Anthem

New York
Medicaid

Managed long-term care provider orientation

Agenda

- Welcome to the Anthem managed care network
- Provider websites: Managed Long-Term Care (MLTC) Provider Portal, Availity Essentials
- Authorization process
- Claims submission
- Appeals and grievances
- Electronic payment and remittance
- Anthem compliance program:
  - Fraud, waste, and abuse (reporting suspected cases)
  - *False Claims Act*
  - *Anti-Kickback Statute*
  - *Health Insurance Portability and Accountability Act of 1996 (HIPAA)*
  - Cultural and linguistic competency

Welcome to the Anthem network

- Anthem believes members receive the best care when we and our network care providers work in true partnership with each other.
- This orientation establishes a foundation for this partnership, ensuring care providers are properly trained and introduced to our values, policies, and procedures.

Anthem provider websites

Requesting access and checking status of referrals, authorizations, claims, and eligibility

MLTC Provider Portal

- A tool that allows care providers to have access to the latest data in a quick and efficient manner
- A web-based application that provides the ability to review referral and authorization information
- A streamlined approach for reviewing and printing service authorizations
  - The application is updated every 15 minutes, Monday through Friday.

MLTC Provider Portal access

Registration is quick and easy	
Requesting access	• Access to Anthem provided website is granted by contacting provider portal support at MLTCProviderPortal@anthem.com. • A temporary password is sent with login instructions via email.
First time login	• Go to the MLTC provider website and select **Log in.** • Enter your email address and password.
Active authorization	• Active authorizations can be viewed by selecting **Authorizations.** • Authorizations can be searched by choosing **Search** on a member's name or any other member-related key.
Status of referrals	• Status of referrals enables you to track active referrals. • Referrals can be viewed by selecting the **Referral Tracking Page.** • A list of active referrals can be exported to Excel.

Availity Essentials

- Availity Essentials is used by providers to securely access patient information such as eligibility, benefits, claim status, and other proprietary information.

- Healthcare providers can use a single login to access multiple health plan providers at no cost.

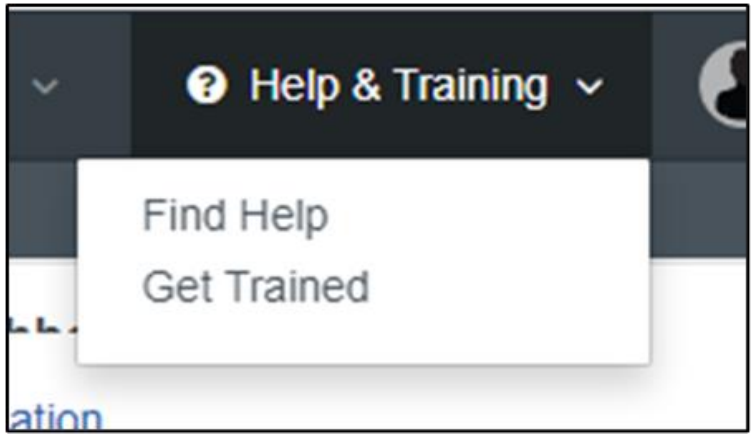
Availity Essentials access

Registration is quick and easy	
Registration	• Go to http://Availity.com and select **Register** to start using Availity Essentials. • Select your organization's primary administrator. • Assign administrator duties to Availity Essentials administrator. **Note:** Ensure the primary admins are able to handle the responsibilities assigned to them in Availity Essentials.
Claims submission	• *Professional Claim Form Direct Data Entry* (DDE)
Claims status search	• A multi-payer claim status details screen enhanced for Anthem with custom value-added information. This is Availity Essentials' legacy *Claim Status screen*. It provides the X12 277 *Claim Status* response information and uses custom Anthem APIs to display value-added information.
Provider Data Management (PDM)	• Use the PDM application to update information about your business and providers and to make your required 90-day updates per the CMS mandate.
ERA enrollment	• Review remittances for any ERAs you are currently receiving in Availity.
Member eligibility inquiry	• Review member eligibility and benefits.

Availity Essentials — training

Visit the **Availity Learning Center** to register for live training or access recorded demos:

- Log in to http://Availity.com .
- Go to *Help & Training* at the top navigation bar on the main page.
- Select **Find Help** or **Get Trained.**
- For direct access to the on-demand trainings go to rebrand.ly/104185.



Requesting authorization, checking status of authorizations, and delegated vendors

Authorization process

- Care providers may request authorizations verbally or in writing:
  - on behalf of a member.
  - for a new service.
  - for a concurrent review to change an existing service:
    - Toll free: **929-946-6500.**
    - Fax: **718-368-6267.**
- Authorization status is available in the MLTC Provider Portal.

Covered services

Examples of services covered by Anthem	
Care management	Podiatry
Nursing home care	Dentistry
Home care: • Nursing services • Home health aide services • Physical therapy • Occupational therapy • Speech pathology • Medical social services	Optometry
Adult day health center	Audiology
Personal care	Social and environmental support
Durable medical equipment (DME)	

Delegated vendors

- Anthem is contracted with the following vendors to offer optimal services to its members:
  - **Dental:** Liberty Dental
  - **Vision:** Superior Vision
- See *Provider Quick Reference Guide* for contact information.

Provider Quick Reference Guide

Service	Contact information
Enrollment	**929-946-6500** (phone) **718-368-6244** (fax)
Care management	**929-946-6500** (phone) **718-368-6267** (fax) **917-436-4597** (fax)
Provider service line	**929-946-6500** (phone) **718-368-6269** (fax) Providerrelations3@anthem.com
Dental services	**Liberty Dental:** **888-325-7924** (phone)
Vision services	**Superior:** **866-819-4298** (phone)
Claims submission	Clearinghouses: **Availity Essentials** Payer ID number: **45302** **800-282-4548** (phone)

Claims submissions and claims search

Electronic claims submission — benefits

- **Electronic claims submission** is the **easiest and fastest** way to submit claims to Anthem.
- Anthem uses Availity Essentials:
  - Payer ID number: **45302**
  - Availity Essentials telephone number: **800-282-4548**
- Submitting **claims electronically** ensures timely, accurate processing of your claims.
- **Electronic claims submission** lowers the number of claims denied.

Timely filing policy

- **Primary services**: 90 days from the service date or by your contract terms
- **Secondary services**: 90 days from *Explanation of Medical Benefits (EOMB)*
- **Appeals**: 60 days from the original *Explanation of Payment (EOP)* denial date
- Paper claims should be sent to:

Anthem

P.O. Box 61010
Virginia Beach, VA 23466-1010

Note: New York state prompt payment law requires claims to be paid or denied within 30 days for electronic and 45 days for paper upon receipt.

Appeals and grievances policy

- Care providers who are dissatisfied with a claim determination made by Anthem can submit a written request for review.
- **Appeals:** 60 days from the original *EOP* denial date
- **Appeals and grievances with all supporting documentation should be sent to:**

  Anthem
  Grievances and Appeals
  1985 Marcus Ave, Suite 150
  Lake Success, NY 11042

- Please refer to the *Claims FAQ* for answers to frequently asked questions.

Claims

- Nursing home claims:
  - Starting March 1, 2025 , nursing home stay claims must include a valid room and board revenue code and a correctly reported rate code in the *UB-04* paper form's *Value Code* section and in the appropriate segment of the 837i transaction. Claims with Anthem as the primary payer need a matching authorization revenue code. Please also include the rate codes for secondary claims.
  - Your service approvals will be issued with a revenue code from the list below, dependent on the type of bed. Your claim must be submitted with a matching revenue and rate code in order to process correctly for payment.

Service description	Rev code	Rate codes
SNF - Sub Acute/Custodial	0190	3810, 3812, 3838, 3839, 2862, 2863
SNF - Sub Acute, Level 3 (AIDS)	0193	3755, 3756, 3766, 3767, 3848, 3849
SNF - Sub Acute, Level 4 (VENT)	0194	3759, 3760, 3775, 3776, 3770, 3771
SNF - Traumatic Brain Injury	0199	3754, 3845, 3753, 3844

Claims

- To ensure the claim system accurately processes and links your claim to a service authorization and your contract terms, please submit your claim with the appropriate bill types and revenue codes based on the service you provide.
- *Institutional Claim form* and 837i requirements for the type of bill and revenue code

Service	Bill type	Rev codes
Consumer directed and licensed home care agency	32x, 33x, 34x	057x, 058x, 0590
Social day care and adult day health care	89x	310x
Home delivered meals	32x, 33x, 34x	0580, 0590
Six month in-home assessment	32x	0560
Environmental supports (chores, pest control)	34x	0580
Personal emergency response system	34x	0590
Home health care (PT, OT, ST, SW, Nurse)	32x	042x(PT), 043x(OT), 044(ST)x, 055x(Nurse), 056x(SW)
Physical, occupation, speech therapy in an outpatient setting	13x, 14x, 22x, 73x, 74x, 77x	042x(PT), 043x(OT), 044(ST)x

Electronic funds transfer and electronic remittance advice

Electronic funds transfer

- **Electronic funds transfer (EFT):**
  - EnrollSafe will replace Payspan as the EFT portal.
- **To register a *new* account:**
  - Go to the EnrollSafe enrollment hub at enrollsafe.payeehub.org to register and enroll in EFT. Once you have completed registration, you'll be directed through the EnrollSafe secure website to the enrollment page where you'll provide the required information to receive direct payment deposits.
- **For *existing* registered accounts with EnrollSafe:**
  - Log onto the EnrollSafe hub at enrollsafe.payeehub.org and review your account to ensure your information and banking details are up to date.

Electronic funds transfer (cont.)

- **For an existing registered account with Payspan:**
  - Go to the EnrollSafe enrollment hub at enrollsafe.payeehub.org to register and enroll with up-to-date EFT information.
- **For help:**
  - Use the attached *EnrollSafe/EFT User Reference Manual*
  - Contact:
    - **Email:** support@payeehub.org
    - **Phone: 877-882-0384** from 9 a.m. to 8 p.m. ET

Electronic remittance advice

- **Electronic remittance advice (ERA):**
  - Availity will replace Payspan for electronic remittance advice.
- **To register or view your ERA profile:**
  - Log in to https:/Availity.com and select **My Providers** from the top navigation bar.
  - Select **Enrollment Center**, then **Transaction Enrollment**
  - Complete the enrollment steps for electronic remittance advice:
    - Use EDI Payer ID – 45302.
- **For help:**
  - For assistance with a missing or late ERA (835), please contact Availity Client Services at **800-282-4548** or work with your clearinghouse.

Compliance program

Compliance program

- **We** are committed to conducting our business with integrity and in compliance with applicable laws and regulations.
- Our **fraud, waste, and abuse (FWA)** compliance program is designed to identify and eliminate FWA.
- We expect our care provider network to adhere to all applicable state and federal compliance program requirements.

FWA — definitions

- **Fraud:** Knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any healthcare benefit program, or to obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by, or under the custody or control of, any healthcare benefit program.
- **Waste:** Includes overusing services, or other practices that, directly or indirectly, **result in unnecessary costs** to the Medicaid program. Waste is generally not considered to be caused by criminally negligent actions but rather by the misuse of resources.
- **Abuse:** Includes actions that may, directly or indirectly, **result in unnecessary costs** to the Medicaid program. Abuse involves payment for items or services when there is not legal entitlement to that payment and the care provider has not knowingly or intentionally misrepresented facts to obtain payment.

Examples of FWA

- **Fraud:** Knowingly submitting claims for services that were not rendered.
- **Waste:** Costs incurred when an individual is receiving more units or hours of service than needed, for example, when an individual's health improves but their intensity of supports remains the same.
- **Abuse:** A personal care provider bills for services during an individual's institutional stay. This is abuse because the provider should have been aware of the rules, which specify that services cannot be billed during an institutional stay.

False Claims Act

- The federal *False Claims Act* creates liability for the submission of a claim for payment to the government that is known to be false — in whole or in part.
- Claims *submitted to the government* include claims submitted to intermediaries such as state agencies, managed care organizations, and other subcontractors under contract with the government to administer healthcare benefits:
  - **Example:** A care provider bills us for personal care services that were supposedly rendered when the patient was in the hospital.

False Claims Act — (31 U.S.C. §§ 3729-3733)

Prohibits:	Criminal penalties	Civil penalties:
• Presenting a false claim for payment or approval • Making or using a false record or statement in support of a false claim • Conspiring to violate the *False Claims Act* • Falsely certifying the type or amount of property to be used by the government • Certifying receipt of property without knowing if it's true • Buying property from an unauthorized government officer • Knowingly concealing or knowingly and improperly avoiding or decreasing an obligation to pay the government	If convicted, the individual shall be: • Fined. • Imprisoned. • Or both. If the violations resulted in death, the individual may be imprisoned for: • Any term of years. • For life . • Or both.	• Damages may be tripled — plus — • Civil money penalty between $5,000 and $10,000 for each claim

Anti-Kickback Statute (42 U.S.C. §§ 1320a-7b b)

- The *Anti-Kickback Statute* makes it a crime for individuals or entities to knowingly and willfully offer, pay, solicit, or receive something of value to induce or reward referrals of business under federal healthcare programs.
- The *Anti-Kickback Statute* is intended to ensure that referrals for healthcare services are based on medical need and not based on financial or other types of incentives to individuals or groups.

Anti-Kickback Statute (42 U.S.C. §§ 1320a-7b b) (cont.)

Prohibits	Penalties
Knowingly and **willfully** soliciting, receiving, offering, or paying remuneration (including any kickback, bribe, or rebate) for referrals for services that are paid in whole or in part under a federal healthcare program (including Medicaid).	• Fine of up to $25,000 • Administrative civil money penalties up to $50,000 • Exclusion from participation in the Federal Health Program • Imprisonment for up to five years **Note:** Can receive both fines and imprisonment

Reporting FWA and compliance Issues

- It is everyone's responsibility to report suspected cases of FWA.
- Do not be concerned about whether or not it is FWA. Report any concerns to:
  - The compliance email: MLTCcomplianceofficer@anthem.com
  - The toll-free compliance hotline: **833-480-0010**

Retaliation in any form against anyone who makes a report of suspected FWA is **strictly prohibited**.

sound

- *HIPAA* privacy rule requires providers to protect and safeguard the Protected Health Information (PHI) of members.
- PHI Includes the following information:
  - Medical records
  - Claims submission for payment
  - Enrollment information
- As a provider who has access to PHI, you are responsible for adhering to *HIPAA*.
- Ways to protect member PHI:
  - Allowing only authorized employees to have access to members' files.
  - Limit members' information on an attendance sheet.
- Members' PHI **must** be safeguarded and kept in confidence.

Provider manual

- The provider manual offers detailed information about policies and procedures, care management, FWA, and other important areas.
- Print and electronic copies of the provider manual are available to all providers to ensure providers understand and adhere to established guidelines.
- Additional information on the compliance program is available in the provider manual.
- Visit providers.anthem.com/ny for the provider manual.

Cultural and linguistic competency training

Provider cultural competency is the ability of care providers to effectively deliver healthcare services that meet the social, cultural, and linguistic needs of patients.

We expect care providers will:

- Complete an annual cultural and linguistic competency training as mandated by *CMS Requirement Section 438.10*.
- Practice culturally competent care by understanding the disability, racial, ethnic, and cultural differences between the care provider and member.
- Attest that this annual training was completed.

Electronic visit verification

- Effective January 1, 2021, electronic visit verification (EVV) requires states to electronically collect service delivery information for personal care services, to verify service type, individual receiving the service, date of service, location of service delivery, individual providing the service, and beginning and end time of the service.
- Under the choice model to implement EVV, care providers will choose a system that best meets their needs and that is compliant with the EVV requirements, and the New York State Department of Health (DOH) will provide a statewide aggregator solution to collect and aggregate the data.
- Questions can be directed to EVVHelp@health.ny.gov.
- EVV website: health.ny.gov/health_care/Medicaid/resdesign/evv

NYBCBS-CD-079722-25 | March 2025