

# IHCP ROADSHOW 2021







## MHS UPDATES, TIPS AND REMINDERS



Hoosier Healthwise | Healthy Indiana Plan | Hoosier Care Connect



# Agenda

-  MHS Updates
-  MHS Provider Claims Issue Resolution Process
-  Prior Authorization Reminders
-  Provider Analytics
-  MHS Provider Relations Team
-  Questions

# MHS Updates

# EFTs 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 [payspanhealth.com](https://payspanhealth.com)



For questions call 1-877-331-7154 or email [providersupport@payspanhealth.com](mailto:providersupport@payspanhealth.com)

PaySpan® Health

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

- Call 1-877-331-7154 for your unique registration code. Then, visit [payspanhealth.com](https://payspanhealth.com) and click **Register**.
- Enter your registration code and click **Submit**.
- Enter your PIN, TIN or EIN, and NPI. Then, click **Start Registration**.

<input type="text"/> National Provider Identifier (NPI) <input type="text"/> Provider Federal Tax Identification Number (TIN) or <input type="text"/> Provider Identification Number (PIN)	<input type="text"/> Exp. Date <input type="text"/> Start a New Account
OR	
<input type="text"/> Billing Site Code (if applicable)	
<input type="button" value="Submit"/>	
- Populate the requested Personal Information. Click **Next**.

<input type="text"/> Provider Contact Name <input type="text"/> Administrator Full Name <input type="text"/> Email Address <small>Notifications will be sent to this address.</small> <input type="text"/> Confirm Email Address <input type="text"/> Telephone Number <small>Must start with the 800-331-7154 Prefix.</small> <input type="text"/> Title <input type="text"/> Office Manager	<input type="text"/> Username <small>Minimum: 8 characters and may include letters (a-z), numbers (0-9), dashes (-), underscores (_), ampersands (&amp;), periods (.)</small> <input type="text"/> Password <input type="text"/> Confirm Password <input type="text"/> Challenge Question <small>In order only when your first pass</small> <input type="text"/> Challenge Answer <input type="button" value="Next"/>
---	--
- Designate an account for fund transfers by completing the required fields. Click **Next**.

Account Name  
This is the account that will be used to identify the incoming account throughout the PaySpan system.  
 Financial Institution Routing Number  
 Provider's Account Number with Financial Institution  
 Confirm Provider's Account Number with Financial Institution  
 Type of Account at Financial Institution  
 Account Checking  
 Enable Electronic Payment  
 Request Paper Remittance  
The Paper does not allow paper remittance.  
 Add paper or additional paper to this remitting account
- Verify your information and check the box to agree to the service agreement. Then, click **Confirm**.
- 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](mailto:providersupport@payspanhealth.com)

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0221.PR.PF.L 2/21

# Smoking Cessation


-  All counseling can be billed to MHS using CPT code 99407- U6.
-  Counseling must be at least 10 minutes.
-  **\$50 “pay above” incentive for initial counseling visit for Hoosier Care Connect members only.**
-  The Indiana Tobacco Quitline:
  - 1-800-QUIT-NOW (1-800-784-8669)
  - Free phone-based counseling service that helps Indiana smokers quit.
  - One on one coaching for tobacco users trying to quit.
  - Resources available for both providers and patients.

# 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



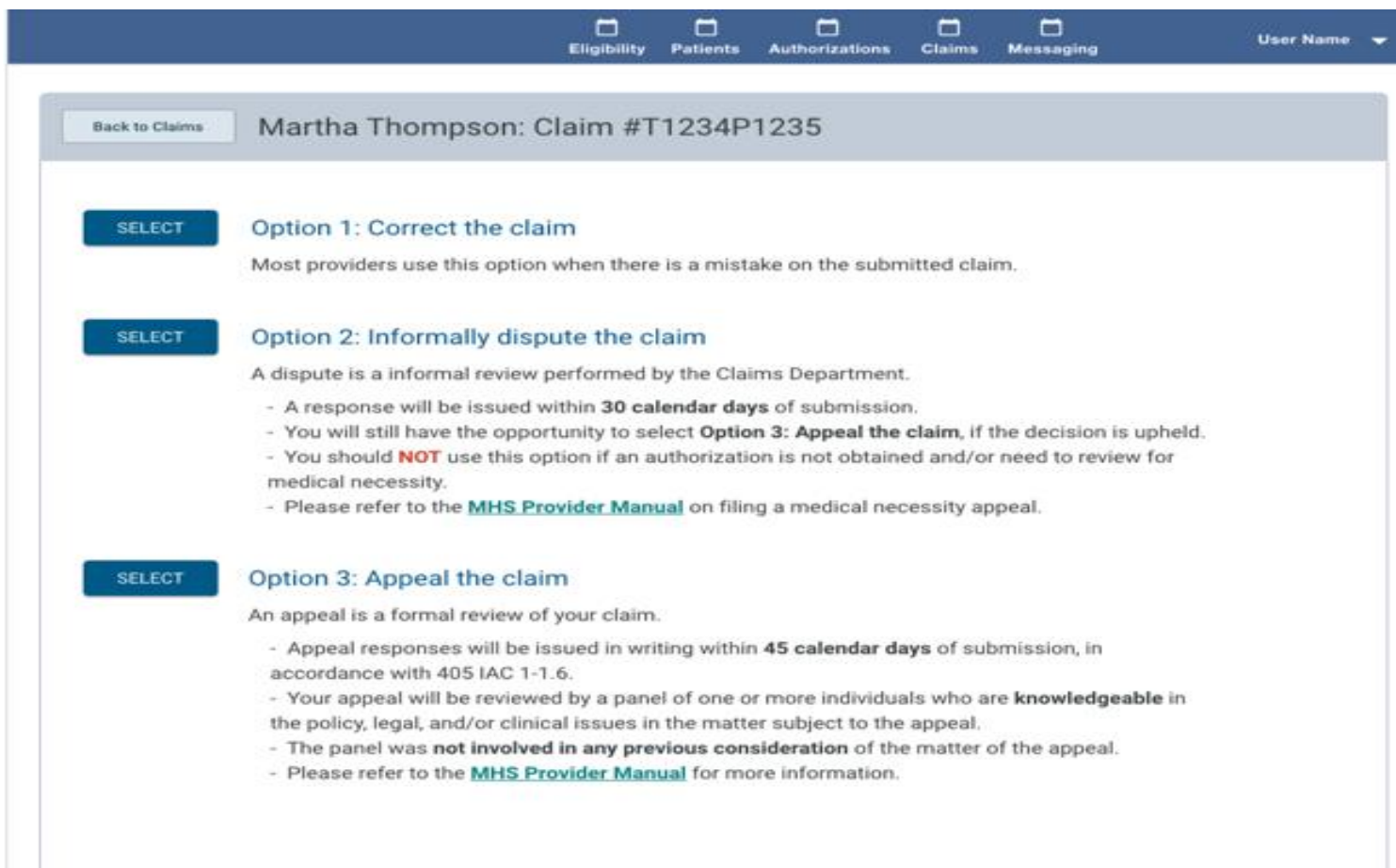
Claim Accepted
In Process
Denied

Participant	Provider	Claim	Most Recent Payment	
<p><b>Participant Name</b> Martha Johnson</p> <p><b>Member ID</b> ID123459</p> <p><b>Member DOB</b> 04/26/1982</p>	<p><b>Ref/Acct No.</b> 1234567890</p> <p><b>Servicing Provider</b> St. Lukes Hospital Allentown Campus</p> <p><b>Servicing NPI</b> 1234567890</p>	<p><b>DOS Range</b> 08/12/2020 - 08/15/2020</p> <p><b>Received Date</b> 09/12/2020</p> <p><b>Billed Amount</b> \$6,1234.12</p>	<p><b>Payment Date</b> --</p> <p><b>Check/EFT No.</b> --</p> <p><b>Check Dated</b> --</p>	<p><b>Paid Claim Amount</b> \$0.00</p> <p><b>Total Check Amount</b> --</p>

**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



The screenshot shows a web interface for a provider portal. At the top, there is a navigation bar with icons and labels for 'Eligibility', 'Patients', 'Authorizations', 'Claims', and 'Messaging', along with a 'User Name' dropdown. Below this, a header bar displays 'Back to Claims' and 'Martha Thompson: 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.

# 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

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**

Participant Name  
**Martha Johnson**

Member ID  
**ID123459**

Member DOB  
**04/26/1982**

**Provider**

Ref/Acct No.  
**1234567890**

Servicing Provider  
**St. Lukes Hospital Allentown Campus**

Servicing NPI  
**1234567890**

**Claim**

DOS Range  
**08/12/2020 - 08/15/2020**

Received Date  
**09/12/2020**

Billed Amount  
**\$6,1234.12**

**Most Recent Payment**

Payment Date  
---

Check/EFT No.  
---

Check Dated  
---

Paid Claim Amount  
**\$0.00**

Total Check Amount  
---

**Service Lines**

Label	Label	Label	Label	Label	Label	Label



# 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

Dispute
Appeal  
U026IA1234566
ABCDE1234567

**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 <b>Martha Johnson</b>	Ref./Acct No. <b>1234567890</b>	DOS Range <b>08/12/2020 - 08/15/2020</b>	Payment Date ---	Paid Claim Amount <b>\$0.00</b>
Member ID <b>ID123459</b>	Servicing Provider <b>St. Lukes Hospital Allentown Campus</b>	Received Date <b>09/12/2020</b>	Check/EFT No. ---	Total Check Amount ---
Member DOB <b>04/26/1982</b>	Servicing NPI <b>1234567890</b>	Billed Amount <b>\$6,1234.12</b>	Check Dated ---	

**Service Lines**

Label	Label	Label	Label	Label	Label	Label

# Prior Authorization/Medical Necessity Appeals on the Provider Secure Portal

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

# Prior Authorization/Medical Necessity Appeals on the Provider Secure Portal

The screenshot shows the mhs Provider Secure Portal dashboard. At the top, there are navigation tabs for Eligibility, Patients, Authorizations, Claims, and Messaging. Below these are search filters for TIN (0000000000) and Plan Type (Medicaid), with a 'Go' button. A red box highlights the 'Authorizations' tab, and a red arrow points to a 'Select "Authorizations"' button. A pink note box contains the following text:

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

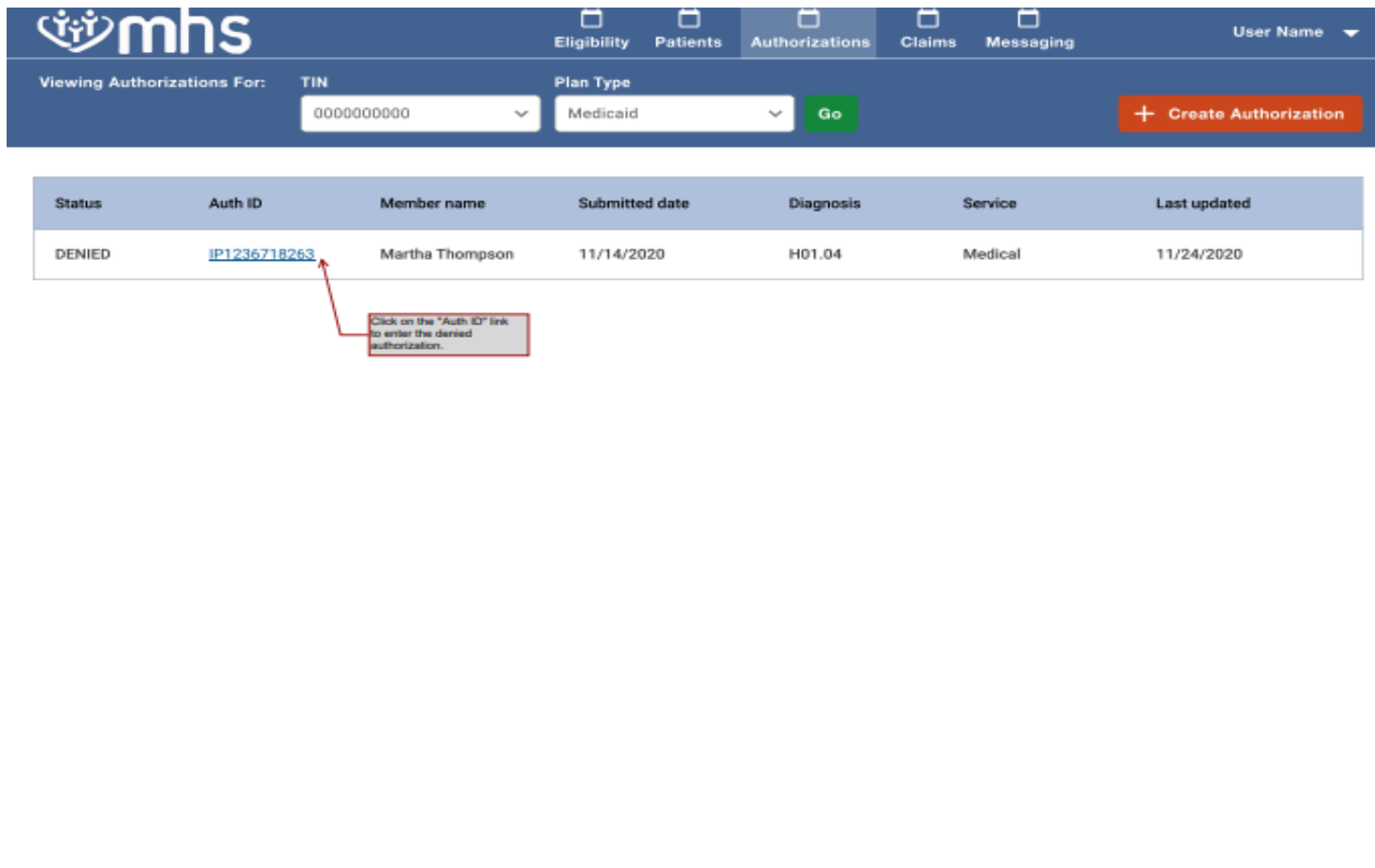
Below the note is a 'Quick Eligibility Check for Medicaid' section with input fields for Member ID or Last Name (47362539 or Smith) and Birthdate (mm/dd/yyyy), and a 'Check Eligibility' button.

The 'Recent Claims' section displays a table with the following data:

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

On the right side, there is a 'Welcome' section with buttons for 'Add a TIN to My ACCOUNT', 'Reports', 'Patient Analytics', 'Provider Analytics', and 'Provider Complaints'. Below this is a 'Recent Activity' section showing '10/10/2020 Claim XYZ' and a 'Quick Links' section with buttons for 'Provider Resources', 'Member Management Forms', 'IHCP Provider Health Portal', 'Peer to Peer Contact Form', and 'Pharmacy'.

# Prior Authorization/Medical Necessity Appeals on the Provider Secure Portal



The screenshot displays the mhs Provider Secure Portal interface. At the top, there are navigation tabs for Eligibility, Patients, Authorizations, Claims, and Messaging. The 'Authorizations' tab is selected. Below the navigation, there is a search area for 'Viewing Authorizations For:' with fields for TIN (0000000000) and Plan Type (Medicaid), a 'Go' button, and a '+ Create Authorization' button. A table below shows a list of authorizations with the following data:

Status	Auth ID	Member name	Submitted date	Diagnosis	Service	Last updated
DENIED	<a href="#">IP1235718265</a>	Martha Thompson	11/14/2020	H01.04	Medical	11/24/2020

A red arrow points from a text box to the 'Auth ID' link in the table. The text box contains the instruction: 'Click on the "Auth ID" link to enter the denied authorization.'

# Prior Authorization/Medical Necessity Appeals on the Provider Secure Portal

The screenshot displays the mhs Provider Secure Portal interface. At the top, there are navigation tabs for Eligibility, Patients, Authorizations, Claims, and Messaging, along with a User Name dropdown. Below this is a search bar for 'Viewing Authorizations For:' with fields for TIN (0000000000) and Plan Type (Medicaid), a 'Go' button, and a '+ Create Authorization' button.

The main content area shows a sidebar with navigation options: Overview, Cost Sharing, Assessments, Health Record, Care Plan, Authorizations (highlighted), Referrals, Coordination of Benefits, Claims, and Document Center. The 'Overview' section for a specific authorization is displayed, showing the following details:

- Auth Status:** DENIED
- Auth Nbr:** IP1236718263
- Amit Date:** 03/27/2019
- Service Date:** 03/27/2019
- Provider of Service(s):** Mary Littlelamb, MD
- Diagnosis Code(s):** H10.04
- Explanation:** Does not meet medical necessity criteria per CH.EH.123 Section 4
- Auth Type:** INPATIENT
- Service:** Medical
- Discharge:** 04/02/2019
- Procedure Code(s):** 92002
- Note & Attachments:** [View](#)

Below the overview is a table with the following columns: Line Item, Service Type, From Date, To Date, Stay Level, Location, Status, Medical Necessity, and Decision Date.

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

Below the table, there is a section for 'Appeal Requests for Authorization IP1236718263'. A red box highlights the text: 'The next screen that will open will list the denied authorization details for the authorization you selected.' An arrow points from this box to a 'REQUEST APPEAL' button.

Below the 'REQUEST APPEAL' button is a table with the following columns: Status, Request ID, Type, Requested by, and Submitted.

Status	Request ID	Type	Requested by	Submitted
No appeal requests have been submitted for this authorization.				

# Prior Authorization/Medical Necessity Appeals on the Provider Secure Portal

Back
Submit Appeal Request

**Authorization Detail**

Authorization Number  
IP1236718263

Patient Full Name  
Martha Thompson

Patient DOB  
06/20/1981

Admittance Date  
03/27/2019

Service Date  
03/27/2019

Discharge Date  
04/02/2019

Provider of Service  
Mary Littlelamb, MD

Authorization Type  
Inpatient

Service  
Medical

Diagnosis Code(s)  
H01.04

Procedure Code(s)  
92002

## Appeal Request Form

Appeal Request for Authorization IP1236718263

**Appeal type\***  
Please select one or more appeal types.

Administrative ← The "Appeal Request Form" page will open. Select the type of appeal for your appeal request.

Medical Necessity

DENIED

Explanation  
Does not meet medical necessity criteria per CH.EH.123 Section 4. ← The denial reason will give the reason for the denial.

[View Notes & Attachments](#)

**Provider Submitting the Appeal\*** **Office Contact Name\*** **Phone\***

Enter last name or NPI

Enter full name

Enter ten-digit number

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

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

2000 characters remaining

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

.../Folder 1/Folder 2/Folder 3/File.pdf UPLOAD FILE

2000 characters remaining

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

SAVE & REVIEW

← Click "Save & Review" to submit the appeal.

# Prior Authorization/Medical Necessity Appeals on the Provider Secure Portal

Back
Submit Appeal Request

**Authorization Detail**

Authorization Number  
IP1236718263

Patient Full Name  
Martha Thompson

Patient DOB  
06/20/1981

Admittance Date  
03/27/2019

Service Date  
03/27/2019

Discharge Date  
04/02/2019

Provider of Service  
Mary Littlelamb, MD

Authorization Type  
Inpatient

Service  
Medical

Diagnosis Code(s)  
H01.04

Procedure Code(s)  
92002

## Appeal Request Form

Appeal Request for Authorization IP1236718263

**Appeal type\***  
Please select one or more appeal types.

Administrative

Medical Necessity

DENIED

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

[View Notes & Attachments](#)

Are you sure you want to go back?

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

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

2000 characters remaining

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

.../Folder 1/Folder 2/Folder 3/File.pdf UPLOAD FILE

2000 characters remaining

File	Type	Size	
PatientHistory_1.pdf	PNG	230kb	<input type="checkbox"/>
MarthaThompson12345_XRAY_010119.png	PNG	9.1mb	<input type="checkbox"/>

SAVE & REVIEW

# Prior Authorization/Medical Necessity Appeals on the Provider Secure Portal

[Back](#) **Review Appeal Request**

The "Review Appeal Request" screen will open to allow you to preview the appeal information prior to submitting.

## Review

Appeal request for Authorization IP1236718263

**Original Authorization**

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

**Appeal Request**

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

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

Evidence Materials & Attachments

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

After verifying the appeals entry information is correct, click "Send Request".

**SEND REQUEST**



# Prior Authorization/Medical Necessity Appeals on the Provider Secure Portal

Thank you! Your Appeal Request has been successfully submitted! After clicking the "Send Request" button, a message appears at the top of the screen to confirm the appeal has been submitted.

[Back to Authorizations](#)

Overview	<b>Auth Status:</b> DENIED <b>Auth Nbr:</b> IP1236718263 <b>Amit Date:</b> 03/27/2019 <b>Service Date:</b> 03/27/2019 <b>Provider of Service(s):</b> Mary Littlelamb, MD <b>Diagnosis Code(s):</b> H10.04	<b>Explanation:</b> Does not meet medical necessity criteria per CH.EH.123 Section 4 <b>Auth Type:</b> INPATIENT <b>Service:</b> Medical <b>Discharge:</b> 04/02/2019 <b>Procedure Code(s):</b> 92002 <b>Note &amp; Attachments:</b> <a href="#">View</a>
----------	--	--

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

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

Status	Request ID	Type	Requested by	Submitted
In-Process	<a href="#">IC-2885</a>	Administrative, Medical Necessity	Mary Littlelamb	11/24/2020

# Prior Authorization/Medical Necessity Appeals on the Provider Secure Portal

**Appeal Request Status**

To check the status of the appeal submission, enter the appeal within your account. The "Appeal Request Status" screen will open.

### Appeal Request for Authorization IP1236718263

Current status: **In-Process**

The "Current status" will reflect the status of the appeal.

The "Appeal Summary" at the bottom of the page will reflect the status of the "In-Process" appeal and allows tracking from submission to decision.

Original Authorization		
Authorization Number IP1236718263	Member Name Martha Thompson	Member DOB 12/32/1921

Appeal Request		
Appeal Request Type Administrative, Medical Necessity	Office Contact Name Jimmy Johnson	Request ID IC-2885
Provider Mary Littlelamb, MD	Office Contact Phone (555) 555-5555	Submitted on 11/24/2020

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

Evidence materials & Attachments

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

### Appeal Summary

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

# Updated Provider EOPs (Explanation of Payment) via the MHS Portal

**Coming soon:** MHS will simplify the process for Providers to access claim summaries of claims paid.

## Benefits



The new EOP is:

- Cleaner
- Easier to read
- Matches what is sent in the mail
- Can be saved and downloaded directly from the EOP screen
- Includes negative balance if available

## Change Overview



The payment history check feature will take the provider to an actual copy of the EOP they received directly from the check company versus the previous portal data dump.

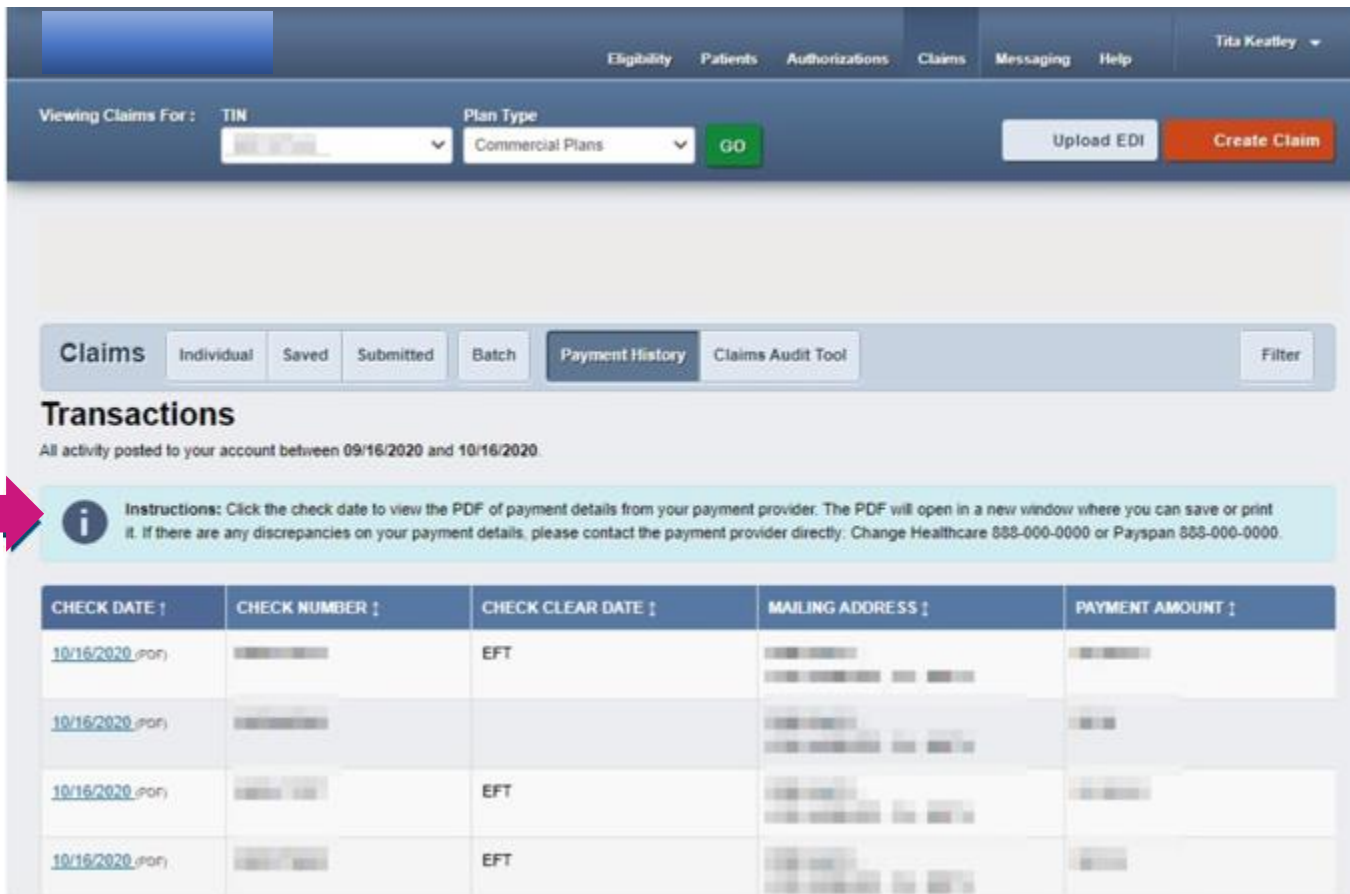


Currently negative balance is not shown on the portal EOP. By having the actual EOP, the negative balance data will now be included whenever it is present on the EOP the provider receives.



My Download feature will be retired as the new PDF file can be saved and downloaded directly from the EOP screen.

# Updated Provider EOPs (Explanation of Payment) via the MHS Portal



The screenshot shows the MHS Portal interface. At the top, there are navigation tabs: Eligibility, Patients, Authorizations, Claims, Messaging, and Help. A user profile for 'Tita Keatley' is visible in the top right. Below the navigation, there are filters for 'Viewing Claims For' (TIN) and 'Plan Type' (Commercial Plans), along with 'Upload EDI' and 'Create Claim' buttons. The main content area is titled 'Claims' and includes sub-tabs: Individual, Saved, Submitted, Batch, Payment History (selected), and Claims Audit Tool. A 'Filter' button is also present. Under the 'Payment History' tab, the section is titled 'Transactions' and shows 'All activity posted to your account between 09/16/2020 and 10/16/2020'. A pink arrow points to an information box that reads: 'Instructions: Click 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 the payment provider directly. Change Healthcare 888-000-0000 or Payspan 888-000-0000.' Below this is a table with the following columns: CHECK DATE, CHECK NUMBER, CHECK CLEAR DATE, MAILING ADDRESS, and PAYMENT AMOUNT. The table contains four rows of transaction data, all dated 10/16/2020 and cleared via EFT.

CHECK DATE	CHECK NUMBER	CHECK CLEAR DATE	MAILING ADDRESS	PAYMENT AMOUNT
10/16/2020 .pdf		EFT		
10/16/2020 .pdf				
10/16/2020 .pdf		EFT		
10/16/2020 .pdf		EFT		

# Updated Provider EOPs (Explanation of Payment) via the MHS Portal

## Old version of the EOP

### Explanation of Payment Details

[Back to Payments List](#)
[Download \(Excel Format\)](#)
[Print](#)

Check/Trace Number: 0000195249    Check Date: 01/28/2021

Insured Name: ██████████

Patient Name: ██████████

Control Number: ██████████

Service Provider: ██████████

Group: ██████████

ID: ██████████

Account: ██████████

NPI: ██████████

[View Service Line Details](#)

Serv	Date	Proc#/ Proc2	Mod	Days/ Cnt Qty	Charged	Allowed	Deduct/ Copay	Coinsur	Discount/ Interest	Med Allow/ Med Paid	TPP	Denied	Remit Codes	Payment
10	01/21/2021	J1050		0/150	300.00	85.50	0.00/0.00	17.10	0.00/0.00	0.00/0.00	0.00	0.00	SR,21	68.40
Sub Total:					300.00	85.50	0.00/0.00	17.10	0.00/0.00	0.00/0.00	0.00	0.00		68.40

#### Remit Code Descriptions

SR  
SEQUESTRATION WAIVED 05-01 TO 12-31-20 DATES OF SERVICE

21  
PAID-CONSURANCE APPLIED

[View Service Line Details](#)

Serv	Date	Proc#/ Proc2	Mod	Days/ Cnt Qty	Charged	Allowed	Deduct/ Copay	Coinsur	Discount/ Interest	Med Allow/ Med Paid	TPP	Denied	Remit Codes	Payment
10	01/07/2021	90750		0/1	165.00	132.00	0.00/0.00	0.00	0.00/0.00	0.00/0.00	0.00	165.00	88,EC	0.00
Sub Total:					165.00	132.00	0.00/0.00	0.00	0.00/0.00	0.00/0.00	0.00	165.00		0.00

# Updated Provider EOPs (Explanation of Payment) via the MHS Portal

## New Version of the EOP

Electronic Service Requested

606 0.7648 AV 0.366 S-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 Ctr/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

# MCG (Milliman Care Guidelines) Auto Auth

 **Coming Soon:** MCG Auto Auth will allow providers the ability to complete Medical Necessity Reviews via the portal when submitting an authorization request.




# **MCG (Milliman Care Guidelines) Auto Auth**

-  Reduce the costs associated with prior authorization process (reduce administrative burden).
-  Drive increased provider web adoption through a mutually beneficial web authorization process.
-  A near real time determination is the incentive for providers to adopt the web authorization process.





# Behavioral Health Integration



## HOW DOES THIS AFFECT ME AS A PMP?

-  PMPs can assist in coordinating care for members with known or suspected behavioral health needs by helping them access an MHS behavioral health provider.
-  You have access to complete claim history via the online MHS Secure Provider Portal that includes detail regarding behavioral health services received by your members.
-  Members may also self-refer for outpatient behavioral health services by scheduling an appointment directly with an MHS provider; these services **DO NOT** require a referral from the PMP.






# Behavioral Health Integration

-  Training is available to assist in the identification of members in need of behavioral health services to ensure coordination of physical and behavioral healthcare among all providers.
-  MHS encourages the use of the Behavioral/Physical Health Coordination Form ([www.mhsindiana.com](http://www.mhsindiana.com)) so that providers can easily, efficiently, and legally exchange information.




# Behavioral Health Trainings

-  MHS also offers a variety of live training opportunities for Providers. Attendees will need to log into the GoToTraining room and will also need to call into the conference number.
-  For a list of upcoming trainings and to register, go to the [GoToTraining](https://mhsindiana.com/GoToTraining) page on mhsindiana.com.





# Behavioral Health Training Examples

-  Substance Related and Addictive Disorders, Module 1
-  Behavioral Health 101 Series, Anxiety
-  DSM 5, Module 1
-  Motivational Interviewing, Level 1, Part 1
-  Behavioral Health 101 Series, Bipolar Disorder

# Person Centered Thinking Training

-  MHS has developed training via podcast for our contracted providers.
-  Please contact your Provider Partnership Associate to register.
-  The core concept training for anything Person Centered teaches staff how to better discover what is important to the person and what is important for the person and to find balance between the two.






# Person Centered Thinking Training Podcasts

-  Lesson 1 – Person Centered Thinking – Overview
-  Lesson 2 – Person Centered Thinking – Core Concepts
-  Lesson 3 – Person Centered Thinking – Promoting Positive Control
-  Lesson 4 – Person Centered Thinking – Moving to Support

# **MHS Provider Claims Issue Resolution**

# Provider Claims Issue Resolution





## PROCESS

-  Level 1: Informal Claims Dispute or Objection Form
-  Level 2: Formal Claim Dispute - Administrative Claim Appeal
-  Level 3: Arbitration
-  For assistance or questions after completing step one:
  - Provider Services Phone Requests & Web Portal Inquiries
-  If additional assistance is needed anytime after Step 1 and after calling Provider Services or completing Web Portal inquiry:
  - Provider Relations Regional Mailboxes



# Informal Claims Dispute or Objection Form

## Level 1:


-  Must be submitted within **60 calendar days** of receipt of the MHS Explanation of Payment (EOP) either utilizing our online reconsideration tool via the MHS Secure Provider Portal or in writing by using the MHS Claim Dispute/Appeal Form, available at [mhsindiana.com/providers/resources/forms](https://mhsindiana.com/providers/resources/forms).
-  The form has now been updated and can be used for either Medical or Behavioral Health claims.
-  The address for submission is listed on the form for both Medical and BH.
-  **Requests received after day 60 will not be considered.**




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

## Previous Screenshot

Back to Claims **Claim Details**

Claim # [REDACTED]: Paid



 Claim Accepted
  In Process
  Paid

Member	Provider	Claim	Most Recent Payment	
Member Name: [REDACTED]	Ref/Acct No.: 1733496	DOS Range: 06/16/2020 - 06/16/2020	Payment Date: 06/22/2020	Paid Claim Amount: \$53.03
Member ID: [REDACTED]	Servicing Provider:	Received Date: 06/17/2020	Check/EFT Number: [REDACTED]	Total Check Amount: \$11,790.03
Member DOB: [REDACTED]	Servicing NPI: [REDACTED]	Billed Amount: \$81.00	Check Dated: 06/22/2020	

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

## Current Screenshot

Back to Claims
Claim Details

Claim #T1234P1235: Denied

COPY

DISPUTE

←

Claim Accepted    In Process    Denied

Participant	Provider	Claim	Most Recent Payment	
Participant Name Martha Johnson	Ref/Acct No. 1234567890	DOS Range 08/12/2020 - 08/15/2020	Payment Date --	Paid Claim Amount \$0.00
Member ID ID123459	Servicing Provider St. Lukes Hospital Allentown Campus	Received Date 09/12/2020	Check/EFT No. --	Total Check Amount --
Member DOB 04/26/1982	Servicing NPI 1234567890	Billed Amount \$6,1234.12	Check Dated --	

**Service Lines**

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

# Medical Claim Dispute/Appeal Form – Medical and Behavioral Health



DO NOT USE THIS FORM FOR MEDICAL NECESSITY APPEALS.

## Medical Claim Dispute/Appeal Form

This form is not required but available to assist in submitting an informal dispute/appeal.

\_\_\_ 1<sup>st</sup> Level (Informal Dispute/Reconsideration)  
 \_\_\_ 2<sup>nd</sup> Level (Appeal) – if you are not satisfied with resolution of informal dispute

This form must be completed in its entirety. In order to consider your request, you must provide an explanation of your appeal and **submit supporting documentation for the dispute/appeal**. Without sufficient documentation, the request cannot be reviewed and the original determination will be upheld.

Provider Name	Provider Tax ID
Provider NPI	Date of last Explanation of Payment
MHS Claim Number *	Dates of Service *
Member Name *	Member ID *

**\* Required fields**

Where more than one of claim number, DOS, member name, or member ID applies for the same appeal reason, please include this information as an attachment.

**Reason for the appeal:**

- Claim was denied for no authorization, but authorization number \_\_\_\_\_ was obtained.
- Claim was denied for no authorization, but no authorization is required for this service.
- Claim was denied for no authorization, however authorization was not obtained due to member's eligibility or medical condition.
- Claims was denied for Member not eligible, but member was eligible on DOS (attach eligibility information).
- Claim was not paid per the terms of my contract with Managed Health Services (attach relevant reimbursement section).
- Claim denied as non-covered benefit (attach supporting documentation as proof the service is a covered benefit).
- Claim was denied "Past Timely Filing" (attach proof of timely filing).
  - o Note: if the past timely filing deadline denials falls on a weekend or a holiday, the provider may request a reconsideration ( see Reconsideration Request Form)
- Claim was paid the incorrect amount (include calculation of expected payment and supporting information).
- Claim denied based on Managed Health Services Payment policy (attach medical records to support services provided).
  - o Note: Payment policies can be found at <https://www.mhsindiana.com/providers/resources/clinical-payment-policies.html>
- Other. Please explain (and provide supporting documentation): \_\_\_\_\_


Please ensure sufficient detail is provided to assist us in the review of your appeal.


Preferred submission via the Provider Portal: Informal disputes – currently available;  
 2<sup>nd</sup> level appeal – available online beginning in early 2021

Paper copies of the completed form and all attachments can be sent to:

<b>Medical Claims:</b> Managed Health Services PO Box 3000 Farmington, MO 63640-3800
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<b>Behavioral Health Claims:</b> Managed Health Services BH Appeals PO Box 6000 Farmington, MO 63640-3809
--

 Medical Claims Address:  
 Managed Health Services  
 PO Box 3000  
 Attn: Appeals Department  
 Farmington, MO 63640-3800


 Behavioral Health Claims Address:  
 Managed Health Services BH Appeals  
 PO Box 6000  
 Attn: Appeals Department  
 Farmington, MO 63640-3809

<https://www.mhsindiana.com/content/dam/centene/mhsindiana/medicaid/pdfs/MHS-Dispute-Appeal-form.pdf>





# Informal Claims Dispute or Objection Form

## Level 1:





- 
- A small icon of the MHS logo, showing three stylized human figures in white within a heart shape.
- Submit all documentation supporting your objection.
    - Copies of original MHS EOP showing how the claims in question were processed.
    - 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).

# Informal Claims Dispute or Objection Form





## Level 1:

-  MHS will make all reasonable efforts to review your documentation and respond to you within 30 calendar days.
-  Upon receipt of our response, you will have 60 calendar days from date of dispute response to initiate a formal claim appeal (Level 2).

# Provider Services Phone Requests & Web Portal Inquiries

-  Contacting Provider Services via phone or Web Portal is not considered a formal notification of provider dispute.
-  Claim issues presented by providers to the Provider Services phone line & Web Portal Inquiries for review 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.**
-  **Provider Web Portal:**  
<https://www.mhsindiana.com/providers/login.html>
  - Use the Messaging Tool

# Provider Relations Regional Mailboxes

-  Provider Relations Regional Mailboxes are not considered a formal notification of provider dispute.
-  If Level 1 results in an upheld denial and calling Provider Services or submitting inquiry through portal does not resolve the issue within 45 calendar days, please contact the Provider Relations team through the claims 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. Response to incoming email can take 2-4 weeks depending on workload.
-  Please do not email your Provider Partnership Associate directly as this may delay the time in getting a response due to their travel.



# Provider Relations Regional Mailboxes

## Helpful Tips:











Please submit the following information when sending an email for claims inquiry 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 & NPI
- Member Name and RID 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

## Regional Mailboxes

-  Northeast Region: [MHS\\_ProviderRelations\\_NE@mhsindiana.com](mailto:MHS_ProviderRelations_NE@mhsindiana.com)
-  Northcentral Region: [MHS\\_ProviderRelations\\_NC@mhsindiana.com](mailto:MHS_ProviderRelations_NC@mhsindiana.com)
-  Northwest Region: [MHS\\_ProviderRelations\\_NW@mhsindiana.com](mailto:MHS_ProviderRelations_NW@mhsindiana.com)
-  Central Region: [MHS\\_ProviderRelations\\_C@mhsindiana.com](mailto:MHS_ProviderRelations_C@mhsindiana.com)
-  Southcentral Region: [MHS\\_ProviderRelations\\_SC@mhsindiana.com](mailto:MHS_ProviderRelations_SC@mhsindiana.com)
-  Southwest Region: [MHS\\_ProviderRelations\\_SW@mhsindiana.com](mailto:MHS_ProviderRelations_SW@mhsindiana.com)
-  Southeast Region: [MHS\\_ProviderRelations\\_SE@mhsindiana.com](mailto:MHS_ProviderRelations_SE@mhsindiana.com)
-  Tier 1 Providers: [IndyProvRelations@mhsindiana.com](mailto:IndyProvRelations@mhsindiana.com)






# Formal Claim Dispute - Administrative Claim Appeal

## Step 2

-  Step 2 is a continuation of Step 1 and 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 either in writing using the claim dispute and appeal form with an explanation including any specific details which may justify reconsideration of the disputed claim or by utilizing our online 2<sup>nd</sup> Level appeal process on the secure provider portal.
-  Administrative claim appeals need to be submitted to: **Managed Health Services, P.O. Box 3000, Farmington, MO 63640**
-  See the MHS Provider Manual Chapter 5 Claims Administrative Reviews and Appeals for more information.  
[https://www.mhsindiana.com/content/dam/centene/mhsindiana/medicaid/pdfs/Provider\\_Manual\\_2020.pdf](https://www.mhsindiana.com/content/dam/centene/mhsindiana/medicaid/pdfs/Provider_Manual_2020.pdf)


# Arbitration

## Step 3:



-  Step 3 is a continuation of Steps 1 & 2 and 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 (Step 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, unless otherwise directed in the letter.
-  See the MHS Provider Manual Chapter 5 Claims Administrative Reviews and Appeals for more information.  
[https://www.mhsindiana.com/content/dam/centene/mhsindiana/medicaid/pdfs/Provider\\_Manual\\_2020.pdf](https://www.mhsindiana.com/content/dam/centene/mhsindiana/medicaid/pdfs/Provider_Manual_2020.pdf)

# **Prior Authorization Reminders**






# Physical Medicine Services

 MHS utilizes a prior authorization program through National Imaging Associates (NIA) for the management of Physical Medicine Services which include Physical Therapy, Occupational Therapy, and Speech Therapy.

# Physical Medicine Services

-  Therapy provided in Hospital ER, Inpatient and Observation status, Acute Rehab Hospital Inpatient, and Inpatient and Outpatient Skilled Nursing Facility settings are excluded from this program.
-  Chiropractors rendering therapy services are exempt from the NIA program.

# Durable & Home Medical Equipment (DME)

-  Managed by Medline.
-  Members and referring providers do not need to search for a DME provider or provider of medical supplies to service their needs.
-  Medline's web portal is used to submit orders and track delivery.
-  Does not apply to items provided by and billed by physician's office.
-  Exclusions applicable to specific hospital-based DME/HME vendors.





# Durable & Home Medical Equipment



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








- **Web Portal:** Simply go to [mhsindiana.com](https://mhsindiana.com), log into the provider portal, and click on “Create Authorization.” Click DME and you will be directed to the Medline portal for order entry.
- **Fax Number:** 1-866-346-0911
- **Phone Number:** 1-844-218-4932

# Outpatient Radiology PA


-  MHS partners with NIA for high dollar outpatient radiology PA process.
  -  PA requests must be submitted via:
    - NIA Web site at [RadMD.com](http://RadMD.com)
    - 1-866-904-5096
- \*Not applicable for ER and Observation requests.

# Cardiac Services

Turning Point Healthcare Solutions manages prior authorizations for the Cardiac Services below:

-  Automated Implantable Cardioverter Defibrillator
-  Leadless Pacemaker
-  Pacemaker
-  Revision or Replacement of Implanted Cardiac Device
-  Coronary Artery Bypass Grafting (Non-Emergent)
-  Coronary Angioplasty and Stenting
-  Non-Coronary Angioplasty and Stenting

 Web Portal Intake: <http://www.myturningpoint-healthcare.com>


 Telephonic Intake: 1-574-784-1005 | 1-855-415-7482

 Facsimile Intake: 1-463-207-5864

# Orthopedic and Spinal Surgical Procedures

-  Turning Point Healthcare Solutions manages prior authorization for medical necessity and appropriate length of stay (when applicable).
-  Web Portal Intake:
  - [myturningpoint-healthcare.com](http://myturningpoint-healthcare.com)
-  Telephone Intake:
  - 574-784-1005 | 855-415-7482
-  Fax Intake: 463-207-5864


# Inpatient Prior Authorization

 MHS no longer accepts phone calls and only accepts notification of an inpatient admission via fax at 1-866-912-4245, using the IHCP universal prior authorization form, or via the MHS Secure Provider Portal.

<https://www.mhsindiana.com/login.html>

# Behavioral Health


## Limitations on Outpatient Mental Health Services:

 MHS follows The Indiana Health Coverage Programs Mental Health and Addiction limitation policy for the following CPT codes that, in combination, are limited to 20 units per member, per provider, per rolling 12-month period.

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




# Behavioral Health

## Limitations on Outpatient Mental Health Services (Cont.):

-  “Per Provider” is defined by MHS as per individual rendering practitioner NPI being billed on the CMS-1500 claim form (Box 24J).

# Behavioral Health

## Limitations on Outpatient Mental Health Services (Cont.):

-  If the member requires additional services beyond the 20 unit limitation, providers may request prior authorization for additional units.
-  Approval will be given based on the necessity of the services as determined by the review of medical records.
-  Providers will need to determine if they have provided 20 units to the member in the past rolling 12 months to determine if a prior authorization request is needed.



# **Provider Analytics**

# MHS Secure Portal

Viewing Dashboard For : 020700664 Medicaid GO

### Quick Eligibility Check for Medicaid

Member ID or Last Name: 123456789 or Smith Birthdate: mm/dd/yyyy **Check Eligibility**

### Recent Claims

STATUS	RECEIVED DATE	MEMBER NAME	CLAIM NO.
🕒	08/12/2019	[REDACTED]	
🕒	08/12/2019	[REDACTED]	
🕒	08/12/2019	[REDACTED]	
🕒	08/12/2019	[REDACTED]	
🕒	08/12/2019	[REDACTED]	

### Welcome

- Add a TIN to My ACCOUNT >
- Reports >
- Patient Analytics >
- Provider Analytics >**

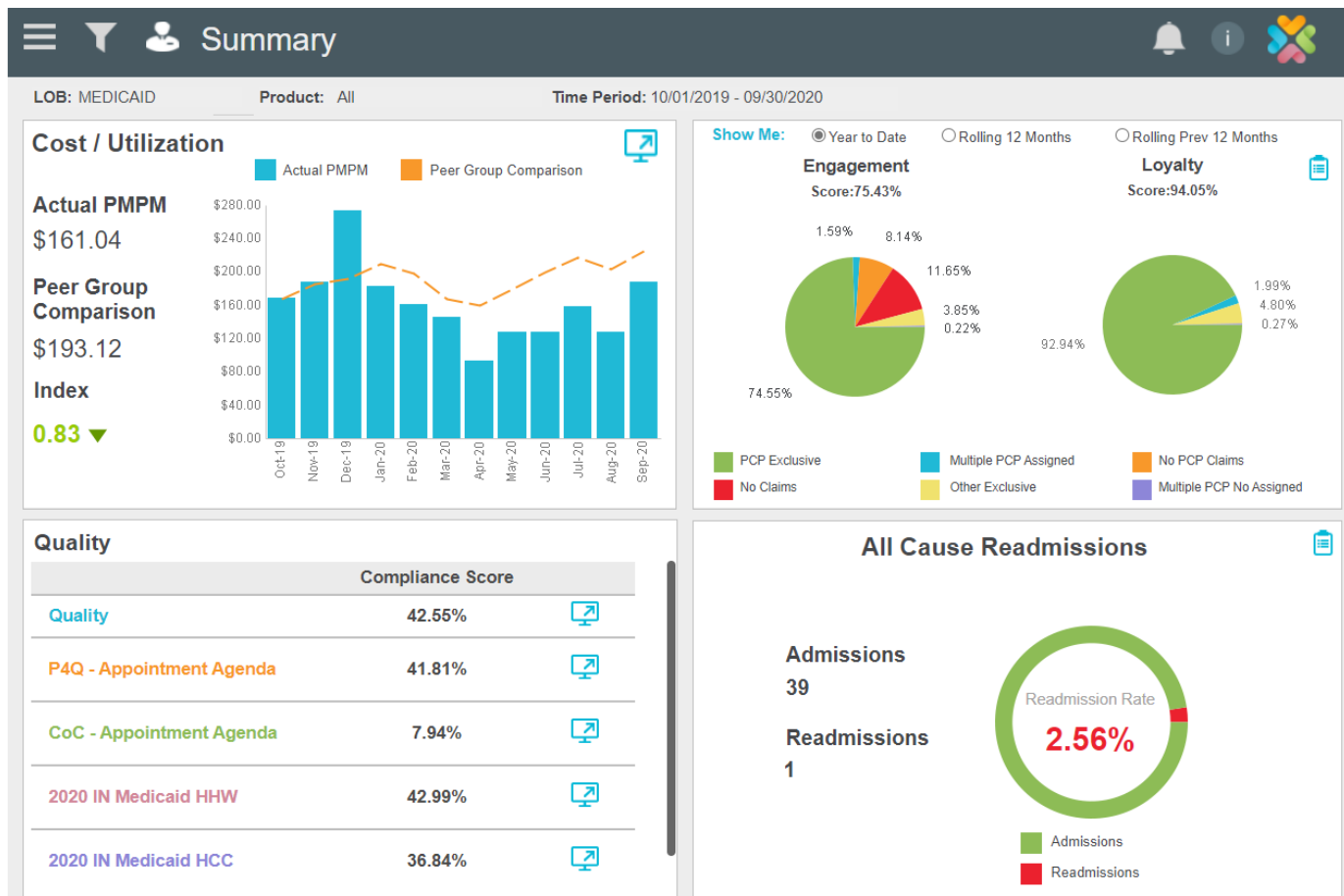
### Recent Activity

Date	Activity
------	----------




### Quick Links

- [Provider Resources](#)
- [Member Management Forms](#)


# Provider Analytics Landing Page










# P4P Overview

-  Bonus Pay for Performance (P4P) fund written into PMP contracts and dependent on product line.
-  Measures aligned with HEDIS and NCQA.
-  Annual payout.

# Continuity of Care (CoC) Program



-  **What is the Continuity of Care (CoC) Program?**
- CoC is a Risk Adjustment bonus program for you, our Provider Partner, aimed at increasing visibility into members' existing, as well as suspected conditions, which leads to enhanced quality of care for chronic condition management and prevention.

# CoC Program Overview

-  Continuity of Care (CoC) - Risk adjustment bonus program for our providers.
-  Bonuses paid for completed and verified appointment agendas and/or submission of a Comprehensive Physical Exam (CPE) medical record.
-  Providers receive bonus payments based on annual assessments of patient's chronic conditions.
-  The intent of the CoC program is to promote proactive management of chronic conditions and preventative services.
-  Appointment Agendas - provide historical diagnosis data for providers to ensure annual assessment of chronic conditions.
-  Claims based program – patient's annual assessment performed by PCP and claim is submitted.
-  Improved health and quality care for members.

# **MHS Provider Relations Team**

# Provider Relations

-  Each provider will have an **MHS Provider Partnership Associate** assigned to them.
-  This team serves as the primary liaison between MHS and our provider network and is responsible for:
  - Provider Education
  - HEDIS/Care Gap Reviews
  - Assist Providers with EHR Utilization
  - Initiate credentialing of a new practitioner
  - Facilitate inquiries related to administrative policies, procedures, and operational issues
  - Monitor performance patterns
  - Contract clarification
  - Membership/Provider roster
  - Assist in Secure Provider Portal registration and Payspan



## MHS Provider Network Territories

### Indiana

#### NORTHEAST REGION

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

#### NORTHWEST REGION

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

#### NORTH CENTRAL REGION

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

#### CENTRAL REGION

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

#### SOUTH CENTRAL REGION

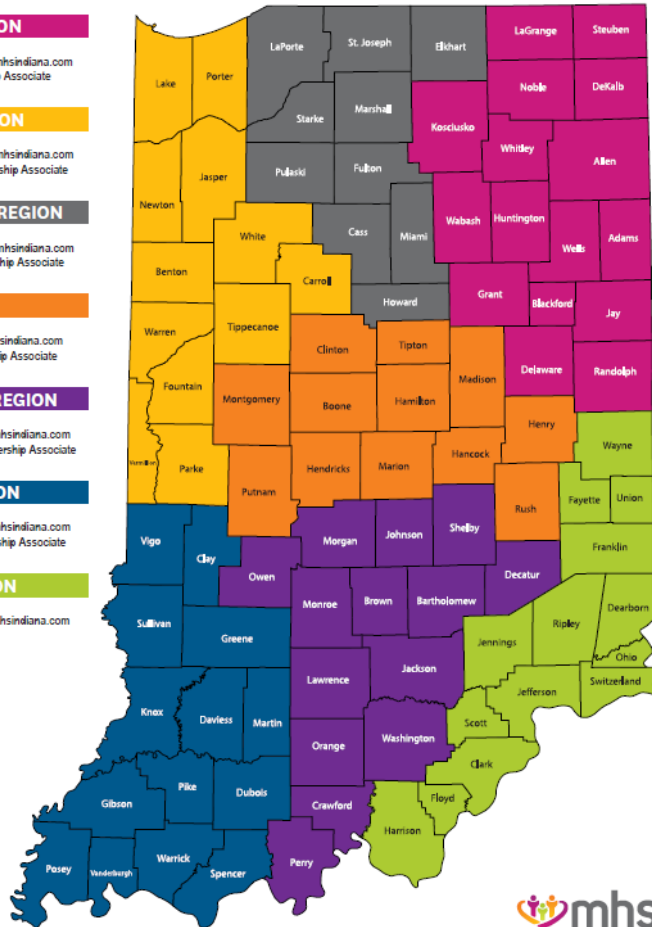
For claims issues, email:  
 MHS\_ProviderRelations\_SC@mhsindiana.com  
 Dalesia Denning, Provider Partnership Associate  
 1-877-647-4848, ext. 20026

#### SOUTHWEST REGION

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

#### SOUTHEAST REGION

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



#### NORTHEAST REGION

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

#### NORTHWEST REGION

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

#### NORTH CENTRAL REGION

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

#### CENTRAL REGION

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

#### SOUTH CENTRAL REGION

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

#### SOUTHWEST REGION

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

#### SOUTHEAST REGION

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

Available online:

[https://www.mhsindiana.com/content/dam/centene/mhsindiana/medicaid/pdfs/ProviderTerritory\\_map\\_2021.pdf](https://www.mhsindiana.com/content/dam/centene/mhsindiana/medicaid/pdfs/ProviderTerritory_map_2021.pdf)



## MHS Provider Network Territories

## Back of Map

### TAWANNA DANZIE

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

### PROVIDER GROUPS

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

### JENNIFER GARNER

Provider Partnership Associate II  
1-877-647-4848 ext. 20149  
jgarner@mhsindiana.com

### PROVIDER GROUPS

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

### NETWORK LEADERSHIP

#### JILL CLAYPOOL

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

#### NANCY ROBINSON

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

#### MARK VONDERHEIT

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

### NEW PROVIDER CONTRACTING

#### TIM BALKO

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

#### MICHAEL FUNK

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

### NETWORK OPERATIONS

#### KELVIN ORR

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

### ENVOLVE DENTAL, INC.

#### ANTWAN PEREZ-ALVAREZ

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

### ENVOLVE VISION, INC.

#### CHANTEL MCKINNEY

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

### Available online:

[https://www.mhsindiana.com/content/dam/centene/mhsindiana/medical/pdfs/ProviderTerritory\\_map\\_2021.pdf](https://www.mhsindiana.com/content/dam/centene/mhsindiana/medical/pdfs/ProviderTerritory_map_2021.pdf)

# **Questions?**

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