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Purpose and Introduction

This Manual is intended to support all entities and individuals that have contracted with Anthem. The use of “Provider” within this manual refers to entities and individuals contracted with Anthem that bill on a CMS 1500. They may also be referred to as Professional Providers in some instances. The use of “Facility” within this manual refers to entities contracted with Anthem that bill on a UB 04, such as Acute General Hospitals and Ambulatory Surgery Centers. General references to “Provider Inquiry”, “Provider Website”, “Provider Network Manager” and similar terms apply to both Providers and Facilities.

Anthem is redesigning the provider public website to make it easier and more useful for Providers and Facilities. Anthem is working hard to move resources into the new redesigned website for an enhanced Provider experience. In the meantime, Providers and Facilities can still access most of our resources on our legacy site. It is possible that links or navigation instructions within this Manual may not work during this transition time. Anthem will work to minimize any disruption during this time.

Anthem

The Anthem Blue Cross and Blue Shield provider manual is a comprehensive document designed to inform Providers and Facilities of Anthem Claim submission guidelines and requirements. In addition, the manual includes, but is not limited to, administrative procedures such as eligibility, admission processes, descriptions and explanations of the remittance advice, utilization management ("UM") guidelines and other helpful information.

Anthem is committed to providing Providers and Facilities with an accurate and up-to-date provider manual; however, there may be instances where new procedures or processes are not immediately reflected in the manual. In such cases, Anthem will make every effort to distribute updated documentation in the next manual update. In those instances that information in this manual differs from that in the Agreement, the Agreement will take precedence over the manual.

We appreciate your participation in the Anthem Network(s). Anthem is committed to working with Providers and Members to provide a high level of satisfaction in delivering quality health care. The Anthem provider manual is an integral part of this commitment.

Future Updates

As necessary, we will update the manual at Anthem.com to provide you with the most current Anthem and policies.

Legal and Administrative Requirements Overview

Coordination of Benefits

If a Member or eligible dependent is covered by more than one Health Benefit Plan, the carriers involved work together to prevent duplicate payments for any services. This cooperative effort is called Coordination of Benefits ("COB"), a provision in most Health Benefit Plans.

If a Plan is other than the primary payor, any further compensation to Provider or Facility from Plan or the Member be determined in accordance with the Agreement, the applicable Health Benefit Plan and any applicable Plan written policies and procedures for coordinating benefits. Such compensation from Plan as a secondary payer plus the amounts owed by all other sources, including the Member, shall add up to one hundred percent (100%) of the Plan rate.

Notwithstanding the foregoing, in no event shall Plan or the Member be required to pay more than they would have paid had the Plan been the primary payor. Providers and Facilities will not collect any amount from the Member if such amount, when added to the amounts collected from the primary and secondary payors, would cause total reimbursement to the Provider or Facility for the Covered Service to exceed the
amount allowed for the Covered Service under the Agreement. Further, this provision shall not be construed to require Providers or Facilities to waive Cost Share in contravention of any Medicare rule or regulation, nor shall this provision be construed to supersede any other Medicare rule or regulation. If, under this Section, Providers and Facilities are permitted to seek payment from other sources by reason of the existence of other group coverage in addition to Plan’s Health Benefit Plan. Providers and Facilities may seek payment from the other sources on a basis other than the Plan rate.

Make the Most of Your Electronic Submissions Coordination of Benefits (COB)

Anthem provides a Companion Guide, to assist Providers and Facilities with the submission of electronic Claims. The Companion Guide contains complete instructions for the electronic billing of Coordination of Benefit Claims. If you would like to learn more, refer to the Companion Guide (appropriate 837 section) online. Go anthem.com. Select Providers and Georgia, scroll and select Find Resources for Georgia. On the Provider Home page select Electronic Data Interchange. On the EDI website, select the Documents menu and choose Companion documents.

When filing Coordination of Benefits Claims on paper submission
Include Explanation of Benefit ("EOB") from primary insurance carrier with coordination of benefits ("COB") Claims submitted for secondary payment.

Dispute Resolution and Arbitration

The substantive rights and obligations of Anthem, Providers and Facilities with respect to resolving disputes are set forth in the Anthem Provider Agreement (the "Agreement") or the Anthem Facility Agreement (the "Agreement"). All administrative remedies set forth above shall be exhausted prior to filing an arbitration demand. The following provisions set forth some of the procedures and processes that must be followed during the exercise of the Dispute Resolution and Arbitration Provisions in the Agreement.

A. Attorney’s Fees and Costs

The shared fees and costs of the non-binding mediation and arbitration (e.g. fee of the mediator, fee of the independent arbitrator, etc.) will be shared equally between the parties. Each party shall be responsible for the payment of that party’s specific fees and costs (e.g. the party’s own attorney’s fees, the fees of the party selected arbitrator, etc.) and any costs associated with conducting the non-binding mediation or arbitration that the party chooses to incur (e.g. expert witness fees, depositions, etc.). Notwithstanding this provision, the arbitrator may issue an order in accordance with Federal Rule of Civil Procedure Rule 11.

B. Location of the Arbitration

The arbitration hearing will be held in the city and state in which the Anthem office, identified in the address block on the signature page to the Agreement, is located except that if there is no address block on the signature page, then the arbitration hearing will be held in the city and state in which the Anthem Plan has its principal place of business. Notwithstanding the foregoing, both parties can agree in writing to hold the arbitration hearing in some other location.

C. Selection and Replacement of Arbitrator(s)

For disputes equal to or greater than (exclusive of interests, costs or attorney’s fees) the dollar thresholds set forth in the Dispute Resolution and Arbitration Article of the Agreement the panel shall be selected in the following manner. The arbitration panel shall consist of one (1) arbitrator selected by Provider/Facility, one (1) arbitrator selected by Anthem, and one (1) independent arbitrator to be selected and agreed upon by the first two (2) arbitrators. If the arbitrators selected by Provider/Facility and Anthem cannot agree in thirty (30) calendar days on who will serve as the independent arbitrator, then the arbitration administrator identified in the Dispute Resolution and Arbitration Article of the Agreement shall appoint the independent arbitrator. In the event that any arbitrator withdraws from or is unable to continue with the arbitration for any reason, a replacement arbitrator shall be selected in the same manner in which the arbitrator who is being replaced was selected.

D. Discovery
The parties recognize that litigation in state and federal courts is costly and burdensome. One of the parties’ goals in providing for disputes to be arbitrated instead of litigated is to reduce the costs and burdens associated with resolving disputes. Accordingly, the parties expressly agree that discovery shall be conducted with strict adherence to the rules and procedures established by the mediation or arbitration administrator identified in the Dispute Resolution and Arbitration Article of the Agreement, except that the parties will be entitled to serve requests for production of documents and data, which shall be governed by Federal Rules of Civil Procedure 26 and 34.

E. Decision of Arbitrator(s)

The decision of the arbitrator, if a single arbitrator is used, or the majority decision of the arbitrators, if a panel is used, shall be binding. The arbitrator(s) may construe or interpret, but shall not vary or ignore, the provisions of the Agreement and shall be bound by and follow controlling law including, but not limited to, any applicable statute of limitations, which shall not be tolled or modified by the Agreement. If there is a dispute regarding the applicability or enforcement of the class waiver provisions found in the Dispute Resolution and Arbitration Article of the Agreement, that dispute shall only be decided by a court of competent jurisdiction and shall not be decided by the arbitrator(s). Either party may request a reasoned award or decision, or if either party makes such a request, the arbitrator(s) shall issue a reasoned award or decision setting forth the factual and legal basis for the decision.

The arbitrator(s) may consider and decide the merits of the dispute or any issue in the dispute on a motion for summary disposition. In ruling on a motion for summary disposition, the arbitrator(s) shall apply the standards applicable to motions for summary judgment under Federal Rule of Civil Procedure 56.

Judgment upon the award rendered by the arbitrator(s) may be confirmed and enforced in any court of competent jurisdiction. Without limiting the foregoing, the parties hereby consent to the jurisdiction of the courts in the State(s) in which Anthem is located and of the United States District Courts sitting in the State(s) in which Anthem is located for confirmation and injunctive, specific enforcement, or other relief in furtherance of the arbitration proceedings or to enforce judgment of the award in such arbitration proceeding.

A decision that has been appealed shall not be enforceable while the appeal is pending.

F. Confidentiality

Subject to any disclosures that may be required or requested under state or federal law, all statements made, materials generated or exchanged, and conduct occurring during the arbitration process including, but not limited to, materials produced during discovery, arbitration statements filed with the arbitrator(s), and the decision of the arbitrator(s), are confidential and shall not be disclosed in any manner to any person who is not a director, officer, or employee of a party or an arbitrator or used for any purpose outside the arbitration. If either party files an action in federal or state court arising from or relating to a mediation or arbitration, all documents must be filed under seal to ensure that confidentiality is maintained. Nothing in this provision, however, shall preclude Anthem or its parent company from disclosing any such details regarding the arbitration to its accountants, auditors, brokers, insurers, reinsurers or retrocessionaires.

Facility Based Physicians

Facility based physicians are physicians, with the exception of residents, interns and fellows, who have a contractual relationship with one or more Facilities to provide professional services. These services may be of either of the following types: (1) administrative, managerial, teaching, or quality management activities compensated by the Facility and that are furnished to the Facility or its general population; or (2) physician services personally rendered to a Member while in the Facility that directly contribute to the diagnosis or treatment of a Member and which ordinarily require performance by a physician, including but not limited to, an emergency room physician, radiologist, pathologist, neonatologist, hospitalist or anesthesiologist. Facility based physicians do not include Primary Care Physicians (“PCP”) or Specialty Care Physicians who are employed by the Facility and have a separate contractual agreement with Anthem.

Anthem and Facility will make commercially reasonable efforts to require each of the contracted or employed facility based physicians to maintain an Agreement, as appropriate, with Anthem at the current Anthem market rates. When a new Facility based physician (or group of physicians) joins the facility, the Facility shall be
provided sixty (60) days to cause such Facility based physicians to execute Agreement(s) with Anthem. Until such time as Facility-based physicians enter into agreements with Anthem, Facility agrees to fully cooperate with Anthem to prevent Members from being billed amounts in excess of the applicable Anthem non-participating reimbursement for such Covered Services. Facility-based physicians may include, but are not limited to, anesthesiologists, radiologists, pathologists, neonatologists, hospitalists and emergency room physicians.

In addition, the Facility shall take any action necessary to ensure that it’s contracted Facility based physicians cooperate with, participate in and are bound by the Anthem utilization and quality management programs and coordinate as appropriate with the admitting physician and PCP.

Financial Institution/Merchant Fees

Providers and Facilities are responsible for any fees or expenses charged to it by their own financial institution or payment service provider.

Home Delivery Pharmacy Prescription Drug Program

Members covered under a Prescription Drug Program may have maintenance prescriptions filled through the Home Delivery pharmacy for benefit information, please refer to the back of the member’s id card.

Maintenance drugs are defined as: approved by the FDA for long-term use for chronic conditions; considered reasonably safe when dispensed in large quantities of up to a 90-day supply; and must not have a potential for abuse.

Maintenance prescriptions may be written for up to a ninety (90) day supply with refills.

For NEW maintenance medications it is recommended that the PCP write two prescriptions:

- one for up to a ninety (90) day* supply plus refills, to be mailed to our designated Pharmacy Benefit Manager and
- a second one, for a thirty (30) day supply, to be filled immediately at a retail pharmacy.

*Note: By law, Home Delivery Pharmacy must fill the prescription for the exact quantity of medication prescribed (e.g., “30 days plus two refills” does not equal one prescription written for “90 days.”)

BlueChoice providers and Members may call ANTHEM Customer Service regarding this program.

Insurance Requirements

A. Providers and Facilities shall, during the term of this Agreement, keep in force with insurers having an A.M. Best rating of A minus or better, or self-insure, the following coverage:

1. Professional liability/medical malpractice liability insurance which limits shall comply with all applicable state laws and/or regulations, and shall provide coverage for claims arising out of acts, errors or omissions in the rendering or failure to render those services addressed by this Agreement. In states where there is an applicable statutory cap on malpractice awards, Providers and Facilities shall maintain coverage with limits of not less than the statutory cap.

   If this insurance policy is written on a claims-made basis, and said policy terminates and is not replaced with a policy containing a prior acts endorsement, Providers and Facilities agree to furnish and maintain an extended period reporting endorsement (“tail policy”) for the term of not less than three (3) years.

2. Workers’ Compensation coverage with statutory limits and Employers Liability insurance.
3. Commercial general liability insurance for Providers and Facilities for bodily injury and property damage, including personal injury and contractual liability coverage.

For Ambulance/Medical Transportation Providers Only, in addition to the above:

- Auto Liability insurance which complies with all applicable state laws and/or regulations, and shall provide coverage for claims arising out of acts, errors or omissions in the rendering or failure to render services.

For Air Ambulance Providers Only, in addition to the above:

- Aviation Liability insurance with limits of not less than $1,000,000 per occurrence and $2,000,000 in the aggregate.

B. Providers and Facilities shall provide Anthem with Evidence of Coverage (EOC) certificates upon execution of this Agreement and upon request during the Agreement Period. Providers and Facilities shall notify Anthem of a reduction in, cancellation of, or lapse in coverage within ten (10) days of such a change.

Misrouted Protected Health Information (PHI)

Providers and Facilities are required to review all Member information received from Anthem to ensure no misrouted PHI is included. Misrouted PHI includes information about Members that a Provider or Facility is not currently treating. PHI can be misrouted to Providers and Facilities by mail, fax, email, or electronic remittance. Providers and Facilities are required to immediately destroy any misrouted PHI or safeguard the PHI for as long as it is retained. 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, Providers and Facilities must contact your local Provider Services to report receipt of misrouted PHI.

Laboratory Tests

Laboratory testing must be sent to a Anthem in-network laboratory provider. Any lab work referred to an out-of-network laboratory without approval prior to services being rendered, will be the financial responsibility of the referring physician.

To the extent the physician draws any lab work or performs any laboratory diagnostic testing in his/her office for any patient, the physician shall perform such in-office testing for Anthem Members. Patient service centers are to be used only by Providers who do not draw any lab work in their office.

Laboratory Corporation of America (“LabCorp”) is the reference laboratory provider for Pathway, HMO/POS, Open Access Members. All laboratory testing for Pathway, HMO/POS, Open Access Members must be referred to LabCorp except those that have been approved as in-office laboratory tests. Approved in-office laboratory procedure codes will be reviewed periodically for additions, deleted and replacement codes.

LabCorp requisition forms must be completed and accompany the Member to the patient service center. Please ensure the requisition is completed correctly. Go to www.labcorp.com for LabCorp’s laboratory requisition procedures and to search for LabCorp Patient Service Centers.

Non-Compliance Policy

The purpose of the Non-Compliance Policy is to monitor and assure compliance with Anthem administrative and UM policies and operational requirements pursuant to Agreements with Providers.

Anthem will notify Provider of any documented occurrence of administrative non-compliance with their agreement. Anthem will track occurrences and provide notification and necessary education to the Provider and staff.

Examples of administrative non-compliance include, but are not limited to:

- Balance billing Members when Member has no financial liability,
- Failure to use/call in a network physician to admit a Anthem Member from the emergency room,
- Referral of a Member to an out-of-network provider,
- Failure to obtain required pre-authorization for admissions and/or procedures,
● Failure to provide timely information for prospective reviews,
● Failure to call in a Network physician for a specialist consultation,

Please contact your provider representative with questions regarding the non-compliance policy.

National Provider Identifier ("NPI")

The National Provider Identifier ("NPI") is a component of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). The NPI is a ten (10) digit single provider identification number the Centers for Medicaid and Medicare Services ("CMS") assigns through the National Plan and Provider Enumerator System ("NPPES") to uniquely identify a physician, other health care professional or institution within specified electronic HIPAA transactions. It is intended to improve the efficiency of the health care system and reduce fraud and abuse.

The NPI has replaced all existing identification numbers including the Medicare, Medicaid, Unique Physician Identification Number ("UPIN") and plan provider identification numbers.

Please note if NPI numbers submitted are INVALID, we will be unable to complete the processing of your Claim(s). Your correct tax identification number ("TIN") and billing address must be included when filing a Claim.

Open Practice

Provider shall give Plan sixty (60) days prior written notice when Provider no longer accepts new patients.

Physician Rights and Responsibilities

Providers have the right to:

- Request that a Covered Individual be reassigned if an acceptable physician-patient relationship cannot be established
- Receive timely payment for Covered Services according to their Agreement
- Be treated courteously and with respect by Anthem Members and personnel
- Obtain all necessary information to treat Members
- Express their opinions, concerns, or complaints in a constructive and respectful manner to Anthem
- File an appeal and be given due process
- Collect any Cost Shares for Covered Services
- Collect for non-Covered Services, with proper disclosure
- Discuss, based on their opinions, all Medically Necessary or appropriate care with Members.

Anthem Providers have a responsibility to:

- Cooperate with all Anthem administrative, quality, and UM guidelines and programs
- Ensure that the confidentiality of medical information is protected
- Treat Members and Anthem personnel with courtesy and respect
- Seek only authorized Cost Shares and specifically authorized payments for non-Covered Services from Anthem Members
- Strive to improve the health of all Members by offering and providing all necessary preventive services appropriate to their specialty
- Discuss a Member’s health care status and treatment options with that Member or his or her legal guardian, regardless of whether the information concerns a Covered Service
- When a Member requests it, disclose a general description of the way their Anthem reimbursement Agreement works
- Respond to Member requests for specific information about their practice, including practice statistics (i.e. the numbers of a specific procedure performed), their credentials (i.e. where they went to medical school, board certification), and patient satisfaction measures.

Preferred Drug List
The objective of the Preferred Drug List (often referred to as “Preferred Drug Formulary”) is to ensure quality and cost-effective prescription drug coverage at an affordable price for our Members. The Pharmacy and Therapeutics (“P&T”) Committee, composed of practicing physicians and pharmacists, has selected safe and effective products for coverage under the Preferred Drug List. The Preferred Drug List is supported by sound medical guidelines and treatment protocols researched from current pharmacological literature, reference books and peer-reviewed journals.

The Preferred Drug List includes coverage for many single-source brand name drugs, essentially all generic equivalent products, and some multi-source brand agents. The Preferred Drug List also targets our most highly-utilized therapeutic categories. Within these top classes, single-source brand name drugs are limited to a specific list. Those drugs not included on the Preferred Drug List are considered non-preferred or non-formulary. Non-preferred agents are not considered a covered prescription benefit unless they meet criteria established by the P&T Committee and approved by the Plan. The ANTHEM Prescription Drug Program includes an exception process to provide coverage for a non-preferred drug prescribed by you when, in your professional judgment, no effective alternative is available on the Preferred Drug List. This process documents the need for an exception when a formulary/preferred product has been proven to be ineffective or causes adverse or harmful reactions to the patient. Please see our web site, www.Anthem.com, for more details.

As a Provider, you are asked to prescribe products from the Preferred Drug List for all ANTHEM Members. By prescribing preferred drugs when appropriate, you help contain the rising costs of health care, ensure the use of high quality pharmaceuticals, and help maintain your patients’ continued drug coverage. We also ask that you assure your patients of the safety and efficacy of generic equivalents. Please use the Preferred Drug List when prescribing for your Anthem patients. To receive a copy of the most current Preferred Drug List, please go to www.Anthem.com or contact your local Network Management Consultant.

Specific drugs may require preauthorization. Specific preauthorization request form will apply to these drugs. The drug-specific preauthorization forms are available on our web site at www.Anthem.com.

Leg

Provider and Facility Responsibilities

Providers and Facilities are responsible for notifying Anthem when changes occur within the Provider practice or Facility. Providers and Facilities should reference their Agreement for specific timeframes associated with change notifications.

Examples of these changes include, but are not limited to:
• adding new or removing practitioners to the group
• change in ownership
• change in Tax Identification Number
• making changes to demographic information or adding new locations
• selling or transferring control to any third party
• acquiring other medical practice or entity
• change in accreditation
• change in affiliation
• change in licensure or eligibility status, or
• change in operations, business or corporation

Responsibilities of the Facility

A Facility must promptly notify Anthem of:
• Any change or notification of possible change in its state licensure,
• Any change in accreditation status by The Joint Commission (“TJC”) or Medicare certification;
• Any change in its ownership or business address;
  Any legal or governmental action or any other problem or situation which might impair the ability of Facility to carry out its duties and obligations under its Anthem Agreement(s) including, but not limited to, employee strikes or walkouts, financial insolvency, or damage to the physical plant resulting in any interruption in medical services;
• Any written complaint, claim or suit or threat of legal action by a Member against the Facility or the Facility’s medical staff;
• Any action taken by Facility or its medical staff against a physician;
Any change or notification of possible change in professional licensure of staff member or a physician; and
Any change or notification of possible change in Facility’s comprehensive general or professional liability insurance limits. If Facility reserves funds to meet the insurance requirements; Facility shall notify Anthem of any change in the reserves.

A Facility must provide at least one hundred twenty (120) days prior written notice of the intention to add, limit or delete any Facility or service. This would include the addition of any freestanding Facilities.

**Referring to Non-Participating Providers**

Anthem’s mission is to provide affordable quality health care benefits to its Members. Members access their highest level of health care benefits from Network/Participating Providers and Facilities. Providers and Facilities put Members at risk of higher out-of-pocket expenses when they refer to non-participating providers in non-emergent situations or without Anthem’s prior approval. Anthem has established Maximum Allowed Amounts for services rendered by non-participating providers. Once Anthem determines the appropriate Maximum Allowed Amount for services provided by a non-participating provider, the payment will be remitted to the Member in most situations rather than the non-participating provider; and Members may be balance-billed by non-participating providers for the difference between the amount they charge for the service and the amount paid to that non-participating provider.

Providers and Facilities are reminded that pursuant to their Agreement with Anthem they are generally required to refer Members to other Network/Participating Providers and Facilities. Providers and Facilities who establish a pattern of referring Members to non-participating providers may be subject to disciplinary action, up to and including termination from the Network. Anthem understands that there may be instances in which Providers and Facilities must refer to a non-participating provider. For additional information on in-network and out-of-network referrals, Providers and Facilities should refer to the applicable sections of their Agreement with Anthem.

**Risk Adjustments**

**Compliance with Federal Laws, Audits and Record Retention Requirements**

Medical records and other health and enrollment information of Members must be handled under established procedures that:

- Safeguard the privacy of any information that identifies a particular Member;
- Maintain such records and information in a manner that is accurate and timely; and
- Identify when and to whom Member information may be disclosed.

In addition to the obligation to safeguard the privacy of any information that identifies a Member, Anthem, Providers and Facilities are obligated to abide by all Federal and state laws regarding confidentiality and disclosure for medical health records (including mental health records) and enrollee information.

**Encounter Data for Risk Adjustment Purposes**

Commercial Risk Adjustment and Data Submission: Risk adjustment is the process used by Health and Human Services (“HHS”) to adjust the payment made to health plans under the Affordable Care Act (“ACA”) based on the health status of Members who are insured under small group or individual health benefit plans compliant with the ACA (aka “ACA Compliant Plans”). Risk adjustment was implemented to pay health plans more accurately for the predicted health cost expenditures of Members by adjusting payments based on demographics (age and gender) as well as health status. Anthem, as a qualifying health plan, is required to submit diagnosis data collected from encounter and claim data to HHS for purposes of risk adjustment. Because HHS requires that health plans submit all ICD10 codes for each beneficiary, Anthem also collects diagnosis data from the Members’ medical records created and maintained by the Provider or Facility.

Under the HHS risk adjustment model, the health plan is permitted to submit diagnosis data from inpatient hospital, outpatient hospital and physician/qualified non-physician e.g. nurse practitioner encounters only.
Maintaining documentation of Members’ visits and of Members’ diagnoses and chronic conditions helps Anthem fulfill its requirements under the Affordable Care Act. Those requirements relate to the risk adjustment, reinsurance and risk corridor, or “3Rs” provision in the ACA. To ensure that Anthem is reporting current and accurate Member diagnoses, Providers and Facilities may be asked to complete an Encounter Facilitation Form (also known as a SOAP note) for Members insured under small group or individual health benefit plans suspected of having unreported or out of date condition information in their records. Anthem’s goal is to have this information confirmed and/or updated no less than annually. As a condition of the Facility or Provider’s Agreement with Anthem, the Provider or Facility shall comply with Anthem’s requests to submit complete and accurate medical records, Encounter Facilitation Forms or other similar encounter or risk adjustment data in a timely manner to Anthem, Plan or designee upon request. Providers and Facilities also agree to cooperate with Anthem’s, or its designee’s, requests to reach out to patients to request appointments or encounters so additional information can be collected to resolve any gaps in care (example - blood tests in certain instances) and to provide the updated and complete Member health information to Anthem to help it fulfill its requirements under the Affordable Care Act.

In addition to the above ACA related commercial risk adjustment requirements, Providers and Facilities also may be required to produce certain documentation for Members enrolled in Medicare Advantage or Medicaid.

**RADV Audits**

As part of the risk adjustment process, HHS will perform a risk adjustment data validation (RADV) audit in order to validate the Members’ diagnosis data that was previously submitted by health plans. These audits are typically performed once a year. If the health plan is selected by HHS to participate in a RADV audit, the health plan and the Providers or Facilities that treated the Members included in the audit will be required to submit medical records to validate the diagnosis data previously submitted.

**ICD-10 CM Codes**

HHS requires that physicians use the ICD-10 CM Codes (ICD-10 Codes) or successor codes and coding practices services under ACA Compliant Plans. In all cases, the medical record documentation must support the ICD-10 Codes or successor codes selected and substantiate that proper coding guidelines were followed by the Provider or Facility. For example, in accordance with the guidelines, it is important for Providers and Facilities to code all conditions that co-exist at the time of an encounter and that require or affect patient care, treatment or management. In addition, coding guidelines require that the Provider or Facility code to the highest level of specificity which includes fully documenting the patient’s diagnosis.

**Medical Record Documentation Requirements**

Medical records significantly impact risk adjustment because:

- They are a valuable source of diagnosis data;
- They dictate what ICD-10 Code or successor code is assigned; and
- They are used to validate diagnosis data that was previously provided to HHS by the health plans.

Because of this, the Provider and Facility play an extremely important role in ensuring that the best documentation practices are established.

HHS record documentation requirements include:

- Patient’s name and date of birth should appear on all pages of record.
- Patient’s condition(s) should be clearly documented in record.
- The documentation must show that the condition was monitored, evaluated, assessed/addressed or treated (MEAT), or there is evidence of treatment, assessment, monitoring or medicate, plan, evaluate, referral (TAMPER).
- The documentation describing the condition and MEAT or TAMPER must be legible.
- The documentation must be clear, concise, complete and specific.
When using abbreviations, use standard and appropriate abbreviations. Because some abbreviations have different meanings, use the abbreviation that is appropriate for the context in which it is being used.

Physician’s/Qualified Non-Physician’s signature, credentials and date must appear on record and must be legible.

Gatekeeper HMO Specific Guidelines

Role of the Primary Care Physician

The primary care physician (“PCP”) is responsible for providing care within the scope of his or her practice and managing all other aspects of the member’s medical care. This includes coordinating notifications for Member referrals to specialists and obtaining pre-authorizations for hospital admissions. PCPs also confer with specialists about admissions recommended by a specialist.

For BlueChoice HMO/Blue Choice Option Members, the PCP will coordinate referrals for specialty care and inpatient admissions, either directly or in collaboration with a specialist.

Specifically, the PCP will:

- Serve as the Member’s personal physician, providing services and treatment without discrimination
- Provide all primary care services in a manner consistent with customary and recognized standards
- Coordinate and manage all other medical services
- Notify ANTHEM about referrals to in-network specialists
- Obtain pre-authorizations for inpatient admissions
- Obtain pre-authorizations for outpatient procedures
- Refer and admit only within the ANTHEM network
- Comply with required ANTHEM procedures
- Accept ANTHEM reimbursement
- Provide 24-hour, 7-day a week access to medical care for Members

For BlueChoice HMO, BlueChoice Option (“POS”) Individuals, PCPs should follow these procedures for office services:

- Verify Member eligibility and PCP assignment (via www.availity.com)
- Provide care
- Collect co-payment
- File CMS 1500 Claim form

NOTE: Nothing in this manual is intended to supersede or substitute for the PCP’s judgment about what is in the Member’s best medical interest.

Member Selection of a PCP

When a Member enrolls in the BlueChoice HMO or BlueChoice Option, he or she will select a PCP from our provider Network. Members may change their PCP by notifying ANTHEM and changes become effective on the first day of the following month if the change is received by the 25th of the month. If the change occurs after the 25th, it will be effective on the first day of the subsequent month.

PCP Scope of Services

At ANTHEM, we want to ensure that our Members receive continuous, appropriate health care in accordance with the physician’s network participation agreement. We also want to ensure that each PCP has the generally acceptable skills necessary to care for common primary care medical conditions. Accordingly, we require our network physicians to meet and comply with the following criteria in their scope of practice.
The PCP will coordinate all aspects of Members’ care, including generating referrals to network specialists and plan notification for POS Members.

The PCP will coordinate, monitor and ensure the continuity of a Member’s care after a referral is approved.

The PCP will seek prior authorization for non-participating provider referrals, except in an emergency. This includes out-of-network specialists, ancillary and facility providers.

The PCP will use designated laboratory, radiology, specialist physicians, ancillary and facility provider networks as outlined in this manual or designated local region communications.

The PCP will comply with the ANTHEM quality assurance and utilization management initiatives and related policies and procedures.

These include:

- Requesting practice closure to new Members as stated above and providing written notification to ANTHEM at least 90 calendar days in advance of the anticipated closure;
- Reporting all patient encounters, including all applicable diagnosis (ICD-10 or successor codes) and procedure (CPT IV) codes;
- Collecting Member copayments at each visit;
- Acknowledging the PCP of record is responsible for a Member’s care (including emergency care) even if the Member has not been treated in the office;
- Cooperating with medical record and site survey processes;
- Obtaining prior authorization for inpatient medical admissions, except emergencies;
- Providing 24-hour, 7-day per week access to primary care services – or providing a covering physician. (Members should go to the emergency room only if an emergency condition exists. Use of urgent care centers will be based on ANTHEM’s policy and referral requirements.)
- Prescribing generic equivalent drugs when possible and using the Preferred Drug List when applicable (see www.Anthem.com);
- Accepting reimbursement as detailed in the PCP network participation agreement.

The PCP will provide comprehensive, continuous medical and preventive care appropriate to the age range of the practice’s specialty.

This care will include, but not be limited to:

- Newborn care, including hospital-based
- Infant care
- Children’s care
- Adolescent care
- Adult care
- Elderly care
- Periodic health assessment and physical exams in accordance with the established Preventive Health Guidelines, including interventions, immunizations and screenings
- Patient education and counseling
- Health promotion counseling, including injury prevention
- Well-woman exams
- Family planning
- Nutrition counseling
- Drug and tobacco counseling
- Cancer screening
- Screening for heart disease
- Emergency and urgent care triage
- Ambulatory, hospital and home care

Note: A PCP may coordinate inpatient hospital care through an in-network hospitalist.
- Nursing home and hospice care
- Treatment for acute illness, including:
• Musculoskeletal (fibromyalgia, tendonitis, etc.)
• ENT (sinusitis, otitis media, etc.)
• Ophthalmic (corneal abrasion, conjunctivitis, etc.)
• Dermatologic (scabies, pediculosis, etc.)
• Infectious (cellulitis, pneumonia, etc.)
• Gynecological (vaginitis, etc.)
• Urologic (urinary tract infection, etc.)
• Gastrointestinal
• Cardiovascular
• Neurological
• Pulmonary
• Treatment for chronic illnesses, including:
  • Cardiovascular (angina, hypertension, stroke, etc.)
  • Endocrine (diabetes, thyroid disease, etc.)
  • Musculoskeletal (rheumatoid arthritis, osteoarthritis, etc.)
  • Pulmonary (asthma, bronchitis, emphysema, etc.)
  • Skin (acne, dermatitis, etc.)
  • Gastrointestinal (ulcer, irritable bowel, etc.)
  • Genitourinary (urinary incontinence, etc.)
• Identifying and recommending treatment for depression, anxiety disorders, stress, grief reaction
• Identifying and recommending treatment for substance abuse
• Comprehensive assessment
• Evaluation of occupational and school health-related illnesses
• Death and dying counseling
• Knowledge about interdisciplinary resources and community and public health resources
• Managed care practice management, including cost-effective care and appropriate use of consultants
• Risk management

The PCP will provide for or coordinate the following in-network or approved out-of-network interventions in the appropriate ambulatory setting:

• EKGs
• Routine sigmoidoscopy
• Injections and immunizations
• Allergen immunotherapy injections
• Vision and hearing screening
• Routine lab work (UA, FBS, Hct, rapid strep, etc.)
• Radiology
• 24-hour holter monitor
• Minor surgery, including laceration repair

**Terminating a Physician-Patient Relationship**

A PCP may request that a Member be removed from his or her patient list. Members selecting a PCP are responsible for making a positive contribution to the physician-patient relationship. If an effective physician-patient relationship cannot be established, the PCP may discharge a Member from his or her care.

After receiving approval to terminate the relationship, the PCP must:

• Provide written notice via Certified Mail to the Member explaining the intention to discharge the Member from his or her patient list.
• Advise the Member to select another PCP. The Member may log on to www.Anthem.com or contact Anthem’s customer service department to select another PCP.
• Send a copy of the notice to Anthem provider representative.
• For thirty (30) calendar days, the PCP is required to provide health care services to the Member until the Member has selected another PCP.
Access Standards

Anthem has developed the following standards to ensure that our Members have timely access to medical care:

Office hours

A physician’s office must be open at least four (4) days per week. If a PCP has more than one office, he or she must be available to Anthem Members a total of four (4) days per week. The PCP must directly provide at least twenty (20) hours of in-office patient care per week. If he or she has more than one (1) office, the PCP must be available to Anthem Members for a total of twenty (20) hours per week.

Appointment availability

- An appointment for a periodic health assessment for preventive care must be scheduled within sixty (60) calendar days of a Member’s initial call or ninety (90) days for OB/GYN.
- An appointment for a routine office visit (such as follow-up, blood pressure and weight checks, prescription refills, etc.) must be scheduled within fourteen (14) days of a Member’s initial call – or within thirty (30) days for OB/GYN – or ten (10) business days for Behavioral Health.
- For emergent diagnoses, PCPs must provide same-day appointments. Behavioral Health providers must be available to assess a patient experiencing an emergent situation within six (6) hours.
- For urgent diagnoses, appointments must be available within twenty-four (24) hours. Behavioral Health providers must be available to assess a patient experiencing an urgent situation within forty-eight (48) hours.
- Same-day appointments must be available depending on the urgency of the Member’s complaint.

After hours coverage

- Twenty-four (24) hours/seven (7) days a week on call coverage
- Physician to call back within two (2) hours
- Covering physicians must be Anthem network physicians
- On-Call physician should provide triage for urgent/emergency care

Office wait time

Office wait time for a scheduled appointment is thirty (30) minutes or less. If the wait time will likely be more than thirty (30) minutes, the Member has a choice of waiting or rescheduling the appointment.

Telephone access

- Incoming phone calls to the provider’s office must be answered within ten (10) rings
- Office staff should ask permission to place callers on hold before doing so. If a caller is placed on hold, the call will be acknowledged every two minutes.
- The physician must provide coverage twenty-four (24) hours, seven (7) days-a-week for appropriate triage.

Role of the Specialty Care Physician

Anthem PCPs refer Members of Anthem to specialists who participate in the Anthem Network*. Except in emergency situations, Members’ specialty care must be coordinated through their PCP. PCPs are required to refer Members only to HMO participating specialists. These specialists work with the Member’s PCP and recognize the PCP’s role as manager of all the Member’s medical care. Members covered under a Point-of-Service (“POS”) plan have benefits available for out-of-network services.

* Note: A referral from a PCP is not required for Behavioral Health Services. Members may self-refer by calling the telephone number on their Member identification card. HMO and Point-of-Service Members do not have out-of-network benefits for Behavioral Health Services and must obtain services from a Participating Provider.
Responsibilities of the Specialist

After confirming that the PCP has notified Anthem of the referral, the specialist’s responsibilities include:

- Confirm a valid referral has been obtained from the PCP (when required) before rendering services to Anthem Members
- Providing appropriate, necessary medical services to the Anthem Member
- Communicating findings and recommended treatment to the PCP in a timely manner
- Consulting with the Member’s PCP before recommending further specialty care or referring the Member to another specialist
- Complying with Utilization Management and Quality Assurance programs as required by Anthem
- Obtaining prior authorization for all hospital admissions, with concurrence of the PCP
- Accepting the Member’s BlueChoice ID card and co-payment in lieu of full payment at the time of service
- Filing Claims for services to Members, using the CMS 1500 form
- Accepting reimbursement as payment in full from Anthem as specified in the Agreement as payment in full from Anthem.
- Billing Anthem Members only for applicable Cost Shares

Specialist Physician Guide

Specialists should use the following guidelines when providing services to BlueChoice Members:

Verify Member eligibility

- Check the Member’s ID card
- Verify eligibility online at www.availity.com or
- Call Anthem for confirmation of coverage and benefits

Ensure proper referral

- Verify the referral has been obtained via online at www.availity.com.
- If a referral notification cannot be confirmed, inform the Member that he or she may be responsible for all or part of the bill for the specialist’s services. The specialist may then contact the PCP, or direct the Member to seek referral notification through the PCP and Anthem.
- Secure authorization from the PCP for additional consultations or services beyond what was initially authorized for a specific condition.

Direct Access Specialists

Ophthalmology, Optometry, OB/GYN, and Dermatology are considered direct access specialties to which Members are entitled to refer themselves to in-network specialists. (No referral from the PCP is necessary.) Covered services are limited to those associated with each provider specialty and are subject to Anthem utilization management guidelines.

PCP referral is not required for a Member to access outpatient or inpatient mental health and substance abuse services. The Member Health Benefit plan requires that Providers render services. Behavioral health providers are strongly encouraged to provide PCPs with updates regarding treatment progress and medication usage.

Specialist to Specialist Referral

Specialists may refer patient to other specialists for Covered Services only in the following circumstances:

- OB/GYNs may refer to:
• any in-network specialist if the Member is pregnant
• in-network general surgeon or interventional radiologist for breast mass
• in-network GYN-Oncologist or Infertility Specialist
• Orthopedists/Neurologists/Neurosurgeons and Rheumatologists may refer to physical therapy.
• Orthopedists may refer to Neurologist for nerve conduction studies (testing only).
• Orthopedists may refer to Physical Medicine and Rehabilitation specialists.
• Specialists may refer Member for diagnostic testing, additional visits, and inpatient and outpatient admission after consulting with PCP.

All other referrals must be submitted by the PCP.

Please note: The ordering physician is responsible for the approval of tests that require precertification or notification.

Self-Referrals by Members

BlueChoice Option (POS) Members may self-refer to any in-network or out-of-network provider and receive services at a significantly reduced benefit level, except in the following cases:

• Preventive Care is covered only if performed by the Member’s PCP (except mammogram, Pap smear, prostate antigen test, and child wellness from birth through age five).
• Behavioral Health Services (Mental Health and Substance Abuse) are not covered if rendered by an out-of-network provider.
• Non-emergency use of the emergency room is not covered.

BlueChoice Option Members must use Provider s for all services to receive in-network benefits. However, they may also self-refer to an out-of-network specialist (for services not listed above) and be subject to a reduced out-of-network benefit level.

BlueChoice HMO Members may self-refer to the following specialists:

• OB/GYNs for annual well-woman exam and any OB/GYN-related medical conditions including pregnancy termination.
• Dermatologist for any related medical conditions.
• Optometrist/Ophthalmologist for consultation of medical conditions of the eyes.
• Behavioral Health providers for Mental Health and Substance Abuse services.
• Oral Surgeons for impacted wisdom teeth.

BlueChoice HMO Members must use Network Providers to receive benefits for these services.

OB/GYN Specific Information

Well Woman Exams

BlueChoice HMO/BlueChoice Option provides coverage for one routine gynecological examination per contract year for all women Members pending group benefit specifics.

By the Member’s choice, the well woman examination may be performed by either the Member’s PCP or a participating Obstetrician or Gynecologist.

Provider s are to bill for well woman services using any office CPT code listed below and the ICD-10 or successor codes V72.3 in any of the diagnostic fields on the professional Claim form.

Office/Preventive Visit: 99201-99215, 99384-99387, 99394-99397

BlueChoice HMO/BlueChoice Option benefits cover only the services listed below, depending on group-specific benefit levels, when part of the well woman examination:

• Medical/Gynecologic history of the Member
• Physician examination of the breast and pelvic organs
• Pap smear through contracted ancillary laboratory (LabCorp)
• Microscopic examination of the vaginal smear through contract ancillary laboratory (LabCorp)
• Treatment of incidental vaginal infections (i.e. yeast, trichomonas, and non-specified infections)
• Rectal examination after age 40 years
• Birth Control administration
• Urinalysis (through LabCorp)
• Hematocrit (through LabCorp)

Mammogram

Initial screening between 35-40 years of age and then every one to two years between ages 40-50. Women over age 50 should have an annual mammogram. Mammograms may be done in a physician’s office if the office is ACR accredited. Physicians who perform mammograms in their office are asked to bill a global fee. The office will be responsible for any reading or interpretation fees associated with the mammogram.

Contraceptive Management

• Norplant removal
• Depo-Provera (per 150 mg. Injection)
• IUD insertion
• IUD removal
• IUD contraceptive device
• Fitting of diaphragm/cap

Obstetrics Care

Vaginal or C-Section delivery global fee includes the following:

• Comprehensive first visit
• All visits related to obstetrical care
• Non-stress test (times two)*
• Ultrasound
• Lab work will be capitated
• Delivery: Vaginal or C-section
• Postpartum care (up to 8 weeks)

* The global fee will be reduced for offices that do not do ultrasounds or non-stress tests.

High Risk Obstetrics Cases

• Gestational diabetes
• Pregnancy induced hypertension
• Pre-existing chronic illnesses such as SLE, renal disease, etc.
• Congenital anomalies affecting delivery or requiring immediate intervention
• Intrauterine fetal growth retardation

Includes all non-stress tests to be done.

Miscarriage and Early Fetal Demise:

• Will be reimbursed as fee-for-service

Past Twenty (20) Weeks:

• Global fee will be paid

Referral and Preauthorization
Please notify the Utilization Management Department of the Member’s pregnancy. Precertification is not required for vaginal and C-section deliveries that do not exceed the mandated two (2) day or four (4) day inpatient stay. Any length of stay beyond those timeframes for vaginal (2 days) and C-section (4 days) deliveries must be precertified by the Utilization Management Department.

**Surgical Assistants at C-Sections**

There has been much confusion over the terms Surgical Assistant versus Assistant Surgeons as they relate to C-sections. After careful review and input from both external consultants and local OB/GYNs, we have now clarified the definition and reimbursement for these services. Please take a moment to review the following so that we all have the same understanding.

Surgical Assistant: A technically skilled professional (not required to be MD) to assist during a surgical procedure.

Assistant Surgeon: A licensed physician. Assistant surgeons are approved and reimbursed based on the medical necessity for an assistant surgeon during this procedure.

**Group Specific Benefits**

Please verify Member benefits to determine if there are group specific benefits for the employer group.

**Emergency services**

- Contact the PCP, if practical
- If the situation is a true emergency, treat the patient, then contact his or her PCP
- Contact the PCP and Anthem within 24 hours of emergency admissions

**File Claims for Members**

- Mail Claims to address on back of Member ID Card
- Submit CMS 1500 to Anthem
- Accept Anthem reimbursement
- Collect deductible, co-insurance and co-payments from the Member

**Covering Physician(s)**

The PCP must be available and accessible to provide or coordinate all health care services for Members (including but not limited to emergency medical care, outpatient services and inpatient hospital services) twenty-four (24) hours per day, seven (7) days per week, either directly or through an appropriate call system providing for timely callback. In the event the PCP cannot provide these services personally, the call coverage must be provided through another Network physician (“Covering Physician”).

PCPs are reimbursed either on a monthly capitation fee or fee for service basis to provide health care services to Members. When the capitated PCP arranges for a Covering Physician, who is also reimbursed on a capitation basis, to provide call coverage, the PCP is responsible for making arrangements to pay the Covering Physician. The Covering Physician may not bill Anthem for any health care services which are covered under the capitation fee because Anthem has already paid the PCP to provide those services. When a fee for service PCP arranges for a Covering Physician, who is also reimbursed on a fee for service basis, to provide call coverage Anthem will reimburse the Covering Physician according to the applicable fee schedule. The PCP is also responsible for ensuring that the Covering Physician (i) only bills a Member for (A) non-Covered Services which Member agrees to in writing BEFORE such services are provided, and (B) all applicable cost share amounts applicable to the Covered Services, and (ii) does not bill a Member for the difference between the Covering Physician’s charges and the amount of compensation paid to the Covering Physician by the PCP (i.e., no balance billing).
**Missed Physician Appointments**

To receive reimbursement when a Member misses a set appointment time, the provider must first establish a written office policy addressing payment for missed appointments. Members should acknowledge their understanding of the policy in writing. Normally this can be accomplished with a one-time signature. Once the policy has been established and the Member has signed his or her acknowledgement, the follow guidelines apply:

- A provider shall not collect a missed appointment fee unless the Member has signed a statement acknowledging understanding of the policy.
- Claim forms for missed appointments should not be submitted.
- Providers are encouraged to accept the Member’s co-pay as the fee for missed appointments.
- Providers should report repeated missed appointments to Customer Service in order for Members to be effectively educated.
- If the Member continues to miss appointments and does not pay for them, the Provider has the right to request that the Member be removed from his or her patient list. (Please refer to: Terminating a physician-patient relationship.)

**Member Copayment**

Anthem Members are only responsible for a copayment amount for Covered Services provided by the PCP in his/her office. The copayment is printed on the Member’s ID card.

A physician copayment may be collected for any visit at which a physician or healthcare professional sees a Member and an office visit CPT procedure code is filed on the Claim. The copayment should not be collected if the Member is only assisted by the administrative staff (examples: picking up a prescription or requisition or drawing for laboratory tests).

Group benefits may supersede the copayment allocation. Please verify Anthem Member eligibility and benefits to determine the appropriate collection of the Member’s copayment.

Please note: Only one copayment may be collected for each patient visit. An additional copayment may be applicable for urgent care visits. Group specific benefit inclusions and/or exclusions will supersede Anthem standard Health Benefit plan structure. Copayment for flu vaccines is dependent on the Member’s benefits as outlined in their Member Certificate Booklet. Please verify Member eligibility and benefits to determine appropriate collection of Member copayment.

**PCP Reimbursement**

PCPs are reimbursed either on a fee-for-service or capitation basis, in accordance with his/her Anthem PCP Agreement. Those PCPs who are reimbursed according to a capitation schedule receive a monthly payment equal to the capitation rate multiplied by the number of Anthem Members assigned to the practice. In addition to that monthly capitation payment, some procedures are separately paid on a fee-for-service basis.

Capitation payments are made on a full month basis only, and are never prorated. Member effective dates of eligibility and PCP changes are, therefore, normally the 1st of the month. Members may be added or cancelled up to sixty days retroactively.

In some cases Members will become effective on dates other than the first of the month (e.g. newborns). Capitation for Members with mid-month effective dates will be paid as follows:

<table>
<thead>
<tr>
<th>Effective Date of Enrollment</th>
<th>Reimbursement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st through 15th</td>
<td>Full capitation for month</td>
</tr>
<tr>
<td>16th through 31st</td>
<td>No capitation for first month</td>
</tr>
</tbody>
</table>

Also, Members may terminate coverage during the month (e.g. they terminate employment with the group who insures them). Capitation for Members with mid-month termination dates will be paid as follows:
Encounter Reporting

All services provided to Anthem Members must be reported in the standard HIPAA compliant Claim format using HIPAA-compliant code sets on the CMS-1500 Claim form or the equivalent, within the filing standards timeframe, and with applicable charges noted. This is necessary for reporting of utilization data and HEDIS purposes. The Claim system will identify CPT codes eligible for fee-for-service payment and will approve those services when appropriate.

Please remember to verify the Member's ID card on each visit to ensure your Claims are submitted with the correct Member ID for that particular date of service. Electronic Claim submission still remains the most efficient way to submit your Claims; however, if you submit a hard copy Claim please refer to the back of the Member’s ID card for the appropriate Claim submission address and customer service number.

Discontinuing Acceptance of New Patients

According to their contractual agreement, PCPs are required to accept BlueChoice HMO or BlueChoice Option Members who select them as their PCP up to the practical limit set by their practice. As long as the physician’s practice is generally open to new patients, he or she must be available for PCP selection by Members.

PCPs may close their practice to BlueChoice HMO and BlueChoice Option Members only if the practice is also closed to all new patients. To close the practice to new patients, PCPs must give 90 (ninety) days advance written notice to Anthem. The ninety (90)-day notice begins on the date Anthem receives a written document indicating the physician’s intent to close the practice. The effective date will be the 91st day following receipt of the notice. PCPs must continue to accept new patients during the ninety (90)-day notice period.

Even if a physician’s practice is closed to new patients, he or she must accept existing patients who convert coverage from another carrier to BlueChoice HMO or BlueChoice Option and choose the physician as their PCP.

When Anthem receives written notification that a physician’s practice is closed to new patients, that information will be posted in the managed care system and at Anthem.com. When the physician or physician’s group is once again accepting new patients, the system will be updated and Anthem.com.

Please send the written notice about closing or reopening a physician practice to your provider network representative.

Changes to Practice

Adding new physicians to the practice group – Participating PCPs shall provide Anthem with thirty (30) days prior written notice when their group adds or deletes physicians. New physicians joining a participating practice must submit a completed application along with contract documents. They must also meet all credentialing criteria required by Anthem to become a Member of the network.

Changing participation status – PCPs who wish to withdraw from the network must notify Anthem in writing one hundred (180) calendar days before the cancellation of the contract. The one hundred eighty (180) day period will begin on the date Anthem receives the written notice. Changes involving adding or discontinuing physicians from a practice, or changing participation status must be sent in writing to your local provider representative. Physicians contracted through Quality Care Providers, Inc. ("QCPI") should refer to Appendix A of this manual for notification requirements.

Members and Enrollment

Enrollment Procedures
New BlueChoice Members must select a PCP from the panel of Provider s. PCPs are physicians those who practice internal medicine, general practice, family practice, or pediatrics. Members must complete enrollment forms for themselves and all dependents. Each Member covered by the contract may choose a different PCP within the network. Anthem will notify the physician of his or her selection as a Member’s PCP. Members may change PCPs by logging on to our website www.Anthem.com or by calling Anthem customer service. PCP changes requested by the 25th of the month are effective the first day of the following month.

Physicians, who have questions about enrollment, Member eligibility, may verify this information at availity.com.

**PCP Practice Age Restrictions**

The age range of patients seen by a PCP will be set as follows unless otherwise requested by the physician:

<table>
<thead>
<tr>
<th>Type of Practice</th>
<th>Age Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Practice</td>
<td>No restriction/will see patients of any age</td>
</tr>
<tr>
<td>Internal Medicine</td>
<td>Fifteen (15) years and older</td>
</tr>
<tr>
<td>Pediatrician</td>
<td>Newborn through age twenty (20) years</td>
</tr>
</tbody>
</table>

The PCP can establish age limitations for his/her practice, as long as those age limitations are applied equally to all managed care plans accepted by the PCP and adhere to the following standards:

- A Pediatrician is not to see an adult Member age twenty-one (21) years or older
- An Internal Medicine physician is not to see a child age fourteen (14) years or younger unless the physician has been approved by the Anthem Medical Director to see this age group.

**Member Identification and Eligibility**

Each Member has an ID card that shows the Member’s contract number and basic coverage information, including office visit co-payment. We urge physicians to keep a copy of the Member’s ID card in the patient’s office file and to verify Members and eligibility periodically.

Presenting a Member ID card does not guarantee eligibility, since Members may cancel their coverage at any time. Eligibility for benefits is determined by the Member’s coverage status at the time of service.

When a Member arrives at the physician’s office, he or she should present his/her Member ID card upon check in. If the Member seeks service before he or she has received a Member ID card the office staff may verify coverage at availity.com.

The office visit co-pay amount is listed on the front of the Member ID card. Co-payments may vary depending on the Member’s Health Benefit Plan. Members should pay the indicated amount for each office visit.

If a Member with a Gatekeeper plan seeks service from a PCP who is not that Member’s designated physician, the office staff should verify the Member’s PCP by checking www.availity.com or by calling the Provider Customer Service Information Line. The Member should then be directed to the correct PCP’s office. If the Member resists going to the designated PCP, he or she must understand that benefits either will not be available or they will be reduced to out-of-Network levels.

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**Directory of Services**

**Quick Reference Guide**

**Anthem Blue Cross and Blue Shield: Anthem.com**

Providers and their staffs have fast, easy access to claim status information twenty-four (24) hours a day, seven (7) days a week through our website.

**Network Management (Provider engagement and contracting)**
Provider relations - Contact provider relations for:
General questions
E-mail: Contact your local provider Representative

Credentialing inquiries

For Provider credentialing and re-credentialing status inquiries contact your Anthem credentialing customer service team:
Telephone: 800-516-7587
Fax #: 800-848-7347
Email: credentialing@anthem.com

For credentialing assistance contact the Council for Affordable Quality Healthcare (CAQH):
E-mail: help@upadmin.acsgs.com Telephone: 888-599-1771 (Help Desk hours: 6 a.m. – 8 p.m. CT). Please have your CAQH Provider ID available when you call.
If you have already started the CAQH application process, please be sure your application is complete and all of the necessary supporting documents have been submitted via fax, toll-free, to CAQH at 866-293-1414. Please be sure to select Anthem as a Healthcare Organization authorized to access your information.

Request fee schedule

Contact your local Provider Representative
Anthem will respond to your request within ten (10) business days by e-mail.

Electronic Claims filing assistance

The Electronic Data Interchange (EDI) Solutions Helpdesk is available Mon. – Fri., 8:00 a.m. – 4:30 p.m. EST for assistance with electronic Claims filing.
E-mail: e-solutions.support@Anthem.com
Telephone: 800-470-9630

Clinical guidelines

As part of our commitment to providing the latest clinical information and educational materials, we’ve adopted nationally recognized clinical guidelines.
You can view them online at: Anthem.com by clicking on Medical Policy and Clinical UM Guidelines on the left side of the page.
Or, if you would like a paper copy mailed to you, contact the Anthem Clinical Quality Representatives at 800-545-0948 ext. 6171.

Interplan Teleprocessing Services (ITS)

Telephone: 800-628-3988
Claims/Correspondence Fax number: 888.859.3046
Claims Mailing Address: PO BOX 105370 ATLANTA GA 30348 Attention: Claims
Appeals or Correspondence: PO BOX 105568 ATLANTA GA 30348-5568 Attention: Appeals

AIM provider website

Real-time imaging requests and inquiries can be addressed 24 hours a day, 7 days a week, 365 days a year when you visit American Imaging Management (AIM) online at www.americanimaging.net.
You can also reach AIM as follows:  
For pre-authorization: call 866-714-1103  
For customer service via e-mail: WebCustomerService@americanimaging.net  
For customer service by phone: 800-252-2021

Anthem automated customer care information line

Call the toll free number on the back of the Member’s ID card. Our automated telephone voice response unit is available 24/7 to verify:
Member eligibility  
Benefits  
Coverage status  
Primary care physician (PCP)  
Menu options direct callers to the correct department.

Anthem departmental customer care lines

Facility Customer Care: 800-284-2609  
Professional Customer Care: 800-241-7475  
ITS Customer Care: 800-628-3988  
BlueCard Eligibility: 800-676-2583  
HMO USA Away From Home Care Guest Membership: 800-535-8291

Anthem PCP Referral Process

To obtain a referral to a specialty care provider, PCPs should follow the guidelines below when referring Members to a Anthem contracted specialty care provider:

Submit requests/notifications online: availity.com or submit requests by telephone dialing the number on the back of the member’s ID card

Submit requests by telephone: 800-662-9023 or 800-722-6614

Fax requests to 404-467-2999 (for HMO Members); 404-848-2384 (for POS Members)  
A referral number is not necessary and will not be supplied. Referrals are notification only. Submit all notifications of referrals prior to the Member receiving services from specialists. Retrospective requests for non-emergency specialist referrals will result in delays and/or denials in Claim payment.

Anthem Utilization Management (UM) services

Anthem will continue to address phone, fax, mail and Interactive Care Reviewer (ICR) requests for review and decision notification.  
The ICR/Availity portal is a secure, online provider authorization, referral and inquiry tool for many Anthem Members.
ICR/Availity: www.Availity.com  
Telephone: Refer to back of the member’s ID card for the Utilization Management number  
Urgent inbound communication can be received 24 hours a day 7 days a week  
Fax #: 877-254-4971  
Mail: 6087 Technology Parkway, Midland, GA. 31820  
Specialty pharmacy predetermination requests are available through INGENIORX at www.Availity.com or phone# 800-293-0659 or via fax at # 888-223-0550

Federal Employee Program (FEHBP)

Case management inquiries can be made by:  
Telephone: 800-711-2225  
Fax: 800-732-8318  
Pre-certifications and UM service inquiries can be made by:
Claims mailing address

Refer to the back of the Member’s ID card for the appropriate Claims mailing address.

Availity®, multi-payer web portal
Website: availity.com
Anthem has collaborated with Availity®, one of the nation’s leading health information networks, to deliver a multi-payer portal to Providers in Georgia. Availity offers a wide variety of online tools that allow providers to access real-time information from multiple payers via one secure sign-on including eligibility and benefits and Claim status information. Go to the Provider home page at Anthem.com for more information.

CAPITATED SPECIALTY NETWORK ADMINISTRATION - ATLANTA AREA ONLY
BlueChoice HMO and BlueChoice Option only

<table>
<thead>
<tr>
<th>Network</th>
<th>Network Name</th>
<th>Network Administrator</th>
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</thead>
<tbody>
<tr>
<td>Allergy</td>
<td>Atlanta Allergy &amp; Asthma Clinic</td>
<td>Anthem</td>
</tr>
<tr>
<td></td>
<td>1965 North Park Place, NW Suite 540</td>
<td>Claims:</td>
</tr>
<tr>
<td></td>
<td>Atlanta, GA 30303</td>
<td>PO Box 105187</td>
</tr>
<tr>
<td></td>
<td>(770) 952-8612</td>
<td>Atlanta, GA 30348</td>
</tr>
<tr>
<td></td>
<td>David Tanner, MD – Medical Director</td>
<td>Correspondence:</td>
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<td></td>
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<td>Anthem</td>
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<tr>
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<td>Georgia Neurosurgical Affiliates</td>
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<td></td>
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<tr>
<td></td>
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<td>PO Box 105187</td>
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<td>Howard Fagin</td>
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<td></td>
<td>Medical Directors: Michael Goodman, MD, H. Dale Richardson, MD</td>
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<td>888-706-3475</td>
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</tbody>
</table>

BlueCard / ITS Program

* The BlueCard/ITS program enable Georgia providers and facilities to submit Claims for Members of other Blue Cross and Blue Shield plans to Anthem. The three character alpha prefix at the beginning of the Member’s ID number is the key data element used by Anthem to identify ITS Claims.

** Anthem provides UM and Network services only for this Plan.

Provider Contracting and Provider Relations

In order to meet the service needs of our Providers and Facilities, we have assembled an experienced staff (consisting of Provider Network Managers, Network Relations Consultants, who are available to assist you. They have access to email and voicemail in the event you are not able to reach them by telephone.
The Provider Network Managers generally serve as the primary contacts for contractual issues and questions.

The Network Relations Consultants ("NRCs") generally serve as provider liaisons and are responsible for physician recruitment, on-site orientation, on-going training, and policy and procedure consultations. These associates are also responsible for researching and resolving Member complaints, capitation payment issues, and provider grievances and appeals.

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**Anthem Provider Web Site**

www.anthem.com
Anthem.com is a public website.

Anthem has redesigned the provider public website to make it easier and more useful for Providers and Facilities.

The website holds timely and important information to assist providers when working with Anthem. Go to anthem.com and Select Providers from the horizontal menu or under Partners in Health. On the **Provider landing page**, pick Georgia and choose content available.

Some items that can be located from the Provider Home page or the horizontal menu include:

- **Provider Resources**
  - Forms and Guides
  - Policies, Guidelines & Manuals
  - Provider Maintenance
  - Pharmacy
  - Behavioral Health Provider Resources
  - Dental Resources
  - Find a Doctor
  - Auality
- **Claims**
  - Claim Submission
  - Electronic Data Interchange (EDI)
  - Prior Authorization
  - Provider Appeals
- **Patient Care**
  - Enhanced Personal Health Care
  - Medicare Advantage
- **Communications**
  - News
  - Contact Us
- **Join Our Network**
  - Getting Started with Anthem
  - Credentialing
  - Employee Assistance Program (EAP)

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**Online Provider Directories and Demographic Data Integrity**

Providers and Facilities are able to confirm their Network participation status by using the Find a Doctor tool. You are able to search by a specific provider name, or view a list of local in-network Providers and Facilities using search features such as provider specialty, zip code, and plan type.
Online Provider Directory

Providers and Facilities who have questions on their participation status are encouraged to contact Provider Services on the back of the member’s ID card.

Accessing the Online Provider Directory:

- Go to anthem.com
- Select the Find a Doctor link at the top right of the page. Select your state.
- To search our online Provider Directory either enter your member information or enter as guest.

If you are directing a Member to another Provider or Facility, please verify that the Provider or Facility is participating in the Member’s specific network.

- To help ensure you are directing a Member to stay within his/her specific Network, utilize the Online Provider Directory one of the following ways:
  - Search as a Member: Search by entering the Member’s ID number (including the three-character prefix), or simply enter the three-character prefix by itself.
  - Search as a Guest: Search by Selecting a Plan or Network. Note: You can usually find the Member’s Network Name on the lower right corner of the front of the Member’s ID card.

Updating your Demographic Data with Anthem

It is critical that your patients receive accurate and current data related to provider availability. Please notify Anthem of any changes to your Provider and Facility information. All requests must be received 30 days prior to change/update. Any requests received within less than 30 days’ notice may be assigned a future effective date. Contractual terms may supersede effective date request.

IMPORTANT: If updates are not submitted 30 days prior to the change, Claims submitted for Members may be the responsibility of the Provider or Facility.

Notes:

- Tax ID changes must be accompanied by a W-9 to be valid.
- For notices of termination from our network, refer to the termination clause in your Agreement for specific notification requirements. Please allow the number of days’ notice of termination from our network as required by your Agreement

Types of demographic data updates can include, but are not limited to:

- Accepting New Patients
- Address – Additions, Terminations, Updates (including physical and billing locations)
- Areas of Expertise (Behavioral Health Only)
- Email Address
- Handicapped Accessibility
- Hospital Affiliation and Admitting Privileges
- Languages Spoken
- License Number
- Name change (Provider/Organization or Practice)
- National Provider Identifier (NPI)
- Network Participation
- Office Hours/Days of Operation
- Patient Age/Gender Preference
- Phone/Fax Number
- Provider Leaving Group, Retiring, or Joining another Practice
- Specialty
- Tax Identification Number (TIN)
Termination of Provider Participation Agreement
Web Address

* Note: To request participation for a new provider or practitioner, even if joining an existing practice, providers or practitioners must first begin the Application process. Go to anthem.com. Select Menu, and under the Support heading select the Providers link. Next, select Begin Application, and pick Your State.

Availity Portal

Anthem is offering an array of online tools through the Availity Portal, a secure multi-health plan portal.

Engage and obtain the information needed instantly with the following tools:

- **Claim Submission** – Submit a single, electronic Claim.
- **Claim Status Inquiry** – See details and payment information including Claim line-level details/processing.
- **Interactive Care Reviewer** – Secure, online provider authorization, referral and inquiry tool for many Anthem Members.
- **AIM Specialty Health** - access link to precertification requests and inquiries for specific services and access the OptiNet® Survey when applicable
- **IngenioRx** - Specialty pharmacy review for non-oncology related drug requests can be submitted via Phone 1-833-293-0659, Fax 1-888-223-0550 or Online (access available 24/7) at www.Availity.com
  Specialty pharmacy for oncology related drug requests would still go thru AIM. The fax number listed for AIM is not valid. Their toll-free phone number is 866 714 1103, I do not have a fax number for them.
- **Medical Attachments** – Submit medical records electronically when requested by the Health Plan. Includes the ability to submit an itemized bill electronically.
- **Member Certificate Booklet** – View a local plan Member’s certificate of coverage, when available
- **Member eligibility and benefits inquiry** – Get real-time patient eligibility, benefits, and accumulative data, including current and historical coverage information, plus detailed co-insurance, co-payment and deductible information for ALL Members, including BlueCard® and FEP®.
- **Member ID Card Viewer** – View the front and back of a Member’s ID card when available.
- **Secure Messaging** – Send a question to clarify the status of a Claim or to get additional information on Claims where applicable

Payer Spaces:

View Anthem specific tools by selecting Payer Spaces, then the Anthem icon to view the following tools:
• Clear Claim Connection – Research procedure code edits and receive edit rationale.

• Custom Learning Center – Access payer-centric training and educational videos.

• Education and Reference Center – Locate important policies, forms and educational resources.

• Remittance Inquiry – View an imaged copy of the paper Anthem remits up to 15 months in the past.

• Patient360 – Real time, robust picture of patient’s health and treatment history, including gaps in care and care reminders.

• Provider Online Reporting – access proprietary Provider specific reports such as Member rosters.

• Plus, links to other Anthem pages, tool overview documents and more.

Take advantage of these Availity benefits

• No charge – Anthem transactions are available at no charge to providers.

• Accessibility – Availity 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.

• Access to both commercial and government payers – Users can access data from Anthem, Medicare, Medicaid and other commercial insurers (See www.availity.com for a full list of payers.)

• Compliance – Availity is 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!

For additional assistance in getting registered, please contact Availity Client Services at 1-800-AVAILITY (282-4548).

Availity Training

After logging into Availity, Providers and Facilities have access to many resources to help jumpstart learning, including free and on-demand training, frequently asked questions, comprehensive help topics and other resources to help ensure Providers and Facilities get the most out of the Availity experience. Availity also offers onboarding modules for new Administrators and Users.

For more information on navigating in Availity, select Help & Training (from the top navigation menu on the Availity home page) | Get Trained, and type “onboarding” in the search catalog field. Or, go to Help & Training | My Learning Plan, and plot your learning journey.

Availity Training for Anthem specific tools

For more information on Anthem features and navigation, select Payer Spaces | Applications | Education and Reference Center to find presentations and reference guides that can be used to educate provider staff on Anthem proprietary tools.

Organization Maintenance
To change/update an Administrator or Organization information:

- To replace the Administrator currently on record with Availity, please call Availity Client Services at 1-800-AVAILITY (282-4548).

- An Administrator can use the Maintain Organization feature to maintain the organization's demographic information, including address, phone number, tax ID, and NPI. Any changes made to this information automatically apply to all Users associated to the organization and affects only the registration information on the Availity Portal.

Eligibility

Member Identification and Verification

Providers may identify and verify benefits for Anthem Members by:

On-line Access

For all Anthem Health Benefit Plans, Providers can obtain eligibility verification online at www.availity.com. Provider can access information once a logon ID and password have been entered. For more information, please visit our web site.

Member ID card

All Members are issued a Member ID card. Members are responsible for presenting their current Member ID card when receiving Health Services. The Member card is for identification purposes only and may not be used to verify eligibility. HMO/POS Members' ID cards will include his/her PCP’s name and telephone number (when required). Samples of Member ID cards are on the following pages. These cards contain:

- Member name – identifies the Member
- Member ID number – the number used to identify each covered family member. The ID number has two parts: the Member’s unique personal number and a two-digit suffix. The suffix indicates the Member’s family member status under the contract. Each Member has his or her own ID card.
- Group number – the number assigned to identify the employer group to which the Member belongs.
- Group name – identifies the name of the employer group.
- PCP name and phone number – Federal Employee Health Benefit Program (FEHBP), Blue Open Access and POS ID cards do not list the PCP.
- Effective date – the latest date of benefits or the most recent update.
- Additional information – including Claims filing address and referral authorization and pre-authorization phone numbers are shown on the back of the Member ID card.
- Co-payment – dollar amount the Member is responsible for paying the Provider at the time of service.

Network - Knowing the member’s network will assist you in identifying the applicable reimbursement schedule. You need to have this information when registering members in your office. The network (BlueChoice, Blue Open Access) will be in the upper, right-hand corner of the identification card and/or at the bottom of the card. Be sure this is the network in which you participate and that you refer the member to other service providers within their network if needed. Members who receive services outside of their network may have no benefits or reduced benefits which could impact the member's financial responsibilities as well as the potential payment for healthcare providers. Be sure to look first for the local network name on the card (BlueChoice or Blue Open Access). If you do not see a local network name on the card, then refer to the suit case logo on the card to identify the network. A blank suitcase logo on a member's ID card means that the member may access our Traditional network subject to their group’s benefits. If there is no local network name on the card, and there is a "PPO in a suitcase” logo, the Blue Choice PPO network applies.
Provider Service Line

We provide Member eligibility and benefits verification via telephone to Providers. Providers may call the Provider Service line toll free at 800-241-7475 from 8 a.m. to 7 p.m. Simply follow the prompts to obtain eligibility information.

The following information is required to verify a Member’s eligibility and benefits and/or to inquire on the status of a submitted Claim:

- Type of Health Benefit Plan (i.e.: BlueChoice HMO, FEHBP, etc.),
- Member’s name,
- Member’s ID number including the alpha prefix and numeric suffix,
- Member’s date of birth (MM/DD/YYYY),
- Date of service (required for Claim status inquiries only) (MM/DD/YYYY),
- Charges submitted (required for Claims status inquiries only)

Electronic Inquiry

Basic Member and benefits eligibility information is available electronically.

Please refer to the Members section of this manual for details about Members issues and processes.

Checking status on Claims submitted to Anthem:

- A Claim’s status may be verified via the Internet at www.availity.com.
- Please wait at least thirty (30) calendar days after submitting a Claim before checking the Claim status via our web site or calling Anthem to verify the status of the Claim. This will allow sufficient time for complete processing of the Claim.
- If the Claim is submitted electronically, verify that the Claim was not rejected electronically and if rejected, and the Claim status is not available through our web site, that it was corrected and resubmitted.
- The status of the Claim may also be obtained by calling the appropriate Anthem telephone number based on the Member’s Health Benefit Plan.

Claims Submission

Claim Submission Filing Tips

Eliminate processing delays and unnecessary correspondence with these Claim filing tips:

CPT Coding

The most current version of the CPT® Professional Edition manual is considered by Anthem as the industry standard for accurate CPT and modifier coding.

Electronic Claims Submissions

Please submit Claims electronically whenever possible. If Providers or Facilities have questions about electronic submissions, or if Providers or Facilities want to learn more about how EDI can work for Providers or Facilities, please review the EDI Submissions section in this manual or call 1-800-470-9630.
Please refer to the subsection titled *Recommended Fields for Electronic 837 Professional (837P) and Institutional (837I) Health Care Claims* for more information on EDI submissions.

**Paper Claims Submissions**

If Providers or Facilities must file Claims on paper, failure to submit them on the most current CMS-1500 (Form 1500 (02-12)) or CMS-1450 (UB04) will cause Claims to be rejected and returned to the Provider or Facility. More information and the most current forms can be found at [www.cms.gov](http://www.cms.gov).

- Submit all paper Claims using the current standard RED CMS Form 1500 (02-12) for professional Claims and the UB-04 (CMS-1450) for Facility Claims.
- If Providers or Facilities are submitting a multiple page Claim, the word “continued” should be noted in the total charge field, with the total charge submitted on the last page of the Claim.
- When submitting a multiple page document, do not staple over pertinent information.
- Complete all mandatory fields.
- Do not highlight any fields.
- Check the printing of Claims from time to time to help ensure proper alignment and that characters are legible.
- Ensure all characters are inside the appropriate fields and do not overlap.
- Change the printer cartridge regularly and do not use a DOT matrix printer.
- Submit a valid member identification number including three digit prefix or R+8 numeric for Federal Employee Program® (FEP®) members on all pages.
- Claims must be submitted with complete provider information, including referring, rendering and billing NPI; tax identification number; name; and servicing and billing addresses on all pages.

Please refer to the subsection titled *Recommended Fields for Paper CMS Form 1500 (02-12) and UB-04 (CMS-1450) Claims* for more information on paper submissions.

**Ambulatory Surgical Centers**

When billing revenue codes, always include the CPT or HCPCS code for the surgery being performed. This code is required to determine the procedure, and including it on the Claim helps us process the Claim correctly and more quickly. Ambulatory surgical Claims must be billed on a CMS-1500 (Form 1500 (02-12)) or CMS-1450 (UB04), as indicated in your Agreement.

**Ancillary Filing Guidelines**

**Ambulance Claims**

- Include the Point of Pickup (POP) ZIP Code for all ambulance (including air ambulance) Claims, both institutional outpatient and professional.
- File the Claims to the plan whose service area the Point of Pickup (POP) ZIP Code is located.
- The POP (Point of Pick-up) ZIP Code should be submitted as follows:
  - **Professional Claims** – for CMS-1500 submitters: the POP ZIP code is reported in field 23
  - **Institutional outpatient Claims** – for UB submitters: the Value Code of ‘A0’ (zero), and the related ZIP Code of the geographic location from which the beneficiary was placed on board the ambulance, should be reported in the Value Code Amount field and billed with the appropriate revenue 54x codes.
Durable/Home Medical Equipment and Supplies

- Durable/Home Medical Equipment and Supplies (D/HME) is determined by the provider specialty code in the provider file, not by CPT codes.
- **Delivered to patient’s home** – File the Claim to the plan in the service area where the item was sent/delivered.
- **Purchased at retail store** – File the Claim to the plan in the service area where the retail store is located.

Home Infusion Therapy - Services and Supplies

- File the Claim with the plan in the service area where the services are rendered or the supply was delivered. Examples: If services are rendered in a member’s home, Claims should be sent to the plan in the member’s state. If Supplies are delivered to the member’s home, Claims should be sent to the plan in the member’s state.

Laboratory Claims

- File the Claim to the plan in the service area where the specimen was drawn, as determined by the referring provider’s location (based on NPI)
- Independent lab Claims are determined by the provider specialty code in the provider file, not by CPT codes.
- Unless exempted by state or other legal guidelines, Anthem requires the CLIA number to be included on each Claim billed for laboratory services by any Provider or Facility performing tests covered by CLIA. Anthem requires the CLIA identification number to be submitted based on the applicable method below:
  - ASC X12 837 professional claim format REF segment as REF02, with qualifier of “X4” in REF01 or
  - Field 23 of the paper CMS-1500

Specialty Pharmacy Claims

- File the Claim to the plan in the service area where the referring provider is located (based on NPI).
- Specialty pharmacy Claims are determined by the provider specialty code in the provider file, not by CPT codes.

Duplicate Claims (aka Tracers)

Providers and Facilities should refrain from submitting a Claim multiple times to avoid potential duplicate denials. Providers or Facilities can check the status of Claims via Availity.

Late Charges

Late charges for Claims previously filed can be submitted electronically. You must reference the original Claim number in the re-billed electronic Claim. If attachments are required, please submit them using the PWK attachment face sheet. (See Electronic Data Interchange website for instructions as www.anthem.com/edi).

Late charges for Claims previously filed can be submitted via paper. Type of bill should contain a 5 in the 3rd position of the TOB (ex: 135). A late billing should contain ONLY the additional late charges. The Provider should also advise the original claim# to which the late charges should be added.

Maternity Delivery Claims

Delivery procedure codes reported on a professional Claim (procedure codes: 59612, 59620, 59400, 59410, 59515, 59614, 59622, 59510, 59610, or 59618) are required to submit with the appropriate Z3A diagnosis code indicating the babies gestational age.

National Drug Codes (NDC)
See separate subsection titled *National Drug Codes*.

**Negative Charges**

When filing Claims for procedures with negative charges, please don’t include these lines on the Claim. Negative charges often result in an out-of-balance Claim that must be returned to the provider for additional clarification.

**Not Otherwise Classified (“NOC””) Codes**

- When submitting Not Otherwise Classified (NOC) codes please follow these guidelines to avoid possible Claim processing delays. **Anthem must have a clear description of the item/service billed with a NOC code for review.**
  - If the NOC is for a drug, include the drug’s name, dosage NDC number and number of units.
  - If the NOC is not a drug, include a specific description of the procedure, service or item.
  - If the item is durable medical equipment, include the manufacture’s description, model number and purchase price if rental equipment.
  - If the service is a medical or surgical procedure, include a description on the Claim and submit medical record and the operative report (if surgical) that support the use of an NOC and medical necessity for the procedure.
  - If the NOC is for a laboratory test, include the specific name of the laboratory test(s) and/or a short descriptor of the test(s)

**NOTE:** NOC codes should only be used if there are no appropriate listed codes available for the item or service. Descriptions should be included in the shaded area for item 24 on professional Claim forms, or locator 43 on facility Claim forms.

**Occurrence Dates**

When billing facility Claims, please make sure the surgery date is within the service from and to dates on the Claim. Claims that include a surgical procedure date that falls outside the service from and to dates will be returned to the provider.

**Other Insurance Coverage**

When filing Claims with other insurance coverage, please ensure the following fields are completed and that a legible copy of the Explanation of Benefits (EOB) from the other insurance coverage is attached to the Claim:

**CMS-1500 Fields:**

Field 9: Other insured's name
Field 9a: Other insured’s policy or group number
Field 9b: Other insured’s date of birth
Field 9c: Employer’s name or school name (not required in EDI)
Field 9d: Insurance plan name or program name (not required in EDI)

**UB-04 CMS-1450 Fields:**

Field 50a-c: Payer Name
Field 54a-c: Prior payments (if applicable)

Including Explanation of Medicare Benefits (EOMB) or other payer Explanation of Benefits (EOB):

When submitting a CMS Form 1500 (02-12) or CMS-1450 (UB04) Claim form with an Explanation of Medicare Benefits (EOMB) attached, the EOMB should indicate Medicare’s Assignment. When submitting a CMS Form 1500 (02-12) or CMS-1450 (UB04) Claim form with an Explanation of Medicare Benefits (EOMB) or other payer Explanation of Benefits (EOB) attached, the EOMB or EOB should match each service line and each service line charge submitted on the CMS Form 1500 (02-12) or CMS-1450 (UB04).

**Preventive Colonoscopy – correct coding**
Anthem allows for preventive colonoscopy in accordance with state mandates. Colonoscopies which are undertaken as a SCREENING colonoscopy, during which a polyp/tumor or other procedure due to an abnormality are discovered, should be covered under benefits for Preventive Services. This has been an area of much confusion in billing by Providers or Facilities of services. Frequently the Provider or Facility will bill for the CPT code with an ICD-10 diagnosis code corresponding to the pathology found rather than the “Special screening for malignant neoplasms, of the colon”, diagnosis code V76.51.

CMS has issued guidance on correct coding for this situation and states that the ICD-10 diagnosis code Z12.11 (Encounter for screening for malignant neoplasm of colon) should be entered as the primary diagnosis and that the ICD-10 diagnosis code for any discovered pathology should be entered as the secondary diagnosis on all subsequent Claim lines.

Anthem endorses this solution for this coding issue as the appropriate method of coding to ensure that the Provider or Facility receives the correct reimbursement for services rendered and that our members receive the correct benefit coverage for this important service.

**Type of Billing Codes**

When billing facility Claims, please make sure the type of bill coincides with the revenue code(s) billed on the Claim. For example, if billing an outpatient revenue code, the type of bill must be for outpatient services.

**Claim Inquiry/Adjustment Filing Tips**

The different types of Claim inquiries should be handled in separate ways depending on what is being requested. Here are some examples:

- **Claim Inquiry**: A question about a Claim or Claim payment is called an inquiry. Claim Inquiries do not result in changes to Claim payments, but the outcome of the Claim Inquiry may result in the initiation of the Claim Payment Dispute. In other words, once the Provider or Facility receives the answer to the Claim Inquiry, the Provider or Facility may opt to begin the Claim Payment Dispute process. Providers and Facilities can send a Secure Message through the Availity Portal, or call the Provider Services number on the back of the Member ID Card and select the Claims prompt. Please reference the Availity Portal section for further details on Secure Messaging.

- **Claim Correspondence**: Claim Correspondence is when Anthem requires more information to finalize a Claim. Typically, Anthem makes the request for this information through the Explanation of Payment (“EOP”). The Claim or part of the Claim maybe denied, but it is only because more information is required to process the Claim. Once the information is received, Anthem will use it to finalize the Claim.

- **Clinical / Medical Necessity Appeals**: An appeal regarding a clinical decision denial, such as an authorization or Claim that has been denied as not medically necessary, experimental/investigational. For more information on Clinical / Medical Necessity Appeals, please refer to the Clinical Appeals section within the Provider Manual.

- **Claim Payment Disputes**: Please see the Claim Payment Dispute section for further details.

- **Precertification Disputes**: Precertification disputes should be handled via the process detailed in the letter received from our precertification department. If Providers or Facilities disagree with a clinical decision, please follow the directions detailed on our letter. Sending precertification/predetermination requests or appeals to the provider correspondence address may delay responses.

- **Corrected Claims**: Submitting corrected Claims should only be utilized to update information on the Claim form. If the inquiry is about the way the Claim processed, please refer to the prior sections. If Providers or Facilities have corrections to be made to the Claim, please submit according to the Corrected Claim Guidance below.
Timely Filing for Claims

Claims must be submitted within the timely filing timeframe specified in your contract.

All additional information reasonably required by Anthem to verify and confirm the services and charges must be provided on request.

*Claims submitted after the timely filing period expires will be denied, unless proof of timely filing can be demonstrated according to the guideline listed below.*

Proof of Timely Filing

Waiver of the timely filing requirement is only permitted when Anthem has received documentation indicating the Member, Provider or Facility originally submitted the claim within the applicable timely filing period.

The documentation submitted must indicate the Claim was originally submitted before the timely filing period expired.

**Acceptable documentation includes the following:**

1. A copy of the Claim with a computer-printed filing date (a handwritten date isn’t acceptable)

2. An original fax confirmation specifying the Claim in question and including the following information: date of service, amount billed, Member name, original date filed with Anthem and description of the service

3. The Provider or Facility’s billing system printout showing the following information: date of service, amount billed, Member name, original date filed with Anthem and description of the service
   
   If the Provider or Facility doesn’t have an electronic billing system, approved documentation is a copy of the Member’s chart indicating the billed date and/or a copy of the billing records indicating the billed date, and the information listed above.

4. If the Claim was originally filed electronically, a copy of Anthem’s electronic Level 2 or your respective clearinghouse’s acceptance/rejection claims report is required; a copy can be obtained from the Provider or Facility’s EDI vendor, EDI representative or clearinghouse representative. The Provider or Facility also must demonstrate that the Claim and the Member’s name are on the original acceptance/rejection report. Note: When referencing the acceptance/reject report, the Claim must show as accepted to qualify for proof of timely filing. Any rejected Claims must be corrected and resubmitted within the timely filing period.

5. A copy of the Anthem letter requesting additional Claim information showing the date information was requested.

Appeals for Claims denied for failing to meet timely filing requirements must be submitted to Anthem in writing. Anthem doesn’t accept appeals over the phone.

Corrected Claim Guidance

When submitting a correction to a previously submitted Claim, submit the entire Claim as a replacement Claim if Providers or Facilities have omitted charges or changed Claim information (i.e., diagnosis codes, procedure codes, dates of service, etc.) including all previous information and any corrected or additional information. To correct a Claim that was billed to Anthem in error, submit the entire Claim as a void/cancel of prior Claim. If there is zero Member, Provider or Facility liability, then a new Claim is needed vs a corrected Claim.

<table>
<thead>
<tr>
<th>Type</th>
<th>Professional Claim</th>
<th>Institutional Claim</th>
</tr>
</thead>
<tbody>
<tr>
<td>EDI</td>
<td>To indicate the Claim is a replacement Claim:</td>
<td>To indicate the Claim is a replacement Claim:</td>
</tr>
<tr>
<td>Type</td>
<td>Professional Claim</td>
<td>Institutional Claim</td>
</tr>
<tr>
<td>-----------</td>
<td>-------------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td>• In element CLM05-3 “Claim Frequency Type Code”</td>
<td>• In element CLM05-3 “Claim Frequency Type Code”</td>
</tr>
<tr>
<td></td>
<td>• Use Claim Frequency Type 7</td>
<td>• Use Claim Frequency Type 7</td>
</tr>
<tr>
<td>To confirm the Claim which is being replaced:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• In Segment “REF – Payer Claim Control Number”</td>
<td>• In Segment “REF – Payer Claim Control Number”</td>
</tr>
<tr>
<td></td>
<td>• Use F8 in REF)! and list the original payer Claim number is REF02</td>
<td>• Use F8 in REF)! and list the original payer Claim number is REF02</td>
</tr>
<tr>
<td>To indicate the Claim was billed in error (Void/Cancel):</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• In element CLM05-3 “Claim Frequency Type Code”</td>
<td>• In element CLM05-3 “Claim Frequency Type Code”</td>
</tr>
<tr>
<td></td>
<td>• Use Claim Frequency Type 8</td>
<td>• Use Claim Frequency Type 8</td>
</tr>
<tr>
<td>To confirm the Claim which is being void/cancelled:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• In Segment “REF – Payer Claim Control Number”</td>
<td>• In Segment “REF – Payer Claim Control Number”</td>
</tr>
<tr>
<td></td>
<td>• Use F8 in REF)! and list the original payer Claim number is REF02</td>
<td>• Use F8 in REF)! and list the original payer Claim number is REF02</td>
</tr>
<tr>
<td>Paper</td>
<td></td>
<td></td>
</tr>
<tr>
<td>To indicate the Claim is a replacement Claim:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• In Item Number 22: “Resubmission and/or Original Reference Number”</td>
<td>• In Form Locator 04: “Type of Bill”</td>
</tr>
<tr>
<td></td>
<td>• Use Claim Frequency Type 7 under “Resubmission Code”</td>
<td>• Use Claim Frequency Type 7</td>
</tr>
<tr>
<td>To confirm the Claim which is being replaced:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• In the right-hand side of Item Number 22 under “Original Ref. No.” list the original payer Claim number for the resubmitted Claim.</td>
<td>• In Form Locator 64: “Document Control Number (DCN)” list the original payer Claim number for the resubmitted Claim.</td>
</tr>
<tr>
<td>To indicate the Claim is a void/cancel of a prior Claim:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• In Item Number 22: “Resubmission and/or Original Reference Number”</td>
<td>• In Form Locator 04: “Type of Bill”</td>
</tr>
<tr>
<td></td>
<td>• Use Claim Frequency Type 8 under “Resubmission Code”</td>
<td>• Use Claim Frequency Type 8</td>
</tr>
<tr>
<td>To confirm the Claim which is being void/cancelled:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• In the right-hand side of Item Number 22 under “Original Ref. No.” list the original payer Claim number for the void/cancelled Claim.</td>
<td>• In Form Locator 64: “Document Control Number (DCN)” list the original payer Claim number for the void/cancelled Claim.</td>
</tr>
</tbody>
</table>

For additional information on provider complaints and appeals, please refer to the *Claim Payment Dispute* and *Clinical Appeals* sections.

**National Drug Codes (NDC)**

All practitioners and providers are required to supply the 11-digit NDC when billing for injections and other drug items on the CMS1500 and UB04 Claim forms as well as on the 837 electronic transactions. **Note:** These billing requirements will apply to Local Plan and BlueCard member Claims only, and will exclude Federal Employee Program (FEP) and Coordination of Benefits/Secondary Claims.

Line items on a claim regarding drugs administered in a physician office or outpatient facility setting for all drug categories will deny if they do not include the following:

- Applicable HCPCS code or CPT code
- Number of HCPCS code or CPT code units
- The valid 11-digit NDC, including the N4 qualifier
- Unit of measure qualifier (F2, GR, ML, UN, MG)
- NDC Units dispensed (must be greater than 0)

Unit of Measurement Requirements

The unit of measurement codes are also required to be submitted. The codes to be used for all Claim forms are:

- F2 – International unit
- GR – Gram
- ML – Milliliter
- UN – Unit
- MG - Milligram

Location of the NDC

The NDC is found on the label of a prescription drug item and must be included on the CMS-1500 or UB04 Claim form or in 837 electronic transactions. The NDC is a universal number that identifies a drug or related drug item.

<table>
<thead>
<tr>
<th>NDC Number Section</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 (five digits)</td>
<td>Vendor/distributor identification</td>
</tr>
<tr>
<td>2 (four digits)</td>
<td>Generic entity, strength and dosage information</td>
</tr>
<tr>
<td>3 (two digits)</td>
<td>Package code indicating the package size</td>
</tr>
</tbody>
</table>

Correcting Omission of a Leading Zero

Providers and Facilities may encounter NDCs with fewer than 11-digits. In order to submit a Claim, Providers and Facilities will need to convert the NDC to an 11-digit number. Sometimes the NDC is printed on a drug item and a leading zero has been omitted in one of the segments. Instead of the digits and hyphens being in a 5-4-2 format, the NDC might be printed in a 4-4-1 format (example, 1234-1234-1), a 5-3-2 format (example, 12345-123-12), or a 5-4-1 format (example, 12345-1234-1).

- If this occurs, when entering the NDC on the Claim form, it will be required to add a leading zero to the beginning of the segment(s) that is missing the zero.
- Do not enter any of the hyphens on Claim forms.

See the examples that follow:

<table>
<thead>
<tr>
<th>If the NDC appears as…</th>
<th>Then the NDC…</th>
<th>And it is reported as …</th>
</tr>
</thead>
<tbody>
<tr>
<td>NDC 12345-1234-12</td>
<td>Is complete</td>
<td>12345123412</td>
</tr>
</tbody>
</table>
Process for Multiple NDC numbers for Single HCPC Codes

- If there is more than one NDC within the HCPCs code, you must submit each applicable NDC as a separate Claim line. Each drug code submitted must have a corresponding NDC on each Claim line.
- If the drug administered is comprised of more than one ingredient (i.e. compound or same drug with different strength, etc.), you must represent each NDC on a Claim line using the same drug code.
- Standard HCPCs billing accepts the use of modifiers to determine when more than one NDC is billed for a service code. They are:
  - KO – Single drug unit dose formulation
  - KP – First drug of a multiple drug unit dose formulation
  - KQ – Second or subsequent drug of a multiple drug unit dose formulation
  - JW – Drug amount discarded/not administered to the patient

How/Where to Place the NDC on a Claim Form

**CMS 1500 Claim Form:**

- Reporting the NDC requires using the upper and lower rows on a Claim line. Be certain to line up information accurately so all characters fall within the proper box and row.
- **DO NOT bill more than one NDC per Claim line.**
- Even though an NDC is entered, a valid HCPCS or CPT code must also be entered in the Claim form.
- If the NDC you bill does not have a specific HCPCS or CPT code assigned, please assign the appropriate miscellaneous code per Correct Coding Guidelines.
- The unit of service for the HCPCS or CPT code is very important. Units for injections must be billed consistent with the HCPCS or CPT description of the code.

The following table provides elements of a proper NDC entry on a CMS-1500 Claim form.

### All Elements are REQUIRED:

<table>
<thead>
<tr>
<th>How</th>
<th>Example</th>
<th>Where</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enter a valid NDC code including the N4 qualifier</td>
<td>NDC 00054352763 is entered as N400054352763</td>
<td>Beginning at left edge, enter NDC in the shaded area of box 24A</td>
</tr>
<tr>
<td>Enter one of five (5) units of measure qualifiers;</td>
<td>GR0.045</td>
<td>In the shaded area immediately following the 11-digit NDC, enter 3 spaces, followed by one of five (5) units of measure</td>
</tr>
<tr>
<td>- F2 – International Unit</td>
<td>ML1.0</td>
<td></td>
</tr>
<tr>
<td>- GR – Gram</td>
<td>UN1.000</td>
<td></td>
</tr>
<tr>
<td>- ML – Milliliter</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
How | Example | Where
---|---|---
- UN – Units
- MG – Milligrams and quantity, **including a decimal point for correct reporting** | J0610 "Injection Calcium Gluconate, per 10 ml" is billed as 1 unit for each 10 ml ampul used | **Non-shaded area** of box 24D

**UB04 Claim Form:**
- Even though an NDC is entered, a valid HCPCS or CPT code must also be entered in the Claim form.
- If the NDC you bill does not have a specific HCPCS or CPT code assigned, please assign the appropriate miscellaneous code per Correct Coding Guidelines.
- DO NOT bill more than one NDC per Claim line.
- The unit of service for the HCPCS or CPT code is very important. Units for injections must be billed consistent with the HCPCS or CPT description of the code.

The following table provides elements of a proper NDC entry on a UB04 Claim form.
All Elements are REQUIRED:

<table>
<thead>
<tr>
<th>How</th>
<th>Example</th>
<th>Where</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enter a valid revenue code</td>
<td>Pharmacy Revenue Code 0252</td>
<td>Form locator (box) 42</td>
</tr>
<tr>
<td>Enter 11- digit NDC, including the N4 qualifier</td>
<td>NDC 00054352763 is entered as N00054352763</td>
<td>Beginning at left edge, enter NDC In locator (box) 43 currently labeled as “Description”</td>
</tr>
<tr>
<td>Enter one of five (5) units of measure qualifiers:</td>
<td>GR0.045, ML1.0, UN1.000</td>
<td>Immediately following the 11 digit NDC, enter 3 spaces followed by one of five (5) units of measure qualifiers, followed immediately by the quantity.</td>
</tr>
<tr>
<td>and quantity, including a decimal point for correct reporting</td>
<td>J0610 “Injection Calcium, per 10ML” is billed as 1 unit for each 10ML ampul used</td>
<td>Form locator (box 44)</td>
</tr>
</tbody>
</table>

Sample Images of the UB04 Claim Form

837 P And 837 I Reporting Fields

Billing or Software Vendor:

You will need to notify your billing or software vendor that the NDC is to be reported in the following fields in the 837 format:

Tips for Using NDCs When Submitting Electronic Claims

<table>
<thead>
<tr>
<th>Loop</th>
<th>Segment</th>
<th>Element Name</th>
<th>Information</th>
<th>Sample</th>
</tr>
</thead>
<tbody>
<tr>
<td>2410</td>
<td>LIN02</td>
<td>Product or Service ID Qualifier</td>
<td>Enter product or NDC qualifier N4</td>
<td>LIN**N4*01234567891~</td>
</tr>
<tr>
<td>2410</td>
<td>LIN03</td>
<td>Product or Service ID</td>
<td>Enter the NDC</td>
<td>LIN**N4*01234567891~</td>
</tr>
<tr>
<td>Loop</td>
<td>Segment</td>
<td>Element Name</td>
<td>Information</td>
<td>Sample</td>
</tr>
<tr>
<td>------</td>
<td>---------</td>
<td>--------------------------------------</td>
<td>------------------------------------------------------------------------------</td>
<td>------------</td>
</tr>
<tr>
<td>2410</td>
<td>CTP04</td>
<td>Quantity</td>
<td>Enter quantity billed</td>
<td>CTP****2'UN~</td>
</tr>
<tr>
<td>2410</td>
<td>CTP05-1</td>
<td>Unit of Basis for Measurement Code</td>
<td>Enter the NDC unit of measurement code: F2: International unit GR: Gram ML: Milliliter UN: Unit MG: Milligram</td>
<td>CTP****2'UN~</td>
</tr>
<tr>
<td>2410</td>
<td>REF01</td>
<td>Reference ID Qualifier (used to report Prescription # or Link Sequence Number when reporting components for a Compound Drug)</td>
<td>VY: Link Sequence Number XZ: Prescription Number</td>
<td>REF01'XZ'123456~</td>
</tr>
<tr>
<td>2410</td>
<td>REF02</td>
<td>Reference Identification</td>
<td>Prescription Number or Link Sequence Number</td>
<td>REF01'XZ'123456~</td>
</tr>
</tbody>
</table>

**Recommended Fields for Electronic 837 Professional (837P) and Institutional (837I) Health Care Claims**


**Recommended Fields for Paper CMS Form 1500 (02-12) Claims**

If these are not completed, Claims may be delayed or returned to the Provider or Facility for additional information.

Field 1a: Insured's ID Number – from Member ID card, including any prefix

Field 2: Patient's Name – do not use nicknames or middle names

Field 3: Patient's Birth Date – date of birth should be 8-digit (MM|DD|YYYY) format and Sex

Field 4: Insured's Name – "same" is acceptable if the insured is the patient

Field 5: Patient's Address – submitted when the patient's address is different than the insured's address. If it's the same, this field does not need to be populated.

Field 6: Patient Relationship to Insured

Field 7: Insured's Address

Field 10: Is Patient's Condition Related to:

Field 10A: Employment?

Field 10B: Auto Accident?

Field 10C: Other Accident?

Field 12: Patient Authorization Signature – If patient signature is on file, “Signature on file” is acceptable

**Important information about Fields 14 and 15:**
CMS Form 1500 (02-12) gives Providers and Facilities two fields (14 and 15) to enter a date with a “Qualifier” that tells payers what the date is for. Field 14 is titled “Date of Current Illness, Injury, or Pregnancy” and field 15 is titled “Other Date”. If the visit is due to an accident, Qualifier “439” must be entered in field 15 along with the appropriate date. This information is consistent with the form instruction manual available on the NUCC website. For more guidance, please see information available on the NUCC website at www.nucc.org.

Field 14: Date of Current Illness, Injury or Pregnancy (LMP) (if applicable) – Enter the 8-digit (MM|DD|YYYY) date of the present illness, injury, or pregnancy. For pregnancy, use the date of the last menstrual period (LMP) as the first date. Enter the applicable qualifier to identify which date is being reported:
  - 431 – Onset of current symptoms or illness
  - 484 – Last Menstrual Period

Field 15: Other Date – Enter another date related to the patient’s condition or treatment. Enter the date in the 8-digit (MM|DD|YYYY) format. Enter the applicable qualifier to identify which date is being reported:
  - 454 – Initial treatment
  - 304 – Latest visit or consultation
  - 453 – Acute manifestation or a chronic condition
  - 439 – Accident
  - 455 – Last X-ray
  - 471 – Prescription
  - 090 – Report start (assumed care date)
  - 091 – Report end (relinquished care date)
  - 444 – First visit or consultation

Field 16: Dates Patient Unable to Work in Current Occupation – This is the time span a patient is or was unable to work

Field 17: Referring physician name – Enter the name of the referring or ordering provider. Enter the applicable qualifier to the left of the vertical, dotted line:
  - DN – Referring provider
  - DK – Ordering provider
  - DQ – Supervising provider

Field 17b: Referring physician NPI

Field 21: Diagnosis or Nature of Illness or Injury – enter the appropriate diagnosis code/nomenclature – Relate A-L to Field 24E

Field 21: ICD Ind - ICD Indicator must be submitted between the vertical, dotted lines in the upper right-hand portion of the field or Claim may be rejected. Enter “9” for Code Set ICD-9-CM diagnosis for dates of service prior to 10/01/2015 or “0” for Code Set ICD-10 diagnosis for dates of service 10/01/2015 and later.

Field 22: Resubmission and/or Original Reference Number – This field is not intended for original Claim submissions. When resubmitting a Claim, enter the original Anthem Claim number and the appropriate bill frequency code (7=Replacement of prior Claim; 8=Void/Cancel of prior Claim) left justified in the left-hand side of the field.

Field 23: Ambulance Providers: Consistent with guidance from the Centers for Medicare and Medicaid Services (CMS), please include the zip code for the point of pick up. Providers or Facilities can report the physical pick up and drop off addresses in field 32.

Claims for Laboratory Services: Include the CLIA number on each Claim billed for laboratory services by any Provider or Facility performing tests covered by CLIA.
Field 24:  NDC - When submitting an NDC the NDC should be submitted in the shaded area and should be preceded with the qualifier N4, followed immediately by the 11 digit NDC code. The NDC quantity should be submitted in positions 17-24 of the same line. The Quantity should be preceded by the appropriate Qualifier. UN (units), F2 (international units), GR (gram), MG (milligram) or ML (milliliter) number. The total dosage administered in mgs or mls can be reported in box 24 (the shaded section) and should not be reported in the Units field. The Units field on the CMS-Form 1500 (02-12) box 24G represents the number of units based on the NDC number.

Field 24A: Date(s) of Service

Field 24B: Place of Service

Field 24D: Procedures, Services or Supplies – Enter the appropriate CPT, HCPCS code/nomenclature; include a narrative description for Non Specific (NOC) codes. Do not use NOC codes when a specific CPT code is available. **Anthem must have a clear description of the item/service billed with a NOC code to review.** Descriptions should be included in the shaded area for item 24 on professional Claim forms. Please indicate appropriate modifier when applicable.

Field 24E: Diagnosis Pointer – refer to field 21 - Be sure to enter the diagnosis code reference (pointer) from Field 21 to relate the date of service and the procedures performed to the primary diagnosis. When multiple services are performed, the primary reference number for each service should be listed first, other applicable services should follow. The references were changed from numeric to alpha characters on the updated 02/12 form version. **Be sure to use alpha characters (A-L) and not numerics in this field.**

Field 24F: $ Charges – line item charge.

Field 24G: Days or Units – When providing anesthesia submit time in minutes. When providing pain management, drugs, etc. it should be submitted in units.

Field 24J: Lower: National Provider Identification number (NPI)

Field 25: Federal Tax ID Number (9-digit)

Field 28: Total Charge – total of line item charges.

Field 31: Full name and title of Physician or Supplier – actual signature or typed/printed designation is acceptable.

Field 32: Service Facility Location Information – Address where services were rendered

Field 32a: Service Facility’s National Provider Identification number (NPI) – Service location NPI

Field 33: Billing Provider Information and Phone # – Complete name, address, city, state and zip code

**Reminder:** If submitting Claims electronic, this field must hold a physical address and should not contain any of the following: "Post Office Box", "P.O. Box", "PO Box", "Lock Box", "Lock Bin", "PO Box"

Field 33a: Billing Provider’s National Provider Identification number (NPI) – Billing Provider NPI

Note: To help improve payment accuracy and timeliness, please remember that when filing Claims, the Tax Identification Number (TIN) and National Provider Identifier (NPI) numbers are required. Additionally, bill Claims using the taxonomy codes as applicable.
HEALTH INSURANCE CLAIM FORM
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 2012

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.</td>
<td>Medicare/Medicaid/Tricare/CHAMPVA/Group Health Plan/FECA/Beneficiary/Other</td>
</tr>
<tr>
<td>B.</td>
<td>Insured's S.I.D. Number (for Program at Item 1)</td>
</tr>
<tr>
<td>C.</td>
<td>Patient's Name (Last Name, First Name, Middle Initial)</td>
</tr>
<tr>
<td>D.</td>
<td>Patient's Birth Date (MM/DD/YY)</td>
</tr>
<tr>
<td>E.</td>
<td>Sex (M/F)</td>
</tr>
<tr>
<td>F.</td>
<td>Insured's Name (Last Name, First Name, Middle Initial)</td>
</tr>
<tr>
<td>G.</td>
<td>Patient's Address (No., Street)</td>
</tr>
<tr>
<td>H.</td>
<td>Relationship to Insured (Self, Spouse, Child, Other)</td>
</tr>
<tr>
<td>I.</td>
<td>Insured's Address (No., Street)</td>
</tr>
<tr>
<td>J.</td>
<td>City</td>
</tr>
<tr>
<td>K.</td>
<td>State</td>
</tr>
<tr>
<td>L.</td>
<td>ZIP Code</td>
</tr>
<tr>
<td>M.</td>
<td>Telephone (Include Area Code)</td>
</tr>
<tr>
<td>N.</td>
<td>Other Insured's Name (Last Name, First Name, Middle Initial)</td>
</tr>
<tr>
<td>O.</td>
<td>Other Insured's Policy or Group Number</td>
</tr>
<tr>
<td>P.</td>
<td>Employment? (Current or Previous) (Yes/No)</td>
</tr>
<tr>
<td>Q.</td>
<td>Auto Accident? (Yes/No)</td>
</tr>
<tr>
<td>R.</td>
<td>Plane Crash? (Yes/No)</td>
</tr>
<tr>
<td>S.</td>
<td>Other Accident? (Yes/No)</td>
</tr>
<tr>
<td>T.</td>
<td>Insurance Plan Name or Program Name</td>
</tr>
<tr>
<td>U.</td>
<td>Claim Codes (Designated by NuCC)</td>
</tr>
<tr>
<td>V.</td>
<td>Is there another health benefit plan? (Yes/No)</td>
</tr>
<tr>
<td>W.</td>
<td>Dates Patient Unable to Work in Current Occupation (MM/DD/YY)</td>
</tr>
<tr>
<td>X.</td>
<td>Hospitalization Dates Related to Current Illness (MM/DD/YY)</td>
</tr>
<tr>
<td>Y.</td>
<td>Additional Claim Information (Designated by NuCC)</td>
</tr>
<tr>
<td>Z.</td>
<td>Diagnosis or Nature of Illness or Injury</td>
</tr>
<tr>
<td>AA.</td>
<td>Diagnosis Code (ICD-10-CM)</td>
</tr>
<tr>
<td>BB.</td>
<td>Original Ref. No.</td>
</tr>
<tr>
<td>CC.</td>
<td>Prior Authorization Number</td>
</tr>
<tr>
<td>DD.</td>
<td>Date(s) of Service (MM/DD/YY)</td>
</tr>
<tr>
<td>EE.</td>
<td>Place of Service (SNOMED)</td>
</tr>
<tr>
<td>FF.</td>
<td>E.D. Diagnosis or Unusual Circumstances</td>
</tr>
<tr>
<td>GG.</td>
<td>Procedure, Services, or Supplies</td>
</tr>
<tr>
<td>HH.</td>
<td>Diagnosis Pointer</td>
</tr>
<tr>
<td>II.</td>
<td>Charges</td>
</tr>
<tr>
<td>JJ.</td>
<td>Total Charge</td>
</tr>
<tr>
<td>KK.</td>
<td>Amount Paid</td>
</tr>
</tbody>
</table>

READ BACK OF FORM BEFORE COMPLETING AND SIGNING THIS FORM.

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE
APPROVED OMB-0938-1197 FORM 1500 (02-12)
Recommended Fields for Paper UB-04 (CMS-1450) Claims

If these fields are not completed, Claims may be delayed or returned to the Provider or Facility for additional information.

For Inpatient and outpatient UB-04 Claim Forms – these fields must be completed:

Field 1: Provider name and complete address
Field 2: Provider’s designated billing name and remittance address
Field 4: Type of Bill
Field 5: Federal Tax Identification Number
Field 6: Statement Covers Period (From-Through)
Field 8: Patient Name
Field 9: Patient Address
Field 10: Birth Date (8-digit (MM|DD|YYYY) format)
Field 11: Sex
Field 12: Admission Date
Field 13: Admission Hour
Field 14: Admission Type – Priority (Type) of Admission or Visit [Inpatient only]
Field 15: Admission SRC – Point of Origin for Admission or Visit [Inpatient only]
Field 16: Discharge Hour [Inpatient only]
Field 17: Patient Discharge Status [Inpatient only]
Fields 31-34: Occurrence Codes and Dates
Fields 39-41: Value Code(s) and Amounts

- If there is a Combined Deductible + Coinsurance + Copay amount on the EOMB greater than zero, there must be a corresponding Value code of A1, B1, C1, 08, 09, 11, A2, B2, C2 A7, B7 or C7 and amount on the UB04.
- If there is a Value Code present and not equal to 02 there must be a Value Code amount.

The Value Codes to be submitted when billing Private Room Revenue codes according to the UB-04 Data Specifications Manual 2014 and CMS Manual Transmittal 1104 are:

- “01” (semi-private room facility) must be accompanied by the semi-private room rate when the facility offers semi-private rooms and the patient’s stay is in a private room
- “02” indicating “private room only” facility with $0.00 when the facility is private room only

Common errors in Fields 39-41:
The following is a quick overview of the most common errors we are seeing on fields 39, 40 and 41, when Medicare is primary and Anthem is secondary:

- **Value codes are missing.** Value codes A1, B1, C1 are deductibles. Value codes 09, 11, A2, B2 and C2 are coinsurance. Value codes A7, B7 and C7 are copay. Value code 06 is blood deductible.

- **The member deductible is missing or does not match the EOMB (Explanation of Medicare Benefits).** If there is a deductible amount indicated on the primary payer’s remittance advice, the UB04 must include the member deductible (A1, B1 or C1 value code) and amount.

- **The coinsurance amount is missing.** If there is coinsurance on the primary payer’s remittance advice, the UB04 must include the coinsurance amount (09, 11, A2, B2 or C2 value code).

- **The copay amount is missing.** If there is copayment on the primary payer’s remittance advice, the UB04 must include the copay amount (A7, B7, or C7 value code).

- **Blood deductible is not noted.** If there is blood deductible on the payer’s remittance advice, the value code 06 must be on the Claim, along with the amount.

- **There are errors in listing multiple value codes.** If more than one value code is submitted on lines a – d, please fill in fields 39a, 40a or 41a before populating 39b, 40b, or 41b.

- **The value code and remittance advice amounts are different.** In all cases, the value code and remittance advice amounts must match.

**Field 42:** Revenue Code(s) – When submitting Revenue Code 011X or 11X and/or 014X or 14X, (X = numeric value) a value code of 01 with an amount greater than zero OR a value code of 02 with zero charges or blank must also be submitted.

**Field 43:** Description – **NDC:** When submitting an unlisted drug HCPCS code, please submit the National Drug Code (NDC) in the shaded area above the drug code. Submit qualifier N4 followed immediately by the 11 digit NDC code. The NDC quantity should be submitted in positions 17-24 of the same line. The Quantity should be preceded by the appropriate Qualifier. UN (units), F2 (international units), GR (gram), MG (milligram) or ML (milliliter). The total dosage administered in mgs or mls can be reported in the shaded section and should not be reported in the Units field. The Service Units Field (46) represents the number of units based on the NDC number.

**Field 44:** HCPCS/Accommodation Rates/HIPPS Rate Codes

**Field 45:** Service Date

**Field 46:** Service Units

**Field 47:** Total Charges

**Field 56:** Providers National Provider Identification number (NPI)

**Field 58:** Insured’s Name

**Field 59:** Patient’s Relationship

**Field 60:** Insured Unique ID – from Member ID card, including any prefix/suffix

**Field 66:** Diagnosis and Procedure Code Qualifier (ICD Version Indicator) – The qualifier that denotes the version of International Classification of Diseases (ICD) reported. The following qualifier codes reflect the edition portion of the ICD: 9 - Ninth Revision for dates of service prior to 10/01/2015 or 0 - Tenth Revision for dates of service 10/01/2015 and later.

**Field 67:** Principal Diagnosis Code and Present on Admission (POA) Indicator

**Fields 67A-Q:** Other Diagnosis Code(s) and Present on Admission (POA) Indicator(s)

**Field 74:** Principal Procedure Code and Date
HMO/POS and Blue Open Access

All services provided must be reported in the standard HIPAA compliant Claim format using HIPAA-compliant code sets on the appropriate Claim form or the equivalent, within the filing standards timeframe, and with applicable charges noted. This is necessary for reporting of utilization data and HEDIS purposes. The Claim system will identify codes eligible for fee-for-service payment and will approve those services when appropriate.

Claims for Members of all products may be mailed to:
Mail Claims to address on back of Member ID Card

Claims and encounters can also be filed electronically. For further information about electronic filing, please contact EDI Services at 1-888-883-2720. Procedures for electronic Claims filing are also available on our web site, www.Anthem.com, and the Electronic Transaction Manual is available under EDI Services.

Medical Records Submission (Solicited and Unsolicited)

Solicited Medical Records Submission

When additional medical records are being submitted in response to Anthem’s request or to support an appeal, please submit them via mail or fax to the appropriate department as directed in the letter received from Anthem to ensure a fast, accurate response. Always include the Anthem letter requesting records on the top of the records. A copy of the Claim is not needed. Please do not place copy of Claim on top of the records.

- If Providers or Facilities are submitting X-Rays, pictures or dental molds, remember to include a valid and complete member identification number on page one of the material sent with these items.
- Medical Records requested (solicited) by Anthem needed for Claim processing can be submitted electronically using the Medical Attachments feature on the Availity Portal. The solicited Medical Attachments feature supports .tiff, .jpg and .pdf attachment file types. To access the solicited Medical Attachments tool, a provider organization’s Availity administrator should complete the following steps:

From My Account Dashboard, select Enrollments Center > Medical Attachments Setup, follow the prompts and complete the following sections:

1. Select Application > Choose Medical Attachments Registration
2. Provider Management > Select Organization from the drop-down.
   - Add NPIs and/or Tax IDs.
   - Multiples can be added separated by spaces or semi-colons.
3. Assign user access by checking the box in front of the user’s name. Users may be removed by unchecking their name.

- To use the solicited Medical Attachments tool, Availity users should complete the following steps:

2. Select Claims and Payments > Medical Attachments > Send Attachment tab.
3. Complete all required fields on the form.
4. Attach supporting documentation.

Unsolicited Medical Records Submission

Anthem will send a request when medical records are required. However, if a Provider or Facility wishes to send medical records with the Claim submission, below are helpful tips to follow.

To determine what medical records or portion of the medical records may be required, refer to the applicable Anthem Medical Policy, Anthem Clinical Guideline, AIM Clinical Guideline, MCG, at www.anthem.com. Review the Position Statement section of the Anthem Medical Policies, the Clinical Indications section of the applicable Anthem or AIM Clinical Guidelines to determine what medical records are needed. Refer to the
Medical Policies, Clinical Guidelines, and/or AIM Specialty Health sections of the Provider Manual for details on accessing this information.

When submitting medical records that are not requested by Anthem, include a clear description of the billed code submitted with the Claim to help ensure prompt processing of the Claim for all miscellaneous, not otherwise classified (NOC), not otherwise specified (NOS), and unlisted HCPCS and CPT codes.

**Types of Medical Records Required**

Medical records needed to determine the medical necessity of a billed code include, depending on the service or procedure, some or all of the following examples:

1. History & Physical, Office Notes, Treatment Records & Response
2. Chemotherapy Regimens, Chemotherapy Drugs, and Records
3. Medications List (current and prior)
4. Radiology, Diagnostic Imaging, or Diagnostic Testing Reports
5. Therapy/Rehabilitation Records
6. Laboratory reports, Pathology reports
7. Exact description of NOC/NOS code
8. Operative/Procedure Report
9. Inpatient Admission Summary, Daily Records, Discharge Summary

**Anthem May Request Additional Records**

Some situations may require additional medical records in addition to what was submitted with the Claim. Although these situations may not have specific rules and guidelines, Anthem will make every attempt to make these requests explicit and limited to the minimal requests necessary to render a decision. Examples include, but are not limited to, the following situations:

1. Medical records requested by a member’s Blue Cross and/or Blue Shield home plan
2. Federal Employee Health Benefits Program requirements
3. Review and investigation of Claims (e.g., pre-existing conditions [for grandfathered policies of the Affordable Care Act], lifetime benefit exclusions)
4. Medical review and evaluation
5. Requests for retro authorizations
6. Medical management review (utilization review) and evaluation
7. Underwriting review and evaluation
8. Adjustments
9. Appeals
10. Quality management (quality of care concerns)
11. Records documenting prolonged services
12. Provider audits
13. Pre-pay review program
14. Fraud, waste and abuse

**HIPAA Privacy Rule – Minimum Necessary**

Anthem complies with HIPAA Privacy Rules and will request the minimum necessary information needed to determine benefits and/or coverage associated with Claim processing. Providers and Facilities are also required under the Minimum Necessary rule to submit only those records requested.

**Electronic Data Interchange (“EDI”) Overview**

Anthem recommends using Electronic Data Interchange (“EDI”) for Claims submission. Electronic Claims submissions can help reduce administrative and operating costs, expedite the Claim process, and reduce errors. Providers and Facilities who use EDI can electronically submit Claims and receive acknowledgements 24 hours a day, 7 days a week.

Anthem has designated Availity to operate and serve as the electronic data interchange (EDI) Gateway. As a mandatory requirement, all trading partners who currently submit directly to the Anthem EDI Gateway must transition to the Availity EDI Gateway. If Providers and Facilities wish to become a direct a trading
partner with Availity, the setup is easy. Use the **Availity Welcome Application** to begin the process of connecting to the Availity EDI Gateway for Anthem EDI transmissions. If Providers or Facilities prefer to use their clearinghouse or billing company, they must work with them to ensure connectivity through the Availity EDI Gateway.

Submitting via EDI may require additional hardware and software needed to automate other tasks in your office. No matter what method you choose to submit your transactions (direct or through a clearinghouse/billing company), Anthem does not charge a fee to submit electronically. Providers and Facilities engaging in electronic transactions should familiarize themselves with the HIPAA transaction requirements.

**Electronic Funds Transfer (“EFT”)**

Providers or Facilities seeking to register or manage account changes for EFT will need to use the Council for Affordable Quality Health Care (CAQH) Enrollment Tool called EnrollHub (at [https://solutions.caqh.org/](https://solutions.caqh.org/)), a secure electronic EFT registration platform. This tool will help eliminate the need for paper registration, reduce administrative time and costs and allow Providers and Facilities to register with multiple payers at one time.

**Electronic Remittance Advice (“ERA”)**

Providers and Facilities must use Availity to manage all account changes and new registrations for ERA transactions.

**Additional Information**

For additional information concerning electronic Claims submission and other electronic transactions, Providers and Facilities can click the Electronic Data Interchange (EDI) website at [www.anthem.com/edi](http://www.anthem.com/edi) and select the appropriate state.

**Overpayments**

Anthem’s Cost Containment Overpayment Avoidance Division reviews Claims for accuracy and requests refunds if Claims are overpaid or paid in error. Some common reasons for overpayment are:

- Paid wrong provider / Member
- Allowance overpayments
- Billed in error
- Non-covered services
- Terminated Members
- Paid wrong Member/ provider number
- Coordination of Benefits
- Late credits
- Duplicate
- Claims editing
- Total charge overpaid

Anthem's Cost Containment Overpayment Avoidance Division also requests refunds for overpayments identified by other Divisions of Anthem, such as Provider Audit or the Special Investigations Unit.

**Anthem Identified Overpayment (aka “Solicited”)**

When refunding Anthem on a Claim overpayment that Anthem has requested, please use the payment coupon included on the request letter and the following information with your check:

- **The payment coupon**
- Member ID number
- Member’s name
- Claim number
- Date of service
- Reason for the refund as indicated in our refund request letter

As indicated in the Anthem refund request letter and in accordance with provider contractual language, provider overpayment refunds not received and applied within the timeframe indicated will result in Claim recoupment from any Claim Provider or Facility submits to Anthem.
Providers and Facilities may direct disputes of amounts indicated on an Anthem refund request letter to the address indicated on the letter.

**Provider and Facility Identified Overpayments (aka “voluntary” or “unsolicited”)**

If Anthem is due a refund as a result of an overpayment discovered by a Provider or Facility, refunds can be made in one of the following ways:

- Submit a refund check with supporting documentation outlined below, or
- Submit the [insert state specific name of the form outlined below] with supporting documentation to have claim adjustment/recoupment done off a future remittance advice

When voluntarily refunding Anthem on a Claim overpayment, please include the following information:

- [insert state specific name of Form] (see directions below for how to access online)
- All documents supporting the overpayment including EOBs from Anthem and other carriers as appropriate
- Member ID number
- Member’s name
- Claim number
- Date of service
- Reason for the refund as indicated in the list above of common overpayment reasons

Please be sure the copy of the provider remittance advice is legible and the Member information that relates to the refund is circled. By providing this critical information, Anthem will be able to expedite the process, resulting in improved service and timeliness to Providers and Facilities.

**Important Note:** If a Provider or Facility is refunding Anthem due to coordination of benefits and the Provider or Facility believes Anthem is the secondary payer, please refund the full amount paid. Upon receipt and insurance primacy verification, the Claim will be reprocessed and paid appropriately.

Please utilize the proper address noted in the grid below to return payment:

<table>
<thead>
<tr>
<th>State</th>
<th>Line of Business (Blue Branded)</th>
<th>Type of Refund</th>
<th>Make Check Payable To:</th>
<th>Regular Mailing Address:</th>
<th>Overnight Delivery Address:</th>
</tr>
</thead>
<tbody>
<tr>
<td>GA</td>
<td>All</td>
<td>Voluntary</td>
<td>Anthem Blue Cross Blue Shield</td>
<td>Central Region-CCOA Lockbox PO Box 73651 Cleveland, OH 44193-1177</td>
<td>Anthem Central Lockbox 73651 4100 West 150th Street Cleveland, Ohio 44135</td>
</tr>
<tr>
<td>GA</td>
<td>All</td>
<td>Solicited Refund with Coupon Letter</td>
<td>Anthem Blue Cross Blue Shield</td>
<td>Anthem PO Box 5281 Carol Stream, IL 60197</td>
<td></td>
</tr>
</tbody>
</table>

**Medicare Crossover Claims**

**Duplicate Claims Handling for Medicare Crossover**

Since January 1, 2006, all Blue Plans have been required to process Medicare crossover Claims for services covered under Medigap and Medicare Supplemental products through Centers for Medicare & Medicaid Services (CMS). This has resulted in automatic submission of Medicare Claims to the Blue secondary payer to eliminate the need for Provider or Facilities or his/her/its billing service to submit an additional Claim to the secondary carrier. Additionally, this has also allowed Medicare crossover Claims to be processed in the same manner nationwide.
Effective October 13, 2013 when a Medicare Claim has crossed over, Providers and Facilities are to wait 30 calendar days from the Medicare remittance date before submitting the Claim to the local Plan if the charges have still not been considered by the Member’s Blue Plan.

To avoid the submissions of duplicate Claims, use the 276/277 Health care Claims status inquiries to verify Claim and adjudication status prior to re-submission of electronic Claims.

If Provider or Facility provides Members’ Blue Plan ID numbers (including three-character prefix) when submitting Claims to the Medicare intermediary, they will be crossed over to the Blue Plan only after they have been processed by the Medicare intermediary. This process will take a minimum of 14 days to occur. This means that the Medicare intermediary will be releasing the Claim to the Blue Plan for processing about the same time Provider or Facility receives the Medicare remittance advice. As a result, upon receipt of the remittance advice from Medicare, it may take up to 30 additional calendar days for Provider or Facility to receive payment or instructions from the Blue Plan.

Providers and Facilities should continue to submit services that are covered by Medicare directly to Medicare. Even if Medicare may exhaust or has exhausted, continue to submit Claims to Medicare to allow for the crossover process to occur and for the Member’s benefit policy to be applied.

Medicare primary Claims, including those with Medicare exhaust services, that have crossed over and are received within 30 calendar days of the Medicare remittance date or with no Medicare remittance date, will be rejected by the local Plan.

Effective October 13, 2013, we will reject Medicare primary provider submitted Claims with the following conditions:

- Medicare remittance advice remark codes MA18 or N89 that Medicare crossover has occurred
  - MA18 Alert: The Claim information is also being forwarded to the patient's supplemental insurer. Send any questions regarding supplemental benefits to them.
  - N89 Alert: Payment information for this Claim has been forwarded to more than one other payer, but format limitations permit only one of the secondary payers to be identified in this remittance advice.
- Received by Provider or Facility's local Plan within 30 calendar days of Medicare remittance date
- Received by Provider or Facility's local Plan with no Medicare remittance date
- Received with GY modifier on some lines but not all
  - A GY modifier is used by Providers and outpatient Facilities when billing to indicate that an item or service is statutorily excluded and is not covered by Medicare. Examples of statutorily excluded services include hearing aids and home infusion therapy.

When these types of Claims are rejected, Anthem will also remind the Provider or Facility to allow 30 days for the crossover process to occur or instruct the Provider or Facility to submit the Claim with only GY modifier service lines indicating the Claim only contains statutorily excluded services.

**Medicare statutorily excluded services – just file once to your local Plan**

There are certain types of services that Medicare never or seldom covers, but a secondary payer such as Anthem may cover all or a portion of those services. These are statutorily excluded services. For services that Medicare does not allow, such as home infusion, Providers and outpatient Facilities need only file statutorily excluded services directly to their local Plan using the GY modifier and will no longer have to submit to
Medicare for consideration. These services must be billed with only statutorily excluded services on the Claim and will not be accepted with some lines containing the GY modifier and some lines without.

For Claims submitted directly to Medicare with a crossover arrangement where Medicare makes no allowance, Providers and Facilities can expect the Member’s benefit plan to reject the Claim advising the Provider or Facility to submit to their local Plan when the services rendered are considered eligible for benefit. These Claims should be resubmitted as a fresh Claim to a Provider or Facility’s local Plan with the Explanation of Medicare Benefits (EOMB) to take advantage of Provider or Facility contracts. Since the services are not statutorily excluded as defined by CMS, no GY modifier is required. However, the submission of the Medicare EOMB is required. This will help ensure the Claims process consistent with the Provider’s or Facility’s contractual agreement.

Effective October 13, 2013:

- Providers or outpatient Facilities who render statutorily excluded services should indicate these services by using GY modifier at the service line level of the Claim.
- Providers or Facilities will be required to submit only statutorily excluded service lines on a Claim (cannot combine with other services like Medicare exhaust services or other Medicare covered services)
- The Provider or outpatient Facility’s local Plan will not require Medicare EOMB for statutorily excluded services submitted with a GY Modifier.

If Providers or outpatient Facilities submit combined line Claims (some lines with GY, some without) to their local Plan, the Provider or outpatient Facility’s local Plan will deny the Claims, instructing the Provider or outpatient Facility to split the Claim and resubmit.

**Original Medicare** – The GY modifier should be used when service is being rendered to a Medicare primary Member for statutorily excluded service and the Member has Blue secondary coverage, such as an Anthem Medicare Supplement plan. The value in the SBR01 field should not be “P” to denote primary.

**Medicare Advantage** – Please ensure SBR01 denotes “P” for primary payer within the 837 electronic Claim file. This helps ensure accurate processing on Claims submitted with a GY modifier.

The GY modifier should not be used when submitting:

- Federal Employee Program Claims
- Inpatient institutional Claims. Please use the appropriate condition code to denote statutorily excluded services.

These processes align Blue Cross and/or Blue Shield plans with industry standards and will result in less administrative work, accurate payments and fewer rejected Claims. Because the Claim will process with a consistent application of pricing, our Members will also see a decrease in health care costs as the new crossover process eliminates or reduces balance billing to the Member.

**Medicare Crossover Claims FAQs**

1. **How do I handle traditional Medicare-related Claims?**
   - When Medicare is primary payer, submit Claims to your local Medicare intermediary.
   - All Blue Claims are set up to automatically cross over (or forward) to the Member’s Blue Plan after being adjudicated by the Medicare intermediary.

2. **How do I submit Medicare primary / Blue Plan secondary Claims?**
   - For Members with Medicare primary coverage and Blue Plan secondary coverage, submit Claims to your Medicare intermediary and/or Medicare carrier.
   - When submitting the Claim, it is essential that you enter the correct Blue Plan name as the secondary carrier. This may be different from the local Blue Plan. Check the Member’s ID card for additional verification.
• Be certain to include the three-character prefix as part of the Member identification number. The Member’s ID will include the three-character prefix in the first three positions. The three-character prefix is critical for confirming membership and coverage, and key to facilitating prompt payments.

When you receive the remittance advice from the Medicare intermediary, look to see if the Claim has been automatically forwarded (crossed over) to the Blue Plan:
• If the remittance advice indicates that the Claim was crossed over, Medicare has forwarded the Claim on your behalf to the appropriate Blue Plan and the Claim is in process. DO NOT resubmit that Claim to Anthem; duplicate Claims will result in processing and payment delays.
• If the remittance advice indicates that the Claim was not crossed over, submit the Claim to your local Anthem Plan with the Medicare remittance advice.
• In some cases, the Member identification card may contain a COBA ID number. If so, be certain to include that number on your Claim.
• For Claim status inquiries, please contact your local Anthem Plan.

3. Who do I contact with Claims questions?
• Your local Anthem Plan.

4. How do I handle calls from Members and others with Claims questions?
• If Members contact you, tell them to contact their Blue Plan. Refer them to the front or back of their ID card for a customer service number.
• A Member’s Blue Plan should not contact you directly, unless you filed a paper Claim directly with that Blue Plan. If the Member’s Blue Plan contacts you to send another copy of the Member’s Claim, refer the Blue Plan to your local Anthem Plan.

5. Where can I find more information?
For more information:
• Please contact your local Anthem Plan.

Claim Payment Disputes

Provider and Facility Claim Payment Dispute Process

If a Provider or Facility disagrees with the outcome of a Claim, the Provider or Facility may begin the Anthem Claim Payment Dispute process. The simplest way to define a Claim Payment Dispute is when the Claim is finalized, but a Provider or Facility disagrees with the outcome.

Please be aware there are three common, Claim-related issues that are not considered Claim Payment Disputes. To avoid confusion with Claim Payment Disputes, they are defined briefly here:

• **Claim Inquiry**: A question about a Claim or Claim payment is called an inquiry. Claim Inquiries do not result in changes to Claim payments, but the outcome of the Claim Inquiry may result in the initiation of the Claim Payment Dispute. In other words, once the Provider or Facility receives the answer to the Claim Inquiry, the Provider or Facility may opt to begin the Claim Payment Dispute process. Providers and Facilities can send a Secure Message through the Availity Portal, or call the Provider Services number on the back of the Member ID Card and select the Claims prompt. Please reference the Availity Portal section for further details on Secure Messaging.

• **Claim Correspondence**: Claim Correspondence is when Anthem requires more information to finalize a Claim. Typically, Anthem makes the request for this information through the Explanation of Payment (“EOP”). The Claim or part of the Claim maybe denied, but it is only because more information is required to process the Claim. Once the information is received, Anthem will use it to finalize the Claim.

• **Clinical / Medical Necessity Appeals**: An appeal regarding a clinical decision denial, such as an authorization or Claim that has been denied as not medically necessary, experimental/investigational. For more information on Clinical / Medical Necessity Appeals, please refer to the Clinical Appeals section within the Provider Manual.
The Anthem Claim Payment Dispute process consists of two steps. Providers and Facilities will **not** be penalized for filing a Claim Payment Dispute, and no action is required by the Member.

1. **Claim Payment Reconsideration:** This is the first step in the Anthem Claim Payment Dispute process. The Claim Payment Reconsideration represents the Provider or Facilities initial request for an investigation into the outcome of the Claim. Most issues are resolved at the Claim Payment Reconsideration step.

2. **Claim Payment Appeal:** This is the second step in the Anthem Claim Payment Dispute process. If you disagree with the outcome of the Claim Payment Reconsideration, Providers or Facilities may request an additional review as a Claim Payment Appeal.

A Claim Payment Dispute may be submitted for multiple reason(s), including:
- Contractual payment issues
- Disagreements over reduced or zero-paid Claims
- Claim code editing issues
- Duplicate Claim issues
- Retro-eligibility issues
- Claim data issues
- Claims that are denied for no authorization when an authorization was obtained, a Claim Payment Dispute may be submitted as long as the authorized services match the Claim details.
- Timely filing issues*

* Anthem will consider reimbursement of a Claim that has been denied due to failure to meet timely filing if the Provider or Facility can: 1) provide documentation the Claim was submitted within the timely filing requirements or 2) demonstrate good cause exists. See “Timely Filing for Claims” and “Proof of Timely Filing” in the Claims Filing Tips section of the Manual for more information.

**Claim Payment Reconsideration**

The first step in the Anthem Claim Payment Dispute process is called the Claim Payment Reconsideration. It is the Provider or Facilities initial request to investigate the outcome of a finalized Claim. Please note, Anthem cannot process a Claim Payment Reconsideration without a finalized Claim on file.

Claim Payment Reconsiderations can be submitted via phone, the web portal, or in writing. Providers and Facilities have a minimum of 12 months from the issue date of the EOP (or such other period as set forth in their Provider or Facility Agreement.)

A determination will be made and the initial payment on the Claim will either be upheld or overturned. If the Provider or Facility is satisfied with this determination, the process will end. If the Provider or Facility disagrees with the determination of the Reconsideration, they can file a second request, called a Claim Payment Appeal.

When submitting Claim Payment Reconsiderations, Providers and Facilities should include as much information as possible to help Anthem understand why the Provider or Facility believes the Claim was not paid as expected. If a Claim Payment Reconsideration requires clinical expertise, it will be reviewed by the appropriate Anthem clinical professionals.

If the decision results in a Claim adjustment, the payment and EOP will be sent separately.

**Claim Payment Appeal**

If a Provider or Facility is dissatisfied with the outcome of a Claim Payment Reconsideration determination, Providers or Facilities may submit a Claim Payment Appeal through Availity or in writing. Please note, Providers and Facilities should submit a Claim Payment Reconsideration before submitting a Claim Payment Appeal.
When submitting a Claim Payment Appeal, Providers and Facilities should include as much information as possible to help Anthem understand why the Provider or Facility believes the Claim Payment Reconsideration determination was in error. If a Claim Payment Appeal requires clinical expertise, it will be reviewed by appropriate Anthem clinical professionals.

If the decision results in a Claim adjustment, the payment and EOP will be sent separately.

**Required Documentation for Claims Payment Disputes**

Anthem requires the following information when submitting a Claim Payment Dispute (Claim Payment Reconsideration or Claim Payment Appeal):

- Provider or Facility name, address, phone number, email, and either NPI or TIN
- The Member's name and Anthem or Medicaid ID number
- A listing of disputed Claims, which should include the Anthem Claim number and the date(s) of service(s)
- All supporting statements and documentation

**How to Submit a Claim Payment Dispute**

- There are several options to file a Claim Payment Dispute:
  - Online through the Availity
  - Mail all required documentation to:
    
    Anthem Attention: Provider Appeals
    P.O. Box 105449
    Atlanta, GA. 30328-5449
  
  - Call the Provider Services Number on the back of the Member ID Card

--Note: Correspondence received from Anthem related to the Claims Payment Dispute Process may not reflect all the nomenclature outlined in this section at this time. Providers and Facilities will continue to receive the same correspondence that has been received related to these requests as they have in the past.

**Clinical Appeals**

Clinical appeals refer to a situation in which an authorization or Claim for a service was denied as not medically necessary or experimental/investigational. Medical necessity appeals/prior authorization appeals are different than Claim Payment Disputes and should be submitted in accordance with the Clinical appeal process.

For questions regarding non-clinical decisions, please refer to the Claim Payment Dispute section. Examples of non-clinical items that fall under Claim Payment Disputes include:

- Contractual payment issues
- Disagreements over reduced or zero-paid Claims
- Claim code editing issues
- Duplicate Claim issues
- Retro-eligibility issues
- Claim data issues
- Claims that are denied for no authorization when an authorization was obtained, a claim dispute may be submitted as long as the authorized services match the claim details.
- Timely filing issues
**Clinical Appeals**

Clinical Appeals can be used if Providers or Facilities disagree with a clinical decision. Clinical Appeals are requests to change decisions based on whether services or supplies are medically necessary or experimental/investigative. UM program Clinical Appeals involve certification decisions, claims, or predetermination decisions evaluated on these bases. Clinical Appeals can be made verbally, in writing, or by using Interactive Care Reviewer for appeals regarding prior authorization adverse decision.

Anthem Members may designate a representative to exercise their complaint and appeal rights. When a Provider or Facility is acting on behalf of a Member as the designated representative, the complaint or appeal may be directed to Provider Customer Service, using the phone number on the back of the Member ID card. These types of issues are reviewed according to Anthem’s Member Complaint and Appeal Procedures, for each applicable state. Provider Customer Service will help Providers and Facilities determine what action must be taken and if a Designate of Representative (“DOR”) form is needed.

**Guidelines and Timeframes for Submitting Clinical Appeals**

- Providers and Facilities have one hundred and eighty (180) calendar days to file a clinical appeal from the date they receive notice of Anthem's initial decision.

- All standard post-service clinical appeals will be resolved within a reasonable period of time appropriate to the medical circumstances, but not later than sixty (60) calendar days from the receipt of the appeal request by Anthem.

- For clinical appeals, there are two (2) types of review: expedited and standard.
  - **Expedited Appeal:** Anthem offers an expedited appeal for decisions meeting the expedited criteria. Please note: Requests to handle a review as "expedited" are always handled as a Member appeal. Both standard and expedited appeals are reviewed by a person who did not make the initial decision. Unless the Member, on his or her own behalf, or another Provider or Facility has already filed an expedited appeal on the service at issue in the appeal, a Provider or Facility that requests an expedited appeal will be deemed to be the Member’s designated representative for the limited purpose of filing the expedited appeal. As a result, the expedited appeal will be handled pursuant to the Anthem Member Appeal Procedures exclusively.
  - **Standard Appeal:** A standard appeal is available following the reconsideration, or initially, if it is formally requested.

- UM decisions are communicated in writing to the Provider or Facility and Member. These letters provide details on appeal rights and the address to use when sending additional information.

Please note: Requests for appeal of Pre-Service requests will always be handled as a Member appeal. An expedited appeal is available for cases meeting the expedited criteria. Please see the instructions detailed in the UM decision letter.

- Appeals should be submitted to Anthem, along with a copy of our response to the original complaint. Send the appeal request to:
  
  Anthem Attention: Grievances and Appeals
  P.O. Box 105449
  Atlanta, GA. 30328-5449

**BlueCard® Members**

Appeals involving clinical decisions related to Medical Necessity, experimental/investigative and/or Utilization Management (UM) decisions involving Pre-certification/Pre-authorization are the responsibility of the Blue Plan insuring or administering benefits for non-Anthem Members (the Member’s Home Plan). Technically the Member, not the Provider or Facility, is responsible for obtaining the necessary authorization prior to the delivery of non-inpatient admission services. Anthem understands that many providers obtain
Pre-certification/Pre-authorization or may wish to dispute these types of denials on behalf of, and as a service to, their patients.

- If the appeal relates to Pre-certification/Pre-authorization, the Provider or Facility may have received information directly from the Member’s Home Plan regarding appeal rights and processes. Please follow the directions provided by the Member’s Home Plan.

- If the appeal relates to Claim denial, and the Provider or Facility did not receive this information from the Member’s Home Plan and wishes to appeal a Medical Necessity or experimental/investigational Claim denial, the local Anthem Plan is the point of contact. When a Provider or Facility expresses dissatisfaction and wishes to file an appeal as indicated in the description above, a Claim Payment Dispute should be submitted, along with attached supporting documentation, to the local Anthem Plan. Please reference the Claim Payment Dispute section for further details.

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**Member Quality of Care ("QOC")/Quality of Service ("QOS") Investigations**

**Overview**

The Grievances and Appeals department develops, maintains and implements policies and procedures for identifying, reporting and evaluating potential quality of care/service ("QOC"/"QOS") concerns or sentinel events involving Anthem Members. This includes cases reviewed as the result of a grievance submitted by a Member and potential quality issues ("PQI") reviewed as the result of a referral received from an Anthem clinical associate. All Anthem associates who may encounter clinical care/service concerns or sentinel events are informed of these policies.

Quality of care grievances and PQIs are processed by clinical associates. Medical records and a response from the Provider and/or Facility are requested. If the clinical associate determines the case is a non-issue with no identifiable quality issue, the clinical associate may assign a severity level C-0. A clinical associate may also assign a severity level rating of C-1 if the case meets the criteria for a known complication. A clinical associate may issue a C-3 rating for a Provider’s or Facility’s failure to submit requested information. Otherwise, the clinical associate will send a case summary to the Medical Director for review (i.e., First Level Peer Review). The case summary will include a list of previous severity levels assigned to the involved Provider and/or Facility on a rolling 12-month basis. If there are no previous severity levels, this will be documented. The Medical Director will select a specialty matched reviewer to evaluate the case, as appropriate. Upon completion of the review, the Medical Director makes a final determination and assigns a severity level for tracking and trending purposes. Upon completion of First Level Peer Review, if the case is a Member grievance, the Member is sent a resolution letter within thirty (30) calendar days of Anthem’s receipt of the grievance. The Member is informed that peer review statutes do not permit disclosure of the details and outcome of the quality investigation. In addition, the clinical associate will send a letter to the Provider and/or Facility explaining the outcome of the review and the severity level assigned.

Significant quality of care issues may be elevated to the regional Peer Review Committee for Second Level Peer Review. This may result in a subsequent referral to the appropriate Credentials Committee.

Trends/patterns of all assigned severity levels are reviewed with the Medical Director for intervention and corrective action planning.

Providers and Facilities have a contractual obligation to actively cooperate with any investigation. When a Member alerts Anthem to a quality concern regarding the care they received, Anthem has an obligation to thoroughly investigate that allegation by reviewing all relevant materials including any internal investigation and their outcomes done by the impacted Providers and/or Facility. This requirement is in the Provider and Facility Agreements and, as a business associate, Anthem has a right to that information.

**Corrective Action Plans ("CAP")**

When corrective action is required, the Medical Director or the applicable local Peer Review Committee will determine appropriate follow-up interventions which can include one or more of the following: a CAP from
the Provider and/or Facility, CME, chart reviews, on-site audits, tracking and trending, Provider and/or Facility counseling, and/or referral to the appropriate committee.

**Reporting**

G&A leadership reports grievance and PQI rates, categories, and trends; to the appropriate Quality Improvement Committee on a bi-annual basis or more often as appropriate. Quality improvement or educational opportunities are reported, and corrective measures implemented, as applicable. Results of corrective actions are reported to the Committee. The Quality Council reviews these trends annually during the process of prioritizing quality improvement activities for the subsequent year.

**Severity Levels for Quality Assurance**

<table>
<thead>
<tr>
<th>Quality of Care</th>
<th>Level</th>
<th>Points Assigned</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>C-0</td>
<td>0</td>
<td>No quality of care issue found to exist.</td>
</tr>
<tr>
<td></td>
<td>C-1</td>
<td>0</td>
<td>Predictable/unpredictable occurrence within the standard of care. Recognized medical or surgical complication that may occur in the absence of negligence and without a QOC concern.</td>
</tr>
<tr>
<td></td>
<td>C-2</td>
<td>5</td>
<td>Communication, administrative, or documentation issue that adversely affected the care rendered.</td>
</tr>
<tr>
<td></td>
<td>C-3</td>
<td>5</td>
<td>Failure of a practitioner/provider to respond to a member grievance regarding a clinical issue despite two requests per internal guidelines.</td>
</tr>
<tr>
<td></td>
<td>C-4</td>
<td>10</td>
<td>Mild deviation from the standard of care. A clinical issue that would be judged by a prudent professional to be mildly beneath the standard of care.</td>
</tr>
<tr>
<td></td>
<td>C-5</td>
<td>15</td>
<td>Moderate deviation from the standard of care. A clinical issue that would be judged by a prudent professional to be moderately beneath the standard of care.</td>
</tr>
<tr>
<td></td>
<td>C-6</td>
<td>25</td>
<td>Significant deviation from the standard of care. A clinical issue that would be judged by a prudent professional to be significantly beneath the standard of care.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Quality of Service</th>
<th>Level</th>
<th>Points Assigned</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>S-0</td>
<td>0</td>
<td>No quality of service or administrative issue found to exist.</td>
</tr>
<tr>
<td></td>
<td>S-1</td>
<td>0</td>
<td>Member grievances regarding practitioner’s office: physical accessibility, physical appearance, and adequacy of the waiting-room and examining-room space.</td>
</tr>
<tr>
<td></td>
<td>S-2</td>
<td>5</td>
<td>Communication, administrative, or documentation issue with no adverse medical effect on member.</td>
</tr>
<tr>
<td></td>
<td>S-3</td>
<td>5</td>
<td>Failure of a practitioner/provider to respond to a member grievance despite two requests per internal guidelines.</td>
</tr>
<tr>
<td></td>
<td>S-4</td>
<td>10</td>
<td>Confirmed discrimination, confirmed HIPAA violation, confirmed confidentiality and/or privacy issue.</td>
</tr>
</tbody>
</table>

**Trend Threshold for Analysis**

**Quality of Care and Service Trend Parameters**

The following accumulation of QOC and QOS cases with severity levels and points, or any combination of cases totaling 20 points or more during a rolling 12 months will be subject to trend analysis:

- 8 cases with a leveling of C-0 and S-0
- 4 cases with a leveling of C-1
- 4 cases with a leveling of C-2 and S-2
• 4 cases with a leveling of C-3 and S-3
• 2 cases with a leveling of C-4
• 2 cases with a leveling of C-5
• 1 case with a leveling of C-6 (automatic referral to the applicable Peer Review Committee)
• 3 cases with a leveling of S-1 (for a specific office location in a 6 month period); refer for site visit
• 4 cases with a leveling of S-4 (automatic referral to the applicable Provider Review Committee)

A rolling 12 month cumulative level report is generated monthly and reviewed by a G&A clinical associate for trend identification. (Four similar complaints constitute a trend).

An analysis is completed by the G&A clinical associate and forwarded to the Medical Director to determine if there is a pattern among the cases. For example, a provider who repeatedly fails to return phone calls to postoperative patients resulting in the potential for or an actual adverse outcome. The Medical Director will determine if further action is warranted, such as the need for a corrective action plan, or referral to the appropriate committee for further review and action, as appropriate.

Corrective action plans received for QOC issues are reviewed by the Medical Director and may be forwarded to the applicable local Peer Review Committee for further review and follow up, as appropriate.

A provider who does not submit the corrective action plan by the deadline or who does not comply with the terms of the corrective action plan will be referred to the Credentialing Committee for further action, which may include termination from the network.
Reimbursement Requirements and Policies

This section includes reimbursement guidelines and policies on how Anthem will reimburse Providers and Facilities services. Reimbursement Policies are published on anthem.com be sure to check both places. To locate the policies online go to Anthem.com. Select Provider; choose Policies, Guidelines and Manuals under Provider Resources in the horizontal menu. Scroll down to Reimbursement Policies and select Access Policies. Anthem reserves the right to review and revise policies when necessary.

Blood, Blood Products, and Administration

Transportation charges are included in the reimbursement for the product itself and are not separately reimbursable. Blood and blood product administration services are not reimbursable on inpatient Claims.

Changes during Admission

There are elements that could change during an admission. The following table shows the scenarios and the date to be used for the entire Claim:

<table>
<thead>
<tr>
<th>CHANGE</th>
<th>EFFECTIVE DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member’s Insurance Coverage</td>
<td>Admission</td>
</tr>
<tr>
<td>Facility’s Contracted Rate (other than DRG)</td>
<td>Admission</td>
</tr>
<tr>
<td>DRG Base Rate</td>
<td>Admission</td>
</tr>
<tr>
<td>DRG Grouper</td>
<td>Discharge</td>
</tr>
<tr>
<td>DRG Relative Weight</td>
<td>Discharge</td>
</tr>
<tr>
<td>CPT &amp; HCPCS coding changes</td>
<td>Discharge</td>
</tr>
</tbody>
</table>

Coding Requirements

Providers and Facilities will submit Claims in a format consistent with industry standards and acceptable to Anthem.

Comprehensive Health Planning

Facility shall not bill Anthem, Plan or a Member for Health Services, expanded facilities, capital operating costs or any other matter of service requiring a certificate of need approval or exemption under existing law, or similar or successor laws that may be adopted from time to time, unless said approval or exemption has been granted in writing.

Courtesy Room

Facility shall not bill Anthem, Plan, and/or Members for any charges related to use of a Courtesy Room in the provision of Health Services to a Member. “Courtesy Room” means an area in the Facility where a professional provider is permitted by Facility to provide Health Services to Members.

Daily Supply or One Time Charge Fees/Items

Supply fees billed daily or one time, which are unidentified and unsupported by medical records or documentation are not reimbursable.
**Different Settings Charges**

If Anthem determines that Facility submits charges differently for the same service performed in a different setting, Anthem will reimburse at the Anthem Rate for the lesser of the two charges.

**Eligibility and Payment**

A verification of eligibility is not a guarantee of payment.

**Emergency Room Supply and Services Charges**

The Emergency Room level reimbursement includes all monitoring, equipment, supply, time and staff charges. Reimbursement for the use of the Emergency Room includes the use of the room and personnel employed for the examination and treatment of patients. This reimbursement does not typically include the cost of physician services.

**Facility Personnel Charges**

Charges for Inpatient Services for Facility personnel are not separately reimbursable and the reimbursement for such is included in the room and board rate. Examples include, but are not limited to, lactation consultants, dietary consultants, overtime charges, transport fees, nursing functions (including IV or PICC line insertion at bedside), professional therapy functions, including Physical, Occupational, and Speech call back charges, nursing increments, therapy increments, and bedside respiratory and pulmonary function services. Outpatient Services for Facility personnel are also not separately reimbursable. Reimbursement is included in the reimbursement for the procedure or observation charge.

**General Industry Standard Language**

Per Anthem policy and the Agreement, Provider and Facility will follow industry standards related to billing. Examples of general industry standards include, but are not limited to, HCPCS, ICD10/CM, health service codes (also known as Revenue Codes) per the UB-04 Claim billing manual or subsequent forms CPT codes.

**Implants**

Implants are objects or materials which are implanted such as a piece of tissue, a tooth, a pellet of medicine, a medical device, a tube, a graft, or an insert placed into a surgically or naturally formed cavity of the human body to continuously assist, restore or replace the function of an organ system or structure of the human body throughout its useful life. Implants include, but are not limited to: stents, artificial joints, shunts, pins, plates, screws, anchors and radioactive seeds, in addition to non-soluble, or solid plastic materials used to augment tissues or to fill in areas traumatically or surgically removed. Instruments that are designed to be removed or discarded during the same operative session during which they are placed in the body are not implants. In addition to meeting the above criteria, implants must also remain in the Member's body upon discharge from the inpatient stay or outpatient procedure. Staples, sutures, clips, as well as temporary drains, tubes, similar temporary medical devices and supplies shall not be considered implants.

Facility shall not bill Anthem, and Anthem shall not reimburse Facility for implants that are deemed contaminated and/or considered waste and/or were not implanted in the Member. Additionally, Anthem will not reimburse Facility for implants that are deemed contaminated and/or considered waste and/or were not implanted in the Member.

**Instrument Trays**

Charges for instrument trays for any procedure are included in the cost of the procedure and are not separately reimbursable. See Operating Room Time and Procedure Charges for additional information.
**Interim Bill Claims**

Anthem shall not adjudicate Claims submitted as interim bills for services reimbursed under DRG methodology.

**IV Sedation and local anesthesia**

Charges for IV Sedation and local anesthesia administered by the provider performing the procedure, and/or nursing personnel, is not separately reimbursable and is included as part of the Operating Room ("OR") time/procedure reimbursement.

**Lab Charges**

Venipuncture, specimen collection, draw fees, phlebotomy, heel stick, processing fees, handling fees, blood storage and processing, blood administration, thawing fees. These charges are inclusive of the procedure/lab test performed and not separately reimbursable.

**Labor Care Charges**

Anthem will reimburse appropriately billed room and board or labor charges. Payment will not be made on both charges billed concurrently. Facilities reimbursed under DRG will not be reimbursed by Anthem for Outpatient Services rendered prior to the admission.

**Medical Care Provided to or by Family Members**

Services for any type of medical care rendered by a Provider to him/herself or to an immediate family Member (as defined below), who is a Member, are not eligible for coverage and should not be billed to Anthem. In addition, a Provider may not be selected as a Primary Care Physician (PCP) by his/her immediate family Member.


**Nursing Procedures**

Anthem will not separately reimburse fees associated with nursing procedures or services provided by Facility nursing staff or unlicensed Facility personnel (technicians) performed during an inpatient ("IP") admission or outpatient ("OP") visit. Examples include, but are not limited, to intravenous ("IV") injections or IV fluid administration/monitoring, intramuscular ("IM") injections, subcutaneous ("SQ") injections, nasogastric tube ("NGT") insertion, urinary catheter insertion, point of care/bedside testing (such as glucose, blood count, arterial blood gas, clotting time, etc.) and inpatient blood transfusion administration/monitoring (with the exception of OP blood administration or OP chemotherapy administration which are submitted without observation/treatment room charges.)

**Observation Services (Facility Reimbursement Policy)**

Anthem considers outpatient observation services to mean active, short-term medical and/or nursing services performed by an acute Facility on that Facility’s premises that includes the use of a bed and monitoring by that acute Facility’s nursing or other staff and are required to observe a patient’s condition to determine if the patient requires an inpatient admission to the Facility. Observation services include services provided to a patient designated as “observation status”, and in general, shall not exceed 24 hours. Observation services may be considered eligible for reimbursement when rendered to patients who meet one or more of the following criteria:

- Active care or further observation is needed following emergency room care to determine if the patient is stabilized.
- The patient has a complication from an outpatient surgical procedure that requires additional recovery time that exceeds the normal recovery time.
• The patient care required is initially at or near the inpatient level; however, such care is expected to last less than a 24 hour time frame.
• The patient requires further diagnostic testing and/or observation to make a diagnosis and establish appropriate treatment protocol.
• The patient requires short term medical intervention of Facility staff which requires the direction of a physician.
• The patient requires observation in order to determine if the patient requires admission into the Facility.

Policy

The payment, if any, for observation services is specified in the Plan Compensation Schedule or Contract with the applicable Facility. Nothing in this Policy is intended to modify the terms and conditions of the Facility’s Agreement with Anthem. If the Facility’s Agreement with Anthem does not provide for separate reimbursement for observation services, then this Policy is not intended to and shall not be construed to allow the Facility to separately bill for and seek reimbursement for observation services.

The patient’s medical record documentation for observation status must include a written order by the physician or other individual authorized by state licensure law and Facility staff bylaws to admit patients to the Facility that clearly states “admit to observation”. Additionally, such documentation shall demonstrate that observation services are required by stating the specific problem, the treatment and/or frequency of the skilled service expected to be provided.

The following situations are examples of services that are considered by Anthem to be inappropriate use of observation services:

• Physician, patient, and/or family convenience
• Routine preparation and recovery for diagnostic or surgical procedures
• Social issues
• Blood administration
• Cases routinely cared for in the Emergency Room or Outpatient Department
• Routine recovery and post-operative care after outpatient surgery
• Standing orders following outpatient surgery
• Observation following an uncomplicated treatment or procedure

Operating Room Time and Procedure Charges

The operating room ("OR") charge will be based on a time or procedural basis. When time is the basis for the charge, it should be calculated from the time the patient enters the room until the patient leaves the room, as documented on the OR nurse’s notes. The operating room charge will reflect the cost of:

• The use of the operating room
• The services of qualified professional and technical personnel
• Linen packs, basic instrument packs, basic packs, basic post-op dressing, equipment and routine supplies such as sutures, gloves, dressings, sponges, prep kits, drapes, and surgical attire.

 Separate charges are allowed for specialized packs such as those used for open heart, eye and scope surgeries, packs for extensive plastic repair and complex post-op dressing or specialized equipment such as hip pins, bone nails, bone plates, and tantalum mesh. This includes the cost of preparing, storing and handling such supplies.

The operating room charge will not reflect the cost of robotic technology and is not eligible for separate reimbursement. Examples of charges that are not eligible for separate or additional reimbursement are listed below:

• Increased operating room unit cost charges for the use of the robotic technology
• Charges billed under CPT or HCPCS codes that are specific to robotic assisted surgery, including, but not limited to, S2900
Other Agreements

If Facility currently maintains a separate Agreement(s) with Anthem solely for the provision and payment of home health care services, skilled nursing Facility services, ambulatory surgical Facility services, or other agreements that Anthem designates (hereinafter collectively "Other Agreement(s)"), said Other Agreement(s) will remain in effect and control the provision and payment of Covered Services rendered there under.

Personal Care Items

Personal care items used for patient convenience are not reimbursable. Examples include but are not limited to: breast pumps, deodorant, dry bath, dry shampoo, lotion, non-medical personnel, mouthwash, powder, soap, telephone calls, television, tissues, toothbrush and toothpaste. Items used for the patient which are needed as a direct result of a procedure or test are considered part of the room and board or procedure charges and are not separately reimbursable. Examples include but are not limited to: bedpans, chux, hot water bottles, icepacks, pillows, sitz baths, and urinals.

Pharmacy Charges

Pharmacy charges will include the cost of the drugs prescribed by the attending physician. Medications furnished to patients shall not include an additional separate charge for administration of drugs, the cost of materials necessary for the preparation and administration of drugs, and the services rendered by registered pharmacists and other pharmacy personnel. Anthem will reimburse at the Anthem Rate for the drug. All other services are included in the Anthem Rate. Example of pharmacy charges which are not separately reimbursable include, but are not limited to: IV mixture fees and Facility staff checking the pharmacy ("RX") cart.

Portable Charges

Portable Charges are included in the reimbursement for the procedure, test or x-ray and are not separately reimbursable.

Pre-Operative Care or Holding Room Charges

Charges for a pre-operative care or a holding room used prior to a procedure are included in the reimbursement for the procedure, and are not separately reimbursed. In addition, nursing care provided in the pre-operative care area will not be reimbursed separately. Reimbursement for the procedure includes all nursing care provided.

Preparation (Set-Up) Charges

Charges for set-up, equipment or materials in preparation for procedures or tests are included in the reimbursement for that particular procedure or test.

Preventable Adverse Events (Facility Reimbursement Policy)

Acute Care General Hospitals (Inpatient)

Three (3) Major Surgical Never Events

When any of the Preventable Adverse Events ("PAEs") set forth in the grid below occur with respect to a Member, the acute care general hospital shall neither bill, nor seek to collect from, nor accept any payment from the Plan or the Member for such events. If acute care general hospital receives any payment from the Plan or the Member for such events, it shall refund such payment within ten (10) business days of becoming aware of such receipt. Further, acute care general hospital shall cooperate with Anthem in any Anthem initiative designed to help analyze or reduce such PAEs.
Whenever any of the events described in the grid below occur with respect to a Member, acute care general hospital is encouraged to report the PAE to the appropriate state agency, The Joint Commission (“TJC”), or a patient safety organization (“PSO”) certified and listed by the Agency for Healthcare Research and Quality.

<table>
<thead>
<tr>
<th>Preventable Adverse Event</th>
<th>Definition / Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Surgery Performed on the Wrong Body Part</td>
<td>Any surgery performed on a body part that is not consistent with the documented informed consent for that patient. Excludes emergent situations that occur in the course of surgery and/or whose exigency precludes obtaining informed consent. Surgery includes endoscopies and other invasive procedures.</td>
</tr>
<tr>
<td>2. Surgery Performed on the Wrong Patient</td>
<td>Any surgery on a patient that is not consistent with the documented informed consent for that patient. Surgery includes endoscopies and other invasive procedures.</td>
</tr>
<tr>
<td>3. Wrong surgical procedure performed on a patient</td>
<td>Any procedure performed on a patient that is not consistent with the documented informed consent for that patient. Excludes emergent situations that occur in the course of surgery and/or whose exigency precludes obtaining informed consent. Surgery includes endoscopies and other invasive procedures.</td>
</tr>
</tbody>
</table>

CMS Hospital Acquired Conditions (“HAC”)

Anthem follows CMS’ current and future recognition of HACs. Current and valid Present on Admission (“POA”) indicators (as defined by CMS) must be populated on all inpatient acute care Facility Claims.

When a HAC does occur, all inpatient acute care Facilities shall identify the charges and/or days which are the direct result of the HAC. Such charges and/or days shall be removed from the Claim prior to submitting to the Plan for payment. In no event shall the charges or days associated with the HAC be billed to either the Plan or the Member.

Providers and Facilities (excluding Inpatient Acute Care General Hospitals)

Four (4) Major Surgical Never Events

When any of the Preventable Adverse Events (“PAEs”) set forth in the grid below occur with respect to a Member, the Provider or Facility shall neither bill, nor seek to collect from, nor accept any payment from the Plan or the Member for such events. If Provider or Facility receives any payment from the Plan or the Member for such events, it shall refund such payment within ten (10) business days of becoming aware of such receipt. Further, Providers and Facilities shall cooperate with Anthem in any Anthem initiative designed to help analyze or reduce such PAEs.

Whenever any of the events described in the grid below occur with respect to a Member, Providers and Facilities are encouraged to report the PAE to the appropriate state agency, The Joint Commission (“TJC”), or a patient safety organization (“PSO”) certified and listed by the Agency for Healthcare Research and Quality.

<table>
<thead>
<tr>
<th>Preventable Adverse Event</th>
<th>Definition / Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Surgery Performed on the Wrong Body Part</td>
<td>Any surgery performed on a body part that is not consistent with the documented informed consent for that patient. Excludes emergent situations that occur in the course of surgery and/or whose exigency precludes obtaining informed consent. Surgery includes endoscopies and other invasive procedures.</td>
</tr>
<tr>
<td>2. Surgery Performed on the Wrong Patient</td>
<td>Any surgery on a patient that is not consistent with the documented informed consent for that patient. Surgery includes endoscopies and other invasive procedures.</td>
</tr>
<tr>
<td>3. Wrong surgical procedure performed on a patient</td>
<td>Any procedure performed on a patient that is not consistent with the documented informed consent for that patient. Excludes emergent situations that occur in the course of surgery and/or whose exigency precludes obtaining informed consent. Surgery includes endoscopies and other invasive procedures.</td>
</tr>
<tr>
<td>Preventable Adverse Event</td>
<td>Definition / Details</td>
</tr>
<tr>
<td>---------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>informed consent. Surgery includes endoscopies and other invasive procedures.</td>
<td></td>
</tr>
<tr>
<td>4. Retention of a foreign object in a patient after surgery or other procedure</td>
<td>Excludes objects intentionally implanted as part of a planned intervention and objects present prior to surgery that were intentionally retained.</td>
</tr>
</tbody>
</table>

**Provider and Facility Records**

Provider and Facility shall prepare and maintain all appropriate medical, financial, administrative and other records as may be needed for Members receiving Health Services. All of Provider’s and Facility’s records on Members shall be maintained in accordance with prudent record keeping procedures and as required by any applicable federal, state or local laws, rules or regulations.

**Recovery Room Charges**

Reimbursement for recovery room services (time or flat fee) includes all used and or available services, equipment, monitoring, nursing care that is necessary for the patient’s welfare and safety during his/her confinement. This will include, but is not limited to EKG monitoring, Dinamap®, pulse oximeter, injection fees, nursing, nursing time, nursing supervision, equipment and supplies, (whether disposable or reusable), defibrillator, and oxygen. Separate reimbursement for these services will not be made.

**Recovery Room Services related to IV sedation and/or local anesthesia**

Anthem will not provide reimbursement for a phase I or primary recovery room charged in connection with IV sedation or local anesthesia. Charges will be paid only if billed as a post procedure room or a phase II recovery (step-down) e.g. arteriograms. The Anthem Rate shall not exceed the Facility’s approved average semi-private room and board rate less discount, as submitted to Anthem.

**Respiratory Services Not Eligible for Separate Reimbursement**

More than one type of respiratory support (for example: mechanical ventilation and CPAP) at the same time and/or on the same day is not eligible for separate reimbursement, unless there is clinical documentation to support that the Member requires different levels of respiratory support.

**Routine Supplies**

Any supplies, items and services that are necessary or otherwise integral to the provision of a specific service and/or the delivery of services in a specific location are considered routine services and not separately reimbursable in the inpatient and outpatient environments.

All items and supplies that may be purchased over-the-counter are not separately reimbursable.

All reusable items, supplies and equipment that are provided to all patients during an inpatient or outpatient admission are not separately reimbursable.

All reusable items, supplies and equipment that are provided to all patients admitted to a given treatment area or unit (i.e., NICU, Burn Unit, PACU, Medical/Surgical Unit), as well as all reusable items, supplies and equipment that are provided to all patients receiving the same service (i.e., an Ambu bag during resuscitation), are not separately reimbursable.

**Semi Private Room Rate**

Anthem must be notified in writing of any changes, and new rates will be loaded thirty (30) days after such notification. No Claims will be reprocessed as a result of changes to semi-private room rates. All eligible charges for Covered Services will be limited to the approved average semi-private room and board rate, less discount, as submitted to Anthem.
Special Procedure Room Charge

Special procedure room charges are included in the reimbursement for the procedure. If the procedure takes place outside of the OR suite, then OR time will not be reimbursed to cover OR personnel/staff being present in the room. Example: ICU, GI lab, etc.

Stand-by Charges

Standby equipment and consumable items such as oxygen, which are on standby, are not reimbursable. Only actual use is covered. Professional staff on standby is included in the reimbursement for the procedure and also is not separately reimbursable.

Stat Charges

Stat charges are included in the reimbursement for the procedure, test and or X-ray. These charges are not separately reimbursable.

Submission of Claim/Encounter Data

Facilities and Providers will submit Claims and encounter data to Anthem on a CMS-1500, UB04, or subsequent form, in a manner consistent with industry standards and policies and procedures as approved by Anthem. Anthem will make best efforts to pay all complete and accurate Claims for Covered Services submitted by Facilities and Providers in accordance with the applicable state statute, exclusive of Claims that have been suspended due to the need to determine Medical Necessity, to the extent of our payment liability, if any, because of issues such as coordination of benefits, subrogation or verification of coverage.

Supplies and Equipment

Charges for medical equipment, including but not limited to, IV pumps, PCA Pumps, and isolation carts and supplies are not separately reimbursable. Also, oxygen charges, including but not limited to, oxygen per minute, per hour and therapy, when billed with room types ICU/CCU/NICU or any Specialty Care area, where equipment is a requirement to be authorized for specialty category, are not separately reimbursable.

Tech Support Charges

Pharmacy Administrative Fees (including mixing medications), any portable fees for a procedure or service, patient transportation fees when taking a patient to an area for a procedure or test are not separately reimbursable. Transporting a patient back to their room following surgery, a procedure, or test, are not separately reimbursable.

Telemetry

Telemetry charges in ER/ ICU/CCU/NICU or telemetry unit are included in the reimbursement for the place of service. Additional monitoring charges are not reimbursable. Separately billed telemetry charges will only be paid if observation (“OBS”) charges do not exceed approved average semi-private room and board rate less discount, as submitted to Anthem.

Test or Procedures Prior to Admission(s) or Outpatient Services

The following diagnostic services, defined by specific Coded Service Identifier(s), are considered part of pre-admission/pre-surgical/preoperative testing:

- 254 – Drugs incident to other diagnostic services
- 255 – Drugs incident to radiology
- 30X – Laboratory
- 31X – Laboratory pathological
Non-diagnostic services are also considered part of pre-admission/pre-surgical/preoperative testing if they are furnished in connection with the principal diagnosis that necessitates the outpatient procedure or the Member’s admission as an inpatient.

Unless the Provider or Facility Agreement with Anthem specifies a different timeframe, pre-admission/pre-surgical/preoperative testing that occurs within seventy-two (72) hours prior to the inpatient admission or outpatient procedure will be included in the DRG Rate, Per Diem Rate, Case Rate or any other Anthem Rate for Covered Services, and will not be paid separately. All Claims billed separately for these services must be accompanied with the appropriate ICD-10 codes.

**Time Calculation**

- **Operating Room ("OR")** – Time should be calculated from the time the patient enters the room until the patient leaves the room, as documented on the OR nurse’s notes.

- **Anesthesia** – Time charges should be calculated from the start and finish times as documented on the anesthesia record. Anesthesia materials may be charged individually as used or included in a charge based on time. A charge that is based on time will be computed from the induction of the anesthesia until surgery is complete. This charge will include the use of all monitoring equipment. Other types of anesthesia such as local, regional, IV sedation etc., must be billed at an appropriate rate for the lower level of anesthesia services.

- **Recovery Room** – Time should be calculated from the time the patient enters the recovery room until the patient leaves the recovery room as documented on the post anesthesia care unit ("PACU") record.

  **Post Recovery Room** – Time charges should be calculated from the time the patient leaves the recovery room until discharge

**Undocumented or Unsupported Charges**

Per Anthem policy, Anthem will not reimburse charges that are not documented on medical records or supported with reasonable documentation.

**Video or Digital Equipment used in Operating Room**

Charges for video or digital equipment used in a surgery are included in the reimbursement for the procedure and are not separately reimbursable. Charges for batteries, covers, film, anti-fogger solution, tapes etc., are not separately reimbursable.

**Additional Reimbursement Guidelines for Disallowed Charges**

For any Claims that are reimbursed at a percent of charge, only Charges for Covered Services are eligible for reimbursement. The disallowed charges (charges not eligible for reimbursement) include, but are not limited to, the following, whether billed under the specified Revenue Code or any other Revenue Code. These Guidelines may be superseded by your specific agreement. Please refer to your contractual fee schedule for payment determination.
The tables below illustrate examples of non-reimbursable items/services codes:

<table>
<thead>
<tr>
<th>Facility Responsibility</th>
<th>Description of Excluded Items</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Typically Billed Under This/These Revenue Codes, but not Limited to the Revenue Codes Listed Below</strong></td>
<td></td>
</tr>
</tbody>
</table>
| **0990 – 0999** | Personal Care Items  
- Courtesy/Hospitality Room  
- Patient Convenience Items (0990)  
- Cafeteria, Guest Tray (0991)  
- Private Linen Service (0992)  
- Telephone, Telegraph (0993)  
- TV, Radio (0994)  
- Non-patient Room Rentals (0995)  
- Beauty Shop, Barber (0998)  
- Other Patient Convenience Items (0999) |
| **0220** | Special Charges |
| **0369** | Preoperative Care or Holding Room Charges |
| **0760 – 0769** | Special Procedure Room Charge |
| **0111 – 0119** | Private Room* (subject to Member’s Benefit) |
| **0221** | Admission Charge |
| **0480 – 0489** | Percutaneous Transluminal Coronary Angioplasty (PTCA) Stand-by Charges |
| **0220, 0949** | Stat Charges |
| **0270 – 0279, 0360** | Video Equipment Used in Operating Room |
| **0270, 0271, 0272** | **Supplies and Equipment**  
- Blood Pressure cuffs/Stethoscopes  
- Thermometers, Temperature Probes, etc.  
- Pacing Cables/Wires/Probes  
- Pressure/Pump Transducers  
- Transducer Kits/Packs  
- SCD Sleeves/Compression Sleeves/Ted Hose;  
- Oximeter Sensors/Probes/Covers  
- Electrodes, Electrode Cables/Wires  
- Oral swabs/toothettes;  
- Wipes (baby, cleansing, etc.)  
- Bedpans/Urinals  
- Bed Scales/Alarms  
- Specialty Beds  
- Foley/Straight Catheters, Urometers/Leg Bags/Tubing  
- Specimen traps/containers/kits;  
- Tourniquets;  
- Syringes/Needles/Lancets/Butterflies  
- Isolation carts/supplies;  
- Dressing Change Trays/Packs/Kits  
- Dressings/Gauze/Sponges; |
## Facility Responsibility

<table>
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<th>Typically Billed Under This/These Revenue Codes, but not Limited to the Revenue Codes Listed Below</th>
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</table>
| • Kerlix/Tegaderm/OpSite/Telfa  
• Skin cleansers/preps;  
• Cotton Balls; Band-Aids, Tape, Q-Tips  
• Diapers/Chucks/Pads/Briefs  
• Irrigation Solutions  
• ID/Allergy bracelets;  
• Foley stat lock;  
• Gloves/Gowns/Drapes/Covers/Blankets;  
• Ice Packs/Heating Pads/Water Bottles  
• Kits/Packs (Gowns, Towels and Drapes);  
• Basins/basin sets;  
• Positioning Aides/Wedges/Pillows;  
• Suction Canisters/Tubing/Tips/Catheters/Liners  
• Enteral/Parenteral Feeding Supplies (tubing/bags/sets, etc.)  
• Preps/prep trays;  
• Masks (including CPAP and Nasal Cannulas/Prongs);  
• Bonnets/Hats/Hoods;  
• Smoke Evacuator Tubing;  
• Restraints/Posey Belts  
• OR Equipment (saws, skin staplers, staples & staple removers, sutures, scalpels, blades etc.)  
• IV supplies (tubing, extensions, angio-caths, stat-locks, blood tubing, start kits, pressure bags, adapters, caps, plugs, fluid warmers, sets, transducers, fluid warmers, etc.); | • Tech Support Charges  
• Pharmacy Administrative Fee (including mixing meds)  
• Portable Fee (cannot charge portable fee unless equipment is brought in from another Facility)  
• Patient transport fees |
| 0220 – 0222, 0229, 0250 | • Utilization Review Service Charges |
| 0223 | • IV Infusion for therapy, prophylaxis (96365, 96366);  
• IV Infusion additional for therapy:  
• IV Infusion concurrent for therapy (96368);  
• IV Injection (96374, 96379) |
| 263 | • Other Special Charges  
• Observations hours may never exceed the charge of a semiprivate room charge  
• Oxygen charges while a patient is on a ventilator  
• Respiratory assessment/vent management charges |
<p>| 0229, 0760 – 0762, 0769, 0270, 410 – 413, 0419 | • Nursing Procedures and 99001 – Handling and/or conveyance of specimen from patient (charge for specimen handling) |</p>
<table>
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<tr>
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<td></td>
</tr>
<tr>
<td>0230</td>
<td>Incremental Nursing – General</td>
</tr>
<tr>
<td>0231</td>
<td>Nursing Charge – Nursery</td>
</tr>
<tr>
<td>0232</td>
<td>Nursing Charge – Obstetrics (OB)</td>
</tr>
<tr>
<td>0233</td>
<td>Nursing Charge – Intensive Care Unit (ICU)</td>
</tr>
<tr>
<td>0234</td>
<td>Nursing Charge – Cardiac Care Unit (CCU)</td>
</tr>
<tr>
<td>0235</td>
<td>Nursing Charge – Hospice</td>
</tr>
<tr>
<td>0239</td>
<td>Nursing Charge – Emergency Room (ER) or Post Anesthesia Care Unit (PACU) or Operating Room (OR)</td>
</tr>
</tbody>
</table>
| **0250 – 0259, 0636** | Pharmacy (non-formulary drugs, compounding fees, nonspecific descriptions)  
- Medication prep  
- Nonspecific descriptions  
- Anesthesia Gases – Billed in conjunction with Anesthesia Time Charges  
- IV Solutions 250 cc or less  
- Miscellaneous Descriptions  
- Non-FDA Approved Medications |
| 0256 | Experimental Drugs |
| **0270, 0300 – 0307, 0309, 0380 – 0387, 0390 – 0392** | Venipuncture (CPT Code 36415, 36416 or G0001)  
- Specimen collection  
- Draw fees  
- Phlebotomy  
- Heel stick  
- Blood storage and processing blood administration (Rev codes 0380, 0390 – 0392; 0399)  
- Thawing/Pooling Fees |
| 0222, 0270, 0272, 0410, 0460 | Portable Charges |
| **0270 – 0279, 0290, 0320, 0410, 0460** | Supplies and Equipment  
- Preparation (Set-up) Charges; Set-up is included in the fee for the procedure and, as such, included in the room and board  
- Oxygen (ICU/CCU/Progressive) O.R., ER and Recovery  
- Instrument Trays and/or Surgical Packs  
- Drills/Saws (All power equipment used in O.R.)  
- Drill Bits  
- Blades  
- IV pumps and PCA (Patient Controlled Analgesia) pumps |
<table>
<thead>
<tr>
<th>Facility Responsibility</th>
<th>Description of Excluded Items</th>
</tr>
</thead>
</table>
| Typically Billed Under This/These Revenue Codes, but not Limited to the Revenue Codes Listed Below | - Isolation supplies  
- Daily Floor Supply Charges  
- X-ray Aprons/Shields  
- Blood Pressure Monitor  
- Beds/Mattress  
- Patient Lifts/Slings  
- Restraints  
- Transfer Belt  
- Bair Hugger Machine/Blankets  
- SCD Pumps  
- Heal/Elbow Protector  
- Burrs  
- Cardiac Monitor  
- EKG Electrodes  
- Vent Circuit  
- Suction Supplies for Vent Patient  
- Electrocautery Grounding Pad  
- Bovie Tips/Electrodes  
- Anesthesia Supplies When Billed with Anesthesia Time Charges  
- Anesthesia Circuit  
- Perfusion Supplies When Billed with Perfusionist Time Charge  
- Case Carts  
- C-Arm/Fluoroscopic Charge  
- Wound Vacuum Pump  
- Bovie/Electro Cautery Unit  
- Wall Suction  
- Retractors  
- Single Instruments  
- Oximeter Monitor  
- CPM Machines  
- Lasers  
- Davinic Machine/Robot |
| 0309 – 0369, 0419, 0619 | After Hours – Call-back |
| 0370 – 0379, 0410, 0460, 0480 – 0489 | Anesthesia (Specifically, conscious/moderate sedation)  
- Nursing care  
- Monitoring  
- Intervention  
- Pre- or Post-evaluation and education  
- IV sedation and local anesthesia  
- Intubation/Extubation  
- CPR |
| 410 | Nursing/Respiratory Functions:  
- Oximetry (94760, 94761, 94762) |
### Facility Responsibility

<table>
<thead>
<tr>
<th>Typically Billed Under This/These Revenue Codes, but not Limited to the Revenue Codes Listed Below</th>
<th>Description of Excluded Items</th>
</tr>
</thead>
</table>
| | • Oximetry reading by nurse or respiratory tech  
| | • Vent Management  
| | • Postural Drainage  
| | • Suctioning Procedure  
| | • Nursing/Respiratory care performed while patient is on vent |
| 0480 – 0489 | Percutaneous Transluminal Coronary Angioplasty (PTCA) stand-by charges |
| 0940 – 0945 | Education/Training |
| 0270, 0272, 0300 – 0309 | Bedside/Point of Care/Near Patient Testing (such as glucose, blood count, arterial blood gas, clotting time, glucose, etc.) |

### Member Responsibility

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>0110 – 0119</td>
<td>Private Room*</td>
</tr>
<tr>
<td>0990</td>
<td>Patient Convenience Items</td>
</tr>
<tr>
<td>0991</td>
<td>Cafeteria, Guest Tray</td>
</tr>
<tr>
<td>0992</td>
<td>Private Linen Service</td>
</tr>
<tr>
<td>0993</td>
<td>Telephone, Telegraph</td>
</tr>
<tr>
<td>0994</td>
<td>TV, Radio</td>
</tr>
<tr>
<td>0995</td>
<td>Non-patient Room Rentals</td>
</tr>
<tr>
<td>0996</td>
<td>Late Discharge</td>
</tr>
<tr>
<td>0998</td>
<td>Beauty Shop, Barber</td>
</tr>
<tr>
<td>0999</td>
<td>Other Patient Convenience Items</td>
</tr>
</tbody>
</table>

* Subject to the Member’s Benefit Agreement.
Medical Policy and Clinical Utilization Management (UM) Guidelines

The Office of Medical Policy & Technology Assessment (“OMPTA”) develops medical policy and clinical UM guidelines (collectively, “Medical Policy”) for Anthem. The principal component of the process is the review for development of Medical Necessity and/or investigational policy position statements or clinical indications that are objective and based on clinical evidence for certain new medical services and/or procedures or for new uses of existing services and/or procedures. The services consisting of medical, surgical, and behavioral health treatments may include, but are not limited to devices, biologics, specialty pharmaceuticals, gene therapies, and professional health services.

The Medical Policy & Technology Assessment Committee (“MPTAC”) is a multiple disciplinary group including physicians from various medical and behavioral health specialties, clinical practice environments and geographic areas. Voting membership may include external physicians in clinical practices and participating in networks, external physicians in academic practices and participating in networks, internal medical directors and Chairs of MPTAC Subcommittees. Non-voting members may include internal legal counsel and internal medical directors.

Additional details regarding the Medical Policy development process, including information about MPTAC and its Subcommittees, is provided in ADMIN.00001 Medical Policy Formation.

Medical Policy and Clinical Utilization Management (“UM”) Guidelines Distinction

Medical Policy and clinical UM guidelines differ in the type of determination being made. Both set forth position statements or clinical indications regarding the medical necessity of individual services and/or procedures. In general, Medical Policy may be developed to address experimental or investigational technologies (including a novel application of an existing technology) and services where there is a significant concern regarding Member safety. Clinical UM guidelines address Medical Necessity criteria for technologies or services where sufficient clinical evidence exists to evaluate the clinical appropriateness of the request, goal length of stay (GLOS), place of service and level of care. In addition, Medical Policies are implemented by all Anthem Plans while clinical UM guidelines are adopted and implemented at the local Anthem Plan or line of business discretion.

Medical Policies and Clinical UM Guidelines are posted online at anthem.com

All Anthem Medical Policy is publicly available on our website, which provides transparency for Providers and Facilities, Members and the public in general. Some vendor guidelines used to make coverage determinations are proprietary and are not publicly available on the Anthem website, but are available upon request.

To locate Medical Policy online, go to anthem.com. Select Providers and your state then scroll to or select Policies, Guidelines and Manuals from the horizontal menu under Provider Resources. Scroll to Medical Policies & Clinical UM Guidelines and select “View Medical Policies & Clinical UM Guidelines”. Search for policies or select “Full List page” to view. Page link is included below:

- Medical Policies and Clinical UM Guidelines (for Local Plan members)
- Coverage Guidelines and Clinical UM Guidelines

To locate Medical Policy and Clinical UM Guidelines and Prior Authorization requirements for BlueCard Out-of-area members go to anthem.com. Select Providers and your state then choose “Prior Authorization” under Claims in the horizontal menu. Scroll down the page to Helpful Links and select “Medical Policy and Prior Authorization for Blue Plans”. Page link is included below:

- Medical Policy, Clinical UM Guidelines, and Pre-Cert Requirements

Clinical UM Guidelines for Local Plan members

The clinical UM guidelines published on our website represent the clinical UM guidelines currently available to all Plans for adoption throughout our organization. Because local practice patterns, claims systems and benefit designs vary, a local Plan or line of business may choose whether to implement a particular clinical
UM guideline. The link below can be used to confirm whether the local Plan or line of business has adopted the clinical UM guideline(s) in question. Adoption lists are created and maintained solely by each local Plan or line of business.

To view the list of specific clinical UM guidelines adopted by Georgia navigate to the Disclaimer page by following the instructions above for Medical Policy and Clinical UM Guidelines (for Local Plan members); scroll to the bottom of the page. Above the “Continue” button, select the link titled Medical Policies and Clinical UM Guidelines

Utilization Management Program

The Utilization Management ("UM") Program goal is to have Members receive the appropriate quantity and quality of healthcare services, delivered at the appropriate time, and in a setting consistent with their medical care needs. Providers and Facilities agree to abide by the following UM Program requirements in accordance with the terms of the Agreement and the Member’s Health Benefit Plan. Providers and Facilities agree to cooperate with Anthem in the development and implementation of action plans arising under these programs. Provider or Facility shall comply with all requests for medical information required to complete Anthem’s UM review. Providers and Facilities agree to adhere to the following provisions and provide the information as outlined within this section.

UM Definitions

1. **Adverse Determination:** means a denial, reduction or failure to make payment (in whole or in part) for a benefit based on a determination that a benefit is experimental, investigational, or not medically necessary or appropriate as defined in the applicable health benefit plan. This may apply to Prospective, Continued Stay, and Retrospective reviews.

2. **Business day:** Monday through Friday, excluding designated company holidays.

3. **Continued Stay Review:** (continuation of services). Continued Stay Review means utilization review that is conducted during a Member’s ongoing stay in a Facility or course of treatment. Continued Stay Review includes continuation of services (Urgent Care & Extensions).

4. **Notification:** The telephonic and/or written/electronic communication to the applicable Providers, Facility and the Member documenting the determination, and informing the Member, Providers, and Facility of their rights if they disagree with the determination.

5. **Pre-certification/Pre-authorization Requirement:** List of procedures that require Pre-service Review by Anthem UM prior to service delivery. For Anthem UM team to perform Pre-service Review, the Provider submits the pertinent information as soon as possible to Anthem UM prior to service delivery.

6. **Pre-Service (Prospective) Review:** Review for Medical Necessity that is conducted on a health care service or supply prior to its delivery to the Member.

7. **Post Service (Retrospective) Review:** means a utilization review that is conducted after the health care service (or supply) has been provided to the Member.

8. **Urgent Care Review:** means request for medical care or services where application of the time frame for making routine or non-life threatening care determinations:
   a. 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, or
   b. Could seriously jeopardize the life, health or safety of the Member or others, due to the Member’s psychological state, or
c. In the opinion of a practitioner who is a licensed or certified professional providing medical care or behavioral healthcare services with knowledge of the Member’s medical or behavioral condition, would subject the Member to adverse health consequences without the care or treatment that is the subject of the request.

Program Overview

Utilization Management (UM) may be required for Pre-certification/Pre-authorization, Pre-service (Prospective) Review, Continued Stay Review, or Post-service (Retrospective) Review.

The determination that services are medically necessary is based on the information provided, and is not a guarantee that benefits will be paid. Payments are based on the Member’s coverage at the time of service. These terms typically include certain exclusions, limitations and other conditions. Benefit payment could be limited, for example, when:

- The information submitted with the Claim, or on the medical record, differs from that given by telephone, fax or electronic communication.
- The service is excluded from coverage.
- The Member is not eligible for coverage when the service is provided.

The review may consider such factors as the Medical Necessity of services provided, and whether the service involves cosmetic or experimental/investigative procedures.

UM may be conducted via multiple communication paths.

Inpatient medical admissions require UM review. UM for inpatient medical services may include but is not limited to: acute hospitalizations, units described as “sub-acute,” “step-down” and “skilled nursing facility,” designated skilled nursing beds/units; comprehensive outpatient rehabilitation Facilities; rehabilitation units; inpatient hospice; and sub-acute rehabilitation Facilities or transitional living centers. These services are subject to admission review for determination of Medical Necessity and appropriateness, site of service and level of care.

Non-inpatient medical services may require Pre-Service Review.

The list of Pre-certification/Pre-authorization Requirements can be accessed online at anthem.com.

Pre-service Review & Continued Stay Review

A. Provider or Facility shall ensure both requirements (1) and (2) are met: (1) that non-emergency admissions and outpatient procedures that require Pre-certification/Pre-authorization as specified by Anthem are submitted for review and have a decision rendered before the service occurs. Information provided to Anthem UM shall include demographic and clinical information including, but not limited to, primary diagnosis. For information on applicable penalties for non-compliance see Failure to Comply with Utilization Management Program section. (2) For non-emergency admissions, Provider or Facility shall also provide confirmation to Anthem UM of the necessary demographic information and primary diagnosis within twenty-four (24) hours or next Business Day following the Member’s admission.

B. If an Emergency admission has occurred, Provider or Facility shall notify Anthem UM within forty-eight (48) hours or the first Business Day following admission. If the forty-eight (48) hours expires on a day that is not a Business Day the timeframe will be extended to include the next Business Day. Information provided to Anthem UM shall include demographic and clinical information including, but not limited to, primary diagnosis. For information on applicable penalties for non-compliance see Failure to Comply with Utilization Management Program section.

C. Provider or Facility shall verify that the Member’s primary care physician has provided a referral as required by certain Health Benefit Plans.

D. Provider or Facility shall comply with all requests for medical information required to complete Anthem’s UM review up to and including discharge planning coordination. To facilitate the review
process, Provider or Facility shall make best efforts to supply requested information within twenty-four (24) hours of request.

E. Anthem specific Pre-certification/Pre-authorization Requirements may be confirmed on the Anthem web site or by contacting the appropriate phone number on the back of the Member’s ID card.

F. When the review is completed, Anthem will provide electronic or written Notification for all Adverse Determinations to the Member and attending practitioner or treating practitioner, as applicable.

G. UM Review Timeframes follow State, Federal and accreditation requirements as may be applicable to the review.

Medical Policies and Clinical UM Guidelines

Please refer to the Medical Policies and Clinical Utilization Management (UM) Guidelines section of this manual for additional information about Medical Policy and Clinical UM Guidelines.

On-Site Review

If Anthem maintains an on-site Initial Request/Continued Stay Review program, the Facility’s UM program staff is responsible for following the Member’s stay and documenting the prescribed plan of treatment, promoting the efficient use of services and resources, and facilitating available alternative outpatient treatment options. Facility agrees to cooperate with Anthem and provide Anthem with access to Member’s medical records, as well as, access to the Members in performing on-site Initial Request/Continued Stay Review and discharge planning related to, but not limited to, the following:

- Emergency and/or maternity admissions
- Ambulatory surgery
- Case management
- Pre-admission testing ("PAT")
- Inpatient Services, including Neonatal Intensive Care Unit ("NICU")
- Focused procedure review

Certain services such as Transplant may be excluded from on-site review.

Discharge Planning

Discharge planning includes the coordination of medical services and supplies, medical personnel and family to facilitate the Member’s timely discharge to a more appropriate level of care following an inpatient admission.

Observation Bed Policy

Please refer to the “Observation Services Policy” located in the Billing and Reimbursement Guidelines section of the Manual.

Retrospective Utilization Management

Medical records and pertinent information regarding the Member’s care may be reviewed to make a Claim determination.

Failure to Comply With Utilization Management Program

Provider and Facility acknowledge that Anthem may apply monetary penalties such as a reduction in payment, as a result of Provider’s or Facility’s failure to provide notice of admission or obtain Pre-service Review on specified outpatient procedures, as required under this Agreement or for Provider’s or Facility’s failure to fully comply with and participate in any cost management programs and/or UM programs. Members may not be balance billed for penalty amounts. Penalties include but are not limited to the following:
If non-emergency admissions and outpatient procedures that require Pre-certification/Pre-authorization as specified by Blue Cross Blue Shield of Georgia are not submitted for review and a decision rendered before the service occurs payment will be subject to a 100% penalty. Providers and Facilities can only appeal the 100% penalty in order to present evidence of extenuating circumstances.

Payment for emergency inpatient admissions will be subject to a 100% penalty if the notification is not provided within forty-eight (48) hours of admission. Providers and Facilities can only appeal the 100% penalty in order to present evidence of extenuating circumstances. If the forty-eight (48) hours expires on a day that is not a Business Day the time frame will be extended to include the next Business Day.

Utilization Statistics Information

On occasion, Anthem may request utilization statistics for disease management purposes using Coded Services Identifiers. These may include, but are not limited to:

- Member name
- Member identification number
- Date of service or date specimen collected
- Physician name and/or identification number
- HEDIS Measures or any other pertinent information Anthem deems necessary

This information will be provided by Provider or Facility to Anthem at no charge to Anthem.

Electronic Data Exchange

Facility will support Anthem by providing electronic data exchange including, but not limited to, ADT (Admissions, Discharge and Transfer), daily census, confirmed discharge date and other relevant clinical data.

Interactive Care Reviewer (ICR)

Anthem’s Interactive Care Reviewer (ICR) is an online tool and the preferred method for the submission of pre-authorization requests offering a streamlined and efficient experience for Providers requesting inpatient and outpatient medical or behavioral health services for Members covered by Anthem plans. Additionally, Providers can use this tool to make inquiries on previously submitted requests regardless of how they were sent (phone, fax, ICR or other online tool).

- Initiate pre-authorization requests online, eliminates the need to fax.
- Allows detailed text, photo images and attachments to be submitted along with your request.
- Make inquiries on previously submitted requests via phone, fax, ICR or other online tool.
- Instant accessibility from almost anywhere including after business hours.
- Update clinical information when the case is still active.
- Update the case with extension of services or discharge information.
- View, download or print all Provider letters associated to the case.
- Utilize the dashboard to provide a complete view of all ICR submitted UM and behavioral health requests with real time status updates.
- Email Notifications if requested using a valid email address to notify activity on the case.
- Real time decisions for some common procedures.
- Access ICR under Authorizations and Referrals via the Availity Portal.
- Request clinical Appeals for any eligible denied authorization affiliated with your tax id / organization.
- Check the status of clinical appeals

To access on demand training demos and sign up for training webinars on anthem.com, select Prior Authorization under the horizontal claims menu. Select your state and scroll down to the Interactive Care Reviewer (ICR) section

For an optimal experience with Anthem’s Interactive Care Reviewer (ICR) online tool, use a browser that supports 128-bit encryption. This includes Internet Explorer, Chrome, Firefox or Safari.

Anthem’s Interactive Care Reviewer (ICR) online tool is not currently available for the following:

- FEP Members
Non Anthem BlueCard®
Some National Account Members Transplant services
Services administered by vendors such as AIM Specialty Health®. (For these requests, follow the same precertification process that you use today).

**Peer to Peer Review Process**

Upon request from a treating practitioner, who is a licensed or certified professional providing medical care or behavioral healthcare services and directly involved in the Member’s care/treatment plan, Anthem provides a clinical peer-to-peer conversation when an adverse medical necessity determination will be made or has been made regarding health care services for Members. The treating practitioner may offer additional information and/or further discuss his/her cases with a peer clinical reviewer. In compliance with accreditation standards, a practitioner or his/her designee may request the peer-to-peer review. Others such as hospital representatives, employers and vendors are not permitted to do so.

**Quality of Care Incident**

Providers and Facilities will notify Anthem in the event there is a quality of care incident that involves a Member.

**Audits/Records Requests**

At any time Anthem may request on-site, electronic or hard copy medical records, utilization review documentation and/or itemized bills related to Claims for the purposes of conducting audits and reviews to determine Medical Necessity, diagnosis and other coding and documentation of services rendered.

**Case Management**

Case Management assists Members to optimize the use of their benefits and available community resources to gain access to quality health care in all settings.

The Case Management programs help coordinate services for Members with health care needs due to serious, complex, and/or chronic health conditions. The programs coordinate benefits and educate Members who agree to take part in the Case Management program to help meet their health-related needs. Case Management programs are confidential and voluntary and are made available at no extra cost. These programs are provided by, or on behalf of and at the request of, health plan case management staff. These Case Management programs are separate from any Covered Services. If the Member meets program criteria and agrees to take part, we will help the Member meet identified health care needs. This is reached through contact and team work with the Member and/or the Member’s chosen authorized representative, treating Physician(s), and other providers.

In addition, assistance may be provided in coordinating care with existing community-based programs and services. This may include giving information about external agencies and community-based programs and services.

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**AIM Specialty Health® (AIM)**

AIM Specialty Health provides clinical solutions that drive appropriate, safe, and affordable care. Serving more than 50 million members across 50 states, D.C. and U.S. territories, AIM promotes optimal care through use of evidence-based clinical guidelines and real-time decision support for both providers and their patients. The AIM platform delivers significant cost-of-care savings across an expanding set of clinical domains, including radiology, cardiology, oncology, specialty drugs, sleep medicine, REHAB, musculoskeletal care, and genetic testing.

Visit AIM's program websites to find program information, clinical guidelines, interactive tutorials, worksheets & checklists, FAQs, and access to AIM Provider PortalSM

- Radiology: [www.aimprovider.com/radiology](http://www.aimprovider.com/radiology)
- Cardiology: [www.aimprovider.com/cardiology](http://www.aimprovider.com/cardiology)
Submit Pre-certification/Pre-authorization requests to AIM

Ordering and servicing Providers may submit Pre-certification/Pre-authorization requests to AIM in one of the following ways:

- Access AIM ProviderPortal directly at providerportal.com. Online access is available 24/7 to process orders in real-time, and is the fastest and most convenient way to request authorization.
- Access AIM via the Availity Portal at availity.com
- Call the AIM Contact Center toll-free number GA 866-714-1103, and for MSK 866-789-0158 Monday–Friday, 8:00 a.m.–6:00 p.m. ET.

OptiNet® Registration

The OptiNet Registration is an important tool that assists ordering providers in real-time decision support information to enable ordering providers to choose high quality, low cost imaging providers for their patients. Servicing providers need to complete the OptiNet Registration online.

To access the OptiNet Registration:

  - You may also access AIM via the Availity Portal at availity.com
- Once logged into AIM, from the My Homepage screen, choose Access Your OptiNet Registration.
- Select the Registration Type, and choose the Access Your OptiNet Registration button.
- Complete requested information.

The registration does not need to be completed in one sitting. Data can be saved as you proceed through the registration. Once the registration has been submitted, a scorecard will be produced. The score for the Facility will be presented to the ordering Provider when the particular Facility is selected as a place of service, which drives Ordering Provider Decision Support.

For technical questions, contact AIM ProviderPortal Web Support at 800-252-2021 or email Webcustomerservice@aimspecialtyhealth.com. For any other questions, contact your Anthem Provider Relations Representative.

Credentiaing

Anthem’s Discretion

The credentialing summary, criteria, standards, and requirements set forth herein are not intended to limit Anthem’s discretion in any way to amend, change or suspend any aspect of Anthem’s credentialing program (“Credentialing Program”) nor is it intended to create rights on the part of practitioners who seek to provide healthcare services to our Members. Anthem further retains the right to approve, suspend, or terminate
individual physicians and health care professionals, and sites in those instances where it has delegated credentialing decision making.

**Credentialing Scope**

Anthem credentials the following licensed/state certified independent health care practitioners:

- Medical Doctors (MD)
- Doctors of Osteopathic Medicine (DO)
- Doctors of Podiatry
- Chiropractors
- Optometrists providing Health Services covered under the Health Benefit Plan
- Doctors of dentistry providing Health Services covered under the Health Benefit Plan including oral and maxillofacial surgeons
- Psychologists who have doctoral or master's level training
- Clinical social workers who have master's level training
- Psychiatric or behavioral health nurse practitioners who have master's level training
- Other behavioral health care specialists who provide treatment services under the Health Benefit Plan
- Telemedicine practitioners who provide treatment services under the Health Benefit Plan
- Medical therapists (e.g., physical therapists, speech therapists, and occupational therapists)
- Genetic counselors
- Audiologists
- Acupuncturists (non-MD/DO)
- Nurse practitioners
- Certified nurse midwives
- Physician assistants (as required locally)
- Registered Dieticians

The following behavioral health practitioners are not subject to professional conduct and competence review under the Credentialing Program, but are subject to a certification requirement process including verification of licensure by the applicable state licensing board to independently provide behavioral health services and/or compliance with regulatory or state/federal contract requirements for the provision of services:

- Certified Behavioral Analysts
- Certified Addiction Counselors
- Substance Abuse Practitioners

Anthem credentials the following Health Delivery Organizations ("HDOs"):

- Hospitals
- Home Health agencies
- Skilled Nursing Facilities (Nursing Homes)
- Ambulatory Surgical Centers
- Behavioral Health Facilities providing mental health and/or substance abuse treatment in inpatient, residential or ambulatory settings, including:
  - Adult Family Care/Foster Care Homes
  - Ambulatory Detox
  - Community Mental Health Centers ("CMHC")
  - Crisis Stabilization Units
  - Intensive Family Intervention Services
  - Intensive Outpatient – Mental Health and/or Substance Abuse
  - Methadone Maintenance Clinics
  - Outpatient Mental Health Clinics
  - Outpatient Substance Abuse Clinics
  - Partial Hospitalization – Mental Health and/or Substance Abuse
  - Residential Treatment Centers ("RTC") – Psychiatric and/or Substance Abuse
- Birthing Centers
- Home Infusion Therapy when **not** associated with another currently credentialed HDO
The following HDOs are not subject to professional conduct and competence review under the Credentialing Program, but are subject to a certification requirement process including verification of licensure by the applicable state licensing agency and/or compliance with regulatory or state/federal contract requirements for the provision of services:

- Clinical laboratories (CLIA Certification of Accreditation or CLIA Certificate of Compliance)
- End Stage Renal Disease (ESRD) service providers (dialysis facilities) (CMS Certification)
- Portable x-ray Suppliers (FDA Certification)
- Home Infusion Therapy when associated with another currently credentialed HDO (CMS Certification)
- Hospice (CMS Certification)
- Federally Qualified Health Centers (FQHC) (CMS Certification)
- Rural Health Clinics (CMS Certification)

**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’s Credentials Committee (“CC”).

The CC will meet at least once every forty-five (45) calendar 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 designate a chair of the CC, as well as a vice-chair in states or regions where both Commercial and Medicaid contracts exist. In states or regions where Medicare Advantage (“MA”) is represented, a second vice-chair representing “MA” may be designated. The chair must be a state or regional lead medical director, or an Anthem medical director designee and the vice-chair must be a lead medical officer or an Anthem medical director designee, for that line of business not represented by the chair. In states or regions where only one (1) line of business is represented, the chair of the CC will designate a vice-chair for that line of business also represented by the chair. The CC will include at least five (5), but no more than ten (10) external physicians representing multiple medical specialties (in general, the following specialties or practice-types should be represented: pediatrics, obstetrics/gynecology, adult medicine (family medicine or internal medicine); surgery; behavioral health, with the option of using other specialties when needed as determined by the chair/vice-chair). CC membership may also include one (1) to two (2) other types of credentialed health providers (e.g. nurse practitioner, chiropractor, social worker, podiatrist) to meet priorities of the geographic region as per chair/vice-chair’s discretion. At least two (2) of the physician committee members must be credentialed for each line of business (e.g. Commercial, Medicare, and Medicaid) offered within the geographic purview of the CC. The chair/vice-chair will serve as a voting member(s) and provide support to the credentialing/re-credentialing process as needed.

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 (1) 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 practitioners.

During the credentialing process, all information that is obtained is confidential and not subject to review by third parties except to the extent permitted by law. Access to information will be restricted to those individuals who are deemed necessary to attain the objectives of the Credentialing Program. In particular, information supplied by the practitioner or HDO in the application, as well as other non-publicly available information will be treated as confidential. Confidential written records regarding deficiencies found, the actions taken, and the recommended follow-up will be kept in a secure fashion. Security mechanisms include secured office facilities and locked filing cabinets, a protected computer infrastructure with password controls and systematic monitoring, and staff ethics and compliance training programs. The procedures and minutes of the CC will be open to review by state and federal regulating agencies and accrediting bodies to the extent permitted by law.

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, Anthem’s credentialing staff (“Credentialing Department”) will contact the practitioner or HDO within thirty (30) calendar days of the identification of the issue. This communication will 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 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 documented in the practitioner’s credentials file. The practitioner or HDO will be given no less than fourteen (14) calendar days in which to provide additional information. On request, the practitioner will be provided with the status of their credentialing or re-credentialing application.

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 programs or provider Network(s) 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 which are provided to the members to meet their needs and preferences, this information is not required in the credentialing and re-credentialing process. Determinations as to which practitioners and providers require additional individual review by the CC are made according to predetermined criteria related to professional conduct and competence. The CC decisions are based on issues of professional conduct and competence as reported and verified through the credentialing process. Anthem will audit credentialing files annually to identify discriminatory practices, if any, in the selection of practitioners. In the event discriminatory practices are identified through an audit or through other means, Anthem will take appropriate action(s) to track and eliminate those practices.

Initial Credentialing

Each practitioner or HDO must complete a standard application form deemed acceptable by Anthem when applying for initial participation in one (1) or more of Anthem’s Networks or Plan Programs. For practitioners, the Council for Affordable Quality Healthcare (“CAQH”) ProView system is utilized. 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 one hundred eighty (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, among other things, 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 Members.</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 registrations</td>
</tr>
<tr>
<td>• The DEA/CDS registration must be valid in</td>
</tr>
</tbody>
</table>
Verification Element

the state(s) in which practitioner will be treating Members. Practitioners who see Members in more than one (1) state must have a DEA/CDS registration for each state.

Malpractice insurance
Malpractice claims history
Board certification or highest level of medical training or education
Work history
State or federal license sanctions or limitations
Medicare, Medicaid or FEHBP sanctions
National Practitioner Data Bank report
State Medicaid Exclusion Listing, if applicable

B. HDOs

Verification Element

Accreditation, if applicable
License to practice, if applicable
Malpractice insurance
Medicare certification, if applicable
Department of Health Survey Results or recognized Accrediting organization certification
License sanctions or limitations, if applicable
Medicare, Medicaid or FEHBP sanctions

Re-credentialing

The re-credentialing process incorporates re-verification 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 (“Credentialing Standards”).

All applicable practitioners and HDOs in the Network within the scope of the Credentialing Program are required to be re-credentialed every three (3) years unless otherwise required by applicable state 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 Network HDOs, within the scope of the Credentialing Program, meet appropriate standards of professional conduct and competence, they are subject to credentialing and re-credentialing programs. In addition to the licensure and other eligibility criteria for HDOs, as described in detail below, in the “Anthem Credentialing Program Standards” section, 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, the appropriate state oversight agency, or a site survey performed by a designated independent external entity within the past thirty-six (36) months for that HDO.

Re-credentialing of HDOs occurs every three (3) years unless otherwise required by regulatory or accrediting bodies. Each HDO applying for continuing participation in Networks or Plan Programs must submit all required supporting documentation.

Upon 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 re-credentialing cycles, Anthem has established an ongoing monitoring program. The Credentialing Department 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 thirty (30) calendar days of the time they are made available from the various sources including, but not limited to, the following:

1. Office of the Inspector General ("OIG")
2. Federal Medicare/Medicaid Reports
3. Office of Personnel Management ("OPM")
4. State licensing Boards/Agencies
5. Member/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 information received from sources deemed reliable by Anthem.

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.

**Appeals Process**

Anthem has established policies for monitoring and re-credentialing practitioners and HDOs who seek continued participation in one (1) or more of Anthem’s Networks or Plan Programs. 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 Network practitioners and HDOs, as well as those applying for participation, fairly and thus provides practitioners and HDOs with a process to appeal determinations terminating/denying 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 Anthem’s intent to give practitioners and HDOs the opportunity to contest a termination of the practitioner’s or HDO’s participation in one (1) or more of Anthem’s Networks or Plan Programs 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 license suspension, probation or revocation, if a practitioner or HDO has been sanctioned, debarred or excluded from the Medicare, Medicaid or FEHB programs, has a criminal conviction, or Anthem’s determination that the practitioner’s or HDO’s continued participation poses an imminent risk of harm to Members. Participating practitioners and HDOs whose network participation has been terminated due to the practitioner’s suspension or loss of licensure or due to criminal conviction are not eligible for informal review/reconsideration or formal appeal. Participating practitioners and HDOs whose network participation has been terminated due to sanction, debarment or exclusion from the Medicare, Medicaid or FEHB are not eligible for 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 (1) or more of its Networks or Plan Programs, Anthem may have an obligation to report such to the NPDB, state licensing board and 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, the process set forth in the NPDB Guidebook will govern.

**Anthem Credentialing Program Standards**

I. Eligibility Criteria

Health care practitioners:

Initial applicants must meet all of the following criteria in order to be considered for participation:
A. Must not be currently federally sanctioned, debarred or excluded from participation in any of the following programs: Medicare, Medicaid or FEHBP;

B. Possess a current, valid, unencumbered, unrestricted, and non-probationary license in the state(s) where he or she provides services to Members; and

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 or she will treat Members; the DEA/CDS registration must be valid in the state(s) in which the practitioner will be treating Members. Practitioners who see Members in more than one (1) state must have a DEA/CDS registration for each state.

D. Meet the education and training criteria as required by the Company.

In addition, initial applicants must meet one of the following board certification criteria as applicable, in order to be considered for participation. The Company reserves the right, in its reasonable discretion, to waive the board certification or alternative requirement when the Company determines that there are extenuating or special circumstances that warrant the waiver of such requirement.

A. For MDs, DOs, DPMs, and DMDs/DDSs practicing oral and maxillofacial surgery, 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 Foot and Ankle Surgery ("ABFAS"), American Board of Podiatric Medicine ("ABPM"), or American Board of Oral and Maxillofacial Surgery ("ABOMS") in the clinical discipline for which they are applying.

B. If not board certified, MDs and DOs will be granted five (5) years or a period of time consistent with ABMS or AOA board eligibility time limits, whatever is greater, after completion of their residency or fellowship training program to meet the board certification requirement.

C. If not board certified, DPMs will be granted five (5) years after the completion of their residency to meet this requirement for the ABPM. Non-certified DPMs will be granted seven (7) years after completion of their residency to meet this requirement for ABFAS.

D. Individuals no longer eligible for board certification are not eligible for continued exception to this requirement.

1. As alternatives to board certification, MDs and DOs meeting any one (1) of the following criteria will be viewed as meeting the education, training and certification requirement:
   a. Previous board certification (as defined by one (1) of the following: ABMS, AOA, RCPSC, CFPC, ABFAS, ABPM, or ABOMS) in the clinical specialty or subspecialty for which they are applying which has now expired and a minimum of ten (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; or
   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’s Network and the applicant’s professional activities are spent at that institution at least fifty percent (50%) of the time.

2. Practitioners meeting one (1) of these three (3) 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. The above alternatives are subject to Anthem review and approval.

For MDs and DOs, the applicant must have unrestricted hospital privileges at a The Joint Commission ("TJC"), National Integrated Accreditation for Healthcare Organizations ("NIAHO"), Center for Improvement in Healthcare Quality ("CIHQ"), a Healthcare Facilities Accreditation Program ("HFAP") 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 practitioner 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 or omissions;
   2. Application attestation signed date within one hundred eighty (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 Members;
   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 System for Award Management (“SAM”), 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 or she will treat Members. The DEA/CDS registration must be valid in the state(s) in which the practitioner will be treating Members. Practitioners who treat Members in more than one (1) state must have a valid DEA/CDS registration for each applicable state.

Initial applicants who have no DEA/CDS registration will be viewed as not meeting criteria and the credentialing process will not proceed. However, if the applicant can provide evidence that he or she has applied for a DEA/CDS registration, 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/CDS registration is obtained.
   c. The applicant agrees to notify Anthem upon receipt of the required DEA/CDS registration.
   d. Anthem will verify the appropriate DEA/CDS registration via standard sources.
      i. The applicant agrees that failure to provide the appropriate DEA/CDS registration within a ninety (90) calendar 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 seeing Anthem's Members will be notified of the need to obtain the additional DEA, unless the practitioner is delivering services in a telemedicine environment only and does not require a DEA or CDS registration in the additional location(s) where such telemedicine services may be rendered under federal or state law. If the applicant has applied for an additional DEA registration the credentialing process may proceed if all the following criteria are met:
         (a) It can be verified that the applicant’s application is pending; and
         (b) The applicant has made an arrangement for an alternative provider to prescribe controlled substances until the additional DEA registration is obtained; and
         (c) The applicant agrees to notify Anthem upon receipt of the required DEA registration; and
         (d) Anthem will verify the appropriate DEA/CDS registration via standard sources; and
(e) The applicant agrees that failure to provide the appropriate DEA registration within a ninety (90) day timeframe will result in termination from the network.

iii. Office-based practitioners who voluntarily choose to have a DEA/CDS registration that does not include all Controlled Substance Schedules (for example, Schedule II, III or IV), if that practitioner certifies the following:
   (a) controlled substances from these Schedules are not prescribed within his/her scope of practice; and
   (b) he or she must provide documentation that an arrangement exists for an alternative provider to prescribe controlled substances from these Schedules should it be clinically appropriate; and
   (c) DEA/CDS registration is or was not suspended, revoked, surrendered or encumbered for reasons other than those aforementioned.

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 (6) months in the past five (5) years with the exception of those gaps related to parental leave or immigration where twelve (12) month gaps will be acceptable.
14. No convictions, or pleadings of guilty or no contest to, or open indictments of, a felony or any offense involving moral turpitude or fraud. In addition, no other criminal or civil litigation history that together with any other relevant facts, raises a reasonable suspicion of future substandard professional conduct and/or competence. A minimum of the past ten (10) years of malpractice case history is reviewed.
15. Meets Credentialing Standards for education/training for the specialty(ies) in which practitioner wants to be listed in Anthem’s 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 and maxillofacial surgeons;
16. No involuntary terminations from an HMO or PPO;
17. 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. An 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 (5) 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 (1) or more of the criteria required for initial applicants.

B. 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 (3) years of the time the practitioner graduated;

c. Full accreditation is required, candidacy programs will not be considered; and

d. If master's level degree does not meet criteria and practitioner obtained PhD degree 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 American Psychological Association ("APA") or be regionally accredited by the Council for Higher Education Accreditation ("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 (1) 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 (1) 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 (3) years of the time the practitioner graduated;

d. Practitioners with PhD training as a clinical psychologist can be reviewed. To meet criteria this doctoral program must either be accredited by the APA or be regionally accredited by the CHEA. A Practitioner with a doctoral degree in one (1) of the fields of study noted will be viewed as acceptable if the institution granting the degree has regional accreditation from the CHEA and;

e. Licensure to practice independently.

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 (1) of the Regional Institutional Accrediting Bodies within three (3) years of the time of 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; and

d. Valid, current, unrestricted DEA/CDS registration, where applicable with appropriate supervision/consultation by a Network practitioner as applicable by the state licensing board. For those who possess a DEA registration, the appropriate CDS registration is required. The DEA/CDS registration must be valid in the state(s) in which the practitioner will be treating Members.

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 (3) 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; and
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 B.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 (“National Register”) in psychology with an area of expertise in neuropsychology may be considered; and
   c. Clinical neuropsychologists who are not 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 (1) or more of the following:
      i. Transcript of applicable pre-doctoral training;
      ii. Documentation of applicable formal one (1) 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); or
      iv. Minimum of five (5) years’ experience practicing neuropsychology at least ten (10) hours per week.

6. Licensed Psychoanalysts:
   a. Applies only to practitioners in states that license psychoanalysts.
   b. Practitioners will be credentialed as a licensed psychoanalyst if they are not otherwise credentialed as a practitioner type detailed in Credentialing Policy (e.g. psychiatrist, clinical psychologist, licensed clinical social worker).
   c. Practitioner must possess a valid psychoanalysis state license.
      i. Practitioner shall possess a master’s or higher degree from a program accredited by one (1) of the Regional Institutional Accrediting Bodies and may be verified from the Accredited Institutions of Post-Secondary Education, APA, CACREP, or the COAMFTE listings. The institution must have been accredited within three (3) years of the time the practitioner graduates.
      ii. Completion of a program in psychoanalysis that is registered by the licensing state as licensure qualifying; or accredited by the American Board for Accreditation in Psychoanalysis (ABAP) or another acceptable accrediting agency; or determined by the licensing state to be the substantial equivalent of such a registered or accredited program.
         a. A program located outside the United States and its territories may be used to satisfy the psychoanalytic study requirement if the licensing state determines the following: it prepares individuals for the professional practice of psychoanalysis; and is recognized by the appropriate civil authorities of that jurisdiction; and can be appropriately verified; and is determined by the licensing state to be the substantial equivalent of an acceptable registered licensure qualifying or accredited program.
         b. Meet minimum supervised experience requirement for licensure as a psychoanalyst as determined by the licensing state.
         c. Meet examination requirements for licensure as determined by the licensing state.

C. Additional Participation Criteria and Exceptions for Nurse Practitioners, Certified Nurse Midwives, Physicians Assistants (Non Physician) Credentialing.

- Process, requirements and Verification – Nurse Practitioners:
i. The nurse practitioner (NP) applicant will submit the appropriate application and supporting documents as required of any other practitioners with the exception of differing information regarding education/training and board certification.

ii. The required education/training will be, at a minimum, the completion of an education program leading to licensure as a registered nurse, and subsequent additional education leading to licensure as a NP. Verification of this will occur either via verification of the licensure status from the state licensing agency provided that that agency verifies the education or from the certification board if that board provides documentation that it performs primary verification of the professional education and training. If the licensing agency or certification board does not verify highest level of education, the education will be primary source verified in accordance with policy.

iii. The license status must be that of NP as verified via primary source from the appropriate state licensing agency. Additionally, this license must be active, unencumbered, unrestricted and not subject to probation, terms or conditions. Any applicants whose licensure status does not meet these criteria, or who have in force adverse actions regarding Medicare or Medicaid will be notified of this and the applicant will be administratively denied.

iv. If the NP has prescriptive authority, which allows the prescription of scheduled drugs, their DEA and/or state certificate of prescriptive authority information will be requested and primary source verified via normal Anthem procedures. If there are in force adverse actions against the DEA, the applicant will be notified of this and the applicant will be administratively denied.

v. All NP applicants will be certified in the area which reflects their scope of practice by any one (1) of the following:
   1. Certification program of the American Nurse Credentialing Center (www.nursecredentialing.org), a subsidiary of the American Nursing Association (http://www.nursingcertification.org/exam_programs.htm);
   2. American Academy of Nurse Practitioners – Certification Program (www.aanpcertification.org);
   3. National Certification Corporation (http://www.nccwebsite.org);
   4. Pediatric Nurse Certification Board (PNCB) Certified Pediatric Nurse Practitioner – (note: CPN – certified pediatric nurse is not a nurse practitioner) (http://www.pncb.org/pliststore/control/exams/ac/progs);
   5. Oncology Nursing Certification Corporation (ONCC) – Advanced Oncology Certified Nurse Practitioner (AOCNP®) – ONLY (http://oncc.org); or
   6. American Association of Critical Care Nurses (https://www.aacn.org/certification/verify-certification) ACNPC – Adult Care Nurse Practitioner; ACNPC-AG – Adult Gerontology Acute Care. This certification must be active and primary source verified.

This certification must be active and primary source verified. If the state licensing board primary sources verifies this certification as a requirement for licensure, additional verification by Anthem is not required. If the applicant is not certified or if his/her certification has expired, the application will be submitted for individual review.

vi. If the NP has hospital privileges, he or she must have hospital privileges at a CIHQ, TJC, NIHAO, or HFAP accredited hospital, or a network hospital previously approved by the committee. Information regarding history of any actions taken against any hospital privileges held by the nurse practitioner will be obtained. Any adverse action against any hospital privileges will trigger a Level II review.

vii. The NP applicant will undergo the standard credentialing processes outlined in Anthem’s Credentialing Policies (“Credentialing Policies” or Credentialing Policy). NPs are subject to all the requirements outlined in the Credentialing Policies including (but not limited to): the requirement for Committee review of Level II files for failure to meet predetermined criteria, re-credentialing every three (3) years, and continuous sanction and performance monitoring upon participation in the network.

viii. Upon completion of the credentialing process, the NP may be listed in Anthem’s provider directories. As with all providers, this listing will accurately reflect their
specific licensure designation and these providers will be subject to the audit process.

ix. NPs will be clearly identified:
   1. On the credentialing file;
   2. At presentation to the CC; and
   3. Upon notification to Network Services and to the provider database.

- Process, Requirements and Verifications – Certified Nurse Midwives:
  i. The Certified Nurse Midwife (CNM) applicant will submit the appropriate application and supporting documents as required of any other practitioner with the exception of differing information regarding education, training and board certification.
  ii. The required educational/training will be at a minimum that required for licensure as a registered nurse with subsequent additional training for licensure as a Certified Nurse Midwife by the appropriate licensing body. Verification of this education and training will occur either via primary source verification of the license, provided that state licensing agency performs verification of the education, or from the certification board if that board provides documentation that it performs primary verification of the professional education and training. If the state licensing agency or the certification board does not verify education, the education will be primary source verified in accordance with policy.
  iii. The license status must be that of CNM as verified via primary source from the appropriate state licensing agency. Additionally, this license must be active, unencumbered, unrestricted and not subject to probation, terms or conditions. Any applicant whose licensure status does not meet these criteria, or who have in force adverse actions regarding Medicare or Medicaid will be notified of this and the applicant will be administratively denied.
  iv. If the CNM has prescriptive authority, which allows the prescription of scheduled drugs, their DEA and/or state certificate of prescriptive authority information will be requested and primary source verified via normal Anthem procedures. If there are current adverse actions against the DEA, the applicant will be notified and the applicant will be administratively denied.
  v. All CNM applicants will be certified by either:
     1. The National Certification Corporation for Ob/Gyn and neonatal nursing;
     or
     2. The American Midwifery Certification Board, previously known as the American College of Nurse Midwives.
     This certification must be active and primary source verified. If the state licensing board primary source verifies one (1) of these certifications as a requirement for licensure, additional verification by Anthem is not required. If the applicant is not certified or if their certification has expired, the application will be submitted for individual review by the geographic CC.
  vi. If the CNM has hospital privileges, they must have unrestricted hospital privileges at a CIHQ, TJC, NIAHO, or HFAP accredited hospital, or a network hospital previously approved by the committee or in the absence of such privileges, must not raise a reasonable suspicion of future substandard professional conduct or competence. Information regarding history of any actions taken against any hospital privileges held by the CNM will be obtained. Any history of any adverse action taken by any hospital will trigger a Level II review. In the event the CNM provides only outpatient care, an acceptable admitting arrangement via the collaborative practice agreement must be in place with a participating OB/Gyn.
  vii. The CNM applicant will undergo the standard credentialing process outlined in Anthem’s Credentialing Policies. CNMs are subject to all the requirements of the Credentialing Policies including (but not limited to): the requirement for CC review for Level II applicants, re-credentialing every three (3) years, and continuous sanction and performance monitoring upon participation in the network.
  viii. Upon completion of the credentialing process, the CNM may be listed in Anthem’s provider directories. As with all providers, this listing will accurately reflect their specific licensure designation and these providers will be subject to the audit process.
  ix. CNMs will be clearly identified:
     1. On the credentialing file;
2. At presentation to the CC; and
3. Upon notification to network services and to the provider database.

- Process, Requirements and Verifications – Physician’s Assistants (PA):
  i. The PA applicant will submit the appropriate application and supporting documents as required of any other practitioners with the exception of differing information regarding education/training and board certification.
  ii. The required education/training will be, at a minimum, the completion of an education program leading to licensure as a PA. Verification of this will occur via verification of the licensure status from the state licensing agency provided that that agency verifies the education. If the state licensing agency does not verify education, the education will be primary source verified in accordance with policy.
  iii. The license status must be that of PA as verified via primary source from the appropriate state licensing agency. Additionally, this license must be active, unencumbered, unrestricted and not subject to probation, terms or conditions. Any applicants whose licensure status does not meet these criteria, or who have in force adverse actions regarding Medicare or Medicaid will be notified of this and the applicant will be administratively denied.
  iv. If the PA has prescriptive authority, which allows the prescription of scheduled drugs, their DEA and/or state certificate of prescriptive authority information will be requested and primary source verified via normal Anthem procedures. If there are in force adverse actions against the DEA, the applicant will be notified and the applicant will be administratively denied.
  v. All PA applicants will be certified by the National Commission on Certification of Physician’s Assistants. This certification must be active and primary source verified. If the state licensing board primary sources verifies this certification as a requirement for licensure, additional verification by Anthem is not required. If the applicant is not certified or if their certification has expired, the application will be classified as a Level II according to Credentialing Policy #8, as adopted or amended by each Anthem Health Plan and submitted for individual review by the CC.
  vi. If the PA has hospital privileges, they must have hospital privileges at a CIHQ, TJC, NIAHO, or HFAP accredited hospital, or a network hospital previously approved by the committee. Information regarding history of any actions taken against any hospital privileges held by the PA will be obtained. Any adverse action against any hospital privileges will trigger a level II review.
  vii. The PA applicant will undergo the standard credentialing process outlined in Anthem’s Credentialing Policies. PAs are subject to all the requirements described in these Credentialing Policies including (but not limited to): committee review of Level II files failing to meet predetermined criteria, re-credentialing every three (3) years, and continuous sanction and performance monitoring upon participation in the network.
  viii. Upon completion of the credentialing process, the PA may be listed in Anthem provider directories. As with all providers, this listing will accurately reflect their specific licensure designation and these providers will be subject to the audit process.
  ix. PA’s will be clearly identified:
     1. On the credentialing file;
     2. At presentation to the CC; and
     3. Upon notification to Network Services and to the provider database.

D. Currently Participating Applicants (Re-credentialing)

2. Submission of complete re-credentialing application and required attachments that must not contain intentional misrepresentations;
3. Re-credentialing application signed date within one hundred eighty (180) calendar days of the date of submission to the CC for a vote;
4. Must not be currently federally sanctioned, debarred or excluded from participation in any of the following programs; Medicare, Medicaid or FEHBP. If, once a practitioner participates in Anthem’s programs or provider Network(s), federal sanction, debarment or exclusion from the Medicare, Medicaid or FEHBP programs occurs, at the time of identification, the practitioner will become immediately ineligible for participation in the
applicable government programs or provider Network(s) as well as Anthem’s other credentialed provider Network(s).
5. Current, valid, unrestricted, unencumbered, unprobated license to practice in each state in which the practitioner provides care to Members;
6. No new history of licensing board reprimand since prior credentialing review;
7. *No current federal sanction and no new (since prior credentialing review) history of federal sanctions (per SAM, OIG and OPM Reports or on NPDB report);
8. Current DEA/CDS registration and/or state controlled substance certification without new (since prior credentialing review) history of or current restrictions;
9. No new 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 practitioner of similar specialty at a Network HDO who provides inpatient care to Members needing hospitalization;
10. No new (since previous credentialing review) history of or current use of illegal drugs or alcoholism;
11. No impairment or other condition which would negatively impact the ability to perform the essential functions in their professional field;
12. No new (since previous credentialing review) history of criminal/felony convictions, including a plea of no contest;
13. 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 (5) years of malpractice history is evaluated and criteria consistent with initial credentialing is used.
14. No new (since previous credentialing review) involuntary terminations from an HMO or PPO;
15. No new (since previous credentialing review) "yes" answers on attestation/disclosure questions with exceptions of the following:
   a. Voluntary resignation from a hospital or organization related to practice relocation or facility utilization;
   b. Voluntary surrender of state license related to relocation or nonuse of said license;
   c. An NPDB report of a malpractice settlement or any report of a malpractice settlement that does not meet the threshold criteria;
   d. 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);
   e. Previous failure of a certification exam by a practitioner who is currently board certified or who remains in the five (5) year post residency training window;
   f. Actions taken by a hospital against a practitioner’s privileges related solely to the failure to complete medical records in a timely fashion;
   g. History of a licensing board, hospital or other professional entity investigation that was closed without any action or sanction.
16. No quality improvement data or other performance data including complaints above the set threshold.
17. Re-credentialed at least every three (3) years to assess the practitioner’s continued compliance with Anthem standards.

*It is expected that these findings will be discovered for currently credentialed network practitioners and HDOs through ongoing sanction monitoring. Network practitioners and HDOs 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 Network practitioners and HDOs that do not meet one (1) or more of the criteria for re-credentialing.

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, the appropriate state oversight agency, or site survey performed by a designated independent external entity within the past
If a HDO has satellite facilities that follow the same policy and procedures, Anthem may limit site visits to the main facility. Non-accredited HDOs are subject to individual review by the CC and will be considered for Member 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 re-credentialed at least every three (3) 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 Members. The license must be in good standing with no sanctions.
2. Valid and current Medicare certification.
3. Must not be currently federally sanctioned, debarred or excluded from participation in any of the following programs; Medicare, Medicaid or the FEHBP. Note: If, once an HDO participates in Anthem’s programs or provider Network(s), exclusion from Medicare, Medicaid or FEHBP occurs, at the time of identification, the HDO will become immediately ineligible for participation in the applicable government programs or provider Network(s) as well as Anthem’s other credentialed provider Network(s).
4. Liability insurance acceptable to Anthem.
5. If not appropriately accredited, HDO must submit a copy of its CMS, state site or a designated independent external entity 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:

**Medical Facilities**

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<thead>
<tr>
<th>Facility Type (Medical Care)</th>
<th>Acceptable Accrediting Agencies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Care Hospital</td>
<td>CIQH, CTEAM, DNV/NIAHO, HFAP, TJC</td>
</tr>
<tr>
<td>Ambulatory Surgical Centers</td>
<td>AAAASF, AAAHC, AAPSF, HFAP, IMQ, TJC</td>
</tr>
<tr>
<td>Birthing Center</td>
<td>AAAHC, CABC, TJC</td>
</tr>
<tr>
<td>Home Health Care Agencies (HHA)</td>
<td>ACHC, CHAP, CTEAM, DNV/NIAHO, TJC</td>
</tr>
<tr>
<td>Home Infusion Therapy (HIT)</td>
<td>ACHC, CHAP, CTEAM, HQAA, TJC</td>
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<tr>
<td>Skilled Nursing Facilities/Nursing Homes</td>
<td>BOC INTL, CARF, TJC</td>
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**Behavioral Health**

<table>
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<tr>
<th>Facility Type (Behavioral Health Care)</th>
<th>Acceptable Accrediting Agencies</th>
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</thead>
<tbody>
<tr>
<td>Acute Care Hospital—Psychiatric Disorders</td>
<td>CTEAM, DNV/NIAHO, TJC, HFAP</td>
</tr>
<tr>
<td>Adult Family Care Homes (AFCH)</td>
<td>ACHC, TJC</td>
</tr>
<tr>
<td>Adult Foster Care</td>
<td>ACHC, TJC</td>
</tr>
<tr>
<td>Community Mental Health Centers (CMHC)</td>
<td>AAAHC, CARF, CHAP, COA, TJC, HFAP</td>
</tr>
<tr>
<td>Crisis Stabilization Unit</td>
<td>TJC</td>
</tr>
<tr>
<td>Intensive Family Intervention Services</td>
<td>CARF</td>
</tr>
<tr>
<td>Intensive Outpatient – Mental Health and/or Substance Abuse</td>
<td>ACHC, CARF, COA, DNV/NIAHO, TJC</td>
</tr>
<tr>
<td>Outpatient Mental Health Clinic and/or Licensed Behavioral Health Clinics</td>
<td>CARF, CHAP, COA, HFAP, TJC</td>
</tr>
<tr>
<td>Partial Hospitalization/Day Treatment—Psychiatric Disorders and/or Substance Abuse</td>
<td>CARF, DNV/NIAHO, TJC</td>
</tr>
<tr>
<td>Residential Treatment Centers (RTC) – Psychiatric Disorders and/or Substance Abuse</td>
<td>CARF, COA, DNV/NIAHO, HFAP, TJC</td>
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</table>

**Rehabilitation**

<table>
<thead>
<tr>
<th>Facility Type (Behavioral Health Care)</th>
<th>Acceptable Accrediting Agencies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Inpatient Hospital – Detoxification Only Facilities</td>
<td>DNV/NIAHO, HFAP, TJC, CTEAM</td>
</tr>
<tr>
<td>Behavioral Health Ambulatory Detox</td>
<td>CARF, TJC</td>
</tr>
</tbody>
</table>
Quality Improvement Program

Quality Improvement Program Overview

“Together, we are transforming health care with trusted and caring solutions.” We believe health care is local and Anthem has the strong local presence required to understand and meet Member needs. Anthem is well positioned to deliver what Members want: innovative, choice-based products; distinctive service; simplified transactions; and better access to information for quality care. Our local presence and broad expertise create opportunities for collaborative programs that reward Providers and Facilities for clinical quality and excellence. Providers and Facilities are expected to cooperate with Quality Improvement activities. Our commitment to health improvement and care management provides added value to Members and Providers – helping improve both health and health care costs. Anthem takes a leadership role to improve the health of communities and is helping to address some of health care’s most pressing issues. The Quality Improvement (“QI”) Program Description defines the quality infrastructure that supports Anthem’s QI strategies.

- The QI Program Description establishes QI Program governance, scope, goals, objectives, structure, and responsibilities encompassing the quality of medical and behavioral health care and services provided to Members.
- The QI Work Plan is developed and implemented which reflects ongoing progress made on QI activities during the year. The QI Work Plan includes Anthem’s approach to patient safety for Members and improving medical and behavioral health care: quality of clinical care, safety of clinical care, quality of service and Members’ experience.
- The QI Evaluation assesses outcomes of Anthem’s medical and behavioral health care programs, processes, activities and performance in the quality and safety of clinical care and service. The QI Evaluation also evaluates how the QI Program goals and objectives were met.

Goals and Objectives

The following QI Program goals and objectives support Anthem’s vision and values, promote continuous improvement in quality care, patient safety for Members and quality of service to Members, Providers and Facilities:

To develop and maintain a well-integrated system to continuously identify, measure, assess, and improve clinical and service quality outcomes through standardized and collaborative activities.

- To respond to the needs and expectations of internal and external customers by evaluating performance and taking action relative to meeting those needs and expectations, including compliance with regulatory and accreditation requirements, policies and procedures.
- To promote processes that help reduce medical errors and improve patient safety for Members by implementing Member-focused, Provider and safety initiatives.
- To identify and promote educational opportunities for Members, medical and behavioral health care Providers.
- For multicultural health strategies – to improve the health care of Anthem’s multicultural Members.
- To help maximize health status, improve health outcomes and reduce health care costs of Members through effective Case Management (“CM”) and Disease Management (“DM”) programs addressing complex care needs.

As part of the QI Program, initiatives in these major areas include, but are not limited to:

Quality and Safety of Clinical Care
• **Chronic Disease and Prevention**: Anthem focuses on Member and/or Provider/Facility outreach for chronic conditions like asthma, heart disease, diabetes, and Chronic Obstructive Pulmonary Disease (“COPD”) and for preventive health services such as immunizations and cancer screenings. Improvements in these areas result in improved clinical measures such as HEDIS® (Healthcare Effectiveness Data and Information Set)

• **Behavioral Health Case Management**: A program designed to provide a comprehensive and integrated approach to early identification, treatment, intensive case management and individualized recovery support for Members with complex behavioral health conditions who are at risk for negative outcomes and high costs.

• **Community Health**: Anthem has committed resources and worked with key entities to co-create community-based health initiatives to address public health concerns and societal problems including behavioral health/substance abuse disorder, cancer, maternal and child health and addressing health disparities.

• **Disease Management**: The ConditionCare program is designed to help maximize health status, improve health outcomes, and reduce health care costs of Members diagnosed with Asthma (pediatric and adult), Diabetes (type 1 and type 2, pediatric and adult), Coronary Artery Disease (“CAD”), Heart Failure (“HF”) and COPD. The DM program was created and developed based on recent versions of nationally accepted evidence-based Clinical Practice Guidelines (“CPGs”). These guidelines are reviewed at least every two years, and program interventions and protocols are updated accordingly.

• **Health and Wellness**: Programs offer a seamless integration of preventive care, wellness, care management coordination services and online and mobile tools. The programs are clinically driven and designed to help Members better manage individual health and make more informed health care decisions. Programs include: MyHealth Coach (“MHC”), MyHealth Advantage (“MHA”), Neonatal Intensive Care Unit (“NICU”) program, Worksite Wellness, Healthy Lifestyles (“HL”) and Healthwise® Knowledge Base (“HWKB”).

**Service Quality**

Anthem periodically surveys its Members, monitors the quality of care and service of network Providers and strives to provide excellent service to Members, Providers and Facilities. Anthem actively analyzes business processes, trends, identifies and takes action on opportunities to improve the Member, Provider and Facility experience, recommending appropriate activities to address root causes.

**Patient Safety for Members**

Patient safety is the absence of preventable harm to a patient during the process of health care and reduction of risk of unnecessary harm associated with health care to an acceptable minimum (World Health Organization, 2019). The overall goal is to build a safer health system and decrease the occurrence of preventable adverse events and hospital acquired conditions by creating a safety culture that improves the delivery of health care and health outcomes and raises awareness of patient safety related issues by providing tools and education for Members regarding patient safety issues.

1 HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

**Member Rights and Responsibilities**

The delivery of quality health care requires cooperation between Members, their Providers and Facilities and their health care benefit plans. One of the first steps is for Members, Providers and Facilities to understand member rights and responsibilities. Therefore, Anthem has adopted a Members’ Rights and Responsibilities statement, which can be accessed by going to anthem.com. Select the Provider link at the top of the landing. Select Policies, Guidelines and Manuals (under the Provider Resources column), if needed pick your state using the Change State link at the top right. Scroll down and select the Read about Member
Rights link under the More Resources/Member Rights and Responsibilities section, then choose “What are my rights as a member?”. Members or Providers who do not have access to the website can request copies by contacting Anthem. If Members need more information or would like to contact us, go to anthem.com and select Contact Us at the bottom of the page. Members can call the Member Services number, and Providers can call the Provider Services number on the back of the Member ID card.

Continuity and Coordination of Care

Anthem encourages communication between all physicians, including primary care physicians (PCPs) and medical specialists, as well as other health care professionals who are involved in providing care to Anthem Members. Please discuss the importance of this communication with each Member and make every reasonable attempt to elicit permission to coordinate care at the time treatment begins. HIPAA allows the exchange of information between Covered Entities for the purposes of Treatment, Payment and Health Care Operations.

The Anthem QI Program is an ongoing and integrative program, which features a number of evaluative surveys and improvement activities designed to help ensure the continuity and coordination of care across physician and other health care professional sites, enhancing the quality, safety, and appropriateness of medical and behavioral health care services offered by Providers.

Continuity of Care/Transition of Care Program

This program is for Members when their Provider or Facility terminates from the network and new Members (meeting certain criteria) who have been participating in active treatment with a provider not within Anthem’s network.

Anthem makes reasonable efforts to notify Members affected by the termination of a Provider or Facility according to contractual, regulatory and accreditation requirements and prior to the effective termination date. Anthem also helps them select a new Provider or Facility.

Anthem will work to facilitate the Continuity of Care/Transition of Care (COC/TOC) when Members, or their covered dependents with qualifying conditions, need assistance in transitioning to in-network Providers or Facilities. The goal of this process is to minimize service interruption and to assist in coordinating a safe transition of care. Completion of Covered Services may be allowed at an in-network benefit and reimbursement level with an out-of-network provider for a period of time, according to contractual, regulatory and accreditation requirements, when necessary to complete a course of treatment and to arrange for a safe transfer to an in-network Provider or Facility.

Completion of Covered Services by a Provider or Facility whose contract has been terminated or not renewed for reasons relating to medical disciplinary cause or reason, fraud or other criminal activity will not be facilitated.

Members may contact Customer Care to get information on Continuity of Care/Transition of Care.

Quality-In-Sights®: Hospital Incentive Program (Q-HIP SM)

The Quality-In-Sights®: Hospital Incentive Program (Q-HIP®) is our performance-based reimbursement program for hospitals. The mission of Q-HIP is to help improve patient outcomes in a hospital setting and promote health care value by financially rewarding hospitals for practicing evidence-based medicine and implementing best practices. Q-HIP strives to promote improvement in health care quality and to raise the bar by moving the bell shaped “quality curve” to the right towards high performance.

Q-HIP measures are credible, valid, and reliable because they are based on measures developed and endorsed by national organizations which may include:

- American College of Cardiology (ACC)
- Center for Medicare and Medicaid Services (CMS)
- Institute for Healthcare Improvement (IHI)
In order to align Q-HIP goals with national performance thresholds, the Q-HIP benchmarks and targets are based on national datasets such as the Centers for Medicare and Medicaid Services’ Hospital Compare database. The measures can be tracked and compared within and among hospital[s] for all patient data – regardless of health plan carrier.

Annual meetings are held with participating hospitals from across the country, offering participants an opportunity to share feedback regarding new metrics and initiatives. Additionally, a National Advisory Panel on Value Solutions (“NAPVS”) was established in 2009 to provide input during the scorecard development process. The NAPVS is made up of patient safety and quality leaders from health systems and academic medical centers from across the country and offers valuable advice and guidance as new measures are evaluated for inclusion in the program.

Participating hospitals are required to provide Anthem with data on measures outlined in the Q-HIP Manual. Q-HIP measures are based on commonly accepted indicators of hospitals' quality of care. Participating hospitals will receive a copy of their individual scorecard which shows their performance on the Q-HIP measures.

**Quality-In-Sights®: Primary Care Incentive Program**

The Quality-In-Sights Primary Care Incentive Program rewards physician practices for meeting or exceeding established targets related to quality, patient safety, applicable external recognition programs, and adoption of technology.

**Specialties included in the Quality-In-Sights Primary Care Incentive Program**

The program is open to Provider and Facilities who specialize in Family Medicine, General Practice, Internal Medicine and/or Pediatrics as their designated primary specialty, who meet eligibility requirements and who provide primary care services to Members of Anthem and Anthem enrolled in a HMO, Point of Service or PPO Health Benefit Plan product.

**Performance Data**

**Provider/Facility Performance Data** means 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 would 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). Provider/Facility Performance Data may be used for multiple Plan programs and initiatives, including but not limited to:

- **Reward Programs** – Pay for performance (P4P), 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.

**Member Safety**

Leapfrog Group
The Leapfrog Group is a voluntary program aimed at mobilizing employer purchasing power to alert America's health industry that big leaps in health care safety, quality and customer value will be recognized and rewarded. Among other initiatives, Leapfrog works with its employer members to encourage transparency and easy access to health care information as well as rewards for hospitals that have a proven record of high quality care.

The Leapfrog Group aims to:
- Reduce preventable medical mistakes and improve the quality and affordability of health care.
- Encourage health providers to publicly report their quality and outcomes so that consumers and purchasing organizations can make informed health care choices.
- Reward doctors and hospitals for improving the quality, safety and affordability of health care.
- Help consumers reap the benefits of making smart health care decisions.
- Network hospitals are encouraged to join the Leapfrog Group and implement policies to reduce medical errors and improve Member safety. In 2006, there was a 30% increase in HMO/POS participation/response to survey and a 20% increase in the PPO participation/response to survey. There was a significant increase in the 'Evidenced Based Hospital Referral' (EHR) leap and 100% of facilities attained the "Fully implemented" rating for "National Quality Forum-Endorsed Safe Practices" (NQF-S) leap.

If your hospital has not completed the survey, you can do so by logging on to the Leapfrog Group Web site at www.leapfroggroup.org.

**Partnership for Health and Accountability**

Georgia's Partnership for Health and Accountability ("PHA"), initiated with the funding of Georgia Hospital Association, an Association of Hospitals and Health Systems, recognizes Member safety as its top priority and describes the elements that support a culture of safety in healthcare organizations. Among these are a pervasive commitment to Member safety, open communication, a blame-free environment, and the importance of safety design in preventing future errors. Acknowledging that success in creating a culture of safety requires the commitment of both organizational leadership and frontline health care workers; PHA stresses the critical role of physicians and employees in the process.

PHA brings together the healthcare field with agencies and individuals to ensure quality and safety in healthy communities. PHA assists in strengthening collaboration between providers, community members, and other stakeholders by providing education and data-driven tools to facilitate improvement.

Anthem serves on the PHA Advisory Council, whose role is to provide advice, develop consensus and make recommendations on major issues and communicate that information to their constituent groups and others that affect health policy throughout the state.

**Health Insurance Portability & Accountability Act (HIPAA)**

Anthem is HIPAA compliant and any request for information or records from a provider is made within the boundaries of HIPAA regulations.

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**Overview of HEDIS®**

HEDIS (Healthcare Effectiveness Data and Information Set) is a set of standardized performance measures used to compare the performance of managed care plans and physicians based on value rather than cost. HEDIS is coordinated and administered by NCQA and is one of the most widely used sets of health care performance measures in the United States. Anthem’s HEDIS Quality Team is responsible for collecting clinical information from Provider offices in accordance with HEDIS specifications. Record requests to Provider offices begin in mid January and Anthem requests that the records be returned within 5 business days to allow time to abstract the records and request additional information from other Providers, if needed. Health plans use HEDIS data to encourage their contracted providers to make improvements in the quality
of care and service they provide. Employers and consumers use HEDIS data to help them select the best health plan for their needs.

For more information on HEDIS visit Anthem.com, Select Providers, Select Forms and Guides (under the Provider Resources column), if needed pick the state using the Change State link at the top right. Scroll down and select Forms and Guides, then scroll down and select HEDIS in the Category drop down.

HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

CAHPS

CAHPS® (Consumer Assessment of Healthcare Providers and Systems) surveys represent an effort to accurately and reliably capture key information from Anthem’s Members about their experiences with Anthem’s Health Plans in the past year. This includes the Member’s access to medical care and the quality of the services provided by Anthem’s network of Providers. Anthem analyzes this feedback to identify issues causing Members dissatisfaction and works to develop effective interventions to address them. Anthem takes this survey feedback very seriously.

Health Plans report survey results to National Committee for Quality Assurance (“NCQA”), which uses these survey results for the annual accreditation status determinations and to create National benchmarks for care and service. Health Plans also use CAHPS® survey data for internal quality improvement purposes.

Results of these surveys are shared with Providers annually via our provider newsletter, so they have an opportunity to learn how Anthem Members feel about the services provided. Anthem encourages Providers to assess their own practice to identify opportunities to improve patients’ access to care and improve interpersonal skills to make the patient care experience a more positive one. Our Provider newsletters can be found online at anthem.com/provider/news.

® CAHPS is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

Clinical Practice Guidelines

Anthem considers clinical practice guidelines to be 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 such as, National Heart, Lung and Blood Institute, American Diabetes Association and the American Heart Association, 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.

Providers can access the up-to-date listing of the medical, preventive and behavioral health guidelines online. To access the guidelines, go to anthem.com. Select Providers and your state then select Policies, Guidelines and Manuals from the horizontal menu under Provider Resources. Scroll to Clinical Practice Guidelines and select Download Index

With respect to the issue of coverage, each Member should review his/her Certificate of Coverage and Schedule of Benefits for details concerning benefits, procedures and exclusions prior to receiving treatment. The Certificate of Coverage and/or Schedule of Benefits supersedes the clinical practice guidelines.
Preventive Health Guidelines

Anthem considers prevention an important component of health care. Anthem develops preventive health 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 Obstetrics and Gynecology (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 and/or preventive health mandates. We encourage physicians to utilize these guidelines to improve the health of our Members.

The current guidelines are available online. To access the guidelines, go to anthem.com. Select Providers and your state then select Policies, Guidelines and Manuals from the horizontal menu under Provider Resources. Scroll to Preventive Health Guidelines and select Review the guidelines

With respect to the issue of coverage, each Member should review his/her Certificate of Coverage and Schedule of Benefits for details concerning benefits, procedures and exclusions prior to receiving treatment. The Certificate of Coverage and/or Schedule of Benefits supersede the preventive health guidelines.

Medical Records Standards

Anthem recognizes the importance of medical record documentation in the delivery and coordination of quality care. Anthem has medical record standards that require Providers and Facilities to maintain medical records in a manner that is current, organized, and facilitates effective and confidential medical record review for quality purposes.

For more information on Medical Record Standards visit Anthem.com, select Providers, select Forms and Guide (under the Provider Resources column), if needed pick your state using the Change State link at the top right, then scroll down and select Medical Records in the Category drop down.

Multicultural Health

Multicultural Health Overview

Anthem identifies and addresses health and healthcare disparities among Members based on key clinical quality metrics, evidence-based research, and member experience metrics. We aim to help eliminate these disparities and promote health equity. Our core strategies for helping to mitigate disparities and achieve equity include the following:

1. Monitor the quality of health care to identify actionable health and health care disparities trends
   a. Identify clinical and geographic areas exhibiting health and health care disparities and design appropriate interventions to help close those gaps
   b. Establish baseline data and measures/evaluates the results of program interventions
   c. Support Member access to equitable treatment, standards of care and services based on their Plan benefits
2. Promote Culturally and Linguistically Appropriate Services ("CLAS")
   a. Offer education, tools and subject matter expertise to Providers and Facilities that may help them achieve the shared goal of providing quality care and service equally to their patients
   b. Facilitate cultural competency of Anthem associates to help meet the Members’ needs for access to culturally sensitive, linguistically appropriate care and service
c. Offer education, tools and subject matter expertise to Members that may help them improve their health literacy, allowing better communication with their doctors and Anthem about their health care and service

d. Promote the Department of Health and Human Services Office of Minority Health’s National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (the National CLAS standards). [https://www.thinkculturalhealth.hhs.gov/clas/standards](https://www.thinkculturalhealth.hhs.gov/clas/standards)

3. Develop programs to help improve health status and outcomes

a. Promote consumer-centered care that addresses the Members’ values, needs and preferences in reaching optimal health care and outcomes standards

b. Support communities in which Anthem does business with cultural and linguistic programs and services

c. Collaborate with other industry and government efforts to help reduce and eliminate health disparities

Anthem Innovation

**MyDiversePatients.com**: An online resource to support your diverse patient panel

Anthem strives to meet the needs of our diverse membership and promotes access to consistently high quality standards across our networks. We believe that by offering our Providers and Facilities the types of learning experiences described above, we can help keep all our Members healthy. In addition, these online experiences reinforce our commitment to promoting health equity for our diverse Members as referenced in our Provider and Facility contractual non-discrimination provisions.

All learning experiences can be found on MyDiversePatients.com, a website that features robust resources for Providers to help support addressing racial and ethnic disparities in health and health care:

- CME learning experiences about disparities, potential contributing factors, and opportunities for Providers to enhance care.
- Real-life stories about diverse patients and the unique challenges they face.
- Tips and techniques for working with your diverse patients to promote improvement in health outcomes.

While there’s no single easy answer to the issue of health care disparities, the vision of MyDiversePatients.com is to start reversing these trends…one patient at a time.

Embrace the knowledge, skills, ideals, strategies, and techniques to accelerate your journey to becoming your patients’ trusted health care partner by visiting MyDiversePatients.com today. Descriptions of the learning experiences and tools are listed below.

**Moving Toward Equity in Asthma Care**

Built upon extensive research and data analytics, the “Moving Toward Equity in Asthma Care” online CME experience offers 1 hour of Continuing Medical Education (“CME”) credit through the American Academy of Family Physicians, and includes scenarios that fulfill the following learning objectives:

- Describe common racial and ethnic asthma disparities – and their effects on diverse patients’ ability to successfully control their asthma.
- Describe ways Providers may unknowingly contribute to poor asthma care for diverse populations.
- Explain ways Providers can improve the quality of asthma care to enhance outcomes among African Americans, Hispanic and Asian patients.
- Explain the importance of using spirometry to assess the severity of asthma accurately.
- Explain the concept of “unconscious bias.”

A “Resources” section contains additional information on asthma disparities.

The experience was developed in an effort to address the substantial gaps in asthma care and outcomes for diverse populations and can be accessed at [www.mydiversepatients.com/le-asthma.html](http://www.mydiversepatients.com/le-asthma.html).
Primary Audiences include: Physicians (Family Practice, Pediatrician, Pulmonologist, Allergist Immunologist), Nurse Practitioners, Registered Nurse (RN), Licensed Vocational Nurse (LVN), and Licensed Practical Nurse (LPN).

**Asthma & Me App**
Are you looking for innovative ways to educate and engage your patients with asthma? The Asthma & Me app is an interactive and fun way to show patients the physiology of their asthma. The app is a free support tool that uses face detection technology along with augmented reality to simulate a diseased airway.

- When the camera on the mobile device is aimed at the patient’s face, an animation of the lungs is overlaid and a short video illustrating the physiology of an asthma attack is produced and recorded.
- The video can be used to facilitate discussion with the patient about what occurs during an asthma attack – airway inflammation, bronchiole constriction, and mucus production.
- The video can be saved and shared via social media or email.
- The app is currently available in three languages: English, Spanish, and Tagalog. The language is selected based on the patient’s smartphone or tablet settings.

The Asthma & Me app can be accessed at [MyDiversePatients.com](http://MyDiversePatients.com) using your smartphone, tablet, or computer. The app supplements the “Moving Toward Equity in Asthma Care” online provider CME experience, which is also available on the site as well as [www.mydiversepatients.com/le-asthma.html](http://www.mydiversepatients.com/le-asthma.html).

**Creating an LGBT-Friendly Practice**
What you may not know about your Lesbian, Gay, Bisexual, or Transgender (“LGBT”) patients may be putting their health at risk. Studies have shown that many LGBT patients fear they will be treated differently in health care settings and that this fear of discrimination prevents them from seeking primary care. Anthem joins you in striving for the best clinical outcomes for everyone, including LGBT populations. That’s why Anthem has created an online experience that provides strategies, tools, and resources to Providers and Facilities interested in attracting or maintaining an LGBT patient panel. Hopefully, as a result of increasing LGBT-friendly practices, we will see an increase in primary care and prevention among LGBT patients. Like you, Anthem strives to meet the needs of our diverse membership and promotes access to consistently high quality standards across our networks. We believe that by offering our Providers and Facilities these types of experiences, we can help keep all our Members healthy. In addition, this online experience reinforces our commitment to equality for our LGBT Members as referenced in our Provider and Facility contractual non-discrimination provisions.

Visit [www.mydiversepatients.com/le-lgbt.html](http://www.mydiversepatients.com/le-lgbt.html) for free 24/7 access to the experience – either via computer, tablet or smartphone. The course has been approved for 1 AAFP Prescribed credit, which is equivalent to AMA PRA Category 1 Credit™.

**Reducing Health Care Stereotype Threat (“HCST”): Assuring your diverse patients they are not being judged due to their race/ethnicity**
Your diverse patients may feel threatened about being personally reduced to group stereotypes. Their fear of being prejudged or stigmatized based on phenotype may be omnipresent throughout their life journeys and may be present during health care interactions with you or your team. A perceived health care stereotype threat is not the same as discrimination. Instead, it is a situational, psychosocial phenomenon that may contribute to disparities.

As a trusted health care Provider, you can make a difference. Find out how to recognize when your patients may be experiencing this threat. Then explore how to foster a threat-safe environment with practical shifts you can make today.

Visit the Provider pages online at [www.mydiversepatients.com/le-hcst.html](http://www.mydiversepatients.com/le-hcst.html) for free 24/7 access to the experience – either via your computer, tablet or smartphone. You will better understand Health Care Stereotype Threat (HCST) and its implications for multicultural patient groups and also learn how to recognize when your patients may be experiencing HCST. In addition, you will learn the benefits of reducing HCST to both your patients and your practice. The course is approved for 1 AAFP Prescribed credit, which is the equivalent to AMA PRA Category 1 Credit™.
Medication Adherence

You want what’s best for your patients’ health. So, it's challenging when a patient doesn't follow your prescribed treatment plan. Why do approximately 50% of patients with chronic illness stop taking their medications within one year of being prescribed1? Where’s the disconnect? What can be done differently?

As a health care provider, you care about your patients. However, you may only be seeing and hearing the tip of the iceberg—the observable portion of the thoughts and emotions your patient is experiencing. The barriers that exist under the waterline -- the Titanic-sized, often invisible, patient self-talk that may not get discussed -- can create a misalignment between patient and provider.

So we’ve created an online learning experience for the skills and techniques that may help you navigate these uncharted patient waters. After completing the learning experience you’ll know how to see the barriers, use each appointment as an opportunity to build trust, and bring to light the concerns that may be occurring beneath the surface of your patient interactions. Understanding and addressing these concerns may help improve medication adherence—and you'll earn CME credit along the way. The course is approved for 1 AAFP Prescribed credit, which is the equivalent to AMA PRA Category 1 Credit™.

Take the next step. Go to MyDiversePatients.com > The Medication Adherence Iceberg: How to navigate what you can’t see to enhance your skills.


Centers of Medical Excellence

Anthem currently offers access to Centers of Medical Excellence (“CME”) programs in solid organ and blood/marrow transplants, bariatric surgery, cancer care, cardiac care, maternity, spine surgery, and knee/hip replacement surgery. As much of the demand for CME programs has come from National Accounts, most of our programs are developed in partnership with the Blue Cross and Blue Shield Association (“BCBSA”) and other Blue plans to ensure adequate geographic coverage. The BCBSA refers to its designated CME providers as Blue Distinction Centers for Specialty Care™ (“BDC”). Using objective information and input from the medical community, the BCBSA has designated hospitals as Blue Distinction Centers that are proven to outperform their peers in the areas that matter to you – quality, safety and, in the case of Blue Distinction Centers+ (“BDC+”), cost efficiency.

For transplants and ventricular assist devices (“VAD”), Members also have access to the Anthem Centers of Medical Excellence Transplant and VAD Network. The CME designation is awarded to qualified programs by a panel of national experts currently practicing in the fields of solid organ, bone marrow transplantation, and cardiac surgery representing centers across the country. Each Center must meet Anthem’s CME participation requirements and is selected through a rigorous evaluation of clinical data that provides insight into the Facility's structures, processes, and outcomes of care. Current transplant designations include the following transplants: autologous/allogeneic bone marrow/stem cell, heart, lung, combination heart/lung, liver, kidney, simultaneous kidney/pancreas and pancreas.

For both the BDC and Anthem CME programs, selection criteria are designed to evaluate overall quality, providing a comprehensive view of how the Facility delivers specialty care. More information on the programs can be accessed online at anthem.com. To view the BDC and Anthem CME program information Click Here

Transplant

- Blue Distinction Centers for Transplant™ (“BDCT”) launched in 2006.
More than 115,082 people in the United States were waiting for a lifesaving organ transplant from one of the nation's more than 140 transplant centers in 2017. There were nearly 34,800 organ transplants in 2017. This was the fifth consecutive record-breaking year.

Blue Distinction Centers and Blue Distinction Centers+ for Transplants have demonstrated their commitment to quality care, resulting in better overall outcomes for transplant patients. Each Facility meets stringent clinical criteria, established in collaboration with expert physicians' and medical organizations' recommendations**, including the Center for International Blood and Marrow Transplant Research ("CIBMTR"), the Scientific Registry of Transplant Recipients ("SRTR"), and the Foundation for the Accreditation of Cellular Therapy ("FACT"), and is subject to periodic re-evaluation as criteria continue to evolve. Both Blue Distinction Centers and Blue Distinction Centers+ for Transplants help simplify the administrative process involved in this complex care so that patients, their families, and physicians can focus on the medical issues.

Hospitals receiving the Blue Distinction Center+ for Transplants designation have met the Blue Distinction Centers' standards for quality while also demonstrating better cost-efficiency relative to their peers.

The Anthem CME Transplant Network is a wrap-around network to the BDCT program and offers Members access to an additional 60 transplant facilities. When BDCT and Anthem CME are combined, Members have access to 200 transplant specific programs for heart, lung, combined heart/lung, liver, liver kidney, pancreas, kidney, combined kidney/pancreas, and bone marrow/stem cell transplant.

Cardiac Care

Blue Distinction Centers for Cardiac Care® launched in January 2006.

According to the Centers for Disease Control and Prevention, the number of adults with a diagnosis of heart disease is 27.6 million, and the percent of adults with diagnosed heart disease is 11.5%. Heart Disease is the #1 Cause of death in the United States.

Research shows that Blue Distinction Centers and Blue Distinction Centers+ demonstrate better quality and improved outcomes for patients, with lower rates of complications following certain cardiac procedures and lower rates of healthcare associated infections compared with their peers. Blue Distinction Centers+ are also 20 percent more cost-efficient than non-designated hospitals for those same cardiac procedures.

Blue Distinction Centers and Blue Distinction Centers+ for Cardiac Care provide a full range of cardiac care services, including inpatient cardiac care, cardiac rehabilitation, cardiac catheterization and cardiac surgery (including coronary artery bypass graft surgery).

Bariatric Surgery

Blue Distinction Centers for Bariatric Surgery® launched in 2008

According to the National Center for Health Statistics report released in November 2015: Prevalence of Obesity among Adults and Youth has grown to more than one-third (36.5%) of U.S. adults which have been diagnosed with obesity, and 32.3% for young adults aged 20-39. Obesity-related conditions include heart disease, stroke, type 2 diabetes and certain types of cancer, which are some of the leading causes of preventable death.

Blue Distinction Centers for Bariatric Surgery have demonstrated their commitment to quality care, resulting in better overall outcomes for bariatric patients. Each facility meets stringent clinical criteria, developed in collaboration with expert physicians and medical organizations, including the American Society for Metabolic and Bariatric Surgery ("ASMBS") and the American College of Surgeons ("ACS"), and is subject to periodic re-evaluation as criteria continue to evolve.
The 2017 Blue Distinction Centers for Bariatric Surgery program uses updated Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program ("MBSAQIP") accreditation levels, which focus on site of service. With this design change, each facility can apply to achieve the BDC or BDC+ designation, as either a Comprehensive Center (including outpatient capability) or an Ambulatory Surgery Center ("ASC").

Cancer Care

Blue Distinction Centers for Cancer Care is a new national designation program that recognizes physicians, physician practices, cancer centers, and hospitals for their efforts in coordinating all types of cancer care. This program incorporates patient-centered and data-driven practices, to coordinate care better and to improve quality of care and safety, as well as affordability. Providers in this Program are paid under a provider agreement with their local BCBS Plan that has value-based reimbursement, rather than traditional fee-for-service, so they must perform against both quality and cost outcome targets in order to receive incentives and rewards for better health outcomes.

Designations will be awarded on an ongoing basis, and the program will continue to expand in the future.

Spine Surgery

Blue Distinction Centers for Spine Surgery® launched in November 2009.

Studies confirm that as many as eight out of 10 Americans suffer from some sort of back pain. Many ways to treat back pain are available, and your doctor can guide you toward the most appropriate recommendation for your situation. For those with severe and/or chronic back pain, spine surgery may be a treatment option.

Research confirms that hospitals designated as Blue Distinction Centers and Blue Distinction Centers+ for Spine Surgery have fewer complications and fewer hospital readmissions than non-designated hospitals. Blue Distinction Centers+ for Spine Surgery also deliver care more efficiently than their peers.

Blue Distinction Centers and Blue Distinction Centers+ for Spine Surgery provide comprehensive inpatient spine surgery services, including discectomy, fusion and decompression procedures.

To date, we have designated hospitals in the majority of states across the U.S.

Knee and Hip Replacement

Blue Distinction Centers for Knee and Hip Replacement™ launched in November 2009.

Blue Distinction Centers and Blue Distinction Centers+ for Knee and Hip Replacement provide comprehensive inpatient knee and hip replacement services, including total knee replacement and total hip replacement surgeries.

Maternity Care

Blue Distinction Centers and Blue Distinction Centers+ for Maternity Care launched in 2016 and offers access to healthcare facilities with demonstrated expertise and a commitment to quality care during the delivery episode of care, which includes both vaginal and cesarean section delivery.
The Maternity Care designation uses publicly available data from Hospital Compare data which includes the Early Elective Delivery (PC-01) and elected patient experience measures at the facility level from Hospital Consumer Assessment of Healthcare Providers and Systems ("HCAHPS").

**Substance Use Treatment and Recovery**

- Blue Distinction Centers for Substance Use Treatment and Recovery launched in January of 2020 to address the treatment of substance use disorders, including opioid use disorder.

- The program aims to improve patient outcomes and cost by addressing the fragmented delivery of substance use disorder treatment. Designations are awarded based on quality criteria that support delivery of timely, coordinated, multidisciplinary, evidence-based care, with a focus on quality improvement and patient-centered care.

**Ventricular Assist Devices**

- Anthem’s Center of Medical Excellence Ventricular Assist Device (VAD), small implantable pumps that assist the heart by pumping blood in the circulatory system of individuals with end-stage heart failure, launched in 2017.

- According to the Centers for Disease Control and Prevention Heart failure reports that about 5.7 million adults in the United States have heart failures a major public health problem associated with significant hospital admission rates, mortality, and costly health care services.

- Based on registry data, >15,000 left ventricular assist devices (LVADs) were implanted from June 2006 to December 2014. An estimated 3000+ VADs will be implanted worldwide this year, but the volume is expected to increase as newer, smaller devices receive regulatory approval, clinical indications slowly expand and the continued increase in centers certified to place these devices.

**Chimeric Antigen Receptor Therapy (“CAR-T”) Cla**

- The FDA has approved a new product Chimeric Antigen Receptor T-cell (CAR-T), a CD19-directed genetically modified autologous T cell immunotherapy which brings new treatment options for cancer patients.

- Two (2) Chimeric Antigen Receptor T cell therapies (CAR-T) have been recently approved by the FDA to treat certain patients with leukemia and lymphoma:

  1. Yescarta for treatment in Adult Patients

  2. Kymriah for treatment in Pediatric and Adult Patients

- These procedures can be performed in the Inpatient (IP) or Outpatient (OP) setting and Care and follow-up continues over the first year.

- These Members are managed by the transplant Case Managers and Anthem Medical Policy requires the procedure be performed at a Certified CAR-T center.

- Currently there is not a designation or contract for CAR-T therapy and each case requires a Letter of Agreement. In 2020 Anthem Centers of Medical Excellence will have a designation and contract for CAR-T

- The Blue Cross Blue Shield Association will also have a designation, but not a contract requirement for CAR-T Providers in 2019.
ACA-compliant health plans
The affordable Care Act (ACA) applies to individuals and small group health plans. These plans can be purchased from the state’s Health Insurance Marketplace, which is commonly referred to as the exchange. Plans can also be purchased off the exchange from traditional sources, such as sales agent.

BlueChoice PPO
BlueChoice PPO is the name of Anthem’s PPO product. BlueChoice PPO provides in-Network benefits and out-of-Network benefits; the Member has the option to choose either a preferred Provider or Facility and have benefits paid at the higher in-Network benefit rate, or a non-preferred provider and have benefits paid at the lower out-of-Network benefit rate.

BlueChoice HMO
BlueChoice Healthcare Plan is the name of the HMO product. This plan is built on the PCP model, emphasizing the PCP as the coordinator of a Member’s health care. Physicians in the following specialties are eligible PCPs:
- Family Practice
- General Practice
- Internal Medicine
- Pediatrics

BlueChoice HMO plan is designed to keep Members healthy. When illness occurs, the plan provides for quality care in the most appropriate setting at an affordable cost to employers and Members. Members have the freedom to select their PCP from a panel of Providers. The PCP provides and arranges all necessary medical services, including preventive care and treatment for illnesses and injuries. The PCP also coordinates referral specialist services and hospitalizations among Providers.

BlueChoice Option
BlueChoice Option is the name of the Point of Service (POS) product. A POS plan is a hybrid of an HMO and traditional indemnity coverage. What distinguishes a POS plan from an HMO plan is the inclusion of out-of-Network benefits.

BlueChoice Option Members are considered in-Network when they access all healthcare services through their designated PCP and use the services of a Network Provider. If a Member uses out-of-Network services that are not coordinated by the PCP, his or her benefits are paid at a lower rate, which results in higher out-of-pocket expenses.

Blue Open Access
Blue Open Access is the name of the next generation Open Access product. Blue Open Access Members are not required to select a PCP and are able to access specialty care through a BlueChoice HMO Specialty Care Physician without a referral from a PCP. Members will be encouraged to establish or maintain a relationship with a PCP, since that physician would be most knowledgeable of the Member’s medical history.

Blue Open Access Members will have a specifically branded Member ID card designating them as an Open Access participant. The card will include copayment amounts along with the standard benefit information included on all Member ID cards.

PPO Network Overview

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<tr>
<th>Network</th>
<th>Product Name</th>
<th>Description</th>
<th>PCP Referrals</th>
<th>Out of Network Benefits</th>
<th>Out of State Access</th>
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<tr>
<td>Network</td>
<td>Product Name</td>
<td>Description</td>
<td>PCP Referrals</td>
<td>Out of Network Benefits</td>
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<td>PPO</td>
<td>BlueChoice PPO</td>
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<td>INN and OON Benefits</td>
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<td>Anthem Lumenos PPO</td>
<td>PPO Consumer Driven Healthcare Product</td>
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<td>Blue Essential PPO</td>
<td>PPO Hospital/Surgical Product</td>
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<td>Limited Benefit Coverage</td>
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**HMO Network Overview**

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<td>HMO Open Access Product</td>
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<td>No Specialist Referrals Required</td>
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<td>POS Open Access Hospital/Surgical Product</td>
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<th>BlueChoice HMO</th>
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<tr>
<td>HMO Product</td>
<td>Requires PCP Selection</td>
<td>Requires Specialist Referrals</td>
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<tr>
<td>INN Benefits Only, Except in Emergencies</td>
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<tr>
<td>Out of Network benefits are not available, except in Emergencies</td>
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<th>BlueChoice Option POS</th>
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<td>POS Gatekeeper Product</td>
<td>Requires PCP Selection</td>
<td>Requires Specialist Referrals</td>
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<td>INN and OON Benefits</td>
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BlueValue Secure Provider Portal

**BlueValue Secure Provider Website**

Please refer to the Links section of this manual for additional information about BlueValue Secure.

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**Medicare Advantage**

**Medicare Advantage Provider Website**

Please refer to the Medicare Eligible website online for additional information at [www.anthem.com/medicareprovider](http://www.anthem.com/medicareprovider).


[https://www.anthem.com/provider/medicare-advantage/](https://www.anthem.com/provider/medicare-advantage/)

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**Federal Employee Health Benefit Program (FEHBP)**

**FEHBP Requirements**

Providers and Facilities acknowledge and understand that Anthem participates in the Federal Employees Health Benefits Program ("FEHBP"). The Anthem FEHBP encompasses the Blue Cross Blue Shield Association Service Benefit Plan, otherwise known as "Federal Employee Program®" or "FEP®", – the health insurance Plan for federal employees. Providers and Facilities further understand and acknowledge that the FEHBP is a federal government program and the requirements of the program are subject to change at the sole direction and discretion of the United States Office of Personnel Management. Providers and Facilities agree to abide by the rules, regulations, and other requirements of the FEHBP as they exist and as they may be amended or changed from time to time, with or without prior notice. Providers and Facilities further agree that, in the event of a conflict between the Provider or Facility agreement or this Provider Manual and the rules, regulations, or other requirements of the FEHBP, the terms of the rules, regulations, and other requirements of the FEHBP shall control.
When a conflict arises between federal and state laws and regulations, the federal laws and regulations supersede and preempt the state or local law (Public Law 105-266). In those instances, FEHBP is exempt from implementing the requirements of state legislation.

Submission of Claims under the Federal Employees Health Benefits Program

All Claims under the FEHBP must be submitted to Plan for payment within the timeframe listed in the Provider or Facility Agreement. This timeframe applies from the date of discharge or from the date of the primary payer’s explanation of benefits. Providers and Facilities agree to provide to Plan, at no cost to Anthem or Member, all information necessary for Plan to determine its liability, including, without limitation, accurate and complete Claims for Covered Services, utilizing forms consistent with industry standards and approved by Plan or, if available, electronically through a medium approved by Plan. If Plan is the secondary payer, the timeframe will not begin to run until Provider or Facility receives notification of primary payer’s responsibility. Plan is not obligated to pay Claims received after the timeframe indicated in the Agreement. Except where the Member did not provide Plan identification, Provider and Facility shall not bill, collect, or attempt to collect from Member for Claims Plan receives after the applicable period regardless of whether Plan pays such Claims.

Erroneous or duplicate Claim payments under the FEHBP

For erroneous or duplicate Claim payments under the FEHBP, either party shall refund or adjust, as applicable, all such duplicate or erroneous Claim payments regardless of the cause. Such refund or adjustment may be made within five (5) years from the end of the calendar year in which the erroneous or duplicate Claim was submitted. In lieu of a refund, Plan may offset future Claim payments.

Coordination of Benefits for FEHBP

In certain circumstances when the FEHBP is the secondary payer and there is no adverse effect on the Member, the FEHBP pays the local Plan allowable minus the Primary payment. The combined payments, from both the primary payer and FEHBP as the secondary payer, might not equal the entire amount billed by the Provider or Facility for covered services.

FEHBP Waiver requirements

- Notice must identify the proposed services.
- Inform the Member that services may be deemed not medically necessary or experimental/investigational, by the Plan.
- Provide an estimate of the cost for services.
- Member must agree in writing to be financially responsible in advance of receiving the services; otherwise, the Provider or Facility will be responsible for the cost of services denied.

FEHBP Member Reconsiderations and Appeals

There are specific procedures for reviewing disputed Claims under the Federal Employees Health Benefits Program. The process has two steps, starting with a review by the local Plan (reconsideration), which may lead to a review by the Office of Personnel Management ("OPM").

The review procedures are designed to provide Members with a way to resolve Claim disputes as an alternative to legal actions.

The review procedures are intended to serve both contract holders and Members. The local Plan and OPM do not accept requests for review from Providers or Facilities, except on behalf of, and with the written consent of, the contract holder or Member.

Providers and Facilities are required to demonstrate that the contract holder or Member has assigned all rights to the Provider or Facility for that particular Claim or Claims.

When a Claim or request for Health Services, drugs or supplies – including a request for precertification or prior approval – is denied, whether in full or partially, the local Plan that denied the Claim reviews the benefit determination upon receiving a written request for review. This request must come from the Member, contract holder or their authorized representative. The request for review must be received within six months of the date of the Plan’s final decision. If the request for review is on a specific Claim(s), the Member must be financially liable in order to be eligible for the disputed Claims process.
The local Plan must respond to the request in writing, affirming the benefits denial, paying the Claim, or requesting the additional information necessary to make a benefit determination, within 30 calendar days of receiving the request for review. If not previously requested, the local Plan is required to obtain all necessary medical information, such as operative reports, medical records and nurses’ notes, related to the Claim. If the additional information is not received within 60 calendar days, the Plan will make its decision based on the information available. Appropriate medical review will also be done at this time. If the Plan does not completely satisfy the Member’s request, the Plan will advise the Member of his/her right to appeal to OPM.

Providers or Facilities may not submit appeals to the OPM. Only the Member or contract holder may do so, as outlined in the Blue Cross and Blue Shield Service Benefit Plan brochure.

**FEHBP Formal Provider and Facility Appeals**

Providers and Facilities are entitled to pursue disputes of their pre-service request (this includes pre-certification or prior approval) or their post-service claim (represents a request for reimbursement of benefits for medical services that have already been performed), by following a formal dispute resolution process.

A formal Provider or Facility appeal is a written request from the rendering Provider or Facility, to his/her local Plan, to have the local Plan re-evaluate its contractual benefit determination of their post-service Claim; or to reconsider an adverse benefit determination of a pre-service request. The request must be from a Provider or Facility and must be submitted in writing within 180 days of the denial or benefit limitation. In most cases, this will be the date appearing on the Explanation of Benefits/Remittance sent by the Plan. For pre-service request denials, the date will be the date appearing on the Plan’s notification letter.

The request for review may involve the Provider or Facility’s disagreement with the local Plan’s decision about any of the clinical issues listed below where the Providers or Facilities are not held harmless. Local Plans should note that this list is not all-inclusive.

1. not medically necessary (NMN);
2. experimental/investigational (E/I);
3. denial of benefits, in total or in part, based on clinical rationale (NMN or E/I);
4. precertification of hospital admissions; and,
5. prior approval (for a service requiring prior approval under FEHBP).

Not all benefit decisions made by local Plans are subject to the formal Provider and Facility appeal process. The formal Provider and Facility appeal process does not apply to any non-clinical case.

When a Claim or request for services, drugs or supplies – including a request for precertification or prior approval – is denied, whether in full or partially, the local Plan that denied the Claim reviews the benefit determination upon receiving a written request for review. This request must come from the rendering/requesting Provider or Facility. The request for review must be received within six months of the date of the local Plan’s final decision. If the request for review is on a specific Claim(s), the Provider or Facility must be financially liable in order to be eligible for the formal Provider and Facility appeal process.

The local Plans must respond to the request in writing, affirming the benefits denial, paying the Claim, or requesting the additional information necessary to make a benefit determination, within 30 calendar days of receiving the request for review. If not previously requested, the local Plan is required to obtain all necessary medical information, such as operative reports, medical records and nurses’ notes, related to the Claim. If the additional information is not received within 60 calendar days, the local Plan will make its decision based on the information available. Appropriate medical review will also be done at this time. Even if the local Plan does not completely satisfy the Provider or Facility’s request, the formal Provider and Facility appeal process is complete; no additional appeal rights are available.

**FEHBP Inpatient Skilled Nursing Facility Care**

- Effective January 1, 2018 benefits are available for up to 30 days of inpatient skilled nursing facility ("SNF") care per benefit year for Standard Option Members who are not enrolled in Medicare Part A.
• Hospitals and Plan staff must be proactive in identifying Members for whom a SNF stay is an appropriate level of care in the continuum toward transition home.

• The Member must be enrolled in case management (“CM”) and the signed consent for CM must be received by the case manager prior to precertification approval of the SNF admission. This will require that the hospital discharge planning staff collaborate with the Plan case manager, and in some cases, will necessitate the hospital case manager/discharge planner’s assistance in delivering the consent to the Member and having it returned to the Plan after the Member/proxy signs the document.

• The transferring facility must submit a detailed description of the Member’s clinical status and the proposed treatment plan for the Plan’s review of the proposed admission.

• Once the Member is admitted and subsequently within the timeframes established by the Plan, the SNF representative must provide specific information regarding the Member’s status, progress towards goals, changes to the treatment plan and/or discharge plan (if applicable) and documentation of any obstacles preventing the Member from achieving the goals.

• The attending physician in the SNF must write admission orders and review the preliminary treatment plan within 24 hours of the Member’s admission. Members admitting on a ventilator must be seen by a pulmonologist within 12 hours of admission and respiratory therapy be available in the facility 24 hours/day.

• Members admitted for rehabilitation must receive an evaluation by a physical therapist and a physical therapy treatment plan must be in place within 16 hours of admission. Members admitted primarily for rehabilitation must receive at least 2 hours of physical therapy and occupational therapy combined at least 5 days per week (logs must be provided to the Plan to document therapy time).

BlueCard Program Overview

BlueCard is a national program that enables Members of one Blue Plan to obtain healthcare service benefits while traveling or living in another Blue Plan’s service area. The program links participating healthcare Providers and Facilities with the independent Blue Plans across the country and in more than 200 countries and territories worldwide through a single electronic network for Claims processing and reimbursement. The program allows Providers and Facilities to submit Claims for Members from other Blue Plans, domestic and international, to Anthem. Anthem is the sole contact for Claims payment, adjustments and issue resolution.


Health Insurance Market Place (Exchanges)

Health Insurance Marketplace

The Affordable Care Act (ACA) authorized the creation of Health Insurance Marketplaces (commonly referred to as exchanges) to help individuals and small employers shop for, select, and enroll in high quality, affordable private health plans.

Anthem offers qualified health plans on the Individual or Small Business Health Options Program (SHOP) Exchange in many states, as well as health plans not purchased on public exchanges. Qualified health plans on the Individual and SHOP Exchange follow the same policies and protocols within this Provider Manual, unless otherwise stated in the Provider or Facility Agreement.
Updates about Anthem’s ACA compliant health plans and the networks supporting these plans are published in Anthem’s provider newsletter, and sent via Anthem’s email service. To sign up for Provider Communications for Georgia, go to https://messageinsite.com/networkupdate.

Additional information and current communications about Health Insurance Exchanges can be found from the provider homepage at anthem.com.

Important reminder:

Providers and Facilities are able to confirm their participation status in our different networks by using the Find a Doctor tool. Please see the Online Provider Directories and Demographic Data Integrity section for more details.

State Health Benefit Plan

Anthem is excited to continue to servicing the Georgia State Health Benefit Plan (SHBP). We are pleased to announce that Anthem is a Medicare Advantage plan option.

State Health Network = SHBP
The State Health Network = SHBP for HRA Plans and HMO plans (active members/early retirees):
  In Georgia = Open Access POS Network
  Outside of Georgia = BlueCard® National PPO Network (for traveling benefits)

Communications
Anthem added a SHBP specific section to our bi-monthly provider newsletter, Network Update, as well as adding a SHBP specific page to our provider website, Anthem.com. SHBP information will be posted as it becomes available on the State Health Benefit Plan page. We will also email late breaking important information via Network eUpdate. If you have not yet registered to receive Network eUpdate, please do so by visiting the Communications page of our provider website, Anthem.com, or contact your Provider Representative for help.

Precertification
SHBP requires precertification for some services that are not required for non-SHBP members. This revised precertification list SHBP Prior Authorization and the SHBP page on our provider website, Anthem.com. Providers must obtain precertification for the services listed in order to receive reimbursement. Future notifications of changes to the posted precertification list will be done through Network Update and posted to the Precertification page and the SHBP page of our provider website, Anthem.com.

AIM Specialty Health℠ (AIM) Programs
AIM programs include management of high-tech imaging, echocardiography, specialty pharmacy, radiation therapy and sleep studies and sleep therapy/treatment. All of these services require precertification. In addition, for providers of high-tech imaging services, sleep testing and sleep therapy/treatment, AIM requires the completion of an OptiNetSM online site assessment. The following AIM programs apply to SHBP:
  - Diagnostic Imaging Program
  - Imaging Cost and Quality Program
  - Outpatient Radiation Therapy Program
  - Sleep Management Program
  - AIM Enhanced Cardiology Program

More information on the AIM programs can be accessed on the Answers@Anthem page, the Precertification page on our Anthem.com provider website, by visiting AIM’s website at aimspecialtyhealth.com, or calling 800-252-2021.

Specialty Pharmacy
SHBP has contracted directly with CVS Caremark as its pharmacy vendor; however some of the pharmaceuticals may be covered under the member’s medical benefit. Please refer to the SHBP page of our
provider website, Anthem.com, for a list of specialty meds that will determine if they are covered under the Medical or Pharmacy benefit.

**Claim Processing**

Certain benefits, as defined by SHBP, will require specific standard industry codes in order for the service to be considered a covered benefit. Claim submission requirements will be posted to the Anthem.com provider website.

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**Audit and Review**

**Anthem Audit Policy**

This Anthem Audit Policy applies to Providers and Facilities. If there is conflict between this Policy and the terms of the applicable Provider or Facility Agreement, the terms of the Agreement will prevail. If there is a conflict in provisions between this Policy and applicable state law that is not addressed in the Provider or Facility Agreement the state law will apply. All capitalized terms used in this Policy shall have the meaning as set forth in the Provider or Facility Agreement between Anthem and Provider or Facility.

Coverage is subject to the terms, conditions, and limitations of a Member’s Health Benefit Plan and in accordance with this Policy.

There may be times when Anthem conducts claim reviews or audits either on a prepayment or post payment basis. Claim reviews and audits are conducted in order to confirm that healthcare services or supplies were delivered in compliance with the Member’s plan of care or to confirm that charges were accurately reported and reimbursed in compliance with Anthem’s policies and procedures as well as general industry standard guidelines and regulations.

In order to conduct such reviews and audits, Anthem or its designee may request documentation, most commonly in the form of patient medical records and/or itemized bill. Anthem may accept additional documentation from Provider or Facility that typically might not be included in medical records such as other documents substantiating the treatment or health service or delivery of supplies.

This policy documents Anthem’s guidelines for claims requiring additional documentation and the Provider’s or Facility’s compliance for the provision of requested documentation.

**Definition:**

The following definitions shall apply to this Audit section only:

- **Agreement** means the written contract between Anthem and Provider or Facility that describes the duties and obligations of Anthem and the Provider or Facility, and which contains the terms and conditions upon which Anthem will reimburse Provider or Facility for Health Services rendered by Provider or Facility to Member(s).

- **Appeal** means Anthem’s or its designee’s review of the disputed portions of the Audit Findings, conducted at the written request of a Provider or Facility and pursuant to this Policy.

- **Appeal Response** means Anthem’s or its designee’s written response to the Appeal after reviewing all Supporting Documentation provided by Provider or Facility.

- **Audit** means a qualitative or quantitative review of Health Services or documents relating to such Health Services rendered by Provider or Facility, and conducted for the purpose of determining appropriate reimbursement under the terms of the Agreement.

- **Notice of Overpayment** means a document that constitutes notice to the Provider or Facility that Anthem or its designee believes an overpayment has been made by Anthem. The Notice of Overpayment shall contain administrative data relating to the amount of overpayment. Unless otherwise stated in the
Agreement between the Provider or Facility and Anthem, Notice of Overpayment shall be sent to Provider or Facility.

- Business Associate or designee means a third party designated by Anthem to perform an Audit or any related function on behalf of Anthem.

- Provider or Facility means an entity with which Anthem has a written Agreement.

- Provider Manual means the proprietary Anthem document available to the Provider and Facility, which outlines Reimbursement Requirements and Policies.

- Recoupment means the recovery of an amount paid to Provider or Facility which Anthem has determined constitutes an overpayment not supported by an Agreement between the Provider or Facility and Anthem. A Recoupment is generally performed against a separate payment Anthem makes to the Provider or Facility which is unrelated to the services which were the subject of the overpayment, unless an Agreement expressly states otherwise or is prohibited by law. Recoupments shall be conducted in accordance with applicable laws and regulations.

- Supporting Documentation means the written material contained in a Member’s medical records or other Provider or Facility documentation that supports the Provider’s or Facility’s Claim.

**Policy**

Upon request from Anthem or its designee, Providers and Facilities are required to submit additional documentation for claims identified for pre-payment review or post payment audit.

Anthem or its designee will use the following guidelines for records requests for Claims identified for prepayment review or post payment audit:

1. Upon confirmation of Provider’s or Facility’s address, an original letter of request for supporting documentation will be sent.
2. When a response is not received within 30 days of the date of the initial request, a second request letter will be sent.
3. When a response is not received within 15 days of date of the second request, a final request letter will be sent.
4. When a response is not received within 15 days of the date of the final request (60 days total):
   a. Anthem or its designee will initiate claim denial for Claims identified as pre-payment review Claims as Provider or Facility failed to submit the required documentation. The Member shall be held harmless for such payment denials.
   or
   b. Anthem or its designee will initiate recoupments for Claims identified as post payment audit claims as Provider or Facility failed to submit the required documentation. The Member shall be held harmless for such recoupments.

Anthem or its designee will not be liable for interest or penalties when payment is denied or recouped when Provider or Facility fails to submit required or requested documentation for Claims identified for prepayment review or post payment audit.

**Procedure:**

1. **Review of Documents.** Anthem or its designee will request in writing any supporting documentation required for audit or review. The Provider or Facility will supply the requested documentation within the time frame outlined above.
2. **Scheduling of Audit (Hospital Bill Audits Only).** After review of the documents submitted, if Anthem or its designee determines an Audit or Review is required, Anthem or its designee will call the Provider or Facility to request a mutually satisfactory time for Anthem or its designee to conduct an Audit; however, the Audit must occur within forty-five (45) calendar days of the request.
3. **Rescheduling of Audit.** Should Provider or Facility desire to reschedule an Audit, Provider or Facility must submit its request with a suggested new date to Anthem or its designee in writing at least seven (7) calendar days in advance of the day of the Audit. Provider’s or Facility’s new date for the Audit must occur
within thirty (30) calendar days of the date of the original Audit. Provider or Facility may be responsible for cancellation fees incurred by Anthem or its designee due to Provider’s or Facility’s rescheduling. While Anthem or its designee prefers to work with the Provider or Facility in finding a mutually convenient time, there may be instances when Anthem or its designee must respond quickly to requests by regulators or its clients. In those circumstances, Anthem or its designee will send a notice to the Provider or Facility to schedule an Audit within the seventy-two (72) hour timeframe.

4. **Under-billed and Late-billed Claims.** During an on-site audit, Provider or Facility may identify Claims for which Provider or Facility under-billed or failed to bill for review by Anthem during the Audit. Under-billed or late-billed Claims not identified by Provider or Facility before the Audit commences will not be evaluated in the Audit. These Claims may, however, be submitted (or resubmitted with provider adjustment form for under-billed Claims) to Anthem for adjudication.

5. **On-Site and Desk Audits.**

   a. **On-site Audits**. Anthem or its designee may conduct Audits on-site at the Provider’s or Facility’s location. If Anthem or its designee conducts an Audit at a Provider’s or Facility’s location, Provider or Facility will make available suitable work space for Anthem’s or its designee’s on-site Audit activities. During the Audit, Anthem or its designee will have complete access to the applicable health records including ancillary department records and/or invoice detail without producing a signed Member authorization. When conducting credit balance reviews, Provider or Facility will give Anthem or its designee a complete list of credit balances for primary, secondary and tertiary coverage, when applicable. In addition, Anthem or its designee will have access to Provider’s or Facility’s patient accounting system to review payment history, notes, Explanation of Benefits and insurance information to determine validity of credit balances. If the Provider or Facility refuses to allow Anthem or its designee access to the items requested to complete the Audit, Anthem or its designee may opt to complete the Audit based on the information available. All Audits (to include medical chart audits and diagnosis related group reviews) shall be conducted free of charge despite any Provider or Facility policy to the contrary.

   b. **Desk Audits**. Anthem or its designee may conduct Audits from its offices. Facility or Provider will comply with timeline and specific requested documentation listed in Anthem’s request for additional documentation.

6. **Completion of Audit (On-site audit only).** Upon completion of the Audit, Anthem or its designee will generate and give to Provider or Facility a final Audit Report. This Audit Report may be provided on the day the Audit is completed or it may be generated after further research is performed. If further research is needed, the final Audit Report will be generated at any time after the completion of the Audit, but generally within ninety (90) days. Occasionally, the final audit report will be generated at the conclusion of the exit interview which is performed on the last day of the Audit. During the exit interview, Anthem or its designee will discuss with Provider or Facility its Audit findings found in the final Audit Report. This Audit Report may list items such as charges unsupported by adequate documentation, under-billed items, late billed items and charges requiring additional supporting documentation. If the Provider or Facility agrees with the Audit findings, and has no further information to provide to Anthem or its designee, then Provider or Facility may sign the final Audit Report acknowledging agreement with the findings. At that point, Provider or Facility has thirty (30) calendar days to reimburse Anthem the amount indicated in the final Audit Report. Should the Provider or Facility disagree with the final Audit Report generated during the exit interview, then Provider or Facility may either supply the requested documentation or Appeal the Audit findings.

7. **Provider or Facility Appeals.** See Audit Appeal Policy.

8. **No Appeal (On-site audit only).** If the Provider or Facility does not formally Appeal the findings in the final Audit Report and submit supporting documentation within the (thirty) 30 calendar day timeframe, the initial determination will stand and Anthem or its designee will process adjustments to recover the amount identified in the final Audit Report.

**Documents Reviewed During an Audit:**
The following is a description of the documents that may be reviewed by Anthem or its designee along with a short explanation of the importance of each of the documents in the Audit process. It is important to note that Providers and Facilities must comply with applicable state and federal record keeping requirements.

A. **Confirm that Health Services were delivered by the Provider or Facility follow the treatment plan.**

   Auditors will verify that Provider’s or Facility’s treatment plan reflected the Health Services delivered by the Provider or Facility. The services are generally documented in the Member’s health or medical records. The Provider or Facility must review, approve and document all such policies and procedures by any applicable accreditation bodies. Policies shall be made available for review by the auditor.

B. **Confirm that charges were accurately reported on the Claim in compliance with Anthem’s Policies as well as general industry standard guidelines and regulations.**

   Auditors may also review the Member’s health record documents. The health record includes the clinical data on diagnoses, treatments, and outcomes. A health record generally includes pertinent information related to care and must support services billed by the Provider or Facility.

**Audit Appeal Policy**

**Purpose:**

To establish a timeline for issuing Audits and responding to Provider or Facility Appeals of such Audits.

**Procedure:**

1. Unless otherwise expressly set forth in an Agreement, Provider or Facility shall have the right to Appeal the findings in the Notice of Overpayment. An Appeal of the Notice of Overpayment must be in writing and received by Anthem or its designee within thirty (30) calendar days of the date of the Notice of Overpayment unless State Statute expressly indicates otherwise. The Appeal should address the findings from the Notice of Overpayment that Provider or Facility disputes, as well as the basis for the Provider’s or Facility’s belief that such finding(s) are not accurate. All findings disputed by the Provider or Facility in the Appeal must be accompanied by relevant Supporting Documentation. Retraction will begin at the expiration of the thirty (30) calendar days unless expressly prohibited by contractual obligations or State Statute.

2. Upon receipt of a timely Appeal, complete with Supporting Documentation as required under this Policy, Anthem or its designee shall issue an Appeal Response to the Provider or Facility. Anthem’s or its designee’s response shall address each matter contained in the Provider’s or Facility’s Appeal. If appropriate, Anthem’s or its designee’s Appeal Response will indicate what adjustments, if any, shall be made to the overpayment amounts outlined in the Notice of Overpayment. Anthem’s or its designee’s response shall be sent via email, mail or portal to the Provider or Facility within thirty (30) calendar days of the date Anthem or its designee received the Provider’s or Facility’s Appeal and Supporting Documentation.

3. The Provider or Facility shall have fifteen (15) calendar days from the date of Anthem’s or its designee’s Appeal Response to respond with additional documentation or, if appropriate in the State, a remittance check to Anthem or its designee. If no Provider or Facility response or remittance check (if applicable) is received within the fifteen (15) calendar day timeframe, Anthem or its designee shall begin recoupment of the amount contained in Anthem’s or its designee’s response, and a confirming recoupment notification will be sent to the Provider or Facility.

4. Upon receipt of a timely Provider or Facility appeal response, complete with Supporting Documentation as required under this Policy, Anthem or its designee shall formulate a final Appeal Response. Anthem’s or its designee’s final Appeal Response shall address each matter contained in the Provider’s or Facility’s response. Anthem’s or its designee’s final Appeal Response shall be sent via email, mail or portal to the Provider or Facility within fifteen (15) calendar days of the date Anthem or its designee received the Provider or Facility response and Supporting Documentation.

5. If applicable in the state, the Provider or Facility shall have fifteen (15) calendar days from the date of Anthem’s or its designee’s final Appeal Response to send a remittance check to Anthem or its
designee. If no remittance check is received within the fifteen (15) calendar day timeframe, Anthem or its designee shall recoup the amount contained in Anthem’s or its designee’s final Appeal Response.

Fraud, Waste and Abuse Detection

We are committed to protecting the integrity of our health care programs and the effectiveness of our operations by preventing, detecting and investigating fraud, waste and abuse (FWA). Combating FWA begins with knowledge and awareness.

- **Fraud** – intentionally falsifying information and knowing that deception will result in improper payment and/or unauthorized benefit. This includes, knowingly soliciting, receiving, and/or offering compensation to encourage or reward referrals for items or services and/or making prohibited referrals for certain designated health services.

- **Waste** – includes overusing services, or other practices that, directly or indirectly, result in unnecessary costs. Waste is generally not considered to be driven by intentional actions, but rather occurs when resources are misused.

- **Abuse** – when health care providers or suppliers do not follow appropriate medical billing/documentation practices or medical practices resulting in unnecessary or excessive costs, incorrect payment, misuse of codes, or services that are not medically necessary.

Investigation Process

The Special Investigations Unit (“SIU”) investigates suspected incidents of FWA for all types of services. We may take corrective action with a Provider or Facility, which may include, but is not limited to:

- **Written warning and/or education**: We send letters to the Provider or Facility advising the Provider or Facility of the issues and the need for improvement. Letters may include education or requests for repayment, or may advise of further action.

- **Medical record review**: We review medical records to investigate allegations or validate the appropriateness of Claims submissions.

- **Edits**: A certified professional coder or investigator evaluates Claims and places payment or system edits in Anthem’s Claims processing system. This type of review prevents automatic Claims payments in specific situations.

- **Recoveries**: We recover overpayments directly from the Provider or Facility. Failure of the Provider or Facility to return the overpayment may result in reduced payment for future Claims, termination from our network, or legal action.

Prepayment Review

One method Anthem uses to detect FWA is through prepayment Claim review. Through a variety of means, certain Providers or Facilities, or certain Claims submitted by Providers or Facilities, may come to Anthem’s attention for behavior that might be identified as unusual for coding, documentation and/or billing issues, or Claims activity that indicates the Provider or Facility is an outlier compared to his/her/its peers.

Once a Claim, or a Provider or Facility, is identified as an outlier or has otherwise come to Anthem’s attention for reasons mentioned above, further review may be conducted by the SIU to determine the reason(s) for the outlier status or any appropriate explanation for unusual coding, documentation, and/or billing practices. If the review results in a determination that the Provider’s or Facility’s actions may involve FWA, the Provider or Facility is notified of their placement on prepayment review and given an opportunity to respond.

When a Provider or Facility is placed on prepayment review, the Provider or Facility will receive written notice of being placed on prepayment review. This means that the Provider or Facility will be required to submit medical records and any other supporting documentation with each Claim so Anthem can review the appropriateness of the services billed, including the accuracy of billing and coding, as well as the sufficiency of the medical records and supporting documentation submitted. Failure to submit medical records and supporting documentation to Anthem in accordance with this requirement will result in a denial of the Claim.
under review. The Provider or Facility will be given the opportunity to request a discussion of his/her/its prepayment review status.

Under the prepayment review program, Anthem may review coding, documentation, and other billing issues. In addition, we may use one or more clinical utilization management guidelines in the review of Claims submitted by the Provider or Facility, even if those guidelines are not used for all Providers or Facilities delivering services to Plan Members.

The Provider or Facility will remain subject to the prepayment review process until Anthem is satisfied that all inappropriate billing, coding, or documentation activity has been corrected. If the inappropriate activity is not corrected, the Provider or Facility could face corrective measures, up to and including termination from our network.

Finally, Providers and Facilities are prohibited from billing a Member for services we have determined are not payable as a result of the prepayment review process, whether due to FWA, any other coding or billing issue or for failure to submit medical records as set forth above. Providers or Facilities whose Claims are determined to be not payable may make appropriate corrections and resubmit such Claims in accordance with the terms of their Provider and Facility Agreement, proper billing procedures and state law. Providers or Facilities also may appeal such a determination in accordance with applicable grievance and appeal procedures.

**Acting on Investigative Findings**

In addition to the previously mentioned actions, we may refer suspected criminal activity committed by a Member, Provider or Facility to the appropriate regulatory and/or law enforcement agencies.

**Recoupment/Offset/Adjustment for Overpayments**

Anthem shall be entitled to offset and recoup an amount equal to any overpayments or improper payments made by Anthem to Provider or Facility ("Overpayment Amount") against any payments due and payable by Anthem or any Affiliate to Provider or Facility with respect to any Health Benefit Plan under this Agreement or under any provider agreement between Provider and an Affiliate regardless of the cause. Provider or Facility shall voluntarily refund the Overpayment Amount regardless of the cause, including, but not limited to, payments for Claims where the Claim was miscoded, non-compliant with industry standards, or otherwise billed in error, whether or not the billing error was fraudulent, abusive or wasteful. Upon determination by Anthem that an Overpayment Amount is due from Provider or Facility, Provider or Facility must refund the Overpayment Amount to Anthem within thirty (30) calendar days of the date of the overpayment refund notice from Anthem to the Provider or Facility. If the Overpayment Amount is not received by Anthem within the thirty (30) calendar days following the date of such notice letter, Anthem shall be entitled to offset the unpaid portion of the Overpayment Amount against other Claims payments due and payable by Anthem or an Affiliate to Provider or Facility under any Health Benefit Plan in accordance with Regulatory Requirements. In such event, Provider or Facility agrees that all future Claim payments, including Affiliate Claim payments, applied to satisfy Provider’s or Facility’s repayment obligation shall be deemed to have been legally paid to Provider or Facility in full for all purposes, including Affiliates and/or Regulatory Requirements as defined by the Provider or Facility Agreement. Should Provider or Facility disagree with any determination by Anthem or a Plan that Provider or Facility has received an overpayment or improper payment, Provider or Facility shall have the right to appeal such determination under Anthem’s procedures set forth in the Provider Manual, provided that such appeal shall not suspend Anthem’s right to recoup the Overpayment Amount during the appeal process unless required by Regulatory Requirements. Anthem reserves the right to employ a third party collection agency in the event of non-payment.

**Pharmacy Home Program**

The availability and access to opioid medications used for the treatment of acute and chronic health conditions is at an all-time high. This access to healthcare is helping patients live longer and healthier lives. However, it can also lead to safety concerns when Members are on multiple controlled medications that are prescribed by multiple healthcare providers. To address the growing opioid epidemic, Anthem implemented the Pharmacy Home Program in April 2016 to allow for better administration of drug benefits through increased communication and coordination amongst prescribing physicians and pharmacies. The information in this section applies to Anthem Members with our prescription drug coverage.
The Pharmacy Home Program helps reduce potential overutilization of prescription medications. If a Member is believed to be at an increased safety risk due to the overutilization of multiple medications, providers and/or pharmacies; and meets enrollment criteria they may be included in this program. Anthem is able to increase communication and coordination amongst prescribing physicians for Members that have been identified and restricted to a single pharmacy. The pharmacy is selected by the Member and/or is assigned based on the retrospective Drug Utilization Review (“DUR”) of their prescription claims history. Following the selection of the Member’s new Pharmacy Home, all prescribing physicians receive notification of the Member’s enrollment into the program, the assigned pharmacy information and a 3-month prescription profile containing a list of all prescribers, medications, dosages, and quantities received by the Member during that timeframe.

The program is designed to limit a qualifying Member to the use of one specific participating pharmacy for a period of no less than 12 consecutive months. This assigned pharmacy, or Pharmacy Home, will fill all of the Member’s prescribed medications throughout the term of their enrollment in this program.

The Pharmacy Home Program includes:

- Reimbursement of Claims when filled at the Member’s Pharmacy Home. All pharmacy Claims\(^1\) are denied if filled at any pharmacy other than the Member’s assigned Pharmacy Home\(^2\).
- Temporary overrides for urgent prescriptions.
- Access to Mail Order and Specialty pharmacies, in addition to the Pharmacy Home.

\(^1\) Both controlled and non-controlled medications must be filled at the designated Pharmacy Home.

\(^2\) A Member may change the designated pharmacy only if the request meets good cause criteria.
Criteria

A Member whose prescription Claims' history shows they meet the below inclusion criteria may be enrolled in the Pharmacy Home Program if:

- The Member received five or more controlled substance prescriptions (government-regulated drugs) in a 90-day period.
- The Member received controlled substance prescriptions from three or more prescribers in a 90-day period.
- The Member visited three or more pharmacies to fill controlled substance prescriptions in a 90-day period.

Communications to Members meeting criteria

Members who meet criteria are sent a notification at least 60-days prior to potential inclusion in the program. After a 60-day monitoring period, if the Member continues to meet the program criteria during that timeframe, he/she is contacted in writing of the decision to place him/her into the Pharmacy Home Program. The Member will then be given 30 additional days to select a Pharmacy Home and/or to file an appeal of the decision. In the event the Member does not select a Pharmacy Home within the allotted timeframe, one will be chosen for the Member on the 31st day based off of their pharmacy Claims. Anthem will ensure both the Member and their Provider will be notified of their new Pharmacy Home in writing. Once they have chosen a Pharmacy Home, a request to change pharmacies will be considered only for good cause situations.

Anthem is more committed than ever to equipping Providers with the tools and support necessary to help curb these trends and save more lives than are lost. If you have any questions or comments regarding enrollment, please contact the Member Services number located on the back of the Member’s ID.

Glossary

Glossary of Anthem, Health Care and Managed Care Terms

65PLUS: 65PLUS* offers Medicare beneficiaries a choice of five of the federally approved Medicare supplement plans: Plans A, B, C, E and F. Because Medicare only pays a portion of hospital and physician charges, these supplements provide certain benefits otherwise unavailable from Medicare. *65PLUS is underwritten by Blue Cross and Blue Shield of Georgia, Inc., an independent licensee of the Blue Cross and Blue Shield Association.

Accreditation:
Certification that an organization meets the reviewing organization’s standards. Examples: accreditation of HMOs by the National Committee for Quality Assurance (“NCQA”) or accreditation of PPOs by URAC.

Affiliate(s):
Any entity owned or controlled, either directly or through a parent or subsidiary entity, by Anthem, or any entity which is under common control, with Anthem and that accesses the rates, terms or conditions of the Agreement. Anthem will have a current listing of such Affiliates available through a commonly available web site or upon request.

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3 Exemption of members with a diagnosis of Cancer, HIV, Multiple Sclerosis, Sickle-cell Anemia or those that are in Hospice Care. (Note: Exemptions are determined by both pharmacy claim history and medical diagnosis.)
American Accreditation HealthCare Commission, Inc./Utilization Review Accreditation Commission, Inc. (AAHCC/URAC):
An independent, not-for-profit corporation established in 1990 by organizations representing the managed health care industry, health care providers, consumers, and regulators to encourage more efficient and effective managed care.

Ancillary:
A term used to describe additional services performed related to care, such as lab work, x-ray, and anesthesia.

Appeals:
Refers to a formal written request (from a practitioner/provider) for reconsideration of a decision previously made by Anthem during the complaint process, (e.g., benefit payment, administrative actions, etc.).

Anthem Rate:
The lesser of Facility’s charges for Covered Services, unless otherwise defined, or the total reimbursement amount that Facility and Anthem have agreed upon as specified in the Plan Compensation Schedule (PSC). The Anthem Rate shall represent payment in full to Facility for Covered Services.

Benefit:
The amount payable by an insurer or employee benefit plan to a claimant, assignee, or beneficiary under the terms of the Health Benefit Plan.

Benefits Package:
A term informally used to refer to the employer’s benefit plan or to the benefit plan options from which the employee can choose. “Benefits package” highlights the fact a health benefits plan is a compilation of specific benefits.

BlueChoice PPO:
BlueChoice PPO is a preferred provider organization (PPO) that offers Members the flexibility of going in or out-of-network for medical care. If Members see a physician, specialist or hospital that is in-network (a preferred provider), they receive more savings and benefits. *BlueChoice PPO is underwritten by Blue Cross and Blue Shield of Georgia, Inc., an independent licensee of the Blue Cross and Blue Shield Association.

Board Certified (Boarded, Diplomat)
Describes a physician who has passed a written and oral examination given by a medical specialty board and who has been certified as a specialist in that area.

Case Management:
A method of coordinating and facilitating services and benefits Members receive to ensure they seek and receive appropriate and necessary care to minimize duplication of services, tests and costs and to maximize benefits available under their Member Agreement.

Case Rate:
The all-inclusive Anthem Rate for an entire admission or one outpatient encounter. Global Case Rate” means the all-inclusive Anthem Rate which includes institutional, professional and physician services for specific Coded Service Identifier(s).

Certificate Booklet:
A detailed document that serves both as an explanation of the benefit plan and as the certificate of insurance. See certificate of coverage.

Certificate of Coverage:
A description of the benefits included in an insurance plan. The certificate of coverage is required by state insurance laws and represents the coverage provided under the policy issued to the contract holder. The certificate is provided to subscribers via the Certificate Booklet.

Chargemaster or Charges:
Facility’s listing of Facility Charges for products, services and supplies.

Claim:
Either the uniform bill Claim form or electronic Claim form in the format prescribed by Plan submitted by a Facility for payment by a Plan for Health Services rendered to a Member. “Complete Claim” means, unless
state law otherwise requires, an accurate Claim submitted pursuant to the Agreement, for which all information necessary to process such Claim and make a benefit determination is included.

**Coded Service Identifier(s):**
A listing of descriptive terms and identifying codes, updated from time to time by the Centers for Medicare and Medicaid Services (CMS) or other industry source, for reporting Health Services on the UB-04 or its successor. The codes include but are not limited to, CPT-4, HCPCS, ICD-9 or successor codes, National Drug Code (NDC) and Revenue Codes, or their successors.

**Concurrent Review:**
A component of Utilization Management program which evaluates a Member’s coverage for Facility services under the terms of the contract.

**Contract:**
A binding written agreement between the insurer and policyholder to evidence the terms and conditions of the policy. The contract between Blue Cross and Blue Shield of Georgia and an insured includes the certificate booklet.

**Coordination of Benefits (COB):**
A provision in a contract that applies when a person is covered under more than one group medical program. It requires that payment of benefits will be coordinated by all programs to eliminate over-payment by insurance or duplication of benefits.

**Cost Share:**
With respect to Covered Services, an amount which a Member is required to pay under the terms of the applicable Health Benefit Plan. Such payment may be referred to as an allowance, coinsurance, copayment, deductible, penalty or other Member payment responsibility, and may be a fixed amount or a percentage of applicable payment for Covered Services rendered to the Member.

**Member:**
Any individual who is eligible, as determined by Plan, to receive Covered Services under a Health Benefit Plan. For all purposes related to the Agreement, including all schedules, attachments, exhibits, manual(s), notices and communications related to the Agreement, the term “Member” may be used interchangeably with the terms Insured, Covered Person, Member, Enrollee, Subscriber, Dependent Spouse/Domestic Partner, Child or Contract Holder, and the meaning of each is synonymous with any such other.

**Member ID Card:**
An identification card issued by PLAN or an Affiliate, which identifies an individual as a Covered Person. (The Member Card is for identification purposes only and may not be used as verification of eligibility.)

**Covered Services:**
Medically Necessary Health Services, as determined by Plan and described in the applicable Health Benefit Plan, for which a Member is eligible.

**Credentialing:**
The process of reviewing a provider’s credentials, i.e., training, experience, or demonstrated ability, for the purpose of determining if criteria for inclusion in a Network are met. Anthem screens all physicians in their Networks. Each physician must meet specific educational and medical practice standards in order to become part of the Network.

**Deductible:**
The amount of covered expenses that must be incurred and paid by each Member before benefits become payable by the insurer. For example, if a plan has a $100 deductible, the deductible is met once the first $100 of the covered medical expenses for that year has been paid. After that, the plan begins to pay toward the cost of covered health care services.

**Dependent:**
A covered person’s spouse (not legally separated from the insured) and unmarried child(ren) who meet eligibility requirements.

**Discharge Planning:**
Component of Utilization Management program which evaluates a Member’s coverage under the terms of the Member’s contract for health care services after discharge from an inpatient setting.

**DRG:**
Diagnosis Related Group as set forth by the CMS or other grouper as may be used by Anthem and updated as codes are updated.

**Drug Formulary:**
A listing of prescription medications which are approved for coverage by the plan. The list is subject to periodic review and modification by the health plan.

**Eligibility:**
The provisions of the group policy or insurance contract that state the requirements that applicants must satisfy to become insured with respect to themselves or their dependents.

**Emergency Condition:**
A condition of recent onset and sufficient severity, including but not limited to severe pain, that would lead a prudent layperson possessing average knowledge of medicine and health, to believe that his or her condition, sickness or injury is of such a nature that failure to obtain immediate medical care could result in: (1) placing the Member’s health in serious jeopardy; (2) serious impairment to bodily functions; (3) serious dysfunction to any bodily organ or part; or (4) other serious medical consequences.

**Employer Group**
A group of eligible employees to whom health care benefits are extended through a health benefits plan provider. The relationship is formalized through a contract. For the employer group to be recognized, a true employee-employer relationship must exist. Examples of groups which would not qualify include social clubs and independent contractors.

**Exclusions:**
Specific conditions or circumstances listed in the Health Benefit Plan for which the policy or plan will not provide benefit payments.

**Facility Based Physician:**
Any physician, with the exception of residents, interns and fellows, who has a contractual relationship with a Facility to provide professional services. These services may be of two types: (1) administrative, managerial, teaching, or quality control activities compensated from or through a Facility which are furnished to a Facility or its general population; or (2) physician services personally rendered to a Member while in a Facility which directly contribute to the diagnosis or treatment of a Member and which ordinarily require performance by a physician, including, an emergency room physician, radiologist, pathologist, and anesthesiologist, and any other physicians contracting with hospitals specified by Anthem, at any time, or from time to time; provided, however, that this term shall not include PCPs or Specialty Care Physicians employed by a Facility who have a separate contractual agreement with Anthem.

**Fee-for-Service Reimbursement:**
A method of reimbursement by which a Provider charges, and is reimbursed, separately for each patient encounter or service rendered.

**Fee Schedule Rate:**
The Anthem Rate payable to Facility based on a specific Coded Service Identifier(s), as set forth in the applicable fee schedule(s).

**FEHBP:**
The “Federal Employee Health Benefit Program” is a group contract to provide health care benefits to federal employees, underwritten by Blue Cross and Blue Shield Plans. The official name of the program is the Government-Wide Service Benefit Plan.

**Group Health Coverage:**
A health benefits plan which covers a group of people as permitted by state and federal law.

**Guest Member:**
Members of an Affiliate of Anthem temporarily residing in a Service Area. Guest Member(s) will be treated as Anthem Members while present in a Service Area.
Health Benefit Plan:
The document(s) describing the partially or wholly: (1) insured, (2) underwritten, and/or (3) administered, marketed health care benefits, or services program between the Plan and an employer, governmental entity, or other entity or individual.

Health Service:
Those services or supplies that a health care Facility is licensed equipped and staffed to provide and which it customarily provides to or arranges for individuals.

HEDIS (Health Plan and Employer Data Information Set):
HEDIS is a standard set of more than 100 indicators developed to assist purchasers/employers in evaluating health plans. HEDIS has become a standard of measurement for the Centers for Medicare and Medicaid Services (CMS), for some state insurance departments and for many large companies. HEDIS has also become a component of the NCQA accreditation process.

Home Health Agency:
A Facility or program licensed, certified or otherwise authorized pursuant to state and federal laws to provide home health care services.

Hospice:
A Facility or program licensed or certified under law to provide palliative and supportive care for the terminally ill.

Indemnity:
Indemnity or “traditional” insurance is a plan which reimburses physicians for covered charges for services performed, or insures for medical expenses incurred.

In-Network:
In-network means seeing a provider that has contracted with Anthem to participate in the network of physicians and hospitals.

Inpatient Services:
Covered Services provided by Facility to a Member who is admitted and treated as a registered inpatient, is assigned a licensed bed within the Facility, remains assigned to such bed and for whom a room and board charge is made.

Length of Stay (LOS):
The number of days that a Member stayed in an inpatient Facility.

Managed Care:
A health plan or insurance program in which beneficiaries receive medical service in a coordinated manner to eliminate unnecessary medical services. In managed care health plans, the Member seeks specialist or hospital care after prior approval of coverage by designated health care professionals, such as PCPs, utilization review nurses, or employer-designated professionals. The primary goal is to deliver cost-effective health care without sacrificing quality or access.

Medically Necessary or Medical Necessity:
Covered Services or supplies provided by a Facility, physician, or other provider to identify or treat an illness or injury and which, as determined by Plan, are: 1) appropriate and consistent with the diagnosis and the omission of which could adversely affect or fail to improve the patient’s condition; 2) compatible with the standards of acceptable medical practice in the United States; 3) not provided solely for the Member’s convenience or the convenience of the physician, health care provider or Facility; 4) not primarily custodial care; and 5) provided in a safe and appropriate setting given the nature of the diagnosis and the severity of the symptoms.

Medicare:
Title XVIII of the Social Security Act which provides payment for medical and health services to the population aged 65 and over regardless of income, as well as certain disabled persons and persons with ESRD.

Member ID Card:
A card given to each Member by Anthem which introduces the Member to physicians and hospitals. Although the cards do not guarantee eligibility for medical care benefits at any given time, they increase the convenience of obtaining health insurance services.

NCQA:
The National Committee for Quality Assurance is an independent, not-for-profit entity that works closely with the managed care industry, health care purchasers, researchers and consumers to develop standards for accreditation to determine whether a managed care organization is founded and practicing principles of quality and is continuously working to improve the services it provides. Typically NCQA auditors use these standards to evaluate managed care organizations with regards to quality management and improvement, utilization management, credentialing, Member rights and responsibilities, preventive health services, and medical records.

Network:
A group of providers that support, through a direct or indirect contractual relationship, some or all of the product(s) and/or program(s) in which Members are enrolled.

Non-Participating Provider(s):
A non-participating provider is a physician, Facility or other medical provider that has not entered into an agreement with Anthem to provide health care services to Members.

Observation:
The services furnished by a Provider on the Facility’s premises, regardless of the length of stay, including use of a bed and periodic monitoring by nursing or other staff, which are reasonable and necessary after surgery or to evaluate an outpatient condition and determine the need for a possible admission to the Facility as an inpatient.

Open Enrollment:
A period when eligible persons can enroll in a health benefits plan.

Other Payors:
Persons or entities, utilizing the Networks/Plan Programs pursuant to an agreement with Anthem or an Affiliate, including without limitation, other Blue Cross and/or Blue Shield Plans that are not Affiliates, self-administered or self-insured programs providing Health Benefit Plans, or employers or insurers.

Outpatient Services:
Covered Services other than Inpatient Services which are provided to a Member by Facility.

Out-of-Pocket:
Those medical expenses which an insured is required to pay because they are not covered under the group contract.

Participation Attachment:
The document(s) attached to, or made a part of the Agreement which identifies the additional duties and obligations related to Network(s) and/or Plan Programs.

Patient Day:
Each approved calendar day of care that a Member receives in the Facility, to the extent such day of care is a Covered Service under the terms of the Member’s Health Benefit Plan, but excluding the day of discharge.

Per Diem Rate:
The Anthem Rate that is expressed as an all-inclusive fixed payment for each Patient Day of admission or one outpatient encounter.

A list of medical services and procedures performed by physicians and other providers. Each service and/or procedure is identified by its own unique 5-digit code. CPT has become the health care industry’s standard for reporting physician procedures and services, thereby providing an effective method of nationwide communication.

Plan:
Refers to (1) Anthem; (2) an Affiliate as designated by Anthem; and/or (3) Other Payor.

**Plan Compensation Schedule (PCS):**
The document(s) attached to, or made a part of the Agreement which set forth the Anthem Rate(s) for the Network(s) in which Facility participates.

**Plan Program:**
Any program now or hereafter established, marketed, administered, sold, or sponsored by Plan, or Blue Cross Blue Shield Association ("BCBSA") (and includes the Health Benefit Plans that access, or are issued, or entered into in connection with such program). Plan Program shall include but is not limited to, a health maintenance organization, a preferred provider organization, a point of service product or program, an exclusive provider organization, an indemnity product and program, and a quality program(s). The term Plan Program shall not include any program excluded by Plan or BCBSA.

**Point-of-Service:**
A managed care product that offers the advantages of an HMO with the flexibility of a traditional health insurance plan. Members decide where to receive care when they need it at the point-of-service.

**Pre-admission Review:**
A component of a Utilization Management program which reviews an inpatient Facility stay prospectively to determine coverage.

**Preauthorization:**
A prospective process to verify coverage of proposed care, to establish covered length of stay and to set a date for concurrent review.

**Preferred Provider Organization (PPO):**
A Network of facilities and physicians who agree to participate in a PPO Network. Members of this type of product may incur higher out-of-pocket expenses for covered services received outside the PPO.

**Protected Health Information (PHI):**
Individually identifiable health information transmitted or maintained in any form or medium (including orally, electronically or on paper).

**Primary Care Physician ("PCP"):**
A primary care physician is a physician who is a family or general practitioner, internist or pediatrician. PCPs provide a broad range of routine medical services and refer Members to specialists, facilities and other providers as necessary. Each covered family Member who participates in BlueChoice HMO or Blue Choice Option, chooses his or her own PCP from the Network’s physicians.

**Specialists:**
Providers whose practices are limited to treating a specific disease (e.g., oncologists), specific parts of the body (e.g., ear, nose and throat), or specific procedures (e.g., oral surgery).

**URAC:**
An independent, not-for-profit corporation established in 1990 by organizations representing the managed health care industry, health care providers, consumers, and regulators to promote continuous improvement in the quality and efficiency of health care management through processes of accreditation and education.

**Utilization Management:**
The process of evaluating a proposed hospitalization, service, or procedure and determining whether the hospitalization, service or procedure meets established guidelines and criteria to be covered under a Member’s contract.

**Wellness Programs:**
A broad range of employer sponsored facilities and activities designed to promote safety and good health among employees. Its purpose is to reduce the costs of accidents, sickness, absenteeism, lower productivity and health care costs.
Notice of Potential Liability Form

NOTICE OF POTENTIAL LIABILITY
BLUE CROSS and BLUE SHIELD OF GEORGIA, INC.

Patient Name ________________________________________________________________

Address ______________________________________________________________________

ID/Contract # ______________________________________________________________________

Group # ___________________________ Date of Service ______/_______/_______

Based on the information available at this time, ______________________________ (Provider or Facility) and Blue Cross and Blue Shield of Georgia, Inc. (Anthem) have determined that the following will not be reimbursed by Anthem under the member’s Membership Agreement.

___________ Inpatient Admission for _______/______/______

___________ Additional Inpatient Treatment after _______/______/______

___________ Other Hospital or Outpatient services _______/______/______

Estimated cost of services: ______________________________________________________

Expenses incurred for the above treatment(s) will be the responsibility of the member/patient.

Should the member or attending physician disagree with this decision, the member or the attending physician should refer the matter to the Utilization Management Division of Anthem.

ACKNOWLEDGEMENTS:

Member Signature ___________________________ Hospital Representative Signature ___________________________

Member Printed Name ___________________________ Hospital Representative Printed Name ___________________________

Date ___________________________ Hospital Representative Title ___________________________

Date ___________________________
FEE SCHEDULE REQUEST FORM

For all participating physicians and hospital based providers statewide.

Please send request via email or fax to:

Email: To your Provider Rep or Fax: 877-551-6184

Chiropractors please contact American Specialty Health Network (ASHN) at 800-972-4226 for Fee Schedule Requests.

Ancillary Providers, please contact Ancillary for Fee Schedule Requests at 404-479-8615.

Please complete the following required information to provide fee schedule:

Provider or Group Name: __________________________________________________________

Provider or Group Address _________________________________________________________

Tax ID: _______________________________________________________________________

NPI #: _________________________________________________________________________

Provider Specialty: _______________________________________________________________

Contact Name: __________________________________________________________________

Contact Phone #: __________________________ ________________________________

Email Address: __________________________________________________________________

➢ Please select the network(s) fee schedule needed:  [ ] HMO  [ ] PPO
                          [ ] PAR  [ ] Open Access
                          [ ] Pathway

Please note that the inclusion of a specific procedure code on the attached report should not be viewed as an assurance or guarantee of coverage or payment. ANTHEM members’ benefit plans vary widely and are subject to change based on the contractual effective dates. Claim payment and procedure coverage determinations are made in accordance with an individual member’s benefits in effect on the date that services are rendered.

ANTHEM will respond to your Fee Schedule Request within five (5) business days by email.
Appendices

APENDIX A: QUALITY CARE PROVIDERS, INC. (ATLANTA AREA ONLY)

Quality Care Providers, Inc. (“QCPI”), a Georgia non-profit corporation, is an independent practice network consisting of over one-thousand, four-hundred and fifty (1450) PCPs, practicing in Internal Medicine, Family Practice and Pediatrics in and around metropolitan Atlanta. QCPI was formed in 1993. Its mission is to meet the recognized objectives of managed care: high quality care, access and cost efficiency. QCPI seeks to integrate its physicians both clinically and economically through a number of activities including, but not limited to:

1. Providing a means of integrating financial and provider management in connection with the delivery of health care services, emphasizing the role served by PCPs as coordinators and managers of patient care in managed health care plans;

2. Providing a means for contracting for health care services with PCPs on a quality-sensitive, discounted, capitated and/or other cost-effective basis;

3. Promoting efficiency and cost-effectiveness in the providing of health care services by techniques such as electronic data interchange among Network/Participating Providers and payors, and offering financial incentives to PCPs to encourage use of these techniques;

4. Providing a means to encourage and be responsible for PCPs’ use of utilization and quality management activities; and

5. Improving access for residents of the Atlanta community to quality, affordable health care.

QCPI currently has an agreement with Anthem to deliver primary care services to purchasers of certain managed care health insurance products.

QCPI CONTACT INFORMATION

Address: Quality Care Providers, Inc.
3445 Peachtree Road NE
Suite 1200
Atlanta, GA 30326

Phone: (678) 553-4600
Fax: (678) 553-4601
Email: contact@qcpi.org

QCPI Officers:

Dr. Miles E. Brett, MD
Chairman

Michael J. Kinstler, MD
President, Chief Medical Officer

Joel A. Goldstein, MD
Executive Vice President, Treasurer

Imani D. VanNory, MD
Executive Vice President, Secretary

J. Vincent Vigil, MD
Assistant Secretary

QCPI Board of Directors:

Family Practitioners: Pediatrics

Miles E. Brett, MD
Joel A. Goldstein, MD

J. Vincent Vigil, MD

Internists

Michael Kinstler, MD
Imani D. Vannoy, MD
NOTIFICATION REQUIREMENTS

Each PCP acknowledges that in order to remain a QCPI provider he/she must, on an ongoing basis, meet QCPI credentialing standards. To view a copy of the standards, visit www.qcpi.org.

In addition, each PCP must notify QCPI within three (3) business days of the occurrence of any of the following:

1. The filing of a professional malpractice lawsuit against the PCP or the final disposition of any professional malpractice lawsuit against the PCP or any judgment or settlement involving the PCP which might materially impair the PCP's ability to provide health care services to Members; or

2. Any revocation, reduction, restriction, suspension, limitation, termination, denial or voluntary relinquishing of any professional license, permit, certification, medical staff membership or privilege or participation in the Medicare or any Medicaid program occurring on or after the date of the PCP’s Independent Physician Agreement, or any notification from any governmental body indicating the potential change in the PCP’s receiving any change or notification of potential change in the PCP’s professional licensure or DEA certificate status; or

3. Any resignation from the medical staff of any hospital or clinic, whether or not such hospital or clinic is a Network /Participating Provider (and such notice must include the reason(s) therefor); or any denial, modification, revocation, curtailment or limitation, in any manner, for any reason, including without limitation, reasons involving patient or medical care, of medical staff privileges of the PCP at any hospital or clinic (whether or not such hospital or clinic is a Participating Provider), excluding temporary suspensions for failure to comply with such institution's medical record regulations; or the taking of any action affecting the medical staff privileges of PCP at any hospital or clinic that may reasonably be expected to impair the ability of the PCP to perform under the PCP's Independent Physician Agreement or as required in this Network Manual; or

4. Any indictment, arrest or conviction for any felony or for any criminal charge related to, incidental to or in any manner involving the PCP or the PCP’s services; or

5. Any determination of bankruptcy, whether initiated voluntarily or involuntarily, of the PCP or any professional corporation or other entity of which the PCP is an owner, partner or employee, or any order appointing a receiver with respect to same; or

6. Any dishonest or unethical behavior by PCP which may result in damage to or discredit upon QCPI.

7. Any denial of or termination of any professional liability insurance; or

8. The PCP’s ceasing to practice in Internal Medicine, Family Practice or Pediatrics with an office which is open a minimum of 4 days per week and with the PCP’s providing at least 20 hours per week of physician-patient contact.

Each PCP is to send a notice to Anthem within three (3) business days of the PCP receiving any change or notification of potential change in his/her professional licensure or DEA certificate status and is to notify Anthem within fifteen (15) days of receipt of actual notice of the occurrence of any of the following:

1. Any change to the information submitted on the initial or recredentialing Physician Application.
2. Any change in ownership or business address.
3. Any legal or governmental action or any other problem or situation which might impair the ability of the PCP to carry out his/her duties and obligations under his agreement with QCPI, including, but not limited to, employee strikes or walkouts, financial insolvency or damages to the physical plant resulting in any interruption of the provision of medical services.
4. Any suit or claim by a Member against the PCP.
5. Any disciplinary action taken by QCPI that result in termination.

Notices required under this Section are to be sent to:

Quality Care Providers, Inc.
3445 Peachtree Road NE
Suite 1200
Atlanta, GA  30326
Fax:  (678) 553-4601
Email: contact@qcpi.org

AND TO:

Anthem
Provider Services
Mail Code GA11-0000
4170 Ashford Dunwoody Road
STE 100
Atlanta, GA 30319

STATUS CHANGES:

ADDING NEW PHYSICIAN(S) TO PRACTICE/GROUP

PCPs must notify Anthem and QCPI, in writing, of the addition of physician(s) to their practice group. A copy of the new physician’s CV is to be submitted with the notice.

The new physician must be approved for participation by QCPI and must meet all credentialing criteria required by QCPI (and by Anthem). In order to be reviewed by the QCPI Credentialing Committee for inclusion in the network, the appropriate credentialing application must be submitted. To view a copy of the standards, visit www.qcpi.org. The QCPI Credentialing Committee meets once a month.

The Board of Directors of QCPI, either directly or through its Executive Committee, in its sole discretion, has the right to accept or reject applications for participation on the PCP’s panel.

Please send notice of addition of physician(s) to the practice group and their CVs to the following addresses:

Quality Care Providers, Inc.
3445 Peachtree Road NE
Suite 1200
Atlanta, GA 30326
Fax: (678) 553-4601
Email: contact@qcpi.org

AND TO:

Anthem
Provider Services
Mail Code GA11-0000
4170 Ashford Dunwoody Road
STE 100
Atlanta, GA 30319

DEPARTURE OF A PHYSICIAN FROM A PRACTICE/GROUP

PCP's must notify QCPI and Anthem, in writing, if he or she leaves his/her current practice or group.

In addition, each practice which has Provider s should also notify QCPI and Anthem if a Provider leaves the practice or group.

Sixty (60) days’ notice is recommended in cases of deletion of a physician(s) from a practice or group in order to allow timely updates.

Please send notice to the following addresses:

Quality Care Providers, Inc.
3445 Peachtree Road NE
Suite 1200
Atlanta, Georgia 30326
AND TO:

Anthem
Provider Services
Mail Code GA11-0000
4170 Ashford Dunwoody Road
STE 100
Atlanta, GA. 30319
Fax: (404) 842-8149

TERMINATION BY PHYSICIAN

A PCP desiring to withdraw from the QCPI network must notify QCPI in writing ninety (90) days in advance of the anticipated termination of his/her Independent Physician Agreement. The 90-day period for notice of cancellation will begin upon the earlier of: when personally delivered, when received or three (3) days after the date mailed. See Article XI, Sections 11.6 and 12.11 of the QCPI Independent Physician Agreement.

Please send notice to the following address:

Quality Care Providers, Inc.
3445 Peachtree Road NE
Suite 1200
Atlanta, GA 30326
Fax: (678) 553-4601

WITH A COPY TO:

Anthem
Provider Services
Mail Code GA11-0000
4170 Ashford Dunwoody Road
STE 100
Atlanta, GA. 30319
Fax: (404) 842-8149

TERMINATION BY QCPI

QCPI may terminate a PCP’s Independent Physician Agreement with or without cause by giving sixty (60) days prior notice to the PCP, as provided for in Section 11.3 of the QCPI Independent Physician Agreement.
APPENDIX B

Georgia Rural Healthcare Initiative (Telemedicine)

Anthem in cooperation with Georgia Insurance and Fire Commissioner, Ralph Hudgens, have launched the Commissioner’s advanced telemedicine network for the delivery of health care services to patients in traditionally underserved rural areas. Telemedicine is a health care delivery method that applies high-speed telecommunication systems, computer technology and specialized medical cameras to examine, diagnose, treat and educate patients from a distance.

For example, through a telemedicine encounter, a patient in Alma, Georgia may seek medical treatment from one of Georgia’s leading specialty hospitals without spending the time and money required to travel for an in-person appointment.

The driving force behind the development of the telemedicine network was to enable patients in rural areas throughout the state to have access to the type of specialty care previously available only in the larger population centers. The program promises to:

- Increase access to specialty care throughout Georgia
- Improve timeliness of diagnosis and treatment
- Improve the quality of care for rural patients

The Georgia telemedicine program utilizes more than 45 specialties including cardiology, dermatology, endocrinology, neurology, pediatrics, psychiatry and rheumatology. The telemedicine network consists of 42 presentation sites located in rural hospitals or hospital-associated clinics connected to academic medical center or related care facilities. The goal is to enable patients anywhere in Georgia to have access to specialty care within a 30-minute drive or less. Current plans call for referral or specialty care sites to be established at:

- Emory University Hospital in Atlanta
- Medical College of Georgia in Augusta
- Piedmont Hospital in Atlanta
- Memorial Health in Savannah
- Archbold Medical Center in Thomasville

While the application of telemedicine varies based on the specialty consult needed, the sites will be equipped to offer two methods as outlined below:

- **Live Video** - Via live video, the primary care provider, the patient and a specialist meet at the same time using telemedicine video and telephone equipment. As the patient’s physician, you decide whether a specialist is needed and if it may be best to use the telemedicine equipment. The patient then agrees to have the appointment via telemedicine rather than in person. The telemedicine presentation site schedules the telemedicine appointment and provides all of the information to the specialist. During the appointment, the patient is “presented” by someone at the presentation site to the specialist using a telemedicine video camera. The specialist then makes the recommendations to help the patient.

- **Store and Forward** – For a Store and Forward telemedicine visit; an image of the patient’s condition is taken and sent electronically to the specialist for review. The patient’s physician must first decide whether a specialist should review the patient’s condition. Once the patient agrees to have an electronic image taken of their condition, the presentation site then forwards the patient’s information and images to the specialist. Based on the images, the specialist makes recommendations to help the patient and returns the recommendations to the presentation site.

Most telemedicine visits take from 15 to 20 minutes. It’s easier and faster for patients to “see” a specialist without driving long distances. As the patient’s physician, you can choose from a variety of specialists to “see” your patients, no matter where they live. Additionally, you can send patient medical information and pictures
of the patient’s condition to a specialist for a second opinion. Most importantly, you stay involved with the care your patients receive. Claims must be submitted with either the GQ or GT modifiers.

The telemedicine network will provide an open web of access points established throughout the state, connecting rural areas, where barriers to specialty care typically exist. This open access network will offer unprecedented access to specialty care.

Links

Contact Us

http://www.Anthem.com/wps/portal/chpproviderAnthem?content_path=provider/noapplication/providerservices/contactus/notertiary/pw_ad031465.htm&rootLevel=3&label=Contact%20Us

Medical Policy and Clinical UM Guidelines Link


Centers of Medical Excellence

http://www.Anthem.com/wps/portal/chpproviderAnthem?content_path=shared/noapplication/healthinformation/preventivecare/tobaccoceassation/pw_b130390.htm&rootLevel=1&label=Centers%20of%20Medical%20Excellence

Federal Employee Health Benefit Program (FEHBP) Website

http://www.fepblue.org/

BlueValue Secure Provider Website


Quality

http://www.Anthem.com/wps/portal/chpproviderAnthem?content_path=provider/noapplication/f0/s0/t0/pw_b126978.htm&rootLevel=1&label=Quality%20Improvement%20and%20Standards

EDI

http://www.Anthem.com/wps/portal/chpproviderAnthem?content_path=provider/noapplication/plansbenefits/electronictransactions/notertiary/pw_ad031449.htm&rootLevel=3&label=Electronic%20Data%20Interchange%20%28EDI%29

Provider Home-Local-GA

http://www.Anthem.com/home-providers.html