Serving Hoosier Healthwise, Healthy Indiana Plan
and Hoosier Care Connect

2020 claim requirements 101

Anthem Blue Cross and Blue Shield
(Anthem)

Agenda

- Reminders and updates
- Eligibility
- Managed care model
- Prior authorization (PA)
- Claims
- Contact information

Reminders and updates

Reminders and updates

- The provider manual is designed for network physicians, hospitals and ancillary providers.
- Our goal is to create a useful reference guide for you and your office staff. We want to help you navigate our managed health care plan to find the most reliable, responsible, timely and cost-effective ways to deliver quality health care to our members.
- Providers can learn how to verify member eligibility, submit a timely claim form, request authorization for services and much more.

Provider file updates and changes

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 **https://www.in.gov** > Family & Health > Medicaid or by calling IHCP Provider Services at **1-800-457-4584**. 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*). You may access the form by visiting **https://www.anthem.com** > Providers > Provider Resources > Provider Maintenance.
3. When Anthem receives the online *PMF*, we will verify the information submitted on both the online *PMF* and IHCP CoreMMIS prior to uploading our files.

Provider file updates and changes (cont.)

Our Provider Engagement and Contracting (PE&C) 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*.

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 medical providers (PMP) (use comments field).

Contact your PE&C representative if you have questions about provider network agreements and provider file information. You can contact us by visiting > **https://www.anthem.com** > Providers > Indiana > Communications > Contact Us.

Eligibility

Eligibility

Always verify a member's eligibility prior to rendering services. Providers can access this information by visiting either:

- *Core*MMIS: **https://portal.indianamedicaid.com/hcp/provider/Home/tabid/135/Default.aspx**
- Availity Portal: **https://www.availity.com** (PMP verification and benefit limitations only)

Eligibility (cont.)

You will need:

- A Hoosier Healthwise or a Hoosier Care Connect ID card.
  - Anthem assigns the YRH prefix along with the member's RID number.
  - When filing claims and inquiries, **always** include the YRH prefix before the member's recipient identification (RID) number.
- A HIP ID card.
  - Anthem assigns the YRK prefix along with the member's RID number.
  - When filing claims and inquiries, **always** include the YRK prefix before the member's recipient identification (RID) number.

Right Choices Program

- Members enrolled in the Right Choices Program (RCP) must see the providers who are assigned per *Core*MMIS.*
- The member's PMP may call customer service to add new providers to the member's list of authorized providers.
- Refer to the provider manual, page 63, available at **https://www.mediproviders.anthem.com/in** > Provider Support > Education & Resources > Manuals, Training & More > Indiana Medicaid Provider Manual.
- Effective April 29, 2020 RCP Members are no longer required to be locked into a single hospital for non-emergent visits.

Managed care model (assigned PMP)

Managed care model (assigned PMP)

All members must see the PMP they are assigned to in our system. Please view the Availity PMP assignment. Other individual practitioners must have a referral from the PMP.

- Include the individual (type one) NPI of the member's assigned referring PMP when you submit the *CMS-1500* claim form or 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 noncontracted provider, you need to obtain PA from Anthem before you provide services to our members enrolled in Hoosier Healthwise, HIP and Hoosier Care Connect.

Managed care model (assigned PMP) (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 PMP, even if that service does not require PA**.

Exceptions to this policy include:

- A PMP 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.
- Services provided after hours (codes 99050 and 99051).
- Diagnostic specialties (such as lab and X-ray services).

Managed care model (assigned PMP) (cont.)

Exceptions to this policy include (cont.):

- The billing or referring physician being an Indian Health Provider; or providing services at a federally qualified health center, or an urgent care center.
- Self-referrals. Members may self-refer for certain services provided by an IHCP-qualified provider.
    - **Note:** Refer to the provider manual for a listing of self-referral services.

Prior authorization

Prior authorization

Participating providers:

- 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).

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) ~~or YRHIN (Medicaid)~~
- Diagnosis with ICD-10 code
- Procedure with CPT code
- Date(s) of service
- PMP, specialist or facility performing services
- Clinical information to support the request
- Treatment and discharge plans (if known)

Prior authorization lookup tool

Visit the provider website to utilize the prior authorization lookup tool at **https://mediproviders.com** > Prior Authorization & Claims > Prior Authorization Lookup Tool.

Providers can quickly determine PA requirements and then utilize our Interactive Care Reviewer (ICR) to request PA. If you have any questions about the prior authorization lookup tool, Availity, or ICR, contact your network representative.

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	**1-844-533-1995**
Hoosier Care Connect	**1-844-284-1798**
Hoosier Healthwise	**1-866-408-6132**

How to obtain prior authorization (cont.)

Fax clinical information for all members to:

	Inpatient	Outpatient
Physical health	**1-888-209-7838**	**1-866-406-2803**
Behavioral health	**1-877-434-7578**	**1-866-877-5229**

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
- BH

Timeliness of UM 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

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 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.

Outpatient services

When authorization of outpatient health care services is required, providers may 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.

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 30 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 are not subject to review by the UM department.

- For questions regarding PA requirements, providers may contact Provider Services Monday through Friday, 8 a.m. to 8 p.m. Eastern time at:

	HIP	**Hoosier Care Connect**	**Hoosier Healthwise**
Phone	**1-844-533-1995**	**1-844-284-1798**	**1-866-408-6132**
Fax	**1-866-406-2803**	**1-866-406-2803**	**1-866-406-2803**

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) 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

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.

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

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.**

National provider identifier denials

- Rendering (type one) providers — health care providers who are **individuals** (including physicians, dentists, specialists, chiropractors and sole proprietors)
  - An individual is eligible for only one NPI.
- Billing (type two) providers — health care providers that 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 bulletins at **www.anthem.com/inmedicaiddoc**.

National provider identifier denials (cont.)

Most common NPI denials:

- Rendering NPI (type one) is not indicated in Box 24J.
- Incorrect rendering NPI is indicated in Box 24J.
- Group billing NPI (type two) is not indicated in Box 33a.
- Incorrect group billing NPI is indicated in Box 33a.
- Rendering NPI and/or group billing NPI are unattested with the state of Indiana.
- Anthem does not receive the NPI provider file updates.
- Anthem’s provider file does not match Indiana’s provider file information.

National provider identifier denials (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 **www.indianamedicaid.in.gov**.

National provider identifier denials (cont.)

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**

For questions regarding electronic formats, please contact our EDI department at **1-800-470-9630** or at **https://www.anthem.com/edi**.

Pricing/benefit code denials

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

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	**1-844-533-1995**
Hoosier Care Connect	**1-844-284-1798**
Hoosier Healthwise	**1-866-408-6132**

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.

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** > Provider Support > Forms.

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

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Claims resolution process (cont.)

Claims dispute and appeal process

- There is a 60-calendar day time limit from the date on the 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 30 calendar days from the date of the claims reconsideration. This can now be done via the Availity Portal.

Important contact information

Important contact information

Provider Services

- Hoosier Healthwise: **1-866-408-6132**
- HIP: **1-844-533-1995**
- Hoosier Care Connect: **1-844-284-1798**

Member Services and 24/7 NurseLine

- Hoosier Healthwise and HIP: **1-866-408-6131**
- Hoosier Care Connect: **1-844-284-1797**

Important contact information (cont.)

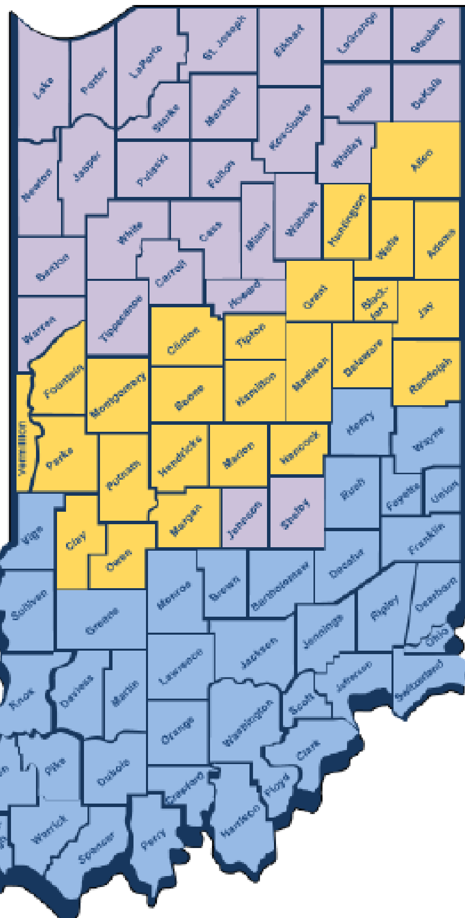
PA requests

- HIP: **1-844-533-1995**
- Hoosier Care Connect**: 1-844-284-1798**
- Hoosier Healthwise: **1-866-408-6132**
- Fax: **1-866-406-2803**

Network representative territory map: www.anthem.com/inmedicaiddoc

Contact information

Behavioral Health



Michele Weaver
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1-317-601-3031

Alisa Phillips
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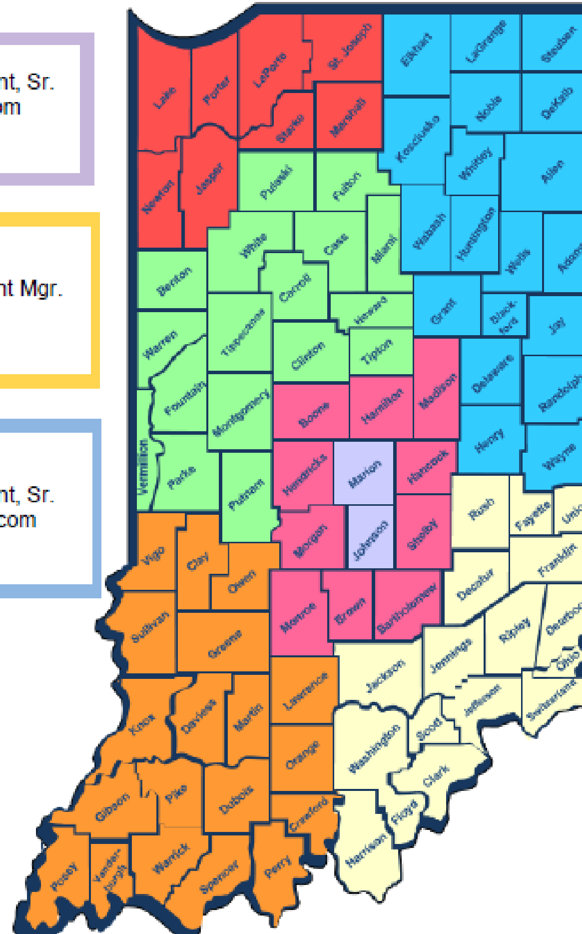
1-317-517-1008

Matthew McGarry
Network Relations Consultant, Sr.
matthew.mcgarry@anthem.com
1-463-202-3579

Physical Health



Northwest Region
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1-317-452-2568

West Central/St. Vincent
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1-317-619-9241

Southwest Region/Deaconess
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1-317-601-9474

Central Region/IU Health
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1-317-306-0077

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Northeast Region/Parkview
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1-317-447-7008

Southeast Region
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1-317-775-9528

Out-of-State Providers, Franciscan
Nicole Bouye
Network Relations Consultant, Sr.
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1-317-517-8862

Indiana Provider Network Solutions
1-800-455-6805

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 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.

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