner at the member's request.

The following is a list of the minimum required standards for practitioner medical record keeping practices, which include medical record content, medical record organization, ease of retrieving medical records and maintaining confidentiality of member information.

Organization and Confidentiality

- Records are organized and stored in a manner that allows easy retrieval.
- Medical records are stored in a secure manner that allows access by authorized personnel only.
- Staff receive periodic training in member information confidentiality, including HIPAA standards.

Demographic Content

- Patient identification information (patient name or identification number) on each written page or electronic file record.
- Identity of the provider rendering the service.

Clinical Content

- All services provided directly by a practitioner who provides primary care services
- Date that the service was rendered
- All ancillary services and diagnostic tests ordered by the practitioner
- Abnormal lab and imaging study results have explicit notations in the record for follow-up plans. All entries should be initialed and dated by the ordering practitioner to signify review.
- All diagnostic and therapeutic services for which a member was referred by a practitioner are documented, including follow-up of outcomes and summaries of treatment rendered elsewhere, such as: home health nursing reports, specialty physician reports, hospital discharge reports (emergency room and inpatient) and physical therapy reports.
- History and physicals
- Allergies and adverse reactions (prominently documented in a uniform location)
- Problem list
- Medications
- Immunization records
- Documentation of clinical findings and evaluation for each visit (including appropriate treatment plan and follow-up schedule)
- Preventive services/risk screenings
- EPSDT services
- Health teaching and/or counseling is documented
- Age appropriate anticipatory guidance
- Appropriate notations concerning tobacco, alcohol and substance use (for members age ≥ 10 years)
- Advance directives
- Documentation of failure to keep an appointment
- Documentation of physical health medical record information sent to Behavioral Health providers, if applicable
- Documentation of cultural, interpreter or linguistic needs of member documented; if not applicable, then documented as N/A
- Electronic health records (EHRs) should facilitate meeting the above-listed requirements. For providers not utilizing EHRs, MHS has provided a set of Well-Child/Adolescent Visit documentation templates for specific age groups. These can be found on the MHS website.

Medical Records Release

Medical records of members shall be confidential and shall not be released without the written consent of the member or a responsible member's legal guardian except as described in this manual or otherwise required by law. When the release of medical records is appropriate, the extent of that release should be based upon medical necessity or on a need-to-know basis.

Pursuant to Indiana Administrative Code 405 IAC 1-1.4-2, records maintained by providers shall be of sufficient quality to fully disclose and document the extent of services provided to individuals receiving Medicaid assistance; and documented at the time the services are provided or rendered, and prior to associated claim submission. All providers shall maintain, for a period of seven years from the date Medicaid services are provided to a member, such medical or other records as are necessary to fully disclose and document the extent of the services provided. A copy of a claim form that has been submitted by the provider for reimbursement is not sufficient documentation, in and of itself, to comply with this requirement.

Providers must maintain records that are independent of claims for reimbursement. Such medical or other records, or both, shall include, at the minimum, the following information and documentation:

- The identity of the individual to whom service was rendered.
- The identity, including dated signature or initials, of the provider rendering the service.
- The identity, including dated signature or initials, and position of the provider employee rendering the service, if applicable.
- The date on which the service was rendered.
- The diagnosis of the medical condition of the individual to whom service was rendered, relevant to physicians and dentists only.
- A detailed statement describing services rendered, including duration of services rendered.
- The location at which services were rendered.
- The amount claimed through Medicaid for each specific service rendered.
- Written evidence of physician involvement, including signature or initials, and personal patient evaluation will be required to document the acute medical needs.
- When required under Medicaid rules, physician progress notes as to the medical necessity and effectiveness of treatment and ongoing evaluations to assess progress and redefine goals.
- X-rays, mammograms, electrocardiograms, ultrasounds, and other electronic imaging records.

The medical records should include details such as prescriptions for medications; inpatient discharge summaries; patient histories (including immunizations) and physicals; a list of substances used and/or abused, including alcohol, smoking and legal and illegal drugs; and a record of outpatient, inpatient and emergency care, specialist referrals, ancillary care, laboratory and X-ray tests and findings.

Written consent is required for the transmission of the medical record information of a current MHS member or former MHS member to any practitioner not connected with MHS. Practitioners may not bill MHS members or MHS for release of medical records.

Medical Records Transfer for New Members

All PMPs are required to document, in the member's medical record, attempts to obtain old medical records for all new MHS members. If the member or member's guardian is unable to remember where they obtained medical care or are unable to provide an appropriate address then this should also be noted in the medical record.

Medical Records Expense

Neither MHS contracted providers nor non-contracted providers may charge a member for medical records access, duplication or transfer. Federal and State regulations prohibit providers from charging any member or member's family for any amount not paid by the program after your claim is adjudicated. The State of Indiana has made clear the intent of the Federal and State regulations is that by participating in and accepting the payments of the plan, the practitioner agrees those payments are payments in full for the services rendered, including the medical record duplications and transfers that are a regular part of running a medical practice. The State of Indiana considers a practitioner who bills for records duplications or transfers to be in violation of his or her agreement to be an IHCP provider and may be subject to a State SUR audit.

Medical Records Audits

Medical records will be periodically audited to determine compliance with MHS' standards for documentation. The coordination of care and services provided to members as well as the outcome of such services shall also be assessed during the medical record audit. In addition, medical records will also be audited for compliance with EPSDT guidelines.

Access to Records and Audits by MHS subject only to applicable State and Federal confidentiality or privacy laws, Provider shall permit MHS or its designated representative access to Provider's Records, at Provider's place of business in this State during normal business hours, or remote access of such Records, in order to audit, inspect, review, perform chart reviews, and duplicate such Records.

Chapter 20: Provider Network

Audit Scoring

Audit scores will be computed and documented using a Medical Records Audit Tool. Results will be reported for every provider audited in terms of overall performance of the medical records reviewed against MHS' standards during the exit interview.

A minimum score of 80% is required to achieve compliance with MHS guidelines. A provider who receives a score of 79 percent or below may be required to submit a written response to MHS, which could include a corrective action plan and completion dates for improving any deficiencies identified. The MHS Chief Medical Director and/or HS Clinical and Service Quality Improvement Committee (CASQIC) reviews corrective action plans. Practitioners who receive a score of 79 percent or below will be re-audited six months after a corrective action plan has been approved. Practitioners who remain non-compliant will be discussed with the MHS Chief Medical Director and the MHS Vice President of Contracting and Network Management for further action. Medical record audit results will be reported to CASQIC for trend analysis and response to any identified network-wide improvement needs. Audit results are also shared with MHS Credentialing for consideration during the re-credentialing process.

The MHS Provider Network team is committed to supporting providers as they care for our members. Through provider orientation, ongoing training and support of daily business operations, we will strive to be your partners in good care. Upon credentialing approval and contracting, each provider will be assigned a Provider Engagement Administrator (PEA). The PEA will contact the provider to welcome the provider and schedule an orientation upon request or monthly orientation webinars are offered for convenience.

Reasons to contact the Provider Network team:
- Schedule an in-service training for new staff
- Conduct ongoing education for existing staff
- Pay-for-Performance and HEDIS review
- Obtain clarification of policies and procedures
- Obtain clarification of a provider contract
- Web Portal education including provider analytics, web authorizations, claims submissions and member eligibility

The goal of Provider Network team is to support providers and their staff with the necessary tools to offer the highest quality of healthcare to MHS members. To contact a Provider Engagement Administrator, please call MHS at 1-877-647-4848.

Assistance with Claims Issues

For assistance with claims issues, please call MHS Provider Services at 1-877-647-4848. You may also contact us online at mhsindiana.com for general questions, or contact us online securely through the MHS Secure Provider Portal at mhsindiana.com/login. Your messages will be returned within one business day. MHS Provider Services staff is available to providers and their staff members to answer questions about filing and processing claims, including:
- Claim adjustments
- Questions about claim submission
- Question about claim appeals
- Claim research
- Global or elevated claims issues
- Updates with regard to billing changes

You may also refer to Chapter 4 for additional information regarding claims.

Provider Complaints

MHS strives to serve your needs. The only way to do this effectively is to listen to your feedback about our services. If you have a concern or complaint related to MHS services, an MHS member, an MHS process, one of MHS' vendors (e.g., behavioral health, vision services, etc.) or any other aspect of working with MHS, please notify your MHS Provider Engagement Administrator or MHS QI staff right away.

If your complaint pertains to some aspect of MHS operations, your interactions with MHS or an MHS vendor, we will inform you of the outcome in writing. If your complaint pertains to another MHS provider, we will review the nature of the issue through our QI department. If that complaint is deemed a quality-of-care or quality-of-service issue, MHS will review, investigate and follow up according to the established MHS process for those issues. MHS QI partners with MHS Provider and Member Services to investigate complaints and resolve issues. If the complaint cannot be resolved in this manner, the issue will be put before CASQIC. This group of physicians and MHS management will review the concern and determine the best course of action.

If you want to discuss an MHS UM decision with the MHS clinician who worked on the case, please call the MHS Appeals Coordinator to arrange for that peer-to-peer meeting. Practitioners who disagree with a determination based on medical necessity may request a peer-to-peer review within seven (7) business days after a service authorization notification letter is received.

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Chapter 21: Frequently Asked Questions

Q. How do I set up an account for the website?
A. Please visit the Provider Portal login page for step-by-step instructions for creating an account.

Q. What are some of the features of the Secure Portal?
A.
- Manage multiple practices under one account
- View member panels
- Submit/check authorizations
- Submit claims in batch
- Claims/Medical
- View HEDIS Pay-for-Performance and Coordination of Care reports
- Check member eligibility
- View medical history and gaps in care
- Submit/check/adjust claims
- Access explanation of payments
- Necessity Appeals

Q. How do we know when an authorization is needed?
A. Providers should refer to the online tool at mhsindiana.com/transactions for specific code requirements.

Q. Do you allow retro authorizations?
A. No, except in the case of retro-eligibility. Please follow this link for the late notification form.

Q. Can I bill MHS secondary claims electronically?
A. Primary insurance information can be accepted by MHS electronically from vendors or via the MHS Secure Provider Portal.

Q. What do I do if primary insurance fails to respond within 90 days?
A. MHS will process claims if you have not received a response within 90 days from primary insurance. Please see Chapter 4 for more details.

Q. What does MHS accept as proof of timely filing?
A. EDI rejections require the provider to contact their clearinghouse and obtain a payer rejection report. All claims must be submitted according to our timely filing guidelines. Please refer to Chapter 8 for additional timeframes.

Q. My claim rejected because the member's DOB is missing or invalid. I have the correct DOB, but the IHCP Provider Healthcare Portal has the incorrect date. What should I do?
A. Member information needs to match what is on file with Indiana Medicaid. The member should work with Indiana Medicaid to update member eligibility.

Q. Can I have handwriting on my claim?
A. MHS cannot process claims with handwriting. Please see Chapter 4 for more details.

Q. Can I bill HIP members for copays that were not collected at the time of service?
A. Yes, copayments are the responsibility of the member.

PLEASE NOTE *Throughout the manual this icon refers to the following statement:*
Healthy Indiana Plan (HIP) cost-sharing, which includes copayments and POWER Account contributions, will continue to be paused. For CHIP and MEDWorks, cost sharing resumed as of July 1, 2024.

Q. Does MHS offer any tools for providers to identify HIP members that have a copay?
A. Yes, the MHS Secure Provider Portal details the name of the HIP member's benefit package and cost-sharing responsibility.

Q. When does maternity coverage term for HIP members?
A. For HIP members, maternity coverage term 12 months after the pregnancy ends. Members are responsible for notifying MHS and the Division of Family Resources (DFR) at the end of their pregnancy.

Q. Where do I find my patient listing?
A. Providers' member panel lists are available via the Secure Provider Portal. The listing can be filtered and downloaded into Excel.

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Chapter 21: Frequently Asked Questions

Q. How can I tell if I am an in-network provider?

A. In-network provider offices, practitioners, facilities, and ancillary service providers are all listed in the MHS Find a Provider search. Please remember, practitioners that are not involved in direct patient care, such as pathologists, radiologists and mid-level practitioners that are not acting as a PMP, will not be displayed on the directory even if they are contracted.

Q. How do I notify MHS when a provider leaves our office?

A. Demographic updates can be made via our online tool on mhsindiana.com.

Q. When are Pay-for-Performance reports updated?

A. Pay-for-Performance (P4P) reports are updated monthly, and available on the Secure Provider Portal, via the via the Provider Analytics tab.

Q. How do I request a Prior Authorization (PA) for a DME item for my patients.

A. Prior Authorization requests must be submitted by the ordering physician. Prior Authorization Requests can be initiated via the Secure Provider Portal. Simply go to mhsindiana.com. Log into the Provider Portal, and click "Create Authorization." Requests can also be initiated by fax at 866-912-4245.

Q. How do I add a member to my panel if its full?

A. The Full Panel Add and Hold Request form and Member Disenrollment form are available on the Secure Provider Portal. Copies of completed paper forms are no longer accepted via fax or email. Please log into your portal account to complete these forms.

Q: Can I submit a sterilization consent form via the provider portal?

A: Yes, via the initial claims submission you can upload the sterilization form with your claim. If you fail to submit the consent form with your original claim submission, please use the corrected claim option via the web portal or by mail.

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Chapter 22: Acronyms

AVR – Automated Voice Response
CASQIC – Clinical and Service Quality Improvement Committee
CC – Credentialing Committee
CHF – Congestive Heart Failure
CHIRP – Children & Hoosiers Immunization Registry Program
CMS – Centers for Medicare & Medicaid Services
CPG – Clinical Practice Guidelines
DFR – Division of Family Resources
DME – Durable Medical Equipment
EOP – Explanation of Payment
EPSDT – Early & Periodic Screening, Diagnosis & Treatment (aka HealthWatch)
HCC – Hoosier Care Connect (program)
HEDIS – Healthcare Effectiveness Data & Information Set
HHW – Hoosier Healthwise (program)
HIP – Healthy Indiana Plan (program)
HIPAA – Health Insurance Portability & Accountability Act
HIV – Human Immunodeficiency Virus
HPV – (genital) Human Papilloma Virus
IAC – Indiana Administrative Code
IHCP – Indiana Health Coverage Programs
IDOH – Indiana State Department of Health
MAC – Member Advisory Council
MCE - Managed Care Entity
MHS – Managed Health Services
MID - Member Identification Number
NCQA – National Committee for Quality Assurance
NOP – Notification of Pregnancy
NPI – National Practitioner Identification number
OMPP – Office of Medicaid Policy and Planning
PA – Prior Authorization
PMP – Primary Medical Provider
QI – Quality Improvement
RCP – Right Choices Program
RID – Recipient Identification (number)
STI – Sexually-Transmitted Infection
TPL – Third Party Liability
UM – Utilization Management
USPSTF – United States Preventive Services Task Force
VFC – Vaccines for Children

NOTES

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