

PRIOR AUTHORIZATIONS 101

2021 Annual IHCP Works Seminar



Agenda

-  Prior Authorization (PA)
-  What You Need to Know
-  Online Provider Portal Services
-  Telephonic and Fax Authorizations
-  Appeals Process
-  MHS Team
-  Questions

Prior Authorization

Prior Authorization

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

 PA for observation level of care **(up to 72 hours for Medicaid)**, diagnostic services, do not require an authorization for contracted facilities.

 If the provider requests an inpatient level of care for a covered/eligible condition, but procedure and documentation supports an outpatient/observation level of care, MHS will send the case for Medical Director review.

Prior Authorization

Inpatient Services:

-  MHS no longer accepts phone calls and only accepts notification of an inpatient admission via fax, using the IHCP universal prior authorization form, or via the MHS Secure Provider Portal.
-  Please submit timely notification and clinical information to support an inpatient admission via fax to 1-866-912-4245 or upload via the MHS Secure Provider Portal.

Prior Authorization

Outpatient Services:

-  All elective procedures that require prior authorization must have request to MHS at least **two business days** prior to the date of service.
-  All ER services do not require prior authorization, but admission, must be called into MHS Prior Authorization Department within **two business days** following the admit.
-  Members **must** be Medicaid Eligible on the date of service.
-  Prior Authorizations are not a guarantee of payment.

Failure to obtain prior authorization for non urgent and emergent services will result in a denial for related claims.

Prior Authorization

Transfers:

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

Prior Authorization

Services that require prior authorization regardless of contract status:
Injectable drugs (see mhsindiana.com/provider-guides for up-to-date list of codes)

-  Nutritional counseling (unless diabetic)
-  Pain management programs, including epidural, facet and trigger point injections
-  PET, MRI, MRA and Nuclear Cardiology/SPECT scans
-  Cardiac rehabilitation
-  Hearing aids and devices
-  Home and Institutional hospice (coverage varies by product)
-  In-home infusion therapy
-  Orthopedic footwear
-  Respiratory therapy services
-  Home care (except after an IP admission with benefit limitations)
-  Physical Therapy, Occupational, and Speech Therapy

Prior Authorization

Is Prior Authorization Needed?

- MHS website:
mhsindiana.com
- Quick Reference Guide
- Non-contracted provider services now align with PA requirements for contracted providers



PROVIDER Quick Reference Guide

Effective August 1, 2020

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.



MANAGED HEALTH SERVICES (MHS)

ELECTRONIC PAYER ID:
68069

BEHAVIORAL HEALTH PAYER ID:
68068

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

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

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

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

Providers have 67 calendar days from the date of the Explanation of Payment to file an adjustment, resubmit, or appeal a decision (effective March 1, 2021, 60 days).

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

MEDICAL CLAIMS REFUNDS:
To refund claims overpayment, please send check and documentation to:
Coordinated Care Corporation
75 Remittance Dr., Suite 6446
Chicago, IL 60675-6446

MHS FAX NUMBERS

MEDICAL APPEALS: 1-866-714-7993

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

REFERRALS AND AUTHORIZATIONS: 1-866-912-4245

MHS WEBSITE: MHSINDIANA.COM

mhsindiana.com/providers Latest MHS provider updates and news, as well as online provider enrollment, office and billing address change forms, quality and care gap tools, forms, manuals, guides, online PA tool and tutorials.

mhsindiana.com/health MHS' Health Library. Click on "KRAMES Health Library" for free print-on-demand patient health fact sheets on over 4,000 topics, available in English and Spanish.

mhsindiana.com/login MHS' Secure Provider Portal lets you submit prior authorization, 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.

0720.PR.P.FL.IL.10/20

Online Prior Authorization Tool

Medicaid Pre-Auth Needed?

Become a Provider

CLAS Standards

MHS Provider
Webinars

Partnered Member
Events

Pharmacy Benefits
Information for
Providers

 Prior Authorization

Transactions

PaySpan Health

POWER Account
Resource Center

Provider Information
Resource Center

Provider Guides

Dental Providers

Presumptive
Eligibility

Quality
Improvement

HEDIS®

Practice Guidelines

Immunization
Information

DISCLAIMER: All attempts are made to provide the most current information on the Pre-Auth Needed Tool. However, this does NOT guarantee payment. Payment of claims is dependent on eligibility, covered benefits, provider contracts, correct coding and billing practices. For specific details, please refer to the [provider manual](#). If you are uncertain that prior authorization is needed, please submit a request for an accurate response.

Vision services need to be verified by [Envolve Vision](#)

Complex Imaging, MRA, MRI, PET and CT scans need to be verified by [NIA](#)

Hoosier Healthwise dental services need to be verified by [State](#)

Healthy Indiana Plan (HIP) and Hoosier Care Connect dental services need to be verified by [Envolve Dental](#)

Ambulance and Transportation services need to be verified by [LCP Transportation](#)

Behavioral Health/Substance Abuse need to be verified by [Cenpatico](#)

Non-participating providers must submit Prior Authorization for all services
For non-participating providers, [Join Our Network](#).

Are Services being performed in the Emergency Department or Urgent Care Center or are these family planning services billed with a contraceptive management diagnosis?

YES ☐ NO ☐

Types of Services	YES	NO
Is the member being admitted to an inpatient facility?	☐	☐
Are services, other than DME, orthotics, prosthetics, and supplies, being rendered in the home?	☐	☐
Are anesthesia services being rendered for pain management?	☐	☐
Are services for infertility?	☐	☐
Is the member receiving dialysis?	☐	☐

Online Prior Authorization Tool

Types of Services	YES	NO
Is the member being admitted to an inpatient facility?	☐	☒
Are services, other than DME, orthotics, prosthetics, and supplies, being rendered in the home?	☐	☒
Are anesthesia services being rendered for pain management?	☐	☒
Are services for infertility?	☐	☒
Is the member receiving dialysis?	☐	☒

Enter the code of the service you would like to check:

Check

N
No

99394 - PREV VISIT EST AGE 12-17
No Pre-authorization required for all providers.

What You Need to Know

Self-Referral Services

Exceptions to prior authorization requirements.

Members can see these specialists and get these services without a direct referral from their PMP:

- Podiatrist
- Chiropractor
- Family planning
- Immunizations
- Routine vision care
- Routine dental care
- Behavioral health by type and specialty
- HIV/AIDS case management
- Diabetes self-management

****Benefit limitations apply.***

National Imaging Associates (NIA)

Physical, Occupational and Speech Therapy

-  Utilization management of these services is managed by NIA.
-  Prior authorization for PT, OT, and ST services is required to determine whether services are medically necessary and appropriate; determination is made by MHS not NIA.
-  All MHS approved training/education materials are posted on the NIA website, [RadMD.com](https://www.radmd.com). For new users to access these web-based documents, a RadMD account ID and password must be created.

NIA

Outpatient Radiology PA Requests

 MHS partners with NIA for **outpatient** radiology PA process.

 PA requests must be submitted via:

- NIA website at [RadMD.com](https://www.RadMD.com)
- 1-866-904-5096

****Not applicable for ER and Observation requests.***

Durable & Home Medical Equipment

Requests should be initiated via **MHS secure portal**.

Prior authorization required by the **ordering physician** for all non-participating DME providers.

- **Web Portal:** Simply go to mhsindiana.com, log into the Secure Provider Portal, and click on “Create Authorization.” Choose DME and you will be directed to the Medline portal for order entry.
- **Fax Number:** 1-866-346-0911
- **Phone Number:** 1-844-218-4932

Turning Point

Musculoskeletal Safety & Quality Program

-  MHS has entered into an agreement with Turning Point Healthcare Solutions, LLC to implement a Musculoskeletal Safety and Quality Program.
-  This program includes prior authorization for medical necessity and appropriate length of stay (when applicable) for both inpatient and outpatient settings.
-  Emergency Related Procedures do not require authorization.
-  Clinical Policies are available by contacting Turning Point at 1-574-784-1005 for access to digital copies.
-  **TRAINING:** Informational webinars are available! Please register at: <https://register.gotowebinar.com/rt/7079530369468972290>.

Turning Point

Cardiovascular Authorizations

 Managed Health Services has delegated its utilization management function to TurningPoint for cardiac services.

 **Services that require prior authorization:**

- Cardiac Surgical Procedures:
 - Automated Implantable Cardioverter Defibrillator
 - Leadless Pacemaker
 - Pacemaker
 - Revision or Replacement of Implanted Cardiac Device

 **Emergent surgeries do not require a prior authorization.**

Web Portal Intake: myturningpoint-healthcare.com Telephone Intake:
1-574-784-1005 | 1-855-415-7482

PA Documentation Needed

Bariatric Surgery:

-  Must include cardiac workup, pulmonary workup, diet and exercise logs, current lab reports, and psychologist report.

Pain Management:

-  Must have documentation of at least six weeks of therapy on area receiving treatment.
-  Include previous procedures/surgeries, medications, description of pain, any contra-indications or imaging studies.
-  Include prior injection test results for injection series.

Home Health:

-  Physician's orders and signed plan of care, including most recent MD notes about the issue at hand.
-  Home care plan, including home exercise program.
-  Progress notes for medical necessity determination.

Sub-Acute Care

MHS conducts clinical review for ongoing authorization and coordination of discharge needs for our members in sub-acute facilities at least every 3-5 days. It is important that you provide a complete current clinical update on our member's status at each review.

 The review should include current information (within one day) on:

- Member's condition
- Level of functioning (prior to admission)
- Medications
- Therapies provided
- Participation in therapies
- Progress toward goals
- New or amended goals
- Updates from care conferences
- Updates to our member's plan of care
- Discharge plans and needs identified (home health/DME, etc.)
- Anticipated discharge date

Sub-Acute Care cont.

 Indiana Code requires that individuals requesting a nursing facility admission to a Medicaid-certified NF meet a nursing facility level of care (*405 IAC 1-3-1* and *405 IAC 1-3-2.*). A PASRR is required before admission and must be submitted with the admission request and when updated according to IAC requirements.

 Please submit this information as requested by MHS nurse reviewer every 3-5 days.

Prior Authorization (PA) Request

MHS strives to return a decision on **all** PA requests within **two business days** of request. Providers can **update** previously approved PAs **within 30 days** of the original date of service prior to claim denial for changes to:

Dates of Service

- CPT/HCPCS codes
- MHS has up to **seven days** to render PA decisions.

 PA approval requires the need for medical necessity.

 Medical Management **does not** verify eligibility or benefit limitations; Provider is responsible for eligibility and benefit verification.

 ***Denied Authorizations must follow the authorization appeal process, not the claims appeal process; claims appeals can not change the status of a denied authorization.***

Continuity of Care PA Request

-  MHS will honor pre-existing authorizations from any other Medicaid program during the first 30 days of enrollment or up to the expiration date of the previous authorization, whichever occurs first, and upon notification to MHS.
-  Include the approval from the prior MCE with the request.

****Reference: MHS Provider Manual Chapter 6***

Pharmacy Requests

MHS' Pharmacy Benefit Manager is Envolve.

Envolve Pharmacy Solutions:

 Preferred Drug Lists and authorization forms are available at mhsindiana.com/provider/pharmacy.

- PA requests
- Phone 1-866-399-0928
- Fax non specialty drugs 1-866-399-0929
- Specialty drugs 1-866-678-6976
- pharmacy.envolvehealth.com

 Formulary integrated into many Electronic Health Records (EHR) solutions.

 Online PA submission available through CoverMyMeds:

- covermymeds.com

 Online PA forms for Specialty Drugs on mhsindiana.com.

Behavioral Health Prior Authorization

Facility Services Requiring Prior Auth:

 Inpatient Admissions

 Intensive Outpatient Treatment (IOT)

 Partial Hospitalization SUD Residential Treatment

Behavioral Health Prior Authorization

-  Psychiatric Diagnostic Evaluation (Limited to 1 per member per 12 month rolling year without authorization.)
-  Behavioral Health Outpatient Therapy “BHOP Therapy” (Limited to 20 visits per member, per practitioner, per 12 month rolling period.)
-  Electroconvulsive Therapy
-  Psychological Testing (unless for Autism-no auth required)
-  Developmental Testing, with interpretation and report (non-EPSDT) Neurobehavioral status exam, with interpretation and report.
-  Neuropsych Testing per hour, face to face. (unless for Autism-no auth required)
-  ABA Services

Behavioral Health Prior Authorization

-  Please call MHS Care Management for inpatient and partial hospitalization authorizations at 1-877-647- 4848.
-  MHS Authorization forms may be obtained on our website:
mhsindiana.com/providers/behavioral-health/bhprovider-forms
-  Outpatient Treatment Request (OTR) Form - Fax: 1-866-694-3649
-  Intensive Outpatient/Day Treatment Form Mental Health/Chemical Dependency - Fax: 1-866-694-3649
-  Applied Behavioral Analysis Treatment (OTR) - Fax: 1-866-694-3649
-  Psychological & Neuropsych Testing Authorization Request Form - Fax: 1-866- 694-3649
-  Residential/Inpatient Substance Use Disorder Treatment Prior Authorization Form
 - Fax Inpatient: 1-844-288-2591; Fax Outpatient: 1-866-694-3649

Behavioral Health Prior Authorization

Limitations on Outpatient Mental Health Services

-  As of April 1, 2021 package C Hoosier Healthwise members are eligible for increased benefits.
-  MHS follows The Indiana Health Coverage Programs Mental Health and Addiction limitation policy for the following CPT codes that, in combination, are limited to 20 units per provider, per rolling 12-month period.

<u>Code</u>	<u>Description</u>
90832 - 90834	Individual Psychotherapy
90837 - 90840	Psychotherapy, with patient and/or family member & Crisis Psychotherapy
90845 - 90847	Psychoanalysis & Family/Group Psychotherapy with or
90849 - 90853	without patient

MHS Secure Provider Portal

Web Portal Authorizations

 Providers can submit Prior Authorizations online via the MHS Secure Provider Portal at mhsindiana.com/login.

- When using the portal, providers can upload supporting documentation directly.

 **Exceptions**: Must submit Inpatient, hospice, home health and biopharmacy PA requests via **fax 1-866-912-4245**.

 Providers can check the authorization status on the portal.



Secure Portal Registration and Login



[Home](#) [Find a Provider](#) [Portal Login](#) [Events](#) [Contact Us](#)

Contrast ☐ On ☒ Off ☐ a ☐ a ☐ language▼

FOR MEMBERS

FOR PROVIDERS

GET INSURED

FOR PROVIDERS

Login

[Become a Provider](#)

[Prior Authorization](#) +

[Dental Providers](#)

[Pharmacy](#) +

[Provider Resources](#) +

[QI Program](#) +

[Provider News](#)

Portal Login

Login/Register

[Click here for more information](#) on the Provider Portal functions and training documents.

Behavioral Health Secure Portal

[Click here for the Cenpatco behavioral health portal.](#)

Registration Help

If you are having trouble with your registration, you may need to submit a non-par set-up form. Visit our [Become a Provider](#) page to get started. For further assistance, you can call our Secure Provider Portal Help Line at 1-866-912-0327.

Create your own online account today!

MHS offers you many convenient and secure tools to assist you. To enter our secure portal, click on the login button. A new window will open. You can login or register.

Creating an account is free and easy.

By creating a MHS account, you can:

- Verify member eligibility
- Submit and check claims
- Submit and confirm authorizations
- View detailed patient list

Please note that Clear Claim Connection does not provide an all inclusive listing of claim edits. MHS does utilize additional prepayment review edits in keeping with NCCI procedures and guidelines.

Registration

Registration Complete!

Your Progress 

Thank you for completing your registration! A Superior HealthPlan provider services specialist will be sending you an email when your profile has been activated. Please allow up to 2 business days for processing.

If you do not receive an email within 2 business days, please log in and contact us using secure messaging or call 866-895-8443 for additional assistance.

Login



The Tools You Need Now!

Our site has been designed to help you get your job done.

For registration or secure website questions call (866) 912-0327.

Manage all products with ease in one location



Check Eligibility

Find out if a member is eligible for service.



Authorize Services

See if the service you provide is reimbursable.



Manage Claims

Submit or track your claims and get paid fast.

Login

User Name (Email)

name@domain.com

Password

Login

[Forgot Password / Unlock Account](#)

Need To Create An Account?

Registration is fast and simple, give it a try.

Create An Account

How to Register

Our registration process is quick and simple. Please click the button to learn how to register.

Provider Registration Video

Provider Registration PDF



Provider Name

Viewing Dashboard For :

Tax ID Number

Medicaid

GO

Quick Eligibility Check

Member ID or Last Name

123456789 or Smith

Birthdate

mm/dd/yyyy

Check Eligibility

Recent Claims

STATUS	RECEIVED DATE	MEMBER NAME	CLAIM NO.
	08/19/2017	C	4
	08/19/2017	T	3
	08/19/2017	E	1
	08/19/2017	F	8

Welcome

Add a TIN to My ACCOUNT >

Manage Accounts >

Reports >

Patient Analytics >

Provider Analytics--Coming Soon >

Recent Activity

Date

Activity

Quick Links

[Provider Resources](#)

Authorizations:

 View, create and filter group authorizations



 Eligibility
  Patients
  Authorizations
  Claims
  Messaging
  Help

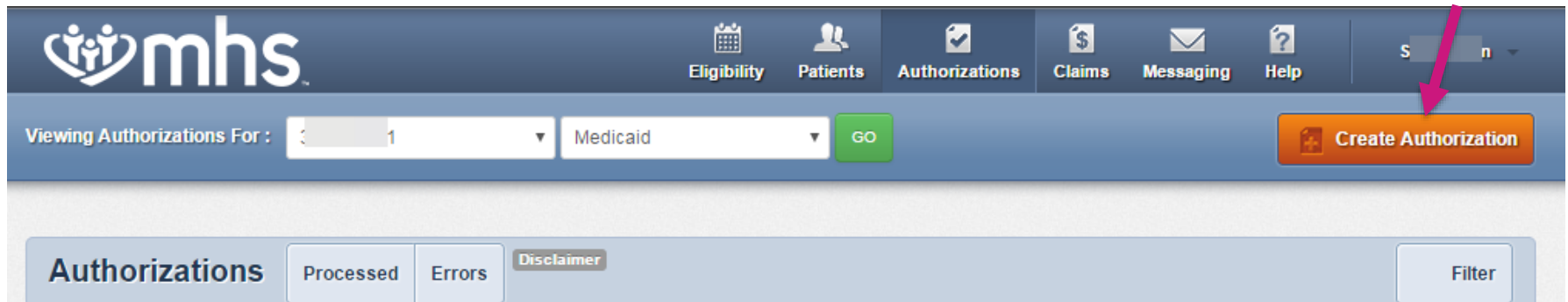
Viewing Authorizations For :

Authorizations

Please call the health plan for questions regarding voided authorization submissions. The authorization page is updated every 24 hours.

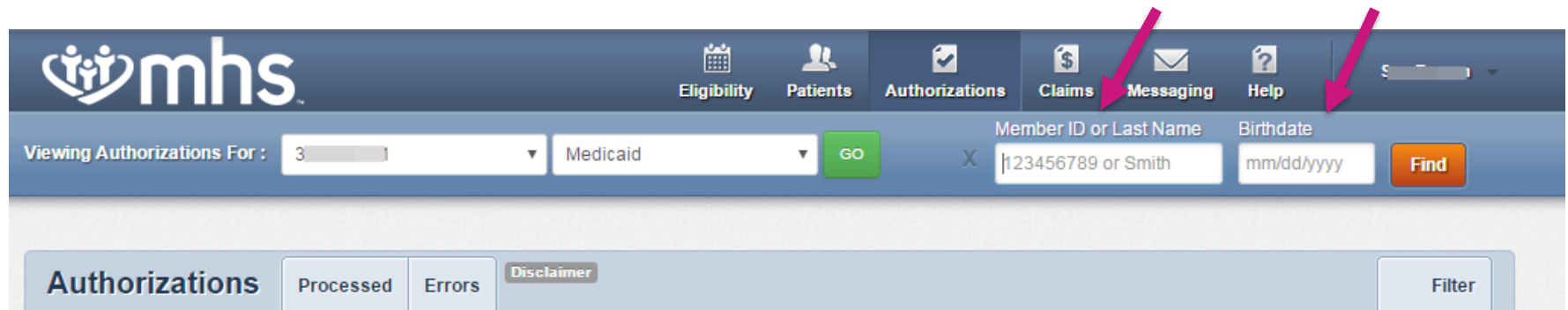
STATUS	AUTH ID	MEMBER	FROM DATE	TO DATE	DIAGNOSIS	AUTH TYPE	SERVICE
APPROVE	O [REDACTED] 1	Al [REDACTED] H	07/24/2017	10/24/2017	E11.9	OUTPATIENT	DME
PARTIAL_APPROVE	C [REDACTED] 9	[REDACTED] V	06/14/2017	09/19/2017	B07.9	OUTPATIENT	Office Visit

Creating a New Authorization



The screenshot shows the MHS interface with the following elements:

- Header:** MHS logo, navigation tabs (Eligibility, Patients, Authorizations, Claims, Messaging, Help), and a user profile dropdown (S...n).
- Filter Bar:** "Viewing Authorizations For:" with a dropdown menu showing "1" and a "Medicaid" filter, a green "GO" button, and an orange "Create Authorization" button with a red arrow pointing to it.
- Content Area:** A section titled "Authorizations" with sub-tabs "Processed", "Errors", and "Disclaimer", and a "Filter" button.

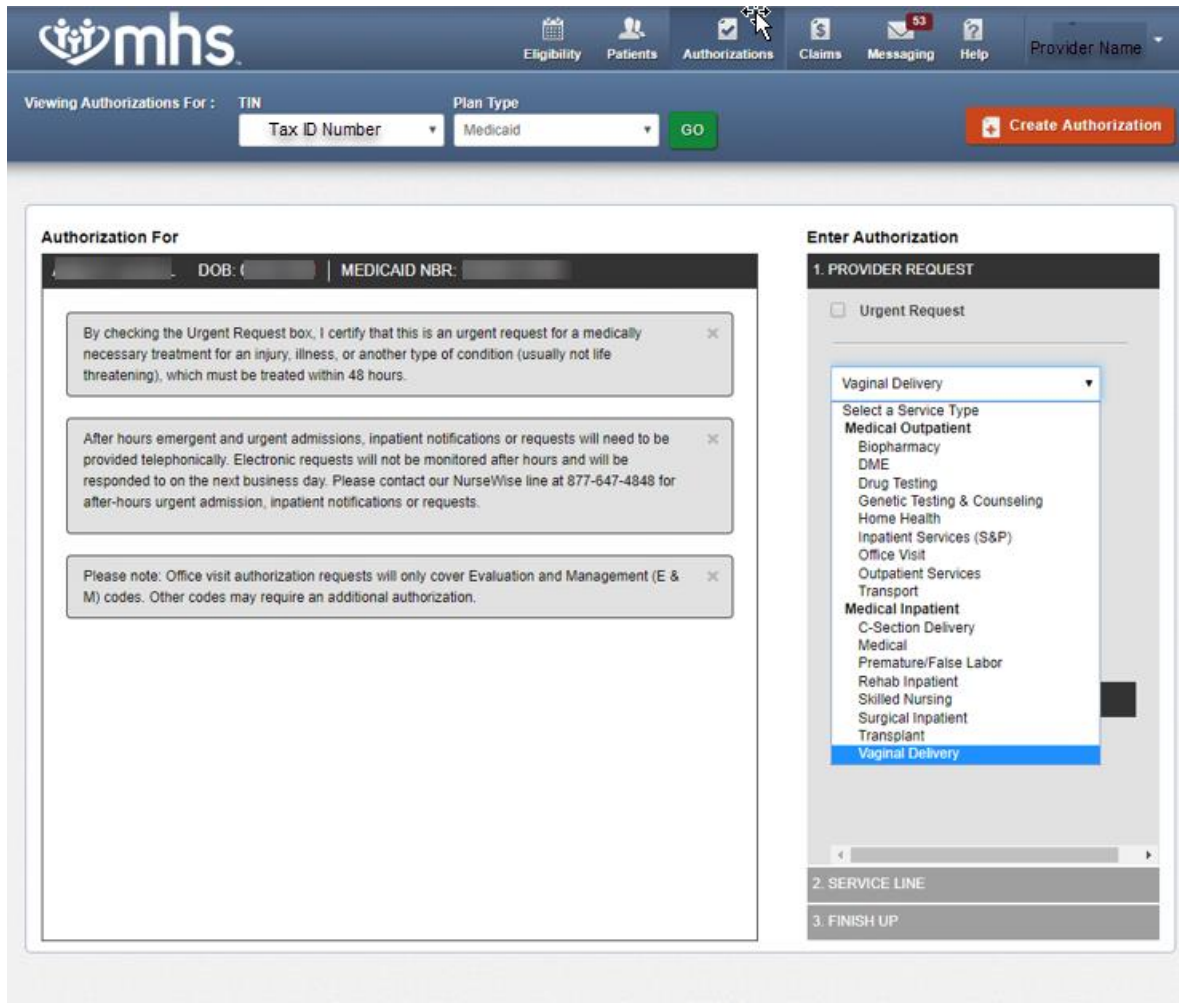


The screenshot shows the MHS interface with the following elements:

- Header:** MHS logo, navigation tabs (Eligibility, Patients, Authorizations, Claims, Messaging, Help), and a user profile dropdown (S...n). Red arrows point to the "Claims" and "Help" tabs.
- Filter Bar:** "Viewing Authorizations For:" with a dropdown menu showing "3" and a "Medicaid" filter, a green "GO" button, and search fields for "Member ID or Last Name" (containing "123456789 or Smith") and "Birthdate" (containing "mm/dd/yyyy"), with a red arrow pointing to the "Find" button.
- Content Area:** A section titled "Authorizations" with sub-tabs "Processed", "Errors", and "Disclaimer", and a "Filter" button.

Creating a New Authorization

Select a Service Type



The screenshot shows the MHS Authorization System interface. At the top, there is a navigation bar with icons for Eligibility, Patients, Authorizations, Claims, Messaging, and Help. A dropdown menu for 'Provider Name' is also present. Below the navigation bar, there is a section for 'Viewing Authorizations For' with fields for 'TIN' (Tax ID Number) and 'Plan Type' (Medicaid), a 'GO' button, and a 'Create Authorization' button.

The main content area is divided into two columns. The left column is titled 'Authorization For' and contains fields for 'DOB' and 'MEDICAID NBR'. Below these fields are three informational boxes:

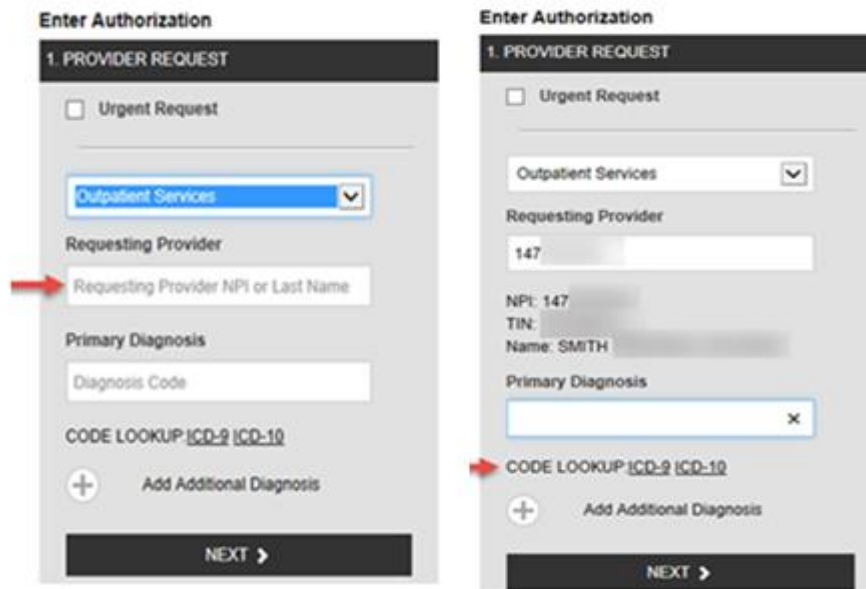
- By checking the Urgent Request box, I certify that this is an urgent request for a medically necessary treatment for an injury, illness, or another type of condition (usually not life threatening), which must be treated within 48 hours.
- After hours emergent and urgent admissions, inpatient notifications or requests will need to be provided telephonically. Electronic requests will not be monitored after hours and will be responded to on the next business day. Please contact our NurseWise line at 877-647-4848 for after-hours urgent admission, inpatient notifications or requests.
- Please note: Office visit authorization requests will only cover Evaluation and Management (E & M) codes. Other codes may require an additional authorization.

The right column is titled 'Enter Authorization' and contains a section for '1. PROVIDER REQUEST'. It includes a checkbox for 'Urgent Request' and a dropdown menu for 'Select a Service Type'. The dropdown menu is open, showing a list of service types categorized under 'Medical Outpatient' and 'Medical Inpatient'. The 'Vaginal Delivery' option is selected and highlighted in blue.

Below the dropdown menu, there are sections for '2. SERVICE LINE' and '3. FINISH UP'.

Creating a New Authorization

Select Provider NPI Add Primary Diagnosis



The image displays two sequential screenshots of the 'Enter Authorization' form, specifically the '1. PROVIDER REQUEST' section.

Left Screenshot: The form is titled 'Enter Authorization' and '1. PROVIDER REQUEST'. It includes a checkbox for 'Urgent Request'. Below this is a dropdown menu for 'Outpatient Services'. The 'Requesting Provider' section has a text input field for 'Requesting Provider NPI or Last Name', which is highlighted with a red arrow. The 'Primary Diagnosis' section has a text input field for 'Diagnosis Code'. At the bottom, there is a 'CODE LOOKUP: ICD-9 ICD-10' link, a plus icon, and the text 'Add Additional Diagnosis'. A 'NEXT >' button is at the bottom.

Right Screenshot: This screenshot shows the form after some data has been entered. The 'Requesting Provider' section now shows '147' in the input field. Below this, the 'NPI: 147', 'TIN:', and 'Name: SMITH' are displayed. The 'Primary Diagnosis' section has a text input field with a clear 'X' button. A red arrow points to the 'CODE LOOKUP: ICD-9 ICD-10' link. The 'Add Additional Diagnosis' section and the 'NEXT >' button are also visible.

Creating a New Authorization

 If required Add Additional Procedures

Authorization For

DOB: MEDICAID NBR:

PROVIDER REQUEST

Service Type: Outpatient Outpatient Services

 **SMITH**

GENERAL SURGERY

Primary Diagnosis: 5430: HYPERPLASIA OF APPENDIX

Additional Diagnosis: 5379: UNSPEC DISORDER STOMACH&DUODENUM

NPI: 147

TIN:

Phone:

Enter Authorization

1. PROVIDER REQUEST [EDIT](#)

2. SERVICE LINE

TIN:

Name: SMITH

07/14/2015 - 07/24/2015

1

Primary Procedure

44970

LAPAROSCOPY RUSGICAL APPENEDECTOMY

[CODE LOOKUP](#)

+ Add Additional Procedures

Select a Place Of Service

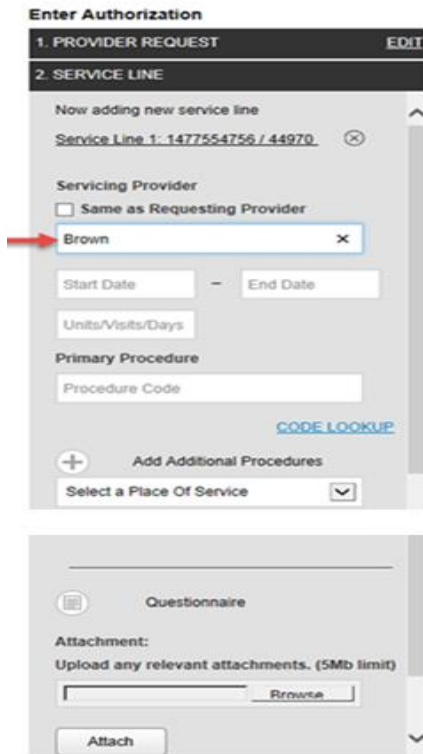
- Ambulatory Surgical Center
- Outpatient Hospital
- Unspecified

+ Add New Service Line

NEXT >

Creating a New Authorization

Service Line Details:



Enter Authorization

1. PROVIDER REQUEST EDIT

2. SERVICE LINE

Now adding new service line

Service Line 1: 1477554756 / 44970 ✕

Servicing Provider

☐ Same as Requesting Provider

Brown ✕

Start Date - End Date

Units/Visits/Days

Primary Procedure

Procedure Code

[CODE LOOKUP](#)

+ Add Additional Procedures

Select a Place Of Service ▼

Questionnaire

Attachment:

Upload any relevant attachments. (5Mb limit)

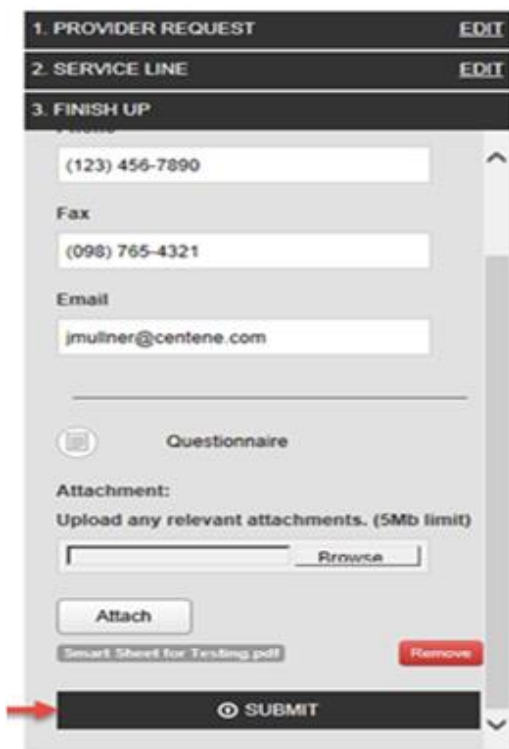
Browse

Attach

- Provider Request will appear on the left side of the screen.
- Update Servicing Provider:
 - Check box if same as Requesting Provider.
 - Update Servicing Provider information if not the same
- Update Start Date and End Date.
- Update Total Units/Visits/Days.
- Update Primary Procedure:
 - Code lookup provided.
- Add any additional procedures.
- Add additional Service Line if applicable:

Creating a New Authorization

-  Submit a new Authorization:
- **Confirmation number.**



1. PROVIDER REQUEST EDIT

2. SERVICE LINE EDIT

3. FINISH UP

(123) 456-7890

Fax

(098) 765-4321

Email

jmuliner@centene.com

Questionnaire

Attachment:

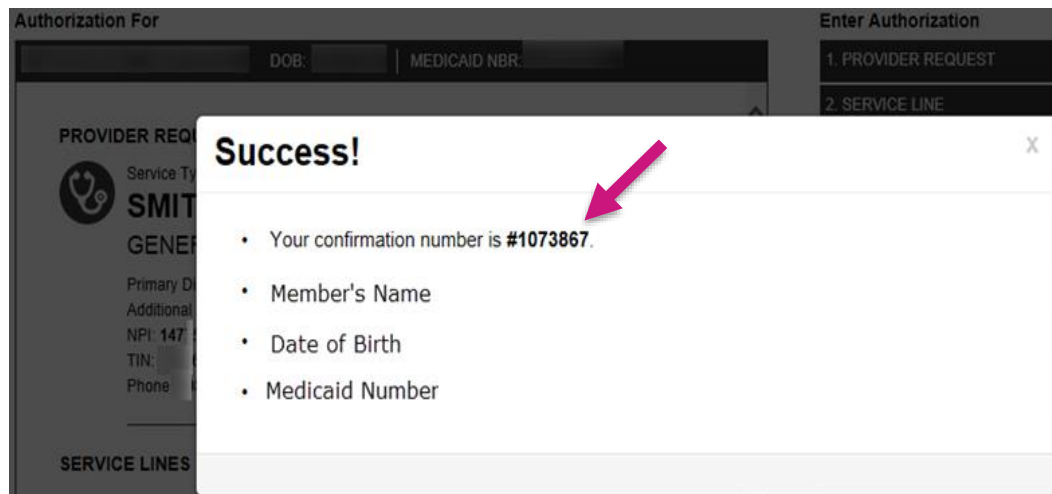
Upload any relevant attachments. (5Mb limit)

Remove

Attach

Smart Sheet for Testing.pdf Remove

 SUBMIT



Authorization For

DOB: MEDICAID NBR:

Enter Authorization

1. PROVIDER REQUEST

2. SERVICE LINE

Success!

- Your confirmation number is **#1073867**.
- Member's Name
- Date of Birth
- Medicaid Number



Telephone and Fax Authorizations

Telephone Authorization

-  Providers can initiate Prior Authorization via the MHS referral line by calling 1-877-647-4848:
 - Monday - Friday 8 a.m. to 5 p.m. (Closed for lunch from noon to 1 p.m.)
 - After hours, MHS 24-hour nurse line available to take emergent requests.
-  The PA process begins at MHS by speaking with the MHS non-clinical referral staff.
-  For procedures requiring additional review, we will transfer providers to a “live” nurse line to facilitate the PA process.
-  Please have all clinical information ready at time of call.

Fax Authorization

MHS Medical Management Department at 1-866-912-4245

Patient Information					
IHCP Member ID (RID):					
Date of Birth:					
Patient Name:					
Address:					
City/State/ZIP Code:					
Patient/Guardian Phone:					
PMP Name:					
PMP NPI:					
PMP Phone:					
Ordering, Prescribing, or Referring (OPR) Provider Information					
OPR Physician NPI:					
Medical Diagnosis (Use of ICD Diagnostic Code Is Required)					
Dx1		Dx2		Dx3	
Please check the requested assignment category below:					
☐ DME	☐ Inpatient	☐ Physical Therapy			
☐ Purchased	☐ Observation	☐ Speech Therapy			
☐ Rented	☐ Office Visit	☐ Transportation			
☐ Home Health	☐ Occupational Therapy	☐ Other			
☐ Hospice	☐ Outpatient				

← Member ID/RID,
DOB Patient name,
required

← Medical Diagnosis
code(s) **required**

← Check service
category

Fax Authorization

Requesting Provider Information:
NPI#:
Tax ID#:
Service Location Code:
Provider Name:
Rendering Provider Information
Ordering Physician NPI#:
Tax ID#:
Name
Address:
City/State/Zip:
Phone:
Fax:

← Enter the **Requesting** provider's information

← Enter the **Rendering** provider's individual NPI#

Fax Authorization

Dates of Service Start Stop		Procedure/ Service Codes	Modifier(s)		Requested Service	Taxonomy	POS	Units	Dollars

Prior Authorization Denial and Appeal Process

Medical PA Denial and Appeal Process

If MHS denies the requested service:

- And the member is still receiving services, the provider has the right to an expedited appeal. The attending physician must request the expedited appeal.
- And the member already has been discharged, the attending physician must submit an appeal in writing within **60 days** of the denial.

The attending physician has the right to a peer-to-peer discussion with an MHS physician:

- Providers initiate peer-to-peer discussions and expedited appeals by calling an MHS appeals coordinator at 1-877-647-4848.
- They must request peer-to-peer within **10 days** of the adverse determination.

Medical PA Denial and Appeal Process

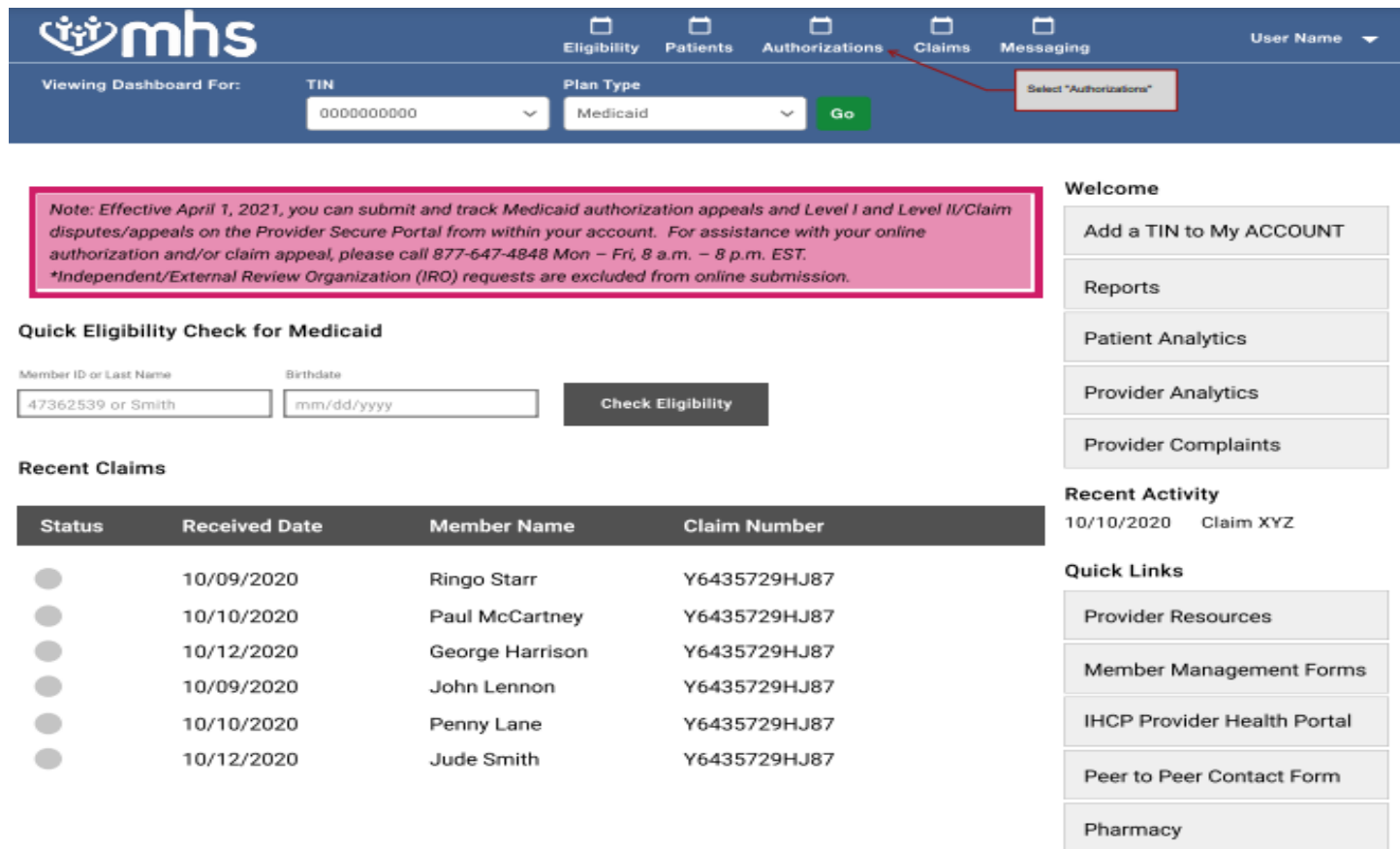
-  Send Prior Authorization/Medical Necessity Appeals to:
Managed Health Services
Attn: Appeals Coordinator
PO Box 441567
Indianapolis, IN 46244
-  Providers must initiate appeals within **60 days** of the receipt of the denial letter for MHS to consider.
-  We will communicate determination to the provider within **30 calendar days** of receipt.
-  ***A prior authorization appeal is different than a claim appeal request.***
-  ***This process is applicable to members and non-contracted providers.***

PA/Medical Necessity Appeals on the Provider Secure Portal



Effective April 1, 2021, Medicaid prior authorization/medical necessity denial appeals can be submitted to Managed Health Services (MHS) and will allow tracking of the appeal from submission through decision on the Secure Provider Portal.

PA/Medical Necessity Appeals on the Provider Secure Portal



mhs Eligibility Patients Authorizations Claims Messaging User Name ▾

Viewing Dashboard For: TIN: 0000000000 Plan Type: Medicaid Go Select "Authorizations"

*Note: Effective April 1, 2021, you can submit and track Medicaid authorization appeals and Level I and Level II/Claim disputes/appeals on the Provider Secure Portal from within your account. For assistance with your online authorization and/or claim appeal, please call 877-647-4848 Mon – Fri, 8 a.m. – 8 p.m. EST.
Independent/External Review Organization (IRO) requests are excluded from online submission.

Quick Eligibility Check for Medicaid

Member ID or Last Name: 47362539 or Smith Birthdate: mm/dd/yyyy Check Eligibility

Recent Claims

Status	Received Date	Member Name	Claim Number
●	10/09/2020	Ringo Starr	Y6435729HJ87
●	10/10/2020	Paul McCartney	Y6435729HJ87
●	10/12/2020	George Harrison	Y6435729HJ87
●	10/09/2020	John Lennon	Y6435729HJ87
●	10/10/2020	Penny Lane	Y6435729HJ87
●	10/12/2020	Jude Smith	Y6435729HJ87

Welcome

- Add a TIN to My ACCOUNT
- Reports
- Patient Analytics
- Provider Analytics
- Provider Complaints

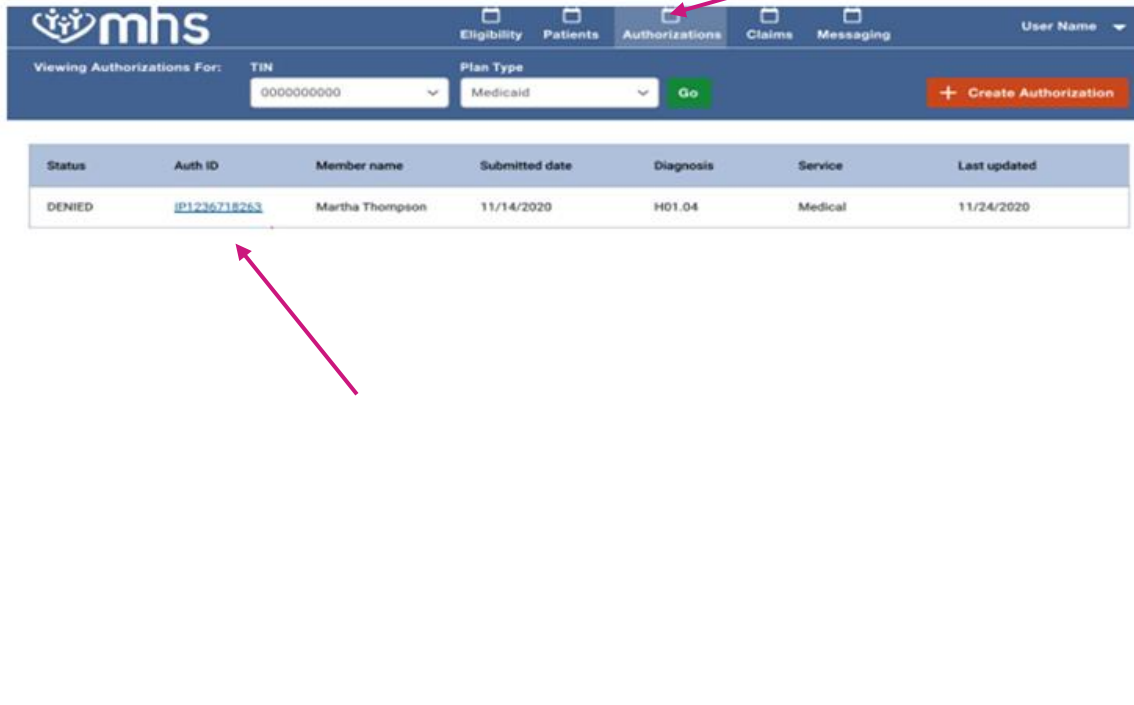
Recent Activity

10/10/2020 Claim XYZ

Quick Links

- Provider Resources
- Member Management Forms
- IHCP Provider Health Portal
- Peer to Peer Contact Form
- Pharmacy

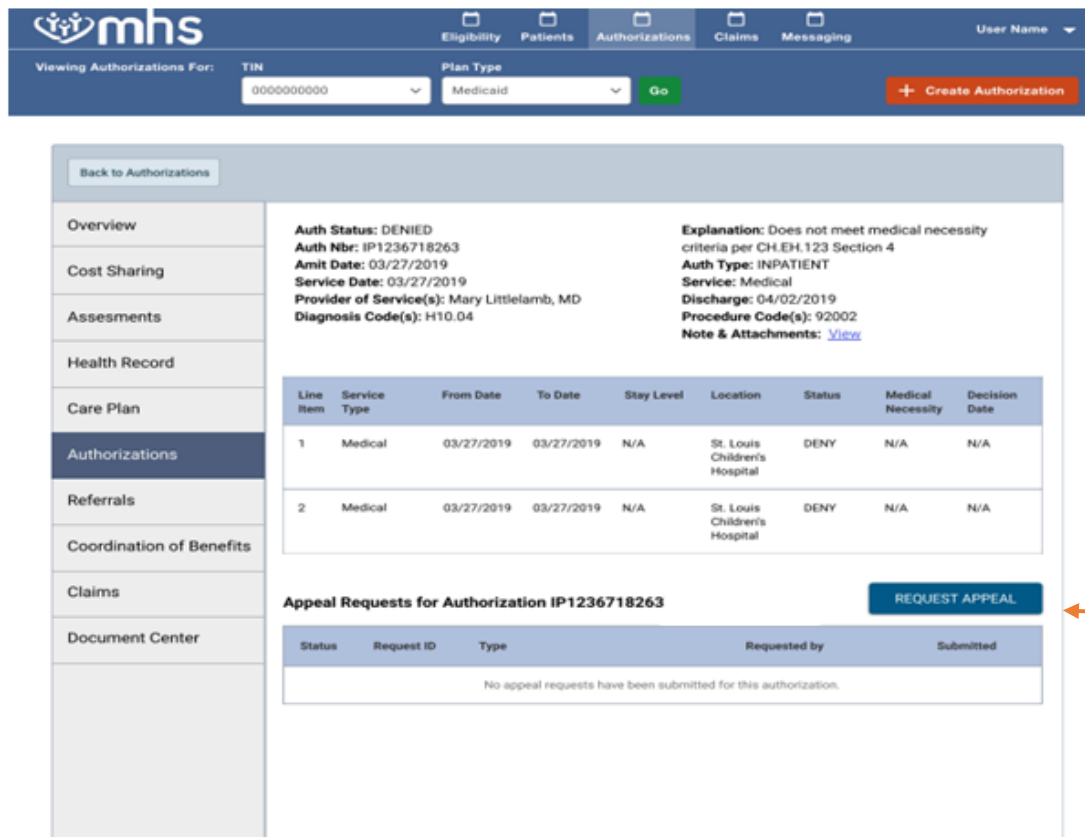
PA/Medical Necessity Appeals on the Provider Secure Portal



The screenshot shows the mhs Provider Secure Portal interface. The top navigation bar includes tabs for Eligibility, Patients, Authorizations, Claims, and Messaging. The 'Authorizations' tab is selected. Below the navigation bar, there is a section for 'Viewing Authorizations For:' with fields for TIN (0000000000) and Plan Type (Medicaid), a 'Go' button, and a '+ Create Authorization' button. Below this is a table with the following data:

Status	Auth ID	Member name	Submitted date	Diagnosis	Service	Last updated
DENIED	IP1236718263	Martha Thompson	11/14/2020	H01.04	Medical	11/24/2020

PA/Medical Necessity Appeals on the Provider Secure Portal



The screenshot shows the mhs Provider Secure Portal interface. At the top, there's a navigation bar with tabs for Eligibility, Patients, Authorizations, Claims, and Messaging. Below this, a search bar allows filtering by TIN (0000000000) and Plan Type (Medicaid). A green 'Go' button and an orange '+ Create Authorization' button are present.

The main content area displays details for a denied authorization (Auth Nbr: IP1236718263). The status is 'DENIED' with an explanation: 'Does not meet medical necessity criteria per CH.EH.123 Section 4'. The auth type is 'INPATIENT', service is 'Medical', and discharge date is '04/02/2019'. The provider is 'Mary Littlelamb, MD' and the diagnosis code is 'H10.04'. A 'View' link is provided for note and attachments.

Line Item	Service Type	From Date	To Date	Stay Level	Location	Status	Medical Necessity	Decision Date
1	Medical	03/27/2019	03/27/2019	N/A	St. Louis Children's Hospital	DENY	N/A	N/A
2	Medical	03/27/2019	03/27/2019	N/A	St. Louis Children's Hospital	DENY	N/A	N/A

Below the table, there's a section for 'Appeal Requests for Authorization IP1236718263'. A blue 'REQUEST APPEAL' button is highlighted with an orange arrow. Below this, a table shows the status of appeal requests, but it indicates that no requests have been submitted for this authorization.

PA/Medical Necessity Appeals on the Provider Secure Portal

Authorization Details

Authorization Number
[REDACTED]

Patient Full Name
[REDACTED]

Admittance Date
08/30/2021

Service Date
08/30/2021

Discharge Date
09/30/2021

Provider of Service
[REDACTED]

Authorization type
OUTPATIENT

Service
Outpatient Services

Diagnosis Code(s)
M47.817

Procedure Code(s)
64493, 64493, 64494, 64494

Appeal Request Form

Appeal request for authorization **IP1236718234**

Appeal type*
Please select one or more appeal types.

☒ Administrative
☐ Medical Necessity

Provider Submitting the Appeal*
[REDACTED]

Office Contact Name*
Betty Blue

Phone*
(555) 555-5555

Enter last name or NPI

Rationale*
Provide a detailed explanation with new information for this appeal.

Lorem Ipsum is simply dummy text of the printing and typesetting industry. Lorem Ipsum has been the industry's standard dummy text ever since the 1500s when an unknown printer took a gallery of type and scrambled it to make a type specimen book.

2000 Characters remaining

Evidence Materials & Attachments
Submit new evidence that will help support your appeal.

.../Folder 1/Folder 2/Folder 3/File.pdf [UPLOAD FILE](#)

File	Type	Size
MarthaThompson12345_xray_010119.png	PNG	230kb

[SAVE & REVIEW](#)

PA/Medical Necessity Appeals on the Provider Secure Portal

[Back](#)

Submit Appeal Request

Authorization Detail

Authorization Number
IP1236718263

Patient Full Name
Martha Thompson

Patient DOB
06/20/1981

Admittance Date
03/27/2019

Service Date
03/27/2019

Discharge Date
04/02/2019

Provider of Service
Mary Littlelamb, MD

Authorization Type
Inpatient

Service
Medical

Diagnosis Code(s)
H01.04

Procedure Code(s)
92002

Appeal Request Form

Appeal Request for Authorization IP1236718263

Appeal type*
Please select one or more appeal types.

☒ Administrative

☐ Medical Necessity

DENIED

Explanation:
Does not meet medical necessity criteria per CH.EH.123 Section 4.

[View Notes & Attachments](#)

Are you sure you want to go back?

By leaving this form, you will lose all of this information.

[NO](#) [YES](#)

Phone*
(555) 555-5555
Enter ten-digit number

2000 characters remaining

Evidence Materials & Attachments*
Submit new evidence that will help support your appeal.

.../Folder 1/Folder 2/Folder 3/File.pdf [UPLOAD FILE](#)

2000 characters remaining

File	Type	Size
PatientHistory_1.pdf	PNG	230kb
MarthaThompson12345_XRAY_010119.png	PNG	9.1mb

[SAVE & REVIEW](#)

PA/Medical Necessity Appeals on the Provider Secure Portal



[Eligibility](#)
[Patients](#)
[Authorizations](#)
[Claims](#)
[Messaging](#)

User Name

[Back](#)
Review Appeal Request

Review

Appeal request for Authorization IP1236718263

Original Authorization

Authorization Number IP1236718263	Member Martha Thompson	Member DOB 12/32/1921
--------------------------------------	---------------------------	--------------------------

Appeal Request

Appeal Request Type Administrative, Medical Necessity	Office Contact Name Jimmy Johnson
Provider Mary Littlelamb, MD	Office Contact Phone (555) 555-5555

Rationale
Lorem Ipsum is simply dummy text of the printing and typesetting industry. Lorem Ipsum has been the industry's standard dummy text ever since the 1500s, when an unknown printer took a galley of type and scrambled it to make a type specimen book.

Evidence Materials & Attachments

File	Type	Size	
PatientHistory_1.pdf	PDF	230kb	
MarthaThompson12345_XRAY_010119.png	PNG	9.1mb	

SEND REQUEST

PA/Medical Necessity Appeals on the Provider Secure Portal



[Eligibility](#)
[Patients](#)
[Authorizations](#)
[Claims](#)
[Messaging](#)

User Name ▾

Thank you! Your Appeal Request has been successfully submitted! ✕

[Back to Authorizations](#)

Overview

Cost Sharing

Assessments

Health Record

Care Plan

Authorizations

Referrals

Coordination of Benefits

Claims

Document Center

Auth Status: DENIED
Auth Nbr: IP1236718263
Amit Date: 03/27/2019
Service Date: 03/27/2019
Provider of Service(s): Mary Littlelamb, MD
Diagnosis Code(s): H10.04

Explanation: Does not meet medical necessity criteria per CHEH.123 Section 4
Auth Type: INPATIENT
Service: Medical
Discharge: 04/02/2019
Procedure Code(s): 92002
Note & Attachments: [View](#)

Line Item	Service Type	From Date	To Date	Stay Level	Location	Status	Medical Necessity	Decision Date
1	Medical	03/27/2019	03/27/2019	N/A	St. Louis Children's Hospital	DENY	N/A	N/A
2	Medical	03/27/2019	03/27/2019	N/A	St. Louis Children's Hospital	DENY	N/A	N/A

Appeal Requests for Authorization IP1236718263
[REQUEST APPEAL](#)

Status	Request ID	Type	Requested by	Submitted
In-Process	IC-2885	Administrative, Medical Necessity	Mary Littlelamb	11/24/2020

PA/Medical Necessity Appeals on the Provider Secure Portal



 Eligibility
  Patients
  Authorizations
  Claims
  Messaging
 User Name

[Back](#)
Review Appeal Request

Appeal request for Authorization IP1236718263
Current status: **In-Process**

Original Authorization

Authorization Number IP1236718263	Member Martha Thompson	Member DOB 12/32/1921
--------------------------------------	---------------------------	--------------------------

Appeal Request

Appeal Request Type Administrative, Medical Necessity	Office Contact Name Jimmy Johnson
Provider Mary Littlelamb, MD	Office Contact Phone (555) 555-5555

Rationale
Lorem Ipsum is simply dummy text of the printing and typesetting industry. Lorem Ipsum has been the industry's standard dummy text ever since the 1500s, when an unknown printer took a galley of type and scrambled it to make a type specimen book.

Evidence Materials & Attachments

File	Type	Size	
PatientHistory_1.pdf	PDF	230kb	
MarthaThompson12345_XRAY_010119.png	PNG	9.1mb	

SEND REQUEST

Appeal Summary

Appeal ID	Status					
ABCD1234	Assigned	 Submitted	 In-Process	 Assigned	 Final Notification Sent	 Resolved
EFGH1234	In-Process	 Submitted	 In-Process	 Assigned	 Final Notification Sent	 Resolved

Behavioral Health PA Denial and Appeal Process

Medical Necessity Appeals

-  Medical Necessity appeals must be received by MHS within 60 calendar days of the date listed on the denial determination letter. The monitoring of the appeal timeline will begin the day MHS receives and receipt-stamps the appeal. Medical necessity behavioral health appeals should be mailed or faxed to:

MHS Behavioral Health
ATTN: Appeals Coordinator
12515 Research Blvd, Suite 400
Austin, TX 78701
FAX: 1-866-714-7991

MHS Team

MHS Provider Network Territories

Indiana

NORTHEAST REGION

For claims issues, email:
MHS_ProviderRelations_NE@mhsindiana.com
Chad Pratt, Provider Partnership Associate
1-877-647-4848, ext. 20454

NORTHWEST REGION

For claims issues, email:
MHS_ProviderRelations_NW@mhsindiana.com
Candace Ervin, Provider Partnership Associate
1-877-647-4848, ext. 20187

NORTH CENTRAL REGION

For claims issues, email:
MHS_ProviderRelations_NC@mhsindiana.com
Natalie Smith, Provider Partnership Associate
1-877-647-4848, ext. 20127

CENTRAL REGION

For claims issues, email:
MHS_ProviderRelations_C@mhsindiana.com
Mona Green, Provider Partnership Associate
1-877-647-4848, ext. 20080

SOUTH CENTRAL REGION

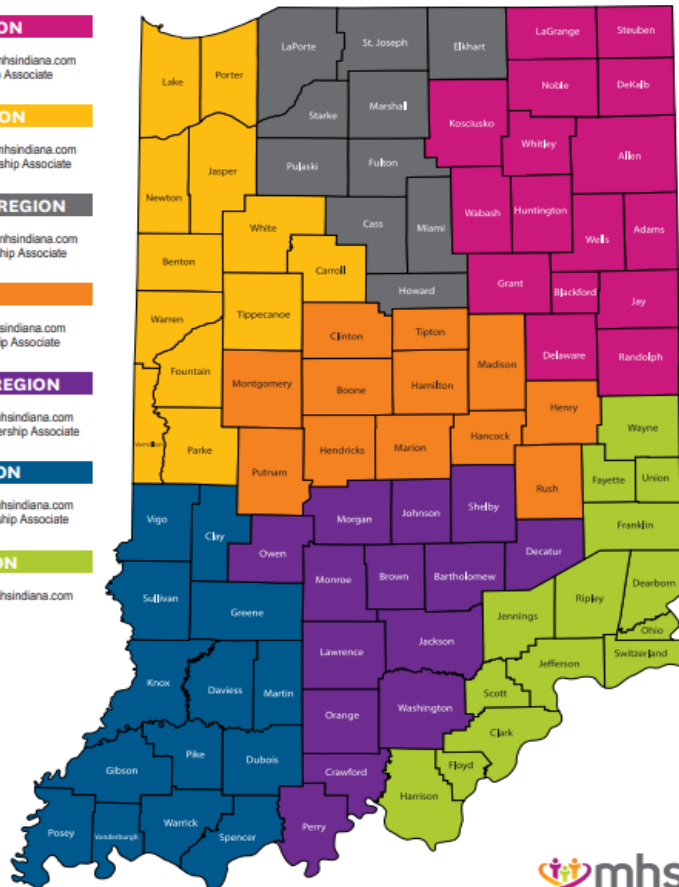
For claims issues, email:
MHS_ProviderRelations_SC@mhsindiana.com
Dalesia Denning, Provider Partnership Associate
1-877-647-4848, ext. 20026

SOUTHWEST REGION

For claims issues, email:
MHS_ProviderRelations_SW@mhsindiana.com
Dawn McCarty, Provider Partnership Associate
1-877-647-4848, ext. 20117

SOUTHEAST REGION

For claims issues, email:
MHS_ProviderRelations_SE@mhsindiana.com
Carolyn Valachovic Monroe
Provider Partnership Associate
1-877-647-4848, ext. 20114



550 N. Meridian Street, Suite 101 • Indianapolis, IN 46204 • 1-877-647-4848 • mhsindiana.com

Allwell from MHS • Ambetter from MHS • Healthy Indiana Plan (HIP) • Hoosier Care Connect • Hoosier Healthwise

0520.PR.P.FL 3/20

NORTHEAST REGION

For claims issues, email:
MHS_ProviderRelations_NE@mhsindiana.com
Chad Pratt, Provider Partnership Associate
1-877-647-4848, ext. 20454

NORTHWEST REGION

For claims issues, email:
MHS_ProviderRelations_NW@mhsindiana.com
Candace Ervin, Provider Partnership Associate
1-877-647-4848, ext. 20187

NORTH CENTRAL REGION

For claims issues, email:
MHS_ProviderRelations_NC@mhsindiana.com
Natalie Smith, Provider Partnership Associate
1-877-647-4848, ext. 20127

CENTRAL REGION

For claims issues, email:
MHS_ProviderRelations_C@mhsindiana.com
Mona Green, Provider Partnership Associate
1-877-647-4848, ext. 20080

SOUTH CENTRAL REGION

For claims issues, email:
MHS_ProviderRelations_SC@mhsindiana.com
Dalesia Denning, Provider Partnership Associate
1-877-647-4848, ext. 20026

SOUTHWEST REGION

For claims issues, email:
MHS_ProviderRelations_SW@mhsindiana.com
Dawn McCarty, Provider Partnership Associate
1-877-647-4848, ext. 20117

SOUTHEAST REGION

For claims issues, email:
MHS_ProviderRelations_SE@mhsindiana.com
Carolyn Valachovic Monroe
Provider Partnership Associate
1-877-647-4848, ext. 20114

Available online:

https://www.mhsindiana.com/content/dam/centene/mhsindiana/medicaid/pdfs/ProviderTerritory_map_2021.pdf

MHS Provider Network Territories

TAWANNA DANZIE

Provider Partnership Associate II
1-877-647-4848 ext. 20022
tdanzie@mhsindiana.com

PROVIDER GROUPS

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

JENNIFER GARNER

Program Manager,
Provider Engagement
1-877-647-4848 ext. 20149
jgarner@mhsindiana.com

PROVIDER GROUPS

American Health Network of Indiana
Columbus Regional Health
Community Physicians of Indiana
HealthNet
Health & Hospital Corporation of
Marion County
Indiana University Health
St. Vincent Medical Group

ENVOLVE DENTAL, INC.

ANTWAN PEREZ-ALVAREZ

Antwan.Perez-Alvarez@EnvolveHealth.com
Tyneshia James
Tyneshia.James@EnvolveHealth.com
Dental Provider Services: 1-855-609-5157
Questions: ProviderRelations@EnvolveHealth.com

ENVOLVE VISION, INC.

CHANTEL MCKINNEY

Chantel.McKinney@EnvolveHealth.com
Yojani Benitez
Yojani.Benitez@EnvolveHealth.com
Vision Provider Services: 1-844-820-6523
Questions: Envolve_AdvancedCaseUnit@EnvolveHealth.com

Network Leadership

NETWORK LEADERSHIP

JILL CLAYPOOL

Vice President, Network
Development & Contracting
1-877-647-4848 ext. 20855
jill.e.claypool@mhsindiana.com

NANCY ROBINSON

Senior Director, Provider Network
1-877-647-4848 ext. 20180
nrobinson@mhsindiana.com

MARK VONDERHEIT

Director, Provider Network
1-877-647-4848 Ext. 20240
mvonderheit@mhsindiana.com

NEW PROVIDER CONTRACTING

TIM BALKO

Director, Network Development & Contracting
1-877-647-4848 ext. 20120
tbalko@mhsindiana.com

MICHAEL FUNK

Manager, Network Development & Contracting
1-877-647-4848 ext. 20017
michael.j.funk@mhsindiana.com

NETWORK OPERATIONS

KELVIN ORR

Director, Network Operations
1-877-647-4848 ext. 20049
kelvin.d.orr@mhsindiana.com

Questions?

**Thank you for being our
partner in care.**