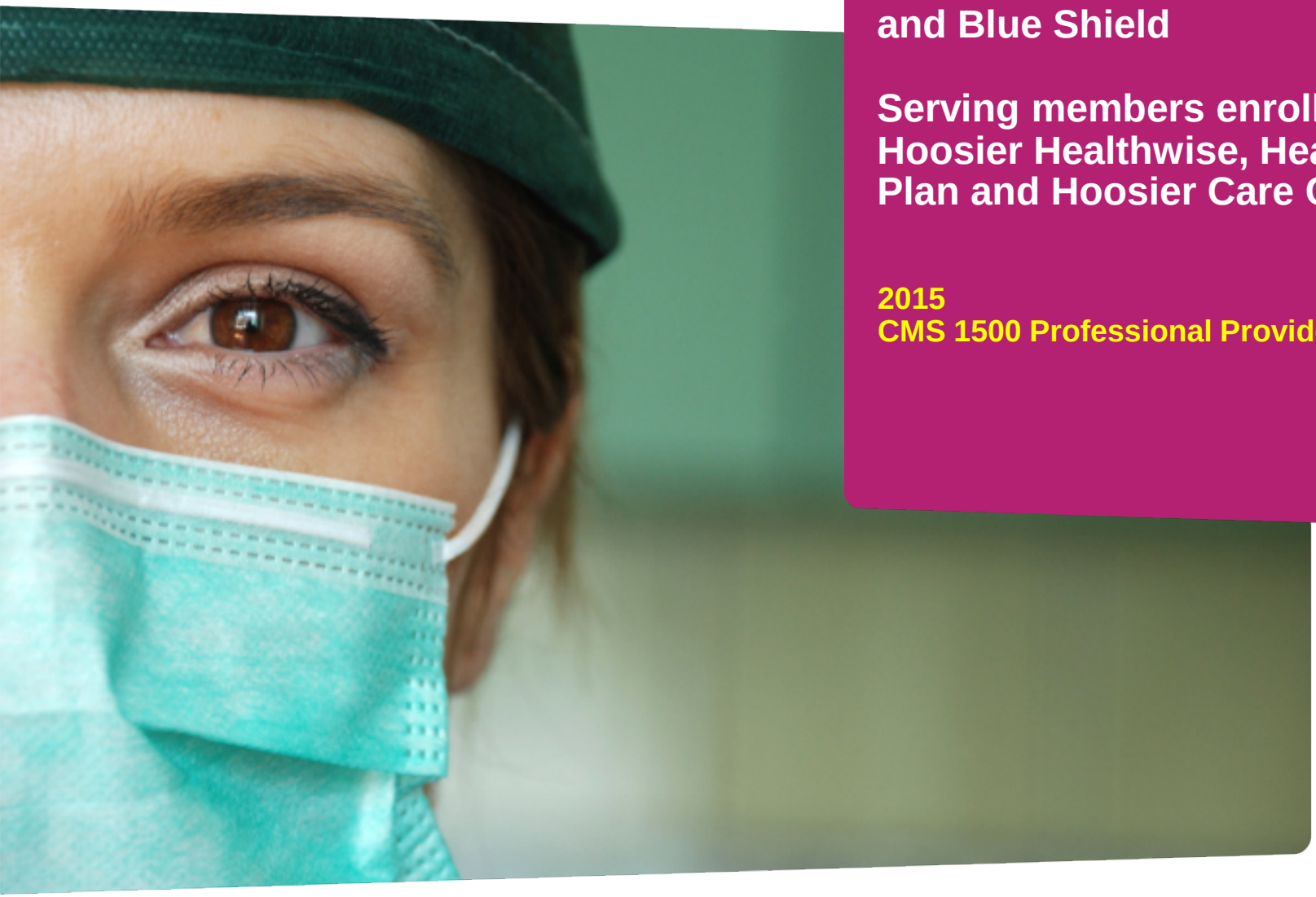
Anthem BlueCross BlueShield



Anthem Blue Cross and Blue Shield

Serving members enrolled in Hoosier Healthwise, Healthy Indiana Plan and Hoosier Care Connect

2015
CMS 1500 Professional Providers

Reminders and updates

The Anthem Blue Cross and Blue Shield (Anthem) provider manual was updated in **April 2015**.

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.

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Reminders and updates (cont.)

The U.S. Department of Health and Human Services has issued a rule finalizing **October 1, 2015**, as the new compliance date for health care providers, health plans and health care clearinghouses to transition to ICD-10.

This deadline allows providers, insurance companies and others in the health care industry time to ramp up operations to ensure systems and business processes are ready to go on **October 1, 2015**.

The final rule also requires the continued use of ICD-9 through **September 30, 2015**.

Provider file updates/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 the health plan at **1-877-707-5750**.
   Note: For more information, please refer to the IHCP Provider Manual, Chapter 4.
2. After information is uploaded by IHCP, the provider will submit the provider information to Anthem using Anthem's online Provider Maintenance Form (PMF).
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.

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Provider file updates/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 PMF.

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Provider file updates/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 address, phone, fax
- Change-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

Eligibility

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

- **https://interchange.indianamedicaid.com** or
- Availity (PMP verification only)

You will need:

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

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Eligibility for Right Choices

Reminder:

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

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Initial claim submission

Claim filing limits:

- 90 calendar days from the date of service for Anthem contracted providers
- Submit the initial claim electronically (www.indianamedicaid.com) or by mail to:

Anthem Blue Cross and Blue Shield

Claims department

P.O. Box 6144

Indianapolis, IN 46206-6144

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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

Prior authorization (cont.)

How to obtain PA

Hoosier Healthwise and Hoosier Care Connect:

- Call our Utilization Management (UM) department at **1-866-408-7187**
- Or, fax the Universal PA form to **1-866-406-2803**

HIP:

- Call our UM department at **1-866-398-1922**
- Or, fax the Universal PA form to **1-866-406-2803**

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Prior authorization (cont.)

When calling/faxing our UM department, have available:

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

Prior authorization denials

Medical policies and clinical guidelines

Anthem develops and maintains medical policies and clinical guidelines to serve as a basis for medical necessity decisions. Medical policies and clinical guidelines are posted on the internet to inform members and their physicians why certain medical/surgical services, behavioral health services, pharmaceutical and medical equipment/devices may or may not be considered medically necessary under their health plan benefit.

Providers may view medical policies and clinical guidelines at **www.anthem.com/inmedicaiddoc**.

Prior authorization denials (cont.)

Time frames:

- Nonurgent reviews are completed within seven calendar days from date of request.
- Urgent reviews are completed within 72 hours from the date of the request.
- Emergency services do not require PA.

Duplicate claim denials

Allow for processing time:

- 21 days for electronic clean claims
- 30 days for paper clean claims before resubmitting a claim
- Check claim status before resubmitting
  - If no record of claim, resubmit

    Note: Be sure to ask the Provider Services representative to verify if the claim is imaged in Filenet/WCF if the claim is not showing in our processing system.
- Do not resubmit if the claim is on file in the processing or image system

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National provider identification denials

Rendering and billing provider:

- 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 number.
- 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 identification 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
- NPI provider file updates are not received by Anthem
- Anthem's provider file does not match Indiana's provider file information

National provider identification denials (cont.)

Claims and billing requirements for CMS-1500:

- Box 24J – rendering provider NPI
- Box 32A – service facility NPI
- Box 33A – billing provider NPI

Note: Remember to attest all of your NPI numbers with the state of Indiana at **www.indianamedicaid.com**.

National provider identification denials (cont.)

The following must be used on all electronic claims. You are encouraged to submit this information on paper claims as well:

- Tax ID
- Billing NPI name and address
- Rendering NPI name and address
- Taxonomy code (provider specialty type)
- Provider taxonomy codes 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**.

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Coordination of benefit denials

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 as this will assist in HEDIS® data review and possibly decrease the number of charts needed.

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

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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 and HIP.
- 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.

Managed care model (assigned PMP) (cont.)

Exceptions to this policy include:

- No PMP has been assigned to the member
- Provider is in the same provider group, or has 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 were provided after hours (codes 99050 and 99051)
- Diagnostic specialties such as lab and X-ray services
- If the billing or referring physician is any of the following: a federally qualified health center, an Indiana health provider or an urgent care center
- Self-referrals: members may self-refer for certain services that are provided by an IHCP-qualified provider (please refer to the IHCP manual for a listing of self-referral services)

Members in the St. Francis network

Please ensure claims for members assigned to St. Francis physicians are billed to St. Francis except for 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

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Claims resolution process

Check follow-up guidelines:

Check status on a claim if you have not received payment or denial within 30 business days of submission.

First, verify the claim wasn't rejected by your billing agent, the Anthem EDI clearinghouse or returned by our mail room. 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.

- 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: **1-800-345-4344**
  - Hoosier Care Connect Provider Helpline: **1-844-284-1798**

Network providers must file claims within 90 calendar days. It is the provider's responsibility to follow-up timely to ensure claims are received and accepted.

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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 words, “corrected claim,” and attach a claim follow-up form.

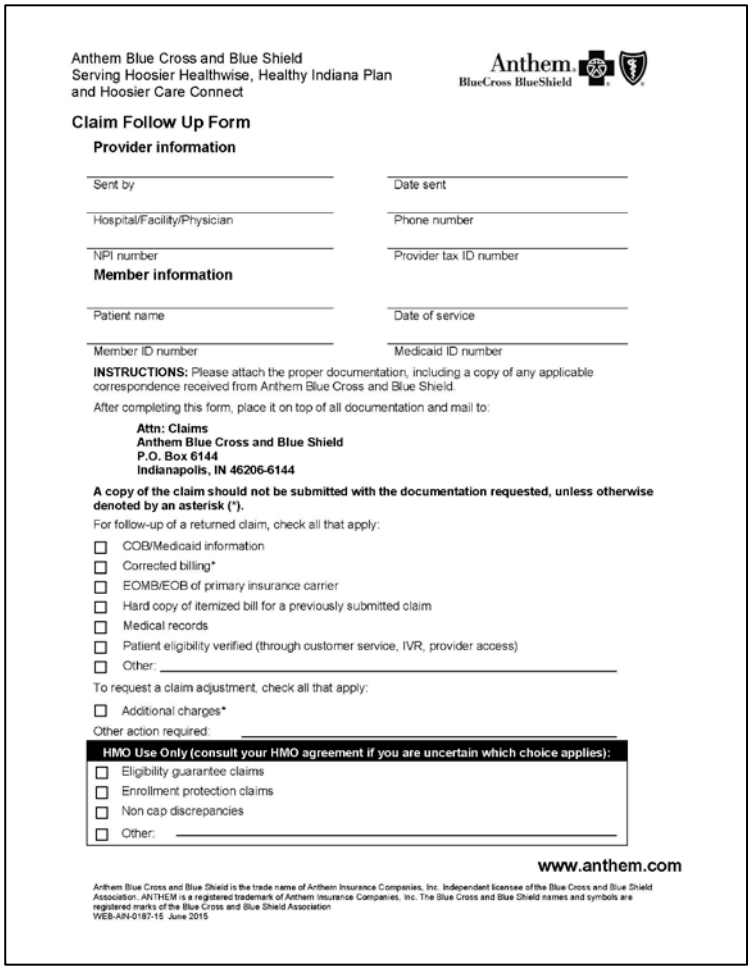
Claims resolution process (cont.)

Corrected claims submission guidelines cont.

- Send paper corrected claims to:

  Anthem Blue Cross and Blue Shield
  Medicaid Corrected Claims
  P.O. Box 6144
  Indianapolis, IN 46206-6144

- The form is available at: **www.anthem.com/inmedicaiddoc** under Provider Support > Forms



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Serving Hoosier Healthwise, Healthy Indiana Plan
and Hoosier Care Connect

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Claim Follow Up Form

Provider information

Sent by | Date sent

Hospital/Facility/Physician | Phone number

NPI number | Provider tax ID number

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:

Attn: Claims
Anthem Blue Cross and Blue Shield
P.O. Box 6144
Indianapolis, IN 46206-6144

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

For follow-up of a returned claim, check all that apply:

- ☐ COB/Medicaid information
- ☐ Corrected billing*
- ☐ EOMB/EOB of primary insurance carrier
- ☐ Hard copy of itemized bill for a previously submitted claim
- ☐ Medical records
- ☐ Patient eligibility verified (through customer service, IVR, provider access)
- ☐ Other: _____

To request a claim adjustment, check all that apply:

- ☐ Additional charges*

Other action required: _____

HMO Use Only (consult your HMO agreement if you are uncertain which choice applies):

- ☐ Eligibility guarantee claims
- ☐ Enrollment protection claims
- ☐ Non cap discrepancies
- ☐ Other: _____

www.anthem.com

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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.

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: **1-800-345-4344**
- 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

- **1-866-800-8780**

PA requests

- Hoosier Healthwise and Hoosier Care Connect: **1-866-408-7187**
- HIP: **1-866-398-1922**
- Fax: **1-866-406-2803**

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Questions?

Thank you for your participation

in serving our members enrolled in Hoosier Healthwise, Healthy Indiana Plan and Hoosier Care Connect!