Kentucky
Medicaid • Commercial

2023 hospital webinar

Becky George and
Brian Richardson
December 5, 2023

Anthem

Agenda

- Provider relationship management representative contacts
- Newsletter and updates
- Medical hospital UM:
  - Commercial
  - Medicare Advantage
  - KY Medicaid
- Medicaid redetermination
- Claims dispute and appeals process
- Enhancing processes RFAI

Note: Discussion includes commercial, Medicare Advantage and Medicaid provider services.

Anthem provider relationship management representative contacts and newsletter updates

Provider contacts

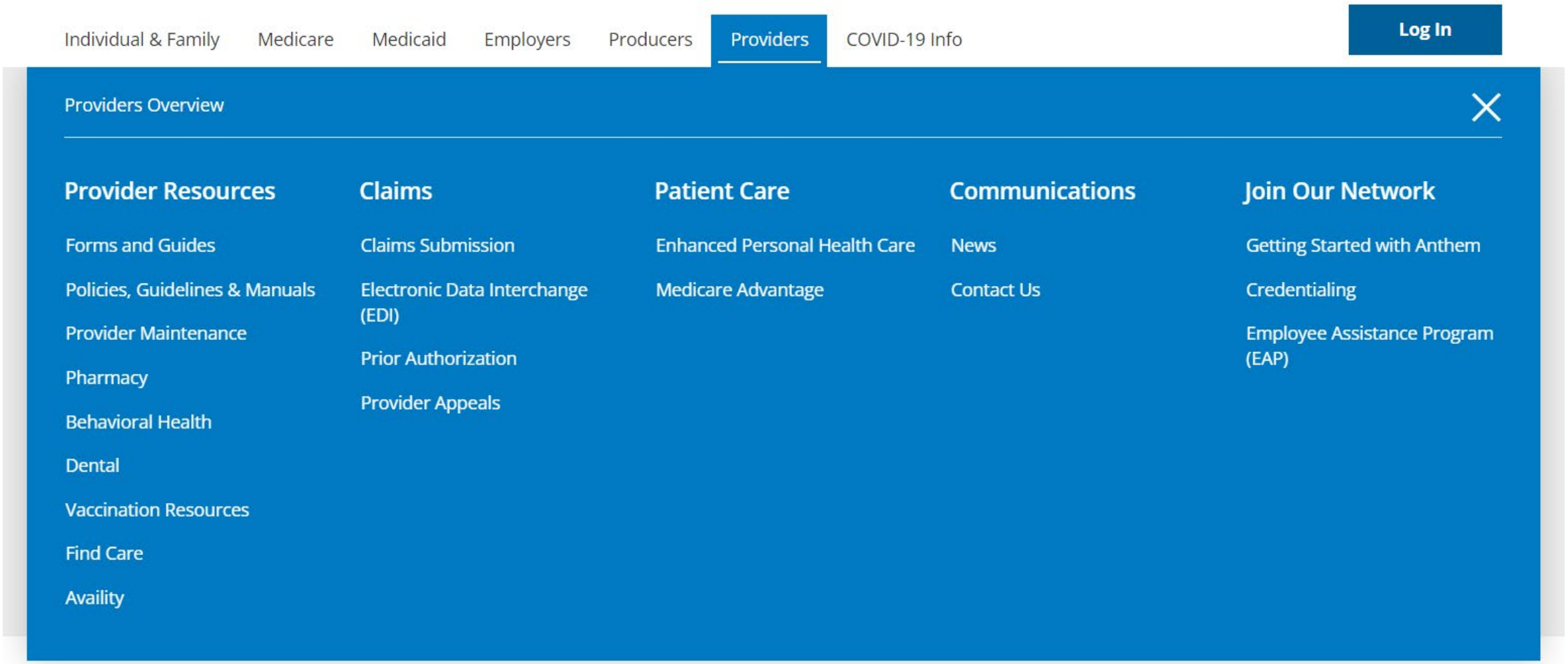
If you have a question about a previously submitted information update, enrollment application, or contracting question not answered here, please check the following resources for additional contact information or send us a message.

Anthem Admin Service Directory ›

Provider Relationship Management Territory Map

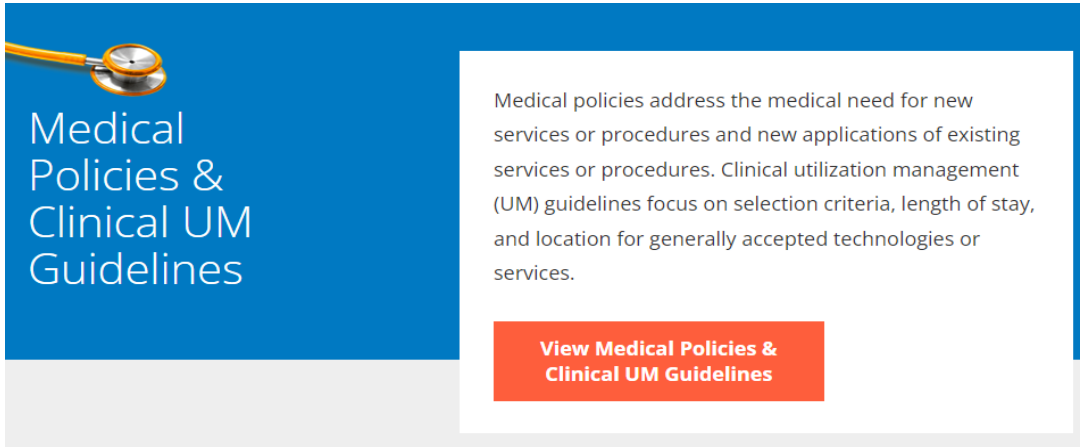
Anthem Blue Cross and Blue Shield Hospital Provider Relationship Account Manager Assignments

Policies, guidelines, and manuals



Note: policy manual updated October 2023

Policies, guidelines, and manuals (etc.)



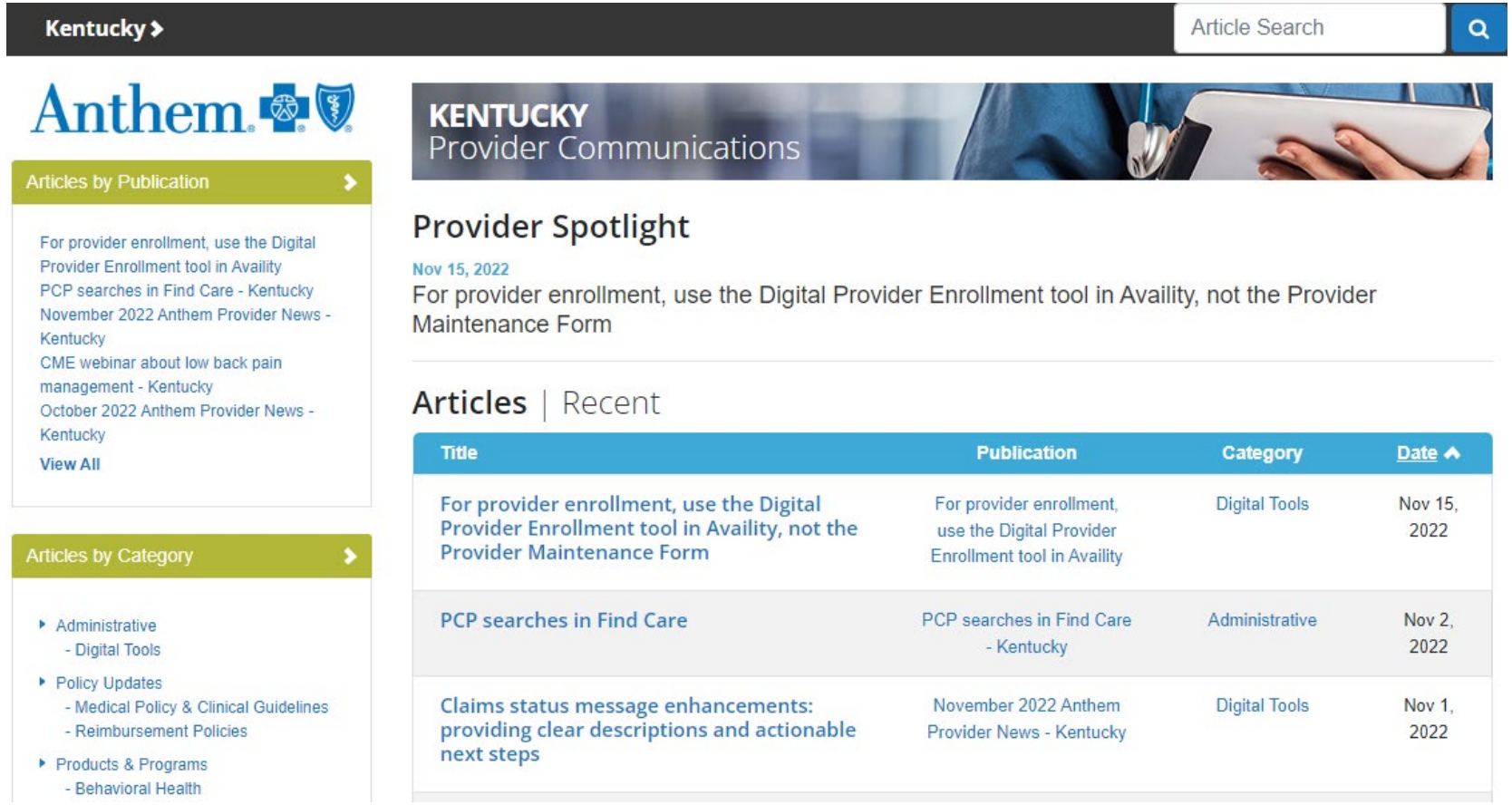
Provider Manual
Anthem's Provider Manual provides information about key administrative areas, including policies, programs, quality standards and appeals.
Download the Manual >

Reimbursement Policies
Our reimbursement policies are available to promote a better understanding of the claims editing logic that may impact payment.
Access policies >

Clinical Practice Guidelines
This index compiles guidelines published by third-parties and recognized by Anthem for the diagnosis and treatment of specific clinical circumstances.
Download the index >

anthem.com/provider/policies/

Policy announcements — newsletters



providernews.anthem.com/Kentucky

Use this link to sign-up for eUpdate Newsletters:
providernews.anthem.com/kentucky/signup

Newsletter updates

September 2023 newsletter

Bulletin link:
providernews.anthem.com/kentucky/articles/update-enhanced-outpatient-facility-editing-for-national-c

Anthem updated our claims editing process for outpatient facility claims by applying the outpatient code editor National Correct Coding Initiative (NCCI). These edits provide an opportunity to shift certain existing back-end reviews to front-end adjudication for outpatient facility claims. While this may facilitate quicker claim adjudication, it may also cause claims to be denied if correct coding guidelines are not followed. For additional information, visit CMS.gov.

Newsletter updates (cont.)

Prior authorization requirement changes effective December 1, 2023.
Medicare Advantage

August 2023 newsletter

https://providernews.anthem.com/kentucky/articles/prior-authorization-requirement-changes-effective-december-1-1

Effective **December 1, 2023,** prior authorization (PA) requirements will change for the following code(s). Codes require PA by Anthem for Medicare Advantage Members. Please see link for listing of codes.

Medical Commercial hospital utilization management

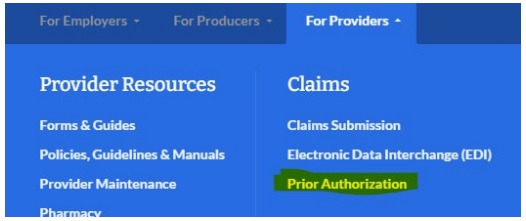
Kentucky Commercial local inpatient

Medical inpatient UM

All inpatient admissions require authorization:

- Acute care hospital
- Inpatient rehabilitation
- Long term acute care
- Skilled nursing facility

Anthem UM authorization requirements can be found at anthem.com.



Core business hours:

- We are available for extended hours on Monday and Friday 8:30 a.m.-6 p.m. EST.
- Tuesday through Thursday we are available 8:30 a.m.-5 p.m. EST.
- We also provide coverage on weekends and holidays.

Medical inpatient UM (cont.)

Authorization for acute initial admission or continued stay can be requested electronically via fax, the provider website, (Interactive Care Reviewer ICR, Availity), or by telephone.

Contact information:

- Fax **800-730-6061**
- Phone **877-814-4803** (please have the member zip code available for accurate call routing)

More about ICR:

- ICR allows providers to electronically submit authorization requests to Anthem at no cost to them, as well as to track the status of authorizations.
- If interested and not yet registered, providers may register to use ICR at Availity.com
- For additional questions regarding the ICR tool, providers can contact their local provider relationship management representatives..

Authorization for post acute initial admission or continued stay are requested through Carelon Post Acute Solutions, LLC.

Skilled nursing facilities (including swing beds), inpatient rehabilitation facilities, and long-term acute care hospitals

Requests accepted via Carelon Post Acute Solutions Portal

or telephone only.

Electronic Medical Record (EMR)

Anthem is pursuing partnerships with our KY facilities to gain access to Anthem members' EMRs.

EMR access would:

- Decrease lack of Information denials.
- Decrease time spent by facilities to submit clinical information.
- Decrease the number of cases pended for clinical information.
- Allow information gathering to enhance collaboration with the facility for discharge planning for successful member outcomes.
- Leverage EMR access for Case Management services as well to assist with discharge planning.

If you are interested in partnering with us for access to your facility's EMR, please contact Mary Hieatt.

Medical inpatient UM (cont.)

Onsite nurse review:

- Currently this function is being performed electronically via fax, Availity, or telephonically.

Clinical review requests:

- When submitting information via fax, always use a coversheet and include the authorization number if known. Also indicate on the coversheet what is being requested, (in other words, continued stay with specific dates, discharge date).
- Only send pertinent clinical information for the length of stay being requested, not the entire medical record. Sending the entire medical record or information that is not pertinent to the current request can potentially delay the decision.
- KY surgeries are always urgent. Authorization requests for surgeries should always be classified urgent, never elective.
- A request should only be classified as **Retrospective** if the member has been discharged from the hospital at the time the request is submitted. Please **do not** classify the case as retrospective via Availity if the member has not been discharged.
- When submitting clinical information via Availity the question **"Is the patient still in the hospital?"** must be answered correctly. If it is answered **No** but the member is still in the hospital, Availity will not let you proceed without entering a discharge date. That will then automatically classify the case as retrospective and can potentially delay the decision.
- Discharge planning begins on admission. Provide the discharge plan as soon as it is available and update with any changes during the course of the hospital stay. This allows for the Anthem nurse to assist with any discharge planning needs as soon as they are known.
- Notify Anthem of discharge dates, include the disposition and the time if known. The inability to close cases timely could result in issues with claim payments.

Medical inpatient UM (cont.)

Adverse determinations:

- In the event of an adverse determination, a re-review may be requested. Submit additional clinical information and indicate that it is a request for re-review.
- A peer-to-peer discussion is also available by calling **877-814-4803**; please provide the patient's name, reference number, service requested, and service date.
- One re-review and one peer-to-peer discussion are available.

Appeals

Send written appeal to the address below. Include the member's name and ID number, name of the provider, dates of service, claim ID or reference number, and the specific reasons for disagreeing with the decision

Anthem

Grievance and Appeals

P.O. Box 105568

Atlanta, GA 30348-5568

Late call penalty

Penalty sanctions will apply to elective, urgent, and emergent IP late precertification requests

The following are examples of when the penalty is not:

- Maternity admits that result in a delivery
- Non-network (one or both providers)
- Insurance information was not available from the member at the time of admission or incorrect information was received from the member, due to illness, mental status, or language differences at the time of services. Including primary payer issues
- Anthem system problems prevented authorization from being obtained or Anthem provides erroneous information

BlueCard

UM does not have any relationships with BlueCross BlueShield plans outside of Anthem's 14 plans. For questions/concerns related to authorization outside of Anthem, the provider must work with that plan directly as we do not have access to that information, nor do we have contacts from a UM perspective to those plans.

Medical inpatient UM (cont.)

Case management:

- Case management is a service provided to all members at no additional cost.
- Case management is a collaborative process of member support that evaluates, develops, implements, and coordinates options, resources, and services. It includes working one-on-one with members, their families, and other members of the interdisciplinary care team.
- Case managers educate and support members to empower self-reliance in best managing their health. Through case management, members understand their options, access available services, and participate in managing their healthcare needs.
- Anthem case managers can begin to contact the member and introduce the case management program while the member is in the facility, offer in-network resources to the hospital/facility case manager or discharge planner.

Contact information for case management referrals:

- Kentucky Local Commercial members: **800-944-0339**
- Kentucky Employee Health Plan (KEHP) members: **877-636-3716**

Medical inpatient UM (cont.)

KY UM contact information:

- Mary Hieatt, UM Manager
  - Phone: **502-216-2475**
  - Email: Mary.Hieatt@anthem.com
- Alicia Wickliffe, Director Medical Management
  - Phone: **502-475-0243**
  - Email: alicia.wickliffe@anthem.com

Medicare Advantage

Medicare Advantage — EMR access

- EMR access helps to reduce administrative time for facilities by not having to fax clinical information for every emergent admission. It also saves facility staff from having to field phone calls requesting additional information before we can complete a medical necessity review on the case.
- EMR access significantly decreases peer-to-peer discussions and eliminates lack of information denials.
- Turnaround time can be improved because there is no waiting for information.
- Once Anthem receives notification of an inpatient admission, the reviewers go in to your EMR and get all information needed in order to make a medical necessity determination.
- We only need to obtain login ID and password for some nurses on each of our teams in all lines of business.

To grant EMR access or to obtain additional information, please contact: Wendy Linscott: wendy.linscott@anthem.com.

Medicare Advantage — post-acute care: Carelon Post Acute Solutions

Carelon Post Acute Solutions is partnered with Anthem to provide utilization management for inpatient post-acute services in the states of CA, CO, CT, GA, IN, KY, ME, MO, NH, NM, NV, OH, VA, WA, and WI. This includes requests from SNFs, IRFs, and LTACHs. Please find important information listed below for the Carelon Post Acute Solutions PAC-IM program.

How can I request an authorization?

There are three ways to submit an authorization request: Carelon Post Acute Solutions Portal., fax, or phone. We encourage the use of the portal as it is the easiest and most efficient way to submit a request.

Carelon Post Acute Solutions Portal

Fax: **833-311-2986**

Phone: **844-411-9622**

What member plans are included?

A list of in-scope plans can be found online at: providers.carelonmedicalbenefitsmanagement.com/postacute

Is Carelon Post Acute Solutions offering training sessions?

Yes, Carelon Post Acute Solutions has training sessions available. Please request information at: PACprovider_relations@carelon.com

- Email for provider questions: pacprovider_network@carelon.com
- Phone number for provider questions: **844-411-9622**, option **6**
- Appeals: mynexusappeals@carelon.com

Medicare Advantage — complex discharge planning and SDoH

- Complex discharge planning (CDP) is a team comprised of clinical and medical management staff dedicated to identification of members at high risk for readmission and SDoH impacts on their health. This team focuses on the needs of the most complex membership.
- The CDP team collaborates with the healthcare team, the member, and caregivers to facilitate the development of a comprehensive and safe discharge plan. This is accomplished by outreach to members in facility throughout their clinical stay and for up to 30 days post discharge for transition of care.
- One of the tools that CDP uses is the SDoH home visit program. This program can provide the consenting member with a home assessment by a trained professional to identify social needs that may prohibit compliance with the discharge plan. Issues addressed include:
  - Housing.
  - Food.
  - Transportation.
  - Utilities.
  - Education/literacy.
  - Finances.
  - Personal safety.
  - Post-discharge readiness
  - Support systems.
- An assessment and action plan are developed by the SDoH professional and sent back to the assigned CDP for review and closure of identified care gaps.
- The CDP will work with member and family for up to 30 days post-discharge to assure that all necessary services and equipment are in place for the member to go home and stay home safely.

Medicare Advantage — The Care Transitions Intervention® (CTI)

Utilizing the evidence-based model created by Dr. Eric Coleman, our team employs transitions coaches who are certified in the CTI model. Anthem implemented the CTI program in 2016 and the program has continued to grow:

- Goal is to reduce avoidable hospital readmissions.
- Objective is for members to learn self management skills, assert a more active role in self-care, and link with community resources.
  - CTI coaches work with members telephonically for 30 days post-hospital discharge and focus on member's personal goal as they transition home, along with the four pillars:
    - Follow-up appointments
    - Medication management
    - Red flags
    - Utilizing a personal health record
- CTI coaches focus on empowerment, rapport building, motivational interviewing, modeling, and skill transference.
- Members are identified on daily acute care census lists based on readmission risk or by internal referrals. The CTI program is offered to various lines of business.

Medicare Advantage — contacts

Wendy Linscott, Manager for Acute IP MA Individual membership	**502-269-5293**	Wendy.linscott@anthem.com
Carrie Lara, Manager for Acute IP MA SNP and under age 65	**216-573-4635**	Carrie.lara@anthem.com
Pam Godfrey, Manager for CDP program	**937-203-6159**	Pamela.godfrey@anthem.com
Sheri DeMange, Manager for CTI program	**937-234-3518**	Sheri.demange@anthem.com
Jeanette Davis, Director for GRS (Group Retiree Solutions)	**470-825-6091**	Jeanette.davis@anthem.com
Kathleen Dunn, Director for Prior Auth	**317-381-1996**	Kathleen.dunn@anthem.com

KY Medicaid

Anthem — inpatient authorization requests

- Notification is required within 24 hours or by the next business day for any inpatient admission, whether emergent or previously authorized. Notifications can be submitted by the following methods:
  - Submit through Availity at Availity.com
  - Fax to **800-964-3627** or direct local fax to **855-270-9580**
  - Call Provider Services at **855-661-2028**; available 24/7
- Anthem requires precertification of all inpatient admissions.
- Please refer to the provider manual for additional details at providers.anthem.com/kentucky-provider/resources/manuals-policies-guidelines
- PA look up tool for outpatient procedures at providers.anthem.com/kentucky-provider/claims/prior-authorization-lookup-tool

Anthem — contacts

Additional contact information	
Medimpact prior authorization call center	
Pharmacy requests	Phone: **844-336-2676** Fax: **844-879-2961**
Medical injectables	Phone: **833-707-3175** Fax: **844-487-9289**
Provider lock-in change request	Phone: **855-661-2027**, extension **10578**
Transplant requests	Phone: **800-687-7149** Fax: **844-430-6801**

Anthem — contacts (cont.)

Additional contact information	
Behavioral health requests	
Phone	**855-661-2028**
Inpatient fax number	**888-881-6272**
Outpatient fax number	**888-881-6283**

Medicaid redetermination

The Public Health Emergency (PHE) ended on May 11, 2023. As a result, all Medicaid beneficiaries will be going through an annual redetermination process.

The KY Department for Medicaid Services (DMS) has resources available online: Medicaid Public Health Emergency Unwinding - KHBE (ky.gov)

This link has member materials for your office Kentucky Medicaid Renewals Resumed as well as How to Reinstate Your Medicaid (ky.gov)

If a member is not eligible for Medicaid, they may still be eligible for insurance coverage from the Exchange. Brokers and kynectors can help a member for free to determine the best option for them.

Medicaid redetermination (cont.)

This will take the state, the providers, and the MCOs all working together to get the word out! The goal is continuous coverage for optimal health outcomes. DMS has received approval to extend coverage for 12 months for children.

Anthem can help your group by providing a listing of members and their revalidation due date with DMS.

Your provider relationship consultant can obtain the report at your request. Please reach out to your consultant with your tax ID number.

Claims resolution steps

Have you tried these steps to resolve claim issues?

1. Provider Chat:

A fast, easy way to get your questions answered

You now have a new option to have questions answered quickly and easily. With Anthem Provider Chat, providers can have a real-time, online discussion through a new digital service, available through Payer Spaces on Availity.

Provider Chat offers:

- Faster access to Provider Services for all questions.
- Real-time answers to your questions about prior authorization and appeals status, claims, benefits, eligibility, and more.
- An easy-to-use platform that makes it simple to receive help.
- The same high level of safety and security you have come to expect with Anthem.

2. Secure Messaging

Availity users can access Secure Messaging from Availity Essentials. The Secure Messaging tool allows providers to send questions about claims in a secured message to the payer. To access this tool, you must be registered with Availity and have access to Claim Status.

To access your secure messages mailbox:

1. In the Availity Essentials navigation bar, select **Payer Spaces**, and then select the payer logo., and then click the payer space for your payer.
2. On the payer space page, select the **Resources** tab, and then select **Secure Messaging**.

To send a secure message:

1. 1. Submit a claim status inquiry for the claim you want.
2. 2. On the claim status inquiry results page, select **Do you have a question about this claim?** under *Send a Secure Message*.

Claims resolution steps (cont.)

3. Contact the appropriate Provider Services/inquiry department

Review the Service Directory to determine which Provider Inquiry number to call. Use the member's subscriber ID # (alpha prefix). If the alpha prefix is not on the Service Directory, it's considered BlueCard.

Make sure to get the name of the Claims Department Rep and call ref # or ref # from Instant Chat or Secure Messaging in Availity.

Service Directory

4. Complete the claim escalation process

Document your attempts for resolution on the claim escalation form (spreadsheet) and send to your provider relationship management representative. Providers must complete the form accurately and list a valid reference number in column N or it will be rejected. Your provider relationship management representative will then submit your spreadsheet to the Provider Issue Resolution (PIR) team for review.

Note: Supply all information in the description column to justify why you disagree with the claim. Also, to include the denial code.

Claims resolution steps (cont.)

5. Submit a claims dispute (Availity) or appeal

Refer to the applicable Provider Manual:

- Commercial/Medicare — Guide to Provider Complaints and Appeals anthem.com/docs/public/inline/CLAIMS_CE_00001.pdf
- Medicaid — Guide to Provider Appeals providers.anthem.com/docs/gpp/KY_CAID_PU_ProviderClaimPaymentAppeals.pdf?v=202111091852

Commercial and Medicare/Medicaid appeal and grievances

A quick overview of Medicare/Medicaid appeal and grievance policy

Commercial and Medicare/Medicaid appeals and grievances

What are disputes?

What are appeals and grievances?

Medicaid G&A

When to submit?

Where to submit?

Proper documentation?

Commercial/Medicare G&A

When to submit?

Where to submit?

Proper documentation?

Commercial and Medicare/Medicaid appeals and grievances (cont.)

What are disputes?

The Anthem Claim Payment Dispute is considered a reconsideration. This would be the same for Medicare and Commercial networks. Providers and facilities will not be penalized for filing a Claim Payment Dispute, and no action is required by the member.

Claim inquiry

A question about a claim, does not result in changes.

Claim correspondence

When Anthem requires more information to finalize a claim

Clinical/medical necessity appeals

An appeal regarding a clinical decision denial, such as authorization or claim that was denied for not medically necessary.

Claim payment reconsideration

This is the first step in the Anthem Claim Payment Dispute process. The claim payment reconsideration can be submitted via phone, Availity, or in writing via a provider adjustment form. Please be sure to keep all reference numbers. Providers have two years to submit a claim payment reconsideration.

Commercial and Medicare/Medicaid appeals and grievances (cont.)

Commercial/Medicare provider appeal

Claim payment appeal:

- If a provider or facility is dissatisfied with the outcome of a claim payment reconsideration determination, providers and facilities may submit a claim payment appeal through Availity or in writing.
- Providers and facilities should submit a claim payment reconsideration before submitting a claim payment appeal. Once providers receive determination of their claim payment reconsideration, they have 90 days to submit a claim payment appeal.
- When submitting a claim payment appeal, providers should include as much information as possible to help Anthem understand why the provider believes the claim payment reconsideration determination was in error.

Commercial and Medicare/Medicaid appeals and grievances (cont.)

Commercial/Medicare payment dispute

Required documentation for claim payment dispute:

- Provider or facility name, address, phone number, email and either NPI or tax ID
- The members name and his/her Anthem assigned ID
- A listing of disputed claims which include the Anthem claim number and dates of service
- All supporting statements and documentation

How to submit a claim payment dispute:

- Online through Availity
- Mail all required documentation to:

Payment Dispute Unit
Anthem
P.O. Box 10557
Atlanta GA 30348-5557

- Call the number on the back of the member ID card.

Commercial and Medicare/Medicaid appeals and grievances (cont.)

Clinical appeals

Clinical appeals can be used if providers or facilities disagree with clinical decisions. Clinical appeals are requests to change decisions based on whether services or supplies are medically necessary or experimental/investigative.

Guidelines and time frames for submitting clinical appeals

Providers and facilities have 180 calendar days to file a clinical appeal from the date they receive notice of Anthem's initial decision.

Send the appeal request to:

Anthem

Attention: Grievances and Appeals

P.O. Box 105568

Atlanta GA 30348-5568

Commercial and Medicare/Medicaid appeals and grievances (cont.)

Medicaid provider dispute

Anthem's Health Care Networks program helps the provider with claims payment and issue resolution.

Contact Provider Services by calling **855-661-2028** and select the claims prompt within Anthem's voice portal. If the appeal must be submitted in writing or if the provider wishes to use the written process instead of the verbal process, the appeal should be submitted to:

Claims Appeal

Anthem

P.O. Box 62429

Virginia Beach VA 23466-1599

Written appeals and supporting documentation can also be submitted via the Provider Availity Payment Appeal Tool at Availity.com.

Payment appeals, whether verbal or written, must be received by Anthem within 90 calendar days of the remittance date.

Commercial and Medicare/Medicaid appeals and grievances (cont.)

Medicaid external review

If a provider does not agree with the determination of the appeal/dispute, the provider can then proceed to the Medicaid external review.

The request for external review must be submitted to the MCO via one of the contact options designated below. DMS will also post the MCO contact information on their website at chfs.ky.gov/agencies/dms.

Requests are not accepted verbally. Additional information will not be considered by the third-party reviewer.

Providers may submit a request for an external independent third-party review within 60 calendar days of receiving an MCO's final decision from the MCO's internal appeal process.

Commercial and Medicare/Medicaid appeals and grievances (cont.)

Medicaid external review

Please send your requests to one of the following:

Email: KYExternalReview@anthem.com

Fax: **502-212-7336**

Mail: Anthem

Central Appeals Processing

P.O. Box 62429

Virginia Beach, VA 23466-2429

Electronic: Availity Essentials Availity.com

Commercial and Medicare/Medicaid appeals and grievances (cont.)

Medicaid provider grievance

A grievance is a notice of concern submitted to the health plan from a provider expressing dissatisfaction and requesting action, such as an investigation. A provider grievance may fall into one of the following categories: process/polices, claims processing (not claim appeal), communications, fraud/waste/abuse, contracting/credentialing, member or other.

The grievance is then assigned to the appropriate provider relationship management representative to investigate the provider's grievance and propose a resolution.

The provider grievance form can be found at providers.anthem.com/ky.

Submit a grievance in writing by letter or fax to:

Health Care Networks

Anthem

13550 Triton Park Blvd., Third Floor

Louisville, KY 40223

Fax: **855-384-4872**

Commercial and Medicare/Medicaid appeals and grievances (cont.)

Where to find:

Further information regarding the Anthem Commercial and Medicare/Medicaid appeals and grievances process can be found in the provider manuals located on the Anthem websites listed below:

Commercial and Medicare Advantage

anthem.com/provider/policies/manuals/

Medicaid

providers.anthem.com/kentucky-provider/resources/manuals-policies-guidelines

Claims status enhancements for Anthem members

Tammy Schlueter
December 5, 2023

Agenda

- Introducing enhancements to the Claim Status application
- What’s new: screen changes
- Questions

Claims Status: Enhancements

Anthem has moved to new Claims Status screens on Availity Essentials. Other payers may be already be using the new screen, making the experienced more streamlined for our providers.

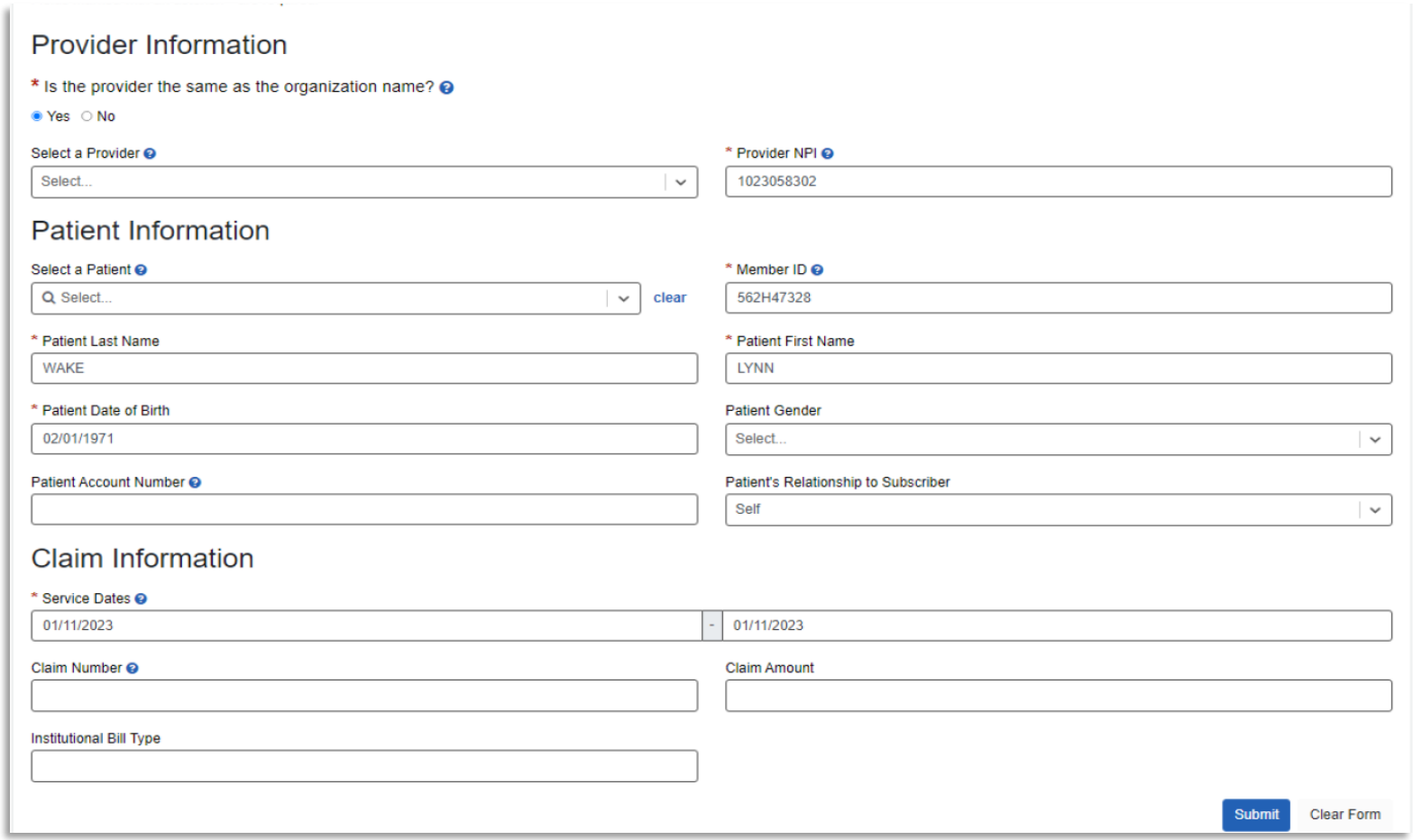
The following enhancements have been made:

- Check amount and cashing details.
- Remit Viewer button – allows provider to review electronic remittance advice from claim status screen.
- Interest a Penalty detail, if applicable
- Patient responsibility
- Corrected Claim details
- Chat with Payer expansion

The following existing features are still available:

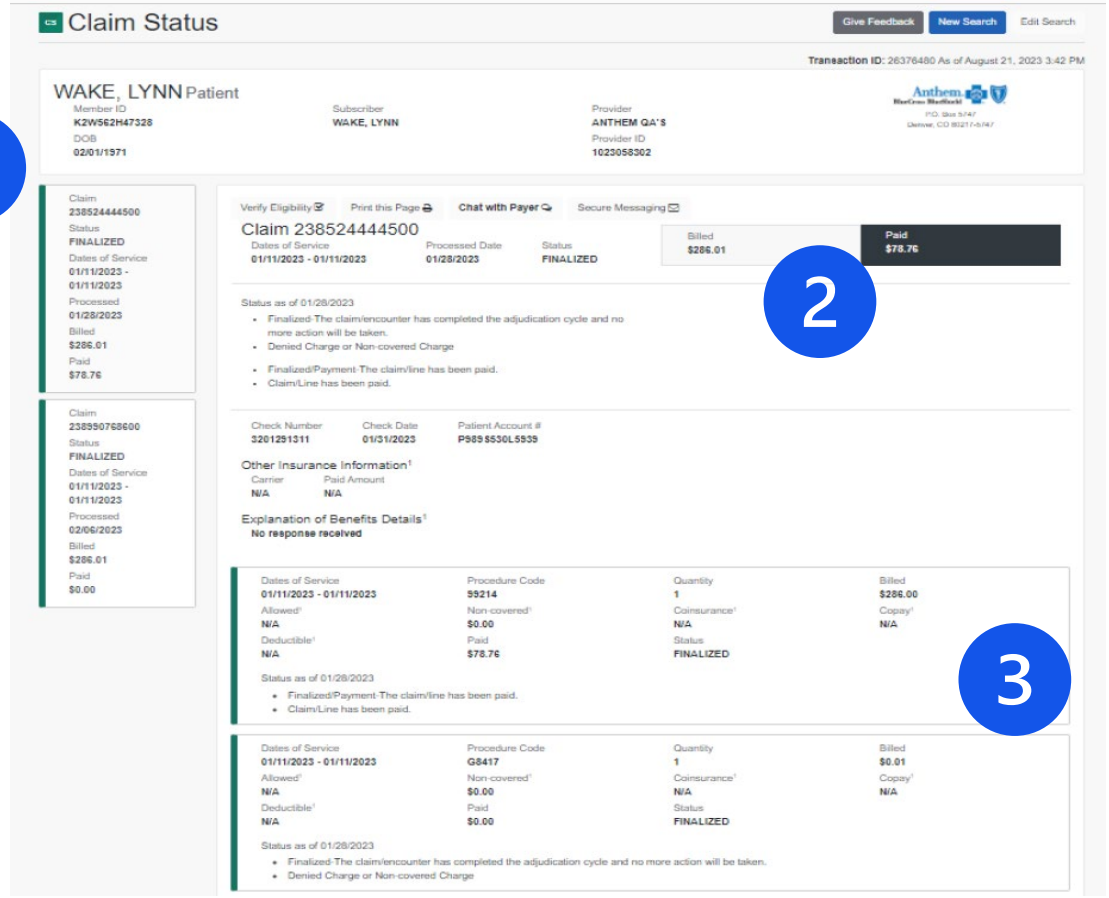
- Attachments button
- Secure Messaging
- Dispute button
- Print this page
- Verify Eligibility Button
- Link to Demo

Claims Status: Enhancements/Search Screen *HIPAA* Parameters



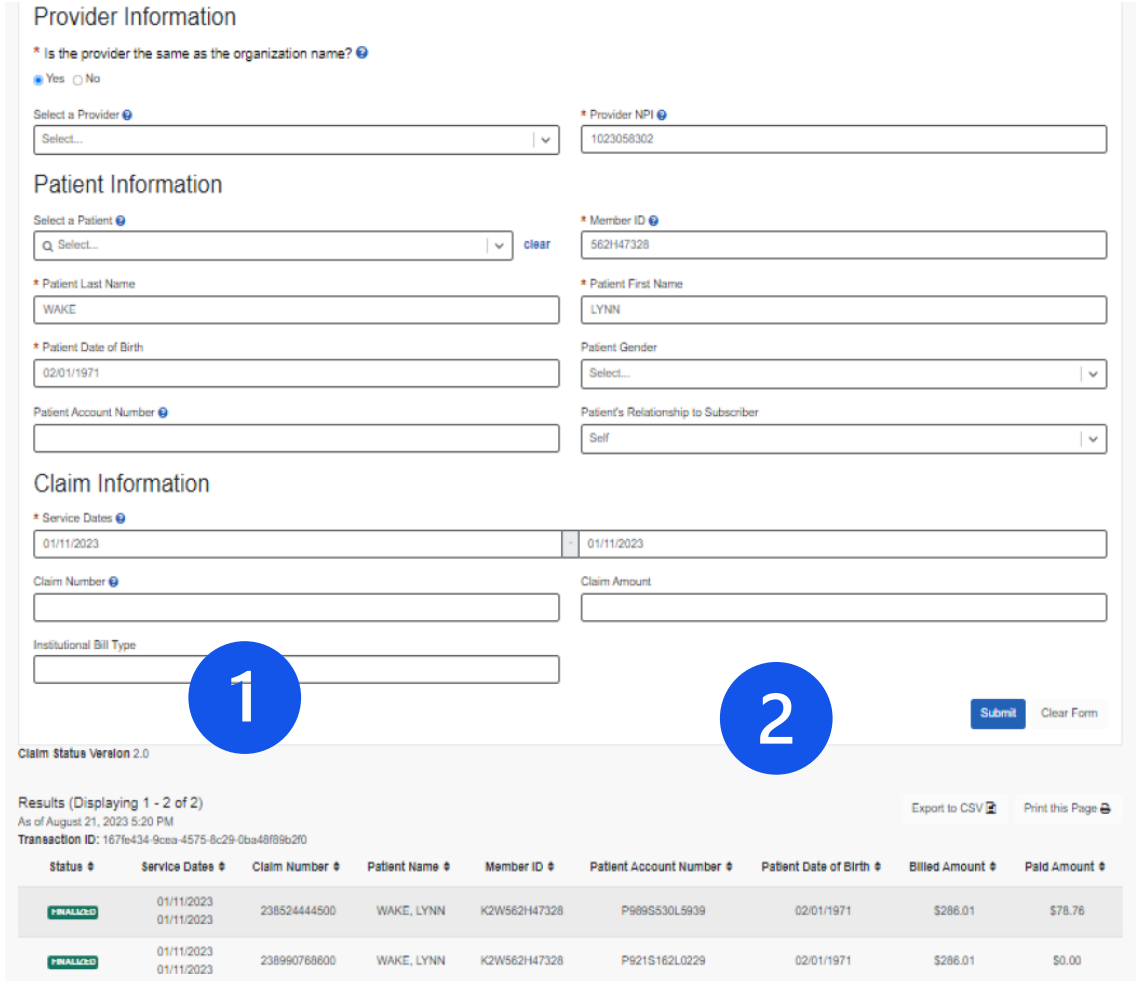
Claims Status: Enhancements/Search Results Page

1. Result Screen takes user to new page. All clams within the time period will show up as a card. Select the card to see details.
2. Section on right shows the details of the claim.
3. Claim lines show up as care with claim line details.



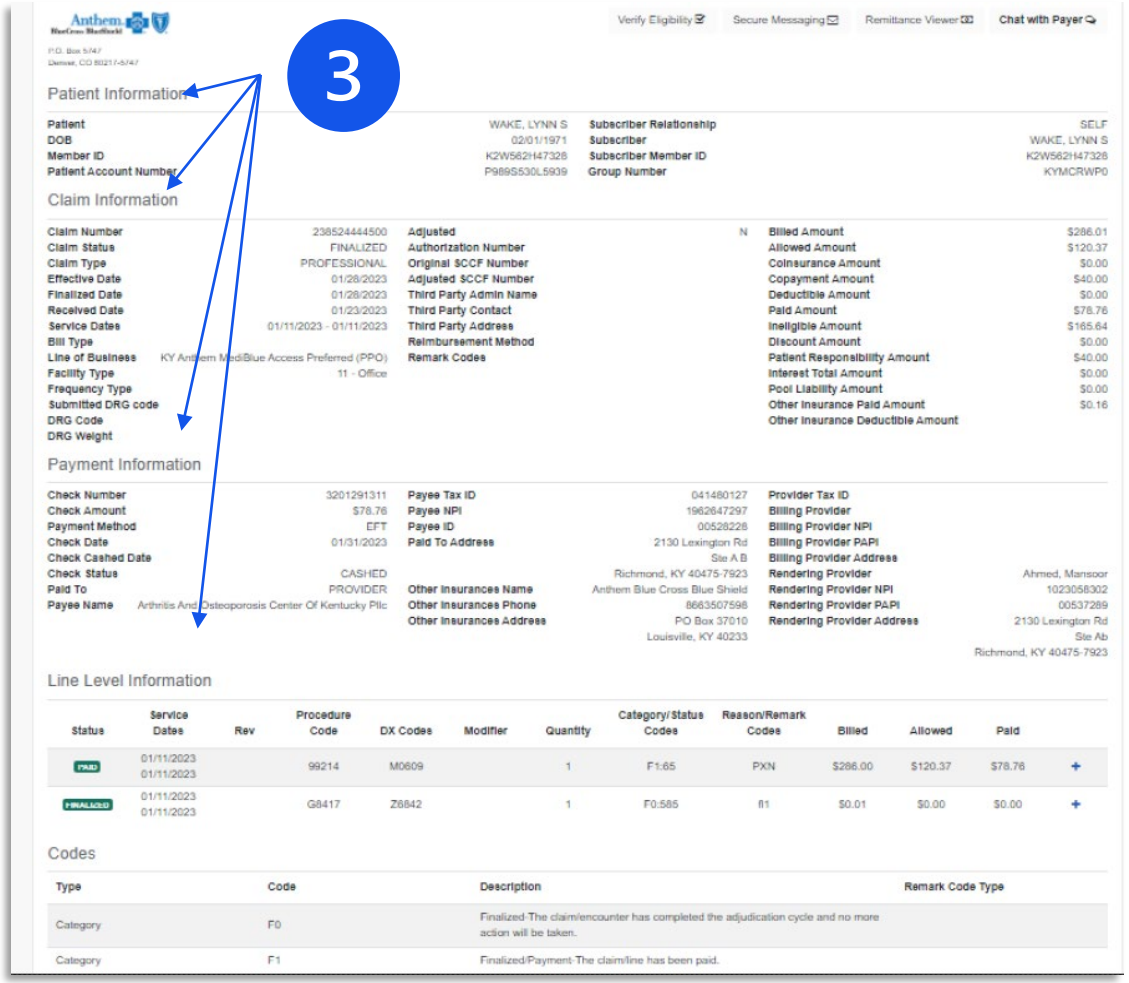
Claims Status: Enhancements/New Search and Results Page

1. Search results in same page as search, allowing user to refine the search parameters.
2. Results can be sorted for each column and can be exported in CSV.

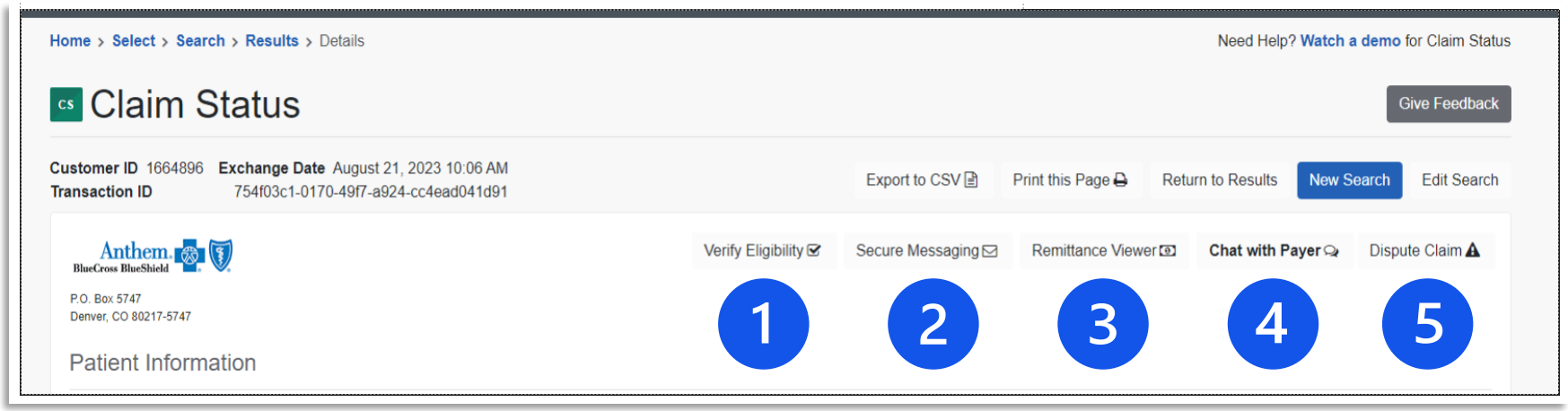


Claims Status: Enhancements/New Search and Results Page (cont.)

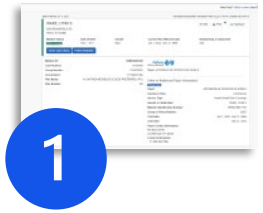
3. A compact view claim details with well-define sections. Avoids page scroll.



Claims Status: Enhancements/Claim Details with New Features and Workflow



Button opens new browser and launches E&B inquiry for member on claim

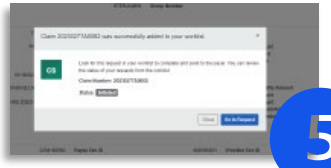


Button opens Secure Message application

Button opens Remittance viewer for the claim

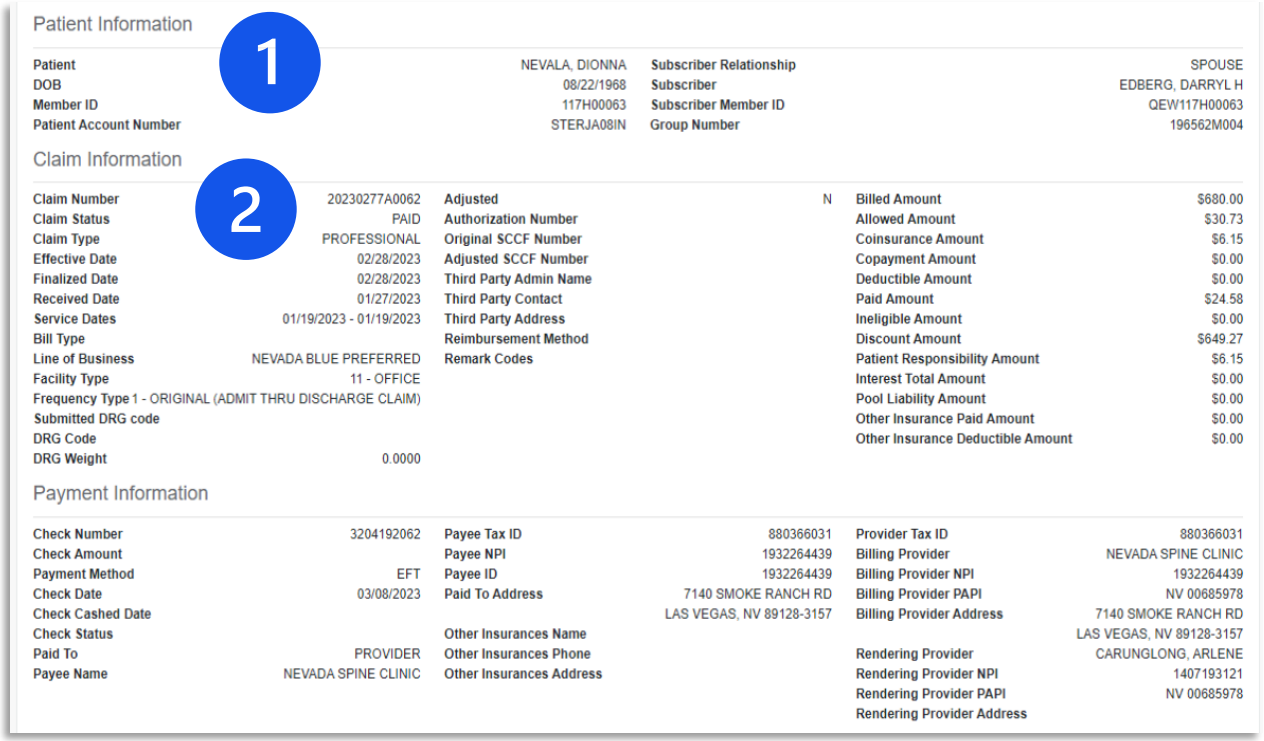
Launches the Chat with Payer app

Allows user to initiate their Dispute. Brings up the prompt that navigates to Appeal Dashboard



If applicable 'Attachment' button shows up, which brings the Attachment form & links to any open Attachment solicited request

Claims Status: Enhancements/Patient and Clam Information



Patient Information

Patient	NEVALA, DIONNA	Subscriber Relationship	SPOUSE
DOB	08/22/1968	Subscriber	EDBERG, DARRYL H
Member ID	117H00063	Subscriber Member ID	QEW117H00063
Patient Account Number	STERJA08IN	Group Number	196562M004

Claim Information

Claim Number	20230277A0062	Adjusted	N	Billed Amount	$680.00
Claim Status	PAID	Authorization Number		Allowed Amount	$30.73
Claim Type	PROFESSIONAL	Original SCCF Number		Coinsurance Amount	$6.15
Effective Date	02/28/2023	Adjusted SCCF Number		Copayment Amount	$0.00
Finalized Date	02/28/2023	Third Party Admin Name		Deductible Amount	$0.00
Received Date	01/27/2023	Third Party Contact		Paid Amount	$24.58
Service Dates	01/19/2023 - 01/19/2023	Third Party Address		Ineligible Amount	$0.00
Bill Type		Reimbursement Method		Discount Amount	$649.27
Line of Business	NEVADA BLUE PREFERRED	Remark Codes		Patient Responsibility Amount	$6.15
Facility Type	11 - OFFICE			Interest Total Amount	$0.00
Frequency Type	1 - ORIGINAL (ADMIT THRU DISCHARGE CLAIM)			Pool Liability Amount	$0.00
Submitted DRG code				Other Insurance Paid Amount	$0.00
DRG Code				Other Insurance Deductible Amount	$0.00
DRG Weight	0.0000				

Payment Information

Check Number	3204192062	Payee Tax ID	880366031	Provider Tax ID	880366031
Check Amount		Payee NPI	1932264439	Billing Provider	NEVADA SPINE CLINIC
Payment Method	EFT	Payee ID	1932264439	Billing Provider NPI	1932264439
Check Date	03/08/2023	Paid To Address	7140 SMOKE RANCH RD	Billing Provider PAPI	NV 00685978
Check Cashed Date			LAS VEGAS, NV 89128-3157	Billing Provider Address	7140 SMOKE RANCH RD
Check Status		Other Insurances Name			LAS VEGAS, NV 89128-3157
Paid To	PROVIDER	Other Insurances Phone		Rendering Provider	CARUNGLONG, ARLENE
Payee Name	NEVADA SPINE CLINIC	Other Insurances Address		Rendering Provider NPI	1407193121
				Rendering Provider PAPI	NV 00685978
				Rendering Provider Address	

1

Patient Information

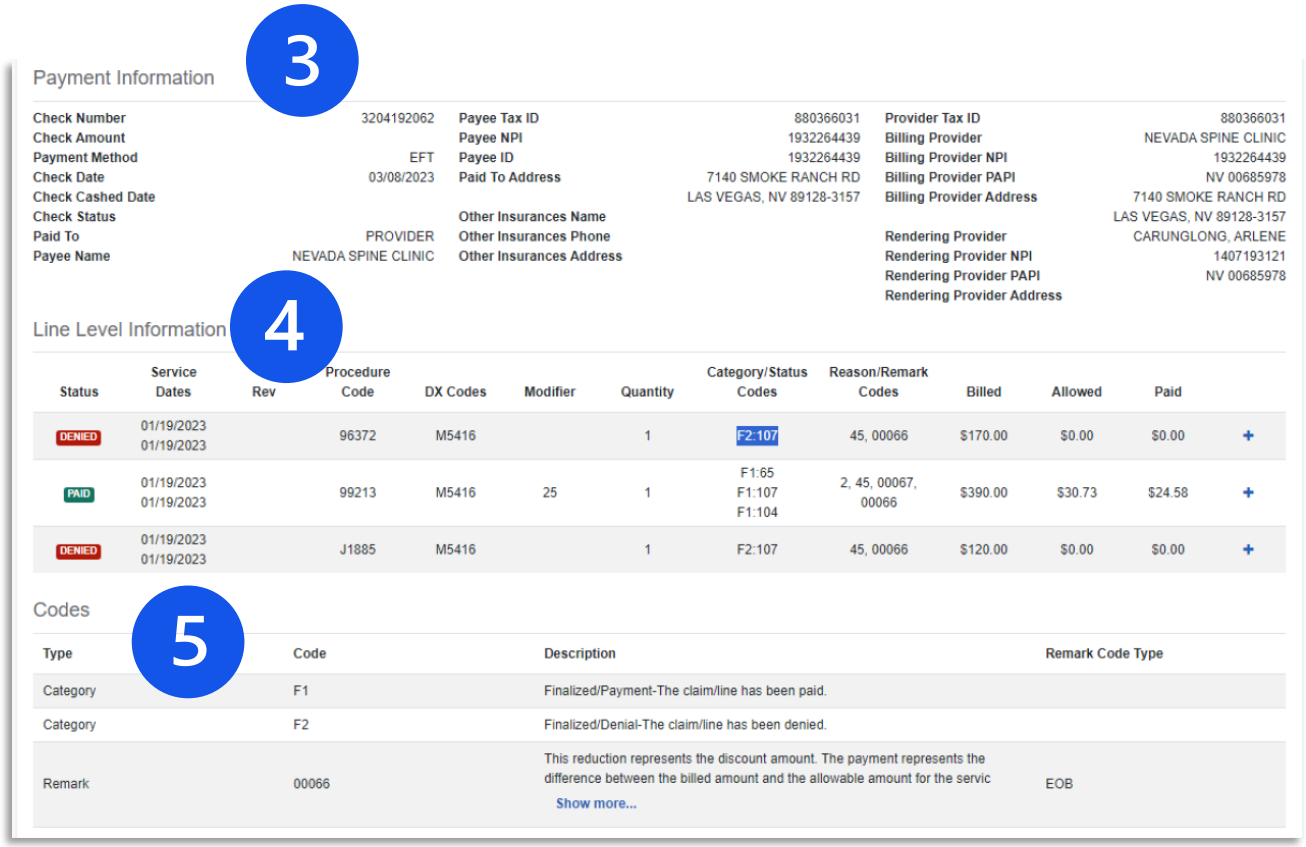
- Relationship
- Group number

2

Claim Information

- Claim type – Profession vs Institutional
- Received Date – date of receipt
- Bill type
- Line of business – displays the subscriber plan/product
- Facility Type – place of service
- DRG – submitted vs priced DRG and weight
- Adjusted – ‘N’ means original claim and ‘Y’ reflects claim was adjusted
- SCCF number – applicable for ITS claims
- Reimbursement method – OPPS pricing method
- Remark code – remittance claim level codes
- Ineligible amount
- Discount amount
- Patient Responsibility
- Interest Amount – interest/penalty dollar amounts
- Other Insurance – what was paid by Other insurance and their deductible

Claims Status: Enhancements/Payment, Line Level and Code data



Payment Information

Check Number	3204192062	**Payee Tax ID**	880366031	**Provider Tax ID**	880366031
Check Amount		**Payee NPI**	1932264439	**Billing Provider**	NEVADA SPINE CLINIC
Payment Method	EFT	**Payee ID**	1932264439	**Billing Provider NPI**	1932264439
Check Date	03/08/2023	**Paid To Address**	7140 SMOKE RANCH RD LAS VEGAS, NV 89128-3157	**Billing Provider PAPI**	NV 00685978
Check Cashed Date				**Billing Provider Address**	7140 SMOKE RANCH RD LAS VEGAS, NV 89128-3157
Check Status		**Other Insurances Name**			
Paid To	PROVIDER	**Other Insurances Phone**		**Rendering Provider**	CARUNGLONG, ARLENE
Payee Name	NEVADA SPINE CLINIC	**Other Insurances Address**		**Rendering Provider NPI**	1407193121
				Rendering Provider PAPI	NV 00685978
				Rendering Provider Address	

Line Level Information

Status	Service Dates	Rev	Procedure Code	DX Codes	Modifier	Quantity	Category/Status Codes	Reason/Remark Codes	Billed	Allowed	Paid	
DENIED	01/19/2023 01/19/2023		96372	M5416		1	F2:107	45, 00066	$170.00	$0.00	$0.00	+
PAID	01/19/2023 01/19/2023		99213	M5416	25	1	F1:65 F1:107 F1:104	2, 45, 00067, 00066	$390.00	$30.73	$24.58	+
DENIED	01/19/2023 01/19/2023		J1885	M5416		1	F2:107	45, 00066	$120.00	$0.00	$0.00	+

Codes

Type	Code	Description	Remark Code Type
Category	F1	Finalized/Payment-The claim/line has been paid.	
Category	F2	Finalized/Denial-The claim/line has been denied.	
Remark	00066	This reduction represents the discount amount. The payment represents the difference between the billed amount and the allowable amount for the servic Show more...	EOB

3

Payment Information:

- Check Amount
- Payment method
- Cashed date
- Status
- Paid to details
- Billing provider
- Rendering provider – for GBD it's the servicing provider details

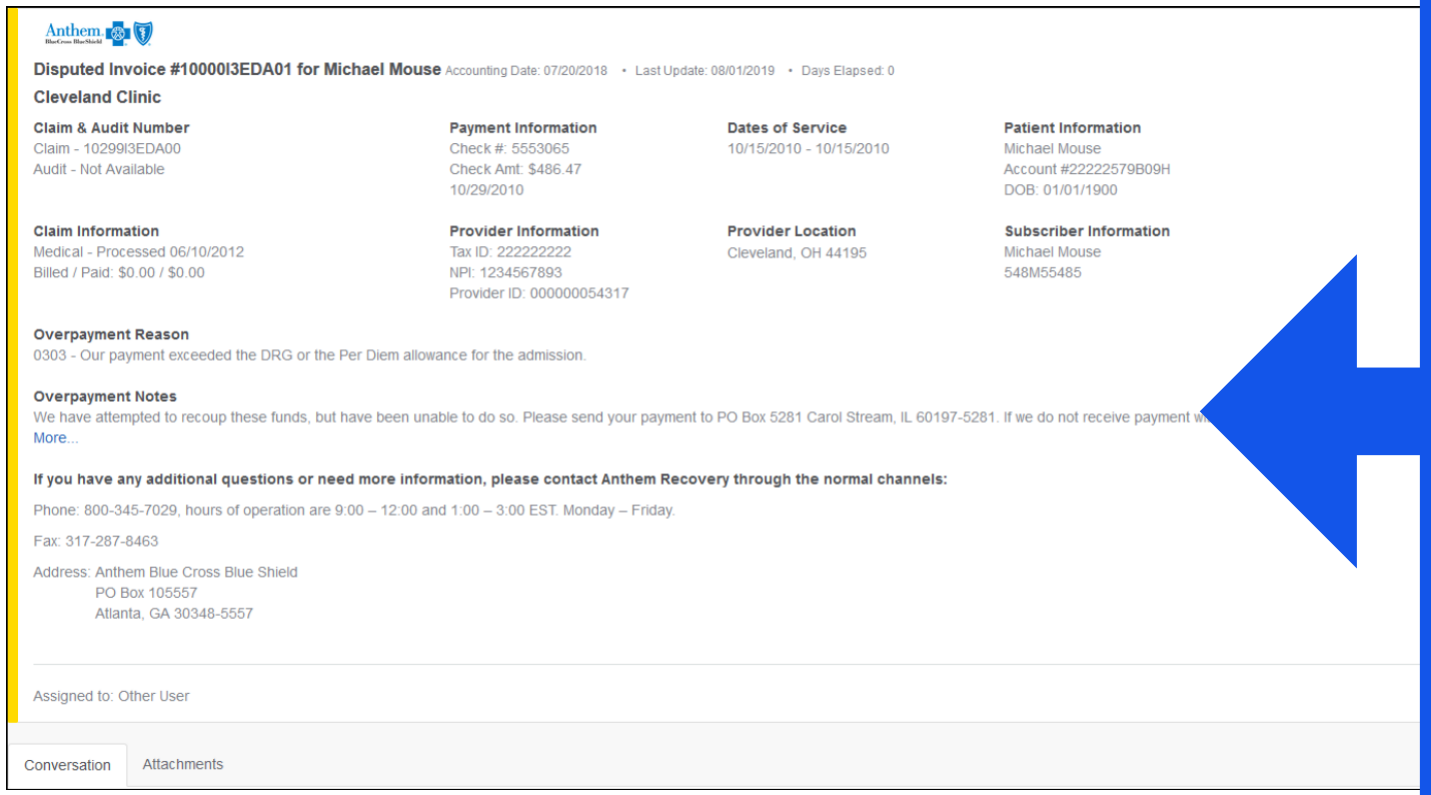
Claim Line: 4

- Diagnosis
- HIPAA Category and Status code
- Reason/remark code –
  - The EOB codes of WGS, 835 Remittance codes and OCE denial codes
  - The EX codes for GBD claims

Codes: 5

- Shows the full description of the Category, Status and Remark codes

Claims Status: Enhancements/Payment, Line Level and Code data (cont.)



On the Detail Card, get all the information you need, including the over-payment reason and any related notes.

Assign the over-payment work to others or to yourself.

Start a conversation if you have information to share and upload related attachments directly to the claim.

Claims Status: enhancements/frequently asked questions

- There is a learning section in Availity.com. In the top right-hand corner select **Help and Training** and then select **Get Trained**. The courses will be in alphabetical order.

- Availity has a microsite link providers can use to enroll in live and on demand training. An Availity username and login is required to enroll. availity.com/documents/learning/LP_AP_EnhancedClaimStatus_SelectPayersTraining/index.html#/

Frequently asked questions

Q. Which markets are affected and when do they go live?

A. Claims Status enhancements were piloted in the summer of 2023. All markets were phased in by the end of November 2023.

Q. What is the role required for Claim Status?

A. The provider organization Availity administrator will be required to give the *Claim Status* role to all employees who need to view the Availity Claim Status application.

Q. I did an EDI batch transaction but don't see the new values returned.

A. Batch claim status transactions will not have new additional values returned. Providers can enjoy the new claims status enhancements when viewing claims from the Claims Status application on Availity.com.

Claims Status: enhancements/frequently asked questions (cont.)

Frequently asked questions (cont.)

Q. Who do I contact with questions or issues?

A. Reach out to the Availity Essentials Client Services at availity.com/contact-us or by phone, Monday through Friday, 8 a.m. to 8 p.m. Eastern, **800-282-4548**.

Q. Will there be a communication to care providers about this new enhancement?

A. Yes, the care providers will receive a newsletter informing them of the new screens with the Availity microsite link to enroll in training.

Training will continue into 2024, use this link to enroll.

Q. Are there any exclusions with the new claim status screens?

A. Claims for FEP members will not see the additional data fields until 2024. Planning for 2024 work is in progress. Electronic Data Interchange (EDI) batch claim status transactions are only viewable from the Claims Status application. The new values will only be returned from Anthem's WGS and GBD Facets claims systems; all other claims systems will return the existing claim status values.

Future enhancements

In addition to additional data fields for FEP, the claims search results screen will be enhanced to *display date received* and *last processed date*.

Where to submit additional questions

Submit additional questions to rebecca.george@anthem.com and brian.richardson2@anthem.com

Carelon Post Acute Solutions, LLC is an independent company providing services on behalf of the health plan.

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