



Serving Hoosier Healthwise, Healthy Indiana Plan
and Hoosier Care Connect

2021 Anthem Blue Cross and Blue Shield (Anthem) Benefit Overview

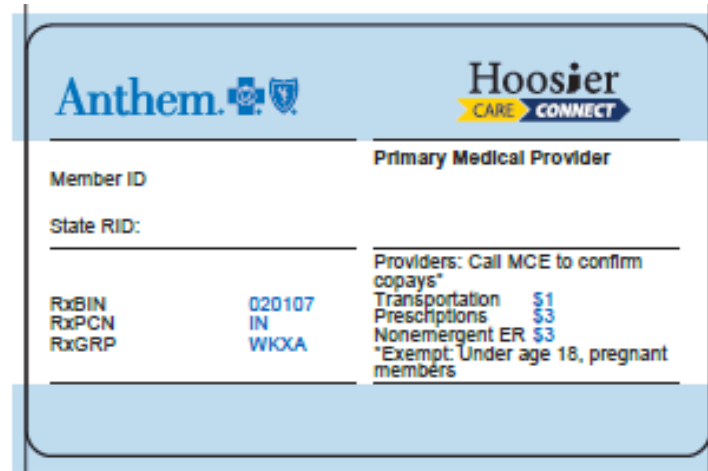


Agenda

- Member ID cards
- Carved out services updates
- Benefits reminders
- Interactive Care Reviewer (ICR)
- Claim resolution process
- Territory updates
 - Maps
 - Contact information

Anthem member ID cards

Anthem member ID card:



- Effective April 1, 2021, Anthem member IDs will be removed for Hoosier Care Connect members. The member ID (also known as RID) will remain on the card.
- Continue to use the prefix YRH and the RID to verify eligibility at <https://www.availity.com>.*

Routine dental benefits

Healthy Indiana Plan (HIP) Plus, HIP State Plans, Hoosier Care Connect and Hoosier Healthwise

- Includes:
 - Exams
 - Cleanings
 - X-rays
 - Fillings
 - Fluoride treatment (age 20 and under)
 - Crowns
 - Extractions

HIP Basic (members 19 to 20 years old)

- Includes:
 - Two exams and cleanings per year
 - Bitewing X-rays once every 12 months
 - One complete set of comprehensive X-rays every three years

Routine dental care is provided by DentaQuest*

- For more information contact:
 - **1-855-453-5286**
 - www.dentaquest.com

For more dental benefit information, please refer to page 23 of the Anthem *Provider Manual* at <https://mediproviders.anthem.com/in/pages/home.aspx>.

Routine vision benefits

Eye exams

HIP Plus, HIP Maternity, HIP State Plans and Hoosier Healthwise

- Members under 21 years of age – One exam per 12-month period.
- Members 21 years of age and older – One exam every two years.

Hoosier Care Connect

- Members under 21 years of age – One exam per 12-month period.
- Members 21 years of age and older – One exam every two years.

HIP Basic

- Members age 19 and 20 – One exam every 12 months.
- Members age 21 years and older – No vision benefits.

Routine vision benefits (cont.)

Glasses (including frames and lenses) and contacts

HIP Plus, HIP Maternity, HIP State Plans and Hoosier Healthwise

- Members under 21 years of age:
 - One pair of glasses per 12-month period
 - Contacts if medically necessary
- Members 21 years of age and older:
 - One pair of glasses every two years
 - Contacts if medically necessary

Hoosier Care Connect

- Members under 21 years of age:
 - Glasses – one pair every year
 - Contact lenses if medically necessary
- Members 21 years of age and older:
 - Glasses – one pair every five years
 - Contact lenses if medically necessary

HIP Basic

- Members age 19 and 20 only:
 - Glasses every two years
 - Contacts if medically necessary

Enhanced vision services – Hoosier Care Connect

- Optional contact lenses for members age 20 and younger
- One new pair of glasses per year for members age 21 and over

Routine vision benefits (cont.)

Effective April 1, 2021

Anthem has changed our vision benefits manager to Superior Vision.* Superior Vision is a division of Versant Health.



Routine vision benefits (cont.)

Contact information		
Provider Relations Monday to Friday 8 a.m. to 6 p.m. ET	To contact a Provider Recruiting Associate, please call 1-844-585-2020 or email prsupport@superiorvision.com .	<ul style="list-style-type: none">• Inquire about becoming a provider• Verify credentialing application status• Update address and office information
Utilization review Monday to Friday 9 a.m. to 5 p.m. ET	Fax: 1-855-313-3106	<ul style="list-style-type: none">• Request prior authorization for services outside regular eligibility cycle• Request prior authorization

Routine vision benefits (cont.)

Contact information

Provider website

www.superiorvision.com

To access the website, enter your provider number and password.

If a login password has not been created, call **1-800-243-1401**.

- Verify eligibility and benefits
- Request authorization for services
- Check claim status
- View formularies
- View updates to benefit info
- Download forms
- Access important links
- *Clinical Practice Guidelines*

Provider Interactive Voice Response (IVR) System

Available 24 hours a day

1-800-507-3800

- Verify eligibility/benefits
- Request authorization for services

Routine vision benefits (cont.)

Contact information		
Customer Service and eligibility	1-800-507-3800	<ul style="list-style-type: none">• Verify eligibility and benefits
Claims Available 24 hours a day	To contact a Claims Associate call 1-866-819-4298 or write to Superior Vision Claims Unit P.O. Box 967 Rancho Cordova, CA 95741-0967	<ul style="list-style-type: none">• Request billing information• Request status of claim payment

Routine vision benefits (cont.)

Contact information

Complaints and appeals

Email:
ProviderCA@versanthealth.com
Phone: **1-888-343-3470**
Fax: **1-888-778-2008**
Or write to:
Versant Health Complaints and Appeals Department
P.O. Box 791
Latham, NY 12110

- Submit a complaint or payment dispute appeal

Website assistance

1-800-507-3800

AIM Specialty Health*

Anthem contracts with AIM Specialty Health (AIM) to provide health services review for prior authorization (PA).

Services reviewed

- Outpatient rehabilitative and habilitative services (OT/PT/ST)
- Outpatient imaging services including but not limited to:
 - Computer tomography scans (including cardiac)
 - Nuclear cardiology
 - Magnetic resonance imaging
 - Positron emission tomography scans
 - Stress echocardiography
 - Radiation oncology testing
- Sleep disorder testing
- Musculoskeletal program
 - Spine surgeries
 - Joint surgeries
 - Interventional pain management procedures

AIM (cont.)

www.aimspecialtyhealth.com

- Clinical guidelines
- Register for the provider portal

Request authorization

- AIM Portal
 - <https://providerportal.com>
- Phone
 - **1-800-714-0040**
 - Monday through Friday, 8 a.m. to 8 p.m. Eastern time

Pharmacy benefits

Anthem is responsible for prescription drug coverage for our members enrolled in Hoosier Healthwise, HIP and Hoosier Care Connect.

- The pharmacy benefit through our pharmacy benefits manager, **IngenioRx**.*
- Members must use an in-network pharmacy for prescription services so that they are not subject to unnecessary out-of-pocket costs.
- Pharmacy providers in the Anthem pharmacy network should submit pharmacy benefit claims to IngenioRx for Hoosier Healthwise, HIP and Hoosier Care Connect members.
- Pharmacies may dispense up to a one-month supply of medication. HIP Plus and Hoosier Care Connect members may receive a 90-day supply of maintenance medication through a retail pharmacy or mail order pharmacy.

Pharmacy benefits (cont.)

Covered drugs

Pharmacy coverage includes:

- Prescription drugs approved by the United States Food and Drug Administration (FDA).
- Prescribed over-the-counter (OTC) items approved by the FDA and covered by Fee-For-Service (FFS) Medicaid Program.
- Self-injectable drugs (including insulin).
- Diabetic supplies per Indiana State Preferred Diabetic Supplies List.
- Smoking cessation drugs.
- Various supplies, such as needles, syringes, blood sugar monitors, test strips, lancets and glucose urine testing strips.
- Free pregnancy test kits from in-network CVS and Walmart stores (select CVS brand or Walmart Equate brand only); limit of three kits per year for female patient.

Pharmacy benefits (cont.)

Non-covered drugs

Services not covered by the pharmacy benefit include:

- Drugs not approved by the FDA.
- Drugs from manufacturers that do not participate in a rebate agreement with the Centers for Medicare & Medicaid Services (CMS).
- Drugs not on the FFS OTC drug formulary.
- Drugs to help members get pregnant.
- Drugs used for cosmetic reasons.
- Drugs for hair growth.
- Drugs used to treat erectile problems.
- Drugs used for weight loss.
- Experimental or investigational drugs.
- Vaccines covered by VFC Program.

Non-covered is not the same as prior authorization required. Non-covered drugs are those that are excluded from benefit coverage. These products are not reimbursable, even with prior authorization.

Pharmacy benefits (cont.)

- Pharmacy prior authorizations:
 - Call Provider Services lines
 - Hoosier Healthwise — **1-866-408-6132**
 - Hoosier Care Connect — **1-844-284-1798**
 - Healthy Indiana Plan — **1-844-533-1995**
 - Providers can submit prior authorization requests for any prescription drugs that require prior authorization to Anthem. Electronic prior authorization (ePA) is available through **CoverMyMeds.***
 - Providers may visit the CoverMyMeds website (<https://www.covermymeds.com>).

Pharmacy benefits (cont.)

Preferred Drug List

- The *Preferred Drug List* for Hoosier Healthwise, Hoosier Care Connect, HIP Basic and HIP Plus can be found at <https://mediprovider.anthem.com/sp/pages/in/pharmacy-benefits/>.

Mail order

- Anthem members may receive a 90-day supply of maintenance medication through our mail order provider. HIP Plus and Hoosier Care Connect members may also obtain a 90-day supply of maintenance medication through a retail pharmacy.

For more information on the pharmacy benefits, see Chapter 4: Pharmacy in the provider manual at

https://mediprovider.anthem.com/dam/medidocuments/ININ_CAID_ProviderManual.pdf?v=202101150221.

Chiropractic benefits

Billing and reimbursement for chiropractors

- The IHCP limits claim payment for chiropractors (provider specialty 150) to certain designated procedure codes for chiropractic and related services.
 - Reimbursement is not available for durable medical equipment (DME) or electromyogram (EMG) testing provided by chiropractors.
 - The IHCP requires that chiropractors bill with certain International Classification of Diseases (ICD) diagnosis codes to indicate the medical necessity of the service provided.

For a list of IHCP-covered procedure codes for chiropractors, as well as a list of the appropriate diagnosis codes for chiropractors to use when billing the services to the IHCP, see Chiropractic Services Codes, accessible from the Code Sets page at

http://provider.indianamedicaid.com/ihcp/Publications/providerCodes/Chiropractic_Services_Codes.pdf.

Chiropractic benefits (cont.)

- Chiropractic services are available to IHCP members, pursuant to restrictions outlined in the individual's benefit plan, when necessitated by a condition-related diagnosis.
- Chiropractic services are limited to 50 units per member per calendar year.¹
 - The 50 units can be a combination of office visits, spinal manipulation or physical medicine services.
 - Office visits are limited to five per year and are included in the 50 units per member per year.

¹ Members on HIP Basic do not have chiropractic coverage.

Opioid Treatment Program

- Opioid treatment services:
 - On September 1, 2017, IHCP began covering the rendering and reimbursement of opioid treatment services. Refer to the *IHCP Bulletin BT201755* for billing guidance and program details.
<http://provider.indianamedicaid.com/ihcp/Bulletins/BT201755.pdf>
- A qualified provider must:
 - Be enrolled with IHCP with an addiction services provider type and a specialty of Opioid Treatment Program (OTP).
 - Maintain a Drug Enforcement Administration (DEA) license.
 - Maintain certification from the state's Division of Mental Health and Addiction (DMHA).
 - Enroll with Anthem by submitting an online *Provider Maintenance Form (PMF)*; in the comments section, indicate *Opioid Treatment Program provider for Hoosier Healthwise, Healthy Indiana Plan and Hoosier Care Connect*. Current participating providers with Anthem wanting to offer OTP services will need to complete the *PMF Form*. <https://central.provider.anthem.com/mwpmf/PMFControllerServlet>

Substance use disorder (SUD) treatment

- Effective March 1, 2018, IHCP expanded coverage of substance use treatment to include residential treatment. Refer to *IHCP Bulletins BT201801 and BT201821* for billing guidance and program details. These services require PA, which can be obtained through the Availity Portal and must include the state's SUD forms.
 - <http://provider.indianamedicaid.com/ihcp/Bulletins/BT201801.pdf>
 - <http://provider.indianamedicaid.com/ihcp/Bulletins/BT201821.pdf>
- A qualified provider must:
 - Have designation by the DMHA as offering American Society of Addiction Medicine (ASAM) Patient Placement Criteria level 3.5 and/or 3.1.
 - Enroll with IHCP with provider type 35 and specialty 836.
 - Refer to their Anthem contract manager to decide if a contract amendment or *PMF* submission is required.

Member benefit overview

Benefit overview

Self-referral services

For psychiatric services, managed care members can self-refer to any IHCP-enrolled provider licensed to provide psychiatric services within their scope of practice. However, for BH services from any of the following provider types, self-referrals must be in-network (that is, to providers enrolled within the MCE network):

- Outpatient mental health clinics
- Community mental health centers (CMHCs)
- Psychologists
- Certified psychologists
- HSPPs
- Certified social workers
- Certified clinical social workers
- Psychiatric nurses
- Independent practice school psychologists
- Advanced practice nurses (APNs), under *Indiana Code IC 25-23-1-1(b)(3)*, credentialed in psychiatric or mental health nursing by the American Nurses Credentialing Center
- Persons holding a master's degree in social work, marital and family therapy, or mental health counseling (under *405 IAC 5-20-8*)

Covered benefits

Hoosier Healthwise (packages A and C), HIP (including maternity) and Hoosier Care Connect covered benefits:

- Inpatient services:
 - Except inpatient services provided in a state psychiatric hospital or psychiatric residential treatment facility (PRTF)
- Residential SUD treatment
- OTP
- Partial hospitalization services
- Outpatient services, including psychological testing
- Applied behavioral therapy
- Smoking cessation services
- Telemedicine
- IOP

Note: Medicaid Rehabilitation Option (MRO) and 1915(i) services are not covered by Anthem but are covered under state benefits and can be coordinated with community mental health centers. Notification of 1915(i) services to our care management department are appreciated.

Coordination of care treatment summary

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



Coordination of Care and Treatment Summary

In accordance with acceptable medical practice, Anthem Blue Cross and Blue Shield requires network behavioral health care providers, primary medical providers and other appropriate medical providers involved in a member's treatment to coordinate care. Please complete this form and send it to the appropriate provider(s) treating this member after obtaining written patient consent in compliance with all applicable state and/or federal regulations.

Member name:	Date of birth:
A. Provider information	
Name:	Phone number:
Practice name:	Address:
B. Other provider information	
Name:	Address:
Phone number:	Fax number:
C. Member clinical information	
1. I am treating the member for the following diagnosis(es):	
2. The member is taking the following prescribed medication(s) that I have prescribed:	
3. (For behavioral health providers only) The member is engaged in the following psychotherapeutic intervention(s):	
Frequency of intervention(s):	
4. Coordination of care issues/other significant information affecting medical or behavioral health care:	
Signature:	Date:
Fax or mail form to (list other provider[s]):	Date mailed or faxed:

Important note: You are not permitted to use or disclose Protected Health Information about individuals who you are not currently treating or are not enrolled to your practice. This applies to Protected Health Information accessible in any online tool, sent in any medium including mail, email, fax or other electronic transmission.

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AINPEC-0958-16 October 2016

Behavioral Health Data Sharing Form

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



Behavioral Health Treatment Data Sharing Form for Hoosier Healthwise and Healthy Indiana Plan members

Once complete, please fax to 1-866-877-5229, Attn: Behavioral Health Care Management department. This form will be forwarded to the member's primary medical provider by an Anthem Blue Cross and Blue Shield associate.

Member name:	Recipient identification number:
Member address:	Member phone number:
Primary medical provider:	Primary medical provider phone number:
Date of initial visit:	Initial diagnosis:
Is this member receiving Medicaid Rehabilitation Option services?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is this member at imminent risk of hospitalization?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, was a crisis plan established?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Summary of initial visit:	
Significant findings from assessment:	
Medications taken or prescribed:	
Other relevant information:	
Treatment requested:*	
Provider name:	Service address:
Facility/group name:	Phone number:
NPI number:	Fax number:
Date of submission:	
Consent obtained to release information related to substance abuse and/or HIV condition:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A

* Any services other than routine outpatient treatment require specific authorization (for example, psychological testing).

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AINPEC-1231-17 April 2017

Access to behavioral health

Access to behavioral health:

- Behavioral health (BH) providers must have a system in place to ensure members are able to call after hours with questions or concerns. Anthem monitors BH provider compliance with after-hours access on a regular basis. Failure to comply may result in corrective action.
- Access to care is outlined in the provider contract and the following resources:
 - *Anthem Blue Cross and Blue Shield Indiana Medicaid Provider Manual*
 - *Behavioral Health Reference Guide*

Access to behavioral health (cont.)

After-hours protocols:

- BH providers must follow the below protocols for response to after-hours inquiries made by members:
 - Emergent: immediately
 - Emergent, non-life-threatening/crisis stabilization: within six hours of request
 - Urgent: within 24 hours of referral or request
 - Behavioral health examination: within 14 days of request
 - Routine outpatient: within 10 business days of request
 - Outpatient following discharge from inpatient hospital: within seven days of discharge

Access to behavioral health (cont.)

Definitions:

- **Emergent:** Emergent treatment is considered an on-demand service and does not require precertification. Members are asked to go directly to emergency rooms for services if they are unsafe or their condition deteriorates.
- **Urgent:** Urgent refers to a service need that is not emergent and can be met by providing an assessment and services within 24 hours of the initial contact. If the member is pregnant and has substance use problems, they are placed in the urgent category.
- **Routine:** Routine refers to a service need that is not urgent and can be met by receiving treatment within 10 days of assessment without causing the member's condition to deteriorate.

If you have questions, contact Provider Services:

- Hoosier Healthwise — **1-866-408-6132**
- Healthy Indiana Plan — **1-844-533-1995**
- Hoosier Care Connect — **1-844-284-1798**

Primary medical and behavioral health providers: Working together to treat the whole person

Working together to treat the whole person

- **Physical health (PH) and behavioral health (BH) go hand in hand.**
- **Collaboration leads to well-informed decisions.**
- **Sharing relevant case information in a timely, useful and confident manner is an Anthem policy.**
 - We abide by standards set by the National Committee for Quality Assurance (NCQA) requiring health plans to ensure coordination of care between primary medical providers (PMPs) and BH providers.

Exchanging health information

- **PMPs and BH providers should exchange health information:**
 - When a member first accesses a PH or BH service.
 - When a change in the member's health or care plan requires a change in another provider's care plan.
 - When a member discontinues care.
 - When a member is admitted to or discharged from the hospital.
 - When a member is admitted and a consultation is warranted.
 - When a member has a physical exam and/or laboratory or radiological tests.

This information should be shared within 24 hours if the member is at risk of hospitalization or five days if they are not at risk. Please use the *BH Data Sharing* form at

https://mediprovider.anthem.com/dam/medidocuments/ININ_CAID_BHTreatmentDataSharingForm_IN_forms.pdf?v=202101270151.

Tips for providers

- **Substance use and depression screening**
 - When doing an annual screening for substance abuse and depression, use standard screening tools. If your patient answers *yes* to any of the screening tool questions, refer the patient to a BH specialist for a complete BH assessment. Contact Anthem if you need help making this referral.

Tips for providers (cont.)

- **Substance use: treatment and follow-up visits after a diagnosis**
 - People who stay in treatment for 90 days or more are less likely to use drugs after they are discharged.
 - If treatment time is increased to 180 days, the likelihood of drug use after discharge falls more than 50%. Therefore, it's important to make sure patients begin treatment immediately upon a diagnosis of substance use.
 - Additionally, per HEDIS[®] requirements, all patients with newly diagnosed substance abuse should be seen:
 - At least once within 14 days of being diagnosed.
 - Two or more times within 30 days of the initial visit.

If you need help arranging treatment for a newly diagnosed patient, call the Provider Helpline.

HEDIS[®] is a registered trademark of the National Committee for Quality Assurance (NCQA).

Tips for providers (cont.)

- **Antidepressant medication management**
 - We strive to meet the HEDIS goals by assessing the adequacy of medication trials for members 18 years of age and older who are diagnosed with a new episode of major depression and treated with (and kept on) antidepressant medication:
- **Effective acute phase treatment**
 - The percentage of newly diagnosed and treated members who remained on an antidepressant medication for at least 12 weeks.
- **Effective continuation phase treatment**
 - The percentage of newly diagnosed and treated members who remained on an antidepressant medication for at least six months.

Tips for providers (cont.)

- **Follow-up visits after an ADHD diagnosis**
 - Anthem has adopted the following HEDIS goals for medication follow-up:
 - At least one follow-up visit with a practitioner within a month of the first prescription of ADHD medication for all children 6 to 12 years old diagnosed with ADHD.
 - At least two follow-up visits in nine months for children who remain on ADHD medication for at least 210 days.

Interactive Care Reviewer

Interactive Care Review (ICR)

- **ICR benefits include:**

- **Free:** There is no additional cost to use.
- **Easy to use:** You can submit requests online using the same, easy-to-use functionality.
- **Access from almost anywhere:** Submit your requests from any computer with internet access. (Note: We recommend you use Internet Explorer 11, Chrome, Firefox or Safari for optimal viewing.)
- **Automated routing to ICR from the Availity Portal:** You will automatically be routed to ICR to begin your precertification or prior authorization request.
- **Inquiry capability:** Ordering physicians, servicing physicians and facilities can inquire to find information on any precertification they are affiliated with previously submitted via phone, fax or the ICR.
- **Determine if preauthorization is needed.** For most requests, when you enter patient, service and provider details, you will receive a message indicating whether or not review is required.
- **Reduces the need to fax:** Submit online precertification requests without the need to fax medical records. ICR allows both text detail and photo/image attachments to be submitted along with the request.
- **Receive viewable decision letter:** You can view, save or print decision letters.
- **Save favorites:** You can save 25 requesting providers, 25 servicing providers, 25 facility/durable medical equipment providers and 25 refer to providers.
- **Comprehensive view of all precertification requests:** You get a complete view of utilization management requests submitted online including the status of request with views of case updates.

ICR (cont.)

- **How do I gain access to ICR?**
 - Access the ICR tool via the Availity Portal.
 - If your organization has not registered to use the Availity Portal, you can register at <https://www.availity.com>. You will select the **Register** button at the top right corner of the screen, then select your **Organization type** from the available options at the bottom of the screen and complete the registration wizard.
 - If your organization already has access to the Availity Portal, your Availity administrator can grant you access to **authorization and referral request** for submission capability and **authorization and referral inquiry** for inquiry capability. You can then find our tool under *Patient Registration and Authorizations & Referrals*.
- **How can I learn more about the ICR tool?**
 - Attend one of the ICR quarterly webinars.

ICR resources located on the Custom Learning Center

- Find resources that will familiarize you with navigating ICR, our online medical and behavioral health self-service authorizations tool that is accessed through the Availity Portal.
 - www.availity.com

ICR resources located on the Custom Learning Center (cont.)

Follow these steps to access ICR courses and resources:

From the Availity home page > Payer Spaces > Anthem Blue Cross and Blue Shield tile > Applications > Access Your Custom Learning Center.

1. Select **Catalog** from the menu located on the upper-left corner of the Custom Learning Center screen.
2. Use the catalog filter and select **Interactive Care Reviewer-Online Authorizations** or **Authorizations** from the Category menu.
3. Select **Apply**.

There are two pages of online courses consisting of on-demand videos and reference documents. Find the course(s) you want to take, then:

4. Select **Enroll** and choose **Start** to take the course immediately or to save for later, select **Return to Dashboard**.

The screenshot displays the Custom Learning Center interface. On the left, a navigation menu includes 'Dashboard', 'Resources', and 'Catalog'. A red circle with the number '1' highlights the 'Catalog' link. Below the menu is a 'Filter Catalog' section with a dropdown menu for 'Categories'. A red circle with the number '2' highlights the 'Interactive Care Reviewer - Online Authorizations' option. Below the categories is a 'Released Before' field with a date picker and an 'Apply' button, with a red circle and the number '3' highlighting the 'Apply' button. The main content area shows a 'Welcome to Your Custom Learning Center' banner with a list of available courses. Below the banner, three course cards are visible. The first card is for 'ICR - Behavioral Health ABA Services - Online Course' with a red circle and the number '4' highlighting the 'Enroll' button. The second card is for 'ICR - Behavioral Health Outpatient Requests - Online Course' with an 'Enrolled' status. The third card is for 'ICR - Dashboard - Online Course' with a red circle and the number '4' highlighting the 'Enroll' button.

Claim dispute process

Claim payment disputes

- If a provider disagrees with the outcome of a claim, they may begin the Anthem Provider Payment Dispute Process.
- Please be aware that there are three common, claim-related issues that are not considered claim payment disputes:
 - Claim inquiry
 - Claim correspondence
 - Medical necessity appeals

Claims inquiry

- A question about a claim or claim payment is called an inquiry. Inquiries do not result in changes to claim payments, but the outcome of the claim inquiry may result in the optional initiation of the claim payment dispute.

Claims correspondence

- Claim correspondence is different from a payment dispute.
 - Correspondence is when Anthem requires more information to finalize a claim. Typically, Anthem makes the request for this information through the *EOP*.
 - Submissions should be mailed to:
Anthem Blue Cross and Blue Shield
Corrected Claims and Correspondence
P.O. Box 61599
Virginia Beach, VA 23466-1599

Claims correspondence (cont.)

Type of issue	What should I do?
Rejected claim(s)	Use the EDI Hotline at 1-800-590-5745 when your claim was submitted electronically but was never paid or was rejected.
<i>EOP</i> requests for supporting documentation	Submit a <i>Claim Follow-Up Form</i> , a copy of your <i>EOP</i> and the supporting documentation.
<i>EOP</i> requests for medical records	Submit a <i>Claim Follow-Up Form</i> , a copy of your <i>EOP</i> and the medical records.
Need to submit a corrected claim due to errors or changes on original submission	Submit a <i>Claim Follow-Up Form</i> and your corrected claim. Clearly identify the claim as corrected. We cannot accept claims with handwritten alterations to billing information. We will return claims that have been altered with an explanation of the reason for the return. Provided the claim was originally received timely, a corrected claim must be received within 60 days of the date of service. In cases where there was an adjustment to a primary insurance payment and it is necessary to submit a corrected claim to Anthem to adjust the other health insurance (OHI) payment information, the timely filing period starts with the date of the most recent OHI <i>EOB</i> .
Submission of coordination of benefits (COB)/third-party liability (TPL) information	Submit a <i>Claim Follow-Up Form</i> , a copy of your <i>EOP</i> and the COB/TPL information.
Emergency room payment review	Submit a <i>Claim Follow-Up Form</i> , a copy of your <i>EOP</i> and the medical records.

Claim payment disputes (cont.)

The dispute process consists of two steps.

- 1. Claim payment reconsideration:** This is the first step in the dispute process. The reconsideration represents your initial request for an investigation into the outcome of the claims.
- 2. Claim payment appeal:** This is the second step in the process. If you disagree with the outcome of the reconsideration, you may request an additional review as a claim payment appeal.

Claim payment disputes (cont.)

- A claim payment dispute may be submitted for multiple reason(s), including:
 - Contractual payment issues.
 - Disagreements over reduced or zero-paid claims.
 - Post-service authorization issues.
 - Other health insurance denial issues.
 - Claim code editing issues.
 - Duplicate claim issues.
 - Retro-eligibility issues.
 - Experimental/investigational procedure issues.
 - Claim data issues.
 - Timely filing issues.²

² We will consider reimbursement of a claim that has been denied due to failure to meet timely filing if you can provide documentation the claim was submitted within the timely filing requirements (See Timely Filing Exceptions in Chapter 10 of the *Provider Manual: Claims Submissions*.)

https://mediprovider.anthem.com/dam/medidocuments/ININ_CAID_ProviderManual.pdf?v=202101150221

Claim payment disputes (cont.)

Good cause

- Good cause may be established by the following:
 - If the claim includes an explanation for the delay (or other evidence which establishes the reason), Anthem will determine good cause based primarily on that statement or evidence.
 - If the evidence leads to doubt about the validity of the statement, Anthem will contact the provider for clarification or additional information necessary to make a *good cause* determination.
- Good cause may be found when a provider claim filing delay was due to:
 - Administrative error.
 - Retroactive enrollment.
 - Incorrect information furnished by the member.
 - Unavoidable delay in securing required documentation or evidence third parties.
 - Unusual, unavoidable or other circumstances beyond the service provider's control.
 - Destruction or other damage of the provider's records.

For more information about good cause, go to

https://mediprovider.anthem.com/dam/publicdocuments/ININ_CAID_RP_RequiredDocumentationProofTimelyFiling.PDF?v=202101142242.

Claim payment reconsideration

- Reconsideration requests can be submitted verbally, in writing or through Availity.
 - They must be received within 60 days from the date on the provider *EOP*.
 - When submitting, provide as much information as you can to help us understand why you think the claim was not paid as you would expect.
 - Anthem will make every effort to resolve the claims payment reconsideration within 30 calendar days of receipt. If additional information is required to make a determination, the determination date may be extended. We will mail you a written extension letter before the expiration of the initial 30 calendar days.

Claim payment reconsideration (cont.)

- We will send you our decision in a determination letter, which will include:
 - A statement of the provider's reconsideration request.
 - A statement of what action Anthem intends to take or has taken.
 - The reason for the action.
 - Support for the action, including applicable statutes, regulations, policies, claims, codes or provider manual references.
 - An explanation of the provider's right to request a claim payment appeal within 60 calendar days of the date of the reconsideration determination letter.
 - An address to submit the claim payment appeal.
- If the decision results in a claim adjustment, the payment, if appropriate, and *EOP* will be sent separately.

Claim payment appeal

- Claim payment appeals can be submitted in writing or through Availity.
 - They must be received within 60 days from the date on the reconsideration decision letter.
 - When submitting, provide as much information as you can to help us understand why you think the claim was not paid as you would expect.
 - Anthem will make every effort to resolve the claims payment appeal within 30 calendar days of receipt.
 - We will send you our decision in a determination letter, which will include:
 - A statement of the provider's reconsideration request.
 - A statement of what action Anthem intends to take or has taken.
 - The reason for the action.
 - If the decision results in a claim adjustment, the payment, if appropriate, and *EOP* will be sent separately.

How to submit claim payment disputes

- Verbally (reconsideration only) through Provider Services:
 - Hoosier Healthwise: **1-866-408-6132**
 - Hoosier Care Connect: **1-844-284-1798**
 - Healthy Indiana Plan: **1-844-533-1995**
- Online (preferred)
 - Use the secure Provider Availity Payment Appeal Tool at <https://www.availity.com>.
 - You can upload supporting documentation and receive immediate acknowledgement of submission.
- Written
 - Mail all required documentation, including the *Provider Dispute Resolution Form* to:
Anthem Blue Cross and Blue Shield
Provider Disputes and Appeals
P.O. Box 61599
Virginia Beach, VA 23466-1599

HIP contacts

- HIP Provider Services: **1-844-533-1995**
- Member Services: **1-866-408-6131 (TTY 711)**
- 24/7 NurseLine: **1-866-408-6131 (TTY 711)**
- Medical and pharmacy precertification: **1-844-533-1995**
- Superior Vision: **1-877-235-5317**
- DentaQuest: **1-888-291-3762**
- Transportation: **1-844-772-6632**
- Submit claims to:
Anthem Blue Cross and Blue Shield
Mailstop: IN999
P.O. Box 61010
Virginia Beach, VA 23466

Physical Health Provider Experience Managers

Serving Hoosier Healthwise, Hoosier Care Connect and HIP

Zone 1/Beacon Health Systems

Jessi Earls, Provider Experience Manager
 Jessica.Wilkerson-Earls@anthem.com • 1-317-452-2568

Zone 2/Ascension St. Vincent

Angelique Jones, Provider Experience Manager
 Angelique.Jones@anthem.com • 1-317-619-9241

Zone 3

Jamaal Wade, Provider Experience Manager
 Jamaal.WadeSr@anthem.com • 1-317-409-7209

Zone 4/Deaconess

Jonathan Hedrick, Provider Experience Manager
 Jonathan.Hedrick@anthem.com • 1-317-601-9474

Zone 5/Parkview

David Tudor, Provider Experience Manager
 David.Tudor@anthem.com • 1-317-447-7008

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

Matt Swingendorf, Provider Experience Manager, Sr.
 Matthew.Swingendorf@anthem.com • 1-317-306-0077
 Home Health and Hospice Providers
 INHHH@anthem.com

Zone 7/Baptist Health

Sophia Brown, Provider Experience Manager
 Sophia.Brown@anthem.com • 1-317-775-9528

Zone 8/Eskenazi

Marvin Davis, Provider Experience Manager
 Marvin.Davis@anthem.com • 1-317-501-7251

Zone 9/Out-of-State Providers, Franciscan, Comm Health Network

Nicole Bouye, Provider Experience Manager, Sr.
 Nicole.Bouye@anthem.com • 1-317-517-8862

Management:
 Jacque Marsalis, Director, Provider Experience
 Jacqueline.Marsalis@anthem.com

Indiana Provider Network Solutions:
 1-800-455-6805



Behavioral Health Provider Experience Managers

Serving Hoosier Healthwise, Hoosier Care Connect and HIP

Each county includes a Subject Matter Expert for the following:

- Federally qualified health center/rural health center (FQHC/RHC)
- Substances use disorder/opioid treatment program (SUD/OTP)
- Community mental health center (CMHC)
- Acute care hospitals

Region 1

Ashley Holmes, Provider Experience Manager
ashley.holmes@anthem.com • 1-317-315-0623

Region 2

Reginald Lumpkin, Provider Experience Manager
Reginald.Lumpkin@anthem.com • 1-317-618-2170

Region 3

Whit'ney McTush, Provider Experience Manager
Whitney.McTush@anthem.com • 1-317-519-1089

Region 4

Tish Jones, Provider Experience Manager
Latisha.Willoughby@anthem.com • 1-317-617-9481

Region 5

Alisa Phillips, Provider Experience Manager, S
Alisa.Phillips@Anthem.com • 1-317-517-1001

Region 6

Michele Weaver, Provider Experience Manager
Michele.Weaver@anthem.com • 1-317-601-3101

Region 7

Matthew McGarry, Provider Experience Manager
Matthew.McGarry@anthem.com • 1-463-202-1001





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. DentaQuest is an independent company providing dental benefit management services on behalf of Anthem Blue Cross and Blue Shield. Superior Vision is an independent company providing routine and medical optometry services on behalf of Anthem Blue Cross and Blue Shield. AIM Specialty Health is an independent company providing some utilization review services on behalf of Anthem Blue Cross and Blue Shield. IngenioRx, Inc. is an independent company providing some utilization review services on behalf of Anthem Blue Cross and Blue Shield. CoverMyMeds is an independent company providing electronic prior authorization services on behalf of Anthem Blue Cross and Blue Shield.

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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-3098-21 May 2021