Anthem

Claims update and dispute process

2023 Indiana Health Coverage Programs (IHCP) works seminar

Agenda

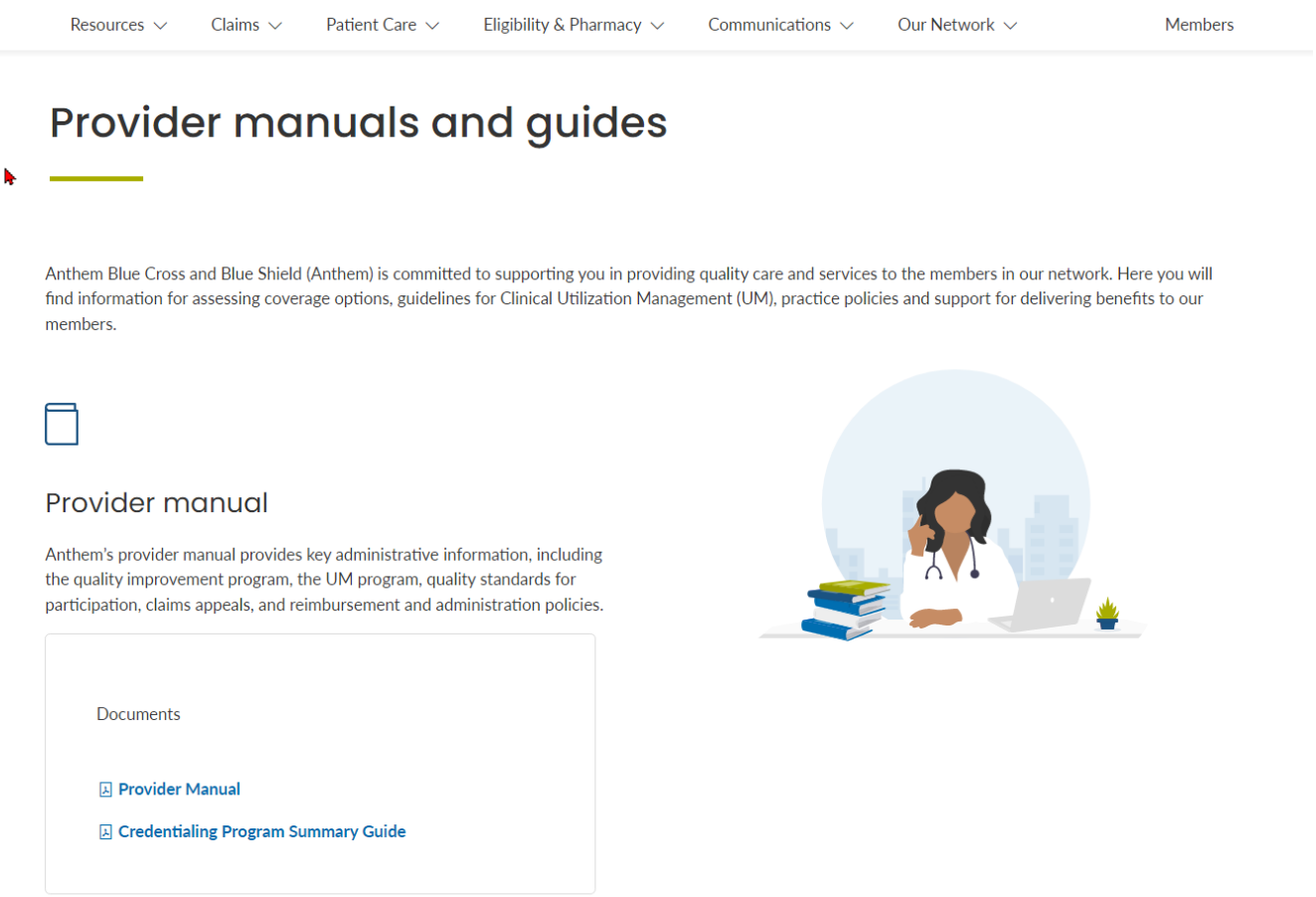
- Acronyms
- Provider manual
- Eligibility
- Managed care model
- Prior authorization (PA)
- Claims
- Dispute process
- Contact information

Acronyms

- **COB** — Coordination of Benefits
- **EDI** — Electronic Data Interchange
- **IHCP** — Indiana Health Coverage Programs
- **MCE** — Managed Care Entity
- **MID** – Member Identification Number
- **PMP** — Primary Medical Provider
- **RCP** — Right Choices Program
- **UM** — Utilization Management

Provider manual

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



Eligibility

Eligibility

Always verify a member's eligibility prior to rendering services. Anthem Blue Cross and Blue Shield (Anthem) recommends a two-step verification process.

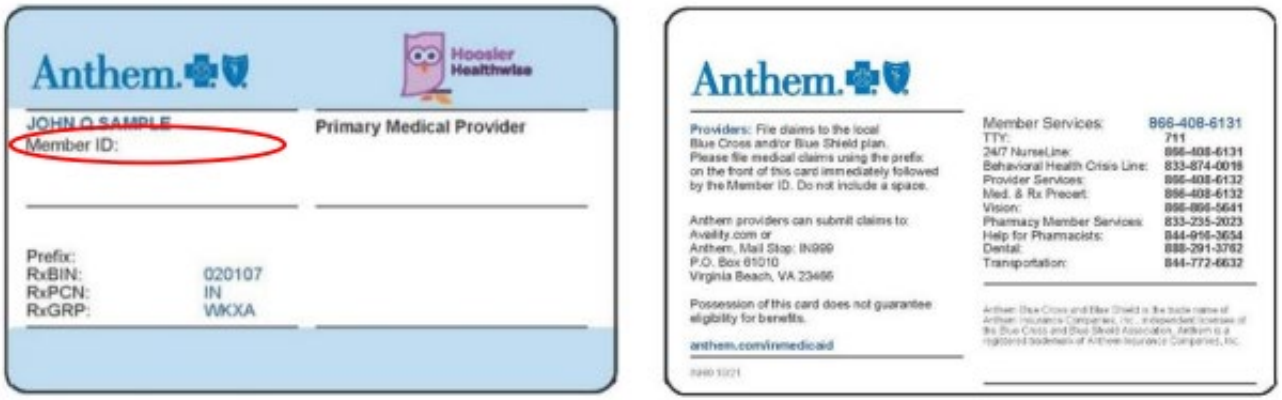
Providers can access this information by visiting:

- IHCP Provider healthcare portal: Use to verify eligibility, assigned Managed Care Entity (MCE), and Medicaid product
- Availity Essentials: use for PMP verification, benefit limitations, COB, and much more

Eligibility (cont.)

Hoosier Healthwise:

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

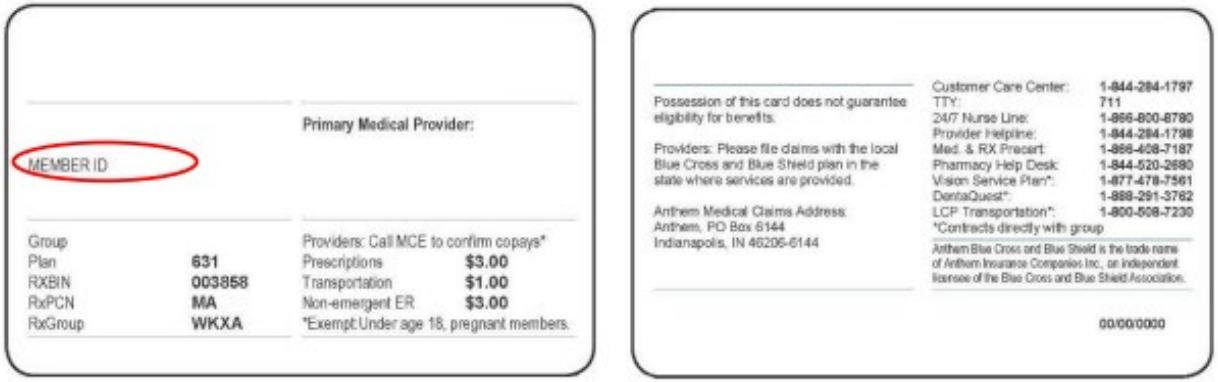


- **It is no longer required to include the YRH prefix before the MID.**

Eligibility (cont.)

Hoosier Care Connect:

- Anthem assigns the YRH prefix with the Member ID.

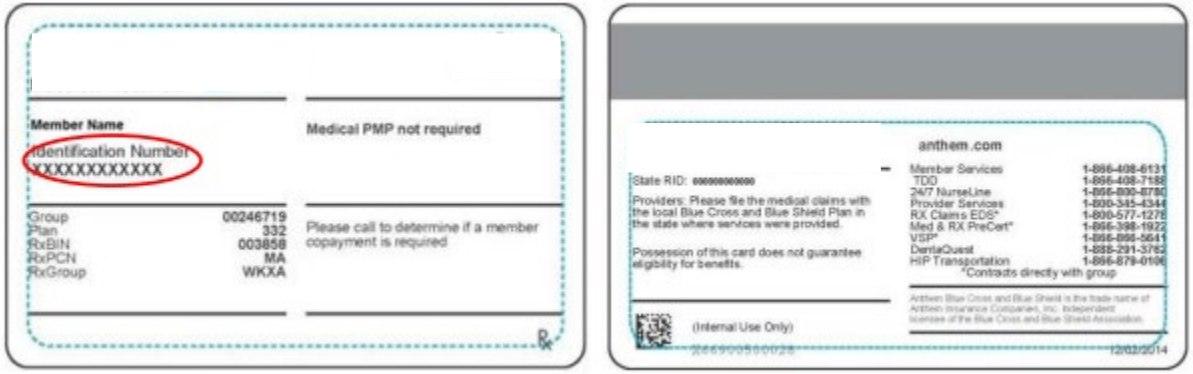


- **It is no longer required to include the YRH prefix before the MID.**

Eligibility (cont.)

Healthy Indiana Plan (HIP):

- Anthem assigns the YRK prefix with the member ID.



- **It is no longer required to include the YRK prefix before the MID.**

Right Choices Program (RCP)

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

RCP (cont.)

- Members enrolled in 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 pages 65 to 68 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.**

Managed Care Model (Assigned PMP)

Managed Care Model (Assigned PMP)

All members must see their assigned PMP. Please view the Availity PMP assignments.

Specialty providers must have a referral from the PMP:

- Include the individual (type one) national provider identifier (NPI) of the member's assigned referring PMP when you submit the *CMS-1500* claim form or electronic data interchange (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 non-contracted provider, you need to obtain prior authorization (PA) from Anthem before you provide services to our members.

Note: Out-of-network behavioral health and routine dental services do not require PA.

Managed Care Model (Assigned PMP) (cont.)

Exceptions to this policy include:

- Self-referrals. Members may self-refer for certain services provided by an IHCP-enrolled provider:
  - **Note:** Refer to the provider manual for a listing of self-referral services.
- A PMP not yet assigned to the member.
- A provider in the same provider group, with the same tax ID, or group NPI as the referring physician (and is an approved provider type).
- Emergency services (services performed in place of service 23).
- Family planning services.

Managed Care Model (Assigned PMP) (cont.)

Exceptions to this policy include (cont.):

- Services provided after hours (codes 99050 – Services provided in the office at times other than regularly scheduled office hours, or days when the office is normally closed and 99051 – Service(s) provided in the office during the regularly scheduled evening, weekend, or holiday office hours).
- Diagnostic specialties (such as lab and X-Ray services).
- The billing or referring physician is an Indian health provider or is providing services at a federally qualified health center (FQHC) or urgent care center.

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.

All authorization requests can be submitted via the **Availity** Authorization Tool.

Claims

Initial claim submission

For participating providers, the claim filing limit is 90 calendar days from the date of service.

Claim submission methods:

- Electronically via electronic data interchange (EDI) - Preferred
- Availity
- 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 claims.

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:

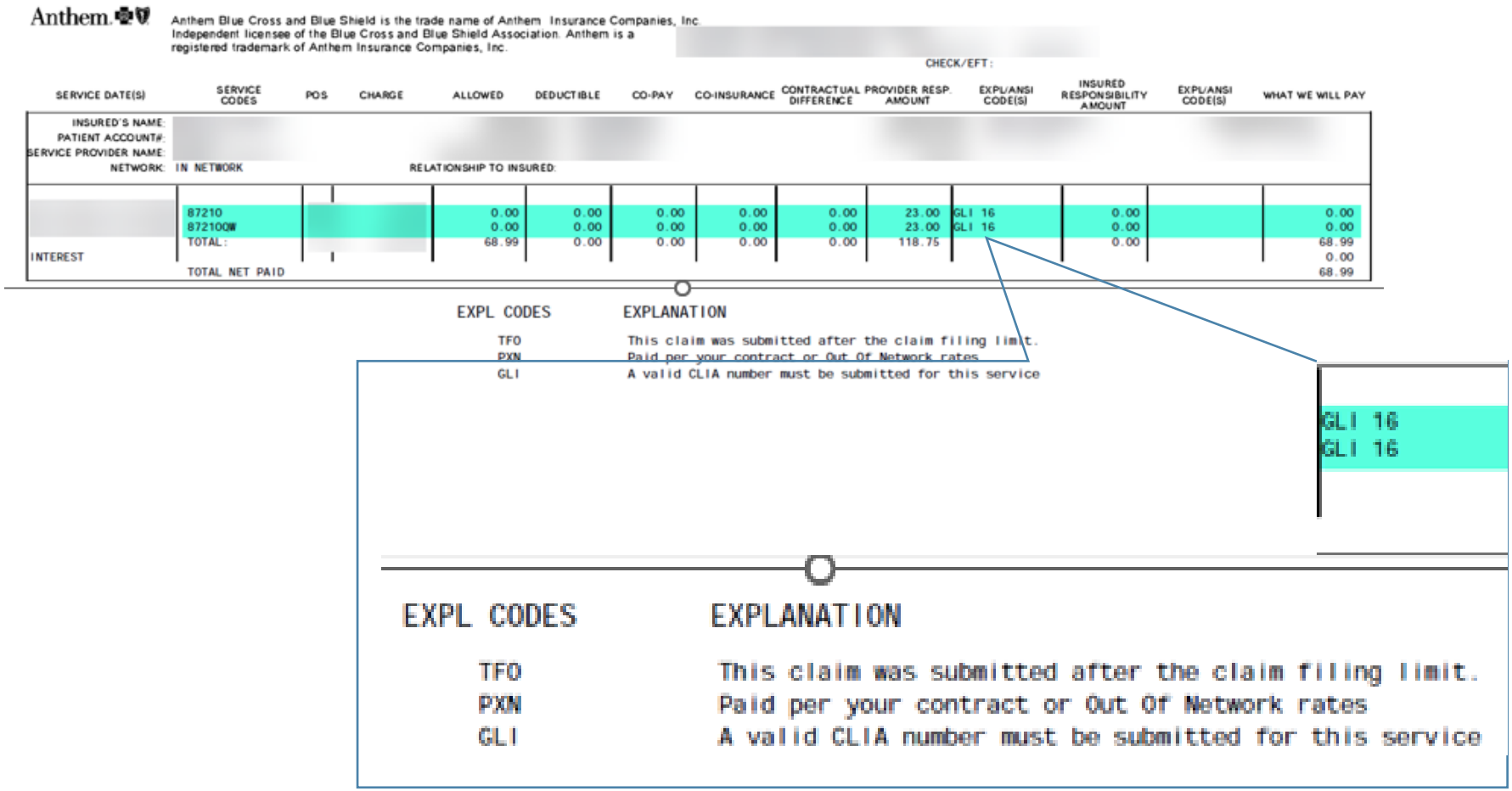
- Claims must be filed to Anthem within 90 days of the date on the primary *Explanation of Payment (EOP)*.

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

- **Example one:** Primary pays $45 for a 99213 and you bill Medicaid as secondary. The Medicaid fee schedule is $31.96. No additional reimbursement would be made.
- **Example two:** 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; this will assist in the HEDIS® data review.

Identifying denials on the *EOP*



Anthem

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Independent licensee of the Blue Cross and Blue Shield Association. Anthem is a
registered trademark of Anthem Insurance Companies, Inc.

CHECK/EFT:

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:													
PATIENT ACCOUNT#:													
SERVICE PROVIDER NAME:													
NETWORK: IN NETWORK			RELATIONSHIP TO INSURED:										
	87210			0.00	0.00	0.00	0.00	0.00	23.00	GLI 16	0.00		0.00
	87210QW			0.00	0.00	0.00	0.00	0.00	23.00	GLI 16	0.00		0.00
	TOTAL:			68.99	0.00	0.00	0.00	0.00	118.75		0.00		68.99
INTEREST													0.00
	TOTAL NET PAID												68.99

EXPL CODES	EXPLANATION
TFO	This claim was submitted after the claim filing limit.
PXN	Paid per your contract or Out Of Network rates
GLI	A valid CLIA number must be submitted for this service

GLI 16
GLI 16

EXPL CODES	EXPLANATION
TFO	This claim was submitted after the claim filing limit.
PXN	Paid per your contract or Out Of Network rates
GLI	A valid CLIA number must be submitted for this service

Identifying denials on the *EOP* (cont.)

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

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.

SP. EXPL/ANSI CODE(S) F

NAME:

DATE:

PL CD:

Y97 252
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Top five denials

Professional claims:

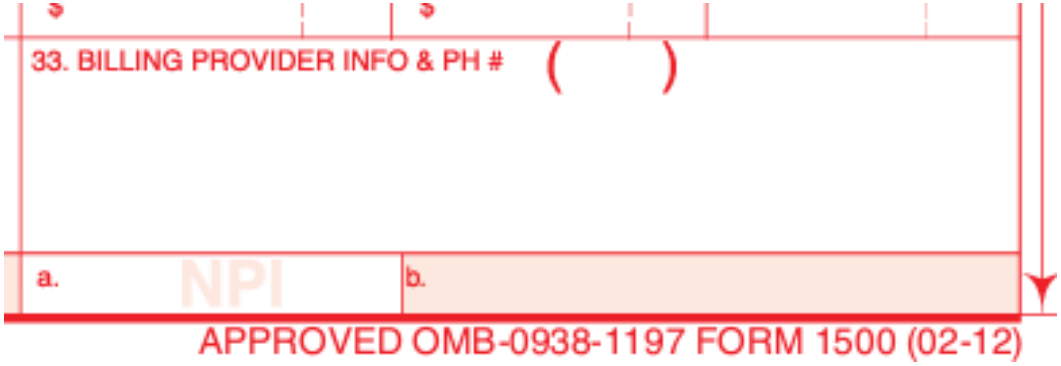
- Billing NPI not registered with the state – Z33
- Submitted after plan filing limit – TF0
- Deny – prior auth not obtained – Y40
- *EOB* required from the primary carrier – QA0
- Rendering NPI not registered with the state – Z34

Institutional claims:

- Submitted after plan filing limit – TF0
- EOB required from the primary carrier - CBP
- Prior Authorization not obtained – Y40
- Billing NPI not registered with the state – Z33
- Definite duplicate claim - CDD

Billing NPI not registered with the state – Z33 – Professional claim

- Z33 refers to the provider NPI in field 33a of the *CMS-1500*/837P claim form.
- Billing providers must be actively enrolled with the state to receive reimbursement from Anthem.
- 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



Claims resolution process

Follow-up guidelines

Use the Availity Essentials 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:

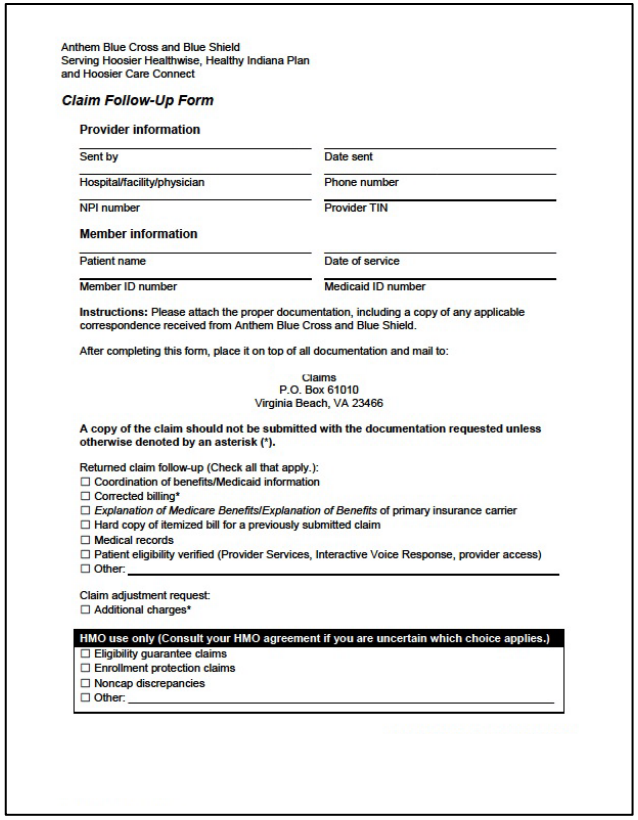
- Submit the corrected claim no later than 60 calendar days from the date of our letter or remittance advice (RA).
- Corrected claims can be submitted by paper, electronically through your clearinghouse, or through the Availity Essentials.

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 https://providers.anthem.com/indiana-provider/home > Resources > Forms > Claims and Billing.



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

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:

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: _____

Claims resolution process (cont.)

Claims dispute and appeal process

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

- There is a 60-calendar day filing 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.)

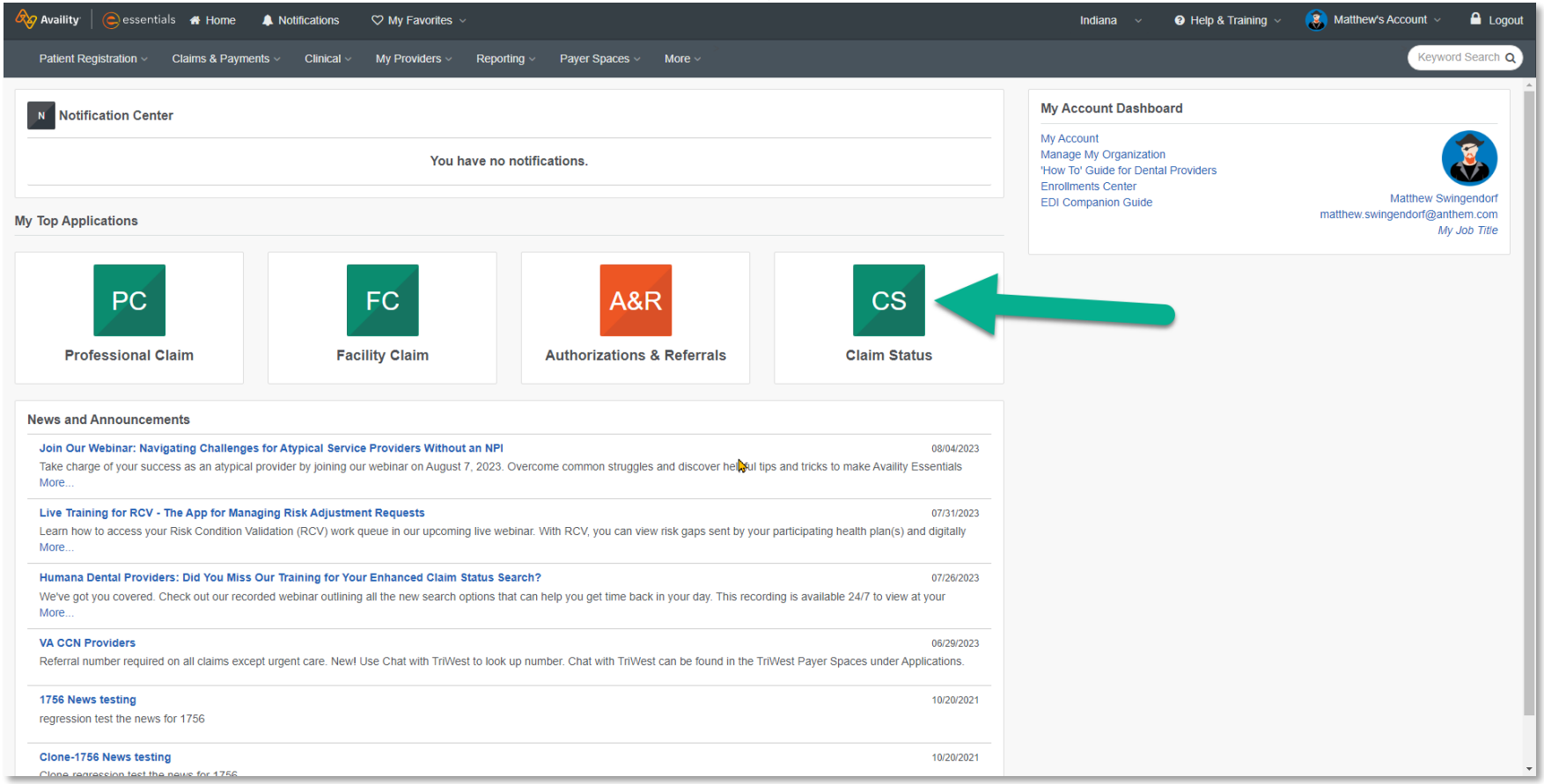
The claims dispute process is as follows:

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 Essentials. 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 Essentials or by mail.

Filing a dispute in Availity

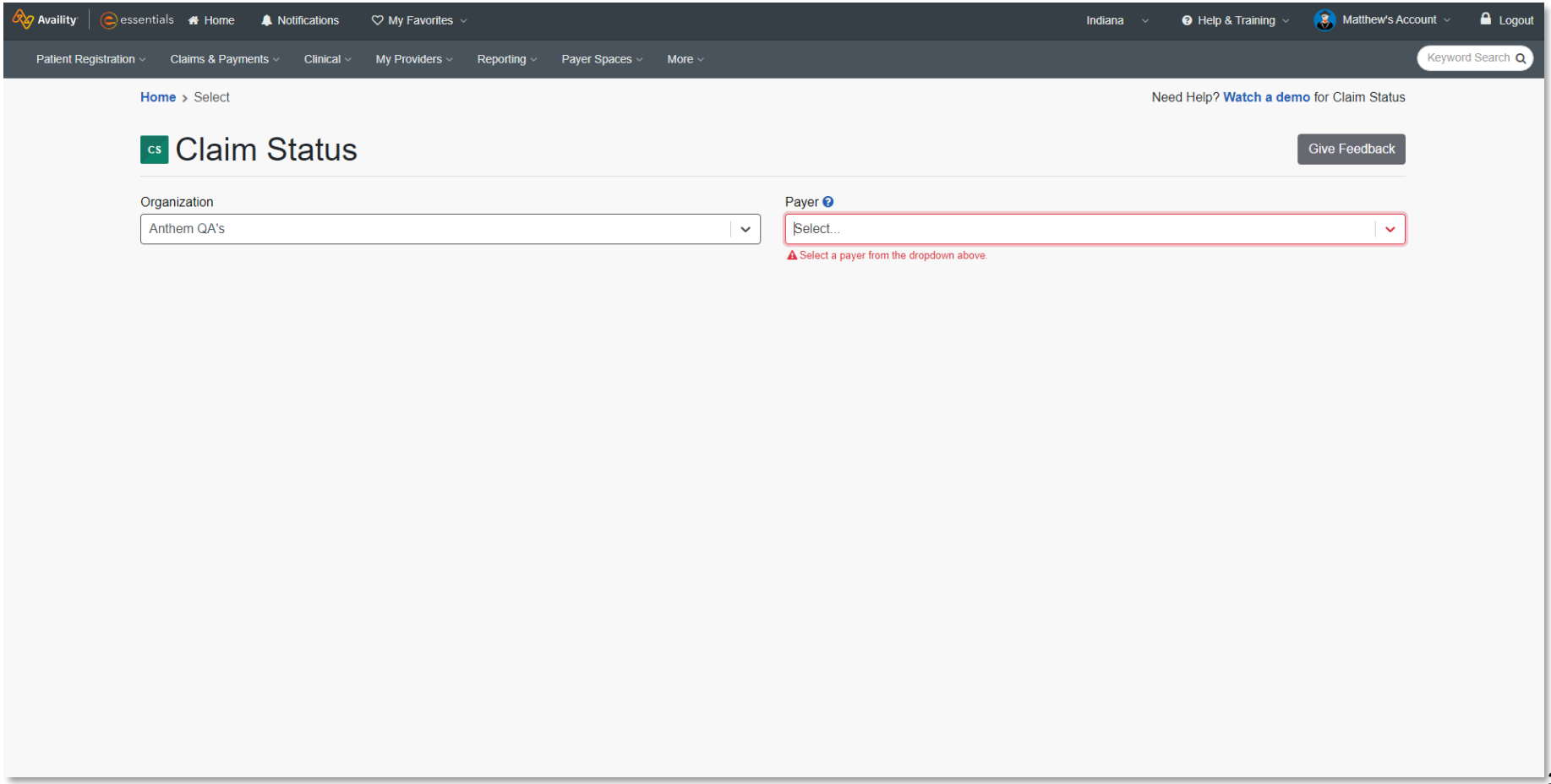
Claims disputes in Availity

- Login and select **Claim Status** on your Dashboard.



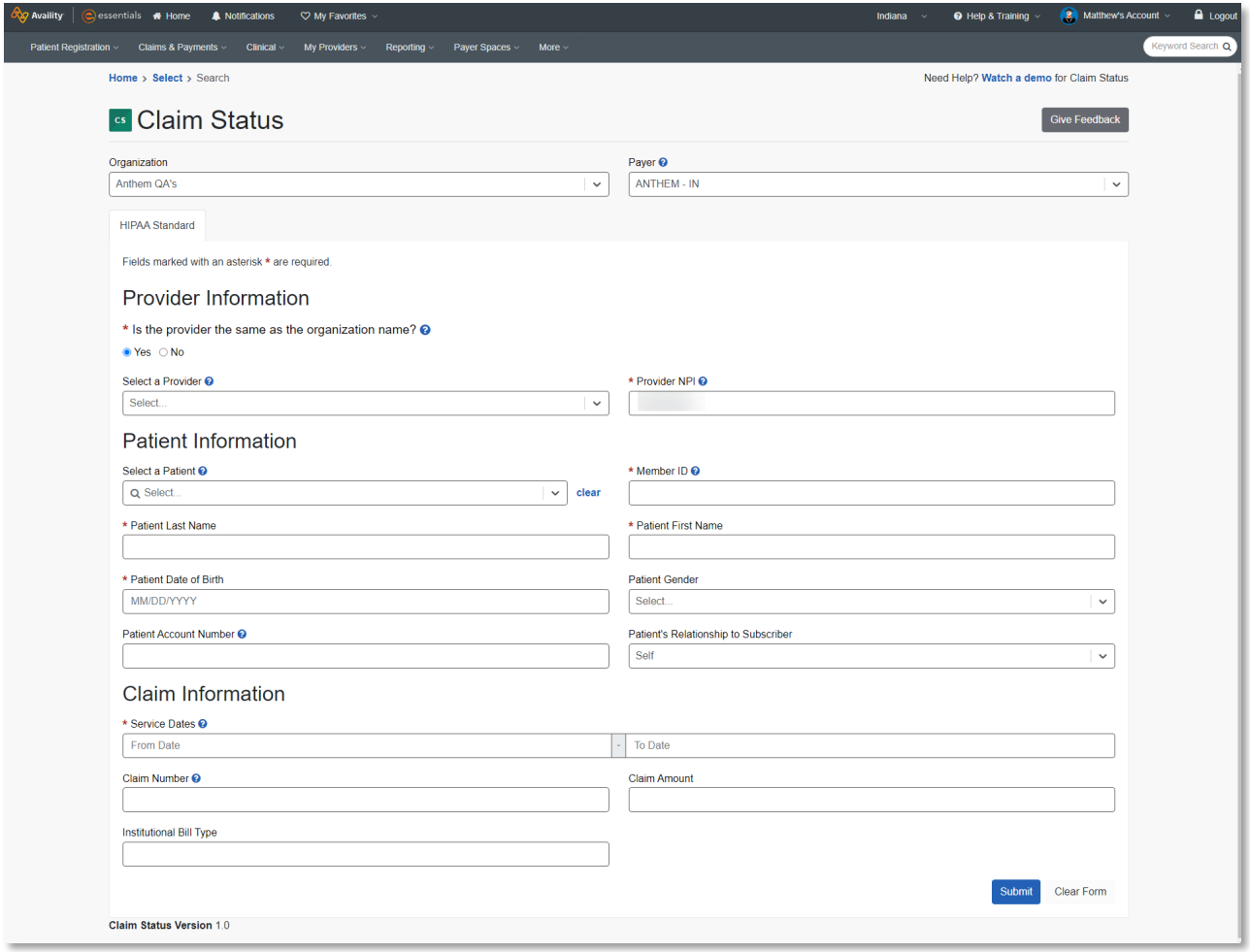
Claims disputes in Availity (cont.)

- Select your **Organization** and **Payer**.



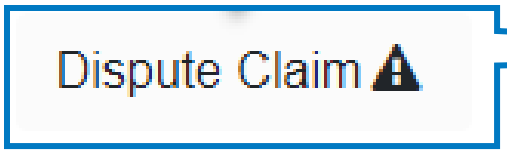
Claims disputes in Availity (cont.)

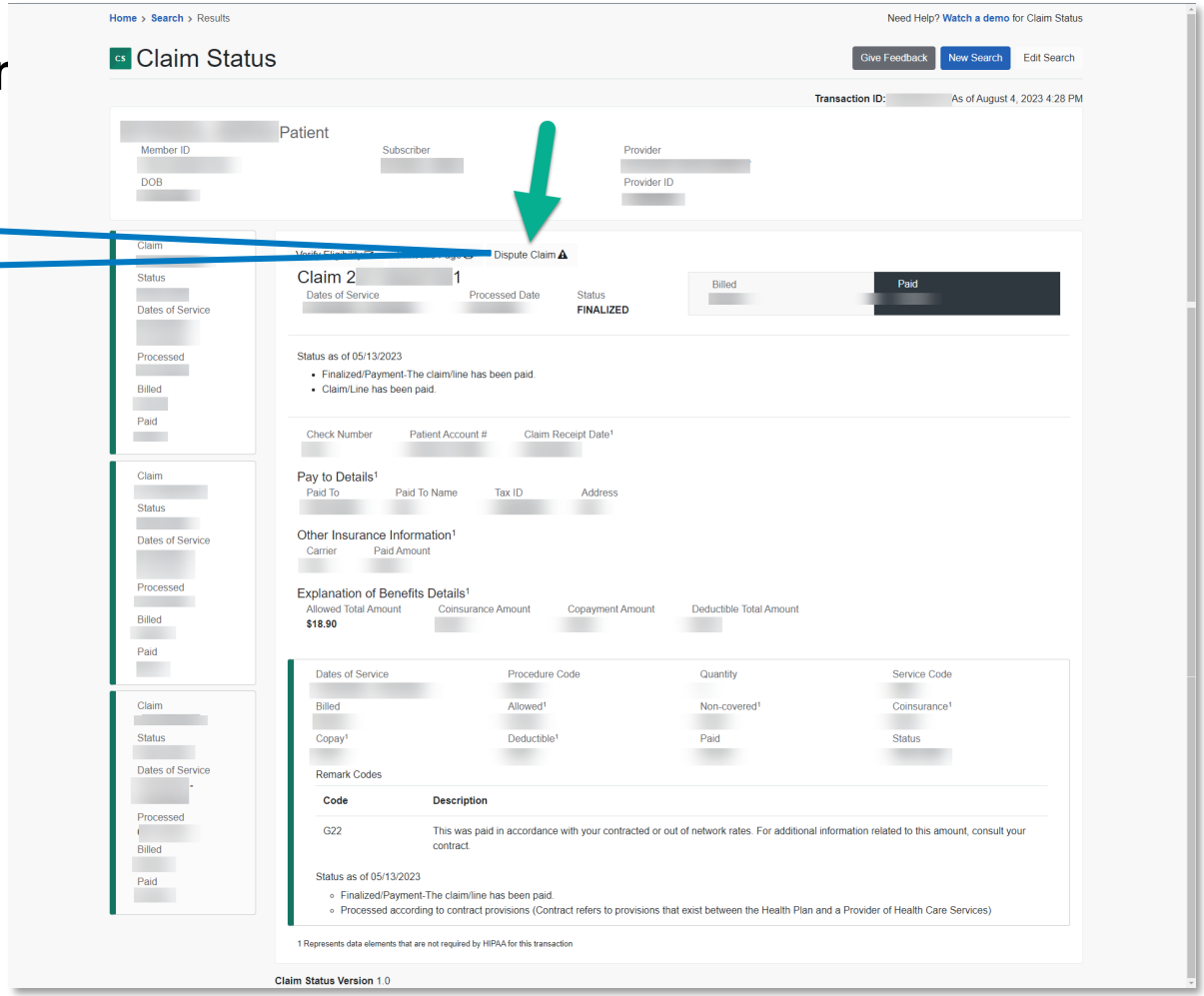
- Fill out the required information as indicated by a red asterisk(*).



Claims disputes in Availity (cont.)

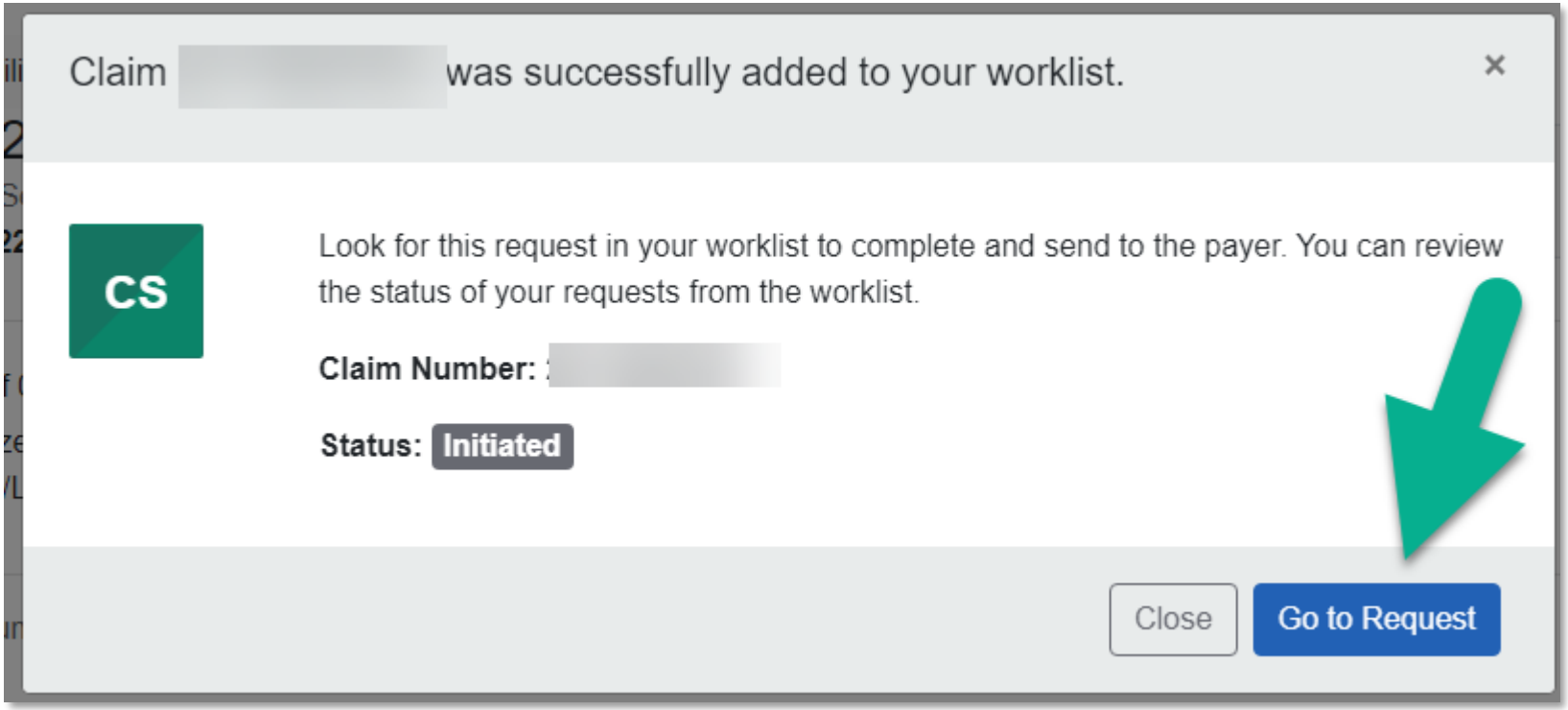
- Select the **Dispute Clair**





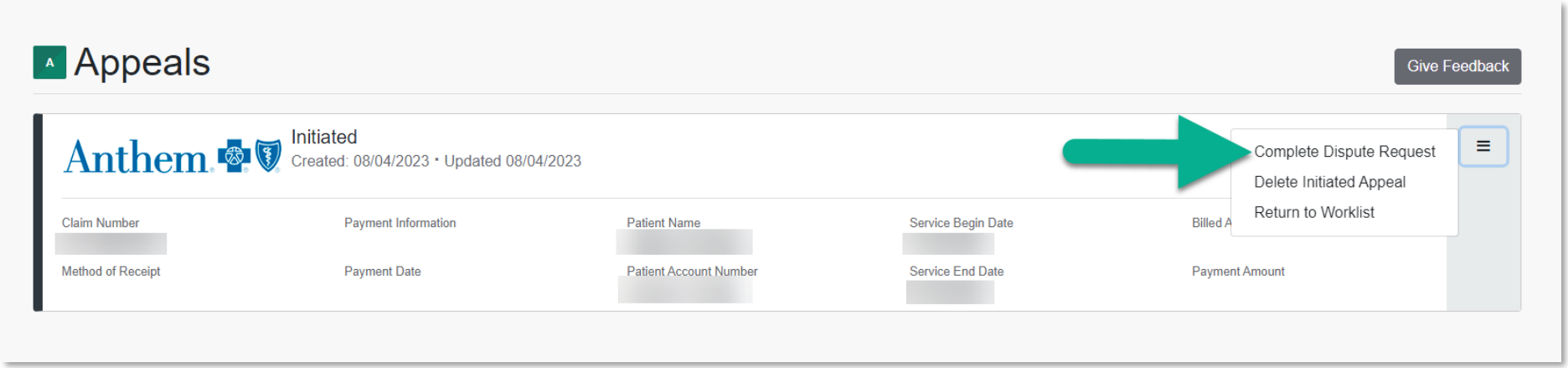
Claims Disputes in Availity (cont.)

- The claim will go to your Worklist. You can add more claims and then select **Go to Request**.



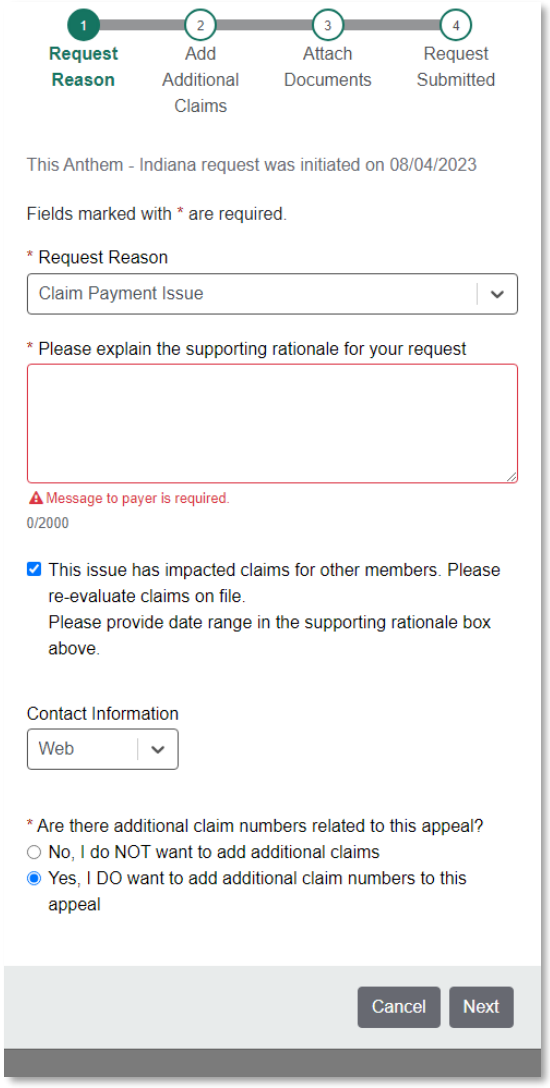
Claims Disputes in Availity (cont.)

- The claim will be in your worklist and show Initiated. Select the three lines and then select **Complete Dispute Request**.

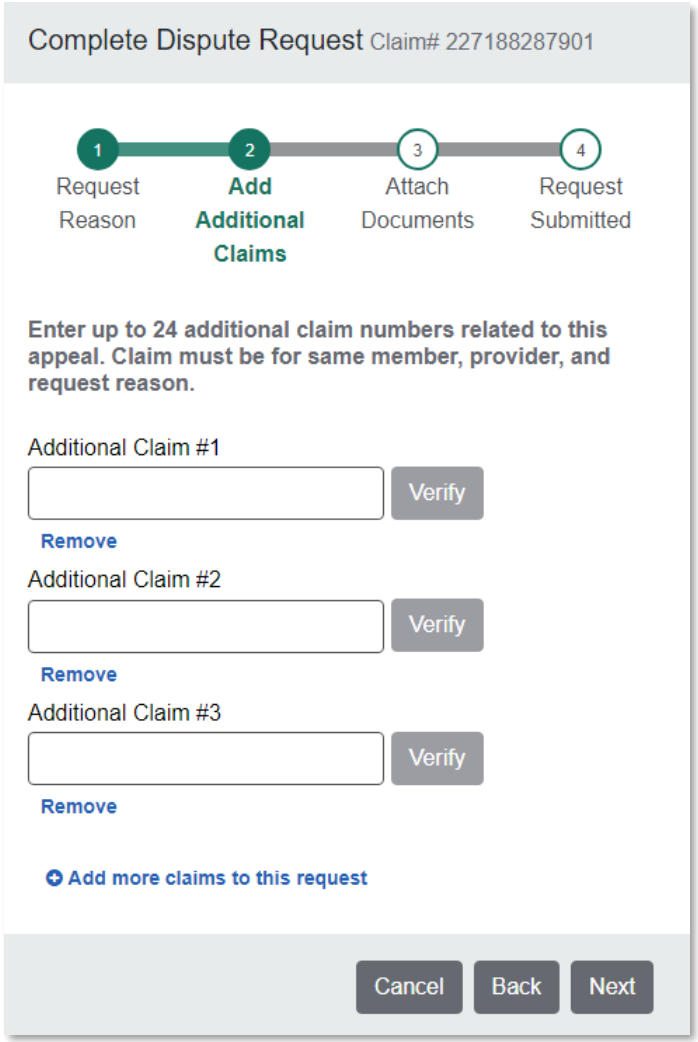


Claims Disputes in Availity (cont.)

- Select **Request Reason.**
- Explain your supporting rationale.
- Select if the issue has impacted claims for other members.
- Select how you want to be contacted.
- Select if there are additional claims numbers for the appeal.
- Select **Next.**

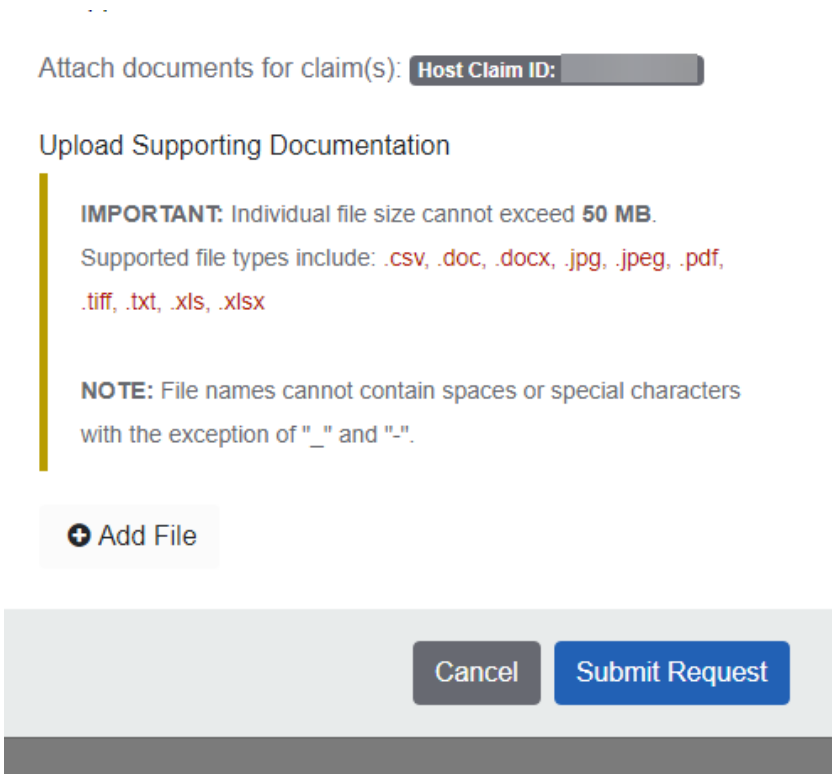


Claims Disputes in Availity (cont.)



- If you said yes to adding additional claim numbers, you would do that here.

Claims Disputes in Availity (cont.)



- Finally, you have the option to upload your supporting documentation:
  - Select: **Add File** to upload your supporting documentation.
- Select **Submit Request** to complete your dispute.

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 Relationship Account Management physical health zone map

Physical health Provider Relationship Account Managers

Zone 1/Beacon Health Systems, St. Joseph Regional Medical Center

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

Zone 2

Whit'ney McTush
Whitney.McTush@anthem.com
317-519-1089

Zone 3/Lutheran

Ashley Holmes
Ashley.Holmes@anthem.com
317-315-0623

Zone 4

Jamaal Wade
Jamaal.WadeSr@anthem.com
317-409-7209

Zone 5/Eskenazi, Home Health and Hospice, Skilled Nursing Facilities

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

Zone 6

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

Zone 7/Baptist Health, Cincinnati Children's Hospital Medical Center, Norton Healthcare

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

Zone 8/Out-of-state providers

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

Indiana University Health, Parkview Regional Health, Ascension	Community Health Network, Franciscan Health, Deaconess
David Tudor David.Tudor@anthem.com **317-447-7008**	Nicole Bouye Nicole.Bouye@anthem.com **317-517-8862**

Director, Provider Relationship Account Management

Jacquie Marsalis
Jacqueline.Marsalis@anthem.com
317-431-2439

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

Provider Relationship Account management behavioral health subject matter experts

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

Acute care hospitals
Tish Jones, Provider Relationship Account Manager
Latisha.Willoughby@anthem.com
317-617-9481

Community mental health centers/Federally qualified health centers/Rural health clinics
Matthew McGarry, Provider Relationship Account Manager
Matthew.McGarry@anthem.com
463-202-3579

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

Michele Weaver, Provider Relationship Account Manager
Michele.Weaver@anthem.com
317-601-3031

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.

INBCBS-CD-040229-23 October 2023