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Anthem Blue Cross and Blue Shield

Hoosier Care Connect provider orientation

Agenda

- Program overview/goals
- Eligibility
- Covered benefits
- Prior authorization
- Care management
- Right Choices program
- Provider reimbursement
- Claims submission
- Hospital-acquired conditions (HAC)
- Present on admission (POA)
- Hospital assessment fee
- Coordination of benefits/third party liability
- Anthem Blue Cross and Blue Shield (Anthem) contact information
- Questions and answers

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Program overview

Hoosier Care Connect begins **April 1, 2015**, and will serve *95,000* members statewide. It will replace the fee-for-service *Care Select* program.

Hoosier Care Connect seeks to improve:

- Quality of care
- Patient safety
- Access to care
- Adherence to treatment plans
- Improved clinical and functional status
- Better health outcomes
- Quality of life

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Program goals

Hoosier Care Connect program goals:

- Improve quality outcomes and consistency of care across delivery systems
- Ensure member choice, protections and access
- Coordinate care across delivery systems and care continuum
- Provide flexible person-centered care

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Member eligibility

Membership will include Medicaid-eligible children and adults in below categories:

- Aged (65+)
- Blind
- Disabled
- Individuals receiving Supplemental Security Income (SSI)
- M.E.D. Works
- Wards and foster children

Providers must check eligibility using Availity or Web interChange.

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Member eligibility

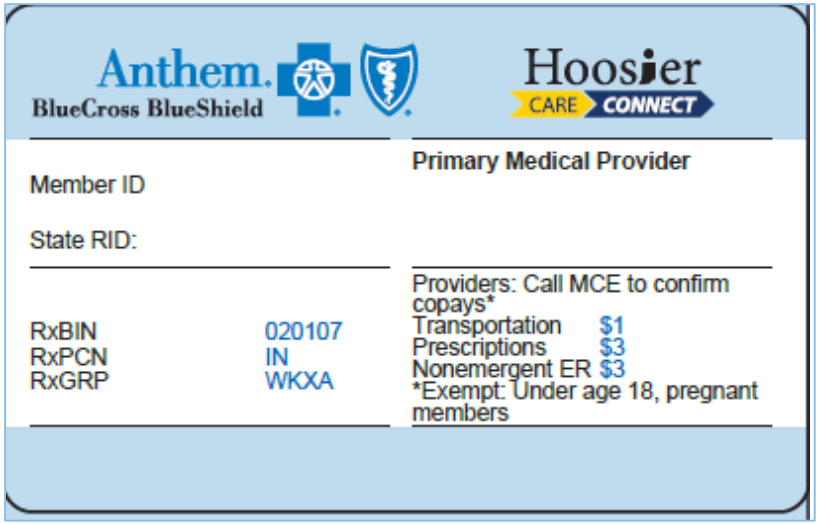
Excluded from the program are members who are:

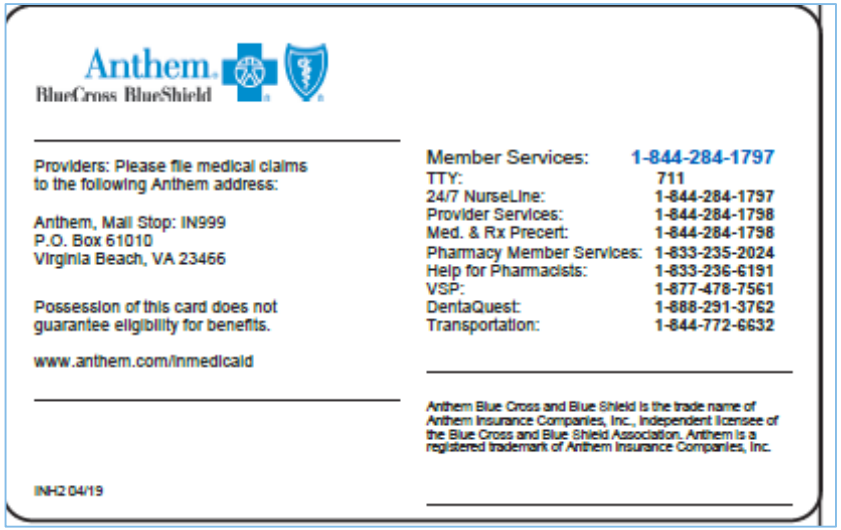
- Medicare dual-eligible
- Enrolled in an institutional setting
- Enrolled in a home and community-based services (HCBS) waiver

Member eligibility

Member ID cards

- Unique ID cards issued by Anthem to members enrolled in Hoosier Care Connect
- Check eligibility through Availity or call the Provider Helpline





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Eligibility verification for providers

Verification steps

- Use Web interChange, AVR or OMNI swipe card
- Verify member's Hoosier Care Connect eligibility on date of service
- Verify member's managed care entity (MCE) for claim submission purposes

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Eligibility and the primary medical provider

- All members must have a primary medical provider (PMP)
- Availity identifies the member's PMP information or the provider can call the Provider Helpline
- Referrals are required the same as for Hoosier Healthwise – providers enter the NPI of the member's PMP in box 17b of the CMS-1500 claim form when a referral has been obtained (see provider operations manual for exceptions and complete instructions)
- PMP rosters are available through the Availity website for Hoosier Care Connect PMPs

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Covered benefits

Covered services are outlined in the Anthem Provider Operations manual located at **www.anthem.com**.

Covered services:

- Similar to Hoosier Healthwise package A benefits
- Includes self-referred services: pharmacy, dental, vision
- Medically necessary
- Consistent with accepted standards of medical practice with respect to illness, injury, condition, primary or secondary disability:
  - Prevent or diagnose
  - Cure, correct, reduce or ameliorate physical, mental, cognitive, or developmental effects
  - Reduce or ameliorate pain

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Self-referred services

Members can self-refer for services below to any Indiana Medicaid provider (see exception):

- Psychiatry services (treatment from a non-psychiatrist must be from an in-network provider)
- Chiropractic care
- Diabetes self-care training
- Emergency services
- Eye and vision care
- Family planning
- HIV/AIDS care management
- Podiatry services
- Immunizations
- Dental (members can use any Indiana Medicaid dentist from **April 1, 2015** to **June 6, 2015**; starting **July 1, 2015**, members can self-refer to any network dentist)

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Carved-out services

Traditional Medicaid provides the following Medicaid-covered services:

- Long-term care stays greater than 60 days
- Admission to a state psychiatric hospital
- Medicaid rehabilitation option (MRO) services
- ICF-MR
- PRTF
- Individual education plans
- Hospice
- Home and community based waiver services

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Prior authorization

Recent updates to services requiring PA

- Cranial orthotics
- Custom durable medical equipment
- Hospital beds
- Orthopedic footwear
- Wheelchairs and wheelchair accessories
- Lifts
- Cervical fusions
- Nonemergent hysterectomies
- Spine surgery

Not all precertification requirements are listed here. To find all precertification and code-specific requirements:

- Go to **www.anthem.com**.
- Select OTHER ANTHEM WEBSITES: **Providers** from the top menu bar.
- Choose **Indiana** from the drop-down menu and select **Enter**.
- From the blue menu on the left side, select **Enter** under *Medical Policies, Clinical UM Guidelines and Pre-Cert Requirements*.
- [Select *Prior Authorization Requirements: Hoosier Healthwise, Healthy Indiana Plan and Hoosier Care Connect*]

*Contact DentaQuest and VSP for dental and vision medical management procedures.

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Care coordination management

Care coordination services are for members with conditions requiring special care and providers. Programs are stratified into three levels:

- Disease management
- Care management
- Complex case management

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Disease management

Disease management (DM) is designed for members with chronic conditions. Each program targets management and prevention of specific needs:

- Asthma
- Depression
- Pregnancy
- ADHD
- Autism/PDD
- COPD
- Coronary artery disease
- Chronic kidney disease
- Congestive heart failure
- Hypertension
- Diabetes
- HIV/AIDS
- Schizophrenia
- Bipolar disorder
- Substance use disorder

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Case management

Case management programs assists the Hoosier Care Connect population in addressing specialized health care needs:

- Assistance with care coordination
- Arranging preventive care appointments
- Access to care for chronic physical or behavioral health conditions

Members receive a dedicated case management representative to coordinate with all providers across the care continuum to create a plan to access appropriate care and improve clinical outcomes.

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Complex case management

Member focus

Coordination of care services with the member and between providers while navigating the extensive systems and resources required for the member.

Provider focus

Coordination of care services with members who choose not to be involved, or are unable to participate, to help navigate the extensive systems and resources required for the member:

- Complete comprehensive health assessment tool
- Two or more disease states
- Inpatient stays
- High-dollar claims over six months
- Post-psychiatric inpatient stay for 90 days and scheduled 7-day follow-up

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Care conferences

Providers who serve Hoosier Care Connect members engaged in care management will need to participate in semi-annual care conferences with an interdisciplinary care team.

The goal is to coordinate services for Hoosier Care Connect members across the care continuum and improve health care outcomes for members in care management.

PMPs may bill for the semi-annual conference using HCPCS code 99211 SC – “office or other outpatient visit for the evaluation and management of an established patient.”

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Right Choices program

Right Choices program (RCP):

- Designed as a safeguard against unnecessary or inappropriate use of Medicaid benefits by members
- Helps improve member care by reducing inappropriate, potentially harmful use of pharmacy and other health services and avoiding unnecessary and wasteful program expenditures
- Primary lock-in provider provides a “medical home” and is better able to manage a member’s care and coordinate services

Right Choices program – general guidelines

- Providers send **lock-in provider notification letter** via Web interchange.
- PMP must refer member if needs treatment by a specialist/other provider.
- Referral must be sent to the Anthem RCP administrator for claims adjudication.
- Referring providers must check Medicaid eligibility and should not treat the lock-in member without a referral.

Right Choices program – general guidelines

- Member to be notified prior to receiving service not covered by Medicaid.
- Members must sign a waiver stating they will be billed for noncovered services before receiving the service.
- RCP members may not pay cash for any Medicaid-covered service. Contact member's case manager if cash is used.
- If the referral provider wants to refer the member to a third physician, the PMP must also sign the referral and send it to the Anthem RCP administrator.
  - Exception: Medical emergencies do not require referral.

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Provider reimbursement

- Providers will be reimbursed at the current Indiana Medicaid rates.
- Hospitals will receive hospital assessment fee wrap payment according to state guidelines.

Claims submission

Fast and accurate claims processing enables better management of your practice and of your patients' care. For the greatest efficiency and accurate reimbursement:

- Submit "clean" claims, making sure the right information is on the right form
- File claims as soon as possible after providing service
- Submit claims within the contract filing time limit

Claims and billing guidelines are outlined in the **Indiana Health Coverage** programs manual online in the chapter on billing:

http://provider.indianamedicaid.com/ihcp/manuals/chapter08.pdf

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Claims submission

Methods for submission:

- Electronically through the **Electronic Data Interchange** *(preferred)*
- Paper or "hard copy"

Filing limits are determined as follows:

- If **Anthem** is the **primary** payer – 90-calendar days from the last date of service on the claim
- If **Anthem** is the **secondary** payer – 90-calendar days from the other payer's remittance advice (RA) date

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Claims submission

Submission forms

Generally, there are two types of forms you'll need for reimbursement:

- **CMS-1450** (UB-04) for institutional services
- **CMS-1500** for professional services

Claim forms must include the full member ID number and the 3-letter alpha prefix "YRH".

Refer to handouts.

Claims submission

Some important required fields to include on CMS-1450 (UB-04) and CMS-1500.

Description	Form	Field number	Field name
Member name	UB-04	58	Insured's name
	CMS-1500	4	Insured's name
Member ID number	UB-04	60	Insured's unique ID
	CMS-1500	1a	Insured's ID number
Prior authorizations	UB-04	63	Treatment authorization codes
	CMS-1500	23	Prior authorization number (PA)
Prior payment information	UB-04	54	Prior payments
	CMS-1500	27	Prior payments
Referrals	UB-04	78	Other
	CMS-1500	17b	Name of referring provider or other source

Refer to claim form handouts for other required fields and specifics.

Hospital-acquired conditions

Hospital-acquired conditions (HAC):

- IHCP utilizes the existing version 18.0 of All Patient Diagnosis-Related Group (AP DRG) for its HAC policy for Medicaid claims using the existing version.
- Hospitals must report whether each diagnosis on a Medicaid claim was present on admission.
- Claims submitted without required present on admission (POA) indicators are denied. Claims with secondary diagnoses on the list of HACs, and not present on admission, do not use the HAC secondary diagnosis for AP DRG grouping.

Refer to the IHCP provider manual or IHCP provider bulletin for a list of the most up-to-date HAC categories and corresponding complication or comorbidity (CC) or major complication or comorbidity (MCC) codes.

Present on admission

Present on admission (POA):

- Defined as a condition “present” at the time the order for inpatient admission occurs
- Conditions that develop during an outpatient encounter, including emergency department, observation or outpatient surgery
- POA indicator must be assigned to principal and secondary diagnoses (as defined in Section II of the *Official Guidelines for Coding and Reporting*)
- IHCP does not require a POA indicator in the External Cause of Injury field locator 72. If entered, it is ignored and not used for AP DRG grouping.

Hospital assessment fee

The Indiana Family and Social Services Administration (FSSA) implemented a hospital assessment fee (HAF) in accordance with Public Law 229-2011, Section 281 as enacted by the 2011 Session of the Indiana General Assembly.

- HAF permits inpatient and outpatient aggregate claims payment at the upper Medicare payment limits without exceeding them.
- In-state acute care hospitals licensed under IC 16-21-2 and freestanding psychiatric hospitals licensed under IC 12-25 are subject to HAF.
- Provider bulletin BT201443 announces changes to HAF factors for inpatient and outpatient claims for claims with DOS on and after **October 1, 2014**.
- Outpatient laboratory services (codes listed on the Medicare clinical laboratory fee schedule) are not subject to the HAF increase.
- The calculation of the fee is determined by hospital cost report which must be filed timely with Myers and Stauffer LC.

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Hospital assessment fee

Effective **September 27, 2014, for dates of service on or after October 1, 2014** (Bulletin BT201443), increases in reimbursement will be based on the following adjustment factors:

- Inpatient diagnosis-related group (DRG) base rate: 2.1
- Inpatient rehabilitation level of care (LOC) rate: 2.6
- Inpatient psychiatric LOC rate: 2.2
- Inpatient burn LOC rate: 1.0
- Outpatient rates (excluding laboratory): 2.7

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Hospital assessment fee

Anthem payment timeline

- Anthem receives a monthly report on or about the last week of each month from FSSA with the amount to be reimbursed to each hospital.
- Vouchers are created for payments to be sent to each hospital
- Once vouchers are created, it goes through the Anthem internal approval process.
- Once approved and funds are received by FSSA, Anthem will mail payment, usually during the first week of the following month.

Note: Ten days (average) processing time from the date the report is received, to the date Anthem mails payment to each hospital.

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Coordination of benefits/third party liability

- Members enrolled in Hoosier Care Connect may have other insurance; coordination of benefits (COB) must take place.
- Members may have other insurance that Anthem and the state are not aware of at the time of service. There will continue to be coordination for third party liability (TPL) for accidents.
- Anthem will recoup claims paid if a member had other insurance – the provider has six months from the date of the recoupment notification to submit claims.
- The provider may not pursue reimbursement from the member for any reason.

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Anthem contact information for Hoosier Care Connect

Hoosier Care Connect Provider Helpline: **1-844-284-1798**

Customer Care Center (members): **1-844-284-1797**

24/7 NurseLine: **1-866-800-8780**

Corrected claims, provider claim disputes, provider appeals submit to:

Anthem Blue Cross and Blue Shield
P.O. Box 6144
Indianapolis, IN 46206-6144

Medical: **1-866-398-1922**
Rx prior authorization: 1-844-284-1798
VSP (vision): **1-866-866-5641**

DentaQuest (dental): **1-888-291-3762**

LCP Transportation: **1-866-879-0106**

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Thank you

www.anthem.com/inmedicaiddoc

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