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

Anthem Blue Cross and Blue Shield (Anthem) Summer Updates

Indiana Health Coverage Programs (IHCP) Summer 2018 Workshop

Our purpose, vision and values

- Our team is comprised of the best and the brightest from a diverse group of businesses, cultures and backgrounds.
- The values we each bring to the table are a part of what makes our company so successful.
- We are working together every day to lay the foundation for a strong company culture.
- This culture has a positive effect on everything we do.
- As a team, our values are derived from the values displayed by our associates on a daily basis.

Topics to be covered

- Access standards and after-hours services
- Transportation
- Opioid Treatment Program
- Chiropractic benefits
- Healthy Indiana Plan (HIP) Maternity
- Physical therapy authorizations
- Retroactive eligibility
- Claims resolution
- Current projects
- Key contacts

How can you help members?

Access to care standards:

- We recognize there can be cultural and linguistic barriers that affect our members' ability to understand or comply with certain instructions or procedures.
- In order to break through these barriers, we encourage you to review our *Caring for Diverse Populations Toolkit* (**www.anthem.com/inmedicaiddoc** > Provider Support > Helping Members > Cultural & Linguistic Resources > Caring for Diverse Populations).

How can you help members? (cont.)

Primary medical providers (PMPs) and specialists must make appointments for members from the time of request as follows:	
Nature of visit:	**Appointment standard:**
Emergency	Immediate access during office hours
Urgent	Within 24 hours of request
Nonurgent — sick	Within 72 hours of request
Nonurgent — routine	Within 21 days of member's request
Specialty care	Within three weeks of request
Outpatient behavioral health (BH)	Within 14 days of request
Routine BH	Within 10 days of request
Outpatient treatment	Within seven days of discharge
Postpsychiatric inpatient care	Within seven days of discharge

We monitor provider compliance with access to care standards on a regular basis.

Failure to comply may result in corrective action.

How can you help members? (cont.)

After-hours services:

- All PMPs must have an after-hours system in place to ensure that our members can call with medical concerns or questions after normal office hours.
- The answering service or after-hours personnel must forward member calls directly to the PMP or on-call physician and instruct the member that the provider will contact him/her within 30 minutes.

How we help

We provide:

- Text and email reminders as well as interactive voice response call reminders to members.
- Assistance with PMP contact information.
- Teams of Community Health workers and Locate and Engage workers that reach out and work with members who are difficult to contact.

We make reminder calls to members and assist with appointment scheduling and transportation assistance.

Transportation (LogistiCare)

- As of December 1, 2017, our transportation vendor is LogistiCare.
  - For more information, view the *Change to nonemergent transportation vendor Provider Bulletin* (**www.anthem.com/inmedicaiddoc** > View all Communications and Updates > Communications and Updates > 2017 > *Change to nonemergent transportation vendor* — 11/8/2017).
- For transportation to and from Medicaid-covered services, Hoosier Healthwise, HIP and Hoosier Care Connect members should contact LogistiCare at **1-844-772-6632** (TTY **1-866-288-3133**).

Opioid Treatment Program

To serve as an Opioid Treatment Program provider, you must:

- Hold a valid Drug Enforcement Administration license.
- Have a certification from the State's Division of Mental Health and Addiction.
- Be contracted and enrolled with IHCP as an Opioid Treatment Program provider.
- Be contracted, enrolled and credentialed with Anthem to serve in our network.
- Provide services in compliance with IHCP policies.
- Bill for rendered services in accordance with IHCP guidelines.

Hoosier Healthwise, HIP and Hoosier Care Connect providers can enroll with IHCP to become Opioid Treatment Program providers.

Opioid Treatment Program (cont.)

Enrollment:

- To be considered, you must request enrollment by completing our online *Provider Maintenance Form (PMF)* (**www.anthem.com/inmedicaiddoc** > The Anthem Network > Join Our Network). Be sure to indicate “Opioid Treatment Program provider for Hoosier Healthwise, HIP and Hoosier Care Connect” in the comment section of the form.
- Upon successfully submitting the online *PMF*, you will receive a confirmation number and a Provider Solutions representative will email you the required contract and/or amendment.

Opioid Treatment Program (cont.)

- Your participation as an Opioid Treatment Program provider is contingent upon meeting or exceeding our credentialing standards for managed care networks.
- Your effective date as an Opioid Treatment Program provider will be no earlier than 30 days after your application is approved by our Credentialing committee.
- If approved, you will be enrolled as an Opioid Treatment Program provider in our provider database system.

Opioid Treatment Program (cont.)

- Addiction Services and Opioid Treatment Program providers are reimbursed a daily bundled rate that includes required opioid treatment services.
- Please refer to *IHCP Bulletin BT201755* for reimbursement of bundled Opioid Treatment Program services.

Chiropractic services

- Effective January 1, 2018, IHCP added coverage of chiropractic services to HIP Plus plan.
- The HIP Plus chiropractic benefit covers services provided by a licensed chiropractor when rendered within the chiropractic scope of practice.
- Coverage does not require prior authorization (PA) or a referral.
    - Spinal manipulation visits are limited to six per covered person per benefit year. Only one service per member per day is allowed. This change does not impact the coverage of chiropractic services currently included under the HIP State Plan Basic or HIP State Plan Plus benefit plans nor does it expand coverage of chiropractic services to HIP Basic.

HIP Maternity coverage

- Starting February 1, 2018, the HIP program encompasses coverage for pregnant women.
- HIP-eligible pregnant women are no longer transitioned to Hoosier Healthwise for coverage.
- Pregnant applicants at or below 138% of the Federal poverty level (FPL) and eligible for the HIP program are enrolled in HIP.
    - Note, the IHCP Eligibility Verification System (EVS) indicates HIP Maternity as the member's coverage and identifies the enrolling managed care entity (MCE).

HIP Maternity coverage (cont.)

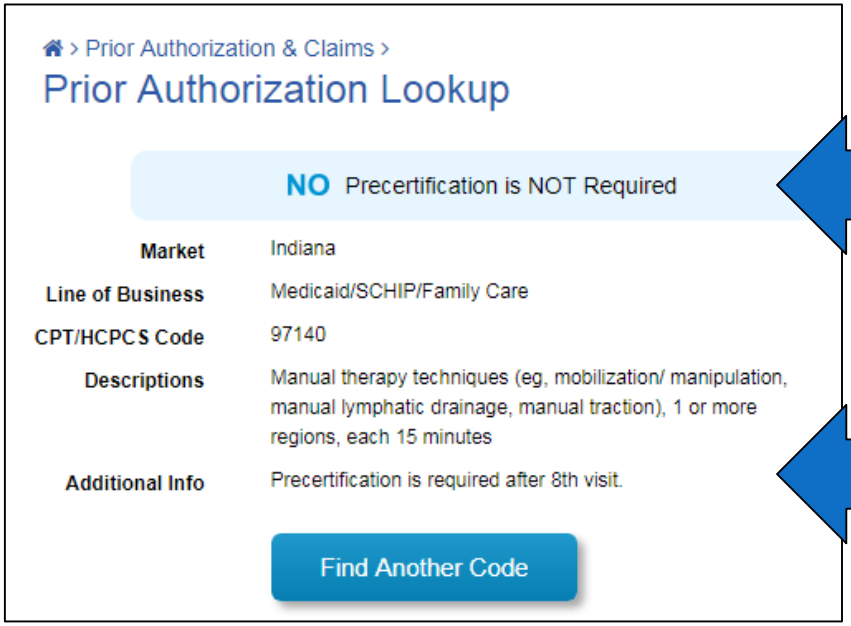
- Pregnant applicants above 138% of the FPL and eligible for IHCP services are enrolled in Hoosier Healthwise.
  - The IHCP EVS indicates Package A Standard Plan as the member's coverage and identifies the enrolling MCE.
- Pregnant applicants, whether enrolled in HIP or Hoosier Healthwise, may also be determined eligible for retroactive coverage for up to three months prior to their application date.
  - If eligible for retroactive coverage, the IHCP EVS will indicate Package A Standard Plan as the member's coverage during the retroactive time period with no enrolling MCE indicated.
  - Retroactive coverage is paid through the fee-for-service delivery system.

Physical therapy services

- As of November 1, 2017, physical, occupational and speech therapy services no longer require PA for the first eight visits of therapy per diagnosis.
  - For more information, view the *First 8 visits of Therapy Provider Bulletin* (**www.anthem.com/inmedicaiddoc** > View all Communications & Updates > Communications and Updates > 2018 > *First 8 Visits of Therapy Provider Bulletin* — 2/27/2018).
- PA is required starting with visit nine, and requests will be reviewed for medical necessity.

Physical therapy services (cont.)

Using the PA Lookup Tool:



Shows that it is not required.

Shows that it's required after the 8th visit.

Retroactive eligibility: PA, utilization management (UM) and claims processing

- Retroactive eligibility occurs when a member's effective date of coverage is back-dated by the state.
- Retroactive identification may be unavoidable in limited situations in which a member was incapacitated (unconscious) at the time of the encounter and was unable to provide insurance/Medicaid information, preventing the provider from being able to perform eligibility verification.

Retroactive eligibility: PA, UM and claims processing (cont.)

- If PA or UM notification is required but was not requested timely:
  - Do not send retro-PA requests or notifications to the PA/UM department.
  - Instead, file the claim normally.
  - When the claim is administratively denied for failure to obtain PA, complete a *Provider Dispute Form*.
- If sufficient details are not included to support retroactive eligibility, the patient was unable to provide demographic and insurance information at the time of service, or the services provided do not meet established medical necessity criteria, the original decision will be upheld and the claim will not be reprocessed.

Retroactive eligibility: PA, UM and claims processing (cont.)

- For disputes related to untimely PA requests and UM notifications, include the following (as applicable) to identify the reason the request/notification was not made timely:
  - Condition or circumstances that prevented the member from providing his/her Medicaid status (for instance, the member was unconscious when brought to the ED)
  - Documentation that demonstrates the member was made retroactively eligible by the state
  - Documentation of attempts to verify eligibility in which incorrect or no information was found (such as screen shots of the eligibility verification tool)
  - Documentation of misrepresentation which may include copies of signed patient forms where the member checked “no” in the insurance/Medicaid field or left them blank
  - Clinical documentation identifying the medical necessity for the services

Retroactive eligibility: PA, UM and claims processing (cont.)

- Newborns are assigned to the same MCE as the mother, retroactive to the date of birth.
  - Hospitals should report all Medicaid newborns to the state as quickly as possible so that a permanent Medicaid member ID can be assigned.
  - Births should be reported to our UM team within three days.
  - You may contact Provider Services to request a temporary ID number, which allows you to request PA and submit newborn claims until a permanent ID is assigned.
  - For additional details, refer to the *Temporary Newborn Cases Provider Bulletin* (**www.anthem.com/inmedicaiddoc** > View all Communications & Updates > Communications and Updates > 2017 > *Temporary Newborn cases* – 7/25/2017).

Top claim denials/institutional — *UB04*

Denial code	Claim denial reason
TF0 — submitted after plan filing limit	This claim was submitted after the claim filing limit.
F00 — charges processed under original submission	Charges processed under original submission.
CDD — definite duplicate claim	This claim is a duplicate of a previously submitted claim for this member.
YPL — resubmit with value code/amount	Resubmit with value code/value amount required for patient liability.
Z33 — billing NPI not registered with state	Billing NPI is not registered with the state. Please resubmit a valid billing NPI.
Z32 — attending NPI not registered with state	Attending NPI is not registered with the state. Please resubmit a valid attending NPI.
HCG — primary payment greater than allowable	Primary payment is greater than allowable.
ST — termination	This service was not paid because the member's coverage was not in effect at the time of the service.
G22 — paid at contracted rate	Paid in accordance to the provider contracted rates or out-of-network rates.
CBP — primary carrier info required	*Explanation of Benefits* is needed from the member's primary carrier.

Top claim denials/professional — *CMS1500*

Denial code	Claim denial reason
Z33 — billing NPI not registered with state	Billing NPI is not registered with the state. Please resubmit a valid billing NPI.
TF0 — submitted after plan filing limit	This claim was submitted after the claim filing limit.
Y3Z — deny preauth not obtained	Deny; no authorization on file.
YW3 — direct claims to Franciscan	Direct claims to Franciscan Medical Group.
CDD — definite duplicate claim	This claim is a duplicate of a previously submitted claim for this member.
Z34 — rendering NPI not registered with state	Rendering NPI is not registered with the state. Please resubmit a valid rendering NPI.
ST — Termination	This service was not paid because the member's coverage was not in effect at the time of the service.
CBP — primary carrier info req	*Explanation of Benefits* is needed from the member's primary carrier.
Y41 — deny preauth not obtained	Deny; no authorization on file.
GBK — disallow for out-of-network provider	Service not allowed for out-of-network provider.

How do I resolve a claim issue?

- Provider Services is your first line of contact:
  - Hoosier Healthwise: **1-866-408-6132**
  - HIP: **1-844-533-1995**
  - Hoosier Care Connect: **1-844-284-1798**
- Please provide the claim number and details regarding the denial. Provider Services will provide you a reference number. This counts as your first level dispute if your claim is sent for review.
- You may also submit a *Provider Dispute Resolution Request Form* (**www.anthem.com/inmedicaiddoc** > Provider Support > Forms > Grievances and Disputes > *Provider Dispute Resolution Request*) or you may submit a dispute via Availity.

How do I resolve a claim issue? (cont.)

- Submit second level administrative appeals in writing.
- Reach out to your network education representative or behavioral health network relations consultant and provide the following:
  - The date you reached out to Provider Services and the reference number provided
  - The date the dispute was submitted
  - A copy of the IHCP policy supporting your rebuttal
  - Supporting documentation
- Note, representatives no longer accept claims spreadsheets.

Current list of projects

- **Z34 — rendering NPI not registered with the state:** Providers with a classification of “Billing” (B) providers (such as DME/HME, ambulance, solo-practitioners not all inclusive) may leave field 24J blank or enter their billing NPI. Until the system update is complete in May or June, weekly sweeps are being done to reprocess denials.
- **Notice of pregnancy (NOP) claims with code 99354TH are being denied with e14 (add-on code billed without primary code):** System update is pending. Discussing weekly claim sweeps.
- **U9 modifier — early elective deliveries:** A bulletin is forthcoming that will advise providers of the time line to discontinue use of U9 and only use UA, UB and UC (per IHCP policy). A claim sweep was completed for claims back to April 1, 2018.

Current list of projects (cont.)

- **Z01 — entity's National Provider Identifier (NPI) claim denials:** Our system requires the operating provider NPI in field 77 (or electronic equivalent) for inpatient hospital, outpatient hospital and ambulatory surgical center (ASC) claims that contain a surgical procedure code (CPT codes 10000 through 69999 except 36415). The *IHCP Provider Reference Manual* identifies that an operating NPI is only required for inpatient claims. We are submitting a request to have the system updated and are running a report to perform a sweep of impacted outpatient hospital and ASC claims.

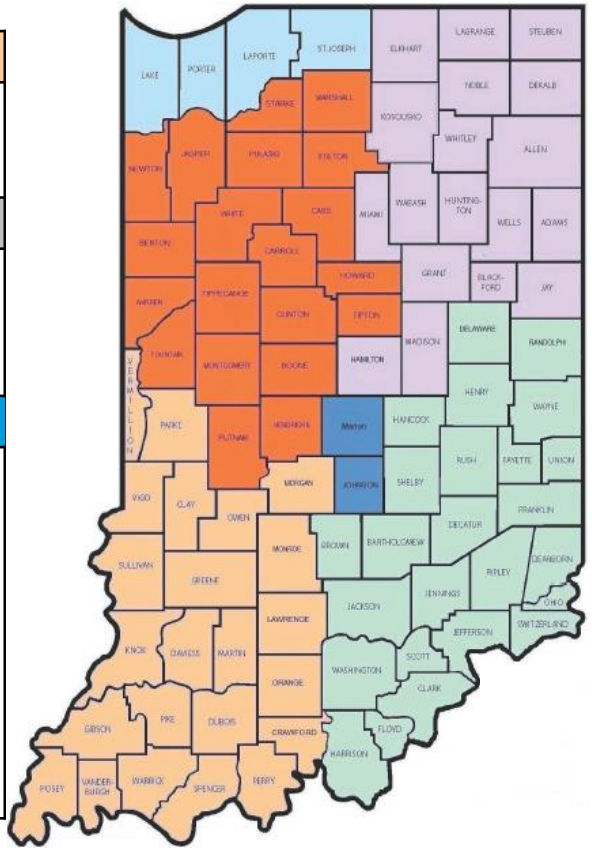
Current list of projects (cont.)

- **Inpatient hospital postpartum claims:** The system is being modified to no longer require documentation for postpartum care with an inpatient place of service. A claims sweep for claims from April 1, 2017, through March 31, 2018, with outpatient places of service is being completed. Watch for a forthcoming bulletin regarding prior denials for inpatient claims.
- **Separate payment for urinalysis with prenatal visits or office visit codes:** This issue is being reviewed for resolution.
- **Separate payment for venipuncture/capillary blood with office visit codes:** This issue is being reviewed for resolution.

Provider Network Relations — Physical Health territory map

Northwest Region/Franciscan	Northeast Region/IU Health	Southwest Region/Deaconess
Randall Mills randall.mills@anthem.com **1-317-452-6219**	Matt Swingendorf matthew.swingendorf@anthem.com **1-317-306-0077**	Jonathan Hedrick jonathan.hedrick@anthem.com **1-317-601-9474**
West Central Region/St. Vincent	**Southeast Region**	**Community Health**
Angelique Jones angelique.jones@anthem.com **1-317-517-1008**	Sophia Brown sophia.brown@anthem.com **1-317-775-9528**	Ron Gibson Network Support Manager rondinel.gibson@anthem.com **1-317-995-7801**

Central Region	
Tina Mason tina.mason@anthem.com **1-463-201-3718** **Marion County:** 46280, 46240, 46250, 46256, 46236, 46216, 46235, 46229, 46220, 46205, 46226, 46218, 46201, 46219, 46203, 46239, 46107, 46259, 46237, 46227, 46204 **Johnson County:** 46162 (Needham), 46124 (Edinburgh), 46184 (New Whiteland), 46131 (Franklin)	Marvin Davis marvin.davis@anthem.com **1-317-501-7251** **Marion County:** 46290, 46260, 46268, 46278, 46254, 46228, 46208, 46202, 46222, 46224, 46214, 46234, 46221, 46225, 46217, 46221, 46241, 46231, 46183, 46113 **Johnson County:** 46106 (Bargersville), 46181 (Trafalgar), 46142 and 46143 (Greenwood), 46164 (Nineveh)



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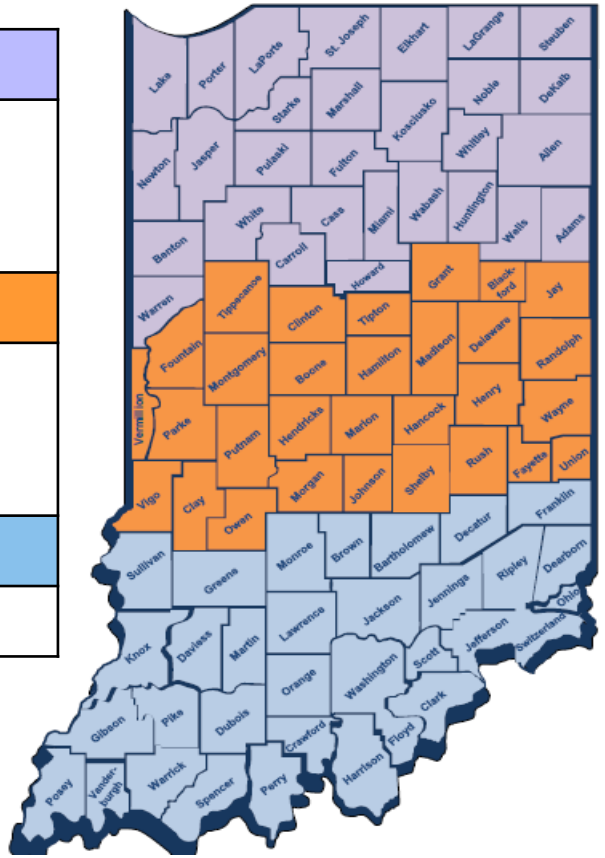
Provider Network Relations — Behavioral Health territory map

- Community mental heath centers and federally qualified health centers should reach out to their assigned Network Relations consultants.
- Behavioral Health and HIP questions can be sent to anthembehavioral@anthem.com.

Northern Region
Wanda Clayton wanda.clayton@anthem.com **1-317-650-0714**
Central Region
Alisa Phillips alisa.phillips@anthem.com **1-317-517-1008**
Southern Region
Open



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Thank you

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