Anthem Blue Cross and Blue Shield

New York Provider Manual

Effective November 1, 2023

Services provided by Anthem HealthChoice HMO, Inc. and/or Anthem HealthChoice Assurance, Inc., licensees of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield plans.

NYBCBS-CM-PM-043798-23
11/1/2023

Table of Contents

INTRODUCTION AND GUIDE TO MANUAL 9

LEGAL AND ADMINISTRATIVE REQUIREMENTS 10

Addition of New Providers to a Provider Group Agreement 10
Admission, Discharge and Transfer Messaging Data 10
Advance Patient Notice for Use of a Non-Participating Provider 11
Advance Patient Notice for Use of an Out-of-Network Breast Reconstruction Surgeon 13
Affiliates 14
Clinical Data Sharing 14
Complaints 15
Coordination of Benefits 15
Copayments and Cost Sharing 16
Dispute Resolution, Mediation and Arbitration 18
Domestic Violence – Alternate Contact Information 20
Financial Institution/Merchant Fees 20
Healthcare Provider Performance Evaluations 21
Insurance Requirements 21
Misrouted Protected Health Information (PHI) 22
Network Participation Termination and Appeals 22
Open Practice 24
Open Dialogue 24
Physician Access/Appointment Availability Standards 24
Physician Responsibilities 26
Physician Office Lab (POL) List 29
Provider and Facility Responsibilities 29
Provider and Facility Digital Engagement 29
Referrals 29
Refund Provisions 31
Risk Adjustments 32
Transitional Care for New Enrollee 34

PROVIDER RESOURCE INFORMATION 34

ANTHEM DIGITAL TOOLS 35
Anthem Provider Website 35
Online Provider Directory and Demographic Data Integrity 36
Availity Essentials 39

ELIGIBILITY AND MEMBER ID CARD SAMPLES 45
Alpha Prefix Information 45
Suitcase Logos 45
ID Card Samples 46
Newborn Enrollment 46

CREDENTIALING 46

STANDARDS OF PARTICIPATION 47

CLAIMS SUBMISSION 48
General Guidelines 48
Electronic Claims Submissions 48
Claim Submission Filing Tips 49
Filing Tips for Contiguous Border County Providers 52
Claim Inquiry/Adjustment Filing Tips 54
National Drug Codes (NDC) 57
Paper Claims Submissions 62
Medical Records Submission 63
Electronic Data Interchange (EDI) 65
Overpayments 67
Medicare Crossover 69

CLAIM PAYMENT DISPUTES 72
Provider and Facility Claim Payment Dispute Process 72
Step 1: Claim Payment Reconsideration 73
Step 2: Claim Payment Appeal 74
Required Documentation for Claims Payment and Coding Disputes 75

CLINICAL APPEALS 75

MEMBER QUALITY OF CARE/QUALITY OF SERVICE INVESTIGATIONS 81
Overview 81
Corrective Action Plans (“CAP”) 82

Reporting 82
Severity Levels for Quality Assurance 82
Trend Threshold for Analysis 84

REIMBURSEMENT REQUIREMENTS AND POLICIES 85

Admissions 85
Blood, Blood Products, and Administration 85
Changes During Admission/Continuous Outpatient Encounter 86
Chargemaster Cap 86
Clinic Services 86
Coding Requirements 87
Comprehensive Health Planning 87
Cosmetic and Reconstructive Surgery 87
Courtesy Room 87
Different Settings Charges 87
Eligibility and Payment 87
Emergency Room Supplies and Services Charges 87
Evaluation and Management (E&M) Services 88
Facility Personnel Charges 88
General Industry Standard Language 88
General Rules Relating to Facility Payment Methodologies 88
Home Sleep Study Policy 89
Incidental Procedures 89
Instrument Trays 89
Interim Bill Claims 89
IV Sedation and Local Anesthesia 89
Lab Charges 89
Labor Care Charges 90
Lesser of Reimbursement 90
Medical Care Provided to or by Family Members 90
Nursing Procedures 90
Operating Room Time and Procedure Charges 90
Other Agreements 91
Outpatient CPT Based Claims 91
Personal Care Items 91

Pharmacy Charges 91
Portable Charges 92
Pre-Operative Care or Holding Room Charges 92
Preparation (Set-Up) Charges 92
Provider and Facility Records 92
Recovery Room Charges 92
Recovery Room Services Related to IV Sedation and/or Local Anesthesia 92
Respiratory Services 92
Rounding of Allowances 93
Routine Supplies 93
Services Related to Non-Covered Services, Supplies, or Treatment 93
Special Procedure Room Charge 93
Stand-by Charges 93
Stat Charges 93
Submission of Claim/Encounter Data 94
Supplies and Equipment 94
Tech Support Charges 94
Telemetry 94
Test or Procedures Prior to Admission(s) or Outpatient Services 94
Time Calculation 95
Transfers 95
Undocumented or Unsupported Charges 95
Video or Digital Equipment used in Operating Room 96
Additional Reimbursement Guidelines for Disallowed Charges 96

CLINICAL PRACTICE GUIDELINES 100

PREVENTIVE HEALTH GUIDELINES 101

MEDICAL POLICIES AND CLINICAL UTILIZATION MANAGEMENT ("UM") GUIDELINES ... 101
Medical Policy and Clinical Utilization Management ("UM") Guidelines Distinction 102
Accessing Medical Policies and Clinical UM Guidelines 102
Clinical UM Guidelines 103
Other Criteria 103

UTILIZATION MANAGEMENT 103
Utilization Management Program 103

UM Definitions ... 103
Program Overview ... 104
Preservice Review & Continued Stay Review ... 105
Medical Policies and Clinical UM Guidelines ... 105
On-Site/Electronic Medical Record Review (EMR) ... 106
Observation Bed Policy ... 106
Retrospective Utilization Management ... 106
Failure to Comply With Utilization Management Program Processes ... 106
Utilization Statistics Information ... 106
Inpatient Electronic Data Exchange ... 106
Submit Prior Authorization Requests Digitally ... 106
Reversals ... 107
Reconsideration (Peer-to-Peer) and Medical Director Availability ... 107
Quality of Care Incident ... 107
Audits/Records Requests ... 108
Case Management ... 108
Notification or Precertification Requirements ... 108
Precertification of Emergency Services ... 109
Anthem's Timeframes for UM Decision Making ... 109
Hospital Admissions and Use of the Last Approved Day (LAD) Report ... 110
Delay in Service Denials ... 111
Medical Necessity Denials ... 111
Specialty Care Center and PCP Specialist Requests ... 111
Predetermination Overview ... 111
Anthem as Secondary Payor ... 112

CARELON MEDICAL BENEFITS MANAGEMENT, INC. ... 112

Submit Precertification/Preauthorization requests to Carelon Medical Benefits Management ... 112
OptiNet® Registration ... 113

QUALITY IMPROVEMENT PROGRAM ... 113

Quality Improvement (QI) Program Overview ... 113
Member Rights and Responsibilities ... 115
Continuity and Coordination of Care ... 116
Continuity of Care/Transition of Care Program ... 116

Quality-In-Sights®: Hospital Incentive Program (Q-HIP®) 117
Performance Data 118
Overview of HEDIS 118
Overview of CAHPS® 119
Medical Record Standards 119
Managed Care Reporting 119
Records, Maintenance, Availability, Inspection and Audit 120
Patient Center Primary Care Program (PCPC) 124

CULTURALLY & LINGUISTICALLY APPROPRIATE SERVICES 124

CENTERS OF MEDICAL EXCELLENCE 126
Transplant 126
Cardiac Care 127
Bariatric Surgery 127
Cancer Care 128
Spine Surgery 128
Knee and Hip Replacement 128
Maternity Care 128
Substance Use Treatment and Recovery 129
Ventricular Assist Devices 129
Cellular Immunotherapy (Chimeric Antigen Receptor Therapy – “CAR-T”) 129

AUDIT AND REVIEW 130
Audit and prepayment Review Policy 130
Audit Appeal Policy 134

FRAUD, WASTE AND ABUSE DETECTION 135
Reporting Fraud, Waste and Abuse 135
Investigation Process 137
Prepayment Review 137
Acting on Investigative Findings 138
Recoupment/Offset/Adjustment for Overpayments 138

PHARMACY HOME PROGRAM 139

HEALTH INSURANCE MARKETPLACE (EXCHANGES) 140

FEDERAL EMPLOYEE HEALTH BENEFITS PROGRAM (FEHBP) 141

FEHBP Requirements 141
Submission of Claims under the FEHBP 141
Erroneous or duplicate Claim payments under the FEHBP 142
Coordination of Benefits for FEHBP 142
FEHBP Waiver requirements 142
FEHBP Member Reconsiderations and Appeals 142
FEHBP Formal Provider and Facility Appeals 143
FEHBP Inpatient Skilled Nursing Facility Care 144
Online information for FEHBP 144

BLUECARD PROGRAM OVERVIEW 144

MEDICARE ADVANTAGE PROVIDER WEBSITE 145

APPENDIX A 146
Americans with Disabilities Act 146
Patient's Self-determination Act 146
Assistance for Non-English Speaking Members 146
Confidentiality Policy 146
Notice of Privacy Practices (as directed towards Members) 148
Confidentiality of HIV Information 152

Introduction and Guide to Manual

Anthem is an independent licensee of the Blue Cross and Blue Shield Association. Anthem maintains a network of independent physicians, multi-specialty group practices, ancillary Providers and healthcare Facilities contracted to provide healthcare services to Members.

Anthem and our health plan affiliates are committed to working together with our care provider partners to make a real impact on health for their patients – our members. That's why we continue our focus to streamline our processes to help make it easier for care provider partners to find and use the information they need for their business interactions with us. With this collaboration, it's one more way that we're working to ensure members have access to high-quality, affordable healthcare.

To that end, this Provider Manual ("Manual") contains important information regarding key administrative requirements, policies and procedures. including but not limited to Claims submission, reimbursement and administrative policies and requirements, credentialing, utilization management and quality improvement. While the Manual covers a wide array of policies, procedures, forms, and other useful information that can be found and maintained on our website at **anthem.com**, a few key topics are:

- Claims submission
- Reimbursement and administrative policies and requirements
- Credentialing
- Utilization management
- Quality improvement

As a participant in our diverse Anthem network, the Agreement you have with Anthem requires Providers and Facilities to comply with Anthem policies and procedures including those contained in this Manual. Payment may be denied, in full or part, should Providers or Facilities fail to comply with the Manual. However, in the event of an inconsistency between the Agreement and this Manual, the Agreement will govern.

The policies and procedures in this Manual apply unless otherwise required by the Agreement.

Provider versus Facility

This Manual is intended to support all entities and individuals who have executed a Provider or Facility Agreement with Anthem. The use of "Provider" within this Manual refers to entities and individuals contracted with Anthem who submit professional Claims. 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 who submit institutional Claims, such as Acute General Hospitals and Skilled Nursing Facilities. General references to "Provider Inquiry", "Provider Website", "Provider Network Manager" and similar terms apply to both Providers and Facilities.

Capitalization

Capitalized terminology shown in this Manual is the same capitalized terminology shown in the Anthem Facility Agreement or Anthem Provider Agreement, referred to in this Manual as "Agreement".

Updates to the Provider Manual

This Manual may be updated at any time and is subject to change. If there is a material change to this Manual, then Anthem will make reasonable efforts to notify our care provider partners in advance of such change through web-posted newsletters or email communications. In such cases, the most recently published information will supersede all previous information and be considered the current directive. The most up-to-date version is available online at **anthem.com.**

Important disclaimer

Please note that this Manual is not intended to be a complete catalog of all Anthem policies and procedures. Other policies and procedures not included in this Manual may be posted on the Anthem website or published in specially targeted communications, including but not limited to bulletins and newsletters. This Manual does not contain legal, tax or medical advice. Care provider partners should consult their advisors for advice on these topics.

Compliance with Provider Manual

Provider and Facility agree to abide by, and comply with, Anthem's Provider manual and all other policies, programs and procedures established and implemented by Anthem. Anthem retains the right to add to, delete from and otherwise modify this Manual but will make good faith effort to provide notice to Provider or Facility at least ninety (90) days in advance of the effective date of material modifications. Providers and Facilities must acknowledge this Manual and any other written materials provided by Anthem as proprietary and confidential. If there is a conflict with the Manual and the Agreement, the Agreement supersedes. Anthem encourages Providers and Facilities to contact an Anthem contracting representative whenever clarification is needed or with any suggestions for improvement to the Manual.

Legal and Administrative Requirements

ADDITION OF NEW PROVIDERS TO A PROVIDER GROUP AGREEMENT

Providers operating under an existing participation Agreement, (individual or group) with Anthem are required to notify Anthem of any new Providers joining or leaving the practice at least forty five (45) days in advance.

No Provider subsequently joining a practice shall be authorized to render services to Members as a participating Provider, until the practice has been notified in writing that Anthem or its designee has completed its credentialing review and system upload of such Provider and approved his or her participation under the executed participation Agreement. In the event that the Provider or practice submits Claims for new Providers prior to Anthem completing its credentialing reviews, the Provider or practice will hold Anthem and Member harmless for the charges.

ADMISSION, DISCHARGE AND TRANSFER MESSAGING DATA

Facilities must provide Anthem with, at minimum, Health Level Seven International (HL7) Admission, Discharge and Transfer (ADT) messaging data for all Members on a near real-time basis, including all standard HL7 message events pertaining to ADT as published by HL7. Facility will transfer required message data segments according to the standard HL7 format, or as

requested by Anthem. For purposes of this section, “near real-time basis” means no later than twenty-four (24) hours from admission, discharge or transfer of any Members.

ADVANCE PATIENT NOTICE FOR USE OF A NON-PARTICIPATING PROVIDER

Consistent with the terms of the participating Agreement, Providers and Facilities are required to refer to participating Facilities, physicians, or practitioners. It is important that Members be made fully aware of the financial implications when they are referred by their physician, on a non-urgent basis, to a non-participating Provider. It is especially critical to notify Members when using a non-participating Provider in their Provider’s own office for services such as laboratory, anesthesia, specialty drugs, infusion therapy or durable medical equipment. Likewise, Members should be made aware if their selected participating surgeon has chosen to use a non-participating assistant surgeon or ambulatory surgery center in a scheduled surgery. In both of these cases, the Member has no way of knowing that a non-participating Provider was involved in their care unless informed, in advance, by their physician. While certain Members may have out-of-network benefits, it is very disconcerting to them when they are presented with unexpected financial obligations for out of network medical services.

In an effort to assist Providers and Facilities in ensuring that Members are active participants in the decision to use a non-participating Provider in the situations described, Anthem has adopted a policy regarding disclosure to Members when a participating Provider involves a non-participating Provider in their patient’s care, “**Use of a Non-Participating Provider Advance Patient Notice Policy (APN form)**”. This policy is intended to ensure that patients receive prior notification of the use of a non-participating Provider when the provision of those services is within the control of the physician or other healthcare Provider and the patient, in the absence of this notice, is unlikely to be aware that he/she will be receiving care from a non-participating Provider until they receive a bill for the services rendered.

This policy is not intended to deter patients from using their out-of-network coverage to the extent available. To the contrary, this policy is designed to ensure that, in non-emergent situations, when Members receive services from a non-participating Provider it is because they were involved in the decision making process and made a conscious election. Therefore, we have developed an Advance Patient Notice (APN) to be used when Providers and Facilities deem it necessary to refer out of network for these services. This APN basically provides the patient with the information he or she would need to make an informed decision about coverage and options. Anthem expects that Providers and Facilities will provide the patient with this form before involving a non-participating Provider in the Member’s care in the situations noted and maintain it in their files for future verification and/or audit.

Note that this policy does not apply to emergent situations. Likewise, this policy does not apply when Providers, Facilities or the Member have obtained Anthem’s prior approval for the referral. When Providers, Facilities or the Member have contacted Anthem and received approval in advance to proceed with an out of network service in the Provider office or Facility or use a non-participating surgical assistant in a scheduled surgery, Providers or Facilities may do so, without use of the APN form. As always, Anthem will grant approval for the use of non-participating Facilities, physicians, or practitioners on an in network basis as provided in the network exception policies (such as when no in network Facility, surgeon or practitioners practicing within an appropriate surgical specialty is available to assist in a surgery requiring a surgical assistant) and as provided or required under applicable law. Of course, Anthem believes the network is large enough to accommodate the needs of Members through participating physicians and Facilities and ask that Providers and Facilities contact Anthem if they feel this is not so.

This prior notification must be in the form of the **APN form** for the following non-participating services:

- In Office Anesthesiologist (i.e., anesthesia for in-office surgeries or anesthesia provided in connection with surgery or services performed at a free standing surgical center owned in whole or in part by the referring physician)
- Surgical Assistant (regardless of surgical setting)
- Specialty Drug vendor for specialty drugs provided in the office
- In Office Home Infusion Therapy (HIT)
- In Office Durable Medical Equipment
- Laboratory services for specimens collected in the physician's office when the specimen is sent to a non- participating reference lab
- Ambulatory Surgical Centers (this excludes Hospital Out-patient Ambulatory Surgical Departments)
- Endoscopy Centers
- Office Based Surgical Suites

Examples:

- A participating gastroenterologist is scheduling an endoscopy and plans to use a non-participating anesthesiologist or assistant surgeon. The patient must be presented with the APN form at the time the procedure is scheduled unless the physician or the patient obtained Anthem's approval.
- A participating gastroenterologist is scheduling an endoscopy and plans to use a non-participating Ambulatory Surgical Center or Endoscopy center. The patient must be presented with the APN form at the time the procedure is scheduled unless the physician or the patient obtained Anthem's approval.
- A Provider collects a lab specimen in the Provider's office but plans to send specimens to a lab other than Quest Diagnostics, LabCorp of America or another participating laboratory. The patient must be presented with the APN form at the time the procedure is scheduled unless the physician or the patient obtained Anthem's approval.
- A participating Primary Care Physician refers to a non-participating specialist and the physician or Member has obtained authorization. The use of the APN form is NOT required.
- A participating orthopedic surgeon refers a Member to a non-participating neuro-surgeon for a future consult in the neurosurgeon's separate office. The use of the APN form is NOT required.
- A physician schedules a procedure at a non-participating surgical suite that is billed as a non-participating Facility. The patient must be presented with the APN form before the procedure is scheduled unless the physician or the patient obtained Anthem's prior approval.

As noted above, once completed, a copy of the signed form should be kept on file to be provided to Anthem upon request. Although the use of the APN form will not be required under some circumstances, the referral shall be subject to Member benefits and any applicable Anthem policies including any policies applicable to referrals.

Anthem will track the use of nonparticipating Facilities, physicians and practitioners in the instances stated above and may request a copy of the APN. Other than an occasional administrative error that can occur, failure to provide a copy of the signed APN will result in an initial warning from Anthem. At this time, Anthem will not invoke a financial penalty after the initial warning but may elect to update this policy in the future. Repeated failure to comply with this policy, after initial warning, may result in termination from the Anthem network.

For a complete listing of Anthem's participating physicians, go to **anthem.com** > **Find Care**. It is important to note which network the Member utilizes as a physician's participation with Anthem may vary by network.

For any questions about the use of this form or Anthem's **Use of a Non-Participating Provider Advance Patient Notice Policy**; contact a Network Management Consultant. Anthem appreciates the cooperation of Providers and Facilities to work together to ensure that Members are active participants in decisions regarding the use of non-participating Providers in their healthcare and welcomes feedback regarding the quality and service of the existing network of participating Providers.

ADVANCE PATIENT NOTICE FOR USE OF AN OUT-OF-NETWORK BREAST RECONSTRUCTION SURGEON

As noted in Anthem's existing "Use of a Non-Participating Provider Advance Patient Notice Policy" which became effective on October 15, 2009, it is important that Members be made fully aware of the financial implications when they are referred by their physician, on a non-emergent basis, to a non-participating Provider. One particular area where we have received complaints is when Members are referred by their in-network mastectomy surgeon to an out-of-network breast reconstruction surgeon when that mastectomy surgeon has recommended that reconstruction surgery be performed in the same operative session as the mastectomy.

Accordingly, Anthem has adopted a separate policy entitled **"Advance Patient Notice for Use of an Out-of-Network Breast Reconstruction Surgeon"** to ensure that Anthem's Members receive prior notification of the surgeon's intent to refer to a non-participating breast reconstruction surgeon when the reconstruction surgery is to be performed in the same operative session as the mastectomy or in a separate operative session. Often, Members mistakenly believe that these breast reconstruction surgeons are participating in Anthem's network because their in-network mastectomy surgeon recommended or referred them to the out-of-network reconstruction surgeon. While some Members may have out of network benefits, others do not. In either case, Members are often surprised and unhappy, when they are presented with unexpected financial obligations for medical services.

Anthem have also updated the Advance Patient Notice (APN) form to require advance written notice prior to the Member being referred to an out-of-network breast reconstruction surgeon. This new APN form will provide Anthem's Members with the pertinent information to make an informed decision about coverage and options when they are being referred to an out-of-network breast reconstruction surgeon. To comply with this policy, provide the Member with the attached APN form for signature **prior to** scheduling services with or making a referral to, an out-of-network breast reconstruction surgeon, and retain the signed original in their files. This prior notification must be in the form of the enclosed APN. This new policy will require the mastectomy surgeon to know whether the reconstruction surgeon participates in the network.

Example: An in-network breast surgeon is scheduling a mastectomy and plans to use an out-of-network breast reconstruction surgeon as part of the procedure. The Member must be presented with the APN form before the procedure is scheduled or the referral made so that the Member

can contact Anthem for information about getting an exception approved for the out-of-network breast reconstruction surgeon before the referral is made and the procedure is scheduled.

Note that this policy does **not** apply to emergencies. Likewise, this policy does not apply when Providers or the Member have obtained Anthem's prior approval for the referral. When Providers or the Member have contacted Anthem and received approval in advance to proceed with an out of network service or use of an out-of-network physician, Providers may do so without use of the APN form. As always, Anthem will grant approval for the use of out-of-network physicians on an in network basis as provided in the network exception policies (such as when no in network surgeon within an appropriate service area is available) or as required under applicable law.

As noted above, once completed, the original signed form should be kept on file to be provided to Anthem upon request and a copy should be given to the Member. Although the use of the APN form will not be required under the circumstances identified in the paragraph above, the referral shall be subject to Member benefits and any applicable Anthem policies including any policies applicable to referrals. Anthem will track the use of out-of-network breast reconstruction surgeons in the instances stated above. Repeated failure to comply with the APN policy, after initial warning, may result in termination from the Anthem network.

For a complete listing of Anthem network Facilities, physicians and Providers, go to **anthem.com** or call Provider Services.

For any questions about the use of the Advance Patient Notice for Use of an Out-of-Network Breast Reconstruction Surgeon form or the Use of a Non-Participating Provider Advance Patient Notice Policy; contact a Network Management Consultant. Anthem appreciates the cooperation of Providers and Facilities to work together to ensure that Members are active participants in decisions regarding the use of out-of-network Providers in their healthcare and welcomes feedback regarding the quality and service of the existing network.

This policy is not intended to deter patients from using their out-of-network coverage to the extent available. To the contrary, this policy is designed to ensure that, when Members receive services from an out-of-network breast reconstruction surgeon in non-emergent situations, they are involved in the decision making process.

AFFILIATES

Affiliates are an important concept in Anthem's Provider and Facility Agreements, as these entities access the rates, terms or conditions of the agreements.

To view a current listing of Anthem affiliates, visit **anthem.com** > **For Providers** > **Provider Resources** > **Forms and Guides,** and then scroll down in the Category drop-down to select **Contracting &** > **Affiliated Companies**.

CLINICAL DATA SHARING

When requested by Anthem, providers are required to submit clinical data (such as discharge summaries, consult notes, and medication lists) and admission, discharge, and transfer (ADT) data to Anthem for certain healthcare operations functions. We collect this data to improve the quality and efficiency of healthcare delivery to our members. Providers are required to submit:

- ADT data to Anthem on a near real-time basis (no later than 24 hours) from the time of admission, discharge, or transfer of a member.
- Clinical data for a member on a daily, weekly, or monthly basis, based on the provider's electronic medical record (EMR) or other electronic data sharing capabilities.

Anthem's permitted uses of the data with respect to clinical data requests include utilization management, case management, identification of gaps in care, conducting clinical quality improvement, risk adjustment, documentation in support of HEDIS® and other regulatory and accrediting reporting requirements, and for any other purpose permitted under HIPAA.

Anthem has determined the data requested is the minimum necessary for Anthem to accomplish its intended purposes. The data will be provided in accordance with data layout and format requirements defined by Anthem.

For details on how to submit clinical data, review the administrative policy by visiting **anthem.com** > **For Providers** > **Forms and Guides,** and then scroll to **Administrative Policies** > **Clinical Data Sharing.**

In the event of a conflict between this Policy and the Provider Agreement, the Provider Agreement shall prevail.

COMPLAINTS

If the time arises when Providers or Facilities disagree with any of Anthem's policies or services, Providers and Facilities may file a complaint.

A complaint is a verbal or written expression of dissatisfaction with any aspect of Anthem's business operations not involving a plan decision.

If Providers or Facilities are dissatisfied with any aspect of Anthem's policies or practices relating to the delivery of services to Members, Providers and Facilities may file a complaint with Anthem. To do so, Providers and Facilities must contact Anthem's Provider Services by telephone at **800-992-2583**, 8:30 a.m. to 5:00 p.m. EST, Monday through Friday or in writing at the address below (No specific form for written complaints is required.)

Anthem Blue Cross and Blue Shield
Attn: Provider Services
PO Box 1407
Church Street Station
New York, New York 10008-1407

The complaint and any supporting documentation submitted by a Provider or Facility will be investigated by a qualified Provider Services Representative and the results will be communicated in a written decision within thirty (30) calendar days of receipt of all necessary information.

This process applies to instances in which Anthem is not being asked to review or overturn a previous administrative or medical management decision resulting in a Claim denial, reduction in Claim payment or denial of preauthorization or certification of covered services.

For information on Claims Payment Disputes or Clinical Appeals reference those sections in this Manual.

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. In cases where the primary payor is Medicare, Plan reimbursement as secondary payor will not exceed the balance after Medicare's primary payment.

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 the Electronic Coordination of Benefits (COB) Submissions

Availity is Anthem's designated electronic data interchange (EDI) gateway. Availity 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. To learn more, Providers and Facilities should contact their EDI vendor or go to Availity.com.

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.

COPAYMENTS AND COST SHARING

Members are responsible for the co-payment amount indicated on their ID cards. Copayments apply to home and office visits but do not apply to in-network Annual Preventative Care visits, Well-Child Care visits, or maternity care. There may be exceptions depending on the Member's contract.

Except for copayments, which may be collected at the time of service or discharge, Providers and Facilities should not bill the Member for any cost-sharing amounts until he/she has received an explanation of benefits (EOB).

Per the Anthem Practitioner Agreement, physician or practitioner agrees to only seek payment from a Member for a health service that is not covered under the Member's benefit plan, whether it is not covered because it is specifically excluded, is not considered medically necessary or is considered investigational, when the physician or practitioner has obtained a signed, **Anthem Non-Covered Services Notification Wavier** which can be found at **anthem.com.**

Billing Policy and Procedure Overview

All Claims must be submitted in accordance with the requirements of the Provider contract, applicable Member's contract, and this Provider Manual. Providers and Facilities may not seek payment for covered services from the Member, except for any applicable visit fees, co-payments, deductibles, coinsurance, or penalties as described in the Member's contract. In no event should a Provider or Facility require a deposit from a Member prior to providing covered services to the Member. Any Administrative charges applied by physicians must be within Anthem's contractual

and policies guidelines and should be prominently displayed within the office and disclosed to Members prior to any services be rendered.

NYS HCRA Surcharge Payments

Anthem has elected to make the surcharge payments required of certain Claims by The New York State Health Care Reform Act ("HCRA") directly to the Office of Pool Administration (the "Pool"). However, certain Claims require the Provider to submit the applicable surcharge to the Pool. The Explanation of Benefits for these Claims note the Provider is responsible for remitting the applicable surcharge to the Pool. Anthem's 835 electronic invoices display the amount of HCRA surcharge that should be remitted by the Provider to the Pool based on the Member's responsibility in the Claims Adjustment Segment (CAS) of OA*137. In both cases, the amount of the surcharge is accounted for and the Provider should not add such amount to the amount billed to the Member. These Claims are discussed below:

No surcharge remittance message present on Claims:

For fixed dollar copayments and deductibles, Anthem will remit the applicable surcharge directly to the Pool.

Remittance message for coinsurance with surcharge:

For coinsurance, Anthem will not pay the applicable surcharge due on the Member's coinsurance nor remit such amount directly to the Pool unless the Member has met the maximum out-of-pocket limit under their contract. Instead, Anthem includes the surcharge applicable to the Member's coinsurance in its Patient Responsibility amount and the Provider must remit the surcharge to the Pool after collecting such amount from the Member. For example, if the Member's EOB indicates a Patient Responsibility of $109.63; a Net Amount of $400.00; and a rate of $500.00, the amount that exceeds Anthem's rate should be remitted to the Pool by the Provider, i.e., $9.63 ($509.63-$500.00). The Provider should not bill Members for any amounts above and beyond any Patient Responsibility amounts indicated on the EOB**. These Claims have a Claim level message of: *An additional amount has been added to the Member's coinsurance to represent the Member's share of the NYS HCRA Surcharge on this Claim. The Provider may not bill the Member more than this additional amount for HCRA surcharge.* For most remittances, the Claim will have a message code of "AIS".**

Remittance message for cost share with surcharge:

For cost sharing, Anthem will not pay the applicable surcharge due on the Member's cost sharing amount nor remit such amount directly to the Pool. Instead, Anthem includes the surcharge applicable to the Member's cost sharing amount in its Patient Responsibility amount and increases its payment to the Provider to include any applicable surcharge. The Provider must remit the surcharge to the Pool after collecting such amount from the Member. For example, if the Member's EOB indicates a Patient Responsibility of $100.00; a Net Amount of $408.78; and a Rate of $500.00, the amount that exceeds Anthem's rate should be remitted to the Pool by the Provider, i.e., $8.78 ($508.78-$500.00). The Provider should not bill Members for any amounts above and beyond any Patient Responsibility amounts indicated on the EOB. **These Claims have a Claim level message code of "ASM": *An additional amount has been added to the Member's cost share to represent the Member's share of the NYS HCRA Surcharge on this Claim. The Provider may not bill the Member more than this additional amount for HCRA surcharge.***

DISPUTE RESOLUTION, MEDIATION 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 the procedures and processes that must be followed during the exercise of the Dispute Resolution and Arbitration Provisions in the Agreement. To the extent possible, the language of the Agreement and the Provider Manual should be read together and harmonized if there are details in one not addressed in the other.

A. Fees and Costs

All fees and costs associated with neutrals, logistics, and administration of confidential non-binding mediation and confidential binding arbitration (i.e. mediator travel and fee, arbitrator(s) travel and fee(s), arbitration association administrative costs, etc.) shall be shared equally between the parties. Each party shall be responsible for the payment of its own fees and costs that the party incurs (i.e. attorney fees, experts, depositions, document production, e-discovery, etc.). Notwithstanding this provision, the arbitrator or panel of arbitrators may issue an order in accordance with Federal Rule of Civil Procedure Rule 11 or the respective state rule counterpart awarding a party its fees if that party requested fees under Rule 11, or the respective state court counterpart rules in its initial pleadings. Notwithstanding this provision, the arbitrator or panel of arbitrators may issue an order in conjunction with a party’s offer of judgment in accordance with Federal Rule of Civil Procedure Rule 68.

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 identified in the Agreement 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. Pre-Arbitration Mediation and Selection and Replacement of Arbitrator(s)

Refer to the Agreement for invoking dispute resolution requirements, monetary thresholds of disputes (exclusive of interest, costs or attorney fees) that require a meeting to discuss and in effort to resolve or that require pre-arbitration mediation and selection of the mediator. In the event of a dispute where the dispute resolution provision is invoked, the first step is for the complaining entity to provide written notice containing a detailed description of the dispute, all relevant underlying facts, a detailed description of the amount(s) in dispute and how they have been calculated and any other information in this Provider Manual describing the policy, procedure, process and so on that is being disputed.

Refer to the Agreement for governing arbitration rules, monetary thresholds (exclusive of interest, costs or attorney fees) as applicable, selection of a single arbitrator or panel of three arbitrators, and replacement of an arbitrator.

D. Consolidation

The arbitrator or panel of arbitrators does not have the authority to consolidate separately filed arbitrations, for discovery or otherwise, without written consent and agreement by the parties. The arbitrator or panel of arbitrators does not have the authority to permit Providers or Facilities under separate Agreements with Anthem to bring one arbitration action without written consent and agreement by the parties. Rather, each Provider or Facility with separate

Agreements should file for separate arbitration in its own name, unless there is written consent and agreement by the parties to consolidate the action, in some fashion.

E. Discovery

The parties recognize that litigation in state and federal courts can be costly and burdensome. One of the parties' goals in providing for disputes to be mediated and 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 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. The parties shall confer and draft an Order Regarding Procedures for Production Format and Electronic Discovery, which shall be presented to the arbitrator or panel of arbitrators for review, approval and entry.

F. 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 upon the parties. 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. The arbitrator(s) shall not toll or modify any applicable statute of limitations, set forth in the Agreement, or controlling law if the Agreement is silent. If there is a dispute regarding the applicability or enforcement of the class waiver provisions found in 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 either a reasoned award or decision, or findings of facts and conclusions of law, and if either party makes such a request, the arbitrator(s) shall issue such an 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, as identified in the address block on the signature page to the Agreement, and of the United States District Courts sitting in the State(s) in which Anthem is located, as identified in the address block on the signature page to the Agreement, for confirmation, specific enforcement, or other relief in furtherance of the arbitration proceedings or to enforce judgment of the award in such arbitration proceeding.

If a party files an interim award, award or judgment with a state or federal district court, then all documents must be filed under seal to ensure confidentiality as outlined below, and only the portions outlining the specific relief or specific enforcement or performance shall be filed and the remainder of the opinion or decision shall be redacted.

Refer to the Agreement for monetary thresholds (inclusive of interest, costs and attorney fees) as applicable for the right to appeal the decision of the arbitrator or panel of arbitrators. A decision that has been appealed shall not be enforceable while the appeal is pending.

G. Interest

Providers or Facilities agree that the state's statutory pre-judgment interest statute is inapplicable to Dispute Resolution and Arbitration. Should the arbitrator(s) determine that pre-judgment interest is appropriate and issue an award including it, pre-judgment shall be simple, not compounded, at an annual percentage rate no more than five percent (5%) or the interest applied for "clean claims", whichever is less. If an award is issued and it includes post-judgment interest, it will not begin accruing until thirty (30) business days after the date of the award to allow time for payment. If an appeal is taken by either side, the obligation to pay any damages and/or interest awarded shall be tolled until a decision is reached as the result of the appeal.

H. 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, retrocessionaires or affiliates and Other Payors whose Claims have been at issue in the arbitration, including Administrative Services Only (ASO) groups and other Blue Plans.

DOMESTIC VIOLENCE – ALTERNATE CONTACT INFORMATION

A new law in New York allows Members who are victims of domestic violence to ask their insurer to send mail with personal information to an alternate address. Anthem will honor any reasonable request to use an alternative address or alternative means of communication if a Member tells Anthem that directing coverage or Claims-related information to the policyholder address poses a threat to the covered person or a child covered under the policy.

Be sure to share this information with Members. A Member can call Anthem at the Member Services phone number on their Anthem ID card or write to Anthem to make a request. A notice with additional information for Members, that can be printed and posted in the Provider office, can be obtained online at **anthem.com**.

Encourage any Member who may be a victim of domestic violence to call for help.

New York State Domestic and Sexual Violence Hotlines:

800-942-6906 (English)

800-942-6908 (Spanish)

800-621-HOPE (4673) or dial 311 (In NYC)

866-604-5350 (TTY)

Anthem is committed to working with Members and their Providers to help Members stay safe.

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.

HEALTHCARE PROVIDER PERFORMANCE EVALUATIONS

Anthem has developed certain Provider evaluation and/or performance policies which includes but is not limited to:

- The information maintained by Anthem to evaluate the performance/practice of health care professionals
- The criteria against which the performance of health care professionals will be evaluated
- The process used to perform the evaluation
- The information used to evaluate the Providers performance will be shared with the Provider to the extent applicable.
- Anthem shall make available on a periodic basis and upon the request of the Provider to the extent applicable, the analysis used to evaluate the Provider's performance
- Each Provider shall be given the opportunity to discuss the unique nature of the Provider's professional patient population which may have bearing on the Provider and to work cooperatively with Anthem to improve performance

INSURANCE REQUIREMENTS

Providers and Facilities shall self-insure or maintain insurance in types and amounts reasonably determined by Providers and Facilities, or as required under applicable licensing or regulatory requirements. 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:

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.

Workers' Compensation coverage with statutory limits and Employers Liability insurance.

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.

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 Provider Services to report receipt of misrouted PHI.

NETWORK PARTICIPATION TERMINATION AND APPEALS

Purpose and Goal

The Network Practitioner Termination and Appeals Policy and Procedure is designed to define the criteria by which Anthem evaluates certain managed healthcare practitioners participating in the network for possible termination or other actions, as necessary.

Policy Statement

Anthem contracts with various practitioners so that it can offer quality, accessible, cost-efficient healthcare to its managed care network Members. Anthem monitors the care provided by the practitioners participating in network and re-credentials them every three years to ensure that such healthcare is being rendered.

Participation Termination and Appeals

Certain circumstances, including but not limited to, professional misconduct of a participating practitioner within the managed care network may require Anthem to take certain actions with respect to the practitioner's participation in the network. Actions may include termination of the practitioner's network participation privileges, as set forth below.

Voluntary Terminations

- All Providers who wish to terminate their contractual relationship with Anthem must abide by the terms of the Provider Agreement, including but not limited provisions concerning notice and continuation of care (See Continuity of Care)

Non-Renewals

- Anthem may elect to non-renew a Provider's Agreement and will provide notice of non-renewal in accordance with the terms of the Provider Agreement. Please note that non-renewal is not considered a termination under New York Public Health Law 4406-d.

Immediate Terminations

- Immediate Terminations can occur in the following instances:
    - Sanctioned, debarred or excluded from participation in any of the following programs: Medicare, Medicaid or Federal Employee Health Benefit Plan.
    - A determination that the conduct of a participating practitioner in Anthem's managed care network poses the threat of imminent harm to the health of network Members; or
    - A finding that a participating practitioner in Anthem's managed care network has perpetrated an act of fraud; or

- A final disciplinary action by a state licensing board or other governmental agency that impairs the ability of a participating practitioner in Anthem's managed care network to practice.

- In the above cases, the participating practitioner in Anthem's managed care network will be immediately terminated from all managed care networks and will not be eligible for hearing.

Administrative Terminations

- These can occur when an administrative issue arises with respect to a participating practitioner in Anthem's managed care network and may include, but is not limited to, noncompliance with Anthem's policies and procedures, such as Anthem's Advance Patient Notice policy (APN). Please see below for hearing procedures.

Hearings

- If Anthem proposes to terminate a health care professional's Agreement and that health care professional is entitled to a hearing under New York law, the following process shall apply:

- The termination notice shall include:
  - The reason(s) for the proposed termination and
  - Notice that the health care professional has the right to request a hearing or review, at the health care professional's discretion, before a panel appointed by Anthem;
  - A statement that the health care professional has 30 days to request a hearing; and
  - A statement that Anthem will schedule a hearing date within thirty days after the date of its receipt of a request for a hearing.

A health care professional's failure to submit a request for a hearing within 30 days will be deemed a waiver of any hearing rights. The proposed contract termination will become final and the Provider will not be afforded any additional appeal rights.

The hearing panel will be comprised of a minimum of three persons, of whom at least one-third will be a clinical peer in the same discipline and the same or similar specialty as the health care professional. The panel can consist of more than three persons, provided the number of clinical peers constitutes one-third or more of the total membership. The hearing panel will render a decision in a timely manner. Decisions will include one of the following and will be provided in writing to the Provider: reinstatement; provisional reinstatement with conditions set forth by Anthem, or termination. Decisions of termination shall be effective not less than 30 days after the receipt by the health care professional of the hearing panel's decision. In no event shall determination be effective earlier than 60 days from receipt of the notice of termination.

Limitation on Terminations

- A practitioner's network participation privileges will not be terminated due to any of the following reasons:
  - Advocating on behalf of a Member
  - Filing a complaint against Anthem
  - Appealing a decision by Anthem
  - Providing information or filing a report that Anthem engaged in conduct prohibited pursuant to Section 4406-c of the Public Health Law
  - Requesting a hearing or review

Appeals Process

Anthem has established policies for monitoring and re-credentialing participating Providers inclusive of HDO's who seek continued participation in one or more of Anthem's networks. Information reviewed during this activity may indicate that the professional conduct and competence standards are no longer being met, and Anthem may wish to terminate Providers. Anthem also seeks to treat participating and applying Providers fairly, and thus provides participating Providers with a process to appeal determinations terminating participation in Anthem's networks for professional competence and conduct reasons, or which would otherwise result in a report to the National Practitioner Data Bank (NPDB). Additionally, Anthem will permit Providers (including HDO's) who have been refused initial participation the opportunity to correct any errors or omissions which may have led to such denial (Informal/ Reconsideration only). It is the intent of Anthem to give practitioners the opportunity to contest a termination of the practitioner's participation in one or more of Anthem's networks or 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 suspension or loss of licensure, criminal conviction, or Anthem's determination that the practitioner's continued participation poses an imminent risk of harm to Anthem's Members. A practitioner whose license has been suspended or revoked has no right to Informal Review/Reconsideration or Formal Appeal.

Reporting Requirements

When Anthem takes a Professional Review Action with respect to a professional Provider's participation in one or more Anthem networks, Anthem may have an obligation to report such to the NPDB and/or HIPDB. Once Anthem receives a verification of the NPDB report, the verification report will be sent to the state licensing board. The credentialing staff will comply with all state and federal regulations in regard to the reporting of adverse determinations relating to professional conduct and competence. These reports will be made to the appropriate, legally designated agencies. In the event that the procedures set forth for reporting reportable adverse actions conflict with the process set forth in the current National Practitioner Data Bank (NPDB) Guidebook and the Healthcare Integrity and Protection Data Bank (HIPDB) Guidebook, the process set forth in the NPDB Guidebook and the HIPDB Guidebook will govern.

OPEN PRACTICE

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

OPEN DIALOGUE

Anthem places no restrictions of any kind on open dialogue between Providers and their patients. Providers are encouraged to discuss all treatment options, regardless of costs or coverage. Providers may also advocate on a Member's behalf, or file complaints with Anthem or government agencies about Anthem's practices that the Provider or Facility may believe affect quality or access of care.

PHYSICIAN ACCESS/APPOINTMENT AVAILABILITY STANDARDS

General Availability Standards

Members must be able to access their PCP 24 hours a day, 7 days a week. As the Member's healthcare manager, the PCP is responsible for providing or arranging healthcare services on a 24/7 basis. (An answering machine does not suffice as access to the Provider.) The PCP must

also have a method to inform his or her Anthem Members about regular office hours and how to obtain care after office hours.

When off-duty or otherwise unavailable, the PCP must arrange for back-up coverage by a network physician so that appropriate medical care is available to Members at all times. The PCP must have available the name, telephone number and address of the physician(s) responsible for providing back-up services to patients. The PCP should contact Anthem Physician Services at **800-552-6630**, 8:30 a.m. to 5:00 p.m. ET, Monday to Friday or Provider Data Management via fax at **518-367-3103** if the designated back-up changes.

The designated back-up physician(s) must participate in the same network and be a comparably trained practitioner as noted below:

- Family Practice – can be backed up by a Provider with the following specialties:

  Family Practice; General Practice and/or a combination consisting of Internal Medicine – for adults and Pediatrics for Children.

- General Practice – can be backed up by a Provider with the following specialties:

  Family Practice; General Practice and/or a combination consisting of Internal Medicine – for adults and Pediatrics for Children.

- Internal Medicine – can be backed up by a Provider with the following specialties:

  Internal Medicine or Family Practice.

- Pediatrics – can be backed up by a Provider with the following specialties:

  Family Practice or Pediatrics

The back-up physician is responsible for communicating with the PCP about patient care he or she rendered. Documentation of all healthcare services provided by the back-up physician must be summarized in the patient's medical record including all pertinent Facility services.

If a Member is out of the area and contacts Anthem with an urgent or emergent situation, the patient will be informed to call his or her PCP directly. If this is not possible, the patient will be told to contact the PCP's back-up physician.

Annually, Anthem will conduct an audit of the after hour availability coverage for PCP network participation to ensure compliance.

Compliance will be met if:

- A live person is reached within two (2) phone calls.
- If an answering service is reached; compliance will be met if the service is cooperative in confirming their association with the physician and identifies how the physician can be reached (ex. pager; calls patched to physician)

In no event shall the messages refer the Member to the ER unless it is a true emergency or advise to call back during normal business hours

Appointment Availability Standards

The following are considered minimums for patient accessibility. Obviously, excellent care and service will often require significantly better performance.

For HMO and POS Members, the PCPs must be in the office treating patients a minimum of 16 hours a week per office location.

Patients should not wait for more than 15 minutes past their appointment time without an explanation about the delay and if necessary, provided with an opportunity to reschedule the appointment.

The physician must be able to schedule appointments within the following time frames:

Type of Appointment	Time Frame
Routine baseline physical exam	Within 4 weeks
Routine follow-up care	Within 2 weeks
Urgent Care	Within 24 hours
Non-Urgent Care	Within 5 days
Emergency Care	Within 2 hours or triage to emergency room
Initial prenatal exam	Within 3 weeks
Initial newborn exam	Within 2 weeks

Availability standards will be monitored through:

- On-site visits by Network Management Consultant,
- Review of appointment books,
- Member satisfaction surveys, and
- Member complaints

PHYSICIAN RESPONSIBILITIES

All participating Providers are expected to comply with certain standards regardless of the networks in which they participate. These include:

- Following Anthem's access/appointment availability standards
- Following Anthem's managed care requirements (if applicable to the Member's benefit plan). Adhering to Anthem's standard practice guidelines
- Submitting Claims for Members, accepting program/network fee schedule and not balance billing Members for covered services
- Not prohibiting Members from completing Anthem surveys and/or otherwise expressing their opinion regarding services received from physicians or Providers
- Will not differentiate or discriminate against any Member as a result of his/her enrollment in a Plan, or because of race, color, creed, national origin, ancestry, religion, sex, marital status, age, disability, payment source, state of health, need for health services, status as a litigant, status as a Medicare or Medicaid beneficiary, sexual orientation, or any other basis prohibited by law. Provider shall not be required to provide any type, or kind of Health Service to Covered Members that it does not customarily provide to others.

HMO Physicians

Physicians participating in the HMO-based networks have certain additional responsibilities, based upon their roles as primary care physicians and/or referral specialists.

Primary Care Physicians

A Primary Care Physician (PCP) is a family physician/family practitioner, general practitioner, internist or pediatrician who is responsible for delivering and/or coordinating care. PCPs must:

- Be accessible 24 hours a day, 7 days a week, and provide back-up coverage
- Provide or arrange for all care delivered to HMO Members
- Provide written referrals to referral specialists, to the extent required by the Member's benefit plan.

Monthly Membership Reports

HMO primary care physicians (PCPs) receive a managed-care monthly membership report during the first week of every month. These reports list Members who have selected the physician as their PCP. The reports contain information about Members including: ID number, date of birth, co-payment and the effective date. In addition to listing current and new Members, the reports list Member cancellations. PCPs should review these reports and keep them on file.

For Direct HMO, a monthly report also is issued to PCPs. This report contains information about Direct HMO Members' visits to specialists and notes the dates that care was delivered and the type of service. This report facilitates the PCP's awareness of specialist services being provided to the PCP's Direct HMO Members.

Physicians shall maintain a minimum of 100 patients as their patient load. Physician can close their practice to new patients once this minimum level has been reached. The physician will give Anthem one hundred twenty (120) days prior written notice when the physician will no longer be accepting new patients.

Referral Specialists

Providers credentialed by Anthem as specialists must:

- Provide specialty care as authorized by PCP
- Obtain a referral for all Members who have an HMO product, except those with Direct HMO
- Provide the Member's PCP with a report on care rendered in a timely manner

PCP who also participates as a Referral Specialist

If a physician has been credentialed by Anthem as both a PCP and a Referral Specialist, the following apply:

- If a Member has selected the physician as their PCP, the Provider cannot bill for a consultation since they are already treating the Member
- If the physician is listed as a back-up to another PCP, the system will process the Claim as a back-up Provider and not allow a consultation unless a referral is on file.
- If the Member has another physician as their PCP, the Member needs to obtain a referral to the Referral Specialist

Provider Status Changes

Physicians may change their specialty status based on the needs of their patient base.

A Provider could request any of the following status changes:

- Referral Specialist (RS) to PCP
- PCP to RS
- RS to Both (PCP/RS)
- PCP to Both (PCP/RS)

Requests should be sent in writing and include a copy of their board certification status for the specialties or documentation of equivalent training in the specialty. All requests should be mailed to a Network Management Consultant.

All requests are subject to approval by the Credentialing Committee. A Network Management Consultant will communicate directly to the Provider or Facility the decision reached by the Committee

Specialty Care Coordinator or Center

A Specialty Care Coordinator is a network Referral Specialist with experience treating the Member's condition or disease that assumes the role of the PCP and provides and/or coordinates the Member's primary and specialty care.

Members who have HMO-based products with a degenerative, disabling, or life-threatening condition or disease that requires specialized medical care for a prolonged period of time may select a Referral Specialist as a Specialty Care Coordinator. Such conditions include, but are not limited to: HIV/AIDS, cerebral palsy, cystic fibrosis, cancer, hemophilia, multiple sclerosis, sickle cell disease, spinal cord injury and conditions that require organ transplants.

If a Provider is a Referral Specialist and would like to receive information on becoming a Specialty Care Coordinator for a specific Member, contact Anthem's Medical Management Department at **800-441-2411**, 8:30 a.m. to 5:00 p.m. ET, Monday through Friday.

Hospital Privileges

Physicians shall maintain an affiliation with at least one hospital in each network in which such Physician participates and shall admit Covered Persons only to network hospitals when required under the terms of the Covered Person's Health Benefit Program. Physician shall inform Anthem immediately in the event such affiliation with a network hospital is discontinued.

If the physician has a sole affiliation with a network hospital and the network hospital has given notice to leave the network, Anthem will communicate via letter of the pending hospital termination and request that those with sole affiliation notify Anthem or obtain alternate affiliation. The letter will also explain the potential impact on the Provider's participation status if alternate affiliations are not obtained.

In the event that alternate affiliations are not obtained, Physicians shall seek a participating PCP backup that will agree to admit the Provider's patients for inpatient care. Both the backup physician and the impacted sole affiliated physician will follow the guidelines of the Exception Backup Policy by completing the appropriate Hospital Coverage document that can be found at **anthem.com.**

PHYSICIAN OFFICE LAB (POL) LIST

Anthem will allow participating HMO, POS, PPO, and EPO network physicians to perform select laboratory services in their office. The lab services are listed on the Physician Office Lab (POL) list.

The Member must be referred to a participating laboratory for lab services not included on the POL list. Claims submitted to Anthem for laboratory services not on the POL list will be denied and the Member cannot be balance billed.

The POL list does not apply to Anthem's indemnity plans. Anthem's POL list can be found at **anthem.com** > **Forms and Guides**, and the find **Physician Office Lab (POL) list**.

PROVIDER AND FACILITY RESPONSIBILITIES

Providers and Facilities are responsible for notifying Anthem when changes occur within the Provider practice or Facility. All changes must be approved by Anthem. 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

PROVIDER AND FACILITY DIGITAL ENGAGEMENT

Anthem expects Providers and Facilities will utilize digital tools unless otherwise mandated by law or other legal requirements for transactions such as filing Claims, verifying eligibility and benefits, etc. Providers and Facilities should refer to the guidance included throughout the Provider Manual where digital tools are available. For a complete list of digital tools, refer to the Provider Digital Engagement Supplement located on **anthem.com**. To access the Provider Digital Engagement Supplement, go to **anthem.com** > **For Providers** > **Provider Resources** > **Forms and Guides**, select the **Digital Tools** category, and then scroll to the **Provider Digital Engagement Supplement**.

REFERRALS

For Members covered under HMO and POS plans that utilize a PCP gatekeeper, it is the responsibility of the PCP (or OB/GYN for OB/GYN diagnosis related illnesses or the specialty care coordinator, if applicable) to complete referral forms when authorizing services from participating referral specialists. Referral forms are available in the "Sample Forms" section of this Provider Manual or at **anthem.com**.

The PCP (or OB/GYN or Specialty Care Coordinator) completes a referral form for participating referral specialists' services (physician and non-physician), including office-based procedures.

No referral form is required for:

- Participating laboratory and radiology services (including ultrasounds, mammograms, CT scans and amniocentesis) Pediatrician exams of well newborns
- Routine vision exams, eyeglass lenses and frames
- No referral from the PCP is required for an OB/GYN to provide the following:
    - Two semiannual Well-Woman office exams*
    - Office-based care resulting from previous OB/GYN
    - Office exams for treatment of acute gynecological conditions
    - Maternity Care

* "Well-Woman Care" includes a pelvic examination, breast exam, collection and preparation of a Pap smear and laboratory and diagnostic services provided in evaluating the Pap smear.

Note: At the time of publication of this Provider Manual, the Anthem products that utilize a PCP gatekeeper model are Anthem HMO, Anthem Direct Pay HMO, Anthem Direct Pay POS and Healthy New York. Referrals are NOT required for Direct HMO, Direct POS, or Direct Share POS.

The Referral Form:

- Should indicate the reason for the referral;
- Is valid for 90 days from the effective date, unless otherwise noted*;
- Should indicate the number of visits authorized by the PCP
- Includes authorization for office-based procedures by the participating specialist (for covered and medically necessary services)
- Should have all required fields completed

Note that a Referral Specialists may request a standing referral for any HMO Member from the Member's PCP. Standing referrals are valid for up to 365 days from the date the referral is written.

The referral form serves to introduce the patient to the specialist. It gives the specialist background information and the reason for the referral. The referral form also authorizes payment to the participating specialist, provided that the services are covered and medically necessary. Visits must take place within the authorization period. If additional visits are necessary after the authorization period, a new referral form is required. Services cannot be authorized retrospectively.

All covered services performed by a participating Provider during an authorized visit and within the terms of the contract are automatically authorized for that Provider. For example, the Provider may draw blood or perform multiple office-based services when the services are directly related to the reason for referral. This includes services with 90000 series CPT codes.

A referral is valid for only one Provider. Specialists may not refer patients to other physicians. In addition, if services are to be performed at a site other than the specialist's office (e.g., in the outpatient department of a Facility), a new referral form is required. However, this does not apply to laboratory or X-ray Facilities on the specialist's premises or in participating Facilities.

In Network Referrals and Transfers

Providers shall when medically appropriate, refer and transfer Covered Members to Participating Providers and Facilities Additionally, Provider represents and warrants that he/she does not give, provide, condone or receive any incentives or kickbacks, monetary or otherwise, in exchange for

the referral of a Covered Member, and if a Claim for payment is attributable to an instance in which Provider provided or received an incentive or kickback in exchange for the referral, such Claim shall not be payable and, if paid in error, shall be refunded to Anthem.

Referrals to Non-Participating Providers

For products with no out of network benefits, Referral requests to an out of network Provider should be made through Medical Management based on the benefit plan for the Member when either the network does not include an available Provider with the appropriate training and experience to meet the needs of the Member or medically necessary services are not available through the network Providers. The referral will be reviewed by Anthem for medical appropriateness and an approval or denial provided.

For non-emergent service the Member may not use a non-participating Provider unless there is no specialist in the network that can provide the required treatment.

If Providers need to request an out of network referral, contact Anthem's Medical Management Department at **800-441-2411**, 8:30 a.m. to 5:00 p.m. ET, Monday through Friday.

REFUND PROVISIONS

Provider and Facility Refund Policy

In the event that Anthem makes an overpayment, erroneous payment or a payment which otherwise exceeds the amount of the contractual obligation of the Agreement, Anthem will provide Provider or Facility with thirty (30) days' notice and Provider or Facility shall refund such payment to Anthem or obtain Anthem's consent to an alternative payment arrangement on or before the expiration of the thirty (30) day notice period. In the event Provider or Facility fails to refund or repay any amounts owed to Anthem within the thirty (30) days and the amount is not appealed, then Anthem shall then be permitted to offset such refund amounts from other Claims or to reach an Agreement with Provider or Facility as to a schedule for repayment of such funds. Notice shall not be required for routine adjustments of Claims (i.e., duplicative payments or Claims payment errors).

Subject to the below exception, no later than two (2) years after full payment to Provider or Facility, Anthem may subsequently review the appropriateness of any bill and Claim payment of a clinical nature; provided, however, that Anthem shall notify Provider or Facility of the particular case under review within thirty (30) days of the commencement of such review and such review shall be completed and notice of the results provided to Provider or Facility no later than one hundred twenty (120) days after it was commenced. Notwithstanding the foregoing, for Anthem's State of New York group customers, City of New York group customers and for the Federal Employee Benefit Program, the post payment review period shall be expanded to six (6) years from the end of the calendar year in which the Claim was submitted. The notice from Anthem shall state the specific reason(s) why Anthem believes the initial payment determination was incorrect and/or request all additional information needed by Anthem to review such determination. Notwithstanding the foregoing, the above listed time limits shall not apply to overpayment recovery efforts that are (1) based on reasonable belief of fraud or other intentional misconduct, or abusive billing, (2) required by, or initiated at the request of, a self-insured plan, or (3) required or authorized by a state or federal government program or coverage that is provided by this state or a municipality thereof to its respective employees, retirees or Members.

Negative Payment Adjustments

The process of reducing future payments by the amount that was adjusted or overpaid is called "negatively adjusting the Facility's account." This is done by systematically retracting a Claim

payment and placing a “negative balance” on the Facility’s account. The EOB will show a minus sign next to the “Payment” column. When this occurs, the overpayment should be removed from the account(s) in question and used to credit the other accounts paid on the remittance advice.

A large retraction may not be satisfied on one EOB. Occasionally, a negative balance will carry over to future EOBs. When this occurs, the EOB will show Claim payments but no check will be issued. The total amount paid will appear at the end of the EOB in the “Net Amount Paid” field.

The “Adjustment from Previous Balance” field will indicate how much money from the previous retraction should be used to satisfy the accounts that appear on this EOB. The original retraction will not be shown on each individual EOB; it will appear only on the EOB from which it was originally taken.

It is very important to keep track of the original retraction so that all of the accounts involved may be correctly credited.

Contact Provider Services with any questions about payment adjustments and have the following information ready before calling:

- The Provider or Facility’s tax identification number
- The six-digit Medicare Provider number or National Provider Identifier (NPI) number
- The Member’s identification number
- The patient’s name, date of birth, date of service and Claim number (if available)

This information will help to expedite the request. Provider Services is available at **800-992-BLUE** (**2583**) Monday through Friday, 8:30 am to 5:00 pm.

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.

TRANSITIONAL CARE FOR NEW ENROLLEE

If a Member has a life-threatening disease or condition or a degenerative and disabling disease or condition, the transitional period is up to 60 days. If the Member has entered the second trimester of pregnancy at the effective date of enrollment, the transitional period shall include provision of post-partum care related to the delivery.

Provider Resource Information

Anthem is committed to helping Providers and Facilities with hassle-free healthcare administration. The following guides can be accessed at **anthem.com** > **For Providers** > **Provider Resources** > **Forms and Guides**:

- **Quick Guide to Useful Contact Information** – Important phone numbers and addresses to help in the day-to-day interactions with Anthem.
- **2021 Product Guide** – This guide is general information only; actual information varies depending on group, network and other requirements
- **New York City Claim Submission Guidelines** – The purpose of this guide is to help determine which insurance carrier to send a Claim to for certain hospital versus medical services. For instructions on how to submit a Claim to Anthem, see the Claim submission references on **anthem.com**.

  In some instances, Anthem is responsible for payment of both the Hospital and Medical benefits for certain New York City accounts. For group numbers starting with 157800,

157801, 157802, and 157803, Anthem pays for Hospital and Medical benefits and does not split coverage.

In some circumstances, Anthem splits coverage for New York City accounts and is NOT responsible for payment of both Hospital and Medical benefits. The following grid does not include all of the New York City account plans but rather reflects the PPO Hospital-Only Contracts for groups starting with 157000 to 157699. The services described pertain to Anthem Primary non-Medicare Members, retirees and their dependents.

While this grid is provided as a general guideline for where to submit Claims, Providers and Facilities should refer to the Anthem Web site for additional information or to the telephone number located on the Member's ID card for Claim submission questions.

- **New York State Claim Submission Guidelines** - The purpose of this guide is to help determine which insurance carrier to send a Claim to for certain hospital versus medical services. To qualify for payment all services must be medically necessary. This document is specific to New York State Health Insurance Program Members only – Prefix YLS.

Anthem Digital Tools

ANTHEM PROVIDER WEBSITE

Anthem.com is a public website.

Anthem designed the Provider public website to make navigation easy 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** > **For Providers** > **Provider Resources** > **Go to Providers Overview,** and choose content available.

Providers and Facilities can also sign-up for the Network eUpdates to be notified when a newsletter is published. Newsletters are designed to educate Providers, Facilities and their staff on updates and notification of changes.

To sign up go to **anthem.com/provider/news/** > **Subscribe Now**.

The website holds timely and important information to assist Providers when working with Anthem. Go to **anthem.com** > **For Providers** > **Provider Resources** > **Go to Providers Overview,** 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
  - Dental
  - Vaccination Resources

- Find Care
- Availity

- Claims
  - Claim Submission
  - Electronic Data Interchange (EDI)
  - Prior Authorization
- Patient Care
  - Enhanced Personal Health Care
  - Medicare Advantage
- Communications
  - News
  - Contact Us
- Join Our Network
  - Getting Started with Anthem
  - Credentialing
  - Employee Assistance Program (EAP)

ONLINE PROVIDER DIRECTORY AND DEMOGRAPHIC DATA INTEGRITY

Providers and Facilities are able to confirm their Network participation status by using the Find Care tool. A search can be done on a specific Provider name or by viewing a list of local in-network Providers and Facilities using search features such as Provider specialty, zip code, and plan type.

Online Provider Directory

Accessing the Online Provider Directory:

- Go to **anthem.com/provider** > **Find Care**
- To search the online Provider Directory either enter the Member information or enter as guest.

Before directing a Member to another Provider or Facility, verify that the Provider or Facility is participating in the Member's specific network.

- To help ensure Members are directed to Providers and Facilities within their 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 and Network. Note: The Member's Network Name should be on the lower right corner of the front of the Member's ID card.

Providers and Facilities who have questions on their participation status listed in the online directory should contact the number on the back of the Member's ID card.

Updating Demographic Data with Anthem

It is critical that Members receive accurate and current data related to Provider availability. Providers and Facilities must notify Anthem of any demographic changes. 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.

Providers and Facilities must have business processes in place to ensure the timely provision of provider directory information to Anthem. A Provider or Facility must submit such provider directory information to Anthem, at a minimum, when a Provider or Facility begins or terminates a network agreement with Anthem; when there are material changes to the content of the provider directory information of the Provider/Facility; and at any other time, including upon the Anthem's request, as the Provider/Facility determines to be appropriate.

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, including facilities certified or authorized by OMH or OASAS
- Languages Spoken
- License Number
- Board Certifications
- Restrictions regarding the availability of provider's services
- 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) (must be accompanied by a W-9 to be valid)
- Termination of Provider Participation Agreement**
- Web Address

*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** > **For Providers** > **Join our Network** > **Begin Application**.

**For notices of termination from an Anthem network, Providers and Facilities should refer to the termination clause in the Agreement for specific notification requirements. Allow the number of days' notice of termination from Anthem's network as required by the Agreement (e.g. 90 days, 120 days, etc.).

Submitting Provider demographic data requests and roster submissions through Roster Automation

Use the Provider Data Management (PDM) application on Availity Essentials to verify and initiate care provider demographic change requests for all professional and facility care providers*. **Going forward, the PDM application is now the preferred intake tool for care providers to submit demographic change requests, including submitting roster uploads.** If preferred, Providers may continue to utilize the Provider Enrollment application in Availity Essentials to submit requests to add new practitioners under existing groups for available provider types.

Within the PDM application, Providers have the choice and flexibility to request data updates via the standard PDM experience or by submitting a spreadsheet via a roster upload.

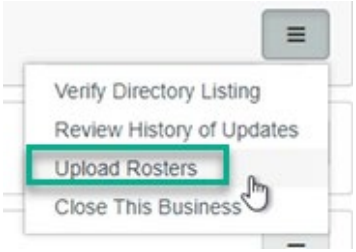
Roster Automation is our new technology solution designed to streamline and automate provider data additions, changes, and terminations that are submitted using a standardized Microsoft Excel document. Any provider, whether an individual provider/practitioner, group, or facility, can use Roster Automation today.**

The resources for this process are listed below and available on our website. Visit **anthem.com** > **For Providers** > **Provider Resources** > **Forms and Guides**, then select the **Digital Tools** category. The ***Roster Automation Rules of Engagement*** and ***Roster Automation Standard Template*** appear under the Digital Tools category.

- *Roster Automation Rules of Engagement*: Is a reference document, available to ensure error-free submissions, driving accurate and more timely updates through automation.
- *Roster Automation Standard Template*: Use this template to submit your information. More detailed instructions on formatting and submission requirements can also be found on the first tab of the Roster Automation Standard Template (*User Reference Guide*).
- Upload your completed roster via the Availity PDM application.

Accessing PDM Application

Log onto **Availity.com** > **My Providers** > **Provider Data Management** to begin the attestation process. If submitting a roster, find the TIN/business name for which you want to verify and update information. Before you select the TIN/business name, select the three-bar menu option on the right side of the window, and select **Upload Rosters** (see screen shot below) and follow the prompts.



Availity Administrators will automatically be granted access to PDM. Additional staff may be given access to **Provider Data Management** by an administrator. To find your administrator, go to **My Account Dashboard** > **My Account** > **Organization(s)** > **Administrator Information**.

***** Exclusions:

- Behavioral Health providers contracted with Carelon Behavioral Health who will continue to follow the process for demographic requests and/or roster submissions, as outlined by Carelon Behavioral Health.

- Any specific state mandates or requirements for provider demographic updates

** If any roster data updates require credentialing, your submission will be routed appropriately for further action.

Verification Process

Anthem is **required by the State of New York** to ensure that we are publishing accurate directory information for Members in both the on-line and paper Provider directories. However, this information is only as good as what is provided by Providers. Anthem conducts quarterly verifications of its demographic and participation information and Providers may receive a fax, phone call, or letter requesting that this information be confirmed. A non-response will result in the Provider practice confirming there are no changes and the information will continue to appear as a participating Provider in either the online Provider Finder or printed directories for all lines of business.

Anthem and its affiliates may use, publish, disclose, and display information and disclaimers, as applicable, relating to Provider and Facilities. Physician based communications and publications need to be approved by Anthem for content prior to its release if the communication or publication will being using Anthem's name and branding to communicate to the physicians' membership.

Anthem will be performing outreach for verification of demographic information quarterly to ensure that Provider information is displayed appropriately in Anthem's Provider and Facility Directories.

AVAILITY ESSENTIALS

Anthem understands that working together digitally streamlines processes and optimizes efficiency. We developed the Provider Digital Engagement supplement to outline our expectations and to fully inform providers about our digital platforms.

This supplement outlines the digital platforms available to participating and nonparticipating providers who serve our members. It is Anthem's expectation based on our provider agreement that providers will utilize these digital platforms and applications, unless otherwise mandated by law. The electronic transaction applications are accessed through these platforms.

Availity.com offers several digital capabilities, including Electronic Data Interchange (EDI) transaction gateway, business-to-business (B2B) application programming interfaces (APIs), and EMR connections.

This section addresses the following processes and transactions:

- Acceptance of digital ID cards
- Eligibility and benefit inquiry and response
- Prior authorization submissions including updates, attachments and authorization status
- Claim submission, including attachments and claim status
- Remittances and payments

It is preferred that these digital applications are used when they are available and in markets where they are not currently available as they are implemented:

- Provider enrollment
- Demographic updates
- Disputes
- Pharmacy prior authorization drug requests

- Services through Carelon Medical Benefits Management, Inc. and Carelon Behavioral Health, Inc.

Anthem expects that all providers transacting any functions and processes above will use available electronic self-service applications in lieu of manual channels (paper, mail, fax, call, etc.). Availity.com provides access to all Anthem self-service applications across all electronic channels outlined above. All digital channels are consistent with industry standards.

Access to all Anthem digital applications and capabilities are available on **Availity.com**. Access Availity to learn more about available EDI, B2B API and EMR connection options. Visit **Administration Simplification standard transaction requirements** for administration simplification standard transaction requirements.

Providers who do not transition to digital applications will experience delays when using non-digital methods such as mail, phone and fax for transactions that can be conducted using digital applications.

Acceptance of digital ID cards

As our members transition to electronic member ID cards, providers may need to implement changes in their processes to accept this new format. Anthem expects that providers will accept the electronic version of the member identification card in lieu of a physical member identification card when presented by members who are transitioning to digital cards. If providers require a copy of a physical member identification card, members can email a copy of the electronic member ID card from their phone application, or providers can access it directly from Availity.com through the Eligibility and Benefits Inquiry application.

Eligibility and benefits inquiry and response

Providers should leverage these Availity hosted channels for eligibility and benefit inquiry and response:

- EDI transaction: X12 270/271 — eligibility inquiry and response (version 5010):
    - Anthem supports the industry standard X12 270/271 transaction set for eligibility and benefit inquiry and response as mandated by *HIPAA*.
- Availity.com:
    - The Eligibility and Benefits Inquiry verification application allows a provider to key an inquiry directly into an online eligibility and benefit look-up form with real-time responses.
- Provider desktop integration via B2B APIs:
    - Anthem has also enabled real-time access to eligibility and benefit verification APIs that can be directly integrated within participating vendors' practice management software, revenue cycle management software and some EMR software. Contact Availity for available vendor integration opportunities.

Authorizations

Prior authorization submission, attachment and status

Providers should leverage these channels for prior authorization submission, status inquiries and to submit electronic attachments on Availity.com to support the authorization:

- EDI transaction: X12 278 — prior authorization and referral (version 5010):

    - Anthem supports the industry standard X12 278 transaction for prior authorization submission and status inquiry as mandated per *HIPAA*.
- EDI transaction: X12 275 — patient information, including HL7 payload (version 5010) for authorization attachments:
    - Anthem supports the industry standard X12 275 transaction for electronic transmission of supporting authorization documentation including medical records via the HL7 payload.
- Availity.com:
    - Authorization Applications include the Availity Essentials multi-payer Authorization and Referral application and the Interactive Care Reviewer (ICR) for authorization submissions not currently accepted through the multi-payer application.
        - Both applications enable prior authorization submission, authorization status inquiry and the ability to review previously submitted authorizations.
- Provider desktop integration via B2B APIs:
    - Anthem has enabled real-time access to prior authorization APIs, which can be directly integrated within participating vendors' practice management software, revenue cycle management software and some EMR software. Contact Availity for available vendor integration.

Claim submissions and status

Providers should leverage these channels for claim submission, attachments (for both pre- and post-payment) and status from Availity.com:

- EDI transaction: X12 837 — professional, institutional and dental claim submission (version 5010):
    - Anthem supports the industry standard X12 837 transactions for all fee-for-service and encounter billing as mandated per *HIPAA*.
    - 837 Claim batch upload through EDI allows a provider to upload an entire batch/file of claims (must be in X12 837 standard format).
- EDI transaction: X12 276/277 — claim status inquiry and response (version 5010):
    - Anthem supports the industry standard X12 276/277 transaction set for claim status inquiry and response as mandated by *HIPAA*.
- Availity Essentials: The Professional Claim and the Facility Claim applications enables a provider or facility to key a claim directly into an online claim form and upload supporting documentation for a defined claim
    - The Claim Status application enables a provider to key an inquiry directly into an online claim status form with real-time responses.
- Provider desktop integration via B2B APIs:
    - Anthem has also enabled real-time access to claim status via APIs, which can be directly integrated within participating vendor's practice management software, revenue cycle management software and some EMR software. Contact Availity for available vendor integration.

Claim attachments

Providers should use these channels for claim attachments from Availity.com:

- EDI transaction: X12 275 — patient information, including HL7 payload attachment (version 5010):
    - Anthem supports the industry standard X12 275 transaction for electronic transmission of supporting claims documentation including medical records via the HL7 payload.
- Availity Essentials — the Claim Status application enables a provider to find a claim through an inquiry and upload supporting documentation to the claim.
    - When documents are required to process a claim, **Digital Request for Additional Information** (Digital RFAI) notifications are sent to the Attachment Dashboard for all providers who are registered in the Medical Attachments application through Availity.com.
    - Claim Status enables claim payment disputes to be submitted digitally.
    - The Medical Attachments application on Availity.com enables the transmission of digital notifications when additional documentation, including medical records, is needed to process a claim.

Remittances and payments electronic funds transfer

Electronic funds transfer (EFT) uses the automated clearinghouse (ACH) network to transmit healthcare payments from a health plan to a healthcare provider's bank account. Health plans can use a provider's banking information only to deposit funds, not to withdraw funds. Anthem expects providers to accept payment via EFT in lieu of paper checks.

EnrollSafe eliminates the need for paper registration. Providers can register, enroll and manage account changes for EFT through EnrollSafe, **https://enrollsafe.payeehub.org**.

To facilitate quicker reimbursement for providers who have not enrolled in EFT, Anthem may move paper checks to a virtual card payment method. Virtual cards allow physicians and facilities to process payments as credit card transactions.

Electronic remittance advice

Providers should use these channels for electronic remittance advice (ERA) on Availity.com:

- EDI transaction: X12 835 — ERA (version 5010)
    - Anthem supports the industry standard X12 835 transaction as mandated per *HIPAA*.
- The Remittance Inquiry application, which provides a digital version of the paper remittance, which providers can download.

Additional digital methods of engagement

- **Carelon Medical Benefits Management**: Access link to precertification requests and inquiries for specific services and access the OptiNet® Survey when applicable at providerportal.com.
- **Claim Status:** See details and payment information including Claim line-level details and processing from Availity.com, select the Claims & Payment tab to access Claim Status.

- **Medical Attachments:** Submit supporting documentation including medical records for initial, pended or denied claims through Availity.com. From the Claims & Payments tab, select Claim Status, submit a claim status inquiry and use the Submit Attachments link from a successful response. Use the Medical Attachments functions to submit an itemized bill electronically through the EDI 275 transaction. For providers registered in Medical Attachments through Availity.com, receive digital notifications about additional documents needed for claims processing through Digital RFAI.
- **Member Certificate Booklet:** View a local plan Member's certificate of coverage, online, where available. From Availity.com select the Patient Registration tab to access Eligibility and Benefits. The Certificate of Coverage link will be at the top of the page of a successful eligibility and benefits transaction if available in your Anthem market.
- **Member Eligibility and Benefits Inquiry**: Get real-time patient eligibility, benefits, and accumulative data, including current and historical coverage information, plus detailed coinsurance, copayment and deductible information for ALL Members, including BlueCard® and FEP®. From Availity.com use the Patient Registration tab to access Eligibility and Benefits Inquiry.

Payer Spaces

To access Anthem specific applications, use **Payer Spaces** from Availity.com:

- **Authorization Look Up Tool:** Determine if an authorization is needed for a commercial Member for a specific outpatient medical or behavioral health service.
- **Chat with Payer:** Providers and Facilities can chat with an online representative about prior authorizations, appeals, Claims, eligibility and more when the information is not available through self-service on Availity.com.
- **Clear Claim Connection:** Research procedure code edits and receive edit rationale.
- **Custom Learning Center:** Access payer-specific training and educational videos.
- **Fee Schedule:** Retrieves professional office-based contracted price information for patient services.
- **Remittance Inquiry**: View an imaged copy of the paper Anthem remits up to 15 months in the past.
- **Patient360**: A robust picture of a Member's health and treatment history, including gaps in care and care reminders.
- **Provider Online Reporting**: access proprietary Provider specific reports such as Member rosters and Provider Contract and Fee Schedule notifications.
- **Provider Enrollment:** Submit an online request to join Anthem's Provider network.
- **Provider Maintenance Form (under Resources)**: Request changes to existing practice profiles.

Take advantage of these Availity Essentials benefits

- **No charge:** Anthem transactions are available at no charge to Providers.
- **Accessibility:** Availity Essentials 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 consistency across payers.
- **Multi-payer access:** Users can access data from Anthem, Medicare, Medicaid and other commercial insurers (See **Availity.com** for a full list of payers.)
- **Compliance:** Availity Essentials is compliant with all Health Insurance Portability and Accountability Act (HIPAA) regulations.

Getting Started and Availity Essentials Training

To register for access to Availity Essentials, go to **availity.com/providers/registration-details/.** For additional assistance in getting registered, contact Availity Client Services at **800-AVAILITY** (**282-4548**).

After logging into Availity Essentials, 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 Essentials experience. Availity Essentials 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.

Availity Training for Anthem-specific tools

Learn about Anthem specific applications through the Custom Learning Center. From **Payer Spaces,** select **Applications** to access the Custom Learning Center for presentations and reference guides. Find additional learning opportunities through the Provider Learning Hub. To visit the Anthem version of the Provider Learning Hub, go to your public provider site and select the Provider Learning Hub link located with Availity information.

Organization Maintenance

To update Administrator or Organization information:

- To replace the Administrator currently on record with Availity Essentials, call Availity Client Services at **800-AVAILITY** (**282-4548**).
- An Administrator can use the Maintain Organization feature on Availity.com to maintain the organization's demographic information, including address, phone number, tax ID, and NPI updates. Any changes made to this information automatically applies to all Users associated to the organization and affects only the registration information on Availity Essentials.

Support

Submit a support ticket for additional help, or technical difficulties through Availity Essentials:

1. Log in to Availity at **Availity.com**
2. Select **Help & Training** > **Availity Support**
3. Select organization > **Continue**
4. Select **Contact Support** from the top menu bar then **Create Case**

Eligibility and Member ID Card Samples

ALPHA PREFIX INFORMATION

The three-character alpha prefix at the beginning of the Member's identification number is the key element used to identify and correctly route out-of-area Claims. The alpha prefix identifies the BCBS Plan or national account to which the Member belongs. It is critical for confirming a patient's membership and coverage.

Some identification cards with a BlueCard suitcase may not have an alpha prefix. This may indicate that the Claims are handled outside the BlueCard program. Look for instructions or a telephone number on the back of the card for information on how to file these Claims. If that information is not available, call the Eligibility Line at **800-713-4173**, 8:30 a.m. to 5:00 p.m. ET, Monday through Friday.

Occasionally, Providers and Facilities may see identification cards from foreign BCBS Plan Members. These identification cards will also contain three-character alpha prefixes. Treat these Members the same as domestic BCBS Plan Members.

SUITCASE LOGOS

To provide the visual symbol that physicians and Facilities need to identify PPO Members, ID cards with the PPO logo for those Members who have BlueCard PPO or BlueCard EPO benefits have been created. The logo, shown below, must appear on the face of the card. A "PPO" in a suitcase logo means that the patient has a PPO program.

Remember: Not all PPO Members are BlueCard PPO Members, only those whose membership cards carry this logo are part of the BlueCard PPO Plan.

To identify all other BlueCard Members, with the exception of those with Medigap coverage, that do not have BlueCard PPO, the blank (empty) suitcase logo is included on the face of the card. The blank suitcase, in conjunction with the alpha prefix, will communicate to Providers how to process Member Claims. A blank suitcase logo on a Member's identification card means that the patient has a Traditional (Indemnity), POS, or HMO product.

ID CARD SAMPLES

Sample member ID cards will be added here once available.

NEWBORN ENROLLMENT

In accordance with New York and federal law, Anthem must pay for inpatient care for a newborn's first 48 hours (vaginal delivery) or 96 hours (c-section delivery), without regard to whether the newborn has been enrolled under the insured benefit plan.

The following provides additional guidance on Anthem's insured benefit plans:

- For coverage beyond the initial inpatient nursery care, all newborn children must be enrolled as dependents within 30 or 60 days of birth, as required by the plan, in order to ensure coverage with no Claims processing delays.
- **Members with Individual, Employee/Spouse or Parent/Child contracts** must submit an Enrollment/Change form to add a newborn, and change their plans to Parent/Child, Parent/Children or Family coverage (and pay the premium) 30 or 60 days, as required by the plan, after the date of the baby's birth for coverage to be retroactive to the date of birth. **Claims submitted before the newborn is enrolled under the correct contract type will be denied. These Claims will be reprocessed once the newborn is enrolled at the normal newborn allowance, as long as it is within 30 or 60 days of the birth, as required by the plan.**
- If Anthem does not receive the Enrollment/Change form within 30 or 60 days, as required by the plan, after the baby's birth, coverage will begin on the actual date Anthem receives the completed form, as long as Anthem receives it during the next open enrollment period after the birth, or during the first year after the birth, whichever occurs first.
- **Members with Family or Parent/Children contracts** have coverage for newborn children but MUST submit an Enrollment/Change form to add the newborn to the benefit contract. Coverage is effective from the newborn's date of birth provided that the newborn is enrolled.

For Enrollment through Employer Online Services

When the contract types are Individual, Employee/Spouse or Parent/Child and the Group Benefits Administrator (GBA) logs on to add the newborn after 30 or 60 days, as required by the plan, from the date of birth, the GBA may select either the current date (at which the GBA logged on) or the date of Open Enrollment as the effective date of coverage for the newborn.

Credentialing

Credentialing is the process Anthem uses to evaluate healthcare practitioners and health delivery organizations (HDOs) to provide care to Members to help ensure Anthem's standards of professional conduct and competence are met.

Anthem's Credentialing Program Summary includes a complete list of the Provider types within Anthem's credentialing scope. The credentials of healthcare practitioners and HDOs are evaluated according to Anthem's criteria, standards, and requirements as set forth in our Program

Summary and applicable state and federal laws, regulatory, and accreditation requirements. Anthem retains discretion to amend, change or suspend any aspect of Anthem's Credentialing Program, and the Program Summary is not intended to create rights on the part of practitioners or HDOs who seek to provide healthcare services to Members. Anthem further retains the right to approve, suspend, or terminate individual practitioners and HDOs in those instances where it has delegated credentialing decision-making.

Anthem's Credentialing Program also includes the recredentialing process which incorporates re-verification and the identification of changes in the practitioner's or HDO's credentials 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. All applicable practitioners and HDOs in Anthem's network within the scope of the Credentialing Program are required to be recredentialed at least every three (3) years unless otherwise required by applicable state contract or state regulations.

Anthem will complete review of the health care professional's application within 60 days of receiving a completed application and notify the health care professional as to (1) whether he or she is credentialed; or (2) whether additional time is necessary to make a determination because of the failure of a third party to provide necessary documentation. In such instances where additional time is necessary because of a lack of necessary documentation, Anthem shall make every effort to obtain such information as soon as possible and shall make a final determination within twenty-one days of receiving the necessary documentation.

Additional information regarding Anthem's Credentialing Program can be found in the Program Summary, which applicable terms are incorporated into this Provider Manual by reference, available on **anthem.com** To access the Program Summary, go to **anthem.com** > **For Providers** > **Join Our Network** > **Credentialing** > **Credentialing Overview** > **Who do we Credential?**

Standards of Participation

Anthem contracts with many types of Providers that do not require credentialing as described in the **Credentialing Program Summary** available on **anthem.com**. However, to become a Network/Participating Provider or Facility, certain standards of participation still must be met. In addition to the insurance requirements listed in the Legal and Administrative Requirements section of this manual, and standards of participation and accreditation requirements outlined in the Provider Agreement, the chart below outlines requirements that must be met in order to be considered for contracting as a Network/Participating Provider or Facility in one of these specialties:

Provider	Standards of Participation
Ambulance (Air & Ground)	Medicare Certification/State Licensure
Ambulatory Event Monitoring	Medicare Certification
Convenient Care Centers (CCCs)/Retail Health Clinics (RHC)	DNV/NIAHO, UCAOA, TJC
Durable Medical Equipment	TJC (JCAHO), CHAP, ACHC, (HQAA) Medicare Certification, The Compliance Team

Provider	Standards of Participation
Hearing Aid Supplier	State Licensure
Intermediate Care Facilities	Medicare Certification/State Licensure
Immunization Clinic	CDC Certification Pharmacy License, Medicare Certification
Orthotics & Prosthetics	TJC, CHAP, The American Board for Certification in Orthotics, Prosthetics & Pedorthics (ABC) or Board of Certification/Accreditation (BOC) Ocularist: National Examining Board of Ocularists NEBO Preferred) Medicare Certification
Private Duty Nursing	TJC, CHAP, CTEAM, ACHC, or DNV/NIAHO
Urgent Care Center (UCC)	AAAHC, IMQ, NUCCA (formerly ABUCM), TJC, UCAOA

This is only a representative listing of Provider types that do not require formal credentialing. For questions about whether a Provider or Facility is subject to the formal credentialing process or the applicable standards of participation, contact Network Management.

Claims Submission

GENERAL GUIDELINES

To facilitate Claims processing, all Claims must:

- Be either the uniform bill Claim form or electronic Claim form in the format prescribed by Anthem
- Be submitted by a Provider for payment by Anthem for Health Services rendered to a Covered Member
- Be considered to be a Complete Claim which means, unless state law otherwise requires, must contain all information necessary to process the Claim and make a benefit determination

ELECTRONIC CLAIMS SUBMISSIONS

Providers and Facilities are expected to submit Claims electronically whenever possible. Claims must be submitted within the timely filing timeframe specified in the Provider or Facility Agreement. Refer to the EDI Submissions section in this Manual for more details about electronic submissions, and to learn more about how EDI can work for Providers and Facilities.

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

Reference the Transaction-Specific Companion Documents available on the EDI webpage. Go to **Anthem EDI Companion Guide** > (appropriate link under) **Section B – Transaction-Specific Documents**.

For instructions on connecting and submitting to the Availity Essentials EDI Gateway, review the **Availity Essentials Batch Companion Guide**.

CLAIM SUBMISSION FILING TIPS

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

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 Anthem 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 the 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.

Independent Clinical 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 place of service 81.
- 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.

Coding Claims

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

Correct coding of Claims expedites processing and speeds payment for services. When submitting Claims or referral forms, it is important to use the most up-to date ICD-10-CM or successor codes and CPT codes.

When completing field 21 of the CMS1500 Claim form, if more than one diagnosis is appropriate, list all the diagnoses that affect the treatment received. PCPs cannot bill for consultations.

To facilitate efficient Claims processing the appropriate, valid procedure and diagnosis codes consistent with the Member's age and gender should be submitted on Claims. CPT and HCPCS modifiers assist in clarifying services and determining reimbursement. Claims reporting incompatible procedures, diagnoses and modifiers may be denied. Likewise, if an unlisted or non-descript procedure code is billed electronically, (code ending in "99") the Claim will be denied. If a denial is received due to a non-descript or unlisted CPT or HCPCS code was billed, a paper Claim with Medical Records attached may be submitted for consideration or the appeal process may be evoked to review the original denial.

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 Essentials.

Late Charges

Late charges for Claims previously filed can be submitted electronically. Providers and Facilities must reference the original Claim number in the re-billed electronic Claim. If attachments are required, submit them using the *Attachment Face Sheet*. (See Electronic Data Interchange website for instructions as **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. Providers and Facilities 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, 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.

Newborn Claims

Well-Baby newborn Claims do not require authorization if there is an authorization on file for the mother

Not Otherwise Classified ("NOC") Codes

When submitting Not Otherwise Classified (NOC) codes 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, 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, 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 and 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.

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 Members receive the correct benefit coverage for this important service.

Type of Billing Codes

When billing Facility Claims, ensure 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.

FILING TIPS FOR CONTIGUOUS BORDER COUNTY PROVIDERS

Providers practicing in a county bordering another state and having contracts with Blue Plans in their home state and the neighboring state should file all Claims with the local Blue Plan, based on where they provided the service, except when a Member has coverage with the neighboring state's Blue Plan.

Here are some examples:

- A Provider is located in a New York county that borders New Jersey and has contracts with Blue Plans in both states. When this Provider renders a service to a New Jersey Member, the Claim is filed with Horizon Blue Cross Blue Shield of New Jersey. All other Claims are filed with Anthem.
- A Provider is located in a New York county that borders New Jersey. The Provider has a contract with Anthem, but not with Horizon. When this Provider renders a service to a New Jersey Horizon Member, the Claim is filed with Anthem.
- A New Jersey Provider in a border county with New York with contracts with Horizon BCBS and Anthem. They should submit Claims for Anthem and Anthem affiliate Members to Anthem. Submit all other Claims to Horizon BCBS.
- A New Jersey Provider located in a border county with New York with a contract with Anthem, but not Horizon BCBS. Submit Claims for Anthem and Anthem affiliate Members to Anthem. Submit all other Claims to Horizon BCBS (where they will be considered non-par).

Claims filing tips for Providers with multiple Blue Plans in their market

If providing care to out-of-area Blue Members from (BlueCard), follow the below Claim-filing guidelines:

If contracting with both Anthem and another Blue plan for the same product type (e.g. PPO or Traditional), file an out-of-area Blue Plan Member's Claim with either Plan. However, Anthem and Anthem affiliate Members Claims must be sent to Anthem for processing.

Anthem's Operating Area and Contiguous Counties

Anthem's Service Area: 28 NY Counties				
	Albany	Fulton	Putnam	Schoharie
	Bronx	Greene	Queens	Suffolk
	Clinton	Montgomery	Rensselaer	Sullivan
	Columbia	Kings	Richmond	Ulster
	Delaware	Nassau	Rockland	Warren
	Dutchess	New York	Saratoga	Washington
	Essex	Orange	Schenectady	Westchester

Contiguous Counties	State	County
	6 contiguous New York counties	Broome, Chenango, Franklin, Hamilton, Herkimer, Otsego
	2 contiguous Connecticut counties	Fairfield, Litchfield
	1 contiguous Massachusetts county	Berkshire
	7 contiguous New Jersey counties	Bergen, Hudson, Middlesex, Monmouth, Passaic, Sussex, Union
	2 contiguous Pennsylvania counties	Pike, Wayne
	5 contiguous Vermont counties	Addison, Bennington, Chittenden, Grand Isle, Rutland

Indirect Care, Support and Remote Provider – An individual or organization that offers care to patients from outside the local Plan's service area. Services may be provided from a single site

or from multiple locations. Examples include laboratories, Durable Medical Equipment, or Infusion Therapy Providers. Often the patient and the remote Provider are in different physical locations. Indirect Care, Support and Remote Providers should contact a Network Management Consultant for Claim filing instructions.

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 dispute a claim online through Availity.com, where available. Use the Claims & Payments tab to access Claim Status. Enter the necessary information to locate the claim and use the Dispute button to upload supporting documentation. Providers and Facilities can Chat with Payer or send a Secure Message through Availity Essentials. If Providers or Facilities are unable to utilize Availity Essentials for the inquiry they can call the number on the back of the Member ID Card and select the *Claims* prompt. For further details on Secure Messaging reference the *Availity Essentials* section in this Manual.
- **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. To upload the requested documentation from Availity.com, select the Claims & Payments tab to access Claims Status. Enter the necessary information to locate the claim and use the Submit Attachments button to upload requested documentation.
- **Clinical/Medical Necessity Appeals:** Information about an appeal regarding a clinical decision denial, such as an authorization or Claim that has been denied as not medically necessary, experimental/investigational is located in the *Clinical Appeals* section within the Provider Manual.
- **Claim Payment Disputes:** See the *Claim Payment Dispute* section for further details.
- **Precertification / Prior Authorization Disputes:** Precertification / Prior Authorization disputes should be handled via the process detailed in the letter received from the precertification department. If Providers or Facilities disagree with a clinical decision follow the directions detailed in the letter. A Precertification/Prior Authorization appeal can be submitted through the digital prior authorization application on Availity.com. Select the Patient Registration tab to access Authorizations & Referrals. Sending precertification/ prior authorization requests or appeals to the Provider correspondence address may delay responses.
- **Corrected Claims:** Submit a corrected Claim should only when updating information on the Claim form. Access your claim on Availity.com through the Claims & Payments tab. If the inquiry is about the way the Claim processed, refer to the prior sections. If Providers or Facilities have corrections to the Claim, submit them according to the Corrected Claim Guidance below.

Proof of Timely Filing

Claims must be submitted within the timely filing timeframe specified in the Provider or Facility Agreement. 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.***

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 the 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 a zero Member, Provider or Facility liability, then a new Claim is needed instead of a corrected Claim.

Regarding paper claims: Claims originally filed on paper are accessible through Availity.com. Submit replacement, void/canceled claims through Availity.com following the instructions below

for digital submission. Do use the paper submission process unless there is a specific reason for filing a paper claim correction.

Type	Professional Claim	Institutional Claim
EDI	**To indicate the Claim is a replacement Claim:** • In element CLM05-3 "Claim Frequency Type Code" • Use Claim Frequency Type 7	**To indicate the Claim is a replacement Claim:** • In element CLM05-3 "Claim Frequency Type Code" • Use Claim Frequency Type 7
	To confirm the Claim which is being replaced: • In Segment "REF – Payer Claim Control Number" • Use F8 in REF01 and list the original payer Claim number is REF02	**To confirm the Claim which is being replaced:** • In Segment "REF – Payer Claim Control Number" • Use F8 in REF01 and list the original payer Claim number is REF02
	To indicate the Claim was billed in error (Void/Cancel): • In element CLM05-3 "Claim Frequency Type Code" • Use Claim Frequency Type 8	**To indicate the Claim was billed in error (Void/Cancel):** • In element CLM05-3 "Claim Frequency Type Code" • Use Claim Frequency Type 8
	To confirm the Claim which is being void/cancelled: • In Segment "REF – Payer Claim Control Number" • Use F8 in REF01 and list the original payer Claim number is REF02	**To confirm the Claim which is being void/cancelled:** • In Segment "REF – Payer Claim Control Number" • Use F8 in REF01 and list the original payer Claim number is REF02
Digital	Submit replacement, void/cancel claims through **Availity.com** Select the **Claims & Payments tab** and click **Professional Claim** Enter the clam information and set the billing frequency and payer control number as follows: • Select **Replacement of Prior Claim** or **Void/Cancel of Prior Claim** for the **Billing Frequency** (or **Frequency Type**) field, in the **Claim Information**. • Set the **Payer Control Number (ICN / DCN)** (or **Payer Claim Control Number**) field to the claim number assigned to the claim by the payer. You can obtain this number from the 835, if available.	Submit replacement, void/cancel claims through **Availity.com** Select the **Claims & Payments tab** and click **Facility Claim** Enter the clam information and set the billing frequency and payer control number as follows: • Select **Replacement of Prior Claim** or **Void/Cancel of Prior Claim** for the **Billing Frequency** (or **Frequency Type**) field, in the **Claim Information**. • Set the **Payer Control Number (ICN / DCN)** (or **Payer Claim Control Number**) field to the claim number assigned to the claim by the payer. You can obtain this number from the 835, if available.

Type	Professional Claim	Institutional Claim
Paper	**To indicate the Claim is a replacement Claim:** • In Item Number 22: "Resubmission and/or Original Reference Number" • Use Claim Frequency Type 7 under "Resubmission Code"	**To indicate the Claim is a replacement Claim:** • In Form Locator 04: "Type of Bill" • Use Claim Frequency Type 7
	To confirm the Claim which is being replaced: In the right-hand side of Item Number 22 under "Original Ref. No." list the original payer Claim number for the resubmitted Claim.	**To confirm the Claim which is being replaced:** In Form Locator 64: "Document Control Number (DCN)" list the original payer Claim number for the resubmitted Claim.
	To indicate the Claim is a void/cancel of a prior Claim: • In Item Number 22: "Resubmission and/or Original Reference Number" • Use Claim Frequency Type 8 under "Resubmission Code"	**To indicate the Claim is a void/cancel of a prior Claim:** • In Form Locator 04: "Type of Bill" • Use Claim Frequency Type 8
	To confirm the Claim which is being void/cancelled: In the right-hand side of Item Number 22 under "Original Ref. No." list the original payer Claim number for the void/cancelled Claim.	**To confirm the Claim which is being void/cancelled:** In Form Locator 64: "Document Control Number (DCN)" list the original payer Claim number for the void/cancelled Claim.

For additional information on Provider complaints and appeals refer to the Claim Payment Dispute and 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, ME)
- 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
- ME - 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.

NDC Number Section	Description
1 (five digits)	Vendor/distributor identification
2 (four digits)	Generic entity, strength and dosage information
3 (two digits)	Package code indicating the package size

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:

If the NDC appears as…	Then the NDC…	And it is reported as …
NDC 12345-1234-12 (5-4-2 format)	Is complete	12345123412
NDC 1234-1234-1 (4-4-1 format)	Needs a leading zero placed at the beginning of the first segment and the last segment	01234123401
NDC 12345-123-12 (5-3-2 format)	Needs a leading zero placed at the beginning of the second segment	12345012312
NDC 12345-1234-1 (5-4-1 format)	Needs a leading zero placed at the beginning of the third segment	12345123401

Process for Multiple NDC numbers for Single HCPC Codes

- If there is more than one NDC within the HCPCs code, Providers and Facilities 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.), Providers and Facilities 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

837 Reporting Fields

Providers and Facilities will need to notify billing or software vendors that the NDC is to be reported in the following fields in the 837 format.

Loop	Segment	Element Name	Information	Sample
2410	**LIN02**	Product or Service ID Qualifier	Enter product or NDC qualifier N4	LIN***N4***01234567891~
2410	**LIN03**	Product or Service ID	Enter the NDC	LIN**N4***01234567891**~
2410	**CTP04**	Quantity	Enter quantity billed	CTP******2***UN~

Loop	Segment	Element Name	Information	Sample
2410	**CTP05-1**	Unit of Basis for Measurement Code	Enter the NDC unit of measurement code: F2: International unit GR: Gram ML: Milliliter UN: Unit ME: Milligram	CTP****2***UN~**
2410	**REF01**	Reference ID Qualifier (used to report Prescription # **or** Link Sequence Number when reporting components for a Compound Drug)	VY: Link Sequence Number XZ : Prescription Number	REF01***XZ***123456~
2410	**REF02**	Reference Identification	Prescription Number **or** Link Sequence Number	REF01*XZ****123456~**

Digital submission through Availity.com:

- From Availity.com select the Claims & Payments tab then select Professional Claim or Facility Claim.
- Enter the NDC code in the NDC Code field that is associated with the procedure code/service line.
- In the NDC Quantity field, you can enter a maximum of 13 numbers before the decimal point and a maximum of two numbers after the decimal point.
- Convert the NDC to 11-digits following the instructions noted above.

For more information about how to submit an electronic claim including the NDC Code field using Availity Essentials, log onto **Availity.com**, select the **Help & Training** tab, and enter Professional or Facility Claim in the search bar.

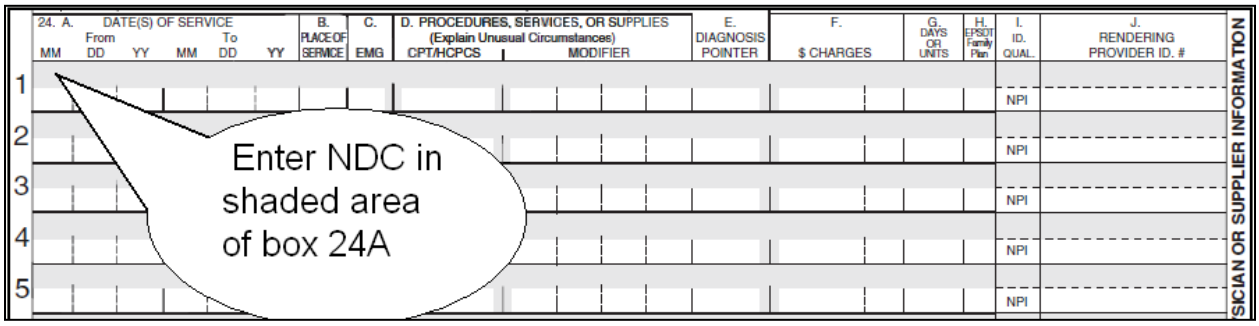
CMS 1500 Claim Form:

- 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 billed does not have a specific HCPCS or CPT code assigned, the appropriate miscellaneous code should be assigned 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:

How	Example	Where
Enter a valid NDC code including the N4 qualifier	NDC 00054352763 is entered as N400054352763	Beginning at left edge, enter NDC in the **shaded area** of box 24A
Enter one of five (5) units of measure qualifiers; • F2 – International Unit • GR – Gram • ML – Milliliter • UN – Units • ME – Milligrams and quantity, **including a decimal point for correct reporting**	GR0.045 ML1.0 UN1.000	In the **shaded area** immediately following the 11-digit NDC, enter 3 spaces, followed by one of five (5) units of measure qualifiers, followed immediately by the quantity
Enter a valid HCPCS or CPT code	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:

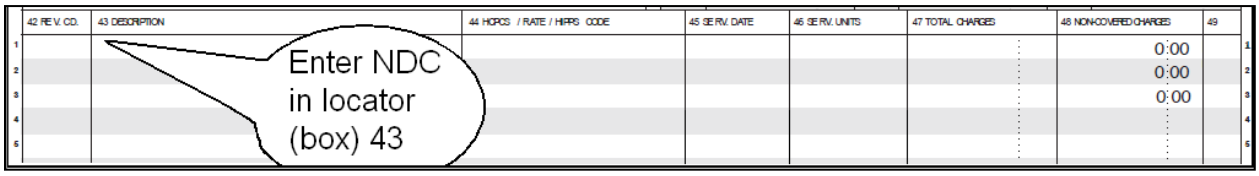
- Even though an NDC is entered, a valid HCPCS or CPT code must also be entered in the Claim form.
- If the NDC billed does not have a specific HCPCS or CPT code assigned, the appropriate miscellaneous code should be assigned per Correct Coding Guidelines.
- DO NOT bill more than one NDC per Claim line.
- 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.

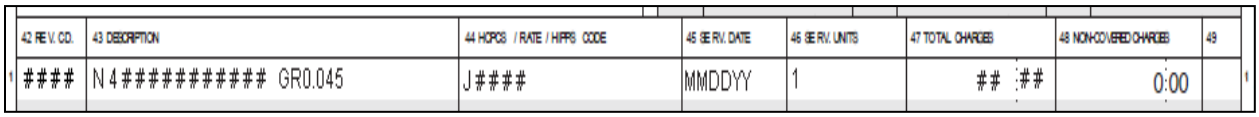
The following table provides elements of a proper NDC entry on a UB04 Claim form. **All Elements are REQUIRED:**

How	Example	Where
Enter a valid revenue code	Pharmacy Revenue Code 0252	Form locator (box) 42
Enter 11- digit NDC, including the N4 qualifier	NDC 00054352763 is entered as N400054352763	Beginning at left edge, enter NDC In locator (box) 43 currently labeled as “Description”

How	Example	Where
Enter one of five (5) units of measure qualifiers; • F2 – International Unit • GR - Gram • ML - Milliliter • UN – Units • ME - Milligrams and quantity, **including a decimal point for correct reporting**	GR0.045 ML1.0 UN1.000	Immediately following the 11 digit NDC, enter 3 spaces followed by one of five (5) units of measure qualifiers, followed immediately by the quantity.
Enter a valid HCPCS or CPT Code	J0610 “injection Calcium, per 10ML” is billed as 1 unit for each 10ML ampul used	Form locator (box 44)

Sample Images of the UB04 Claim Form





PAPER CLAIMS SUBMISSIONS

Digital claim submission, either through the claim submission applications on Availity.com or through EDI, are the preferred method for receiving claims. Filing paper claims can cause delays due to errors associated with using this manual claim submission process. If Providers or Facilities file a paper Claim, 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 **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.

Recommended CMS Form 1500 (02-12)

A sample form and instructions are available on the **CMS website**.

UB-04 (CMS-1450)

A sample form is available on the **CMS website: CMS Forms | CMS along with instructions on how to complete the paper claim form**

MEDICAL RECORDS SUBMISSION

When submitting documentation in response to Anthem's request, the recommended method is to submit them electronically via the 275 transaction or digitally through the Attachments Dashboard. To manually submit requested documentation, navigate to Availity Essentials Claim Status, locate your claim and use the Send Attachment link to upload your documents. **Always include a copy of the request letter as part of your attachment**. The documentation should be formatted as a -.tiff, .jpg or pdf file. Providers should submit medical records within ten calendar days of Anthem's request, or sooner depending upon the urgency of the matter (e.g., expedited appeals) and/or as required by state or federal law, statute or regulation. Providers can view the status of submitted documentation in Availity Essentials Attachment New.

A Provider organization's Availity Essentials administrator should complete the following set-up steps to authorize user access to the Medical Attachments New tool:

From **My Providers**, 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 billing NPIs and Tax IDs. (both are recommended)
    - 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.

If Availity Essentials set-up has not been completed and medical records must be sent via mail or fax, send them to the appropriate department as directed in the notification from Anthem. **Always include a copy of the request letter on top of the records**. **Do not** place a copy of the 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 Submission with Initial Claim

Providers and Facilities can expedite claim processing by sending medical records with the 837 Claim submission or Direct Data Entry.

To determine what medical records or portion of the medical records may be required, refer to the applicable Anthem Medical Policy, Anthem Clinical Guideline, Carelon Clinical Criteria, or MCG at **anthem.com**. Review the Position Statement section of the Anthem Medical Policies or the Clinical Indications section of the applicable Anthem Clinical Guidelines, or the Clinical Criteria section of Carelon to determine what medical records are needed. Refer to the *Medical Policies*, *Clinical Guidelines*, and *Carelon Medical Benefits Management* 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 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.

Providers and Facilities can now submit unsolicited medical records using Availity Essentials.

A Provider organization's Availity Essentials administrator should complete the set-up steps listed above in the Medical Records Submission section to authorize user access to the Medical Attachments tool.

Submit an EDI 837 (claims) batch, which includes a PWK segment containing the attachment control number in loops 2300/2400; this detail is the linkage between the electronic Claim and the documentation. The attachment control number can be assigned by the provider organization or vendor and must be unique.

- Log in to Availity Essentials portal
- Select **Claims & Payments** > **Attachments - New**
- From the **Inbox** tab, locate the appropriate Claim
- Add files with supporting documentation
- When a PWK segment is submitted with the claim, an intake with the attachment control number will display in the Attachment New inbox for seven calendar days. If the document is not received within this time, documentation can be uploaded using the claim status method by locating your claim and attaching the document.

Types of Medical Records Required

Medical records needed to determine the medical necessity of a billed code. To follow are examples of the types of records we may need to make the determination. Only submit the records requested for that specific claim, procedure and date of service. Do not send more records than requested or required:

- History & Physical, Office Visit/Clinical Notes, Treatment Records & Response
- Chemotherapy Regimens, Oncology Drugs, and Records
- Medications List (current and prior)
- Radiology, Diagnostic Imaging, or Diagnostic Testing Reports
- Therapy/Rehabilitation Records
- Laboratory reports, Pathology reports
- Exact description of NOC/NOS code
- Operative/Procedure Report

- Inpatient Admission, History & Physical, Discharge Summary, Physician Progress Notes, Operative/Procedure Report, CT/MRI Report

Anthem May Request Additional Records

Some situations may require 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 effort to make these requests explicit and limited to what is minimally necessary to render a decision. Examples include, but are not limited to, the following situations:

- Medical records requested by a Member's Blue Cross Blue Shield (BlueCard) home plan
- Federal Employee Health Benefits Program (FEP) requirements
- Review and investigation of Claims (e.g., pre-existing conditions [for grandfathered policies of the Affordable Care Act], lifetime benefit exclusions)
- Medical review and evaluation
- Requests for retro authorizations
- Medical management review (utilization review) and evaluation
- Underwriting review and evaluation
- Adjustments
- Appeals
- Quality management (quality of care concerns)
- Records documenting prolonged services
- Provider audits
- Pre-pay review program
- Fraud, waste and abuse

Medical Record Appeals

When a request for information is received in support of the resolution of a grievance or appeal, the provider shall respond within ten calendar days of the request, or sooner, depending upon the urgency of the matter or as required by state or federal law, statute or regulation.

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)

Anthem uses Availity for managing all electronic data interchange (EDI) transactions. Electronic Data Interchange (EDI), including Electronic Remittance Advices (ERA) (835). Electronic Funds Transfers (EFT) allows for a faster, more efficient and cost-effective way to work together.

Advantages of Electronic Data Interchange (EDI)

- Faster claims processing that allows submissions of corrected claims, primary payment detail and offers choices for submitting documentation to support your claims.
- Reduce overhead and administrative costs by eliminating paper Claim submissions

Use Availity for the following EDI transactions

- Healthcare Claim: Professional (837P)
- Healthcare Claim: Institutional (837I)
- Healthcare Claim: Dental (837D)
- Healthcare Eligibility Benefit Inquiry and Response (270/271)
- Healthcare Services Prior Authorization (278)
- Healthcare Services Inpatient Admission and Discharge Notification (278N)
- Healthcare Claim Payment/Advice (835)
- Healthcare Claim Status Request and Response (276/277)
- Medical Attachments (275)

How Providers and Facilities can efficiently use the Availity EDI Gateway

Availity EDI submission options:

- Availity EDI Clearinghouse for Direct Submitters (requires practice management or revenue cycle software)
- Or use the Provider or Facility's existing clearinghouse or billing vendor. Requires the vendor to have a connection to the Availity EDI Gateway

Electronic Data Interchange Trading Partner

Trading partners connect with Availity's EDI gateway to send and receive EDI transmissions. A trading partner can be a Provider organization using software to submit direct transmissions, billing company or a clearinghouse vendor.

To become an EDI trading partner visit **Availity.com**:

- Existing users, select **Login** > **My Providers** > **Transaction Enrollment**.
- New users, select **Register**.

EDI Response Reports

Claims submitted electronically will return response reports that may contain rejections. If using a Clearinghouse or Billing Vendor, please work with them to ensure you are receiving all reports.

It's important to review the response reports as rejections will require correction and resubmission. For questions on electronic response reports contact your Clearinghouse or Billing Vendor or Availity if you submit directly using your practice management software at **800-AVAILITY** (**800-282-4548**).

Payer IDs

Payer IDs route EDI transactions to the appropriate payer. The **Availity Essentials Payer ID list** is available on Availity Essentials. If a Provider or Facility uses a clearinghouse, billing service or vendor, work with them directly to determine payer ID.

Electronic Funds Transfer (EFT)

Electronic claims payment through electronic funds transfer (EFT) is a safe, secure and fast way to receive payment. EFT deposit is assigned a trace number that is matched to the 835 Electronic Remittance Advice (ERA) for simple payment reconciliation.

To register or manage Electronic Funds Transfer (EFT):

Go to **anthem.com/edi** > **State** > **EDI Resources** > **Electronic Funds Transfer**

Electronic Remittance Advice (835)

The 835 eliminates the need for paper remittance reconciliation.

Use Availity Essentials to register and manage ERA account changes with these three easy steps:

Log in to **Availity** > **My Providers** > **Enrollment Center** > **Transaction Enrollment**

Note: *If you use a clearinghouse or vendor, work with them for ERA registration and receiving your ERA's.*

Use EDI to submit corrected claims

For corrected electronic claims use one the following frequency codes:

- 7 – Replacement of Prior Claim
- 8 – Void/Cancel Prior Claim

EDI segments required:

- Loop 2300 – CLM – Claim frequency code
- Loop 2300 – REF – Original claim number

Work with your vendor on how to submit corrected claims or contact Availity.

Contact Availity Essentials

Contact Availity Client Services with any questions at **800-AVAILITY** (**282-4548**)

Useful EDI Documentation

- **Availity EDI Connection Service Startup Guide** – This guide includes information to get started with submitting Electronic Data Interchange (EDI) transactions to Availity, from registration to ongoing support.
- **Availity EDI Companion Guide** – This Availity Essentials EDI Guide supplements the HIPAA TR3s and describes the Availity Essentials Health Information Network environment, interchange requirements, transaction responses, acknowledgements, and reporting for each of the supported transactions as related to Availity Essentials.
- **Availity Essentials Registration Page** – Availity Essentials registration page for users new to Availity Essentials.
- **X12 External Code Listing** – X12 code descriptions used on EDI transactions.

OVERPAYMENTS

Anthem's Program Integrity department 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
- Coordination of Benefits
- Allowance overpayments
- Late credits
- Billed in error
- Duplicate

- Non-covered services
- Claims editing
- Terminated Members
- Total charge overpaid
- Paid wrong Member/ Provider number

Anthem's Program Integrity department 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, use the payment coupon included on the request letter and supply the following information with the check:

- The payment coupon
- Member ID number
- Member's name
- Claim number
- Date of service
- Reason for the refund as indicated in the 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 the 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 because 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 Refund Check Information Form with supporting documentation to have Claim adjustment/recoupment done off a future remittance advice

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

- Refund Check Information 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

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,* ***refund the full amount paid****. Upon receipt and insurance primacy verification, the Claim will be reprocessed and paid appropriately.*

How to access the Refund Check Information Form online:

To download the *Provider Adjustment Form* directly from **anthem.com** > **For Providers** > **Provider Resources** > **Forms and Guides** > **Refund Check Information Form**.

Utilize the correct address noted below to return payment:

Make Check Payable To:	Regular Mailing Address:	Overnight Delivery Address:
Anthem Blue Cross Blue Shield	Anthem Blue Cross Blue Shield P.O. Box 73651 Cleveland, OH 44193-1177	Anthem Blue Cross Blue Shield Lockbox 73651 4100 West 150th Street Cleveland, OH 44135

MEDICARE CROSSOVER

Duplicate Claims Handling for Medicare Crossover

All Blue Plans are 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 their 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.

When a Medicare Claim has crossed over, Providers and Facilities must 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 healthcare Claims status inquiries to verify Claim and adjudication status prior to re-submission of electronic Claims.

The Claims Providers and Facilities submit to the Medicare intermediary will be crossed over to the Blue Plan only after they have been processed by the Medicare intermediary. This process may take approximately 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 Providers or Facilities 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.

Anthem 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 the 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.

- 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 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 –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. 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, 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

How do Providers and Facilities handle traditional Medicare-related Claims?

- When Medicare is primary payer, submit Claims to the 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.

How do Providers and Facilities submit Medicare primary / Blue Plan secondary Claims?

- For Members with Medicare primary coverage and Blue Plan secondary coverage, submit Claims to the Medicare intermediary and/or Medicare carrier.
- It is essential that Providers and Facilities 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 Providers and Facilities 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 behalf of the Provider or Facility 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 the 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 the Claim.
- For Claim status inquiries, contact the local Anthem Plan.

Who do Providers and Facilities contact with Claims questions?

- The local Anthem Plan.

How do Providers and Facilities handle calls from Members and others with Claims questions?

- If Members contact a Provider or Facility, 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 Providers or Facilities directly, unless a paper Claim was filed directly with that Blue Plan. If the Member's Blue Plan contacts the Provider or Facility to send another copy of the Member's Claim, refer the Blue Plan to the local Anthem Plan.

Where can Providers and Facilities find more information?

For more information:

- Visit Anthem's Web site at **anthem.com** or
- Contact Anthem.

Claim Payment Disputes

This section was previously referred to as *Complaints and Grievances*.

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. Providers and Facilities must complete the Claim Payment Reconsideration and Claim Payment Appeal processes set forth in this Provider Manual before they can initiate the dispute resolution and arbitration process set forth in your Provider or Facility Agreement.

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*
- Disputes of prepayment itemized bill review findings

* 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 **Claim Submission Filing Tips** section of the Manual for more information.

Please note: The Claim Payment Dispute process described in this section does not apply to appeals regarding a clinical decision denial, such as a utilization management authorization or a Claim that has been denied as not medically necessary or experimental/investigational. For more information on Clinical / Medical Necessity Appeals, refer to the *Clinical Appeals* section within the Provider Manual.

There are other, Claim-related matters 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 utilize the Chat with Payer or send a Secure Message through the Availity Portal. If Providers or Facilities are unable to utilize the Availity Portal for the inquiry they can call the number on the back of the Member ID Card and select the *Claims* prompt. For further details on Secure Messaging reference the *Availity Portal* section in this Manual.
- **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, refer to the *Clinical Appeals* section within the Provider Manual.

Reference the *Claims Submission Filing Tips* section for additional information.

The Anthem Claim Payment Dispute process consists of **two steps**: **Claim Payment Reconsideration and Claim Payment Appeal**. Providers and Facilities will **not** be penalized for filing a Claim Payment Dispute, and no action is required by the Member.

STEP 1: 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. Anthem cannot process a Claim Payment Reconsideration without a finalized Claim on file. Most issues are resolved at the Claim Payment Reconsideration Step.

Claim Payment Reconsiderations can be submitted via phone, Availity Essentials, or in writing. Providers and Facilities within 180 days from the issue date of the EOP, unless otherwise required by State law or such time-period set forth in the Provider or Facility Agreement.)

A determination will be made and the initial adjudication of 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 proceed with Step 2 and file a Claim Payment Appeal. Providers and Facilities cannot submit another Claim Payment Reconsideration request.

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.

Anthem will make every effort to resolve the Claim Payment Reconsideration within 60 calendar days of receipt.

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

Except in cases where the Provider or Facility presents evidence of an extenuating circumstance, Anthem will not accept Claim Payment Reconsiderations that are not submitted timely according to the procedures set forth above. If a Provider or Facility submits a request for a Claim Payment Reconsideration more than 180 calendar days from the issue date of the EOP without evidence of an extenuating circumstance, the request is deemed ineligible and requests for payment will be denied. In such cases, Providers or Facilities will not be permitted to bill Anthem, Plan or the Covered Individual for those services for which payment was denied.

Provider and Facilities will be notified of the Claims Payment Reconsideration determination in writing or through an EOP.

STEP 2: CLAIM PAYMENT APPEAL

A Claim Payment Appeal is the second step in the Claim Payment Dispute process. If a Provider or Facility is dissatisfied with the outcome of a Claim Payment Reconsideration determination, Providers and Facilities may submit a Claim Payment Appeal through Availity or in writing. Providers and Facilities must submit a Claim Payment Reconsideration before submitting a Claim Payment Appeal. In addition, Providers and Facilities must submit Claims Payment Appeals within 90 days from the date of the determination of the Claims Payment Reconsideration.

Except in cases where the Provider or Facility presents evidence of an extenuating circumstance, Anthem will not accept Claim Payment Appeals that are not submitted timely according to the procedures set forth above. If a Provider or Facility submits a request for a Claim Payment Appeal more than 90 calendar days from the date of the Claims Payment Reconsideration determination without evidence of an extenuating circumstance, the request is deemed ineligible and requests for payment will be denied. In such cases, Providers or Facilities will not be permitted to bill Anthem or the Covered Individual for those services for which payment was denied.

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. Provider and Facilities will be notified of the Claims Payment Appeal determination in writing or through an EOP.

REQUIRED DOCUMENTATION FOR CLAIMS PAYMENT AND CODING DISPUTES

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

- The Provider or Facility position statement explaining the nature of the dispute
- Provider or Facility name, address, phone number, email, and either NPI or TIN
- The Member's name and their Anthem ID number, including the prefix
- A listing of disputed Claims, which should include the Anthem Claim number and the date(s) of service(s)
- All supporting statements and documentation, including but not limited to Medical Records.

How to Submit a Claim Payment Dispute

Mail all required documentation to:

Anthem Claim Payment Dispute
P.O. Box 1407, Church Street Station
New York, NY 10008

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, 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
- Disputes of Prepayment Itemized Bill Review Findings.

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/ investigational. UM program Clinical Appeals involve certification decisions, Claims, or predetermination decisions evaluated on these bases. Clinical Appeals may be initiated through Availity.com using the Authorizations & Referrals application, where available, verbally, or in writing, for appeals regarding prior authorization clinical adverse decisions.
- Anthem Members may designate a representative to exercise their complaint and appeal rights. **A Designation of An Authorized Representative form (DOR)** is needed for the Member to allow/ designate a Provider or Facility to request an appeal on their behalf. The Designation Of An Authorized Representative form ("DOR") can be found online at: **anthem.com** > **For Providers** > **Provider Resources** > **Forms and Guides**, if needed, select **New York** link at the top right. Scroll down and select **Forms and Guides**, then scroll down, and select **Grievances & Appeals** in the Category drop down and select **Designation of an Authorized Representative (DOR).**

Guidelines and Timeframes for Submitting Clinical Appeals

- Providers and Facilities have one hundred 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: standard and expedited.
    - *Standard Appeal:* A standard appeal is available following an initial adverse determination.
    - *Expedited Appeal:* Anthem offers an expedited appeal for decisions meeting the expedited criteria. 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.

      When a request for information is received in support of the resolution of a clinical appeal, the provider is required to respond within ten (10) days of the request or sooner dependent upon the clinical urgency of the case in accordance with the state or federal law, statute, or regulation.
- UM decisions are communicated in writing to the Provider, Facility and Member. These letters provide details on appeal rights and the address to use when sending additional information. A Provider or Facility may file an appeal for a retrospective denial.

Standard Appeals

If Anthem Medical Management determines that an admission, extension of a continued stay, or some other health care service is not medically necessary the Provider, Facility, the Member or

his/her authorized representative may appeal an adverse determination in the following manner. Note: Requests for appeal of Pre-Service or Concurrent requests will always be handled as a Member appeal. An expedited appeal is available for cases meeting the expedited criteria. See the instructions detailed in the UM decision letter.

The following can be appealed internally by the Provider or Facility with Anthem:

- An initial adverse determination provided by Utilization Management

Appeals should be attached to the Provider Clinical Appeal Request cover page, accompanied by a letter stating why the decision is being appealed and why the Provider or Facility feels the decision should be overturned. Also include the information necessary to review it, such as the medical record. Appeals will be acknowledged within fifteen (15) days of receipt, based on the Health Benefit plan. If additional information is necessary to conduct a standard internal appeal, Anthem will notify the Provider or Facility within fifteen (15) days of receipt of the appeal to identify and request the necessary information. In the event that only a portion of the requested necessary information is received, Anthem shall request the missing information, in writing, within five (5) business days of the partial information receipt. Anthem will notify the Member, the Member's designee and the Provider or Facility in writing of the appeal determination within two (2) business days of the decision, based on the health benefit plan.

An appeal is initiated by calling or writing to the Anthem Medical Management Appeals Department at **800-634-5605**, select the pound (#) key and follow the instructions, 8:30 a.m. to 5:00 p.m. EST, Monday through Friday, or in writing, with Provider Clinical Appeal Request cover page, to:

Anthem Blue Cross and Blue Shield
Attention: Appeals Department
P.O. Box 5063
Middletown, NY 10940

**Failure to submit a clinical appeal request with the required accompanying "Provider Clinical Appeal Request Cover Page" and/or to the appropriate Grievances and Appeals P.O. Box listed above may result in an extension of Anthem's appeal review timeframe equal to the additional time the request takes to reach the Grievances and Appeals Department.

Level 1 Appeals must be initiated within one hundred eighty (180) calendar days of Anthem's initial decision. Appeals filed after that date will not be considered, and the Provider or Facility will receive a letter stating that the opportunity to file an appeal has been exhausted. The appeal should be attached to the Provider Clinical Appeal Request cover page, accompanied by a letter stating why the determination is being appealed and why it should be overturned, as well as the information necessary to review it, such as the medical record.

If a decision is made in favor of the person filing the appeal, written notification is sent stating that the initial denial decision has been reversed. If Anthem makes a final adverse determination upholding the prior decision, Anthem will provide written notification that will include:

- The basis and clinical rationale upon which the appeal determination is based
- The words "final adverse determination" (based on the health benefit plan)
- The health service that was denied, including the Facility, Provider and/or the developer/ manufacturer of service as available (based on the health benefit plan).
- Information and rights regarding filing a request for a Level 2 appeal to Anthem (if available). A clear statement in bold that the Member or Member's authorized

representative has four months from the final adverse determination to request an external appeal; or for Provider initiated appeals (retrospective services), a statement that the Provider or Facility has forty five (45) days from the final adverse determination to request an external appeal (external appeals are available based on the health benefit plan).

- A statement that choosing a 2nd level of internal appeal, if available under the health benefit plan, may cause time to file external appeal to expire. Statement that Member may be eligible for external appeal and timeframes for external appeal (based on the health benefit plan)
- Standard description of external appeals process is attached (based on the health benefit plan)
- Anthem Appeals contact and telephone number (based on the health benefit plan)
- The type of coverage the appellant is enrolled in (based on the health benefit plan)
- The name and address of the UR agent including a contact person and telephone number (based on the health benefit plan)

Failure by Anthem to make an appeal determination within the applicable timeframes set forth in NYS Public Health Law and Insurance Law Sections 4904.5 and 4905(e), respectively, shall be deemed to be a reversal of Anthem's adverse determination. **Notwithstanding the foregoing, the aforementioned requirement as far as the reversal of an adverse determination shall only apply to insured benefit plans that are regulated by New York law.**

Note: The Member and Anthem may jointly agree to waive the internal appeal process; if this occurs, Anthem will provide a written letter with information regarding the process for filing an external appeal to the Member within twenty-four (24) hours of the Agreement to waive Anthem's internal appeal process.

Expedited Appeals

- The Provider, Facility, Member or his/her authorized representative may request an urgent/expedited appeal to be implemented when the denial of coverage involves any of the following: Cases involving continued or extended healthcare services, procedures or treatments (including home health care services following an inpatient hospital admission);
- Requests for additional services for a patient undergoing a continuing course of treatment
- Any case in which the Member's Provider or Facility believes an immediate appeal is warranted.

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.

Note: There is only one (1) level of expedited appeal. Expedited appeals that are not resolved to the satisfaction of the appealing party may be further appealed via the standard Anthem Member Appeal Procedures exclusively as a Level 2 appeal or through the external appeal process (based on the health benefit plan). Retrospective appeals are not eligible to be expedited. If sufficient documentation to conduct the expedited appeal is not provided, the Anthem Appeals Department will immediately notify the Member and the Member's Provider or Facility by telephone or facsimile

to identify and request the necessary information followed by written notification.

Written notice of final adverse determinations concerning an expedited UR appeal shall be transmitted to Members within twenty-four (24) hours of rendering the determination.

Expedited appeals will be decided within 2 business days of receipt of necessary information, or 72 hours when additional information requested. Written notice of final adverse determination concerning an expedited appeal shall be transmitted to the Member within 24 hours of rendering the determination. Expedited appeal outcomes are also telephonically relayed to the person filing the appeal.

Reasonable access to a Clinical Peer Reviewer shall be made available within one (1) business day of receiving notice of the request for an expedited appeal.

An Expedited Appeal is initiated by calling or writing to the Anthem Medical Management Appeals Department at **800-634-5605** select the pound (#) key and follow the instructions, 8:30 a.m. to 5:00 p.m. EST, Monday – Friday, or by writing to:

Anthem Blue Cross and Blue Shield
Attention: Appeals Department
P.O. Box 5063
Middletown, NY 10940

Be sure to include the Provider Clinical Appeal Request cover page with the written appeal request.

Summary of Provider and Facility Appeal Timeframes (Plan's response timeframe will be indicated on the acknowledgement letter)

Level of Appeal	Type of Appeal	Timeframe to request Appeal	Timeframe to respond
Level 1	Post-Service	180 calendar days from the initial denial	30/60 calendar days based on the Health Benefit Plan

**Failure to submit a clinical appeal request with the required accompanying "Provider Clinical Appeal Request Cover Page" and/or to the appropriate Grievances and Appeals P.O. Box listed above may result in an extension of Anthem's appeal review timeframe equal to the additional time the request takes to reach the Grievances and Appeals Department.

Levels of appeal available to Members or Designated Representatives on behalf of the Member (Plan's response timeframe will be indicated on the acknowledgement letter)

Level of Appeal	Type of Appeal	Timeframe to request Appeal	Timeframe to respond
Level 1	Expedited	180 calendar days from the initial denial	2 business days of receipt of necessary information or 72 hours when additional information requested
Level 1	Pre-Service	180 calendar days from the initial denial	15/30 calendar days based on the Health Benefit Plan
Level 1	Post-Service	180 calendar days from the initial denial	30/60 calendar days based on the Health Benefit Plan
Level 2	Pre-Service	60 calendar days from the first level appeal denial letter	15/30 calendar days based on the Health Benefit Plan
Level 2	Post-Service	60 calendar days from the	30/60 calendar days based on the

		first level appeal denial letter	Health Benefit Plan

External Appeals

Based on applicable New York State Insurance and Public Health Law, if services in whole or in part, were denied based on medical necessity or a determination that they are experimental or investigational, subsequent to an appeal the Provider or Facility may have the right to an external review. Providers and Facilities can initiate an external review using the form Anthem will send when the final adverse determination is made. A Member, the Member's designee and, in connection with concurrent and retrospective adverse determinations, a Member's Provider or Facility shall have the right to request an external review.

An external appeal may be filed:

- When the Member has had coverage of a health care service which would otherwise be a covered benefit under a subscriber contract or governmental health benefit program, denied on appeal, in whole or in part, on the grounds that such health care services is not medically necessary and Anthem has rendered a final adverse determination with respect to such health care services or both Anthem and the Member have jointly agreed to waive any internal appeal.
- When the Member has had coverage of a health care service denied on the basis that such service is experimental or investigational and the denial has been upheld on appeal or both Anthem and the Member have jointly agreed to waive any internal appeal and the Member's attending physician has certified that the Member has a life-threatening or disabling condition or disease (a) for which standard health services or procedures have been ineffective or would be medically inappropriate or (b) for which there does not exist a more beneficial standard health service or procedure covered by Anthem or (c) for which there exists a clinical trial and the Member's attending, physician, who must be a licensed, board-certified or board-eligible physician qualified to practice in the area of practice appropriate to treat the Members life threatening or disabling condition or disease, must have recommended either (a) a health service or procedure (including a pharmaceutical product within the meaning of PHL 4900 (5)(b)(B), that based on two documents from the available medical and scientific evidence, is likely to be more beneficial to the Member than any covered standard health service or procedure; or (b) a clinical trial for which the Member is eligible. Any physician certification provided shall include a statement of the evidence relied upon by the physician in certifying his or her recommendation, and the specific health service or procedure recommended by the attending physician would otherwise be covered under the policy except for the health care plan's determination that the health service or procedure is experimental or investigational.

Note: The Member and Anthem may jointly agree to waive the internal appeal process; if this occurs Anthem will provide a written letter with information regarding filing an external appeal to Member within twenty-four (24) hours of the Agreement to waive Anthem's internal appeal process.

An external appeal must be submitted within one hundred and twenty (120) days upon receipt of the final adverse determination of the first level appeal, regardless of whether or not the Member requested a second level appeal. If a Member chooses to request a second level internal appeal, the time may expire for the Member to request an external appeal.

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. Providers must obtain the necessary authorization prior to the delivery of inpatient admission services. Failure to obtain the necessary authorization may result in non-payment or penalty reduction to the Provider. Anthem understands that many Providers and Facilities 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. 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 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 Plan. Reference the Claim Payment Dispute section for further details.
- Providers submitting an appeal on behalf of the Member are required to submit a Member Designation of Representation (DOR) authorization form. Home Plans may have a specific DOR authorization form.

Member Quality of Care/Quality of Service 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

Quality of Care		
Level	**Points Assigned**	**Description**
C-0	0	No quality of care issue found to exist.
C-1	0	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.

Quality of Care		
Level	**Points Assigned**	**Description**
C-2	5	Communication, administrative, or documentation issue that adversely affected the care rendered.
C-3	5	Failure of a practitioner/Provider to respond to a Member grievance regarding a clinical issue despite two requests per internal guidelines.
C-4	10	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.
C-5	15	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.
C-6	25	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.

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

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

Reimbursement for services that Providers and Facilities provide to Anthem Members is based upon the Agreements that Anthem has with Providers and Facilities, Anthem's Members' benefit application, Anthem's medical policy application and Anthem's reimbursement requirements and policies.

This section includes reimbursement requirements and policies on how Anthem will reimburse Providers and Facilities for certain services. Reimbursement Policies are published on **anthem.com** be sure to check both places. To locate the policies online go to **anthem.com**. Anthem reserves the right to review and revise policies when necessary.

ADMISSIONS

An Admission is considered to occur when a Member is registered as an inpatient in the Facility upon the orders of the Member's attending physician.

If the Facility decides to keep a Member receiving outpatient Covered Services (i.e. outpatient surgery, emergency room services) past midnight for observation, the overnight stay will NOT be considered an admission unless the Member is admitted as an inpatient as set forth above.

Notwithstanding the foregoing, the Facility will not be reimbursed for inpatient services unless inpatient Covered Services are deemed to be Medically Necessary. In the context of an admission, this means that such service(s) could not be safely provided on an outpatient basis and there were complications that required an inpatient level of care. Without limiting the generality of the foregoing, an admission is not Medically Necessary when a Member: (1) is being evaluated or observed to determine whether the Member has a complication or specific diagnosis for which treatment is required; or (2) when the Member is diagnosed with a complication or specific diagnosis which requires treatment and the necessary treatment (a) is reasonably expected to be less than 24 hours and (b) due to the level of acuity, could be safely provided on an outpatient basis such as services that could be provided at a Facility-based observation level of care (regardless of whether the Facility has a designated observation unit). In cases where it is determined that inpatient services were not Medically Necessary, Facility shall be reimbursed in accordance with the applicable outpatient rate for the Covered Services provided. Until such time as this payment provision is automated, it is the Facility's responsibility to submit a corrected Claim indicating an outpatient place of service for payment at the applicable outpatient rates or Facility may appeal the inpatient Claim as the Claim will initially be denied.

BLOOD, BLOOD PRODUCTS, AND ADMINISTRATION

Blood and blood products such as platelets or plasma are reimbursable. Administration of blood or blood products by nursing/facility personnel are not separately reimbursable on inpatient claims. Administration of Blood or Blood Products by nursing/facility personnel billed on outpatient claims are separately reimbursable when submitted without observation/treatment room charges.

Charges for blood storage, transportation, processing, and preparation such as thawing, splitting, pooling, and irradiation are also not separately reimbursable. Lab tests such as typing, Rh, matching, etc., are separately reimbursable charges.

CHANGES DURING ADMISSION/CONTINUOUS OUTPATIENT ENCOUNTER

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

CHANGE	EFFECTIVE DATE
Facility's Contracted Rate (other than DRG)	Admission/First day of continuous Outpatient Encounter
DRG Base Rate	Discharge
DRG Grouper	Discharge
DRG Relative Weight	Discharge
CPT & HCPCS coding changes	Discharge/Last day of continuous Outpatient Encounter

CHARGEMASTER CAP

Facility will provide thirty (30) days prior written notice of any increase to the Chargemaster above the Chargemaster Cap set forth in the Agreement, via certified letter from the Facility's chief financial officer or other appropriate officer of Facility. Such notice shall include Facility's estimate of the amount of net increase based on the book of business covered under the Agreement and shall provide a copy of the Chargemaster.

Anthem shall have the right, upon request and consistent with the audit provisions of the Agreement, to audit any and all Facility records, documents and other information to validate the net impact of the Chargemaster increase. The audit will be conducted using inpatient and out-patient utilization for all Claims paid under this Agreement and will be conducted using the revenue and usage (utilization) data for the fiscal period (annual) subject to audit as opposed to using fiscal period data from any other period than the audit.

In the event the Facility increases its Chargemaster, in the aggregate, taking into account the book of business under this Agreement, by more than the Chargemaster Cap during any applicable contract year, the parties agree that the Percentage Rate paid will be decreased by a percentage equal to the percent in excess of the Chargemaster Cap by Anthem. In other words, Anthem shall decrease the discount off charges for any Covered Services paid on a Percentage Rate basis to ensure that the amount payable under this Agreement does not exceed the amount that would have been payable had the Facility not exceeded the Chargemaster Cap. Plan reserves the right to recoup any amounts paid over the Chargemaster Cap between the time that the Chargemaster increase caused payments to exceed the Chargemaster Cap until the payment rates were adjusted downwardly to bring Facility into compliance with this section.

Facility will make Chargemaster available to Anthem electronically upon request. This data shall be in a format acceptable to Anthem and shall include, at a minimum, the following data elements: (1) all Facility charge codes and related charge revenue (Coded Service Identifier(s)); (2) charge number; (3) current Charge and previous Charge; (4) effective date of change; (5) departmental code; and (6) Facility tax identification number.

CLINIC SERVICES

For purposes of this paragraph, the term "clinic" shall mean setting for physical examination and treatment of ambulant patients who are not hospitalized and who are not treated in an emergency or ambulatory surgery setting. If Covered Services are rendered to a Member by a Professional Provider at any clinic owned, operated or controlled by a Facility, the Facility agrees that it will not

bill or seek reimbursement for any claimed technical or overhead component of the clinic charges (e.g. UB-04 revenue codes 510-529 or any successor codes) from any Plan or Member, and shall only seek reimbursement of the Facility clinic charges from such Professional Provider. Until such time that Anthem develops the system capability to automatically adjudicate Claims submitted for clinic charges, Anthem may use a post payment audit process, which may result in recoupment of any impermissible clinic charges.

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.

COSMETIC AND RECONSTRUCTIVE SURGERY

Cosmetic surgery is not a covered service because it is performed to reshape the structure of the body in order to alter the appearance or to alter the manifestation of the aging process. Reconstructive surgery is covered when it is performed to improve or restore bodily function or to correct a functional defect resulting from disease, trauma, or congenital or developmental anomalies. When surgery is done for both cosmetic and reconstructive purposes, the allowed amount will be prorated based on the percentage of the surgery that was reconstructive in nature. However, breast reconstruction following mastectomy for cancer is not considered cosmetic. This includes surgery on the contra lateral breast for symmetry.

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.

DIFFERENT SETTINGS CHARGES

If Anthem determines that Facility submits charges differently for the same service performed in a different setting, Anthem may 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 SUPPLIES AND SERVICES CHARGES

The emergency room level reimbursement includes payment for all monitoring, equipment (i.e., MRI, CT, etc.), supplies, 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.

- Follow up Care – Initial emergency room includes full compensation for the subsequent follow up care by Facility employees or subcontractors in the emergency room. Anthem

shall not make any additional payment to the Facility, and Facility shall not seek any payment from the Member in relation to follow up care, including any payment which would otherwise be due for the emergency room visit, i.e., stitch removal, wound care, cast care, or any procedure with a CPT coding guidelines global period)

- Emergency Admissions – Unless otherwise required by federal or state law, if a Member presents in the emergency room or for an Outpatient Service, but requires a higher level of care and is admitted or transferred for Inpatient Services at Facility or another Facility that i) operates under the same Facility Agreement, and (ii) has the same tax identification number as Facility, then the inpatient reimbursement shall supersede the emergency room or outpatient service allowance (there will be no separate payment for any emergency room visit or Outpatient Service) and shall be considered all inclusive. There will be no separate payment for emergency room Covered Services but the day of admission shall be deemed to have occurred when the patient presented to the Emergency Room.

EVALUATION AND MANAGEMENT (E&M) SERVICES

Prior to payment, Anthem may review E&M Claims to determine, in accordance with correct coding requirements and/or reimbursement policy as applicable, whether the E&M code level submitted is higher than the E&M code level supported on the Claim. If the E&M code level submitted is higher than the E&M code level supported on the Claim, Anthem reserves the right to:

- Deny the Claim and request resubmission of the Claim with the appropriate E&M level;
- Pend the Claim and request that the Facility or Provider submit documentation supporting the E&M level billed; and/or
- Adjust reimbursement to reflect the lower E&M level supported by the Claim

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 or procedure charge. 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), 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. Per the UB-04 and CMS1500 (or subsequent forms) billing manual referenced as Coded Service Identifier(s).

GENERAL RULES RELATING TO FACILITY PAYMENT METHODOLOGIES

Services are reimbursed using a Case Rate, Per Diem, Per Visit, Fee Schedule Rate, Percentage Rate and Other Outpatient Rate payment methodology based on the Facility Agreement. These allowances include, but is not limited to, reimbursement for professional services, blood, blood products, processing, storage and administration, monitoring services performed in connection with devices inserted or equipment used in part of an Inpatient or Outpatient Service,

comprehensive health planning, courtesy room, daily supply or one time charge fees/items, Facility personnel charges, instrument trays, implants, equipment and supplies, drugs/ medications, nursing procedures, all ancillary services (including but not limited to laboratory and x-ray), DME, room and board charges, personal care items, portable charges, pre-operative care and holding room charges, preparation charges, ambulance charges, recovery room, special procedure room charge, stand-by charges and video equipment used in operating room.

HOME SLEEP STUDY POLICY

Anthem considers home sleep studies a professional service. As a result, Anthem shall only consider reimbursement for Claims billed globally on a CMS-1500 form or 837 P electronic submitted by the physician performing the reading. Claims submitted by a Facility on a UB-04 Claim form or 837I electronic shall not be considered for reimbursement and Members shall have no liability. To the extent the physician performing the reading does not own the equipment; the physician should work with the equipment supplier directly on any related costs associated with the equipment use, as the equipment will not be reimbursed separately by the Anthem.

For additional information on sleep studies, clinical guidelines are available at **carelonmedicalbenefitsmanagement.com/anthem/** or contact a dedicated Network Management Consultant.

INCIDENTAL PROCEDURES

Procedures that are performed concurrently with, and are clinically an integral part of, the primary procedure will not be reimbursed separately. The fees for any incidental procedure will be denied and Anthem will reimburse the allowed amount for the primary procedure only. Certain services and supplies that are considered part of overall care are not separately reimbursed. These may include procedures identified as Status “B” by CMS.

Anthem considers the use of surgical trays and supplies to be incidental (part of the technique) to surgical procedures and therefore not separately reimbursed. Anthem’s fees for surgical procedures include these items and techniques.

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 and Routine Supplies sections 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

The reimbursement of charges for specimen collection are considered facility personnel charges and the reimbursement is included in the room and board or procedure/observation charges.

Examples include venipuncture, urine/sputum specimen collection, draw fees, phlebotomy, heel sticks, and central line draws.

Processing, handling, and referral fees are considered included in the procedure/lab test performed and are 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.

LESSER OF REIMBURSEMENT

Reimbursement for Covered Services will be paid at the lesser of Physician, Practitioner or Facilities' actual charge or the amount set forth in the agreed upon negotiated allowances specific for each product, i.e., HMO, PPO, EPO, etc. The calculation of "lesser of" shall occur at the line level for Physicians **(excluding services that are non-covered)** and at the Claim level **(excluding services that are non-covered)** for Facilities.

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.

Unless otherwise set forth in a Member's Health Benefit Plan, an immediate family Member includes: father, mother, children, spouse, domestic partner, legal guardian, grandparent, grandchild, sibling, step-father, step-mother, step-children, step-grandparent, step-grandchild, and/or step-sibling.

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, pulse oximetry 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.)

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 is defined as surgical suites, major and minor, treatment rooms, endoscopy labs, cardiac cath labs, Hybrid Rooms, X-ray, pulmonary and cardiology procedural rooms. The operating room reimbursement will reflect the cost of:

- The use of the operating room

- The services of qualified professional and technical personnel
- Any supplies, items, equipment, and services that are necessary or otherwise integral to the provision of a specific service and/or the delivery of services. Refer to Routine Supplies section of the manual.

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
- Supplies billed related to the use of robotic technology.
- Reference the Technology Assisted Surgical Procedures reimbursement policy online.

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.

OUTPATIENT CPT BASED CLAIMS

For Providers and Facilities contracted for outpatient CPT processing, Anthem will process (based on individual contract with Facility) outpatient diagnostic, therapy, home infusion and ambulatory surgery Claims based on CPT codes that are billed in conjunction with revenue codes based on the Medicare Physician Fee Schedule Non-Facility allowable as indicated at www.cms.gov. If there is no allowable indicated at www.cms.gov, the services will be reimbursed at Anthem's standard reimbursement fee schedule which may be updated from time to time.

CPT outpatient ambulatory surgery Claims will be reimbursed based on the revenue code and CPT surgical procedure code. Anthem will reimburse multiple CPT surgical procedure codes. Anthem does not accept Modifier 50 for Claims processing, so bilateral procedures reported with the same CPT/HCPCS must be billed on separate lines using an LT/RT Modifier.

Medicare crossover Claims are excluded from the CPT payment methodology, as Anthem reimburse Medicare balances only.

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.

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 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, IV diluents such as saline and sterile water, IV Piggyback (IVPB), Heparin and saline flushes to administer IV drugs, 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.

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

Mechanical Ventilation/CPAP/BIPAP support and other bedside respiratory and pulmonary function services are considered facility personnel, equipment, and/or supply charges and are not eligible for separate reimbursement.

ROUNDING OF ALLOWANCES

Covered Services priced at a Case Rate, Per Diem Rate or Per Visit rate, including those being modified for the Q-HIP adjustment, if applicable, will be rounded to the nearest whole dollar. In addition, the base rate used to calculate the DRG Case Rate shall be rounded to the whole penny to the extent applicable.

Covered Services priced at a Fee Schedule Rate, including those being modified for the Q-HIP adjustment, will be calculated using whole percentages. The resulting Fee Schedule Rate allowance will be rounded to two (2) decimal places.

Covered Services priced at a Percentage Rate will be rounded to two (2) decimal places. By way of example but not limited to, if the Anthem Rate requires a price adjustment due to an audit finding, the resulting Percentage Rate will be modified and rounded to two (2) decimal places.

If applicable, when Q-HIP adjustment and inflationary Rate Increases coincide on the same effective date, the Q-HIP adjustment and the rate increase will first be added together and the result will be applied to the Anthem Rate using the rounding rules previously detailed above. For illustrative purposes only, if the rate increase was 3.5%, the Q-HIP adjustment was 0.85%, the Anthem Rate was $755 Per Diem, and the inflationary Anthem Rate with Q-HIP adjustment would equal $.

(1.035 +.0085) x 755 = 1.0435 x 755 = $787.8425 which would be rounded to $788.

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.

SERVICES RELATED TO NON-COVERED SERVICES, SUPPLIES, OR TREATMENT

Reimbursement shall not be made for claims submitted for services, supplies, or treatment related to, or for complications directly related to a service that is not covered by this Plan. Directly related means that the care took place as a direct result of the non-covered Service and would not have taken place without the non-covered Service.

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, then OR time will not be reimbursed to cover OR personnel/staff being present in the room. Example: ICU, ER, etc.

STAND-BY CHARGES

Standby equipment and consumable items such as oxygen, which are on standby, are not reimbursable. Only actual use is covered. 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 Anthem's 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 therapy per minute/per hour, mechanical ventilation and ventilation management, continuous positive airway pressure (CPAP), and bilevel positive airway pressure (BIPAP), 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
32X – Radiology diagnostic
341 – Nuclear medicine, diagnostic
35X – CT scan
40X – Other imaging services
46X – Pulmonary function
48X -- Cardiology
53X – Osteopathic services
61X – MRI
62X – Medical/surgical supplies, incident to radiology or other services
73X – EKG/ECG

74X – EEG
92X – Other diagnostic services

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/ pre-operative 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 fixed 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.
- **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

- **Hospital/ Technical Anesthesia Component**- Time should be calculated from the time the patient enters the operating room (OR) until the patient leaves the room, as documented on the OR nurse's notes. The time the anesthesiologist spends with the patient in pre-op and in the recovery room is not to be included in the hospital anesthesia time calculation.

TRANSFERS

Transfer to and from other Facilities requires prior authorization by Anthem's Medical Management Department. Anthem does not approve transfers between acute Facilities unless the transfer is considered to be Medically Necessary. When a transfer is approved for an inpatient Covered Service for which Facility is reimbursed on a "Per Case" basis or actual charges due to "Lesser of" reimbursement methodology (i.e. when Facility's actual charge is less than the "Per Case" negotiated amount), reimbursement to Facility will be apportioned so as to avoid duplicate payment based on the percentage of the admission that the patient was inpatient at Facility. The per diem rate is calculated by dividing the DRG case rate by the average length of stay (GMLOS for MS DRG). For transfers for admissions for which Facility is reimbursed under a "Per Diem" payment methodology, the inpatient stay at each applicable Facility shall be treated as an "Admission" as defined above and Facility shall be reimbursed under the "Admission" rules described above.

UNDOCUMENTED OR UNSUPPORTED CHARGES

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

VIDEO OR DIGITAL EQUIPMENT USED IN OPERATING ROOM

Charges for video or digital equipment used for visual enhancement during a procedure 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 the Facility or Provider Agreement. Refer to the contractual fee schedule for payment determination.

The tables below illustrate examples of non-reimbursable items/services:

Facility Responsibility	
Typically Billed Under This/These Revenue Codes, but not Limited to the Revenue Codes Listed Below	**Description of Excluded Items**
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)
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	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.)

Facility Responsibility	
Typically Billed Under This/These Revenue Codes, but not Limited to the Revenue Codes Listed Below	**Description of Excluded Items**
	• 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; • 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/Supplies (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.);
0220 – 0222, 0229, 0250	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
0223	Utilization Review Service Charges

263	• IV Infusion for therapy, prophylaxis (96365, 96366);
	• IV Infusion additional for therapy:
	  ○ IV Infusion concurrent for therapy (96368);
	  ○ IV Injection (96374, 96379)

Facility Responsibility	
Typically Billed Under This/These Revenue Codes, but not Limited to the Revenue Codes Listed Below	**Description of Excluded Items**
0229, 0760 – 0762, 0769, 0270, 410 – 413, 0419	Other 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
0230, 0270 – 0272, 0300 – 0307, 0309, 0390 – 0392, 0310	Nursing Procedures and 99001 – Handling and/or conveyance of specimen from patient (charge for specimen handling)
0230	Incremental Nursing – General
0231	Nursing Charge – Nursery
0232	Nursing Charge – Obstetrics (OB)
0233	Nursing Charge – Intensive Care Unit (ICU)
0234	Nursing Charge – Cardiac Care Unit (CCU)
0235	Nursing Charge – Hospice
0239	Nursing Charge – Emergency Room (ER) or Post Anesthesia Care Unit (PACU) or Operating Room (OR)
0250 – 0259, 0636	Pharmacy (non-formulary drugs, compounding fees, nonspecific descriptions) • Medication prep • Nonspecific descriptions • Anesthesia Gases – Billed in conjunction with Anesthesia 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 • Thawing/Pooling/Splitting, etc. 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/or, 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

Facility Responsibility	
Typically Billed Under This/These Revenue Codes, but not Limited to the Revenue Codes Listed Below	**Description of Excluded Items**
	• Blades • IV pumps and PCA (Patient Controlled Analgesia) pumps • 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 • Heel/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 Charges • Case Carts • C-Arm/Fluoroscopic Charge • Wound Vacuum Pump • Bovie/Electro Cautery Unit • Wall Suction • Retractors • Single Instruments • Oximeter Monitor • CPM Machines • Lasers • DaVinci 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) • Oximetry reading by nurse or respiratory tech • Vent Management

Facility Responsibility	
Typically Billed Under This/These Revenue Codes, but not Limited to the Revenue Codes Listed Below	**Description of Excluded Items**
	• 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, etc.)

Member Responsibility	
Typically Billed Under This/These Revenue Codes, but not Limited to the Revenue Codes Listed Below	**Description of Excluded Items**
0110 – 0119	Private Room*
0990	Patient Convenience Items
0991	Cafeteria, Guest Tray
0992	Private Linen Service
0993	Telephone, Telegraph
0994	TV, Radio
0995	Non-patient Room Rentals
0996	Late Discharge
0998	Beauty Shop, Barber
0999	Other Patient Convenience Items

* Subject to the Member's Benefit Agreement.

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 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. Anthem reviews the guidelines at least every year 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** > **For Providers** > **Provider Resources** > **Policies, Guidelines & Manuals**.

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 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. Anthem reviews 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. Anthem encourages physicians to utilize these guidelines to improve the health of Members.

The current guidelines are available on online. To access the guidelines, go to **anthem.com** > **For Providers** > **Provider Resources** > **Policies, Guidelines & Manuals** > **Preventive Health 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 Policies 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 position statements or clinical indications that are objective and based on medical 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.

Medical Policies are intended to reflect current scientific data and clinical thinking. While Medical Policy sets forth position statements or clinical indications regarding the medical necessity of individual services and/or procedures, Federal and State law, as well as contract language, including definitions and specific provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage.

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 may be developed to 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 discretion of the local Anthem Plan or line of business.

ACCESSING MEDICAL POLICIES AND CLINICAL UM GUIDELINES

Anthem Medical policies and clinical UM guidelines are available on **anthem.com**, which provides transparency for Providers, 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 policies and clinical guidelines online, go to **anthem.com** > **For Providers** > **Provider Resources** > **Policies, Guidelines & Manuals** > **Select Your State** > **View Medical Policies & Clinical UM Guidelines**. Search for policies or select **Full List page** to view. Page link is included below:

Medical Policy 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** > **For Providers** > **Claims** > **Prior Authorization** > **Helpful Links** > **Medical Policy and Prior Authorization for Blue Plans**. Page link is included below:

Medical Policy and Prior Authorization for Blue Plans

CLINICAL UM GUIDELINES

The clinical UM guidelines published on online represent the clinical UM guidelines currently available to all Plans for adoption throughout the organization. Because local practice patterns, Claims systems and benefit designs vary, a local Plan or line of business may choose whether to adopt 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 Anthem scroll to the bottom of the Clinical UM Guidelines section and select the link titled **Clinical UM Guidelines adopted by Anthem BlueCross BlueShield**.

OTHER CRITERIA

In addition to medical policy and clinical UM guidelines maintained for coverage decisions, Anthem may adopt third party criteria developed and maintained by other organizations. Where Anthem has developed criteria that addresses a service also described in one of the third party other sets of criteria, Anthem's policy supersedes. To access third party criteria, go to **anthem.com** > **For Providers** > **Provider Resources** > **Policies, Guidelines & Manuals** > **Select Your State** > **View Medical Policies & Clinical UM Guidelines** > **Other Criteria,** and then select the desired criteria.

Utilization Management

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 decisions, sometimes referred to as utilization review, are based on medical necessity and appropriateness of care and service, and the organization does not specifically reward denials of coverage.

UM DEFINITIONS

- **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 Preservice, Continued Stay, and Retrospective reviews.
- **Business Day:** Monday through Friday, excluding designated company holidays.

- **Continued Stay Review** (continuation of services): 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).
- **Medically Necessary:** Services that a medical practitioner exercising prudent clinical judgment would provide to a covered individual for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms.
- **Discharge Planning:** includes 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.
- **Notification:** The telephonic and/or written/electronic communication to the applicable Providers, Facility and the Member documenting the determination.
- **Precertification/Preauthorization Requirement:** List of services 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.
- **Preservice (Prospective) Review:** Utilization review for Medical Necessity that is conducted on a health care service or supply prior to its delivery to the Member.
- **Post Service (Retrospective) review:** Utilization review that is conducted after the health care service (or supply) has been provided to the Member.
- **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

UM review may be required for Precertification/Preauthorization, Preservice (Prospective) Review, Continued Stay Review, or Post-service (Retrospective) Review. UM may be conducted via multiple communication paths.

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 for the pre-Claim UM review.
- 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.

Inpatient admissions require UM review. UM for inpatient 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; residential treatment facilities; 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 services may require Pre-Service Review.

The list of Precertification/Preauthorization Requirements can be accessed online. Go to **anthem.com** > **For Providers** > **Claims** > **Prior Authorization**, and then select the appropriate link depending on the type of Member.

PRESERVICE REVIEW & CONTINUED STAY REVIEW

A. For Preservice elective inpatient admission and outpatient procedures that require Precertification/Preauthorization 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.

B. For Emergency inpatient admissions, 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 Precertification/Preauthorization 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 Federal, State and accreditation requirements as may be applicable to the review.

MEDICAL POLICIES AND CLINICAL UM GUIDELINES

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/ELECTRONIC MEDICAL RECORD REVIEW (EMR)

If the Facility agrees to provide on-site EMR access for inpatient admission review.

Certain services may be excluded from On-Site or EMR Review.

OBSERVATION BED POLICY

Refer to the "Observation Services Policy" located in the Reimbursement Policies section of **anthem.com**.

RETROSPECTIVE UTILIZATION MANAGEMENT

Medical records and pertinent information regarding the Member's care may be reviewed to make a determination for services that require prior authorization after services have been rendered. For information on medical records submission refer to the "Member Medical Records Submission" located in the Claims Submission section of **anthem.com**.

Penalties may result for failing to preauthorize elective inpatient admissions, outpatient procedures, or providing notification within 48 hours of an emergency admission even if records are reviewed retrospectively.

Members may not be balance billed for penalty amounts. See below for additional information on penalties.

FAILURE TO COMPLY WITH UTILIZATION MANAGEMENT PROGRAM PROCESSES

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 the 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.

UTILIZATION STATISTICS INFORMATION

On occasion, Anthem may request utilization data. 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.

INPATIENT ELECTRONIC DATA EXCHANGE

For additional information go to the Admission, Discharge and Transfer Messaging Data section of this manual which can be found under Legal and Administrative Requirements.

SUBMIT PRIOR AUTHORIZATION REQUESTS DIGITALLY

Using the Availity.com to submit prior authorizations offers a streamlined and efficient experience for Providers requesting inpatient and outpatient medical services for Members covered by

Anthem plans. Providers can also use the Availity Essentials Authorization application to check authorization status, regardless of how the authorization was submitted. For additional information go to the Availity Essentials section of this manual which can be found under Anthem Digital Applications.

Transplant Prior Authorization requests should be submitted via telephone, fax or secured e-mail notification.

REVERSALS

Utilization Management can reverse a pre-authorized treatment, service or procedure on retrospective review if:

i. relevant medical information is materially different from information presented during the pre-authorization review; and

ii. information existed at the time of the pre-authorization review, but was withheld or not made available; and

iii. Anthem was not aware of the existence of the information at the time of pre-authorization review; and

iv. had Anthem been aware of the information, the treatment, service or procedure being requested would not have been authorized.

RECONSIDERATION (PEER-TO-PEER) AND MEDICAL DIRECTOR AVAILABILITY

Anthem offers a Reconsideration (clinical peer-to-peer conversation) when an adverse medical necessity determination has been rendered regarding health care services for Members. A practitioner, or his/her designee may offer additional information and/or further discuss the Member's case 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 third party, employers and vendors are not permitted to do so. To initiate a reconsideration (peer to peer) and speak to an Anthem Medical Director, please refer to the written denial notification, which includes contact information for the applicable Medical Management department.

When an adverse determination is rendered without an opportunity for the ordering physician to discuss the case with a Medical Director, the treating practitioner/ordering health care Providers, or designees have the right to request a Reconsideration. Reconsiderations (peer to peer conversations) are completed within one business day of receipt of the request and are between the enrollee's health care Providers and the clinical peer reviewer (Medical Director) rendering the denial decision. If Anthem upholds its determination that the services are not medically necessary after a reconsideration, Anthem will issue a written notice of that determination.

Anthem will also ensure that an expedited appeal shall be reviewed by a peer reviewer other than the peer reviewer who rendered the adverse determination.

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 documentations 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, Anthem will help the Member meet identified health care needs. This is reached through contact and teamwork 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.

NOTIFICATION OR PRECERTIFICATION REQUIREMENTS

For HMO-Based Products

For hospital services, if Medical Management is not notified within the required time frames, Anthem will deny payment for the days of service prior to the date of notification. The Medical Management Department will conduct a medical review based on medical necessity criteria only from the date that notification of the hospital admission is received, if the Member is still in the hospital, or for outpatient services, the date notification of services is received. If the Member has already been discharged or outpatient services terminated at the time of the notification, Medical Management will not review the services or admission and the Claim will be denied.

Providers are required to pre-certify services for HMO-based products. Failure to obtain precertification for services will result in a denial of payment to the Provider.

For PPO, EPO and Indemnity Products

Except as expressly stated in the Member's health benefit plan on **anthem.com**, the responsibility of precertification for PPO, EPO and Indemnity products is placed on the Member, based on the terms of the Member's health benefit plan. If the Member fails to notify Medical Management for a service requiring precertification, the service will either:

- Be denied if upon retrospective review, the service is determined to be not medically necessary or investigational. In such instances however, pursuant to the participating Provider contract, the Provider or Facility cannot balance bill the covered Member unless a waiver is signed by the covered Member in advance OR

The covered /Member will be subject to a monetary penalty specific to his or her health benefit plan if the covered service is medically necessary. If Anthem subsequently denies a Claim for

lack of medical necessity upon retrospective review and a waiver has not been signed by the covered Member, the Provider or Facility will have the right to appeal.

Anthem encourages Providers and Facilities to pre-certify services where required on behalf of the Member.

PRECERTIFICATION OF EMERGENCY SERVICES

Emergency services are not subject to prior approval, but the Provider must notify the plan of the service according to notification requirements.

Emergency service shall mean those covered services provided in connection with an emergency condition. Emergency condition means a medical or behavioral condition, the onset which is sudden, that manifests itself with symptoms of sufficient severity, including severe pain that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention could result in:

- placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition placing the health of such person or others in serious jeopardy;
- serious impairment to bodily functions;
- serious dysfunction of any bodily organ or part of such person; or
- serious disfigurement of such person.

To the extent the Member is admitted, Anthem requires notification of all inpatient emergency admissions within forty-eight hours of the admission. To comply with this requirement, call Anthem's Medical Management Program at **800-982-8089**. Select the option for precertification on the telephone menu selections. During non-business hours Providers will have an option to leave a voicemail message.

Providers may notify Anthem of an emergency admission by submitting the information through Availity. Doing so will provide a fast and dependable way to notify Anthem of admissions without having to make a telephone call Availity is available 24/7, with the exception of brief periods when the website undergoes system maintenance.

ANTHEM'S TIMEFRAMES FOR UM DECISION MAKING

Pre-Service Non-Urgent	Decision and notification to Member and Provider by phone and in writing within three (3) business days of receipt of all necessary information.
Continued Stay	Decision and notification to Member and Provider by phone and in writing within one (1) business day of receipt of all necessary clinical information or 72 hours, whichever is shorter.
Urgent	Decision and notification to Member and Provider by phone and in writing within one (1) business day of all necessary clinical information or 72 hours whichever is shorter.
Home Care Request Following Inpatient Admission	Decision and notification to Member and Provider by phone and in writing within one (1) business day of receipt of all necessary information. If the day after the request for services falls on a weekend or holiday, within seventy two (72) hours of receipt of necessary information.

Post-Service	Decision and written notification to Member and Provider within thirty (30) calendar days of receipt of all necessary clinical information.

Note: failure of Anthem to make a UM determination within the time periods above is deemed to be an adverse determination subject to appeal.

For more information regarding Anthem's Medical Management Program, visit **anthem.com**.

HOSPITAL ADMISSIONS AND USE OF THE LAST APPROVED DAY (LAD) REPORT

To help better prioritize the management of Facility utilization review resources pursuant to the Facility Agreement, Anthem's UM will fax a Last Approved Day (LAD) Report to participating Facilities on a daily basis. This report is faxed by 7:00 a.m., Monday through Sunday to the hospital's UR office to assist in the identification of Anthem Members who require additional clinical information to approve coverage for the continued hospital stay. This report will not list Members who are managed by third-party utilization vendors. The Facility will need to contact the specific third-party utilization management vendor directly.

The report's format allows easy identification of Member's status in relation to Anthem's Medical Management decisions from the previous day, current day, and the next review date. The report will reflect information received in Anthem's Medical Management System by end of business of the previous day. The column marked "Next Review Date" will identify those Members for whom additional clinical information is required to continue authorization for the hospital stay. This information must be communicated to Anthem's Medical Management Department via fax or phone before 3 p.m. of the day indicated in the next review date column or as soon as reasonably possible. If information needs to be communicated after 5 p.m. by the Facility or Provider, call Medical Management at **800-982-8089**. During non-business hours Facilities and Providers will have an option to leave a voicemail message or reach a nurse on weekend or holiday business hours.

If any of the information contained in the report is perceived to be incorrect, the Facility shall contact Anthem's nurse reviewer staff at the toll-free number indicated in the column specific to that Member on the report.

The Facility staff is expected to amend the LAD report with a "Discharge Date" indicating actual date of discharge so that the Member can be removed from the LAD report and included in the Discharge Summary Report faxed separately. The Facility will fax the marked LAD report to Anthem at **800-464-5731**. The Facility shall use good faith efforts to contact the admitting physician to obtain a discharge order when appropriate and Anthem shall reasonably cooperate with such efforts.

An indication in the LAD report that a case has been "Certified" means that Anthem has determined the services described are medically necessary for that date of service, based on the information provided. An indication of "DRG Notify upon D/C" means that Anthem has determined the services described are medically necessary and that the DRG case rate is appropriate. Coverage for a particular date of service is NOT certified for any Member not included on the LAD report for that date. It is the Facility's responsibility to notify Anthem of any Members not included on the LAD report. If authorization is denied, the denial will be indicated on the LAD report. In addition, Anthem will provide a separate written notice of determination, consistent with applicable legal requirements.

DELAY IN SERVICE DENIALS

If an Anthem covered Member has his or her inpatient hospital stay extended as a result of an unwarranted delay in the provision of hospital services due to the unavailability of any hospital equipment, personnel, Facilities or test results we will not reimburse the Facility or Provider for the additional bed day(s). Some examples of service delays are equipment failure, operating room scheduling backlog, and unavailable test results.

Coverage denials based on the fact that there was, in Anthem's judgment, an unnecessary delay in providing a service do not involve a medical necessity determination. They are, therefore, not subject to appeal under Anthem's Medical Management Reconsideration and Appeals Process. The Member must be held harmless and the Facility or the physician may file a grievance under Anthem's grievance procedure.

MEDICAL NECESSITY DENIALS

A written notice of an initial adverse determination (denial of coverage) will be sent to an Anthem covered Member and Provider and includes:

- The reasons for the determination including the clinical rationale, if any;
- Instructions on how to initiate internal appeals (standard and expedited appeals) and eligibility for external appeals;
- Notice of the availability, upon request of the Member or Member's designee of the clinical review criteria relied upon to make the determination; and
- What, if any additional information must be provided to, or obtained by, Anthem in order to render an appeal decision, if requested.

SPECIALTY CARE CENTER AND PCP SPECIALIST REQUESTS

A referral to a specialty care center and/or a specialist as a PCP may be requested when:

- A Member is diagnosed with a life-threatening condition or disease or degenerative, disabling condition or disease

  AND

  Due to the condition/disease as above, the Member requires specialized medical care over a prolonged period of time.

Anthem's Medical Management nurses will request documentation of the treatment plan, and seek approval of the PCP and specialist before determining if the referral will be approved by Anthem.

Anthem's Medical Management Department will assess a request for a specific specialty care center or specialist PCP, or can provide names of specialty care centers or specialist PCP's appropriate for the enrollee's condition.

If Providers or Facilities need to request a referral to a specialty care center or request a specialist PCP, contact Anthem's Medical Management Department at **800-441-2411**, 8:30 a.m. to 5:00 p.m. ET, Monday through Friday.

PREDETERMINATION OVERVIEW

Anthem has established a predetermination process for services where precertification is not required and Providers and Facilities can confirm in advance of providing the service whether

the service meets medical policy criteria. Services available for predetermination include bariatric surgeries, spinal surgeries and specialty pharmacy drugs. The predetermination enables the Member and physician or other healthcare Provider to verify the service meets Anthem's medical necessity criteria before delivering the care. Although a predetermination is not required, Anthem encourages physicians or other healthcare Providers to obtain one prior to performing any of these procedures.

When a predetermination is not obtained prior to the procedure, the Claim for the service will be reviewed for medical necessity on a retrospective basis. In cases when an adverse determination is issued, the Provider, Facility and the Member may access available appeal levels before delivery of the service. The medical necessity criterion is available online for review at **anthem.com**.

ANTHEM AS SECONDARY PAYOR

If Anthem is the secondary payor, it will not require the Facility, Provider or the Member to obtain precertification from Anthem, and will not deny or reduce amounts that would otherwise be owed because a Facility, Provider or Member did not comply with its administrative or utilization review requirements, including notification, precertification, or concurrent review. However, Anthem will not be bound by the primary Payor's decisions concerning the medical necessity of a service.

Carelon Medical Benefits Management, Inc.

Carelon Medical Benefits Management 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, Carelon Medical Benefits Management promotes optimal care using evidence-based clinical guidelines and real-time decision support for both Providers and their patients. The Carelon Medical Benefits Management platform delivers significant cost-of-care savings across an expanding set of clinical domains, including cancer care quality, cardiology, genetic testing, musculoskeletal care, medical and radiation oncology, radiology, rehabilitation, sleep medicine and surgical.

Visit Carelon Medical Benefits Management's program microsite **here** to find program information, resources, clinical guidelines, interactive tutorials, worksheets and checklists, FAQs, and access to Carelon Medical Benefits Management provider portal.

SUBMIT PRECERTIFICATION/PREAUTHORIZATION REQUESTS TO CARELON MEDICAL BENEFITS MANAGEMENT

Ordering and servicing Providers may submit Precertification/Preauthorization requests to Carelon Medical Benefits Management in one of the following ways:

- Access the provider portal 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.
- Call the Carelon Medical Benefits Management Contact Center toll-free number: **877-430-2288**, Monday through Friday, 8:00 a.m. to 5:00 p.m. ET.

OPTINET® REGISTRATION

The ***Opti****Net* Registration is an important tool that assists ordering Providers in real-time decision support information to enable ordering Providers to choose a high quality, low-cost imaging and genetic counseling Providers for their patients. Servicing Providers need to complete the ***Opti****Net* Registration online.

To access the ***Opti****Net* Registration:

- Access AIM ***Provider****Portal* directly at **providerportal.com.**
- Once logged into Carelon Medical Benefits Management, 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 throughout the registration process. Once the registration has been submitted, a score card 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 Web Support at **800-252-2021**. For any other questions, contact an Anthem Provider Relations Representative.

Quality Improvement Program

QUALITY IMPROVEMENT (QI) PROGRAM OVERVIEW

Anthem has a strong local presence required to understand and meet Member needs and provide access to care according to benefits for covered health services. 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. 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 activities. 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 key healthcare issues.

Guided by our strategy, Anthem is an agile organization that uses digital-first solutions to provide exceptional experiences, affordability, quality and access to our consumers and communities. Our digital strategy supports and is the driving force behind shaping our strategy. Digital is the enabler that allows us to create value, respond to societal shifts and meet market and consumer needs. We have a continued focus on integrating data, analytics, insights and digital technologies into every aspect of the business. As we advance in the digital journey, we will see inherent customer advocacy and collaboration throughout the health ecosystem as a core component of our structure.

- The Quality Improvement Program Description (QIPD) defines the quality infrastructure that supports Anthem's QI strategies. The QIPD establishes QI program governance, scope, goals, objectives, structure, and responsibilities encompassing the quality of medical and behavioral healthcare and services accessible to Members.
- The annual QI Work Plan is a dynamic process with updates throughout the year to reflect ongoing progress made on quality activities. The QI Work Plan includes measurable objectives for the year to determine how well the health plan is performing, including the approach to improving medical and behavioral healthcare: quality of clinical care, safety of clinical care, quality of service and Members' experience.
- The QI Program Evaluation assesses outcomes of Anthem's medical and behavioral health programs, processes and activities toward established goals and objectives.

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 identify, measure, assess and improve clinical and service quality outcomes through standardized and collaborative activities.
- To evaluate performance and take action and respond to the needs of internal/external customers, including compliance with policies, procedures and regulatory and accreditation requirements.
- Build a safer equitable health system and decrease the occurrence of patient safety events through the creation of a safety culture that improves the delivery of healthcare, health outcomes and alignment with national patient safety efforts.
- To identify and promote educational opportunities for Members, medical and behavioral health Providers.
- Advance health equity locally and nationally to improve lives and communities.
- Address the cultural and linguistic needs of eligible Members to promote improved health and healthcare outcomes for diverse Members.
- To help maximize health status, improve health outcomes and reduce healthcare costs of Members through effective Case Management ("CM"), which includes Behavioral Health ("BH") and Disease Management ("DM") programs addressing complex care needs and Population Health Management ("PHM") which includes CM, BH and DM.

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

Quality and Safety of Clinical Care

- **Behavioral Health Case Management:** The program serves Members of all ages who are impacted by a behavioral health condition(s). This program includes complex case management and Behavioral Health Post-Discharge Management. The program assists Members and their families with obtaining appropriate behavioral health treatment, offering community resources to address Member needs and "gaps in care", providing education and telephonic support and promoting provider collaboration. The program

provides care coordination and ongoing case management services for Members based on Member's level of need with focus on risk.

- **Disease Management:** The Condition Care program is designed to help maximize health status, improve health outcomes, and reduce healthcare costs for Members diagnosed with Asthma (pediatric and adult), Diabetes (type 1 and type 2, pediatric and adult), Coronary Artery Disease, Heart Failure and Chronic Obstructive Pulmonary Disease. The DM program was created and developed based on nationally accepted evidence-based clinical practice guidelines. These guidelines are reviewed at least every two years and program interventions and protocols are updated accordingly.
- **Health and Wellness:** MyHealth Advantage is a proactive program that translates a Member's health information into personal guidance to help improve the safety, quality and coordination of a Member's healthcare. This program provides personalized, actionable messaging to Members and their Providers on ways they can improve their health; optimize healthcare spending; avoid critical health issues.
- MyHealth Advantage is a proactive program that translates a Member's health information into personal guidance to help improve the safety, quality and coordination of a Member's healthcare. This program provides personalized, actionable messaging to Members and their Providers on ways they can improve their health; optimize healthcare spending; avoid critical health issues.

Patient Safety for Members

Anthem's mission is improving lives and communities, and the quality framework supports this with the promotion of continuous improvement in patient safety. The patient safety goals are to build a safer, more equitable health system and decrease the occurrence of patient safety events by creating a safety culture that improves the delivery of healthcare, health outcomes and alignment with national patient safety efforts. This will be accomplished through the promotion of safe clinical practices in aspects of clinical care and service; to engage Members and medical and behavioral health Providers concerning patient safety in aspects of patient interaction; and to identify opportunities for system and process improvements that promote patient safety within individual practices and across the healthcare continuum. Areas for monitoring are selected by analyzing patient safety data for Members inherent to quality of medical and behavioral healthcare delivery and service. Areas of focus include Population Health Management programs that target keeping members healthy, managing members with emerging risk, patient safety or outcomes across setting and managing multiple chronic illnesses.

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** > **For Providers** > **Provider Resources** > **Policies, Guidelines and Manuals** > **Member Rights and Responsibilities** > **Read about Member rights** > **What are my rights as a Member** FAQ question. Members or Providers who do not have access to the website can request copies by contacting Anthem or by calling the 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), behavioral health practitioners and medical specialists, as well as other health care professionals who are involved in providing care to Anthem Members. 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 Quality Improvement 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 or Facility 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.

In addition to the above, due to the requirements of the Federal Consolidation Appropriations Act (CAA), effective January 1, 2022, there are federal continuity of care obligations resulting from (i) the termination of Providers or Facilities from Anthem's network and (ii) the termination of a group health plan from Anthem that results in a loss of benefits provided under such group health plan with respect to Provider or Facility.

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

Anthem's Medical Management will approve continued care depending upon the benefit plan if the Member meets the conditions described below and the Provider meets the outlined requirements:

When a Member's PCP or specialist terminates from the plan and the Member is receiving an ongoing course of treatment for a disabling, degenerative or life threatening condition, he or she may continue to receive covered treatment from the terminated Provider for up to 90 days from the date the Member received notice of the termination. After that, the Member must choose a network Provider. This policy also applies to pregnant Members when they receive notice of their

Provider's termination from the plan. The Provider may give covered services, including the delivery and postpartum care directly related to the delivery.

The Provider and Facility Agreement obligates Providers and Facilities to continue to treat patients who are receiving a course of treatment from the Provider or Facility at the time the Provider or Facility participation terminates. Specifically, Providers and Facilities are required to continue treating these patients and to continue accepting the rates applicable under the Provider or Facility Agreement, until the completion of their course of treatment or appropriate transfer to another participating Provider. This obligation applies to all products. In no such event shall a physician abandon any patient for any reason.

In all such cases, Anthem requires that the non-network Provider:

- Meet Anthem's Quality Assurance standards
- Agree to accept as payment in full those payment rates that were in effect when he or she was a participating network Provider
- Agree to provide Anthem with all necessary information related to the care given to the Member
- Agree to adhere to all relevant Anthem policies and procedures, including the rules regarding referrals and precertification of certain services.

QUALITY-IN-SIGHTS®: HOSPITAL INCENTIVE PROGRAM (Q-HIP®)

The Quality-In-Sights®: Hospital Incentive Program (Q-HIP®) is Anthem's 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)
- National Quality Forum (NQF)
- The Joint Commission (JC)
- The Society of Thoracic Surgeons (STS)

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.

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 total cost of care shared savings/risk programs, enhanced fee schedules and episode 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.

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. Data is collected in four ways: Administratively, Hybrid, Survey or via Electronic Clinical Data Systems. Currently, HEDIS includes 96* measures across 6* domains:

- Effectiveness of Care
- Access/Availability of Care
- Experience of Care
- Utilization and Risk Adjusted Utilization
- Health Plan Descriptive Information
- Measures Reported using Electronic Clinical Data Systems

Record requests to Provider offices is a year round process. Anthem requests the records be returned within the specified time frame to allow time to abstract the records and request additional information if needed from other Providers. 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** > **For Providers** > **Provider Resources** > **Forms and Guides,** then scroll down and select **HEDIS** in the Category drop down.

*Subject to change

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

OVERVIEW OF 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 the 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. Provider newsletters can be found online at **anthem.com** > **For Providers** > **Communications** > **News**.

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

MEDICAL RECORD 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, view our **Medical Record Standards** on **anthem.com**.

- Each Member will have a separate medical record
- Each medical record will verify that the PCP coordinates and manages care
- The retention period for medical records shall be retained for a period of six (6) years after the date of service, and in the case of a minor, for three (3) years after majority or six (6) years after the date of service, whichever is later
- For Medicare Advantage Members, the retention period for medical records shall be retained for a period of ten (10) years after the date of service
- Prenatal Care – Physician will need to maintain a centralized medical record for the provision of prenatal care and all other related services

Additional Medical Record requirements are outlined in Quality Management Program.

MANAGED CARE REPORTING

The Healthcare Effectiveness Data and Information Set (HEDIS®) and Quality Assurance Reporting Requirements (QARR) measure performance on important aspects of preventive, acute and chronic healthcare issues. Anthem collects and reports these measures annually.

Why Anthem collects this data:

- Anthem uses HEDIS/QARR results to measure its performance on important aspects of preventive, acute and chronic care.
- The performance measures in HEDIS are related to significant public health issues such as cancer, diabetes, smoking and heart disease.
- In addition to clinical measures, HEDIS also includes a standardized survey of consumers' experiences that evaluates plan performance in areas such as customer service, access to care and Claims processing.
- Anthem annually compares its HEDIS/QARR rates to the regional and national benchmarks to evaluate its performance and identify opportunities for improvement of the quality of care its Members receive and to address the needs of its Members along the health continuum.

How Providers can help?

Physicians play an integral role in promoting the health of Anthem's Members. We realize the data collection process can be time-consuming, but the efforts assist us in assuring that all Anthem Members receive the appropriate preventive health interventions. To assist us in accurately capturing the data:

- Document recommended services in a patient's medical record (i.e., mammogram screenings, cervical cancer screenings, colon cancer screenings, and immunizations). If the Member has declined the recommendation, include this information in the documentation as well. This will Anthem to target interventions more appropriately.
- Document the outcomes of any specialist referrals.
- Encourage Members to provide the name of any specialists that they may have seen without a referral. This will help us ensure continuity and coordination of care and obtain additional information from the specialists.
- Take time to review a medical record when it is requested by Anthem for clinical information and provide Anthem with the requested information.
- Submit Claims in a timely manner.

Anthem's HEDIS/QARR results are available on Anthem's website at **anthem.com**.

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

RECORDS, MAINTENANCE, AVAILABILITY, INSPECTION AND AUDIT

Medical Record Guidelines

Consistent and complete documentation in the medical record is an essential component of quality patient care. Medical records at primary care offices must be reflective of all services performed by the primary care practitioner (PCP), all ancillary and diagnostic tests ordered by a practitioner, and all services for which a Member has been referred to another Provider by a PCP (see coordination of care). The organization's medical record review is based on the best judgment of the reviewer against these medical records standards. Any patterns or trends are also taken into consideration prior to arriving at the final score. In addition, the organization gives practices the opportunity to make sure that all documentation is provided to the organization before a final score is determined.

The following ratings are used to indicate the % of time the standards are documented in the medical record:

- Never = 0% of the time
- Occasionally = 25% of the time
- Generally = 50% of the time
- Frequently = 75% of the time
- Always = 100% of the time
- NA = Non-applicable

To help ensure that medical records are maintained in a manner which is current, detailed, legible and organized for the organization's Members who are treated by a health care practitioner, the following Performance Standards are employed:

Performance Goal	The organization's documentation standards will be met in all medical records.
Access and Availability	Practitioner/practice sites shall maintain organized records in such a manner that permits timely and easy retrieval of patient information for each patient/practitioner encounter or, upon request, by other legitimate users.
Confidentiality	Patient care offices or sites shall meet or exceed state and federal confidentiality requirements, including HIPAA and are expected to have implemented mechanisms that guard against unauthorized or inadvertent disclosure of confidential information. Records must be stored securely with only authorized personnel having access to the medical records. Patient care offices must ensure that the staff receives periodic training in confidentiality of Member information. Medical records should be kept in a secure environment, away from public access, that allows access by authorized personnel only. Patient care offices or sites should be able to provide the organization, upon request, a written Policy and Procedure for the Release of Patient Information that demonstrates confidentiality of all patient information in accordance with applicable state and federal laws and evidence of continued training of office staff on confidentiality.

Documentation Standards

The following standards will be met in the medical records at least 85% of the time:

Patient Identification	• Patient name or ID number (identification number) on all pages • Personal/biographical information (i.e., date of birth, patient address, employer, home/ work telephone number(s) and • Patient's ethnicity is documented on an intake form or with biographical information
Overall Quality of Medical Records	**All medical record entries:** • Are signed or co-signed • Are dated • Are legible • History of current medical conditions are noted and dated

	• Past medical history noted, easily identifiable, and includes serious accidents, operations, and illnesses for Members having at least three (3) visits. • Health maintenance is noted Problem list is updated as necessary • Medication list (includes both current and PRN medication) is updated as necessary BMI, nutrition, exercise, symptoms of depression, tobacco use, alcohol use, substance use, and sexual activity are noted for patients 14 years and older • Physical exams are documented • Clinical findings and evaluation for each visit is documented • Documentation of advance directive discussion in a prominent part of the medical record for adult patients who are Medicare Advantage Members; and documentation on whether or not a patient has executed an advance directive with a copy to be included in the medical record. We encourage Providers to maintain documentation of advance directive discussions and copies of executed advance directives in patients' files for other Members.
Allergies/Adverse Reactions	• Medication allergies and adverse reactions are prominently noted and dated in the record. If no known allergies, NKA or NKDA is noted.
Continuity and Coordination of Care	**Labs/tests:** • Results of all ancillary services and diagnostic tests or studies ordered by a practitioner are reviewed by the PCP. They may be initialed or a note indicating the lab work was reviewed may be present in the progress/office note. • Indication that the patient has been notified of abnormal test or lab results and explicit follow-up plans for all abnormal labs or test results. **Consults:** • Consultant's reports or documentation of discussions with consulting physicians should be in the medical record. • The consultant's reports and/or specialty care Providers summary has been reviewed by the Provider. They may be initialed or a note indicating the summary was reviewed may be present in the progress/office note. • Encounter forms or notes have a notation, when indicated, regarding follow-up care, calls, or visits. The specific time of return is noted in weeks, months, or PRN. • There is a notation of any instructions/education given to patients regarding follow-up visits, care, treatment, or medication schedules, and diagnostic and therapeutic services where Members are referred for services. • Home health nursing reports • Specialty physician reports • Hospital discharge reports • Outpatient/ambulatory surgery reports
Immunization Record	• Childhood, adolescent and adult immunizations per the Organization's Preventive Health Guidelines
Lead Screening	• Lead screening per state requirements and at the physicians discretion based on community or individual risks
Preventive Services	• There is evidence of required age-specific preventive screenings based on approved practice guidelines and State Requirements.

Administrative Follow Up

Review Results	Written results of the medical record review will be provided the day of the audit for on-site reviews. The practitioner/office must meet a performance goal of 85%. A written summary will be sent to all practitioners/offices within fifteen (15) business days of completion of the review for records mailed/faxed to the Plan. Any identified deficiencies will be noted in the letter in order for the office to implement improvement plans.
Medical Record Improvement Plan	For those offices that score 66%-84%, education will be provided on areas that require improvement in documentation. The Plan can make available medical record keeping tools and provide counseling on medical record standards or prevention monitoring. A medical record review will be conducted within six (6) to twelve (12) months.
Follow-up to Medical Record Quality Improvement Plan	Those practice sites that score 65% or below will be required to submit a Quality Improvement Plan (QIP) detailing how they will address the identified deficiencies. The QIP will be reviewed by the Plan, and a medical record review will be conducted again within six (6) to twelve (12) months. Those practices that, upon re-review, fail to take appropriate actions to improve their medical record keeping practices will be referred to the organization's Medical Director. For additional information on the Medical Record Standards, refer to Quality Management.

Medical Record Review

Compliance with these standards is assessed through medical record audits. These audits are conducted annually by nurses from Anthem's Quality Department and individual scores are communicated to the physician. Anthem has set a minimum compliance threshold of 85 percent for these standards. All physicians are expected to achieve or surpass this threshold score. Any physician scoring below this threshold will be reviewed again within a year. If the physician scores below this threshold on two consecutive reviews he/she will be referred to Anthem's Credentialing Committee for evaluation. Possible actions by the Credentialing Committee may include educational efforts, focused reviews, and in some cases, termination from Anthem's physician network.

- The review of medical records may also be done for one or more of the following, when applicable: Follow-up on prior review findings or corrective action plan
- HEDIS/QARR quality improvement studies
- Investigation of quality of care complaints
- Sentinel Event review

All physicians are required to participate in Anthem's Quality and Medical Management Programs to meet New York State Department of Health, federal and regulatory requirements. Physicians are obligated by contract to allow inspection, auditing, and duplication of medical records during quality improvement, medical management, and peer or grievance reviews. Anthem, or a designated representative, will request submission of medical records in connection with such

reviews. PCPs are also required to assist in the orderly transfer of medical records when a patient changes his or her primary care physician.

For question regarding the medical record documentation standards or the quality improvement process in general, contact Anthem Physician Services at **800-552-6630**, 8:30 a.m. to 5:00 p.m. EST, Monday to Friday.

PATIENT CENTER PRIMARY CARE PROGRAM (PCPC)

Today, the fundamental issue in health care is how to improve quality while reducing costs. Much of health care delivery is fragmented and episodic with no clear way to improve patient health. We believe the doctor-patient relationship is the most important in health care. It is key to improving quality and outcomes and, subsequently, lowering costs. Therefore, Anthem is making a significant investment in primary care to help doctors do what they do best: manage all aspects of their patients' care.

Anthem's new Patient Centered Primary Care Program will increase revenue opportunities for primary care physicians, enhance information sharing, and provide care management support from Anthem clinical staff.

For more information on PCPC, contact a Network Management Consultant or visit **anthem.com**.

Culturally & Linguistically Appropriate Services

Patient panels are increasingly diverse and needs are becoming more complex. It is important for Providers and Facilities to have the knowledge, resources, and tools to offer culturally competent and linguistically appropriate care. Anthem wants to help work together to achieve health equity.

The U.S. Department of Health and Human Services (HHS) defines cultural competence as the ability to honor and respect the beliefs, languages, interpersonal styles, and behaviors of individuals and families receiving services, as well as staff Members who are providing such services. It is a dynamic, ongoing developmental process requiring long-term commitment. The Agency for Healthcare Research and Quality (AHRQ) Patient Safety Network explains that healthcare is defined through a cultural lens for both patients and Providers. A person's cultural affiliations can influence:

- Where and how care is accessed; how symptoms are described,
- Expectations of care and treatment options, and
- Adherence to care recommendations.

Providers and Facilities also bring their own cultural orientations, including the culture of medicine. Offering culturally and linguistically appropriate care incorporates a variety of skills and knowledge, including, but not limited to, the ability to:

- Recognize the cultural factors (norms, values, communication patterns and world views) that shape personal and professional behavior.

- Develop understanding of others' needs, values and preferred means of having those needs met.
- Formulate culturally competent treatment plans.
- Understand how and when to use language support services, including formally trained interpreters and auxiliary aids and services, to support effective communication.
- Avoid use of family Members, especially minors, to act as interpreters for limited English proficient patients.
- Understand and adhere to regulations to support the needs of diverse patients, such as the Americans with Disabilities Act (ADA).
- Use culturally appropriate community resources as needed to support patient needs and care.

Anthem ensures Providers and Facilities have access to resources to help support delivery of culturally and linguistically appropriate services. Anthem encourages Providers and Facilities to access and utilize **MyDiversePatients.com**.

The My Diverse Patients website offers resources, information, and techniques, to help Providers and Facilities provide the individualized care every Member deserves, regardless of their diverse backgrounds. The site also includes learning experiences on topics related to cultural competency and disparities that offer free Continuing Medical Education (CME) credit. Current CME offerings include:

- **Caring for Children with ADHD:** Promotes understanding of and adherence to diagnosis and treatment guidelines; use of AAP's Resource Toolkit for Clinicians; awareness of and strategies for addressing disparities.
- **My Inclusive Practice – Improving Care for LGBTQIA+ Patients:** Helps Providers understand the fears and anxieties LGBTQIA+ patients often feel about seeking medical care, learn key health concerns of LGBTQIA+ patients, & develop strategies for providing effective health care to LGBTQIA+ patients.
- **Improving the Patient Experience:** Helps Providers identify opportunities and strategies to improve patient experience during a health care encounter.
- **Medication Adherence:** Helps Providers identify contributing factors to medication adherence disparities for diverse populations & learn techniques to improve patient-centered communication to support needs of diverse patients.
- **Moving Toward Equity in Asthma Care:** Helps Providers understand issues often faced by diverse patients with asthma & develop strategies for communicating to enhance patient understanding.
- **Reducing Health Care Stereotype Threat (HCST):** Helps Providers understand HCST and the implications for diverse patients as well as the benefits of reducing HCST to both Providers' patients and practices, and how to do so.

Anthem appreciates the shared commitment by Provides and Facilities to ensure Members receive culturally and linguistically appropriate services to support effective care and improved health outcomes.

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 care, spine surgery, knee/hip replacement surgery fertility care, cellular immunotherapy – CAR-T, gene therapy (for ocular disorders), and substance use treatment and recovery. As much of the demand for CME programs has come from National Accounts, most of Anthem's 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. Using objective information and input from the medical community, the BCBSA has designated ambulatory surgery centers (ASCs) hospitals, physicians, and/or clinics as Blue Distinction Centers (BDC) that are proven to outperform their peers in the areas of– quality, safety and, in the case of Blue Distinction Centers+ ("BDC+"), cost efficiency.

For transplants, cellular immunotherapy CAR-T and ventricular assist devices ("VAD"), Members also have access to the Anthem Centers of Medical Excellence Transplant, Cellular Immunotherapy 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: adult and pediatric autologous/allogeneic bone marrow/stem cell, adult and pediatric heart, adult and pediatric lung, adult combination heart/lung, adult and pediatric liver, adult and pediatric kidney, adult simultaneous kidney/pancreas and adult 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.
- Nearly 105,000 people in the United States were waiting for a lifesaving organ transplant from one of the nation's more than 250 transplant centers in the United States as of December, 2022.
- There were nearly 41,000 organ transplants in 2021. In 2022, The U.S reached 1 million transplants.
- 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 programs. When BDCT and Anthem CME are combined, Members have access to over 800 transplant specific programs for adult and pediatric heart, lung, liver, kidney, and bone marrow/stem cell transplant, and adult combined heart/lung, combined liver/kidney, pancreas, and combined kidney/pancreas 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 30.3 million, and the percent of adults with diagnosed heart disease is 12.1%. 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+ (BDC+)are also 21 percent more cost-efficient than non-BDC+ 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 and cardiac valve surgery).

BARIATRIC SURGERY

- Blue Distinction Centers for Bariatric Surgery® launched in 2008.
- According to the National Center for Health Statistics report released in October 2017: Prevalence of Obesity among Adults and Youth has grown to more than one-third (42.4%) of U.S. adults which have been diagnosed with obesity, and 40% 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 2020 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 for Providers to work with Members, to guide them toward the most appropriate recommendation for their 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, cervical and lumbar fusion, cervical laminectomy, lumbar laminectomy/discectomy and decompression procedures.
- To date, Anthem has 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.
- In 2019, Blue Distinction Specialty Care Program for Knee and Hip Replacement expanded to include alternate sites of care, such as ambulatory surgery centers (ASCs) and hospitals without an onsite ICU.
- 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 and revision 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, and safety 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), Cesarean Section (PC-02) and

selected patient experience measures at the Facility level from Hospital Consumer Assessment of Healthcare Providers and Systems ("HCAHPS"). As well as additional measures to support safe practices in childbirth.

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.

This includes medication-assisted treatment (MAT) and other evidence-based therapies across care settings. Care settings include residential and inpatient care, intensive outpatient (IOP), and partial hospitalization (PH) treatment. At minimum, all providers must offer treatment for opioid use disorder.

VENTRICULAR ASSIST DEVICES

- Anthem's Centers of Medical Excellence Ventricular Assist Device (VAD) launched in 2017. VADs are implantable pumps that assist the heart by pumping blood in the circulatory system of individuals with end-stage heart failure.
- According to the Centers for Disease Control and Prevention Heart failure reports that about 6.2 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.

CELLULAR IMMUNOTHERAPY (CHIMERIC ANTIGEN RECEPTOR THERAPY – "CAR-T")

- The U.S. Food & Drug Administration (FDA) continues to approve new cellular immunotherapy products called Chimeric Antigen Receptor T-cell (CAR-T), which are genetically modified autologous T cell immunotherapies that provides new treatment options for cancer patients. This treatment involves genetic re-engineering of a patient's white blood cells.
- There are six (6) Chimeric Antigen Receptor T-cell therapies (CAR-T) products, listed below, approved by the FDA. This list continues to grow as new products are approved.

    1. Yescarta® (axicabtagene ciloleucel) for treatment in Adult Patients
    2. Kymriah® (tisangenlecleucel) for treatment in Pediatric and Adult Patients
    3. Tecartus ™ (brexucabtagene autoleucel) for treatment in Adult Patients

4. Abecma® (idecabtagene vicleucel) for treatment in Adult Patients
5. Breyanzi® (idecabtagene maraleucel) for treatment in Adult Patients
6. Carvykti® (ciltacabtagene autoleucel) for treatment in 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.
- Anthem has a Centers of Medical Excellence Network that continues to expand. These programs are reviewed by the Bone Marrow National Transplant Quality Review Committee. Currently there are eight contracted CAR-T CME Providers. Until a Provider or Facility is contracted, each referral will require a Letter of Agreement.

  The Blue Cross Blue Shield Association has a designation, but not a contract requirement for CAR-T Providers in 2020. Providers must be certified by a product manufacturer certification program to deliver CAR-T therapy.

Audit and Review

AUDIT AND PREPAYMENT REVIEW POLICY

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, unless otherwise defined below for this section. This section does not apply to audits or reviews performed by the Special Investigations Unit, ("SIU"). For information on SIU processes, refer to the Fraud Waste and Abuse section located in this Manual.

There may be times when Anthem conducts Claim reviews or audits to confirm that charges for covered healthcare services are accurately reported and reimbursed in compliance with the Provider or Facility Agreement and 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 or third-party independent reviewer 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.

Definitions

The following definitions shall apply to this Audit and Review 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 a written request with supporting documentation to Anthem from a Provider or Facility to reconsider a payment determination.
- 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 post payment evaluation 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 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. In accordance with applicable laws, regulations and unless an Agreement expressly states otherwise, a Recoupment may be performed against a separate Anthem payment unrelated to the service or subject made to the Provider or Facility.
- Review means the Claim and supporting documentation will be evaluated prior to payment.
- Supporting Documentation means the written material contained in a Member's medical records or other Provider or Facility documentation. Claim details, prior authorization clinical information, and supply invoices supporting the Provider's or Facility's Claim.

Documents Reviewed During an Audit or Review:

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 and Review processes. 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 Auditors/Reviewers will verify that Provider or Facility's Claim is corroborated by Supporting Documentation reflecting the Health Services delivered and billed by the Provider or Facility. The Provider or Facility must review, approve and document all such policies and procedures by any applicable accreditation bodies.

B. Confirm charges were accurately reported on the Claim in compliance with Anthem's Policies as well as general industry standard guidelines and regulations.

   Auditors/Reviewers may review Supporting Documentation including 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. Auditors/Reviewers may review the Claim Itemized Billing for a breakdown of the services billed and supply invoices for pricing determinations.

Auditors/Reviewers may reference the Anthem Reimbursement Policies available on anthem.com.

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 pre-payment review or post payment audit. A request may be made via a paper or an electronic format.

- A Provider's or Facility's physical or electronic address may be confirmed prior to an original letter of request for supporting documentation is sent.
- When a response is not received within 30 days of the date of the initial request, a second request letter will be sent.
- When a response is not received within 15 days of date of the second request, a final request letter will be sent.
- When a response is not received within 15 days of the date of the final request (60 days total):
    - Anthem or its designee will initiate Claim denial for Claims identified as pre-payment review or post payment audit as Provider or Facility failed to submit the required documentation. The Member shall be held harmless for such payment denials.

  or

    - 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

- **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.
- **Desk or Off-site Audits:** Anthem or its designee may conduct Audits from its offices and/or offsite locations. Facility or Provider will comply with timeline and specific requested documentation listed in Anthem's request for additional documentation.
- **Completion of Desk or Off-site Audit:** Upon completion of the Audit where an overpayment is identified, Anthem will generate a Notice of Overpayment. The Notice of Overpayment will identify the Claim overpayment and include an explanation remark for the overpayment. If the Provider or Facility agrees with the Notice of Overpayment, then the Provider or Facility has thirty (30) calendar days to reimburse Anthem the amount indicated in the form of a refund.

Should the Provider or Facility disagree with the Notice of Overpayment, then the Provider or Facility may Appeal the Notice of Overpayment. If the Provider or Facility does not submit an Appeal against the Notice of Overpayment and does not reimburse Anthem within the thirty (30) calendar days, then Anthem will initiate recoupment as applicable and determined per Provider or Facility Agreement and state guidelines.

- **Provider or Facility Appeals:** See Audit Appeal Policy.
- **On-site Audits:** Anthem or its designee may, but is not required to, 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 workspace 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.
- **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.
- **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.

- **Scheduling of Audit (Hospital Bill Audits Only):** After review of the documents submitted, if Anthem or its designee determines an Audit 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.
- **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.
- **Under-billed and Late-billed Claims**: During an 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.

AUDIT APPEAL POLICY

Purpose

To establish a timeline for responding to Provider or Facility Appeals of Audits. This section does not apply to appeals or reconsideration of Claims denied on pre-payment review. If Provider or Facility does not agree with the Claim determination for Claims denied on a pre-payment review basis, follow the directions in the Claims Payment Dispute section of this Provider Manual.

Procedure

- 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 applicable law 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. If the Provider or Facility does not appeal timely, retraction will begin at the expiration of the thirty (30) calendar days unless expressly prohibited by contractual obligations or applicable law.
- 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.

- 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.
- 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.
- 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

Anthem is committed to protecting the integrity of Anthem's health care programs and the effectiveness of operations by preventing, detecting and investigating fraud, waste and abuse (FWA). Combating FWA begins with knowledge and awareness.

- **Fraud**: Any type of intentional deception or misrepresentation made with the knowledge that the deception could result in some unauthorized benefit to the person committing it – or any other person.
- **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 good medical practices resulting in excessive costs, incorrect payment, misuse of codes, or services that are not medically necessary.

One of the most important steps to help prevent Member fraud is as simple as confirming the individual's name on their photo ID is the same as the name on the Member identification card. This ensures that the individual seeking services is the same as the Member listed on the card. It is the first line of defense against possible fraud. Learn more at **fighthealthcarefraud.com**.

REPORTING FRAUD, WASTE AND ABUSE

If someone suspects a Member or Provider/Facility has committed fraud, waste or abuse, they have the right to report it. No individual who reports violations or suspected fraud and abuse will

be retaliated against for doing so. The name of the person reporting the incident and any other information will be kept in strict confidence by investigators.

Report concerns by:

- Visiting **anthem.com** > **Healthcare Fraud Prevention** to be directed to the **fighthealthcarefraud** education site; at the top of the page click **Report it** and complete the ***Report Waste, Fraud and Abuse*** form.
- Calling Provider Solutions.

Any incident of fraud, waste or abuse may be reported to Anthem anonymously; however, Anthem's ability to investigate an anonymously reported matter may be limited if Anthem doesn't have enough information. Anthem encourages Providers and Facilities to give as much information as possible. Anthem appreciates referrals for suspected fraud, but be advised that Anthem does not routinely update individuals who make referrals as it may potentially compromise an investigation.

Examples of Member Fraud, Waste and Abuse

- Forging, altering or selling prescriptions
- Letting someone else use the Member's ID (Identification) card
- Using someone else's ID card

When reporting concerns involving a Member include:

- The Member's name
- The Member's date of birth, Member ID or case number if available
- The city where the Member resides
- Specific details describing the fraud, waste or abuse

Examples of Provider/Facility Fraud, Waste and Abuse (FWA):

- Altering medical records to misrepresent actual services provided
- Billing for services not provided
- Billing for medically unnecessary tests or procedures
- Billing professional services performed by untrained or unqualified personnel
- Misrepresentation of diagnosis or services
- Soliciting, offering or receiving kickbacks or bribes
- Unbundling – when multiple procedure codes are billed individually for a group of procedures which should be covered by a single comprehensive procedure code
- Upcoding – when a Provider bills a health insurance payer using a procedure code for a more expensive service than was actually performed

When reporting concerns involving a Provider (a doctor, dentist, counselor, medical supply company, etc.) include:

- Name, address and phone number of Provider
- Name and address of the Facility (hospital, nursing home, home health agency, etc.)
- Medicaid number of the Provider and Facility, if applicable
- Type of Provider (doctor, dentist, therapist, pharmacist, etc.)
- Names and phone numbers of other witnesses who can help in the investigation
- Dates of events
- Summary of what happened

To learn more about health care fraud and how to aid in the prevention on it, visit **fighthealthcarefraud.com**.

INVESTIGATION PROCESS

The Special Investigations Unit ("SIU") investigates suspected incidents of FWA for all types of services. Anthem may take corrective action with a Provider or Facility, which may include, but is not limited to:

- *Written warning and/or education*: We send certified letters to the Provider or Facility documenting the issues and the need for improvement. Letters may include education or requests for recoveries, or may advise of further action.
- *Medical record review*: We review medical records to substantiate allegations or validate Claims submissions.
- *Prepayment Review*: A certified professional coder evaluates Claims prior to payment of designated claims. This type of edit prevents automatic Claim payment 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 of future Claims and/or future legal action.

If working with the SIU, all communication (checks, correspondence) should be sent to:

Anthem Blue Cross and Blue Shield
Special Investigations Unit
740 W Peachtree Street NW
Atlanta, Georgia 30308
Attn: investigator name, #case number

Paper medical records and Claims are a different address, which is supplied in correspondence from the SIU. For questions, contact the investigator. An opportunity to submit Claims and medical records electronically is an option if registering for an Availity Essentials account. Contact Availity Essentials Client Services at **800-AVAILITY** (**282-4548**) for more information.

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. The Provider or Facility may have an opportunity to explain their coding, documentation, and/or billing practices. If the review results in a determination that the Provider's or Facility's actions exhibit indicators of possible FWA, unless exigent circumstances exist, the Provider or Facility is notified of their placement on prepayment review and given an opportunity to respond.

When a Provider or Facility is on prepayment review, the Provider or Facility will be required to submit medical records and any other supporting documentation with each Claim containing the code(s) at issue 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. Failure to furnish 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 their prepayment review status.

Under the prepayment review program, Anthem may review coding, documentation, and other billing issues. In addition, Anthem 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 the network.

Providers and Facilities are prohibited from billing a Member for services Anthem has determined are not payable as a result of the prepayment review process, whether due to possible 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, Anthem 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 Claims 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 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 the 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 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 Anthem prescription drug coverage.

The Pharmacy Home Program helps reduce potential overutilization of controlled substance medications. If a Member is believed to be at an increased safety risk due to the overutilization of multiple controlled substances, from multiple Providers and/or pharmacies, and they meet 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 of the Member's 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 all prescribed Schedule II-V controlled medications for a period of no less than 12 consecutive months. This assigned pharmacy, or Pharmacy Home, will fill the Member's controlled substance medications throughout the term of their enrollment in this program.

The Pharmacy Home Program includes:

- Reimbursement of controlled substance Claims when filled at the Member's Pharmacy Home. All controlled substance Claims are denied if filled at any pharmacy other than the Member's assigned Pharmacy Home[1].
- Temporary overrides for urgent prescriptions.
- Access to Mail Order and Specialty pharmacies, in addition to the Pharmacy Home.

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 (5) 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.

Note:

- A Member may change the designated pharmacy only if the request meets good cause criteria.
- Exemption of Members with a diagnosis of Cancer, 2nd degree burns, 3rd degree burns, Sickle-cell Anemia or those that are in Hospice Care. (Note: Exemptions are determined by both pharmacy claim history and medical diagnosis.)

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 on 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 lives. For questions or comments regarding enrollment, contact the Member Services number located on the back of the Member's ID card.

Health Insurance Marketplace (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.

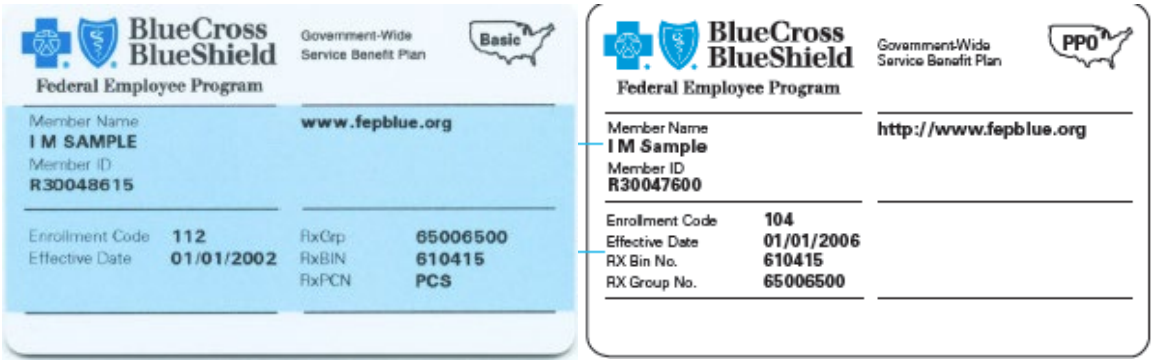
Anthem offers qualified health plans on the Individual or Small Business Health Options Program (SHOP) Exchange in many states, as well as health plans not purchased on public exchanges. Qualified health plans on the Individual and SHOP Exchange follow the same policies and protocols within this Provider 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 access the newsletter, go **anthem.com** > **For Providers** > **Communications** > **News**. The option to sign up for provider communications updates is also on this webpage.

Important reminder:

Providers and Facilities are able to confirm their participation status in different networks by using the Find Care tool. See the **Online Provider Directory and Demographic Data Integrity** section for more details.

Federal Employee Health Benefits 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/or 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, and/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 FEHBP

All Claims under the FEHBP must be submitted to the 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 (6) 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 thirty (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 sixty (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 one hundred eighty (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.

- not medically necessary (NMN);
- experimental/investigational (E/I);
- denial of benefits, in total or in part, based on clinical rationale (NMN or E/I);
- precertification of hospital admissions; and,
- 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 (6) 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 thirty (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 sixty (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 thirty (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 seventy two (72) of the Member's admission. Members admitting on a ventilator must be seen by a pulmonologist within twelve 12 hours of admission at least weekly thereafter, and respiratory therapy be available in the Facility twenty four 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 24 hours of admission. Members admitted primarily for rehabilitation must receive at least one (1) hour of physical therapy and occupational therapy combined at least five (5) days per week (logs must be provided to the Plan to document therapy time).

ONLINE INFORMATION FOR FEHBP

Refer to the benefits and services on the FEHBP website **fepblue.org** for additional information.

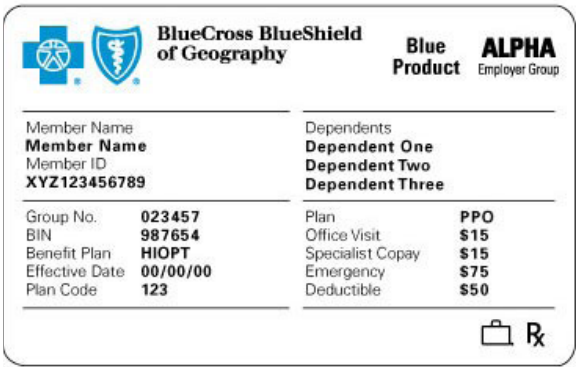
BlueCard Program Overview

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

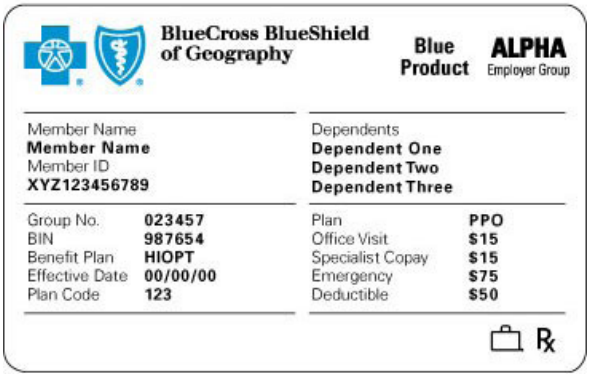
country and in more than 200 countries and territories worldwide through a single electronic network for Claims processing and reimbursement. The program allows Providers and Facilities to submit Claims for Members from other Blue Plans, domestic and international, to Anthem. Anthem is the sole contact for Claims payment, adjustments and issue resolution.

For more information about the BlueCard Program, Providers and Facilities can access the BlueCard Provider Manual, online at **anthem.com** > **For Providers** > **Provider Resources** > **Policies, Guidelines & Manuals** > **Provider Manual**. Click **Provider Manual Library** to find the BlueCard Provider Manual.

BlueCard ID card Sample:



BlueCard (Out of Area) Members:



Medicare Advantage Provider Website

Refer to the Medicare Advantage website for additional information at **www.anthem.com/medicareprovider.**

Select **For Provider** then choose **Policies, Guidelines and Manuals** under the horizontal menu, scroll to the **Provider Manual** section and select **Download the Manual**. Scroll to the Provider Manual Library section and choose **Medicare Advantage Provider Manual**.

- **Medicare Advantage Provider Guidebook**

Appendix A

AMERICANS WITH DISABILITIES ACT

The Americans with Disabilities Act is a comprehensive civil rights law that prohibits discrimination on the basis of disability and includes a requirement that all Facilities and services be accessible to individuals with disabilities. All Providers are required to comply with the Americans with Disabilities Act in order to participate in Anthem's Provider networks.

PATIENT'S SELF-DETERMINATION ACT

Members have the RIGHT to:

- Make medical decisions.
- Accept or refuse treatment, including the right to refuse life-sustaining medical and surgical treatment.
- Make advance directives about their medical care in the event they cannot make decisions.

Members can learn more about their rights and responsibilities, and their rights under the Patient's Self-Determination Act by calling Member Services at the telephone number located on the back of their Member identification card.

ASSISTANCE FOR NON-ENGLISH SPEAKING MEMBERS

Anthem strives to ensure that HMO Members who speak a language other than English are able to obtain assistance from the Member Services department. Anthem does this by providing translation services to Members via an AT&T Language Line translator.

CONFIDENTIALITY POLICY

When a Member Services representative receives a call from someone who speaks a language other than English, the representative puts the caller on hold and calls the AT&T Language Line. The AT&T Language Line operator links the Member Services Representative and the caller to an interpreter in the appropriate language. Through a three-way connection, the interpreter facilitates the Member's inquiry.

In recognition of the need for Member privacy, and in compliance with federal and state laws and regulations, Anthem has a policy on the confidentiality of Member medical information.

- Anthem has in place and enforces appropriate safeguards to protect the confidentiality, security and integrity of Member medical information, which is used, disclosed, exchanged or transmitted orally, in writing or electronically.
- Confidential Member medical information is accessible only to those Anthem employees and authorized third persons who need it to perform their jobs. All persons are required to comply with Anthem policies and procedures and federal and state laws and regulations concerning the request for, the use, disclosure, transmission, security, storage and destruction of confidential Member medical information.

- Anthem does not disclose Member nonpublic personal information, including Member medical information, to any of Anthem affiliates or to nonaffiliated third parties, except as permitted by law to allow Anthem to conduct business.
- Disclosure of confidential information to external vendors for purposes of payment or healthcare operations is made only in accordance with appropriate confidentiality agreements and contractual arrangements. Data shared with external entities for measurement purposes or research is released only in accordance with appropriate confidentiality agreements and contractual arrangements or in an aggregate form that does not allow for direct or indirect Member identification.
- Member medical information is not shared with the Member's employer, unless permitted or required by law. Because Anthem is not a Provider of medical services, it generally does not maintain medical records created by the Member's Provider of service. If a Member requires access to his or her Provider's medical records, the Member should contact his or her Provider to arrange access.
- Anthem contractually requires all of its network practitioners and Providers to comply with all state and federal laws regarding confidentiality of Member records to ensure the privacy and to protect the confidentiality of Members' medical information.
- When a Member becomes covered under an Anthem health benefit plan, the Member agrees that Anthem, or its designee, may use and/or disclose the Member's confidential medical information for purposes of payment and healthcare operations as permitted or required by law or regulation. In addition, each Anthem Member agrees that any healthcare Provider, healthcare pay or government agency shall furnish to Anthem or its designee all records pertaining to medical history, services rendered and payments made for use and/or disclosure by Anthem to administer the terms of the health benefit plan.
- A Member may request access to information that is maintained by or for Anthem by calling Customer Service to arrange access. A Member may request an amendment of records maintained by and for Anthem, or a Member may request an accounting of disclosures as permitted by law. Members can call Customer Service for more information.
- Generally, under state and federal law (e.g., the Health Insurance Portability and Accountability Act (HIPAA) Privacy Regulations), the use and disclosure of Member medical information for purposes of treatment, payment and healthcare operations that occur between a Provider and a health plan, clearinghouse, another Provider, or other insurance carrier is permitted without the necessity of seeking an authorization from the Member For example, under HIPAA, determinations of medical necessity, appropriate-ness of care, justification of charges and utilization review activities are included within the definition of payment; and conducting quality assessment and improvement activities, reviewing the qualifications of healthcare Providers and conducting fraud and abuse detection and compliance programs are included within the definition of healthcare operations.
- Except as stated above and as may be permitted or required by law, Anthem does not release confidential Member medical information to anyone outside Anthem without a specific "written authorization" to release authorized by the Member or Member's designee, which may be revoked at any time. The authorization must be signed and dated and must specify:
    - The information that can be disclosed and to whom
    - What the information will be used for

- The time period for which the authorization applies

NOTICE OF PRIVACY PRACTICES (AS DIRECTED TOWARDS MEMBERS)

Anthem respects the privacy and confidentiality of Member's medical information. Below is Anthem's Notice of Privacy Practices, which summarizes Anthem's Privacy Policy regarding Members. It is directed to, and was distributed to, Members in order to inform them of how information about them may be used and disclosed by Anthem. This includes, but is not limited to, uses and disclosures for treatment, payment activities and healthcare operations. Anthem encourages Providers, Facilities and anyone in the practice that handles Anthem Members' health information to read the notice in order to become familiar with the privacy practices.

NOTICE OF PRIVACY PRACTICES Important information about your rights and our responsibilities

Protecting your personal health information is important. Each year, we're required to send you specific information about your rights and some of our duties to help keep your information safe. This notice combines three of these required yearly communications:

- State notice of privacy practices
- Health Insurance Portability and Accountability Act (HIPAA) notice of privacy practices
- Breast reconstruction surgery benefits

Would you like to go paperless and read this online or on your mobile app? Go to ***anthem.com*** and sign up to get these notices by email.

State notice of privacy practices

When it comes to handling your health information, we follow relevant state laws, which are sometimes stricter than the federal HIPAA privacy law. This notice:

- Explains your rights and our duties under state law.
- Applies to health, dental, vision and life insurance benefits you may have.

Your state may give you additional rights to limit sharing your health information. Please call the Member Services phone number on your ID card for more details.

Your personal information

Your nonpublic (private) personal information (PI) identifies you and it's often gathered in an insurance matter. You have the right to see and correct your PI. We may collect, use and share your PI as described in this notice. Our goal is to protect your PI because your information can be used to make judgments about your health, finances, character, habits, hobbies, reputation, career and credit.

We may receive your PI from others, such as doctors, hospitals or other insurance companies. We may also share your PI with others outside our company — without your approval, in some cases. But we take reasonable measures to protect your information. If an activity requires us to give you a chance to opt out, we'll let you know and we'll let you know how to tell us you don't want your PI used or shared for an activity you can opt out of.

THIS NOTICE DESCRIBES HOW MEDICAL, VISION AND DENTAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION WITH REGARD TO YOUR HEALTH BENEFITS. PLEASE READ CAREFULLY.

HIPAA notice of privacy practices

We keep the health and financial information of our current and former Members private as required by law, accreditation standards and our own internal rules. We're also required by federal law to give you this notice to explain your rights and our legal duties and privacy practices.

Your protected health information

There are times we may collect, use and share your Protected Health Information (PHI) as allowed or required by law, including the HIPAA Privacy rule. Here are some of those times:

Payment: We collect, use and share PHI to take care of your account and benefits, or to pay Claims for health care you get through your plan.

Health care operations: We collect, use and share PHI for your health care operations.

Treatment activities: We don't provide treatment, but we collect, use and share information about your treatment to offer services that may help you, including sharing information with others providing you treatment.

Examples of ways we use your information:

- We keep information on file about your premium and deductible payments.
- We may give information to a doctor's office to confirm your benefits.
- We may share explanation of benefits (EOB) with the subscriber of your plan for payment purposes.
- We may share PHI with your doctor or hospital so that they may treat you.
- We may use PHI to review the quality of care and services you get.
- We may use PHI to help you with services for conditions like asthma, diabetes or traumatic injury.
- We may collect and use publicly and/or commercially available data about you to support you and help you get health plan benefits and services.
- We may use your PHI to create, use or share de-identified data as allowed by HIPAA.
- We may also use and share PHI directly or indirectly with health information exchanges for payment, health care operations and treatment. If you don't want your PHI to be shared in these situations, visit anthem.com/privacy for more information.

Sharing your PHI with you: We must give you access to your own PHI. We may also contact you about treatment options or other health-related benefits and services. When you or your dependents reach a certain age, we may tell you about other plans or programs for which you may be eligible, including individual coverage. We may also send you reminders about routine medical checkups and tests. You may get emails that have limited PHI, such as welcome materials. We'll ask your permission before we contact you.

Sharing your PHI with others: In most cases, if we use or share your PHI outside of treatment, payment, operations or research activities, we have to get your okay in writing first. We must also get your written permission before:

- Using your PHI for certain marketing activities.
- Selling your PHI.
- Sharing any psychotherapy notes from your doctor or therapist.

We may also need your written permission for other situations not mentioned above. You always have the right to cancel any written permission you have given at any time.

You have the right and choice to tell us to:

- Share information with your family, close friends or others involved with your current treatment or payment for your care.
- Share information in an emergency or disaster relief situation.

If you can't tell us your preference, for example in an emergency or if you're unconscious, we may share your PHI if we believe it's in your best interest. We may also share your information when needed to lessen a serious and likely threat to your health or safety.

Other reasons we may use or share your information:

We are allowed, and in some cases required, to share your information in other ways — usually

for the good of the public, such as public health and research. We can share your information for these specific purposes:

- Helping with public health and safety issues, such as:
  - Preventing disease
  - Helping with product recalls
  - Reporting adverse reactions to medicines
  - Reporting suspected abuse neglect, or domestic violence
  - Preventing or reducing a serious threat to anyone's health or safety
- Doing health research.
- Obeying the law, if it requires sharing your information.
- Responding to organ donation groups for research and certain reasons.
- Addressing workers' compensation, law enforcement and other government requests, and to alert proper authorities if we believe you may be a victim of abuse or other crimes.
- Responding to lawsuits and legal actions.

If you're enrolled with us through an employer, we may share your PHI with your group health plan. If the employer pays your premium or part of it, but doesn't pay your health insurance Claims, your employer can only have your PHI for permitted reasons and is required by law to protect it.

Authorization: We'll get your written permission before we use or share your PHI for any purpose not stated in this notice. You may cancel your permission at any time, in writing. We will then stop using your PHI for that purpose. But if we've already used or shared your PHI with your permission, we cannot undo any actions we took before you told us to stop.

Genetic information: We cannot use your genetic information to decide whether we'll give you coverage or decide the price of that coverage.

Race, ethnicity and language: We may receive race, ethnicity and language information about you and protect this information as described in this notice. We may use this information to help you, including identifying your specific needs, developing programs and educational materials and offering interpretation services. We don't use race, ethnicity and language information to decide whether we'll give you coverage, what kind of coverage and the price of that coverage. We don't share this information with unauthorized persons.

Your rights

Under federal law, you have the right to:

- Send us a written request to see or get a copy of your PHI, including a request for a copy of your PHI through email. Remember, there's a risk your PHI could be read by a third party when it's sent unencrypted, meaning regular email. So we will first confirm that you want to get your PHI by unencrypted email before sending it to you. We will provide you a copy of your PHI usually within 30 days of your request. If we need more time, we will let you know.
- Ask that we correct your PHI that you believe is wrong or incomplete. If someone else, such as your doctor, gave us the PHI, we'll let you know so you can ask him or her to correct it. We may say "no" to your request, but we'll tell you why in writing within 60 days.
- Send us a written request not to use your PHI for treatment, payment or health care operations activities. We may say "no" to your request, but we'll tell you why in writing.
- Request confidential communications. You can ask us to send your PHI or contact you using other ways that are reasonable. Also, let us know if you want us to send your mail to a different address if sending it to your home could put you in danger.
- Send us a written request to ask us for a list of those with whom we've shared your PHI. We will provide you a list usually within 60 days of your request. If we need more time, we will let you know.
- Ask for a restriction for services you pay for out of your own pocket: If you pay in full for

any medical services out of your own pocket, you have the right to ask for a restriction. The restriction would prevent the use or sharing of that PHI for treatment, payment or operations reasons. If you or your Provider submits a Claim to us, we may not agree to a restriction (see "Your rights" above). If a law requires sharing your information, we don't have to agree to your restriction.

- Call Member Services at the phone number on your ID card to use any of these rights. A representative can give you the address to send the request. They can also give you any forms we have that may help you with this process.

How we protect information

We're dedicated to protecting your PHI, and we've set up a number of policies and information practices to help keep your PHI secure and private. If we believe your PHI has been breached, we must let you know.

We keep your oral, written and electronic PHI safe using the right procedures, and through physical and electronic ways. These safety measures follow federal and state laws. Some of the ways we keep your PHI safe include securing offices that hold PHI, password-protecting computers, and locking storage areas and filing cabinets. We require our employees to protect PHI through written policies and procedures. These policies limit access to PHI to only those employees who need the data to do their jobs. Employees are also required to wear ID badges to help keep unauthorized people out of areas where your PHI is kept. Also, where required by law, our business partners must protect the privacy of data we share with them as they work with us. They're not allowed to give your PHI to others without your written permission, unless the law allows it and it's stated in this notice.

Potential impact of other applicable laws

HIPAA, the federal privacy law, generally doesn't cancel other laws that give people greater impact of other privacy protections. As a result, if any state or federal privacy law requires us to give you applicable laws more privacy protections, then we must follow that law in addition to HIPAA.

Calling or texting you

We, including our affiliates and/or vendors, may call or text you by using an automatic telephone dialing system and/or an artificial voice. But we only do this in accordance with the Telephone Consumer Protection Act (TCPA). The calls may be about treatment options or other health-related benefits and services for you. If you don't want to be contacted by phone, just let the caller know or call **844-203-3796** to add your phone number to our Do Not Call list. We will then no longer call or text you.

Complaints

If you think we haven't protected your privacy, you can file a complaint with us at the Member Services phone number on your ID Card. You may also file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by visiting hhs.gov/ocr/privacy/hipaa/complaints/. We will not take action against you for filing a complaint.

Contact information

You may call us at the Member Services phone number on your ID card. Our representatives can help you apply your rights, file a complaint or talk with you about privacy issues.

Copies and changes

You have the right to get a new copy of this notice at any time. Even if you have agreed to get this notice by electronic means, you still have the right to ask for a paper copy. We reserve the right to change this notice. A revised notice will apply to PHI we already have about you, as well as any PHI we may get in the future. We're required by law to follow the privacy notice that's in effect at this time. We may tell you about any changes to our notice through a newsletter, our website or a letter.

Effective date of this notice

The original effective date of this Notice was April 14, 2003. The most recent revision is noted in the footer at the end of this document.

Breast reconstruction surgery benefits

A mastectomy that's covered by your health plan includes benefits that comply with the Women's Health and Cancer Rights Act of 1998, which provides for:

- Reconstruction of the breast(s) that underwent a covered mastectomy.
- Surgery and reconstruction of the other breast to restore a symmetrical appearance.
- Prostheses and coverage for physical complications related to all stages of a covered mastectomy, including lymphedema.

You'll pay your usual deductible, copay and/or coinsurance. For details, contact your plan administrator.

For more information about the Women's Health and Cancer Rights Act, go to the United States Department of Labor website at www.dol.gov/agencies/ebsa/laws-and-regulations/laws/whcra.

It's important we treat you fairly

We follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently based on race, color, national origin, sex, age or disability. If you have disabilities, we offer free aids and services. If your main language isn't English, we offer help for free through interpreters and other written languages. Call the Member Services number on your ID card for help (**TTY/TDD:711**).

If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint through one of these ways:

- Write to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160 Richmond, VA 23279.
- File a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201.
- Call **800-368-1019** (TDD: **800-537-7697**).
- Go online at ocrportal.hhs.gov/ocr/portal/lobby.jsf and fill out a complaint form at hhs.gov/ocr/office/file/index.html.

Get help in your language

One more right that you have the right to get this information in your language for free. If you'd like extra help to understand this in another language, call the Member Services number on your ID card (**TTY/TDD: 711**).

Aside from helping you understand your privacy rights in another language, we also offer this notice in a different format for Members with visual impairments. If you need a different format, please call the Member Services number on your ID card.

(Revision 5/18; Reviewed 3/2021)

CONFIDENTIALITY OF HIV INFORMATION

Providers are reminded that they are obligated by law to comply with the confidentiality restrictions of Public Health Law Article 27-F and Section 2784, dealing with patient-specific information related to HIV infection.

Providers are also reminded of the following requirements.

Providers shall develop policy and procedures to assure confidentiality of HIV related information. The policy and procedures must include:

- Initial and annual in-service education of staff, contractors
- Identification of staff allowed access and limits of access
- Procedure to limit access to trained staff (including contractors)
- Protocol for secure storage (including electronic storage)
- Procedures for handling for HIV/related information
- Protocols to protect person with or suspected of having HIV infection from discrimination

Providers are also reminded of the following requirements.

- Required HIV pre-testing counseling with clinical recommendation of testing for all pregnant women. Those women and newborns must have access to services for positive management of HIV disease, psychosocial support and case management for medical, social, and addictive services.

Carelon Medical Benefits Management, Inc. is an independent company providing utilization management services on behalf of the health plan.

Carelon Behavioral Health, Inc. is an independent company providing utilization management services on behalf of the health plan.