2021 claims 101

2021 Indiana Health Coverage Programs (IHCP) Works Virtual Seminar

Serving Hoosier Healthwise, Healthy Indiana Plan and Hoosier Care Connect

Agenda

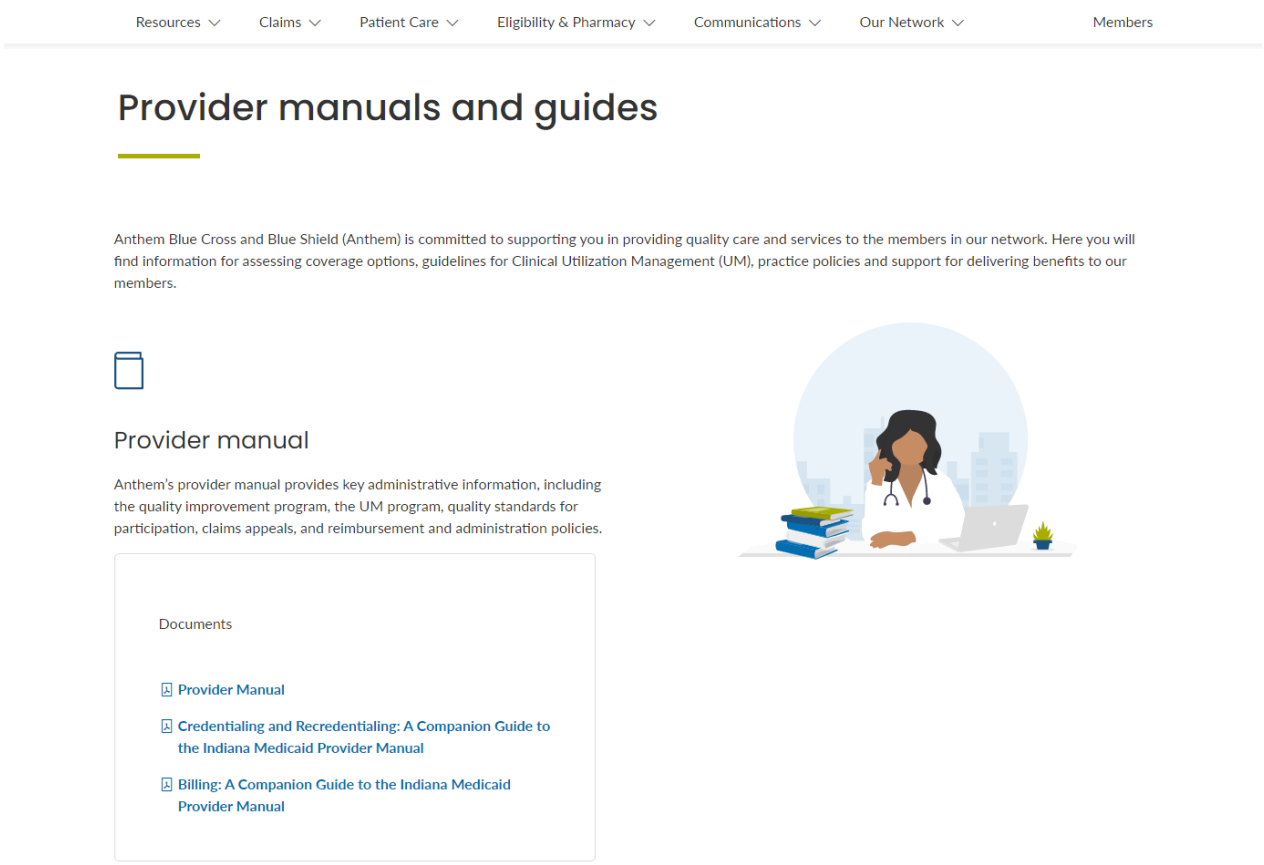
- Terms
- Provider manual
- Eligibility
- Managed care model
- Prior authorization (PA)
- Claims
- Contact information

Terms

- ***PMF*** — *Provider Maintenance Form*
- ***IHCP*** — *Indiana Health Coverage Programs*
- **PSO** — Provider Solutions Organization
- **HIP** — Healthy Indiana Plan
- **MCE** — Managed Care Entity
- **PMP** — Primary Medical Provider
- **COB** — Coordination of Benefits
- **RCP** — Right Choices Benefits
- **EDI** — Electronic Data Interchange
- **UM** — Utilization Management
- **ICR** — Interactive Care Reviewer

Provider manual

https://providers.anthem.com/indiana-provider/resources/manuals-and-guides



Provider file updates and changes

Anthem Blue Cross and Blue Shield (Anthem) provider files must match Indiana's provider information. This is a three-step process:

1. Submit all accurate provider updates to Indiana Health Coverage Programs (IHCP) by visiting www.in.gov/medicaid/providers or by calling IHCP Provider Services at **800-457-4584**. For more information, please refer to the IHCP provider reference modules.
2. After IHCP uploads the information, the provider will submit the information to Anthem using the online *Provider Maintenance Form (PMF)*.
3. When Anthem receives the online *PMF*, we will verify the information submitted on both the online *PMF* and the provider healthcare portal.

Provider file updates and changes (cont.)

The online PMF has all the fields needed to submit your Medicaid information. Use the comments field at the bottom of the PMF for any additional information that will help us enter your provider file information appropriately. The online PMF should be used to:

- Term an existing provider within your group.
- Change the address, phone, or fax number.
- Change the panel for primary care physicians (PCP) (use comments field).

Provider file updates and changes (cont.)

Our Provider Solutions Organization (PSO) department handles all provider file updates. This includes the following provider networks:

- Medicaid under Anthem:
  - Hoosier Healthwise
  - Healthy Indiana Plan (HIP)
  - Hoosier Care Connect
- Commercial insurance under Anthem

All provider file updates use our PMF.

If you have questions about provider network agreements and provider file information, you can contact your assigned Provider Experience manager and they can get you to your PSO representative.

Eligibility

Eligibility

Always verify a member's eligibility prior to rendering services. Anthem recommends a two-step verification process.

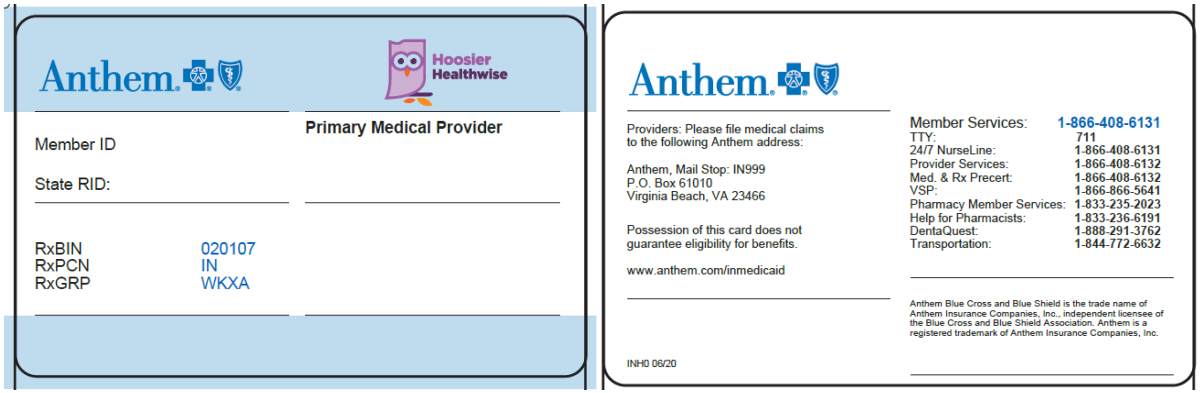
Providers can access this information by visiting:

- Provider healthcare portal: Use to verify eligibility, assigned Managed Care Entity (MCE), and Medicaid product
- Availity Portal:* use for primary medical provider (PMP) verification, benefit limitations, *Coordination of Benefits (COB)*, the Anthem member ID (if needed), and much more

Eligibility (cont.)

Hoosier Healthwise:

- Anthem assigns the YRH prefix and a unique member ID.

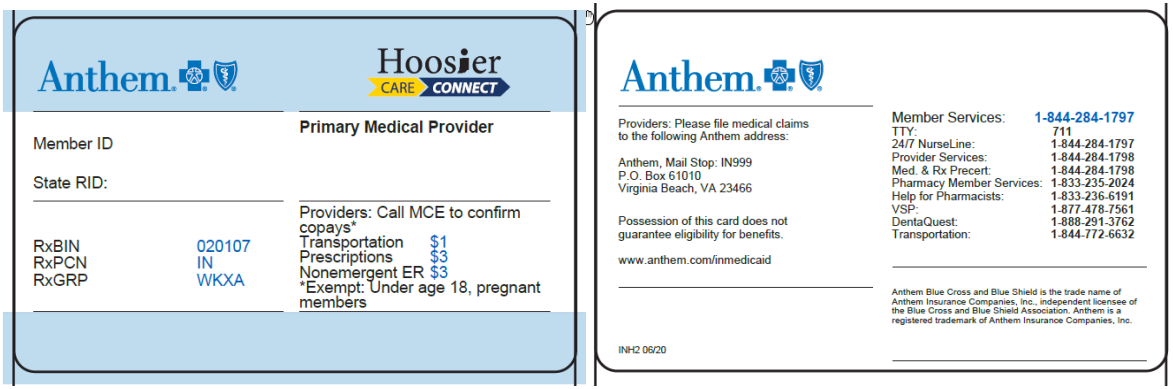


- The member's state recipient ID (RID) number is also on the card.
- *When filing claims and inquiries, **always** include the YRH prefix before the member's unique ID number.*

Eligibility (cont.)

Hoosier Care Connect:

- Anthem assigns the YRH prefix.

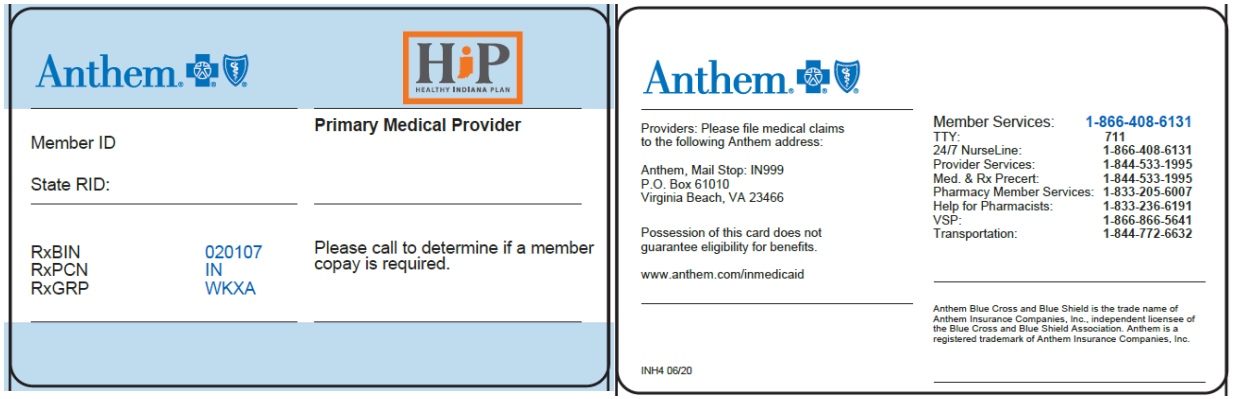


- As of April 1, 2021, Hoosier Care Connect members will only have the RID number on their card.
- *When filing claims and inquiries, **always** include the YRH prefix before the member's recipient identification (RID) number.*

Eligibility (cont.)

Healthy Indiana Plan (HIP):

- Anthem assigns the YRK prefix and a unique member ID.



- The member's state recipient ID (RID) number is also on the card.
- *When filing claims and inquiries, **always** include the YRH prefix before the member's unique ID number.*

Right Choices Program (RCP)

- RCP is a program for Indiana Medicaid recipients who may need assistance learning how to properly use their health insurance.
- The program provides members a lock-in provider who acts as a safeguard against the unnecessary or inappropriate use of benefits.

RCP (cont.)

- Members enrolled in the Right Choices Program (RCP) must see the providers who are assigned per CoreMMIS.
- The member's PCP may call **866-902-1690 option 1** to add new providers to the member's list of authorized providers.
- Refer to page 54 of the Anthem provider manual for more information.
- RCP members are no longer required to be locked into a single hospital.
  - **Although members are no longer locked into a single hospital, they will still be locked into one primary medical provider to coordinate their care and one pharmacy to fill prescriptions.**

Managed care model (assigned PCP)

Managed care model (assigned PCP)

All members must see their assigned primary care physician (PCP). Please view the Availity PCP assignments.

Specialty providers must have a referral from the PCP:

- Include the individual (type one) national provider identifier (NPI) of the member's assigned referring PCP when you submit the *CMS-1500* claim form or electronic data interchange (EDI) claim.
- If one physician is on call or covering for another, the billing provider must complete Box 17b of the *CMS-1500* claim form to receive reimbursement.

If you are a non-contracted provider, you need to obtain prior authorization (PA) from Anthem before you provide services to our members.

Managed care model (assigned PCP) (cont.)

If you are a contracted provider and providing a service to a member not assigned to you, **you still must have a referral from that member's PCP, even if that service does not require PA**.

Exceptions to this policy include:

- Self-referrals. Members may self-refer for certain services provided by an IHCP-enrolled provider:
  - **Note:** Refer to the provider manual for a listing of self-referral services.
- A PCP not yet assigned to the member.
- A provider in the same provider group, or with the same tax ID or NPI as the referring physician (and is an approved provider type).
- Emergency services (services performed in place of service 23).
- Family planning services.

Managed care model (assigned PCP) (cont.)

Exceptions to this policy include (cont.):

- Services provided after hours (codes 99050 and 99051).
- Diagnostic specialties (such as lab and X-ray services).
- The billing or referring physician being an Indiana Health Provider or is providing services at a federally qualified health center or urgent care center.

Prior authorization

Prior authorization

Participating providers:

- Prior authorization (PA) is not required when referring a member to an in-network specialist.
- PA is required when referring a member to an out-of-network provider.
- Check the prior authorization lookup tool regularly for updates.

Nonparticipating providers:

- All services require PA (except emergencies).

Precertification lookup tool

Visit the provider website to utilize the precertification lookup tool at https://providers.anthem.com/in > Claims > Precertification Lookup Tool

Providers can quickly determine PA requirements. If a PA is required, we strongly recommend utilizing our Interactive Care Reviewer (ICR) to request PA.

How to obtain prior authorization

Providers may call Anthem to request PA for medical and behavioral health (BH) services using the following phone numbers.

Program	Phone number
HIP	**844-533-1995**
Hoosier Care Connect	**844-284-1798**
Hoosier Healthwise	**866-408-6132**

How to obtain prior authorization (cont.)

Fax clinical information for all members to:

	Inpatient	Outpatient
Physical health	**888-209-7838**	**866-406-2803**
Behavioral health	**844-452-8074**	**844-456-2698**

How to obtain prior authorization (cont.)

When calling/faxing our Utilization Management (UM) department, have the following information available:

- Member name and ID
- Prefix — YRK (HIP), YRH (Hoosier Healthwise, Hoosier Care Connect)
- Diagnosis with ICD-10 code
- Procedure with CPT® code
- Date(s) of service
- PCP, specialist, or facility performing services
- Clinical information can be uploaded to the ICR or faxed to support the request
- Treatment and discharge plans (if known)

How to obtain prior authorization (cont.)

Anthem is pleased to offer the Interactive Care Reviewer (ICR), a website providers can use to request PA for Hoosier Healthwise, HIP, and Hoosier Care Connect services. ICR is accessible via the Availity Portal at no cost to providers. ICR will accept the following types of requests for our members:

- Inpatient
- Outpatient
- Medical/surgical
- Behavioral health

If you have any questions about the prior authorization lookup tool, Availity, or ICR, contact your assigned Provider Experience manager.

Timeliness of prior authorization decisions

Request type	Turn around time from request time
Emergency services	Does not require PA
Urgent concurrent requests	1 business day
Urgent pre-service requests	72 hours
Routine non-urgent requests	7 days
Urgent appeals	72 hours
Routine appeals	30 days

Outpatient services

When authorization of outpatient healthcare services is required, providers should utilize ICR, call, or fax to request PA.

- Providers should submit all clinical documentation required to determine medical necessity at the time of the request.
- We will make at least one attempt to contact the requesting provider to obtain missing clinical information:
  - If additional clinical information is not received, a decision is made based upon the information available.

Cases are either approved or denied based upon medical necessity and/or benefits. Members and providers will be notified of the determination by letter. Upon adverse determination, providers will also be notified verbally.

Emergency medical services and admission

For emergency medical conditions and services, Anthem does not require PA for treatment. In the event of an emergency, members may access emergency services 24/7. The facility does not have to be in the network.

- In the event that the emergency room visit results in the member's admission to the hospital, hospitals must notify Anthem of the admission within 48 hours (excludes Saturdays, Sundays and observed holidays).
- This must be followed by a written certification of medical necessity within 14 business days of admission.

Emergency medical services and admission (cont.)

Note: If the provider fails to notify Anthem within the required time frame, the admission will be administratively denied. Providers should submit all clinical documentation required to determine medical necessity at the time of the notification.

Hospital admissions for observation up to 72 hours do not require PA.

Medical necessity denials

When a request is determined to not be medically necessary, the requesting provider will be notified of:

- The decision.
- The process for appeal.
- How to reach the reviewing physician for peer-to-peer (P2P) discussion of the case, if desired.

Medical necessity denials (cont.)

The provider may request a P2P discussion within seven days of notification of an adverse determination:

- Upon request for P2P discussion beyond seven days, the provider will be directed to the appeal process:
  - Clinical information submitted after a determination has been made, but not in conjunction with a P2P discussion or appeal request, will not be considered.

If a provider disagrees with the denial, an appeal may be requested:

- The appeal request must be submitted within 60 days from the date of the denial.

Late notifications or failure to obtain PA

- Late notifications of admission or failure to obtain PA for services when PA is required will not receive a medical necessity review, and the claim will be administratively denied.

- If you have questions regarding PA requirements, providers may contact Provider Services Monday through Friday, 8 a.m. to 8 p.m. ET at:

	HIP	Hoosier Care Connect	Hoosier Healthwise
Phone	**844-533-1995**	**844-284-1798**	**866-408-6132**
Fax	**866-406-2803**	**866-406-2803**	**866-406-2803**

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, or by mail to:

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

Coordination of benefits

Coordination of Benefits (COB) is when a member shows to have primary insurance:

- Claims must be filed to Anthem within 90 days of the date on the primary *Explanation of Payment (EOP)*.

If the primary carrier pays more than the Medicaid allowable, no additional money will be paid.

- **Example one:** Primary pays $45 for a 99213 and you bill Medicaid as secondary. Medicaid fee schedule is $31.96. No additional money would be paid.
- **Example two:** Primary allows $45 for a 99213 but applies it all towards a deductible and you bill Medicaid as secondary. Medicaid will pay the $31.96 since primary applied all to the deductible.

Note: Bill all secondary claims, even if we will not pay additional money; this will assist in HEDIS® data review.

Claim turnaround

Processing time:

- 21 days for electronic clean claims
- 30 days for paper clean claims

If the claim isn’t showing in our processing system, ask the Provider Services representative to verify if the claim is in imaging. **Do not resubmit if the claim is on file in the processing or image system.**

Identifying denials on the *EOP*

SERVICE DATE(S)	SERVICE CODES	POS	CHARGE	ALLOWED	DEDUCTIBLE	CO-PAY	CO-INSURANCE	CONTRACTUAL DIFFERENCE	PROVIDER RESP. AMOUNT	EXPL/ANSI CODE(S)	INSURED RESPONSIBILITY AMOUNT	EXPL/ANSI CODE(S)	WHAT WE WILL PAY
INSURED'S NAME: [redacted]													
PATIENT ACCOUNT#: [redacted]													
SERVICE PROVIDER NAME: [redacted]													
NETWORK: IN NETWORK			RELATIONSHIP TO INSURED:										
[redacted]	99213	[redacted]	60.38	0.00	0.00	0.00	0.00	55.62	PXN 45	0.00			60.38
	81025QW		8.61	0.00	0.00	0.00	0.00	17.13	PXN 45	0.00			8.61

Anthem

Anthem Blue Cross and Blue Shield is the trade name of Anthem Insurance Companies, Inc. Independent licensee of the Blue Cross and Blue Shield Association. Anthem is a registered trademark of Anthem Insurance Companies, Inc.

[redacted]

CHECK/EFT:

SERVICE DATE(S)	SERVICE CODES	POS	CHARGE	ALLOWED	DEDUCTIBLE	CO-PAY	CO-INSURANCE	CONTRACTUAL DIFFERENCE	PROVIDER RESP. AMOUNT	EXPL/ANSI CODE(S)	INSURED RESPONSIBILITY AMOUNT	EXPL/ANSI CODE(S)	WHAT WE WILL PAY
INSURED'S NAME: [redacted]													
PATIENT ACCOUNT#: [redacted]													
SERVICE PROVIDER NAME: [redacted]													
NETWORK: IN NETWORK			RELATIONSHIP TO INSURED:										
[redacted]	87210	[redacted]	0.00	0.00	0.00	0.00	0.00	23.00	GLI 16	0.00			0.00
	87210QW		0.00	0.00	0.00	0.00	0.00	23.00	GLI 16	0.00			0.00
	TOTAL:		68.99	0.00	0.00	0.00	0.00	118.75		0.00			68.99
INTEREST													0.00
	TOTAL NET PAID												68.99

EXPL CODES	EXPLANATION
TFO	This claim was submitted after the claim filing limit.
PXN	Paid per your contract or Out Of Network rates
GLI	A valid CLIA number must be submitted for this service

National provider identifier (NPI)

The following must be included on all claims:

- Tax ID
- Billing NPI name and service location address
- Rendering NPI name and address
- Taxonomy code (provider specialty type)
  - Can be obtained from www.wpc-edi.com/reference

If you have questions regarding electronic formats, please contact our EDI department at **800-470-9630** or at https://www.anthem.com/edi.

NPI (cont.)

Claims and billing requirements for *CMS-1500*:

- Box 24J — rendering provider NPI Box 33 — service facility address with complete 9-digit ZIP code
- Box 33A — billing provider NPI
- Box 33B — billing taxonomy code

Note: Remember to attest all of your NPI numbers with the state of Indiana at https://providers.anthem.com/in.

NPI (cont.)

Rendering (type one) providers — Healthcare providers who are **individuals** (including physicians, dentists, specialists, chiropractors and sole proprietors):

- An individual is eligible for only one NPI.

Billing (type two) providers — Healthcare providers who are organizations (including physician groups, hospitals, residential treatment centers, laboratories, group practices, and the corporation formed when an individual incorporates as a legal entity)

Refer to the NPI billing bulletins at https://providers.anthem.com/in.

Pricing/benefit code denials

Please review all codes used on the claim to ensure they are valid.

- This can be done by reviewing the *IHCP* fee schedule to determine if the codes are covered by *IHCP*.

Codes may also lack pricing:

- **Example one:** We may receive a new code for which pricing has not yet been established.
- **Example two:** Pricing may not be established because the code is noncovered.

Claims resolution process

Follow-up guidelines

Use the Availity Portal to check claim status online. You can also call the appropriate helpline:

Plan	Phone number
HIP	**844-533-1995**
Hoosier Care Connect	**844-284-1798**
Hoosier Healthwise	**866-408-6132**

It is the provider's responsibility to follow up timely and ensure claims are received and accepted.

Claims resolution process (cont.)

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:

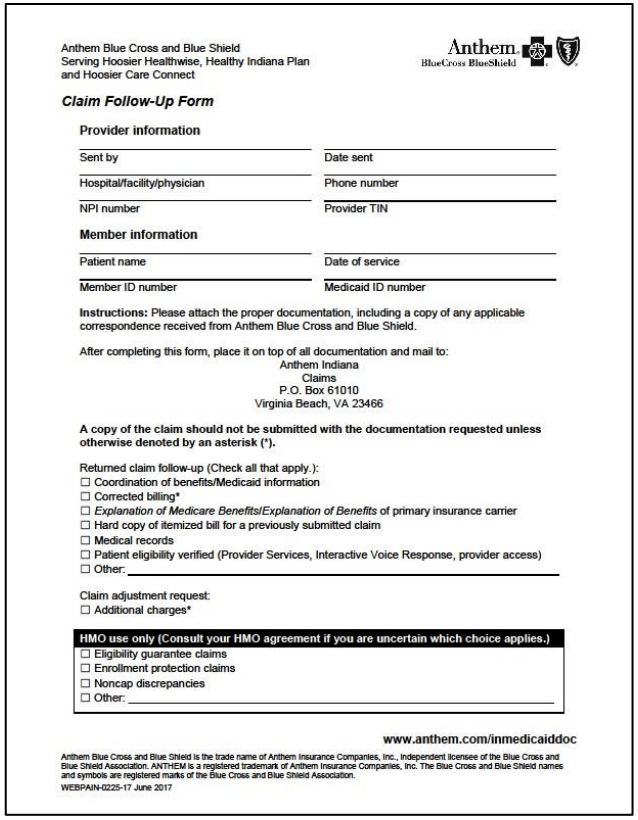
- Submit the corrected claim no later than 60 calendar days from the date of our letter or remittance advice (RA).
- Corrected claims can be submitted by paper, electronically through your clearinghouse or through the Availity Portal.

Claims resolution process (cont.)

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 www.anthem.com/inmedicaiddoc > Resources > Forms > Claims and Billing.



Anthem Blue Cross and Blue Shield
Serving Hoosier Healthwise, Healthy Indiana Plan and Hoosier Care Connect

Anthem BlueCross BlueShield

Claim Follow-Up Form

Provider information

Sent by | Date sent

Hospital/facility/physician | Phone number

NPI number | Provider TIN

Member information

Patient name | Date of service

Member ID number | Medicaid ID number

Instructions: Please attach the proper documentation, including a copy of any applicable correspondence received from Anthem Blue Cross and Blue Shield.

After completing this form, place it on top of all documentation and mail to:
Anthem Indiana
Claims
P.O. Box 61010
Virginia Beach, VA 23466

A copy of the claim should not be submitted with the documentation requested unless otherwise denoted by an asterisk (*).

Returned claim follow-up (Check all that apply.):
☐ Coordination of benefits/Medicaid information
☐ Corrected billing*
☐ *Explanation of Medicare Benefits*/*Explanation of Benefits* of primary insurance carrier
☐ Hard copy of itemized bill for a previously submitted claim
☐ Medical records
☐ Patient eligibility verified (Provider Services, Interactive Voice Response, provider access)
☐ Other: _____

Claim adjustment request:
☐ Additional charges*

HMO use only (Consult your HMO agreement if you are uncertain which choice applies.)
☐ Eligibility guarantee claims
☐ Enrollment protection claims
☐ Noncap discrepancies
☐ Other: _____

www.anthem.com/inmedicaiddoc

WEBPAIN-0225-17 June 2017

Claims resolution process (cont.)

Claims dispute and appeal process

The dispute process is if a provider disagrees with full or partial denial on the claim:

- There is a 60-calendar daytime limit from the date on the remittance advice (RA) in which to dispute any claim.
- Disputes and appeals that are not filed within the defined time frames will be denied without a review for merit.

Claims resolution process (cont.)

The claims dispute process is as follows:

1. **Claims reconsideration** — must be received within 60 calendar days from the date on the RA. Disputes can be done verbally through provider services, in writing or online through the Availity Portal. 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 be done via the Availity Portal or by mail.

Important contact information

Important contact information

Provider Services:

- Hoosier Healthwise: **866-408-6132**
- HIP: **844-533-1995**
- Hoosier Care Connect: **844-284-1798**

Member Services and 24/7 NurseLine:

- Hoosier Healthwise and HIP: **866-408-6131**
- Hoosier Care Connect: **844-284-1797**

Important contact information (cont.)

PA requests:

- HIP: **844-533-1995**
- Hoosier Care Connect: **844-284-1798**
- Hoosier Healthwise: **866-408-6132**
- Fax: **866-406-2803**

Provider Experience Manager territory map:
www.anthem.com/inmedicaiddoc > Our network > Network Relations Map

Provider Experience

Physical health Provider Experience managers

Zone 1/Beacon Health Systems

Jessi Earls
Jessica.Wilkerson-Earls@anthem.com
317-452-2568

Zone 2/Ascension St. Vincent

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

Zone 3

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

Zone 4/Deaconess

Jonathan Hedrick
Jonathan.Hedrick@anthem.com
317-601-9474

Zone 5/Parkview

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

Zone 6/IU Health; St. Joseph Regional Medical Health Center; Home Health and Hospice

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

Zone 7/Baptist Health

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

Zone 8/Eskenazi

Marvin Davis
Marvin.Davis@anthem.com
317-501-7251

Zone 9/Out-of-state providers, Franciscan, Community Health Network

Nicole Bouye
Nicole.Bouye@anthem.com
317-517-8862

Statewide behavioral health (BH) subject matter experts (SME)

Acute hospitals
Tish Jones, Provider Experience Manager
Latisha.Willoughby@anthem.com
317-617-9481

Community mental health centers/federally qualified health centers/rural health clinics
Matthew McGarry, Provider Experience Manager
Matthew.McGarry@anthem.com
463-202-3579

Substance use disorder (SUD)/Opioid treatment program (OTP)
Alisa Phillips, Provider Experience Manager, Sr.
Alisa.Phillips@anthem.com
317-618-2170

SME — SUD/OTP
Michele Weaver, Provider Experience Manager
Michele.Weaver@anthem.com
317-601-3031

Solo BH and applied behavior analysis providers

Zones 1, 2, 5, 6
Ashley Holmes
Ashley.Holmes@anthem.com
317-315-0623

Zones 3, 4, 7, 8
Whit'ney McTush
Whitney.McTush@anthem.com
317-519-1089

Questions?

Thank you for your participation in serving our members enrolled in Hoosier Healthwise, HIP, and Hoosier Care Connect!

Serving Hoosier Healthwise, Healthy Indiana Plan
and Hoosier Care Connect

* Availity, LLC is an independent company providing administrative support services on behalf of Anthem Blue Cross and Blue Shield.

https://providers.anthem.com/in

Providers who are contracted with Anthem Blue Cross and Blue Shield to serve Hoosier Healthwise, Healthy Indiana Plan and Hoosier Care Connect 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.

AINPEC-3480-21 September 2021