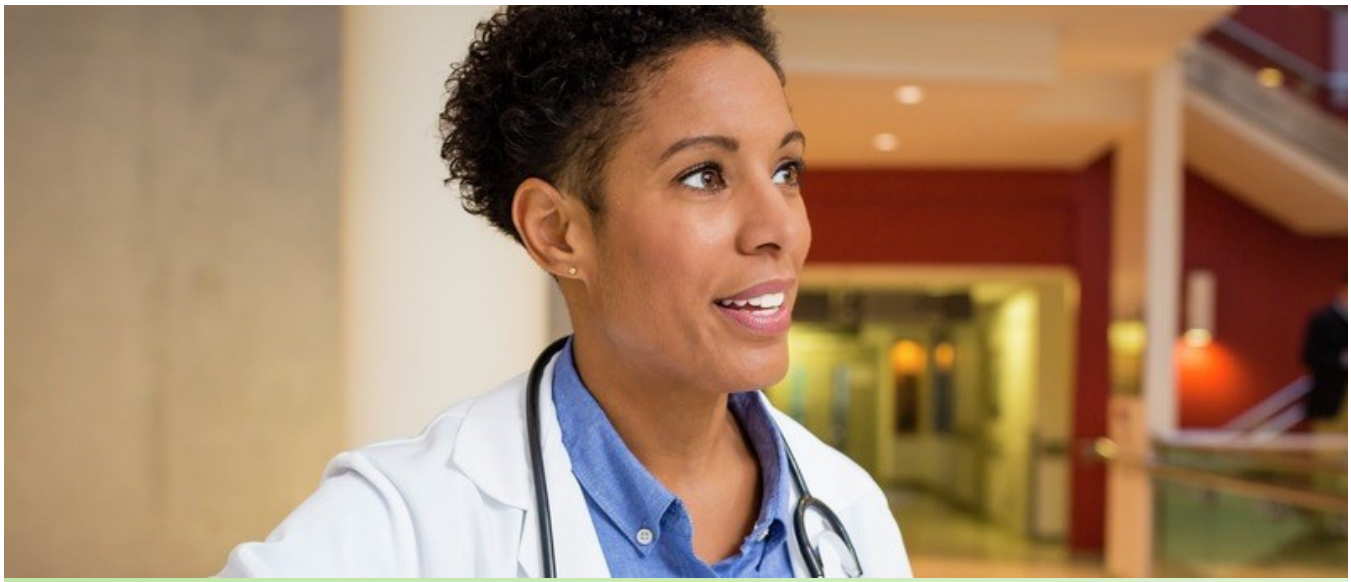
IHCP *banner page*

INDIANA HEALTH COVERAGE PROGRAMS BR201426 JULY 1, 2014



Anthem assumes responsibility for HIP ESP claims processing effective July 1, 2014

The Healthy Indiana Plan (HIP) Enhanced Services Plan (ESP) program was discontinued as of December 31, 2013. At that time, members with continued eligibility transitioned to a HIP managed care entity (MCE) or continued ESP participation under Xerox through April 30, 2014.

Effective July 1, 2014, Anthem Insurance Companies, Inc. will assume responsibility for processing outstanding nonpharmacy claims for members who continued participation in the ESP program administered by Xerox. Anthem will follow existing policies and procedures for processing ESP claims. The time limit for filing claims is 365 days from the date of service, and all providers contracted with the Indiana Health Coverage Programs (IHCP) are considered to be in network. Services will be paid at the appropriate Medicare rates, or 130% of the Medicaid rates, as instructed by the *HIP Reimbursement Manual* at indianamedicaid.com.

ESP claims should continue to be filed on paper and submitted to the same mailing address:

ESP Claims
P.O. Box 33077
Indianapolis, IN 46203-0077

In addition to processing claims, beginning July 1, 2014, Anthem will also handle

continued

MORE IN THIS ISSUE

disputes and appeals related to ESP claims, including disputes and appeals related to claims previously processed by Xerox. The IHCP reminds providers that claim disputes must be received within 60 calendar days of the date of the explanation of benefits (EOB) or Remittance Advice. Appeals must be received within 33 calendar days of a dispute decision.

Anthem has assigned an ESP run-out specialist to oversee related processes and assist providers. Providers should direct questions to Anthem toll-free at 1-844-784-8417 or via email at ESPRUN-Out@Anthem.com.

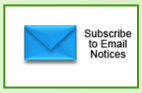
Audit 6110 to be made obsolete

Effective August 1, 2014, the Indiana Health Coverage Programs (IHCP) will make audit 6110 – *Component procedures not payable when global procedure paid - radiology services* obsolete. This change applies retroactively to fee-for-service (FFS) claims with dates of service on or after October 1, 2010. Providers with claims for radiology services that denied for explanation of benefits (EOB) code 6110 – *Reimbursement is not available for component procedures when global procedures has been paid*, which were not ultimately paid through the administrative review process, may resubmit their claims for reimbursement consideration. Claims beyond the original one-year filing limit must include a copy of this banner page as an attachment and must be filed within one year of the publication date.

QUESTIONS?

If you have questions about this publication, please contact Customer Assistance at 1-800-577-1278.

SIGN UP FOR IHCP EMAIL NOTIFICATIONS



To receive email notices of IHCP publications, subscribe by clicking the blue subscription envelope here or on the pages of indianamedicaid.com.

COPIES OF THIS PUBLICATION

If you need additional copies of this publication, please download them from indianamedicaid.com.

TO PRINT

A printer-friendly version of this publication, in black and white and without graphics, is available for your convenience.