UB-04: Mastering Claims Submission and Billing Best Practices

2025 Indiana Health Coverage Programs (IHCP) Annual Works Seminar

Agenda

- MHS Overview
- Claim Submission Process
- Claim Rejections
- MHS Provider Claims Issue Resolution Process
- Additional Claims Assistance
- MHS Secure Provider Portal Functionality
- Facility Billing
- Provider Portal Claim and Payment Review
- Online Claim Reconsiderations on the MHS Secure Provider Portal
- Prior Authorization
- MHS Provider Engagement
- Questions

MHS Overview

Who Is MHS?

Managed Health Services (MHS) is a health insurance provider that has been proudly serving Indiana residents for 30 years through Hoosier Healthwise (HHW), the Healthy Indiana Plan (HIP) and Hoosier Care Connect (HCC).

MHS is your choice for better healthcare.

Claim Submission Process

Medical Claim Submission

- **Electronic Data Interchange (EDI) Submission:**
  - Preferred method of claims submission.
  - Faster and less expensive than paper submission.
  - MHS Electronic Payor ID **68069.**
- **Online through the MHS Secure Portal**
  - Provides immediate confirmation of received claims and acceptance:
  - Institutional and Professional
  - Batch Claims
  - Claim Adjustments/Corrections
  - Claim review/Adjustments Request
- **Paper Claims:**

  Managed Health Services

  P.O. Box 3002

  Farmington, MO 63640-3802

Behavioral Health Claim Submission

- **Electronic Submission:**
  - Payer ID **68068.**
  - MHS accepts Third Party Liability (TPL) information via Electronic Data Interchange (EDI).
  - It is the responsibility of the provider to review the error reports received from the clearinghouse (Payer Reject Report).
- **Online through the MHS Secure Portal**
  - Provides immediate confirmation of received claims and acceptance:
  - Institutional and Professional
  - Batch Claims
  - Claim Adjustments/Corrections
  - Claim review/Adjustments Request
- **Paper Claims:**

  MHS Behavioral Health
  P.O. Box 6800
  Farmington, MO 63640-3818

Claim Billing with Ease

Tips to help you bill with ease

- The National Provider Identifier (NPI), Taxonomy Code, and Zip +4 is necessary for the system to make a one-to-one match based on the information provided on the claim and the information on file with Indiana Medicaid.

- Secondary Claims Third Party Liability (TPL):
  - Accepted electronically from vendors or via the **MHS Secure Portal**

Claim Submission

In-Network providers: 90 calendar days from the date of service or discharge date.

Out-of-Network providers: 180 calendar days from the date of service or discharge date.

Exceptions:

- Newborns (30 days of life or less) – Claims must be received within 365 calendar days from the date of service. Claim must be filed with the newborn's Medicaid Identification number.
- TPL – Claims with primary insurance must be received within 365 calendar days of the date of service with a copy of the primary Explanation of Payment (EOP).
    - If the EOP is received after the 365 calendars days, providers have 60 days from date of primary EOP to file claim to MHS. If the third party does not respond within 90 calendar days, claims may be submitted to MHS for consideration. Claims submitted must be accompanied by proof of filing with the patient's primary.

Claim Submission and Acceptance

Claim Acceptance and Adjudication

- System reviews claim for errors and critical fields (i.e., dates of service, billing/rendering provider, etc.) prior to acceptance.
- Regulatory requirements (federal and state) mandate certain information to be present to accept and pay a claim.
- Common rejection/denial; provider information on claim must match record at Indiana Health Coverage Programs (IHCP) enrollment – a state requirement.

Paper Claim Correction

A corrected claim can be submitted following IHCP claim adjustment processes.

- Corrections should be submitted with the correct resubmission code in the 3rd digit of the bill type located in box 4. (Corrected claim will be 7.)
- The original claim number must also be listed in box 64 on the corrected claim.
- A rejection must be submitted as a 1st time claim, not as a corrected claim.
- Handwriting or stamping on a claim will not be accepted as submission of a corrected claim, and will be rejected with code RE.

Claim Rejections

Claim Rejections

- A rejected claim contains invalid, or missing data elements requires for acceptance of the claim in the claim processing system.

- Rejected claims need corrected and submitted as a first-time new claim.

- Timely filing is not substantiated when a claim is rejected.

Claims EDI Rejections

- EDI rejections require the provider to contact their clearinghouse and obtain a Payer Rejection Report.
- MHS website tools :
  - **MHS Resources**
  - Refer to Rejection Code Help Aid.
  - Scroll down to Claims/Billing:
    - Top 10 Rejections Codes Help AID.
    - Reject Reason Codes and Descriptions..
  - Paper to electronic mapping.

Reason for Claim Rejections

Medical

07 Invalid Subscriber/Member ID
09 Member Invalid on Date of Service
01 Invalid Provider ID Billing Physician
08 Invalid Member Date of Birth
76 Original Claim Number Required
40 Diagnosis Code Is Missing
90 Invalid or Missing Modifier
B5 Missing/Incomplete/Invalid Clinical
77 Invalid Claim Type
A3 Claim Exceeded the Maximum 97 line

Behavioral Health

09 Member Invalid on Date of Service
07 Invalid Subscriber/Member ID
08 Invalid Member Date of Birth
01 Invalid Provider ID Billing Physician
76 Original Claim Number Required
40 Diagnosis Code Is Missing
31 Invalid Service Procedure Code
A3 Claim Exceeded the Maximum 97line

MHS Provider Claims Issue Resolution Process

Provider Claims Issue Resolution Process

- **Level 1**: Informal Claims Dispute
- **Level 2**: Formal Claim Dispute - Administrative Claim Appeal
- **Level 3**: Arbitration

Please note, this is different than an authorization appeal. A claim appeal cannot change a denied authorization status. To change authorization status, you must appeal the denied authorization.

Claim Dispute/Appeal – Medical and Behavioral Health

Medical Claims Address:

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

Behavioral Health Claims Address:

Managed Health Services BH Appeals
P.O. Box 6000
Attn: Appeals Department
Farmington, MO 63640-3809

Informal Claims Dispute or Objection Form

Level 1:

- Submit all documentation supporting your objection.
  - Copies of any subsequent MHS EOPs or other determinations on the claim(s) in question.
  - Documentation of any previous attempt you have made to resolve the issue with MHS.
  - Other documentation that supports your request for reprocessing or reconsideration of the claim(s).
- Must be submitted via the MHS Secure Provider Portal or in writing within 60 calendar days of receipt of the MHS Explanation of Payment by using the Medical Claim Dispute/Appeal Form.
  - Requests received after day 60 will not be considered.

Informal Claims Dispute or Objection Form

Level 1:

- MHS will make all reasonable efforts to review your documentation and respond to you within **30 calendar days.**

- At that time (or upon receipt of our response if sooner), you will have up to **60 calendar days** from date of dispute response to initiate a Formal Claim Appeal (Level 2).

Informal Claims Dispute and Helpful Tips

Level 1: Helpful Tips

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

Provider Services Phone Requests & Provider Portal Inquiries

- After the Informal Claims Dispute (Level 1) has been submitted, for assistance or questions, the provider can access the Provider Service Phone Line or Provider Portal. The inquiries will be logged and assigned a ticket number. Please keep this ticket number for your reference.
- Phone: 1-877-647-4848; Provider Services
  8:00 a.m. to 8:00 p.m. EST.
- Provider Web Portal: MHS Secure Portal
  - Use the Messaging Tool.

Provider Services Phone Requests & Provider Portal Inquiries Helpful Tips

Helpful Tips:

Disputing multiple Claim Denials:

- Provide the Provider Services Representative or Provider Portal Team Member with one claim number as an example of the specific denial. Communication is key!
- Inform the representative you have a “claims research request” to review all claims for the specific denial reason.
- State if this denial is happening for one or multiple practitioners within your group or clinic; (if multiple, provide your Taxpayer Identification Number (TIN)).
- Provide the MHS Denial Code and description found on the EOP.
- Briefly describe why you are disputing this denial or seeking research.

Formal Claim Dispute

Level 2:

- Level 2 is a Formal Claim Dispute, Administrative Claim Appeal.

- In the event the provider is not satisfied with the Informal Claim Dispute/Objection Resolution, the provider may file an Administrative Claim Appeal. The appeal must be filed within 60 calendar days from receipt of the Informal Dispute Resolution Notice.

Formal Claim Dispute - Administrative Claim Appeal

Level 2:

- An Administrative Claim Appeal must be submitted via the **MHS Secure Portal** or in writing by using the Medical Claim Dispute/Appeal Form with an explanation including any specific details which may justify reconsideration of the disputed claim. The appeal should be clearly marked on the form as Level 2.
- In the comment box clearly state your reason for the dispute.

Arbitration

Level 3:

- Level 3 is a part of the formal MHS Provider Claims Dispute Process.
- In the event a provider is not satisfied with the outcome of the Administrative Claim Appeal Process (Level 2), the provider may request arbitration. Claims with similar issues from the same provider may be grouped together for the purpose of requesting arbitration.
- To initiate arbitration, the provider should submit a written request to MHS on company letterhead. The request must be postmarked no later than 60 calendar days after the date the provider received MHS' decision on the Administrative Claim Appeal.

Arbitration requests need to be mailed to:

MHS Arbitration
429 N Pennsylvania St., Suite 109
Indianapolis, IN 46204

State Fair Hearing (SFH)

A State Fair Hearing must be initiated in writing by the member, member's authorized representative, member's provider of record, or a healthcare practitioner with knowledge of the member's medical condition. 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

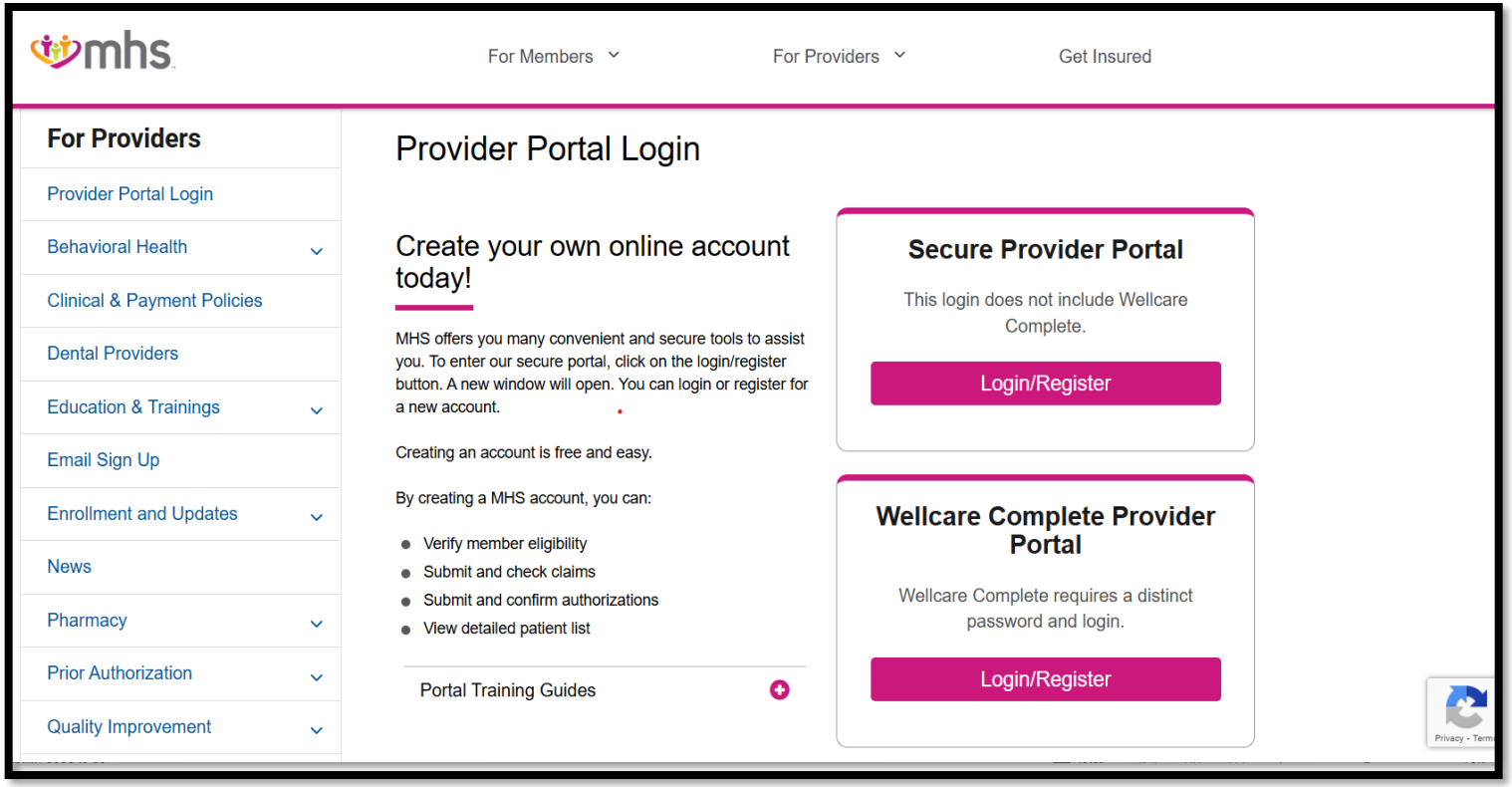
Additional Claim Assistance

Provider Engagement Account Manager (PEAM) Regional Mailboxes

- If all claim denials are upheld after following the dispute processes and the provider has not received resolution by calling Provider Services or utilizing the secure messaging on the Provider Portal, please contact MHS Provider Relations through the Claim Issues Mailbox assigned to your region.
- Issues will be logged by the internal Provider Relations team and providers will receive a response email with next steps and any assigned reference numbers.
- Please do not email your Provider Engagement Account Manager directly, as this may delay the time in getting a response due to their travel.

MHS Secure Provider Portal Functionality

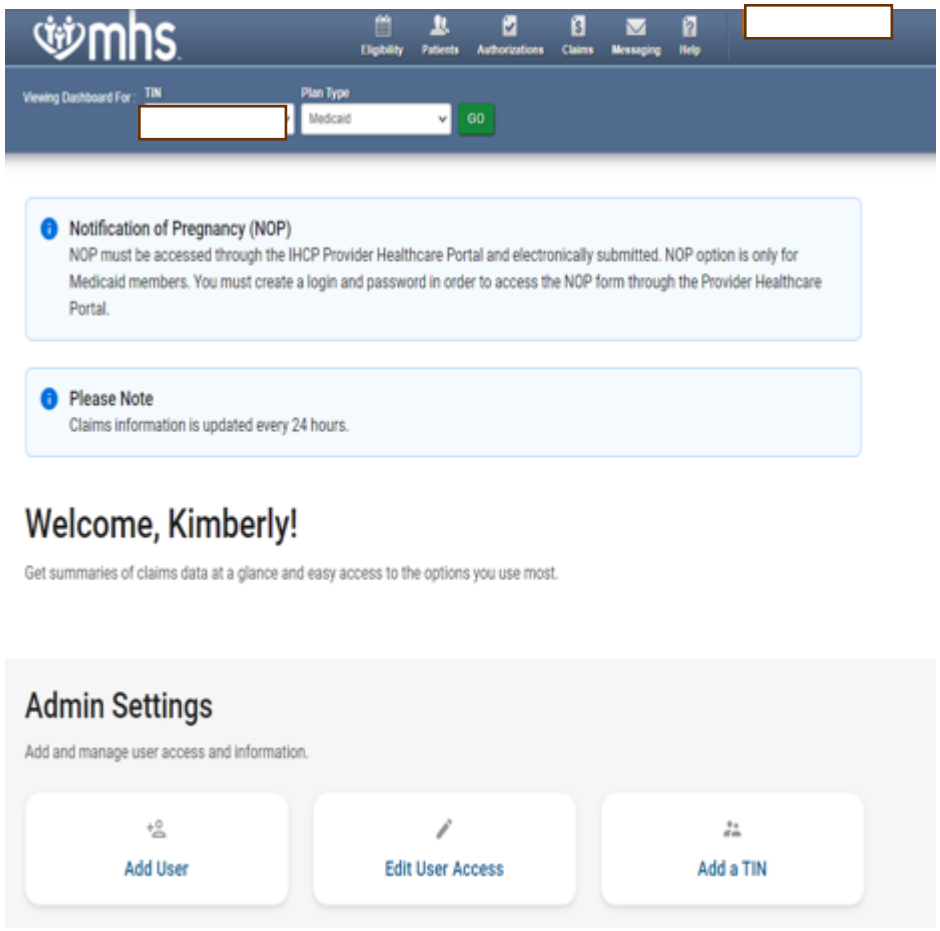
Secure Web Portal Login or Registration

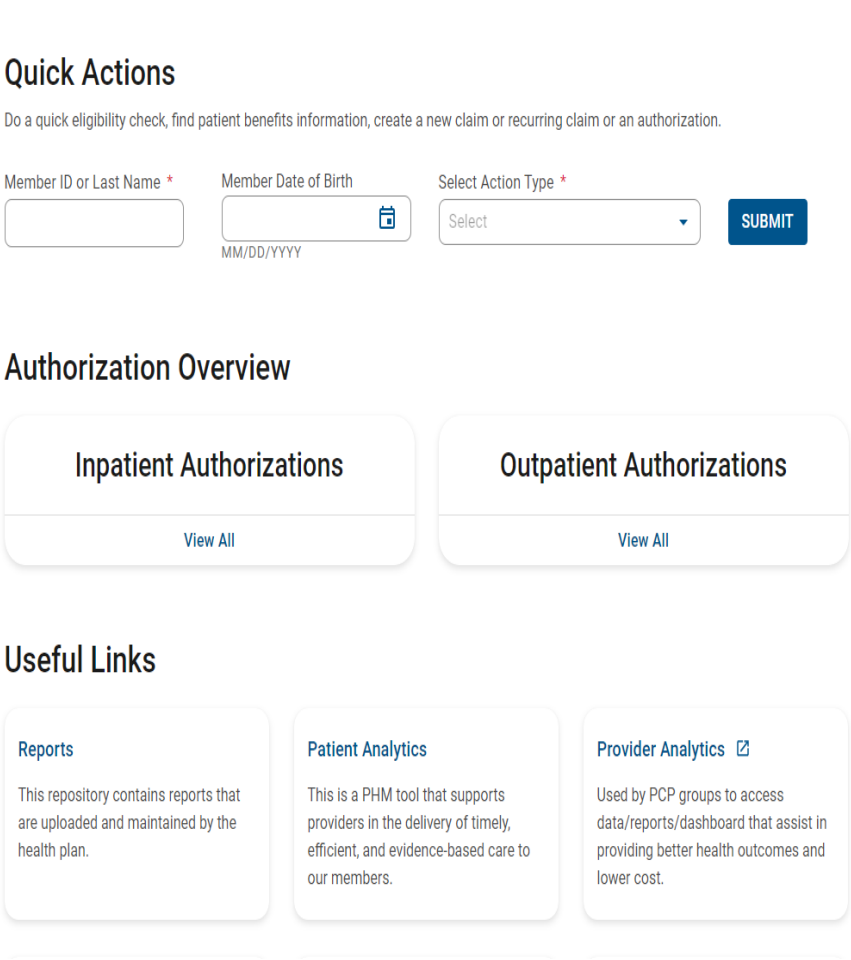


Create a login or sign into the **Online Portal** to get started

Homepage - MHS (Medicaid)

After logging into the portal this homepage will appear that allows providers to access information





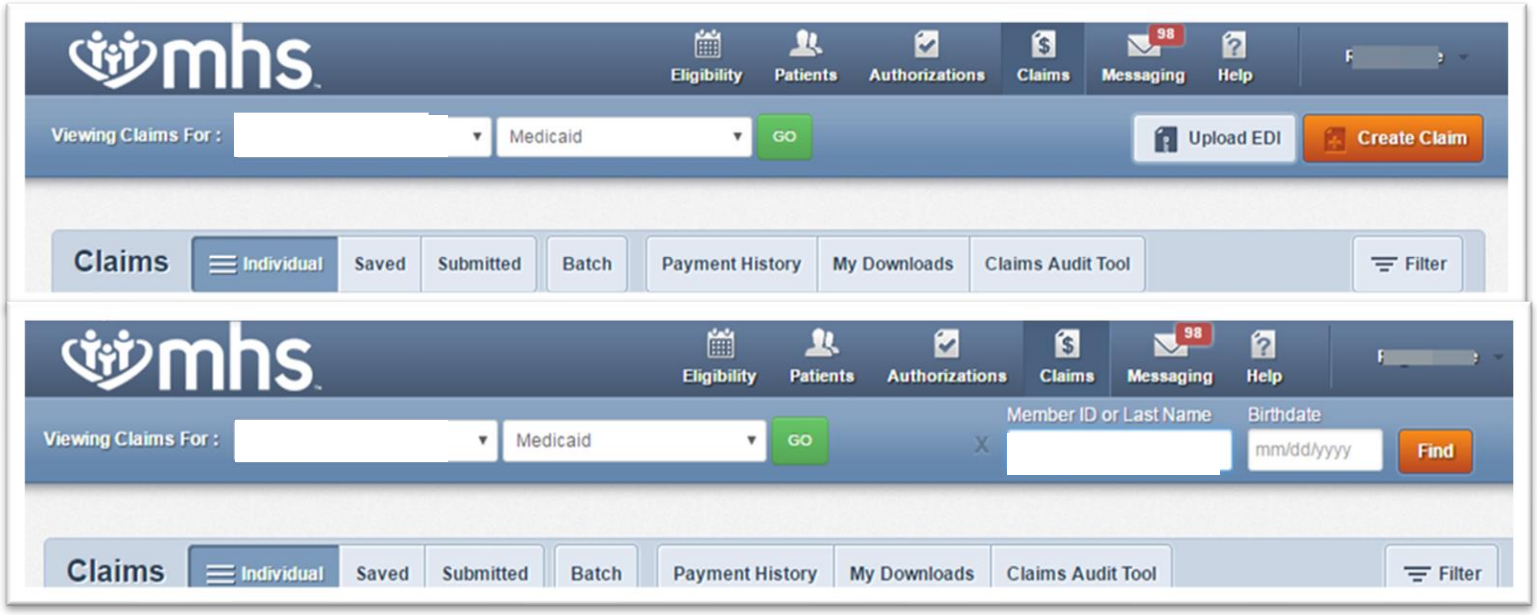
Claims

Provider Portal Claims Functionalities:

- Submit new claim.
- Review claims information on file for a patient.
- Correct claims.
- View payment history.

Submit a New Claim:

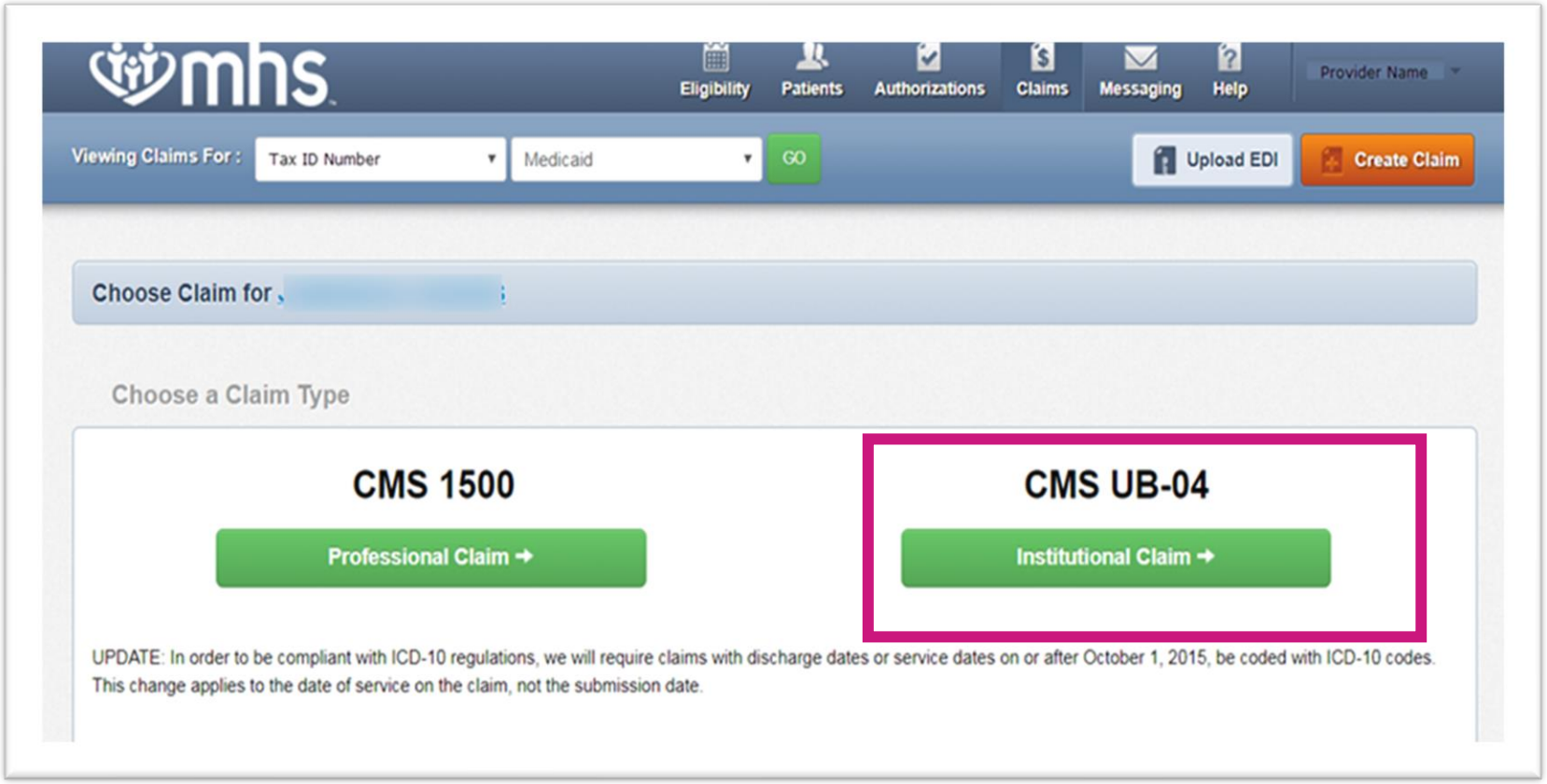
- Click **Create Claim** and enter **Member ID** and **Birthdate.**



Claim Submission

Choose the Claim Type:

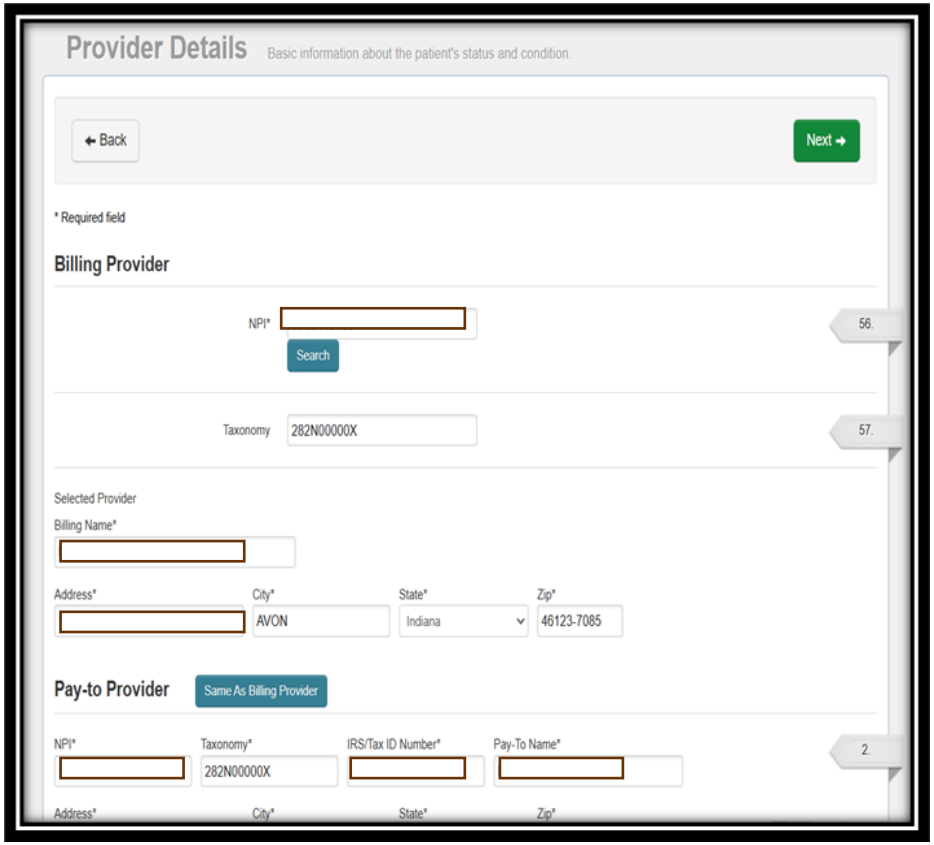
- Professional or Institutional Claim Submission.



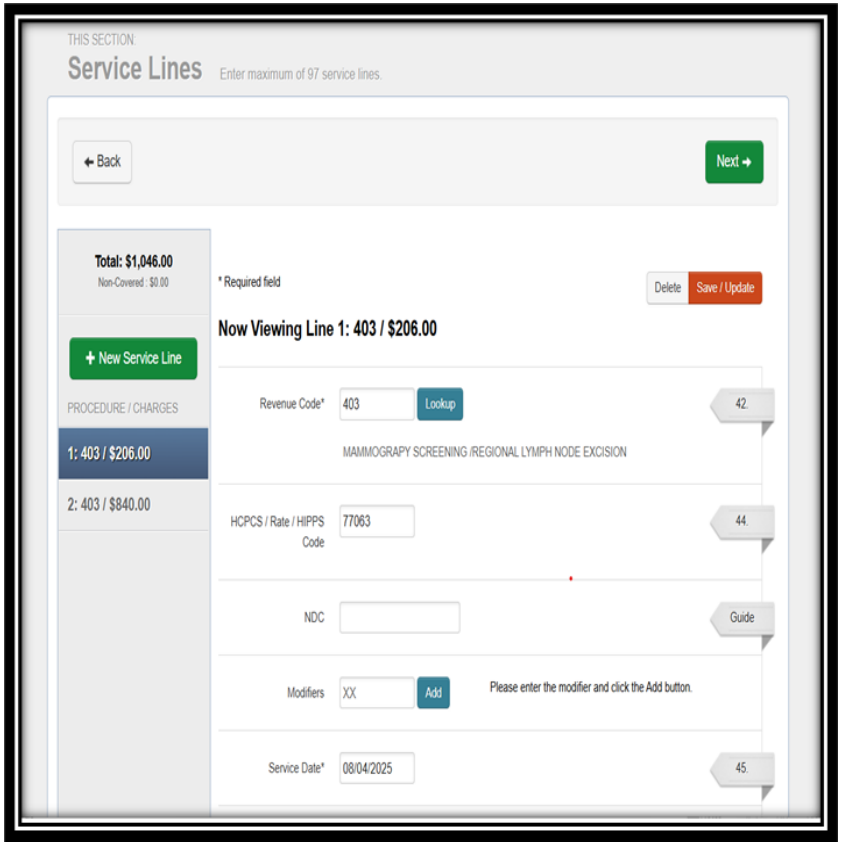
Facility Billing

UB-04 Billing

Add the provider information. Click **save** and click **next** to proceed

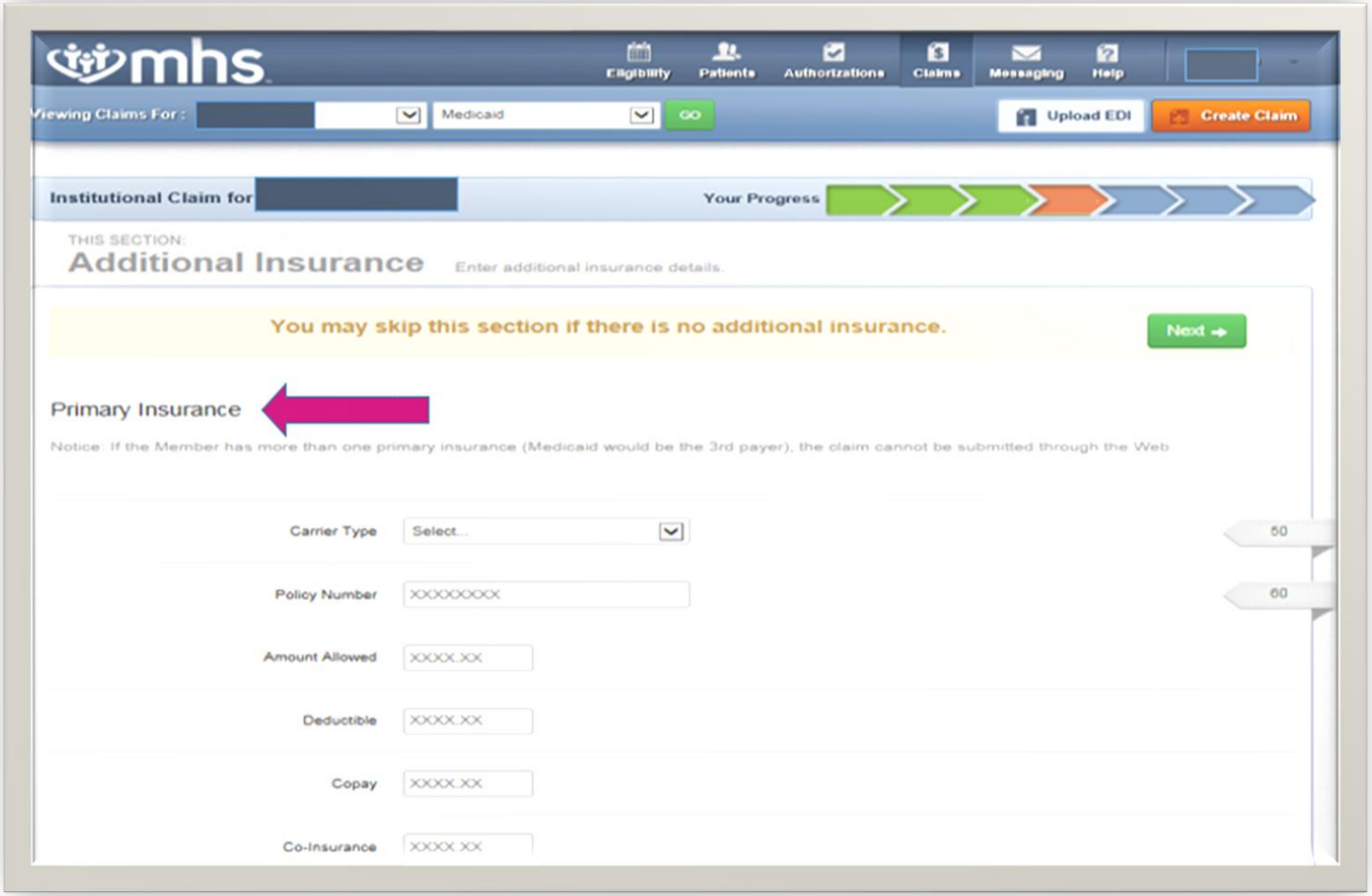


Click **Add New Service Line** and enter the service line's information.

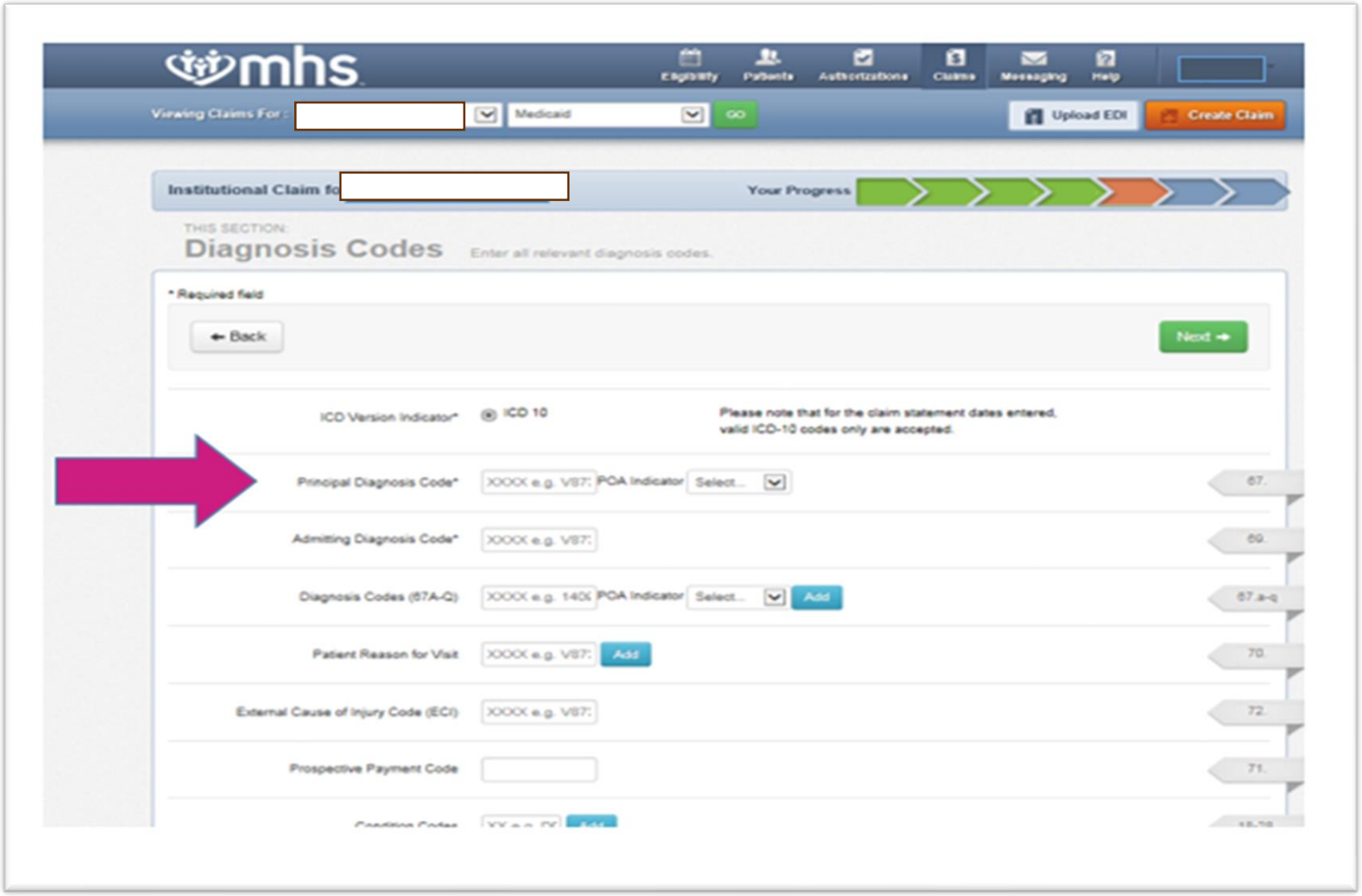


UB-04 Adding Insurance

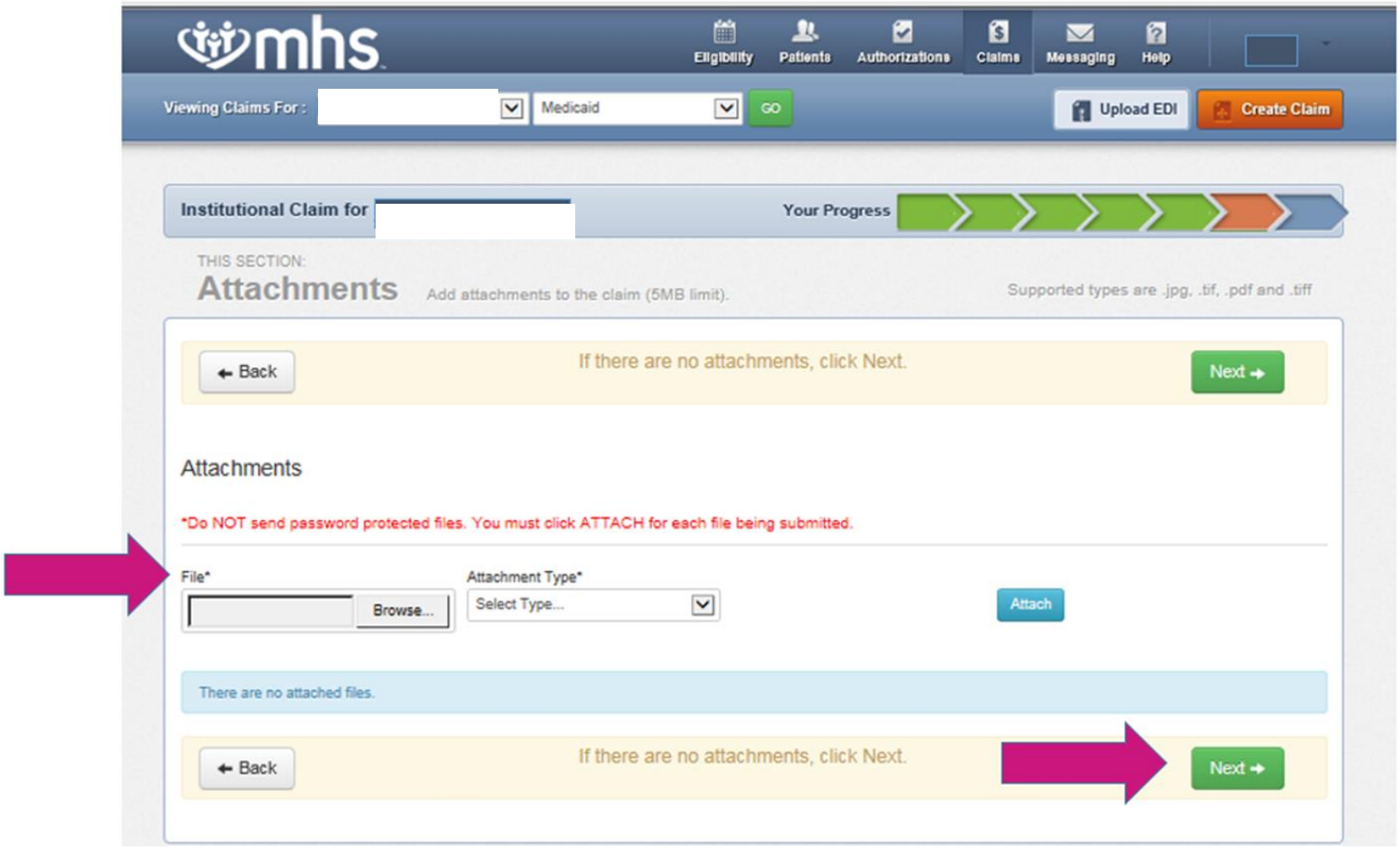
- Enter Additional Insurance (if applicable).



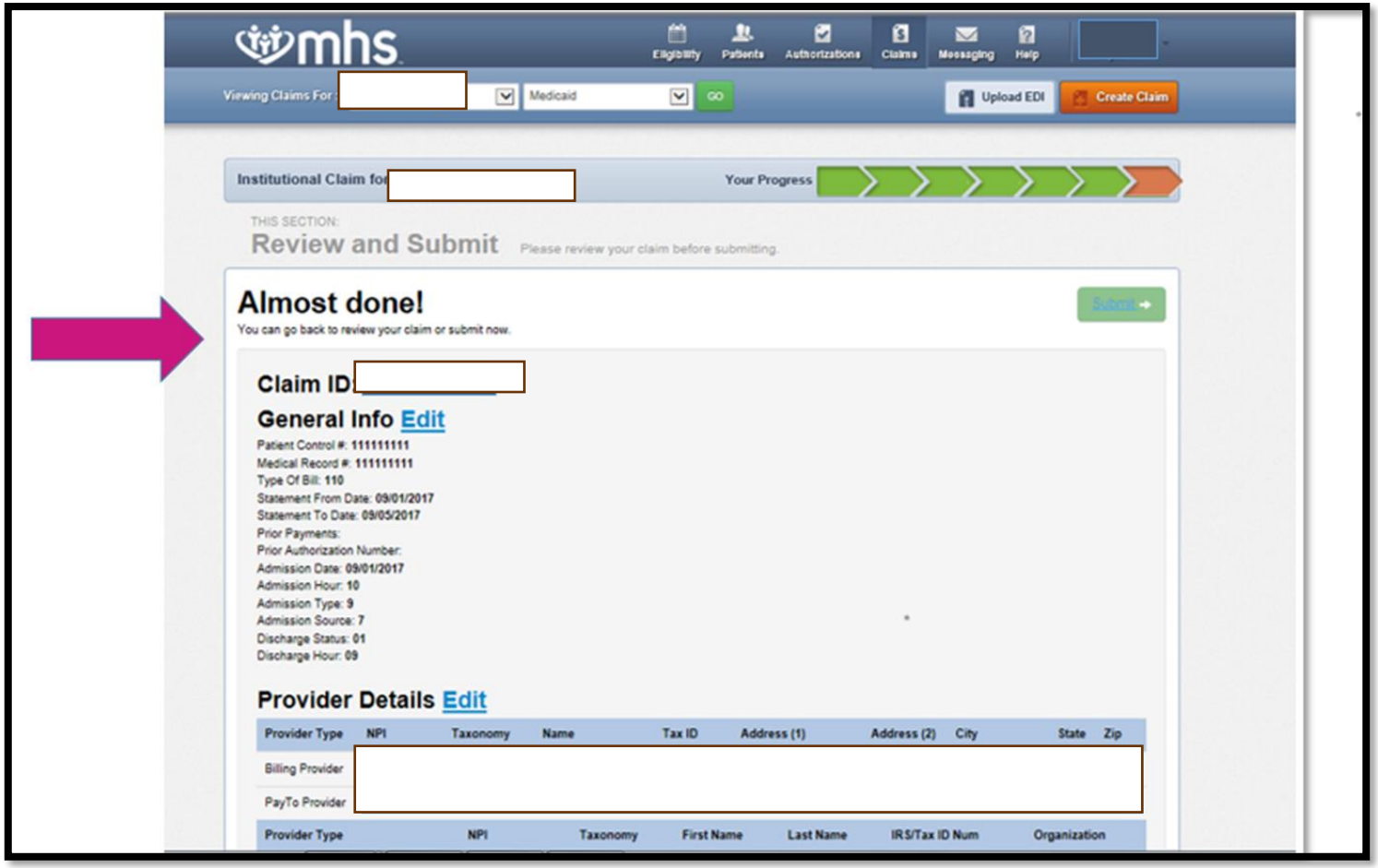
Enter Diagnosis Codes



Adding Attachments



Review Claim and Submit

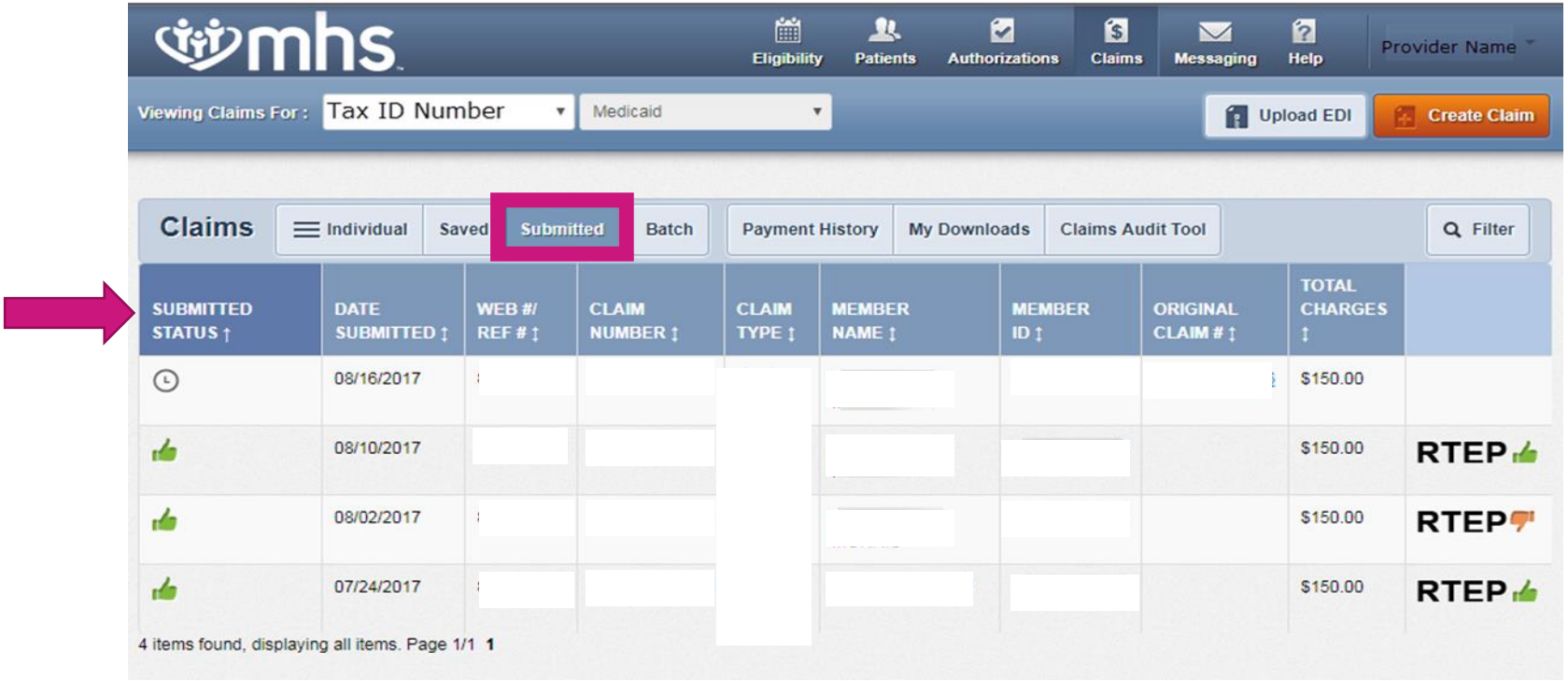


Provider Portal Claim and Payment Review

Submitted Claims

The Submitted tab will only display claims created via the MHS Secure Provider Portal:

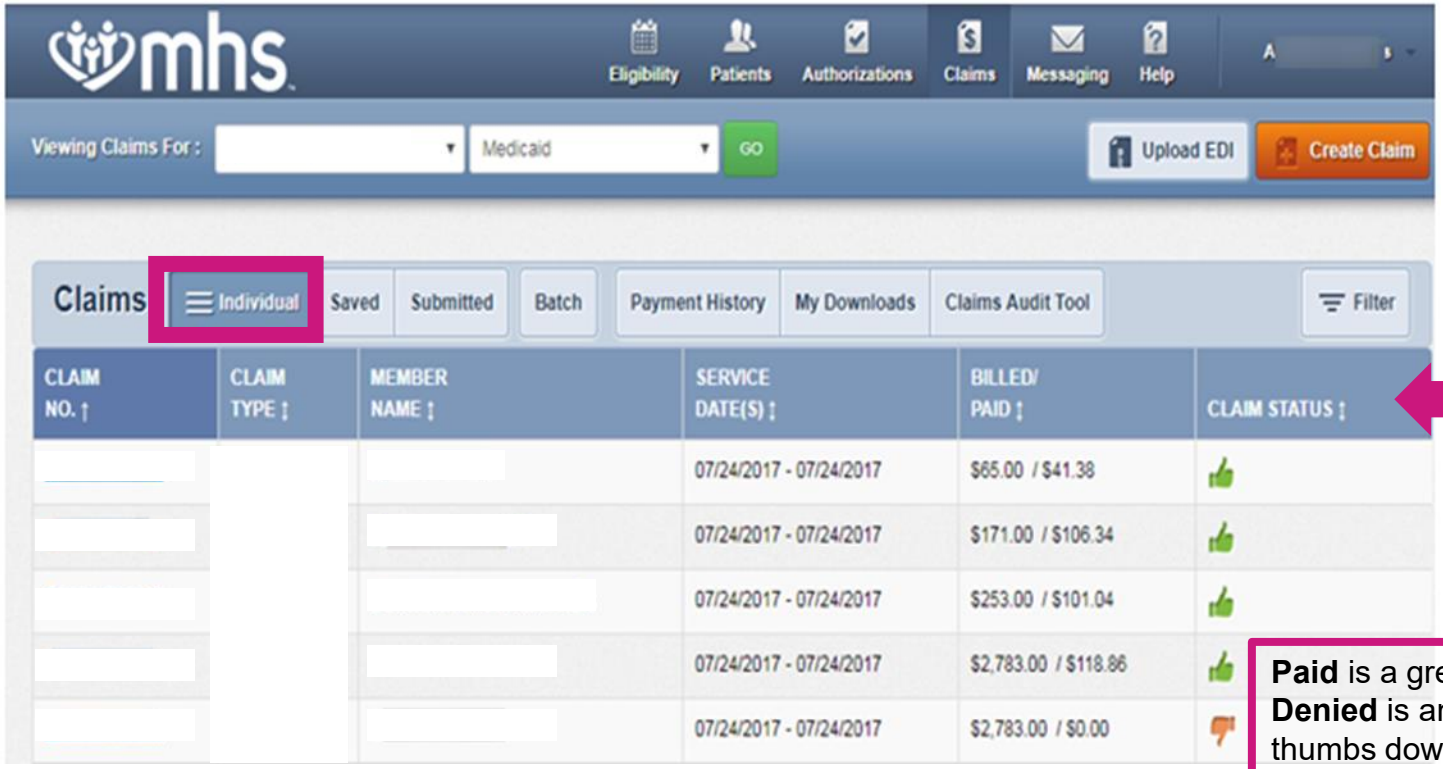
- Paid is a **green** thumbs up.
- Denied is an **orange** thumbs down.
- Pending is a clock.
- Real Time Editing and Pricing (RTEP) claims also show if eligible (i.e., line 3 was submitted, but was not eligible for RTEP).



Individual Claims

On the Individual tab, submitted using Provider Portal, Clearinghouse, or paper:

- View the Claim Number, Claim Type, Member Name, Service Date(s), Billed/Paid, and Claim Status.



Paid is a green thumbs up, **Denied** is an orange thumbs down and a clock is **Pending.**

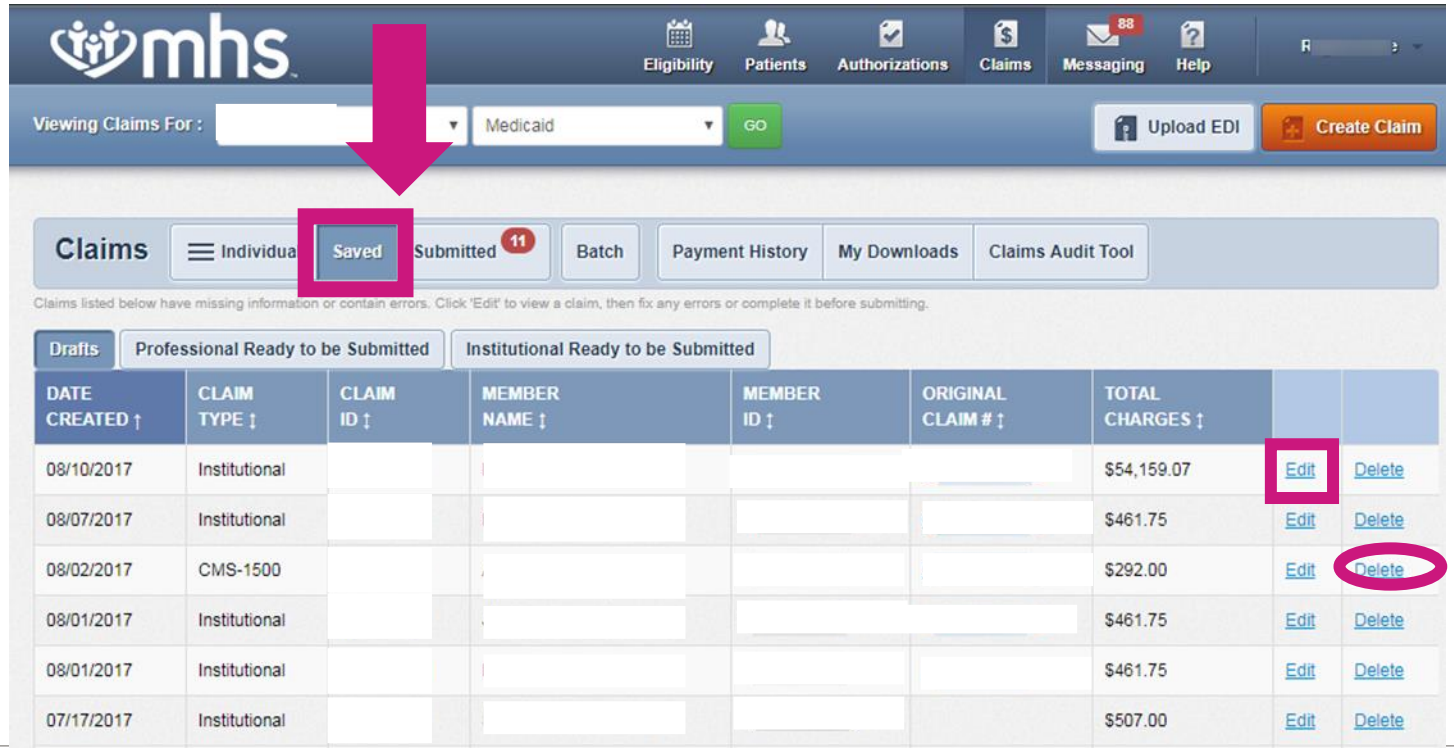
Saved Claims

To view Saved claims: Drafts, or Institutional:

1. Select Saved.
2. Click Edit to view a claim.
3. Fix any errors or complete before submitting.

Or

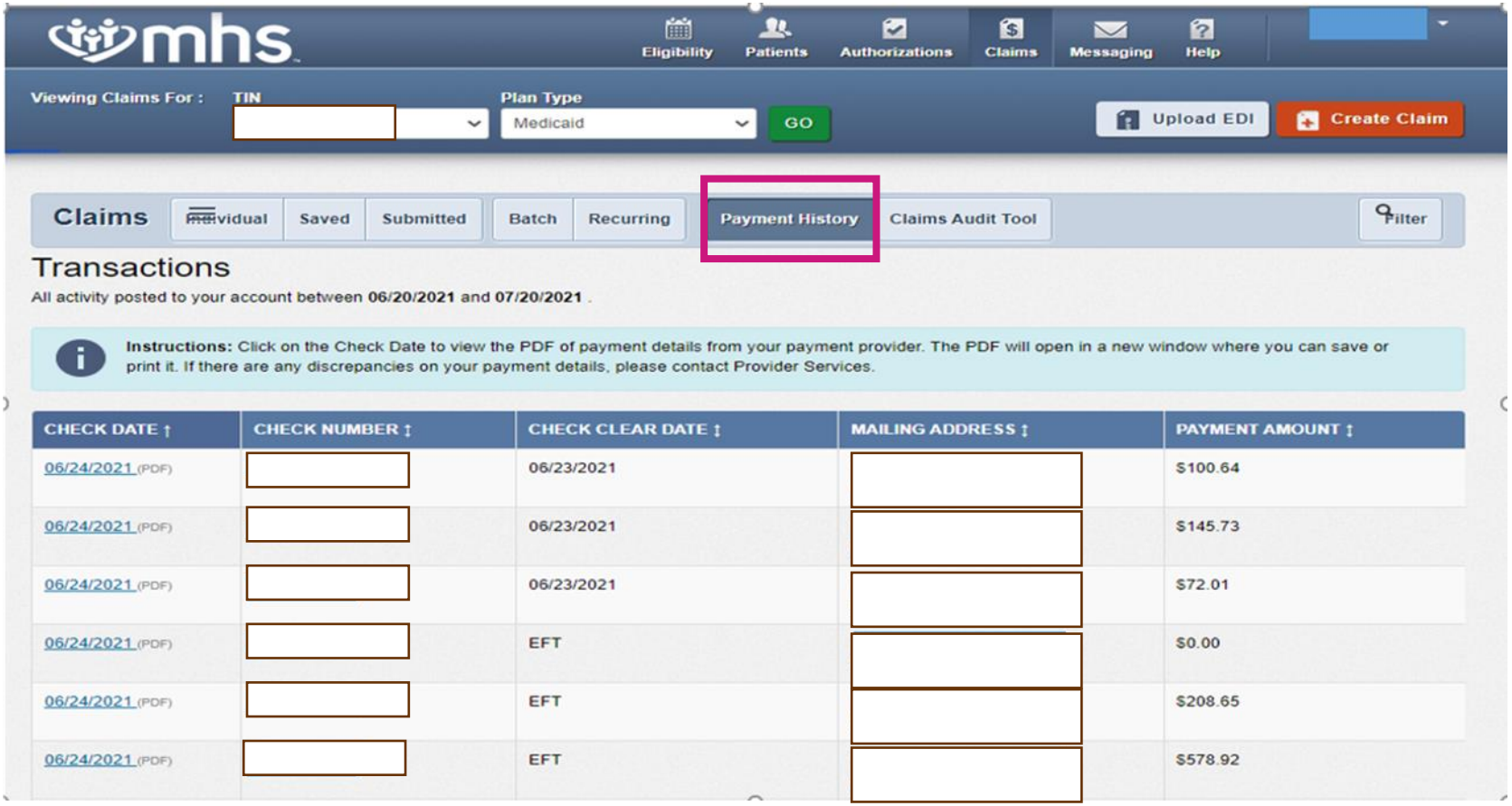
1. Click Delete to delete saved claim that is no longer necessary.
2. Click OK to confirm the deletion.



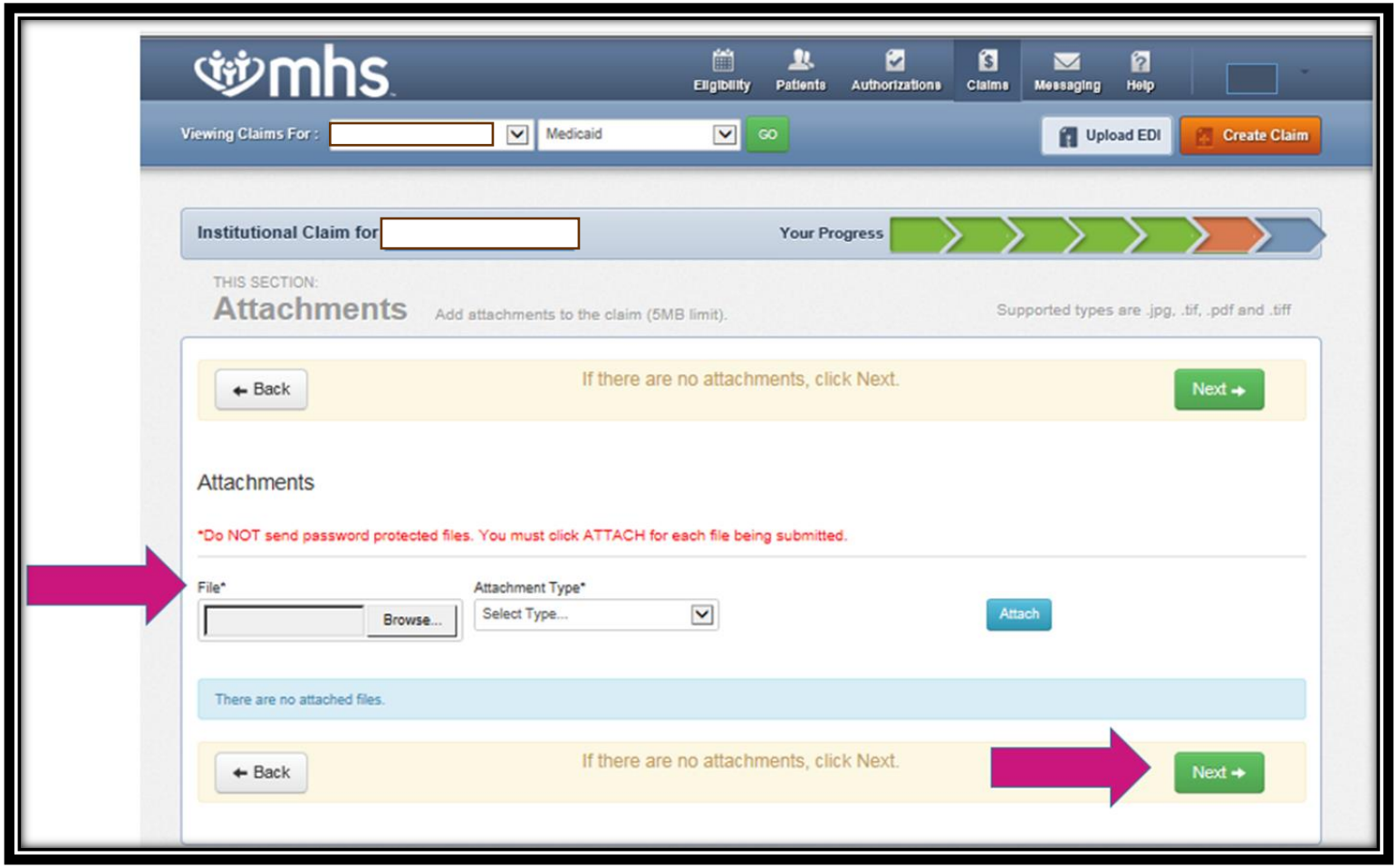
Payment History

Click on Payment History to view Check Date, Check Number, Check Clear Date, Mailing Address and Payment Amount.

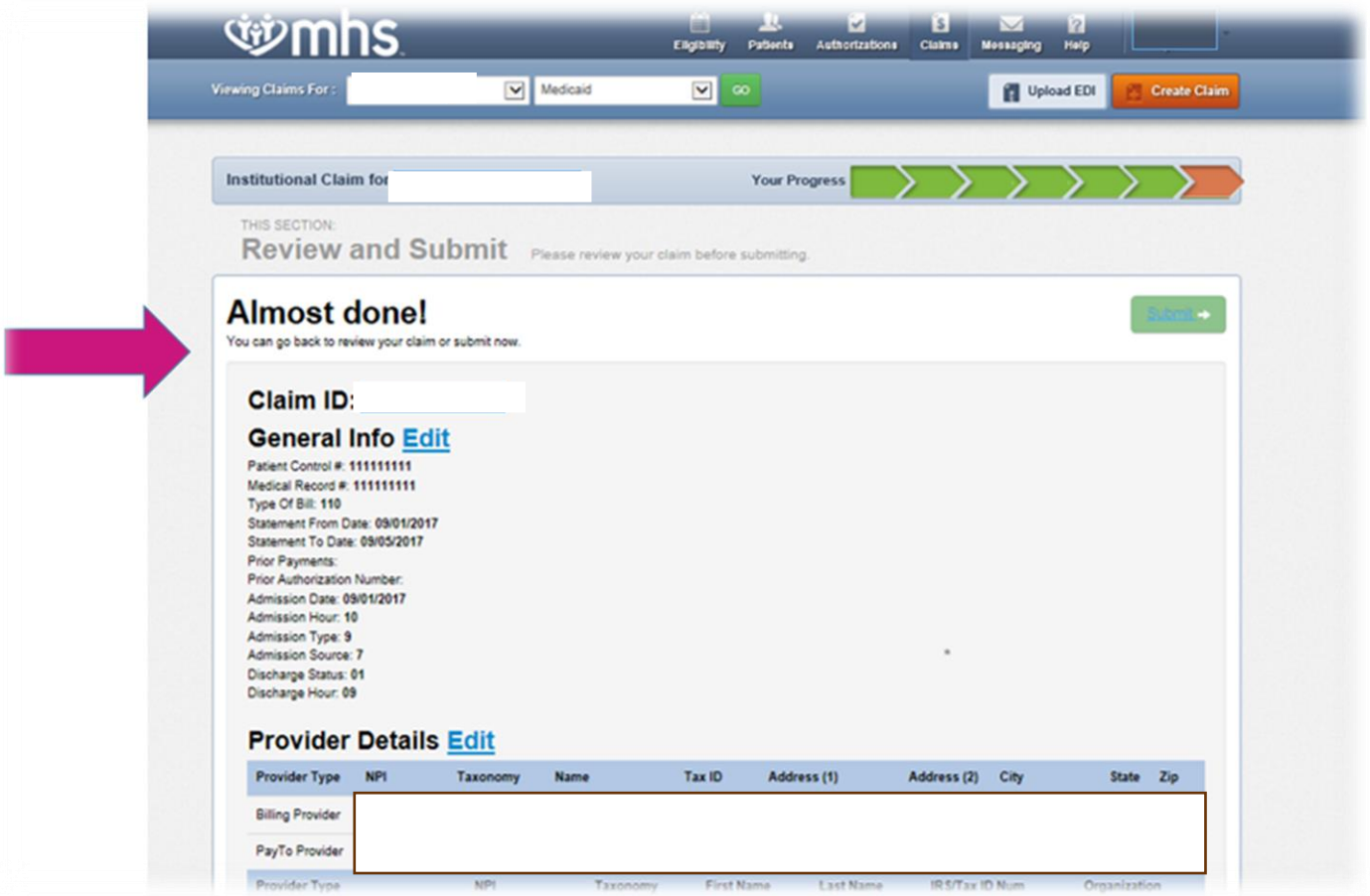
- Click on Check Date to view Explanation of Payment.



Add Attachment If Applicable



Review and Submit Claim



Electronic Funds Transfer(EFT) and Electronic Remittance Advice (ERA)s

PaySpan Health

- Web-based solution for:
  - EFTs and ERAs
- One-year retrieval of remittance advice.
- Provided at no cost to providers and allows online enrollment.
- Registration and more information here: PaySpan
- For questions call PaySpan: 1-877-331-7154 8:00a.m-8:00p.m EST.

Tips to Remember

- Clicking on items (claim numbers, check numbers, dates) that are highlighted **blue** will reveal additional information.
- When filtering to find a claim or payment history, only a 30-calendar day span within the same month can be used.
- Click on the Saved Claims tab to view claims that have been created but not Submitted. Claims in this queue can be edited for submission or deleted from this tab.
- To utilize the correct claim feature, the claim needs to be in a paid or denied status.

Online Claims Reconsiderations On the MHS Secure Provider Portal

Summary of Online Reconsiderations

Skip the phone call.

- Providers can make their case directly on the Provider Portal.

Make the case.

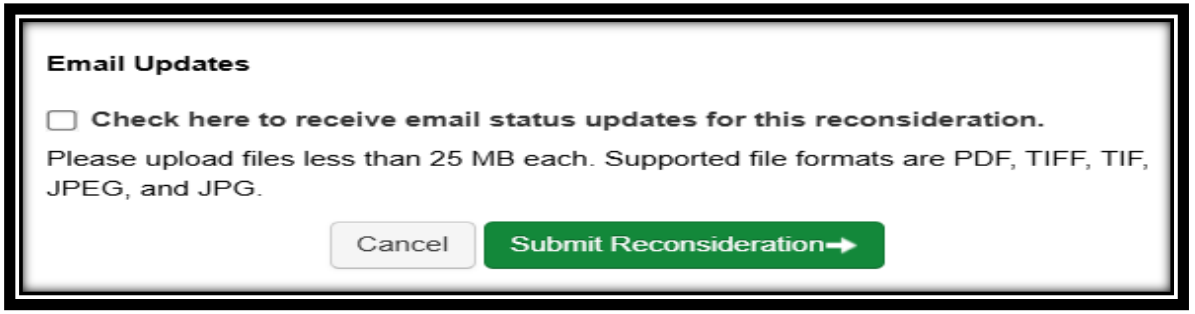
- Providers can submit informal Dispute/Reconsideration comments using expanded text fields.

Add context.

- Providers can easily attach supporting documentation when filing an Informal Dispute/Reconsideration.

Stay current.

- Providers may opt in/out for Informal Dispute/Reconsideration status change emails when submitting online.
- Providers may also view status online.



Online Reconsiderations

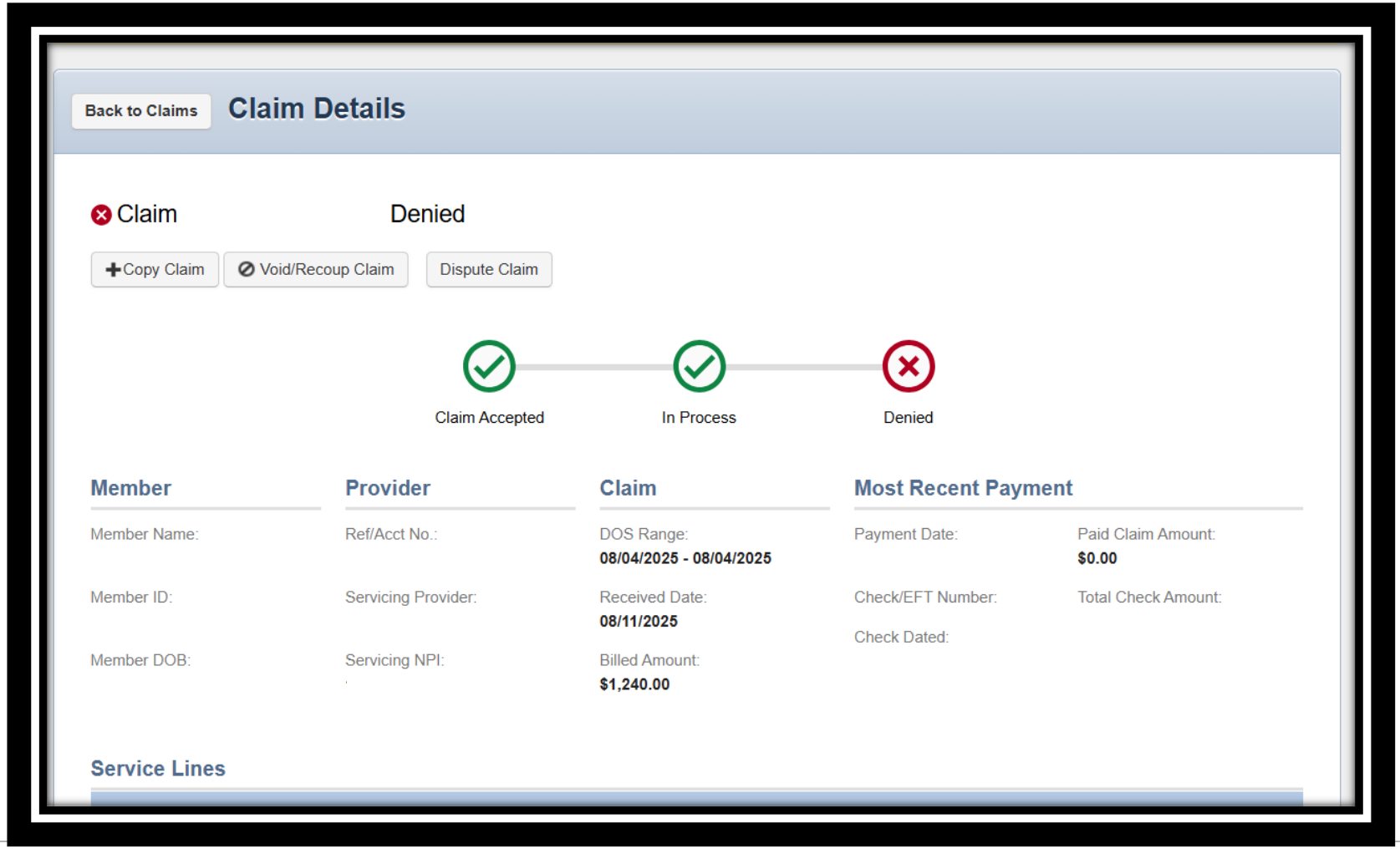
Providers can:

- Submit informal disputes/reconsiderations on the **Secure Provider Portal.**
- Submit corrected claims.
- Upload/view supporting documents.
- View acknowledgement letters.
- Track real-time updates.
- View denial code information.

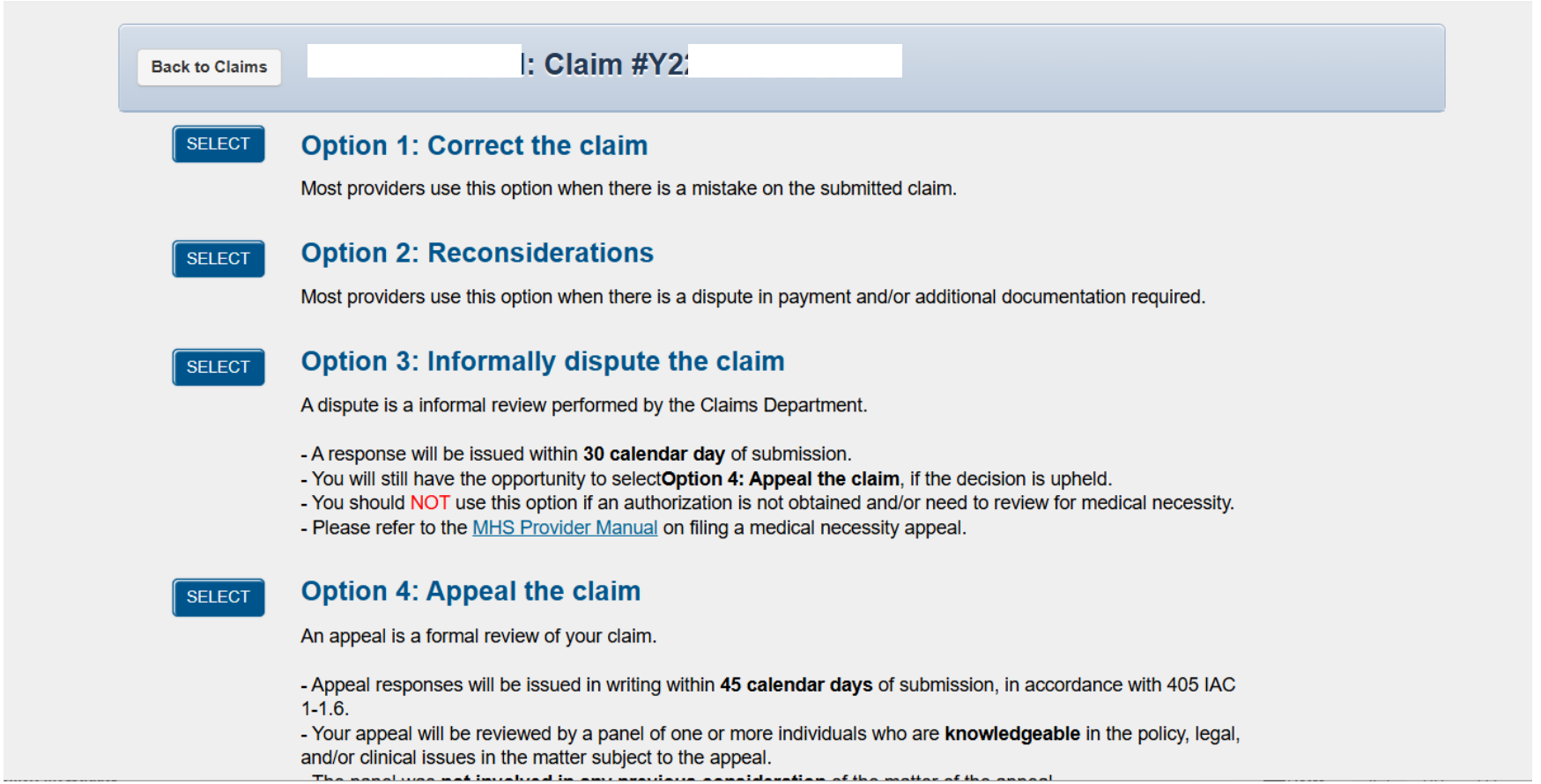
Online Reconsideration Tips

- It is important to note that all requests submitted via the online Provider Portal for Level 1 will be considered an Informal Dispute. Secure messages are not considered Reconsiderations/Appeals.
- Calling MHS Provider Services will not pause the time frame for timely submissions for Informal Disputes.
- Providers do not need to call prior to submitting an online Claim Reconsideration/Information Dispute.
- Providers may include a Dispute Form, but it is not required, as they may include comments directly into the Provider Portal.

Level 1 Informal Claim Dispute and Level 2 Claim Appeals On The MHS Secure Provider Portal

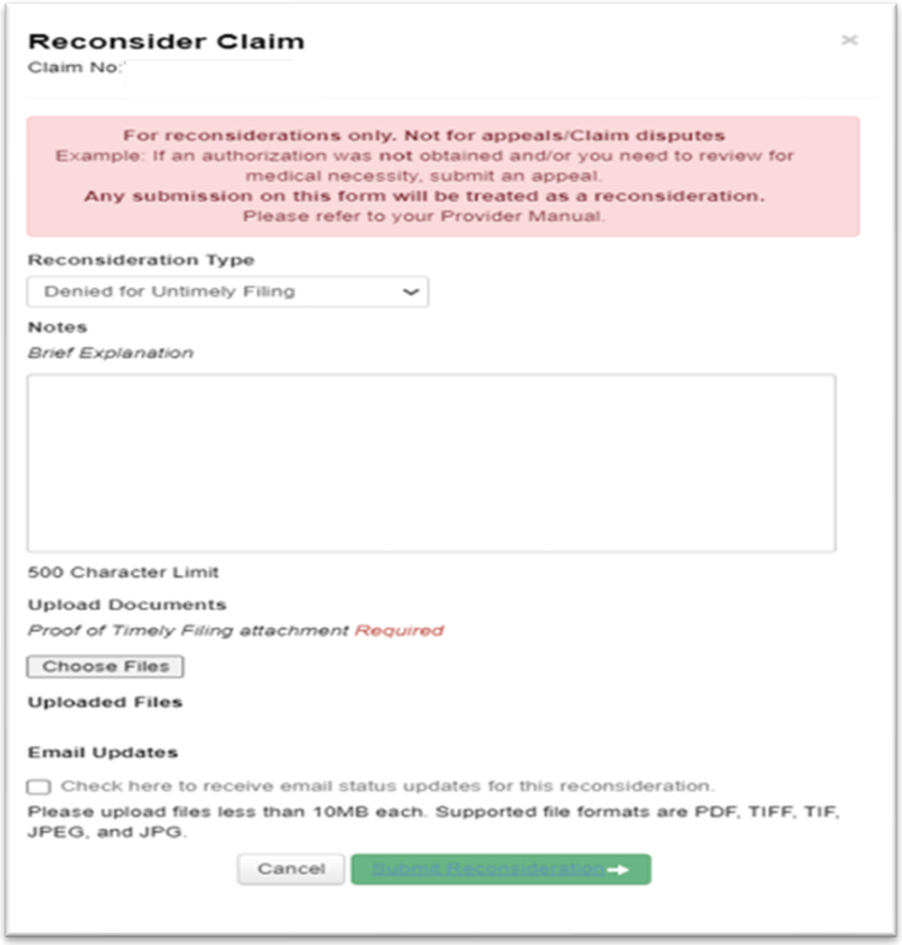


Level 1 and Level 2 Claim Appeals Options On The MHS Secure Provider Portal

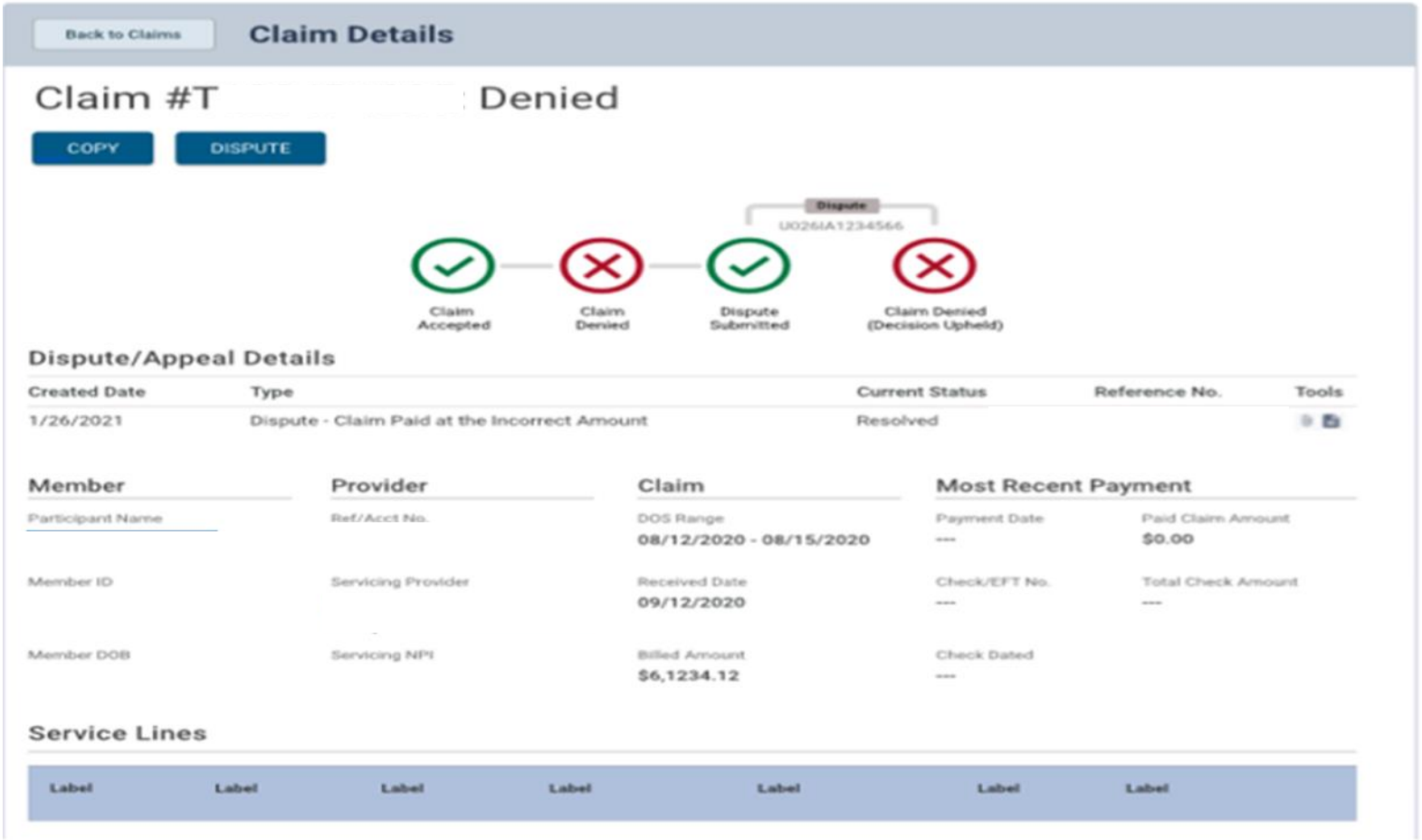


Claim Reconsiderations

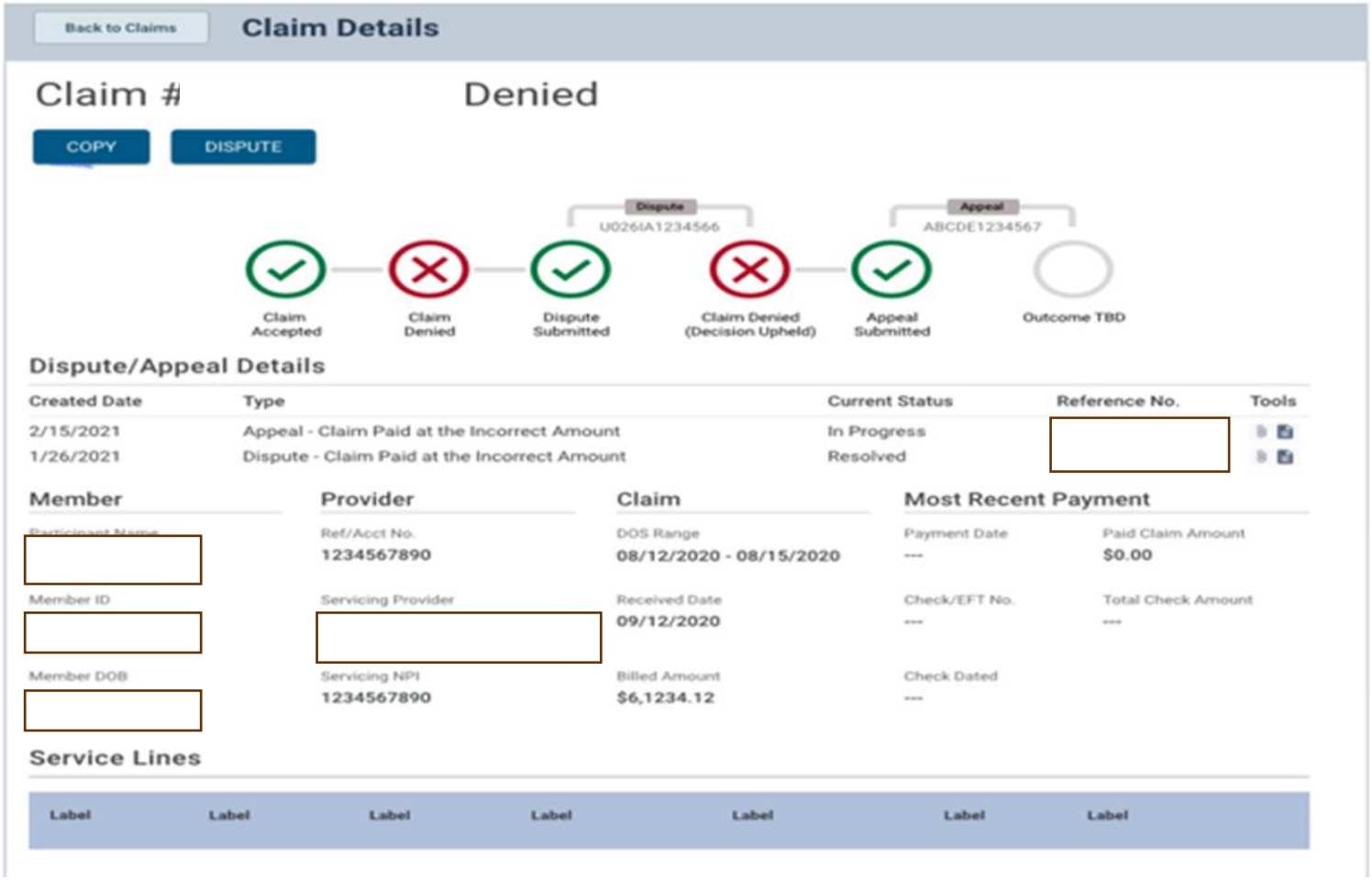
Enter your explanation for reconsideration and check email updates.



Level 1 Claim Appeals Details

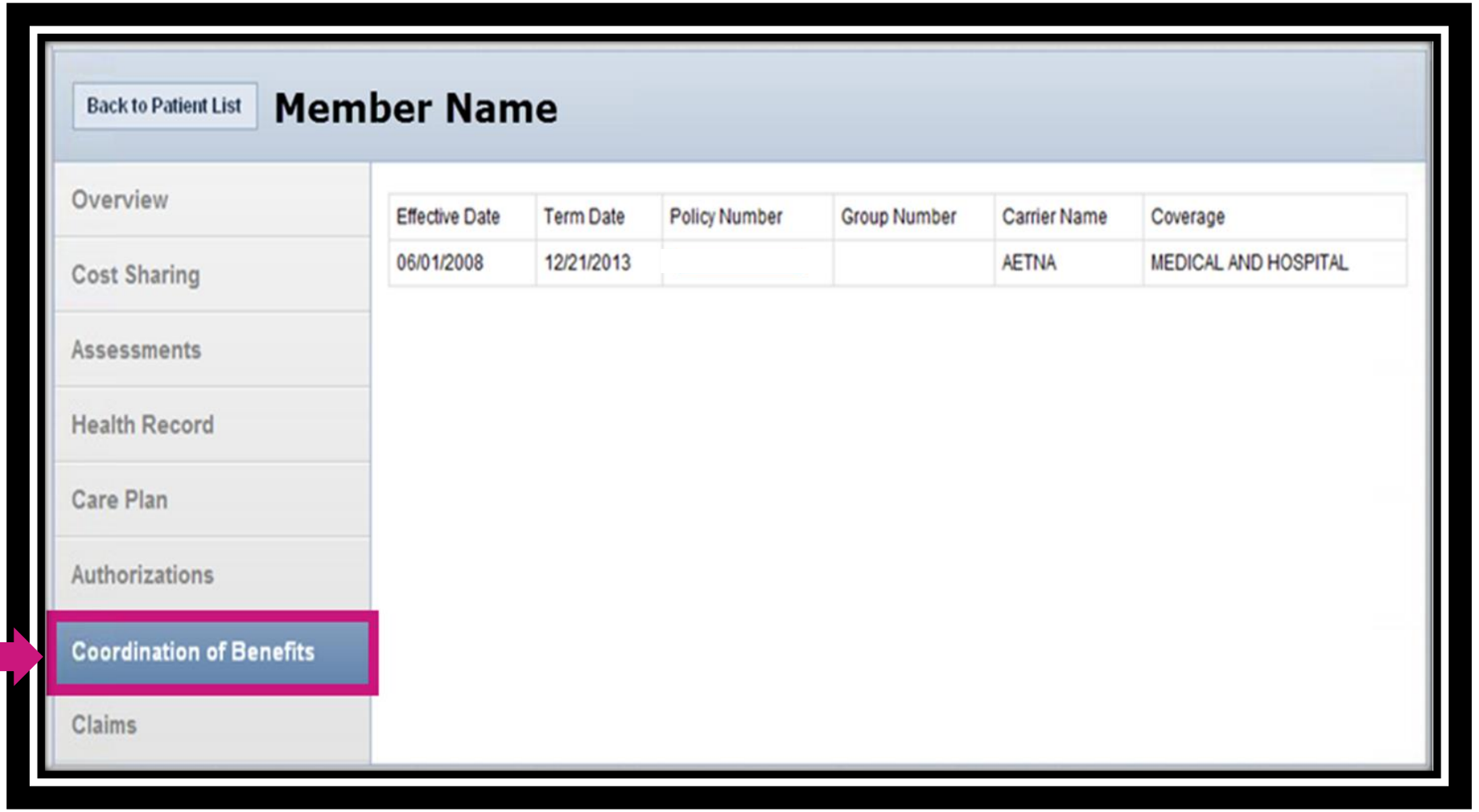


Level 1 Informal Claim Dispute Detail Screen



Coordination of Benefits

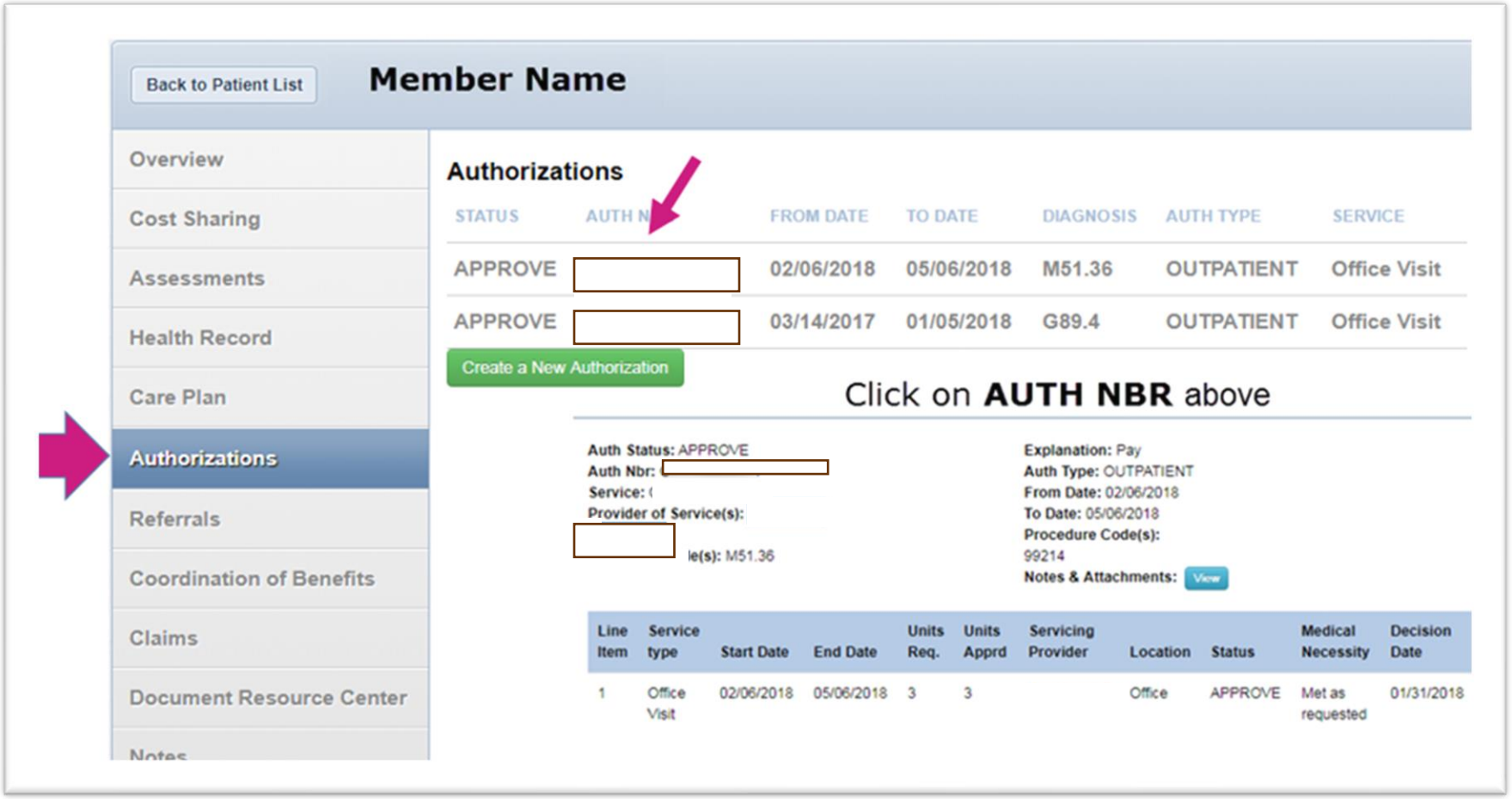
This screen shows if a member has other insurance.



Prior Authorization

Authorizations

View previously submitted or create a new authorization.



Authorization Considerations

Need to know what requires authorization:

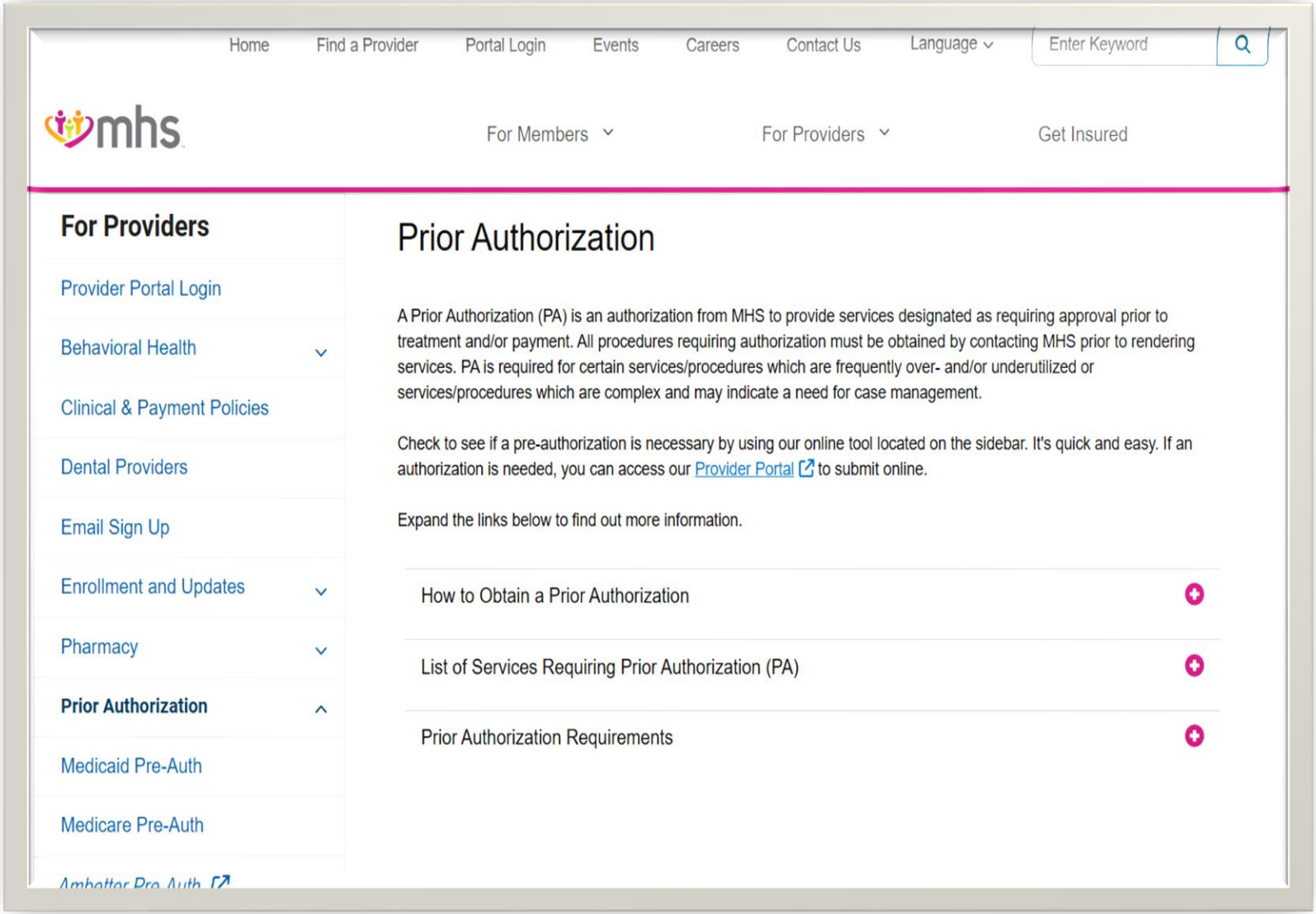
- Pre-Authorization tool.
  - **PA Tool.**

How to obtain authorization:

- Online: Obtaining **Prior Authorization.**
- Phone: 1-877-647-4848 8:00am-8:00pm EST.
- Fax: 1-866-912-4245.

Authorizations do not guarantee payment.

Prior Authorization



MHS Provider Engagement

MHS Resources

- For additional information, please contact your MHS Provider Engagement Account Manager to schedule an appointment today

- Additional resources available at on the **MHS Website**

- Register online for additional **Monthly Web Sessions**

PEAM Contact Information

NORTHEAST REGION

For claims issues, email:
MHS_ProviderRelations_NE@mhsindiana.com
joy.k.diarra@mhsindiana.com
Joy Diarra, Provider Engagement Account Manager
1-317-864-2378

NORTHWEST REGION

For claims issues, email:
MHS_ProviderRelations_NW@mhsindiana.com
Candace.V.Ervin@mhsindiana.com
Candace Ervin, Provider Engagement Account Manager
1-317-364-7635

NORTH CENTRAL REGION

For claims issues, email:
MHS_ProviderRelations_NC@mhsindiana.com
Natalie.Smith@mhsindiana.com
Natalie Smith, Provider Engagement Account Manager
1-317-379-9035

CENTRAL REGION

For claims issues, email:
MHS_ProviderRelations_C@mhsindiana.com
ldavis@mhsindiana.com
Latisha Davis, Provider Engagement Account Manager
1-317-601-5999

SOUTH CENTRAL REGION

For claims issues, email:
MHS_ProviderRelations_SC@mhsindiana.com
DDENNING@mhsindiana.com
Dalesia Denning, Provider Engagement Account Manager
1-317-951-3800

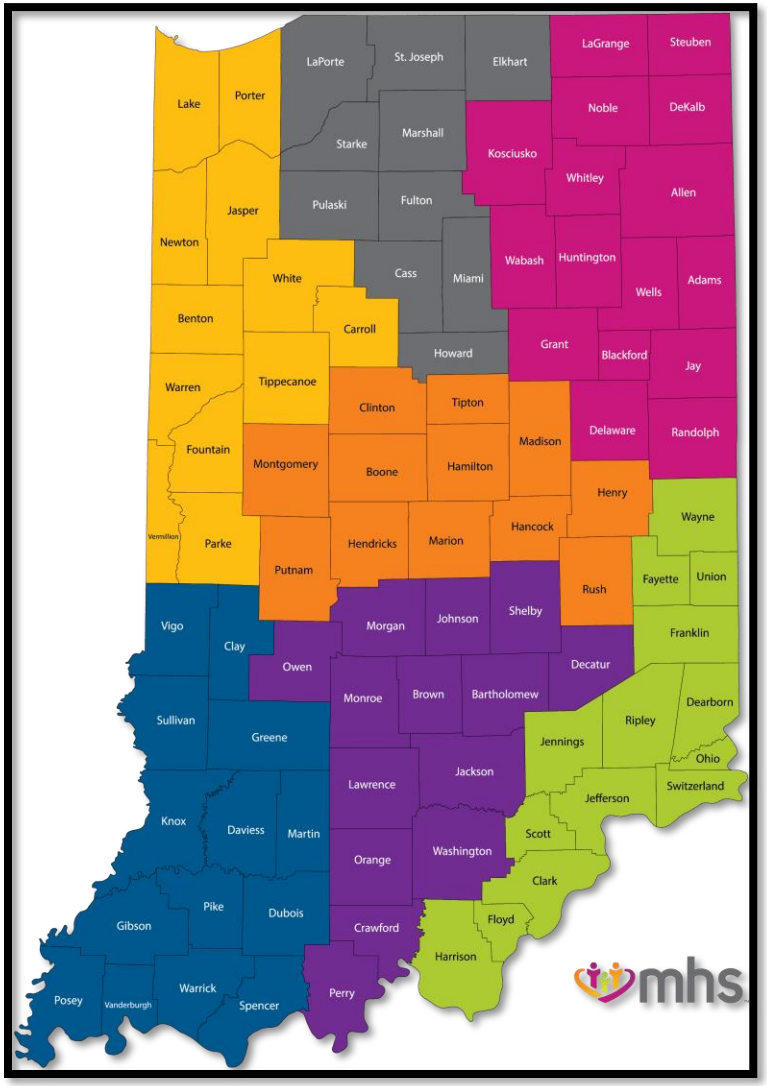
SOUTHWEST REGION

For claims issues, email:
MHS_ProviderRelations_SW@mhsindiana.com
Dawnalee.A.McCarty@mhsindiana.com
Dawn McCarty, Provider Engagement Account Manager
1-317-556-6171

SOUTHEAST REGION

For claims issues, email:
MHS_ProviderRelations_SE@mhsindiana.com
tiffany.calloway@centene.com
Tiffany Calloway,
Provider Engagement Account Manager
1-812-697-8126

PEAM Manager Map Color Key



Large Provider Groups - Carolyn

CAROLYN VALACHOVIC MONROE

Provider Engagement Account Manager

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PROVIDER GROUPS

- Eskenazi/The Health and Hospital Corp.
- Baptist Health
- Lifespring
- Wellcare
- Deaconess (including Little Company of Mary)
- Good Samaritan
- Norton (including King's Daughters, Clark & Scott Memorial)
- Indiana University Health
- Reid Hospital
- St. Elizabeth Hospital
- Community Health

Large Provider Groups - Mona

MONA GREEN

Provider Engagement Account Manager
1-812-614-1003
mona.green@mhsindiana.com

PROVIDER GROUPS

St. Vincent/Ascension
Wellcare Complete
Lutheran Medical Group
Parkview Health System
Beacon Medical Group
American Senior Care
CarDon & Associates
OrthoIndy
Heart City Health
ONE
Franciscan Health

Behavioral Health Provider Contact

ANGEL JOHNSON
Provider Engagement Account Manager
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PROVIDER GROUPS

Park Center
Otis Bowen
Centerstone
Valley Oaks Health
Grant-Blackford
Four County
Hamilton Center
Community Mental Health Center (Lawrenceburg)
Oaklawn
Northeastern Center
Edgewater Health
Regional Mental Health
Swanson Center
Porter-Starke Services
Southwestern Behavioral
Community Mental Health Center (Vevay/Batesville)

Additional Contact Information

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CENTENE DENTAL

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Dental Provider Services: 1-855-609-5157

Thank You for Attending!

By taking a few moments to complete the event and sessions evaluations, you'll help us understand your experience and shape the future of our programs.

TQRCG

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Questions?

Thank you for being our partner in care.