Anthem Blue Cross and Blue Shield

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

2015
CMS 1450 (UB-04) Institutional Providers

Reminders and updates

The Anthem Blue Cross and Blue Shield 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 their operations to ensure their 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 two-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. Once information is uploaded by IHCP, the provider will submit the provider-updated provider information to Anthem's Provider Engagement and Contracting (PE&C) department.
   Note: Anthem does not receive the information from IHCP to update our provider file system.

Provider file updates/changes (cont.)

Anthem's PE&C department handles all provider file updates. This includes the following networks:

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

Submit all provider file updates using our Provider Maintenance Form (PMF).

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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 (primary medical provider 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 (issued by Anthem)
  - 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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Time filing limit denials

Claim filing limits:

- 90 calendar days from the date of service for Anthem-contracted providers
- Submit the initial claim electronically or by mail to:

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

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Duplicate claim denials

Allow for processing time:

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

Prior authorization denials

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 any updates on services that require PA.

Nonparticipating providers:

- All services require PA.

Prior authorization denials (cont.)

How to obtain PA

For Hoosier Healthwise and Hoosier Care Connect:

- Call UM department at **1-866-408-7187**
- Or fax the Universal PA form to **1-866-406-2803**

For HIP:

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

Prior authorization denials (cont.)

What to have ready when calling/faxing UM:

- 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 (cont.)

Medical policies and clinical guidelines

- Anthem develops and maintains medical policy 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 and 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:

- Non-urgent 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.

Pricing/benefit code denials

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

Codes may also lack pricing:

- Example 1: We may receive a new code that pricing has not yet been established.
- Example 2: Pricing may not be established because the code is noncovered.

Members in the St. Francis network

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

- Claims for family planning and behavioral health should be billed to Anthem directly.
- Submit all claims for St. Francis to:

St. Francis Health Network
P.O. Box 502090
Indianapolis, IN 46250

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Claims resolution process

Claim 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 or the Anthem Electronic Data Interchange 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.
- 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 be sure 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 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.

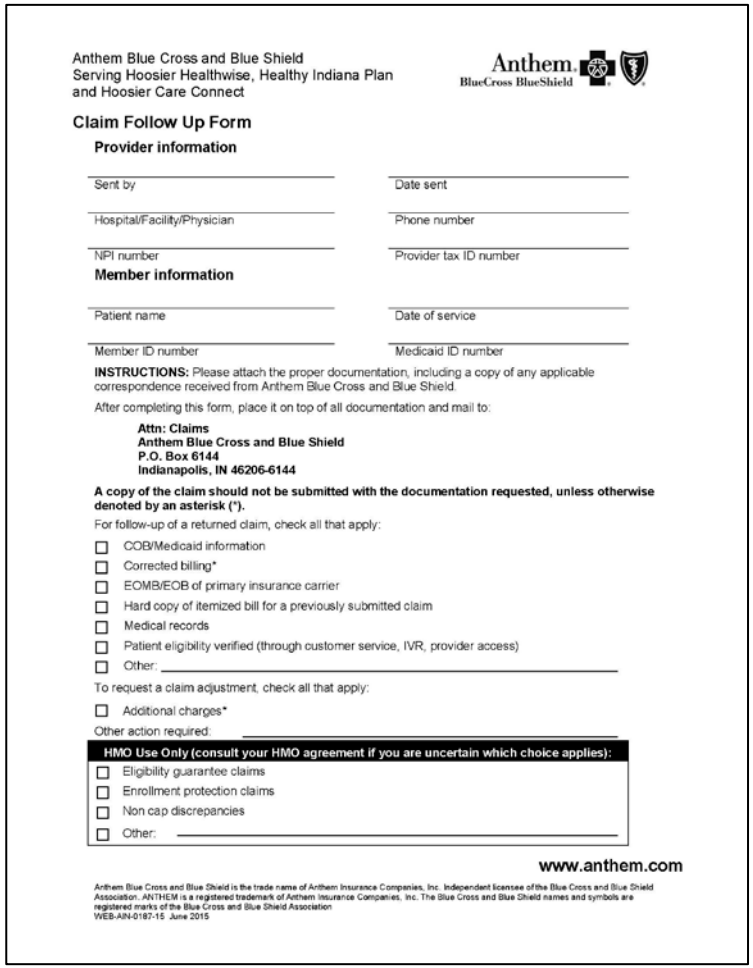
Claims resolution process (cont.)

Corrected claims submission guidelines

- Send paper corrected claims to:

  Anthem Indiana 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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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 still 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!