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

CMS 1450 (UB-04) institutional providers

2017 Annual Workshop

Reminders and updates

The Anthem Blue Cross and Blue Shield 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 two-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 provider-updated 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 and 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

Submit all provider file updates using 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

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 web portal: **www.Availity.com** (PMP verification and benefit limitations only)

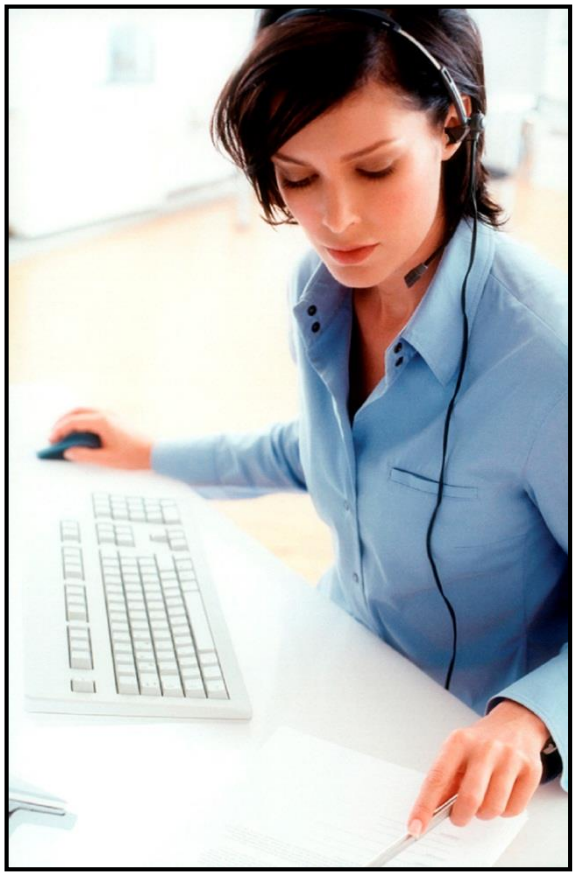
Eligibility (cont.)

You will need:

- Hoosier Healthwise and Hoosier Care Connect ID card
  - When filing claims and inquiries, ALWAYS include the YRH prefix before the member's RID number.
- HIP ID card (issued by Anthem)
  - 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 *Core*MMIS.
- The member's PMP may call customer service to add new providers to the member's list of authorized providers.



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 UM department, have available:

- Member name and ID
- Prefix —YRK or YRH
- 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 (PLUTO)

Please visit our provider website to utilize our Prior Authorization Lookup Tool at **www.anthem.com/inmedicaiddoc**.

Locate the Prior Authorization Drop Down Menu

Click on Prior Authorization Lookup Tool

Providers can quickly determine prior authorization requirements and then utilize our ICR to request prior authorizations.

If you have any questions about Availity, the Prior Authorization Lookup 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 **physical health** clinical information for all Anthem members to:

- Physical health inpatient: **1-888-209-7838**
- Physical health outpatient: **1-866-406-2803**

Fax **behavioral health** clinical information for all Anthem members to:

- Behavioral health inpatient: **1-877-434-7578**
- Behavioral health outpatient: **1-866-877-5229**

How to obtain prior authorization (cont.)

Anthem is pleased to offer Interactive Care Reviewer (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 utilization management 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.

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.

Outpatient services (cont.)

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	**Healthy Indiana Plan**	**Hoosier Care Connect**
Phone: 1-866-408-6132	Phone: 1-844-533-1995	Phone: 1-844-284-1798
Fax: 1-866-406-2803	Fax: 1-866-406-2803	Fax: 1-866-406-2803

Prior authorization denials

Time frames:

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

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

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 is not showing in our processing system, ask the Provider Services representative to verify if the claim is imaged in Filenet/WCF or Macess. Do not resubmit if the claim is on file in the processing or image system.

Pricing/benefit code denials

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

Codes may also lack pricing:

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

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.)

- 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: **1-844-284-1798**

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:

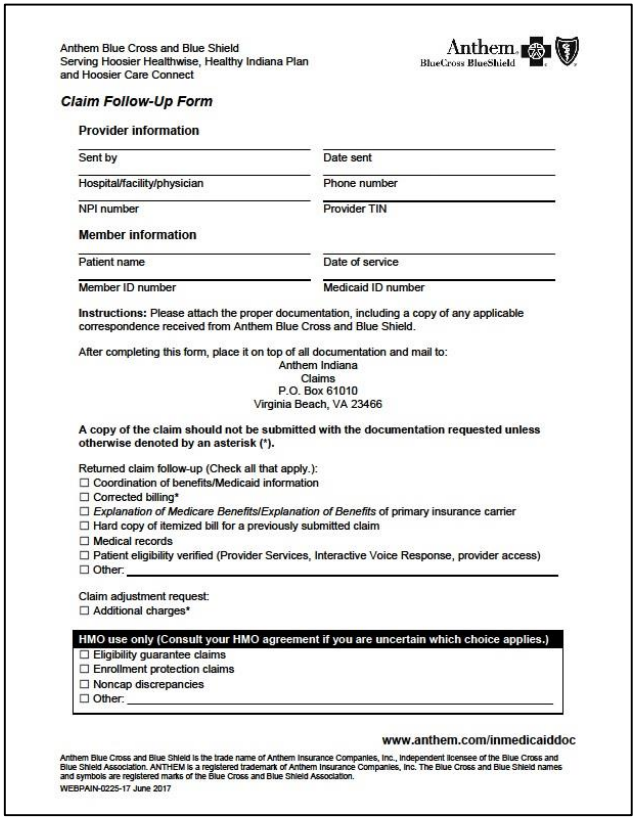
- Submit the corrected claim no later than 60 calendar days from the date of our letter or remittance advice (RA).
- Submit the corrected claim as a paper claim through the mail, even if the original claim was sent electronically.
- Clearly mark the paper claim at the top with the words "corrected claim," 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
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.

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

Important contact information (cont.)

PA requests

- Hoosier Healthwise: **1-866-408-7187**
- HIP: **1-844-533-1995**
- **Hoosier Care Connect: 1-844/284/1798**

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!

Thank you

www.anthem.com/inmedicaiddoc

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