



End-to-end process for filing a *CMS-1500* *Professional Claim*

2022 Indiana Health Coverage
Programs (IHCP) works seminar



Agenda

- Acronyms
- Provider manual
- Eligibility
- Managed care model
- 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>

Resources ▾

Claims ▾

Patient Care ▾

Eligibility & Pharmacy ▾

Communications ▾

Our Network ▾

Members

Provider manuals and guides

Anthem Blue Cross and Blue Shield (Anthem) is committed to supporting you in providing quality care and services to the members in our network. Here you will find information for assessing coverage options, guidelines for Clinical Utilization Management (UM), practice policies and support for delivering benefits to our members.



Provider manual

Anthem's provider manual provides key administrative information, including the quality improvement program, the UM program, quality standards for participation, claims appeals, and reimbursement and administration policies.

Documents

[Provider Manual](#)

[Credentialing Program Summary Guide](#)



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. After IHCP uploads the information, the provider will submit the information to Anthem using the Digital Provider Enrollment (DPE) tool via Availity* to enroll new providers. When Anthem receives the DPE application, we will verify the information submitted on both the application and the provider healthcare website.

Or submit any demographic changes through the [Provider Maintenance Form](#).

Provider file updates and changes (cont.)

Our 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 (PE) 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 PMP verification, benefit limitations, COB the Anthem member ID (if needed), and much more

Eligibility (cont.)

Hoosier Healthwise:

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

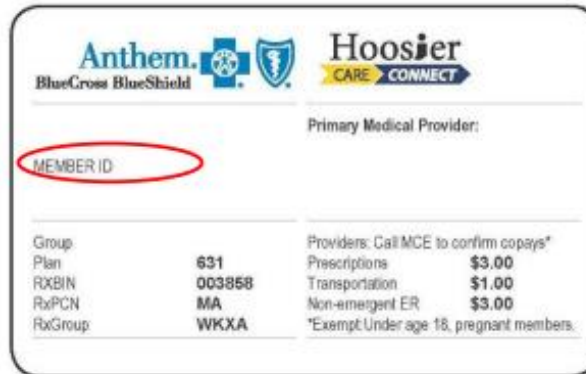


- *Effective January 1, 2023, when filing claims and inquiries, it will no longer be required to include the YRH prefix before the MID.*

Eligibility (cont.)

Hoosier Care Connect:

- Anthem assigns the YRH prefix.



Anthem BlueCross BlueShield logo and Hoosier CARE CONNECT logo.

Primary Medical Provider:

MEMBER ID

Group		Providers: Call MCE to confirm copays*
Plan	631	Prescriptions \$3.00
RxBIN	003858	Transportation \$1.00
RxPCN	MA	Non-emergent ER \$3.00
RxGroup	WKXA	*Exempt: Under age 18, pregnant members.



Anthem BlueCross BlueShield logo.

Possession of this card does not guarantee eligibility for benefits.

Providers: Please file claims with the local Blue Cross and Blue Shield plan in the state where services are provided.

Anthem Medical Claims Address:
Anthem, PO Box 6144
Indianapolis, IN 46206-6144

Customer Care Center:	1-844-284-1797
TTY:	711
24/7 Nurse Line:	1-866-800-8780
Provider Helpline:	1-844-284-1798
Med. & RX Precart:	1-866-468-7187
Pharmacy Help Desk:	1-844-520-2880
Vision Service Plan:	1-877-478-7561
DentaQuest:	1-888-291-3762
LCP Transportation:	1-800-568-7230

*Contracts directly with group.

Anthem Blue Cross and Blue Shield is the trade name of Anthem Insurance Companies Inc., an independent licensee of the Blue Cross and Blue Shield Association.

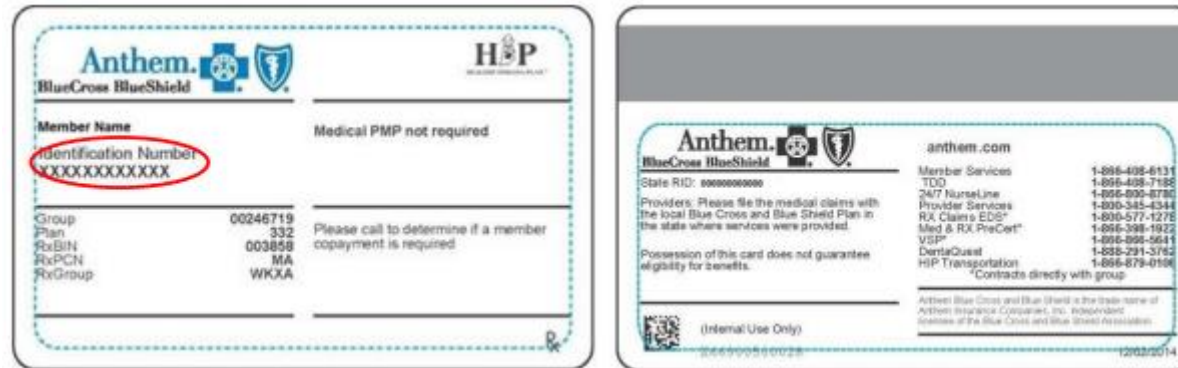
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- *Effective January 1, 2023, when filing claims and inquiries, it will no longer be required to include the YRH prefix before the MID.*

Eligibility (cont.)

Healthy Indiana Plan (HIP):

- Anthem assigns the YRK prefix with the member ID.



- *Effective January 1, 2023, when filing claims and inquiries, it will no longer be required to include the YRK 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 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 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.**



**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 (PLUTO)

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 the *Availity Authorization Tool*, or 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.

- If 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 observations 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 seven days of notification of an adverse determination:

- Upon request for P2P 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 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 the following numbers:

	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 claims.

Claim Submissions

Using Availity to file a professional claim



Log on to Availity

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

The screenshot displays the Availity user dashboard. At the top, the navigation bar includes the Availity logo, Home, Notifications, My Favorites, and user-specific options like 'Indiana', 'Help & Training', 'Matthew's Account', and 'Logout'. A secondary navigation bar lists 'Patient Registration', 'Claims & Payments', 'My Providers', 'Reporting', 'Payer Spaces', and 'More'. A search bar is located on the right side of the navigation bar.

The main content area features a large banner for the 'COVID-19 Resource Center' with an image of hands being washed. Below this is a 'Notification Center' which shows 'You have no notifications.'.

The 'My Top Applications' section contains four tiles: 'EB Eligibility and Benefits Inquiry', 'PC Professional Claim', 'FC Facility Claim', and 'CS Claim Status'.

The 'News and Announcements' section includes a tip titled 'Do You Have Groundhog Day Syndrome? Try this Time Saving Tip' dated 02/02/2021.

On the right side, the 'My Account Dashboard' shows the user's profile for Matthew Swingendorf, with links for 'My Account', 'My Administrators', 'Manage My Organization', 'How To Guide for Dental Providers', 'Enrollments Center', and 'EDI Companion Guide'. Below this is a carousel slide titled 'Do You Have Out-of-Area Blue Plan Members?' with a 'LEARN MORE' button.

At the bottom left, the URL 'https://qa-apps.availity.com/public/apps/dashboard' is visible, and at the bottom right, the text 'et to Working with the Availity Portal' and the date '02/02/2021' are present.

Filing a claim

Select the drop-down **Claims & Payments** and select **Professional Claim**.

The screenshot displays the Avallity web application interface. At the top, the navigation bar includes 'Avallity', 'Home', 'Notifications', 'My Favorites', 'Indiana', 'Help & Training', 'Matthew's Account', and 'Logout'. Below this, a secondary navigation bar contains 'Patient Registration', 'Claims & Payments', 'My Providers', 'Reporting', 'Payer Spaces', and 'More'. A red arrow points to the 'Claims & Payments' dropdown menu, which is open. Inside this menu, the 'Professional Claim' option is highlighted with a red rectangular box. Other options in the menu include 'Claim Status & Payments' (with sub-items: CS Claim Status, RV Remittance Viewer, OP Overpayments, A Appeals), 'EDI Clearinghouse' (with sub-items: TE Transaction Enrollment, CG EDI Companion Guide, Payer List), 'FC Facility Claim', and 'DA Dental Attachments'. Below the navigation, the 'Notification Center' shows 'You have no notifications.' The 'My Top Applications' section features four tiles: 'EB Eligibility and Benefits Inquiry', 'PC Professional Claim', 'FC Facility Claim', and 'CS Claim Status'. The 'News and Announcements' section at the bottom contains a post titled 'Do You Have Groundhog Day Syndrome? Try this Time Saving Tip' dated 02/02/2021. On the right side of the dashboard, the 'My Account Dashboard' shows the user's name 'Matthew Swingendorf' and email 'matthew.swingendorf@anthem.com'. Below this is a promotional banner for 'Aetna Providers: Did you know ... You can submit your Aetna appeals on Avallity?' with a 'Show me how' button and the Aetna logo.

Filing a claim (cont.)

Select your *organization*.

The screenshot shows the Avallity web interface for filing a Professional Claim. The top navigation bar includes the Avallity logo, Home, Notifications, My Favorites, and user account information (Indiana, Help & Training, Matthew's Account, Logout). A secondary navigation bar contains Patient Registration, Claims & Payments, My Providers, Reporting, Payer Spaces, and More. A search bar is located on the right. The main content area is titled 'Professional Claim' with a 'Give Feedback' button. Below the title, an information icon and text prompt the user to confirm their organization and payer. A dropdown menu labeled 'Organization' with 'Select...' is provided, followed by a 'Continue' button.

Filing a claim (cont.)

Select your *transaction type* (professional claim).

The screenshot shows the Avallity web application interface for filing a Professional Claim. The top navigation bar includes the Avallity logo, Home, Notifications, My Favorites, and user account information for Matthew's Account. A secondary navigation bar contains links for Patient Registration, Claims & Payments, My Providers, Reporting, Payer Spaces, and More. A search bar is located on the right side of the navigation bar. The main content area is titled "Professional Claim" and includes a "Give Feedback" button. Below the title, there is an information icon and a prompt: "Confirm which organization and payer you would like to submit claims for." Two dropdown menus are present: "Organization" with "Anthem QA's" selected, and "Transaction" with "Select..." selected. A "Continue" button is located below the dropdown menus.

Filing a claim (cont.)

Select the *payer* and then **Continue**.

The screenshot shows the Avility web application interface for filing a Professional Claim. The top navigation bar includes the Avility logo, Home, Notifications, My Favorites, and user account information (Indiana, Help & Training, Matthew's Account, Logout). A secondary navigation bar contains Patient Registration, Claims & Payments, My Providers, Reporting, Payer Spaces, and More. A search bar is located on the right side of the navigation bar.

The main content area displays the breadcrumb "Home > Professional Claim" and the title "Professional Claim" with a "Give Feedback" button. Below the title, there is an instruction: "Confirm which organization and payer you would like to submit claims for." The form consists of three dropdown menus:

- Organization: Anthem QA's
- Transaction: Professional Claim
- Payer: ANTHEM - IN


A red arrow points to the "Continue" button located below the Payer dropdown menu.

Claim form (cont.)

- Select **Responsibility Sequence**:
 - Primary
 - Secondary
 - Tertiary
- Fill in the *patient information* section:
 - All fields with the red asterisk (*) are required fields.


Home > Select > Professional Claim

Professional Claim

Give Feedback 

Fields marked with an asterisk * are required.




INSURANCE COMPANY/BENEFIT PLAN INFORMATION

* Responsibility Sequence 
Primary | v




PATIENT INFORMATION


Select a patient (Patients in the list are from your eligibility and benefits inquiries in the last 24 hours for the current organization)
Type to search... | v

* Last Name * First Name Middle Name or Initial Suffix

* Country  * Address  Suite 

* City * State * Zip Code

* Date of Birth  Date of Death  * Gender * Relationship 

Patient Amount Paid 

Release signature from provider on behalf of patient

ANCILLARY CLAIM/TREATMENT INFORMATION

Patient's Condition Is Related To: (Select all options that apply to patient's condition)

- Current or previous employment
- Auto accident
- Other accident

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, MID.

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

The image shows a screenshot of a claim form with several sections. A blue arrow points from the text on the left to the 'Subscriber ID' field in the 'SUBSCRIBER INFORMATION' section. The form includes the following sections and fields:

- SUBSCRIBER INFORMATION**
 - * Subscriber ID (with a help icon)
 - Policy or Group Number (with a help icon)
 - * Authorized Plan to Remit Payment to Provider? (with a help icon and a dropdown menu)
- SECONDARY INSURANCE PLAN INFORMATION** (checked)
 - * Subscriber ID (with a help icon)
 - Policy or Group Number (with a help icon)
 - Remaining Patient Liability
 - This subscriber is different from the primary subscriber
 - This is a Medicare payer
 - * Other Payer Name
 - * Other Payer ID (with a help icon)
 - Other Payer Identification Number
 - Other Payer Claim Control Number
 - * Information Release (with a help icon and a dropdown menu)
 - * Claim Filing Indicator (with a dropdown menu)
 - * Other Payer Benefits Assignment Certification (with a help icon and a dropdown menu)
 - Country (with a help icon and a dropdown menu)
 - Address (with a help icon)
 - Suite (with a help icon)
 - City
 - State (with a dropdown menu)
 - Zip Code
 - Release signature from provider on behalf of patient
 - Employer's Identification Number (with a help icon)
 - Prior Authorization Number (with a help icon)
 - * Payment / Adjustment Type (with a help icon and a dropdown menu)
 - Claim Adjustment Indicator
- OUTPATIENT MEDICARE ADJUDICATION INFORMATION** (unchecked)

Claim form (cont.)

The provider's billing information goes into this field.

BILLING PROVIDER

Select a Provider [?](#)

Type to search... | v

* NPI ?	Specialty Code	Payer Assigned Provider ID (PAPI)
<input type="text"/>	Type to search... v	<input type="text"/>
* Organization or Last Name ?	First Name	Middle Name
<input type="text"/>	<input type="text"/>	<input type="text"/>
Contact Name ?	* EIN ?	* SSN ?
<input type="text"/>	<input type="text"/>	<input type="text"/>
Country ?	* Address ?	Suite ?
United ... x v	<input type="text"/>	<input type="text"/>
* City	* State	* Zip Code
<input type="text"/>	Type to search... v	<input type="text"/>

PAY TO ADDRESS (IF DIFFERENT FROM BILLING PROVIDER ADDRESS)

Claim form (cont.)

The following slides will show what each of these fields looks like in detail. If you select the box, it will expand for you to fill out the information.



- TREATMENT LOCATION INFORMATION
- RENDERING PROVIDER
- SUPERVISING PROVIDER
- REFERRING PROVIDER ?
- ATTACHMENTS ?

Claim form (cont.)

Enter the provider's service location information here.

TREATMENT LOCATION INFORMATION

Select a Provider [?](#) | Select a Provider Address

Type to search... | v | Type to search... | v

* Location Name [?](#) | NPI [?](#)

Country [?](#) | * Address [?](#) | Suite [?](#)

United ... x | v | |

* City | * Service Facility State | * Zip Code

Type to search... | v |

Claim form (cont.)

Enter the rendering provider's information here.

RENDERING PROVIDER

Select a Provider [?](#)

Type to search... | v

* NPI [?](#) Specialty Code Payer Assigned Provider ID (PAPI)

 Type to search... | v

* Organization or Last Name [?](#) First Name Middle Name Suffix

Claim form (cont.)

Enter the referring provider's information here.

REFERRING PROVIDER ?

Select a Provider ?

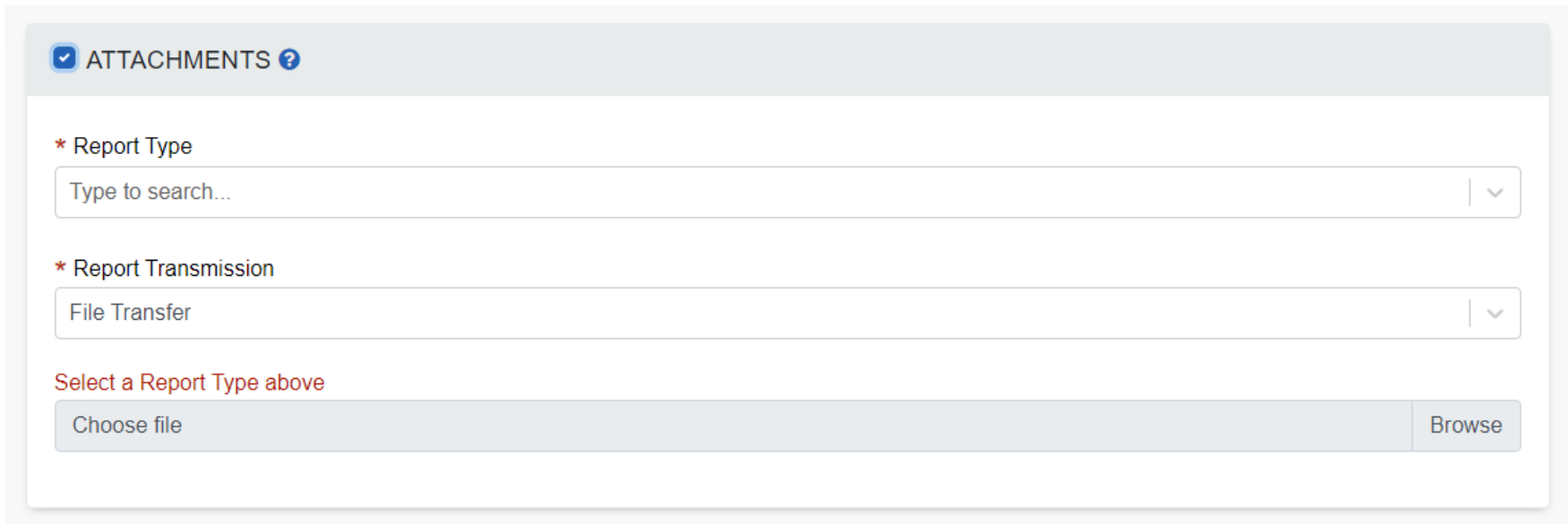
Type to search... | v

* NPI ?	Referral Number	Payer Assigned Provider ID (PAPI)	
<input type="text"/>	<input type="text"/>	<input type="text"/>	
* Organization or Last Name ?	* First Name	Middle Name	Suffix
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

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 a primary Explanation Of Benefits, consent form, or medical records.
- The bottom field is where providers can upload attachments.



The screenshot shows a form section titled "ATTACHMENTS" with a checked checkbox and a help icon. It contains three main fields: a search box for "Report Type" with the placeholder "Type to search...", a dropdown menu for "Report Transmission" currently showing "File Transfer", and a file upload area with the text "Choose file" and a "Browse" button. A red instruction "Select a Report Type above" is positioned above the file upload area.

ATTACHMENTS ?

* Report Type
Type to search... | v

* Report Transmission
File Transfer | v

Select a Report Type above

Choose file | Browse

Claim form (cont.)

The required fields here are:

- **Patient Control Number:**
 - Enter your patient account number.
- **Place of Service:**
 - This dropdown will provide the place of service code.
- **Frequency Type:**
 - *1 - Admit thru Discharge Claim*
 - *7 – Replacement of Prior Claim***
 - *8 – Void/Cancel of Prior Claim***
- Select the *Claim Filing Indicator*.

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

The screenshot displays a form titled "CLAIM INFORMATION" with the following fields:

- * Patient Control Number / Claim Number**: Text input field.
- Medical Record Identification Number**: Text input field.
- * Place of Service**: Dropdown menu with "Type to search..." placeholder.
- * Frequency Type**: Dropdown menu with "1 - Admit thru Discharge Claim" selected.
- * Provider Accepts Assignment**: Dropdown menu with "Assigned" selected.
- * Release of Information**: Dropdown menu with "Type to search..." placeholder.
- * Provider Signature on File**: Dropdown menu with "Type to search..." placeholder.
- * Claim Filing Indicator**: Dropdown menu with "CI - Commercial Insurance Co." selected.
- Prior Authorization Number**: Text input field.
- Care Plan Oversight Number**: Text input field.
- Acute Manifestation Date**: Date input field with a calendar icon and "mm/dd/yyyy" format.
- Spinal Manipulation Service Patient Condition Code**: Dropdown menu with "Type to search..." placeholder.
- Clinical Laboratory Improvement Amendment Number**: Text input field.

Claim form (cont.)

Enter claim service line information here:

- Select your **Place of Service**.
- Providers will need to enter:
 - **Service Start Date**
 - **Procedure Code**
 - **Charge Amount**
 - **Quantity**
 - **Quantity Type**
 - **Prior Authorization number (if required)**
 - **Any modifiers**
 - **Diagnosis Pointer (up to 4)**
 - **CLIA information (if required)**

1

Service Line Control Number [?](#)

Place of Service

* Service Start Date [?](#)

Service End Date

* Procedure Code [?](#)

Procedure Description

* Charge Amount

* Qty [?](#)

* Quantity Type [?](#)

This claim was an emergency

Prior Authorization Number

Modifier 1

Modifier 2

Modifier 3

Modifier 4

* Diagnosis Code Pointer 1 [?](#)

Diagnosis Code Pointer 2

Diagnosis Code Pointer 3

Diagnosis Code Pointer 4

Clinical Laboratory Improvement Amendment Number

Referring Clinical Laboratory Improvement Amendment Number

Additional Information Line Note

Claim form (cont.)

These fields are the continuation of the claim service lines.

NATIONAL DRUG CODE (NDC) INFORMATION

DURABLE MEDICAL EQUIPMENT (DME) INFORMATION ⓘ

DME CERTIFICATE OF MEDICAL NECESSITY (CMN) INFORMATION

RENDERING PROVIDER

SUPERVISING PROVIDER

REFERRING PROVIDER ⓘ

ORDERING PROVIDER





TREATMENT LOCATION INFORMATION

[+ Add another row](#)

Claim form (cont.)




NATIONAL DRUG CODE (NDC) INFORMATION

* National Drug Code 	* National Drug Unit Count	* Drug Quantity Unit Code Qualifier
Type to search... 		Unit 
Prescription Number Type		
Type to search... 		

Claim form (cont.)




DURABLE MEDICAL EQUIPMENT (DME) INFORMATION 

DME Length of Medical Necessity in days

DME Rental Price

DME Rental Unit Price Indicator

DME Purchase Price

Claim form (cont.)

DME CERTIFICATE OF MEDICAL NECESSITY (CMN) INFORMATION

DME Certification Type Code

 |

* DME Condition Code 1

 |

DME Condition Code 2

 |

* DME Duration (months)

* Patient Height (in)

Last Certification Date

Claim form (cont.)

RENDERING PROVIDER

Select a Provider ?

Type to search... | v

* NPI ? Specialty Code Payer Assigned Provider ID (PAPI)

Type to search... | v

* Organization or Last Name ? First Name Middle Name Suffix

Type to search... | v

Claim form (cont.)

SUPERVISING PROVIDER

Select a Provider [?](#)

Type to search... | v

* NPI [?](#) Payer Assigned Provider ID (PAPI)

* Organization or Last Name [?](#) * First Name Middle Name Suffix

Claim form (cont.)



REFERRING PROVIDER ?

Select a Provider ?

Type to search... | v

* NPI ? Referral Number Payer Assigned Provider ID (PAPI)

* Organization or Last Name ? * First Name Middle Name Suffix

Claim form (cont.)

ORDERING PROVIDER

Select a Provider [?](#)

Type to search... | v

NPI [?](#) Payer Assigned Provider ID (PAPI)

* Organization or Last Name [?](#) * First Name Middle Name Suffix

Country [?](#) Address [?](#) Suite [?](#)

U... x | v

City Ordering Provider State Zip Code

Type to search... | v

Claim form (cont.)

TREATMENT LOCATION INFORMATION

Select a Provider ?

 | v

* Location Name ?

NPI ?

Country ?

 | v

* Address ?

Suite ?

* City

* Service Facility State

 | v

* Zip Code

Claim form (cont.)

The screenshot displays a web-based claim form interface. At the top, there are two light gray rectangular sections, each with a small square icon and text: the first is labeled 'ORDERING PROVIDER' and the second is 'TREATMENT LOCATION INFORMATION'. Below these is a horizontal line. Underneath the line is a button with a blue plus icon and the text 'Add another row', which is highlighted with a red rectangular border. At the bottom right of the form area, there are two buttons: a light blue button labeled 'Start Over' and a dark blue button labeled 'Submit'. A red arrow points from the right side of the form area towards the 'Start Over' button.

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 a 99213 and you bill Medicaid as secondary. The Medicaid fee schedule is \$31.96. No additional money would be paid.
- **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*



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CHECK/EFT:

SERVICE DATE(S)	SERVICE CODES	POS	CHARGE	ALLOWED	DEDUCTIBLE	CO-PAY	CO-INSURANCE	CONTRACTUAL DIFFERENCE	PROVIDER RESP AMOUNT	EXPLANSI CODE(S)	INSURED RESPONSIBILITY AMOUNT	EXPLANSI CODE(S)	WHAT WE WILL PAY
INSURED'S NAME: [REDACTED]													
PATIENT ACCOUNT#: [REDACTED]													
SERVICE PROVIDER NAME: [REDACTED]													
NETWORK: IN NETWORK RELATIONSHIP TO INSURED: [REDACTED]													
	87210			0.00	0.00	0.00	0.00	0.00	23.00	GLI 16	0.00		0.00
	87210W			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				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

Professional claims – top 5 denials

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

Billing NPI not registered with the state – Z33

- 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

Submitted after plan filing limit – TF0

- In-Network Providers = 90 days from the last date of service on the claim
- Out-of-Network Providers = 180 days from the last date of service on the claim
- Auto-denial in our system
- 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 delays
- Submit dispute and include documentation that clearly identifies the reason for the filing delay

Prior authorization not obtained – Y40

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

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.
- The member is responsible for notifying Anthem if a primary policy is updated or terminates
- Data mining, provider updates
- Other payer information is available via Availity during the eligibility verification process
- Anthem 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.

Rendering NPI not registered with the state – Z34

- Z34 refers to the NPI in field 24J of the CMS-1500/837P claim form
- Claims billed by provider groups must contain a rendering NPI
- Servicing provider must be enrolled as a rendering provider with the state
- Billing entities (hospitals, DME, ambulance, etc.) are not required to include a rendering provider NPI on the claim
- Anthem matches the NPI with the State Assigned Provider ID file received from the state

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/inmedicaidoc >
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/inmedicaidoc

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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 time 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
 Jamaal.WadeSr@anthem.com
 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

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>

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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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