Anthem Blue Cross and Blue Shield | Serving Hoosier Healthwise, Healthy Indiana Plan, Hoosier Care Connect, and Indiana PathWays for Aging

Home Health Updates Overview

2024 IHCP Works Annual Seminar

Agenda

- Managed Care Programs
- Member Eligibility
- Home Health Benefits:
  - Covered services
  - Non-covered Services
- Provider Contracting Information
- Prior Authorization
- Electronic Visit Verification (EVV)
- Billing:
  - Revenue Codes and HCPCS codes
  - Units of Service
  - Overhead
- Reimbursement
- Claims:
  - Submissions
  - Resolution process
- Contact information

Managed Care Programs

Hoosier Healthwise (HHW) options for this program include:

- Package A: Standard (children newborn thru 18 years of age, transitional low-income parents/caretakers, and some pregnant members).
- Package C: Children's health plan (CHIP).

Hoosier Care Connect (HCC) includes:

- Aged, blind, disabled, and some wards and foster children.

Managed Care Programs - HIP

Healthy Indiana Plan (HIP) is available to Hoosiers aged 19 to 64 includes:

- HIP Basic.
- HIP State Plan Basic.
- HIP Plus.
- HIP State Plan Plus.
- HIP Maternity:
  - HIP Maternity offers access to all benefits available under the State plan to pregnant members who are enrolled in or determined eligible for HIP during the member's pregnancy and for a 365-day postpartum period.

Member Eligibility – Indiana PathWays for Aging

PathWays member eligibility:

- 60 years of age or older.
- Be eligible for Medicaid based on age, blindness, or disability.

They may also:

- Have full Medicare benefits (dually eligible).
- Reside in a nursing facility or receiving hospice services.
- Be receiving long term services and support (LTSS) in a home or community-based setting, including those on the PathWays waiver.

Member Eligibility

Always verify prior to rendering services. Providers can access this information by visiting:

- IHCP Provider Healthcare Portal and Availity Essentials via Availity.com (PMP verification only).
- Failure to verify member eligibility could lead to claim denials.

To verify member eligibility, you will need:

- The member ID card issued to members by Anthem.

Home Health Benefit

Home health services require prior authorization (PA) and are available to members of any age in their place of residence when the services are:

- Medically necessary.
- Ordered in writing by a physician and performed on a part-time and intermittent basis in accordance with a written plan of care.

The medical necessity for home health services must be certified by the member's qualifying treating physician as described in the home health services per the Indiana Health Coverage Programs (IHCP) Provider Reference Module for home health services.

Covered Services

Home health services include:

- Skilled nursing.
- Home health aid services.
- Skilled therapies:
  - Physical therapy
  - Speech-language pathology
  - Occupational therapy.

Home health benefits include covered services performed by practitioners such as:

- Registered nurses (RN).
- Licensed practical nurses (LPN).
- Physical therapists.
- Occupational therapists.
- Speech-language pathologists.
- Home health aide.

Non-Covered Services

- Transporting the member to grocery stores, pharmacies, or banks
- Homemaker services (shopping, laundry, cleaning, or meal prep)
- Chores (picking up prescriptions and running errands)
- Sitter or companion services (activity planning, escorting the member to events)
- Respite care

Note: Although these services are not covered for home health billing, they may be covered for eligible members under the applicable IHCP PathWays waiver program, or (in the case of transporting members to the pharmacy) as a fee for service benefit.

Prior Authorization (PA)

Home health services are covered by Anthem:

- All home health services require PA for both providers who are contracted with Anthem and providers who are not contracted with Anthem.
- Additional information related to obtaining PA maybe found at anthem.com/inmedicaiddoc either in the provider operations manual or PA sections.
- Failure to obtain PA may result in denied claims.

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- All home health services require PA for both providers who are contracted with Anthem and providers who are not contracted with Anthem.
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Prior Authorization – Requesting PA

Requesting prior authorization for nursing services:

- PAs must reflect the appropriate home visit nursing code.
- PAs for nursing services do not need to indicate whether an RN, LPN, or home health aide is to perform the service because that level of detail is reported on the claim.
- The plan of care must accompany the PA request.
- Supporting clinical documentation must accompany the PA request.
- The face-to-face encounter notes must accompany all new initial home healthcare PA requests.

Prior Authorization – Requesting PA (continued)

Requesting prior authorization for nursing services (continued):

- Interactive Care Reviewer via Availity
- Contact Anthem Utilization Management (UM) via phone to request PA:
  - Hoosier Healthwise, Hoosier Care Connect, and PathWays phone: **866-408-6132**
  - Healthy Indiana Plan phone: **844-533-1995**
  - Fax: **866-406-2803** or direct fax line **844-765-5157**

Prior Authorization – PA Exception

PA exception for hospital discharge:

- Providers can perform certain home health services without PA following a member's discharge from an inpatient hospital if a physician orders the service in writing prior to the member's discharge:
  - RN, LPN, and home health aide services, not to exceed 120 units within 30 calendar days following the discharge.
  - Any combination of therapy services, not to exceed 30 units in 30 calendar days following the discharge.
- The hospital discharge date is counted as day one.
- Providers should use occurrence code 42 with the corresponding date of discharge in the occurrence code and occurrence date fields of the institutional claim (fields *31a–34b* on the *UB-04 Claim form*) to bypass PA requirements associated with the preceding parameters. Home health services may not continue beyond the limits noted unless PA is obtained.

Electronic Visit Verification (EVV) System

The 21st Century Cures Act (CURES Act), signed into law on December 13, 2016, requires states to implement an electronic visit verification (EVV) system for personal care services and home healthcare services.

Providers are responsible for ensuring their chosen EVV system complies with federal requirements for documentation of the following visit information:

- Date of service
- Location of service
- Individual providing service
- Type of service
- Individual receiving service
- Time the service begins and ends

For more information refer to the EVV Page on the IHCP website.

EVV Requirements

EVV is the use of technology to record the time and location of paid caregivers during a scheduled visit check-in and check-out.

This method of verification has been proven to provide an accurate account of provider's time while minimizing or eliminating inappropriate claims.

EVV is required for providers that deliver care to Medicaid members in HCBS settings.

The IHCP is using Sandata as the state-sponsored system for implementing federal EVV requirements. Anthem's claim-processing system has been configured to integrate with the Sandata EVV system.

Providers may choose to use an EVV system other than Sandata. However, those providers will be required to export data from their alternate system to the Sandata "Aggregator" for integration with CoreMMIS. The Aggregator will capture EVV data from both Sandata users and from users of alternate EVV systems.

Services requiring verified EVV-compliant data elements are defined by FSSA and are found in the Provider Code Tables here.

For additional training visit the training site on the IHCP Website.

Billing

- All home health providers must be IHCP enrolled providers and contract with Anthem.
- Anthem follows IHCP billing guidelines for home health claim submission and adjudication.
- See the Home Health Provider Reference Module.
- Submit all claims on a *UB-04 Claim Form* or 837I electronic transaction.
- Bill for days approved by the UM unit for Anthem.

EVV Billing

Anthem's claims adjudication system is integrated with the state-sponsored EVV aggregator, Sandata, for claims matching.

Anthem's claims system will place the claim in a pending status and perform a check with the Sandata aggregator.

Claims will deny if EVV elements are not present:

If there is a match (all EVV data elements are present), the claim will continue to payment.

If no match is found (no corresponding EVV visit), the claim will deny following codes on the *Explanation of Payment* (*EOP*):

- ZIG: No visit found
- ZIF: Unmatched units

Revenue and Healthcare Common Procedure Coding System (HCPCS) Codes

42X - G0151	—	Physical therapy in home health setting
43X - G0152	—	Occupational therapy in home health setting
44X - G0153	—	Speech therapy in home health setting
552 - 99600	—	Skilled nursing home health visit (modifier TD for RN and TE for LPN or licensed vocational nurse (LVN)
572 - 99600	—	Home health aide home health visit

Units of Services

Home health aide, LPN, and RN visits are based on one-hour units.

- Round to the nearest unit:
  - If in the home for any part of the first hour, providers can bill for the entire first hour if a service was provided. For any subsequent hours in the home providers should round down for 29 minutes or less.

Therapy visits are based on 15-minute units of service.

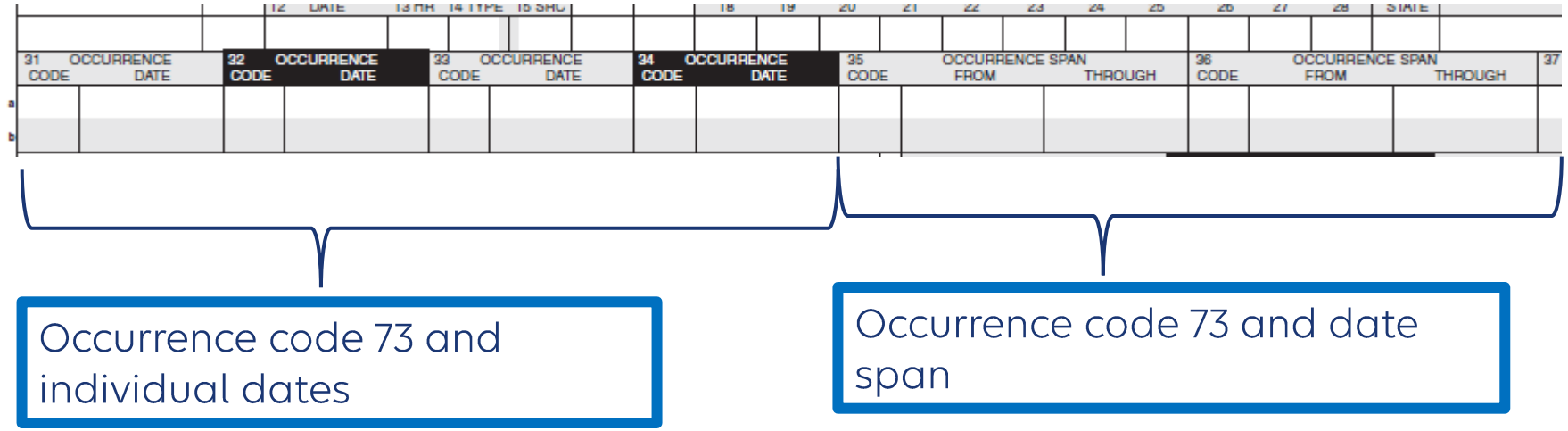
- Round to the nearest unit:
  - If therapist is in the home less than eight minutes, the service cannot be billed.
  - Bill each date of service as a separate line item.
  - Bill each level of service, such as RN or LPN, as a separate line item, for each date of service.
- If the same service is provided, such as multiple RN visits on the same day, the services should be combined and billed on one claim.

Overhead

- For each encounter at home, home health providers receive an overhead rate for administrative costs.
- Providers can only report one overhead encounter per recipient per day.
- In a multi-member situation (for example, husband and wife both treated during same encounter), only one overhead is allowed.
- If the dates of service billed are not consecutive, enter occurrence code 73 and the date for each date of service.
- If the dates of service are consecutive, enter occurrence code 73 and the occurrence span dates.

Tip: Plan ahead. Providers are limited to four spans on claim submissions. (See next slide)

UB-04 Paper Claim



Note: When filing claims in Availity, the occurrence code 73 is not recognized for individual dates. Claims will need to be submitted using the occurrence span codes.

Reimbursement

The Anthem rate is based on one hundred percent of the State of Indiana Medicaid fee schedule on file with Anthem.

Facility agrees that under no circumstances shall it balance bill the covered individual for amounts exceeding the Anthem rate.

Claims – Initial Claim Submission

- For participating providers, the claim filing limit is 90 calendar days from the date of service.
- Submit the initial claim electronically via electronic data interchange (EDI), Availity Essentials, or a paper claim by mail to:

Anthem Blue Cross and Blue Shield
Claims Department
Mail Stop: IN999
P.O. Box 61010
Virginia Beach, VA 23466

Note: Nonparticipating providers have 180 calendar days from the date of service to submit claims.

Claims – Turnaround Times

- Processing time:
  - 21 calendar days for electronic clean claims
  - 30 calendar days for paper clean claims
- If the claim isn't showing in Availity contact the Provider Services via phone or chat to verify if the claim is in imaging.

Note: Do not resubmit if the claim is on file, in the processing or image system.

Claims Resolution Process – Follow-up Guidelines

- Use the Availity Essentials platform within 30 calendar days to check claim status online. You can also call the appropriate helpline.
- Network providers must file claims within 90 calendar days. It is the provider's responsibility to follow up timely and ensure claims are received and accepted.

Plan	Phone number
HIP	844-533-1995
Hoosier Care Connect	844-284-1798
Hoosier Healthwise	866-408-6132
Indiana PathWays for Aging	833-569-4739

Claims Resolution Process – Corrected Claims

Corrected claims submission guidelines:

- Submit a corrected claim when the claim is denied or only paid in part due to an error on the original claim submission.

When submitting corrected claims, follow these guidelines:

- Submit the corrected claim no later than 60 calendar days from the date of our letter or remittance advice (RA).
- Corrected claims can be submitted electronically through your clearinghouse, through the Availity Essentials platform, or by paper.

Claims Resolution Process – Paper Corrected Claims

Send corrected paper claims to:

Anthem Blue Cross and Blue Shield
Corrected Claims and Correspondence Department
P.O. Box 61599
Virginia Beach, VA 23466

The *Claim Follow-Up Form* is available at Indiana Providers > Resources > Forms > Claims and Billing.

Claims Resolution Process – Dispute Process

The claims dispute process is as follows:

1. Claims reconsideration — Must be received within 60 calendar days from the date on the Remittance Advice (RA). Disputes can be done verbally through provider services, in writing or online through the Availity Essentials platform. Submit a claims reconsideration if you disagree with full or partial claim rejection or denial, or the payment amount.

2. Claim payment appeal — If you are not satisfied with the reconsideration, you may submit a claim payment appeal. We must receive this appeal within 60 calendar days from the date of the claim reconsideration. This can now be done via the Availity Essentials platform.

If you choose to submit via mail:
Anthem Blue Cross and Blue Shield
Provider Disputes and Appeals
PO Box 61599
Virginia Beach, VA 23466

Important Contact Information

Important Contact Information – Provider and Member Services

Provider Services:
- Hoosier Healthwise: **866-408-6132**
- HIP: **844-533-1995**
- Hoosier Care Connect: **844-284-1798**
- Indiana PathWays for Aging: **833-569-4739**

Member Services and 24/7 NurseLine:
- Hoosier Healthwise and HIP: **866-408-6131**
- Hoosier Care Connect: **844-284-1797**
- Indiana PathWays for Aging: **833-412-4405**

All Service lines are open 8:00a to 8:00p eastern time.

Important Contact Information - Contracting

If you have contractual issues and/or questions, contact:

Alina Cruz
Provider Network Management Sr. (Home Health, Hospice and Skilled Nursing Facilities)
Email (preferred contact) – Alina.Cruz@elevancehealth.com

For Indiana PathWays for Aging members, contact your Provider Services representative or email INMLTSSprovidercontracting@elevancehealth.com.

It is essential to keep your demographic information current, so for any changes, let us know as soon as possible.

Important Contact Information – Prior Authorizations

- HIP: **844-533-1995**
- Hoosier Care Connect/Indiana PathWays for Aging: **844-284-1798**
- Hoosier Healthwise: **866-408-6132**
- Fax: **866-406-2803**

Provider Relationship Account Management Physical Health Zone Map

Zone 1
Jamaal Wade
Jamaal.WadeSr@anthem.com
317-409-7209

Zone 2
Angelique Jones
Angelique.Jones@anthem.com
317-619-9241

Zone 3
Whit'ney McTush
Whitney.McTush@anthem.com
317-519-1089

Zone 4
Matthew McGarry
Matthew.McGarry@anthem.com
463-202-3579

Zone 5
David Tudor
David.Tudor@anthem.com
317-447-7008

Zone 6
Matt Swingendorf
Matthew.Swingendorf@anthem.com
317-306-0077

Zone 7
Sophia Brown
Sophia.Brown@anthem.com
317-775-9528

https://providers.anthem.com/docs/gpp/IN_CAID_PU_NetworkRelationsMap.pdf?v=202110061311

Provider Relationship Account Management Physical Health

Indiana University Health
Michelle Fitch
Michelle.Fitch@elevancehealth.com
317-646-4514

Ascension, Parkview Health
Open

Community Health Network, Franciscan Health, Deaconess Health
Trent Mast
Trenton.Mast@anthem.com
317-526-2304

Indiana Orthopedic Hospital (OrthoIndy), South Bend Clinic, Eskenazi, American Health Network, Beacon, Union Hospital, Lutheran Health Network, Community Munster, St. Joseph Regional Health (Trinity)
Julie Fiedler
Julie.Fiedler@anthem.com
260-600-9342

Schneck Medical Center, Goshen Hospital, Columbus Regional Health, Good Samaritan, Logansport Memorial Hospital, Major Medical Group, Unity Lafayette, Margaret Mary Health, Methodist Gary, Hancock Health, Hendricks Regional Health, Witham, Henry Community Health, Johnson Memorial Health, Riverview Health
Jonathan Hedrick
Jonathan.Hedrick@anthem.com
317-601-9474

Indiana PathWays for Aging Network Relations Specialists

Home and Community-Based Services, Home Health/Personal Care Attendant

Northern Indiana
LaTasha Cobb
Network Relations Specialist
LaTasha.Cobb@anthem.com
317-503-0843

Central Indiana
Clair Conlon
Network Relations Specialist
Clair.Conlon@anthem.com
765-744-8034

Southern Indiana
Rayshon Chambers
Network Relations Specialist
Rayshon.Chambers@anthem.com
317-671-4409

Marion County
David Castaneda
Network Relations Specialist
David.Castaneda@anthem.com
317-726-6358

Shanise Taylor
Network Relations Specialist
Shanise.Taylor@anthem.com
463-290-1715

https://providers.anthem.com/docs/gpp/IN_CAID_PathWaysForAgingNetworkRelationsMapAndSupports.pdf?v=202407091642

Indiana PathWays for Aging Network Relations Specialists – Additional Resources and Contacts

Website:
providers.anthem.com/in > Patient Care >Indiana PathWays for Aging

LTSS Provider Relations email:
INMLTSSProviderRelations@anthem.com

LTSS Provider Contracting email:
INMLTSSContracts@anthem.com

LTSS Provider Relations phone:
833-569-4739

Manager, LTSS Network Relations
Wendy Dragoo
Wendy.dragoo@anthem.com
463-269-3423

Claims Educator
[TBD]
[Email]
[Phone]

Workforce Development Administrator
Ben Evans
Ben.Evans@anthem.com
317-671-2141

Value Based Program Specialist
Haley Osborne
Haley.Osborne@anthem.com
317-671-2141

LTSS Provider Training Specialist
Ryan Fennessy,
Network Education Representative
Ryan.Fennessy@anthem.com
317-671-3230

HCBS Contracting Network Specialist
April Walton, Network Relations Consult Sr.
April.Walton@anthem.com
219-742-5323

Questions?

Providers who are contracted with Anthem Blue Cross and Blue Shield to serve Hoosier Healthwise, Healthy Indiana Plan, Hoosier Care Connect, and Indiana PathWays for Aging through an accountable care organization (ACO), participating medical group (PMG) or Independent Physician Association (IPA) are to follow guidelines and practices of the group. This includes but is not limited to authorization, covered benefits and services, and claims submittal. If you have questions, please contact your group administrator or your Anthem network representative.

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