Anthem Blue Cross and Blue Shield

Indiana Medicaid Provider Manual

Serving Hoosier Healthwise, Healthy Indiana Plan, Hoosier Care Connect, and Indiana PathWays for Aging

INBCBS-CD-PM-070775-24

Anthem

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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 (HHW)** – The state of Indiana's Medicaid program, separated into Package A for children and some 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 (HCC)** – The state's program for Indiana Medicaid enrollees who are 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.
- **Indiana PathWays for Aging (PathWays)** – A statewide coordinated care program for Indiana's Medicaid enrollees who are 60 years of age or older, and eligible for Medicaid on the basis of age, blindness, or disability and have limited income and resources. Eligibility is determined by the state of Indiana's FSSA Division of Family Resources (DFR). Additional information can be found in the ***Indiana PathWays for Aging Addendum***.

Within this manual, you will find valuable information about how we can support you in service of our Medicaid members. This manual can be found on our Indiana Medicaid Provider Website at **providers.anthem.com/in.** We encourage you to explore this website to familiarize yourself with the breadth of information provided, including information on becoming an Indiana Medicaid provider, contracting and enrolling with Anthem, accessing and navigating our provider website, accessing services for your patients, submitting claims, and much more. On our provider website and within this Manual, you will also find contact information should you have any questions or need further support.

Who we are

Anthem is an MCE serving Hoosiers for nearly 80 years through Commercial, Medicare, and Medicaid Programs. Headquartered right here in Indiana, our parent company is Elevance Health, Inc. While Elevance Health serves members across the country, Anthem operates under a local model here in Indiana, deeply invested in the communities in which we live and work. Specific to Medicaid, we have had the privilege of serving Hoosiers through contracts with Indiana's Family and Social Services Administration (FSSA) since 2007.

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 **providers.anthem.com/in** under **Provider Tools & Resources**, or by contacting Provider Services. For information specific to the Indiana PathWays for Aging program, please visit **https://providers.anthem.com/indiana-provider/patient-care/pathways-aging**.

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, Hoosier Care Connect, and/or Indiana PathWays for Aging 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 phone and fax numbers, websites, and addresses. The first chart below gives you contact information for resources available through the state of Indiana. The second chart displays contact information for Anthem services in support of Hoosier Healthwise, Healthy Indiana Plan, Hoosier Care Connect, and Indiana PathWays for Aging members.

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 (Department of Family Resources)	**800-403-0864**
Enrollment	Hoosier Healthwise: **800-889-9949** Healthy Indiana Plan: **877-438-4479** Hoosier Care Connect: **866-963-7383** Indiana PathWays for Aging: **877-284-9294**
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	**www.in.gov/fssa/dmha/4521.htm**

State of Indiana	Contact information
Addiction	
Indiana Office of Medicaid Policy and Planning	**https://www.in.gov/fssa/ompp/**
Indiana Family and Social Services Administration (FSSA)	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**

Anthem services	Hoosier Healthwise	Healthy Indiana Plan	Hoosier Care Connect	Indiana PathWays for Aging
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.	**833-569-4739** Monday through Friday, 8 a.m. to 8 p.m.
Prior Authorization — Utilization Management	**https://Availity.com (preferred)** **866-408-6132** Monday through Friday, 8 a.m. to 5 p.m.	**https://Availity.com (preferred)** **844-533-1995** Monday through Friday, 8 a.m. to 5 p.m.	**https://Availity.com (preferred)** **844-284-1798** Monday through Friday, 8 a.m. to 5 p.m.	**https://Availity.com (preferred)** **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,			**866-406-2803**

Anthem services	Hoosier Healthwise	Healthy Indiana Plan	Hoosier Care Connect	Indiana PathWays for Aging
	and orthotics)			
Behavioral Health Prior Authorization - Availity Essentials.	Mental health/substance abuse authorizations should be submitted using our preferred method electronically via **https://Availity.com**. If you prefer to paper fax, you may submit to: • Inpatient: **844-452-8074** • Outpatient: **844-456-2698**	**877-410-0623**		
Behavioral Health 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.	**833-569-4739** Monday through Friday, 8 a.m. to 5 p.m.
Carelon Medical Benefits Management, Inc.	**844-767-8158** Monday through Friday, 8 a.m. to 5 p.m. Log in to **providerportal.com** or **https://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.			

Anthem services	Hoosier Healthwise	Healthy Indiana Plan	Hoosier Care Connect	Indiana PathWays for Aging
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	**844-691-2487** 24 hours a day, 7 days a week
Pharmacy Prior Authorization	**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.	**833-569-4739** Monday through Friday, 8 a.m. to 8 p.m.
	Prior Authorization Fax: • Retail: **844-864-7860** • Medical Injectables: **888-209-7838**			
Claims	**https://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	Overpayment Recovery P.O. Box 92420 Cleveland, OH 44193 **For overnight delivery:** Overpayment Recovery Lockbox 92420 4100 W. 150th St. Cleveland, OH 44135

Anthem services	Hoosier Healthwise	Healthy Indiana Plan	Hoosier Care Connect	Indiana PathWays for Aging
Contracting	**800-455-6805** Monday through Friday, 8 a.m. to 5 p.m.			inmltssprovidercontracting@elevancehealth.com **833-569-4739**
Fraud, Waste, or Abuse Reporting	**877-283-1524** **www.fighthealthcarefraud.com**			
Grievances and Appeals	**866-408-6132**	**844-533-1995**	**844-284-1798**	**833-569-4739**
Grievances and Appeals — fax	• Fax: **855-535-7445** • Expedited fax: **855-516-1083**			
24/7 NurseLine	**866-408-6131**		**844-284-1797**	**833-412-4405**
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** Available 24 hours a day, 7 days a week			
Member oral	Provider Services	Provider Services	Provider Services	Provider Services

Anthem services	Hoosier Healthwise	Healthy Indiana Plan	Hoosier Care Connect	Indiana PathWays for Aging
interpreter services (telephonically and in person)	**866-408-6132** Member Services **866-408-6131**	**844-533-1995** Member Services **866-408-6131**	**844-284-1798** Member Services **844-284-1797**	**833-569-4739** Member Services **833-412-4405**
Vision services	Superior Vision 877-235-5317 **www.superiorvision.com**			**866-866-5641** **(TTY 800-428-4833)**
Dental services	DentaQuest **855-453-5286** **www.dentaquest.com**			**866-291-3762** **(TTY 800-466-7566)**
Anthem transportation services Schedule non-emergent transportation at least two business days in advance	**844-772-6632** TTY: **888-238-9816** Monday through Friday, 8 a.m. to 8 p.m. Anthem Transportation Services has an online booking tool found here **anthem.com/inmedicaid > Transportation** Register here **https://passengerportal.welltransnemt.com/Account/Login** to book your ride online with WellTrans			
General address for all correspondence	Anthem Blue Cross and Blue Shield P.O. Box 61599 Virginia Beach, VA 23466			

Frequently asked questions

Q: How do I contact Anthem?

A: You can log in to Availity at **https://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**
- Indiana PathWays for Aging**: 833-569-4739**

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.**

For the Indiana PathWays for Aging program, find the Provider Relations map here: **Indiana PathWays for Aging Network Relations Map**.

Q: How do I check member eligibility?

A: Providers can verify member eligibility for all plans 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 which will transfer the call to GABBY. GABBY, the provider self-service IVR, will lead callers through the provider authentication process.** Providers can ask to check member eligibility or authorization.
- Once it is verified that the member is assigned to Anthem, log in to **https://Availity.com** 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 **https://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**
- Indiana PathWays for Aging: **833-569-4739**

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

Specific information about what types of services do or do not require prior authorization can be located in the ***Indiana PathWays for Aging Addendum***.

Q. How do I submit a claim?

A: Claims can be submitted via Availity. Log in to **https://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

Indiana PathWays for Aging claims will be submitted through Availity Essential's Payer Spaces, Care Central for LTSS/atypical providers. Additional information can be found in the ***Indiana PathWays for Aging Addendum.***

Provider and Facility Digital Guidelines

Anthem understands that working together digitally streamlines processes and optimizes efficiency. We developed the Provider and Facility Digital Guidelines to outline our expectations and to fully inform Providers and Facilities about our digital platforms.

Anthem expects Providers and Facilities will utilize digital tools unless otherwise prohibited by law or other legal requirements.

Digital guidelines establish the standards for using secure digital Provider platforms (websites) and applications when transacting business with Anthem. These platforms and applications are accessible to both participating and nonparticipating Providers and Facilities and encompass https://Availity.com, electronic data interchange (EDI), electronic medical records (EMR) connections, and business-to-business (B2B) desktop integration.

The Digital Guidelines outline the digital/electronic platforms Anthem has available to participating and nonparticipating Providers and Facilities who serve its Members. The expectation of Anthem is based on our contractual agreement that Providers and Facilities will use these digital platforms and applications unless otherwise mandated by law or other legal requirements.

Digital and/or electronic transaction applications are accessed through these platforms:

- Availity EDI Clearinghouse
- B2B application programming interfaces (APIs)
- EMR connections

Digital guidelines available through Availity Essentials include:

- Acceptance of digital ID cards
- Eligibility and benefits inquiry and response
- Prior authorization submissions including updates, clinical attachments, authorization status, and clinical appeals
- Claim submission, including attachments, claim status
- Remittances and payments
- Provider enrollment
- Demographic updates

Additional digital applications available to Providers and Facilities include:

- Pharmacy prior authorization drug requests
- Services through Carelon Medical Benefits Management, Inc.
- Services through Carelon Behavioral Health, Inc.

Anthem expects Providers and Facilities transacting any functions and processes above will use available digital and/or electronic self-service applications in lieu of manual channels (paper, mail, fax, call, chat, etc.). All channels are consistent with industry standards. All EDI transactions use version 5010.

Note: As a mandatory requirement, all trading partners must currently transmit directly to the Availity EDI gateway and have an active Availity Trading Partner Agreement in place. This includes providers using their practice management software & clearinghouse billing vendors.

Providers and Facilities who do not transition to digital applications may experience delays when using non-digital methods such as mail, phone, and fax for transactions that can be conducted using digital applications.

Section 1: Accepting digital ID cards

As our Members transition to digital Member ID cards, Providers and Facilities may need to implement changes in their processes to accept this new format. Anthem expects that Providers and Facilities will accept the digital version of the member identification card in lieu of a physical card when presented. If Providers and Facilities require a copy of a physical ID card, Members can email a copy of their digital card from their smartphone application, or Providers and Facilities may access it directly from Availity Essentials through the Eligibility and Benefits Inquiry application.

Section 2: Eligibility and benefits inquiry and response

Providers and Facilities should leverage these Availity Clearinghouse hosted channels for electronic eligibility and benefit inquiry and response:

- EDI transaction: X12 270/271 – eligibility inquiry and response
  - Anthem supports the industry-standard X12 270/271 transaction set for eligibility and benefits inquiry and response as mandated by HIPAA.
- Availity Essentials

    - The Eligibility and Benefits Inquiry verification application allows a Provider and Facility to key an inquiry directly into an online eligibility and benefit look-up form with real-time responses.
- Provider desktop integration via B2B APIs
    - Anthem has also enabled real-time access to eligibility and benefit verification APIs that can be directly integrated within participating vendors' practice management software, revenue cycle management software, and some EMR software. Contact Availity for available vendor integration opportunities.

Section 3: Prior authorization submission, attachment, status, and clinical appeals
Providers and Facilities should leverage these channels for prior authorization submission, status inquiries, and to submit electronic attachments related to prior authorization submissions:

- EDI transaction: X12 278 – prior authorization and referral:
    - Anthem supports the industry-standard X12 278 transaction for prior authorization submission and status inquiry as mandated per HIPAA.
- EDI transaction: X12 275 – patient information, including HL7 payload for authorization attachments:
    - Anthem supports the industry-standard X12 275 transaction for electronic transmission of supporting authorization documentation including medical records via the HL7 payload.
- Availity Essentials:
    - Authorization applications include the Availity Essentials multi-payer Authorization and Referral application for authorization submissions not accepted through Availity Essentials' multi-payer application.
        - Both applications enable prior authorization submission, authorization status inquiry, and the ability to review previously submitted authorizations.
- Provider desktop integration via B2B APIs:
    - Anthem has enabled real-time access to prior authorization APIs, which can be directly integrated within participating vendors' practice management software, revenue cycle management software, and some EMR software. Contact Availity for available vendor integration.

Section 4: Claims – submissions, claims payment disputes, attachments, and status
Claim submissions status and claims payment disputes
Providers and Facilities should leverage these channels for electronic Claim submission, attachments (for both pre- and post-payment), and status:

- EDI transaction: X12 837 – Professional, institutional, and dental Claim submission (version 5010):
    - Anthem supports the industry-standard X12 837 transactions for all fee-for-service and encounter billing as mandated per HIPAA.
    - 837 Claim batch upload through EDI allows a provider to upload a batch/file of Claims (must be in X12 837 standard format).
- EDI transaction: X12 276/277 – Claim status inquiry and response:
    - Anthem supports the industry-standard X12 276/277 transaction set for Claim status

inquiry and response as mandated by HIPAA.

- Availity Essentials: The Claims & Payments application enables a provider to enter a Claim directly into an online Claim form and upload supporting documentation for a defined Claim.
  - Claim Status application enables a provider to access online Claim status. Access the Claim payment dispute tool from Claim Status. Claims Status also enables online claim payment disputes in most markets and for most claims. It is the expectation of Anthem that electronic Claim payment disputes are adopted when and where it is integrated.
- Provider desktop integration via B2B APIs:
  - Anthem has also enabled real-time access to Claim Status via APIs, which can be directly integrated within participating vendors' practice management software, revenue cycle management software, and some EMR software. Contact Availity for available vendor integration.

Claim attachments

Providers and Facilities should leverage these channels for electronic Claim attachments from **https://Availity.com**:

- EDI transaction: X12 275 – Patient information, including HL7 payload attachment:
  - Anthem supports the industry-standard X12 275 transaction for electronic transmission of supporting Claim documentation including medical records via the HL7 payload.
- Availity Essentials – Claim Status application enables a Provider or Facility to digitally submit supporting Claims documentation, including medical records, directly to the Claim.
  - Digital Request for Additional Information (Digital RFAI) – The Medical Attachments application on Availity Essentials enables the transmission of digital notifications when additional documentation, including medical records, is needed to process a Claim.

Section 5: Electronic remittance advice and electronic claims payment

Electronic remittance advice

Electronic remittance advice (ERA) is an electronic data interchange (EDI) transaction of the explanation of payment of your claims. Anthem supports the industry-standard X12 835 transaction as mandated per *HIPAA*.

Providers and Facilities can register, enroll, and manage ERA preferences through **https://Availity.com**. Printing and mailing remittances will automatically stop thirty (30) days after the ERA enrollment date.

- Viewing an ERA on Availity Essentials is under Claims & Payments, Remittance Viewer. Features of the remittance viewer include the ability to search a two (2) year history of remittances and access the paper image.
- Viewing a portable document format (PDF) version of a remit is under Payer Spaces which provides a downloadable PDF of the remittance.

To stop receiving ERAs for your claims, contact Availity Client Services at **800-AVAILITY** (**282-4548**).

To re-enable receiving paper remittances, contact Provider Services.

Electronic claims payment

Electronic claims payment is a secure and fast way to receive payment, reducing administrative processes. There are several options to receive claims payments electronically.

- **Electronic Funds Transfer (EFT)**
  Electronic funds transfer (EFT) uses the automated clearinghouse (ACH) network to transmit healthcare payments from a health plan to a Provider's or Facility's bank account at no charge for the deposit. Health plans can use a Provider's or Facility's banking information only to deposit funds, not to withdraw funds. The EFT deposit is assigned a trace number (TRN) to help match the payment to the correct 835 electronic remittance advice (ERA), a process called reassociation.
  To enroll in EFT: Providers and Facilities can register, enroll, and manage account changes for EFT through EnrollSafe at **enrollsafe.payeehub.org**. EnrollSafe enrollment eliminates the need for paper registration. EFT payments are deposited faster and are generally the lowest cost payment method. For help with enrollment, **use this convenient EnrollSafe User Reference Manual**.
  To disenroll from EFT: Providers and Facilities are entitled to disenroll from EFT. Disenroll from EFT payments through EnrollSafe at **enrollsafe.payeehub.org**.
- **Virtual Credit Card (VCC)**
  For Providers and Facilities who don't enroll in EFT, and in lieu of paper checks, Anthem is shifting some reimbursements to the virtual credit card (VCC). VCC allows Providers and Facilities to process payments as credit card transactions. Check with your merchant processor regarding standard transaction fees that will apply.
  Note that Anthem may receive revenue for issuing a VCC.
  Opting out of virtual credit card payment. Providers and Facilities are entitled to opt out of electronic payment. To opt out of virtual credit card payment, there are two (2) options:
  - Enrolling for EFT payments automatically opts you out of virtual credit card payments. To receive EFT payments instead of virtual credit card payments, enroll for EFT through EnrollSafe at **enrollsafe.payeehub.org**.
    OR
  - To opt out of virtual credit card payments, call **800-833-7130** and provide your taxpayer identification number.
- **Zelis Payment Network (ZPN) electronic payment and remittance combination**
  The Zelis Payment Network (ZPN) is an option for Providers and Facilities looking for the additional services Zelis can offer. Electronic payment (ACH or VCC) and Electronic Remittance Advice (ERA) via the Zelis portal are included together with additional services. For more information, go to **Zelis.com**. Zelis may charge fees for their services.
  Note that Anthem may receive revenue for issuing ZPN.
  ERA through Availity is not available for Providers and Facilities using ZPN.
  To disenroll from ZPN payment, there are two (2) options:
  - Enrolling for EFT payments automatically removes you from ZPN payments. To

receive EFT payments instead of ZPN payments, enroll for EFT through EnrollSafe at **enrollsafe.payeehub.org**.
OR

- To disenroll from ZPN payments, update your Zelis registration on the Zelis provider portal or contact Zelis at **877-828-8770**.

Not being enrolled for EFT, VCC, or ZPN will result in paper checks being mailed.

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 for all plans 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 (**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, which will transfer the call to GABBY. GABBY, the provider self-service IVR, will lead callers through the provider authentication process.** Providers can ask to check member eligibility or authorization.
- 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, Hoosier Care Connect, and Indiana PathWays for Aging 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 (HIP, HHW, and HCC only)
- Telephone numbers for vital services, including:
  - Member Services

- 24/7 NurseLine
- Provider Services
- Pharmacy
- Dental and vision, as applicable
- Transportation
- Behavioral Health Crisis Line
- Long-term services and supports, as applicable

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:

- **Indiana PathWays for Aging** is a statewide coordinated care program for Indiana's Medicaid enrollees who are 60 years of age or older, eligible for Medicaid on the basis of age, blindness, or disability, and have limited income and resources. Additional information on Indiana PathWays for Aging can be found in the ***Indiana PathWays for Aging Addendum***.
- **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 some pregnant members. Members do not have any cost-sharing obligations.
  - **Package C (CHIP):** This is a full-service plan for children enrolled in the 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 and most pregnant members. 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.

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 benefit 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, Hoosier Care Connect, and Indiana PathWays for Aging. 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, Hoosier Care Connect, and Indiana PathWays for Aging 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 the 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 • Self-referral	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

Benefits	Package A	Package C
Emergency room services: • PA not required for ER services or observation room	Covered	Covered
Lab and radiology: PA required for some services	Covered	Covered
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 • PA required	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 for generic, compound, sole source drugs, and multi-source brand drugs preferred on the SUPDL over available generics; and • $10.00 for all

Benefits	Package A	Package C
		other brand-name drugs
Physician services: • PA required for some services	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: • PA required	Covered	Covered
Substance use disorder services — residential treatment: • PA required	Covered	Covered
Substance use disorder services — outpatient: • PA required for some services or notification required • 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

Benefits	HIP Basic[1]	HIP Plus	HIP State Plans HIP Maternity
Behavioral health — outpatient: • PA required for some services or notification required • 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 • Limit one unit per day and six units per covered person per benefit year	Not covered	Covered	Covered
Dental: • Self-referral	Covered only for ages 19 to 20 or pregnant members	Covered	Covered
Diabetes self-management training • Self-referral	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

Benefits	HIP Basic[1]	HIP Plus	HIP State Plans HIP Maternity
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	Covered	Covered	Covered
Podiatry services: • Self-referral • Limit six visits per year	Covered	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	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 • Self-referral	Covered	Covered	Covered
Therapy services — physical occupational, speech, hearing, and language: • PA required • 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	Not covered	Not covered[2]	Covered

Benefits	HIP Basic[1]	HIP Plus	HIP State Plans HIP Maternity
air ambulance NEMT			
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
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 Indiana PathWays for Aging benefits and services

Benefits	HCC and Indiana PathWays for Aging package*
Behavioral health — inpatient: • PA required	Covered
Behavioral health — outpatient: • Notification required or PA required for some services • 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
Routine Dental: • Self-referral	Covered
Diabetes self-management training • Self-referral	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 member's place of residence
Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)	Covered

Benefits	HCC and Indiana PathWays for Aging package*
Emergency room services: • PA not required for ER services or observation room	Covered
Hospice care:	Covered
Hospital services — inpatient: • PA required	Covered
Intermediate care facilities for individuals with intellectual disabilities (ICF/IID)	Not covered
Lab and radiology: • PA required for some services	Covered
Long-term care	Covered for Indiana PathWays for Aging members
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
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	Covered
Podiatry services: • Self-referral	Covered
Rehab services- acute inpatient: • PA required	Covered

Benefits	HCC and Indiana PathWays for Aging package*
Respiratory therapy: • PA may be required	Covered
Skilled nursing facility — short-term: • PA required	Covered
Smoking cessation	Covered
Speech, hearing, and language: • PA required	Covered
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 • Self-Referral	Covered
Occupational therapy services: • PA required	Covered
Physical therapy services: • PA required	Covered
Transportation — nonemergent: • PA may be required for out-of-state NEMT travel	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**.	

Indiana PathWays for Aging Programs and Covered Services

Additionally, Indiana PathWays for Aging members who are determined to be nursing facility level of care may be eligible for the following covered services.

Benefits	Indiana PathWays for Aging
Adult Day Services: • Category 1 – Level 1, 2, 3 • Category 2 – Level 1, 2	Covered
Assisted Living: • Monthly – Level 1, 2, 3 • Daily – Level 1, 2, 3	Covered
Attendant Care • Agency, Non-Agency	Covered

Benefits	Indiana PathWays for Aging
Consumer Directed	Covered
Participant-Directed Attendant Care • Unskilled	Covered
Home and Community Assistance • Agency, Non-Agency	Covered
Respite • Unskilled	Covered
Adult Family Care • Now Community Home Share – (Level 1, 2, 3)	Covered
Community Transition	Covered
Home Delivered Meals	Covered
Home Modifications Assessment	Covered
Home Modifications	Covered
Integrated Health Care Coordination	Covered
Nutritional Supplements	Covered
Personal Emergency Response (PERS) - Install • Install, Maintenance	Covered
Pest Control	Covered
Specialized Medical Equipment • New DME, Replacement or Repair	Covered
Structured Family Caregiving • (Level 1, 2, 3)	Covered
Non-Emergency, Non-medical Transportation • Base Trip, Mileage	Covered
Non-Emergency, Non-medical Transportation Assisted • Base Trip, Mileage	Covered
Vehicle Modification – Maintenance	Covered
Vehicle Modification	Covered
Caregiver Coaching and Behavior Management	Covered
Nursing Facility	Covered
Residential-Based Habilitation	Covered

The most up-to-date billing guidance on billing codes, modifiers, and lifetime caps can be found in the IHCP module.

In addition to the regular benefits offered to our members, Anthem offers many great extras such

as healthy meals delivered to your home, nonemergency transportation, and personal care items. These extra benefits ensure members are receiving the highest quality of care and services. Some extra benefits are limited to certain members only and may change or end at any time. To view the current list of the extra benefits, visit **anthem.com/inmedicaid**.

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
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 (21+)	Two exams per year	One cleaning per year	• One complete set every three years • One set of bitewing X-rays every year

Benefit level	Oral examinations	Cleanings	X-rays
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 (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
Indiana PathWays for Aging	Two exams per year	One cleaning per year	• One set of bitewing X-rays • One complete set of X-rays every 3 years

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
- Indiana PathWays for Aging

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.
- One eye exam every two years for Indiana PathWays for Aging members

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 five years for members 21 years and older.
- One pair of glasses every five years for Indiana PathWays for Aging members.
- 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 Indiana PathWays for Aging, 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 non-ambulatory), taxis, bus services, and ambulance services — must be enrolled as IHCP providers. Anthem contracts with an NEMT broker that administers the NEMT program in accordance with contract requirements and Medicaid-covered benefits:

- HIP Maternity members, HIP members with State Plan Benefits, Indiana PathWays for Aging, 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 high school equivalency exams
    - $25 in bus tickets, $25 gas card, or $25 ride-share card ― HCC, HHW, and HIP Plus
    - $50 gas card or $50 rideshare card, and 6 round trips of on-demand transportation with a companion caregiver – Indiana PathWays for Aging
- 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.

Hospice care

Hospice care is covered for members who meet the criteria under the Healthy Indiana Plan, Hoosier Care Connect, and Indiana PathWays for Aging. Services may be provided in the home or in a hospice facility. Indiana PathWays for Aging members may receive Hospice services and personal care services through HCBS attendant care simultaneously. Notification is required for all members who have elected the hospice benefit. For notification, providers should follow the current hospice notice:

- **Hospice notification updates - Provider News (anthem.com)**
- 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. DOT is not a covered benefit with Hoosier Care Connect, Hoosier Healthwise, Healthy Indiana Program, and Indiana PathWays for Aging. 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

Hoosier Care Connect, Hoosier Healthwise, and Healthy Indiana Program exclude certain services 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.

The Indiana PathWays for Aging program excludes some benefits from coverage under managed care. These benefits are available under traditional Medicaid or other waiver programs.

Listed below are the services excluded from the Indiana PathWays for Aging program:

- Psychiatric Treatment in a State Hospital
- Intermediate Care Facilities for Individuals with Intellectual Disabilities
- Traumatic Brain Injury Waiver
- Community Integration and Habilitation Waiver
- Family Supports Waiver

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 Anthem Indiana Medicaid. Some PathWays members may have drug coverage through Medicare that is not managed by Anthem, and we can help coordinate that coverage. 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 members. Pharmacies may dispense up to a one-month supply of medication. Members may receive a 90-day supply of maintenance medication through a retail pharmacy or mail-order pharmacy. (Specialty medication is not eligible for a 90-day supply.)

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 the 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.
- Over-the-counter 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 the 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

Anthem follows the Statewide Uniform Preferred Drug List (SUPDL), or formulary, which is a list of all brand-name and generic drugs managed by the IHCP. All managed care plans and the fee-for-service program serving Indiana Medicaid follow the SUPDL. Medications and supplies that are not part of the SUPDL/formulary are referred to as "neutral", or non-formulary, drugs and are managed by Anthem. Requests for exception to either SUPDL/formulary or neutral/non-formulary drug lists should be submitted to Anthem for review through the standard prior authorization process.

The ***SUPDL and neutral drugs*** for Anthem Indiana Medicaid 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/non-formulary drugs. Prior to making any changes to the contents of the approved neutral/non-formulary drug list or any changes to prior authorization or medical necessity criteria applied to the neutral/non-formulary drug list, Anthem submits the proposed change(s) to the OMPP at least 60 days prior to the intended implementation date. OMPP may disapprove or modify the proposed changes within 30 days of receipt. If no response is received from OMPP within 30 days, Anthem may implement the proposed changes. The formulary and non-formulary covered drug lists shall be updated and posted on or before the intended implementation date to reflect all changes in the status of a drug or the addition of new drugs. 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 formulary/SUPDL and non-formulary/neutral drug lists 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. 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 for 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, Hoosier Healthwise, and Indiana PathWays for Aging:

- 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 be submitted to Acentra Health. 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 or otherwise specified on the SUPDL.

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

- 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 a formulary/SUPDL or non-formulary/neutral drug list exception request, providers must contact Anthem by telephone, fax, web-based system, or in writing. 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, Hoosier Care Connect, and Indiana PathWays for Aging 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, compound, sole source drugs, and multi-source brand drugs preferred on the SUPDL over available generics; and $10 for all other brand-name drugs.
- **Hoosier Care Connect**: $0 copay.
- **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/Alaska Native, pregnant, or residing in a nursing facility.

- **HIP Plus, State Plan Plus, and HIP Maternity:** $0 copay.
- **Indiana PathWays for Aging:** $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 Indiana Medicaid members may receive a 90-day supply of maintenance medication through our mail order provider. Members may also receive a 90-day supply of maintenance medication through a retail pharmacy. (Specialty medication is not eligible for a 90-day supply.)

We will enable 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 Healthcare Common Procedure Coding System (HCPCS)/Current Procedural Terminology® (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

At Anthem, our mission is to enhance the physical and behavioral health of our members through a whole-person, person-centered, and integrated approach to healthcare. We are committed to promoting mental health, preventing substance misuse, and providing our members with access to treatments and supports that foster recovery while ensuring equitable access and better outcomes. By prioritizing a comprehensive range of mental health and substance use services and supports, we adhere to fundamental principles of equity, trauma-informed care, data-driven practices, and a commitment to recovery.

We are dedicated to a coordinated, comprehensive, and holistic approach to healthcare, working collaboratively with hospitals, group practices, independent providers, community agencies, and community mental health centers to ensure improved outcomes for all our members. We have developed protocols to integrate behavioral health services with physical healthcare, complying with IHCP guidelines and ensuring a seamless continuum of care for all our members.

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

Goals:

1. **Promote Integration of Care**:
    - Promote the integration of the management and delivery of physical and behavioral health services.
2. **Evaluate and Monitor Coordination**:
    - Evaluate and monitor the coordination of physical and behavioral health services to enhance the continuity and quality of care.
3. **Ensure and Expand Service Accessibility**:
    - Ensure and expand service accessibility to eligible members, providing comprehensive care within their reach.
4. **Achieve Quality Initiatives**:
    - Achieve quality initiatives, including those related to HEDIS®, NCQA, and Indiana OMPP performance requirements.
5. **Support Member Recovery**:
    - Work collaboratively with members, providers, and community supports to provide recovery tools and create an environment that supports members' progress toward their recovery goals.
6. **Ensure Appropriate Care Utilization**:
    - Ensure utilization of the most appropriate, least restrictive medical and behavioral healthcare in the right place at the right time.
7. **Mitigate Behavioral Health Disparities**:
    - Mitigate behavioral health disparities by addressing social drivers of health (SDOH), such as social injustice, unemployment, education levels, lack of transportation, food insecurity, and housing instability.

Objectives:

1. **Promote Continuity and Coordination of Care:**
    - Foster seamless continuity and coordination of care that considers the whole person, ensuring all aspects of a member's health and well-being are integrated.
2. **Enhance Member Satisfaction:**
    - Enhance member satisfaction by implementing personalized, holistic, and trauma-informed support that addresses the unique needs and goals of each individual.
3. **Member Education and Empowerment:**
    - Provide comprehensive education on treatment options and recovery pathways, empowering members to make informed decisions about their healthcare.
4. **High-Quality Case Management and Care Coordination:**
    - Deliver high-quality case management and care coordination services that are individualized and culturally sensitive, promoting overall health and resilience (see **Chapter 7: Case Management for more information**).
5. **Ensure Medically Necessary and Appropriate Care:**
    - Actively collaborate with care providers to ensure the provision of medically necessary, trauma-informed, and appropriate care tailored to each member's situation.
6. **Enhance Provider Satisfaction and Success:**
    - Foster collaborative and supportive relationships with providers to enhance their satisfaction and success, ultimately improving member care outcomes.
7. **Promote Collaborative Healthcare Partnerships:**
    - Encourage and facilitate bidirectional communication between all healthcare partners, creating a cohesive network that supports person-centered and whole-person care.
8. **Utilize and Promote Evidence-Based Guidelines:**
    - Employ and advocate for evidence-based guidelines and clinical criteria that support high-quality, trauma-informed care practices.
9. **Maintain Compliance with Regulatory Standards:**
    - Ensure adherence to state and federal requirements to promote safe and effective care, and implement protocols aligned with best practices, regulations, policies, and procedures.
10. **Continuous Progress Monitoring and Improvement**
    - Evaluate and monitor the effectiveness of policies and procedures for physical and behavioral health coordination and develop and implement improvements based on the outcomes to enhance coordination and continuity of care.

Coordination of behavioral health and physical health

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

- Implement standardized screening and assessment protocols for the early identification

and intervention of physical, mental, and behavioral health conditions, enabling timely referral and access to appropriate care.
- Identify gaps in care by analyzing patient data, utilizing routine screenings, collecting patient feedback, and ensuring seamless communication and coordination among healthcare providers.
- Evaluate and address the significant impact that physical and behavioral health have on each other, as physical conditions often lead to behavioral health issues, and untreated behavioral conditions can adversely affect physical health, necessitating a comprehensive, whole-person care approach.
- Implement streamlined referral and follow-up after the referral process to ensure timely and appropriate access to specialty services, including mental health, substance use treatment, and social services.
- Develop highly individualized, patient-centered treatment plans that actively involve members, alongside their caregivers and support networks.
- Ensure continuous communication and coordination between Primary Medical Providers (PMPs), specialty providers, including behavioral health (mental health and substance use) providers, and Anthem Case Management.
- Active participation in treatment planning discussions and Case Conferences with Anthem 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 receiving behavioral health services, behavioral health, and physical health providers are required to document and reciprocally share the following information for that member:

- 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

Prior Member Consent

Prior member consent is required to disclose sensitive health information, a subset of protected health information. Impacted conditions include Substance Use Disorder (SUD). Consent requirements are based on federal and state requirements.

For SUD, federal rule 42 CFR PART 2 exists to encourage people to engage in substance use treatment without fear of legal prosecution. This rule is commonly called "Part 2." Key elements of the Substance Use Disorder Patient Records final rule include:

- A single consent can now be used for all future uses and disclosures of patient records for purposes including treatment, payment, and healthcare operations.
- HIPAA-covered entities and their business associates that receive these patient records with the patient's consent can further disclose the records in line with HIPAA regulations.
- For a blanket future-use consent, the recipient can be described generally, such as "my

treating providers, health plans, third-party payers, and people helping to operate this program."
- If the recipient is a covered entity or business associate receiving records for treatment, payment, or healthcare operations. This includes developing protocols, managing cases, coordinating care, and informing providers and patients about alternative treatments.

All network providers are contractually required to ask and encourage members to sign a release of information for their Primary Medical Provider (PMP), specialists, and Anthem. There must be documented evidence if the member refused to provide such a signature.

Outpatient treatment services
Reimbursement for all outpatient behavioral health services requires that a physician, HSPP, LCSW, LMFT, LMHC, LCAC, or APRN certify the diagnosis and supervise the plan of treatment. Qualified behavioral health practitioners who are enrolled in the IHCP may bill directly for services rendered, using their own NPI as the rendering provider on the claim.

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 practitioner as the rendering provider and the NPI of the clinic, facility, or other enrolled billing entity as the billing provider. The procedure code must be billed with the modifier **HE** – *Services provided by any behavioral health practitioner (excluding physicians, HSPPs, and physician assistants).*

For behavioral health services provided by an APRN and billed under a supervising practitioner's NPI, the modifier HE should be used in conjunction with the modifier SA. Physicians, HSPPs, and physician assistants are always required to bill under their own NPI. See the Medical Practitioner Reimbursement module for additional billing and reimbursement guidance for APRNs and physician assistants.

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.

IHCP allows reimbursement for behavioral health services provided by interns in the community mental health center (CMHC) setting. The provider billing for these services must be enrolled with the IHCP as a CMHC (provider type 11, specialty 111). Behavioral health providers outside of CMHCs are not eligible for reimbursement for services rendered by an intern. CMHCs that are owned by or affiliated with a hospital, however, are an exception to this allowance. CMHCs associated with hospitals may not bill separately for intern services because reimbursement for intern services is included in the hospital's medical education add-on to inpatient claims.

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 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 IHCP, ABA therapy services under HCPCS codes 97151–97158, 0362T, and 0373T must

include specific modifiers to indicate the provider type:

- **U1:** Registered Behavior Technician (RBT)
- **U2:** Bachelor-level Board Certified Assistant Behavior Analyst (BCaBA)
- **U3:** Physician, Doctoral-level BCBA-D, Master's-level BCBA, or Health Service Provider in Psychology (HSPP)

Procedure code 97155 may be billed concurrently with code 97153 when a QHP directs the technician, but a single QHP cannot bill both services simultaneously.

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 provider types HSPP, BCBA-D, and BCBA under provider type 11 and provider specialty 615.

Residential Substance Use Disorder (SUD) Treatment services

Anthem provides coverage for short-term low-intensity and high-intensity residential treatment for opioid use disorder (OUD) and other substance use disorders (SUD) in settings of all sizes, including facilities that qualify as institutions of mental disease (IMDs). Prior authorization is required for all residential SUD services, which can be obtained through Availity or fax and must include the state's SUD forms. The form is located online at **https://providers.anthem.com/IN** under Forms.

Qualified residential SUD providers must be:

- Designated 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.
- Certified as a residential (sub-acute stabilization) facility by DMHA.
- Enrolled with IHCP with provider type 11 and specialty 836.

Providers should bill for residential SUD treatment using a professional claim. Reimbursement for residential stays for SUD treatment is made on a per diem basis. Services that are included under the per diem payment will not be reimbursed separately for a member for the same dates

of service as the per diem payment is reimbursed. An IHCP provider enrolled as an SUD residential addiction treatment facility (provider type 11, specialty 836) is limited to billing only the following procedure codes:

- H2034 U1 or U2 – Low-intensity residential treatment
- H0010 U1 or U2 – High-intensity residential treatment

Specific billing guidance for low-intensity and high-intensity residential treatment services is provided in the **IHCP Behavioral Health and Addiction Services** provider reference module.

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 a complete range of medical and rehabilitative services to individuals with an opioid use disorder. The weekly bundled rate includes dispensing opioid treatment medication, case management, drug testing, testing for illnesses associated with opioid use, and individual and group therapy. Prior authorization is not required for OTP services.

Providers must maintain documentation in the member's records that demonstrates medical necessity, fulfillment of coverage criteria, and the individual's length of treatment. Take-home dosing can be initiated in the first week of treatment if appropriate. For moderately stable individuals, a 14-day supply of take-home doses can be provided after 14 days of treatment. For stable individuals, a 28-day supply of take-home doses can be provided after 31 days of treatment. Safeguards like diversion control procedures remain.

OTPs are expected to obtain the required release of information to disclose information pertaining to the member's substance use condition and actively participate in case management. Case management means the management of patient activities identified in the individualized treatment plan that assist in patient goal attainment, including referrals to other service providers, such as mental health, physical health, housing, education, vocational rehabilitation, and other employment services providers, and linking patients to recovery support groups. Anthem utilizes data and predictive models to identify members for internal case management services as well as provider and member self-referral.

Qualified providers must:

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

Behavioral health-related LTSS services and limitations are outlined in the *Indiana PathWays for Aging Addendum.*

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 proactive care management, clinical discussions, care coordination, and discharge planning processes with Anthem Case Management for each member under your care.
- Behavioral health providers are encouraged to ensure that Anthem case managers have timely access to the clinical staff, case managers, or peer support professionals who are directly involved in the member's care for effective care coordination. It is important that case managers engage directly with the member's care team rather than being directed to medical records professionals or other administrative personnel for discussions related to active treatment and necessary referrals.
- Behavioral health providers are expected to be trained and knowledgeable of restrictions and limitations related to HIPPA and 42 CFR Part 2 and how it pertains to care coordination with Anthem Case Management.
- Behavioral health and physical health providers are contractually required to document and reciprocally share the member's primary and secondary diagnoses, findings from assessments, medication prescribed, psychotherapy prescribed, and any other relevant information.
- Ensure that members receiving inpatient services or emergency treatment for a behavioral health condition or substance use disorder are scheduled for follow-up and/or continuing treatment prior to discharge. Anthem requires the post-discharge follow-up appointment to occur within 7 days from the date of discharge, but not on the day of discharge. Providers are required to confirm attendance of this appointment, upon request.
- Allow Anthem Case Management access to members telephonically or in person when they are admitted to an inpatient or substance use disorder residential level of care.
- Offer hours of operation that are no less than the hours of operation offered to commercial members.
- Comply with the quality standards of our health plan and the Indiana Office of Medicaid Policy and Planning (OMPP).
- Participate in Anthem's routine audits, assessing policies, record quality, adherence to best practices, compliance with regulations, and reducing fraud, waste, and abuse.
- Seek prior authorization for all services for which it is required.
- Ask and encourage members to sign a consent to share substance abuse treatment information.
- PMPs and behavioral health providers are encouraged to access the Availity Essentials platform to view the Member Health Profile for their members at least quarterly.

PMPs and behavioral health providers are encouraged to utilize the Availity Essentials platform to view real-time digital alerts such as member ADT notifications, member records, and treatment planning.

Clinical documentation is a cornerstone of effective and continuous care, ensuring accurate tracking and communication of treatment. Facilities and providers should adhere to the principle that "if it is not documented, it did not happen". Ensure all documentation is compliant with the

Health Insurance Portability and Accountability Act to protect patient privacy and confidentiality. In accordance with state and federal regulations, all Medicaid records shall be maintained for seven years. Member records must include the following documentation throughout the member's treatment journey:

- Facilities must provide evidence of integrated care coordination and ongoing communication with the Primary Medical Provider (PMP).
- Providers must address care gaps through education, coordination, referrals, and information sharing with the member's Primary Medical Provider (PMP) or specialist per NCQA guidelines, with accurate documentation of actions and outcomes in the member's record.
- Documentation must confirm that referrals to appropriate medical or social support professionals have been made and must include follow-up to ensure the member was successfully linked to these referrals.

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 complete a comprehensive assessment with a detailed description of the member's physical and mental health status at the time of admission to services. Behavioral health providers are required to use DSM-5 when assessing the member for behavioral health conditions. Behavioral health providers are required to document the DSM-5 diagnosis and outcome of assessment information in the member's medical record. The assessment must be reviewed and signed by the supervising practitioner if completed by a mid-level provider not enrolled with IHCP within 7 days of the intake process. The comprehensive assessment 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
- Mental health assessment tools
    - Use standardized assessment tools (e.g., PHQ-9, GAD-7)
- Education history
- Medical assessment:
    - Screening for medical problems and gaps in care
- Medical history
- Primary care provider
- Present medication/prescriber information
- Substance use assessment:
    - Including 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
- Social Drivers of Health (SDOH)
- Assessment of the member's strengths, protective factors, and personal goals
- Assessment of needs and barriers to treatment adherence

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 guardians, participated in the development and subsequent reviews of the treatment plan as evidenced by a member and/or caregiver signature.

Reimbursement for all outpatient behavioral health services requires that a physician, HSPP, LCSW, LMFT, LMHC, LCAC, or APRN certify the diagnosis and supervise the plan of treatment. The support and care plan must be completed within 7 days of admission to behavioral health services and updated every 90 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. The supervising practitioner must be available for emergencies and must see the patient or review the information obtained by the rendering practitioner. During the course of treatment, at intervals not to exceed 90 days, the supervising practitioner must see the patient again or review the documentation to certify the treatment plan and specific treatment modalities. All reviews must be documented in writing; a co-signature is not sufficient.

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 identified problem, written in member-friendly language.
- **SMART Goals** (Specific, Measurable, Achievable, Relevant, Time-bound) addressing each problem.
- Target dates for the completion of objectives.
- Responsible parties for each objective.
- Specific, measurable action steps to accomplish each objective.

- Incorporate evidence-based approaches to treatment, aligning documentation and care plans with the latest research and clinical guidelines.
- Individualized steps for the prevention and/or resolution of a crisis or safety risk, including:
    - 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.
    - The member's preferred treatment options, including psychopharmacology, in the event of a mental health crisis.
- Actions to be taken when progress toward goals is less than originally planned by the member and provider.
- Dated signatures of the member, family members, caregivers, or legal guardians, as appropriate.
- Documentation of semiannual care conferences for Hoosier Care Connect members.
- Date of review and signature by the supervising qualified behavioral health practitioner if completed by a mid-level provider in accordance with IHCP guidelines.

Progress notes

Creating comprehensive progress notes is essential for justifying the services rendered and maintaining an accurate account of a member's treatment. The best practice is to document progress notes in real-time during the visit or immediately afterward and finalize them within 24-48 hours. All notes must be finalized and signed before submitting any claims for the rendered service.

Key elements of a comprehensive progress note for behavioral health services should include the following elements:

- Basic Information: Date of service, session start and stop time, place of service, patient name, Medicaid ID, and date of birth.
- Chief Complaint/Reason for Visit: The primary reason the patient is seeking treatment or the focus of the current session.
- Subjective Information: The patient's self-reported symptoms, concerns, experiences, and any relevant personal history since the last session.
- Objective Information: Observable facts such as the patient's behavior, physical appearance, mood, affect, and any relevant test results or findings.
- Assessment/Clinical Impressions: The clinician's interpretation of the subjective and objective information, including any diagnosis, changes in symptoms, and progress towards treatment goals.
- Interventions and Services Provided: Details of the psychotherapy techniques, therapeutic interventions, medications prescribed, and any other services provided during the session.
- Patient's Response to Treatment: The patient's reactions, participation level, and any changes observed during the session.
- Progress Toward Goals: An evaluation of the patient's progress regarding the goals and objectives outlined in the treatment plan.

- Plan: Any adjustments to the treatment plan, including upcoming treatments, referrals, homework assignments, and recommendations for the next steps.
- Safety Plan (if applicable): Any specific crisis intervention strategies or safety plans discussed and agreed upon.
- Follow-Up: The date and time of the next appointment and any other follow-up actions or reminders.
- Notes on Communication: Any significant communication with family members, caregivers, or other healthcare providers.
- Provider Name and Credentials: The full name, title, signature, and credentials of the rendering provider, as well as the supervising provider if applicable. Additionally, include the date and time the note is finalized.

Discharge Summary:

Discharge planning starts at admission and is one of the most important components in a patient's recovery. Most importantly, a patient's safe and effective discharge plans have been proven to reduce incidents of post-discharge suicide. Additionally, proper behavioral and medical after-care appointments reinforce the patient's overall well-being and can reduce unwanted relapses, recurrences, and re-admissions.

- **Acute Psychiatric Hospital**: Summary sent to Anthem and PMP within 72 hours of discharge, including details of the treatment received, the patient's response, medication management, and detailed appointment information for follow-up care with a behavioral health provider within 7 days following the day of discharge.
- **SUD Residential Treatment**: Summary sent to Anthem and PMP within 7 calendar days of discharge, covering treatment provided, patient progress, outcomes, incidents, medication administration, and detailed appointment information for follow-up care with a behavioral health provider within 7 days following the day of discharge, or other follow-up recommendations such as social and recovery supports.
- **Behavioral Health Outpatient Services**: Summary sent to Anthem and PMP within 15 calendar days following service termination, with an overview of treatment, patient response, goals achieved, challenges, and future care recommendations.

Psychotropic medications

Prescribing providers must inform all members being considered for psychotropic medications about the benefits, risks, side effects, alternative medications, and other treatment options. If obesity is also a concern, the medical record should document that a healthy diet and exercise plan has been provided, or if applicable, note a referral to a nutritionist or obesity specialist. For members with diabetes, the medical record should include a discussion about their condition, identify their treating provider, and detail coordination efforts with that provider. Additionally, the medical record should reflect that these conversations took place and indicate that the prescription data has been shared with the member's PMP.

Members on psychotropic medications may be at higher risk for various disorders. Therefore, providers are expected to be well-informed about the side effects and risks of these medications and to regularly check for any side effects. This is particularly important for the following:

- 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 and other professional organizations. Summary guidelines are referenced in our ***Clinical Practice Guidelines*** located on our website at **https://providers.anthem.com/IN** by using the Resources tab > Provider manuals and guides > Medical Policies and Clinical UM Guidelines. Although the prescriber is not expected to personally conduct all these tests, they must ensure the tests are performed when necessary and initiate appropriate interventions for any adverse results. All 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.

988 Suicide & Crisis Lifeline

988 Suicide & Crisis Lifeline will offer a direct connection to compassionate, accessible care and support for anyone experiencing mental health-related distress – whether that is thoughts of suicide, mental health or substance use crisis, or any other kind of emotional distress. As part of the 988 Suicide and Crisis Lifeline initiative implemented by House Enrolled Act (HEA) 1222 (2022), effective July 1, 2023, the Indiana Health Coverage Programs (IHCP) added Medicaid coverage for crisis intervention services rendered by mobile crisis teams designated by the Division of Mental Health and Addiction (DMHA). Prior authorization is not required for mobile crisis services.

Mobile crisis units are classified using the following provider enrollment type and specialty codes:

- Provider type 11 – Behavioral Health Provider
- Provider specialty 622 – Mobile Crisis Unit

Only mobile crisis units that are designated by the DMHA and follow Indiana Code IC 12-21-8-3 and IC 12-21-8-10 will receive IHCP reimbursement.

Mobile Crisis Services include:

- Triage/Screening: Determines the level of risk that is faced by the individual in crisis and assesses the most appropriate response.
- Assessment: Collects information on the circumstances of the crisis event, safety, and risk related to the individual and others involved, medication and substance use, strengths and resources of the individual, recent inpatient hospitalizations or mental health services, mental health conditions, medical history, and other pertinent information.
- De-escalation through brief counseling: Brief counseling techniques specific to the crisis that aim to lower risks and resolve the crisis so that a higher level of care is not needed.
- Safety planning: Engagement of the individual in a crisis planning process, resulting in the creation or update of planning tools, including an individualized safety plan. The safety plan aims to keep an individual in crisis and their environment safe and may include lethal means counseling and other evidence-based interventions.
- Peer recovery support: Support provided by a paraprofessional with lived experience with mental health and/or substance use disorder concerns.
- Follow-up stabilization services: Follow-up contacts in-person, via phone, or telehealth up to 14 days following initial crisis intervention and can be billable for up to 90 days.

Behavioral health referrals

Self-referrals

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

PMPs and specialists may provide clinically appropriate behavioral health services within the scope of their practice, 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 must refer members to appropriate care if they are experiencing acute symptoms of a chronic behavioral health disorder, showing sudden symptom onset, or are in a crisis state. PMPs must also refer members to more intensive care if their symptoms of anxiety or mild depression persist or worsen. Any member suspected of developing medication toxicities prescribed by a psychiatrist should be referred to the behavioral health system for observation and monitoring of medications.

Any member with a history of or symptoms indicative of these conditions should be referred to a behavioral health provider for further assessment and intervention:

- Adjustment disorder
- Behavioral disorders of children and adolescents
- Bipolar disorder
- Eating disorder
- Substance use disorder
- Psychosis

- Schizophrenia
- Treatment-Resistant Major Depressive Disorder
- Post-traumatic stress disorder

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 > Provider manuals and guides > Medical Policies and Clinical UM Guidelines > ***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), the American Academy of Pediatrics (AAP), and Bright Futures.
- Refer members, as appropriate, to dentists, optometrists/ophthalmologists, 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.

Health Needs Screening

The Health Needs Screening (HNS) gives providers the baseline they need to help assess, manage, and educate members' physical and behavioral health, encouraging members to become more active in their healthcare. 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.**
- Call **866-408-6131** (Hoosier Healthwise, Healthy Indiana Plan) or **844-284-1797** (Hoosier Care Connect) (TTY **711**). A representative will assist the members.
- For Indiana PathWays for Aging members, the HNS will be completed with the member's care coordinator.

Early and Periodic Screening. Diagnostic and Treatment Services (EPSDT)

The federally mandated Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program is a preventive healthcare program providing initial and periodic examinations and medically necessary follow-up care for all members from birth to age 21. For more information on HealthWatch, visit **https://www.in.gov/medicaid/providers/files/epsdt.pdf**.

EPSDT 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. EPSDT services are applicable to members ages 21 and under and do not apply to Indiana PathWays for Aging members.

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 ages of 28 months and 72 months who 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**.

Indiana PathWays for Aging – information can be found in the ***Indiana PathWays for Aging Addendum***.

Maternal health services

New Baby, New Life℠

New Baby, New Life is a proactive case-management program for all expectant members and their newborns. We use several resources to identify pregnancies as early as possible. Sources of identification include state enrollment files, claims data, and hospital census reports 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 management services to mitigate risk.

Experienced case managers work with members and providers to establish a care plan for our highest risk pregnant members. They may also collaborate with community partners to facilitate connecting members to local and national agencies who can assist with services and support.

When it comes to our pregnant members, we are committed to healthy outcomes for our members and their babies. That's why we encourage all of our pregnant and postpartum members to take part in our New Baby, New Life program ― a comprehensive program offering:

- Individualized, one-on-one case management support for pregnant members at the highest risk
- Care coordination for those who may need a little extra support
- Digital perinatal educational tools
- 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, perinatal members have access to a digital perinatal offering. The digital offering is available via a smartphone app and provides pregnant and postpartum members with timely, proactive, and culturally appropriate education. Once members are identified as being pregnant, they will receive an invitation to access this program by downloading the app. After the app is installed and the member registers, they are asked to complete a pregnancy screener. The answers provided in the screener allow Anthem to assess their pregnancy risk.

After the risk assessment is complete, the app delivers gestational-age-appropriate education directly to the member. This digital offering does not replace the high-touch, individual case

management approach for our highest risk pregnant members; however, it does serve as a supplementary tool to extend our health education outreach. The goal of the expanded outreach is to ensure maternity education is available to all perinatal members and help Anthem identify members who experience a change in risk acuity throughout the perinatal period.

We encourage healthcare providers to share information about the New Baby, New Life program, and the digital perinatal app offered at Anthem with members. Members may access information about the products that are available by visiting the Anthem member website. For more information about the New Baby, New Life program or the digital app, reach out to your OB Practice Consultant or Provider Services at **866-902-1690**.

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 who 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 procedure 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.

Neonatal Intensive Care Unit (NICU) Care Management

If a baby is born premature or with a serious health condition, they may be admitted to the NICU. We believe the more parents know, the better they will be able to care for their infant. To support them, we have a NICU Case Management program.

We extend our support by helping parents to prepare themselves and their homes for when the baby is released from the hospital. After the baby is home, our case managers continue to provide education and assistance in improving the baby's health, preventing unnecessary hospital readmissions, and guiding parents to community resources if needed.

The NICU can be a stressful place, bringing unique challenges and concerns that parents may have never imagined. The anxiety and stress related to having a baby in the NICU can potentially lead to symptoms of post-traumatic stress disorder (PTSD) in parents and caregivers. To reduce the impact of PTSD among our members, we assist by:

- Helping parents engage with hospital-based support programs

- Facilitating parent screenings for potential PTSD
- Connecting parents with behavioral health program resources and community support as needed
- Actively asking for their feedback on the provided resources and how an increased awareness of PTSD has helped

For more information about our NICU Case Management program, reach out to Provider Services **at 866-902-1690**.

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

Indiana PathWays for Aging Care and Service Coordination Section is outlined in the ***Indiana PathWays for Aging Addendum.***

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 > Provider manuals and guides > Medical Policies and Clinical UM Guidelines, 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 ensure that the PMP has authorized the visit to the referral provider.
- The referral must be sent to Anthem's RCP administrator to ensure 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), **844-284-1797** (Hoosier Care Connect), or **833-412-4405** (Indiana PathWays for Aging).

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 a 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 for providing 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), **844-284-1797** (Hoosier Care Connect), and **833-412-4405** (Indiana PathWays for Aging). 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).

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: **https://www.in.gov/health/tpc/cessation/indiana-tobacco-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 the 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

WW® Program

In addition, Anthem offers members various enhanced services that target weight management. Through referrals from members, 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 members with a referral.

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 members 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 members.
- Understand and adhere to regulations to support the needs of diverse members, such as the *Americans with Disabilities Act* (*ADA*).
- Use culturally appropriate community resources as needed to support member 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 member 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.
- **My Inclusive Practice - Improving Care for LGBTQIA+ Patients:** Helps providers understand the fears and anxieties LGBTQIA+ members and their families often feel about seeking medical care, learn key health concerns of LGBTQIA+ members, and develop strategies for providing effective healthcare to LGBTQIA+ patients.
- **Improving the Member Experience:** Helps providers identify opportunities and strategies to improve member 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 members.
- **Moving Toward Equity in Asthma Care:** Helps providers understand issues often faced by diverse members with asthma and develop strategies for communicating to enhance member understanding.
- **Reducing Healthcare Stereotype Threat (HCST):** Helps providers understand HCST and the implications for diverse members as well as the benefits of reducing HCST to both providers' members 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 members.

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 members.

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**
  - Indiana PathWays for Aging: **833-569-4739**
- Member Services:
  - Hoosier Healthwise, Healthy Indiana Plan: **866-408-6131**
  - Hoosier Care Connect: **844-284-1797**
  - Indiana PathWays for Aging: **833-412-4405**
  - 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.

The Indiana PathWays for Aging program will encompass a wide array of ongoing services delivered over a long period of time, paid and unpaid, that are designed to meet the holistic needs of individuals of any age living with disabilities, chronic health conditions, or who need help with daily activities in a home- and community-based setting or institutional setting of choice. Additional information on Indiana PathWays for Aging can be found in the ***Indiana PathWays for Aging Addendum***.

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 and Availability

All providers are expected to meet the federal and state accessibility standards and those defined in the *Americans with Disabilities Act of 1990*. Healthcare services provided through Anthem must be accessible to all individuals served by Anthem.

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.

Definitions

Emergency/Emergent: Per 405 IAC 5-2-9, emergency services are defined as a service provided to a member after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity that the absence of immediate medical attention could reasonably be expected to result in: (1) placing the patient's health in serious jeopardy; (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part.

Urgent: A service need that is not emergent and means services furnished to an individual who requires services to be furnished within twelve (12) hours in order to avoid the likely onset of an emergency medical condition 42 CFR 405.400.

Routine: A service need that is not urgent and can be met by receiving treatment within 10 days of the assessment without deterioration in the individual’s functioning or worsening of his or her condition.

General appointment scheduling standards

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

Nature of visit	Appointment standards
Emergency/Emergent 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

Nature of visit	Appointment standards
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 a 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

As outlined in *42 CFR 438.102,* 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.
- Anthem is not required to provide coverage for counseling or referral services if Anthem objects to services on moral or religious grounds.
- 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 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.

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

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 **https://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 who are contracted with Carelon Behavioral Health and 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

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. The Indiana Child Abuse and Neglect Hotline phone number is **800-800-5556.** On the **Indiana Department of Child Services website** there are fact sheets and information when calling the Hotline number. In addition, providers must submit a follow-up written report to the local law enforcement agency within the time frames as required by law.

Adult Protective Services (APS) is responsible for defining, receiving reports of, and investigating suspected neglect, battery, or exploitation of an endangered adult. Any incident that meets APS's definition of a critical incident must be reported to APS. Instructions for reporting can be found at **FSSA: Aging Home: Incident Reporting**.

Please call **800-992-6978** or visit **https://aps-govcloud.my.site.com/APSOnlineReport/s/**.
For additional information on Critical Incident Reporting can be found on Page 216 of this Manual.

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/bulletins-banner-pages-and-reference-modules/ihcp-provider-reference-modules/#claims-billing**.

Healthy Indiana Plan (HIP) members: Anthem uses *Medicare National Correct Coding Initiative (NCCI) Guidelines* HIP claims will be reimbursed at 100% of the Indiana Medicaid Fee Schedule. 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**.

Indiana PathWays for Aging members: Anthem reimburses claims at 100% of the Indiana Medicaid Fee Schedule. Additional guidance for Indiana PathWays for Aging is available in the **Claims submission section in the *Indiana PathWays for Aging Addendum***.

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 are not 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 that was 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.https://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 **https://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

For Home and Community-Based Services (HCBS) providers who have a Legacy Provider ID (LPI), refer to the **Indiana PathWays for Aging Addendum for additional information**.

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.
- Provider is enrolled 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, compound, sole-source drugs, and multi-source brand drugs preferred on the SUPDL over available generics; and $10 for all other brand-name drugs

Indiana PathWays for Aging
Indiana PathWays for Aging members do not have copays. For additional information, please see the ***Addendum***.

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 Reference Module* at **Indiana Medicaid: Providers: IHCP Provider Reference Modules**.

Cost-sharing

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 Anthem Medicaid 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 be denied 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.

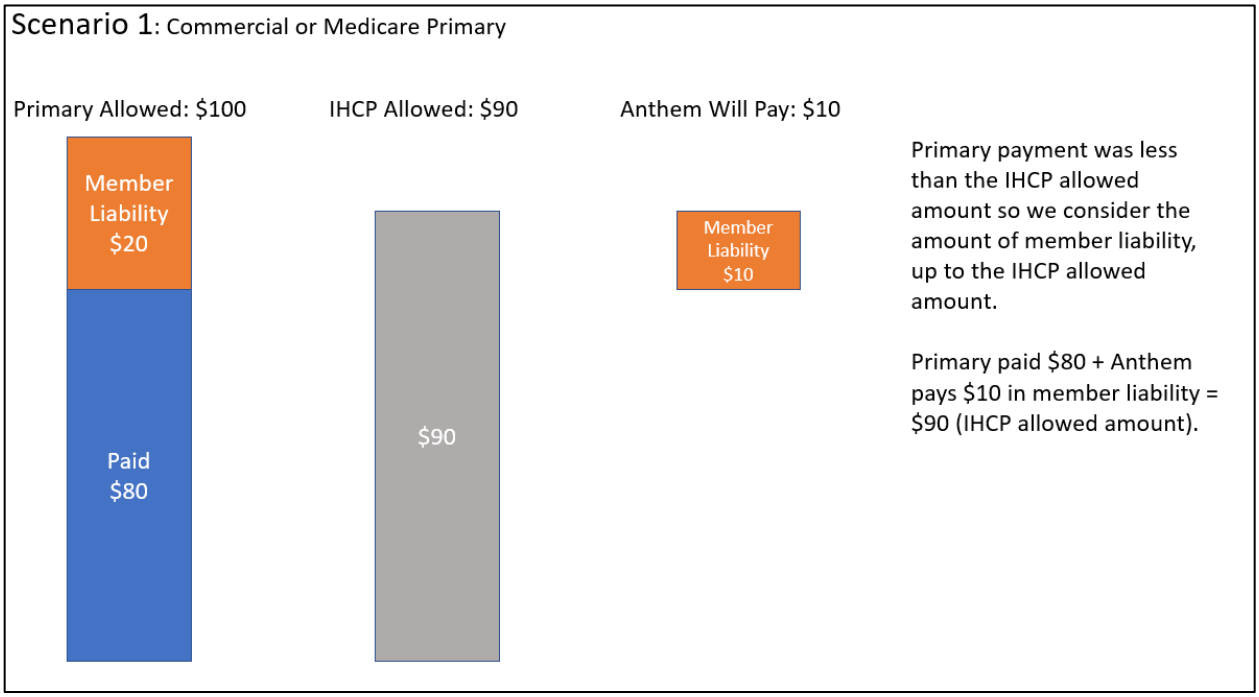
Anthem members may have other insurance coverage that may be found after a claim has been paid that Anthem was not aware existed at the time of service. In these situations, Anthem will notify the provider of the existence of the other insurance coverage.

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.

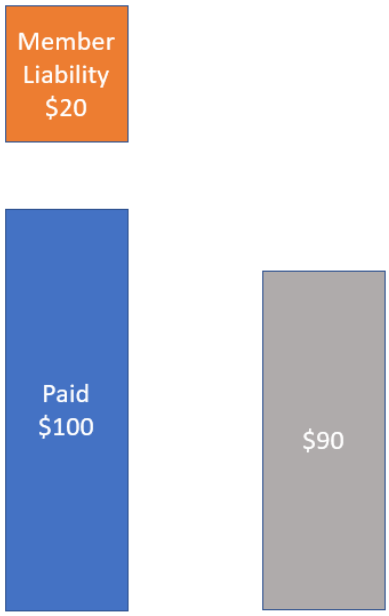


Scenario 2: Commercial or Medicare Primary

Primary Allowed: $120

IHCP Allowed: $90

Anthem Will Pay: $0



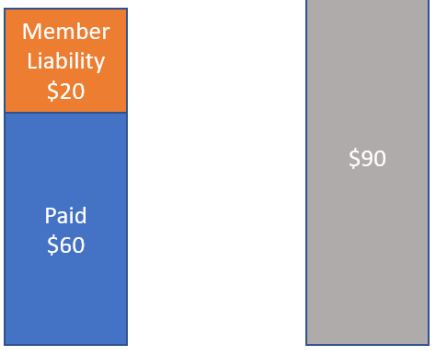
Primary payment exceeded the IHCP allowable therefore no additional payment is made by Anthem.

Scenario 3.A: **Commercial** Primary

Commercial Primary Allowed: $80

IHCP Allowed: $90

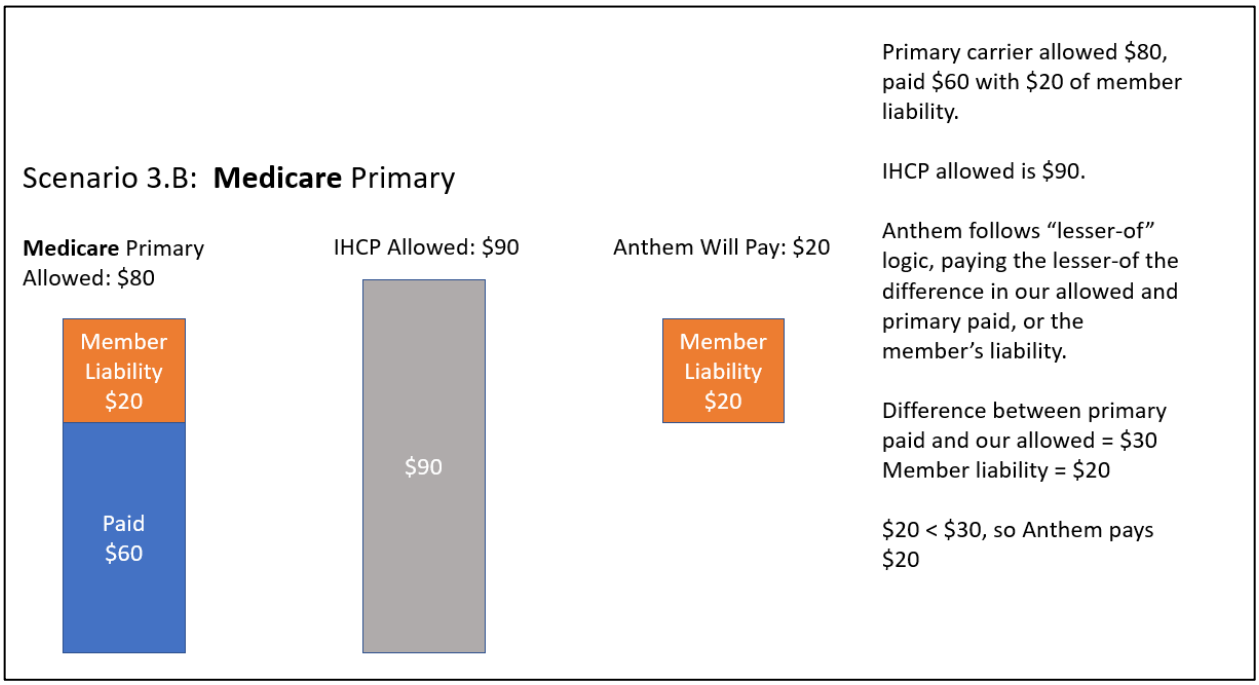
Anthem Will Pay: $30



Primary carrier allowed $80, paid $60 with $20 of member liability.

IHCP allowed is $90.

Anthem pays $30, even though $10 of the difference is provider/primary contractual write-off.



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: **https://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
- Monitor Digital Request for Additional Information (Digital RFAI) with the Medical Attachments application on Availity Essentials and submit needed documentation to process a claim

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 **https://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 and medical review 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 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 HCPCS and CPT manuals are used but changes are made to the codes quarterly or annually.	Only codes recognized by IHCP can be used; therefore, providers must also check IHCP billing

Problem	Explanation	Resolution
	Manuals may be purchased at any technical bookstore, through the American Medical Association or the Practice Management Information Corporation.	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 pay claims using different room rates for the same type of room to adjust for nursing care.	Do not submit bills for nursing charges.

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*

Action	Type of service to be billed	Time frame
		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 **https://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 Virginia Beach, VA 23466	60 days from the date on the claims dispute response.

Processes to resolve claim issues

Issue	Action
Claim denied or **paid the wrong amount** due to incorrect billing by the provider,	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

Issue	Action
or Resubmitting claim returned for information such as: *EOB* of primary insurance, itemized bills, medical records, etc.	the top of the form, 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** • Indiana PathWays for Aging: **833-569-4739** 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 a 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** • Indiana PathWays for Aging: **833-569-4739** Allow 60 days for adjustments but follow up before 90 days. All follow-ups 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 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 CPT codes, 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 Hierarchy

Claims submitted for payments must meet all aspects of the criteria for reimbursement. The reimbursement hierarchy is the order of payment conditions that must be met for a claim to be reimbursed. 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 and 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. Our vendor partner or our internal team may review these claims as part of our itemized bill review (IBR) program to ensure appropriate reimbursement. Upon completion of the review, documentation, including a summary of adjusted charges, will be provided for each claim. Disputes related to the review may be submitted according to the instructions in the Claims Payment Disputes section of this manual.

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 audits or reviews.

Blood, Blood Products, and Administration

Blood and blood products such as platelets or plasma are reimbursable. Administration of Blood or Blood Products by nursing/facility personnel is not separately reimbursable on inpatient claims. Administration of blood or blood products by nursing/facility personnel billed on outpatient claims are separately reimbursable when submitted without observation/treatment room charges.

Charges for blood storage, transportation, processing, and preparation such as thawing, splitting, pooling, and irradiation, are also not separately reimbursable. Lab tests such as typing, Rh, matching, etc., are separately reimbursable charges.

Emergency Room Supplies and Services Charges

The Emergency Room level reimbursement includes all monitoring, equipment, supply, 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 or procedure charge. 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), 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 and are included in the reimbursement 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, and 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, are not separately reimbursable and are included as part of the Operating Room (OR) time/procedure reimbursement. Charges for medications/drugs used for sedation and local anesthesia are separately reimbursable.

Lab Charges

The reimbursement of charges for specimen collection 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, handling, and referral fees are considered included in the procedure/lab test performed and are not separately reimbursable.

We are bound by the *Clinical Laboratory Improvement Amendments* (*CLIA*) of 1988. The purpose of the CLIA program is to ensure laboratories testing specimens in interstate commerce consistently provide accurate procedures and services. As a result of *CLIA*, any laboratory soliciting or accepting specimens in interstate commerce for laboratory testing is required to hold a valid license or letter of exemption from licensure.

Claims that are submitted for laboratory services subject to the *Clinical Laboratory Improvement Amendments* of *1988 (CLIA)* statute and regulations require additional information to be considered for payment.

To be considered for reimbursement of clinical laboratory services, a valid *CLIA* certificate identification number must be reported on a *1500 Health Insurance Claim Form* (*CMS-1500*) or its electronic equivalent for clinical laboratory services. The *CLIA* certificate identification number must be submitted in one of the following manners:

Claim format and elements	*CLIA* number location options	Referring provider name and NPI number location options	Servicing laboratory physical location
***CMS-1500* (formerly *HCFA-1500*)**	Must be represented in field 23	Submit the referring provider name and NPI number in fields 17 and 17b, respectively.	Submit the servicing provider name, full physical address, and NPI number in fields 32 and 32A, respectively, if the servicing address is not equal to the billing provider address. The servicing provider address must match the address associated with the *CLIA* ID entered in field 23.
HIPAA 5010 837 Professional	Must be represented in the 2300 loop, REF02 element, with a qualifier of X4 in REF01	Submit the referring provider name and NPI number in the 2310A loop, NM1 segment.	Physical address of the servicing provider must be represented in the 2310C loop if not equal to the billing provider address and must match the address associated with the *CLIA* ID submitted in the 2300 loop, REF02.

To be considered for reimbursement of reference laboratory services, the referring laboratory must be an independent clinical laboratory. Modifier 90 must be submitted to denote the referred laboratory procedure. Per the Centers for Medicare & Medicaid (CMS), an independent clinical laboratory that submits claims in paper format may not combine non-referred or self-performed and referred services on the same *CMS-1500* claim form. Thus, when the referring laboratory bills for both non-referred and referred tests, it must submit two separate paper claims: one claim for non-referred tests and the other for referred tests. If submitted electronically, the reference laboratory must be represented in the 2300 or 2400 loop, REF02 element, with a qualifier of F4 in REF01.

Providers who have obtained a *CLIA Waiver* or *Provider Performed Microscopy Procedure* accreditation must include the QW modifier when any *CLIA*-waived laboratory service is reported on a *CMS-1500* claim form.

Laboratory procedures must be rendered by an appropriately licensed or certified laboratory having the appropriate level of *CLIA* accreditation for the particular test performed. Thus, any claim that does not contain the *CLIA* ID, has an invalid ID, has a lab accreditation level that does

not support the billed service code, renders services outside of the effective dates of the CLIA certificate, does not have complete servicing provider demographic information, and/or applicable reference laboratory provider demographic information, will be considered incomplete and rejected or denied.

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, nasogastric tube (NGT) insertion, urinary catheter insertion, point of care/bedside testing (such as glucose, blood count, arterial blood gas, clotting time, pulse oximetry, etc.), and inpatient blood transfusion administration/monitoring (with the exception of OP blood administration, OP chemotherapy administration, or OP infusion administration which are submitted without a room charge, observation charges, treatment room charges, or procedure charges other than blood, chemotherapy, or infusion administration).

Operating Room Time and Procedure Charges

The operating room (O.R.) charge will be reimbursed 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 O.R. nurse's notes. The Operating Room is defined as surgical suites, major and minor, treatment rooms, endoscopy labs, cardiac cath labs, Hybrid Rooms, X-ray, pulmonary and cardiology procedural rooms. The operating room charge will reflect the cost of:

- The use of the operating room
- The services of qualified professional and technical personnel
- Any supplies, items, equipment, and services that are necessary or otherwise integral to the provision of a specific service and/or the delivery of services. Refer to the Routine Supplies section of the manual.

Personal Care Items and services

Personal care items used for patient convenience are not separately reimbursable. Examples include but are not limited to the following: breast pumps, deodorant, dry baths, dry shampoo, eye lubricants, lotion, non-medical personnel, mouthwash, powder, soap, telephone calls, television, tissues, toothbrushes, and toothpaste.

Pharmacy Charges

Pharmacy charges will be reimbursed to include only the cost of the drugs prescribed by the attending physician. Medications furnished to patients shall not include an additional separate charge 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. All other services are included in the drug reimbursement rate. Examples of pharmacy

charges that 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 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. Reimbursement for the procedure includes all nursing care provided.

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 all used and/or available services, equipment, monitoring, and nursing care that is necessary for the patient's welfare and safety during their 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 or step-down recovery room (e.g., arteriograms).

Respiratory Services

Mechanical Ventilation/CPAP/BIPAP support and other respiratory and pulmonary function services provided at the bedside are considered facility personnel, equipment, and/or supply charges and not eligible for separate reimbursement.

Routine Supplies

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 supplies and not separately reimbursable in the inpatient and outpatient environments. Reimbursement for routine services and supplies is included in the reimbursement for the room, procedure, or observation charges.

Special Procedure Room Charge

Charges for the Special procedure room, billed in addition to the procedure itself, are included in the reimbursement for the procedure. If the procedure takes place outside of the OR (refer to

Operating Room Time and Procedure Charges for OR definition), then OR time will not be reimbursed to cover OR personnel/staff being present in the room. Example: procedures performed in the ICU, ER, etc.

Stand-by Charges

Standby equipment and consumable items such as oxygen, which are on standby, are not reimbursable. Only actual use is covered. 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, isolation carts, mechanical ventilators, continuous positive airway pressure (CPAP)/bilevel positive airway pressure (BIPAP) machines, and related supplies are not separately reimbursable. Oxygen charges, including but not limited to, oxygen therapy per minute/per hour when billed with room types ICU/CCU/NICU or any Specialty Care area are not separately reimbursable.

Tech Support Charges

Pharmacy Administrative Fees (including mixing medications), any portable fees for a procedure or service, and patient transportation fees when taking a patient to an area for a procedure or test are not separately reimbursable. Transporting a patient back to their room following surgery, a procedure, or a test, is not separately reimbursable.

Telemetry

Telemetry charges in ER/ICU/CCU/NICU or telemetry units (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 from 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.

Undocumented or Unsupported Charges
Charges that are not documented on medical records or supported with documentation are not reimbursed.

Video or Digital Equipment used in Procedures
Charges for video or digital equipment used for visual enhancement during a procedure are included in the reimbursement for the procedure and are not separately reimbursable. Examples include but are not limited to Ultrasound and Fluoroscopy guidance. Charges for batteries, covers, film, anti-fogger solution, tapes, etc., are also not separately reimbursable.

Additional Reimbursement Guidelines for Disallowed Charges
For any Claims that are reimbursed at a percent of charge, only Charges for Covered Services are eligible for reimbursement. 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 the Provider or Facility Agreement. Refer to the contractual fee schedule for payment determination.

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

Examples of non-reimbursable items/services codes (including, but not limited to):	
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
0480 – 0489	Percutaneous Transluminal Coronary

Examples of non-reimbursable items/services codes (including, but not limited to):	
Typically Billed Under This/These Revenue Codes but not Limited to the Revenue Codes Listed Below	**Description of Excluded Items**
	Angioplasty (PTCA) Stand-by Charges
0220, 0949	Stat Charges
0270 – 0279, 0360	Video or Digital Equipment Used in Procedures
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 • Suction

Examples of non-reimbursable items/services codes (including, but not limited to):	
Typically Billed Under This/These Revenue Codes but not Limited to the Revenue Codes Listed Below	**Description of Excluded Items**
	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	**Tech Support Charges** • Pharmacy Administrative Fee (including mixing meds) • Portable Fee (cannot charge a 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 and 99001 – Handling and/or conveyance of specimen from the patient (charge for specimen handling)
0230	Incremental Nursing – General
0231	Nursing Charge – Nursery

Examples of non-reimbursable items/services codes (including, but not limited to):	
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** • Compounding fees • 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
0270, 0300 – 0307, 0309, 0380 – 0387, 0390 – 0392	**Venipuncture** • Specimen collection • Draw fees • Venipuncture • Phlebotomy • Heel stick • Blood storage and processing blood administration • Thawing/Pooling Fees
0270, 0272, 0300 – 0309	Bedside/Point of Care/Near Patient Testing (such as glucose, blood count, arterial blood gas, clotting time, etc.)
0222, 0270, 0272, 0410, 0460	Portable Charges
0270 – 0279, 0290, 0320, 0410, 0460	**Supplies and Equipment** • Oxygen • Instrument Trays and/or Surgical Packs • Drills/Saws (All power equipment used in

Examples of non-reimbursable items/services codes (including, but not limited to):	
Typically Billed Under This/These Revenue Codes but not Limited to the Revenue Codes Listed Below	**Description of Excluded Items**
	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 • Heel/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** (Specifically, conscious/moderate sedation by same physician or procedure nurse) • Nursing care • Monitoring • Intervention

Examples of non-reimbursable items/services codes (including, but not limited to):	
Typically Billed Under This/These Revenue Codes but not Limited to the Revenue Codes Listed Below	**Description of Excluded Items**
	• Pre- or Post-evaluation and education • IV sedation and local anesthesia if provided by the same physician or procedure nurse • Intubation/Extubation • CPR
410	**Nursing/Respiratory Functions:** • Oximetry • Vent management • Medication Administration via Nebs, Metered dose (MDI), etc. • Postural Drainage • Suctioning Procedure
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**) (for Indiana PathWays for Aging contracting

guidance, see the Credentialing and Re-Credentialing Activities Section of the ***Indiana PathWays for Aging Addendum***)

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 is 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.
- Indiana PathWays for Aging members who are 60 years and older and eligible for Medicaid on the basis of age, blindness, or disability and have limited income and resources.

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 in making 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.

CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

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.
- **Obstetrics Prenatal Incentive Program** incentivizes provider groups who meet certain benchmarks for deliveries and completion of prenatal and/or postpartum visits.
- **Behavioral Health Quality 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 update the status of those referrals to indicate that a Member attended that appointment.

- **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.

LTSS-specific value-based provider programs are outlined in the LTSS-specific ***Indiana PathWays for Aging Addendum***.

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, validating encounters with members reflected in claims submitted, 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 of 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 and 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.

As outlined in Administrative Code 405 IAC 1-10.5-5, (a) healthcare-acquired conditions and other provider-preventable conditions apply to all inpatient hospital facility reimbursement to include Medicaid supplemental payments, Medicaid enhanced payments, and Medicaid disproportionate share hospital payments; (b) inpatient stay DRG shall not result in higher payment based on the presence of a healthcare-acquired condition that was not present on the date of admission; (c) if a secondary diagnosis is present on the date of admission, the diagnosis will be included as part of the claim information submitted by an inpatient hospital facility for Medicaid reimbursement to be made; (d) "healthcare-acquired condition" means a condition associated with a diagnosis selected by the Secretary of the U.S. Department of Health and Human Services pursuant to 42 U.S.C. 1395ww(d)(4)(D) and *42 CFR 447.26(b)* and in effect on the date of admission; and (e) the state shall not pay for other provider-preventable conditions, as defined at *42 CFR 447.26(b)*. Anthem requires that providers must identify provider-preventable conditions that are associated with claims for Medicaid payment or with courses of treatment furnished to Medicaid patients for which Medicaid payment would otherwise be available as outlined in federal regulation *42 CFR 447.26(d)*. Additional information can be found at **https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-447/subpart-A/section-447.26**. 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. If Anthem identifies cases involving potential fraud, waste, and abuse with provider billing or service practices (including overpayments), Anthem's payment integrity team will recover identified overpayments and determine if disciplinary action against the provider is warranted.

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. A list of Serious Reportable Events (aka SRE or "never events") can be found at **https://www.qualityforum.org/Topics/SREs/List_of_SREs.aspx**.

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 that 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** > Resources > Provider manuals and guidelines > Medical Policies and Clinical UM Guidelines.

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
- Indiana Code
- Indiana Administrative Code
- Member benefits
- IHCP Provider References Modules, Bulletins, and Banners for state-directed topics
- MCG™ non-customized criteria including Medicare National Coverage Determinations (NCDs) and the Medicare Local Coverage Determinations (LCDs) for Indiana
- Anthem Medical Policy when approved by the state
- Clinical Utilization Management Guidelines when approved by the state
- Anthem Behavioral Health Medical Necessity Criteria when approved by the state
- American Society of Addiction Medicine
- Carelon Medical Benefits Management clinical appropriateness guidelines when approved by the state

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**
- Indiana PathWays for Aging: **833-569-4739**

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 questions and requests are answered within one hour. Any subsequent post-stabilization hospital care provided in an observation setting will not require prior authorization or notification.

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	Indiana PathWays for Aging
Providers: **866-408-6132** Members: **866-408-6131**	Providers: **844-533-1995** Members: **866-408-6131**	Providers: **844-284-1798** Members: **844-284-1797**	Providers: **833-569-4739** Members: **833-412-4405**

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.

Prior Authorization tools on Availity

The quickest, most efficient way to request prior authorization is to use our secure provider website Availity, and/or the Interactive Care Reviewer (ICR) via Availity at **https://Availity.com**. Availity offers a streamlined and efficient experience for providers requesting inpatient and outpatient medical and behavioral health services for Anthem members. Providers can also use these tools to inquire about previously submitted requests regardless of how they were submitted (phone, fax, Availity, or ICR via Availity, or another online tool). The Availity Prior Authorization tools and/or 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 Availity/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 CPT code
- Date of injury or hospital admission and third-party liability information (if applicable)
- Facility name and NPI (if applicable)
- Primary medical provider
- Specialist or attending physician name and NPI
- 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 plan

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
- 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 hospital (LTACH)
- 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

Dual Eligible Members

- Dual aligned: Members that have Anthem Medicare Advantage and Anthem Medicaid
- Dual unaligned: Members that have traditional Medicare or Medicare Advantage with another
- MCE and Anthem Medicaid
- HIDE SNP: Highly Integrated Dual Eligible Special Needs Plan
    - A HIDE SNP is an integrated care plan that combines the benefits of Medicare Advantage and Medicaid from a managed care entity (MCE) into a more unified care plan.
- Physical health UM will review Medicaid PAs when Medicare is denied or the request is for a non-covered benefit
- Behavioral health UM will review Medicaid PAs when Medicare is denied or the request is for a non-covered benefit

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. Peer-to-peer and appeal requests 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 will be 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 digitally by Availity or via surface mail letter.

Pre-service review time frame

For routine, non-urgent requests, the UM team will complete preservice reviews within **5 business days (not including weekends and state-approved holidays)** 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 digitally by Availity or via surface mail letter within **five business days** from receipt of the request for the UM team's approval, modification, or denial.

Urgent requests
For urgent requests, the UM team completes the pre-service review within **48 hours** 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.

Emergent review time frame

For initial and concurrent emergent review requests, the UM team will complete the review and send a decision notification to providers and members within 48 hours.

Retrospective review time frame

Retrospective reviews, which are review requests received on or after the date of inpatient discharge, are reviewed and decision notification is sent to providers and members within 30 calendar days of request.

Timeliness of utilization management decisions	• For non-urgent pre-service requests: within five business days • For urgent pre-service requests: within 48 hours • For concurrent reviews: within 48 hours • 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 inpatient admission to the hospital, providers must notify Anthem within 48 business 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*, which contains thousands of diagnosis codes. Anthem compares the first six diagnosis codes on the claim against the state's *ED Autopay List*; if any of the first six diagnosis 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.

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, any subsequent post-stabilization hospital care provided in an observation setting will not require prior authorization or notification. Claims for observation will pay according to benefits, without clinical review.

For subsequent inpatient 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 48 hours of that notification. Providers can reach the Health Plan 24 hours a day, seven days a week via our provider services helpline. The helpline will respond to questions regarding the provider's request for continued treatment after the health plan's member has been stabilized and the emergency room provider believes continued treatment is necessary to maintain stabilization within one hour.

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.

In situations where the plan representative and the treating physician cannot reach an agreement concerning the member's care, the health plan must allow the treating physician to consult with a health plan physician, and the treating physician may continue with the care of the patient until a plan physician is reached or one of the following conditions is met:
- A health plan physician with privileges at the treating hospital assumes responsibility for the member's care.
- A health plan physician assumes responsibility for the member's care through transfer.
- A health plan representative and the treating physician reach an agreement concerning the member's care.
- The member is discharged.

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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 business 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 Indiana Medicaid 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 that more 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 a preservice or initial emergent 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, acute inpatient rehabilitation, long-term acute care hospitals, or skilled nursing facilities. Anthem identifies member admissions by utilizing data obtained via the following methods:

- Facilities reporting admissions
- Providers 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 guidelines, 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 48 hours of receipt of clinical documentation. 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 48 hours of the determination.

Denial of service

Only a medical or behavioral health practitioner 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 member, requesting provider,

servicing provider, and servicing facility will be notified of the decision. The provider and facility will also be informed of the processes for reconsideration, and how to reach the reviewing physician for peer-to-peer discussion of the case, or appeal.

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, P2P, or appeal of denied services:

- Reconsideration ― within seven business days of the denial date
- P2P ―
    - Healthy Indiana Plan, Hoosier Care Connect, Hoosier Healthwise: within seven business days of the denial date (initial or reconsideration)
    - Indiana PathWays for Aging: within fifteen business days of the denial date (initial or reconsideration)
- Appeals ― within 60 calendar days of the 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 provider. Second opinions regarding medical necessities are offered at no cost to our members.
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Behavioral health

For information about behavioral health services, please see **Chapter 5: Behavioral health**.
Indiana PathWays for Aging – information can be found in the ***Indiana PathWays for Aging Addendum*.**

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, Inc.

Anthem's subsidiary Carelon Medical Benefits Management, Inc. will provide a health services review for prior authorization (PA) of the following services:

Outpatient habilitation and rehabilitation services
Carelon Medical Benefits Management, Inc. provides PA reviews for physical therapy, occupational therapy, and speech therapy.

Outpatient imaging services
The service requests reviewed by Carelon Medical Benefits Management, Inc. 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
Carelon Medical Benefits Management, Inc. provides PA reviews for sleep disorder testing and treatment.

Genetic testing
Carelon Medical Benefits Management, Inc. provides PA reviews for genetic testing services.

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 reviewed by Carelon Medical Benefits Management, Inc. 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, Inc. website at **www.providerportal.com** or access the Carelon Medical Benefits Management, Inc. website via Availity at **https://Availity.com**.
- Providers may contact Carelon Medical Benefits Management, Inc. 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 with 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 at any time after the provider or member becomes 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 Informal Disputes:** This is the first step in the provider payment dispute process. The claim payment informal dispute or 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 Formal 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 formal 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
A good cause determination will be based primarily on the statements or evidence you submit and a determination of whether or not the evidence leads to doubt about the validity of the statements. If necessary, we will contact you for clarification or additional information to make the good cause determination. If you cannot demonstrate good cause, our untimely filing decision will stand, and your claim(s) will not be considered for further payment.
Good cause may be established by the following:

- Administrative error: incorrect or incomplete information furnished by official sources (for example, carrier, intermediary, the Centers for Medicare & Medicaid Services, etc.) to the provider or supplier
- Retroactive enrollment (retroactive eligibility posting affecting the processing of the original submitted claim or for other events affecting the dispute submission that are out of the provider's control)
- Incorrect information furnished by the member to the provider or supplier resulting in erroneous filing with another care management organization plan or the state
- Unavoidable delays in securing the required supporting claim documentation or evidence from one or more third parties despite reasonable efforts by the provider/supplier to secure such documentation or evidence
- Unusual, unavoidable, or other circumstances beyond the service provider's control that demonstrate the provider or supplier could not reasonably be expected to have been aware of the need to file in a timely manner
- Destruction or other damage to the provider's or supplier's records unless such destruction or damage was caused by the provider's or supplier's willful act of negligence

Informal Claim Disputes
The first step in the claim payment dispute process is called informal claim dispute or reconsideration. It is your initial request to investigate the outcome of a finalized claim. Note that we cannot process an informal dispute without a finalized claim on file.

We accept informal 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). Informal disputes filed more than 60 days from the *EOP* will be considered untimely and denied unless good cause can be established.

When submitting informal disputes, 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 an informal dispute requires clinical expertise, the appropriate clinical professionals will review it. Anthem will

make every effort to resolve the claims payment informal dispute 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 informal dispute or 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.

Formal Appeals

If you are dissatisfied with the outcome of a reconsideration determination, you may submit a claim payment appeal. Note that we cannot process a formal appeal without an informal dispute on file. We accept formal appeals through our provider website or in writing within 60 calendar days of the date on the reconsideration determination letter.

Formal 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 formal appeal, please include as much information as you can to help us understand why you think the informal dispute determination was in error. If a claim payment formal appeal requires clinical expertise, it will be reviewed by appropriate clinical professionals.

Anthem will make every effort to resolve the formal 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 formal 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 informal disputes only): Call Provider Services.
- Online (for informal dispute and formal appeals): Use the secure **Provider Availity Payment Appeal Tool** at **https://Availity.com**. Through Availity, you can upload

supporting documentation and will receive immediate acknowledgment of your submission.
- Written (for informal dispute and formal appeal) – 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 (Formal and Informal):
- 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

If you are dissatisfied with the decision of a formal appeal, you may submit the matter to binding arbitration in accordance with your provider agreement. Anthem will work with you to resolve the matter.

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/Prior Authorization 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. This process is in accordance with the member appeal process such that providers may assist the member with their appeal.

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:** At any time after 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 at any time 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's grievance, 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 *42 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**
  - Indiana PathWays for Aging: **833-412-4405**
  - 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, Hoosier Care Connect, and Indiana PathWays for Aging 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 who 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

Indiana PathWays for Aging member enrollment information is located in the Individual Enrollment Section of the ***Indiana PathWays for Aging Addendum*.**

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.

Indiana PathWays for Aging members are able to disenroll from Anthem in accordance with 42 CFR 438.3(q)(5); 42 CFR 438.56(c)(1); and 42 CFR 438.56(c)(2)(i)-(iii).

- For just cause at any time.
- Without cause within ninety (90) days after initial enrollment or during the ninety (90) days following notification of enrollment, whichever is later.
- Without cause at least once every twelve (12) months.
- Without cause when Anthem repeatedly fails to meet substantive requirements in sections 1903(m) or section 1932(e)(2)(B)(ii) of the Social Security Act and 42 CFR 438.56(b)-(d).
- Without cause upon reenrollment if a temporary loss of enrollment has caused the enrollee to miss the annual disenrollment period.

Additional member rights to disenroll from Indiana PathWays for Aging include:

- During a plan selection period which will be aligned with the Medicare open enrollment window (mid-October to mid-December) to be effective the following calendar year.

In accordance with 42 CFR 438.56(d)(2)(i)-(v), members may request disenrollment if the:

- Member moves out of the service area.
- Anthem does not cover the service the enrollee seeks because of moral or religious objections.
- Member needs related services to be performed at the same time and not all related services are available within the provider network. The member's provider must determine that receiving the services separately would subject the member to unnecessary risk.
- Anthem's provider status changes from in-network to out-of-network and causes the member to have to change their residential, institutional, or employment supports provider, and, as a result, the member would experience a disruption in their residence or employment. This requirement is specific to LTSS programs.
- Member experiences poor quality of care, lack of access to services covered, or lack of access to providers experienced in dealing with the member's care needs.

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), **833-412-4405** (Indiana PathWays for Aging), or **(TTY 711)**.
- Get information about Anthem's structure and operation.
- Be treated with respect and with due consideration for their dignity and privacy.

- Receive information on available treatment options and alternatives, presented in a way that is right for their condition and that they can understand.
- Voice complaints or appeals about Anthem, the plan, or the care it provides.
- Make an Advance Directive.
- 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 that the date they joined Anthem is the date their benefits begin, and Anthem will not cover services they received before that date.
- Choose a primary medical provider (PMP) who is part of the network and change their PMP without cause or reason.
- 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 have and review a care plan and a service plan, and the right to refuse treatment.
- Know which hospitals they should use and have access to them.
- 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. 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 in a culturally competent manner.
- 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.
- Find out how Anthem decides if new technology or treatments should be part of a benefit.
- Have their problems taken care of quickly. This includes things they think are wrong, as well as issues that have to do with their benefits, 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), **833-412-4405** (Indiana PathWays for Aging), or **(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.
- Know that Anthem can make changes to their health plan benefits as long as we tell them in writing before the changes take effect.
- Know that Anthem does not take the place of workers' compensation insurance.
- 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).
- For Indiana PathWays for Aging members,
    - Have a care coordinator they can contact directly who will develop a care plan with them. Their care coordinator will work with them, their caregiver, their healthcare providers, and other service providers to assess their healthcare needs and ensure they are met.
    - Have a service coordinator they can contact directly who will develop a service plan with them if they are receiving home- and community-based services.
    - Have the right to request a fair hearing if they are not given the choice of home- and community-based waiver services instead of the institutional level of care, if they are denied the service(s) or the provider(s) of their choice, or if their services are denied, suspended, reduced, or terminated. The right to request a fair hearing includes providing a notice of action.
- 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, health condition, or disability

Members have the following responsibilities:

- Tell us, their doctor, and other healthcare providers what we need to know to treat them.
- Provide information to help us and their healthcare providers know how to support their healthcare needs.
- 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, or let us know when the plan needs to be adjusted to help them be successful in reaching their goals.
- 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 or reach out to us for support as 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, waste, and abuse

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. This includes any act that constitutes fraud under applicable Federal or State law.
- **Waste:** Includes overusing services, or other practices that, directly or indirectly, result in excessive costs. Waste is generally not considered to be driven by intentional actions, but rather occurs when resources are misused.
- **Abuse:** Behaviors that are inconsistent with sound financial, business, and medical practices and result in unnecessary costs and payments for services that are not medically necessary or fail to meet professionally recognized standards for healthcare. This includes any member actions that result in unnecessary costs.

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 or 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 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, waste, and abuse:

- 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
- 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, waste, and abuse:

- 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

When reporting concerns involving a member include:

- The member's name
- The member's date of birth, member ID, 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 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.

- **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.

Offsets. Anthem shall be entitled to offset claims and recoup an amount equal to any overpayments ("Overpayment Amount") or improper payments made by the health plan to Provider or Facility against any payments due and payable by the health plan to Provider or Facility with respect to any Health Benefit Plan under any contract with our company regardless of the cause. Provider or Facility shall voluntarily refund the Overpayment Amount regardless of the cause, including, but not limited to, payments for Claims where the Claim was miscoded, non-compliant with industry standards, or otherwise billed in error, whether or not the billing error was fraudulent, abusive or wasteful. Upon determination by the health plan that an Overpayment Amount is due from Provider or Facility, Provider or Facility must refund the Overpayment Amount within the timeframe specified in the letter notifying the Provider or Facility of the Overpayment Amount. If the Overpayment Amount is not received within the timeframe specified in the notice letter, the health plan shall be entitled to offset the unpaid portion of the Overpayment Amount against other Claims payments due and payable by Anthem to Provider or Facility under any Health Benefit Plan in accordance with Regulatory Requirements. Should Provider or Facility disagree with any determination, Provider or Facility shall have the right to appeal such determination under Anthem procedures set forth in this Provider Manual, on condition that such appeal shall not suspend Anthem's right to recoup the Overpayment Amount during the appeal process unless required by Regulatory Requirements.

Anthem reserves the right to employ a third-party collection agency in the event of non-payment.

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.

Addendum to the *Anthem Blue Cross and Blue Shield Indiana Medicaid Provider Manual*

Indiana PathWays for Aging

This supplement to the Anthem Indiana Medicaid provider manual specifically discusses the Indiana PathWays for Aging program. For all other information, please refer to the general Anthem Indiana Medicaid provider manual. Indiana PathWays for Aging is a statewide coordinated care program for Indiana's Medicaid enrollees who are 60 years of age and older and are eligible for Medicaid on the basis of age, blindness, or disability and have limited income and resources.

Enrollees include members who have a full Medicare benefit, those in a nursing facility, and those who are receiving long-term services and supports (LTSS) in a home or community-based setting. Anthem's fundamental approach through the PathWays program is founded on person-centered principles and practices to facilitate member- and family-driven services and supports that are responsive and meaningful to evolving preferences, support needs, and personal goals.

Anthem is dedicated to assisting all members in exploring service and support options to maximize community integration in alignment with their personal goals. Through this commitment, Anthem supports members to succeed in communities of their choice and also partners with providers, stakeholders, and associations.

The primary quality goals of this program are to:

- Develop service plans and deliver services in a manner that is person-centered, member-

driven, holistic, involves caregivers, and addresses social drivers of health (SDOH).
- Ensure continuity of care and seamless experiences for members as they transition into the Indiana PathWays for Aging program among providers, settings, or coverage types.
- Assure timely access to appropriate services and supports to enable members to live in their settings of choice and promote their well-being and quality of life.

Long-term services and supports (LTSS) providers will be assigned a local and dedicated Provider Relations representative who will work hand-in-hand with them and provide in-person and virtual education and training to include monthly webinars, office hours, and onboarding orientations to support Providers in Indiana PathWays for Aging.

Provider Relations roles and responsibilities include, but are not limited to:
- Providing one-on-one technical assistance and dedicated LTSS subject matter expertise
- Helping providers comply and maintain compliance with the HCBS Settings Rule
- Providing tailored onboarding through support visits, visit tools, and training
- Connecting providers with Anthem subject matter experts as innovative programs are introduced
- Providing ongoing quality monitoring and training
- Developing and implementing the Provider Engagement Plan
- Assisting with workforce development supports
- Providing service initiation and supporting the network development plan
- Conducting quality monitoring and implementing corrective action plans as necessary, providing ongoing LTSS provider reports

The LTSS Provider Relations Representatives will collaborate with the Workforce Development Administrator and Provider Capacity Specialists who will work with providers in assessing their workforce barriers and identifying financial incentives, training, and tools needed for providers to increase their capacity (through recruitment, retention, and training).

Quick Reference Information

Please call Indiana PathWays for Aging Provider Services at **833-569-4739** for precertification/notification, health plan network information, individual eligibility, claims information/questions, inquiries, and recommendations you may have about improving our processes and managed care program. An Anthem representative will acknowledge all inquiries within 2 business to review/discuss questions/concerns submitted through email, phone calls, faxes, and letters.

Contact Information

Providers can call Provider Services at 833-569-4739 for:
- A Provider Services representative — available Monday through Friday, 8 a.m. to 8 p.m. Eastern time.
    - This helpline will be closed on New Year's Day, Martin Luther King Jr. Day, Memorial Day, Independence Day (July 4th), Thanksgiving, and Christmas.
    - Speak to a live agent about precertification/notification, health plan network information, individual eligibility, claims information, and inquiries.
- Automated Provider Inquiry Line, interactive voice response service — 24 hours a day, 7

days a week.
    - Check claims status and eligibility.
    - Request interpreter services.
- Provider Relations Department: **833-569-4739**
- Provider Website: **https://providers.anthem.com/in**
- LTSS Provider Relations Email: INMLTSSProviderRelations@anthem.com
- Behavioral Health Services Fax: **877-410-0623**
- Behavioral Health Crisis Line (available 24 hours a day, 7 days a week): **833-874-0016**
- Electronic Data Interchange (EDI) Hotline: **800-470-9630**
- Electronic Visit Verification (EVV) Help Desk: **800-457-4584**, **option 5**
- Fraud, Waste, and Abuse Hotline: **877-283-1524**
- Grievances and Appeals:
    - Phone: **833-569-4739**
    - Fax: **855-535-7445**
- Availity: **800-AVAILITY** (**800-282-4548**)
- EVV Assistance email box: **DL-Indianaevv@anthem.com**

Enrolled members can call 833-412-4405 for:

- Member services — available Monday through Friday, 8 a.m. to 8 p.m. Eastern time
- The Nurse HelpLine **833-412-4405**:
    - Clinical services are available 24 hours a day, 7 days a week.
    - We can help coordinate behavioral healthcare needs.

State of Indiana Contact Information:

- Indiana Health Coverage Programs (IHCP) Provider Customer Assistance: **800-457-4585**
- Member Customer Assistance: **800-457-4584**
- Member Applications: **800-403-0864**
- Website: **https://www.in.gov/medicaid/providers/**
- IHCP Quick Reference Guide: **IHCP Quick Reference Guide (in.gov)**
- Eligibility: **800-403-0864**
- Grievances and Appeals:
    Office of Administrative Law Proceeding
    402 W. Washington St, Room E034
    Indianapolis, IN 46204-2739
    317-233-4454
- Indiana Division of Disability and Rehabilitation Services: **https://www.in.gov/fssa/ddrs/**
- Indiana Division of Mental Health and Addiction: **https://www.in.gov/fssa/dmha/**
- Indiana Office of Medicaid Policy and Planning (OMPP): **https://www.in.gov/fssa/ompp**
- Indiana Family and Social Services Administration (FSSA):
    402 Washington St.
    Room W374, MS07
    Indianapolis, IN 46204-2739
    317-233-4454
    https://www.in.gov/fssa
- IHCP Provider Healthcare Portal: **portal.indianamedicaid.com**
- Indiana Tobacco Quitline: **800-784-8669**

Member Eligibility

Nursing Facility Level of Care (NFLOC) is determined based on state law and administrative rules. The population for this program is individuals 60 and older who are eligible for Medicaid on the basis of age, blindness, or disability and have limited income and resources. This includes members who have full Medicare benefits and those in nursing facilities. Eligibility requirements for the Indiana PathWays for Aging program include:

- Individuals aged 60 years of age or over who are enrolled in Medicaid based on eligibility as:
    - Aged (MA A).
    - Blind (MA B).
    - Disabled (MA D).
    - SSI recipients (MASI).
    - MED Works (MADW, MADI).
    - Full-Benefit Dually Eligible individuals (QMB-also, SLMB-also, and FBDE).
- Including those who are:
    - Eligible for the A&D waiver.
    - In a nursing facility.
    - Receiving hospice services.
- Those with functional eligibility as determined by the InterRAI Assessment.

Member Enrollment

For individuals who come into the program with no current Medicaid coverage, MCE assignment will be effective on the date of eligibility approval. Medicaid coverage may be effective up to three (3) months retroactively from their application date. Retroactive coverage will be in the fee-for-service (FFS) program; the managed care assignment will not be retroactive. For individuals transitioning from an existing Medicaid Managed Care program or FFS, MCE assignment will be effective the first day of the month following the notice of change in eligibility.

Plan selection can be made by calling the enrollment broker within sixty (60) days of coverage start. The enrollment broker will be responsible for providing choice counseling to the member. If a member does not select a plan, there will be an assignment process in place directed by the State. Plan assignment will favor plan alignment between Medicare and Medicaid to the greatest extent allowable. Other factors may be considered, such as the residential provider of the member (if applicable).

In accordance with 42 CFR 438.3(q)(5), 42 CFR 438.56(c)(1), and 42 CFR 438.56(c)(2)(i)-(iii), members have the right to disenroll from the Anthem:

- For just cause at any time.
- Without cause within ninety (90) days after initial enrollment or during the ninety (90) days following notification of enrollment, whichever is later.
- Without cause at least once every twelve (12) months.
- Without cause when Anthem repeatedly fails to meet substantive requirements in sections 1903(m) or section 1932(e)(2)(B)(ii) of the Social Security Act and 42 CFR 438.56(b)-(d).

- Without cause upon reenrollment if a temporary loss of enrollment has caused the enrollee to miss the annual disenrollment period.

Additional member rights to disenroll from Indiana PathWays for Aging include:

- During a plan selection period which will be aligned with the Medicare open enrollment window (mid-October to mid-December) to be effective the following calendar year.

In accordance with 42 CFR 438.56(d)(2)(i)-(v), members may request disenrollment if the:

- Member moves out of the service area.
- Anthem does not cover the service the enrollee seeks because of moral or religious objections.
- Member needs related services to be performed at the same time, and not all related services are available within the provider network. The member's provider must determine that receiving the services separately would subject the member to unnecessary risk.
- Anthem's provider status changes from in-network to out-of-network and causes the member to have to change their residential, institutional, or employment supports provider, and, as a result, the member would experience a disruption in their residence or employment. This requirement is specific to LTSS programs.
- Member experiences poor quality of care, lack of access to services covered, or lack of access to providers experienced in dealing with the member's care needs.

Indiana PathWays for Aging Referrals

Providers are selected during the member assessment process completed by Anthem. Petitioning members with the expectation of being selected as the service provider or petitioning existing members who receive Indiana PathWays for Aging services to change Indiana PathWays for Aging providers is prohibited. Additionally, communicating with hospitals, discharge planners, or other institutions for the purposes of soliciting potential Indiana PathWays for Aging members is prohibited. Requests from a provider to be added as a service provider for any member will prompt the assigned Indiana PathWays for Aging coordinator to outreach to the member for clarification of the member's preference. Updates to add service providers are solely driven by members and their designated representatives.

HCBS Credentialing and Re-credentialing activities

HCBS providers are excluded from the National Committee for Quality Assurance (NCQA) guidelines and therefore are not required to go through a traditional credentialing process. Instead, Anthem reviews the provider's compliance with contractual requirements and ensures the provider's eligibility to participate in the program, thus resulting in a *deemed credentialed* status.

Initial Credentialing/Certification

Anthem's network of providers must be credentialed and re-credentialed in a manner that is consistent with the National Committee for Quality Assurance (NCQA). However, for all HCBS providers, Anthem does not conduct traditional NCQA credentialing. Anthem works with FSSA, Division of Aging (DA), Office of Medicaid Policy and Planning, IHCP, and contracted providers to develop and implement a consolidated process for (deemed) credentialing and

(deemed) re-credentialing home- and community-based providers, included in the Indiana PathWays for Aging LTSS Program, that seeks to minimize MCE and provider burden resulting from duplicative review processes when a provider is certified with IHCP.

Per advisement from FSSA, Anthem will deem HCBS providers as credentialed (certified) and offer a provider agreement to all qualified HCBS providers certified by IHCP, meeting the necessary provider qualifications set out in 455 IAC 1-3 and in the IHCP provider manual. Anthem abides by the "deemed" status and does not establish additional requirements, credentialing processes, or standards for participation in the Anthem network. Upon application, Anthem will review the below-listed documents submitted to verify certification and enrollment are accurate and in accordance with the provider's qualifications.

After an initial application for network participation, (deemed) credentialing/certification of LTSS providers will include the collection of required documents, including but not limited to:

- Copy of the certification letter verifying that the provider is approved through the Division of Aging (DA)/Office of Medicaid Policy and Planning (OMPP) and Indiana Health Coverage Program
- Copy of current Certificate of Insurance (COI) — see property and personal liability insurance as required by 455 IAC 2-6-2 and 455 IAC 2-12-1(4)
- Current *W-9* form
- In addition to the required documentation, Anthem's LTSS Provider Qualifications include that a provider:
    - Is not excluded from participation in the LTSS program by the Federal Government under Section 1128 or Section 1128A of the Social Security Act or by the State's Medicaid program for fraud, abuse, or neglect
    - Is certified by the Division of Aging (DA)/Office of Medicaid Policy and Planning (OMPP) to provide waiver services
    - Is not an individual or entity who is debarred, suspended, or otherwise excluded from participating in accordance with 42 CFR 438.610, as defined in the Federal Acquisition Regulation, of a person described above
    - For non-HCBS providers only, has a National Provider Identifier (NPI) Number OR
    - Has a Legacy Provider Identifier (LPI) obtained from Indiana Health Coverage Programs (IHCP) through Gainwell Technologies
    - Is compliant with the HCBS Settings Rule detailed in 42 CFR § 441.301(c)(4)-(5)
    - Maintain records of services provided for 10 years in accordance with 455 IAC 2 Maintenance of records of services provided
    - FSSA's access and availability standards
    - Is compliant with accessibility standards issued under the Americans with Disabilities Act (ADA) where applicable
    - Has policies and processes in place to ensure:
        - Appropriate use of the EVV system
        - Cultural and linguistic competency and training

Re-Credentialing

Traditional NCQA re-credentialing for applicable provider types occurs on a three-year cycle. Recognizing that this is not applicable to HCBS providers, ongoing Indiana PathWays for Aging

HCBS provider's eligibility for program participation is verified (ensure ongoing [deemed] credentialing/certification status) annually.

As part of ongoing recredentialing requirements, Anthem will review HCBS provider data, including but not limited to HCBS utilization management, HCBS provider satisfaction scores, and HCBS Settings Rule reviews to assess the provider's continued participation in the network. Additionally, LTSS Provider Relations shall conduct Support Visits to ensure providers remain in compliance with contractual requirements and the provider's eligibility to participate in the program (IHCP standards). The assigned Provider Relations Representative will utilize an LTSS Provider Relations Site Visit Tool prescribed by FSSA to document and track continued program eligibility. At a minimum, recredentialing of HCBS providers shall include verification of continued licensure (only as applicable) and/or certification; compliance with policies and procedures identified during credentialing.

Electronic Visit Verification System

The 21st Century Cures Act (CURES Act), signed into law on December 13, 2016, requires states to implement an Electronic Visit Verification (EVV) system for Personal Care Services and Home Health Care Services. Services excluded from Indiana EVV requirements are:

- Self-direction
- Healthcare coordination
- Structured family care
- Caregiver coaching
- Behavior management

Providers are responsible for ensuring their chosen EVV system complies with federal requirements for documentation of the following visit information:

- Type of service performed
- Individual receiving the service
- Date of the service
- Location of service delivery
- Individual providing the service
- Time the service begins and ends

Providers are required to use EVV for recording visits for all personal care and home health services outlined in the **IHCP Provider Code tables.** The tables outline the impacted procedure code and modifier combinations.

Primary methods of capturing records are:

- Mobile Visit Verification (smartphone application)
- Telephonic Visit Verification (using a member's landline telephone)

Anthem encourages the use of mobile or telephonic visit verification to capture visit information. In the event neither method is available manual visit entry is available, to document visit information. Anthem will monitor visit information for excessive use of manual visit entry method and proactively support providers to reduce the number of visits that are manual entry as a percentage of total visits recorded.

Contracted providers must have at least two staff persons fully trained on the EVV system who can train others on using the device in the member's home. An additional expectation is that at least one staff person with the contracted provider is dedicated to monitoring activity and supporting the proper use of visit verification, including monitoring the use of manual visit entry.

Anthem's claims adjudication system is integrated with the state-sponsored EVV aggregator, Sandata Technologies, for claims matching. When a provider submits a claim through Availity/CareCentral with a procedure code requiring EVV data elements, Anthem's claims system will place the claim in a pending status and perform a check with the Sandata aggregator.

Soft Launch (Claims will not be denied if EVV elements are not present): [7/1/2024 - TBD]
If there is a match (all EVV data elements are present), the claim will continue to payment. If no match is found (no corresponding EVV visit), the claim will continue to payment with the following codes on the Explanation of Payment (EOP):

- ZIG: No visit found
- ZIF: Unmatched units

Hard Launch (Claims will be denied if EVV elements are not present): [Date TBD]
If there is a match (all EVV data elements are present), the claim will continue to payment. If no match is found (no corresponding EVV visit), the claim will deny the following codes on the Explanation of Payment (EOP):

- ZIG: No visit found
- ZIF: Unmatched units

Performance Metrics for Provider Compliance

Anthem monitors the following criteria to determine provider agency compliance:

- Manual visit entry percentage as a percentage of total visits recorded

LTSS for Individuals Enrolled in Indiana PathWays for Aging

In addition to the physical and behavioral health benefits listed in the Medicaid provider manual, we provide LTSS services (including HCBS and nursing facility care) to members who have been enrolled in the Indiana PathWays for Aging program.

The following Long-Term Services and Support Benefits are available to members enrolled in Indiana PathWays for Aging when the services have been determined medically necessary through the Anthem assessment process and documented in the member's authorized initial person-centered support plan and comprehensive assessment.

LTSS/HCBS Services and Limitations

Service	Limitation
Adult Day Services	ADS are allowed for a maximum of 10 hours per day.
Adult Family Care	No more than 4 waiver participants residing in a home. If there are more than 4, the provider would have to be licensed as an assisted living facility.
Assisted Living	If a member is in the facility just one day out of the entire month, the AL may bill charges for the entire month with the exception of initial admit and final discharge months – which the billing would be daily.
Attendant Care	Please see the waiver language about DSPs transporting members to medical appointments and transportation out of state.
Care Management	N/A
Caregiver Coaching and Behavior Management	The following restrictions are made for Caregiver Coaching and Behavior Management: • Medicaid-participating Structured Family Caregiving agencies may be service providers; agencies must employ caregiver coaches with the experience and qualifications appropriate to the needs of each family. • Educational content delivered by provider agencies to caregivers and delivery methods must be appropriate to the needs of lay caregivers. Note: Maximum billable quarter hours units per month is 32
Community Transition	The following restrictions are made for community transition services: • This service is only available for people transitioning from an NF after having a 90-day or longer admission. This is IN's Money Follows the Person. • Reimbursement for community transition is limited to a lifetime cap for setup expenses of up to $1,500. • When the participant is discharged from the facility, the community transition service must be identified, ordered, delivered, and reimbursed within three months. • The state will not bill for federal financial participation (FFP) until after the participant departs the institution and enters the waiver.
Home and Community Assistance	N/A
Home-Delivered Meals	No more than 2 meals per day. Providers will send meals 2 weeks at a time. If a member switches

Service	Limitation
	providers prior to receiving the meals, the old provider will not be able to bill. The service coordinator must collaborate with both providers on billing.
Home Modification Assessment	An annual cap of $574.38 is available for home modification assessment services unless Anthem requests an additional assessment to help mediate disagreements between the home modification provider and the participant.
Home Modifications	The following limits apply to the home modification service: • A lifetime cap of $20,000 is available for home modifications – installation (procedure code and modifier S5165 U7 NU); however, the cap on any single project is $15,000. The cap represents a cost for basic modification of a participant's home for accessibility and safety and accommodates the participant's needs for housing modifications. • The cost of a home modification includes all materials, equipment, labor, and permits to complete the project. No parts of a home modification may be billed separately as part of any other service category (such as specialized medical equipment). • In addition to the $20,000 lifetime cap, $1,000 is allowable annually for the repair, replacement, or an adjustment to an existing home modification that was funded by an HCBS waiver. • Home modification — maintenance is limited to $1,000 annually for the repair and service of environmental modifications that have been provided through an HCBS waiver. The following apply for these home modification maintenance services: • Requests for service must detail parts cost and labor cost. • If the need for maintenance exceeds $1,000, the care manager will work with other available funding streams and community agencies to fulfill the need. If service costs exceed the annual limit, those parts and labor costs funded through the waiver must be itemized clearly to differentiate the waiver service provision from those parts and labor funded through a nonwaiver funding source. • Items requested that are not listed in the Allowable Activities section must be reviewed

Service	Limitation
	and a decision rendered by the state DA director or state agency designee. • Requests for modifications at two or more locations may only be approved at the discretion of the DA director or designee. • Requests for modifications may be denied if the state DA director or State agency designee determines the documentation does not support residential stability and/or the service requested. • The services under home modifications are limited to additional services not otherwise covered under the Medicaid State Plan, including Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) but consistent with waiver objectives of avoiding institutionalization.
Integrated Health Care Coordination	IHCC services will not duplicate services provided under the Medicaid State Plan or any other waiver service. IHCC services are: • A minimum of one face-to-face visit per month • Not to exceed 16 hours of healthcare coordination per month, including travel time
Nonmedical Transportation	Services provided under nonmedical transportation services will not duplicate services provided under the Medicaid State Plan or any other waiver service.
Nursing Facility	Nursing Facility Services outside of the state of Indiana will not be covered. The following apply for Nursing Facility services: • Bed-holds will not be reimbursed as a member benefit unless the member is receiving hospice care. • Anthem will ensure Nursing Facilities do not charge members for services not requested. • Will educate members and the Nursing Facility on any bed-hold policies and periods. • Anthem will inform members in writing, prior to a hospital transfer for therapeutic leave that bed-holds will not be reimbursed by Medicaid. • Anthem has a written policy regarding members' readmission to the Nursing Facility, members will be admitted to the first available bed; semi-private if required and member is eligible for nursing facility-level services.
Nutritional Supplements	The following limits apply to nutritional supplements services: • An annual cap of $1,200 is available for

Service	Limitation
	nutritional supplements services. • The services under nutritional supplements are limited to additional services not otherwise covered under the Medicaid State Plan, but consistent with waiver objectives of avoiding institutionalization. • The meals provided as part of these services shall not constitute a full nutritional regimen.
Personal Emergency Response System	Members may receive 1 personal emergency response system (PERS) device per lifetime to provide round-the-clock emergency service. Member must not reside in a residential or nursing facility.
Pest Control	An annual cap of $4,000 is available for pest control services.
Respite Services	Please see the rollover language for unused respite hours and requirements for tracking rollover hours.
Specialized Medical Equipment and Supplies	Maintenance is limited to $1,000 annually for the repair and service of items that have been provided through an HCBS waiver: • Requests for service must detail parts and labor costs. • If the need for maintenance exceeds $1,000, the care manager works with other available funding streams and community agencies to fulfill the need. If service costs exceed the annual limit, parts and labor costs funded through the waiver must be itemized clearly to differentiate parts of the waiver service provision from parts and labor provided through a nonwaiver funding source.
Structured Family Caregiving	Please see the waiver service language on the requirements of face-to-face visits and respite.
Vehicle Modifications	A lifetime cap of $15,000 is available for one vehicle per every 10-year period for a participant's household. In addition to the applicable lifetime cap, $1,000 will be allowable annually for repair, replacement, or an adjustment to an existing modification that was funded by an HCBS waiver.

For more information on services listed above, such as service descriptions, standards, and qualifications, please refer to the FSSA's Division of Aging – HCBS Waiver Provider Manual.

In addition to Indiana PathWays for Aging benefits, members can receive enhanced benefits just for being our member:

Person-centered support services	Details
Fresh Food Connect	Choice of home-delivered meals, farm fresh produce boxes, or a yearly membership for online grocery delivery.
Healthy Adults, Healthy Results	Online on-demand fitness and exercise videos, plus a choice of a home fitness kit to increase strength and flexibility, improve overall health, and help members stay in their homes safely.
Personal Care Items	Up to $50 toward over-the-counter personal care essentials, including dental, nail, skin, and hair care products, laundry supplies, and germ-prevention materials.
Memory Aids Kit	Memory care remembrance book, iron-on labels, decorative labels, markers, and an mp3 player with a music gift card to help improve symptoms of memory decline.
Companion Connect	Two smart speakers with video calling features — one for you and one for your loved one. Available to members in a nursing facility.
Healthy Lifestyle Aids	One healthy lifestyle aid per year, including items such as digital scales, lumbar pillows, and diabetic supplies.
Sensory Products	Up to $75 in coloring books, puzzles, games, arts and crafts, weighted blankets, and other sensory products to help improve memory and hand/eye coordination.
Caregiver Way Membership	Access to the Caregiver Way online platform that identifies, alleviates, and prevents caregiver burnout and prevents member institutionalization due to caregiver fatigue. The platform supports guides, educational videos, and a community forum to assist in the continuous education of caregiving support.

Help with smooth transitions	Details
Home essentials	Choice of a $50 thrift store card, a $50 discount store card, or up to $50 worth of basic household items, such as bedding, kitchen items, small appliances, and more.
Vision rehabilitation training	For members with visual impairments. Community and home-based services to help you stay safely at home.
Post-discharge meals	Medically-tailored meals brought to your home after you return from an inpatient hospital or nursing home stay.
Home safety benefit	One home safety product per year to help prevent accidents and falls. Choose from items like carbon monoxide detectors, medication lock boxes, smoke alarms, night lights, and more.
Access to services	**Details**
Transportation essentials	$50 gas card, $50 rideshare card, or 6 round trips of on-demand transportation with a companion caregiver.
Digital mental health toolkit	Manage stress, improve your mood, and get inspired with our online emotional well-being resources and CommonGround Library.

Help with smooth transitions	Details
COPD relief products	Select one COPD relief product, such as an inhaler vaporizer kit, travel nebulizer compressor system, hypoallergenic bedding, pillow cover, and HEPA air purifier.
Smartphone Member Connect	Get support and guidance to enroll in the Affordable Connectivity Program. Stay in touch with family, friends, doctors, and social services.
Community Resource Link	Find help in your community with food, jobs, housing, and other things you may need. Visit **https://mss.anthem.com/in/member-resources/community-support.html** to search for community resources near you.

Some benefits are limited to certain members only, and members may need to complete certain activities to be eligible. Benefits may change or end at any time. Go to **anthem.com/inmedicaid** to learn more.

Home and Community-Based Service Descriptions

Members eligible for Home and Community-Based Services (HCBS) may use different services to meet their support needs, in combination with informal caregiver supports and other community resources. Through the development of the Individualized Care Plan and Service Plan, members and their care and service coordinators along with input from others chosen by the member will determine the best supports to meet the person's needs and support achievement of self-identified quality of life goals.

LTSS-Specific Value-Based Programs

Proposed LTSS-Specific programs	Description and methodology
Attendant Care Quality Incentive Program (ACQIP)	Incentives offered for Attendant Care (AC) agencies that meet quality, service, utilization, and workforce development goals. Performance indicators include inpatient utilization, emergency room (ER) utilization, AC caregiver training, AC caregiver assignment consistency, and member satisfaction with AC provider services.
Nursing Facility Quality Incentive Program (NFQIP)	High-performing NFs that meet quality, service, utilization, and workforce development goals are eligible to receive incentive payments. Performance indicators used include inpatient utilization, ER utilization, inpatient admissions within 30 days of NF discharge, patient satisfaction, and CMS Nursing Home Compare Star Ratings for Quality Measures, and Staffing.
Nursing Facility Transition Quality Incentive Program (NFTIP)	NFTIP offers incentives to encourage best practices in facilitating member transitions from an NF to a home or community-based setting of their choice and reducing the likelihood of readmission. The performance indicators for NFTIP are based on the number of members discharged from the NF to home- and community-based settings who remained out of any NF for an established period of time from the NF discharge date.

Proposed LTSS-Specific programs	Description and methodology
	For Indiana PathWays for Aging, we will expand the NFTIP program to include a new performance measure focused on promoting collaboration between the NF and the HCBS provider prior to and following the transition.
Assisted Living Facility Quality Incentive Program (ALFQIP)	Incentives are offered to ALFs who are meeting quality, service, and workforce development goals, including incentives that support compliance with HCBS Settings Rules. Performance indicators include initial and ongoing compliance with the HCBS Settings Rule, completed vaccinations, transitions to other facilities, notification of hospital admissions including ERs and behavioral health (BH) facilities, coordination of care efforts, care plan sharing with a PMP, and completion of Falls Risk assessment and screenings.

Existing Programs to Expand to LTSS Providers	
Integrated Care Quality Incentive Program (ICQIP)	ICQIP incents BH providers to enter into Care Compacts with PMPs and to formalize referral protocols, care transition expectations, and Care Management responsibilities BH and physical health providers have an increased ability to earn an incentive the more integrated they become with their physical health and BH counterparts. The incentive measures are focused on both BH and physical health. ICQIP performance measures include ER admissions; inpatient admissions, and PMP visits per year
Social Determinants of Health Performance Incentive Program (SDOHPIP)	Incentives offered for evaluating and referring to food, health, housing, job training, and education programs, and billing the appropriate diagnosis codes. Beginning in 2022, we expanded the incentive program to include employment and education as additional SDOH domains. We are expanding the activities that are eligible for incentives so that providers are rewarded for completing SDOH assessments, billing appropriate diagnosis codes, initiating referrals to appropriate community organizations using Community Resource Link, and tracking and closed-loop referrals.
Health Needs Screening Performance Incentive Program (HNSPIP)	This program offers provider incentives to improve health outcomes by increasing the number of members who complete the Health Needs Screening (HNS) during the first 90 days of enrollment. Anthem incentivizes providers who have members complete the HNS at an office visit during this period. Members are eligible to complete the HNS once during their first 90 days of enrollment. Current Participation: Available to all applicable provider types, including PMPs, FQHCs, and Person-Centered Medical Homes (PCMHs).
Screening, Brief Intervention, and Treatment Quality Improvement Program (SBIRTQIP)	SBIRTQIP offers incentives to PMPs, FQHCs, PCMHs, and BH providers who complete SBIRT screenings and engage in motivational interviewing to encourage change or refer

Existing Programs to Expand to LTSS Providers	
	members to substance use disorder (SUD) treatment as appropriate. SBIRTQIP encourages providers to screen and deliver early intervention services.
Smoking Cessation Provider Incentive Program (SCPIP)	To encourage PMPs to support members who use tobacco products, SCPIP offers participating providers incentives for providing smoking cessation counseling.
Behavioral Health Performance Incentive Program (BHPIP)	BHPIP seeks to improve quality outcomes and consistency of care by incentivizing providers to conduct follow-up (F/U) visits with members after ER visits and/or hospitalization for BH needs. Performance Indicators: (FUA) F/U After ER visit for Alcohol or Other Drug Abuse and (FUH) F/U After Hospitalization for Mental Illness.

Anthem will evaluate opportunities to include a health equity enhancement in our provider incentive programs. We will leverage experience from our Indiana Medicaid program health equity enhancement that complements our existing Quality Incentive Program and includes bonus payments to providers who demonstrate improvements in delivering the preventive services needed to reverse racial health disparities. We are collecting baseline data for health equity incentives with the goal of making future bonus payments available. Based on this analysis, we will determine appropriate performance metrics for this incentive, such as improving a minority-specific rate for a HEDIS measure from the baseline period to the performance measurement period. As we pilot this enhancement, we will assess opportunities to tailor it for our LTSS provider incentive programs.

Pharmacy Benefit

Anthem is responsible for prescription drug coverage for our members enrolled in Indiana PathWays for Aging. Anthem manages the pharmacy benefit through our pharmacy benefits manager, CarelonRx, Inc.

The Indiana PathWays for Aging populations includes both, Dual-eligible and Non-dual-eligible members. Dual members are eligible for Medicare and Medicaid. Dual members may elect a Medicare Part D plan. For members who do not elect a Part D plan, they will not have coverage of Medicare Part D eligible drugs. Non-dual members are eligible for Medicaid only. According to the reimbursement hierarchy, pharmacy providers must submit pharmacy claims to the member's Medicare Part D plan first. After submission to Medicare Part D, the pharmacy provider may submit a coordination of benefits claim to Medicaid as a secondary payer. Medicaid is the payer of last resort. Medicare Part D drugs as defined by CMS are not covered under Medicaid. Dual-eligible members may be responsible for a copay for Medicare Part D drugs processed by their Medicare Part D plan.

Non-Medicare covered drugs that are on the Indiana Statewide Uniform Preferred Drug List (SUPDL), such as OTC drugs, are covered by Medicaid with a $0 copay. Pharmacy providers must first submit non-Medicare claims to the Medicare plan followed by the secondary claim to Medicaid.

Non-dual Medicaid members must use an in-network pharmacy for prescription services so that

they are not subject to unnecessary out-of-pocket costs.

Pharmacy providers should submit pharmacy benefit claims to CarelonRx. Pharmacies may dispense up to a 30-day supply of medication. Non-Dual members may receive a 90-day supply of maintenance medication through a retail pharmacy or mail-order pharmacy. (Specialty medication is not eligible for a 90-day supply.) Dual-eligible members will be subject to the benefits and limits of their Medicare plan.

Covered and non-covered drugs
Dual Eligible members (Medicare and Medicaid)
Pharmacy coverage includes:

- Medicare Part D Prescription drugs approved by the United States Food and Drug Administration (FDA) will be covered by the member's Medicare Part D plan. Medicaid does not cover these drugs and the member may owe a copay.
- Over-the-counter (OTC) items approved by the FDA and covered by the Indiana Fee-For-Service (FFS) Program and still require a prescription in order to be covered under the Medicaid plan and for the pharmacy to be able to dispense the medication. Members will not have a copay.

Non-Dual Medicaid eligible members:
Please refer to **Chapter 4: Pharmacy in the *Indiana Medicaid Provider Manual.***

Member Cost-Sharing

Anthem shall adhere to state and federal law, the State Plan, and the requirements set forth in *42 CFR 447.50* through *447.57* when imposing any cost-sharing charges on members.

Federal regulations at *42 CFR 447.56* place aggregate limits on cost-sharing and prohibit total member cost-sharing per family from exceeding 5% of the family's income, as determined by the State, in a monthly or quarterly period. Anthem will accept family data income from the State's fiscal agent and track member copayments, premiums, member debt collected, and/or any other cost-sharing information available against the total family income data provided by the state as a means of ensuring the family's total cost-sharing does not exceed 5% of the family's income in a calendar quarter. When 5% is met, this is communicated back to CoreMMIS via the Supplemental File so that the Provider Portal indicates to each provider that the member is not to be charged copays at that time. The status should be reset at the beginning of the following quarter. Anthem will send a letter to the individual to indicate when cost-share has been met for the quarter, including that it will be reset at the start of the following quarter.

Member Payment Liability

Anthem will ensure that Indiana PathWays for Aging providers do not balance bill its members, i.e., charge the member for covered services above the amount paid to the provider by the Contractor per 42 CFR 438.3(k), 42 CFR 438.230(c)(1)-(2), and section 1932(b)(6) of the Social Security Act.

If Anthem becomes aware that an out-of-network, non-IHCP provider, such as an out-of-state emergency services provider, is balance billing a member, Anthem will instruct the provider to

stop billing the member and to enroll in the IHCP and complete Anthem's contracting process in order to receive reimbursement from Anthem. Anthem will contact the member to help resolve issues related to the billing.

Anthem providers are prohibited from charging a member, or the family of the member, for any amount not paid as billed for a covered Anthem service. Provider acceptance of payment from Anthem as payment in full is a condition of participation. Anthem providers can bill a member only when the following conditions have been met:

a. The provider must establish that authorization has been requested and denied prior to rendering the service;
b. The service rendered is determined to be non-covered by Anthem;
c. The member has exceeded the program limitations for a particular service;
d. The member must understand, before receiving the service, that the service is not covered under Anthem, and that the member is responsible for the charges associated with the service; and
e. The provider must maintain documentation that the member voluntarily chose to receive the service, knowing that Anthem did not cover the service. A generic consent form is not acceptable unless it identifies the specific procedure to be performed, and the member signs the consent before receiving the service.

In cases where prior authorization is denied, a provider can bill a member for covered services if certain safeguards are in place and followed by the provider. Anthem shall establish, communicate, and monitor compliance with these procedures, which shall include at least the following:

a. The provider must establish that authorization has been requested and denied prior to rendering the service;
b. The provider has requested a review of the authorization decision by Anthem. Anthem will inform the provider of the contact person, the means for contact, the information required to complete the review, and the procedures for expedited review if necessary. The standard appeal turnaround time is 30 calendar days and expedited turnaround time is 48 hours.
c. If Anthem maintains the decision to deny authorization, the provider must inform the member that the service requires authorization, and that authorization has been denied—if the provider is an out-of-network provider, the provider must also explain that covered services may be available without cost in-network if authorization is provided;
d. The member must be informed of the right to contact Anthem to file an appeal if the member disagrees with the decision to deny authorization;
e. The provider must inform the member of the member's responsibility for payment if the member chooses to or insists on receiving the services without authorization;
f. The provider must have the right to appeal any denial of payment by Anthem for denial of authorization;
g. If the provider chooses to use a waiver to establish member responsibility for payment, the use of such a waiver shall meet the following requirements:
    - The waiver is signed only after the member receives the appropriate notification.
    - The waiver does not contain any language or condition to the effect that if authorization is denied, the member is responsible for payment.

- Providers must not use non-specific patient waivers. A waiver must be obtained for each encounter or patient visit that falls under the scenario of non-covered services.
- The waiver must specify the date the services are provided and the services that fall under the waiver's application.

PathWays will not include copayment requirements from any member for Medicaid-covered services. Some members will be responsible for paying out-of-pocket costs imposed by the Medicare program or other Medicaid waiver liability. Per IC 27-13-1-8, copayment means an amount, or a percentage of the charge, that an enrollee must pay to receive a specific service that is not fully prepaid.

Transfer of Property Penalties
If the Division of Family Resources (DFR) determines an applicant or member has inappropriately transferred assets without adequate consideration in order to qualify for Medicaid, as specified in 405 IAC 2-3-1.1. A monthly "facility rate" will be set by the state annually, and the transfer penalty period will be equal to the amount of the disallowed transfer divided by the facility rate to arrive at the number of months of penalty. The dates of any penalty period will be communicated to Anthem from the MMIS system.

During a penalty period, LTSS services above the member's State Plan benefits are not payable by Medicaid. The provider portal and eligibility-checking systems must indicate to providers the start and end dates of member ineligibility due to transfer of property penalty. Transfer of property penalties will always start on the first day of a month in which a member will be assigned a TOP plan ID for that period but can end on any day of the month. Once the TOP penalty period expires, the member will be transitioned into a non-TOP plan ID which will allow for Anthem to pay for HCBS/NF services.

Waiver Liability

Waiver liability only applies to members who receive home- and community-based services (HCBS) and is similar to a deductible. When the Medicaid-allowable LTSS expenses exceed the waiver liability amount, the expenses will then be paid by Anthem. Medicaid will not reimburse LTSS services until the waiver liability amount has been met. The provider is responsible for verifying the waiver liability obligation and balance in the portal when checking eligibility.

Monthly waiver liability notices must be sent to the member and any authorized representative detailing the services and amounts applied to the waiver liability. The member is not required to pay the provider until the expense has been included in the waiver liability summary notices. The only exception to this rule is pharmacy claims.

Patient Liability

Patient liability applies to members who reside, or are likely to reside, in a nursing home for 30 or more consecutive days. For members with patient liabilities, imposed in accordance with *42 CFR § 435.725*, liability amounts are to be deducted from the total reimbursement of monthly claims to the facility. Providers must apply current income to current needs. As an example, a social security benefit check received in October must be applied to October charges. The only

exception is the direct deposit benefit check that is sometimes recorded by the bank at the end of one month instead of early in the next month when it would normally be received. Because most resources are available on a calendar month basis, all accounts that involve resource deductions must be billed on a calendar-month basis, for example, June 1 through June 30, or July 1 through July 31. Providers are not to indicate or exclude the liability when submitting claims. The patient liability amount should be visible in the provider portal, or when the provider checks eligibility. State Plan services can be paid without regard to whether the patient's liability has been met.

Note: Providers must deduct patient resources from the payment in the month that the resources are received. A Veteran's pension will not prevent a member from receiving the monthly personal needs allowance typically allotted for Medicaid members.

When a member transfers between facilities during a billing period, the member liability is deducted from the first claim received and processed by the MCE. Therefore, the facilities involved in the transfer must coordinate any liability deductions.

Providers, whether contract or non-contract, shall comply with all federal requirements (*42 CFR* Part 455) on disclosure reporting. All tax-reporting provider entities that bill and/or receive Indiana PathWays for Aging funds as the result of this Contract shall submit routine disclosures in accordance with timeframes specified in *42 CFR* Part 455, Subpart B and Indiana PathWays for Aging policies and procedures, including at the time of initial contracting, contract renewal, at any time there is a change to any of the information on the disclosure form, within thirty-five (35) days after any change in ownership of the disclosing entity, at least once every three (3) years, and at any time upon request. For providers, this requirement may be satisfied through Indiana PathWays for Aging's provider registration process.

Retroactive Adjustment of Member Liabilities

In the event a patient liability amount is added, removed, or modified retroactively, claims should be automatically adjusted. Claims that are subject to adjustments are long term care, hospice, and medical claims billed by specialty 040-Rehabilitation Facility.

If a Provider is no longer willing or able to provide Medicaid Covered Services to an Indiana PathWays for Aging Member they must:

- Provide at least thirty (30) days advanced written notice to Anthem; the provider is expected to continue to provide services until a new provider has started services or the end of the 30-day period has expired, whichever comes first;
- Include the reason for the decision and work with the care coordinator to facilitate a seamless transition to alternate providers;
- Participate in an interdisciplinary care team meeting to coordinate care to a new provider;
- Agree to continue serving the member until a new provider furnishing similar services is in place. During the continuation period, the provider will agree to:
    - Accept reimbursement from Anthem for all Covered Services.
    - Adhere to Anthem's Policies, including but not limited to, policies regarding quality assurance requirements, referrals, pre-authorization, and treatment planning.

Provider Responsibilities and Requirements

Under the Indiana PathWays for Aging program providers must:

- Ensure staff have appropriate job-specific qualifications prior to employment and conduct routinely during employment.
- Ensure staff have required licensure and/or certification and submit as applicable to Anthem.
- Conduct a criminal background check for every person who possesses a license or certificate as a healthcare professional.
- Ensure direct service workers (DSWs) have a pre-employment criminal history check and/or background investigation on file prior to providing direct support or services.
- Ensure DSWs:
    - Are at least 18 years of age
    - Be competent to provide services according to the individualized care plan
    - Demonstrate effective communication
    - Provide a copy of a current negative TB test or negative chest x-ray annually
- Upon hire, possess a current, valid state-issued driver's license, and provide proof of current insurance on the vehicle if transporting a member. DSWs must maintain licensure on a continual basis after initial validation upon hire. Help ensure the integrated delivery of physical health, behavioral health, and long-term care services to Indiana PathWays for Aging Members, including but not limited to participation in the continuity and coordination among physical health, behavioral health, and long-term care services and collaboration among physical health, behavioral health, and long-term care providers.
- Utilize the approved EVV system for applicable home- and community-based services in accordance with State of Indiana requirements and Section 12006(a) of the 21st Century Cures Act to verify the initiation and daily provision of such services. The provider will also work with Anthem to take immediate action to resolve any service gap and transfer copies of all records related to an individual to a new provider within five (5) business days in compliance with HIPAA regulations.
- Deliver at no charge all Provider evaluations/assessments and/or progress reports requested by the Care Coordinator and/or Anthem including but not limited to case notes, documentation of the type of contact made with an Indiana PathWays for Aging Member, and/or all persons who may be involved with Indiana PathWays for Aging Member's care.
- If an initial report involves an Indiana PathWays for Aging member death, accident, or an allegation or suspicion of abuse, neglect, or exploitation, the report must be submitted within twenty-four (24) hours of the Provider's first knowledge of the incident. All other incident reports must be submitted to FSSA within forty-eight (48) hours of the time of an incident or becoming aware of an incident. Incident reports shall be submitted through the FSSA's web-based Incident Reporting System. If web access is unavailable, incidents can be reported to FSSA by telephone and e-mail. Providers are required to submit an incident report for any reportable incident.
- Establish written procedures for informing each of the following: (a) Adult Protective Services, as applicable; (b) the Indiana PathWays for Aging Member's legal representative, if applicable; (c) the appropriate ombudsmen, if applicable; (d) any other person designated by the Indiana PathWays for Aging Member; (e) the Anthem

Care/Service Coordinator. Indiana law requires reporting of known or suspected abuse, neglect, or exploitation of an adult to Adult Protective Services. A twenty-four (24) hour hotline connected to the statewide Adult Protective Services (APS) system is available for this reporting, or reports can be made to the local APS or an Indiana County Prosecutor's office. Providers can also submit a report online at **https://aps-govcloud.my.site.com/APSOnlineReport/s/** (on the FSSA website).

- Immediately report any deviations to the Indiana PathWays for Aging Member's Care Coordinator from an Indiana PathWays for Aging Member's service schedule that would affect service authorizations.
- Ensure that it has staff sufficient to provide the Covered Service(s) authorized by Anthem in accordance with the Indiana PathWays for Aging Member's Individualized Care Plan, as appropriate, including the amount, frequency, duration, and scope of each service in accordance with the Indiana PathWays for Aging Member's service schedule.
- Provide backup for their own staff if they are unable to fulfill their assignment for any reason and ensure that backup staff meet the qualifications for the authorized service.
- Not require an Indiana PathWays for Aging Member to choose the Provider as a provider of multiple services as a condition of providing any service to the Indiana PathWays for Aging Member.
- Maintain compliance with the HCBS Settings Rule detailed in *42 CFR § 441.301 (c)(4)-(5).*
- Develop and maintain policies concerning fire evacuation and natural disasters, including ensuring staff are knowledgeable about evacuation procedures and any available safety equipment (e.g., fire extinguishers).
- Routinely monitor the maintenance of a sanitary and comfortable living environment and/or program site and shall develop and maintain policies for staff to identify and report any individual or systemic problems identified.
- Develop and maintain policies to routinely inspect any vehicles, including adaptive equipment used in such vehicles, and report and resolve any deficiencies with these vehicles.
- Develop and maintain a crisis intervention policy that is consistent with the applicable state agency requirements and approved by Anthem. As applicable, policies shall include instructions for the use of psychotropic medications and behavioral safety interventions.
- Develop and maintain policies to ensure any medications are provided and administered by trained and qualified staff consistent with a physician's orders. Provider shall ensure that medication administration records are properly maintained and that all medication is properly stored and accessible to Indiana PathWays for Aging Members when needed. Such Providers shall also develop and maintain policies to track and trend medication variance and omission of reportable events to analyze trends and implement prevention strategies.
- Develop and maintain policies approved by Anthem that ensure Indiana PathWays for Aging Members are treated with dignity and respect, including training staff on person-centered practices. Such policies shall include, but are not limited to:
    - Ensuring Indiana PathWays for Aging Members/representatives and family are given the opportunity to participate in the selection and evaluation of their direct support staff, if applicable;
    - Soliciting Indiana PathWays for Aging Member/representative and family

feedback on Provider services;
    - Ensuring the Indiana PathWays for Aging Member/representative has information to make informed choices about available Medicaid Covered Services;
    - Ensuring Indiana PathWays for Aging Members are allowed to exercise personal control and choice related to their possessions;
    - Supporting Indiana PathWays for Aging Members in exercising their rights;
    - Periodically reviewing Indiana PathWays for Aging member's day services and promoting meaningful day activities, if applicable;
    - Supporting the Indiana PathWays for Aging member in pursuing employment goals; and
    - Only restricting Indiana PathWays for Aging members' rights as provided in the Indiana PathWays for Aging Member's Individualized Care Plan.
- Develop and maintain policies to ensure that Indiana PathWays for Aging Members have good nutrition while being allowed to exercise personal choice and that Indiana PathWays for Aging member's dietary and nutritional needs are met (residential providers only).

Provider Contract Termination

Anthem will notify the State of any provider (including HCBS/NF) contract termination and will submit an Excel spreadsheet that includes the provider's name, IHCP provider identification number, NPI number, and the number of members affected within five business days of the provider's termination. If the termination was initiated by the provider, the notice to the State will include a copy of the provider's notification to Anthem. Anthem will maintain documentation of all information, including a copy of the actual member notice(s), on-site. Upon request, Anthem will provide the State a copy of the following: one or more of the actual member notices mailed, an electronic listing in Excel identifying each member to whom a notice was sent, a transition plan for the members affected, and documentation from Anthem's mail room or outside vendor indicating the quantity and date member notices were mailed as proof of compliance with the member notification requirements. If termination of the Anthem provider agreement with any provider, whether or not the termination is initiated by the provider or by Anthem, places Anthem out of compliance with the network requirements, Anthem will provide a written plan to come into compliance and will submit GeoAccess reports in the manner and timeframe required by the State.

Person-Centered Practices

All providers are expected to conduct all member interactions using a person-centered approach and ensure member choice and self-determination are supported at all times. For successful person-centered planning to occur, the provider must have a clear understanding and shared appreciation of what is important to and for each member and how they want to be supported.

Using person-centered language is an important aspect of person-centered practices as it recognizes the impact of language on thoughts and actions. It ensures language does not diminish the uniqueness and intrinsic value of each individual and allows a full range of thoughts, feelings, and experiences to be communicated. It is important to emphasize cultural preferences and communication style when training a direct support professional, so they can best support the individual.

The HCBS Settings Rule supports enhanced quality in HCBS programs that are central to an effective and meaningful person-centered planning process. A rights-based, person-centered planning process is a means to ensure LTSS consumers receive effective and robust person-centered care that:

- Is integrated into and supports full access of individuals to the greater community;
- Is selected by the individual from among setting options based on the individual's needs and preferences, and for residential settings, resources available for room and board;
- Optimizes individual initiative, autonomy, and independence in making life choices;
- Facilitates individual choice regarding services and supports, and who provides them; and
- Supports a life of purpose and meaning.

Indiana PathWays for Aging Care and Service Coordination

Each member in the Indiana PathWays for Aging program will have an assigned Care Coordinator who will facilitate the coordination of physical and behavioral services and supports which are documented and tracked in an Individualized Care Plan (ICP). Members who meet the Nursing Facility Level of Care and are receiving Long Term Supports and Services will also have an assigned Service Coordinator to facilitate the coordination of LTSS and like services which are captured in a Service Plan. The Care and Service Coordinators are the central, primary point of contact to ensure consistent ongoing communication between the member, providers, caretakers, and all other participants of the Individual Care Team. Anthem may utilize one associate acting in both roles or two associates performing the roles separately depending on the member's support needs and preferences. Some of the core responsibilities of the Care and Service Coordinator roles include:

- Supporting members with timely and coordinated access to an array of providers, covered services, and supports.
- Monitoring for SDOH support needs and connecting individuals to community-based services.
- Using a person-centered approach at all times to ensure each member remains in control of their care planning and their individual needs are supported in a way that aligns with how they want to be supported.
- Representation and advocacy with agencies, providers, and facilities on behalf of the member.
- Care and Service Coordinators coordinate with Medicare payers, Medicare Advantage plans and Medicare providers as appropriate to coordinate the care and benefits of members who are also eligible for Medicare.

Care and Service Coordinators play an important role in relation to LTSS Providers. Some of the primary ways a Care or Service Coordinator supports providers include:

- Assess for and communicate information about member-specific support needs and preferences to facilitate effective referral matches.
- Facilitate provider selection by providing the member with all available options to support service delivery.
- Connect members to community-based resources to address all identified SDOH needs.
- Submit timely service authorization requests that align with Care and Service Plans.

- Engage with all LTSS providers and community-based providers identified to ensure they fully understand their role in supporting the members to achieve their desired outcomes as identified in the ICP and Service Plan.
- Follow up with members to ensure all service delivery is in place and is being conducted in alignment with the ICP and Service Plan to include both LTSS providers and community-based supports.
- Engage with providers in the development and ongoing revisions of Care and Service Plans.
- Keep providers informed about the status of Care and Service Plan outcomes and changes.
- Facilitate resolution when a member/provider grievance occurs.

It is the responsibility of every provider to notify the Care and Service Coordinator if any of these scenarios are identified by the provider:

- Change in member condition, environment, or availability of caregiver supports
- Inpatient hospitalization or ER occurrence
- Suspected abuse, neglect, or exploitation
- Needed modification to a goal or support strategy or barriers to achieve the member's desired outcome
- A change in the member's preferences about the existing Care or Service Plan
- Any other situation that would necessitate a Care or Service Plan revision

We will provide training to all LTSS providers regarding the value and available modes of communication and remind them that the member's identification card indicates if a member is enrolled in Indiana PathWays for Aging. Through the LTSS provider training, providers will also be educated on how to contact the care and service coordinators including contacting Member Services or using the LTSS coordination email boxes.

Individualized Care Plans and Service Plans

Anthem utilizes Individualized Care Plans and Service Plans in accordance with the minimum requirements as defined by FSSA, compliant with NCQA and HCBS Settings Rule standards, and inclusive of the Anthem Best Practice model. Anthem Care and Service Coordinators support each member by facilitating the process of developing Care and Service Plans using a person-centered planning approach to document the member's strengths, support needs, goals, and desired outcomes and preferences a description of how each member wants to be supported through a combination of paid, community-based, and natural supports. The person-centered planning process is always directed by the member and may include representatives of the member's choosing to assist with decision-making and to participate in the care planning process. If the member has a guardian or conservator, the member shall lead the planning process to the maximum extent possible, and the guardian or conservator shall have a participatory role as needed and defined by the member, except as explicitly defined under State law and the order of guardianship or conservatorship. Any decisions made on the member's behalf should be made using principles of substituted judgment and supported decision-making. This planning process, and the resulting Care and Service Plans, will assist the member in achieving a personally defined lifestyle and outcomes in the most integrated community setting appropriate, ensure delivery of services in a manner that reflects personal preferences and choices, and contribute to

the assurance of health, welfare, and personal growth. HCBS services will be authorized, provided, and reimbursed only as specified in the Service Plan.

For Members residing in a Nursing Facility

For members in a Nursing Facility, the member's Service Coordinator may:

- Defer to the Service Plan developed by the nursing facility for service delivery in lieu of creating an additional Service Plan if the existing plan is sufficient to address all of the member's support needs.
- Supplement the Service Plan as necessary with the development and implementation of targeted strategies to improve health, functional ability, or quality of life outcomes (e.g., related to Population Health services or pharmacy management) or to increase and/or maintain functional abilities.
- Facilitate resolution of any discrepancies between the NF plan of care and Anthem Individualized Care Plan (ICP)/Service Plan (SP) by communicating directly with the NF, member, and other Interdisciplinary Care Team (ICT) members as appropriate ensuring all plans of care are updated to be aligned.
- Participate in care rounds.
- Regular ongoing contact with the member and their assigned representatives where applicable to monitor the progress of the NF plan of care, ICP, and SP as well as identification of any new or escalated issues.
- Ongoing assessment of member desire to transition to the community and the supports needed to do so.
- Comprehensive transition support upon a member's decision to transition back to the community or to a less restrictive environment to include identification and coordination of all formal and community-based supports needed to support a safe transition. Coordination with the transition ICT to include the NF and HCBS providers to ensure continuity of care throughout the transition process.

Care and Service Coordinators will participate in the nursing facility's care planning process and advocate for the member. All members will still receive an Individualized Care Plan with support from their Care Coordinator.

The member's Care and Service Coordinator, as well as the Transition Support Team, is responsible for coordinating the member's physical health, behavioral health, and LTSS needs, which will include coordinating with the nursing facility as necessary to facilitate access to physical health and/or behavioral health services needed by the member and to help ensure the proper management of the member's acute and/or chronic physical health or behavioral health conditions, including services covered by Anthem that are beyond the scope of the nursing facility services benefit.

For Members in Community Based Settings

For members in Community Based Settings, the Care/Service Coordinator will coordinate and facilitate a care/service planning team that includes the member, those identified by the member who acts as natural supports, providers, other support coordinators, and community-based partners. The Care/Service Coordinator will include or seek input from others as authorized by the member to assist with needs assessment and care planning activities as needed.

Some of the activities the Care/Service Coordinator conducts as a part of Care and Service Plan development include:

- Gathering pertinent demographic information regarding the member, including the name and contact information of any representative and a list of other persons authorized by the member to have access to healthcare (including long-term-care-related information) and assisting with assessment, planning, and/or implementation of healthcare (including long term care related services and supports).
- Determining care, including specific tasks and functions that will be performed by family members and other caregivers.
- Determining home health, private duty nursing, and LTSS services the member will receive from other payer sources including the payer of such services.
- Determining home health and private duty nursing services that will be authorized by Anthem.

HCBS services that will be authorized by Anthem Service Coordinators include:

- The amount, frequency, duration, and scope (tasks and functions to be performed) of each service to be provided.
- The schedule of when such care is needed.

The ICP and Service Plan will include the following elements:

- Description of the member's current physical and behavioral health conditions and functional status (i.e., areas of functional deficit) and the member's physical, behavioral, and functional needs
- Description of the member's physical environment and any modifications necessary to ensure the member's health and safety
- Description of medical equipment used or needed by the member (if applicable)
- Description of each member's communication style as well as any special communication needs, including interpreters or special devices
- Description of the member's psychosocial needs, including any housing or financial assistance needs that could impact the member's ability to maintain a safe and healthy living environment
- Description of goals, objectives, and desired health, and the functional and quality of life outcomes for the member
- Description of other services that will be provided to the member, including:
    - Covered physical and behavioral health services that will be provided by Anthem to help the member maintain or improve his or her physical or behavioral health status, or functional abilities and maximize independence
    - Other social support services and assistance needed in order to ensure the member's health, safety, and welfare and, as applicable, to delay or prevent the need for more expensive institutional placement
    - Any noncovered services including services provided by other community resources, including plans to link the member to financial assistance programs, including housing, utilities, and food as needed
- Relevant information from the person's treatment plan for any member receiving behavioral health services that is needed by an LTSS provider, caregiver, or the care coordinator to ensure appropriate delivery of services or coordination of services

- Relevant information regarding the member's physical health condition(s), including the treatment and medication regimen needed by an LTSS provider, caregiver, or the care coordinator to ensure appropriate delivery of services or coordination of care
- Frequency of planned Care/Service coordinator contacts needed, which will include consideration of the person's member needs and circumstances
- Additional information for members who elect consumer direction of HCBS, including whether the member requires a representative to participate in consumer direction and the specific services that will be consumer-directed
- Any steps the member and/or representative should take in the event of an emergency that differs from the standard emergency protocol
- A disaster preparedness plan specific to the member

The member's Care/Service Coordinator will provide a copy of the member's completed Individualized Care Plan (ICP) and Service Plan, including any updates, to the member, the member's representative, and the member's providers authorized to deliver care to the member, and other ICT members as applicable. A member can elect not to share their ICP or Service Plan. When this occurs, the Care and Service Coordinator will ensure that providers who do not receive a copy are informed in writing of all relevant information needed to ensure the provision of quality care for the member and to help ensure the member's health, safety and welfare, including the tasks and functions to be performed.

Within five business days of completing a reassessment of a member's needs, the member's care coordinator/care coordination team will update the member's plan of care as appropriate and authorize and initiate HCBS in the updated Service Plan.

Participant Directed Attendant Care Services (PDACS)

We offer Self-Direction of Participant Directed Attendant Care to all HCBS members enrolled in Indiana PathWays for Aging who are determined through the needs assessment/reassessment process to need attendant care. No other services are eligible for participant direction. PDACS affords members the opportunity to have choice and control over how eligible HCBS are provided, who provides the services, and how they will receive their services. Self-directed supports may not be delivered by a parent of a minor child participant, the spouse of a participant, the attorney-in-fact (POA) of a participant, or the healthcare representative. Eligible individuals are those enrolled in the Indiana PathWays for Aging program who are not residing in a congregate setting and who are able to self-direct their services, perform the function of support staff employer, and accept risks and responsibilities associated with employing their caregiver and directing their own care.

If a member chooses not to direct his or her care, he or she will receive authorized attendant care through contract providers. Members who participate in PDACS choose either to serve as the employer of record for their workers or to designate a representative to serve as the employer of record on his or her behalf. Member participation in PDACS is voluntary. Members may elect to participate in or withdraw from PDACS at any time, without affecting their enrollment in Indiana PathWays for Aging.

Nursing Facility — Pre-Admission Screening and Resident Review

Anthem follows state policy found in the IHCP Long-Term Care Provider Reference Module for Level of Care (LOC) Level I and Level II and Pre-Admission Screening Resident Review (PASRR) requirements. Level of Care and PASRR determinations are the responsibility of an independent FSSA vendor with oversight from the State. Level-of-Care possible outcomes for an LOC assessment include the following:

- Approved for short-term nursing facility stay (30, 60, 90, or 120 calendar days)
- Approved for long-term nursing facility stay (more than 120 days)
- Denied for nursing facility stay

Before the nursing facility can be reimbursed for the care provided, the nursing facility or other appropriate entity must request a Pre-Admission Screening Resident Review (PASRR) for nursing facility placement. The State or independent vendor must then approve the PASRR request and designate the appropriate level of care in the MMIS. Anthem coordinates care for its members who are transitioning into long-term care by working with the facility to ensure timely submission of the request for a PASRR, as described in the IHCP Provider Manual. Anthem is responsible for payment for up to sixty (60) days for the authorized care of its members placed in a long-term care facility while the level of care determination is pending.

The Service Coordinator shall conduct a face-to-face visit with the member and complete and approve a Service Plan within five (5) business days of receiving the member's NFLOC determination notification from the State-designated entity. Within twenty (20) business days of receiving a notification from the State-designated entity that a member meets NFLOC, all HCBS included on a member's Service Plan, except Home Modification and Vehicle Modification, must be delivered or started.

Nursing Facility Level of Care Determination Requirement

Within 30 calendar days of the Anthem effective date, LTSS members in a nursing facility will complete the Comprehensive Health Assessment or State-approved NFLOC assessment with their coordinator. Maximus/Ascend will complete the Nursing Facility Level of Care (NFLOC) and send it to Anthem. The Service Coordinator will use components of the Comprehensive Health Assessment Tool (CHAT) and/or Level of Care (LOC) assessment as the foundation to develop a person-centered support plan (Service Plan) to address the member's LTSS needs and goals. Additional LTSS-specific assessments and reassessments may be conducted to ensure members' choices and/or preferences, needs, and risk factors are documented during the assessment to ensure the member's choices are identified. As part of the eligibility criteria, the Nursing Facility's Level of Care is determined by the InterRAI assessment and meets the requirements under *Indiana Code 12-10-11.5-4*. The LOC will be completed by an Enrollment Contractor selected by the State.

The NFLOC will be reassessed for individuals who do not meet the respective time period (the time period of 30, 60, 90, or 120 days). NFLOCs will be reassessed at least annually for members receiving LTSS.

Nursing Facility Level of Care Re-determination Requirement

Anthem will work with the FSSA Enrollment Contractor to ensure that all members have a

current and accurate level of care as determined by the InterRAI, (in accordance with Section 2.1.2 LTC Functional Screen). The re-determination level of care will be completed at a minimum annually by Maximus. If there is a change in the member's condition, re-determination may be necessitated to include a post-enrollment re-determination.

Nursing Facility Diversion

The nursing facility diversion process targets the following groups for diversion activities:

- Members who are waiting for placement in a nursing facility
- Members residing in their own homes who have a negative change in circumstances and/or deterioration in health or functional status and who request nursing facility services
- Members residing in adult care homes or other community-based residential alternative settings who have a negative change in circumstances and/or deterioration in health or functional status and who request nursing facility services
- Members receiving services admitted to an inpatient hospital or inpatient rehabilitation who are not residents of a nursing facility
- Members receiving services who are placed short-term in a nursing facility, regardless of payer source

The nursing facility diversion process will not prohibit or delay a member's access to nursing facility services when these services are medically necessary and requested by the member. Nursing facility diversion activities involve increasing community-based support that can include services and access to community-based residential alternatives in lieu of nursing facility placement when the member prefers to remain in the community setting.

Nursing Facility-to-Community Transition

Anthem identifies members who may have the ability and/or desire to transition from a nursing facility to the community. Our methods include:

- Referrals, including from the following sources:
    - Treating physician
    - Nursing facility
    - Other providers
    - Community-based organizations
    - Family
    - Self-referrals
- Identification through the care coordination process, including:
    - Assessments
    - Information gathered from nursing facility staff
    - Participation in Grand Rounds
    - Conversation/discussion with the member residing in a nursing facility who expresses interest in returning to the community to live
- Review and analysis of members identified by Indiana PathWays for Aging on minimum data set from nursing facilities

For transition referrals by or on behalf of a nursing facility resident, regardless of referral source, we conduct an in-facility visit with the member to determine the person's interest in and

potential ability to transition to the community. In addition, we provide orientation and information to the member regarding transition activities within 14 days of the referral.

For identification by means other than a referral or the care coordination process of a member who may have the ability and/or desire to transition from a nursing facility to the community, we conduct an in-facility visit with the member to determine whether or not the person is interested in and has the potential ability to pursue a transition to the community within 90 days of such identification.

The member's Care/Service Coordinator will document in the member's case file that transition was discussed with the person and indicate the member's wishes as well as the member's potential for transition. Anthem will not require a member to transition when the person expresses a desire to continue receiving nursing facility services.

If the member wishes to pursue transition to the community, within 14 days of the initial visit or within 14 days of identification through the service coordination process, the Service Coordinator will conduct an in-facility assessment of the member's ability and/or desire to transition using tools and protocols specified or prior approved in writing by Indiana PathWays for Aging. This assessment will include the identification of any barriers to a safe transition.

As part of the transition assessment, the care coordinator will assess for risks related to the member's transition to the community. This will include assessing for known risks, documenting those risks, and developing a mitigation plan for those risks. The transition assessment is completed in collaboration with the member and/or his or her representative and will also involve discussions with current caregivers in the nursing facility.

The member's Care/Service Coordination team will evaluate whether the member's needs can be safely and effectively met in the community and at a cost that does not exceed nursing facility care.

Where risks and barriers to transition indicate that immediate transition cannot be safely supported, the Care/Service Coordinator will work with the member and their support team to develop goals and strategies that progress the member toward resolution of the identified barriers needed to reside in the community.

For those members whose transition assessment indicates that they are candidates for immediate transition to the community, the care coordinator will facilitate the development of and complete a transition plan.

The Service Coordinator will include other persons such as the member's family and/or caregiver in the transition planning process if the member requests and/or approves and such persons are willing and able to participate.

As part of transition planning, prior to the member's physical move to the community, the Care/Service Coordinator will visit the residence where the member will live to conduct an on-site evaluation of the physical residence and meet with the member's family or another caregiver

who will be residing with the member (as appropriate). The Service Coordinator will include in the transition plan, activities and/or services needed to mitigate any perceived risks in the residence, including an increase in face-to-face visits beyond the minimum required contacts.

The transition plan will address all services necessary to safely transition the member to the community and include:

- A thorough description of all physical, behavioral, functional, and social supports needed to facilitate a safe transition.
- Identification of all formal providers, informal caregivers, and community-based supports and a description of each participant's role in supporting transition.
- Housing plan with environmental assessment and details of environmental modifications as applicable.
- Plan for securing adaptive aids and DME needed upon transition.
- Plan for obtaining medications upon transition, neighborhood pharmacy identification, and supports for set up of medication boxes and administration as applicable.
- Appointment schedule with PMP and all specialty providers pre- and post-transition.
- Transportation planning for medical appointments as well as social engagement.
- Assessment and plan for all other SDOH needs such as food and socialization.

The transition plan will also identify any barriers to a safe transition and strategies to overcome those barriers.

The Care Coordinator will update the ICP and the Service Coordinator will work with the member and ICT to create a Service Plan that addresses the support needs in the community setting.

We will not prohibit a member from transitioning to the community once the member has been counseled regarding risk. However, we may determine that the member's needs cannot be safely and effectively met in the community and at a cost that does not exceed nursing facility care. In such a case, we will seek written review and approval from the Office of Medical Policy and Planning (OMPP) prior to the denial of any member's request to transition to the community. If OMPP approves the request, we will notify the member in accordance with OMPP rules and regulations, and the transition assessment protocol, and the member will have the right to appeal the determination.

Anthem will approve the transition plan and authorize any covered or cost-effective alternative services included in the plan within 10 business days of completion of the plan. The transition plan will be fully implemented within 90 days from approval of the transition plan, except under extenuating circumstances, which must be documented in writing.

The member's Care/Service Coordinator will monitor all aspects of the transition process and take immediate action to address any barriers that arise during the transition.

For members transitioning to a setting other than a community-based residential alternative setting, the Service Coordinator will upon transition utilize the EVV system to monitor the initiation and daily provision of services in accordance with the member's new Service Plan and

will take immediate action to resolve any service gaps.

For members who will live independently in the community or whose on-site visit during transition planning indicated an elevated risk, within the first 24 hours, the care coordinator will visit the member in his or her residence. During the initial 90-day post-transition period, the care coordinator will conduct monthly face-to-face in-home visits to ensure that the:

- Person-centered support plan is being followed.
- Person-centered support plan continues to meet the member's needs.
- Member has successfully transitioned to the community.
- Modify or increase supports as determined by a person's changing needs.

For members transitioning to a community-based residential alternative setting or who will be living with a relative or other caregiver, within the first 24 hours, the care coordinator will contact the member and within seven days after the person has transitioned to the community, the care coordinator will visit the member in his or her new residence. During the initial 90-day post-transition period, the care coordinator will:

- Contact the member by telephone each month to ensure that the person-centered support plan:
    - Is being followed.
    - Continues to meet the member's needs.
- Ensure the member has successfully transitioned to the community.
- Conduct additional face-to-face visits as necessary to address issues and/or concerns.
- Ensure the member's needs are met.

The member's Care Coordinator will monitor hospitalizations and short-term nursing facility stays for members who transition to identify and address issues that may prevent the member's long-term community placement. The Care Coordinator will:

- Monitor hospitalizations and nursing facility readmission for members who transition from a nursing facility to the community to identify issues and implement strategies to improve transition outcomes.
- Coordinate or subcontract with local community-based organizations to assist in the identification, planning, and facilitation processes related to nursing facility-to-community transitions.
- Develop and implement any necessary assessment tools, transition plan templates, protocols, or training necessary to ensure issues that may hinder a member's successful transition are identified and addressed. Any tool, template, or protocol must be prior approved in writing.

Ongoing Care and Service Coordination

It is the responsibility of the Care and Service Coordinators to perform ongoing monitoring through regular, ongoing communication with the member and their chosen representatives, oversight of delivery of services as outlined in the ICP and Service Plan, facilitating communication between ICT members, coordinating with ICT members for ongoing planning and revisions to the ICP and Service Plan, facilitating any new services to include provider identification, auth submission, and verification of service delivery and member satisfaction. For new LTSS support needs identified in the Service Plan, the Service Coordinator will provide

the member with information about potential providers for each HCBS that will be provided by Anthem and assist members with any requests for information that will help the member in choosing a provider and, if applicable, in changing providers, subject to the provider's capacity and willingness to provide service:

- Upon the scheduled initiation of services identified in the person-centered support plan, the member's care coordinator/care coordination team will begin to monitor services to ensure services have been initiated and continue to be provided as authorized; this will include ongoing monitoring via EVV to ensure that services are provided in accordance with the member's person-centered support plan, including the amount, frequency, duration and scope of each service, in accordance with the member's service schedule; ensure services continue to meet the member's needs.
- Identify and address service gaps, ensure that backup plans are implemented and effectively working, and evaluate service gaps to determine their cause and to minimize gaps going forward; describe in policies and procedures the process for identifying, responding to, and resolving service gaps in a timely manner.
- Identify changes to a member's risk, address those changes, and update the ICP and Service Plans needed.
- Reassess a member's needs and update the member's Service Plan in accordance with appropriate requirements and timelines.
- At a minimum, Anthem will consider the following significant changes in needs or circumstances requiring an ICT meeting and revision to the Care and Service Plan.
    - Change of residence or primary caregiver or loss of essential social supports
    - Significant change in health and/or functional status
    - Loss of mobility
    - An event that significantly increases the perceived risk to a member
    - Member has been referred to APS because of abuse, neglect, or exploitation
    - Identify and immediately respond to problems and issues, including circumstances that would impact the member's ability to continue living in the community
- Maintain appropriate ongoing communication with the community and natural supports to monitor and support their ongoing participation in the member's care.
- For services not covered by Anthem, coordinate with other payors or community organizations that provide services that are important to the health, safety, and well-being of members. This may include referrals to other agencies for assistance and assistance as needed with applying for programs, but Anthem will not be responsible for the provision or quality of noncovered services provided by other entities.
- Perform additional requirements for consumer direction of HCBS as necessary.
- Facilitate access to physical and/or behavioral health services as needed, including transportation to services; transportation for HCBS is not included.
- Monitor and ensure the provision of covered physical health, behavioral health, and/or LTSS services; and services provided as a cost-effective alternative to other covered services; and ensure that services provided meet the member's needs.
- Monitor member's utilization of the emergency department (ED), identify reasons for frequent usage of ED resources, and develop strategies to mitigate ongoing utilization of this resource as applicable.
- Provide assistance in resolving concerns about service delivery or providers.

- Coordinate with a member's PCP, specialists, and other providers, such as the member's mental health case manager, to facilitate a comprehensive, holistic, person-centered approach to care.
- Contact providers and workers on a periodic basis and coordinate with providers and workers to collaboratively address issues regarding member service delivery and maximize community placement strategies.
- Share relevant information with and among providers and others when information is available, and it is necessary to share it for the well-being of the member.
- Determine the appropriate course as specified herein upon:
    - Receipt of any contact made by or on behalf of a member, regardless of source, which asserts that the member's needs are not met by currently authorized services
    - The member's hospitalization
    - Other circumstances which warrant review and potential modification of services authorized for the member
- Ensure that all Pre-Admission Screening and Resident Review (PASRR) requirements are met prior to the member's admission to a nursing facility.
- Update consent forms as necessary.
- Assure that the organization of and documentation included in the member's file meets all applicable Anthem standards.

We will provide information regarding the role of the care coordinator and will request providers and caregivers to notify a member's care coordinator, as expeditiously as warranted by the member's circumstances, of any significant changes in the member's condition or care, hospitalizations, or recommendations for additional services. Anthem will provide training to key providers and caregivers regarding the value of this communication and remind them that the member identification card indicates if a person is enrolled in Indiana PathWays for Aging. Providers will be instructed on how to contact the coordinators by contacting Member Services or through the LTSS coordination email box **LTSScoordination@anthem.com**.

We facilitate timely communication between internal departments and the Care/Service Coordinators to ensure that each coordinator receives all relevant information regarding his or her assigned members (e.g., member services, Condition Care services, utilization management, and claims processing). The Care/Service Coordinator will follow up on this information as appropriate (e.g., documenting this information in the member's person-centered support plan, monitoring outcomes, and, as appropriate, conducting a needs reassessment and updating the plan of care).

We will monitor and evaluate a member's emergency department and behavioral health crisis service utilization to determine the reason for these visits. The Care Coordinator will take appropriate action to facilitate appropriate utilization of these services (e.g., communicating with the member's providers, educating the member, conducting a needs reassessment, and/or updating the member's person-centered support plan and to better manage the member's physical health or behavioral health condition(s)).

Care coordinators are actively involved in discharge planning when a member enrolled in

Indiana PathWays for Aging is hospitalized. The Care/Service Coordinator will conduct a face-to-face visit to complete a needs reassessment and an update to the member's ICP and Service Plan as needed.

The following observations will be documented at each face-to-face visit:

- Member's physical condition, including observations of the member's skin, weight changes, and any visible injuries
- Member's physical environment
- Member's satisfaction with services and care
- Member's upcoming appointments
- Member's mood and emotional well-being
- Member's falls and any resulting injuries
- A statement by the member regarding any concerns or questions
- A statement from the member's representative or caregiver regarding any concerns or questions (when the representative/caregiver is available)
- Community integration

We will assess for, identify, and immediately respond to problems and issues, including:

- Service gaps
- SDOH support needs such as food, clothing, utilities, socialization, housing, and transportation
- Emerging health risks
- Environmental safety
- Any signs of abuse, neglect, or exploitation
- Complaints or concerns regarding the quality of care rendered by providers, workers, or care coordination staff

Minimum Care Coordinator Contacts

Regular ongoing contact Care/Service coordination contacts could be as frequent as monthly but will vary depending on the complexity of the support needs and the member's individual preferences. Member contacts will ideally occur face-to-face but may also occur telephonically to accommodate the member's preference. In addition to regularly scheduled contacts the Care/Service Coordinators will also make contact upon notification of any change of condition, change of natural supports, change in environment or formal supports, and as requested by the member.

Critical Incidents/Unusual Occurrences

Under the Indiana PathWays for Aging program, critical incidents may also be referred to as unusual occurrences. These fall into three categories:

- HCBS Critical Incidents, examples include:
    - Significant injuries requiring emergent medical intervention, including but not limited to, a fracture, burn greater than first degree, choking that requires intervention, contusions, or lacerations
    - Injuries of unknown origin
    - Any threat or attempt of suicide

    - Any unusual hospitalization due to a significant change in health and/or mental status that may require a change in service provision OR admission of an individual to a nursing facility, excluding respite stays
    - Member elopement or missing person
    - Inadequate formal or informal support for a member, including inadequate supervision which endangers the member
    - Medication errors resulting in outcomes that require medical treatment beyond an ER/physician evaluation or monitoring of vital signs
    - A residence that compromises the health and safety of a member
    - Environmental or structural problems with a dwelling
    - A residential fire resulting in relocation, personal injury, property loss
    - Suspected or observed criminal activity by staff or family member
    - Police arrest of a member or any person responsible for the care of the member
    - A major disturbance or threat to public safety created by the member
    - Any instance of restrictive intervention (including chemical or physical restraints or seclusion)
    - Falls with injury
- Abuse, Neglect, and Exploitation (ANE) Incidents
    - Any alleged, suspected, reported, observed, or actual abuse/battery, assault, neglect, or exploitation of a member
    - Unexpected death of a member
- All Other Critical Incidents
    - Any critical incident that does not meet the definition of an HBCS or ANE critical incident; when in doubt report the unusual occurrence, so it can be reviewed, and issues resolved

Mandatory Reporting

Individuals who are victims of ANE may not realize that they are in an unhealthy environment. Depending on their relationship with the abuser, the member may not want to come forward and report such abuse. It is within the provider's scope to report any suspected abuse, neglect, or exploitation of the member even if the member does not explicitly state abuse is happening.

Adult Protective Services (APS) is responsible for defining, receiving reports of, and investigating suspected neglect, battery, or exploitation of an endangered adult. Any incident that meets APS's definition of a critical incident must be reported to APS. Instructions for reporting can be found at **FSSA: Aging Home: Incident Reporting**.

The Indiana Department of Health (IDOH) receives reports for critical incidents that occur at hospitals and other acute care facilities. Any incident that meets the IDOH's definition of a critical incident must be reported by staff and personnel of acute care facilities licensed by IDOH. The definition and reporting form can be found at **https://www.in.gov/health/cshcr/acute-and-continuing-care/report-an-incident-regarding-an-acute-care-facility/.**

Reporting Critical Incidents/Unusual Occurrences in HCBS Settings

Anthem staff and providers are expected to report any critical incident of which they have

knowledge. If a provider perceives an immediate threat to the participant's life or safety, follow emergency procedures which may include calling 911. Other options to submit reports:

- HCBS Critical Incidents – Submit a report via FSSA's DDRS/DA Incident and Follow-Up Reporting Tool (IFUR) at **https://ddrsprovider.fssa.in.gov/IFUR/**. The provider must submit these reports within **48 hours** of the time of the incident or becoming aware of it, whichever is sooner.
- ANE Critical Incidents – Report to local APS office within **24 hours**, including interventions underway or anticipated intervention. Link: **https://dmha.fssa.in.gov/dmha_mir/.**
- APS is not an emergency responder. If you believe someone is in immediate danger, call 911 immediately.

Suicide and Crisis Lifeline – Free and confidential support for people in distress, prevention, and crisis resources is available by dialing '988' to access the 988 Suicide & Crisis Lifeline.

Reporting Critical Incidents/Unusual Occurrences in Non-HCBS Settings

Comprehensive Care and Licensed Residential facilities are required to report to the IDOH Division of Long Term Care any allegations of abuse and any unusual occurrences that directly threaten the welfare, safety, or health of a resident of the licensed facility. The IDOH Long Term Care Abuse and Incident Reporting Policy may be found at **https://www.in.gov/health/ltc/incident/**.

The Indiana Division of Mental Health and Addiction (DMHA) receives reports for critical incidents that occur during the provision of mental health and addiction services. Applicable provider types include: DMHA Contracted Providers, Private Mental Health Institutions, State Psychiatric Hospitals, Opioid Treatment Programs, and other Residential Reporting Agencies. The definition and reporting form can be found at **https://www.in.gov/health/ltc/incident/**.

Preventing and Reporting Critical Incidents/Unusual Occurrences

Providers are expected to have a policy in place that describes how critical incidents will be prevented, reported, mitigated, and tracked over time. Providers should utilize critical incident data to determine opportunities for improvement. Reports submitted are tracked by the State and Anthem. Late reports and repeat issues are noted. The State expects the MCE to provide oversight of critical incident reporting, management, and mitigation. Provider agreements include provisions to ensure providers understand:

- Requirements to submit an incident report;
- Requirements to notify the member's service coordinator for any reportable HCBS critical incident within 48 hours of the time of the incident or becoming aware of the incident, whichever is sooner;
- How to comply with the critical incident reporting requirements;
- Take potential action to protect health and welfare;
- Consequences for non-compliance.

Home- and Community-Based Services Settings Rule Compliance

Home- and community-based service (HCBS):

- Is integrated in and supports access to the greater community.
- Provides opportunities to seek employment and work in competitive integrated settings, engage in community life, and control personal resources.
- Ensures the person receives services in the community to the same degree of access as individuals not receiving Medicaid home- and community-based services.
- Is selected by the person among setting options including non-disability-specific settings and an option for a private unit in a residential setting.

The intent of the HCBS final rule is to ensure members receiving long-term services and supports through HCBS programs under the 1915(c), 1915(i), and 1915(k). Medicaid authorities have full access to benefits of community living and an opportunity to receive services in the most integrated setting appropriate and enhance the quality of HCBS and provide protections to participants.

Prior to Anthem executing a *Provider Agreement* with a provider seeking Medicaid reimbursement for Indiana PathWays for Aging, OMPP verifies the provider is compliant with the HCBS Settings Rule detailed in *42 CFR § 441.301(c)(4)-(5)* as a part of the Division for Aging Waiver Provider certification and IHCP enrollment process. Anthem will verify provider compliance during the re-credentialing/re-certification. If a provider is not compliant with the HCBS Settings Rule, Anthem cannot contract with the provider. If at any time a previously compliant provider is deemed to be out of compliance with the HCBS Settings Rule, Anthem will require the provider to complete a corrective action plan detailing action steps and timelines to remedy any noncompliance. If a provider does not follow the corrective action plan, or if the provider determines it is unwilling or unable to continue compliance with the HCBS Settings Rule, such provider will be terminated from the Indiana PathWays for Aging network and any currently served members receiving HCBS will be transferred to a compliant provider.

Anthem will utilize FSSA's Compliance and Settings Rule tool, in alignment with the Division of Disability and Rehabilitative Services (DDRS), reviewed within the Anthem Support Visit Tool to verify compliance with the Settings Rule. Anthem will complete annual provider visits that include evaluating physical location, policies procedures, and other written documentation, employee training, and sampling employee files. In addition, we will conduct ongoing provider education training and technical assistance on the HCBS Settings Rule as deemed necessary.

The Anthem Settings Compliance Committee for Indiana PathWays for Aging will review referrals provided by the care/service coordinator leadership and, as part of their review, they will complete the following:

- Reviewing any proposed or emergency right restrictions and restraints included and not included in a Behavioral Support Plan (BSP), PCSP, or POC for potential human rights violations and ensuring informed consent of any restriction.
- Provide input for any modifications to member's rights when the member resides in a provider-owned or controlled residential setting prior to the modification being included in the member's person-centered support plan.

- Review potential violations of HCBS Settings Rules in instances in which a member is living in an unlicensed setting or licensed setting other than those covered in benefits for Indiana PathWays for Aging members that may be in violation of HCBS Settings Rules and make recommendations for coming into compliance with HCBS Settings rules.
- Reviewing and making recommendations regarding complaints received pertaining to potential human rights violations.
- Ensuring that the proposed restriction is the least restrictive viable alternative and is not excessive.
- Ensuring that the proposed restriction is not for staff convenience.

Claims Submission

For **general information** on claims submissions to Anthem, **Chapter 10: Claims Submission** in the ***Indiana Medicaid Provider Manual*** provides information on claims, including:

- Submitting clean claims
- Claims filing limits
- Claims from non-contracted providers
- Claims disputes
- Paper claims submission
- Member copayments
- Balance billing
- Cost-sharing
- Third Party Liability (TPL) or *Coordination of Benefits* (*COB*)
- Claims overpayment recovery procedure
- Other filing limits
- Processes to resolve claim issues
- Reimbursement policies
- Claims overpayment recovery procedure
- Claim resubmissions
- Claims disputes

In addition, 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/**.

Waiver & Patient Liability

Long-term care claims are not reimbursable until Waiver or Patient Liability has been met. Providers will be able to see liability the obligation and balance in the Care Central Portal. FSSA determines the amounts for Waiver Liability and Patient Liability. Additional information can be found in the **Patient Liability** and **Waiver Liability** sections of this manual.

Waiver Liability (HCBS):

- This term refers to the monetary amount that a member will contribute to their monthly care.

Patient Liability (NF/ICF):

- Applies to members in a nursing home or intermediate care facility for 30 days or more.

- For liabilities for members related to rule 42 C.F.R 435.725, the amount of the liability will be deducted from the total reimbursement of monthly claims to the facility.
- Providers must apply current income to current needs.

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. Electronic claims submission is further outlined in **Chapter 10: Claim Submissions.**

Availity Essential's Anthem Payer Spaces: Care Central

Availity Essentials gives users functionality and real-time information exchange to manage daily transactions with Anthem. Features include:

- **Electronic transactions** provide a secure platform where providers can perform eligibility and benefit inquiries, check claim status, and track remittances.
- **Multi-payer portal** ensures a consistent workflow for all participating health plans, allowing providers the same user experience.
- Through this multi-payer portal, providers can access several Anthem's **Care Central** applications, the one-stop shop for LTSS providers.
- Initiating Availity Essentials registration starts at **https://Availity.com**.

Indiana PathWays for Aging providers will use Care Central as the primary method for submitting electronic claims. Accessible through Availity Essential's Anthem Payer Spaces, Care Central is a one-stop shop for LTSS/Atypical providers, with tailored billing, authorization, and member management dashboards in addition to other provider-supporting features, which:

- Enables a simplified, seamless, and tailored online experience reducing administrative burden
- Reduces errors, manual processes, and obsolete technology
- Empowers the provider with quick access to information necessary to initiate and maintain member care
- Streamlines resources and contacts optimized for LTSS/Atypical providers
- Provides a clear line of sight into critical data and reporting

Claims submission within Care Central leverages the information we already have about an LTSS/Atypical provider obtained through the Availity registration process to streamline claim(s) submission. When submitting a claim, the provider will be required to first select the member(s) who they have an existing authorization on the member dashboard and will then be requested to enter claims information. Claim information, if for the same service, can be entered once to submit claims for multiple members. Claims settings, once established for a provider, can be edited but will not be required to be entered each time a claim needs to be submitted. Once a claim has been reviewed and submitted, providers can track the status of their claim in the Claims Dashboard tab within Care Central.

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.

Legacy Provider Identifier (LPI)

For Home- and Community-Based Services (HCBS) providers who do not have an NPI number, the Legacy Provider ID (LPI) assigned by IHCP will be used for claim submissions. The LPI including on the claim will need to align with the corresponding field on the State Master Provider File to prevent any claim delays or rejections.

Additional information on the National Provider Identifier (NPI), can be found in ***Chapter 10: Claims Submission*** along with the standard claims submission process.

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 HCBS claim within 7 business days for Indiana PathWays for Aging 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

Submitted claims can be monitored within the Availity Essentials portal by navigating to Claim & Payments > Claim Status. Additionally, LTSS providers can further view the status of their claims by navigating to the Care Central application with *Payer Spaces*. Monitoring claims within Care Central can be completed in the Claims tab. It is here where providers have the ability to see the status of their claims along with other cumulative information about their claim history.

Disclaimers

Carelon Medical Benefits Management, Inc. is an independent company providing utilization management services on behalf of the health plan.

CarelonRx, Inc. is an independent company providing pharmacy benefit management services.


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