



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.

										30 PROC. CONT. I	9513	1	TYPE OF BILL																																						
										31 PROC. CONT. II	9513	21																																							
										5 FREQ. TAX NO.		6 STATEMENT COVERED PERIOD FROM	THROUGH																																						
											01.04.2024	01.31.2024																																							
8 PATIENT NAME				9 PATIENT ADDRESS																																															
										15	IN	47130	4																																						
10 BIRTHDATE	11 SEX	12 ADMISSION DATE		13 HR.	14 TIME	15 BKG.	16 CHG.	17 STAT.					18			19			20			21			22			23			24			25			26			27			28			29			30		
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31 OCCURRENCE CODE		32 OCCURRENCE DATE		33 OCCURRENCE CODE		34 OCCURRENCE DATE		35 OCCURRENCE CODE		36 OCCURRENCE DATE		37 OCCURRENCE CODE		38 OCCURRENCE DATE		39 OCCURRENCE CODE		40 OCCURRENCE DATE		41 OCCURRENCE CODE		42 OCCURRENCE DATE		43 OCCURRENCE CODE		44 OCCURRENCE DATE		45 OCCURRENCE CODE		46 OCCURRENCE DATE		47 OCCURRENCE CODE		48 OCCURRENCE DATE		49 OCCURRENCE CODE		50 OCCURRENCE DATE													
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40 REV. CD.		41 DESCRIPTION				42 ICDPCS RATE / HPCS CODE				43 REV. DATE		44 REV. UNITS		45 TOTAL CHARGES		46 NONCOVERED CHARGES		47		48		49		50		51		52		53		54		55		56		57		58											
0120										01.04.2024		28		8773 80																																					

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

For Providers

Login

Behavioral Health Providers

Clinical & Payment Policies

Dental Providers

Email Sign Up

Enrollment and Updates

Pharmacy

Prior Authorization

Provider Education & Training

Provider Resources

QI Program

Provider News

Opioid Resources

Portal Login

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/register button. A new window will open. You can login or register for a new account.

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

Portal Training Guides



Secure Provider Portal

This login does not include Wellcare Complete.

Login/Register

Wellcare Complete Provider Portal

Wellcare Complete requires a distinct password and login.

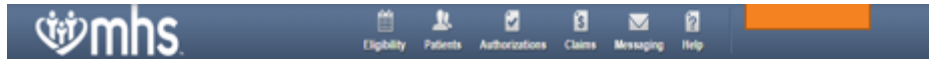
Login/Register

Provider Email Sign Up

Sign Up

Please note that Clear Claim Connection does not provide an all inclusive listing of claim edits. MHS does utilize additional

Homepage-MHS (Medicaid)



Eligibility Patients Authorizations Claims Messaging Help

Viewing Dashboard For: TIN [dropdown] Plan Type [Medicaid] [GO]

Notification of Pregnancy (NOP)
NOP must be accessed through the IHCP Provider Healthcare Portal and electronically submitted. NOP option is only for Medicaid members. You must create a login and password in order to access the NOP form through the Provider Healthcare Portal.

Please Note
Claims Information is updated every 24 hours.

Welcome, Kimberly!

Get summaries of claims data at a glance and easy access to the options you use most.

Admin Settings

Add and manage user access and information.

[Add User](#) [Edit User Access](#) [Add a TIN](#)

Quick Actions

Do a quick eligibility check, find patient benefits information, create a new claim or recurring claim or an authorization.

Member ID or Last Name *

Member Date of Birth  MM/DD/YYYY

Select Action Type *

[SUBMIT](#)

Authorization Overview

Inpatient Authorizations

[View All](#)

Outpatient Authorizations

[View All](#)

Useful Links

[Reports](#)
This repository contains reports that are uploaded and maintained by the health plan.

[Patient Analytics](#)
This is a PHM tool that supports providers in the delivery of timely, efficient, and evidence-based care to our members.

[Provider Analytics](#) 
Used by PCP groups to access data/reports/dashboard that assist in providing better health outcomes and lower cost.

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**

The screenshot displays the mhs web portal interface. At the top, the mhs logo is on the left, and navigation icons for Eligibility, Patients, Authorizations, Claims, Messaging (with a 98 notification), and Help are on the right. Below this, a search bar shows 'Viewing Claims For: 3' and 'Medicaid' with a 'GO' button. To the right of this bar is an 'Upload EDI' button and a prominent orange 'Create Claim' button. A secondary navigation bar below features a 'Claims' menu with options: Individual, Saved, Submitted, Batch, Payment History, My Downloads, Claims Audit Tool, and a Filter button. The bottom section of the page shows a search form with 'Member ID or Last Name' (123456789 or Smith) and 'Birthdate' (mm/dd/yyyy) fields, a 'Find' button, and a red arrow pointing to the 'Find' button.

Claim Submission

Choose the Claim Type

- Professional or Institutional claim submission

The screenshot shows the mhs web application interface. At the top left is the mhs logo. To the right are navigation icons for Eligibility, Patients, Authorizations, Claims, Messaging, and Help, along with a dropdown for Provider Name. Below the navigation bar is a search area with 'Viewing Claims For:' followed by two dropdown menus: 'Tax ID Number' and 'Medicaid', and a green 'GO' button. To the right of this are two buttons: 'Upload EDI' and 'Create Claim'. Below the search area is a light blue bar with the text 'Choose Claim for'. Underneath is the heading 'Choose a Claim Type'. There are two main options, each with a green button: 'CMS 1500 Professional Claim →' and 'CMS UB-04 Institutional Claim →'. At the bottom of the main content area is an update notice: 'UPDATE: In order to be compliant with ICD-10 regulations, we will require claims with discharge dates or service dates on or after October 1, 2015, be coded with ICD-10 codes. This change applies to the date of service on the claim, not the submission date.'

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.

* Required field

[Next →](#)

Patient Control #*

Medical Record #

Type Of Bill*


Statement Dates*

Prior Payments

Referral Number

Prior Authorization Number

Admission



UB-04 Billing (Continued)

Admission

Time MM/DD/YYYY

12-13.

Type*

14.

Source*

15.

Discharge

Status*

17.

Hour*

16.

Next →

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.

The screenshot shows the 'Provider Details' section of the mhs Institutional Claim form. A pink arrow points to the 'Next' button at the top right of the section. Another pink arrow points to the 'Billing Provider' section, which contains a red-bordered input field for the NP# with the value 'XXXXXXXXXXXXXX' and a 'Search' button. Below this are fields for Taxonomy, Pay-to Provider, and Attending Provider information.

The screenshot shows the 'Service Lines' section of the mhs Institutional Claim form. A pink arrow points to the 'Next' button at the top right. The section includes a 'Total: \$0.00' summary, a 'New Service Line' button, and a form for adding a new service line with fields for Revenue Code, HCPCS / Rate / HPPS Code, NDC, Modifiers, Service Date, Service Units, and Charge Amount. A 'Save / Update' button is also visible.

UB-04 Billing (continued)

- Enter Additional Insurance (if applicable)

The screenshot shows the mhs web portal interface. At the top, there is a navigation bar with icons for Eligibility, Patients, Authorizations, Claims, Messaging, and Help. Below this, a header indicates 'Viewing Claims For:' with a dropdown menu set to 'Medicaid' and a 'GO' button. To the right are 'Upload EDI' and 'Create Claim' buttons. The main content area is titled 'Institutional Claim for [redacted]' and includes a 'Your Progress' indicator with a series of arrows. The current section is 'Additional Insurance', with a sub-header 'THIS SECTION: Additional Insurance' and the instruction 'Enter additional insurance details.' A yellow banner states 'You may skip this section if there is no additional insurance.' with a 'Next >' button. Below this, the 'Primary Insurance' section is highlighted with a pink arrow. A notice reads: 'Notice: If the Member has more than one primary insurance (Medicaid would be the 3rd payer), the claim cannot be submitted through the Web.' The form fields include: Carrier Type (dropdown menu), Policy Number (text field with placeholder 'XXXXXXXX'), Amount Allowed (text field with placeholder 'XXXX.XX'), Deductible (text field with placeholder 'XXXX.XX'), Copay (text field with placeholder 'XXXX.XX'), and Co-insurance (text field with placeholder 'XXXX.XX').

Enter Diagnosis Codes (use Add button) (Continued)

The screenshot shows the 'mhs' web application interface. At the top, there is a navigation bar with icons for Eligibility, Patients, Authorizations, Claims, Messaging, and Help. Below this, a header indicates 'Viewing Claims For: [Medicaid]'. A progress bar shows the current step is 'Diagnosis Codes'. The main section is titled 'Diagnosis Codes' with the instruction 'Enter all relevant diagnosis codes.' Below this, there are several input fields:

- ICD Version Indicator***: Set to 'ICD 10'. A note states: 'Please note that for the claim statement dates entered, valid ICD-10 codes only are accepted.'
- Principal Diagnosis Code***: A text input field with a dropdown menu for POA Indicator. A large pink arrow points to this field.
- Admitting Diagnosis Code***: A text input field with a dropdown menu for POA Indicator.
- Diagnosis Codes (87A-Q)**: A text input field with a dropdown menu for POA Indicator and an 'Add' button.
- Patient Reason for Visit**: A text input field with an 'Add' button.
- External Cause of Injury Code (ECI)**: A text input field with a dropdown menu for POA Indicator.
- Prospective Payment Code**: A text input field.

Add Attachment (continued)

mhs Eligibility Patients Authorizations Claims Messaging Help

Viewing Claims For: [dropdown] Medicaid [dropdown] GO Upload EDI Create Claim

Institutional Claim for [redacted] Your Progress [progress bar]

THIS SECTION:
Attachments Add attachments to the claim (5MB limit). Supported types are .jpg, .tif, .pdf and .tiff

← Back If there are no attachments, click Next. Next →

Attachments

*Do NOT send password protected files. You must click ATTACH for each file being submitted.

File* [input] Browse... Attachment Type* [dropdown] Attach

There are no attached files.

← Back If there are no attachments, click Next. Next →

Review Claim and Submit

The screenshot shows the mhs web portal interface. At the top, there is a navigation bar with icons for Eligibility, Patients, Authorizations, Claims, Messaging, and Help. Below this, a search bar shows 'Viewing Claims For:' with a dropdown menu set to 'Medicaid' and a 'GO' button. To the right are 'Upload EDI' and 'Create Claim' buttons.

The main content area features a progress bar labeled 'Your Progress' with several green arrows pointing right, indicating the current step. Below the progress bar, the text reads 'THIS SECTION: Review and Submit Please review your claim before submitting.'

A pink arrow points to a box titled 'Almost done!' which contains the text 'You can go back to review your claim or submit now.' and a 'Submit' button with a right-pointing arrow.

Below this box, there is a 'Claim ID:' field with a redacted value. Underneath is a 'General Info' section with an 'Edit' link. The details listed are:

- Patient Control #: 111111111
- Medical Record #: 111111111
- Type Of Bill: 110
- Statement From Date: 09/01/2017
- Statement To Date: 09/05/2017
- Prior Payments:
- Prior Authorization Number:
- Admission Date: 09/01/2017
- Admission Hour: 10
- Admission Type: 9
- Admission Source: 7
- Discharge Status: 01
- Discharge Hour: 09

Below the general info is a 'Provider Details' section with an 'Edit' link. It contains two tables. The first table has columns: Provider Type, NPI, Taxonomy, Name, Tax ID, Address (1), Address (2), City, State, Zip. The second table has columns: Provider Type, NPI, Taxonomy, First Name, Last Name, IRS/Tax ID Num, Organization. Both tables have redacted data.

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.

The screenshot displays the 'Claims' interface. At the top, there is a navigation bar with the following elements: 'Claims' (header), a menu icon, 'Individual' (selected), 'Saved', 'Submitted' (with a red notification badge '1'), 'Batch', 'Recurring', 'Payment History', and 'Claims Audit Tool'. Below the navigation bar, the section is titled 'Claims: Recent'. There is a search bar with the text 'Search: Date Range : 07/14/2024 to 08/14/2024 Change dates' and two buttons: 'Filter' and 'Search'. The main content is a table with the following columns: 'CLAIM NO.', 'CLAIM TYPE', 'MEMBER NAME', 'SERVICE DATE(S)', 'BILLED/PAID', and 'CLAIM STATUS'. The table contains 9 rows of data, all with 'CMS-1500' as the claim type and 'Paid' as the claim status.

CLAIM NO.	CLAIM TYPE	MEMBER NAME	SERVICE DATE(S)	BILLED/PAID	CLAIM STATUS
XXXXXXXXXX	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.



Claims									
Individual		Saved	Submitted ¹	Batch	Recurring	Payment History		Claims Audit Tool	
Claims listed below have missing information or contain errors. Click 'Edit' to view a claim, then fix any errors or complete it before submitting.									
Drafts	Professional Ready to be Submitted			Institutional Ready to be Submitted					
DATE CREATED ↑	CLAIM TYPE ↓	CLAIM ID ↓	MEMBER NAME ↓	MEMBER ID ↓	ORIGINAL CLAIM # ↓	TOTAL CHARGES ↓			
08/13/2024	CMS-1500					\$0.00	Edit	Delete	
08/09/2024	CMS-1500					\$372.00	Edit	Delete	
08/06/2024	CMS-1500					\$192.00	Edit	Delete	
07/30/2024	CMS-1500					\$274.00	Edit	Delete	
07/18/2024	CMS-1500					\$0.00	Edit	Delete	
07/11/2024	CMS-1500					\$427.00	Edit	Delete	

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.

Viewing Claims For : TIN [] Plan Type Medicaid [] GO [] Upload EDI [] Create Claim []

Claims [] Individual [] Saved [] Submitted [] Batch [] Recurring [] **Payment History** [] Claims Audit Tool [] Filter []

Transactions

All activity posted to your account between 06/20/2021 and 07/20/2021 .

i **Instructions:** Click on the Check Date to view the PDF of payment details from your payment provider. The PDF will open in a new window where you can save or print it. If there are any discrepancies on your payment details, please contact Provider Services.

CHECK DATE ↑	CHECK NUMBER ↓	CHECK CLEAR DATE ↓	MAILING ADDRESS ↓	PAYMENT AMOUNT ↓
06/24/2021 (PDF)	[]	06/23/2021	[]	\$100.64
06/24/2021 (PDF)	[]	06/23/2021	[]	\$145.73
06/24/2021 (PDF)	[]	06/23/2021	[]	\$72.01
06/24/2021 (PDF)	[]	EFT	[]	\$0.00
06/24/2021 (PDF)	[]	EFT	[]	\$208.65
06/24/2021 (PDF)	[]	EFT	[]	\$578.92

Provider Explanation of Payment (EOP)

PT#480827



Electronic Service Requested

2800708113



606 0.7648 AV 0.386 5-DIGIT 30374

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] Member ID: [REDACTED] Claim No: [REDACTED]
 Patient Name: [REDACTED] PCN: [REDACTED] Carrier: DE Provider ID: [REDACTED]
 Service Provider: [REDACTED] LNPI: [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	.00	.00	.00	.00	A0 SR 30	258.47
0200	[REDACTED]	[REDACTED]	G5	1.00	6388.16	263.75	.00	.00	.00	.00	.00	.00	A0 SR 30	258.47
0300	[REDACTED]	[REDACTED]	G5	1.00	6388.16	263.75	.00	.00	.00	.00	.00	.00	A0 SR 30	258.47
0400	[REDACTED]	[REDACTED]	G5	1.00	6388.16	263.75	.00	.00	.00	.00	.00	.00	A0 SR 30	258.47
0500	[REDACTED]	[REDACTED]	G5	1.00	6388.16	263.75	.00	.00	.00	.00	.00	.00	A0 SR 30	258.47
0600	[REDACTED]	[REDACTED]	G5	1.00	6388.16	263.75	.00	.00	.00	.00	.00	.00	A0 SR 30	258.47
0700	[REDACTED]	[REDACTED]	G5	1.00	6388.16	263.75	.00	.00	.00	.00	.00	.00	A0 SR 30	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.

PaySpan® Health

FOLLOW THESE INSTRUCTIONS TO GET STARTED WITH PAYSAN® HEALTH, AN EFT AND ERA WEB BASED SOLUTION:

- 1** Call 1-877-331-7154 for your unique registration code. Then, visit [payspanhealth.com](#) and click **Register**.
- 2** Enter your registration code and click **Submit**.
- 3** Enter your PIN, TIN or EIN, and NPI. Then, click **Start Registration**.
- 4** Populate the requested Personal Information. Click **Next**.
- 5** Designate an account for fund transfers by completing the required fields. Click **Next**.
- 6** Verify your information and check the box to agree to the service agreement. Then, click **Confirm**.
- 7** Within a few business days, you will receive a deposit of less than \$1 from PaySpan. Then, follow these steps to complete registration:
 - ▶ Contact your financial institution to obtain the amount deposited by PaySpan.
 - ▶ Log into PaySpan, and click **Payments**.
 - ▶ Click the **Account Verification** link on the left side of the screen.
 - ▶ Enter the amount of the deposit in this format: 0.00.
(The deposit does not need to be returned.)

For PaySpan registration assistance, call: 1-877-331-7154
Email: providersupport@payspanhealth.com

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0221.PR.P.FL 2/21

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

[Back to Claims](#) **Claim Details**

Claim #T1234P1235: Denied

[COPY](#) [DISPUTE](#)



Claim Accepted — In Process — Denied

Participant	Provider	Claim	Most Recent Payment	
Participant Name [REDACTED]	Ref/Acct No. 1234567890	DOS Range 08/12/2020 - 08/15/2020	Payment Date —	Paid Claim Amount \$0.00
Member ID ID123459	Servicing Provider [REDACTED]	Received Date 09/12/2020	Check/EFT No. —	Total Check Amount —
Member DOB [REDACTED]	Servicing NPI [REDACTED]	Billed Amount \$6,1234.12	Check Dated —	

Service Lines

Label	Label	Label	Label	Label	Label	Label	Label
-------	-------	-------	-------	-------	-------	-------	-------

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

The screenshot displays the Secure Provider Portal interface. At the top, a dark blue navigation bar contains icons and labels for 'Eligibility', 'Patients', 'Authorizations', 'Claims', and 'Messaging', along with a 'User Name' dropdown menu. Below this, a light blue header bar features a 'Back to Claims' button and a text field containing a redacted ID followed by ': Claim #T1234P1235'. The main content area lists three options, each with a 'SELECT' button:

- Option 1: Correct the claim**
Most providers use this option when there is a mistake on the submitted claim.
- Option 2: Informally dispute the claim**
A dispute is a informal review performed by the Claims Department.
 - A response will be issued within **30 calendar days** of submission.
 - You will still have the opportunity to select **Option 3: Appeal the claim**, if the decision is upheld.
 - You should **NOT** use this option if an authorization is not obtained and/or need to review for medical necessity.
 - Please refer to the [MHS Provider Manual](#) on filing a medical necessity appeal.
- Option 3: Appeal the claim**
An appeal is a formal review of your claim.
 - Appeal responses will be issued in writing within **45 calendar days** of submission, in accordance with 405 IAC 1-1.6.
 - Your appeal will be reviewed by a panel of one or more individuals who are **knowledgeable** in the policy, legal, and/or clinical issues in the matter subject to the appeal.
 - The panel was **not involved in any previous consideration** of the matter of the appeal.
 - Please refer to the [MHS Provider Manual](#) for more information.

Claim Reconsiderations

Enter your explanation for reconsideration and check email updates.

Reconsider Claim

Claim No:

For reconsiderations only. Not for appeals/Claim disputes
Example: If an authorization was not obtained and/or you need to review for medical necessity, submit an appeal.
Any submission on this form will be treated as a reconsideration.
Please refer to your Provider Manual.

Reconsideration Type
Denied for Untimely Filing

Notes
Brief Explanation

500 Character Limit

Upload Documents
Proof of Timely Filing attachment Required

Uploaded Files


Email Updates
 Check here to receive email status updates for this reconsideration.
Please upload files less than 10MB each. Supported file formats are PDF, TIFF, TIF, JPEG, and JPG.

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


Back to Claims
Claim Details

Claim #T1234P1235: Denied


COPY
DISPUTE




Claim Accepted



Claim Denied





Dispute Submitted



Claim Denied (Decision Upheld)

Dispute
U026IA1234566

Dispute/Appeal Details

Created Date	Type	Current Status	Reference No.	Tools
1/26/2021	Dispute - Claim Paid at the Incorrect Amount	Resolved	U026IA1234566	 

Member	Provider	Claim	Most Recent Payment	
Participant Name [REDACTED]	Ref./Acct No. 1234567890	DOS Range 08/12/2020 - 08/15/2020	Payment Date ---	Paid Claim Amount \$0.00
Member ID ID123459	Servicing Provider [REDACTED]	Received Date 09/12/2020	Check/EFT No. ---	Total Check Amount ---
Member DOB [REDACTED]	Servicing NPI 1234567890	Billed Amount \$6,1234.12	Check Dated ---	

Service Lines

Label	Label	Label	Label	Label	Label	Label	Label

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

Back to Claims

Claim Details

Claim #T1234P1235: Denied

COPY
DISPUTE

```

graph LR
    A((Claim Accepted)) --> B((Claim Denied))
    B -- Dispute U026IA1234566 --> C((Dispute Submitted))
    C --> D((Claim Denied Decision Upheld))
    D -- Appeal ABCDE1234567 --> E((Appeal Submitted))
    E --> F((Outcome TBD))
            
```

Dispute/Appeal Details

Created Date	Type	Current Status	Reference No.	Tools
2/15/2021	Appeal - Claim Paid at the Incorrect Amount	In Progress	ABCDE1234567	
1/26/2021	Dispute - Claim Paid at the Incorrect Amount	Resolved	U026IA1234566	

Member	Provider	Claim	Most Recent Payment
Participant Name <div style="background-color: #0056b3; height: 15px; width: 100%;"></div>	Ref/Acct No. 1234567890	DOS Range 08/12/2020 - 08/15/2020	Payment Date ---
Member ID ID123459	Servicing Provider <div style="background-color: #0056b3; height: 20px; width: 100%;"></div>	Received Date 09/12/2020	Check/EFT No. ---
Member DOB <div style="background-color: #0056b3; height: 15px; width: 100%;"></div>	Servicing NPI 1234567890	Billed Amount \$6,1234.12	Paid Claim Amount \$0.00
			Total Check Amount ---
			Check Dated ---

Service Lines

Label	Label	Label	Label	Label	Label	Label

Coordination of Benefits

This screen shows if a member has other insurance.

[Back to Patient List](#) **Member Name**

Overview	Effective Date	Term Date	Policy Number	Group Number	Carrier Name	Coverage
Cost Sharing	06/01/2008	12/21/2013	V. [REDACTED]		AETNA	MEDICAL AND HOSPITAL
Assessments						
Health Record						
Care Plan						
Authorizations						
Coordination of Benefits						
Claims						

Prior Authorization

Authorizations

View previously submitted or Create a New Authorization.

Back to Patient List
Member Name

Overview

Cost Sharing

Assessments

Health Record

Care Plan

Authorizations

Referrals

Coordination of Benefits

Claims

Document Resource Center

Notes

Authorizations

STATUS	AUTH NBR	FROM DATE	TO DATE	DIAGNOSIS	AUTH TYPE	SERVICE
APPROVE	C	02/06/2018	05/06/2018	M51.36	OUTPATIENT	Office Visit
APPROVE	C	03/14/2017	01/05/2018	G89.4	OUTPATIENT	Office Visit

Create a New Authorization

Click on **AUTH NBR** above

Auth Status: APPROVE

Auth Nbr: C

Service: Office Visit

Provider of Service(s): [REDACTED]

Diagnosis Code(s): M51.36

Explanation: Pay

Auth Type: OUTPATIENT

From Date: 02/06/2018

To Date: 05/06/2018

Procedure Code(s): 99214

Notes & Attachments: View

Line Item	Service type	Start Date	End Date	Units Req.	Units Apprd	Servicing Provider	Location	Status	Medical Necessity	Decision Date
1	Office Visit	02/06/2018	05/06/2018	3	3	[REDACTED]	Office	APPROVE	Met as requested	01/31/2018

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

For Providers
Login
Behavioral Health Providers ▼
Clinical & Payment Policies
Dental Providers
Email Sign Up
Enrollment and Updates ▼
Pharmacy ▼
Prior Authorization ▲
Medicaid Pre-Auth
Ambetter Pre-Auth ↗
Medicare Pre-Auth
Provider Education & Training ▼
Provider Resources ▼
QI Program ▼
Provider News
Opioid Resources

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?	<input type="radio"/>	<input checked="" type="radio"/>
Are anesthesia services being rendered for pain management?	<input type="radio"/>	<input checked="" type="radio"/>
Are services for infertility?	<input type="radio"/>	<input checked="" type="radio"/>

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

Indiana

NORTHEAST REGION

For claims issues, email:
MHS_ProviderRelations_NE@mhsindiana.com
Joy Diarra, Provider Engagement Administrator
1-317-864-2378

NORTHWEST REGION

For claims issues, email:
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1-317-364-7635

NORTH CENTRAL REGION

For claims issues, email:
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1-317-379-9035

CENTRAL REGION

For claims issues, email:
MHS_ProviderRelations_C@mhsindiana.com
ldavis@mhsindiana.com
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1-317-601-5999

SOUTH CENTRAL REGION

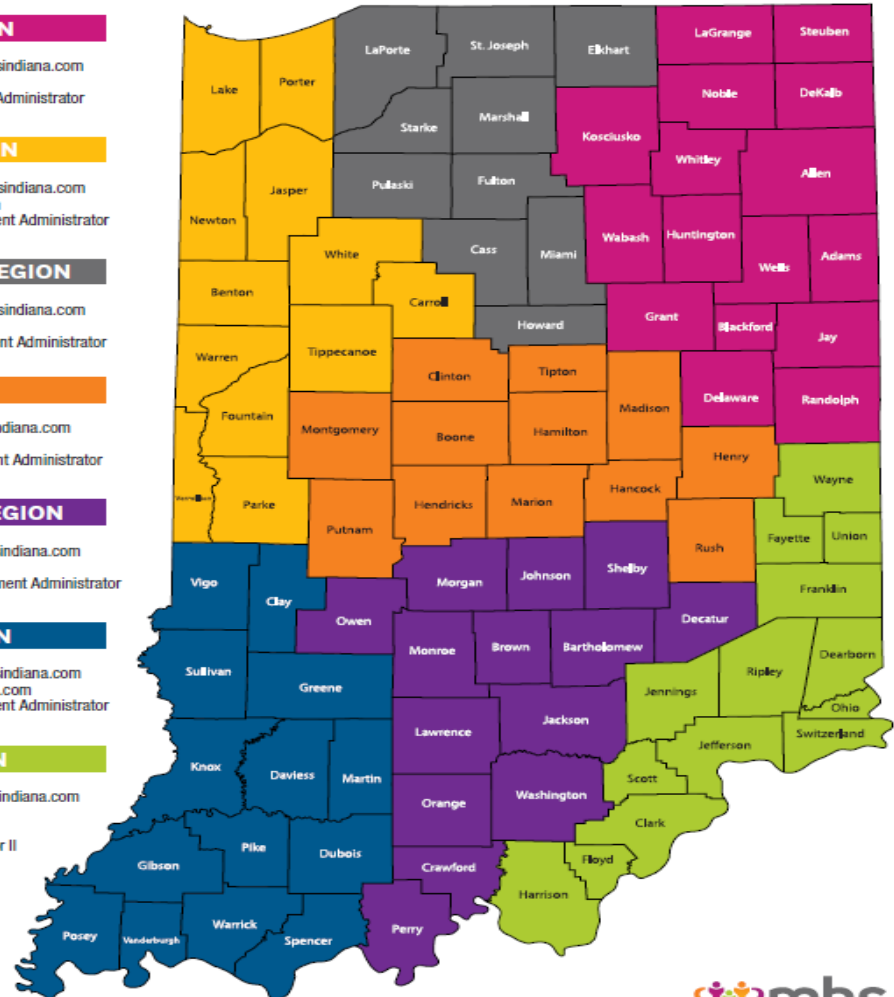
For claims issues, email:
MHS_ProviderRelations_SC@mhsindiana.com
DDENNING@mhsindiana.com
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<https://www.mhsindiana.com/providers/resources/guides-and-manuals.html>



MHS Team (continued)

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PROVIDER GROUPS

Community Health Network
Indiana University Health
Wayspring Health
Reid Hospital
Norton Hospital
St. Elizabeth Hospital

MONA GREEN

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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?
