Claims *CMS-1500* Billing

2024 IHCP Works Annual Seminar

Agenda

- MHS Overview
- Claim Submission Process
- MHS Provider Claims Issue Resolution Process
- Additional Claims Assistance
- Portal Functionality
- Professional 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 twenty-five 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 Claims Submission

- Electronic Data Interchange (EDI) Submission:
  - Preferred method of claims submission
  - Faster and less expensive than paper submission
  - MHS Electronic Payor ID **68069**

- Online Portal
  - Provides immediate confirmation of received claims and acceptance
    - Institutional and Professional
    - Batch Claims
    - Claim Adjustments/Corrections
    - Claim review/Adjustments request

- Paper Claims:

  Managed Health Services
  P.O. Box 3002
  Farmington, MO 63640-3802

Behavioral Health Claims 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 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

Claims Billing with Ease

- National Provider Identification (NPI), Tax ID, Zip +4

- This information 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 (MID) is required for payment

- Attachment Forms:
    - Required forms need to accompany the claim form

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

Claim Submission

- Medicaid Timely Filing is:
  - In-Network providers: 90 calendar days from the date of service or discharge date.
  - Out-of-Network providers: 180 calendar days from the date of service or discharge date.

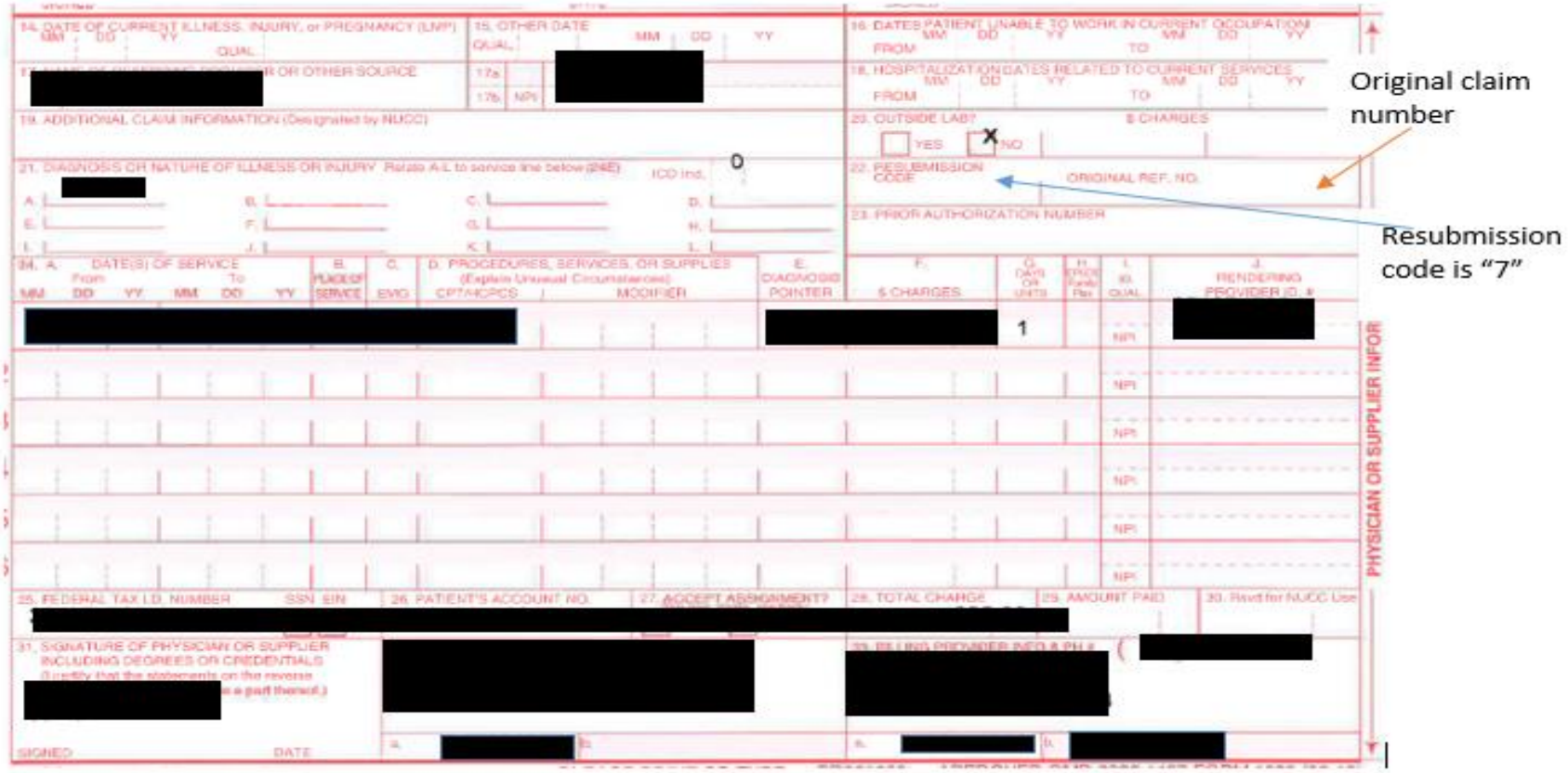
- Exceptions:
  - Newborns (30 days of life or less) – Claims must be received within 365 calendar days from the date of service. Claim must be filed with the newborn's Member ID (MID).
  - TPL – Claims with primary insurance must be received within 365 calendar days of the date of service with a copy of the primary insurance Explanation of Payment (EOP).
    - If primary insurance 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.

Paper Claim Corrections

- A corrected claim can be submitted following Indiana Health Coverage Programs (IHCP) claim adjustment processes.
- A claim adjustment code is required on all claims, based on the type of claim submitted.
    - Example: Frequency 7 entered in Box 22 of the *CMS-1500* form.
- The original claim number must also be listed on the corrected claim.
    - Box 22 on the *CMS-1500*.
    - Remember: A rejection must be submitted as a first-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 rejection code RE.

Paper Claim Corrections CMS-1500 Example

- If you must submit via paper – never handwrite “corrected claim” on the claim form.
- Complete box 22 (Resubmission Code) to include a 7 (the "Replace" billing code) to notify us of a corrected or replacement claim.



Laboratory Billing

- All providers that bill laboratory services on a *CMS-1500* form must have Clinical Laboratory Improvement Amendments (CLIA) certification or a CLIA waiver certification equal to the procedure code being billed and included on the *CMS-1500* form.

- EXc1 DENIED: INVALID CLIA NUMBER:
  This denial code will appear on the provider's EOP. This verification will ensure that MHS is compliant with the Centers for Medicare & Medicaid Services (CMS) guidelines. Provider's will have to submit a corrected claim timely with proper CLIA certificate number entered on their claim submission.

Laboratory Billing Cont.

Physician's Office Lab Testing (POLT)

MHS Policy CC.PP.055: To ensure laboratory tests are performed in the correct setting, the health plan will limit the performance of in-office laboratory testing to the Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes listed in the Short Turnaround Time (STAT) laboratory (lab) code list included in this policy.

Laboratory Billing Cont.

- These tests on the POLT list are those needed immediately, in order to manage medical emergencies or urgent conditions. Therefore, specific clinical laboratory tests have been designated as appropriate to be performed in the office setting.

- The health plan's automated claims adjudication system will deny in-office (place of service 11) laboratory procedures that are not included on the STAT lab list found on the MHS Indiana website.

- Policy and list can be found at:

  https://www.mhsindiana.com/content/dam/centene/mhsindiana/policies/payment-policies/CC.PP.055.pdf

Transportation Claims

- MHS will process all Medicaid emergent and non-emergent ambulance claims, including air ambulance, which would have previously been processed by LCP Transportation.

- Claims for the following services should be sent to MHS:
  - 911 Transports.
  - Medically necessary non-emergent hospital transports requiring an ambulance with advanced life support (ALS) or basic life support (BLS).
  - Air ambulance.

- Only providers enrolled with the IHCP are eligible for reimbursement. Claims must be filed within:
  - 90 calendar days of the Date of Service (DOS) for contracted providers.
  - 180 calendar days of the DOS for non-contracted providers.

- Claims should be submitted to MHS via a CMS-1500 professional claim form. Claims may be submitted via EDI (preferred), MHS web portal, or paper.

  Managed Health Services
  P.O. Box 531097
  Indianapolis, IN 46253

Transportation Claims Cont.

- MHS will follow IHCP billing guidelines for coding and reimbursement.

  For more information on Medicaid ambulance billing guidelines, please visit Transportation Module.

- **Claim Inquiries**:
  - Check status online via the MHS Secure Web Portal.
  - Call Provider Services at 1-877-647-4848.

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.
- Timely filing is not substantiated.
- Rejected claims must be corrected and submitted as a first-time new claim.
- EDI rejections require the provider to contact their clearinghouse and obtain a payer rejection report.

Common Claim Rejections

Medical

- **07** Invalid Subscriber/Member ID
- **02** Invalid Provider ID-Rendering Physician (Provider State Crosswalk File)
- **09** Member Invalid on Date of Service
- **01** Invalid Provider ID Billing Physician (Provider State Crosswalk File)
- **08** Invalid Member Date of Birth
- **76** Original claim number required
- **90** Invalid or Missing Modifier
- **40** Diagnosis code is missing
- **B5** Missing/incomplete/Invalid CLIA

Behavioral Health

- **02** Invalid Provider ID-Rendering Physician (Provider State Crosswalk File)
- **09** Member Invalid on Date of Service
- **07** Invalid Subscriber/Member ID
- **01** Invalid Provider ID Billing Physician (Provider State Crosswalk File)
- **08** Invalid Member Date of Birth
- **76** Original claim number required
- **40** Diagnosis code is missing
- **31** Invalid Service Procedure code

MHS Provider Claims Issue Resolution Process

Provider Claims Issue Resolution

PROCESS

- Level 1: Informal Claims Dispute Online or with Medical Claim Dispute/Appeal form
- Level 2: Formal Claim Dispute – Administrative Claim Appeal Online or with Medical Claim Dispute/Appeal form
- Level 3: Arbitration

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

Claim Dispute/Appeal Form- Medical and Behavioral Health

- Medical Claims Address:
  Managed Health Services
  Attn: Appeals Department
  P.O. Box 3002
  Farmington, MO 63640-3802

- Behavioral Health Claims Address:
  Managed Health Services BH Appeals
  Attn: Appeals Department
  P.O. Box 6800
  Farmington, MO 63640

Informal Claims Dispute or Objection Form

- Submit all documentation supporting your dispute:
  - Copies of original MHS EOP showing how the claims in question were processed.
  - 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).
  - Can be submitted via the Secure Web Portal within 60 calendar days of receipt of the MHS EOP.
  - Requests received after the 60 calendar days will not be considered.

Informal Dispute or Objection Form

- Level 1: Informal Dispute: MHS will make all reasonable efforts to review your documentation and respond to your request within 30 calendar days.

- At that time (or upon receipt of our response if sooner), providers will have up to 60 calendar days from date of dispute response to initiate a formal claim appeal which is (Level 2).

Informal Claims Dispute Objection Form

Helpful Tips

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

Provider Services Phone Requests and Web Portal Inquiries

- After the informal claims dispute (Level 1) has been submitted, the provider can access the Provider Service Phone line or Web Portal for assistance or questions. 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. Eastern time zone.

- Provider Web Portal
  - Use the Messaging Tool.

Provider Services Phone Requests and Web Inquiries

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.

Formal Claims Dispute- Administrative Claim Appeal

- Level 2 is a Formal Claim Appeal, 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 or in writing by using the Medical Claim Dispute/Appeal Form with an explanation including any specific details which may justify reconsideration of the disputed claim. The appeal should be clearly marked on the form as Level 2.

- See the MHS Provider Manual Chapter 5 Claims Administrative Reviews and Appeals for more information.

Arbitration

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 must be mailed to:

MHS Arbitration

550 N. Meridian Street, Suite 101

Indianapolis, IN 46204

See the MHS Provider Manual Chapter 5 Claims Administrative Reviews and Appeals for more information.

Additional Claim Assistance

Provider Relations Regional Mailboxes

- If claim denials are upheld after following the informal dispute processes and the provider has not received resolution by calling Provider Services or utilizing the secure messaging on the portal, please contact the Internal 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 Representative directly as this may delay the time in getting a response due to their travel.

Provider Relations Regional Mailboxes Cont.

Helpful Tips:

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

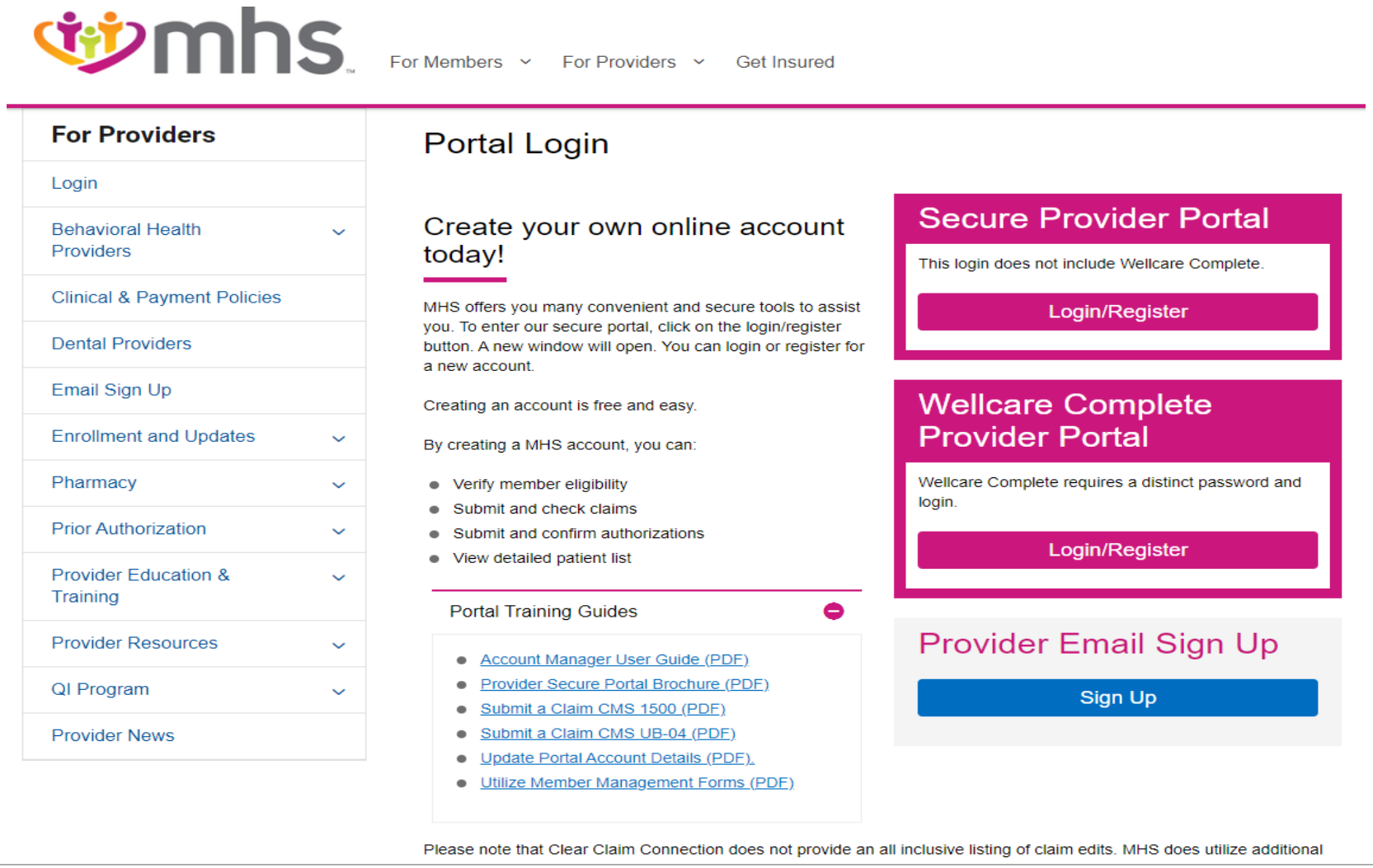
    - Issue Reference Number(s)
    - TIN
    - Group/Facility Name
    - Practitioner Name and NPI
    - Member Name and MID Number
    - Product (Medicaid/Ambetter/Wellcare by Allwell)
    - Claim Number(s)
    - DOS or DOS Range if multiple denials
    - Related Prior Authorization Numbers (this is key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

Provider Relations Regional Mailboxes Cont.

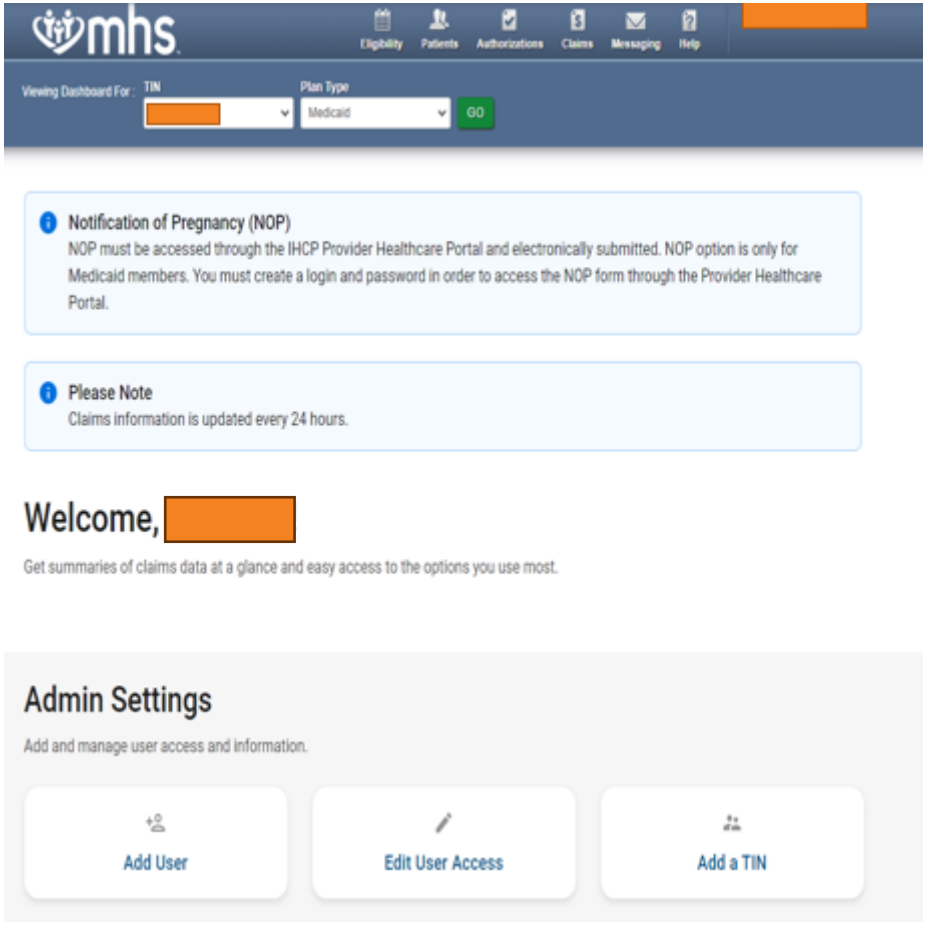
- Regional Mailboxes
  - Northeast Region: MHS_ProviderRelations_NE@mhsindiana.com
  - North Central Region: MHS_ProviderRelations_NC@mhsindiana.com
  - Central Region: MHS_ProviderRelations_C@mhsindiana.com
  - Northwest Region: MHS_ProviderRelations_NW@mhsindiana.com
  - Southwest Region: MHS_ProviderRelations_SW@mhsindiana.com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

Portal Functionality

Secure Web Portal Login or Registration

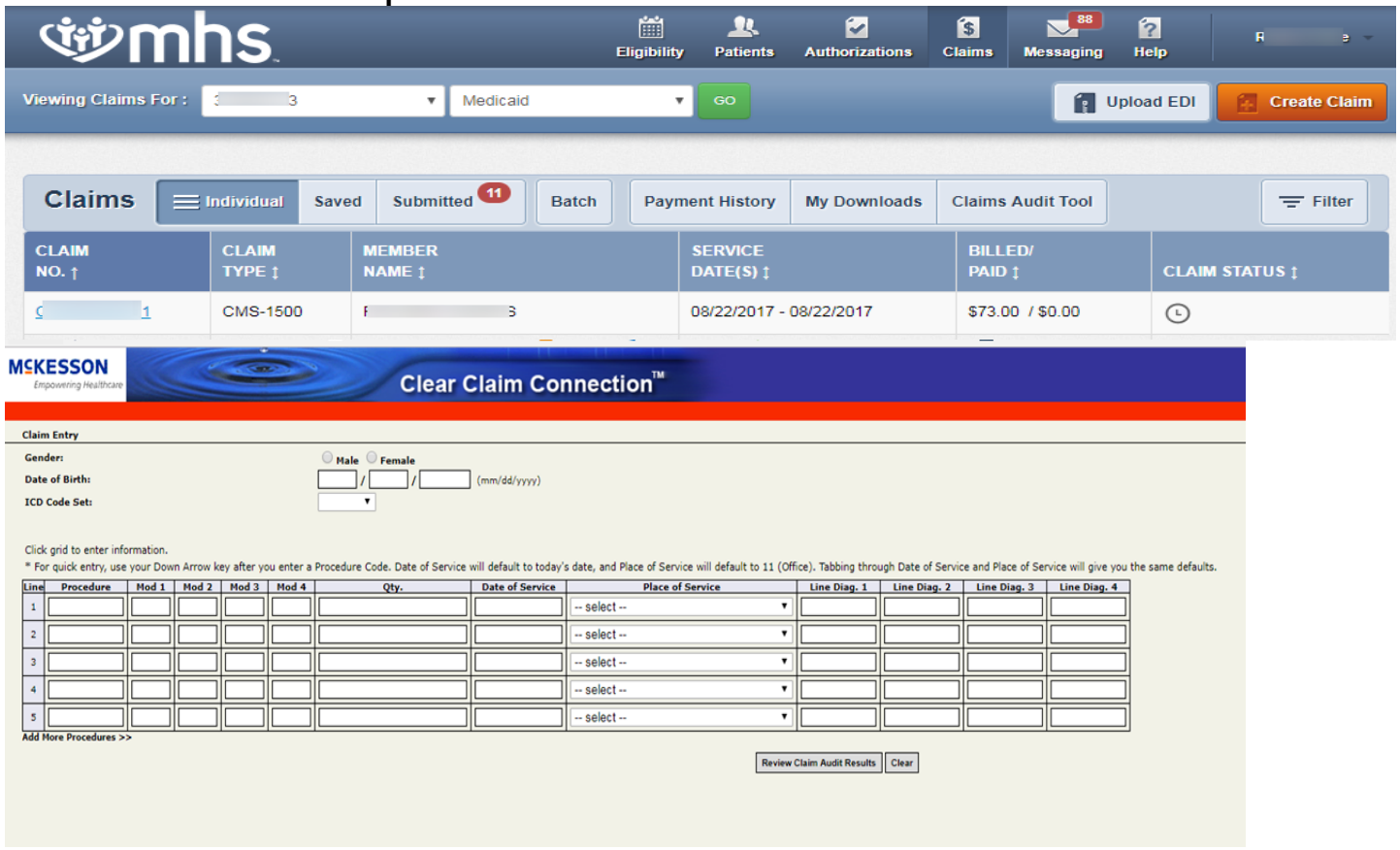


Homepage - MHS (Medicaid)



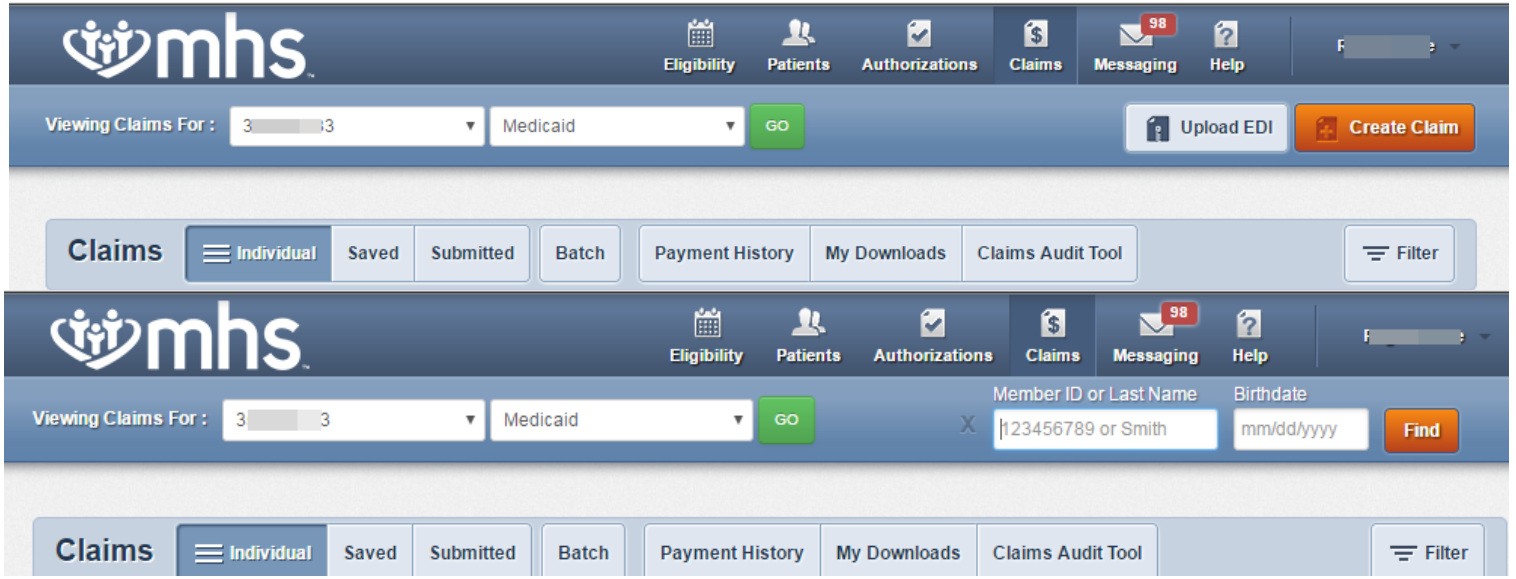
Claims Audit Tool

- The Clear Claim Connection screen appears, allowing you to enter the Procedure Code, Quantity, Modifiers, Date and Place of Service, and Diagnosis for a claim proactively before you submit or retroactively after you submit to resolve question can this code be billed with another code.



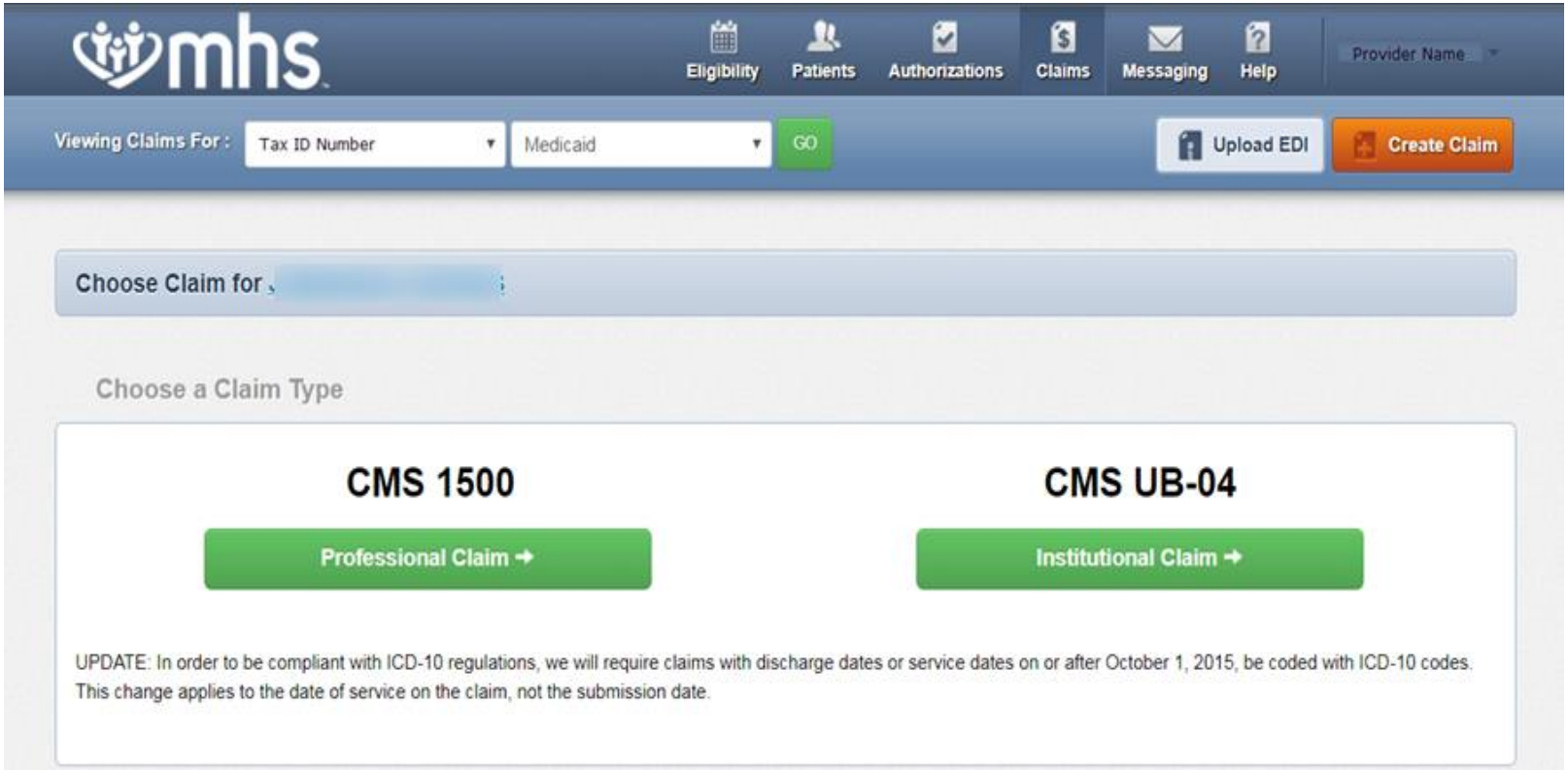
Claims

- **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.**



Claims Submission

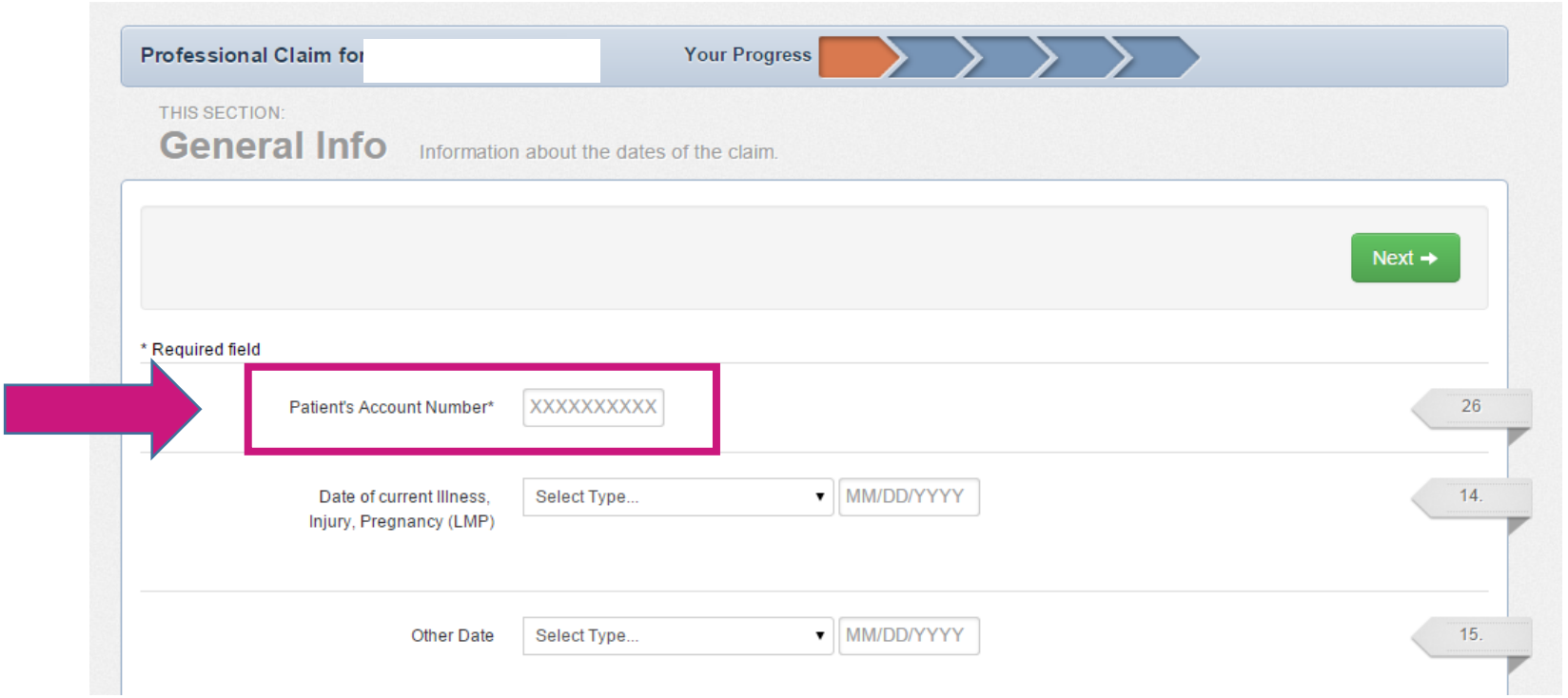
- Choose the **Claim Type**
  - **Professional** or **Institutional** claim submission



Professional Billing

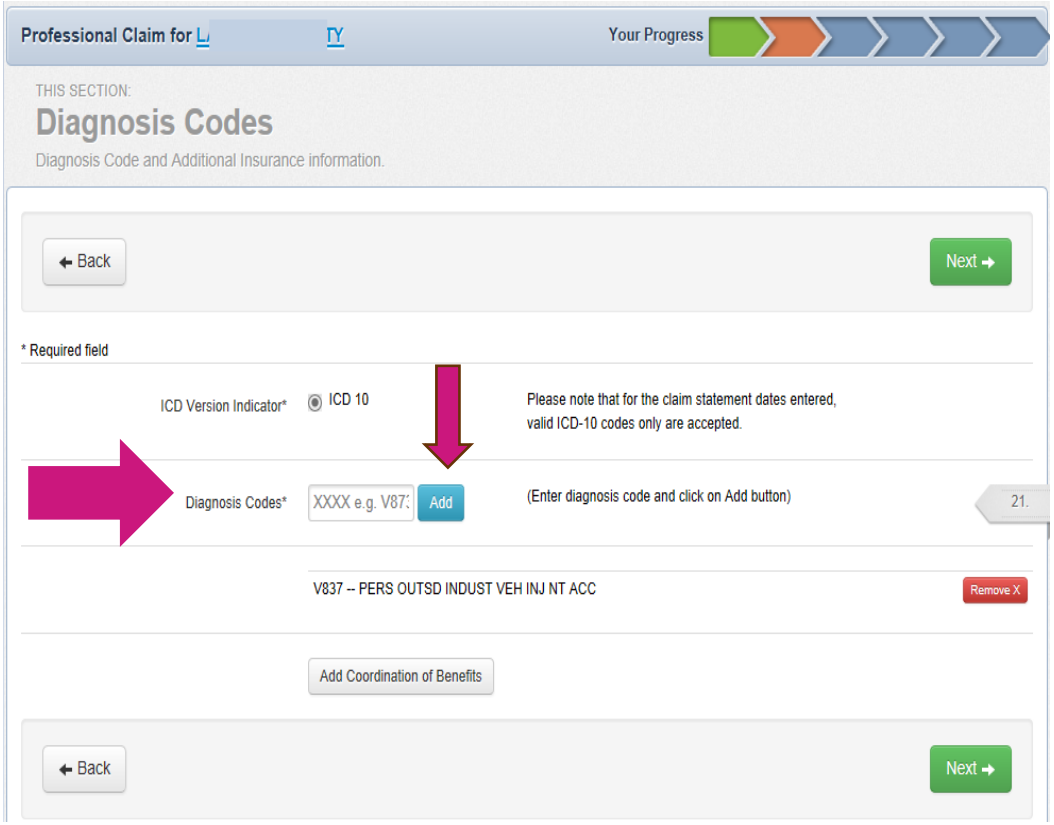
Professional Claims Submission

- In the **General Info** section, populate the **Patient's Account Number** as assigned to your member account and other information related to the patient's condition by typing into the appropriate fields.
- Click **Next**.



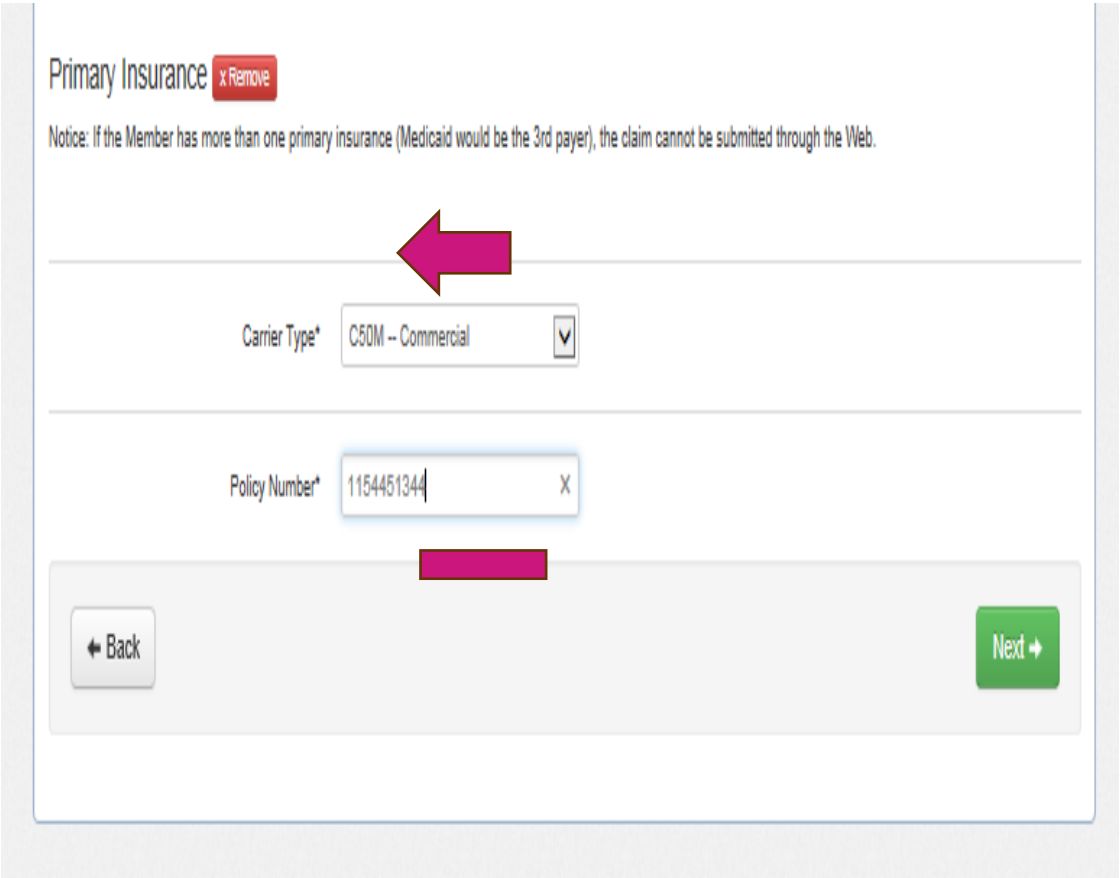
Professional Claims Submission Cont.

- Add the **Diagnosis Codes** for the patient in Box 21. There are some situations that a specific diagnosis is required in position 1, and will deny the claim if it is not listed in primary location.
- Click the **Add** button to save.



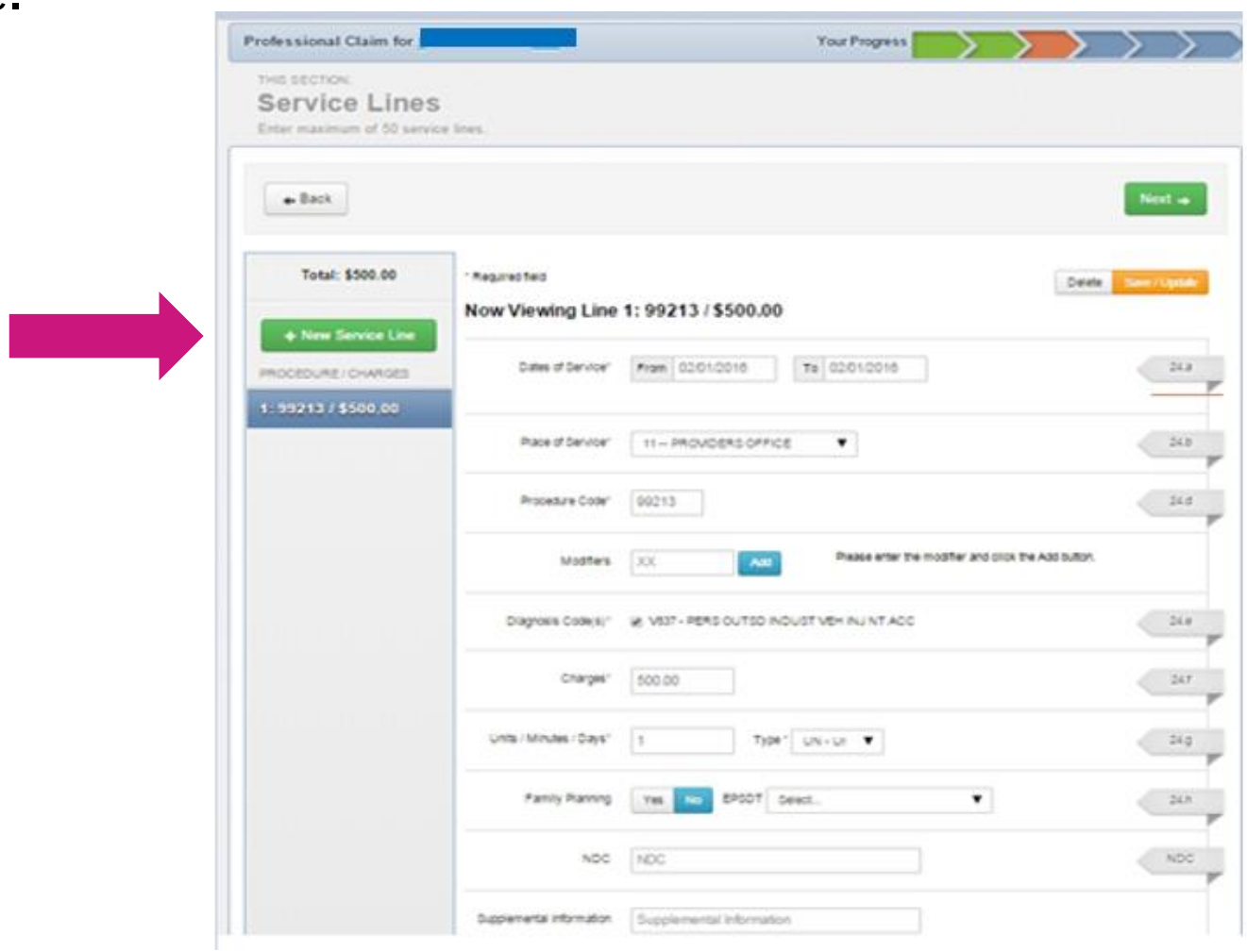
Professional Claims Submission Cont.

Click **Add Coordination of Benefits** to include any payments made by another insurance carrier (if applicable).



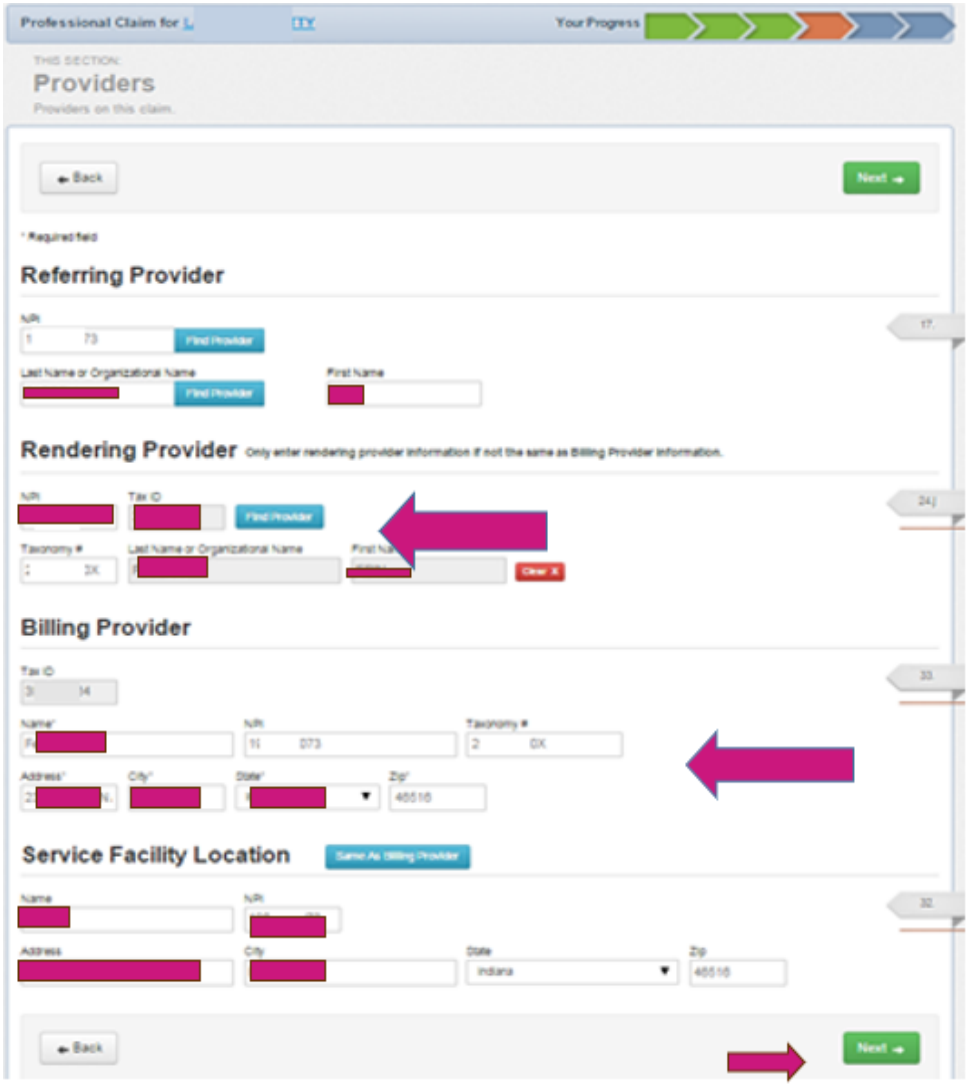
Professional Claims Submission Cont.

- **Add** Service Lines, and any applicable COB information at bottom of each line**.**



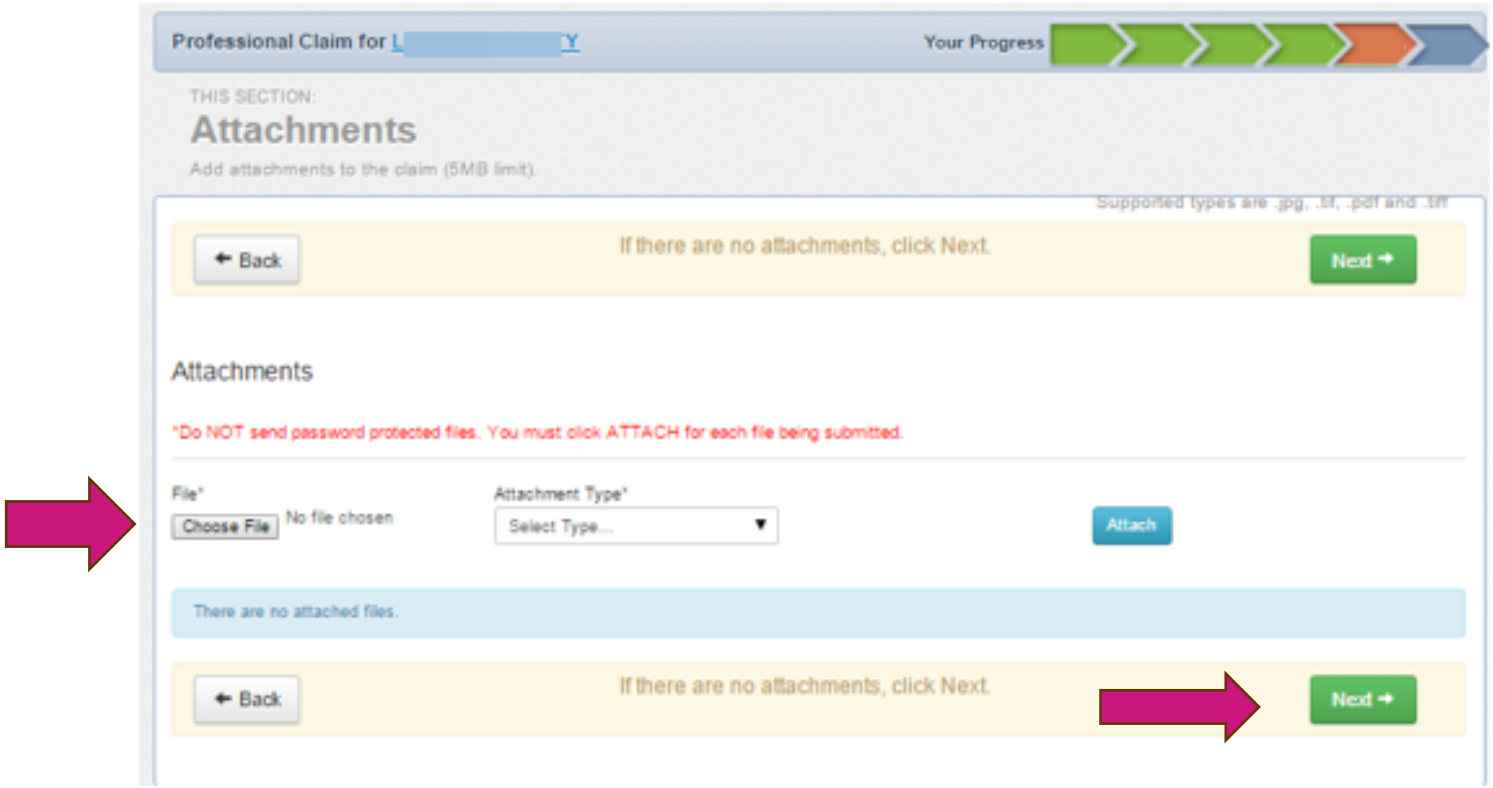
Professional Claims Submission Cont.

- Enter **Referring, Rendering,** and **Billing provider information.**
- **Service Facility Location**.
- Click **Next**.

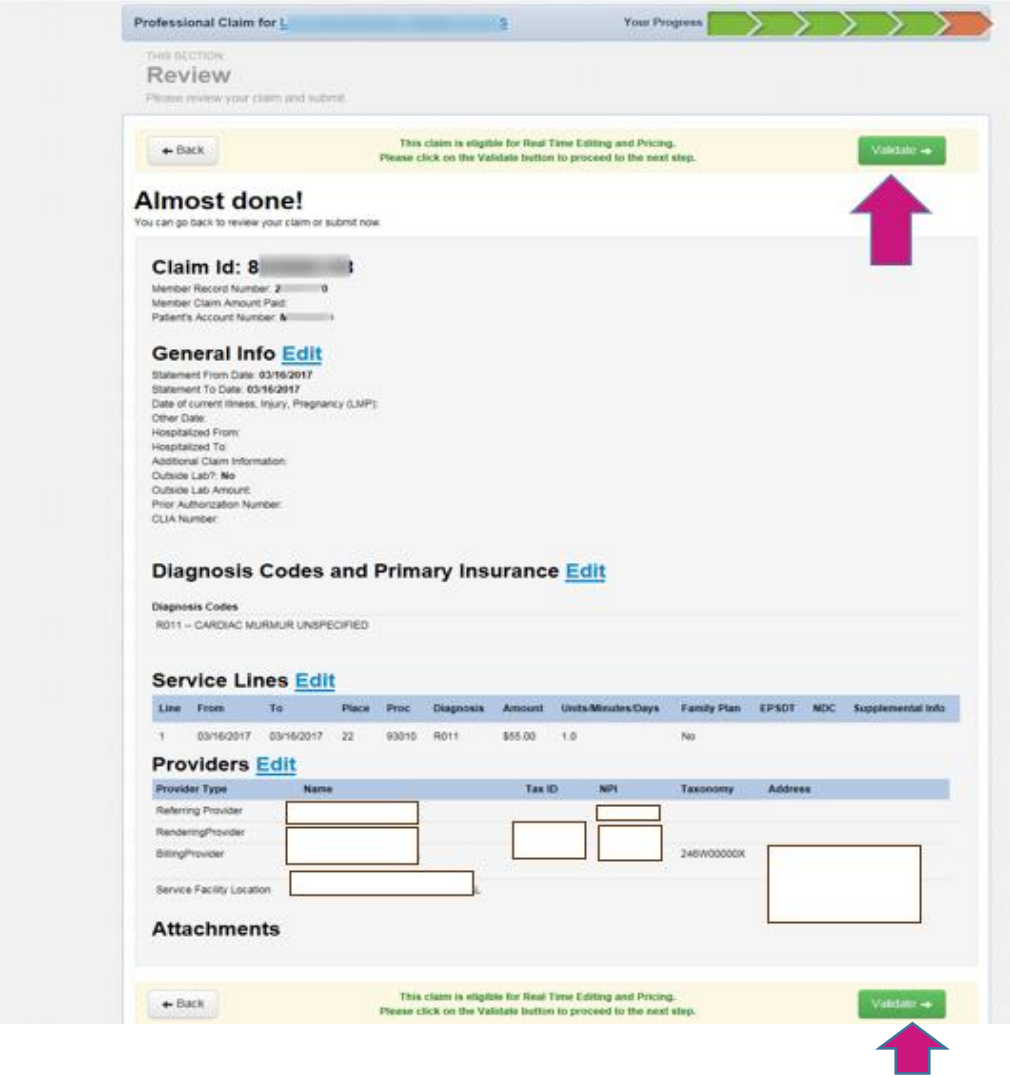


Professional Claims Submission Cont.

- In the Attachments section you can **Browse** and **Attach** any documents to the claim as desired. (Note: If you have no attachments, skip this section.)
- Click **Next**.



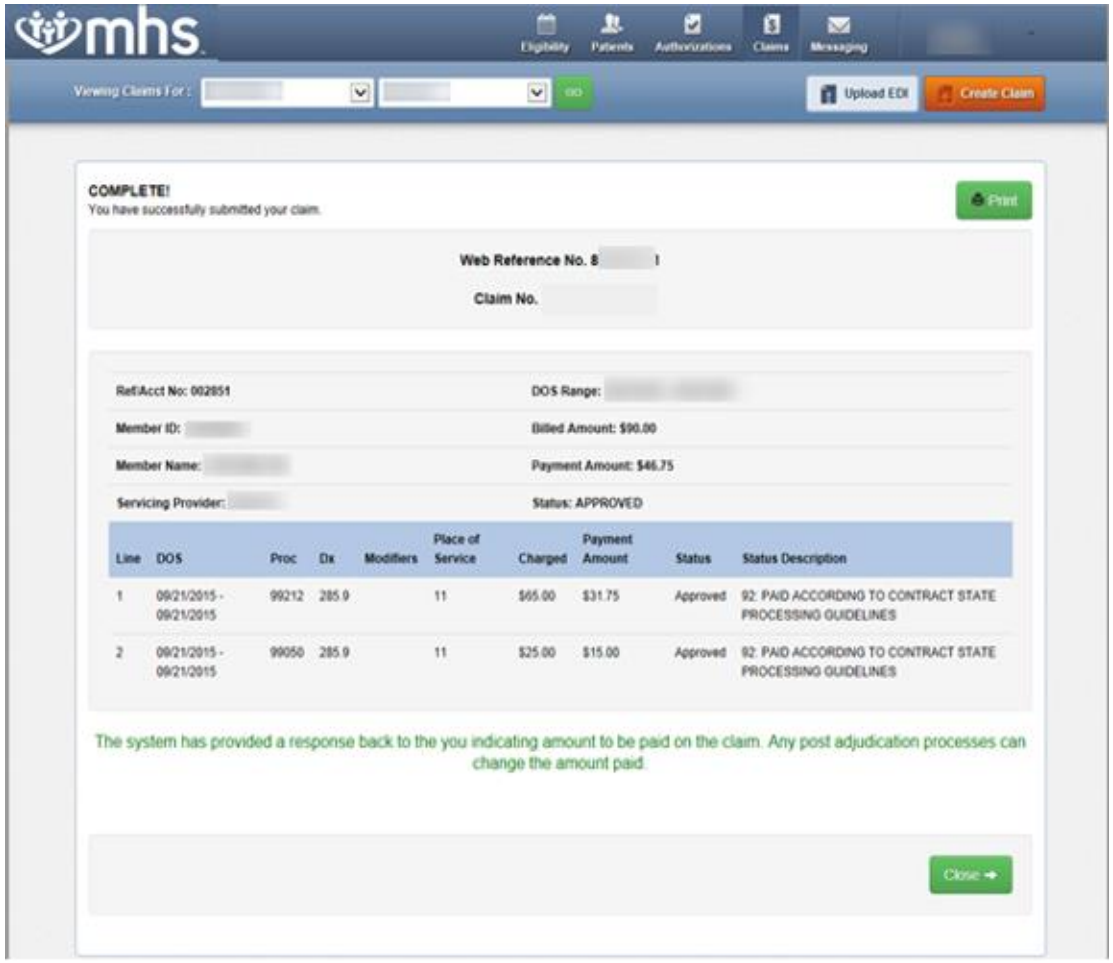
Professional Claims Submission Cont.



- In the **Review** section, you can see if the claim is eligible for Real Time Editing and Pricing (RTEP).

- Click **Validate** for RTEP claims and click **Submit** for regular processed claims.

RTEP Claim Pricing View



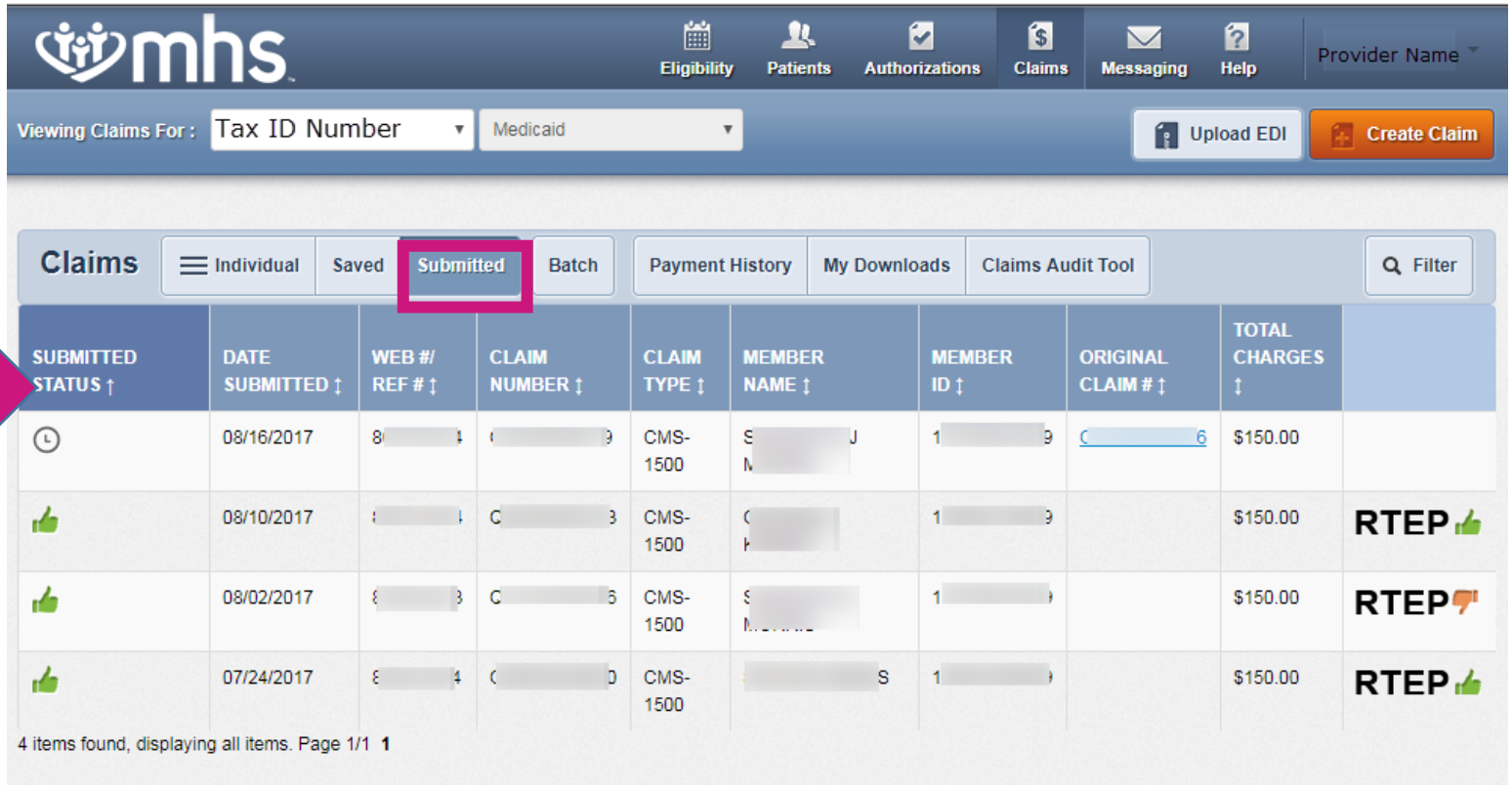
Real Time Edit Processing (RTEP) Overview:

- On the final screen, each procedure code will receive a reimbursement estimate, pending claim explanation, or denial reason.
- Claims with a reimbursement estimate or pending explanation may be impacted by final adjudication, including a change to the reimbursement amount or a denial.
- Adjudication status may be affected by code editing or other payment rules.

Web Portal Claim and Payment Review

Submitted Claims

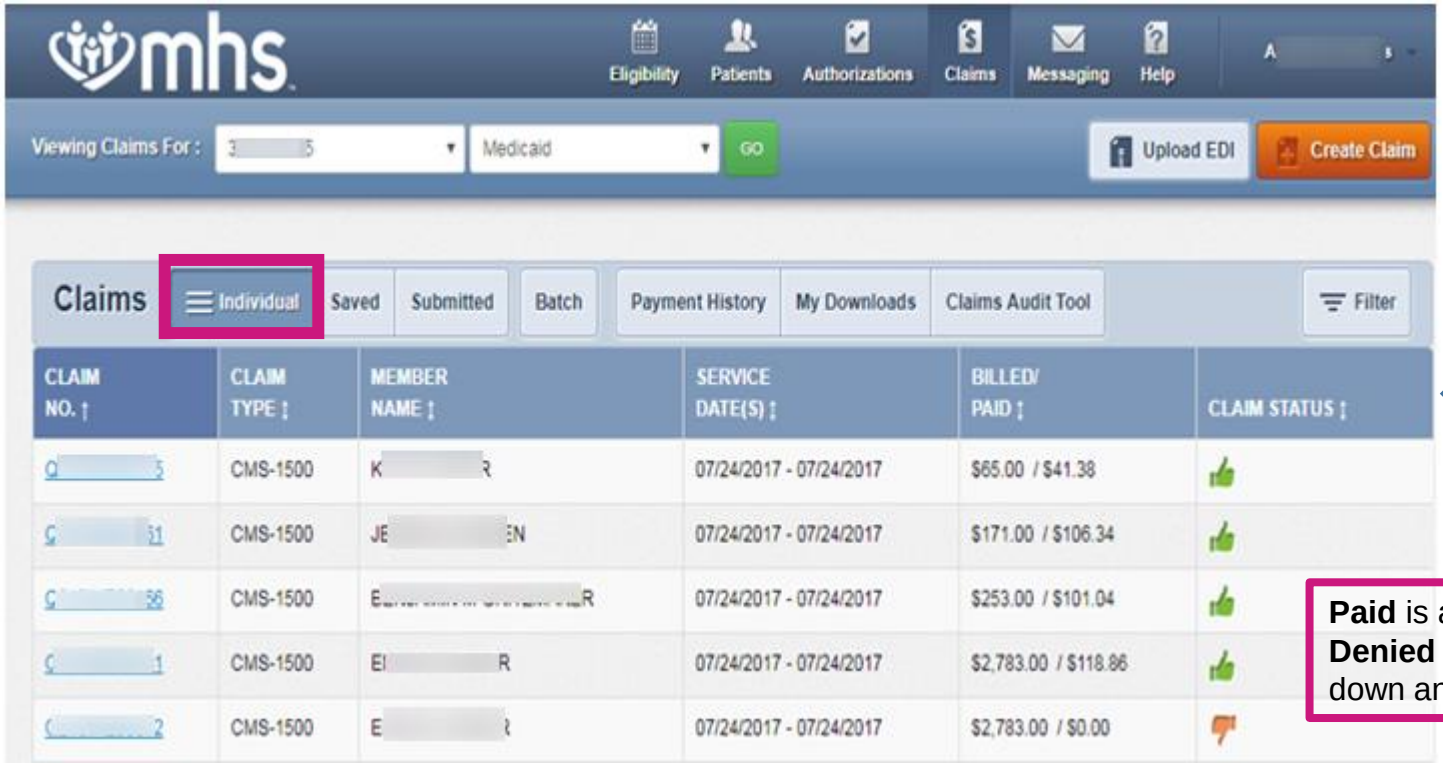
- The **Submitted** tab will only display claims created via the MHS portal:
  - **Accepted** is a **green** thumbs up.
  - **Denied** is an **orange** thumbs down.
  - **Pending** is a clock.
- **RTEP** indicators on the right claims also show if eligible (i.e., line 3 was submitted but was not eligible for RTEP).



Individual Claims

On the **Individual** tab, claims can be reviewed that had been submitted and accepted using paper, portal, or EDI clearing house methods.

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



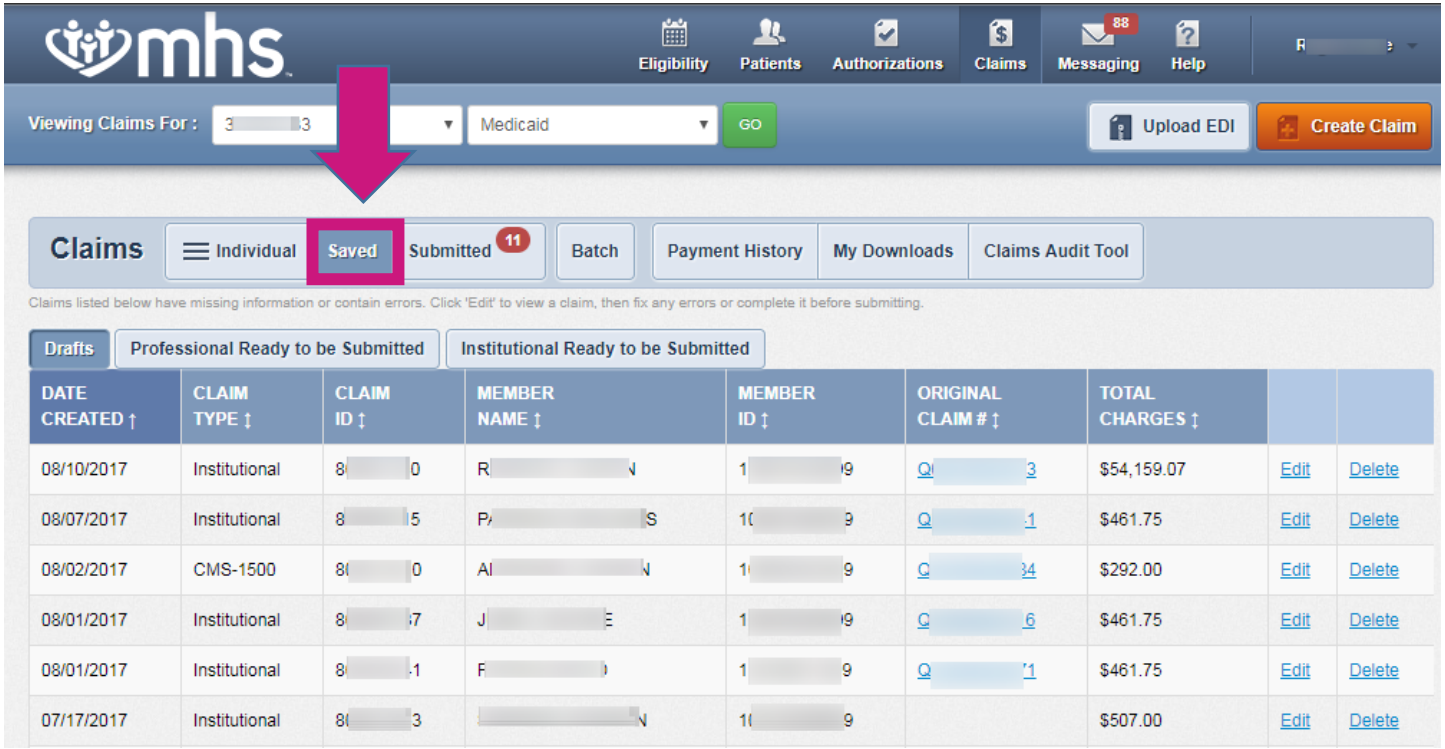
Paid is a green thumbs up, **Denied** is an orange thumbs down and a clock is **Pending.**

Saved Claims

To view **Saved** claims: Drafts, Professional, or Institutional:

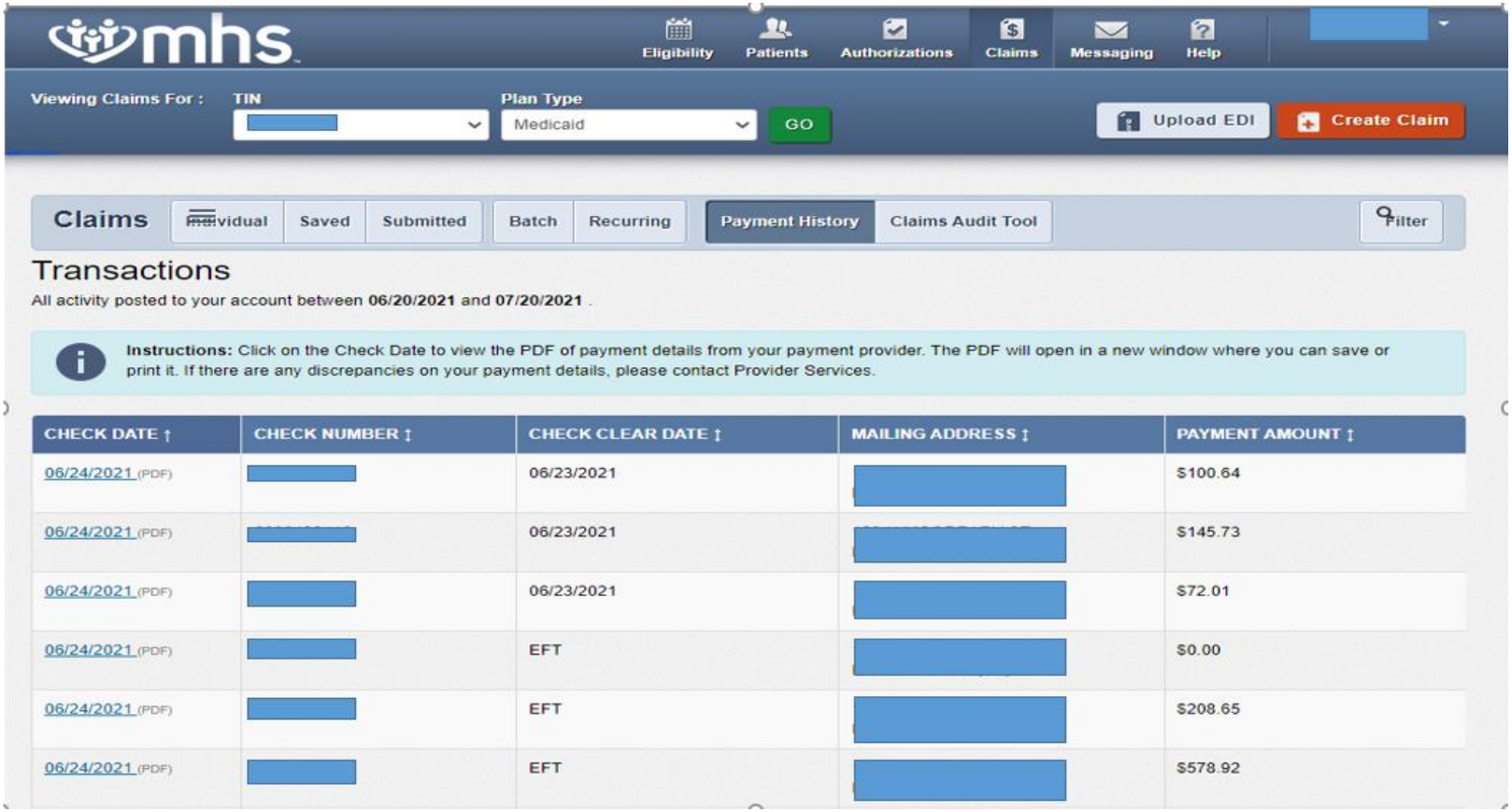
1. Select **Saved.**
2. Click **Edit** to view a claim.
3. Fix any errors or complete before submitting.

   Or
4. Click **Delete** to delete saved claim that is no longer necessary.
5. Click **OK** to confirm the deletion.

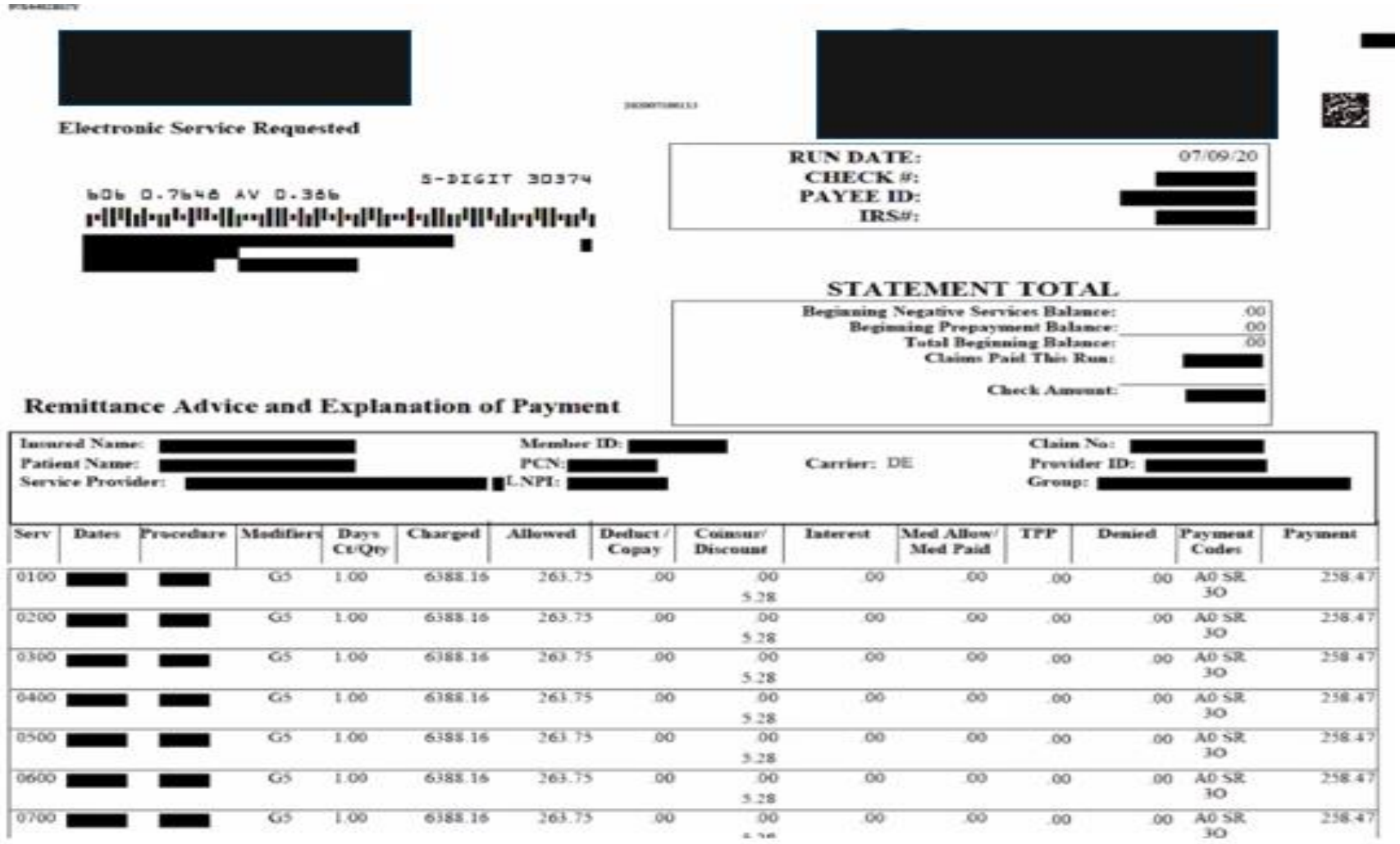


Payment History

- 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 EOP



[redacted]

Electronic Service Requested

5-DIGIT 30374

bOb 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

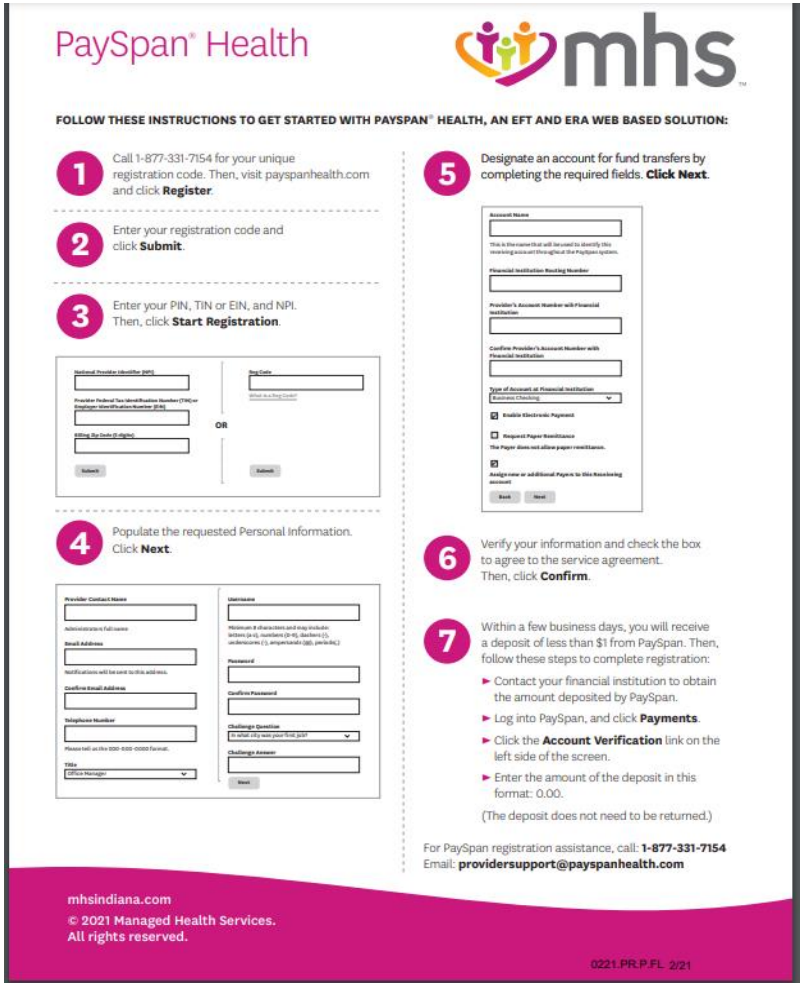
Insured Name: [redacted]
Patient Name: [redacted]
Service Provider: [redacted]
Member ID: [redacted]
PCN: [redacted]
LNPI: [redacted]
Carrier: DE
Claim No: [redacted]
Provider ID: [redacted]
Group: [redacted]

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).
  - Electronic Remittance Advices (ERAs).
- One year retrieval of remittance advice.
- Provided at no cost to providers and allows online enrollment.
- Register at: Payspan
- For questions call Payspan at: 1-877-331-7154.



PaySpan® Health

mhs

FOLLOW THESE INSTRUCTIONS TO GET STARTED WITH PAYSPAN® 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**.

OR

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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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 calendar day** span within the same month can be used.
- Click on the **Saved Claims** tab to view claims that have been created but not Submitted. Claims in this queue can be edited for submission or deleted from this tab.
- In order to utilize the **Correct Claim** feature, the claim needs to be in a **Paid** or **Denied** status.

Online Claim 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 the status online.

Online Reconsiderations

Providers are able to:

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

Online Reconsiderations Cont.

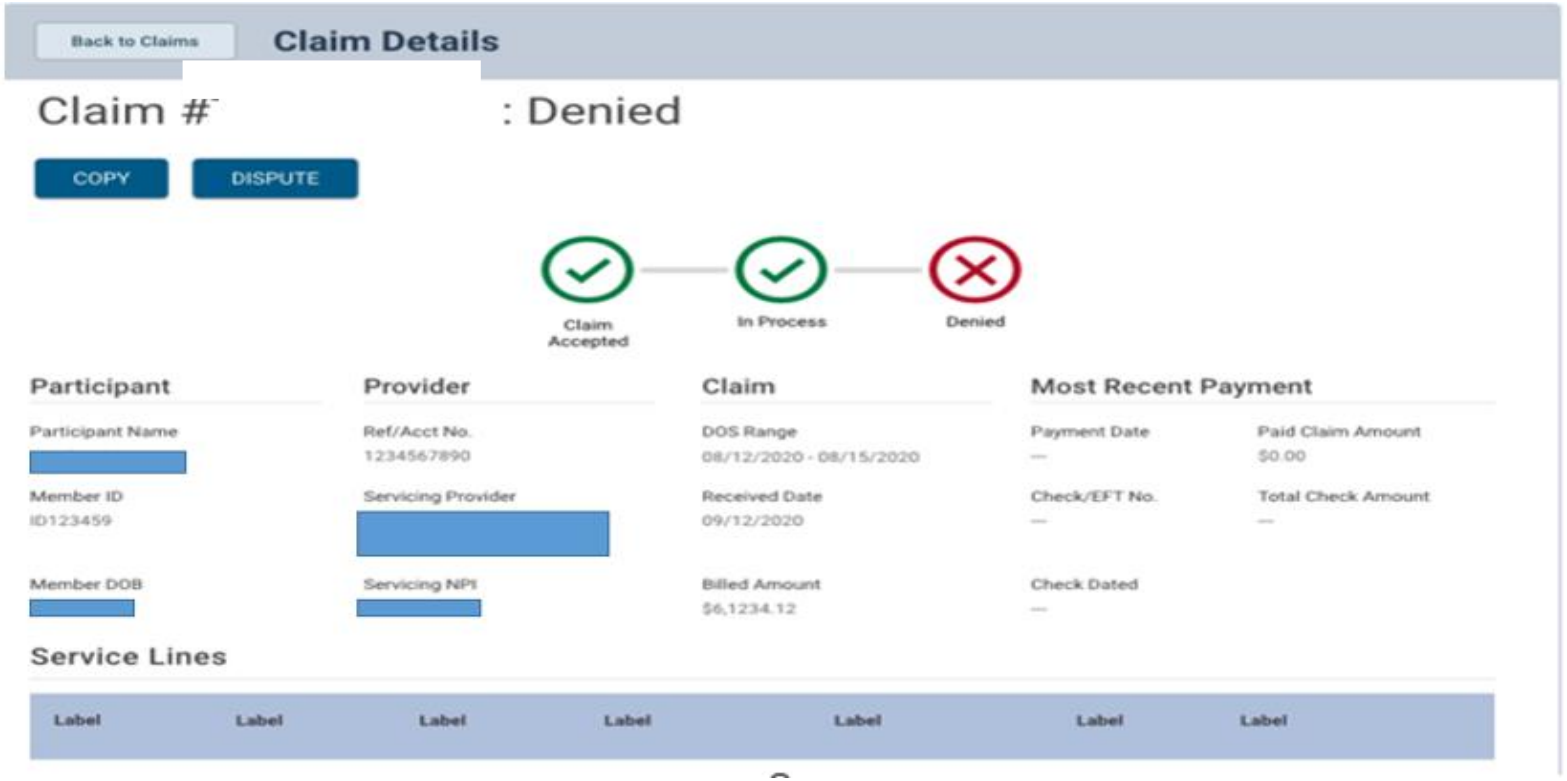
- It is important to note that all requests submitted via the online Portal for Level 1 will be considered an **informal dispute.** Secure messages are not considered reconsiderations/appeals.

- Calling Provider Services **will not** pause the time frame for timely submissions for informal disputes.

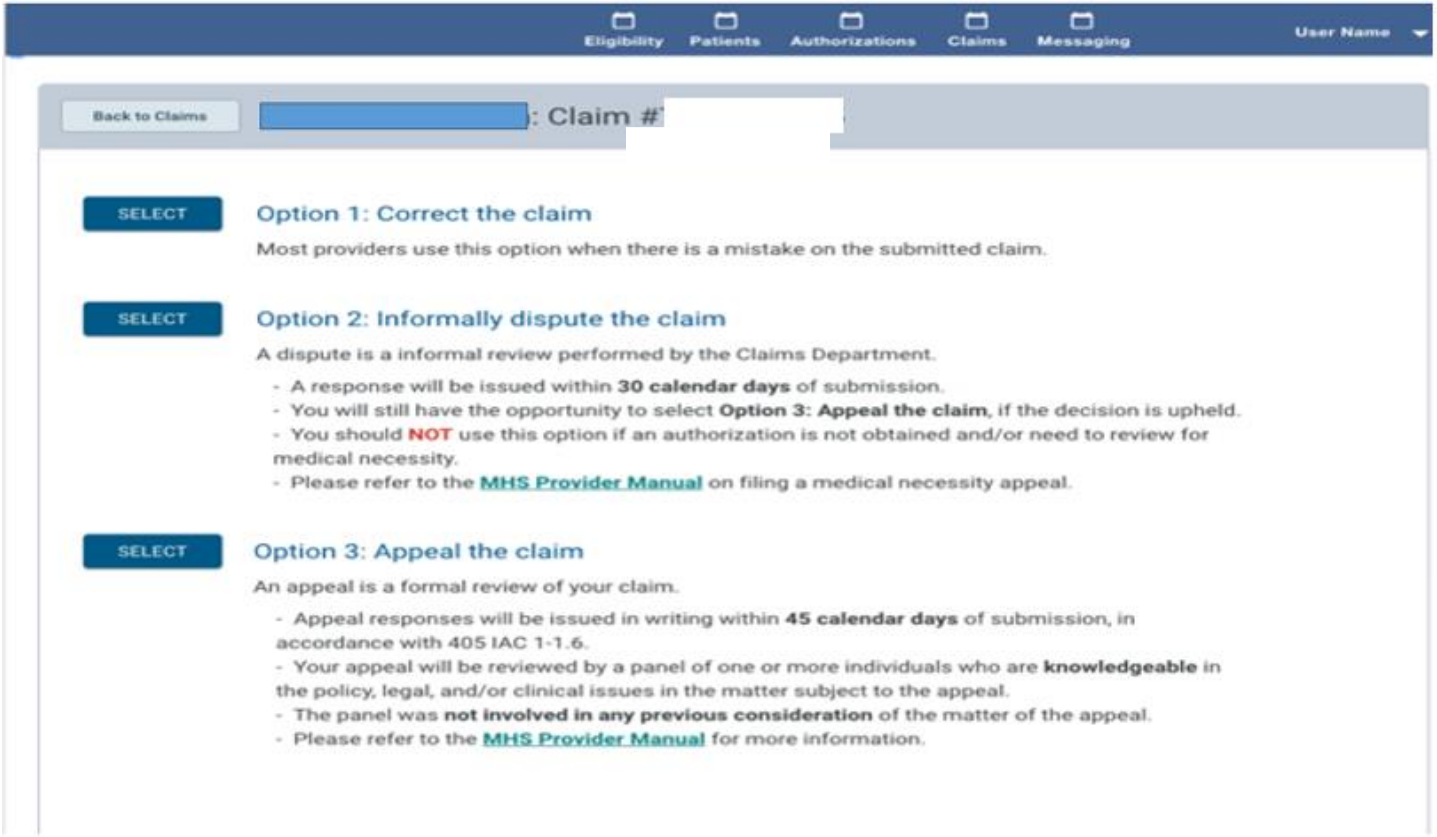
- Providers **do not** need to call prior to submitting an online claim reconsideration/information dispute.

- 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

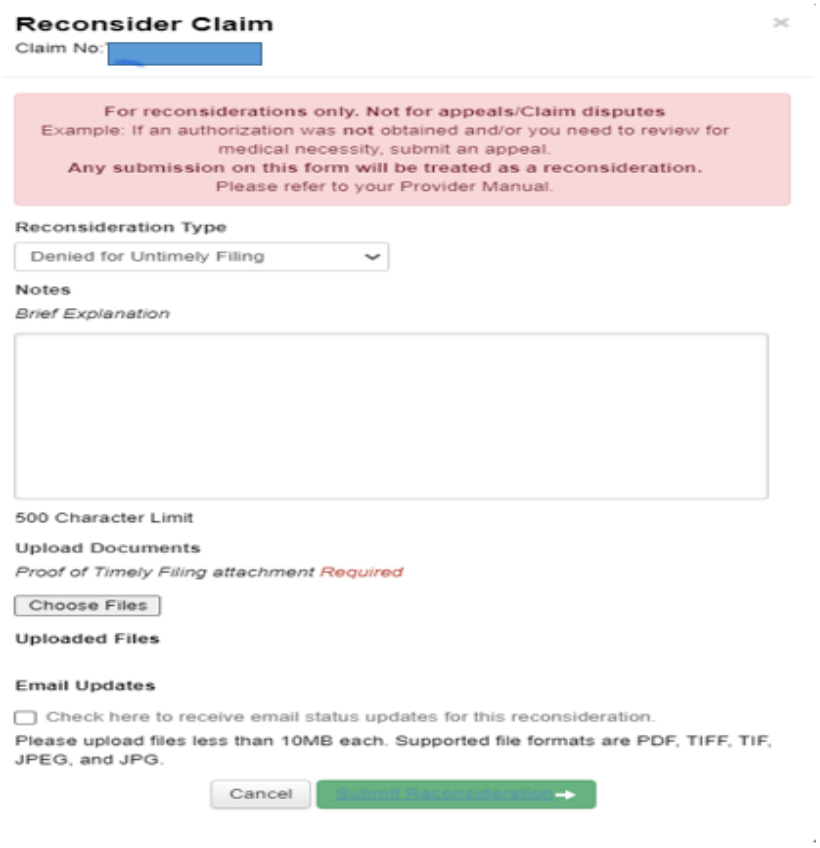


Level 1 Informal Claim Dispute and Level 2 Claim Appeals on the Secure Provider Portal Cont.

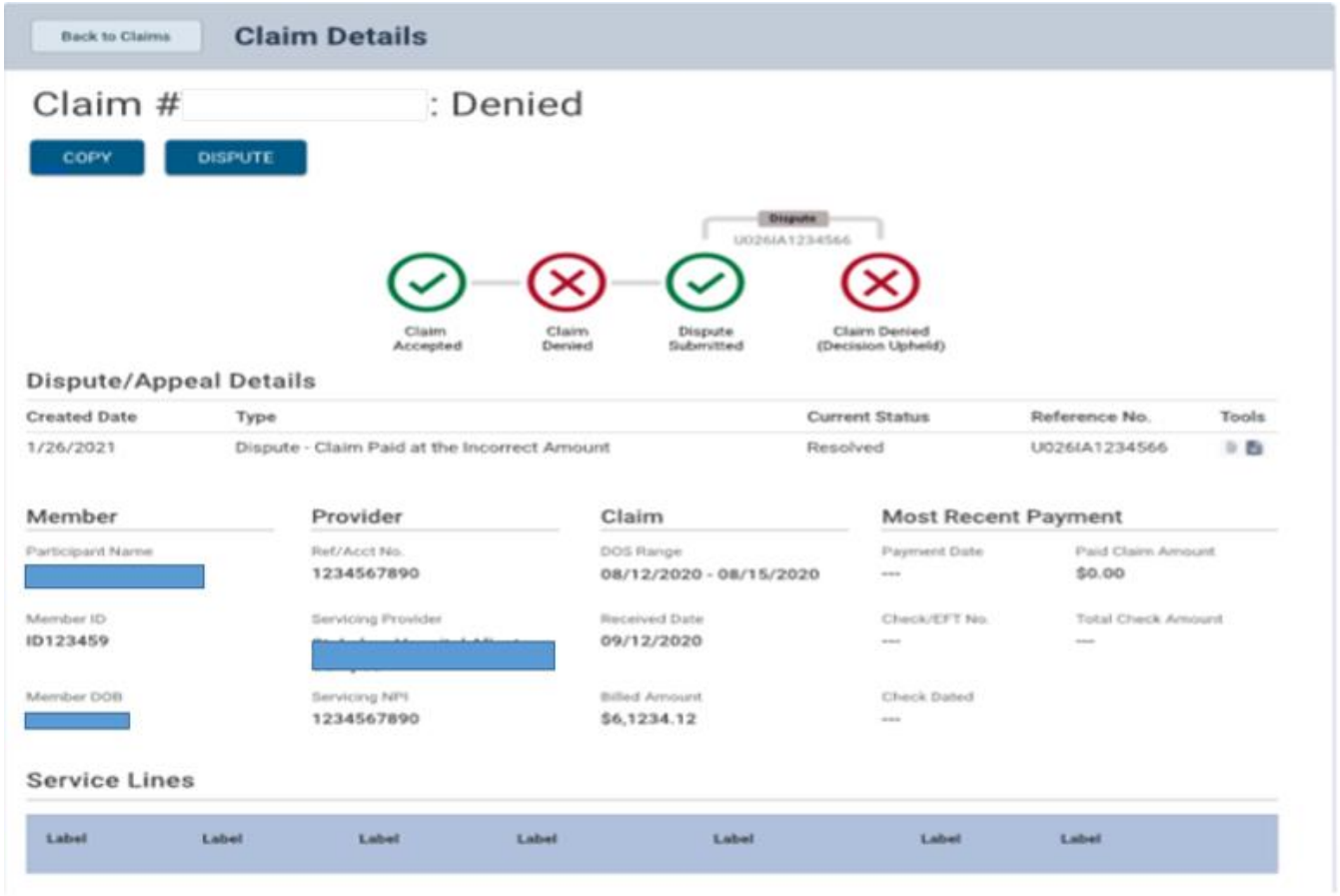


Claim Reconsideration

- Enter your explanation for reconsideration and check email updates.



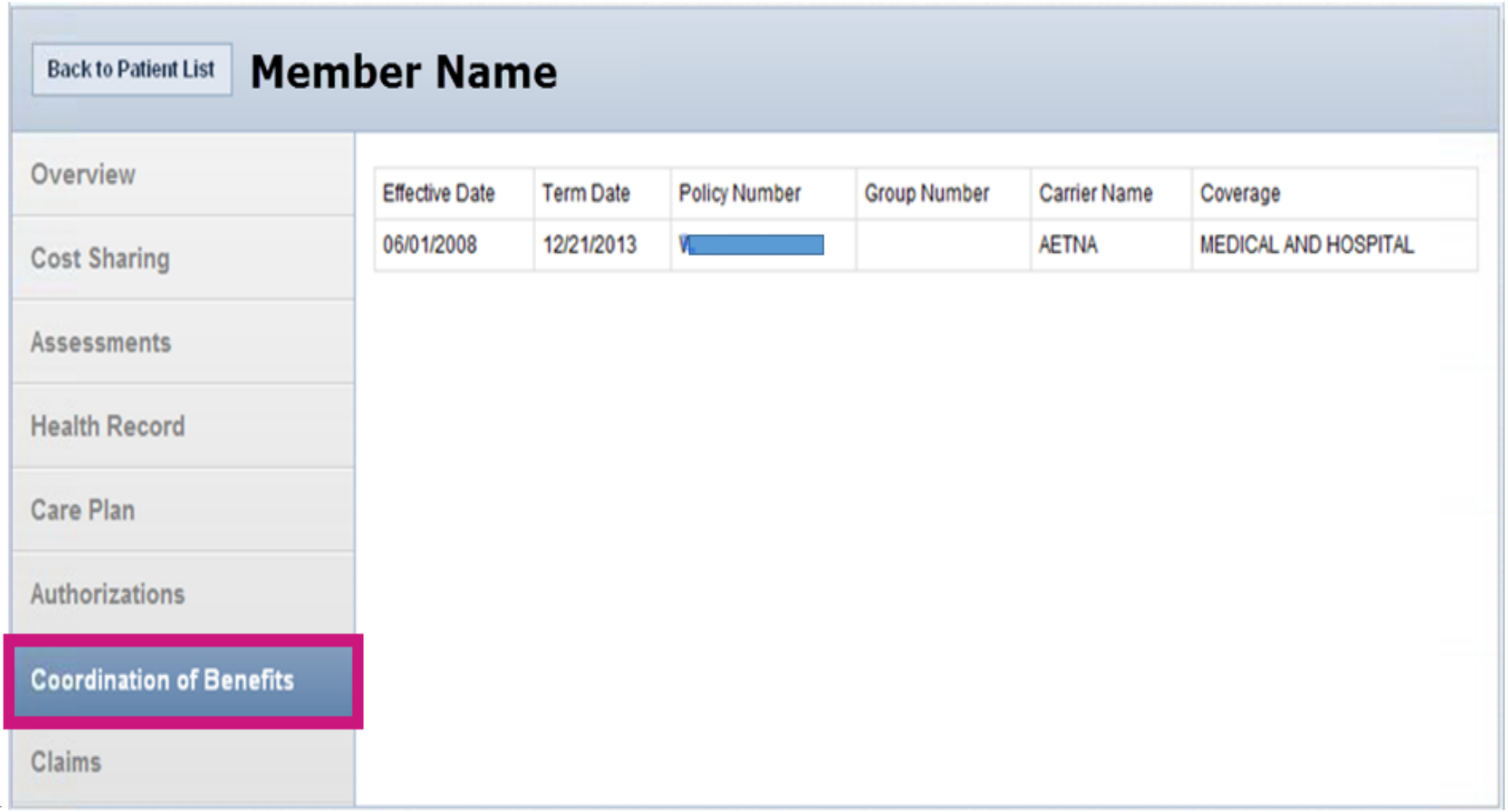
Level 1 Informal Claim Dispute and Level 2 Claim Appeals on the Secure Provider Portal Cont.



Coordination of Benefits

Coordination of Benefits

- This screen is available if a member has other insurance, it is found on the Patient List tab.



Prior Authorization

Prior Authorization Considerations

Need to know what requires Authorization

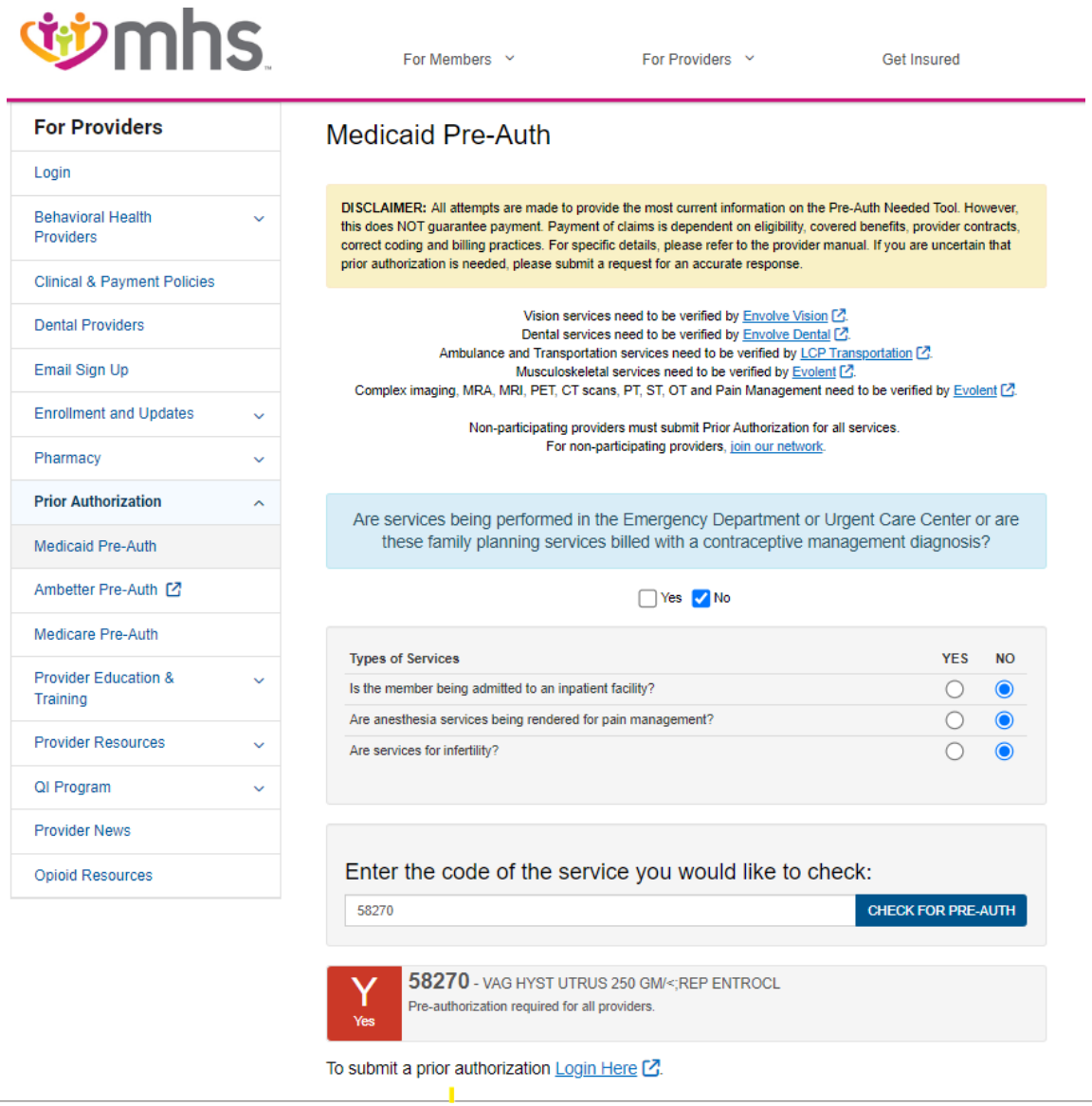
- Pre-Authorization tool

How to obtain Authorization

- Online thru the Portal
- Phone: 1-877-647-4848 8am to 8pm Eastern
- Fax: 1-866-912-4245

Authorizations do not guarantee payment

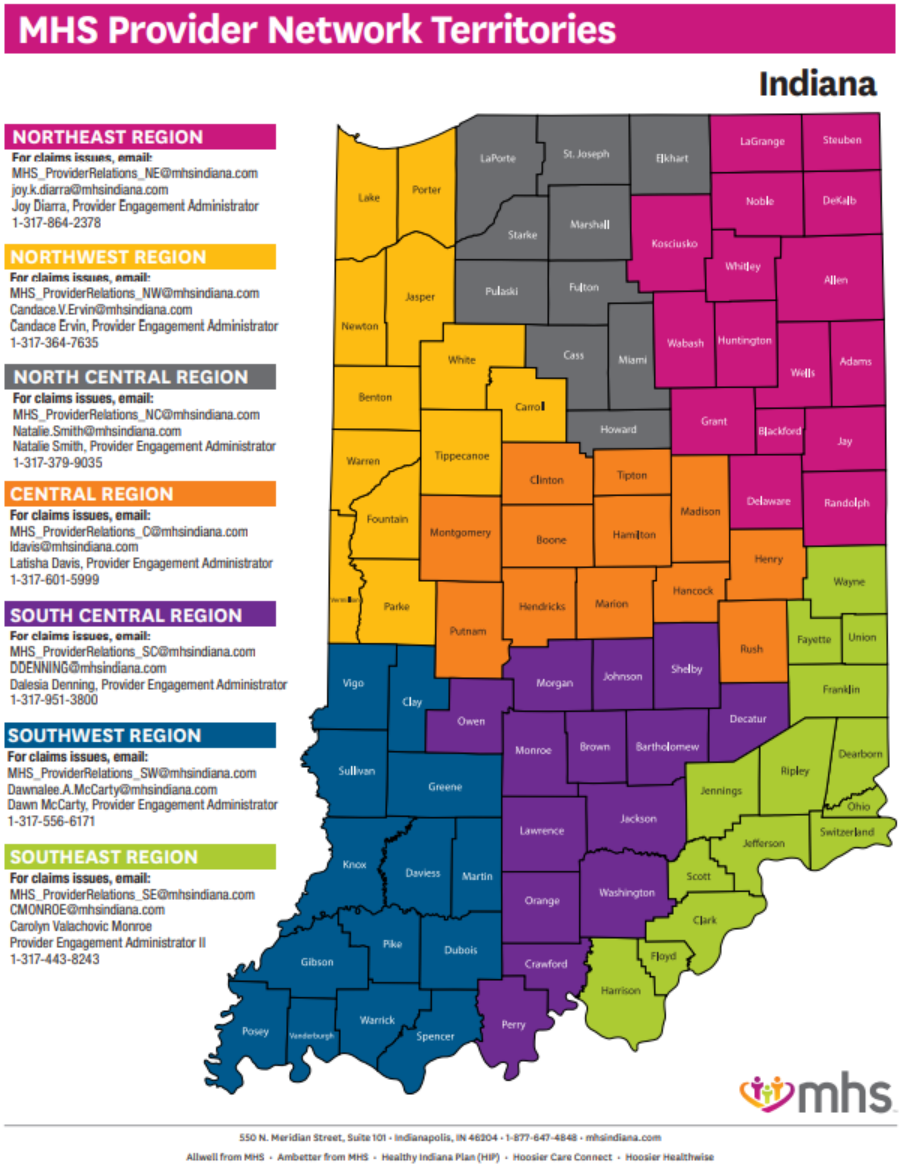
Prior Authorization



MHS Team

MHS Team

MHS Provider Network Territories



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

MHS Team Cont.

MHS Provider Network Territories

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Parkview Health System
Beacon Medical Group
American Senior Care
CarDon & Associates
Orthoindy
Heart City Health
ONE
Franciscan Health

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

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Questions?
Thank you for being our partner in care.