# End to End Process For Filing a UB04 Facility Claim Form

2022 Indiana Health Coverage Programs (IHCP) Works Seminar

Serving Hoosier Healthwise, Healthy Indiana Plan and Hoosier Care Connect

# Agenda

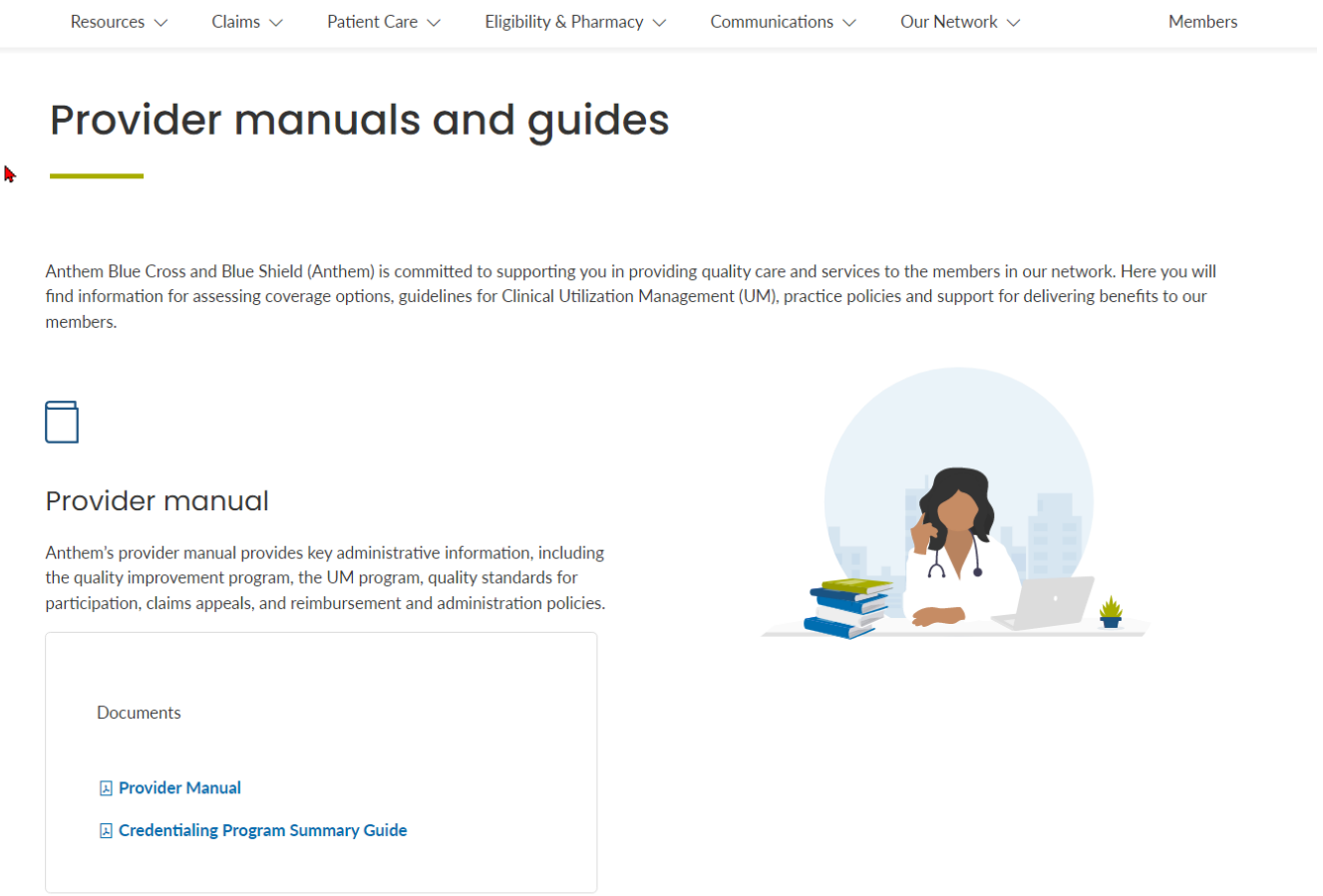
- Provider manual
- Eligibility
- Prior authorization (PA)
- Claims
- Contact information

# Acronyms

- **PMF** — Provider Maintenance Form
- **IHCP** — Indiana Health Coverage Programs
- **PSO** — Provider Solutions Organization
- **HIP** — Healthy Indiana Plan
- **MCE** — Managed Care Entity
- **PMP** — Primary Medical Provider
- **COB** — Coordination of Benefits
- **RCP** — Right Choices Benefits
- **EDI** — Electronic Data Interchange
- **UM** — Utilization Management
- **ICR** — Interactive Care Reviewer

# Provider manual

https://providers.anthem.com/indiana-provider/resources/manuals-and-guides



# Provider file updates and changes

Anthem Blue Cross and Blue Shield (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.in.gov/medicaid/providers or by calling IHCP Provider Services at **800-457-4584**. For more information, please refer to the IHCP provider reference modules.
2. Complete the Organization Provider Maintenance Form to request a contract or update your facility demographics.

# Provider file updates and changes (cont.)

Our Provider Solutions Organization (PSO) department handles all provider file updates. This includes the following provider networks:

- Medicaid under Anthem:
  - Hoosier Healthwise
  - Healthy Indiana Plan (HIP)
  - Hoosier Care Connect
- Commercial insurance under Anthem

If you have questions about provider network agreements and provider file information, you can contact your assigned Provider Experience manager and they can get you to your PSO representative.

# Eligibility

# Eligibility

Always verify a member's eligibility prior to rendering services. Anthem recommends a two-step verification process.

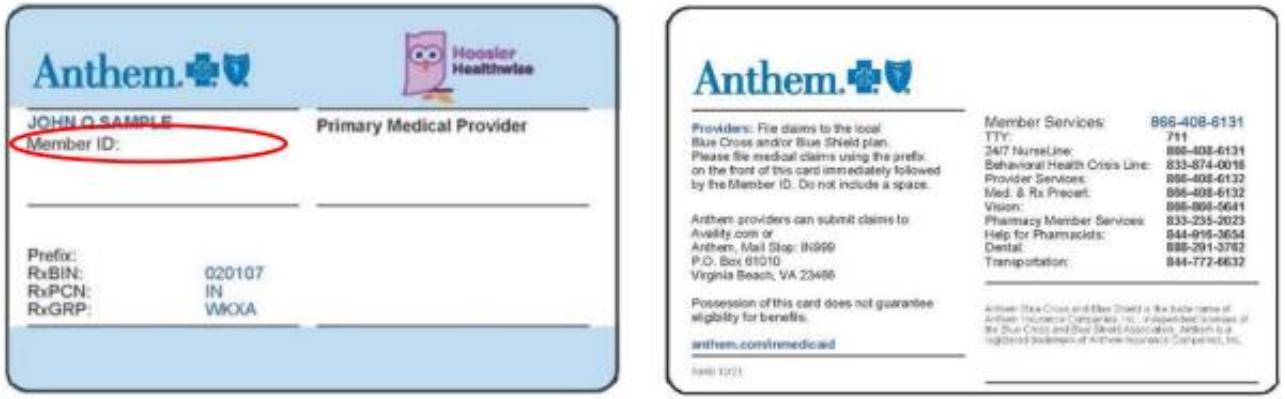
**Providers can access this information by visiting:**

- IHCP Provider healthcare portal: Use to verify eligibility, assigned Managed Care Entity (MCE), and Medicaid product
- Availity Portal:* use for primary medical provider (PMP) verification, benefit limitations, COB, the member ID (if needed), and much more

# Eligibility (cont.)

Hoosier Healthwise:

- Anthem assigns the YRH prefix with the state member ID (MID).

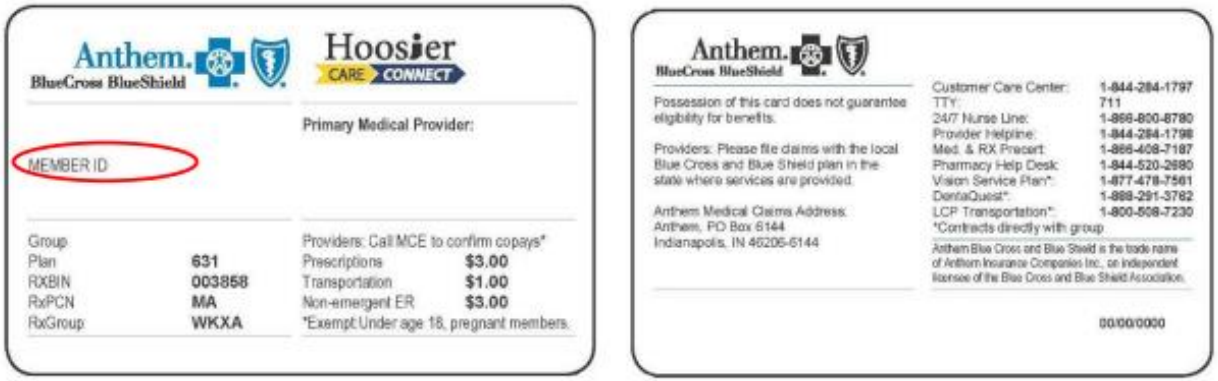



- Effective January 1, 2023, when filing claims and inquiries, it will no longer be required to include the YRH prefix before the MID.

# Eligibility (cont.)

Hoosier Care Connect:

- Anthem assigns the YRH prefix.

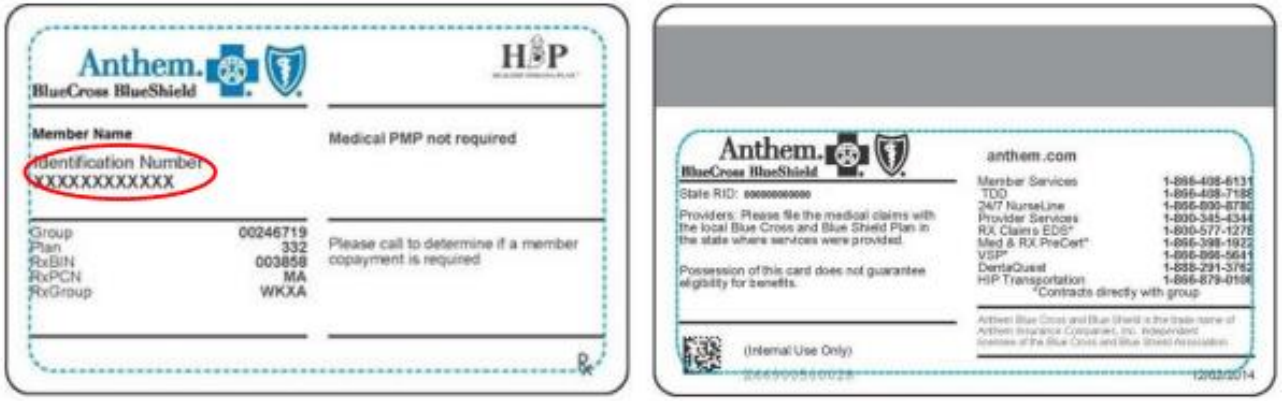



- Effective January 1, 2023, when filing claims and inquiries, it will no longer be required to include the YRH prefix before the MID.

# Eligibility (cont.)

Healthy Indiana Plan (HIP):

- Anthem assigns the YRK prefix with the MID.




- Effective January 1, 2023, when filing claims and inquiries, it will no longer be required to include the YRH prefix before the MID.

# RCP

- RCP is a program for Indiana Medicaid recipients who may need assistance learning how to properly use their health insurance.
- The program provides members a lock-in provider who acts as a safeguard against the unnecessary or inappropriate use of benefits.

# RCP (cont.)

- Members enrolled in the RCP must see the providers who are assigned per CoreMMIS.
- The member's PMP may call **866-902-1690 option 1** to add new providers to the member's list of authorized providers.
- Refer to page 54 of the Anthem provider manual for more information.
- RCP members are no longer required to be locked into a single hospital.
  - **Although members are no longer locked into a single hospital, they will still be locked into one primary medical provider to coordinate their care and one pharmacy to fill prescriptions.**

# Prior authorization

# Precertification lookup tool

Visit the provider website to utilize the precertification lookup tool at https://providers.anthem.com/indana-provider/home > Claims > Precertification Lookup Tool.

Providers can quickly determine PA requirements for outpatient services. If a PA is required, we strongly recommend utilizing our Availity Authorization tool to request PA.

Note: All inpatient services require PA.

# How to obtain prior authorization

Providers may call Anthem to request PA for medical and behavioral health (BH) services using the following phone numbers.

| Program | Phone number |
|---|---|
| HIP | **844-533-1995** |
| Hoosier Care Connect | **844-284-1798** |
| Hoosier Healthwise | **866-408-6132** |

# How to obtain prior authorization (cont.)

Fax clinical information for all members to:

| | Inpatient | Outpatient |
|---|---|---|
| **Physical health** | **888-209-7838** | **866-406-2803** |
| **Behavioral health** | **844-452-8074** | **844-456-2698** |

# How to obtain prior authorization (cont.)

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

- Member name and ID
- Prefix — YRK (HIP), YRH (Hoosier Healthwise, Hoosier Care Connect)
- Diagnosis with ICD-10 code
- Procedure with CPT® code
- Date(s) of service
- PMP, specialist, or facility performing services
- Clinical information can be uploaded to the Availity Authorization Tool, ICR, or faxed to support the request
- Treatment and discharge plans (if known)

# How to obtain prior authorization (cont.)

Anthem is pleased to offer the Availity Authorization Tool, to request PA for Hoosier Healthwise, HIP, and Hoosier Care Connect services at no cost to providers. This tool will accept the following types of requests for our members:

- Inpatient
- Outpatient
- Medical/surgical

If you have any questions about the prior authorization lookup tool or Availity, contact your assigned PE Manager.

# Timeliness of prior authorization decisions

| Request type | Turn around time from request time |
|---|---|
| Emergency services | Does not require PA |
| Urgent concurrent requests | 1 business day |
| Urgent pre-service requests | 72 hours |
| Routine non-urgent requests | 7 days |
| Urgent appeals | 48 hours |
| Routine appeals | 30 days |

# Outpatient services

When authorization of outpatient healthcare services is required, providers should utilize Availity Authorization Tool, call, or fax to request PA.

- 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.

# Emergency medical services and admission

For emergency medical conditions and services, Anthem does not require PA 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 observed holidays).
- This must be followed by a written certification of medical 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 for observation up to 72 hours do not require PA.

# Medical necessity denials

When a request is determined to not be medically necessary, the requesting provider, servicing provider, and the member will be notified in writing of:

- The review outcome
- The clinical rationale
- How to request a copy of how the decision was made
- How to reach the reviewing physician for peer-to-peer (P2P) discussion of the case, if desired.
- The Member's rights.
  - The process for grievance and appeals
  - State Fair Hearing

# Medical necessity denials (cont.)

The provider may request a P2P discussion within 7 days of notification of an adverse determination:

- Upon request for P2P discussion beyond 7 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 P2P discussion 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 60 days from the date of the denial.

# Late notifications or failure to obtain PA

- Late notifications of admission or failure to obtain PA for services when PA is required will not receive a medical necessity review, and the claim will be administratively denied.
- If you have questions regarding PA requirements, providers may contact Provider Services Monday through Friday, 8 a.m. to 8 p.m. ET at:

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

# Claims

# 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), Availity, or by mail to:

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

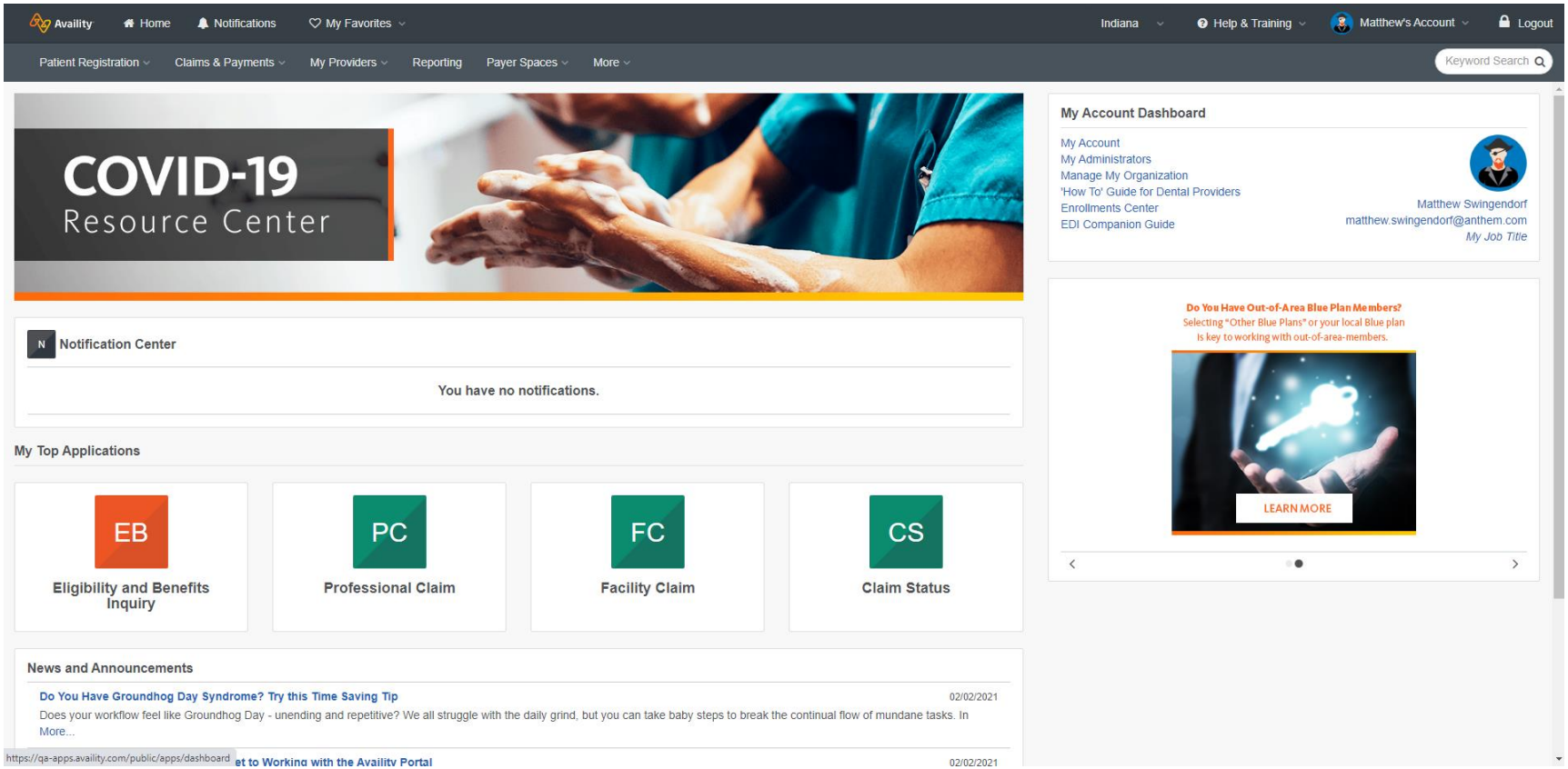
Note: Nonparticipating providers have 180 days from the date of service to submit their claims. All out of network services require PA.

# Claim Submissions

Using Availity to file a facility claim

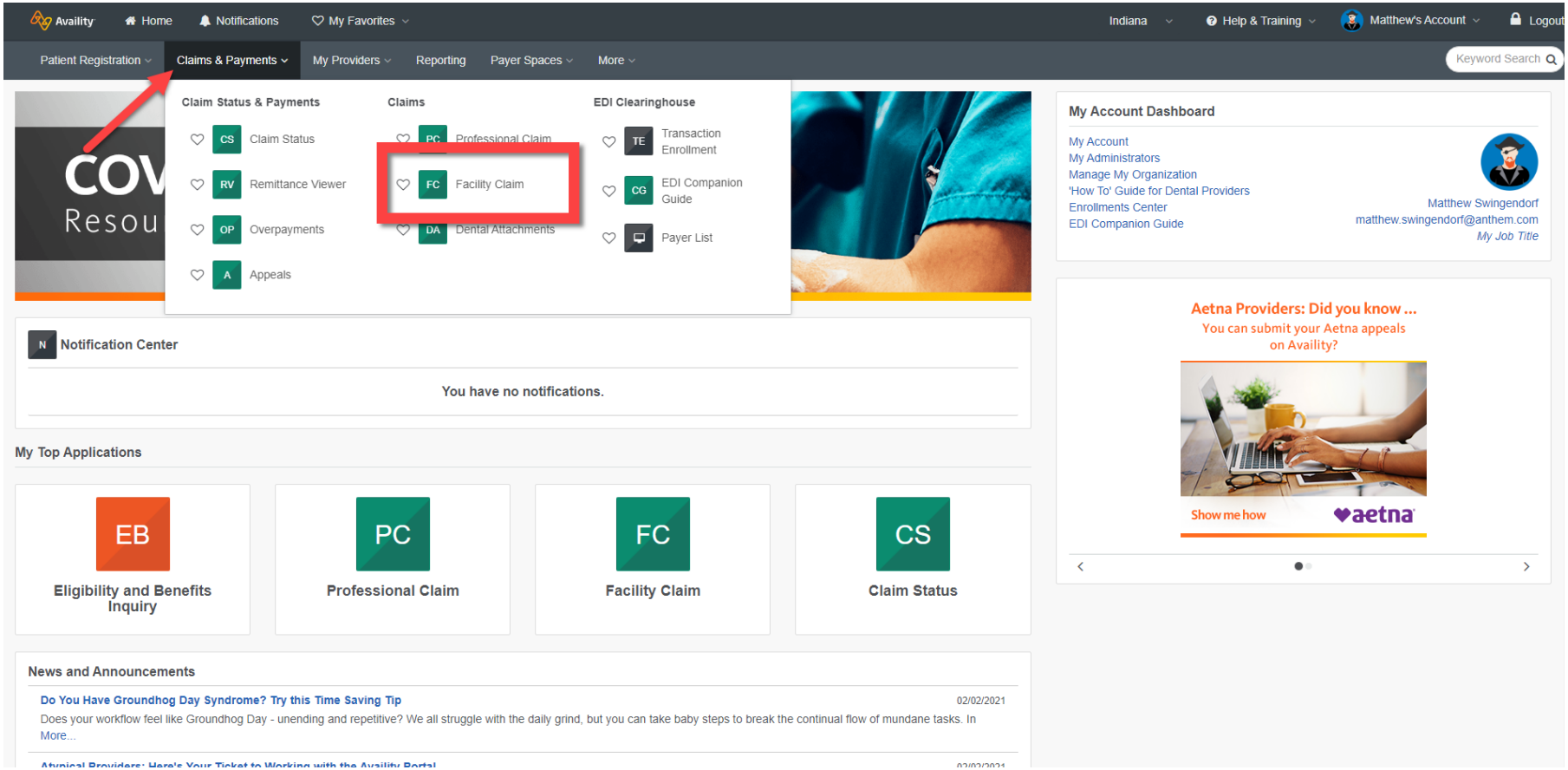
# Log on to Availity*

Once logged in, this is what the home page will look like.



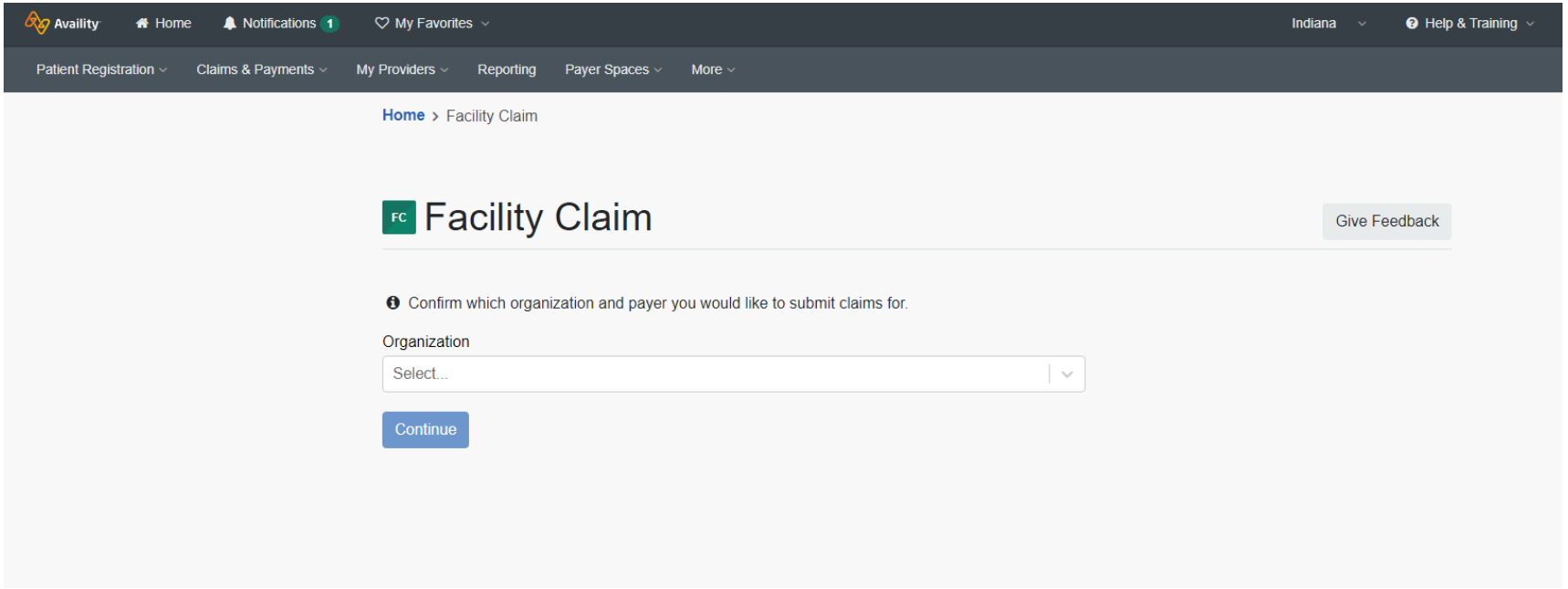
# Filing a claim

From the *Claims & Payments* dropdown menu, select **Facility Claim**.



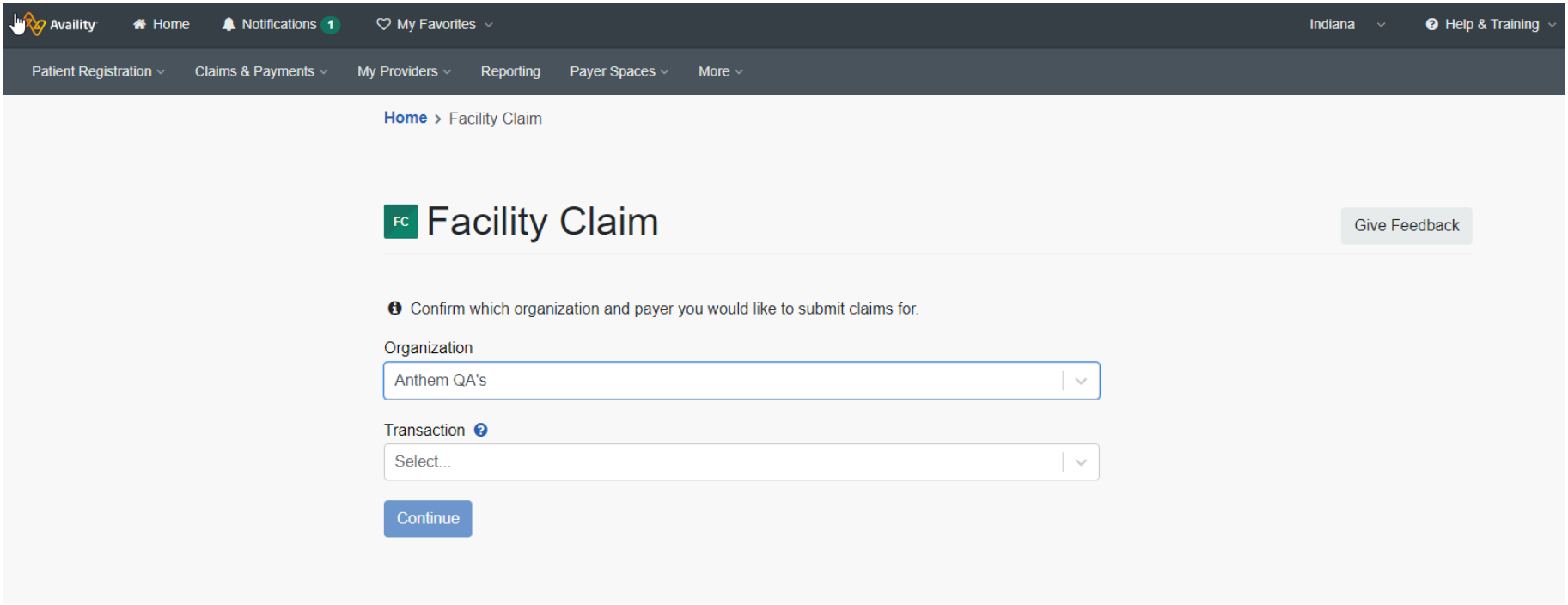
# Filing a claim (cont.)

Select your **Organization**.



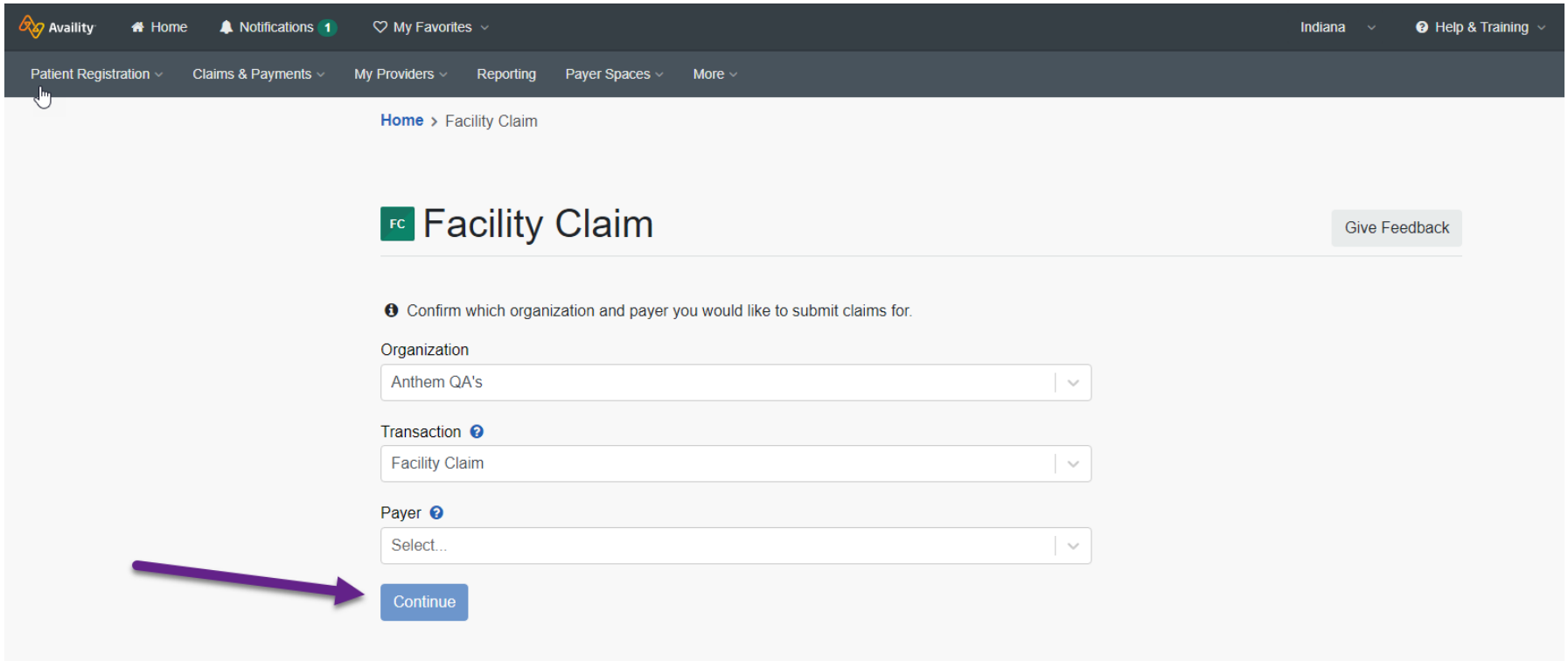
# Filing a claim (cont.)

Select your **Transaction** type.



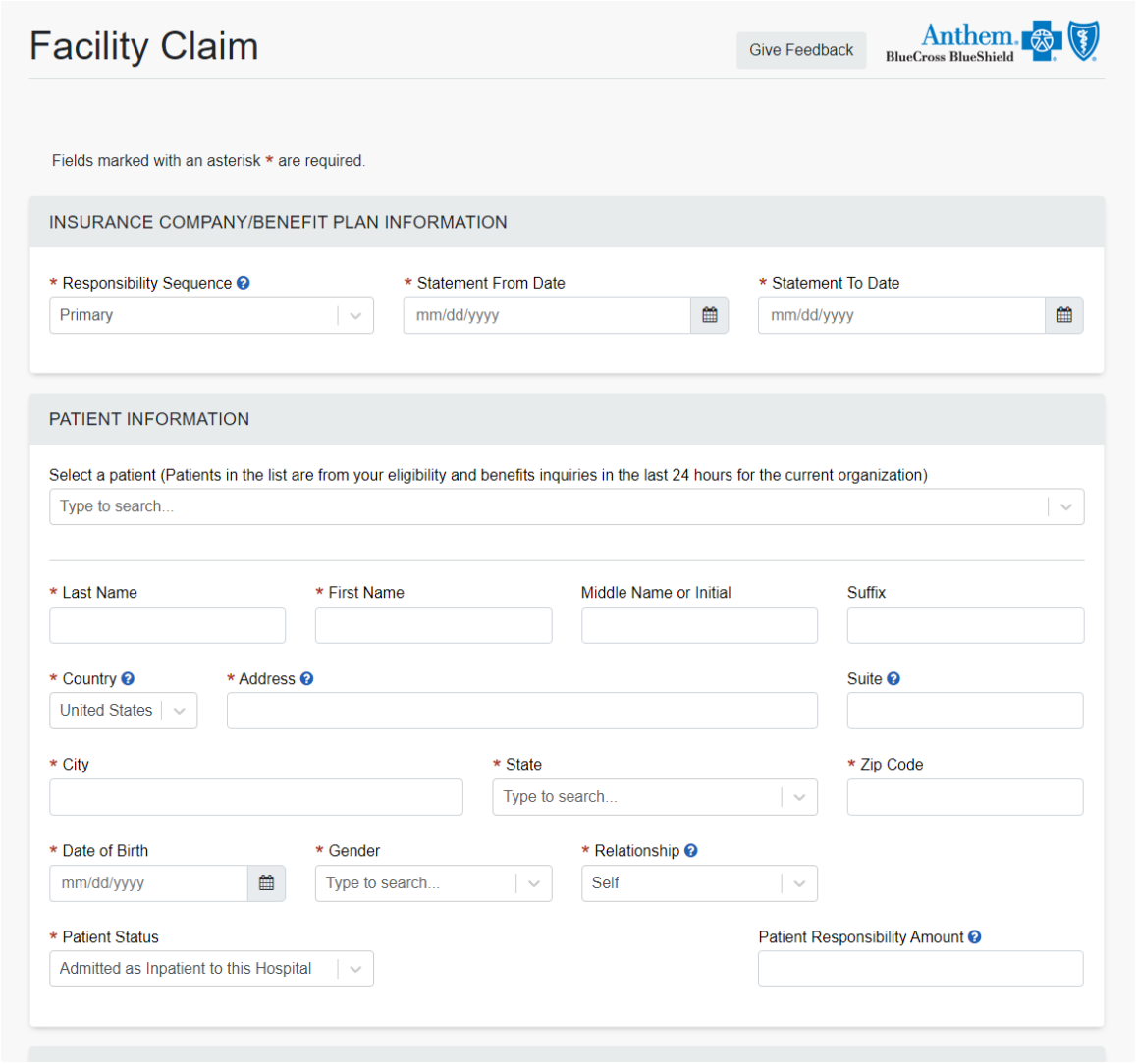
# Filing a claim (cont.)

Select the payer and **Continue**.



# Claim form

- Select **Responsibility Sequence**
  - Primary
  - Secondary
  - Tertiary
- Add the **Statement From/To Date**
- Fill in the patient information
  - All fields with the red asterisk* are required fields

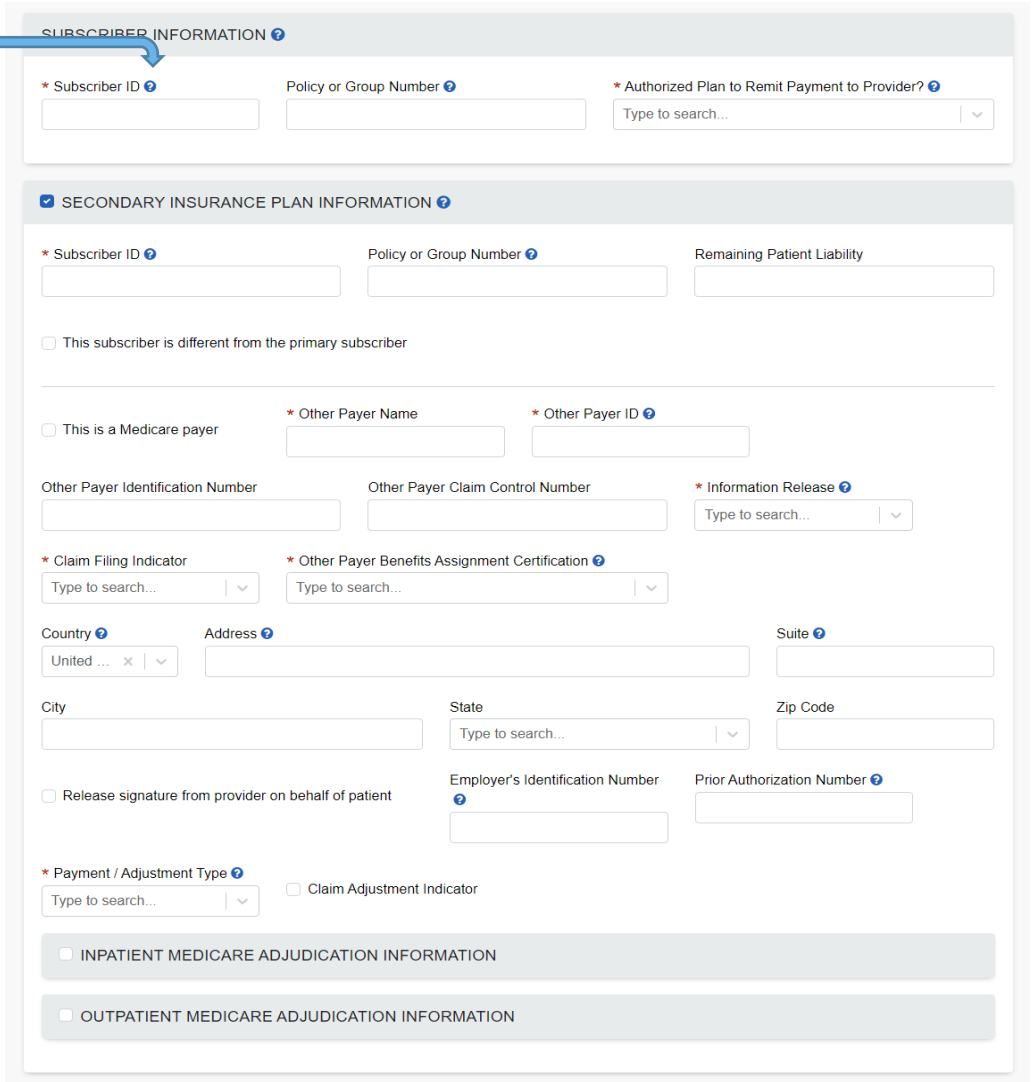


# Claim form (cont.)

The member ID goes here as well as their other insurance if there is another policy.

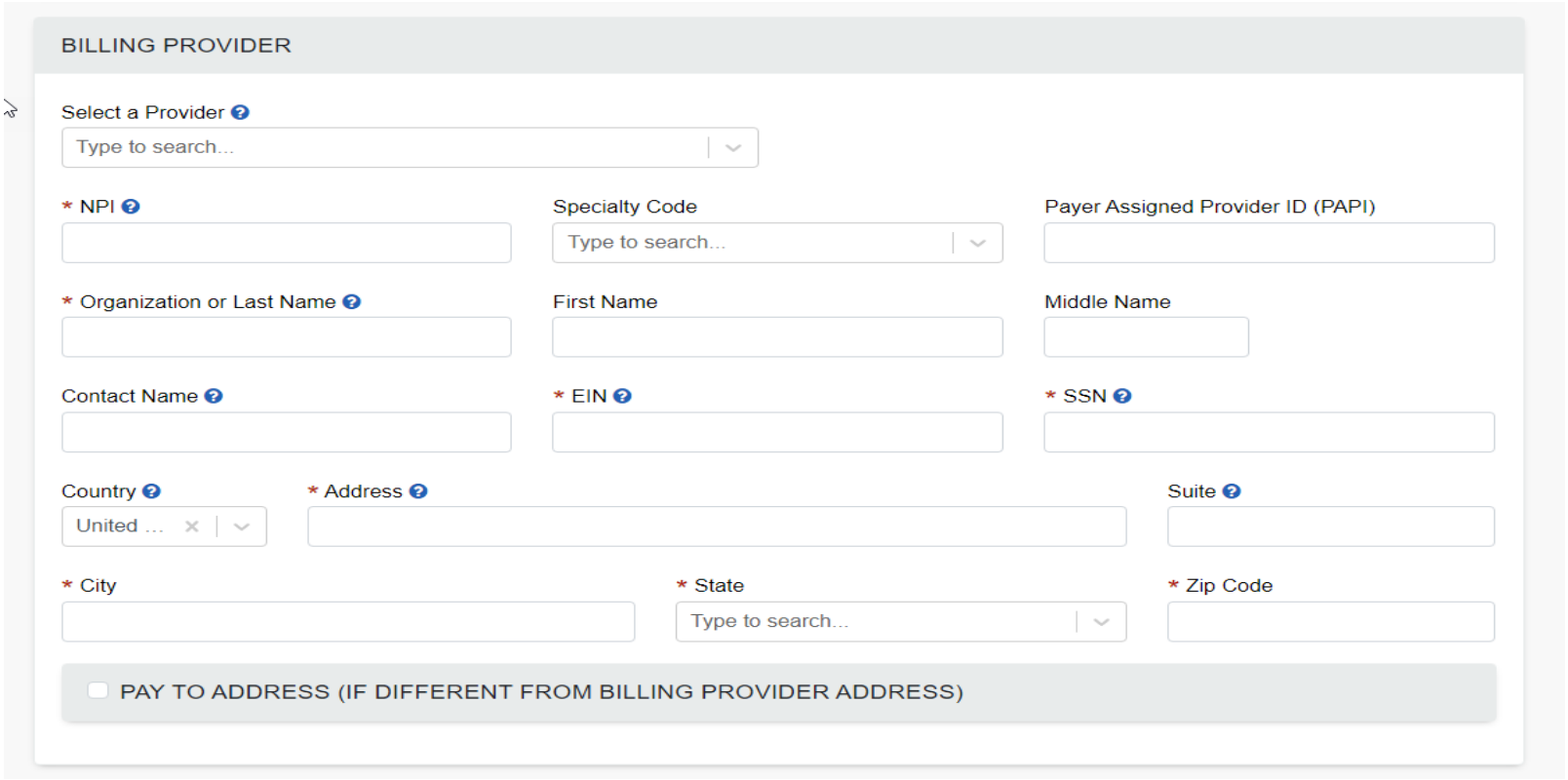
When entering the subscriber ID, be sure to enter the prefix YRH or YRK, plus the MID.

- Starting January 1, 2023, the prefix will not be required.



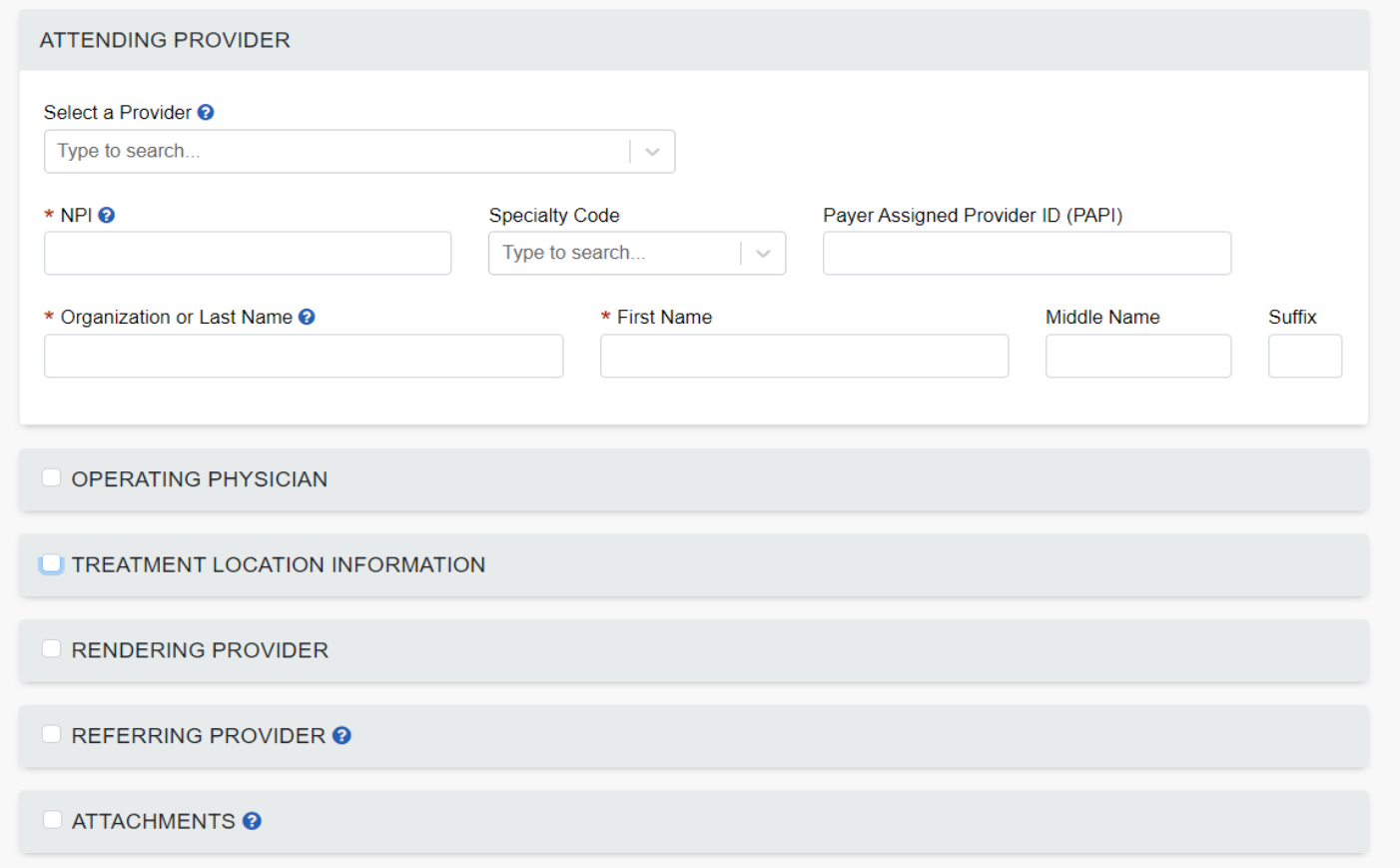
# Claim form (cont.)

This field is used for the provider's billing information.



# Claim form (cont.)

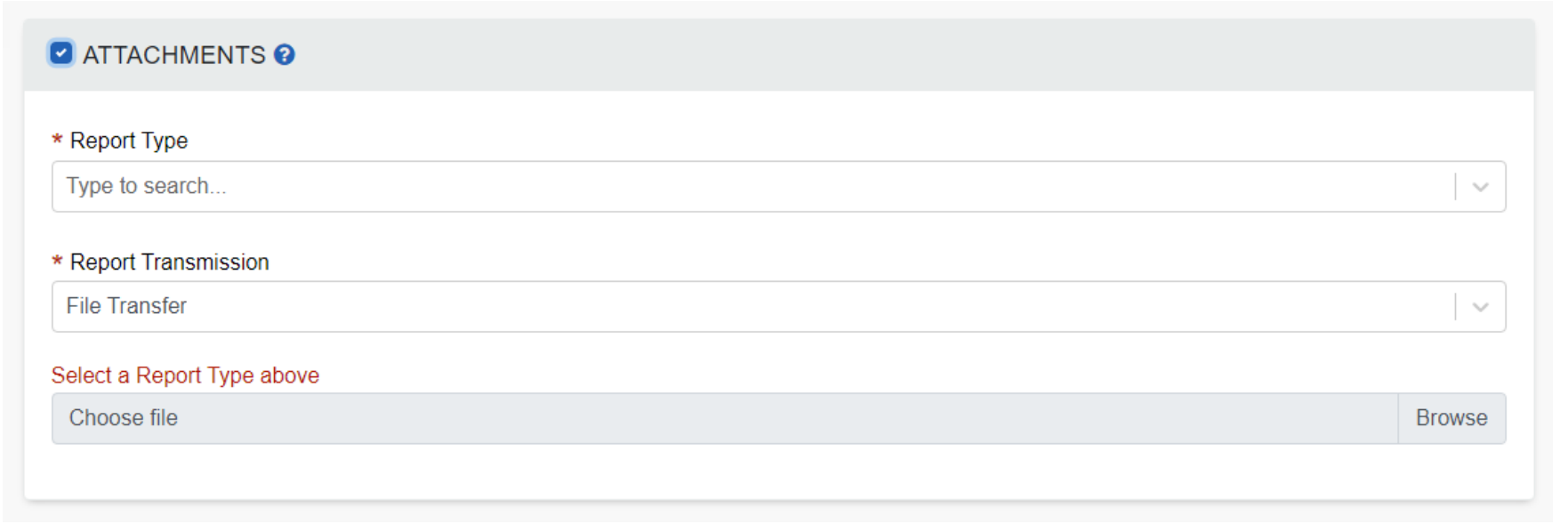
These fields are for the attending provider, operating provider, if necessary, treatment or service location, rendering and referring providers, and where you upload additional documentation.



# Claim form (cont.)

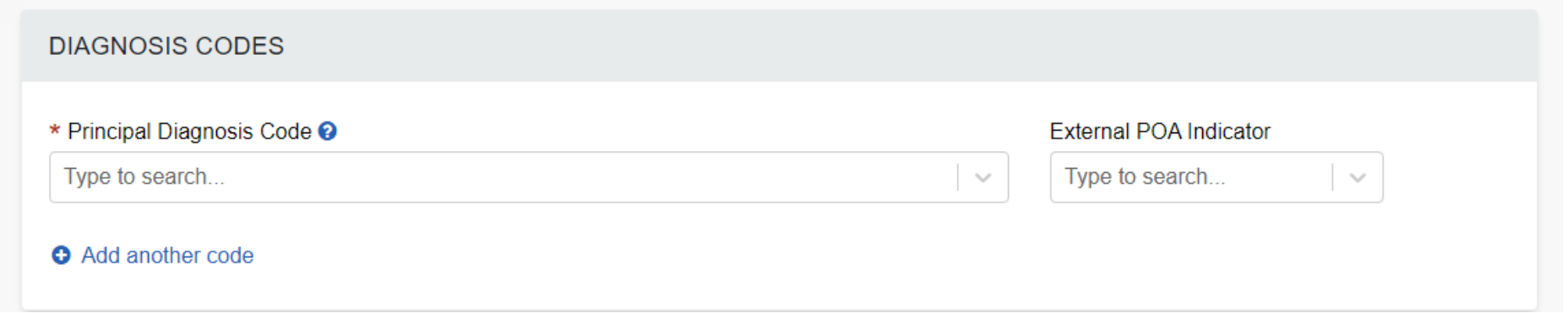
In this field, you can add attachments to your claim.

- Under *Report Type*, providers can select what type of information is being attached, such as, primary *EOB*, consent form or medical records.
- The bottom field is where providers can upload attachments.



# Claim form (cont.)

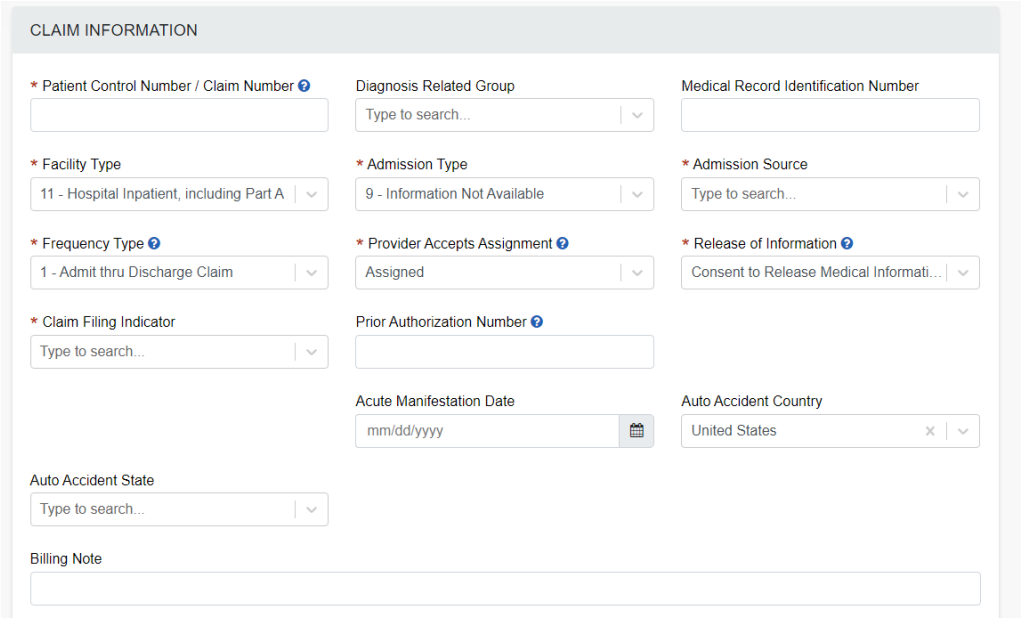
Add the diagnosis codes and principal diagnosis code indicators here. Choose **Add another code** to add additional ICD-10 codes.



# Claim form (cont.)

The required fields for this section are:

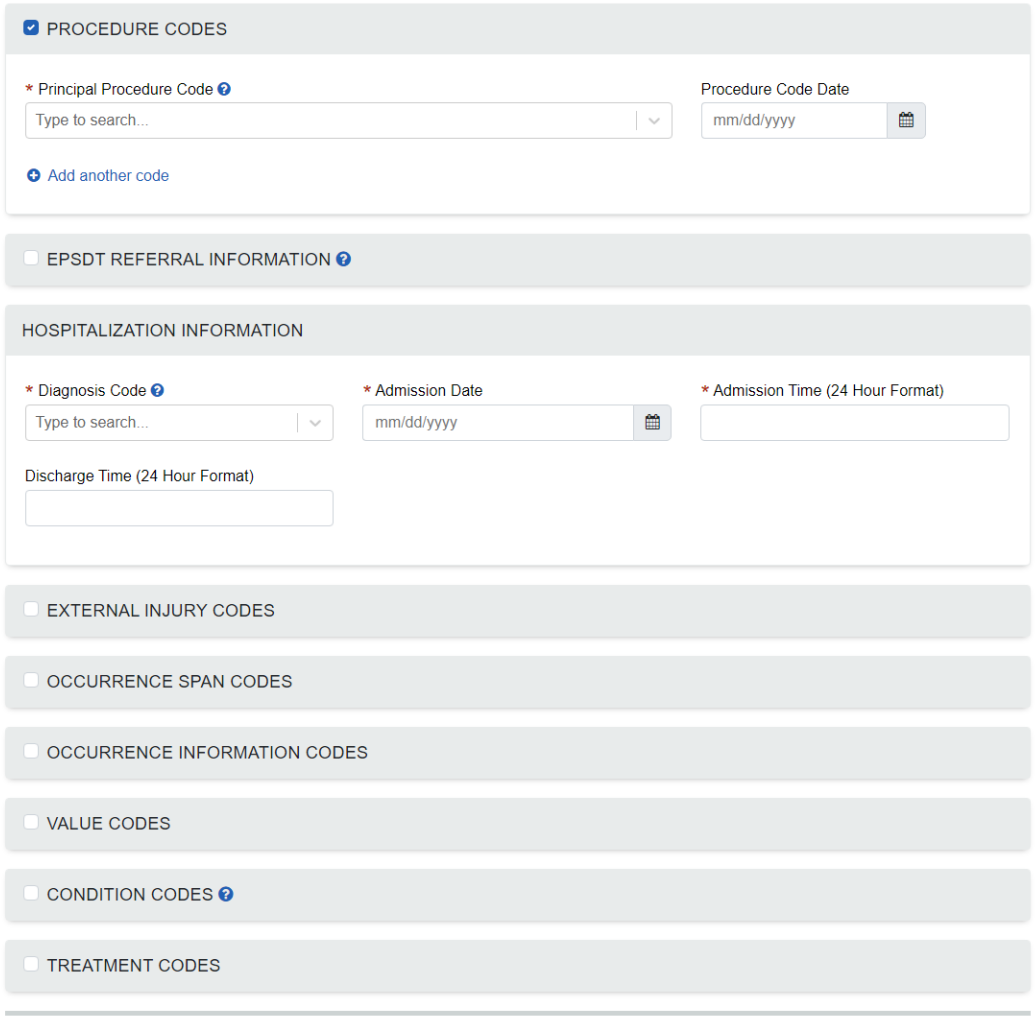
- **Patient Control Number**
  - Enter your patient account number.
- **Facility Type**
- **Frequency Type**
  - 1 - Admit thru Discharge Claim
  - 7 – Replacement of Prior Claim*
  - 8 – Void/Cancel of Prior Claim*
- Select the **Claim Filing Indicator**
- **Admission Type**
- **Admission Source**




* If these fields are selected, a field will pop up for the original claim number.

# Claim form (cont.)

Enter your coding in these fields, with the exception of your service line codes.

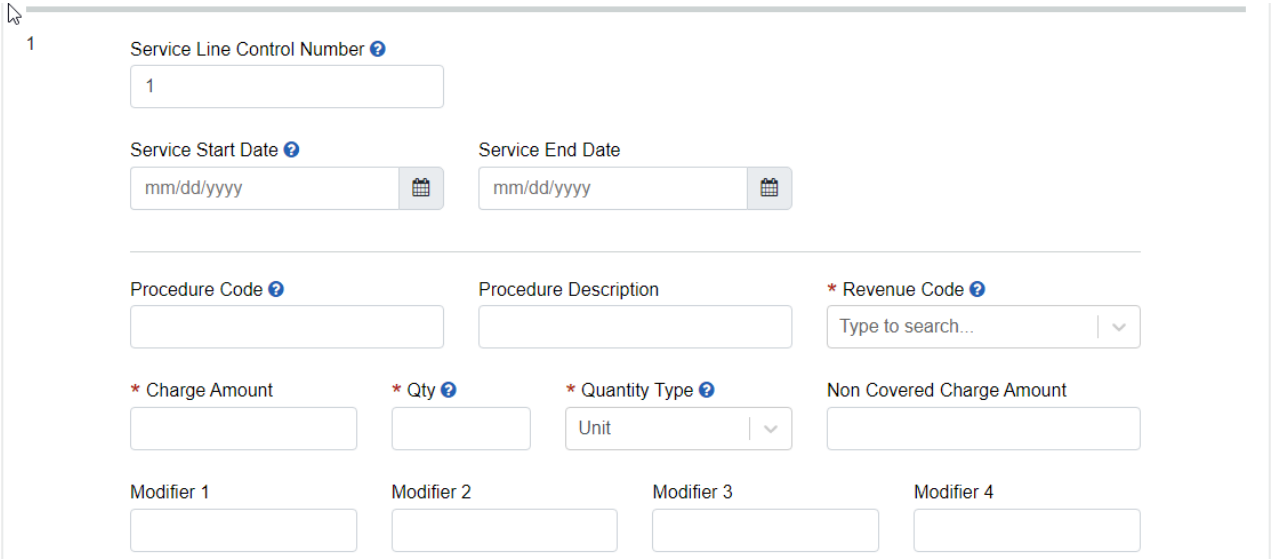


# Claim form (cont.)

This section is the claims service lines.

To select your place of service, providers will need to enter the following information:

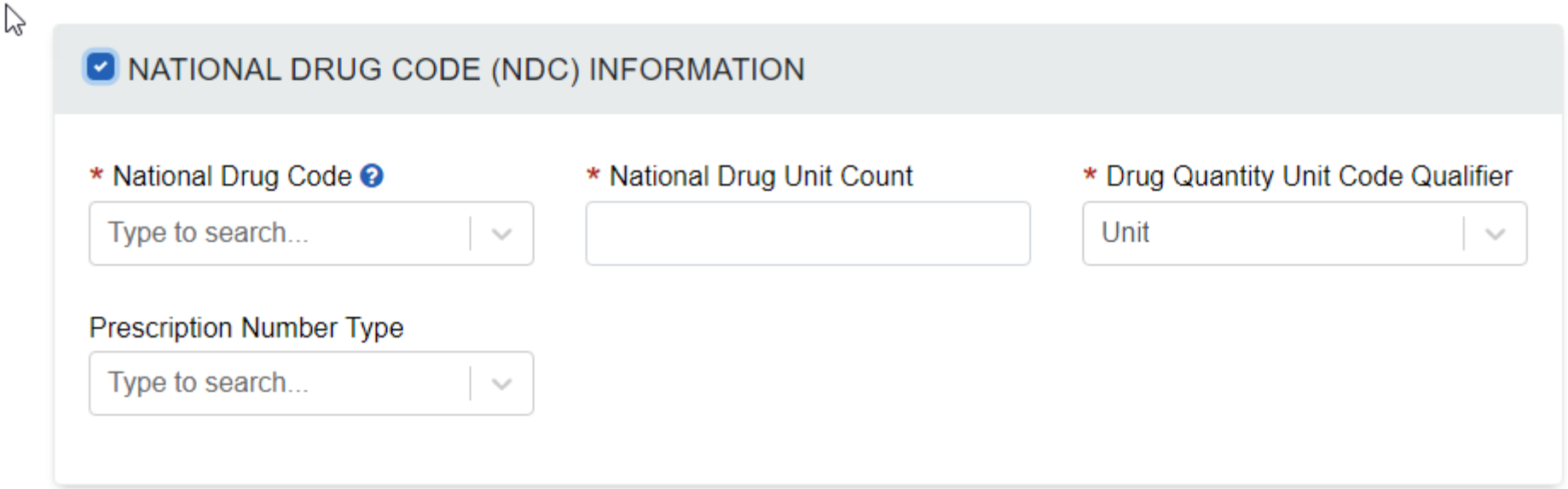
- **Service Start Date**
- **Service End Date**
- **Procedure Code**
- **Revenue Cost**
- **Charge Amount**
- **Quantity**
- **Quantity Type**
- **Any modifiers**



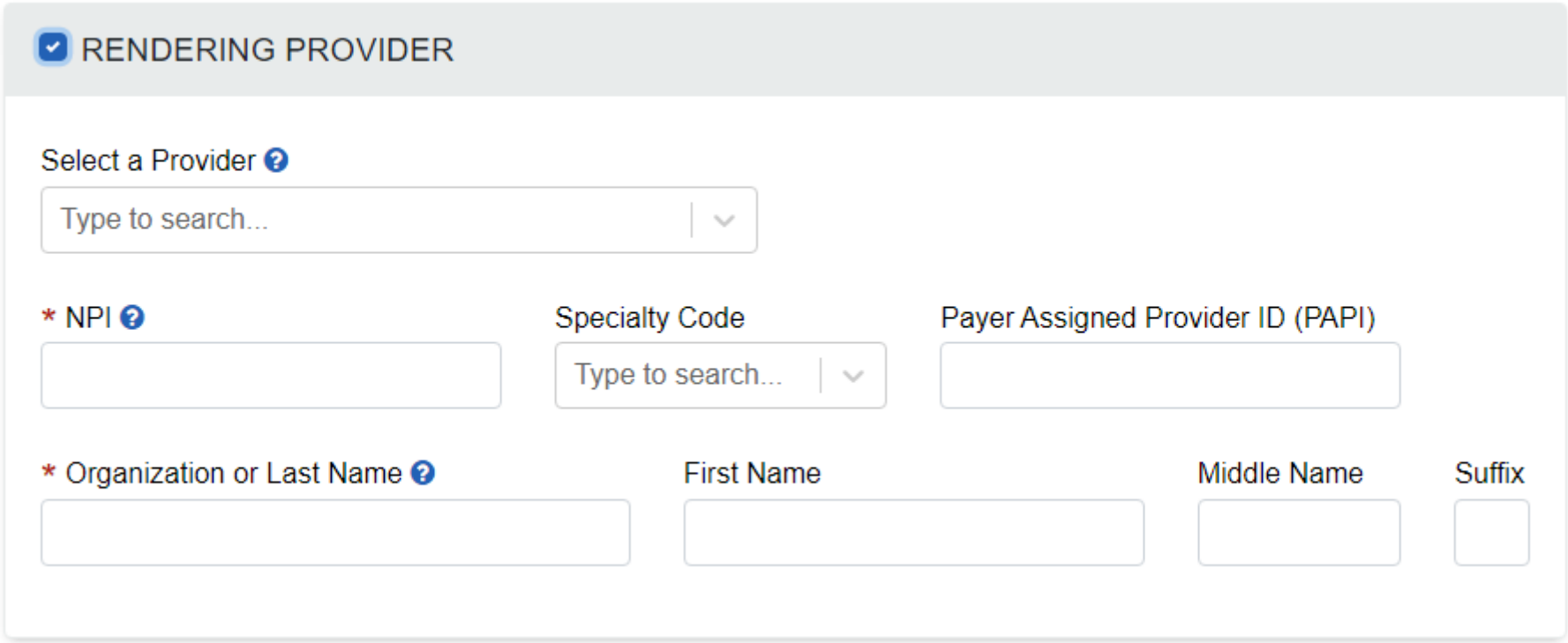
# Claim form (cont.)

These fields are the continuation of the claim service lines.

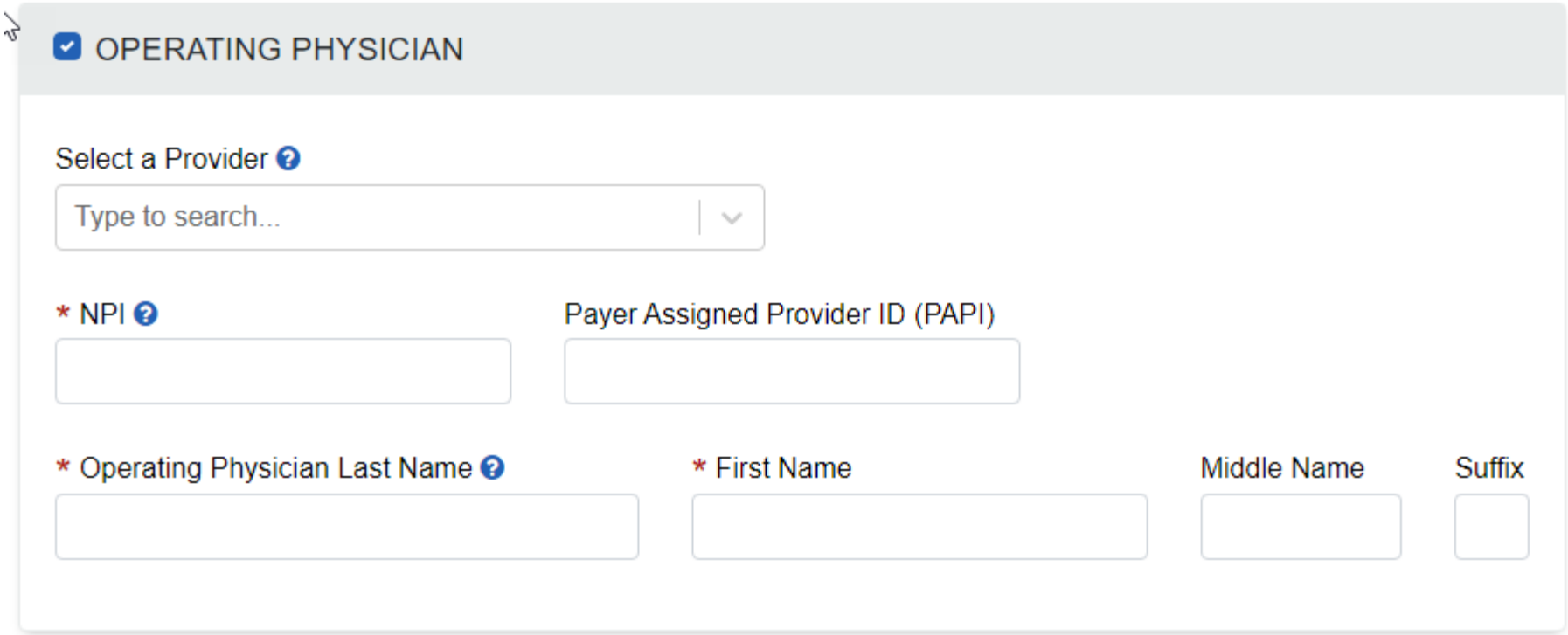
# Claim form (cont.)



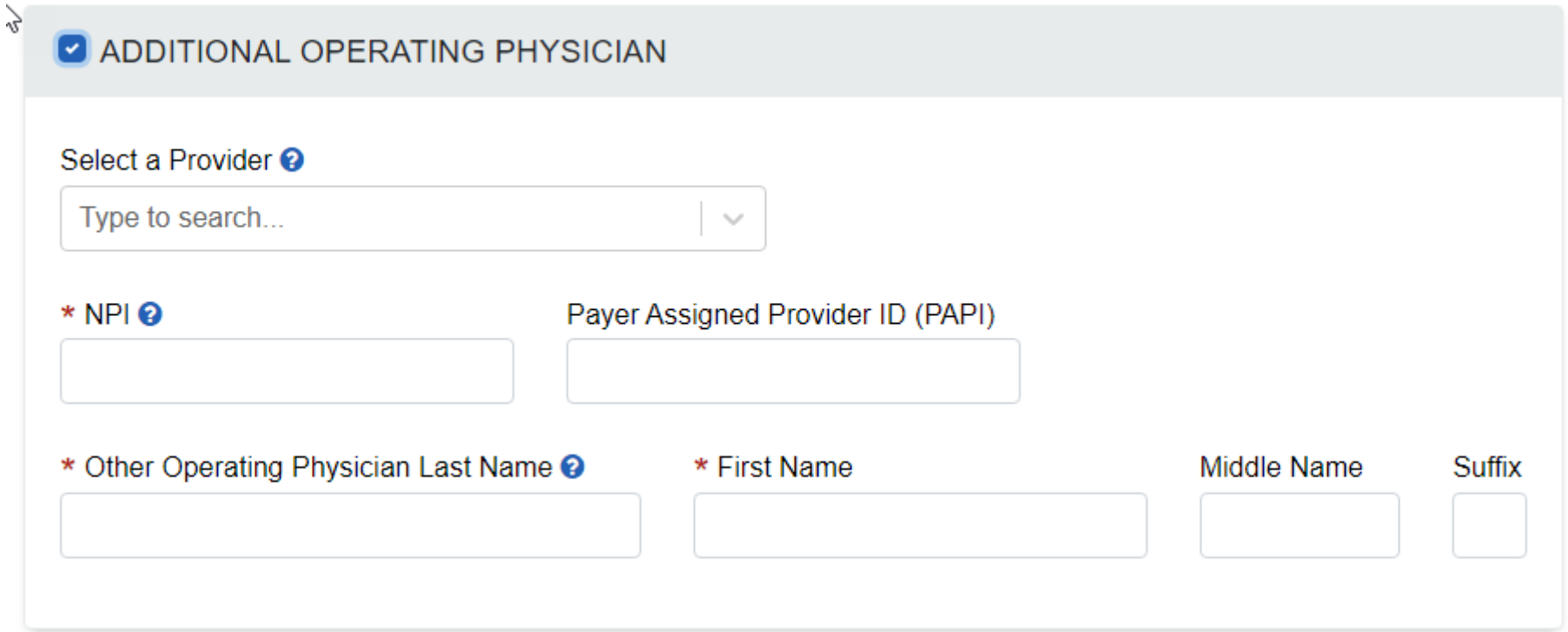
# Claim form (cont.)



# Claim form (cont.)

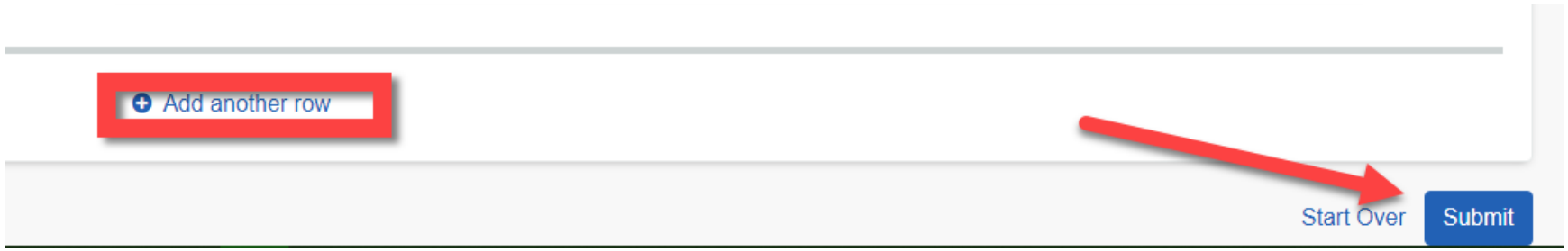


# Claim form (cont.)



# Claim form (cont.)

When you reach the bottom of the claim service lines, you have the option to add additional rows or **Submit**.



# Claim turnaround

Processing time:

- 21 days for electronic clean claims
- 30 days for paper clean claims

If the claim isn't showing in our processing system, ask the Provider Services representative to verify if the claim is in imaging. **Do not resubmit if the claim is on file in the processing or image system.**

# COB

COB is when a member shows to have primary insurance:

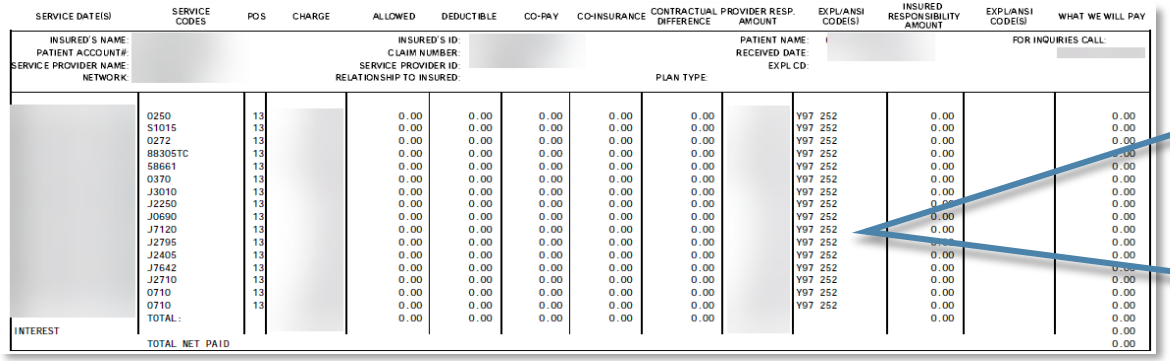
- Claims must be filed to Anthem within 90 days of the date on the primary Explanation of Payment (EOP).

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

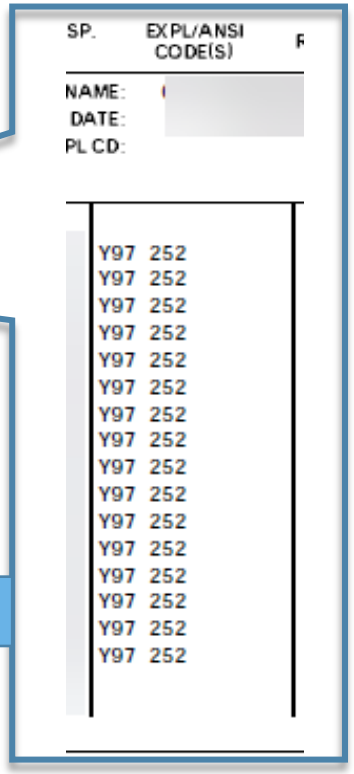
- **Example one:** Primary pays $45 for revenue code 451 and you bill Medicaid as secondary. Medicaid fee schedule is $25.00. No additional money would be paid.
- **Example two:** Primary allows $45 for revenue code 451 but applies it all towards a deductible and you bill Medicaid as secondary. Medicaid will pay the $25.00 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.

# Identifying denials on the EOP



| SERVICE DATE(S) | SERVICE CODES | POS | CHARGE | ALLOWED | DEDUCTIBLE | CO-PAY | CO-INSURANCE | CONTRACTUAL DIFFERENCE | PROVIDER RESP. AMOUNT | EXPL/ANSI CODE(S) | INSURED RESPONSIBILITY AMOUNT | EXPL/ANSI CODE(S) | WHAT WE WILL PAY |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| INSURED'S NAME: | | | | INSURED'S ID: | | | | | PATIENT NAME: | | | FOR INQUIRIES CALL: | |
| PATIENT ACCOUNT#: | | | | CLAIM NUMBER: | | | | | RECEIVED DATE: | | | | |
| SERVICE PROVIDER NAME: | | | | SERVICE PROVIDER ID: | | | | | EXPL CD: | | | | |
| NETWORK: | | | | RELATIONSHIP TO INSURED: | | | | PLAN TYPE: | | | | | |
| | 0250 | 13 | | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | | Y97 252 | 0.00 | | 0.00 |
| | S1015 | 13 | | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | | Y97 252 | 0.00 | | 0.00 |
| | 0272 | 13 | | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | | Y97 252 | 0.00 | | 0.00 |
| | 88305TC | 13 | | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | | Y97 252 | 0.00 | | 0.00 |
| | 58661 | 13 | | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | | Y97 252 | 0.00 | | 0.00 |
| | 0370 | 13 | | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | | Y97 252 | 0.00 | | 0.00 |
| | J3010 | 13 | | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | | Y97 252 | 0.00 | | 0.00 |
| | J2250 | 13 | | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | | Y97 252 | 0.00 | | 0.00 |
| | J0690 | 13 | | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | | Y97 252 | 0.00 | | 0.00 |
| | J7120 | 13 | | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | | Y97 252 | 0.00 | | 0.00 |
| | J2795 | 13 | | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | | Y97 252 | 0.00 | | 0.00 |
| | J2405 | 13 | | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | | Y97 252 | 0.00 | | 0.00 |
| | J7642 | 13 | | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | | Y97 252 | 0.00 | | 0.00 |
| | J2710 | 13 | | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | | Y97 252 | 0.00 | | 0.00 |
| | 0710 | 13 | | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | | Y97 252 | 0.00 | | 0.00 |
| | 0710 | 13 | | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | | Y97 252 | 0.00 | | 0.00 |
| | TOTAL: | | | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | | | 0.00 | | 0.00 |
| INTEREST | | | | | | | | | | | | | 0.00 |
| | TOTAL NET PAID | | | | | | | | | | | | 0.00 |



SP. EXPL/ANSI CODE(S) F

NAME:
DATE:
PL CD:

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| EXPL CODES | EXPLANATION |
|---|---|
| PXN | Paid per your contract or Out Of Network rates |
| G18 | The submitted service is not allowed per your contract |
| INC | Included in per diem/case rate |
| G22 | Paid in accordance to the provider contracted rates or Out Of Network rates |
| G37 | The charges for this service have been combined into the primary procedure. |
| ER3 | Triage rate. Request PLP w/I 120 days @Anthem BCBS-Provider Disputes-PO Box 61599-Virginia Beach-VA-23466. See www.Anthem.com/INMedicaidDoc |
| M62 | ER visit approved after medical record review, paid at level billed |
| Y97 | Valid consent form required |
| ST | This service was not paid because the member's coverage was not in effect at the time of the service. |
| PPC | Exceeds the Ambulatory Payment Classification (APC) rate |
| 45 | CHARGE EXCEEDS FEE SCHEDULE/MAXIMUM ALLOWABLE OR CONTRACTED/LEGISLATED FEE ARRANGEMENT. USAGE: THIS ADJUSTMENT AMOUNT CANNOT EQUAL THE TOTAL SERVICE OR CLAIM CHARGE AMOUNT; AND MUST NOT DUPLICATE PROVIDER ADJUSTMENT AMOUNTS (PAYMENTS AND CONTRACTUAL REDUCTIONS) THAT HAVE RESULTED FROM PRIOR PAYER(S) ADJUDICATION. |
| 256 | SERVICE NOT PAYABLE PER MANAGED CARE CONTRACT. |
| 97 | THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/ PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT, IF PRESENT. |
| 94 | PROCESSED IN EXCESS OF CHARGES. |
| 252 | AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. |
| 27 | EXPENSES INCURRED AFTER COVERAGE TERMINATED. |

# Institutional claims – Top 5 Denials

1. Submitted after plan filing limit – TF0
2. EOB required from the primary carrier - CBP
3. Preauth not obtained – Y40
4. Billing NPI not registered with the state – Z33
5. Definite duplicate claim - CDD

# Submitted after plan filing limit – TF0

- In-Network Providers = 90 days from last date of service on the claim
- Out-of-Network Providers = 180 days from the last date of service on the claim
- Auto-denial
- Filing limit can be extended
  - Other primary insurance – 90 days from the date of the primary EOB
  - Member retroactive eligibility
  - Delay/error loading a prior authorization
  - Other administrative delay
- Submit dispute and include documentation that clearly identifies the reason for the filing delay

# EOB required from the primary carrier – CBP/ QA0

- Medicaid is the payer of last resort
- If the member has other insurance, the provider must submit the claim to the other payer prior to billing Anthem Medicaid.
- The member is responsible for notifying Anthem if a primary policy is updated or terminates
- Other payer information is available via Availity during eligibility verification process
- Anthem Medicaid coordinates payment, up to the provider's contract allowable. Any remaining amount is a contractual adjustment and cannot be billed to the member.

# EOB required from the primary carrier – CBP/ QA0 (cont.)

- Per IHCP Third Party Liability Module, page 14: “When a provider submits a claim to the IHCP for the difference between the amount billed and the primary insurer’s payment, the IHCP pays the difference, up to the IHCP allowable charge. If the primary insurer payment is equal to or greater than the IHCP-allowable charge, no payment is made by the IHCP. **Providers cannot bill members for any balance.**

# Prior Authorization not obtained – Y40

- Providers may use the Prior Authorization Look Up Tool (PLUTO) to determine if a service requires authorization - https://providers.anthem.com/indiana-provider/claims/prior-authorization-requirements/precertification-lookup
- This tool is for outpatient services only; all IP services require PA
- Routine, non-urgent requests must be received seven calendar days
- Urgent requests must be received within three calendar days
- Emergency admission requests must be received within 48 hours of admission

# Prior Authorization not obtained – Y40 (cont.)

- Claims denied for Y40 may be submitted as a dispute with documentation demonstrating medical necessity and explanation of failure to obtain authorization in the required time frame
- If authorization was requested but denied:
  - Reconsideration — within seven business days of denial date
  - P2P — within seven business days of a denial date (initial or reconsideration)
  - Appeals — within 60 calendar days of denial date

# Billing NPI not registered with the state – Z33

- Institutional Claim: Z33 refers to the provider NPI in field 56 of the UB-04/837I claim form
- Billing providers must be actively enrolled with the state to receive reimbursement from Anthem Medicaid
- There must be a one-to-one match between the data submitted on the claim and the State Assigned Provider ID file received from the state
  - NPI, taxonomy, zip+4 = 1 State Provider ID = Match
  - NPI, taxonomy, zip+4 = 2+ State Provider IDs = No Match, Z33 denial

# Definite duplicate claim - CDD

- Claim for the same member, same provider, same date of service, same services has already been processed
- To have claim reconsidered:
  - Submit corrected claim or
  - Submit claim dispute if correction is not applicable
  - Do not resubmit as a “new” claim
- Corrected claim will deny as a duplicate and corrections will be made to original claim

# Claims resolution process

## Follow-up guidelines

Use the Availity Portal to check claim status online. You can also call the appropriate helpline:

| Plan | Phone number |
|---|---|
| HIP | 844-533-1995 |
| Hoosier Care Connect | 844-284-1798 |
| Hoosier Healthwise | 866-408-6132 |

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:

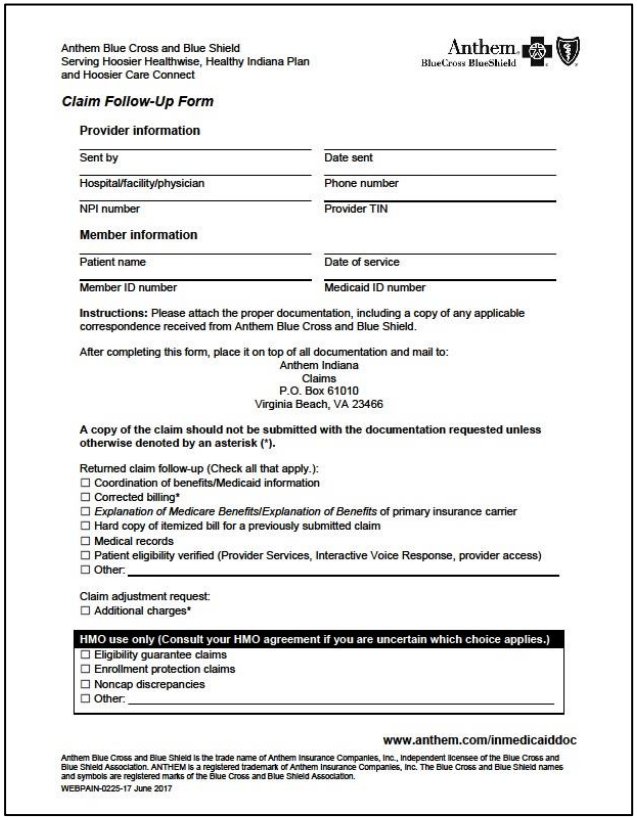
- Submit the corrected claim no later than 60 calendar days from the date of our letter or remittance advice (RA).
- Corrected claims can be submitted by paper, electronically through your clearinghouse or through the Availity Portal.

# Claims resolution process (cont.)

Send corrected paper 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 > Resources > Forms > Claims and Billing.



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**


WEBPAIN-0225-17 June 2017

# Claims resolution process (cont.)

**Claims dispute and appeal process**

The dispute process is if a provider disagrees with full or partial denial on the claim:

- There is a 60-calendar day limit from the date on the remittance advice (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.)

The claims dispute process is as follows:

1. **Claims reconsideration** — must be received within 60 calendar days from the date on the RA. Disputes can be done verbally through provider services, in writing or online through the Availity Portal. Submit a claims reconsideration if you disagree with full or partial claim rejection or denial, or the payment amount.
2. **Claim payment appeal** — if you are not satisfied with the reconsideration, you may submit a claim payment appeal. We must receive this appeal within 60 calendar days from the date of the claim reconsideration. This can be done via the Availity Portal or by mail.

# Important contact information

# Important contact information

**Provider Services:**

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

**Member Services and 24/7 NurseLine:**

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

# Important contact information (cont.)

**PA requests:**

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

# Provider Experience Physical Health Zone Map

## Physical health Provider Experience managers

**Zone 1/Beacon Health Systems**

Jessi Earls
Jessica.Wilkerson-Earls@anthem.com
317-452-2568

**Zone 2/Ascension St. Vincent**

Angelique Jones
Angelique.Jones@anthem.com
317-619-9241

**Zone 3**

Jamaal Wade
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317-409-7209

**Zone 4/Deaconess**

Jonathan Hedrick
Jonathan.Hedrick@anthem.com
317-601-9474

**Zone 5/Parkview**

David Tudor
David.Tudor@anthem.com
317-447-7008

**Zone 6/IU Health; St. Joseph Regional Medical Health Center; Home Health and Hospice**

Matt Swingendorf
Matthew.Swingendorf@anthem.com
317-306-0077

**Zone 7/Baptist Health**

Sophia Brown
Sophia.Brown@anthem.com
317-775-9528

**Zone 8/Eskenazi**

Marvin Davis
Marvin.Davis@anthem.com
317-501-7251

**Zone 9/Out-of-state providers, Franciscan, Community Health Network**

Nicole Bouye
Nicole.Bouye@anthem.com
317-517-8862


**Dir, Provider Experience**
Jacquie Marsalis
Jacqueline.Marsalis@anthem.com

https://providers.anthem.com/docs/gpp/IN_CAID_PU_NetworkRelationsMap.pdf?v=202110061311

# Provider Experience behavioral health subject matter experts

## Statewide behavioral health (BH) subject matter experts (SME)

**Acute hospitals**
Tish Jones, Provider Experience Manager
Latisha.Willoughby@anthem.com
317-617-9481

**Community mental health centers/federally qualified health centers/rural health clinics**
Matthew McGarry, Provider Experience Manager
Matthew.McGarry@anthem.com
463-202-3579

**Substance use disorder (SUD)/Opioid treatment program (OTP)**
Alisa Phillips, Provider Experience Manager, Sr.
Alisa.Phillips@anthem.com
317-517-1008

**SME – SUD/OTP**
Michele Weaver, Provider Experience Manager
Michele.Weaver@anthem.com
317-601-3031

## Solo BH and applied behavior analysis providers

**Zones 1, 2, 5, 6**
Ashley Holmes
Ashley.Holmes@anthem.com
317-315-0623

**Zones 3, 4, 7, 8**
Whit'ney McTush
Whitney.McTush@anthem.com
317-519-1089

# Questions?

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


Serving Hoosier Healthwise, Healthy Indiana Plan
and Hoosier Care Connect

* Availity, LLC is an independent company providing administrative support services on behalf of Anthem Blue Cross and Blue Shield.

**https://providers.anthem.com/in**



Providers who are contracted with Anthem Blue Cross and Blue Shield to serve Hoosier Healthwise, Healthy Indiana Plan and Hoosier Care Connect through an accountable care organization (ACO), participating medical group (PMG) or Independent Physician Association (IPA) are to follow guidelines and practices of the group. This includes but is not limited to authorization, covered benefits and services, and claims submittal. If you have questions, please contact your group administrator or your Anthem network representative.

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