



INDIANA PROVIDER MANUAL October 2019

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Introduction and Guide to Manual

Purpose and Introduction

This provider manual will present a general overview of information regarding key administrative areas; including but not limited to the quality improvement program, the utilization management program, and quality standards for Provider and Facility participation, reimbursement and administration policies and provider appeals.

Anthem Blue Cross and Blue Shield in Indiana ("Anthem") is committed to providing Providers and Facilities with an accurate and up to date manual; however, there may be instances where new procedures or processes are not immediately reflected in the manual. In such cases, Anthem will make every effort to provide updated documentation in the next manual update. In those instances where Anthem determines that information in the manual conflicts with the Agreement, the Agreement will take precedence over the manual.

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

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

Information Sources

- Anthem Web site – An internet site available to Anthem BlueCross and BlueShield ("Anthem") Providers and Facilities at www.Anthem.com. The site provides information on:
 - Anthem products
 - Contact phone numbers
 - Provider services
 - Health information
 - Provider directories
 - Network eUpdates
 - Facility and Professional Reimbursement Policies
 - Medical Policies and UM Guidelines
 - Joining Anthem Networks
- Network Update – A periodic newsletter publication designed to educate physicians, facilities and hospitals and their appropriate staff on administrative issues.

Capitalized terminology in this document is defined in your Anthem Facility Agreement or Anthem Provider Agreement otherwise referred to in this manual as "Agreement". The provisions of the provider manual apply unless otherwise provided for in your Agreement.

Legal and Administrative Requirements Overview

[Appointment Access and Geographic Availability](#)

Anthem uses these standards to assess the access of services and experience satisfaction of our Indiana Commercial members. Offices are to make best efforts to provide access in accordance with the members' needs and expectations for their medical and behavioral health circumstances.

OFFICE APPOINTMENT ACCESSIBILITY Assessment of appointment timeliness to meet members needs	
MEDICAL APPOINTMENT ACCESS	COMPLIANCE
MEDICAL APPOINTMENT ACCESS	COMPLIANCE
Emergency	Immediate access 24/7/365 or refer to 911 or ER.
Urgent / Acute Care	Within 24 hours - <ul style="list-style-type: none"> ▪ Patient can be seen in the office by their doctor, another participating practitioner in the practice or a covering practitioner within the timeframe. ▪ Patient is directed to Urgent Care, 911 or ER, as appropriate.
Non-Urgent (Symptomatic or chronic)	Within 72 hours - <ul style="list-style-type: none"> ▪ Patient can be seen in the office by their doctor, another participating practitioner in the practice or a covering practitioner within the timeframe.
Routine / Check-up	Within 10 business days - <ul style="list-style-type: none"> ▪ Patient can be seen in the office by their doctor, another participating practitioner in the practice or a covering practitioner within the timeframe.
Preventive Care	Within 30 calendar days - <ul style="list-style-type: none"> ▪ Patient can be seen in the office by their doctor, another participating practitioner in the practice or a covering practitioner within the timeframe.
Office Wait Time	Recommended not to exceed 30 minutes or less before taken to the exam room.
After Hours Urgent Care (Required arrangements)	24/7/365 phone access - All Members shall have phone access to urgent medical help or instructions after regular business hours through their primary care physician via: <ul style="list-style-type: none"> ▪ Live person connects the caller to their available doctor or on-call doctor. ▪ Recording or live person directs the patient to Urgent Care, 911 or ER, as appropriate. In addition to, but not in place of the above criteria, the caller may be directed to contact a live health care practitioner (via cell, pager, beeper, transfer system) or get a call back for urgent instructions. Having no provision is non-compliant.
BEHAVIORAL HEALTH APPOINTMENT ACCESS	COMPLIANCE
Emergency	Immediate access 24/7/365 or refer to 911, ER or crisis center.
Discharge Follow-up BH Appointment	Within 7 days - <ul style="list-style-type: none"> ▪ New or existing patient can be seen in the office by designated BH practitioner within the timeframe after discharge from an inpatient psychiatric hospitalization.

<i>Emergent - Non-Life Threatening</i>	Within 6 hours - <ul style="list-style-type: none"> ▪ Patient can be seen in the office by their BH practitioner, another participating practitioner in the practice or a covering practitioner within the timeframe. ▪ Patient is directed to 911, ER or 24 hour crisis services, as appropriate.
<i>Urgent Care</i>	Within 48 hours - <ul style="list-style-type: none"> ▪ Patient can be seen in the office by their BH practitioner, another participating practitioner in the practice or a covering practitioner within the timeframe. ▪ Patient is directed to 911, ER or 24 hour crisis services, as appropriate.
<i>Routine - Initial Appointment</i>	Within 10 business days – <ul style="list-style-type: none"> ▪ New patient can be seen in the office by a designated BH practitioner or another appropriate participating practitioner within the timeframe. (After the intake assessment or referral.)
<i>Routine - Follow-up Appointment</i>	Within 30 calendar days – <ul style="list-style-type: none"> ▪ New or existing patient can be seen in the office by their BH practitioner, another participating practitioner in the practice or a covering practitioner within the timeframe.
<i>After Hours Urgent Care</i> <i>(Required arrangements)</i>	24/7/365 phone access - All Members shall have phone access to emergent/urgent instructions/consultation after regular business hours through their BH practitioner via: <ul style="list-style-type: none"> ▪ Recording or live person directs patient to 24 hour crisis services. 911 or ER, as appropriate. ▪ Caller is directed to contact a BH Practitioner (via cell, pager, beeper, transfer system) or get a call back for instructions or consultation. Having no provision is non-compliant.
<i>Out of Office Coverage</i>	Arrangement for coverage when the practitioner is unavailable (vacation, illness, holiday, etc.) via: <ul style="list-style-type: none"> ▪ Cell phone, pager, etc. ▪ Patient is directed to another BH practitioner in the practice, on call or covering practitioner. ▪ Prior arrangement with patients.
PROVIDER AVAILABILITY	
Assessment of numbers and types to meet members needs	
MEDICAL NETWORK ADEQUACY	
<i>OPEN PRACTICE</i> <i>Note: Keep Anthem updated of status for web directory.</i>	At least 90% of Primary Care Physician's practices will be open for new patient selection.
GEOGRAPHIC AVAILABILITY OF MEDICAL PROVIDERS	
Mileage is based upon member and provider zip code coordinates and locality definitions per GeoAccess® software.	
MEDICAL GEOGRAPHICS	MEASURE
• <i>Primary Care Physicians:</i> Family Medicine, Internal Medicine and Pediatrics.	<ul style="list-style-type: none"> ▪ 2 of each type within 5 miles (urban) ▪ 2 of each type within 12 miles (suburban) ▪ 2 of each type within 30 miles (rural)
• <i>OB/GYN</i>	<ul style="list-style-type: none"> ▪ 1 within 15 miles (urban) ▪ 1 within 30 miles (suburban) ▪ 1 within 40 miles (rural)
• <i>Specialists</i>	<ul style="list-style-type: none"> ▪ 1 of each major specialty type within 30 miles
• <i>Hospitals</i>	<ul style="list-style-type: none"> ▪ 1 within 30 miles
• <i>Skilled Nursing Facility</i>	<ul style="list-style-type: none"> ▪ 1 within 30 miles

BEHAVIORAL HEALTH NETWORK ADEQUACY	
GEOGRAPHIC AVAILABILITY OF BEHAVIORAL HEALTH PROVIDERS Mileage is based upon member and provider coordinates and locality definitions per GeoAccess® software.	
BH GEOGRAPHICS	MEASURE
<ul style="list-style-type: none"> Psychiatrist (MD/DO) (Include Sub-Abuse) 	<ul style="list-style-type: none"> 2 within 10 miles (urban) 2 within 25 miles (suburban) 2 within 60 miles (rural)
<ul style="list-style-type: none"> Non-MD Professionals: Psychologist and Masters Level Therapists (Include Sub-Abuse) 	<ul style="list-style-type: none"> 2 of each type within 10 miles (urban) 2 of each type within 25 miles (suburban) 2 of each type within 60 miles (rural)
<ul style="list-style-type: none"> BH Treatment Facilities (Facilities offering IP BH services) 	<ul style="list-style-type: none"> 1 within 35 miles (urban /suburban combined) 1 within 75 miles (rural)
MULTICULTURAL HEALTH Practitioners meeting the needs and preferences of their patients	
<ul style="list-style-type: none"> Doctors are expected to identify their patient's needs by explaining things in a way they can understand, listen carefully, show respect for what they have to say and spend enough time with the patient. 	
<ul style="list-style-type: none"> Anthem has provided offices with a tool (link below) that provides ideas, resources and tools that can help doctors and their staffs better understand and communicate with select patient groups with specific needs. This allows for patients to fully understand their medical situation and get the maximum benefit from their time with their doctor. 	
<ul style="list-style-type: none"> Please see the Multicultural Health section of this manual for more information on resources for Providers to help support addressing racial and ethnic disparities in health and healthcare. Features include CME learning experiences, real-life stories about unique challenges faced by diverse patients and tips and techniques to promote improved health outcomes. 	
<p style="text-align: center;">https://mydiversepatients.com</p>	
<ul style="list-style-type: none"> Practitioners can provide Anthem with their gender and race / ethnicity for the provider directory via the Provider Maintenance Form (PMF) at anthem.com. Select Menu, and then under the <i>Support</i> heading select the Providers link. On the Provider landing page, choose Find Resources for Your State and choose Indiana from the list. On the Provider Home page, Select Answers@Anthem, choose the Provider Maintenance Form or Select Here. <p>This information will be utilized in online provider directories available to your customers to locate a doctor who meets their cultural, racial, ethnic, gender and language needs and preferences.</p>	

Coordination of Benefits

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

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

Notwithstanding the foregoing, in no event shall Plan or the Member be required to pay more than they would have paid had the Plan been the primary payor. Providers and Facilities will not collect any amount from the Member if such amount, when added to the amounts collected from the primary and secondary payors, would cause total reimbursement to the Provider or Facility for the Covered Service to exceed the amount allowed

for the Covered Service under the Agreement. Further, this provision shall not be construed to require Providers or Facilities to waive Cost Share in contravention of any Medicare rule or regulation, nor shall this provision be construed to supersede any other Medicare rule or regulation. If, under this Section, Providers and Facilities are permitted to seek payment from other sources by reason of the existence of other group coverage in addition to Plan's Health Benefit Plan. Providers and Facilities may seek payment from the other sources on a basis other than the Plan rate.

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

Anthem provides a Companion Guide, to assist Providers and Facilities with the submission of electronic Claims. The Companion Guide contains complete instructions for the electronic billing of Coordination of Benefit Claims. If you would like to learn more, refer to the Companion Guide (appropriate 837 section) online. Go **anthem.com**. Select **Menu**, and under the *Support* heading select the **Providers** link. Next, select **Indiana** then choose the **Access EDI** or [Select Here](#).

When filing Coordination of Benefits Claims on paper submission

Include Explanation of Benefit. ("EOB") from primary insurance carrier with coordination of benefits ("COB") Claims submitted for secondary payment.

[Dispute Resolution and Arbitration](#)

Please note in the instances where the information in this section conflicts with the Agreement the Agreement will take precedence.

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

A. Attorney's Fees and Costs

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

B. Location of the Arbitration

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

C. Selection and Replacement of Arbitrator(s)

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

reason, a replacement arbitrator shall be selected in the same manner in which the arbitrator who is being replaced was selected.

D. Discovery

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

E. Decision of Arbitrator(s)

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

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

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

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

F. Confidentiality

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

[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.

Insurance Requirements

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

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

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

2. Workers' Compensation coverage with statutory limits and Employers Liability insurance.
3. Commercial general liability insurance for Providers and Facilities for bodily injury and property damage, including personal injury and contractual liability coverage.
4. Professional Providers located in Indiana must participate in the Indiana Patient Compensation Fund.

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.

Acceptable self-insurance can be in the form of a captive or self-management of a large retention through a Trust. A self-insured Provider or Facility shall maintain and provide evidence of a valid self-insurance program consisting of at least one of the following upon request:

1. Actuarially validated reserve adequacy for incurred Claims, incurred but not reported Claims, and future Claims based on past experience;
2. Designated claim third party administrator or appropriately licensed and employed claims professional or attorney;
3. Evidence of surety bond, reserve or line of credit as collateral for the self-insured limit.

B. *Providers and Facilities shall notify Anthem of a reduction in, cancellation of, or lapse in coverage within ten (10) days of such a change. A certificate of insurance shall be provided to Anthem upon execution of this Agreement and upon request during the Agreement period.*

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.

Office-Based Anesthesia

If a provider performs office based anesthesia the provider will be accredited in accordance with 844 IAC 5-5.

Open Practice

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

Privacy Policy Statement

Information regarding Anthem's Corporate Privacy Policy Statement that sets forth guidelines regarding a Member's right to access and amend information in Anthem's possession is available by selecting the "Privacy Statement" at the bottom of the Provider Landing page of our public provider website. To access this information go to www.anthem.com, select Provider under "Other Anthem Websites" at the top of the page. On the Provider Landing page, scroll to the bottom and click on the "Privacy Statement" link.

Provider and Facility Responsibilities

Providers are required to comply with Federal and State Laws. In addition, providers must verify their employees, contractors, subcontractors or agents have not been identified as ineligible persons on the General Services Administration' List of Parties Excluded from Federal Programs and the HHS/OIG list of Excluded Individual/Entities or as otherwise designated by the Federal government.

Providers are responsible for notifying Anthem when changes occur within the Provider Organization. Our Provider Agreement requires Providers give Anthem at least 30 days prior notice when making changes. All changes must be approved by Anthem.

Examples of these changes include, but are not limited to:

- adding a new practitioner to your group
- change in ownership
- change in Tax Identification Number
- making changes to your 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

Referring to Non-Participating Providers

Anthem's mission is to provide affordable quality health care benefits to its Members. To maximize the value of our Member's benefit plans, it is imperative that Members access their highest level of health care benefits from Network/Participating Providers and Facilities. Providers and Facilities put Members at risk of higher out of pocket expenses when they refer to non-participating providers. To help manage cost, Anthem has in place a non-participating provider Claims payment policy; however, that policy cannot prohibit non-participating providers from billing Members the difference between the amount they charge for the service and the amount paid to that non-participating provider.

Providers are reminded that per their Agreement with Anthem they are generally required to refer Members to Network/Participating Providers. Providers and Facilities who establish a pattern of referring Members to non-participating providers are subject to disciplinary action, up to and including termination from the Network. We understand that there may be instances in which a Network/Participating Provider must refer to a non-participating provider. For additional information on the non-participating provider Claims payment policy please refer to the reimbursement policy section of this manual.

[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.

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 medication, 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.

Directory of Services

[Network Relations and Contracting](#)

In order to meet the service needs of our Providers and Facilities, we have assembled an experienced staff consisting of Provider Network Managers and Network Relation Consultants available to assist you. They have access to email and voicemail in the event that you are not able to reach them by telephone.

The **Network Relations Consultants** generally serve as a liaison and are responsible for on-site orientation, ongoing training and policy/procedure consultation. They will assist you with administrative policy and procedure problem resolution and service needs. They have access to email and voicemail in the event that you are not able to reach them by telephone.

The **Network Development Managers** generally serve as the primary contacts for Network contracting.

Providers and Facilities can call Network Management at 1-800-455-6805 in order to identify the appropriate Network Relations Consultants and/or Network Development Managers.

[Provider Directory](#)

The provider directory is available on our website at www.anthem.com. If you do not have internet access contact the Provider Inquiry Department for assistance in identifying Network Providers and Facilities.

Providers using the directory for referrals to in-network providers should note that not all providers are contracted for all Anthem networks. Please note that non-credentialed providers are not found on the online Provider Directory,

[Provider Services](#)

Contact a **Provider Service Representative** by calling the Provider Inquiry Department at (800) 345-4344 or the phone number provided on the back of the Member's identification card ("ID") (which can now be found on Availity) for questions/comments concerning:

- Claims status
- Eligibility
- Claims reviews
- Complaints
- Claims coding and or submission

[Online Provider Directories and Demographic Data Integrity](#)

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

[Online Provider Directory](#)

Providers and Facilities who have questions on their participation status are encouraged to contact Provider Services at: 1-800-455-6805.

Accessing the Online Provider Directory:

- Go to **www.anthem.com > Provider > Find Resources for your State > Indiana > Search as a guest.**

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

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

[Updating your Demographic Data with Anthem](#)

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

Notes:

- **Tax ID changes must be accompanied by a W-9 to be valid.**
- **For notices of termination from our network, refer to the termination clause in your Agreement for specific notification requirements. Please allow the number of days' notice of termination from our network as required by your Agreement (e.g. 90 days, 120 days, etc.).**

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

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

Please send us this information online at: **anthem.com > Provider > Tab > Indiana > Answers@Anthem > Provider Maintenance Form** or [Select Here](#).

* Note: To request participation for a new provider or practitioner, even if joining an existing practice, providers or practitioners must first begin the Application process. Go to **anthem.com > Menu > Providers > Indiana > Begin Application**.

[Availity Portal](#)

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

Engage and obtain the information you need instantly with the following tools:

- **Care Reminders** – Receive clinical alerts on members' care gaps and medication compliance indicators, when available.
- **Claim Submission** – Submit a single, electronic Claim.
- **Claim Status Inquiry** – See details and payment information including Claim line-level details/processing.
- **Interactive Care Reviewer** – Secure, online provider authorization, referral and inquiry tool for many Anthem members.
- **Medical Attachments** – Submit your medical records electronically when requested to support a pending or denied claim. Includes the ability to submit an itemized bill electronically.
- **Member Certificate Booklet** – View a local plan Member's certificate of coverage, when available.
- **Member Eligibility and Benefits Inquiry** – Get real-time patient eligibility, benefits, and accumulative data, including current and historical coverage information, plus detailed co-insurance, co-payment and deductible information for ALL members, including BlueCard® and FEP®.

- **Member ID Card Viewer** – View the front and back of a member's ID card when available.
- **Secure Messaging** – Send a question to clarify the status of a claim or to get additional information on claims.

Payer Spaces:

View Anthem specific tools by selecting **Payer Spaces**, then the **Anthem icon** to view the following tools:

- **Clear Claim Connection** – Research procedure code edits and receive edit rationale.
- **Education and Reference Center** – Locate important policies, forms and educational resources.
- **Fee Schedule** – Retrieves professional office-based contracted price information for patient services performed.
- **Remittance Inquiry** – View an imaged copy of the paper Anthem remits up to 15 months in the past.
- **Patient360** – Real time, robust picture of your patient's health and treatment history.
- **Plus**, links to other Anthem pages, tool overview documents and more, such as:
 - **AIM Specialty Health® (AIM)** – link to precertification requests and inquiries through AIM
 - **OptiNet® Survey on AIM** – link to the survey via AIM Specialty Health.

Take advantage of these Availity benefits

- **No charge** – Anthem transactions are available at no charge to providers.
- **Accessibility** – Availity functions are available 24 hours a day from any computer with Internet access.
- **Standard responses** – Responses from multiple payers returned in the same format and screen layout, providing users with a consistent look and feel.
- **Access to both commercial and government payers** – Users can access data from Anthem, Medicare, Medicaid and other commercial insurers (See www.availity.com for a full list of payers.)
- **Compliance** – Availity is compliant with all Health Insurance Portability and Accountability Act (HIPAA) regulations.

How to get started

To register for access to Availity, go to www.availity.com/providers/registration-details/. It's that simple!
If you need further assistance getting registered, please contact Availity Client Services at 1-800-AVAILITY (282-4548).

Availity Training

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

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

Availity Training for Anthem specific tools

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

Organization Maintenance

To change/update an Administrator or Organization information:

- To replace the Administrator currently on record with Availity, please call Availity Client Services at 1-800-AVAILITY (282-4548).
- An Administrator can use the *Maintain Organization* feature to maintain the organization's demographic information, including address, phone number, tax ID, and NPI. Any changes made to this information automatically apply to all Users associated to the organization and affects only the registration information on the Availity Portal.

Anthem Provider Web Site

www.Anthem.com

Anthem.com is the unsecured section of the web portal. The public provider website holds timely and important information to assist providers when working with Anthem. Some items that can be located from the Provider Home Page include:

- Self Service and Support
 - Medical Policies and Clinical UM Guidelines
 - Facility and Professional Reimbursement Policies
 - Behavioral Health Provider Resources
 - Electronic Data Interchange (EDI)
 - Electronic Self-Service Options
 - Precertification (Tools)
 - Precertification Guidelines
 - Provider Maintenance Form
- Our Plans & Benefits
 - Medicare & State-Sponsored Plans
- Health and Wellness
- Communications & Updates
 - Health Care Reform and Notifications
 - ICD-10
 - Network eUPDATE (formerly Rapid Update)
 - Network Update (Provider Newsletter)
- Important Updates
- Link to sign up for Anthem's Network eUPDATE (formerly Rapid Update)
- Contact Us
- Link to Availity Workshop & Seminar Registration

Claims Submission

[Service Area](#)

The service area for Anthem in Indiana contains the following counties:

Adams, Allen, Bartholomew, Benton, Blackford, Boone, Brown, Carroll, Cass, Clay, Clinton, Daviess, Dearborn, Decatur, De Kalb, Delaware, Dubois, Elkhart, Fayette, Fountain, Franklin, Fulton, Gibson, Grant, Greene, Hamilton, Hancock, Hendricks, Henry, Howard, Huntington, Jackson, Jasper, Jay, Jennings, Johnson, Knox, Kosciusko, Lagrange, Lake, La Porte, Lawrence, Madison, Marion, Marshall, Martin, Miami, Monroe, Montgomery, Morgan, Newton, Noble, Ohio, Owen, Parke, Perry, Pike, Porter, Posey, Pulaski, Putnam, Randolph, Ripley, Rush, Shelby, Spencer, St. Joseph, Starke, Steuben, Sullivan, Switzerland, Tippecanoe, Tipton, Vanderburgh, Vermillion, Vigo, Wabash, Warren, Warrick, Wayne, Wells, White, Whitley.

Please refer to the Anthem Kentucky website for more information for the following Indiana counties serviced by Anthem in Kentucky:

Clark, Crawford, Floyd, Harrison, Jefferson, Orange, Scott, Washington.

[Claim Submission Filing Tips](#)

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

CPT Coding

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

Electronic Claims Submissions

Please submit Claims electronically whenever possible. If Providers or Facilities have questions about electronic submissions, or if Providers or Facilities want to learn more about how EDI can work for Providers or Facilities, please review the EDI Submissions section in this manual or call 1-800-470-9630.

Please refer to the subsection titled [Recommended Fields for Electronic 837 Professional \(837P\) and Institutional \(837I\) Health Care Claims](#) for more information on EDI submissions.

Paper Claims Submissions

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

- Submit all paper Claims using the current standard RED CMS Form 1500 (02-12) for professional Claims and the UB-04 (CMS-1450) for Facility Claims.
- If Providers or Facilities are submitting a multiple page Claim, the word “continued” should be noted in the total charge field, with the total charge submitted on the last page of the Claim.
- When submitting a multiple page document, do not staple over pertinent information.
- Complete all mandatory fields.
- Do not highlight any fields.

- Check the printing of Claims from time to time to help ensure proper alignment and that characters are legible.
- Ensure all characters are inside the appropriate fields and do not overlap.
- Change the printer cartridge regularly and do not use a DOT matrix printer.
- Submit a valid member identification number including three digit prefix or R+8 numeric for Federal Employee Program® (FEP®) members on all pages.
- Claims must be submitted with complete provider information, including referring, rendering and billing NPI; tax identification number; name; and servicing and billing addresses on all pages.

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

Ambulatory Surgical Centers

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

Ancillary Filing Guidelines

Ambulance Claims

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

Durable/Home Medical Equipment and Supplies

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

Home Infusion Therapy - Services and Supplies

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

Laboratory Claims

- File the Claim to the plan in the service area where the specimen was drawn, as determined by the referring provider's location (based on NPI)

- Independent lab Claims are determined by the provider specialty code in the provider file, not by CPT codes.

Specialty Pharmacy Claims

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

Duplicate Claims (aka Tracers)

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

Itemized Bill

Providers and Facilities are required to submit a complete itemized bill for all Inpatient Acute and Children's Facilities with charges over \$40,000.

Late Charges

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

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

Maternity Delivery Claims

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

National Drug Codes (NDC)

See separate subsection titled *National Drug Codes*.

Negative Charges

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

Not Otherwise Classified ("NOC") Codes

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

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

Occurrence Dates

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

Other Insurance Coverage

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

CMS-1500 Fields:

Field 9: Other insured's name

Field 9a: Other insured's policy or group number

Field 9b: Other insured's date of birth

Field 9c: Employer's name or school name (not required in EDI)

Field 9d: Insurance plan name or program name (not required in EDI)

UB-04 CMS-1450 Fields:

Field 50a-c: Payer Name

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

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

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

Preventive Colonoscopy – correct coding

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

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

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

Type of Billing Codes

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

[Claim Inquiry/Adjustment Filing Tips](#)

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

- **Claim Inquiry:** A question about a Claim or Claim payment is called an inquiry. Claim Inquiries do not result in changes to Claim payments, but the outcome of the Claim Inquiry may result in the initiation of the Claim Payment Dispute. In other words, once the Provider or Facility receives the answer to the Claim Inquiry, the Provider or Facility may opt to begin the Claim Payment Dispute process. Providers and Facilities can send a Secure Message through the Availity Portal, or call the Provider Services number on the back of the Member ID Card and select the *Claims* prompt. Please reference the *Availity Portal* section for further details on Secure Messaging.
- **Claim Correspondence:** Claim Correspondence is when Anthem requires more information to finalize a Claim. Typically, Anthem makes the request for this information through the Explanation of Payment (“EOP”) The Claim or part of the Claim maybe denied, but it is only because more information is required to process the Claim. Once the information is received, Anthem will use it to finalize the Claim.
- **Clinical / Medical Necessity Appeals:** An appeal regarding a clinical decision denial, such as an authorization or Claim that has been denied as not medically necessary, experimental/investigational. For more information on Clinical / Medical Necessity Appeals, please refer to the *Clinical Appeals* section within the Provider Manual.
- **Claim Payment Disputes:** Please see the *Claim Payment Dispute* section for further details.
- **Precertification Disputes:** Precertification disputes should be handled via the process detailed in the letter received from our precertification department. If Providers or Facilities disagree with a clinical decision, please follow the directions detailed on our letter. Sending precertification/predetermination requests or appeals to the provider correspondence address may delay responses.
- **Corrected Claims:** Submitting corrected Claims should only be utilized to update information on the Claim form. If the inquiry is about the way the Claim processed, please refer to the prior sections. If Providers or Facilities have corrections to be made to the Claim, please submit according to the Corrected Claim Guidance below.

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.

Type	Professional Claim	Institutional Claim
EDI	To indicate the Claim is a replacement Claim: <ul style="list-style-type: none">• In element CLM05-3 “Claim Frequency Type Code”• Use Claim Frequency Type 7	To indicate the Claim is a replacement Claim: <ul style="list-style-type: none">• In element CLM05-3 “Claim Frequency Type Code”• Use Claim Frequency Type 7
	To confirm the Claim which is being replaced: <ul style="list-style-type: none">• In Segment “REF – Payer Claim Control Number”	To confirm the Claim which is being replaced: <ul style="list-style-type: none">• In Segment “REF – Payer Claim Control Number”

Type	Professional Claim	Institutional Claim
	<ul style="list-style-type: none"> Use F8 in REF) and list the original payer Claim number is REF02 	<ul style="list-style-type: none"> Use F8 in REF) and list the original payer Claim number is REF02
	To indicate the Claim was billed in error (Void/Cancel): <ul style="list-style-type: none"> In element CLM05-3 "Claim Frequency Type Code" Use Claim Frequency Type 8 	To indicate the Claim was billed in error (Void/Cancel): <ul style="list-style-type: none"> In element CLM05-3 "Claim Frequency Type Code" Use Claim Frequency Type 8
	To confirm the Claim which is being void/cancelled: <ul style="list-style-type: none"> In Segment "REF – Payer Claim Control Number" Use F8 in REF) and list the original payer Claim number is REF02 	To confirm the Claim which is being void/cancelled: <ul style="list-style-type: none"> In Segment "REF – Payer Claim Control Number" Use F8 in REF) and list the original payer Claim number is REF02
	To indicate the Claim is a replacement Claim: <ul style="list-style-type: none"> 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: <ul style="list-style-type: none"> In Form Locator 04: "Type of Bill" Use Claim Frequency Type 7
Paper	To confirm the Claim which is being replaced: <ul style="list-style-type: none"> 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: <ul style="list-style-type: none"> 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: <ul style="list-style-type: none"> 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: <ul style="list-style-type: none"> In Form Locator 04: "Type of Bill" Use Claim Frequency Type 8
	To confirm the Claim which is being void/cancelled: <ul style="list-style-type: none"> 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: <ul style="list-style-type: none"> 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, please refer to the *Claim Payment Dispute* and *Clinical Appeals* sections.

National Drug Codes (NDC)

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

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

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

Unit of Measurement Requirements

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

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

Location of the NDC

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



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

How/Where to Place the NDC on a Claim Form

CMS 1500 Claim Form:

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

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

All Elements are REQUIRED:

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; <ul style="list-style-type: none"> • F2 – International Unit 	GR0.045 ML1.0 UN1.000	In the shaded area immediately following the 11-digit NDC, enter 3 spaces, followed by one of

How	Example	Where
<ul style="list-style-type: none"> GR – Gram ML – Milliliter UN – Units MG – Milligrams and quantity, including a decimal point for correct reporting		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 you bill does not have a specific HCPCS or CPT code assigned, please assign the appropriate miscellaneous code per Correct Coding Guidelines.
- DO NOT bill more than one NDC per Claim line.

The unit of service for the HCPCS or CPT code is very important. Units for injections must be billed consistent with the HCPCS or CPT description of the code.

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”
Enter one of five (5) units of measure qualifiers; <ul style="list-style-type: none"> F2 – International Unit GR - Gram ML - Milliliter UN – Units MG - 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)

The following table provides elements of a proper NDC entry on a UB04 Claim form.

24. A. DATE(S) OF SERVICE		B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)	E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
From MM DD YY	To MM DD YY			MODIFIER						
1									NPI	
2									NPI	
3									NPI	
4									NPI	
5									NPI	

Enter NDC in shaded area of box 24A

SICIAN OR SUPPLIER INFORMATION

42. REV. CD.	43. DESCRIPTION	44. HPOS / RATE / HPOS CODE	45. SERV. DATE	46. SERV. UNITS	47. TOTAL CHARGES	48. NON-COVERED CHARGES	49.
1####	N4##### GR0.045	J####	MMDDYY	1	##.##	0.00	1

837 P And 837 I Reporting Fields

Billing or Software Vendor:

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

Tips for Using NDCs When Submitting Electronic Claims

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~
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 MG: 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~

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

Please reference our Transaction Specific Companion Documents available on our EDI webpage. Go to www.anthem.com/edi. **Select your state** from the dropdown list and **enter**. Under the *Documents tab*, select **Companion Guide**, then see the appropriate link under the *Section B – Transaction Specific Companion Documents* heading.

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

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

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

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

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

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

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

Field 6: Patient Relationship to Insured

Field 7: Insured's Address

Field 10: Is Patient's Condition Related to:

Field 10A: Employment?

Field 10B: Auto Accident?

Field 10C: Other Accident?

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

Important information about Fields 14 and 15:

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

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

- 431 – Onset of current symptoms or illness
- 484 – Last Menstrual Period

Field 15: Other Date – Enter another date related to the patient's condition or treatment. Enter the date in the 8-digit (MM|DD|YYYY) format. Enter the applicable qualifier to identify which date is being reported:

- 454 – Initial treatment
- 304 – Latest visit or consultation
- 453 – Acute manifestation or a chronic condition
- 439 – Accident

- 455 – Last X-ray
- 471 – Prescription
- 090 – Report start (assumed care date)
- 091 – Report end (relinquished care date)
- 444 – First visit or consultation

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

Field 17: Referring physician name – Enter the name of the referring or ordering provider. Enter the applicable qualifier to the left of the vertical, dotted line:

- DN – Referring provider
- DK – Ordering provider
- DQ – Supervising provider

Field 17b: Referring physician NPI

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

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

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

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

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

Field 24A: Date(s) of Service

Field 24B: Place of Service

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

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

Field 24F: \$ Charges – line item charge.

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

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

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

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

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

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

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

Field 33: Billing Provider Information and Phone # – Complete name, address, city, state and zip code
Reminder: If submitting Claims electronic, this field must hold a physical address and should not contain any of the following: "Post Office Box", "P.O. Box", "PO Box", "Lock Box", "Lock Bin", "PO Box"

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

Note: To help improve payment accuracy and timeliness, please remember that when filing Claims, the Tax Identification Number (TIN) and National Provider Identifier (NPI) numbers are required. Additionally, bill Claims using the taxonomy codes as applicable.



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

												PICA <input type="checkbox"/>	
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA <input type="checkbox"/> BULKING <input type="checkbox"/> OTHER <input type="checkbox"/>												1a. INSURED'S I.D. NUMBER (For Program in Item 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)												4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
3. PATIENT'S BIRTH DATE MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>												7. INSURED'S ADDRESS (No., Street)	
5. PATIENT'S ADDRESS (No., Street)												8. RESERVED FOR NUCC USE	
6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>												CITY STATE	
CITY STATE												ZIP CODE TELEPHONE (Include Area Code)	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)												11. INSURED'S POLICY GROUP OR FECA NUMBER	
10. IS PATIENT'S CONDITION RELATED TO:												13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.	
a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input type="checkbox"/>												b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>	
b. RESERVED FOR NUCC USE												c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>	
c. RESERVED FOR NUCC USE												10d. CLAIM CODES (Designated by NUCC)	
d. INSURANCE PLAN NAME OR PROGRAM NAME												d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, complete items 9, 9a, and 9d.	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE												13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE	
SIGNED DATE												SIGNED	
14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) MM DD YY QUAL												15. OTHER DATE QUAL MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE												18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? YES <input type="checkbox"/> NO <input type="checkbox"/> \$ CHARGES	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. A. B. C. D. E. F. G. H. I. J. K. L.												22. RESUBMISSION CODE ORIGINAL REF. NO.	
23. PRIOR AUTHORIZATION NUMBER													
24. A. DATE(S) OF SERVICE From To B. PLACE OF SERVICE C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS F. \$ CHARGES G. DAYS OR UNITS H. I. ID. QUAL J. RENDERING PROVIDER ID. #													
1												NPI	
2												NPI	
3												NPI	
4												NPI	
5												NPI	
6												NPI	
25. FEDERAL TAX ID. NUMBER SSN EIN												26. PATIENT'S ACCOUNT NO.	
27. ACCEPT ASSIGNMENT? YES <input type="checkbox"/> NO <input type="checkbox"/>												28. TOTAL CHARGE \$	
29. AMOUNT PAID \$												30. Rsvd for NUCC Use	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)												32. SERVICE FACILITY LOCATION INFORMATION	
33. BILLING PROVIDER INFO & PH # ()													
SIGNED DATE												a. NPI b. NPI	

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

Recommended Fields for Paper UB-04 (CMS-1450) Claims

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

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

Field 1: Provider name and complete address

Field 2: Provider's designated billing name and remittance address

Field 4: Type of Bill

Field 5: Federal Tax Identification Number

Field 6: Statement Covers Period (From-Through)

Field 8: Patient Name

Field 9: Patient Address

Field 10: Birth Date (8-digit (MM|DD|YYYY) format)

Field 11: Sex

Field 12: Admission Date

Field 13: Admission Hour

Field 14: Admission Type – Priority (Type) of Admission or Visit *[Inpatient only]*

Field 15: Admission SRC – Point of Origin for Admission or Visit *[Inpatient only]*

Field 16: Discharge Hour *[Inpatient only]*

Field 17: Patient Discharge Status *[Inpatient only]*

Fields 31-34: Occurrence Codes and Dates

Fields 39-41: Value Code(s) and Amounts

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

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

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

Common errors in Fields 39-41:

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

- Value codes are missing. Value codes A1, B1, C1 are deductibles. Value codes 09, 11, A2, B2 and C2 are coinsurance. Value codes A7, B7 and C7 are copay. Value code 06 is blood deductible.
- The member deductible is missing or does not match the EOMB (Explanation of Medicare Benefits). If there is a deductible amount indicated on the primary payer's remittance advice, the UB04 must include the member deductible (A1, B1 or C1 value code) and amount.

- The coinsurance amount is missing. If there is coinsurance on the primary payer's remittance advice, the UB04 must include the coinsurance amount (09, 11, A2, B2 or C2 value code).
- The copay amount is missing. If there is copayment on the primary payer's remittance advice, the UB04 must include the copay amount (A7, B7, or C7 value code).
- Blood deductible is not noted. If there is blood deductible on the payer's remittance advice, the value code 06 must be on the Claim, along with the amount.
- There are errors in listing multiple value codes. If more than one value code is submitted on lines a – d, please fill in fields 39a, 40a or 41a before populating 39b, 40b, or 41b.
- The value code and remittance advice amounts are different. In all cases, the value code and remittance advice amounts must match.

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

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

Field 44: HCPCS/Accommodation Rates/HIPPS Rate Codes

Field 45: Service Date

Field 46: Service Units

Field 47: Total Charges

Field 56: Providers National Provider Identification number (NPI)

Field 58: Insured's Name

Field 59: Patient's Relationship

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

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

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

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

Field 74: Principal Procedure Code and Date

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

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

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

1. Select Application > Choose **Medical Attachments Registration**
 2. Provider Management > Select **Organization** from the drop-down.
 - Add NPIs and/or Tax IDs.
 - Multiples can be added separated by spaces or semi-colons.
 3. Assign user access by checking the box in front of the user's name. Users may be removed by unchecking their name.
- To use the *solicited* Medical Attachments tool, Availity users should complete the following steps:
 1. Log in to www.availity.com.
 2. Select **Claims and Payments > Medical Attachments > Send Attachment** tab.
 3. Complete all required fields on the form.
 4. Attach supporting documentation.

Unsolicited Medical Records Submission

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

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

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

Types of Medical Records Required

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

1. History & Physical, Office Notes, Treatment Records & Response
2. Chemotherapy Regimens, Chemotherapy Drugs, and Records
3. Medications List (current and prior)
4. Radiology, Diagnostic Imaging, or Diagnostic Testing Reports

5. Therapy/Rehabilitation Records
6. Laboratory reports, Pathology reports
7. Exact description of NOC/NOS code
8. Operative/Procedure Report
9. Inpatient Admission Summary, Daily Records, Discharge Summary

Anthem May Request Additional Records

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

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

HIPAA Privacy Rule – Minimum Necessary

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

Electronic Data Exchange (EDI) Overview

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

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

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

Electronic Funds Transfer (“EFT”)

Providers or Facilities seeking to register or manage account changes for EFT will need to use the Council for Affordable Quality Health Care (CAQH) Enrollment Tool called [EnrollHub](#) (at <https://solutions.caqh.org/>), a

secure electronic EFT registration platform. This tool will help eliminate the need for paper registration and reduce administrative time and costs and allow you to register with multiple payers at one time.

Electronic Remittance Advice (“ERA”)

Effective June 1, 2018, Providers and Facilities must use Availity to manage all account changes and new registrations for ERA transactions.

Additional Information

For additional information concerning electronic Claims submission and other electronic transactions, you can click the Electronic Data Interchange (EDI) website at www.anthem.com/edi > [Indiana](#) or [Select Here](#)

Overpayments

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

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

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

Anthem Identified Overpayment (aka “Solicited”)

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

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

As indicated in the Anthem refund request letter and in accordance with provider contractual language, provider overpayment refunds not received and applied within the timeframe indicated will result in Claim recoupment from any Claim Provider or Facility submits to Anthem.

Providers and Facilities may direct disputes of amounts indicated on an Anthem refund request letter to the address indicated on the letter.

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

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

- Submit a refund check with supporting documentation outlined below, or
- Submit the **Provider Inquiry/Refund /Adjustment Form** with supporting documentation to have claim adjustment/recoupment done off a future remittance advice

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

- **Provider Inquiry/Refund /Adjustment Form (see directions below for how to access online))**

- All documents supporting the overpayment including EOBs from Anthem and other carriers as appropriate
- Member ID number
- Member's name
- Claim number
- Date of service
- Reason for the refund as indicated in the list above of common overpayment reasons

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

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

How to access the Provider Inquiry/Refund /Adjustment Form online:

To download the Provider Adjustment Form: **anthem.com > Menu > Providers > Indiana > Answers@Anthem > Provider Forms > Provider Adjustment Request Form**. Providers can also reference the Links section of the manual for the direct link information.

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

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

Medicare Crossover

Duplicate Claims Handling for Medicare Crossover

Since January 1, 2006, all Blue Plans have been required to process Medicare crossover Claims for services covered under Medigap and Medicare Supplemental products through Centers for Medicare & Medicaid Services (CMS). This has resulted in automatic submission of Medicare Claims to the Blue secondary payer to eliminate the need for Provider or Facilities or his/her/its billing service to submit an additional Claim to the secondary carrier. Additionally, this has also allowed Medicare crossover Claims to be processed in the same manner nationwide.

Effective October 13, 2013 when a Medicare Claim has crossed over, Providers and Facilities are to wait 30 calendar days from the Medicare remittance date before submitting the Claim to the local Plan if the charges have still not been considered by the Member's Blue Plan.

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

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

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

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

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

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

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

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

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

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

Effective October 13, 2013:

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

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

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

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

The GY modifier *should not* be used when submitting:

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

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

Medicare Crossover Claims FAQs

- **How do I handle traditional Medicare-related Claims?**
 - When Medicare is primary payer, submit Claims to your local Medicare intermediary.
 - All Blue Claims are set up to automatically cross over (or forward) to the Member's Blue Plan after being adjudicated by the Medicare intermediary.
- **How do I submit Medicare primary / Blue Plan secondary Claims?**
 - For Members with Medicare primary coverage and Blue Plan secondary coverage, submit Claims to your Medicare intermediary and/or Medicare carrier.
 - When submitting the Claim, it is essential that you enter the correct Blue Plan name as the secondary carrier. This may be different from the local Blue Plan. Check the Member's ID card for additional verification.
 - Be certain to include the three-character prefix as part of the Member identification number. The Member's ID will include the three-character prefix in the first three positions. The three-character prefix is critical for confirming membership and coverage, and key to facilitating prompt payments.

When you receive the remittance advice from the Medicare intermediary, look to see if the Claim has been automatically forwarded (crossed over) to the Blue Plan:

- If the remittance advice indicates that the Claim was crossed over, Medicare has forwarded the Claim on your behalf to the appropriate Blue Plan and the Claim is in process. **DO NOT** resubmit that Claim to Anthem; duplicate Claims will result in processing and payment delays.
- If the remittance advice indicates that the Claim was not crossed over, submit the Claim to your local Anthem Plan with the Medicare remittance advice.
- In some cases, the Member identification card may contain a COBA ID number. If so, be certain to include that number on your Claim.
- For Claim status inquiries, please contact your local Anthem Plan.
- **Who do I contact with Claims questions?**
 - Your local Anthem Plan.
- **How do I handle calls from Members and others with Claims questions?**
 - If Members contact you, tell them to contact their Blue Plan. Refer them to the front or back of their ID card for a customer service number.
 - A Member's Blue Plan should not contact you directly, unless you filed a paper Claim directly with that Blue Plan. If the Member's Blue Plan contacts you to send another copy of the Member's Claim, refer the Blue Plan to your local Anthem Plan.
- **Where can I find more information?**

For more information:

 - Visit Anthem's Web site at www.anthem.com.
 - Please contact your local Anthem Plan.

Claim Payment Disputes

[Provider and Facility Claim Payment Dispute Process](#)

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

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

- **Claim Inquiry:** A question about a Claim or Claim payment is called an inquiry. Claim Inquiries do not result in changes to Claim payments, but the outcome of the Claim Inquiry may result in the initiation of the Claim Payment Dispute. In other words, once the Provider or Facility receives the answer to the Claim Inquiry, the Provider or Facility may opt to begin the Claim Payment Dispute process. Providers and Facilities can send a Secure Message through the Availity Portal, or call the

Provider Services number on the back of the Member ID Card and select the *Claims* prompt. Please reference the *Availity Portal* section for further details on Secure Messaging.

- **Claim Correspondence:** Claim Correspondence is when Anthem requires more information to finalize a Claim. Typically, Anthem makes the request for this information through the Explanation of Payment (“EOP”) The Claim or part of the Claim maybe denied, but it is only because more information is required to process the Claim. Once the information is received, Anthem will use it to finalize the Claim.
- **Clinical / Medical Necessity Appeals:** An appeal regarding a clinical decision denial, such as an authorization or Claim that has been denied as not medically necessary, experimental/investigational. For more information on Clinical / Medical Necessity Appeals, please refer to the *Clinical Appeals* section within the Provider Manual.

Please reference the *Claims Submission Filing Tips* section for additional information.

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

1. **Claim Payment Reconsideration:** This is the first step in the Anthem Claim Payment Dispute process. The Claim Payment Reconsideration represents the Provider or Facilities initial request for an investigation into the outcome of the Claim. Most issues are resolved at the Claim Payment Reconsideration step.
2. **Claim Payment Appeal:** This is the second step in the Anthem Claim Payment Dispute process. If you disagree with the outcome of the Claim Payment Reconsideration, Providers or Facilities may request an additional review as a Claim Payment Appeal.

A Claim Payment Dispute may be submitted for multiple reason(s), including:

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

* Anthem will consider reimbursement of a Claim that has been denied due to failure to meet timely filing if the Provider or Facility can: 1) provide documentation the Claim was submitted within the timely filing requirements or 2) demonstrate good cause exists.

[Claim Payment Reconsideration](#)

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

Anthem accepts Claim Payment Reconsideration requests in writing, within 180 days (or according to the Agreement) from the date on the EOP (see below for further details on how to submit). Claim Payment Reconsiderations filed beyond this timeframe will be considered untimely and denied unless good cause can be established.

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.

Anthem will send the Provider or Facility the decision in a determination letter, which will include:

- A statement of the Provider or Facility's Reconsideration request.
- A statement of what action Anthem intends to take or has taken.
- The reason for the action.
- Support for the action, including applicable statutes, regulations, policies, Claims, codes or Provider Manual references.
- An explanation on how to request a Claim Payment Appeal within 30 calendar days of the date of the Reconsideration determination letter.
- Options and instructions for how to submit a Claim Payment Appeal.

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

[Claim Payment Appeal](#)

If a Provider or Facility is dissatisfied with the outcome of a Claim Payment Reconsideration determination, Providers or Facilities may submit a Claim Payment Appeal. Please note, Anthem cannot process a Claim Payment Appeal without a Claim Payment Reconsideration on file.

Anthem accepts Claim Payment Appeals in writing within 30 calendar days of the Claim Payment Reconsideration determination or according to the Agreement.

Claim Payment Appeals received beyond this timeframe will be considered untimely and upheld unless good cause can be established.

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.

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

Anthem will send the Provider or Facility the decision in a determination letter, which will include:

- A statement of the Provider or Facility's Claim Payment Appeal request.
- A statement of what action Anthem intends to take or has taken.
- The reason for the action.
- Support for the action, including applicable statutes, regulations, policies, Claims, codes or provider manual references.

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

[Required Documentation for Claims Payment Disputes](#)

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

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

[How to Submit a Claim Payment Dispute](#)

- Mail all required documentation including the *Provider Adjustment Form*, to:

Anthem Blue Cross and Blue Shield
P.O. Box 105557
Atlanta, GA 30348-5557
Or
Fax: 1-800-376-0247

- The Provider Adjustment Form can be found at: www.anthem.com > Providers > Find Resources for your State > Indiana > Answers @Anthem > Provider Adjustment Form or [Select Here](#).

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

Clinical Appeals

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

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

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

[Clinical Appeals](#)

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

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

[Guidelines and Timeframes for Submitting Clinical Appeals](#)

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

- All standard post-service clinical appeals will be resolved within a reasonable period of time appropriate to the medical circumstances, but not later than sixty (60) calendar days from the receipt of the appeal request by Anthem.
- For clinical appeals, there are two (2) types of review : expedited and standard.
 - *Expedited Appeal:* Anthem offers an expedited appeal for decisions meeting the expedited criteria. Please note: Requests to handle a review as “expedited” are always handled as a Member appeal. Both standard and expedited appeals are reviewed by a person who did not make the initial decision. Unless the Member, on his or her own behalf, or another Provider or Facility has already filed an expedited appeal on the service at issue in the appeal, a Provider or Facility that requests an expedited appeal will be deemed to be the Member’s designated representative for the limited purpose of filing the expedited appeal. As a result, the expedited appeal will be handled pursuant to the Anthem Member Appeal Procedures exclusively.
 - *Standard Appeal:* A standard appeal is available following the reconsideration, or initially, if it is formally requested.
- UM decisions are communicated in writing to the Provider or Facility and Member. These letters provide details on appeal rights and the address to use when sending additional information.

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

- Appeals should be submitted to Anthem, along with a copy of our response to the original complaint. Send the appeal request to:

Anthem Blue Cross and Blue Shield
 Attention: Grievances and Appeals
 P.O. Box 105568
 Atlanta GA 30348-5568

[BlueCard® Members](#)

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

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

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

Overview

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

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

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

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

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

Corrective Action Plans ("CAP")

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

Reporting

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

Severity Levels for Quality Assurance

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.
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 Policies and Procedures

This section includes reimbursement guidelines and policies on how Anthem will reimburse Providers and Facilities for certain services. Additional Professional and Facility Reimbursement Policies are published on anthem.com be sure to check both places. Anthem reserves the right to review and revise policies when necessary.

Anthem's public provider website is your source for reimbursement policies. **Go to anthem.com > Providers > Find Resources for Your State > Indiana > Answers@Anthem > Reimbursement Policies-Professional** or [Select Here](#) or **Reimbursement Policies-Facility** or [Select Here](#). You can also access the policies via the Availity Portal. If you are a registered Availity user, **log into Availity > Payer Spaces with Anthem as the Payer > Education and Reference Center > Reimbursement Policies-Facility or Reimbursement Policies-Professional.**

If you do not have an Availity user ID and Password, contact your organization's Availity Access Administrator. If your organization is not registered for Availity, go to www.availity.com and select the link to register.

Blood, Blood Products, Processing, Storage and Administration

Blood and blood products such as platelets or plasma are reimbursable. Blood product processing fees (typing, serology and cross-matching and blood storage) are also reimbursable. However, transportation charges are included in the reimbursement for the product itself and are not separately reimbursable. Blood and blood product administration services are reimbursable only on an outpatient basis when billed hourly or as a flat rate with total eligible Charges capped at the average approved semi-private room rate less discount, as submitted to Anthem. Blood and blood product administration services are not reimbursable on inpatient claims.

Changes During Admission

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

CHANGE	EFFECTIVE DATE
Member's Insurance Coverage	Admission

CHANGE	EFFECTIVE DATE
Facility's Contracted Rate (other than DRG)	Admission
DRG Base Rate	Admission
DRG Grouper	Discharge
DRG Relative Weight	Discharge

DRG Grouper Version / DRG Relative Weight changes can occur any time after October 1st each year.

[Charge Master Data and Corresponding Rate Changes](#)

Hospitals will provide electronic submission of data to Anthem for evaluation of charge masters annually, and as requested by us, and thirty (30) days prior to the effective date of any charge master rate changes. This includes room rate changes.

This data should be in a format acceptable to Anthem. Data elements included in electronic submission should be CPT/HCPCS/Revenue Codes, procedure and service description codes, charge number, current price, previous price, departmental code, effective date and facility tax ID. These fields are not to be considered all-inclusive. After review of charge master data the hospital will work with us for any follow up evaluation and refunding of payment, if applicable.

Anthem's review and analysis of the Hospital's charge master rate changes will include rounding of price changes to the nearest whole dollar, e.g., \$0.01 to \$0.49 will be rounded down to the nearest dollar and \$0.50 to \$0.99 will be rounded up to the nearest dollar.

[Clinic Charges / Treatment Room](#)

Professional Providers

When a Professional Provider performs a service that is considered by the Plan to be an office-based service (e.g., office visit, outpatient consultation, professional interpretation and report) in any setting, including an office-based setting located within a facility, a facility campus, facility affiliate, or facility or facility affiliate-owned site, division, or other location (e.g., clinic, treatment room and courtesy room), he/she must submit a CMS-1500 claim form or the electronic equivalent 837p for the office-based service. In such cases, the office-based service fee and the office-based overhead (e.g., practice expense) are included in the professional provider health care service Anthem Rate.

Facility and Other Facility

When a Professional Provider performs a service that is considered by the Plan to be an office-based service (e.g., office visit, outpatient consultation, professional interpretation and report) in any setting, including an office-based setting located within a facility, a facility campus, facility affiliate, or facility or facility affiliate-owned site, division, or other location (e.g., clinic, treatment room and courtesy room), the facility is not eligible to receive reimbursement for any component of the professional provider office-based services (e.g., room charge) or any item or service included in the payment to the professional provider. If a UB04 claim form or the electronic equivalent 837i is received from the facility for the office-based services, reimbursement will not be made to the facility. The facility is eligible to receive reimbursement for any covered ancillary service (e.g., laboratory test, radiologic study) related to the office visit or consultation according to their contract.

[Consultations](#)

When a Professional Provider (e.g., physician specialist) completes an initial outpatient consultation in his/her office or clinic that is located within any setting, including facility or on a facility campus, the reimbursement to the Professional Provider for the consultation includes payment for the consultation services **and** costs associated with office-based service fee and overhead. The facility is not eligible to receive reimbursement for a facility component for the outpatient consultation performed by the consulting Professional Health Care

Provider because payment to the Professional Provider includes the office-based service fee and overhead (e.g. practice expense).

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 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.

Coordination of Benefits/Subrogation

When payment for Covered Services is subject to either coordination of benefits or subrogation between two (2) or more sources of payment and Anthem is not the primary source, payment shall be based upon the Anthem Rate for the applicable network/program in which the Member participates, reduced by the amount paid for the Covered Services by other source(s). Providers and Facilities agree to accept such amount as payment in full for the Covered Services and shall not balance bill the Member. Notwithstanding the foregoing, this provision shall not be construed to require Provider or Facility to waive Cost Shares in contravention of any Medicare rule or regulation, nor shall this provision be construed to supersede any other Medicare rule or regulation.

To the extent permitted by law, Plan may, under third party liability, third party recovery, or similar provisions of Health Benefit Plans, service agreements, certificates or other documents setting forth terms and conditions of health coverage, become entitled to refunds of benefit amounts paid by Plan. However, the right of Plan to such a refund will not, in any case, affect or increase the maximum compensation to which Provider or Facility is entitled under the Agreement for any services that are, or in the absence of Plan's right to such refund would be, Covered Services.

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, which could otherwise be provided in an office setting.

Daily Supply or One Time Charge Fees/Items

Supply fees billed daily or one time, which are unidentified and unsupported by medical records or documentation are not reimbursable. Examples of daily supplies include those commonly used services and supplies provided in relatively equal quantities to all patients in similar circumstances, including but not limited to: wound care supplies/equipment, dressings, tape, wound care vac, wound vac sponges, test strips for POC bedside testing, specialty beds, rented equipment. It also includes those inexpensive supplies and medications for which it is uneconomical to account separately.

Different Settings Charges

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

Eligibility and Payment

A verification of eligibility is not a guarantee of payment.

Emergency Room Supply and Service Charges

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

Facility Personnel Charges

Charges for Inpatient Services for Facility personnel are not separately reimbursable and the reimbursement for such is included in the room and board rate. Examples include, but are not limited to, lactation consultants, dietary consultants, overtime charges, transport fees, nursing functions (including IV or PIOC line insertion at bedside), professional therapy functions, including Physical, Occupational, and Speech (typically billed in Revenue Codes 976, 977, 978 and 979), call back charges, nursing increments, therapy increments, and bedside respiratory and pulmonary function services (typically billed in Revenue Codes 410-419, 460 and 469). Outpatient Services for Facility personnel are also not separately reimbursable. Reimbursement is included in the reimbursement for the procedure or observation charge.

General Industry Standard Language

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

Implants

Implants are objects or materials which are implanted such as a piece of tissue, a tooth, a pellet of medicine, a medical device, a tube, a graft, or an insert placed into a surgically or naturally formed cavity of the human body to continuously assist, restore or replace the function of an organ system or structure of the human body throughout its useful life. Implants include, but are not limited to: stents, artificial joints, shunts, pins, plates, screws, anchors and radioactive seeds, in addition to non-soluble, or solid plastic materials used to augment tissues or to fill in areas traumatically or surgically removed. Instruments that are designed to be removed or discarded during the same operative session during which they are placed in the body are not implants. In addition to meeting the above criteria, implants must also remain in the Member's body upon discharge from the inpatient stay or outpatient procedure for a period of six (6) months or longer. Staples, sutures, clips, as well as temporary drains, tubes, similar temporary medical devices and supplies shall not be considered implants.

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

Anthem also requires an itemization of all implant kits that contain procedure tools or medical supplies. If an implant is supplied during the inpatient stay or outpatient procedure as part of a kit, then the implant will be the only component of the kit that shall be reimbursed by Anthem.

Instrument Trays

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

Interim Bill Claims

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

IV Sedation and Local Anesthesia

Administered by the provider performing the procedure, and/or nursing personnel, is not separately reimbursable and is included as part of the OR time/procedure reimbursement.

Lab Charges

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

Labor Care Charges

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

Medical Care Provided to or by Family Members

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

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.

Non-Participating Provider Claims Payment Policy

Anthem has established Maximum Allowed Amounts for services rendered by non-participating providers. Once Anthem determines the appropriate Maximum Allowed Amount for services provided by a non-participating provider, the payment will be remitted to the Member in most situations and not the non-participating provider.

Nursing Procedures

Anthem will not separately reimburse fees associated with nursing procedures or services or monitoring 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 testing, blood count, arterial blood gas, clotting time, etc.), monitors (such as glucose meter, vital sign monitor, cardiac monitor, spirometer, oximeter, etc.), and inpatient blood transfusion administration/monitoring (with the exception of OP blood administration or OP chemotherapy administration which are submitted without observation/treatment room charges.)

Observation Services Policy

Description

Anthem considers outpatient observation services to mean active, short-term medical and/or nursing services performed by an acute facility on that facility's premises that includes the use of a bed and monitoring by that acute facility's nursing or other staff and are required to observe a patient's condition to determine if the patient requires an inpatient admission to the facility. Observation services include services provided to a patient designated as "observation status", and in general, shall not exceed 24 hours. Observation services may be

considered eligible for reimbursement when rendered to patients who meet one or more of the following criteria:

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

Policy

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

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

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

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

Operating Room Time and Procedure Charges

The operating room ("O.R.") 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 O.R. 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 charge will reflect the cost of:

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

tubing, connectors, trocars, drill bits, clips, catheters, cords, batteries, sheathes, guide/glide wires, balloons, introducers, dilators, needles, pumps, arterial line, irrigation fluids, closure devices, staplers/staples all types, anesthesia supplies (i.e. mask, stylet, ET tubes, blades, oxi-sensor, circuit breathing, circuit adult/peds, gases, oxygen) this list is not all inclusive.

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

Examples of charges that are not eligible for separate or additional reimbursement are listed below, but not limited to:

- 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, not limited to S2900
- Supplies billed related to the use of robotic technology

Separate charges are allowed for specialized packs, which are necessitated by the procedure not by physician preference, such as those used for open heart, eye and scope surgeries, packs for extensive plastic repair and complex post-op dressing or specialized equipment such as hip pins, bone nails, bone plates, and tantalum mesh. This includes the cost of preparing, storing and handling such supplies. These charges will be subject to medical review with supporting documentation.

Other Agreements

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

Personal Care Items

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

Pharmacy Charges

Pharmacy charges will include the cost of the drugs prescribed by the attending physician. Medications furnished to patients shall not include an additional separate charge for administration of drugs, the cost of materials necessary for the preparation and administration of drugs, and the services rendered by registered pharmacists and other pharmacy personnel. Anthem will reimburse based on 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.

Place of Service and Evaluation & Management Facility Reimbursement Policy

Description

This provision describes Anthem's policy regarding facility reimbursement for services provided outside of the primary structure on the campus of a hospital or institutional provider and for Evaluation & Management (E&M) services provided within the primary structure on the campus of a hospital or institutional provider.

The primary structure on the campus of a hospital or an institutional provider is the physical site location where there are state licensed inpatient beds and/or a state licensed emergency room or emergency department, as well as provision of 24 hours per day seven days a week on site continuous physician and nursing services for diagnosis and treatment of patients.

E&M services are defined as professional services rendered by a physician or other qualified health care professional for the prevention or diagnosis and treatment of illness or injury and the promotion of optimal health. E&M services typically include development of medical history, physical examination, medical decision making or counseling and coordination of care.

Policy

- Services that are rendered in an office, professional building, medical office building, clinic or a space owned by a hospital or an institutional provider, other than the primary structure on the campus of the hospital or institutional provider, or rented by a professional from the hospital or an institutional provider, must be billed on a CMS-1500 claim form and are not reimbursable if they are billed on a UB-04 claim form.
- Anthem shall not separately reimburse a clinic fee or any other facility fee associated with space used to provide E&M services in the event they are billed on a UB-04 claim form.
- Anthem does not reimburse for professional E&M charges billed on a UB-04 claim form regardless of where services are rendered; reimbursement for these charges are included in the professional fee allowance.
- All professional services including, but not limited to, those rendered by hospital-based physicians such as emergency room physicians, radiologists, anesthesiologists, hospitalists, independent practitioners, physical therapists, occupational therapists, speech therapists, and Certified Registered Nurse Anesthetists (CRNA) must be billed on a CMS-1500 claim form using the appropriate CPT[®]/HCPCS codes.
- Services rendered outside of the primary structure on the campus of a hospital or an institutional provider shall not be billed or reimbursed on a UB-04 claim form. The Member is not responsible for these charges. Examples of Revenue Codes under which such services shall not be billed or reimbursed include, but are not limited to, the following groupings:

0280 – 0289 Oncology Clinic
0300 – 0309 Laboratory
0300 – 0319 Laboratory Pathological
0320 – 0329 Radiology Diagnostic
0330 – 0339 Radiology – Therapeutic and/or Chemotherapy Administration
0340 – 0349 Nuclear Medicine
0350 – 0359 CT Scan
0420 – 0429 Physical Therapy
0430 – 0439 Occupational Therapy
0440 – 0449 Speech Therapy
0481 – 0489 Cardiology Clinic
0510 – 0519 Clinic
0520 – 0529 Free Standing Clinic
0530 – 0539 Osteopathic Services
0540 – 0549 Ambulance
0610 – 0619 Magnetic Resonance Technology
0630 – 0637 Pharmacy
0740 – 0749 Sleep Study
0760 – 0769 Treatment or Observation Room
0770 – 0779 Preventive Care Codes
0780 – 0789 Telemedicine
0960 – 0989 Professional Fees

- Professional E&M services shall not be billed or reimbursed on a UB-04 Claim form. The Member is not responsible for these charges.

Portable Charges

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

Pre-Operative Care or Holding Room Charges

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

Preparation (Set-Up) Charges

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

Preventable Adverse Events ("PAE") Policy

Acute Care General Hospitals (Inpatient)

Three (3) Major Surgical Never Events

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

Whenever any of the events described in the grid below occur with respect to a Member, acute care general hospital is encouraged to report the PAE to the appropriate state agency, The Joint Commission ("TJC"), or a patient safety organization ("PSO") certified and listed by the Agency for Healthcare Research and Quality.

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

CMS Hospital Acquired Conditions ("HAC")

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

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

Providers and Facilities (excluding Inpatient Acute Care General Hospitals)

Four (4) Major Surgical Never Events

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

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

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

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.

Pursuant Provider's Agreement with Anthem, the Provider may not charge Anthem or the member for the cost of copies of medical records.

Psychiatric Outpatient/Residential Services

The billing requirements for psychiatric outpatient/residential services apply to each approved and medically necessary service date in a licensed psychiatric outpatient/residential program, and include payment for all services rendered during a psychiatric outpatient/residential visit including, but not limited to, facility use (that includes all nursing care), laboratory, radiology, supplies, equipment, pharmaceuticals, and all other services incidental to the outpatient/residential visit. A psychiatric outpatient/residential visit means a single service date.

Anthem recognizes the below Levels of Care. These levels differ in terms of the degree of services required, as defined by the combination of ICD-10 or successor diagnosis codes and revenue codes.

Level 1

Intensive outpatient structured program (e.g., evening care) and partial hospitalization (three to five (3 to 5) hours per day); Level 1 is the default, unless Level 2 is approved by utilization management.

Level 2

This includes partial hospitalization (six to eight (6-8) hours per day), residential care and outpatient electroconvulsive therapy. All Level 2 care requires Utilization Review approval/certification.

Special billing instructions and requirements:

1. ICD-10 diagnosis codes must be included for each care level.
2. Revenue Codes must be included for each care level. Appropriate Revenue Codes are 0901, 0911-0914, 0944 or 0945.
3. Utilization management must approve the level of care for all services. An authorization number is required for each Claim.
4. Each service date must be billed as a separate line item.

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 includes, 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.

Reimbursement Methodologies

If reimbursement methodologies are outlined differently in the Rate Sheet or Plan Compensation Schedule they will supersede those that are outlined below.

Case Rate Methodology

A Per Case Rate is an all-inclusive level of reimbursement for a specific inpatient or outpatient Covered Service, as specified by DRG, CPT/HCPCS/Revenue Code in the reimbursement section of the Anthem Agreement. Unless otherwise specified, no additional reimbursement shall be made for any covered service(s) submitted on the same Claim as a covered service reimbursed under Per Case Rate methodology.

Combination Emergency Room/Observation Services

The following provisions are applicable unless otherwise specified in your Agreement.

If a Member is admitted through the ER, OBS, or following SURG, Plan shall reimburse Facility according to the diagnosis and Anthem Rate associated with the Inpatient Services. Plan shall not reimburse Facility separately for the ER, OBS, and/or SURG.

If a Per Unit Rate, as set forth on the Rate Sheet, for such services as MRI, CT, or Mammogram, then such rate will be paid in addition to any other service or combination outlined below.

If ER, OBS and/or SURG services are provided during a single outpatient encounter and any such services are individually reimbursed as a Case Rate as specified in this PCS, Plan shall reimburse Facility as follows:

- ER/OBS: If a Case Rate has been negotiated for ER only, as set forth on the Rate Sheet, Plan shall reimburse Facility the ER Case Rate for the entire Claim.
- ER/OBS: If a Case Rate has been negotiated for OBS only, as set forth on the Rate Sheet, Plan shall reimburse Facility the OBS Case Rate for the entire Claim.

If a Case Rate has been negotiated for both ER and OBS, as set forth on the Rate Sheet, Plan shall reimburse Facility the highest Case Rate for the entire Claim.

- ER/SURG: If a Case Rate has been negotiated for surgery, as set forth on the Rate Sheet, Plan shall reimburse Facility the SURG Case Rate for the entire Claim.

For all other Claims, Plan shall reimburse Facility the surgery rate, as set forth on the Rate Sheet, for the entire Claim. There will be no additional reimbursement for other services, or as set forth on the Rate Sheet.

- SURG/OBS: If a Case Rate has been negotiated for surgery, as set forth on the Rate Sheet, Plan shall reimburse Facility the SURG Case Rate for the entire Claim.

For all other Claims, Plan shall reimburse Facility the surgery rate, as set forth on the Rate Sheet, for the entire Claim. There will be no additional reimbursement for other services, or as set forth on the Rate Sheet.

DRG Methodology

DRG means Diagnostic/Diagnosis Related Group as set forth by the CMS or other grouper as may be used by Anthem and updated as codes are updated.

DRG Rate means the all-inclusive dollar amount applied to the appropriate DRG Weight which results in the Anthem Rate, if the reimbursement methodology as shown on the PCS reimbursement schedule is on a DRG basis.

DRG Weight means the computed value assigned to each DRG using CMS cost weights.

For inpatient admissions on or after the Agreement effective date for which the total Facility charges for Covered Services is less than or equal to the DRG Outlier amount specified on the Reimbursement section of the Agreement, we will reimburse the DRG Rates specified in effect on the date of inpatient admission and specified on the reimbursement section of the Agreement multiplied by the weight for the assigned DRG in effect on the date of discharge, using the relative weights as established (and amended from time to time) by CMS.

For inpatient admissions on or after the Agreement effective date for which the total of Facility charges for Covered Services is greater than the DRG Outlier amount specified in the reimbursement section of the Agreement, we will reimburse the DRG Outlier Rate percentage as specified in the reimbursement section of the Agreement.

For inpatient admissions for Members who are transferred out of the hospital to another Facility for purposes of providing Inpatient Covered Services, we will reimburse the DRG Outlier Rate percentage as specified in the reimbursement section of the Agreement..

For those Facilities reimbursed on a methodology other than DRG, for Inpatient Services and Outpatient Services rendered on or after the Agreement effective date, the applicable Anthem Rate is pursuant to the reimbursement section of the Agreement. The Outlier Rate will not apply to services reimbursed in accordance with a methodology other than DRG, unless specifically identified in the reimbursement section of the Agreement. The Outlier Rate will not apply to coronary services Network services reimbursed on a Per Case Rate basis.

Fixed Outpatient Reimbursement Methodology

Fixed Outpatient Reimbursement methodology provides Anthem with the ability to reimburse outpatient Facility Claims utilizing the CPT/HCPCS Codes currently being reported on Claims. Revenue Codes will require a companion CPT/HCPCS Code when Facility's Agreement includes Fixed Outpatient Reimbursement.

Outlier Reimbursement

Paid in accordance with the reimbursement section of the Agreement, the Outlier Rate percentage will not apply to services reimbursed as a Per Diem Rate, Per Case Rate, or Percentage Rate, unless specifically identified in the Reimbursement section of the Agreement.

Outpatient Facility Fee Schedules

The Outpatient Facility Fee Schedule methodology provides Anthem with the ability to reimburse specified Outpatient Services based on a fee schedule utilizing the CPT/HCPCS Code.

Revenue Codes Requiring Additional Coded Service Identifiers

The following is a current listing of services and Revenue Codes that will require a CPT/HCPCS Code when the Facility's reimbursement section of the Agreement includes one or more Outpatient Facility Fee Schedules:

Service	Revenue Code(s)
Cardiology	48X, 73X
Drugs	25X, 63X
Lab	30X, 31X, 39X
PT/OT/Speech	42X, 43X, 44X
Radiology	32X, 333, 34X, 402

Claims that include specified CPT/HCPCS Code(s) will be reimbursed in accordance with the Anthem Rate in the reimbursement section of the Agreement unless such Claim includes a service reimbursed under a Case Rate methodology. Outpatient Facility Fee Schedule services provided in conjunction with a service reimbursed under Case Rate methodology are considered incidental to the Case Rate service and are not separately payable.

Other Outpatient Services

Anthem will reimburse other Outpatient Services not defined by fee schedule, Per Diem, Per Case, Per Visit or Per Unit at the other Outpatient Services percentage as specified in the reimbursement section of the Agreement.

Per Diem Rate

Per Diem Rate as specified in the reimbursement section of the Anthem Agreement is an all-inclusive fixed payment for each full day of covered services or one (1) outpatient encounter. A full day begins at midnight and ends twenty (24) hours later. The day of admission counts as a full day. The day of discharge, death, or

transfer is not counted as a full day. If admission and discharge, death or transfer occurs on the same day, the day is counted as one (1) inpatient full day.

Outpatient surgery reimbursed at a Per Diem Rate will apply multiple surgery logic.

Per Unit Rate

The flat rate payment made to a Participating Provider for all Covered Services rendered to a Covered Person for each unit of service performed within an Outpatient Service Category as indicated in the reimbursement section of the Agreement.

Per Visit Rate

Services reimbursed at a Per Visit Rate include but are not limited to physical therapy, occupational therapy, speech therapy, and respiratory therapy. A Per Visit Rate means a single date of service. Per Visit Rates include, but are not limited to: facility use, therapist/professional services, laboratory, radiology, supplies, equipment, pharmaceuticals, and other services incidental to the visit.

[Routine Supplies](#)

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

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

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

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

[Semi-Private Room Rate](#)

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

[Special Procedure Room Charge](#)

Special procedure room charges are included in the reimbursement of the procedure, defined as, but not limited to:

- Revenue Code 761 (treatment room)
- When billed with procedures such as dialysis or emergency department procedures, the fee for the treatment room (Rev Code 761) is not separately reimbursable.
- When billed in conjunction with a PICC line insertion.
- When billed in conjunction with a Procedure (CPT) in addition to Cast Room (Revenue Code 761), the Cast Room is not separately reimbursable
- When billed in conjunction with inserting a peripheral IV, the treatment room is not separately reimbursable

Stand-by Charges

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

Stat Charges

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

Submission of Claim/Encounter Data

Facilities and Providers will submit Claims and encounter data to Anthem on a CMS-1500, UB04 or subsequent form, in a manner consistent with industry standards and policies and procedures as approved by Anthem. Anthem will make best efforts to pay all complete and accurate Claims for Covered Services submitted by Facilities and Providers in accordance with the applicable state statute, exclusive of Claims that have been suspended due to the need for additional information including, but not limited to, information to determine medical necessity, coordination of benefits, subrogation or verification of coverage.

Supplies and Equipment

Charges for medical equipment, including but not limited to, IV pumps, PCA Pumps, and isolation carts and supplies are not separately reimbursable. Also, oxygen charges, including but not limited to, oxygen per minute, per hour and therapy, when billed with room types ICU/CCU 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 emergency room ("ER") and intensive care unit ("ICU") 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 Anthem Rate for Covered Services, and shall not be billed or paid separately. All Claims billed separately for these services must be accompanied with the appropriate ICD-10 codes.

Time Calculation

- Operating Room ("O.R.") – O.R. time should be calculated from the time the patient enters the room until the patient leaves the room, as documented on the O.R. nurse's notes.
- Anesthesia – Time charges should be calculated from the start and finish times as documented on the anesthesia record. Anesthesia materials may be charged individually as used or included in a charge based on time. A charge that is based on time will be computed from the induction of the anesthesia until surgery is complete. This charge will include the use of all monitoring equipment. Other types of anesthesia such as local, regional, and IV sedation, must be billed at an appropriate rate for the lower level of anesthesia services.
- Recovery Room – Time should be calculated from the time the patient enters the recovery room until the patient leaves the recovery room as documented on the post anesthesia care unit record.
- Post Recovery Room – Time charges should be calculated from the time the patient leaves the recovery room until discharge. Charges are not to exceed the approved average semi-private room and board rate, less discount, as submitted to Anthem.

Undocumented or Unsupported Charges

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

Video Equipment used in Operating Room

Charges for video equipment used in a surgery are included in the reimbursement for the procedure and are not separately reimbursable. Charges such as batteries, covers, film, anti-fogger solution, and tapes are not separately reimbursable. The use of technology to generate visual assistance in the operating room is part of the operation services and not separately reimbursable. Examples of technology used to generate visual assistance in the operating room which are not separately reimbursable would include, but are not limited to, Fluoroscopy, Ultrasound, and Computer Assisted Navigation.

Additional Reimbursement Guidelines for Disallowed Charges

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.

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 <ul style="list-style-type: none"> • Courtesy/Hospitality Room • Patient Convenience Items (0990) • Cafeteria, Guest Tray (0991) • Private Linen Service (0992) • Telephone, Telegraph (0993) • TV, Radio (0994) • Non-patient Room Rentals (0995) • Beauty Shop, Barber (0998) • Other Patient Convenience Items (0999)
0220	Special Charges
0369	Preoperative Care or Holding Room Charges
0760 – 0769	Special Procedure Room Charge
0111 – 0119	Private Room* (subject to Member's Benefit)
0221	Admission Charge
0480 – 0489	Percutaneous Transluminal Coronary Angioplasty (PTCA) Stand-by Charges
0220, 0949	Stat Charges
0270 – 0279, 0360	Video Equipment Used in Operating Room
0270, 0271, 0272	Supplies and Equipment <ul style="list-style-type: none"> • Blood Pressure cuffs/Stethoscopes • Thermometers, Temperature Probes, etc. • Pacing Cables/Wires/Probes • Pressure/Pump Transducers • Transducer Kits/Packs • SCD Sleeves/Compression Sleeves/Ted Hose; • Oximeter Sensors/Probes/Covers • Electrodes, Electrode Cables/Wires • Oral swabs/toothettes; • Wipes (baby, cleansing, etc.) • Bedpans/Urinals • Bed Scales/Alarms • Specialty Beds • Foley/Straight Catheters, Urometers/Leg Bags/Tubing • Specimen traps/containers/kits; • Tourniquets; • Syringes/Needles/Lancets/Butterflies

Facility Responsibility	
Typically Billed Under This/These Revenue Codes, but not Limited to the Revenue Codes Listed Below	Description of Excluded Items
	<ul style="list-style-type: none"> • 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 (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 <ul style="list-style-type: none"> • 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)
0229, 0760 – 0762, 0769, 0270, 410 – 413, 0419	Other Special Charges <ul style="list-style-type: none"> • Observations hours may never exceed the charge of a semiprivate room charge • Oxygen charges while a patient is on a ventilator

Facility Responsibility	
Typically Billed Under This/These Revenue Codes, but not Limited to the Revenue Codes Listed Below	Description of Excluded Items
	<ul style="list-style-type: none"> 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) <ul style="list-style-type: none"> Medication prep Nonspecific descriptions Anesthesia Gases – Billed in conjunction with Anesthesia Time Charges IV Solutions 250 cc or less Miscellaneous Descriptions Non-FDA Approved Medications
0256	Experimental Drugs
0270, 0300 – 0307, 0309, 0380 – 0387, 0390 – 0392	Venipuncture (CPT Code 36415, 36416 or G0001) <ul style="list-style-type: none"> Specimen collection Draw fees Phlebotomy Heel stick Blood storage and processing blood administration (Rev codes 0380, 0390 – 0392; 0399) Thawing/Pooling Fees
0222, 0270, 0272, 0410, 0460	Portable Charges
0270 – 0279, 0290, 0320, 0410, 0460	Supplies and Equipment

Facility Responsibility	
Typically Billed Under This/These Revenue Codes, but not Limited to the Revenue Codes Listed Below	Description of Excluded Items
	<ul style="list-style-type: none"> • Preparation (Set-up) Charges; Set-up is included in the fee for the procedure and, as such, included in the room and board • Oxygen (ICU/CCU/Progressive) O.R., ER and Recovery • Instrument Trays and/or Surgical Packs • Drills/Saws (All power equipment used in O.R.) • Drill Bits • Blades • IV pumps and PCA (Patient Controlled Analgesia) pumps • Isolation supplies • Daily Floor Supply Charges • X-ray Aprons/Shields • Blood Pressure Monitor • Beds/Mattress • Patient Lifts/Slings • Restraints • Transfer Belt • Bair Hugger Machine/Blankets • SCD Pumps • Heal/Elbow Protector • Burrs • Cardiac Monitor • EKG Electrodes • Vent Circuit • Suction Supplies for Vent Patient • Electrocautery Grounding Pad • Bovie Tips/Electrodes • Anesthesia Supplies When Billed with Anesthesia Time Charges • Anesthesia Circuit • Perfusion Supplies When Billed with Perfusionist Time Charge • Case Carts • C-Arm/Fluoroscopic Charge • Wound Vacuum Pump • Bovie/Electro Cautery Unit • Wall Suction • Retractors • Single Instruments • Oximeter Monitor • CPM Machines • Lasers • Davinic Machine/Robot

Facility Responsibility	
Typically Billed Under This/These Revenue Codes, but not Limited to the Revenue Codes Listed Below	Description of Excluded Items
0309 – 0369, 0419, 0619	After Hours – Call-back
0370 – 0379, 0410, 0460, 0480 – 0489	Anesthesia (Specifically, conscious/moderate sedation) <ul style="list-style-type: none"> • Nursing care • Monitoring • Intervention • Pre- or Post-evaluation and education • IV sedation and local anesthesia • Intubation/Extubation • CPR
410	Nursing/Respiratory Functions: <ul style="list-style-type: none"> • Oximetry (94760, 94761, 94762) • Oximetry reading by nurse or respiratory tech • Vent Management • Postural Drainage • Suctioning Procedure • Nursing/Respiratory care performed while patient is on vent
0480 – 0489	Percutaneous Transluminal Coronary Angioplasty (PTCA) stand-by charges
0940 – 0945	Education/Training
0270, 0272, 0300 – 0309	Bedside/Point of Care/Near Patient Testing (such as glucose, blood count, arterial blood gas, clotting time, glucose, etc.)

Member Responsibility	
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

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

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 policy position statements or clinical indications that are objective and based on clinical evidence for certain new medical services and/or procedures or for new uses of existing services and/or procedures. The services consisting of medical, surgical, and behavioral health treatments include, but are not limited to devices, biologics and specialty pharmaceuticals, and professional health services.

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

Additional details regarding the Medical Policy development process, including information about MPTAC and its Subcommittees, is provided in ADMIN.00001 Medical Policy Formation. [Select Here](#)

[Medical Policy and Clinical Utilization Management \("UM"\) Guidelines Distinction](#)

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

[Medical Policies and Clinical UM Guidelines are posted online at anthem.com](#)

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

To locate Medical Policy online: anthem.com > Providers > Policies and Guidelines > Indiana > View Medical Policies and UM Guidelines > either Medical Policy and Clinical UM Guidelines (for Local Plan members) or Medical Policy and Clinical UM Guidelines for (BlueCare/Out-of-area members) > Continue > chose either Medical Policies or UM Guidelines or:

- Medical Policy and Clinical UM Guidelines (for Local Plan members) or [Select Here](#)
- Medical Policy and Clinical UM Guidelines (for BlueCard/Out-of-area members) or [Select Here](#)

Clinical UM Guidelines for Local Plan members

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

To view the list of specific clinical UM guidelines adopted by Indiana navigate to the Disclaimer page by following the instructions above for Medical Policy and Clinical UM Guidelines (for Local Plan members); scroll to the bottom of the page. Above the "Continue" button, select the link titled "Specific Clinical UM Guidelines adopted by Anthem Blue Cross and Blue Shield of Indiana." [Select Here](#)

Utilization Management

Utilization Management Program

Providers and Facilities agree to abide by the following Utilization Management ("UM") Program requirements in accordance with the terms of the Agreement and the Member's Health Benefit Plan. Providers and Facilities agree to cooperate with Anthem in the development and implementation of action plans arising under these programs. Provider or Facility shall comply with all requests for medical information required to complete Anthem's UM review. Providers and Facilities agree to adhere to the following provisions and provide the information as outlined within this section.

UM Definitions

1. **Pre-service (Prospective) Review:** Review for Medical Necessity that is conducted on a health care service or supply prior to its delivery to the Member.
2. **Continued Stay Review:** (continuation of services). Continued Stay Review means utilization review that is conducted during a Member's ongoing stay in a facility or course of treatment. Continued Stay Review includes continuation of services (Urgent Care & Extensions).
3. **Pre-certification/Pre-authorization Requirement:** List of procedures that require Pre-service Review by Anthem UM prior to service delivery. For Anthem UM team to perform Pre-service Review, the provider submits the pertinent information, as referenced below, as soon as possible to Anthem UM prior to service delivery.
 - Place of Service (ex, Inpatient, Outpatient)
 - Type of Service (ex. Medical, Surgical, Behavioral Health)

- Date of Service
 - Member Identification Number (with 3 character prefix if there is one)
 - Member Name and Member's Date of Birth
 - Level of Service (ex. Elective, Urgent, Emergent)
 - Diagnosis
 - HCPCS or CPT Codes for scheduled Procedure
 - Name and address of Provider and NPI
 - Name and address of Facility and NPI
 - Clinical information to support the request
4. **Business Day:** Monday through Friday, excluding designated company holidays.
5. **Notification:** The telephonic and/or written/electronic communication to the applicable Providers, Facility and the Member documenting the determination, and informing the Member, Providers, and Facility of their rights if they disagree with the determination.
6. **Adverse Determination:** means a denial, reduction or failure to make payment (in whole or in part) for a benefit based on a determination that a benefit is experimental, investigational, or not medically necessary or appropriate as defined in the applicable health benefit plan. This may apply to prospective, continued stay, and retrospective reviews.
7. **Post Service (Retrospective) review:** means a utilization review that is conducted after the health care service (or supply) has been provided to the Member.
8. **Urgent Care Review:** means review of health care services which in the opinion of the treating Provider or any health care provider with knowledge of the Member's medical condition or based on a prudent layperson's judgment which, in the absence of urgent care review time frames could:
- Seriously jeopardize the life or health of the Member or the ability of the Member to regain maximum function or;
 - Would subject the Member to severe pain that cannot be adequately managed without the health care service or treatment that is the subject of the request.

Program Overview

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

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

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

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

UM may be conducted via multiple communication paths. See "Electronic Submission Required" below for more information.

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

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

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

UM for behavioral health inpatient and non-inpatient services, including but not limited to Residential, Partial Hospitalization and intensive outpatient services, require Pre-Service Review or Continued Stay Review.

[Electronic Submission Required](#)

In 2018, the Indiana legislature passed House Bill 1143 related to prior authorizations for health care services. The final requirement of the legislation is effective January 1, 2020, and requires health care providers to submit and health plans to accept requests for most prior authorization requests through secure electronic transmission.

To learn more about this law, please visit the Indiana Legislature website and view [Indiana House Bill 1143](#) and the final statute – [Request for prior authorization; electronic transmission; standardized form \(IC 27-1-37.5-10\)](#).

Anthem has multiple secure electronic transmission portals available for providers to submit prior authorization requests depending on the type of health service being provided. See “Electronic Data Exchange” below for more information.

[Pre-service Review & Continued Stay Review](#)

- A. Provider or Facility shall ensure both requirements (1) and (2) are met: (1) that non-emergency admissions and outpatient procedures that require Pre-certification/Pre-authorization as specified by Anthem are submitted for review and have a decision rendered before the service occurs. Information provided to Anthem UM shall include demographic and clinical information including, but not limited to, primary diagnosis. For information on applicable penalties for non-compliance see Failure to Comply with Utilization Management Program section. (2) For non-emergency admissions, Provider or Facility shall also provide confirmation to Anthem UM of the necessary demographic information and primary diagnosis within twenty-four (24) hours or next Business Day following the Member's admission.
- B. If an Emergency admission has occurred, Provider or Facility shall notify Anthem UM within forty-eight (48) hours or the first Business Day following admission. If the forty-eight (48) hours expires on a day that is not a Business Day the timeframe will be extended to include the next Business Day. Information provided to Anthem UM shall include demographic and clinical information including, but not limited to, primary diagnosis. For information on applicable penalties for non-compliance see Failure to Comply with Utilization Management Program section.
- C. Provider or Facility shall verify that the Member's primary care physician has provided a referral as required by certain Health Benefit Plans.
- D. Provider or Facility shall comply with all requests for medical information required to complete Anthem's UM review up to and including discharge planning coordination. To facilitate the review process, Provider or Facility shall make best efforts to supply requested information within twenty-four (24) hours of request.
- E. Anthem specific Pre-certification/Pre-authorization Requirements may be confirmed on the Anthem web site or by contacting customer service.

- F. When the review is completed, the physician, hospital, facility, or other health care professional(s) and the Member receive notification of the UM determination.

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

[Medical Policies and Clinical UM Guidelines](#)

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

[On-Site Review](#)

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

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

Certain services may be excluded from on-site review including but not limited to Transplant.

[Discharge Planning](#)

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

[Observation Bed Policy](#)

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

[Retrospective Utilization Management](#)

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

[Failure to Comply With Utilization Management Program](#)

Provider and Facility acknowledge that Anthem may apply monetary penalties such as a reduction in payment, as a result of Provider's or Facility's failure to provide notice of admission or obtain Pre-service Review on specified outpatient procedures, as required under this Agreement or for Provider's or Facility's failure to fully comply with and participate in any cost management programs and/or UM programs. Members may not be balance billed for penalty amounts. Penalties include but are not limited to the following:

If non-emergency admissions and outpatient procedures that require Pre-certification/Pre-authorization as specified by Anthem are not submitted for review and a decision rendered before the service occurs

payment will be subject to a 50% penalty. Providers and Facilities must present evidence of extenuating circumstances in the event that a provider or facility elects to dispute these reimbursement penalties.

Payment for emergency inpatient admissions will be subject to a 50% penalty if the notification is not provided within forty-eight (48) hours of admission. If the forty-eight (48) hours expires on a day that is not a Business Day the time frame will be extended to include the next Business Day. Providers and Facilities must present evidence of extenuating circumstances in the event that a provider or facility elects to dispute these reimbursement penalties.

Utilization Statistics Information

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

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

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

Electronic Data Exchange

Facility will support Anthem by providing electronic data exchange including, but not limited to, ADT (Admissions, Discharge and Transfer), daily census, confirmed discharge date and other relevant clinical data. Anthem's **Interactive Care Reviewer (ICR)** is an online tool and the preferred method for the submission of pre-authorization requests offering a streamlined and efficient experience for providers requesting inpatient and outpatient medical or behavioral health services for Members covered by Anthem plans. Additionally, providers can use this tool to make inquiries on previously submitted requests regardless of how they were sent (phone, fax, ICR or other online tool).

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

Please visit our ICR Help Page on anthem.com to access on demand training demos and to sign up for monthly live training webinars.

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

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

- FEP Members
- Non Anthem BlueCard®

- Some National Account Members
- Transplant services

Services administered by vendors such as AIM Specialty Health® and OrthoNet LLC. (For these requests, follow the same precertification process that you use today)

Peer to Peer Review Process

Upon the provider's request, from an attending physician or treating provider, Anthem provides a clinical peer-to-peer conversation when an adverse medical necessity determination will be made or has been made regarding health care services for Members. The attending physician or treating provider may offer additional information and/or further discuss his/her cases with a physician or other appropriate reviewer. In compliance with accreditation standards, a provider or his/her designee may request the peer-to-peer review. Others such as hospital representatives, employers and vendors are not permitted to do so.

Quality of Care Incident

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

Audits/Records Requests

At any time Anthem may request on-site, electronic or hard copy medical records, utilization review sheets 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 is a voluntary Member Health Benefit Plan management program designed to support the use of cost effective alternatives to inpatient treatment, such as home health or skilled nursing facility care, while maintaining or improving the quality of care delivered. The nurse case manager in Anthem's case management program works with the treating physician(s), the Member and/or the Member's Authorized Representative, and appropriate Facility personnel to both identify candidates for case management, and to help coordinate benefits for appropriate alternative treatment settings. The program requires the consent and cooperation of the Member or Member's Authorized Representative, as well as collaboration with the treating physicians.

A Member (or Member's Authorized Representative) may self-refer or a Provider or Facility may refer a Member to Anthem's Case Management program by calling the Customer Service number on the back of the member's ID card

AIM Specialty Health® (AIM)

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

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

- Radiology: www.aimprovider.com/radiology
- Cardiology: www.aimprovider.com/cardiology

- Medical Oncology: www.cancerqualityprogram.com
- Radiation Oncology: www.aimprovider.com/radoncology
- Genetic Testing: www.aimprovider.com/geneticstesting
- Sleep: www.aimspecialtyhealth.com/gowebsleep
- Specialty Drugs: www.aimprovider.com/specialtyrx
- Musculoskeletal: www.aimprovider.com/msk
- Surgical Procedures: www.aimproviders.com/surgicalprocedures
- Rehabilitation: www.aimproviders.com/rehabilitation

[Submit Pre-certification/Pre-authorization requests to AIM](#)

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

- Access AIM **ProviderPortal**SM directly at providerportal.com. Online access is available 24/7 to process orders in real-time, and is the fastest and most convenient way to request authorization.
- Access AIM via the Availity Portal at availity.com
- Call the AIM Contact Center toll-free number: 800-554-0580, Monday-Friday, 8:30 a.m. – 7:00 p.m. ET.

[OptiNet® Registration](#)

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

To access the **OptiNet** Registration:

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

The registration does not need to be completed in one sitting. Data can be saved as you proceed through the registration. Once the registration has been submitted, a 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 AIM **ProviderPortal** Web Support at 800-252-2021. For any other questions, contact your Anthem Provider Relations Consultant.

Credentialing

Anthem's Discretion

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

Credentialing Scope

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

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

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

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

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

- Hospitals
- Home Health Agencies
- Skilled Nursing Facilities (Nursing Homes)
- Ambulatory Surgical Centers
- Behavioral Health Facilities providing mental health and/or substance abuse treatment in inpatient, residential or ambulatory settings, including:
 - Adult Family Care/Foster Care Homes
 - Ambulatory Detox

- Community Mental Health Centers ("CMHC")
- Crisis Stabilization Units
- Intensive Family Intervention Services
- Intensive Outpatient – Mental Health and/or Substance Abuse
- Methadone Maintenance Clinics
- Outpatient Mental Health Clinics
- Outpatient Substance Abuse Clinics
- Partial Hospitalization – Mental Health and/or Substance Abuse
- Residential Treatment Centers ("RTC") – Psychiatric and/or Substance Abuse
- Birthing Centers
- Home Infusion Therapy when not associated with another currently credentialed HDO

The following Health Delivery Organizations are not subject to professional conduct and competence review under Anthem's credentialing program, but are subject to a certification requirement process including verification of licensure by the applicable state licensing agency and/or compliance with regulatory or state/federal contract requirements for the provision of services:

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

Credentials Committee

The decision to accept, retain, deny or terminate a practitioner's participation in a Network or Plan Program is conducted by a peer review body, known as Anthem's Credentials Committee ("CC").

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

The CC will access various specialists for consultation, as needed to complete the review of a practitioner's credentials. A committee member will disclose and abstain from voting on a practitioner if the committee member (i) believes there is a conflict of interest, such as direct economic competition with the practitioner; or (ii) feels his or her judgment might otherwise be compromised. A committee member will also disclose if he or she has been professionally involved with the practitioner. Determinations to deny an applicant's participation, or terminate a practitioner from participation in one or more Networks or Plan Programs, require a majority vote of the voting members of the CC in attendance, the majority of whom are Network practitioners.

During the credentialing process, all information that is obtained is confidential and not subject to review by third parties except to the extent permitted by law. Access to information will be restricted to those individuals

who are deemed necessary to attain the objectives of Anthem's credentialing program. In particular, information supplied by the Practitioner or HDO in the application, as well as other non-publicly available information will be treated as confidential. Confidential written records regarding deficiencies found, the actions taken, and the recommended follow-up will be kept in a secure fashion. Security mechanisms include secured office facilities and locked filing cabinets, a protected computer infrastructure with password controls and systematic monitoring, and staff ethics and compliance training programs. The procedures and minutes of the CC will be open to review by state and federal regulating agencies and accrediting bodies to the extent permitted by law.

Practitioners and HDOs are notified that they have the right to review information submitted to support their credentialing applications. In the event that credentialing information cannot be verified, or if there is a discrepancy in the credentialing information obtained, the Credentialing staff will contact the practitioner or HDO within thirty (30) calendar days of the identification of the issue. This communication will notify the practitioner or HDO of the right to correct erroneous information or provide additional details regarding the issue in question. This notification will also include the process for submission of this additional information, including where it should be sent. Depending on the nature of the issue in question, this communication may occur verbally or in writing. If the communication is verbal, written confirmation will be sent at a later date. All communication on the issue(s) in question, including copies of the correspondence or a detailed record of phone calls, will be documented in the practitioner's credentials file. The practitioner or HDO will be given no less than fourteen (14) calendar days in which to provide additional information. On request, the practitioner will be provided with the status of their credentialing or recredentialing application.

Anthem may request and will accept additional information from the applicant to correct or explain incomplete, inaccurate, or conflicting credentialing information. The CC will review the information and rationale presented by the applicant to determine if a material omission has occurred or if other credentialing criteria are met.

Nondiscrimination Policy

Anthem will not discriminate against any applicant for participation in its programs or provider network(s) on the basis of race, gender, color, creed, religion, national origin, ancestry, sexual orientation, age, veteran, or marital status or any unlawful basis not specifically mentioned herein. Additionally, Anthem will not discriminate against any applicant on the basis of the risk of population they serve or against those who specialize in the treatment of costly conditions. Other than gender and language capabilities which are provided to the members to meet their needs and preferences, this information is not required in the credentialing and recredentialing process. Determinations as to which practitioners and providers require additional individual review by the Credentials Committee are made according to predetermined criteria related to professional conduct and competence. Credentials Committee decisions are based on issues of professional conduct and competence as reported and verified through the credentialing process. Anthem will audit credentialing files annually to identify discriminatory practices, if any, in the selection of practitioners. Should discriminatory practices be identified through audit or through other means, Anthem will take appropriate action(s) to track and eliminate those practices.

Initial Credentialing

Each practitioner or HDO must complete a standard application form deemed acceptable by Anthem when applying for initial participation in one or more of Anthem's Networks or Plan Programs. For practitioners, the Council for Affordable Quality Healthcare ("CAQH") ProView system is utilized. To learn more about CAQH, visit their web site at www.cagh.org.

Anthem will verify those elements related to an applicants' legal authority to practice, relevant training, experience and competency from the primary source, where applicable, during the credentialing process. All verifications must be current and verified within the one hundred eighty (180) calendar day period prior to the CC making its credentialing recommendation or as otherwise required by applicable accreditation standards.

During the credentialing process, Anthem will review, among other things, verification of the credentialing data as described in the following tables unless otherwise required by regulatory or accrediting bodies. These tables represent minimum requirements.

A. Practitioners

Verification Element
License to practice in the state(s) in which the practitioner will be treating Members.
Hospital admitting privileges at a TJC, NIAHO or AOA accredited hospital, or a Network hospital previously approved by the committee.
DEA/CDS and state controlled substance registrations <ul style="list-style-type: none"> The DEA/CDS registration must be valid in the state(s) in which practitioner will be treating Members. Practitioners who see Members in more than one state must have a DEA/CDS registration for each state.
Malpractice insurance
Malpractice claims history
Board certification or highest level of medical training or education
Work history
State or Federal license sanctions or limitations
Medicare, Medicaid or FEHBP sanctions
National Practitioner Data Bank report
State Medicaid Exclusion Listing, if applicable

B. HDOs

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

Recredentialing

The recredentialing process incorporates re-verification and the identification of changes in the practitioner's or HDO's licensure, sanctions, certification, health status and/or performance information (including, but not limited to, malpractice experience, hospital privilege or other actions) that may reflect on the practitioner's or HDO's professional conduct and competence. This information is reviewed in order to assess whether practitioners and HDOs continue to meet Anthem credentialing standards.

All applicable practitioners and HDOs in the Network within the scope of Anthem Credentialing Program are required to be recredentialed every three (3) years unless otherwise required by contract or state regulations.

Health Delivery Organizations

New HDO applicants will submit a standardized application to Anthem for review. If the candidate meets Anthem screening criteria, the credentialing process will commence. To assess whether Network HDOs, within the scope of the Credentialing Program, meet appropriate standards of professional conduct and competence, they are subject to credentialing and recredentialing programs. In addition to the licensure and other eligibility criteria for HDOs, as described in detail in Anthem Credentialing Program Standards, all Network HDOs are required to maintain accreditation by an appropriate, recognized accrediting body or, in the absence of such accreditation, Anthem may evaluate the most recent site survey by Medicare, the appropriate state oversight agency, or a site survey performed by a designated independent external entity within the past 36 months for that HDO.

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

On request, HDOs will be provided with the status of their credentialing application. Anthem may request, and will accept, additional information from the HDO to correct incomplete, inaccurate, or conflicting credentialing information. The CC will review this information and the rationale behind it, as presented by the HDO, and determine if a material omission has occurred or if other credentialing criteria are met.

Ongoing Sanction Monitoring

To support certain credentialing standards between the recredentialing cycles, Anthem has established an ongoing monitoring program. Credentialing performs ongoing monitoring to help ensure continued compliance with credentialing standards and to assess for occurrences that may reflect issues of substandard professional conduct and competence. To achieve this, the credentialing department will review periodic listings/reports within thirty (30) calendar days of the time they are made available from the various sources including, but not limited to, the following:

1. Office of the Inspector General ("OIG")
2. Federal Medicare/Medicaid Reports
3. Office of Personnel Management ("OPM")
4. State licensing Boards/Agencies
5. Member/Customer Services Departments
6. Clinical Quality Management Department (including data regarding complaints of both a clinical and non-clinical nature, reports of adverse clinical events and outcomes, and satisfaction data, as available)
7. Other internal Anthem Departments
8. Any other information received from sources deemed reliable by Anthem.

When a practitioner or HDO within the scope of credentialing has been identified by these sources, criteria will be used to assess the appropriate response.

Appeals Process

Anthem has established policies for monitoring and re-credentialing practitioners and HDOs who seek continued participation in one or more of Anthem's Networks or Plan Programs. Information reviewed during this activity may indicate that the professional conduct and competence standards are no longer being met, and Anthem may wish to terminate practitioners or HDOs. Anthem also seeks to treat Network practitioners and HDOs, as well as those applying for participation, fairly and thus provides practitioners and HDOs with a process to appeal determinations terminating/denying participation in Anthem's Networks for professional competence and conduct reasons, or which would otherwise result in a report to the National Practitioner Data Bank ("NPDB"). Additionally, Anthem will permit practitioners and HDOs who have been refused initial participation the opportunity to correct any errors or omissions which may have led to such denial (informal/reconsideration only). It is the intent of Anthem to give practitioners and HDOs the opportunity to contest a termination of the practitioner's or HDO's participation in one or more of Anthem's Networks or Plan Programs and those denials of request for initial participation which are reported to the NPDB that were based on professional competence and conduct considerations. Immediate terminations may be imposed due to the practitioner's or HDO's license suspension, probation or revocation, or if a practitioner or HDO has been sanctioned, debarred or excluded from the Medicare, Medicaid or FEHB programs, or has a criminal conviction, or Anthem's determination that the practitioner's or HDO's continued participation poses an imminent risk of harm to Members. Participating practitioners and HDOs whose network participation has been terminated due to the practitioner's suspension or loss of licensure or due to criminal conviction are not eligible for Informal Review/Reconsideration or Formal Appeal. Participating practitioners and HDOs whose network participation has been terminated due to sanction, debarment or exclusion from the Medicare, Medicaid or FEHB are not eligible for Informal Review/Reconsideration or Formal Appeal.

Reporting Requirements

When Anthem takes a professional review action with respect to a practitioner's or HDO's participation in one

or more of its Networks or Plan Programs, Anthem may have an obligation to report such to the NPDB, state licensing board and legally designated agencies. . In the event that the procedures set forth for reporting reportable adverse actions conflict with the process set forth in the current NPDB Guidebook, the process set forth in the NPDB Guidebook will govern.

Anthem Credentialing Program Standards

I. Eligibility Criteria

Health care practitioners:

Initial applicants must meet the following criteria in order to be considered for participation:

- A. Must not be currently federally sanctioned, debarred or excluded from participation in any of the following programs: Medicare, Medicaid or FEHBP; and
- B. Possess a current, valid, unencumbered, unrestricted, and non-probationary license in the state(s) where he/she provides services to Members; and
- C. Possess a current, valid, and unrestricted Drug Enforcement Agency ("DEA") and/or Controlled Dangerous Substances ("CDS") registration for prescribing controlled substances, if applicable to his/her specialty in which he/she will treat Members; the DEA/CDS registration must be valid in the state(s) in which the practitioner will be treating Members. Practitioners who see Members in more than one state must have a DEA/CDS registration for each state.

Initial applications should meet the following criteria in order to be considered for participation, with exceptions reviewed and approved by the CC:

- A. For MDs, DOs, DPMs, and DMDs/DDs practicing oral and maxillofacial surgery, the applicant must have current, in force board certification (as defined by the American Board of Medical Specialties ("ABMS"), American Osteopathic Association ("AOA"), Royal College of Physicians and Surgeons of Canada ("RCPSC"), College of Family Physicians of Canada ("CFPC"), American Board of Foot and Ankle Surgery ("ABFAS"), American Board of Podiatric Medicine ("ABPM"), or American Board of Oral and Maxillofacial Surgery ("ABOMS")) in the clinical discipline for which they are applying.
 - B. If not certified, MDs and DOs will be granted five years or a period of time consistent with ABMS or AOA board eligibility time limits, whatever is greater, after completion of their residency or fellowship training program to meet the board certification requirement.
 - C. If not certified, DPMs will be granted five years after the completion of their residency to meet this requirement for the ABPM. Non-certified DPMs will be granted seven years after completion of their residency to meet this requirement for ABFAS.
 - D. Individuals no longer eligible for board certification are not eligible for continued exception to this requirement.
1. As alternatives, MDs and DOs meeting any one of the following criteria will be viewed as meeting the education, training and certification requirement:
- a. Previous board certification (as defined by one of the following: ABMS, AOA, RCPSC, CFPC, ABFAS, ABPM, or ABOMS) in the clinical specialty or subspecialty for which they are applying which has now expired AND a minimum of ten (10) consecutive years of clinical practice. OR
 - b. Training which met the requirements in place at the time it was completed in a specialty field prior to the availability of board certifications in that clinical specialty or subspecialty. OR
 - c. Specialized practice expertise as evidenced by publication in nationally accepted peer review literature and/or recognized as a leader in the science of their specialty AND a faculty appointment of Assistant Professor or higher at an academic medical center and teaching Facility in Anthem's Network AND the applicant's professional activities are spent at that institution at least fifty percent (50%) of the time.

2. Practitioners meeting one of these three (3) alternative criteria (a, b, c) will be viewed as meeting all Anthem education, training and certification criteria and will not be required to undergo additional review or individual presentation to the CC. These alternatives are subject to Anthem review and approval. Reports submitted by delegate to Anthem must contain sufficient documentation to support the above alternatives, as determined by Anthem.
- B. For MDs and DOs, the applicant must have unrestricted hospital privileges at a The Joint Commission ("TJC"), National Integrated Accreditation for Healthcare Organizations ("NIAHO"), Center for Improvement in Healthcare Quality ("CIHQ"), a Healthcare Facilities Accreditation Program ("HFAP") accredited hospital, or a Network hospital previously approved by the committee. Some clinical disciplines may function exclusively in the outpatient setting, and the CC may at its discretion deem hospital privileges not relevant to these specialties. Also, the organization of an increasing number of physician practice settings in selected fields is such that individual physicians may practice solely in either an outpatient or an inpatient setting. The CC will evaluate applications from practitioners in such practices without regard to hospital privileges. The expectation of these physicians would be that there is an appropriate referral arrangement with a Network practitioner to provide inpatient care.

II. Criteria for Selecting Practitioners

A. New Applicants (Credentialing)

1. Submission of a complete application and required attachments that must not contain intentional misrepresentations or omissions;
2. Application attestation signed date within one hundred eighty (180) calendar days of the date of submission to the CC for a vote;
3. Primary source verifications within acceptable timeframes of the date of submission to the CC for a vote, as deemed by appropriate accrediting agencies;
4. No evidence of potential material omission(s) on application;
5. Current, valid, unrestricted license to practice in each state in which the practitioner would provide care to Members;
6. No current license action;
7. No history of licensing board action in any state;
8. No current federal sanction and no history of federal sanctions (per System for Award Management ("SAM"), OIG and OPM report nor on NPDB report);
9. Possess a current, valid, and unrestricted DEA/CDS registration for prescribing controlled substances, if applicable to his/her specialty in which he/she will treat Members. The DEA/CDS registration must be valid in the state(s) in which the practitioner will be treating Members. Practitioners who treat Members in more than one state must have a valid DEA/CDS registration for each applicable state.

Initial applicants who have NO DEA/CDS registration will be viewed as not meeting criteria and the credentialing process will not proceed. However, if the applicant can provide evidence that he/she has applied for a DEA/CDS registration, the credentialing process may proceed if all of the following are met:

- a. It can be verified that this application is pending.
- b. The applicant has made an arrangement for an alternative practitioner to prescribe controlled substances until the additional DEA/CDS registration is obtained.
- c. The applicant agrees to notify Anthem upon receipt of the required DEA/CDS registration.
- d. Anthem will verify the appropriate DEA/CDS registration via standard sources.
 - i. The applicant agrees that failure to provide the appropriate DEA/CDS registration within a ninety (90) calendar day timeframe will result in termination from the Network.
 - ii. Initial applicants who possess a DEA certificate in a state other than the state in which they will be seeing Anthem's members will be notified of the need to obtain the additional DEA, unless the practitioner is delivering services in a telemedicine environment only and does not require a DEA or CDS registration in the additional location(s) where such telemedicine

services may be rendered under federal or state law. If the applicant has applied for an additional DEA registration the credentialing process may proceed if all the following criteria are met:

- (a) It can be verified that the applicant's application is pending; and
 - (b) The applicant has made an arrangement for an alternative provider to prescribe controlled substances until the additional DEA registration is obtained; and
 - (c) The applicant agrees to notify Anthem upon receipt of the required DEA registration; and
 - (d) Anthem will verify the appropriate DEA/CDS registration via standard sources; and
 - (e) The applicant agrees that failure to provide the appropriate DEA registration within a 90 day timeframe will result in termination from the network.
- iii. Office-based practitioners who voluntarily choose to have a DEA/CDS registration that does not include all Controlled Substance Schedules (for example, Schedule II, III or IV), if that practitioner certifies the following:
- (a) controlled substances from these Schedules are not prescribed within his/her scope of practice; and
 - (b) he/she must provide documentation that an arrangement exists for an alternative provider to prescribe controlled substances from these Schedules should it be clinically appropriate; and
 - (c) DEA/CDS registration is or was not suspended, revoked, surrendered or encumbered for reasons other than those aforementioned.
10. No current hospital membership or privilege restrictions and no history of hospital membership or privileges restrictions;
11. No history of or current use of illegal drugs or history of or current alcoholism;
12. No impairment or other condition which would negatively impact the ability to perform the essential functions in their professional field.
13. No gap in work history greater than six (6) months in the past five (5) years with the exception of those gaps related to parental leave or immigration where twelve (12) month gaps will be acceptable.
14. No convictions, or pleadings of guilty or no contest to, or open indictments of, a felony or any offense involving moral turpitude or fraud. In addition, no other criminal or civil litigation history that together with any other relevant facts, raises a reasonable suspicion of future substandard professional conduct and/or competence. A minimum of the past ten (10) years of malpractice case history is reviewed.
15. Meets Credentialing Standards for education/training for the specialty(ies) in which practitioner wants to be listed in Anthem's Network directory as designated on the application. This includes board certification requirements or alternative criteria for MDs and DOs and board certification criteria for DPMs, and oral and maxillofacial surgeons;
16. No involuntary terminations from an HMO or PPO;
17. No "yes" answers to attestation/disclosure questions on the application form with the exception of the following:
- a. investment or business interest in ancillary services, equipment or supplies;
 - b. voluntary resignation from a hospital or organization related to practice relocation or facility utilization;
 - c. voluntary surrender of state license related to relocation or nonuse of said license;
 - d. a NPDB report of a malpractice settlement or any report of a malpractice settlement that does not meet the threshold criteria.
 - e. non-renewal of malpractice coverage or change in malpractice carrier related to changes in the carrier's business practices (no longer offering coverage in a state or no longer in business);
 - f. previous failure of a certification exam by a practitioner who is currently board certified or who remains in the five (5) year post residency training window;
 - g. actions taken by a hospital against a practitioner's privileges related solely to the failure to complete medical records in a timely fashion;
 - h. history of a licensing board, hospital or other professional entity investigation that

w as closed w ithout any action or sanction.

Note: the CC will individually review any practitioner that does not meet one or more of the criteria required for initial applicants.

B. Additional Participation Criteria and Exceptions for Behavioral Health practitioners (Non Physician) Credentialing.

1. Licensed Clinical Social Workers ("LCSW") or other master level social work license type:
 - a. Master or doctoral degree in social work with emphasis in clinical social work from a program accredited by the Council on Social Work Education ("CSWE") or the Canadian Association on Social Work Education ("CASWE").
 - b. Program must have been accredited within three (3) years of the time the practitioner graduated.
 - c. Full accreditation is required, candidacy programs will not be considered.
 - d. If master's level degree does not meet criteria and practitioner obtained PhD degree as a clinical psychologist, but is not licensed as such, the practitioner can be reviewed. To meet the criteria, the doctoral program must be accredited by the American Psychological Association ("APA") or be regionally accredited by the Council for Higher Education Accreditation ("CHEA"). In addition, a doctor of social work from an institution with at least regional accreditation from the CHEA will be viewed as acceptable.
2. Licensed professional counselor ("LPC") and marriage and family therapist ("MFT") or other master level license type:
 - a. Master's or doctoral degree in counseling, marital and family therapy, psychology, counseling psychology, counseling with an emphasis in marriage, family and child counseling or an allied mental field. Master or doctoral degrees in education are acceptable with one of the fields of study above.
 - b. Master or doctoral degrees in divinity do not meet criteria as a related field of study.
 - c. Graduate school must be accredited by one of the Regional Institutional Accrediting Bodies and may be verified from the Accredited Institutions of Post-Secondary Education, APA, Council for Accreditation of Counseling and Related Educational Programs ("CACREP"), or Commission on Accreditation for Marriage and Family Therapy Education ("COAMFTE") listings. The institution must have been accredited within three (3) years of the time the practitioner graduated.
 - d. Practitioners with PhD training as a clinical psychologist can be reviewed. To meet criteria this doctoral program must either be accredited by the APA or be regionally accredited by the CHEA. A Practitioner with a doctoral degree in one of the fields of study noted will be viewed as acceptable if the institution granting the degree has regional accreditation from the CHEA and;
 - e. Licensure to practice independently.
3. Clinical nurse specialist/psychiatric and mental health nurse practitioner:
 - a. Master's degree in nursing with specialization in adult or child/adolescent psychiatric and mental health nursing. Graduate school must be accredited from an institution accredited by one of the Regional Institutional Accrediting Bodies within three (3) years of the time of the practitioner's graduation.
 - b. Registered Nurse license and any additional licensure as an Advanced Practice Nurse/Certified Nurse Specialist/Adult Psychiatric Nursing or other license or certification as dictated by the appropriate State(s) Board of Registered Nursing, if applicable.
 - c. Certification by the American Nurses Association ("ANA") in psychiatric nursing. This may be any of the following types: Clinical Nurse Specialist in Child or Adult Psychiatric Nursing, Psychiatric and Mental Health Nurse Practitioner, or Family Psychiatric and Mental Health Nurse Practitioner.
 - d. Valid, current, unrestricted DEA/CDS registration, where applicable with appropriate supervision/consultation by a Network practitioner as applicable by the

state licensing board. For those who possess a DEA registration, the appropriate CDS registration is required. The DEA/CDS registration must be valid in the state(s) in which the practitioner will be treating Members.

4. Clinical Psychologists:
 - a. Valid state clinical psychologist license.
 - b. Doctoral degree in clinical or counseling, psychology or other applicable field of study from an institution accredited by the APA within three (3) years of the time of the practitioner's graduation.
 - c. Education/Training considered as eligible for an exception is a practitioner whose doctoral degree is not from an APA accredited institution, but who is listed in the National Register of Health Service Providers in Psychology or is a Diplomate of the American Board of Professional Psychology.
 - d. Master's level therapists in good standing in the Network, who upgrade their license to clinical psychologist as a result of further training, will be allowed to continue in the Network and will not be subject to the above education criteria.
5. Clinical Neuropsychologist:
 - a. Must meet all the criteria for a clinical psychologist listed in C.4 above and be Board certified by either the American Board of Professional Neuropsychology ("ABPN") or American Board of Clinical Neuropsychology ("ABCN").
 - b. A practitioner credentialed by the National Register of Health Service Providers in Psychology with an area of expertise in neuropsychology may be considered.
 - c. Clinical neuropsychologists who are not Board certified, nor listed in the National Register, will require CC review. These practitioners must have appropriate training and/or experience in neuropsychology as evidenced by one or more of the following:
 - i. Transcript of applicable pre-doctoral training, OR
 - ii. Documentation of applicable formal one (1) year post-doctoral training (participation in CEU training alone would not be considered adequate), OR
 - iii. Letters from supervisors in clinical neuropsychology (including number of hours per week), OR
 - iv. Minimum of five (5) years experience practicing neuropsychology at least ten (10) hours per week.
6. Licensed Psychoanalysts:
 - a. Applies only to Practitioners in states that license psychoanalysts.
 - b. Practitioners will be credentialed as a licensed psychoanalyst if they are not otherwise credentialed as a practitioner type detailed in Credentialing Policy (e.g. psychiatrist, clinical psychologist, licensed clinical social worker).
 - c. Practitioner must possess a valid psychoanalysis state license.
 - i. Practitioner shall possess a master's or higher degree from a program accredited by one of the Regional Institutional Accrediting Bodies and may be verified from the Accredited Institutions of Post-Secondary Education, APA, CACREP, or the COAMFTE listings. The institution must have been accredited within 3 years of the time the Practitioner graduates.
 - ii. Completion of a program in psychoanalysis that is registered by the licensing state as licensure qualifying; or accredited by the American Board for Accreditation in Psychoanalysis (ABAP) or another acceptable accrediting agency; or determined by the licensing state to be the substantial equivalent of such a registered or accredited program.
 - a. A program located outside the United States and its territories may be used to satisfy the psychoanalytic study requirement if the licensing state determines the following: it prepares individuals for the professional practice of psychoanalysis; and is recognized by the appropriate civil authorities of that jurisdiction; and can be appropriately verified; and is determined

by the licensing state to be the substantial equivalent of an acceptable registered licensure qualifying or accredited program.

- b. Meet minimum supervised experience requirement for licensure as a psychoanalyst as determined by the licensing state.
- c. Meet examination requirements for licensure as determined by the licensing state.

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

1. Process, requirements and Verification – Nurse Practitioners:

- i. The nurse practitioner applicant will submit the appropriate application and supporting documents as required of any other Practitioners with the exception of differing information regarding education/training and board certification.
- ii. The required education/training will be, at a minimum, the completion of an education program leading to licensure as a Registered Nurse, and subsequent additional education leading to licensure as a NP. Verification of this will occur either via verification of the licensure status from the state licensing agency provided that that agency verifies the education or from the certification board if that board provides documentation that it performs primary verification of the professional education and training. If the licensing agency or certification board does not verify highest level of education, the education will be primary source verified in accordance with policy.
- iii. The license status must be that of NP as verified via primary source from the appropriate state licensing agency. Additionally, this license must be active, unencumbered, unrestricted and not subject to probation, terms or conditions. Any applicants whose licensure status does not meet these criteria, or who have in force adverse actions regarding Medicare or Medicaid will be notified of this and the applicant will be administratively denied.
- iv. If the NP has prescriptive authority, which allows the prescription of scheduled drugs, their DEA and/or state certificate of prescriptive authority information will be requested and primary source verified via normal Anthem procedures. If there are in force adverse actions against the DEA, the applicant will be notified of this and the applicant will be administratively denied.
- v. All NP applicants will be certified in the area which reflects their scope of practice by any one of the following:
 - 1. Certification program of the American Nurse Credentialing Center (www.nursecredentialing.org), a subsidiary of the American Nursing Association (http://www.nursingcertification.org/exam_programs.htm); or
 - 2. American Academy of Nurse Practitioners – Certification Program (www.aanpcertification.org); or
 - 3. National Certification Corporation (<http://www.nccwebsite.org>); or
 - 4. Pediatric Nurse Certification Board (PNCB) Certified Pediatric Nurse Practitioner – (note: CPN – certified pediatric nurse is not a nurse practitioner) (<http://www.pncb.org/ptistore/control/exams/ac/progs>); OR
 - 5. Oncology Nursing Certification Corporation (ONCC) – Advanced Oncology Certified Nurse Practitioner (AOCNP®) – ONLY (<http://oncc.org>);
 - 6. American Association of Critical Care Nurses (<https://www.aacn.org/certification/verify-certification>) ACNPC – Adult Care Nurse Practitioner; ACNPC-AG – Adult Gerontology Acute Care. This certification must be active and primary source verified.

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

- vi. If the NP has hospital privileges, they must have hospital privileges at a CIHQ, TJC, NIAHO, or HFAP accredited hospital, or a network hospital previously approved by the committee. Information regarding history of any actions taken against any hospital privileges held by the NP will be obtained. Any adverse action against any hospital privileges will trigger a level II review.
 - vii. The NP applicant will undergo the standard credentialing processes outlined in Anthem's Credentialing Policies. NPs are subject to all the requirements outlined in these Credentialing Policies including (but not limited to): the requirement for Committee review of Level II files for failure to meet predetermined criteria, re-credentialing every three years, and continuous sanction and performance monitoring upon participation in the network.
 - viii. Upon completion of the credentialing process, the NP may be listed in Anthem's provider directories. As with all providers, this listing will accurately reflect their specific licensure designation and these providers will be subject to the audit process.
 - ix. NPs will be clearly identified as such:
 - 1. On the credentialing file;
 - 2. At presentation to the Credentialing Committee; and
 - 3. On notification to Network Services and to the provider database.
2. Process, Requirements and Verifications – Certified Nurse Midwives:
- i. The Certified Nurse Midwife (CNM) applicant will submit the appropriate application and supporting documents as required of any other Practitioner with the exception of differing information regarding education, training and board certification.
 - ii. The required educational/training will be at a minimum that required for licensure as a Registered Nurse with subsequent additional training for licensure as a Certified Nurse Midwife by the appropriate licensing body. Verification of this education and training will occur either via primary source verification of the license, provided that state licensing agency performs verification of the education, or from the certification board if that board provides documentation that it performs primary verification of the professional education and training. If the state licensing agency or the certification board does not verify education, the education will be primary source verified in accordance with policy.
 - iii. The license status must be that of CNM as verified via primary source from the appropriate state licensing agency. Additionally, this license must be active, unencumbered, unrestricted and not subject to probation, terms or conditions. Any applicant whose licensure status does not meet these criteria, or who have in force adverse actions regarding Medicare or Medicaid will be notified of this and the applicant will be administratively denied.
 - iv. If the CNM has prescriptive authority, which allows the prescription of scheduled drugs, their DEA and/or state certificate of prescriptive authority information will be requested and primary source verified via normal Anthem procedures. If there are in force adverse actions against the DEA, the applicant will be notified and the applicant will be administratively denied.
 - v. All CNM applicants will be certified by either:
 - 1. The National Certification Corporation for Ob/Gyn and Neonatal Nursing; or
 - 2. The American Midwifery Certification Board, previously known as the American College of Nurse Midwives.

This certification must be active and primary source verified. If the state licensing board primary source verifies one of these certifications as a requirement for licensure, additional verification by Anthem is not required. If the applicant is not certified or if their certification has expired, the application will be submitted for individual review by the geographic Credentialing Committee.
 - vi. If the CNM has hospital privileges, they must have unrestricted hospital privileges at a CIHQ, TJC, NIAHO, or HFAP accredited hospital, or a network hospital previously approved by the committee or in the absence of such privileges, must not raise a reasonable suspicion of future substandard professional conduct or competence. Information regarding history of any actions taken against any

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

ix. PA's will be clearly identified such:

1. On the credentialing file;
2. At presentation to the Credentialing Committee; and
3. On notification to Network Services and to the provider database.

D. Currently Participating Applicants (Recredentialing)

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

17. Recredentialed at least every three (3) years to assess the practitioner's continued compliance with Anthem standards.

*It is expected that these findings will be discovered for currently credentialed Network practitioners and HDOs through ongoing sanction monitoring. Network practitioners and HDOs with such findings will be individually reviewed and considered by the CC at the time the findings are identified.

Note: the CC will individually review any credentialed Network practitioners and HDOs that do not meet one or more of the criteria for recredentialing.

III. HDO Eligibility Criteria

All HDOs must be accredited by an appropriate, recognized accrediting body or in the absence of such accreditation, Anthem may evaluate the most recent site survey by Medicare, the appropriate state oversight agency, or site survey performed by a designated independent external entity within the past 36 months. If a HDO has satellite facilities that follow the same policy and procedures, Anthem may limit site visits to the main facility. Non-accredited HDOs are subject to individual review by the CC and will be considered for Member access need only when the CC review indicates compliance with Anthem standards and there are no deficiencies noted on the Medicare or state oversight review which would adversely affect quality of care or patient safety. HDOs are recredentialed at least every three (3) years to assess the HDO's continued compliance with Anthem standards.

A. General Criteria for HDOs:

1. Valid, current and unrestricted license to operate in the state(s) in which it will provide services to Members. The license must be in good standing with no sanctions.
2. Valid and current Medicare certification.
3. Must not be currently federally sanctioned, debarred or excluded from participation in any of the following programs; Medicare, Medicaid or the FEHBP. Note: If, once an HDO participates in Anthem's programs or provider Network(s), exclusion from Medicare, Medicaid or FEHBP occurs, at the time of identification, the HDO will become immediately ineligible for participation in the applicable government programs or provider Network(s) as well as Anthem's other credentialed provider Network(s).
4. Liability insurance acceptable to Anthem.
5. If not appropriately accredited, HDO must submit a copy of its CMS, state site or a designated independent external entity survey for review by the CC to determine if Anthem's quality and certification criteria standards have been met.

B. Additional Participation Criteria for HDO by Provider Type:

HDO Type and Anthem Approved Accrediting Agent(s)

Medical Facilities

Facility Type (Medical Care)	Acceptable Accrediting Agencies
Acute Care Hospital	CIOH, CTEAM, DNV/NAHO, HFAP, TJC
Ambulatory Surgical Centers	AAAASF, AAAHC, AAPSF, HFAP, IMQ, TJC
Birthing Center	AAAHC, CABC, TJC
Clinical Laboratories	CLIA, COLA
Dialysis Center	CMS Certification, TJC
Home Health Care Agencies (HHA)	ACHC, CHAP, CTEAM, DNV/NAHO, TJC
Home Infusion Therapy (HIT)	ACHC, CHAP, CTEAM, HQAA, TJC
Portable Xray Services	FDA Certification
Skilled Nursing Facilities/Nursing Homes	BOC INTL, CARF, TJC

Behavioral Health

Facility Type (Behavioral Health Care)	Acceptable Accrediting Agencies
Acute Care Hospital—Psychiatric Disorders	CTEAM, DNV/NAHO, TJC, HFAP

Adult Family Care Homes (AFCH)	ACHC, TJC
Adult Foster Care	ACHC, TJC
Community Mental Health Centers (CMHC)	AAAH, CARF, CHAP, COA, TJC
Crisis Stabilization Unit	TJC
Intensive Family Intervention Services	CARF
Intensive Outpatient – Mental Health and/or Substance Abuse	ACHC, CARF, COA, DNV/NIAHO, TJC
Outpatient Mental Health Clinic	CARF, CHAP, COA, HFAP, TJC
Partial Hospitalization/Day Treatment—Psychiatric Disorders and/or Substance Abuse	CARF, DNV/NIAHO, HFAP, TJC
Residential Treatment Centers (RTC) – Psychiatric Disorders and/or Substance Abuse	CARF, COA, DNV/NIAHO, HFAP, TJC

Rehabilitation

Facility Type (Behavioral Health Care)	Acceptable Accrediting Agencies
Acute Inpatient Hospital – Detoxification Only Facilities	DNV/NIAHO, HFAP, TJC, CTEAM
Behavioral Health Ambulatory Detox	CARF, TJC
Methadone Maintenance Clinic	CARF, COA, TJC
Outpatient Substance Abuse Clinics	CARF, TJC

Standards of Participation

Anthem contracts with many types of providers that do not require formal credentialing. However, to become a 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, the chart below outlines requirements that must be met in order to be considered for contracting as a Provider or Facility in one of these specialties:

Provider	Standards of Participation
Ambulance (Air & Ground)	Medicare Certification
Ambulatory Infusion Suites	TJC, CHAP or ACHC State & Pharmacy Licensure
Convenient Care Centers (CCCs)/Retail Health Clinics (RHC)	DNV/NIAHO, UCAOA, TJC
Durable Medical Equipment	TJC, CHAP, ACHC, (HQAA) Medicare Certification
Hearing Aid Supplier	State Licensure
Intermediate Care Facilities	CTEAM
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
Urgent Care Center (UCC)	AAAH, IMQ, NUCCA (formerly ABUCM), TJC, UCAOA

Please note: This is only a representative listing of provider types that do not require formal credentialing. If you have questions about whether you are subject to the formal credentialing process or the applicable standards of participation for your provider type, please call Network Management.

Quality Improvement Program

[Quality Improvement Program Overview](#)

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

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

Goals and Objectives

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

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

- To respond to the needs and expectations of internal and external customers by evaluating performance and taking action relative to meeting those needs and expectations, including compliance with regulatory and accreditation requirements, policies and procedures.
- To promote processes that help reduce medical errors and improve patient safety for Members by implementing member-focused, provider and safety initiatives.
- To identify and promote educational opportunities for Members, medical and behavioral health care providers and other health care professionals.
- For multicultural health strategies – to improve the health and health care of Anthem’s multicultural Members.

- To help maximize health status, improve health outcomes and reduce health care costs of Members through effective Case Management (“CM”) and Disease Management (“DM”) programs addressing complex care needs.

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

Quality and Safety of Clinical Care

- *Chronic Disease and Prevention:* Anthem focuses on Member and/or Provider/Facility outreach for chronic conditions like asthma, heart disease, diabetes, and Chronic Obstructive Pulmonary Disease (“COPD”) and for preventive health services such as immunizations and cancer screenings. Improvements in these areas result in improved clinical measures such as HEDIS® (Healthcare Effectiveness Data and Information Set)¹.
- *Behavioral Health Case Management:* A program designed to provide a comprehensive and integrated approach to early identification, treatment, intensive case management and individualized recovery support for Members with complex behavioral health conditions who are at risk for negative outcomes and high costs.
- *Community Health:* Anthem has committed resources and worked with key entities to co-create community-based health initiatives to address public health concerns and societal problems including behavioral health/substance abuse disorder, cancer, diabetes and maternal and child health.
- *Disease Management:* The ConditionCare program is designed to help maximize health status, improve health outcomes, and reduce health care costs of Members diagnosed with Asthma (Pediatric and Adult), Diabetes (Type 1 and Type 2, Pediatric and Adult), Coronary Artery Disease (“CAD”), Heart Failure (“HF”) and COPD. The DM program was created and developed based on recent versions of nationally accepted evidence-based Clinical Practice Guidelines (“CPGs”). These guidelines are reviewed at least every two years, and program interventions and protocols are updated accordingly.
- *Health and Wellness:* Programs offer a seamless integration of preventive care, wellness, care management coordination services and online and mobile tools. The programs are clinically driven and designed to help Members better manage individual health and make more informed health care decisions. Programs include: MyHealth Coach (“MHC”), MyHealth Advantage (“MHA”), Neonatal Intensive Care Unit (“NICU”) program, Worksite Wellness, Healthy Lifestyles (“HL”), and Healthwise® Knowledge Base (“HWKB”).

Service Quality

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

Patient Safety for Members

The strategic vision is to establish and maintain goals in advancing patient safety for Members. This program is structured to align with the overall mission and national patient safety for Members’ strategy. The goals are to work with physicians, hospitals in the network and other health care partners to reduce adverse drug events, health care associated conditions, hospital readmissions and avoidable cost of care, as well as develop innovative programs to accelerate improvements in quality and safety. Priority areas include medication safety, radiation safety, surgical safety, infection control, protection, engagement, care management and payment innovation. Patient safety for member initiatives are managed by various business units within the enterprise, but tracked by a single unit. These member- and provider-facing initiatives/activities are designed to meet regulatory and accreditation requirements and consumer needs. Whenever possible, nationally endorsed clinical metrics are used to evaluate progress.

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

Overview of HEDIS®

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

For more information on HEDIS: **Anthem.com > Providers > Policies and Guidelines > Indiana > View Med Policies and UM Guideline > Health & Wellness > Quality Improvement and Standards > HEDIS Information or [Select Here](#).**

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 our provider newsletter, so they have an opportunity to learn how Anthem Members feel about the services provided. Anthem encourages Providers to assess their own practice to identify opportunities to improve patients' access to care and improve interpersonal skills to make the patient care experience a more positive one. Our Provider newsletters can be found at: **[www.anthem.com > Provider > Indiana > Find Resources for Indiana > Communications > Publications or Select Here](#).**

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

Clinical Practice Guidelines

Anthem considers clinical practice guidelines to be an important component of health care. Anthem adopts nationally recognized clinical practice guidelines, and encourages physicians to utilize these guidelines to improve the health of our Members. Several national organizations such as, National Heart, Lung and Blood Institute, American Diabetes Association and the American Heart Association, produce guidelines for asthma, diabetes, hypertension, and other conditions. The guidelines, which Anthem uses for quality and disease

management programs, are based on reasonable medical evidence. We review the guidelines at least every two years or when changes are made to national guidelines for content accuracy, current primary sources, new technological advances and recent medical research.

Providers can access the up-to-date listing of the medical, preventive and behavioral health guidelines online. To access the guidelines, go to **anthem.com > Menu > Providers > Find Resources for Your State > Indiana > Health and Wellness > Practice Guidelines > Clinical Practice Guidelines** or [Select Here](#).

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

Preventive Health Guidelines

Anthem considers prevention an important component of health care. Anthem develops preventive health guidelines in accordance with recommendations made by nationally recognized organizations and societies such as the American Academy of Family Physicians (AAFP), the American Academy of Pediatrics (AAP), the Advisory Committee on Immunizations Practices (ACIP), the American College of Obstetrics and Gynecology (ACOG) and the United States Preventive Services Task Force (USPSTF). The above organizations make recommendations based on reasonable medical evidence. We review the guidelines annually for content accuracy, current primary sources, new technological advances and recent medical research and make appropriate changes based on this review of the recommendations and/or preventive health mandates. We encourage physicians to utilize these guidelines to improve the health of our Members.

The current guidelines are available on our website. To access the guidelines, go to **anthem.com > Menu > Providers > Find Resources for Your State > Indiana > Health and Wellness > Practice Guidelines > Preventive Health Guidelines** or [Select Here](#).

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

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 on Medical Record standards, please go to the "Provider" home page at anthem.com. Click on the "Provider" link at the top of the new landing page (under the "Other Anthem Websites" section). Select your state and click enter. On the Provider home page under the Health and Wellness tab (on the blue toolbar), choose Quality Improvement and Standards, and then scroll down to "Medical Record Review".

Multicultural Health

[Multicultural Health Overview](#)

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

1. Monitor the quality of health care to identify actionable health and health care disparities trends
 - a. Identify clinical and geographic areas exhibiting health and health care disparities and design appropriate interventions to help close those gaps
 - b. Establish baseline data and measures/evaluates the results of program interventions
 - c. Support Member access to equitable treatment, standards of care and services based on their Plan benefits
2. Promote Culturally and Linguistically Appropriate Services (“CLAS”)
 - a. Offer education, tools and subject matter expertise to Providers and Facilities that may help them achieve the shared goal of providing quality care and service equally to their patients
 - b. Facilitate cultural competency of Anthem associates to help meet the Members’ needs for access to culturally sensitive, linguistically appropriate care and service
 - c. Offer education, tools and subject matter expertise to Members that may help them improve their health literacy, allowing better communication with their doctors and Anthem about their health care and service
 - d. Promote the Department of Health and Human Services Office of Minority Health’s National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (the National CLAS standards). <https://www.thinkculturalhealth.hhs.gov/clas/standards>
3. Develop programs to help improve health status and outcomes
 - a. Promote consumer-centered care that addresses the Members’ values, needs and preferences in reaching optimal health care and outcomes standards
 - b. Support communities in which Anthem does business with cultural and linguistic programs and services
 - c. Collaborate with other industry and government efforts to help reduce and eliminate health disparities

[Anthem Innovation](#)

[MyDiversePatients.com](#) or [Select Here](#): **An online resource to support your diverse patient panel**

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

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

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

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

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

Moving Toward Equity in Asthma Care

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

- Describe common racial and ethnic asthma disparities – and their effects on diverse patients’ ability to successfully control their asthma.

- Describe ways Providers may unknowingly contribute to poor asthma care for diverse populations.
- Explain ways Providers can improve the quality of asthma care to enhance outcomes among African Americans, Hispanic and Asian patients.
- Explain the importance of using spirometry to assess the severity of asthma accurately.
- Explain the concept of “unconscious bias.”

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

The experience was developed in an effort to address the substantial gaps in asthma care and outcomes for diverse populations and can be accessed at [**www.mydiversepatients.com/Learning Experience/Asthma & Me**](http://www.mydiversepatients.com/Learning Experience/Asthma & Me) or **Select Here**.

Primary Audiences include: Physicians (Family Practice, Pediatrician, Pulmonologist, Allergist Immunologist), Nurse Practitioners, Registered Nurse (RN), Licensed Vocational Nurse (LVN), and Licensed Practical Nurse (LPN).

Asthma & Me App

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

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

The Asthma & Me app can be accessed at www.MyDiversePatients.com using your smartphone, tablet, or computer. The app supplements the “**MovingToward Equity in Asthma Care**” online provider CME experience, which is also available on the site as well as [**www.mydiversepatients.com/Learning Experience/Asthma & Me**](http://www.mydiversepatients.com/Learning Experience/Asthma & Me) or **Select Here**.

Creating an LGBT-Friendly Practice

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

Visit [**www.mydiversepatients.com/Learning Experience/Creating LGBT-Friendly Practice**](http://www.mydiversepatients.com/Learning Experience/Creating LGBT-Friendly Practice) or **Select Here** for free 24/7 access to the experience – either via computer, tablet or smartphone. The course has been approved for 1 AAFP Prescribed credit, which is equivalent to AMA PRA Category 1 Credit™.

Reducing Health Care Stereotype Threat (“HCST”): Assuring your diverse patients they are not being judged due to their race/ethnicity

Your diverse patients may feel threatened about being personally reduced to group stereotypes. Their fear of being prejudged or stigmatized based on phenotype may be omnipresent throughout their life journeys and may be present during health care interactions with you or your team. A perceived health care stereotype threat is not the same as discrimination. Instead, it is a situational, psychosocial phenomenon that may contribute to disparities.

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

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

Medication Adherence

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

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

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

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

¹Center for Disease Control and Prevention. (2017, February 1). *Overcoming Barriers to Medication Adherence for Chronic Conditions*. Retrieved from <https://www.cdc.gov/cdcgrandrounds/archives/2017/february2017.htm>

Centers of Medical Excellence

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

For transplants and ventricular assist devices ("VAD"), Members also have access to the Anthem Centers of Medical Excellence Transplant and VAD Network. The CME designation is awarded to qualified programs by a panel of national experts currently practicing in the fields of solid organ, marrow transplantation, and cardiac

surgery representing centers across the country. Each Center must meet Anthem's CME participation requirements and is selected through a rigorous evaluation of clinical data that provides insight into the Facility's structures, processes, and outcomes of care. Current transplant designations include the following transplants: autologous/allogeneic bone marrow/stem cell, heart, lung, combination heart/lung, liver, kidney, simultaneous kidney/pancreas and pancreas.

For both the BDC and Anthem CME programs, selection criteria are designed to evaluate overall quality, providing a comprehensive view of how the Facility delivers specialty care. More information on our programs can be accessed online at [anthem.com](https://www.anthem.com) > **Providers** > **Find Resources in Your State** > **Indiana** > **Health & Wellness** > **Centers of Medical Excellence** or [Select Here](#).

Transplant

- Blue Distinction Centers for Transplant™ ("BDCT") launched in 2006.
- More than 115,082 people in the United States were waiting for a lifesaving organ transplant from one of the nation's more than 140 transplant centers in 2017. There were nearly 34,800 organ transplants in 2017. This was the fifth consecutive record-breaking year.
- Blue Distinction Centers and Blue Distinction Centers+ for Transplants have demonstrated their commitment to quality care, resulting in better overall outcomes for transplant patients. Each Facility meets stringent clinical criteria, established in collaboration with expert physicians' and medical organizations' recommendations**, including the Center for International Blood and Marrow Transplant Research ("CIBMTR"), the Scientific Registry of Transplant Recipients ("SRTR"), and the Foundation for the Accreditation of Cellular Therapy ("FACT"), and is subject to periodic re-evaluation as criteria continue to evolve. Both Blue Distinction Centers and Blue Distinction Centers+ for Transplants help simplify the administrative process involved in this complex care so that patients, their families, and physicians can focus on the medical issues.
- Hospitals receiving the Blue Distinction Center+ for Transplants designation have met the Blue Distinction Centers' standards for quality while also demonstrating better cost-efficiency relative to their peers.
- The Anthem CME Transplant Network is a wrap-around network to the BDCT program and offers Members access to an additional 60 transplant facilities. When BDCT and Anthem CME are combined, Members have access to 200 transplant specific programs for heart, lung, combined heart/lung, liver, pancreas, kidney, combined kidney/pancreas, and bone marrow/stem cell transplant.

Cardiac Care

- Blue Distinction Centers for Cardiac Care® launched in January 2006.
- According to the Centers for Disease Control and Prevention, the number of adults with a diagnosis of heart disease is 27.6 million, and the percent of adults with diagnosed heart disease is 11.5%. Heart Disease is the #1 Cause of death in the United States.
- Research shows that Blue Distinction Centers and Blue Distinction Centers+ demonstrate better quality and improved outcomes for patients, with lower rates of complications following certain cardiac procedures and lower rates of healthcare associated infections compared with their peers. Blue Distinction Centers+ are also 20 percent more cost-efficient than non-designated hospitals for those same cardiac procedures.
- Blue Distinction Centers and Blue Distinction Centers+ for Cardiac Care provide a full range of cardiac care services, including inpatient cardiac care, cardiac rehabilitation, cardiac catheterization and cardiac surgery (including coronary artery bypass graft surgery).

Bariatric Surgery

- Blue Distinction Centers for Bariatric Surgery® launched in 2008
- According to the National Center for Health Statistics report released in November 2015: Prevalence

of Obesity among Adults and Youth has grown to more than one-third (36.5%) of U.S. adults which have been diagnosed with obesity, and 32.3% for young adults aged 20-39. Obesity-related conditions include heart disease, stroke, type 2 diabetes and certain types of cancer, which are some of the leading causes of preventable death.

- Blue Distinction Centers for Bariatric Surgery have demonstrated their commitment to quality care, resulting in better overall outcomes for bariatric patients. Each facility meets stringent clinical criteria, developed in collaboration with expert physicians and medical organizations, including the American Society for Metabolic and Bariatric Surgery (“ASMBS”) and the American College of Surgeons (“ACS”), and is subject to periodic re-evaluation as criteria continue to evolve
- The 2017 Blue Distinction Centers for Bariatric Surgery program uses updated Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (“MBSAQIP”) accreditation levels, which focus on site of service. With this design change, each facility can apply to achieve the BDC or BDC+ designation, as either a Comprehensive Center (including outpatient capability) or an Ambulatory Surgery Center (“ASC”).

Cancer Care

- Blue Distinction Centers for Cancer Care is a new national designation program that recognizes physicians, physician practices, cancer centers, and hospitals for their efforts in coordinating all types of cancer care. This program incorporates patient-centered and data-driven practices, to coordinate care better and to improve quality of care and safety, as well as affordability. Providers in this Program are paid under a provider agreement with their local BCBS Plan that has value-based reimbursement, rather than traditional fee-for-service, so they must perform against both quality and cost outcome targets in order to receive incentives and rewards for better health outcomes.
- Designations will be awarded on an ongoing basis, and the program will continue to expand in the future.

Spine Surgery

- Blue Distinction Centers for Spine Surgery® launched in November 2009.
- Studies confirm that as many as eight out of 10 Americans suffer from some sort of back pain. Many ways to treat back pain are available, and your doctor can guide you toward the most appropriate recommendation for your situation. For those with severe and/or chronic back pain, spine surgery may be a treatment option.
- Research confirms that hospitals designated as Blue Distinction Centers and Blue Distinction Centers+ for Spine Surgery have fewer complications and fewer hospital readmissions than non-designated hospitals. Blue Distinction Centers+ for Spine Surgery also deliver care more efficiently than their peers.
- Blue Distinction Centers and Blue Distinction Centers+ for Spine Surgery provide comprehensive inpatient spine surgery services, including discectomy, fusion and decompression procedures.
- To date, we have designated hospitals in the majority of states across the U.S.

Knee and Hip Replacement

- Blue Distinction Centers for Knee and Hip Replacement™ launched in November 2009.
- Blue Distinction Centers and Blue Distinction Centers+ for Knee and Hip Replacement provide comprehensive inpatient knee and hip replacement services, including total knee replacement and total hip replacement surgeries.

Maternity Care

- Blue Distinction Centers and Blue Distinction Centers+ for Maternity Care launched in 2016 and offers access to healthcare facilities with demonstrated expertise and a commitment to quality care during the delivery episode of care, which includes both vaginal and cesarean section delivery.
- The Maternity Care designation uses publicly available data from Hospital Compare data which includes the Early Elective Delivery (PC-01) and elected patient experience measures at the facility level from Hospital Consumer Assessment of Healthcare Providers and Systems (“HCAHPS”).

Ventricular Assist Devices

- Anthem's Center of Medical Excellence Ventricular Assist Device (VAD), small implantable pumps that assist the heart by pumping blood in the circulatory system of individuals with end-stage heart failure, launched in 2017.
- According to the Centers for Disease Control and Prevention Heart failure reports that about **5.7 million** adults in the United States have heart failures a major public health problem associated with significant hospital admission rates, mortality, and costly health care services.
- Based on registry data, >15,000 left ventricular assist devices (LVADs) were implanted from June 2006 to December 2014. An estimated 3000+ VADs will be implanted worldwide this year, but the volume is expected to increase as newer, smaller devices receive regulatory approval, clinical indications slowly expand and the continued increase in centers certified to place these devices.

Chimeric Antigen Receptor Therapy (“CAR-T”)

- The FDA has approved a new product Chimeric Antigen Receptor T-cell (CAR-T), a CD19-directed genetically modified autologous T cell immunotherapy which brings new treatment options for cancer patients.
- Two (2) Chimeric Antigen Receptor T cell therapies (CAR-T) have been recently approved by the FDA to treat certain patients with leukemia and lymphoma:
 1. Yescarta for treatment in Adult Patients
 2. Kymriah for treatment in Pediatric and Adult Patients
- These procedures can be performed in the Inpatient (IP) or Outpatient (OP) setting and Care and follow-up continues over the first year.
- These Members are managed by the transplant Case Managers and Anthem Medical Policy requires the procedure be performed at a Certified CAR-T center.
- Currently there is not a designation or contract for CAR-T therapy and each case requires a Letter of Agreement. In 2019 Anthem Centers of Medical Excellence will have a designation and contract for CAR-T
- The Blue Cross Blue Shield Association will also have a designation, but not a contract requirement for CAR-T Providers in 2019.

Product Summary

[Anthem Blue Cross and Blue Shield Products](#)

Please refer to Plans and Benefits on www.Anthem.com or its successor for additional information.

[Federal Employee Health Benefit Program Plans](#)

Please refer to the Benefits and Services on the Federal Employee Health Benefit Program (FEHBP) Web Site at www.fepblue.org for additional information.

[Other Products](#)

Please refer to Plans and Benefits on www.Anthem.com or its successor for additional information.

Medicare Advantage

[Medicare Advantage Provider Website](#)

Please refer to the Medicare Eligible website online for additional information at www.anthem.com/medicareprovider.

Medicare Advantage Provider Manuals and Medicare Advantage Provider Guidebook are available on the Medicare Eligible website referenced above.

- Medicare Advantage Provider Guidebook or [Select Here](#)
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Federal Employees Health Benefits Program

[FEHBP Requirements](#)

Providers and Facilities acknowledge and understand that Anthem participates in the Federal Employees Health Benefits Program ("FEHBP"). The Anthem FEHBP encompasses the Blue Cross Blue Shield Association Service Benefit Plan, otherwise known as "Federal Employee Program®" or "FEP®", – the health insurance Plan for federal employees. Providers and Facilities further understand and acknowledge that the FEHBP is a federal government program and the requirements of the program are subject to change at the sole direction and discretion of the United States Office of Personnel Management. Providers and Facilities agree to abide by the rules, regulations, and other requirements of the FEHBP as they exist and as they may be amended or changed from time to time, with or without prior notice. Providers and Facilities further agree that, in the event of a conflict between the Provider or Facility agreement or this Provider Manual and the rules, regulations, or other requirements of the FEHBP, the terms of the rules, regulations, and other requirements of the FEHBP shall control.

When a conflict arises between federal and state laws and regulations, the federal laws and regulations supersede and preempt the state or local law (Public Law 105-266). In those instances, FEHBP is exempt from implementing the requirements of state legislation.

[Submission of Claims under the Federal Employees Health Benefits Program](#)

All Claims under the FEHBP must be submitted to Plan for payment within the timeframe listed in the Provider or Facility Agreement. This timeframe applies from the date of discharge or from the date of the primary payer's

explanation of benefits. Providers and Facilities agree to provide to Plan, at no cost to Anthem or Member, all information necessary for Plan to determine its liability, including, without limitation, accurate and complete Claims for Covered Services, utilizing forms consistent with industry standards and approved by Plan or, if available, electronically through a medium approved by Plan. If Plan is the secondary payer, the timeframe will not begin to run until Provider or Facility receives notification of primary payer's responsibility. Plan is not obligated to pay Claims received after the timeframe indicated in the Agreement. Except where the Member did not provide Plan identification, Provider and Facility shall not bill, collect, or attempt to collect from Member for Claims Plan receives after the applicable period regardless of whether Plan pays such Claims.

Erroneous or duplicate Claim payments under the FEHBP

For erroneous or duplicate Claim payments under the FEHBP, either party shall refund or adjust, as applicable, all such duplicate or erroneous Claim payments regardless of the cause. Such refund or adjustment may be made within five (5) years from the end of the calendar year in which the erroneous or duplicate Claim was submitted. In lieu of a refund, Plan may offset future Claim payments.

Coordination of Benefits for FEHBP

In certain circumstances when the FEHBP is the secondary payer and there is no adverse effect on the Member, the FEHBP pays the local Plan allowable minus the Primary payment. The combined payments, from both the primary payer and FEHBP as the secondary payer, might not equal the entire amount billed by the Provider or Facility for covered services.

FEHBP Waiver requirements

- Notice must identify the proposed services.
- Inform the Member that services may be deemed not medically necessary or experimental/investigational, by the Plan
- Provide an estimate of the cost for services
- Member must agree in writing to be financially responsible in advance of receiving the services; otherwise, the Provider or Facility will be responsible for the cost of services denied

FEHBP Member Reconsiderations and Appeals

There are specific procedures for reviewing disputed Claims under the Federal Employees Health Benefits Program. The process has two steps, starting with a review by the local Plan (reconsideration), which may lead to a review by the Office of Personnel Management ("OPM").

The review procedures are designed to provide Members with a way to resolve Claim disputes as an alternative to legal actions.

The review procedures are intended to serve both contract holders and Members. The local Plan and OPM do not accept requests for review from Providers or Facilities, except on behalf of, and with the written consent of, the contract holder or Member.

Providers and Facilities are required to demonstrate that the contract holder or Member has assigned all rights to the Provider or Facility for that particular Claim or Claims.

When a Claim or request for Health Services, drugs or supplies – including a request for precertification or prior approval – is denied, whether in full or partially, the local Plan that denied the Claim reviews the benefit determination upon receiving a written request for review. This request must come from the Member, contract holder or their authorized representative. The request for review must be received within six months of the date of the Plan's final decision. If the request for review is on a specific Claim(s), the Member must be financially liable in order to be eligible for the disputed Claims process.

The local Plan must respond to the request in writing, affirming the benefits denial, paying the Claim, or requesting the additional information necessary to make a benefit determination, within 30 calendar days of receiving the request for review. If not previously requested, the local Plan is required to obtain all necessary medical information, such as operative reports, medical records and nurses' notes, related to the Claim. If the

additional information is not received within 60 calendar days, the Plan will make its decision based on the information available. Appropriate medical review will also be done at this time. If the Plan does not completely satisfy the Member's request, the Plan will advise the Member of his/her right to appeal to OPM.

Providers or Facilities may not submit appeals to the OPM. Only the Member or contract holder may do so, as outlined in the Blue Cross and Blue Shield Service Benefit Plan brochure.

FEHBP Formal Provider and Facility Appeals

Providers and Facilities are entitled to pursue disputes of their **pre-service request** (this includes pre-certification or prior approval) or their **post-service claim** (represents a request for reimbursement of benefits for medical services that have already been performed), by following a formal dispute resolution process.

A formal Provider or Facility appeal is a written request from the rendering Provider or Facility, to his/her local Plan, to have the local Plan re-evaluate its contractual benefit determination of their post-service Claim; or to reconsider an adverse benefit determination of a pre-service request. The request must be from a Provider or Facility and must be submitted in writing within 180 days of the denial or benefit limitation. In most cases, this will be the date appearing on the Explanation of Benefits/Remittance sent by the Plan. For pre-service request denials, the date will be the date appearing on the Plan's notification letter.

The request for review may involve the Provider or Facility's disagreement with the local Plan's decision about any of the **clinical issues** listed below where the Providers or Facilities are *not* held harmless. Local Plans should note that this list is not all-inclusive.

1. not medically necessary (NMN);
2. experimental/investigational (E/I);
3. denial of benefits, in total or in part, based on clinical rationale (NMN or E/I);
4. precertification of hospital admissions; and,
5. prior approval (for a service requiring prior approval under FEHBP).

Not all benefit decisions made by local Plans are subject to the formal Provider and Facility appeal process. The formal Provider and Facility appeal process does not apply to any non-clinical case.

When a Claim or request for services, drugs or supplies – including a request for precertification or prior approval – is denied, whether in full or partially, the local Plan that denied the Claim reviews the benefit determination upon receiving a written request for review. This request must come from the rendering/requesting Provider or Facility. The request for review must be received within six months of the date of the local Plan's final decision. If the request for review is on a specific Claim(s), the Provider or Facility must be financially liable in order to be eligible for the formal Provider and Facility appeal process.

The local Plans must respond to the request in writing, affirming the benefits denial, paying the Claim, or requesting the additional information necessary to make a benefit determination, within 30 calendar days of receiving the request for review. If not previously requested, the local Plan is required to obtain all necessary medical information, such as operative reports, medical records and nurses' notes, related to the Claim. If the additional information is not received within 60 calendar days, the local Plan will make its decision based on the information available. Appropriate medical review will also be done at this time. Even if the local Plan does not completely satisfy the Provider or Facility's request, the formal Provider and Facility appeal process is complete; no additional appeal rights are available.

FEHBP Inpatient Skilled Nursing Facility Care

- Effective January 1, 2018 benefits are available for up to 30 days of inpatient skilled nursing facility ("SNF") care per benefit year for Standard Option Members who are not enrolled in Medicare Part A.
- Hospitals and Plan staff must be proactive in identifying Members for whom a SNF stay is an appropriate level of care in the continuum toward transition home.
- The Member must be enrolled in case management ("CM") and the signed consent for CM must be received by the case manager prior to precertification approval of the SNF admission. This

will require that the hospital discharge planning staff collaborate with the Plan case manager, and in some cases, will necessitate the hospital case manager/discharge planner's assistance in delivering the consent to the Member and having it returned to the Plan after the Member/proxy signs the document.

- The transferring facility must submit a detailed description of the Member's clinical status and the proposed treatment plan for the Plan's review of the proposed admission.
- Once the Member is admitted and subsequently within the timeframes established by the Plan, the SNF representative must provide specific information regarding the Member's status, progress towards goals, changes to the treatment plan and/or discharge plan (if applicable) and documentation of any obstacles preventing the Member from achieving the goals.
- The attending physician in the SNF must write admission orders and review the preliminary treatment plan within 24 hours of the Member's admission. Members admitting on a ventilator must be seen by a pulmonologist within 12 hours of admission and respiratory therapy be available in the facility 24 hours/day.
- Members admitted for rehabilitation must receive an evaluation by a physical therapist and a physical therapy treatment plan must be in place within 16 hours of admission. Members admitted primarily for rehabilitation must receive at least 2 hours of physical therapy and occupational therapy combined at least 5 days per week (logs must be provided to the Plan to document therapy time).

BlueCard Program Overview

BlueCard is a national program that enables Members of one Blue Plan to obtain healthcare service benefits while traveling or living in another Blue Plan's service area. The program links participating healthcare Providers and Facilities with the independent Blue Plans across the country and in more than 200 countries and territories worldwide through a single electronic network for Claims processing and reimbursement. The program allows Providers and Facilities to submit Claims for Members from other Blue Plans, domestic and international, to Anthem. Anthem is the sole contact for Claims payment, adjustments and issue resolution.

For more information about the BlueCard Program, Providers and Facilities can access the BlueCard Provider Manual, online at **[anthem.com > Provider > Indiana > Communications > General Information or Select Here.](#)**

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 new sletter, and sent via Anthem's email service. To sign up for Provider Communications for Indiana, go to <https://messageinsite.com/netw orkeupdate>.

Additional information and current communications about Health Insurance Exchanges can be found from the provider homepage at [anthem.com](#).

Important reminder:

Providers and Facilities are able to confirm their participation status in our different networks by using the Find a Doctor tool. Please see the **Online Provider Directories and Demographic Data Integrity** section for more details.

Audit**Anthem Audit Policy**

This Anthem Audit Policy applies to Providers and Facilities. If there is conflict between this Policy and the terms of the applicable Provider or Facility Agreement, the terms of the Agreement will prevail. If there is a conflict in provisions between this Policy and applicable state law that is not addressed in the Provider or Facility Agreement the state law will apply. All capitalized terms used in this Policy shall have the meaning as set forth in the Provider or Facility Agreement between Anthem and Provider or Facility.

Coverage is subject to the terms, conditions, and limitations of a Member's Health Benefit Plan and in accordance with this Policy.

There may be times when Anthem conducts claim reviews or audits either on a prepayment or post payment basis. Claim reviews and audits are conducted in order to confirm that healthcare services or supplies were delivered in compliance with the Member's plan of treatment or to confirm that charges were accurately reported in compliance with Anthem's policies and procedures as well as general industry standard guidelines and regulations.

In order to conduct such reviews and audits, Anthem or its designee may request documentation, most commonly in the form of patient medical records. 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, Provider's or Facility's established internal policies, professional licensure standards that reference standards of care, or business practices justifying the healthcare service or supply. The Provider or Facility must review, approve and document all such internal policies and procedures as required by The Joint Commission ("TJC") or other applicable accreditation bodies and such policies shall be made available for review by the auditor.

This policy documents Anthem's guidelines for claims requiring additional documentation and the Provider's or Facility's compliance for the provision of requested documentation.

Definition:

The following definitions shall apply to this Audit section only:

- Agreement means the written contract between Anthem and Provider or Facility that describes the duties and obligations of Anthem and the Provider or Facility, and which contains the terms and conditions upon which Anthem will reimburse Provider or Facility for Health Services rendered by Provider or Facility to Member(s).
- Appeal means Anthem's or its designee's review of the disputed portions of the Audit Report, conducted at the written request of a Provider or Facility and pursuant to this Policy.
- Appeal Response means Anthem's or its designee's written response to the Appeal after reviewing all Supporting Documentation provided by Provider or Facility.
- Audit means a qualitative or quantitative review of Health Services or documents relating to such Health Services rendered by Provider or Facility, and conducted for the purpose of determining whether such Health Services have been appropriately reimbursed under the terms of the Agreement.

- Audit Report and Notice of Overpayment ("Audit Report") means a document that constitutes notice to the Provider or Facility that Anthem or its designee believes an overpayment has been made by Anthem and identified as the result of an Audit. The Audit Report shall contain administrative data relating to the Audit, including the amount of overpayment and findings of the Audit, that constitute the basis for Anthem's or its designee's belief that the overpayment exists. Unless otherwise stated in the Agreement between the Provider or Facility and Anthem, Audit Reports shall be sent to Provider or Facility in accordance with the Notice section of the Agreement.
- Business Associate or designee means a third party designated by Anthem to perform an Audit or any related Audit function on behalf of Anthem pursuant to a written agreement with Anthem.
- Provider or Facility means an entity with which Anthem has a written Agreement.
- Provider Manual means the proprietary Anthem document available to the Provider and Facility, which outlines certain Anthem Policies.
- Recoupment means the recovery of an amount paid to Provider or Facility which Anthem has determined constitutes an overpayment not supported by an Agreement between the Provider or Facility and Anthem. A Recoupment is generally performed against a separate payment Anthem makes to the Provider or Facility which is unrelated to the services which were the subject of the overpayment, unless an Agreement expressly states otherwise or is prohibited by law. Recoupments shall be conducted in accordance with applicable laws and regulations.
- Supporting Documentation means the written material contained in a Member's medical records or other Provider or Facility documentation that supports the Provider's or Facility's claim or position that no overpayment has been made by Anthem.

Policy:

Upon request from Anthem or its designee, facilities are required to submit additional documentation for claims identified for pre-payment review or post payment audit. Applicable types of claims include, but are not limited to:

1. Claims being reviewed to validate the correct diagnosis related group (DRG) assignment/payment (DRG validation audits)
2. Claims being reviewed to validate items and services billed are documented in the medical record for hospital bill audits (also known as hospital charge audits)
3. Claims with unlisted or miscellaneous codes
4. Claims for services requiring clinical review
5. Claims for services found to possibly conflict with covered benefits for Members after validity review of the Member's medical records
6. Claims for services found to possibly conflict with Medical Necessity of covered benefits for Members
7. Claims requesting an extension of benefits
8. Claims being reviewed for potential fraud, abuse or demonstrated patterns of billing/coding inconsistent with peer benchmarks
9. Claims for services that require an invoice
10. Claims for services that require an itemized bill
11. Claims for beneficiaries where other health insurance (OHI) is indicated with the claim submission
12. Claims requiring documentation of the receipt of an informed consent form
13. Claims requiring a certificate of Medical Necessity
14. Appealed claims where supporting documentation may be necessary for determination of payment
15. Other documentation required by other entities such as the Centers for Medicare and Medicaid Services (CMS), and state or federal regulation
16. Documentation for such services as the provision of durable medical equipment, prosthetics, orthotics, and supplies, rehabilitation services, and home health care

Anthem or its designee will use the following guidelines for records requests and the adjudication of claims identified for prepayment review or post payment audit:

1. Upon confirmation of Provider's or Facility's address, an original letter of request for supporting documentation will be sent.
2. When a response is not received within 30 days of the date of the initial request, a second request letter will be sent.
3. When a response is not received within 15 days of date of the second request, a final request letter will be sent.
4. When a response is not received within 15 days of the date of the final request (60 days total):
 - a. Anthem or its designee will initiate claim denial for claims identified as pre-payment review claims as Provider or Facility failed to submit the required documentation. The Member shall be held harmless for such payment denials.
 - Or
 - b. Anthem or its designee will initiate claim retractions 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 payment retractions.

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 or post payment audit.

[This policy will not supersede any individual Provider or Facility contract provisions or state or federal guidelines.]

Procedure:

1. Review of Documents. Anthem or its designee will request in writing or verbally, final and complete itemized bills and/or complete medical records for all Claims under review. The Provider or Facility will supply the requested documentation in the format requested by Anthem or its designee within the time frame outlined above.
2. Scheduling of Audit. 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.
3. Rescheduling of Audit. Should Provider or Facility desire to reschedule an Audit, Provider or Facility must submit its request with a suggested new date to Anthem or its designee in writing at least seven (7) calendar days in advance of the day of the Audit. Provider's or Facility's new date for the Audit must occur within thirty (30) calendar days of the date of the original Audit. Provider or Facility may be responsible for cancellation fees incurred by Anthem or its designee due to Provider's or Facility's rescheduling.
4. Under-billed and Late-billed Claims. During the scheduling of the Audit, Provider or Facility may identify Claims for which Provider or Facility under-billed or failed to bill for review by Anthem during the Audit. Under-billed or late-billed Claims not identified by Provider or Facility before the Audit commences will not be evaluated in the Audit. These Claims may, however, be submitted (or resubmitted for under-billed Claims) to Anthem for adjudication.
5. Scheduling Conflicts. Should the Provider or Facility fail to work with Anthem, or its designee in scheduling or rescheduling the Audit, Anthem or its designee retains the right to conduct the Audit with a seventy-two (72) hour advance written notice, which Anthem or its designee may invoke at any time. 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.
6. On-Site and Desk Audits. Anthem or its designee may conduct Audits from its offices or on-site at the Provider's or Facility's location. If Anthem or its designee conducts an Audit at a Provider's or Facility's Location, Provider or Facility will make available suitable work space for Anthem's or its designee's on-site Audit activities. During the Audit, Anthem or its designee will have complete access to the applicable

health records including ancillary department records and/or invoice detail without producing a signed Member authorization. When conducting credit balance reviews, Provider or Facility will give Anthem or its designee a complete list of credit balances for primary, secondary and tertiary coverage, when applicable. In addition, Anthem or its designee will have access to Provider's or Facility's patient accounting system to review payment history, notes, Explanation of Benefits and insurance information to determine validity of credit balances. If the Provider or Facility refuses to allow Anthem or its designee access to the items requested to complete the Audit, Anthem or its designee may opt to complete the Audit based on the information available. All Audits (to include medical chart audits and diagnosis related group reviews) shall be conducted free of charge despite any Provider or Facility policy to the contrary.

7. Completion of Audit. 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.
8. Provider or Facility Appeals. See Audit Appeal Policy.
9. No Appeal. If the Provider or Facility does not formally Appeal the findings in the final Audit Report **and** submit supporting documentation within the (thirty) 30 calendar day timeframe, the initial determination will stand and Anthem or its designee will process adjustments to recover the amount identified in the final Audit Report.

Documents Reviewed During an Audit:

The following is a description of the documents that may be reviewed by Anthem or its designee along with a short explanation of the importance of each of the documents in the Audit process. It is important to note that Providers and Facilities must comply with applicable state and federal record keeping requirements.

- A. Confirm that Health Services were delivered by the Provider or Facility in compliance with the plan of treatment.

Auditors will verify that Provider's or Facility's plan of treatment reflected the Health Services delivered by the Provider or Facility. The services are generally documented in the Member's health or medical records. In situations where such documentation is not found in the Member's medical record, the Provider or Facility may present other documents substantiating the treatment or Health Service, such as established institutional policies, professional licensure standards that reference standards of care, or business practices justifying the Health Service or supply. The Provider or Facility must review, approve and document all such policies and procedures as required by The Joint Commission ("TJC") or other applicable accreditation bodies. Policies shall be made available for review by the auditor.

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

The auditor will verify that the billing is free of keystroke errors. Auditors may also review the Member's health record documents. The health record records the clinical data on diagnoses, treatments, and outcomes. A health record generally records pertinent information related to care and in some cases, the health record may lack the documented support for each charge on the Member's Claim. Other appropriate documentation for Health Services provided to the Member may exist within the Provider's

or Facility's ancillary departments in the form of department treatment logs, daily charge records, individual service/order tickets, and other documents. Anthem or its designee may have to review a number of documents in addition to the health record to determine if documentation exists to support the Charges on the Member's Claim. The Provider or Facility should make these records available for review and must ensure that Policies exist to specify appropriate documentation for health records and ancillary department records and/or logs.

[Audit Appeal Policy](#)

Purpose:

To establish a timeline for issuing Audits and responding to Provider or Facility Appeals of such Audits.

Procedure:

1. Unless otherwise expressly set forth in an Agreement, Provider or Facility shall have the right to Appeal the Audit Report. An Appeal of the Audit Report must be in writing and received by Anthem or its designee within thirty (30) calendar days of the date of the Audit Report unless State Statute expressly indicates otherwise. The request for Appeal must specifically detail the findings from the Audit Report that Provider or Facility disputes, as well as the basis for the Provider's or Facility's belief that such finding(s) are not accurate. All findings disputed by the Provider or Facility in the Appeal must be accompanied by relevant Supporting Documentation. Retraction will begin at the expiration of the thirty (30) calendar days unless expressly prohibited by contractual obligations or State Statute.
2. A Provider's or Facility's written request for an extension to submit an Appeal complete with Supporting Documentation or payment will be reviewed by Anthem or its designee on a case-by-case basis. If the Provider or Facility chooses to request an Appeal extension, the request should be submitted in writing within thirty (30) calendar days of receipt of the Audit Report. One Appeal extension may be granted during the Appeal process at Anthem's or its designee's sole discretion, for up to thirty (30) calendar days from the date the Appeal would otherwise have been due. Any extension of the Appeal timeframes contained in this Policy shall be expressly conditioned upon the Provider's or Facility's agreement to waive the requirements of any applicable state prompt pay statute and/or provision in an Agreement which limits the timeframe by which a Recoupment must be completed. It is recognized that governmental regulators are not obligated to the waiver.
3. 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 Audit Report. Anthem's or its designee's response shall be sent via certified mail 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. Revisions to the Audit data will be included in this mailing if applicable.
4. 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.
5. Upon receipt of a timely Provider or Facility 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. If appropriate, Anthem's or its designee's final Appeal Response will indicate what adjustments, if any, shall be made to the overpayment amounts outlined in the Audit Report or final Appeal Response. Anthem's or its designee's final Appeal Response shall be sent via certified mail 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. Revisions to the Audit Report will be included in this mailing if applicable.

6. 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, and a confirming Recoupment notification will be sent to the Provider or Facility.
7. If Provider or Facility still disagrees with Anthem's or its designee's position after receipt of the final Appeal Response, Provider or Facility may invoke the dispute resolution mechanisms under the Agreement.

Fraud, Waste and Abuse Detection

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

- *Fraud – intentionally falsifying information and knowing that deception will result in improper payment and/or unauthorized benefit. This includes, knowingly soliciting, receiving, and/or offering compensation to encourage or reward referrals for items or services and/or making prohibited referrals for certain designated health services.*
- *Waste – includes overusing services, or other practices that, directly or indirectly, result in unnecessary costs. Waste is generally not considered to be driven by intentional actions, but rather occurs when resources are misused.*
- *Abuse – when health care providers or suppliers do not follow appropriate medical billing/documentation practices or medical practices resulting in unnecessary or excessive costs, incorrect payment, misuse of codes, or services that are not medically necessary.*

Investigation Process

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

- *Written warning and/or education:* We send letters to the Provider or Facility advising the Provider or Facility of the issues and the need for improvement. Letters may include education or requests for repayment, or may advise of further action.
- *Medical record review:* We review medical records to investigate allegations or validate the appropriateness of Claims submissions.
- *Edits:* A certified professional coder or investigator evaluates Claims and places payment or system edits in Anthem's Claims processing system. This type of review prevents automatic Claims payments in specific situations.
- *Recoveries:* We recover overpayments directly from the Provider or Facility. Failure of the Provider or Facility to return the overpayment may result in reduced payment for future Claims, termination from our network, or legal action.

Prepayment Review

One method Anthem uses to detect FWA is through prepayment Claim review. Through a variety of means, certain Providers or Facilities, or certain Claims submitted by Providers or Facilities, may come to Anthem's attention for behavior that might be identified as unusual for coding, documentation and/or billing issues, or Claims activity that indicates the Provider or Facility is an outlier compared to his/her/its peers.

Once a Claim, or a Provider or Facility, is identified as an outlier or has otherwise come to Anthem's attention for reasons mentioned above, further investigation is conducted by the SIU to determine the reason(s) for the outlier status or any appropriate explanation for unusual coding, documentation, and/or billing practices. If the

investigation results in a determination that the Provider's or Facility's actions may involve FWA, the Provider or Facility is notified and given an opportunity to respond.

If, despite the Provider's or Facility's response, Anthem continues to believe the Provider's or Facility's actions involve FWA, or some other inappropriate activity, the Provider or Facility may be placed on prepayment review. If that occurs, the Provider or Facility will receive written notice of being placed on prepayment review. This means that the Provider or Facility will be required to submit medical records and any other supporting documentation with each Claim so Anthem can review the appropriateness of the services billed, including the accuracy of billing and coding, as well as the sufficiency of the medical records and supporting documentation submitted. Failure to submit medical records and supporting documentation to Anthem in accordance with this requirement will result in a denial of the Claim under review. The Provider or Facility will be given the opportunity to request a discussion of his/her/its prepayment review status.

Under the prepayment review program, Anthem may review coding, documentation, and other billing issues. In addition, we may use one or more clinical utilization management guidelines in the review of Claims submitted by the Provider or Facility, even if those guidelines are not used for all Providers or Facilities delivering services to Plan Members.

The Provider or Facility will remain subject to the prepayment review process until Anthem is satisfied that all inappropriate billing, coding, or documentation activity has been corrected. If the inappropriate activity is not corrected, the Provider or Facility could face corrective measures, up to and including termination from our network.

Finally, Providers and Facilities are prohibited from billing a Member for services we have determined are not payable as a result of the prepayment review process, whether due to FWA, any other coding or billing issue or for failure to submit medical records as set forth above. Providers or Facilities whose Claims are determined to be not payable may make appropriate corrections and resubmit such Claims in accordance with the terms of their Provider and Facility Agreement, proper billing procedures and state law. Providers or Facilities also may appeal such a determination in accordance with applicable grievance and appeal procedures.

Acting on Investigative Findings

In addition to the previously mentioned actions, we may refer suspected criminal activity committed by a Member, Provider or Facility to the appropriate regulatory and/or law enforcement agencies

Recoupment/Offset/Adjustment for Overpayments

Anthem shall be entitled to offset and recoup an amount equal to any overpayments or improper payments made by Anthem to Provider or Facility ("Overpayment Amount") against any payments due and payable by Anthem or any Affiliate to Provider or Facility with respect to any Health Benefit Plan under this Agreement or under any provider agreement between Provider and an Affiliate regardless of the cause. Provider or Facility shall voluntarily refund the Overpayment Amount regardless of the cause, including, but not limited to, payments for Claims where the Claim was miscoded, non-compliant with industry standards, or otherwise billed in error, whether or not the billing error was fraudulent, abusive or wasteful. Upon determination by Anthem that an Overpayment Amount is due from Provider or Facility, Provider or Facility must refund the Overpayment Amount to Anthem within thirty (30) calendar days of the date of the overpayment refund notice from Anthem to the Provider or Facility. If the Overpayment Amount is not received by Anthem within the thirty (30) calendar days following the date of such notice letter, Anthem shall be entitled to offset the unpaid portion of the Overpayment Amount against other Claims payments due and payable by Anthem or an Affiliate to Provider or Facility under any Health Benefit Plan in accordance with Regulatory Requirements. In such event, Provider or Facility agrees that all future Claim payments, including Affiliate Claim payments, applied to satisfy Provider's or Facility's repayment obligation shall be deemed to have been legally paid to Provider or Facility in full for all purposes, including Affiliates and/or Regulatory Requirements as defined by the Provider or Facility Agreement. Should Provider or Facility disagree with any determination by Anthem or a Plan that Provider or Facility has received an overpayment or improper payment, Provider or Facility shall have the right to appeal such determination under Anthem's procedures set forth in the Provider Manual, provided that such appeal shall not suspend Anthem's right to recoup the Overpayment Amount during the appeal process unless required by Regulatory Requirements. Anthem reserves the right to employ a third party collection agency in the event of non-payment.

Pharmacy Home Program

The availability and access to opioid medications used for the treatment of acute and chronic health conditions is at an all-time high. This access to healthcare is helping patients live longer and healthier lives. However, it can also lead to safety concerns when Members are on multiple controlled medications that are prescribed by multiple healthcare providers. To address the growing opioid epidemic, Anthem implemented the Pharmacy Home Program in April 2016 to allow for better administration of drug benefits through increased communication and coordination amongst prescribing physicians and pharmacies. The information in this section applies to Anthem Members with our prescription drug coverage.

The Pharmacy Home program helps reduce potential overutilization of prescription medications. If a Member is believed to be at an increased safety risk due to the overutilization of multiple medications, providers and/or pharmacies; and meets enrollment criteria they may be included in this program. Anthem is able to increase communication and coordination amongst prescribing physicians for Members that have been identified and restricted to a single pharmacy. The pharmacy is selected by the Member and/or is assigned based on the retrospective Drug Utilization Review ("DUR") of their prescription claims history. Following the selection of the Member's new Pharmacy Home, all prescribing physicians receive notification of the Member's enrollment into the program, the assigned pharmacy information and a 3-month prescription profile containing a list of all prescribers, medications, dosages, and quantities received by the Member during that timeframe.

The program is designed to limit a qualifying Member to the use of one specific participating pharmacy for a period of no less than 12 consecutive months. This assigned pharmacy, or Pharmacy Home, will fill all of the Member's prescribed medications throughout the term of their enrollment in this program.

The Pharmacy Home program includes:

- Reimbursement of Claims when filled at the Member's Pharmacy Home. All pharmacy Claims¹ are denied if filled at any pharmacy other than the Member's assigned Pharmacy Home².
- 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 if³:

- The Member received five or more controlled substance prescriptions (government-regulated drugs) in a 90-day period.
- The Member received controlled substance prescriptions from three or more prescribers in a 90-day period.
- The Member visited three or more pharmacies to fill controlled substance prescriptions in a 90-day period.

Communications to Members meeting criteria

Members who meet criteria are sent a notification at least 60 days prior to potential inclusion in the program. After a 60-day monitoring period, if the Member continues to meet the program criteria during that timeframe, he/she is contacted in writing of the decision to place him/her into the Pharmacy Home program and will be

¹ Both controlled and non-controlled medications must be filled at the designated Pharmacy Home.

² A Member may change the designated pharmacy only if the request meets good cause criteria.

³ Exemption of members with a diagnosis of Cancer, HIV, Multiple Sclerosis, Sickle-cell Anemia or those that are in Hospice Care. (Note: Exemptions are determined by both pharmacy claim history and medical diagnosis.)

given 30 additional days to select a Pharmacy Home and/or to file an appeal of the decision. In the event the Member does not select a Pharmacy Home within the allotted timeframe, one will be chosen for the Member on the 31st day based off of their pharmacy Claims. Anthem will ensure both the Member and their Provider will be notified of their new Pharmacy Home in writing. Once they have chosen a Pharmacy Home, a request to change pharmacies will be considered only for good cause situations.

Anthem is more committed than ever to equipping Providers with the tools and support necessary to help curb these trends and save more lives than are lost. If you have any questions or comments regarding enrollment, please contact the Member Services number located on the back of the Member's ID.

Workers' Compensation

This section of the Indiana Provider Manual applies to those providers who participate in the Anthem Workers' Compensation Network.

Provider Guidelines:

The Provider should ask the injured worker who is seeking medical treatment the nature of the illness or injury to confirm the illness or injury is work-related. Provider should further determine whether the injured worker's illness or injury is:

1. Nonemergency. Instruct the injured worker to obtain authorization from the employer before treatment is rendered.
2. Emergency. If an injured worker requires emergency treatment, care must be provided to the injured person. Determining workers' compensation coverage should be made within the next 72 hours.

When an injured worker seeks services for a work-related illness or injury, the Injured Worker will be directed to a participating provider. In the event the participating provider is unable to treat the Injured Worker, the provider shall refer or transfer the injured worker to a health care professional that participates in the Anthem Workers' Compensation Network. If the provider elects to treat the injured worker, the provider must complete a Physicians Report, as defined in the State Regulations. As payment for such medical services rendered, the provider agrees to accept, as payment in full, compensation in accordance with the reimbursement set forth in the Workers' Compensation Plan Compensation Schedule, Participation Attachment or Agreement.

All Anthem Workers' Compensation-related correspondence should be sent to:

Anthem Workers' Compensation
Attn: Customer Relations
3080 Bristol Street, Suite 200
Costa Mesa, CA 92626-3077

For questions regarding your Anthem Workers' Compensation Participation Attachment or Agreement, or other workers' compensation issues, please call 866-700-2168.

For questions regarding your Anthem Workers' Compensation reimbursement rate please call 855-766-3719.

Utilization Management Guidelines:

Utilization Management Guidelines are defined by the Other Payor, State Regulation, or processes internal to the Anthem Workers' Compensation Network (if applicable).

The Workers' Compensation Act of Indiana Standards:

The Workers' Compensation Act of Indiana has established standards for injured workers to access care and guidelines to improve the quality of medical care for occupational injuries. Participating providers must adhere to the guidelines below.

- Refer or transfer within the Anthem Workers' Compensation Network. To find a participating Anthem Workers' Compensation Network Provider, visit our website at www.anthemwc.com and click on "Find a Provider" and then "Indiana".
- Services obtained outside of the network may not be paid. Contact the claims adjuster for authorization for any medical care outside the network.
- Maintain medical records, records of accounts and payments, reports and other documents that were necessary for the delivery of the medical services as required by State Regulations. All such records, including records pertaining to the cost to the health care practitioner for delivery of the medical care and the payments received by the health care practitioner for such care, will be made available to the network, on request, during regular business hours.
- Submit bills to the appropriate workers' compensation Other Payor within the number of days required by State Regulation following the delivery of health care services. The Explanation of Review will indicate that rates are in accordance with your Anthem Workers' Compensation Participation Attachment or Agreement.
- The workers' compensation Other Payor will ensure payment for authorized medical services rendered while a claim is under investigation, until such time as a denial of the claim is made by the Other Payor.

Other Payors Accessing the Anthem Workers' Compensation Network :

A list of participating Other Payors may be accessed by accessing the Availity Web Portal or by requesting a list by calling 866-700-2168.

To register for the Availity Web Portal, go to www.availity.com and click on "get started".

Once you are registered, the "Anthem Workers' Compensation Network Leasing List" can be accessed by selecting "Payer Spaces", then "Anthem". From the Anthem Payer Space Page, select "Resources", then, Anthem Workers' Compensation Other Payor Network Leasing List".

Rules for Calculating Permanent Disability:

The calculation of permanent disability is to be in accordance with State Regulations.

If you feel you are unable to calculate permanent disability in accordance with State Regulation, contact the claims examiner to refer the patient to another participating Anthem Workers' Compensation Network provider who is able to calculate disability in accordance with State Regulations.

Grievances:

Anthem participating providers with a complaint or grievance may call 866-700-2168.

Additional Information:

For additional information regarding the obligations of the treating physician for Workers' Compensation, visit the Workers' Compensation Board of Indiana website at <http://www.in.gov/wcb/> or visit the Anthem Workers' Compensation website at www.anthemwc.com, and click on the provider tab, forms and resources and select Indiana as the service area or contact us at 866-700-2168.

Important Links

Anthem

<https://www.anthem.com/>

Availity

<https://www.availity.com/>

Blue Card®

http://www.anthem.com/wps/portal/ahpprovider?content_path=provider/oh/f5/s1/t0/pw_035482.htm&state=in&rootLevel=4&label=The%20Blue%20Card%20Program&state=in&rootLevel=4

Centers of Medical Excellence/Blue Distinction

http://www.anthem.com/wps/portal/ahpprovider?content_path=provider/noapplication/f2/s3/t0/pw_ad094863.htm&state=in&rootLevel=1&label=Centers_of_Medical_Excellence

Coordination of Benefits Questionnaire

http://www.anthem.com/provider/noapplication/f1/s0/t0/pw_ad095423.pdf?refer=ahpprovider&state=in

Federal Employee Program

<http://www.fepblue.org/>

Medicare Advantage Provider Information

<http://www.anthem.com/medicareprovider>

Network eUpdate (formerly Rapid Update) Email Sign-up Form

http://www.anthem.com/forms/central/netw_ork_rapid_updates.html

Provider Adjustment Form

http://www.anthem.com/wps/portal/ahpprovider?content_path=provider/in/f4/s0/t0/pw_ad080342.htm&rootLevel=3&state=in&label=Provider%20Adjustment%20Forms&state=in&rootLevel=3

Provider Maintenance Form

<https://central.provider.anthem.com/mwpmf/PMFControllerServlet>

Quality

https://www.anthem.com/wps/portal/ahpprovider?content_path=shared/noapplication/f2/s3/t0/pw_e174981.htm&label=Quality%20Improvement%20and%20Standards&rootLevel=1&state=in
