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CHAPTER 1: INTRODUCTION

Welcome

Welcome, and thank you for being part of the Anthem Blue Cross and Blue Shield provider network. Anthem has been selected by the State of Indiana as one of the Managed Care Entities to provide access to health care services for Hoosier Healthwise, Healthy Indiana Plan and Hoosier Care Connect Members.

Hoosier Healthwise (HHW) is the State of Indiana’s Medicaid program for children and pregnant women. The program is separated into packages designed to provide quality care to eligible participants from the following categories:

- **Hoosier Healthwise Package A:** For children and pregnant women.
- **Hoosier Healthwise Package C:** For preventive, primary and acute care for children under 19-years of age.
- **Hoosier Healthwise Package P:** For pregnant women who are found to be Presumptively Eligible (PE) for Medicaid. Package P gives short-term prenatal benefits to pregnant women until determination for Hoosier Healthwise is complete.

**Effective January 1, 2014,** new Members are no longer assigned to Package B. Package B was transitioned into Package A, effective 2014.

The Healthy Indiana Plan (HIP) is an affordable health care program created by the State of Indiana. Designed to resemble Health Incentive Plans, the Plan covers adults (ages 19 – 64) whose income is up to 133% of the Federal Poverty Level (FPL). HIP emphasizes preventive care and personal responsibility.

Healthy Indiana Plan (HIP) Members have a $2,500 deductible, but it is completely offset by the $2,500 POWER Account. Providers don’t have to worry about funds being available for paying claims. The Member’s employer may pay up to 100% of the Member’s contribution. Not-for-profit organizations may also pay up to 100% of a Member’s required contribution. HIP Members who become pregnant are eligible to receive maternity benefits through either their existing HIP benefit plan, or through the HIP Maternity program. HIP Maternity Members have the same benefits as HHW pregnant Members. For more information reference this handbook or the IHCP provider manual, http://provider.indianamedicaid.com/ihcp/manuals/chapter02.pdf.

Hoosier Care Connect is the state’s program for Indiana Medicaid enrollees with a disability who are not Medicare eligible and do not have an institutional level of care. The program provides coordinated, person-centered care across the delivery system and care continuum with the goal of continued improvement of quality of care and health outcomes, including improved clinical and functional status, enhanced quality of life, improved Member safety, enhanced Member autonomy and adherence to treatment plans.

For Hoosier Healthwise, Healthy Indiana Plan and Hoosier Care Connect, Anthem’s commitment is to ensure access to primary and preventive care services, improve access to all necessary health care services, encourage coordination of medical care, emphasize prevention and education, and provide first-class customer service.

At Anthem, we’re proud of our Circle of Care Model. Anthem’s innovative Member centric, provider focused approach, assigns our AnthemConnect Team, led by our regional field-based physical and behavioral health care managers, social workers, Member outreach specialists, nurse practice consultants and network relations representatives throughout Indiana. Our team also includes the Anthem departments and employees performing support activities for our Members and providers, assisting them
in navigating the health care system. They are the primary points of contact for providers in their assigned region. By establishing collaborative, supportive relationships with our PMPs and CMHCs we support our Member’s Medical Home as the center of the care delivery system.

Together, they link Providers, Members and community agencies to Anthem resources and provide support and assistance to Providers to best serve Anthem Members. AnthemConnect Team Members are available to:

- Provide training for health care professionals and their staff regarding enrollment, covered benefits, managed care operations and linguistic services.
- Provide Member support services, including health education referrals, event coordination, and coordination of cultural and linguistic services.
- Provide care management services to supplement Providers' treatment plans and improve our Members' overall health. They do so by informing, educating and encouraging self-care in the prevention, early detection and treatment of existing conditions and chronic disease. Coordinate access to community health education resources for breastfeeding, smoking cessation, diabetes and asthma, to name just a few.

About This Manual

This **Provider Manual** is designed for network physicians, hospitals and ancillary Providers. Our goal is to create a useful reference guide for you and your office staff. We want to help you navigate our managed health care plan to find the most reliable, responsible, timely and cost-effective ways to deliver quality health care to our Members.

We recognize that managing our Members’ health can be a complex undertaking. It requires familiarity with the rules and regulations of a system that includes a wide array of health care services and responsibilities, including from initial health assessments to case management and from proper storage of medical records to billing for emergencies. With that in mind, we’ve divided this manual into broad sections that reflect your questions, concerns and responsibilities before and after a **Hoosier Healthwise, Healthy Indiana Plan or Hoosier Care Connect** Member walks through your doors. The sections are conceived as follows:
Chapter 1: Introduction

• Legal Requirements
• Contact Numbers
• Before Rendering Services
• After Rendering Services
• Operational Standards, Requirements & Guidelines
• Additional Resources

Legal Requirements
The information contained in this manual is proprietary, will be updated regularly and is subject to change. This section provides specific information on the legal obligations of being part of the Anthem network.

Contact Numbers
This section is your ready reference for important contact numbers, websites and mailing addresses.

Before Rendering Services
This section provides the information and tools you'll need before providing services, including Member Eligibility and a list of Covered and Noncovered Services. It also includes a chapter on the Prior Authorization process and the coordination of complex care through Care Management.

We take pride in our pro-active approach to health. The chapter on Health Services programs details how we can partner with you to make the services you provide more effective. For example, the Health Needs Screening (HNS) is our first step in providing information regarding preventive care. The ER Action Campaign is aimed at promoting proper use of emergency room services.

After Rendering Services
At Anthem, our goal is to make the billing process as streamlined as possible. This section provides guidelines and detailed coding charts for fast, secure and efficient Billing, including specific information on filing claims for professional and institutional services. In addition, the Member Transfers chapter outlines the steps for Members who want to change their assignment of Primary Medical Provider or transfer to another health plan. When there are questions or concerns about a claim determination or questions regarding access to care, our chapter on Grievances and Appeals will take you step-by-step through the process.

Operational Standards, Requirements & Guidelines
This section summarizes the requirements for Provider office operations, including Access Standards, which ensure across-the-board consistency when Members need to consult with Providers for Initial Health Assessments, referrals, coordination of care and follow-up care.

Separate chapters detail Provider Credentialing, Provider Roles & Responsibilities and Enrollment & Marketing guidelines. Chapters on Clinical Practice & Preventive Health Guidelines and Case Management outline the steps Providers should take to coordinate care and help Members take a pro-active stance in the fight against disease. And finally, there is a chapter on our commitment to participate in Quality Assessments, which helps Anthem continually measure, compare and improve our standards of care.

Using This Manual
This manual is provided to you under Provider Communications on the Provider Resources page of our website at www.anthem.com. For specific instructions on how to access the online version of this manual, as well as the extensive collection of tools, information and forms available to you on our website, please see How to Access Information, Forms and Tools on Our Website below.

Click on any topic in the Table of Contents and you will be taken directly to that topic. Click on any web address and you will be redirected to that site. Each chapter may also contain cross-links to other chapters, to our website or to outside websites containing additional information. Icons, bold type, or boxes may draw attention to important information.

To help Providers serve a diverse and ever-evolving patient population, we have created a cultural competency tool kit titled Caring for Diverse Populations to help improve Provider/Member communications by cutting through language and other cultural barriers.

In addition, Anthem works with nationally recognized health care organizations to stay current on the latest health care breakthroughs and discoveries. This manual provides easy links to access that information. We also provide forms and reference guides you’ll need on a wide variety of subjects.

Unless otherwise specifically noted, the information in the manual applies to the Hoosier Healthwise, Healthy Indiana Plan and Hoosier Care Connect programs. If you have any questions about the content of this manual, contact our Provider Helpline at:

- Hoosier Healthwise: 1-866-408-6132
- Healthy Indiana Plan: 1-800-345-4344
- Hoosier Care Connect: 1-844-284-1798

How to Access Information, Forms and Tools on Our Website

A wide array of tools, information and forms are accessible via the Provider Resources page of our website, www.anthem.com. Throughout this manual, we will often refer you to items located on the Provider Resources page. To access this page, please follow these steps:

1. Go to www.anthem.com
2. Select OTHER ANTHEM WEBSITES: Providers
3. Select Providers | Spotlight: State Sponsored Plans – Indiana Hoosier Healthwise, Healthy Indiana Plan and Hoosier Care Connect
4. Select Indiana Hoosier Healthwise, Healthy Indiana Plan (HIP) and Hoosier Care Connect
CHAPTER 2: LEGAL AND ADMINISTRATIVE REQUIREMENTS

Proprietary Information

The information contained in this Provider Manual is proprietary to the State of Indiana, CMS and Anthem. By accepting this manual, Anthem Providers agree to:

- Protect and hold the manual’s information as proprietary
- Use this manual solely for the purposes of referencing information regarding the provision of medical services to Hoosier Healthwise, Healthy Indiana Plan and/or Hoosier Care Connect Members enrolled for services through Anthem Blue Cross and Blue Shield (herein referenced as “Anthem” or the “Plan”).

Privacy and Security

Anthem’s latest Health Insurance Portability and Accountability Act of 1996 (HIPAA)-compliant privacy and security statements can be found under on the Provider Resources page of our website at www.anthem.com. To read them, please scroll down to Standards and Policies and select Notice of Privacy Practices (NOPP).

Throughout this manual, there are instances where information is provided as an example. Because actual situations may vary, this information is meant to be illustrative only and is not intended to be used or relied upon as guidance for actual situations.

There are also places within the online manual where you may be invited to leave the Anthem site and enter another site operated by a third party. These links are provided for your convenience and reference only. Anthem and its subsidiary companies do not control such sites and do not necessarily endorse them. Anthem is not responsible for their content, products or services.

Please be aware that when you travel from the Anthem site to another site, whether through links provided by Anthem or otherwise, you will be subject to the privacy policies (or lack thereof) of the other sites. Anthem cautions you to determine the privacy policy of such sites before providing any personal information.

Misrouted Protected Health Information

Providers and facilities are required to review all Member information received from Anthem to ensure no misrouted Protected Health Information (PHI) is included. Misrouted PHI includes information about Members that a Provider or facility is not treating. PHI can be misrouted to Providers and facilities by mail, fax, e-mail, or electronic Remittance Advice. Providers and facilities are required to destroy immediately any misrouted PHI or safeguard the PHI for as long as it is retained as well as contact Anthem of the situation. Anthem is required to inform Indiana Family and Social Services Administration Privacy Officer within 1 business day of any Security Incident/Breach. In no event are Providers or facilities permitted to misuse or re-disclose misrouted PHI. If Providers or facilities cannot destroy or safeguard misrouted PHI, please contact the Provider Helpline at:

- Hoosier Healthwise: 1-866-408-6132
- Healthy Indiana Plan: 1-800-345-4344
- Hoosier Care Connect: 1-844-284-1798

Updates and Changes

The Provider Manual, as part of your Provider Agreement and related Addendums, may be updated at any time and is subject to change. In the event of an inconsistency between information contained in the manual and the Agreement between you or your facility and Anthem, the Agreement shall govern.
In the event of a material change to the Provider Manual, we will make all reasonable efforts to notify you in advance of such change through web-posted newsletters, fax communications, and other mailings. In such cases, the most recently published information should supersede all previous information and be considered the current directive.

The manual is not intended to be a complete statement of all **Anthem** policies or procedures. Other policies and procedures not included in this manual may be posted on our website or published in specially targeted communications, including but not limited to bulletins and newsletters.

This manual does not contain legal, tax or medical advice. Please consult your own advisors for advice on these topics.
CHAPTER 3: CONTACTS

Hoosier Healthwise
Anthem Medicaid Provider Helpline Phone: 1-866-408-6132
Anthem Medicaid Provider Helpline Fax: 1-866-408-7087
Hours of Operation: Monday to Friday, 8 a.m.-8 p.m.

Healthy Indiana Plan
Anthem Provider Helpline Phone: 1-800-345-4344
Anthem Provider Helpline Fax: 1-800-376-0247
Hours of Operation: Monday to Friday, 8 a.m.-8 p.m.

Hoosier Care Connect
Anthem Medicaid Provider Helpline Phone: 1-844-284-1798
Anthem Medicaid Provider Helpline Fax: 1-866-408-7087
Hours of Operation: Monday to Friday, 8 a.m.-8 p.m.

Overview

The following resource grid is a consolidation of the most-used phone and fax numbers, websites and addresses found within the manual itself. We’ve also included other valuable contact information for you and your staff. The first chart below gives you contact information for Hoosier Healthwise, Healthy Indiana Plan and Hoosier Care Connect. The second chart is contact information for the health services programs handled by the state.

<table>
<thead>
<tr>
<th>If you have questions about…</th>
<th>Hoosier Healthwise (HHW) and HIP Maternity</th>
<th>Healthy Indiana Plan (HIP)</th>
<th>Hoosier Care Connect</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address</td>
<td>General address for all correspondence and initial claims submittals: Anthem Blue Cross and Blue Shield P.O. Box 6144 Indianapolis, IN 46206-6144 Note: For faster service, please also indicate how you want it routed – for example: &quot;Attn: Claims Follow-Up.&quot;</td>
<td>General address for all correspondence and initial claims submittals: Anthem Blue Cross and Blue Shield P.O. Box 6144 Indianapolis, IN 46206-6144 Note: For faster service, please also indicate how you want it routed – for example: &quot;Attn: Claims Follow-Up.&quot;</td>
<td>General address for all correspondence and initial claims submittals: Anthem Blue Cross and Blue Shield P.O. Box 6144 Indianapolis, IN 46206-6144 Note: For faster service, please also indicate how you want it routed – for example: &quot;Attn: Claims Follow-Up.&quot;</td>
</tr>
<tr>
<td>Prior Authorization</td>
<td>Utilization Management Department 1-866-408-7187 Monday to Friday, 8am-5pm Fax: 1-866-406-2803 <a href="http://www.anthem.com">www.anthem.com</a></td>
<td>Utilization Management Department 1-866-398-1922 Monday to Friday, 8am-5pm Fax: 1-866-406-2803 <a href="http://www.anthem.com">www.anthem.com</a></td>
<td>Utilization Management Department 1-866-408-7187 Monday to Friday, 8 a.m.-5 p.m. Fax: 1-866-406-2803 <a href="http://www.anthem.com">www.anthem.com</a></td>
</tr>
</tbody>
</table>
## Contact Information for Hoosier Healthwise, Healthy Indiana Plan and Hoosier Care Connect

<table>
<thead>
<tr>
<th>If you have questions about…</th>
<th>Hoosier Healthwise (HHW) and HIP Maternity</th>
<th>Healthy Indiana Plan (HIP)</th>
<th>Hoosier Care Connect</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral Health Services</td>
<td><strong>Anthem</strong> Medicaid Provider Helpline 1-866-408-6132 Fax: 1-800-376-0247</td>
<td><strong>Anthem</strong> Provider Helpline 1-800-345-4344 Fax: 1-800-376-0247</td>
<td><strong>Anthem</strong> Medicaid Provider Helpline 1-844-284-1798 Fax: 1-800-376-0247</td>
</tr>
<tr>
<td>Benefits, eligibility, Primary Medical Provider verification and general provider questions</td>
<td>Please refer to the <a href="#">State Contacts Table</a> for Indiana's Web interChange and Indiana Health Coverage Programs information. <strong>Anthem</strong> Medicaid Provider Helpline 1-866-408-6132 TTY: 1-866-408-7188 Monday to Friday, 8 a.m.-8 p.m. Fax: 1-866-408-7087 Call 24/7 NurseLine (see below) after-hours to verify Member eligibility.</td>
<td>Please refer to the <a href="#">State Contacts Table</a> for Indiana's Web interChange and Indiana Health Coverage Programs information. <strong>Anthem</strong> Provider Helpline 1-800-345-4344 TTY: 1-866-408-7188 Monday to Friday, 8 a.m.-8 p.m. Fax: 1-800-376-0247 Call 24/7 NurseLine (see below) after-hours to verify Member eligibility.</td>
<td>Please refer to the <a href="#">State Contacts Table</a> for Indiana's Web interChange and Indiana Health Coverage Programs information. <strong>Anthem</strong> Medicaid Provider Helpline 1-866-408-6132 TTY: 1-866-408-7188 Monday to Friday, 8 a.m.-8 p.m. Fax: 1-866-408-7087 Call 24/7 NurseLine (see below) after-hours to verify Member eligibility.</td>
</tr>
<tr>
<td>Case Management Referrals/Right Choices Program</td>
<td>1-866-902-1690, Option 2 Monday to Friday, 8 a.m.-5 p.m. Fax: 1-855-417-1289 Response within three business days</td>
<td>1-866-902-1690, Option 2 Monday to Friday, 8 a.m.-5 p.m. Fax: 1-855-417-1289 Response within three business days</td>
<td>1-866-902-1690, Option 2 Monday to Friday, 8 a.m.-5 p.m. Fax: 1-855-417-1289 Response within three business days</td>
</tr>
<tr>
<td>Claims</td>
<td>Log in to <a href="http://www.availity.com">www.availity.com</a> and follow instructions to register. Hours of operation: 24 Hours a Day, 7 Days a Week <strong>Anthem</strong> Medicaid Provider Helpline 1-866-408-6132 Monday to Friday, 8 a.m.-8 p.m. Claims address (initial claims only) Attn: Claims <strong>Anthem</strong> Blue Cross and Blue Shield P.O. Box 6144 Indianapolis, IN 46206-6144</td>
<td>Log in to <a href="http://www.availity.com">www.availity.com</a> and follow instructions to register. Hours of operation: 24 Hours a Day, 7 Days a Week <strong>Anthem</strong> Provider Helpline 1-800-345-4344 Monday to Friday, 8 a.m.-8 p.m. Claims address (initial claims only) Attn: Claims <strong>Anthem</strong> Blue Cross and Blue Shield P.O. Box 6144 Indianapolis, IN 46206-6144</td>
<td>Log in to <a href="http://www.availity.com">www.availity.com</a> and follow instructions to register. Hours of operation: 24 Hours a Day, 7 Days a Week <strong>Anthem</strong> Medicaid Provider Helpline 1-866-408-6132 Monday to Friday, 8 a.m.-8 p.m. Claims address (initial claims only) Attn: Claims <strong>Anthem</strong> Blue Cross and Blue Shield P.O. Box 6144 Indianapolis, IN 46206-6144</td>
</tr>
</tbody>
</table>
## Contact Information for Hoosier Healthwise, Healthy Indiana Plan and Hoosier Care Connect

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<th>Hoosier Care Connect</th>
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<tbody>
<tr>
<td><strong>Claims Overpayment</strong></td>
<td>Mail overpayment to: Overpayment Recovery P.O. Box 92420 Cleveland, OH 44193</td>
<td>Mail overpayment to: Central Region – CCOA Lockbox P.O. Box 73651 Cleveland, OH 44193-1177</td>
<td>Mail overpayment to: Overpayment Recovery P.O. Box 92420 Cleveland, OH 44193</td>
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<td></td>
<td>For overnight delivery: Overpayment Recovery Lockbox 92420 4100 West 150th Street Cleveland, OH 44135</td>
<td>For overnight delivery: Anthem Central Lockbox 73651 4100 West 150th Street Cleveland, OH 44135</td>
<td>For overnight delivery: Overpayment Recovery Lockbox 92420 4100 West 150th Street Cleveland, OH 44135</td>
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<tr>
<td><strong>Contracting</strong></td>
<td>1-800-455-6805</td>
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<td>Monday to Friday, 8 a.m.-5 p.m.</td>
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<tr>
<td><strong>Practice Consultants, Provider Network Representatives</strong></td>
<td>1-866-408-6132</td>
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<td></td>
<td>Monday to Friday, 8 a.m.-8 p.m.</td>
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<td>Representatives are located throughout the State and can be reach through our central number</td>
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<tr>
<td><strong>Dental Services</strong></td>
<td>IHCP Customer Assistance Unit 1-317-655-3240 or 1-800-577-1278 <a href="http://www.indianamedicaid.com">www.indianamedicaid.com</a></td>
<td>DentaQuest 1-888-291-3762 dentaquestgov.com</td>
<td>DentaQuest 1-888-291-3762 dentaquestgov.com</td>
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<td><strong>Electronic Data Interchange</strong></td>
<td>Anthem EDI Solutions Helpdesk: 1-800-470-9630</td>
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<td></td>
<td>Monday to Friday, 8 a.m.-4:30 p.m. Eastern Time</td>
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<td>EDI Solutions E-mail: <a href="mailto:ent.edi.support@Anthem.com">ent.edi.support@Anthem.com</a></td>
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<td></td>
<td>Website: <a href="http://www.anthem.com/edi">www.anthem.com/edi</a></td>
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<tr>
<td><strong>Special Investigation Unit</strong></td>
<td>Phone: 1-877-725-2702 Fax: 1-866-494-8279</td>
<td>Phone: 1-877-725-2702 Fax: 1-866-494-8279</td>
<td>Phone: 1-877-725-2702 Fax: 1-866-494-8279</td>
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<tr>
<td><strong>Grievances &amp; Appeals</strong></td>
<td>1-866-408-7187 Fax: 1-866-387-2968 24 hours a day, 7 days a week</td>
<td>1-866-408-7187 Fax: 1-866-387-2968 24 hours a day, 7 days a week</td>
<td>1-866-408-7187 Fax: 1-866-387-2968 24 hours a day, 7 days a week</td>
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</table>
# Chapter 3: Contacts

## Contact Information for Hoosier Healthwise, Healthy Indiana Plan and Hoosier Care Connect

<table>
<thead>
<tr>
<th>If you have questions about…</th>
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<th>Healthy Indiana Plan (HIP)</th>
<th>Hoosier Care Connect</th>
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<tbody>
<tr>
<td>Member Interpreter Services (Available over the phone and face to face)</td>
<td><strong>Anthem</strong> Medicaid Provider Helpline 1-866-408-6132 (Provider) Customer Care Center 1-866-408-6131 (Member)</td>
<td><strong>Anthem</strong> Provider Helpline 1-800-345-4344 (Provider) Customer Care Center 1-866-408-6131 (Member)</td>
<td><strong>Anthem</strong> Medicaid Provider Helpline 1-844-284-1798 (Provider) Customer Care Center 1-844-284-1797 (Member)</td>
</tr>
<tr>
<td>Lead Exposure Testing Kits</td>
<td>MEDTOX Laboratories 1-800-334-1116 (ext. 4)</td>
<td>MEDTOX Laboratories 1-800-334-1116 (ext. 4)</td>
<td>MEDTOX Laboratories 1-800-334-1116 (ext. 4)</td>
</tr>
<tr>
<td>Members with hearing or speech loss</td>
<td>Relay Indiana 1-800-743-3333 or 711 24 hours a day, 7 days a week</td>
<td>Relay Indiana 1-800-743-3333 or 711 24 hours a day, 7 days a week</td>
<td>Relay Indiana 1-800-743-3333 or 711 24 hours a day, 7 days a week</td>
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<tr>
<td>Nurse Help Line</td>
<td>24/7 NurseLine 1-866-800-8780 TTY: 1-800-368-4424 24 hours a day, 7 days a week, and available after normal business hours to verify Member eligibility or to obtain over the phone interpreter assistance after normal business hours</td>
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<tr>
<td>Pharmacy – Auditing, Authorization Requests, Preferred Drug Lists and Claims Processing</td>
<td>Catamaran Clinical and Technical Help Desk Pharmacy Services Point of Sale (POS), Member and Provider Inquiries, Pharmacy Claims Processing, Pharmacy Clinical Inquiries and Requests for Pharmacy Prior Authorizations 1-855-577-6317 24 hours a day, 7 days a week Email: <a href="mailto:MemberServicesINM@sxc.com">MemberServicesINM@sxc.com</a></td>
<td>Express Scripts Technical Help Desk Pharmacy Services (POS), Provider Inquiries, Pharmacy Claims Processing, 1-844-520-2680 24 hours a day, 7 days a week Provider inquiries for Pharmacy Prior Authorizations should go through <strong>Anthem</strong> Provider Services at: 1-866-398-1922 Member inquiries for Pharmacy Prior Authorizations should go through <strong>Anthem</strong> Member Services at: 1-866-408-6131 6 a.m. to 6 p.m. ET, Monday - Friday</td>
<td>Express Scripts Technical Help Desk Pharmacy Services (POS), Provider Inquiries, Pharmacy Claims Processing, 1-844-520-2680 24 hours a day, 7 days a week Provider inquiries for Pharmacy Prior Authorizations should go through <strong>Anthem</strong> Provider Services at: 1-866-398-1922 Member inquiries for Pharmacy Prior Authorizations should go through <strong>Anthem</strong> Member Services at: 1-844-284-1797 6 a.m. to 6 p.m. ET, Monday - Friday</td>
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### Contact Information for Hoosier Healthwise, Healthy Indiana Plan and Hoosier Care Connect

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<th>If you have questions about…</th>
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<th>Healthy Indiana Plan (HIP)</th>
<th>Hoosier Care Connect</th>
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<tr>
<td>Transportation (non-emergency)</td>
<td>LCP Transportation, LLC</td>
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<td>Schedule appointments: <strong>1-800-508-7230</strong></td>
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<td>Monday to Friday, 8 a.m.-5 p.m.</td>
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<td>After-hours service <strong>1-866-408-6131</strong></td>
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<td>24 hours a day, 7 days a week</td>
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<td><a href="http://www.lcptransportation.com">www.lcptransportation.com</a></td>
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<td>Transportation-related grievance and appeals:</td>
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<td></td>
<td><strong>Attn: Appeals Department</strong></td>
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<td></td>
<td>LCP Transportation</td>
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<tr>
<td></td>
<td>4308 Guion Road, Suite D</td>
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<td></td>
<td>Indianapolis, IN 46254</td>
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<td>Vision Services</td>
<td>Vision Service Plan (VSP)</td>
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<td><a href="http://www.vsp.com">www.vsp.com</a></td>
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<td>Claims and Membership questions:</td>
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<td></td>
<td><strong>1-800-615-1883</strong></td>
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<td>For Members: <strong>1-866-866-5641</strong></td>
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<td><strong>TTY: 1-800-428-4833</strong></td>
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<td></td>
<td>Monday to Friday, 7 a.m.-7 p.m.</td>
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### State of Indiana

#### Contact Information for the State of Indiana

<table>
<thead>
<tr>
<th>If you have questions about….</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breastfeeding Support Line</td>
<td><strong>1-800-231-2999</strong></td>
</tr>
<tr>
<td>Children's Special Health Care Services (CSHCS)</td>
<td><a href="http://www.in.gov/isdh/19613.htm">www.in.gov/isdh/19613.htm</a></td>
</tr>
<tr>
<td>Dental Services: Indiana Health Coverage Program (IHCP) (Hoosier Healthwise Only)</td>
<td>Medicaid Member Services (including Dental) <strong>1-800-457-4587</strong></td>
</tr>
<tr>
<td>Eligibility (For Members to check if they are eligible for Medicaid, HIP Hoosier Care Connect)</td>
<td><strong>1-800-403-0864</strong></td>
</tr>
<tr>
<td>If you have questions about….</td>
<td>Contact Information</td>
</tr>
<tr>
<td>-------------------------------</td>
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</tr>
<tr>
<td><strong>Enrollment</strong>&lt;br&gt;(For Members to enroll in/change MCEs)</td>
<td>Hoosier Healthwise: 1-800-889-9949&lt;br&gt;Healthy Indiana Plan: 1-877-GET-HIP-9 (1-877-438-4479)&lt;br&gt;Hoosier Care Connect: 1-866-963-7383</td>
</tr>
<tr>
<td><strong>Grievances &amp; Appeals: State Fair Hearing</strong>&lt;br&gt;Indiana Family and Social Services Administration (FSSA)</td>
<td>FSSA Hearing and Appeals Section MS-04&lt;br&gt;402 W. Washington St. Room W392&lt;br&gt;Indianapolis, IN 46204-2773&lt;br&gt;317-233-4454</td>
</tr>
<tr>
<td><strong>Grievances &amp; Appeals: Mediation &amp; Arbitration</strong>&lt;br&gt;Indiana Family and Social Services Administration (FSSA)</td>
<td>FSSA Hearing and Appeals Section MS-04&lt;br&gt;402 W. Washington St. Room W392&lt;br&gt;Indianapolis, IN 46204-2773&lt;br&gt;317-233-4454</td>
</tr>
<tr>
<td><strong>Hearing or Speech Loss: Relay Indiana</strong></td>
<td>1-800-743-3333 or 711</td>
</tr>
<tr>
<td><strong>Hoosier Healthwise Helpline</strong>&lt;br&gt;(Operated by Indiana Family and Social Services Administration- FSSA)</td>
<td>Helpline: 1-800-403-0864</td>
</tr>
<tr>
<td><strong>Indiana Division of Disability and Rehabilitation Services (DDRS)</strong></td>
<td><a href="http://www.in.gov/fssa/2328.htm">www.in.gov/fssa/2328.htm</a></td>
</tr>
<tr>
<td><strong>Indiana Division of Mental Health and Addiction (DMHA)</strong></td>
<td><a href="http://www.in.gov/fssa/dmha/4521.htm">www.in.gov/fssa/dmha/4521.htm</a></td>
</tr>
<tr>
<td><strong>Indiana Family and Social Services Administration (FSSA)</strong></td>
<td>Indiana Family and Social Services Administration (FSSA)&lt;br&gt;402 W. Washington St.&lt;br&gt;Room W374, MS07&lt;br&gt;Indianapolis, IN 46204-2739&lt;br&gt;317-655-3240&lt;br&gt;Email: <a href="mailto:PEHelp@fssa.in.gov">PEHelp@fssa.in.gov</a></td>
</tr>
</tbody>
</table>
### Contact Information for the State of Indiana

<table>
<thead>
<tr>
<th>If you have questions about….</th>
<th>Contact Information</th>
</tr>
</thead>
</table>
| Indiana Health Coverage Program (IHCP) | Automated Voice Response:  
Indianapolis Area: 317-692-0819  
Other Areas: 1-800-738-6770  
Customer Care Center: 1-800-553-2019  
Monday to Friday, 7 a.m.-8 p.m.  
| Indiana Tobacco Quitline | 1-800-784-8669 |
| Pharmacy Services: State of Indiana | 1-855-577-6317  
Catamaran Member Services  |
| Pharmacy Services | [https://inm.providerportal.catamaranrx.com](https://inm.providerportal.catamaranrx.com) |
| Preferred Drug List | [https://inm.providerportal.catamaranrx.com](https://inm.providerportal.catamaranrx.com) |
| Web interChange | [https://interchange.indianamedicaid.com/Administrative/logon.aspx](https://interchange.indianamedicaid.com/Administrative/logon.aspx) |
| Women, Infants and Children (WIC) Program | 1-800-522-0874  
[www.in.gov/isdh/24777.htm](http://www.in.gov/isdh/24777.htm) |
CHAPTER 4: COVERED AND NONCOVERED SERVICES

Overview

This chapter outlines some of the specific covered and non-covered services for Hoosier Healthwise, Healthy Indiana Plan and Hoosier Care Connect. For a complete list of covered and noncovered services see Chapter 2 of the IHCP Manual at http://provider.indianamedicaid.com/ihcp/manuals/chapter02.pdf.

Hoosier Healthwise, the managed care program for Indiana children and pregnant women is divided into packages:

- **Hoosier Healthwise Package A**: For children and pregnant women for Managed Care Medicaid.
- **Hoosier Healthwise Package C (CHIP)**: For preventive, primary and acute care for children under 19 years of age.
- **Hoosier Healthwise Package P**: For pregnant women who are found to be Presumptively Eligible (PE) for Medicaid. Package P gives short-term benefits to pregnant women until determination for Medicaid is complete.

The Healthy Indiana Plan (HIP) is for adults between the ages of 19-64 who are not covered by Medicare Parts A, B and/or D and are not covered by any other qualifying medical insurance.

**Note**: HIP has four products: HIP Basic, HIP Plus, State Plan Basic and State Plan Plus. Additionally, some Members qualify for state plan benefits, which are the same as Hoosier Healthwise benefits. Those Members are in either HIP Basic with state plan benefits, or HIP Plus with state plan benefits.

Hoosier Care Connect is for Indiana Medicaid enrollees with a disability who are not Medicare eligible and do not have an institutional level of care.

**Hoosier Healthwise Packages A & C, and HIP State Plan Basic Benefits, and HIP State Plan Plus Benefits** cover the following services:

- Behavioral Health: Inpatient, Outpatient & Partial Hospital Stay
- Chiropractic
- Dental
- Diabetes Self-Management
- Family Planning
- Home Health Care
- Hoosier HealthWatch Early and Periodic Screening, Diagnostic and Treatment (EPSDT)
- Hospital Services: Inpatient & Outpatient
- Lab & Radiology
- Medical Supplies & Equipment
- Nurse-Midwife Services
- Nurse Practitioner Services
- Organ Transplants (excluding Package C)
- Physician Services
- Podiatry Services
- Prescription Services
- Preventive Care
- Rehab Services: Inpatient
- Respiratory Therapy
- Skilled Nursing Facility
• Smoking Cessation
• Speech, Hearing and Language Services
• Substance Abuse: Inpatient, Outpatient & Partial Hospital Stay
• Therapy (Speech, Occupational and Physical)
• Medicaid Rehab Option (carved out)
• Transportation: Emergency & Nonemergency
• Vision Services

**Hoosier Healthwise Package P** is the managed care program for presumptive eligibility for pregnant women (PEPW). To qualify for **PEPW**, a potential Member must:

- Be an Indiana resident
- Be a U.S. citizen
- Be pregnant
- Have a gross family income of less than 200% of the federal poverty level
- Not be a Hoosier Healthwise Member
- Not be in prison

**Package P** covers outpatient services related to pregnancy, including:

- Prenatal Care Services

Services related to conditions that may cause pregnancy problems **Hoosier Healthwise Package P does not cover**:

- Abnormal Products of Conception
- Abortion
- Contraception
- Ectopic Pregnancy Services
- Hospice
- Inpatient Hospital Services
- Labor & Delivery Services
- Long-Term Care
- Postpartum Care
- Sterilization

**Please Note:** Providers contracted with **Anthem** 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.


<table>
<thead>
<tr>
<th>Hoosier Healthwise (HHW) Packages A and C and HIP Maternity</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Benefits/Limitations</strong></td>
</tr>
<tr>
<td>Behavioral Health – Inpatient</td>
</tr>
</tbody>
</table>
## Hoosier Healthwise (HHW) Packages A and C and HIP Maternity

<table>
<thead>
<tr>
<th>Benefits/Limitations</th>
<th>HHW Package A, and HIP Maternity</th>
<th>HHW Package C Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Requires Prior Authorization</td>
<td>hospital</td>
<td>• Psychotherapy (group, family and individual)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Psychiatric diagnosis interview, exam and treatment</td>
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<td></td>
<td></td>
<td>• Psychological and neuropsychological tests</td>
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<tr>
<td></td>
<td></td>
<td>• Requires prior authorization</td>
</tr>
<tr>
<td>Behavioral Health - Outpatient</td>
<td>• Psychotherapy (group, family and individual)</td>
<td>• Psychotherapy (group, family and individual)</td>
</tr>
<tr>
<td>• Requires notification</td>
<td>• Psychiatric diagnosis interview, exam and treatment</td>
<td>• Psychiatric diagnosis interview, exam and treatment</td>
</tr>
<tr>
<td>Members may self-refer</td>
<td>• Psychological and neuropsychological tests</td>
<td>• Psychological and neuropsychological tests</td>
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<tr>
<td></td>
<td>o Requires prior authorization</td>
<td>Requires prior authorization</td>
</tr>
<tr>
<td>Chiropractic Services</td>
<td>• 5 visits</td>
<td>• 14 therapeutic physical medicine treatments per year (Up to 36 more treatments available with prior authorization).</td>
</tr>
<tr>
<td>Members may self-refer</td>
<td>• 50 therapeutic physical medicine treatments per year</td>
<td>• One full spine X-ray per year</td>
</tr>
<tr>
<td></td>
<td>• One full spine X-ray per year</td>
<td></td>
</tr>
<tr>
<td>Dental</td>
<td>Covered by Indiana Medicaid Refer to <a href="http://www.indianamedicaid.com">www.indianamedicaid.com</a> for HHW Package A and HIP Maternity *Covered by Anthem for HIP State Plan Benefits</td>
<td>Covered by Indiana Medicaid Refer to <a href="http://www.indianamedicaid.com">www.indianamedicaid.com</a></td>
</tr>
<tr>
<td>Diabetes Self-management training</td>
<td>• Nutrition and exercise advice</td>
<td>• Nutrition and exercise advice</td>
</tr>
<tr>
<td>• Benefit covers a total of 4 hours per year. Additional may be authorized upon request.</td>
<td>• Drug advice</td>
<td>• Drug advice</td>
</tr>
<tr>
<td></td>
<td>• Blood sugar self-check</td>
<td>• Blood sugar self-check</td>
</tr>
<tr>
<td></td>
<td>• Insulin shot</td>
<td>• Insulin shot</td>
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<tr>
<td></td>
<td>• Foot, skin, dental care</td>
<td>• Foot, skin, dental care</td>
</tr>
<tr>
<td>Family Planning</td>
<td>• Education and advice</td>
<td>• Education and advice</td>
</tr>
<tr>
<td>Members may self-refer</td>
<td>• Counseling</td>
<td>• Counseling</td>
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<td></td>
<td>• Physical exam</td>
<td>• Physical exam</td>
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<tr>
<td></td>
<td>• Annual cervical cancer screening</td>
<td>• Annual cervical cancer screening</td>
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<td></td>
<td>• Birth control</td>
<td>• Birth control</td>
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<td></td>
<td>• Follow-up care</td>
<td>• Follow-up care</td>
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<tr>
<td></td>
<td>• Pregnancy tests</td>
<td>• Pregnancy tests</td>
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<tr>
<td></td>
<td>• Sterilization</td>
<td>• Sterilization</td>
</tr>
<tr>
<td></td>
<td>• Lab tests</td>
<td>• Lab tests</td>
</tr>
<tr>
<td></td>
<td>• Sexually transmitted infection screenings</td>
<td>• Sexually transmitted infection screenings</td>
</tr>
<tr>
<td></td>
<td>• HIV screening, testing and counseling for at-risk Members; referrals for treatment</td>
<td>HIV screening, testing and counseling for at-risk Members; referrals for treatment</td>
</tr>
</tbody>
</table>
## Hoosier Healthwise (HHW) Packages A and C and HIP Maternity

<table>
<thead>
<tr>
<th>Benefits/Limitations</th>
<th>HHW Package A, and HIP Maternity</th>
<th>HHW Package C Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Health Care</td>
<td>• Skilled Nursing Services</td>
<td>• Skilled Nursing Services</td>
</tr>
<tr>
<td></td>
<td>• Physical, occupational, speech</td>
<td>• Physical, occupational, speech and respiratory therapy</td>
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<tr>
<td></td>
<td>and respiratory therapy</td>
<td>• Renal dialysis</td>
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<td></td>
<td>• Renal dialysis</td>
<td></td>
</tr>
<tr>
<td>Early and Periodic Screening, Diagnostic and Treatment (EPSDT)</td>
<td>For Members under 21 years of age:</td>
<td>For Members under 21 years of age:</td>
</tr>
<tr>
<td></td>
<td>• Health and Development history exam</td>
<td>• Health and Development history exam</td>
</tr>
<tr>
<td></td>
<td>• Physical exam</td>
<td>• Physical exam</td>
</tr>
<tr>
<td></td>
<td>• Vaccines</td>
<td>• Vaccines</td>
</tr>
<tr>
<td></td>
<td>• Lab test including blood lead screenings</td>
<td>• Lab test including blood lead screenings</td>
</tr>
<tr>
<td></td>
<td>• Health Education</td>
<td>• Health Education</td>
</tr>
<tr>
<td>Hospital Services - Inpatient</td>
<td>• Shared room (unless private room is medically-necessary)</td>
<td>• Shared room (unless private room is medically-necessary)</td>
</tr>
<tr>
<td></td>
<td>• Elective inpatient services require Prior Authorization</td>
<td>• Overnight stay for dental work if need is severe or another health issue is present</td>
</tr>
<tr>
<td>Emergency Services</td>
<td>• Emergency room use and observations stays</td>
<td>• Emergency room use and observations stays</td>
</tr>
<tr>
<td></td>
<td>• Emergency dental services for children under the age of 21</td>
<td>• Emergency dental services for children under the age of 21</td>
</tr>
<tr>
<td>Lab and Radiology</td>
<td>• Select Lab and X-ray services</td>
<td>• Select Lab and X-ray services</td>
</tr>
<tr>
<td></td>
<td>• Mammograms</td>
<td>• Mammograms</td>
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<tr>
<td></td>
<td>• CT scans and MRIs</td>
<td>• CT scans and MRIs</td>
</tr>
<tr>
<td></td>
<td>• PET and SPECT scans</td>
<td>• PET and SPECT scans</td>
</tr>
<tr>
<td>Long-term Care</td>
<td>Short term stays may be covered. Members transfer to traditional Medicaid when they need long-term care greater than 60 days.</td>
<td>Short term stays may be covered. Members transfer to traditional Medicaid when they need long-term care greater than 60 days.</td>
</tr>
<tr>
<td>Benefits/Limitations</td>
<td>HHW Package A, and HIP Maternity</td>
<td>HHW Package C Coverage</td>
</tr>
<tr>
<td>----------------------------------------------------------</td>
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<td>----------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Medical Supplies - Durable Medical Equipment (DME)</td>
<td>Covered when medically necessary</td>
<td>Covered when medically necessary. DME coverage limited by a maximum benefit of $2000 per year or $5000 per lifetime.</td>
</tr>
<tr>
<td>• Custom-made DME requires Prior Authorization</td>
<td></td>
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<tr>
<td>Nurse-midwife services</td>
<td>• Well-woman care</td>
<td>• Well-woman care</td>
</tr>
<tr>
<td></td>
<td>• Family planning</td>
<td>• Family planning</td>
</tr>
<tr>
<td></td>
<td>• Pregnancy care</td>
<td>• Pregnancy care</td>
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<tr>
<td></td>
<td>• Prenatal care</td>
<td>o Prenatal care</td>
</tr>
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<td></td>
<td>• Labor and delivery</td>
<td>o Labor and delivery</td>
</tr>
<tr>
<td></td>
<td>• Postpartum care</td>
<td>o Postpartum care</td>
</tr>
<tr>
<td>Nurse practitioner services</td>
<td>Services that are medically necessary or for preventive care</td>
<td>Services that are medically necessary or for preventive care</td>
</tr>
<tr>
<td>Organ Transplants</td>
<td>• Kidney</td>
<td>Does not apply to Package C</td>
</tr>
<tr>
<td>• Requires Prior Authorization</td>
<td>• Kidney/pancreas</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Liver</td>
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<td></td>
<td>• Bone Marrow</td>
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<td></td>
<td>• Cornea</td>
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<td></td>
<td>• Small intestine</td>
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<tr>
<td></td>
<td>• Multivisceral</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Heart</td>
<td></td>
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<tr>
<td></td>
<td>• Lung</td>
<td></td>
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<tr>
<td></td>
<td>• Heart/Lung</td>
<td></td>
</tr>
<tr>
<td>Physician Services</td>
<td>• Diagnostic</td>
<td>• Diagnostic</td>
</tr>
<tr>
<td>Some services may require prior authorization</td>
<td>• Preventive Care</td>
<td>• Preventive Care</td>
</tr>
<tr>
<td></td>
<td>• Therapy</td>
<td>• Therapy</td>
</tr>
<tr>
<td></td>
<td>• Treatment</td>
<td>• Treatment</td>
</tr>
<tr>
<td>Podiatry Services</td>
<td>• Foot Surgery</td>
<td>• Foot Surgery</td>
</tr>
</tbody>
</table>
### Hoosier Healthwise (HHW) Packages A and C and HIP Maternity

<table>
<thead>
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<th>HHW Package A, and HIP Maternity</th>
<th>HHW Package C Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Members may self-refer</td>
<td>• Lab Tests</td>
<td>• Lab Tests</td>
</tr>
<tr>
<td></td>
<td>• X-rays</td>
<td>• X-rays</td>
</tr>
<tr>
<td></td>
<td>Member is covered for up to 6 routine foot care visits per year</td>
<td>Routine foot care is not covered</td>
</tr>
<tr>
<td><strong>Rehab Services - Inpatient</strong></td>
<td><strong>Requires Prior Authorization</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Inpatient treatment to improve ability to function independently:</td>
<td>Inpatient treatment to improve ability to function independently:</td>
</tr>
<tr>
<td></td>
<td>• Cognitive</td>
<td>• Cognitive</td>
</tr>
<tr>
<td></td>
<td>• Communication</td>
<td>• Communication</td>
</tr>
<tr>
<td></td>
<td>• Continence</td>
<td>• Continence</td>
</tr>
<tr>
<td></td>
<td>• Mobility</td>
<td>• Mobility</td>
</tr>
<tr>
<td></td>
<td>• Pain management</td>
<td>• Pain management</td>
</tr>
<tr>
<td></td>
<td>• Perceptual motor function</td>
<td>• Perceptual motor function</td>
</tr>
<tr>
<td></td>
<td>Self-care</td>
<td>Self-care</td>
</tr>
<tr>
<td><strong>Respiratory Therapy</strong></td>
<td>• Review of and treatment for breathing problems</td>
<td>• Review of and treatment for breathing problems</td>
</tr>
<tr>
<td></td>
<td>• Inpatient or Outpatient care for Members with severe heart or lung problems</td>
<td>• Inpatient or Outpatient care for Members with severe heart or lung problems Coverage is limited to 50 sessions per rolling 12-month period</td>
</tr>
<tr>
<td><strong>Skilled Nursing Facility - Short term</strong></td>
<td>• Shared room (unless private room is medically necessary)</td>
<td>Benefit does not apply to Package C</td>
</tr>
<tr>
<td></td>
<td>• Short term stays may be covered. Members transfer to traditional Medicaid when they need long-term care greater than 60 days.</td>
<td></td>
</tr>
<tr>
<td><strong>Smoking Cessation</strong></td>
<td>One 12-week course of treatment per 12 months that includes:</td>
<td>One 12-week course of treatment per 12 months that includes:</td>
</tr>
<tr>
<td></td>
<td>• Prescription or over-the-counter smoking cessation products (for up to 24 weeks per rolling 12-month period)</td>
<td>• Prescription or over-the-counter smoking cessation products (for up to 24 weeks per rolling 12-month period)</td>
</tr>
<tr>
<td></td>
<td>• Limited to 8 hours of counseling services per rolling 12-month period</td>
<td>• Limited to 8 hours of counseling services per rolling 12-month period</td>
</tr>
<tr>
<td><strong>Speech, hearing and language</strong></td>
<td>Speech and language services include group therapy and treatment for a single Member with these limits:</td>
<td>Speech and language services include group therapy and treatment for a single Member with these limits:</td>
</tr>
<tr>
<td></td>
<td>• Hearing services include 1 exam by a licensed audiologist every three years</td>
<td>• Limit of three hours of service per evaluation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Limit of 50 visits per rolling year per</td>
</tr>
</tbody>
</table>
### Hoosier Healthwise (HHW) Packages A and C and HIP Maternity

<table>
<thead>
<tr>
<th>Benefits/Limitations</th>
<th>HHW Package A, and HIP Maternity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Substance Abuse Services - Inpatient</td>
<td>Services provided in a psychiatric hospital or acute care hospital</td>
</tr>
<tr>
<td>• Requires Prior Authorization</td>
<td>Coverage is available for inpatient psychiatric services provided to an individual between 22 and 65 years of age in a certified psychiatric hospital of 16 beds or less</td>
</tr>
<tr>
<td>HHW Package C Coverage</td>
<td>type of therapy</td>
</tr>
<tr>
<td></td>
<td>• Hearing services include 1 exam by a licensed audiologist every three years</td>
</tr>
<tr>
<td>Substance Abuse Services - Outpatient</td>
<td>Group, family and individual psychotherapy Medicaid Rehab Option (carved out)</td>
</tr>
<tr>
<td>• Requires Prior Authorization after 13 sessions</td>
<td>Group, family and individual psychotherapy</td>
</tr>
<tr>
<td>Substance Abuse Services – Partial hospital stay</td>
<td>Facility-based services requiring inpatient stay</td>
</tr>
<tr>
<td>Therapy Services</td>
<td>Physical Therapy</td>
</tr>
<tr>
<td></td>
<td>Occupational Therapy</td>
</tr>
<tr>
<td></td>
<td>Speech Therapy</td>
</tr>
<tr>
<td>Transportation</td>
<td>Non-Emergency Transportation Services:</td>
</tr>
<tr>
<td></td>
<td>• Members are entitled to unlimited trips to any covered health care, behavioral health, dental and vision appointment</td>
</tr>
<tr>
<td></td>
<td>• <strong>Anthem</strong> also provides a value added benefit health education, Women, Infant and Children (WIC) or OMPP Hoosier Healthwise redetermination appointment.</td>
</tr>
<tr>
<td></td>
<td>• <strong>Anthem</strong> also provides a value added benefit as transportation to</td>
</tr>
<tr>
<td></td>
<td>o pharmacies as a stop to fill a prescription when returning</td>
</tr>
<tr>
<td></td>
<td>Non-Emergency Transportation Services:</td>
</tr>
<tr>
<td></td>
<td>• Members are entitled to unlimited trips to any covered health care, behavioral health, dental and vision appointment</td>
</tr>
<tr>
<td></td>
<td>• <strong>Anthem</strong> also provides a value added benefit health education, Women, Infant and Children (WIC) or OMPP Hoosier Healthwise redetermination appointment.</td>
</tr>
<tr>
<td></td>
<td>• <strong>Anthem</strong> also provides a value added benefit as transportation to</td>
</tr>
<tr>
<td></td>
<td>o pharmacies as a stop to fill a prescription when returning from a medical appointment</td>
</tr>
<tr>
<td></td>
<td>o health education</td>
</tr>
</tbody>
</table>
### Benefits Matrix for Healthy Indiana Plan Services

**Please Note:** Providers who are contracted with **Anthem** 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.

HIP Members who become pregnant are eligible to receive maternity benefits through either their existing HIP benefit plan, or through the HIP Maternity program. HIP Maternity Members have the same benefits as HHW pregnant Members. For more information reference this handbook or the IHCP provider manual, [http://provider.indianamedicaid.com/ihcp/manuals/chapter02.pdf](http://provider.indianamedicaid.com/ihcp/manuals/chapter02.pdf). Pregnant Members have no cost sharing or contribution responsibilities.

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<table>
<thead>
<tr>
<th>Benefits/Limitations</th>
<th>HHW Package A, and HIP Maternity</th>
<th>HHW Package C Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>from a medical appointment</td>
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<tr>
<td></td>
<td>o health education</td>
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<tr>
<td></td>
<td>o Women, Infant and Children (WIC)</td>
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<tr>
<td></td>
<td>o Medicaid redetermination</td>
<td></td>
</tr>
<tr>
<td></td>
<td>appointment</td>
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<tr>
<td></td>
<td>Members must schedule an</td>
<td></td>
</tr>
<tr>
<td></td>
<td>appointment with LCP at least</td>
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<tr>
<td></td>
<td>48 hours in advance.</td>
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<td>Prior approval is required, in</td>
<td></td>
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<td></td>
<td>the event of an urgent</td>
<td></td>
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<tr>
<td></td>
<td>transportation need.</td>
<td></td>
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<tr>
<td></td>
<td>Emergency transport to get</td>
<td></td>
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<tr>
<td></td>
<td>medical care and treatment in a</td>
<td></td>
</tr>
<tr>
<td></td>
<td>true emergency</td>
<td></td>
</tr>
<tr>
<td>Vision Services</td>
<td>One eye exam every 12 months</td>
<td></td>
</tr>
<tr>
<td></td>
<td>for Members of all ages</td>
<td></td>
</tr>
<tr>
<td>Members may self-refer</td>
<td>One pair of glasses per year for</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Members through age 20</td>
<td></td>
</tr>
<tr>
<td></td>
<td>HHW - One pair of glasses every</td>
<td></td>
</tr>
<tr>
<td></td>
<td>five years for Members age 21 or</td>
<td></td>
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<tr>
<td></td>
<td>older</td>
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<tr>
<td></td>
<td>Contact lenses (when medically</td>
<td></td>
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<tr>
<td></td>
<td>necessary)</td>
<td></td>
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<td></td>
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<td></td>
</tr>
<tr>
<td></td>
<td>o Women, Infant and Children (WIC)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>o Medicaid redetermination</td>
<td></td>
</tr>
<tr>
<td></td>
<td>appointment</td>
<td></td>
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<tr>
<td></td>
<td>Members must schedule an</td>
<td></td>
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<tr>
<td></td>
<td>appointment with LCP at least</td>
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<td></td>
<td>48 hours in advance.</td>
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<td></td>
<td>Prior approval is required, in</td>
<td></td>
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<tr>
<td></td>
<td>the event of an urgent transportation need.</td>
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</tr>
<tr>
<td></td>
<td>Emergency transport to get</td>
<td></td>
</tr>
<tr>
<td></td>
<td>medical care and treatment in a</td>
<td></td>
</tr>
<tr>
<td></td>
<td>true emergency</td>
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<tr>
<td></td>
<td>Ambulance transport between</td>
<td></td>
</tr>
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<td></td>
<td>facilities when medically</td>
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</tr>
<tr>
<td></td>
<td>necessary ($10 copay applies for</td>
<td></td>
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<tr>
<td></td>
<td>each ambulance transport)</td>
<td></td>
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</tr>
</tbody>
</table>
## HIP Basic and Plus Plans

<table>
<thead>
<tr>
<th>Benefits/Limitations</th>
<th>HIP Basic</th>
<th>HIP Plus</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral Health – Inpatient</td>
<td>Services given in a certified psychiatric hospital or an acute care hospital</td>
<td>Services given in a certified psychiatric hospital or an acute care hospital</td>
</tr>
<tr>
<td>• Requires Prior Authorization</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| Behavioral Health - Outpatient         | • Psychotherapy (group, family and individual)  
• Psychiatric diagnosis interview, exam and treatment  
• Psychological and neuropsychological tests  
  o Requires prior authorization | • Psychotherapy (group, family and individual)  
• Psychiatric diagnosis interview, exam and treatment  
• Psychological and neuropsychological tests  
  o Requires prior authorization |                                                                                                                                                                                                            |
| Members may self-refer                 |                                                                                                                                                                                                            |                                                                                                                                                                                                            |
| Chiropractic Services                  | • Not covered except during pregnancy                                                                                                                                                                      | • Not covered except during pregnancy                                                                                                                                                                   |
| Members may self-refer                 |                                                                                                                                                                                                            |                                                                                                                                                                                                            |
| Dental                                 | Covered only for ages 19 & 20 and for pregnant Members. Benefits are administered by DentaQuest for **Anthem HIP** and are the same as State Plan Benefits | Covered  
HIP Plus benefits include 2 exams and cleanings and 4 bitewing x-rays. Up to 4 minor restorations and 1 major (crown) per year.  
Pregnant women have the State Plan Dental Benefits. Dental services are administered by DentaQuest for **Anthem HIP** |                                                                                                                                                                                                            |
| Diabetes Self-management training      | • Nutrition and exercise advice  
• Drug advice  
• Blood sugar self-check  
• Insulin shot  
• Foot, skin, dental care | • Nutrition and exercise advice  
• Drug advice  
• Blood sugar self-check  
• Insulin shot  
• Foot, skin, dental care |                                                                                                                                                                                                            |
### Chapter 4: Covered and Noncovered Services

#### Covered and Noncovered Services

**Anthem Blue Cross and Blue Shield**
**Hoosier Healthwise, Healthy Indiana Plan**
**and Hoosier Care Connect**

<table>
<thead>
<tr>
<th>Benefits/Limitations</th>
<th>HIP Basic</th>
<th>HIP Plus</th>
</tr>
</thead>
</table>
| **Family Planning**  | • Education and advice  
| Members may self-refer | • Counseling  
|                      | • Physical exam  
|                      | • Annual cervical cancer screening  
|                      | • Birth control  
|                      | • Follow-up care  
|                      | • Pregnancy tests  
|                      | • Sterilization  
|                      | • Lab tests  
|                      | • Sexually transmitted infection screenings  
|                      | • HIV screening, testing and counseling for at-risk Members; referrals for treatment | • Education and advice  
|                      | • Counseling  
|                      | • Physical exam  
|                      | • Annual cervical cancer screening  
|                      | • Birth control  
|                      | • Follow-up care  
|                      | • Pregnancy tests  
|                      | • Sterilization  
|                      | • Lab tests  
|                      | • Sexually transmitted infection screenings  
|                      | HIV screening, testing and counseling for at-risk Members; referrals for treatment |
| **Home Health Care** | • Skilled Nursing Services  
| Requires Prior Authorization | • Physical, occupational, speech and respiratory therapy | • Skilled Nursing Services  
|                      | • Physical, occupational, speech and respiratory therapy |
| **Early and Periodic Screening, Diagnostic and Treatment (EPSDT)** | For Members under 21 years of age:  
|                      | • Health and Development history exam  
|                      | • Physical exam  
|                      | • Vaccines  
|                      | • Lab test including blood lead screenings  
|                      | • Health Education | For Members under 21 years of age:  
|                      | • Health and Development history exam  
|                      | • Physical exam  
|                      | • Vaccines  
|                      | • Lab test including blood lead screenings  
|                      | • Health Education |
| **Hospital Services - Inpatient** | • Shared room (unless private room is medically-necessary) | • Shared room (unless private room is medically-necessary) |
## HIP Basic and Plus Plans

<table>
<thead>
<tr>
<th>Benefits/Limitations</th>
<th>HIP Basic</th>
<th>HIP Plus</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Services</td>
<td>• Emergency room use and observations stays</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Within the current benefit period, Member pays copay if nonemergent: $8 for first in current benefit period; $25 for each subsequent nonemergent ER visit</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Copay waived if Member:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Is Native American, pregnant or has hit 5% cost-sharing limit</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Called <strong>Anthem</strong> NurseLine prior to ER visit and is advised to go to the ER</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Has an emergent condition per prudent layperson standard</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Is admitted to the hospital on the same day as visit</td>
<td></td>
</tr>
</tbody>
</table>

Prior to assessing the copayment, the Member must be screened to ensure they do not have an emergency health condition. The requirements for a medical screening examination and stabilizing treatment when an individual presents at the emergency room remain in place regardless of the Member’s ability to pay.

If a Member calls the **Anthem** 24/7 NurseLine prior to going to the ER and is not advised to go to the ER, the NurseLine will educate the Member about available nonemergent care providers near their residence that can provide urgent medical services. The Member will also be educated that their assigned primary medical provider (PMP) is their first resource for nonemergent medical care and remind them that their PMP is available 24 hours a day to assist them with their medical care.

Copayments are collected from the Member at the time of service. If a copayment is collected and it is later determined that it should have been waived, the copayment must be returned to the Member.

<table>
<thead>
<tr>
<th>Benefits/Limitations</th>
<th>HIP Basic</th>
<th>HIP Plus</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lab and Radiology</td>
<td>• Lab and X-ray services</td>
<td>• Lab and X-ray services</td>
</tr>
<tr>
<td></td>
<td>• Mammograms</td>
<td>• Mammograms</td>
</tr>
<tr>
<td></td>
<td>• CT scans and MRIs</td>
<td>• CT scans and MRIs</td>
</tr>
<tr>
<td></td>
<td>• PET and SPECT scans</td>
<td>• PET and SPECT scans</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medical Supplies - Durable Medical Equipment (DME)</th>
<th>Covered when medically necessary</th>
<th>Covered when medically necessary.</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Some DME requires Prior Authorization</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Nurse-midwife services</th>
<th>Services that are medically necessary or for preventive care</th>
<th>Services that are medically necessary or for preventive care</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Well-woman care</td>
<td>• Well-woman care</td>
</tr>
<tr>
<td></td>
<td>• Family planning</td>
<td>• Family planning</td>
</tr>
<tr>
<td></td>
<td>• Pregnancy care</td>
<td>• Pregnancy care</td>
</tr>
<tr>
<td></td>
<td>o Prenatal care</td>
<td>o Prenatal care</td>
</tr>
<tr>
<td></td>
<td>o Labor and delivery</td>
<td>o Labor and delivery</td>
</tr>
<tr>
<td></td>
<td>o Postpartum care</td>
<td>o Postpartum care</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Nurse practitioner services</th>
<th></th>
<th></th>
</tr>
</thead>
</table>
### HIP Basic and Plus Plans

<table>
<thead>
<tr>
<th>Benefits/Limitations</th>
<th>HIP Basic</th>
<th>HIP Plus</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organ Transplants</td>
<td>• Kidney</td>
<td>• Kidney</td>
</tr>
<tr>
<td></td>
<td>• Kidney/pancreas</td>
<td>• Kidney/pancreas</td>
</tr>
<tr>
<td></td>
<td>• Liver</td>
<td>• Liver</td>
</tr>
<tr>
<td></td>
<td>• Bone Marrow</td>
<td>• Bone Marrow</td>
</tr>
<tr>
<td></td>
<td>• Cornea</td>
<td>• Cornea</td>
</tr>
<tr>
<td></td>
<td>• Small intestine</td>
<td>• Small intestine</td>
</tr>
<tr>
<td></td>
<td>• Multivisceral</td>
<td>• Multivisceral</td>
</tr>
<tr>
<td></td>
<td>• Heart</td>
<td>• Heart</td>
</tr>
<tr>
<td></td>
<td>• Lung</td>
<td>• Lung</td>
</tr>
<tr>
<td></td>
<td>• Heart/Lung</td>
<td>• Heart/Lung</td>
</tr>
<tr>
<td></td>
<td>• Requires Prior Authorization</td>
<td>• Requires Prior Authorization</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>Covered by <strong>Anthem</strong> / Express Scripts. Refer to <strong>Anthem HIP Basic Plan</strong> Formulary</td>
<td>Covered by <strong>Anthem</strong> / Express Scripts. Refer to <strong>Anthem HIP Plus Plan</strong> Formulary</td>
</tr>
<tr>
<td>Physician Services</td>
<td>• Diagnostic</td>
<td>• Diagnostic</td>
</tr>
<tr>
<td></td>
<td>• Preventive Care</td>
<td>• Preventive Care</td>
</tr>
<tr>
<td></td>
<td>• Therapy</td>
<td>• Therapy</td>
</tr>
<tr>
<td></td>
<td>• Treatment</td>
<td>• Treatment</td>
</tr>
<tr>
<td>Podiatry Services</td>
<td>• Foot Surgery</td>
<td>• Foot Surgery</td>
</tr>
<tr>
<td></td>
<td>• Lab Tests</td>
<td>• Lab Tests</td>
</tr>
<tr>
<td></td>
<td>• X-rays</td>
<td>• X-rays</td>
</tr>
<tr>
<td></td>
<td>Routine foot care is not covered</td>
<td>Routine foot care is not covered</td>
</tr>
<tr>
<td></td>
<td>• Members may self-refer</td>
<td>• Members may self-refer</td>
</tr>
<tr>
<td></td>
<td>• Requires Prior Authorization</td>
<td>• Requires Prior Authorization</td>
</tr>
<tr>
<td></td>
<td>Inpatient treatment to improve ability to function independently: cognitive, communication, continence, mobility, pain management, perceptual motor function, self-care</td>
<td>Inpatient treatment to improve ability to function independently: cognitive, communication, continence, mobility, pain management, perceptual motor function, self-care</td>
</tr>
<tr>
<td>Respiratory Therapy</td>
<td>• Review of and treatment for breathing problems</td>
<td>• Review of and treatment for breathing problems</td>
</tr>
<tr>
<td></td>
<td>• Inpatient or Outpatient care for Members with severe heart or lung problems</td>
<td>• Inpatient or Outpatient care for Members with severe heart or lung problems</td>
</tr>
<tr>
<td></td>
<td>• Coverage is limited to a total of 60 sessions per condition or episode for all types of therapies combined</td>
<td>• Coverage is limited to a total of 75 sessions per condition or episode for all types of therapies combined</td>
</tr>
</tbody>
</table>
### HIP Basic and Plus Plans

<table>
<thead>
<tr>
<th>Benefits/Limitations</th>
<th>HIP Basic</th>
<th>HIP Plus</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skilled Nursing Facility - Short term</td>
<td>• Shared room (unless private room is medically necessary)</td>
<td>• Shared room (unless private room is medically necessary)</td>
</tr>
<tr>
<td></td>
<td>• Short term stays may be covered. Members transfer to traditional Medicaid when they need long-term care greater than 100 days.</td>
<td>• Short term stays may be covered. Members transfer to traditional Medicaid when they need long-term care greater than 100 days.</td>
</tr>
<tr>
<td>Smoking Cessation</td>
<td>One 12-week course of treatment per 12 months that includes:</td>
<td>One 12-week course of treatment per 12 months that includes:</td>
</tr>
<tr>
<td></td>
<td>• Prescription or over-the-counter smoking cessation products (for up to 24 weeks per rolling 12-month period)</td>
<td>• Prescription or over-the-counter smoking cessation products (for up to 24 weeks per rolling 12-month period)</td>
</tr>
<tr>
<td></td>
<td>• Limited to eight hours of counseling services per rolling 12-month period</td>
<td>• Limited to eight hours of counseling services per rolling 12-month period</td>
</tr>
<tr>
<td>Speech, hearing and language services</td>
<td>Speech and language services include group therapy and treatment for a single Member with these limits:</td>
<td>Speech and language services include group therapy and treatment for a single Member with these limits:</td>
</tr>
<tr>
<td></td>
<td>• Hearing services include 1 exam by a licensed audiologist every three years</td>
<td>• Hearing services include 1 exam by a licensed audiologist every three years</td>
</tr>
<tr>
<td>Substance Abuse Services - Inpatient</td>
<td>Services given in a psychiatric hospital or acute care hospital</td>
<td>Services for Members treated in an acute care hospital</td>
</tr>
<tr>
<td>• Requires Prior Authorization</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Substance Abuse Services - Outpatient</td>
<td>Group, family and individual psychotherapy</td>
<td>Group, family and individual psychotherapy</td>
</tr>
<tr>
<td>• Requires Prior Authorization after 13 sessions</td>
<td>MRO Services are not covered</td>
<td>MRO Services are not covered</td>
</tr>
<tr>
<td>Substance Abuse Services – Partial hospital stay</td>
<td>Facility-based services requiring inpatient stay</td>
<td>Facility-based services requiring inpatient stay</td>
</tr>
<tr>
<td>Therapy: PT, OT, ST, Cardiac, Respiratory, and Autism</td>
<td>No prior authorization needed if therapy occurs within 30 days of hospital discharge Limit of 60 combined per episode or condition per benefit period</td>
<td>No prior authorization needed if therapy occurs within 30 days of hospital discharge Limit of 75 combined per episode or condition per benefit period</td>
</tr>
</tbody>
</table>
## HIP Basic and Plus Plans

<table>
<thead>
<tr>
<th>Benefits/Limitations</th>
<th>HIP Basic</th>
<th>HIP Plus</th>
</tr>
</thead>
</table>
| **Transportation**   | Nonemergency Transportation Services:  
- Members are entitled to unlimited trips to any covered health care, behavioral health, dental and vision appointment  
- **Anthem** also provides a value added benefit health education, Women, Infant and Children (WIC) or OMPP Hoosier Healthwise redetermination appointment.  
- **Anthem** also provides a value added benefit as transportation to pharmacies as a stop to fill a prescription when returning from a medical appointment  
- Health education  
- Women, Infant and Children (WIC)  
- Medicaid redetermination appointment  
- Members must schedule an appointment with LCP at 48 hours in advance.  
- Prior approval is required, in the event of an urgent transportation need.  
- Emergency transport to get medical care and treatment in a true emergency | Nonemergency Transportation Services:  
- Members are entitled to unlimited trips to any covered health care, behavioral health, dental and vision appointment  
- **Anthem** also provides a value added benefit health education, Women, Infant and Children (WIC) or OMPP Hoosier Healthwise redetermination appointment.  
- **Anthem** also provides a value added benefit as transportation to pharmacies as a stop to fill a prescription when returning from a medical appointment  
- Health education  
- Women, Infant and Children (WIC)  
- Medicaid redetermination appointment  
- Members must schedule an appointment with LCP at 48 hours in advance.  
- Prior approval is required, in the event of an urgent transportation need.  
- Emergency transport to get medical care and treatment in a true emergency |
| **Vision Services**  | One eye exam every 12 months for Members of all ages  
One pair of glasses every two years  
Contact lenses (when medically necessary) | One eye exam every 12 months for Members of all ages  
One pair of glasses every two years  
Contact lenses (when medically necessary) |

**Please Note:** Providers contracted with **Anthem** 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.

<table>
<thead>
<tr>
<th>Benefits/Limitations</th>
<th>Hoosier Care Connect Package – Additional Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral Health – Inpatient</td>
<td>Covered, except for: Inpatient services provided in a state psychiatric hospital or psychiatric residential treatment facility (PRTF). Hoosier Care Connect Members are disenrolled from <strong>Anthem</strong> upon admission.</td>
</tr>
<tr>
<td>• Requires authorization</td>
<td>• Psychotherapy (group, family and individual)</td>
</tr>
<tr>
<td></td>
<td>• Psychiatric diagnosis interview, exam and treatment</td>
</tr>
<tr>
<td></td>
<td>• Partial hospitalization services</td>
</tr>
<tr>
<td></td>
<td>• Clinic Option services,</td>
</tr>
<tr>
<td></td>
<td>• Psychological and neuropsychological testing</td>
</tr>
<tr>
<td>Behavioral Health - Outpatient</td>
<td>Medicaid Rehabilitation Option (MRO) and 1915(i) services as are not covered by <strong>Anthem</strong>, but are covered under state benefits and can be coordinated with Community Mental Health Centers.</td>
</tr>
<tr>
<td>• Notification required for visits; prior authorization</td>
<td></td>
</tr>
<tr>
<td>• Members may self-refer but if the service is not delivered by a psychiatrist, the Member must use an in-network provider</td>
<td></td>
</tr>
<tr>
<td>Chiropractic Services</td>
<td>• Five visits</td>
</tr>
<tr>
<td>Members may self-refer</td>
<td>• 50 therapeutic physical medicine treatments per year</td>
</tr>
<tr>
<td></td>
<td>• One full spine X-ray per year</td>
</tr>
<tr>
<td>Dental</td>
<td>Covered:</td>
</tr>
<tr>
<td></td>
<td>• Diagnostic services</td>
</tr>
<tr>
<td></td>
<td>• Full mouth X-rays – 1 set every three years</td>
</tr>
<tr>
<td></td>
<td>• Bitewing radiographs – 1 set every 12 months</td>
</tr>
<tr>
<td></td>
<td>• Comprehensive detailed oral evaluation – one per lifetime, per recipient, per provider</td>
</tr>
<tr>
<td></td>
<td>• Limited oral evaluation – one every six months</td>
</tr>
<tr>
<td></td>
<td>• Topical fluoride – not covered for Members 21 years of age or older</td>
</tr>
<tr>
<td></td>
<td>• Prophylactic visits – one every six months for ages 12 months up to their 21st birthday and one every 12 months for Members 21 and older</td>
</tr>
<tr>
<td></td>
<td>• Periodontal surgery is only covered for drug-induced periodontal hyperplasia. Payment for office visits is not covered; reimbursement is only available for covered services actually performed</td>
</tr>
<tr>
<td></td>
<td>• All medically necessary dental services are provided for children under age 21 even if the service is not otherwise covered</td>
</tr>
<tr>
<td>Diabetes Self-management Training</td>
<td>• Limited to 16 units per Member per year. Additional units may be prior authorized.</td>
</tr>
<tr>
<td>• Additional services above those covered require prior authorization</td>
<td>• Nutrition and exercise advice</td>
</tr>
<tr>
<td></td>
<td>• Drug advice</td>
</tr>
<tr>
<td></td>
<td>• Blood sugar self-check training</td>
</tr>
<tr>
<td></td>
<td>• Insulin injections training</td>
</tr>
<tr>
<td></td>
<td>• Foot and skin care, dental care education</td>
</tr>
</tbody>
</table>

**Chapter 4: Covered and Noncovered Services**

**Anthem Blue Cross and Blue Shield**

**Indiana Medicaid Provider Manual**

**Hoosier Healthwise, Healthy Indiana Plan and Hoosier Care Connect**

**Version 2.4**

**April 1, 2015**

**Chapter 4: Page 40**
## Hoosier Care Connect

<table>
<thead>
<tr>
<th>Benefits/Limitations</th>
<th>Hoosier Care Connect Package – Additional Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Family Planning</strong></td>
<td>• History and physical exam</td>
</tr>
<tr>
<td>Members may self-refer</td>
<td>• Cervical cancer screening performed according to the United States Preventive Services Task Force Guidelines</td>
</tr>
<tr>
<td></td>
<td>• Contraception</td>
</tr>
<tr>
<td></td>
<td>• Education and counseling on contraception</td>
</tr>
<tr>
<td></td>
<td>• Sexually transmitted infection (STI) screenings for initial diagnosis and initial treatment</td>
</tr>
<tr>
<td></td>
<td>• Lab testing needed for contraceptive choice or STI testing</td>
</tr>
<tr>
<td></td>
<td>• Pregnancy testing and counseling</td>
</tr>
<tr>
<td></td>
<td>• Sterilization</td>
</tr>
<tr>
<td></td>
<td>• HIV screening, testing and counseling for at-risk members; referrals for treatment</td>
</tr>
<tr>
<td><strong>Food Supplements, Nutritional Supplements, and Infant Formulas</strong></td>
<td>• Covered when no other means of nutrition is feasible or reasonable</td>
</tr>
<tr>
<td></td>
<td>• Not available in cases of routine or ordinary nutritional needs</td>
</tr>
<tr>
<td><strong>Home Health Care</strong></td>
<td>• Skilled Nursing Services when medically necessary in the home</td>
</tr>
<tr>
<td>• Requires prior authorization</td>
<td>• Home health aide services, physical, occupational, speech and respiratory therapy, when medically necessary in the home</td>
</tr>
<tr>
<td></td>
<td>• Renal dialysis when medically necessary in the home</td>
</tr>
<tr>
<td><strong>Early and Periodic Screening, Diagnostic and Treatment (EPSDT)</strong></td>
<td>For Members up to 21 years of age:</td>
</tr>
<tr>
<td></td>
<td>• Health and Development history exam</td>
</tr>
<tr>
<td></td>
<td>• Physical exam</td>
</tr>
<tr>
<td></td>
<td>• Vaccines</td>
</tr>
<tr>
<td></td>
<td>• Lab tests including blood lead screenings</td>
</tr>
<tr>
<td></td>
<td>• Health Education</td>
</tr>
<tr>
<td></td>
<td>• Vision services</td>
</tr>
<tr>
<td></td>
<td>• Dental services</td>
</tr>
<tr>
<td></td>
<td>• Hearing services</td>
</tr>
<tr>
<td></td>
<td>• Other necessary services in accordance with the HealthWatch EPSDT periodicity and screening schedule</td>
</tr>
<tr>
<td><strong>Emergency Services</strong></td>
<td>• Emergency room use and observations stays are covered</td>
</tr>
<tr>
<td>• Prior Authorization not required for ER services or observation</td>
<td>• Coverage subject to the prudent layperson standard of an emergency medical condition.</td>
</tr>
<tr>
<td><strong>Hospice Care</strong></td>
<td>Covered by Anthem unless in an inpatient setting. Inpatient hospice care is available through Indiana state Medicaid.</td>
</tr>
<tr>
<td>Hoosier Care Connect</td>
<td>Hoosier Care Connect Package – Additional Details</td>
</tr>
<tr>
<td>----------------------</td>
<td>--------------------------------------------------</td>
</tr>
</tbody>
</table>
| **Benefits/Limitations** | **Hospital Services - Inpatient**  
- Inpatient services require authorization  
  - Shared room (unless private room is medically necessary) |
|                      | **Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID)**  
ICF/IID is not a covered benefit under Anthem Hoosier Care Connect. Coverage is available through Indiana state Medicaid. Anthem provides coverage for up to 60 days to allow for transition. |
|                      | **Lab and Radiology**  
- Mammograms do not require prior authorization  
- Some labs and radiology services may require prior authorization  
Lab and Radiology services are covered. |
|                      | **Long-term Care**  
Long-term care is not a covered benefit under Anthem Hoosier Care Connect. Coverage is available through Indiana state Medicaid after an approved preadmission screening. Anthem provides coverage for up to 60 days to allow for transition to long term care from short term skilled nursing facility services (see Skilled Nursing Facility - Short-term) |
|                      | **Long Term Acute Care**  
Hospitalization require prior authorization  
Covered |
|                      | **Medical Supplies - Durable Medical Equipment (DME)**  
- Custom-made DME and some select equipment and supplies require prior authorization  
Covered when medically necessary |
|                      | **Nurse-Midwife Services**  
- Well-woman care  
- Family planning  
- Pregnancy care  
  - Prenatal care  
  - Labor and delivery  
  - Postpartum care |
|                      | **Nurse Practitioner Services**  
Services that are medically necessary are covered. |
|                      | **Organ Transplants**  
- Require prior authorization  
Covered |
## Hoosier Care Connect

<table>
<thead>
<tr>
<th>Benefits/Limitations</th>
<th>Hoosier Care Connect Package – Additional Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Orthodontia</td>
<td>Orthodontia not covered except in cases of craniofacial deformity or cleft palate.</td>
</tr>
<tr>
<td>Out-of-state Medical Services</td>
<td>• Services rendered by out-of-state Anthem-contracted providers are covered.</td>
</tr>
<tr>
<td></td>
<td>• Out-of-state services with non-contracted providers may be covered if medically necessary services are not available with an in-network provider or within Indiana. Prior authorization is required.</td>
</tr>
<tr>
<td></td>
<td>• Emergency services provided out-of-state do not require prior authorization.</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>Pharmacy is covered by Express Scripts, Inc.</td>
</tr>
<tr>
<td></td>
<td>Refer to Anthem Hoosier Care Connect Formulary</td>
</tr>
<tr>
<td>Physician Services</td>
<td>• Diagnostic</td>
</tr>
<tr>
<td>Some services require prior</td>
<td>• Preventive care</td>
</tr>
<tr>
<td>authorization</td>
<td>• Treatment</td>
</tr>
<tr>
<td>Podiatry Services</td>
<td>• Medical diagnosis and treatment</td>
</tr>
<tr>
<td>Members may self-refer</td>
<td>• Covered for up to six routine foot care visits per year for Members with systemic disease that makes these visits medically necessary</td>
</tr>
<tr>
<td></td>
<td>• Corrective footwear when medically necessary and with prior authorization</td>
</tr>
<tr>
<td>Rehab Services - Inpatient</td>
<td>Inpatient treatment to improve a demonstrated impairment related to:</td>
</tr>
<tr>
<td>Require prior authorization</td>
<td>• Cognitive</td>
</tr>
<tr>
<td></td>
<td>• Communication</td>
</tr>
<tr>
<td></td>
<td>• Continence</td>
</tr>
<tr>
<td></td>
<td>• Mobility</td>
</tr>
<tr>
<td></td>
<td>• Pain management</td>
</tr>
<tr>
<td></td>
<td>• Perceptual motor function</td>
</tr>
<tr>
<td></td>
<td>• Self-care</td>
</tr>
<tr>
<td>Respiratory Therapy</td>
<td>Covered:</td>
</tr>
<tr>
<td>May require prior authorization</td>
<td>• Limited to three hours of service per evaluation.</td>
</tr>
<tr>
<td>Skilled Nursing Facility - Short-term</td>
<td>Covered on a short-term basis (fewer than 30-calendar days) if medically necessary</td>
</tr>
<tr>
<td>Requires prior authorization</td>
<td></td>
</tr>
<tr>
<td>Smoking Cessation</td>
<td>One 12-week course of treatment per calendar year.</td>
</tr>
<tr>
<td></td>
<td>• Treatment may include prescription of smoking cessation products</td>
</tr>
<tr>
<td></td>
<td>• Counseling must be included in treatment.</td>
</tr>
<tr>
<td></td>
<td>Anthem offers coordination with Indiana’s QUITLINE services –</td>
</tr>
</tbody>
</table>
## Hoosier Care Connect

<table>
<thead>
<tr>
<th>Benefits/Limitations</th>
<th>Hoosier Care Connect Package – Additional Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Speech, Hearing and Language</td>
<td>Covered – limited to three hours of service per evaluation</td>
</tr>
<tr>
<td>May require prior authorization</td>
<td></td>
</tr>
<tr>
<td>Substance Abuse Services -</td>
<td>Services provided in a psychiatric hospital or acute care hospital</td>
</tr>
<tr>
<td>Inpatient</td>
<td>Coverage is available for inpatient psychiatric services provided to an individual between 22 and 65 years of age</td>
</tr>
<tr>
<td>Requires prior authorization</td>
<td></td>
</tr>
<tr>
<td>Substance Abuse Services -</td>
<td>Group, family and individual psychotherapy</td>
</tr>
<tr>
<td>Outpatient</td>
<td>Services are available under the Medicaid Rehab Option through Indiana state Medicaid benefits</td>
</tr>
<tr>
<td>Requires Prior Authorization after 13 sessions</td>
<td></td>
</tr>
<tr>
<td>Substance Abuse Services –</td>
<td>Facility-based services requiring inpatient stay</td>
</tr>
<tr>
<td>Partial hospital stay</td>
<td></td>
</tr>
<tr>
<td>Physical Therapy Services</td>
<td>Covered – limited to three hours of service per evaluation.</td>
</tr>
<tr>
<td>May require prior authorization</td>
<td></td>
</tr>
<tr>
<td>Occupational Therapy Services</td>
<td>Covered - limited to three hours of service per evaluation.</td>
</tr>
<tr>
<td>Therapy for rehabilitative services will be</td>
<td></td>
</tr>
<tr>
<td>covered for a recipient no longer than two</td>
<td></td>
</tr>
<tr>
<td>years from the initiation of the therapy</td>
<td></td>
</tr>
<tr>
<td>unless there is a significant change in</td>
<td></td>
</tr>
<tr>
<td>medical condition requiring longer therapy.</td>
<td></td>
</tr>
<tr>
<td>The following are not covered by Medicaid:</td>
<td></td>
</tr>
<tr>
<td>• General strengthening exercise programs for</td>
<td></td>
</tr>
<tr>
<td>recuperative purposes</td>
<td></td>
</tr>
<tr>
<td>• Passive range of motion services as the only</td>
<td></td>
</tr>
<tr>
<td>or primary modality of therapy</td>
<td></td>
</tr>
<tr>
<td>• Occupational therapy psychiatric services</td>
<td></td>
</tr>
<tr>
<td>Transportation</td>
<td>Nonemergency transportation – unlimited trips for “covered” health care services, including trips:</td>
</tr>
<tr>
<td></td>
<td>- To WIC offices for those enrolled in the Women, Infants, and Children (WIC) program</td>
</tr>
<tr>
<td></td>
<td>- To the Division of Family Resources (DFR)</td>
</tr>
<tr>
<td></td>
<td>- To <strong>Anthem</strong>-approved health education programs</td>
</tr>
<tr>
<td></td>
<td>- To the pharmacy after leaving the doctor’s office</td>
</tr>
<tr>
<td></td>
<td><strong>Anthem</strong> Member</td>
</tr>
<tr>
<td></td>
<td>Emergency transportation – covered without prior authorization.</td>
</tr>
</tbody>
</table>
**Hoosier Care Connect** does **not** cover the following services (see chart above):

- Long-Term Institutional Care
- Hospice in an Institutional Setting
- Psychiatric Treatment in a State Hospital
- Psychiatric Residential Treatment Facility (PRTF) Services
- Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID)
- Home and Community Based Services (HCBS) Waiver

Members receiving these services can receive them under Traditional Medicaid and will be disenrolled from **Anthem** during this time.

**Pharmacy Benefits – Hoosier Healthwise (HHW)**

The State of Indiana’s Pharmacy Benefits Manager is Catamaran. The PBM administers pharmacy benefits for **Hoosier Healthwise**. For more information on this topic, please go to: [www.indianamedicaid.com](http://www.indianamedicaid.com) and select Providers > Pharmacy Services.

Pharmacy Providers bill the state's PBM for the following HHW charges:

- Prescription drugs approved by the United States Food and Drug Administration (FDA)
- Over-The-Counter (OTC) items approved by the FDA (Hoosier Healthwise)
- Self-injectable drugs (including insulin)
- Smoking cessation drugs
- Various equipment, such as needles, syringes, blood sugar monitors, test strips, lancets and glucose urine testing strips

**Please Note:** Only those drugs listed on the OTC Drug Formulary are covered. You can find the OTC Drug Formulary on the Internet at: [www.indianamedicaid.com](http://www.indianamedicaid.com).

Services **not** covered by the pharmacy benefit include:

- Drugs not approved by the FDA
- Drugs not on the OTC Drug Formulary
- Drugs to help Members get pregnant
- Drugs used for cosmetic reasons
- Drugs for hair growth
- Drugs used to treat erectile problems
- Drugs used for weight loss

<table>
<thead>
<tr>
<th>Benefits/Limitations</th>
<th>Hoosier Care Connect Package – Additional Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vision Services</td>
<td>• One eye exam every 12 months for Members under age 21</td>
</tr>
<tr>
<td></td>
<td>• One eye exam every 2 years for Members ages 21 and older unless additional exams are medically necessary</td>
</tr>
<tr>
<td></td>
<td>• One pair of glasses per year for Members through age 20</td>
</tr>
<tr>
<td></td>
<td>• One pair of glasses every five years for Members age 21 or older</td>
</tr>
<tr>
<td>Members may self-refer</td>
<td></td>
</tr>
</tbody>
</table>

**Hoosier Care Connect** Package – Additional Details:

- One eye exam every 12 months for Members under age 21
- One eye exam every 2 years for Members ages 21 and older unless additional exams are medically necessary
- One pair of glasses per year for Members through age 20
- One pair of glasses every five years for Members age 21 or older

**Hoosier Healthwise**, **Healthy Indiana Plan** and **Hoosier Care Connect**
• Experimental or investigational drugs

**Preferred Drug List**

The **Preferred Drug List** (PDL) for Hoosier Healthwise is located on the state’s website at: [https://inm.providerportal.catamaranrx.com](https://inm.providerportal.catamaranrx.com). Click on **Preferred Drug List** in the right hand column.

**Preferred Drug List: Prior Authorization (PA) Forms**

All prior authorization forms for pharmacy can be found on the state’s website at: [https://inm.providerportal.catamaranrx.com](https://inm.providerportal.catamaranrx.com). Click on PA Criteria and Administrative Forms in the right hand column.

**Prior Authorization of Prescription Benefits – Full Listing**

For a full listing of prescriptions that require prior authorization, please see the **Preferred Drug List** at [https://inm.providerportal.catamaranrx.com](https://inm.providerportal.catamaranrx.com). Click on **Preferred Drug List** in the right hand column.

**Healthy Indiana Plan and Hoosier Care Connect: Covered and Non-Covered Drugs**

**Anthem** is responsible for prescription drug coverage for our Members enrolled in HIP and Hoosier Care Connect. Our Pharmacy Benefits Manager is Express Scripts, Inc.

There are four levels of HIP Pharmacy Benefits: Basic, Plus, State Plan Basic, and State Plan Plus.

With some exceptions, the **Healthy Indiana Plan** covers retail and mail-order prescriptions for drugs on the HIP formulary, including brand name drugs, generic prescription drugs, and prescribed over-the-counter drugs, including insulin.

Hoosier Care Connect covers retail and mail-order prescriptions for drugs on the Hoosier Care Connect formulary, including brand name drugs, generic prescription drugs, and prescribed over-the-counter drugs, including insulin.

Prescription drugs **excluded** from **Healthy Indiana Plan and Hoosier Care Connect** benefits include:

• Anti-Obesity drugs
• Brand name drugs where generic substitution is possible per Indiana Pharmacy Law
• Cosmetic/Hair growth
• Experimental or Investigational Drugs
• Fertility Drugs
• Sexual Dysfunction drugs, oral and injectable

**Please Note:** Noncovered is **not** the same as prior authorization required. Noncovered drugs are those that are excluded from benefit coverage. These products are not available even with prior authorization. Prior authorization criteria are set to allow for coverage if certain predetermined criteria are met.

**Preferred Drug List**

The **Preferred Drug Lists** (PDLs) for Healthy Indiana Plan and Hoosier Care Connect can be found on [www.anthem.com](http://www.anthem.com).

**Mandatory Generic Drug Policy**

Generic substitution for brand name drugs is required by state law.Generic drugs must be provided when available. When a generic drug is available, brand name products will only be approved through written **Prior Authorization**, with the exception of the **Narrow Therapeutic Index** (NTI) medications.
The following procedures are to be followed when generic prescriptions are substituted for a brand name prescription:

- If the prescribed brand name medication has a generic equivalent and the prescribing Provider has not requested **dispense as written**, only the FDA approved generic equivalent will be covered.
- If the generic equivalent medication is not medically appropriate, the Provider is required to submit a prior authorization request.
- If the request meets the approval criteria set forth above, the request will be approved and the brand name medication will be a covered benefit.
- If the request does not meet the approval criteria, then only the generic equivalent will be covered.

Requests that meet the criteria are approved for one year.

**Please Note:** Mandatory generic substitution is not applicable for brand name medications that are Narrow Therapeutic Index drugs.

One of the following criteria must be met for Members to receive brand name prescriptions instead of generic equivalents:

- The Member must have failed adequate trials of the branded medication’s generic equivalent.
- The Member has an allergy or contraindication to the generically equivalent product and prescribing physician determines the brand medication is medically necessary.

If a Member request for a brand name drug is denied, one of the following state-mandated denial criteria must be met:

- Member has not had a trial of the generic product and does not have an allergy or contraindication to the generic product.
- The prescribing Provider has not declared the brand name product to be medically necessary.

**Anthem** covers prescription drugs under its HIP program effective 2/1/2015, and for Hoosier Care Connect Members effective 4/1/2015. (Hoosier Healthwise prescription drug benefit continues to be administered by Catamaran. For HHW pharmacy-related questions, please contact Catamaran Corporation at 1-855-577-6317.) Providers will submit all pharmacy claims as well as prior authorization requests for any prescription drugs that require prior authorization to **Anthem**. Providers may contact **Anthem** at 1-866-398-1922 or visit our website at for access to preferred drug lists and prior authorization information.

**Anthem** maintains a distinct preferred drug list (PDL) for the HIP Basic, HIP Plus, and HIP State Plan packages, and for Hoosier Care Connect. **Anthem’s** prescription drug benefit covers at least the same level of services as the base benchmark pharmacy benefit, including one drug in every category and class or the number of drugs covered in each category and class as the base benchmark, whichever is greater.

For the HIP program, **Anthem** develops its formularies to align with the State’s overall program goals aimed at encouraging Member participation in HIP Plus. Therefore, at a minimum, the HIP Basic plan formulary must be more limited and restrictive than the HIP Plus plan formulary, while still meeting the base benchmark pharmacy requirements. For example, the HIP Basic plan may provide unrestricted use of generic drugs, while placing additional restrictions on brand-name drugs that are not applied to the HIP Plus formulary. Additionally, **Anthem’s** PDLs maximize the utilization of generic drugs where possible and as clinically appropriate.

**Anthem** utilizes a Pharmacy and Therapeutics Committee (P&T) which meets quarterly to make recommendations for changes to its PDL and/or formularies. Prior to removing one (1) or more drugs from the PDL and/or formularies or otherwise placing new restrictions on one (1) or more drugs, **Anthem**
Anthem will submit the proposed change to the FSSA which shall forward the proposal to the Indiana Drug Utilization Review (DUR) Board in advance of the change. The Indiana DUR Board will provide a recommendation regarding approval of the proposed change to the PDL and/or formularies. FSSA will approve, disapprove or modify the PDL and/or formulary based on the Indiana DUR Board’s recommendation. **Anthem** may add a drug to the PDL or formulary without approval from FSSA. A provider may submit a request to the Anthem P&T Committee through the www.anthem.com webpage. Go to www.anthem.com/pharmacyinformation to complete the necessary form.

**Anthem** supports e-Prescribing technologies to communicate the PDL and formularies to prescribers through electronic medical records (EMRs) and e-Prescribing applications. **Anthem** encourages the utilization of e-Prescribing technologies to ensure appropriate prescribing for Members based on the Member’s HIP benefit plan or Hoosier Care Connect plan. Much of the e-Prescribing activity is supported by prescribing providers through web and office-based applications or certified electronic health record (EHR) systems to communicate with the pharmacies.

**Anthem** administers its pharmacy benefits in accordance with all applicable state and federal laws and regulations and therefore will establish prior authorization requirements for applicable drugs. For any drugs which require prior authorization, providers must contact **Anthem** who will provide a response by telephone or other telecommunication device within twenty-four (24) hours of a request for prior authorization. Additionally, **Anthem** provides for the dispensing of at least a 72 hour supply of a covered outpatient prescription drug in an emergency situation. **Anthem** allows a pharmacist to dispense the 72-hour supply using a claim override process without the need for a phone call to **Anthem**. The pharmacist should follow-up the Member’s physician or **Anthem** the next business day regarding the prior authorization requirement.

**Anthem** will implement retrospective drug use reviews to identify patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care, among physicians, pharmacists and individuals receiving benefits, or associated with specific drugs or groups of drugs.

**Dental Services**

**Dental Services** are covered:

- For HIP Members under age 21
- Hoosier Care Connect Members
- Pregnant Members
- Members in HIP Plus
- Members in HIP with State Plan Benefits
- Under Hoosier Healthwise (IHCP)

**Anthem** provides dental services for HIP and Hoosier Care Connect Members through DentaQuest

The **Indiana Health Coverage Programs** (IHCP), which includes all state Medicaid programs such as **Hoosier Healthwise**, provides dental services for Hoosier Healthwise Members and can be reached at the following contact points:

**IHCP Customer Assistance Unit:** 1-317-655-3240 or 1-800-577-1278

**IHCP Website:** www.indianamedicaid.com

Primary Medical Providers in **Anthem’s** network perform dental screenings as part of the **Initial Health Assessments** (IHAs) and preventive exams for adults and children. This inspection follows guidelines established under the **U.S. Preventive Task Force Guidelines**.
Dental Services: Screening for Dental Problems
Primary Medical Providers should conduct an inspection of the teeth, gums and mouth as part of the Initial Health Assessment and refer Members to a Dentist if appropriate.

Dental Services: Dental Referral Procedures – under 21 years of age
Referrals to a dentist will occur, at a minimum, during the Initial Health Assessment and following each subsequent preventive care assessment, if needed. Members who have medical conditions or who are taking medication that affects the condition of the mouth or teeth should be referred on an as-needed basis. One example: Members who are immuno-compromised due to HIV or chemotherapy are at risk for developing mouth lesions that will require immediate care.

Dental referral for children is a priority. Medicaid-eligible children over the age of three should be referred to a dentist for preventive dental care, diagnosis and treatment of existing problems. Parents needing assistance with scheduling dental appointments should be referred to Indiana’s HealthWatch program, also known as the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program.

Examples of covered dental services include the following:
- Clinical exam
- Intra-oral
- Limited oral evaluation
- Panoramic film
- Periodic oral exam
- Radiographs/diagnostic imaging

For a complete list of covered and noncovered services see Chapter 2 of the IHCP Manual at http://provider.indianamedicaid.com/ihcp/manuals/chapter02.pdf.

Dental Services: Dental Coverage for Accidents
Dental services are covered under Hoosier Healthwise, HIP and Hoosier Care Connect when a Member has an accident and it is the initial repair of an injury to the jaw, sound natural teeth, mouth or face. The following services are covered:
- Emergency Care
- Outpatient Care
- Physician Care
- Urgent Care

Initial dental work to repair injuries due to an accident should be provided within 48 hours of the injury, or as soon as possible. Covered services include all exams and treatment needed to complete the repair, such as:
- Lab Tests
- Mandibular/Maxillary Reconstruction
- Oral Exams
- Oral Surgery and Anesthesia
- Prosthetic Services
- Restorations
Vision Services

Vision Services are covered for:

- HIP Members with Vision Benefits, including:
  - All Members age 19 & 20
  - All pregnant Members
  - Members in HIP Plus
  - Members with State Plan Benefits
- Members in Hoosier Healthwise
- Members in Hoosier Care Connect

Vision services are provided by Vision Service Plan (VSP). For claims and Member questions call 1-800-615-1883.

Vision services may be provided by the following:

- Ophthalmologists
- Optometrists
- Opticians

See Chapter 4 for information about covered vision services for Hoosier Healthwise, Healthy Indiana Plan and Hoosier Care Connect.

Children may be able to have further eye tests and glasses as a part of Indiana's state program, HealthWatch. The following are typical benefits that require pre-service review:

- Contact lenses and tinted lenses
- Frames and lenses provided from a source other than the current vision volume purchase contract optical laboratory
- Low or subnormal vision aids
- Orthoptic or pleoptic training
- Photochromatic lenses
- Prosthetic eye

Behavioral Health Services

For information about Behavioral Health services, please see Chapter 5: Behavioral Health Services. Members may self-refer for outpatient behavioral health services.

Hospice Care

Hospice care is covered under the Healthy Indiana Plan. Services may be provided in the home or in a hospice facility.

Hospice care is also covered under Hoosier Care Connect only in a home setting. Inpatient hospice care is available through Indiana State Medicaid.

Hospice care is not covered under the Hoosier Healthwise program. However, terminally ill Members may qualify for hospice care provided directly by the state if they disenroll from our health plan and apply directly to the state. The procedure to enter into hospice care is as follows:
Chapter 4: Covered and Noncovered Services

Anthem
Blue Cross and Blue Shield
Hoosier Healthwise, Healthy Indiana Plan
and Hoosier Care Connect

- The hospice Provider submits a hospice election form to the Indiana Health Coverage Program's (IHCP) Prior Authorization Unit. For more information, go to their website at: http://provider.indianamedicaid.com/ihcp/manuals/hospice_benefit_manual.pdf
- The IHCP Prior Authorization Unit will then initiate the disenrollment of the Member from managed care and facilitate hospice coverage.
- Anthem will coordinate care for Members who are transitioning into hospice by providing any information required to complete the hospice election form for terminally ill Members desiring hospice, as described in the IHCP Hospice Provider Manual.

County and State-Linked Services

To ensure continuity and coordination of care for our Members, Anthem enters into agreements with locally based public health programs. Providers are responsible for notifying Anthem’s Case Management department when a referral is made to one of the agencies listed below.

Case Management Phone: 1-866-902-1690
Case Management Fax: 1-855-417-1289

This notification ensures that case manager nurses and social workers can follow up with Members to coordinate their care. Our AnthemConnect Team works with our provider partners to ensure that Members receive all necessary services.

State Services and Programs

The following information identifies state services and programs, and the services these state programs provide upon referral.

Indiana Division of Mental Health and Addiction (DMHA): Provides treatment for re-integration into the community.

DMHA Website: www.in.gov/fssa/dmha/4521.htm

Indiana Division of Disability & Rehabilitation Services: Provides independence through in-home services, supported employment, independent living, nutrition assistance, services for Members with hearing loss, blindness or visual impairment, as well as social security disability eligibility.

DDRS Website: www.in.gov/fssa/2328.htm

Children’s Special Health Care Services (CSHCS): CSHCS is a non-Medicaid program administered by the Indiana State Department of Health (ISDH) that provides financial assistance for needed medical treatment to children with serious and chronic medical conditions to reduce complications and promote maximum quality of life.

CSHCS Website: www.in.gov/isdh/19613.htm

Essential Public Health Services

Anthem collaborates with public health entities in all service areas to ensure essential public health services for Members. Services include:

- Coordination and follow-up of suspected or confirmed cases of childhood lead exposure
- Ensuring appropriate public health reporting (communicable diseases and/or diseases preventable by immunization)
- Investigation, evaluation and preventive treatment of persons with whom the Member has come into contact
- Notification and referral of communicable disease outbreaks involving Members
Referral for tuberculosis and/or sexually transmitted infections or HIV contact
Referral for Women, Infants, and Children (WIC) services and information sharing

Directly Observed Therapy

Tuberculosis (TB) has reemerged as an important public health problem at the same time as drug resistance to the disease continues to rise. In large part, this resistance can be traced to poor compliance with medical regimens. In Directly Observed Therapy (DOT), the Member receives assistance in taking medications prescribed to treat TB. Members with TB showing evidence of poor compliance should be referred to the Local Health Department (LHD) for DOT services.

Reportable Diseases

By state mandate, Providers must report communicable diseases and conditions to local health departments. Anthem’s Providers are to comply with all state laws in the reporting of communicable diseases and conditions. Timely reporting is vital to minimize outbreaks and prevalence.

WIC Referrals

The Women, Infants and Children (WIC) program provides healthy food to pregnant women and mothers of young children. Providers have the following responsibilities for Women, Infants and Children (WIC) program referrals:

- Complete the WIC Program Referral Form that documents the following information:
  - Anthropometric data: height, current weight, pregravid weight
  - Any current medical conditions
  - Biochemical data: hemoglobin, hematocrit
  - Expected Date of Delivery (EDD)
- Provide Member with completed referral form to be presented at the local WIC agency

The Indiana WIC Program Referral Form is located on the state's website at www.in.gov/isdh/24777.htm.

Indiana WIC Phone: 1-800-522-0874
CHAPTER 5: BEHAVIORAL HEALTH SERVICES

Behavioral Health Services

Overview
Anthem Blue Cross and Blue Shield (Anthem) facilitates integrated physical and behavioral Health Services as an integral part of health care. Our mission is to coordinate the physical and behavioral health care of Members by offering a wide range of targeted interventions, education and enhanced access to care to ensure improved outcomes and quality of life for Members. Anthem works collaboratively with hospitals, group practices and independent behavioral health care providers, as well as community agencies and Indiana’s Community Mental Health Centers and other resources to successfully meet the needs of Members with mental health, substance use and intellectual and developmental disabilities.

Goals
The goals of the Behavioral Health program are to:

- Ensure and expand service accessibility to eligible Members
- Promote the integration of the management and delivery of physical and behavioral health services
- Achieve quality initiatives including those related to HEDIS, NCQA and Indiana OMMP performance requirements
- Work with Members, Providers and community supports to provide recovery tools and create an environment that supports Members’ progress toward their recovery goals
- Ensure utilization of the most appropriate, least restrictive, medical and behavioral health care in the right place at the right time

Objectives
The objectives of the Behavioral Health program are to:

- Promote continuity and coordination of care between physical and behavioral health care practitioners
- Enhance Member satisfaction by implementing individualized and holistic support and care plans that allow Members to achieve their recovery goals
- Provide Member education on treatment options and pathways toward recovery
- Provide high quality case management and care coordination services that identify Member needs and address them in a personal and holistic manner
- Work with care providers to ensure the provision of medically necessary and appropriate care and services, including inpatient care, alternative care settings, and outpatient care at the least restrictive level
- Enhance provider satisfaction and success through collaborative and supportive relationships built on mutually agreed upon goals, outcomes and incentives
- Promote collaboration between all health care partners to achieve recovery goals through education, technological support and the promotion of recovery ideals
- Use evidence-based guidelines and clinical criteria and promote their use in the Provider community
- Maintain compliance and accreditation standards with local, state and federal requirements
• Anthem-contracted providers deliver behavioral health and substance use disorder services in accordance with best practice guidelines, rules and regulations, and policies and procedures set forth by the State of Indiana.

Guiding Principles of the Behavioral Health Program

Recovery is a Member-driven process in which people find their paths to work, learn and participate fully in their communities. Resiliency is the ability to live a fulfilling and productive life despite the continued presence of a disability. Physical and behavioral health services are rendered in a manner that allows the achievement of recovery for Members experiencing mental illness and substance use disorders. Treatment supports the development of resiliency for those facing mental illness, serious emotional disturbance and/or substance use disorder issues.

The Substance Abuse and Mental Health Services Administration (SAMHSA) released a consensus statement on mental health recovery reflecting the desire that all behavioral health services be delivered in a manner that promotes individual recovery and builds resiliency. The ten fundamental components of recovery identified by SAMHSA are:

- **Self-direction**: Members lead, control and determine their own paths of recovery by optimizing autonomy, independence and control of resources to achieve a self-determined life.
- **Individualized care**: There are multiple pathways to recovery based on an individual’s unique strengths and resiliency, as well as his or her needs, preferences and experiences including past trauma and cultural background.
- **Empowerment**: Members have the authority to choose from a range of options and to participate in all decisions, including the allocation of resources, which will affect their lives and are educated and supported in so doing.
- **Holistic**: Recovery embraces all aspects of life, including housing, employment, education, mental and health care treatment and services, complementary and naturalistic services (e.g., recreational services, libraries, museums, etc.), addictions treatment, spirituality, creativity, social networks, community participation and family supports as determined by the person.
- **Nonlinear**: Recovery is not a step-by-step process but one based on continual growth, occasional setbacks and learning from experience. Recovery begins with an initial stage of awareness in which a person recognizes that positive change is possible. This awareness enables the consumer to move on to fully engage in the work of recovery.
- **Strengths-based**: Recovery focuses on valuing and building on the multiple capacities, resiliencies, talents, coping abilities and inherent worth of individuals.
- **Peer support**: Mutual support including the sharing of experiential knowledge, skills and social learning plays an invaluable role in recovery.
- **Respect**: Community, systems and societal acceptance and appreciation of consumers — including protecting their rights and eliminating discrimination and stigma — are crucial to achieve recovery.
- **Responsibility**: Members have a personal responsibility for their own self-care and journeys of recovery.
- **Hope**: Recovery provides the essential and motivating message of a better future — that people can and do overcome the obstacles that confront them. Hope is internalized but can be fostered by peers, family, friends, Providers and others. Hope is the catalyst of the recovery process.

Resiliency is the ability of an individual or family to cope and adapt to the challenges and changes brought on by distress or disability. Becoming resilient is a dynamic developmental process that requires patience and effort to pursue steps that enhance positive responses to adverse circumstances. Accepting and managing one’s life in a manner that displays optimism for personal successes manifested by traits of self-efficacy and high self-esteem is achieved by building resiliency. Resilience is learned and developed.
Systems of Care

Services provided to people with serious emotional disturbances and their families are best delivered based on the System of Care Values and Principles that are endorsed by SAMHSA and the Center for Mental Health Services (CMHS). Services should be:

- Person-centered and family-focused with the needs of the person and family dictating the types and mix of services provided.
- Community-based with the focus of services as well as management and decision making responsibility resting at the community level.
- Culturally competent with agencies, programs, and services that are responsive to the cultural, racial, and ethnic differences of the populations they serve.
- Comprehensive, covering an array of services that address physical, emotional, social, educational and cultural needs.
- Personalized as evidenced by an individualized service plan formulated to meet unique needs and potential.
- Delivered in the least restrictive, most normative environment that is clinically appropriate.
- Integrated and coordinated between agencies and include mechanisms for planning, developing and coordinating services inclusive of case management or similar mechanisms to ensure that multiple services are delivered in a coordinated, therapeutic manner and adapted in accordance with the changing needs of the person and their family.
- Delivered without regard to race, religion, national origin, sex, physical disability or other characteristics.
- Oriented to recovery, providing services that are flexible and evolve over time.

Coordination of Behavioral Health and Physical Health Treatment

Key elements of the model for coordinated and integrated physical and behavioral health services include:

- Ongoing communication and coordination between Primary Medical Providers and specialty providers, including behavioral health (mental health and substance use) providers.
- Screening by Primary Medical Providers for mental health, substance use and co-occurring disorders.
- Discussions by behavioral health Provider of physical health conditions.
- Referrals to Primary Medical Providers or specialty Providers, including behavioral health providers, for assessment and/or treatment for consumers with co-occurring disorders and/or any known or suspected and untreated physical health disorders.
- Development of patient-centered treatment plans Involving Members as well as caregivers and family Members when appropriate.
- Case management and disease management programs to support the coordination and integration of care between Providers.

Fostering a culture of collaboration and cooperation helps sustain a seamless continuum of care between physical and behavioral health and positively impacts Member outcomes. To maintain continuity of care, patient safety and Member well-being, communication between behavioral health and physical care providers is critical, especially for Members with co-morbidities receiving pharmacological therapy.

Provider Roles and Responsibilities

The behavioral health care benefit is fully integrated with the rest of the health care programs. This coordination of healthcare resources requires certain roles and responsibilities for behavioral health Providers, including the following:
Participate in the care management and coordination process for each Anthem Member under your care.

Seek Prior Authorization for all services that require it.

Provide Anthem and the Member’s Primary Medical Provider with a summary of the Member’s initial assessment, primary and secondary diagnosis and prescribed medications if the Member is at risk for hospitalization. This information must be provided within 24 hours after the initial treatment session.

Provide, at a minimum, a summary of the findings from the Member’s initial visit to Anthem and the Primary Medical Provider. This must be provided within five-calendar days of the visit for Members not at risk for hospitalization. This notification must include the behavioral health Provider’s contact information, visit date, presenting problem, diagnosis and a list of any medications prescribed.

Notify Anthem and the Member’s Primary Medical Provider of any significant changes in the Member’s status and/or change in the level of care.

Ensure that Members receiving inpatient psychiatric services are scheduled for an outpatient follow-up and/or continuing treatment prior to discharge. This treatment must be provided within seven-calendar days from the date of the Member’s discharge.

Offer hours of operation that are no less than the hours of operation offered to commercial Members.

Encourage Members to consent to the sharing of substance abuse treatment information.

Transition after Acute Psychiatric Care

To assist in the transition of Anthem Members from an acute psychiatric facility to home or an alternative setting, Anthem recommends scheduling a transition appointment. A licensed behavioral health practitioner should conduct this therapy session, which must take place after discharge, but before the Member actually leaves the facility. The process is as follows:

The acute care facility obtains authorization for the transition appointment by working with Anthem’s care manager.

The care manager provides a Transitions Program Appointment Authorization Worksheet.

The licensed Provider completes signs and faxes the worksheet to the utilization review team following the appointment. (The appropriate fax number is listed at the top of the worksheet.)

Anthem will authorize payment.

For more information, please call Utilization Management at 1-866-408-7187 (for Hoosier Healthwise, Healthy Indiana Plan and Hoosier Care Connect.)

Provider Success

We believe the success of Providers is necessary to achieve our goals. We are committed to supporting and working with qualified Providers to ensure that we jointly meet quality and recovery goals. Our commitment includes:

Improving communication of the clinical aspects of behavioral health care to improve outcomes and recovery

Supporting providers in delivering integrated, coordinated physical and behavioral health services to meet the needs of the whole person

Simplifying precertification rules, referrals, claims and payment processes to help Providers reduce administrative time and focus on the needs of Members

Health Plan Clinical Staff
All clinical staff are licensed and have at least four years of prior clinical experience. Our Medical Director is board certified in psychiatry and licensed in the State of Indiana. Our highly trained and experienced team of clinical care managers, case managers and support staff provide high quality care management and care coordination services to our Members and strive to work collaboratively with all Providers.

**Coordination of Physical and Behavioral Health Services**

As a network Provider, you are required to notify a Member’s Primary Medical Provider when a Member first enters behavioral health care and anytime there is a significant change in care, treatment, medications or need for medical services. You must secure the necessary release of information from the Member or the Member’s legal guardian. You should provide initial and summary reports to the Primary Medical Provider on at least a quarterly basis. The minimum elements to include are:

- Patient demographics
- Date of initial or most recent behavioral health evaluation
- Recommendation to see Primary Medical Provider, if medical condition identified or need for evaluation by a medical practitioner has been determined for the Member (e.g., EPSDT screen, complaint of physical ailments)
- Diagnosis and/or presenting behavioral health problem(s)
- Prescribed medication(s)
- Behavioral health clinician’s name and contact information

**Case Management**

Anthem’s behavioral health case management programs are designed to improve Member health outcomes by integrating with our medical care programs and making reliable and proven protocols available to Providers.

We view case management as a continuum of services and supports that are matched on an individualized basis to the needs of the Member. Members who are identified as at-risk for hospitalization due to behavioral health or substance use disorders are offered ongoing case management support. In addition, Members who are discharged from inpatient stays are provided case management support for a minimum of 90-days post discharge.

Anthem Providers are encouraged to engage and direct development and provide feedback to our Members’ care plans.

Hoosier Care Connect Members who would benefit from case management services, but either actively choose not to participate or are unable to participate, may be managed through a provider-focused program.

Providers who serve Hoosier Care Connect Members engaged in care management shall participate in semiannual care conferences with an interdisciplinary care team. The goal is to coordinate services for Hoosier Care Connect Members across the care continuum. Providers may bill for the semiannual conference using HCPCS code 99211 SC.

Anthem provides clinical teams staffed with Indiana-based behavioral health and medical case managers working in close collaboration with community and Provider-based case managers. The main functions of the Anthem behavioral health case managers include, but are not limited to:

- Use health risk appraisal data gathered by Anthem from Members upon enrollment to identify Members who will benefit from engagement in individualized care coordination and case management.
Use “trigger report data” based upon medical and behavioral health claims to identify Members at risk.

Consult and collaborate with our medical case managers and disease management clinicians regarding Members who present with comorbid conditions.

**Comorbid** is either the presence of one or more disorders (or diseases) in addition to a primary disease or disorder, or the effect of such additional disorders or diseases.

Refer Members to Provider-based case management for ongoing intensive case management and then continue involvement with the Member and the Provider to coordinate care, when needed, among different agencies, medical providers, etc.

Work directly with the Member and Provider based upon the severity of the Member’s condition.

Document all actions taken and outcomes achieved for Members in Anthem’s information system to ensure accurate and complete reporting.

**Member Records and Treatment Planning: Comprehensive Assessment**

Member records must meet the following standards and contain the following elements, if applicable, to permit effective service provision and quality reviews:

Information related to the provision of appropriate services to a Member must be included in his or her record with documentation in a prominent place whether there is an executed declaration for mental health treatment.

Providers must submit a comprehensive assessment that provides a description of the Member’s physical and mental health status at the time of admission to services. It should include:

- **Psychiatric and psychosocial assessment** including:
  - Description of the presenting problem
  - Psychiatric history and history of the Member’s response to crisis situations
  - Psychiatric symptoms
  - Multi-axial diagnosis using the most current edition of Diagnostic and Statistical Manual of Mental Disorders (DSM)
  - Mental status exam

- **Medical assessment** including:
  - Screening for medical problems
  - Medical history
  - Present medications
  - Medication history

- **Substance use assessment** that includes:
  - Frequently used over-the-counter medications
  - Current and historical usage of alcohol and other drugs reflecting impact of substance use in the domains of the community functioning assessment
  - History of prior alcohol and drug treatment episodes and their effectiveness
  - History of alcohol and drug use

- **Community functioning assessment** or an assessment of the Member’s functioning in the following domains:
  - Living arrangements, daily activities (vocational/educational)
Chapter 5: Behavioral Health Services

- Social support
- Financial
- Leisure/recreational
- Physical health
- Emotional/behavioral health
- An assessment of the Member’s strengths, current life status, personal goals and needs

**Member Records and Treatment Planning: Personalized Support and Care Plan**

A patient-centered support and care plan based on the psychiatric, medical substance use and community functioning assessments found in the initial comprehensive assessment must be completed for any Member who receives behavioral health services. There must be documentation in every case that the Member and, as appropriate, his or her family Members, caregivers or legal guardian, participated in the development and subsequent reviews of the treatment plan.

The support and care plan must be completed within the first 14 days of admission to behavioral health services and updated every 180 days, or more frequently as necessary based on the Member’s progress toward goals or a significant change in psychiatric symptoms, medical condition and/or community functioning.

There must be a signed release of information to provide information to the Member Primary Medical Provider or evidence that the Member refused to provide a signature. There must be documentation that referral to appropriate medical or social support professionals have been made.

A Provider who discovers a gap in care is responsible to help the Member get that gap in care fulfilled and documentation should reflect the action taken in this regard.

For Providers of multiple services, one comprehensive treatment/care/support plan is acceptable as long as at least one goal is written, and updated as appropriate, for each of the different services that are being provided to the Member.

The treatment/support/care plan must contain the following elements:

- Identified problem(s) for which the Member is seeking treatment
- Member goals related to each problem(s) identified, written in Member-friendly language
- Measurable objectives to address the goals identified
- Target dates for completion of objectives
- Responsible parties for each objective
- Specific measurable action steps to accomplish each objective
- Individualized steps for prevention and/or resolution of crisis, which includes identification of crisis triggers (situations, signs and increased symptoms); active steps or self-help methods to prevent, de-escalate or defuse crisis situations; names and phone numbers of contacts who can assist the Member in resolving crisis; and the Member’s preferred treatment options, to include psychopharmacology, in the event of a mental health crisis
- Actions agreed to be taken when progress toward goals is less than originally planned by the Member and Provider
- Signatures of the Member as well as family Members, caregivers or legal guardian as appropriate.
- Document semiannual care conferences for Hoosier Care Connect Members

**Member Records and Treatment Planning: Progress Notes**
Progress Notes must document the status of the goals and objectives indicated on the treatment plans and should include:

- Correspondence concerning the Member’s treatment and signed and dated notations of telephone calls concerning the Member’s treatment
- Indication of active follow up actions for referrals given to the Member and actions to fill gaps in care
- A brief discharge summary must be completed within 15-calendar days following discharge from services or death
- Discharge summaries for psychiatric hospital and residential treatment facility admissions that occur while the Member is receiving behavioral health services
- Treatment and care plan and progress notes should be signed by the supervising physician
- Semiannual care conference notes for Hoosier Care Connect Members

Psychotropic Medications

Prescribing Providers must inform all Members considered for prescription of psychotropic medications of the benefits, risks and side effects of the medication, alternate medications and other forms of treatment. If obesity is also a problem, the medical record needs to reflect that a healthy diet and exercise plan has been prepared and given to the Member or if appropriate a referral to a nutritionist or obesity medical professional. If diabetes is a problem, the medical record needs to reflect a discussion with the Member about their condition and their treating provider should be identified in the documentation and coordination efforts with that provider should be indicated as well. The medical record is expected to reflect such conversations as having occurred. The medical record is expected to indicate the prescription data has been shared with the Member’s Primary Medical Provider.

Members on psychotropic medications may be at increased risk for various disorders. As such it is expected that providers are knowledgeable about side-effects and risks of medications and regularly inquire about and seek for any side-effects from medications. This especially includes:

- Follow-up to inquire about suicidality or self-harm in children placed on anti-depressant medications as per Food and Drug Administration and American Psychiatric Association guidelines
- Regular and frequent weight checks and measurement of abdominal girth especially for those on antipsychotics or mood stabilizers
- Glucose tolerance test or hemoglobin A-1C tests especially for those Members on antipsychotics or mood stabilizers
- Triglyceride and cholesterol checks especially for those Members on antipsychotics and mood stabilizers
- ECG checks for Members placed on medications with risk for significant QT-prolongation.
- Ongoing checks for movement disorders related to antipsychotic use and psychotic disorders.

Guidelines for such testing and follow-up are provided by the American Psychiatric Association among others. Summary guidelines are referenced in our Clinical Practice Guidelines located on our website at www.anthem.com. While the prescriber is not expected to personally conduct all of these tests, the prescriber is expected to ensure that these tests occur where indicated and to initiate appropriate interventions to address any adverse results. These tests and the interventions must be documented in the Member’s medical record.

Utilization Management

As a corporation and as individuals Utilization Management (UM) Decisions are governed by the following statements:

- UM-decision making is based only on appropriateness of care and service and existence of coverage.
Practitioners or other individuals are not specifically rewarded for issuing denial of coverage care. Decisions about hiring, promoting or terminating practitioners or other staff are not based on the likelihood or perceived likelihood that they support, or tend to support, denial of benefits.

Financial incentives for UM decision-makers do not encourage decisions that result in underutilization or create barriers to care and service.

Behavioral Health Services

UM Guidelines can be found on the Provider Resources page of our website under Prior Authorization and Preservice Review > Utilization Management Clinical Guidelines. For directions on how to access the Provider Resources page of our website, please see Chapter 1: How to Access Information, Forms and Tools on Our Website.

Timeliness of Decisions on Requests for Authorization

| Behavioral Health | 1. Urgent, Pre-Service Requests: Within 72 hours of request  
|                   | 2. Urgent Concurrent Requests: Within 24 hours of request  
|                   | 3. Routine, Non-Urgent Requests: seven days  
|                   | 4. Retrospective Review Requests: Within 30 days of request |

Access to Care Standards

This grid outlines standards for timely and appropriate access to quality behavioral health care.

| Behavioral Health | 1. Emergent: Immediately  
|                   | 2. Emergent, Non-Life-Threatening/Crisis Stabilization; within 24 hours of request  
|                   | 3. Urgent: Within 48 hours of referral / request  
|                   | 4. Routine Outpatient: Within 10 days of request  
|                   | 5. Outpatient following discharge from an IP Hospital: Within seven days of discharge |

Definitions

**Emergent:** Treatment is considered to be an on-demand service and does not require precertification. Members are asked to go directly to emergency rooms for services if they are either unsafe or their conditions are deteriorating.

**Urgent:** Means a service need that is not emergent and can be met by providing an assessment and services within 48 hours of the initial contact. If the Member is pregnant and has substance use problems she is to be placed in the urgent category.

**Routine:** Means a service need that is not urgent and can be met by receiving treatment within 10 days of the assessment without resultant deterioration in the individual's functioning or worsening of his or her condition.

How to Provide Notification or Request Preauthorization

You may request preauthorization for non-routine outpatient mental health services that require prior preauthorization via phone by calling 1-866-408-7187 24 hours a day, seven days a week, 365 days a year. Please be prepared to provide clinical information in support of the request at the time of the call.

You may request preauthorization via fax for certain levels of care. Fax forms are located on the Provider Resources page of our website at www.anthem.com. For information on how to access the Provider Resources page, please see Chapter 1: How to Access Information, Forms and Tools on Our Website.
Website. The fax numbers to use when providing notification or requesting prior authorization for behavioral health services are:

**Outpatient requests:** 1-877-276-5036

Note: All requests for precertification for psychological and neuropsychological testing should be submitted via fax at 1-877-276-5036. Psychological and neurological testing request forms can also be mailed to:

Behavioral Health Department  
Indiana Medicaid  
P.O. Box 6144  
Indianapolis, IN 46204

All facility-based behavioral health and substance use services require prior authorization.

### Necessity Determination and Peer Review

- When a Provider requests initial or continued precertification for a covered service, our Utilization Managers obtain necessary clinical information and review it to determine if the request meets applicable medical necessity criteria.
- If the information submitted does not appear to meet such criteria, the Utilization Manager submits the information for review by the Medical Director, or other appropriate practitioner, as part of the peer review process.
- The reviewer, or the requesting Provider, may initiate a peer-to-peer conversation to discuss the relevant clinical information with the clinician working with the Member.
- If an adverse decision is made by the reviewer without such a peer-to-peer conversation having taken place (as may occur when the Provider is unavailable for review), the Provider may request such a conversation. In this case, we will make a Medical Director, or other appropriate practitioner, available to discuss the case with the requesting Provider. This conversation may result in the decision being upheld or changed.
- Members requesting Providers and applicable facilities are notified of any adverse decision within notification timeframes that are based on the type of care requested and in conformance with regulatory and accreditation requirements.

### Non-Medical Necessity Adverse Decisions (Administrative Adverse Decision)

If you received an Administrative Adverse Determination and think that this decision was in error, please see Chapter 13: Grievances and Appeals for information and instructions on appeals, grievances and payment disputes.

### Provider Appeals, Grievances and Payment Disputes

If you did not receive a precertification for a requested service and think that this decision was in error, please see Chapter 13: Grievances and Appeals for information and instructions on appeals, grievances and payment disputes.

### Avoiding an Adverse Decision

Most administrative adverse decisions result from non-adherence to, or a misunderstanding of, utilization management policies. Familiarizing yourself and your staff with notification and precertification policies and acting to meet those policies can eliminate the majority of these decisions. Other administrative adverse decisions result from misinformation about the Member’s status or benefits. Such information is readily available from us by calling 1-866-408-7187.
Adverse decisions of a medical nature are rare. Such adverse decisions usually involve a failure of the clinical information to meet evidenced-based national guidelines. We are committed to working with all Providers to ensure that such guidelines are understood and easily identifiable for Providers. Peer-to-peer conversations (between a Medical Director and the Provider clinicians) are one way to ensure the completeness and accuracy of the clinical information.

**Medical record reviews** are another way to ensure that clinical information is complete and accurate. Providers who can appropriately respond in a timely fashion to peer-peer and medical record requests are less likely to encounter dissatisfaction with the utilization management process. We are committed to ensuring a process that is quick and easy and will work with participating Providers to ensure a mutually satisfying process.

**Clinical Practice Guidelines**

All providers have access to evidence-based clinical practice guidelines for a variety of behavioral health disorders commonly seen in primary care including Attention deficit hyperactivity disorder, bipolar disorder for children and adults, major depressive disorder, schizophrenia and substance use disorders. These clinical practice guidelines are located online at [www.anthem.com](http://www.anthem.com).

**Emergency Behavioral Health Services**

Primary Medical Providers should immediately refer any Member who is in crisis or who is a threat to self or others for emergency care. An emergency referral for behavioral health services does not require prior authorization or pre-service review.

**Behavioral Health Self-Referrals**

Members may self-refer to any behavioral health care Provider in Anthem’s network or to an Indiana Health Coverage Program (IHCP) psychiatrist. If the Member is unable or unwilling to access timely services through community Providers, call Anthem’s Customer Care Center for assistance.

Primary Medical Providers may treat Members with situational behavioral health disorders, the most common of which are depression and anxiety. For Members whose behavioral health does not respond to treatment in a primary care setting, contact us for referral and authorization information regarding assessment and ongoing services at:

**Behavioral Health Services: 1-866-408-7187**

Primary Medical Providers are required to refer Members who are experiencing acute symptoms of a chronic behavioral health disorder, exhibiting an acute onset of symptoms, or are in a crisis state. Please refer to the **Benefits Matrix** for the range of services covered.

Primary Medical Providers are also required to make referrals for Members whose symptoms of anxiety and mild depression persist or become worse. Any Member suspected of developing toxicities to medications that have been prescribed by a psychiatrist will need to be referred back to the behavioral health system for observation and monitoring of medications.

Primary Medical Providers should refer any Member with the following established diagnosis or suspected onset of symptoms indicative of these disorders to a behavioral health Specialist:

- Adjustment Disorder
- Behavioral Disorders of Children and Adolescents
- Bipolar Disorders
- Eating Disorders
- Multiple Diagnosis
Psychoses, Involutional, Depressive
Schizophrenia
Unipolar Depression

Behavioral Health Services: Criteria for Provider Type Selection
The following criteria should be met before directing a Member to a psychiatrist:
- Member can self-refer for behavioral health treatment
- Member is taking psychoactive medication
- Member is referred by Primary Medical Provider or under Primary Medical Provider treatment for relevant problem
- Member, if a child, had prior treatment for same problem without medication and problem is severe or disabling in some area of life
- Problem is cognitive and Member has had previous inpatient or day treatment
- Problem is cognitive and overall dysfunction is severe or disabling
- Problem recurrent or greater than six months and Member has prior treatment
- Problem recurrent of greater than six months and dysfunction severe or disabling in any area of functioning
- Problem is somatic and referral was not from Primary Medical Provider
- Problem is somatic, Member is under Primary Medical Provider care, and problem is severe or disabling in some area of functioning

Psychologist or Licensed Clinical Social Worker (LCSW)
The following criteria should be met before directing a Member to a psychologist or Licensed Clinical Social Worker:
- Identifiable stressor is present
- Member is not taking psycho-actives
- Member not referred by Primary Medical Provider, not under Primary Medical Provider treatment for relevant problem
- Problem not recurrent, not greater than six months duration
- Problem not severe or disabling in any area of functioning

Links to Forms, Guidelines and Screening Tools
Mental Health and Substance Use Covered Services: www.anthem.com
Services Requiring Precertification: www.anthem.com
Non-covered diagnoses: www.anthem.com
Screening tools for Primary Medical Providers and behavioral health providers: www.anthem.com
Our Clinical Practice Guidelines (CPGs) Summary guidelines: www.anthem.com
CHAPTER 6: MEMBER ELIGIBILITY

Overview

Given the increasing complexities of health care administration, widespread potential for fraud and abuse, and constant fluctuations in program Membership, Providers need to be vigilant about Member eligibility. Eligibility should be verified before services are rendered every time a Member comes in for services.

To prevent fraud and abuse, Providers should confirm the identity of the person presenting the ID card. Providers must also verify a Member’s eligibility before services are delivered. Because eligibility can change, it should be verified at every visit. Remember that claims submitted for services rendered to non-eligible Members will not be eligible for payment.

How to Verify Member Eligibility

Providers can verify Member eligibility by doing any one of the following:

- Log in to www.Availity.com
- Swipe the Member’s ID card through a Point of Service (POS) device (HIP Members) or enter the Member ID (Note HIP Members have an Anthem ID in addition to their Medicaid Recipient ID (RID)): Hoosier Healthwise Members have an ID card issued by the state. Healthy Indiana Plan and Hoosier Care Connect Members have an ID card issued by Anthem.
- Use the Indiana Health Coverage Program (IHCP) Automated Voice Response (AVR) system at: 1-800-738-6770 or 1-317-692-0819 (for Providers in the 317 Area Code) Enter the Member’s RID
- Log in to Indiana’s secure website, Web interChange, at: https://interchange.indianamedicaid.com/Administrative/logon.aspx Enter the Member’s RID

To apply for a Web interChange user ID and password:

1. Complete the Web interChange administrator access request form available at: https://interchange.indianamedicaid.com/Administrative/logon.aspx
2. Print the form and mail it to the address on the form.

Providers will be notified by e-mail when the application is approved.

Please Note: Indiana’s Family and Social Services Administration (FSSA) will provide eligibility status, but will not provide Primary Medical Provider assignment during enrollment.

HIP Member Copays

Members who do not make their POWER Account contributions and their income is below 100% of the Federal Poverty Level (FPL) or under $973 per month for an individual and $1,988 per month for a family of four are automatically moved to HIP Basic. HIP Basic Members must make a copayment every time they receive a health care service including physician visits, hospital stays or prescription drugs at the time the service is rendered. The cost of incurring copayments for every health care service is unpredictable and could cost more than making the monthly POWER Account contributions. The table below describes Member copayments based on the category of health care service utilized.

HIP Plus members do not make copayments except for emergency room services.
### Chapter 6: Member Eligibility

<table>
<thead>
<tr>
<th>Benefit</th>
<th>State Plan Basic (&amp; State Plan Basic CT)</th>
<th>State Plan Plus (&amp; State Plan Plus CT)</th>
<th>State Plan Basic Pregnancy (&amp; State Plan Basic Pregnancy CT)</th>
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<tr>
<td>POWER Account</td>
<td>$2,500</td>
<td>$2,500</td>
<td>None – Power Account is Frozen</td>
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<tr>
<td>Contributions</td>
<td>None</td>
<td>Required</td>
<td>None</td>
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<tr>
<td>Copays</td>
<td>Out Pat - $4</td>
<td>ER $8 first /$25 each additional non-emergent use (waived if member calls the 24/7 Nurse Line)</td>
<td>None</td>
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<tr>
<td></td>
<td>In Pat - $75</td>
<td></td>
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<tr>
<td></td>
<td>Preferred RX - $4</td>
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<td></td>
<td>Non Preferred RX - $8</td>
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<td></td>
<td>ER - $8 first /$25</td>
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<td></td>
<td>additional non-emergent use (waived if member calls the 24/7 Nurse Line)</td>
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</tr>
</tbody>
</table>

Please note: Pregnant or Native American Members are exempt from any cost sharing responsibilities including the copayments listed above including non-emergent use of the emergency room.

**HIP Member POWER Account**

In order to participate in HIP Plus or HIP State Plus plan, individuals are required to help fund the $2,500 deductible by contributing to their POWER Account on a monthly basis. The state funds the difference between the member’s required monthly POWER Account contributions and the $2,500 POWER Account. For the monthly contribution, the member is liable for 2% of their income, up to a maximum of $100 a month ($1,200 per year).

Please note: Pregnant or Native American Members are exempt from any cost sharing responsibilities including the copayments listed above including non-emergent use of the emergency room.

**Member ID Cards**

Following enrollment, eligible enrollees will receive a Member ID Card. Hoosier Healthwise Members will receive only a state-issued ID card, the Hoosier Health Card. Healthy Indiana Plan and Hoosier Care Connect Members will receive only an Anthem-issued ID card, the Anthem Member ID Card.

**Hoosier Health Card**

The Hoosier Health Card, issued by the state, authorizes medical services for Hoosier Healthwise Members through their managed care plan. The card is a permanent, plastic ID card that Members retain during their lifetime. The card includes the following Member information:

- Name
- Sex
- Date of Birth
- Recipient Identification Number (RID)

Please Note: The Recipient Identification (RID) number is what Providers should use to verify Member eligibility. The Hoosier Health Card is used for identification purposes only.

Please Note: Healthy Indiana Plan Members do not receive a Hoosier Health Card.

**Anthem Healthy Indiana Plan Card**
Following enrollment, a Healthy Indiana Plan Member receives an Anthem Healthy Indiana Plan Card that must be presented at each Provider or facility visit.

Anthem’s Healthy Indiana Plan Card contains the following Member information:

- Name
- Anthem Member ID Number
- Group Number and Plan Code
- RXBIN
- Recipient Identification Number (RID)
- Telephone Numbers for 24/7 NurseLine, Member Services, Transportation, Provider Services

If a card is lost, Members may receive replacement cards upon request through our Customer Care Center.

Please Note: At each Member visit, Providers must ask to see the Member’s ID card. This verification should be done before rendering services and before submission of claims to Anthem.

Presumptive Eligibility for pregnant women (PEPW)

Presumptive Eligibility for pregnant women (PEPW) is short-term coverage of outpatient prenatal care to women while a Medicaid application for Membership in Hoosier Healthwise is pending. The Presumptive Eligibility for Pregnant Women program enables eligible women to receive prenatal care early in their pregnancies. Low-income pregnant women are determined presumptively eligible through an application process. For questions about Presumptive Eligibility, contact Indiana’s Family and Social Services Administration Customer Service:

FSSA Customer Service: 1-317-655-3240
E-Mail: PEHelp@fssa.in.gov

Hospital Presumptive Eligibility - HIP (PE)

Individuals may be determined presumptively eligible on the first day of a qualified hospital stay. Members will receive the HIP Basic benefit package. The Member will not have a POWER Account and will be subject to copays.

Right Choices Program (RCP)

The Right Choices Program (RCP) is designed as a safeguard against unnecessary or inappropriate use of Medicaid benefits by Members who use Indiana Health Coverage Programs (IHCP) services more extensively than their peers. The goal is to help improve our Members’ care by reducing inappropriate use of pharmacy and other health services, which could harm the Member and create unnecessary and wasteful program expenditures.

Primary Lock-In Provider Responsibilities in the RCP

By providing a medical “home,” the Primary Lock-In Provider is better able to manage a Member’s care and coordinate services. By utilizing the Right Choices Program, a single Provider is made aware of all of the Member’s treatments and medications. This reduces the potential for contradictory treatments and adverse health outcomes.
Providers will be notified of lock-in status through a Lock-in Physician Notification Letter generated via the state's Web interChange.

The Primary Medical Provider is required to use referrals if the RCP Member requires evaluation or treatment by a Specialist or another Provider. The purpose of the referral is to assure that the Primary Medical Provider has authorized the visit to the referral Provider.

The referral must be sent to Anthem’s RCP Administrator to assure that claims from referral Providers will be processed for payment.

Referral Providers who treat lock-in Members are also responsible for checking Medicaid eligibility and should not treat the Member if the Primary Medical Provider’s referral has not been obtained.

The Member must be notified in advance of receiving any service that is not covered by Medicaid.

The Member must sign a waiver acknowledging that he or she will be billed for the non-covered service before receiving the service.

If a Member pays cash (and a Provider receives cash) for any Medicaid-covered service, it is considered a fraudulent activity by both parties.

If the referral Provider wants to refer the Member to a third physician, the Primary Medical Provider must also sign the referral and send it to Anthem’s RCP Administrator before the third Provider will be added to the Member’s lock-in list. Additionally, each referral must include the following information:

- **Indiana Health Coverage Program** Member’s name
- **Indiana Health Coverage Program** Member’s RID (Recipient Identification)
- First and last name of the referral Provider (the second physician)
- First and last name of the referral Provider (the third physician)
- New Provider’s **National Provider Identifier** (NPI)
- Date of the referral
- The Primary Medical Provider’s manual or electronic signature (office staff signatures are unacceptable)
- Date(s) of service for which the referral is valid

**Please Note:** If no time period is specified on the referral, it will be approved for up to one year depending on the type of Provider being added. The start date of the referral will be the date indicated on the referral unless an alternate start date is specified by the Primary Medical Provider. A second hospital or pharmacy may be added for the dates of service only.

**Exceptions:**

If the Primary Medical Provider has not sent a referral for the Member to Anthem’s RCP Administrator, and the Primary Medical Provider is not available to write a referral, temporary Provider coverage may be approved by the RCP Administrator.

Referrals are not required for Medicaid services covered directly by the state, **unless** prescriptions related to those services are going to be dispensed from a pharmacy. The services that do not require referrals include the following:

- Behavioral Health
- Dental
- Ophthalmology/optometry care
- Podiatry
- Waiver Services
If prescriptions are needed from Providers who render services directly from the state, the following options are available:

- The Primary Medical Provider may write the prescription for the referral Provider
- The rendering Provider may send the Primary Medical Provider’s referral to Anthem’s RCP Administrator for that prescription's addition to the Member’s lock-in list

Retroactive referrals may be sent in cases where the Primary Medical Provider approves services provided on the date of service but failed to send the referral to Anthem’s RCP Administrator at that time.

Retroactive referrals may be accepted if the start date of the retroactive referral is within the claims filing limit. The retroactive referral may be valid for up to one year from the retroactive start date. The Primary Medical Provider’s medical records for the Member should indicate on or near the date of service that the referred service was approved. The Primary Medical Provider is not required to approve any service for which he or she had no knowledge on the date of service. The following circumstances may be eligible for a retroactive referral:

- Auto-assigned Member lives in an underserved area and is unable to select a Primary Medical Provider from that area
- Death of Primary Medical Provider
- Newly-transitioned Members into the program (i.e., wards and foster children) who are in need of treatment within the first 60 days of enrollment
- Primary Medical Provider change is still pending after a previously auto-assigned Member has selected a new Primary Medical Provider
- Primary Medical Provider moves out of the region and fails to notify the program
- Urgent, emergent or ongoing issues (i.e., dialysis or ER admission) where the Member is unable to access necessary services and the assigned Primary Medical Provider is unwilling or unable to provide services or the appropriate referral

Termination of RCP Member Care:

Providers may opt to terminate a Member’s care for specific reasons outlined in the Provider’s internal office policies and the state’s RCP Provider Manual, available at the state's Medicaid website: www.indianamedicaid.com.

Reasons for termination include noncompliance with treatment recommendations or abusiveness to office staff. The following are the requirements for termination of a RCP Member:

- The Provider is required to deliver a letter to the Member, with 30-day’s notice, stating that the Member’s care (by this Provider) is being terminated.
- A copy of this letter should be mailed or faxed to Anthem’s RCP Administrator with any applicable reassignment request forms. The RCP Administrator’s staff will work with the Member to select another Provider.
- Referrals made by the terminating Provider expire 30-calendar days after RCP Administrator’s receipt of the dismissal. Upon approval from the Administrator’s Medical Director, the expiration date may be extended under the following extenuating circumstances:
  - New Provider is unable to see Member within 30-calendar days
  - RCP Member eligibility terminates during the process of changing the Primary Medical Provider and the Member is auto-assigned to the dismissing Provider

Claims Review and Adjudication
A major factor in the success of the Right Choices Program is timely and appropriate claims adjudication. Procedures on proper claims submission can be found at www.indianamedicaid.com under the Manuals section, or within the applicable RCP Administrator’s claims processing manual. Claims for RCP Members may be suspended if all claim processing guidelines have not been followed. The following claims processing guidelines are specific to RCP Members:

Claims from Referral Providers

- The referral Provider must receive from the Member’s Primary Medical Provider a referral authorizing the Member’s care for initial service. The referral Provider must confirm that the Member was not referred through other means, such as Member self-referral.
- The Primary Medical Provider must directly supply his or her IHCP Provider number to the referral Provider. This number should not be given to the RCP Member.
- If the referral Provider writes a prescription, it is recommended that the written referral accompany the prescription to the primary lock-in pharmacy. If the referral does not accompany the prescription, the pharmacy should contact the RCP Administrator to verify validity of the referral.

Claims from Out-Of-State Providers

Out-Of-State (OOS) generic Provider numbers will not bypass the lock-in list or be accepted as valid. Therefore, all Providers must have an IHCP Provider number to be a covered Provider for the Right Choices Program. If the Provider is out-of-state, the primary lock-in pharmacy should determine whether the Provider has an IHCP Provider number.

- If the Provider has an IHCP Provider number, he may be considered a covered Provider if the RCP Administrator deems the referral or use of service valid.
- If the out-of-state Provider does not have an IHCP Provider number, the Provider is not a RCP covered Provider and the RCP Administrator should be contacted in order to process an override, if appropriate.

Claims from Lock-In Hospitals and Other Acute Care Facilities

The primary lock-in hospital and other acute care facilities should file claims as they would for any non-RCP Member, but only if the hospital’s Indiana Health Coverage Program number is on the Member’s lock-in list.

Member Eligibility

Primary Lock-In Hospital Responsibilities in the RCP

Selection of Primary Lock-In Hospital

The primary lock-in hospital will be notified of lock-in status through a Hospital Provider Notification Letter generated via the state’s Web interChange. The notification will be sent after Anthem’s RCP Administrator receives the RCP Member’s hospital selection. The primary lock-in hospital should be a full-service hospital and one where the Primary Medical Provider has been issued admitting privileges.

Role of the Primary Lock-In Hospital

The primary lock-in hospital is responsible for ensuring that RCP Members receive appropriate inpatient and outpatient services, including emergency room services. If a Member is found to be using the ER to obtain nonemergent services however, the Member’s Primary Medical Provider and Anthem’s RCP Administrator should be notified. The hospital is strongly encouraged to educate Members on appropriate use of the ER and redirect them to their assigned Primary Medical Provider as appropriate. The RCP Administrator will also provide ER education.
Services Provided in the Emergency Room

For Indiana's Traditional Medicaid RCP Members, a referral is not necessary for services provided in the emergency room. However, only services rendered in the ER setting for medical emergencies will be reimbursed. Once the RCP Member has been stabilized, approval from the Primary Medical Provider must be obtained for further treatment. The lock-in hospital should notify the Primary Medical Provider whenever a RCP Member is treated in the ER.

Nonemergent services rendered in the ER will not be covered for Hoosier Healthwise, Healthy Indiana Plan and Hoosier Care Connect Members. In this case, the hospital should refer the Member to his or her Primary Medical Provider, educate the Member on appropriate ER use, and notify the Member’s Primary Medical Provider of the visit.

Hospital Services

If the primary lock-in hospital is not the desired hospital for a specific inpatient or outpatient service, the Primary Medical Provider may refer the Member to a second hospital or facility and request that it be added to the Member’s lock-in list. The secondary hospital will be added only for the dates of service or time span specified by the Primary Medical Provider upon approval by the RCP Administrator.

Prescriptions upon Discharge from Hospital

If discharge prescriptions are being written for the RCP Member to be filled at the primary lock-in pharmacy, the hospital should contact the Member’s Primary Medical Provider prior to discharge. The Primary Medical Provider should request that the discharge Provider be added to the Member’s lock-in list for a specified timeframe.

Please Note: If an emergency supply of discharge medications is provided by the hospital pharmacy to the RCP Member upon discharge, claims for the prescriptions will not be reimbursed by Indiana Medicaid unless there is an emergency indicator on the pharmacy claim and the Primary Medical Provider has made a valid referral for the discharge Provider to be added to the Member’s lock-in list for the specified timeframe.
CHAPTER 7: UTILIZATION MANAGEMENT

Utilization Management Staff Availability

Anthem makes UM staff available at least eight hours a day on normal business days to answer UM-related calls. Member or Provider UM-related calls received are handled by UM staff.

After normal business hours, an answering service is available to take UM-related messages. If a Provider opts to request an authorization for admission for post-stabilization care after normal business hours we are available 24 hours a day, 7 days a week to Hoosier Healthwise, Healthy Indiana Plan and Hoosier Care Connect Providers who need authorizations for post-stabilization medical admissions or behavioral health care.

Anthem will respond to a post-stabilization request within one hour, and a determination of the medical necessity will be rendered within 24 hours of that response.

Please Note: The UM staff Member will identify himself/herself by name, title and organization when initiating or returning calls regarding UM issues.

Please Note: For benefits to be paid, the Member must be eligible on the date of service and the service must be a covered benefit. Except in an emergency, failure to obtain prior authorization may result in a denial for reimbursement.

Overview

Utilization Management (UM) is a cooperative effort with Providers to promote, provide and document the appropriate use of quality health care resources. Our goal is to provide access to the right care, to the right Member, at the right time, in the appropriate setting.

The UM team takes a multidisciplinary approach to meet the medical and psychosocial needs of our Members. Anthem’s decision-making process reflects the most up-to-date UM standards from the National Committee for Quality Assurance.

When making Utilization Management (UM) decisions, Anthem utilizes the following criteria:

- Federal and State Mandates
- Member Benefits
- Anthem Medical Policy
- Clinical Utilization Management Guidelines
- Milliman Care Guidelines
- Anthem Policy and Procedures
- Anthem Behavioral Health Medical Necessity Criteria

The decision-making criteria used by the UM team are evidence-based and consensus-driven. We periodically update criteria as standards of practice and technology change. We involve practicing physicians in these updates and notify Providers of changes through Provider bulletins. Based on sound clinical evidence, the UM team provides the following service reviews:

- Prior authorizations
- Continued stay reviews
- Post-service reviews

Please Note: Providers contracted with Anthem to serve Hoosier Healthwise, Healthy Indiana Plan and Hoosier Care Connect through an Accountable Care Organization (ACO), Participation Medical Group (PMG) or Independent Physician Association (IPA) should follow the guidelines and practices of the group. This includes:
Chapter 7: Utilization Management

- Authorization
- Covered benefits and services
- Claims submittal

If you have questions, please contact your group administrator or your Anthem network representative.

Decisions affecting the coverage or payment for services are made in a fair, consistent and timely manner. The decision-making incorporates nationally recognized standards of care and practice from sources including:

- American College of Cardiology
- American College of Obstetricians and Gynecologists
- American Academy of Pediatrics
- America Academy of Orthopedic Surgeons
- Cumulative professional expertise and experience

Once a case is reviewed, decisions and notification time frames will be given for:

- Approval of services
- Modification of services
- Deferral of services
- Denial of services

Please Note: We do not reward practitioners and other individuals conducting utilization reviews for issuing denials of coverage or care. There are no financial incentives for UM decision-makers that encourage decisions resulting in under-utilization.

Clinical UM Guidelines Available Online

Clinical UM Guidelines are available on our website at www.anthem.com. To locate them, go to the Provider Resources page and select Enter under Medical Policy, Clinical UM Guidelines and Pre-Cert Requirements. For directions on how to access the Provider Resources page of our website, please see Chapter 1: How to Access Information, Forms and Tools on Our Website.

If you disagree with a Utilization Management decision and want to discuss the decision with the physician reviewer, you can call the UM department at 1-866-408-7187.

Services Requiring Prior Authorization

- Air Ambulance
- Behavioral Health: For information about Behavioral Health Case Management, please see Chapter 5: Behavioral Health Services
- Biofeedback
- Biopharmaceutical and Injectable Medications/Specialty Drugs
- Dental Services
- Some Durable Medical Equipment and Disposable Supplies
- Genetic Testing
- Home Health Care Services, including Hospice Care
- Hyperbaric Oxygen Therapy
- Infusion Therapy, including Chemotherapy
• Inpatient Hospital Services
  o Inpatient Skilled Nursing Facility (SNF)
  o Long-Term Acute Care Facility (LTAC)
  o Newborn Stays Beyond Mother
  o Rehabilitation Facility Admissions
• Laboratory Tests (specific)
• Out-Of-Network services
• Physician Services - Referrals to Specialists
• Radiology Services
• Select Outpatient Surgeries/Procedures
• Sensory Integration Therapy
• Transplant Services
• Vision Services

A more comprehensive list of Services Requiring Prior Authorization can be found under the Prior Authorization and Preservice Review heading on the Provider Resources page of our website at: www.anthem.com. For directions on how to access the Provider Resources page of our website, please see Chapter 1: How to Access Information, Forms and Tools on Our Website.

Please Note: For advanced imaging services, Anthem uses Diagnostic Imaging Guidelines developed by and proprietary to AIM Specialty Health. These advanced imaging guidelines are available on their website at www.aimspecialtyhealth.com/clinical-guidelines/agreementAccess.
Prior Authorization Toolkit

Our Prior Authorization Toolkit can be found under the Prior Authorization and Preservice Review heading on the Provider Resources page of our website at: www.anthem.com. For directions on how to access the Provider Resources page of our website, please see Chapter 1: How to Access Information, Forms and Tools on Our Website.

The toolkit contains information on Specialty Procedure Codes, as well as the Request for Preservice Review form.

Starting the Process

When authorization of a health care service is required, call us with questions and requests, including requests for:

- Routine, non-urgent care reviews
- Urgent or expedited pre-service reviews
- Urgent concurrent or continued stay reviews

An urgent request is any request for coverage of medical care or treatment with in which the length of time required to make non-urgent care determinations could result in one of the following:

- Could seriously jeopardize the life or health of the Member or the Member’s ability to regain maximum function, based on a prudent layperson's judgment
- In the opinion of a practitioner with knowledge of the Member’s medical condition, would subject the Member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request

Providers can also fax the UM team and include requests for:

- Urgent or expedited pre-service reviews
- Non-urgent concurrent or continued stay reviews

Faxes are accepted during and after normal business hours. Faxes received after hours will be processed the next business day.

Provider Notifications of Changes to Authorization Procedures

We notify providers of changes to authorization procedures via provider bulletins. Provider bulletins are distributed to all network providers and then posted under the Provider Communications heading on the Provider Resources page of our website: www.anthem.com. Bulletins posted on the Provider Resources page of our website are available to all providers. This Manual is then updated with changes during its next scheduled revision.

For directions on how to access the Provider Resources page of our website, please see Chapter 1: How to Access Information, Forms and Tools on Our Website.

Requesting Authorization

To request a pre-service review or report a medical admission, call the UM department and have the following information ready:

- Member name and identification (ID) number
- Diagnosis with the International Classification of Diseases (ICD) code
• Date of injury or hospital admission and third party liability information (if applicable)
• Facility name (if applicable)
• Primary Medical Provider
• Specialist or attending physician name
• Clinical justification for the request
• Level of care
• Lab tests, radiology and pathology results
• Medications
• Treatment plan including time frames
• Prognosis
• Psychosocial status
• Exceptional or special needs issues
• Ability to perform activities of daily living
• Discharge plans

Additional information to have ready for the clinical reviewer includes, but is not limited to:
• Office and hospital records
• History of the presenting problem
• Clinical exam
• Treatment plans and progress notes
• Diagnostic testing results
• Information on consultations with the treating practitioner
• Evaluations from other health care practitioners and Providers
• Photographs
• Operative and pathological reports
• Rehabilitative evaluations
• Printed copy of criteria related to the request
• Information regarding benefits for services or procedures
• Information regarding the local delivery system
• Patient characteristics and information
• Information from responsible family Members

All Providers—including physicians, hospitals and Ancillary Provider—are required to provide information to the UM department.

Authorization Forms

Our Prior Authorization Toolkit can be found under the Prior Authorization and Preservice Review heading on the Provider Resources page of our website at: www.anthem.com. For directions on how to access the Provider Resources page of our website, please see Chapter 1: How to Access Information, Forms and Tools on Our Website.

Here are some tips for filling out the forms and getting the fastest response to your authorization request:

➢ Fill out the form online, then print and fax it. This ensures legibility.
➢ Fill out the form completely; unanswered questions typically result in delays.
Access the forms online when you need one, rather than pre-printing and storing them. We revise the forms periodically, and outdated forms can delay your request.

Requests with Insufficient Clinical Information

When the UM team receives requests with insufficient clinical information, we will contact the Provider with a request for the information reasonably needed to determine medical necessity.

We will make at least one attempt to contact the requesting Provider to obtain this additional information. If additional clinical information is not received a decision is made based upon the information available. Cases are either approved or denied coverage based on medical necessity and/or benefits. Members and Provider will be notified of the determination by letter.

Pre-Service Review Time Frame

For routine, nonurgent requests, the UM team will complete preservice reviews within seven-calendar days from receipt of the request. Requests that do not meet medical policy guidelines are sent to the physician advisor or medical director for further review.

Providers and Members will be sent notification by phone or fax within seven-calendar days from receipt of the request of the UM team’s approval, modification, deferral or denial.

Urgent Pre-Service Requests

For urgent requests, the UM team completes the pre-service review within 72 hours or as expeditiously as the Member’s condition warrants from receipt of the request.

Generally speaking, the Provider is responsible for contacting us to request pre-service review for both professional and institutional services. However, the hospital or Ancillary Provider should also contact Anthem to verify pre-service review status for all non-urgent care before rendering services.

| Timeliness of Utilization Management Decisions | 1. Urgent, Preservice Requests: Within 72 hours of receipt of request or as expeditiously as the Member’s health condition warrants request |
| | 2. Urgent Concurrent Requests: Within 24 hours of request if the request is received 24 hours prior to the expiration of the previous authorization |
| | 3. Routine, Nonurgent Requests: seven days of request |
| | 4. Retrospective Review Requests: Within 30 days of request |

Emergency Medical Conditions and Services

Anthem does not require prior authorization for treatment of emergency medical conditions, which is defined as a condition that could seriously jeopardize the life or health of the Member or the Member’s ability to regain maximum function, based on a prudent layperson’s judgment.

In the event of an emergency, Members can access emergency services 24 hours a day, seven days a week. The facility does not have to be in-network. In the event that the emergency room visit results in the Member’s admission to the hospital, Providers must contact Anthem within 48 hours of admission.

Emergency Stabilization and Post-Stabilization

The emergency department’s treating physician determines the services needed to stabilize the Member’s emergency medical condition. After the Member is stabilized, the emergency department’s physician must contact the Member’s Primary Medical Provider for authorization of further services. The Member’s
Primary Medical Provider is noted on the back of the ID card. If the Primary Medical Provider does not respond within one hour, the needed services will be considered authorized.

The emergency department should send a copy of the emergency room record to the Primary Medical Provider’s office within 24 hours. The Primary Medical Provider should:

- Review the chart and file it in the Member’s permanent medical record
- Contact the Member
- Schedule a follow-up office visit or a Specialist referral, if appropriate

If post-stabilization care is required, the hospital care provided in the 72-hour observation setting does not require authorization or notification. Claims for 72-hour observation will pay according to benefits, without clinical review.

However, as with all non-elective admissions, notification must be made within 24 hours. The medical necessity of that admission will be reviewed upon receipt of notification and a determination of the medical necessity will be rendered within 24 hours of that notification. If a Provider requests authorization for admission for post-stabilization care after normal business hours, the Care Management team is available 24 hours per day, 7 days per week and 365 days a year, to process such requests. A Utilization Management nurse will respond to a call within one hour, and a determination of the medical necessity will be rendered within 24 hours of that notification.

**Referrals to Specialists**

The UM team is available to assist Providers in identifying a network Specialist and/or arranging for Specialist care. Keep the following in mind when referring Members:

- UM authorization is not required if referring a Member to an in-network Specialist for consultation or a nonsurgical course of treatment.
- UM authorization is required when referring to an out-of-network Specialist.
- UM authorization is required for an out-of-network referral when an in-network Specialist is not available in the geographical area.

Provider responsibilities include documenting referrals in the Member’s chart and requesting that the Specialist provide diagnosis and treatment updates.

**Please Note:** Please obtain a prior authorization approval number before referring Members to an out-of-network Provider. For out-of-network Providers, we require this prior authorization for the initial consultation and each subsequent service provided.

**Out-Of-Network Exceptions**

There are several geographical exceptions to using only network Providers:

- **Anthem** Members are allowed to use the services of out-of-network nurse practitioners if no nurse practitioner is available in the Member’s service area.
- For HIP Members, **Anthem** makes covered services provided by **Federally Qualified Health Clinics** (FQHCs) and **Rural Health Clinics** (RHCs) available to Members out-of-network if those clinics are not available in the Member’s service area and within **Anthem’s** network.
- If **Anthem** is unable to provide necessary covered medical services within 60 miles of the Member’s residence by **Anthem’s** Provider network, **Anthem** authorizes out-of-network services and covers the services for as long as those services are unavailable in-network.

**Anthem** also allows Members with special needs that have been determined to need a course of treatment or regular care monitoring to directly access a Specialist via a standing referral from the Member’s
Primary Medical Provider. Treatment provided by the Specialist must be appropriate for the Member’s condition.

**Hospital Inpatient Admissions**

Hospitals must notify the UM department of inpatient medical or behavioral health admissions within 24 hours or no later than the first business day after admission. Once notification of an inpatient admission is received, we will send a request for clinical information supporting the admission’s medical necessity. Evidence-based criteria are used to determine medical necessity and the appropriate level of care.

**Clinical Information for Continued-Stay Review**

When a Member’s hospital stay is expected to exceed the number of days authorized during preservice review, or when the inpatient stay did not have preservice review, the hospital must contact us for continued stay review. We require clinical reviews on all Members admitted as inpatients to:

- Acute-care hospitals
- Intermediate facilities
- Skilled nursing facilities

We perform these reviews to assess medical necessity and determine whether the facility and level of care are appropriate. **Anthem** identifies Members admitted as inpatients by:

- Facilities reporting admissions
- Providers reporting admissions
- Members or their representatives reporting admissions
- Claims submitted for services rendered without authorization
- Pre-service authorization requests for inpatient care

The UM team will complete continued-stay inpatient reviews within 24 hours of receipt of clinical information or sooner, consistent with the Member’s medical condition. UM nurses will request clinical information from the hospital on the same day they are notified of the Member’s admission and/or continued stay. Please include information on the discharge plans, including identified needs, with the initial review. Our UM department is available to assist with any care transition needs.

If the information meets medical necessity review criteria, we will approve the request within 24 hours from the time the information is received. Requests that do not meet medical policy guidelines will be sent to the physician adviser or medical director for further review and determination.

We will notify Providers within 24 hours. We will send written notification of any denial or modification of the request to the Member and requesting Provider.

**Anthem** makes decisions regarding approval or denial of urgent care within the 24 hours of receipt of information, but may extend the time frame in limited situations only when at least one of the following criteria is met:

The request to approve additional days for urgent continued stay care is related to care not previously approved by **Anthem** and **Anthem** documents that it made at least one attempt to contact the Provider and was unable to obtain the needed clinical information within the initial 24 hours after the request for coverage of additional days. In this case, **Anthem** has up to 72 hours to make the decision.

- If the request by the provider/facility to extend urgent continued stay care was not made at least 24 hours prior to the expiration of the prescribed period of time or number of treatments, the request may be treated as an urgent preservice decision, **Anthem** may make the decision within 72 hours.
The health plan documents that the Member voluntarily agrees to extend the decision-making time frame. In this case, **Anthem** has up to 72 hours to make the decision.

If the decision time frame is extended and the decision is a denial or modification, the Provider and Member are notified verbally, electronically or in writing within 72 hours of the receipt of the request.

**Denial of Service**

Only a medical or behavioral health Provider who possesses an active professional license or certification can deny services for lack of medical necessity, including the denial of:

- Procedures
- Hospitalization
- Equipment

When a request is determined to be not medically necessary, the requesting Provider will be notified of the following:

- The decision
- The process for appeal
- How to reach the reviewing physician for peer-to-peer discussion of the case

Providers can contact the physician clinical reviewers to discuss any UM decision by calling the UM department. For more information about UM decisions and how to appeal them, see Chapter 13 Grievances & Appeals.

**Post-Service/Retrospective Review**

Post-service review determines the medical necessity and/or level of care for services that were provided without getting required preservice or concurrent/continued stay authorization. For inpatient admissions where no notification was received and no patient days were authorized, facilities are required to submit a copy of the medical record with the claim.

**Self-Referral**

Members do not need a referral from their provider or prior authorization from **Anthem** and may self-refer to the services listed below. Members may be directed to providers in the network for self-referral services. However, with the exception of behavioral health services, Members may receive self-referral from **Indiana Health Coverage Program**-qualified providers. Services include:

- Chiropractic Services
- Diabetes Self-Management
- Emergency Services
- Family Planning
- Immunizations
- Outpatient Behavioral Health (In-network only if not provided by a psychiatrist)
- Psychiatric Services
- Podiatric
- Routine Vision

**Second Opinions**
There are several important guidelines regarding second opinions:

- A second opinion must be given by an appropriately-qualified health care professional.
- The second opinion must come from a Provider of the same specialty.
- The secondary Specialist must be within Anthem’s network and may be selected by the Member.

(When there is no network Provider who meets the specified qualification, we may authorize a second opinion by a qualified Provider outside of the network upon request by the Member or Provider.)

Second opinions regarding medical necessities are offered at no cost to our Members.

**Additional Services: Behavioral Health**

For information about Behavioral Health services, please see Chapter 5: Behavioral Health Services.

**Additional Services: Vision Care**

Anthem contracts with Vision Service Plan (VSP) Providers for basic vision care. For prior authorization of all vision services, contact:

**Vision Service Plan:** 1-866-866-5641 or 1-800-428-4833 (TTY)

**Please Note:** Vision services are covered only for Hoosier Healthwise and Hoosier Care Connect Members. Healthy Indiana Plan Members do not have vision service benefits.
CHAPTER 8: HEALTH SERVICES PROGRAMS

Overview

Anthem’s health services programs are designed to help improve our Members' overall health and well-being by informing, educating and encouraging self-care in the early detection and treatment of existing conditions and chronic disease.

These targeted programs, which supplement Providers' treatment plans, are divided into three categories:

- Preventive Care Programs, including the Initial Health Assessment
- Health Management Programs, including New Baby New Life℠ pregnancy and newborn case management program to support pregnant women to have the best outcomes for their pregnancy.
- Health Education Programs, including the 24/7 NurseLine for all health-related questions and instruction on the proper use of emergency room services

Preventive Care: Health Screenings & Immunizations

One of the best ways to promote and protect good health is to prevent illness. Hoosier Healthwise, Healthy Indiana Plan and Hoosier Care Connect Members are covered for routine health screenings and immunizations. Additionally, our health services programs provide Members with guidelines, reminders and encouragement to stay well. Our Members may receive:

- Information about health issues
- Flu shot reminders
- Health screening reminders, such as breast and cervical cancer screenings

Provider Responsibilities

The following are Provider responsibilities that help Members maintain healthy lifestyles:

- Document all health care screenings, immunizations, procedures, health education and counseling in the Member’s medical record
- Provide immunizations as needed at all Well Child visits and according to the schedule established by the Advisory Committee on Immunization Practices (ACIP), American Academy of Family Physicians (AAFP) and the American Academy of Pediatrics (AAP)
- Refer Members, as appropriate, to Dentists, Optometrist/Ophthalmology or other Specialists as needed; document referrals in the Member’s medical record
- Schedule preventive care appointments for all children following the AAP periodicity schedule

Preventive Care: Initial Health Assessments

Initial Health Assessments give Providers the baseline they need to assess and manage a Member’s physical condition. Once the Initial Health Assessment has been completed, Providers can give our Members the kind of educational support that allows them to become more actively engaged in their own treatment and preventive health care.

Initial Health Assessments (IHA) of new Members should be performed by the Primary Medical Provider within 90 days of enrollment. The IHA consists of the following categories of patient information:

- Patient History
- Physical Examination
• Developmental Assessment
• Vision & Hearing Screening
• Health Education
• Screenings & Immunizations
• Behavior Assessment

Please Note: An Initial Health Assessment is not necessary under the following conditions:

➢ If the new Member is one of the Primary Medical Provider’s existing patients (but new to us) with an established medical record showing baseline health status. This record must include sufficient information for the Primary Medical Provider to understand the Member’s health history and provide treatment recommendations as needed.

➢ If the new Member is not an existing patient, transferred medical records can also meet the requirements for an IHA if a completed health history is included.

Members also complete a Health Needs Screening online at www.UandIcare.com or over the phone by calling 1-888-849-0895.

Preventive Care: HealthWatch

In Indiana, the Early and Periodic Screening, Diagnostic and Treatment Services Program (EPSDT) for children is called HealthWatch. HealthWatch is a children’s preventive health care program providing initial and periodic examinations and medically necessary follow-up care.

As an integral part of this program, Primary Medical Providers offer age-appropriate preventive care screening and testing during each Well Child visit and during an acute illness episode, if appropriate. The age range for these screenings depends upon the Member’s health plan:

Hoosier Healthwise and Hoosier Care Connect: Birth to 21 years of age
Healthy Indiana Plan: Ages 19 and 20 years of age
HealthWatch Screening Requirements

Primary Medical Providers should offer health education, counseling and guidance to the Member, parent or guardian. An evaluation of age-appropriate risk factors should be performed at each visit. In addition, Primary Medical Providers should perform the following:

- A comprehensive health and developmental history, including both physical and behavioral health development
- A comprehensive unclothed physical exam, which includes pelvic exams and Pap tests for sexually active females
- Appropriate immunizations according to age and health history
- Documented and current immunizations
- Laboratory tests, including screenings for blood lead levels
- Nutritional assessment
- Tuberculosis screening
- Dental Assessment
- Sensory screening (vision and hearing)
- Health Education

For Healthy Indiana Plan Members

- HIP Members ages 19 and 20 are eligible for EPSDT services

HealthWatch Responsibilities

Information on our preventive care programs is provided in Anthem’s Member Handbook which is sent to new Members at the time of enrollment. Member newsletters and the Member website include special features about the HealthWatch program, on-going reminders on the importance of an initial health assessment, Well Child visits, immunizations and regular checkups.

In addition, Anthem uses an automated call system to reach out to Members as outlined below:

- Health Needs Screening (HNS) reminder calls to all newly-enrolled Members within 90 days of enrollment – Members can also complete the HNS online at www.UandIcare.com or over the phone by calling 1-888-849-0895
- Immunization reminder calls to the parents/guardians of Members at ages 3-months, 6-months, 9-months, 12-months, 15-months and 18-months old
- Annual preventive care/well visit reminder calls to Members 2 through 20 years of age on their birth months

Providers should document unsuccessful attempts to contact a Member, attempts to schedule an IHA, missed appointments or the Member’s refusal to schedule an IHA, as evidence that an IHA was attempted.
Preventive Care: Childhood Lead Exposure Testing/Free Blood Test Kits

The Centers for Medicare & Medicaid Services require that all children enrolled in Medicaid be tested for lead exposure at 1 and 2 years of age. Children from 3 to 6 years of age who have not been tested also need screening regardless of their risk factors.

Please Note: Completion of a lead risk assessment questionnaire does not fulfill this screening requirement; a blood draw is also required.

Anthem has contracted with MEDTOX Laboratories to provide free, easy-to-use lead exposure screening kits to Providers. These kits contain:

- A blood sample card
- Lancets (upon request)
- A plastic, sealable storage bag
- Pediatric lead/hemoglobin requisition form
- Prepaid envelope (large envelopes are available upon request)

To order your free MEDTOX lead exposure blood testing kits, please call MEDTOX to arrange for an initial order and to set up an account.

MEDTOX: 1-888-834-8315

Preventive Care: Member Incentives (Healthy Indiana Plan Only)

The Healthy Indiana Plan (HIP) has a built in reward for Members who have their required preventive services and have money remaining in their POWER Account at the end of their benefit period. The full unspent balance rolls over to reduce the amount they have to pay in the next benefit period when they have their required preventive services. If the Member does not have their required preventive services, only the portion of the balance that the Member contributed can rollover to reduce their contributions in the subsequent benefit period.

The Healthy Indiana Plan will consider all Members as having received appropriate preventive services if they had one of the following services during their 12-month benefit period: a preventive exam or general physical; Well Woman Exam (including Pap and/or mammogram if applicable), Colorectal Cancer Screening (if age appropriate), Diabetes Testing HbA1c, LDL, Eye Exam and/or Kidney Function (if diabetic), Cholesterol Testing (if history of Coronary Heart Disease) or Flu shot.

If the Member does not receive all necessary preventive care, only the Member’s contribution to the POWER Account will be rolled over; the state’s portion will be returned to the state.

The POWER Account, which is created by contributions from the Member, the Member’s employer or Community Organization (if applicable), and the State, is equal to the $2,500 yearly deductible for health care services.
Disease Management

Overview

Anthem Disease Management Centralized Care Unit (DMCCU) is based on a system of coordinated care management interventions and communications designed to help physicians and other health care professionals manage Members with chronic health conditions. DMCCU services include a holistic, member-centered care management approach that allows care managers to focus on multiple needs of Members. Our disease management programs include:

- Asthma
- Bipolar disorder
- Chronic obstructive pulmonary disorder
- Congestive heart failure
- Coronary artery disease
- Diabetes
- HIV/AIDS
- Hypertension
- Major depressive disorder
- Schizophrenia
- Substance use disorder
- Attention deficit hyperactivity disorder
- Chronic kidney disease
- Autism/pervasive developmental disorder

The 14 condition-specific disease management programs, allows us to manage Members with multiple health conditions like cerebrovascular disease, fibromyalgia and musculoskeletal complications.

Program Features

- Proactive identification process
- Evidence-based clinical practice guidelines from recognized sources
- Collaborative practice models that include the physician and support providers in treatment planning
- Continuous self-management education, including:
  - Primary prevention
  - Behavior modification
  - Compliance and surveillance
  - Home visits
  - Case management for high-risk Members
- Ongoing process and outcome measurements, evaluation and management
- Ongoing communication with providers regarding patient status

Disease management clinical practice guidelines are located at www.anthem.com. Simply access the Indiana state page and log into the secure site by entering your user name and password. Please select the Clinical Policy & Guidelines link on the top navigation menu to view and print a copy of the guidelines or you can call Provider Helpline at 1-866-408-6132 for Hoosier Healthwise, 1-800-345-4344 for Healthy Indiana Plan and 1-844-284-1798 for Hoosier Care Connect.

Who Is Eligible?

All Members with any condition listed above are eligible. Eligible Members are identified through:

- Continuous case finding welcome calls
- Claims mining
- Referrals
As a valued provider, we welcome your referral of patients who can benefit from additional education and care management support. Our care managers will work collaboratively with you to obtain your input in the development of care plans. Members identified for participation in any of the programs are assessed and risk stratified based on the severity of their condition. They are provided with continuous education on self-management, which includes primary prevention, behavior modification and compliance, as well as case/care management for high-risk members. Program evaluation, outcome measurements and process improvements are built into all programs. Providers are given telephonic and/or written updates regarding patient status and progress.

**Disease Management Centralized Care Unit provider Rights and Responsibilities**

You have the right to:

- Have information about **Anthem**, including:
  - Provided programs and services
  - Our staff
  - Our staff’s qualifications
  - Any contractual relationships
- Decline to participate in or work with any of our programs and services for your patients.
- Be informed of how we coordinate our interventions with your patients’ treatment plans.
- Know how to contact the person who manages and communicates with your patients.
- Be supported by our organization when interacting with patients to make decisions about their health care.
- Receive courteous and respectful treatment from our staff.
- Communicate complaints about DMCCU (see our provider complaint and grievance procedure).

**Hours of operation**

Our DMCCU case managers are licensed nurses and social workers. They are available from 5:30 a.m. to 8:30 p.m. local time. Confidential voicemail is available 24 hours a day.

**Contact**

You can call a DMCCU team member at **1-888-830-4300** or visit [www.anthem.com/inmedicaid](http://www.anthem.com/inmedicaid) for more information.
Health Management: New Baby, New Life℠

Anthem provides comprehensive perinatal services to our expectant Members through the New Baby, New Life℠ program, a comprehensive case management and care coordination program offering Members:

- Individualized, one-on-one case management support for women at the highest risk
- Care coordination for women that may need a little extra support
- Educational materials and information on community resources
- Incentives to keep up with prenatal and postpartum checkups as well as well-child visits after the baby is born

The main objective of the New Baby, New Life℠ program is to help pregnant women achieve positive birth outcomes by encouraging early and ongoing prenatal and postpartum care, and by increasing access to perinatal care. At Anthem, we work in partnership with Members, their primary medical provider and their obstetrician/gynecologist. We also coordinate care for high-risk pregnancies and actively collaborate with providers to assist us in identifying pregnant Members. All identified pregnant women are automatically enrolled in New Baby, New Life℠.

As part of New Baby, New Life℠ Members will receive:

- A Prenatal Packet that includes a booklet and brochures to help Members learn about pregnancy and childbirth.
- An OB High Risk Screening will be completed to determine the Member’s level of risk for delivering a premature infant.
- A Postpartum Packet that includes a booklet on infant care, postpartum depression and reminders on the importance of seeing their doctor for a checkup after giving birth between 21-56 days, as well as reminders to the baby’s checkup.
- Members are enrolled into My Advocate™ a program that provides innovative health communications. This is an automated service that promotes regular doctor visits, compliance with prescription medications and general health education through automated telephone outreach, text messaging or smartphone app throughout the pregnancy and postpartum period including well baby messaging.

For more information on this program, call case management at 1-866-408-7187, option 1.

Reimbursement for the NOP risk assessment

The NOP is used by all IHCP MCEs. Prenatal care providers that electronically complete and submit the NOP in adherence with IHCP guidelines and using Web interChange may be eligible for a $60 incentive payment.

To be eligible for the incentive payment:

- The pregnant woman must be enrolled with an MCE.
- The woman’s pregnancy must be less than 30 weeks gestation at the time of the office visit on which the NOP is based.

The NOP must be submitted via Web interChange no more than five-calender days from the date of the office visit on which the information on the NOP is based.

Providers must bill the MCE for the NOP incentive payment using Current Procedural Terminology (CPT®) code 99354 with modifier TH. The date of service (DOS) on the NOP claim should be the date of the office visit on which the information on the NOP is based.
Only one NOP per Member, per pregnancy, is eligible for reimbursement. NOPs for presumptively eligible pregnant women enrolled with an MCE may be submitted and are eligible for reimbursement. Uninsured pregnant women, including those with pending IHCP applications, should be referred to qualified providers so that presumptive eligibility can be established.

**Breastfeeding Support Tools and Services**

The American Academy of Pediatrics, the American College of Obstetrics and Gynecology, and the American Public Health Association recognize breastfeeding as the preferred method of infant feeding. Providers should encourage breastfeeding for all pregnant women unless it is not medically appropriate.

To support this goal, we ask you to:

- Assess all pregnant women for health risks that are contraindications to breastfeeding, such as AIDS and active tuberculosis.
- Provide breastfeeding counseling and support to all breastfeeding postpartum women immediately after delivery.
- Assess postpartum women to determine the need for lactation durable medical equipment such as breast pumps and breast pump kits.
- Document all referrals and treatments related to breastfeeding in the Member’s medical record. (Pediatricians should document frequency and duration of breastfeeding in baby’s medical record.)
- Refer Members to prenatal classes prior to delivery by calling the Health Management and Education department at 1-800-319-0662.
- Refer pregnant and postpartum women to 24/7 NurseLine for information, support and referrals.
- Refer pregnant women to community resources that support breastfeeding such as Women, Infants and Children (WIC) at 1-800-522-0874.
- Support continued breastfeeding during the postpartum visit.

**Health Management: Maternal Postpartum Outreach program**

The Maternal Postpartum Outreach Program is designed to identify mothers post-delivery and provide outreach and support with completing their postpartum visit within 21-56 days. New moms are identified via the hospital census and entered into the MPOP program. A health outreach specialist will contact new mothers by telephone within 5-7 days after delivery. The purpose of the call is to confirm that she has a postpartum follow-up appointment and address any barriers to her receiving this care. The Member will receive a reminder call and/or reminder postcard 5 days prior to her appointment. The provider will receive a call one day after the appointment is to occur to confirm that the Member completed the appointment. Collaboration with providers is vital to the success of the program. The program will allow Anthem and its Providers to:

- Increase postpartum follow-up visits
- Enhance Member engagement
- Increase quality health care outcomes for mothers and their babies
- Raise Healthcare Effectiveness Data and Information Set (HEDIS) scores

If you have any questions about the Maternal Postpartum Outreach Program, contact the Maternal Outreach Program at 1-844-430-MPOP (6767).

Additionally, Providers should submit the Newborn Enrollment Notification Report to Anthem within three days of delivery. The form is located under Clinical and Preventive Care Tools in the Forms Library on the Provider Resources homepage. For directions on how to access the Provider Resources page of our website, please see Chapter 1: How to Access Information, Forms and Tools on Our Website.
If you have any questions about the New Mother and Baby Post-Delivery Outreach Program, contact Anthem’s Utilization Management department at:

Utilization Management: 1-866-408-7187

Health Education: No-Cost Classes

Anthem offers health education services and programs to meet the specific health needs of our Members to promote healthy lifestyles and improve the health of those living with chronic diseases. Health education classes take place at hospitals and/or community-based organizations. Classes are available at no charge to the Member and are accessible upon self-referral or referral by Anthem network Providers.

Classes vary from county to county, and include the following:

- Asthma Management
- Childbirth/Lamaze
- Diabetes Management
- Injury Prevention
- Nutrition
- Parenting/Well Child
- Prenatal Education
- Sexually Transmitted Infections (STIs)
- Smoking Cessation/Tobacco Prevention
- Substance Abuse

Members receive information about health education classes through enrollment materials, Member newsletters, Practice Consultants (PCs) and Provider offices. To schedule a health education class, Members should call the Health Management and Education department at 1-800-319-0662.

Follow-Up

After attending the class at a participating hospital or community-based organization, we send an Attendance Confirmation letter to the Member’s Primary Medical Provider with the Member’s name, ID number and the title of class attended. If a Member does not show up for the registered class, we mail a No Show letter to the Member’s Primary Medical Provider. Primary Medical Providers must document health education services in the Member’s medical record.

For more information on health education classes, Members or Providers can call our Health Management and Education department at 1-800-319-0662.

Health Education: 24/7 NurseLine

We recognize that questions about health care prevention and management don’t always come up during office hours. 24/7 NurseLine, a 24 hours a day, 7 days a week phone line staffed by registered nurses, provides a powerful Provider support system and is an invaluable component of after-hours care. 24/7 NurseLine allows Members to closely monitor and manage their own health by giving them the ability to ask questions whenever they come up.

24/7 NurseLine: 1-866-800-8780 or 1-800-368-4424 (TTY)

Members can call 24/7 NurseLine for:

- Self-care information, including assistance with symptoms, medications and side-effects, and reliable self-care home treatments.
- Access to specialized nurses trained to discuss health issues specific to our teenage Members.
• Information on more than 300 health care topics through the 24/7 NurseLine audio tape library.

Providers may use 24/7 NurseLine as a resource for Members to call for non-emergent questions and information.

HIP Members who contact the 24/7 NurseLine prior to visiting an emergency room will not be subject to copays.

Please Note: 24/7 NurseLine has access to telephone interpreter services for callers who do not speak English. All calls are confidential.

Health Education: Weight Management Programs

Healthy Lifestyles Healthy Weight is a comprehensive weight management program that engages, educates, motivates and supports people in achieving a healthy weight.

Healthy Lifestyles Healthy Weight helps each individual Member develop a personalized weight management plan tailored to their unique needs. The plan is based on their current state of health and risk factors, behaviors and lifestyle. It also takes into consideration the psychological and preference factors associated with the change process.

Childhood Obesity Education

“Get Up and Get Moving!” is our health education program addressing childhood obesity. The focus is to empower families with young children with knowledge of proper nutrition and physical activity. The key educational concept of this program is that regular exercise and nutrition are the basis of a healthy family lifestyle. Family workbooks are available in English and Spanish to parents of children ages 6 to 12 by calling our Medicaid Provider Helpline at 1-866-408-6132.

Health Education: Tobacco Treatment Programs

Anthem Blue Cross and Blue Shield supports the National Cancer Institute's health education program for Members who want to quit smoking. The program's goals are to:

• Assist Members in improving their health status and quality of life by becoming more actively involved in their own care.
• Encourage Members to quit smoking.
• Support Members' tobacco cessation efforts with resources and education.

The National Cancer Institute has developed a booklet called "Clearing the Air." The booklet provides tips to support tobacco cessation by identifying available resources and offering tools for quitting, such as:

• Winning strategies of successful quitters
• Coping skills for fighting the urge to smoke
• Strategies for success after a relapse
• National Quitline contact information

National Quitline: 1-877-44U-QUIT (1-877-448-7848)

Requests for the booklet can be made in several ways. Once enrolled, Members can make a direct request by using the contact information provided in the Plan's welcome packet. Or, they can request the booklet through the 24/7 NurseLine. They can also make the request in person by talking to care management nurses or social workers.

The booklet is available to download from the following websites:

Smokefree.gov: www.smokefree.gov

Tobacco Cessation Program:  Indiana Tobacco Quitline

Providers are encouraged to refer Members age 18 and over to the **Indiana Tobacco Quitline**, which is confidential and free of charge to Indiana residents. The **Indiana Tobacco Quitline** offers education and coaching over the telephone, as well as **Nicotine Replacement Therapy** patches and lozenges and the medication Varenicline (Chantix).

Members are limited to 12 weeks of medications and 8 hours of counseling per rolling 12-month period. Copayments of 50 cents are required for over-the-counter medications, and co-payments of $3 are required for prescription medications. Counseling is required to be a part of any medication treatment plan.

**Indiana Tobacco Quitline:**  1-800-QUIT-NOW

**Hours of Operation:**  8 a.m.-12 a.m. Monday to Sunday

**Website:**  [www.in.gov/quitline/](http://www.in.gov/quitline/)

**Healthy Lifestyles Tobacco Free** helps each Member develop a personalized "quit tobacco plan." The plan is based on the Member’s current state of health, their risk factors, behaviors and lifestyle. It also takes into consideration the psychological and preference factors associated with the change process.

**Healthy Lifestyles Tobacco Free** provides each individual with the support, resources and motivation to successfully achieve their goal.

**Provider Assessment of Tobacco Use**

The following are Provider guidelines to help Members quit smoking:

- Assess the Member’s smoking status and offer advice about quitting.
- Refer Members to the **National Quit Line** or Indiana's **Tobacco Quitline**, a free, phone-based counseling service. Services are available 7 days a week in more than 170 languages and include:
  - 4 prearranged calls w/coach
  - 10 prearranged calls for pregnant woman (special program)
  - 5 prearranged calls for youth
  - Unlimited Web coaching
  - Unlimited call in privileges and access to coaches
  - Free 2-week NRT starter kit (uninsured, Medicaid, Medicare)
  - Stage-based Support Materials
  - Resources for Providers who want to improve patient outcomes
  - Support for family and friends who want to help loved ones stop smoking

- Use the state’s online **Notification of Pregnancy** (NOP) form at [https://interchange.indianamedicaid.com/Administrative/logon.aspx](https://interchange.indianamedicaid.com/Administrative/logon.aspx) as a way to notify us, through the state, of pregnant women who smoke. Women are more likely to quit smoking during pregnancy.

- Encourage pregnant women to stop smoking and not resume after pregnancy.

- Women who are pregnant and voice desire to quit smoking will be directly referred to the Indiana Tobacco Quitline by **Anthem Staff**. Additionally may be referred to Indiana Baby and Me Tobacco Free program if available in the Member’s community.

**Additional Resources to Help Members Stop Smoking**
Anthem offers one additional educational resource to help women who are pregnant or of childbearing age quit smoking and avoid starting again. Copies of Quit Smoking For Your Baby's Sake can be downloaded from the Health Education Programs section of the Providers Resources page at: www.anthem.com. For directions on how to access the Provider Resources page of our website, please see Chapter 1: How to Access Information, Forms and Tools on Our Website.

Provider types who may perform tobacco cessation counseling include:

- Physicians
- Physician assistants
- Nurse practitioners
- Registered nurses
- Psychologists
- Pharmacists
- Dentists

Counseling is required as a part of any covered tobacco cessation course of treatment.
CHAPTER 9: CLAIMS & BILLING

Overview

Having a fast and accurate system for processing claims allows Providers to manage their practices and our Members’ care more efficiently.

With that in mind, Anthem has made claims processing as streamlined as possible. Share the following guidelines with your staff, billing service and electronic data processing agents as appropriate.

- Submit “clean” claims, making sure that the right information is on the right form.
- Submit claims as soon as possible after providing service.
- Submit claims within the contractual filing time limit.

For Anthem Members enrolled in Hoosier Healthwise and Hoosier Care Connect: Providers should follow claims and billing guidelines outlined in the Indiana Health Coverage Programs (IHCP) manual. The chapter on billing instructions may be found on the state website: http://provider.indianamedicaid.com/ihcp/manuals/chapter08.pdf.

For Anthem Members enrolled in the Healthy Indiana Plan (HIP): Anthem uses Medicare NCCI coding guidelines. Healthy Indiana Plan claims will be reimbursed at 100% of Indiana Medicare or 130% of Medicaid if a Medicare fee is not available. Please refer to the Indiana Health Coverage Programs HIP Reimbursement Manual at http://provider.indianamedicaid.com/general-provider-services/manuals.aspx.

Please Note: In order to be contracted as an Anthem HIP or HHW Provider, providers must first contract with the Indiana Health Coverage Programs (IHCP) as a Medicaid Provider.

Providers who are contracted with Anthem 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) should follow the guidelines and practices of the group. This includes but is not limited to authorization, covered benefits and services, and claims submission. If you have questions, please contact your group administrator or Anthem network representative.

McKesson ClaimsXten

For Hoosier Healthwise, Healthy Indiana Plan and Hoosier Care Connect, Anthem uses claims editing software from McKesson called ClaimsXten. ClaimsXten incorporates the McKesson editing rules that determine whether a claim should be paid, rejected or requires manual processing.

These editing rules assess Current Procedural Terminology (CPT®) and Healthcare Common Procedure Coding System (HCPCS) codes on the CMS-1500 form. A claim auditing action then determines how the procedure codes and code combinations will be adjudicated. The auditing action recognizes historical claims related to current submissions and may result in adjustments to previously processed claims. You can find descriptions of specific reimbursement policies in this manual.

ClaimsXten may be updated periodically. Anthem will notify Providers with advance notice as per your Provider agreement. For the latest information and current ClaimsXten rules, please look under Forms and Tools on the Provider Resources page at www.anthem.com. For directions on how to access the Provider Resources page of our website, please see Chapter 1: How to Access Information, Forms and Tools on Our Website.

Submitting “Clean” Claims
Claims submitted correctly the first time are called “clean,” meaning that all required fields have been filled in and that the correct form was used for the specific type of service provided.

A claim may be returned if it is submitted with incomplete or invalid information. If you use the Electronic Data Interchange (EDI), claims will be returned for incomplete or invalid information. They may also be returned if they aren’t submitted with the proper HIPAA-compliant code set. In each case, an error report will be sent to you and the claim will not be sent through for payment. You and your staff are responsible for working with your EDI vendor to ensure that “errored out” claims are corrected and resubmitted.

Generally, there are two types of forms you’ll need for reimbursement. They are:

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

These forms are available in both electronic and hard copy/paper formats. Click on the form name to link to a copy of the form with a general description of each field and the information required.

Please Note: Using the wrong form or not correctly or completely filling out the form causes the claim to be returned. This results in processing and payment delays.

Claims Filing Limits

Claims must be submitted within the contracted filing limit to be considered for payment. Claims submitted after that time period will be denied.

Please Note: Anthem is not responsible for a claim never received. If a claim is submitted inaccurately, delayed resubmission may cause you to miss the filing deadline. Claims must pass basic edits in order to be considered received. To avoid missing deadlines, submit “clean” claims as soon as possible after delivery of service.

Filing limits are determined as follows:

- If Anthem is the primary payer, you have a specific time period between the last date of service on the claim and the Anthem receipt date: 90-calendar days.
- If Anthem is the secondary payer, you have a specific time period between the other payer’s Remittance Advice (RA) date and the Anthem receipt date: 90-calendar days.

Claims from Non-Contracted Providers

Noncontracted providers must be attested with IHCP prior to rendering services to Anthem Members.

- Emergency Services: 365-calendar days from date of service or discharge date
- Non-contracted providers: 365-calendar days from date of service

Reimbursement Policy

Reimbursement Policies serve as a guide to assist you in accurate claims submissions and to outline the basis for reimbursement if the service is covered by a Member’s Anthem benefit plan. The determination that a service, procedure, item, etc. is covered under a Member’s benefit plan is not a determination that you will be reimbursed. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis, as well as to the Member’s state of residence. You must follow proper billing and submission guidelines. You are required to use industry-standard, compliant codes on all claim submissions. Services should be billed with Current Procedural Terminology (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes and/or Revenue codes. The codes denote the services and/or procedures performed. The billed code(s) are required to be fully supported in the
medical record and/or office notes. Unless otherwise noted within the policy, our policies apply to both Participating and Nonparticipating providers and facilities.

**Anthem** Reimbursement Policies are developed based on nationally accepted industry standards and coding principles. These policies may be superseded by mandates in provider or State contracts, or State, Federal or Centers for Medicare & Medicaid Services (CMS) requirements. System logic or setup may prevent the loading of policies into the claims platforms in the same manner as described; however **Anthem** strives to minimize these variations.

**Anthem** reserves the right to review and revise its policies periodically when necessary. When there is an update we will publish the most current policy to: www.anthem.com

### Reimbursement Hierarchy

Claims submitted for payment must meet all of aspects of criteria for reimbursement. The reimbursement hierarchy is the order of payments conditions that must be met for a claim to be reimbursed. Conditions of payment could include benefit coverage, medical necessity, authorization or stipulations within a reimbursement policy. Neither payment rates nor methodology are considered to be conditions of payment.

Reimbursement Policies go through a review every two years for updates to state contracts, or state, federal or Centers for Medicare & Medicaid Services (CMS) requirements. Additionally, updates may be made at any time if we are notified of a mandate change or due to an **Anthem** business decision. When there is an update we will publish the most current policy to www.anthem.com.

### Medical Coding

The Medical Coding Department ensures that correct coding guidelines have been applied consistently throughout **Anthem**. Those guidelines include, but are not limited to:

- Correct modifier use
- Effective date of transaction code sets (CPT, HCPCS, ICD-9 diagnosis/procedures, revenue codes, etc.)
- Code editing rules are appropriately applied and within regulatory requirements

Analysis of codes, code definition and appropriate use

### Reimbursement by Code Definition

**Anthem** allows reimbursement for covered services based on their procedure code definition, or descriptor, as opposed to their appearance under a particular Current Procedure Terminology (CPT) category section, unless otherwise noted by State or provider contracts, or State, Federal or CMS requirements. There are seven CPT Sections:
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- Evaluation and Management
- Anesthesia
- Surgery
- Radiology (Nuclear Medicine and Diagnostic Imaging)
- Pathology and Laboratory
- Medicine
- Temporary Codes for Emerging Technology, Service or Procedure

Various procedure codes are located in particular CPT categories, although the procedure may not be classified within that particular category (e.g., venipuncture is located in the CPT Surgical Section, although it is not a surgical procedure).

Documentation Standards for an Episode of Care

**Anthem** requires that upon request for clinical documentation to support claims payment for services, the provided information should:

- Identify the Member;
- Be legible
- Reflect all aspects of care

To be considered complete, documentation for episodes of care will include, at a minimum, the following elements:

- Patient identifying information
- Consent forms
- Health history, including applicable drug allergies
- Physical examinations
- Diagnoses and treatment plans for individual episodes of care
- Physician orders
- Face-to-face evaluations, when applicable
- Progress notes
- Referrals, when applicable
- Consultation reports, when applicable
- Laboratory reports, when applicable
- Imaging reports (including x-ray), when applicable
- Surgical reports, when applicable
- Admission and discharge dates and instructions, when applicable
- Preventive services provided or offered, appropriate to Member’s age and health status
- Evidence of coordination of care between primary and specialty physicians, when applicable

Providers should refer to standard data elements to be included for specific episodes of care as established by The Joint Commission (TJC), formerly the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). A single episode of care refers to continuous care or a series of intervals of brief separations from care to a Member by a provider or facility for the same specific medical problem or condition.

Documentation for all episodes of care must meet the following criteria:
• Legible to someone other than the writer
• Information identifying the Member must be included on each page in the medical record
• Each entry in the medical record must be dated and include author identification, which may be a handwritten signature, unique electronic identifier, or initials
• Other documentation not directly related to the Member
• Other documentation not directly related to the Member, but relevant to support clinical practice, may be used to support documentation regarding episodes of care, including:
  • Policies, procedures, and protocols
  • Critical incident/occupational health and safety reports
  • Statistical and research data
  • Clinical assessments
  • Published reports/data

Anthem may request that providers submit additional documentation, including medical records or other documentation not directly related to the Member, to support claims submitted by the provider. If documentation is not provided following the request or notification, or if documentation does not support the services billed for the episode of care, Anthem may:
  • Deny the claim
  • Recover and/or recoup monies previously paid on the claim

Anthem is not liable for interest or penalties when payment is denied or recouped because the provider fails to submit required or requested documentation.

Methods for Submission

There are two methods for submitting a claim:
  • Electronically through Electronic Data Interchange (preferred)
  • Paper or "hard copy"

Electronic submission through Anthem’s Electronic Data Interchange is preferred for accuracy, convenience and speed. Providers will receive notification that an electronic claim has been submitted within 24 hours.

If the claim contains all required information, Anthem enters it into the claims system for processing and sends you either a Remittance Advice (RA) or a Claims Disposition Notice (CDN) when the claim is finalized.

Clean electronic claims are paid within 21-calendar days; clean paper claims are paid within 30-calendar days. Anthem pays interest on clean claims paid after these time frames.

Prefixes Required on the CMS-1500 and CMS-1450 Forms

For each claim, you need to submit a CMS-1500 or CMS 1450 (UB-04) form. The claims form must include the full Member ID number and a 3-letter alpha prefix:
  • The alpha prefix YRH for Hoosier Healthwise
  • The alpha prefix YRK for the Healthy Indiana Plan
  • The alpha prefix YRH for the Hoosier Care Connect
Hoosier Healthwise Members must present their State-issued Hoosier Healthwise ID card. Healthy Indiana Plan and Hoosier Care Connect Members must present their Anthem ID card.

Please Note: The prefix is necessary to route the claim to the right location for prompt processing. If the prefix is omitted, your claim may go to the wrong location and cause payment delay.
Electronic Claims

Electronic filing methods are preferred for accuracy, convenience and speed. **Electronic Data Interchange** (EDI) allows Providers and facilities to submit and receive electronic transactions from their computer systems. EDI is available for most common health care business transactions. For more information on EDI, please contact the **Anthem EDI Solutions Helpdesk** at:

**Anthem EDI Solutions Helpdesk:** 1-800-470-9630  
**Hours of Operation:** Monday to Friday, 8 a.m.-4:30 p.m. Eastern Time  
**EDI Solutions E-mail:** ent.edi.support@Anthem.com

For the most detailed information, there is a website dedicated to sharing billing information with Providers and EDI vendors, including clearinghouses, software vendors and billing agencies. This information includes details on how to submit, receive and troubleshoot electronic transactions. To access all EDI manuals, forms and communications, go to [www.anthem.com/edi](http://www.anthem.com/edi).

The following is available online:

- EDI registration information and forms
- EDI contacts and support information
- EDI communications and electronic submission tips
- Information on electronic filing benefits and cost-savings
- Filing instructions for EDI submission of eligibility, benefit and claim status inquiries
- **Anthem HIPAA Companion Guide** and **EDI User Guide** with complete information on submitting and receiving electronic transactions
- **Anthem** report descriptions
- Lists of clearinghouses, software vendors and billing agencies
- FAQ's about electronic transactions
- Information and links to the **Health Insurance Portability and Accountability Act** (HIPAA) website
- Contractual agreements with our trading partners

**National Provider Identifier**

The **National Provider Identifier** (NPI) is a 10-digit, all numeric identifier. NPIs are issued only to Providers of health services and supplies. As one provision of the **Health Insurance Portability and Accountability Act of 2010** (HIPAA), the NPI is intended to improve efficiency and reduce fraud and abuse.

NPIs are divided into two types:

- **Type 1:** Individual Providers, which includes but is not limited to Physicians, Dentists and Chiropractors
- **Type 2:** Hospitals and medical groups, which includes but is not limited to hospitals, group practices, **Federally Qualified Health Centers** and **Rural Health Centers**

For billing purposes, NPIs should be used with the following guidelines:

- Claims must be filed with the appropriate NPI for billing, rendering and referring Providers.
- The NPI must always be attested with **Indiana Health Coverage Programs** (IHCP) in the same manner as contracted with **Anthem**, including effective dates for individual Providers within groups.
- Claims will be denied when the NPI listed is not the same number attested with IHCP.
Providers may apply for an NPI online at the National Plan and Provider Enumeration System (NPPES) website, http://nppes.cms.hhs.gov/NPPES/Welcome.do. Or, you can get a paper application by calling NPPES at 1-800-465-3203.

The following websites offer additional NPI information:

- Centers for Medicare & Medicaid Services: http://cms.hhs.gov/
- Workgroup for Electronic Data Interchange: www.wedi.org/
- National Uniform Claims Committee: www.nucc.org/

### Use of Referring Provider's NPI on Claims Submissions

If the **Primary Medical Provider** refers a Member to a Specialist or another Provider, the Primary Medical Provider must provide his own NPI. The Specialist is then required to **add** the Primary Medical Provider's NPI when submitting claims for the referred Member. If the Primary Medical Provider does not provide their NPI at the time of referral, the billing Provider is responsible for obtaining that information. That can be done by calling the Primary Medical Provider's office or by going online to the NPI Registry website:

https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do

There are some exceptions to the requirement of providing the referring Primary Medical Provider's NPI when submitting a claim for services provided to a Member not assigned to you. The exceptions include the following:

- If no Primary Medical Provider is identified for the Member
- If one physician is on call or covering for another (in this case, the billing Provider must complete Box 17b of the CMS-1500 claim form to receive reimbursement)
- If the Provider is in the same Provider group, or has the same tax ID or NPI as the referring physician and is an approved Provider type
- Services were provided after hours (codes 99050 & 99051)
- Emergency services (services performed in place of service 23)
- Family Planning services
- Diagnostic specialties such as lab and X-ray services
- Anesthesia claims
- Professional Inpatient claims
- Obstetrics/Gynecology claims
- If the billing or referring physician is from any of the following:
  - Federally Qualified Health Center
  - Indian Health Provider or an
  - Urgent Care Center

### Unattested NPIs

**Anthem** will deny claims with an unattested NPI, even if you provide legacy information.

**Attestation:** The process of registering and reporting your NPI with IHCP.

Providers serving Indiana Medicaid Members are required to register and attest their NPI with Indiana's Family and Social Services Administration (FSSA). You can attest your NPIs on the FSSA website at http://provider.indianamedicaid.com/become-a-provider.aspx by selecting National Provider Identifier (NPI).
Paper Claims

Paper claims are scanned for clean and clear data recording. To get the best results, paper claims must be legible and submitted in the proper format. Follow these requirements to speed processing and prevent delays:

- Use the correct form and be sure the form meets Centers for Medicare & Medicaid Services standards.
- Use black or blue ink (do not use red ink, as the scanner may not be able to read it).
- Use the “remarks” field for messages.
- Do not stamp or write over boxes on the claim form.
- Send the original claim form to Anthem, and retain a copy for your records.
- Do NOT staple original claims together; Anthem will consider the second claim as an attachment and not an original claim to be processed separately.
- Remove all perforated sides from the form; leave a 1/4-inch border on the left and right side of the form after removing perforated sides. This helps our scanning equipment scan accurately.
- Type information within the designated field. Be sure the type falls completely within the text space and is properly aligned.
- Don't highlight any fields on the claim forms or attachments; doing so makes it more difficult to create a clear electronic copy when scanned.
- If using a dot matrix printer, do not use “draft mode” since the characters generally do not have enough distinction and clarity for the optical scanner to read accurately.

If you submit paper claims, you must include the following Provider information:

- Provider name
- Rendering Provider Group or Billing Provider
- Federal Provider Tax Identification Number (TIN)
- The Anthem Payer Identification Number
- National Provider Identifier (NPI)
- Medicare number (if applicable)

Please 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.

Mail paper claims to:

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

Paper Claims Processing

All submitted paper claims are assigned a unique Document Control Number (DCN). The DCN identifies and tracks claims as they move through the claims processing system. This number contains the Julian date, which indicates the date the claim was received. Document Control Numbers are composed of 11 digits:

- 2-digit plan year
- 3-digit Julian date
Claims entering the system are processed on a line-by-line basis except for inpatient claims, which are processed on a whole-claim basis. Each claim is subjected to a comprehensive series of checkpoints called “edits.” These edits verify and validate all claim information to determine if the claim should be paid, denied or pended for manual review.

The Provider is responsible for all claims submitted with the Provider number, regardless of who completed the claim. If you use a billing service you must help ensure that your claims are submitted properly.

**Member Copayments and Balance Billing**

Medicaid participating Providers may not “balance bill” or direct bill Medicaid Members, which means that Members cannot be charged for covered services above the amount Anthem pays to the Provider or direct billed for the costs of the services. Providers that accept Medicaid in any other state are still prohibited from “balancing billing” and/or direct billing Medicaid Members. Providers may only bill Members for copayments if a copay applies. Member copays are identified on the Anthem ID Card for Healthy Indiana Plan Members.

Out-of-network Providers and non-Indiana Health Coverage Program (IHCP) registered Providers may not balance bill Members. Following state requirements, Providers are to enroll in the IHCP to receive reimbursement for providing services to our Members.

An IHCP Provider may bill a Member only when the following conditions have been met:

- The service is noncovered or the Member has exceeded the program limitations and the Member signed a waiver prior to each service that meets federal standards for Medicaid members
- The Member understands and signs a waiver that meets federal standards, before receiving the service, that the service is not covered and that the Member is responsible for the charges associated with the service
- The Provider documents the waiver that the Member voluntarily chose to sign and to receive the service, and that the Member was informed via a waiver prior to receiving the service that he or she was receiving a noncovered service

**Please Note:** A general waiver must identify the specific procedure to be performed, the cost, and the Member must sign the waiver prior to receiving the service. Any Provider that fails to obtain a waiver that meets federal and IHCP standards for each individual service forfeits the ability to bill the member. See the Indiana Health Coverage Programs Provider Manual for more information at: http://provider.indianamedicaid.com/, select Manuals.

Providers may balance bill a Member when prior authorization of a covered service is denied; however, the Provider must establish and demonstrate compliance with the following procedures:

- Establish that authorization was requested and denied prior to rendering service.
- Request to review Anthem’s authorization decision.
- Notify the Member that the service requires prior authorization and that Anthem has denied authorization. If out-of-network, the Provider must also explain to the Member that covered services may be available without cost when provided by an in-network Provider. In such cases, authorization of service will still be required.
- Inform the Member of his or her right to file an appeal if he or she disagrees with the decision to deny authorization.
The Member must be informed of his or her responsibility for payment for receiving non-authorized services. If the Provider chooses to use a waiver to establish Member responsibility for payment, the waiver must meet the following requirements:

- The waiver is signed only after the Member receives appropriate notification
- The waiver does not contain any language or condition to the effect that if authorization is denied, the Member is responsible for payment
- Providers may not use non-specific patient waivers; a waiver must be obtained for each encounter or Member visit that falls under the scenario of noncovered services
- The waiver must specify the date services are provided and the services that fall under the waiver's application

The Provider has the right to appeal any denial of Anthem payment resulting from a denial of authorization.

POWER Account funds cannot be used for Member copayments, Please Note: Providers are required to hold Members liable for copayments.
**Cost-Sharing**

Copays will be waived if a Healthy Indiana Plan Member’s health care costs exceed 5% of the family’s income for the quarter. Web interChange will properly note if a Member is exempt from copayments.

**Third Party Liability (TPL) or Coordination of Benefits (COB)**

**Anthem Members may have other health insurance.** **Anthem** is the payer of last resort per federal and state guidelines. **Anthem** coordinates **Hoosier Healthwise, Healthy Indiana Plan** and **Hoosier Care Connect** benefits with any other health care program that covers our Members, including Medicare. Indicate “Other Coverage” information on the appropriate claim form. If there is a need to coordinate benefits, include at least one of the following items from the other health care program when submitting a **Coordination of Benefits** (COB) claim:

- Third Party Remittance Advice (RA)
- Third party letter explaining either the denial of coverage or reimbursement

COB claims received without at least one of these items will be mailed back to you with a request to submit to the other health care program first. Please make sure that the information you submit explains all coding listed on the other carrier’s RA or letter. We cannot process the claim without this specific information.

**Anthem** must receive COB claims within 90 days from the date on the other program’s RA or letter of denial of coverage.

HIP Members may have other insurance coverage that may be found after **Anthem** has paid a claim that **Anthem** and/or the State were not aware existed at the time of service. In these situations, **Anthem** will notify the provider of the existence of the other insurance coverage. **Anthem** must recoup the claim and the provider must file a claim with the other insurance according to that carrier’s billing rules. Per federal rules, the provider has six months from the date of **Anthem’s** recoupment notification to file with the other insurance carrier. Providers cannot pursue reimbursement from Members per federal rules under any circumstance.

**Claims Filed With Wrong Plan**

If you file a claim with the wrong insurance carrier, **Anthem** will process your claim without denying it for failure to file within the filing time limits if:

- There is documentation verifying that the claim was initially filed in a timely manner.
- The corrected claim was filed within 90 days of the date of the other carrier’s denial letter or Remittance Advice (RA) form.

**Payment of Claims**

Once we receive a claim, the following steps are taken:

1. **Anthem’s** processing systems analyze and validate the claim for Member eligibility, covered services and proper formatting.
2. **Anthem’s** processing systems validate billing, rendering and referring Provider information against **Anthem** and IHCP files.
3. **Anthem’s** processing systems validate against processing rules such as requirement for referral, Prior Authorization or NDC and McKesson ClaimsXten Correct Coding rules.
4. Medical review is performed, as necessary.
5. If no payment is warranted, **Anthem** sends a **Claims Disposition Notice** to the Provider with the specific claims processing information.

6. **Anthem** systems reference Groupers, Pricers and Fee Schedules based on the type of claim to determine pricing.

**Anthem** will finalize a clean electronic claim within 21-calendar days from the date the claim is received. Clean paper claims are paid within 30-calendar days. **Anthem** will pay interest on clean claims not decided within these times frames. The interest rate is established annually based on the **Indiana State Auditor's Report** and set by the **Indiana Department of Insurance**.

### Monitoring Submitted Claims

Claims status can be monitored by doing the following:

- Monitor claim status online via Availity: [www.Availity.com](http://www.Availity.com)
- Monitor claim status through the **Interactive Voice Response** (IVR)
- Correct any errors and resubmit immediately to prevent denials due to late filing

**Please Note:** The **Interactive Voice Response** (IVR) accepts either your **National Provider Identifier** (NPI) or your **Federal Tax Identification Number** (TIN) for Provider ID. Should the system not accept those numbers, it will redirect your call to the **Anthem Provider Helpline**. For purposes of assisting you, we may ask again for your TIN.

**Interactive Voice Response:** 1-800-345-4344

### Electronic Remittance Advice

**Anthem** offers secure electronic delivery of remittance advices, which explain claims in their final status. For more information on electronic remittances, Providers and vendors may call the **Anthem EDI Solutions Helpdesk** at 1-800-470-9630.

### Electronic Funds Transfer

**Anthem** allows **Electronic Funds Transfer** (EFT) for claims payment transactions. This means that claims payments can be deposited directly into a previously selected bank account. You can enroll in this service by completing an application found at [www.anthem.com/edi](http://www.anthem.com/edi) or, you can contact us by email at [cashdisbursementseft@Anthem.com](mailto:cashdisbursementseft@Anthem.com).

### Claims Overpayment Recovery Procedure

**Anthem** seeks recovery of all excess claims payments from the person or entity to whom the benefit check is made payable. When an overpayment is discovered, **Anthem** initiates the overpayment recovery process by sending written notification.

If you are notified by **Anthem** of an overpayment, or discover that you have been overpaid, mail the check, along with a copy of the notification or other supporting documentation within 30 days to the appropriate address:

For **Hoosier Healthwise** or **Hoosier Care Connect**:

**Overpayment Recovery**

P.O. Box 92420

Cleveland, OH 44193

The address above cannot accept overnight packages. For overnight delivery, please use the following address:

**Overpayment Recovery Lockbox 92420**
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4100 West 150th Street
Cleveland, OH 44135

For Healthy Indiana Plan:
Central Region – CCOA Lockbox
P.O. Box 73651
Cleveland, OH 44193-1177

For overnight delivery:
Anthem Central Lockbox 73651
4100 West 150th Street
Cleveland, OH 44135

If you believe the overpayment notification was created in error, you should contact Anthem’s Cost Containment Department in writing or by phone at 1-800-345-7029.

For claims re-evaluation, send your correspondence to the address indicated on the overpayment notice. If Anthem does not hear from you or receive payment within 45 days, the overpayment amount is deducted from your future claims payments. In cases where Anthem determines that recovery is not feasible, the overpayment is referred to a collection service.

Third Party Recovery

Providers may not interfere with or place any liens upon the state’s right or Anthem’s right, acting as the state’s agent, to recovery from third party billing.

Hospital Readmissions Policy

A readmission is defined as a hospital admission within three days following a previous hospital admission and discharge for the same or related condition. Readmissions greater than three days following a previous hospital discharge are treated as separate stays for payment purposes, but are subject to medical review.

Claim Resubmissions

When resubmitting a claim, the resubmission must be received by Anthem within 60 days from the date on the Explanation of Benefits (EOB) or letter with the following information:

- Complete all required fields as originally submitted and mark the change(s) clearly
- Write or stamp "Corrected Claim" across the top of the form
- Attach a copy of the EOB and state the reason for resubmission
- Send to:
  Anthem Indiana Medicaid Corrected Claims
  P.O. Box 6144
  Indianapolis, IN 46206-6144

Please Note: Corrected UB-04 (CMS 1450) claims can be sent electronically with the third digit of the type of bill indicating correction or cancel. You can follow-up to determine the status of a claim if there has been no response from Anthem to a submitted claim after 30 business days from the date the claim was submitted.

To follow up on a claim, you can:

- Verify that the claim was not rejected by EDI or returned by mail
- Call Interactive Voice Response (IVR) at: 1-800-345-4344
Contact the Anthem Provider Helpline at: 1-866-408-6132 (Hoosier Healthwise)
1-800-345-4344 (Healthy Indiana Plan)
1-844-284-1798 (Hoosier Care Connect)

Check MyAnthem, the secure Provider website at www.anthem.com.

Please Note: Claim search functionality is now available from the online Availity Health Information Network. To register for Availity, take the following steps:

1. Go to www.availity.com
2. Click on Register Now
3. Complete the online registration wizard
4. Print, sign and fax the application
5. You will receive e-mail from Availity with a temporary password and next steps

Please note: The Interactive Voice Response (IVR) accepts either your billing National Provider Identifier (NPI) or your Federal Tax Identification Number (TIN) for Provider ID. Should the system not accept those numbers, it will redirect your call to an Anthem Provider Helpline representative who will help you with your question.

Claims Disputes

If there is a full or partial claim rejection or the payment is not the amount expected, submit a claims dispute form, called a Provider Dispute/Resolution Request Form. Please refer to the Grievances & Appeals chapter in this manual for more information.

Reference: Clinical Submissions Categories

The following is a list of claims categories for which we may routinely require submission of clinical information before or after payment of a claim:

- Claims involving precertification/prior authorization/predetermination (or some other form of utilization review) including but not limited to:
  - Claims pending for lack of precertification or prior authorization
  - Claims involving medical necessity or experimental/investigative determinations
  - Claims involving drugs administered in a physician’s office requiring Prior Authorization
- Claims requiring certain modifiers
- Claims involving unlisted codes
- Claims for which we cannot determine from the face of the claim whether it involves a covered service; thus, benefit determination cannot be made without reviewing medical records, including but not limited to pre-existing condition issues, emergency service-prudent layperson reviews, and specific benefit exclusions
- Claims for abortion: All abortion claims require review of medical records to determine if the pregnancy is the result of an act of rape or incest. Or, in cases where the woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed
- Claims that we have reason to believe involve inappropriate (including fraudulent) billing
- Claims that are the subject of an audit (internal or external), including high-dollar claims
- Claims for individuals involved in case management or disease management
Claims that have been appealed (or that are otherwise the subject of a dispute, including claims being mediated, arbitrated or litigated)

Other situations in which clinical information might routinely be requested:
- Accreditation activities
- Coordination of benefits
- Credentialing
- Quality improvement/assurance efforts
- Recovery/subrogation
- Requests relating to underwriting (including but not limited to Member or Provider misrepresentation/fraud reviews and stop-loss coverage issues)

Examples provided in each category are for illustrative purposes only and are not meant to represent an exhaustive list within the category.

**Reference: National Drug Codes**

Providers must include National Drug Codes (NDCs), Unit of Measurement and Quantity of Drug on all Hoosier Healthwise claims that include physician-administered drugs. This applies to drugs dispensed in both professional and institutional outpatient settings.

Indiana’s Family and Social Services Administration (FSSA) requires that Anthem report the National Drug Code information to the FSSA every month.

Anthem will deny professional and outpatient institutional claims containing physician-administered drugs for Hoosier Healthwise Members if any of the following elements are missing or invalid:
- NDCs
- Unit of Measurement
- Quantity of Drug

**Please Note:** The NDC is an 11-digit number on the package or container from which medication is administered.

**Reference: Claim Forms & Filing Limits**

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<thead>
<tr>
<th>Form</th>
<th>Type of Service to be Billed</th>
<th>Time Limit to File (Refer to Provider contract to confirm)</th>
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<tbody>
<tr>
<td>CMS-1500 Claim Form</td>
<td>Physician and other professional services. Specific ancillary services including the following:</td>
<td>Within 90 days of service date</td>
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<td>• Audiologists</td>
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</table>
### Orthotics
- Physical Therapy
- Prosthetics
- Skilled Nursing Facility (SNF)
- Speech Therapy

Some Ancillary Providers may use a UMS-1450 if they are ancillary institutional Providers. Ancillary charges by a hospital are considered facility charges.

<table>
<thead>
<tr>
<th>CMS-1450 Claim Form</th>
<th>Hospitals, Institutions and Home Health Services</th>
<th>Within 90 days of service date (if the Member is an inpatient for longer than 30 days, interim billing is required as described in the Hospital Agreement).</th>
</tr>
</thead>
</table>

#### Reference: Other Filing Limits

<table>
<thead>
<tr>
<th>Action</th>
<th>Type of Service to be Billed</th>
<th>Time Frame</th>
</tr>
</thead>
<tbody>
<tr>
<td>Third Party Liability (TPL) or Coordination of Benefits</td>
<td>If the claim has TPL or COB or requires submission to a third party before submitting to Anthem, the filing limit starts from the date on the notice from the third party.</td>
<td>From date of notice from third party: 90 days for CMS-1500 claims 90 days for CMS-1450 claims</td>
</tr>
<tr>
<td>Checking Claim Status</td>
<td>Providers should not inquire about the status of a specific claim until at least 30 business days after submission. This is generally considered a reasonable time to process a claim. For general claim status inquiries, refer to the weekly Remittance Advice (RA), the Automated Voice Response (AVR) system, or Electronic Data Interchange.</td>
<td>After 30 business days from Anthem’s receipt of claim, submit a Follow-Up Request Form. Or, call the Customer Care Center Interactive Voice Response (IVR), or check online via <a href="http://www.availity.com">www.availity.com</a>.</td>
</tr>
<tr>
<td>Claim Follow-Up</td>
<td>To submit a corrected claim following Anthem’s request for more information or correction to claim.</td>
<td>You must return requested information to Anthem within: 60 days from the date of the request.</td>
</tr>
<tr>
<td>Provider Dispute</td>
<td>To request a claim appeal, send your request in writing to: Anthem Blue Cross and Blue Shield P.O. Box 6144 Indianapolis, IN 46206-6144 Care Management Appeals: Anthem Blue Cross and Blue Shield P.O. Box 6144 Indianapolis, IN 46206-6144</td>
<td>60 days from the receipt of Anthem’s Remittance Advice (RA) of notice of action. If Anthem requires additional information, the Provider must return the information to Anthem within 21 days from the date of Anthem’s request. If the information is not received within 21 days, Anthem may close the case. If the appeal deadline falls on a weekend or holiday, the deadline</td>
</tr>
</tbody>
</table>

---

**Anthem Blue Cross and Blue Shield**
**Indiana Medicaid Provider Manual**
**Hoosier Healthwise, Healthy Indiana Plan and Hoosier Care Connect**

Version 2.4
April 1, 2015
Chapter 9: Page 110
### Reference: Common Reasons for Rejected and Returned Claims

Many claims are denied due to these common billing errors:

<table>
<thead>
<tr>
<th>Problem</th>
<th>Explanation</th>
<th>Resolution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member’s ID Number is Incomplete</td>
<td>Hoosier Healthwise: Missing the correct Member ID number listed on the state’s Hoosier Healthwise card and/or the YRH prefix. &lt;br&gt;Healthy Indiana Plan: Missing the correct Member ID on the Anthem ID card and/or the YRK prefix. &lt;br&gt;Hoosier Care Connect: Missing the correct Member ID on the Anthem ID card and/or the YRH prefix.</td>
<td>Hoosier Healthwise: Use the Member’s Medicaid ID number on the state’s Hoosier Healthwise card plus the YRH prefix. &lt;br&gt;Healthy Indiana Plan: Use the Anthem ID number listed on the Anthem HIP card plus the YRK prefix.</td>
</tr>
<tr>
<td>Duplicate Claim Submission</td>
<td>Overlapping service dates for the same service create a question about duplication. &lt;br&gt;Claim was submitted to Anthem twice without additional information for consideration.</td>
<td>List each date of service, line by line, on the claim form. Avoid spanning dates, except for inpatient billing. &lt;br&gt;Make sure you read your RAs and CDNs for important claim determination information before resubmitting a claim. Additional information may be needed. &lt;br&gt;A corrected claim needs to be clearly marked as “Corrected” so that we don’t process it as a duplicate.</td>
</tr>
<tr>
<td>Problem</td>
<td>Explanation</td>
<td>Resolution</td>
</tr>
<tr>
<td>---------</td>
<td>-------------</td>
<td>------------</td>
</tr>
<tr>
<td><strong>Authorization Number Missing/Does Not Match Services</strong></td>
<td>The authorization number is missing, or the approved services do not match the services described in the claim.</td>
<td>Confirm the correct Authorization Number is provided on the claim form (CMS-1500 Box 24 and CMS-1450 Box 63) and that approved services match the provided services. Contact UM to revise the service for authorization if changes occur.</td>
</tr>
<tr>
<td><strong>Missing Codes for Required Service Categories</strong></td>
<td>Current Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) manuals are used but changes are made to the codes quarterly or annually. Manuals may be purchased at any technical bookstore, through the American Medical Association or the Practice Management Information Corporation.</td>
<td>Only codes recognized by IHCP can be used, therefore Providers must also check IHCP billing instructions, as well as HCPCS and CPT manuals. Make sure all services are coded with the correct codes. Check the codebooks or ask someone in your office who is familiar with coding.</td>
</tr>
<tr>
<td><strong>Unlisted Code for Service</strong></td>
<td>Some procedures or services do not have a code associated with them, so an unlisted procedure code is used.</td>
<td><strong>Anthem</strong> needs a description of the procedure and medical records in order to calculate reimbursement. DME, prosthetic devices, hearing aids or blood products require a manufacturer’s invoice. For drugs/injections, the National Drug Code (NDC) number is required.</td>
</tr>
<tr>
<td><strong>By Report Code for Service</strong></td>
<td>Some procedures or services require additional information.</td>
<td><strong>Anthem</strong> needs a description of the procedure and medical records to calculate reimbursement. DME, prosthetic devices, hearing aids or blood products require a manufacturer’s invoice. For drugs/injections, the NDC number is required.</td>
</tr>
<tr>
<td><strong>Unreasonable Numbers Submitted</strong></td>
<td>Unreasonable numbers, such as “9999” may appear in the Service Units fields.</td>
<td>Make sure to check your claim for accuracy before submitting it.</td>
</tr>
<tr>
<td><strong>Submitting Batches of Claims</strong></td>
<td>Stapling claims together can make the subsequent claims appear to be attachments, rather than individual claims.</td>
<td>Make sure each individual claim is clearly identified and not stapled to another claim.</td>
</tr>
<tr>
<td>Problem</td>
<td>Explanation</td>
<td>Resolution</td>
</tr>
<tr>
<td>-----------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>----------------------------</td>
</tr>
<tr>
<td>Nursing Care</td>
<td>Nursing charges are included in the hospital and outpatient care charges. Nursing charges that are billed separately are considered unbundled charges and are not payable. In addition, Anthem will not pay claims using different room rates for the same type of room to adjust for nursing care.</td>
<td>Do not submit bills for nursing charges.</td>
</tr>
</tbody>
</table>
## Processes to Resolve Claim Issues

<table>
<thead>
<tr>
<th>Issue</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claim denied or paid wrong amount due to incorrect billing by provider, OR Resubmitting claim returned for information such as: EOB of primary insurance, itemized bill, medical records, etc…</td>
<td>Submit a Claim Follow-Up Form / Corrected Claim. It must be received by Anthem within 60 days from date on the EOB or letter. All required fields are to be completed as originally submitted and the change(s) clearly marked and write or stamp “Corrected Claim” across top of the form, and attach copy of the EOB and state the reason for re-submission. Send to: Anthem Indiana Medicaid Corrected Claims P.O. Box 6144 Indianapolis, IN 46206-6144 Note that corrected UB claims can be sent electronically with the third digit of the type of bill indicating correction or cancel.</td>
</tr>
<tr>
<td>Unknown status of claim submitted more than 30 days ago (after verifying not rejected by EDI (electronic) or returned by mail room (paper)).</td>
<td>Call the Anthem Provider Helpline. Hoosier Healthwise: 1-866-408-6132 HIP: 1-800-345-4344 Hoosier Care Connect: 1-844-284-1798 Network providers must file claims within 90 days, and it is the provider’s responsibility to timely follow up to be sure claims are received.</td>
</tr>
<tr>
<td>Follow up on status of a claim adjustment or reprocessing resulting from: Claim Dispute, Claim Appeal, or Provider Help Line/ Provider Services action.</td>
<td>Call the Anthem Provider Helpline. Hoosier Healthwise: 1-866-408-6132 HIP: 1-800-345-4344 Hoosier Care Connect: 1-844-284-1798 Allow 60 days for adjustments, but follow up before 90 days. All follow-up to previous actions or interactions must be within 90 days.</td>
</tr>
<tr>
<td>Provider disagrees with full or partial claim rejection OR Payment is not the amount expected.</td>
<td>Submit Claims Dispute. A complete Provider Dispute Resolution Request Form must be received by Anthem within 60 days from date on the EOB. Multiple claims for the same situation can be submitted on one form. Send to: Anthem Indiana Medicaid Claims Dispute P.O. Box 6144 Indianapolis, IN 46206-6144 Note that it is the provider’s responsibility to check EOBs and submit Claims Disputes timely.</td>
</tr>
<tr>
<td>Provider disagrees with Claims Dispute response.</td>
<td>Submit Claims Appeal. This is the 2nd step after a Claim Dispute and considered a formal appeal. An appeal request must be received by Anthem within 30 days from the date on the Claims Dispute response. Send to: Anthem Indiana Medicaid Claims Appeal P.O. Box 6144 Indianapolis, IN 46206-6144</td>
</tr>
<tr>
<td>Complicated, involved claim issues.</td>
<td>Submit Written Correspondence. Send electronically through Availity, or send paper correspondence to: Anthem Indiana Medicaid Correspondence P.O. Box 6144 Indianapolis, IN 46206-6144</td>
</tr>
</tbody>
</table>
CHAPTER 10: BILLING PROFESSIONAL & ANCILLARY CLAIMS

Overview

Providers can depend upon efficient claims handling and faster reimbursement when they follow Anthem’s professional and ancillary billing requirements. These requirements include using standardized codes for most of our health services. This section is broken down into health service categories to help you find the specific billing codes you’ll need for each one.

You will also find information on the proper method for filling out the CMS-1500 claim form.

To help you navigate the various billing requirements and codes, we’ve divided them into the following service categories:

- Behavioral Health
- Emergency Services
- Hospital Readmission Policy
- Immunizations Covered by Vaccines for Children (VFC)
- Immunizations Not Covered by Vaccines for Children
- Initial Health Assessments
- Maternity Services
- Newborns
- On Call Services
- Preventive Medicine Services: New Patient
- Preventive Medicine Services: Established Patient
- Self-Referable Services
- Present on Admission Indicators and Hospital-Acquired Conditions

For the most efficient claims processing, accurately filled-out claims are essential. Follow these general guidelines for claims filing:

- Indicate the Provider’s National Provider Identifier (NPI) number in Box 24J of the CMS-1500 form. Missing or invalid numbers may result in nonpayment.

- Mid-level practitioners should put their NPI number in Box 19 of the CMS-1500 and the supervising Provider’s NPI number in Box 24J. The following types of practitioners are defined as mid-level:
  - Physician Assistants
  - Nurse Practitioners
  - Certified Nurse Midwives

- Hoosier Healthwise: Use the alpha prefix YRH along with the 12-digit Member number provided by the State

- Healthy Indiana Plan: Use the alpha prefix YRK along with the 9-digit Member Anthem ID number

- Hoosier Care Connect: Use the alpha prefix YRH along with the 12-digit Member Anthem ID number

- Federally Qualified Health Centers (FQHC) may put their billing/group NPI number in Box 24J and 33.
Coding

In order to process claims in an orderly and consistent manner, we use standardized codes. The Healthcare Common Procedure Coding System (HCPCS), sometimes referred to as National Codes, provides coding for a wide variety of services.

There are two principal coding levels, referred to as Level I and Level II:

- **Level I:** Current Procedural Terminology (CPT) codes maintained by the American Medical Association (AMA)
  - These codes are represented by 5 numeric digits
- **Level II:** Codes that identify products, supplies and services not included in the CPT codes, such as ambulance supplies and Durable Medical Equipment (DME)
  - These are sometimes called the alphanumeric codes because they consist of a single alphabetical letter followed by 4 numeric digits
- In some cases, 2-digit/character modifier codes should accompany the Level I or Level II coding

There are two useful reference guides for coding claims:

- The Healthcare Common Procedure Coding System (HCPCS) published by the Centers for Medicare & Medicaid Services (CMS). To order, call 1-800-621-8335

Please Note: Anthem does not accept global billing codes. If Anthem receives a claim with global coding, it will be denied requesting a corrected claim be submitted using itemized codes.

National Drug Codes

Providers must include National Drug Codes (NDCs) on all claims that involve products or services with an NDC. The contractor shall submit this NDC information to the state with its encounter claims submissions in accordance with Section 9.6.2.

Initial Health Assessments

Anthem Primary Medical Providers function as a Member’s “medical home.” For that reason, we strongly recommend that an Initial Health Assessment (IHA) consisting of a complete history and physical and preventive services be conducted within the following time frames:

- **Newborns:** within 14 days of enrollment
- **Children:** within 60 days of enrollment
- **Adults (18-21):** within 8 weeks of enrollment

When billing for Initial Health Assessments, use the following International Classification of Diseases (ICD) diagnosis codes:

- V20.2 for children (newborn to 18-years old)
- V70.0 for adults (19 years and older)

The Member can also complete the Health Needs Screening online at www.UandIcare.com or over the phone by calling 1-888-849-0895 and receive an incentive.

Preventive Medicine Services: New Patient
Preventive medicine services for a new patient start with an initial comprehensive preventive medicine evaluation. That includes an age and gender-appropriate history, examination, counseling, risk factor interventions, and the ordering of appropriate immunizations, laboratory and diagnostic procedures. Bill for these services using the following codes:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99381</td>
<td>Infant (Under 1 Year)</td>
</tr>
<tr>
<td>99382</td>
<td>Early Childhood (Ages 1-4)</td>
</tr>
<tr>
<td>99383</td>
<td>Late Childhood (Ages 5-11)</td>
</tr>
<tr>
<td>99384</td>
<td>Adolescent (Ages 12-17)</td>
</tr>
<tr>
<td>99385</td>
<td>Ages 18-39</td>
</tr>
</tbody>
</table>

**Preventive Medicine Services: Established Patient**

Preventive medicine services for an established patient involve re-evaluation and management of existing conditions, if any. That includes an age and gender-appropriate history, examination, counseling, risk factor interventions, and the ordering of appropriate immunizations, laboratory and diagnostic procedures.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99391</td>
<td>Infant (Under 1 Year)</td>
</tr>
<tr>
<td>99392</td>
<td>Early Childhood (Ages 1-4)</td>
</tr>
<tr>
<td>99393</td>
<td>Late Childhood (Ages 5-11)</td>
</tr>
<tr>
<td>99394</td>
<td>Adolescent (Ages 12-17)</td>
</tr>
<tr>
<td>99395</td>
<td>Ages 18-39</td>
</tr>
<tr>
<td>99396</td>
<td>Ages 40-64</td>
</tr>
<tr>
<td>99397</td>
<td>Ages 65 and older</td>
</tr>
</tbody>
</table>

**Self-Referable Services**

Members may access the following services at any time without pre-authorization or referral by their Primary Medical Provider:

- Behavioral Health Services (Hoosier Healthwise, Healthy Indiana Plan and Hoosier Care Connect)
  - Psychiatric Services: Anthem Members may self-refer to any IHCP-enrolled Behavioral Health Services psychiatrist.
  - Behavioral Health Services not rendered by a psychiatrist: Anthem Members may self-refer to any in-network Behavioral Health Services Provider, including behavioral health, substance abuse and chemical dependency
- Chiropractic Services (Hoosier Healthwise, HIP Pregnant Members and HIP Maternity and HIP Members with State Plan Benefits, Hoosier Care Connect)
- Diabetes Self-Care Training (Hoosier Healthwise, Healthy Indiana Plan, Hoosier Care Connect)
- Emergency Services (Hoosier Healthwise, Healthy Indiana Plan, Hoosier Care Connect)
• Eye & Vision Care, except surgery (Hoosier Healthwise, HIP Plus, HIP Pregnant Members and HIP Maternity, HIP Members under Age 21 and HIP Members with State Plan Benefits, Hoosier Care Connect)
• Family Planning (Hoosier Healthwise, Healthy Indiana Plan, Hoosier Care Connect)
• Podiatry - Routine foot care is not covered (Hoosier Healthwise, Healthy Indiana Plan, Hoosier Care Connect)
• Vaccines (Hoosier Healthwise, Healthy Indiana Plan, Hoosier Care Connect)

Behavioral Health

Behavioral Health Services are provided by Anthem for Hoosier Healthwise, Healthy Indiana Plan and Hoosier Care Connect Members. All claims for services should be billed to Anthem. For more information, please call 1-866-398-1922.

Anthem has contracted with a network of hospitals, group practices and independent behavioral health Providers, as well as a number of Indiana’s Community Mental Health Centers (CMHCs) to provide behavioral health services. See Chapter 5: Behavioral Health Services for information about behavioral health benefits.

Providers rendering medically necessary behavioral health services should bill Anthem using behavioral health CPT codes.

Emergency & Related Professional Services

Emergency services, as defined by state and local law, the Provider contract and our Member Handbook, are reimbursed in accordance with the Anthem Provider contract.

Please Note: Authorizations are not required for medically necessary emergency services.

Emergency: Any condition manifesting itself by acute symptoms of sufficient severity such that a layperson possessing an average knowledge of health and medicine could reasonably expect that the absence of immediate medical care could:

• Place the Member’s health or, with respect to a pregnant woman, the health of the woman and her unborn child, in serious jeopardy
• Cause serious impairment to bodily functions
• Cause serious dysfunction to any bodily organ or part

Covered Emergency Services include:

• Hospital-based emergency department services (room & ancillary) needed to evaluate or stabilize the emergency medical or behavioral health condition
• Services by emergency Providers

Emergency Services for Healthy Indiana Plan Members ONLY:

If a HIP Member receives treatment in a hospital emergency room for a nonemergent condition, a copayment is required. HIP Members pay $8 for the first nonemergent use of the ER, and $25 for each subsequent nonemergent use of the ER in the same 12-month benefit period. Members are not required to pay the copay if they call Anthem’s 24/7 NurseLine prior to going to the ER. POWER Account funds cannot be used by the Member to pay the copayment.

The copayment requirement will be waived according to prudent layperson guidelines. If Anthem determines through the claims process that the copayment should not have been charged, and the hospital collected a copayment, you must refund the copayment to the Member.
Providers shall not collect copayments from Healthy Indiana Plan Members for emergency room visits resulting in an inpatient admission. Related professional services offered by Providers during an emergency room visit are reimbursed according to your Anthem Provider contract.

Assuming the Member has an available and accessible non-emergency services Provider, and a determination has been made that the Member does not have an emergent condition, the hospital must inform the Member before providing nonemergency services of the following:

- The hospital may require a copayment before the service can be provided
- The hospital will provide the name and location of an alternate non-emergency services Provider who is actually available and accessible
- An alternate Provider can provide the services without a copayment
- The hospital will provide a referral to coordinate scheduling of services

All Members should be referred back to their Primary Medical Provider for follow-up care. Unless clinically required, follow-up care should never occur in a hospital emergency room.

Hospitals will be reimbursed for emergency services billed with codes:

- 99284
- 99285

Please Note: Hospitals may only bill Revenue Code 451 if the emergency room screening determines that the visit is nonemergent.

Hospital reimbursement will be reduced by 40% for services billed with codes:

- 99281
- 99282
- 99283

Hospital Readmission Policy

Anthem does not reimburse for readmission for a related condition if the Member’s readmission occurs within three days of discharge. These charges must be added to the original claim. Anthem may require medical records and review readmissions within 30 days of discharge to determine if the Member was discharged early. Based on medical review, readmission within 30 days due to early discharge may be denied.

Immunizations Covered By Vaccines for Children

Anthem network Providers who administer vaccines to children 0-18 years of age may enroll in the Vaccines for Children (VFC) program. Anthem will only reimburse the administration fee for any vaccine available through the VFC program.

When billing immunizations provided to you by the (VFC) program, use the CMS-1500 form and do the following:

- On one line of Box 24D, use the appropriate CPT code
- On another line of Box 24D, use the appropriate administration procedure code (90471 through 90474)
- In Box 23, insert the Primary Medical Provider name

Immunizations Not Covered By Vaccines for Children
When billing for immunizations not covered by the VFC program, use the CMS-1500 form and do the following:

- On one line of Box 24D, use the appropriate CPT code
- On another line of Box 24D, use the appropriate administration procedure code
- The SL modifier is not required

**Additional Services during EPSDT Exams**

If a patient is evaluated and treated for a problem during the same visit as an EPSDT annual exam or Well Child visit, the problem-oriented exam can be billed separately if accompanied by the 25 modifier. The problem must require additional moderate level evaluation to qualify as a separate service on the same date.

**Maternity Services**

Maternity services are now covered by the Healthy Indiana Plan (HIP). A HIP Member who becomes pregnant has the choice to transfer to Hoosier Healthwise or remain on HIP.

There are no copays for maternity services and once a Member is verified to be pregnant, she will have no copays for any services, and no POWER Account.

Pregnancy continues to be a covered benefit for Hoosier Healthwise. Please refer to the IHCP Manual (Chapter 8) for detailed instructions. Billing requirements for Hoosier Healthwise pregnancy services are also listed in Chapter Eight: Billing Instructions of the Indiana Health Coverage Programs Provider Manual. You can access the state’s manual at http://provider.indianamedicaid.com/ > Manuals.

Anthem requires itemization of maternity services when submitting claims for reimbursement. Please use the CMS-1500 claim form with the appropriate CPT and HCPCS codes, along with ICD diagnosis codes. This includes the applicable “Evaluation and Management” (E&M) code, along with coding for all other procedures performed.

Maternity billing guidelines are as follows:

- **Anthem** reimburses only one delivery or cesarean section procedure per Member in a 7-month period. Reimbursement includes multiple births.
- Delivering Providers who perform regional anesthesia or nerve block may not receive additional reimbursement because these charges are included in the reimbursement for the delivery.
- **Anthem** reimburses anesthesia services and delivery at full allowance when provided by the delivering obstetrician.
- **Anthem** will reimburse antepartum care, deliveries including cesarean sections performed by physicians, and postpartum care:
  - Codes 59409, 59514, 59612 and 59620: Vaginal and Cesarean Deliveries
  - Code 59430: Postpartum care only
  - Code 59425: Antepartum care only (2-6 visits)
  - Code 59426: Antepartum care only (7 or more visits)
- When billing **Anthem**, you must itemize each service individually and submit claims as the services are rendered. The filing deadline will be applied to each individual date of service submitted.
- Laboratory (including pregnancy test) and radiology services provided during pregnancy must be billed separately and be received by **Anthem** within 90 days from the date of service.
➢ Use of the appropriate antepartum or postpartum CPT codes is necessary for appropriate reimbursement. You should indicate the estimated date of confinement (EDC) on the CMS-1500 claim form.

➢ If a Member is admitted to the hospital during the course of her pregnancy, the diagnosis necessitating the admission should be the primary diagnosis on the claim.

➢ If high risk, the high-risk diagnosis must be documented on the claim form.

➢ The nature of a high-risk care visit must be identified in the diagnosis field on the CMS-1500 claim form, or the appropriate field.

➢ For professional claims only, the date of the Member’s last menstrual period must be included.

➢ All pregnancy-related claims for Members must include one of the modifiers below to indicate the trimester or diagnosis Code V24 for postpartum:
  - Modifier U1: First Trimester
  - Modifier U2: Second Trimester
  - Modifier U3: Third Trimester

Maternity Services: Claims for Obstetric Deliveries Require a Modifier

Claims submitted for obstetric deliveries with procedure codes: 59409, 59410, 59514, 59515, 59612, 59614, 59620 or 59622 will require one of the following modifiers:

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>U1</td>
<td>Medically necessary delivery prior to 39 weeks of gestation</td>
</tr>
<tr>
<td>U2</td>
<td>Delivery at 39 weeks of gestation or later</td>
</tr>
<tr>
<td>U3</td>
<td>Non-medically necessary delivery prior to 39 weeks of gestation</td>
</tr>
</tbody>
</table>

Claims submitted for antepartum care with procedure Codes 59425 or 59426 require one of the following:

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>U1</td>
<td>Medically necessary delivery prior to 39 weeks of gestation</td>
</tr>
<tr>
<td>U2</td>
<td>Delivery at 39 weeks of gestation or later</td>
</tr>
<tr>
<td>U3</td>
<td>Non-medically necessary delivery prior to 39 weeks of gestation</td>
</tr>
</tbody>
</table>

Maternity Services: Cesarean Sections

Medicaid restricts any Cesarean section, labor induction, or any delivery following labor induction to one of the following additional criteria:

- Gestational age of the fetus should be determined to be at least 39 weeks or fetal lung maturity must be established before delivery.
- When the delivery occurs prior to 39 weeks, maternal and/or fetal conditions must dictate medical necessity for the delivery.

Cesarean sections, labor inductions, or any deliveries following labor induction that occur prior to 39 weeks of gestation and are not considered medically necessary will be denied.

Records will be subject to retrospective review. Payments made for non-medically-indicated Cesarean section, labor induction, or any delivery following labor induction that fails to meet these criteria, (as
determined by review of medical documentation) will be subject to claim recoupment. Recoupment may apply to all services related to the delivery, including additional Provider and hospital fees.

**Maternity Services: Newborns**

Submit newborn claims to **Anthem** for Hoosier Healthwise using the state-issued Medicaid ID number of the newborn. Do not use the temporary ID numbers (those ending with NB followed by one or more digits). **Anthem** rejects claims with temporary ID numbers.

You will also need to submit the name, date of birth and other pertinent information about the newborn. To prevent any lapse in **Anthem** coverage for newborns, please ask your patients to take these important steps as soon as their babies are born:

- Immediately contact the **Indiana Family and Social Services Administration** (FSSA) or their social worker to request the required paperwork
- Fill out and return the required paperwork to the state to enroll their newborn in Medicaid
- **Anthem** requests that you notify us of all deliveries **within three days of delivery**. Use the **Newborn Enrollment Notification Report** found on in the **Forms Library** of the **Provider Resources** page on our website at [www.anthem.com](http://www.anthem.com). For directions on how to access the **Provider Resources** page of our website, please see **Chapter 1: How to Access Information, Forms and Tools on Our Website**.
- Also notify **Anthem** via the Newborn Enrollment Notification Report referenced above when you receive a newborn’s **permanent Medicaid ID number**.

Hospitals may bill for newborn delivery and other newborn services separately from the claims for services they provide for the mother.

**Newborns: Circumcision**

All circumcisions performed on Members more than 30 days after birth will require authorization from the Plan’s **Utilization Management** department and will be subject to medical necessity.

**On-Call Services**

**On-Call Services** can be billed when the rendering physician is not the Primary Medical Provider, but is covering for or has received permission from the Primary Medical Provider to provide service that day. Insert **On-Call** for Primary Medical Provider on the **CMS-1500** claim form.

**Recommended Fields for CMS-1500**

All professional Providers and vendors should bill **Anthem** using the most current version of the **UMS-1500** claim form. The following guidelines will assist in completing the **UMS-1500** form. The letter “M” indicates a **mandatory** field.

For more information, you may also refer to the **Centers for Medicare & Medicaid Services** website at [www.cms.hhs.gov/cmsforms](http://www.cms.hhs.gov/cmsforms).

**Member ID Number**

Use the Member's **Anthem** ID number, including alpha prefixes:

- **Hoosier Healthwise**: YRH
- **Healthy Indiana Plan**: YRK
- **Hoosier Care Connect**: YRH
## Recommended Fields for CMS-1500

The following guidelines will assist in completing the CMS-1500 form.


<table>
<thead>
<tr>
<th>Form Locator</th>
<th>Narrative Description/Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>INSURANCE CARRIER SELECTION – Enter X for Traditional Medicaid. <strong>Required.</strong></td>
</tr>
<tr>
<td>1a</td>
<td>INSURED’S I.D. NUMBER (FOR PROGRAM IN ITEM 1) – Enter the IHCP Member identification number (RID). Must be 12 digits. <strong>Required.</strong></td>
</tr>
<tr>
<td>2</td>
<td>PATIENT’S NAME (Last Name, First Name, Middle Initial) – Provide the Member’s last name, first name, and middle initial obtained from the Automated Voice Response (AVR) system, electronic claim submission (ECS), Omni, or Web interChange verification. <strong>Required.</strong></td>
</tr>
<tr>
<td>3</td>
<td>PATIENT’S BIRTH DATE – Enter the Member’s birth date in [MM/DD/YY] format. Optional. SEX – Enter X in the appropriate box. Optional.</td>
</tr>
<tr>
<td>4</td>
<td>INSURED’S NAME (Last Name, First Name, Middle Initial) – Not applicable.</td>
</tr>
<tr>
<td>5</td>
<td>PATIENT’S ADDRESS (No., Street), city, state, ZIP code, telephone (include area code) – Enter the Member’s complete address information. Optional.</td>
</tr>
<tr>
<td>6</td>
<td>PATIENT RELATIONSHIP TO INSURED – Not applicable.</td>
</tr>
<tr>
<td>7</td>
<td>INSURED’S ADDRESS (No., Street), city, state, ZIP code, telephone (include area code) – Not applicable.</td>
</tr>
<tr>
<td>8*</td>
<td>RESERVED FOR NUCC Use – Not applicable.</td>
</tr>
<tr>
<td>9</td>
<td>OTHER INSURED’S NAME (Last Name, First Name, Middle Initial) – If other insurance is available, and the policyholder is other than the Member shown in fields 1a and 2, enter the policyholder’s name. Required, if applicable.</td>
</tr>
<tr>
<td>9a</td>
<td>OTHER INSURED’S POLICY OR GROUP NUMBER – If other insurance is available, and the policyholder is other than the Member noted in fields 1a and 2, enter the policyholder’s policy and group number. Required, if applicable.</td>
</tr>
<tr>
<td>9b*</td>
<td>RESERVED FOR NUCC USE – Not applicable.</td>
</tr>
<tr>
<td>9c*</td>
<td>RESERVED FOR NUCC USE – Not applicable.</td>
</tr>
<tr>
<td>9d</td>
<td>INSURANCE PLAN NAME OR PROGRAM NAME – If other insurance is available, and the policyholder is other than the Member shown in field 1a and 2, enter the policyholder’s insurance plan name or program name information. Required, if applicable.</td>
</tr>
<tr>
<td>10</td>
<td>IS PATIENT’S CONDITION RELATED TO – Enter X in the appropriate box in each of the three categories. This information is needed for follow-up third-party recovery actions. Required, if applicable.</td>
</tr>
<tr>
<td>10a</td>
<td>EMPLOYMENT (CURRENT OR PREVIOUS) – Enter X in the appropriate box. Required, if applicable.</td>
</tr>
<tr>
<td>10b</td>
<td>AUTO ACCIDENT – Enter X in the appropriate box. Required, if applicable. PLACE (State) – Enter the two-character state code. Required, if applicable.</td>
</tr>
<tr>
<td>10c</td>
<td>OTHER ACCIDENT – Enter X in the appropriate box. Required, if applicable.</td>
</tr>
<tr>
<td>10d*</td>
<td>CLAIM CODES (Designated by NUCC) – Not applicable.</td>
</tr>
<tr>
<td>Form Locator</td>
<td>Narrative Description/Explanation</td>
</tr>
<tr>
<td>--------------</td>
<td>----------------------------------</td>
</tr>
<tr>
<td>Fields 11 and 11a through 11d</td>
<td>are used to enter Member insurance information.</td>
</tr>
<tr>
<td>11</td>
<td><strong>INSURED'S POLICY GROUP OR FECA NUMBER</strong> – Enter the Member’s policy and group number of the other insurance. <strong>Required, if applicable.</strong></td>
</tr>
<tr>
<td>11a</td>
<td><strong>INSURED'S DATE OF BIRTH</strong> – Enter the Member’s birth date in MMDDYY format. <strong>Required, if applicable.</strong></td>
</tr>
<tr>
<td></td>
<td><strong>SEX</strong> – Enter an X in the appropriate sex box. <strong>Required, if applicable.</strong></td>
</tr>
<tr>
<td>11b*</td>
<td>OTHER CLAIM ID (Designated by NUCC) – Not applicable.</td>
</tr>
<tr>
<td>11c</td>
<td><strong>INSURANCE PLAN NAME OR PROGRAM NAME</strong> – Enter the Member’s insurance plan name or program name. <strong>Required, if applicable.</strong></td>
</tr>
<tr>
<td>11d*</td>
<td>IS THERE ANOTHER HEALTH BENEFIT PLAN? – Enter X in the appropriate box. If the response is Yes, complete fields 9, 9a, and 9d. <strong>Required, if applicable.</strong></td>
</tr>
<tr>
<td>12</td>
<td><strong>PATIENT’S OR AUTHORIZED PERSON’S SIGNATURE</strong> – Not applicable.</td>
</tr>
<tr>
<td>13</td>
<td><strong>INSURED’S OR AUTHORIZED PERSON’S SIGNATURE</strong> – Not applicable.</td>
</tr>
<tr>
<td>14*</td>
<td><strong>DATE OF CURRENT ILLNESS (First symptom date) OR INJURY (Accident date) OR PREGNANCY (LMP date)</strong> – Enter the date of the last menstrual period (LMP) for pregnancy-related services in MMDDYY format. Required if applicable</td>
</tr>
<tr>
<td></td>
<td><strong>Note:</strong> Qualifier code is not applicable.</td>
</tr>
<tr>
<td>15*</td>
<td><strong>OTHER DATE</strong> – Enter date in MMDDYY format. Optional.</td>
</tr>
<tr>
<td></td>
<td><strong>Note:</strong> Qualifier code is not applicable.</td>
</tr>
<tr>
<td>16</td>
<td><strong>DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION</strong> – If field 10a is Yes, enter the applicable FROM and TO dates in a MMDDYY format. Required, if applicable.</td>
</tr>
<tr>
<td>17*</td>
<td><strong>NAME OF REFERRING PROVIDER OR OTHER SOURCE</strong> – Enter the name of the referring physician. Required, if applicable. For waiver-related services, enter the provider or case manager name. Optional.</td>
</tr>
<tr>
<td></td>
<td><strong>Note:</strong> Qualifier code is not applicable. The term referring provider includes physicians primarily responsible for the authorization of treatment for lock-in or Right Choices Program Members.</td>
</tr>
<tr>
<td>17a</td>
<td><strong>ID NUMBER OF REFERRING PROVIDER, ORDERING PROVIDER OR OTHER SOURCE</strong> – Enter the qualifier in the first shaded box of 17a, indicating what the number reported in the second shaded box of 17a represents. Atypical providers should report the IHCP LPI provider number in the second box of 17a. Healthcare providers should report the taxonomy code in the second box of 17a. The qualifier is required when entering the IHCP LPI provider number or taxonomy. Qualifiers to report to IHCP:</td>
</tr>
<tr>
<td></td>
<td>• 1D and G2 are the qualifiers that apply to the IHCP provider number, also called the LPI for the atypical nonhealthcare provider. The LPI includes nine numeric characters and one alpha character for the service location.</td>
</tr>
<tr>
<td></td>
<td>• ZZ and PXC are the qualifiers that apply to the provider taxonomy code. The taxonomy code includes 10 alphanumeric characters. Taxonomy may be needed to establish a one-to-one NPI/LPI match if the provider has multiple locations.</td>
</tr>
<tr>
<td></td>
<td>• Required when applicable and for any waiver-related services.</td>
</tr>
<tr>
<td></td>
<td>• Required if applicable.</td>
</tr>
<tr>
<td>17b</td>
<td><strong>NPI</strong> – Enter the 10-digit numeric NPI of the referring provider, ordering provider, or other source. Required if applicable.</td>
</tr>
<tr>
<td>18</td>
<td><strong>HOSPITALIZATION DATES RELATED TO CURRENT SERVICES</strong> – Enter the requested FROM and TO dates in MMDDYY format. Required, if applicable.</td>
</tr>
<tr>
<td>19*</td>
<td><strong>ADDITIONAL CLAIM INFORMATION</strong>. (Designated by NUCC) – Not applicable.</td>
</tr>
<tr>
<td>20</td>
<td><strong>OUTSIDE LAB?</strong> – Not applicable.</td>
</tr>
<tr>
<td></td>
<td><strong>CHARGES</strong> – Not applicable.</td>
</tr>
</tbody>
</table>
Sterilization and Hysterectomy

Sterilization and hysterectomy procedures must comply with federal rules and regulations noted in 42 CFR 441.250-441.259 and 405 IAC 5-28-8 and 405 IAC 5-28-9.

Sterilizations

Sterilization renders a person unable to reproduce. **Anthem** reimburses for sterilizations when the consent form accompanies all claims connected with the service for men and women according to 405 IAC 5-28-8.

Note: Providers must note partial sterilization on the face of the claim form, preferably on the line below the HCPCS procedure code. For sterilizations performed at the time of delivery, providers must bill with a 59 modifier.

A sterilization form is not necessary when a provider renders a patient sterile as a result of an illness or injury. The physician must attach a certification to the claim indicating that the sterilization occurred due to an illness or injury when prior acknowledgement was not possible. The provider must also include a description of the nature of the emergency.

Limitations

**Anthem** may reimburse for the sterilization of an individual only if that individual meets the following requirements:

- Is 21 years old or over at the time the informed consent is given, 42 CFR 441.253
- Is neither mentally incompetent nor institutionalized, 42 CFR 441.251
- Has voluntarily given informed consent, 42 CFR 441.257 through 441.258

For claims submitted with the procedure codes and diagnosis codes shown in Table 8.182, the IHCP suspends the claims for an analyst to review the consent form or documentation of partial sterilization.

Procedure Codes That Suspend for Analyst Review of Consent Form

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>00851</td>
<td>Anesthesia for intraperitoneal procedures in lower abdomen including laparoscopy; tubal ligation/transection</td>
</tr>
<tr>
<td>00921</td>
<td>Anesthesia for procedures on male genitalia (including open urethral procedures); vasectomy, unilateral or bilateral</td>
</tr>
<tr>
<td>55250</td>
<td>Vasectomy, unilateral or bilateral (separate procedure) including postoperative semen examination(s)</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>--------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>55450</td>
<td>Ligation (percutaneous) of vas deferens, unilateral or bilateral (separate procedure)</td>
</tr>
<tr>
<td>58565</td>
<td>Hysteroscopy, surgical; with bilateral fallopian tube cannulation to induce occlusion by placement of permanent implants</td>
</tr>
<tr>
<td>58570</td>
<td>Laparoscopy, surgical, with total hysterectomy, for uterus 250g or less</td>
</tr>
<tr>
<td>58571</td>
<td>Laparoscopy, surgical, with total hysterectomy, for uterus 250g or less; with removal of tube(s) and/or ovary(s)</td>
</tr>
<tr>
<td>58572</td>
<td>Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250g</td>
</tr>
<tr>
<td>58573</td>
<td>Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250g; with removal of tube(s) and/or ovary(s)</td>
</tr>
<tr>
<td>58600</td>
<td>Ligation or transection of fallopian tube(s), abdominal or vaginal approach, unilateral or bilateral</td>
</tr>
<tr>
<td>58605</td>
<td>Ligation or transection of fallopian tube(s), abdominal or vaginal approach, postpartum, unilateral or bilateral, during same hospitalization (separate procedure)</td>
</tr>
<tr>
<td>58611</td>
<td>Ligation or transection of fallopian tube(s) when done at the time of cesarean section or intra-abdominal surgery (not a separate procedure) (List separately in addition to code for primary procedure)</td>
</tr>
<tr>
<td>58615</td>
<td>Occlusion of fallopian tube(s) by device (e.g., band, clip, Falope ring) vaginal or suprapubic approach</td>
</tr>
<tr>
<td>58661</td>
<td>Laparoscopy, surgical; with removal of adnexal structures (partial or total oophorectomy and/or salpingectomy)</td>
</tr>
<tr>
<td>58670</td>
<td>Laparoscopy, surgical; with fulguration of oviducts (with or without transection)</td>
</tr>
<tr>
<td>58671</td>
<td>Laparoscopy, surgical; with occlusion of oviducts by device (e.g., band, clip, or Falope ring)</td>
</tr>
<tr>
<td>A9900</td>
<td>Miscellaneous DME supply, accessory and/or service component of another HCPCS code</td>
</tr>
<tr>
<td>63.70</td>
<td>Male sterilization procedure, not otherwise specified</td>
</tr>
<tr>
<td>63.71</td>
<td>Ligation of vas deferens</td>
</tr>
<tr>
<td>63.72</td>
<td>Ligation of spermatic cord</td>
</tr>
<tr>
<td>63.73</td>
<td>Vasectomy</td>
</tr>
<tr>
<td>66.21</td>
<td>Bilateral endoscopic ligation and crushing of fallopian tubes</td>
</tr>
<tr>
<td>66.22</td>
<td>Bilateral endoscopic ligation and division of fallopian tubes</td>
</tr>
<tr>
<td>66.29</td>
<td>Other bilateral endoscopic destruction or occlusion of fallopian tubes</td>
</tr>
<tr>
<td>66.31</td>
<td>Other bilateral ligation and crushing of fallopian tubes</td>
</tr>
<tr>
<td>66.32</td>
<td>Other bilateral ligation and division of fallopian tubes</td>
</tr>
<tr>
<td>66.39</td>
<td>Other bilateral destruction or occlusion of fallopian tubes</td>
</tr>
<tr>
<td>66.51</td>
<td>Removal of both fallopian tubes at same operative episode</td>
</tr>
<tr>
<td>66.52</td>
<td>Removal of remaining fallopian tube</td>
</tr>
<tr>
<td>66.63</td>
<td>Bilateral partial salpingectomy, not otherwise specified</td>
</tr>
</tbody>
</table>
Hysteroscopic sterilizations with an implant device provide a nonincision permanent sterilization option. **Anthem** covers this procedure for eligible female Members 21 years old and older. This procedure can be performed in the office, as an outpatient, or in an ambulatory surgical center (ASC).

Providers should bill the procedure using Current Procedural Terminology (CPT) code 58565 – Hysteroscopy, surgical; with bilateral fallopian tube cannulation to induce occlusion by placement of permanent implants. However, CPT code 58579 – Unlisted hysteroscopy procedure, uterus is not appropriate billing for the hysteroscopic sterilization procedure with an implant device, and claims will suspend for manual review.

The implant device must be billed separately on the CMS-1500 claim form using HCPCS code A9900 – Miscellaneous DME supply, accessory and/or service component of another HCPCS code. This is the only code billable for the implant device.

An outpatient hospital or ASC must adhere to the following billing instructions to receive reimbursement for the implant device in addition to the outpatient ASC rate. No additional reimbursement is available for the implant device if performed in an inpatient setting. Table 8.183 provides billing instructions for these services.

### Billing Instructions for the Hysteroscopic Sterilization Procedure with Implant Device

<table>
<thead>
<tr>
<th>Provider</th>
<th>Claim Type</th>
<th>Bill for the Procedure and the Supply</th>
<th>Additional Billing Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient Hospital or ASC</td>
<td>UB-04</td>
<td>58565 with appropriate revenue code</td>
<td>Print the name of the implant device in the body of the claim form or on the accompanying invoice</td>
</tr>
<tr>
<td></td>
<td>CMS-1500 bill for the device under the professional or durable medical equipment (DME) provider number</td>
<td>Bill the device using A9900 – Include a cost invoice with the claim to support the actual cost of the device</td>
<td>• Submit a valid, signed Sterilization Consent Form with the claim</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Enter ICD V25.2-Sterilization as the primary diagnosis on the claim</td>
</tr>
<tr>
<td>Physician</td>
<td>CMS-1500</td>
<td>58565</td>
<td>Bill the device on a separate line using A9900 – Include a cost invoice</td>
</tr>
</tbody>
</table>

Providers must adhere to the following procedures:
- Submit the manufacturer’s suggested retail price (MSRP) with the claim to support the cost of the device. The IHCP reimburses 75% of the amount listed on the manufacturer’s cost invoice up to a statewide maximum of $1,700 for dates of service on or after **April 1, 2010**.
- Submit a valid, signed Sterilization Consent Form with the claim.
- Ensure the primary diagnosis on the claim is ICD code V25.2 – Sterilization.
- Print “Sterilization Implant Device” on the claim form or on the accompanying invoice.

### Informed Consent

Providers must allow at least 30 days, but not more than 180 days, to pass between the date when the Member gives the informed consent, and the date when the provider performs the sterilization procedure. The patient must give the informed consent at least 30 days before the expected date of delivery or confinement. The Indiana Health Coverage Programs (IHCP) defines premature delivery as labor before 37 weeks’ gestation. The following exceptions apply to premature delivery or emergency abdominal surgery:
- The Member must sign the informed consent for the sterilization for family planning 72 hours before the sterilization when done at the time of a premature delivery.
• The physician must indicate the reason for the surgery being performed early and the individual’s expected date of delivery. The reason for the surgery must be only because of premature delivery or emergency abdominal surgery.
• The person who obtains informed consent must verbally communicate all information about a sterilization procedure to the Member to be sterilized, including a Member who is blind, deaf or otherwise handicapped. Providers must furnish an interpreter if a language barrier exists. For a full description of the informed-consent process, 42 CFR 441.257 provides additional information.

Providers cannot obtain informed consent while the Member to be sterilized is in one of the following situations:
• In labor or childbirth
• Seeking or obtaining an abortion
• Under the influence of alcohol or other substances that affect the Member’s state of awareness

Retroactive Eligibility or Failure to Provide Proof of Eligibility

If the provider does not obtain the required State sterilization consent form before the procedure because of a retroactive eligibility situation or because the patient failed to inform the provider of IHCP eligibility, the IHCP does not cover the service. Anthem or Medicaid cannot pay for sterilizations performed if the Member did not sign the consent form before the procedure. The provider cannot bill the member for the procedure if there was no consent signed prior to the procedure. To prevent this situation and to ensure IHCP coverage, providers may use the State consent form for sterilization notification for all Medicaid patients in their practice. Other nonsterilization procedures may be separately billable.

Note: If unrelated services are provided at the same time as sterilization for an Anthem Member, the provider can be reimbursed for medically necessary services unrelated to the sterilization when the sterilization is noncovered due to consent not being obtained. Medically necessary services are subject to the IHCP’s established policy on retroactive services as outlined in Chapter 2: Member Eligibility and Benefit Coverage of the IHCP Provider Manual located at www.indianamedicaid.com.

Consent Forms

A properly completed Consent for Sterilization form, found online at the U.S. Department of Health and Human Services at hhs.gov, must accompany all claims for voluntary sterilization. Refer to Consent for Sterilization Form Instructions in Chapter 8 of the IHCP Provider Manual for more information.

When providers properly complete the Consent for Sterilization form (HHS-687), Anthem receives all the necessary information regarding consent, interpreter’s statement, statement of person obtaining consent and physician’s statement. Request copies of the Consent for Sterilization form from the following address:

HP Forms Request
P.O. Box 7263
Indianapolis, IN 46207-7263

Form requests must clearly indicate the Consent for Sterilization form (HHS-687), specify the number of copies requested, and list the IHCP provider number and the address for shipping. Providers may download the Consent for Sterilization form (HHS-687) from indianamedicaid.com. A Spanish version of the form is also available.

Documentation Requirements

A completed consent form must accompany all claims for sterilization and related services. This requirement extends to all providers: attending physicians and surgeons, assistant surgeons, anesthesiologists, inpatient and outpatient hospital facilities, or other providers of related services.
Providers must attach a photocopy of the consent form for sterilization and related services to each claim form or send it separately as an attachment to the electronic claim transaction.

**Anthem** must receive a properly completed consent form before making payment. To ensure timely payment to related service providers, the primary service provider should forward exact copies of the properly completed consent form to the related service providers.

### Hysterectomy Billing

The IHCP provides coverage for a medically necessary hysterectomy performed to treat an illness or injury. The IHCP does not cover a hysterectomy performed solely to render a Member permanently incapable of bearing children, whether performed as a primary or secondary procedure.

#### Informed Consent and Acknowledgement Statement

The IHCP covers hysterectomy only when medically necessary, and only when the Member has given informed consent. The provider must have informed the Member orally and in writing that the procedure will render the Member permanently incapable of reproducing, and the Member must have signed a written acknowledgement of receipt of that information.

The Member or Member’s representative must sign an informed consent or acknowledgement except when the patient is already sterile, or a life-threatening emergency exists for which the physician determines prior acknowledgement is not possible. However, the physician who performs the hysterectomy under these circumstances must complete the following requirements:

- Certify in writing that the individual was already sterile at the time the hysterectomy was performed.
- State the cause of the sterility at the time of the hysterectomy.
- Certify in writing that the hysterectomy was performed under a life-threatening emergency in which the physician determined that prior acknowledgement was not possible. The physician must also include a description of the nature of the emergency.

Claims billed with the procedure codes for hysterectomy shown in the following table require a document that includes the information necessary to satisfy documentation and certification requirements for hysterectomies. **Providers cannot use the sterilization consent form for hysterectomy procedures under any circumstances.**

#### Procedure Codes – Hysterectomy Services

<table>
<thead>
<tr>
<th>00846</th>
<th>00944</th>
<th>01962</th>
<th>01963</th>
</tr>
</thead>
<tbody>
<tr>
<td>01969</td>
<td>45126</td>
<td>51597</td>
<td>51925</td>
</tr>
<tr>
<td>58150</td>
<td>58152</td>
<td>58180</td>
<td>58200</td>
</tr>
<tr>
<td>58210</td>
<td>58240</td>
<td>58260</td>
<td>58262</td>
</tr>
<tr>
<td>58263</td>
<td>58267</td>
<td>58270</td>
<td>58275</td>
</tr>
<tr>
<td>58280</td>
<td>58285</td>
<td>58290</td>
<td>58291</td>
</tr>
<tr>
<td>58292</td>
<td>58293</td>
<td>58294</td>
<td>58541</td>
</tr>
<tr>
<td>58542</td>
<td>58543</td>
<td>58544</td>
<td>58548</td>
</tr>
<tr>
<td>58550</td>
<td>58552</td>
<td>58553</td>
<td>58554</td>
</tr>
<tr>
<td>58570</td>
<td>58571</td>
<td>58572</td>
<td>58573</td>
</tr>
<tr>
<td>58951</td>
<td>58953</td>
<td>58954</td>
<td>58956</td>
</tr>
<tr>
<td>59135</td>
<td>59525</td>
<td>68.4</td>
<td>68.5</td>
</tr>
<tr>
<td>68.6</td>
<td>68.7</td>
<td>68.8</td>
<td></td>
</tr>
</tbody>
</table>

Providers must attach the appropriate documentation to the paper claim form or send it separately as an attachment to the electronic claim transaction. See the Paper Attachments with Electronic Claims section in Chapter 8 of the IHCP Provider Manual for more information. All providers of hysterectomy-related...
services must attach a photocopy of the appropriate acknowledgement or physician certification to the claim. The primary service provider should forward copies of the acknowledgement or physician certification statement to the related service providers to ensure timely payment.

**Retroactive Eligibility**

Retroactive eligibility rules parallel those noted above according to 42 CFR 441.255. The IHCP pays for hysterectomies performed during an individual’s retroactive eligibility if the physician who performed the hysterectomy certifies the following in writing:

- The physician informed the individual before the operation that the hysterectomy would make her permanently incapable of reproducing.
- The individual was already sterile before the hysterectomy.
- The individual required a hysterectomy because of a life-threatening emergency. The physician determined that prior acknowledgement was not possible, and the physician who performed the hysterectomy did one of the following:
  - Certified in writing that the individual was already sterile at the time of the hysterectomy, and stated the cause of the sterility.
  - Certified in writing that the hysterectomy was performed under a life-threatening emergency situation and prior acknowledgement was not possible.
  - Included a description of the nature of the emergency.

Please note: Providers must check eligibility for the date of service to determine Medicaid coverage in the event of retroactive Member eligibility.
CHAPTER 11: BILLING INSTITUTIONAL CLAIMS

Overview

Billing for hospitals and other health care facilities and services can require special attention because major services have their own set of billing requirements. Throughout this section, specific billing requirements will be broken down into the following service areas:

- Emergency Room Visits
- Urgent Care Visits
- Maternity
- Termination of Pregnancy
- Inpatient Acute Care
- Hospital Stays of Less Than 24 Hours
- Inpatient Sub-Acute Care
- Outpatient Laboratory, Radiology and Diagnostic Services
- Outpatient Surgical Services
- Outpatient Therapies
- Outpatient Infusion Therapy Visits and Pharmaceuticals

Also included are helpful billing guidelines for the ancillary services Providers use most often, including diagnostic imaging. Ancillary services include the following:

- Ambulance Services
- Ambulatory Surgical Centers
- Dialysis
- Durable Medical Equipment
- Home Health Care
- Home Infusion Therapy
- Hospice
- Laboratory and Diagnostic Imaging
- Physical, Speech and Occupational Therapy
- Skilled Nursing Facilities

Please Note: A Member’s benefits may not cover some of these services; you must confirm coverage before providing service.

And finally, this section will take a look at specific coding guidelines for the standard hospital and health care facilities claim form, the CMS-1450.

Basic Billing Guidelines

In general, here are the basic billing guidelines you’ll need for institutional claims submitted to Anthem:

- **Use HCPCS, CPT or Revenue Codes:** Valid HCPCS, CPT or revenue codes are required for all line items billed, whether sent on paper or electronically.

- **Split Year-End Claims:** Services that begin before or in December and extend beyond December 31st should be billed as a split claim at calendar year end. Two CMS-1500 forms must be used and must be submitted together.
Split Dates of Service for a Provider Contract Change: When a Provider contract change occurs during the course of treatment, reimbursement will default to the contract that is active at discharge.

Itemize Services: Service itemization is required when the “From” and “Through” service dates are the same.

Provide Medical Records: Medical records for certain procedures may be requested for determination of medical necessity.

Use Modifiers: Use modifiers in accordance with your specific billing instructions.

Use Codes for Unlisted Procedures: Some Provider services or procedures are not found in CPT; therefore, specific code numbers for reporting unlisted procedures have been designated. When an unlisted procedure code is used, will need a description of the service in order to calculate the appropriate reimbursement. Medical records may be requested.

Do Not Use CPT Code 99070: This code, for supplies and materials provided over and above those usually included with an office visit or other services, is not accepted by Anthem. Health care Providers must use HCPCS Level II Codes, which give a detailed description of the service provided. Anthem will pay for surgical trays only for specific surgical procedures. Surgical trays billed with all other services will be considered incidental and will not be paid separately.

Please Note: System edits are in place for both electronic and paper claims. Claims submitted improperly cannot be easily processed and could be denied.

National Drug Codes

Providers must include National Drug Codes (NDCs), Unit of Measurement and Quantity of Drug on all HIP and Hoosier Healthwise claims that include physician-administered drugs. This applies to drugs dispensed in both professional and institutional outpatient settings.

Indiana’s Family and Social Services Administration (FSSA) require that Anthem report the National Drug Code information to the FSSA every month. Anthem will deny professional and outpatient institutional claims containing physician-administered drugs if any of the following elements are missing or invalid:

- NDCs
- Unit of Measurement
- Quantity of Drug

Please Note: The NDC is an 11-digit number on the package or container from which medication is administered.

Billing Requirements by Service Category: Emergency Room Visits

The billing requirements for an emergency room visit apply to the initial treatment of a medical or psychiatric emergency, but only if the patient does not remain overnight. If the emergency room visit results in an admission, then all services provided in the emergency room must be billed in conformity with the guidelines and requirements for inpatient acute care.

Reimbursement for emergency room services relates to the nature of the emergency diagnosis and can be based on urgent care rates, depending on the diagnosis. The billing requirements for emergency room treatment cover all diagnostic and therapeutic services, including, but not limited to:

- Equipment
- Facility use (including nursing care)
- Laboratory
- Pharmaceuticals
• Radiology
• Supplies
• Other services incidental to the emergency room visit

**Anthem** will not reimburse Providers for services rendered in an emergency room for treatment of conditions that do not meet the prudent layperson standard as an emergency medical condition. There are three exceptions to this requirement:

• **Anthem** will reimburse the physician screening fee and facility fee, even if the condition is not an emergency
• **Anthem** will reimburse if the services were authorized by **Anthem** or if the Primary Medical Physician referred the Member for treatment
• **Anthem** will reimburse if the Member called the **24/7 NurseLine** and received prior authorization to go to the emergency room

**Anthem** will review **Hoosier Healthwise, Healthy Indiana Plan and Hoosier Care Connect** emergency services claims to determine appropriate use of the emergency room and whether an emergency medical condition existed. At a minimum, both the facility and the physician will receive reimbursement for screening services:

- For physician services billed on a CMS-1500 claim: If a prudent layperson review determines that the service was not an emergency, **Anthem** is required to reimburse, at minimum, for **Current Procedural Terminology** (CPT) code 99281, the **Emergency Department Visit Level 1** screening fee.
- For facility charges billed on a UB-04: If a prudent layperson review determines the service was not an emergency, we must reimburse for revenue code 451, **EMTALA Emergency Medical Screening Services**.

**Special emergency room billing instructions and requirements:**

Specific coding is required for emergency room billing. Use the following guidelines, including:

- Bill each service date as a separate line item.
- Members should receive screening examination regardless of payment of copay.
- No ER copay is necessary if the patient is admitted; the ER copay only applies to non-emergent services provided in an ER setting.
- Use CPT codes 99284 or 99285 for emergency room billing.
- Use ICD principal diagnosis codes, as required, for all services provided in an emergency room setting.
- Use revenue codes 0450-0452, and 0459, as required.

**Please Note:** Unless clinically required, follow-up care should never occur in the emergency department. Members should be referred back to their **Primary Medical Provider** and correct billing should follow standard, nonemergency guidelines.

**Billing Requirements by Service Category: Urgent Care Visits**

The billing requirements for urgent care visits apply to all urgent care cases treated and discharged from the hospital outpatient department or emergency room.

**Urgent Care:** Nonscheduled, nonemergency hospital services required to prevent serious deterioration of a patient’s health as a result of an unforeseen illness or injury.

Urgent care billing should detail all diagnostic and therapeutic services including, but not limited to:
Chapter 11: Billing Institutional Claims

- Equipment
- Facility use (including nursing care)
- Laboratory
- Pharmaceuticals
- Radiology
- Supplies
- Other services incidental to the visit

Urgent care visits do not apply to those cases that are admitted and treated for inpatient care following urgent care treatment.

**Special urgent care billing instructions:**

Specific coding is required for urgent care billing. Use the following guidelines, including:

- Bill each service date as a separate line item.
- Use current ICD-9/ICD-10 principal diagnosis codes, as required, for all services provided in an urgent care setting or designated facility.
- Use the required CPT codes: 99281-83.
- Use the required revenue codes: 045X, 0516, 0526, 0700, 072X.
- Use billing code 99050 for after-hours care.

**Please Note:** If the Member is admitted following urgent care, then the entire billing requirement shifts to acute or sub-acute care.

**Billing Requirements by Service Category: Maternity**

The billing requirements for maternity care apply to all live and stillbirth deliveries. They include payment for services including, but not limited to:

- Room and board for mother (including nursing care)
- Nursery for baby (including nursing care)
- Delivery room/Surgical suites
- Equipment
- Laboratory
- Pharmaceuticals
- Radiology
- Other services incidental to admission

The maternity care rate covers the entire admission, except for admissions approved for extension beyond the contracted time limit for continuous inpatient days. In such cases, the billing requirements for the entire admission shifts to those for inpatient acute care (later in this section) for each approved and medically necessary service day.

Therapeutic abortions, treatment for ectopic and molar pregnancies and similar conditions are excluded from payment under this rate.

**Billing Requirements by Service Category: Inpatient Acute Care**

The billing requirements for inpatient acute care apply to each approved and medically necessary service day in a licensed bed. They include, but are not limited to:

- Room and board (including nursing care)
Prior authorization is required for all admissions except standard vaginal delivery and Cesarean sections.

Special billing instructions and requirements:

- Must be an **Indiana Health Coverage Programs** (IHCP) facility
- **Utilization Management** approval is required for all admissions, except routine deliveries
- Billing observation room or outpatient charges with an inpatient stay:
  - The dates reported on the CMS 1450 form in the “From” box of **Form Locator 6 (FL 6)** and **Form Locator 17 (FL 17)** should be the same. These charges should also reflect the date the patient was admitted as an inpatient to the hospital.
  - Using the “From” box of (FL 6) and (FL 17) to reflect the date of an observation stay or outpatient charges that may have occurred prior to inpatient admission is incorrect and may cause processing delays.

**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. Originally effective for two years, the HAF has been extended until **June 30, 2015**. The fee is used in part to increase reimbursement to eligible hospitals for services provided in fee-for-service and managed care programs, and as the State’s share of disproportionate share hospital (DSH) payments.

**Reimbursement changes**

The HAF increases inpatient and outpatient reimbursement for eligible hospitals so that aggregate payments reasonably approximate the Medicare upper-payment limits without exceeding those limits. The increases in reimbursement will be based on adjusting factors that will be applied to the inpatient diagnosis-related group (DRG), inpatient level-of-care (LOC) *per-diem* rates and outpatient rates. For more information on adjustment factors, providers can view provider bulletins BT201412 and BT201443 at [http://provider.indianamedicaid.com/news,-bulletins,-and-banners/bulletins.aspx](http://provider.indianamedicaid.com/news,-bulletins,-and-banners/bulletins.aspx). Effective **September 27, 2014**, for dates of service beginning **August 1, 2014**, increases in reimbursement will be based on the following adjustment factors for both inpatient and outpatient claims:

- 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
Anthem will receive a monthly report by the end of each month from FSSA with amount to be paid to each eligible hospital. The payments will be based on historical utilization. Anthem will generate payments and distribute the increased reimbursement to eligible hospitals the month following the month Anthem receives the report. On average, Anthem expects the process to be 10 days from the time we receive the report at the end of the month to the first of the following month when the first check is mailed to each hospital.

**Billing Requirements by Service Category: Hospital Stays of Less Than 24 Hours**

When submitting claims for hospital stays of less than 24 hours, bill the claim as an **Outpatient Hospital Services** claim and follow these guidelines:

- **Service Codes:** Include the correct CPT/HCPCS codes for each service
- **Line Items:** Bill each service for each date as separate line items
- **Revenue Codes:** Bill the revenue codes with the appropriate CPT/HCPCS codes
- **Type of Bill:** Type of bill field entry must be 13X

Claims denied for a stay of less than 24 hours are claims that have the same admit and discharge date, or have a discharge date of the day after admission. Patients who are transferred out within 24 hours of admission should be billed as outpatient claims.

**Please Note:** This does not apply to neonatal claims, which are expressly one-day stays that fall under the following **Diagnosis-Related Groups** (DRGs):

- DRG 637 – Neonate, died within 1 day of birth, born here
- DRG 638 - Neonate, died within 1 day of birth, not born here
- DRG 639 - Neonate, transferred less than 5 days old, born here
- DRG 640 - Neonate, transferred less than 5 days old, not born here

Inpatient claims with next day discharge are assumed to be less than 24 hours if medical records are not provided. Claims submitted for inpatient stays with the "though date" of service one day later than the "from date" of service will be subject to post payment review.

**Billing Requirements by Service Category: Inpatient Sub-Acute Care**

The billing requirements for inpatient sub-acute care include each approved and medically necessary service day in a licensed and accredited facility at the appropriate level of care.

**Sub-Acute Care:** Includes levels of inpatient care less intensive than those required in an inpatient acute care setting.

Each inpatient sub-acute care admission is considered a separate admission from any preceding or subsequent acute care admission, and should be billed separately.

Covered services include, but are not limited to:

- Room and board (including nursing care)
- Equipment
- Laboratory
- Pharmaceuticals
- Radiology
- Supplies
- Other services incidental to the admission
Please note: All sub-acute admissions require prior authorization and a treatment plan.

The treatment plan must accompany the admission and include:

- Functional, reasonable, objective and measurable goals within a predictable time frame for each skilled discipline
- A discharge plan and options that are individually customized and identified from the admission date, and that are carried forward from the admission date
- Weekly summaries for each discipline, and bi-weekly conference reports

Billing Requirements by Service Category: Outpatient Laboratory, Radiology and Diagnostic Services

There are specific billing requirements for outpatient laboratory, pathology, radiology and other diagnostic tests. These include billing for services related to the diagnostic tests, including, but not limited to:

- Facility use
- Nursing care (including incremental nursing)
- Equipment
- Professional services
- Specified supplies and all other services incidental to the outpatient visit

Please note: Outpatient radiation therapy is excluded from this service category and should be billed under the requirements of the Other Services category (later in this chapter).

Billing Requirements by Service Category: Outpatient Surgical Services

There are specific billing requirements for outpatient surgical services. The billing requirements include, but are not limited to:

- Facility use (including nursing care)
- Blood
- Equipment
- Imaging services
- Implantable prostheses
- Laboratory
- Pharmaceutical
- Radiology
- Supplies
- All other services incidental to the outpatient surgery visit

Special outpatient surgical services billing instructions:

Specific dates, codes and medical records may be required for billing:

- Follow the billing requirements for outpatient surgery when the respiratory therapy department performs an ECG, EEG or EKG; do not apply the outpatient therapy billing requirements.
- Include service dates for each procedure (both principal and other).
- Include CPT/HCPCS codes for each surgical procedure in form locators 44 (HCPCS/RATES).
Provide medical records when Anthem needs to review and determine the correct grouping for services not defined in the surgery grouping.

- Use billing field entry 13X.
- Use revenue codes 036X, 0480, 0481, 0490, 070X, 071X, 075X, 076X, 079X and 0975, as required, with the appropriate CPT/HCPCS code.
- Use the CPT/HCPCS code, as mandated by the HIPAA, for outpatient surgery billing.

**Billing Requirements by Service Category: Outpatient Therapies**

Outpatient therapy services include physical, occupational, speech and respiratory therapies. An outpatient therapy visit means a single service date. Billing requirements for these visits include, but are not limited to:

- Facility use (including nursing care)
- Therapist/professional services
- Equipment
- Pharmaceuticals
- Supplies
- Other services incidental to the outpatient therapy visit

**Special outpatient therapies billing instructions:**

There are specific requirements for billing outpatient therapies, including:

- Bill each service date as a separate line item.
- Use the required revenue codes, including:
  - Occupational therapy = 043X
  - Physical therapy = 042X
  - Respiratory therapy = 041X
  - Speech Therapy = 044X
- Use the applicable CPT/HCPCS codes, as required.

**Billing Requirements by Service Category: Outpatient Infusion Therapies and Pharmaceuticals**

**Outpatient Infusion Therapies**

Billing requirements for outpatient infusion therapy visits apply to each outpatient hospital visit and include, but are not limited to:

- Facility use (including nursing care)
- Equipment
- Intravenous solutions (excluding pharmaceuticals)
- Kinetic dosing
- Laboratory
- Professional services
- Radiology
- Supplies (including syringes, tubing, line insertion kits, etc.)
- Other services incidental to the outpatient infusion therapy visit
Outpatient Infusion Pharmaceuticals

These billing requirements apply to drugs such as chemotherapy, hydration and antibiotics used during each outpatient infusion therapy visit. One important exception is for blood and blood products, which are billed under “other services.”

Special outpatient infusion pharmaceuticals billing instructions:

Specific codes and service dates are required, including:
- Use revenue codes 026X, 028X, 0331, 0335 or 0940, as required, for each outpatient infusion therapy visit
- Use revenue code 0940 or 0949 with 36511-36513, 36515-36516 or 36522 CPT/HCPCS codes when billing for therapeutic aphaeresis claims
- List each drug for each visit as a separate line item and include the service date
- Use HCPCS codes, as required, for all pharmaceuticals when:
  - Billed with revenue codes 0250-0252, 0256-0259 or 063X; you must include the units with pharmaceutical CPT/HCPCS codes.
  - Billed with revenue codes 026X, 028X, 0331, 0335 or 0940.
- When using an unlisted CPT/HCPCS code, provide the name of the drug or medication in Box 43 of the CMS-1450 claim form

Billing Requirements by Service Category: Hospital-Acquired Conditions/Present on Admission Indicators

The IHCP utilizes a hospital-acquired conditions (HAC) policy for Medicaid claims using its existing version 18.0 of the All Patient Diagnosis-Related Group (AP DRG) grouper. Hospitals are required to report whether each diagnosis on a Medicaid claim was present on admission. Claims submitted without the required POA indicators are denied. For claims containing secondary diagnoses that are included in the list of HACs in Table 8.13 and for which the condition was not present on admission, the HAC secondary diagnosis is not used for AP DRG grouping. That is, the claim is paid as though any secondary diagnoses included in the table below were not present on the claim.

HAC Categories and Corresponding CC or MCC Codes

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Corresponding CC or MCC Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Foreign Object Retained After Surgery</td>
<td>998.4 (CC)</td>
</tr>
<tr>
<td></td>
<td>998.7 (CC)</td>
</tr>
<tr>
<td>Air Embolism</td>
<td>999.1 (MCC)</td>
</tr>
<tr>
<td>Blood Incompatibility</td>
<td>999.60 (CC)</td>
</tr>
<tr>
<td></td>
<td>999.61 (CC)</td>
</tr>
<tr>
<td></td>
<td>999.62 (CC)</td>
</tr>
<tr>
<td></td>
<td>999.63 (CC)</td>
</tr>
<tr>
<td></td>
<td>999.69 (CC)</td>
</tr>
<tr>
<td>Pressure Ulcer Stages III &amp; IV</td>
<td>707.23 (MCC)</td>
</tr>
<tr>
<td></td>
<td>707.24 (MCC)</td>
</tr>
<tr>
<td>Falls and Trauma:</td>
<td>800-829</td>
</tr>
<tr>
<td>• Fracture</td>
<td>830-839</td>
</tr>
<tr>
<td>• Dislocation</td>
<td>850-854</td>
</tr>
<tr>
<td>• Intracranial Injury</td>
<td>925-929</td>
</tr>
<tr>
<td>Diagnosis</td>
<td>Corresponding CC or MCC Codes</td>
</tr>
<tr>
<td>---------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>• Crushing Injury</td>
<td>940-949</td>
</tr>
<tr>
<td>• Burn</td>
<td>991-994</td>
</tr>
<tr>
<td>• Other Injuries</td>
<td></td>
</tr>
<tr>
<td>Catheter-Associated Urinary Tract Infection (UTI)</td>
<td>996.64 (CC) Also excludes the following from acting as a CC/MCC: 112.2 (CC) 590.10 (CC) 590.11 (MCC) 590.2 (MCC) 590.3 (CC) 590.80 (CC) 590.81 (CC) 595.0 (CC) 597.0 (CC) 599.0 (CC)</td>
</tr>
<tr>
<td>Vascular Catheter-Associated Infection</td>
<td>999.31 (CC) 999.32 (CC) 999.33 (CC)</td>
</tr>
<tr>
<td>Manifestations of Poor Glycemic Control</td>
<td>250.10-250.13 (MCC) 250.20-250.23 (MCC) 251.0 (CC) 249.10-249.11 (MCC) 249.20-249.21 (MCC)</td>
</tr>
<tr>
<td>Surgical Site Infection, Mediastinitis, Following Coronary Artery Bypass Graft (CABG)</td>
<td>519.2 (MCC) And one of the following procedure codes: 36.10–36.19</td>
</tr>
<tr>
<td>Surgical Site Infection Following Certain Orthopedic Procedures</td>
<td>996.67 (CC) 998.59 (CC) And one of the following procedure codes: 81.01–81.08 81.23 81.24 81.31–81.38 81.83 81.85</td>
</tr>
<tr>
<td>Surgical Site Infection Following Bariatric Surgery for Obesity</td>
<td>Principal Diagnosis – 278.01 539.01 (CC) 539.81 (CC) 998.59 (CC) And one of the following procedure codes: 44.38 44.39 44.95</td>
</tr>
<tr>
<td>Surgical Site Infection Following Cardiac Implantable Electronic Device (CIED)</td>
<td>996.61 (CC) 998.59 (CC) And one of the following procedure codes: 00.50 00.51</td>
</tr>
</tbody>
</table>
### Diagnosis | Corresponding CC or MCC Codes
--- | ---
00.52 & 00.53 & 00.54
37.74 & 37.75 & 37.76 & 37.77 & 37.79 & 37.80 & 37.81 & 37.82 & 37.83 & 37.85 & 37.86 & 37.87 & 37.89 & 37.94 & 37.96 & 37.98

Deep Vein Thrombosis and Pulmonary Embolism Following Certain Orthopedic Procedures
415.11 (MCC) & 415.13 (MCC) & 415.19 (MCC) & 453.40-453.42 (CC) & And one of the following procedure codes:
00.85-00.87 & 81.51-81.52 & 81.54

Iatrogenic Pneumothorax with Venous Catheterization
512.1 (CC) & And the following procedure code:
38.93

### Present on Admission Indicator

POA is 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 are considered POA. A POA indicator must be assigned to principal and secondary diagnoses (as defined in Section II of the *Official Guidelines for Coding and Reporting*). CMS does not require a POA indicator for an external cause of injury code unless it is being reported as an “other diagnosis.” Therefore, the IHCP does not require a POA indicator in the External Cause of Injury field locator 72. If a POA indicator is entered in the External Cause of Injury field, it is ignored and not used for AP DRG grouping.

A new exemption effective **July 1, 2012**, for HAC/POA is Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) diagnoses following a total knee replacement or hip replacement for pediatric and obstetric patients. When all these conditions are present on the claim, the HAC/POA requirement is bypassed and *none* of the diagnosis codes included on the claim is suppressed.

### Hospital Acquired Condition List

The IHCP updated the list of hospital-acquired conditions (HACs) to comply with the federally defined list. The IHCP follows CMS’ HAC determinations, including any future additions or changes to the current list of HAC conditions, as well as diagnosis codes that are exempt from HAC reporting. The list of exempt diagnosis codes can be found in the *Hospital-Acquired Conditions* page at [cms.gov](http://www.cms.gov).
Chapter 11: Billing Institutional Claims

Provider Preventable Conditions

CMS issued Change Request (CR) 6405 to instruct hospitals how to bill for erroneous surgeries. Effective July 1, 2012, the IHCP adopted the CMS rule and does not cover surgical or other invasive procedures to treat particular medical conditions when the practitioner performs the surgery or invasive procedure erroneously, including:

- Incorrect surgical or other invasive procedures
- Surgical or other invasive procedures on the wrong body part
- Surgical or other invasive procedures on the wrong patient

The IHCP also does not cover hospitalizations and other services related to these noncovered procedures. All services provided in the operating room when an error occurs are considered related and therefore not covered. All providers in the operating room when the error occurs, that could bill individually for their services, are not eligible for payment. All related services provided during the same hospitalization in which the error occurred are not covered.

The IHCP will deny payments to providers for inpatient, inpatient crossover, inpatient crossover Medicare Replacement Plan, outpatient, outpatient crossover, outpatient crossover Medicare Replacement Plan, physician, physician crossover, and physician crossover Medicare Replacement Plan claims when provider preventable conditions (PPC) are performed on a patient. These institutional and physician claims will deny when submitted with the following E codes:

- E876.5 – Performance of wrong operation (procedure) on correct patient (existing code)
- E876.6 – Performance of operation (procedure) on patient not scheduled for surgery
- E876.7 – Performance of correct operation (procedure) on wrong side/body part

The following PPC modifiers must be submitted on physician, physician crossover, and physician crossover Medicare Replacement Plan claims indicating errors:

- PA – Surgery wrong body part
- PB – Surgery wrong patient
- PC – Wrong surgery on patient

Ancillary Billing: Overview

Hoosier Healthwise, Healthy Indiana Plan and Hoosier Care Connect follow ancillary billing guidelines as outlined in the state of Indiana provider manuals at:


Most ancillary claims are submitted for laboratory/diagnostic imaging or Durable Medical Equipment (DME). This section will provide special billing requirements for each.

Please Note: The Member’s benefits may not cover some of the services listed. Please confirm benefit coverage.

Ancillary Billing Requirements by Service Category: Ambulance Services

Ambulance Providers, including municipalities, should use the CMS-1500 form to bill for ambulance services. Use the appropriate 2-digit origin and destination codes that describe the “to” and “from” locations.

Ancillary Billing Requirements by Service Category: Ambulatory Surgical Centers

Most outpatient surgery delivered in an ambulatory surgery center requires Prior Authorization.
Ambulatory surgical centers bill on the CMS-1500 form.

**Ancillary Billing Requirements by Service Category: Physical Therapy**

The physical therapy setting determines the correct billing form or successor forms:

- **Form CMS-1500**: When providing services in an office, clinic or outpatient setting
- **Form CMS-1450**: When providing services in a rehabilitation center
- **Form UB-04b**: For physical therapists affiliated with home health agencies, providing services in a patient’s home

**Ancillary Billing Requirements by Service Category: Speech Therapy**

The speech therapy setting determines the correct billing form or successor forms:

- **Form CMS-1500**: When providing services in an office, clinic or outpatient setting
- **Form UB-04**: For speech therapists affiliated with home health agencies, providing services in a patient’s home

**Ancillary Billing Requirements by Service Category: Occupational Therapy**

The occupational therapy setting determines the correct billing form or successor forms:

- **Form CMS-1500**: When providing services in an office, clinic or outpatient setting
- **Form UB-04**: For occupational therapists affiliated with home health agencies, providing services in a patient’s home

**Ancillary Billing Requirements by Service Category: Durable Medical Equipment**

Billing for custom-made **Durable Medical Equipment** (DME), prescribed to preserve bodily functions or prevent disability, requires **Prior Authorization**. Without such review, claims for DME will be denied. Prior to dispensing, please contact **Anthem’s Utilization Management** (UM) department.

**Please note:** The presence of a Healthcare Common Procedure Coding System (HCPCS) code does not necessarily mean that the benefit is covered or that payment will be made. Some DME codes may be By Report (customized) and therefore require additional information for pre-service review and processing.

**Special Guidelines for Durable Medical Equipment Billing**

**Durable Medical Equipment** billing requires a differentiation between rentals and purchased equipment. It also requires specific codes and modifiers.

- Use the appropriate modifier to identify rentals versus purchases (new or used). Claims submitted without the right modifier will be reimbursed at the rental rate.
- Use HCPCS codes for DME or supplies.
- Use an unlisted or miscellaneous code (such as E1399) when an HCPCS code doesn’t exist for a particular item of equipment.
- Use valid codes for DME and supplies; unlisted codes will not be accepted if valid HCPCS codes exist.
- Attach the manufacturer’s invoice to the claim if using a miscellaneous or unlisted code. The invoice must be from the manufacturer, not the office making the purchase.

**Please Note:** Catalog pages are not acceptable as a manufacturer’s invoice.

**Ancillary Billing Requirements by Service Category: DME Rentals**
Most DME is dispensed on a rental basis. These rentals require medical documentation from the prescribing Provider. Rented items remain the property of the DME Provider until the purchase price is reached. Charges for rentals exceeding the reasonable charge for a purchase are not accepted, and rental extensions may be obtained only on approved items.

**Please Note:** DME Providers should use normal equipment collection guidelines. **Anthem** is not responsible for equipment not returned by Members.

**Ancillary Billing Requirements by Service Category: DME Purchase**

DME may be reimbursed on a rent-to-own basis over a period of 10 months, unless otherwise specified at the time of review by our **Utilization Management** department.

**Ancillary Billing Requirements by Service Category: DME Wheelchairs/Wheeled Mobility Aids**

At **Anthem**, we follow Medicaid guidelines for calculating By Report (customized) wheelchair claims. Claims must include the following:

- Catalog number
- Item description
- Manufacturer’s name
- Model number

Each catalog page or invoice line must be marked so it can be matched to the appropriate claim line. Also, the Reserved for Local Use field (Box 19) on the CMS-1500 form must be filled in with the total MSRP of the wheelchair, including:

- Accessories
- Modifications or replacement parts
- Name of the employed **Rehabilitation and Assistive Technology of America** (RESNA) certified technician

For wheeled mobility aids, there is one additional requirement: The invoice must be an amount published by the manufacturer before **August 1, 2003**. If the item was not available before then, you must list the date of availability in the **Reserved for Local Use** field (Box 19) of the UMS-1500 claim form. The catalog page where the item was first published must be attached to the claim.

If you are a wheelchair manufacturer billing as a Provider, your billing must include:

- The MSRP from a catalog page dated before **August 1, 2003**
- If the item was not available before that date, the manufacturer’s invoice must accompany the claim
- The initial date of availability must be documented in the Reserved for Local Use field (Box 19) of the CMS-1500 claim form

**Ancillary Billing Requirements by Service Category: Dialysis**

Dialysis centers and other entities performing dialysis should use the CMS-1450 form to bill for dialysis services. All dialysis care must be pre-authorized (except where Medicare is the primary payer). Contact **Anthem’s Utilization Management** (UM) department for authorization prior to delivery of service.

**Ancillary Billing Requirements by Service Category: Home Infusion Therapy**
Home infusion therapy requires **Prior Authorization**. When billing for home infusion therapy, use the CMS-1500 form and follow these guidelines:

- Get **Prior Authorization**, as required, from Anthem’s Utilization Management (UM) department for all infusion therapy.
- Submit all claims within the contracted filing limit.
- Use the appropriate HCPCS injection codes to bill for all injections.
- Use HCPCS code J3490 along with the **National Drug Code** (NDC) for billing injections only if an appropriate injection code is not found.

**Please Note:** By Report HCPCS codes, including HCPCS code A9999 for supplies and accessories, are reimbursed at the lesser of the amount billed or the manufacturer’s purchase invoice amount, plus a 24% mark-up.

**Ancillary Billing Requirements by Service Category: Laboratory and Diagnostic Imaging**

For laboratory and diagnostic imaging, use the CMS-1500 form and refer to the basic billing guidelines found in the beginning (**Overview**) of this segment, **Billing Institutional Claims**.

**Ancillary Billing Requirements by Service Category: Skilled Nursing Facilities**

All skilled nursing facility care requires **Prior Authorization**. Contact Anthem’s Utilization Management (UM) department for authorization prior to SNF admission and bill using the CMS-1450 form. Use codes: 0550-52, 0559, 90300-903XX.

**Ancillary Billing Requirements by Service Category: Home Health Care**

All home health care must be pre-authorized. Contact Anthem’s Utilization Management (UM) department for authorization prior to delivery of service. When billing for a home health care visit, use the CMS-1450 form.

**Please Note:** When billing for supplies and equipment used in a home health care visit, please refer to the **Durable Medical Equipment** section (earlier in this chapter) for billing requirements.

**Ancillary Billing Requirements by Service Category: Hospice**

Hospice services require **Prior Authorization**. Contact Anthem’s Utilization Management (UM) department for authorization prior to hospice admission and bill for services on the CMS-1450 form.

**Additional Billing Resources**

The following reference books provide detailed instructions on uniform billing requirements:

- Healthcare Common Procedure Coding System (HCPCS), National Level II (current year)
- ICD (current edition) Volumes 1,2,3 (current year), published by the Practice Management Information Corporation

**Coding Guidelines: The CMS-1450 Claim Form**

All Medicare-approved facilities should bill **Anthem** using the most up-to-date version of the CMS-1450 claim form.

All fields must be completed using standardized code sets. These code sets are used to ensure that claims are processed in an orderly and consistent manner. The **Healthcare Common Procedure Coding System**
(HCPCS) provides codes for a variety of services and consists of two main subsystems, referred to as Level I and Level II:

- **Level I: Current Procedural Terminology** (CPT) codes determined by the American Medical Association (AMA)
  - CPT codes are represented by 5 numeric digits
- **Level II:** Other codes that identify products, supplies and services not included in the CPT codes, such as ambulance services and Durable Medical Equipment (DME)
  - These are sometimes called the alphanumeric codes because they consist of a single alphabetical letter followed by 4 numeric digits.
- In some cases, 2-digit/character modifier codes should accompany the Level I or Level II coding.

**The CMS-1450 Revenue Codes**

UMS-1450 revenue codes are required for all institutional claims.

**Institutional Inpatient Coding**

For institutional inpatient coding, use the guidelines in the following code manuals:

- Use current ICD applicable and procedure codes in Boxes 74-74e of the CMS-1450 claim form when the claim indicates that a procedure was performed.
- Use modifier codes when appropriate; refer to the current edition of the physician’s *Current Procedural Terminology* manual published by the AMA.
- Please refer to your Provider’s contract for Diagnostic Related Grouping (DRG) information.

**Institutional Outpatient Coding**

For institutional outpatient coding, use the guidelines in the following code manuals:

- *Healthcare Common Procedure Coding System* (HCPCS), published by the Centers for Medicare and Medicaid Services (CMS)

**Please Note:** When using an unlisted CPT/HCPCS code, provide the name of the drug or medication in Box 43 of the CMS-1450 claim form.

**Recommended Fields for CMS-1450 (UB-04)**

The following guidelines will assist in completing the CMS-1450 form. "R" indicates a mandatory field. For additional information, please refer to the IHCP Provider Manual website at: http://provider.indianamedicaid.com/general-provider-services/manuals.aspx.

<table>
<thead>
<tr>
<th>Field #</th>
<th>Box Title</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 (R)</td>
<td>Blank</td>
<td>Facility name, address, and phone number.</td>
</tr>
<tr>
<td>2</td>
<td>Blank</td>
<td>Required when the address for payment is different than that of the Billing Provider information located in Field 1.</td>
</tr>
<tr>
<td>3a</td>
<td>PAT. CNTL. #</td>
<td>Member’s account number.</td>
</tr>
<tr>
<td>3b</td>
<td>MED. REC #</td>
<td>Member’s record number, which can be up to 20 characters long.</td>
</tr>
<tr>
<td>4 (R)</td>
<td>TYPE OF BILL</td>
<td>Enter the Type of Bill (TOB) code.</td>
</tr>
<tr>
<td>5 (R)</td>
<td>FED. TAX NO.</td>
<td>Enter the provider’s Federal tax ID number</td>
</tr>
</tbody>
</table>
### Field # | Box Title | Description
--- | --- | ---
6 (R) | STATEMENT COVERS PERIOD | “FROM” and “THROUGH” date(s) covered by the claim being submitted
7 | Blank | Leave blank.
8a–b (R) | PATIENT NAME | Member’s name.
9a–e (R) | PATIENT ADDRESS | Complete address (number, street, city, state, ZIP code, telephone number).
10 (R) | BIRTHDATE | Member’s date of birth in MM/DD/YY format.
11 (R) | SEX | Member’s gender.
12 (R) | ADMISSION DATE | Member’s admission date to the facility in MM/DD/YY format.
13 (R) | ADMISSION HR | Member’s admission hour to the facility in military time (00 to 23) format.
14 (R) | ADMISSION TYPE | Type of admission.
15 (R) | ADMISSION SRC | Source of admission.
16 (R) | DHR | Member’s discharge hour from the facility in military time (00 to 23) format.
17 (R) | STAT | Patient status.
18–28 | CONDITION CODES | Enter Condition Code (81) X0 – X9.
29 | ACDT STATE | Accident State.
30 | Blank | Leave blank.
31–34 (R) | OCCURRENCE CODE OCCURRENCE DATE | Occurrence code (42) and date, if applicable.
35–36 | OCCURRENCE SPAN (CODE, FROM, & THROUGH) | Enter dates in MM/DD/YY format.
37 | Blank | Leave blank.
38 | Blank | Enter the responsible party name and address, if applicable.
39–41 | VALUE CODES (CODE & AMOUNT) | Enter value codes, if applicable.
42 (R) | REV. CD. | Revenue Code. Revenue codes are required for all institutional claims.
43 (R) | DESCRIPTION | Description of services rendered
44 (R) | HCPCS/RATE/HIPPS CODE | Enter the accommodation rate per day for inpatient services or HCPCS/CPT code for outpatient services.
45 (R) | SERV. DATE | Date of services rendered.
46 (R) | SERV. UNITS | Number/units of occurrence for each line or service being billed.
47 (R) | TOTAL CHARGES | Total charge for each line of service being billed
<table>
<thead>
<tr>
<th>Field #</th>
<th>Box Title</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>48</td>
<td>NONCOVERED CHARGES</td>
<td>Enter any noncovered charges.</td>
</tr>
<tr>
<td>49</td>
<td>Blank</td>
<td>Leave blank.</td>
</tr>
<tr>
<td>50</td>
<td>PAYER NAME</td>
<td>Payer Identification. Enter any third party payers.</td>
</tr>
<tr>
<td>51 (R)</td>
<td>HEALTH PLAN ID</td>
<td>Leave blank. Assigned by Plan.</td>
</tr>
<tr>
<td>52 (R)</td>
<td>REL INFO</td>
<td>Release of information certification indicator.</td>
</tr>
<tr>
<td>53</td>
<td>ASG BEN.</td>
<td>Assignment of benefits certification indicator.</td>
</tr>
<tr>
<td>54</td>
<td>PRIOR PAYMENTS</td>
<td>Prior payments.</td>
</tr>
<tr>
<td>55</td>
<td>EST. AMOUNT DUE</td>
<td>Estimated amount due.</td>
</tr>
<tr>
<td>56 (R)</td>
<td>NPI</td>
<td>Enter the NPI number. (Required after May 23, 2007).</td>
</tr>
<tr>
<td>57 (R)</td>
<td>OTHER PRIV ID</td>
<td>Enter the other provider ID.</td>
</tr>
<tr>
<td>58 (R)</td>
<td>INSURED’S NAME</td>
<td>Member’s name.</td>
</tr>
<tr>
<td>59 (R)</td>
<td>P. REL</td>
<td>Patient’s relationship to insured (N/A: Member is the insured).</td>
</tr>
<tr>
<td>60 (R)</td>
<td>INSURED’S UNIQUE ID</td>
<td>For Hoosier Healthwise, use the 12-digit Medicaid ID number (Recipient Identification [RID] Number), along with the YRH prefix. For Healthy Indiana Plan, use the 9-digit <strong>Anthem</strong> ID number, along with the YRK prefix For Hoosier Care Connect, use the 12-digit <strong>Anthem</strong> ID number, along with the YRH prefix</td>
</tr>
<tr>
<td>61</td>
<td>GROUP NAME</td>
<td>Insured group name — enter the name of any other health plan.</td>
</tr>
<tr>
<td>62</td>
<td>INSURANCE GROUP NO.</td>
<td>Enter the policy number of any other health plan.</td>
</tr>
<tr>
<td>63</td>
<td>TREATMENT AUTHORIZATION CODES</td>
<td>Authorization number or authorization information must be entered on this field.</td>
</tr>
<tr>
<td>64</td>
<td>DOCUMENT CONTROL NUMBER</td>
<td>The control number assigned to the original bill.</td>
</tr>
<tr>
<td>65</td>
<td>EMPLOYER NAME</td>
<td>Name of organization from which the insured obtained the other policy.</td>
</tr>
<tr>
<td>66 (R)</td>
<td>DX/PROC qualifier</td>
<td>Enter the diagnosis and procedure code qualifier (ICD version indicator).</td>
</tr>
<tr>
<td>67 (R)</td>
<td>DX</td>
<td>Principal Diagnosis Codes. Enter the ICD-9/ICD-10 diagnostic codes, if applicable.</td>
</tr>
<tr>
<td>67a–q (R)</td>
<td>DX</td>
<td>Other Diagnostic Codes. Enter the ICD-9/ICD-10 diagnostic codes, if applicable. Indicate POA.</td>
</tr>
<tr>
<td>Field #</td>
<td>Box Title</td>
<td>Description</td>
</tr>
<tr>
<td>---------</td>
<td>-----------</td>
<td>-------------</td>
</tr>
<tr>
<td>69</td>
<td>ADMIT DX</td>
<td>Admission diagnosis code — enter the ICD-9/ICD-10 code.</td>
</tr>
<tr>
<td>70a–c</td>
<td>PATIENT REASON DX</td>
<td>Enter the Member’s reason for this visit, if applicable.</td>
</tr>
<tr>
<td>71</td>
<td>PPS CODE</td>
<td>Prospective Payment System (PPS) code (not required).</td>
</tr>
<tr>
<td>72</td>
<td>ECI</td>
<td>External cause of injury code.</td>
</tr>
<tr>
<td>73</td>
<td>Blank</td>
<td>Leave blank.</td>
</tr>
<tr>
<td>74 (R)</td>
<td>PRINCIPAL PROCEDURE (CODE/DATE)</td>
<td>ICD-9/ICD-10 principal procedure code and dates, if applicable.</td>
</tr>
<tr>
<td>74a–e (R)</td>
<td>OTHER PROCEDURE (CODE/DATE)</td>
<td>Other Procedure Codes.</td>
</tr>
<tr>
<td>75</td>
<td>Blank</td>
<td>Leave blank.</td>
</tr>
<tr>
<td>76 (R)</td>
<td>ATTENDING</td>
<td>Enter the attending physician’s ID number. (NPI required after May 23, 2007.)</td>
</tr>
<tr>
<td>77 (R)</td>
<td>OPERATING</td>
<td>Enter the provider number if you use a surgical procedure on this form. (NPI required after May 23, 2007.)</td>
</tr>
<tr>
<td>78–79</td>
<td>OTHER</td>
<td>Enter any other provider numbers, if applicable. (NPI required after May 23, 2007.)</td>
</tr>
<tr>
<td>80</td>
<td>REMARKS</td>
<td>Use this field to explain special situations.</td>
</tr>
<tr>
<td>81a–d (R)</td>
<td>CC</td>
<td>Enter taxonomy code with qualifier B3.</td>
</tr>
</tbody>
</table>
CHAPTER 12: MEMBER TRANSFERS & DISENROLLMENT

Overview

Members have the freedom to choose their most important link to quality health care: their doctor. We strongly encourage our Members to select a Primary Medical Provider and remain with that Provider because we believe in the positive impact of having a medical "home." This home establishes a centralized hub from which all health care can begin and can be coordinated, no matter how many other caregivers become involved. Our AnthemConnect team establishes collaborative supportive relationships to support our Members medical home as the center of the of the care delivery system.

Occasionally, Members may encounter barriers to effective relationships with their Primary Medical Provider. These obstacles may be cultural and language difficulties, geographical access, or simply personal preferences. Members who want to change their Primary Medical Provider may do so at any time, for any reason.

Members also have the right to change health care plans, following specific rules and timelines. If a Member requests disenrollment, Anthem will provide information and assistance in the disenrollment process. For more information, see the section below Member Transfers to Other Plans.

Anthem notifies Primary Medical Providers of Member transfers through monthly enrollment reports. Primary Medical Providers can find these reports online through our secure Anthem website, MyAnthem, located at www.anthem.com > OTHER ANTHEM WEBSITES: Providers > Providers | Spotlight: State Sponsored Plans or by calling our Anthem Provider Helpline. The effective date of a Primary Medical Provider transfer will be the same as the date of the Member request.

We are committed to supporting Providers’ practices as well. Providers have the right to request that a Member be reassigned to another Primary Medical Provider under certain conditions and following specific guidelines.

Primary Medical Provider-Initiated Member Transfers

Primary Medical Providers can request Member reassignment to a different Primary Medical Provider by completing and submitting the Provider Request for Member Deletion from PMP Assignment form located in the Forms Library on the Providers Resources page at www.anthem.com. For directions on how to access the Provider Resources page of our website, please see Chapter 1: How to Access Information, Forms and Tools on Our Website.

The Provider is required to coordinate care services for up to 30 days after the date Anthem receives the change request form. Upon completing the Primary Medical Provider change, Anthem forwards the form and any other information related to the case to the customer care representative. This representative informs the Member of the change within five working days. The change will be effective the day Anthem makes it effective.

Primary Medical Provider-Initiated Member Disenrollment

A Primary Medical Provider may request disenrollment of a Member from his or her primary care assignment. The Primary Medical Provider may request Member disenrollment for the following reasons:

- The Member is abusive to the Primary Medical Provider, exhibiting disruptive, unruly, threatening or uncooperative behavior
- The Member is abusive to staff, exhibiting disruptive, unruly, threatening or uncooperative behavior
- The Member misuses or loans their Membership card to another person
The Member fails to follow prescribed treatment plans

To request disenrollment, the Primary Medical Provider must do the following:

- Complete the Provider Request for Member Deletion from PMP Assignment form located in the Forms Library on the Providers Resources page at www.anthem.com. For directions on how to access the Provider Resources page of our website, please see Chapter 1: How to Access Information, Forms and Tools on Our Website.
- Mail or fax (preferred) the form to Anthem at 1-866-408-7087
  
  Anthem Blue Cross and Blue Shield
  P.O. Box 6144
  Indianapolis, IN 46206-6144

- Continue to manage the Member’s care, as required, until we can reassign the Member to another Primary Medical Provider, or not more than 30 days from the day we receive the Provider Request for Member Deletion from PMP Assignment form, whichever comes first.

Prior to disenrollment, Anthem will make every attempt to resolve issues and keep the Member in our health care plan. If these attempts fail, Anthem will either reassign the Member to another Primary Medical Provider or forward the disenrollment request form to the appropriate state agency requesting Member reassignment to another health care plan.

Primary Medical Provider- Initiated Member Disenrollment Process

The disenrollment process for abusive behavior and failure to follow prescribed treatment plan is as follows:

- The Primary Medical Provider completes the Provider Request for Member Deletion from PMP Assignment, and then mails or faxes it to Anthem.
- Anthem scans and logs the form into the system for tracking purposes.
- Anthem reassigns the Member a new Primary Medical Provider for continuity of care. The effective date is no later than 30 days from the date on the Provider Request for Member Deletion form.
- Anthem logs the new Primary Medical Provider assignment into its tracking system.
- Anthem sends an ID card and Member Welcome Packet indicating the newly assigned Primary Medical Provider’s name, address and telephone number.
- Anthem documents any abusive behavior and notifies the Fraud and Abuse department if abusive behavior continues.
- Anthem sends a warning letter to the Member stating that if the behavior continues, Anthem will file a disenrollment request with Indiana’s Family and Social Services Administration (FSSA). If approval is granted by FSSA, Anthem will proceed with the disenrollment process.

Anthem may also request disenrollment for a Member who has moved out of the service area. When a Member moves out of our service area, the Member is responsible for notifying the state of their new permanent address. After that, Indiana’s Family and Social Services Administration will disenroll the Member from Anthem.

State Agency- Initiated Member Disenrollment

Contracted state agencies inform Anthem of Membership changes by sending daily and monthly enrollment reports. These reports contain all active Membership data and incremental changes to eligibility records. Anthem disenrolls Members who are not listed on the monthly full replacement file effective as of the designated disenrollment date for the following reasons:
Chapter 12: Member Transfers & Disenrollment

Anthem Blue Cross and Blue Shield
Hoosier Healthwise, Healthy Indiana Plan and Hoosier Care Connect

- Admission to a long-term care or intermediate care facility beyond the month of admission and the following month
- Change in eligibility status
- County changes
- Death
- Incarceration
- Loss of benefits
- Member has other non-government or government sponsored health coverage
- Permanent change of residence out of service area
- Voluntary disenrollments

Member-Initiated Primary Medical Provider Transfers

Members have the right to change their Primary Medical Provider at any time. When a Member enrolls in any of our programs, they can choose a Primary Medical Provider or allow their Primary Medical Provider to be assigned. After that, if they want to make a change, Members are instructed to call our Customer Care Center to request an alternate Primary Medical Provider.

Anthem accommodates Member requests for transfers whenever possible. Our staff will work with the Member to make the new selection, focusing on special needs. Our policy is to maintain Continued Access to Care and Continuity of Care during the transfer process.

When a Member calls to request a Primary Medical Provider change:

- The Customer Care Center (CCC) representative checks the availability of the Member’s choice. If the Member can be assigned to the selected Primary Medical Provider, the CCC representative will do so. If the Primary Medical Provider is not available, the CCC representative will assist the Member in finding an available Primary Medical Provider. If the Member advises the CCC that he or she is hospitalized, the Primary Medical Provider change will take effect upon discharge.

- **Anthem** notifies Primary Medical Providers of Member transfers through monthly enrollment reports. Primary Medical Providers can request these reports by calling our Customer Care Center.

- The effective date of a Primary Medical Provider transfer will be the same as the date of the Member request. We may assign a Member retroactively.

- To support Member transfers, Primary Medical Providers are encouraged to maintain open panels. The state requires that 80% of Anthem’s Primary Medical Providers have open panels, and your open panel will assist us in meeting this requirement.

**Open Panel:** The commitment by an Anthem Provider to accept new Anthem Members.

Member Transfers to Other Plans

Members can choose a different Managed Care Entity (MCE) on an annual basis during the open enrollment period. As required by federal regulations, this open enrollment period lasts for 90-calendar days. After the open enrollment period ends, Healthy Indiana Plan members may not switch MCEs after their first POWER Account contribution without just cause. Members remain with their chosen MCE for the remaining 12-month period after this occurs. To change MCEs at their annual redetermination period, the member may call the Enrollment Broker.

However, Members retain the right to change their Managed Care Entity when they have “just cause,” which can be any of the following:
• Lack of access to necessary services covered under the MCE’s contract, this does not include enhanced services offered by Anthem
• Lack of access to Providers experienced in dealing with the Member’s health care needs
• MCE does not, for moral or religious objections, cover the services the Member seeks
• Member’s concerns over quality of care
• Member needs related services performed at the same time and not all related services are available within the MCE’s network
• Member’s Primary Medical Provider leaves the MCE and participates with another MCE under contract with the state of Indiana, so long as the Member requests transfer to that MCE

Members can call the enrollment broker at the numbers below to find out how to choose a new MCE.

• Hoosier Healthwise: 1-800-889-9949
• Healthy Indiana Plan: 1-877-GET-HIP-9 (1-877-438-4479)
• Hoosier Care Connect: 1-866-963-7383

**Member Disenrollment from the Plan**

Member disenrollment may be requested by the Member, Anthem or the Indiana Family and Social Services Administration (FSSA). If the request comes from a Member and includes a Member grievance, the grievance will be processed separately through the grievance process. Disenrollment may result in the following:

• Enrollment with another Plan
• Termination of eligibility
• Return to traditional Medicaid for continuity of care if the Member’s benefits fall into a voluntary aid code

If the enrollee is a mandatory Medicaid recipient, the enrollment broker instructs him or her to select another health plan option. If the enrollee does not make a choice, the enrollment broker automatically assigns another health plan to the enrollee. The enrollment broker offers voluntary Medicaid enrollees the option to join another plan, if one is available, or return to the fee-for-service coverage plan.

When Members enroll in our program, we provide instructions on disenrollment procedures. Disenrollments become effective the last day of the calendar month following administrative cut-off or are subject to state cut-off.

If a Member asks a Provider how to disenroll from Anthem, the Provider should direct the Member to call the Customer Care Center at 1-866-408-6131. From there, the Member will be transferred to the state's enrollment broker phone number. The state's enrollment broker determines Membership eligibility, enrollment and disenrollment.

**Please Note:** Providers may not take retaliatory action against any Member for requesting transfer or disenrollment.

**Member-Initiated Disenrollment Process**

When Anthem’s Customer Care Center (CCC) receives a call from a Member who wants to disenroll, the CCC follows these steps:

1. The CCC representative attempts to find out the reason for the request.
2. If the situation is something that the CCC representative can address and resolve, the representative reminds the Member that he or she has the right to request disenrollment, but also
offers to resolve the issue. The representative then asks the Member if he or she wants to delay the disenrollment process pending resolution.

3. If a Member agrees to allow us to attempt resolution, **Anthem’s CCC** representative initiates the process that would properly address the situation.

4. If the Member declines, the CCC representative refers the Member to the Indiana's FSSA and provides the Member with the FSSA phone number.

5. The CCC representative informs the Member that the disenrollment process will take 15 to 45 days.
CHAPTER 13: GRIEVANCES & APPEALS

Overview
We encourage Anthem Providers and Members to seek resolution of issues through our Grievances & Appeals process. Grievances are tracked and trended, resolved within established time frames and referred to peer review when needed. Anthem’s Grievances & Appeals process meets all requirements of state law and accreditation agencies.

The building blocks of this process are the Grievance and the Appeal.

**Grievance:** Any expression of dissatisfaction to Anthem by a Provider or Member about any matter other than an Action or Adverse Determination.

**Appeal:** A formal request for Anthem to review an Action or Adverse Determination. Providers may file appeals on a member’s behalf, but do not have a separate distinct process. See Claims Disputes below.

An Action or Adverse Determination is defined as follows:

**Action/Adverse Determination:** A denial, modification or reduction of services based on eligibility, benefit coverage or medical necessity.

If a Provider or Member has a grievance, Anthem would like to hear from them, either by phone or in writing. Providers and Members have the right to file a grievance regarding any aspect of Anthem’s services.

Please Note: Anthem does not discriminate against Members or Providers for filing a grievance or an appeal. Providers are prohibited from penalizing a Member in any way for filing a grievance.

Provider Grievances & Appeals are classified into the following two categories:

- Provider Grievances relating to the operation of the Plan, including:
  - Benefit Interpretation
  - Claim Processing
  - Reimbursement
- Provider Appeals related to Actions/Adverse Determinations

Member Grievances can include, but are not limited to, the following:

- Access to health care services
- Care and treatment by a Provider
- Issues having to do with how we conduct business

Please Note: Anthem offers an Expedited Grievances & Appeals process for decisions involving urgently needed care. Both standard and expedited grievances and appeals are reviewed by a person who is not subordinate to the initial decision-maker.

Provider Grievances Relating to the Operation of the Plan

A Provider may be dissatisfied or concerned about another Provider, a Member, or an operational issue, including claims processing and reimbursement, If the Provider wants to file a Grievance, please use the Provider Grievance Form located in the Forms Library on the Providers Resources page at www.anthem.com. For directions on how to access the Provider Resources page of our website, please see Chapter 1: How to Access Information, Forms and Tools on Our Website.
Provider grievances must be submitted in writing and include the following:

- Provider’s name
- Date of the incident
- Description of the incident

The Grievance should be submitted to the following address:

ATTN: Appeals and Grievances Department  
Anthem Blue Cross and Blue Shield  
P.O. Box 6144  
Indianapolis, IN 46206-6144

Providers may also fax the grievance to 1-866-387-2968.

A Grievance may be filed up to 60-calendar days from the date the Provider became aware of the problem.

Anthem may request medical records or an explanation of the issues raised in the Grievance in the following ways:

- By telephone
- By fax, with a signed and dated letter
- By mail, with a signed and dated letter

The timelines for responding to the request for more information are as follows:

- **Standard Grievances or Appeals**: Providers must comply with the request for additional information within 10 days of the date that appears on the request.

- **Expedited Grievances or Appeals**: Providers must comply with the request for additional information within 24 hours of the date of our request.

Providers are notified in writing of the resolution, including their right of appeal, if any. Findings or decisions of peer review or quality of care issues are not disclosed.

**When to Expect Resolution for a Grievance or Appeal**

- **Provider Grievances**: Anthem sends a written resolution letter to the Provider within 20 business days of the receipt of the Grievance.

- **Provider Appeals**: Anthem sends a written resolution letter to the Provider within 20 business days of the receipt of the Appeal.

**Claims Disputes**

If a Provider does not agree with the outcome of a claim determination, a Claims Dispute is the process by which the decision may be challenged. If there is a full or partial claim rejection or the payment is not the amount expected, submit the claims dispute Provider Dispute /Resolution Request form located in the Forms Library on the Providers Resources page at: www.anthem.com. For directions on how to access the Providers Resources page of our website, please see Chapter 1: How to Access Information, Forms and Tools on Our Website.

This form must be received by Anthem within 60 days from the date on the Explanation of Benefits. Multiple claims for the same situation may be submitted on one form. Mail to:

ATTN: Appeals and Grievances Department  
Anthem Blue Cross and Blue Shield  
P.O. Box 6144
Indianapolis, IN 46206-6144

As an alternative, your Claims Dispute can be sent electronically at www.availity.com.

Claims Disputes Resolutions

Claims Disputes are resolved within 30 days of receipt of the written request. When we resolve a Claim Dispute regarding a previous claim disposition, a resolution letter with the details of our decision is sent to the Provider.

If a Provider is not satisfied with the outcome of the review process, there are additional steps that can be taken:

- Mediation (per the Anthem physician agreement)
- Arbitration (per the Anthem physician agreement)

If the above processes have been exhausted, the Provider may file a complaint with:

Indiana Family and Social Services Administration (FSSA)
402 W. Washington St.
Room W374, MS07
Indianapolis, IN 46204-2739

FSSA Phone: 1-317-233-4454

Member Grievances & Appeals

To help ensure that Members' rights are protected, all Anthem Members are entitled to a grievance and appeals process. The building blocks of this process are the Grievance, the Grievance Appeal (a request to review a grievance decision), and the Appeal:

- **Grievance:** Any expression of dissatisfaction by a Member to Anthem about any matter other than an Action or Adverse Determination.
- **Grievance Appeal:** A formal request for Anthem to review a grievance resolution.
- **Appeal:** A formal request for Anthem to review an Action or Adverse Determination.

Members: When to File

Members have the following periods of time to file:

- **Grievance:** Within 60 days of the date the Member became aware of the issue
- **Grievance Appeal:** Within 33 days of the date when the grievance was resolved
- **Appeal:** Within 33 days of the date on the notification letter of denial

Members: Grievances

If a Member wants to file a Grievance, he/she should fill out a Member Grievance Form or write a letter telling us about the problem. The Member Grievance Form is located in the Forms Library on the Providers Resources page at www.anthem.com. For directions on how to access the Provider Resources page of our website, please see Chapter 1: How to Access Information, Forms and Tools on Our Website.

Member grievance forms are also available at the places where Members receive their health care, such as their Primary Medical Provider’s office. When filing the grievance, the Member will need to tell us the following:

- **Who is part of the grievance**
• What happened
• When it happened
• Where it happened
• Why they were not happy with the health care services
• Attach documents that will help us look into the problem

The Grievance Form should be mailed to:

ATTN: Appeals and Grievances Department
Anthem Blue Cross and Blue Shield
P.O. Box 6144
Indianapolis, IN 46206-6144

Grievance Fax: 1-866-387-2968

If the Member cannot mail the form or letter, we will assist the Member by documenting a verbal request. Interpreter services, including sign language interpreters, are available to the Member throughout the grievance and appeals process, at no cost, by contacting the Customer Care Center.

Members: Grievance Appeals

If a Member is not satisfied by the response to a grievance, the Member may file a Grievance Appeal. The Member Grievance Form, which Members may request by calling the Customer Care Center at 1-866-408-6131, may be filed by fax or mail to the following address:

ATTN: Appeals and Grievances Department
Anthem Blue Cross and Blue Shield
P.O. Box 6144
Indianapolis, IN 46206-6144

Grievance Appeal FAX: 1-866-387-2968

After we receive the Member’s Grievance Form by fax or mail, we will send an acknowledgment letter within three business days from the date we receive it. If we receive a request for an Expedited Grievance Appeal, the Medical Director will review the request without delay to determine if the request involves an imminent and/or serious threat to the health of the Member, including, but not limited to, severe pain and potential loss of life, limb or major bodily function. This determination is made within one working day of the receipt of the expedited request.

If the request meets the criteria for an Expedited Grievance Appeal, we immediately acknowledge it by telephone, if possible. Expedited Grievance Appeals are resolved within 48 hours of receipt.

If the Medical Director determines a request involves medical care or treatment for which the application of the standard time period is appropriate the request will be handled and resolved in 45-calendar days. A Grievances & Appeals representative immediately notifies the Member by telephone, if possible, of the determination. In addition, a Grievances & Appeals associate provides the Member with a written notice of the denial to expedite the resolution within two calendar days of the receipt of the Grievance Appeal.

Members: Grievance Appeal Resolutions

Anthem will investigate the Member’s Grievance Appeal to develop a resolution. This investigation includes the following steps:

- Anthem will have the grievance reviewed by appropriate staff and, if necessary, the Medical Director.
- Anthem may request medical records or an explanation from the Provider(s) involved in the case.
Anthem will notify Providers of the need for additional information either by phone, mail or fax. Written correspondence to Providers will include a signed and dated letter.

Providers are expected to comply with requests for additional information within 10-calendar days.

Anthem will arrange a Grievance Appeal Panel meeting where the Member can communicate their concerns directly to the panel Members.

The Member will receive a Grievance Appeal Resolution Letter within 20 business days of the date we receive the Grievance Appeal request. The letter will:

- Describe their Grievance Appeal
- Tell them what will be done to solve the problem
- Tell them how to ask for a Medicaid Hearing or an External Independent Review
- Tell them how to contact the Hoosier Healthwise or Indiana Family Social Services Administration

Members Appeals

If the Member’s grievance is related to an Action or Adverse Determination, it is considered an Appeal.

**Action/Adverse Determination:** The denial or limited authorization of a requested service, including the type or level of service.

Actions/Adverse Determinations may include the following:

- Denial or limited authorization of a requested service, including the type or level of service
- The reduction, suspension or termination of a previously authorized service
- The denial, in whole or in part, of payment for service
- Failure to provide services in a timely manner, as defined by the State
- Failure of Anthem to act within required timeframes
- For a resident of a rural area with only one Contractor, the denial of a Member’s request to exercise his right, under 42 CFR 438.52(b)(2)(ii), to obtain services outside of the network (if applicable)

If a Member would like to file an Appeal with regard to how we solved their problem, they must notify us within 33-calendar days of the date on the Notification Letter of Denial. The request for an Appeal must be filed in writing following an oral request, unless the Member files and expedited appeal.

Please Note: Anthem will resolve any grievance or appeal, internal or external, at no cost to the Member.

Member Appeals are divided into two categories: Standard Appeals and Expedited Appeals.

**Standard Appeals:** The appropriate process when a Member or his/her representative requests that Anthem reconsider the denial of a service or payment for services, in whole or in part.

**Expedited Appeals:** The appropriate process when the amount of time necessary to participate in a standard appeal process could jeopardize the Member’s life, health or the ability to maintain or regain maximum function.

Members have the right to appeal Anthem’s denial of services or payment for services, in whole or in part. A denial of this type is called an Action or Adverse Determination. With the exception of expedited appeals, all oral appeals must be confirmed in writing and signed by the Member or his/her representative.

**Member Appeals: Response to Standard Appeals**
Once an oral or written appeal request is received, the case is taken under consideration and investigated by the Grievances & Appeals department. The Member, his/her representative and the Provider are all given the opportunity to submit written comments and documentation relevant to the appeal. **Anthem** may request medical records or a Provider explanation of the issues raised in the appeal in the following ways:

- By telephone
- By fax, with a signed and dated letter
- By mail, with a signed and dated letter

Providers are expected to comply with the request for additional information within 10-calendar days.

When the appeal is the result of a medical necessity determination, a health care professional who was not involved in the initial decision reviews the case. The health care professional contacts the Provider, if needed, to discuss possible alternatives.

**Member Appeals: Resolution of Standard Appeals**

Standard appeals are resolved within 20-business days of receipt of the initial written or oral request. Members are notified in writing of the appeal resolution within 5 days and their right to further appeal (if any).

**Member Appeals: Extensions**

The resolution time frame for an appeal not related to an ongoing hospitalization or emergency may be extended up to 10-business days if:

- The Member or his representative requests an extension
- **Anthem** shows that there is a need for additional information and that the delay is in the Member’s interest

**Member Appeals: Expedited**

If the amount of time necessary to participate in a standard appeal process could jeopardize the Member’s life, health or ability to attain, maintain or regain maximum function, the Member may request an Expedited Appeal.

**Anthem** will inform the Member of the time available for providing information and that limited time is available for expedited appeals. Members may request an expedited appeal by calling our Customer Care Center at 1-866-408-6131.

**Member Appeals: Timeline for an Expedited Appeal**

Members have the right to request an Expedited Appeal within 33-calendar days from the date on the initial Notice of Action letter. Expedited appeals are acknowledged by telephone, if possible, immediately. **Anthem** will follow up with an acknowledgement in writing.

If **Anthem** denies a request for an expedited appeal, **Anthem** must:

- Transfer the appeal to the time frame for standard resolution.
- Make a reasonable effort to give the Member prompt oral notice of the denial, and follow up within two-calendar days with a written notice.

**Member Appeals: Response to Expedited Appeals**
Anthem may request medical records or a Provider explanation of the issues raised in an expedited appeal by the following means:

- By Phone
- By Fax, with a signed and dated letter
- By Mail, with a signed and dated letter

Providers are expected to comply with the request for additional information within 24 hours.

**Member Appeals: Resolution of Expedited Appeals**

Anthem resolves expedited appeals as quickly as possible and **within 48 hours**. The Member is notified by telephone of the resolution, if possible.

**Member Appeals: Other Options for Filing Grievances**

After exhausting Anthem’s Grievances & Appeals process, if a Member is still dissatisfied with the decision, the Member has the right to request an External Independent Review (EIR) or file an appeal with the Indiana FSSA to request a State Fair Hearing.

**Member Appeals: External Independent Review**

The Member, the Member’s authorized representative, the Provider, or Provider on behalf of a Member may file a written request for an External Independent Review (EIR) through the Grievances & Appeals department within 120-calendar days after the Member is notified of Anthem’s resolution. The process is as follows:

- **Anthem** sends a letter acknowledging receipt of the request for the EIR within three-business days for a standard request and within 24 hours for an expedited request.
- **Anthem** selects an EIR agency from the list of organizations certified by the state of Indiana. All documents related to the Member’s appeal case are forwarded to the review agency.
- If at any time during the EIR process the Member submits information that was not considered during the utilization review or appeal determination processes, Anthem will reconsider its resolution. At this time the EIR agency will stop their review.
- **Anthem** will make a decision in this reconsideration process within 72 hours of receipt of the information for an expedited request and within 15-business days of the receipt of this information for a standard request.
- If the decision is adverse to the Member, the Member may request that the EIR agency resume their review.

The EIR agency must make a decision on an expedited request **within 72 hours** after the request is filed. For a standard request the agency must make a decision within 15 business days after the request is filed. The EIR agency notifies Anthem and the Member of their decision. Their decision is binding on Anthem.

**Member Appeals: State Fair Hearing**

Anthem Members may request a State Fair Hearing after they have exhausted all of Anthem’s internal appeal processes. The request must be filed within 33-calendar days of the initial action to be reviewed. The request must be submitted in writing to the State of Indiana:

**Indiana Family Social Services Administration**
**Hearings and Appeals Section, MS-04**
**402 W. Washington Street, Room W392**
Indianapolis, IN 46204-2773

Once the state receives the Member’s request, the process is as follows:

- The state sends a notice of the hearing request to Anthem.
- Upon receipt of the request, all documents related to the request and are forwarded to the state.
- The state notifies all parties of the date, time and place of the hearing. Representatives from our administrative, medical and legal departments may attend the hearing to present testimony and arguments. Our representatives may cross-examine the witnesses and offer rebutting evidence.
- An Administrative Law Judge renders a decision in the hearing within 90-business days of the date the hearing request was made.
- If the judge overturns Anthem’s position, we must adhere to the judge’s decision and ensure that it is carried out.

Confidentiality

All Grievances and Appeals are handled in a confidential manner and we do not discriminate against a Member for filing a grievance or requesting a State Fair Hearing. We also notify Members of the opportunity to receive information about our Grievances & Appeals process; they can request a translated version in a language other than English.

Discrimination

Members who contact us with an allegation of discrimination are immediately informed of the right to file a Grievance. This also occurs when one of our representatives working with a Member identifies a potential act of discrimination. The Member is advised to submit an oral or written account of the incident and is assisted in doing so, if he requests assistance.

We document, and track and trend all alleged acts of discrimination. A Grievances & Appeals associate will review and trend cultural and linguistic grievances in collaboration with a cultural and linguistic specialist.

Continuation of Benefits for Indiana Medicaid Members during Appeal

Hoosier Healthwise, Healthy Indiana Plan and Hoosier Care Connect Members may continue benefits while their Appeal is pending in accordance with federal regulations when all of the following criteria are met:

- Member or representative must request the Appeal within 10 days of our mail date of the adverse action notification, or prior to the effective date on the written notice if the initial notification was made by phone.
- The Appeal involves the termination, suspension, or reduction of a previously authorized course of treatment
- Services were ordered by an authorized Provider.
- The original period covered by the initial authorization has not expired.
- Member requests extension of benefits.

If the final resolution of the appeal is not in the member’s favor and upholds Anthem’s original decision, the member may be held liable for some of the costs of the services rendered while the appeal was pending. We will notify the member in advance that costs may be recovered.
CHAPTER 14: CREDENTIALING & REcredentialing

Hoosier Healthwise, Healthy Indiana Plan, Hoosier Care Connect

Credentialing Department Phone: 1-800-516-7587
Credentialing Department Fax: 1-888-470-6606
Hours of Operation: Monday to Friday, 7 a.m.-5 p.m.

Credentialing Scope

Anthem credentials the following health care practitioners: medical doctors, doctors of osteopathic medicine, doctors of podiatry, chiropractors, and optometrists providing health services covered under the Health Benefits Plan and doctors of dentistry providing health services covered under the Health Benefits Plan including oral maxillofacial surgeons.

Anthem also credentials behavioral health practitioners, including psychiatrists and physicians who are certified or trained in addiction psychiatry, child and adolescent psychiatry, and geriatric psychiatry; doctoral and clinical psychologists who are state licensed; master’s level clinical social workers who are state licensed; master’s level clinical nurse specialists or psychiatric nurse practitioners who are nationally and state certified and state licensed; and other behavioral health care specialists who are licensed, certified, or registered by the state to practice independently. In addition, medical therapists (e.g., physical therapists, speech therapists and occupational therapists) and other individual health care practitioners listed in the Anthem network directory will be credentialed.

Anthem credentials the following Health Delivery Organizations (HDOs): hospitals; home health agencies; skilled nursing facilities; (nursing homes); free-standing surgical centers; lithotripsy centers treating kidney stones and free-standing cardiac catheterization labs if applicable to certain regions; as well as behavioral health facilities providing mental health and/or substance abuse treatment in an inpatient, residential or ambulatory setting.

Credentials Committee

The decision to accept, retain, deny or terminate a practitioner’s participation in a network or plan program is conducted by a peer review body, known as Anthem Blue Cross and Blue Shield Credentials Committee (CC).

The CC will meet at least once every 45 days. The presence of a majority of voting CC Members constitutes a quorum. The chief medical officer, or a designee appointed in consultation with the vice president of Medical and Credentialing Policy, will chair the CC and serve as a voting Member (the Chair of the CC). The CC will include at least two participating practitioners, including one who practices in the specialty type that most frequently provides services to Anthem Covered Individuals and who falls within the scope of the credentialing program, having no other role in Anthem Network Management. The Chair of the CC may appoint additional Network practitioners of such specialty type, as deemed appropriate for the efficient functioning of the CC.

The CC will access various specialists for consultation, as needed to complete the review of a practitioner’s credentials. A committee Member will disclose and abstain from voting on a practitioner if the committee Member (i) believes there is a conflict of interest, such as direct economic competition with the practitioner; or (ii) feels his or her judgment might otherwise be compromised. A committee Member will also disclose if he or she has been professionally involved with the practitioner. Determinations to deny an applicant’s participation, or terminate a practitioner from participation in one or more Networks or Plan Programs, require a majority vote of the voting Members of the CC in attendance, the majority of whom are Network Providers.

During the credentialing process, all information that is obtained is highly confidential. All CC meeting minutes and practitioner files are stored in locked cabinets and can only be seen by appropriate
Credentialing staff, medical directors, and CC Members. Documents in these files may not be reproduced or distributed, except for confidential peer review and credentialing purposes.

Practitioners and HDOs are notified that they have the right to review information submitted to support their credentialing applications. In the event that credentialing information cannot be verified, or if there is a discrepancy in the credentialing information obtained, the Credentialing staff will contact the practitioner or HDO within 30-calendar days of the identification of the issue. This communication will specifically notify the practitioner or HDO of the right to correct erroneous information or provide additional details regarding the issue in question. This notification will also include the specific process for submission of this additional information, including where it should be sent. Depending on the nature of the issue in question, this communication may occur verbally or in writing. If the communication is verbal, written confirmation will be sent at a later date. All communication on the issue(s) in question, including copies of the correspondence or a detailed record of phone calls, will be clearly documented in the practitioner’s credentials file. The practitioner or HDO will be given no less than 14-calendar days in which to provide additional information.

Anthem may request and will accept additional information from the applicant to correct or explain incomplete, inaccurate, or conflicting credentialing information. The CC will review the information and rationale presented by the applicant to determine if a material omission has occurred or if other credentialing criteria are met.

Nondiscrimination Policy

Anthem will not discriminate against any applicant for participation in its Plan Programs or Networks on the basis of race, gender, color, creed, religion, national origin, ancestry, sexual orientation, age, veteran, or marital status or any unlawful basis not specifically mentioned herein. Additionally, Anthem will not discriminate against any applicant on the basis of the risk of population they serve or against those who specialize in the treatment of costly conditions. Other than gender and language capabilities that are provided to the Covered Individuals to meet their needs and preferences, this information is not required in the credentialing and recredentialing process. Determinations as to which practitioners/ HDOs require additional individual review by the CC are made according to predetermined criteria related to professional conduct and competence as outlined in Anthem Credentialing Program Standards. CC decisions are based on issues of professional conduct and competence as reported and verified through the credentialing process.

Initial Credentialing

Each practitioner or HDO must complete a standard application form when applying for initial participation in one or more Anthem Plan Programs or Networks. This application may be a state mandated form or a standard form created by or deemed acceptable by Anthem. For practitioners, the Council for Affordable Quality Healthcare (CAQH), a Universal Credentialing Data source is utilized. CAQH is building the first national provider credentialing database system, which is designed to eliminate the duplicate collection and updating of provider information for health plans, hospitals and practitioners. To learn more about CAQH, visit their web site at www.caqh.org.

Anthem will verify those elements related to an applicants’ legal authority to practice, relevant training, experience and competency from the primary source, where applicable, during the credentialing process. All verifications must be current and verified within the 180-calendar day period prior to the CC making its credentialing recommendation or as otherwise required by applicable accreditation standards.

During the credentialing process, Anthem will review verification of the credentialing data as described in the following tables unless otherwise required by regulatory or accrediting bodies. These tables represent minimum requirements.
A. Practitioners

<table>
<thead>
<tr>
<th>Verification Element</th>
</tr>
</thead>
<tbody>
<tr>
<td>License to practice in the state(s) in which the practitioner will be treating Covered Individuals.</td>
</tr>
<tr>
<td>Hospital admitting privileges at a TJC, NIAHO or AOA accredited hospital, or a Network hospital previously approved by the committee.</td>
</tr>
<tr>
<td>DEA, CDS and state controlled substance certificates</td>
</tr>
<tr>
<td>- The DEA/CDS must be valid in the state(s) in which practitioner will be treating Covered Individuals. Practitioners who see Members in more than one state must have a DEA/CDS for each state.</td>
</tr>
<tr>
<td>Malpractice insurance</td>
</tr>
<tr>
<td>Malpractice claims history</td>
</tr>
<tr>
<td>Board certification or highest level of medical training or education</td>
</tr>
<tr>
<td>Work history</td>
</tr>
<tr>
<td>State or Federal license sanctions or limitations</td>
</tr>
<tr>
<td>Medicare, Medicaid or FEHBP sanctions</td>
</tr>
<tr>
<td>National Practitioner Data Bank report</td>
</tr>
</tbody>
</table>

B. HDOs

<table>
<thead>
<tr>
<th>Verification Element</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accreditation, if applicable</td>
</tr>
<tr>
<td>License to practice, if applicable</td>
</tr>
<tr>
<td>Malpractice insurance</td>
</tr>
<tr>
<td>Medicare certification, if applicable</td>
</tr>
<tr>
<td>Department of Health Survey Results or recognized accrediting organization certification</td>
</tr>
<tr>
<td>License sanctions or limitations, if applicable</td>
</tr>
<tr>
<td>Medicare, Medicaid or FEHBP sanctions</td>
</tr>
</tbody>
</table>

**Recredentialing**

The recredentialing process incorporates reverification and the identification of changes in the practitioner’s or HDO’s licensure, sanctions, certification, health status and/or performance information (including, but not limited to, malpractice experience, hospital privilege or other actions) that may reflect on the practitioner’s or HDO’s professional conduct and competence. This information is reviewed in order to assess whether practitioners and HDOs continue to meet Anthem credentialing standards.

During the recredentialing process, Anthem will review verification of the credentialing data as described in the tables under Initial Credentialing unless otherwise required by regulatory or accrediting bodies. These tables represent minimum requirements.

All applicable practitioners and HDOs in the Network within the scope of Anthem Credentialing Program are required to be recredentialed every three years unless otherwise required by contract or state regulations.

**Health Delivery Organizations**

New HDO applicants will submit a standardized application to Anthem for review. If the candidate meets Anthem screening criteria, the credentialing process will commence. To assess whether participating
Anthem Network HDOs, within the scope of the Credentialing Program, meet appropriate standards of professional conduct and competence, they are subject to credentialing and recredentialing programs. In addition to the licensure and other eligibility criteria for HDOs, as described in detail in Anthem Credentialing Program Standards, all Network HDOs are required to maintain accreditation by an appropriate, recognized accrediting body or, in the absence of such accreditation, Anthem may evaluate the most recent site survey by Medicare or the appropriate state oversight agency performed within the past 36 months for that HDO.

Recredentialing of HDOs occur every three years unless otherwise required by regulatory or accrediting bodies. Each HDO applying for continuing participation in Anthem Programs or Networks must submit all required supporting documentation.

On request, HDOs will be provided with the status of their credentialing application. Anthem may request, and will accept, additional information from the HDO to correct incomplete, inaccurate, or conflicting credentialing information. The CC will review this information and the rationale behind it, as presented by the HDO, and determine if a material omission has occurred or if other credentialing criteria are met.

**Ongoing Sanction Monitoring**

To support certain credentialing standards between the recredentialing cycles, Anthem has established an ongoing monitoring program. Credentialing performs ongoing monitoring to help ensure continued compliance with credentialing standards and to assess for occurrences that may reflect issues of substandard professional conduct and competence. To achieve this, the credentialing department will review periodic listings/reports within 30-calendar days of the time they are made available from the various sources including, but not limited to, the following:

2. Federal Medicare/Medicaid Reports
3. **Office of Personnel Management (OPM)**
4. State licensing Boards/Agencies
5. Covered Individual/Customer Services Departments
6. Clinical Quality Management department (including data regarding complaints of both a clinical and non-clinical nature, reports of adverse clinical events and outcomes, and satisfaction data, as available)
7. Other internal Anthem departments
8. Any other verified information received from appropriate sources

When a practitioner or HDO within the scope of credentialing has been identified by these sources, criteria will be used to assess the appropriate response including but not limited to: review by the Chair of Anthem CC, review by the Anthem Medical Director, referral to the CC, or termination. Anthem credentialing departments will report providers to the appropriate authorities as required by law.

**Appeals Process**

Anthem has established policies for monitoring and recredentialing practitioners and HDOs who seek continued participation in one or more of Anthem’s Plan Programs or Networks. Information reviewed during this activity may indicate that the professional conduct and competence standards are no longer being met, and Anthem may wish to terminate practitioners or HDOs. Anthem also seeks to treat practitioners and HDOs and applying providers fairly, and thus provides practitioners and HDOs with a process to appeal determinations terminating participation in Anthem’s Networks for professional competence and conduct reasons, or which would otherwise result in a report to the National Practitioner
Data Bank (NPDB). Additionally, Anthem will permit practitioners and HDOs who have been refused initial participation the opportunity to correct any errors or omissions which may have led to such denial (informal/reconsideration only). It is the intent of Anthem to give practitioners and HDOs the opportunity to contest a termination of the practitioner’s or HDO’s participation in one or more of Anthem’s Plan Programs or Networks and those denials of request for initial participation which are reported to the NPDB that were based on professional competence and conduct considerations. Immediate terminations may be imposed due to the practitioner’s or HDO’s suspension or loss of licensure, criminal conviction, or Anthem’s determination that the practitioner’s or HDO’s continued participation poses an imminent risk of harm to covered individuals. A practitioner/HDO whose license has been suspended or revoked has no right to informal review/reconsideration or formal appeal.

**Reporting Requirements**

When Anthem takes a professional review action with respect to a practitioner’s or HDO’s participation in one or more Plan Programs or Networks, Anthem may have an obligation to report such to the NPDB and/or Healthcare Integrity and Protection Data Bank (HIPDB). Once Anthem receives a verification of the NPDB report, the verification report will be sent to the state licensing board. The credentialing staff will comply with all state and federal regulations in regard to the reporting of adverse determinations relating to professional conduct and competence. These reports will be made to the appropriate, legally designated agencies. In the event that the procedures set forth for reporting reportable adverse actions conflict with the process set forth in the current NPDB Guidebook and the HIPDB Guidebook, the process set forth in the NPDB Guidebook and the HIPDB Guidebook will govern.

**Anthem Credentialing Program Standards**

I. **Eligibility Criteria**

Health care practitioners:

- **Initial** applicants must meet the following criteria in order to be considered for participation:
  
  A. Possess a current, valid, unencumbered, unrestricted, and non-probationary license in the state(s) where he/she provides services to covered individuals

  C. Possess a current, valid, and unrestricted Drug Enforcement Agency (DEA) and/or Controlled Dangerous Substances (CDS) registration for prescribing controlled substances, if applicable to his/her specialty in which he/she will treat covered individuals; the DEA/CDS must be valid in the state(s) in which the practitioner will be treating covered individuals. Practitioners who see covered individuals in more than one state must have a DEA/CDS for each state

  D. Must not be currently debarred or excluded from participation in any of the following programs:
     - Medicare, Medicaid or FEHBP
     - For MDs, DOs, DPMs and oral & maxillofacial surgeons, the applicant must have current, in force board certification (as defined by the American Board of Medical Specialties (ABMS), American Osteopathic Association (AOA), Royal College of Physicians and Surgeons of Canada (RCPSC), College of Family Physicians of Canada (CFPC), American Board of Podiatric Surgery (ABPS), American Board of Podiatric Surgery or American Board of Oral and Maxillofacial Surgery (ABOMS) in the clinical discipline for which they are applying. Individuals will be granted five years after completion of their residency program to meet this requirement.
       1. As alternatives, MDs and DOs meeting any one of the following criteria will be viewed as meeting the education, training and certification requirement:
a. Previous board certification (as defined by one of the following: ABMS, AOA, RCPSC or CFPC) in the clinical specialty or subspecialty for which they are applying which has now expired AND a minimum of 10 consecutive years of clinical practice.

b. Training which met the requirements in place at the time it was completed in a specialty field prior to the availability of board certifications in that clinical specialty or subspecialty.

c. Specialized practice expertise as evidenced by publication in nationally accepted peer review literature and/or recognized as a leader in the science of their specialty AND a faculty appointment of Assistant Professor or higher at an academic medical center and teaching facility in Anthem Network AND the applicant’s professional activities are spent at that institution at least 50% of the time.

2. Practitioners meeting one of these three alternative criteria (a, b, c) will be viewed as meeting all Anthem education, training and certification criteria and will not be required to undergo additional review or individual presentation to the CC. These alternatives are subject to Anthem review and approval. Reports submitted by delegate to Anthem must contain sufficient documentation to support the above alternatives, as determined by Anthem.

E. For MDs and DOs, the applicant must have unrestricted hospital privileges at a The Joint Commission (TJC), National Integrated Accreditation for Healthcare Organizations (NIAHO) or an AOA accredited hospital, or a Network hospital previously approved by the committee. Some clinical disciplines may function exclusively in the outpatient setting, and the CC may at its discretion deem hospital privileges not relevant to these specialties. Also, the organization of an increasing number of physician practice settings in selected fields is such that individual physicians may practice solely in either an outpatient or an inpatient setting. The CC will evaluate applications from practitioners in such practices without regard to hospital privileges. The expectation of these physicians would be that there is an appropriate referral arrangement with a network/participating Provider to provide inpatient care.

II. Criteria for Selecting Practitioners

A. New Applicants (Credentialing)

1. Submission of a complete application and required attachments that must not contain intentional misrepresentations

2. Application attestation signed date within 180-calendar days of the date of submission to the CC for a vote

3. Primary source verifications within acceptable timeframes of the date of submission to the CC for a vote, as deemed by appropriate accrediting agencies

4. No evidence of potential material omission(s) on application

5. Current, valid, unrestricted license to practice in each state in which the practitioner would provide care to Covered Individuals

6. No current license action

7. No history of licensing board action in any state

8. No current federal sanction and no history of federal sanctions (per OIG and OPM report nor on NPDB report)

9. Possess a current, valid, and unrestricted DEA/CDS registration for prescribing controlled substances, if applicable to his/her specialty in which he/she will treat covered individuals. The
DEA/CDS must be valid in the state(s) in which the practitioner will be treating covered individuals. Practitioners who treat covered individuals in more than one state must have a valid DEA/CDS for each applicable state.

Initial applicants who have NO DEA/CDS certificate will be viewed as not meeting criteria and the credentialing process will not proceed. However, if the applicant can provide evidence that he has applied for a DEA the credentialing process may proceed if all of the following are met:

a. It can be verified that this application is pending
b. The applicant has made an arrangement for an alternative practitioner to prescribe controlled substances until the additional DEA certificate is obtained
c. The applicant agrees to notify Anthem upon receipt of the required DEA
d. Anthem will verify the appropriate DEA/CDS via standard sources
   i. The applicant agrees that failure to provide the appropriate DEA within a 90-day timeframe will result in termination from the Network.
   ii. Initial applicants who possess a DEA certificate in a state other than the state in which they will be treating covered individuals will be notified of the need to obtain the additional DEA. If the applicant has applied for additional DEA the credentialing process may proceed if ALL the following criteria are met:
      (a) It can be verified that this application is pending
      (b) The applicant has made an arrangement for an alternative practitioner to prescribe controlled substances until the additional DEA certificate is obtained
      (c) The applicant agrees to notify Anthem upon receipt of the required DEA
      (d) Anthem will verify the appropriate DEA/CDS via standard sources; applicant agrees that failure to provide the appropriate DEA within a 90-calendar day timeframe will result in termination from the Network
      (e) Must not be currently debarred or excluded from participation in any of the following programs: Medicare, Medicaid or FEHBP

10. No current hospital Membership or privilege restrictions and no history of hospital Membership or privileges restrictions

11. No history of or current use of illegal drugs or history of or current alcoholism

12. No impairment or other condition which would negatively impact the ability to perform the essential functions in their professional field

13. No gap in work history greater than six months in the past five years with the exception of those gaps related to parental leave or immigration where 12-month gaps will be acceptable. Other gaps in work history of six to 24 months will be reviewed by the Chair of the CC and may be presented to the CC if the gap raises concerns of future substandard professional conduct and competence. In the absence of this concern the Chair of the CC may approve work history gaps of up to two years.

14. No history of criminal/felony convictions or a plea of no contest

15. A minimum of the past 10 years of malpractice case history is reviewed

16. Meets Credentialing Standards for education/training for specialty(ies) in which practitioner wants to be listed in the Anthem Network directory as designated on the application. This
includes board certification requirements or alternative criteria for MDs and DOs and board certification criteria for DPMs and oral & maxillofacial surgeons

17. No involuntary terminations from an HMO or PPO

18. No "yes" answers to attestation/disclosure questions on the application form with the exception of the following
   a. investment or business interest in ancillary services, equipment or supplies
   b. voluntary resignation from a hospital or organization related to practice relocation or facility utilization
   c. voluntary surrender of state license related to relocation or nonuse of said license
   d. a NPDB report of a malpractice settlement or any report of a malpractice settlement that does not meet the threshold criteria
   e. non-renewal of malpractice coverage or change in malpractice carrier related to changes in the carrier’s business practices (no longer offering coverage in a state or no longer in business)
   f. previous failure of a certification exam by a practitioner who is currently board certified or who remains in the five year post residency training window
   g. actions taken by a hospital against a practitioner’s privileges related solely to the failure to complete medical records in a timely fashion
   h. history of a licensing board, hospital or other professional entity investigation that was closed without any action or sanction

Note: the CC will individually review any practitioner that does not meet one or more of the criteria required for initial applicants.

 Practitioners who meet all participation criteria for initial or continued participation and whose credentials have been satisfactorily verified by the Credentialing department may be approved by the Chair of the CC after review of the applicable credentialing or recredentialing information. This information may be in summary form and must include, at a minimum, practitioner’s name and specialty.

B. Currently Participating Applicants (Recredentialing)

1. Submission of complete recredentialing application and required attachments that must not contain intentional misrepresentations

2. Recredentialing application signed date within 180-calendar days of the date of submission to the CC for a vote

3. Primary source verifications within acceptable timeframes of the date of submission to the CC for a vote, as deemed by appropriate accrediting agencies

4. No evidence of potential material omission(s) on recredentialing application

5. Current, valid, unrestricted license to practice in each state in which the practitioner provides care to Covered Individuals

6. *No current license probation

7. *License is unencumbered

8. No new history of licensing board reprimand since prior credentialing review
9. *No current federal sanction and no new (since prior credentialing review) history of federal sanctions (per OIG and OPM Reports or on NPDB report)

10. Current DEA, CDS Certificate and/or state controlled substance certification without new (since prior credentialing review) history of or current restrictions

11. No current hospital Membership or privilege restrictions and no new (since prior credentialing review) history of hospital Membership or privilege restrictions; OR for practitioners in a specialty defined as requiring hospital privileges who practice solely in the outpatient setting there exists a defined referral relationship with a Network/Participating Provider of similar specialty at a Network hospital who provides inpatient care to Covered Individuals needing hospitalization

12. No new (since previous credentialing review) history of or current use of illegal drugs or alcoholism

13. No impairment or other condition which would negatively impact the ability to perform the essential functions in their professional field

14. No new (since previous credentialing review) history of criminal/felony convictions, including a plea of no contest

15. Malpractice case history reviewed since the last CC review. If no new cases are identified since last review, malpractice history will be reviewed as meeting criteria. If new malpractice history is present, then a minimum of last five years of malpractice history is evaluated and criteria consistent with initial credentialing is used

16. No new (since previous credentialing review) involuntary terminations from an HMO or PPO

17. No new (since previous credentialing review) "yes" answers on attestation/disclosure questions with exceptions of the following
   a. investment or business interest in ancillary services, equipment or supplies
   b. voluntary resignation from a hospital or organization related to practice relocation or facility utilization
   c. voluntary surrender of state license related to relocation or nonuse of said license
   d. an NPDB report of a malpractice settlement or any report of a malpractice settlement that does not meet the threshold criteria
   e. nonrenewal of malpractice coverage or change in malpractice carrier related to changes in the carrier’s business practices (no longer offering coverage in a state or no longer in business)
   f. previous failure of a certification exam by a practitioner who is currently board certified or who remains in the five year post residency training window
   g. Actions taken by a hospital against a practitioner’s privileges related solely to the failure to complete medical records in a timely fashion
   h. History of a licensing board, hospital or other professional entity investigation that was closed without any action or sanction

18. No QI data or other performance data including complaints above the set threshold

19. Recredentialed at least every three years to assess the practitioner’s continued compliance with Anthem standards
*It is expected that these findings will be discovered for currently credentialed Providers and Facilities through ongoing sanction monitoring. Providers and Facilities with such findings will be individually reviewed and considered by the CC at the time the findings are identified.

Note: the CC will individually review any credentialed Provider or Facility that does not meet one or more of the criteria for recredentialing.

C. Additional Participation Criteria and Exceptions for Behavioral Health practitioners (Non Physician) Credentialing.

1. **Licensed Clinical Social Workers (LCSW) or other master level social work license type:**
   a. Master or doctoral degree in social work with emphasis in clinical social work from a program accredited by the Council on Social Work Education (CSWE) or the Canadian Association on Social Work Education (CASWE).
   b. Program must have been accredited within three years of the time the practitioner graduated.
   c. Full accreditation is required, candidacy programs will not be considered.
   d. If master’s level degree does not meet criteria and practitioner obtained PhD training as a clinical psychologist, but is not licensed as such, the practitioner can be reviewed. To meet the criteria, the doctoral program must be accredited by the APA or be regionally accredited by the Council for Higher Education (CHEA). In addition, a doctor of social work from an institution with at least regional accreditation from the CHEA will be viewed as acceptable.

2. **Licensed professional counselor (LPC) and marriage and family therapist (MFT) or other master level license type:**
   a. Master’s or doctoral degree in counseling, marital and family therapy, psychology, counseling psychology, counseling with an emphasis in marriage, family and child counseling or an allied mental field. Master or doctoral degrees in education are acceptable with one of the fields of study above.
   b. Master or doctoral degrees in divinity do not meet criteria as a related field of study.
   c. Graduate school must be accredited by one of the Regional Institutional Accrediting Bodies and may be verified from the Accredited Institutions of Post-Secondary Education, APA, Council for Accreditation of Counseling and Related Educational Programs (CACREP), or Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE) listings. The institution must have been accredited within three years of the time the practitioner graduated.
   e. If master’s level degree does not meet criteria and practitioner obtained PhD training as a clinical psychologist, but is not licensed as such, the practitioner can be reviewed. To meet criteria this doctoral program must either be accredited by the APA or be regionally accredited by the CHEA. In addition, a doctoral degree in one of the fields of study noted above from an institution with at least regional accreditation from the CHEA will be viewed as acceptable.

3. **Clinical nurse specialist/psychiatric and mental health nurse practitioner:**
   a. Master’s degree in nursing with specialization in adult or child/adolescent psychiatric and mental health nursing. Graduate school must be accredited from an institution accredited by one of the Regional Institutional Accrediting Bodies within three years of the time of
Chapter 14: Credentialing & Re-Credentialing

Anthem Blue Cross and Blue Shield
Hoosier Healthwise, Healthy Indiana Plan and Hoosier Care Connect

the practitioner’s graduation.

b. Registered Nurse license and any additional licensure as an Advanced Practice Nurse/Certified Nurse Specialist/Adult Psychiatric Nursing or other license or certification as dictated by the appropriate State(s) Board of Registered Nursing, if applicable.

c. Certification by the American Nurses Association (ANA) in psychiatric nursing. This may be any of the following types: Clinical Nurse Specialist in Child or Adult Psychiatric Nursing, Psychiatric and Mental Health Nurse Practitioner or Family Psychiatric and Mental Health Nurse Practitioner.

d. Valid, current, unrestricted DEA Certificate, where applicable with appropriate supervision/consultation by a Provider as applicable by the state licensing board. For those who possess a DEA Certificate, the appropriate CDS Certificate is required. The DEA/CDS must be valid in the state(s) in which the practitioner will be treating covered individuals.

4. Clinical Psychologists:
   a. Valid state clinical psychologist license.
   b. Doctoral degree in clinical or counseling, psychology or other applicable field of study from an institution accredited by the APA within three years of the time of the practitioner’s graduation.
   c. Education/Training considered as eligible for an exception is a practitioner whose doctoral degree is not from an APA accredited institution but who is listed in the National Register of Health Service Providers in Psychology or is a Diplomat of the American Board of Professional Psychology.
   d. Master’s level therapists in good standing in the Network, who upgrade their license to clinical psychologist as a result of further training, will be allowed to continue in the Network and will not be subject to the above education criteria.

5. Clinical Neuropsychologist:
   a. Must meet all the criteria for a clinical psychologist listed in C.4 above and be Board certified by either the American Board of Professional Neuropsychology (ABPN) or American Board of Clinical Neuropsychology (ABCN).
   b. A practitioner credentialed by the National Register of Health Service Providers in Psychology with an area of expertise in neuropsychology may be considered.
   c. Clinical neuropsychologists who are neither board certified nor listed in the National Register will require CC review. These practitioners must have appropriate training and/or experience in neuropsychology as evidenced by one or more of the following:
      i. Transcript of applicable pre-doctoral training
      ii. Documentation of applicable formal one year post-doctoral training (participation in CEU training alone would not be considered adequate)
      iii. Letters from supervisors in clinical neuropsychology (including number of hours per week)
      iv. Minimum of five-years’ experience practicing neuropsychology at least 10 hours per week
III. HDO Eligibility Criteria

All HDOs must be accredited by an appropriate, recognized accrediting body or in the absence of such accreditation, Anthem may evaluate the most recent site survey by Medicare or the appropriate state oversight agency performed within the past 36 months. Nonaccredited HDOs are subject to individual review by the CC and will be considered for covered individual access need only when the CC review indicates compliance with Anthem standards and there are no deficiencies noted on the Medicare or state oversight review which would adversely affect quality or care or patient safety. HDOs are recredentialed at least every three years to assess the HDO’s continued compliance with Anthem standards.

A. General Criteria for HDOs:

1. Valid, current and unrestricted license to operate in the state(s) in which it will provide services to covered individuals. The license must be in good standing with no sanctions.
2. Valid and current Medicare certification.
3. Must not be currently debarred or excluded from participation in any of the following programs: Medicare, Medicaid or FEHBP.
4. Liability insurance acceptable to Anthem.
5. If not appropriately accredited, HDO must submit a copy of its CMS or state site survey for review by the CC to determine if Anthem’s quality and certification criteria standards have been met.

B. Additional Participation Criteria for HDO by Provider Type:

A. MEDICAL FACILITIES

<table>
<thead>
<tr>
<th>Facility Type (MEDICAL CARE)</th>
<th>Acceptable Accrediting Agencies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Care Hospital</td>
<td>TJC, HFAP, NIAHO, CIQH, CTEAM</td>
</tr>
<tr>
<td>Ambulatory Surgical Centers</td>
<td>TJC, HFAP, AAPSF, AAAHC, AAAASF, IMQ</td>
</tr>
<tr>
<td>Free Standing Cardiac Catheterization Facilities</td>
<td>TJC, HFAP (may be covered under parent institution)</td>
</tr>
<tr>
<td>Lithotripsy Centers (Kidney stones)</td>
<td>TJC</td>
</tr>
<tr>
<td>Home Health Care Agencies</td>
<td>TJC, CHAP, ACHC, CTEAM</td>
</tr>
<tr>
<td>Skilled Nursing Facilities</td>
<td>TJC, CARF, BOC Int’l</td>
</tr>
<tr>
<td>Nursing Homes</td>
<td>TJC, BOC Int’l</td>
</tr>
</tbody>
</table>

B. BEHAVIORAL HEALTH

<table>
<thead>
<tr>
<th>Facility Type (BEHAVIORAL HEALTH CARE)</th>
<th>Accreditors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Care Hospital—Psychiatric Disorders</td>
<td>TJC, HFAP, NIAHO, CTEAM</td>
</tr>
<tr>
<td>Residential Care—Psychiatric Disorders</td>
<td>TJC, HFAP, NIAHO CARF, COA</td>
</tr>
<tr>
<td>Partial Hospitalization/Day Treatment—</td>
<td>TJC, HFAP, NIAHO CARF for programs</td>
</tr>
<tr>
<td>Service Type</td>
<td>Accreditation/Standards Description</td>
</tr>
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<td>-------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Psychiatric Disorders</td>
<td>associated with an acute care facility or Residential Treatment Facilities.</td>
</tr>
<tr>
<td>Intensive Structured Outpatient Program—Psychiatric Disorders</td>
<td>TJC, HFAP NIAHO, COA, for programs affiliated with an acute care hospital or health care organization that provides psychiatric services to adults or adolescents. CARF if program is a residential treatment center providing psychiatric services</td>
</tr>
<tr>
<td>Acute Inpatient Hospital—Chemical Dependency/Detoxification and Rehabilitation</td>
<td>TJC, HFAP, NIAHO</td>
</tr>
<tr>
<td>Acute Inpatient Hospital—Detoxification Only Facilities</td>
<td>TJC, HFAP, NIAHO</td>
</tr>
<tr>
<td>Residential Care—Chemical Dependency</td>
<td>TJC, HFAP, NIAHO, CARF, COA</td>
</tr>
<tr>
<td>Partial Hospitalization/Day Treatment—Chemical Dependency</td>
<td>TJC, NIAHO, for programs affiliated with a hospital or health care organization that provides drug abuse and/or alcoholism treatment services to adults or adolescents; CHAMPUS or CARF for programs affiliated with a residential treatment center that provides drug abuse and/or alcoholism treatment services to adults or adolescents</td>
</tr>
<tr>
<td>Intensive Structured Outpatient Program—Chemical Dependency</td>
<td>TJC, NIAHO, COA for programs affiliated with a hospital or health care organization that provides drug abuse and/or alcoholism treatment services to adults or adolescents; CARF for programs affiliated with a residential treatment center that provides drug abuse and/or alcoholism treatment services to adults or adolescents.</td>
</tr>
</tbody>
</table>
CHAPTER 15: ACCESS STANDARDS & ACCESS TO CARE

Overview

This chapter outlines Anthem’s standards for timely and appropriate access to quality health care. Following guidelines set by the National Committee for Quality Assurance (NCQA), the American College of Obstetricians and Gynecologists (ACOG), and the Indiana Family and Social Services Administration (FSSA), these standards help ensure that medical appointments, emergency services and continuity of care for new and transferring Members are provided fairly, reasonably, and within specific time frames.

We recognize that there can be cultural and linguistic barriers that affect our Members’ ability to understand or comply with certain instructions or procedures. In order to break through those barriers, we encourage Providers to review Anthem’s Caring for Diverse Populations Toolkit which can be found under the Health Education heading on the Provider Resources page at www.anthem.com.

Anthem monitors Provider compliance with access to care standards on a regular basis. Failure to comply may result in corrective action.

Medical Appointment Standards: General Appointment Scheduling

Primary Medical Providers and Specialists must make appointments for Members from the time of request as follows:

<table>
<thead>
<tr>
<th>Nature of Visit</th>
<th>Appointment Standards</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Examinations</td>
<td>Immediate Access During Office Hours</td>
</tr>
<tr>
<td>Urgent Examinations</td>
<td>Within 24 Hours of Request</td>
</tr>
<tr>
<td>Non-Urgent &quot;sick visits&quot;</td>
<td>Within 72 Hours of Request</td>
</tr>
<tr>
<td>Non-Urgent routine exams*</td>
<td>Within 21 days of Member’s request</td>
</tr>
<tr>
<td>Specialty Care Examinations</td>
<td>Within 3 Weeks of Request</td>
</tr>
<tr>
<td>Outpatient Behavioral Health Examinations</td>
<td>Within 14 Days of Request</td>
</tr>
<tr>
<td>Routine Behavioral Health Visits</td>
<td>Within 10 Days of Request</td>
</tr>
<tr>
<td>Outpatient Treatment</td>
<td>Within 7 Days of Discharge</td>
</tr>
<tr>
<td>Post-Psychiatric Inpatient Care</td>
<td>Within 7 Days of Discharge</td>
</tr>
</tbody>
</table>

*Exceptions are permitted for routine cases, other than clinical preventive services, when Primary Medical Provider capacity is temporarily limited.

Medical Appointment Standards: Services for Members under the Age of 21

Anthem strongly recommends that Primary Medical Providers perform an Initial Health Assessment (IHA) and Preventive Care assessment with new Members.

Please Note: An IHA is not needed if the Member is an existing patient of the Primary Medical Provider group (but new to Anthem). In addition, follow-up is not needed if there is an established medical record that shows baseline health status. This record should include sufficient information for the Primary Medical Provider to understand the Member’s health history and to provide treatment recommendations as needed. Transferred medical records meet the recommendations for an IHA if a completed health history is included.
### Nature of Visit | Appointment Standards
---|---
**Initial Health Assessments**
Newborns: Within 14 Days of Enrollment  
Children: Within 60 Days of Enrollment  
Adults (18-21): Within 8 Weeks of Enrollment  
**Preventive Care Visits**
According to the American Academy of Pediatrics (AAP) Periodicity Schedule found within the Preventive Health Guidelines (PHG)

**Medical Appointment Standards: Services for Members 21 Years and Older**

### Nature of Visit | Appointment Standards
---|---
**Initial Health Assessments**
Within 90 Days of Enrollment  
**Preventive Care Visits**
According to the American Academy of Pediatrics (AAP) Periodicity Schedule found within the Preventive Health Guidelines (PHG)

**Medical Appointment Standards: Prenatal and Postpartum Visits**

### Nature of Visit | Appointment Standards
---|---
**First Trimester**
Within 14 Days of Request  
**Second Trimester**
Within 7 Days of Request  
**Third Trimester**
Within 3 Business Days of Request or Immediately if an Emergency  
**High-Risk Pregnancy**
Within 3 Business Days of Request or Immediately if an Emergency  
**Postpartum Exam**
Between 3-8 Weeks After Delivery

**Medical Appointment Standards: Missed Appointment Tracking**

When Members miss appointments, Providers must do the following:

- Document the missed appointment in the Member’s medical record.
- Make at least three attempts to contact the Member to determine the reason for the missed appointment.
- Provide a reason in the Member’s medical record for any delays in performing an examination, including any refusals by the Member.

**After-Hours Services**

Our Members have access to quality health care 24 hours a day, 7 days a week. That means Primary Medical Providers must have a system in place to ensure that Members can call after hours with medical questions or concerns. **Anthem** monitors Primary Medical Provider compliance with after-hours access standards on a regular basis. Failure to comply may result in corrective action.

Primary Medical Providers must adhere to the following after-hours protocols:
Answering service or after-hours personnel must:

- Forward Member calls directly to the Primary Medical Provider or on-call Provider or instruct the Member that the Provider will contact the Member **within 30 minutes**.
- Ask the Member if the call is an emergency. In the event of an emergency, they must immediately direct the Member to **Dial 911** or proceed directly to the nearest hospital emergency room.
- Have the ability to contact a telephone interpreter for Members with language barriers.
- Return all calls.

Members can also call the **24/7 NurseLine** information phone line to speak to a registered nurse. Nurses provide health information and options for accessing care, including emergency services, if appropriate.

**Answering machine messages:**

- May be used in the event that staff or an answering service is not immediately available.
- Must instruct Members with emergency health care needs to **Dial 911** or proceed directly to the nearest hospital emergency room.
- Must provide instructions on how to contact the Primary Medical Provider or on-call Provider in a non-emergency situation.
- Must provide instructions in English, Spanish and any other language appropriate to the Primary Medical Provider’s practice.

**Please Note:** **Anthem** prefers that Primary Medical Providers use an **Anthem**-contracted, in-network Provider for on-call services. When that is not possible, the Primary Medical Provider must use his or her best efforts to help ensure that the on-call Provider abides by the terms of the **Anthem** Provider contract.

**Continuity of Care**

**Anthem** provides continuity of care for Members with **qualifying conditions** when health care services are not available within the network or when the Member or Provider is in a state of transition.

**Qualifying Condition:** A medical condition that may qualify a Member for continued access to care and continuity of care. These conditions include, but are not limited to:

- Acute conditions (cancer, for example)
- Degenerative and disabling conditions, including conditions or diseases caused by a congenital or acquired injury or illness that require a specialized rehabilitation program or a high level of service, resources or coordination of care in the community
- Newborns, who are covered retroactive to the date of birth
- Organ transplant or tissue replacement
- Pregnancy, with 12 weeks or less remaining before the expected delivery date, through immediate postpartum care
- Scheduled inpatient/outpatient surgery that has been prior approved and/or pre-certified through the applicable Indiana **Family and Social Services Administration** (FSSA) process
- Serious chronic conditions (hemophilia, for example)
- Terminal illness

**States of transition may be any one of the following:**

- The Member is newly enrolled
- The Member is moving out of the service area
- The Member is disenrolling from **Anthem** to another health plan
• The Member is exiting Hoosier Healthwise, Healthy Indiana Plan or Hoosier Care Connect to receive excluded services
• The Member is hospitalized on the effective date of transition
• The Member is transitioning through behavioral health services
• The Member is undergoing the Indiana Preadmission Screening/Resident Review Screening for long-term care placement
• The Member has appointments within the first month of Plan Membership with specialty Providers that were scheduled prior to the effective date of Membership
• The Provider’s contract terminates

Anthem Providers help ensure continuity and coordination of care through collaboration. This includes the confidential exchange of information between Primary Medical Providers and Specialists as well as behavioral health Providers. In addition, Anthem helps coordinate care when the Provider's contract has been discontinued to help with a smooth transition to a new Provider.

Providers must maintain accurate and timely documentation in the Member’s medical record including, but not limited to:

• Consultations
• Prior Authorizations
• Referrals to Specialists
• Treatment Plans

All Providers share responsibility in communicating clinical findings, treatment plans, prognosis and the Member’s psychosocial condition as part of the coordination process. Care management nurses review Member and Provider requests for continuity of care. These nurses facilitate continuation with the current Provider until a short-term regimen of care is completed or the Member transitions to a new practitioner.

Adverse determination decisions are sent in writing to the Member and Provider within two-business days of the decision. Members and Providers can appeal the decision by following the procedures in the Member Grievances and Appeals chapter in this manual. Reasons for continuity of care denials include, but are not limited to the following:

• Course of treatment is complete
• Member is ineligible for coverage
• Not a qualifying condition
• Request is for change of Primary Medical Provider only and not for continued access to care
• Requested services are not a covered benefit
• Services rendered are covered under a global fee
• Treating Provider is currently contracted with our network

Please Note: Anthem does not impose any pre-existing condition limitations on its Medicaid Members, nor require evidence of insurability to provide coverage to any Anthem Member.

Provider Contract Termination

Anthem will arrange for continuity of care for Members affected by a Provider whose contract is terminated. A terminated Provider who is actively treating Members must continue to treat Members until the Provider's date of termination. Primary Medical Providers must give at least 90-days advance notice and Specialists must give at least 120-days advance notice to Anthem before terminating the agreement unless the Primary Medical Provider or the group of Primary Medical Providers provides 30% or more of
Anthem’s services. In that case, the Primary Medical Provider must give at least 120-days advance notice.

Once Anthem receives a provider’s notice to terminate a contract, Anthem will make its best effort to notify all impacted Members. A letter will be sent at least 15 days in advance to inform the affected Members of:

- The impending termination of their Provider
- Their right to request continued access to care
- The Customer Care Center telephone number to make Primary Medical Provider changes and/or forward referrals to Case Management for continued access to care consideration

Members under the care of Specialists may also submit requests for continued access to care, including continued care after the transition period. Members should contact the Customer Care Center at 1-866-408-6131.
Newly Enrolled

Our goal is to ensure that the health care of our newly enrolled Members is not disrupted or interrupted. **Anthem** ensures continuity in the care of our newly enrolled Members when:

- The Member’s health or behavioral health condition has been treated by Specialists.
- The Member’s health could be placed in jeopardy if medically necessary covered services are disrupted or interrupted.

**Anthem** will pay a newly enrolled Member’s existing out-of-network Provider for medically necessary covered services until that regimen of care is completed. The Member’s records, clinical information and care can then be transferred to an **Anthem** Provider.

Payment to out-of-network Providers is made within the same time period required for those within the network. In addition, we will comply with out-of-network Provider reimbursement rules as adopted by the FSSA. However, we are not obligated to reimburse the Member’s existing out-of-network Providers for on-going care under the following conditions:

- More than 90 days after the Member enrolls in **Anthem**
- More than nine months in the case of a Member who, at the time of enrollment in our plan, was diagnosed with and receiving treatment for a terminal illness and remains enrolled in our health care plan

All new enrollees receive **Evidence of Coverage** (EOC) Membership information in their enrollment packets. This also provides information regarding Members’ rights to request continuity of care.

Newly Enrolled - Pregnant

Pregnancy services are covered by **HIP Maternity, Hoosier Healthwise and Hoosier Care Connect**. Women who are pregnant at the time of application are enrolled in Hoosier Healthwise. If a woman becomes pregnant while enrolled in the HIP, she will have the choice to continue in HIP or to move to HIP Maternity. Pregnant Members have no-cost sharing responsibilities. This means they don’t pay **POWER** Account contributions or copayments if they remain in HIP during their pregnancy.

When a pregnant **Anthem** HIP Member transfers to **Anthem** Hoosier Healthwise, they may continue with their same **Anthem** provider even if the provider isn’t enrolled in **Anthem**’s Hoosier Healthwise network.


POWER Account Contributions and Change Information

State subsidies make it possible for **Healthy Indiana Plan** Members to have health insurance by requiring minimal monthly contributions, based on income. These monthly contributions go into what is known as the Member’s **POWER Account**. Combined with contributions from the state, the federal government and the Member’s employer, if applicable, **POWER Account** money is used to pay for health services until the Member’s yearly deductible is met.

**HIP Plus Plan** Members are required to make a contribution to their **POWER Account** every month. HIP Plus Members who become more than 60-days delinquent, are moved from the HIP Plus Plan to HIP Basic Plan. If the Member’s income is over 100% of the Federal Poverty level, they will be termed from the Healthy Indiana Plan and must wait 6 months to reapply. Members who have income at or below 100% of the FPL will be moved to the HIP Basic Plan. The HIP Basic Plan does not require monthly contribution payments, but Members must pay copayments for most services.

Members Moving Out of Service Area
If a Member moves out of the service area, **Anthem** will continue to provide services and pay out-of-network Providers until the end of the month in which **Anthem** has received payment from the State for the Member.

**Services Not Available Within Network**

**Anthem** will provide Members with timely and adequate access to out-of-network services for as long as those services are necessary and not available within the network. However, **Anthem** is not obligated to provide Members with access to out-of-network services if such services become available from a network Provider.

When a Provider refers a Member for additional treatment or services, the referring Provider must forward their NPI to the Provider being referred to. **Anthem** has streamlined this process by providing a **Record of Referral to Specialty Care** form, which is located the **Forms Library** on the **Providers Resources** page at [www.anthem.com](http://www.anthem.com). For directions on how to access the **Provider Resources** page of our website, please see **Chapter 1: How to Access Information, Forms and Tools on Our Website**.

The referring Primary Medical Provider and the Specialist should follow these steps:

- The Primary Medical Provider should fax the form to the Specialist to ensure that the Specialist has the Primary Medical Provider's NPI.
- If the referring Primary Medical Provider’s NPI number is not provided, the Specialist will be responsible for contacting the Primary Medical Provider’s office to obtain it.
- The Member must be made aware that the Provider they are being referred to is in-network or out-of-network.

**Please Note:** Referrals are valid for as long as the Member is under the care of the Specialist.

**Second Opinions**

**Anthem** will help ensure that Members have access to a second opinion regarding any medically necessary covered service. Members will be allowed access to a second opinion from a network Provider, or, if a network Provider is not available, from an out-of-network Provider. This service is provided at no cost to the Member.

**Emergency Transportation**

**Anthem** covers emergency transportation services without **Prior Authorization**. When a Member’s condition is life-threatening and requires use of special equipment, life support systems and close monitoring by trained attendants while en route to the nearest appropriate facility, we will provide emergency transport by ambulance.

Examples of conditions considered for emergency transport include, but are not limited to:

- Acute and severe illnesses
- Acute or severe injuries from auto accidents
- Extensive burns
- Loss of consciousness
- Semi-consciousness, having a seizure or receiving cardiopulmonary resuscitation (CPR) treatment during transport
- Untreated fractures

Emergency transportation also is available for facility-to-facility transfers when the required emergency treatment is not available at the first facility.
Nonemergency Transportation

Nonemergency transportation is a covered service for Hoosier Healthwise, Hoosier Care Connect and HIP Members who are pregnant or who have State Plan Benefits. As an added value, Anthem provides nonemergent transportation to Members in HIP Basic and HIP Plus Plans. Limited nonemergency transportation will be provided by a certified ambulance, taxi or other certified transportation providers.

- Members are entitled to unlimited trips to any covered health care, behavioral health, dental and vision appointment
- **Anthem** also provides a value added benefit health education, Women, Infant and Children (WIC) or OMPP Hoosier Healthwise redetermination appointment.
- **Anthem** also provides a value added benefit as transportation to
  - pharmacies as a stop to fill a prescription when returning from a medical appointment
  - health education
  - Women, Infant and Children (WIC)
  - Medicaid redetermination appointment
- Members must schedule an appointment with LCP at 48 hours in advance.
- Prior approval is required, in the event of an urgent transportation need.
- Emergency transport to get medical care and treatment in a true emergency

Pregnant HIP Members, HIP Members with State Plan Benefits, and **Anthem** Members enrolled in Hoosier Healthwise or Hoosier Care Connect are allowed an unlimited numbers of trips. Members enrolled in **Anthem** HIP Basic and HIP Plus Plans are limited to 20-one-way trips, up to 50 miles per trip, in a rolling 12-month period.

Dental Services – Adults & Children

Hoosier Healthwise Members receive dental service through the State’s Fee-for-Service dental network. HIP Plus Members, HIP pregnant Members, HIP Members with State Plan Benefits, and Hoosier Care Connect Members receive dental benefits from **Anthem**’s subcontractor, DentaQuest.

Accident Related Dental Services:

When a Member has a dental-related accident and requires repair of an injury to the jaw, sound natural teeth, mouth or face, **Anthem** covers the initial dental work and oral surgery, including anesthesia and drugs, for services provided in the following settings:

- Outpatient
- Doctor’s office
- Emergency care
- Urgent care

The services are limited to the care needed to give proper treatment. Injury as a result of chewing or biting is not considered an accidental injury. Initial dental work refers to services provided within 48 hours of the injury, or as soon as possible. Covered services include all exams and treatment to complete the repair, such as:

- Anesthesia
- Lab tests
- Mandibular/Maxillary reconstruction
- Oral exams
- Oral surgery
- Prosthetic services
- Restorations
- X-Rays
CHAPTER 16: PROVIDER ROLES & RESPONSIBILITIES

Overview

At Anthem, our goal is to provide quality health care to the right Member, at the right time, in the appropriate setting.

To achieve this goal, Primary Medical Providers, Specialists and Ancillary Providers must fulfill their roles and responsibilities with the highest integrity. We lean on their extensive health care education and experience and rely on their dedication to our Members who, in turn, look to them to get well and stay well.

Primary Medical Providers

Anthem’s Primary Medical Providers are the principle point of contact for our Members. Their role is to provide Members with a medical “home,” their first stop in the health care process and a centralized hub for a wide variety of ongoing health care needs. Anthem furnishes each Primary Medical Provider with a current list of enrolled Members assigned to that Primary Medical Provider.

The Primary Medical Provider’s role is to:

- Pull Member panel roster off Availity
- Coordinate a Member’s health care, 24 hours a day, 7 days a week
- Integrate physical and behavioral healthcare for their patients.
- Develop the Member’s care and treatment plan, including preventive care
- Maintain the Member’s current medical record, including documentation of all services provided by the Primary Medical Provider and any specialty or referral services
- Adhere to wait times, as outlined within the Provider contract and Provider Manual
- Refer Members for specialty care
- Coordinate with physical and behavioral services
- Provide complete information about proposed treatments and prognosis for recovery to our Members or their representatives
- Facilitate interpreter services by presenting information in a language that our Members or their representatives can understand
- Ensure that Members' medical and personal information is kept confidential as required by state and federal laws

Anthem Providers are encouraged to engage and direct development and provide feedback to our Members’ care plans.

Hoosier Care Connect Members who would benefit from case management services, but either actively choose not to participate or are unable to participate, may be managed through a provider focused program.

Providers who serve Hoosier Care Connect Members engaged in care management shall participate in semiannual care conferences with an interdisciplinary care team. The goal is to coordinate services for Hoosier Care Connect Members across the care continuum. Providers may bill for the semiannual conference using HCPCS code 99211 SC.

The Primary Medical Provider’s scope of responsibilities includes providing or arranging for:

- Routine and preventive health care services
• Emergency care services
• Hospital services
• Ancillary services
• Specialty referrals
• Interpreter services
• Coordination with outpatient clinical services, such as therapeutic, rehabilitative or palliative services

Please note: Services should always be provided without regard to race, religion, sex, color, national origin, age, or physical/behavioral health status.

Anthem Members select a contracted Primary Medical Provider as their primary Provider of health care services within the first 30-calendar days of the Member’s effective date of enrollment. If, after 30-calendar days, the Member has not selected a Primary Medical Provider, Anthem will assign a Primary Medical Provider to the Member.

We keep Providers up-to-date with detailed Member information. Anthem furnishes each Primary Medical Provider with a current list of assigned Members and, from time to time, provides medical information about the Members’ potential health care needs. That way, Providers can more effectively provide care and coordinate services.

Primary Medical Providers See Only Assigned Members

Please remember that when seeing Anthem Members enrolled in Hoosier Healthwise, Healthy Indiana Plan or Hoosier Care Connect, you should provide service only to those Members who have chosen you as their Primary Medical Provider. You can confirm that a Member is assigned to you by:

- Calling the Anthem Medicaid Provider Helpline at 1-866-408-6132 or the Anthem Provider Helpline at 1-800-345-4344.
- Use the Interactive Voice Response (IVR) system to verify Primary Medical Provider assignment
- Speak to a customer service representative
- Log into MyAnthem, located at www.anthem.com to see monthly Primary Medical Provider rosters.

You may experience delays in claims payments if you treat Members who are not assigned to you on the date of service. If it is necessary to provide services to an Anthem Member not assigned to you, it is important to get authorization before providing services. If you are a noncontracted Provider, you will need to obtain prior authorization before providing services to our Members.

Referrals

Primary Medical Providers coordinate and make referrals to Specialists, Ancillary Providers and community services. Providers should refer Members to network facilities and Providers. When this is not possible, Providers should follow the appropriate process for requesting out-of-network referrals.

Please Note: Specialty referrals to network Providers do not require prior authorization.

All Primary Medical Providers:

- Are expected to help Members schedule appointments with other health care Providers, including Specialists.
- Are expected to track and document appointments, clinical findings, treatment plans and care received by Members referred to Specialists or other health care Providers to ensure continuity of care.
Are expected to refer Members to health education programs and community resource agencies, when appropriate.

Must coordinate with the Woman, Infants and Children (WIC) program to provide medical information necessary for WIC eligibility determinations, such as height, weight, hematocrit or hemoglobin.

Coordinate with the local tuberculosis (TB) control program to ensure that all Members with confirmed or suspected TB have a contact investigation and receive Directly Observed Therapy (DOT).

Report to the Indiana Family and Social Services Administration (FSSA) or the local TB control program any Member who is noncompliant, drug resistant or who is or may be posing a public health threat.

Are responsible for screening and evaluation procedures for detection and treatment of, or referral for, any known or suspected behavioral health problems and disorders.

Out-Of-Network Referrals

We recognize that there may be instances when an out-of-network referral is justified. Anthem’s Care Management (UM) team will work with the Primary Medical Provider to determine medical necessity; after that, out-of-network referrals will be authorized on a limited basis. The UM department may be contacted at:

**Hoosier Healthwise:** 1-866-408-7187 (Monday to Friday, 8 a.m.-5 p.m.)
**Healthy Indiana Plan:** 1-866-398-1922 (Monday to Friday, 8:30 a.m.-5 p.m.)
**Hoosier Care Connect:** 1-866-408-7187 (Monday to Friday, 8 a.m.-5 p.m.)

Interpreter Services

Providers must notify Members of the availability of interpreter services and strongly discourage the use of friends and family Members, especially children, acting as interpreters. Multi-lingual staff should self-assess their non-English language speaking and understanding skills prior to interpreting on the job. You can find the current recommended employee language skills self-assessment tool on the Forms Library on the Providers Resources page at www.anthem.com. For directions on how to access the Provider Resources page of our website, please see Chapter 1: How to Access Information, Forms and Tools on Our Website.

For those instances when you cannot communicate with a Member due to language barriers, interpreter services are available at no cost to you or the Member. Face-to-face interpreters for Members needing language assistance, including American Sign Language, are available by placing a request at least 72 hours in advance. A 24-hour cancellation notice is required.

To request interpreter services, Providers and Members should call:

**Anthem Medicaid Provider Helpline:** 1-866-408-6132
**Customer Care Center (Members):** 1-866-408-6131

Providers can also email their request for a face to face interpreter by using the address in the Interpreter Services section of the Provider Resources portal.

Initial Health Assessment

Primary Medical Providers should review their monthly eligibility list provided by Anthem and proactively contact their assigned Members to make an appointment for an Initial Health Assessment (IHA). These appointments should occur within the following time frames:
Newborns: Within 14 Days of Enrollment
Children: Within 60 Days of Enrollment
Adults (18-21): Within 8 Weeks of Enrollment

The Primary Medical Provider’s office is responsible for making and documenting all attempts to contact assigned Members. Members’ medical records must reflect the reason for any delays in performing the IHA, including any refusals by the Member to have the exam.

Transitioning Members between Facilities or Back Home
Primary Medical Providers initiate or help with the discharge or transfer of:

- Members at an inpatient facility to the appropriate level of care facility (including skilled nursing or rehabilitation facility) when medically indicated, or home
- Members who are hospitalized in an out-of-network facility to an in-network facility, or to home with home health care assistance (within benefit limits) when medically indicated

The coordination of Member transfers from non-contracted out-of-network facilities to contracted in-network facilities is a priority that may require the immediate attention of the Primary Medical Provider. Contact Anthem’s Care Management to assist in this process:

**Hoosier Healthwise:** 1-866-408-7187 (Monday to Friday, 8 a.m.-5 p.m.)
**Healthy Indiana Plan:** 1-866-398-1922 (Monday to Friday, 8:30 a.m.-5 p.m.)
**Hoosier Care Connect:** 1-866-408-7187 (Monday to Friday, 8 a.m.-5 p.m.)

**HIP Medically Frail**
HIP Members with complex medical or behavioral health conditions, called ‘medically frail’ are eligible to receive a benefit package called the “State Plan,” which is more appropriate for their health care conditions. An individual is medically frail if he or she has been determined to have one or more of the following:

- Disabling mental disorder;
- Chronic substance abuse disorder;
- Serious and complex medical condition;
- Physical, intellectual or developmental disability that significantly impairs the individual’s ability to perform one or more activities of daily living; or
- Disability determination from the Social Security Administration.

Their access to the State Plan benefit is temporary while we confirm their status as medically frail. You may be contacted to provide information to verify your patient’s medical frailty.

If you have a HIP patient that you think may qualify as medically frail or if you if you have questions, please contact Anthem or go online to [http://www.in.gov/fssa/hip/](http://www.in.gov/fssa/hip/) for information on these additional benefits.

**Specialists**
Specialists, licensed with additional training and expertise in a specific field of medicine, supplement the care given by Primary Medical Providers and are charged with the same responsibilities. That includes the responsibility for ensuring that necessary prior authorizations have been obtained before providing services.

Access to specialty care begins in the Primary Medical Provider’s office. The Primary Medical Provider will refer a Member to a Specialist for conditions beyond the Primary Medical Provider’s scope of
practice that are medically necessary. Specialists diagnose and treat conditions specific to their area of expertise.

Please Note: Specialty care is limited to Anthem benefits.

The following guidelines are in place for Specialists Providers:

- For urgent care, the Specialist should see the Member within 24 hours of receiving the request.
- For routine care, the Specialist should see the Member within 2 weeks of receiving the request.

In some cases, a Member may self-refer to a Specialist. These cases include, but are not limited to:

- Family planning and evaluation
- Diagnosis, treatment and follow-up of Sexually Transmitted Infections (STIs)

Please Note: Specialists are responsible for ensuring that necessary pre-authorizations have been obtained prior to providing services.

For some medical conditions, it makes sense for the Specialist to be the Primary Medical Provider. Members may request that the Specialist be assigned as the Primary Medical Provider if:

- The Member has a chronic illness
- The Member has a disabling condition
- The Member is a child with special health care needs

Behavioral Health Providers

For information about Behavioral Health providers, please see Chapter 5: Behavioral Health Services.

Behavioral Health Providers – Transition after Acute Psychiatric Care

For information about Behavioral Health transition after acute psychiatric care, please see Chapter 5: Behavioral Health Services.

Hospital Scope of Responsibilities

Primary Medical Providers refer Members to Plan-contracted network hospitals for conditions beyond the Primary Medical Provider’s scope of practice that are medically necessary. Hospital care is limited to Plan benefits. Hospital professionals diagnose and treat conditions specific to their area of expertise.

Hospital responsibilities include the following:

Notification of Admission and Services

The hospital must notify Anthem or the review organization of an admission or service at the time the Member is admitted or service is rendered. If the Member is admitted or a service is rendered on a day other than a business day, the hospital must notify Anthem of the admission or service the morning of the next business day following the admission or service.

Notification of Preservice Review Decision

If the hospital has not received notice of preservice review determination at the time of a scheduled admission or service, as required by the Utilization Management Guidelines and the Hospital Agreement, the hospital should contact Anthem and request the status of the decision.

Any admission or service that requires preservice review, as discussed in the Utilization Management Guidelines and the Hospital Agreement, and has not received the appropriate review, may be subject to post-service review denial. Generally, the Provider is required to perform all preservice review functions.
with **Anthem**; however, the hospital may ensure, before services are rendered, that such has been performed, or risk postservice denial.

### Ancillary Scope of Responsibilities

Primary Medical Providers and Specialists refer Members to Plan-contracted network ancillary professionals for conditions beyond the Primary Medical Provider’s or Specialist’s scope of practice that are medically necessary. Ancillary professionals diagnose and treat conditions specific to their area of expertise. Ancillary care is limited to Plan benefits.

**Anthem** has a wide network of participating health care professionals and facilities. All services provided by the health care professional, and for which the health care professional is responsible, are listed in the **Ancillary Agreement**.

### Responsibilities Applicable to ALL Providers

There are a number of responsibilities applicable to all **Anthem** Providers. They include:

- After-Hours Services
- Disenrollees
- Eligibility Verification
- Collaboration
- Confidentiality
- Continuity of Care
- Licenses and Certifications
- Mandatory Reporting of Abuse
- Medical Records Standards & Documentation
- Office Hours
- Open Clinical Dialog/Affirmative Statement
- Oversight of Non-Physician Practitioners
- Pre-Service Reviews
- Prohibited Activities
- Provider Contract Terminations
- Termination of Ancillary Provider/Patient Relationship
- Updating Provider Information

### Office Hours

To maintain continuity of care, Providers’ office hours must be clearly posted and Members must be informed about the Provider’s availability at each site. There are strict guidelines for providing access to health care 24 hours a day, 7 days a week:

- Providers must be available 24 hours a day by telephone.
- During those times when a Provider is not available, an on-call Provider must be available to take calls.

### After-Hours Services

All Primary Medical Providers must have an after-hours system in place to ensure that our Members can call with medical concerns or questions after normal office hours.
The answering service or after-hours personnel must forward Member calls directly to the Primary Medical Provider or on-call physician, or instruct the Member that the Provider will contact him or her within 30 minutes.

**Emergencies**

The answering service or after-hours personnel must ask the Member if the call is an emergency. In the event of an emergency, the Member must be immediately directed to dial 911 or to proceed directly to the nearest hospital emergency room.

If the Primary Medical Provider’s staff or answering service is not immediately available, an answering machine may be used. The answering machine message must instruct Members with emergency health care needs to dial 911 or go directly to the nearest hospital emergency room. The message must also give Members an alternative contact number so they can reach the Primary Medical Provider or on-call Provider with medical concerns or questions.

**Language-Appropriate Messages**

Non-English speaking Members who call their Primary Medical Provider after hours should expect to get language appropriate messages. In the event of an emergency, these messages should direct the Member to dial 911 or proceed directly to the nearest hospital emergency room. In a nonemergency situation, Members should receive instruction on how to contact the on-call Provider. If an answering service is used, the service should know where to contact a telephone interpreter for the Member. All calls taken by an answering service must be returned.

**Network On-Call Providers**

Anthem prefers that Primary Medical Providers use network Providers for on-call services. When that is not possible, the Primary Medical Provider must help ensure that the covering on-call physician or other professional provider abides by the terms of the Anthem Provider contract.

Anthem will monitor Primary Medical Provider compliance with after-hours access standards on a regular basis. Failure to comply may result in corrective action.

Members can also call the 24/7 NurseLine information line, 24 hours a day, 7 days a week, to speak to a registered nurse. These nurses provide health information regarding illness and options for accessing care, including emergency services.

**24/7 NurseLine:** 1-866-800-8780 (24 hours a day, 7 days a week)
1-800-368-4424 (TTY)

**Licenses and Certifications**

Providers must maintain all licenses, certifications, permits, accreditations or other prerequisites required by Anthem and federal, state and local laws to provide medical services.

**Eligibility Verification**

All Providers must verify Member eligibility immediately by using Availity and the IHCP Web interChange before providing services, supplies or equipment. Eligibility may change monthly so a Member eligible on the last day of the month may not be eligible on the first of the following month. Anthem is not responsible for charges incurred by ineligible persons.

**Collaboration**

Providers share the responsibility of giving respectful care, working collaboratively with Anthem Specialists, hospitals, Ancillary Providers and Members and their families. Providers must permit Members to participate actively in decisions regarding medical care, including, except as limited by law,
their decision to refuse treatment. The Provider also facilitates interpreter services and provides information about the Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT) program.

**Continuity of Care**

The Primary Medical Provider maintains frequent communication with Specialists, hospitals and Ancillary Providers to ensure continuity of care. **Anthem** encourages Providers to maintain open communication with their patients regarding appropriate treatment alternatives, regardless of their benefit coverage limitations. The Primary Medical Provider is responsible for providing an ongoing source of primary care appropriate to the Member’s needs.

**Anthem** has established comprehensive mechanisms to ensure continued access to care for Members when Providers leave our health care program. Under certain circumstances, Members may finish a course of treatment with the terminating Provider. For more information, refer to the Access Standards chapter.

**Medical Records: Standards**

Medical records must be maintained in a manner that ensures effective and confidential Member care and quality review. At **Anthem**, we perform medical record reviews upon signing a Provider contract and, at minimum, every three years thereafter to ensure that Providers are in compliance with these standards.

Medical records must be stored and retrieved in a manner that protects patient information according to the Confidentiality of Medical Information Act. This act prohibits a provider of health care from disclosing any individually identifiable information regarding a patient’s medical history, treatment, or behavioral and physical condition, without the patient’s or legal representative’s consent or specific legal authority.

Records required through a legal instrument may be released without patient or patient representative consent. Providers must be familiar with the security requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and be in compliance.

For more information on medical records standards, please refer to our chapter on Access Standards.

**Mandatory Reporting of Child Abuse, Elder Abuse or Domestic Violence**

Providers must ensure that their office staff knows about local reporting requirements and procedures to make telephone and written reports of known or suspected cases of abuse. All health care professionals must immediately report actual or suspected child abuse and neglect, elder abuse, and domestic violence or physical or sexual abuse to the local law enforcement agency by telephone. In addition, Providers must submit a follow-up written report to the local law enforcement agency within the time frames as required by law.

**Updating Provider Information**

**Anthem** network Providers are required to inform us of any material changes to their practice, including:

- Change in professional business ownership
- Change in business address or the location where services are provided
- Change in federal 9-digit Tax Identification Number (TIN)
- Change in specialty
- If the Provider provides services to children
- Languages spoken
- Change in demographic data (for example: phone numbers, languages of Providers and/or office personnel)
- Legal or governmental action initiated against a health care professional. This includes, but is not limited to, an action for professional negligence, for violation of the law, or against any license or accreditation which, if successful, would impair the ability of the health care professional to carry out the duties and obligations under the Provider Agreement
- Other problems or situations that may impair the ability of the health care professional to carry out the duties and obligations under the Provider Agreement care review and grievance resolution procedures
- Notification that the Provider is accepting new patients

Notify Anthem of changes by using the Provider Maintenance Form for Professional Providers, which is available on our website at www.anthem.com.

Facility and Ancillary Provider submit changes on company letterhead to your Anthem contractor.

If Anthem determines that the quality of care or services provided by a health care professional is not satisfactory, as evidenced by Member satisfaction surveys, Member complaints or grievances, utilization management data, complaints or lawsuits alleging professional negligence, or any other quality of care indicators, Anthem may terminate the Provider Agreement.

Oversight of Non-Physician Practitioners

All Providers using non-physician practitioners must provide supervision and oversight of nonphysician practitioners consistent with state and federal laws. The supervising physician and the nonphysician practitioner must have written guidelines for adequate supervision, and all supervising providers must follow state licensing and certification requirements.

Nonphysician practitioners include the following categories:

- Advanced Registered Nurse Practitioners
- Certified Nurse Midwives
- Physician Assistants

These nonphysician practitioners are licensed by the state and working under the supervision of a licensed physician as mandated by state and federal regulations.

Open Clinical Dialogue/Affirmative Statement

Nothing within the Provider’s Provider Agreement or this Provider Manual should be construed as encouraging Providers to restrict medically necessary covered services or limit clinical dialog between Providers and their patients, regardless of benefit coverage limitations. Providers may communicate freely with Members regarding:

- Treatment options available to them, including medication treatment options,
- Information the Member may need to decide among all relevant treatment options
- The risks, benefits, and consequences of treatment or non-treatment
- The Member’s right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions

Provider Contract Termination

A terminated Provider who is actively treating Members must continue to treat Members until the Provider’s date of termination. That date is the end of the 90-day period following written notice of termination, or time lines determined by the medical group contract.
Once we receive a Provider’s notice to terminate a contract, we notify Members impacted by the termination. Anthem sends a letter to inform affected Members of:

- The impending termination of their Provider
- Their right to request continued access to care
- The Customer Care Center telephone number to make Primary Medical Provider changes
- Referrals to Utilization Management for continued access to care consideration

Members under the care of Specialists can also submit requests for continued access to care, including continued care after the transition period, by calling the Customer Care Center.

Member Customer Care Center:

- 1-866-408-6131 (Hoosier Healthwise and HIP)
- 1-844-284-1797 (Hoosier Care Connect)
- 1-866-408-7188 (TTY)
Termination of the Ancillary Provider/Patient Relationship

Under certain circumstances, an Ancillary Provider may terminate the professional relationship between the Ancillary Provider and a Member as provided for and in accordance with the provisions of this manual. However, Ancillary Providers may not terminate the relationship because of the Member’s medical condition or the amount, type or cost of covered services required by the Member.

Disenrollees

When a Member disenrolls and requests transfer to another health plan, Providers are required to work with the Anthem case managers who are responsible for helping the Member make the transition. This transition must occur without disruption of any regimen of care that qualifies as a Continuity of Care condition. The case manager will coordinate with the Member, the Member’s Providers and the case manager at the new health plan to help ensure an orderly transition.

Provider Rights

Anthem network Providers, acting within the lawful scope of practice, shall not be prohibited from advising a Member or advocating on behalf of a Member for any of the following:

- The Member’s health status, medical care or treatment options, including any alternative treatment that may be self-administered
- Any information the Member needs in order to decide among all relevant treatment options
- The risks, benefits and consequences of treatment or non-treatment
- The Member’s right to participate in decisions regarding their health care, including the right to refuse treatment and to express preferences about future treatment decisions
- To receive information on the Grievances & Appeals and State Fair Hearing procedures
- To have access to policies and procedures covering authorization of services
- To be notified of any decision to deny a service authorization request, or to authorize a service in an amount, duration or scope that is less than requested
- To challenge, on behalf of our Members, the denial of coverage, or payment for, medical assistance
- To be free from discrimination for the participation, reimbursement or indemnification of any Provider who is acting within the scope of his/her license or certification under applicable law solely based on that license or certification

Anthem’s network Provider selection policies and procedures do not discriminate against particular Providers who serve high-risk populations or specialize in conditions that require costly treatment.

Prohibited Activities

All Providers are prohibited from:

- Billing eligible Members for covered services and billing members for non-covered services without a waiver that meets federal standards
- Segregating Members in any way from other persons receiving similar services, supplies or equipment
- Discriminating against Anthem Members or Medicaid participants
CHAPTER 17: CLINICAL PRACTICE AND PREVENTIVE HEALTH CARE GUIDELINES

Overview

At Anthem, we believe that providing quality health care shouldn't be limited to the treatment of injury or illness. We are committed to helping Providers and Members become more pro-active in the quest for better overall health.

To accomplish that goal, we offer Providers tools to help them find the best, most cost-effective ways to:

- Provide Member treatment
- Empower Members through education
- Encourage Member lifestyle changes where possible

We want Providers to have access to the most up-to-date clinical practice and preventive health care guidelines. These guidelines, offered by nationally recognized health care organizations and based on extensive research, include the latest standards for treating the most common, stubborn and serious illnesses, such as diabetes and hypertension. They also include guidelines for preventive screenings, immunizations and Member counseling based on age and gender.

Preventive Health Care Guidelines

Anthem considers prevention an important component of health care. Anthem develops Preventive Health Care Guidelines in accordance with recommendations made by nationally recognized organizations and societies such as the American Academy of Family Physicians (AAFP), the American Academy of Pediatrics (AAP), the Advisory Committee on Immunizations Practices (ACIP), the American College of Obstetricians and Gynecologists (ACOG) and the United States Preventive Services Task Force (USPSTF). The above organizations make recommendations based on reasonable medical evidence. We review the guidelines annually for content accuracy, current primary sources, new technological advances and recent medical research, and make appropriate changes based on this review of the recommendations. We encourage physicians to utilize these guidelines to improve the health of our Members.

The guidelines, educational materials and health management programs can be found under the Quality Improvement Program heading on the Provider Resources page of our website, www.anthem.com. For directions on how to access the Provider Resources page of our website, please see Chapter 1: How to Access Information, Forms and Tools on Our Website.

The website offers the most up-to-date clinical resources for preventive screenings, immunizations and counseling for our Members. If you do not have Internet access, you can request a hard copy of the Preventive Health Care Guidelines by calling our Provider Helpline at:

<table>
<thead>
<tr>
<th>Provider</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hoosier Healthwise</td>
<td>1-866-408-6132</td>
</tr>
<tr>
<td>Healthy Indiana Plan</td>
<td>1-800-345-4344</td>
</tr>
<tr>
<td>Hoosier Care Connect</td>
<td>1-844-284-1797</td>
</tr>
</tbody>
</table>

Please Note: With respect to the issue of coverage, each Member should review his or her Certificate of Coverage and Schedule of Benefits for details concerning benefits, procedures and exclusions prior to receiving treatment. The Member Handbook supersedes the Preventive Health Care Guidelines.

Clinical Practice Guidelines
Anthem considers clinical practice guidelines an important component of health care. Anthem adopts nationally recognized clinical practice guidelines and encourages physicians to utilize these guidelines to improve the health of our Members. Several national organizations produce guidelines for asthma, diabetes, hypertension and other conditions. The guidelines, which Anthem uses for quality and disease management programs, are based on reasonable medical evidence. We review the guidelines at least every two years or when changes are made to national guidelines for content accuracy, current primary sources, new technological advances and recent medical research.

You can access the Clinical Practice Guidelines under the Quality Improvement Program heading on the Provider Resources page of our website, www.anthem.com. For directions on how to access the Provider Resources page of our website, please see Chapter 1: How to Access Information, Forms and Tools on Our Website.

The website offers the most up-to-date clinical resources and guidelines. If you do not have Internet access, you can request a hard copy of the Clinical Practice Guidelines by calling our Provider Helpline at:

- Hoosier Healthwise: 1-866-408-6132
- Healthy Indiana Plan: 1-800-345-4344
- Hoosier Care Connect: 1-844-284-1797
CHAPTER 18: CASE MANAGEMENT

Case Management Phone: 1-866-902-1690 Option 2
Case Management Fax: 1-855-417-1289
Hours of Operation: Monday to Friday, 8 a.m.-5 p.m.
WIC: 1-800-522-0874
Breastfeeding Support Line: 1-800-231-2999
Access to Care Fax: 1-877-604-0476

Overview

Case Management is a process that emphasizes collaborative, multidisciplinary teamwork to develop, implement, coordinate and monitor treatment plans in order to optimize our Members’ health care benefits. The integration of physical and behavioral health is core to our holistic care management of our Members.

At Anthem, we’re proud of our Circle of Care Model. Anthem’s innovative Member centric, provider focused approach, assigns our AnthemConnect team, led by our regional field-based physical and behavioral health care managers, social workers, Member outreach specialists, nurse practice consultants and network relations representatives throughout Indiana. Our team also includes the Anthem departments and employees performing support activities for our Members and providers, assisting them in navigating the health care system. They are the primary points of contact for providers in their assigned region. By establishing collaborative, supportive relationships with our PMPs and CMHCs we support our Member’s Medical Home as the center of the care delivery system.

Together, they link Providers, Members and community agencies to Anthem resources and provide support and assistance to Providers to best serve Anthem Members. AnthemConnect team Members are available to:

➢ Provide training for health care professionals and their staff regarding enrollment, covered benefits, managed care operations and linguistic services.
➢ Provide Member support services, including health education referrals, event coordination, and coordination of cultural and linguistic services.
➢ Provide care management services to supplement Providers’ treatment plans and improve our Members’ overall health. They do so by informing, educating and encouraging self-care in the prevention, early detection and treatment of existing conditions and chronic disease. Coordinate access to community health education resources for breastfeeding, smoking cessation diabetes and asthma, to name just a few.

Anthem’s case management program, provided at no cost to Providers and Members, offers expert assistance in the coordination of complex health care, including the integration of physical and behavioral health needs. The case manager, through partnership with Providers and Members, collects data and analyzes information about actual and potential care needs for the purpose of developing a treatment plan. Cases referred to case management may be identified by disease or condition, dollars spent or high utilization of services.

Anthem Providers are encouraged to engage and direct development and provide feedback to our Members’ care plans.

Hoosier Care Connect Members who would benefit from case management services, but either actively choose not to participate or are unable to participate, may be managed through a provider focused program.
Providers who serve Hoosier Care Connect Members engaged in care management shall participate in semiannual care conferences with an interdisciplinary care team. The goal is to coordinate and services for Hoosier Care Connect Member across the care continuum. Providers may bill for the semiannual conference using HCPCS code 99211 SC.

Please Note: The Anthem Case Management team is sensitive to cultural diversity and the impact it has on our Members and their interaction within the health care system. We encourage Providers to become familiar with our cultural and linguistic training materials, available under Health Education: Caring for Diverse Populations on the Provider Resources page of our website, www.anthem.com. For directions on how to access the Provider Resources page of our website, please see Chapter 1: How to Access Information, Forms and Tools on Our Website. Interpreter services are available at no cost to support the Case Management process.

Role of the Case Manager
The case manager’s role is to assess the Member’s health care status, develop a health care plan and:
- Facilitate communication and coordination within the health care team.
- Facilitate communication with the Member and his or her family in the decision-making process.
- Educate the Member and Providers on the health care team about care management, community resources, benefits, cost factors and all related topics so that informed decisions can be made.
- Encourage appropriate use of medical facilities and services, with the goal of improving quality of care and maintaining cost-effectiveness on a case-by-case basis.

The case management team includes experienced and credentialed registered nurses, many of whom are Certified Case Managers (CCMs). The team also includes social workers. The case manager social workers add valuable skills that allow us to address not only our Members’ medical needs, but also their psychological, social and financial issues.

Provider Responsibility
Providers have the responsibility to participate in the case management process by sharing information and facilitating the process by:
- Referring Members who could benefit from case management.
- Sharing information as soon as possible and as early as the Initial Health Assessment if the Primary Medical Provider identifies complex health care needs.
- Collaborating with case management staff on an ongoing basis.
- Participate in semiannual care conferences for Hoosier Care Connect Members
- Recommending referrals to Specialists, as required.
- Monitoring and updating the care plan to promote health care goals.
- Notifying Case Management if Members are referred to services provided by the state or some other institution not covered by the Anthem agreement.
- Coordinating county or state-linked services such as public health, behavioral health, schools and waiver programs. The Provider may call Case Management for additional assistance for:
  - Hoosier Healthwise Members who are enrolled in the Individualized Family Services Plan (IFSP), Providers should notify us of special needs children who would benefit from case management and are responsible for coordinating with Anthem and Indiana's Family and Social Services Administration's (FSSA) First Steps System. First Steps provides early intervention services for children from birth to three years of age who are experiencing developmental delays and/or have a diagnosed condition that has a high probability of resulting in developmental delays.
- **Hoosier Healthwise Members** involved in the state's **Individualized Education Plan (IEP)**, which provides services to special needs students, including physical therapy, speech pathology, audiology, school nursing and rehabilitation counseling. **Anthem** network Providers are responsible for communicating and coordinating with the school to ensure continuity of care and avoid duplication of services.

**Procedures**

When a Member has been identified as having a condition that may benefit from case management, the case manager contacts the referring Provider and Member for input on completion of an initial assessment. Then, with the involvement of the Member or the Member’s representative and the Provider, the case manager develops an individualized care plan. That plan may involve coordinating services with public and behavioral health departments, schools and other community health resources.

The case manager periodically re-assesses the care plan to monitor the following:

- Progress toward goals
- Determine if their present care levels are adequate
- Necessary revisions
- New issues that need to be addressed to help ensure that the Member receives the support needed to achieve care plan goals

Hoosier Care Connect Members or providers can request a level of care redetermination at any time to ensure the right level of care is being met.

Once goals are met or case management can no longer impact the case, the case manager closes the Member’s case.

**Potential Referrals**

Providers, nurses, social workers and Members or their representatives may request case management services. Examples of cases appropriate for referral include:

- Adults with special health care needs requiring coordination of care
- Auto-immune diseases such as HIV/AIDS
- Children with special health care needs
- Chronic illness such as asthma, diabetes and heart failure
- Complex or multiple-care needs such as multiple trauma or cancer
- Frequent hospitalizations or emergency room utilization
- Hemophilia, sickle cell anemia, cystic fibrosis, cerebral palsy
- Spinal injuries
- High-risk pregnancies
- Potential transplants
- Pre-term births
- HIP medically frail
- Member on Home- and Community-based Services Waiver waitlist
- Foster children

**Referral Process**
Providers, nurses, social workers and Members or their representative may refer Members to Case Management in one of two ways:

**Phone:** 1-866-902-1690 Option 2  
**Fax:** 1-855-417-1289

A case manager will respond to a faxed request within three business days.

**Accessing Specialists**

Case managers are available to assist Primary Medical Providers with access to Specialists.

**Please Note:** Standing referrals or an approved number of visits for access to in-network Specialists do **not** require prior authorization. Referrals to out-of-network Specialists **do** require prior authorization.

**Behavioral Health Case Management**

**Anthem** ensures the integration of physical and behavioral health care management. For information about Behavioral Health Case Management, please see Chapter 5: **Behavioral Health Services**.

**Behavioral Health Clinical Authorization and Protocols**

For information about Behavioral Health clinical authorization and protocols, please see Chapter 5: Behavioral Health Services.
CHAPTER 19: QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT

Overview

The goal of Anthem Blue Cross and Blue Shield (Anthem) is continuous, measurable improvement in the delivery of, and access to high quality health care. Following regulatory and accrediting body requirements, we have a Quality Assessment and Performance Improvement (QAPI) program to monitor and evaluate the quality, safety and appropriateness of medical and behavioral health care and service offered by the health network. The QAPI program also serves to identify and act on opportunities for improvement.

The Anthem Board of Directors (BOD) is responsible for organizational governance and have final authority and accountability for the QAPI program. The BOD delegates responsibility for development and implementation of the QAPI program to the Medicaid Quality Management Committee (QMC).

External advisory guidance is sought to provide external input into internal programming. Service and operations committees also work together to coordinate clinical and service quality improvement activities. Quality Management Leadership has day-to-day oversight of the QAPI program. There are quality processes in place throughout the enterprise in order to maintain the connection with the local Members, Providers and community.

The QOC reviews and approves the annual quality program documents, including the QAPI program description, QI Work Plan and the QAPI program’s annual evaluation. The results of the annual QAPI Evaluation are used to develop and prioritize the next year’s annual QI Work Plan.

The QAPI program is collaborative in nature and includes focused studies and reviews that measure quality of care in specific clinical and service areas. Providers are expected to participate to help us achieve our goal of providing responsive, safe and cost-effective health care that makes a difference in our Member’s lives.

Program Monitoring

To enable comprehensive assessment of the Plan’s health system and meaningful prioritization of initiatives, Anthem selects critical monitors from the QAPI program components inherent to the promotion of quality clinical care and service including:

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<tr>
<th>• Accessibility of Services</th>
<th>• Health Equities and Cultural and Linguistic Services</th>
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<tr>
<td>• Availability of Practitioners</td>
<td>• Health Services Programs</td>
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<td>• Behavioral Health</td>
<td>• Maternity Management</td>
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<td>• CAHPS® Member Satisfaction Survey</td>
<td>• Medical Record Review</td>
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<td>• Preventive Health Guidelines</td>
<td>• Member, Practitioner and Provider Communications</td>
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<td>• Clinical Practice Guidelines for Medical and Behavioral Health</td>
<td>• Patient Safety</td>
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<td>• Complaints, Grievances and Appeals</td>
<td>• Pharmacy and Therapeutics</td>
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<td>• Continuity/Coordination of Care</td>
<td>• Provider Credentialing/Recredentialing</td>
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<td>• Contracting</td>
<td>• Provider Satisfaction</td>
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Internally, areas to monitor are selected by identifying aspects of care and/or service that are high in volume, risk, or problem prone. Selections are based on the probability that the review will have a positive impact on Members’ health and well-being. Priority is given those areas with issues related to major population groups, Members’ health risks, and where actions are likely to have the greatest Member impact.

Externally, states may require certain clinical measures to achieve a specific benchmark, or will provide incentives/performance guarantees for individual measures. Also, the Centers for Medicare & Medicaid Services (CMS) in conjunction with the State of Indiana, may specify performance measures and topics for Performance Improvement Projects (PIPs), and require mechanisms to detect both underutilization and overutilization of services. Ongoing PIPs are typical and include measuring performance using objective quality indicators; implementation of interventions to achieve improvement in quality; evaluation of the effectiveness of the interventions, and planning and initiating activities for increasing or sustaining improvement. PIPs can be focused on either clinical or nonclinical services.

Healthcare Effectiveness Data and Information Set (HEDIS®) measures and the requirements of the National Committee for Quality Assurance (NCQA) are also considered, whether clinically based or service related.

Finally, we are committed to working collaboratively with Network Physicians and Hospitals to identify Preventable Adverse Events (PAE) as a means of improving the quality and safety of patient care.

**Accreditation**

Anthem maintains health plan accreditation through the National Committee for Quality Assurance (NCQA). Accreditation is a process for an impartial organization to review a company’s operations to ensure it is conducting business consistent with national standards. Accreditation fulfills State regulatory requirements, in some instances serving as a substitute for meeting a state’s quality requirements. It also supports continuous improvement, guiding the plan to measure, analyze, report and improve the quality of services provided to Members.

National evaluations of health plan performance and customer satisfaction are driven by NCQA and used in the accreditation process. Two of the most important measures of performance and Member satisfaction are the Healthcare Effectiveness Data and Information Set (HEDIS®) and the Consumer Assessment of Healthcare Providers and Systems (CAHPS®). HEDIS® is a set of standardized performance measures used to compare the performance of managed care plans and measures for physicians based on value rather than cost. More than 90% of America’s health plans use the HEDIS® tool and report rates annually. The CAHPS® survey is a Member satisfaction survey administered annually to a random sample of:

- **Hoosier Healthwise** Members who are under age 19 or pregnant
- **Healthy Indiana Plan** Members age 19-64 or who are low-income caretaker parents
- **Hoosier Care Connect** Members who are Aged, Blind and Disabled eligible and non-dually eligible

Individual plan scores are compared to other health plans’ scores on specific measures for benchmarking purposes.
Accreditation results are displayed on public websites; these “report cards” assist employers and individual consumers to make informed decisions about their health plan options based on quality and value.

Quality Improvement Program

Anthem’s QAPI program focuses on developing and implementing standards for clinical care and service, measuring conformity to those standards and taking action to improve performance. The scope of the QAPI program includes, but is not limited to, the monitoring and evaluation of:

- Utilization Management, Disease Management and Maternity Management Programs
- Case Management of Members with complex health conditions
- Behavioral Health Programs
- Clinical Practice and Preventive Health Guidelines
- Patient safety
- Coordination of medical and behavioral health care
- Access and availability of services and practitioners
- Facility site review
- Medical record review
- Pharmacy and Therapeutics
- Provider/Member satisfaction
- Service quality
- Health equities, and Cultural and Linguistic Program
- Complaints, grievances and appeals

The QAPI program is defined within three quality documents that support program excellence:

1. **Quality Improvement Program Description (QIPD):** Describes the overall health plan approach to Quality Improvement (QI), what is to be accomplished (goals and objectives) and how the QAPI Program will be managed and monitored by the organization.

2. **QI Work Plan:** Lists the various quality interventions and activities, and how the goals/objectives are tracked and monitored throughout the year through reports to the quality committees.

3. **QI Evaluation:** The annual reporting method used to evaluate the progress and results of planned activities toward established goals. It describes the accomplishments of the QAPI Program and QI Work Plan.

Each year as part of the continuous quality improvement (CQI) process, Anthem:

- Reviews its QAPI Program Description
- Establishes goals/objectives for its QI activities and implements a QI Work Plan to improve the level of care and service provided to its Members
- Conducts a QAPI Evaluation to assess the effectiveness of the activities implemented throughout the year, and determines if the goals and objectives were met

QAPI Program revisions are made based on outcomes, trends, contractual, accreditation, and regulatory standards and requirements, and overall satisfaction with the effectiveness of the program.

Providers support the activities of the QAPI Program by:

- Completing corrective action plans, when applicable
• Participating in the facility site review and medical record review processes
• Providing access to medical records for quality improvement projects and studies
• Responding in a timely manner to requests for written information and documentation if a quality of care or grievance issue has been filed
• Using Preventive Health and Clinical Practice Guidelines in Member care

Please feel free to contact Anthem if more information on the quality program, its achievements, processes and outcomes is of interest.

Healthcare Effectiveness Data and Information Set (HEDIS®)

Practitioners and providers must allow Anthem to use performance data in cooperation with our quality improvement program and activities.

Practitioner/Provider Performance Data refers to compliance rates, reports and other information related to the appropriateness, cost, efficiency and/or quality of care delivered by an individual healthcare practitioner, such as a physician, or a healthcare organization, such as a hospital. Common examples of performance data include the Healthcare Effectiveness Data and Information Set (HEDIS), quality of care measures maintained by the National Committee for Quality Assurance (NCQA) and the comprehensive set of measures maintained by the National Quality Forum (NQF). Practitioner/Provider Performance Data may be used for multiple plan programs and initiatives, including by not limited to:

• Reward Programs - Pay for Outcome (P4O), pay for value (PFV) and other results-based reimbursement programs that tie provider or facility reimbursement to performance against a defined set of compliance metrics. Reimbursement models include but are not limited to shared savings programs, enhanced fee schedules and bundled payment arrangements.
• Recognition Programs - Programs designed to transparently identify high value providers and facilities and make that information available to consumers, employers, peer practitioners and other healthcare stakeholders.

Anthem is ready to help when Providers and their office staff need training to participate in required HEDIS evaluations. Providers can request consultations and training in the following areas:

• Information about the year’s selected HEDIS studies
• How data for those measures will be collected
• Codes associated with each measure
• Tips for smooth coordination of medical record data collection

Anthem’s Quality Improvement staff will contact the Provider’s office when needed to review or copy any medical records required for quality improvement studies. Office staff must provide access to medical records for review and copying.

Quality Management

Over-utilization and under-utilization is reviewed annually utilizing HEDIS data. The purpose of Under and Over Utilization analysis is to facilitate the delivery of appropriate care by monitoring the impact of Utilization Management (UM) Programs as well as identify and correct potential over-utilization and under-utilization.

The annual analysis of the data provides insight into the potential under and over utilization of services. Anthem utilizes the data to measure compliance with established goals and/or national averages/benchmarks where applicable.
Best Practice Methods

Best practice methods are Anthem’s most up-to-date compilation of effective strategies for quality health care delivery. We share best practice methods with Providers during Provider site visits. Quality and Provider Relations teams offer Anthem policies and procedures, along with educational toolkits, to help guide improvements. Toolkits may include examples of best practices from other offices, including:

- Resources for improving compliance with preventive health services
- Clinical practice guidelines
- Care for Members with special or chronic care needs
- Office Practice Optimizations

Member Satisfaction Surveys

Anthem conducts Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Member satisfaction surveys each year through a contracted vendor certified by the NCQA. The CAHPS® survey includes “Rating” measures of Members’ overall satisfaction with their health plan, all health care received, personal doctor and specialists. Other areas of assessment include ease of accessing care, quality of physician services, customer service and claims processing. Our privately-contracted survey allows Anthem to add additional questions to the survey to help us better understand our Members’ perceptions and enable the development of meaningful interventions.

CAHPS® survey results (scores) are compared to the previous years’ scores as well as to the NCQA Quality Compass®. This is a database maintained by NCQA that includes results from all CAHPS® health plan surveys nationwide as well as National Averages & Percentiles. Opportunities for improvement are identified and priorities are set based on the review and analysis of scores, and also consider those areas where the Plan can make the greatest impact. Recommendations for prioritizing the focus areas for improvement are reviewed with the appropriate quality committees and stakeholders.

Anthem shares the results of the CAHPS® survey with providers annually through an article in our Provider newsletter. Providers are encouraged to review the results, share them with office staff, and address any areas of deficiency in their offices.

On an annual basis, Member satisfaction is comprehensively analyzed by combining the results of CAHPS® surveys with Member complaints, grievances and appeals. Together these important barometers of Member satisfaction are considered when making plans for improving service and customer satisfaction.

Provider Satisfaction Surveys

Anthem may conduct Provider surveys to monitor and measure Provider satisfaction with Anthem’s services and to identify areas for improvement. Provider participation in these surveys is highly encouraged and your feedback is very important. We inform Providers of the results and plans for improvement through Provider bulletins, newsletters, meetings or training sessions.

Medical Record and Facility Site Reviews

Anthem conducts medical records and facility site reviews in order to determine:

- Provider compliance with standards for providing and documenting health care
- Provider compliance with standards for storing medical records
- Provider compliance with processes that maintain safety standards and practices
- Provider involvement in the continuity and coordination of Member care
Please Note: The Indiana Family and Social Services Administration (FSSA), Anthem and CMS have the right to enter into the premises of Providers to inspect, monitor, audit or otherwise evaluate the work performed. We perform all inspections and evaluations in such a manner as not to unduly delay work, in accordance with the Provider contract.

Medical Record Documentation Standards

Anthem requires Providers to maintain medical records in a manner that is current, organized, and permits effective and confidential Member care and quality review. We perform random medical record reviews of all Primary Medical Providers (General Practice, Family Practice, Internal Medicine, Pediatrics and select Obstetrics/Gynecology) to ensure that network Providers are in compliance with these standards.

Network Providers shall agree to maintain the confidentiality of Member information and information contained in a Member’s medical records according to the Health Information Privacy and Accountability Act (HIPPA) standards. Medical records must be stored and retrieved in a manner that protects patient information according to the Confidentiality of Medical Information Act, which requires the following:

- The act prohibits a Provider of health care from disclosing any individually identifiable information regarding a patient's medical history, mental and physical condition, or treatment without the patient's or legal representative's consent or specific legal authority
- Records required through a legal instrument may be released without patient or patient representative consent
- Providers must be familiar with the security requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and will only release such information as permitted by applicable federal, state and local laws and that is
  - Necessary to other Providers and the health plan related to treatment, payment or health care operations.
  - Upon the Member’s signed and written consent.

Security

The medical record must be secure and inaccessible to unauthorized access in order to prevent loss, tampering, disclosure of information, alteration or destruction of the record. Information must be accessible only to authorized personnel within the Provider’s office, Anthem, the Indiana Family and Social Services Administration, or to persons authorized through a legal instrument. Records must be made available to Anthem for purposes of quality review, HEDIS and other studies.

Storage and Maintenance

Active medical records shall be secured and must be inaccessible to unauthorized persons. Medical records are to be maintained in a manner that is current, detailed and organized, and that permits effective patient care and quality review while maintaining confidentiality. Inactive records are to remain accessible for a period of time that meets state and federal guidelines.

Electronic record keeping system procedures shall be in place to ensure patient confidentiality, prevent unauthorized access, authenticate electronic signatures and maintain upkeep of computer systems. Security systems shall be in place to provide back-up storage and file recovery, to provide a mechanism to copy documents and to ensure that recorded input is unalterable.

Availability of Medical Records
The medical records system must allow for prompt retrieval of each record when the Member comes in for a visit. Providers must maintain Members’ medical records in a detailed and comprehensive manner that accomplishes the following:

- Conforms to good professional medical practice
- Facilitates an accurate system for follow-up treatment
- Permits effective professional medical review and medical audit processes

Medical records must be legible, signed and dated. They must be maintained for at least seven years as required by state and federal regulations.

Providers must offer a copy of a Member’s medical record upon reasonable request by the Member at no charge, and the Provider must facilitate the transfer of the Member’s medical record to another Provider at the Member’s request. Confidentiality of, and access to, medical records must be provided in accordance with the standards mandated in the Health Insurance Portability and Accountability Act (HIPAA) and all other state and federal requirements.

Providers must permit Anthem and representatives of Indiana's Family and Social Services Administration (FSSA) to review Members’ medical records for the purposes of monitoring the Provider’s compliance with the medical record standards, capturing information for clinical studies, monitoring quality, or any other reason. FSSA encourages Providers to use technology, including health information exchanges, where appropriate, to transmit and store medical record data.

**Medical Record Documentation Standards**

Every medical record is, at a minimum, to include:

- The patient’s name or ID number on each page in the record
- Personal biographical data including home address, employer, emergency contact name and telephone number, home and work telephone numbers, and marital status
- All entries dated with month, day and year
- All entries contain the author’s identification (for example, handwritten signature, unique electronic identifier or initials) and title
- Identification of all Providers participating in the Member’s care, and information on services furnished by these Providers
- A problem list, including significant illnesses and medical and psychological conditions
- Presenting complaints, diagnoses and treatment plans, including the services to be delivered
- Physical findings relevant to the visit including vital signs, normal and abnormal findings, and appropriate subjective and objective information
- Information on allergies and adverse reactions (or a notation that the patient has no known allergies or history of adverse reactions)
- Information on advance directives
- Past medical history, including serious accidents, operations, illnesses, and for patients 14 years old and older, substance abuse (for children and adolescents, past medical history relates to prenatal care, birth, operation and childhood illnesses)
- Physical examinations, treatment necessary and possible risk factors for the Member relevant to the particular treatment
- Prescribed medications, including dosages and dates of initial or refill prescriptions
• For patients 14 years and older, appropriate notations concerning the use of cigarettes, alcohol and substance abuse (including anticipatory guidance and health education)
• Information on the individuals to be instructed in assisting the patient
• Medical records must be legible, dated, and signed by the physician, physician assistant, nurse practitioner or nurse midwife providing patient care
• An immunization record for children that is up-to-date or an appropriate history for adults
• Documentation attempts to provide immunizations. If the Member refuses immunization, proof of voluntary refusal of the immunization in the form of a signed statement by the Member or guardian shall be documented in the Member’s medical record
• Evidence of preventive screening and services in accordance with Anthem’s preventive health practice guidelines
• Documentation of referrals, consultations, diagnostic test results, and inpatient records (evidence of the Provider’s review may include the Provider’s initials or signature and notation in the patient’s medical record of the Provider’s review and patient contact, follow-up treatment, instructions, return office visits, referrals and other patient information)
• Notations of patient appointment cancellations or “No Shows” and the attempts to contact the patient to reschedule
• No evidence that the patient is placed at inappropriate risk by a diagnostic test or therapeutic procedure
• Documentation on whether an interpreter was used, and, if so, that the interpreter was also used in follow-up

Advance Directives

Recognizing a person's right to dignity and privacy, our Members have the right to execute an advance directive, also known as a "Living Will," to identify their wishes concerning health care services should they become incapacitated. Providers may be asked to assist Members in procuring and completing the necessary forms. More information can be found under the Standards and Policies heading on the Provider Resources page of our website at www.anthem.com. For directions on how to access the Provider Resources page of our website, please see Chapter 1: How to Access Information, Forms and Tools on Our Website.

Advance Directive documents should be on hand in the event a Member requests this information. Any request should be properly noted in the Medical Record.

Medical Record Review Process

Anthem’s Quality team will call the Provider’s office to schedule a medical record review on a date and time that will occur within 30 days of the initial call. On the day of the review, the Quality team Member will:

1. Request the number and type of medical records required.
2. Review the appropriate type and number of medical records per Provider.
3. Complete a medical record review.
4. Meet with the Provider or office manager to review and discuss the results of the medical record review.
5. Provide a copy of the medical record review results to the office manager or doctor or sends a final copy within 10 days of the review.
6. Schedule follow-up reviews for any corrective actions identified.

Providers must attain a score of 80% or greater in order to pass the medical record review. Anthem completes a random medical record review annually according to our medical records standards.

**Facility Site Review Process**

Anthem will conduct a facility site review (FSR) and inspection if three formal complaints have been received by Members for a Primary Medical Provider.

An FSR inspection consists of 13 elements, which include:

1. Accessibility
2. Appearance
3. Safety and Infectious waste
4. Office Policies
5. Provider Availability
6. Treatment areas
7. Patient services
8. Process of documentation
9. Personnel
10. Medications, to include emergency supplies
11. Referral process
12. Medical records elements and organization
13. Appointment accessibility

Anthem’s Quality team will call the Provider’s office to schedule an appointment date and time for the facility site review. The Practice Consultants will fax or mail a confirmation letter with an explanation of the audit process and required documentation.

During the facility site review, the Quality staff will:

1. Lead a pre-review conference with the Provider or office manager to review and discuss the process of facility review and answer any questions.
2. Conduct the review of the facility.
3. Complete the facility site review.
4. Develop a corrective action plan, if applicable.

After the facility site review is completed, Anthem’s Practice Consultants will meet with the Provider or office manager to:

1. Review and discuss the results of the facility site review and explain any required corrective actions.
2. Provide a copy of the facility site review results and the corrective action plan to the office manager or Provider. The Practice Consultants may send a final copy within 10 days of the review.
3. Educate the Provider and office staff about Anthem’s standards and policies.
4. Schedule a follow-up review for any corrective actions identified.

Providers must attain a score of 80% or greater to pass.

**Facility Site Review: Corrective Actions**
If the facility site review results in a non-passing score, **Anthem** will immediately notify Providers of the non-passing score, all cited deficiencies and corrective action requirements. The Provider offices will develop and submit corrective action plans and **Anthem** will conduct follow-up visits every six months until the site complies with **Anthem** standards.

The Provider and office staff will:

1. Provide an appointment time for the review.
2. Be available to answer questions and participate in the exit interview.
3. Schedule follow-up reviews, if applicable.
4. Complete a corrective action plan.
5. Sign an attestation that corrective actions are complete.
6. Submit the completed corrective action plan, supporting documents and signed attestation to our Clinical Quality Compliance Administrator.

**Preventable Adverse Events**

The breadth and complexity of today’s health care system means there are inherent risks, many of which can be neither predicted nor prevented. However, when there are preventable adverse events, they should be tracked and reduced, with the ultimate goal of eliminating them.

Providers and health care systems, as advocates for our Members, are responsible for the continuous monitoring, implementation and enforcement of applicable health care standards. Focusing on patient safety, we work collaboratively with Providers and hospitals to identify preventable adverse events and to implement appropriate strategies and technologies to avoid them. Our goal is to enhance the quality of care received not only by our Members but all patients receiving care in these facilities.

Prevention of adverse events may require the disclosure of protected health information. The **Health Insurance Portability and Accountability Act of 1996** (HIPAA) specifies that Protected Health Information (PHI) can be disclosed for the purpose of health care operations in relation to quality assessment and improvement activities. Moreover, the information you share with us is legally protected through the peer review process; as such, it will be maintained in a strictly confidential manner. If you receive a request for medical records, please provide them within 10 days from the date of request.

We will continue to monitor activities related to the list of adverse events from federal, state and private payers, including “**Never Events**.”

Preventable adverse events should not occur. When they do, we firmly support the concept that a health plan and its Members should not pay for resultant services.

**Please Note:** Medicaid is prohibited from paying for certain **Health Care Acquired Conditions** (HCAC). This applies to all hospitals.

**Never Events:** As defined by the **National Quality Forum (NQF)**, are adverse events that are serious, but largely preventable, and of concern to both the public and health care providers.
CHAPTER 20: ENROLLMENT AND MARKETING RULES

Overview

The delivery of quality health care poses numerous challenges, not least of which is the commitment shared by Anthem and its Providers to protect our Members. We want our Members to make the best health care decisions possible for themselves and their families. When they ask for our assistance, we want to help them make those decisions without undue influence.

Anthem recognizes that Providers occupy a unique, trusted and respected part of people’s lives. Given the complexity of modern-day healthcare and the inherent difficulties communicating with some of the populations we serve, there are potentially serious pitfalls when Anthem or network Providers try to assist in the decision-making process. Sometimes, even though the intent is to help make our Members’ lives better, we can overstep.

For that reason, we are committed to following strict enrollment and marketing guidelines created by the Indiana Family and Social Services Administration (FSSA) and to honoring the rules for all State health care programs.

Marketing Policies

Anthem Providers are prohibited from making marketing presentations and advising or recommending to an eligible individual that he or she select Membership in a particular plan. The Indiana Family and Social Services Administration marketing practice policies prohibit Providers from making the following false or misleading claims:

- That the Primary Medical Provider’s office staff are employees or representatives of the State, county or federal government
- That Anthem is recommended or endorsed by any State or county agency or any other organization
- That the State or county recommends that a prospective Member enroll with a specific health care plan
- That a prospective Member or medical recipient loses Medicaid or other welfare benefits if the prospective Member does not enroll with a specific health care plan

These policies also prohibit Providers from taking the following actions:

- Offering or giving away any form of compensation, reward or loan to a prospective Member to induce or procure Member enrollment in a specific health care plan
- Engaging in direct marketing to Members that is designed to increase enrollment in a particular health care plan. The prohibition should not constrain Providers from engaging in permissible marketing activities consistent with broad outreach objectives and application assistance
- Using any list of Members obtained originally for enrollment purposes from confidential State or county data sources, or from the data sources of other contractors
- Employing marketing practices that discriminate against potential Members based on marital status, age, religion, sex, national origin, language, sexual orientation, ancestry, pre-existing psychiatric problem or medical condition (such as pregnancy, disability or acquired immune deficiency syndrome), other than those specifically excluded from coverage under our contract
- Reproducing or signing an enrollment application for the Member
- Displaying materials only from the Provider’s contracted managed health care organizations and excluding others
Providers are permitted to:

- Assist the Member in applying for benefits by directing him or her to call the **Hoosier Healthwise, Healthy Indiana Plan** and **Hoosier Care Connect** help lines for enrollment information:
  - **Hoosier Healthwise**: 1-800-403-0864
  - **Healthy Indiana Plan**: 1-877-GET-HIP-9 (1-877-438-4479)
  - **Hoosier Care Connect**: 1-866-963-7383
- Distribute copies of HIP applications to potential Members
- File a complaint with **Anthem** if a Provider or Member objects to any form of marketing, either by other Providers or by **Anthem** representatives. (Please refer to the **Grievances and Appeals** chapter of this manual for more information on the grievance process.)

**Enrollment Process**

The **Indiana Family and Social Services Administration (FSSA)** determines the eligibility and enrollment for **Hoosier Healthwise, Healthy Indiana Plan and Hoosier Care Connect Members**. Then the process is as follows:

- The FSSA presents managed health care plan options to individuals and families eligible for **Hoosier Healthwise** and the **Healthy Indiana Plan**.
- Eligible Members enroll in the plan of their choice and select a **Primary Medical Provider**. If, after 30-calendar days, the Member has not selected a Primary Medical Provider, **Anthem** assigns a Primary Medical Provider to the Member. For **Hoosier Healthwise**, the parent or guardian completes applications and makes selections on behalf of children eligible for **Early and Periodic Screening, Diagnostic and Treatment Services**.
- The enrollment broker informs **Anthem** of new Member enrollment, and after enrollment, of any changes in Member eligibility, status or contact information (such as change of address).
- Providers are given notice of new Members assigned to their care through **Anthem** monthly eligibility reports. Providers can access these reports by logging into our secure website, **MyAnthem**, located at [www.anthem.com](http://www.anthem.com).
- **Anthem** sends each new Member a New Member Kit within five business days after receiving the new Member enrollment file. **Anthem** HIP Members receive an **Anthem** ID card that may be swiped in an Availity card reader for Member information. The new Member kit includes a Member Handbook.

**Please Note:** FSSA will automatically re-enroll any Member who loses **Hoosier Healthwise** or HIP eligibility but becomes eligible again within six months or less. Members will automatically return to the same health care plan and Primary Medical Provider that they had prior to disenrollment, if available. Members may choose to switch plans.

**Please Note:** To support the Member enrollment process, Primary Medical Providers are encouraged to maintain open panels. The state requires that 80% of **Anthem** Primary Medical Providers have open panels; your open panel will assist us in meeting this requirement.

**Open Panels:** The commitment by **Anthem**-contracted Providers to accept new **Anthem** Members.

**Hospital Presumptive Eligibility - HIP (HPE)**

Individuals may be determined by a qualified provider (QP) or other authorized entity to be presumptively eligible and will be enrolled with a managed care entity (MCE) for a presumptively
eligible period. This period begins on the day a QP makes a determination that the individual is
presumptively eligible and ends on the earlier of:

- For an individual whose Indiana Health Coverage Program (IHCP) application has been filed –
  the day that a decision is made on the member’s complete application.
- For an individual whose IHCP application has not been filed – the last day of the month
  following the month in which a QP determined the individual to be eligible.

Members will receive the HIP Basic benefit package. The Member will not have a POWER Account and
will be subject to copays.
CHAPTER 21: FRAUD, ABUSE AND WASTE

Overview

We are committed to protecting the integrity of our health care program and the efficiency of our operations by preventing, detecting and investigating fraud, abuse and waste.

Understanding Fraud, Abuse and Waste

Combating fraud, abuse and waste begins with knowledge and awareness.

Fraud: Any type of intentional deception or misrepresentation made with the knowledge that the deception could result in some unauthorized benefit to the person committing it -- or any other person. The attempt itself is fraud, regardless of whether or not it is successful.

Abuse: Any practice inconsistent with sound fiscal, business or medical practices that results in an unnecessary cost to the Medicaid program, including administrative costs from acts that adversely affect Providers or Members.

Waste: Generally defined as activities involving careless, poor or inefficient billing or treatment methods causing unnecessary expenses and/or mismanagement of resources.

Examples of Provider Fraud, Abuse and Waste

The following are examples of Provider fraud, abuse and waste:

- Altering medical records
- Direct billing or balance billing Medicaid members
- Billing for services not provided
- Billing for medically unnecessary tests
- Billing professional services performed by untrained personnel
- Misrepresentation of diagnosis or services
- Overutilization
- Soliciting, offering or receiving kickbacks or bribes
- Unbundling
- Under-utilization
- Upcoding

Examples of Member Fraud, Abuse and Waste

The following are examples of Member fraud, abuse and waste:

- Disruptive or threatening behavior
- Frequent emergency room visits for nonemergent conditions
- Forging, altering or selling prescriptions
- Letting someone else use a Member’s Hoosier Healthwise, Healthy Indiana Plan or Hoosier Care Connect ID
- Not telling the truth about the amount of money or resources the Member has in order to get benefits
- Not telling the truth about a medical condition to get medical treatment
- Obtaining controlled substances from multiple Providers
• Relocating to out-of-service area
• Using more than one Provider to obtain similar treatments and/or medications
• Using a Provider not approved by the Primary Medical Provider
• Using someone else’s Hoosier Healthwise, Healthy Indiana Plan or Hoosier Care Connect ID
• Violation of the Pain Management Contract

Pain Management Contract: A written agreement between a Provider and Member that the Member will not misrepresent his or her need for medication. If the contract is violated, the Provider has the right to drop the Member from his or her practice.

Reporting Provider or Recipient Fraud, Abuse or Waste

If you suspect either a Provider (doctor, dentist, counselor, etc.) or Member (a person who receives benefits) has committed fraud, abuse or waste, you have the right and responsibility to report it.

Providers can report allegations of fraud, abuse or waste to:

ANTHEM MEDICAID SPECIAL INVESTIGATIONS UNIT
4425 Corporation Lane
Virginia Beach, VA 23462
Phone: 1-877-725-2702
Fax: 1-866-494-8279

The MSIU E-mail: corpinvest@anthem.com

Members should let us know if they suspect a Provider, Dentist, Pharmacist, other health care Providers or another person receiving benefits is doing something wrong.

Members can report fraud, abuse or waste, choose one of the following:


When reporting on a Provider (a Doctor, Dentist, Counselor, etc.) include:

• Name, address, and phone number of Provider
• Name and address of the facility (hospital, nursing home, home health agency, etc.)
• Medicaid number of the Provider and facility, if you have it
• Type of Provider (Doctor, Dentist, Therapist, Pharmacist, etc.)
• Names and phone numbers of other witnesses who can help in the investigation
• Dates of events
• Summary of what happened

When reporting about a Member who receives benefits, include:

• The person’s name
• The person’s date of birth, Social Security number or case number if you have it
• The city where the person lives
• Specific details about the fraud, abuse or waste

Anonymous Reporting of Suspected Fraud, Abuse and Waste
Any incident of fraud, abuse or waste may be reported to us anonymously; however, in certain instances, we may not be able to pursue an investigation without additional information. In such cases, we will need the following:

- The name of the person reporting and their relationship to the person suspected
- A call-back phone number for the person reporting the incident

Please Note: The name of the person reporting the incident and his callback number will be kept in strict confidence by investigators to maintain that person's anonymity.

Investigation Process

We do not tolerate acts that adversely affect Providers or Members. We investigate all reports of fraud, abuse and waste. Allegations and the investigative findings are reported to the Indiana Family and Social Services Administration (FSSA) as well as regulatory and law enforcement agencies. In addition to reporting, we take corrective action, such as:

- **Written warning and/or education**: We send certified letters to the Provider or Member documenting the issues and the need for improvement. Letters may include education, request for recoveries, or may advise of further action.
- **Medical record audit**: We may review medical records to substantiate allegations or validate claims submissions.
- **Special claims review**: A special claims review places payment or system edits on file to prevent automatic claim payment; this requires a medical reviewer evaluation.
- **Recoveries**: We recover overpayments directly from the Provider within 30 days. Failure of the Provider to return the overpayment may be reflected in reduced payment of future claims or further legal action.

Acting on Investigative Findings

We refer all criminal activity, be it Member or Provider, to the appropriate regulatory and law enforcement agencies.

If a **Provider** has committed fraud, abuse or waste, the Provider:

- Will be referred to the **Quality Management** department
- May be presented to the credentials committee and/or peer review committee for disciplinary action, including Provider termination

Failure to comply with program policy, procedures or any violation of the contract will result in termination from our plan.

If a **Member** has committed fraud, exhibited abusive or threatening behavior, or has failed to correct issues, he or she may be involuntarily disenrolled from our health care plan, with state approval. (Refer to the **Member Transfers** chapter for more information on the disenrollment process.)

False Claims Act

We are committed to complying with all applicable federal and State laws, including the federal **False Claims Act** (FCA).

The **False Claims Act** is a federal law that allows the government to recover money stolen through fraud by government contractors. Under the FCA, anyone who knowingly submits or causes another person or entity to submit false claims for payment of government funds is liable for three times the damages, or loss, to the government, plus civil penalties of $5,500 to $11,000 per false claim.
The FCA also contains Qui Tam or “whistleblower” provisions. A “whistleblower” is an individual who reports in good faith an act of fraud or waste to the government or files a lawsuit on behalf of the government. Whistleblowers are protected from retaliation from their employer under Qui Tam provisions in the FCA and may be entitled to a percentage of the funds recovered by the government.
CHAPTER 22: MEMBER RIGHTS & RESPONSIBILITIES

Overview

Members should be clearly informed about their rights and responsibilities in order to make the best health care decisions. That includes the right to ask questions about the way we conduct business, as well as the responsibility to learn about their health care coverage.

The following Member rights are defined by the state of Indiana and appear in the Anthem Member welcome packets and Member Handbook. They are also posted on our website at www.anthem.com under OTHER ANTHEM WEBSITES, select Providers > Under Providers/Spotlight select State-Sponsored Plans – Indiana Hoosier Healthwise, Health Indiana Plan and Hoosier Care Connect >Select Indiana Hoosier Healthwise, Healthy Indiana Plan (HIP) and Hoosier Care Connect >scroll down to Forms and Tools >select Member Rights and Responsibilities >go to the chapter of the Provider Manual for the current version.

Member Rights

Members have the right to:

- Receive information about Anthem, the services Anthem provides, Anthem’s provider network and their rights and responsibilities. We send a Member handbook and a Member newsletter upon Member enrollment annually. Information about Anthem is available on our website at www.anthem.com/inmedicaid and via the Customer Care Center at 1-866-408-6131 (TTY 1-866-408-7188).
- Be treated with respect and with due consideration for their dignity and privacy.
- Receive information on available treatment options and alternatives, presented in a way that is understandable and right for the Member’s condition.
- Know if their physician takes part in a physician incentive plan through Anthem. You may call us to learn more about this. Anthem does not give incentives to providers for not providing care.
- Take part in all decisions about their health care. This includes the right to refuse treatment.
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in federal laws on the use of restraints and seclusions.
- Request and receive a copy of their medical records. And as the Member requests, the records may be amended or corrected, as stated in State and federal health care privacy laws.
- Have timely access to covered services and medically necessary care.
- Have honest talks with their providers about the right treatment for their condition, in spite of the cost or benefit coverage.
- Have their health plan, doctors and all of their care providers keep their medical records and health insurance information private.
- Have their problems taken care of fast. (This includes things they think are wrong, as well as issues that have to do with coverage, payment of services or getting Anthem approval.)
- Have access to medical advice from their provider, either in person or by phone, 24 hours a day, seven days a week. (This includes emergency or urgent care.)
- Get interpreter services at no charge if they speak a language other than English or if they have hearing, vision or speech loss.
- Ask for information and other Anthem materials (letters, newsletters) in other formats. These include Braille, large-size print or audio CD, at no charge to the Member. Call the toll free Customer Care Center at 1-866-408-6131 (TTY 1-866-408-7188).
• Tell us what they would like to change about their health plan.
• Question a decision we make about coverage for care they received from a provider. (Member will not be treated differently if they file a complaint.)
• Ask about our quality program and tell us if they would like to see changes made.
• Ask us how we do utilization review and give us ideas on how to change it.
• Know they will not be held liable if their health plan becomes insolvent (bankrupt and cannot pay its bills).
• Know that Anthem, their doctors or other health care providers cannot treat them differently for these reasons:
  – Their age
  – Their sex
  – Their race
  – Their national origin
  – Their language needs
  – The degree of their illness or health condition

**Member Responsibilities**

Members have the following responsibilities:

• Tell us, their doctor and other health care providers what we need to know to treat them
• Understand their health problems
• Follow the treatment plans that they, their doctors and other health care providers agree to
• Do the things that keep them from getting sick
• Treat their doctor and other health care providers with respect
• Make appointments with their doctor when needed
• Keep all scheduled appointments and be on time
• Call their doctor if they cannot make it to an appointment
• Always call their PMP first for all medical care (unless they have an emergency)
• Show their ID card each time they get medical care
• Use the emergency room only for true emergencies
• Pay any required copays
• Pay all monthly contribution payments on time (if they are a HIP Member who is required to pay something)
• Tell us and their social worker if:
  – They move
  – They change phone numbers
  – They have any changes to their insurance
  – The number of people in their household changes
  – They become pregnant
CHAPTER 23: CULTURAL DIVERSITY & LINGUISTIC SERVICES

Overview

At Anthem, we recognize that providing health care services to a diverse population can present challenges. Those challenges arise when Providers need to cross a cultural divide to treat Members who may have different behaviors, attitudes and beliefs concerning health care. Differences in our Members' ability to read may add an extra dimension of difficulty when Providers try to encourage follow through on treatment plans.

Anthem’s Cultural Diversity and Linguistic Services Toolkit, called "Caring For Diverse Populations," was developed to give you specific tools for breaking through cultural and language barriers in an effort to better communicate with your patients.

Sometimes the solution is as simple as finding the right interpreter for an office visit. Other times, a greater awareness of cultural sensitivities can open the door to the kind of interaction that makes treatment plans most effective: has the patient been raised in a culture that frowns upon direct eye contact or receiving medical treatment from a Member of the opposite sex? Is the patient self-conscious about his or her ability to read instructions?

This toolkit gives you the information you'll need to answer those questions and continue building trust. It will enhance your ability to communicate with ease, talking to a wide range of people about a variety of culturally sensitive topics, and it offers cultural and linguistic training to your office staff so that all aspects of an office visit can go smoothly.

We strongly encourage you to access the complete Health Education: Caring for Diverse Populations toolkit on the Provider Resources page of our website, www.anthem.com. For directions on how to access the Provider Resources page of our website, please see Chapter 1: How to Access Information, Forms and Tools on Our Website.

The toolkit contents are organized into the following sections:

Improving Communications with a Diverse Patient Base

- Encounter tips for Providers and their clinical staff
- A mnemonic to assist with patient interviews
- Help in identifying literacy problems

Tools and Training for Your Office in Caring for a Diverse Patient Base

- Interview guide for hiring clinical staff who have an awareness of cultural competency issues
- Availability of Medical Consumerism training for health educators to share with patients

Resources to Communicate Across Language Barriers

- Tips for locating and working with interpreters
- Common signs and common sentences in many languages
- Language identification flashcards
- Language skill self-assessment tools

Primer on How Cultural Background Impacts Health Care Delivery

- Tips for talking with people across cultures about a variety of culturally sensitive topics
- Information about health care beliefs of different cultural backgrounds
Regulations and Standards for Cultural and Linguistic Services

- Identifies some important legislation impacting cultural and linguistic services including a summary of the “Culturally and Linguistically Appropriate Service” standards (CLAS) which serve as a guide on how to meet these requirements

Resources for Cultural and Linguistic Services

- A bibliography of print and Internet resources for conducting an assessment of the cultural and linguistic
- Needs of your own practice’s patient population
- Staff and physician cultural and linguistic competency training resources
- Links to additional tools in multiple languages and/or written for limited English proficiency

This toolkit contains materials developed by and used with the permission of the Industry Collaboration Effort (ICE) Cultural and Linguistic Workgroup, a volunteer, multi-disciplinary team of Providers, health plans, associations, state and federal agencies and accrediting bodies working collaboratively to improve health care regulatory compliance through public education. More information on the ICE Workgroup may be obtained on the ICE Workgroup website at www.iceforhealth.org.

Interpreter Services

For those instances when you cannot communicate with a Member due to language barriers, interpreter services, including over-the-phone and face-to-face interpreters, are available at no cost to you or the Member. Providers must notify Members of the availability of interpreter services and strongly discourage the use of friends and family, particularly minors, to act as interpreters. Face-to-face interpreters for Members needing language assistance, including American Sign Language, are available by placing a request at least 72 hours in advance. A 24-hour cancellation notice is required.

To request interpreter services, Providers and Members should call:

**Anthem Medicaid Provider Helpline:** 1-866-408-6132
**Customer Care Center (Members):** 1-866-408-6131

For after-hours interpreter services, call **24/7 NurseLine at 1-866-800-8780** or **1-800-368-4424 (TTY)** and follow these steps:

1. Give the Customer Care associate the Member’s ID number
2. Explain the need for an interpreter and state the language
3. Wait on the line while the connection is made
4. Once connected to the interpreter, the associate or **24/7 NurseLine** nurse introduces the Member, explains the reason for the call and begins the dialogue

**TTY and Relay Services (for Members with Hearing Loss or Speech Impairment)**

During business hours, call Anthem’s TTY line at **1-866-408-7188**. The Indiana relay service is available 24 hours a day by calling **1-800-743-3333** or **711**.

For additional information on interpreter services, please go to the Health Education: Interpreter Services section on the Provider Resources page of our website, [www.anthem.com](http://www.anthem.com). For directions on how to access the Provider Resources page of our website, please see Chapter 1: How to Access Information, Forms and Tools on Our Website.