Claims UB-04
2024 IHCP Works Annual Seminar

Agenda

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

MHS Overview

Who is MHS?

- Managed Health Services (MHS) is a health insurance provider that has been proudly serving Indiana residents for more than 25 years through Hoosier Healthwise, the Healthy Indiana Plan (HIP) and Hoosier Care Connect.

- MHS is your choice for better healthcare.

MHS Products

Claim Submission Process

Medical Claim Submission

- Electronic Data Interchange Submission
  - Preferred method of claims submission
  - Faster and less expensive than paper submission
  - MHS Electronic Payor ID **68069**
- Online through the **MHS Secure Provider Portal**
- 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**
  - Payor ID **68068**
  - MHS accepts Third Party Liability (TPL) information via Electronic Data Interchange
  - It is the responsibility of the provider to review the error reports received from the Clearinghouse (Payor Reject Report)
- Online through the **MHS Secure Provider 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

The National Provider Identifier (NPI), Tax ID, 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.

- Member Information
  - Newborn's Member ID is required for payment
- Attachment Forms
  - Required forms need to accompany the claim form
- Secondary Claims (TPL)
  - Accepted electronically from vendors or via the MHS Secure Provider 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:

- 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 insurance Explanation of Benefits.
- If primary insurance Explanation of Payment (EOP) is received after the 365 calendar days, providers have 60 calendar days from date of primary insurance 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 insurance.

Claim Submission (continued)

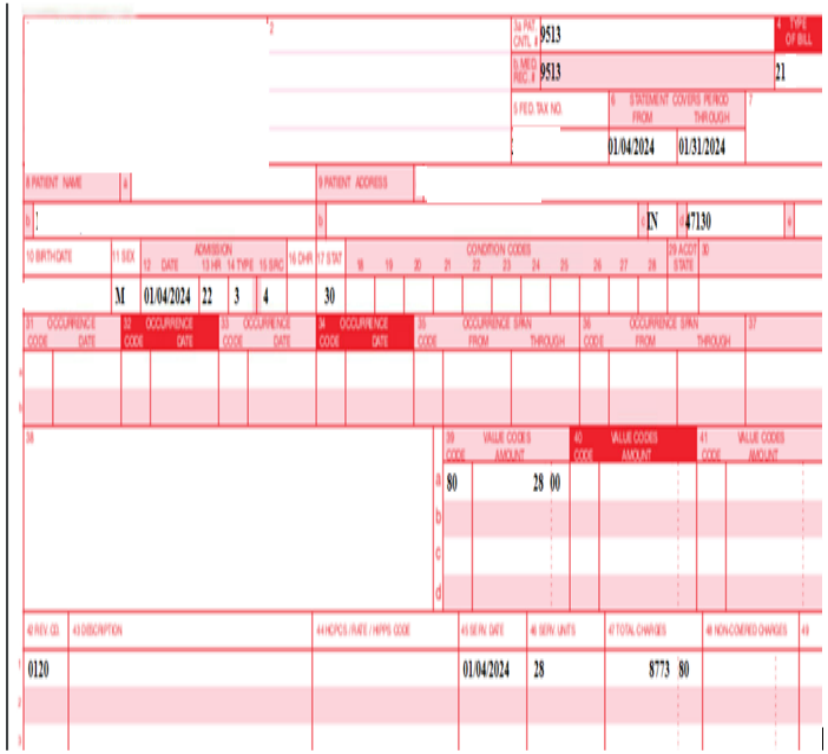
Claim Acceptance and Adjudication

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

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

- A rejection is an unclean claim that contains invalid or missing data elements required for acceptance of the claim in the claim process system.
- Rejected claims need to be corrected and submitted as a new claim.
- Timely filing is not substantiated when a claim is rejected.
- EDI rejections require the provider to contact their clearinghouse and obtain a payer rejection report.

MHS Provider Claims Issue Resolution Process

Provider Claims Issue Resolution

- 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.

Medical and Behavioral Health Addresses

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

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).
- May be submitted via the Secure Web Portal within 60 calendar days of the MHS EOP date.
  - Requests received after day 60 will not be considered.

Informal Claims Dispute (continued)

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).

Formal Claim Dispute - Administrative Claim Appeal

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.
- An administrative claim appeal must be submitted via the Secure Portal with an explanation including any specific details which may justify reconsideration of the disputed claim. The appeal clearly marked as Level 2.
- Click here for the MHS Provider Manual to view Chapter 5 Claims Administrative Reviews and Appeals for more information.

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
  550 N. Meridian Street, Suite 101
  Indianapolis, IN 46204
- Arbitration decisions are all final attempts at getting the claim reconsidered for payment.
- Click here for the MHS Provider Manual Chapter 5 Claims Administrative Reviews and Appeals for more information.

Provider Services Phone Requests & Web Portal Inquiries

- After the informal claims dispute has been submitted, for assistance or questions, the provider can access the Provider Service phone line or Web 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 a.m. to 8 p.m. EST
- Provider Web Portal

Informal Claims Dispute

Helpful tips:

- Disputing multiple claim denials:
  - Submit separate informal claim dispute for each member/patient experiencing the denial.
  - Provide additional information such as:
    - The MHS denial code and description found on the EOP/remit.
    - 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.

Additional Claim Assistance

Provider Relations 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 portal, please contact the Provider Relations team 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 Partnership Associate directly as this may delay the time in getting a response.

Provider Relations Regional Mailboxes

Helpful Tips:

Please submit the following information to the provider relations regional mailbox (attach spreadsheet if multiple claims but below fields must be included):

- Issue Reference Number(s)
- TIN
- Group/Facility Name
- Practitioner Name and NPI
- Member Name and MID Number
- Product (Medicaid/Ambetter/Allwell)
- Claim Number(s)
- DOS or DOS Range if multiple denials
- Related Prior Authorization Numbers (this is key if issue involves claims denied for no authorization)
- Provider reason for dispute

Provider Relations Regional Mailboxes (continued).

Regional Mailboxes

- Northeast Region: MHS_ProviderRelations_NE@mhsindiana.com
- North Central Region: MHS_ProviderRelations_NC@mhsindiana.com
- Central Region: MHS_ProviderRelations_C@mhsindiana.com
- Northwest Region: MHS_ProviderRelations_NW@mhsindiana.com
- Southwest Region: MHS_ProviderRelations_SW@mhsindiana.com
- Southeast Region: MHS_ProviderRelations_SE@mhsindiana.com
- South Central Region: MHS_ProviderRelations_SC@mhsindiana.com
- Tier 1 Providers: IndyProvRelations@mhsindiana.com

Provider Services Phone Requests & Web Portal Inquiries

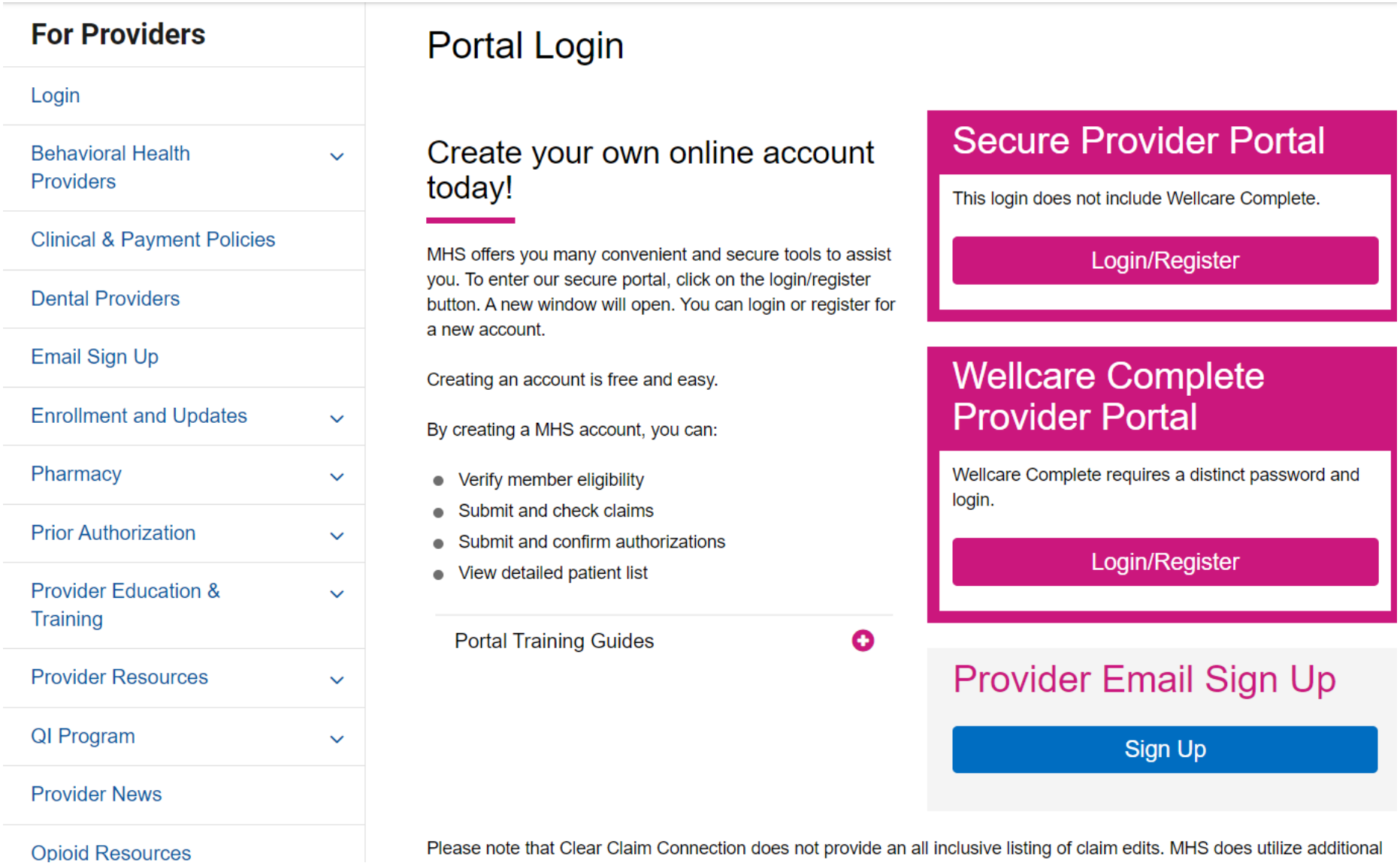
Helpful Tips:

Disputing multiple claim denials:

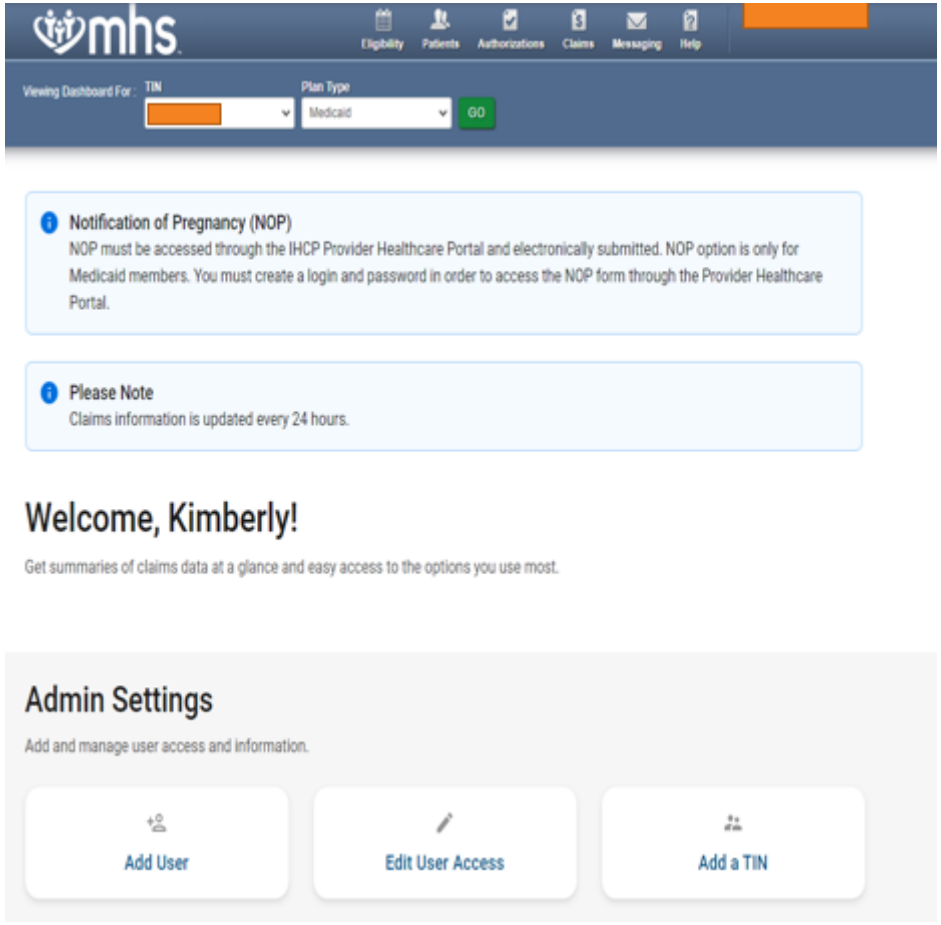
- Provide the provider services rep or web portal team member with one claim number as an example of the specific denial. Communication is key!
- Inform the rep you have a “claims research request” to review all claims for the specific denial reason.
- State if this denial is happening for one or multiple practitioners within your group or clinic (if multiple, provide your TIN).
- Provide the MHS denial code and description found on the EOP.
- Briefly describe why you are disputing this denial or seeking research.

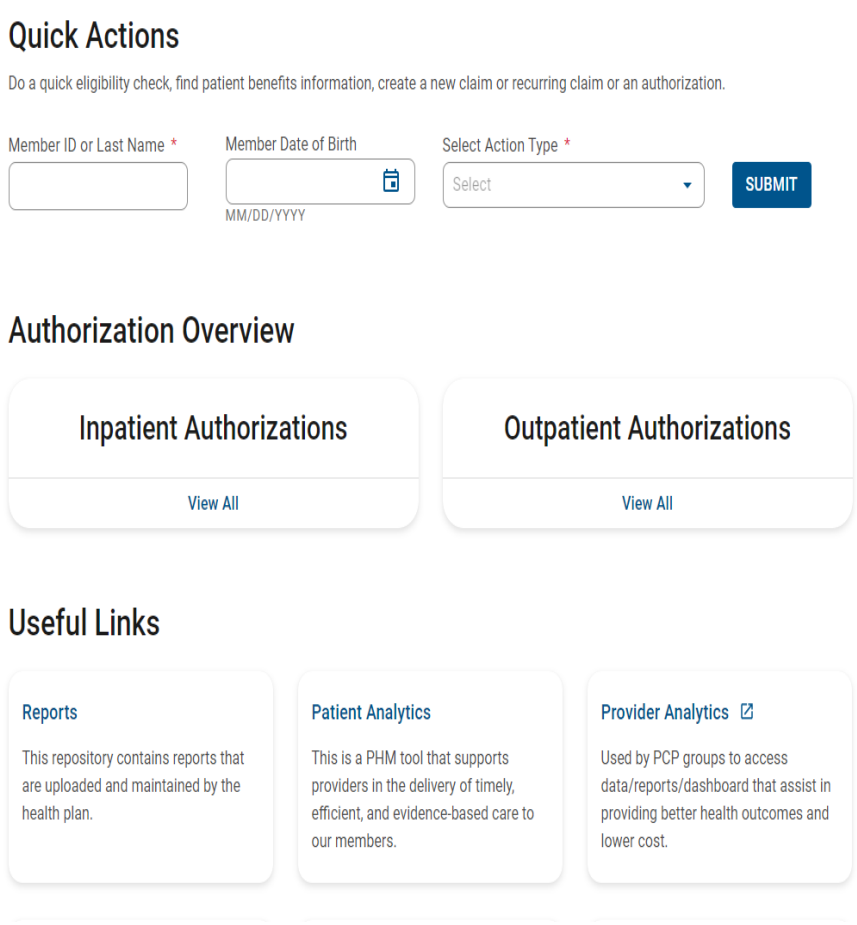
Portal Functionality

Secure Web Portal Login or Registration



Homepage-MHS (Medicaid)





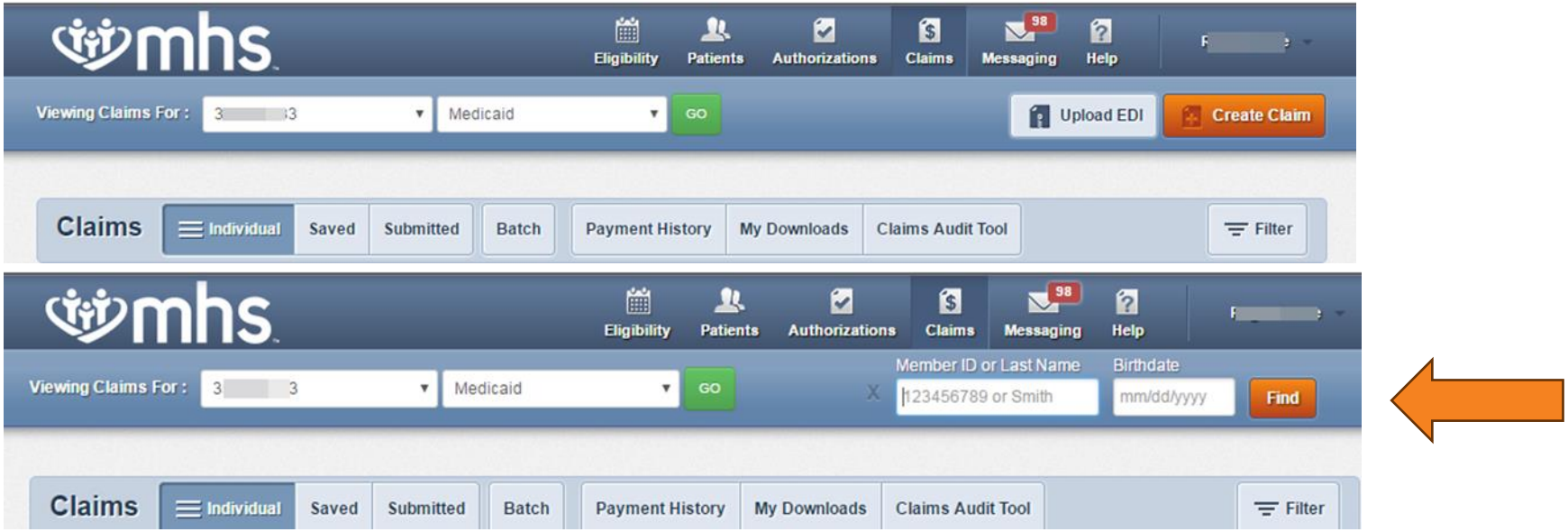
Claims

Web Portal Claims Functionalities

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

Submit a New Claim:

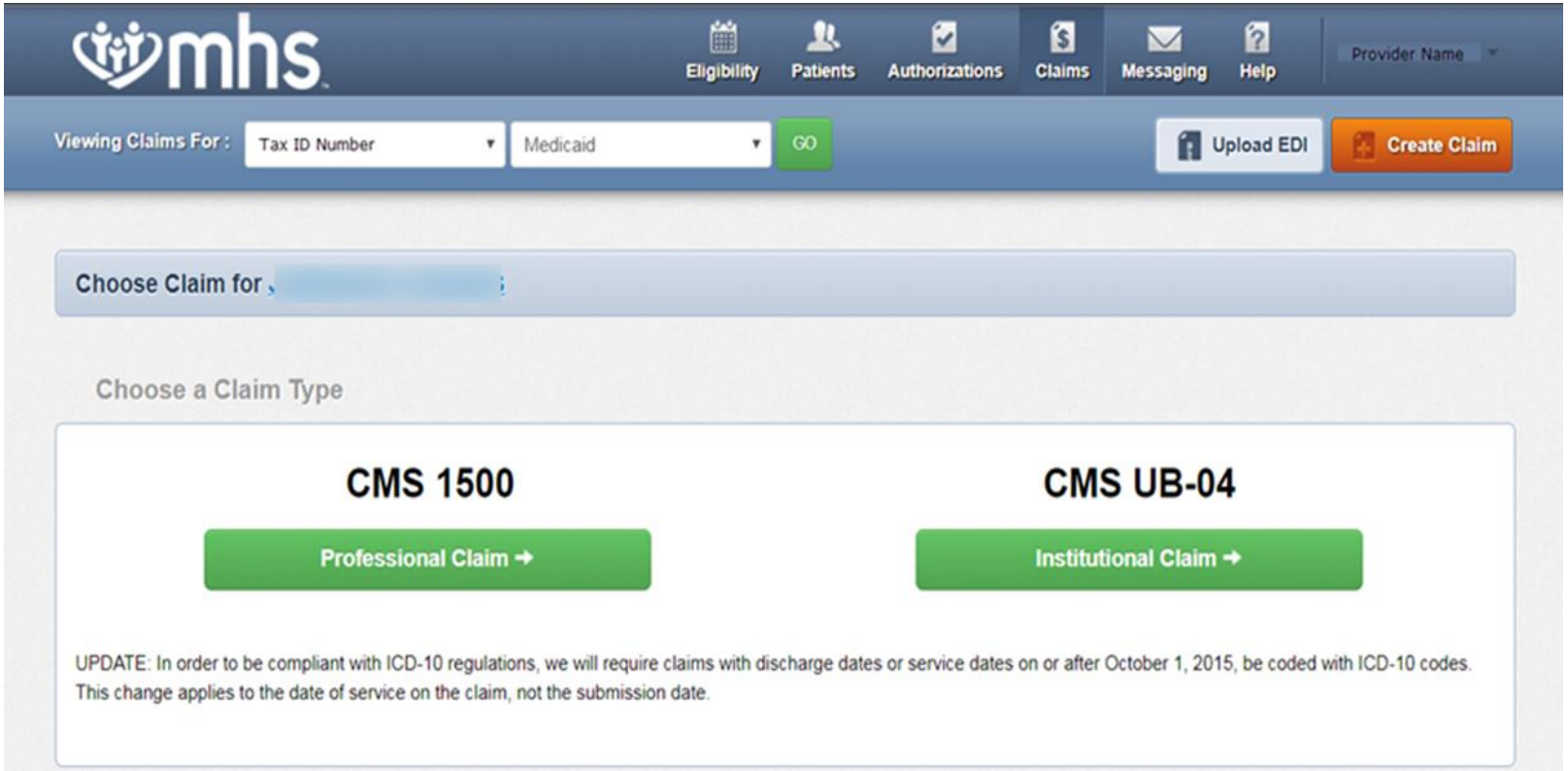
- Click **Create Claim** and enter **Member ID** and **Birthdate**



Claim Submission

Choose the Claim Type

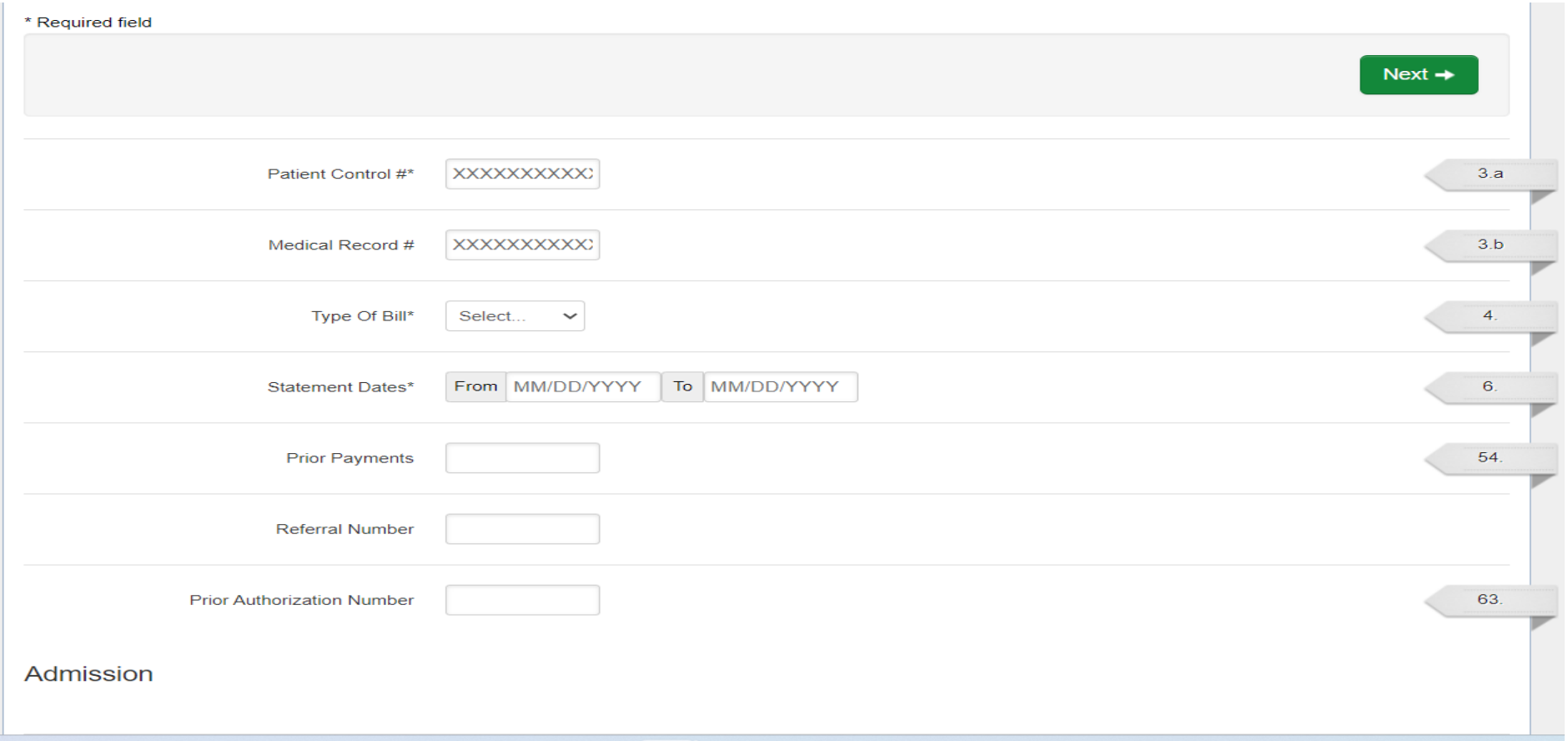
- Professional or Institutional claim submission



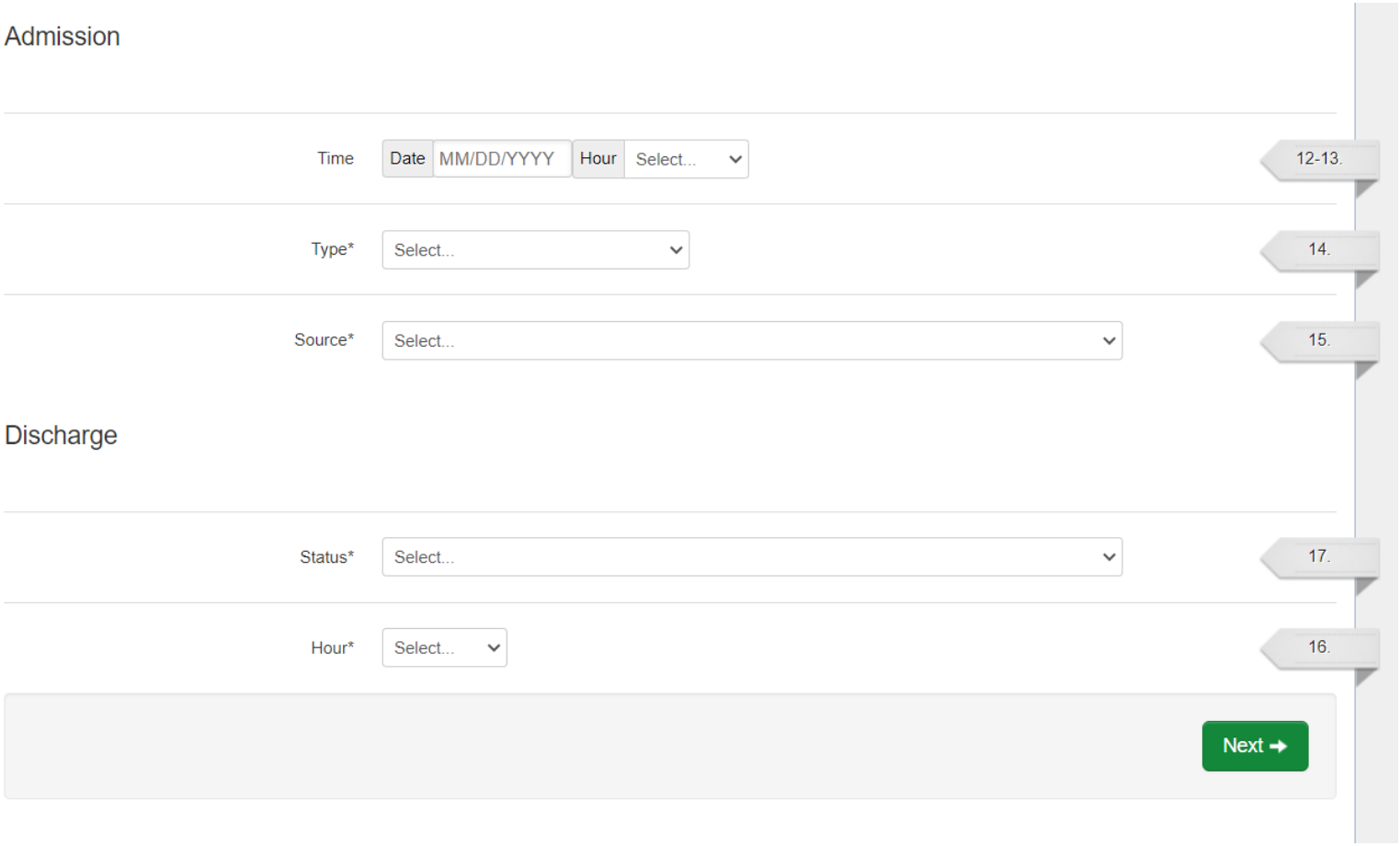
Facility Billing

UB-04 Billing

- In the General Info section, populate the Patient's Control Number and other information related to the patient's condition by typing into the appropriate fields.
- Click Next.

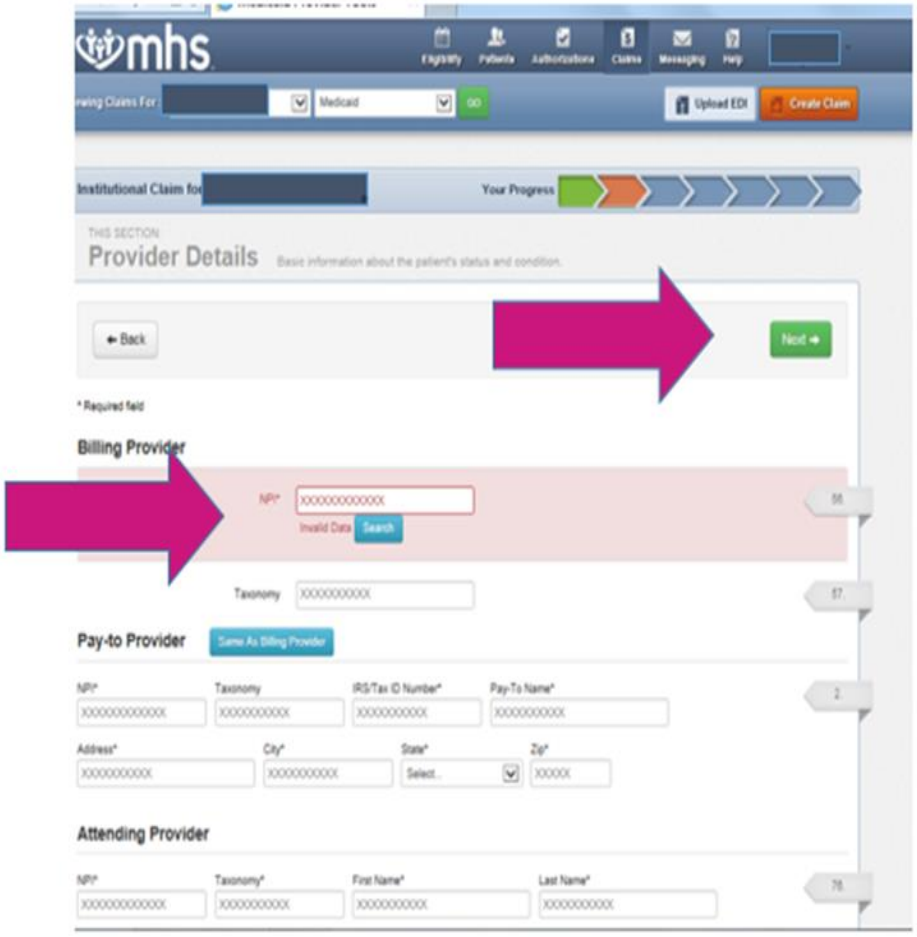


UB-04 Billing (Continued)

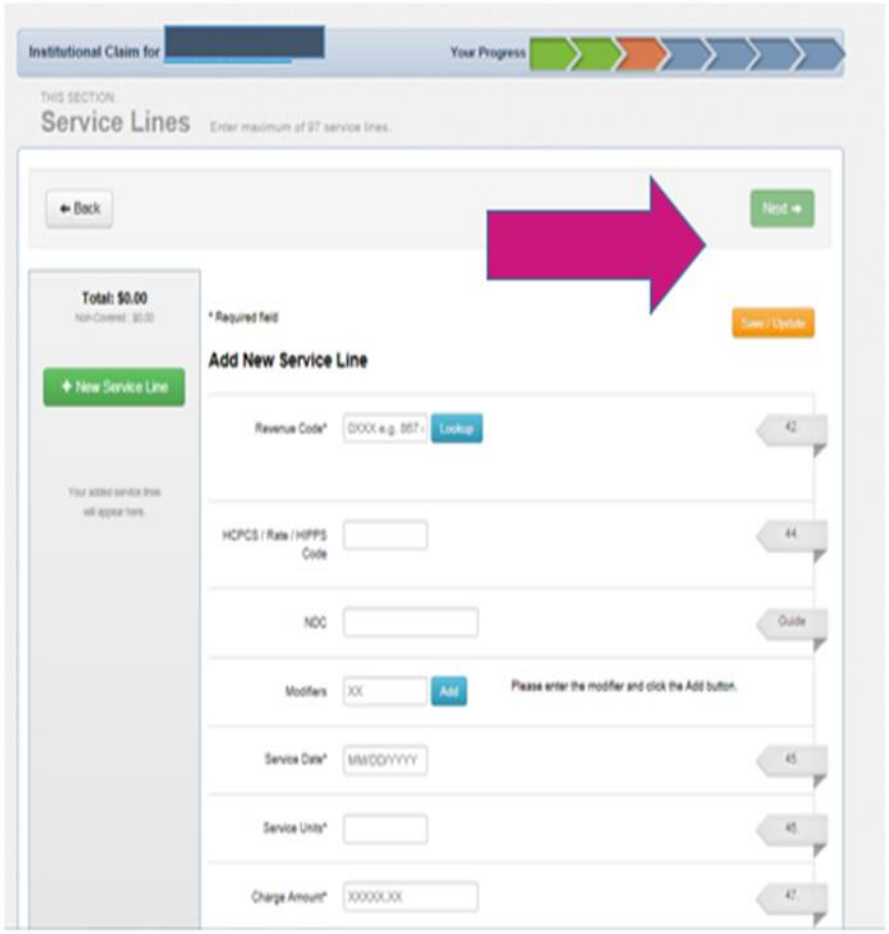


UB-04 Billing (continued)

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

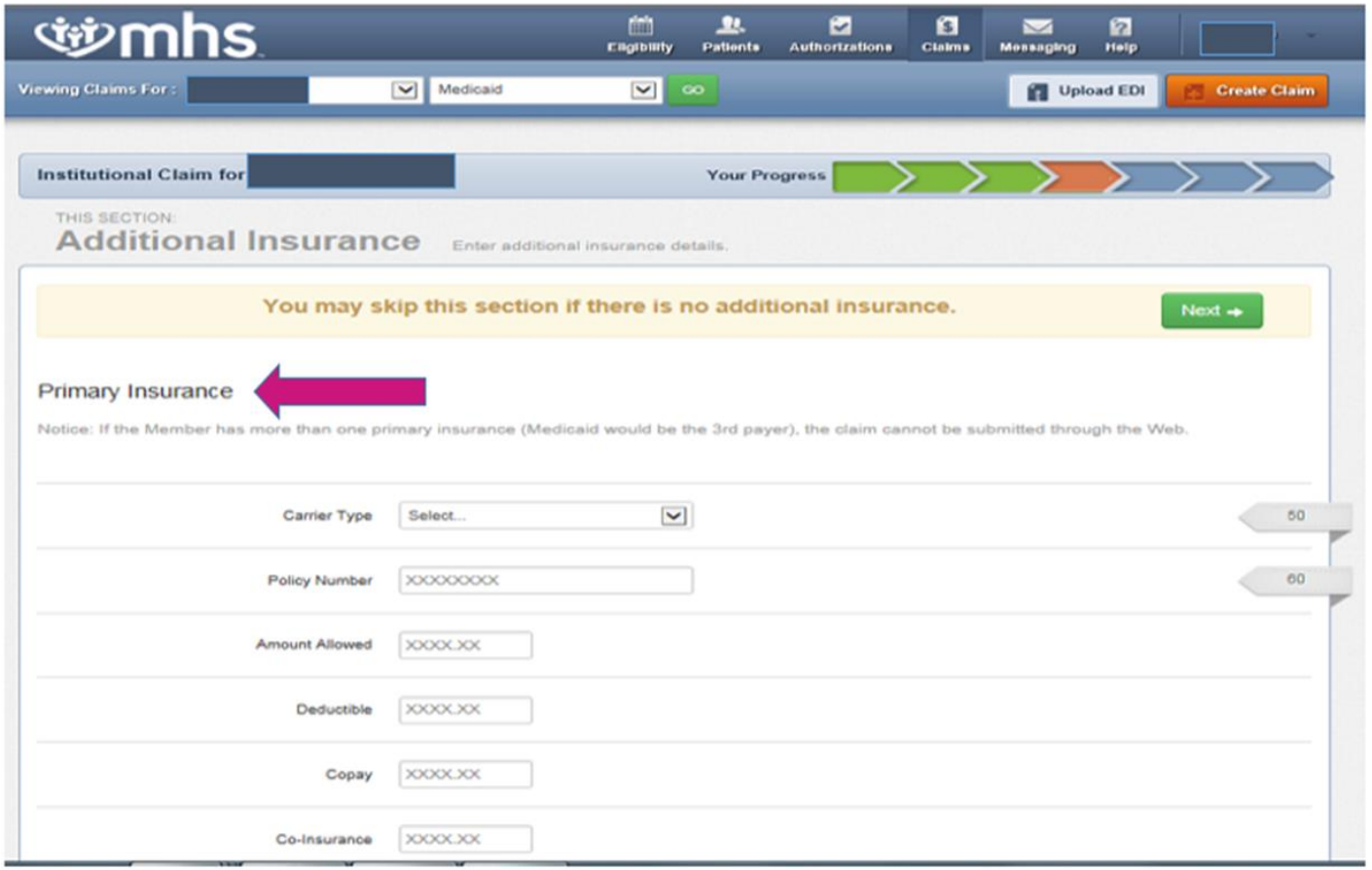


Click **Add New Service Line** and enter the service lines information.

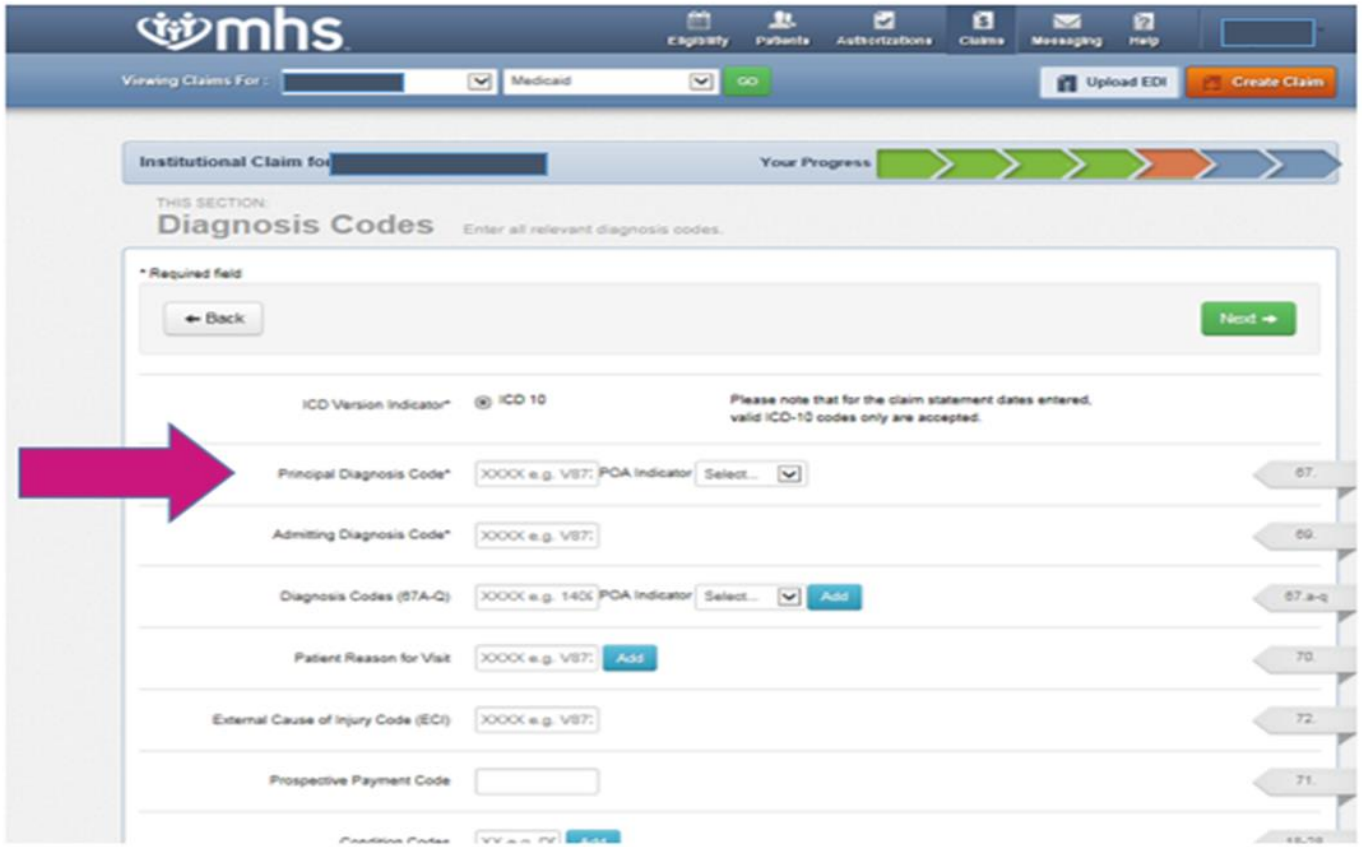


UB-04 Billing (continued)

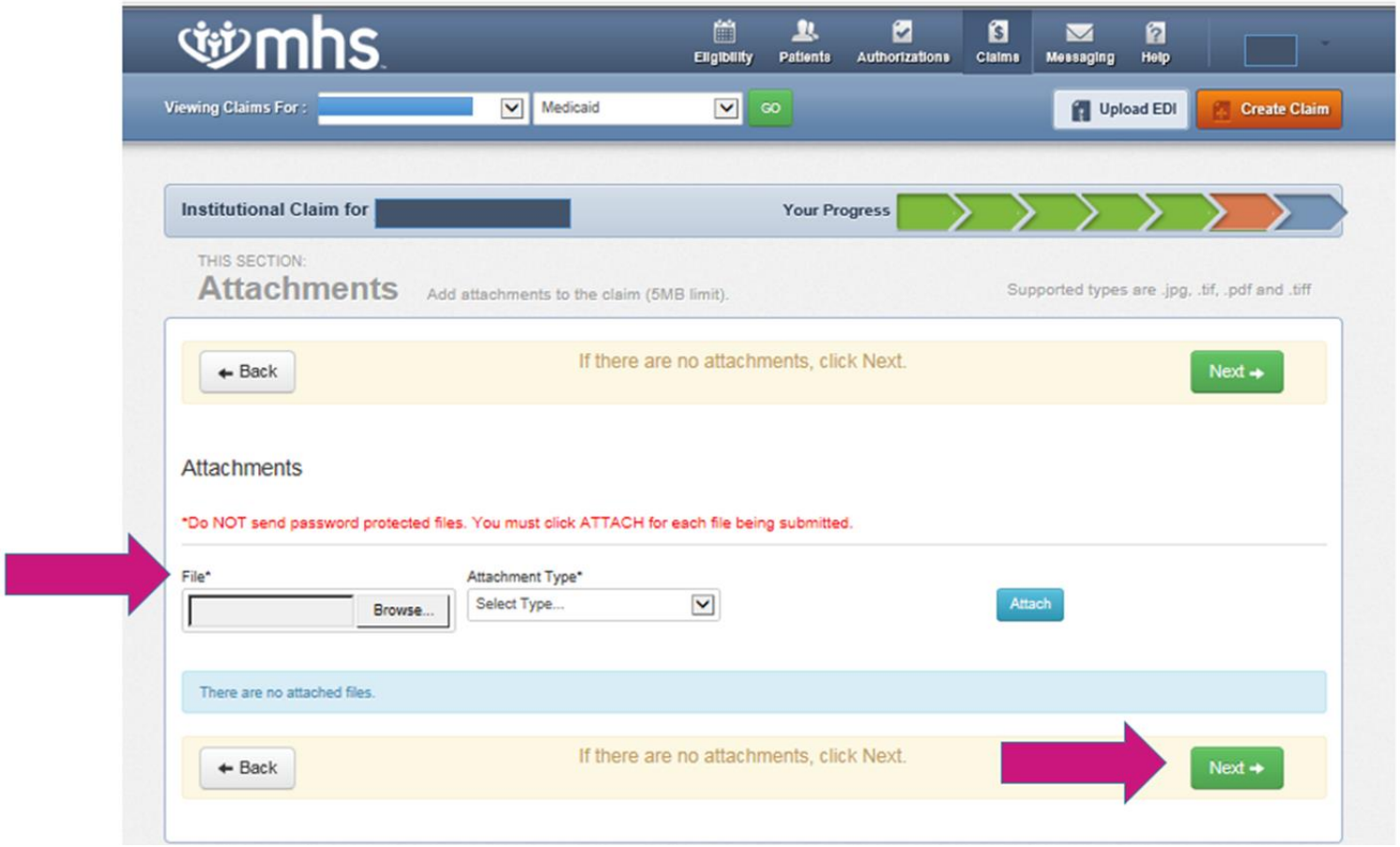
- Enter Additional Insurance (if applicable)



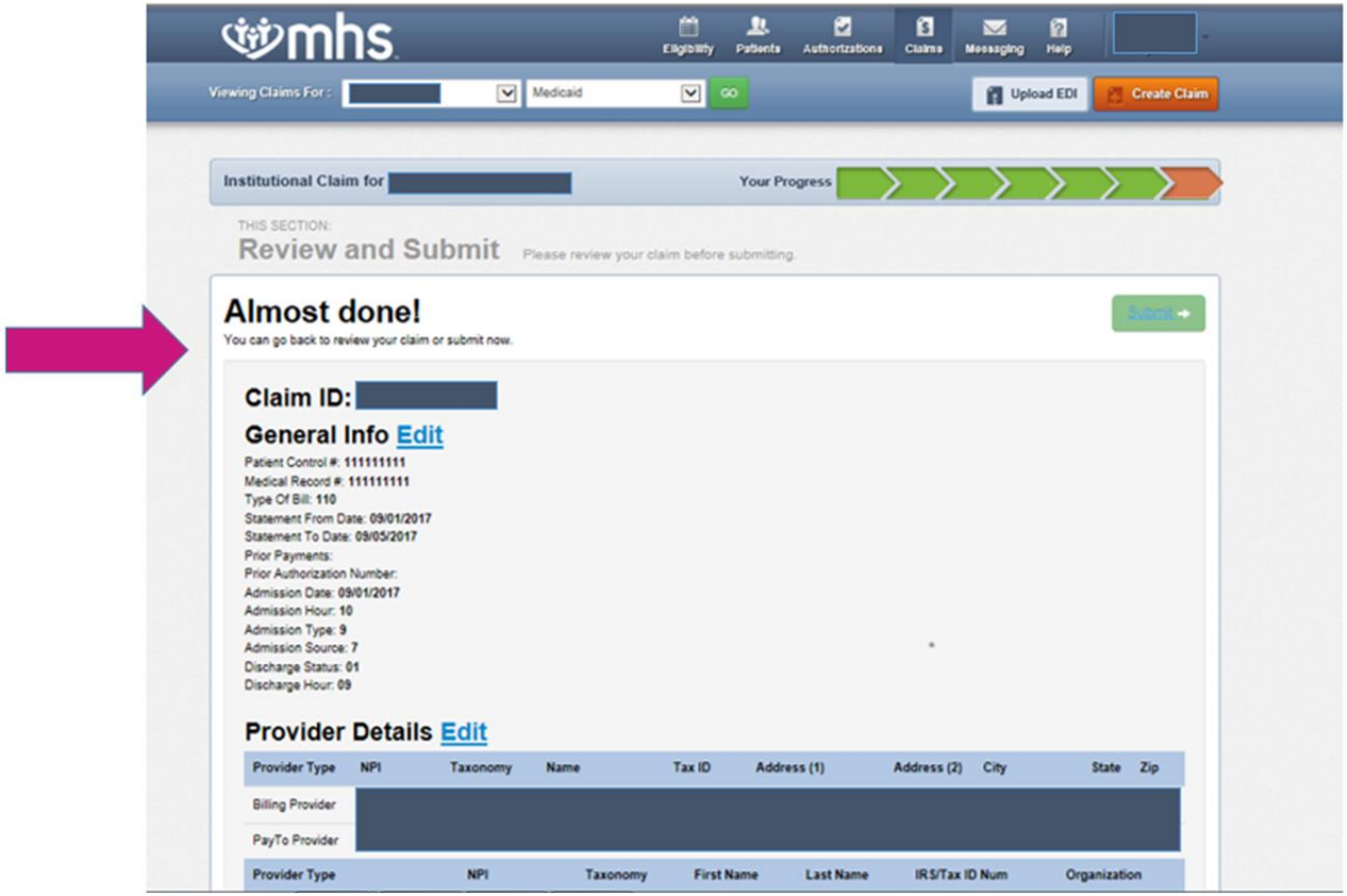
Enter Diagnosis Codes (use Add button) (Continued)



Add Attachment (continued)



Review Claim and Submit

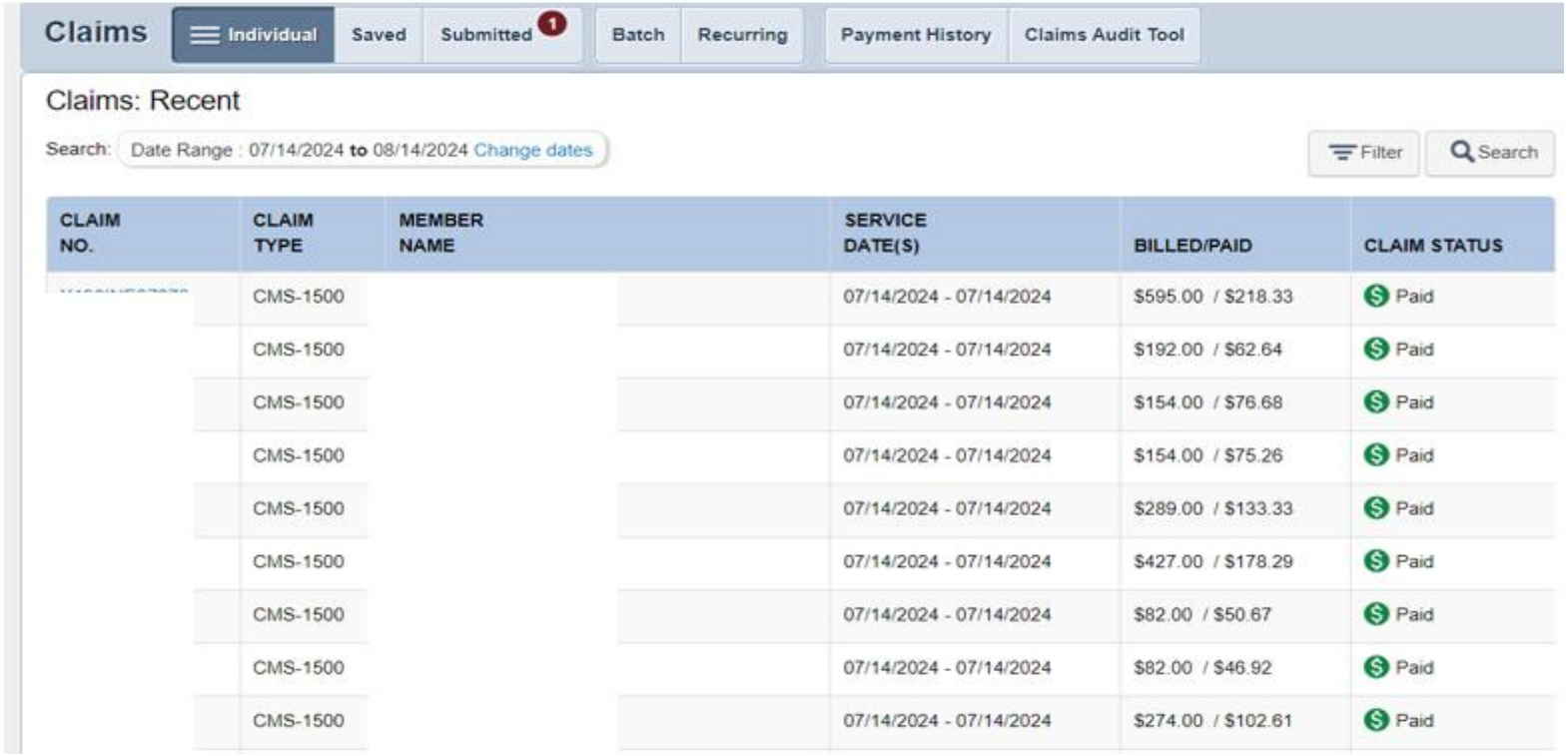


Web Portal Claim and Payment Review

Individual Claims

On the Individual tab, submitted using paper, portal, or clearinghouse:

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



CLAIM NO.	CLAIM TYPE	MEMBER NAME	SERVICE DATE(S)	BILLED/PAID	CLAIM STATUS
	CMS-1500		07/14/2024 - 07/14/2024	$595.00 / $218.33	Paid
	CMS-1500		07/14/2024 - 07/14/2024	$192.00 / $62.64	Paid
	CMS-1500		07/14/2024 - 07/14/2024	$154.00 / $76.68	Paid
	CMS-1500		07/14/2024 - 07/14/2024	$154.00 / $75.26	Paid
	CMS-1500		07/14/2024 - 07/14/2024	$289.00 / $133.33	Paid
	CMS-1500		07/14/2024 - 07/14/2024	$427.00 / $178.29	Paid
	CMS-1500		07/14/2024 - 07/14/2024	$82.00 / $50.67	Paid
	CMS-1500		07/14/2024 - 07/14/2024	$82.00 / $46.92	Paid
	CMS-1500		07/14/2024 - 07/14/2024	$274.00 / $102.61	Paid

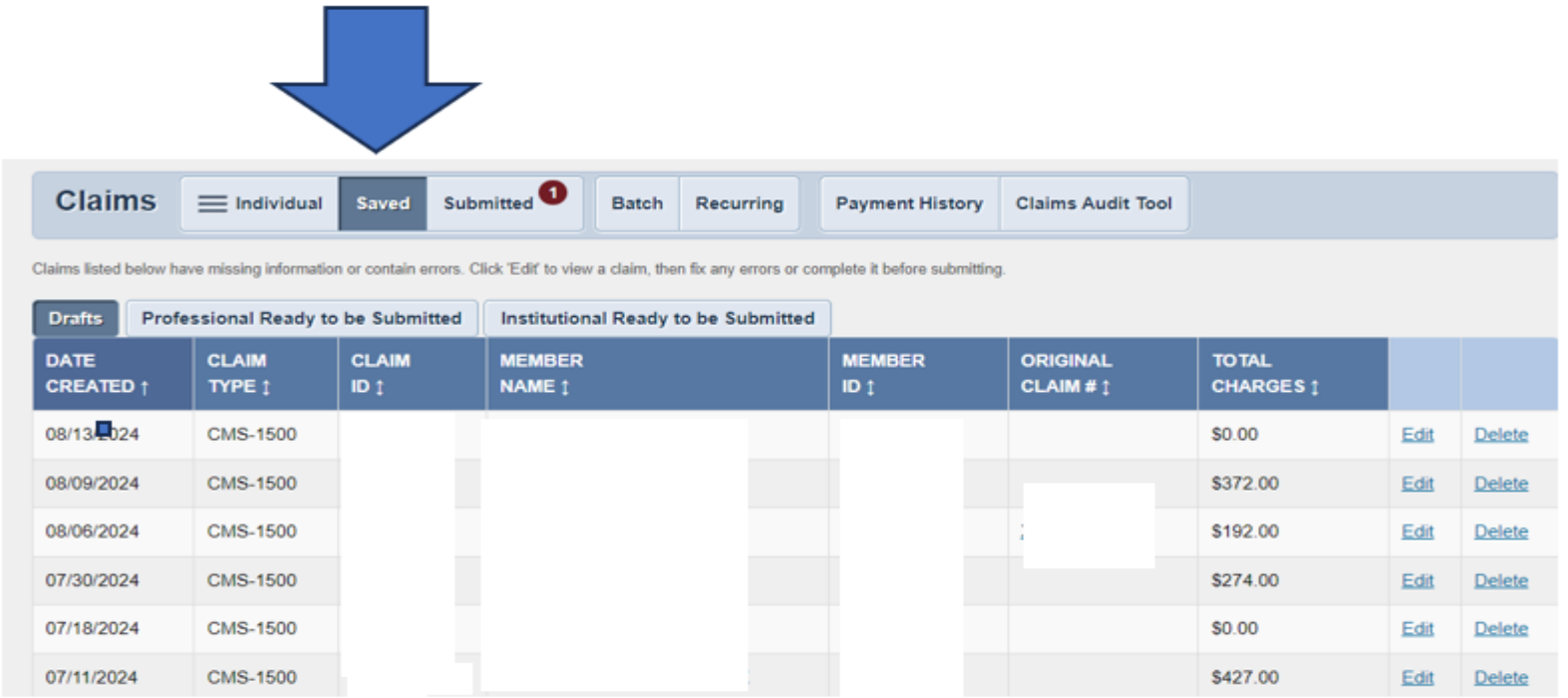
Saved Claims

To view Saved claims: Draft Professional or Institutional:

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

Or

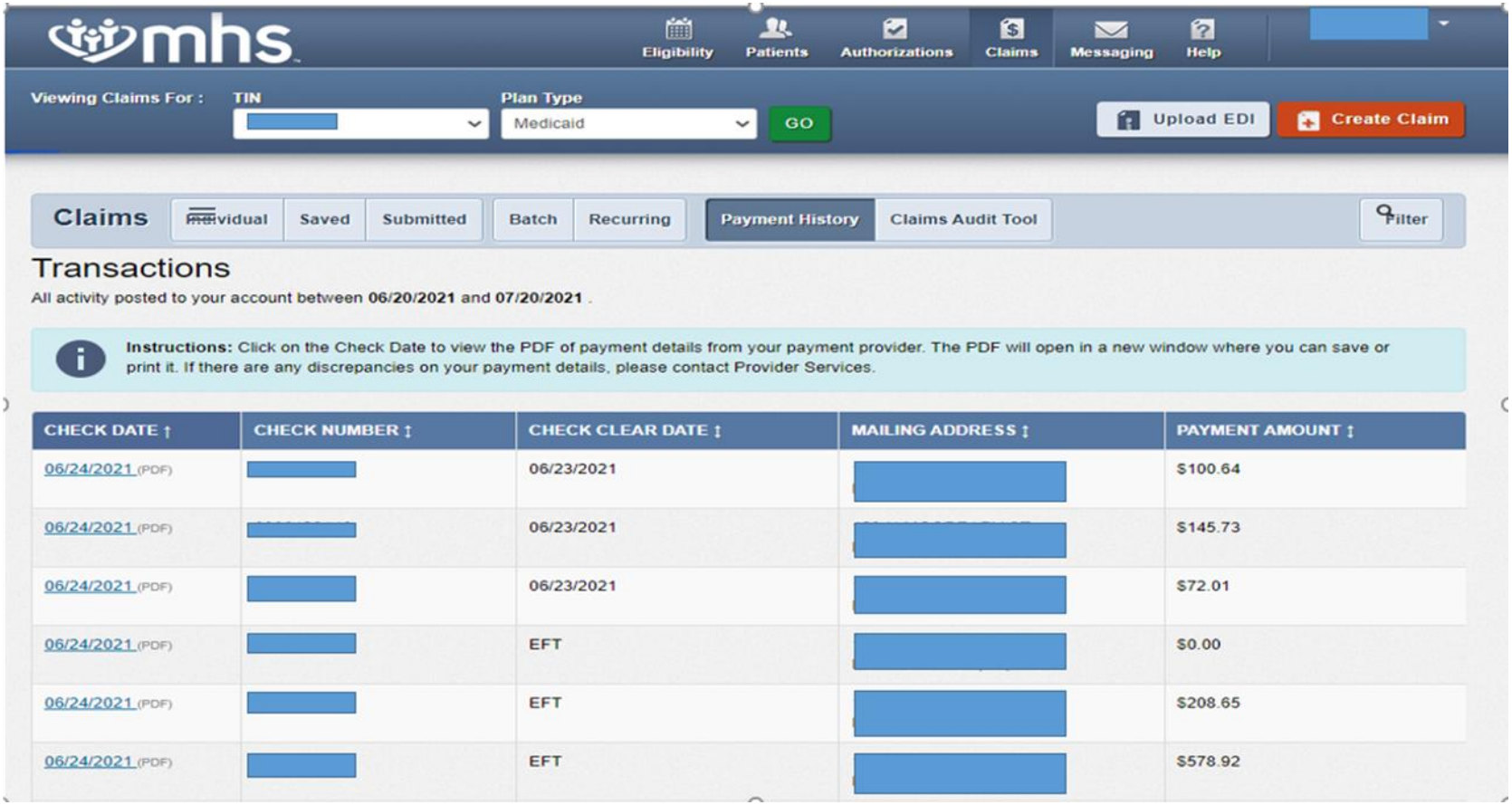
1. Click Delete to delete saved claim that is no longer necessary.
2. Click OK to confirm the deletion.



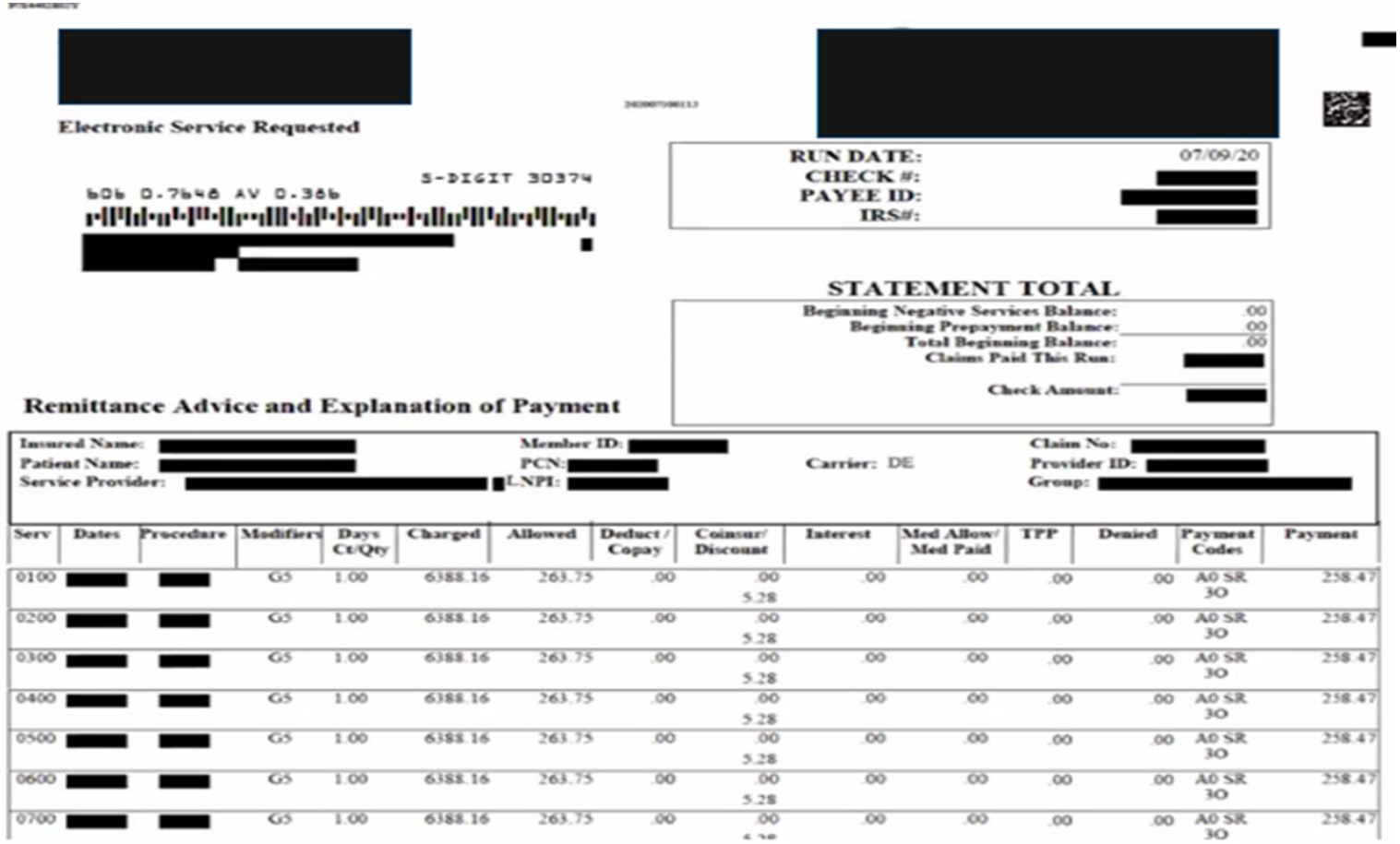
Payment History

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.



Provider Explanation of Payment (EOP)



[redacted]

Electronic Service Requested

[redacted]

5-DIGIT 30374

b0b 0.7b48 AV 0.38b

[redacted]

RUN DATE: 07/09/20
CHECK #: [redacted]
PAYEE ID: [redacted]
IRS#: [redacted]

STATEMENT TOTAL

Beginning Negative Services Balance: .00
Beginning Prepayment Balance: .00
Total Beginning Balance: .00
Claims Paid This Run: [redacted]
Check Amount: [redacted]

Remittance Advice and Explanation of Payment

Insured Name: [redacted]
Patient Name: [redacted]
Service Provider: [redacted]
Member ID: [redacted]
PCN: [redacted]
LNPI: [redacted]
Carrier: DE
Claim No: [redacted]
Provider ID: [redacted]
Group: [redacted]

Serv	Dates	Procedure	Modifiers	Days Ct/Qty	Charged	Allowed	Deduct / Copay	Coinsur/ Discount	Interest	Med Allow/ Med Paid	TPP	Denied	Payment Codes	Payment
0100	[redacted]	[redacted]	G5	1.00	6388.16	263.75	.00	.00 5.28	.00	.00	.00	.00	A0 SR 3O	258.47
0200	[redacted]	[redacted]	G5	1.00	6388.16	263.75	.00	.00 5.28	.00	.00	.00	.00	A0 SR 3O	258.47
0300	[redacted]	[redacted]	G5	1.00	6388.16	263.75	.00	.00 5.28	.00	.00	.00	.00	A0 SR 3O	258.47
0400	[redacted]	[redacted]	G5	1.00	6388.16	263.75	.00	.00 5.28	.00	.00	.00	.00	A0 SR 3O	258.47
0500	[redacted]	[redacted]	G5	1.00	6388.16	263.75	.00	.00 5.28	.00	.00	.00	.00	A0 SR 3O	258.47
0600	[redacted]	[redacted]	G5	1.00	6388.16	263.75	.00	.00 5.28	.00	.00	.00	.00	A0 SR 3O	258.47
0700	[redacted]	[redacted]	G5	1.00	6388.16	263.75	.00	.00	.00	.00	.00	.00	A0 SR 3O	258.47

EFT and ERAs

PaySpan Health

Web based solution for:

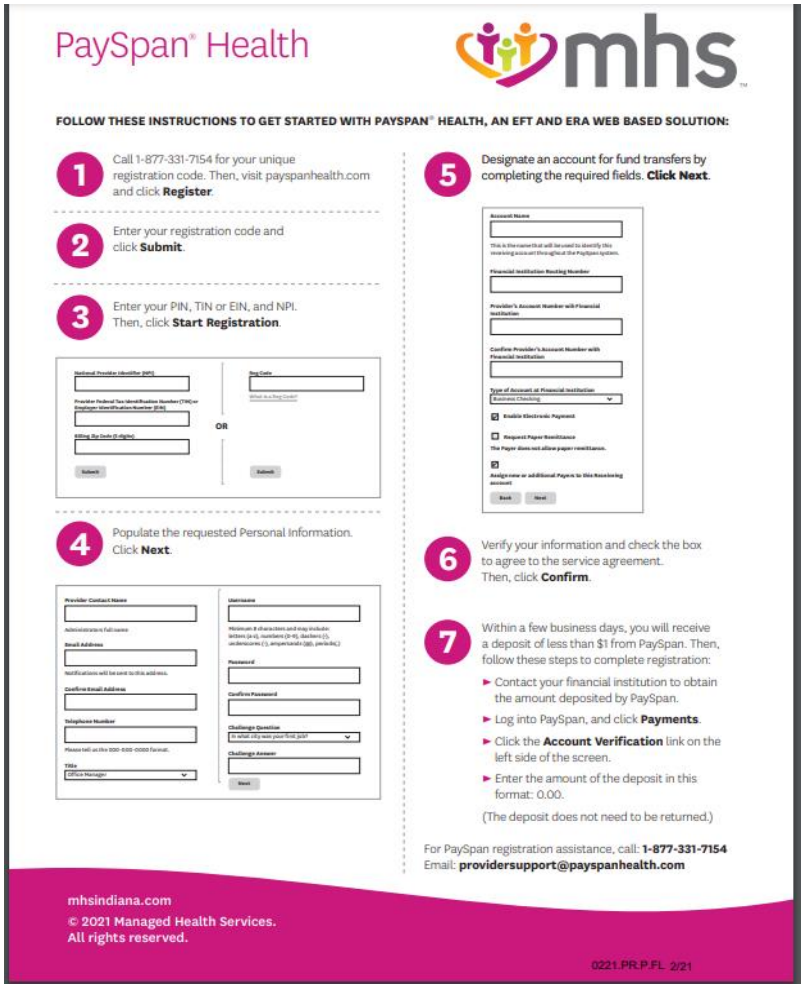
- Electronic Funds.
- Transfers (EFTs) and Electronic Remittance Advices (ERAs).

One year retrieval of remittance advice.

Provided at no cost to providers and allows online enrollment.

Register at [Payspan | Healthcare Payment Reimbursement Solutions](#).

For questions call 1-877-331-7154.



Tips to Remember

- Clicking on items (claim numbers, check numbers, or dates) that are highlighted blue will reveal additional information.
- When filtering to find a claim or payment history, only a 30-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.
- In order 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 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.
- Providers may also view status online.

Online Reconsiderations

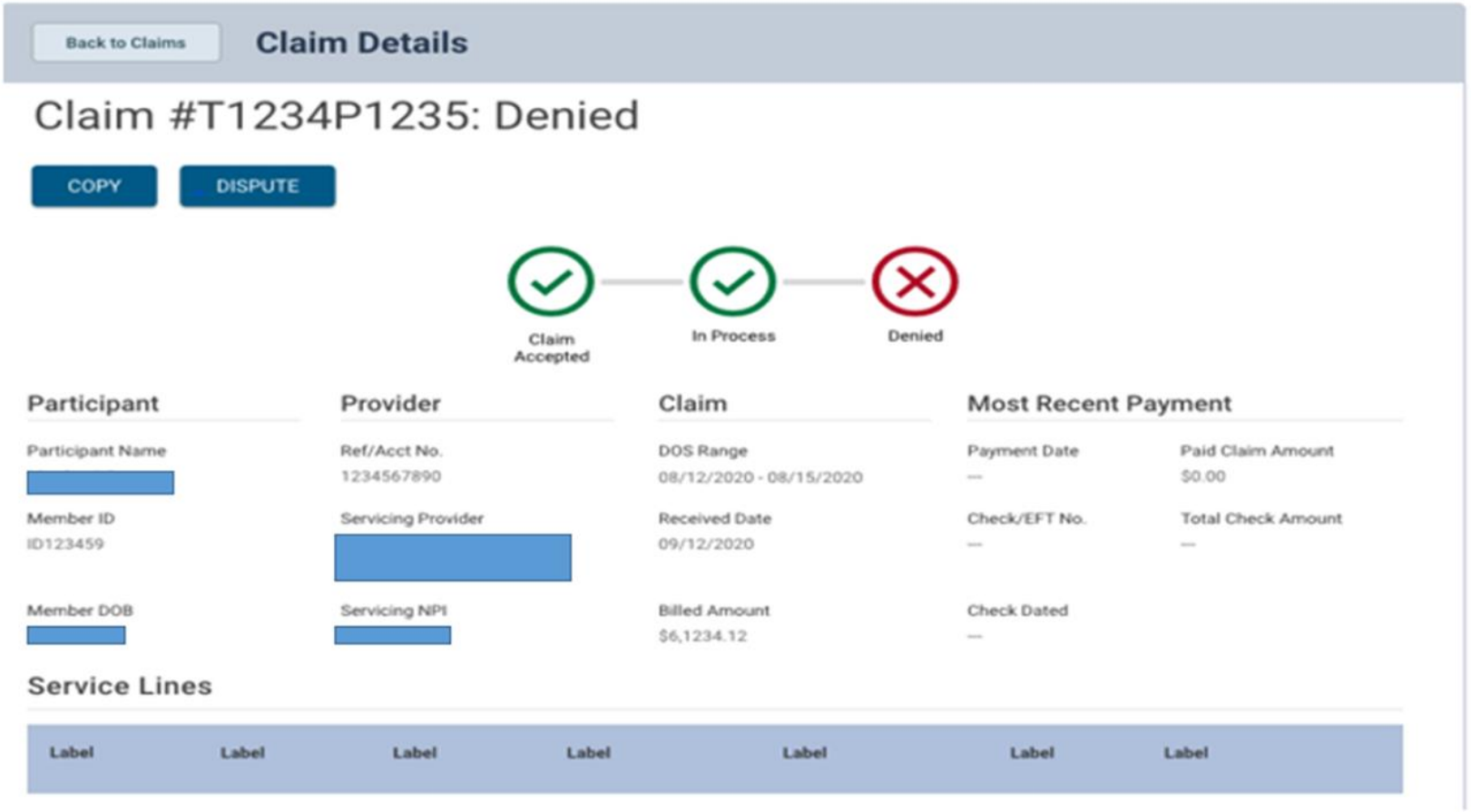
Providers are able to:

- Submit informal disputes/reconsiderations on the secure portal.
- Upload/view supporting documents.
- View acknowledgement letters.
- Track real time updates.
- View denial code information.

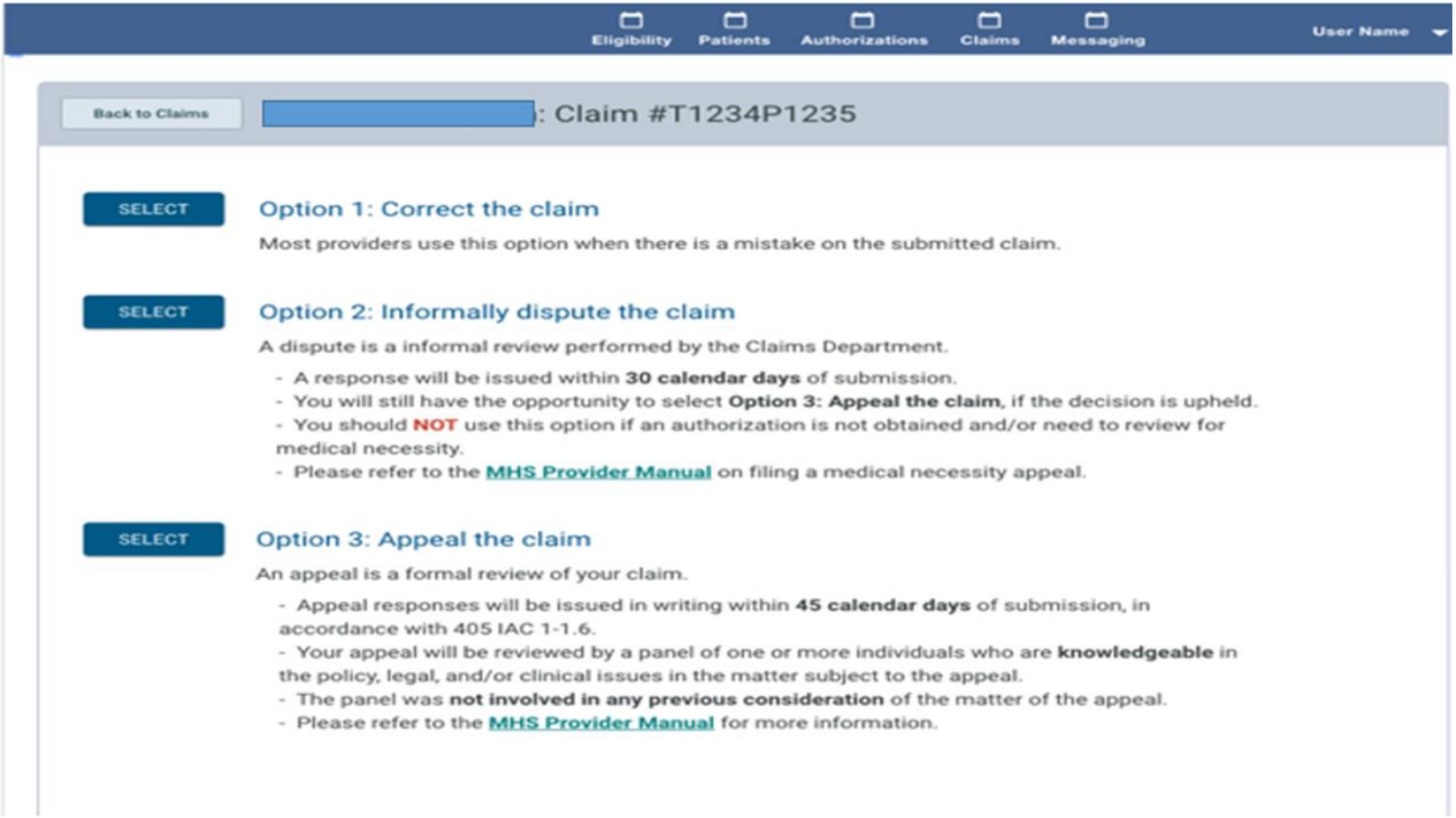
Online Reconsiderations (continued)

- It is important to note that all requests submitted via the online Portal for Level 1 will be considered an informal dispute. Secure messages are not considered reconsiderations/appeals.
- Calling 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 portal.

Level 1 Informal Claim Dispute and Level 2 Claim Appeals on the Secure Provider Portal

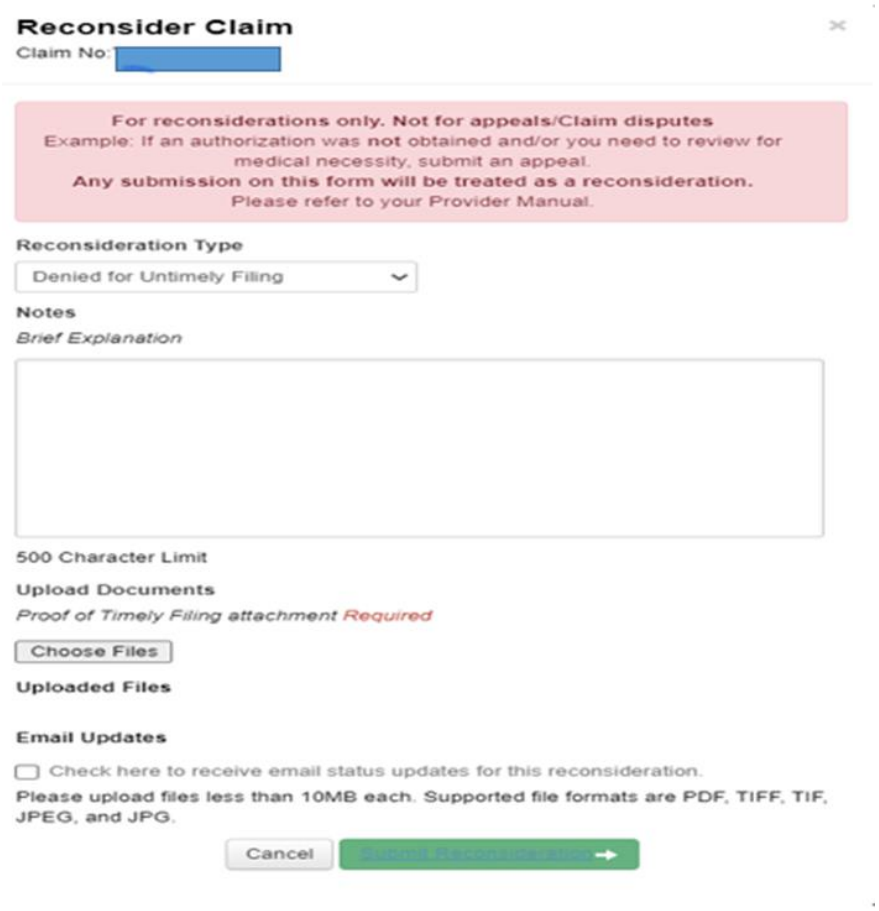


Level 1 Informal Claim Dispute and Level 2 Claim Appeals on the Secure Provider Portal (Continued)

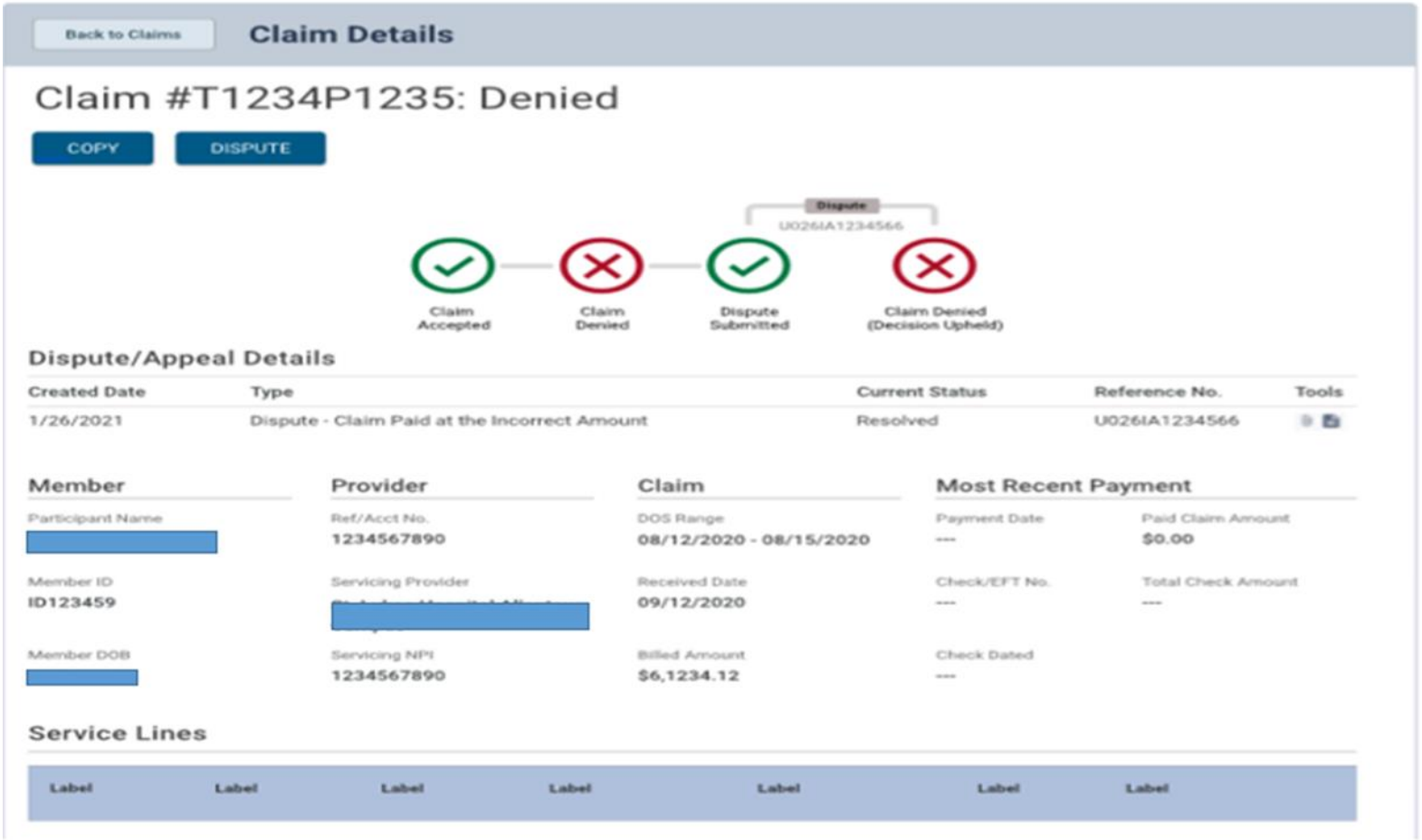


Claim Reconsiderations

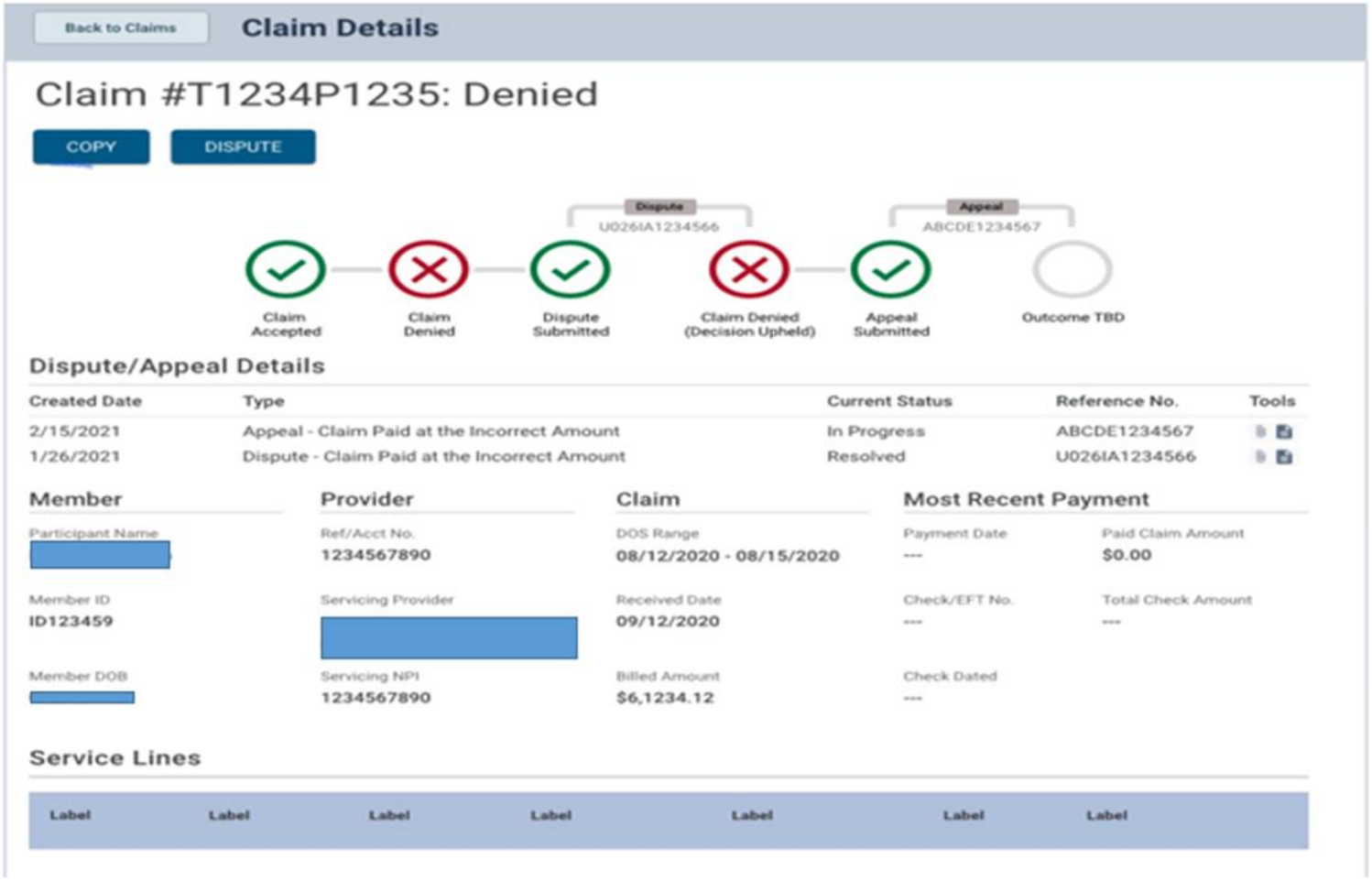
Enter your explanation for reconsideration and check email updates.



Level 1 Informal Claim Dispute and Level 2 Claim Appeals on the Secure Provider Portal

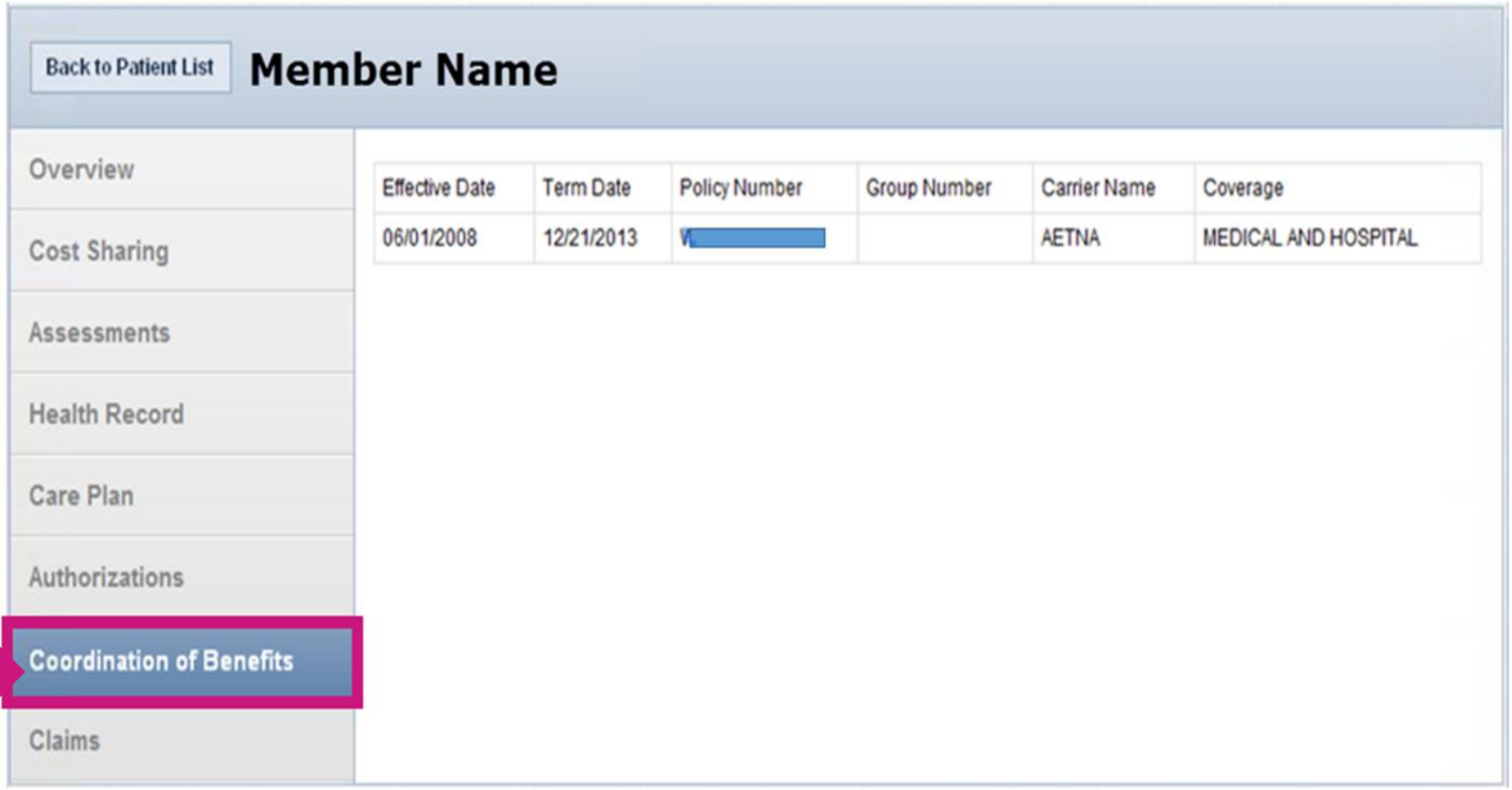


Level 1 Informal Claim Dispute and Level 2 Claim Appeals on the Secure Provider Portal (continued)



Coordination of Benefits

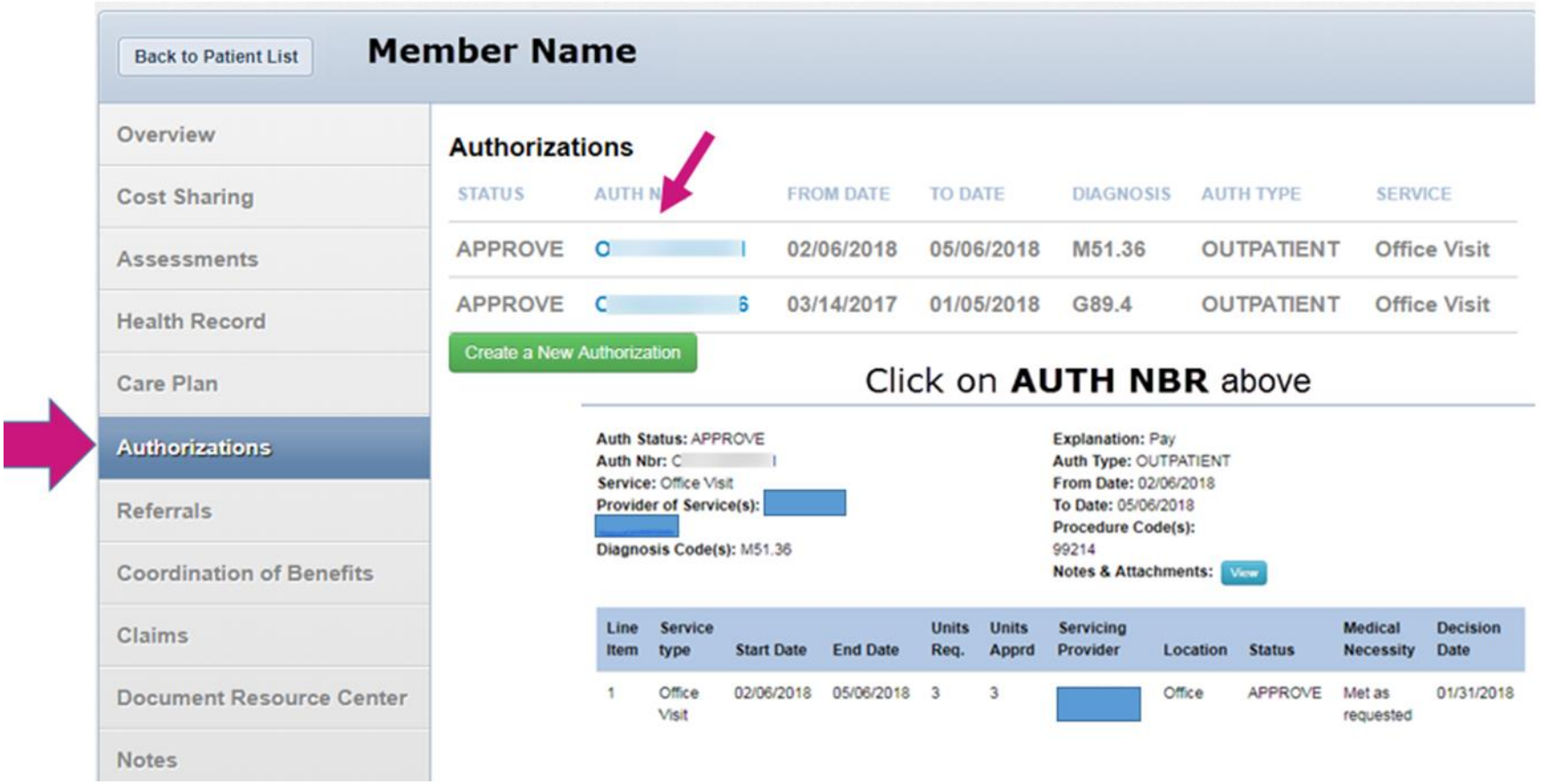
This screen shows if a member has other insurance.



Prior Authorization

Authorizations

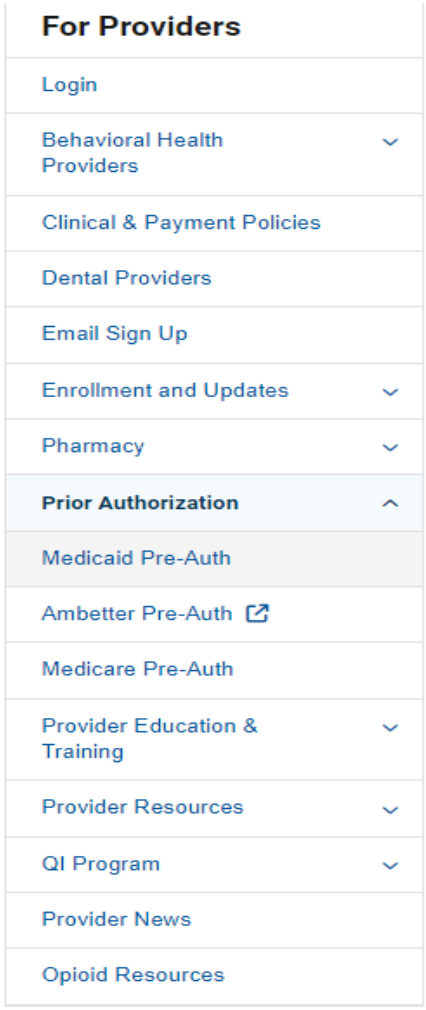
View previously submitted or Create a New Authorization.



Authorization Considerations

- **Need to know what requires authorization:**
  - Pre-Authorization tool
- **How to obtain authorization:**
  - Online: https://www.mhsindiana.com/providers/prior-authorization.html
  - Phone: 1-877-647-4848
  - Fax: 1-866-912-4245
- **Authorizations do not guarantee payment.**

Prior Authorization



Medicaid Pre-Auth

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.
Dental services need to be verified by Envolve Dental.
Ambulance and Transportation services need to be verified by LCP Transportation.
Musculoskeletal services need to be verified by Evolent.
Complex imaging, MRA, MRI, PET, CT scans, PT, ST, OT and Pain Management need to be verified by Evolent.

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 anesthesia services being rendered for pain management?	○	◉
Are services for infertility?	○	◉

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

Enter Service Code | CHECK FOR PRE-AUTH

To submit a prior authorization Login Here.

2023 30 Most Frequently Submitted CPT Codes (PDF)

MHS Provider Engagement Team

MHS Team

MHS Provider Network Territories

NORTHEAST REGION
For claims issues, email:
MHS_ProviderRelations_NE@mhsindiana.com
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ldavis@mhsindiana.com
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DDENNING@mhsindiana.com
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https://www.mhsindiana.com/providers/resources/guides-and-manuals.html

MHS Team (continued)

MHS Provider Network Territories

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PROVIDER GROUPS
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Reid Hospital
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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

https://www.mhsindiana.com/providers/resources/guides-and-manuals.html

Questions?