HEDIS®: Top 10 Reasons to Participate in HEDIS!

Thank you for participating in HEDIS 2012. The annual Healthcare Effectiveness Data and Information Set (HEDIS) project begins again in February! For 2013 the National Committee for Quality Assurance (NCQA) has set the final deadline as May 15th for collecting HEDIS data. We appreciate your cooperation and timeliness in submitting the requested medical record information and/or accommodating the on-site appointment with the review nurses.

Do you ever wonder WHY you should participate in this necessary project each year? Here are the top 10 reasons why taking a few minutes to provide information for HEDIS is beneficial:

Drum roll please…

#10 – HEDIS is used by more than 90% of America’s healthplans to measure performance on important components of care and service.

#9 – As a participating provider, you have agreed to participate and cooperate with our quality and audit programs, including providing medical records where needed.

#8 – Centers for Medicare and Medicaid Services (CMS) requires this information to ensure that quality care is provided to Medicare and Medicaid patients.

#7 – Many states use HEDIS data for development of educational programs and public service announcements directed at areas of low compliance.

#6 – HEDIS results are used by consumers to help in the selection of a health plan which means your office could acquire new patients.

<table>
<thead>
<tr>
<th>Customer Service and 24/7 Nurseline</th>
<th>Community Resource Coordinators</th>
<th>Authorizations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Customer Care Center 1-866-408-6132</td>
<td>Central (Indianapolis) 1-866-795-5440</td>
<td>Utilization Management/ Prior Authorization 1-866-408-7187 (phone)</td>
</tr>
<tr>
<td>24/7 NurseLine 1-866-800-8789</td>
<td>Northwest (Merrillville) 1-866-724-6533</td>
<td>Pharmacy Authorization 1-866-879-0106</td>
</tr>
<tr>
<td></td>
<td>Southwest (Evansville) 1-866-461-3586</td>
<td></td>
</tr>
</tbody>
</table>
#5 – Opportunity for contact with HEDIS staff to answer any questions related to the HEDIS project and keep the lines of communication open. We are all on the same team with the same ultimate goals.

#4 – HEDIS data can be used to track healthcare effectiveness and utilization trends across states and regions which may impact the way your practice chooses to direct care.

#3 – Identifies potential gaps in services for your patients allowing for education between providers and patients about the importance of getting these services for optimum health care.

#2 – Your feedback helps us identify opportunities to send health care reminders to your patients on important preventive screenings.

And the #1 Reason…

As healthcare providers and administrators, we all strive for optimum health for our communities and the people we serve. HEDIS focuses on timely preventive care and results that support this goal. When we meet our goals, patients are healthier and happier and health care costs are reduced.

As you can see, we need you and we value you! We thank you and your staff for demonstrating teamwork and partnership as we work together to improve the health of our members, and your patients. We look forward to working with you this HEDIS season.
Care Management Programs

Managing illness can sometimes be a difficult thing to do. Knowing who to contact, what test results mean or how to get needed resources can be a bigger piece of a healthcare puzzle that for some, are frightening and complex issues to handle.

Anthem Blue Cross and Blue Shield (Anthem) is available to offer assistance in these difficult moments with our Care Management Programs. Our Case Managers are part of an interdisciplinary team of clinicians and other resource professionals that are there to support members, families, primary medical providers and caregivers. The care management process utilizes experience and expertise of the care coordination team whose goal is to educate and empower our members to increase self management skills, understand their illness, and learn about care choices in order to access quality, efficient health care.

Members or caregivers can refer themselves or family members by calling the customer service number on the back of their health plan card. They will be transferred to a team member based on the immediate need. Physicians can also refer by contacting us. No issue is too big or too small. We can help with transitions across level of care so that patients and caregivers are better prepared and informed about healthcare decisions and goals.

How do you contact us?

<table>
<thead>
<tr>
<th>CM Telephone Number</th>
<th>1-800-231-8254</th>
</tr>
</thead>
<tbody>
<tr>
<td>CM Email Address</td>
<td><a href="mailto:CMReferralSpecialistNE@WellPoint.com">CMReferralSpecialistNE@WellPoint.com</a></td>
</tr>
<tr>
<td>CM Business Hours</td>
<td>Monday - Friday 8:00 a.m. – 5:00 p.m.</td>
</tr>
</tbody>
</table>

Initiative to Increase Influenza Vaccination Rates for African-American and Hispanic Members

Anthem, along with America’s Health Insurance Plans (AHIP) and the Department of Health and Human Services (DHHS), supports the Office of Minority Health’s 2011-2012 Minority Flu Outreach Campaign. The objective of the campaign is to help reduce the disparity in influenza vaccination in African-American and Hispanic populations. Key goals of the campaign are to:

- Raise awareness,
- Promote access to vaccines, and
- Promote community outreach through partnerships.

In order to support the Minority Flu Outreach Campaign, we are asking Primary Medical Providers (PMPs) and Obstetrics and Gynecology (OB/GYN) specialists to help promote Influenza (flu) vaccination to African American and Hispanic members.

Take Advantage of Free Materials to Promote Flu Vaccination

To help our providers, we have included information on how to access a broad portfolio of free, culturally appropriate materials designed to help educate and encourage flu vaccination among minority populations. These materials include a provider toolkit, posters, fliers, brochures, e-Cards, handouts, multicultural materials and much more.
The Cobb National Medical Association Health Institute Immunization Toolkit


¹ The National Medical Association (NMA) launched the W. Montague Cobb/NMA Health Institute in December 2004 to develop, evaluate, and implement strategies to promote wellness and eliminate health disparities and racism in medicine.

The Toolkit for Healthcare Professionals includes information to help providers develop a successful campaign to increase awareness and educate patients on the benefits of flu vaccination:
- Fact Sheets providers can share with their patients:
  - Myths About the Flu
  - Influenza Disparities in Minorities and Seniors
  - Protecting All From Flu mini-brochure

The toolkit also includes resources to support provider offices in implementing an influenza campaign to promote awareness to patients:
- Flu season promotional campaign work plan
- Patient vaccination monitoring and chart review tips
- Promotional materials and reminder letters
- Evaluation and planning for next year
- Websites, recommendations and resources

The “Flu Ends With U” Campaign by the Centers for Disease Control

The Centers for Disease Control and Prevention (CDC) offers the following free tools and resources at
[www.cdc.gov/flu/freeresources](http://www.cdc.gov/flu/freeresources):
- Posters – 8 ½ x 11 inch (letter size) posters with important messages promoting flu vaccination to African American and Hispanic populations.
- Multicultural materials that can be downloaded and reproduced either in color or black and white.
- A variety of fliers, handouts and brochures in English, Spanish and Chinese to help parents, caregivers and others understand the facts about flu and flu vaccination.
- E-Cards that can be used to remind members about the flu season, vaccination, hand washing and other important health-conscious messages.

Help Us Help Our Members

Together, Anthem, PCPs and OB/GYNs can help educate minorities on the importance of flu vaccination and help increase vaccination rates. We thank our providers in advance for helping to promote flu vaccination and improve health outcomes for our members.

For More Information

If you would like more information, please contact your Community Resource Center:
Central (Indianapolis) 1-866-795-5440
Northwest (Merrillville) 1-866-724-6533
Southwest (Evansville) 1-866-461-3586

Additional Resources
- The Department of Health and Human Services/ Centers for Disease Control and Prevention: [www.cdc.gov/flu](http://www.cdc.gov/flu) or call 1-800-CDC-INFO.
Child and Adolescent Immunizations: Five Steps to Quality Improvement in Practice

Managing child and adolescent immunizations can be challenging. While the reasons vary, physicians and their staff can do much to increase immunization rates in their practice.

Consider these five key steps:

1. Recommend to parents they comply with the immunization schedule. Most parents believe in the benefits of immunization for their children. However, as a health care practitioner, you may encounter parents who question the need for, or safety of, childhood vaccines. Parents may choose to delay or forgo immunizing their children with some or all of the recommended vaccines.

Physicians and providers are the most important source of truth and influence in members’ health care decision making. To help parents make well-informed decisions about immunizing their children, providers should be prepared to respond effectively to concerns and questions. The Centers for Disease Control and Prevention (CDC) offers guides and tools to assist you. You can locate these resources on their website at www.cdc.gov/vaccines/pubs/providers-guide-parents-questioning-vacc.htm.

2. Use a Vaccine Administration Record. Accurate, up-to-date patient records are critical to providing optimal healthcare. Whether paper or electronic, each patient’s medical record should have a current vaccine administration record. When all data fields are filled in, the immunization information you need is readily available for your review. For a printable version of the vaccine administration record recommended by the CDC, as well as instruction and sample records for documenting the administration of vaccines, including combination vaccines, go to: www.immunize.org/catg.d/p2022.pdf.

3. Participate in a population-based immunization information system or immunization registry. Patients often receive vaccines in more than one setting, such as at school, public health clinics, pharmacies and grocery stores. Immunization registries are a centralized repository for immunization records and an important tool to help ensure that children receive their immunizations according to the recommended schedules. These immunization registries can also help to prevent over-immunizing. The CDC maintains a point and click map of the 50 states where you can access state-specific immunization websites. To locate these websites, go to www.cdc.gov/vaccines/spec-grps/prog-mgrs/grantee-imz-websites.htm.

4. Use a patient reminder system - also known as a Reminder/Recall process - to notify parents when their children are due for vaccinations. A Reminder/Recall (RR) process can help providers communicate with individual patients, parents, guardians or other responsible parties. The Reminder/Recall process lets the patient, parent, guardian or other individual know that the patient is due now, on a future date (reminder), or is past due (recall) for one or more recommended immunizations. The main goal of a RR process is to improve timeliness and completion of recommended immunizations. The Task Force on Community Preventive Services recommends reminder and recall interventions based on strong evidence that the process effectively improves vaccination rates.¹

5. Ask about immunizations at all office contacts, including non-routine visits. Ideally, immunizations should be administered as part of a comprehensive child health care exam. To help eliminate barriers and obstacles (e.g. appointment-only systems and unnecessary pre-vaccination physical examinations) that impede efficient vaccine delivery, providers are encouraged to take advantage of all health care visits as opportunities to provide vaccinations.

The National Vaccine Advisory Committee (NVAC) recommends standards for immunization policies and practices which are approved by the U.S. Public Health Service and endorsed by the American Academy of Pediatrics. You may access these standards by visiting: www.cdc.gov/mmwr/preview/mmwrhtml/00020935.htm.

¹ www.thecommunityguide.org/vaccines/universally/clientreminder.html
HIPAA 5010

As you know from prior communications, Anthem has been following the evolution of the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act (HIPAA) since its inception in 1996. Our goal is to help ensure that our systems, supporting business processes, policies, and procedures successfully meet the implementation standards and deadlines mandated by the United States Department of Health and Human Services (DHHS).

HIPAA Title II, sometimes called Administrative Simplification, has two primary areas of regulation: 1) the standardization of certain electronic health care related transactions, and 2) the implementation of controls to protect an individual’s health information.

The HIPAA Administrative Simplification rules and regulations apply to covered entities defined to include health plans, health care clearinghouses, and health care providers who transmit any health information in any electronic form in connection with transactions covered under the rules, and who receive, maintain, or disclose individually identifiable health information in any form or medium. All covered entities must comply with the standards adopted by HIPAA. If you need additional information please visit the 5010 Web pages located on the main EDI sites at www.empireblue.com/edi/5010 or contact EDI SOLUTIONS 1-800-470-9630 or email EDI.ENT.Support@anthem.com

Medicaid Drug Rebate Program Drives Changes to Hoosier Healthwise Claims Billing

Earlier this year you received information on Health Care Reform legislation which initiated changes to utilization reporting requirements for Medicaid Managed Care Organizations (MCOs), including Anthem. The new reporting requirements impact rebates issued by drug manufacturers to the Indiana Health Coverage Programs (IHCP). The requirements indicated the need to include National Drug Codes (NDCs), Unit of Measurement and Quantity of Unit, on all claims Hoosier Healthwise claims billed to Anthem.

To comply with the legislation, we require NDCs on Hoosier Healthwise claims which include physician-administered drugs. This applies to drugs dispensed in both professional (medical) and institutional (facility) outpatient settings.

As of February 18, 2012, Anthem started to deny professional and outpatient institutional claims containing physician administered drugs for Hoosier Healthwise members if any of the below elements are missing or invalid:
- NDC(s)
- Unit of Measurement
- NDC Unit

The state of Indiana Office of Medicaid Policy and Planning (OMPP) requires Anthem report the NDC information to the OMPP each month. IHCP submits this data to pharmaceutical manufacturers in order to obtain rebates under the Medicaid Drug Rebate Program. It is important that you submit claims correctly to ensure that the state receives timely Medicaid Drug Rebates from drug manufacturers.

For instructions on submitting professional and outpatient institutional claims containing physician-administered drugs, please read the Medicaid Drug Rebate Program Drives Changes to Hoosier Healthwise Claims Billing Provider Bulletin located on the Anthem website at www.anthem.com.

To locate the bulletin:
2. Click on Providers.
3. Under Providers | Spotlight, click on State Sponsored Plans | Indiana Hoosier Healthwise and Healthy Indiana Plan.
4. On the State Sponsored Plans webpage, click on Indiana Hoosier Healthwise and Healthy Indiana Plan (HIP).
5. Scroll down to Provider Communication and click on Provider Operations Manual and Important Updates.
6. Click on the provider bulletin titled Medicaid Drug Rebate Program Drives Changes to Hoosier Healthwise Claims Billing.

We thank you for your participation with Anthem and your commitment to caring for Anthem members enrolled in Hoosier Healthwise. If you have any questions about billing with NDC codes, please contact Customer Care Center at 1-866-408-6132.
Availity® Services Offered for Anthem Blue Cross and Blue Shield Providers

Register today for Availity services offered to Anthem Blue Cross and Blue Shield providers

Did you know... Your access to Anthem Blue Cross and Blue Shield (Anthem) Online Eligibility, Benefit, Claim Status Inquiry and Secure Messaging is moving exclusively to Availity® on November 2, 2012? Getting started with Availity is easy and free training is available! Go to www.availity.com to register or log in.

Note: Electronic transactions submitted via our Enterprise EDI Gateway are unaffected; you may continue to submit all X12 transactions through your current EDI transmission channels.

A free, secure multi-health plan portal
Availity’s secure multi-health plan portal – available at no charge to physicians, hospitals and other health care professionals – improves efficiencies through simplified and streamlined health plan administration. Availity is health information when and where you need it – and that benefits patients, providers and health plans.

Get the information you need instantly
Providers can access real-time eligibility, benefits, and claims status information and much more through one secure Web portal at www.availity.com. Submit eligibility and benefit inquiries for single or multiple patients for multiple plans and receive a consolidated response in a consistent format.

- **Member eligibility and benefits inquiry** - real-time patient eligibility, benefits, and accumulative data including current and historical coverage information. Detailed co-insurance, co-payment and deductible information for ALL members, including BlueCard® and FEP.

- **Claim status inquiry** – details and payment information including claim line-level details/processing.

- **Secure Messaging*** - send a question to clarify the status of a claim or to get additional information on claims.

- **New! Online Remits*** – link to online remits under Claims Management/Remittance Review.

*Anthem-specific products that can be accessed through Availity require continued registration on MyAnthem™.

Take advantage of the many benefits of using Availity
Benefits include:

- **No charge** – Health plan transactions are available at no charge to providers.

- **Accessibility** – Functions are available 24 hours a day from any computer with Internet access.

- **Standard responses** – Responses from multiple payers returned in the same format and screen layout, providing users with a consistent look and feel.

- **Commercial and Government Payers** – Access data from Anthem, Medicare, Medicaid and other commercial carriers. (See www.availity.com for a full list of payers)

- **Compliance** – Compliant with all Health Insurance Portability and Accountability Act (HIPAA) regulations.
How to get started

To register for access to Availity, go to: www.availity.com/providers/registration-details/. It’s that simple!

*Registering an Availity User for Anthem Services

1. Log in to Availity and click My Account | Anthem Services Registration. If prompted, select your organization next.

2. In the Display field, click Non-Registered Users.

3. Enter the user Anthem Blue Cross and Blue Shield User ID, also known as the EAM ID, in the field provided.
   - To enable the Register button, enter one or more user Anthem Blue Cross and Blue Shield User ID
   - If the user does not have an Anthem Blue Cross and Blue Shield User ID, contact Anthem to obtain one, and then return to this page to register the user.

4. Click Register.

5. Note that the User(s) Registered page displays.
   - If registration is successful, the user(s) can begin using the services immediately.
   - If an error message displays, the registration or change was not successful for that user. Review the message and verify the information you entered. Make note of the Transaction ID if you need to contact Availity Client Services for assistance. Please note that the user’s first name, last name, and Anthem EAM ID in Availity must match exactly with how the user is registered with Anthem.

Once you log into the secure portal, you’ll have access to free live training to jumpstart your learning, frequently asked questions, comprehensive help topics and other resources to help ensure you get the most out of your Availity experience. Client service representatives are also available Monday through Friday to answer your questions at 1-800-AVAILITY (1-800-282-4548).

Availity services and coverage are always expanding. Please check frequently for new offerings.

For an online demonstration or to register for access to the Availity Health Information Network, visit www.availity.com

Availity, an independent company, provides claims management services for Anthem Blue Cross and Blue Shield.

Rev 6/2012
Quick Reference Guide to Resolve Claims Issues

Getting your claims paid correctly is important to us. The table below demonstrates a variety of typical claims issues and offers the appropriate actions that will help to achieve our goal of rapid and efficient claim payments for you.

<table>
<thead>
<tr>
<th>Issue</th>
<th>Action</th>
</tr>
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<tbody>
<tr>
<td><strong>Claim denied or paid wrong amount</strong> due to incorrect billing by provider, OR <strong>Resubmitting claim returned</strong> for information such as:</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: <strong>Anthem Indiana Medicaid Corrected Claims</strong> PO 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 – see the Provider Operations Manual.</td>
</tr>
<tr>
<td><strong>Unknown status of claim</strong> 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 Network providers must file claims within 90 calendar days and it is the provider’s responsibility to follow-up timely to be sure claims are received.</td>
</tr>
<tr>
<td><strong>Follow-up on status of a claim adjustment or reprocessing</strong> 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 Allow 60 calendar days for adjustments, but follow-up before 90 days. All follow-up to previous actions or interactions must be within 90 calendar days</td>
</tr>
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### New Report for Behavioral Health Review

Anthem Blue Cross and Blue Shield (Anthem) completes a Behavioral Health Review which gives providers a high-level view of behavioral health services and prescription medications for their patients who are Anthem members. We send this information as a tool to help you identify patients who may not be following their treatment plan, and those who may not be in compliance with evidence-based guidelines.

We wanted to let you know of recent changes made to the Behavioral Health Review you receive.

The Behavioral Health Review has been enhanced to provide Medicaid members’ assigned primary medical providers with a monthly communication that summarizes critical information on behavioral health conditions and prescription medicine history over a three-month period. This enhanced report uses more up-to-date claims information and is processed on a monthly basis to help identify potential issues sooner. We have also enhanced the design of the report to present information in a more user-friendly format.

Note: Due to data issues the prescription quantity column may be blank. We are working to resolve this issue so the quantity information populates. Please do not be alarmed if the quantity is zero.

Please call [1-866-408-7197](tel:1-866-408-7197) if you have any questions or need more information about the Behavioral Health Review.

<table>
<thead>
<tr>
<th>Provider disagrees with full or partial claim rejection OR Payment is not the amount expected.</th>
<th>Submit Claims Dispute.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>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 PO Box 6144 Indianapolis, IN 46206-6144</td>
</tr>
<tr>
<td>Note that it is the provider’s responsibility to check EOBs and submit Claims Disputes timely.</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Provider disagrees with Claims Dispute response.</th>
<th>Submit Claims Appeal.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>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 PO Box 6144 Indianapolis, IN 46206-6144</td>
</tr>
</tbody>
</table>

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<tr>
<th>Complicated, involved claim issues.</th>
<th>Submit Written Correspondence.</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Send electronically through Availity, or send paper correspondence to: Anthem Indiana Medicaid Correspondence PO Box 6144 Indianapolis, IN 46206-6144</td>
</tr>
</tbody>
</table>
**McKesson’s ClaimsXten™ Rules, Reimbursement Policies**

You may be familiar with ClaimsXten™, a claims editing software product from McKesson used by Anthem Blue Cross and Blue Shield (Anthem) Hoosier Healthwise and Healthy Indiana Plan since 2010. ClaimsXten uses claim rules, which apply plan reimbursement policies to submitted claims. Effective **December 8, 2012**, we are updating the Reimbursement Policies and McKesson’s ClaimsXten™ Rules.

To help you with this update we have created a McKesson ClaimsXtenTM Rules grid. This grid includes all rules in effect for Anthem and includes all new, revised and existing rules to give you a comprehensive list for reference and review. The effective dates for the new and revised rules are noted on the grid, which is available on the Anthem Medicaid web site.

**McKesson ClaimsXtenTM Rules grid**

You can view the McKesson ClaimsXtenTM Rules grid at [www.anthem.com](http://www.anthem.com). Go to the upper left hand corner or under OTHER ANTHEM WEBSITES and click on **Providers** then click on **State Sponsored Plans – Indiana Hoosier Healthwise and Healthy Indiana Plan** link, scroll down to **Provider Communications** and click on **Provider Operations Manual and Important Updates**.

If you have any questions about these changes, please contact our Provider Customer Care Center at **1-866-408-6132**.

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**B-Bundled Codes not separately reimbursed**

Effective for dates of service on or after August 1, 2012, the Indiana Health Coverage Programs (IHCP) will not separately reimburse certain Current Procedural Terminology (CPT®) and Healthcare Common Procedure Coding System (HCPCS) codes with a designated status of “B” (indicating a bundled procedure) by the Centers for Medicare & Medicaid Services’ (CMS) National Physician Fee Schedule (NPFS) Relative Value File. B-Bundled Codes are not reimbursable services, regardless of whether they are billed alone or in conjunction with other services on the same date. The codes included in this policy, for which separate reimbursement will not be made, can be found in the table in the code list referenced below.

Per the public use file that accompanies the NPFS Relative Value File, a status indicator of “B” means the following:

“Payment for covered services are always bundled into payment for other services not specified. If [Relative Value Units] RVUs are shown, they are not used for Medicare payment. If these services are covered, payment for them is subsumed by the payment for the services to which they are incident. (An example is a telephone call from a hospital nurse regarding care of a patient).”

For a complete list of the codes please visit the IHCP website at [http://provider.indianamedicaid.com](http://provider.indianamedicaid.com). Select **Bulletins** then **view Bulletins** under the **News, Bulletins, and Banners** tab located at the top of the page. Scroll down to Bulletin # BT201223 date 06/26/2012 **B-Bundled Codes Not Separately Reimbursed**.

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**Policies, Updates and Reminders**

**Hoosier Healthwise and Healthy Indiana Plan.** Click on the **Indiana Hoosier Healthwise and Healthy Indiana Plan** link, scroll down to **Forms and Tools** and click on **McKesson ClaimsXtenTM Rules**.

**Reimbursement Policy**

As applicable, Anthem Medicaid will follow state-specific guidelines and policies for reimbursement. To view these policies please see the Indiana State Medicaid Provider Manual located at [http://provider.indianamedicaid.com/general-provider-services/manuals.aspx](http://provider.indianamedicaid.com/general-provider-services/manuals.aspx). Also view the Anthem Medicaid Provider Manual at [www.anthem.com](http://www.anthem.com). Go to the upper left hand corner or under OTHER ANTHEM WEBSITES and click on **Providers** then click on **State Sponsored Plans – Indiana Hoosier Healthwise and Healthy Indiana Plan**. Click on the **Indiana Hoosier Healthwise and Healthy Indiana Plan** link, scroll down to **Provider Communications** and click on **Provider Operations Manual and Important Updates**.
Annual Satisfaction Survey

We would like to provide a reminder to all of our providers that our Annual Satisfaction Survey was sent to members in October. The survey asks members for their feedback on how the Health Plan and our network of providers are meeting members’ needs. In keeping with our “customer first” philosophy, Anthem solicits this feedback in order to make health coverage effective, accessible and easy-to-use for our members.

Most of the questions in the survey can be answered by simply filling in the selected answer. Completing the survey takes only a few minutes, and we ask that you encourage your patients, our members, to complete and submit the survey. Those who would like help completing the survey, can contact The Dieringer Research Group at 1-877-837-8074 for help.