

June 12, 2018

Retroactive eligibility — prior authorization/utilization management and claims processing

Retroactive eligibility occurs when a member's effective date of coverage is back-dated by the state. This can happen for various reasons. *Retroactive identification* is the identification of a member as a Medicaid beneficiary after services have been rendered, and may be unavoidable in limited situations in which a member was incapacitated (for example, unconscious) at the time of the encounter and was unable to provide identification and insurance/Medicaid information. This may prevent the provider from performing eligibility verification at the time of service.

Retroactive eligibility and retroactive identification can result in administrative denials (denials for reasons other than medical necessity), such as:

- Claim filed past the filing limit.
- Failure to obtain prior authorization (PA).
- Failure to notify Utilization Management (UM) in a timely manner.

For patients believed to fall under retroactive eligibility or retroactive identification, reimbursement will be considered in these situations:

- If UM notification is required but was not performed timely, and the patient has not been discharged (has an active case):
 - Contact UM to provide the notification as soon as possible, including documentation to identify the reason the notification was not submitted in a timely manner.
 - If supported by the documentation, the reviewer will give special consideration to the reason the provider was unable to adhere to requirements for notifying UM within the established time frame. The services will be reviewed for medical necessity back to the first day of eligibility.
 - If the documentation does not include sufficient details to support the patient's inability to provide necessary information at the time of the service to allow the provider to provide timely UM notification, or if the services do not meet the established medical necessity criteria, the request will be denied.
 - The provider may file an appeal. Refer to the Anthem Blue Cross and Blue Shield (Anthem) *Indiana Medicaid Provider Manual* found at www.anthem.com/inmedicaidoc for instructions.
- If PA is required but was not requested timely, or if UM notification is required but was not performed timely, and the patient has already been discharged:
 - Do not send retro-PA requests or notifications to the PA/UM department. Instead, **file the claim normally** (see below for claim filing instructions). When the claim is administratively denied for failure to obtain PA, complete the *Provider Dispute*

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Form, found at www.anthem.com/inmedicaidoc. If the original administrative determination (denial) is overturned as a result of the dispute, the claim will be reviewed for medical necessity. If medical necessity criteria are met, the claim will be reprocessed or the provider will be notified of any actions they need to take to obtain reimbursement.

- If the provider did not include sufficient details to support retroactive eligibility or retroactive identification, or if the services provided do not meet established medical necessity criteria, the original decision will be upheld and the claim will not be reprocessed.
- For disputes related to untimely PA requests and UM notifications, include the following documentation, as applicable, to identify the reason the request/notification was not made timely:
 - The condition or circumstances that prevented the member from providing his/her Medicaid status (for example, member was unconscious upon admission)
 - Documentation that demonstrates the member was made retroactively eligible by the state
 - Documentation of attempts to verify eligibility in which incorrect information or no information was found, such as screenshots of the eligibility verification tool
 - Documentation of misrepresentation by the member, which may include copies of signed patient forms in which the member checked *no* in the insurance/Medicaid field or left them blank
 - Clinical documentation demonstrating the medical necessity for the services provided

Special consideration will not be given for situations in which the provider did not follow proper procedures that led to the denial, such as:

- Failure to verify eligibility at the time of service
- Failure to request PA in advance of the service (**prior** authorization must occur **prior** to the service being rendered)
- Failure to notify the UM department in the required time frame, despite having access to the necessary information

Newborns

Newborns are assigned to the same managed care entity as the mother, retroactive to the date of birth. Hospitals should report all Medicaid newborns to the state as quickly as possible so a permanent Medicaid member ID can be assigned. Providers should report these births to Anthem UM within three days. Providers may contact Provider Services to request a temporary ID number, which will allow them to request PA and submit newborn claims until a permanent ID is assigned. Refer to Anthem provider bulletin *Temporary Newborn Cases* dated July 2017 for additional details.

Submission of appeals, claims disputes and claims

Providers may submit appeals, claims and claims disputes electronically by visiting <https://www.availity.com> or via mail.

Electronic claims

Electronic filing methods are preferred for accuracy, convenience and speed. Electronic data interchange (EDI) allows providers and facilities to submit and receive electronic transactions from their computer systems. EDI is available for most common health care business transactions. For more information on EDI, contact the Anthem EDI Solutions Helpdesk at:

- Phone: **1-800-470-9630**
- Hours of operation: Monday to Friday, 8 a.m. to 4:30 p.m. ET
- Email: ent.edi.support@anthem.com

Paper claims

Paper claims are scanned for clean and clear data recording. To get the best results, paper claims must be legible and submitted in the proper format. Follow these requirements to speed processing and prevent delays:

- Use the correct form and be sure the form meets Centers for Medicare & Medicaid Services standards.
- Use black or blue ink to ensure the scanner can read the claim.
- Use the **remarks** field for messages.
- Do not stamp or write over boxes on the claim form.
- Send the original claim form to Anthem and retain a copy for your records.
- Do not staple original claims together. Anthem will consider the second claim as an attachment and not an original claim to be processed separately.
- Remove all perforated sides from the form. Leave a one-quarter-inch border on the left and right side of the form after removing perforated sides to help our scanning equipment function accurately.
- Type information completely within the designated field and ensure it is properly aligned.
- Don't highlight any fields on the claim forms or attachments. Doing so makes it more difficult to create a clear electronic copy when scanned.
- If using a dot matrix printer, do not use draft mode since the characters generally do not have enough distinction and clarity for the optical scanner to read accurately.

Mail paper claims to:

Anthem Blue Cross and Blue Shield
Claims
Mailstop: IN999
P.O. Box 61010
Virginia Beach, VA 23466

To file a claim dispute

If there is a full or partial claim rejection or the payment is not the amount expected, submit a claims dispute form, called a *Provider Dispute/Resolution Request Form*, which can be found at www.anthem.com/inmedicaidoc.

Your claims dispute can be sent electronically at <https://www.availity.com> or, as an alternative, send the completed *Provider Dispute/Resolution Request Form* and documentation to:

Anthem Blue Cross and Blue Shield
Provider Disputes and Appeals
P.O. Box 61599
Virginia Beach, VA 23466

For questions, providers may contact Provider Services Monday to Friday, 8 a.m. to 8 p.m. ET at:

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