Anthem
“Serving Hoosier Healthwise”
State Sponsored Business
Overview – CMS 1500

- Community Resource Center
- Who to Contact
- Member Benefits
- Resources
- Provider File Information
- Prior Authorization
- Claims – CMS 1500
- Remittance Advice
- Claims Reconsideration
- Claims Overpayment Recovery
- Grievances and Appeals
We Are Local

We are not just another health plan.....

We are your neighbor!
In The Community, Reaching Out To Help

Community Resource Centers (CRC)

- Staffed to connect members and providers to needed resources:
  - Director/Manager
  - Network Education Representative
  - Health Promotion Consultant
  - Outreach Specialist
  - RN Quality Management Specialist
  - Administrative Assistant
# Community Resource Centers (CRC) Staff

### Southeast Indiana 877-255-0595
**Columbus**

- Brenda Wheat, Director
- Connie Menale, Network Education Rep
- Michelle Eilerman, Outreach Specialist

### Southwest Indiana 866-461-3586
**Evansville**

- Lisa Lant, Manager
- Cory Hadley-Hurt, Network Education Rep
- Kayci Merriwether, Outreach Specialist
- Tammy Queen, RN Quality Management Specialist
- Ginny France, Health Promotion Consultant

### Central Indiana 866-795-5440
**Indianapolis**

- Julia Brillhart, Statewide Director
- Renee Hudson-Johnson, Network Education Rep
- Ada Hart, Outreach Specialist
- Jeane Maitland, RN Quality Management Specialist
- April Thayer, Health Promotion Consultant

### Northern Indiana 866-724-6533
**Merrillville**

- Tye Demby, Manager
- Angela Edmond, Network Education Rep
- Chantelle Johnson, Outreach Specialist
- Acquanetta McKinney, RN Quality Management Specialist
- Juanita Fitzgerald, Health Promotion Consultant
CRCs – Our Hands And Heart In The Community

- Building strong provider and member relations.
- Working with Members, Government, Providers and Communities to help improve the health and lives of low income families and individuals.

CRCs enable Anthem to truly help improve lives
Working In The Community To Improve Lives

Refer Members to Agencies for Assistance (child care, transportation, utility assistance, etc.)

Provide Grants to Non-profit Agencies
  • Annual mini grants for programs designed to improve health.

Community and Agency Events/Programs (agency and school-based)
  • Sponsorship
  • Participation – We’d like to set up a booth at your event.

Community Outreach Vehicle
  (home visits, events, etc.)

Serving on Boards of Local Non-profit Agencies

Collaborating With Community Partners to Promote Health
  • Have an idea? Please let us know.
Who to Contact

• **Network Education Representative** - available to work with providers as it relates to:
  • Provider Contracting
  • Provider Education
  • Provider Servicing

• **Customer Care Center** – first point of contact to help you with:
  • Claim status
  • Claim inquiries
  • Member eligibility
  • Routine claims submission questions
  • Benefit questions
  • Customer Care Center Phone Number: **866-408-6132**
Coverage For Members

Benefits include:

- Medical
- Pharmacy
- Vision
- Behavioral Health
- Chiropractic
- Dental
- Long-term Care
**Member Benefit Packages**

**Package A** – The standard plan which provides full coverage for children, low-income families and some pregnant women.

**Package B** – The pregnancy coverage only plan which provides pregnancy-related and urgent care services for some pregnant women.

**Package C** – The Children’s Health Insurance Plan (CHIP) which provides primary and acute care services for some children under 19 years old.

*Note: Refer to the Provider Operations Manual (POM), Benefits Matrix, Chapter 4 for covered/non-covered services.*
Going Beyond Health Coverage

We offer our members these additional benefits:

• **Free, unlimited transportation** to medical, dental, vision appointments, health ed, and re-determination appointments. **Phone # is 800-508-7230.**

• MedCall® 24-hour nurse hotline.

• Home visits.

• Help understanding and navigating the healthcare system.

• Connecting them to other community services.

• Local programs for healthy living.

• A gift to new mothers who complete their postpartum visit.

• Health education.
Interpreter Service

- Interpreters are available by calling the Customer Care Center during normal business hours: 866-408-6132
- Need 72 business hours advance notice
- 24 business hours to cancel the request
- Additional information located online at www.anthem.com
- The type of interpreters available are:
  - Interpreters available for 140 languages
  - Telephone Interpreters
  - Services for Members with Hearing Loss
  - Face-to-Face Interpreters
  - Sign Language Interpreters
  - Assistance for the Visually Impaired
Member Eligibility

Helpful Hints

• You should verify the member’s eligibility prior to services.

• You are able to check member eligibility through the Web Interchange at: https://interchange.indianamedicaid.com

• Members are issued 2 cards:
  1. One card from the State listing the Medicaid #.
  2. One card from Anthem Hoosier Healthwise listing the ID # beginning with a prefix of YRH.

• In Form Locator 1A of the CMS 1500, **ALWAYS** include the **YRH prefix** in front of the member’s Medicaid #.
Outreach Specialist

Services of our Outreach Specialists:

- Member orientations.

- Member benefit education. *(Note: A member may request Health Education Materials by calling 800-319-0662.)*

- Community events.

- Health fairs.

- Assisting members with community resources, such as food, clothing, heating, etc.
Outreach Specialist continued

• Helping expectant mothers with pre-selection of a Primary Care Provider for their new baby.

• Conduct member home visits at the request from a provider or our case management department.

• When to use the Outreach Request Form:
  • The member is noncompliant.
  • The member needs assistance making their doctor appointments.
  • The member needs health education classes.
  • The member needs new member benefits orientation.
  • The member needs assistance from community resources.
Health Promotion

Prenatal Program – a comprehensive program designed to:

- Identify members who are pregnant.
- Encourage early and ongoing prenatal care.
- Increase members’ access to prenatal information and services.
- Encourage self-care throughout the stages of pregnancy.
- Gift incentive for timely prenatal care.

- Members are identified through:
  - Physician notification.
  - Outreach Calls
  - Visits
  - Member calls to Customer Care Center
  - Claims Data
Resources

Anthem Website – [www.anthem.com](http://www.anthem.com)

- Claims Status
- Member Handbook
- Provider Bulletins
- Provider Operations Manual (POM)
- Prior Authorization Toolkit
- Forms and Tools Library
- Anthem Medical Policies
- Clinical Practice Guidelines
- Pharmacy Guidelines

Indiana Health Coverage Programs - [www.indianamedicaid.com](http://www.indianamedicaid.com)

- Provider Services
- Pharmacy Services
- Managed Care
- Publications
Provider File Information

- It’s important to have current provider file information in our system for claims processing and claim payments.

- Adding a practitioner to your group (Participating or non-participating providers):
  - Complete the State Sponsored Business Practice Information Form.

- Report any changes to us in writing using your letterhead, such as:
  - Provider Name
  - Tax ID
  - Practice Location
  - Phone Number
  - Specialty
  - Practitioner leaving your group

- Mail provider file updates to:  
  Anthem Blue Cross and Blue Shield 
  Attn: Network Services 
  PO Box 6144 
  Indianapolis, IN 46206-6144
Prior Authorization

- Prior Authorization Toolkit listed on our website: www.anthem.com

- Website includes the Services Requiring Prior Authorization.

- Request for Preservice Review.

- Non-par providers, all services require prior authorization.

- Participating providers: some services require Prior Authorization such as:
  - Home Oxygen
  - Apnea monitors
  - CPAP/ BIPAP
  - Hearing aids
  - Motorized and manual wheelchairs / scooters
  - See materials insert for a more inclusive list
Prior Authorization

Helpful Hints

• Physician is responsible for obtaining the preservice review for both professional and institutional services.

• Hospital or ancillary provider should always contact us to verify pre-service review status.

• Authorization not required if referring a member to an in-network specialist.

• Authorization is required when referring to an out-of-network specialist.
Prior Authorization

Include the following on the Request for Preservice Review:

- Member name and Medicaid ID # including the YRH prefix.
- Diagnosis with ICD-9 code.
- Procedure with CPT/HCPCS code.
- Date of injury/date of hospital admission.
- Third party liability information (if applicable).
- Facility name (if applicable).
- Primary medical provider name.
- Specialist or name of attending physician.
- Clinical information supporting request.
Prior Authorization

Phone: 866-408-7187
Fax: 866-408-2803

- Timeframe: usually a 3-day turnaround time.
- If request has missing information, it may take longer.
- If you have an urgent request, please call and indicate this to the Intake Specialist.
- Urgent requests will be completed within 24 hours.
- Note: an urgent request means that a delay in the authorization would be detrimental to the member’s health.
Pharmacy

- **Formulary** is available through the Anthem website: [www.anthem.com](http://www.anthem.com).

- **Epocrates** is a drug reference software application that allows you to check:
  - Formulary status
  - Prior authorization requirements
  - Formulary alternatives
  - General substitutes
  - Quantity limits
Pharmacy continued

• **Epocrates** also features drug reference information including:
  • Indication
  • Dosing
  • Contraindications
  • Drug interactions
  • Adverse reactions
  • Cost information

• Epocrates website: [www.epocrates.com](http://www.epocrates.com)
Claims – CMS 1500

Initial Health Assessments

- It is recommended that the PMP perform an initial health assessment, consisting of a complete history and physical, within 90 days from the member’s date of enrollment with us.

- Billing codes for Initial Health Assessments:
  - V20.2 for children (newborn to 18 years of age)
  - V70.0 for adults (19 years of age and older)
Claims – CMS 1500

OB/ Maternity

- Bill OB professional CPT codes with modifiers U1, U2, U3.
- Delivery charges are to be billed with appropriate CPT codes:
  - 59514 – C-section only
  - 59409 – Vaginal delivery only
  - 59620 – C-section delivery only, following attempted vaginal delivery (after previous cesarean delivery)
  - 59515 – C-section only including postpartum
  - 59410 – Vaginal only including postpartum
  - 59614 – Vaginal delivery only after previous cesarean delivery, including postpartum care
  - 59622 – C-section delivery only following attempted vaginal delivery after previous cesarean delivery including postpartum
Claims – CMS 1500

High Risk Pregnancy

- 59425 – Antepartum Care Visits, 4, 5 & 6
- 59426 – Antepartum Visits 7 and above

- Additional $10.00 reimbursement for high risk diagnoses when billed with the procedure codes listed above.

- Refer to the IHCP Provider Manual on the Indiana Medicaid website, Chapter 8 for a listing of the high risk diagnoses.

- Examples of high risk pregnancy:
  - 643.00 – Excessive vomiting in pregnancy
  - 641.02 – Infections affecting pregnancy
  - 642.00 – Hypertension and related disorders in current or previous pregnancy
Claims – CMS 1500

Newborns

- Encourage the pregnant patient to select a PMP for her child prior to its birth.

- Pre-selection Form will soon be available on our website. A copy is in your packet.

- All newborns must be billed under their own Medicaid ID number. **DO NOT** bill under the mother’s Medicaid ID number

- It could be 30 days before our system will receive the newborn’s Medicaid ID number in our system.
Newborns continued:

We have instituted a process to allow for billing when you have the Newborn’s Medicaid ID number before we receive it in our membership file.
Newborns continued:

Step 1:
- Fill out the Newborn Notification Enrollment Report. See www.anthem.com for the form.
- Email materials to membershipD950@wellpoint.com or fax materials to 877-833-5735.

Step 2:
- File your claims electronically after the 3rd business day from the date you submitted the Newborn Notification Enrollment Report. Daily cutoff is 3:00 pm. Eastern (Indianapolis time)
Claims – CMS 1500

Anesthesia Services

Modifiers:

- Bill all modifiers associated with the services.
- If the modifier will increase the reimbursement, bill that modifier first.
Claims – CMS 1500

PMPs (Primary Medical Providers)

- Specialties: Family Practice, General Practice, Internal Medicine, Pediatrics, and OBGyn.

- Members may change their PMP at anytime.

- PMP may request a member reassignment to another PMP by completing and submitting a Provider Request for Member Deletion from PMP Assignment Form.

- Referrals:
  - Referrals to an in-network specialist do not require Prior Authorization.
Claims – CMS 1500

PMPs, continued

• After Hour Fee:
  • Anthem will pay an after hour fee for 99050 and 99051.
  • A flat fee of $30 will be paid for these services.

Note: PMPs can only have members assigned to 2 locations, but you can have multiple locations loaded into our system and listed in the Provider Directory.
Podiatry Services

- Limited to 6 routine foot care visits per year.

- Orthotics may require Prior Authorization.
Claims – CMS 1500

Chiropractic Services

• Limited to 5 office visits per rolling 12 month period.

• Limited to 50 spinal manipulations or physical medicine treatments per rolling 12 month period.
Ambulance Transportation

• Emergency Transportation:
  • All emergency transportation should be billed Anthem Hoosier Healthwise.
  • Emergency Transportation is any transportation requiring Advanced or Basic Life Support.
  • A0425 – Ground Mileage, per statute mile.
  • Modifiers include: U1, U2, U3, U4, and U5
Claims – CMS 1500

Ambulance Transportation, continued

- Non emergent transportation:
  - Should be arranged through LCP Transportation at 800-508-7230
  - 48 hours notice for non emergent appointments
  - 24 hours or less notice may be given in a case of sickness with a physician appointment scheduled that day.
  - Non emergent transportation is unlimited.
Claims – CMS 1500

Therapists – PT, OT, ST, Audiology

- Limited to 50 visits per year per type of therapy with no Prior Authorization
- Visits over 50 will require Prior Authorization
- Visits are limited to 3 hours for initial evaluation and re-evaluations.
Claims – CMS 1500

Laboratories / Professional Components

- Hospital outpatient – bill on UB92/CMS1450/UB 04
- Physicians and Independent Labs – bill on CMS 1500.
Claims – CMS 1500

Coordination of Benefits (COB)

• When submitting COB claims, specify the other coverage in Boxes 9a-d of the CMS 1500 claim form.

• We must receive COB claims within 180 days from the date on the other carrier’s or program’s RA, or letter denial of coverage.

• COB claims must be submitted on paper. Do not file electronically.

• Include the member’s Medicaid number, including the YRH prefix, on the claim form in box 1A.

• Attach the third party Remittance Advice or letter explaining the denial with the CMS claim form.
Helpful Hints for Electronic claim filing:

- EDI Help Desk: 800-470-9630
- Use the CMS 1500 format.
- COB Medicaid claims cannot be filed electronically.
- The member’s ID must include the YRH prefix.
- Use the Anthem 12-digit PIN and/or NPI.
- Include the Tax ID number.
Helpful Hints for **Electronic** claim filing continued:

- Include the Provider Medicaid ID Number.

- The Anthem Payor ID number is:
  - 00630 (professional claims)
  - 00130 (institutional claims)

- Review your electronic submission reports from Anthem.

- Call the Anthem EDI Help Desk if you/your vendor has problems with electronic claims filing.
Helpful Hints for filing Paper claims:

- Use the CMS 1500 claim form.
- The member’s Medicaid ID number must include the YRH prefix.
- Use your Medicaid ID # in Form Locator 33 of the CMS 1500 form. (Do not use your Anthem 12-digit PIN).
- Medicaid COB claims must be filed on the paper CMS 1500 form.
- Mail your paper claims to:

  Anthem Blue Cross and Blue Shield
  PO Box 37010
  Louisville, KY 40233-7010
Check and Remittance Advices are issued daily.

Example of RA below.

Remark Code 45 - also in the “Plan Not Allowed” column of the Remittance Advice for another code. Explanations for codes are at the end of the Remittance Advice in the Remittance Advice Summary.

<table>
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<th>Date of Service</th>
<th>Service Description</th>
<th>Billed Amount</th>
<th>Procedure Code</th>
<th>Procedure Units</th>
<th>Plan Allowed</th>
<th>Plan Not Allowed</th>
<th>Other Carrier/Payment</th>
<th>Member Co-pay</th>
<th>Interest</th>
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</tbody>
</table>
Remittance Advice (RA)

- A specific Reason Code can be found in the “Plan Not Allowed” column.

- A general remark code appears in the “Remark Codes” column.

- DRG payments will show an additional line item at the end of the claim with the DRG pricing.

- Whole claim pricing claims will not show a DRG or procedure code and will show payment on an additional line item at the end of the claim.

- Explanations of codes used will be at the end on a Summary Page.
Electronic Funds Transfer & Electronic RA

- Electronic Funds Transfer (EFT) option for claims payment transactions.

- Claim payments to be deposited directly into a selected bank account.

- Contracted providers may choose to receive Electronic Remittance Advice (ERA).

- Enroll by completing the ERA/EFT Enrollment Form found in the Forms Toolkit on our website: www.anthem.com

- Submit the form to the address or fax number indicated on the ERA/EFT Enrollment Form.
Claims Reconsideration

• Providers may request a reconsideration of a claim payment or denial.

• Provider would complete the Dispute Resolution Request Form. Refer to www.anthem.com.

• The Dispute Resolution Request Form must be submitted within 60 days from the date you receive the Remittance.
Claims Reconsideration

Mail Reconsideration Requests to:

Anthem Blue Cross Blue Shield
PO Box 6144
Indianapolis, IN. 46209-9210

• Claims will be resolved 45 business days from the receipt of the dispute.
Claims Overpayment Recovery

- Anthem seeks recovery of all excess claim payments from the payee to whom the benefit check is made payable.

- When an overpayment is discovered, an overpayment recovery process is initiated by sending written notification of the overpayment to the provider.

- Mail a copy of the overpayment notification and/or the EOB from Anthem or other carriers and a check to:

  Anthem Blue Cross and Blue Shield
  Attn: Cost Containment
  PO Box 9207
  Oxnard, CA. 93031-9207
Grievances and Appeals

- Providers can file a written grievance related to dissatisfaction or concern about:
  - Another Anthem provider
  - Anthem
  - A member

- Providers may file a written appeal on behalf of a member for:
  - Denial
  - Deferral
  - Modification of a prior authorization request
Grievances and Appeals

Complete and submit the form to:

Anthem Blue Cross and Blue Shield
Attn: Appeals and Complaints Department
PO Box 6144
Indianapolis, IN. 46209-9210

Complete and submit via fax to:
866-387-2968
Grievances and Appeals

Timelines for filing:

**Grievance:** 60 calendar days from the date the provider became aware of the issue

**Appeals:** 30 calendar days from the date of the notice of action letter advising of the adverse determination

**Anthem’s Response/Resolution:**
- Grievances within 20 business days from the receipt
- Appeals within 30 business days
We’re partnering with health care providers to improve the health of our communities and the lives of the people we serve.

Thank you!