Anthem HealthKeepers Plus
Offered by HealthKeepers, Inc.

Claims and Billing Manual

Virginia | HealthKeepers, Inc. | Anthem HealthKeepers Plus Medicaid products

Claims and billing overview

We've streamlined claims processing. A fast and accurate system for processing claims allows care providers to manage their practice and the care of our members more efficiently.

Please share the following guidelines with your staff, billing service, and electronic data processing agents:

- Submit clean claims, ensuring the correct information is on the proper form.
- Submit claims as soon as possible after providing the service(s).
- Submit claims within the contracted filing time limit.

You can check claims status using Availity Essentials (https://Availity.com) or https://Anthem.com/va/provider.

Note: You must register with Availity Essentials (https://Availity.com) to access the secure portion of the website. Once registered, you can log in to a single account and perform numerous administrative tasks.

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

- CMS-1500: to be used for professional services
- CMS-1450 (UB-04): to be used for institutional services

These forms can be found on the CMS website (https://CMS.gov > Medicare > Forms & notices > CMS forms > CMS forms list) and are available in both electronic and paper formats.

Note: Using the wrong form, not filling it out correctly, or not filling it out completely will result in your claim being returned and subsequent processing and payment delays.

Submitting clean claims

Claims are defined as clean when submitted without defects, with all required information for processing, and within the specified timeframe.

An error report is generated and sent to you for claims that aren't accepted. Scenarios where claims may be returned include:

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- Claims submitted with incomplete or invalid information (including those submitted through electronic data interchange, EDI).
- Claims submitted without the proper HIPAA-compliant code set.

You are responsible for working with your EDI vendor to ensure returned claims are corrected and resubmitted.

Claim filing limits

If we are the primary or secondary payer, you have 365 days to file the claim. Claims must be submitted within the contracted filing limit to be considered for payment, and claims submitted outside this timeframe are not eligible for reimbursement for timely filing. Compliance is determined using the last date of service on the claim and our receipt date.

For specific details regarding filing limits for the claim types listed below, review the provider manual https://Anthem.com/va/provider > Resources > Policies, Guidelines and Manuals):

- Physician and institutional claims
- Third-party liability/coordination of benefits claims
- Claim follow-up
- Provider disputes
- Retro eligible member claims

Electronic claims submission

We encourage care providers to submit claims electronically using Availity Essentials (https://Availity.com) or a clearinghouse using EDI (claim payer ID = 00660 for professional services and 00160 for institutional services).

Benefits of using the Availity Essentials (https://Availity.com) include:

- **Multiple payers:** A single sign-on provides access to multiple payers.
- **No charge:** Our transactions are free to care providers.
- **Accessible:** Availity Essentials functions are available 24/7 from any computer with internet access.
- **User-friendly:** A standard screen format makes it easy to find necessary information and increases staff productivity.
- **Compliant:** Availity Essentials is compliant with HIPAA regulations.
- **Training:** Live, web-based, and prerecorded training is free to users.
- **Support:** Availity Client Services is available Monday through Friday from 8 a.m. to 7 p.m. ET at **800-AVAILITY (800-282-4548)**.

To start the electronic claims submission process or for questions, contact EDI at **800-470-9630**. For assistance, reference the website, https://Anthem.com/va/provider > Resources > Provider Training Academy > Training and tutorials > CMS Toolkit.

Submitting paper claims

Paper claims are scanned for clean and clear data recording. Paper claims must be legible and submitted in the proper format to obtain the best results.

To speed up processing and prevent delays, follow the requirements below:

- Use the correct form and be sure it meets CMS standards.
- Use black or blue ink.
- Don't stamp or write over boxes on the claim form.
- Don't staple claims together. We will consider the second claim an attachment and not an original claim to be processed separately.
- Remove all perforated sides from the form, leaving a quarter-inch border on the left and right sides.
- Type information within designated fields, ensuring it falls entirely within the text space and is properly aligned.
- Don't highlight fields on the claim form or attachments. Highlighting makes creating a clear electronic copy difficult when the document is scanned.
- Use the Remarks field for messages.
- Send the original claim form to the address below and retain a copy for your records:

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

When submitting paper claims, you must include the following provider information:

- Name
- Rendering provider group ID number/billing provider ID number
- TIN
- NPI number (excluding atypical care providers)
- Medicare number (if applicable)

Note: Some claims may require additional attachments. Be sure to include all supporting documentation when submitting your claim. Claims with attachments should be submitted on paper.

After filing a paper claim, you will receive a response within 30 business days of our receipt of it. If your claim contains all the required information, we will enter your claim into the system for processing and send you a remittance advice or a claims disposition notice when the claim is finalized.

Monitoring submitted claims

After submitting a claim, you can monitor and make changes to the claim by:

- Using Availity Essentials (https://Availity.com).
- Contacting Provider Services at 800-901-0020.
- Confirming receipt of Batch Status Reports from your vendor/clearinghouse to ensure we have accepted claims.
- Correcting and resubmitting Batch Status Reports and Error Reports electronically.
- Correcting errors and immediately resubmit to prevent being ineligible for reimbursement due to late filing.

Electronic remittance advice

You can choose to receive electronic remittance advice (ERA). ERAs are received through an electronic mailbox between us and you and/or your clearinghouse. For more information, call the EDI Solutions Help Desk at 800-590-5745.

Client participation/member liability

A portion of members eligible for Medicaid based on being a member in an institutional setting or receiving a 1915(c) home- and community-based services waiver have member liability (also referred to as client participation) that must be met before Medicaid reimbursement for services is available. The Virginia Department of Medical Assistance Services (DMAS) determines member liability amounts. Through DMAS eligibility and enrollment files, we are notified of any applicable member liability amounts. This information is made available to you, and you must collect this amount from members and bill gross/full charges. We adjudicate claims and deduct patient liability amounts.

We will compensate you when the sum of any applicable third-party payments and the member's financial participation is less than the reimbursement amount established for services.