Anthem®

Serving Hoosier Healthwise, Healthy Indiana Plan and Hoosier Care Connect

Anthem Blue Cross and Blue Shield

Indiana Medicaid Provider Manual

For Hoosier Healthwise, Healthy Indiana Plan and Hoosier Care Connect

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Chapter 1: Introduction

Welcome

Welcome! Thank you for being part of the Anthem Blue Cross and Blue Shield (Anthem) provider network. At Anthem, we believe providers like you and your organization play an important role in managing the care of our members.

Anthem has been selected by the state of Indiana as one of the Managed Care Entities (MCEs) to provide access to healthcare services for the following programs:

- **Hoosier Healthwise** – the state of Indiana's Medicaid program, separated into Package A for children and pregnant members and Package C for children under age 19.
- **Healthy Indiana Plan (HIP)** – an affordable healthcare program created by the state of Indiana to cover adults ages 19 to 64 whose income is up to 138% of the Federal Poverty Level (FPL).
- **Hoosier Care Connect** – the state's program for Indiana Medicaid enrollees who are aged, blind, or disabled and who are not Medicare eligible and do not have an institutional level of care. Members who are currently or formerly in foster care, receiving adoption assistance, or are wards of the state may also opt in to receive Hoosier Care Connect coverage.

Our strategy

We're proud of our innovative member-centric and provider-focused approach to healthcare delivery. The Anthem team consists of regional field-based physical and behavioral healthcare managers, social workers, member outreach specialists, nurse practice consultants, community health workers, and Network Relations consultants to work closely with you and our members throughout Indiana. The Anthem team is available to provide:

- Training for healthcare professionals and their staff regarding enrollment, covered benefits, managed care operations, and linguistic services.
- Member support services including health education referrals, event coordination, and coordination of cultural and linguistic services.
- Care management services to supplement provider treatment plans and improve our members' overall health by educating and encouraging self-care in the prevention, early detection, and treatment of existing conditions and chronic diseases.

Our mission

Improving lives and communities. Simplifying healthcare. Expecting more.

Our vision

To be the most innovative, valuable, and inclusive partner.

Our values:

- Leadership — Redefine what's possible.
- Community — Committed, connected, invested.
- Integrity — Do the right thing, with a spirit of excellence.
- Agility — Deliver today — transform tomorrow.
- Diversity — Open our hearts and minds.

About this manual

The *Provider Manual* is designed for network physicians, hospitals, and ancillary providers. We recognize that managing our members' health can be a complex undertaking, requiring familiarity with the rules and regulations of a system that includes a wide array of healthcare services and responsibilities.

Our goal is to create a useful reference guide for you and your office staff. We want to help you navigate our managed healthcare plan to find the most reliable, responsible, timely, and cost-effective ways to deliver quality healthcare to our members.

Providers may access a copy of the provider manual at **https://providers.anthem.com/indiana-provider/home** under **Provider Tools & Resources**, or by contacting Provider Services.

Proprietary information

The information contained in this provider manual is proprietary to the State of Indiana, CMS, and Anthem. By accepting this manual, Anthem providers agree to:

- Protect and hold the manual's information as proprietary.
- Use this manual solely for the purposes of referencing information regarding the provision of medical services to Hoosier Healthwise, Healthy Indiana Plan, and/or Hoosier Care Connect members enrolled for services through Anthem Blue Cross and Blue Shield (herein referenced as "*Anthem*" or the "*Plan*").

Updates and changes

The *Provider Manual*, as part of your *Provider Agreement* and related *Addendums*, may be updated at any time and is subject to change. In the event of an inconsistency between information contained in the *Provider Manual* and the *Provider Agreement* between you or your facility and Anthem, the *Provider Agreement* shall govern.

In the event of a material change to the *Provider Manual*, we will make all reasonable efforts to notify you of such change through web-posted newsletters, fax communications, and other mailings. In such cases, the most recently published information should supersede all previous information and be considered the current directive.

The *Provider Manual* is not intended to be a complete statement of all *Anthem Policies or Procedures*. Policies and procedures not included in this *Provider Manual* may be posted on our website or published in specially targeted communications, including but not limited to bulletins and newsletters.

This *Provider Manual* does not contain legal, tax, or medical advice. Please consult your own advisors for advice on these topics.

Contact information

The following resource grid provides the most used phone and fax numbers, websites, and addresses. The first chart below gives you contact information for Anthem services for Hoosier Healthwise, Healthy Indiana Plan, and Hoosier Care Connect. The second chart displays contact information for the health services programs handled by the state.

Unless indicated in particular sections, all references to contact information throughout the *Provider Manual* can be found in this section.

Anthem services	Hoosier Healthwise	Healthy Indiana Plan	Hoosier Care Connect
Provider Services	**866-408-6132** Monday through Friday, 8 a.m. to 8 p.m.	**844-533-1995** Monday through Friday, 8 a.m. to 8 p.m.	**844-284-1798** Monday through Friday, 8 a.m. to 8 p.m.
Prior Authorization — Utilization Management	**866-408-6132** Monday through Friday, 8 a.m. to 5 p.m.	**844-533-1995** Monday through Friday, 8 a.m. to 5 p.m.	**844-284-1798** Monday through Friday, 8 a.m. to 5 p.m.
Prior Authorization — fax	Fax lines: • **866-406-2803** (physical health inpatient and outpatient services) • **844-765-5156** (concurrent reviews for inpatient, skilled nursing facility, long-term acute care hospital, and acute inpatient rehabilitation) • **844-765-5157** (outpatient services such as durable medical equipment, home healthcare, and orthotics)		
Behavioral Health Prior Authorization — Utilization Management	**866-408-6132** Monday through Friday, 8 a.m. to 8 p.m.	**844-533-1995** Monday through Friday, 8 a.m. to 8 p.m.	**844-284-1798** Monday through Friday, 8 a.m. to 8 p.m.
Behavioral Health Prior Authorization — fax	Mental health/substance abuse authorizations should be submitted using our preferred method electronically via **www.Availity.com**.* If you prefer to paper fax, you may submit to: • Inpatient: **844-452-8074** • Outpatient: **844-456-2698**		
Carelon Medical Benefits Management, Inc.*	**844-767-8158** Monday through Friday, 8 a.m. to 5 p.m. Log in to **providerportal.com** or **www.Availity.com** for prior authorizations. For Carelon Medical Benefits Management clinical criteria, go to **providerportal.com**.		
Case Management/ Right Choices Program	**866-902-1690** Fax: **855-417-1289** Monday through Friday, 8 a.m. to 5 p.m.		
Pharmacy/ Pharmacists (POS)	**844-916-3654** 24 hours a day, 7 days a week	**844-916-3652** 24 hours a day, 7 days a week	**844-916-3653** 24 hours a day, 7 days a week
	Fax: • Prescriptions: **844-864-7860** • Medical injectables: **844-512-7023**		

Anthem services	Hoosier Healthwise	Healthy Indiana Plan	Hoosier Care Connect
Pharmacy Providers	**866-408-6132** Monday through Friday, 8 a.m. to 8 p.m.	**844-533-1995** Monday through Friday, 8 a.m. to 8 p.m.	**844-284-1798** Monday through Friday, 8 a.m. to 8 p.m.
Claims	**www.availity.com** Paper claims (initial only): Anthem Blue Cross and Blue Shield Claims Mailstop: IN999 P.O. Box 61010 Virginia Beach, VA 23466		
Claims Overpayment	Overpayment Recovery P.O. Box 92420 Cleveland, OH 44193 **For overnight delivery:** Overpayment Recovery Lockbox 92420 4100 W. 150th St. Cleveland, OH 44135	Central Region – CCOA Lockbox P.O. Box 73651 Cleveland, OH 44193 **For overnight delivery:** Anthem Central Lockbox 73651 4100 W. 150th St. Cleveland, OH 44135	Overpayment Recovery P.O. Box 92420 Cleveland, OH 44193 **For overnight delivery:** Overpayment Recovery Lockbox 92420 4100 W. 150th St. Cleveland, OH 44135
Contracting	**800-455-6805** Monday through Friday, 8 a.m. to 5 p.m.		
Fraud, Waste, or Abuse Reporting	**877-283-1524** **www.fighthealthcarefraud.com**		
Grievances and Appeals	**866-408-6132**	**844-533-1995**	**844-284-1798**
Grievances and Appeals — fax	• Fax: **855-535-7445** • Expedited fax: **855-516-1083**		
24/7 NurseLine	**866-408-6131**		**844-284-1797**
Behavioral Health Crisis Line	**833-874-0016** Available 24 hours a day, 7 days a week		
Relay Indiana Members with Hearing/Speech Loss	**800-743-3333** or **711**		
Member oral interpreter services (telephonically and in person)	Provider Services **866-408-6132** Member Services **866-408-6131**	Provider Services **844-533-1995** Member Services **866-408-6131**	Provider Services **844-284-1798** Member Services **844-284-1797**
Vision services	Superior Vision* 877-235-5317 **www.superiorvision.com**		
Dental services	DentaQuest* **855-453-5286** **www.dentaquest.com**		
Anthem transportation services	**844-772-6632** TTY: **888-238-9816** Monday through Friday, 8 a.m. to 8 p.m.		

Anthem services	Hoosier Healthwise	Healthy Indiana Plan	Hoosier Care Connect
Schedule non-emergent transportation at least two business days in advance.			
General address for all correspondence	Anthem Blue Cross and Blue Shield P.O. Box 61599 Virginia Beach, VA 23466		

State of Indiana	Contact information
Indiana Health Coverage Programs (IHCP)	Provider Customer Assistance **800-457-4584** Member Customer Assistance **800-457-4584** Member Applications **800-403-0864** **www.in.gov/medicaid/providers/465.htm**
Eligibility	**800-403-0864**
Enrollment	Hoosier Healthwise: **800-889-9949** Healthy Indiana Plan: **877-438-4479** Hoosier Care Connect: **866-963-7383**
Grievances and Appeals:	Office of Administrative Law Proceedings 402 W. Washington St., Room E034 Indianapolis, IN 46204 **317-233-4454**
Children's Special Healthcare Services (CSHCS)	**www.in.gov/isdh/19613.htm**
Indiana Division of Disability and Rehabilitation Services	**www.in.gov/fssa/2328.htm**
Indiana Division of Mental Health and Addiction	**www.in.gov/fssa/dmha/4521.htm**
Indiana Family and Social Services Administration	Indiana Family and Social Services Administration 402 W. Washington St. Room W374, MS07 Indianapolis, IN 46204-2739 **317-233-4454** **https://www.in.gov/fssa**
State of Indiana Medicaid providers website	**www.in.gov/medicaid/providers**
Provider healthcare portal	**portal.indianamedicaid.com**
Indiana Tobacco Quitline	**800-784-8669**
Breastfeeding Support Line	**800-231-2999**
Women, Infants, and Children (WIC) Program	**800-522-0874** **www.in.gov/isdh/19691.htm**

Q: How do I contact Anthem?

A: You can log in to Availity at **www.availity.com** > select Indiana as state > Payer Spaces > Anthem > Chat with Payer or contact Anthem for your questions and assistance by calling Provider Services, Monday to Friday, 8 a.m. to 8 p.m. at the following numbers:

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

Q: How do I find the Network Relations consultant in my territory?

A: You can find your assigned Network Relations consultant here: **https://providers.anthem.com/docs/gpp/IN_CAID_PU_NetworkRelationsMap.pdf?v=20211006131**.

Q: How do I check member eligibility?

A: Providers can verify member eligibility by doing any one of the following:

- Log in to Indiana's secure website, IHCP Provider Healthcare Portal, and enter the member's ID: IHCP Provider Portal > Home (**indianamedicaid.com**). Review the member's enrollment and verify they are assigned to Anthem.
- Providers may also use the Indiana Health Coverage Programs (IHCP) interactive voice response (IVR) system at **800-457-4584** and select **option 2** followed by **option 5**. Enter the member's ID and verify the member is active and assigned to Anthem.
- Once it is verified that the member is assigned to Anthem, log in to **Availity** and enter the member ID for verification of the primary medical provider (PMP) assignment.

Q: How do I obtain prior authorization?

A: The interactive care reviewer (ICR) is the preferred method for the submission of preauthorization requests. Access ICR under *Authorizations and Referrals* via Availity at **www.availity.com**.

Prior authorization can also be obtained by calling:

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

By fax:

- **866-406-2803** — physical health inpatient and outpatient services
- **844-765-5156** — concurrent reviews for inpatient, skilled nursing facility, long-term acute care hospital, and acute inpatient rehabilitation
- **844-765-5157** — outpatient services such as durable medical equipment, home healthcare, out-of-network, and orthotics

Q. How do I submit a claim?

A: Claims can be submitted via Availity. Log in to **www.availity.com** and follow the instructions to register if you are using PMS software or work with your clearinghouse or

billing vendor to ensure they have a connection to Availity. Visit the EDI website **www.anthem.com/edi** for EDI Details.

For paper claims, mail them to the following address:
Anthem Blue Cross and Blue Shield
Claims
Mailstop: IN999
P.O. Box 61010
Virginia Beach, VA 23466

Chapter 2: Member eligibility and program information

Given the increasing complexities of healthcare administration, the widespread potential for fraud and abuse, and constant fluctuations in program membership, member eligibility should be verified before services are rendered every time a member comes in for services. To prevent fraud and abuse, providers should confirm the identity of the person presenting the ID card. **Providers must also verify a member's eligibility before services are delivered and at every visit**. Claims submitted for services rendered to non-eligible members will not be eligible for payment.

Verifying member eligibility

Providers can verify member eligibility by doing any one of the following:

- Log in to Indiana's secure website, Provider Healthcare Portal, and enter the member's ID: IHCP Provider Portal > Home (**https://portal.indianamedicaid.com**). Review the member's enrollment and verify they are assigned to Anthem.
- Providers may also use the Indiana Health Coverage Programs (IHCP) interactive voice response (IVR) system at **800-457-4584** and select **option 2** followed by **option 5.** Enter the member's ID and verify the member is active and assigned to Anthem.
- Once it is verified that the member is assigned to Anthem, log in to **Availity** and enter the member ID for verification of the primary medical provider (PMP) assignment.

To apply for a Provider Healthcare Portal user ID and password, complete the Provider Healthcare Portal registration at **https://portal.indianamedicaid.com.**

Note: Indiana's Family and Social Services Administration (FSSA) will provide eligibility status but will not provide primary medical provider assignment during enrollment.

Member ID cards

Following enrollment, eligible enrollees will receive a member ID card. All Hoosier Healthwise, Healthy Indiana Plan, and Hoosier Care Connect members will receive an Anthem-issued ID card that contains the following member information:

- Name
- Member ID and applicable plan pre-fix
- Group Number and Plan Code, if applicable
- Pharmacy BIN, PCN, and Group
- Member's PMP information
- Telephone numbers for vital services, including:
    - Member Services
    - 24/7 NurseLine
    - Provider Services
    - Pharmacy
    - Dental and vision, as applicable
    - Transportation
    - Behavioral Health Crisis Line

If a card is lost, members may receive replacement cards upon request through Anthem Member Services. Digital copies of member ID cards can be accessed on the Sydney Health app.

Note: At each member visit, providers must ask to see the member's ID card and verify eligibility. This verification should be done before rendering services and before submission of claims to Anthem.

Indiana Health Coverage Programs (IHCP)

Anthem has been selected by the State of Indiana as one of the Managed Care Entities (MCE) to provide access to healthcare services for the following programs:

Hoosier Healthwise (HHW) is the state of Indiana's Medicaid program, separated into two benefit packages:

- **Package A:** This is a full-service plan for children and pregnant members. Members do not have any cost-sharing obligations.
- **Package C (CHIP):** This is a full-service plan for children enrolled in Children's Health Insurance Program (CHIP). There is a small monthly premium payment and co-pay for some services based on family income.

Hoosier Care Connect (HCC) is the state's program for Indiana Medicaid enrollees who are aged, blind, or disabled, who are not Medicare eligible, and who do not have an institutional level of care. Members who are currently or formerly in foster care, receiving adoption assistance, or are wards of the state may also opt in to receive Hoosier Care Connect coverage.

Healthy Indiana Plan (HIP) is for adults between the ages of 19 to 64. HIP members have POWER (Personal Wellness and Responsibility) accounts to pay for the first $2,500 of covered benefits. HIP is available in several benefit packages including HIP Basic, HIP Plus, HIP Maternity, and HIP State Plans. Some members qualify for state plan benefits that include expanded benefits to meet these members' needs. The State Plan includes either HIP Plus or HIP Basic cost-sharing elements. HIP members who become pregnant are eligible to receive maternity benefits through the HIP Maternity program. HIP Maternity members have the same expanded benefits as HIP State Plan members but without cost-sharing. Members in the HIP Maternity plan receive HIP Maternity benefits for the entirety of their pregnancy plus 12 months of post-partum care. During the member's post-partum period, the member receives the same full benefit package they received during the pregnancy.

Members with complex medical or behavioral health conditions may be considered **medically frail,** making them eligible to receive the expanded State Plan benefit package, which is more appropriate for their healthcare conditions. Individuals are medically frail if they have been determined to meet state medically frail guidelines and have one or more of the following:

- Disabling mental disorder
- Chronic substance use disorder
- Serious and complex medical condition
- Physical, intellectual, or developmental disability that significantly impairs the individual's ability to perform one or more activities of daily living
- Disability determination from the Social Security Administration

You may be contacted to provide information to verify your patient's medical frailty. Once the frail status is confirmed, the member will be moved to a state plan.

If you have a HIP patient you think may qualify as medically frail or if you have questions, please contact Anthem's Transition Coordination team at **844-276-3509** or go online to

http://www.in.gov/fssa/hip > Am I eligible? > Conditions that may qualify you as medically frail for information on these additional benefits.

HIP member POWER account

All HIP members have a special savings account called a Personal Wellness and Responsibility Account, or POWER account. The POWER account is used to pay the first $2,500 of approved healthcare costs. The account for members with HIP Basic, HIP Maternity, and State Plan Basic is entirely funded by the state; however, HIP Basic and State Plan Basic members may have copays for services (see **Chapter 10: Member copayments**). To participate in HIP Plus or HIP State Plus plan, individuals are required to help fund the $2,500 deductible by contributing to their POWER account monthly. The state funds the difference between the member's required monthly POWER account contributions and the $2,500 POWER account. For the monthly contribution, the member is liable for a tiered amount based on annual income. Additionally, members who use tobacco products will have a 50% tobacco surcharge added to their monthly contribution. The surcharge is applicable for the entire calendar year, even if the member's tobacco use status changes to *No* during the calendar year.

POWER Account Contribution (PAC) tiers table

Federal poverty level	Monthly PAC single person	Monthly PAC per spouse	PAC with tobacco surcharge	Spouse PAC when one has tobacco surcharge	Spouse PAC when both have tobacco surcharge (each)
22% and under	$1	$1	$1.50	$1 & $1.50	$1.50
23% to 50%	$5	$2.50	$7.50	$2.50 & $3.75	$3.75
51% to 75%	$10	$5	$15	$5 & $7.50	$7.50
76% to 100%	$15	$7.50	$22.50	$7.50 & $11.25	$11.25
101% to 138%	$20	$10	$30	$10 & $15	$15

Cost share information

If a member's healthcare costs in a quarter are more than 5% of their family's income, the member's copayments will be turned off until the end of that quarter. POWER account payments will only be one dollar per month through the end of that quarter. If a member is pregnant, a Native American, or an Alaskan Native, the member will not have a POWER account payment or a copayment.

Presumptive eligibility

Presumptive eligibility individuals may be determined by a qualified provider (QP) or other authorized entity to be presumptively eligible to receive temporary health coverage through fee-for-service under the Indiana Health Coverage Programs (IHCP) until official IHCP eligibility is determined. The period begins on the day a QP determines that the individual is presumptively eligible and ends:

- When a decision is made on the member's complete filed application, or
- The last day of the month following the month in which a QP determined the individual to be eligible if an IHCP application is not filed.

Presumptive eligibility benefit plans include:

- **Presumptive Eligibility for Pregnant Members (PEPM):** Limited coverage for prenatal visits, lab work, prescriptions, and emergency transportation
- **Presumptive Eligibility Family Planning Services:** Limited coverage for services and supplies intended to prevent or delay pregnancy
- **Presumptive Eligibility — Adult:** Coverage through fee-for-service under IHCP that mirrors HIP Basic
- **Presumptive Eligibility — Package A Standard Plan: A b**enefit package for infants, children, parents/caretakers, and former foster children that offers full Medicaid benefits under Package A
- **Presumptive Eligibility for Inmates:** Coverage for qualifying inmates that is limited to inpatient care only

For questions about presumptive eligibility, contact FSSA Customer Service at **317-655-3240**, via email at **PresumptiveEligibility@fssa.in.gov**, or visit **www.in.gov/medicaid/providers/715.htm.**

Chapter 3: Benefits and services

This chapter outlines some of the specific covered and non-covered services for Hoosier Healthwise, Healthy Indiana Plan, and Hoosier Care Connect. All covered services are contingent upon medical necessity and benefit coverage at the time of service. **Refer to Anthem's Precertification Lookup Tool at https://providers.anthem.com/IN** > Claims > Precertification Lookup Tool for prior authorization requirements. For a complete list and descriptions of covered and non-covered services, *see the Member Eligibility and Benefit Coverage* module of the *IHCP Provider Reference Modules* at **https://www.in.gov/medicaid/providers/provider-references**.

Note: Providers contracted with Anthem 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.

Hoosier Healthwise benefits and services

Benefits	Package A	Package C
Behavioral Health — inpatient: • PA required	Covered	Covered
Behavioral health — outpatient: • PA required for some services or notification required • Refer to Precertification Lookup Tool at **https://providers.anthem.com/IN** • Self-referral	Covered	Covered
Medicaid Rehabilitation Option (MRO)	Covered as a carve-out through Indiana Health Coverage Programs from IHCP-enrolled providers.	
Chiropractic services: • Self-referral	Covered	Covered
Dental: • Self-referral	Covered	Covered
Diabetes self-management training	Covered	Covered
Family planning: • Self-referral	Covered	Covered
Home healthcare: • PA required	Covered	Covered
Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)	Covered	Covered
Hospital services — inpatient: • PA required	Covered	Covered
Emergency room services: • PA not required for ER services or observation room	Covered	Covered
Lab and radiology: • PA required for some services	Covered	Covered

Benefits	Package A	Package C
• Refer to Precertification Lookup Tool at **https://providers.anthem.com/IN**		
Long-term acute care hospitalization: • PA required	Covered	Covered up to 50 days per calendar year.
Durable medical equipment (DME): • PA required for all rental and custom-made DME	Covered	Covered — maximum benefit of $2,000 per year or $5,000 per lifetime for durable medical equipment. Equipment may be purchased or leased depending on which is more cost-efficient.
Nurse-midwife services	Covered	Covered
Nurse practitioner services	Covered	Covered
Nursing facility services — short term	Covered	Not covered
Organ transplants: • PA required	Covered	Not covered
Orthodontia	Not covered except in cases of craniofacial deformity or cleft palate.	
Out-of-state medical services	• Covered for services by out-of-state Anthem-contracted providers. • Covered for services by out-of-state non-contracted providers if medically necessary services are not available through an in-network provider or within Indiana. PA required. • Regardless of their Anthem contracting status, providers must be enrolled with the IHCP. • PA not required for out-of-state ER services.	
Pharmacy	Covered	Covered — $3.00 generic and $10.00 brand name
Physician services: • PA required for some services • Refer to Precertification Lookup Tool at **https://providers.anthem.com/IN**	Covered	Covered
Podiatry services: • Self-referral	Covered	Covered
Acute inpatient rehab services: • PA required	Covered	Covered — up to 50 calendar days per calendar year
Respiratory therapy	Covered	Covered
Smoking cessation	Covered	Covered
Substance use disorder services — inpatient:	Covered	Covered

Benefits	Package A	Package C
• PA required		
Substance use disorder services — residential treatment: • PA required	Covered	Covered
Substance use disorder services — outpatient: • PA required for some services or notification required • Refer to Precertification Lookup Tool at **https://providers.anthem.com/IN** • Self-referral	Covered	Covered
Therapy services — physical occupational, speech, hearing, and language: • PA required	Covered	Covered
Transportation — non-emergent (NEMT): • PA required for out-of-state and air ambulance NEMT	Covered	Not covered except for ambulance services for non-emergencies between medical facilities when requested by a participating physician — $10 copay
Transportation — emergent/ambulance	Covered	Covered — $10 copay for emergent transportation
Vision services: • Self-referral for non-surgical eye care	Covered	Covered

Healthy Indiana Plan benefits and services

Benefits	HIP Basic[1]	HIP Plus	HIP State Plans HIP Maternity
Behavioral health — inpatient: • PA required	Covered	Covered	Covered
Behavioral health — outpatient: • PA required for some services or notification required • Refer to Precertification Lookup Tool at **https://providers.anthem.com/IN** • Self-referral	Covered	Covered	Covered
Medicaid Rehabilitation Option (MRO)	Covered as a carve-out through Indiana Health Coverage Programs from IHCP-enrolled providers		
Chiropractic services: • Self-referral — includes out-of-network providers	Not covered	Covered	Covered

Benefits	HIP Basic[1]	HIP Plus	HIP State Plans HIP Maternity
• Limit one unit per day and six units per covered person per benefit year			
Dental: • Self-referral	Covered only for ages 19 to 20 or pregnant members	Covered	Covered
Diabetes self-management training	Covered	Covered	Covered
Family planning: • Self-referral	Covered	Covered	Covered
Home healthcare: • PA required • Limit 100 visits per year	Covered	Covered	Covered
Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)	Covered	Covered	Covered
Hospice Care	Covered	Covered	Covered
Hospital services — inpatient: • PA required	Covered	Covered	Covered
Long-term acute care hospitalization: • PA required	Covered	Covered	Covered
Emergency room services: • PA not required for ER services or observation room	Covered	Covered	Covered
Lab and radiology: • PA required for some services	Covered	Covered	Covered
Durable medical equipment (DME): • PA required for all rental and custom-made DME	Covered	Covered	Covered
Nurse-midwife services	Covered	Covered	Covered
Nurse practitioner services	Covered	Covered	Covered
Organ transplants: • PA required	Covered	Covered	Covered
Out-of-state medical services	• Covered for services by out-of-state Anthem-contracted providers. • Covered for services by out-of-state non-contracted providers if medically necessary services are not available through an in-network provider or within Indiana. PA required. • Regardless of their Anthem contracting status, providers must be enrolled with the IHCP. • PA not required for out-of-state ER services.		
Pharmacy	Covered	Covered	Covered
Physician services: • PA required for some services • Refer to Precertification Lookup Tool at	Covered	Covered	Covered

Benefits	HIP Basic[1]	HIP Plus	HIP State Plans HIP Maternity
https://providers.anthem.com/IN			
Podiatry services: • Self-referral • Limit six visits per year	Not covered	Not covered	Covered
Acute inpatient rehab services: • PA required • Limit 90 days annual maximum	Covered	Covered	Covered
Skilled nursing facility — short-term: • PA required • Limit 100 days per benefit period; room and board services are not covered when temporary leave permitted	Covered	Covered	Covered
Smoking cessation	Covered	Covered	Covered
Substance use disorder services — inpatient: • PA required	Covered	Covered	Covered
Substance use disorder services — outpatient: • PA required for some services or notification required • Refer to Precertification Lookup Tool at https://providers.anthem.com/IN • Self-referral	Covered	Covered	Covered
Therapy services — physical occupational, speech, hearing, and language: • PA required • Refer to Precertification Lookup Tool at https://providers.anthem.com/IN • Limit 60 (Basic Plan); 75 (Plus Plan) combined visits annually for PT, OT, ST, and cardiac rehabilitation	Covered	Covered	Covered
Transportation — non-emergent (NEMT) • PA required for out-of-state and air ambulance NEMT	Not covered	Not covered[2]	Covered
Transportation — emergent/ambulance: • PA not required for ER services or observation room	Covered	Covered	Covered
Vision services: • Self-referral	Coverage available for ages 19 to 20	Covered	Covered

Benefits	HIP Basic[1]	HIP Plus	HIP State Plans HIP Maternity
1 Certain members may have copays for their HIP Basic benefit. For more information on copays and amounts, see **Chapter 10: Member copayments**. 2 Coverage is through Anthem's NEMT enhanced benefit only.			

Hoosier Care Connect benefits and services

Benefits	HCC package*
Behavioral health — inpatient: • PA required	Covered
Behavioral health — outpatient: • Notification required or PA required for some services • Refer to Precertification Lookup Tool at **https://providers.anthem.com/IN** • Self-referral	Covered
Medicaid Rehabilitation Option (MRO)	Covered as a carve-out through Indiana Health Coverage Programs from IHCP-enrolled providers
Care conferences: • Coverage of procedure code 99211 with the SC modifier for HCC care conferences, payment of $40 reimbursement to the provider.	Covered
Chiropractic services: • Self-referral — includes out-of-network providers	Covered
Dental: • Self-referral	Covered
Diabetes self-management training	Covered
Family planning: • Self-referral	Covered
Food supplements, nutritional supplements, and infant formulas: • PA may be required	Covered when no other means of nutrition is feasible or reasonable Not covered in cases of routine or ordinary nutritional needs
Home healthcare: • PA required	Covered when medically necessary in the home
Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)	Covered
Emergency room services: • PA not required for ER services or observation room	Covered
Hospice care: • Notification required for members in a nursing facility who have elected hospice benefits	Covered
Hospital services — inpatient: • PA required	Covered

Benefits	HCC package*
Intermediate care facilities for individuals with intellectual disabilities (ICF/IID)	Not covered
Lab and radiology: • PA required for some services	Covered
Long-term care	Not covered
Long-term acute care hospitalization: • PA required	Covered
Durable medical equipment (DME): • PA required for all rental and custom-made DME	Covered
Nurse-midwife services	Covered
Nurse practitioner services	Covered for medically necessary services
Organ transplants: • PA required	Covered
Orthodontia	Not covered except in cases of craniofacial deformity or cleft palate
Out-of-state medical services	• Covered for services by out-of-state Anthem-contracted providers. • Covered for services by out-of-state non-contracted providers if medically necessary services are not available through an in-network provider or within Indiana. PA required. • Regardless of their Anthem contracting status, providers must be enrolled with the IHCP. • PA not required for out-of-state ER services.
Pharmacy	Covered
Physician services: • PA required for some services • Refer to Precertification Lookup Tool at **https://providers.anthem.com/IN**	Covered
Podiatry services: • Self-referral	Covered
Acute inpatient rehab services: • PA required	Covered
Respiratory therapy: • PA may be required	Covered
Skilled nursing facility — short-term: • PA required	Covered
Smoking cessation	Covered
Speech, hearing, and language: • PA required • Refer to Precertification Lookup Tool at **https://providers.anthem.com/IN**	Covered

Benefits	HCC package*
Substance use disorder services — inpatient: • PA required	Covered
Substance use disorder services — residential treatment: • PA required	Covered
Substance use disorder services — outpatient: • PA or notification required • Refer to Precertification Lookup Tool at **https://providers.anthem.com/IN** • Self-Referral	Covered
Occupational therapy services: • PA required • Refer to Precertification Lookup Tool at **https://providers.anthem.com/IN**	Covered
Physical therapy services: • PA required • Refer to Precertification Lookup Tool at **https://providers.anthem.com/IN**	Covered
Transportation — nonemergent: • PA required for out-of-state and air transport NEMT	Covered
Transportation — emergent/ambulance: • PA not required for ER services or observation room	Covered
Vision services: • Self-referral	Covered
* Certain members may have copays for their HCC benefit. For more information on copays and amounts, see **Chapter 10: Member copayments**.	

In addition to the regular benefits offered to our members, there are extra benefits available to ensure they are receiving the highest quality of care and services:

Extra benefits	Hoosier Healthwise	Healthy Indiana Plan	Hoosier Care Connect
$75 in healthy lifestyle aids, such as digital scales and lumbar pillows			X
$50 in exercise equipment			X
Gym membership		X*	X
WW® membership (formerly Weight Watchers) for up to four months with a referral from your doctor		X*	X
$50 in school supplies for students ages 5 to 18	X		X
Trips to WIC, benefit redetermination, health education, employment interviews, and pharmacies to fill prescriptions	X	X*	X
Gas or ride-share cards	X	X*	X
Boys & Girls Club memberships ages 5 to 18	X		X

Extra benefits	Hoosier Healthwise	Healthy Indiana Plan	Hoosier Care Connect
$75 in enhanced vision benefits for contact lenses and glasses			X
Asthma/COPD and allergy relief products	X	X*	X
$25 gift card to start an INvestABLE bank account to help save money			X
High school equivalency assistance	X	X*	X
Tutoring assistance to help with grades and educational success			X**
Skills training and job search tool through our Jump Start program		X	X
Home-delivered meals	X	X	X
Medical alert jewelry for conditions like diabetes or high blood pressure			X
Personal care essentials/hygiene products	X	X*	X
Extra minutes for SafeLink cellphone	X	X	X
Caregiver toolkits			X
Essentials for expectant moms	X	X*	X
Online fitness and exercise resources	X	X	X
$50 in exercise equipment			X
Pain management products	X	X*	
$75 in healthy lifestyle aids			X
Duffel bag with luggage tag			X**
Community Resource Link	X	X	X
* HIP Plus, HIP State Plan Plus, and HIP Maternity members only. ** For members who are current/former foster care, receiving adoption assistance, or wards of the state.			

Dental benefits

Routine dental care is covered for qualifying members by Anthem through DentaQuest. For more information contact DentaQuest at **855-453-5286** or visit **www.dentaquest.com**.

Benefit level	Oral examinations	Cleanings	X-rays
HIP Basic (19 and 20)	2 exams per year	2 cleanings per year	• One complete set every three years • One set of bitewing X-rays every year
HIP Basic (21+)*	No Coverage	No Coverage	No Coverage
HIP Plus	Two exams per year	Two cleanings per year	• One complete set every five years • One set of bitewing X-rays every year
HIP State Plan (19 & 20) (Both State Plan Plus and State Plan Basic)	Two exams per year	Two cleanings per year	• One complete set every three years • One set of bitewing X-rays every year

Benefit level	Oral examinations	Cleanings	X-rays
HIP State Plan (21+) (Both State Plan Plus and State Plan Basic)	Two exams per year	One cleaning per year	• One complete set every three years • One set of bitewing X-rays every year
HIP Maternity (19 and 20)	Two exams per year	Two cleanings per year	• One complete set every three years • One set of bitewing X-rays every year
HIP Maternity (21+)	Two exams per year	One cleaning per year	• One complete set every three years • One set of bitewing X-rays every year
HHW (under 21)	Two exams per year	Two cleanings per year	• One complete set every three years • One set of bitewing X-rays every year
HHW (over 21)	Two exams per year	One cleaning per year	• One complete set every three years • One set of bitewing X-rays every year
HCC (Under 21)	Two exams per year	Two cleanings per year	• One complete set every three years • One set of bitewing X-rays every year
HCC (Over 21)	Two exams per year	One cleaning per year (unless institutionalized then receive two cleanings per year)	• One complete set every three years • One set of bitewing X-rays every year

Dental screening

PMPs in Anthem's network perform dental screenings of the teeth, gums, and mouth as part of the initial health assessments (IHAs) and preventive exams for adults and children. This inspection follows guidelines established under the *U.S. Preventive Task Force Guidelines*.

Dental referral procedures — under age 21

Referrals to a dentist will occur, at a minimum, during the initial health assessment and following each subsequent preventive care assessment if needed. Members who have medical conditions or who are taking medication that affects the condition of the mouth or teeth should be referred on an as-needed basis. One example: members who are immuno-compromised due to HIV or chemotherapy are at risk for developing mouth lesions that will require immediate care.

Dental referral for children is a priority. Children may be referred for oral health assessment after their first tooth eruption and no later than 12 months of age per Bright Futures. Parents needing assistance with scheduling dental appointments should be referred to Indiana's HealthWatch

program, also known as the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program. Examples of covered dental services include the following:

- Clinical exam
- Intra-oral
- Limited oral evaluation
- Panoramic film
- Periodic oral exam
- Radiographs/diagnostic imaging

For a complete list of covered and non-covered dental services, see the *Dental Services IHCP Provider Reference Modules* at https://www.in.gov/medicaid/providers/810.htm.

Dental services are covered under the Anthem medical benefit for Hoosier Healthwise, Healthy Indiana Plan, and Hoosier Care Connect when a member has an accident and the initial repair of an injury to the jaw, sound natural teeth, mouth, or face. The following services are covered:

- Emergency care
- Outpatient care
- Physician care
- Urgent care
- Dental coverage for accidents

Initial dental work to repair injuries due to an accident should be provided within 48 hours of the injury, or as soon as possible. Covered services include all exams and treatment needed to complete the repair, such as:

- Lab tests
- Mandibular/maxillary reconstruction
- Oral exams
- Oral surgery and anesthesia
- Prosthetic services
- Restorations
- X-rays

Vision benefits

Routine vision care is covered for qualifying members by Anthem through Superior Vision. For more information, contact Superior Vision at **877-235-5317** or visit **www.SuperiorVision.com**. Eye care benefits are available for members in the following plans:

- HCC
- HHW
- HIP Plus
- HIP Basic members ages 19 to 20 *only*
- HIP State Plan Plus
- HIP State Plan Basic
- HIP Maternity

Eye exams:

- One eye exam per year for members under 21 years old.
- One eye exam every two years for members 21 years and older.
- Additional examinations must be medically necessary.

Eyeglasses (including frames and lenses):

- One pair of eyeglasses per year for members under 21 years old, unless medically necessary under EPSDT.
- One pair of eyeglasses every 5 years for members 21 years and older.
- Repairs or replacement of eyeglasses for reasons that are beyond the member's control, such as fire, theft, or car accident.

Contact lenses:

- Available only if medically necessary, for example for members who cannot wear frames due to facial deformity or allergies.

Enhanced Benefit for Hoosier Care Connect members:

- $75 allowance for eye care per year to include eyeglasses and/or contact lenses.

Other vision services

Non-surgical vision services are available to Anthem members on a self-referral basis. Members may see any Indiana Health Coverage Programs (IHCP) enrolled provider.

All routine vision services for refractive eye care are processed by Superior Vision. Superior Vision also processes certain primary medical eye care services furnished by an optometrist as well. For Superior Vision claims and member questions, call **877-235-5317**. Primary medical eye care provided by a physician (MD/DO) is processed directly by Anthem.

Eye care surgeries are not self-referral and do require prior authorization (PA) in most cases. Out-of-network providers will always require PA for ophthalmic surgeries.

Vision services may be provided by the following:

- Ophthalmologists
- Optometrists
- Opticians

Children may qualify for further eye tests and glasses as a part of Indiana's state program, HealthWatch. The following are typical benefits that require pre-service review:

- Contact lenses and tinted lenses
- Frames and lenses provided from a source other than the current vision volume purchase contract optical laboratory
- Low or subnormal vision aids
- Orthoptic or pleoptic training
- Photochromatic lenses
- Prosthetic eye

Non-emergency transportation (NEMT)

Non-emergency medical transportation is a covered benefit for Hoosier Healthwise (Package A), Hoosier Care Connect, and Healthy Indiana Plan members who are pregnant or who have State Plan Benefits and are going to IHCP-attested providers for medically necessary services. As an added value, Anthem provides limited non-emergent transportation to members in the HIP Plus plan and HHW Package C plan. NEMT services are intended for members who have no other means of transportation available to them. NEMT providers rendering brokered transportation services ― including common carriers (ambulatory and nonambulatory), taxis, bus services, and ambulance services ― must be enrolled as IHCP providers. Anthem contracts with an NEMT broker which administers the NEMT program in accordance with contract requirements and Medicaid-covered benefits:

- HIP Maternity members, HIP members with State Plan Benefits, and Anthem members enrolled in Hoosier Healthwise Package A or Hoosier Care Connect are allowed an unlimited number of trips.
- Hoosier Healthwise Package C Ambulance services for non-emergencies between medical facilities are covered when requested by a participating physician.
- NEMT is not a covered benefit for the HIP Basic plan, HIP Plus plan, and Hoosier Healthwise Package C plan.
- Anthem provides other, nonemergent transportation as a value-added benefit.[1]
    - Additional community trips: Health education, redetermination appointments, trips to the pharmacy, WIC offices, Anthem-sponsored events, the Division of Family Resources, and job interviews
    - $50 in bus tickets or $50 gas card, or $50 ride-share card ― HHW and HIP Plus
    - $100 gas card for members in rural areas ― HCC
- Members must schedule an appointment with Anthem Transportation Services at least two business days in advance (requests less than two business days or same-day may be authorized for certain services such as urgent care services, dialysis, wound care, provider-ordered labs, etc.). Standing orders can be used to set up recurring trips for certain healthcare appointments such as wound care, cancer treatments, substance use disorder treatment, or dialysis.
- NEMT benefit covers ambulatory, sedans, vans, taxis, wheelchair lift-equipped vehicles, public transportation passes, and mileage reimbursement for IHCP-attested drivers including reimbursement for members who drive themselves and/or friends and family who drive a member to any IHCP-attested medical provider.
- Contact Anthem Transportation Services at **844-772-6632** (TTY **888-238-9816**), Monday through Friday, 8 a.m. to 8 p.m.

1 Value-added benefit not available to HIP Basic Plan

Hospice care

Hospice care is covered under the Healthy Indiana Plan and Hoosier Care Connect. Services may be provided in the home or in a hospice facility. Notification is required for Hoosier Care Connect members who reside in a nursing facility and have elected the hospice benefit. Notification is **not** required for home hospice.

For notification, providers should send the following:

- Fax a completed Indiana Health Coverage Programs (IHCP) *Prior Authorization (PA) Request Form* and *Indiana Hospice Election Form* to **844-765-5157** or submit an *Indiana Hospice Election Form* via Availity at **www.availity.com**.
- The nursing facility NPI and tax ID and the hospice IHCP Provider ID number(s) must be on the appropriate forms.
- Clinical documentation is not needed.

Hospice care is **not** covered under the Hoosier Healthwise program. However, terminally ill members may qualify for hospice care provided directly by the state if they disenroll from their managed care plan and apply directly to the state. The procedure to enter into hospice care is as follows:

- The hospice provider submits a hospice election form to the Indiana Health Coverage Program's (IHCP) Prior Authorization Unit. For more information, please see the *Hospice Services IHCP Provider Reference Module* at **https://www.in.gov/medicaid/providers/provider-references/**.
- The IHCP Prior Authorization Unit will then initiate the disenrollment of the member from managed care and facilitate hospice coverage.
- Anthem will coordinate care for members who are transitioning into hospice by providing any information required to complete the hospice election form for terminally ill members desiring hospice, as described in the *Hospice Services IHCP Provider Reference Module*.

County and state-linked services

To ensure continuity and coordination of care for our members, Anthem enters into agreements with locally based public health programs. Providers are responsible for notifying Anthem's Case Management department when a referral is made to one of the agencies listed below.

State services and programs

The following information identifies state services and programs, and the services these state programs provide upon referral:

- Indiana Division of Mental Health and Addiction (DMHA): Provides treatment for re-integration into the community: **www.in.gov/fssa/dmha/4521.htm**
- Indiana Division of Disability & Rehabilitation Services (DDRS): Provides independence through in-home services, supported employment, independent living, nutrition assistance, services for members with hearing loss, blindness, or a visual impairment, as well as social security disability eligibility: **www.in.gov/fssa/2328.htm**
- Children's Special Healthcare Services (CSHCS): A non-Medicaid program administered by the Indiana State Department of Health (ISDH) that provides financial assistance for

needed medical treatment to children with serious and chronic medical conditions to reduce complications and promote maximum quality of life: **www.in.gov/isdh/19613.htm**

For more information, please refer to the provider reference modules at **https://www.in.gov/medicaid/providers/provider-references/**.

Essential public health services

Anthem collaborates with public health entities in all service areas to ensure essential public health services for members. Services include:

- Coordination and follow-up of suspected or confirmed cases of childhood lead exposure
- Ensuring appropriate public health reporting (communicable diseases and/or diseases preventable by immunization):
    - Investigation, evaluation, and preventive treatment of persons with whom the member has come into contact
    - Notification and referral of communicable disease outbreaks involving members
    - Referral for tuberculosis and/or sexually transmitted infections or HIV contact
- Referral for Women, Infants, and Children (WIC) services and information sharing

Directly observed therapy

Tuberculosis (TB) has reemerged as an important public health problem at the same time as drug resistance to the disease continues to rise. In large part, this resistance can be traced to poor compliance with medical regimens. In Directly Observed Therapy (DOT), the member receives assistance in taking medications prescribed to treat TB. Members with TB showing evidence of poor compliance should be referred to the Local Health Department (LHD) for DOT services.

Reportable diseases

By state mandate, providers must report communicable diseases and conditions to local health departments. Anthem's providers are to comply with all state laws in the reporting of communicable diseases and conditions. Timely reporting is vital to minimize outbreaks and prevalence.

Excluded services

Certain services are excluded from managed care, and members must be disenrolled or suspended from managed care and moved to a fee-for-service program when they qualify for such services, including:

- Psychiatric residential treatment facility (PRTF) services
- Long-term care services in a nursing facility (NF)
- Intermediate care facility for individuals with intellectual disability (ICF/IID)
- 590 Program services
- 1915(c) HCBS waiver or Money Follows the Person (MFP) demonstration grant services, including:
    - Aged and Disabled (A&D) Waiver services
    - Traumatic Brain Injury (TBI) Waiver services

- Community Integration and Habilitation (CIH) Waiver services
- Family Supports Waiver (FSW) services

Visit **https://www.in.gov/medicaid/providers** for more about member benefits and services.

Chapter 4: Pharmacy

Anthem is responsible for prescription drug coverage for our members enrolled in Hoosier Healthwise, Healthy Indiana Plan, and Hoosier Care Connect. Anthem manages the pharmacy benefit through our pharmacy benefits manager, CarelonRx, Inc.* Members must use an in-network pharmacy for prescription services so that they are not subject to unnecessary out-of-pocket costs.

Pharmacy providers in the Anthem pharmacy network should submit pharmacy benefit claims to CarelonRx for HHW, HIP, and HCC members. Pharmacies may dispense up to a one-month supply of medication. HIP Plus, HIP State Plan Plus, and HCC members may receive a 90-day supply of maintenance medication through a retail pharmacy or mail-order pharmacy.

Covered and non-covered drugs

Pharmacy coverage includes:

- Prescription drugs approved by the United States Food and Drug Administration (FDA)
- Over-the-counter (OTC) items approved by the FDA and covered by Indiana Fee-For-Service (FFS) Program; OTC items still require a prescription in order to be covered under the Medicaid plan and for the pharmacy to be able to dispense the medication
- Self-injectable drugs (including insulin); claims for physician-administered injectable medications should be submitted to the medical benefit with a *CMS-1500* form and include a procedure code and an NDC
- Diabetic supplies per *Indiana State Preferred Diabetic Supplies List*
- Smoking cessation drugs
- Various supplies, such as needles, syringes, blood sugar monitors, test strips, lancets, and glucose urine testing strips

Services **not** covered by the pharmacy benefit include:

- Drugs not approved by the FDA
- Drugs from manufacturers that do not participate in a rebate agreement with the Centers for Medicare and Medicaid Services (CMS), with the exception of certain drugs for MAT
- Drugs not on the *FFS OTC Drug Formulary*
- Drugs to help members get pregnant
- Drugs used for cosmetic reasons
- Drugs for hair growth
- Drugs used to treat erectile problems
- Drugs used for weight loss
- Experimental or investigational drugs
- Vaccines covered by VFC Program (administration fee is covered for a VFC-enrolled pharmacy)

Non-covered is not the same as prior authorization required. Non-covered drugs are those that are excluded from benefit coverage. These products are not reimbursable, even with prior authorization.

Preferred Drug List

The Statewide Uniform Preferred Drug List (SUPDL) is a list of all brand-name and generic drugs available on the plan which is managed by the IHCP. All managed care plans and the fee-for-service program serving Hoosier Healthwise, Healthy Indiana Plan, and Hoosier Care Connect use the SUPDL. Medications and supplies that are not part of the SUPDL are referred to as neutral drugs and are managed by Anthem.

The ***SUPDL and neutral drugs*** for Hoosier Healthwise, Healthy Indiana Plan, and Hoosier Care Connect can be found at **https://providers.anthem.com/IN** > Eligibility & Pharmacy > Pharmacy Benefits.

Anthem utilizes a Pharmacy and Therapeutics Committee (P&T), which meets quarterly to make recommendations for changes to the neutral drugs. Prior to making any changes to the neutral drugs, removing one or more drugs from the PDL and/or formularies, or otherwise placing new restrictions on one or more drugs, Anthem submits the proposed change to the FSSA, which forwards the proposal to the Indiana Drug Utilization Review (DUR) Board in advance of the change. The Indiana DUR Board provides a recommendation regarding the approval of the proposed change to the *PDL* and/or formularies. FSSA approves, disapproves, or modifies the DUR Board recommendation. Anthem may add a drug to the *PDL* or formulary without approval from FSSA. Providers are notified of changes to the *PDL*/formulary at least 30 days prior to the change. A provider may submit a request to the Anthem P&T Committee through **https://providers.anthem.com/IN** > Contact Us and select the appropriate Provider Services.

Anthem supports e-Prescribing technologies to communicate the *PDL* and formularies to prescribers through electronic medical records (EMRs) and e-prescribing applications. Anthem encourages the utilization of e-prescribing technologies to ensure appropriate prescribing for members based on the member's plan, HHW, HIP, or HCC. Much of the e-prescribing activity is supported by prescribing providers through web and office-based applications or certified electronic health record (EHR) systems to communicate with the pharmacies.

Mental health drugs

In accordance with Indiana law, all antianxiety, antidepressant, and antipsychotic drugs are considered preferred. Cross-indicated drugs are also considered preferred that are:

1. Classified in a central nervous system drug category or classification (according to *Drug Facts and Comparisons* created after March 12, 2002).
2. Prescribed for the treatment of a mental illness (as defined by the most recent publication of the *American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders*).

Quantity supply limit

The quantity supply limit is the maximum amount of a drug a pharmacy can dispense at a given time. Anthem has a prior authorization (PA) program that adheres to FDA-approved dosing guidelines. If a prescribing provider feels a quantity supply greater than the defined maximum is medically necessary, a written PA request must be submitted to validate the medical rationale for exceeding the recommended dosage.

Dose Optimization Program

The Dose Optimization Program identifies claims where multiple capsules or tablets per day are being used and encourages an optimal dose. In some situations, a single daily dose may be encouraged. Without getting PA of benefits, the system will reject claims submitted with the quantity exceeding the set limit.

Drugs carved out of Managed Care

The IHCP designates certain drugs as *carved out* of the managed care delivery system. These drugs are reimbursed as fee-for-services (FFS) for all IHCP members, including those enrolled in Healthy Indiana Plan, Hoosier Care Connect, and Hoosier Healthwise:

- For a list of drugs that are carved out of managed care under the **pharmacy benefit**, see *Drug Therapies Carved-Out of the Managed Care Pharmacy Benefit*, accessible from the **Carved-out Pharmacy Benefit Drugs** quick link on the OptumRx Indiana Medicaid website (**https://inm-providerportal.optum.com/providerportal/faces/PreLogin.jsp**). All pharmacy claims and PA requests (if applicable) for these agents must be submitted to the FFS pharmacy benefit manager, OptumRx. The FFS *Preferred Drug List* (*PDL*), prior authorization requirements, and billing guidelines apply. Questions regarding the FFS PDL, prior authorization criteria, billing procedures, or other related matters for these drugs should be directed to the OptumRx Clinical and Technical Help Desk; call toll-free at **855-577-6317** or fax toll-free at **877-293-1845**. The FFS *PDL* and PA criteria can also be accessed from the OptumRx Indiana Medicaid website.
- For a list of physician-administered drugs that are carved out of managed care under the **medical benefit**, see *Physician-Administered Drugs Carved Out of Managed Care and Reimbursable Outside the Inpatient Diagnosis-Related Group*, accessible from the *Code Sets* page at **https://www.in.gov/medicaid/providers/business-transactions/billing-and-remittance/code-sets/**. These physician-administered drugs must be billed to Gainwell using the professional claim for all members. PA requests, if applicable, must also be submitted to Gainwell. For additional information about physician-administered drugs, see the *Injections, Vaccines, and Other Physician-Administered Drugs Codes* module.

For drugs that have been designated as carved out of managed care, PA requests or claims submitted to a member's Managed Care Entity (MCE) will be denied.

Requirements for the 340B Program

Section 340B of the *Public Health Service Act* limits the cost of covered outpatient drugs to certain facilities and groups like federal grantees, FQHCs, FQHC look-alikes, and qualified disproportionate share hospitals. This enables these entities to purchase 340B drugs at discounted rates and optimize federal resources.

Anthem's pharmacy benefit manager requires pharmacy providers submitting 340B claims under the pharmacy benefit to identify with BCD 08 or the SCC 20. Under the medical benefit, Anthem accepts JG or TB on 340B claims for physician-administered drug claims.

Pursuant to ***Indiana Health Coverage Programs Bulletin BT201413***, policy regarding the 340B Program follows:

- Federal law allows eligible entities to decide if they do or do not want to serve Medicaid members using 340B stock. This decision is wholly at the discretion of the entity. However, once an eligible entity makes a decision to serve or not serve Medicaid members with 340B stock, the entity is *locked* into that decision and not permitted to dispense a mix of 340B and non-340B drugs to Medicaid members.
- If the entity wishes to serve Medicaid members using 340B stock, it must only dispense 340B stock drugs and bill the program accordingly at its acquisition cost for the drug, plus the Medicaid dispensing fee.
- If the entity wishes to serve Medicaid members using a separate, non-340B stock, it may not use 340B stock at any time. The entity is to bill the program at its usual and customary (U&C) charge rates to Medicaid.
- Federal law prohibits the entity from buying at 340B acquisition cost, providing 340B-purchased stock to Medicaid members, and billing Medicaid at U&C charge rates.

Mandatory generic drug policy

Generic substitution for brand-name drugs is required by state law. Generic drugs must be provided when available. When a generic drug is available, brand-name products will only be approved through written prior authorization, with the exception of the Narrow Therapeutic Index (NTI) medications.

The following procedures are to be followed when generic prescriptions are substituted for a brand-name prescription:

- If the prescribed brand-name medication has a generic equivalent and the prescribing provider has not requested **dispense as written**, only the FDA-approved generic equivalent will be covered.
- The prescriber must sign the prescription as dispense as written AND write the phrase *Brand Name Medically Necessary* on the prescription.
- If the generic equivalent medication is not medically appropriate, the provider is required to submit a prior authorization request.
- If the PA request meets the approval criteria, the request will be approved, and the brand-name medication will be a covered benefit; if the PA request does not meet the approval criteria, then only the generic equivalent will be covered.
- Requests that meet the criteria are approved for one year.

Prior authorization for prescription drugs

Providers will submit prior authorization requests for any prescription drugs that require prior authorization to Anthem. Electronic prior authorization (ePA) is available through CoverMyMeds. This PA method saves time; submitting ePA requests is faster than phone/fax requests, and there is no paperwork to manage. Providers may visit the CoverMyMeds website (**https://www.covermymeds.com**) through their electronic medical records tool and utilize the ePA functionality if it exists.

Note: Pharmacists are not permitted to submit PA requests per *Indiana Code (IC 12-15-35.5-4)*. If ePA is not available, providers may contact Provider Services.

Visit our website at **https://providers.anthem.com/IN** > Eligibility & Pharmacy > Pharmacy Benefits for access to **preferred drug lists and prior authorization information**.

For any drugs that require prior authorization or an exception request, providers must contact Anthem. Anthem will provide a response by telephone or another telecommunication device within 24 hours of a request for prior authorization. Additionally, Anthem provides for the dispensing of at least a 72-hour supply of a covered outpatient prescription drug in an emergency situation. Anthem allows a pharmacist to dispense the 72-hour supply using a claim override process without the need for a phone call to Anthem. The pharmacist should follow up with the member's physician or Anthem the next business day regarding the prior authorization requirement.

Dispense-as-written codes

For the Hoosier Healthwise, Healthy Indiana Plan, and Hoosier Care Connect pharmacy benefits, only dispense-as-written (DAW) codes 0, 1, 5, 8, and 9 should be submitted by providers. Incorrect use of these codes may result in full or partial recoupment. Table 3 shows general information about these codes:

	DAW code	Code description
0	No product selection was indicated.	
1	Substitution is not allowed by the prescriber.	
5	Substitution allowed – brand drug dispensed as a generic.	
8	Substitution allowed – generic drug not available in the marketplace.	
9	Substitution allowed by prescriber but plan requests brand — patient's plan requested brand product to be dispensed.	

Phoned-in prescriptions indicating DAW 1 must be followed up with a written or electronic request from the physician stating, *brand medically necessary (IC 16-42-22-10(b) Substitution Prohibited)*. The phoned-in prescription alone, without the subsequent written or electronic prescription order indicating the brand is a medically necessary request, is not sufficient and is subject to audit and recovery.

Pharmacy copayment

Certain members may have copays for their pharmacy benefit. For more information on pharmacy copays and amounts, see **Chapter 10: Member copayments**:

- **Hoosier Healthwise:**
  - Package A: $0 copay.
  - Package C: $3 for generic drugs and single-source brands and $10 for multisource brand-name drugs.
- **Hoosier Care Connect**: $3 per prescription. Copay does not apply to members in the following categories: American Indian/Alaskan Native, under the age of 18, pregnant, or residing in a nursing facility.
- **HIP Basic and State Plan Basic:** $4 for preferred drugs and $8 for non-preferred drugs. Copay does not apply to members in the following categories: American Indian/Alaskan Native, pregnant, or residing in a nursing facility.
- **HIP Plus, State Plan Plus, and HIP Maternity:** $0 copay.

Medication Therapy Management (MTM)

Anthem members may be offered Medication Therapy Management, a program designed to work closely with providers, pharmacists, and members to provide additional assurances that the prescribed medications are safe, effective, and being utilized appropriately. Members meeting the criteria for the program receive written information about the program and have the opportunity to opt in or out of the program.

Mail order

Anthem HIP Plus, including HIP State Plan Plus, and Hoosier Care Connect members may receive a 90-day supply of maintenance medication through our mail order provider. HIP Plus, including HIP State Plan Plus, and HCC members may also receive a 90-day supply of maintenance medication through a retail pharmacy.

As an enhanced service, we will enable HIP Plus members on medications for chronic conditions to synchronize their 90-day refills to a single date. Through this process, the member will only need to make one trip to the pharmacy to pick up all their medications, simplifying the refill process.

Reimbursement for physician-administered pharmacy benefits

Anthem allows reimbursement for drug claims received with HCPCS/CPT® procedure codes that do not contain medically unlikely edit (MUE) limits and are within the physical quantities of drugs (also known as units) unless provider, state, federal or CMS contracts and/or requirements indicate otherwise.

Drug claims must be submitted as required with applicable HCPCS or CPT procedure code(s), national drug codes, appropriate qualifier, unit of measure, of units, and price per unit. Units should be reported in the multiples included in the code descriptor used for the applicable HCPCS codes.

Reimbursement will be considered up to the clinical unit limits (CUL) allowed for the prescribed/administered drug. Anthem utilizes the CMS MUE value. When there is no MUE assigned by CMS, identified codes will have a CUL assigned or be calculated based on the prescribing information, the FDA, and established reference compendia.

Claims that exceed the CUL will be reviewed for documentation to support the additional units. If the documentation does not support the additional units billed, the additional units will be denied.

For more information, go to **https://providers.anthem.com/IN** > Claims > **Reimbursement Policies** > Drugs.

Chapter 5: Behavioral health

Our mission is to coordinate the physical and behavioral healthcare of members by offering a wide range of targeted interventions, education, and enhanced access to care. We work collaboratively with hospitals, group practices, independent providers, community agencies, community mental health centers, as well as other resources to help ensure improved outcomes for members with mental health, substance use, and intellectual and developmental disabilities.

For additional information, please review the **IHCP Behavioral Health and Addiction Services** provider reference module.

Goals:

- Promote the integration of the management and delivery of physical and behavioral health services.
- Evaluate and monitor the coordination of physical and behavioral health coordination in order to improve coordination and continuity of care.
- Ensure and expand service accessibility to eligible members.
- Achieve quality initiatives including those related to HEDIS®, NCQA, and Indiana OMPP performance requirements.
- Work with members, providers, and community supports to provide recovery tools and create an environment that supports members' progress toward their recovery goals.
- Ensure utilization of the most appropriate, least restrictive, medical, and behavioral healthcare in the right place at the right time.

Objectives:

- Promote continuity and coordination of care.
- Enhance member satisfaction by implementing individualized and holistic support.
- Provide member education on treatment options and pathways toward recovery.
- Provide high-quality case management and care coordination services (see **Chapter 7: Case management** for more information).
- Work with care providers to ensure the provision of medically necessary and appropriate care.
- Enhance provider satisfaction and success through collaborative relationships.
- Promote collaboration between all healthcare partners.
- Use and promote evidence-based guidelines and clinical criteria.
- Maintain compliance and accreditation standards with local, state, and federal requirements.
- Deliver services per state best practice guidelines, rules regulations, and policies and procedures.

HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Guiding principles of the behavioral health program

Recovery is a member-driven process in which people find their pathways to work and learn and participate fully in their communities.

Resiliency is the ability of an individual or family to cope and adapt to the challenges and changes brought on by distress or disability. Becoming resilient is a dynamic developmental process that requires patience and effort to pursue steps that enhance positive responses to adverse circumstances.

The Substance Abuse and Mental Health Services Administration (SAMHSA) released a consensus statement on mental health recovery reflecting the desire that all behavioral health services be delivered in a manner that promotes individual recovery and builds resiliency. The ten fundamental components of recovery identified by SAMHSA are:

- Person-driven
- Culture
- Many pathways
- Holistic
- Relational
- Strengths/responsibility
- Peer support
- Respect
- Addresses trauma
- Hope

Visit **www.samhsa.gov** to find out more.

Systems of care

Services provided to people with serious emotional disturbances and their families are best delivered based on the System of Care Values and Principles that are endorsed by SAMHSA and the Center for Mental Health Services (CMHS). Services should be:

- Person-centered and family-focused.
- Community-based with a focus on services and decision-making at the community level.
- Culturally competent and responsive to cultural, racial, and ethnic differences.
- Comprehensive, to address physical, emotional, social, educational, and cultural needs.
- Personalized with individualized service plans that meet unique needs and potential.
- Delivered in the least restrictive, most normative environment that is clinically appropriate.
- Integrated and coordinated between agencies to deliver multiple services in a coordinated, therapeutic manner, and to meet the changing needs of the person and their family.
- Delivered without regard to race, religion, national origin, sex, physical disability, or other characteristics.
- Oriented to recovery; providing services that are flexible and evolve over time.

Coordination of behavioral health and physical health

Key elements of the model for coordinated and integrated physical and behavioral health services include:

- Ongoing communication and coordination between Primary Medical Providers (PMPs) and specialty providers, including behavioral health (mental health and substance use) providers, with oversight and evaluation by Anthem.
- Screening by PMPs for mental health, substance use, and co-occurring disorders.
- Discussions of physical health conditions by behavioral health providers.
- Referrals to PMPs or specialty providers, including other behavioral health providers, for assessment and/or treatment for members with co-occurring disorders and/or any known or suspected and untreated physical health disorders.
- Development of patient-centered treatment plans with the involvement of the members as well as appropriate caregivers and supports.
- Case management and Condition Care programs to support the coordination and integration of care between providers. (See **Chapter 7: Support services** for more information.)

To ensure that services are properly coordinated for members, behavior health providers are required to notify a member's PMP regarding initial services or significant changes within five calendar days, as well as provide initial and summary reports at least quarterly, to include the following:

- Patient demographics
- Date of initial or most recent behavioral health evaluation
- Findings from assessments
- Primary and secondary diagnoses
- Medication prescribed
- Behavioral health clinician's name and contact information

Outpatient treatment services

Outpatient behavioral health services provided by mid-level practitioners who are not separately enrolled with IHCP must be billed under the NPI of the supervising medical doctor or health service provider in psychology (HSPP). The procedure code must be accompanied by the applicable modifier to denote the level of the practitioner rendering the service.

The allowable mid-level modifiers are the following:

- AH: clinical psychologist — not licensed HSPP
- AJ: clinical social worker
- HE/SA combination: nurse practitioner/clinical nurse specialist
- HF: licensed clinical addiction counselor
- HE: services provided by any other mid-level practitioner as addressed in the *405 IAC 5-20-8 (10)*

In alignment with the State outpatient reimbursement policy, mid-level services are not separately reimbursable on the same day as a facility behavioral health claim.

Applied behavioral analysis

Applied behavioral analysis (ABA) therapy is covered for the treatment of autism spectrum disorder (ASD). Specifically, ABA therapy is available to members from the time of initial diagnosis through 20 years of age when it is medically necessary for the treatment of autism. These services require PA, subject to the criteria outlined in *Indiana Administrative Code 405 IAC 5-3* for members ages 20 and younger.

Provider requirements

For purposes of the initial diagnosis and comprehensive diagnostic evaluation, a qualified provider includes any of the following:

- Licensed physician
- Licensed pediatrician
- Another behavioral health specialist with training and experience in the diagnosis and treatment of ASD and acting within the scope of licensure and expertise

ABA therapy services must be delivered by an appropriate provider. For the purposes of ABA therapy, appropriate providers include:

- HSPP
- Licensed or board-certified behavior analysts, including bachelor-level (BCaBA), master-level (BCBA), and doctoral-level (BCBA-D) behavior analysts
- Credentialed registered behavior technicians (RBT)

Services performed by a Board-Certified Assistant Behavior Analyst (BCaBA) or RBT must be under the direct supervision of a BCBA, BCBA-D, or an HSPP. IHCP enrolls BCBA-D and BCBA under provider type 11 and provider specialty 615.

Substance use disorder services (SUD)

Anthem covers substance use disorder services, including residential treatment. Some services require prior authorization, which can be obtained through Availity and must include the state's SUD forms. Qualified residential providers must:

- Have designation by the Division of Mental Health and Addiction (DMHA) as offering American Society of Addiction Medicine (ASAM) Patient Placement Criteria level 3.5 and/or 3.1
- Enroll with IHCP with provider type 11 and specialty 836

Opioid treatment services

As part of Anthem's comprehensive approach to opioid use disorder treatment, we cover Opioid Treatment Program (OTP) services for our members and contract with all DMHA-certified OTP providers across Indiana. Anthem provides full OTP coverage, including all levels of care, methadone treatment, and testing for illnesses associated with opioid use, with no prior authorization required. We use data and predictive models to identify members for case management, and provider and member self-referral to coordinate care and or case management. Qualified providers must:

- Be enrolled with IHCP with a behavioral health provider type and a specialty of opioid treatment program (OTP).
- Maintain a Drug Enforcement Administration (DEA) license and certification from the state's DMHA.
- Enroll with IHCP with provider type 11 and specialty 835.

Provider roles and responsibilities

The behavioral healthcare benefit is fully integrated with all Anthem healthcare programs. This coordination of healthcare resources requires certain roles and responsibilities for behavioral health providers, including the following:

- Participate in the care management and coordination process for each Anthem member under your care.
- Notify Anthem within five calendar days of the member's initial visit, and submit information about the treatment plan, diagnosis, medications, and other relevant information on Anthem's *Data Sharing* form.
- Seek prior authorization for all services that require it.
- Work reciprocally with physical health providers to document and share the member's primary and secondary diagnoses, findings from assessments, medication prescribed, psychotherapy prescribed, and any other relevant information.
- Provide, at a minimum, a summary of the findings from the member's initial visit to the Primary Medical Provider (PMP). This must be provided within five calendar days of the visit for members **who are not** at risk for hospitalization. This notification must include the behavioral health provider's contact information, visit date, presenting problem, diagnosis, and a list of any medications prescribed.
- Notify Anthem and the member's PMP of any significant changes in the member's status and/or change in the level of care including timely notification of discharge and aftercare plan.
- Ensure that members receiving inpatient psychiatric services are scheduled for follow-up and/or continuing treatment prior to discharge. Anthem requires providers to schedule this treatment between the day after discharge and day seven after discharge.
- Offer hours of operation that are no less than the hours of operation offered to commercial members.
- Encourage members to consent to the sharing of substance abuse treatment information.

Member records and treatment planning

Member records must meet the following standards and contain the following elements, if applicable, to permit effective service provision and quality reviews, with documentation in a prominent place whether there is an executed declaration for behavioral health treatment.

Comprehensive assessment

Providers must submit a comprehensive assessment with a description of the member's physical and mental health status at the time of admission to services. The assessment must be reviewed and approved by the supervising HSPP or MD if completed by a mid-level provider not enrolled with IHCP. It should include:

- Psychiatric and psychosocial assessment:

    - Description of the presenting problem
- Psychiatric history, past treatment, and history of the member's response to crisis situations
- Psychiatric symptoms
- Mental status exam
- Risk assessment
- Family history
- Education history
- Medical assessment:
    - Screening for medical problems
- Medical history
- Primary care provider
- Present medication/prescriber information
- Substance use assessment:
    - Frequently used over-the-counter medications
- Current and historical usage of alcohol and substances
- Impact of substance use in the domains of the community functioning assessment
- History of prior alcohol and substance use disorder treatment episodes and their effectiveness
- Community functioning assessment:
    - Living arrangements, daily activities (vocational/educational)
    - Social support
    - Financial
    - Leisure/recreational
- Physical health
- Emotional/behavioral health
- An assessment of the member's strengths, current life status, personal goals, and needs

Personalized support and care plan

A patient-centered support and care plan based on the psychiatric, medical, substance use, and community functioning assessments found in the initial comprehensive assessment must be completed for any member who receives behavioral health services. There must be documentation in every case that the member and, as appropriate, their family members, caregivers, or legal guardian, participated in the development and subsequent reviews of the treatment plan.

The support and care plan must be completed within the first 14 days of admission to behavioral health services and updated every 180 days, or more frequently as necessary based on the member's progress toward goals or a significant change in psychiatric symptoms, medical condition, and/or community functioning.

There must be a signed release of information to provide information to the member's PMP or evidence that the member refused to provide a signature. There must be documentation that referrals to appropriate medical or social support professionals have been made.

A provider who discovers a gap in care is responsible to help the member get that gap in care fulfilled and documentation should reflect the action taken in this regard.

For providers of multiple services, one comprehensive treatment/care/support plan is acceptable as long as at least one goal is written, and updated as appropriate, for each of the different services that are being provided to the member. The treatment/support/care plan must contain the following:

- Identified problem(s) for which the member is seeking treatment
- Member goals related to each problem identified, written in member-friendly language
- Measurable objectives to address the goals identified
- Target dates for completion of objectives
- Responsible parties for each objective
- Specific measurable action steps to accomplish each objective
- Individualized steps for prevention and/or the resolution of the crisis, which includes identification of crisis triggers (situations, signs, and increased symptoms); active steps or self-help methods to prevent, de-escalate or defuse crisis situations; names and phone numbers of contacts who can assist the member in resolving the crisis; and the member's preferred treatment options, to include psychopharmacology, in the event of a mental health crisis
- Actions agreed to be taken when progress toward goals is less than originally planned by the member and provider
- Signatures of the member as well as family members, caregivers, or legal guardians as appropriate
- Document semiannual care conferences for Hoosier Care Connect members
- Review and signature by the supervising HSPP or MD if completed by a mid-level provider

Progress notes

Progress notes must document the status of the goals and objectives indicated in the treatment plans. Remember, if it is not documented, it did not happen. Progress notes should include:

- Correspondence concerning the member's treatment and signed and dated notations of telephone calls concerning the member's treatment
- Indication of active follow-up actions for referrals given to the member and actions to fill gaps in care
- A brief discharge summary must be completed within 15 calendar days following discharge from services or death
- Discharge summaries for a psychiatric hospital and residential treatment facility admissions that occur while the member is receiving behavioral health services
- The treatment received and the patient's response
- Indication of any severe reaction to medication or need for further monitoring and adjustment of dosage in a controlled setting
- Semiannual care conference notes for Hoosier Care Connect members

Psychotropic medications

Prescribing providers must inform all members considered for the prescription of psychotropic medications of the benefits, risks, and side effects of the medication, alternate medications, and other forms of treatment. If obesity is also a problem, the medical record needs to reflect that a healthy diet and exercise plan has been prepared and given to the member or if appropriate a

referral to a nutritionist or obesity medical professional. If diabetes is a problem, the medical record needs to reflect a discussion with the member about their condition, and their treating provider should be identified in the documentation, and coordination efforts with that provider should be indicated as well. The medical record is expected to reflect such conversations as having occurred. The medical record is expected to indicate the prescription data has been shared with the member's PMP.

Members on psychotropic medications may be at increased risk for various disorders. As such, it is expected that providers are knowledgeable about the side effects and risks of medications and regularly inquire about and seek information about any side effects from medications. This especially includes:

- Follow up to inquire about suicidality or self-harm in children placed on anti-depressant medications as per Food and Drug Administration and American Psychiatric Association guidelines
- Regular and frequent weight checks and measurement of abdominal girth especially for those on antipsychotics or mood stabilizers
- Glucose tolerance test or hemoglobin A1C tests especially for those members on antipsychotics or mood stabilizers
- Triglyceride and cholesterol checks, especially for those members on antipsychotics and mood stabilizers
- ECG checks for members placed on medications with a risk for significant QT-prolongation
- Ongoing checks for movement disorders related to antipsychotic use and psychotic disorders

Guidelines for such testing and follow-up are provided by the American Psychiatric Association among others. Summary guidelines are referenced in our ***Clinical Practice Guidelines*** located on our website at **https://providers.anthem.com/IN** by using the Resources tab > Quality Assurance > Quality Improvement programs. While the prescriber is not expected to personally conduct all of these tests, the prescriber is expected to ensure that these tests occur where indicated and to initiate appropriate interventions to address any adverse results. These tests and interventions must be documented in the member's medical record.

Emergency behavioral health services

Primary medical providers (PMPs) should immediately refer any member who is in crisis or who is a threat to self or others for emergency care. An emergency referral for behavioral health services does not require prior authorization or pre-service review.

Providers can call or refer members to Anthem's Behavioral Health Crisis Line at **833-874-0016**. The behavioral health crisis intervention service is available 24 hours per day, 7 days per week.

Behavioral health referrals

Self-referrals

Members may self-refer to any behavioral healthcare provider in Anthem's network or to an Indiana Health Coverage Program's (IHCP) psychiatrist. If the member is unable or unwilling to access timely services through community providers, call Anthem Member Services for assistance.

PMPs may treat members with situational behavioral health disorders, the most common of which are depression and anxiety. For members whose behavioral health does not respond to treatment in a primary care setting, contact us for information regarding assessment and ongoing services.

Behavioral health services

PMPs are required to refer members who are experiencing acute symptoms of a chronic behavioral health disorder, exhibiting an acute onset of symptoms, or are in a crisis state.

PMPs are also required to make referrals for members whose symptoms of anxiety and mild depression persist or become worse. Any member suspected of developing toxicities to medications that have been prescribed by a psychiatrist will need to be referred back to the behavioral health system for observation and monitoring of medications:

- Adjustment disorder
- Behavioral disorders of children and adolescents
- Bipolar disorders
- Eating disorders
- Substance use disorder
- Co-morbid conditions
- Psychosis
- Schizophrenia
- Major depression
- Post-traumatic stress disorder

Criteria for provider type selection

The following criteria should be met before directing a member to a psychiatrist:

- Member can self-refer for behavioral health treatment
- Member is taking psychoactive medication
- Member is referred by their PMP or under primary medical provider treatment for a relevant problem
- Member, if a child, had prior treatment for the same problem without medication and the problem is severe or disabling in some area of life
- Problem is cognitive and the member has had previous inpatient or day treatment
- Problem is cognitive and overall dysfunction is severe or disabling
- Problem is recurrent or of greater than six months duration and the member has prior treatment
- Problem is recurrent or of greater than six months duration and dysfunction is severe or disabling in any area of functioning
- Problem is somatic and the referral was not from PMP
- Problem is somatic, the member is under PMP, and the problem is severe or disabling in some areas of functioning

Psychologist, licensed clinical social worker (LCSW), licensed mental health counselor (LMHC), or licensed marriage and family therapist (LMFT)

The following criteria should be met before directing a member to a psychologist or other licensed behavioral health professional:

- Identifiable stressor is present
- Member is not taking psycho-active medication
- Member not referred by their PMP, nor under primary medical provider treatment for relevant problem
- Problem is not recurrent nor of greater than six months duration
- Problem is not severe or disabling in any area of functioning

Clinical Practice Guidelines

All providers have access to evidence-based *Clinical Practice Guidelines* for a variety of behavioral health disorders commonly seen in primary care including, but not limited to, attention deficit hyperactivity disorder, bipolar disorder for children and adults, major depressive disorder, schizophrenia, and substance use disorders. These ***Clinical Practice Guidelines*** are located online at **https://providers.anthem.com/IN** by using the Resources tab > Quality Assurance > Quality Improvement > Related Resources > ***Clinical Practice Guidelines***.

Chapter 6: Preventive care and maternal health services

Preventive care

One of the best ways to promote and protect good health is to prevent illness. Members are covered for routine health screenings and immunizations. Additionally, our health services programs provide members with guidelines, reminders, and encouragement to stay well. The following are provider responsibilities that help members maintain healthy lifestyles:

- Document all healthcare screenings, immunizations, procedures, health education, and counseling in the member's medical record.
- Provide immunizations as needed at all well-child visits and according to the schedule established by the Advisory Committee on Immunization Practices (ACIP), the American Academy of Family Physicians (AAFP), and the American Academy of Pediatrics (AAP).
- Refer members, as appropriate, to dentists, optometrists/ophthalmology, or other specialists as needed; document referrals in the member's medical record.
- Schedule preventive care appointments for all children following the AAP periodicity schedule.

Initial Health Assessment

The *Initial Health Assessment* (*IHA*) gives providers the baseline they need to assess and manage a member's physical condition and provide educational support to help them become more active in their healthcare. *IHAs* should be performed within 90 days of enrollment with the following categories:

- Patient history
- Physical examination
- Developmental assessment
- Vision and hearing screening
- Health education
- Screenings and immunizations
- Behavior assessment

Health Needs Screening

In addition to the *IHA*, members also complete the *Health Needs Screening* (*HNS*) to help assess and manage their physical and behavioral health. As an incentive to complete the *HNS*, members will receive up to $30 for retail purchases as part of our Healthy Rewards program. Members must complete the HNS within 90 days of enrollment. There are multiple ways to complete the *HNS* including:

- Going online to **https://hns.anthem.com.**
- Calling **866-408-6131** (Hoosier Healthwise, Healthy Indiana Plan) or **844-284-1797** (Hoosier Care Connect) (TTY **711**). A representative will assist the member.

HealthWatch

HealthWatch is Indiana's Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program. It is a preventive healthcare program providing initial and periodic examinations and medically necessary follow-up care for children in Hoosier Healthwise and Hoosier Care Connect from birth through age 21. For Healthy Indiana Plan, HealthWatch covers members ages 19 and 20. For more information on HealthWatch, visit **https://www.in.gov/medicaid/providers/files/epsdt.pdf**.

HealthWatch screening requirements

Primary medical providers (PMP) should offer health education, counseling, and guidance to the member, parent, or guardian. An evaluation of age-appropriate risk factors should be performed at each visit. In addition, PMPs should perform the following:

- A comprehensive health and developmental history, including both physical and behavioral health development
- A comprehensive unclothed physical exam, which includes pelvic exams and Pap tests for sexually active females
- Appropriate immunizations according to age and health history
- Review documented and current immunizations
- Laboratory tests, including screenings for blood lead levels
- Nutritional assessment
- Tuberculosis screening
- Oral assessment
- Sensory screening (vision and hearing)
- Health education

Members can also call Member Services at **866-408-6131** (Hoosier Healthwise, Healthy Indiana Plan) or **844-284-1797** (Hoosier Care Connect) (TTY 711) for more information about HealthWatch.

Childhood lead exposure

The Centers for Medicare & Medicaid Services require that all children enrolled in Medicaid receive a blood lead screening between the ages of nine months and 15 months, or as close as reasonably possible to the child's appointment. Children should have another blood lead test between the ages of 21 months and 27 months, or as close as reasonably possible to the child's appointment. Any child between the age of 28 months and 72 months that does not have a record of any prior blood lead test must have a blood lead test as soon as possible.

Completion of a lead risk assessment questionnaire does not fulfill this screening requirement; a blood draw is also required.

Anthem has contracted with MEDTOX Laboratories* to provide free, easy-to-use lead exposure screening kits to providers. These kits contain:

- A blood sample card
- Lancets (upon request)
- A plastic, sealable storage bag
- Pediatric lead/hemoglobin requisition form

- Prepaid envelope (large envelopes are available upon request)

To order your free MEDTOX lead exposure blood testing kits, please call MEDTOX at **800-334-1116**, **ext. 4** to arrange for an initial order and to set up an account.

Member incentives

Healthy Rewards program

Anthem encourages members to seek preventive care through our incentive program called Healthy Rewards. Members can earn incentives by participating in preventive services such as pregnancy care, annual wellness checkups, smoking cessation, and completing the Health Needs Screening. Members and providers can learn more at **www.anthem.com/AnthemRewards**.

HIP rollover credit

The Healthy Indiana Plan (HIP) also offers incentives for members to seek preventive care. Referred to as the HIP rollover, members who get certain preventive care services may have the opportunity to lower future POWER account contributions.

HIP Plus members who have money remaining in their POWER account at the end of the benefit year may roll over the portion that they contributed. By getting preventive care, they may qualify to double that amount to reduce their future contributions.

HIP Basic members who get their preventive care may be able to move up to HIP Plus at a discount when they are determined eligible for another benefit year and continue in HIP. The discount may reduce monthly POWER account contributions by up to 50%.

HIP members need only receive one of the preventive services to be considered eligible for the rollover credit. The list of preventive services mirrors the IHCP preventive care services for *HIP and PE Adult Provider Code Table* available on the IHCP code set site.

Maternal health services

New Baby, New Life℠

New Baby, New Life is a proactive case-management program for all expectant mothers and their newborns. It identifies pregnant members as early in their pregnancies as possible through a review of state enrollment files, claims data, hospital census reports, Availity, and notification of pregnancy forms as well as provider and member self-referrals. Once pregnant members are identified, we act quickly to assess obstetrical risk and ensure appropriate levels of care and case management services to mitigate risk.

Experienced case managers work with members and providers to establish a care plan for our highest risk pregnant members. Case managers collaborate with community agencies to ensure mothers have access to necessary services.

When it comes to our pregnant members, we are committed to keeping both mom and baby healthy. That's why we encourage all of our moms-to-be to take part in our New Baby, New Life program — a comprehensive case management and care coordination program offering:

- Individualized, one-on-one case management support for women at the highest risk.

- Care coordination for moms who may need a little extra support.
- Educational materials and information on community resources.
- Incentives to keep up with prenatal and postpartum checkups and well-child visits after the baby is born.

As part of the New Baby, New Life program, members are offered the My Advocate®* program. This program provides pregnant members with proactive, culturally appropriate outreach and education through interactive voice response (IVR). Eligible members receive regular phone calls with tailored content from a voice personality, or they may choose to access the program via a smartphone application or website. This program does not replace the high-touch case management approach for high-risk pregnant members. However, it does serve as a supplementary tool to extend our health education reach. The goal of the expanded outreach is to identify pregnant members who have become high-risk, to facilitate connections between them and our case managers, and improve member and baby outcomes. For more information on My Advocate visit **www.myadvocatehelps.com**.

We encourage providers to complete the Availity platform's *Maternity Module*:

- Perform an *Eligibility and Benefits (E&B) Request* on the desired member.
- Choose one of the following benefit service types: maternity, obstetrical, gynecological, or obstetrical/gynecological.
- Before the benefit results screen, you will be asked if the member is pregnant. Choose **Yes**, if applicable. If you indicate **Yes**, you may provide the estimated due date, if it is known, or leave it blank if the due date is unknown.
- After submitting your answer, the E&B will display. If the member was identified as pregnant, a *Maternity* form will be generated. You may access the form by navigating to the **Applications** tab and selecting the **Maternity** link.

Indiana Pregnancy Promise Program

The Indiana Pregnancy Promise Program is a no-cost, voluntary program for pregnant Medicaid members who use opioids or have used opioids in the past. The goals of the Pregnancy Promise Program are for participants to:

- Enter prenatal care.
- Access the opioid treatment needed to achieve sustained recovery.
- Receive ongoing support and follow-up care for the mother and infant during and after pregnancy.
- Provide hope and set a strong foundation for the future.

Why is the Indiana Pregnancy Promise Program important?

- Opioid use disorder during pregnancy is increasing in Indiana and nationwide.
- Treatment of opioid use disorder during pregnancy has a high rate of success.
- Treating opioid use during pregnancy reduces the risks of harmful effects on mothers and infants.

Who can participate?

The Pregnancy Promise Program is available to pregnant individuals in the state of Indiana. To be eligible, participants must meet the following criteria:

- Pregnant or within [90] days of the end of pregnancy
- Identify as having current or previous opioid use
- Be eligible for or receive Medicaid health coverage

What are the Pregnancy Promise Program benefits?

- **Connection:** Participants in the Pregnancy Promise Program will be matched with a case manager. Case managers will offer confidential support during enrollment to be sure parents and infants receive the care and resources they need during and after pregnancy to be healthy and well.
- **Coordination:** Pregnancy Promise Program case managers will work with participants and their team of doctors and providers to coordinate care and identify community resources for families.
- **Prevention:** By connecting pregnant individuals with healthcare and treatment as early as possible, the Pregnancy Promise Program aims to reduce and prevent the negative impacts of opioid use on the parent and child.

To make a referral visit **www.PregnancyPromise.in.gov**, email **PregnancyPromise@fssa.in.gov**, call **317-234-5336,** or call toll-free at **888-467-2717**. You can also make a referral by calling Anthem Provider Services at one of the following numbers:

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

Reimbursement for the *NOP Risk Assessment*

The *Notice of Pregnancy (NOP) Assessment* was developed by the state of Indiana and is used by all IHCP MCEs. Prenatal care providers that electronically complete and submit the *NOP* in adherence with IHCP guidelines via the IHCP Provider Healthcare Portal may be eligible for a $60 incentive payment. To be eligible for the incentive payment:

- The pregnant members must be enrolled with an MCE.
- The member's pregnancy must be less than 30 weeks gestation at the time of the office visit on which the *NOP* is based.

The *NOP* must be submitted via the IHCP Provider Healthcare Portal no more than five calendar days from the date of the office visit on which the *NOP* is based.

Additionally, in order to receive the *NOP* payment, providers must bill the MCE for the *NOP* incentive payment using Current Procedural Terminology (CPT) code 99354 with modifier TH. The date of service (DOS) on the *NOP* claim should be the date of the office visit on which the information on the *NOP* is based.

Only one *NOP* per member, per pregnancy, is eligible for reimbursement. Uninsured pregnant members, including those with pending IHCP applications, should be referred to Qualified Providers (QPs) so that presumptive eligibility can be established.

Additionally, providers should submit the ***MCS Notification of Delivery Form*** to Anthem within 24 hours of delivery. The form is located online at **https://providers.anthem.com/IN** under Patient Care > Maternal Child Services.

NICU Case Management program

For parents with infants admitted to the neonatal intensive care unit (NICU), we offer the NICU Case Management program. This program provides education and support designed to help parents with the day-to-day stress of having a baby in the NICU, encourages parent/caregiver involvement, and helps to prepare themselves and their homes for discharge. Parents are provided with education and resources that outline successful strategies they may use to collaborate with their baby's NICU care team while inpatient and manage their baby's health after discharge.

Once discharged, NICU case managers continue to provide education and support to foster improved outcomes, prevent unnecessary hospital readmissions, and promote efficient community resource consumption as needed.

The stress of having an infant in the NICU may result in post-traumatic stress disorder (PTSD) symptoms for parents and loved ones. To reduce the impact of PTSD among our members, we assist by:

- Guiding parent(s) into hospital-based support programs.
- Screening parent(s) for PTSD approximately one month after their baby's date of birth.
- Referring parent(s) to behavioral health program resources.
- Reconnecting with a one-month follow-up call to assess if the parent(s) received a benefit from initial contact and PTSD awareness.

Our case managers are here to help you. If you have a member in your care that would benefit from OB and/or NICU case management, please call us at **866-902-1690**. Members can also call our 24-hour NurseLine, available 24 hours per day, 7 days per week for information, support, and referrals: **866-408-6131** (Hoosier Healthwise, HIP) or **844-284-1797** (Hoosier Care Connect).

Breastfeeding support tools and services

The American Academy of Pediatrics, the American College of Obstetrics and Gynecology, and the American Public Health Association recognize breastfeeding as the preferred method of infant feeding. Providers should encourage breastfeeding for all pregnant members unless it is not medically appropriate.

To support this goal, we ask you to:

- Assess all pregnant members for health risks that are contraindications to breastfeeding, such as AIDS and active tuberculosis.
- Provide breastfeeding counseling and support to all breastfeeding postpartum women immediately after delivery.
- Assess postpartum members to determine the need for lactation-durable medical equipment such as breast pumps and breast pump kits.
- Document all referrals and treatments related to breastfeeding in the member's medical record. Pediatricians should document the frequency and duration of breastfeeding in the baby's medical record.
- Refer members to prenatal classes prior to delivery by calling the Health Management and Education department at **866-902-1690**.
- Refer pregnant and postpartum members to 24/7 NurseLine for information, support, and referrals: **866-408-6131** (Hoosier Healthwise, HIP) or **844-284-1797** (Hoosier Care Connect).
- Refer pregnant members to community resources that support breastfeeding such as Women, Infants, and Children (WIC) at **800-522-0874**.
- Support continued breastfeeding during the postpartum visit.

WIC referrals

The Women, Infants, and Children (WIC) program provides healthy food to pregnant members and mothers of young children. Providers have the following responsibilities for Women, Infants, and Children (WIC) program referrals:

- Complete the *WIC Program Referral Form* that documents the following information:
  - Anthropometric data: height, current weight, pregravid weight
  - Any current medical conditions
  - Biochemical data: hemoglobin, hematocrit
  - Expected Date of Delivery (EDD)
- Provide members with a completed referral form to be presented at the local WIC agency

Contact Indiana WIC at **800-522-0874.** Visit **https://www.in.gov/isdh/19691.htm** for the *WIC Program Referral Form*.

Chapter 7: Support services

Case management

Case management is a process that emphasizes collaborative, multidisciplinary teamwork to develop, implement, coordinate, and monitor treatment plans to optimize our members' healthcare benefits. The integration of physical and behavioral health is core to the holistic care management of our members.

The Anthem team takes an innovative approach that is member-centric and provider-focused and is led by our regional physical and behavioral healthcare managers, social workers, member outreach specialists, nurse practice consultants, and Network Relations managers. Our team provides:

- Support and assistance to providers and members, assisting them in navigating the healthcare system.
- Training for healthcare professionals and their staff regarding enrollment, covered benefits, managed care operations, and linguistic services.
- Member support services, including health education referrals, event coordination, and coordination of cultural and linguistic services.
- Care management services to supplement providers' treatment plans and improve our members' overall health.

Anthem's Case Management program is provided at no cost to providers and members and offers expert assistance in the coordination of complex healthcare, including the integration of physical and behavioral health needs. Providers are encouraged to engage and direct development and provide feedback to our members' care plans. Members who would benefit from case management services, but either actively choose not to participate or are unable to participate, may be managed through a provider-focused program.

Role of the case manager

The case manager's role is to assess the member's healthcare and resource needs and:

- Collaborate with the member, family/caregiver, physicians/providers, and case managers to assist with a plan of care.
- Facilitate communication and coordination within the healthcare team and with the member and their family in the decision-making process.
- Educate the member and providers of the healthcare team about care management, community resources, benefits, cost factors, and all related topics so that informed decisions can be made.
- Encourage appropriate use of medical facilities and services, with the goal of improving the quality of care and maintaining cost-effectiveness on a case-by-case basis.
- Provide member assistance in helping with identified psychosocial needs/issues such as caregiver issues, community resource referrals, emergency needs, financial assistance, and long-term care planning.

The Case Management team includes experienced and credentialed registered nurses, many of whom are certified case managers (CCMs), as well as social workers to assist in addressing our members' psychological, social, and financial issues.

Provider responsibility

Providers have the responsibility to participate in the case management process by sharing information and facilitating the process by:

- Referring members who could benefit from case management.
- Sharing information as soon as possible and as early as the initial health assessment if the PMP identifies complex healthcare needs.
- Collaborating with the Case Management team on an ongoing basis.
- Participating in semiannual care conferences for Hoosier Care Connect members.
- Recommending referrals to specialists, as required.
- Monitoring and updating the care plan to promote healthcare goals.
- Notifying the Case Management team if members are referred to services provided by the state or some other institution not covered by the Anthem agreement.

Coordinating county or state-linked services such as public health, behavioral health, schools, and waiver programs. Providers may call the Case Management team for additional assistance for members enrolled in the Individualized Family Services Plan (IFSP) for special needs children and the state's Individualized Education Plan (IEP).

Procedures

When a member has been identified as having a condition that may benefit from case management (CM), the case manager contacts the referring provider to notify them of enrollment and closure of CM. The assigned case manager will also provide direct contact to the CM for provider collaboration and support as needed. Then, with the involvement of the member or the member’s representative and the provider, the case manager develops an individualized care plan. That plan may involve coordinating services with public and behavioral health departments, schools, and other community health resources. The case manager periodically re-assesses the care plan to monitor the following:

- Progress toward goals
- Determine if their present care levels are adequate
- Necessary revisions
- New issues that need to be addressed to help ensure that the member receives the support needed to achieve care plan goals

Potential referrals

There are multiple ways Anthem members may be considered for and referred to complex case management services, including:

- Medical management program referral
- Discharge planner referral
- Member or caregiver referral
- Practitioner referral
- Anthem’s Transition Coordination team when a member transfers to Anthem with former case management services

Providers, nurses, social workers, and members (or their representatives) may request case management services. Examples of cases appropriate for referral include, but are not limited to:

- Auto-immune diseases such as HIV/AIDS
- Adults and children with certain healthcare needs
- Chronic illnesses such as asthma, diabetes, and heart failure
- Hepatitis C
- Complex- or multiple-care needs such as multiple trauma or cancer
- Frequent hospitalizations or ER use
- Hemophilia, sickle cell anemia, cystic fibrosis, cerebral palsy
- Spinal injuries
- High-risk pregnancies
- Potential transplants
- Pre-term births
- HIP medically frail
- HCBS Waiver waitlist members
- Foster children

Providers, nurses, social workers, and members or their representatives may refer members to Case Management by phone at **866-902-1690** or fax at **855-417-1289**.

Accessing specialists

Case managers are available to assist PMPs with access to specialists. Standing referrals or an approved number of visits for access to in-network specialists **do not** require prior authorization. Referrals to out-of-network specialists **do** require prior authorization.

Behavioral health case management

The main functions of the Anthem behavioral health case managers include, but are not limited to:

- Gathering health-risk appraisal data to identify members who would benefit from case management.
- Identifying members at risk using *trigger report data* from medical/behavioral health claims.
- Collaborating with our medical case managers and Condition Care clinicians for members presenting with **co-morbid** conditions.
- Referring members to provider-based case management and coordinating with members and providers with various agencies, medical providers, etc.
- Documenting all actions taken and member outcomes to ensure accurate and complete reporting.

Members who are identified as at-risk for hospitalization due to behavioral health or substance use disorders are offered ongoing case management support. In addition, members who are discharged from inpatient stays are provided case management support for a minimum of 90 days post-discharge.

Condition Care Program

Anthem Condition Care (CNDC) Program is based on a system of coordinated care management interventions and communications designed to help physicians and other healthcare professionals manage members with chronic health conditions.

Our CNDC Managers are registered nurses available at **888-830-4300** from 8:30 a.m. to 5:30 p.m. local time. Confidential voicemail is available 24 hours a day. The 24/7 NurseLine is available for our members 24/7: **866-408-6131** (Hoosier Healthwise, HIP) or **844-284-1797** (Hoosier Care Connect). Visit **https://providers.anthem.com/IN** > Patient Care > Disease Management for more information.

CNDC services include a holistic, member-centered care management approach that allows Case Managers to focus on the multiple needs of members. Our condition care programs include:

- Asthma
- Attention deficit hyperactivity disorder
- Autism/pervasive development disorder
- Bipolar disorder
- Chronic kidney disease
- Chronic obstructive pulmonary disorder
- Congestive heart failure
- Coronary artery disease
- Diabetes
- HIV/AIDS
- Hypertension
- Major depressive disorder — adult and child/adolescent
- Schizophrenia
- Substance use disorder
- Sickle Cell Disease

In addition to our condition-specific condition care (CNDC) Programs, our member-centric holistic approach allows us to assist members with weight management and smoking cessation education.

Program features:

- Proactive identification process
- Program content is based on evidence-based *Clinical Practice Guidelines* from recognized sources
- Collaborative practice models that include the physician and support providers in treatment planning for members
- Continuous self-management education
- Ongoing communication with primary ancillary providers regarding patient status
- Nine of our Condition Care programs are National Committee for Quality Assurance accredited and incorporate outreach, education, care coordination, and follow-up to improve treatment compliance and enhance self-care

Clinical Practice Guidelines

Clinical Practice Guidelines are located on our provider website at **https://providers.anthem.com/IN.** Go to Resources > Quality Assurance > Quality Improvement, or you can call Anthem Provider Services (see **Chapter 1: Contact information**).

Who is eligible?

All members diagnosed with one or more of the listed conditions are eligible for CNDC.

As a valued provider, we welcome your referral of patients who can benefit from additional education and care management support. Our case managers will work collaboratively with you to obtain your input in the development of care plans. Members identified for participation in any of the programs are assessed and risk-stratified based on the severity of their condition. They are provided with continuous education on self-management concepts, which include primary prevention and coaching related to healthy behaviors and compliance/monitoring, as well as case/care management for high-risk members. Providers are given telephonic and/or written updates regarding patient status and progress.

Provider rights

You have the right to:

- Have information about Anthem, including:
  - Provided programs and services
  - Our staff
  - Our staff's qualifications
  - Any contractual relationships
- Decline to participate in or work with any of our programs and services for your patients.
- Be informed of how we coordinate our interventions with your patients' treatment plans.
- Know how to contact the person who manages and communicates with your patients.
- Be supported by our organization when interacting with patients to make decisions about their healthcare.
- Receive courteous and respectful treatment from our staff.

Communicate complaints about the CNDC Program (refer to Chapter 13: Grievances and appeals)

Healthy Families Program

The Healthy Families Program offers families assistance with leading a healthy lifestyle and reducing childhood obesity among our members ages 7 to 17. The Healthy Families program helps members by providing education, community resources, and individualized plans of care over a six-month period.

Right Choices Program (RCP)

The Right Choices Program (RCP) is designed as a safeguard against unnecessary or inappropriate use of Medicaid benefits by members who use Indiana Health Coverage Programs (IHCP) services more extensively than their peers. The goal is to help improve our members' care by reducing the inappropriate use of pharmacies and other health services, which could harm the member and create unnecessary and wasteful program expenditures.

Primary lock-in provider responsibilities in the RCP

By providing a medical *home*, the primary lock-in provider is better able to manage a member's care and coordinate services. By utilizing the Right Choices Program, the member's PMP is made aware of all of the member's treatments and medications. This reduces the potential for contradictory treatments and adverse health outcomes:

- Providers will be notified of lock-in status through a *Lock-in Physician Notification Letter* generated via the state's provider healthcare portal.
- The PMP is required to use referrals if the RCP member requires evaluation or treatment by a specialist or another provider. The purpose of the referral is to assure that the PMP has authorized the visit to the referral provider.
- The referral must be sent to Anthem's RCP administrator to assure that claims from referral providers will be processed for payment.
- Referral providers who treat lock-in members are also responsible for checking Medicaid eligibility and should not treat the member if the PMP's referral has not been obtained.
- The member must be notified in advance of receiving any service that is not covered by Medicaid.
- The member must sign a waiver acknowledging that they will be billed for the non-covered service before receiving the service:
    - The waiver will identify the specific procedure to be performed and the cost, and the member must sign the waiver prior to receiving the service.
- If a member pays cash (and a provider receives cash) for any Medicaid-covered service, it may be considered a fraudulent activity by both parties.
- If the referral provider wants to refer the member to a third physician, the PMP must also sign the referral and send it to Anthem's RCP administrator before the third provider will be added to the member's lock-in list. Additionally, each referral must include the following information:
    - Indiana Health Coverage Program's member's name
    - Indiana Health Coverage Program's member's ID (recipient identification)
    - First and last name of the referral provider (the second physician)
    - First and last name of the referral provider (the third physician)
    - New provider's national provider identifier (NPI)
    - Date of the referral
    - The PMP's manual or electronic signature (office staff signatures are unacceptable)
    - Date(s) of service for which the referral is valid

If no time period is specified on the referral, it will be approved for up to one year depending on the type of provider being added. The start date of the referral will be the date indicated on the referral unless an alternate start date is specified by the PMP. A second pharmacy may be added for the dates of service only.

Exceptions

If the PMP has not sent a referral for the member to Anthem's RCP administrator, and the PMP is not available to write a referral, temporary provider coverage may be approved by the RCP administrator.

Referrals are not required for Medicaid services covered directly by the state unless prescriptions related to those services are going to be dispensed from a pharmacy. The services that do not require referrals include the following:

- Behavioral health
- Dental
- Ophthalmology/optometry care
- Podiatry
- Waiver services

If prescriptions are needed from providers who render services directly from the state, the following options are available:

- The PMP may write the prescription for the referral provider
- The rendering provider may send the PMP's referral to Anthem's RCP administrator for that prescription's addition to the member's lock-in list

Retroactive referrals may be sent in cases where the PMP approves services provided on the date of service but failed to send the referral to Anthem's RCP administrator at that time.

Retroactive referrals may be accepted if the start date of the retroactive referral is within the claims filing limit. The retroactive referral may be valid for up to one year from the retroactive start date. The PMP's medical records for the member should indicate on or near the date of service that the referred service was approved. The PMP is not required to approve any service for which they had no knowledge on the date of service. The following circumstances may be eligible for a retroactive referral:

- Auto-assigned member lives in an underserved area and is unable to select a PMP from that area
- Death of the PMP
- Newly transitioned members into the program (such as wards and foster children) who are in need of treatment within the first 60 days of enrollment
- PMP change is still pending after a previously auto-assigned member has selected a new PMP
- PMP moves out of the region and fails to notify the program
- Urgent, emergent, or ongoing issues (such as dialysis or ER admission) where the member is unable to access necessary services and the assigned PMP is unwilling or unable to provide services or the appropriate referral
- Termination of RCP member care
- Providers may opt to terminate a member's care for specific reasons outlined in the provider's internal office policies and the state's *Right Choices Program Reference Module* available at **https://www.in.gov/medicaid/providers/810.htm**

Reasons for termination include noncompliance with treatment recommendations or abusiveness to office staff. The following are the requirements for the termination of an RCP member:

- The provider is required to deliver a letter to the member, with a 30-day notice, stating that the member's care (by this provider) is being terminated.
- A copy of this letter should be mailed or faxed to Anthem's RCP administrator with any applicable reassignment request forms. The RCP administrator's staff will work with the member to select another provider.
- Referrals made by the terminating provider expire 30 calendar days after the RCP administrator's receipt of the dismissal. Upon approval from the administrator's medical director, the expiration date may be extended under the following extenuating circumstances:
    - New provider is unable to see the member within 30 calendar days
    - RCP member eligibility terminates during the process of changing the PMP and the member is auto-assigned to the dismissing provider

Claims review and adjudication

A major factor in the success of the Right Choices Program is timely and appropriate claims adjudication. Procedures on proper claims submission can be found in the Right Choices Program Reference Module available at **https://www.in.gov/medicaid/providers/810.htm**. Claims for RCP members may be suspended if all claim processing guidelines have not been followed. The following claims processing guidelines are specific to RCP members:

- **Claims from referral providers:**
    - The referral provider must receive from the member's PMP a referral authorizing the member's care for initial service. The referral provider must confirm that the member was not referred through other means, such as member self-referral.
    - The PMP must directly supply their IHCP provider number to the referral provider. This number should not be given to the RCP member.
    - If the referral provider writes a prescription, it is recommended that the written referral accompany the prescription to the primary lock-in pharmacy. If the referral does not accompany the prescription, the pharmacy should contact the RCP administrator to verify the validity of the referral.
- **Claims from out-of-state providers—**Out-of-state (OOS) generic provider numbers will not bypass the lock-in list or be accepted as valid. Therefore, all providers must have an IHCP provider number to be covered providers for the Right Choices Program. If the provider is out-of-state, the primary lock-in pharmacy should determine whether the provider has an IHCP provider number:
    - If the provider has an IHCP provider number, they may be considered a covered provider if the RCP administrator deems the referral or use of service valid.
    - If the out-of-state provider does not have an IHCP provider number, the provider is not an RCP-covered provider and the RCP administrator should be contacted in order to process an override, if appropriate.

Prescriptions upon discharge from the hospital

If discharge prescriptions are being written for the RCP member to be filled at the primary lock-in pharmacy, the hospital should contact the member's PMP prior to discharge. The PMP should request that the discharging provider be added to the member's lock-in list for a specified timeframe.

If an emergency supply of discharge medications is provided by the hospital pharmacy to the RCP member upon discharge, claims for the prescriptions will not be reimbursed by Indiana Medicaid unless there is an emergency indicator on the pharmacy claim and the PMP has made a valid referral for the discharging provider to be added to the member's lock-in list for the specified time frame.

24/7 NurseLine

We recognize that questions about healthcare prevention and management don't always come up during office hours. The Anthem 24/7 NurseLine, a phone line staffed 24 hours per day, 7 days per week by registered nurses, provides a powerful provider support system and is an invaluable component of after-hours care. The 24/7 NurseLine allows members to closely monitor and manage their own health by giving them the ability to ask questions whenever they come up. For the NurseLine, call **866-408-6131** (Hoosier Healthwise, Healthy Indiana Plan) or **844-284-1797** (Hoosier Care Connect).

24/7 NurseLine information:

- Self-care information, including assistance with symptoms, medications and side effects, and reliable self-care home treatments.
- Access to specialized nurses trained to discuss health issues specific to our teenage members.
- Information on more than 300 healthcare topics through the 24/7 NurseLine audio tape library.
- Providers may use the 24/7 NurseLine as a resource for members to call for non-emergent questions and information.
- Members who contact the 24/7 NurseLine prior to visiting the emergency room but are advised to go to an emergency room, will not be subject to copays.
- 24/7 NurseLine has access to telephone interpreter services for callers who do not speak English.
- All calls made to the 24/7 NurseLine are confidential.

Behavioral Health Crisis Line

Providers frequently recognize escalating member situations and are often best positioned to identify and prevent crises. A critical component of a crisis plan is to have an identified support available to assist. The Anthem Behavioral Health Crisis Line provides access to BH clinicians who maintain continuous, active engagement with members to assist in de-escalation and stabilization. They work closely with the member and parents, including foster parents or caregivers, to establish a plan for crisis resolution and follow-up that is appropriate to the member's needs and the services or supports available such as community resources.

Behavioral Health Crisis Line: **833-874-0016**
Available 24 hours per day, 7 days per week

Suicide Prevention Outreach Team (SPOT)

Anthem's Suicide Prevention Outreach Team (SPOT) targets adolescents ages 12 to 17 and young adults ages 18 to 26 who are at high risk for suicide and/or have made a suicide attempt. Members are identified through data modeling to be at high risk or critical risk of suicide. The program provides:

- Materials designed for parents/guardians focused on mindfulness, distress tolerance, interpersonal effectiveness, and emotional regulation, including skills training and self-care action plan.
- Crisis telephone support for Anthem's Behavioral Health Crisis Line.
- More intensive support for members identified via phone communications such as 24/7 crisis support and a dedicated telephonic care manager to support the parent/guardian or young adult to provide additional coaching on threat assessment, means reduction, appropriate boundaries, and related psychosocial support and skills training.

Tobacco treatment programs

Anthem offers our Smoking Cessation Provider Incentive Program as a way of rewarding our providers to provide smoking cessation counseling to members who use tobacco, including referring them to Indiana's Tobacco Quitline. Speak with your Network Relations manager or call Provider Services to learn more about the program.

We support the National Cancer Institute's health education program for members who want to quit smoking. Program goals are to:

- Assist members in improving their health status and quality of life by becoming more actively involved in their own care.
- Encourage members to quit smoking.
- Support members' tobacco cessation efforts with resources and education.

The National Cancer Institute has developed a booklet called *Clearing the Air*. The booklet provides tips to support tobacco cessation by identifying available resources and offering tools for quitting, such as:

- Winning strategies of successful quitters
- Coping skills for fighting the urge to smoke
- Strategies for success after a relapse
- National Quitline contact information — **877-44U-QUIT (877-448-7848)**

Requests for the booklet can be made in several ways. Once enrolled, members can make a direct request by using the contact information provided in the Plan's welcome packet, or they can request the booklet through the 24/7 NurseLine: **866-408-6131** (Hoosier Healthwise, Healthy Indiana Plan) and **844-284-1797** (Hoosier Care Connect). They can also make the request by talking to a care manager.

The booklet is available to download from the following websites:

- Smokefree.gov: **https://smokefree.gov/sites/default/files/pdf/clearing-the-air-accessible.pdf**
- National Cancer Institute: **https://www.cancer.gov/publications/patient-education/clearing-the-air**

Providers are encouraged to refer members to the Indiana Tobacco Quitline, which is confidential and free of charge to Indiana residents. The Indiana Tobacco Quitline offers education, including vaping literature and in-school programs, and coaching over the telephone, as well as Nicotine Replacement Therapy patches and lozenges and the medication Varenicline (Chantix).

Members are limited to 180 days of medications per calendar year. There is no limit to tobacco counseling services. Copayments when applicable are required for over-the-counter (OTC) and prescription medications. Counseling should be included in any combination of treatments:

- Indiana Tobacco Quitline: **800-QUIT-NOW**
- Hours of Operation: 8 a.m. to midnight Monday to Sunday
- Website: **www.in.gov/quitline**

Healthy Lifestyles Tobacco Free helps each member develop a personalized *Quit Tobacco Plan*. The plan is based on the member's current state of health, risk factors, behaviors, and lifestyle. It also takes into consideration the psychological and preference factors associated with the change process. Healthy Lifestyles Tobacco Free provides each individual with the support, resources, and motivation to successfully achieve their goal.

Provider assessment of tobacco use

The following are provider guidelines to help members quit smoking:

- Assess the member's smoking status and offer advice about quitting.
- Refer members to the National Quit Line or the Indiana Tobacco Quitline, a free, phone-based counseling service. Services are available 7 days a week in more than 170 languages and include:
    - Four prearranged calls with a coach for adults.
    - Ten prearranged calls with a coach for a pregnant member (special program).
    - Five prearranged calls with a coach for youth.
    - Seven prearranged calls with a coach for members with behavioral health diagnoses.
    - Unlimited web coaching.
    - Unlimited call-in privileges and access to coaches.
    - Free two-week NRT starter kit (uninsured, Medicaid, Medicare).
    - Stage-based support materials.
    - Resources for providers who want to improve patient outcomes.
    - Support for family and friends who want to help loved ones stop smoking.
    - Services specific to individuals with qualifying behavioral health diagnoses.

Use the state's online *Notification of Pregnancy* (*NOP*) form at **https://portal.indianamedicaid.com** to notify us, through the state, of pregnant members who smoke. Members are more likely to quit smoking during pregnancy.

Encourage pregnant members to stop smoking and not resume after pregnancy. Members who are pregnant and voice a desire to quit smoking will be directly referred to the Indiana Tobacco Quitline by Anthem staff. Additionally, members may be referred to Indiana Baby and Me Tobacco Free Program, if available in the member's community.

Additional resources

Anthem offers additional educational resources to help members who are pregnant or of childbearing age quit smoking and avoid starting again. Read the **New Baby, New Life flyer** for information about incentives for moms who engage in the Indiana Tobacco Quitline**.** Refer

members to **www.anthem.com/AnthemRewards** for more information on tobacco cessation and other incentives. Provider types who may perform tobacco cessation counseling include:

- Physicians
- Physician assistants
- Nurse practitioners
- Registered nurses
- Psychologists
- Pharmacists
- Dentists

Weight management programs

Healthy Lifestyles Healthy Weight is a comprehensive weight management program that engages, educates, motivates, and supports people in achieving a healthy weight. The program helps each individual member develop a personalized weight management plan tailored to their unique needs. The plan is based on their current state of health and risk factors, behaviors, and lifestyle. It also takes into consideration the psychological and preference factors associated with the change process.

Childhood obesity education

Get Up and Get Moving! is our health education program addressing childhood obesity. The focus is to empower families with young children with knowledge of proper nutrition and physical activity. The key educational concept of this program is that regular exercise and nutrition are the basis of a healthy family lifestyle. Family workbooks are available in English and Spanish to parents of children ages 6 to 12 by calling Provider Services.

WW® Program

In addition, Anthem offers members various enhanced services which target weight management. Through referrals from their PMPs or case managers, qualifying Hoosier Care Connect and Healthy Indiana Plan Plus members with a body mass index over 30 may participate in a WW® (formerly Weight Watchers) program. Gym memberships or home fitness kits are another enhanced service Anthem offers qualifying Healthy Indiana Plan Plus members with a referral from their PMPs or Case Managers.

Culturally and linguistically appropriate services

Patient panels are increasingly diverse, and needs are becoming more complex. It is important for providers to have the knowledge, resources, and tools to offer culturally competent and linguistically appropriate care. Anthem wants to help, as we all work together to achieve health equity.

The U.S. Department of Health and Human Services (HHS) defines cultural competence as the ability to honor and respect the beliefs, languages, interpersonal styles, and behaviors of individuals and families receiving services, as well as staff members who are providing such services. It is a dynamic, ongoing developmental process requiring a long-term commitment. The Agency for Healthcare Research and Quality (AHRQ) Patient Safety Network explains that

healthcare is defined through a cultural lens for both patients and providers. A person's cultural affiliations can influence:

- Where and how care is accessed and how symptoms are described.
- Expectations of care and treatment options.
- Adherence to care recommendations.

Providers also bring their own cultural orientations, including the culture of medicine.

Offering culturally and linguistically appropriate care incorporates a variety of skills and knowledge, including, but not limited to, the ability to:

- Recognize the cultural factors (norms, values, communication patterns, and world views) that shape personal and professional behavior.
- Develop an understanding of others' needs, values, and preferred means of having those needs met.
- Formulate culturally competent treatment plans.
- Understand how and when to use language support services, including formally trained interpreters and auxiliary aids and services, to support effective communication.
- Avoid the use of family members, especially minors, to act as interpreters for limited English proficient patients.
- Understand and adhere to regulations to support the needs of diverse patients, such as the Americans with Disabilities Act (ADA).
- Use culturally appropriate community resources as needed to support patient needs and care.

Anthem ensures providers have access to resources to help support the delivery of culturally and linguistically appropriate services. We encourage providers to access and utilize the following resources.

MyDiversePatients.com: The My Diverse Patient website offers resources, information, and techniques, to help provide the individualized care every patient deserves regardless of their diverse backgrounds. The site also includes learning experiences on topics related to cultural competency and disparities that offer free Continuing Medical Education (CME) credit. Current CME offerings include:

- **Caring for Children with ADHD:** Promotes understanding of and adherence to diagnosis and treatment guidelines; use of AAP's *Resource Toolkit for Clinicians*; awareness of and strategies for addressing disparities.
- **Creating an LGBT-Friendly Practice:** Helps providers understand the fears and anxieties LGBT patients and their families often feel about seeking medical care, learn key health concerns of LGBT patients, and develop strategies for providing effective healthcare to LGBT patients.
- **Improving the Patient Experience:** Helps providers identify opportunities and strategies to improve patient experience during a healthcare encounter.
- **Medication Adherence:** Helps providers identify contributing factors to medication adherence disparities for diverse populations and learn techniques to improve patient-centered communication to support the needs of diverse patients.

- **Moving Toward Equity in Asthma Care:** Helps providers understand issues often faced by diverse patients with asthma and develop strategies for communicating to enhance patient understanding.
- **Reducing Healthcare Stereotype Threat (HCST):** Helps providers understand HCST and the implications for diverse patients as well as the benefits of reducing HCST to both providers' patients and practices, and how to do so.
- **Cultural Competency Training (Cultural Competency and Patient Engagement):** A training resource to increase cultural and disability competency to help effectively support the health and healthcare needs of your diverse patients.
- **Caring for Diverse Populations Toolkit:** A comprehensive resource to help providers and office staff increase effective communication by enhancing knowledge of the values, beliefs, and needs of diverse patients.

Anthem appreciates the shared commitment to ensuring members receive culturally and linguistically appropriate services to support effective care and improved health outcomes.

Interpreter services

Providers must notify members of the availability of oral interpreter services and strongly discourage the use of friends and family members, especially children, acting as interpreters. Multi-lingual staff should self-assess their non-English language speaking and understanding skills prior to interpreting on the job. You can find an employee language prescreening tool in our **Caring for Diverse Populations Toolkit** on our website **https://providers.anthem.com/indiana-provider/home** under Training Academy > Cultural Competency Resources > Caring for Diverse Populations.

For those instances when you cannot communicate with a member due to language barriers, Anthem offers 24-hour access to telephone interpreter services in more than 140 languages at no cost to you or the member. Face-to-face interpreters for members needing language assistance, including American Sign Language, are available by placing a request at least 72 hours in advance. A 24-hour cancellation notice is required.

To request interpreter services, providers and members should call the following numbers:

- Provider Services:
  - Hoosier Healthwise: **866-408-6132**
  - Healthy Indiana Plan: **844-533-1995**
  - Hoosier Care Connect: **844-284-1798**
- Member Services:
  - Hoosier Healthwise, Healthy Indiana Plan: **866-408-6131**
  - Hoosier Care Connect: **844-284-1797**
  - TTY: **711**

Providers can also email their request for a face-to-face interpreter to ssp.interpret@anthem.com.

Support for members with hearing loss or speech impairment

The Indiana relay service is available 24 hours a day by calling **800-743-3333** or **711**. For additional information on interpreter services, please go to **https://providers.anthem.com/indiana-provider/home** under the Training Academy > Cultural Competency Resources.

Advance directives

Recognizing a person's right to dignity and privacy, our members have the right to execute an advance directive, also known as a *Living Will*, to identify their wishes concerning healthcare services should they become incapacitated. Providers may be asked to assist members in procuring and completing the necessary forms. More information can be found on our website **https://providers.anthem.com/indiana-provider/home** under Patient care > Health education.

Advance Directive documents should be on hand in the event a member requests this information. Any request should be properly noted in the medical record.

Chapter 8: Provider types, access, and availability

At Anthem, our goal is to provide quality healthcare to the right member, at the right time, in the appropriate setting. To achieve this goal, PMPs, specialists, and ancillary providers must fulfill their roles and responsibilities with the highest integrity.

Provider types

Primary medical providers

Anthem's primary medical providers (PMPs) are the principal point of contact for our members. Their role is to provide members with a medical *home*, their first stop in the healthcare process, and a centralized hub for a wide variety of ongoing healthcare needs. The PMP's role is to:

- Pull the member panel roster off Availity.
- Coordinate a member's healthcare, 24 hours per day, 7 days per week.
- Integrate physical and behavioral healthcare for their patients.
- Develop the member's care and treatment plan, including preventive care.
- Maintain the member's current medical record, including documentation of all services provided by the PMP and any specialty or referral services.
- Adhere to the general appointment scheduling, as outlined within this provider manual.
- Refer members for specialty care.
- Coordinate with physical and behavioral services.
- Provide complete information about proposed treatments and prognosis for recovery to our members or their representatives.
- Facilitate interpreter services by presenting information in a language that our members or their representatives can understand.
- Ensure that members' medical and personal information is kept confidential as required by state and federal laws.

Physician assistants and advanced practice nurses (APRNs)

Anthem will allow IHCP-enrolled physician assistants and advanced practice registered nurses (APRNs) to serve as PMPs. The types of APRNs who may now serve as PMPs with Anthem include:

- Nurse practitioners (NPs)
- Certified nurse midwives (CNMs)
- Clinical nurse specialists (CNSs)

To serve as a PMP, physician assistants, and APRNs must:

- Hold the appropriate certification and licensure to practice medicine in the state of Indiana.
- Be contracted and enrolled with Indiana Health Coverage Programs (IHCP) and be attested at all practice service locations.
- Be contracted, enrolled, and credentialed with Anthem to serve as a PMP in our network.

- Have a collaborative agreement with a physician participating in the affiliated group (**Note**: the supervising physician must be a member of the group either as a PMP or specialist).
- Provide services in compliance with IHCP policies.
- Bill for rendered services in accordance with IHCP guidelines.
- File claims with their individual NPI as the rendering provider.
- Physician Assistants and APRNs can serve at one or two PMP service locations.

Anthem providers are encouraged to engage and direct development and provide feedback to our members' care plans. Services should always be provided without regard to race, religion, sex, color, national origin, age, or physical/behavioral health status.

Anthem members select a contracted PMP as their primary provider of healthcare services. If the member does not select a PMP, Anthem will assign a PMP to the member. Members may choose to change their PMP at any time.

We keep providers up to date with detailed member information. Anthem furnishes each PMP with a current list of assigned members and, from time to time, provides medical information about the members' potential healthcare needs. In this way, providers can more effectively provide care and coordinate services.

Semiannual Care Conferences

Providers who serve Hoosier Care Connect members engaged in care management shall participate in **Semiannual Care Conferences** with an interdisciplinary care team. The goal is to coordinate services for Hoosier Care Connect members across the care continuum. Providers may bill for the semiannual conference using HCPCS code 99211 SC.

Hoosier Care Connect members who would benefit from case management services, but either actively choose not to participate or are unable to participate, may be managed through a provider-focused program.

Specialists

Specialists, licensed with additional training and expertise in a specific field of medicine, supplement the care given by PMPs and are charged with the same responsibilities. That includes the responsibility for ensuring that necessary prior authorizations have been obtained before providing services.

Access to specialty care begins in the PMP's office. The PMP will refer a member to a specialist for conditions beyond the PMP's scope of practice that are medically necessary. Specialists diagnose and treat conditions specific to their area of expertise. Specialty care is limited to Anthem benefits.

The following guidelines are in place for specialist providers:

- For **urgent care**, the specialist should see the member within 24 hours of receiving the request.
- For **routine care**, the specialist should see the member within 2 weeks of receiving the request.

In some cases, a member may self-refer to a specialist. These cases include, but are not limited to:

- Family planning and evaluation
- Diagnosis, treatment, and follow-up of sexually transmitted infections (STIs)

Specialists are responsible for ensuring that necessary pre-authorizations have been obtained prior to providing services.

For some medical conditions, it makes sense for the specialist to **be** the PMP. Members may request that the specialist be assigned as the PMP if:

- The member has a chronic illness.
- The member has a disabling condition.
- The member is a child with special healthcare needs.

Referrals

PMPs coordinate and make referrals to specialists, ancillary providers, and community services. Providers should refer members to network facilities and providers. When this is not possible, providers should follow the appropriate process for requesting out-of-network referrals. Specialty referrals to network providers do not require prior authorization.

All primary medical providers:

- Are expected to help members schedule appointments with other healthcare providers, including specialists.
- Are expected to track and document appointments, clinical findings, treatment plans, and care received by members referred to specialists or other healthcare providers to ensure continuity of care.
- Are expected to refer members to health education programs and community resource agencies, when appropriate.
- Must coordinate with the Women, Infants, and Children (WIC) program to provide medical information necessary for WIC eligibility determinations, such as height, weight, hematocrit, or hemoglobin.
- Coordinate with the local tuberculosis (TB) control program to ensure that all members with confirmed or suspected TB have a contact investigation and receive directly observed therapy (DOT).
- Report to the Indiana Family and Social Services Administration (FSSA) or the local TB control program any member who is noncompliant, drug-resistant, or who is or may be posing a public health threat.
- Are responsible for screening and evaluation procedures for detection and treatment of, or referral for, any known or suspected behavioral health problems and disorders.

Out-of-network referrals

We recognize that there may be instances when an out-of-network referral is justified. Anthem's Utilization Management (UM) team will work with the PMP to determine medical necessity; after that, out-of-network referrals will be authorized on a limited basis.

Office hours

To maintain continuity of care, providers' office hours must be clearly posted, and members must be informed about the provider's availability at each site. There are strict guidelines for providing access to healthcare 24 hours per day, 7 days per week:

- Providers must be available 24 hours per day by telephone.
- When a provider is not available, an on-call provider must be available to take calls.

After-hours services

Our members have access to quality healthcare 24 hours per day, 7 days per week. That means PMPs must have a system in place to ensure that members can call after hours with medical questions or concerns. Anthem monitors PMP compliance with after-hours access standards on a regular basis. Failure to comply may result in corrective action. PMPs must adhere to the following after-hours protocols.

Answering service or after-hours personnel must:

- Forward member calls directly to the PMP or on-call provider or instruct the member that the provider will contact the member **within 30 minutes**.
- Ask the member if the call is an emergency. In the event of an emergency, they must immediately direct the member to dial **911** or proceed directly to the nearest hospital emergency room.
- Have the ability to contact a telephone interpreter for members with language barriers.
- Return all calls.

Members can also call the 24/7 NurseLine information phone line to speak to a registered nurse. Nurses provide health information and options for accessing care, including emergency services, if appropriate.

Answering machine messages:

- May be used in the event that staff or an answering service is not immediately available.
- Must instruct members with emergency healthcare needs to dial **911** or proceed directly to the nearest hospital emergency room.
- Must provide instructions on how to contact the PMP or on-call provider in a non-emergency situation.
- Must provide instructions in English, Spanish, and any other language appropriate to the PMP's practice.

Network on-call providers

Anthem prefers that PMPs use network providers for on-call services. When that is not possible, the PMP must help ensure that the covering on-call physician or other professional provider abides by the terms of the Anthem *Provider Contract*.

Anthem will monitor PMP compliance with after-hours access standards on a regular basis. Failure to comply may result in corrective action.

Members can also call the 24/7 NurseLine information line, 24 hours per day, 7 days per week, to speak to a registered nurse. These nurses provide health information regarding illness and options for accessing care, including emergency services.

Access to care standards

Following guidelines set by the National Committee for Quality Assurance (NCQA), the American College of Obstetricians and Gynecologists (ACOG), and the Indiana Family and Social Services Administration (FSSA), access to care standards help ensure that medical appointments, emergency services, and continuity of care for new and transferring members are provided fairly, reasonably, and within specific time frames. Anthem monitors provider compliance with access to care standards on a regular basis. Failure to comply may result in corrective action.

General appointment scheduling

PMPs, specialists, and behavioral healthcare providers must make appointments for members from the time of request as follows:

Nature of visit	Appointment standards
Emergency examinations	Immediate access during office hours
Behavioral health emergent, non-life-threatening, and crisis stabilization	Within 6 hours of request
Urgent examinations	Within 24 hours of request
Urgent: behavioral health	Within 48 hours of referral/request
Non-urgent sick visits	Within 72 hours of request
Non-urgent routine exams	Within 21 days of member request
Specialty care examinations	Within 3 weeks of request
Outpatient behavioral health examinations	Within 10 days of request
Routine behavioral health visits/initial visit for routine care	Within 10 business days of request
Outpatient treatment	Within 7 days of discharge
Post-psychiatric inpatient care	Within 7 days of discharge

Exceptions are permitted for routine cases, other than clinical preventive services when PMP capacity is temporarily limited.

Prenatal and postpartum visits

Nature of visit	Appointment standards
First trimester	Within 14 days of request
Second trimester	Within 7 days of request
Third trimester	Within 3 business days of request or immediately if an emergency
High-risk pregnancy	Within 3 business days of request or immediately if an emergency
Postpartum Exam	Between 1 to 12 weeks after delivery

Missed appointment tracking

When members miss appointments, providers must do the following:

- Document the missed appointment in the member's medical record.
- Make at least three attempts to contact the member to determine the reason for the missed appointment.
- Provide a reason in the member's medical record for any delays in performing an examination, including any refusals by the member.

Continuity of care

Anthem provides continuity of care for members who are in a state of transition.

Qualifying condition: A medical condition that may qualify a member for continued access to care and continuity of care. These conditions include, but are not limited to:

- Acute conditions (cancer, for example)
- Degenerative and disabling conditions, including conditions or diseases caused by a congenital or acquired injury or illness that require a specialized rehabilitation program or a high level of service, resources, or coordination of care in the community
- Newborns, who are covered retroactively to the date of birth
- Organ transplant or tissue replacement
- Pregnancy, with 12 weeks or less remaining before the expected delivery date, through immediate postpartum care
- Scheduled inpatient/outpatient surgery that has been prior approved and/or pre-certified through the applicable Indiana Family and Social Services Administration (FSSA) process
- Serious chronic conditions (hemophilia, for example)
- Terminal illness

States of transition may be any one of the following:

- The member is newly enrolled
- The member is moving out of the service area
- The member is disenrolling from Anthem to another health plan
- The member is exiting Hoosier Healthwise, HIP, or Hoosier Care Connect to receive excluded services
- The member is hospitalized on the effective date of transition
- The member is transitioning through behavioral health services
- The member is undergoing the *Indiana Preadmission Screening/Resident Review Screening* for long-term care placement

- The member has appointments within the first month of plan membership with specialty providers that were scheduled prior to the effective date of membership
- The provider's contract terminates

Anthem providers help ensure continuity and coordination of care through collaboration. This includes the confidential exchange of information between PMPs and specialists as well as behavioral health providers. In addition, Anthem helps coordinate care when the provider's contract has been discontinued to help with a smooth transition to a new provider.

Providers must maintain accurate and timely documentation in the member's medical record including, but not limited to:

- Consultations
- Prior authorizations
- Referrals to specialists
- Treatment plans

All providers share responsibility for communicating clinical findings, treatment plans, prognosis, and the member's psychosocial condition as part of the coordination process. Care management nurses review member and provider requests for continuity of care. These nurses facilitate continuation with the current provider until a short-term regimen of care is completed or the member transitions to a new practitioner.

Adverse determination decisions are sent in writing to the member and provider within two business days of the decision. Members and providers can appeal the decision by following the procedures in **Chapter 13: Grievances and appeals**. Reasons for continuity of care denials include, but are not limited to the following:

- Course of treatment is complete
- Member is ineligible for coverage
- Not a qualifying condition
- Request is for change of PMP only and not for continued access to care
- Requested services are not covered
- Services rendered are covered under a global fee

Anthem neither imposes any pre-existing condition limitations on its Medicaid members nor requires evidence of insurability to provide coverage to any Anthem member.

Members moving to an out-of-service area

If a member moves to an out-of-service area, Anthem continues to provide coverage until the member's eligibility is ended.

Services not available within the network

Anthem will provide members with timely and adequate access to out-of-network services for as long as those services are necessary and not available within the network. When referring a member for additional services, the referring provider must forward their NPI to the provider being referred to. The referring PMP and the specialist should follow these steps:

- The PMP should fax the form to the specialist to ensure that the specialist has the PMP's NPI.
- If the referring PMP’s NPI number is not provided, the specialist will be responsible for contacting the PMP’s office to obtain it.
- The member must be made aware that the provider they are being referred to is in-network or out-of-network.
- Referrals are valid for as long as the member is under the care of the specialist.

Chapter 9: Provider procedures and responsibilities

Provider rights and responsibilities

Rights

Anthem network providers, acting within the lawful scope of practice, shall not be prohibited from advising a member or advocating on behalf of a member for any of the following:

- The member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered.
- Any information the member needs in order to decide among all relevant treatment options.
- The risks, benefits, and consequences of treatment or non-treatment.
- The member's right to participate in decisions regarding their healthcare, including the right to refuse treatment and to express preferences about future treatment decisions.
- To receive information on the *Grievance and Appeal* and *State Fair Hearing* procedures.

Anthem network providers have the right to the following:

- To have access to policies and procedures covering authorization of services.
- To be notified of any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested.
- To challenge, on behalf of our members, the denial of coverage, or payment for, medical assistance.
- To be free from discrimination for the participation, reimbursement, or indemnification of any provider who is acting within the scope of their license or certification under applicable law solely based on that license or certification.

Anthem's network provider selection of policies and procedures does not discriminate against providers who serve high-risk populations or specialize in conditions that require costly treatment.

Prohibited activities

All providers are prohibited from:

- Billing eligible members for covered services and billing members for non-covered services without a waiver that meets federal standards.
- Segregating members in any way from other persons receiving similar services, supplies, or equipment.
- Discriminating against Anthem members or Medicaid participants.

Responsibilities

There are a number of responsibilities applicable to all Anthem providers. They include:

- After-hours services
- Member disenrollment
- Initial health assessment
- Eligibility verification
- Collaboration
- Confidentiality
- Licenses and certifications
- Mandatory reporting of abuse
- Medical records standards and documentation
- Office hours
- Open clinical dialog/affirmative statement
- Oversight of non-physician practitioners
- Pre-service reviews
- Prohibited activities
- Provider contract terminations
- Termination of ancillary provider/patient relationship
- Updating provider information
- Maintain all licenses, certifications, permits, accreditations, or other prerequisites required by anthem and federal, state, and local laws

Submitting provider demographic data requests and roster submissions through roster automation

Use the Provider Data Management (PDM) application on Availity Essentials to verify and initiate care provider demographic change requests for all professional and facility care providers*. **Going forward, the PDM application is now the preferred intake tool for care providers to submit demographic change requests, including submitting roster uploads.** If preferred, Providers may continue to utilize the Provider Enrollment application in Availity Essentials to submit requests to add new practitioners under existing groups for available provider types.

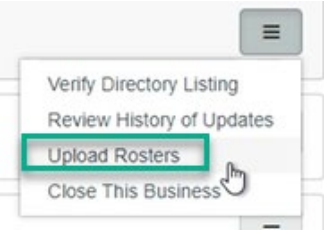
Within the PDM application, Providers have the choice and flexibility to request data updates via the standard PDM experience or by submitting a spreadsheet via a roster upload.

Roster Automation is our new technology solution designed to streamline and automate provider data additions, changes, and terminations that are submitted using a standardized Microsoft Excel document. Any provider, whether an individual provider/practitioner, group, or facility, can use Roster Automation today:**

The resources for this process are listed below and available on our website. Visit **https://providers.anthem.com/IN**, then under For Providers, select Forms and Guides. The **Roster Automation Rules of Engagement** and **Roster Automation Standard Template** appear under the Digital Tools category.

- **Roster Automation Rules of Engagement**: This is a reference document, available to ensure error-free submissions, driving accurate and more timely updates through automation.
- **Roster Automation Standard Template:** Use this template to submit your information. More detailed instructions on formatting and submission requirements can also be found on the first tab of the Roster Automation Standard Template (*User Reference Guide*).
- Upload your completed roster via the Availity PDM application.

Accessing PDM Application:
Log onto **availity.com** and select **My Providers > Provider Data Management** to begin the attestation process. If submitting a roster, find the TIN/business name for which you want to verify and update information. Before you select the TIN/business name, select the three-bar menu option on the right side of the window, select **Upload Rosters** (see screenshot below), and follow the prompts.



Availity Administrators will automatically be granted access to PDM. Additional staff may be given access to **Provider Data Management** by an administrator. To find your administrator, go to **My Account Dashboard > My Account > Organization(s) > Administrator Information**.
***** Exclusions:

- Behavioral Health providers contracted with Carelon Behavioral Health who continue to follow the process for demographic requests and/or roster submissions, as outlined by Carelon Behavioral Health
- Any specific state mandates or requirements for provider demographic update

****** If any roster data updates require credentialing, your submission will be routed appropriately for further action.

Hospital scope of responsibilities

PMPs refer members to plan-contracted network hospitals for conditions beyond the PMP's scope of practice that are medically necessary. Hospital care is limited to plan benefits. Hospital professionals diagnose and treat conditions specific to their area of expertise. Hospital responsibilities include the following:

- **Notification of admission and services**
  - The hospital must notify Anthem or the review organization of admission or service at the time the member is admitted or a service is rendered. If the member is admitted or a service is rendered on a day other than a business day, the hospital must notify Anthem of the admission or service the morning of the next business day following the admission or service.
- **Notification of preservice review decision**

- If the hospital has not received notice of preservice review determination at the time of a scheduled admission or service, as required by the *Utilization Management Guidelines* and the *Hospital Agreement*, the hospital should contact Anthem and request the status of the decision.

Any admission or service that requires preservice review, as discussed in the *Utilization Management Guidelines* and the *Hospital Agreement*, and has not received the appropriate review, may be subject to post-service review denial. Generally, the provider is required to perform all preservice review functions with Anthem; however, the hospital may ensure, before services are rendered, that such has been performed, or risk post-service denial.

Ancillary scope of responsibilities

PMPs and specialists refer members to plan-contracted network ancillary professionals for conditions beyond the PMP's or specialist's scope of practice that are medically necessary. Ancillary professionals diagnose and treat conditions specific to their area of expertise. Ancillary care is limited to plan benefits.

Anthem has a wide network of participating healthcare professionals and facilities. All services provided by the healthcare professional, and for which the healthcare professional is responsible, are listed in the *Ancillary Agreement.*

Eligibility verification

All providers must verify member eligibility each time they encounter the member before services are delivered. Eligibility may change frequently. Anthem is not permitted to reimburse for charges incurred by ineligible persons.

Collaboration

Providers share the responsibility of giving respectful care, working collaboratively with Anthem specialists, hospitals, ancillary providers, and members and their families. Providers must permit members to participate actively in decisions regarding medical care, including, except as limited by law, their decision to refuse treatment. The provider also facilitates interpreter services and provides information about the Early and Periodic Screening, Diagnostic, and Treatment Services (EPSDT) program.

Updating provider information

Anthem network providers are required to inform us of any material changes to their practice, including:

- Change in professional business ownership
- Change in business address or the location where services are provided
- Change in federal nine-digit Tax Identification Number (TIN)
- Change in specialty
- If the provider provides services to children
- Languages spoken
- Change in demographic data (for example, phone numbers, languages of providers, and/or office personnel)
- Legal or governmental action initiated against a healthcare professional; this includes, but is not limited to, an action for professional negligence, for violation of the law, or against any license or accreditation which, if successful, would impair the ability of the healthcare professional to carry out the duties and obligations under the *Provider Agreement*
- Other problems or situations that may impair the ability of the healthcare professional to carry out the duties and obligations under the *Provider Agreement* care review and grievance resolution procedures
- Notification that the provider is accepting new patients

Providers should notify Anthem of changes by using the *Provider Maintenance Form for Professional Provider*s, which is available on our website at **https://providers.anthem.com/IN.**

Facility and ancillary providers should submit changes on company letterhead to their Anthem contractor.

If Anthem determines that the quality of care or services provided by a healthcare professional is not satisfactory, as evidenced by member satisfaction surveys, member complaints or grievances, utilization management data, complaints or lawsuits alleging professional negligence, or any other quality of care indicators, Anthem may terminate the *Provider Agreement*.

Oversight of non-physician practitioners

All providers using non-physician practitioners must provide supervision and oversight of non-physician practitioners consistent with state and federal laws. The supervising physician and the non-physician practitioner must have written guidelines for adequate supervision, and all supervising providers must follow state licensing and certification requirements. Non-physician practitioners include the following categories:

- Advanced nurse practitioners
- Certified nurse midwives
- Physician assistants

These non-physician practitioners are licensed by the state and work under the supervision of a licensed physician as mandated by state and federal regulations. Please consult the latest IHCP bulletins and banners for up-to-date guidance on the oversight of non-physician providers.

Open Clinical Dialogue/Affirmative Statement

Nothing within the *Provider Agreement* or this provider manual should be construed as encouraging providers to restrict medically necessary covered services or limit clinical dialog between providers and their patients, regardless of benefit coverage limitations. Providers may communicate freely with members regarding:

- Treatment options available to them, including medication treatment options.
- Information the member may need to decide among all relevant treatment options.
- The risks, benefits, and consequences of treatment or non-treatment.
- The member's right to participate in decisions regarding their healthcare, including the right to refuse treatment, and to express preferences about future treatment decisions.

Provider contract termination

A terminated provider who is actively treating members must continue to treat members until the provider's date of termination. The term date is the end of the 90-day period following written notice of termination, or timelines determined by the medical group contract.

Once we receive a provider's notice to terminate a contract, we notify members impacted by the termination to assist them in choosing a new PMP in the Anthem network, if necessary. If the member does not choose another PMP, Anthem will assign the member to a network PMP before the original PMP's disenrollment is effective. Anthem sends a letter to inform affected members of:

- The impending termination of their provider.
- Their right to request continued access to care.
- The Member Services telephone number to make PMP changes.

- Referrals to utilization management for continued access to care consideration.

Members under the care of specialists can also submit requests for continued access to care, including continued care after the transition period, by calling Member Services.

Termination of the ancillary provider/patient relationship

Under certain circumstances, an ancillary provider may terminate the professional relationship between the ancillary provider and a member as provided for and in accordance with the provisions of this Manual. However, ancillary providers may not terminate the relationship because of the member's medical condition, or the amount, type, or cost of covered services required by the member.

Transitioning members between facilities or home

PMPs initiate or help with the discharge or transfer of:

- Members at an inpatient facility to the appropriate level of care facility (including skilled nursing or rehabilitation facility) when medically indicated, or at home
- Members who are hospitalized in an out-of-network facility to an in-network facility, or at home with home healthcare assistance (within benefit limits) when medically indicated

The coordination of member transfers from non-contracted out-of-network facilities to contracted in-network facilities is a priority that may require the immediate attention of the PMP. Contact Anthem Care Management at **866-902-1690** to assist in this process.

Transitioning to another health plan

When a member transfers to another health plan, providers are required to work with the Anthem case managers who are responsible for helping the member make the transition. This transition must occur without disruption of any regimen of care that qualifies as a continuity of care condition. The case manager will coordinate with the member, the member's providers, and the case manager at the new health plan to help ensure an orderly transition.

Mandatory reporting: Child/elder abuse, domestic violence

Providers must ensure that their office staff knows about local reporting requirements and procedures to make telephone and written reports of known or suspected cases of abuse. All healthcare professionals must immediately report actual or suspected child abuse and neglect, elder abuse, domestic violence, or physical or sexual abuse to the local law enforcement agency by telephone. In addition, providers must submit a follow-up written report to the local law enforcement agency within the time frames as required by law.

Chapter 10: Claim submission

Timely and accurate claims processing allows providers to spend more time with our members without having to worry about administratively burdensome tasks.

Hoosier Healthwise and Hoosier Care Connect members: Providers should follow claim and billing guidelines outlined in the *Indiana Health Coverage Programs (IHCP) Manual*. The chapter on billing instructions may be found on the state website: **https://www.in.gov/medicaid/providers/provider-references/**.

Healthy Indiana Plan (HIP) members: Anthem uses *Medicare National Correct Coding Initiative (NCCI) Guidelines*. HIP claims will be reimbursed at 100% of Medicare or 130% of Indiana Medicaid if a Medicare fee is not available. For further guidance on billing, see the *Provider Manual Companion Guide for Billing Professional, Institutional, and Ancillary Claims*, available online at **https://providers.anthem.com/IN**.

Submitting clean claims

Claims submitted correctly the first time are called *clean*, meaning that all information necessary to adjudicate the claim is provided with the submission.

A claim may be returned if it is submitted with incomplete or invalid information. If you use electronic data interchange (EDI), claims will be returned for incomplete or invalid information on response reports from Availity. They may also be returned if they aren't submitted with the proper *Health Insurance Portability and Accountability Act (HIPAA)* compliant code set. In each case, an error report will be sent to you and the claim will not be sent through for payment. You and your staff are responsible for working with your EDI vendor (sometimes known as a clearinghouse) to ensure any claims on the response reports are corrected and resubmitted.

While some claims will be rejected if they are structurally incomplete, others that lack necessary information — such as certain situations requiring medical records — will be accepted by the Anthem system but denied until additional information is received.

Claims filing limits

Claims must be submitted within the contracted filing limit to be considered for payment. Claims submitted after that time period will be denied. Anthem is not responsible for a claim never received. If a claim is submitted inaccurately, delayed resubmission may cause you to miss the filing deadline. Claims must pass basic edits in order to be considered received. Filing limits are determined as follows:

If Anthem is the:

- **Primary payer:** 90 calendar days between the last date of service on the claim and the Anthem receipt date. If the member is an inpatient for longer than 30 days, interim billing is required as described in the *Hospital Agreement*.
- **Secondary payer**: 90 calendar days between the other payer's remittance advice (RA) date and the Anthem receipt date.

Claims from non-contracted providers

Non-contracted providers must be attested with IHCP prior to rendering services to Anthem members. Timely filing limits for non-contracted providers are as follows:

- Emergency services: 365 calendar days from the date of service or discharge date
- Non-contracted providers: 180 calendar days from the date of service

Timely filing exceptions

Timely filing requirements for claims are waived if the claim was:

- Originally filed incorrectly by Anthem.
- *Denied for EOB* (*Explanation of Benefits*) when there is no *Coordination of Benefits* (*COB*).
- Denied for no authorization and authorization is now loaded or is no longer required.
- Denied after the filing limit but the member becomes retroactively eligible.

Claims filed with the wrong plan

If you file a claim with the wrong insurance carrier, Anthem will process your claim without denying it for failure to file within the filing time limits if:

- There is documentation verifying that the claim was initially filed in a timely manner.
- The corrected claim was filed within 90 days of the date of the other carrier's denial letter or *Remittance Advice (RA)* form.

Claims disputes

For more information about claims disputes, appeals, and follow-up, please refer to **Chapter 13: Grievances and appeals**.

Prefixes on the *CMS-1500* and *CMS-1450* forms

Claims forms should include the member's ID number and a three-letter alpha prefix: The prefixes listed below help us route the claim to the right location for prompt processing and avoid rejection and payment delay:

- **YRH —** Hoosier Healthwise, Hoosier Care Connect
- **YRK —** Healthy Indiana Plan (HIP)

Electronic claims submission

Anthem uses Availity as its exclusive partner for managing all electronic data interchange (EDI) transactions. Electronic data interchange (EDI), including electronic remittance advice (835), allows for a faster, more efficient, and cost-effective way for providers to do business.

Register with Availity:

- Choose an administrator to register your organization.
- When the admin is ready to register, choose the ***register button*** at the top of the page.
- Select your organization type and complete the registration process.
- Admin should check email to verify the account.
- Once the account is verified, the admin will agree to the disclaimer, set up your security questions, change your password, and set up authorized users.

Advantages of EDI:

- Process claims faster by submitting coordination of benefits electronically and fixing errors early with in-system notification and correction.
- Reduce overhead and administrative costs by eliminating paper claim submissions.

Use Availity for the following EDI transactions:

- Healthcare Claim: Professional (837P)
- Healthcare Claim: Institutional (837I)
- Healthcare Eligibility Benefit Inquiry and Response (270/271)
- Healthcare Services Prior Authorization (278)
- Healthcare Services Inpatient Admission and Discharge Notification (278N)
- Healthcare Claim Payment/Advice (835)
- Healthcare Claim Status Request and Response (276/277)
- Medical Attachments (275)

Ways you can use the Availity EDI gateway

Availity's EDI submission options:

- **Availity EDI Clearinghouse for Direct Submitters** (requires practice management or revenue cycle software)
- Your existing clearinghouse or billing vendor (work with your vendor to ensure connection to the Availity EDI Gateway)

Availity EDI payer IDs:

- **00130 —** Institutional claims
- **00630 —** Professional claims

Note: If you use a clearinghouse, billing service, or vendor, please work with them directly to determine the payer ID.

Electronic remittance advice (ERA)

The 835 eliminates the need for paper remittance reconciliation.

Use Availity to register and manage ERA account changes with these easy steps:

- Log in to Availity (**https://apps.availity.com/availity/web/public.elegant.login**).
- Select **My Providers.**
- Select **Enrollment Center.**
- Select **Transaction Enrollment.**

Note: If you use a clearinghouse or vendor, please work with them on ERA registration, updates, and/or changes.

Contact Availity

Contact Availity Client Services with any questions at **800-Availity** (**800-282-4548**), 8 a.m. to 8 p.m. EST.

Electronic funds transfer (EFT)

Electronic claims payment through EFT is secure and the fastest way to receive payment reducing administrative processes. An EFT deposit is assigned a trace number that is matched to the 835 electronic remittance advice (ERA) for simple payment reconciliation.

Use EnrollSafe **(https://enrollsafe.payeehub.org/)** to register and manage EFT account changes.

Web-based submission using direct data entry

Claims can be submitted directly via Availity. Providers can log in to **www.availity.com** > Claims and Payment Menu > Choose Professional and Institutional Claim and follow the form to submit your direct data entry claim. Please ensure you have an Availity **EDI role** to review your response reports if using this option.

Paper claims submission

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

- Use the correct *CMS-1500* and *CMS-1450* forms available at **www.cms.hhs.gov.**
- Use black or blue ink (do **not** use red ink, as the scanner may not be able to read it).
- Use the **Remarks** field for messages.
- Do not stamp or write over boxes on the claim form.
- Send the original claim form to Anthem and retain a copy for your records.
- Do **not** staple original claims together; Anthem will consider the second claim as an attachment and not an original claim to be processed separately.
- Remove all perforated sides from the form; leave a 1/4-inch border on the left and right sides of the form after removing the perforated sides. This helps our scanning equipment scan accurately.

If you submit paper claims, you must include the required information and mail them to the address below:

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

National provider identifier

A national provider identifier (NPI) is a unique 10-digit identification number issued to healthcare providers in the United States by the Centers for Medicare and Medicaid Services. NPIs are issued only to Providers of health services and supplies. As one provision of the *Health Insurance Portability and Accountability Act (HIPAA)*, the NPI is intended to improve efficiency and reduce fraud and abuse.

NPIs are divided into two types:

- **Type 1:** Individual providers, which includes but is not limited to physicians, dentists, and chiropractors
- **Type 2:** Hospitals and medical groups, which include but are not limited to hospitals, group practices, federally qualified health centers (FQHC), and rural health centers (RHC)

For billing purposes, NPIs should be used with the following guidelines:

- Claims must be filed with the appropriate NPI for billing, rendering, ordering, and referring providers.
- The NPI must always be attested with Indiana Health Coverage Programs (IHCP) in the same manner as contracted with Anthem, including effective dates for individual providers within groups.
- Claims will be denied when the NPI listed is not the same number attested with IHCP.

Providers may apply for an NPI online at the National Plan and Provider Enumeration System (NPPES) website, **http://nppes.cms.hhs.gov/NPPES**. Or you can get a paper application by calling NPPES at **800-465-3203**.

The following websites offer additional NPI information:

- Centers for Medicare & Medicaid Services: **www.CMS.gov**
- Workgroup for Electronic Data Interchange: **www.wedi.org**
- National Uniform Claims Committee: **www.nucc.org**

Referring provider's NPI on claims submissions

If the PMP refers a member to a specialist or another provider, the PMP must provide their own NPI. The specialist is then required to **add** the PMP's NPI when submitting claims for the referred member. If the PMP does not provide their NPI at the time of referral, the billing provider is responsible for obtaining that information. That can be done by calling the PMP's office or by going online to the NPI registry: **https://npiregistry.cms.hhs.gov/search.**

There are some exceptions to the requirement of providing the referring PMP's NPI when submitting a claim for services provided to a member not assigned to you. The exceptions include the following:

- If no PMP is identified for the member
- If one physician is on call or covering for another (in this case, the billing provider must complete Box 17b of the CMS-1500 claim form to receive reimbursement)
- If the Provider is in the same provider group, or has the same tax ID or NPI as the referring physician and is an approved provider type
- Services were provided after hours (codes 99050 and 99051)
- Emergency services (services performed in place of service 23)
- Family planning services
- Diagnostic specialties such as lab and X-ray services
- Anesthesia claims
- Professional inpatient claims
- Obstetrics/gynecology claims
- If the billing or referring physician is from any of the following:
  - Federally qualified health center
  - Indian health provider
  - Urgent care center

Anthem will deny claims with an unattested NPI, even if you provide legacy information. Providers serving Indiana Medicaid members are required to register and attest their NPI with Indiana's Family and Social Services Administration (FSSA). You can attest your NPIs on the FSSA website at **www.in.gov/medicaid/providers/591.htm**.

Member copayments

Providers should collect the member copayments listed below per respective category at the time of service but cannot deny a member covered services for inability to pay a state-mandated copayment. The provider can bill the member for any copayments not collected at the time of service. Review the member's eligibility prior to service to understand whether copays are applicable for that date of service. Some members have exceptions to copays based on their financial or health status.

Hoosier Healthwise (HHW)

The following copays apply to HHW Package C members:

- Ambulance transport: $10 copay
- Pharmacy: $3 for generic drugs and $10 for brand-name drugs

Hoosier Care Connect (HCC)

The following copays apply to HCC members:

- Non-emergent use of the ER: $3 (waived if a member calls the 24/7 NurseLine or PMP and is instructed to go to the ER)
- Pharmacy: $3 per prescription
- Transportation: $1 per one-way trip

Copays do not apply to HCC members who are:

- Under 18 years old
- Pregnant
- American Indian or Alaskan Native
- Receiving services related to maternal, preventive, or family planning services

HCC members who have reached the maximum out-of-pocket threshold of 5% of income within each quarter will not be required to make copays.

Healthy Indiana Plan (HIP)

The table below describes HIP member copays based on the type of healthcare service. HIP Basic and HIP State Plan Basic members must make a copay for most healthcare services. HIP Plus and HIP State Plan Plus members do not make copays except for non-emergent use of the ER.

Additionally, pregnant and American Indian/Alaska Native members are exempt from copays. HIP members who have reached the maximum out-of-pocket threshold of 5% of income within each quarter also will not be required to make copays.

Benefit	HIP Basic and State Plan Basic	HIP Plus and State Plan Plus	HIP Maternity
POWER account	$2,500	$2,500	None — POWER account is frozen
Contributions	None	Required — except for American Indian/Alaska Native members	None
Copays	• Outpatient — $4 • Inpatient — $75	Non-emergent ER — $8 (waived	None

Benefit	HIP Basic and State Plan Basic	HIP Plus and State Plan Plus	HIP Maternity
	• Preferred drug — $4 • Non-preferred drug — $8 • Non-emergent ER — $8 (waived if a member calls the 24/7 NurseLine or PMP and is instructed to go to the ER) • Except for American Indian/Alaska Native HIP members who are exempt from cost-sharing requirements	if a member calls the 24/7 NurseLine and is instructed to go to the ER)	

Balance billing

Providers may not *balance bill* or direct bill Medicaid members, which means that members cannot be charged for covered services above the amount Anthem pays to the provider or direct billed for the costs of the services. Providers may only bill members for copayments if a copay applies.

An IHCP provider may bill a member only when the following conditions have been met:

- The service is non-covered or the member has exceeded the program limitations and the member signed a waiver prior to each service that meets federal standards for Medicaid members.
- The provider documents the waiver that the member voluntarily chose to sign and to receive the service and that the member was informed via a waiver prior to receiving the service that they are receiving a non-covered service.

A general waiver must identify the specific procedure to be performed and the cost, and the member must sign the waiver prior to receiving the service. Providers may also balance bill a member when prior authorization of a covered service is denied under certain conditions. For more information, see the *IHCP Provider Enrollment Reference Module* at **https://www.in.gov/medicaid/providers/provider-references/**.

Cost-sharing

Cost-sharing will be waived or reduced if a member's healthcare cost reaches 5% of the family's income for the quarter. Members who pay contributions will have their monthly amount reduced to $1.00 (or $1.50 if there is a tobacco surcharge) for the remainder of the quarter.

The IHCP Provider Portal will note if a member is exempt from copayments. Once a member has been exempted for a quarter, the member will not participate in any cost share for the remainder of the quarter. At the start of the next calendar quarter, the member's cost-share responsibilities are re-calculated.

Third-Party Liability (TPL) or Coordination of Benefits (COB)

Anthem members may have other health insurance. Anthem is the payer of last resort per Federal and State guidelines. We coordinate HHW, HIP, and HCC benefits with any other healthcare program that covers our members, including Medicare. Indicate **Other Coverage** information on

the appropriate claim form. If there is a need to coordinate benefits, include at least one of the following items from the other healthcare program when submitting a *Coordination of Benefits (COB)* claim:

- Third-Party *Remittance Advice* (*RA*) or *Explanation of Payment* (*EOP*)
- Third-party letter explaining either the denial of coverage or reimbursement

Paper *COB* claims received without at least one of these items will be mailed back to you with a request to submit to the other healthcare program first. Electronic *COB* claims will deny with a code indicating the need for more materials. Please make sure that the information you submit explains all coding listed on the other carrier's RA/*EOP* or letter. We cannot process the claim without this specific information.

Anthem must receive *COB* claims within 90 days from the date on the other program's *RA*/*EOP* or letter of denial of coverage.

Anthem members may have other insurance coverage that may be found after a claim has been paid that Anthem was not aware existed at the time of service. In these situations, Anthem will notify the provider of the existence of the other insurance coverage.

If the member's primary coverage was Medicare and the payment was within 24 months, Anthem must recoup the claim and the provider must file a claim with the member's Medicare carrier.

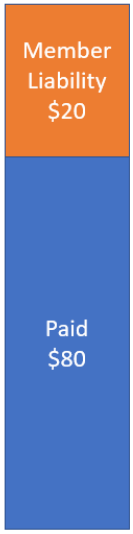
If the member's primary coverage was a commercial plan, Anthem will coordinate the payment with the other carrier. Through this process, Anthem will update the claim so that it appears Anthem paid as secondary; however, the funds will not be recovered. Anthem will be made whole from the other carrier. In this instance, the provider should receive an *Explanation of Payment* (*EOP*) from the primary carrier commemorating their allowed amount.

Providers cannot pursue reimbursement from members per federal rules under any circumstance or interfere with or place any liens upon the state's right or Anthem's right, acting as the state's agent, to recover from third-party billing.

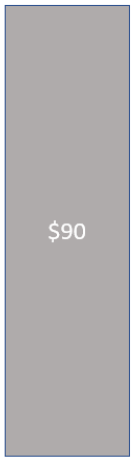
Anthem adjudicates COB claims in alignment with the **IHCP Third Party Liability Module**, specifically that Anthem will pay up to the IHCP allowed amount.

Scenario 1: Commercial or Medicare Primary

Primary Allowed: $100



IHCP Allowed: $90



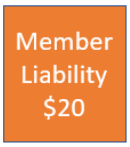
Anthem Will Pay: $10

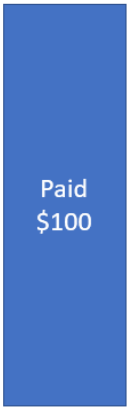
Primary payment was less than the IHCP allowed amount so we consider the amount of member liability, up to the IHCP allowed amount.

Primary paid $80 + Anthem pays $10 in member liability = $90 (IHCP allowed amount).

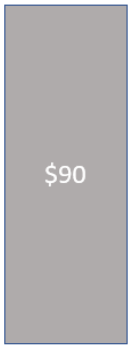
Scenario 2: Commercial or Medicare Primary

Primary Allowed: $120



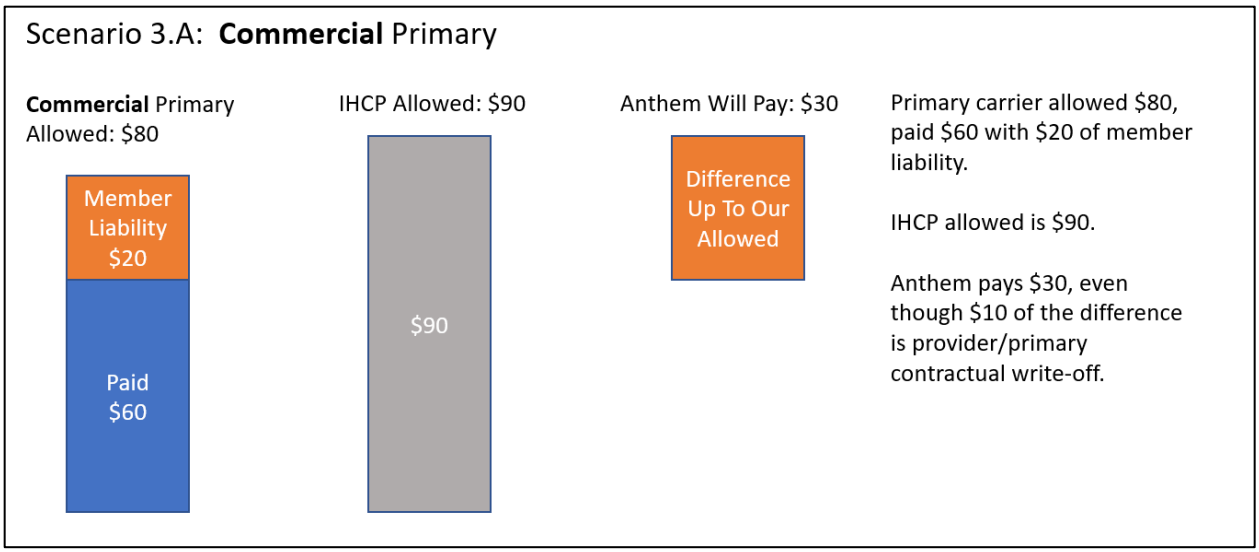


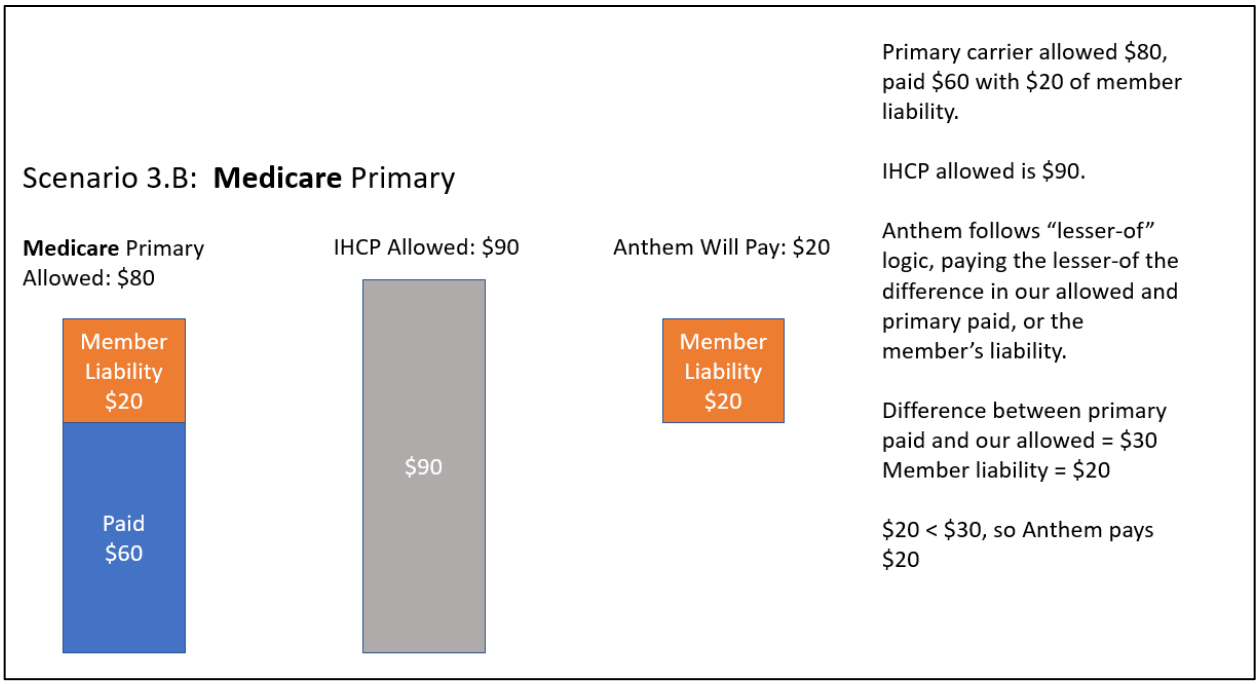
IHCP Allowed: $90



Anthem Will Pay: $0

Primary payment exceeded the IHCP allowable therefore no additional payment is made by Anthem.





Payment of claims

Once we receive a claim, Anthem takes the following steps:

- Anthem's processing systems analyze and validate the claim for member eligibility, covered services, and proper formatting.
- Anthem's processing systems validate billing, rendering, and referring provider information against Anthem and IHCP files.
- Anthem's processing systems validate against processing rules such as a requirement for referral, prior authorization, or NDC and McKesson ClaimsXten Correct Coding rules.
- Medical review is performed, as necessary.
- If no payment is warranted, Anthem sends a *Claims Disposition Notice* to the provider with the specific claims processing information.

- Anthem systems reference Groupers, Pricers, and Fee Schedules based on the type of claim to determine the pricing.

Anthem will finalize a clean electronic claim within 21 calendar days from the date the claim is received. Clean paper claims are paid within 30 calendar days. Anthem will pay interest on clean claims not decided within these time frames. The interest rate is established annually based on the **Indiana State Auditor's Report** and set by the Indiana Department of Insurance.

Monitoring submitted claims

Claims status can be monitored by doing the following:

- Monitor claim status online via Availity: **www.Availity.com**
- Monitor claim status through the interactive voice response (IVR): **844-533-1995**
- Correct any errors and resubmit immediately to prevent denials due to late filing

The IVR accepts either the national provider identifier (NPI) or the federal tax identification number (TIN) as identification. Should the system not accept those numbers, it will redirect your call to an Anthem Network Relations manager.

Providers should not inquire about the status of a specific claim until at least 30 calendar days after submission, generally accepted as the standard time to process a claim. For general claim status inquiries, refer to the weekly *Remittance Advice (RA)*, the IVR system, or electronic data interchange.

Claims overpayment recovery procedure

Refunds may be identified by two entities: Anthem (and its contracted vendors) or the providers themselves. Anthem researches and notifies the provider of an overpayment requesting a refund check. The provider may also identify an overpayment and proactively submit a refund check to reconcile the overpayment amount.

Anthem will notify the provider of the overpayment once it has been identified. The overpayment notification will include instructions on how to refund the overpayment as well as information on how to dispute the overpayment if they believe it to be incorrect. Refunds not remitted or disputed by the provider will be automatically recovered at the end of the dispute period.

If a provider identifies an overpayment and submits a refund, a completed *Refund Notification Form* specifying the reason for the return must be included. This form can be found on the provider website at **https://providers.anthem.com/IN** under Resources > **Forms**. The submission of the *Refund Notification Form* will allow Cost Containment to process and reconcile the overpayment in a timely manner. The provider can also complete a *Recoupment Notification Form*. The provider gives Anthem the authorization to adjust claims and create claim offsets. This form can also be found on our website under Provider Support > **Forms**. For questions regarding the refund notification procedure or recoupment process, please call Provider Services.

Claim resubmissions

Claim resubmissions must be received by Anthem within 60 days from the date on the *Explanation of Benefits (EOB)* or letter with the information and to the address below:

Anthem Blue Cross and Blue Shield
Corrected Claims and Correspondence
P.O. Box 61599
Virginia Beach, VA 23466

- Complete all required fields as originally submitted and mark the change(s) clearly.
- Write or stamp **Corrected Claim** across the top of the form.
- Attach a copy of the *EOB* and state the reason for resubmission.

Corrected *UB-04* (*CMS 1450*) claims can be sent electronically with the third digit of the type of bill indicating correction or cancellation. You can follow up to determine the status of a claim if there has been no response from Anthem to a submitted claim after 30 business days from the date the claim was submitted.

To follow up on a claim, you can:

- Verify that the claim was not rejected electronically or returned by mail.
- Call IVR at: **844-533-1995.**
- Contact Provider Services (see **Chapter 1: Contact information**).

Claim search functionality is now available from the online Availity Health Information Network. To register for Availity, take the following steps:

- Go to **www.availity.com.**
- Click on **Register Now.**
- Complete the online registration wizard.
- Print, sign, and fax the application.
- You will receive an e-mail from Availity with a temporary password and the next steps.

The IVR accepts either the billing NPI or your TIN for the provider ID. Should the system not accept those numbers, it will redirect your call to an Anthem Network Relations manager who will help you with your question.

Claims disputes

For more information about claims disputes, appeals, and follow-up, please refer to **Chapter 13: Grievances and appeals**.

Clinical submissions categories

The following is a list of claims categories for which we may routinely require the submission of clinical information before or after payment of a claim:

- Claims involving precertification/prior authorization/predetermination (or some other form of utilization review) including but not limited to:
    - Claims pending for lack of precertification or prior authorization.
    - Claims involving medical necessity or experimental/investigative determinations.
    - Claims involving drugs administered in a physician's office requiring prior authorization.
    - Claims billed with certain modifiers.
    - Claims involving unlisted codes.

- Claims for which we cannot determine from the face of the claim whether it involves a covered service; thus, benefit determination cannot be made without reviewing medical records, including but not limited to pre-existing condition issues or specific benefit exclusions.
- Claims for emergency department services that are subject to prudent layperson reviews.
- Claims for abortion: all abortion claims require a review of medical records to determine if the pregnancy is the result of an act of rape or incest. Or in cases where the woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed.
- Claims that we have reason to believe involve inappropriate (including fraudulent) billing.
- Claims that are the subject of an audit (internal or external), including high-dollar claims.
- Claims for individuals involved in case management or Condition Care.

Other situations in which clinical information might routinely be requested:

- Accreditation activities
- Coordination of benefits
- Credentialing (for further guidance, see the *Provider Manual Companion Guide for Credentialing and Recredentialing* online at **https://providers.anthem.com/IN**)
- Quality improvement/assurance efforts
- Recovery/subrogation
- Requests relating to underwriting (including but not limited to member or provider misrepresentation/fraud reviews and stop-loss coverage issues)

Examples provided in each category are for illustrative purposes only and are not meant to represent an exhaustive list within the category.

Common reasons for rejected or denied claims

Problem	Explanation	Resolution
Member's ID number is incomplete	Missing the correct member ID number listed on the member's Anthem ID card.	Use the member ID number on the Anthem ID card.
Duplicate claim submission	Overlapping service dates for the same service create a question about duplication. The claim was submitted to Anthem twice without additional information for consideration.	List each date of service, line by line, on the claim form. Avoid spanning dates, except for inpatient billing. Make sure you read your *RAs* and CDNs for important claim determination information before resubmitting a claim. Additional information may be needed. A corrected claim needs to be clearly marked as "Corrected" so

Problem	Explanation	Resolution
		that it doesn't get processed as a duplicate.
Authorization number missing/does not match the services	The authorization number is missing, or the approved services do not match the services described in the claim.	Confirm the correct authorization number is provided on the claim form (*CMS-1500* box 24 and *CMS-1450* box 63) and that the approved services match the provided services. Contact UM to revise the service for authorization if changes occur.
Missing codes for required service categories	Current Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) manuals are used but changes are made to the codes quarterly or annually. Manuals may be purchased at any technical bookstore, through the American Medical Association or the Practice Management Information Corporation.	Only codes recognized by IHCP can be used; therefore, providers must also check IHCP billing instructions, as well as HCPCS and CPT manuals. Make sure all services are coded with the correct codes. Check the codebooks or ask someone in your office who is familiar with coding.
Unlisted code for service	Some procedures or services do not have a code associated with them, so an unlisted procedure code is used.	Anthem needs a description of the procedure and medical records in order to calculate reimbursement. DME, prosthetic devices, hearing aids, or blood products require a manufacturer's invoice. For drugs/injections, the National Drug Code (NDC) number is required.
Report code for service	Some procedures or services require additional information.	Anthem needs a description of the procedure and medical records to calculate reimbursement. DME, prosthetic devices, hearing aids, or blood products require a manufacturer's invoice. For drugs/injections, the NDC number is required.
Unreasonable numbers submitted	Unreasonable numbers, such as 9999 may appear in the **Service Units** fields.	Make sure to check your claim for accuracy before submitting it.
Submitting batches of claims	Stapling claims together can make the subsequent claims appear to be attachments, rather than individual claims.	Make sure each individual claim is clearly identified and not stapled to another claim.
Nursing care	Nursing charges are included in the hospital and outpatient care charges. Nursing charges that are billed separately are considered unbundled charges and are not payable. In addition, Anthem will not	Do not submit bills for nursing charges.

Problem	Explanation	Resolution
	pay claims using different room rates for the same type of room to adjust for nursing care.	

Other filing limits

Action	Type of service to be billed	Time frame
Third-Party Liability (TPL) or *Coordination of Benefits*	If the claim has *TPL* or *COB* or requires submission to a third party before submitting to Anthem, the filing limit starts from the date on the notice from the third party.	From the date of notice from the third party: • 90 days for *CMS-1500* claims • 90 days for *CMS-1450* claims
Checking claim status	Providers should not inquire about the status of a specific claim until at least 30 calendar days after submission. This is generally considered a reasonable time to process a claim. For general claim status inquiries, refer to the weekly *Remittance Advice (RA)*, the interactive voice response (IVR) system, or electronic data interchange.	After 30 business days from Anthem's receipt of the claim, submit a *Follow-Up Request Form*. Or call the Customer Care Center IVR, or check online via **www.availity.com**.
Claim follow-up	To submit a corrected claim following Anthem's request for more information or correction to the claim.	You must return the requested information to Anthem within: • 60 days from the date of the request
Provider dispute	To request a claim appeal, send your request in writing to: Anthem Blue Cross and Blue Shield Provider Disputes and Appeals P.O. Box 61599 Virginia Beach, VA 23466 Care Management appeals: Anthem Blue Cross and Blue Shield Member Appeals and Grievances P.O. Box 62429 Virginia Beach, VA 23466	60 days from the receipt of Anthem's *Remittance Advice (RA)* of notice of the action. If Anthem requires additional information, the provider must return the information to Anthem within 21 days from the date of Anthem's request. If the information is not received within 21 days, Anthem may close the case. If the appeal deadline falls on a weekend or holiday, the deadline is extended to the next business day.
Provider appeal	Submit claims appeal. This is the second step after a claim dispute and is considered a formal appeal. An appeal request must be received by Anthem within 60 days from the date on the claims dispute response. Send to: Anthem Blue Cross and Blue Shield Provider Disputes and Appeals P.O. Box 61599	60 days from the date on the claims dispute response.

Action	Type of service to be billed	Time frame
	Virginia Beach, VA 23466	

Processes to resolve claim issues

Issue	Action
Claim denied or **paid the wrong amount** due to incorrect billing by the provider, ***or*** Resubmitting claim returned for information such as: *EOB* of primary insurance, itemized bills, medical records, etc.	Submit a *Claim Follow-Up Form/Corrected Claim*. It must be received by Anthem within 60 days from the date on the *EOB* or letter. All required fields are to be completed as originally submitted and the change(s) clearly marked and write or stamp **Corrected Claim** across the top of the form and attach a copy of the *EOB* and state the reason for re-submission. Send to: Anthem Blue Cross and Blue Shield Corrected Claims and Correspondence P.O. Box 61599 Virginia Beach, VA 23466 Note that corrected UB claims can be sent electronically with the third digit of the type of bill indicating correction or cancellation.
Unknown status of claim submitted more than **30** days ago — after verifying not rejected by EDI (electronic) or returned by mail room (paper).	Call Anthem Provider Services: • Hoosier Healthwise: **866-408-6132** • Healthy Indiana Plan: **844-533-1995** • Hoosier Care Connect: **844-284-1798** Network providers must file claims within 90 days, and it is the provider's responsibility to perform timely follow up to be sure claims are received.
Follow up on the status of a claim adjustment or reprocessing resulting from: Claim dispute, claim appeal, or Provider Help Line/Provider Services action.	Call Anthem Provider Services: • Hoosier Healthwise: **866-408-6132** • Healthy Indiana Plan: **844-533-1995** • Hoosier Care Connect: **844-284-1798** Allow 60 days for adjustments but follow up before 90 days. All follow up to previous actions or interactions must be within 90 days.
Provider disagrees with a full or partial claim denial ***or*** Payment is not the amount expected.	**Submit claims dispute** A complete *Provider Dispute Resolution Request Form* must be received by Anthem within 60 days from the date on the *EOB*. Multiple claims for the same situation can be submitted on one form. Send to: Anthem Blue Cross and Blue Shield Provider Disputes and Appeals P.O. Box 61599 Virginia Beach, VA 23466 Note that it is the provider's responsibility to check *EOBs* and submit claims disputes timely.
Provider disagrees with claims dispute response.	**Submit claims appeal** This is the second step after a claim dispute and is considered a formal appeal. An appeal request must be received by Anthem

Issue	Action
	within 60 days from the date on the claims dispute response. Send to: Anthem Blue Cross and Blue Shield Provider Disputes and Appeals P.O. Box 61599 Virginia Beach, VA 23466

Reimbursement policies

Reimbursement policies serve as a guide to assist you in accurate claim submissions and to outline the basis for reimbursement if the service is covered by a member's Anthem benefit plan. These Policies can be accessed on the provider site. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis as well as to the member's state of residence. Covered services do not guarantee reimbursement unless specific criteria are met.

You must follow proper billing and submission guidelines, including using industry-standard, compliant codes on all claim submissions. Services should be billed with Current Procedure Terminology (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes, and/or revenue codes which indicate the services and/or procedures performed. The billed code(s) are required to be fully supported in the medical record and/or office notes. Unless otherwise noted, Anthem Policies apply to participating providers and facilities.

If appropriate *Coding and Billing Guidelines* or current reimbursement policies are not followed, Anthem may:

- Reject or deny the claim.
- Recover and/or recoup claim payment.
- Adjust the reimbursement to reflect the appropriate services and/or procedures performed.

Anthem reimbursement policies are developed based on nationally accepted industry standards and coding principles. These policies may be superseded by mandates in provider, state, federal, or CMS contracts and/or requirements. System logic or setup may prevent the loading of policies into the claims platforms in the same manner as described; however, Anthem strives to minimize these variations.

Reimbursement criteria

Claims submitted for payments must meet all aspects of the criteria for reimbursement. Conditions of payment could include benefits coverage, medical necessity/clinical criteria, authorization requirements, and/or stipulations within a reimbursement policy. Neither payment rates nor methodology is considered to be conditions of payments.

Review schedules and updates to reimbursement policies

Reimbursement policies undergo reviews for updates to state contracts or federal or CMS requirements. Additionally, updates may be made at any time if we are notified of a mandated change or due to an Anthem business decision. We reserve the right to review and revise our

policies when necessary. When there is an update, we will publish the most current policies on our provider website.

Reimbursement by code definition

Anthem allows reimbursement for covered services based on their procedure code definitions or descriptors unless otherwise noted by state or provider contracts, or state, federal, or CMS requirements. There are eight CPT sections:

1. Evaluation and management
2. Anesthesia
3. Surgery
4. Radiology (nuclear medicine and diagnostic imaging)
5. Pathology and laboratory
6. Medicine
7. Category II codes: supplemental tracking codes that can be used for performance measurement
8. Category III codes: temporary codes for emerging technology, services, or procedures

For more information about Anthem reimbursement policies, visit **https://providers.anthem.com/IN** > Claims > **Reimbursement Policies**.

Outlier Reimbursement Audit and Review Process

Requirements and Policies

This section includes guidelines on reimbursement to Providers and Facilities for services on claims paid by DRG with an outlier paid at percent of billed charge or where the entire claim is paid at percent of billed charge.

In addition to any header in this section, please refer to all other service specific sections which may have more stringent guidelines. There may be multiple sections that apply to any given reimbursable service.

Audits/Records Requests

At any time, a request may be made for on-site, electronic or hard copy medical records, utilization review documentation and/or itemized bills related to Claims for the purposes of conducting audit or reviews.

Blood, and Blood Products

Administration of Blood or Blood Products are not separately reimbursable on inpatient claims. Administration charges on outpatient claims are separately reimbursable when submitted without observation/treatment room charges.

Charges for blood storage and processing, thawing fees charges, irradiation, and other processing charges, are also not separately reimbursable.

Emergency Room Supplies and Services Charges

The Emergency Room level reimbursement includes all monitoring, equipment, supplies, and, time and staff charges. Reimbursement for the use of the Emergency Room includes the use of the room and personnel employed for the examination and treatment of patients. This reimbursement does not typically include the cost of physician services.

Facility Personnel Charges
Charges for Inpatient Services for Facility personnel are not separately reimbursable and the reimbursement for such is included in the room and board rate. Examples include, but are not limited to, lactation consultants, dietary consultants, overtime charges, transport fees, nursing functions (including IV or PICC line insertion at bedside), professional therapy functions, including Physical, Occupational, and Speech call back charges, nursing increments, therapy increments, and bedside respiratory and pulmonary function services. Charges for Outpatient Services for facility personnel are also not separately reimbursable. The reimbursement is included in the payment for the procedure or Observation charge.

Implants
Implants are objects or materials which are implanted such as a piece of tissue, a tooth, a pellet of medicine, a medical device, a tube, a graft, or an insert placed into a surgically or naturally formed cavity of the human body to continuously assist, restore or replace the function of an organ system or structure of the human body throughout its useful life. Implants include, but are not limited to: stents, artificial joints, shunts, pins, plates, screws, anchors and radioactive seeds, in addition to non-soluble, or solid plastic materials used to augment tissues or to fill in areas traumatically or surgically removed. Instruments that are designed to be removed or discarded during the same operative session during which they are placed in the body are not implants. In addition to meeting the above criteria, implants must also remain in the Member's body upon discharge from the inpatient stay or outpatient procedure.

Staples, sutures, clips, as well as temporary drains, tubes, similar temporary medical devices and supplies shall not be considered implants. Implants that are deemed contaminated and/or considered waste and/or were not implanted in the Member will not be reimbursed.

IV sedation and local anesthesia
Charges for IV sedation and local anesthesia administered by the provider performing the procedure, and/or nursing personnel, is not separately reimbursable and is included as part of the Operating Room (“OR”) time/procedure reimbursement. Medications used for IV sedation and local anesthesia are separately reimbursable.

Lab Charges
The reimbursement of charges for specimen are considered facility personnel charges and the reimbursement is included in the room and board or procedure/Observation charges. Examples include venipuncture, urine/sputum specimen collection, draw fees, phlebotomy, heel sticks, and central line draws.

Processing fees, handling fees, and referral fees are considered included in the procedure/lab test performed and not separately reimbursable.

Labor Care Charges
Reimbursement will be made for appropriately billed room and board or labor charges. Payment will not be made on both charges when billed concurrently.

Nursing Procedures
Fees associated with nursing procedures or services provided by Facility nursing staff or unlicensed Facility personnel (technicians) performed during an inpatient ("IP") admission or outpatient ("OP") visit will not be reimbursed separately. Examples include, but are not limited,

to intravenous ("IV") injections or IV fluid administration/monitoring, intramuscular ("IM") injections, subcutaneous ("SQ") injections, IV or PICC line insertion at bedside, nasogastric tube ("NGT") insertion, urinary catheter insertion, point of care/bedside testing (such as glucose, blood count, arterial blood gas, clotting time, etc.) and inpatient blood transfusion administration/monitoring (with the exception of OP blood administration or OP chemotherapy administration which are submitted without observation/treatment room charges.)

Operating Room Time and Procedure Charges

The operating room ("OR") charge will be based on a time or procedural basis. When time is the basis for the charge, it should be calculated from the time the patient enters the room until the patient leaves the room, as documented on the OR nurse's notes. The operating room charge will reflect the cost of:

- The use of the operating room
- The services of qualified professional and technical personnel

Personal Care Items and services

Personal care items used for patient convenience are not separately reimbursable. Examples include but are not limited to: breast pumps, deodorant, dry bath, dry shampoo, lotion, non-medical personnel, mouthwash, powder, soap, telephone calls, television, tissues, toothbrush and toothpaste, bedpans, chux, hot water bottles, icepacks, pillows, sitz baths, and urinals.

Pharmacy Charges

Reimbursement will be made for the cost of drugs prescribed by the attending physician. Additional separate charges for the administration of drugs, the cost of materials necessary for the preparation and administration of drugs, and the services rendered by registered pharmacists and other pharmacy personnel will not be reimbursed separately. All other services are included in the drug reimbursement rate. Example of pharmacy charges which are not separately reimbursable include, but are not limited to: IV mixture fees, IV diluents such as saline and sterile water, IV Piggyback (IVPB), Heparin and saline flushes to administer IV drugs, and facility staff checking the pharmacy ("Rx") cart.

Portable Charges

Portable Charges are included in the reimbursement for the procedure, test, or x-ray, and are not separately reimbursable.

Pre-Operative Care or Holding Room Charges

Charges for a pre-operative care or a holding room used prior to a procedure are included in the reimbursement for the procedure and are not separately reimbursed. In addition, nursing care provided in the pre-operative care areas will not be reimbursed separately.

Preparation (Set-Up) Charges

Charges for set-up, equipment, or materials in preparation for procedures or tests are included in the reimbursement for that procedure or test.

Recovery Room Charges

Reimbursement for recovery room services (time or flat fee) includes the use of all and/or available services, equipment, monitoring, and nursing care that is necessary for the patient's

welfare and safety during his/her confinement. This will include but is not limited to cardiac/vital signs monitoring, pulse oximeter, medication administration fees, nursing services, equipment, supplies, (whether disposable or reusable), defibrillator, and oxygen. Separate reimbursement for these services will not be made.

Recovery Room services related to IV sedation and/or local anesthesia

Separate reimbursement will not be made for a phase I or primary recovery room charged in connection with IV sedation or local anesthesia. Charges will be paid only if billed as a post procedure room or a phase II recovery (step-down) Examples of procedures include arteriograms and cardiac catheterization.

Supplies and Services

Items used for the patient which are needed as a direct result of a procedure or test are considered part of the room and board or procedure charges and are not separately reimbursable.

Any supplies, items, and services that are necessary or otherwise integral to the provision of a specific service and/or the delivery of services in a specific location are considered routine services and not separately reimbursable in the inpatient and outpatient environments.

Special Procedure Room Charge

Special procedure room charges are included in the reimbursement for the procedure. If the procedure takes place outside of the OR suite, then OR time will not be reimbursed to cover OR personnel/staff being present in the room. Example: ICU, GI lab, etc.

Stand-by Charges

Standby equipment and consumable items which are on standby, are not reimbursable. Standby charges for facility personnel are included in the reimbursement for the procedure and not separately reimbursable.

Stat Charges

Stat charges are included in the reimbursement for the procedure, test, and/or X-ray. These charges are not separately reimbursable.

Supplies and Equipment

Charges for medical equipment, including but not limited to, IV pumps, PCA Pumps, Oxygen, and isolation carts and supplies are not separately reimbursable.

Telemetry

Telemetry charges in ER/ ICU/CCU/NICU or telemetry unit (step-down units) are included in the reimbursement for the place of service. Additional monitoring charges are not reimbursable.

Time Calculation

- **Operating Room ("OR")**: Time should be calculated on the time the patient enters the room until the patient leaves the room, as documented on the OR nurse's notes.
- **Hospital/ Technical Anesthesia**: Reimbursement of technical anesthesia time will be based on the time the patient enters the operating room (OR) until the patient leaves the room, as documented on the OR nurse's notes. The time the anesthesiologist spends with the patient in pre-op and the recovery room will not be reimbursed as part of the hospital anesthesia time.

- **Recovery Room**: The reimbursement of Recovery Room charges will be based on the time the patient enters the recovery room until the patient leaves the recovery room as documented on the post anesthesia care unit ("PACU") record.
- **Post Recovery Room:** Reimbursement will be based on the time the patient leaves the Recovery Room until discharge.

Video or Digital Equipment used in Operating Room

Charges for video or digital equipment used in a surgery are included in the reimbursement for the procedure and are not separately reimbursable. Charges for batteries, covers, film, anti-fogger solution, tapes etc., are not separately reimbursable.

Additional Reimbursement Guidelines for Disallowed Charges

The disallowed charges (charges not eligible for reimbursement) include, but are not limited to, the following, whether billed under the specified Revenue Code or any other Revenue Code. These Guidelines may be superseded by your specific agreement. Please refer to your contractual fee schedule for payment determination.

The tables below illustrate examples of non-reimbursable items/services codes.

Examples of non-reimbursable items/services codes	
Typically Billed Under This/These Revenue Codes but not Limited to the Revenue Codes Listed Below	**Description of Excluded Items**
0990 – 0999	Personal Care Items Courtesy/Hospitality Room Patient Convenience Items (0990) Cafeteria, Guest Tray (0991) Private Linen Service (0992) Telephone, Telegraph (0993) TV, Radio (0994) Non-patient Room Rentals (0995) Beauty Shop, Barber (0998) Other Patient Convenience Items (0999)
0220	Special Charges
0369	Preoperative Care or Holding Room Charges
0760 – 0769	Special Procedure Room Charge
0111 – 0119	Private Room* (subject to Member's Benefit)
0221	Admission Charge

Examples of non-reimbursable items/services codes	
Typically Billed Under This/These Revenue Codes but not Limited to the Revenue Codes Listed Below	**Description of Excluded Items**
0480 – 0489	Percutaneous Transluminal Coronary Angioplasty (PTCA) Stand-by Charges
0220, 0949	Stat Charges
0270 – 0279, 0360	Video Equipment Used in Operating Room
0270, 0271, 0272	Supplies and Equipment Blood Pressure cuffs/Stethoscopes Thermometers, Temperature Probes, etc. Pacing Cables/Wires/Probes Pressure/Pump Transducers Transducer Kits/Packs SCD Sleeves/Compression Sleeves/Ted Hose Oximeter Sensors/Probes/Covers Electrodes, Electrode Cables/Wires Oral swabs/toothettes; Wipes (baby, cleansing, etc.) Bedpans/Urinals Bed Scales/Alarms Specialty Beds Foley/Straight Catheters, Urometers/Leg Bags/Tubing Specimen traps/containers/kits Tourniquets Syringes/Needles/Lancets/Butterflies Isolation carts/supplies Dressing Change Trays/Packs/Kits Dressings/Gauze/Sponges Kerlix/Tegaderm/OpSite/Telfa Skin cleansers/preps Cotton Balls; Band-Aids, Tape, Q-Tips Diapers/Chucks/Pads/Briefs Irrigation Solutions ID/Allergy bracelets Foley stat lock Gloves/Gowns/Drapes/Covers/Blankets Ice Packs/Heating Pads/Water Bottles Kits/Packs (Gowns, Towels and Drapes) Basins/basin sets Positioning Aides/Wedges/Pillows

Examples of non-reimbursable items/services codes	
Typically Billed Under This/These Revenue Codes but not Limited to the Revenue Codes Listed Below	**Description of Excluded Items**
	Suction Canisters/Tubing/Tips/Catheters/Liners Enteral/Parenteral Feeding Supplies (tubing/bags/sets, etc.) Preps/prep trays Masks (including CPAP and Nasal Cannulas/Prongs) Bonnets/Hats/Hoods Smoke Evacuator Tubing Restraints/Posey Belts OR Equipment (saws, skin staplers, staples & staple removers, sutures, scalpels, blades etc.) IV supplies (tubing, extensions, angio-caths, stat-locks, blood tubing, start kits, pressure bags, adapters, caps, plugs, fluid warmers, sets, transducers, fluid warmers, heparin and saline flushes, etc.)
0220 – 0222, 0229, 0250	Pharmacy Administrative Fee (including mixing meds) Portable Fee (cannot charge portable fee unless equipment is brought in from another Facility) Patient transport fees
0223	Utilization Review Service Charges
263	IV Infusion for therapy, prophylaxis (96365, 96366) IV Infusion additional for therapy IV Infusion concurrent for therapy (96368) IV Injection (96374, 96379)
0230, 0270 – 0272, 0300 – 0307, 0309, 0390-0392, 0310	Nursing Procedures
0230	Incremental Nursing – General
0231	Nursing Charge – Nursery

Examples of non-reimbursable items/services codes	
Typically Billed Under This/These Revenue Codes but not Limited to the Revenue Codes Listed Below	**Description of Excluded Items**
0232	Nursing Charge – Obstetrics (OB)
0233	Nursing Charge – Intensive Care Unit (ICU)
0234	Nursing Charge – Cardiac Care Unit (CCU)
0235	Nursing Charge – Hospice
0239	Nursing Charge – Emergency Room (ER) or Post Anesthesia Care Unit (PACU) or Operating Room (OR)
0250 – 0259, 0636	Pharmacy (non-formulary drugs, compounding fees, nonspecific descriptions) Medication prep Nonspecific descriptions Anesthesia Gases – Billed in conjunction with Anesthesia Time Charges IV Solutions 250 cc or less, except for pediatric claims Miscellaneous Descriptions Non-FDA Approved Medications
0270, 0300 – 0307, 0309, 0380 – 0387, 0390 – 0392	Specimen collection Draw fees Venipuncture Phlebotomy Heel stick Blood storage and processing blood administration (Rev codes 0380, 0390 – 0392; 0399) Thawing/Pooling Fees
0270, 0272, 0300 – 0309	Bedside/Point of Care/Near Patient Testing (such as glucose, blood count, arterial blood gas, clotting time, glucose, etc.)
0222, 0270, 0272, 0410, 0460	Portable Charges
0270 – 0279, 0290, 0320, 0410, 0460	Supplies and Equipment Oxygen Instrument Trays and/or Surgical Packs

Examples of non-reimbursable items/services codes	
Typically Billed Under This/These Revenue Codes but not Limited to the Revenue Codes Listed Below	**Description of Excluded Items**
	Drills/Saws (All power equipment used in O.R.) Drill Bits Blades IV pumps and PCA (Patient Controlled Analgesia) pumps Isolation supplies Daily Floor Supply Charges X-ray Aprons/Shields Blood Pressure Monitor Beds/Mattress Patient Lifts/Slings Restraints Transfer Belt Bair Hugger Machine/Blankets SCD Pumps Heal/Elbow Protector Burrs Cardiac Monitor EKG Electrodes Vent Circuit Suction Supplies for Vent Patient Electrocautery Grounding Pad Bovie Tips/Electrodes Anesthesia Supplies Case Carts C-Arm/Fluoroscopic Charge Wound Vacuum Pump Bovie/Electro Cautery Unit Wall Suction Retractors Single Instruments Oximeter Monitor CPM Machines Lasers Da Vinci Machine/Robot
0370 – 0379, 0410, 0460, 0480 – 0489	Anesthesia Nursing care Monitoring Intervention Pre- or Post-evaluation and education

Examples of non-reimbursable items/services codes	
Typically Billed Under This/These Revenue Codes but not Limited to the Revenue Codes Listed Below	**Description of Excluded Items**
	IV sedation and local anesthesia if provided by RN Intubation/Extubation CPR
410	Respiratory Functions: Oximetry reading by nurse or respiratory Respiratory assessment/vent management Medication Administration via Nebs, Metered dose (MDI), etc. Charges Postural Drainage Suctioning Procedure Respiratory care performed by RN
0940 – 0945	Education/Training

Chapter 11: Quality management

The goal of Anthem is continuous, measurable improvement in the delivery of, and access to high-quality healthcare. Following regulatory and accrediting body requirements, we have a Quality Improvement Program (QIP) to monitor and evaluate the quality, safety, and appropriateness of physical and behavioral healthcare services and identify opportunities for improvement.

The Anthem Board of Directors (BOD) is responsible for organizational governance and has final authority and accountability for the QIP. The BOD delegates responsibility for the development and implementation of the QIP to the Medicaid Quality Management Committee (QMC). External advisory guidance is sought to provide external input into internal programming.

The QIP is collaborative in nature and includes focused studies and reviews that measure the quality of care in specific clinical and service areas. Providers are expected to participate to help us achieve our goal of providing responsive, safe, and cost-effective healthcare that makes a difference in our members' lives.

Quality Improvement Program

Anthem's Quality Improvement Program (QIP) focuses on developing and implementing standards for clinical care and service, measuring conformity to those standards, and taking action to improve performance. The scope of the QIP includes but is not limited to, the monitoring and evaluation of:

- Accessibility of services
- Availability of practitioners
- Behavioral health
- Member/provider satisfaction surveys
- Medical record review
- Preventive health guidelines
- Member and provider communications
- Clinical practice guidelines
- Grievances and appeals
- Continuity/coordination of care
- Contracting
- Cultural competency
- Health services programs
- Maternity management
- Patient safety
- Pharmacy and therapeutics
- Utilization and case management
- HEDIS
- Facility site review
- Provider credentialing/recredentialing (for further guidance, see the *Provider Manual Companion Guide for Credentialing and Recredentialing* at **https://providers.anthem.com/IN**)

Internally, areas to monitor are selected by identifying aspects of care and/or service that are high in volume, risk, or problem-prone. Selections are based on the probability that the review will have a positive impact on members' health and well-being. Priority is given to those areas with issues related to major population groups, members' health risks, and where actions are likely to have the greatest member impact.

Externally, states may require certain clinical measures to achieve a specific benchmark or will provide incentives/performance guarantees for individual measures. Also, the Centers for Medicare & Medicaid Services (CMS) in conjunction with the State of Indiana, may specify performance measures and topics for Performance Improvement Projects (PIPs), and require mechanisms to detect both underutilization and overutilization of services. Ongoing PIPs are typical and include measuring performance using objective quality indicators; implementation of interventions to achieve improvement in quality; evaluation of the effectiveness of the interventions; and planning and initiating activities for increasing or sustaining improvement. PIPs can be focused on either clinical or nonclinical services.

The QIP is defined within three quality documents that support program excellence:

- **Quality Improvement Program Description (QIPD):** Describes the overall health plan approach to **Quality Improvement (QI),** what is to be accomplished (goals and objectives), and how the QIP will be managed and monitored by the organization.
- ***QI Work Plan*:** Lists the various quality interventions and activities, and how the goals/objectives are tracked and monitored throughout the year through reports to the quality committees.
- **QI evaluation:** The annual reporting method used to evaluate the progress and results of planned activities toward established goals. It describes the accomplishments of the QIP and *QI Work Plan*.

Each year as part of the Continuous Quality Improvement (CQI) process, Anthem:

- Reviews its *QIP Description*.
- Establishes goals/objectives for its QI activities and implements a *QI Work Plan* to improve the level of care and service provided to its members.
- Conducts a QIP evaluation to assess the effectiveness of the activities implemented throughout the year and determines if the goals and objectives were met.

QIP revisions are made based on outcomes, trends, contractual, accreditation, and regulatory standards and requirements, and overall satisfaction with the effectiveness of the program. Providers support the activities of the QIP by:

- Completing corrective action plans, when applicable.
- Participating in the facility site review and medical record review processes.
- Providing access to medical records for quality improvement projects and studies.
- Responding in a timely manner to requests for written information and documentation if a quality of care or grievance issue has been filed.
- Using *Preventive Health and Clinical Practice Guidelines* in member care.

Please feel free to contact your Anthem Network Relations representative if more information on the quality program, its achievements, processes, and outcomes are of interest.

Accreditation

Anthem maintains health plan accreditation through the National Committee for Quality Assurance (NCQA). Accreditation is a process for an impartial organization to review a company's operations to ensure it is conducting business consistently with national standards. Accreditation fulfills State regulatory requirements, in some instances serving as a substitute for meeting a state's quality requirements. It also supports continuous improvement, guiding the plan to measure, analyze, report, and improve the quality of services provided to members.

National evaluations of health plan performance and customer satisfaction are driven by NCQA and used in the accreditation process. Two of the most important measures of performance and member satisfaction are the Healthcare Effectiveness Data and Information Set (HEDIS) and the Consumer Assessment of Healthcare Providers and Systems (CAHPS®). HEDIS is a set of standardized performance measures used to compare the performance of managed care plans and measures for physicians based on value rather than cost. More than 90% of America's health plans use the HEDIS tool and report rates annually. The CAHPS survey is a member experience survey administered annually to a random sample of:

- Hoosier Healthwise members who are under age 19 or pregnant.
- Healthy Indiana Plan members ages 19 to 64 or who are low-income caretaker parents.
- Hoosier Care Connect members who are aged, blind, or disabled and non-dually eligible.

Individual plan scores are compared to other health plans' scores on specific measures for benchmarking purposes.

Accreditation results are displayed on public websites; these "report cards" assist employers and individual consumers to make informed decisions about their health plan options based on quality and value.

Healthcare Effectiveness Data and Information Set (HEDIS)

Practitioners and providers must allow Anthem to use performance data in cooperation with our quality improvement program and activities.

Practitioner/provider performance data refers to compliance rates, reports, and other information related to the appropriateness, cost, efficiency, and/or quality of care delivered by an individual healthcare practitioner, such as a physician, or a healthcare organization, such as a hospital. Common examples of performance data include the HEDIS, quality of care measures maintained by the NCQA, and the comprehensive set of measures maintained by the National Quality Forum (NQF). Practitioner/provider performance data may be used for multiple plan programs and initiatives, including but not limited to:

- **Reward programs:** Provider Quality Incentive Programs (PQIP), Pay for Outcomes (P4O), and other results-based reimbursement programs that tie provider or facility reimbursement to performance against a defined set of compliance metrics. Reimbursement models include but are not limited to shared savings programs, enhanced fee schedules, and bundled payment arrangements. (See **Provider Incentive Programs** below.)
- **Recognition programs:** Programs designed to transparently identify high-value providers and facilities and make that information available to consumers, employers, peer practitioners, and other healthcare stakeholders.

Anthem is ready to help when providers and their office staff need training to participate in required HEDIS evaluations. Providers can request consultations and training in the following areas:

- Information about the year's selected HEDIS studies.
- How data for those measures will be collected.
- Codes associated with each measure.
- Tips for smooth coordination of medical record data collection.

Anthem's Quality Improvement staff will contact the provider's office when needed to review or copy any medical records required for quality improvement studies. Office staff must provide access to medical records for review and copying.

Provider Incentive Programs

Anthem offers a number of innovative incentive programs to reward our providers for their commitment to our members' health and well-being, as well as their dedication to cost and quality of care. Our provider incentive strategy focuses on four key areas:

- Access and wellness
- Population health
- Specialized services
- Social determinants and supports

Our programs are designed to improve quality outcomes and consistency of care across the entire delivery system and include:

- **Smoking Cessation Provider Incentive Program** encourages providers to provide smoking cessation counseling to members who use tobacco, including referring them to Indiana's Tobacco Quitline.
- **Health Needs Screening Provider Incentive Program** encourages providers to assist Medicaid Members in completing the *HNS* during an office visit.

- **Obstetrics Prenatal Incentive Program** incentivizes provider groups who meet certain benchmarks for deliveries and completion of prenatal and/or postpartum visits.
- **Behavioral Health Provider Incentive Program** rewards providers for two key performance indicators: Follow Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependency (FUA) and Follow Up After Hospitalization for Mental Illness (FUH).
- **Social Determinants of Health Provider Incentive Program** incentivizes providers to screen Members for SDOH needs, to submit appropriate SDOH-related diagnosis codes on their claims, to refer Members to relevant Community-Based Organizations (CBOs), and for updating the status of those referrals to indicate that a Member attended that appointment.
- **Screening, Brief Intervention, and Referral to Treatment Provider Incentive Program** is designed to encourage Providers to screen and deliver early intervention services for risky substance users. The additional incentive can be paid once every calendar year per unique member.
- **Provider Quality Incentive Program (PQIP)** rewards providers for the quality care they provide our members and seeks to encourage efficient, preventive, and cost-effective healthcare practices.
- **PQIP Essentials (PQIPE)** rewards providers for the quality of care in support of transitioning members from a fragmented and transactional healthcare delivery system to a patient-centered system by investing in primary care and focusing on closing gaps in care.
- **Integrated Care Quality Incentive Program** is designed to encourage the integration of behavioral health and physical health to help identify underlying behavioral health, intervene with patients at risk for complications due to behavioral and psychosocial needs, and decrease costs by treating patients effectively and holistically.

Anthem reviews our incentive programs on an annual basis and updates them as necessary to ensure industrywide, evidence-based information is used to measure and incentivize providers. We reserve the right to modify, amend, or terminate programs at any time at our discretion.

To find out more about these programs and eligibility requirements, speak with your Network Relations manager or call Provider Services.

Overutilization and underutilization reviews

Overutilization and underutilization are reviewed annually utilizing HEDIS data. The purpose of analyzing underutilization and overutilization is to facilitate the delivery of appropriate care by monitoring the impact of Utilization Management (UM) programs as well as identify and correct potential overutilization and underutilization.

The annual analysis of the data provides insight into the potential underutilization and overutilization of services. Anthem utilizes the data to measure compliance with established goals and/or national averages/benchmarks where applicable.

Best Practice Methods

Best Practice Methods are Anthem's most up-to-date compilation of effective strategies for quality healthcare delivery. We share *Best Practice Methods* with providers during provider site visits. Quality and Network Relations Management teams offer *Anthem Policies and Procedures*, along with educational toolkits, to help guide improvements. Toolkits may include examples of best practices from other offices, including:

- Resources for improving compliance with preventive health services
- *Clinical Practice Guidelines*
- Care for members with special or chronic care needs
- Office practice optimizations

Member experience surveys

Anthem conducts Consumer Assessment of Healthcare Providers and Systems (CAHPS) member experience surveys each year through a contracted vendor certified by the NCQA. The CAHPS survey includes rating measures of members' overall satisfaction with their health plan, all healthcare received, personal doctors, and specialists. Other areas of assessment include ease of accessing care, quality of physician services, customer service, and claims processing. Our privately contracted survey allows Anthem to add additional questions to the survey to help us better understand our members' perceptions and enable the development of meaningful interventions.

CAHPS survey results (scores) are compared to the previous years' scores as well as to the NCQA Quality Compass®. This is a database maintained by NCQA that includes results from all CAHPS health plan surveys nationwide as well as national averages and percentiles. Opportunities for improvement are identified and priorities are set based on the review and analysis of scores, and also consider those areas where the plan can make the greatest impact. Recommendations for prioritizing the focus areas for improvement are reviewed with the appropriate quality committees and stakeholders.

Anthem shares the results of the CAHPS survey with providers annually through an article in our provider newsletter. Providers are encouraged to review the results, share them with office staff, and address any areas of deficiency in their offices.

Quality Compass® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Provider satisfaction surveys

Anthem may conduct provider surveys to monitor and measure provider satisfaction with Anthem's services and to identify areas for improvement. Provider participation in these surveys is highly encouraged and your feedback is very important. We inform providers of the results and plans for improvement through provider bulletins, newsletters, meetings, or training sessions.

Medical record documentation standards

Anthem requires providers to maintain medical records in a manner that is current and organized and permits effective and confidential member care and quality review. All records must be maintained and, if requested, made available at least seven years from the date of final claim

payment. We perform random medical record reviews of all PMPs (general practice, family practice, internal medicine, pediatrics, and select obstetrics/gynecology) to ensure that network providers are in compliance with these standards.

Network providers shall agree to maintain the confidentiality of member information and information contained in a member's medical records according to *HIPAA* standards. Medical records must be stored and retrieved in a manner that protects patient information according to the *Confidentiality of Medical Information Act,* which requires the following:

- The act prohibits a provider of healthcare from disclosing any individually identifiable information regarding a patient's medical history, mental, and physical condition, or treatment without the patient's or legal representative's consent or specific legal authority.
- Records required through a legal instrument may be released without patient or patient representative consent.
- Providers must be familiar with the security requirements of *HIPAA* and will only release such information as permitted by applicable federal, state, and local laws and that is:
    - Necessary to other providers and the health plan related to treatment, payment, or healthcare operations.
    - Upon the member's signed and written consent.

Security

The medical record must be secure and inaccessible to unauthorized access in order to prevent loss, tampering, disclosure of information, alteration, or destruction of the record. Information must be accessible only to authorized personnel within the provider's office, Anthem, the Indiana Family and Social Services Administration, or to persons authorized through a legal instrument. Records must be made available to Anthem for purposes of quality review, HEDIS, and other studies.

Storage and maintenance

Active medical records shall be secured and must be inaccessible to unauthorized persons. Medical records are to be maintained in a manner that is current, detailed, and organized, and that permits effective patient care and quality review while maintaining confidentiality. All records must be maintained and, if requested, made available at least seven years from the date of final claim payment.

Electronic record-keeping system procedures shall be in place to ensure patient confidentiality, prevent unauthorized access, authenticate electronic signatures, and maintain the upkeep of computer systems. Security systems shall be in place to provide backup storage and file recovery and to provide a mechanism to copy documents and ensure that recorded input is unalterable.

Availability of medical records

The medical records system must allow for prompt retrieval of each record when the member comes in for a visit. Providers must maintain members' medical records in a detailed and comprehensive manner that accomplishes the following:

- Conforms to good professional medical practice.
- Facilitates an accurate system for follow-up treatment.

- Permits effective professional medical review and medical audit process.

Medical records must be legible, signed, and dated. They must be maintained for at least seven years as required by federal regulations.

Providers must offer a copy of a member's medical record upon reasonable request by the member at no charge, and the provider must facilitate the transfer of the member's medical record to another provider at the member's request. Confidentiality of, and access to, medical records must be provided in accordance with the standards mandated in the *HIPAA* and all other state and federal requirements.

Providers must permit Anthem and representatives of the FSSA to review members' medical records for the purposes of monitoring the provider's compliance with the medical record standards, capturing information for clinical studies, monitoring quality, or any other reason. FSSA encourages providers to use technology, including health information exchanges, where appropriate, to transmit and store medical record data.

Medical record documentation standards

Every medical record is, at a minimum, to include:

- The patient's name or ID number on each page in the record.
- Personal biographical data including home address, employer, emergency contact name and telephone number, home, and work telephone numbers, and marital status.
- All entries dated with month, day, and year.
- All entries with the location at which service was rendered.
- Amount claimed through Medicaid for each specific service rendered.
- All entries contain the author's identification (for example, handwritten signature, unique electronic identifier, or initials) and title.
- Identification of all providers participating in the member's care, and information on services furnished by these providers.
- A list including significant illnesses and medical and psychological conditions.
- Presenting complaints, diagnoses, and treatment plans, including the services to be delivered.
- A current plan of treatment and progress notes as to the medical necessity and effectiveness of treatment and ongoing evaluations to assess progress and refine goals.
- Physical findings relevant to the visit including vital signs, normal, and abnormal findings, and appropriate subjective and objective information.
- Information on allergies and adverse reactions (or a notation that the patient has no known allergies or history of adverse reactions).
- Information on advance directives.
- Past medical history, including serious accidents, operations, illnesses, and for patients 14 years old and older, substance abuse (for children and adolescents, past medical history relates to prenatal care, birth, operation, and childhood illnesses).
- Physical examinations, treatment necessary, and possible risk factors for the member relevant to the particular treatment.
- Prescribed medications, including dosages and dates of initial or refill prescriptions.
- For patients 14 years and older, appropriate notations concerning the use of cigarettes, alcohol, and substance abuse (including anticipatory guidance and health education).

- Information on the individuals to be instructed in assisting the patient.
- Medical records must be legible, dated, and signed by the physician, physician assistant, nurse practitioner, or nurse midwife providing patient care.
- An immunization record for children that is up-to-date or an appropriate history for adults.
- Documentation of attempts to provide immunizations. If the member refuses immunization, proof of voluntary refusal of the immunization in the form of a signed statement by the member or guardian shall be documented in the member's medical record.
- Evidence of preventive screening and services in accordance with Anthem's preventive health practice guidelines.
- Documentation of referrals, consultations, diagnostic test results, and inpatient records (evidence of the provider's review may include the provider's initials or signature and notation in the patient's medical record of the provider's review and patient contact, follow-up treatment, instructions, return office visits, referrals, and other patient information).
- Notations of patient appointment cancellations or no-shows and attempts to contact the patient to reschedule.
- No evidence that the patient is placed at inappropriate risk by a diagnostic test or therapeutic procedure.
- Documentation on whether an interpreter was used, and if so, that the interpreter was also used in follow-up.

Medical record and facility site reviews

Anthem conducts medical records and facility site reviews in order to determine compliance with:

- Standards for providing and documenting healthcare.
- Standards for storing medical records.
- Processes that maintain safety standards and practices.
- Continuity and coordination of member care.

The Indiana FSSA, Anthem, and CMS have the right to enter into the premises of providers to inspect, monitor, audit, or otherwise evaluate the work performed. We perform all inspections and evaluations in such a manner as not to unduly delay work, in accordance with the provider contract.

Medical record review process

Our Quality team will call the provider's office to schedule a medical record review on a date and time that will occur within 30 days of the initial call. On the day of the review, the Quality team member will:

- Request the number and type of medical records required.
- Review the appropriate type and number of medical records per provider.
- Complete a medical record review.
- Meet with the provider or office manager to review and discuss the results of the review.

- Provide a copy of the review results to the office manager or doctor or send a final copy within 10 days of the review.
- Schedule follow-up reviews for any corrective actions identified.

Providers must attain a score of 80% or greater in order to pass the medical record review. Anthem completes a random medical record review annually according to our medical records standards.

Facility site review process

Anthem will conduct a facility site review (FSR) and inspection if three formal complaints have been received by members for a PMP. The review consists of 13 elements:

- Accessibility
- Appearance
- Safety and infectious waste
- Office policies
- Provider availability
- Treatment areas
- Patient services
- Process of documentation
- Personnel
- Medications, including emergency supplies
- Referral process
- Medical record elements and organization
- Appointment accessibility

Anthem's Quality team will call the provider's office to schedule an appointment date and time for the facility site review. The practice consultants will fax or mail a confirmation letter with an explanation of the audit process and required documentation. During the facility site review, the Quality staff will:

- Lead a pre-review conference with the provider or office manager to review and discuss the process of facility review and answer any questions.
- Conduct the review of the facility.
- Complete the facility site review.
- Develop a corrective action plan, if applicable.

After the facility site review is completed, Anthem's practice consultants will meet with the provider or office manager to:

- Review and discuss the results of the review and explain any required corrective actions.
- Provide a copy of the facility site review results and the corrective action plan to the office manager or provider or send a final copy within 10 days of the review.
- Educate the provider and office staff about Anthem's standards and policies.
- Schedule a follow-up review for any corrective actions identified.

Providers must attain a score of 80% or greater to pass.

Corrective actions

If the facility site review results in a non-passing score, Anthem will immediately notify providers of the non-passing score, all cited deficiencies, and corrective action requirements. The provider offices will develop and submit corrective action plans and Anthem will conduct follow-up visits every six months until the site complies with Anthem standards. The provider and office staff will:

- Provide an appointment time for the review.
- Be available to answer questions and participate in the exit interview.
- Schedule follow-up reviews, if applicable.
- Complete a corrective action plan.
- Sign an attestation that corrective actions are complete.
- Submit the completed corrective action plan, supporting documents, and signed attestation to our Clinical Quality Compliance administrator.

Preventable adverse events

The breadth and complexity of today's healthcare system mean there are inherent risks, many of which can be neither predicted nor prevented. However, when there are preventable adverse events, they should be tracked and reduced, with the ultimate goal of eliminating them.

Providers and healthcare systems, as advocates for our members, are responsible for the continuous monitoring, implementation, and enforcement of applicable healthcare standards. Focusing on patient safety, we work collaboratively with providers and hospitals to identify preventable adverse events and implement appropriate strategies and technologies to avoid them. Our goal is to enhance the quality of care received not only by our members but all patients receiving care in these facilities.

Prevention of adverse events may require the disclosure of protected health information. The *Health Insurance Portability and Accountability Act of 1996* (*HIPAA*) specifies that protected health information (PHI) and electronically protected health information (ePHI) can be disclosed for the purpose of healthcare operations in relation to quality assessment and improvement activities. Moreover, the information you share with us is legally protected through the peer review process; as such, it will be maintained in a strictly confidential manner. If you receive a request for medical records, please provide them within 10 days from the date of request.

We will continue to monitor activities related to the list of adverse events from federal, state, and private payers, including **never events,** defined by the National Quality Forum (NQF), as adverse events that are serious, but largely preventable, and of concern to both the public and healthcare providers.

Preventable adverse events should not occur. When they do, we firmly support the concept that a health plan and its members should not pay for resultant services. Note, Medicaid is prohibited from paying for certain Healthcare Acquired Conditions (HCAC). This applies to all hospitals.

Clinical Practice and *Preventive Health Guidelines*

At Anthem, we believe that providing quality healthcare shouldn't be limited to the treatment of injury or illness. We are committed to helping providers and members become more proactive in the quest for better overall health. To accomplish that goal, we offer providers tools to help them find the best, most cost-effective ways to:

- Provide member treatment

- Empower members through education
- Encourage member lifestyle changes where possible

We want providers to have access to the most up-to-date clinical practice and preventive healthcare guidelines. These guidelines, offered by nationally recognized healthcare organizations and based on extensive research, include the latest standards for treating the most common, stubborn, and serious illnesses, such as diabetes and hypertension. They also include guidelines for preventive screenings, immunizations, and member counseling based on age and gender.

Preventive Healthcare Guidelines

Anthem considers prevention an important component of healthcare. Anthem develops *Preventive Healthcare Guidelines* in accordance with recommendations made by nationally recognized organizations and societies such as the American Academy of Family Physicians (AAFP), the American Academy of Pediatrics (AAP), the Advisory Committee on Immunizations Practices (ACIP), the American College of Obstetricians and Gynecologists (ACOG), and the United States Preventive Services Task Force (USPSTF). The above organizations make recommendations based on reasonable medical evidence. We review the guidelines annually for content accuracy, current primary sources, new technological advances, and recent medical research, and make appropriate changes based on this review of the recommendations. We encourage physicians to utilize these guidelines to improve the health of our members.

The guidelines, educational materials, and health management programs can be found on our website at **https://providers.anthem.com/IN** under Resources **>** **Quality Assurance.**

Clinical Practice Guidelines

Anthem considers *Clinical Practice Guidelines* an important component of healthcare. Anthem adopts nationally recognized *Clinical Practice Guidelines* and encourages physicians to utilize these guidelines to improve the health of our members. Several national organizations produce guidelines for asthma, diabetes, hypertension, and other conditions. The guidelines, which Anthem uses for Quality and Condition Care programs are based on reasonable medical evidence. We review the guidelines at least every two years or when changes are made to national guidelines for content accuracy, current primary sources, new technological advances, and recent medical research.

You can access the *Clinical Practice Guidelines* on our website at **https://providers.anthem.com/IN** under Resources **>** **Quality Assurance**.

Chapter 12: Utilization management

Utilization management (UM) is a cooperative effort with providers to promote, provide, and document the appropriate use of quality healthcare resources. Our goal is to provide access to the right care, to the right member, at the right time, in the appropriate setting.

The UM team takes a multidisciplinary approach to meet the medical and psychosocial needs of our members. Anthem's decision-making process reflects the most up-to-date UM standards from the NCQA. When making UM decisions, Anthem utilizes the following criteria:

- Federal and state mandates
- Member benefits
- *Anthem Medical Policy*
- *Clinical Utilization Management Guidelines*
- *Anthem Behavioral Health Medical Necessity Criteria*
- American Society of Addiction Medicine
- *Carelon Medical Benefits Management Health Guidelines*
- State guidelines, when applicable
- MCG™ non-customized criteria

The decision-making criteria used by the UM team are evidence-based and consensus-driven. We periodically update criteria as standards of practice and technology change. We involve practicing physicians in these updates and notify providers of changes through provider bulletins. Based on sound clinical evidence, the UM team provides the following service reviews:

- Prior authorizations
- Continued stay reviews

Decisions affecting the coverage or payment for services are made in a fair, consistent, and timely manner. The decision-making incorporates nationally recognized standards of care and practice from sources including:

- American College of Cardiology
- American College of Obstetricians and Gynecologists
- American Academy of Pediatrics
- American Academy of Orthopedic Surgeons
- Cumulative Professional Expertise and Experience

Once a case is reviewed, decisions and notifications will be given for:

- Approval of services
- Modification of services
- Deferral of services
- Denial of services

Utilization review decisions are based only on the appropriateness of care, service, and the existence of benefit coverage. We do not financially reward practitioners and other individuals conducting utilization reviews for issuing denials of coverage or care. Decisions about hiring, promoting, or terminating practitioners or other staff are not based on the likelihood or perceived likelihood that they support, or tend to support, the denial of benefits. There are no financial incentives for UM decision-makers that encourage decisions resulting in underutilization or creating barriers to care and service. If you disagree with a UM decision you can discuss the decision with the physician reviewer at the following numbers:

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

Utilization management-related resources and forms are available on our website at **https://providers.anthem.com/IN** at Claims > Prior Authorization Requirements.

Our online *Clinical UM Guidelines* are also available upon request by call or fax:

- Call: **866-902-4628**
- Fax: **844-470-8860**

UM staff availability

Anthem makes UM staff available at least eight hours a day on normal business days to answer UM-related calls. Member or provider UM-related calls received are handled by UM staff, who will identify themselves by name, title, and organization. For more information, refer to the numbers below.

After normal business hours, an answering service is available to take UM-related messages. If a provider opts to request authorization for admission for post-stabilization care or behavioral healthcare after normal business hours, we are available 24 hours per day, 7 days per week. This is only available for inpatient requests. We do not take calls for outpatient requests after normal business hours. Post-stabilization requests are answered within one hour, and a determination of the medical necessity will be rendered within 24 hours of that response.

Language assistance is available. Members and providers can access our interpreter services (available over the phone and face-to-face) at the following numbers:

Hoosier Healthwise	Healthy Indiana Plan	Hoosier Care Connect
Providers: **866-408-6132** Members: **866-408-6131**	Providers: **844-533-1995** Members: **866-408-6131**	Providers: **844-284-1798** Members: **844-284-1797**

Starting the process

Requests for prior authorization with all supporting documentation must be submitted at a minimum of 72 hours prior to the scheduled admission. Failure to comply with notification rules will result in an administrative denial. The member must be eligible on the date of service and the service must be a covered benefit. Except in an emergency, failure to obtain prior authorization may result in a denial of reimbursement.

When authorization of a healthcare service is required, call us at the numbers listed above with questions and requests, including requests for:

- Routine, non-urgent care reviews
- Urgent or expedited pre-service reviews
- Urgent concurrent or continued stay reviews

An urgent request is any request for coverage of medical care or treatment within which the length of time required to make non-urgent care determinations could result in one of the following:

- Could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, based on a prudent layperson's judgment.
- In the opinion of a practitioner with knowledge of the member's medical condition, would subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.

Interactive Care Reviewer

The quickest, most efficient way to request prior authorization is via the Interactive Care Reviewer (ICR) on our secure provider website Availity at **www.availity.com**. You can register for ICR access through Availity. The ICR offers a streamlined and efficient experience for providers requesting inpatient and outpatient medical behavioral health services for Anthem members. Providers can also use this tool to inquire about previously submitted requests regardless of how they were submitted (phone, fax, ICR, or another online tool). The ICR can be accessed under *Authorizations and Referrals* on Availity for the following capabilities:

- **Initiate preauthorization requests online**, eliminating the need to fax. ICR allows detailed text, photo images, and attachments to be submitted along with your request.
- **Review** requests previously submitted via phone, fax, ICR, or another online tool.
- **Instant accessibility** from almost **anywhere**, including after business hours.
- **Utilize the dashboard** to provide a complete view of all utilization management requests with real-time status updates.
- **Real-time results** for some common procedures.
- **Enhanced analytics** that can provide immediate authorizations for certain higher levels of care
- **Increased efficiency** so that the use of fax is no longer needed.

For an optimal experience with the ICR, use a browser that supports 128-bit encryption. This includes Microsoft Edge, Internet Explorer 11, Chrome, Firefox, or Safari. The website will be updated as additional functionality and lines of business are added throughout the year.

Authorization forms

Providers who prefer to submit requests using an authorization form can visit our website at **https://providers.anthem.com/IN** and select Claims > **Prior Authorization Requirements** to find the ***Universal Authorization Form*****.** Here are some tips for filling out the online form and getting the fastest response to your authorization request:

- To ensure legibility, fill out the form and print it before faxing (see **Chapter 1: Contact information**).
- Fill out the form completely; unanswered questions typically result in delays.
- Access the forms online when you need them, rather than pre-printing and storing them. We revise the forms periodically, and outdated forms can delay your request.

To request a pre-service review or report a medical admission, please submit your request via our ICR or fax and have the following information ready:

- Member name and identification (ID) number
- Diagnosis with the *International Classification of Diseases* (ICD) code
- Procedure with the Current Procedural Terminology (CPT) code
- Date of injury or hospital admission and third-party liability information (if applicable)
- Facility name (if applicable)
- Primary medical provider
- Specialist or attending physician name
- Clinical justification for the request
- Level of care
- Lab tests, radiology, and pathology results
- Medications
- Treatment plan including time frames
- Prognosis
- Psychosocial status
- Exceptional or special needs issues
- Ability to perform activities of daily living
- Discharge plans

Additional information, to have ready within the requested time frame for the clinical reviewer includes, but is not limited to:

- Office and hospital records
- History of the presenting problem
- Clinical exam
- Treatment plans and progress notes
- Diagnostic testing results
- Information on consultations with the treating practitioner
- Evaluations from other healthcare practitioners and providers
- Photographs
- Operative and pathological reports
- Rehabilitative evaluations
- Printed copy of criteria related to the request
- Information regarding benefits for services or procedures
- Information regarding the local delivery system
- Patient characteristics and information
- Information from responsible family members

Services requiring prior authorization

All covered services are contingent upon medical necessity and benefit coverage at the time of service. Refer to Anthem's **Precertification Lookup Tool** **(Prior Authorization Lookup** Tool**) at https://providers.anthem.com/IN** for prior authorization requirements:

- Elective air ambulance
- Behavioral health
- Biofeedback
- Biopharmaceutical and injectable medications/specialty drugs
- Dental services
- Some durable medical equipment and disposable supplies
- All rental and custom DME equipment
- Genetic testing
- Home healthcare services (except home health code 42 services)
- Hyperbaric oxygen therapy
- Infusion therapy, including chemotherapy
- Laboratory tests (specific)
- Out-of-network services
- Physician services — referrals to out-of-network specialists
- Inpatient hospital services
- Inpatient BH service
- Inpatient skilled nursing facility (SNF)
- Long-term acute care facility (LTACF)
- Newborn stays beyond standard post-delivery observation
- Rehabilitation facility admissions
- Radiology services
- Select outpatient surgeries/procedures
- Sensory integration therapy
- Surgery requests
- Transfer requests
- Transplant services
- Vision services

Administrative denial

Administrative denial is a denial of services based on reasons other than medical necessity and is made when a contractual requirement is not met, such as late notification of admissions, lack of precertification, or benefit exhaustion. Appeals for administrative denials must address the reason for the denial (such as why we were notified late or why precertification was not obtained). If Anthem overturns its administrative decision, then the case will be reviewed for medical necessity and if approved, the claim will be reprocessed, or the requestor will be notified of the action that needs to be taken.

Requests with insufficient clinical information

When the UM team receives requests with insufficient clinical information, we will contact the provider with a request for the information reasonably needed to determine medical necessity.

We will make at least one attempt to contact the requesting provider to obtain this additional information. If additional clinical information is not received a decision is made based on the information available. Cases are either approved or denied coverage based on medical necessity and/or benefits. Members and providers will be notified of the determination by letter.

Pre-service review time frame

For routine, non-urgent requests, the UM team will complete preservice reviews within **seven calendar days** from receipt of the request. Requests that do not meet medical policy guidelines are sent to the physician advisor or medical director for further review.

Providers and members will be sent a notification by phone or fax within **seven calendar days** from receipt of the request for the UM team's approval, modification, deferral, or denial.

Urgent requests

For urgent requests, the UM team completes the pre-service review within **three calendar days** or as expeditiously as the member's condition warrants from receipt of the request.

Generally speaking, the provider is responsible for contacting us to request a pre-service review for both professional and institutional services. However, the hospital or ancillary provider should also contact Anthem to verify the pre-service review status for all non-urgent care before rendering services.

Timeliness of utilization management decisions	• For non-urgent pre-service requests: seven calendar days • For urgent pre-service requests: three calendar days • For concurrent reviews: within three calendar days of a request • For retrospective reviews: within 30 calendar days of a request

Emergency medical conditions and services

Anthem does not require prior authorization for treatment of emergency medical conditions, which is defined as a condition that could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, based on a prudent layperson's judgment.

In the event of an emergency, members can access emergency services 24 hours a day, seven days a week. The facility does not have to be in-network. In the event that the emergency room visit results in the member's admission to the hospital, providers must notify Anthem within 48 hours of admission.

Note: Copays for Healthy Indiana Plan and Hoosier Care Connect members will be waived if the member calls the 24/7 NurseLine and is instructed to go to the ER.

Emergency department triage fee and prudent layperson (PLP) review

Emergency department (ED) claims are adjudicated in accordance with the prudent layperson (PLP) standard, and, as explained below, utilizing the State's *ED Autopay List* accessible from the **Codes Sets** page at **https://www.in.gov/medicaid/providers/business-transactions/billing-and-remittance/code-sets**.

To reduce the administrative burden on providers, Anthem utilizes the State's *ED Autopay List*, in accordance with BT202009, which contains thousands of diagnosis codes. Anthem compares the first six diagnoses codes on the claim against the State's *ED Autopay List*; if any of the first six diagnoses codes from the claim match a code included on the *ED Autopay List*, then Anthem will pay the claim as **emergent** at the corresponding fee schedule (or contracted) rate. If none of the first six diagnosis codes on the claim match the *ED Autopay List*, and if the provider did not submit medical records with the submission of the initial claim for a PLP review, then Anthem will pay the claim at the triage rate. Anthem uses the State's *ED Autopay List*, which is public, so providers can decide whether to submit medical records with the claim submission. If a provider believes an ED claim should have been paid as emergent rather than triage, they should follow the dispute process. The deadline to submit a dispute for PLP review was extended to 120 calendar days after the notification of the triage payment. Additional details including how to file a dispute can be found here:
https://providers.anthem.com/docs/gpp/IN_CAID_EmergencyDeptClaimsProcess.pdf

Transportation

Anthem covers emergency transportation services without prior authorization when a member's condition is life-threatening and requires the use of special equipment, life support systems, and close monitoring. Examples of conditions include, but are not limited to:

- Acute/severe illnesses
- Acute/severe injuries from auto accidents
- Extensive burns
- Loss of consciousness
- Semi-consciousness
- Having a seizure
- Receiving CPR during transport
- Critical or multiple fractures

Emergency stabilization and post-stabilization

The emergency department's treating physician determines the services needed to stabilize the member's emergency medical condition. After the member is stabilized, the emergency department's physician must contact the member's PMP for authorization of further services. The member's PMP is noted on the back of the ID card. If the PMP does not respond within one hour, the needed services will be considered authorized.

The emergency department should send a copy of the emergency room record to the PMP's office within 24 hours. The PMP should:

- Review the chart and file it in the member's permanent medical record.
- Contact the member.
- Schedule a follow-up office visit or a specialist referral, if appropriate.

If post-stabilization care is required, the hospital care provided in the 72-hour observation setting does not require authorization or notification. Claims for 72-hour observation will pay according to benefits, without clinical review.

However, as with all non-elective admissions, the notification must be made within 48 hours of admission, not including Saturday, Sunday, or legal holidays. The medical necessity of that admission will be reviewed upon receipt of notification and a determination of the medical necessity will be rendered within 24 hours (one business day), not including Saturday, Sunday, or legal holidays of that notification. If a provider requests authorization for admission for post-stabilization care after normal business hours, the Care Management team is available 24 hours per day, 7 days per week, and 365 days a year, to process such requests. Determination of the medical necessity will be rendered within 24 hours (one business day), not including Saturday, Sunday, or legal holidays of that notification.

Referrals to specialists

The UM team is available to assist providers in identifying a network specialist and/or arranging for specialist care. Keep the following in mind when referring members:

- UM authorization **is not** required if referring a member to an in-network specialist for consultation or a nonsurgical course of treatment.
- UM authorization **is** required when referring to an out-of-network specialist.

Provider responsibilities include documenting referrals in the member's chart and requesting that the specialist provide diagnosis and treatment updates.

Note: Obtain a prior authorization approval number before referring members to an out-of-network provider. For out-of-network providers, we require this prior authorization for the initial consultation and each subsequent service provided.

Out-of-network exceptions

There are several geographical exceptions to using only network providers:

- Anthem members are allowed to use the services of out-of-network nurse practitioners if no nurse practitioner is available in the member's service area, as well as for emergency care, continuity of care, and self-referral services.
- For HIP members, Anthem makes covered services provided by federally qualified health clinics (FQHCs) and rural health clinics (RHCs) available to members out-of-network if those clinics are not available in the member's service area and within Anthem's network.
- If Anthem is unable to provide necessary covered medical services within 60 miles of the member's residence by Anthem's provider network, Anthem authorizes out-of-network services and covers the services for as long as those services are unavailable in-network.

Anthem also allows members with special needs determined to need a course of treatment or regular care monitoring to directly access a specialist via a standing referral from the member's PMP for treatment appropriate for the member's condition.

Hospital inpatient admissions

The facility must notify Anthem of emergent inpatient admissions within 48 hours of admission, not including Saturdays, Sundays, or legal holidays. Clinical documentation demonstrating medical necessity must be submitted with the initial request. Requests will be reviewed, and decisions will be rendered using non-customized *MCG™ Criteria* and *Clinical Guidelines* available on the provider's website. To search for specific *Clinical Guidelines*, visit **www.anthem.com/cptsearch_shared.html**. Hospital admissions to observation for up to 72 hours do not require prior authorization for in-network facilities. Out-of-network or per-diem facilities must obtain prior authorization for observation services.

Inpatient stays less than 24 hours must be billed as an outpatient service. Outpatient services within three days preceding a less-than-24-hour inpatient stay are billed as an outpatient service. Inpatient stays less than 24 hours that are billed as an inpatient service will be denied. Exceptions to this requirement are:

- Newborns who expire within one day of birth.

Procedure codes listed on the *Procedure Codes Payable as an Inpatient Service When Delivered in an Inpatient Setting for Stays of Less Than 24 Hours* code set. Anthem will bypass the 24-hour rule to allow certain procedure codes designated by Medicare as **inpatient-only** to be reimbursed as inpatient services when the service is delivered in an inpatient setting to a patient discharged or expired within 24 hours of admission. For a list of the HCPCS and CPT codes to which this exception applies, see the *Inpatient Hospital Services Codes* at **IHCP Provider Code Tables (indianamedicaid.com)**. Certain DRGs include neonate transfer cases only and are exempt from transfer reimbursement policies. The DRGs that include only transfer cases are as follows:

- APR 581 (all severity levels)/AP 639 — Neonate, transferred less than 5 days old, born here
- APR 580 (all severity levels)/AP 640 — Neonate, transferred less than 5 days old, not born here

To facilitate quality utilization management delivery, please ensure greater than 24 hours of clinical information is submitted with your request for an inpatient admission review. Inpatient utilization management review requests for admissions confirmed to be less than 24 hours will be administratively denied.

Clinical information for continued-stay review

When a member's hospital stay is expected to exceed the number of days authorized during the preservice review, or when the inpatient stay did not have a preservice review, the hospital must contact us for continued stay review. Clinical reviews to assess for medical necessity and appropriate level of care are completed for all members admitted for an inpatient stay to acute-care hospitals, intermediate facilities, or skilled nursing facilities. Anthem identifies member admissions by utilizing data obtained via the following methods:

- Facilities reporting admissions
- Providers reporting admissions
- Members or their representatives reporting admissions
- Claims submitted for services rendered without authorization
- Pre-service authorization requests for inpatient care

We recommend that our providers review the applicable *MCG™ Criteria* or *Clinical Guidelines* if the medical necessity for continued stay is in question. If you do not have the applicable guideline, please request a copy from the Network Relations team. Submitted documentation should include current clinical updates and any anticipated discharge planning needs such as durable medical equipment, therapies, follow-up appointments, home health, and social service needs, for example. If the member has been recently discharged, the documentation should include the discharge date and discharge summary.

Clinical reviews for medical necessity will be completed within one business day of receipt of clinical documentation, up to a total of 72 hours from the initial notification of the request. Requests that do not meet medical policy guidelines will be sent to the physician adviser or medical director for further review and determination.

We will send written notification of any denial or modification of the request to the member, and the rendering and requesting provider within one business day of the determination.

Anthem makes decisions regarding approval or denial of urgent care within one business day of receipt of information, but may extend the time frame in limited situations only when at least one of the following criteria is met:

- The request to approve additional days for urgent continued stay care is related to care not previously approved by Anthem and Anthem documents that it made at least one attempt to contact the provider and was unable to obtain the needed clinical information within the initial one business day after the request for coverage of additional days. In this case, Anthem has up to 72 hours to make the decision.
- If the request by the provider/facility to extend urgent continued stay care was not made at least one business day prior to the expiration of the prescribed period of time or number of treatments, the request may be treated as an urgent pre-service decision, Anthem may make the decision within 72 hours.
- The health plan documents that the member voluntarily agrees to extend the decision-making time frame. In this case, Anthem has up to 72 hours to make the decision.
- If the decision time frame is extended and the decision is a denial or modified, the providers and members are notified verbally, electronically, or in writing within 72 hours of the receipt of the request.

Denial of service

Only a medical or behavioral health provider with an active professional license or certification can deny services for lack of medical necessity, including the denial of procedures, hospitalization, or equipment.

When a request is determined to be not medically necessary, the requesting provider will be notified of the following decision, the process for appeal, and how to reach the reviewing physician for peer-to-peer discussion of the case.

Providers can contact the physician clinical reviewers to discuss any UM decision by calling the UM department. For more information about UM decisions and how to appeal them, see **Chapter 13: Grievances and appeals.**

Reconsideration

A reconsideration process is available to providers following an adverse determination. During the reconsideration process, providers will have an opportunity to submit additional information to substantiate medical necessity for a previously denied pre-service or concurrent inpatient stay.

Reconsideration is not considered to be an appeal and does not limit subsequent appeal rights.

A Peer-to-Peer (P2P) process will give the provider an opportunity to discuss an administrative denial or a medical necessity denial decision with a health plan medical director (or another appropriate practitioner) at any time during the reconsideration process.

Timeframes for reconsideration of denied services:

- 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 (For more information about secondary appeals and State Fair Hearings, see **Chapter 13: Grievance and appeals**)

Self-referral

Members do not need a referral from their provider or prior authorization from Anthem to see a non-contracted provider and may self-refer to the services listed below. A non-contracted provider must be attested with IHCP prior to rendering services to Anthem members. Authorization may still be required if the service itself requires a medical necessity authorization. Members may be directed to providers in the network for self-referral services. However, with the exception of behavioral health services, members may receive self-referral from Indiana Health Coverage Programs (IHCP) qualified providers. Services include:

- Chiropractic services
- Diabetes self-management
- Emergency services
- Urgent care services
- Family planning
- Immunizations
- Outpatient behavioral health (in-network only if not provided by a psychiatrist)

- Psychiatric services
- Podiatric
- Routine vision and dental

Second opinions

There are several important guidelines regarding second opinions:

- A second opinion must be given by an appropriately qualified healthcare professional.
- The second opinion must come from a provider of the same specialty.
- The secondary specialist must be within Anthem's network and may be selected by the member.

When there is no network provider who meets the specified qualification, we may authorize a second opinion by a qualified provider outside of the network upon request by the member or provider. Second opinions regarding medical necessities are offered at no cost to our members.

Behavioral health

For information about behavioral health services, please see **Chapter 5: Behavioral health**.

Vision care

Anthem contracts with Superior Vision providers for basic vision care. For prior authorization of all vision services, contact Superior Vision at **877-235-5317.**

Carelon Medical Benefits Management

Anthem contracts with Carelon Medical Benefits Management to provide health services review for prior authorization (PA) of the following services:

Outpatient habilitation and rehabilitation services

Carelon Medical Benefits Management provides PA reviews for physical therapy, occupational therapy, and speech therapy. For the most current Clinical Guidelines access Carelon Medical Benefits Management at **www.providerportal.com**.

Outpatient imaging services

The service requests reviewed by Carelon Medical Benefits Management will include, but not limited to:

- Computer tomography scans (including cardiac)
- Nuclear cardiology
- Magnetic resonance (including cardiac)
- Positron emission tomography scans (including cardiac)
- Stress echocardiography
- Resting transthoracic echocardiography
- Transesophageal echocardiography
- Arterial ultrasound
- Cardiac catheterization

- Percutaneous coronary intervention (PCI)
- Radiation oncology services

Sleep disorder testing and treatment

All sleep disorder testing and treatment currently require prior authorization.

Genetic testing

All genetic testing services currently require prior authorization.

Musculoskeletal program

Medical necessity reviews are conducted for spine surgeries, joint surgeries, and interventional pain management procedures. Services provided as part of an elective planned inpatient admission require PA and are handled by Carelon Medical Benefits Management. The following services require PA:

Spine surgery — cervical, thoracic, lumbar, and sacral	
• Bone grafts • Bone growth stimulators • Cervical/lumbar foraminotomies • Cervical/lumbar spinal fusions • Cervical/lumbar spinal laminectomy	• Cervical/lumbar spinal discectomy • Cervical/lumbar spinal disc arthroplasty (replacement) • Spinal deformity (scoliosis/kyphosis) • Vertebroplasty/kyphoplasty
Joint surgery (including all associated revision surgeries)	
• Hip arthroscopy • Knee arthroscopy • Meniscal allograft transplantation • Shoulder arthroscopy	• Total hip replacement • Total knee replacement • Total shoulder replacement • Treatment of osteochondral defects
Interventional pain management	
• Epidural steroid injections • Paravertebral facet joint injection/nerve block/neurolysis	• Sacroiliac steroid injections • Spinal cord stimulators • Regional sympathetic nerve block

Visit **www.providerportal.com** and click on the **Clinical Guidelines** menu for the *Carelon Medical Benefits Management Clinical Criteria* used to determine the medical necessity of these services. To request prior authorization for services, please follow this process:

- Log in to the Carelon Medical Benefits Management website at **https://providerportal.com** or access the Carelon Medical Benefits Management website via Availity at **https://www.availity.com**.
- Providers may contact Carelon Medical Benefits Management toll-free at **844-767-8158**. Hours of operation are Monday through Friday from 8 a.m. to 8 p.m. Eastern time.

Chapter 13: Grievances and appeals

We encourage Anthem providers and members to seek resolution of issues through our grievances and appeals process. Anthem's grievances and appeals process meets all requirements of state law and accreditation agencies:

- **Grievance:** Any expression of dissatisfaction to Anthem by a provider or member about any matter other than an action or adverse determination.
- **Appeal:** A formal request for Anthem to review an action or adverse determination. Providers may file appeals on a member's behalf but do not have a separate distinct process. See **Claims payment disputes**.

An action or adverse determination is defined as a denial, modification, or reduction of services based on eligibility, benefit coverage, or medical necessity.

Providers and members have the right to file a grievance regarding any aspect of Anthem's services. Anthem does not discriminate against members or providers for filing a grievance or an appeal. Providers are prohibited from penalizing a member in any way for filing a grievance. Provider grievances and appeals are classified into the following two categories:

- Provider grievances relating to the operation of the plan, including benefit interpretation, claim processing, and reimbursement.
- Provider appeals related to actions/adverse determinations.

Member grievances can include, but are not limited to, the following:

- Access to healthcare services
- Care and treatment by a provider
- Issues having to do with how we conduct business

Anthem offers an expedited grievance and appeal process for decisions involving urgently needed care. Both standard and expedited grievances and appeals are reviewed by a person who is not subordinate to the initial decision-maker.

Provider grievances relating to the operation of the plan

A provider may be dissatisfied or concerned about another provider, a member, or an operational issue, including claims processing and reimbursement. If the provider wants to file a grievance, please use the ***Provider Grievance Form*** located on our website at **https://providers.anthem.com/IN** > Resources > Forms.

Provider grievances must be submitted **in writing** and include the following:

- Provider's name
- Date of the incident
- Description of the incident

Grievances can be submitted by fax to **855-535-7445** or the following address:

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

A grievance may be filed up to **60 calendar days** from the date the provider became aware of the problem. Anthem may request medical records or an explanation of the issues raised in the grievance in the following ways:

- By telephone
- By fax, with a signed and dated letter
- By mail, with a signed and dated letter

The timelines for responding to the request for more information are as follows:

- **Standard grievance or appeal:** Providers must comply with the request for additional information within 10 days of the date that appears on the request.
- **Expedited grievance or appeal:** Providers must comply with the request for additional information within 24 hours of the date of our request.

Providers are notified in writing of the resolution, including their right of appeal, if any. Findings or decisions of peer review or quality of care issues are not disclosed.

When to expect a resolution for a grievance or appeal:

- **Provider grievance:** Anthem sends a written resolution letter to the provider within 30 calendar days of the receipt of the grievance.
- **Provider appeals:** Anthem sends a written resolution letter to the provider within 30 calendar days of the receipt of the appeal.

Claims payment disputes

Provider claim payment dispute process

If you disagree with the outcome of a claim, you may begin the Anthem provider payment dispute process. The simplest way to define a claim payment dispute is when the claim is finalized, but you disagree with the outcome.

The provider payment dispute process consists of two internal steps. You will **not** be penalized for filing a claim payment dispute, and no action is required by the member:

1. **Claim payment reconsideration:** This is the first step in the provider payment dispute process. The reconsideration represents your initial request for an investigation into the outcome of the claim. Most issues are resolved at the claim payment reconsideration step.
2. **Claim payment appeal:** This is the second step in the process. If you disagree with the outcome of the reconsideration, you may request an additional review as a claim payment appeal.

A claim payment dispute may be submitted for multiple reason(s), including:

- Contractual payment issues
- Disagreements over reduced or zero-paid claims
- Post-service authorization issues
- Other health insurance denial issues
- Claim code editing issues
- Duplicate claim issues
- Retro-eligibility issues
- Experimental/investigational procedure issues
- Claim data issues
- Timely filing issues*

* We will consider reimbursement of a claim that has been denied due to failure to meet timely filing if you can: 1) provide documentation the claim was submitted within the timely filing requirements, or 2) demonstrate good cause exists. See **Timely filing exceptions** in **Chapter 10: Claims submissions**.

Good cause

Good cause may be established by the following:

- If the claim includes an explanation for the delay (or other evidence which establishes the reason), Anthem will determine the good cause based primarily on that statement or evidence.
- If the evidence leads to doubt about the validity of the statement, Anthem will contact the provider for clarification or additional information necessary to make a good cause determination.

Good cause may be found when a provider claim filing delay was due to:

- Administrative error
- Retroactive enrollment
- Incorrect information furnished by the member
- Unavoidable delay in securing required documentation or evidence from third parties
- Unusual, unavoidable, or other circumstances beyond the service provider's control
- Destruction or other damage to the provider's records

For more information about good cause, go to **https://providers.anthem.com/IN >** Claims > Reimbursement Policies > Reimbursement Administration — General > **Requirements for Documentation of Proof of Timely Filing**.

Claim payment reconsideration

The first step in the claim payment dispute process is called reconsideration. It is your initial request to investigate the outcome of a finalized claim. Note, we cannot process a reconsideration without a finalized claim on file.

We accept reconsideration requests in writing, verbally, and through our secure provider website within 60 calendar days from the date on the *EOP* (see below for further details on how to submit). Reconsiderations filed more than 60 days from the *EOP* will be considered untimely and denied unless good cause can be established.

When submitting reconsiderations, please include as much information as you can to help us understand why you think the claim was not paid as you would expect. If a reconsideration requires clinical expertise, the appropriate clinical professionals will review it.

Anthem will make every effort to resolve the claims payment reconsideration within 30 calendar days of receipt. If the determination of the reconsideration requires additional information to resolve, the determination date may be extended by 30 additional calendar days. We will mail you a written extension letter before the expiration of the initial 30 calendar days. We will send you our decision in a determination letter, which will include:

- A statement of the provider's reconsideration request.
- A statement of what action Anthem intends to take or has taken.
- The reason for the action.
- Support for the action, including applicable statutes, regulations, policies, claims, codes, or *Provider Manual* references.
- An explanation of the provider’s right to request a claim payment appeal within 60 calendar days of the date of the reconsideration determination letter.
- An address to submit the claim payment appeal.

If the decision results in a claim adjustment, the payment and *EOP* will be sent separately.

Claim payment appeal

If you are dissatisfied with the outcome of a reconsideration determination, you may submit a claim payment appeal. Note, we cannot process a claim payment appeal without a reconsideration on file.

We accept claim payment appeals through our provider website or in writing within 60 calendar days of the date on the reconsideration determination letter.

Claim payment appeals received more than 60 calendar days after the determination letter will be considered untimely and upheld unless good cause can be established.

When submitting a claim payment appeal, please include as much information as you can to help us understand why you think the reconsideration determination was in error. If a claim payment appeal requires clinical expertise, it will be reviewed by appropriate clinical professionals.

Anthem will make every effort to resolve the claim payment appeal within 45 calendar days of receipt. If a determination is not made within 45 days, the decision will be rendered in favor of the provider. We will send you our decision in a determination letter, which will include:

- A statement of the provider's claim payment appeal request.
- A statement of what action Anthem intends to take or has taken.
- The reason for the action.
- Support for the action, including applicable statutes, regulations, policies, claims, codes, or *Provider Manual* references.

If the decision results in a claim adjustment, the payment and *EOP* will be sent separately.

How to submit a claim payment dispute

We have several options to file a claim payment dispute:

- Verbally (for reconsiderations only): Call Provider Services.
- Online (for reconsiderations and claim payment appeals): Use the secure **Provider Availity Payment Appeal Tool** at **https://www.availity.com**. Through Availity, you can upload supporting documentation and will receive immediate acknowledgment of your submission.
- Written (for reconsiderations and claim payment appeals): Mail all required documentation (see below for more details), including the ***Provider Dispute Resolution Request*** form, to:

  Anthem Blue Cross and Blue Shield
  Provider Disputes and Appeals
  P.O. Box 61599
  Virginia Beach, VA 23466-1599

Required documentation for claims payment disputes

Anthem requires the following information when submitting a claim payment dispute (reconsideration or claim payment appeal):

- Your name, address, phone number, email, and either your NPI or TIN
- The member’s name and their member ID
- A listing of disputed claims, including the Anthem claim number and the dates of services
- All supporting statements and documentation

Claim inquiries

A question about a claim or claim payment is called an inquiry. Inquiries do not result in changes to claim payments, but the outcome of the claim inquiry may result in the optional initiation of the claim payment reconsideration.

Our Network Relations Program helps you with claim inquiries. Just call Provider Services and select the *Claims* prompt within our voice portal. We will connect you with a dedicated resource team, called the Provider Service Unit (PSU), to ensure:

- Availability of helpful, knowledgeable representatives to assist you.
- Increased first contact and issue resolution rates.
- Significantly improved turnaround time of inquiry resolution.
- Increased outreach communication to keep you informed of your inquiry status.

Claim correspondence

Claim correspondence is different from a payment dispute. Correspondence is when Anthem requires more information to finalize a claim. Typically, Anthem makes the request for this information through the *EOP*. The claim or part of the claim may, in fact, be denied, but it is only because more information is required to process the claim. Once the information is received, Anthem will use it to finalize the claim.

The following table provides examples of the most common correspondence issues along with guidance on the most efficient ways to resolve them. Submissions should be mailed to:

Anthem Blue Cross and Blue Shield
Corrected Claims and Correspondence
P.O. Box 61599
Virginia Beach, VA 23466-1599

Type of issue	What do I need to do?
Rejected claim(s)	Use the EDI Hotline at **800-590-5745** when your claim was submitted electronically but rejected during the EDI processing.
EOP requests for supporting documentation	Submit a *Claim Follow-up Form*, a copy of your *EOP*, and the supporting documentation.
EOP requests for medical records	Submit a *Claim Follow-up Form*, a copy of your *EOP*, and the medical records.
Need to submit a corrected claim due to errors or changes on the original submission	Submit a *Claim Follow-up Form* and your corrected claim. Clearly identify the claim as corrected. We cannot accept claims with handwritten alterations to billing information. We will return claims that have been altered with an explanation of the reason for the return. Provided the claim was originally received timely, a corrected claim must be received within 60 days of the date of service.
Submission of *Coordination of Benefits (COB)/ Third-Party Liability (TPL)* information	Submit a *Claim Follow-up Form*, a copy of your *EOP*, and the *COB/TPL* information. In cases where there was an adjustment to a primary insurance payment and it is necessary to submit a corrected claim to Anthem to adjust the *COB/TPL* payment information, the timely filing period starts with the date of the most recent *TPL EOB*.
Emergency room payment review	Submit a *Claim Follow-up Form*, a copy of your *EOP*, and the medical records.

Medical necessity appeals

Medical necessity appeals refer to a situation in which authorization for a service was denied prior to the service. Medical necessity appeals/prior authorization appeals are different than claim payment disputes and should be submitted in accordance with the medical necessity appeal process.

Member grievance and appeal

To help ensure that members' rights are protected, all Anthem members are entitled to a grievance and appeal process at no cost to the member.

- **Grievance:** Any expression of dissatisfaction by a member to Anthem about any matter other than an action or adverse determination.
- **Appeal:** A formal request for Anthem to review an action or adverse determination.

Forms are located on our website at **https://providers.anthem.com/IN** > Resources > Forms. Member Grievance Forms are also available at the places where members receive their healthcare, such as their PMP's office. Forms should be mailed to:

Anthem Blue Cross and Blue Shield
Member Appeals and Grievances
P.O. Box 62429
Virginia Beach, VA 23466

Grievance fax: **855-535-7445**

If the member cannot mail the form or letter, we will assist the member by documenting a verbal request. Interpreter services, including sign language interpreters, are available to the member throughout the grievance and appeal process, at no cost, by contacting Member Services.

When to file

Members have the following periods of time to file:

- **Grievance:** Within 60 calendar days of the date the member became aware of the issue
- **Appeal:** Within 60 calendar days of the date on the notification letter of denial

Member appeal or grievance consent

Pursuant to the general requirements regulation, *42 CFR §438.402,* when a provider submits a grievance or appeal on behalf of a member, the provider must obtain a signed and dated written consent from the member giving the provider permission to file the grievance or appeal on the member's behalf. Without written consent from the member, the grievance or appeal will be dismissed. Members, or providers acting on the member's behalf, have 60 calendar days from the date of action notice within which to file an appeal.

Member grievances

If a member wants to file a **grievance**, they should fill out a *Member Grievance Form*, write a letter, or contact Member Services at the number on the back of their ID card.

When filing the grievance, the member will need to tell us the following:

- Who is part of the grievance
- What happened
- When it happened
- Where it happened
- Why they were not happy with the healthcare services
- Attach documents that will help us look into the problem

Grievance

After we receive the *Member Grievance Form* by fax or mail, we will send an acknowledgment letter within three business days from the date we receive it.

If we receive a request for an **expedited grievance**, the medical director will review the request without delay to determine if the request involves an imminent and/or serious threat to the health of the member, including, but not limited to, severe pain and potential loss of life, limb, or major bodily function. This determination is made within one working day of the receipt of the expedited request.

Members must request an expedited grievance by fax or by calling Member Services.

Fax: **855-516-1083.**

If the request meets the criteria for an **expedited grievance,** we immediately acknowledge it by telephone, if possible. **Expedited grievances** are resolved **within 48 hours** of receipt.

If the medical director determines a request involves medical care or treatment for which the application of the standard time period is appropriate, the request will be handled and resolved in 30 calendar days. A grievance representative immediately notifies the member by telephone, if possible, of the determination. In addition, the grievance representative provides the member with a written notice of the denial to expedite the resolution within two calendar days of the receipt of the grievance.

Grievance resolutions

Anthem will investigate the member's grievance to develop a resolution. This investigation includes the following steps:

- Anthem will have the grievance reviewed by the appropriate staff and, if necessary, the medical director.
- Anthem may request medical records or an explanation from the provider(s) involved in the case.
- Anthem will notify providers of the need for additional information either by phone, mail, or fax. Written correspondence to providers will include a signed and dated letter.
- Providers are expected to comply with requests for additional information within 10 calendar days.

The member will receive a *Grievance Resolution Letter* within 30 calendar days of the date we receive the grievance request. The letter will:

- Describe their grievance.
- Tell them what will be done to solve the problem.

Members appeals

If the member's grievance is related to an **action** or **adverse determination,** it is considered an **appeal**. Action/adverse determination is the denial or limited authorization of a requested service, including the type or level of service.

Actions/adverse determinations may include the following:

- Denial or limited authorization of a requested service, including the type or level of service
- The reduction, suspension, or termination of a previously authorized service
- The denial, in whole or in part, of payment for service
- Failure to provide services in a timely manner, as defined by the state
- Failure of Anthem to act within the required timeframes
- For a resident of a rural area with only one contractor, the denial of a member's request to exercise his right, under 4*2 CFR 438.52(b)(2)(ii),* to obtain services outside of the network (if applicable)

If a member would like to file an appeal with regard to the outcome of their grievance decision, whether it was actionable or not, they must notify us within 60 calendar days of the date on the *Notification Letter of Denial.* Member appeals are divided into two categories:

- **Standard appeals:** The appropriate process when a member or their representative requests that Anthem reconsider the denial of a service or payment for services, in whole or in part.
- **Expedited appeals:** The appropriate process when the amount of time necessary to participate in a standard appeal process could jeopardize the member's life, health, or ability to maintain or regain maximum function.

Response to standard appeals

Once an oral or written appeal request is received, the case is taken under consideration and investigated by the Grievances and Appeals department. The member, their representative, and the provider are all given the opportunity to submit written comments and documentation relevant to the appeal. Anthem may request medical records or a provider explanation of the issues raised in the appeal in the following ways:

- By telephone
- By fax, with a signed and dated letter
- By mail, with a signed and dated letter

Providers are expected to comply with the request for additional information within 10 calendar days.

When the appeal is the result of a medical necessity determination, a clinical reviewer **who was not involved in the initial** decision reviews the case. The clinical reviewer contacts the provider, if needed, to discuss possible alternatives.

Resolution of standard appeals

Standard appeals are resolved within 30 calendar days of receipt of the initial written or oral request. Members are notified in writing of the appeal resolution within five days and their right to further appeal (if any).

Extensions

The resolution time frame for an appeal **not** related to an ongoing hospitalization or emergency may be extended up to 14 calendar days if:

- The member or their representative requests an extension.
- Anthem shows that there is a need for additional information and that the delay is in the member's interest.

Expedited appeals

If the amount of time necessary to participate in a standard appeal process could jeopardize the member's life, health, or ability to attain, maintain or regain maximum function, the member has the right to request an **expedited appeal** within 60 calendar days from the date on the initial *Notice of Action* letter. Expedited appeals are acknowledged by telephone with follow-up in writing. Anthem will inform members of the time available for providing information and that limited time is available for **expedited appeals**. Members must request an **expedited appeal** by fax or by calling Member Services. Please contact us in one of these ways:

- Member Services:
  - Hoosier Healthwise or Healthy Indiana Plan: **866-408-6131**
  - Hoosier Care Connect: **844-284-1797**
  - TTY: **711**
- Fax: **855-516-1083**

If Anthem denies a request for an expedited appeal, Anthem must:

- Transfer the appeal to the time frame for standard resolution.
- Make a reasonable effort to give the member prompt oral notice of the denial, and follow up within two calendar days with a written notice.

Anthem may request medical records or a provider explanation of the issues raised in an expedited appeal by the following means by phone or by fax/mail with a signed and dated letter. Providers are expected to comply with the request for additional information within 24 hours.

Resolution of expedited appeals

Anthem resolves expedited appeals as quickly as possible and **within 48 hours**. The member is notified by telephone and written letter of the resolution, if possible.

Other appeal options

After exhausting Anthem's **grievance and appeal process**, if a member is still dissatisfied with the decision, the member has the right to request an **external independent review (EIR)** and/or file an Appeal with the Indiana FSSA to request a State Fair Hearing.

External independent review (EIR)

The member, the member's authorized representative, the provider, or the provider on behalf of a member may file a written request for an EIR through the Grievances and Appeals department within 120 calendar days after the member is notified of Anthem's resolution. The process is as follows:

- Anthem sends a letter acknowledging receipt of the request for the EIR within three business days for a standard request and within 24 hours for an expedited request.
- Members must request an expedited EIR by fax. Fax to **855-516-1083.**
- Anthem selects an EIR agency from a rotating list of organizations certified by the state of Indiana. All documents related to the member's appeal case are forwarded to the review agency.
- If at any time during the EIR process the member submits information that was not considered during the utilization review or appeal determination processes, Anthem will reconsider its resolution. At this time, the EIR agency will stop its review.
- Anthem will make a decision in this reconsideration process within 72 hours of receipt of the information for an expedited request and within 15 business days of the receipt of this information for a standard request.
- If the decision is adverse to the member, the member may request that the EIR agency resume its review.

The EIR agency must make a decision on an expedited request **within 72 hours** after the request is filed. For a standard request, the agency must make a decision within 15 business days after the request is filed. The EIR agency notifies Anthem and the member of their decision. This decision is binding for Anthem.

State Fair Hearing

Anthem members may request a **State Fair Hearing** after they have exhausted all of Anthem's internal appeal processes. The request must be filed within 120 calendar days of the initial action to be reviewed. The request must be submitted in writing to the state of Indiana Office of Administrative Law Proceedings (OALP) at:

Office of Administrative Law Proceedings
402 W. Washington Street, Room E034
Indianapolis, IN 46204-2773

Once the state receives the member's request, the process is as follows:

- The state sends a notice of the hearing request to Anthem.
- Upon receipt of the request, all documents related to the request are forwarded to the state.
- The state notifies all parties of the date, time, and place of the hearing. Representatives from our administrative, medical, and legal departments may attend the hearing to present testimony and arguments. Our representatives may cross-examine the witnesses and offer rebutting evidence.
- An administrative law judge (ALJ) renders a decision in the hearing within 90 business days of the date the hearing request was made.
- If the judge overturns Anthem's position, we must adhere to the ALJ's decision and ensure that it is carried out.

Confidentiality

All grievances and appeals are handled in a confidential manner, and we do not discriminate against a member for filing a grievance or requesting a State Fair Hearing. We also notify members of the opportunity to receive information about our grievance and appeal process; they can request a translated version in a language other than English.

Discrimination

Members who contact us with an allegation of discrimination are immediately informed of the right to file a grievance. This also occurs when one of our representatives working with a member identifies a potential act of discrimination. The member is advised to submit an oral or written account of the incident and is assisted in doing so if they request assistance.

We document, track, and trend all alleged acts of discrimination. A Grievances and Appeals representative will review and trend cultural and linguistic grievances in collaboration with a cultural and linguistic specialist.

Continuation of benefits

Hoosier Healthwise, Healthy Indiana Plan, and Hoosier Care Connect members may continue benefits while their appeal is pending in accordance with federal regulations when all of the following criteria are met:

- Member or representative must request the Appeal within 10 days of our mail date of the *Adverse Action Notification*, or prior to the effective date on the written notice if the initial notification was made by phone.
- The **appeal** involves the termination, suspension, or reduction of a previously authorized course of treatment.
- Services were ordered by an authorized provider.
- The original period covered by the initial authorization has not expired.
- Member requests extension of benefits.

If the final resolution of the appeal is not in the member's favor and upholds Anthem's original decision, the member may be held liable for some of the costs of the services rendered while the appeal was pending. We will notify the member in advance that costs may be recovered.

Chapter 14: Member transfers and disenrollment

Members have the freedom to choose their most important link to quality healthcare: their doctor. We strongly encourage our members to select a PMP and remain with that provider because we believe in the positive impact of establishing a relationship with a PMP and having a medical home.

Occasionally, members may encounter barriers to effective relationships with their PMP. Members who want to change their PMP may do so at any time, for any reason.

We are committed to supporting providers' practices as well. Providers have the right to request that a member be reassigned to another PMP under certain conditions and following specific guidelines.

Primary medical provider-initiated member transfers

PMPs can request member reassignment to a different PMP by completing and submitting the ***Provider Request for Member Deletion from PMP Assignment*** form located on our website at **https://providers.anthem.com/IN** > Resources > Forms.

The provider is required to coordinate care services for up to 30 days after the date Anthem receives the change request form. Upon completing the PMP change, Anthem forwards the form and any other information related to the case to the customer care representative. This representative informs the member of the change within five working days. The change will be effective the day Anthem makes it effective.

Primary medical provider-initiated member disenrollment

A PMP may request disenrollment of a member from their primary care assignment. The PMP may request member disenrollment for the following reasons:

- The member is abusive to the PMP and/or staff, exhibiting disruptive, unruly, threatening, or uncooperative behavior.
- The member misuses or loans their membership card to another person.
- The member fails to follow prescribed treatment plans.

To request disenrollment, the PMP must do the following:

- Complete the ***Provider Request for Member Deletion from PMP Assignment*** form located on our website at **https://providers.anthem.com/IN** > Changes and Referrals > Resources > Forms.
- Fax (preferred) to **866-406-2803** or mail the form to:

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

- Continue to manage the member's care, as required, until we can reassign the member to another PMP, or not more than 30 days from the day we receive the *Provider Request for Member Deletion from PMP Assignment* form, whichever comes first.

Prior to disenrollment, Anthem will make every attempt to resolve issues and keep the member in our healthcare plan. If these attempts fail, Anthem will either reassign the member to another PMP or forward the disenrollment request form to the appropriate state agency requesting member reassignment to another healthcare plan.

Primary medical provider-initiated disenrollment process for abusive behavior and/or non-adherence

The disenrollment process for members who display abusive behavior and/or fail to follow the prescribed treatment plan is as follows:

- The PMP completes the *Provider Request for Member Deletion from PMP Assignment*, and then mails or faxes it to Anthem to process.
- Anthem reassigns the member to a new PMP for continuity of care. The effective date is no later than 30 days from the date on the request form.
- Anthem sends an updated ID card indicating the newly assigned PMP's name, address, and telephone number.
- Anthem documents any abusive behavior and notifies the Fraud and Abuse department if the abusive behavior continues.
- Anthem sends a warning letter to the member stating that if the behavior continues, Anthem will file a disenrollment request with Indiana's Family and Social Services Administration (FSSA). If approval is granted by FSSA, Anthem will proceed with the disenrollment process.

Anthem may also request disenrollment for a member who has moved out of the service area. When a member moves out of our service area, the member is responsible for notifying the state of their new permanent address. After that, Indiana's Family and Social Services Administration will disenroll the member from Anthem.

State agency-initiated member disenrollment

The State informs Anthem of membership changes by sending daily and monthly enrollment files. These files contain all active membership data and incremental changes to eligibility records. Anthem disenrolls members for whom we receive term records effective as of the designated disenrollment date for the following reasons:

- Admission to a long-term care or intermediate care facility beyond the month of admission and the following month
- Change in eligibility status
- County changes
- Death
- Incarceration
- Loss of benefits
- Member has other non-government or government-sponsored health coverage
- Permanent change of residence out of service area
- Voluntary disenrollments

Member-initiated primary medical provider transfers

Members have the right to change their PMP at any time. When a member enrolls in any of our programs, they can choose a PMP or allow their PMP to be assigned. After that, if they want to make a change, members are instructed to call our Member Services to request an alternate PMP.

Anthem accommodates member requests for transfers whenever possible. Our staff works with the member to make the new PMP selection, focusing on any special needs of the member. Our policy is to maintain continued access to care and continuity of care during the transfer process.

When a member calls to request a PMP change:

- The Member Services representative checks the availability of the member's PMP choice. If the member can be assigned to the selected PMP, the Member Services representative will do so. If the PMP is not available, the Member Services representative will assist the member in finding an available PMP. If the member advises the Member Services that they are hospitalized, the PMP change will take effect upon discharge.
- Anthem notifies PMPs of member transfers through monthly enrollment reports. PMPs can request these reports by calling our Member Services.
- The effective date of a PMP transfer will be the same as the date of the member request. We may assign a member retroactively.
- To support member transfers, PMPs are encouraged to maintain open panels. The state requires that 80% of Anthem's PMPs have open panels, and your open panel will assist us in meeting this requirement.

Member transfers to other plans

Hoosier Healthwise and Hoosier Care Connect members can choose a different Managed Care Entity (MCE) on an annual basis during their open enrollment period when they must recertify their Medicaid eligibility. As required by federal regulations, this open enrollment period lasts for 90 calendar days. After the open enrollment period ends, members may not switch MCEs. Members remain with their chosen MCE for the remaining 12-month period after this occurs. To change MCEs during their annual redetermination period, the member may call the enrollment broker.

Healthy Indiana Plan members can choose a different MCE on an annual basis during the *Health Plan Selection Period*, which occurs annually from November 1 to December 15. Members will stay with the same health plan all year, even if they disenroll from HIP and re-enroll during the year. Members that were unable to take part in MCE selection during this time frame because they were in a different program, or were not fully enrolled in HIP, have 30 days to select a new health plan.

HIP members must also recertify eligibility every year. This recertification process is called **redetermination**. The annual redetermination process occurs on the anniversary of the member's enrollment in Medicaid.

Members retain the right to change their MCE when they have **just cause**, which can be any of the following:

- Lack of access to necessary services covered under the MCE's contract, this does not include enhanced services offered by Anthem
- Lack of access to providers experienced in dealing with the member's healthcare needs
- MCE does not, for moral or religious objections, cover the services the member seeks
- Member's concerns over the quality of care
- Member needs related services performed at the same time and not all related services are available within the MCE's network
- Member's PMP leaves the MCE and participates with another MCE under contract with the state of Indiana, so long as the member requests transfer to that MCE

Member disenrollment from the plan

Member disenrollment may be requested by the member, Anthem, or the Indiana Family and Social Services Administration (FSSA). If the request comes from a member, the member must first file a **just cause** grievance with Anthem. The member's grievance is processed, and notification of the resolution is sent to the member. Following the grievance resolution notification, if the member decides to continue with the disenrollment, then the member can contact the enrollment broker.

Disenrollment may result in the following:

- Enrollment with another plan
- Termination of eligibility
- Return to traditional Medicaid for continuity of care if the member's benefits fall into a voluntary aid code

If the enrollee is a mandatory Medicaid recipient, the enrollment broker instructs them to select another health plan option. If the enrollee does not make a choice, the enrollment broker automatically assigns another health plan to the enrollee. The enrollment broker offers voluntary Medicaid enrollees the option to join another plan, if one is available, or return to the fee-for-service coverage plan.

When members enroll in our program, we provide instructions on disenrollment procedures. Disenrollments become effective the last day of the calendar month following administrative cut-off or are subject to state cut-off.

If a member asks a provider how to disenroll from Anthem, the provider should direct the member to call Member Services at the number on the back of their ID card (see **Chapter 2: Member eligibility and program information**).

Providers may not take retaliatory action against any member for requesting transfer or disenrollment.

When Anthem's Member Services receives a call from a member who wants to disenroll, the Member Services follows these steps:

- The Member Services representative attempts to find out the reason for the request.

- If the situation is something that the Member Services representative can address and resolve, the representative reminds the member that they have the right to request disenrollment, but also offers to resolve the issue. The representative then asks the member if they want to delay the disenrollment process pending resolution.
- If a member agrees to allow us to attempt resolution, Anthem's Member Services representative initiates the process that would properly address the situation.
- If the member declines, the Member Services representative shares the disenrollment requirement and guidelines related to **just cause** grievance which is required for disenrollment outside the annual enrollment period.
- If the member declines and it's during the annual enrollment period, the Member Service representative refers the member to Indiana's FSSA Enrollment Broker and provides the member with the FSSA phone number.
- The Member Services representative informs the member that the disenrollment process will take 15 to 45 days.

Chapter 15: Compliance and regulatory requirements

Privacy and security

Anthem's latest *Health Insurance Portability and Accountability Act of 1996 (HIPAA)*-compliant privacy and security statements can be found on our website at **https://providers.anthem.com/IN**. To read them, please select **Privacy Policy**.

Throughout this manual, there are instances where information is provided as an example. Because actual situations may vary, this information is meant to be illustrative only and is not intended to be used or relied upon as guidance for actual situations.

There are also places within the online manual where you may be invited to leave the Anthem site and enter another site operated by a third party. These links are provided for your convenience and reference only. Anthem and its subsidiary companies do not control such sites and do not necessarily endorse them. Anthem is not responsible for their content, products, or services.

Be aware that when you travel from the Anthem site to another site, whether through links provided by Anthem or otherwise, you will be subject to the privacy policies (or lack thereof) of the other sites. Anthem cautions you to determine the privacy policy of such sites before providing any personal information.

Misrouted protected health information

Providers and facilities are required to review all member information received from Anthem to ensure no misrouted protected health information (PHI) is included. Misrouted PHI includes information about members that a provider or facility is not treating. PHI can be misrouted to providers and facilities by mail, fax, email, or electronic remittance advice. Providers and facilities are required to immediately destroy any misrouted PHI or safeguard the PHI for as long as it is retained as well as contact Anthem about the situation. Anthem is required to inform the Indiana Family and Social Services Administration Privacy Officer within one business day of any security incident/breach. In no event are providers or facilities permitted to misuse or re-disclose misrouted PHI. If providers or facilities cannot destroy or safeguard misrouted PHI, please contact Provider Services.

Member Rights and Responsibilities

Members should be clearly informed about their rights and responsibilities in order to make the best healthcare decisions. That includes the right to ask questions about the way we conduct business, as well as the responsibility to learn about their healthcare coverage. Members and Providers can get a copy of the *Member Rights and Responsibilities* by mail, fax, email, or on our website. Members have the right to:

- Receive information about Anthem, the services Anthem provides, doctors and facilities in our plan, and their rights and responsibilities. Information about Anthem is available on our website at **https://providers.anthem.com/IN** and via Member Services at **866-408-6131 (Hoosier Healthwise, HIP); 844-284-1797 (Hoosier Care Connect)** (**TTY 711**).

- Be treated with respect and with due consideration for their dignity and privacy.
- Voice complaints or appeals about Anthem, the plan, or the care it provides.
- Make recommendations about the member rights and responsibilities policy.
- Receive information on available treatment options and alternatives, presented in a way that is understandable and right for the member's condition.
- Know if their physician takes part in a physician incentive plan through Anthem. You may call us to learn more about this. Anthem does not give incentives to providers for not providing care.
- Take part in all decisions about their healthcare. This includes the right to refuse treatment.
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, as specified in federal laws on the use of restraints and seclusions.
- Request and receive a copy of their medical records. And as the member requests, the records may be amended or corrected, as stated in State and federal healthcare privacy laws.
- Have timely access to covered services and medically necessary care.
- Have honest talks with their providers about the right treatment for their condition, in spite of the cost or benefit coverage.
- Have their health plan, doctors, and all of their care providers keep their medical records and health insurance information private.
- Have their problems taken care of fast. This includes things they think are wrong, as well as issues that have to do with coverage, payment of services, or getting Anthem approval.
- Have access to medical advice from their provider, either in person or by phone, 24 hours per day, 7 days per week. This includes emergency or urgent care.
- Get interpreter services at no charge if they speak a language other than English or if they have hearing, vision, or speech loss.
- Ask for information and other Anthem materials (letters, newsletters) in other formats. These include Braille, large-size print, or audio CD, at no charge to the Member. Call Member Services toll free at **866-408-6131 (Hoosier Healthwise, HIP); 844-284-1797 (Hoosier Care Connect) (TTY 711**).
- Question a decision we make about coverage for the care they received from a provider. Members will not be treated differently if they file a complaint.
- Ask about our quality program and tell us if they would like to see changes made.
- Ask us how we do a utilization review and give us ideas on how to change it.
- Know they will not be held liable if their health plan becomes insolvent (bankrupt and cannot pay its bills).
- Know that Anthem, their doctors, or other healthcare providers cannot treat them differently for these reasons:
    - Their age
    - Their sex or gender identity
    - Their sexual orientation
    - Their race
    - Their national origin
    - Their language needs
    - The degree of their illness or health condition

Members have the following responsibilities:

- Tell us, their doctor, and other healthcare providers what we need to know to treat them.
- Understand their health problems and take part in developing shared treatment goals, to the best degree possible.
- Follow the treatment plans that they, their doctors, and other healthcare providers agree to.
- Do the things that keep them from getting sick.
- Treat their doctor and other healthcare providers with respect.
- Make appointments with their doctor when needed.
- Keep all scheduled appointments and be on time.
- Call their doctor if they cannot make it to an appointment.
- Always call their PMP first for all medical care (unless they have an emergency).
- Show their ID card each time they get medical care.
- Use the emergency room only for true emergencies.
- Pay any required copays.
- Pay all monthly contribution payments on time (if they are a HIP member who is required to pay something).
- Tell us and the Division of Family Resources (DFR) at **800-403-0864** if:
    - They move
    - They change phone numbers
    - They have any changes to their insurance
    - The number of people in their household changes
    - They become pregnant

Nondiscrimination

Anthem does not engage in, aid, or perpetuate discrimination against any person by providing significant assistance to any entity or person that discriminates on the basis of race, color, or national origin in providing aid, benefits, or services to beneficiaries. Anthem does not utilize or administer criteria having the effect of discriminatory practices on the basis of gender or gender identity. Anthem does not select site or facility locations that have the effect of excluding individuals from, denying the benefits of, or subjecting them to discrimination on the basis of gender or gender identity. In addition, in compliance with the *Age Act*, Anthem may not discriminate against any person on the basis of age, or aid or perpetuate age discrimination by providing significant assistance to any agency, organization, or person that discriminates on the basis of age. Anthem provides health coverage to our members on a nondiscriminatory basis, according to state and federal law, regardless of gender, gender identity, race, color, age, religion, national origin, physical or mental disability, or type of illness or condition.

Members who contact us with an allegation of discrimination are informed immediately of their right to file a grievance. This also occurs when an Anthem representative working with a member identifies a potential act of discrimination. The member is advised to submit a verbal or written account of the incident and is assisted in doing so if the member requests assistance. We document, track, and trend all alleged acts of discrimination.

Members are also advised to file a civil rights complaint with the U.S. Department of Health and Human Services Office for Civil Rights (OCR):

- Through the OCR complaint portal at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**
- By mail to: U.S. Department of Health and Human Services, 200 Independence Ave. SW, Room 509F, HHH Building, Washington, DC 20201
- By phone at: **800-368-1019** (TTY/TTD: **800-537-7697**)

Anthem provides free tools and services to people with disabilities to communicate effectively with us. Anthem also provides free language services to people whose primary language is not English.

If you or your patient believe that Anthem has failed to provide these services or discriminated in any way on the basis of race, color, national origin, age, disability, gender, or gender identity, you can file a grievance.

Equal program access on the basis of gender

Anthem provides individuals with equal access to health programs and activities without discriminating on the basis of gender. Anthem must also treat individuals consistent with their gender identity and is prohibited from discriminating against any individual or entity on the basis of a relationship with, or association with, a member of a protected class (such as race, color, national origin, gender, gender identity, age, or disability).

Anthem may not deny or limit health services that are ordinarily or exclusively available to individuals of one gender, to a transgender individual based on the fact that a different gender was assigned at birth, or because the gender identity or gender recorded is different from the one in which health services are ordinarily or exclusively available.

Marketing policies

Anthem recognizes that providers occupy a unique, trusted, and respected part of people's lives. The delivery of quality healthcare poses numerous challenges, not least of which is the commitment shared by Anthem and its providers to protect our members. For that reason, we are committed to following FSSA enrollment and marketing guidelines and all State healthcare program rules.

Anthem providers are prohibited from making marketing presentations and advising or recommending to an eligible individual that they select membership in a particular plan. FSSA Policies prohibit providers from making the following false or misleading claims:

- The PMP's office staff are employees or representatives of the State, county, or federal government.
- Anthem is recommended or endorsed by any State or county agency or any other organization.
- The State or county recommends a prospective member enroll with a specific healthcare plan.
- A prospective member or medical recipient loses Medicaid or other welfare benefits if the prospective member does not enroll in a specific healthcare plan.

These policies also **prohibit** providers from taking the following actions:

- Offering or giving away any form of compensation, reward, or loan to a prospective member to induce or procure member enrollment in a specific healthcare plan.
- Engaging in direct marketing to members that is designed to increase enrollment in a particular healthcare plan. The prohibition should not constrain providers from engaging in permissible marketing activities consistent with broad outreach objectives and application assistance.
- Using any list of members obtained originally for enrollment purposes from confidential State or county data sources, or from the data sources of other contractors.
- Employing marketing practices that discriminate against potential members based on marital status, age, religion, sex, national origin, language, sexual orientation, ancestry, pre-existing psychiatric problem, or medical condition (such as pregnancy, disability, or acquired immune deficiency syndrome), other than those specifically excluded from coverage under our contract.
- Reproducing or signing an enrollment application for the member.
- Displaying materials only from the provider's contracted Managed Care Entities and excluding others.

Providers are permitted to:

- Assist the members in applying for benefits by directing them to the enrollment brokers (see **Chapter 1: Contact information**).
- File a complaint with Anthem if a provider or member objects to any form of marketing, either by other providers or by Anthem representatives.

Fraud, abuse, and waste

We are committed to protecting the integrity of our healthcare program and the effectiveness of our operations by preventing, detecting, and investigating fraud, waste, and abuse. Combating fraud, waste, and abuse begins with knowledge and awareness:

- *Fraud* — any type of intentional deception or misrepresentation made with the knowledge that the deception could result in some unauthorized benefit to the person committing it or any other person. The attempt itself is a fraud, regardless of whether or not it is successful.
- *Waste* — includes overusing services or other practices that, directly or indirectly, result in unnecessary costs. Waste is generally not considered to be driven by intentional actions, but rather occurs when resources are misused.
- *Abuse* — when healthcare providers or suppliers do not follow good medical practices resulting in unnecessary or excessive costs, incorrect payment, misuse of codes, or services that are not medically necessary.

To help prevent fraud, waste, and abuse, providers can assist by educating members. For example, spending time with members and reviewing their records for prescription administration will help minimize drug fraud. One of the most important steps to help prevent member fraud is as simple as reviewing the member identification card. It is the first line of defense against possible fraud. Learn more at **www.fighthealthcarefraud.com**.

Reporting fraud, waste, and abuse

If you suspect a provider (for example, provider group, hospital, doctor, dentist, counselor, medical supply company, etc.) or any member (a person who receives benefits) has committed fraud, waste, or abuse, you have the right to report it. No individual who reports violations or suspected fraud and abuse will be retaliated against for doing so. The name of the person and their information, if supplied, who reports the incident is kept in strict confidence by the Special Investigations Unit (SIU).

You can report your concerns by:

- Visit our **www.fighthealthcarefraud.com** education site; at the top of the page, click **Report it** and complete the ***Report Waste, Fraud, and Abuse*** form.
- Calling Network Relations.
- Calling Customer Service.
- Calling the SIU Fraud Hotline: **866-847-8247**.

Any incident of fraud, waste, or abuse may be reported to us anonymously; however, our ability to investigate an anonymously reported matter may be handicapped without enough information. Hence, we encourage you to give as much information as possible. We appreciate your time in referring suspected fraud but be advised that we do not routinely update individuals who make referrals as it may potentially compromise an investigation.

Examples of provider fraud, abuse, and waste:

- Altering medical records to misrepresent actual services provided
- Billing for services not provided
- Billing for medically unnecessary tests or procedures
- Billing professional services performed by untrained or unqualified personnel
- Misrepresentation of diagnosis or services
- Soliciting, offering, or receiving kickbacks or bribes
- Overutilization
- Soliciting, offering, or receiving kickbacks or bribes
- Unbundling — when multiple procedure codes are billed individually for a group of procedures that should be covered by a single comprehensive procedure code
- Upcoding — when a provider bills a health insurance payer using a procedure code for a more expensive service than was actually performed

Examples of member fraud, abuse, and waste:

- Forging, altering, or selling prescriptions
- Letting someone else use the member's ID card
- Relocating to an out-of-service plan area and not notifying us
- Using someone else's ID card
- Violating the pain management contract and written agreement between a provider and member that the member will not misrepresent their need for medication. If the contract is violated, the provider has the right to drop the member from their practice.

When reporting concerns involving a member include:

- The member's name
- The member's date of birth, social security number, or case number, if you have it
- The city where the member resides
- Specific details describing the fraud, waste, or abuse

When reporting concerns involving a provider include:

- Name, address, and phone number of the provider
- Name and address of the facility (hospital, nursing home, home health agency, etc.)
- Medicaid number of the provider and facility, if you have it
- Type of provider (doctor, dentist, therapist, pharmacist, etc.)
- Names and phone numbers of other witnesses who can help in the investigation
- Dates of events
- Summary of what happened

Investigation process

We do not tolerate acts that adversely affect providers or members. We investigate all reports of fraud, abuse, and waste. Allegations and investigative findings are reported to the Indiana Family and Social Services Administration (FSSA) as well as regulatory and law enforcement agencies. In addition to reporting, we take corrective action, such as:

- **Written warning and/or education:** We send certified letters to the provider or member documenting the issues and the need for improvement. Letters may include education, request for recoveries, or may advise of further action.
- **Medical record review:** We may review medical records to substantiate allegations or validate claims submissions.
- **Special claims review:** A special claims review places payment or system edits on file to prevent automatic claim payment; this requires a medical reviewer evaluation.
- **Prepayment review:** We may place providers on prepayment review and require that providers submit paper claims with supporting medical documentation.
- **Recoveries:** We recover overpayments directly from the provider within 30 days. Failure of the provider to return the overpayment may be reflected in reduced payment of future claims or further legal action.

If you are working with the SIU, all checks and correspondence should be sent to:

Special Investigations Unit
Attn: Investigator name, Case number
740 W Peachtree Street NW
Atlanta, Georgia 30308

Paper medical records and claims are at a different address, which is supplied in correspondence from the SIU. If you have questions, contact your investigator. An opportunity to submit claims and medical records electronically is an option if you register for an Availity account. Contact Availity Client Services at **800-AVAILITY** (**282-4548**) for more information.

Acting on investigative findings

If, after investigation, the SIU determines a provider appears to have committed fraud, waste, or abuse, the provider:

- Will be referred to FSSA Program Integrity for further investigation.
- Will be referred to the Quality Management Department.
- May be presented to the credentials committee and/or peer review committee for disciplinary action, including provider termination.

Failure to comply with program policy and procedures, or any violation of the contract, will result in termination from our plan.

If a member has committed fraud, exhibited abusive or threatening behavior, or has failed to correct issues, they will also be referred to FSSA Program Integrity and may be involuntarily disenrolled from our healthcare plan, with state approval (see **Chapter 14: Member transfers and disenrollment** for more information on the disenrollment process).

False Claims Act

We are committed to complying with all applicable federal and State laws, including the federal *False Claims Act (FCA)*.

The *False Claims Act* is a federal law that allows the government to recover money stolen through fraud by government contractors. Under the *FCA*, anyone who knowingly submits or causes another person or entity to submit false claims for payment of government funds is liable for three times the damages, or loss, to the government, plus civil penalties of $5,500 to $11,000 per false claim.

The *FCA* also contains Qui Tam or *whistleblower* provisions. A whistleblower is an individual who reports in good faith an act of fraud or waste to the government or files a lawsuit on behalf of the government. Whistleblowers are protected from retaliation from their employer under Qui Tam provisions in the *FCA* and may be entitled to a percentage of the funds recovered by the government.

Disclaimers

* Availity is an independent company that administers the secure provider portal on behalf of Anthem Blue Cross and Blue Shield.

* Carelon Medical Benefits Management, Inc. is an independent company providing utilization management services on behalf of the health plan.

* Superior Vision is an independent company providing vision services on behalf of Anthem Blue Cross and Blue Shield.

* DentaQuest is an independent company providing dental services on behalf of Anthem Blue Cross and Blue Shield.

* CarelonRx, Inc. is an independent company providing pharmacy benefit management services on behalf of the health plan.

* MEDTOX Laboratories is an independent company providing lead screenings on behalf of Anthem Blue Cross and Blue Shield.

* Change Healthcare is an independent company managing the My Advocate program on behalf of Anthem Blue Cross and Blue Shield.