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

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

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

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

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

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

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

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

MHS FAX NUMBERS
MEDICAL APPEALS: 1-866-714-7993
CASE MANAGEMENT: 1-866-694-3653
Ex. Member Referrals to CM/DM
REFERRALS AND AUTHORIZATIONS: 1-866-912-4245

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

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

You can find out more about the information in this Guide in the MHS Provider Manual, online at mhsindiana.com/providers/resources, or by contacting MHS at 1-877-647-4848.
REFERRALS
Referrals to a specialist do not require a referral from MHS for an initial or recurring office visit, unless the service otherwise requires authorization. The PMP and specialist offices may communicate directly for any needed referrals.

PRIOR AUTHORIZATIONS (PA)
All faxed PA requests must be submitted on the IHCP’s Universal PA request form.

Information needed to complete all PAs:
• Member name, ID and date of birth
• Type of service needed (i.e., office visit, outpatient surgery, DME, inpatient admission, testing, therapy, etc.)
• Date(s) of service
• Ordering physician
• Servicing physician
• HCPC/S/CPT codes requested for approval
• Diagnosis code
• Clinical information to support medical necessity including: history of symptoms, previous treatment and results, physician rationale for ordering treatments and/or testing

DME PA request also require the following additional information:
• Certificate of medical necessity must be complete and have current (within 3 months) information and MD signature within the year.
• Physician’s order
• Indicate if request is purchase or rental authorization
• Power wheelchairs (must have home evaluation)
• Enteral/Formula: current height/weight, growth charts, nutrition history, previous testing/imaging/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
• Must include cardiac workup, pulmonary workup, diet and exercise logs, current lab reports, psychologist report

Pain Management
• Must have documentation of at least 6 weeks of therapy on area to be treated
• Include previous procedures/surgeries, medications, description of pain, any contra-indications or imaging studies
• Include prior injection test results for injection series

IMAGING PRIOR AUTHORIZATION REQUESTS
National Imaging Associates (NIA) manages non-emergent, advanced, outpatient imaging services to include prior authorization for MHS members.

• The ordering physician is responsible for obtaining authorization prior to rendering the below listed services. To obtain authorization, the provider should go to the NIA website RadMD.com or through the NIA dedicated toll-free phone number, 1-866-904-5096.
• Providers rendering the services listed below should verify that the necessary authorization has been obtained by visiting RadMD.com, or by calling NIA at 1-866-904-5096. Failure to do so may result in nonpayment of your claim.
• Emergency room, observation and inpatient imaging procedures do not require authorization.

Prior authorization required for the following outpatient imaging procedures:
• 3D Mammograms • Echocardiography
• CT/CTA • Stress Echocardiography
• CCTA • MUGA Scan
• MRI/MRA • Myocardial Perfusion Imaging
• PET Scan

PLEASE NOTE ABOUT PA REQUESTS:
• Always check member eligibility for date of service as requests may be delayed if the member is with another MCE or not eligible.
• MHS will accept PA requests for emergent services up to 2 business days post services for both contracted and non-contracted providers.
• Previously approved PAs can be updated for changes to practitioner and/or dates of service, (unless the DOS overlaps a previous adverse determination [denial or partial approval] OR the DOS includes retro days [dates more than 1 business day prior to the initial request]), within 30 days of the original request submission. These updates must be requested prior to related claim denials.
• PA approval is for medical necessity only. If your claim subsequently is denied, please contact Provider Services at 1-877-647-4848 to determine the cause of the denial.
• Any request received more than 7 calendar days in advance to the start of services will be considered a standard request.

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

Fast Track
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) and fax the form to MHS.

After eligibility has been established, the MCE will return a Full Eligibility Notification Form to the provider via fax. This form will contain the member’s MCE assignment and Member ID (also known as RID). The notification will occur within 7 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.

For information on processes to be followed when a member has no Fast Track, is a mother covered by MHS or not covered by MHS, please refer to your Provider Manual.

NON-CONTRACTED PROVIDER PRIOR AUTHORIZATION REQUIREMENTS
Non-contracted providers requesting authorization for elective/routine services that require a PA must obtain it at least two days prior to the date of service. No PA will be granted outside this requirement, except in the event of an emergent situation. Urgent care will always require PA.

Non-contracted DME providers are excluded and require authorization for all services.
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 at mhsindiana.com/transactions 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 2nd business day after admission
- Newborn deliveries by 2nd business day after admission
- Rehabilitation facility admissions
- Skilled nursing facility admissions
- Transfer between facilities
- Transplants, including evaluations
- Hysterectomy

OUTPATIENT SERVICES AUTHORIZATION (NON-SELECTIVE ELECT)
- Abortions (spontaneous 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
- Hysterectomy and hysterectomy
- Implantable devices including cochlear implants
- Infertility services
- Injectable Drugs (see mhsindiana.com/providers/prior-authorization.html for a complete list of codes that require PA)
- All orders for DME or supplies must be submitted by the ordering provider to Medline via:
  - Web Portal: Simply go to mhsindiana.com, log into the provider portal, and click on “Create Authorization.” Choose DME and you will be directed to the Medline portal for order entry.
  - Fax Number: 1-866-346-0911
  - Phone Number: 1-844-218-4932
- 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.

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

- Diabetic footwear and insulin pump supplies: A9274, A9277, A9278
- Light Therapies: E0691-E0694
- Monitors and Medical Devices: A4210, E0615-E0619, E2100, E2120
- Neuromuscular Stimulators, Bone Growth Stimulation: E0740, E0745, E0747, E0748, E0760, E0770, E0785, E0806, L8680-L8684, L8686-L8689, Q0479-Q0484, Q0489-Q0491, Q0495-Q0496, Q0502-Q0506
- Orthotics, Parenteral, Enteral: B4100-B4216, 5B000-B9999
- Prosthetics: E0445, E0455-E0483, E0500, E0550, E0466, E0574, E0575, E0601, E0602, E0610, E1390-E1391
- Infertility services
- Mammoplasty
- MRI and MRA unless performed as part of an observation stay
- Nutritional counseling (non-diabetic 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
- 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.

MUSCULOSKELETAL PROCEDURES
Specific musculoskeletal (orthopedic and spinal surgical) procedures require prior authorization by Turning Point. For a complete list of codes that require PA and to submit a PA request, contact Turning Point via:
- Web: myturningpoint-healthcare.com
- Fax Number: 1-463-207-5864
- Phone Number: 1-574-784-1005

NON-EMERGENCY 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.

CONTRACTED AND NON-CONTRACTED PROVIDERS PRIOR AUTHORIZATION OR NOTIFICATION REQUIREMENTS
Please call for prior authorization for the following HHW/HIP/HCC and Presumptive Eligibility services: Facility services billed with revenue codes, including inpatient hospitalization, partial hospitalization and certain professional services including ECT and psych testing.

**CLAIMS ADDRESS:**
MHS Behavioral Health
ATTN: Claims Department
P.O. Box 6800
Farmington, MO 63640-3817

**CLAIMS REFUND ADDRESS:**
MHS Behavioral Health
Attn: Claims Recoupment
75 Remittance Dr., Suite 6446
Chicago, IL 60675-6446

**CLAIMS APPEALS ADDRESS:**
MHS Behavioral Health
ATTN: MHS BH Appeals
P.O. Box 6000
Farmington, MO 63640-3809

**MEDICAL NECESSITY APPEALS ADDRESS:**
MHS Behavioral Health
ATTN: Appeals Coordinator
12515-8 Research Blvd, Suite 400
Austin, TX 78759
FAX: 1-866-714-7991

**CLAIMS REFUND ADDRESS:**
MHS Behavioral Health
ATTN: Claims Department
P.O. Box 6800
Farmington, MO 63640-3817

**CLAIMS APPEALS ADDRESS:**
MHS Behavioral Health
ATTN: MHS BH Appeals
P.O. Box 6000
Farmington, MO 63640-3809

**MEDICAL NECESSITY APPEALS ADDRESS:**
MHS Behavioral Health
ATTN: Appeals Coordinator
12515-8 Research Blvd, Suite 400
Austin, TX 78759
FAX: 1-866-714-7991

**TRANSPORTATION - LCP**
Ambulance claims are paid through MHS. Non-Ambulance transportation claims are paid through LCP Transportation.

PHONE: 1-877-647-4848

**NON-AMBULANCE CLAIMS ADDRESS:**
P.O. Box 531097 • Indianapolis, IN 46253

PHONE: 1-855-609-5157
EMAIL: providerrelations@envolvehealth.com

**CLAIMS ADDRESS:**
Envolve Vision
ATTN: Claims
P.O. Box 7548
Rocky Mount, NC 27804

**ELECTRONIC CLAIMS:**
Payor Number 56190
WEB-SUBMISSION CLAIMS:
visionbenefits.envolvehealth.com (for participating providers)

**VISION - ENVOLVE VISION**
Routine vision services are a self-referral service and do not require primary medical provider referral or MHS prior authorization. Members receive enhanced vision services from Envolve Vision network providers. Surgical vision services are coordinated by MHS directly.

PHONE: 1-877-647-4848 or 1-844-820-6523
FAX: 1-252-451-2182
WEBSITE: visionbenefits.envolvehealth.com

**DENTAL - ENVOLVE DENTAL**
Routine dental services are a self-referral service and do not require primary medical provider referral or MHS prior authorization. Members receive comprehensive dental services from Envolve Dental network providers. Outpatient/hospital services are coordinated by MHS directly.

PHONE: 1-855-609-5157
EMAIL: providerrelations@envolvehealth.com

**CLAIMS ADDRESS:**
Envolve Dental - Claims: IN
PO Box 20847
Tampa, FL 33622-0847

**WEB-SUBMISSIONS:**
envolvedental.com

**EDI CLAIMS:**
Electronic claim submission through select clearinghouses: Payor ID 46278

**CREDENTIALING HOTLINE:** 1-855-609-5157
**CREDENTIALING FAX:** 1-844-847-9807

Managed Health Services (MHS) • 550 N. Meridian Street, Suite 101 • Indianapolis, IN 46204 • 1-877-647-4848 • (TDD/TTY: 1-800-733-3333)

MHS is a health coverage provider that has been proudly serving Indiana residents for more than 25 years through Hoosier Healthwise, the Healthy Indiana Plan and Hoosier Care Connect. MHS also offers a qualified health plan through the Health Insurance Marketplace called Ambetter from MHS, and Allwell from MHS, a Medicare Advantage Plan. MHS is your choice for better healthcare. Learn more at mhsindiana.com.