



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



CMS-1500 professional providers

2017 annual workshop

Reminders and updates

The *Anthem Blue Cross and Blue Shield (Anthem) Provider Manual* was updated in **July 2017**.

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 **www.indianamedicaid.com** or by calling IHCP Provider Services at **1-877-707-5750**. 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 Anthem's online *Provider Maintenance Form (PMF)*.

Provider file updates and changes (cont.)

3. When Anthem receives the online *PMF*, we will verify the information submitted on both the online *PMF* and IHCP web interchange prior to uploading our files.

Note: Anthem does not receive the information from IHCP to update our provider file system.

Provider file updates and changes (cont.)

Anthem's Provider Engagement and Contracting (PE&C) department handles all provider file updates. This includes the following provider networks:

- Anthem Hoosier Healthwise
- Anthem Healthy Indiana Plan (HIP)
- Anthem Hoosier Care Connect
- Anthem commercial

All provider file updates use our *Provider Maintenance Form (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 provider (PMP) (use comments field)

Contact your Anthem PE&C representative if you have questions about provider network agreements and provider file information.

Claims and billing



Anthem Blue Cross and Blue Shield
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and Hoosier Care Connect

Eligibility

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

- *CoreMMIS*:
<https://portal.indianamedicaid.com/hcp/provider/Home/tabid/135/Default.aspx>
- Availity Portal: **<https://www.availity.com>** (PMP verification only)

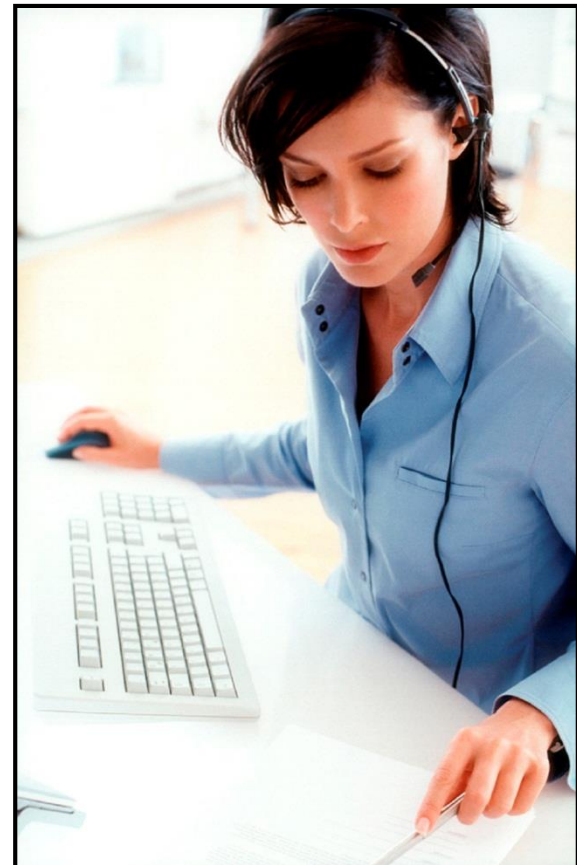
Eligibility (cont.)

You will need:

- A Hoosier Healthwise and Hoosier Care Connect ID card.
 - When filing claims and inquiries, **ALWAYS** include the YRH prefix before the member's RID number.
- A HIP ID card.
 - Anthem assigns the YRK prefix along with the member's RID number.
 - YRK must be used when submitting claims and inquiries.

Eligibility for Right Choices

- Right Choices members must see the providers (physicians, hospitals, etc.) that are assigned per *CoreMMIS*.
- The member's PMP may call customer service to add new providers to the member's list of authorized providers.



Managed care model (assigned PMP)

All members must see the PMP they are assigned to in our system. Please view Availity PMP assignment.

Other individual practitioners must have a referral from the PMP.

- Include the individual (type 1) 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, Healthy Indiana Plan 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 has same tax ID or NPI as the referring physician (and is an approved provider type).
- Emergency services (that is, 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 either: a federally qualified health center, an Indiana health provider 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

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 PA list regularly for updates.

Nonparticipating providers:

- All services require PA (except emergencies).

Prior authorization (cont.)

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

- Member name and ID.
- Prefix — YRK, YRH or YRHIN.
- Diagnosis with ICD-10 code.
- Procedure with CPT code.
- Date(s) of service.
- Primary physician, specialist or facility performing services.
- Clinical information to support the request.
- Treatment and discharge plans (if known).

Prior Authorization Look-Up Tool

Visit the provider website to utilize our Prior Authorization Look-Up Tool (PLUTO):

- Visit **www.anthem.com/inmedicaiddoc**.
- Locate the Prior Authorization drop-down menu.
- Select *Prior Authorization Look-Up Tool*.

Providers can quickly determine prior authorization requirements and then utilize our Interactive Care Reviewer (ICR) to request prior authorizations.

If you have any questions about Availity, the Prior Authorization Look-Up Tool or ICR, please contact your network representative.

How to obtain prior authorization

Providers may call Anthem to request prior authorization for **medical and behavioral** health services using the following phone numbers:

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

Fax clinical information for all Anthem 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 ICR, a website providers can use to request prior authorization for Hoosier Healthwise, Healthy Indiana Plan (HIP) and Hoosier Care Connect services. **ICR is accessible via Availity at no cost to providers.** ICR will accept the following types of requests for Indiana Medicaid members:

- Inpatient
- Outpatient
- Medical/surgical
- Behavioral health

Timeliness of UM decisions

- Routine nonurgent requests: within seven days of the request
- Urgent preservice requests: within 72 hours of the request
- Urgent concurrent requests: within one business day of the request
- Routine appeals: within 30 days of the request
- Urgent appeals: within 72 hours of the request

Emergency medical services and admission

For emergency medical conditions and services, Anthem does not require precertification 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 legal 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 to observation for up to 72 hours do not require prior authorization.

Outpatient services

When authorization of outpatient health care services is required, providers may utilize ICR, call or fax to request prior authorization.

- 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 following:

- The decision
- The process for appeal
- How to reach the reviewing physician for peer-to-peer discussion of the case if desired

Medical necessity denials (cont.)

The provider may request a peer-to-peer discussion within seven days of notification of an adverse determination.

- Upon request for peer-to-peer 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 peer-to-peer 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 33 days from the date of the denial.

Late notifications or failure to obtain prior authorization

Late notifications of admission or failure to obtain authorization for services when prior authorization is required are not subject to review by the Utilization Management department.

For questions regarding prior authorization requirements, providers may contact Provider Services Monday through Friday, 8 a.m. to 8 p.m. at:

Hoosier Healthwise

Phone: 1-866-408-6132

Fax: 1-866-406-2803

Healthy Indiana Plan (HIP)

Phone: 1-844-533-1995

Fax: 1-866-406-2803

Hoosier Care Connect

Phone: 1-844-284-1798

Fax: 1-866-406-2803

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

Members in the St. Francis network

Please ensure claims for members assigned to St. Francis physicians are billed to St. Francis. This excludes claims for family planning and mental health services, which should be billed to Anthem directly.

Submit claims for St. Francis to:
St. Francis Health Network
P.O. Box 502090
Indianapolis, IN 46250

Coordination of benefits

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

- Example 1: 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 2: 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 before resubmitting a claim
- Before you resubmit, check the claim status. If there is no record of the claim, resubmit.
- If the claim isn't showing in our processing system, ask the Provider Services representative to verify if the claim is imaged in Filenet/WCF or Maccess. Do not resubmit if the claim is on file in the processing or image system.

National provider identifier denials

- Rendering (type 1) 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 2) providers: Health care providers that are organizations, including physician groups, hospitals, residential treatment centers, laboratories and group practices and the corporation formed when an individual incorporates as a legal entity

National provider identifier denials (cont.)

Most common NPI denials:

- Rendering NPI (type 1) is not indicated in Box 24J.
- Incorrect rendering NPI is indicated in Box 24J.
- Group billing NPI (type 2) 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 and rendering taxonomy code
- 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.com**.

National provider identifier denials (cont.)

The following must be included on all electronic claims; you are also encouraged to submit this information on paper claims:

- Tax ID
- Billing NPI name and 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 Anthem Electronic Data Interchange (EDI) department at **1-800-470-9630** or **<https://www.anthem.com/edi>**.

Claims resolution process

Follow-up guidelines

- Check the claim status if you have not received payment or denial within 30 business days of submission.
- First, verify the claim wasn't returned by our mail room or rejected by your billing agent or the Anthem EDI clearinghouse. Use this process to also follow up on claim adjustments resulting from provider helpline intervention, claims dispute or appeal. Allow 60 calendar days for adjustments to be processed.

Claims resolution process (cont.)

Follow-up guidelines (cont.)

- Use Availity to check claim status online. You can also call the appropriate helpline:
 - Hoosier Healthwise Provider Helpline: **1-866-408-6132**
 - HIP Provider Helpline: **1-844-533-1995**
 - Hoosier Care Connect Provider Helpline: **-844-284-1798**

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).
- Submit the corrected claim as a paper claim through the mail, even if the original claim was sent electronically.
- Clearly mark the paper claim at the top with the words “corrected claim,” and attach a *Claim Follow-Up Form*.

Claims resolution process (cont.)

Send paper, corrected 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
under **Provider Support > Forms.**

Anthem Blue Cross and Blue Shield
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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: _____

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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.)

Claims dispute and appeal process (cont.)

The claims dispute process is as follows:

1. Claims dispute – Must be received in writing within 60 calendar days from the date on the RA. Verbal requests must also be filed in writing within the 60-calendar day time frame. Submit a claims dispute if you disagree with full or partial claim rejection or denial, or the payment amount.
2. Administrative claims appeal – If you are not satisfied with the claims dispute resolution, you may submit an administrative claims appeal. We must receive this appeal within 33 calendar days from the date of the claims dispute resolution.

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

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

24/7 NurseLine

- Hoosier Healthwise: **1-866-408-613**
- HIP: **1-844-533-1995**
- Hoosier Care Connect: **1-844-284-1798**



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Important contact information (cont.)

PA requests

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

Network representative territory map

- www.anthem.com/inmedicaiddoc

Questions?

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



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Legal

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