Georgia
Facility and Professional Provider Manual

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Introduction and Guide to Manual

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

This Provider Manual (Manual) contains important information regarding key administrative requirements, policies and procedures. While the Manual covers a wide array of policies, procedures, forms, and other useful information that can be found and maintained on the Anthem website, a few key topics are:

- Digital guidelines
- Claims submission
- Reimbursement and administrative policies and requirements
- Utilization management

As a participant in our diverse Anthem network, our care provider partners (Providers and Facilities) agree to comply with Anthem policies and procedures including those contained in this Manual. Payment may be denied, in full or part, should Providers or Facilities fail to comply with the Manual. However, in the event of an inconsistency between the Provider or Facility Agreement with Anthem (“Agreement”) and this Manual, the Agreement will govern.

Provider versus Facility

This Manual is intended to support all entities and individuals who have executed a Provider or Facility Agreement with Anthem.

The use of “Provider” within this Manual refers to entities and individuals contracted with Anthem who submit professional Claims. They may also be referred to as Professional Providers in some instances.

The use of “Facility” within this manual refers to entities contracted with Anthem who submit institutional Claims, such as Acute Care Hospitals and Skilled Nursing Facilities.

General references to Provider Website and similar terms apply to both Providers and Facilities.

Capitalization

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

Updates to the Provider Manual

This Manual may be updated at any time and is subject to change. If there is a material change to this Manual, then Anthem will make reasonable efforts to notify Providers and Facilities in advance of such change through web-posted newsletters or email communications. In such cases, the most recently published information will supersede all previous information and be considered the current directive.

Important disclaimer

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

Professional and Respectful Communication Standards

Anthem maintains an ongoing commitment to fostering a respectful, collaborative, and professional environment, recognizing that effective communication is an integral component. Your Participating Provider Agreement (the “Agreement”) with Anthem outlines your obligations as a Participating Provider with Anthem regarding conduct and professionalism. Providers, including those who represent them, such as office staff, billing entities, etc., are expected to conduct themselves in a professional and respectful manner in all interactions with Anthem members, employees, and representatives. Professional and respectful communication is not just a courtesy, but a fundamental responsibility that supports collaboration, builds trust, and enhances the quality of service we offer to our members. By upholding these standards, Providers contribute to a positive and inclusive atmosphere where every individual feels valued and respected.

In addition to the standard policies and guidelines outlined in this manual and your participating Provider Agreement, Anthem maintains a zero-tolerance policy for abusive or disruptive behavior, whether physical or verbal, from Providers, or those representing Providers, during the course of business. Violent acts and/or continued abusive or disruptive behavior will result in the termination of your participation in Anthem’s provider network.

Examples of behavior that will not be tolerated include, but are not limited to, any act of violence, threats, harassment, intimidation, and other disruptive behavior. Such behavior can include actual physical injury, direct or indirect verbal or written statements, disruptive behavior, suggestions of self-harm, threats of retaliation to others, or gestures that communicate a threat of physical harm.

Legal and Administrative Requirements

Affiliates

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

To view a current listing of Anthem affiliates, visit the **Anthem Provider Home page**. Under the **Resources** menu, select **Forms and Guides,** then scroll down to the **Contracting & Updates** section and select **Provider Agreement Affiliates List**.

Artificial Intelligence (AI) – Restrictions on AI Use in Performing a Health Plan Function

Providers who have been delegated to perform a health plan function (e.g., Utilization Management, credentialing, and/or claims payment) shall not use AI in the performance of any delegated health plan function without the advance written consent of the health plan. Providers shall request such approval in accordance with the notice provisions of the Provider Agreement, and the health plan shall provide its written response in accordance with the notice provisions of the Provider Agreement.

Clinical Data Sharing

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

- Facilities must provide Anthem with, at minimum, Health Level Seven International (HL7) Admission, Discharge and Transfer (ADT) messaging data for all Members on a near real-time basis, including all standard HL7 message events pertaining to ADT as published by HL7. Facility will transfer required message data segments according to the standard HL7 format, or as requested by Anthem. For purposes of this section, "near real-time basis" means no later than twenty-four (24) hours from admission, discharge, or transfer of any Members.
- Clinical data for a Member on a daily, weekly, or monthly basis, in a mutually agreeable format and method based on the Provider's electronic medical record (EMR) or other electronic data sharing capabilities, e.g., industry-standard CCDA clinical data format.

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

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

For details on how to submit clinical data, review the administrative policy by visiting the **Anthem Provider Home page**. Under the **Resources** menu, select **Forms and Guides,** then scroll down to the **Administrative Policies** section and select **Clinical Data Sharing**.

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

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 the Provider or Facility from the Plan or the Member will 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.

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 Electronic Coordination of Benefits (COB) Submissions

Availity is Anthem's designated electronic data interchange (EDI) gateway. The **Anthem Companion Guide** contains the required segments to bill Coordination of Benefit Claims electronically. To learn more, contact the EDI vendor.

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, Mediation and Arbitration

The substantive rights and obligations of Anthem, Providers and Facilities with respect to resolving disputes are set forth in the Anthem Provider or Facility Agreement. All administrative remedies set forth in the Agreement, including appeal, dispute resolution, and mediation procedures as well as any applicable state law exhaustion requirements, must be exhausted prior to filing an arbitration demand. The following provisions set forth the procedures and processes that must be followed during the exercise of the Dispute Resolution and Arbitration Provisions in the Agreement. To the extent possible, the language of the Agreement and the Provider Manual should be read as a whole, in context, if there are details in one not addressed in the other.

A. Fees and Costs

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

B. Location of the Arbitration

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

C. Pre-Arbitration Mediation and Selection and Replacement of Arbitrator(s)

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

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

D. Consolidation

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

E. Discovery

The parties recognize that litigation in state and federal courts can be costly and burdensome. One of the parties' goals in providing for disputes to be mediated and arbitrated instead of litigated is to reduce the costs and burdens associated with resolving disputes. Accordingly, the parties expressly agree that discovery shall be conducted with strict adherence to the rules and

procedures established by the mediation or arbitration administrator identified in the Agreement, except that the parties will be entitled to serve requests for production of documents and data, which shall be governed by Federal Rules of Civil Procedure 26 and 34. The parties shall confer and draft an Order Regarding Procedures for Production Format and Electronic Discovery, which shall be presented to the arbitrator or panel of arbitrators for review, approval and entry.

F. Decision of Arbitrator(s)

The decision of the arbitrator, if a single arbitrator is used, or the majority decision of the arbitrators, if a panel is used, shall be binding upon the parties. The arbitrator(s) may construe or interpret, but shall not vary or ignore, the provisions of the Agreement and shall be bound by and follow controlling law. The arbitrator(s) shall not toll or modify any applicable statute of limitations, set forth in the Agreement, or controlling law if the Agreement is silent. If there is a dispute regarding the applicability or enforcement of the class waiver provisions found in the Agreement, that dispute shall only be decided by a court of competent jurisdiction and shall not be decided by the arbitrator(s). Either party may request either a reasoned award or decision, or findings of facts and conclusions of law, and if either party makes such a request, the arbitrator(s) shall issue such an award or decision setting forth the factual and legal basis for the decision.

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

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

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

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

G. Interest

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

H. Confidentiality

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

Facility-Based Physicians

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

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

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

Financial Institution/Merchant Fees

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

Home Delivery Pharmacy Prescription Drug Program

Members covered under a Prescription Drug Program may have maintenance prescriptions filled through the Home Delivery Pharmacy Prescription Drug Program. For benefit information, refer to the back of the Member’s ID card.

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

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

For NEW maintenance medications, it is recommended that the primary care physician (PCP) write two prescriptions:

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

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

BlueChoice Providers and Members may call Anthem Customer Service regarding this program.

Insurance Requirements

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

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 the local Provider Services to report receipt of misrouted PHI.

Laboratory Tests

The Provider Agreement requires referrals to in-network Providers, and using an in-network laboratory helps Members maximize their laboratory benefits and minimize their out-of-pocket expenses. A complete and current list of in-network participating laboratories may be obtained on anthem.com. From the menu, select For Providers, then select Georgia and from the Provider home page select Find Care at the top right side of the webpage. The directory may also be accessed via this link: **Online Provider Directory**

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

Providers and Facilities are reminded that pursuant to their Agreement with Anthem, they are generally required to refer Members to other Network/Participating Providers and Facilities. Providers and Facilities who establish a pattern of referring Members to non-participating providers may be subject to disciplinary action, up to and including termination from the Network.

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

Non-Compliance Policy

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

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

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

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

Contact the **Provider Relationship Account Management team** with questions regarding the non-compliance policy.

National Provider Identifier (NPI)

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

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

Note if NPI numbers submitted are INVALID, Anthem will be unable to complete the processing of Claim(s). Correct tax identification number (TIN) and billing address must be included when filing a Claim.

Open Practice

Providers shall give Anthem sixty (60) days prior written notice when Provider no longer accepts new patients. Providers contracted with Anthem should utilize Availity's Provider Demographic Management (PDM) application hosted on **Availity.com** to request changes to existing practice information.

Patient Safety Standards Attestation Required by Hospitals

As a qualified health plan (QHP) issuer, Anthem must ensure compliance with federal regulation 42 CFR 156.1110 when contracting with hospitals with more than fifty (50) beds. This regulation mandates QHPs verify that hospitals meet these specific patient safety standards:

- The hospital must use a patient safety evaluation system as defined in 42 CFR 3.20 by:
    - Collecting and reporting data to patient safety organizations (PSOs)
    - Implementing a mechanism for comprehensive person-centered hospital discharge
    - Improving care coordination and healthcare quality for each patient
- If the hospital is not working with a PSO, the hospital must implement an evidence-based initiative to improve healthcare quality, reduce preventable harm, prevent readmission, and improve care coordination.

To help us ensure compliance, we require participating hospitals to attest to meeting these patient safety standards by completing the Patient Safety Standards form annually. To access the form, go to the **Anthem Provider Home page**, and under the **Resources** menu, select **Forms and Guides.** Under the **Affordable Care Act** section, select **Patient Safety Standards Form**.

Preferred Drug List

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

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

Providers, are asked to prescribe products from the Preferred Drug List for all Anthem Members. By prescribing preferred drugs when appropriate, Providers help contain the rising costs of health care, ensure the use of high quality pharmaceuticals, and help maintain patients’ continued drug coverage. Anthem asks that Providers assure patients of the safety and efficacy of generic equivalents. Use the Preferred Drug List when prescribing to Anthem Members. To receive a copy of the most current Preferred Drug List, go to **anthem.com** or contact the local **Provider Relationship Account Management team**.

Specific drugs may require preauthorization. Specific preauthorization request form will apply to these drugs. The drug-specific preauthorization forms are available on **anthem.com**.

Provider Data Verification Required

The Consolidated Appropriations Act (CAA) of 2021 is a federal act containing legal and regulatory requirements for health plans and providers to improve the accuracy of provider directory information.

Providers are required to review and verify the accuracy of this information in the online provider directory every ninety (90) days:

- Provider/facility name
- Address
- Specialty
- Phone number
- Digital contact information

Providers who fail to verify to their information every 90 days may be removed from the online provider directory.

Providers will be reinstated to the online provider directory once verification is completed.

To review, verify and update your online directory information, Anthem uses the provider data management (PDM) capability available on Availity.com to update provider or facility data. Using the Availity PDM capability meets the verification requirement to validate provider demographic data set by the CAA.

For details on Availity PDM, refer to the ***Online Provider Directory and Demographic Data Integrity*** subsection of this manual.

Provider and Facility Digital Engagement

Anthem expects Providers and Facilities will utilize digital tools unless otherwise prohibited by law or other legal requirements for transactions such as filing Claims, prior authorizations, verifying eligibility and benefits, paperless payments etc. Providers and Facilities should refer to the guidance included throughout this Manual where digital tools are available. For a complete list of digital tools, refer to the *Digital Applications* section and *Provider and Facility Digital Guidelines* subsection in this Manual.

Provider and Facility Notification Responsibilities

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

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

- Adding new or removing practitioners to the group
- Change in ownership
- Change in tax identification number
- Making changes to demographic information or adding new locations
- Selling or transferring control to any third party
- Acquiring other medical practice or entity
- Change in accreditation

- Change in affiliation
- Change in licensure or eligibility status
- Change in operations, business, or corporation
- Any change in its ownership or business address
- Any legal or governmental action or any other problem or situation which might impair the ability of Facility to carry out its duties and obligations under its Anthem Agreement(s), including, but not limited to, employee strikes or walkouts, financial insolvency, or damage to the physical plant resulting in any interruption in medical services
- Any written complaint, Claim or suit, or threat of legal action by a Member against the Facility or the Facility's medical staff
- Any action taken by Facility or its medical staff against a physician
- Any change or notification of possible change in professional licensure of staff Member or a physician

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

Risk Adjustment

Compliance with Federal Laws, Audits, and Record Retention Requirements

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

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

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

Encounter Data for Risk Adjustment Purposes

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

Under the HHS risk adjustment model, the health plan is permitted to submit diagnosis data from inpatient hospital, outpatient hospital and physician/qualified non-physician e.g. nurse practitioner encounters only.

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

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

RADV Audits

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

ICD-10 CM-Codes

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

Medical Record Documentation Requirements

Medical records significantly impact risk adjustment because:

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

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

HHS record documentation requirements include:

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

Substance Use Disorder (SUD) Confidentiality Protections for Members

Providers and Facilities subject to federal regulation 42 CFR Part 2 as "Part 2 Programs" must obtain compliant consent from their patients allowing for the use of records for treatment, payment, and healthcare operations (TPO). Without this consent, the Part 2 Program should not submit Claims for payment.

Part 2 programs are federally assisted programs that offer substance use disorder (SUD) diagnosis, treatment, or referral for treatment, and are subject to specific confidentiality regulations outlined in 42 CFR Part 2.

Use of a Non-Participating Provider

Anthem's mission is to provide affordable, quality healthcare benefits to its Members. Members access their highest level of healthcare benefits when receiving services from Network/Participating Providers and Facilities. Providers and Facilities put Members at risk of higher out-of-pocket expenses when they refer to, utilize, or transfer Members to Non-participating Providers or Facilities in non-emergent situations, without Anthem's prior approval, or instances in which no Participating Provider is available to render the same services within the same geographic area.

Providers and Facilities are reminded that, pursuant to their Agreement with Anthem, they are required to refer to, utilize, or transfer Members to other Network/Participating Providers and Facilities.

Providers and Facilities that establish a pattern of referring to, utilizing, or transferring Members to Non-participating Providers may be subject to disciplinary action, up to and including financial penalties, or termination from the Anthem Network(s). Anthem understands there may be instances in which Providers and Facilities must utilize Non-participating Providers. In such cases, Providers and Facilities must present evidence of extenuating circumstances if they choose to dispute any resulting disciplinary action.

Providers and Facilities can contact their Anthem contract manager for additional information.

Digital Applications

Anthem Provider Website

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

Anthem designed the provider public website to make navigation easy and useful for Providers and Facilities. The website holds timely and important information to assist Providers when working with Anthem. To access our Provider website:

- Go to **anthem.com** and select **For Providers** at the top of the webpage
- From the **Provider Welcome page**, select **Georgia** to go to the **Anthem Provider Home page**

Information available on the provider website includes:

- Resources
  - Forms and Guides
  - Policies, Guidelines and Manuals
  - Medical Policies & Clinical UM Guidelines
  - Availity, EMR and Digital Solutions
  - Referrals
  - Prior Authorization
  - Education & Training
  - Vaccination Resources
  - Medicare Advantage
  - News
- Claims
  - Claim Submission
  - Reimbursement Policies
  - Electronic Data Interchange (EDI)
- Patient Care
  - Behavioral Health
  - Dental
  - Enhanced Personal Health Care
- Communications
  - News
  - News Archives
- Pharmacy
- Provider Enrollment and Maintenance
  - Join our Network
  - Provider Maintenance and Demographic Updates
  - Employee Assistance Program (EAP)

E-mail Communications

Anthem produces a monthly newsletter, *Provider News*, designed to notify Providers, Facilities, and their staff about updates, events, and changes in processes and policies. Providers and Facilities can sign up for email communications to be notified when a newsletter is published and receive other notifications from Anthem. To sign up for our email communications, go to our ***Provider News website*** and select the **Subscribe to Email** button.

Online Provider Directory & Demographic Data Integrity

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

Online Provider Directory

Accessing the Online Provider Directory:

- Go to **anthem.com**
- Select the **Find Care** link at the top right of the page.
  - To search the online Provider Directory either enter the Member information or enter as guest.

Before directing a Member to another Provider or Facility, verify that the Provider or Facility is participating in the Member's specific network. ***Note***: The Member's Network Name should be on the lower right corner of the front of the Member's ID card.

- To help ensure Members are directed to Providers and Facilities within their specific Network, utilize the Online Provider Directory one of the following ways:
  - **Use Member ID for Basic Search**: Search by entering the Member's ID number (including the three-character prefix), or simply enter the three-character prefix by itself.
  - Select **Basic Search as Guest**.

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

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

Updating Demographic Data with Anthem

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

All requests must be received thirty (30) days **prior** to change/update. Any requests received within less than thirty (30) days' notice may be assigned a future effective date. Contractual terms may supersede effective date request.

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

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) (must be accompanied by a W-9 to be valid)
- Termination of provider participation agreement******
- Web address

***** To request participation for a new provider or practitioner, even if joining an existing practice, providers or practitioners must first begin the Application process. Go to the **Anthem Provider Home page** and under the **Provider Enrollment and Maintenance** menu, select **Join our Network**.

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

Methods for updating provider data

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

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

Roster Automation is our technology solution designed to streamline and automate Provider data additions, changes, and terminations that are submitted using a standardized Microsoft Excel document. Any Provider, whether an individual provider/practitioner, group, or facility, can use Roster Automation today. If any roster data updates require credentialing, your submission will be routed appropriately for further action.

The resources for this process are listed below and available on our website. Go to the **Anthem Provider Home page**, and under the **Resources** menu select **Forms and Guides**. The **Roster**

Automation Rules of Engagement and **Roster Automation Standard Template** appear under the **Digital Tools** category.

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

Accessing PDM Application

Log onto **Availity.com** and select My Providers > Provider Data Management to begin the attestation process. If submitting a roster, find the TIN/business name to be verified and update the information. Before selecting the TIN/business name, select the three-bar menu option on the right side of the window, and select **Upload Rosters** and follow the prompts.

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

Exclusions

- Behavioral Health providers contracted with Carelon Behavioral Health who will continue to follow the process for demographic requests and/or roster submissions, as outlined by Carelon Behavioral Health.
- Any specific state mandates or requirements for provider demographic updates

Availity Essentials

We offer digital solutions to enhance collaboration and streamline interactions with Anthem, helping to eliminate complexities and improve transparency, traceability, and the entire experience for Providers and Facilities.

Availity Essentials is available to all Providers and Facilities:

- **Multi-payer access:** Users can access data from Anthem Medicare, Medicaid and other Commercial insurers. See **Availity.com** for a full list of payers.
- **No charge:** Anthem transactions are available at no charge to Providers and Facilities.
- **Standard responses:** Responses from multiple payers returned in the same format and screen layout, providing users with consistency across payers.
- **Compliance:** Availity Essentials is compliant with all Health Insurance Portability and Accountability Act (HIPAA) regulations.
- **Accessibility:** Availity Essentials functions are available 24/7 from any computer with Internet access.

Availity Essentials simplifies the way we work together through these applications and processes:

- **Eligibility and Benefits application:** Access current Member coverage, benefits information and Member's digital ID cards. Use the Patient Registration tab to access Eligibility and Benefits.
- **Submit Claims:** Use either the Claims & Payments application or EDI gateway.
- **Claims Status application:** Monitor claim status, submit documents, and file claims disputes online. Access Claims Status from the Claims & Payments tab.
- **Authorizations:** Submit for medical or behavioral health inpatient or outpatient services, file appeals and track authorization cases. Access the Authorization from the Patient Registration tab.
- **Provider Data Management:** Update demographic information digitally. Access the Provider Data Management application through the My Providers tab.
- **Roster Automation:** Use standardized forms, identify necessary changes, and update the demographic system seamlessly.
- **Remittance Advice:** View, print, or save a copy of remittance advice through the Claims Status application or through Remittance Inquiry in Payer Spaces
- **Clinical Documentation Lookup Application:** Search our Medical Policies by CPT code to view a list of documents needed to process your Claim.

Additional digital methods of engagement include:

- **Carelon Medical Benefits Management**: Access link to precertification requests and inquiries for specific services and access the OptiNet® Survey at providerportal.com.
- **Medical Attachments:** Submit supporting documentation including medical records for initial, pended or denied claims through Availity.com. From the Claims & Payments tab, select Claim Status, submit a claim status inquiry and use the Submit Attachments link from a successful response. Use the Medical Attachments functions to submit an itemized bill electronically through the EDI 275 transaction. For providers registered in Medical Attachments through Availity.com, receive digital notifications about additional documents needed for claims processing through Digital RFAI.
- **Member Certificate Booklet:** View a local plan Member's certificate of coverage, online, where available. From Availity.com select the Patient Registration tab to access Eligibility and Benefits. The Certificate of Coverage link will be at the top of the page of a successful eligibility and benefits transaction if available in your Anthem market.
- **Secure Messaging**: Claim status is available through the Claims & Payments application. If you have claims questions that require additional clarification, Secure Message may be available. From a successful claim status transaction, select the Secure Messaging link to submit a question on the claim. From Availity.com, go to Payer Spaces, select the payer then use the Resources Tab to access Secure Messaging responses.

Payer Spaces

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

- **Alerts Hub:** Primary Care Providers (PCPs) can receive timely information about their patients including admission, discharge and transfer (ADT) and against medical advice discharge notifications.
- **Authorization Look Up Tool:** Determine if an authorization is needed for a commercial Member for a specific outpatient medical or behavioral health service.
- **Chat with Payer:** When the information is not available through self-service on Availity.com, Providers and Facilities can chat with an online representative about prior authorizations, appeals, Claims, eligibility, benefits and more.
- **Clear Claim Connection:** Research procedure code edits and receive edit rationale.
- **Custom Learning Center:** Access payer-specific educational materials.
- **Fee Schedule:** Retrieves professional office-based contracted price information for patient services.
- **Preference Center:** A resource for Providers and Facilities to share correspondence preferences related to specific transactions, for example, prior authorization decision letters and PCPs patient event notifications.
- **Provider Digital RFAI Progress Dashboard:** For Providers and Facilities enrolled in Medical Attachments and using the Attachments Dashboard to receive digital notifications when additional documentation is needed to process Claims, use this Dashboard to show your organization's attachment performance.
- **Provider Online Reporting**: Access proprietary Provider specific reports such as Member rosters and Provider Contract and Fee Schedule notifications.
- **Provider Enrollment:** Submit an online request to join Anthem's Provider network.
- **Remittance Inquiry**: The Remittance Inquiry application provides a digital version of the paper remittance providers can download. View an imaged copy of the paper Anthem remits up to twenty-four (24) months in the past.
- **Total Member View (TMV)**: A robust picture of a Member's health and treatment history, including gaps in care and care reminders.

Getting Started and Availity Essentials Training

To register for access to Availity Essentials, go to **Availity.com/providers/registration-details/**. For additional assistance in getting registered, contact Availity Client Services at **1-800-AVAILITY (282-4548)**.

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

From Availity.com select **Help & Training** (from the top navigation menu on the Availity Essentials home page), then select **Get Trained**, and type "*onboarding*" in the search catalog field.

Availity Essentials Training for Anthem-specific tools

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

Organization Maintenance

To update Administrator or Organization information:

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

Support

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

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

Provider and Facility Digital Guidelines

Anthem understands that working together digitally streamlines processes and optimizes efficiency. We developed the Provider and Facility Digital Guidelines to outline our expectations and to fully inform Providers and Facilities about our digital platforms.

Anthem expects Providers and Facilities will utilize digital tools unless otherwise mandated by law or other legal requirements.

The Digital Guidelines establish the standards for using secure digital Provider platforms (websites) and applications when transacting business with Anthem. These platforms and applications are accessible to both participating and nonparticipating Providers and Facilities and encompass Availity.com, electronic data interchange (EDI), electronic medical records (EMR) connections, and business-to-business (B2B) desktop integration.

Digital and/or electronic transaction applications are accessed through these platforms:

- Availity EDI Clearinghouse
- B2B application programming interfaces (APIs)
- EMR connections

Digital functionality available through Availity Essentials includes:

- Acceptance of digital ID cards
- Eligibility and benefit inquiry and response

- Prior authorization submissions, including updates, clinical attachments, authorization status, and clinical appeals
- Claim submission, including attachments, and claims status
- Remittances and payments
- Provider enrollment and network management
- Demographic updates

Additional digital applications available to Providers and Facilities include:

- Pharmacy prior authorization drug requests
- Services through Carelon Medical Benefits Management
- Services through Carelon Behavioral Health

Anthem expects Providers and Facilities transacting any functions and processes above will use available digital and/or electronic self-service applications in lieu of manual channels (paper, mail, fax, call, chat, etc.). All channels are consistent with industry standards. All EDI transactions use version 5010.

Note: *As a mandatory requirement, all trading partners must currently transmit directly to the Availity EDI gateway and have an active Availity Trading Partner Agreement in place. This includes Providers and Facilities using their practice management software and clearinghouse billing vendors.*

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

Section 1: Accepting digital ID cards

As our members transition to digital Member ID cards, Providers and Facilities may need to implement changes in their processes to accept this new format. Anthem expects that Providers and Facilities will accept the digital version of the Member identification card in lieu of a physical card when presented. If Providers and Facilities require a copy of a physical ID card, Members can email a copy of their digital card from their smartphone application, or Providers and Facilities may access it directly from Availity Essentials through the Eligibility and Benefits Inquiry application.

Section 2: Eligibility and benefits inquiry and response

Providers and Facilities should leverage these Availity clearinghouse-hosted channels for electronic eligibility and benefit inquiry and response:

- EDI transaction: X12 270/271 – eligibility inquiry and response:
    - Anthem supports the industry standard X12 270/271 transaction set for eligibility and benefit inquiry and response as mandated by HIPAA.
- Availity Essentials:
    - The Eligibility and Benefits Inquiry verification application allows Providers and Facilities to key an inquiry directly into an online eligibility and benefit look-up form with real-time responses.
- Provider desktop integration via B2B APIs:

- Anthem has also enabled real-time access to eligibility and benefit verification APIs that can be directly integrated within participating vendors' practice management software, revenue cycle management software and some EMR software. Contact Availity for available vendor integration opportunities.

Section 3: Prior authorization submission, attachment, status, and clinical appeals.

Providers and Facilities should leverage these channels for prior authorization submission, status inquiries, and submit electronic attachments related to prior authorization submissions:

- EDI transaction: X12 278 – prior authorization and referral:
  - Anthem supports the industry standard X12 278 transaction for prior authorization submission and status inquiry as mandated per HIPAA.
- EDI transaction: X12 275 – patient information, including HL7 payload for authorization attachments:
  - Anthem supports the industry standard X12 275 transaction for electronic transmission of supporting authorization documentation, including medical records, via the HL7 payload.
- Availity Essentials:
  - The Availity Essentials multi-payer Authorization application facilitates prior authorization submission, authorization status inquiry, and the ability to review previously submitted authorizations.
- Provider desktop integration via B2B APIs:
  - Anthem has enabled real-time access to prior authorization APIs, which can be directly integrated within participating vendors' practice management software, revenue cycle management software, and some EMR software. Contact Availity for available vendor integration.

Section 4: Claims: submissions, Claims payment disputes, attachments, and status

<u>Claim submissions status and Claims payment disputes</u>

Providers and Facilities should leverage these channels for electronic Claim submission, attachments (for both pre- and post-payment), and status:

- EDI transaction: X12 837 – professional, institutional, and dental Claim submission (version 5010):
  - Anthem supports the industry standard X12 837 transactions for all fee-for-service and encounter billing as mandated per HIPAA.
  - 837 Claim batch upload through EDI allows Providers and Facilities to upload a batch/file of Claims (must be in X12 837 standard format).
- EDI transaction: X12 276/277 – Claim status inquiry and response:
  - Anthem supports the industry standard X12 276/277 transaction set for Claim status inquiry and response as mandated by HIPAA.
- Availity Essentials – Claims & Payments application
  - The Claims & Payments application enables Providers and Facilities to enter a Claim directly into an online Claim form and upload supporting documentation for a defined Claim.

- The Claim Status application enables Providers and Facilities to access online Claim status. Access the Claim payment dispute tool from Claim Status. Claims Status also enables online Claim payment disputes in most markets and for most Claims. It is the expectation of Anthem that electronic Claim payment disputes are adopted when and where they are integrated.

- Provider desktop integration via B2B APIs:
  - Anthem has also enabled real-time access to Claim status via APIs, which can be directly integrated within participating vendors' practice management software, revenue cycle management software, and some EMR software. Contact Availity for available vendor integration.

Claim attachments

Providers and Facilities should leverage these channels for electronic Claim attachments from Availity.com:

- EDI transaction: X12 275 – patient information, including HL7 payload attachment:
  - Anthem supports the industry standard X12 275 transaction for electronic transmission of supporting Claims documentation, including medical records via the HL7 payload.
- Availity Essentials – Claim Status application
  - The Claim Status application enables Providers and Facilities to digitally submit supporting Claims documentation, including medical records, directly to the Claim.
  - Digital Request for Additional Information (Digital RFAI) – The Medical Attachments application on Availity Essentials enables the transmission of digital notifications when additional documentation, including medical records, is needed to process a Claim.

Section 5: Electronic remittance advice and electronic Claims payment

Electronic remittance advice

Electronic remittance advice (ERA) is an electronic data interchange (EDI) transaction of the explanation of payment of your Claims. Anthem supports the industry standard X12 835 transaction as mandated per HIPAA.

Providers and Facilities can register, enroll, and manage their ERA preference through **Availity.com**. Printing and mailing remittances will automatically stop thirty (30) days after the ERA enrollment date.

- Viewing an ERA on Availity Essentials is under Claims & Payments, Remittance Viewer. Features of remittance viewer, include the ability to search a two (2) year history of remittances and access the paper image.
- Viewing a portable document format (PDF) version of a remit is under Payer Spaces, which provides a downloadable PDF of the remittance.

To stop receiving ERAs for Claims, contact Availity Client Services at **1-800-AVAILITY** (282-4548).

To re-enable receiving paper remittances, contact Provider Services.

Electronic Claims payment

Electronic Claims payment is a secure and fast way to receive payment by reducing administrative processes. There are several options to receive Claims payments electronically.

- **Electronic Funds Transfer (EFT)**

  Electronic funds transfer (EFT) uses the automated clearinghouse (ACH) network to transmit healthcare payments from a health plan to a Provider's or Facility's bank account at no charge for the deposit. Health plans can use a Provider's or Facility's banking information only to deposit funds, not to withdraw funds. The EFT deposit is assigned a trace number (TRN) to help match the payment to the correct 835 electronic remittance advice (ERA), a process called reassociation.

  To enroll in EFT: Providers and Facilities can register, enroll, and manage account changes for EFT through EnrollSafe at **enrollsafe.payeehub.org**. EnrollSafe enrollment eliminates the need for paper registration. EFT payments are deposited faster and are generally the lowest cost payment method. For help with enrollment, **use this convenient EnrollSafe User Reference Manual**.

  To disenroll from EFT: Providers and Facilities are entitled to disenroll from EFT. Disenroll from EFT payments through EnrollSafe at **enrollsafe.payeehub.org**.

- **Virtual Credit Card (VCC)**

  For Providers and Facilities who don't enroll in EFT, and in lieu of paper checks, Anthem is shifting some reimbursements to virtual credit card (VCC). VCC allows Providers and Facilities to process payments as credit card transactions. Check with your merchant processor regarding standard transaction fees that will apply.
  Note that Anthem may receive revenue for issuing a VCC.
  Opting out of virtual credit card payment. Providers and Facilities are entitled to opt out of electronic payment. To opt out of virtual credit card payment, there are two (2) options:

  - Enrolling for EFT payments automatically opts you out of virtual credit card payments. To receive EFT payments instead of virtual credit card payments, enroll for EFT through EnrollSafe at **enrollsafe.payeehub.org**.

    OR

  - To opt out of virtual credit card payments, call **800-833-7130** and provide your taxpayer identification number.

- **Zelis Payment Network (ZPN) electronic payment and remittance combination**

  The Zelis Payment Network (ZPN) is an option for Providers and Facilities looking for the additional services Zelis can offer. Electronic payment (ACH or VCC) and Electronic Remittance Advice (ERA) via the Zelis portal are included, together with additional services. For more information, go to **Zelis.com**. Zelis may charge fees for its services.
  Note that Anthem may receive revenue for issuing ZPN.
  ERA through Availity is not available for Providers and Facilities using ZPN.
  To disenroll from ZPN payment, there are two (2) options:

  - Enrolling for EFT payments automatically removes you from ZPN payments. To receive EFT payments instead of ZPN payments, enroll for EFT through EnrollSafe at **enrollsafe.payeehub.org**.

    OR

  - To disenroll from ZPN payments, update your Zelis registration on the Zelis provider portal or contact Zelis at **877-828-8770**.

Not being enrolled for EFT, VCC, or ZPN will result in paper checks being mailed.

Section 6: Provider Enrollment and Network Management

Provider Enrollment

- **Simplified enrollment process:** Providers and Facilities can enroll as a new care provider in our network for professional, ancillary, institutional, and facility provider types through Availity Essentials.
- **Real-Time Tracking:** Providers and Facilities can track the status of their requests in the **My Dashboard** section of the Provider Enrollment and Network Management application.

Contract Changes

- **Streamlined Contract Change Requests**: Providers and Facilities can easily submit certain requests for contract changes through Availity Essentials:
  - Amendment requests to add a network or line of business
  - Change of Ownership notice
  - Contract, line of business, or Network Termination requests
  - TIN Change
- **Real-Time Tracking**: Providers and Facilities can track the status of their requests in the **My Dashboard** section of the Provider Enrollment and Network Management application.

My Roster

Providers and Facilities can download roster data through Availity Essentials. This allows the review of data within our system and updates using the formatted file to provide changes.

- To request a roster, go to Availity.com > Payer Spaces > Select Payer Tile > Provider Enrollment and Network Management > Request Current Roster.
- Providers and Facilities will be prompted to select the organization name and TIN they would like included in the roster. Multiple TINs can be included in one request.
- A Roster File Submission confirmation message displays. When the roster is ready to download, it will be available by clicking Download Requested Roster. Rosters are usually available within four (4) hours. Rosters cannot be requested more than once a day.

Providers and Facilities can edit the downloaded roster and upload the updated version via Availity's Provider Data Management *Upload Roster File* screen to easily make changes to their data. Because the download is correctly formatted, it should enable automatic processing.

See *Section 7: Demographic Updates* section below for more information about Provider Data Management.

Provider and Facilities access for Provider Enrollment and Network Management features:

- To access these features, go to **Availity.com** > Payer Spaces > Select Payer Tile > Provider Enrollment and Network Management application.
- For organizations already using Availity Essentials, the organization's Availity Essentials administrator should go to **My Account Dashboard** from the Availity Essentials home page to register new users and update or unlock accounts for existing users. Staff who need access to

the Provider Enrollment and Network Management application need to be granted the role of Provider Enrollment.

Section 7: Demographic updates

Provider Data Management (PDM)

Availity Essentials Provider Data Management (PDM) is the digital intake application for Providers and Facilities to submit demographic change requests – it is also where Providers can upload a roster with demographic changes. If submitting a roster, find the TIN/business name for which you want to verify and update information. Before you select the TIN/business name, select the three-bar menu option on the right side of the window, and select Upload Rosters and follow the prompts.

For Providers and Facilities using the roster upload option, additional resources are available:

- **Error Report:**
  - Providers and Facilities can use this Error Report to understand where errors occurred (specifically which sheet, tab, and row), the cause of the issue, and how to fix it.
  - Providers and Facilities are responsible for using the Error Report to identify errors in a roster, correct them, and resubmit the roster rows that contain errors. Rows in a roster that contain an error will not be processed, and the addition, change, or termination will not be updated in our systems.
- **Results Report:** When a roster has the status partially complete or complete a Results Report will be created for any rosters received on and after June 15, 2024. The Results Report is an Excel file that shows the additions and updates made to your provider group's demographic data based on the information contained in a specific roster.
- **Use the *Roster Submission Guide:*** For Providers and Facilities using the roster upload option, additional information about the Error Report and Results Report can be found in our *Roster Submission Guide*. Find it online at **Availity.com** > Payer Spaces > Select Payer Tile > Resources > Roster Submission Guide using Provider Data Management.

Provider Participation

Provider Enrollment through Availity

Digital provider enrollment (DPE) is a tool in Availity available for **professional practitioners only.** With this tool, practitioners can:

- Apply to add new practitioners to an already contracted group
- Apply and request a provider agreement to enroll a new group of practitioners
- Apply to enroll as an individual provider
- Monitor submitted application status in real-time with a digital dashboard

The system pulls in all your professional and practice details from Council for Affordable Quality Healthcare (CAQH) Provider Data Portal to populate the information Anthem needs to complete the enrollment process — including credentialing, claims, and directory administration. The online enrollment application guides the applicant through the process.

To access the provider enrollment application, log onto **Availity.com** and select Payer Spaces > Anthem > Applications > Provider Enrollment to begin the enrollment process.

For organizations already using Availity, your administrator(s) will automatically be granted access to the provider enrollment tool. Staff using the provider enrollment tool need to be granted the user role Provider Enrollment by an administrator. To find yours, go to My Account Dashboard > My Account > Organization(s) > Administrator Information.

Note: Providers and Facilities who submit rosters or have delegated agreements will continue to use the existing enrollment process in place.

Credentialing

Credentialing is the process Anthem uses to evaluate healthcare practitioners and health delivery organizations (HDOs) to provide care to Members to help ensure Anthem's standards of professional conduct and competence are met. Anthem's Credentialing and Provider Enrollment Program Summary includes a complete list of the Provider types within Anthem's credentialing scope. The credentials of healthcare practitioners and HDOs are evaluated according to Anthem's criteria, standards, and requirements as set forth in our Program Summary and applicable state and federal laws, regulatory, and accreditation requirements. Anthem retains discretion to amend, change or suspend any aspect of Anthem's Credentialing and Provider Enrollment Program, and the Program Summary. It is not Anthem's intent to create rights on the part of practitioners or HDOs who seek to provide healthcare services to Members. Anthem further retains the right to approve, suspend, or terminate individual practitioners and HDOs in those instances where it has delegated credentialing decision-making.

Anthem's Credentialing and Provider Enrollment Program also includes the recredentialing process which incorporates re-verification and the identification of changes in the practitioner's or HDO's credentials that may reflect on the practitioner's or HDO's professional conduct and competence. This information is reviewed in order to assess whether practitioners and HDOs continue to meet Anthem credentialing standards. All applicable practitioners and HDOs in Anthem's network within the scope of the Credentialing and Provider Enrollment Program are required to be recredentialed at least every

three (3) years unless otherwise required by applicable state contract or state regulations. Additional information regarding Anthem's Credentialing and Provider Enrollment Program can be found in the Program Summary, which applicable terms are incorporated into this Provider Manual by reference," available on Anthem.com. To access the Program Summary go to the **Anthem Provider Home page**, under the **Provider Enrollment and Maintenance** menu, select **Join our Network**, then select **Program Summary** under the question, **Who do we Credential?.**

Standards of Participation for Non-Credentialed Providers and Facilities

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

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

Provider/Facility	Standards of Participation
Ambulance (Air & Ground)	Medicare Certification/State Licensure
Ambulatory Event Monitoring	Medicare Certification
Convenient Care Centers (CCCs)/Retail Health Clinics (RHC)	DNV/NIAHO, UCAOA, TJC
Durable Medical Equipment	TJC (JCAHO), CHAP, ACHC, (HQAA) Medicare Certification, The Compliance Team
Hearing Aid Supplier	State Licensure
Intermediate Care Facilities	Medicare Certification/State Licensure
Immunization Clinic	CDC Certification Pharmacy License, Medicare Certification
Orthotics & Prosthetics	TJC, CHAP, The American Board for Certification in Orthotics, Prosthetics & Pedorthics (ABC) or Board of Certification/Accreditation (BOC) Ocularist: National Examining Board of Ocularists NEBO Preferred) Medicare Certification
Private Duty Nursing	TJC, CHAP, CTEAM, ACHC, or DNV/NIAHO
Urgent Care Center (UCC)	AAAHC, IMQ, NUCCA (formerly ABUCM), TJC, UCAOA

Claims Submission

Electronic Claims Submissions

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

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

Reference the Transaction-Specific Documents available on the **EDI Companion Guide webpage**. Go to the **Anthem Provider Home page**, then under the **Claims** menu, select **Electronic Data Interchange (EDI)**, scroll down to **Review the Guide**, then see the appropriate link under the *Section B – Transaction Specific Companion Documents* heading.

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

Claim Submission Filing Tips

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

Ambulatory Surgical Centers

When billing revenue codes, always include the CPT or HCPCS code for the surgery being performed. This code is required to determine the procedure and including it on the Claim helps 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 (UB-04), as indicated in the Agreement.

Ancillary Filing Guidelines

Ambulance Claims

- Include the Point of Pickup (POP) ZIP Code for all ambulance (including air ambulance) Claims, both institutional outpatient and professional.
- Ground or Independently contracted ambulance Providers should file the Claims to the plan whose service area the Point of Pickup (POP) ZIP Code is located.
- Air ambulance providers contracted through a facility and submitting services on UB-04 CMS-1450 (facility claim forms) should file claims to the Plan whose service area matches the facility (local Plan).
- 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 or 54
    - *Institutional outpatient Claims* – for UB submitters: the Value Code of ‘A0’ (zero), and the related ZIP Code of the geographic location from which the beneficiary was placed on board the ambulance, should be reported in the Value Code Amount field and billed with the appropriate revenue 54x codes.

Durable/Home Medical Equipment and Supplies

Durable/Home Medical Equipment and Supplies (D/HME) is determined by the Provider specialty code in the Provider file, not by CPT codes.

- **Delivered to patient's home** – File the Claim to the plan in the service area where the item was sent/delivered.
- **Purchased at retail store** – File the Claim to the plan in the service area where the retail store is located.

Home Infusion Therapy - Services and Supplies

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

Independent Clinical Laboratory Claims

- File the Claim to the plan in the service area where the specimen was drawn, as determined by the referring Provider's location (based on NPI)
- Independent lab Claims are determined by place of service 81. Unless exempted by state or other legal guidelines, Anthem requires the CLIA number to be included on each Claim billed for laboratory services by any Provider or Facility performing tests covered by CLIA. Anthem requires the CLIA identification number to be submitted based on the applicable method below:
    - ASC X12 837 professional Claim format REF segment as REF02, with qualifier of "X4" in REF01 or
    - Field 23 of the paper CMS-1500

Specialty Pharmacy Claims

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

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.

Duplicate Claims

Providers and Facilities should refrain from submitting a Claim multiple times to avoid potential duplicate denials. Providers or Facilities can check the status of Claims via Availity Essentials. From the Claims & Payments tab select Claims Status.

Late Charges

Late charges for Claims previously filed can be submitted electronically. Providers and Facilities must reference the original Claim number when submitting a corrected electronic Claim. If attachments are required, submit them using the *Attachment Face Sheet*. Refer to the **Electronic Data Interchange webpage** on the Anthem website for instructions.

Late charges for Claims previously filed can be submitted via paper. Type of bill should contain a five (5) in the third position of the TOB (ex: 135). A late billing should contain ONLY the additional late charges. Providers and Facilities should also advise the original Claim number 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 baby's gestational age.

National Drug Codes (NDC)

See separate subsection titled *National Drug Codes*.

Negative Charges

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

Not Otherwise Classified (NOC) Codes

When submitting Not Otherwise Classified (NOC) codes, follow these guidelines to avoid possible Claim processing delays**. Anthem must have a clear description of the item/service billed with a NOC code for review**.

- If the NOC is for a drug, include the drug's name, dosage, NDC number, and number of units.
- If the NOC is not a drug, include a specific description of the procedure, service, or item.
- If the item is durable medical equipment, include the manufacture's description, model number and purchase price if rental equipment.
- If the service is a medical or surgical procedure, include a description on the Claim and submit medical record/and the operative report (if surgical) that support the use of an NOC and medical necessity for the procedure.
- If the NOC is for a laboratory test, include the specific name of the laboratory test(s) and/or a short descriptor of the test(s)

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

Occurrence Dates

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

Other Insurance Coverage

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

<u>CMS-1500 Fields:</u>

- 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 (UB-04) 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 (UB-04) 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 (UB-04).

Preventive Colonoscopy – correct coding

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

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

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

Type of Billing Codes

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

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 utilize Chat with Payer or send a Secure Message through Availity Essentials. If Providers or Facilities are unable to utilize the Availity Essentials for the inquiry, they can call the number on the back of the Member ID Card and select the *Claims* prompt. For further details on Secure Messaging reference the *Availity Essentials* section in this Manual.

- **Claim Correspondence:** Claim Correspondence is when Anthem requires more information to finalize a Claim. Typically, Anthem makes the request for this information through the Explanation of Payment (EOP). The Claim or part of the Claim maybe denied, but it is only because more information is required to process the Claim. Once the information is received, Anthem will use it to finalize the Claim. To upload the requested documentation from Availity.com, select the Claims & Payments tab to access Claims Status. Enter the necessary information to locate the claim and use the Submit Attachments button to upload requested documentation.
- **Clinical Medical Necessity Appeals:** Information about an appeal regarding a clinical decision denial, such as an authorization or Claim that has been denied as not medically necessary, experimental/investigational is located in the *Clinical Appeals* section within the Provider Manual.
- **Claim Payment Disputes:** Refer to the *Claim Payment Dispute* section for further details.
- **Pre-certification Disputes:** Pre-certification disputes should be handled via the process detailed in the letter received from the Utilization Management department. If Providers or Facilities disagree with a clinical decision follow the directions detailed in the letter. A Pre-certification appeal can be submitted through the digital prior authorization application on Availity.com. Select the Patient Registration tab to access Authorizations & Referrals. Sending pre-certification requests or appeals to the provider correspondence address may delay responses.
- **Corrected Claims:** Submit a corrected Claim when updating information on the Claim form. Access your Claim on Availity.com through the Claims & Payments tab. If the inquiry is about the way the Claim processed refer to the prior sections. If Providers or Facilities have corrections to the Claim, submit them according to the Corrected Claim Guidance below.

Proof of Timely Filing

Claims must be submitted within the timely filing timeframe specified in the Provider or Facility Agreement. All additional information reasonably required by Anthem to verify and confirm the services and charges must be provided on request. ***Claims submitted after the timely filing period expires will be denied, unless proof of timely filing can be demonstrated according to the guideline listed below.***

Waiver of the timely filing requirement is only permitted when Anthem has received documentation indicating the Member, Provider or Facility originally submitted the Claim within the applicable timely filing period. The documentation submitted **must** indicate the Claim was originally submitted before the timely filing period expired.

Acceptable documentation includes the following:

1. A copy of the Claim with a **computer-printed filing date** (a handwritten date isn't acceptable).
2. An original fax confirmation specifying the Claim in question and including the following information: date of service, amount billed, Member name, original date filed with Anthem and description of the service.

3. The Provider or Facility's billing system printout showing the following information: date of service, amount billed, Member name, original date filed with Anthem and description of the service.

   If the Provider or Facility doesn't have an electronic billing system, approved documentation is a copy of the Member's chart indicating the billed date and/or a copy of the billing records indicating the billed date, and the information listed above.

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

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

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

Corrected Claim Guidance

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

Regarding paper claims: Claims originally filed on paper are accessible through Availity.com. Submit replacement, void/canceled Claims through Availity.com following the instructions below for digital submission. Do not use the paper submission process unless there is a specific reason for filing a paper claim correction.

Type	Professional Claim	Institutional Claim
EDI	**To indicate the Claim is a replacement Claim:** • In element CLM05-3 "Claim Frequency Type Code" • Use Claim Frequency Type 7	**To indicate the Claim is a replacement Claim:** • In element CLM05-3 "Claim Frequency Type Code" • Use Claim Frequency Type 7
	To confirm the Claim which is being replaced: • In Segment "REF – Payer Claim Control Number" • Use F8 in REF)! and list the original payer Claim number is REF02	**To confirm the Claim which is being replaced:** • In Segment "REF – Payer Claim Control Number" • Use F8 in REF)! and list the original payer Claim number is REF02
	To indicate the Claim was billed in error (Void/Cancel): • In element CLM05-3 "Claim Frequency Type Code" • Use Claim Frequency Type 8	**To indicate the Claim was billed in error (Void/Cancel):** • In element CLM05-3 "Claim Frequency Type Code" • Use Claim Frequency Type 8

Type	Professional Claim	Institutional Claim
	To confirm the Claim which is being void/cancelled: • 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:** • In Segment "REF – Payer Claim Control Number" • Use F8 in REF)! and list the original payer Claim number is REF02
Digital	Submit replacement, void/cancel Claims through **Availity.com**	Submit replacement, void/cancel Claims through **Availity.com**
	Select the Claims & Payments tab and click Professional Claim	Select the Claims & Payments tab and click Facility Claim
	Enter the clam information and set the billing frequency and payer control number as follows: • Select **Replacement of Prior Claim** or **Void/Cancel of Prior Claim** for the **Billing Frequency** (or **Frequency Type**) field, in the **Claim Information** • Set the **Payer Control Number (ICN / DCN)** (or **Payer Claim Control Number**) field to the claim number assigned to the claim by the payer. You can obtain this number from the 835, if available.	Enter the clam information and set the billing frequency and payer control number as follows: • Select **Replacement of Prior Claim** or **Void/Cancel of Prior Claim** for the **Billing Frequency** (or **Frequency Type**) field, in the **Claim Information** • Set the **Payer Control Number (ICN / DCN)** (or **Payer Claim Control Number**) field to the claim number assigned to the claim by the payer. You can obtain this number from the 835, if available.
Paper	**To indicate the Claim is a replacement Claim:** • In Item Number 22: "Resubmission and/or Original Reference Number" • Use Claim Frequency Type 7 under "Resubmission Code"	**To indicate the Claim is a replacement Claim:** • In Form Locator 04: "Type of Bill" • Use Claim Frequency Type 7
	To confirm the Claim which is being replaced: • In the right-hand side of Item Number 22 under "Original Ref. No." list the original payer Claim number for the resubmitted Claim.	**To confirm the Claim which is being replaced:** • In Form Locator 64: "Document Control Number (DCN)" list the original payer Claim number for the resubmitted Claim.
	To indicate the Claim is a void/cancel of a prior Claim: • In Item Number 22: "Resubmission and/or Original Reference Number" • Use Claim Frequency Type 8 under "Resubmission Code"	**To indicate the Claim is a void/cancel of a prior Claim:** • In Form Locator 04: "Type of Bill" • Use Claim Frequency Type 8
	To confirm the Claim which is being void/cancelled: • In the right-hand side of Item Number 22 under "Original Ref. No." list the original payer Claim number for the void/cancelled Claim.	**To confirm the Claim which is being void/cancelled:** • In Form Locator 64: "Document Control Number (DCN)" list the original payer Claim number for the void/cancelled Claim.

For additional information on provider disputes and appeals refer to the *Claim Payment Dispute* and *Clinical Appeals* sections of this Manual.

National Drug Codes (NDC)

All practitioners and Providers are required to supply the 11-digit NDC when billing for injections and other drug items on the CMS1500 and UB04 Claim forms as well as on the 837 electronic transactions.

Note: These billing requirements will apply to Local Plan and BlueCard Member Claims only, and will exclude Federal Employee Program (FEP) and Coordination of Benefits/ Secondary Claims.

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

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

Unit of Measurement Requirements

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

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

Location of the NDC

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

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

Correcting Omission of a Leading Zero

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

- If this occurs, when entering the NDC on the Claim form, it will be required to add a leading zero to the beginning of the segment(s) that is missing the zero.

- Do not enter any of the hyphens on Claim forms.

See the examples that follow:

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

Process for Multiple NDC numbers for Single HCPC Codes

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

How/Where to Place the NDC on a Claim Form

837 Reporting Fields

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

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

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

Digital submission through Availity.com:

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

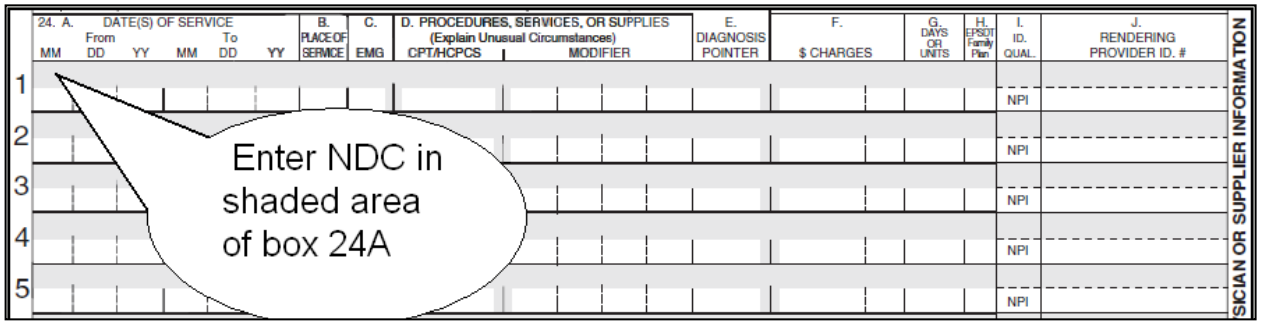
For more information about how to submit an electronic Claim, including the NDC Code field using Availity Essentials, log onto Availity.com, select the Help & Training tab, and enter Professional or Facility Claim in the search bar.

CMS 1500 Claim Form:

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

The following table provides elements of a proper NDC entry on a CMS-1500 Claim form. **All Elements are REQUIRED:**

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



UB-04 Claim Form:

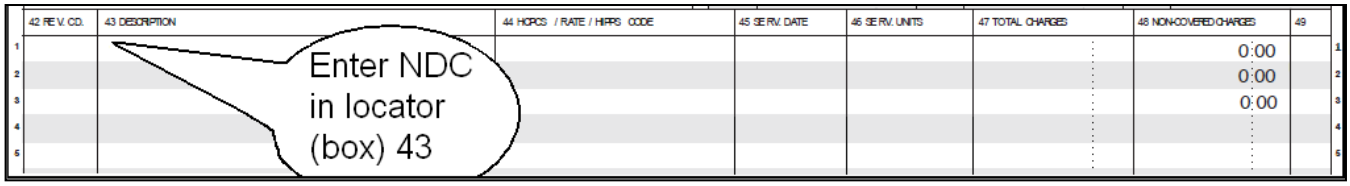
- Even though an NDC is entered, a valid HCPCS or CPT code must also be entered in the Claim form.
- If the NDC billed does not have a specific HCPCS or CPT code assigned, the appropriate miscellaneous code should be assigned per Correct Coding Guidelines.
- DO NOT bill more than one NDC per Claim line.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

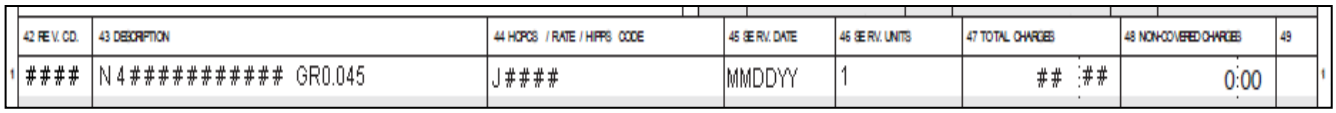
The following table provides elements of a proper NDC entry on a UB-04 Claim form.
All Elements are REQUIRED:

How	Example	Where
Enter a valid revenue code	Pharmacy Revenue Code 0252	Form locator (box) 42

How	Example	Where
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 (1) of five (5) units of measure qualifiers; F2 – International Unit GR - Gram ML - Milliliter UN – Units ME - Milligrams and quantity, **including a decimal point for correct reporting**	GR0.045 ML1.0 UN1.000	Immediately following the 11-digit NDC, enter three (3) spaces followed by one (1) 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 one (1) unit for each 10ML ampul used	Form locator (box 44)

Sample Images of the UB04 Claim Form





Paper Claims Submissions

Digital claim submission, either through the claim submission applications on Availity.com or through EDI, are the preferred method for receiving Claims. If Providers or Facilities file a paper Claim, failure to submit them on the most current CMS-1500 (Form 1500 (02-12)) or CMS-1450 (UB04) will cause Claims to be rejected and returned to the Provider or Facility. If fields are missing or not completed, Claims may be delayed or returned to the Provider or Facility for additional information. More information and the most current forms can be found at **cms.gov**.

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

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

CMS Form 1500 (02-12) Claim Form – A sample form with completion and coding instructions is available on the **CMS website.**

UB-04 (CMS-1450) Claim Form – A sample form with completion and coding instructions is available on the **CMS website.**

Medical Records Submission

Solicited Medical Records Submission

When submitting documentation in response to Anthem's request, the recommended method is to submit them electronically via the 275 transaction or digitally through the Attachments Dashboard. To attach requested documentation, navigate to Availity Essentials Claim Status, locate your Claim and use the Send Attachment link to upload your documents.

Always include a copy of the request letter as part of your attachment. The documentation should be formatted as a .tiff, .jpg or pdf file. Providers and Facilities should submit medical records within ten (10) calendar days of Anthem's request, or sooner depending upon the urgency of the matter and or as required by state or federal law, statute or regulation. Providers and Facilities can view the status of submitted documentation in Availity Essentials Attachment New.

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

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

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

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

If Providers or Facilities are submitting X-rays, pictures or dental molds, remember to include a valid and complete Member identification number on page one (1) of the material sent with these items.

Medical Records Submission with Initial Claim

Providers and Facilities can expedite Claim processing by sending medical records with the 837 Claim submission or direct data entry.

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

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

Providers and Facilities can also access the Clinical Documentation Lookup Tool to access information about the documents needed when submitting a claim. Access the Clinical Documentation Lookup Tool from our public website: **clinicaldocumentationtool.anthem.com**

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

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

- Log in to Availity Essentials portal
- Select **Claims & Payments** to access **Attachments – New**
- From the **Attachments Dashboard Inbox**, locate the appropriate Claim
- Add files with supporting documentation
- When a PWK segment is submitted with the claim, an intake with the attachment control number will display in the Attachment Dashboard inbox for seven (7) calendar days.
- If the document is not received within the seven (7) calendar day requirement, documentation can be uploaded using the Claim status by locating your Claim and attaching the document.

Digital Request for Additional Information (RFAI)

- Providers and Facilities registered for the Medical Attachments application will receive digital notifications when additional documentation is needed to process your Claim. Digital notifications will be posted to your Attachments Dashboard daily when additional documentation is needed. Most Claims will pend for up to thirty (30) days. After the 30-day pend period, the Claim will deny and you will receive the explanation of payment. An additional digital notification will be posted to your Dashboard for an additional forty-five (45) days.
- Digital RFAI notifications reduce the amount of time it takes for Anthem to receive needed documentation to process your Claims. This reduces Claims processing time and Claims are paid faster.

- Visit the Availity, EMR & Digital Solutions webpage on **anthem.com** for more information about Digital RFAI.

Types of Claims Documentation Required

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

- History & physical, office visit/clinical notes, treatment records & response
- Chemotherapy regimens, oncology drugs, and records
- Medications list (current and prior)
- Radiology, diagnostic imaging, or diagnostic testing reports
- Therapy/rehabilitation records
- Laboratory reports, pathology reports
- Exact description of NOC/NOS code
- Operative/procedure report
- Inpatient admission, history & physical, discharge summary, physician progress notes, operative/procedure report, CT/MRI report

Anthem May Request Additional Documentation

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

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

Medical Record Appeals

When a request for additional information is received in support of the resolution of a grievance or appeal, Providers and Facilities should respond within ten (10) calendar days of the request, or

sooner, depending upon the urgency of the matter (e.g., expedited appeals) or as required by state or federal law or regulation.

HIPAA Privacy Rule – Minimum Necessary

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

Electronic Data Interchange (EDI)

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

Payer IDs

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

Advantages of Electronic Data Interchange (EDI)

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

Use Availity for the following EDI transactions

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

How Providers and Facilities Can Efficiently Use the Availity EDI Gateway

Availity EDI submission options:

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

Electronic Data Interchange Trading Partner

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

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

Select Login if already an Availity Essentials user, choose My Providers > Transaction Enrollment or choose Register if new to Availity Essentials.

EDI Response Reports

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

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

Electronic Funds Transfer (EFT)

Electronic claims payment through electronic funds transfer (EFT) is a safe, secure and fast way to receive payment. There is no charge for the deposit and EFT reduces administrative time related to posting and reconciling payments. EFT deposit is assigned a trace number that is matched to the 835 Electronic Remittance Advice (ERA) for simple payment reconciliation.

To register or manage Electronic Funds Transfer (EFT)

To register or manage Electronic Funds Transfer (EFT), use EnrollSafe at **enrollsafe.payeehub.org** to register and manage EFT account changes.

Access EFT enrollment through the Anthem website. Go to the **Anthem Provider Home page**, then under the **Claims** menu, select **Electronic Data Interchange (EDI).** Under **EDI Resources**, select the Electronic Funds Transfer tab.

Virtual Credit Cards (VCCs)

For Providers and Facilities who don't enroll in EFT, and in lieu of paper checks, Anthem is shifting some reimbursements to virtual credit cards (VCCs). VCCs allow Providers and Facilities to process payments as credit card transactions. Check with your merchant processor regarding standard transaction fees that will apply. For detailed information, refer to the *Provider and Facility Digital Guidelines* section of this Manual.

Electronic Remittance Advice (ERA) 835

The 835 ERA eliminates the need for paper remittance reconciliation. Use Availity Essentials to register and manage ERA account changes:

1. Log onto Availity.com
2. Select **My Providers**
3. Click on **Enrollment Center** and select **Transaction Enrollment**

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

Use EDI to submit corrected claims

For corrected electronic Claims use one of the following frequency codes:

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

EDI segments required:

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

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

Contact Availity Essentials

Contact Availity Client Services with any questions at 1-800-Availity (282-4548)

Useful EDI Documentation

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

Overpayments

Anthem's Program Integrity department reviews Claims for accuracy and requests refunds if Claims are overpaid or paid in error. Some common reasons for overpayment are:

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

Anthem's Program Integrity department also requests refunds for overpayments identified by other divisions of Anthem, such as Complex and Clinical Audit (CCA) or the Special Investigations Unit (SIU).

Anthem Identified Overpayment (aka "Solicited")

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

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

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

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

Disputes/Inquiries through Availity

For Providers and Facilities who use the Availity Overpayment Portal, an inquiry or dispute must be submitted through Availity.

Provider and Facility Identified Overpayments

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

- Submit a refund check with supporting documentation outlined below, or
- Submit supporting documentation to have Claim adjustment/recoupment done off a future remittance advice

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

- 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

Ensure 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.

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

Utilize the correct address noted below to return payment:

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

Medicare Crossover

Claims Handling for Medicare Crossover

All Blue Plans are required to process Medicare crossover Claims for services covered under Medigap and Medicare Supplemental products through the Centers for Medicare & Medicaid Services (CMS). This has resulted in automatic submission of Medicare Claims by Medicare to the Blue secondary payer to eliminate the need for Provider or Facilities or their billing service to submit an additional Claim to the secondary carrier. Additionally, this has also allowed Medicare crossover Claims to be processed in the same manner nationwide.

When a Medicare Claim has crossed over, Providers and Facilities must wait thirty (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 submission of duplicate Claims, use the 276/277 healthcare Claims status inquiries to verify Claim and adjudication status prior to re-submission of electronic Claims.

The Claims Providers and Facilities submit to the Medicare intermediary will be crossed over to the Blue Plan only after they have been processed by the Medicare intermediary. This process may take approximately fourteen (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 thirty (30) additional calendar days for Providers or Facilities to receive payment or instructions from the Blue Plan.

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

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

Anthem will reject Medicare primary Provider submitted Claims with the following conditions:

- Medicare remittance advice remark codes MA18 or N89 that Medicare crossover has occurred
  - MA18 Alert: The Claim information is also being forwarded to the patient's supplemental insurer. Send any questions regarding supplemental benefits to them.
  - N89 Alert: Payment information for this Claim has been forwarded to more than one other payer, but format limitations permit only one of the secondary payers to be identified in this remittance advice.
- Received by Provider or Facility's local Plan within thirty (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 thirty (30) days for the crossover process to occur or instruct the Provider or Facility to submit the Claim with only GY modifier service lines indicating the Claim only contains statutorily excluded services.

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

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

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

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

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

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

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

The GY modifier *should <u>not</u>* be used when submitting:

- Federal Employee Program Claims

- Inpatient institutional Claims. Use the appropriate condition code to denote statutorily excluded services.

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

Medicare Crossover Claims FAQs

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

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

   The local Anthem Plan.
4. **How do Providers and Facilities handle calls from Members and others with Claims questions?**
   - If Members contacts a Provider or Facility, tell them to contact their Blue Plan. Refer them to the front or back of their ID card for a customer service number.
   - A Member's Blue Plan should not contact Providers or Facilities directly, unless a paper Claim was filed directly with that Blue Plan. If the Member's Blue Plan contacts the

Provider or Facility to send another copy of the Member's Claim, refer the Blue Plan to the local Anthem Plan.

5. Where can Providers and Facilities find more information?

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

A Claim Payment Dispute may be submitted for multiple reasons, including:

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

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

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

There are other common, Claim-related matters that are **not** considered Claim Payment Disputes. To avoid confusion with Claim Payment Disputes, they are defined briefly here:

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

- **Claim Correspondence:** Claim Correspondence is when Anthem requires more information to finalize a Claim. Anthem can request this information through the Explanation of Payment (EOP), a digital notification if the provider is registered for Medical Attachments and is using the Digital RFAI process, or through paper mail. The Claim or part of the Claim maybe denied, but it is only because more information is required to process the Claim. Once the information is received, Anthem will use it to finalize the Claim.
- **Clinical/Medical Necessity Appeals**: An appeal regarding a clinical decision denial, such as an authorization or Claim that has been denied as not medically necessary, experimental/investigational. For more information on Clinical / Medical Necessity Appeals, refer to the *Clinical Appeals* section in this Manual.

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

The Anthem Claim Payment Dispute process consists of two (2) steps**: Claim Payment Reconsideration and Claim Payment Appeal**. Providers and Facilities will **not** be penalized for filing a Claim Payment Dispute, and no action is required by the Member.

Step 1: Claim Payment Reconsideration

The first step in the Anthem Claim Payment Dispute process is called the Claim Payment Reconsideration. It is the Provider or Facility's initial request to investigate the outcome of a finalized Claim. Anthem cannot process a Claim Payment Reconsideration without a finalized Claim on file. Most issues are resolved at the Claim Payment Reconsideration Step.

Claim Payment Reconsiderations can be submitted via phone, Availity Essentials or in writing. Providers and Facilities have three-hundred sixty-five (365) calendar days from the issue date of the EOP, unless otherwise required by state law or such time-period set forth in the Provider or Facility Agreement.

A determination will be made, and the initial adjudication of the Claim will either be upheld or overturned. If the Provider or Facility is satisfied with this determination, the process will end. If the Provider or Facility disagrees with the determination of the Reconsideration, they can proceed with *Step 2* and file a Claim Payment Appeal. Providers and Facilities cannot submit another Claim Payment Reconsideration request.

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

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

Except in cases where the Provider or Facility presents evidence of an extenuating circumstance, Anthem will not accept Claim Payment Reconsiderations that are not submitted timely and according to the procedures set forth above. If a Provider or Facility submits a request for a Claim Payment Reconsideration more than three-hundred sixty-five (365) calendar days from the issue date of the EOP without evidence of an extenuating circumstance, the request is deemed ineligible and requests for payment will be denied. In such cases, Providers or Facilities will not be permitted to bill Anthem, Plan or the Member for those services for which payment was denied.

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

Step 2: Claim Payment Appeal

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

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

When submitting a Claim Payment Appeal, Providers and Facilities should include as much information as possible to help Anthem understand why the Provider or Facility believes the Claim Payment Reconsideration determination was in error. If a Claim Payment Appeal requires clinical expertise, it will be reviewed by appropriate Anthem clinical professionals. Provider and Facilities will be notified of the Claims Payment Appeal determination in writing or through an EOP.

Required Documentation for Claims Payment Disputes

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

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

How to Submit a Claim Payment Dispute

There are several options to file a Claim Payment Dispute:

- Online through the Availity
- Mail all required documentation to:
- Anthem Claim Payment Dispute
  P.O. Box 105449
  Atlanta, GA. 30328-5449
- Call the number on the back of the Member ID Card

Clinical Appeals

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

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

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

Clinical Appeals 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 through **Availity.com** using the Authorizations & Referrals application, where available, verbally, or in writing, for appeals regarding prior authorization clinical adverse decisions.

Anthem Members may designate a representative to exercise their complaint and appeal rights. 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 Designation Of An Authorized Representative form is needed. The Designation Of An Authorized Representative form (DOR) can be found online at anthem.com. Go to the **Anthem Provider Home page**. Under the **Resources** menu, select **Forms and Guides,** then scroll down and to the section **Claims & Appeals** and select **Designation of an Authorized Representative (DOR).**

Guidelines and Timeframes for Submitting Clinical Appeals

- Providers and Facilities have one hundred eighty (180) calendar days to file a clinical appeal from the date they receive notice of Anthem's initial decision.
- All standard post-service clinical appeals will be resolved within a reasonable period of time appropriate to the medical circumstances, but not later than sixty (60) calendar days from the receipt of the appeal request by Anthem.

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

      When a request for information is received in support of the resolution of a clinical appeal, the Provider is required to respond within seven (7) days of the request or sooner dependent upon the clinical urgency of the case in accordance with the state or federal law, statute, or regulation.
    - *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.

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. Detailed instructions are included in the UM decision letter.

Appeals should be submitted to Anthem, along with:

- A copy of the response to the original complaint.
- Provider or facility name, address, phone number, email and either NPI or TIN
- The member's name and Anthem ID number
- Claim, authorization, or reference number and date of service
- Specific reason(s) for disagreement with decision
- All supporting statements and documentation (medical records, etc.)
- A signed DOR (Designation of Representation) is needed if the provider is appealing on behalf of the member. No DOR is required when the provider is appealing on their own behalf.
- Send the appeal request to:
  Anthem Blue Cross and Blue Shield
  ATTN: 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. Providers must obtain the necessary authorization prior to the delivery of inpatient admission services. Failure to obtain the necessary authorization may result in non-payment or penalty reduction to the Provider Anthem understands that many Providers obtain Pre-certification/Pre-authorization or may wish to dispute these types of denials on behalf of, and as a service to, their patients.

- If the appeal relates to Pre-certification/Pre-authorization, the Provider or Facility may have received information directly from the Member's Home Plan regarding appeal rights and processes. Follow the directions provided by the Member's Home Plan.
- If the appeal relates to Claim denial, and the Provider or Facility did not receive this information from the Member's Home Plan and wishes to appeal a Medical Necessity or experimental/investigational Claim denial, the local 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. Reference the Claim Payment Dispute section for further details.
- Providers submitting an appeal on behalf of the member are required to submit a member Designation of Representation (DOR) authorization form. Home Plans may have a specific DOR authorization form.

Member Quality of Care/Quality of Service Investigations

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. Requests for information, including medical records, must be returned by Providers and/or Facilities on or before the due date on the request letter so that a determination can be made regarding the severity of the Potential QOC/QOS concern. Failure to return or timely return the requested information may result in escalation of the issue and potential corrective action, up to and including, review for termination of contract and removal from the network.

If the clinical associate determines, based on the circumstances and applicable review of records, that the matter is a non-issue with no identifiable quality concern or that the evidence suggests a known or recognized complication, the clinical associate may assign a severity level consistent with such a finding. If the circumstances and/or evidence suggests a QOC concern beyond a known or recognized complication, then the clinical associate will prepare and send a summary to the appropriate Medical Director for review.

Specialty matched reviewers evaluate the matter and an appropriate Medical Director makes a determination of the severity of the QOC matter. If the QOC matter was initiated by a Member, the Member is advised that a resolution was reached but the details and outcome of the review are protected by peer review statutes and will not be provided.

The Provider and/or Facility will also receive a letter advising of the QOC/QOS determination and any associated corrective action.

Significant quality of care issues and/or failure to participate or respond to information requests may be elevated for additional review and appropriate action including, but not limited to, referrals to the Credentialing Committee.

Providers and Facilities are contractually obligated to actively cooperate with QOC/QOS reviews/investigations.

Allegations of quality concerns regarding the care of our members requires review of relevant materials, including, but not limited to, records of member treatment and internal investigations performed by Providers and Facilities in connection with the allegations received. This information is protected by Peer Review confidentiality which will be maintained during Anthem’s QOC review.

Corrective Action Plan (CAP)

When corrective action is required, Providers and/or Facilities will be notified of appropriate follow-up interventions which can include one or more of the following: development of a CAP from the Provider and/or Facility to address the reviewed issues of concern, Continuing Medical Education, chart reviews, on-site audits, tracking and trending, Provider and/or Facility counseling, and/or referral to

the appropriate committee for additional action. Providers and Facilities that fail to comply with requests associated with potential QOC/QOS allegations, such as the request for information for investigations, the completion of corrective action plans by the noticed deadline and/or failure to comply with the terms of a corrective action plan will be referred to the Credentialing Committee for further actions, up to and including, termination of contract and removal from the network.

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.

Reimbursement Requirements and Policies

This section includes reimbursement requirements and policies on how Anthem will reimburse Providers and Facilities for certain services. Anthem reserves the right to review and revise policies when necessary.

Reimbursement policies serve as a guide to assist Providers and Facilities in accurate claim submissions and to outline the basis for reimbursement if the service is covered by a Member's Anthem benefit plan.

Anthem's public provider website is the source for reimbursement policies. To locate the policies online, go to the **Anthem Provider Home page**, then under the **Claims** menu, choose **Reimbursement Policies**.

Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis as well as to the Member's state of residence. Covered services do not guarantee reimbursement unless specific criteria are met.

Proper billing and submission guidelines must be followed, including using industry standard, compliant codes on all claim submissions. Services should be billed with Current Procedure Terminology (CPT®) codes, Healthcare Common Procedure Coding System (HCPCS) codes and/or revenue codes that indicate the services and/or procedures performed. The billed code(s) are required to be fully supported in the medical record and/or office notes.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, Anthem may:

- Reject or deny the claim.
- Recover and/or recoup claim payment.
- Adjust the reimbursement to reflect the appropriate services and/or procedures performed.

Anthem reimbursement policies are developed based on nationally accepted industry standards and coding principles. These policies may be superseded by mandates in provider, state, federal, or CMS contracts and/or requirements. System logic or setup may prevent the loading of policies into the claims platforms in the same manner as described; however, Anthem strives to minimize these variations.

Reimbursement Hierarchy

Claims submitted for payments must meet all aspects of criteria for reimbursement. The reimbursement hierarchy is the order of payment conditions that must be met for a claim to be reimbursed. Conditions of payment could include benefits coverage, medical necessity/clinical criteria, authorization requirements and/or stipulations within a reimbursement policy. Neither payment rates nor methodology are considered to be conditions of payments.

Review Schedule and Updates to Reimbursement Policies

Reimbursement policies undergo reviews for updates to state contracts, federal or CMS requirements. Additionally, updates may be made at any time if we are notified of a mandated change or due to an Anthem business decision. We reserve the right to review and revise our policies when necessary. When there is an update, we will publish the most current policies to our provider website.

Reimbursement Procedures for Effective Claims Management

Below are specifications governing specific Commercial reimbursement processes, ensuring Providers and Facilities are aligned with Anthem's requirements.

Changes During Admission/Continuous Outpatient Encounter

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/First day of continuous Outpatient Encounter *(subject to the Member's health benefit plan)*
Facility's Contracted Rate (other than DRG)	Admission/First day of continuous outpatient encounter
DRG Base Rate	Discharge*
DRG Grouper	Discharge
DRG Relative Weight	Discharge
CPT & HCPCS coding changes	Discharge/Last day of continuous outpatient encounter

*In the event of an inconsistency between the Agreement and this Manual, the Agreement will govern.

Comprehensive Health Planning

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

Different Settings Charges

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

Eligibility and Payment

Anthem shall provide methods for identifying a Member either through an issued document or through telephonic, paper, or electronic communication to Provider or Facility. The identification will include information to contact Anthem, but doesn't guarantee the individual's eligibility at the time of rendering a Health Service. Verification of eligibility doesn't guarantee payment, and lack of identification does not disqualify an individual from being a Member. Eligibility requires more than possession or access to this identification.

Evaluation and Management (E&M) Services

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

- Deny the Claim and request resubmission of the Claim with the appropriate E&M level;
- Pend the Claim and request that the Facility or Provider submit documentation supporting the E&M level billed; and/or

- Adjust reimbursement to reflect the lower E&M level supported by the Claim.

General Industry Standard Language

Per Anthem policy and the Agreement, Provider and Facility will follow industry standards related to billing. Per the UB-04 and CMS1500 (or subsequent forms) billing manual referenced as Coded Service Identifier(s).

Interim Bill Claims

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

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 their 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-covered Services, Supplies, or Treatment

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

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.

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.

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

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

Is there a possibility to add an edit that states oncology maintenance diagnosis are excluded from pre-admission testing. We are having issues with claims denying because the audit team is following this portion of the manual and denying claims when the member had routine cancer treatment done prior to admission.

Reimbursement Audit and Review Process

The Reimbursement Audit and Review Process is subject to the policy and processes outlined in the Audit and Review section of this Manual and includes the following claim types:

- Claims reimbursed by DRG with an outlier reimbursed at percent of billed charges
- Claims reimbursed at percent of billed charges
- Claims reimbursed partly or fully based on a percent of billed charges

Our vendor-partner(s) or our internal team may review these claims as part of our itemized bill review (IBR) program or hospital bill audit (HBA) program to ensure appropriate reimbursement. Upon completion of the review, documentation, including a summary of adjusted charges, will be provided

for each claim. Disputes related to the review may be submitted according to the instructions in the documentation supplied upon completion of the review.

In addition to the services listed below, please refer to all other service-specific sections which may have more stringent guidelines. There may be multiple sections that apply to any given reimbursable service.

Blood, Blood Products, and Administration

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

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

Courtesy Room

Courtesy Room means an area in the Facility where a professional Provider is permitted by the Facility to provide Health Services to Members. Anthem will not reimburse for Courtesy Room charges separately.

Emergency Room Supplies and Services Charges

The Emergency Room level reimbursement includes all monitoring, equipment, supply, and 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. See Facility Personnel Charges and Nursing Procedures sections for additional information.

Facility Personnel Charges

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

Instrument Trays

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

IV Sedation and Local Anesthesia

Charges for IV Sedation and local anesthesia administered by the provider performing the procedure, and/or nursing personnel, are not separately reimbursable and are included as part of the Operating

Room (OR) time/procedure reimbursement. Charges for medications-drugs used for sedation and local anesthesia are separately reimbursable.

Lab Charges

The reimbursement of charges for specimen collection is considered a facility personnel charge, and the reimbursement is included in the room and board or procedure/observation charges. Examples include venipuncture, urine/sputum specimen collection, draw fees, phlebotomy, heel sticks, and central line draws.

Processing, handling, and referral fees are considered included in the procedure/lab test performed and are not separately reimbursable.

Labor Care Charges

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

Neuromonitoring (Technical component)

Anthem will consider the technical component for neuromonitoring services performed in an operating room setting to be included in the surgical procedure reimbursement.

Therefore, Claims submitted by anyone other than the rendering facility will not be eligible for separate or additional reimbursement. If the rendering facility utilizes a neuromonitoring vendor to perform any services, then it is the rendering facility's responsibility to reimburse the vendor directly. Any Claims submitted to Anthem for these additional services will be denied as they will be considered part of the all-inclusive facility reimbursement.

Nursing Procedures

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

Operating Room Time and Procedure Charges

The operating room (OR) charge will be reimbursed on a time or procedural basis. When time is the basis for the charge, it should be calculated from the time the patient enters the room until the patient leaves the room, as documented on the OR nurse's notes. The Operating Room is defined as surgical suites, major and minor, treatment rooms, endoscopy labs, cardiac catheterization (cath) labs, Hybrid Rooms, X-ray, pulmonary, and cardiology procedural rooms. The operating room reimbursement will reflect the cost of:

- The use of the operating room
- The services of qualified professional and technical personnel

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

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

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

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, eye lubricants, lotion, non-medical personnel, mouthwash, powder, soap, telephone calls, television, tissues, toothbrush, and toothpaste.

Pharmacy Charges

Pharmacy charges will be reimbursed to include only the cost of the drugs prescribed by the attending physician. Medications furnished to patients shall not include an additional separate charge for administration of drugs, the cost of materials necessary for the preparation and administration of drugs, and the services rendered by registered pharmacists and other pharmacy personnel. Anthem will reimburse at the Anthem Rate for the drug. All other services are included in the Anthem Rate. Examples of pharmacy charges which are not separately reimbursable include, but are not limited to: IV mixture fees, IV diluents such as saline and sterile water, IV Piggyback (IVPB), Heparin and saline flushes to administer IV drugs, and Facility staff checking the pharmacy (Rx) cart.

Portable Charges

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

Pre-Operative Care or Holding Room Charges

Charges for 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.

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 their confinement. This will include, but is not limited to cardiac monitoring, Dinamap®, pulse oximeter, injection fees, nursing, nursing time, nursing supervision, equipment and supplies (whether

disposable or reusable), defibrillator, and oxygen. Separate reimbursement for these services will not be made.

Recovery Room Services Related to IV Sedation and/or Local Anesthesia

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

Respiratory Services

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

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 supplies and not separately reimbursable in the inpatient and outpatient environments. Reimbursement for routine services and supplies is included in the reimbursement for the room, procedure, or observation charges.

board rate, less discount, as submitted to Anthem.

Special Procedure Room Charge

Charges for a special procedure room, billed in addition to the procedure itself, are included in the reimbursement for the procedure. If the procedure takes place outside of the OR (Refer to Operating Room Time and Procedure Charges for OR definition), then OR time will not be reimbursed to cover OR personnel/staff being present in the room. Example: procedures performed in the ICU, ER, etc.

Stand-by Charges

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

Stat Charges

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

Submission of Claim/Encounter Data

Providers and Facilities will submit Claims and Encounter Data to Anthem in a format that is consistent with industry standards and acceptable to Anthem. Claims must be submitted using the CMS 1500, UB04, or successor forms, according to Coded Service Identifier(s) guidelines using HIPAA-compliant codes. This submission should occur within the time frames and requirements set forth in your Provider or Facility Agreement.

A "Claim" refers to either a uniform Claim form or an electronic form prescribed by the Anthem for the purpose of requesting payment for Health Services offered to a Member. Such Claim needs to contain all the necessary information needed for processing and making a benefit determination.

"Encounter Data" means Claim information and any additional information submitted by a Provider or Facility under capitated or risk-sharing arrangements for Health Services rendered to Members.

Anthem will make best efforts to pay all complete and accurate Claims for Covered Services submitted by Facilities and Providers in accordance with your Provider or Facility Agreement, and applicable state statutes, exclusive of Claims that have been suspended due to the need to determine Medical Necessity, to the extent of Anthem's payment liability, if any, because of issues such as coordination of benefits, subrogation or verification of coverage.

Supplies and Equipment

Charges for medical equipment, including but not limited to IV pumps, PCA Pumps, isolation carts, mechanical ventilators, continuous positive airway pressure (CPAP)/ bilevel positive airway pressure (BIPAP) machines, and related supplies, are not separately reimbursable. Oxygen charges, including but not limited to oxygen therapy per minute/per hour when billed with room types ICU/CCU/NICU or any Specialty Care area, 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 is not separately reimbursable.

Telemetry

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

Time Calculation

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

Undocumented or Unsupported Charges

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

Video or Digital Equipment used in Procedures

Charges for video or digital equipment used for visual enhancement during a procedure are included in the reimbursement for the procedure and are not separately reimbursable. Examples include, but are not limited to, Ultrasound and Fluoroscopy guidance (including but not limited to, for access and/or placement of medical devices, implants, or lines). Charges for batteries, covers, film, anti-fogger solution, tapes, etc., are also not separately reimbursable.

Additional Reimbursement Guidelines for Disallowed Charges

For any Claims that are reimbursed at a percent of charge, only Charges for Covered Services are eligible for reimbursement. The disallowed charges (charges not eligible for reimbursement) include, but are not limited to, the following, whether billed under the specified Revenue Code or any other Revenue Code. These Guidelines may be superseded by a specific Agreement. Refer to the contractual fee schedule for payment determination.

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

Facility Responsibility	
Typically Billed Under This/These Revenue Codes, but not Limited to the Revenue Codes Listed Below	**Description of Excluded Items**
0990 – 0999	**Personal Care Items** • Courtesy/Hospitality Room • Patient Convenience Items (0990) • Cafeteria, Guest Tray (0991) • Private Linen Service (0992) • Telephone, Telegraph (0993) • TV, Radio (0994) • Non-patient Room Rentals (0995) • Beauty Shop, Barber (0998) • Other Patient Convenience Items (0999)
0369	Preoperative Care or Holding Room Charges
0760 – 0769	Special Procedure Room Charge
0111 – 0119	Private Room* (subject to Member's Benefit)
0221	Admission Charge
0480 – 0489	Stand-by Charges
0220, 0949	Add on Stat Charges
0270 – 0279, 0360	Video Equipment Used in Procedures
0270, 0271, 0272	**Supplies and Equipment** • Blood Pressure cuffs/Stethoscopes • Thermometers, Temperature Probes, etc. • Pacing Cables/Wires/Probes • Pressure/Pump Transducers • Transducer Kits/Packs • SCD Sleeves/Compression Sleeves/Ted Hose • Oximeter Sensors/Probes/Covers • Electrodes, Electrode Cables/Wires

Facility Responsibility	
Typically Billed Under This/These Revenue Codes, but not Limited to the Revenue Codes Listed Below	**Description of Excluded Items**
	• Oral swabs/toothettes • Wipes (baby, cleansing, etc.) • Bedpans/Urinals • Bed Scales/Alarms • Specialty Beds • Foley/Straight Catheters, Urometers/Leg Bags/Tubing • Specimen traps/containers/kits • Tourniquets • Syringes/Needles/Lancets/Butterflies • Isolation carts/supplies • Dressing Change Trays/Packs/Kits • Dressings/Gauze/Sponges • Kerlix/Tegaderm/OpSite/Telfa • Skin cleansers/preps • Cotton Balls • Band-Aids, Tape, Q-Tips • Diapers/Chucks/Pads/Briefs • Irrigation Solutions • ID/Allergy bracelets • Foley stat lock • Gloves/Gowns/Drapes/Covers/Blankets • Ice Packs/Heating Pads/Water Bottles • Kits/Packs (Gowns, Towels and Drapes) • Basins/basin sets • Positioning Aides/Wedges/Pillows • Suction Canisters/Tubing/Tips/Catheters/Liners • Enteral/Parenteral Feeding Supplies (tubing/bags/sets, etc.) • Preps/prep trays • Masks (including CPAP and Nasal Cannulas/Prongs) • Bonnets/Hats/Hoods • Smoke Evacuator Tubing • Restraints/Posey Belts • OR Equipment/Supplies (saws, skin staplers, staples & staple removers, sutures, scalpels, blades etc.) • IV supplies (tubing, extensions, angio-caths, stat-locks, blood tubing, start kits, pressure bags, adapters, caps, plugs, fluid warmers, sets, transducers, fluid warmers, etc.)
0220 – 0222, 0229, 0250	**Tech Support Charges** • Pharmacy Administrative Fee (including mixing meds) • Portable Fee (cannot charge portable fee unless equipment is brought in from another Facility) • Patient transport fees
0223	Utilization Review Service Charges
263	IV Infusion for therapy, prophylaxis (96365, 96366)

Facility Responsibility	
Typically Billed Under This/These Revenue Codes, but not Limited to the Revenue Codes Listed Below	**Description of Excluded Items**
	IV Infusion additional for therapy: • IV Infusion concurrent for therapy (96368); • IV Injection (96374, 96379)
0229, 0760 – 0762, 0769, 0270, 410 – 413, 0419	**Other Charges** • Observations hours may never exceed the charge of a semiprivate room charge • Oxygen charges while a patient is on a ventilator • Respiratory assessment/vent management charges
0230, 0270 – 0272, 0300 – 0307, 0309, 0390-0392, 0310	Nursing Procedures and 99001 – Handling and/or conveyance of specimen from patient (charge for specimen handling)
0230	Incremental Nursing – General
0231	Nursing Charge – Nursery
0232	Nursing Charge – Obstetrics (OB)
0233	Nursing Charge – Intensive Care Unit (ICU)
0234	Nursing Charge – Cardiac Care Unit (CCU)
0235	Nursing Charge – Hospice
0239	Nursing Charge – Emergency Room (ER) or Post Anesthesia Care Unit (PACU) or Operating Room (OR)
0250 – 0259, 0636	**Pharmacy** • Compounding fees • Medication prep • Nonspecific descriptions • Anesthesia Gases – Billed in conjunction with Anesthesia Charges • IV Solutions 250 cc or less • Miscellaneous Descriptions • Non-FDA Approved Medications (subject to UM determination- Medical Policies)
0256	Experimental Drugs (subject to UM determination- Medical Policies)
0270, 0300 – 0307, 0309, 0380 – 0387, 0390 – 0392	**Venipuncture** (CPT Code 36415, 36416 or G0001) • Specimen collection • Draw fees • Phlebotomy • Heel stick • Blood storage and processing blood administration • Thawing/Pooling/Splitting, etc.
0222, 0270, 0272, 0410, 0460	Portable Charges
0270 – 0279, 0290, 0320, 0410, 0460	**Supplies and Equipment** (including rentals)

Facility Responsibility	
Typically Billed Under This/These Revenue Codes, but not Limited to the Revenue Codes Listed Below	**Description of Excluded Items**
	• Preparation (Set-up) Charges; Set-up is included in the fee for the procedure and/or the room and board • Oxygen (ICU/CCU/Progressive) O.R., ER and Recovery • Instrument Trays and/or Surgical Packs • Drills/Saws (All power equipment used in O.R.) • Drill Bits • Blades • IV pumps and PCA (Patient Controlled Analgesia) pumps • Isolation supplies • Daily Floor Supply Charges • X-ray Aprons/Shields • Blood Pressure Monitor • Beds/Mattress • Patient Lifts/Slings • Restraints • Transfer Belt • Bair Hugger Machine/Blankets • SCD Pumps • Heel/Elbow Protector • Burrs • Cardiac Monitor • EKG Electrodes • Vent Circuit • Suction Supplies for Vent Patient • Electrocautery Grounding Pad • Bovie Tips/Electrodes • Anesthesia Supplies When Billed with Anesthesia Charges • Case Carts • C-Arm/Fluoroscopic Charge • Wound Vacuum Pump and supplies • Bovie/Electro Cautery Unit • Wall Suction • Retractors • Single Instruments • Oximeter Monitor • CPM Machines • Lasers • DaVinci Machine/Robot
0309 – 0369, 0419, 0619	After Hours – Call-back
0370 – 0379, 0410, 0460, 0480 – 0489	**Anesthesia** (Specifically, conscious/moderate sedation by same physician or procedure nurse) • Nursing care • Monitoring • Pre- or Post-evaluation and education

Facility Responsibility	
Typically Billed Under This/These Revenue Codes, but not Limited to the Revenue Codes Listed Below	**Description of Excluded Items**
	• IV sedation and local anesthesia by same physician or procedure nurse • Intubation/Extubation • CPR
410	**Nursing/Respiratory Functions** • Oximetry (94760, 94761, 94762) • 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, 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* **Subject to the Member's Benefit Agreement*
0990	Patient Convenience Items
0991	Cafeteria, Guest Tray
0992	Private Linen Service
0993	Telephone, Telegraph
0994	TV, Radio
0995	Non-patient Room Rentals
0996	Late Discharge
0998	Beauty Shop, Barber
0999	Other Patient Convenience Items

Medical Policies and Clinical Guidelines

Clinical Practice Guidelines

Anthem considers clinical practice guidelines to be an important component of health care. Anthem adopts nationally recognized clinical practice guidelines and encourages physicians to utilize these guidelines to improve the health of Members. Several national organizations, such as the National Heart, Lung, and Blood Institute, the American Diabetes Association, and the American Heart Association, produce guidelines for asthma, diabetes, hypertension, and other conditions. The guidelines, which Anthem uses for quality and disease management programs, are based on reasonable medical evidence. Anthem reviews the guidelines at least every year or when changes are made to national guidelines for content accuracy, current primary sources, new technological advances and recent medical research.

Providers can access the up-to-date listing of the medical, preventive, and behavioral health guidelines online. To access the guidelines, go to the **Anthem Provider Home page**, then under the **Resources** menu, select **Policies, Guidelines and Manuals**. Scroll to **Clinical Practice Guidelines** and select **Download the Index**.

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

Preventive Health Guidelines

Anthem considers prevention an important component of health care. Anthem develops preventive health guidelines in accordance with recommendations made by nationally recognized organizations and societies such as the American Academy of Family Physicians (AAFP), the American Academy of Pediatrics (AAP), the Advisory Committee on Immunizations Practices (ACIP), the American College of Obstetrics and Gynecology (ACOG) and the United States Preventive Services Task Force (USPSTF). The above organizations make recommendations based on reasonable medical evidence.

Anthem reviews the guidelines annually for content accuracy, current primary sources, new technological advances and recent medical research and make appropriate changes based on this review of the recommendations and/or preventive health mandates. Anthem encourages physicians to utilize these guidelines to improve the health of Members.

The current guidelines are available online. To access the guidelines, go to the **Anthem Provider Home page**, then under the **Resources** menu, select **Policies, Guidelines and Manuals**. Scroll to **Preventive Health Guidelines** and select **Review the guidelines**.

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

Medical Policies and Clinical Utilization Management (UM) Guidelines

The Office of Medical Policy & Technology Assessment (OMPTA) develops medical policy and clinical Utilization Management (UM) guidelines (collectively, “Medical Policy”) for the health plan. The principal component of the process is the review for development of medical necessity and/or

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

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

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

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

Medical Policy and Clinical Utilization Management (UM) Guidelines Distinction

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

Accessing Medical Policies and Clinical UM Guidelines

Medical policies and clinical UM guidelines are available on our websites, which provides transparency for Providers, Facilities, Members, and the public in general. Some vendor guidelines used to make coverage determinations are proprietary and are not publicly available on the health plan's websites but are available upon request.

To locate Medical Policy online, go to the **Anthem Provider Home page**, then under the **Resources** menu, select **Policies, Guidelines and Manuals**. Scroll down to select **View Medical Policies & Clinical UM Guidelines**. Search for policies and guidelines using a keyword or code, or select **Full List page** to view. Page link is below:

Medical Policy and Clinical UM Guidelines

BlueCard. To locate medical policy and clinical UM guidelines and prior authorization requirements for BlueCard Out-of-area members, go to the **Anthem Provider Home page**, then under the **Resources** menu, select **Prior Authorization**. Scroll to **Helpful Links.** Select **Medical Policy and Prior Authorization for Blue Plans**. Select **Type of information being requested,** enter **Alpha Prefix**, select **Go.** Review external link acknowledgement and select **Continue.** Read the

acknowledgment reference of general policies of Anthem Blue Cross and Blue Shield and select **Continue**. Page link is below:

Medical Policy and Prior Authorization for Blue Plans

Clinical UM Guidelines

The clinical UM guidelines published on the health plan's 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 adopt a particular clinical UM guideline. The link below can be used to confirm whether the local Plan or line of business has adopted the clinical UM guideline(s) in question. Adoption lists are created and maintained solely by each local Plan or line of business.

To view the list of specific clinical UM guidelines adopted by Georgia], go to the **Anthem Provider Home page**, then under the **Resources** menu, select **Policies, Guidelines and Manuals**. Scroll down to select **View Medical Policies & Clinical UM Guidelines**. Scroll to the bottom of the Clinical UM Guidelines section and select the link titled **Clinical UM Guidelines adopted by Anthem Blue Cross and Blue Shield** .

Other Criteria

In addition to medical policy and clinical UM guidelines maintained for coverage decisions, the health plan may adopt third party criteria, which is developed and maintained by other organizations. Where the health plan has developed criteria that addresses a service also described in one of the third party's sets of criteria, the health plan's medical policy supersedes.

To access third party criteria, go to the **Anthem Provider Home page**, then under the **Resources** menu, select **Policies, Guidelines and Manuals**. Scroll down to select **View Medical Policies & Clinical UM Guidelines**. Select **View Medical Policies & Clinical UM Guidelines**, scroll to **Other Criteria**, and select the desired criteria

- MCG
- Carelon Medical Benefit Management
- Carelon Rx
- Carelon Post Acute Solutions

Utilization Management

Utilization Management (sometimes referred to as Utilization Review) is our evaluation of clinical information for the purpose of making favorable determinations and adverse determinations to ensure appropriateness of care.

Utilization Management Program

The Utilization Management (UM) Program goal is to have Members receive the appropriate quantity and quality of healthcare services, delivered at the appropriate time, and in a setting consistent with their medical care needs. Providers and Facilities agree to abide by the following UM Program requirements in accordance with the terms of the Agreement and the Member's Health Benefit Plan. Providers and Facilities agree to cooperate with Anthem in the development and implementation of action plans arising under these programs. Providers and Facilities 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 Utilization Management section.

Decisions are based on medical necessity and appropriateness of care and service, and the organization does not specifically reward denials of coverage.

UM Definitions

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

Business Day: Monday through Friday, excluding designated company holidays.

Continued Stay Review (continuation of services)**:** Utilization review 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).

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

Notification: The telephonic and/or written/electronic communication to the applicable Provider(s), Facility, and the Member documenting the UM determination.

Pre-certification (includes Pre-authorization, Pre-Service, Prospective): List of services that require review by UM prior to service delivery. For the UM team to perform reviews, the Provider submits the pertinent information as soon as possible to UM prior to service delivery.

Review Types:

- **Prospective Review:** UM review conducted on a health care service (or supply) that requires pre-certification prior to its delivery to the Member.
- **Continued Stay Review:** UM review conducted during a Member's ongoing stay in a Facility or course of treatment. Continued Stay Review includes Continuation of Services (Urgent Care & Extensions).

- **Retrospective Review:** UM review conducted after the healthcare service (or supply) has been provided to the Member.
- **Urgent Care Review:** request for medical care or services where application of the time frame for making routine or non-life-threatening care determinations:
    a. Could seriously jeopardize the life or health of the Member or the Member's ability to regain maximum function, based on a prudent layperson's judgment, or
    b. Could seriously jeopardize the life, health, or safety of the Member or others, due to the Member's psychological state, or
    c. In the opinion of a practitioner who is a licensed or certified professional providing medical care or behavioral healthcare services with knowledge of the Member's medical or behavioral condition, would subject the Member to adverse health consequences without the care or treatment that is the subject of the request.

Program Overview

UM review may be required for Prospective, Continued Stay, or Retrospective services. UM may be conducted via multiple communication paths.

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

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

UM will provide electronic or written Notification for all determinations to the Member, Provider, and/or Facility, as applicable.

UM review timeframes follow Federal, State, and accreditation requirements as applicable to the 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 for the pre-Claim UM review.
- The service is excluded from coverage.
- The Member is not eligible for coverage when the service is provided.

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

Non-inpatient services may require Pre-certification review.

The list of Pre-certification requirements can be accessed online. Go to the **Anthem Provider Home page**, then under the **Resources** menu, select **Prior Authorization**. Select **Georgia** to see the appropriate link depending on the type of Member Plan. The Pre-certification requirements may be confirmed by contacting the appropriate phone number on the back of the Member's ID card.

Providers and Facilities shall verify that the Member's primary care physician has provided a referral as required by certain Health Benefit Plans.

Prospective Review and Continued Stay Review

A. Elective inpatient admission and outpatient procedures require review and to have a decision rendered **before** the service occurs. Information provided to UM shall include demographic and clinical information, including, but not limited to, primary diagnosis. For information on applicable penalties for non-compliance, see the *Failure to Comply with Utilization Management Program* section.

B. Emergency inpatient admission requires Providers and Facilities to notify 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 UM shall include demographic and clinical information, including, but not limited to, primary diagnosis. For information on applicable penalties for non-compliance, see the *Failure to Comply with Utilization Management Program* section.

Retrospective Utilization Management

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

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

For information on applicable penalties for non-compliance, see the *Failure to Comply with Utilization Management Program* section.

Medical Policies and Clinical UM Guidelines

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

On-Site/Electronic Medical Record Review (EMR)

If applicable, the Facility agrees to provide UM with onsite, or EMR access through the facility portal or through Epic Payor Platform (EPP), for inpatient admission reviews.

If applicable, the Facility agrees to provide UM with on-site or EMR access, for inpatient admission reviews.

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

Failure to Comply With Utilization Management Program Processes

Providers and Facilities 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-certification review on specified outpatient procedures, as required under the Agreement or for

Provider's or Facility's failure to fully comply with and participate in any cost management programs and/or UM programs. Members may not be balance billed for penalty amounts.

Penalties include, but are not limited to, the following:

- Pre-certification review is required for elective inpatient admissions and outpatient procedures that require Pre-certification as specified by Anthem that are not submitted for review and a decision rendered **BEFORE** the service occurs will be subject to a 100% payment penalty unless extenuating circumstances exist as further described below. Providers and Facilities can only dispute the one hundred percent (100%) penalty in order to present evidence of extenuating circumstances.
- Payment for emergency inpatient admissions will be subject to a one hundred (100%) penalty if the notification is not provided within forty-eight (48) hours of admission. Providers and Facilities can only dispute the one hundred percent (100%) penalty in order to present evidence of extenuating circumstances by requesting a Claim Payment Reconsideration as further described in the Claims Payment Disputes section of this manual. 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.

Extenuating Circumstances Approval List

- Insurance information was not available from the Member at the time of admission, or incorrect information was received from the Member, due to illness, mental status, or language differences at the time of services. Including primary payer issues (e.g., Medicare, AKA admissions, or VIP member admitted under a false name, etc.).
- Anthem health system problems prevented authorization from being obtained or Anthem health provides erroneous information, (e.g., misinformation about authorization requirements or Member eligibility).
- Admission or services received are court-ordered.
- The need for another covered service was revealed and performed at the time the original authorized service was performed, the newly revealed covered service would not receive a late call penalty
- The Member presented with an emergency/urgent condition or life-threatening illness/injury/trauma (e.g., intubation or loss of consciousness).
- Routine maternity admissions/newborn admissions – active/Coordination of Benefits membership
- Proof of timely notification of admission of emergency admission was received 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. Substantiation may be requested.
- Provider or Facility was given misinformation about authorization or patient eligibility by an Anthem Health employee or Department of Medical Assistance (DMAS).
- Transition of Care. This includes transfer from one hospital to another or transfer to home.
- The Member was traveling out of the area, and the Provider or Facility had difficulty finding who to call for the authorization.

- Retro enrollment issues where the member was terminated and then reinstated, but the application was not loaded timely.
- Member's plan reinstated post-admission and retroactive to a date prior to the admission.
- A Provider or Facility system outage extending forty-eight (48) hours beyond the date of service requiring authorization prevented the authorization from being obtained, and the Provider or Facility has provided adequate evidence of the system outage.
- A Member is admitted to observation and then becomes inpatient.
- Any other Extenuating Circumstances specific to the health plan.

Utilization Statistics Information

On occasion, Anthem may request utilization data. These may include, but are not limited to:

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

This information will be provided by Providers or Facilities at no charge to Anthem.

Inpatient Electronic Data Exchange

For additional information go to the Clinical Data Sharing section of this Manual which can be found under Legal and Administrative Requirements.

Prior Authorization Determinations and Submissions

Use our digital tools to determine and submit prior authorizations**.**

- **Determinations:** To **determine** prior authorization requirements:
  - **Online:** The preferred method for Providers to verify outpatient prior authorization requirements is by using Availity.com.
    - Log into **Availity.com**
    - Go to the **Payer Spaces** tab
    - Select the applicable plan
    - Click on **Authorization Rules Lookup**
    - Enter the required Provider information
    - Select **Next** to enter the required Member information

    Note: There could be infrequent scenarios where the lookup tool indicates a prior authorization is needed, but upon submission of the prior authorization request, it is determined not to be required based on additional information provided.
  - **Website:** The list of prior authorization requirements can also be accessed online:
    - Go to the Anthem Provider Home page

        - Under the Resources heading, select Prior Authorization
        - Select the applicable state
        - Select the appropriate link depending on the type of Member Plan
        - If the Member's home plan is not with Anthem, the applicable home plan will determine prior authorization requirements. The prefix lookup tool within anthem.com will inform the Member's home plan.
    - **Phone:** The prior authorization requirements may be confirmed by calling the appropriate phone number on the back of the Member's ID card.

- **Submissions:** To **submit** prior authorization requests

  Using Availity.com to submit prior authorizations offers a streamlined and efficient experience for Providers and Facilities requesting inpatient and outpatient medical services for members covered by Anthem plans. Providers and Facilities can also use the Availity Essentials Authorization application to check authorization status, regardless of how the authorization was submitted.

  - To submit digital prior authorizations:
    - Log onto Availity.com
    - Select the Patient Registration tab to access Authorizations and Referrals
    - Select Authorization Request
  - Transplant Pre-certification requests should be submitted via telephone, fax or secured e-mail notification.

Peer-to-Peer Review Process

Upon request from a treating practitioner, who is a licensed or certified professional providing medical care or behavioral healthcare services and directly involved in the Member's care/treatment plan, Anthem provides a clinical peer-to-peer conversation when an adverse medical necessity determination will be made or has been made regarding health care services for Members. The treating practitioner may offer additional information and/or further discuss their cases with a peer clinical reviewer.

In compliance with accreditation standards, a practitioner or their 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 anytime, Anthem may request on-site, electronic, or hard copy medical records, utilization review documentation, and/or itemized bills related to Claims for the purposes of conducting audits and reviews to determine Medical Necessity, diagnosis, and other coding and documentation of services rendered.

Case Management

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

The Case Management programs help coordinate services for Members with healthcare needs due to serious, complex, and/or chronic health conditions. The programs coordinate benefits and educate Members who agree to take part in the Case Management program to help meet their health-related needs. Case Management programs are confidential and voluntary and are made available at no extra cost. These programs are provided by, or on behalf of and at the request of, case management staff. These Case Management programs are separate from any Covered Services. If the Member meets program criteria and agrees to take part, the case manager will help the Member meet identified health care needs. This is reached through contact and teamwork with the Member and/or the Member's chosen authorized representative, treating Physician(s), and other Providers. Assistance may be provided in coordinating care with existing community-based programs and services. This may include giving information about external agencies and community-based programs and services.
Case Management services ***may*** be provided by Carelon Health Services, Inc.

Carelon Medical Benefits Management

Carelon Medical Benefits Management (Carelon MBM) provides clinical solutions that drive appropriate, safe, and affordable care. Serving more than 50 million Members across 50 states, D.C. and U.S. territories, Carelon MBM promotes optimal care using evidence-based clinical guidelines and real-time decision support for both providers and their patients. The Carelon MBM platform delivers significant cost-of-care savings across an expanding set of clinical domains, including cancer care quality, cardiology, genetic testing, musculoskeletal care, medical and radiation oncology, radiology, rehabilitation, sleep medicine, post-acute, and surgical procedures.

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

Pre-certification requests to Carelon MBM

Ordering and servicing Providers and Facilities may submit Pre-certification requests to Carelon MBM in one of the following ways:

- Access ***Provider****Portal*$_{SM}$ 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.
- Call the Carelon Medical Benefits Management Contact Center toll-free number: 866-714-1103, Monday through Friday, 8:00 a.m. to 6:00 p.m. ET.

Provider Connections

Providers and Facilities are encouraged to visit Carelon MBM's **Provider Connections website**, a news blog for prior authorization staff and provider portal users. Visit the site frequently to learn about the best ways to use the Carelon MBM provider portal and how to reduce unnecessary calls by using all available features. Our goal is to provide tips and tricks to make Providers and Facilities days easier and more efficient.

OptiNet Registration

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

To access the OptiNet Registration:

- Access the provider portal directly at **providerportal.com**
    - Once logged into Carelon Medical Benefits Management, from the **My Homepage** screen, choose **Access OptiNet Registration**.
- Select the Registration Type and choose the Access OptiNet Registration button.
- Complete requested information.

The registration does not need to be completed in one sitting. Data can be saved throughout the registration process. Once the registration has been submitted, a score card will be produced for Radiation Solution Facilities. Genetics Testing Facilities will not have a score card. The score for the Facility will be presented to the ordering Provider or Facility when the particular Facility is selected as a place of service, which drives Ordering Provider Decision Support.

For technical questions, contact Provider Portal Web Support at **800-252-2021**. For specific OptiNet customer service requests, contact **877-202-6543**. For any other questions, contact the Anthem **Provider Relationship Account Management team**.

Quality Improvement Program

Anthem Quality Improvement (QI) Program is outlined in the Quality Improvement Program Description (QIPD), which details Anthem's quality infrastructure and activities that support its QI strategies.

This document defines the program governance, scope, goals, objectives, structure and responsibilities, all of which ensure the quality of medical and behavioral healthcare available to covered members.

Local Presence and Member Needs

Healthcare is local, and Anthem's strong local presence is crucial for understanding and supporting member needs to provide accessible, covered care.

Anthem is well-positioned to deliver innovative, choice-based products, distinctive service, simplified transactions, and better access to information for quality care.

This local presence, combined with broad expertise, facilitates collaborative programs that reward providers and facilities for achieving clinical quality and excellence. Participating providers and facilities are expected to cooperate with quality activities, which enhance member value and improve health and healthcare costs. Anthem plays a leadership role in addressing key healthcare issues and improving community health.

"Whole Health" Strategy and Digital Solutions

Guided by its "Whole Health" strategy, Anthem employs digital-first solutions to deliver exceptional experiences, affordability, high quality, and broader access to care.

Digital solutions are the cornerstone of Anthem's strategy, enabling value creation and responsiveness to societal shifts, market demands and consumer needs. Anthem focuses on integrating data, analytics, insights, and digital technologies throughout the business.

Commitment to Continuous Quality Improvement

Continuous QI is essential for supporting member health and Anthem's business objectives. This commitment aligns with Anthem's mission statement: "Improving lives and communities. Simplifying healthcare. Expecting more." The pursuit of excellence, driven by this mission, forms the foundation for programs and initiatives that aim to achieve meaningful and measurable quality outcomes for members.

Vision and Core Values

Anthem's vision is to be the most innovative, valuable, and inclusive partner. Anthem is dedicated to enhancing member and provider satisfaction, improving health status and quality of care,

delivering value-based products and services, enhancing patient safety, improving care coordination and promoting access to medical services.

The comprehensive and integrated QI program involves departments that support quality initiatives, systematically monitoring and evaluating the safety, appropriateness and quality of medical and behavioral healthcare services by network providers and identifying opportunities for continuous improvement.

Core values such as leadership, community, integrity, agility and diversity provide a solid foundation for achieving success.

QI Program Goals and Objectives

The goals and objectives of the QI program support Anthem's vision and values and respond to the evolving needs of members, providers, facilities and the healthcare community.

These goals focus on establishing Anthem as a valued health partner across the healthcare continuum. Anthem implements evidence-based interventions from both external and internal sources to deliver the best value to customers.

Goals and Objectives

- Quality Of Clinical Care
    - Goal: Improve Member health through the enhancement of clinical quality outcomes
    - Objective 1: Identify, monitor and report priority HEDIS measures
    - Objective 2: Promote evidence-based practices
- Safety of Clinical Care
    - Goal: Promote patient safety and health equity
    - Objective 1: Promote transparency and collaboration to improve patient safety
    - Objective 2: Identify and analyze health disparities
- Quality of Service
    - Goal: Provide high quality services to Members
    - Objective 1: Maintain operational excellence through compliance with policies and standards
    - Objective 2: Streamline processes to enhance operational efficiency
- Member Experience
    - Goal: Optimize the Member experience
    - Objective 1: Gather, analyze and act on member feedback
    - Objective 2: Encourage use of technology to ease member access

Patient Safety for Members

Patient safety continuous improvement efforts support the mission for improving lives and communities. Areas for monitoring are selected by analyzing data for Members, inherent to quality of medical and behavioral healthcare delivery and service. Areas of focus include PHM programs that target keeping Members healthy, managing Members with emerging risk, patient safety or outcomes across settings and managing multiple chronic illnesses.

Patient safety may be addressed through the following:

- Identification, monitoring and resolution of complaints and grievances including those related to potential quality of care and quality of service issues. Implementation of processes to address quality of care and service issues, internally and among the network of Providers and Facilities.
- Integrate and automate reporting of the Member-level quality of care cases from all lines of business at the Provider level.

- Credentialing and recredentialing processes confirm Providers' credentials and qualifications to practice as network Providers and perform services appropriately within their scope of practice. Providers must complete the initial credentialing process prior to caring for Anthem Members. Ongoing monitoring of license sanctions, Medicare and Medicaid sanctions, complaints, and adverse events occurs between comprehensive recredentialing reviews.
- Provider education via the distribution of evidenced-based clinical practice guidelines and preventive health guidelines.
- Educating Members to become actively involved in their own care, as well as providing education around medication safety compliance and targeted "gaps in care".
- Establish procedures for safety in pharmaceutical prescribing and medication management.
- Patient safety activities/programs designed to promote safe practices by identifying opportunities for improvement, such as PHM and medication adherence.
- Work with regulators and industry leaders such as CMS, NQF, AHRQ, Leapfrog, etc. on updating Seriously Reportable Events list; clarifying and advancing payment policies; contribute to literature on patient safety, quality improvement and health equity.

Member Rights and Responsibilities

The delivery of quality health care requires cooperation between Members, their Providers and Facilities and their health care benefit plans. One of the first steps is for Members, Providers and Facilities to understand Member rights and responsibilities. Therefore, Anthem has adopted a Members' Rights and Responsibilities statement which can be accessed by going to the **Anthem Provider Home page**, then under the **Resources** menu, select **Policies, Guidelines and Manuals**. Scroll down and select the **Read about member rights** link under the **More Resources/Member Rights and Responsibilities** section. Select **Laws and Rights that Protect You** on the left column, then choose the **What are my rights as a Member** FAQ question. Members or Providers who do not have access to the website can request copies by contacting Anthem or by calling the number on the back of the Member ID card.

Continuity and Coordination of Care

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

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

Continuity of Care/Transition of Care Program

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

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

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

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

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

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

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

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

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

- American College of Cardiology (ACC)
- Center for Medicare and Medicaid Services (CMS)
- Institute for Healthcare Improvement (IHI)
- National Quality Forum (NQF)
- The Joint Commission (JC)
- The Society of Thoracic Surgeons (STS)

In order to align Q-HIP goals with national performance thresholds, the Q-HIP benchmarks and targets are based on national datasets such as the Centers for Medicare and Medicaid Services' Hospital Compare database. The measures can be tracked and compared within and among hospital[s] for all patient data – regardless of health plan carrier.

Annual meetings are held with participating hospitals from across the country, offering participants an opportunity to share feedback regarding new metrics and initiatives. Additionally, a National Advisory Panel on Value Solutions (NAPVS) was established in 2009 to provide input during the scorecard

development process. The NAPVS is made up of patient safety and quality leaders from health systems and academic medical centers from across the country and offers valuable advice and guidance as new measures are evaluated for inclusion in the program.

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

Quality-In-Sights®: Primary Care Incentive Program

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

Specialties included in the Quality-In-Sights Primary Care Incentive Program
The program is open to Providers who specialize in Family Medicine, General Practice, Internal Medicine and/or Pediatrics as their designated primary specialty, who meet eligibility requirements and who provide primary care services to Members of Anthem and Anthem enrolled in a HMO, Point of Service or PPO Health Benefit Plan product.

Performance Data

Provider/Facility Performance Data means compliance rates, reports and other information related to the appropriateness, cost, efficiency and/or quality of care delivered by an individual healthcare practitioner, such as a physician, or a healthcare organization, such as a hospital. Common examples of performance data would include the Healthcare Effectiveness Data and Information Set (HEDIS) quality of care measures maintained by the National Committee for Quality Assurance (NCQA) and the comprehensive set of measures maintained by the National Quality Forum (NQF).
Provider/Facility Performance Data may be used for multiple Plan programs and initiatives, including but not limited to:

- **Reward Programs** – Pay for performance (P4P), pay for value (PFV) and other results-based reimbursement programs that tie Provider or Facility reimbursement to performance against a defined set of compliance metrics. Reimbursement models include but are not limited to shared savings programs, enhanced fee schedules and bundled payment arrangements.
- **Recognition Programs** – Programs designed to transparently identify high value Providers and Facilities and make that information available to consumers, employers, peer practitioners and other healthcare stakeholders.

Overview of HEDIS®

HEDIS (Healthcare Effectiveness Data and Information Set) is a set of standardized performance measures used to compare the performance of managed care plans and physicians based on value rather than cost. HEDIS is coordinated and administered by NCQA and is one of the most widely used sets of health care performance measures in the United States. Anthem's HEDIS Quality Team is responsible for collecting clinical information from Provider offices in accordance with HEDIS specifications. Data is collected in four ways: Administratively, Hybrid, Survey or via Electronic Clinical Data Systems. Currently, HEDIS includes eighty-eight (88)* measures across six (6)* domains:

- Effectiveness of Care
- Access/Availability of Care

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

Record requests to Provider offices is a year round process. Anthem requests the records be returned within the specified time frame to allow time to abstract the records and request additional information if needed from other Providers. Health plans use HEDIS data to encourage their contracted Providers to make improvements in the quality of care and service they provide. Employers and consumers use HEDIS data to help them select the best health plan for their needs

For more information on HEDIS, go to the **Anthem Provider Home page**, and under the **Resources** menu, select **Forms and Guides**. Scroll down and select the **HEDIS** category.

*Subject to change

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

Overview of CAHPS

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

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

Results of these surveys are shared with Providers annually, 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.

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

Member Safety

Leapfrog Group

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

The Leapfrog Group aims to:

- Reduce preventable medical mistakes and improve the quality and affordability of health care.
- Encourage health Providers to publicly report their quality and outcomes so that consumers and purchasing organizations can make informed health care choices.

- Reward doctors and hospitals for improving the quality, safety and affordability of health care.
- Help consumers reap the benefits of making smart health care decisions.
- Network hospitals are encouraged to join the Leapfrog Group and implement policies to reduce medical errors and improve Member safety. In 2006, there was a thirty percent (30%) increase in HMO/POS participation/response to survey and a twenty percent (20%) increase in the PPO participation/ response to survey. There was a significant increase in the 'Evidenced Based Hospital Referral' (EHR) leap and one-hundred percent (100%) of facilities attained the "Fully implemented" rating for "National Quality Forum-Endorsed Safe Practices" (NQF-S) leap.

Hospitals that have not completed the survey, can do so by logging on to the Leapfrog Group Website at **leapfroggroup.org**.

Partnership for Health and Accountability

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

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

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

Culturally & Linguistically Appropriate Services

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

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

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

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

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

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

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

- **Caring for Children with ADHD:** Promotes understanding of and adherence to diagnosis and treatment guidelines; use of AAP's Resource Toolkit for Clinicians; awareness of and strategies for addressing disparities.

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

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

Centers of Medical Excellence

Anthem currently offers access to Centers of Medical Excellence (CME) programs in solid organ and blood/marrow transplants, bariatric surgery, cancer care, cardiac care, maternity care, spine surgery, knee/hip replacement surgery, fertility care, cellular immunotherapy – CAR-T, gene therapy, and substance use treatment and recovery. As much of the demand for CME programs has come from National Accounts, most of Anthem's programs are developed in partnership with the Blue Cross Blue Shield Association (BCBSA) and other Blue plans to ensure adequate geographic coverage. The BCBSA refers to its designated CME providers as Blue Distinction Centers for Specialty Care™. Using objective information and input from the medical community, the BCBSA has designated hospitals, ambulatory surgery centers (ASCs), physicians, and/or clinics as Blue Distinction Centers (BDC) that are proven to outperform their peers in the areas of quality, safety and, in the case of Blue Distinction Centers+ (BDC+), cost efficiency.

For transplants, cellular immunotherapy CAR-T and ventricular assist devices (VAD), Members also have access to the Anthem Centers of Medical Excellence Transplant, Cellular Immunotherapy and VAD Network. The CME designation is awarded to qualified programs by a panel of national experts currently practicing in the fields of solid organ, bone marrow transplantation, and cardiac surgery representing centers across the country. Each Center must meet Anthem's CME participation requirements and is selected through a rigorous evaluation of clinical data that provides insight into the Facility's structures, processes, and outcomes of care. Current Anthem CME transplant designations include the following transplants: adult and pediatric autologous/allogeneic bone marrow/stem cell, adult and pediatric heart, adult and pediatric lung, adult combination heart/lung, adult and pediatric liver, adult and pediatric kidney, adult simultaneous kidney/pancreas and adult pancreas.

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

Transplant

- Blue Distinction Centers for Transplant™ (BDCT) launched in 2006.
- Nearly 104,000 people in the United States were waiting for a lifesaving organ transplant from one of the nation's more than 250 transplant centers in the United States as of December, 2022. In the United States, more than 42,800 organ transplants in 2022. In 2022, annual records were set for total number of kidney, liver, heart and lung transplants.
- Blue Distinction Centers and Blue Distinction Centers+ for Transplants have demonstrated their commitment to quality care, resulting in better overall outcomes for transplant patients. Each Facility meets stringent clinical criteria, established in collaboration with expert physicians' and medical organizations' recommendations**, including the Center for International Blood and Marrow Transplant Research (CIBMTR), the Scientific Registry of Transplant Recipients (SRTR), and the Foundation for the Accreditation of Cellular Therapy (FACT), and is subject to periodic re-evaluation as criteria continue to evolve. Both Blue Distinction Centers and Blue Distinction Centers+ for Transplants help simplify the administrative process involved in this complex care so that patients, their families, and physicians can focus on the medical issues.

- Hospitals receiving the Blue Distinction Center+ for Transplants designation have met the Blue Distinction Centers' standards for quality while also demonstrating better cost-efficiency relative to their peers.
- The Anthem CME Transplant Network is a wrap-around network to the BDCT program and offers Members access to an additional 60 transplant programs. When BDCT and Anthem CME are combined, Members have access to over 800 transplant specific programs for adult and pediatric heart, lung, liver, kidney, and bone marrow/stem cell transplant, and adult combined heart/lung, combined liver kidney, pancreas, and combined kidney/pancreas transplant.

Cardiac Care

- Blue Distinction Centers for Cardiac Care® launched in January 2006.
- According to the Centers for Disease Control and Prevention, the number of adults with a diagnosis of heart disease is 30.3 million, and the percent of adults with diagnosed heart disease is 12.1%. Heart Disease is the number one (1) cause of death in the United States. The American Heart Association projects the number of Americans with cardiovascular disease to rise to 131.2 million by 2035.
- Research shows that Blue Distinction Centers and Blue Distinction Centers+ demonstrate better quality and improved outcomes for patients, with lower rates of complications following certain cardiac procedures and lower rates of healthcare associated infections compared with their peers. Blue Distinction Centers+ (BDC+) are also 21 percent more cost-efficient than non-BDC+ designated hospitals for those same cardiac procedures.
- Blue Distinction Centers and Blue Distinction Centers+ for Cardiac Care focuses elective cardiac procedures, including cardiac valve surgery, coronary artery bypass graft (CABG), and angioplasty (percutaneous coronary intervention (PCI) while providing a full range of cardiac care services, including inpatient cardiac care, cardiac rehabilitation, cardiac catheterization and cardiac surgery.

Bariatric Surgery

- Blue Distinction Centers for Bariatric Surgery® launched in 2008
- According to the National Center for Health Statistics report released in October 2017 Prevalence of Obesity among Adults and Youth has grown to more than one-third (42.4%) of U.S. adults which have been diagnosed with obesity, and 40% for young adults aged 20-39. Obesity-related conditions include heart disease, stroke, type 2 diabetes and certain types of cancer, which are some of the leading causes of preventable death.
- Blue Distinction Centers for Bariatric Surgery have demonstrated their commitment to quality care, resulting in better overall outcomes for adult bariatric patients ages 18 and older. Each facility meets stringent clinical criteria, developed in collaboration with expert physicians and medical organizations, including the American Society for Metabolic and Bariatric Surgery (ASMBS) and the American College of Surgeons (ACS), and is subject to periodic re-evaluation as criteria continue to evolve
- The 2020 Blue Distinction Centers for Bariatric Surgery program uses updated Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP) accreditation levels, which focus on site of service. With this design change, each facility can apply to

achieve the BDC or BDC+ designation, as either a Comprehensive Center (including outpatient capability) or an Ambulatory Surgery Center (ASC).

Cancer Care

- Blue Distinction Centers for Cancer Care launched in 2018.
- This national designation program recognizes physicians, physician practices, cancer centers, hospitals, and accountable care organizations (ACOs) 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 (8) out of ten (10) Americans suffer from some sort of back pain. Many ways to treat back pain are available for Providers to work with Members, to guide them toward the most appropriate recommendation for their situation. For those with severe and/or chronic back pain, spine surgery may be a treatment option.
- Research confirms that hospitals designated as Blue Distinction Centers and Blue Distinction Centers+ for Spine Surgery have fewer complications and fewer hospital readmissions than non-designated hospitals. Blue Distinction Centers+ for Spine Surgery also deliver care more efficiently than their peers.
- In 2019, Blue Distinction Specialty Care Program for Spine Surgery expanded to include alternate sites of care, such as ambulatory surgery centers (ASCs) and hospitals without an on-site ICU.
- Blue Distinction Centers and Blue Distinction Centers+ for Spine Surgery provide comprehensive inpatient spine surgery services, including discectomy, cervical and lumbar fusion, cervical laminectomy, lumbar laminectomy/discectomy and decompression procedures.
- To date, Anthem has designated hospitals in the majority of states across the U.S.

Knee and Hip Replacement

- Blue Distinction Centers for Knee and Hip Replacement™ launched in November 2009.
- In 2019, Blue Distinction Specialty Care Program for Knee and Hip Replacement expanded to include alternate sites of care, such as ambulatory surgery centers (ASCs) and hospitals without an on-site ICU.
- Blue Distinction Centers and Blue Distinction Centers+ for Knee and Hip Replacement provide comprehensive inpatient knee and hip replacement services, including total knee replacement and total hip replacement and revision surgeries.

Maternity Care

- Blue Distinction Centers and Blue Distinction Centers+ for Maternity Care launched in 2016. The program offers access to healthcare facilities with demonstrated expertise, a commitment to quality care, and safety during the delivery episode of care, which includes both vaginal and cesarean section delivery.
- Recent updates to the program address the goal of reducing racial disparities in maternal health and maternal health crisis in the United States. Criteria included recommendations from organizations to enhance outcomes and reduce adverse events. Organizations included the Department of Health and Human Services (HHS), American College of Obstetricians and Gynecologists (ACOG), Alliance for Innovation on Maternal Health (AIM), and the California Maternal Quality Care Collaborative (CMQCC).
- The Maternity Care designation uses publicly available data from Hospital Compare data which includes the Early Elective Delivery (PC-01), Cesarean Section (PC-02) and selected patient experience measures at the facility level from Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS). As well as additional measures to support safe practices in childbirth, prenatal and postpartum care.

Substance Use Treatment and Recovery

- Blue Distinction Centers for Substance Use Treatment and Recovery launched in January 2020 to address the treatment of substance use disorders, including opioid use disorder.
- The program aims to improve patient outcomes and cost by addressing the fragmented delivery of substance use disorder treatment. Designations are awarded based on quality criteria that support delivery of timely, coordinated, multidisciplinary, evidence-based care, with a focus on quality improvement and patient-centered care.
- This includes medication-assisted treatment (MAT) and other evidence-based therapies across care settings. Care settings include residential and inpatient care, intensive outpatient (IOP), and partial hospitalization (PH) treatment. At minimum, all providers must offer treatment for opioid use disorder.

Ventricular Assist Devices

- Anthem's Centers of Medical Excellence Ventricular Assist Device (VAD) launched in 2017. VADs are implantable pumps that assist the heart by pumping blood in the circulatory system of individuals with end-stage heart failure.
- According to the Centers for Disease Control and Prevention Heart failure reports that about 6.2 million adults in the United States have heart failures a major public health problem associated with significant hospital admission rates, mortality, and costly health care services.
- Based on registry data, >33,000 left ventricular assist devices (LVADs) were implanted from June 2006 to June 2021. An estimated 3000+ VADs will be implanted worldwide this year, but the volume is expected to increase as newer, smaller devices receive regulatory approval, clinical indications slowly expand and the continued increase in centers certified to place these devices.

Cellular Immunotherapy (Chimeric Antigen Receptor Therapy – CAR-T)

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

- There are eight (8) Chimeric Antigen Receptor T cell therapies (CAR-T) products, listed below, approved by the FDA. This list continues to grow as new products are approved:
    1. Yescarta® (axicabtagene ciloleucel) for treatment in Adult Patients
    2. Kymriah® (tisangenlecleucel) for treatment in Pediatric and Adult Patients
    3. Tecartus™ (brexucabtagene autoleucel) for treatment in Adult Patients
    4. Abecma® (idecabtagene vicleucel) for treatment in Adult Patients
    5. Breyanzi® (idecabtagene maraleucel) for treatment in Adult Patients
    6. Carvykti® (ciltacabtagene autoleucel) for treatment in Adult Patients
    7. Omisirge (omidubicel) for treatment in Pediatric and Adult Patients
    8. Tecelra (afamitresgene autoleucel) for treatment of Adults Patients with unresectable or metastatic synovial sarcoma
- These procedures can be performed in the Inpatient (IP) or Outpatient (OP) setting and Care and follow-up continues over the first year.
- These Members are managed by the transplant Case Managers and Anthem Medical Policy requires the procedure be performed at a Certified CAR-T center.
- Anthem has a Centers of Medical Excellence Network that continues to expand. These programs are reviewed by our Bone Marrow National Transplant Quality Review Committee. Currently we have eight (8) contracted CAR-T CME Providers. Until a Provider or Facility is contracted, each referral will require a Letter of Agreement.
- The Blue Cross Blue Shield Association also has a designation, but not a contract requirement for CAR-T Providers in 2020. Providers must be certified by a product manufacturer certification program to deliver CAR-T therapy.

Gene Therapy

- The U.S. Food & Drug Administration (FDA) continues to approve new gene therapy products which provide new treatments for various conditions. This treatment involves gene therapy that introduces or is related to the introduction of genetic material into a person intended to replace or correct faulty or missing genetic material.
    - Zynteglo (Betibeglogene autotemcel) for treatment of adults and children with beta-thalassemia requiring red blood cell transfusions.
    - Skysona (Elivaldogene autotemcel) for treatment of pediatric patients with cerebral adrenoleukodystrophy – early active disease
    - Casgevy (Exagamglogene autotemcel; exa-cel) for treatment of patients 2 years and older with recurrent vaso-occlusive crises (VOC) or patients 12 year and older with transfusion-dependent beta-thalessemia
    - Lyfgenia (Lovotibeglogene autotemcel; exa-cel) for treatment of patients 12 years and older with sickle cell disease and a history of vaso-occlusive events
    - Lenmeldy (OTL-200; Atidarsagene autotemcel) for treatment of pediatric patients with metachromatic leukodystrophy disease

Audit and Review

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

Anthem Claims Audit and Review Policy

All capitalized terms used in this Policy shall have the meaning as set forth in the Provider or Facility Agreement between Anthem and Provider or Facility, unless otherwise defined below for this section.

There may be times when Anthem conducts Claim reviews or audits to confirm that charges for covered healthcare services are accurately reported and reimbursed in compliance with the Provider or Facility Agreement and Anthem's policies and procedures, as well as general industry standard guidelines and regulations.

In order to conduct such reviews and audits, Anthem or its designee may request documentation, most commonly in the form of patient medical records and/or itemized bill. Anthem may accept additional documentation from Provider or Facility that typically might not be included in medical records such as other documents substantiating the treatment or health service or delivery of supplies.

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

Definitions

The following definitions shall apply to this Audit and Review section only:

- Agreement means the written contract between Anthem and Provider or Facility that describes the duties and obligations of Anthem and the Provider or Facility, and which contains the terms and conditions upon which Anthem will reimburse Provider or Facility for Health Services rendered by Provider or Facility to Member(s).
- Audit Appeal means a written request with supporting documentation to Anthem from a Provider or Facility to reconsider a payment determination.
- Audit Appeal Response means Anthem's or its designee's written response to the Appeal after reviewing all Supporting Documentation provided by Provider or Facility.
- Audit means post payment evaluation of Health Services or documents relating to such Health Services rendered by Provider or Facility, and conducted for the purpose of determining appropriate reimbursement under the terms of the Agreement.
- Business Associate or designee means a third party designated by Anthem to perform an Audit or any related function on behalf of Anthem.
- Notice of Overpayment means a document that constitutes notice to the Provider or Facility that Anthem or its designee believes an overpayment has been made by Anthem. The Notice of Overpayment shall contain administrative data relating to the amount of overpayment. Unless otherwise stated in the Agreement between the Provider or Facility and Anthem, Notice of Overpayment shall be sent to Provider or Facility.

- Provider Manual means the proprietary Anthem document available to the Provider and Facility, which outlines Reimbursement Requirements and Policies.
- Recoupment means the recovery of an amount paid to Provider or Facility which Anthem has determined constitutes an overpayment not supported by an Agreement between the Provider or Facility and Anthem. In accordance with applicable laws, regulations and unless an agreement expressly states otherwise, a Recoupment may be performed against a separate Anthem payment unrelated to the service or subject made to the Provider or Facility.
- Review means the Claim and supporting documentation will be evaluated prior to payment.
- Supporting Documentation means the written material contained in a Member's medical records or other Provider or Facility documentation, Claim details, prior authorization clinical information, and supply invoices supporting the Provider's or Facility's Claim.

Documents Reviewed During an Audit or Review

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

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

B. Confirm charges were accurately reported on the Claim in compliance with Anthem's Policies as well as general industry standard guidelines and regulations.
   Auditors/Reviewers may review Supporting Documentation including the Member's health record documents. The health record includes the clinical data on diagnoses, treatments, and outcomes. A health record generally includes pertinent information related to care and must support services billed by the Provider or Facility.

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

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

Policy

Upon request from Anthem or its designee, Providers and Facilities are required to submit additional documentation for Claims identified for pre-payment review or post payment audit.

Anthem or its designee will use the following guidelines for additional documentation requests when Claims are identified for pre-payment review or post payment audit. A request may be made via paper or electronic format.

- A Provider's or Facility's physical or electronic address may be confirmed prior to sending an initial request for supporting documentation.
- When a response is not received within thirty (30) days of the date of the initial request, a second request will be sent.

- When a response is not received within fifteen (15) days of date of the second request, a final request will be sent.
- When a response is not received within fifteen (15) days of the date of the final request, sixty (60) days total:
  - Anthem or its designee will initiate a Claim denial for Claims identified for pre-payment review or post payment audit when a Provider or Facility fails to submit the required documentation. The Member shall be held harmless for such payment denials.

    or
  - Anthem or its designee will initiate a full or partial recoupments for Claims identified for post-payment audit when a Provider or Facility fails to submit the required documentation. Anthem or its designee will review all submitted documentation, if any, to make a determination as to whether a full or partial recoupment is appropriate. The Member shall be held harmless for such recoupments.

Anthem or its designee will not be liable for interest or penalties when payment is denied or recouped when Provider or Facility fails to submit required or requested documentation for Claims identified for pre-payment review or post payment audit.

Procedure

Review of Documents: Anthem or its designee will request in writing any supporting documentation required for audit or review. The Provider or Facility will supply the requested documentation within the time frame outlined above.

Desk or Off-site Audits: Anthem or its designee may conduct Audits from its offices and/or offsite locations. Facility or Provider will comply with timeline and specific requested documentation listed in Anthem's request for additional documentation.

Completion of Desk or Off-site Audit: Upon completion of the Audit where an overpayment is identified, Anthem will generate a Notice of Overpayment. The Notice of Overpayment will identify the Claim overpayment and include an explanation remark for the overpayment. If the Provider or Facility agrees with the Notice of Overpayment, then the Provider or Facility has thirty (30) calendar days to reimburse Anthem the amount indicated in the form of a refund.

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

Provider or Facility Audit Appeals: See Audit Appeal Policy.

On-site Audits: Anthem or its designee may, but is not required to, conduct Audits on-site at the Provider's or Facility's location. If Anthem or its designee conducts an Audit at a Provider's or Facility's location, Provider or Facility will make available suitable workspace for Anthem's or its designee's on-site Audit activities. During the Audit, Anthem or its designee will have complete access to the applicable health records including ancillary department records and/or invoice detail without producing a signed Member authorization.

When conducting credit balance reviews, Provider or Facility will give Anthem or its designee a complete list of credit balances for primary, secondary and tertiary coverage, when applicable. In addition, Anthem or its designee will have access to Provider's or Facility's patient accounting system

to review payment history, notes, Explanation of Benefits and insurance information to determine validity of credit balances. If the Provider or Facility refuses to allow Anthem or its designee access to the items requested to complete the Audit, Anthem or its designee may opt to complete the Audit based on the information available.

All Audits (to include medical chart audits and diagnosis related group reviews) shall be conducted free of charge despite any Provider or Facility policy to the contrary.

Completion of Audit (On-site Audit only): Upon completion of the Audit, Anthem or its designee will generate and give to Provider or Facility a final Audit Report. This Audit Report may be provided on the day the Audit is completed or it may be generated after further research is performed. If further research is needed, the final Audit Report will be generated at any time after the completion of the Audit, but generally within ninety (90) days. Occasionally, the final audit report will be generated at the conclusion of the exit interview which is performed on the last day of the Audit.

During the exit interview, Anthem or its designee will discuss with Provider or Facility its Audit findings found in the final Audit Report. This Audit Report may list items such as charges unsupported by adequate documentation, under-billed items, late billed items and charges requiring additional supporting documentation.

If the Provider or Facility agrees with the Audit findings and has no further information to provide to Anthem or its designee, then Provider or Facility may sign the final Audit Report acknowledging agreement with the findings. At that point, Provider or Facility has thirty (30) calendar days to reimburse Anthem the amount indicated in the final Audit Report. Should the Provider or Facility disagree with the final Audit Report generated during the exit interview, then Provider or Facility may either supply the requested documentation or Appeal the Audit findings.

No Appeal (On-site audit only): If the Provider or Facility does not formally Appeal the findings in the final Audit Report **and** submit supporting documentation within the thirty (30) calendar day timeframe, the initial determination will stand and Anthem or its designee will process adjustments to recover the amount identified in the final Audit Report.

Scheduling of Audit (Hospital Bill Audits Only): After review of the documents submitted, if Anthem or its designee determines an Audit or Review is required, Anthem or its designee will call the Provider or Facility to request a mutually satisfactory time for Anthem or its designee to conduct an Audit; however, the Audit must occur within forty-five (45) calendar days of the request.

Rescheduling of Audit: Should Provider or Facility desire to reschedule an Audit, Provider or Facility must submit its request with a suggested new date to Anthem or its designee in writing at least seven (7) calendar days in advance of the day of the Audit. Provider's or Facility's new date for the Audit must occur within thirty (30) calendar days of the date of the original Audit. Provider or Facility may be responsible for cancellation fees incurred by Anthem or its designee due to Provider's or Facility's rescheduling. While Anthem or its designee prefers to work with the Provider or Facility in finding a mutually convenient time, there may be instances when Anthem or its designee must respond quickly to requests by regulators or its clients. In those circumstances, Anthem or its designee will send a notice to the Provider or Facility to schedule an Audit within the seventy-two (72) hour timeframe.

Under-billed and Late-billed Claims: During an on-site audit, Provider or Facility may identify Claims for which Provider or Facility under-billed or failed to bill for review by Anthem during the Audit. Under-billed or late-billed Claims not identified by Provider or Facility before the Audit commences will not be evaluated in the Audit.

Claims Audit Appeal Policy

Purpose

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

Procedure

- Unless otherwise expressly set forth in an Agreement, Provider or Facility shall have the right to Appeal the findings in the Notice of Overpayment. An Appeal of the Notice of Overpayment must be in writing and received by Anthem or its designee within forty-five (45) calendar days of the date of the Notice of Overpayment unless applicable law expressly indicates otherwise. The Appeal should address the findings from the Notice of Overpayment that Provider or Facility disputes, as well as the basis for the Provider's or Facility's belief that such finding(s) are not accurate. All findings disputed by the Provider or Facility in the Appeal must be accompanied by relevant Supporting Documentation. If the Provider or Facility does not timely appeal, retraction will begin at the expiration of the forty-five (45) calendar days unless expressly prohibited by contractual obligations or applicable law.

- Upon receipt of a timely Appeal, complete with Supporting Documentation as required under this Policy, Anthem or its designee shall issue an Appeal Response to the Provider or Facility. Anthem's or its designee's response shall address each matter contained in the Provider's or Facility's Appeal. If appropriate, Anthem's or its designee's Appeal Response will indicate what adjustments, if any, shall be made to the overpayment amounts outlined in the Notice of Overpayment. Anthem's or its designee's response shall be sent via email, mail or portal to the Provider or Facility within forty-five (45) calendar days of the date Anthem or its designee received the Provider's or Facility's Appeal and Supporting Documentation.

- The Provider or Facility shall have thirty (30) 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 thirty (30) calendar day timeframe, Anthem or its designee shall begin recoupment of the amount contained in Anthem's or its designee's response, and a confirming recoupment notification will be sent to the Provider or Facility.

- Upon receipt of a timely Provider or Facility appeal response, complete with Supporting Documentation as required under this Policy, Anthem or its designee shall formulate a final Appeal Response. Anthem's or its designee's final Appeal Response shall address each matter contained in the Provider's or Facility's response. Anthem's or its designee's final Appeal Response shall be sent via email, mail or portal to the Provider or Facility within fifteen (15) calendar days of the date Anthem or its designee received the Provider or Facility response and Supporting Documentation.

- If applicable in the state, the Provider or Facility shall have thirty (30) 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 thirty (30) calendar day timeframe, Anthem or its designee shall recoup the amount contained in Anthem's or its designee's final Appeal Response.

Chargemaster Audit Process

1. Process

Anthem conducts retrospective audits and interim reviews to confirm that the impact of Chargemaster pricing changes for Covered Services complies with the Facility's Agreement (Chargemaster Audit). Anthem has the right to audit and request documentation from the Facility for the purposes of a Chargemaster audit. This Chargemaster Audit Process documents Anthem's guidelines and process for such Chargemaster Audits, including data requests, the Facility's obligation to comply with such requests, and the audit process.

A Chargemaster Audit is a retrospective review to determine whether the impact on Anthem of the Chargemaster pricing changes for the Facility Fiscal Year exceeded the Maximum Allowed Percentage Impact (MAPI) based on actual Anthem commercial utilization for services reimbursed at a Percentage Rate for the Facility's Fiscal Year.

To initiate a Chargemaster Audit, Anthem shall provide the Facility with notice of intent to audit, which shall include a data request for specified periods. The Facility shall provide requested data within thirty (30) days of request in an electronic format acceptable to Anthem, which includes:

i) The Facility's full Chargemaster that is in effect as of the date(s) included in Anthem's request and its effective date (the "Audit Year") with the data fields set forth below,

ii) The Facility's Chargemaster that was in effect immediately prior to and its effective date (the "Base Year") with the data fields set forth below, and

iii) Claim utilization data for Anthem Commercial Covered Individuals for Claims reimbursed or partially reimbursed using a Percentage Rate for the Audit Year and the Base Year with the data fields below.

For the purposes of the Chargemaster Audit, Claims for Covered Services reimbursed at the lesser of the Anthem Rate or the percentage of Eligible Charges set forth on the Rate Sheet when the Percentage Rate reimbursement applies shall be considered as claims reimbursed using a Percentage Rate.

Charges added or deleted from the prior Chargemaster shall also be included where a crosswalk can be identified for codes replaced or added/deleted.

Chargemaster submissions under subparts (i) and (ii) listed above shall include, but are not limited to, the following fields:

- Facility Identifier
- Chargemaster line item identification code (Chargemaster Charge Code)
- Charge code description
- Charge (price)
- Applicable codes (e.g., CPT/HCPC, Revenue Code, NDC)
- Charge effective date

Utilization submissions under subpart (iii) listed above shall include, but are not limited to, the following fields:

- Facility Identifier
- Patient account number

- Date of service
- Charge code description
- Billed Charges
- Billed units

2. Definitions

The definitions below apply to this Chargemaster Audit Process section only. All capitalized terms used in this Process shall have the meaning as set forth in the Facility Agreement between Anthem and Facility, unless otherwise defined below for this section.

a) **Baseline Period** is the twelve (12) months prior to the Audit Year.

b) **Actual Charges** is the total dollar amount charged for the Audit Year for Claims for Anthem commercial Covered Individuals reimbursed at the Percentage Rate extracted from Anthem's claim system.

c) **The Chargemaster Charge Code** detail will be utilized for analysis if submitted by the Facility. In the absence of that submission, the average per unit charge by CPT/HCPCS for Outpatient Services and by room and bed revenue code for Inpatient Services will be used as a proxy for the analysis.

d) **Repriced Charges** are calculated by taking the average unit price for all Charge codes from the Base Year, across all methods of payment, and multiplying it by the Audit Year utilization. This would have been the total charge amount if no Chargemaster pricing change was implemented.

e) **Adjusted Charges** are the Repriced Charges increased by the greater of the MAPI or what was provided in the Facility notice of Chargemaster pricing Impact.

f) **Charge Variance** is the difference in dollars between the Actual Charges for the Audit Year and the Adjusted Charges.

g) **Actual Chargemaster Impact Percentage** is calculated as the difference between the Repriced Charges and the Actual Charges.

h) **Percentage Variance** is the percentage difference between the Actual Charges and the Adjusted Charges.

i) **The Overpayment Amount** is the Charge Variance multiplied by the Average Percentage Rate.

j) **The Maximum Allowed Percentage Impact (MAPI)** for purposes of this Chargemaster Audit section includes but is not limited to other similar descriptions that may exist in a Facility Agreement such as Average compounded percentage increase (ACPI), Average Maximum Percentage Increase (AMPI), Average Annual Aggregate Percentage Increase (AAAPI), Chargemaster Impact Percentage (CIP) and Chargemaster Threshold (CMT)

3. Chargemaster Audit

Upon receipt of the requested data from the Facility, Anthem shall make its best efforts to complete its analysis of the impact to Anthem of the changes made to the Facility's Chargemaster in excess of MAPI in accordance with the following calculations and example within thirty (30) days of receipt of the applicable data. Results of such audit shall be provided to the Facility for review.

Formula:

Overpayment Amount = (Actual Charges – (Repriced Charges * (1 + Greater of MAPI or Facility Notice of Chargemaster Impact))) * Percentage of Charge

Example:

- Actual Charges = $100
- Repriced Charges = $90 (Audit Year utilization x average per unit Charge by CPT code for Baseline Period)
- MAPI = 2%
- Facility Notice of Chargemaster pricing impact = 3%
- Average Percentage of Charge = 50%

Overpayment Amount = ($100 - ($90 * (1 + 3%))) * 50% = $3.65

Standard rounding procedures shall be used calculating to the nearest whole dollar or two decimal places for percentages.

If Anthem determines through the Chargemaster Audit that the impact to Anthem of Facility's Chargemaster pricing changes exceeded the MAPI, then Anthem overpaid Facility for claims for Covered Individuals reimbursed on a percent of charge basis, and Anthem shall be entitled to:

i) Full reimbursement of such overpayments within thirty (30) days unless otherwise agreed to by the parties in writing, and
ii) Rate adjustment to neutralize the impact of Chargemaster pricing changes in excess of the MAPI.

4. Chargemaster Audit Dispute

The Facility shall have thirty (30) days to dispute the Chargemaster Audit results. The Facility shall initiate such dispute in writing and provide the basis for the dispute and any supporting documentation to Anthem. If the Facility does not dispute the results within the thirty (30) day period, then the Facility shall be deemed to have accepted the results.

Anthem shall review the Facility's dispute and the additional data and information and provide a response to the Facility in writing. Any dispute to the adjusted Anthem Rates that is not accompanied by data to substantiate such dispute shall not be considered.

If the additional data or feedback from the Facility results in a revision of the Chargemaster Audit results, Anthem shall provide the Facility with revised audit results, and the Facility shall have thirty (30) days to dispute the revised results following the same process set forth above.

5. Chargemaster Overage Remedies

The following conditions outlined in subsections (i) - (iv) below allow Anthem to address Chargemaster overages to prospectively adjust the Anthem Rates to offset any excess above MAPI reported in written notices from Facilities or identified through Chargemaster Audits without requiring an amendment to the Agreement. Anthem shall also provide the Facility with thirty (30) days' notice of related payments Anthem made due to the Chargemaster overage in excess of the MAPI from the date the Chargemaster pricing change went into effect until the date that the adjusted Anthem Rates would into effect. The Facility has thirty (30) days to reimburse Anthem for such Chargemaster overage unless otherwise agreed to by the parties in writing. These

adjustments ensure reimbursement for Covered Services would not exceed what would have been reimbursed if the Facility had not increased its Chargemaster to yield an increase greater than MAPI. Additionally, any applicable thresholds tied to charge-based calculations shall be increased by the same percentage as the Inpatient Charges and Outpatient Charges.

i) Upon notice by the Facility that a previous or upcoming Chargemaster pricing change exceeded MAPI and was unaccounted for in any rate adjustment.

ii) If Facility fails or refuses to provide Anthem with requested data for an audit in the required format within thirty (30) days of the request, unless an exception was requested from and approved by Anthem. If the Facility subsequently provides the requested data within sixty (60) days of the implementation date of the adjusted Anthem Rates, then Anthem shall proceed in accordance with the process and procedure in section 3 above. Claims already processed at the adjusted Anthem Rates shall not be reprocessed. Data submissions more than sixty (60) days after the implementation date of the rate adjustment shall not be considered.

iii) If a completed audit indicates MAPI has been exceeded.

iv) If an audit indicates MAPI has been exceeded, and the Facility's dispute of such audit is untimely, incomplete, or resolved.

Please note that for the purposes of Chargemaster violations, any contractual or statutory claims adjustment period shall be inapplicable to Anthem's right to reimbursement for overpayments due to a Chargemaster overage, unless prohibited by Regulatory Requirements.

Fraud, Waste and Abuse Detection

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

- **Fraud**: Any type of intentional deception or misrepresentation made with the knowledge that the deception could result in some unauthorized benefit to the person—or any other person—committing it. This includes any act that constitutes fraud under applicable Federal or State law.
- **Waste:** Includes overusing services, or other practices that, directly or indirectly, result in excessive costs. Waste is generally not considered to be driven by intentional actions, but rather occurs when resources are misused.
- **Abuse:** Behaviors that are inconsistent with sound financial, business and medical practices and result in unnecessary costs and payments for services that are not medically necessary or fail to meet professionally recognized standards for health care. This includes any member actions that result in unnecessary costs.

One of the most important steps to help prevent Member fraud is as simple as reviewing the Member identification card to ensure that the individual seeking services is the same as the Member listed on the card. It is the first line of defense against possible fraud. Learn more at **fighthealthcarefraud.com**.

Reporting Fraud, Waste, and Abuse

If someone suspects any Member (a person who receives benefits) or Provider has committed fraud, waste or abuse, they have the right to report it. No individual who reports violations or suspected fraud and abuse will be retaliated against for doing so. The name of the person reporting the incident and his or her call back number will be kept in strict confidence by investigators.

Report concerns:

- Visit anthem.com, scroll to the bottom footer, and click on "Health Care Fraud Prevention" to be directed to the **Fight Health Care Fraud** education site; at the top of the page, click "Report it" and complete the "**Report Waste, Fraud and Abuse**" form
- Participating providers can call Provider Solutions
- Non-participating providers can call customer service

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

Examples of **Member** Fraud, Waste, and Abuse

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

- Relocating to an out-of-service Plan area and not letting the Plan know
- Using someone else's Member ID card

When reporting concerns involving a **Member,** include:

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

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

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

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

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

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

Investigation Process

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

- Written warning and/or education: Anthem sends letters to the Provider or Facility advising the Provider or Facility of the issues and the need for improvement. Letters may include education or may advise of further action.
- Medical record review: Anthem reviews medical records to investigate allegations or validate the appropriateness of Claims submissions. Failure to submit medical records when requested may result in an overpayment determination and/or placement on prepayment review.
- Prepayment Review: Specific to a Provider or Facility under investigation, a certified professional coder in the SIU evaluates Claims prior to payment. Edits in Anthem's Claims processing systems identify these Claims for review to prevent automatic Claims payments in specific situations.
- Recoveries: Anthem recovers 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, and/or legal action.

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

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

If a Provider or Facility is working with the SIU and sending paper medical records and/or Claims based on an SIU request, that address is supplied in correspondence from the SIU. If you have questions, contact your investigator.

An opportunity to submit Claims and medical records **electronically** is an option if you register for an Availity account. For more information see the Availity Essentials section of the manual or contact Availity Client Services at 800-AVAILITY (282-4548) for assistance.

Anthem does not accept postdated checks. Any fees incurred for a check returned due to insufficient funds is the responsibility of the Provider or Facility.

SIU 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 their/its peers.

Once a Claim, or a Provider or Facility, is identified as an outlier or has otherwise come to Anthem's attention for reasons mentioned above, further review may be conducted by the SIU to determine the reason(s) for the outlier status or any appropriate explanation for unusual coding, documentation, and/or billing practices. If the review results in a determination that the Provider's or Facility's actions may involve FWA, unless exigent circumstances exist, the Provider or Facility is notified of their placement on prepayment review and given an opportunity to respond.

When a Provider or Facility is on prepayment review, the Provider or Facility will be required to submit medical records and any other supporting documentation with each Claim 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. During the pendency of the prepayment review, if requested, The Provider or Facility will be given the opportunity to discussion of their prepayment review status.

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

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

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

Acting on Investigative Findings

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

Recoupment/Offset/Adjustment for Overpayments

Anthem is entitled to recover any overpayments or incorrect payments made to a Provider or Facility (Overpayment Amount) by offsetting these amounts against any payments due to the Provider or Facility under any Health Benefit Plan agreement. When Anthem identifies an overpayment, the Provider or Facility is required to refund the amount within thirty (30) calendar days of receiving notification. If the refund is not provided within this period, Anthem may offset future payments to recoup the overpaid amount. Providers and Facilities are obliged to return overpayments for any reason, including errors in billing, regardless of whether they were intentional.

Should a Provider or Facility contest the determination of an overpayment, they have the right to appeal this decision through Anthem’s established procedures. However, this appeal does not suspend Anthem’s ability to recover the overpayment unless mandated by regulatory requirements. In cases of non-payment, Anthem reserves the right to enlist a third-party collection agency.

Pharmacy & Prescriber 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 or Facilities. To address the growing opioid epidemic, Anthem's Pharmacy & Prescriber Home Program allows for better administration of drug benefits through increased communication and coordination amongst prescribing physicians and pharmacies. The information in this section applies to Anthem Members with Anthem's prescription drug coverage.

One of the primary goals of the Pharmacy & Prescriber Home Program is to help reduce overutilization of controlled substance medications for non-medically necessary situations. If a Member is believed to be at an increased safety risk due to the overutilization of controlled medications and they meet enrollment criteria, they may be included in this program. Anthem reduces this risk by assigning Members to a single pharmacy and/or prescriber Provider and monitoring their behavior through their enrollment. The pharmacy and/or prescriber Provider is selected by the Member or is assigned based on the retrospective Drug Utilization Review (DUR) of their prescription Claims history if no selection is made during the allotted enrollment period. Following the selection of the Member's new Pharmacy and/or Prescriber Home, all of the Member's prescribing physicians will receive notification of the Member's enrollment into the program, the assigned pharmacy/prescriber information and a three (3) month prescription profile containing a list of controlled substance 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 or prescriber for all prescribed Schedule II-V controlled medications for a period of no less than twelve (12) consecutive months. This assigned Provider, or Pharmacy/Prescriber Home, will write and/or fill the Member's controlled substance medications throughout the term of their enrollment in this program.

The Pharmacy & Prescriber Home Program includes:

- Reimbursement of Controlled Substance Claims when written by the designated prescriber and/or filled at the Member's Pharmacy Home. All controlled substance Claims are denied if written by any prescriber or filled at any pharmacy other than the Member's assigned Pharmacy or Prescriber Home.
- Temporary overrides for urgent or emergent situations only.[1]
- 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 & Prescriber Home Program if:[2]

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

Communications to Members

Members who meet criteria are sent a notification at least sixty (60) days prior to potential inclusion in the program. After the sixty (60)-day monitoring period, if the Member continues to meet the enrollment criteria during that timeframe, he/she is contacted in writing of the decision to place him/her into the Pharmacy & Prescriber Home Program. The Member will then be given thirty (30) additional days to select a Pharmacy and/or Prescriber Home and/or to file an appeal of the decision. In the event the Member does not select a Pharmacy or Prescriber Home within the allotted timeframe, one (1) will be chosen for the Member on the 31st day based on recency and frequency of use within their Claims history. Anthem will ensure both the Member and their Provider will be notified of their new Pharmacy and/or Prescriber Home in writing. Once they have chosen a Pharmacy and/or Prescriber Home, a request to change pharmacies will be considered for good cause situations only.

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

[1] Changes to the designated pharmacy and/or prescriber will only be approved if the request meets good cause criteria

[2] Members with a diagnosis of cancer, second degree burns, third degree burns, sickle-cell anemia or those that are in hospice care may be exempt from enrollment in the program. **Note:** Exemptions are determined by both the member's pharmacy and medical claims history.

Product Summary

Important Reminder: Providers and Facilities are able to confirm their Network participation status by using the Find Care tool. For information refer to the* Online Provider Directory & Demographic Data Integrity *section located in this Manual.

ACA-compliant health plans

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 Exchange in many states, as well as health plans not purchased on public exchanges. Qualified health plans on the Individual Exchange follow the same policies and protocols within this Provider Manual, unless otherwise stated in the Provider or Facility Agreement.

Updates about Anthem's ACA-compliant health plans and the networks supporting these plans are published in Anthem's Provider newsletter and sent via Anthem's email service. To access the newsletter, go to our ***Provider News* website**. The option to sign up for all email communications is also on this webpage.

BlueChoice PPO

BlueChoice PPO is the name of Anthem's PPO product. BlueChoice PPO provides in-Network benefits and out-of-Network benefits; the Member has the option to choose either a preferred Provider or Facility and have benefits paid at the higher in-Network benefit rate, or a non-preferred Provider and have benefits paid at the lower out-of-Network benefit rate.

BlueChoice HMO

BlueChoice Healthcare Plan is the name of the HMO product. This plan is built on the PCP model, emphasizing the PCP as the coordinator of a Member's health care. Physicians in the following specialties are eligible PCPs:

- Family Practice
- General Practice
- Internal Medicine
- Pediatrics

BlueChoice HMO plan is designed to keep Members healthy. When illness occurs, the plan provides for quality care in the most appropriate setting at an affordable cost to employers and Members. Members have the freedom to select their PCP from a panel of Providers. The PCP provides and arranges all necessary medical services, including preventive care and treatment for illnesses and injuries. The PCP also coordinates referral specialist services and hospitalizations among Providers

Blue Open Access POS

Blue Open Access Members are not required to select a PCP and are able to access specialty care without a referral from a PCP. Members will be encouraged to establish or maintain a relationship with a PCP, since that physician would be most knowledgeable of the Member's medical history.

Blue Open Access Members will have a specifically branded Member ID card designating them as an Open Access participant. The card will include copayment amounts along with the standard benefit information included on all Member ID cards.

Network	Line of Business	Type	Geographic Area	Out of Network Benefit	Out of State Benefit	Suitcase	Gatekeeper
Blue Open Access	Employer Group	HMO	Statewide	No*	No*+	Empty Suitcase+	No
		POS	Statewide	Yes	OOA Coverage available and not limited to Emergency and Urgent Care when using these networks. OON benefits available in state using the Blue Open Access POS Network OOA in network level of benefits using the standard BlueCard PPO network	Suitcase with PPO Inside	No
Blue Choice	Employer Group	HMO	Statewide	No*	No*	Empty Suitcase	Yes
		POS	Statewide	Yes	BlueCard PPO	Suitcase with PPO Inside	Yes
		PPO	Statewide	Yes	BlueCard PPO	Suitcase with PPO Inside	No
Blue Connection	Employer Group	EPO	Atlanta, Columbus, Augusta, Savannah	No*	No*	Suitcase with HPN Inside	No
Pathway	Marketplace (Exchange)	Pathway HMO	141 counties	No	No*	Empty Suitcase	No
	Marketplace (Exchange)	Pathway Guided Access HMO	Remaining 18 counties	No*	No*	Empty Suitcase	Yes
	Off exchange	Anthem AEC EPO	Statewide	No*	No*	Empty Suitcase	No
Blue Value	Marketplace (exchange)	HMO	Savannah, Macon, Valdosta, Atlanta, Columbus	No*	No*	Empty Suitcase	Yes

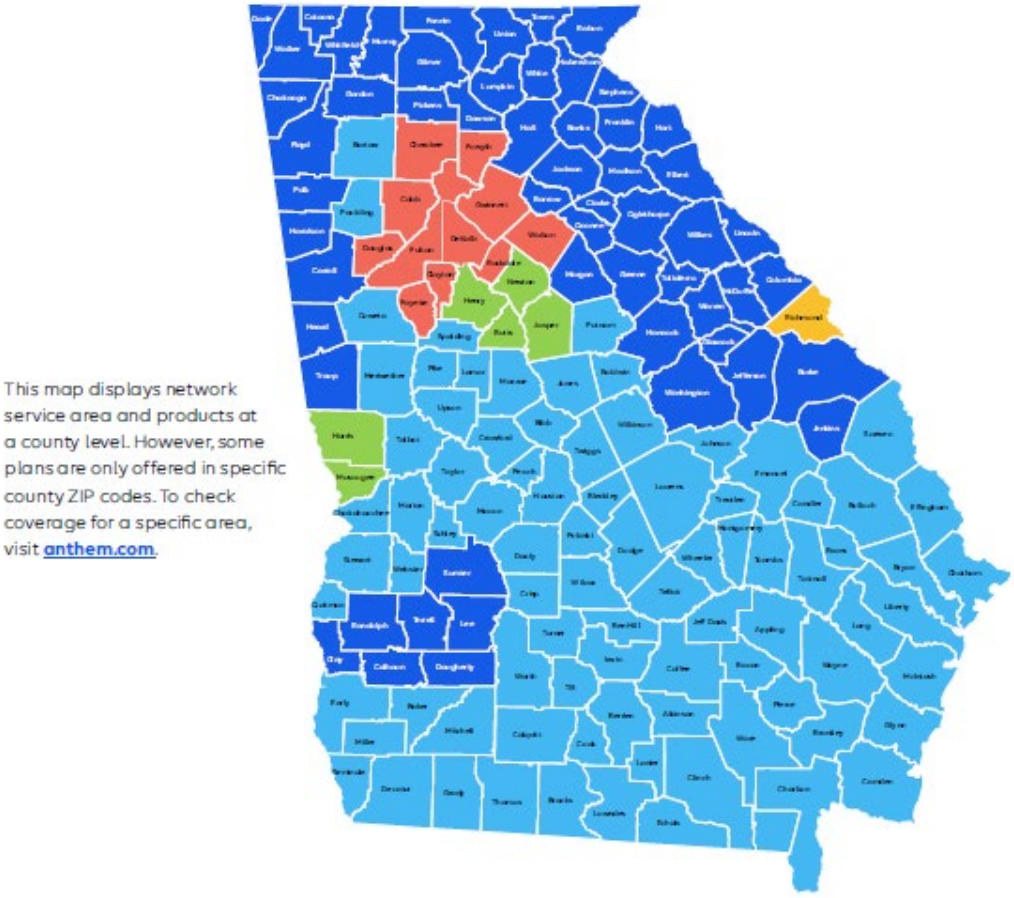
*Coverage for emergency and urgent care only

+ Except SHBP

Georgia

State-wide network service area

Effective January 1, 2025



Network	Pathway HMO	Blue Value Individual Network HMO
Open Access Products	Pathway HMO Open Access	
Gatekeeper Products	Pathway HMO Guided Access Pathway PCP Copay Choice	Blue Value HMO
Base contract	Anthem	AGMP Managed Care Co.

Federal Employees Health Benefits Program (FEHBP) and Postal Service Health Benefits Program (PSHBP)

FEHBP and PSHBP Requirements

Providers and Facilities acknowledge and understand that Anthem participates in the Federal Employees Health Benefits Program (FEHBP) and the Postal Health Benefits Program (PSHBP). The Anthem FEHBP and PSHBP 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 and PSHBP are federal government programs, and the program's requirements are subject to change at the sole direction and discretion of the United States Office of Personnel Management.

Providers and Facilities agree to abide by the rules, regulations, and/or other requirements of the FEHBP and PSHBP as they exist and as they may be amended or changed from time to time, with or without prior notice. Providers and Facilities further agree that, in the event of a conflict between the Provider or Facility agreement or this Provider Manual and the rules, regulations, and/or other requirements of the FEHBP and PSHBP, the terms of the rules, regulations, and other requirements of the FEHBP and PSHBP 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 and PSHBP are exempt from implementing the requirements of state legislation.

Submission of Claims under the FEHBP and PSHBP

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

Providers and Facilities agree to provide to Plan, at no cost to Anthem or Member, all information necessary for Plan to determine its liability, including, without limitation, accurate and complete Claims for Covered Services, utilizing forms consistent with industry standards and approved by Plan or, if available, electronically through a medium approved by Plan.

If the Plan is the secondary payer, the timeframe will not begin to run until the Provider or Facility receives notification of the primary payer's responsibility. The 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.

Omnibus Budget Reconciliation Act of 1993 (OBRA '93)

As a result of the Omnibus Budget Reconciliation Act of 1993 (OBRA '93) legislation, all FEHBP and PSHBP fee-for-service carriers are required to price certain Claims per the Medicare Part B equivalent amount. This legislative change became effective on January 1, 1995. OBRA '93 applies the Medicare Part B equivalent amount to Claims for physicians' services to retirees and annuitants enrolled in the FEHBP and PSHBP who are 65 years of age and older and who do not participate in Medicare Part B. The Office of Personnel Management (OPM) has defined the individuals to whom

the law applies as those who are enrolled in an FEHBP and PSHBP Program and are annuitants or former spouses. In addition, the law also applies to family Members covered by a family enrollment of an annuitant or former spouse.

The covered Member must:

- Not be employed in a position that confers FEHBP and PSHBP coverage
- Be age 65 or older
- Not be covered by Medicare Part B

Erroneous or Duplicate Claim Payments under the FEHBP and PSHBP

For erroneous or duplicate Claim payments under the FEHBP and PSHBP, 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, the Plan may offset future Claim payments.

Coordination of Benefits for FEHBP and PSHBP

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

FEHBP and PSHBP 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 and PSHBP Member Reconsiderations and Appeals

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

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

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

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

When a Claim or request for Health Services, drugs, or supplies – including a request for precertification or prior approval – is denied, whether in full or partially, the local Plan that denied the Claim reviews the benefit determination upon receiving a written request for review. This request must

come from the Member, contract holder, or their authorized representative. The request for review must be received within six (6) months of the date of the Plan's final decision. If the request for review is on a specific Claim(s), the Member must be financially liable in order to be eligible for the disputed Claims process.

The local Plan must respond to the request in writing, affirming the benefits denial, paying the Claim, or requesting the additional information necessary to make a benefit determination, within thirty (30) calendar days of receiving the request for review. If not previously requested, the local Plan is required to obtain all necessary medical information, such as operative reports, medical records, and nurses' notes, related to the Claim. If the additional information is not received within sixty (60) calendar days, the Plan will make its decision based on the information available. Appropriate medical review will also be done at this time. If the Plan does not completely satisfy the Member's request, the Plan will advise the Member of their right to appeal to OPM.

Providers or Facilities may not submit appeals to the OPM without authorization from the Member. Only the Member or contract holder may do so, as outlined in the Blue Cross and Blue Shield Service Benefit Plan brochure.

FEHBP and PSHBP 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 their local Plan to have the local Plan re-evaluate its contractual benefit determination of their post-service Claim or to reconsider an adverse benefit determination of a pre-service request. The request must be from a Provider or Facility and must be submitted in writing within one hundred eighty (180) days of the denial or benefit limitation. In most cases, this will be the date appearing on the Explanation of Benefits/Remittance sent by the Plan. For pre-service request denials, the date will be the date appearing on the Plan's notification letter.

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

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
5. Prior approval (for a service requiring prior approval under FEHBP and PSHBP).

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

When a Claim or request for services, drugs, or supplies – including a request for precertification or prior approval – is denied, whether in full or partially, the local Plan that denied the Claim reviews the benefit determination upon receiving a written request for review. This request must come from the rendering/requesting Provider or Facility. The request for review must be received within six (6) months of the date of the local Plan's final decision. If the request for review is on a specific Claim(s),

the Provider or Facility must be financially liable in order to be eligible for the formal Provider and Facility appeal process.

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

FEHBP and PSHBP Inpatient Skilled Nursing Facility Care

Please see the Blue Cross® and Blue Shield® Service Benefit Plan brochure at **fepblue.org** for the skilled nursing benefit.

Online information for FEHBP and PSHBP

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

BlueCard Program Overview

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

Contiguous Counties

Providers located in contiguous service areas have the ability to contract with more than one Blue Plan. Submission of Claims in a contiguous service area is dependent on which Plan(s) the provider contracts within that service area, the type of contract the provider has (ex. PPO, Traditional), and the type of contract the Member has with their BCBS Plan.

BlueCross Blue Shield of Tennessee Only:

In Georgia, Catoosa, Dade, and Walker counties are considered an overlapping service area with another Blue Plan, BlueCross BlueShield of Tennessee.

- For Anthem Members, Claims must be filed with Anthem.
- For BlueCross BlueShield of Tennessee members in Catoosa, Dade, and Walker counties, claims must be filed with BlueCross BlueShield of Tennessee. For Anthem Members in Catoosa, Dade, and Walker counties, claims must be filed with Anthem.
- For BlueCross BlueShield of Tennessee members outside of Catoosa, Dade, and Walker counties, claims must be filed with Anthem (i.e., BlueCard).
- For non-Anthem and non-BlueCross BlueShield of Tennessee, claims must be filed with the local BCBS Plan.

For more information about the BlueCard Program, Providers and Facilities can access the BlueCard Provider Manual online. Go to the **Anthem Provider Home page**, then under the **Resources** menu, select **Policies, Guidelines, and Manuals, scroll down to the Provider Manual section,** and select **Download the Manual**. Scroll to the **Provider Manual Library** section and choose the **BlueCard Provider Manual**.

Medicare Advantage

Refer to the Medicare Advantage website online for additional information at **anthem.com/ga/provider/individual-commercial/medicare-advantage.**

The Medicare Advantage Provider Manual is available on the Anthem website. Go to the **Anthem Provider Home page**, then under the **Resources** menu, select **Policies, Guidelines and Manuals**, scroll down to the **Provider Manual** section and select **Download the Manual**. Scroll to the **Provider Manual Library** section and choose **Medicare Advantage Provider Manual**.

Medicare Advantage Provider Guidebook

State Health Benefit Plan

Anthem is excited to continue servicing the Georgia State Health Benefit Plan (SHBP).

State Health Network = SHBP

The State Health Network = SHBP for HRA Plans and HMO plan (active Members/early retirees):

- In Georgia = Open Access POS Network
- Outside of Georgia = BlueCard® National PPO Network (for traveling benefits)

Anthem - State Health Benefit Plan (SHBP)

Communications

Anthem's monthly provider newsletter, ***Provider News***, has a State Health Benefit Plan category to view SHBP communications. Anthem will also email late breaking important information. Providers and Facilities not yet registered to receive email communications should do so by visiting the **Provider News** website and selecting the **Subscribe to Email** button, or contacting a Provider Representative for help.

Precertification

SHBP has a custom precertification list for SHBP members available on the **Prior Authorization** page on **anthem.com.** Providers must obtain precertification for the services listed in order to receive reimbursement. Future notifications of changes to the posted precertification list will be done through *Provider News* and posted to the Prior Authorization page on **anthem.com**.

Carelon Medical Benefits Management (Carelon MBM) programs include management of high-tech imaging, echocardiography, specialty pharmacy, radiation therapy and sleep studies, and sleep therapy/treatment. All of these services require precertification. In addition, for Providers of high-tech imaging services, sleep testing, and sleep therapy/treatment, Carelon Medical Benefits Management (Carelon MBM) requires the completion of an OptiNet online site assessment. The following Carelon MBM programs apply to SHBP:

- Diagnostic Imaging Program
- Musculoskeletal Program
- Imaging Cost and Quality Program
- Outpatient Radiation Therapy Program
- Sleep Management Program
- Carelon Medical Benefits Management Enhanced Cardiology Program

More information on the Carelon Medical Benefits Management programs can be accessed on the **Prior Authorization** page on **anthem.com**, by visiting the **Carelon Medical Benefits Management** website, or calling 800-252-2021.

Specialty Pharmacy

SHBP has contracted directly with CVS Caremark as its pharmacy vendor; however, some of the pharmaceuticals may be covered under the Member's medical benefit.

Gatekeeper HMO Specific Guidelines

Role of the Primary Care Physician

The primary care physician (PCP) is responsible for providing care within the scope of his or her practice and managing all other aspects of the Member's medical care. This includes submitting Member referrals to specialists and obtaining pre-authorizations for hospital admissions and other services that require pre-authorizations.

For members of gatekeeper plans, the PCP will submit referrals for specialty care and inpatient admissions, either directly or in collaboration with a specialist.

Specifically, the PCP will:

- Serve as the Member's personal physician, providing services and treatment without discrimination
- Provide all primary care services in a manner consistent with customary and recognized standards
- Coordinate and manage all other medical services
- Submit referrals to in-network specialists through Availity
- Obtain pre-authorizations for inpatient admissions
- Obtain pre-authorizations for outpatient procedures
- Refer and admit only within the member's Anthem network
- Comply with required Anthem procedures
- Accept Anthem reimbursement and not balance bill members for covered services
- Provide 24-hour, 7-day a week access to medical care for Members

PCPs should follow these procedures for office services:

- Verify Member eligibility and PCP assignment (via **Availity.com**)
- Provide care
- Collect copayment
- File CMS 1500 Claim form

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

Member Selection of a PCP

When a Member enrolls in an Anthem Plan through their employer group, he or she will select a PCP from the Anthem Provider Network. Members enrolling through healthcare.gov will be auto-assigned a PCP. Members can change their PCP at any time. For PCP changes in real time, members can call Members Services or chat with a live agent on the Sydney App. Members can change their PCP on anthem.com or the Sydney App and will update within 24 hours. Once selected, a new ID card is generated and mailed. Members have access to their online cards through the Sydney App.

PCP Scope of Services

Anthem wants to ensure that Members receive continuous, appropriate health care in accordance with the physician's network participation Agreement. Anthem also want to ensure that each PCP has the generally acceptable skills necessary to care for common primary care medical conditions.

Accordingly, Anthem requires network physicians to meet and comply with the following criteria in their scope of practice.

- The PCP will coordinate all aspects of Members' care, including generating referrals to network specialists and plan notification for HMO Members.
- The PCP will coordinate, monitor and ensure the continuity of a Member's care after a referral is approved.
- The PCP will seek prior authorization for non-participating Provider referrals, except in an emergency. This includes out-of-network specialists, ancillary and Facility Providers.
- The PCP will use designated laboratory, radiology, specialist physicians, ancillary and Facility Provider networks as outlined in this manual or designated local region communications.
- The PCP will comply with the Anthem quality assurance and utilization management initiatives and related policies and procedures.

These include:

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

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

This care will include, but not be limited to:

- Newborn care, including hospital-based
- Infant care
- Children's care

- Adolescent care
- Adult care
- Elderly care
- Periodic health assessment and physical exams in accordance with the established Preventive Health Guidelines, including interventions, immunizations and screenings
- Patient education and counseling
- Health promotion counseling, including injury prevention
- Well-woman exams
- Family planning
- Nutrition counseling
- Drug and tobacco counseling
- Cancer screening
- Screening for heart disease
- Emergency and urgent care triage
- Ambulatory, hospital and home care
- Note: A PCP may coordinate inpatient hospital care through an in-network hospitalist.
- Nursing home and hospice care
- Treatment for acute illness, including:
- Musculoskeletal (fibromyalgia, tendonitis, etc.)
- ENT (sinusitis, otitis media, etc.)
- Ophthalmic (corneal abrasion, conjunctivitis, etc.)
- Dermatologic (scabies, pediculosis, etc.)
- Infectious (cellulitis, pneumonia, etc.)
- Gynecological (vaginitis, etc.)
- Urologic (urinary tract infection, etc.)
- Gastrointestinal
- Cardiovascular
- Neurological
- Pulmonary
- Treatment for chronic illnesses, including:
- Cardiovascular (angina, hypertension, stroke, etc.)
- Endocrine (diabetes, thyroid disease, etc.)
- Musculoskeletal (rheumatoid arthritis, osteoarthritis, etc.)

- Pulmonary (asthma, bronchitis, emphysema, etc.)
- Skin (acne, dermatitis, etc.)
- Gastrointestinal (ulcer, irritable bowel, etc.)
- Genitourinary (urinary incontinence, etc.)
- Identifying and recommending treatment for depression, anxiety disorders, stress, grief reaction
- Identifying and recommending treatment for substance abuse
- Comprehensive assessment
- Evaluation of occupational and school health-related illnesses
- Death and dying counseling
- knowledge about interdisciplinary resources and Community and public health resources
- Managed care practice management, including cost-effective care and appropriate use of consultants
- Risk management

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

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

Terminating a Physician-Patient Relationship

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

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

- Provide written notice via Certified Mail to the Member explaining the intention to discharge the Member from his or her patient list.
- Advise the Member to select another PCP. The Member may log on to **anthem.com** or contact Anthem's customer service department to select another PCP.

- Send a copy of the notice to Anthem Provider representative.
- For thirty (30) calendar days, the PCP is required to provide health care services to the Member until the Member has selected another PCP.

Access Standards

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

Office hours

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

Appointment availability

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

After hours coverage

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

Office wait time

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

Telephone access

- Incoming phone calls to the Provider's office must be answered within ten (10) rings

- Office staff should ask permission to place callers on hold before doing so. If a caller is placed on hold, the call will be acknowledged every two minutes.
- The physician must provide coverage twenty-four (24) hours, seven (7) days-a-week for appropriate triage.

Role of the Specialty Care Physician

Anthem PCPs refer Members of Anthem to specialists who participate in the Anthem Network*. Except in emergency situations, Members' specialty care must be coordinated through their PCP. PCPs are required to refer Members only to HMO participating specialists. These specialists work with the Member's PCP and recognize the PCP's role as manager of all the Member's medical care.

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

Responsibilities of the Specialist

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

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

Specialist Physician Guide

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

Verify Member eligibility

- Check the Member's ID card
- Verify eligibility online at **Availity.com** or
- Call Anthem for confirmation of coverage and benefits

Ensure proper referral

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

Direct Access Specialists

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

Behavioral health Providers are strongly encouraged to provide PCPs with updates regarding treatment progress and medication usage.

Specialist to Specialist Referral

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

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

All other referrals must be submitted by the PCP.

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

Self-Referrals by Members

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

- Preventive Care is covered only if performed by the Member's PCP (except mammogram, Pap smear, prostate antigen test, and child wellness from birth through age 5).
- Behavioral Health Services (Mental Health and Substance Abuse) are not covered if rendered by an out-of-network Provider.
- Non-emergency use of the emergency room is not covered.

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

OB/GYN Specific Information

Well Woman Exams

Anthem Plans provide coverage for one routine gynecological examination per contract year for all women Members pending group benefit specifics.

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

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

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

Anthem Gatekeeper Plan benefits cover only the services listed below, depending on group-specific benefit levels, when part of the well woman examination:

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

Mammogram

Initial screening between 35-40 years of age and then every one (1) to two (2) years between ages 40-50. Women over age 50 should have an annual mammogram. Mammograms may be done in a physician's office if the office is ACR-accredited. Physicians who perform mammograms in their office are asked to bill a global fee. The office will be responsible for any reading or interpretation fees associated with the mammogram.

Contraceptive Management

- Norplant removal
- Depo-Provera (per 150 me. Injection)
- IUD insertion
- IUD removal
- IUD contraceptive device

- Fitting of diaphragm/cap

Obstetrics Care

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

- Comprehensive first visit
- All visits related to obstetrical care
- Non-stress test (times two (2))*
- Ultrasound
- Lab work will be capitated
- Delivery: Vaginal or C-section
- Postpartum care (up to eight (8) weeks)

*Maternity non-stress tests in excess of two per pregnancy per patient are not eligible for separate reimbursement unless such service is related to a problem-oriented diagnosis.

High Risk Obstetrics Cases

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

Miscarriage and Early Fetal Demise

- Will be reimbursed as fee-for-service

Past Twenty (20) Weeks

- Global fee will be paid

Referral and Preauthorization

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

Group Specific Benefits

Verify Member benefits to determine if there are group-specific benefits for the employer group.

Emergency services

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

File Claims for Members

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

Covering Physician(s)

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

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

Missed Physician Appointments

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

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

Member Copayment

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

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

Group benefits may supersede the copayment allocation. Verify Anthem Member eligibility and benefits to determine the appropriate collection of the Member's copayment.

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

PCP Reimbursement

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

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

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

Effective Date of Enrollment	Reimbursement
1st through 15th	Full capitation for month
16th through 31st	No capitation for first month

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

Effective Date of Termination	Reimbursement
1st through 15th	No capitation for final month
16th through 31st	Full capitation for month

Encounter Reporting

All services provided to Anthem Members must be reported in the standard HIPAA compliant Claim format using HIPAA-compliant code sets on the CMS-1500 Claim form or the equivalent, within the filing standards timeframe, and with applicable charges noted. This is necessary for reporting of

utilization data and HEDIS purposes. The Claim system will identify CPT codes eligible for fee-for-service payment and will approve those services when appropriate.

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

Discontinuing Acceptance of New Patients

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

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

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

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

Send the written notice about closing or reopening a physician practice to the **Provider Relationship Account Management team**.

Changes to Practice

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

Changing participation status – PCPs who wish to withdraw from the network must notify Anthem in writing one hundred eighty (180) calendar days before the cancellation of the contract. The one hundred eighty (180) day period will begin on the date Anthem receives the written notice. Changes involving adding or discontinuing physicians from a practice, or changing participation status must be sent in writing to the local Provider representative.

Members and Enrollment

Enrollment Procedures

New BlueChoice Members must select a PCP from the panel of Providers. PCPs are physicians who practice internal medicine, general practice, family practice, or pediatrics. Members must complete enrollment forms for themselves and all dependents. Each Member covered by the contract may

choose a different PCP within the network. Anthem will notify the physician of his or her selection as a Member's PCP. Members may change PCPs by logging on to Anthem's website **anthem.com** or by calling Anthem customer service. PCP changes requested by the 25th of the month are effective the first day of the following month.

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

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

Family Practice	No restriction/will see patients of any age
Internal Medicine	Fifteen (15) years and older
Pediatrician	Newborn through age twenty (20) years

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

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

Member Identification and Eligibility

Each Member has an ID card that shows the Member's contract number and basic coverage information, including office visit copayment. We urge physicians to keep a copy of the Member's ID card in the patient's office file and to verify Members and eligibility periodically.
Presenting a Member ID card does not guarantee eligibility, since Members may cancel their coverage at any time. Eligibility for benefits is determined by the Member's coverage status at the time of service.

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

The office visit copay amount is listed on the front of the Member ID card. Copayments may vary depending on the Member's Health Benefit Plan. Members should pay the indicated amount for each office visit.

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

Glossary

65PLUS:

65PLUS* offers Medicare beneficiaries a choice of five of the federally approved Medicare supplement plans: Plans A, B, C, E, and F. Because Medicare only pays a portion of hospital and physician charges, these supplements provide certain benefits otherwise unavailable from Medicare.

**65PLUS is underwritten by Blue Cross Blue Shield Healthcare Plan of Georgia, Inc., an independent licensee of the Blue Cross Blue Shield Association.*

Accreditation:

Certification that an organization meets the reviewing organization's standards. Examples: accreditation of HMOs by the National Committee for Quality Assurance (NCQA) or accreditation of PPOs by URAC.

Affiliate(s):

Any entity owned or controlled, either directly or through a parent or subsidiary entity, by Anthem, or any entity under common control with Anthem and that accesses the rates, terms, or conditions of the Agreement. Anthem will have a current listing of such Affiliates available through a commonly available website or upon request.

American Accreditation HealthCare Commission, Inc./Utilization Review Accreditation Commission, Inc. (AAHCC/URAC):

An independent, not-for-profit corporation established in 1990 by organizations representing the managed health care industry, healthcare Providers, consumers, and regulators to encourage more efficient and effective managed care.

Ancillary:

A term used to describe additional services performed related to care, such as lab work, x-ray, and anesthesia.

Appeals:

Refers to a formal written request (from a practitioner/Provider) for reconsideration of a decision previously made by Anthem during the complaint process (e.g., benefit payment, administrative actions, etc.).

Anthem Rate:

The lesser of Facility's charges for Covered Services, unless otherwise defined, or the total reimbursement amount that Facility and Anthem have agreed upon as specified in the Plan Compensation Schedule (PSC) for the network designated by Anthem or Other Payors for the Member. The Anthem Rate shall represent payment in full to the Facility for Covered Services.

Assistant Surgeon:

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

Benefit:

The amount payable by an insurer or employee benefit plan to a Claimant, assignee, or beneficiary under the terms of the Health Benefit Plan.

Benefits Package:

A term informally used to refer to the employer's benefit plan or to the benefit plan options from which the employee can choose. "Benefits package" highlights the fact a health benefits plan is a compilation of specific benefits.

BlueChoice PPO:

BlueChoice PPO is a preferred Provider organization (PPO) that offers Members the flexibility of going in or out-of-network for medical care. If Members see a physician, specialist or hospital that is in-network (a preferred Provider), they receive more savings and benefits.

BlueChoice PPO is underwritten by Blue Cross Blue Shield Healthcare Plan of Georgia, Inc., an independent licensee of the Blue Cross and Blue Shield Association.

Board Certified (Boarded, Diplomat)

Describes a physician who has passed a written and oral examination given by a medical specialty board and who has been certified as a specialist in that area.

Case Management:

A method of coordinating and facilitating services and benefits Members receive to ensure they seek and receive appropriate and necessary care to minimize duplication of services, tests and costs and to maximize benefits available under their Member Agreement.

Case Rate:

The all-inclusive Anthem Rate for an entire admission or one outpatient encounter. "Global Case Rate" means the all-inclusive Anthem Rate, which includes institutional, professional, and physician services for specific Coded Service Identifier(s).

Certificate Booklet:

A detailed document that serves both as an explanation of the benefit plan and as the certificate of insurance. See certificate of coverage.

Certificate of Coverage:

A description of the benefits included in an insurance plan. The certificate of coverage is required by state insurance laws and represents the coverage provided under the policy issued to the contract holder. The certificate is provided to subscribers via the Certificate Booklet.

Chargemaster or Charges:

Facility's listing of Facility Charges for products, services, and supplies.

Claim:

Either the uniform bill Claim form or electronic Claim form in the format prescribed by Plan submitted by a Facility for payment by a Plan for Health Services rendered to a Member. "Complete Claim" means, unless state law otherwise requires, an accurate Claim submitted pursuant to the Agreement,

for which all information necessary to process such Claim and make a benefit determination is included.

Coded Service Identifier(s):

A listing of descriptive terms and identifying codes, updated from time to time by the Centers for Medicare and Medicaid Services (CMS) or other industry source, for reporting Health Services on the UB-04 or its successor. The codes include but are not limited to CPT-4, HCPCS, ICD-9 or successor codes, National Drug Code (NDC), and Revenue Codes, or their successors.

Concurrent Review:

A component of the Utilization Management program that evaluates a Member's coverage for Facility services under the terms of the contract.

Contract:

A binding written Agreement between the insurer and policyholder to evidence the terms and conditions of the policy. The contract between Blue Cross Blue Shield Healthcare Plan of Georgia and an insured includes the certificate booklet.

Coordination of Benefits (COB):

A provision in a contract that applies when a person is covered under more than one group medical program. It requires that payment of benefits will be coordinated by all programs to eliminate overpayment by insurance or duplication of benefits.

Cost Share:

With respect to Covered Services, an amount that a Member is required to pay under the terms of the applicable Health Benefit Plan. Such payment may be referred to as an allowance, coinsurance, copayment, deductible, penalty, or other Member payment responsibility, and may be a fixed amount or a percentage of the applicable payment for Covered Services rendered to the Member.

Member:

Any individual who is eligible, as determined by the Plan, to receive Covered Services under a Health Benefit Plan. For all purposes related to the Agreement, including all schedules, attachments, exhibits, manual(s), notices and communications related to the Agreement, the term "Member" may be used interchangeably with the terms Insured, Covered Person, Member, Enrollee, Subscriber, Dependent Spouse/Domestic Partner, Child or Contract Holder, and the meaning of each is synonymous with any such other.

Member ID Card:

An identification card issued by PLAN or an Affiliate, which identifies an individual as a Covered Person. (The Member Card is for identification purposes only and may not be used as verification of eligibility.)

Covered Services:

Medically Necessary Health Services, as determined by Plan and described in the applicable Health Benefit Plan, for which a Member is eligible.

Credentialing:

The process of reviewing a Provider's credentials, i.e., training, experience, or demonstrated ability, for the purpose of determining if criteria for inclusion in a Network are met. Anthem screens all physicians in its Networks. Each physician must meet specific educational and medical practice standards in order to become part of the Network.

Deductible:

The amount of covered expenses that must be incurred and paid by each Member before benefits become payable by the insurer. For example, if a plan has a $100 deductible, the deductible is met once the first $100 of the covered medical expenses for that year have been paid. After that, the plan begins to pay toward the cost of covered healthcare services.

Dependent:

A covered person's spouse (not legally separated from the insured) and unmarried child(ren) who meet eligibility requirements.

Discharge Planning:

Component of the Utilization Management program which evaluates a Member's coverage under the terms of the Member's contract for healthcare services after discharge from an inpatient setting.

DRG:

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

Drug Formulary:

A listing of prescription medications that are approved for coverage by the plan. The list is subject to periodic review and modification by the health plan.

Eligibility:

The provisions of the group policy or insurance contract that state the requirements that applicants must satisfy to become insured with respect to themselves or their dependents.

Emergency Condition:

A condition of recent onset and sufficient severity, including but not limited to severe pain, that would lead a prudent layperson possessing average knowledge of medicine and health, to believe that his or her condition, sickness or injury is of such a nature that failure to obtain immediate medical care could result in: (1) placing the Member's health in serious jeopardy; (2) serious impairment to bodily functions; (3) serious dysfunction to any bodily organ or part; or (4) other serious medical consequences.

Employer Group

A group of eligible employees to whom healthcare benefits are extended through a health benefits plan Provider. The relationship is formalized through a contract. For the employer group to be recognized, a true employee-employer relationship must exist. Examples of groups that would not qualify include social clubs and independent contractors.

Exclusions:

Specific conditions or circumstances listed in the Health Benefit Plan for which the policy or plan will not provide benefit payments.

Facility-Based Physician:

Any physician, with the exception of residents, interns, and fellows, who has a contractual relationship with a Facility to provide professional services. These services may be of two types: (1) administrative, managerial, teaching, or quality control activities compensated from or through a Facility which are furnished to a Facility or its general population; or (2) physician services personally rendered to a Member while in a Facility which directly contribute to the diagnosis or treatment of a Member and which ordinarily require performance by a physician, including, an emergency room physician, radiologist, pathologist, and anesthesiologist, and any other physicians contracting with hospitals specified by Anthem, at any time, or from time to time; provided, however, that this term shall not include PCPs or Specialty Care Physicians employed by a Facility who have a separate contractual Agreement with Anthem.

Federal Employee Health Benefit Program (FEHBP):

The “Federal Employee Health Benefit Program” is a group contract to provide health care benefits to federal employees, underwritten by Blue Cross and Blue Shield Plans. The official name of the program is the Government-Wide Service Benefit Plan.

Fee-for-Service Reimbursement:

A method of reimbursement by which a Provider charges, and is reimbursed, separately for each patient encounter or service rendered.

Fee Schedule Rate:

The Anthem Rate payable to the Facility based on a specific Coded Service Identifier(s), as set forth in the applicable fee schedule(s).

Group Health Coverage:

A health benefits plan that covers a group of people as permitted by state and federal law.

Guest Member:

Members of an Affiliate of Anthem receiving services in a Service Area. Guest Member(s) will be treated as Anthem Members while present in a Service Area.

Health Benefit Plan:

The document(s) describing the partially or wholly: (1) insured, (2) underwritten, and/or (3) administered, marketed healthcare benefits, or services program between the Plan and an employer, governmental entity, or other entity or individual.

Health Service:

Those services or supplies that a healthcare Facility is licensed, equipped, and staffed to provide and which it customarily provides to or arranges for individuals.

HEDIS (Health Plan and Employer Data Information Set):

HEDIS is a standard set of more than 100 indicators developed to assist purchasers/employers in evaluating health plans. HEDIS has become a standard of measurement for the Centers for Medicare

and Medicaid Services (CMS), for some state insurance departments, and for many large companies. HEDIS has also become a component of the NCQA accreditation process.

Home Health Agency:

A Facility or program licensed, certified, or otherwise authorized pursuant to state and federal laws to provide home health care services.

Hospice:

A Facility or program licensed or certified under law to provide palliative and supportive care for the terminally ill.

Indemnity:

Indemnity or “traditional” insurance is a plan that reimburses physicians for covered charges for services performed or insures for medical expenses incurred.

In-Network:

In-network means seeing a Provider that has contracted with Anthem to participate in the network of physicians and hospitals.

Inpatient Services:

Covered Services provided by Facility to a Member who is admitted and treated as a registered inpatient, is assigned a licensed bed within the Facility, remains assigned to such bed, and for whom a room and board charge is made.

Length of Stay (LOS):

The number of days that a Member stayed in an inpatient Facility.

Managed Care:

A health plan or insurance program in which beneficiaries receive medical services in a coordinated manner to eliminate unnecessary medical services. In managed care health plans, the Member seeks specialist or hospital care after prior approval of coverage by designated health care professionals, such as PCPs, utilization review nurses, or employer-designated professionals. The primary goal is to deliver cost-effective healthcare without sacrificing quality or access.

Medically Necessary or Medical Necessity:

Covered Services or supplies provided by a Facility, physician, or other Provider to identify or treat an illness or injury and which, as determined by Plan, are: 1) appropriate and consistent with the diagnosis and the omission of which could adversely affect or fail to improve the patient’s condition; 2) compatible with the standards of acceptable medical practice in the United States; 3) not provided solely for the Member’s convenience or the convenience of the physician, health care Provider or Facility; 4) not primarily custodial care; and 5) provided in a safe and appropriate setting given the nature of the diagnosis and the severity of the symptoms.

Medicare:

Title XVIII of the Social Security Act, which provides payment for medical and health services to the population aged 65 and over, regardless of income, as well as certain disabled persons and persons with ESRD.

Member ID Card:

A card given to each Member by Anthem, which introduces the Member to physicians and hospitals. Although the cards do not guarantee eligibility for medical care benefits at any given time, they increase the convenience of obtaining health insurance services.

NCQA:

The National Committee for Quality Assurance is an independent, not-for-profit entity that works closely with the managed care industry, health care purchasers, researchers, and consumers to develop standards for accreditation to determine whether a managed care organization is founded and practicing principles of quality and is continuously working to improve the services it provides. Typically, NCQA auditors use these standards to evaluate managed care organizations with regard to quality management and improvement, utilization management, credentialing, Member rights and responsibilities, preventive health services, and medical records.

Network:

A group of Providers that support, through a direct or indirect contractual relationship, some or all of the product(s) and/or program(s) in which Members are enrolled.

Non-Participating Provider(s):

A non-participating Provider is a physician, Facility, or other medical Provider that has not entered into an Agreement with Anthem to provide health care services to Members.

Observation:

The services furnished by a Provider on the Facility's premises, regardless of the length of stay, including use of a bed and periodic monitoring by nursing or other staff, which are reasonable and necessary after surgery or to evaluate an outpatient condition and determine the need for a possible admission to the Facility as an inpatient.

Open Enrollment:

A period when eligible persons can enroll in a health benefits plan.

Other Payors:

Persons or entities, utilizing the Networks/Plan Programs pursuant to an Agreement with Anthem or an Affiliate, including, without limitation, other Blue Cross and/or Blue Shield Plans that are not Affiliates, self-administered or self-insured programs providing Health Benefit Plans, or employers or insurers.

Outpatient Services:

Covered Services other than Inpatient Services, which are provided to a Member by the Facility.

Out-of-Pocket:

Those medical expenses that an insured is required to pay because they are not covered under the group contract.

Participation Attachment:

The document(s) attached to, or made a part of the Agreement, which identify the additional duties and obligations related to Network(s) and/or Plan Programs.

Patient Day:

Each approved calendar day of care that a Member receives in the Facility, to the extent such day of care is a Covered Service under the terms of the Member's Health Benefit Plan, but excluding the day of discharge.

Per Diem Rate:

The Anthem Rate is expressed as an all-inclusive fixed payment for each Patient Day of admission or one outpatient encounter.

Physician's Current Procedural Terminology (CPT):

A list of medical services and procedures performed by physicians and other Providers. Each service and/or procedure is identified by its own unique 5-digit code. CPT has become the health care industry's standard for reporting physician procedures and services, thereby providing an effective method of nationwide communication.

Plan:

Refers to (1) Anthem; (2) an Affiliate as designated by Anthem; and/or (3) Other Payor.

Plan Compensation Schedule (PCS):

The document(s) attached to, or made a part of, the Agreement, which set forth the Anthem Rate(s) for the Network(s) in which the Facility participates.

Plan Program:

Any program now or hereafter established, marketed, administered, sold, or sponsored by Plan, or Blue Cross Blue Shield Association (BCBSA) (and includes the Health Benefit Plans that access, or are issued, or entered into in connection with such program). Plan Program shall include, but is not limited to, a health maintenance organization, a preferred Provider organization, a point of service product or program, an exclusive Provider organization, an indemnity product and program, and a quality program(s). The term Plan Program shall not include any program excluded by the Plan or BCBSA.

Point-of-Service:

A managed care product that offers the advantages of an HMO with the flexibility of a traditional health insurance plan. Members decide where to receive care when they need it at the point-of-service.

Pre-admission Review:

A component of a Utilization Management program that reviews an inpatient Facility stay prospectively to determine coverage.

Preauthorization:

A prospective process to verify coverage of proposed care, to establish the covered length of stay, and to set a date for concurrent review.

Preferred Provider Organization (PPO):

A Network of facilities and physicians who agree to participate in a PPO Network. Members of this type of product may incur higher out-of-pocket expenses for covered services received outside the PPO.

Protected Health Information (PHI):

Individually identifiable health information transmitted or maintained in any form or medium (including orally, electronically, or on paper).

Primary Care Physician (PCP):

A primary care physician is a physician who is a family or general practitioner, internist, or pediatrician. PCPs provide a broad range of routine medical services and refer Members to specialists, facilities, and other Providers as necessary. Each covered family Member who participates in BlueChoice HMO or BlueChoice POS chooses his or her own PCP from the Network's physicians.

Specialists:

Providers whose practices are limited to treating a specific disease (e.g., oncologists), specific parts of the body (e.g., ear, nose, and throat), or specific procedures (e.g., oral surgery).

Surgical Assistant:

A technically skilled professional (not required to be an MD) who may assist during a surgical procedure. Until or unless state law requires otherwise, Surgical Assistants are not a covered provider type.

URAC:

An independent, not-for-profit corporation established in 1990 by organizations representing the managed health care industry, health care Providers, consumers, and regulators to promote continuous improvement in the quality and efficiency of healthcare management through processes of accreditation and education.

Utilization Management:

The process of evaluating a proposed hospitalization, service, or procedure and determining whether the hospitalization, service, or procedure meets established guidelines and criteria to be covered under a Member's contract.

Wellness Programs:

A broad range of employer-sponsored facilities and activities designed to promote safety and good health among employees. Its purpose is to reduce the costs of accidents, sickness, absenteeism, lower productivity, and healthcare costs.

Exhibit

NOTICE OF POTENTIAL LIABILITY FORM

NOTICE OF POTENTIAL LIABILITY

Patient Name _____

Address _____

ID/Contract # _____

Group # _____ Date of Service _____/_____/_____

Based on the information available at this time, _____ (Provider or Facility) and have determined that the following will not be reimbursed by Anthem under the Member's Membership Agreement.

_____ Inpatient Admission for _____/_____/_____

_____ Additional Inpatient Treatment after _____/_____/_____

_____ Other Hospital or Outpatient services _____/_____/_____

Estimated cost of services: _____

Expenses incurred for the above treatment(s) will be the responsibility of the Member/patient.

Should the Member or attending physician disagree with this decision, the Member or the attending physician should refer the matter to the Utilization Management Division of Anthem.

ACKNOWLEDGEMENTS:

_____
Member Signature

_____
Member Printed Name

_____
Date

_____
Hospital Representative Signature

_____
Hospital Representative Printed Name

_____
Hospital Representative Title

_____
Date