

Indiana | Anthem Blue Cross and Blue Shield

Serving Hoosier Healthwise, Healthy Indiana Plan, Hoosier Care Connect, and Indiana PathWays for Aging



The ABCs of Federally Qualified Health Centers

IHCP Works Annual Seminar
Fall 2026

Agenda

- Reimbursement, Enrollment, and Terminations
- Covered Services
- Claim and Billing Information
- Top Denials
- Resources
- Questions



Reimbursement, Enrollment, and Terminations

Prospective Payment System (PPS) Reimbursement

PPS Reimbursement Model:

- In accordance with the Benefits Improvement and Protection Act (BIPA) of 2000, the IHCP uses a Prospective Payment System (PPS) to reimburse FQHCs for covered services

Facility-Specific Payment Rates:

- Each FQHC receives a facility-specific PPS rate
- PPS rates are determined by Myers and Stauffer, the IHCP rate-setting contractor



Enrollment Process

IHCP Enrollment Requirements:

- Providers must enroll with the IHCP as an FQHC
- A copy of the CMS approval letter verifying FQHC status must be submitted with the completed enrollment application
- Documentation is submitted to the IHCP Provider Enrollment Unit

Non-Enrollable Specialties:

- When services are provided by a qualifying practitioner whose specialty is not eligible for the IHCP enrollment, the claim must include the NPI of the IHCP-enrolled supervising practitioner as the rendering provider

Rendering Provider Requirements

Rendering Provider Enrollment:

- All qualifying FQHC practitioner specialties eligible for the IHCP enrollment must be enrolled as rendering providers
- Each practitioner's Provider ID and National Provider Identifier (NPI) must be linked to the FQHC group enrollment

Provider Maintenance Requirements:

- FQHCs must keep rendering provider information current
- When a practitioner is no longer affiliated with the clinic, the change must be reported to the IHCP Provider Enrollment Unit
- Updates can be submitted in writing or through the Provider Maintenance page on the IHCP Provider Healthcare Portal (IHCP Portal)

Termination of FQHC Status

- If a clinic loses status as a FQHC, the provider must enroll with the IHCP as a medical provider
- If the provider does not re-enroll as a medical provider, they will be disenrolled as a provider and are subject to losing Primary Medical Provider (PMP) assigned membership at that location
- Status changes begin with CMS, are then sent to FSSA/OMPP who then communicates with the IHCP Provider Enrollment Unit

Covered Services

Services

Covered Services and Supplies:

- The IHCP reimburses FQHCs for covered services and supplies incidental to those services when they would otherwise be covered if provided by a physician
- Any ambulatory service included in the Indiana Medicaid State Plan is considered a covered FQHC service if offered by the clinic

Prior Authorization Requirements:

- FQHCs are subject to the same prior authorization requirements as all other IHCP providers

Covered Services (cont.)

Homebound Patient Services:

- IHCP reimburses services provided to homebound individuals only when the FQHC is in an area designated by the FSSA as having a shortage of home health agencies

Preventive and Care Coordination Services:

- FQHCs may provide preventive health services, care coordination, and patient encounters
- Clinics may also provide Early and Periodic Screening, Diagnostic and Treatment (EPSDT)/HealthWatch services for eligible members

Claim and Billing Information

Filing Limits

Primary

- 90 calendar days from last date of service
- Must pass front-end edits
- Late claims deny
- Track submissions

Secondary

- 90 calendar days from primary remittance advice
- Retain EOB documentation
- COB requirements
- Timely follow-up

Encounter Claim Requirements

Definition of a Valid Encounter:

- A valid FQHC encounter is a face-to-face visit between an IHCP member and a qualifying practitioner
- Encounters may occur in person or via telehealth
- Services must be provided at an FQHC or another qualifying non-hospital setting

Claim Submission Requirement:

- FQHCs must submit Anthem Medicaid claims using the appropriate encounter code and claim type to receive reimbursement

Medical Encounter Claims

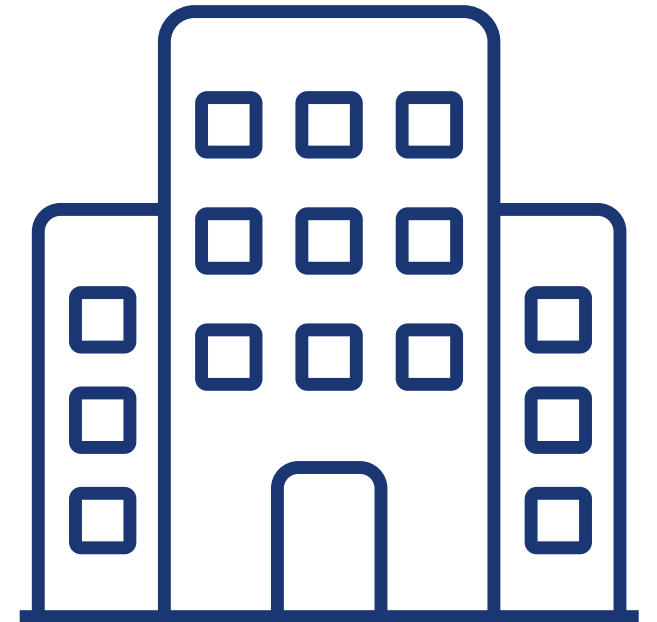
Medical Encounter Billing:

- Submit valid medical encounters on a professional claim (*CMS-1500*, IHCP Portal, or 837P transaction)
- Report HCPCS code T1015 — Clinic, visit/encounter, all-inclusive

Encounter Claims POS

Required Place of Service (POS) codes:

- 02 — Telehealth provided other than in patient's home
- 03 — School
- 04 — Homeless Shelter
- 10 — Telehealth provided in patient's home
- 11 — Office
- 12 — Home
- 31 — Skilled nursing facility
- 32 — Nursing facility
- 50 — Federally qualified health center
- 72 — Rural health clinic



Encounter Claims

- Claims submitted with eligible POS codes (02, 03, 04, 10, 11, 12, 31, 32, 50, or 72) must include encounter code T1015 (medical)
- Claims missing the required encounter code will deny
- Denied claims may be corrected and resubmitted with the appropriate encounter code and valid CPT/HCPCS service code included

Encounter Claim Adjudication

Required Claim Elements:

- Claims must include the appropriate encounter code (T1015 for medical) and all applicable CPT, CDT, and HCPCS service codes performed during the visit:
 - FQHCs are not required to include encounter code T1015 on crossover claims
 - This applies to both automatically crossed-over claims and claims submitted directly to the IHCP after Medicare processing

When Encounter Criteria Are Met:

- If at least one approved encounter-qualifying procedure code and a valid FQHC POS code are present, the encounter rate is reimbursed using the provider-specific PPS rate
 - Additional service codes on the claim are denied because payment is included in the PPS encounter rate

Encounter Claim Adjudication Tips

Invalid Place of Service:

- If a qualifying encounter procedure code is billed with an invalid POS code, the entire claim will be denied
- Claims may be corrected and resubmitted with the appropriate POS code

No Valid Encounter Procedure Code:

- If the claim does not contain an approved encounter-qualifying procedure code, the entire claim is denied as “Not a Valid Encounter”
- Claims denied as invalid encounters should not be resubmitted for payment unless corrected to include a valid encounter service

Multiple and Consecutive Encounter Guidelines

Consecutive Dates of Service:

- Only one unit of T1015 may be billed per claim line
- Services provided on consecutive days must be billed on separate claim lines for each date of service

Multiple Encounters on the Same Day:

- The IHCP generally reimburses one medical encounter (T1015) per member, per provider, per day
- Additional same-day encounters are allowed only when each encounter has a different primary diagnosis

Multiple and Consecutive Encounter Guidelines (cont.)

Duplicate Claim Denials:

- Same-day encounter claims with the same primary diagnosis are denied as duplicates

Billing Additional Same-Day Visits:

- If a member has two separate visits on the same day for different diagnoses, a second claim may be submitted for the additional encounter
- Providers may not split diagnoses from a single visit across multiple claims to receive additional reimbursement

Multiple Practitioners, Same Day:

- When two qualifying practitioners (for example, a physician and psychologist) see the same member on the same day, each encounter should have a different principal diagnosis

Services Provided Outside a Valid Encounter

Encounters Considered Not Valid:

- Services such as blood draws, urine specimen collection, laboratory testing, X-rays, prescription dispensing, injections, and optician services do not qualify as encounters on their own:
 - These services may be included in encounter reimbursement when performed as part of a face-to-face visit with a qualifying practitioner
 - Services provided outside a valid encounter (such as a nurse-administered injection without a qualifying visit) are not separately billable
- Reimbursement for these services is incorporated into the facility's PPS rate

Claim Disputes

- Reconsideration and Appeals process:
 - Utilize Availity [Providers | Availity](#)
 - Within 60 calendar days of receipt of the RA
- Supporting documentation:
 - Explain why you believe it should be reconsidered
- Follow-up expectations:
 - Provide details for what you want to happen with the claim
- Escalation steps:
 - Understand Anthem's processes and follow accordingly
- Anthem Provider Manual, Chapter 13:
 - [2026 Indiana BCBS Medicaid Provider Manual](#)



Top Denials



Top Denials

- Duplicate
- Termination
- Preauthorization not obtained
- Submitted after plan filing limit
- NPI:
 - Billing NPI not registered with state
 - Order, Prescribing, Referring (OPR) NPI not certified
 - Rendering not affiliated with billing

**Information taken from August 2026 claim denial report

Resources



Customer Service Contacts

Anthem Services	Hoosier Healthwise	Healthy Indiana Plan	Hoosier Care Connect	Indiana PathWays for Aging
Pharmacy	844-916-3654 24 hours a day, 7 days a week	844-916- 3652 24 hours a day, 7 days a week	844-916- 3653 24 hours a day, 7 days a week	844-691-2487 24 hours a day, 7 days a week
Vision	Superior Vision 877-235-5317 superiorvision.com	Superior Vision 877-235-5317 superiorvision.com	Superior Vision 877-235-5317 superiorvision.com	866-866-5641 (TTY 800-428-4833)
Dental	DentaQuest 855-453-5286 dentaquest.com	DentaQuest 855-453-5286 dentaquest.com	DentaQuest 855-453-5286 dentaquest.com	855-453-5286 (TTY 800-466-7566)
Behavioral Health	866-408-6132 Monday through Friday, 8 a.m. to 8 p.m.	844-533- 1995 Monday through Friday, 8 a.m. to 8 p.m.	844-284-1798 Monday through Friday, 8 a.m. to 8 p.m.	833-569-4739 Monday through Friday, 8 a.m. to 8 p.m.

Anthem Resources

- Availity: [Availity Essentials - Sign In](#)
- Provider Services: [Contact Us](#)
- Webform: [Webform](#)
- Provider Relationship Account Manager
- FQHC Office Hours



Questions?



Thank you

We'd like to know how this presentation helped you and if there is any additional information or clarification we could offer.

Please take a moment to complete the survey by scanning the QR code or following [this link](#).





Providers who are contracted with Anthem Blue Cross and Blue Shield to serve Hoosier Healthwise, Healthy Indiana Plan, Hoosier Care Connect, and Indiana PathWays for Aging 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. Anthem Blue Cross and Blue Shield is the trade name of Anthem Insurance Companies, Inc. Independent licensee of the Blue Cross Blue Shield Association. Anthem is a registered trademark of Anthem Insurance Companies, Inc.

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